Northern Inyo Hospital

December 19 2018 Regular Meeting

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DRAFT AGENDA

NORTHERN INYO HEALTHCARE DISTRICT
BOARD OF DIRECTORS REGULAR MEETING
December 19, 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. New Business
   A. Strategic Plan update, Workforce Experience Committee report (*information item*).
   B. Election of Board Officers for 2019 calendar year (*action item*).
   C. 2013 CMS Survey Validation Monitoring reports and Financial and Statistical reports (*information item*).
   D. Approval of District Board Resolution 18-08, affiliated entity: Pioneer Home Health (*action item*).
   E. Ad Hoc Board Meeting January 19 or 28 2019, Board Education/Training (*discussion item*).
   F. Approval of recommended add to Capital Budget (*action item*)
   G. Medical Staff Leadership Expansion (*action item*).
   H. Explanation of Exit Interview process (*information item*).
4. Old Business
   A. Athena update (*information item*).
   B. Pharmacy update (*information item*).
   C. Receipt and approval of NIHD Annual Audit for 2017/2018 fiscal year, Wipfli LLP (*action item*).

Consent Agenda

5. Approval of minutes of the November 14 2018 regular meeting
6. Approval of minutes of the December 12 2018 special meeting
7. Policy and Procedure annual approvals

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8. Chief of Staff Report; Allison Robinson MD:

A. Policies and Procedures (*action items*):

1. *Breastfeeding the Term Infant*
2. *Crash Cart and Defibrillator Check Policy*
3. *Dental Emergencies in the Emergency Department*
4. *Disclosure of the Unanticipated Outcome*
5. *Evaluation and Assessment of Patient's Nutritional Needs*
6. *Newborn and Pediatric Abduction Prevention Safety and Security*
7. *Newborn Pulse Oximetry Screen*
8. *Respiratory Therapist Patient Assessment and Reassessment*
9. *Transcutaneous Bilirubin Testing (Bili Scan)*

B. Medical Staff/Allied Health Professional reappointments and Privileges (*action items*):

	Practitioner	Title	Category	Specialty	Privileges Granted Through:
1.	Arndal, L. Jeanine	MD	Active	OB/GYN	2019-2020
2.	Bloomfield, Peter	MD	Active	Emergency Medicine	2019-2020
3.	Boo, Thomas J.	MD	Active	Family Medicine	2019-2020
4.	Bourne, Sierra	MD	Active	Emergency Medicine	2019-2020
5.	Cowan, John Daniel	MD	Active	Anesthesiology	2019-2020
6.	Cromer-Tyler, Robbin	MD	Active	General Surgery	2019-2020
7.	Drew, Tracy	NP	AHP	Family Nurse Practitioner	2019-2020
8.	Engblade, Joy	MD	Active	Internal Medicine	2019-2020
9.	Figueroa, Jennifer A.	PA	AHP	Physician Assistant	2019-2020
10.	Gasior, Anne	MD	Active	Family Medicine	2019-2020
11.	Goshgarian, Anne	MD	Active	Emergency Medicine	2019-2020
12.	Helvie, Charlotte C.	MD	Active	Pediatrics	2019-2020
13.	Inforzato, Michelle	MD	Active	Internal Medicine	2019-2020
14.	Joos, Jennifer L.	PA	AHP	Physician Assistant	2019-2020
15.	Kip, Katrinka	MD	Telemedicine	Pediatric Cardiology	2019-2020
16.	Leja, Catherine	MD	Active	Family Medicine	2019-2020
17.	Ludwick, Joseph	MD	Telemedicine	Pediatric Cardiology	2019-2020

18.	McEvoy, Colleen	NP	AHP	Pediatric Nurse Practitioner	2019-2020
19.	Morgan, Jayson	MD	Telemedicine	Cardiology	2019-2020
20.	Nicholson, David L.	CRNA	AHP	Nurse Anesthesia	2019-2020
21.	Pansawira, Irin	OD	Telemedicine	Optometry	June 30, 2019
22.	Paulson, Jessica	MD	Temporary	Emergency Medicine	2019
23.	Robinson, Allison	MD	Active	General Surgery	2019-2020
24.	Robinson, Mark K.	MD	Active	Orthopedic Surgery	2019-2020
25.	Schneider, Jeanette	MD	Consulting	Psychiatry	2019-2020
26.	Sharma, Uttama	MD	Active	Family Medicine	2019-2020
27.	Siddiqi, Saif H.	MD	Telemedicine	Radiology	2019-2020
28.	Souders, Stuart	MD	Active	Radiology	2019-2020
29.	Theis, Jacqueline	OD	Telemedicine	Optometry	June 30, 2019
30.	Timbers, William	MD	Active	Emergency Medicine	2019-2020
31.	Walker, Jennie G.	MD	Active	Emergency Medicine	2019-2020
32.	Wise, Matthew	MD	Active	OB/GYN	2019-2020
33.	Wolf, Charlie	MD	Temporary	Emergency Medicine	2019
34.	Yolken, Mara	NP	AHP	Adult Nurse Practitioner	2019-2020

9. Reports from Board members (*information items*).
10. Adjournment to closed session to/for:
    A. Confer with Legal Counsel regarding threatened litigation, 1 matter pending (*pursuant to Government Code Section 54956.9(d)(2)*).
11. Return to open session and report of any action taken in closed session.
12. 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.

BEFORE THE BOARD OF DIRECTORS OF THE
NORTHERN INYO HEALTHCARE DISTRICT

RESOLUTION 18-08

DESIGNATION OF AFFILIATED COVERED ENTITY ("ACE") STATUS FOR HIPAA ADMINISTRATION

WHEREAS, HIPAA allows covered entities under common ownership or control to join together to form a single "Affiliated Covered Entity" ("ACE") for purposes of compliance with HIPAA; and

WHEREAS, the District is a healthcare provider and a "covered entity" for HIPAA patient privacy and administrative purposes; and

WHEREAS, Pioneer Home Health Care, Inc. "(Pioneer") is a healthcare provider and a "covered entity" for HIPAA patient privacy and administrative purposes; and

WHEREAS, the District and Pioneer are affiliated by reason of the District's status as sole corporate member of Pioneer; and

WHEREAS, designation of an ACE between affiliated healthcare providers allows for shared used of patient data for the purposes of HIPAA administrative oversight programs, including implementation of joint privacy practice and consent form practices, joint training, uniform business associate contracting, and patient healthcare access needs assessment.

NOW, THEREFORE, the Board of Directors hereby resolve:

1. To designate the existence of an Affiliated Covered Entity for HIPAA purposes by and between the Northern Inyo Healthcare District and Pioneer Home Health Care, Inc.

2. To authorize management to complete the administrative organization of the ACE and to thereupon implement shared HIPAA administration as management deems advantageous to the District.

PASSED AND ADOPTED this 19th day of December, 2018, by the following votes:

AYES:__________________

NOES:__________________

ABSENT:________________

____

Secretary, Board of Directors
Northern Inyo Healthcare District

____

Chair, Board of Directors
Northern Inyo Healthcare District

BEFORE THE BOARD OF DIRECTORS OF
PIONEER HOME HEALTH CARE, INC.

[INSERT DATE]

DESIGNATION OF AFFILIATED COVERED ENTITY ("ACE") STATUS FOR HIPAA ADMINISTRATION

WHEREAS, HIPAA allows covered entities under common ownership or control to join together to form a single "Affiliated Covered Entity" ("ACE") for purposes of compliance with HIPAA; and

WHEREAS, Pioneer Home Health Care, Inc. "(Pioneer") is a healthcare provider and a "covered entity" for HIPAA patient privacy and administrative purposes; and

WHEREAS, the Northern Inyo Health Care District ("District") is a healthcare provider and a "covered entity" for HIPAA patient privacy and administrative purposes; and

WHEREAS, the District and Pioneer are affiliated by reason of the District's status as sole corporate member of Pioneer; and

WHEREAS, designation of an ACE between affiliated healthcare providers allows for shared used of patient data for the purposes of HIPAA administrative oversight programs, including implementation of joint privacy practice and consent form practices, joint training, uniform business associate contracting, and patient healthcare access needs assessment.

NOW, THEREFORE, the Board of Directors hereby resolve:

1. To designate the existence of an Affiliated Covered Entity for HIPAA purposes by and between the Northern Inyo Healthcare District and Pioneer Home Health Care, Inc.

2. To authorize management to complete the administrative organization of the ACE and to thereupon implement shared HIPAA administration as management deems advantageous to the Pioneer Home Health Care, Inc.

PASSED AND ADOPTED this ____ day of ____, 2018, by the following votes:

AYES:__________________

NOES:__________________

ABSENT:________________

____
Secretary, Board of Directors
Pioneer Home Health Care, Inc.

____
Chair, Board of Directors
Pioneer Home Health Care, Inc.

NORTHERN INYO HEALTHCARE DISTRICT
One Team. One Goal. Your Health.

NORTHERN INYO HOSPITAL

Northern Inyo Healthcare District

150 Pioneer Lane
Bishop, California
93514
(760) 873-5811 voice
(760) 872-2768 fax

Board of Directors

- **M.C. Hubbard President**
- **Mary Mae Kilpatrick, Vice President**
- **Jean Turner, Secretary**
- **Robert Sharp Treasurer**
- **Peter Tracy Member at Large**
- **Kevin S. Flanigan, MD, MBA, CEO**

Improving our Communities one Life at a Time. One Team. One Goal. Your Health!

Web Site
www.nih.org

December 5, 2018

Memo To: Board of Directors

From: John Tremble, CFO

Subject: Recommendation to Add $570,645 to the 2019 Capital Budget

As outlined in the 2020 Budget Calendar. A supplemental request for additional Capital expenditures for Fiscal 2019 has been prepared, reviewed by the Medical Executive Committee and is being presented to you for consideration.

The Medical Executive Committee was presented with a listing of 24 requests worth $779,239. The Committee was also presented with the attached cash flow projection where it is projected that the cash on hand for NIHD will end the year at $17,835,000 equal to 77.5 days.

The District is projected to have a net loss of ($1,240,000) for the year (primarily due to the low volumes of September, 2018), use $3,148,000 in cash to purchase assets authorized in the first 2019 Capital Budget (attached as a reference), retire $2,168,000 in long term debt, have an IGT receivable of $1,560,000 at year end and use $2,500,000 through higher end of year accounts receivables. All of this activity leads to a projected reduction of cash on hand of ($4,134,000).

The District has a number of financial ratios it is to maintain according to the Bonds outstanding and issued by the District. A key ratio is debt service coverage. If the District maintains 75 days cash on hand, the debt service ratio drops lowered to 1.25 from 1.50 to 1. It is my recommendation that we maintain a floor of 75 days cash on hand in order to have this more lenient covenant ratio going forward.

With a 75 days cash on hand floor, that calculates to $575,000 of additional cash available for Capital purchases in 2019. The Medical Executive Committee used this calculation to select the items being presented for consideration.

