

August 15 2018 Regular Meeting

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DRAFT AGENDA

NORTHERN INYO HEALTHCARE DISTRICT BOARD OF DIRECTORS REGULAR MEETING

**August 15, 2018 at 5:30 p.m.
2957 Birch Street, Bishop, CA**

1. Call to Order (at 5:30 pm).
2. At this time persons in the audience may speak on any items not on the agenda on any matter within the jurisdiction of the District Board (*Members of the audience will have an opportunity to address the Board on every item on the agenda. Speakers are limited to a maximum of three minutes each.*).
3. Adjournment to closed session for:
 - A. Discussion of Labor Negotiations; Agency Designated Representative: Irma Rodriguez Moisa, Employee Organization: AFSCME Council 57 (*pursuant to Government Code Section 54957.6*).
4. Return to open session and report of any action taken.
5. New Business
 - A. Workforce Experience Committee report (*information item*).
 - B. Compliance Department Quarterly report (*action item*).
 - C. Policy and Procedure Approval, *ICU Acutities* (*action item*).
 - D. Policy and Procedure Approval, *Safe Patient Handling – Minimal Lift Program* (*action item*).
 - E. Policy and Procedure Approval, *Acute/Subacute Care Services Method of Practice: Patient Coordinated Care* (*action item*).
 - F. Language Access Services Strategic Plan (*action item*).
 - G. Policy and Procedure approval, *Establishment of Statistically Valid Sample Sized for Business and Quality Process Analysis and Improvement* (*action item*).
 - H. Quarterly report, Financial and Statistical reports as of June 30, 2018 (*action item*).
 - I. Approval of Work Flow for Appointments to Fill NIHD Board vacancies (*action item*).
 - J. Board of Directors Policy and Procedure approval, *Suggested Guidance to Fill a Board Vacancy By Appointment* (*action item*).

Consent Agenda

6. Approval of minutes of the June 28 2018 special meeting

7. Approval of minutes of the July 18 2018 regular meeting
8. 2013 CMS Survey Validation Monitoring, August 2018
9. Policy and Procedure annual approvals

10. Chief of Staff Report; Allison Robinson, MD:

A. Policies/Procedures/Protocols/Order Sets (*action items*):

1. *Abuse Policy for Swing Bed Patients*
2. *Cepheid Xpert CT/NG PCR Assay*
3. *Coroner's Cases*
4. *Delayed Blood Bank Banding of Patients*
5. *Emergency Department Telephone Advice Information*
6. *Emergency Order and Shipment of Blood Components from UBS*
7. *Malignant Hypothermia Cart Check*
8. *Newborn Blood Glucose Monitoring*
9. *Scope of Service ICU*
10. *Sexual Assault Exam Policy*
11. *Surveillance for Hospital Acquired Infections (HAI's)*

B. Medical Staff Resignations (*action items*):

1. Ryan Berecky, MD (*Tahoe Carson Radiology*) – effective July 11, 2018
2. Nicholas Carlevato, MD (*Tahoe Carson Radiology*) – effective July 11, 2018

C. Medical Staff Appointments/Privileges (*action item*)

1. Kevin M. Deitel, MD (*orthopedic surgery*) – Provisional Consulting Staff, on-call only

11. Reports from Board members (*information items*).

12. Adjournment to closed session to/for:

- A. Discuss trade secrets, new programs and services (estimated public session date for discussion yet to be determined) (*Health and Safety Code Section 32106*).
- B. Confer with Legal Counsel regarding pending and threatened litigation, existing litigation and significant exposure to litigation, 2 matters pending (*pursuant to Government Code Section 54956.9*).
- C. Discussion of a personnel matter (*pursuant to Government Code Section 54957*).

13. Return to open session and report of any action taken in closed session.

14. Adjournment.

In compliance with the Americans with Disabilities Act, if you require special accommodations to participate in a District Board meeting, please contact administration at (760) 873-2838 at least 48 hours prior to the meeting.



Northern Inyo Healthcare District

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Bishop, CA 93514
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Compliance Report August 2018

1. Comprehensive Compliance Program review
 - a. As of July 27, 2018, 67% of the District's employee workforce have reviewed the Compliance Program.
 - b. The Compliance Department has been following up individually with employee workforce members who have not read the assigned Compliance Program, since it is mandatory.
2. Breaches
 - a. Calendar Year (CY) 2018 – (attachment A)
 - i. 44 alleged breaches of PHI (Personal Health Information) potentially affecting 119 patients have been investigated by the Compliance Office
 - ii. 19 of the alleged breaches of PHI have been reported to California Department of Public Health (CDPH) and the Office of Civil Rights (OCR)
 1. CDPH has completed investigation of 13 cases. All 13 breaches were substantiated, but assigned no deficiency.
 2. Six (6) cases are still pending CDPH investigation.
3. Issues and Inquiries
 - a. CY 2018 – More than 200 requests for research and input on a wide variety of topics have been made to the Compliance Department
 - b. Compliance currently reviews all new referring physicians to verify they are not on a Federal or State exclusions list. To date in 2018, Compliance has verified over 200 providers. Conducting business with anyone on an exclusions list places NIHD at risk. It is considered fraud to bill any government payer for diagnostic or treatment claims, if ordered by an excluded provider.
4. The Compliance Department has conducted over 20 investigations related to compliance concerns that are not breaches.
5. Audits
 - a. Employee Access Audits (attachment B) - The Compliance Office manually completes audits for access of patient information systems to ensure that employees access records only on a work-related, "need to know," and "minimum necessary" basis.

- i. The HIPAA and HITECH Acts imply that organizations must perform due diligence by actively auditing and monitoring for appropriate use of PHI. These audits are also required by the Joint Commission and are a component of the “Meaningful Use” requirements.
 - ii. Access audits monitor who is accessing records by audit trails created in the systems. These audits allow us to detect unusual or unauthorized access of patient medical records.
 - iii. Compliance performs between 300-500 audits monthly.
 1. Each audit ranges from hundreds of lines of data to hundreds of thousands of lines of data.
 - iv. Protenus has been selected to provide semi-automated auditing software services to NIHD beginning shortly after we go live with Athena and partners.
 - b. Business Associates Agreements audit
 - i. Contracts are currently under review to ensure all vendors, individuals, and entities providing services that access, disclose, retain, or transmit PHI for NIHD have an up-to-date Business Associates Agreement.
 - ii. We currently have around 100 Business Associates Agreements.
 - c. Transfer agreement audit
 - i. Audit of 29 patient transfer agreements for effective date, patient type, and expiration date.
 - d. 340B – monitoring to ensure only processing approved providers and locations
 - e. HIPAA Security Risk Assessment
 - i. Annual requirement to assess security and privacy risk areas as defined in 45 CFR 164.3. Review of 157 privacy and security elements performed in conjunction with Information Technology Services.
6. Conflicts of Interest questionnaires
 - a. Compliance has processed more than 610 Conflict of interest disclosure forms since January 1, 2018.
 - b. The Management Plan form has been re-designed to simplify the process for our leadership team. We have management plans in place for 83% of the workforce for which they are needed. We are working with leadership teams to develop and review the plans for the remaining 2 employees.
7. CPRA Requests
 - a. The Compliance office has prepared documents for 2 CPRA request in CY 2018.



Northern Inyo Healthcare District

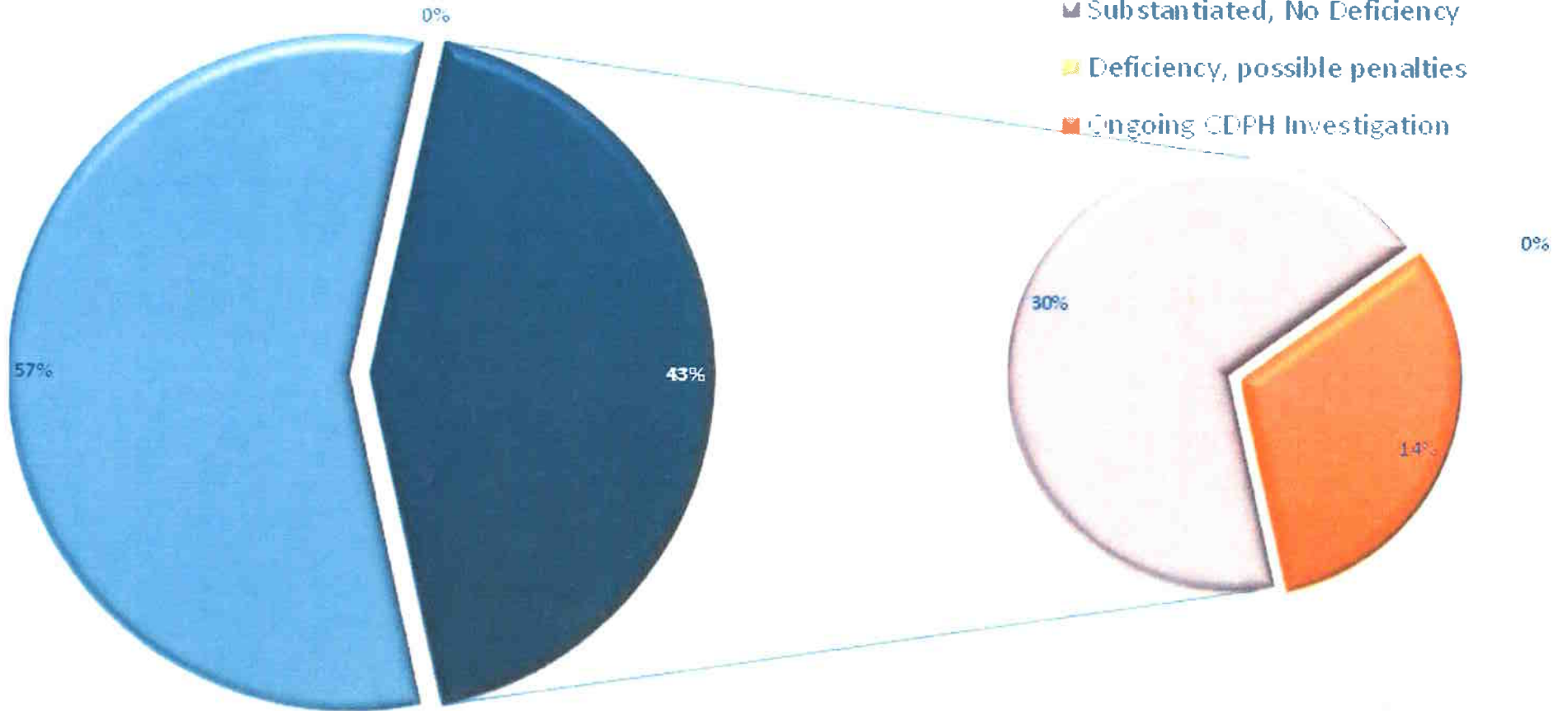
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- b. This is a significant reduction in public records requests from the past several years.
- 8. Compliance Workplan (attachment C)
 - a. The Department of Health and Human Services Office of Inspector General's (OIG) creates an annual workplan for auditing, based on areas of high concern for fraud, waste, and abuse. The Centers for Medicare/Medicaid Services Medicare Administrative contractors (MACs) also create an annual audit workplan.
 - b. OIG recommends that annual Compliance Department workplans are created, based on the facility Compliance Program, and the OIG and MAC workplans, along with areas of risk for the organization.
 - c. The attached workplan was approved by the Compliance and Business Ethics Committee in its April 2018 meeting, and updated for progress.
- 9. Quality Review Reports
 - a. Reviewing all QRRs to assess processing
 - b. More frequent data trending, providing results to leadership teams to resolve repetitive, high risk, or high occurrence issues quickly
 - c. Reviewing project for tracking software – would allow combination of QRRs, complaints, breaches, and investigations to be tracked and followed in the same system, using same tools, allowing crossover evaluation and trending

2018 Breach Outcomes

44 Breach investigations potentially affecting 119 patients

- Near-miss breach (no CDPH reporting)
- Reported to CDPH
- Unsubstantiated
- Substantiated, No Deficiency
- Deficiency, possible penalties
- Ongoing CDPH Investigation

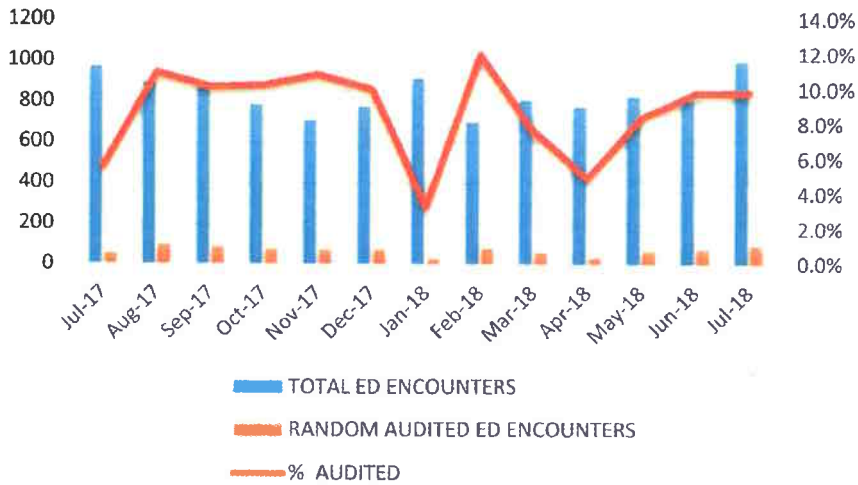


July 27, 2018

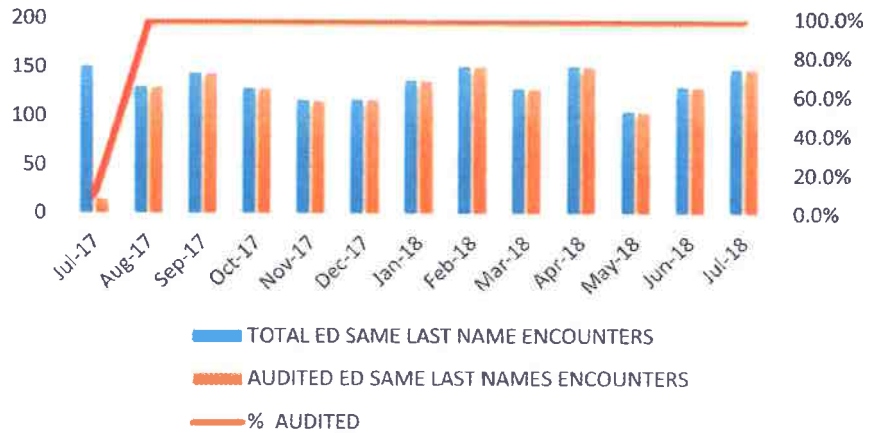
Employee EHR Access Audits

Emergency Room Encounters

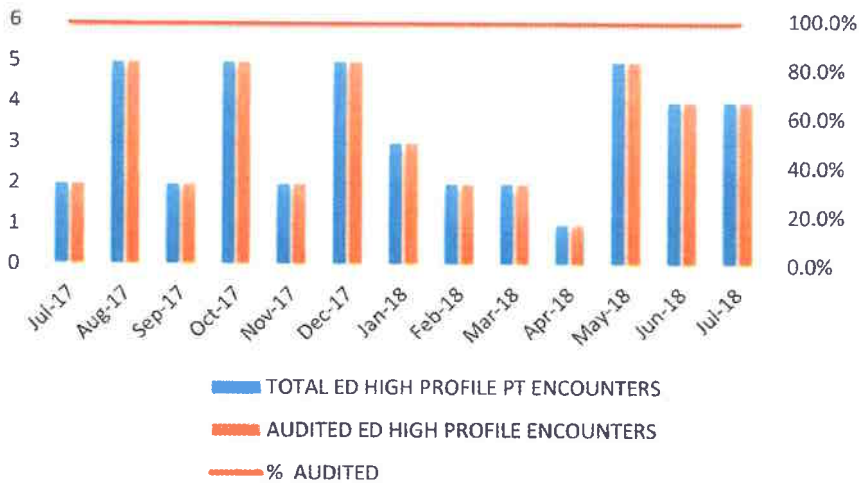
Random ED Encounter Audits



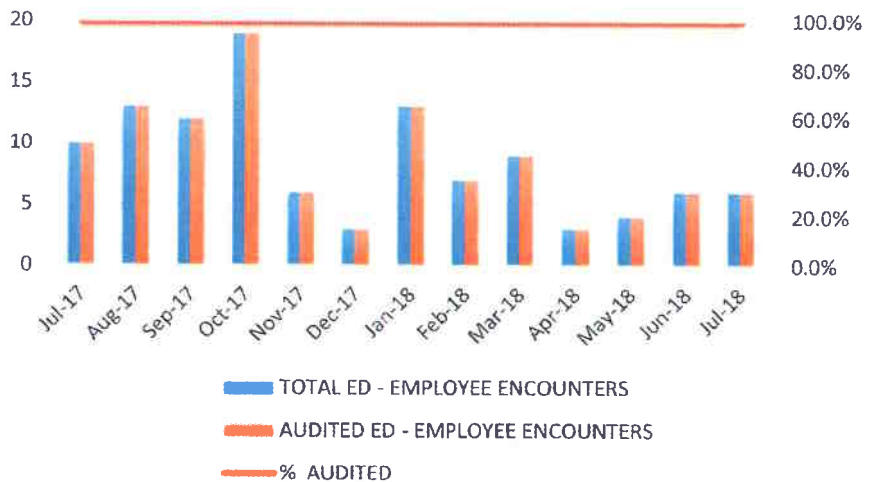
ED Patient with the same last name as an employee



HPP ED Encounters

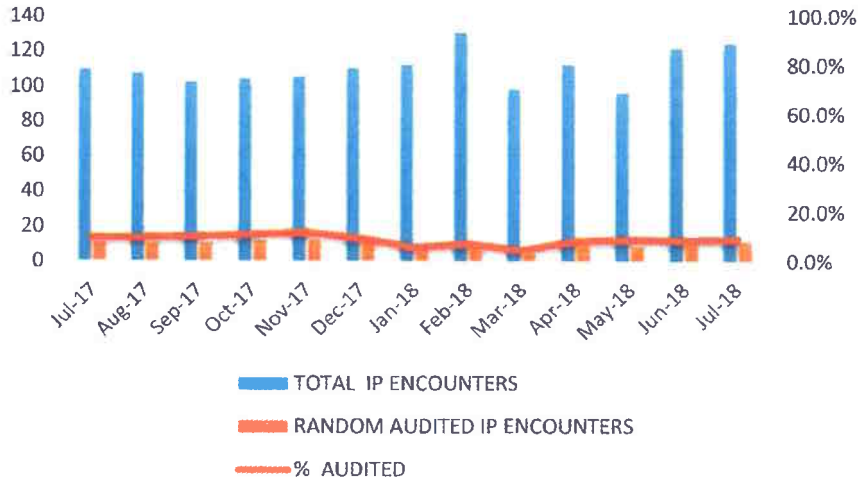


Employee ED Encounters

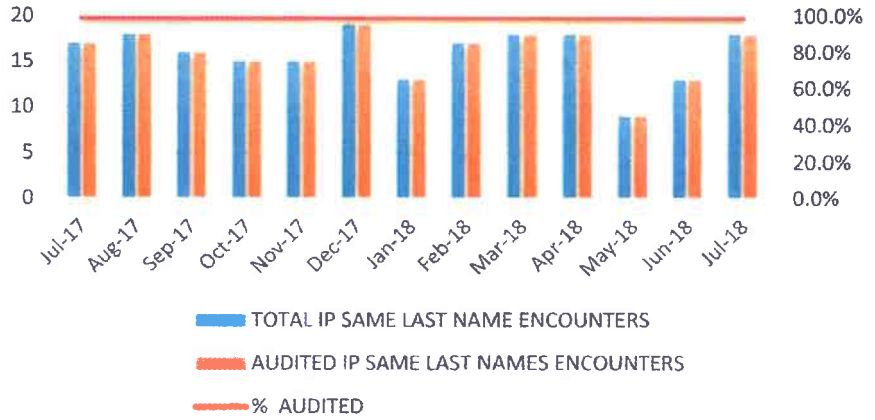


Employee EHR Access Audits Inpatient Encounters

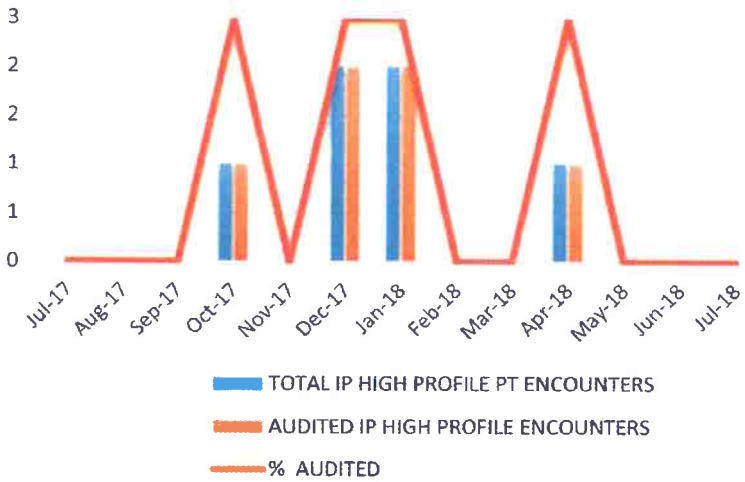
Random IP encounter Audits



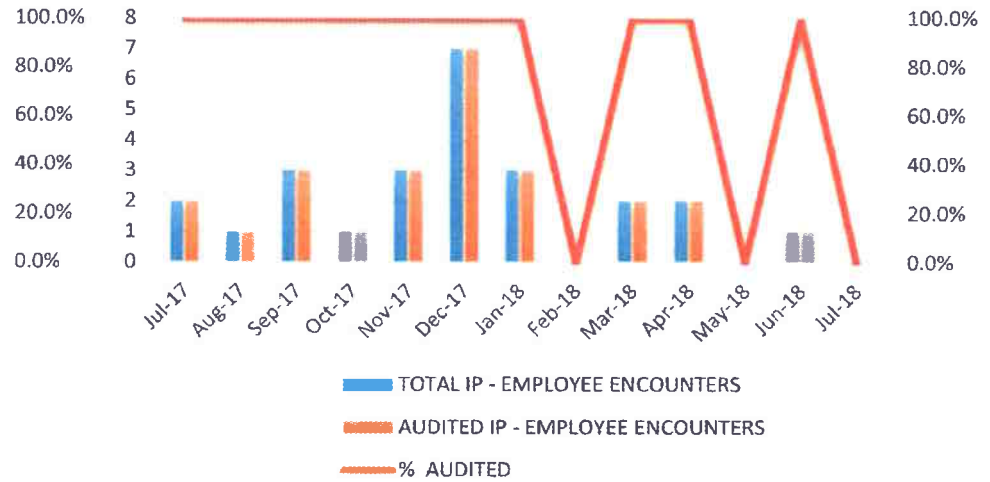
Inpatient with the same last name as an employee



