September 18 2019 Regular Meeting

September 18 2019 Regular Meeting - September 18 2019 Re

DRAFT AGENDA

NORTHERN INYO HEALTHCARE DISTRICT
BOARD OF DIRECTORS REGULAR MEETING

September 18, 2019 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 Planning Session, David Sandberg, Cycle of Business (*information item*).
4. Chief of Staff Report, Stacey Brown, MD:
   A. Policy and Procedure approvals (*action items*):
      1. *Medication Security*
      2. *Classifying Adverse Transfusion Reactions*
      3. *Standardized Procedure for Admission of the Well Newborn*
      4. *ED: Initiation of Buprenorphine in the Emergency Department*
      5. *Opioid Administration*
      6. *Controlled Substance*
      7. *Healthcare Worker Health Screening and Maintenance Requirements Policy*
      8. *Placenta Disposal*
      9. *Da Vinci Robot Cleaning and Maintenance*
   B. Medical Staff Appointments (*action items*):
      1. David Amsalem, MD (*emergency medicine*) – Provisional Active Staff
      2. Bo Loy, MD (*orthopedic surgery*) – Provisional Active Staff
   C. Advanced Practice Provider Appointment (*action item*):
      1. Tamara Loy, PNP – Pediatric Clinic
   D. Reappointments to New Staff Category (*action items*):
      1. Tamara McBride, MD (*family medicine/hospitalist*) – change from Temporary Staff to Provisional Active Staff

2. Monika Mehrens, DO (*family medicine/hospitalist*) – change from Temporary Staff to Provisional Active Staff

E. Temporary Privileges for 60 days (*action item*):

1. Jennifer Kosek, MD (*radiology*) – for the locum tenens coverage of Dr. Stuart Souders

F. Extension of Temporary Privileges for an Additional 60 days (*action items*):

1. Joseph BenPerlas, MD (*internal medicine*) – locums hospitalist
2. Michael Rhodes, MD (*internal medicine*) – locums hospitalist

G. Resignations (*action items*):

1. N. Michelle Inforzato, MD (*internal medicine*)
2. Leo Pisculli, MD (*psychiatry*)

H. Advancement (*action item*):

1. Anne Wakamiya, MD (*internal medicine*) – recommended for advancement from Provisional Active Staff to Active Staff

I. Physician recruitment update (*information item*).

Consent Agenda (action items)

5. Approval of minutes of the August 21 2019 regular meeting
6. Approval of minutes of the September 9 2019 special meeting
7. Financial and statistical reports as of June 30, 2019
8. Compliance Board Report September 2019, quarterly
9. Policy and Procedure Annual Approvals

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10. Reports from Board members (*information items*).
11. Adjournment to closed session to/for:
    A. Conference with Labor Negotiators; Agency Designated Representative: Irma Moisa; Employee Organization: AFSCME Council 57 (*pursuant to Government Code Section 54957.6*).
12. Return to open session and report of any action taken in closed session.
13. Adjournment.

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

NORTHERN INYO 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: William Timbers, MD, Chief of Medical Staff
DATE: September 3, 2019
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 item*)
    1. *Medication Security*
    2. *Classifying Adverse Transfusion Reactions*
    3. *Standardized Procedure for Admission of the Well Newborn*
    4. *ED: Initiation of Buprenorphine in the Emergency Department*
    5. *Opioid Administration*
    6. *Controlled Substance*
    7. *Healthcare Worker Health Screening and Maintenance Requirements Policy*
    8. *Placenta Disposal*
    9. *da Vinci Robot Cleaning and Maintenance*

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I. Physician recruitment update (*information item*)

NORTHERN INYO HOSPITAL
POLICY AND PROCEDURE

Title: **Medication Security**	
Scope: Hospital-Wide	Department: **Pharmacy**
Source: Pharmacy Director	Effective Date: 6/16/2004

PURPOSE:

To ensure compliance with State and Federal law regarding the security of dangerous drugs and controlled substances

POLICY:

1. The Pharmacy shall be locked and the alarm activated at all times that the pharmacy is closed.
2. The supportive Pharmacy personnel have access from 0630-1700.
3. Keys and locks to any area, cabinet or drawer storing medications shall be under the supervision of the Director of Pharmacy or pharmacist designee.
4. Locks and/or keys to any of these areas may only be installed or replaced by contacting the Director of Pharmacy or pharmacist designee. The Maintenance Department will not install or replace locks to medication areas, cabinets or drawers, except at the request of the Director of Pharmacy or pharmacist designee.
5. If the keys to a locked medication area, cabinet or drawer are taken from the hospital a UOR Form should be completed and the Director of Pharmacy or pharmacist designee should be notified.
6. Locks will be replaced at the discretion of the Director of Pharmacy or pharmacist designee.
7. Drugs shall be accessible only to responsible personnel designated by the director of pharmacy or to patients in accordance with existing policy regarding bedside medications and patient self-medication. The following are designated personnel for purposes of this section:
    a. Licensed independent practitioners
    b. Licensed nurses
    c. Pharmacists and supportive personnel under the direct supervision of a pharmacist
    d. Respiratory Therapists
    e. Licensed Radiological Technologists
8. All spaces and areas used for the storage of drugs shall be locked and accessible to authorized personnel only.
9. The Omnicels will only be allowed access pursuant to Director of Pharmacy approval.
10. In the event of a declared or undeclared disaster where power interruption prevents the use of the key card for entry into the pharmacy an emergency key to access the department is held permanently by the Pharmacy Director and a second key is securely stored in the Diagnostic Imaging Omnicell accessible only to a pharmacist. It is noteworthy that if the disaster is significant enough to disable the back up generation of power supply of the District and the Pharmacy Director cannot immediately be reached there is only a 20 minute window to access the Omnicell in Diagnostic Imaging as the battery back up supply will only provide power to the Omnicell for 20 minutes.