Northern Inyo Healthcare District
Statement of Cash Flow
For Fiscal Year 2018 & 2019
Capital Budget Impact Statement

	FY 2017	FY 2018	FY 2019
Cash on Hand	18,616,934	16,058,324	21,969,594
Used for Other Investments	(248,369)	(133,052)	(1,515,000)
Increase in Patient A/R	(2,995,894)	(406,758)	(2,500,000)
Change in Other Receivables	501,536	460,757	(1,560,850)
Change in Inventory	(843,685)	301,810	-
Change in Prepaid Expenses	(315,821)	(627,014)	60,000
Change in Special Purpose Assets	(1,157,516)	(1,455,016)	-
Change in Revenue Bonds with Trustee	3,395,095	(25,587)	(45,000)
Change in Long Term Investments	(197,857)	250,000	-
Change in Net Property et al.	3,260,381	2,965,374	3,147,945
Change in current Liabilities	(3,810,215)	3,911,779	360,000
Change in long term debt	(2,048,220)	(2,092,000)	(2,168,000)
Accreted Interest change	1,326,585	1,326,585	1,326,585
Change in Pension liability	190,710	767,099	-
Change in Temporarily Restricted	1,157,516	30,376	-
Net Income (Loss)	(772,856)	636,917	(1,240,000)
Ending Cash on Hand	16,058,324	21,969,594	17,835,274
Total Operating Expenses plus Principal	74,465,243	78,565,420	84,000,000
Average Cash Used Per Day	204,014	215,248	230,137
Ending Days Cash on Hand	78.7	102.1	77.5
Organizational Goal		90.0	90.0
Minimum Floor			75.0
Available Additional for 2nd Capital Review:		$	575,000

Northern Inyo Hospital - 2018-19 Capital Expenditure Requests - 2nd Half of Year

New Items Requested for the Consideration	Recommended by Medical Executive Committee 12/4/2018

1-Patient Safety, Regulatory Compliance
2-Patient Satisfaction
3 - Strategic Purchase & New Services
4 - End of Life Assets
5- Dependent on EHR Selection/Installation
6- Future year purchase per Exec
7- Staff Safety
8 - OSHPD Required

Dept ID	Department	Description	Purpose	Est Cost of Capital > $3,000	Yrs of Life	Primary Reason	Secondary Benefit	Med Staff Priority	note	Annual Est. Depr
8480	Information Technology	Nagios Network	Perpetual license for Internet and System monitoring	$ 3,495.00	3	1	3			$ 1,165.00
6170	Med/Surg Inpatient	2 Hillrom VC765 P3200 Versacare Beds	Patient Bed	$ 37,662.66	10	4			package unit	$ 3,766.27
6170	Med/Surg Inpatient	Nursing Station Printer		$ 9,800.00	5	4				$ 1,960.00
6010	ICU	Hillrom pro 825 P7500 Progressa bed package	Patient Bed	$ 33,600.00	10	4				$ 3,360.00
7450	Anesthesia	Phillips Anesthesia Monitors	Monitors to integrate with Athena	$ 172,051.75	7	4	1		Requesting 3 Monitors in Total	$ 24,578.82
7010	Emergency Department	Cardiac Monitors		$ 34,136.50	5	4				$ 6,827.30
6010	ICU	Central Monitoring System		$ 32,865.50	5	4				$ 6,573.10
6170	Med/Surg Inpatient	Cardiac Monitors		$ 93,493.50	5	4				$ 18,698.70
7427	PACU	Central Monitoring System		$ 44,658.25	5	4				$ 8,931.65
6170	Med/Surg Inpatient	Multi-department central monitoring infrastructure		$ 86,279.78	5	4				$ 17,255.96
6170	Med/Surg Inpatient	HL7 ADT Infrastructure for central monitoring		$ 22,601.75	5	4				$ 4,520.35
		New & Updated Requests for 2019		$ 570,644.69						$ 97,637.14
		Totals for All Central Monitoring Equipment	(Replacing equipment installed in new building)	$ 314,035.28	5				(Existing may still be depreciating)	$ 62,807.06

Northern Inyo Hospital - 2018-19 Approved Capital Expenditure

1-Patient Safety, Regulatory Compliance
2-Patient Satisfaction
3 - Strategic Purchase & New Services
4 - End of Life Assets
5- Dependent on EHR Selection/Installation
6- Future year purchase per Exec
7- Staff Safety
8 - OSHPD Required

Dept ID	Department	Description	Purpose	Est Cost of Capital > $2,500	Yrs of Life
9516	NIA Ortho Clinic	Replace Carpet with sheet vinyl	Update flooring for medical office space	$ 7,342.32	10
7070	Rural Health Clinic	Replace Carpet with sheet vinyl in exam rooms	Update flooring for medical office space	$ 13,813.90	10
7010	Emergency Department	HoverJack Air Patient Lift	System to lift patients who have fallen	$ 6,200.00	5
7590	EKG	Badge Access for EKG	Replace keys with electronic access	$ 4,000.00	5
6400	Perinatal	IntelliVue X3 infant monitor	Add C02 monitoring capability per recommendation	$ 12,370.00	5
8460	Maintenance	Re-tube Ajax Boilers	Used for Medical Waste	$ 13,058.00	10
7070	Rural Health Clinic	Adjustable height exam table	Address concerns for certain patients	$ 4,000.00	7
7780	Speech Language	Fiberoptic endoscopic evaluation for swallowing	Mobile unit to replace use of fluoroscopy suite	$ 35,000.00	7
7070	Rural Health Clinic	Point of Care Lead Testing Machine	Testing available at RHC	$ 13,000.00	5
6170	Surgery	Integrated Video System (replacement & upgrade)	for all three OR Rooms icludes all wiring & install	$ 243,240.00	10
8480	Information Technology	(4) Cisco 3850-48U-L access layer switches	allows enhanced bandwith serves up to 192 units	$ 28,000.00	7
8480	Information Technology	Offsite storage of data unit	disaster recovery component	$ 6,600.00	5
8480	Information Technology	Uninterrupted Power Source	disaster recovery component	$ 5,000.00	5
8480	Information Technology	Microsoft Exchange Archive Storage	disaster recovery component	$ 6,600.00	5
6400	Perinatal	Neonatal Bilirubin Blanket (need one more)	Used to treat typerbilirubinemia in the newborn	$ 4,000.00	5
7502	Microbiology	PCR Testing Equipment	reduce turn around time for cultures	$ 75,000.00	7
7730	Pulmonary Function	Pulmonary Function System (replace 2008)	Provide pulmonary function studies	$ 47,000.00	8
7070	Rural Health Clinic	Laboratory Room Refrigerator	End of Life Replacement	$ 4,000.00	7
7070	Rural Health Clinic	Medication Freezer	End of Life Replacement	$ 6,000.00	7
7070	Rural Health Clinic	Medication Refrigerator	End of Life Replacement	$ 4,000.00	7
8320	Dietary	Vulcan double deck oven	End of Life Replacement	$ 7,360.00	7
6170	Med/Surg Inpatient	Refrigerator & Freezer Combo	True T023DT model	$ 6,500.00	7
6170	Med/Surg Inpatient	Medication Refrigerator	End of Life Replacement	$ 5,000.00	7
6170	Med/Surg Inpatient	Replace to Workstations on Wheels (2)	Computer system on wheels for care coordination	$ 11,175.00	5
6010	ICU	Dietary Refridgerator	End of Life Replacement	$ 4,000.00	7
6010	ICU	Replace to Workstations on Wheels	Computer system on wheels for care coordination	$ 5,587.58	5
7010	Emergency Department	Cardiac Monitors	End of Life Replacement	$ 34,136.50	7
7010	Emergency Department	Cardiac Montiors - Primary Server	End of Life Replacement	$ 34,136.50	7
6170	Med/Surg Inpatient	Cardiac Monitors with hardware, software and install	End of Life Replacement	$ 93,500.00	7
7427	Surgery & PACU	Stryker eye gurney	End of Life Replacement	$ 8,236.00	7
7427	PACU	PACU gurneys (2)	End of Life Replacement	$ 15,874.00	7
6400	Perinatal	Radiant Infant Warmer	End of Life Replacement	$ 18,500.00	7
6400	Perinatal	Dietary Refridgerator	End of Life Replacement	$ 4,000.00	7
6400	Perinatal	Breastmilk Refridgerator	End of Life Replacement	$ 5,400.00	7
6400	Perinatal	Laboratory Room Refrigerator	End of Life Replacement	$ 4,000.00	7
7420	Surgery	Replace all 9 current Operating Room Monitors	End of Life Replacement with upgrade in system	$ 47,872.00	5
6400	Perinatal	Replace to Workstations on Wheels (3)	Computer system on wheels for care coordination	$ 16,765.00	5
8380	Sterile Processing	V-Pro-Max Steris hydrogen peroxide sterilizer	Improved results over current V-Pro	$ 120,256.00	5
7680	Nuclear Medicine	Gamma Camera	End of Life Replacement as software is outdated	$ 340,000.00	7
7630	Diagnostic Imaging	GE TIMS Unit - video recording of swallow studies	End of Life Replacement	$ 25,000.00	7
7520	Pathology	Laboratory Room Refrigerator	End of Life Replacement	$ 4,000.00	7
8460	Maintenance	Penthouse Area Above Infusion Roof Replacement	End of Life Replacement	$ 15,000.00	10
8460	Maintenance	Replace steam humidifier	End of Life Replacement	$ 19,000.00	10
7010	Emergency Department	Hospital PIICiX ADT & Vital Sign Results via IBE	Moves Philips monitor results into Athena	$ 19,100.00	5
8390	Pharmacy	Modular Clean Room	Upgrade clearn room to be CDPH and OSHPD compliant	$ 210,859.00	15
8390	Pharmacy	Relocated Pharmacy to 1981 building	Upgrade to be CDPH and OSHPD compliant	$ 1,534,464.00	15
				$ 3,147,945.80	

CALL TO ORDER	The meeting was called to order at 5:30 pm by M.C. Hubbard, President.
PRESENT	M.C. Hubbard, President Mary Mae Kilpatrick, Vice President Jean Turner, Secretary Robert Sharp, Treasurer Peter Tracy, 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 Michelle Garcia, CHRO Administrative Assistant
OPPORTUNITY FOR PUBLIC COMMENT	Ms. Hubbard announced at this time person in the audience may speak on any items not on the agenda for this meeting on any matter within the jurisdiction of the District Board, and speakers will be limited to a maximum of three minutes each. No comments were heard.
STRATEGIC PLAN UPDATE, FINANCE COMMITTEE REPORT	Genifer Owens, Northern Inyo Healthcare District (NIHD) Controller provided an update on the activities and goals of the Finance Committee established for the purpose of addressing the finance-related goals of the District's Strategic Plan. Ms. Owens reported the following: - 75% of NIHD leadership has attended finance education trainings (end goal is 95% completion) - 55% of NIHD leadership has submitted budget variance reports to the Committee (end goal is 75% completion) - A Market Share Sub Committee is currently being formed for the purpose of analyzing data relating to what percentage of community healthcare services the District is currently capturing
CHIEF EXECUTIVE OFFICER REPORT	Chief Executive Officer (CEO) Kevin S. Flanigan MD, MBA provided a bi-monthly CEO report that included the following: - NIHD is partnering with Big Pine Emergency Medical Technicians (EMT's) in an effort to help improve and expand upon local EMT programs - Local news media recently published an article on the Healthcare District partnering with Bright Heart Health to provide behavioral health services, however at this time no such partnership or taskforce has been established - Per information received from Pioneer Home Health, the number of referrals they receive has increased significantly following the formation of their partnership with NIHD
NIHD ANNUAL AUDIT, 20187/2018 FISCAL YEAR	Doctor Flanigan also reported that Wipfli LLP will present the District's annual audit report at the December 19 2018 Board of Directors meeting.