HPP IP Encounters

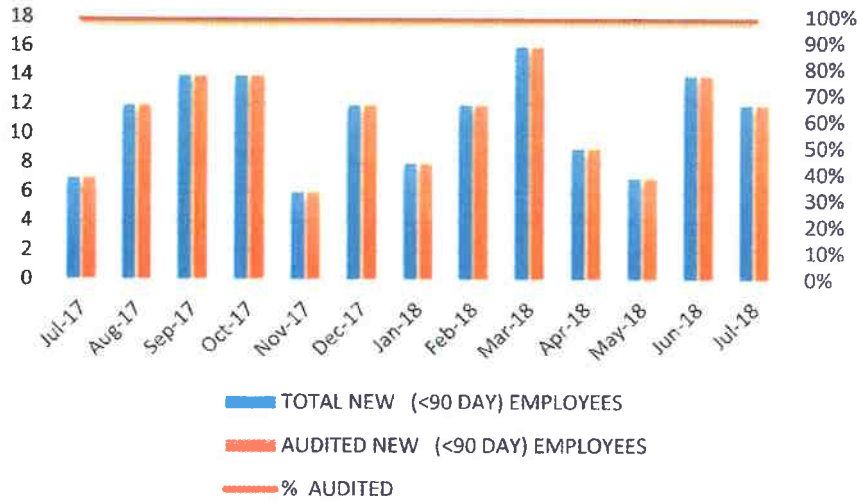


Employee IP Encounters

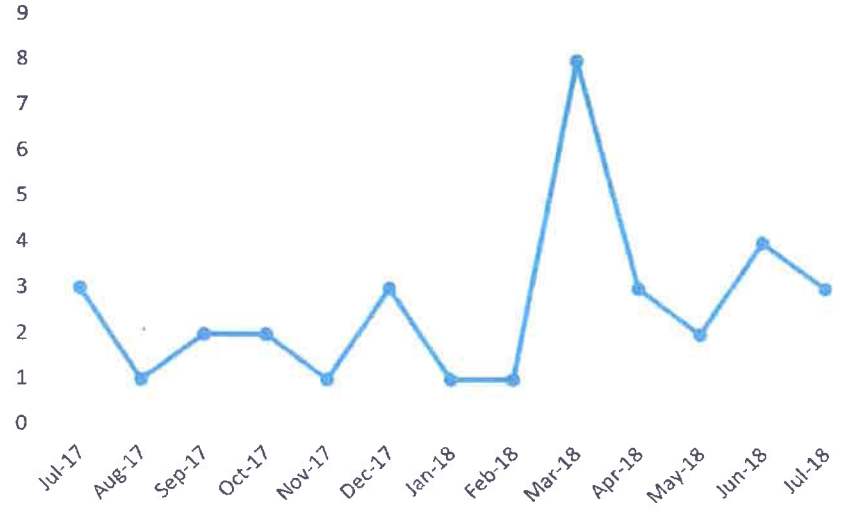


Employee EHR Access Audits

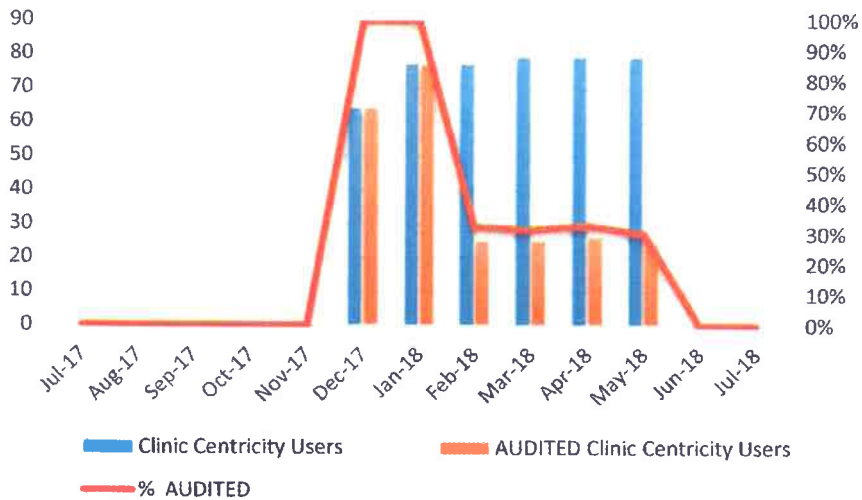
New Employee



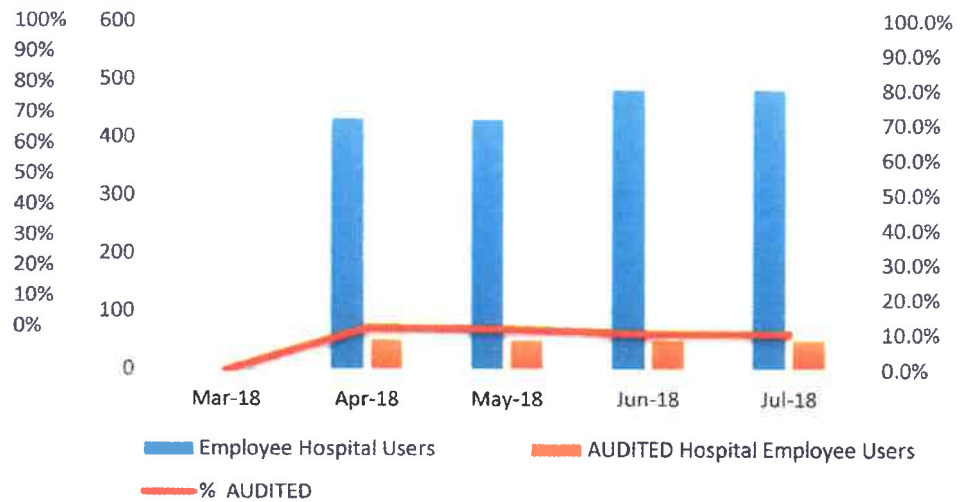
FOR-CAUSE AUDITS



Clinic EHR Users

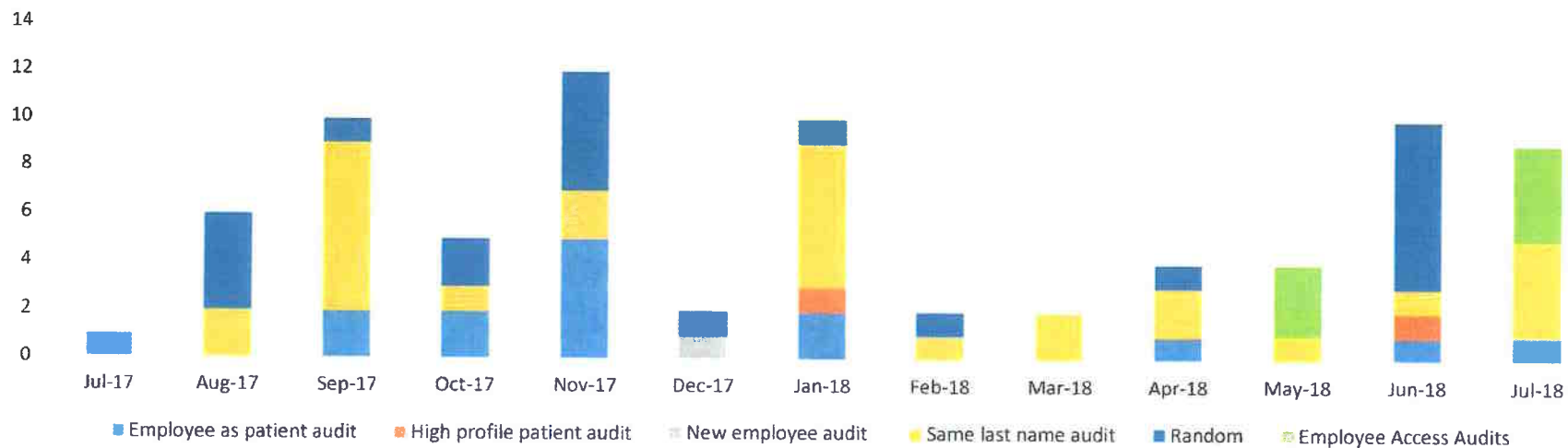


District EHR Users

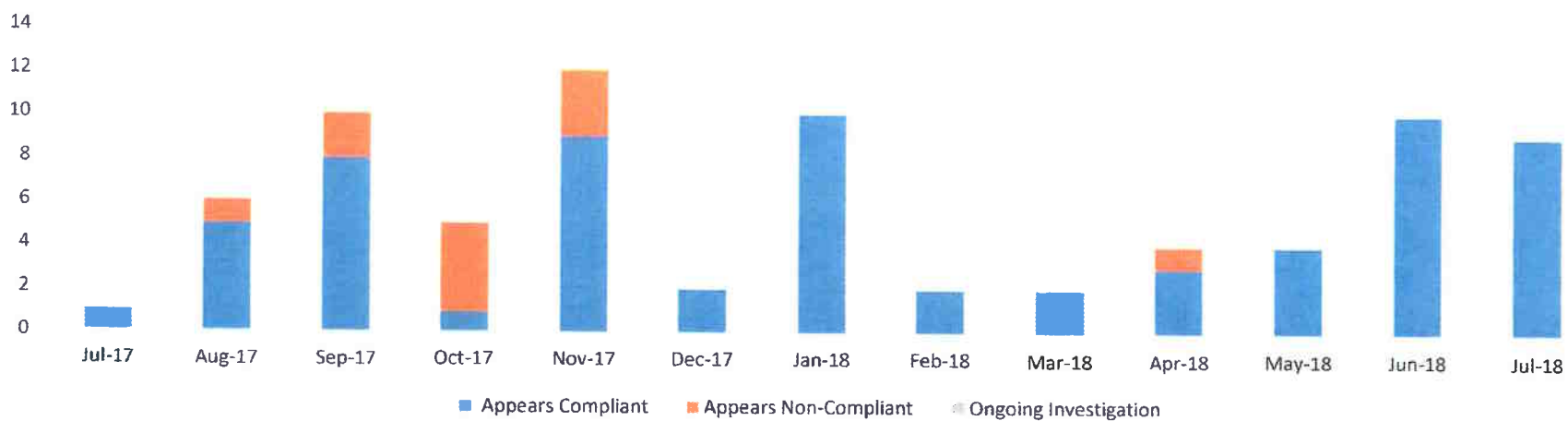


Employee EHR Access Audits

"FLAGS" - Audits requiring further investigation



"FLAGS" Outcomes



2018 Compliance Work Plan

No.	Item	Reference	Comments
Compliance Oversight and Management			
1.	Review and update charters and policies related to the duties and responsibilities of the Compliance Committees.	NIHD Compliance Program (p.17)	7/30/2018 - in progress
2.	Develop and deliver the annual briefing and training for the Board on changes in the regulatory and legal environment, along with their duties and responsibilities in oversight of the Compliance Program.	NIHD Compliance Program (p.17)	
3.	Develop a Compliance Department budget to ensure sufficient staff and other resources to fully meet obligations and responsibilities.		Completed June 1, 2018
Written Compliance Guidance			
4.	Audit of required Compliance related policies.		7/30/2018 - Completed
5.	Annual review of Code of Conduct to ensure that it currently meets the needs of the organization and is consistent with current policies. (Note: Less than 12 pages, 10 grade reading level or below)		7/30/2018 - Completed
6.	Verify that the Code of Conduct has been disseminated to all new employees and workforce.		Completed 7/2018
Compliance Education and Training			
7.	Verify all workforce receive compliance training and that documentation exists to support results. Report results to Compliance Committee.		November 2018
8.	Ensure all claims processing staff receive specialized training programs on proper documentation and coding.		
9.	Review and assess role-based access for EHR and partner programs. Implement/evaluate standardized process to assign role-based access.		In progress, Role - based access team created 7/2018
10.	Compliance training programs: fraud and abuse laws, coding requirements, claim development and submission processes, general prohibitions on paying or receiving remuneration to induce referrals and other current legal standards.		
Compliance Communication			
11.	Review investigation log. Prepare summary report for Compliance Committee on types of issues reported and resolution		Quarterly 2018
12.	Develop a report that evidences prompt documenting, processing, and resolution of		

	complaints and allegations received by the Compliance Department.		
13.	Document test and review of Compliance Hotline.		Completed 7/2018
14.	Physically verify Compliance hotline posters appear prominently on employee boards in work areas.		Verified 7/2018
Compliance Enforcement and Sanction Screening			
15.	Verify that sanction screening of all employees/workforce and others engaged by NIHD against OIG List of Excluded Individuals and Entities has been performed in a timely manner, and is documented by a responsible party.		Completed 6/2018
16.	Develop a review and prepare a report regarding whether all actions relating to the enforcement of disciplinary standards are properly documented.		
	a. Arrangements with physician (database)		
	b. EMTALA		
	c. Cost reports	Wipfli	
	d. Payment patterns		
	e. Bad debt/ credit balances		
	f. OPS - Home health and DME	HHS OIG target	
	Lab services	MAC target	
	Imaging services (high cost/high usage)	MAC target	
	Rehab services	HHS OIG workplan	
18.	Ensure that high risks associated with HIPAA and HITECH Privacy and Security requirements for protecting health information undergo a compliance review.		
	a. Annual Security Risk Assessment		Security Risk Assessment due in Feb 2019
	b. Periodic update to SRA		
	c. Monthly employee access audits		Current through 7/2018
19.	Audit required signage		Clinic signage is going up (completed in RHC, Surgery Clinic, and Specialty Clinic) in 7/2018. Main lobbies of NIH are being evaluated for sign holders.
20.	Audit HIMS scanned document accuracy		
21.	Develop metrics to assess the effectiveness and progress of the Compliance Program		

22.	Implement automated access monitoring/auditing software (Protenus)		Starts October 2018
23.	Review CMS CoPs (CAH)		
Response to Detected Problems and Corrective Action			
24.	Verify that all identified issues related to potential fraud are promptly investigated and documented		
25.	Review all corrective action measures taken related to compliance to verify they have been completed and validated as being effective. Prepare a summary report for the CBEC		
26.	Conduct a review that ensures all identified overpayments are promptly reported and repaid.		

**NORTHERN INYO HOSPITAL
POLICY AND PROCEDURE**

Title: ICU Acutities ICU Acutities	Manual: ICU Structure Standards
Scope: ICU	Effective Date:
Source: Manager ICU Acute/Subacute	

Field Code Changed

Field Code Changed

Field Code Changed

PURPOSE:

To identify criteria to meet guidelines and regulations to meet ICU nurse to patient staffing. To ensure that California Code of Regulations: Title 22 ICU staffing regulations are appropriately followed. ~~The nurse:patient ratio shall be 1:2 or fewer at all times.~~

POLICY:

1. Definition: A 1:1 assignment is made when a patient's nursing care needs (acuity) require on-going nursing assessment; and, based on the assessment, require continuous intervention and reassessments to determine response to the interventions. A 2:1 assignment is made when a patient's nursing care needs (acuity) are so critical that 2 staff members, one of which must be a RN, are needed to care for one patient. A 2:1 ratio may be needed to continuously intervene and assess the patient's response to the care interventions. The house supervisor may use nursing judgment after conferring with the patient's primary nurse to supersede this policy, while maintaining title 22 staffing ratios, and determine if additional care is required for any patient admitted to the ICU. 1:2 refers to 1 RN to 2 patients, 1:1 refers to 1 RN to 1 patient, 2:1 refers to 2 nurses (1 may be an LVN) to 1 patient.
2. 1:2 Criteria: The following are guidelines to assist in determining patient acuity for assigning 1:2 nursing care.
 - a. Vital signs every hour or more frequently.
 - b. I&O every 2 hours or more frequently.
 - c. Vasoactive or cardioactive or other drips requiring close monitoring or titration.
 - d. Observation/Anticipation for potential life threatening s/s from:
 - i. Post operative – fluid/blood management
 - ii. R/O MI
 - iii. Overdose
 - iv. Trauma/head injury
 - v. Respiratory distress
 - e. Ventilator and new to BiPap patients
 - f. Any patient deemed too unstable to be placed on the M/S unit
 - g. Any M/S overflow patient in the ICU shall be considered 1:2
 - i. Patients cared for in the ICU whether ICU or M/S overflow will be staffed with a minimum of 1:2 ratio.
3. 1:1 Criteria: The following are guidelines to assist in determining patient acuity for assigning 1:1 nursing care. One or more of the following criteria must be present:
 - a. Hemodynamic instability, e.g. Monitoring of hemodynamic parameters more frequently than every 15 minutes for a period of greater than 2 consecutive hours, or where there is a rapid decline in a patient's condition.
 - b. Patients receiving neuromuscular blocking agents ~~until they are stabilized and sedated.~~
 - c. Frequent (every 15 minutes) titration of ~~3-2~~ or more vasoactive or cardioactive drips.
 - e. ~~→ Willing to change to 2 or more drips *~~
 - d. Patients who are compromised hemodynamically because of a refractory life-threatening arrhythmia. An example would be a patient in recurrent ventricular tachycardia requiring defibrillation.
 - e. Patients with uncontrolled intracranial pressure requiring continuous monitoring for changes in neurological status.

**NORTHERN INYO HOSPITAL
POLICY AND PROCEDURE**

Title: ICU Acutities ICU Acutities	
Scope: ICU	Manual: ICU Structure Standards
Source: Manager ICU Acute/Subacute	Effective Date:

Field Code Changed

Field Code Changed

Field Code Changed

- f. Patients during the organ procurement process.
 - g. Patients who are actively bleeding or experiencing excessive fluid loss and requiring a combination (more than one) of multiple vasopressors, VS every 5-15 minutes, multiple blood products, ~~etceet~~.
 - h. Patients who require 4 point leather restraints.
 - i. Two or more invasive lines that require hourly monitoring and interventions. (i.e. CVP monitoring, A-line, etc.).
 - j. For patients admitted or returning to the ICU straight from the OR without PACU recovery time, the first hour of recovery in the ICU will be 1:1.
 - +k. Suicidal patients, unless a separate sitter is available.
4. 2:1 Criteria (2nd nurse may be an LVN): The following are guidelines to assist in determining patient acuity for assigning 2:1 nursing care. One or more of the following criteria must be present:
- a. Major Trauma, requiring insertion of multiple lines, chest tube, etc., until transport is available.
 - b. Major burn victim, requiring fluids, burn care, and stabilizing until transport is available.
 - c. Arrest victim – Code Blue until stable.
 - d. Post surgical/GI bleeding requiring constant lavage and transfusions.
 - e. MI's receiving thrombolytics.
 - f. Hemodynamically unstable due to active bleeding, requiring continuous replacement of multiple blood products.

REFERENCES: California Code of Regulations: Title 22, Division 5, Section 70217

CROSS REFERENCE P&P:

1. ICU Staffing
2. Floating Nursing Staff
3. Cross-Training of RN Staff

Approval	Date
NEC	1/17/18
OCC	1/16/2018
Board of Directors	
Last Board of Director Review	

Initiated: 1/18, jn

Reviewed:

Revised:

Index Listings: Acuity Level - ICU

**NORTHERN INYO HOSPITAL
POLICY AND PROCEDURE**

Title: Safe Patient Handling – Minimal Lift Program	
Scope: Clinical Staff	Manual: CPM – Patient Safety (PS)
Source: Employee Health Nurse	Effective Date: 10/1/14

PURPOSE:

NIH wants to ensure that patients are cared for safely, while maintaining a safe work environment for employees. This document describes the practices at NIH to ensure employees use safe patient handling and movement techniques for patients in patient care areas.

POLICY:

1. Patient care areas include all areas of the District where care and treatment of services are rendered directly to the District’s patient population and include, but are not limited to Rural Health Clinics, Nursing Services, Diagnostic Imaging Services, Cardiopulmonary, NIA Clinics, Lab and Rehabilitation Services.
2. Direct patient care staff members in all patient care areas will assess all patient handling tasks in advance to determine the safest way to accomplish the tasks.
 - a. Mechanical lift aids will be used as appropriate for the patient and all direct patient care employees are expected to assist each other in the execution of safe patient handling matters.
 - b. District Leaders are required to ensure that employee have appropriate assistance in implementing this policy on a task by task basis and have trained their staff members on appropriate safe patient handling matters.
3. For patients admitted to the hospital, an RN will serve as the coordinator of care assessing the patient’s mobility needs (functional screen in the nursing assessment) and identify in the Plan of Care, the level of assistance required and mechanical device usage.
 - a. A referral will be generated to Rehabilitation Services based on the Functional Screen and/or physician order for additional patient assessment and care planning.
4. An inventory of mechanical device equipment for patient care areas will be maintained by the department management.
5. Staff training will be provided on the use of mechanical device equipment as appropriate to the position hired.
6. Mechanical lift devices are to be used on patients requiring assistance. Manual lifting without a mechanical lift device is discouraged.
 - a. If some degree of lifting is unavailable, caregivers should seek assistance from other staff members and/or employ mechanical aids whenever possible.
7. Employees who do not utilize proper safe patient handling practices may be subject to corrective action.
 - a. Discipline will not occur with respect to a health care worker who refuses to lift, reposition, or transfer a patient due to concerns about patient or worker safety or lack of equipment or trained lift personnel.
8. Any injury resulting from patient lifting or positioning, including strains, sprains, or any other muscular skeletal injury must be handled according to the Work related Accidents Policy.
9. If a patient is unable to assist the HCW with repositioning or transfers, then the lifting and moving of the patient will be done with minimum of two person assist with or without the use of an assistive device.
10. Transferring patients out of the unit on a gurney or bed will be done with a minimum of two person assistance.

Commented [e1]: Please include the current poundage limitation (e.g., 15 pound) in CA.

DEFINITIONS:

1. Manual Lifting: Lifting, transferring, repositioning, and moving patients using a caregiver’s body strength without the use of lifting equipment/aids that reduce forces on the worker’s muscular skeletal structure.
2. Patient Handling Equipment and Aids: Equipment or aids used to decrease the risk of injury from patient handling activities and includes, but is not limited to the following:
 - a. **Lifting Equipment** includes portable/floor-based designs and their accompanying slings that function to assist in lifting and transferring patients, ambulating patients, repositioning patients, and other patient handling tasks.
 - b. **Lateral Transfer Devices** Provide assistance in moving patients horizontally from one surface to another (e.g., transfers from bed to stretcher).

**NORTHERN INYO HOSPITAL
POLICY AND PROCEDURE**

Title: Safe Patient Handling – Minimal Lift Program	
Scope: Clinical Staff	Manual: CPM – Patient Safety (PS)
Source: Employee Health Nurse	Effective Date: 10/1/14

- c. **Beds** that provide assistance with patient handling tasks such as lateral rotation therapy, transportation, percussion, bringing patients to sitting positions, etc.
 - d. **Repositioning Aids** provide assistance in turning patients and pulling patients up to the head of the bed and up in chairs.
 - e. **Equipment/bed/wheelchair transport assistive devices** assist caregivers in pushing heavy equipment.
 - f. **Patient Handling Aids:** Non-mechanical equipment used to assist in the lift or transfer process. Examples include stand assist aids, sliding boards, and surface friction-reducing devices.
 - g. **Powered Height-adjustable exam tables** assist in transfer of patients onto exam tables and in bringing patients to sitting position, and raise the table surface to a more ergonomically safe working level.
3. **High Risk Patient Handling Tasks:** Patient handling tasks that have a high risk of musculoskeletal injury for staff performing the tasks. These include but are not limited to transferring and lifting tasks, repositioning tasks, bathing patients in bed, making occupied beds, ambulating and dressing patients, turning patients in bed, tasks with long durations, standing for long periods of time bariatric, and other patient handling tasks.
4. **Designated Health Care Worker:** NIH staff who have been specifically trained to handle patient lifts, repositioning, and transfers using patient transfer, repositioning, or lifting devices as appropriate for the specific patient. It means staff working together to accomplish these patient related tasks safely.

PROCEDURE:

- A. **Direct Patient Care Employee Responsibility**
 - 1. Take responsibility for their own health and safety, as well as that of their co-workers and their patients during patient handling activities.
 - 2. Complete initial training and annual training as required.
 - a. Complete additional training to correct improper use/understanding of safe patient handling and movement.
 - b. Notify manager of need for re-training in the use of patient handling equipment and aids.
 - 3. Assess patient for condition and ability to cooperate with transfer and appropriate level of patient assist.
 - a. Identify and avoid hazardous manual patient handling and movement tasks whenever possible.
 - 4. Use proper techniques, mechanical lifting devices, and other approved equipment and/or aids during performance of high risk patient handling tasks.
 - 5. Promptly report to manager or shift supervisor any injury without fear of negative consequence.
 - 6. Follow procedures for reporting patient handling equipment in need of repair.
- B. **RN Coordinator of Care Admitted Patients.**
 - 1. To follow initial Nursing Admission Assessment Policy and Procedure.
 - a. Develop Nursing Care Plan Mobility deficit as appropriate
- C. **Management of Direct Patient Care Employees.**
 - 1. Be educated and remain up-to-date in the use of mechanical lifts and transfer aids. Be aware of department worker's compensation costs and injury rates and continue to make efforts to reduce the number of incidents in all areas of responsibility.
 - 2. Through employee observation, documentation review and other means, make sure that all employees are assessing the patient prior to any movement and that all patient handling tasks are completed safely, using mechanical lifting devices and other approved handling aids.
 - 3. Department inventory of mechanical lifting devices/aids are available in proper working order, maintained regularly and stored readily accessible in the clinical areas.
 - a. see Patient Lifting Handling Equipment/Aids per Department reference sheet
 - 4. Review orientation checklists to make sure that employees complete initial training; ensure employees demonstrate competency; provide re-training when employees are non-compliant with safe patient handling practices; maintain training records for a period of three years.
 - 5. Refer all staff reporting patient handling injuries to the Shift Supervisor and/or Emergency Department for immediate evaluation and treatment.

**NORTHERN INYO HOSPITAL
POLICY AND PROCEDURE**

Title: Safe Patient Handling – Minimal Lift Program	
Scope: Clinical Staff	Manual: CPM – Patient Safety (PS)
Source: Employee Health Nurse	Effective Date: 10/1/14

D. Rehabilitation Services

1. Physical Therapy and/or designee will:
 - a. Complete training of newly hired staff members on the use of the lift equipment/aids and assist with ongoing training for unit staff members. Provide reference materials with the information needed for troubleshooting.
 - b. Training will include use of lifting devices and equipment to handle patient safety and the five areas of body exposure: vertical, lateral, bariatric, repositioning, and ambulation.
2. PT and/or designee will conduct ergonomic rounds quarterly to assess for patient handling lift training opportunities and to encourage and motivate staff in the use of lifts/transfer devices, report unsafe situations related to the use of the lift equipment and assist with organization and accessibility of equipment.
3. Remain knowledgeable and current on all lift equipment/transfer aids available to staff members and stay abreast of updates/changes.
4. Assure equipment and any needed supplies are readily available in departments; communicate supply issues to Manager.

E. Facilities Management:

1. Biomedical Engineering shall maintain patient care equipment in proper working order.
2. Consult with equipment manufacturers to provide safe equipment installations.

F. Reporting of Injuries:

1. Employees are required to follow the Work related Accidents Policy for any patient handling injury event
2. Employees who are non-compliant with the Safe Patient Handling Policy must be re-trained and demonstrate competency in equipment use before returning to work. Continued failure to use proper patient handling practices may result in corrective action up to and including termination.

REFERENCES:

1. ANA (2013) Safe Patient Handling and Mobility: Inter-professional National Standards. Nursebooks.org.
2. California Code of Regulations (2013) Safe Patient Handling Bill (AB1136).
www.dir.ca.gov/oshsb/safe_patient_handling.htm;

CROSS REFERENCE P&P:

1. Completing Quality Review Report in Performance Excellence Manual
2. Employee Requests to be Excluded From Patient Care in HR /Employee Handbook
3. TJC (2012) Improving Patient and Worker Safety: Opportunities for Synergy, Collaboration and Innovation. Oakbrook Terrace, Illinois.
4. Work Related Accidents in Human Resources/Employee Handbook
5. Injury and Illness Prevention Program located in Employee Health Manual

Approval	Date
Clinical Consistency Oversight Committee	05/21/2018
Patient Safety Committee	06/13/2018
Safe Patient Handling Subcommittee	06/14/2018
Board of Directors	10/14
Last Board of Director review	3/17/18

Developed: 2/2013

Reviewed:

**NORTHERN INYO HOSPITAL
POLICY AND PROCEDURE**

Title: Safe Patient Handling – Minimal Lift Program	
Scope: Clinical Staff	Manual: CPM – Patient Safety (PS)
Source: Employee Health Nurse	Effective Date: 10/1/14

Revised: 10/2014, 6/18CO
Index Listings:

draft

**NORTHERN INYO HOSPITAL
POLICY AND PROCEDURE**

Title: Acute/Subacute Care Services Method of Practice: Patient Coordinated Care*	
Scope: Medical-Surgical/Telemetry, Medical-Surgical Peds, Swing/Inpatient Hospice	Manual: MS - Standards of Practice Independent/Interdependent
Source: Manager - ICU Acute/Subacute	Effective Date: 1/1/2015

PURPOSE:

To identify the care delivery model (method of practice) for the Acute/Subacute Care patients.

POLICY:

1. A Charge Nurse or RN assigns patient care to the nursing staff scheduled for the shift
2. An RN oversees and coordinates the delivery of care for the assigned shift case load of patients.
3. Patient Coordinated Care is the method of practice that defines the role relationship for care delivery.
 - a. The priority is to focus patient care to the point of care, the patient, by developing a team of healthcare workers to identify and meet the holistic needs of the patient.
 - b. The RN is in the leadership role prescribing (assessing, implementing and evaluating care), delegating, and coordinating care of each patient.
 - c. The CNA, Department Clerk and other members of the interdisciplinary team support the RN in achieving the plan of care goals.
4. The Patient Coordinated Care skill mix is comprised of an RN with a maximum ratio of 1:5 patients and pediatric and telemetry patients 1:4 (based on Title 22 and acuity) and a CNA (1:8 patients) days and a CNA (1:16 patients) nights.
 - a. When possible an RN supplements care from 1100-2330 to provide meal breaks, staff education time for completion of Learning Management System, QA/PI projects, assist with admissions, discharges, transfers and patient education.
5. The RN delivers care based on the nursing process
6. The RN delegates care to the CNA based on the CNA competency and skills checklist. The RN retains accountability for the coordination of care and the outcome of care.

PROCEDURE:

1. Prior to the start of each shift, the Shift Charge reviews the department census, acuity of the patients, and the scheduled staff.
 - a. Patients are assigned to the scheduled staff (using the P&P, Deployment of Nursing Staff at Department Level and Patient Care Assignments).
 - b. Patient assignment is kept consistent as possible keeping the same RN/CNA with the same case load.
 - c. Meal assignments are made in collaboration with the charge nurse, an RN, or House Supervisor as soon as possible at the start of the shift.
 - d. The Shift Report handoff is completed RN to RN by bedside report.
2. The RN delegates care assignments to the CNA.
 - a. The CNA keeps the RN informed of patient response to care delivery.
3. Throughout the shift, the Shift Charge adjusts the case load assignments based on admissions, transfers, discharges, and patient care needs.
 - a. Any conflict or issues are addressed with the House Supervisor, Department Manager or Assistant Manager, and/or Director of Nursing (DON).
4. The department's Standard of Care and Practices are followed to deliver care.
5. The RN presents the patient progress toward the patient's individualized goals at the daily interdisciplinary care conference. A care conference involving the patient and/or patient's family may be planned in collaboration with the case manager for those patients with special needs, etc.

**NORTHERN INYO HOSPITAL
POLICY AND PROCEDURE**

Title: Acute/Subacute Care Services Method of Practice: Patient Coordinated Care*	
Scope: Medical-Surgical/Telemetry, Medical-Surgical Peds, Swing/Inpatient Hospice	Manual: MS - Standards of Practice Independent/Interdependent
Source: Manager - ICU Acute/Subacute	Effective Date: 1/1/2015

REFERENCES:

1. California Board of Nursing Nurse Practice Act
2. Title 22

CROSS REFERENCE P&P:

1. Patient Acuity – Patient Care Flow Sheet

Approval:	Date:
NEC	7/26/18
Board of Directors	12/14
Last Board of Director review	4/19/17

Developed: 10/14

Reviewed: 4/16, 11/16

Revised: 02/18 ak



Northern Inyo Healthcare District Language Access Services Strategic Plan

Section I

Executive Summary

Communication between health care staff and patients is a key component of diagnosis and treatment. Although in-person interpreters are the preferred method of communication, this may not always be possible. The Language Access Services Department primary objective is to ensure effective communication for equal and meaningful access to health care services for patients experiencing language or communication barriers¹. This is driven by Northern Inyo Healthcare District (NIHD) own Mission: Improving our communities, one life at a time. One Team. One Goal. Your Health.

The reason behind the requirement to providing language or communication assistance is to prevent discrimination, and to ensure Limited English Proficient (LEP) individuals receive language or communication assistance when needed. NIHD abides by all federal, and state laws, and by the Joint Commission Standards for Patient-Centered Communication; including but not limited to Title VI of the 1964 Civil Rights Act, ACA Section 1557, and the California Health and Safety Code Section 1259, just to name a few.

NIHD's Four-Factor Analysis indicates the District's need to provide language or communication assistance to its LEP population, by ensuring the availability of competent interpreter and translation services. NIHD is required to utilize the necessary but reasonable resources to meet its patients' language needs, thus NIHD is encouraged to maximize the use of its own resources in order to provide language or communication assistance. Since 2007, with the creation of the District's Language Access Services Department, NIHD has been in compliance with all laws and regulations; with this Language Access Services Strategic Plan, NIHD will have an action plan for the development and implementation of the different services it can deploy to meet its LEP population needs.

By maximizing the use of its own staff, NIHD will be able to provide timely and competent language or communication assistance at a reasonable cost. The redesigned Dual-Role Interpreter Program, along with a team of full-time interpreters will provide the in-person

¹ California Health and Safety Code Section 1259 (a) (1) "The Legislature finds and declares that California is becoming a land of people whose languages and cultures give the state a global quality. The Legislature further finds and declares that access to basic health care services is the right of every resident of the state, and that access to information regarding basic health care services is an essential element of that right. (2) Therefore, it is the intent of the Legislature that when language or communication barriers exist between patients and the staff of any general acute care hospital, arrangements shall be made for interpreters or bilingual professional staff to ensure adequate and speedy communication between patients and staff."



Northern Inyo Healthcare District Language Access Services Strategic Plan

interpreting coverage that is so much appreciated by both patient and provider. Implementing the use of telephonic or video conferencing interpreting services in all clinics' patient rooms, should improve utilization of competent interpreter services.

NIHD is committed to providing competent language or communication assistance through the equal utilization of all and any of its resources: telephonic or video remote interpreting, dual-role or dedicated interpreter, or approved bilingual workforce.

Section II

Purpose

This Language Access Services Strategic Planning is designed to set the overall goals for the department's operations over the next three years, and it's guided by the District's Mission: "Improving our communities, one life at a time. One Team. One Goal. Your Health."

This Plan includes a described list, and analysis of the District's resources for providing language or communication assistance; the opportunities with their strengths, weaknesses, and challenges; and the action plan to achieve the goals set forth hereafter.

Section III

Language Access Services Strategy

The strategy is communication, accurate, competent and timely communication. LEP patients experiencing language or communication barriers have the right to receive language assistance services.

The Language Access Services Department primary objective is to ensure LEP patients receive equal and meaningful communication with the healthcare team in order to bridge the divide that happens without clear understanding between the patient/family caregiver and the district staff. In order to provide excellence in care to our patients, it is essential that all parties involved communicate clearly. The language services interpreter functions as a conduit to assure this communication meets the needs with the patient, who is at the center of the care.

NIHD is committed to culturally competent and equal access to hospital services for non- and Limited-English speaking patients, and for the hearing impaired. Ethically and legally, it is the responsibility of NIHD to provide competent language or communication assistance. These services will be provided with compassion and integrity per the values of NIHD.



Northern Inyo Healthcare District Language Access Services Strategic Plan

The Language Access Services Department strategy is to provide the highest quality language access services in a financially responsible manner, by maximizing the utilization of the District's resources; while maintaining compliance with all federal and state laws and regulations, as well as the Joint Commission Standards for patient-centered communication².

Section IV

Background

A. Four-Factor Analysis

NIHD is required to take reasonable steps to ensure **meaningful access** to its services by LEP persons. The DHHS Guidance³ explains that the obligation to provide meaningful access is fact-dependent and starts with an individualized assessment that balances four factors:

1. **The number or proportion of LEP** persons eligible to be served or likely to be encountered by the program/service;
2. **The frequency** with which LEP individuals come into contact with the program/service;
3. **The nature and importance of the program, activity or service** provided by the recipient to its beneficiaries; and
4. **The resources available** to the recipient **and the costs of interpretation/translation services**.

The following **Four-Factor Analysis** will serve as the guide for determining which **language assistance measures** NIHD will take to ensure access to NIHD services by LEP persons:

1. **Number or proportion of LEP** persons eligible to be served or likely to be encountered at NIHD.

While this language access strategic plan will include measures to ensure access for all patients, regardless of the language spoken, as required⁴ the more people who speak a particular language, and are eligible to be served or likely to be encountered, the more services are needed.

² TJC CAMCAH 2016, RI.01.01.01 Elements of performance 5& 6

³ Department of Health and Human Services, Guidance to Federal Financial Assistance Recipients Regarding Title VI Prohibition Against National Origin Discrimination Affecting Limited English Proficient Persons

⁴ Title VI, CA Health and Safety Code Section 1259, ACA Section 1557.



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The city of Bishop has the largest population in Inyo County. Over the last 14 years some of the racial and ethnic groups have seen remarkable growth. The two largest minority groups in Inyo County are Hispanics and Native Americans, according to U.S. Census Bureau data (Table 1). It is important to note that the category, ‘Hispanic’ refers to ethnicity and technically falls into the White Race category. Since many Hispanics do not consider themselves White, the U.S. Census Bureau added Hispanic as a separate race category.

Table 1 - Population by Race and Ethnicity, Inyo County & City of Bishop

	INYO COUNTY			CITY OF BISHOP		
	2010 Census	Share of Population	Change from 2000	2010 Census	Share of Population	Change from 2000
White	13,741	66%	-8%	2867	73.9%	-5.5%
Black	109	1%	+410%	22	0.6%	+310%
Asian	243	1%	+45%	61	1.6%	+26%
Native American & Alaskan Native	2,121	10%	+13%	91	2.3%	+19.7%
Hispanic	3,597	19%	+59%	1200	30.9%	+93%
Multiracial	640	2%	-12%	114	2.9%	-68%
Other	1,692	1%	-5%	723	18.6%	+100%
TOTAL	18,546	100%	+3.3%	3879	100%	+7.8%

Source: U.S. Census Bureau, 2000 & 2010

NIHD’s service area includes a total population of nearly 20,000 people. The city of Bishop covers an area of just 2 square miles, but 30% of its population self-identify as Hispanic, as shown in Table 1., making it a substantial number of potential LEP persons likely to be encountered at NIHD.

2. **The frequency** with which LEP individuals come into contact with NIHD services.

The more frequent the contact the greater the need for interpreters, translators or other language assistance tools⁵.

NIHD is required⁶ to collect data on patient’s primary and preferred language, race, and ethnicity.

⁵ Title VI, CA Health and Safety Code Section 1259, ACA Section 1557



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In 2013 Hispanics accounted for 14.69% of all patients' admissions at NIHD. This did not include outpatient services (i.e. RHC, DI services, etc.) where NIHD is the main provider for primary care services in the district; even without this data it is safe to estimate a high frequency of LEP patients seeking services or likely to be encountered at NIHD.

3. **The nature and importance of the services** provided by NIHD.

The more important the service, the more likely high quality, and timely language assistance are needed. The consequences of ineffective communication could be life-threatening.

NIHD recognizes that access to basic health care services is the right of every patient. Health care information is critical and can be life-threatening. Effective communication is at the center of providing culturally and linguistically appropriate health care services.

Health care is critical in nature; NIHD is the major health care provider in nearly a 200-mile radius. Even the most basic service is critical given our rural location. Patients experiencing language or communication barriers face additional challenges when seeking health care services. NIHD is committed to addressing the needs of its patients experiencing unequal access to health care services, not limited to any particular racial, ethnic, or linguistic population group.

4. **The resources available to NIHD, and the cost of translation/interpretation services.**

Language Access Services means providing language or communication assistance, including: interpreting, translation, and communication assistance devices; and it may be provided in two forms: in-person (human resources) or remotely (technology resources).

Human Resources

Just as the local demographics have changed in the last 10 years, the human resources at NIHD have also changed. Over the last 10 years NIHD has seen an increase in the number of Hispanic patients seeking services, and in the number of employees who self-identify as Hispanics. Currently, NIHD Hispanic employees occupy positions in 21 different departments.

As of 7/2/2018 NIHD has 464 regular employees including 63 who self-identify as Hispanic, from which 13 have the language skills to be designated Approved Bilingual Non-Clinical, and 14 Approved Bilingual Clinical employees; 12 have completed the training to be classified as qualified Dual-Role Interpreter; and 1 is a full-time healthcare interpreter; in addition to one

⁶ California Health and Safety Code Section 1259; ACA Section 1557; The Joint Commission Standard PC.02.01.21, and Standard RC.02.01.01



Northern Inyo Healthcare District Language Access Services Strategic Plan

Language Access Services Manager, who is nationally accredited as a Certified Healthcare Interpreter. Additionally, there are 20 employees who have passed the language proficiency test at level 4 or better, and qualify to take the interpreters' training. There is a great benefit in adding a large number of interpreters to the dual-role program.

Approved Bilingual employees have the skills to provide direct services in the patient's preferred language (Spanish) without the assistance of an interpreter; they are not interpreters.

NIHD qualified interpreters provide interpreting services in both, clinical and non-clinical settings. Interpreters are employees who have completed the criteria to obtain the interpreter designation.

During the FY 2017-2018, NIHD approved the creation of the Language Access Services Call Center. The call center, as designed and approved, when fully staffed will include 4 full-time interpreters working through the Health Care Interpreter Network (HCIN) platform, providing video remote interpreter services for all of the Network members, including NIHD; and limited in-person interpretation throughout the District's facilities. Currently, only one full-time interpreter has been hired for the call center; the second is scheduled to start in August, and the last two positions have not been filled.

Technology

Having no dedicated interpreters for in-person services, and a team of dual-role interpreters with a very limited availability, NIHD highly depends on technology to provide language or communication assistance.

There are two different technologies to provide interpreting services: over the phone, and video remote interpreting (VRI).

Over the phone interpreting was the only technology available for many decades. In 2009, NIHD's rural location give it the benefit of qualifying as a "lite" member with the Health Care Interpreter Network (HCIN), bringing video remote interpreting (VRI) to NIHD, and was able to join a network of hospitals sharing their interpreter services at a very low membership fee. Additionally, NIHD received two video remote interpreting units at no cost, and 6 months of free service. In 2014, the two original video remote interpreting units were retired, and NIHD bought 8 iPads for video remote interpreting.



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HCIN provides VRI in 40 different languages, including American Sign Language (ASL). Currently NIHD has eight video units. All units can only be used for VRI and are connected through NIHD’s wireless secured network to a closed Network of hospitals throughout the country sharing their qualified healthcare interpreters.

Over-the-phone or VRI services are available 24 hours a day, seven days a week; these services ensure NIHD provides access to LEP patients in over 200 languages.

Cost of Translation/Interpretation services

Whether we use technology or human resources to provide language or communication assistance services to LEP persons, the benefit outweighs the cost.

Provision of language or communication assistance is mandated by state and federal law; it’s not a reimbursed service, nor can the patient be charged. However, it should not only be seen as a cost of being in business, but as an investment. An investment in patient and provider satisfaction while reducing the District’s liability risk. Communication between patient and staff is essential to provision of excellent health care.

Table 4 - Dual-Role Interpreter Program annual cost

Dual-role Interpreters		
	Interpreting Sessions	Annual Stipend
2007	359	Data not available
2008	1,596	Data not available
2009	2,121	Data not available
2010	2,422	Data not available
2011	2,870	Data not available
2012	3,046	\$16,325.00
2013	2,645	\$14,775.00
2014	1,076	\$8,175.00

During the time the Dual-Role Interpreter was in place, interpreters were compensated based on the number of interpreting sessions performed each month. An interpreter with zero interpreting sessions would get \$50.00 dollars, from 1-5 sessions: \$75.00, 6-10 sessions: \$100.00, 11-15 sessions: \$150.00, and 16 or more: \$200.00 dollars as a monthly stipend. Based on this formula, the most the District would have spent in 2013 would have been \$28,800.00 dollars (12 interpreters x \$200.00/month x 12 months). However, the actual cost was \$14,775.00. The actual cost for 2014 it’s

just above \$8,000.00 due to the program’s cancellation during the first half of the year. See *Table 4* for details.

Since its creation, interpreters participating in the dual-role interpreter program were able to provide coverage for most of the District’s needs for Spanish. See *Table 5*.

Table 5 – Frequency (%) of interpreting sessions by mode

April 2011		
	Sessions/Calls	Minutes
Dual-role interpreters	302 (82%)	5,582 (87%)
Phone & Video interpreting	67 (18%)	821 (13%)
Total	369 (100%)	6403 (100%)

In 2014, after the dual-role interpreter program was cancelled, over-the-phone interpreting services increased from 4,915 minutes in 2012, to 27,111 minutes; an increase of more than 400%. See *Table 6* for details. After noticing the increasing trend on the cost for over-the-phone interpreting, NIHD changed its over the phone service provider to CyraCom interpreting services in November of 2014; a change bringing the District a 48% savings compared to LanguageLine. See *Table 6* for details.

Table 6 - NIHD Annual cost for contracted interpreting services

	Over the phone Interpreting			Video Remote Interpreting			Combined Annual Cost
	Calls	Minutes	Cost	Calls	Minutes	Cost	
2007	Data not available	Data not available	Data not available	Service not available till 2009			Data not available
2008	216	2,084	Data not available	Service not available till 2009			Data not available
2009	300	3,068	\$5,327.84	18	51	\$68.85	\$5,396.69
2010	297	3,194	\$5,678.72	69	917	\$4,260.30	\$9,939.02
2011	399	4,475	\$7,312.15	90	1,289	\$6,936.26	\$14,248.41
2012	392	4,915	\$8,234.85	172	2,469	\$8,658.86	\$16,893.71
2013	1,168	13,678	\$23,060.00	398	6,670	\$15,272.97	\$38,332.97
2014	1,855	27,111	\$43,351.73	519	8,777	\$18,624.80	\$61,976.53
2015	1,599	26,738	\$24,810.96	962	18,485	\$41,796.27	\$66,607.23
2016	2,265	35,841	\$32,691.14	1,161	19,851	\$38,272.70	\$70,963.84
2017	2,305	35,880	\$32,599.78	1,125	19,735	\$41,476.61	\$74,076.39

The Language Access Services Manager is the primary source for in-person interpreting services in addition to other responsibilities; the services demand exceeds the department capacities currently. The current cost for interpreting services is listed in *Table 7*.

Table 7 – Hourly rate for interpreting services per modality

Interpreting Service Type	Cost per hour as of 7/10/18
----------------------------------	------------------------------------



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Dual-Role interpreter @ NIHD	No compensation is given.
Full-time interpreter @ NIHD	\$20.11 - \$27.14 plus benefits
Over-the-phone – CyraCom	\$54.00
Over-the phone - LanguageLine	\$103.80
Spoken languages over Video Remote Interpreting – HCIN	\$72.00 - \$93.00
American Sign Language – HCIN	\$174.00 - \$201.00

NIHD’s current state (depending primarily on contracted services) is not meeting the language access needs of our patient population, it is not in line with state and federal guidelines for a **balanced language access plan**, and it creates significant gaps in services.

There have been a number of patients, and providers complaining about our interpreter services or the lack thereof. Complaints about interpreter services include technological and functional aspects with the video remote interpreting units or the dedicated telephones for interpreting services.

Over the last 11 years, there have been very few requests for translations into languages other than Spanish. The Language Access Services Manager has been the source for all translations into Spanish up until recently when about two dozen translations were outsourced.

Translations are charged per word, and the amount varies depending on the type of document, language, and the company providing the service. NIHD’s need for outsourced translations is minimal but that may change as the Department management needs change.

Four-Factor Analysis Conclusion

Balancing these four-factors will determine the level of language access to provide meaningful access.

The quality and accuracy of the service is critical. The competence of an interpreter means more than self-identification as bilingual, and it’s required by law. Interpreter competency means ability to:

- a) communicate in English and in the other language,
- b) demonstrated language proficiency,
- c) knowledge of medical terminology in both languages, and
- d) understanding of confidentiality and impartiality;



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Basically, the interpreter must have the language and interpreting skills required to assist in providing competent interpreting services, and must be trained in the standards of practice, ethics, and the role of an interpreter.⁷

There are situations in health care settings that could be life-threatening, without language assistance health care providers are unable to communicate with LEP. NIHD must take reasonable steps to provide competent language assistance and provide LEP persons access to its services.

NIHD shall provide language or communication assistance services to address the identified needs of the LEP population it serves. This four-factor analysis demonstrates the need for a combination of different language access services is required. The correct combination of services should be based on what is both **necessary and reasonable**.

NIHD shall provide language or communication assistance through the best utilization of its human resources, as described in the Language Access Services Program; including its Approved Bilingual Clinical, and Non-Clinical staff, qualified Dual-Role interpreters, full-time interpreters, contracted remote interpreter services, and in-house or contracted professional translation services in order to provide meaningful access to LEP populations.

NIHD's unique rural location comes with a limitation on the number and type of resources readily available. NIHD is restricted to use its own staff, and shall use that for its advantage.

The actual cost per hour to providing interpreter services suggest NIHD would reduce spending by utilizing its own Dual-Role and full-time interpreters. A staff interpreter may cost NIHD \$20.00 to \$28.00 dollars plus employees' benefits, which it is still significantly less than \$54.00 dollars per hour of over the phone interpreting with CyraCom.

⁷ Joint Commission Standard HR.01.02.01 The hospital defines staff qualifications. Note 4: Qualifications for language interpreters and translators may be met through language proficiency assessment, education, training, and experience. The use of qualified interpreters and translators is supported by the Americans with Disabilities Act, Section 504 of the Rehabilitation Act of 1973, and Title VI of the Civil Rights Act of 1964.



Northern Inyo Healthcare District Language Access Services Strategic Plan

B. Opportunities, Strengths, Weaknesses, and Challenges

Opportunities	Strengths	Weaknesses	Challenges
Increase bilingual workforce	Ability to provide direct bilingual services in more areas of the District.	Bilingual staff may not be available 24/7.	Difficulty recruiting bilingual staff for some positions.
Reinstate the Dual-Role interpreter program as a dedicated in-home department interpreter.	Add more resources to provide interpreting services for their own department. Ability to track usage.	Interpreters are not available 24/7.	Provide interpreter training to a large number of employees. Provide compensation for the time they are interpreting.
Hire full-time interpreters dedicated to primarily providing in-person interpreting.	Add a dedicated in-person interpreter. When not providing in-person interpreting, the interpreter will be working from the call center.	Office space (requires noise controlled area dedicated to call center).	Interpreting services for District Patients are required intermittently.
Upgrade telephone and video conferencing equipment.	Provide better equipment for interpreting services.	Technology could fail, and it must be upgraded periodically.	Cost of equipment, and installing the necessary infrastructure.
Install telephones and video conferencing telephones in all patient-rooms at all clinics.	Hardwired equipment is more reliable than wireless equipment.	Video telephone screens are no more than 5 inches wide on the current video telephone models.	Cost of equipment and installation.
Fully staffed call center	Should pay for most of	Difficulty in finding	Office space.



Northern Inyo Healthcare District Language Access Services Strategic Plan

for interpreting services.	its operational cost. Adds more dedicated interpreters to the staff.	qualified interpreters. It may not pay for itself.	
Develop Call Center Clinical Ladder.	Motivate interpreters to improve performance.	Interpreters may reach top of pay scale earlier than normal.	Difficulty in completing requirements without compromising performance

Section V

Goals & Priorities

Short term goals (6 months)

1. Fully operational call center for interpreting services.
Action Plan: recruit and hire last 2 interpreters for call center; work with management to identify required office space.
2. Schedule a Dual-Role interpreter training.
Action Plan: NIHD should schedule an interpreters’ training during regular work hours to allow staff attending during work hours. Staff shall be paid to attend.
3. Develop strategy (with HR) to recruit more bilingual staff in most patient-contact areas.
Action Plan: Language Access Services Manager shall work with HR recruiter in order to identify positions where bilingual staff is most needed, and create strategies to attract qualified bilingual applicants. Assessment for Spanish skills during interview for bilingual preferred positions should be instituted.
4. Install up to ¼ of patient rooms in RHC with telephone/video telephone.
Action Plan: a project charter should be develop in order to work with all departments involved in such task; i.e. IT, maintenance, RHC, Language Access Services, etc.
5. Convene a Language Access Services Task Force to provide feedback to Language Access Services Department on the District’s language or communication assistance needs. This should function as a standing Task Force, meeting regularly.
Action Plan: The Language Access Services Department shall identify and convene the key stakeholders within NIHD staff and leadership.

Mid-term goals (6-18 months)

1. Develop compensation plan for Dual-Role interpreters.
Action Plan: Language Access Services should develop a compensation plan that it’s fair and simple; allowing NIHD to track usage. Interpreters would need to clock-in and -out, and be paid for their actual time interpreting. The plan should be presented to leadership for approval and implementation.
2. Hire full-time interpreter for in-person service primarily.