DETERMINATION OF DATES FOR BOARD EDUCATION	January 19 2019 and January 28 2019 have been chosen as possible dates for Board Education to be provided by District legal counsel Colin Coffey. A final decision on the date for the training will be made at the December 19 2018 meeting of the District Board.
NEWSPAPER ARTICLE ON ADDICTION SERVICES	Doctor Flanigan reported he has conducted an interview with Inyo Register Editor Terrance Vestal on the topic of how the District defines and develops its partnerships and collaborations.
CHIEF OPERATING OFFICER REPORT	Chief Operating Officer (COO) Kelli Huntsinger provided a bi-monthly COO report which included the following: - Departmental focuses have largely been aimed toward Athena system implementation - The Cardiopulmonary Department now has 9 full-time staff members, and new Pulmonary Function Testing equipment has been purchased - Diagnostic Services and the Laboratory Department are now fully-staffed with no open positions - This year's Moonlight Mammograms event ran for three consecutive nights and a total of 81 patients were seen - The Health Information Management Department has on-boarded 6 remote Coders and has one telework Coder - The District's daily Safety Huddle continues to meet Monday thru Friday, and it has identified a total of 92 safety-related issues. The District is also in the process of developing new Safety Coaches in an effort to continue to grow that program. - The Community Safety Taskforce group continues to work on improving safety for all members of this community - The NIHD Dietary Department is currently distributing Thanksgiving turkeys to all District staff - The Laundry Department is helping to provide Pioneer Home Health with laundry services Ms. Huntsinger additionally reported that she recently completed Rural Health Clinic Professional Certification.
CHIEF FINANCIAL OFFICER REPORT	Chief Financial Officer (CFO) John Tremble provided a financial report which included the following: - The Financial Statement Summary for the month of September 2018 shows that inpatient days were well below budget. During the month of September, the number of District FTE's grew by 40 members, and an overall net loss of $1,871,584 was realized for the month. - Looking forward, revenue for the month of October is expected to be better, and patient volume was over budget for the month. Regarding the month of November, as of November 13 revenue was running 15% under budget.

PRIMARY BANKING INSTITUTION RFP RESULTS AND BOARD RESOLUTION 18-06

Mr. Tremble called attention to the Primary Banking Institution RFP results review, and approval of District Board Resolution 18-06. Director Sharp excused himself from the meeting at this time due to an employment conflict of interest. Mr. Tremble stated that in an effort to reduce District banking fees (which total approximately $57,000 annually) a banking RFP process was launched in September, which netted responses from Union Bank and from Eastern Sierra Community Bank. Following an in-depth review of both proposals and a question and answer period, it was moved by Ms. Kilpatrick, seconded by Ms. Turner, and unanimously passed to select Eastern Sierra Community Bank (ESCB) to be the Primary Banking Institution for NIHD, and to approve District Board Resolution 18-06 as presented, with Director Sharp being absent from the vote. It was noted that an important determining factor in the selection of ESCB was a potential for annual interest earnings totaling approximately $27,000. A recommendation was also made to negotiate for a 3-year guarantee of the new banking relationship with ESCB. It was noted that Director Sharp informed the Board that he did not participate in the ESCB RFP process, as Branch Manager of the Bishop ESBC branch. Following the conclusion of discussion and the vote on this agenda item, Director Sharp re-entered the meeting.

FISCAL 2020 BUDGET PROCESS AND CALENDAR

Mr. Tremble called attention to the proposed fiscal year 2020 Budget Process and Calendar, noting that it supports the mission, vision, and values of the District. The proposal includes the change of primary banking institution; a second 340B pharmacy contract, and a review of employee compensation and benefits. It was moved by Robert Sharp, seconded by Peter Tracy, and unanimously passed to approve the proposed fiscal year 2020 Budget Process and Calendar as presented.

RED FLAG RULES POLICY

Mr. Tremble also called attention to a proposed Policy titled *Identity Theft Red Flag Rules*. It was moved by Mr. Sharp, seconded by Mary Mae Kilpatrick, and unanimously passed to approve the *Identity Theft Red Flag Rules* policy as presented.

SMALL BALANCE WRITE OFF POLICY

Mr. Tremble then called attention to a proposed policy titled *Small Balance Write Off Policy*. It was moved by Mr. Sharp, seconded by Ms. Kilpatrick, and unanimously passed to approve the *Small Balance Write Off* Policy as presented.

CREDIT BALANCE REFUND POLICY

Mr. Tremble also called attention to a proposed *Credit Balance Refund* Policy. It was moved by Mr. Sharp, seconded by Ms. Kilpatrick, and unanimously passed to approve the proposed *Credit Balance Refund* Policy as presented.

CHIEF NURSING OFFICER REPORT

Chief Nursing Officer (CNO) Tracy Aspel RN provided a bi-monthly Chief Nursing Officer report which included the following:

- A Pain Management Project Team has been developed to review

new Joint Commission standards on pain assessments
- The Inter-Disciplinary Team continues to meet on a daily basis to review inpatient care and care coordination. Pioneer Home Health now participates in that meeting.
- Nursing training programs have been developed in the Perinatal; ICU and OR units
- The ICU unit currently has 4 open positions which are being filled with travelers
- The Language Services Department has conducted a dual-role interpreter training, which involved 17 District staff participants

CDPH SURVEY FINDINGS AND RESPONSE

Ms. Aspel also reviewed the District's California Department of Public Health (CDPH) survey findings and response, noting that the District has submitted a revised Plan of Correction to CDPH.

CHIEF HUMAN RESOURCES OFFICER REPORT

Chief Human Resources Officer (CHRO) Evelyn Campos Diaz provided the following report:
- The District's Employee Engagement Survey will be deployed in January of 2019, for a third consecutive year
- An update was given on the accomplishments of the Workforce Council
- A 7 Habits training was recently held and 14 workforce members attended
- The District's V-PAT (violence prevention) team continues to meet on a regular basis
- Information of the District's exit interview process will be provided at the December regular meeting of the District Board

QUARTERLY COMPLIANCE REPORT

Compliance Officer Patty Dickson provided a quarterly Compliance Report which included the following:
- Report on breaches and actions taken for calendar year 2018
- Report on issues, inquiries, audits, and investigations for calendar year 2018
- Report on Conflict of Interest disclosure forms processed
- Review of the Compliance Depart workplan
- Report on CDPH Licensing Survey Response Monitoring

It was moved by Ms. Kilpatrick, seconded by Ms. Turner, and unanimously passed to approve the Compliance Department Quarterly Report as presented.

APPROVAL OF REAL ESTATE PURCHASE AND BOARD RESOLUTION 18-07

Dr. Flanigan called attention to approval of a real estate purchase for 376 West Yaney Street, Bishop, California and Board Resolution 18-07. At this time Director Tracy excused himself from the meeting due to an existing relationship between himself and the realtors involved in the transaction. Following a brief question and answer period it was moved by Ms. Turner, seconded by Mrs. Sharp, and unanimously passed to approve the real estate purchase of 376 West Yaney Street, Bishop, California and District Board Resolution 18-07 as presented, with

Director Tracy being absent from the voting. Following conclusion of the voting, Director Tracy re-entered the meeting.

CONSENT AGENDA

Ms. Hubbard called attention to the Consent Agenda for this meeting, which contained the following items:

- Approval of minutes of the October 17, 2018 regular meeting
- 2013 CMS Survey Validation Monitoring, November 2018
- Financial and statistical reports for September 2018
- Policy and Procedure annual approvals

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

CHIEF OF STAFF REPORT

POLICIES, PROCEDURES, PROTOCOLS, AND ORDER SETS

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:

1. *Cardiac Monitoring*
2. *Malignant Hyperthermia*
3. *Pediatric and Newborn Consultation Requirements*

It was moved by Ms. Turner, seconded by Mr. Sharp, and unanimously passed to approve all three Policies, Procedures, Protocols, and Order Sets as presented.

MEDICAL STAFF APPOINTMENTS AND PRIVILEGING

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 Appointment and Privileging:

1. Laura Sullivan, MD (*cardiology, Renown*) – telemedicine staff

It was moved by Mr. Sharp, seconded by Ms. Kilpatrick, and unanimously passed to approve the Medical Staff appointment and privileging of Laura Sullivan MD as requested.

Doctor Robinson additionally reported the Medical Executive Committee recommends approval of the following Allied Health Professional Appointments and Privileges:

1. Nancy Fong, FNP (*Rural Health Clinic*)
2. Alissa Dell, FNP (*Rural Health Clinic/Internal Medicine Clinic*)

It was moved by Mr. Sharp, seconded by Ms. Turner, and unanimously passed to approve the Allied Health Professional Appointments and Privileges as requested.

Doctor Robinson also reported the Medical Executive Committee recommends approval of the following Telemedicine Staff Appointments and Privileging, credentialing by proxy as follows:
As per the approved Telemedicine Physician Credentialing and Privileging Agreement, and as outlined and allowed by 42 CFR 482.22, the Medical Staff has chosen to recommend the following practitioners for Telemedicine Privileges relying upon Quality Nighthawk's credentialing

and privileging decisions:

1. Benjamin Ge, MD (*diagnostic radiology, Quality Nighthawk*)

It was moved by Mr. Sharp, seconded by Mr. Tracy, and unanimously passed to approve the Telemedicine Staff appointment and privileging of Doctor Ge as requested.

Doctor Robinson additionally stated the Medical Executive Committee recommends approval of the following additional privileges:

1. Erik Maki, MD (*interventional radiology*) – new privileges in Radiofrequency ablation
2. Tammy O'Neill, PA-C (*Rural Health Clinic*) – new privileges as generalist Physician Assistant in the Rural Health Clinic

It was moved by Mr. Sharp, seconded by Ms. Turner, and unanimously passed to approve both additional privileges as requested.

MEDICAL STAFF RESIGNATIONS

Doctor Robinson also reported the Medical Executive Committee recommends approval of the following Medical Staff resignations:

1. Sheldon Kop, MD (*radiology*) – effective 10/30/18
2. David Landis, MD (*radiology*) - effective 10/30/18
3. Arsen Mkrtchyan, MD (*internal medicine*) – effective 12/31/18

It was moved by Ms. Turner, seconded by Mr. Tracy, and unanimously passed to approve all three Medical Staff resignations as recommended.

CORE PRIVILEGE FORMS

Doctor Robinson additionally reported following careful review and consideration and approval by the appropriate Committees, the Medical Executive Committee recommends approval of the following Core Privilege Forms:

1. Pathology (*new*)
2. Psychiatry (*new*)
3. Pediatrics (*revised*)
4. Obstetrics and Gynecology (*revised*)
5. Family Medicine (*revised*)

It was moved by Ms. Kilpatrick, seconded by Mr. Sharp, and unanimously passed to approve all five Core Privilege Forms as requested.

BOARD MEMBER REPORTS

Ms. Hubbard asked if any members of the Board of Directors wished to report on any items of interest. Director Sharp thanked Doctor Flanigan for a recent tour of the hospital facility, and noted he recently had the opportunity to have conversations with Medical Staff from Mammoth Hospital during which he emphasized an interest in collaboration between the two Healthcare Districts. Director Kilpatrick reported that the recent NIHD Foundation fundraising dinner was a success, and it was a pleasure to honor the District's employee, physician, and Daisy Award winners for the year. Director Turner also commended the Foundation Board for the success of the fundraising dinner.

ADJOURNMENT TO CLOSED SESSION	At 7:56 pm Ms. Hubbard announced the meeting would adjourn to Closed Session to allow the Board of Directors to: A. Confer with Legal Counsel regarding threatened litigation, 1 matter pending (*pursuant to Government Code Section 54956.9*).
RETURN TO OPEN SESSION AND REPORT OF ACTION TAKEN	At 8:28 pm the meeting returned to Open Session. Ms. Hubbard reported the Board took no reportable action.
ADJOURNMENT	The meeting was adjourned at 8:30 pm.