Northern Inyo Healthcare District Language Access Services Strategic Plan

Action Plan: a dedicated in-person interpreter should be hired, and should have a video remote interpreting work station for in-person downtime.

3. Schedule additional interpreter training (one every 12 months).

Action Plan: an interpreters' training will be scheduled on a yearly basis.

4. Install additional telephone/video telephone in 50% of patient rooms at RHC.

Action Plan: a project charter should be develop in order to work with all departments involved in such task; i.e. IT, maintenance, RHC, Language Access Services.

5. Develop Call Center Clinical Ladder.

Action Plan: The Language Access Services Department shall develop a plan to motivate staff development and improved performance.

Long term goals (18 – 36 months)

1. Evaluate dual-role interpreter program at 12 months after compensation it's implemented.

Action Plan: Language Access Services should collect, and analyze the data required to evaluate the program's effectiveness. The data should be shared with the Language Access Services Task Force for review and comment.

2. Evaluate call center at 12, and 24 months after fully staffed.

Action Plan: Language Access Services should collect, and analyze the data required to evaluate the call center's effectiveness. The data should be shared with the Language Access Services Task Force for review and comment.

3. Install telephone/video telephone in the rest of patient rooms at RHC.

Action Plan: a project charter should be develop in order to work with all departments involved in such task; i.e. IT, maintenance, RHC, Language Access Services.

4. Start installing telephone/video telephone at all patient rooms in all clinics.

Action Plan: a project charter should be develop in order to work with all departments involved in such task; i.e. IT, maintenance, clinics managers, and Language Access Services.

The main priority is communication. NIHD shall give priority to all actions leading to providing language or communication assistance to LEP patients. Technology should be seen as a valuable and necessary tool in providing language or communication assistance. A priority should be given to acquiring and installing the equipment necessary to increase the availability of interpreter services devices. Concurrently, the remaining two positions for the call center should be filled, and an additional interpreter should be hired to provide greater in-person interpreting coverage.



Northern Inyo Healthcare District Language Access Services Strategic Plan

Section VI

Strategic Plan Performance Analysis

The data collected from the different operations, and being analyzed periodically, will be compiled for a three-year assessment, and will be used to develop the next Language Access Services Strategic Plan.

**NORTHERN INYO HEALTHCARE DISTRICT
POLICY AND PROCEDURE**

Title: Establishment of Statistically Valid Sample Sized for Business and Quality Process Analysis and Improvement	
Scope: District-Wide	Manual:
Source: Chief Financial Officer	Effective Date:

PURPOSE:

POLICY:

Northern Inyo Healthcare District determined in the fall of 2016 that it would use statistically valid data to drive both care delivery and business decisions of the organization. For NIHD to be a data driven organization, all departments will adopt statistically valid practices for analysis and decision making.

Northern Inyo Healthcare District has reviewed the various statistical methods available and has not found practical guidelines for determining the baseline method to be used by a frontier Critical Access Hospital. As such, NIHD has referenced the American Hospital Association resources and chooses to follow the basis of valid statistical sampling outlined in the model corporate compliance plan. Northern Inyo Healthcare District has found that the Health Resources Services Administration uses a 90% percent confidence level, with a 10% error rate to determine statistical sample size.

Northern Inyo Healthcare District hereby adopts the same parameters used by HRSA for the determination of a sample size. Departments are to use actual or expected annual volumes of the area to be sampled as the base population, a confidence level of 90% and an acceptable error rate of 10% to determine the required minimum sample size. Results will need to be acquired from the minimum sample size in order for analysis to be considered statistically valid per this policy.

If a department or user has questions on determining their sample size. They should ask Accounting (CFO, Controller or Accountant) to assist them in determining the appropriate population and reviewing the outcomes of the sample size generator program. Accounting is available to assist in the analysis of data gathered from statistical samples.

Additional information about statistical sampling and a working population sample size generator is attached.

PROCEDURE:

1. How to Determine Sample Size
 - a. CONFIDENCE INTERVAL; The confidence interval is the plus-or-minus figure that represents the accuracy of the reported.
 - I. Consider the following example:

A Canadian national sample showed “Who Canadians spend their money on for Mother’s Day.” Eighty-two percent of Canadians expect to buy gifts for their mom, compared to 20 percent for their wife and 15 percent for their mother-in-law. In terms of spending, Canadians expect to spend \$93 on their wife this Mother’s Day versus \$58 on their mother. The national findings are accurate, plus or minus 2.75 percent, 19 times out of 20.

For example, if you use a confidence interval of 2.75 and 82% percent of your sample indicates they will “buy a gift for mom” you can be “confident (95% or 99%)” that if you had asked the question to ALL CANADIANS,

**NORTHERN INYO HEALTHCARE DISTRICT
POLICY AND PROCEDURE**

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somewhere between 79.25% (82%-2.75%) and 84.75% (82%+2.75%) would have picked that answer.

b. CONFIDENCE LEVEL

- I. The confidence level tells you how confident you are of this result. It is expressed as a percentage of times that different samples (if repeated samples were drawn) would produce this result. The 95% confidence level means that 19 times out of twenty that results would fall in this – + interval confidence interval. The 95% confidence level is the most commonly used.

- II. When you put the confidence level and the confidence interval together, you can say that you are 95% (19 out of 20) sure that the true percentage of the population that will “buy a gift for mom” is between 79.25% and 84.75%.

- III. Wider confidence intervals increase the certainty that the true answer is within the range specified. These wider confidence intervals come from smaller sample sizes. When the costs of an error is extremely high (a multi-million dollar decision is at stake) the confidence interval should be kept small. This can be done by increasing the sample size.

- IV. A valid Calculator is located at: <https://www.qualtrics.com/blog/calculating-sample-size/>
 - i. Using the Calculator: One can determine the sample size for validity within a sample of a population. If you wanted to know with statistical validity the success rate colonoscopies. (I.E. completion of the procedure without adverse events) You would populate your population: 420 cases a year, determine your confidence level if you desire 90% confidence with a 5% error rate says to have 165 samples in order to have a statistically valid sample or at the minimum required level of a 10% error rate a sample size of 59.

REFERENCES:

CROSS REFERENCE P&P:

Approval	Date
Data & Information Committee	
Board of Directors	
Last Board of Directors Review	

Developed: 7/17/18 JT

Reviewed:

Revised:

Supersedes:

Index Listings:

NORTHERN INYO HEALTHCARE DISTRICT
PRELIMINARY STATEMENT OF OPERATIONS
for period ending June 30, 2018

	ACT MTD	BUD MTD	VARIANCE	ACT YTD	BUD YTD	VARIANCE
Unrestricted Revenues, Gains & Other Support						
Inpatient Service Revenue						
Routine	1,001,595	778,471	223,124	11,765,116	9,471,418	2,293,698
Ancillary	2,991,343	2,700,381	290,962	33,178,371	32,854,616	323,755
Total Inpatient Service Revenue	3,992,938	3,478,852	514,086	44,943,487	42,326,034	2,617,453
Revenue	8,647,228	7,857,438	789,790	104,670,404	95,598,894	9,071,510
Gross Patient Service Revenue	12,640,166	11,336,290	1,303,876	149,613,891	137,924,928	11,688,963
Less Deductions from Revenue						
Patient Service Revenue Deductions	162,574	227,153	64,579	2,579,227	2,763,678	184,451
Contractual Adjustments	6,180,038	4,348,068	(1,831,970)	64,463,760	52,901,495	(11,562,265)
Prior Period Adjustments	(1,039,499)	(12,967)	1,026,532	(4,804,354)	(157,771)	4,646,583
Total Deductions from Patient Service Revenue	5,303,113	4,562,254	(740,859)	62,238,632	55,507,402	(6,731,230)
Net Patient Service Revenue	7,337,053	6,774,036	563,017	87,375,259	82,417,526	4,957,733
Other revenue	368,468	74,342	294,126	1,148,561	904,486	244,075
Total Other Revenue	368,468	74,342	294,126	1,148,561	904,486	244,075
Expenses:						
Salaries and Wages	2,252,945	2,253,618	673	25,722,266	27,419,022	1,696,756
Employee Benefits	1,823,581	1,538,619	(284,962)	19,815,966	18,719,888	(1,096,078)
Professional Fees	1,124,690	701,142	(423,548)	12,841,604	8,530,527	(4,311,077)
Supplies	516,818	627,567	110,749	8,870,011	7,635,410	(1,234,601)
Purchased Services	441,750	348,470	(93,280)	3,999,551	4,239,724	240,173
Depreciation	351,448	428,731	77,283	4,456,698	5,216,234	759,536
Bad Debts	213,584	234,952	21,368	3,026,167	2,858,585	(167,582)
Other Expense	414,112	341,327	(72,785)	4,831,134	4,152,776	(678,358)
Total Expenses	7,138,928	6,474,426	(664,502)	83,563,397	78,772,166	(4,791,231)
Operating Income (Loss)	566,594	373,952	192,642	4,960,423	4,549,846	410,577
Other Income:						
District Tax Receipts	43,955	47,513	(3,558)	527,460	578,069	(50,609)
Tax Revenue for Debt	128,647	160,148	(31,501)	1,543,761	1,948,473	(404,712)
Partnership Investment Income	-	-	-	66,526	-	66,526
*Grants and Other Contributions						
Unrestricted	-	41,096	(41,096)	1,559,430	500,002	1,059,428
Interest Income	26,986	16,302	10,684	353,252	198,338	154,914
Interest Expense	(239,892)	(252,142)	12,250	(2,945,241)	(3,067,730)	122,489
Other Non-Operating Income	312	2,344	(2,032)	47,162	28,518	18,644
Net Medical Office Activity	(449,116)	(352,201)	(96,915)	(4,750,212)	(4,670,786)	(79,426)
340B Net Activity	76,393	16,439	59,954	71,406	200,008	(128,602)
Non-Operating Income/Loss	(412,715)	(320,501)	(92,214)	(3,526,456)	(4,285,108)	758,652
Net Income/Loss	153,879	53,451	400,428	1,433,967	264,738	1,169,229

***Northern Inyo Healthcare District
Preliminary Balance Sheet
Period Ending June 30, 2018***

Assets:	Current Month	Prior Month	Change
Current Assets			
Cash and Equivalents	5,672,114	5,360,119	311,995
Short-Term Investments	15,859,495	8,720,501	7,138,994
Assets Limited as to Use	-	-	-
Plant Replacement and Expansion Fund	-	-	-
Other Investments	1,094,029	1,094,029	-
Patient Receivable	58,366,562	60,823,121	(2,456,559)
Less: Allowances	(46,172,939)	(46,947,366)	774,427
Other Receivables	4,424,796	8,809,799	(4,385,002)
Inventories	4,312,454	4,100,318	212,136
Prepaid Expenses	1,999,722	1,612,575	387,146
Total Current Assets	45,556,234	43,573,097	1,983,137
Internally Designated for Capital			
Acquisitions	0	1,125,397	(1,125,396)
Special Purpose Assets	100,084	964,558	(864,474)
	-	-	-
Limited Use Asset; Defined Contribution			
Pension	1,541,073	1,457,067	84,006
Limited Use Assets Defined Benefit Plan	13,365,385	13,365,385	-
Limited Use Asset Defined Benefit Plan 003	14,391	14,391	-
Revenue Bonds Held by a Trustee	3,191,282	3,031,508	159,775
Less Amounts Required to Meet Current Obligations	-	-	-
Assets Limited as to use	18,212,215	19,958,305	(1,746,089)
Long Term Investments	1,600,000	1,750,000	(150,000)
Property & equipment, net of Accumulated			
Depreciation	76,789,746	77,225,146	(435,399)
Unamortized Bond Costs	-	-	-
Total Assets	142,158,195	142,506,547	(348,352)

***Northern Inyo Healthcare District
Preliminary Balance Sheet
Period Ending June 30, 2018***

Liabilities and Net Assets	Current Month	Prior Month	Change
Current Liabilities:			
Current Maturities of Long-Term Debt	2,110,089	2,110,089	-
Accounts Payable	2,185,263	2,808,789	(623,526)
Accrued Salaries, Wages & Benefits	6,151,557	7,288,680	(1,137,124)
Accrued Interest and Sales Tax	641,372	506,001	135,371
Deferred Income	77,428	121,383	(43,955)
Due to 3rd Party Payors	1,163,149	1,136,742	26,407
Due to Specific Purpose Funds	-	(620,882)	620,882
Other Deferred Credits; Pension	4,521,207	4,521,207	-
Total Current Liabilities	16,850,064	17,872,009	(1,021,945)
Long Term Debt, Net of Current Maturities	41,839,947	41,839,947	-
Bond Premium	534,494	541,740	(7,247)
Accreted Interest	12,193,679	12,083,130	110,549
Other Non-Current Liabilities; Pension	30,487,532	30,487,532	-
Total Long Term Debt	85,055,652	84,952,350	103,302
Net Assets			
Unrestricted Net Assets less Income			
Clearing	38,667,021	38,717,631	(50,610)
Temporarily Restricted	1,585,458	964,558	620,900
Net Income (Income Clearing)	(1,433,966)	(1,415,278)	(18,688)
Total Net Assets	40,252,479	39,682,189	570,290
Total Liabilities and Net Assets	142,158,195	142,506,547	(348,352)

Northern Inyo Healthcare District

Preliminary Financial Indicators as of June 30, 2018

	Target	Jun-18	May-18	Apr-18	Mar-18	Feb-18	Jan-18	Dec-17	Nov-17	Oct-17	Sep-17	Aug-17	Jul-17	Jun-17	May-17
Current Ratio	>1.5-2.0	2.70	2.44	2.46	2.43	2.47	2.50	2.41	2.18	2.26	2.45	2.42	2.49	3.39	3.83
Quick Ratio	>1.33-1.5	2.07	1.63	1.63	1.66	2.06	2.09	1.99	1.83	1.84	1.82	1.81	2.05	2.84	3.23
Days Cash on Hand prior method	>75	160.82	134.64	132.72	137.59	168.44	166.36	165.72	169.35	165.31	140.47	142.06	160.31	154.70	160.60
Sources	>75	94.05	61.83	57.21	51.38	83.49	81.30	83.05	87.18	81.28	53.95	59.26	79.93	79.37	75.71
Debt Service Coverage	>1.5-2.0	2.65	2.47	2.49	2.52	2.68	2.73	2.67	2.74	2.78	2.79	2.87	2.34	1.81	1.96
Operating Margin		5.57	5.57	5.50	5.18	5.09	4.87	5.79	5.87	7.64	7.49	8.45	6.67	4.71	6.18
Revenue		69.96	70.10	69.97	69.49	69.74	69.53	69.25	69.52	69.46	69.13	69.83	66.58	69.86	69.96
Cash flow (CF) margin (EBIDA to revenue)		3.18	3.33	3.43	3.53	4.17	4.31	4.05	4.30	4.69	4.82	5.62	3.68	2.48	2.84
Days in Patient Accounts Receivable	<60 Days	70.80	75.40	79.80	81.50	85.60	85.90	82.80	81.80	81.40	82.10	81.40	74.10	78.90	89.00

Debt Service Coverage as outlined in 2010 and 2013 Revenue Bonds require that the district has a debt service coverage ratio of 1.50 to 1 (can be 1:25 to 1 with 75 days cash on hand)

Debt Service Coverage is calculated as Net Income (Profit/Loss) from the Income Statement PLUS Depreciation & Interest Expense added back divided by the Current Interest & Principle for TOTAL DEBT from the Debt Information divided by number of closed fiscal periods

Current Ratio Equals (from Balance Sheet) Current Assets divided by Current Liabilities

Quick Ratio Equals (from Balance Sheet) Current Assets;Cash and Equivalents through Net Patient Accounts Receivable Only divided by Current Liabilities

Updated Days Cash on hand Short Term = current cash & short term investments / by total operating expenses year-to-date / by days in fiscal year

Operating Margin Equals (from Income Statement) Year-to-date Operating Income / (Year-to-date Net Patient Service Revenue+Other Operating Revenue+District Tax Receipts) *100

Outpatient Revenue % of Total Revenue Equal (from Income Statement) Gross Outpatient/Total Gross Patient Revenue

Cash Flow (CF) margin (EBIDA to revenue) Equals (from Income Statement) [Net Income+Interest+Depreciation+Amorization(if any)/Total Revenue] x 100

Accounts Receivable Days are pulled from the AR Aging report

NORTHERN INYO HEALTHCARE DISTRICT
Preliminary OPERATING STATISTICS
for period ending June 30, 2018

		FYE 2018	FYE 2017	Variance	Variance %
	Month to Date	Year-to-Date	Year-to-Date	from PY	
Licensed Beds	25	25	25		
Total Patient Days with NB	314	3,815	3,539	276	8%
Total Patient Days without NB	284	3,474	3,195	279	9%
Swing Bed Days	33	496	394	102	26%
Discharges without NB	99	1,106	1,091	15	1%
Swing Discharges	4	69	65	4	6%
Days in Month	30	365	365		
Occupancy without NB	9.47	9.52	8.75	0.8	9%
Average Stay (days) without NB	2.87	3.14	2.93	0.2	7%
Average LOS without NB/Swing	2.64	2.87	2.73	0.1	5%
Hours of Observation	896	8,920	9,025	(105)	-1%
Observation Adj Days	37	372	376	(4)	-1%
ER Visits All Visits	719	9,554	9,864	(310)	-3%
RHC Visits	2,002	29,237	24,364	4,873	20%
Outpatient Visits	-	-	-	-	#DIV/0!
IP Surgeries	26	249	274	(25)	-9%
OP Surgery	113	1,330	1,239	91	7%
Worked FTE's	348.52	346.21	333.24	13	4%
Paid FTE's	393.23	388.74	372.67	16	4%
Hours Worked to Hours Paid%	88.6%	89.1%	89.4%	-0.4%	0%
Payor %					
Medicare		43%	41%	2%	
Medi-Cal		20%	23%	-2%	
Insurance, HMO & PPO		34%	33%	1%	
Indigent (Charity Care)		0.8%	1%	-0.4%	
All Other		2%	2%	0%	
Total		<u>100%</u>	<u>100%</u>		

NORTHERN INYO HEALTHCARE DISTRICT
Investments as of June 30, 2018

ID	Purchase Date	Maturity Dat	Institution	Broker	Rate	Principal Invested
2	30-Jun-18	01-Jul-18	Local Agency Investment Fund	Northern Inyo Hospital	1.85%	15,459,495.25
3	28-Nov-14	28-Nov-18	American Express Centurion Bank	Financial Northeaster Corp.	2.00%	150,000.00
	15-Jun-18	15-Mar-19	BK Phoenixville - FNC	Financial Northeaster Corp.	2.20%	250,000.00
Short Term Investments						15,859,495.25
4	02-Jul-14	02-Jul-19	Barclays Bank	Financial Northeaster Corp.	2.05%	250,000.00
5	02-Jul-14	02-Jul-19	Goldman SachsBank USA NY CD	Financial Northeaster Corp.	2.05%	250,000.00
6	20-May-15	20-May-20	American Express Centurion Bank	Financial Northeaster Corp.	2.05%	100,000.00
7	26-Sep-16	27-Sep-21	Comenity Capital Bank	Multi-Bank Service	1.70%	250,000.00
8	02-Sep-16	28-Sep-21	Capital One Bank	Multi-Bank Service	1.70%	250,000.00
9	28-Sep-16	28-Sep-21	Capital One National Assn	Multi-Bank Service	1.70%	250,000.00
10	28-Sep-16	28-Sep-21	Wells Fargo Bank NA	Multi-Bank Service	1.70%	250,000.00
Long Term Investments						\$ 1,600,000.00
Total Investments						\$ 17,459,495.25
1	30-Jun-18	01-Jul-18	LAIF Defined Cont Plan	Northern Inyo Hospital	1.85%	1,541,072.72
LAIF PENSION INVESTMENTS						\$ 1,541,072.72

NORTHERN INYO HEALTHCARE DISTRICT

Preliminary BUDGET VARIANCE ANALYSIS

Fiscal Year Ending June 30, 2018

Year to date for the month ending June 30, 2018

276	or	7.8%	more IP days than in the prior fiscal year
\$ 2,617,453	or	6.2%	over budget in Total IP Revenue and
\$ 9,071,510	or	9.5%	over budget in OP Revenue resulting in
\$ 11,688,963	or	8.5%	over budget in gross patient revenue &
\$ 4,957,733	or	6.0%	over budget in net patient revenue

Year-to-date Net Revenue was	\$		87,375,259
Total Operating Expenses were:	\$		83,563,397
		for the fiscal Year To Date	
\$ (4,791,231)	or	-6.1%	over budget. Salaries and Wages were
\$ 1,696,756	or	6.2%	under budget and Employee Benefits
\$ (1,096,078)	or	-5.9%	over budget
		77%	Employee Benefits as Percentage of Wages

The following expense areas were also over budget for the year for reasons listed:

\$ (4,311,077)	or	-50.5%	Professional Fees are over budget due to contract labor budgeted as employees
\$ (678,358)	or	-16.3%	Other Expenses are over budget due to timing difference on Liability Insurance, Surgery Lease, Plant Utilities as well as Chemistry and Pharmacy spending
\$ (167,582)	or	-5.9%	Bad Debts are over budget due to higher volume of Outpatient services provided

Other Information:

\$ 4,960,423	Operating Income, less		
\$ (3,526,456)	loss in non-operating activities resulted in a Net Income of:		
\$ 1,433,967	or	\$ 1,169,229	over budget.
		41.60%	Actual Contractual Percentages for Year versus
		40.24%	Budgeted Contractual Percentages including

\$ 4,804,354	in prior year cost report favorable settlement activity for Medicare & Medi-Cal		
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Non-Operating activities included:

\$ (4,750,212)	loss	\$ (79,426)	unfavorable to budget in Medical Office Activities
\$ 1,559,430		\$ 1,059,428	favorable to budget in Grants and Other Contributions

NORTHERN INYO HEALTHCARE DISTRICT

Restricted and Specific Purpose Fund Balances

for period ending June 30, 2018

	Current Month	Prior Month	Change
Board Designated Funds:			
Tobacco Fund Savings Account	\$ 1,098,670	\$ 1,098,670	-
Equipment Fund Savings Account	\$ 26,727	\$ 26,727	0
Total Board Designated Funds:	\$ 1,125,397	\$ 1,125,397	\$ 0
Specific Purpose Funds:			
* Bond and Interest Savings Account	\$ 1,545,944	\$ 834,044	\$ 711,900
Nursing Scholarship Savings Account	\$ 30,448	\$ 30,448	\$ -
Medical Education Savings Account	\$ -	\$ -	\$ -
Joint NIHD/Physician Group Savings Account	\$ 100,066	\$ 100,066	\$ -
Total Specific Purpose Funds:	\$ 1,676,458	\$ 964,558	\$ 711,900
Grand Total Restricted and Specific Purposes Funds:	\$ 2,801,855	\$ 2,089,954	\$ 711,901

CALL TO ORDER The meeting was called to order in the main lobby of Northern Inyo Hospital at 150 Pioneer Lane, Bishop, California at 5:30 pm by John Ungersma MD, District Board President.

PRESENT John Ungersma MD, President
M.C. Hubbard, Vice President
Mary Mae Kilpatrick, Secretary
Jean Turner, Treasurer
Robert Sharp, Member-at-Large
Kevin S. Flanigan MD, MBA, Chief Executive Officer
Kelli Huntsinger, Chief Operating Officer
John Tremble, Chief Financial Officer
Tracy Aspel RN, Chief Nursing Officer
Evelyn Campos Diaz, Chief Human Resources Officer
Allison Robinson MD, Chief of Staff
Sandy Blumberg, Executive Assistant

OPPORTUNITY FOR PUBLIC COMMENT Doctor Ungersma stated at this time persons in the audience may speak on any items not on the agenda on any matter within the jurisdiction of the District Board. Members of the audience will have an opportunity to address the Board on every item on the agenda, and speakers will be limited to a maximum of three minutes each. Comments regarding the contract renewal between the American Federation of State, County, and Municipal Employees (AFSCME) and Northern Inyo Healthcare District (NIHD) were heard from the following:

- Vickie Labraque RN
- Laura Partridge RN
- Lori Gable RN
- Cynthia McCarthy RN
- Allison Jackson RN
- Andrew Stevens RN
- Lauren Ricksecker RN
- Tavis Ricksecker RN
- Althea Gallahan RN

CHIEF EXECUTIVE OFFICER REPORT Chief Executive Officer Kevin S. Flanigan MD, MBA provided a bi-monthly Chief Executive Officer Report which included the following:

- The California Department of Public Health is on site this week for the purpose of conducting a full facility site survey
- The NIHD Quality Department has been reorganized, and Quality tasks have been imbedded into a larger number of departments within the organization. As a result of the reorganization additional quality monitoring responsibilities have been assigned to the Medical Staff Office; the Compliance Department; and to clinical areas.

MEDICAL STAFF
SERVICES REPORT

Doctor Flanigan reviewed the quarterly Medical Staff Services Pillars of Excellence report, which showed a dramatic increase in the number of Medical Staff applications processed as the result of the District adding new services. The majority of the metrics reported upon showed that Medical Staff Services performance exceeds expectations.