____
M.C. Hubbard, President

Attest: ______________________________
Jean Turner, Secretary

CALL TO ORDER	The meeting was called to order at 3:30 pm by M.C. Hubbard, President, in the Northern Inyo Healthcare District (NIHD) Board Room at 2957 Birch Street, Bishop, California.
PRESENT	M.C. Hubbard, President Mary Mae Kilpatrick, Vice President Jean Turner, Secretary Robert Sharp, Treasurer Peter Tracy, Member at Large
ALSO PRESENT FOR RELEVANT PORTIONS	Kevin S. Flanigan MD, MBA, Chief Executive Officer
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.
ADJOURNMENT TO CLOSED SESSION	At 3:31 pm Ms. Hubbard announced the meeting would adjourn to Closed Session for: A. Discussion of a Personnel Matter, Employment Status, Potential Discipline Considerations (Pursuant to Government Code Section 54957). B. Personnel, Performance Evaluation, CEO (pursuant to Government Code Section 54957).
RETURN TO OPEN SESSION AND REPORT OF ACTION TAKEN	At 5:52 pm the meeting returned to Open Session. Ms. Hubbard stated that the Board discussed some anonymous allegations that were received and looked into. They have found these allegations to be unfounded and not supported by any factual findings, therefore no action was taken. Ms. Hubbard also stated that the Northern Inyo Healthcare District Board of Directors wholeheartedly supports Doctor Kevin S. Flanigan as Chief Executive Officer, and they look forward to his strong leadership in continuing to take NIHD to the highest level of performance.
ADJOURNMENT	The meeting was adjourned at 5:53 pm.

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M.C. Hubbard, Vice President

Attest: ____________________________________
Mary Mae Kilpatrick, Secretary

POLICY AND PROCEDURE ANNUAL APPROVALS:

Smoking Policy

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: December 6, 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 and Procedures (*action items*)
   1. *Breastfeeding the Term Infant*
   2. *Crash Cart and Defibrillator Check Policy*
   3. *Dental Emergencies in the Emergency Department*
   4. *Disclosure of the Unanticipated Outcome*
   5. *Evaluation and Assessment of Patient's Nutritional Needs*
   6. *Newborn and Pediatric Abduction Prevention Safety and Security*
   7. *Newborn Pulse Oximetry Screen*
   8. *Respiratory Therapist Patient Assessment and Reassessment*
   9. *Transcutaneous Bilirubin Testing (Bili Scan)*

B. Medical Staff/Allied Health Professional Reappointments and Privileges (*action items*)

The following applicants submitted an application for renewal of privileges and underwent a recredentialing process in accordance with the Medical Staff bylaws. The Medical Executive Committee recommends the following applicants for reappointment to the Medical Staff/Allied Health Professional (AHP) Staff in the category listed effective January 1, 2019, for a period not to exceed two years:

	Practitioner	Title	Category	Specialty	Privileges Granted Through:
1.	Arndal, L. Jeanine	MD	Active	OB/GYN	2019-2020
2.	Bloomfield, Peter	MD	Active	Emergency Medicine	2019-2020
3.	Boo, Thomas J	MD	Active	Family Medicine	2019-2020
4.	Bourne, Sierra	MD	Active	Emergency Medicine	2019-2020
5.	Cowan, John Daniel	MD	Active	Anesthesiology	2019-2020
6.	Cromer-Tyler, Robbin	MD	Active	General Surgery	2019-2020
7.	Drew, Tracy	NP	AHP	Family Nurse Practitioner	2019-2020
8.	Engblade, Joy	MD	Active	Internal Medicine	2019-2020
9.	Figueroa, Jennifer A	PA	AHP	Physician Assistant	2019-2020

10.	Gasior, Anne	MD	Active	Family Medicine	2019-2020
11.	Goshgarian, Anne	MD	Active	Emergency Medicine	2019-2020
12.	Helvie, Charlotte C	MD	Active	Pediatrics	2019-2020
13.	Inforzato, Michelle	MD	Active	Internal Medicine	2019-2020
14.	Joos, Jennifer L.	PA	AHP	Physician Assistant	2019-2020
15.	Kip, Katrinka	MD	Telemedicine	Pediatric Cardiology	2019-2020
16.	Leja, Catherine	MD	Active	Family Medicine	2019-2020
17.	Ludwick, Joseph	MD	Telemedicine	Pediatric Cardiology	2019-2020
18.	McEvoy, Colleen	NP	AHP	Pediatric Nurse Practitioner	2019-2020
19.	Morgan, Jayson	MD	Telemedicine	Cardiology	2019-2020
20.	Nicholson, David L.	CRNA	AHP	Nurse Anesthesia	2019-2020
21.	Pansawira, Irin	OD	Telemedicine	Optometry	June 30, 2019
22.	Paulson, Jessica	MD	Temporary	Emergency Medicine	2019
23.	Robinson, Allison	MD	Active	General Surgery	2019-2020
24.	Robinson, Mark K	MD	Active	Orthopedic Surgery	2019-2020
25.	Schneider, Jeanette	MD	Consulting	Psychiatry	2019-2020
26.	Sharma, Uttama	MD	Active	Family Medicine	2019-2020
27.	Siddiqi, Saif H	MD	Telemedicine	Radiology	2019-2020
28.	Souders, Stuart	MD	Active	Radiology	2019-2020
29.	Theis, Jacqueline	OD	Telemedicine	Optometry	June 30, 2019
30.	Timbers, William	MD	Active	Emergency Medicine	2019-2020
31.	Walker, Jennie G	MD	Active	Emergency Medicine	2019-2020
32.	Wise, Matthew	MD	Active	OB/GYN	2019-2020
33.	Wolf, Charlie	MD	Temporary	Emergency Medicine	2019
34.	Yolken, Mara	NP	AHP	Adult Nurse Practitioner	2019-2020

NORTHERN INYO HOSPITAL
POLICY AND PROCEDURE

Title: Breastfeeding the Term Infant*	
Scope: Perinatal Services	Manual: Perinatal
Source: Manager of Perinatal Department	Effective Date: 8/23/16

PURPOSE:

To create a philosophy that supports and views breastfeeding as the normal way to feed an infant, and to provide guidelines for safe and effective methods to assist the new mother in establishing a successful and satisfying breastfeeding experience.

POLICY:

All mothers will be given education and support to initiate and promote exclusive breastfeeding for the first 6 months of life and to continue breastfeeding after complementary foods are introduced for 1 year or longer, or as long as mutually desirable by the mother and infant. Northern Inyo Hospital believes that breastfeeding is the optimal feeding choice for most babies and will promote exclusive breast milk feeding. Those mothers, after education and documentation, that choose to formula feed will be supported in their decision and be given individual education on the preparation, storage, and administration of infant formula.

Exclusive breastmilk feeding will be defined according to the WHO's definition of "the infant only receives breast milk without any additional food or drink, not even water."

This policy is based on the latest evidence-based practice and recommendations from the most recent breastfeeding policy statements published by the Office on Women's Health (US Department of Health and Human Services), The Joint Commission's Perinatal Core Measures for Exclusive Breastfeeding, the American Academy of Pediatrics (AAP), the American College of Obstetricians and Gynecologists (ACOG), the American Academy of Family Physicians, the World Health Organization (WHO), the American Dietetic Association, the Academy of Breastfeeding Medicine, UNICEF/WHO evidence-based "Ten Steps to Successful Breastfeeding," and Baby Friendly USA.

PRECAUTIONS:

1. The mother's wishes regarding infant feedings will be respected and supported by the nursing staff.
2. Literature on infant feeding will be supplied as requested by the patient or as necessary according to the judgment of the nursing staff.
3. Assess patient's willingness and need for technological interventions/supplies. These supplies are meant for short-term problem solving and can lead to poor feeding practices if not used correctly. These patients should be referred to the International Board Certified Lactation Consultant (IBCLC).
4. Assess the woman's desire to breastfeed as well as what information or support she will need. Frequently new mothers are overwhelmed by too many different suggestions/techniques offered by friends, relatives and health care providers. It is essential that assistance to these mothers be given in a **consistent and repetitive** way that takes into account the transient problems with memory functions frequently encountered during the initial postpartum period. If problems arise that cannot be solved with basic interventions, or if further assistance will be needed after discharge, referral to the patient's health care provider, a home visit (i.e. Home Health nurse), and/or a lactation consult may be indicated.

PROCEDURE:

1. **Policy management, orientation, and training**
    a. The Director of Nursing Perinatal, clinical staff educator (CSE), Peri-Peds Committee, and NEST trained staff will be responsible for the development, updating, evaluation, and revision of this policy.

b. All staff that comes into direct contact with pregnant, laboring or postpartum women or newborn infants are responsible for implementing the policy.
c. New hires will be oriented to the policy by their preceptor or supervisor within two weeks of their start date.
d. All maternity staff will receive 20 hours of education in breastfeeding and lactation management. The curriculum for this education will cover the 15 sessions identified by Baby-Friendly USA and include 5 hours of supervised clinical training.
e. All new hires will be required to complete the breastfeeding training course as outlined by Baby Friendly USA within 6 months of hire.
f. Certificate of completion of course and clinical training competency will be documented in employee's file.
g. If training occurred prior to employment, employee must provide certificate of completion and verify that the other facility was certified as Baby Friendly at the time of taking the course. The employee will complete the same clinical competency as all maternity staff at NIH.
h. The Perinatal Nurse Manager is responsible for ensuring all staff are trained in accordance with this policy and the maintenance of competency documentation.
i. The policy will be reviewed every two years per NIH protocol, and revisions will take place at that time as needed. Revisions will take place more frequently than every two years if evidence steers current practice to a different procedure/technique.

2. **Inform all pregnant women about the benefits and management of breastfeeding**
   a. The Perinatal department at NIH has developed an education plan aimed at reaching pregnant women through the OB/GYN office, First 5, Toiyabe Indian Health Project, WIC, and the NEST (Newborn Evaluation Support and Teaching) program. NIH fosters the development of community-based programs that make available individual counseling or group education on breastfeeding and collaborates with community-based programs to coordinate breastfeeding messages. Staff in the Perinatal department at NIH have provided to other organizations that offer prenatal services a sample curriculum that includes essential information to be taught to the pregnant woman regarding breastfeeding. In addition, members of the staff participate in the local breastfeeding coalition. Physicians, Nurse Practitioners, Certified Nurse Midwives, nursing staff, NEST staff, and clinic staff will all be responsible to provide prenatal breastfeeding education, guidance, and educational materials.
      i. Education given during prenatal clinic visits
      ii. Prenatal classes offered periodically (collaboration with NIH, First 5, WIC, and Toiyabe)
      iii. NEST preadmission visits performed in the patient's third trimester (see NEST standards of practice)
   b. Education will include but not be limited to:
      1. The benefits of breastfeeding/risks of formula feeding
      2. The importance of exclusive breastfeeding for a minimum of 6 months and continued breastfeeding after complementary foods are introduced for 1 year or longer, or as long as mutually desirable by the mother and infant

3. Labor management techniques aimed at reducing the need for pharmacologic intervention
4. Early initiation of breastfeeding (within 1 hour preferably)
5. Immediate, uninterrupted skin-to-skin contact after birth
6. 24-hour rooming-in practices
7. Basic breastfeeding management - baby-led feeding in response to feeding cues, proper positioning and latch, frequency of feeds to establish and maintain milk supply, and signs of infant satiety
8. Hand expression of breastmilk and use of a pump if indicated
9. Medical indications for supplementation will be addressed on an individual basis when applicable
10. Contraindications to breastfeeding will be addressed on an individual basis when applicable
11. Formula feeding will only be addressed on an individual basis if, after education, the patient has chosen to formula feed

c. All educational handouts will be compliant with the International Code of Marketing Breastmilk Substitutes.
d. All prenatal breastfeeding education performed will be documented in the patient's medical record.

3. Help mothers initiate breastfeeding within 1 hour of birth

a. Skin-to-skin care will be offered to all mothers and infants: The infant will be dressed in no more than a diaper and hat and placed on the mother's bare chest covered by a warm blanket.
b. The safety and stability of both mother and infant will be addressed prior to initiation of skin-to-skin. If there is a medical contraindication, skin-to-skin will be delayed.
c. Regardless of planned feeding modality, all eligible infant-mother pairs will be offered direct skin-to-skin contact. If mother and infant are both medically stable, the infant will be placed skin-to-skin immediately after a vaginal birth or a cesarean section birth (after initial stabilization of infant under radiant warmer).
d. The nursing staff present at delivery has the responsibility to create the optimal environment for transition of the infant and initiation of the first breastfeeding: A stable infant will be immediately placed prone on the mother's chest and/or abdomen. The infant should be able to access the mother's breast with no interference. Support for breastfeeding will be provided, including help in identifying feeding cues and allowing the infant to self-attach to the breast. A warm blanket will be laid over the mother and infant. If both patients remain stable, there will be no interruption of contact for at least one hour. If the mother chooses to formula feed, she will still be encouraged to engage in skin-to-skin time.
e. Routine procedures should be done with the baby skin-to-skin with the mother including medication administration. Procedures requiring the cessation of skin-to-skin should be delayed until after this initial skin-to-skin contact period is completed. Procedures such as weight,

measurements, and the infant bath should be delayed and conducted at the mother's bedside whenever possible.

f. If the infant is transferred to another facility for NICU care, the mother will be educated regarding the importance of skin-to-skin care.
g. In the event that mother and baby are separated for medical reasons, skin-to-skin contact will be initiated as soon as possible.
h. After cesarean birth, stable babies will be placed in continuous, uninterrupted skin-to-skin contact with the mother as soon as she is responsive, alert, and medically stable. Babies may be placed skin-to-skin with the support person if unable to be with the mother.
i. Documentation of the time skin-to-skin is initiated and the duration of at least 1 hour will occur in the infant's medical record.

4. Breastfeeding Support

a. Perinatal Unit nurses and cross-trained nurses will assess and document the mother's breastfeeding techniques and, if needed, demonstrate and assist mothers with appropriate breastfeeding positions and latching at least twice per shift and more frequently according to infant/mother need. The documentation will occur in the infant's medical record.
b. All patients should be seen by a Certified Lactation Educator Counselor (CLEC) or International Board Certified Lactation Consultant (IBCLC) prior to discharge.
c. The following patients should be referred to see an IBCLC as soon as possible:
    i. Maternal:
        1. Mother/infant separation
        2. Cracks, abrasions, or bleeding nipples
        3. History of breast surgery
        4. Unsuccessful breastfeeding with prior child/children
        5. Questionable medication usage
        6. Severe engorgement, plugged ducts, or mastitis
    ii. Infant:
        1. Multiples
        2. Weight loss greater than 7% during the hospital stay in a breastfeeding newborn
        3. Late Preterm Infants (born between 34 0/7 and 36 6/7 weeks gestation)
        4. Small For Gestational Age (SGA) infants
        5. Ineffective latch after 24 hours of age
        6. Supplementation protocol initiated
        7. Infants with anomalies
        8. Signs of dehydration
        9. Persistent symptomatic hypoglycemia
        10. Ankyloglossia (tongue-tie) with difficulty feeding
        11. Infant being treated for hyperbilirubinemia
d. Breastfeeding mothers should be educated on basic breastfeeding practices, including:

i. The importance of exclusive breastfeeding for the first 6 months of life and continued breastfeeding after complementary foods have been introduced
ii. How to recognize and feed their infants on cue (increased alertness, rooting, licking or smacking of lips, hands to mouth, increased activity)
iii. Normal newborn feeding behavior such as cluster feeding, feeding throughout the night and feeding at least 10 times in a 24-hour period to maintain lactation
iv. No limitations will be taught to mothers regarding feeding lengths or number of feedings
v. Proper positioning, latch, and detachment
vi. Newborn stomach capacity and milk supply in relation to day of life
vii. Elimination patterns
viii. Signs of a good feeding (bursts of sucking, pause and self start, audible swallows)
ix. Manual hand expression of breastmilk
x. How to deal with situations such as sore nipples, engorgement and proper pumping techniques
xi. Normal infant weight loss patterns (average of 7%, not to exceed 10%) with expected birth weight regained by day of life 10-14
xii. Reasons to contact the clinician or IBCLC for breastfeeding support

e. In cases of mother/baby separation
i. The mother will be educated on hand expression and breast massage
ii. The mother will be given a double-electric hospital-grade breast pump and initiate pumping as soon as possible, or within 6 hours of delivery if the mother is stable
iii. She will be instructed to pump a minimum of every 3 hours for a 15-minute duration
iv. Expressed breastmilk will be given to the infant as soon as the infant is stable and able to tolerate feeds (see supplementation)
v. Mothers will receive education related to pumping, handling, and storage of breastmilk
vi. Expressed breastmilk may remain at room temperature for up to 4 hours. After 4 hours the Perinatal Unit staff will take the mother's milk, label it with the mother or infant label, date, and time, and place in the breastmilk refrigerator until it is needed

5. **No food or drink (i.e., supplemental water, glucose water, or formula) other than breastmilk will be given to infants unless medically indicated or by the mother's documented and informed request (formula only)**

a. When a mother requests that her breastfed infant be given infant formula, the staff will address the mother's reason for the request. Staff will provide education regarding the risks of formula feeding and benefits of breastfeeding. If the mother still requests formula, the process of counseling, education and informed decision will be documented in the medical record.
i. These mothers will receive individual written and verbal instruction about baby-led feeding, safe formula preparation, handling, and feeding based on the World Health Organization's guidelines.~~with the type of infant formula the mother intends to use after discharge~~
ii. This education will be documented in infant's medical record

b. Possible indications for supplementation
  i. Infant Indications
    1. Weight loss guidelines
      a. ~~Infants who are down 6% or more at 24 hours~~Weight loss between 75th and 90th percentile for age (Based on nomogram: www.newbornweight.org)
        i. Initiate pumping/hand expression and provide infant with pumped milk if any
        ~~i.~~ii. Initiate BID weights
        ~~ii.~~iii. Consider supplemental feeding plan (see below) after breastfeeding evaluation completed by OB RN or IBCLC and in discussion with infant's provider
        ~~iii. Initiate BID weights~~
      b. ~~Infants who are down 10% or more at any time~~Weight loss greater than 90th percentile for age (based on nomogram: www.newbornweight.org)
        i. Initiate supplemental feeding plan (see below)
        ii. Initiate BID weights
    2. ~~Asymptomatic hypoglycemia~~ Hypoglycemia ~~that is unresponsive to appropriate, frequent breastfeeding~~ per Newborn Blood Glucose Monitoring policy.
    ~~3. Any infant with potentially severe hypoglycemia in which the hypoglycemia protocol is initiated and IV glucose is indicated per policy. While awaiting IV start, may provide supplementation (ml's given per day of life) with a doctor's order.~~
    ~~4.~~3. Clinical and laboratory evidence of significant dehydration (e.g., ~~10% weight loss,~~ high sodium, poor feeding, lethargy, etc.) that has not improved after skilled assessment and proper management of breastfeeding
    ~~5.~~4. Delayed bowel movements or continued meconium stools on day 5 (120 hours)
    ~~6.~~5. Insufficient intake despite an adequate milk supply (poor milk transfer) after infant is 24 hours old
    ~~7.~~6. Hyperbilirubinemia
      a. ~~"Neonatal" jaundice~~ Suboptimal intake jaundice of the newborn associated with ~~starvation where~~ poor breastmilk intake ~~is poor~~ despite appropriate intervention
      b. Breastmilk jaundice when levels reach 20–25 mg/dL ~~(mol/L)~~ in an otherwise thriving infant and where a diagnostic and/or therapeutic interruption of breastfeeding may be helpful
    ~~8.~~7. Macronutrient supplementation is indicated (e.g., inborn errors of metabolism)
  ii. Maternal Indications:
    1. Delayed lactogenesis II (day 3–5 or later [72–120 hours]) and inadequate intake by the infant

~~2. Retained placenta (lactogenesis probably will occur after placental fragments are removed)~~
~~3. Sheehan's syndrome (postpartum hemorrhage followed by absence of lactogenesis)~~
~~4.~~2. Primary glandular insufficiency, ~~occurs in less than 5% of women (primary lactation failure),~~ as evidenced by poor breast growth during pregnancy and minimal indications of lactogenesis
~~5.~~3. Breast pathology or prior breast surgery resulting in poor milk production
4. Intolerable pain during feedings unrelieved by interventions
~~6.~~5. Temporary cessation of breastfeeding due to certain medications or temporary separation of mother and baby without expressed breast milk available

c. Supplemental Feeding Plan- for above listed indications
   i. Breastfeed infant on cue, at least every 2-3 hours. In addition to breastfeeding, give supplements per day of life.
   ii. Once supplementing is indicated, initiate pumping using a hospital grade, double-electric breast pump and pump each breast for 15 min after each feed, or every 2-3 hours
   iii. All efforts will be made to supplement the infant with the mother's own milk. If mother's milk supply is inadequate, a combination of breastmilk and formula will be used until mother's milk volume increases.
   iv. The supplementation guidelines are in addition to breastfeeding and should occur at the breast. The amount should reflect the physiologic stomach capacity of a newborn.
      1. Day 1: 5-10 ml's at each feed
      2. Day 2: 10-20 ml's at each feed
      3. Day 3:20-30 ml's at each feed
      4. Day 4: 30-45 ml's at each feed
      5. Day 5: 45-60 ml's at each feed
   v. Methods for supplementation
      1. When supplementation is medically indicated, all efforts will be made to avoid artificial nipples and an alternate feeding method will be utilized. These alternate feeding methods decrease the risk of flow preference and preserve the mother/infant breastfeeding skills. The mother will be educated and instructed on how to administer the supplementation by the RN or lactation specialist.
         a. The ideal supplementation is at the breast. Use a 5 French feeding tube connected to a 12 ml syringe, or a supplemental nursing system (SNS)
         b. Finger feeding- with a gloved finger, use 5 French feeding tube and 12 ml syringe. Feed infant with pad side up.
         c. Cup feeding- using a Foley cup or spoon feeding
         d. Paced bottle feeding- used as a last resort
   vi. When Supplemental feeding plan is indicated, refer to IBCLC if possible
   vii. Place order after discussion with physician or per protocol for above listed indications for supplementation as infant formula is not a part of the standing newborn order set

viii. Document the type of supplementation, method, and reason for supplementation in the infant's medical record.
ix. Formula will not be placed in or around the breastfeeding infant's room or bassinette

d. Contraindications to breastfeeding
   i. Infant indications
      1. Inborn errors of metabolism (e.g., Galactosemia, maple syrup urine disease)
   ii. Maternal indications
      1. Infected with HIV (in developed countries)
      2. Untreated, active tuberculosis. Tuberculosis is not transmitted through breastmilk and therefore, the mother can pump her breasts and expressed breastmilk can be given to the infant. If mother starts antituberculin therapy, she should be able to resume direct breastfeeding after treatment for 2 weeks when the mother is no longer contagious.
      3. Untreated varicella infection
      4. Infected with human T-cell lymphotropic virus type I or type II
      5. Undergoing radiation therapy
      6. Active herpes lesions on the breast. May breastfeed if the sores can be covered so that the baby does not come into contact with them. If the sores are anywhere the baby may touch, the mother should express milk from that breast until the sores heal, while continuing to breastfeed on the unaffected breast. May resume breastfeeding when lesions are fully healed. Mother's should use careful hand hygiene and cover any lesions that infant may come into contact with.
      7. Substance abuse, illicit drug use, or excessive alcohol intake
         a. If maternal urine drug screen is negative, may continue to breastfeed
         b. If maternal urine drug screen is positive, may pump and dump until a negative screen is achieved
         c. Mothers in a supervised methadone maintenance program may still breastfeed if testing comes back negative for illicit drugs
         d. THC is considered a relative contraindication to breastfeeding. If mother tests positive for THC, then she will be encouraged to discontinue THC use. Risks will be discussed regarding breastfeeding and TCH usage referencing Medications and Mother's Milk book. Mother may still choose to breastfeed after education is provided. Nursing or physicians may provide the education with proper referencing.
      8. Taking medications contraindicated with breastfeeding (e.g., chemotherapy agents, antiretroviral medications)
         a. Acceptable reference to check medications: Medications and Mothers' Milk book by Dr. Thomas Hale, LACTMED website-http://toxnet.nlm.nih.gov