CHIEF OPERATING
OFFICER REPORT

Chief Operating Officer Kelli Huntsinger provided a report which included the following:

- The District is expanding training and educational opportunities for staff, including a "Grow Your Own" training program for the Clinical Lab
- Career ladders have been established for the Clinical Lab and Rehabilitation Services Departments
- The District's survey readiness efforts are ongoing
- The talent pool established for the purpose of training employees to work in multiple areas of the hospital is proving to be successful
- Safety and Workplace Violence Prevention continue to be a focus in all areas of the District
- The District is acting as the lead in a community-wide Safety Task Force created for the purpose of violence prevention

INTERIM DIRECTOR/S
OF NUTRITIONAL
SERVICES

Ms. Huntsinger additionally reported NIHD's Director of Nutritional Services Amber Morin has relocated out of the area, and District leadership requests approval to designate herself and Denice Hynd (Manager of Nutrition Services) to act as Co-Interim Directors of NIHD Nutritional Services until such time as a replacement for Ms. Morin can be found. It was moved by M.C. Hubbard, seconded by Mary Mae Kilpatrick, and unanimously passed to approve Ms. Huntsinger and Ms. Hynd to act as Co-Directors of NIHD Nutritional Services as requested.

CHIEF NURSING
OFFICER REPORT

Chief Nursing Officer Tracy Aspel, RN provided an update on Nursing Department Services which included the following:

- A preceptor program has been developed for newly-hired RNs
- The District will switch to the *Relias* learning management system
- NIHD's Language Services Call Center is up and running
- Rhonda Aihara, RN has received certification as a lactation consultant
- NIHD Nursing Staff continues to prepare for implementation of the Athena Health Information System in September

POLICY & PROCEDURE
APPROVAL,
AUTHORIZATION OF
HOURS WORKED
BEYOND REGULARLY
SCHEDULED SHIFT

Ms. Aspel also called attention to a revised Policy and Procedure titled *Authorization of Hours Worked Beyond Regularly Scheduled Shift (Including Overtime Request)*. It was moved by Ms. Kilpatrick, seconded by Jean Turner, and unanimously passed to approve the revised Policy and Procedure titled *Authorization of Hours Worked Beyond Regularly Scheduled Shift (Including Overtime Request)* as presented.

CHIEF HUMAN
RESOURCES OFFICER
REPORT

Chief Human Resources Officer (CHRO) Evelyn Campos Diaz provided an update on NIHD Human Resources Department services, noting the District continues its efforts in the areas of employee engagement and empowerment, and in expanding leadership and staff development trainings and opportunities. She additionally reported on the District's workplace violence prevention efforts; on orientations for on-boarding new leaders; and on the District's newly established Telework program.

HUMAN RESOURCES
POLICY AND
PROCEDURE
APPROVALS

Ms. Campos Diaz also called attention to approval of the following revised Human Resources Policies and Procedures:

- *Introduction*
- *Acknowledgement Form*
- *Employee Recognition*
- *Learning Internships, Clinical or Academic Rotations, and Career Shadowing Opportunities*

She additionally called attention to a new District-wide Policy and Procedure titled *Discrimination and Harassment Prevention Policy and Procedure*, which is a combination of several pre-existing policies. It was moved by Ms. Kilpatrick, seconded by Ms. Turner, and unanimously passed to approve all four revised Human Resources Policies and Procedures, and the new Policy and Procedure titled *Discrimination and Harassment Prevention Policy and Procedure* as presented.

CHIEF FINANCIAL
OFFICER REPORT

Chief Financial Officer John Tremble provided a Finance Department report which included the following:

- The Accounting Department continues to prepare for Athena Health Information System implementation. Once the Athena system has been implemented, the Finance Department will be working with a total of four different software systems.
- The District's annual audit will take place during the month of August
- Thanks in part to the receipt of Intergovernmental Transfer funds, the District will realize it's goal of achieving 90 days cash on hand by the end of the fiscal year
- The number of days that patient accounts are in receivables is improving

STRATEGIC PLAN
UPDATE, FINANCE

Controller Gennifer Owens provided a report from the Financial and Market Share Committee, which has been established to help accomplish the finance-related goals of the District's Strategic Plan. Ms. Owens introduced Committee members to the Board, and reported that the metrics they are studying relate to budget adherence and to market share analysis.

OLD BUSINESS

ATHENA
IMPLEMENTATION
UPDATE

Director of Information Technology Services Robin Cassidy provided an update on the progress of the Athena Health Information System project, noting the District is 69 days away from Go Live. It is possible the date

for Go Live may be moved to October 1st in order to allow the changeover to take place at the end of a fiscal quarter. The Athena Go Live project will bring 9 new electronic products onboard for the District.

GRANT FUNDING
UPDATE

Doctor Flanigan reported that the grant funding sought by the District and the County of Inyo for the purpose of providing improved adolescent education will not be forthcoming, due to the fact that the proposed program does not meet funding eligibility requirements.

PROCESS FOR FILING
BOARD VACANCIES
AND ONBOARDING OF
NEW BOARD
MEMBERS

Ms. Campos Diaz called attention to draft policies and procedures relating to the filling of Board vacancies and the on-boarding of new Board Members. The draft policies will be reviewed, revised, and improved upon during the next month, and it is expected that they will be presented for approval at the August regular meeting of the District Board.

CONSENT AGENDA

Doctor Ungersma called attention to the Consent Agenda for this meeting, which contained the following items:

- Approval of minutes of the June 20 2018 regular meeting
- Financial and Statistical reports as of May 31 2018
- 2013 CMS Survey Validation Monitoring, July 2018
- Policy and Procedure annual approvals

It was moved by Robert Sharp, seconded by Ms. Kilpatrick, and unanimously passed to approve all four Consent Agenda items as presented.

CHIEF OF STAFF
REPORT

Chief of Staff Allison Robinson MD reported following careful review, consideration, and approval by the appropriate Committees the Medical Executive Committee recommends approval of the following Policies, Procedures, Protocols, and Order Sets:

POLICIES,
PROCEDURES,
PROTOCOLS, AND
ORDER SETS

1. *Accepting Orders for Outpatient Infusion Services from Non-Privileged Practitioners*
2. *Ambulatory Care Pharmacist Interview Questions*
3. *Blood Product Replacement During Obstetric Hemorrhage*
4. *Fentanyl Patch Ordering Protocol*
5. *Heparin Dosing Protocol*
6. *Home Medication Verification - Medication Reconciliation*
7. *Intravenous Medication Policy*
8. *Methadone for Withdrawal Order Verification*
9. *Point of Care Accu-Chek Blood Glucose Testing*
10. *Thrombolytic Therapy for Acute Myocardial Infarction*
11. *Vancomycin Dosing*
12. *Furnishing Medications/Devices Policy for the Nurse Practitioner or Certified Nurse Midwife - Standardized Procedure*

It was moved by Ms. Hubbard, seconded by Ms. Turner, and unanimously passed to approve all twelve Policies, Procedures, Protocols, and Order Sets 2 as presented.

FAMILY MEDICINE CORE PRIVILEGE FORM	Doctor Robinson also stated the Medical Executive Committee requests approval of the <i>Family Medicine Core Privilege Form</i> . It was moved by Mr. Sharp, seconded by Ms. Kilpatrick, and unanimously passed to approve the <i>Family Medicine Core Privilege Form</i> as presented.
MEDICAL STAFF RESIGNATIONS	Doctor Robinson reported the Medical Executive Committee also recommends approval of the following Medical Staff resignations: <ol style="list-style-type: none">1. Michael Abdulian MD (<i>Orthopedic Surgery, Adventist Health</i>) - effective June 11 20182. Helena Black MD (<i>Emergency Medicine</i>) effective June 30 20183. Gregg McAninch MD (<i>Radiology</i>) - effective June 30 2018 It was moved by Ms. Kilpatrick, seconded by Ms. Hubbard, and unanimously passed to approve all three Medical Staff resignations as requested.
MEDICAL STAFF APPOINTMENTS AND PRIVILEGES	Doctor Robinson also reported following careful review, consideration, and approval by the appropriate Committees the Medical Executive Committee recommends approval of the following Medical Staff appointments and privileges: <ol style="list-style-type: none">1. Jared M. Kasper MD (<i>Radiology</i>) - Provisional Consulting Staff2. Anne K. Wakamiya MD (<i>Internal Medicine</i>) - Provisional Active Staff It was moved by Mr. Sharp, seconded by Ms. Hubbard and unanimously passed to approve both Medical Staff appointments and privileges as requested.
STAFF CATEGORY CHANGES	Doctor Robinson additionally requested approval of the following Medical Staff Category changes: <ol style="list-style-type: none">1. Arsen Mkrtchyan MD (<i>Internal Medicine/Hospitalist</i>) - from Locum Tenens Staff to Provisional Active Staff2. Helena Black MD (<i>Emergency Medicine</i>) - appointment to Honorary Staff It was moved by Ms. Hubbard, seconded by Ms. Turner, and unanimously passed to approve both Medical Staff Category changes as requested.
TELEMEDICINE STAFF APPOINTMENTS / PRIVILEGES	Doctor Robison also reported the Medical Executive Committee recommends approval of the following Telemedicine Staff Appointments/Privileges - Proxy Credentialing: <ol style="list-style-type: none">1. Navid Ezra MD (<i>Dermatology</i>) - Adventist Health, Telemedicine Staff2. Shiela Lezcano MD (<i>correction to Rheumatology, not Endocrinology</i>) - Adventist Health, Telemedicine Staff It was moved by Ms. Turner, seconded by Ms. Kilpatrick, and unanimously passed to approve both Telemedicine Staff Appointments/Privileges - Proxy Credentialing as requested.
BOARD MEMBER REPORTS	Doctor Ungersma asked if any members of the Board of Directors wished to comment on any items of interest. Director Hubbard was pleased to

announce that NIHD has received Association of California Healthcare Districts (ACHD) Certification, making NIHD one of only 20 Healthcare Districts in the State of California which are certified.

Doctor Ungersma then provided a presentation titled "*The Universe Is Change*" for the pleasure of those present. Doctor Ungersma's presentation provided an overview of the history of the Healthcare District since its inception, and whimsically predicted what healthcare may look like in the future. At the end of his presentation, Doctor Ungersma announced that following 18 years of service he will resign from the District Board effective July 19, 2018. Those presented applauded Doctor Ungersma for his years of dedicated service, and expressed how much he is appreciated and how much he will be missed.

ADJOURNMENT TO
CLOSED SESSION

At 8:02 pm Doctor Ungersma announced the meeting would adjourn to Closed Session to allow the Board of Directors to/for:

- A. Discussion of Labor Negotiations; Agency Designated Representative: Kevin Dale; Employee Organization: AFSCME Council 57 (*pursuant to Government Code Section 54957.6*)
- B. Discuss trade secrets, new programs and services (estimated public session date for discussion yet to be determined) (*Health and Safety Code Section 32106*).
- C. Confer with Legal Counsel regarding pending and threatened litigation, Existing litigation and significant exposure to litigation, 4 matters pending (*pursuant to Government Code Section 54956.9*).

RETURN TO OPEN
SESSION AND REPORT
OF ACTION TAKEN

At 9:10 pm the meeting returned to open session. Doctor Ungersma reported the Board took no reportable action.

ADJOURNMENT

The meeting was adjourned at 9:11 pm.

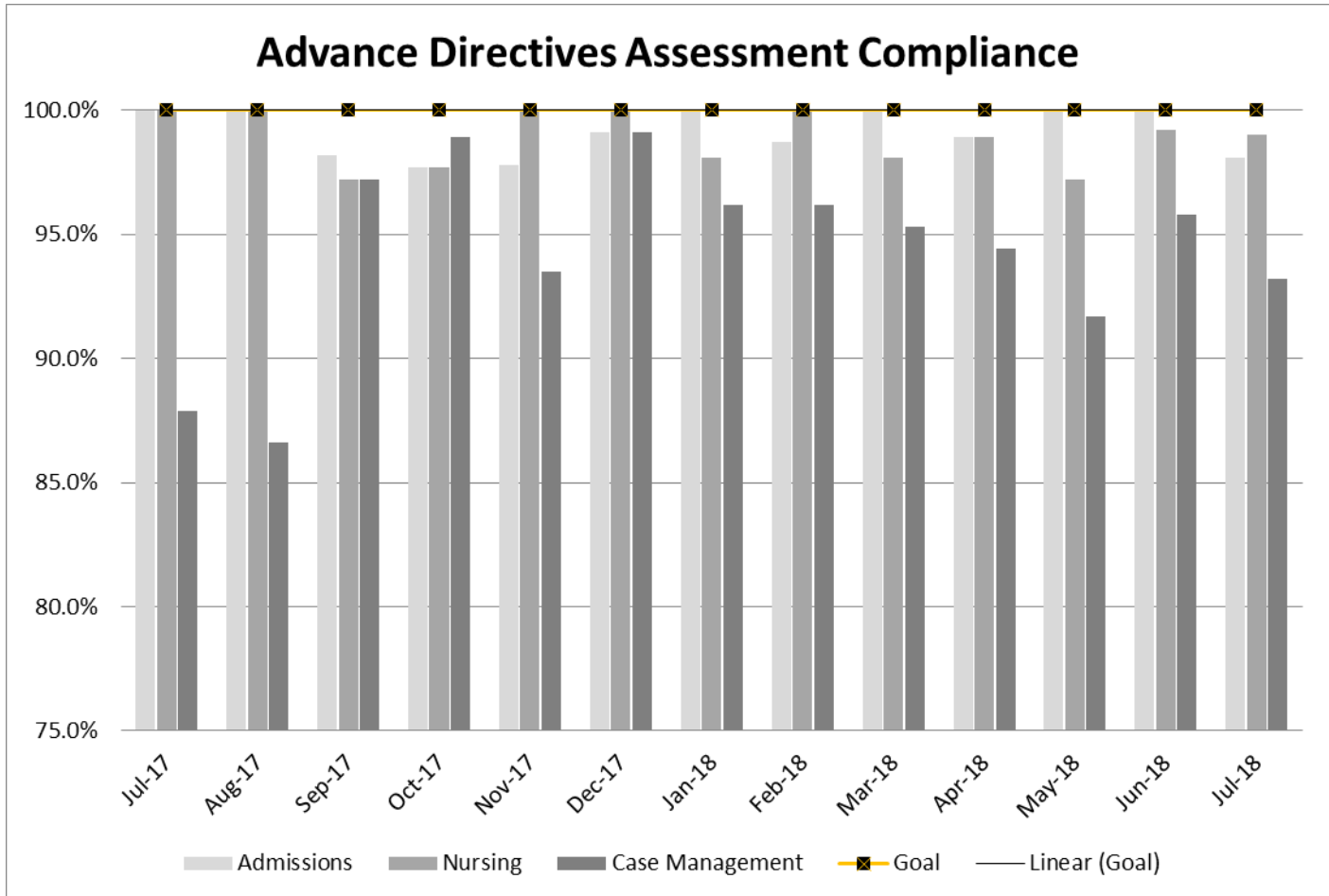
John Ungersma, President

Attest:

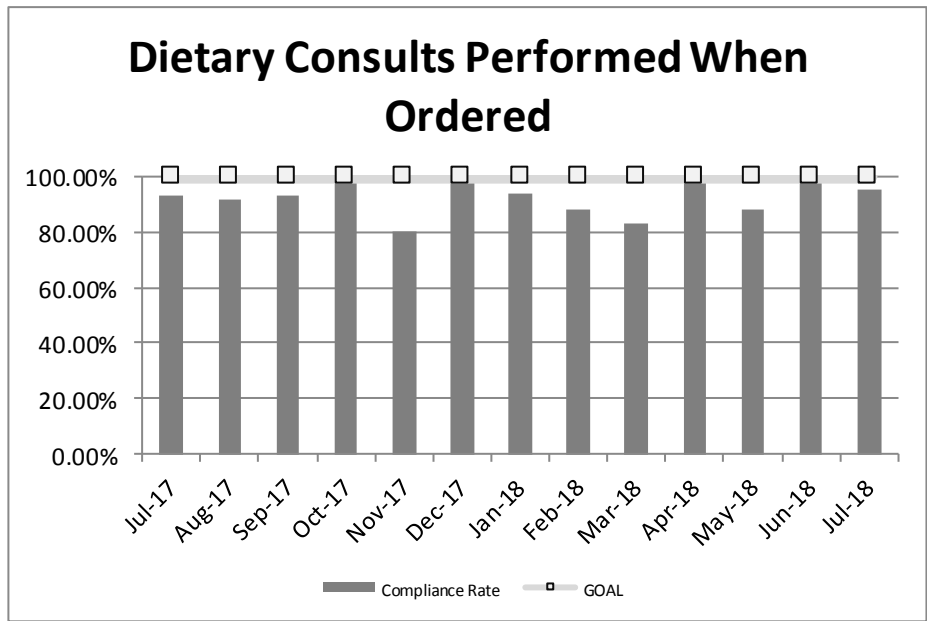
Mary Mae Kilpatrick, Secretary

2013 CMS Validation Survey Monitoring-August 2018

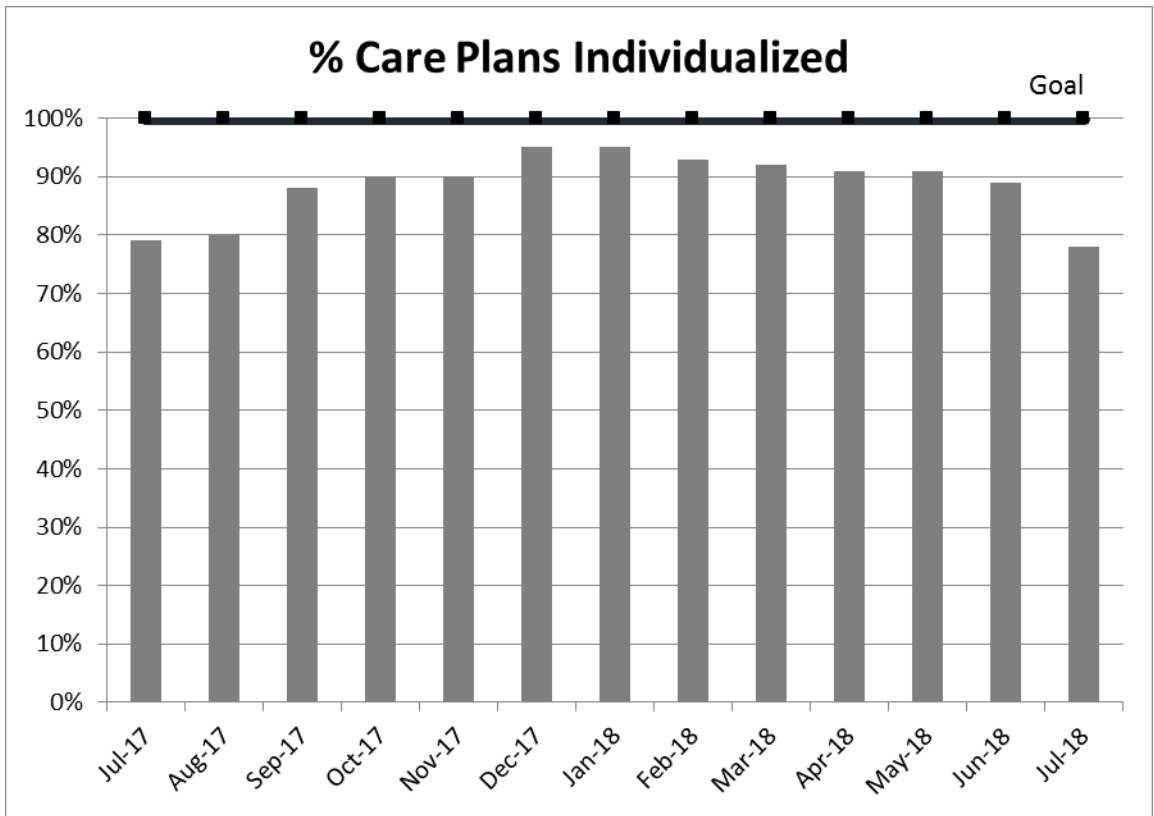
1. QAPI continues to receive and monitor data related to the previous CMS Validation Survey, including but not limited to, restraints, dietary process measures, case management, pain re-assessment, as follows:
 - a. Advance Directives Monitoring.



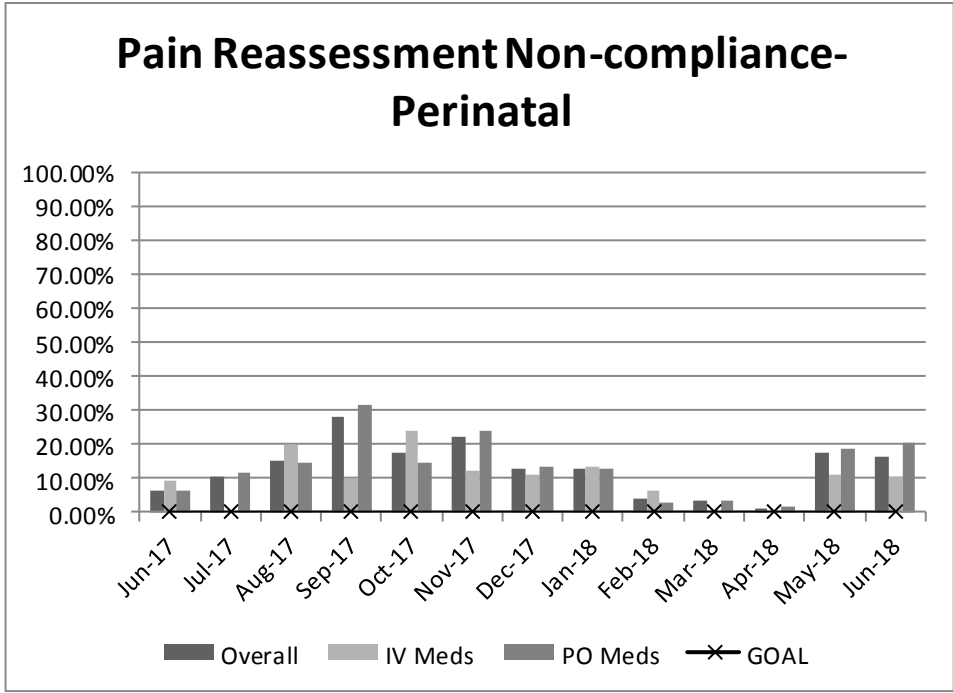
- b. Positive Lab Cultures are being routed to Infection Prevention and each positive is being investigated as to source. Monitoring has been ongoing and reported through Infection Control Committee. QAPI receives data.
 - c. Safe Food cooling monitored for compliance with approved policy and procedure. 100% compliance since May 6, 2013.
 - d. Dietary hand washing logs have been reported and are at 100% compliance since May 6, 2013.
 - e. QAPI continues to monitor dietary referrals and the number of consults completed within 24 hours.



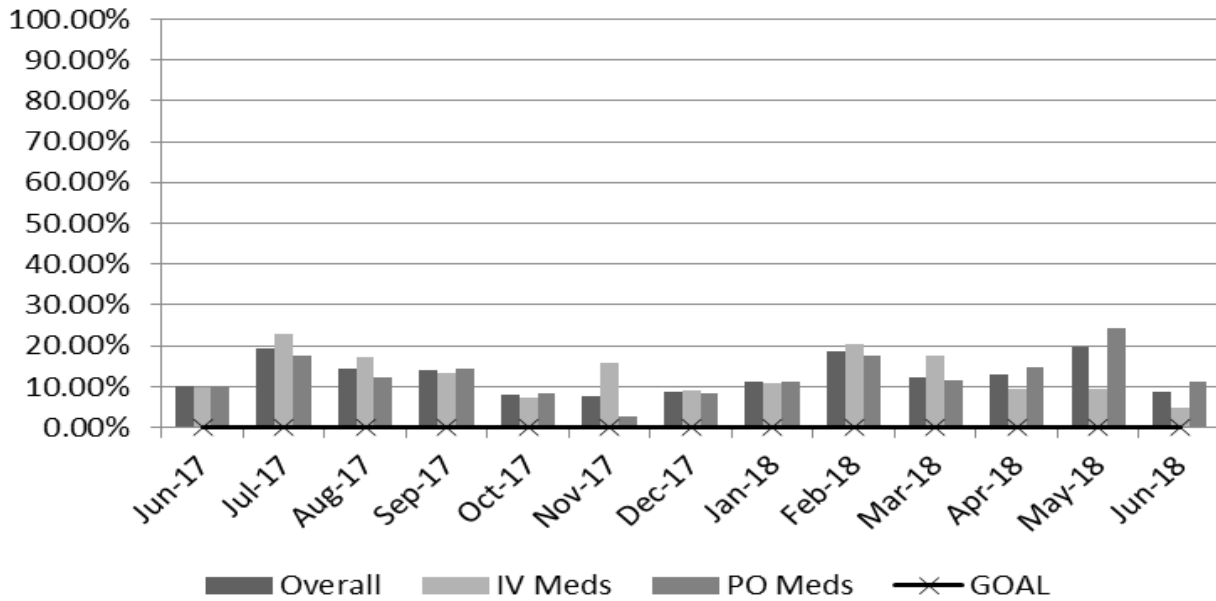
f. Care plans reviewed by Case Management and interventions made to produce care plans. Progress has been made in developing individualized care plans.



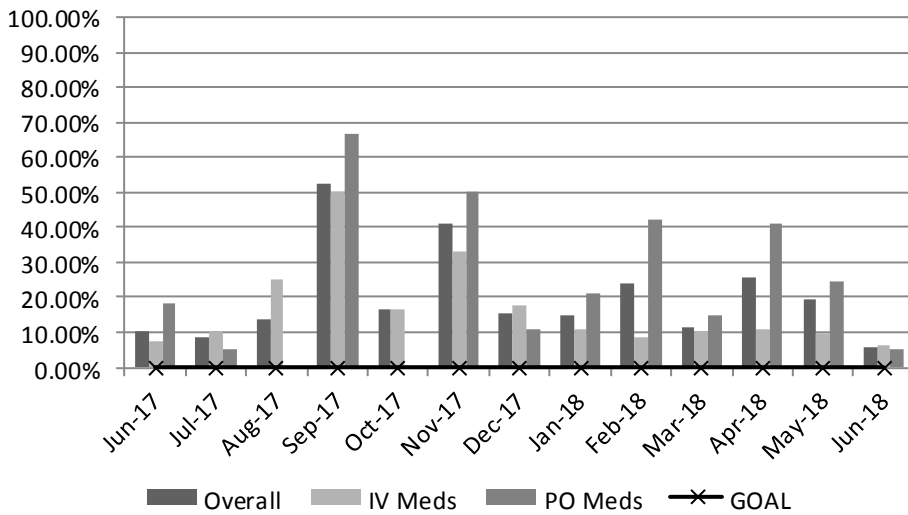
- g. Fire drill date, times, attendance and outcomes, smoke detector tests, and fire extinguisher test grids have been approved. All fire drills were complete and compliant from May 6, through present.
- h. Pain Re-Assessment. NIH conducts pain re-assessment after administering pain medications and uses a 1-10 scale.