6. The avoidance of artificial nipples and pacifiers for breastfeeding infants

a. Perinatal staff will educate all breastfeeding mothers about how the use of bottles and/or pacifiers interferes with the development of optimal breastfeeding. Pacifiers will not be given to well, full-term breastfeeding infants.
b. When a mother requests that her breastfed infant be given a bottle and/or pacifier, the staff will address the mother's reason for the request. Alternate methods for soothing and feeding her baby will be discussed. If the mother still requests a bottle or pacifier, the process of counseling, education and informed decision will be documented in the medical record. The mother will be supported in her decisions.
c. Pacifiers will only be used to comfort infants needing pain relief from painful procedures (e.g., circumcision). Once the procedure is completed, the pacifier will be disposed of; the infant will not return to the mother with a pacifier.
d. In the case that a mother and infant must be separated due to medical necessity for an extended period of time, a pacifier may be used to comfort the infant. Once the mother and infant are reunited, the pacifier will be disposed of; the infant will not return to the mother with a pacifier.
e. All artificial nipples, infant feeding bottles and breastmilk substitutes are purchased at a fair market value by this facility

7. Rooming-in practices

a. NIH promotes the practice of rooming-in to encourage family-centered care, good attachment between the mother and her infant, emotional stability, protection from infection, and increased breastfeeding rates. Rooming-in will be encouraged to all mothers regardless of feeding type.
b. Staff will not routinely offer to take the infant to the well baby nursery.
c. Rooming-in is defined as keeping the infant in the mother's room 24 hours per day. For procedures that require mother-baby separation, 1 hour in a 24-hour period is acceptable. All procedures that can be done in the mother's room will be done in the mother's room (e.g., bath, hearing screen, newborn screen, weights, lab draws).
d. Mothers who give birth vaginally will begin rooming-in immediately. Mothers who give birth by cesarean will begin rooming-in once the mother is back on the Perinatal Unit.
e. Location of the infant and the reason for interruption of rooming-in must be documented each time the infant leaves the mother's room, as well as the time the infant returns to the mother's room as quality assurance measurements.
f. If maternal or infant condition warrants separation, all efforts will be made to return the infant to the mother's room once the mother or infant is stabilized.
g. If a mother requests her infant be taken to the nursery, the healthcare staff will:
    i. Explore the reason for the request
    ii. Educate and encourage the mother about the advantages of rooming-in 24 hours per day
    iii. Support the mothers decision
    iv. If the mother still requests that the baby be cared for in the nursery, the infant will be brought back to the mother PRN feeding cues or every 3 hours (whichever comes first) to feed to encourage exclusive breastfeeding

v. All education and interruption of rooming-in will be documented in the infant's medical record including the length of time that the couplet was separated

8. **Continuity of care and breastfeeding support upon discharge and beyond**
   a. Prior to discharge, the breastfeeding mother should be able to
      i. Position the infant correctly at the breast
      ii. Latch the baby to the breast properly
      iii. State when the baby is swallowing milk
      iv. State that the baby should be nursed at least 10 times in 24 hours
      v. State the appropriate elimination patterns (at least 6 or more wet diapers and 3 or more stools per day by day of life 6)
      vi. List indications for contacting the physician or lactation consultant
      vii. Demonstrate manual expression of breastmilk
      viii. This education will be documented in the medical record prior to discharge
   b. Included in the delivery stay is the follow-up portion of the NEST program. All mother/infant dyads are encouraged to return to the hospital 24-48 hours after discharge for assessment and breastfeeding support
      i. This appointment will be set up prior to discharge and written into the patient's discharge instructions
   c. All patients will be given, with their discharge instructions, a copy of a community resource list
   d. NIH has set up a weekly breastfeeding support group, which all mothers are encouraged to attend. A CLEC or IBCLC should be present at each meeting for encouragement and support.
   e. Collaboration between First 5 Inyo County, WIC, and Toiyabe Indian Health Project is in place to support breastfeeding women throughout the county.
9. **International Code of Marketing of Breastmilk Substitutes**
   a. Employees of manufacturers or distributers of breastmilk substitutes, bottles, nipples and pacifiers have no direct communication with pregnant women and mothers
   b. The facility does not receive free gifts, non-scientific literature, materials, equipment, money, or support for breastfeeding education or events from manufacturers of breastmilk substitutes, bottles, nipples, and pacifiers
   c. No pregnant women, mothers, or families are given marketing materials or samples or gift packs by the facility that consist of breastmilk substitutes, bottles, nipples, pacifiers, or other infant feeding equipment or coupons for the above items
   d. Any educational materials distributed to breastfeeding mothers are free from messages that promote or advertise infant food or drinks other than breastmilk

10. **The Ten Steps to Successful Breastfeeding**
    a. Have a written breastfeeding policy that is routinely communicated to all health care staff.
    b. Train all health care staff in the skills necessary to implement this policy.
    c. Inform all pregnant women about the benefits and management of breastfeeding.
    d. Help mothers initiate breastfeeding within one hour of birth.

Title: Breastfeeding the Term Infant*	
Scope: Perinatal Services	Manual: Perinatal
Source: Manager of Perinatal Department	Effective Date: 8/23/16

e. Show mothers how to breastfeed and how to maintain lactation, even if they are separated from their infants.
f. Give infants no food or drink other than breastmilk, unless medically indicated.
g. Practice rooming-in - allow mothers and infants to remain together 24 hours a day.
h. Encourage breastfeeding on demand.
i. Give no pacifiers or artificial nipples to breastfeeding infants.
j. Foster the establishment of breastfeeding support groups and refer mothers to them on discharge from the hospital or birth center.

REFERENCES:

http://pediatrics.aappublications.org/content/129/3/e827.full.pdf
http://www.who.int/nutrition/topics/exclusive_breastfeeding/en/
http://www.uptodate.com/contents/late-preterm-infants
http://www.centertrt.org/content/docs/Intervention_Documents/Intervention_Materials/BFHI/LactationconsultantReferralGuidelines.pdf
https://www2.aap.org/breastfeeding/curriculum/documents/pdf/Hospital%20Breastfeeding%20Policy_FINAL.pdf
http://www.bfmed.org/Media/Files/Protocols/protocol_2GoingHome_revised2014.pdf
http://www.womenshealth.gov/breastfeeding/pumping-and-milk-storage/
http://www.who.int/foodsafety/publications/micro/PIF_Bottle_en.pdf
http://www.bfmed.org/Resources/Download.aspx?filename=ABMProtocol_3%20Revised.pdf
http://www.tensteps.org/step-6-successful-breastfeeding.shtml
http://www.cdc.gov/breastfeeding/disease/index.htm
http://pediatrics.aappublications.org/content/100/6/1035.full
http://www.uptodate.com/contents/breastfeeding-parental-education-and-support?source=search_result&search=breastfeeding+and+tuberculosis&selectedTitle=5%7E150
http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2994120/

CROSS REFERENCE P&P's:

1. Newborn Blood Glucose Monitoring

Approval	**Date**
CCOC	11/19/18
Peri-Peds Committee	10/12/18
Medical Executive Committee	12/4/18
Board of Directors	
Last Board of Director review	1/18/17

Developed: 12/98
Revised: 12/98, 9/11jn, 5/15 NM,
Reviewed: 01/01, 03/2004, 9/11jn, 9/2012jn, 1/2018sg
Supersedes: 6/16ms

NORTHERN INYO HOSPITAL
POLICY AND PROCEDURE

Title: Crash Cart and Defibrillator Check Policy	
Scope: NIHD	Manual: Cardiovascular, Circulation (OXC), CPM - Respiratory, Oxygen
Source: Manager of Emergency Services	Effective Date: 6/30/16

PURPOSE:
To ensure availability of all drugs, equipment, and supplies necessary to initiate advanced life-support measures and ensure uniformity of emergency carts throughout Northern Inyo Hospital.

POLICY:

1. Ensuring that crash cart contents are complete, not outdated, or damaged will be the responsibility of each department.
   a. A staff member will check the crash cart a minimum of once per day while the unit is open~~., or a minimum of once per day while the unit is open.~~ If the unit is closed, the staff member will write closed under the day with no check~~. If the unit opens in an emergency~~ Upon reopening of the unit the crash cart will be checked. ~~within one hour of the unit reopening.~~
   ~~b.~~ The crash cart expiration spreadsheet will be checked monthly. ~~by a designated staff member for out dates the last week of every prior to the first day of the coming month. The date will be written on the out date sticker in washable or erasable marker. All drawers will have stickers attached that signify when the earliest expiration date is for any of the contents of the drawer.~~ All drawers and contents must be visually inspected annually. ~~rechecked monthly following the Monthly Crash Cart Check List.~~
   c. A QRR will be completed anytime outdated supplies are found.

2. Each unit will be responsible to provide all items not under the responsibility of Pharmacy or Cardiopulmonary Department.~~,~~ Pharmacy supplies will be in a sealed tray with the earliest expiration date marked on the outside of the package. Two sealed trays will be stored for quick restocking of a crash cart after use. Respiratory supplies will be checked by respiratory staff.~~.~~

3. Pharmacy shall be responsible for maintaining all pharmaceuticals in the crash cart. This will include drawers one and two and part of drawer five. Pharmacy will have the contents of drawer one and two placed in four locked drawer inserts with the earliest outdate marked. Drawer five contains a sealed tray with IV fluids with the earliest expiration marked on the outside of the package.~~ .~~

4. Respiratory will be responsible for all items located in drawer six of the crash cart. This will include a locked intubation roll for pediatric and adult patients. It will also be the responsibility to ensure all intubation equipment is in good working order.

5. All crash carts will be checked as per the following:
   a. The defibrillator and cardiac monitor shall be checked and appropriately documented for performance on both battery and electrical current once daily while the unit is open. , The defibrillator will remain plugged into~~ a~~ emergency power electrical outlet at all times, except during battery testing or use.
   b. The crash cart lock will be checked once daily while units are open. The last three numbers on the lock will be written into the crash cart checklist. If the locks are changed, the new number will be placed on the checklist.
   ~~c.~~ When crash cart is opened it will be restocked by the unit staff and a yellow securement device will be applied. Pharmacy will be notified to check cart and apply a red lock.

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NORTHERN INYO HOSPITAL
POLICY AND PROCEDURE

Title: Crash Cart and Defibrillator Check Policy	
Scope: NIHD	Manual: Cardiovascular, Circulation (OXC), CPM - Respiratory, Oxygen
Source: Manager of Emergency Services	Effective Date: 6/30/16

d.c.

6. Request for change in crash cart contents, shall be reviewed by the Resuscitation Commit

REFERENCE:

TJC (2016) Comprehensive Accreditation Manual for Critical Access Hospitals.
Standard PC 02.01.09 and Standard PC 02.01.1. Joint Commission Resources. Oakbrook, Illinois.

CROSS REFERENCE P&P:

Approval	**Date**
Resuscitation Committee	05/2016
ER Medical Services	~~05/2016~~11/7/18
MEC	~~06/2016~~12/4/18
Board	06/2016
Last Board of Director review	6/21/17

Developed: 04/2013 AS, 9/18gr
Reviewed: 5/17 la
Revised: 05/2016 AS

draft

NORTHERN INYO HEALTHCARE DISTRICT
POLICY AND PROCEDURE

Title: **Dental Emergencies in the Emergency Department**	
Scope: Emergency Department	Manual: Emergency Department
Source: Emergency Department Manager	Effective Date:

PURPOSE:
To establish appropriate guidelines for utilization of on-call Dental Staff in the Emergency Department (ED)

POLICY:
On-call Dental Staff are to be utilized only for dental emergencies requiring immediate intervention.

PROCEDURE:

1. The Dental Physician on-call will be contacted when the need for emergent dental care has been determined by the ER Physician.

    a. House Supervisor must be notified of any emergent surgical procedures to be performed within the facility.

2. A list of local area dentist can be provided to patients who have no local dentist for follow- up.

REFERENCES:

1. EMTALA: A Guide to Patient Anti -Dumping Laws. (2009)

CROSS REFERENCE P&P:

1. EMTALA Policy
2. Evaluation and Screening of Patients Presenting to Emergency Department.

Approval	**Date**
CCOC	1/29/18
Emergency Services committee	11/7/18
Medical Executive Committee	12/4/18
Board of Directors	
Last Board of Directors Review	6/21/2017

Developed: 1/2018gr
Reviewed:
Revised:
Supersedes: Dental Emergency Protocol

draft

NORTHERN INYO HEALTHCARE DISTRICT
POLICY AND PROCEDURE

Title: Disclosure of the Unanticipated Outcome	
Scope: Northern Inyo Healthcare District	Manual: Medical Staff
Source: Medical Staff Support Manager	Effective Date: 10/05/2012

PURPOSE:
To honor the dignity of our patient and ensure patient safety, our patients will be provided meaningful information regarding the status of their condition and care, including, but not limited to, unanticipated outcomes of treatment. This information is not intended to assign blame to any person or department, but to inform the patient in support of future medical decisions.

Examples of "unanticipated outcome"

1. A result that differs significantly from what was anticipated.
2. Known or unknown risk or complication of the procedure results.
3. Accident that results in injury or death, extraordinary pain, suffering, or disfigurement.
4. A sentinel event.

POLICY:
1. Northern Inyo Healthcare District (NIHD) shall provide its patients with outcomes of care, which require informed decisions regarding future clinical treatment.

PROCEDURE:
1. The attending physician, with the direct or indirect support and concurrence of appropriate hospital staff and medical staff peers, will inform the patient of the unanticipated outcome. After disclosure, the physician shall answer the patient's questions and plan treatment going forward with the patient's informed consent.
   a. Examples of appropriate hospital staff:
      i. Director of Nurses
      ii. Nursing Supervisor
      iii. Department and Unit Manager
      iv. Medical Staff Service Chief
      v. Others indicated by the individual situation
2. Disclosures must be timely. "Timely" can indicate a spectrum from "immediately" to as soon as appropriate support and/or information, can be obtained, e.g., test results.
3. Without assigning or admitting blame, the physician, or hospital staff may express regret or apologize for an unfavorable medical outcome.
4. The healthcare professional/physician who informed the patient shall document in the medical record that the discussion took place with the patient or with the patient's representative (by name and relationship) with the date, time, and signature.
5. The patient's physician shall document in the medical record the patient's plan of care.

NORTHERN INYO HEALTHCARE DISTRICT
POLICY AND PROCEDURE

Title: Disclosure of the Unanticipated Outcome	
Scope: Northern Inyo Healthcare District	Manual: Medical Staff
Source: Medical Staff Support Manager	Effective Date: 10/05/2012

REFERENCES:

1. RI.01.02.01 EP 20. Joint Commission Standards for Critical Access Hospitals. 2018.

Approval	Date
Medical Executive Committee	11/6/18
Board of Directors	
Last Board of Directors Review	

Developed:
Reviewed: 3/03; 8/08; 9/09; 8/2010; 8/2011; 11/2016
Revised: 11/2016 dp
Supersedes: PA- Patient Safety: Disclosure of the Unanticipated Outcome

NORTHERN INYO HOSPITAL
POLICY AND PROCEDURE

Title: Evaluation and Assessment of Patients' Nutritional Needs	
Scope: Hospital-Wide	Department: Dietary
Source: DieticianDietitian	Effective Date: May 2, 2013October 11, 2018

PURPOSE:

To codify the method evaluation and assessment of patients' nutritional needs by the healthcare team.

POLICY:

1. Evaluation and assessment of patients' nutritional needs by a Registered Dietician Dietitian shall be initiated in response to any of the following:
   a. Score below 3 on Nursing Admission nutritional assessment
   b. Recent weight loss of 10% or more of usual body weight noted by nursing
   c. A diagnosis of Cancer, diabetes, malnutrition, obesity, gastrointestinal disorder, cardiovascular disease, trauma or surgery
   d. Referral by Physician, Patient, Patient's representative, or member of the healthcare team
   e. Report of poor appetite, continued return of uneaten food
   f. Order for tube feeding or parenteral nutrition
   a. Mini-Nutritional Assessment (MNAI) score of ≤7 indicating malnutrition
   b. Consult order by Physician, Patient, Patient's representative, or member of the healthcare team
   c. Order for tube feeding or parenteral nutrition
   d. New diagnosis of Diabetes
   e. Patients with non-healing wounds or Stage II or greater Decubitus Ulcers

2. Patients in need of nutritional assessment or intervention will be assessed within 24 hours of referral or discovery of need.
   Evaluation and assessment of patients' nutritional needs by a Registered Dietitian shall be initiated within 48 hours in response to the following:
   a. MNA score between 8 and 11 indicating at-risk of malnutrition
   2.
3. If there is no nutritional risk, the Registered Dietitian will evaluate need for assessment in patients with a stay longer than 3 days (the morning of the 4th day).

4. The Registered Dietitian will be on campusavailable M-F. On weekends, the on-call RD may be contacted and she will consult for malnutrition, new tube-feed/TPN, other physician request.

5. Best practices will include parameters of Assessment, Diagnosis, Intervention, Monitoring and Evaluation (ADIME) -and will be updated as needed according to standards set by the Academy of Nutrition and Dietetics.

2. Minimum parameters addressed in nutritional assessments shall be:
c. Age

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d. Name
e. Actual Body Weight (ABW), Ideal Body Weight (IBW), height
f. Laboratory Values
g. Special diets the patient followed prior to admission
h. Appropriateness/adequacy of diet order by physician
i. Need for nutritional education
j. Admitting diagnosis(es)
k. Attending Physician
l. Summary of food habits and preferences
m. Food Allergies
n. Nutritional and feeding problems
o. Medications affecting nutrient utilization or intake
p. Diet Prescription or dietary recommendations and follow up

3.6. Dietary assessment, recommendations, diet prescription, assessment of effects of nutritional therapy and follow up must be charted immediately upon completion of dietary assessment by the DieticianDietitian.

4.7. Nutritional assessment calculations shall be made using Ideal Body Weight IBW and recommendations are referenced from the Nutrition Care Manual unless specifically ordered otherwise by a physician.

Committee Approval	Date
CCOC	10/22/18
Medical Executive Committee	12/4/18
Board of Directors	
Board of Directors Last Review	

Revised: 4/-27-13
10/18ds0-11-18
Reviewed:
Supercedes:

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Page 2 of 2

NORTHERN INYO HOSPITAL
POLICY AND PROCEDURE

Title: Newborn & Pediatric Abduction Prevention Safety and Security	
Scope: Pediatric & Perinatal	Manual: CPM - Patient Safety (PS), Safety
Source: Perinatal Nurse Manager	Effective Date: 11/15/2018

PURPOSE:

1. To provide for the security and safety of all newborns in the Perinatal Department and pediatric patients in the Acute Sub Acute Department.
2. To prevent newborn and pediatric abduction and to provide guidelines in the case of such an occurrence. For clarification:
   Neonate (Newborn) = Birth to 27 days of age
   Pediatric= 28 days of age until 13th Birthday

POLICY:

1. All newborns in the Perinatal Department will be under the direct observation of a member of the nursing staff and/or direct care giver at all times. Under no circumstances will a newborn be left unattended.
2. All newborns and pediatric patients in the Acute Sub Acute Department will be under the supervision of a member of the nursing staff and/or direct care giver at all times.
3. All newborn/pediatric patients will be banded with a security tag on admission or at birth. This tag will be activated as stated in the HUGS/PEDZ policy.
4. The primary care giver of the patient will be informed of security precautions at the time of admission or as soon as they are available.
5. Nursing staff will document patient and family education of newborn/pediatric security on the nursing admission assessment form.
6. In the Perinatal Department, all newborns will be identified in the following manner:
   a. All mother-baby couples will have matching ID bands placed on them either in the birthing room or O.R., prior to separating mother and infant. However, if an emergency exists, the infant will be properly banded as soon after admission to the nursery as possible.
7. All pediatric patients will be identified in the following manner:
   a. All newborn and pediatric patients and their designated legal guardian will have matching ID bands placed on them at the time of admission.
8. Hospital staff will notify and work closely with law enforcement agencies, if an abduction occurs.

PROCEDURE:

A. Security Measures:

1. At Northern Inyo Hospital (NIH) an electronic surveillance system by HUGS is utilized for all infant and pediatric patients. Refer to HUGS/PEDZ policy
2. Infant-Mother ID bands will be placed on each mother-baby as soon after delivery as possible. Indicate to the parents verbally and visually that the name bands are matching. Document the band number and time bands were applied on the Labor and Delivery Record. The mother will have one wristband, and the baby will have two bands – one applied to a wrist, and the other to an ankle. These bands must be verified as matching and include the following information:

a. Mom's last name, Mom's first name, Baby [Infant sex]." Example: "Smith, Jane BABY GIRL.
b. Date and Time of infant's birth

3. Infant bar code scanning tag will be added once the infant has been registered and infant labels are available. Apply an infant label to the designated tag and attach it directly to the Mother-Baby band that is on the infant's ankle. Verify that all patient identification indicators are identical. This tag will be used for scanning purposes.
4. All Perinatal Department nurses wear pink accented photo ID badges.
5. Pediatric patients will utilize the HUGS system in addition to the regular hospital wristband. A regular hospital ID band with the patient identification label will be placed on the legal parent/guardian at the time of admission.
6. Inform mothers of security procedures which include but are not limited to:
   a. Check for proper identification before giving the baby to anyone
   b. Never leave the baby alone or unsupervised in the room
   c. Place the baby's bassinet on the side of the bed that is away from the door.
   d. All infants should remain in their cribs during transport i.e. from nursery to mother's room, thus family members and staff should not be carrying infant in hallways or outside the Perinatal Department. Each crib will have a crib card with infant's name, birth date and physician.
   e. Instruct patients and family members to observe the visiting hours and rules and **NOT** to open the main security door to permit access to other visitors.
   f. Only staff members should allow access to visitors according to patient privacy laws.

B. **In the event of an abduction:**

1. Follow the CODE AMBER abduction procedure outlined in the Emergency Preparedness Procedure chart. AKA "Rainbow chart".
2. In the event of an abduction, the downtime Code Amber form will be completed and a copy provided to law enforcement.
3. House Supervisors, Directors of Nursing, Nurse Managers, or Administration:
   a. Consider moving the primary care giver of the abducted child to a private room off the Department and assign a staff member (preferably the nurse assigned to the mother, House Supervisor or nurse manager) to accompany them at all times protecting them from stressful contact with the media and other interference.
   b. If the incident occurred at shift change, hold the shift scheduled to leave until excused by law enforcement.
   c. The House Supervisor or nurse manager should brief all involved staff. In turn, nurses should then explain the situation to other patients in the unit (preferably while the mother and her infant are together).

d. Nursing Administration should be sensitive to the fact that the staff may suffer post trauma stress as a result of the abduction.
e. Protect the crime scene (area where the abduction occurred) in order to preserve the subsequent collection of any forensic evidence by law enforcement.
f. Coordinate with the police department by involving the media search for the infant if indicated.
g. Coordinate with the police department in notifying the Center for Missing and Exploited Children (NCMEC) at 1-800-843-5678 for technical assistance in handling on-going crisis management indicated.
h. Any facility providing care to infants and pediatric patients in the surrounding area such as but not limited to Hospitals, physician offices, Clinics, should be notified about the incident and provided with a full description of the patient and the abductor.