Pain Reassessment Non-compliance- MedSurg



Pain Reassessment Non-compliance- ICU



Note: Due to small sample sizes in the ICU, results should be interpreted with caution for this unit.

Pain Reassessment Non-compliance- ED

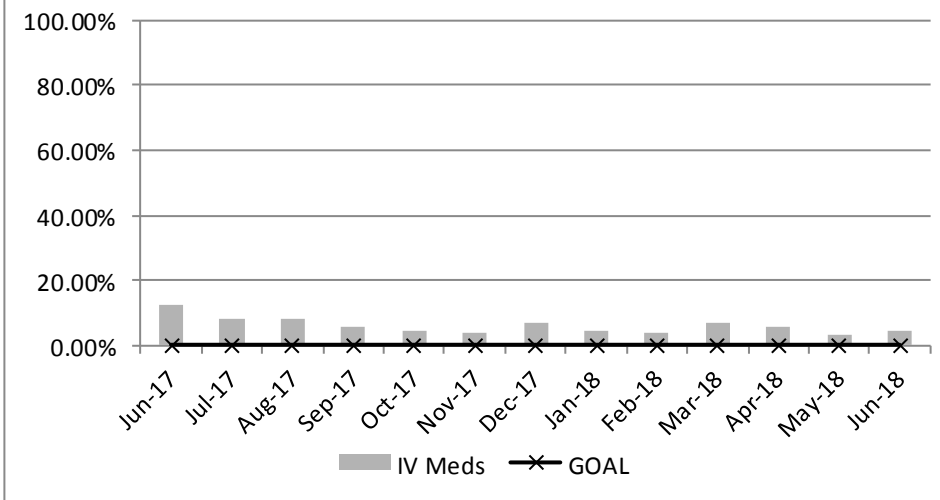


Table 6. Restraint chart monitoring for legal orders.

	<i>Dec 2017</i>	<i>Jan 2018</i>	<i>Feb* 2018</i>	<i>Mar 2018</i>	<i>April 2018</i>	<i>May 2018</i>	<i>June 2018*</i>	<i>July 2018*</i>	<i>Goal</i>
Restraint verbal/written order obtained within 1 hour of restraints	3/3 (100%)	1/1 (100%)		2/2 (100%)	1/1 (100%)	1/2 (50%)			100%
Physician signed order within 24 hours	2/3 (66%)	0/1 (0%)		2/2 (100%)	1/1 (100%)	1/2 (50%)			100%
Physician Initial Order Completed (all areas completed and form/time/date noted/signed by MD and RN)	1/3 (33%)	0/1 (0%)		1/2 (50%)	0/1 (0%)	1/2 (50%)			100%
Physician Re-Order Completed (all areas completed and form time/date/noted/signed by MD and RN)	2/6 (33%)	N/A		3/6 (50%)	N/A	N/A			100%
Orders are for 24 hours	9/9 (100%)	1/1 (100%)		8/8 (100%)	1/1 (100%)	2/2 (100%)			100%
Is this a PRN (as needed) Order	0/9 (0%)	0/1 (0%)		0/8 (0%)	0/1 (0%)	0/2 (0%)			0%

***Indicates no patients for this time frame**

COMPLIANCE DEPARTMENT
POLICY AND PROCEDURE ANNUAL APPROVALS
AUGUST 2018

1. FALSE CLAIMS ACT EMPLOYEE TRAINING AND PREVENTION POLICY
2. GOVERNMENTAL AGENT SERVICES
3. MINIMUM NECESSARY ACCESS, USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION (PHI)
4. REGULATORY SURVEY SECURITY POLICY AND PROCEDURE

POLICIES TO THE BOD
Diagnostic Imaging

POLICY & PROCEDURES TO THE BOARD

August

DEPT. DI Department

		TO BOD	COMMENTS
1	Screening mammography -3D	8/1/2018	
2	DI - Communication of Mammography results to the patient	8/1/2018	
3	DI Mammography infection control policy	8/1/2018	
4	Contrast use with patients on metformin	8/1/2018	
5			
6			
7			
8			

**POLICIES TO THE BOD
ENVIRONMENTAL**

POLICY & PROCEDURES TO THE BOARD

8/15/2018

DEPT. ENVIRONMENTAL

		TO BOD	COMMENTS
1	Cleaning Procedures: Room/Building Components: Light Fixtures	8/15/2018	
2	Cleaning Procedures: Room/Building Components: Machine Buffing	8/15/2018	
3	Cleaning Procedures: Room/Building Components: Machine Scrubbing	8/15/2018	
4	Cleaning Procedures: Room/Building Components: Vacuuming	8/15/2018	
5	Cleaning Procedures: Room/Building Components: Walls	8/15/2018	
6	Cleaning Procedures: Room/Building Components: Wet Mopping	8/15/2018	
7	Cleaning Procedures: Room/Building Components: Windows	8/15/2018	
8	Cleaning Procedures: Specialized Areas: Central Supply	8/15/2018	
9	Cleaning Procedures: Specialized Areas: Nursery	8/15/2018	
10	Cleaning Procedures: Specialized Areas: Operating Rooms, Between Cases	8/15/2018	
11	Cleaning Procedures: Specialized Areas: Perinatal Unit	8/15/2018	
12	Cleaning Procedures: Specialized Areas: Surgical Suite (In-Depth)	8/15/2018	
13	Cleaning Procedures: Various Non-Patient Care Equipment	8/15/2018	
14	Cleaning the Pharmacy Sterile IV Preparation Area. (Clean Room)	8/15/2018	
15	Competency Plan	8/15/2018	
16	Compliance: Competency/Criteria Based on Job Description Form	8/15/2018	
17	Compliance: Documentation of Annual Competencies	8/15/2018	
18	Compliance: Miscellaneous Information	8/15/2018	
19	De-escalation Team	8/15/2018	

Maintenance *Life Safety* Policies and Procedures 2018

1. Assessment of Responsibility for Life Safety Activities
2. Appointment of Life Safety Program
3. Performing Life Safety Building Assessment
4. Maintaining Current Life Safety Drawings
5. Meeting Survey PFI (Plan for Improvement)
6. Documenting Inspections and Approvals by Fire Control Agencies
7. Removing Life Safety Features
8. ILSM (Interim Life Safety Measures)
9. Fire Watch
10. Building and Fire Protection Features (Healthcare)
11. Maintaining Means of Egress
12. Fire and Smoke Protection
13. Fire Alarm Systems
14. Providing & Maintaining Fire Extinguishing Systems
15. Special Fire Protection Features
16. Building Services
17. Decorations, Receptacles & Heating Devices

Medical Staff Office Policies and Procedures

Revised 8/8/2018

Number	Policy Title	Source	Manual
1	Accepting Orders for Outpatient Infusion Services from Non-Privileged Practitioners	Med Staff Manager	Infusion Center/ Med Staff
2	Anesthesia Clinical Standards and Professional Conduct	Chief of Surgery	Anesthesia/ Med Staff
3	Credentialing - da Vinci Robotic Surgery	Chief of Surgery/ Med Staff Manager	Med Staff
4	Credentialing Health Care Practitioners in the Event of a Disaster	Med Staff Manager	Med Staff
5	End of Life Option Act	Med Staff	CPM?
6	Focused and Ongoing Professional Practice Evaluation	Med Staff Manager	Med Staff
7	Medical Ethics Referrals and Consultations	Chief of Staff	Med Staff
8	Medical Staff and Allied Health Professional Application Fee Processing	Med Staff Manager	Med Staff
9	Medical Staff and Allied Health Professional Educational Requirements	Med Staff Manager	Med Staff
10	Order Set Approval and Archiving	Chief of Staff	Med Staff
11	Practitioner Complaint Resolution Process	Med Staff Manager	Med Staff
12	Pre and Post Operative Anesthesia Visits	Chief of Surgery	Anesthesia
13	Professional Conduct. Prohibition of Disruptive or Discriminatory Behavior	Kevin Flanigan/ Med Staff	Med Staff
14	Request for Establishment of New Privilege or Service	Med Staff Manager	Med Staff
15	Scope of Anesthesia Practice	Chief of Surgery	Anesthesia

CALL TO ORDER The meeting was called to order at 6:00 pm by M.C. Hubbard, Vice President in the Northern Inyo Healthcare District Board Room at 2957 Birch Street, Bishop, California.

PRESENT M.C. Hubbard, Vice President
Mary Mae Kilpatrick, Secretary
Jean Turner, Treasurer
Robert Sharp, Member at Large
Evelyn Campos Diaz, Chief Human Resources Officer
Sandy Blumberg, Executive Assistant

ABSENT John Ungersma MD, President
Kevin S. Flanigan MD, MBA, Chief Executive Officer
Kelli Huntsinger, Chief Operating Officer
John Tremble, Chief Financial Officer
Tracy Aspel RN, Chief Nursing Officer
Richard Meredick MD, Chief of Staff

OPPORTUNITY FOR PUBLIC COMMENT Ms. Hubbard announced at this time persons in the audience may speak only on items listed on the Notice for this meeting, and speakers will be limited to a maximum of three minutes each. No comments were heard.

DEVELOPMENT OF PROCESS FOR FILLING BOARD VACANCIES AND ON-BOARDING NEW BOARD MEMBERS An open discussion took place on the subject of developing a process for filling Northern Inyo Healthcare District (NIHD) Board vacancies and on-boarding new Board members. A draft process was developed that will be reviewed further and presented for the approval of the full Board at a future meeting.

ADJOURNMENT The meeting was adjourned at approximately 7:30 pm.

M.C. Hubbard, Vice President

Attest:

Mary Mae Kilpatrick, Secretary



NORTHERN INYO HOSPITAL
Northern Inyo Healthcare District
150 Pioneer Lane, Bishop, California 93514

Medical Staff Office
(760) 873-2136 voice
(760) 873-2130 fax

TO: NIHD Board of Directors
FROM: Allison Robinson, MD, Chief of Medical Staff
DATE: August 7, 2018
RE: Medical Executive Committee Report

The Medical Executive Committee met on this date. Following careful review and consideration, the Committee agreed to recommend the following to the NIHD Board of Directors:

A. Policies/Procedures/Protocols/Order Sets (*action items*)

1. *Abuse Policy for Swing Bed Patients*
2. *Cepheid Xpert CT/NG PCR Assay*
3. *Coroner's Cases*
4. *Delayed Blood Bank Banding of Patients*
5. *Emergency Department Telephone Advice Information*
6. *Emergency Order and Shipment of Blood Components from UBS*
7. *Malignant Hypothermia Cart Check*
8. *Newborn Blood Glucose Monitoring*
9. *Scope of Service ICU*
10. *Sexual Assault Exam Policy*
11. *Surveillance for Hospital Acquired Infections (HAI's)*

B. Medical Staff Resignations (*action items*)

1. Ryan Berecky, MD (*Tahoe Carson Radiology*) – effective July 11, 2018
2. Nicholas Carlevato, MD (*Tahoe Carson Radiology*) – effective July 11, 2018

C. Medical Staff Appointments/Privileges (*action item*)

1. Kevin M. Deitel, MD (*orthopedic surgery*) – Provisional Consulting Staff, on-call only

**NORTHERN INYO HOSPITAL
POLICY AND PROCEDURE**

Title: Abuse Policy for Swing Bed Patients	
Scope: Acute/Subacute Services	Manual: Patient Safety (PS), Swing Bed
Source: Manager - ICU Acute/Subacute	Effective Date: 12/17/14

PURPOSE:

1. To provide physical and emotional safety, courtesy, dignity, and respect for all swing bed patients. Northern Inyo Hospital makes every attempt to ensure that residents are free from all forms of abuse, and takes appropriate action for any suspected cases of abuse.
2. To outline actions and procedures to be taken by Northern Inyo Hospital upon report of suspected patient abuse. Abuse can be categorized as follows: verbal, sexual, emotional, exploitative or neglect.

POLICY:

1. All employees are responsible for being observant and reporting all suspected or obvious incidents of patient abuse.
2. NIH performs appropriate screening of all new employees and does not hire anyone that has been found to have a prior conviction of elder abuse.
3. Any suspected dependent adult/elder abuse will be reported to the CEO or designee with collaboration of employee's immediate supervisor, using the appropriate form.

PROCEDURE:

NIHD investigates, documents, takes corrective action when needed, reports all cases of suspected abuse and misappropriation of patient's property to appropriate agencies. The Administrator will be notified as soon as possible of any such incidents.

1. Any employee who receives information about suspected abuse as a hospital employee is a "mandated reporter" and is responsible for reporting it to their immediate supervisor and/or Human Resources. *(California code states, "Any mandated reporter, who, in his or her professional capacity, or within the scope of his or her employment, has observed or has knowledge of an incident that reasonably appears to be abuse, is required to report immediately or as soon as practically possible ".)*
 - a. Alleged violations related to abuse and neglect are reported within two (2) hours of allegation in instances of abuse or serious bodily injury and within twenty-four (24) of allegation if not involving abuse or serious bodily injury.
2. Any employee who receives information about abuse or misappropriation of patient property will immediately, verbally, report the incident or suspicion to their immediate supervisor. Supervisors are to proceed with reporting allegations to Chief Nursing Officer and/or Human Resources.
3. When an incident of any form of patient abuse is suspected, reported, or observed, the following measures must be initiated: Chief Nursing Officer, or her designee, will notify the California Department of Public Health (CDPH) immediately using 800-344-2896, or faxing the information to 909-888-2315. This will be followed up with a brief written report of the allegation within 5 working days faxed or mailed to the CDPH.
4. The report will include the date and time of the suspected incident, the name of the abused patient, the name of the employee involved, the circumstances surrounding the incident, any others who witnessed the incident, and any other pertinent information.
5. The immediate supervisor of the employee alleged to have committed an abusive act will be notified that the allegations have been made.

**NORTHERN INYO HOSPITAL
POLICY AND PROCEDURE**

Title: Abuse Policy for Swing Bed Patients	
Scope: Acute/Subacute Services	Manual: Patient Safety (PS), Swing Bed
Source: Manager - ICU Acute/Subacute	Effective Date: 12/17/14

6. The employee alleged to have committed the abuse will be permitted the opportunity to respond in writing to the allegations.
7. When abuse is suspected or alleged, the hospital will perform an investigation into the allegation of abuse. At that time the employee who was reported/involved will not be returned to patient care until the investigation has been completed and a decision made.
8. The immediate supervisor of the employee alleged to have committed the abusive act will contact the alleged victim of the abuse and take written notes of their description of the incident as well as encourage them to provide a written response outlining the alleged incident.
9. The designated hospital representative will work with CDPH and cooperate in their investigation. The outcome of their investigation will be implemented and the hospital will determine any need for employee disciplinary action.
10. The employee alleged to have committed the abuse shall be notified in writing of the outcome of the investigation.
11. If a patient or relative reports a suspicion of abuse, the affected employee will be assigned to an area with no patient contact until the investigation has been completed, or they will be given time off according to NIH policy.
12. When a report of suspected abuse is received, it will be documented on the appropriate NIH form. Form # SBA10

REFERENCES:

1. Critical Access Hospital/ Swing Bed State Operational Manual—C-0382 and C-0383 Interpretive guidelines 483.13(b) and (c)
2. The Joint Commission: Comprehensive Accreditation Manual for Critical Access Hospitals. RI.01.06.03

CROSS REFERENCE P&P:

1. Abuse Policy for Swing Bed Patients
2. Abuse Policy for Swing Bed Patients

Approval	Date
CCOC	7/23/18
Medical Services/ICU Committee	7/26/18
Medical Executive Committee	8/7/18
Board of Directors	
Last Board of Director review	4/19/17

Developed: 5/08

Revised: 1/09 BSS, 3/10 BSS; 3/11 RC; 9/12 BS, 10/14 BS, 03/18 JN

Reviewed: 1/17 LA



NORTHERN INYO HOSPITAL POLICY AND PROCEDURE

Title: Cepheid Xpert CT/NG PCR Assay	
Scope: Microbiology	Department: Laboratory
Author: Immunology Coordinator	Effective Date:
Copy Location: Microbiology	Revised Date:

I. Intended Use

The Xpert® CT/NG (Chlamydia trachomatis/Neisseria gonorrhoeae) Assay, performed on the Cepheid GeneXpert® Instrument Systems, is a qualitative real-time PCR test for the detection of genomic DNA from Chlamydia trachomatis and Neisseria gonorrhoeae. Detection of C. trachomatis and N. gonorrhoeae aids in the diagnosis of urogenital disease. Urine specimens or endocervical/vaginal swab specimens from asymptomatic and symptomatic individuals may be tested.

II. Summary and Principle

Chlamydia trachomatis (CT) is a gram-negative bacterium that exists as an obligate intracellular parasite of eukaryotic cells due to its inability to synthesize ATP. The CT species is comprised of at least fifteen serovars that can cause disease in humans; serovars D through K are the major cause of genital chlamydial infections in men and women. Left untreated, CT can cause non-gonococcal urethritis, epididymitis, proctitis, cervicitis, and acute salpingitis. In women, untreated CT can lead to pelvic inflammatory disease (PID) and cause infertility. PID can manifest as endometritis, salpingitis, pelvic peritonitis, and tubo-ovarian abscesses.

Neisseria gonorrhoeae (NG) is a gram-negative diplococcus and the causative agent of gonorrheal disease, the second most commonly reported bacterial sexually transmitted disease (STD). The majority of urethral infections caused by NG among men produce symptoms that cause them to seek curative treatment. Among women infections often do not produce recognizable symptoms until complications (e.g. PID) have occurred.

The Xpert CT/NG test cartridges include reagents for the 5' exonuclease real-time PCR detection of CT and NG. The primers and probes in the Xpert CT/NG Assay detect chromosomal sequences in the bacteria. One target is detected for CT (CT1) and two different targets are detected for NG (NG2 and NG4). Both NG targets need to be positive for the Xpert CT/NG Assay to result a positive NG.

III. Materials and Reagents

a. Materials

i. Xpert CT/NG Assay cartridges

1. Store at 2 °C – 28 °C.
2. Do not use expired reagents or cartridges.
3. Do not open a cartridge until ready to test.
4. Use cartridges within 30 minutes after opening the cartridge lid.
5. Do not use reagents that have become cloudy or discolored.
6. Do not use a cartridge which has been dropped or shaken

NORTHERN INYO HOSPITAL POLICY AND PROCEDURE

Title: Cepheid Xpert CT/NG PCR Assay	
Scope: Microbiology	Department: Laboratory
Author: Immunology Coordinator	Effective Date:
Copy Location: Microbiology	Revised Date:

- ii. 1 ml transfer pipettes
- iii. 70% alcohol
- iv. 10% bleach

IV. Specimens:

a. Sample Types:

- i. First-catch urine, unpreserved
- ii. Endocervical or vaginal swab specimens in the Vaginal/Endocervical Transport tube
 - 1. Do not use brands other than the Cepheid transport tubes

b. Stability:

- i. Urine
 - 1. From females
 - a. stable up to 24 hours at room temperature
 - b. stable up to 8 days refrigerated
 - 2. From males
 - a. stable up to 3 days at room temperature
 - b. stable up to 8 days refrigerated
- ii. Vaginal/Endocervical Specimens in the Vaginal/Endocervical Transport tube
 - 1. Stable up to 60 days at 2-30C

V. Safety

- a. Pathogenic microorganisms, including hepatitis viruses and HIV, may be present in clinical specimens. Treat all biological specimens, including used cartridges, as if capable of transmitting infectious agents.
- b. In the event of contamination of the work area or equipment with specimens or controls, thoroughly clean the contaminated area with a 10% fresh bleach solution. Allow the surface to dry completely before proceeding.

VI. Quality Control

a. Instrumentation System Control (Check Status)

- i. When cartridges are loaded onto the instrument there is a software check that includes:
 - 1. Optics
 - 2. Readiness of the modules mechanical components
 - 3. Temperature of module
 - 4. Physical integrity of cartridge
- ii. If failure occurs assay terminates and ERROR is reported

b. Internal Controls



NORTHERN INYO HOSPITAL POLICY AND PROCEDURE

Title: Cepheid Xpert CT/NG PCR Assay	
Scope: Microbiology	Department: Laboratory
Author: Immunology Coordinator	Effective Date:
Copy Location: Microbiology	Revised Date:

- i. Each cartridge includes a Sample Processing Control (SPC), a Sample Adequacy Control (SAC) and a Probe Check Control (PCC).
 - ii. Sample Processing Control (SPC)
 - 1. Verifies:
 - a. The effectiveness of on-board sample processing
 - b. The integrity of extracted nucleic acids
 - c. PCR performance
 - d. The absence of excess PCR inhibitors
 - 2. The SPC can be positive or negative when the test result is positive
 - 3. The SPC must be positive when the test result is negative. If the SPC is negative, an INVALID result is reported
 - iii. Sample Adequacy Control (SAC)
 - 1. Ensures that the sample contains human cells or DNA
 - 2. Is significant only in a negative sample
 - 3. When negative indicates that no human cells are present in the sample due to either insufficient mixing or improper collection. An INVALID result will be reported
 - iv. Probe Check Control (PCC)
 - 1. The probe check is performed on each cartridge. It verifies reagent rehydration, PCR tube filling in the cartridge, probe integrity, and dye stability.
 - 2. Fluorescence readings are measured in the reaction tube for each probe and compared to default setting established by Cepheid
 - a. If the readings match, the probe check passes
 - b. If the readings do not match, the assay is terminated and ERROR is reported.
- c. External Controls
 - i. Material
 - 1. Positive Chlamydia control: ZeptoMetrix NATrol Catalog # NATCT(434)-6MC
 - 2. Positive Neisseria control: ZeptoMetrix NATrol Catalog #NATNG-6MC
 - 3. Negative control ZeptoMetrix NATrol Catalog# NATCT/NGNEG-6MC
 - ii. Store 2-8C
 - iii. Perform QC monthly and with each new lot or shipment of cartridges
 - iv. Testing
 - 1. Preparation of QC material:
 - a. Positive control:



NORTHERN INYO HOSPITAL POLICY AND PROCEDURE

Title: Cepheid Xpert CT/NG PCR Assay	
Scope: Microbiology	Department: Laboratory
Author: Immunology Coordinator	Effective Date:
Copy Location: Microbiology	Revised Date:

- i. Pipette 500uL or half a vial of positive Chlamydia control material and 500mL or half a vial of positive Neisseria control material into a transport container.
 - ii. Label container with names and lot numbers of control materials, date added, and initial
 - b. Negative control:
 - i. Pipette 500uL or half a vial of negative control material into a transport container
 - ii. Label container with name and lot number of control material, expiration date, date added, and initial
2. Test as you would a patient sample
3. When starting the QC testing on the Cepheid:
 - a. Click "Create Test"
 - b. Manually enter "POS CNTRL" or "NEG CNTRL" when prompted to scan specimen id,
 - c. Scan in the cartridge ID at the next prompt
 - d. When the screen changes, enter your initials at the bottom in "notes"
 - e. Click "Start Test" and place the cartridge in the slot with the blinking green light
4. If QC is out:
 - a. Repeat
 - b. Make new QC material
 - c. Call Technical Services

VII. Procedure

a. Preparing the Cartridge

- i. Obtain the following items:
 1. Xpert® CT/NG Assay cartridge
 2. Transfer pipette
 3. Appropriately collected and labeled test sample
 4. Specimen labels
- ii. Inoculate the cartridge in the bio safety cabinet
 1. Clean hood counter with 10% bleach followed by 70% alcohol
 2. Check patient label on sample container
 3. Place a patient label on the side or back of the cartridge
 4. Gently invert sample container 3 to 4 times to ensure adequate mixing of sample and transport matrix.



NORTHERN INYO HOSPITAL POLICY AND PROCEDURE

Title: Cepheid Xpert CT/NG PCR Assay	
Scope: Microbiology	Department: Laboratory
Author: Immunology Coordinator	Effective Date:
Copy Location: Microbiology	Revised Date:

- a. Do not test the endocervical or vaginal specimens received in transport tubes without the swab present. A false negative test result may occur.
 5. Unwrap the transfer pipette.
 6. Open the sample container, compress the bulb of the transfer pipette, insert the pipette into the sample, and release the bulb to fill the transfer pipette above the mark on the pipette shaft. Ensure no air bubbles are present.
 7. Open the cartridge lid.
 - a. Do not open the cartridge lid except when adding sample
 8. Empty the pipette into the sample chamber of the cartridge
 9. Close the cartridge lid.
 10. Change gloves if they become contaminated with specimen
 11. After inoculating cartridges, clean hood counter with 10% bleach followed by 70% alcohol
- b. Starting the Test
- i. On the Windows desktop, double-click the GeneXpert Dx shortcut icon if present on the screen and log onto the system (user name and password=nihmicro). Otherwise skip to step ii.
 - ii. In the GeneXpert System window, click Create Test (upper left icon)
 - iii. You will be prompted to scan or type in the sample ID barcode. This is the accession number.
 - iv. Next you will be prompted to scan the cartridge barcode. This is the 3D barcode on the cartridge.
 - v. Type in patient name in the “patient id” area at top, last name first
 - vi. Type in your initials in “notes” area at bottom.
 - vii. Click “Start Test”
 - viii. Open the instrument module door with the blinking green light and load the cartridge.
 - ix. Close the door. The test starts and the green light stops blinking. The test takes approximately 90 minutes. When the test is finished, the light turns off.
 - x. Wait until the system releases the door lock before opening the module door and removing the cartridge.
 - xi. Dispose used cartridges in a biohazard waste container.
- c. Viewing and Printing Results
- i. Results will print automatically.