REFERENCES:

1. National Center for Missing and Exploited Children; January, 2016, “For Healthcare Professionals: Guidelines on Prevention of and Response to Infant Abductions”

CROSS REFERENCE P&P:

1. HUGS/PEDZ policy

Approval	**Date**
Safety Committee	11/9/16
CCOC	11/19/18
MEC	12/4/18
Board of Directors	
Last Board of Director review	4/18/18

Developed: 10/16 la
Reviewed:
Revised: 11/18ap
Supersedes: Child/Infant Abduction Policy, Infant Security Policy, Safety and Security Infant/Pediatric Abduction Prevention

NORTHERN INYO HOSPITAL
POLICY AND PROCEDURE

Title: Newborn Pulse Oximetry Screen	
Scope: Perinatal, Respiratory Therapy	Manual: OB/Gyn
Source: Manager Perinatal Unit	Effective Date:

PURPOSE:
To provide a guideline for screening of the newborn in LDRP to identify the presence of Critical Congenital Heart Disease (CCHD)

POLICY:
1. Pulse oximetry will be performed on all newborns at 24-36 hours of age to allow for follow-up if necessary. It can be done earlier if the patient is an early discharge, however results should be discussed with the pediatrician prior to discharge.
2. Licensed LDRP and cross trained staff can perform this procedure. Respiratory Therapy may assist.

PROCEDURE:
1. Assemble the equipment, the pulse oximeter monitor and the oximetry probe appropriate for that unit.
2. Place the oximetry probe on a clean, dry site on the Right Hand and either foot toward the heel. This can be done in parallel or one after another.
3. Apply the sensor so the LED and the photodector are opposing each other.
4. Use an opaque material to shield the sensor when phototherapy lights are used.
5. With the infant quiet, observe pulse oximeter reading
6. Wait until the pulse oximeter detects a steady, clear pulse signal and steady oxygen saturation is displayed. If a steady clear pulse signal is not displayed, try the other lower extremity and ensure the site is clean and dry.
7. Interpretation of results (see attached algorithm):
   a. For O_2 saturations of greater or equal to 95% or higher in Right Hand or foot and difference of 3 or less between RH and foot readings test is complete (Occasional desaturations are normal, as long as infant has saturations reaching 95%). This is true for a test at any time during the newborns hospitalization.
   b. For O_2 saturations less than 95% contact RT to assist and confirm. A pre and post ductal measurement will be taken using 2 separate monitors simultaneously.
   c. Notify the MD immediately for saturations below 88% or if pre-ductal and post- ductal differences are greater than 3%.
   d. For oxygen saturations of 88%-94% complete pre-ductal and post- ductal testing 3 times, an hour apart. Call the MD during day hours for results and further orders.

DOCUMENTATION:
1. Nursing will document the following on the newborn record:
   a. Date and time of test
   b. Hours of age at time of test
   c. Probe location
   d. Result and who performed the test whether it was nursing or RT
   e. MD notification
2. RT will document on their record if they have been involved in the process.

REFERENCES:

1. American Academy of Pediatrics. (2016). "Newborn screening for critical congenital heart disease (CCHD)-2016 state actions" [Online]. Accessed July 2017 via the Web at https://www.aap.org/en-us/Documents/2016_CCHD_Newborn_Screening_State_Actions.pdf

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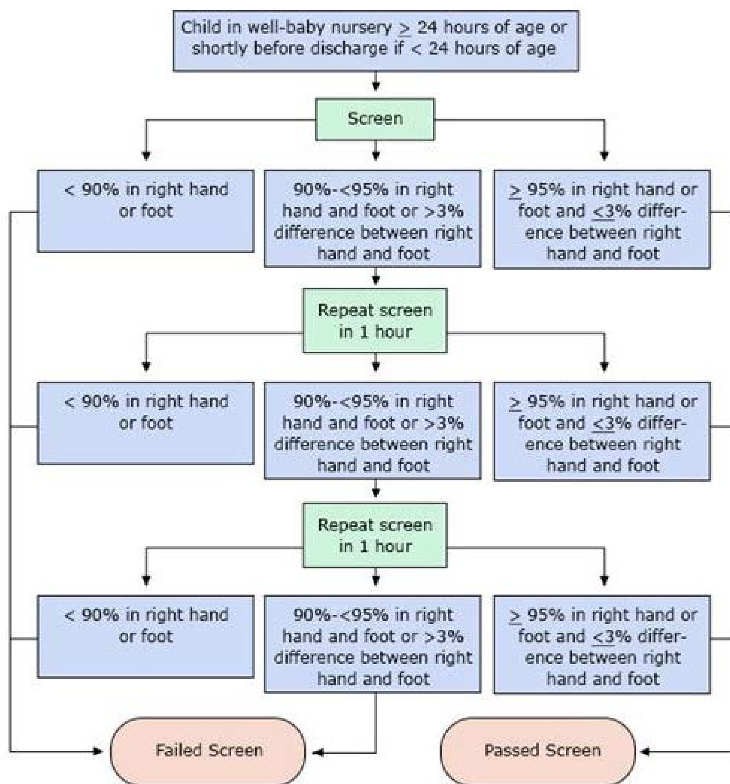
NORTHERN INYO HOSPITAL
POLICY AND PROCEDURE

Title: Newborn Pulse Oximetry Screen	
Scope: Perinatal, Respiratory Therapy	Manual: OB/Gyn
Source: Manager Perinatal Unit	Effective Date:

Approval	**Date**
CCOC	9/24/18
Peri-Peds Committee	10/12/18
Medical Executive Committee	12/4/18
Board of Directors	
Last Board of Director review	2/15/17

Revised: 11/13 jk; 03/18sg
Reviewed:



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NORTHERN INYO HEALTHCARE DISTRICT
POLICY AND PROCEDURE

Title: Respiratory Therapist Patient Assessment and Reassessment	
Scope: Respiratory Therapist	Manual: Respiratory
Source: Director of Cardiopulmonary	Effective Date:

PURPOSE:

The goal of patient assessment and reassessment is to perform and confirm the appropriateness of therapy, assess the patient's previous and current respiratory status, evaluate the patient's response to therapy, prioritize patient care, and prepare or alter patient care plans.

POLICY:

1. Patients shall be assessed prior to and following all Respiratory treatments and procedures for heart rate, respiratory rate, breath sounds and Spo_2
2. Patients shall be assessed following any change in FiO2 or oxygen device
3. Patients shall be assessed upon admission on oxygen or home non-invasive ventilation every 4 hours or per physician order, and prn.
4. Patients on High Flow Oxygen shall be assessed at the beginning of each shift and every 2 hours
5. Patients on mechanical ventilation shall be assessed at the beginning of each shift and every 2 hours. The skin integrity shall be assessed q shift and the endotracheal tube shall be moved Q day.
6. The Respiratory Therapist shall also assess skin integrity of the patient prior to placement and removal of the non-invasive mask and behind the ears on patients wearing nasal cannula once a shift
7. The Respiratory Therapist shall use the group notes or progress notes in the EHR to expand on information pertinent to the patient's assessment

PROCEDURE:

1. Review the chart for
    1. Diagnosis
    2. Physician orders
    3. Criteria and objectives
    4. Smoking history
    5. Latest chest X-ray report
    6. Latest arterial blood gas or Spo2
    7. Home-regimen respiratory medications

2. Auscultate the chest

3. Observe the patient for
    1. Tachypnea
    2. Dyspnea on exertion
    3. Dyspnea at rest
    4. Use of accessory muscles
    5. Intercostal retractions
    6. Takes a breath between each word or sentence
    7. Pursed-lip breathing
    8. Diaphoresis
    9. Cough effort
    10. Nasal flaring

Title: Respiratory Therapist Patient Assessment and Reassessment	
Scope: Respiratory Therapist	Manual: Respiratory
Source: Director of Cardiopulmonary	Effective Date:

4. Complete Care Plans upon admission, as patient condition changes, evaluate each shift and close when patient is discharged

REFERENCES:

1. Clinical Manifestations and Assessment of Respiratory Disease, 6th edition
   By Terry Des Jardins Med RRT and George G. Burton MD FACP FCCP FAARC
1. 2. The Joint Commission (January 2013) Comprehensive Accreditation Manual for Critical Access Hospitals. Functional Chapter Provision of Care, Treatment and Services. PC 01.02.01, PC 01.02.03, PC 01.02.05.

CROSS REFERENCE P&P:

1. Nursing care plan
2. Respiratory Therapist Patient Assessment and Reassessment

Approval	**Date**
CCOC	1/29/18
Medical Services/ICU Committee	4/26/18
Medical Executive Committee	12/4/18
Board of Directors	
Last Board of Directors Review	

Developed: 1/2018kc
Reviewed:
Revised:
Supersedes:
Index Listings:

NORTHERN INYO HOSPITAL
POLICY AND PROCEDURE

Title: Transcutaneous Bilirubin Testing (Bili Scan)	
Scope: Perinatal Services	Manual: Perinatal, Perinatal - Diagnostic Test and Lab Test (DLT)
Source: Manager of Perinatal Department	Effective Date: 10/22/2015

PURPOSE:

To identify infant's with hyperbilirubinemia. Transcutaneous assessment of bilirubin levels in the neonate reduces the need for blood sampling procedures.

POLICY:

All infants will have a bili scan prior to discharge. Biliscan will be performed at any age if clinically indicated.

All infants should be assessed visually for jaundice every shift. A biliscan will be performed within 24 hours of age and every day until discharge. Special attention should be given to the following population:

- Infants with documented ABO incompatibility.
- Infants with documented Rh sensitivity
- Infants with delayed meconium passage (> 12-24 hours)
- Infants with significant birth trauma or bruising, such as cephalohematoma.
- Less than 37 weeks gestation or low birth weight
- Positive Coombs

PROCEDURE:

- Following the manufacturer's instructions{see OneSource "Bilichek by Respironics" under manufacturer Philips} perform patient test on forehead
- Prior to calling the MD with results determine risk level by going to"bilitool.org".
  - In "Bilitool.org" enter the infant's date/time of birth (or the hours of life) and the bili scan results into the calculator.
  - Use the neuro toxicity risk zone as an aid in determining which category the infant is in for determining the threshold for start of phototherapy
  - If the bili scan results fall into the "High-Intermediate" or "High" risk zones, staff will place a neonatal bilirubin (nbili) blood level order to be drawn prior to calling physician. Calculate the risk of the blood level by following the same steps as described above. Notify the physician if phototherapy is recommended and to receive orders.
    1. For outpatient newborn follow-up visits in the NEST, if bili scan result is "High-Intermediate" or "High" risk zones, greater than 13, greater than 75th percentile, phototherapy recommended, order a neonatal-bilirubin level to be drawn by lab or Perinatal NEST staff and call results to MD.
- Have information such as infant birth weight, current weight, feeding assessment, presence of stools/urine, and other pertinent information available when calling the MD.

- When calculating and reading the results, take into account any risk factors to determine which neurotoxicity risk zone the infant falls into. These factors include but are not limited to:
  - Isoimmune Hemolytic Disease
  - G6PD deficiency
  - Asphyxia
  - Significant lethargy

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- Temperature instability
- Sepsis
- Acidosis
- Albumin < 3.0 g/dL

- For outpatient testing after discharge: Follow the NEST Practice Standards policy

Documentation:

- Document the results in the EHR per department practice.

Can be performed by: Perinatal Staff, Float, or Cross-Trained Staff (RN and LVN) who have completed the competency.

Approval	Date
Perinatal Pediatrics Committee	10/12/18
CCOC	5/21/18
Medical Executive Committee	12/4/18
Board of Directors	
Last Board of Director review	2/15/17

Initiated:
Revised: 06/2003, 10/10jk, 11/11jk, 2/12jk, 4/2012jk 10/2014; 03/18sg
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