NORTHERN INYO HOSPITAL POLICY AND PROCEDURE

Title: Cepheid Xpert CT/NG PCR Assay	
Scope: Microbiology	Department: Laboratory
Author: Immunology Coordinator	Effective Date:
Copy Location: Microbiology	Revised Date:

- ii. To view results on screen, go to “View Results” and enter patient name and/or specimen id in appropriate areas. See operator’s manual for further details.

VIII. Interpretation of Results

Results are interpolated from measured fluorescent signals and embedded calculation algorithms

- a. CT DETECTED or NG DETECTED
 - a. PCR amplification of the CT target and the two NG targets give counts within the valid range and fluorescence endpoints above the minimum setting.
- b. CT NOT DETECTED or NG NOT DETECTED
 - a. PCR amplification of the CT target and the two NG targets give counts below the valid range and fluorescence endpoints below the minimum setting.
- c. INVALID or ERROR
 - a. Presence or absence of CT and NG target DNA cannot be determined.
 - b. Repeat test.
- d. NO RESULT
 - a. Presence or absence of CT and NG target DNA cannot be determined
 - b. Insufficient data were collected to produce a test result (for example, the operator stopped a test that was in progress).
 - c. Repeat test.

IX. Reporting Results:

- a. Enter positive or negative results into LIS for Chlamydia trachomatis and Neisseria gonorrhoeae in the appropriate result area using the drop down menu
- b. “Invalid” and “See Comment” can also be used in these result areas
- c. Positive results will be reported to the California Department of Public Health automatically.

X. Expected Values

The prevalence of infection with CT and/or NG in patient populations depends on risk factors such as age, gender, the presence or absence of symptoms, the type of clinic, and the sensitivity of the test used to detect infections. During the clinical evaluation of the Xpert CT/NG Assay, the observed CT prevalence rates in females and males were 5.4% and 5.7%, respectively. The observed NG prevalence rates in females and males were 1.4% and 3.5%, respectively.

NORTHERN INYO HOSPITAL POLICY AND PROCEDURE

Title: Cepheid Xpert CT/NG PCR Assay	
Scope: Microbiology	Department: Laboratory
Author: Immunology Coordinator	Effective Date:
Copy Location: Microbiology	Revised Date:

XI. Limitations

- a. The Xpert CT/NG Assay has only been validated with the following specimen types:
 - i. Endocervical swabs
 - ii. Patient-collected vaginal swabs, collected in a clinical environment
 - iii. Urine
- b. Erroneous test results might occur from improper specimen collection, technical error, sample mix-up, or because the number of organisms are below the limit of detection of the test.
- c. Modification to these procedural steps may alter the performance of the test.
- d. With endocervical and patient-collected vaginal specimens, assay interference may be observed in the presence of: blood (>1% v/v) or mucin (>0.8% w/v).
- e. With urine specimens, assay interference may be observed in the presence of: blood (>0.3% v/v), mucin (>0.2% w/v), bilirubin (>0.2 mg/mL), or Vagisil feminine powder (>0.2% w/v).
- f. Collection and testing of urine specimens with the Xpert CT/NG Assay is not intended to replace cervical exams and endocervical sampling for diagnosis of urogenital infection. Other genitourinary tract infections can be caused by other infectious agents.
- g. The effects of other potential variables such as vaginal discharge, use of tampons, douching, and specimen collection variables have not been determined.
- h. A negative test result does not exclude the possibility of infection because test results may be affected by improper specimen collection, technical error, specimen mix-up, concurrent antibiotic therapy, or the number of organisms in the specimen which may be below the sensitivity of the test.
- i. The Xpert CT/NG Assay should not be used for the evaluation of suspected sexual abuse or for other medico-legal indications. Additional testing is recommended in any circumstance when false positive or false negative results could lead to adverse medical, social, or psychological consequences.
- j. The Xpert CT/NG Assay provides qualitative results. No correlation can be drawn between the magnitude of the Ct value and the number of cells in an infected sample.
- k. The predictive value of an assay depends on the prevalence of the disease in any particular population.
- l. Positive results may be observed after successful antibiotic treatment due to target nucleic acids from residual non-viable organisms.
- m. Xpert CT/NG Assay performance has not been evaluated in patients less than 14 years of age.



NORTHERN INYO HOSPITAL POLICY AND PROCEDURE

Title: Cepheid Xpert CT/NG PCR Assay	
Scope: Microbiology	Department: Laboratory
Author: Immunology Coordinator	Effective Date:
Copy Location: Microbiology	Revised Date:

- n. Xpert CT/NG Assay performance has not been evaluated in pregnant women, or in patients with a history of hysterectomy.
- o. The patient-collected vaginal swab specimens are an option for screening women when a pelvic exam is not otherwise indicated.
- p. The Xpert CT/NG Assay has not been validated for use with vaginal swab specimens collected by patients at home. The patient-collected vaginal swab specimen application is limited to healthcare facilities where support/counseling is available to explain procedures and precautions.
- q. The Xpert CT/NG Assay has not been evaluated with patients who are currently being treated with antimicrobial agents active against CT or NG.
- r. As with many diagnostic tests, results from the Xpert CT/NG Assay should be interpreted in conjunction with other laboratory and clinical data available to the physician.

XII. Reference

Xpert® CT/NG Assay Package Insert 301-0234, Rev. D March 2016
 Cepheid
 904 Caribbean Drive
 Sunnyvale, CA 94089
 Phone: +1 408.541.4191
 Fax: +1 408.541.4192

Reviewed by	Date
CCOC	7/16/18
Laboratory Medical Director	7/12/18
Medical Executive Committee	8/7/18
Board of Directors	
Board of Directors Last Review	

**EDNORTHERN INYO HOSPITAL
POLICY AND PROCEDURE**

Title: Coroner's Cases	
Scope: Multi- Department	Department: ED, Perinatal. Surgery, ICU, Acute/ Sub-acute
Source: Emergency Dept Nurse Manager	Effective Date: 04/86

PURPOSE: To provide a procedure for establishing, reporting and preparing coroner's cases.

POLICY:

All deaths in the hospital are reported to the House Supervisor (HS) . The HS calls the coroner about the death that falls under the classification of reportable cases. In no instance should a body under the jurisdiction of the Coroner be released to a funeral establishment, or removed from surgery or emergency room except by explicit instructions from the Coroner's office. Permission from the deceased's family for autopsy is desirable but not mandatory. The Coroner is entitled to the custody of the remains until the conclusion of his autopsy or medical investigation.

TYPE OF CONORER'S CASES:

1. No physician in attendance at the time of death.
 - a. If the physician has not seen the patient during the 20 days before death.
 - b. If the physician has been in attendance less than 24 hours, or when attending physician is unable to make the diagnosis.
2. Known or suspected homicide.
3. Known or suspected suicide.
4. Involving any criminal action or suspicion of a criminal act, such as criminal abortion or euthanasia.
5. Related or following known or suspected self-induced criminal abortion.
6. Associated with a known or alleged rape or abnormal sex act.
7. Following an accident or injury (primary or contributory) occurring recently or at some remote time.
8. Drowning, fire, hanging, gunshot, stabbing, cutting, starvation, ~~cutting~~-exposure, acute alcoholism, drug addiction, strangulation or aspiration.
9. Accidental poisoning (food, chemical, drug, therapeutic agent).
10. Occupational diseases or occupational hazards.
11. Known or suspected contagious disease constituting a public hazard.

**EDNORTHERN INYO HOSPITAL
POLICY AND PROCEDURE**

Title: Coroner's Cases	
Scope: Multi- Department	Department: ED, Perinatal. Surgery, ICU, Acute/ Sub-acute
Source: Emergency Dept Nurse Manager	Effective Date: 04/86

12. All deaths in an operating room.
13. All deaths where a patient has not recovered from an anesthetic, whether in surgery, recovery room or elsewhere.
14. All deaths in which the patient is comatose throughout the period of physician's attendance, whether at home or in the hospital.
15. Deaths of patients in state mental hospitals serving the mentally disabled and developmentally disabled operated by State Agencies.
16. Deaths wherein suspected cause is Sudden Infant Death Syndrome.
- ~~17.~~ In prison or while under sentence.
- ~~18.~~ All solitary death unattended by physician or other person in period preceding death.
- ~~19.~~ All deaths of unidentified persons.
- ~~20.~~ Deaths under such circumstances as to afford a reasonable ground to suspect that the death was caused by a criminal act.

PROCEDURE:

1. Notify the House Supervisor of all patient deaths. The HS can call the coroner at (760) 873-4266 to notify of death. **If you have doubt, or not sure if the cause should be a coroner's case, call the coroner and ask.**
2. Do not remove any tubes (example: ET, IV, Foley, Chest Tubes, etc.). Simply clamp off the ones that may drain.
3. Do not clean the body (example: it could remove powder burns or other forms of evidence).
4. Wait for the coroner to pick up the body.
5. The coroner will complete the "Authorization for Release of Body to Mortuary" form. This completed form is then part of the medical record.
6. The patient's belongings are given to the coroner. Do not release any evidence or personal property to law enforcement or family without the knowledge and consent of coroner.

**EDNORTHERN INYO HOSPITAL
POLICY AND PROCEDURE**

Title: Coroner's Cases	
Scope: Multi- Department	Department: ED, Perinatal. Surgery, ICU, Acute/ Sub-acute
Source: Emergency Dept Nurse Manager	Effective Date: 04/86

DOCUMENTATION:

1. Document in medical record:
 - a. All documentation regarding the patient's death.
 - b. Time of death according to physician pronouncement.
 - c. Family members notified.
 - d. Time coroner picked up the body.
 - e. Tubes left in place.
 - f. Any belongings sent with the body or home with the family. The clothing may be given to the family only with the permission and in the presence of the coroner

REFERENCE:

1. California Public Law. Health and Safety Code (2010). Article 3. *Responsibility of Coroner*. Section 102850-10286
2. Center for Disease Control and Prevention. Coroner/Medical Examiner Laws. Retrieved from <http://www.cdc.gov/phlp/publications/coroner/california.html>.
3. California Code, Government Code Section 27491. Retrieved from <https://codes.findlaw.com/ca/government-code/gov-sect-27491.html>

CROSS REFERENCE:

1. Neonatal Death, Fetal Demise & Spontaneous Abortion Procedure
2. Death- Disposition of Body
3. Death in the Operating Room
4. Pronouncement of Death.
5. Dead on Arrival

Approval	Date
CCOC	5/21/18
Emergency Services Committee	<u>7/11/18</u>
Med/ICU Committee	<u>7/26/18</u>
Peri-Peds Committee	<u>6/22/18</u>
Surgery-Tissue Committee	<u>7/25/18</u>
MEC <u>Medical Executive Committee</u>	<u>8/7/18</u>
Board of Directors	

**EDNORTHERN INYO HOSPITAL
POLICY AND PROCEDURE**

Title: Coroner's Cases	
Scope: Multi- Department	Department: ED, Perinatal. Surgery, ICU, Acute/ Sub-acute
Source: Emergency Dept Nurse Manager	Effective Date: 04/86

Last Board of Director Review	6/21/2017
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Revised/Reviewed: 4/86, 7/91, 2/95, 11/99, 03/09/04 MR; 7/11as; 2/15as, 4/18 gr

Draft



NORTHERN INYO HOSPITAL POLICY AND PROCEDURE

Title: Delayed Blood Bank Banding of Patients	
Scope: Hospital Wide	Department: Laboratory
Author: Immunology Coordinator	Effective Date: July 2018
Copy Location:	Revised Date:

Purpose:

This policy and procedure explains how specimens for blood bank work are collected from patients when collection occurs several days to a week before surgery or transfusion.

Policy:

Before collecting specimens for blood bank work on a patient, the patient is positively identified at the time of collection by name, birth date, and medical record number. The sample is labeled legibly and immediately after collection in the presence of the patient. The specimen label includes: the patient’s name, birth date, medical record number, the collection date and time, a unique blood bank ID number and barcode, and the initials of the collector. In addition, a blood bank bracelet is made for the patient with the same information. The verification of id is documented on the form “Verification of Patient Identification for Delayed Placement of Blood Bank Bands”. The form is stored with the bracelet in the blood bank until the day of surgery/transfusion.

When the patient returns on the day of surgery or transfusion, the patient is again positively identified by name, birth date, and medical record number. The blood bank bracelet is examined to confirm the correct name, birth date and medical record number, compared to the hospital ID bracelet, and placed on the patient’s wrist. This verification of id is documented on the verification form that is added to the patient’s medical record.

Procedure:

1. The individual collecting a sample for presurgery/transfusion blood bank work initially identifies the patient by asking the patient to repeat their name and date of birth. This information is compared to the patient’s name and date of birth on the preprinted label in the patient’s registration material.
2. The medical record number on the preprinted label is compared with the medical record number in the patient’s registration material.
3. If the identifiers in steps 1 and 2 agree, the blood bank sample is drawn.
4. Immediately after collection and while the patient is still present, the sample is labeled with the preprinted label that has the patient’s name, date of birth, and medical record number. The date and time of collection and the collector’s initial is written on the label. Additionally, a unique blood bank identification number and barcode is placed on the sample.
5. The individual collecting the sample also prepares a blood bank bracelet. A label identical to the sample label is placed in the sleeve of the Typenex bracelet along with the unique blood bank identification number.
6. The form “Verification of Patient Identification for Delayed Placement of Blood Bank Bands” is filled out to document the identification process and confirmation of patient name, birthdate and medical record number. The bracelet is clipped to the verification form and stored in the blood bank until the patient returns for surgery or for transfusion.
7. When the patient returns for surgery or transfusion, the presurgery or infusion department notifies lab personnel. A lab employee takes the band and verification form to the patient area.



NORTHERN INYO HOSPITAL POLICY AND PROCEDURE

Title: Delayed Blood Bank Banding of Patients	
Scope: Hospital Wide	Department: Laboratory
Author: Immunology Coordinator	Effective Date: July 2018
Copy Location:	Revised Date:

8. The patient is again identified by comparing the name, date of birth, and medical record number on the BB band with the information on the patient's registration form and on the hospital ID band. In addition, the patient is asked to repeat their name and date of birth.
9. If the identifiers in step 8 agree, the band is placed on the patient's wrist.
10. The lab employee fills out the form to document the positive identification of the patient and signs the form
11. The form is added to the patient's medical record, in the laboratory section.

Reviewed by	Date
Surgery/Tissue/Transfusion/Anesthesia Committee	8/3/18
Medical Executive Committee	8/7/18
Board of Directors	



Northern Inyo Healthcare District
 150 Pioneer Lane
 Bishop, California 93514

Patient Label

NORTHERN INYO HEALTHCARE DISTRICT
 Verification of Patient Identification for Delayed Placement of Blood Bank (BB) Bands

Date of BB draw _____

Confirm the following:

- Patient's stated name and birth date match the name and birth date on the BB band, the sample labels and in the registration papers.
- The medical record number on the BB band, the sample labels and in the registration papers is the same.

Signature _____ Date/Time _____

Printed Name/Title _____

Date of BB band placement _____

Confirm the following:

- Patient's stated name and birth date match the name and birth date on the BB band, the Hospital ID bracelet, and in the patient's chart.
- The medical record number on the BB band, the Hospital ID bracelet, and in the patient's chart is the same.

Signature _____ Date/Time _____

Printed Name/Title _____

**NORTHERN INYO HOSPITAL
POLICY AND PROCEDURE**

Title: Emergency Department Telephone Advice Information	
Scope: Emergency Department	Department: Emergency Dept
Source: Emergency Dept Nurse Manager	Effective Date: 6/2001

PURPOSE:

To define the parameters of advice or information that may be given to a person calling the Emergency Department staff seeking advice or medical information.

SPECIAL CONSIDERATIONS:

~~Physician Order required: NO~~

~~Procedure may be preformed by: RN only (except as is detailed in policy)~~

~~Special education required to perform procedure: No X Yes (RN knowledgeable in ED policies and procedures with appropriate available information and resources).~~

~~Age specific consideration: Pertinent to patient.~~

POLICY:

It is the policy of Northern Inyo Hospital that any person that calls the Emergency Department (ED) for telephone advice or information shall be informed that we do not give advice to persons that were not recent ED patients. It is our policy to only give information to patients calling for clarification of their discharge instructions or to relay or discuss their test results. It is our policy to give advice to emergency type of calls (911) that are put through to us by law enforcement or other EMS dispatch.

PROCEDURE:

1. Any person that calls and asks to be connected to the ED (and not the clerk) should be asked if they are calling for advice. If they are calling for advice they should be asked if they are calling about a recent ER visit. If they are calling about a recent visit they should be transferred to the ED.

~~If they are not calling about a recent ER visit they should be transferred to the ER advice line at 3111. If the person calling for advice has reached the ER, and is not calling about a recent ER visit, they should be transferred to extension 3111. If that line is not available the message should be read to them.~~

2. Recent ED patients calling for advice, clarification of instructions or test results will receive advice and /or results specific to their diagnosis and current symptoms or concerns. The Registered Nurse (RN) or Qualified Medical provider (QMP) will review the chart and the appropriate advice will be given. If at any time it is unclear as to what the concern or question is, or if the patient feels their condition is worsening they will be advised to call their doctor, return to the ED or call 911.

3. 911 Call patched through to the Emergency Department:

In a life-threatening situation, while waiting for medical help to arrive, law enforcement may put a call through to the ED via phone from a person that needs immediate medical assistance and information. In this case the most appropriate QMP or ED RN may give advice over the phone.

4. Emergency Services (EMS) radio or telephone patched through to the ED:

If further advice or orders are needed after initial EMS protocols are initiated on scene, the QMP may give further orders to EMS providers.

5. When a caller that is asking for advice is not asking about a recent ED visit, they should be transferred to extension 3111. They will then be given the following message.

You have been connected to the ER telephone advice line.

**NORTHERN INYO HOSPITAL
POLICY AND PROCEDURE**

Title: Emergency Department Telephone Advice Information	
Scope: Emergency Department	Department: Emergency Dept
Source: Emergency Dept Nurse Manager	Effective Date: 6/2001

Our policy does not allow us to give telephone advice to people that we have not seen.

Hang up and dial 911 if you have a medical emergency.

If you need to see a doctor you may come to the ER. You can be seen and treated even if you cannot pay.

If you have a medical question your doctor may be able to help you

If you need poison control advice, that number is 1-800-222-1222.

If you have a question about a recent ER visit, discharge instructions or test results please call back and tell the operator you need to talk to an ER doctor or nurse about your ER visit.

Documentation:

1. A brief note about the call and any further action will be documented as an addendum in the patient's original visit chart.
2. Any advice given over the phone or base station radio to EMS must be documented in the ambulance run sheet.

REFERENCE:

CROSS REFERENCE:

1. Pre- Hospital Policy
2. MICN Policy

Approval	Date
CCOC	5/21/18
Emergency Services Committee	7/9/18
Medical Executive Committee	
Board of Directors	
Last Board of Directors Review	

Developed:

Reviewed:

Revised: 5/18 gr

Supersedes:

Index Listings:

**NORTHERN INYO HOSPITAL
POLICY AND PROCEDURE**

Title: Emergency Department Telephone Advice Information	
Scope: Emergency Department	Department: Emergency Dept
Source: Emergency Dept Nurse Manager	Effective Date: 6/2001

Index Listings: Telephone Advice/Information
Revised: 6/2001; 10/2001; 2/2004; 6/11as; 2/15as
Last Board of Director review: 6/21/17

Draft



NORTHERN INYO HOSPITAL POLICY AND PROCEDURE

Title: Emergency Order and Shipment of Blood Components from UBS	
Scope: Transfusion Service	Department: Laboratory
Author: Coordinator of Immunology	Effective Date: March 2016
Copy Location: Transfusion Service	Revised Date:

I. Principle

- a. In an emergency when a hemorrhaging patient will need more blood products than what is on site, the transfusion service in the lab arranges an emergency shipment of blood.
- b. There are two methods for emergency transport of blood products from UBS Reno
 - i. California and Nevada Highway Patrol
 - ii. Couriers

II. Procedure

- a. California and Nevada Highway Patrol
 - i. The physician must declare an extreme life-threatening emergency.
 - ii. Determine what and how many products are needed—packed cells, platelets, FFP, etc. We only want to make one emergency blood run per incident.
 - iii. Order products from UBS and explain that this is an emergency and you will contact CHP and NHP for immediate transport.
 - iv. Call the CHP dispatcher in Bishop at **1-760-872-5900**. Request an emergency blood transport from Reno. CHP needs the patient and physician names.
 - v. Tell the CHP that you are calling NHP. Sometimes CHP will call NHP and make arrangements and you can skip steps (vi) and (viii).
 - vi. Call the NHP dispatcher in Reno, at **1-775-687-0400**, requesting an emergency blood transport from Reno to Bishop. NHP will contract their supervisor for permission. NHP needs the patient and physician names.
 - vii. Give the NHP dispatcher in Reno the address and phone number of UBS—**1125 Terminal Way, Reno, NV 89502, 1-775-329-6451 or 800-365-9471**
 - viii. Ask NHP to contact the CHP Bishop dispatcher. The two agencies will decide where to meet—usually they exchange the shipment at the California/Nevada border.
 - ix. Notify the physician and the nursing supervisor of the progress of the transport.
- b. Courier
 - i. The physician does not need to declare an extreme life-threatening emergency, just an urgent situation.
 - ii. Order products from UBS Reno and explain this is an emergency.
 - iii. UBS Reno will send a courier as far as Bridgeport, and we will send a courier to pick up the shipment in Bridgeport. Usually the two couriers meet at the MoMart located at the corner of Twin Lakes Road and US-395.
 - iv. Notify the physician and the nursing supervisor of the progress of the transport.

Reviewed by	Date
Peri-Peds Committee	6/22/18
Emergency Room Service Committee	7/11/18
Pharmacy & Therapeutics Committee	7/5/18
Surgery/Tissue Committee	7/25/18
Medical Executive Committee	8/7/18
Board of Directors	

**NORTHERN INYO HOSPITAL
POLICY AND PROCEDURE**

Title: Malignant Hyperthermia Cart Check*	
Scope: Nursing Services, Cardiovascular, Circulation (OXC), CPM - Respiratory, Oxygen Services	Manual: Cardiovascular, Circulation (OXC), CPM - Respiratory, Oxygen
Source: DON Perioperative Services	Effective Date: 12/1/13

PURPOSE:

To insure availability of all drugs, equipment, and supplies necessary to initiate advanced life-support measures in a malignant hyperthermia crisis.

POLICY:

1. One Malignant Hyperthermia cart will be kept in the **PACU** for usage throughout Northern Inyo Hospital.
2. The Malignant Hyperthermia cart will be checked **monthly** for outdates by the **PACU** staff.
3. The **PACU** staff checking the cart will be responsible for replacing expired supplies prior to the expiration date.
4. A listing of all Malignant Hyperthermia medications with drug outdates will be maintained by Pharmacy.
5. The Pharmacy staff will be responsible for replacing expired medications prior to expiration.
6. A listing of all supplies will be maintained by the **Resuscitation Committee**.
7. ~~The Malignant Hyperthermia cart contents and QAPI will be overseen by the Resuscitation Committee.~~

PROCEDURE:

1. An assigned **PACU** staff member will check the Malignant Hyperthermia cart **in the last week of each month**.
2. The Surgery Department staff / House Supervisor will use the Malignant Hyperthermia cart checklist (see attachment to check off the following):
 - a. The 2 drawers will be checked for an intact lock.
 - b. The refrigerator temperature is on an automatic monitoring system.
 - i. Action will be taken for any Temperature outside of range including notification of Pharmacy and Biomed.
 - c. The refrigerator will be plugged into a red outlet.
 - d. ~~The Emergency Department staff will double check the pharmacy medication expiration dates.~~
 - i. ~~If ready to expire, notify Pharmacy.~~
 - e. ~~Supply equipment expiration dates will be reviewed on the Malignant Hyperthermia cart supply/equipment/medication list.~~
 - i. ~~Any supply/equipment due to expire will be replaced with the same item that is not outdated and the checklist expiration date is to be updated with the new expiration date.~~
 - f. ~~All external contents of cart (side and back) will be checked using the supply/equipment/medication checklist and verified daily.~~
3. ~~The Pharmacy will be responsible for maintaining all pharmaceuticals in the Malignant Hyperthermia cart.~~
 - a. ~~This includes the drugs on the Equipment/Supply/Drugs Malignant Hyperthermia Cart set up list.~~
 - b. Any request for change in the Malignant Hyperthermia Equipment/Supply/Drugs list shall be reviewed by the Resuscitation Committee. Drugs to be included on the Malignant Hyperthermia Cart ~~supplies/equipment~~ shall be reviewed by P&T Committee Annually **as well as** the Resuscitation Committee ~~then~~.

**NORTHERN INYO HOSPITAL
POLICY AND PROCEDURE**

Title: Malignant Hyperthermia Cart Check*	
Scope: Nursing Services, Cardiovascular, Circulation (OXC), CPM - Respiratory, Oxygen Services	Manual: Cardiovascular, Circulation (OXC), CPM - Respiratory, Oxygen
Source: DON Perioperative Services	Effective Date: 12/1/13

4. The Malignant Hyperthermia Hotline may be called 24/7 at 1-800-644-9737 to manage a Malignant Hyperthermia crisis or view the crisis page on MHAUS.
5. Ice is available from all ice machines and ice machines in the first floor satellite kitchen.

REFERENCE:

1. MHAUS (2013), <http://www.mhaus.org/healthcare-professionals/be-prepared>. FAQ's: Stocking a Malignant Hyperthermia Cart

CROSS REFERENCE P&P:

1. Malignant Hyperthermia
2. Crash Cart

Approval	Date
CCOC	6/18/18
Resuscitation Committee	
Surgery Tissue Committee	7/25/18
Pharmacy & Therapeutic Committee	7/5/18
Medical Executive Committee	8/7/18
Board of Directors	
Last Board of Director review	1/17/18

Developed: 05/29/2013

Reviewed:

Revised: 10/16/2013, 6/18aw

**NORTHERN INYO HEALTHCARE DISTRICT
POLICY AND PROCEDURE**

Title: Newborn Blood Glucose Monitoring	
Scope: Perinatal	Manual: Perinatal
Source: Manager of Perinatal Department	Effective Date:

PURPOSE:

Blood glucose monitoring is done to ensure stable blood glucose levels in neonates at risk.

POLICY:

1. All newborns will be assessed for the need to monitor blood glucose levels.
2. Only infants with risk factors for hypoglycemia (asymptomatic) or clinical signs consistent with hypoglycemia (symptomatic) will undergo routine glucose screening.
3. All testing will be done by heelstick blood sugar (HSBS) unless otherwise indicated.

PROCEDURE:

1. Assess **all newborns** for hypoglycemia risk factors (see below)
2. **INITIAL** feed: All infants should be fed within the first hour of life and prior to the first BG check unless unstable
3. **Screen all at risk** (see below) **infants within 2 hours** of birth
4. **Screen all symptomatic newborns immediately** (irritability, exaggerated Moro reflex, high pitched cry, decreased suck, temperature instability, jittery, tachypnea, apnea, lethargy, decreased tone, seizures)
5. Screen all asymptomatic newborns with risk factors at the times described below:
 - Screen for **24 hours** (1 hour of age then approximately 4, 7, 13 and 19 hours of age, prior to feeds whenever possible. Further screening needed if any of the last three are <45 and immediate screening needed if infant becomes symptomatic)
 - PRETERM (less than 37 wks gestation)
 - SGA (*UpToDate chart attached*)
 - Trisomy 21
 - Endocrine/metabolism disorders, or midline defect or microphallus
 - Maternal intrapartum dextrose infusion or maternal hypoglycemia
 - Screen for **12 hours** (1 hour of age then approximately 4 and 7 hours of age, prior to feeds whenever possible. Further screening needed if any of these are <45 and immediate screening needed if infant becomes symptomatic)
 - LGA 4000 grams
 - IDM
 - Post dates (>42 wks)
 - Discordant twin (weight 10% less than twin)
 - Perinatal stress (arterial cord pH <7, Apgar score <7 @ 5 minutes)
 - Suspected sepsis, maternal infection or maternal fever > 38.3°C
 - Prolonged respiratory distress >30 minutes (Respiratory rate >60, requiring oxygen)
 - Infants requiring continuous IV fluids >5mL/hr
 - Maternal treatment with terbutaline, propranolol or labetalol within 48 hours prior to delivery
 - Congenital cardiac malformations
 - Hyperviscosity/polycythemia (Hct >65%)

**NORTHERN INYO HEALTHCARE DISTRICT
POLICY AND PROCEDURE**

Title: Newborn Blood Glucose Monitoring	
Scope: Perinatal	Manual: Perinatal
Source: Manager of Perinatal Department	Effective Date:

CRITICAL	URGENT	OBSERVE
<p><20 mg/dL (birth to 4 hours) <30 mg/dL (over 4 hours or if symptomatic)</p>	<p>20-44 mg/dL(birth to 4 hours) 30-49 mg/dL (over 4 hours or if symptomatic)</p>	<p>>45 mg/dL(birth to 4 hours or if symptomatic) >50 mg/dL (over 4 hours)</p>
<p>Confirm blood sugar with venous sample but do not wait for results to start treatment. Notify MD</p>	<p>Confirm blood sugar with venous sample. If bedside BG is <40 or if symptomatic do not wait for venous result to give GEL. If > 40 may wait for venous sample result.</p>	<p>Do not need to confirm with venous sample</p>
<p>Start IV and give IV Dextrose*, call MD for orders</p> <p>Give GEL** while preparing for IV start but DO NOT delay IV.</p> <p>Recheck in 30 min after GEL or IV bolus</p>	<p>Give GEL**, then breastfeed or give supplemental feeding if not breastfeeding***</p> <p>Recheck 30 minutes after GEL</p> <p>If still in this range, repeat GEL** and give supplemental feeding*** prior to breastfeeding</p> <p>Recheck 30 minutes after GEL</p> <p>May repeat GEL and check 30 minutes afterward three times but if blood sugar remains in this category call MD for IV orders</p>	<p>Continue feeding ad lib</p> <p>If asymptomatic with risk factors, continue following blood glucose checks as outlined above</p> <p>If previously low, check BG every 2-3 hours before feeds until three readings remain in this range and minimum number of checks completed according to above risk factors</p> <p>If no risk factors and spot checking performed, no further testing needed</p>

*IV Dextrose dose: Call MD for orders but anticipate D10W 2mL/kg over 1-2 minutes then start continuous infusion D10W IV at 80 ml/kg/day

**GEL: Dextrose gel 40% 0.5 ml/kg – rub into dry buccal surfaces, breast feed immediately after giving GEL whenever possible.

***Supplemental feeding: give at least 8 ml and up to 30 ml, if tolerated, of expressed breast milk or formula (MO should pump to promote lactogenesis anytime formula is given)

**NORTHERN INYO HEALTHCARE DISTRICT
POLICY AND PROCEDURE**

Title: Newborn Blood Glucose Monitoring	
Scope: Perinatal	Manual: Perinatal
Source: Manager of Perinatal Department	Effective Date:

SGA Chart (per UpToDate)

Gestation	Male	Female
36	≤2407	≤ 2300
37	≤ 2596	≤ 2484
38	≤ 2769	≤ 2657
39	≤ 2908	≤ 2796
40	≤ 2986	≤ 2872
41	≤ 3007	≤ 2891
42	≤ 2998	≤ 2884

REFERENCES:

1. *Overview of the routine management of the healthy newborn infant*, UpToDate
2. *Management and outcome of neonatal hypoglycemia*, UpToDate
3. *AWHONN Templates for Protocols and Procedures for Maternity Services*, 2nd edition, Patti Besuner, RN, MN, CNS Washington, DC 2010 P123-124

CROSS REFERENCE P&P:

1. Admission, Care, Discharge and Transfer of the Newborn

Approval	Date
PeriPeds	4/20/2018
COCC	7/16/18
Medical Executive Committee	<u>8/7/18</u>
Board of Directors	
Last Board of Directors Review	

Developed: 4/1/2018

Reviewed:

Revised:

Supersedes: Newborn Blood Glucose Monitoring

Index Listings:

**NORTHERN INYO HEALTHCARE DISTRICT
POLICY AND PROCEDURE**

Title: Scope of Service ICU	
Scope: ICU	Manual: ICU/CCU
Source: Manager - ICU Acute/Subacute	Effective Date:

I. Department Description:

The ICU unit is comprised of 4 private beds. There are 3 locked entrances with badge swipe accessibility by approved staff. The primary entrance has a video intercom system with door lock release available at the nurse's station.

II. Scope:

The ICU unit is designed, equipped, and staffed to treat some, but not all, Medical/Surgical emergencies. The management goals consist of stabilization, diagnosis, and treatment of the Medical/Surgical emergency. The ICU has limited equipment and facilities for certain acute and long term management of critically ill patients. These limitations include, but are not limited to:

1. Patients requiring hemodialysis
2. Patient requiring heart-lung bypass
3. Cardiac patients requiring extensive testing and treatment
4. Acute management of head trauma or a catastrophic neurologic event
5. Major traumas

The above patients will require transfer to a higher level of care for further management. The decision to continue medical care or transfer the patient will not be made indiscriminately. Rather, it will be based on the services available at NIHD, the needs of the patient, or consultation with a physician from another facility.

III. Staffing:

Medical care is provided by a privileged hospitalist 24/7. Private physicians may choose to care for their patients, if properly credentialed by NIHD. Specialty physicians, such as surgeons, may also choose to care for their own patients, or they may consult with the hospitalist for coordinated care.

Patient acuity will determine the nurse:patient ratio, as well as adhering to Title 22 California state staffing ratios. Nursing staff includes: Manager, Assistant Manager, RNs, and LVNs.

IV. Customers:

The ICU services are a collaboration of multidisciplinary staff and close cooperation with, but not limited to: rehab services, cardio pulmonary services, lab, pharmacy, dietary, radiology, social services, case management, and outpatient services.

V. Ages Serviced:

- The patient age-specific population served is:
- a. Adult: 18 years of age to 65 years of age
 - b. Geriatric: > 65 years of age

VI. QA/PI:

The ICU Manager and Assistant Manager integrate all nursing quality improvement functions on the unit, track identified problems, assist the nursing unit in the development and evaluation of effective performance improvement reviews, ensure appropriate follow up occurs, and prepare a yearly Pillar of Excellence report concerning nursing quality improvement programs. The pillars will be documented

**NORTHERN INYO HEALTHCARE DISTRICT
POLICY AND PROCEDURE**

Title: Scope of Service ICU	
Scope: ICU	Manual: ICU/CCU
Source: Manager - ICU Acute/Subacute	Effective Date:

in the minutes of the unit staff meetings and will be reported to the Nurse Executive Council (NEC) and QA/PI department.

VII. Budgeted Staff:

Refer to master staffing plan.

Approval	Date
CCOC	4/23/18
Medical Services/ICU Committee	7/26/18
Medical Executive Committee	8/7/18
Board of Directors	
Last Board of Directors Review	4/19/17

Developed: 11/94, 08/11jk

Reviewed: 02/98jk, 02/01, 02/04, 09/09jk, 08/11jk

Revised: 11/94, 08/11jk, 04/18ak

Supersedes:

Index Listings:

**NORTHERN INYO HOSPITAL
POLICY AND PROCEDURE**

Title: Sexual Assault Exam Policy	
Scope: Emergency Dept	Manual: Emergency Department
Source: Manager - Emergency Department	Effective Date: 12/01/2014

PURPOSE:

To promote appropriate physical care and compassionate emotional care to victims of suspected sexual assault.

POLICY:

1. To provide a complete forensic examination with accurate documentation.
2. To provide the patient with the necessary follow-up options regarding data, medical, emotional and financial issues.

PROCEDURE ON PATIENT ARRIVAL:

1. Triage patient. **First respond to acute injury and trauma care needs.**
 - Forensic exam process can continue only after emergent and traumatic injuries have been evaluated and treated as necessary.
2. The victim will be provided with privacy immediately upon arrival and during all aspects of care.
3. Notify law enforcement if not already notified of patients arrival in the Emergency Department (ED).
 - If patient arrives with law enforcement, obtain a brief history from officer
 - If patient arrives by self, with family, friend, or rape crisis advocate, notify law enforcement.
 - Law enforcement should be notified regardless of whether the victim wants to report the assault or not.
4. Notify Wild Iris advocate of patient arrival if not already notified by law enforcement.
 - Wild iris advocate is valuable emotional support and can provide patient with information regarding victim services.
5. Obtain authorization from law enforcement for sexual assault (SA) evidentiary forensic exam.
6. Obtain consent from patient for SA forensic exam.
 - In CA. Age of consent for SA examination is 12 and above.
 - California Family Code Section 6928 statute requires the professional person providing medical treatment to a minor victim of sexual assault must attempt to contact the minor's parent unless the treating professional person reasonably believes the parent/guardian was the perpetrator. CHA recommends that the treating professional talk to the minor sexual assault victim about contacting the parent and then contact the parent unless the minor voices significant concern.
 - Document time and date of call from ED to parent/guardian and whether contact was successful or not. The basic message should be, "Your child is in the hospital."
 - Initial verbal consent from patient is acceptable to initiate SA process but written consent should be signed soon after.
7. **Forensic SA evidentiary examination can be done only if both law enforcement authorization and patient consent is given.**
8. SA forensic examination will be provided by ED registered nurse (RN) in order of availability.
 - Sexual Assault Forensic Examiner (SAFE) RN on duty.
 - ED RN with completed SA competencies and SA hospital training on duty.
 - Called in SAFE RN not on duty
 - Called in SA hospital trained, competent ED RN not on duty
9. Notify House Supervisor of SA patient's presence in ED and pending examination for staff coverage.
10. An ED chart is generated as normally done.
 - Clerk will provide labels for evidence collection.
 - ED chart labels will not have patients Primary Medical doctor (PMD).

**NORTHERN INYO HOSPITAL
POLICY AND PROCEDURE**

Title: Sexual Assault Exam Policy	
Scope: Emergency Dept	Manual: Emergency Department
Source: Manager - Emergency Department	Effective Date: 12/01/2014

11. Have MD order lab tests through Paragon for urine early pregnancy test (EPT), HIV, Hepatitis C antibody.
- Collect dirty urine specimen for pregnancy test. (no wiping before or after urine collection).
 - Draw blood for HIV and Hepatitis C antibody.
 - If initial interview reveals possible drug or alcohol involvement in assault, physician may order urine toxicology screen and serum blood alcohol level.
 - Law enforcement may request separate forensic blood tubes for evidence kit.

PROCEDURE FOR FORENSIC EXAM:

1. Make sure all consents are signed by law enforcement and patient before start of exam.
 - Cal-EMA 2-923 Form. (Victim- acute assault < 72 hrs.)
 - Authorization to Disclose Health Information- released to patient's preference.
1. Provide physical comfort.
 - If patient is cold, collect clothing as per evidentiary procedure and provide gown and blanket.
 - If thirsty, collect oral swabs before fluids are given.
2. Gather all necessary equipment for exam. Preferably in Rm. # 6.
 - SA Cart (in Supply Storage Room)- contains tape, scissors, markers, extra slides, cover slips, Envelopes, bindle paper, 10 ml saline, 10 ml sterile water, lab tubes, Speculums, anoscope, peri- pads, lab tubes
 - Victim Evidence Kit
 - Specimen Dryer- wipe dryer with 10 % bleach wipe prior to use and turn fan on to maximum hour.
 - Woods Lamp
 - Camera
 - Red Box with SA medications.
3. Proceed with evidentiary exam as per Cal- EMA protocol.
 - Examiner obtains assault history, perform physical examination and evidentiary collection according to protocol
 - ED Physician will perform pelvic and anal exam.
 - RN is responsible for labeling all evidence including vaginal/cervical/anal swabs collected by MD.
 - All evidence collected goes inside evidence kit. Forensic blood tubes, if collected, go in a separate box.
4. NEVER LEAVE THE EVIDENCE UNATTENDED. Have another staff member check in room occasionally if anything is needed.
5. Double check Cal-EMA form for completeness.
6. Make 2 copies of completed Cal-EMA exam forms.
 - 1 copy goes to law enforcement
 - 1 goes with ED chart
 - Original form goes inside evidence box before it is sealed.
7. Do not tear down ED chart.
 - Place Cal-EMA forms and ED chart in yellow envelope marked *Confidential* and deliver to Emergency Department Manager.
 - During off- hours, request house supervisor to open Managers office and leave chart on desk.

**NORTHERN INYO HOSPITAL
POLICY AND PROCEDURE**

Title: Sexual Assault Exam Policy	
Scope: Emergency Dept	Manual: Emergency Department
Source: Manager - Emergency Department	Effective Date: 12/01/2014

TREATMENT and FOLLOW UP:

1. Offer patient hospital emergency contraception and sexually transmitted disease (STD) prophylaxis.
 - Verify results of EPT before giving meds.
 - Medications are in red box- in med room.
 - Ceftriaxone 125 mg intramuscular injection
 - Azithromycin 1 Gram by mouth
 - Metronidazole 2 Grams by mouth
 - Plan B 1 tablet by mouth
 - If patient is allergic to any meds, there are other options available (call pharmacy)
 - If patient takes any of the meds, fill out charge sheet and send with ED chart and call pharmacy to refill box.
2. Inform patient they can choose to have the follow up with their primary physician or with Inyo County Health Dept.
 - If pt. chooses to follow up with Health Dept, follow up call will be in 5-7 days.
 - Contact Health Department SA RN and give information re: date of exam and patients name, meds given, labs drawn and brief patient medical history.
 - Further information can be obtained by Health Department from Medical Records
3. Follow up may include:
 - Test result disclosure
 - HIV/Hepatitis C Counseling
 - Re-evaluation of physical injuries
 - Reevaluation for pregnancy and STD
 - Assessment for Rape Trauma Syndrome
 - Social services assistance
4. Discharge patient through Logicare with diagnosis of sexual assault and other medical diagnosis if present. Include teaching regarding any prophylactic medications given in ED.
5. Notify Director of Revenue Cycle of SA examination and give date, name of RN, and MD involved in exam. This is for charging purposes since SA chart does not follow the usual charging process.

DOCUMENTATION:

1. Documentation will be done as always in the ED chart. Triage complaint is entered as Sexual Assault and medication profile completed in Paragon.
2. All information related to the forensic evidentiary examination are documented in the appropriate Cal-EMA form.

**NORTHERN INYO HOSPITAL
POLICY AND PROCEDURE**

Title: Sexual Assault Exam Policy	
Scope: Emergency Dept	Manual: Emergency Department
Source: Manager - Emergency Department	Effective Date: 12/01/2014

REFERENCES:

1. California SART Report (2009). California Clinical Forensic Medical Training Center. UC Davis Health System.
2. California Hospital Association Consent Manual 2016. Section 2, page 2.23

CROSS REFERENCES:

1. Suspicious Injury Reporting
2. Working with other Agencies in the Community
3. Intimate Partner Abuse Guidelines
4. Child Abuse or Suspected Abuse or Sexual Assault Guidelines

Approval	Date
Clinical Consistency Oversight Committee	5/21/18
Emergency Room Medical Committee	7/9/18
MEC	8/7/18
Board of Directors	
Last Board of Director review	

Developed: 12/2000
 Reviewed: 2003, 2006, 2009, 2012, 2015as, 4/2018 gr
 Revised: 12/2000; 2/2002, 2014as
 Supersedes:

**NORTHERN INYO HEALTHCARE DISTRICT
POLICY AND PROCEDURE**

Title: Surveillance for Hospital Acquired Infections (HAI's)	
Scope: NIHD	Manual: CPM-Infection Control Patient
Source: Quality Nurse Specialist/Infection Preventionist Manager	Effective Date: 05/2/2013

PURPOSE:

Surveillance is an essential component of the prevention and control of infections. It consists of the routine collection of data on infections among patients or staff, its analysis and the dissemination of the resulting information to those who need to know so that appropriate action can result. Surveillance also forms part of clinical audit and clinical governance; it assists in reducing the frequency of adverse events such as infection or injury, identify areas for improvement, and to meet public reporting mandates and pay for performance goals.

POLICY:

1. Northern Inyo Hospital has the responsibility to monitor Hospital-Associated Infections (HAI's) that manifest during admission and after the patient is discharged from the hospital. The Infection Preventionist Manager, Employee Health/Infection Control Specialist and or the physician is the appropriate persons to determine that such an infection has occurred. Surveillance is carried out in a timely and effective manner.
2. NIHD will follow the Center for Disease Control and Prevention (CDC) National Healthcare Safety Network (NHSN) system definitions that are used to identify healthcare associated infections. The surveillance data will be appropriately analyzed and used to monitor and improve infection control and healthcare outcomes.

DEFINITIONS:

1. **Active surveillance:** Involves prospective steps to identify patients who have or who may develop HAI's, using standardized definitions of infection, pre-determined criteria, and protocols that result in risk adjusted HAI incidence rates. Active surveillance is used to identify patients at high risk for infections related to device associated infections, surgeries, and high risk patients.
2. **Hospital acquired infection (HAI):** A localized or systemic condition resulting from an adverse reaction to the presence of an infectious agent not present at the time of admission to the healthcare facility. HAI may be referred to as nosocomial infection.
3. **Passive surveillance:** Relies on data retrospectively gathered from medical records
4. **Surveillance:** The continuous and systematic process of collection, analysis, interpretation and dissemination of descriptive information for monitoring health problems.

PROCEDURE:

1. Analyze infection control data for:
 - i. For infections clusters
 - ii. Significant and unusual pathogens
 - iii. Occurrence of healthcare associated infections that exceed the usual baseline levels
2. Compile and analyze surveillance data to identify trends in healthcare associated, community, and occupational acquired infectious diseases and to develop appropriate measures for prevention and control. Infection rates for targeted surveillance will be calculated and benchmarked using NHSN national rates and/or data definitions on Infection Control Pillars of Excellence. The below infections

**NORTHERN INYO HEALTHCARE DISTRICT
POLICY AND PROCEDURE**

Title: Surveillance for Hospital Acquired Infections (HAI's)	
Scope: NIHD	Manual: CPM-Infection Control Patient
Source: Quality Nurse Specialist/Infection Preventionist Manager	Effective Date: 05/2/2013

will be monitored and reported.

- i. Central line associated bloodstream infections (CLABSI's)
 - ii. Catheter associated urinary tract infections (CAUTI's)
 - iii. Ventilator associated events (VAE's)
 - iv. Surgical Site Infections (SSI)
 - v. MRSA and VRE Bloodstream infections
 - vi. C-difficile Infections hospital onset
3. All positive cultures will be reviewed at least every two weeks.
 4. If patient is transferred to another facility prior to final results the Microbiology Department will notify the receiving facility of results via phone or fax.
 5. Once determined that the infection is a possible HAI a further investigation will take place using the patient record, discussion with staff involved and a review of the reason the culture was ordered from the ordering physician
 6. Healthcare workers are to promptly report suspected or confirmed HAI, using the "NIHD Confirmed/Suspected Infection Report" and return to Infection Control within seven days. Form is located on NIHD intranet>forms> Infection Prevention.
 7. After a complete evaluation and review of the infection the information will be entered into NHSN and presented quarterly at Infection Control Committee, Nurse Executive Committee. All surgical site infections that meet NHSN criteria will be presented at quarterly Surgery Tissue Committee. These findings will be sent to Quality Assurance and Performance Improvement Department (QAPI) quarterly.
 8. Detect and investigate clusters or outbreaks and provide intervention and control
 9. Develop, implement, support, and sustain evidenced-based interventions to prevent HAI's and organism transmissions.
 10. Provide education on infection control matters relating to the prevention and management of HAI's.
 11. Observe healthcare workers practices that include:
 - i. Hand hygiene
 - ii. Cleaning and disinfecting
 - iii. Transmission based precautions
 12. Detect and report reportable disease to the local health department
 13. Complete annual risk assessment and update if indicated.

REFERENCES:

1. The Joint Commission (2017). Critical Access Hospitals Infection Prevention and Control. IC.01.04.01. Retrieved from <https://e-dition.jcrinc.com/MainContent.aspx>
2. The Joint Commission (2018). Critical Access Hospital Infection Prevention and Control. IC.01.05.01. Retrieved from <https://e-dition.jcrinc.com/MainContent.aspx>
3. The Joint Commission (2018). Critical Access Hospital Infection Prevention and Control. IC.02.01.01. Retrieved from Retrieved from <https://e-dition.jcrinc.com/MainContent>.
4. California Department of Public Health. (2017). Surgical Site Surveillance. Retrieved from https://www.cdph.ca.gov/Programs/CHCQ/HAI/CDPH%20Document%20Library/16_SSI.Surveillance.20171006.vk-ADA.pdf
5. California Department of Public Health. (2017). Clostridium Difficile Infection Surveillance. Retrieved from

**NORTHERN INYO HEALTHCARE DISTRICT
POLICY AND PROCEDURE**

Title: Surveillance for Hospital Acquired Infections (HAI's)	
Scope: NIHD	Manual: CPM-Infection Control Patient
Source: Quality Nurse Specialist/Infection Preventionist Manager	Effective Date: 05/2/2013

https://www.cdph.ca.gov/Programs/CHCO/HAI/CDPH%20Document%20Library/13_CDI.Surveillance.Approved12.01.17-ADA.pdf

6. California Department of Public Health. (2017). Healthcare-Associated Infections Program. Retrieved from https://www.cdph.ca.gov/Programs/CHCO/HAI/CDPH%20Document%20Library/13_IntroNHSN_20170915.vk.pdf
7. Infection Control Today. (2017). The Role of Surveillance in HAI Prevention. Retrieved from <http://www.infectioncontroltoday.com/epidemiology-surveillance/role-surveillance-hai-prevention>
8. Centers for Disease Control and Prevention. (2017). National Health and Safety Network (NHSN). Retrieved from <https://www.cdc.gov/nhsn/index.html>

CROSS REFERENCE P&P:

1. Infection Control Plan
2. Multi-Drug Organism Control Plan
3. Role of Microbiology in Infectious Disease Control

Approval	Date
CCOC	4/23/18
Infection Control Committee	5/22/18
Surgery Tissue Committee	7/25/18
Medical Executive Committee	8/7/18
Board of Directors	
Last Board of Directors Review	

Developed: 04/2018 RC

Reviewed:

Revised:

Supersedes: Post discharge surveillance

Index Listings: HAI's, NHSN, and Surveillance