REFERENCES:

California State Board of Pharmacy 4023.5, 4029, 4106., 4116

CROSS REFERENCES

US PHARMACIST June 2013

NORTHERN INYO HOSPITAL
POLICY AND PROCEDURE

Title: **Medication Security**	
Scope: Hospital-Wide	Department: **Pharmacy**
Source: Pharmacy Director	Effective Date: 6/16/2004

Am J Pharm Educ. 2013 Dec 16; 77(10): 233**MACIST**

Committee Approval	**Date**
CCOC	7/29/19
Pharmacy and Therapeutics Committee	6/20/19
Medical Executive Committee	
Board of Directors	6/16/04
Board of Directors Last Review	

Revised: 4/14/04
Reviewed: 10/05 10/08, 10/10, 10/12, 12/13, 4/19/17
Supersedes: 4/30/03

Title: Classifying Adverse Transfusion Reactions	
Scope: Hospital-wide	Department: Laboratory
Author: Immunology Coordinator	Effective Date: July 2016
Copy Location:	Revised Date:

Purpose:

To define how adverse reactions are classified, evaluated and reported at Northern Inyo Hospital as required by AABB Standard 7.3

Policy:

Acute and delayed adverse transfusion reactions are identified, evaluated, classified and reported by clinical staff caring for the transfusion recipient.

Symptoms of adverse transfusion reactions as well as immediate steps to take if such symptoms appear and documentation of these actions are described in the nursing "Blood and Blood Component Transfusion" policy and procedure.

Classifying Adverse Reactions:

~~The pathologist will review and determine the classification based on t~~The following are the CDC's standardized definitions of adverse transfusion events:

1. Transfusion-associated Circulatory Overload (TACO)
   New onset or exacerbation of 3 or more of the following within 6 hours of cessation of transfusion:
   a. Acute respiratory distress (dypsnea, orthopnea, cough)
   b. Elevated BNP
   c. Elevated central venous pressure (CVP)
   d. Evidence of left heart failure
   e. Evidence of positive fluid balance
   f. Radiographic evidence of pulmonary edema
2. Transfusion-related acute lung injury (TRALI)
   All five of the following are present:
   a. NO evidence of acute lung injury (ALI) prior to transfusion
   b. ALI onset during or within 6 hours of cessation of transfusion
   c. Hypoxemia defined by any of these methods:
      i. PaO2/FiO2 less than or equal to 300 mm Hg
      ii. Oxygen saturation less than 90% on room air
      iii. Other clinical evidence
   d. Radiographic evidence of bilateral infiltrates
   e. No evidence of left atrial hypertension (i.e. circulatory overload)
3. Transfusion-associated dypsnea (TAD)
   Both of the following are true:
   a. Acute respiratory distress occurring within 24 of cessation of transfusion
   b. Allergic reaction, TACO, and TRALI definitions are not applicable
4. Allergic reaction (minor allergic reactions (non-severe) do not need to be reported)

Title: Classifying Adverse Transfusion Reactions	
Scope: Hospital-wide	Department: Laboratory
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Two or more of the following occurring during or within 4 hours of cessation of transfusion:

a. Conjunctival edema
b. Edema of lips, tongue and uvula
c. Erythema and edema of the periorbital area
d. Generalized flushing
e. Hypotension
f. Localized angioedema
g. Maculopapular rash
h. Pruritus (itching)
i. Respiratory distress; bronchospasm
j. Urticaria (hives)

5. Hypotensive transfusion reaction

All other adverse reactions presenting with hypotension are excluded and hypotension occurs during or within 1 hour after cessation of transfusion:

a. Adults (18 years and older):
   Drop in systolic BP of greater than or equal to 30 mmHg and systolic BP less than or equal to 80 mmHG
b. Infants, children and adolescents (1 year to less than 18 years):
   Greater than 25% drop in systolic BP from baseline (e.g., drop in systolic BP of 120mmHg to below 90mmHg).
c. Neonates and small infants less than 1 year or less than 12 kg body weight:
   Greater than 25% drop in baseline value using whichever measurement is being recorded

6. Febrile non-hemolytic transfusion reaction (FNHTR)

Occurs during or within 4 hours of cessation of transfusion and either of the following occur:

a. Fever (greater than or equal to 38C oral and a change of at least 1C from pretransfusion value)
b. Chills/rigors

7. Acute hemolytic transfusion reaction (AHTR)

Occurs during, or within 24 hours of cessation of transfusion with new onset of any of the following:

a. Back/flank pain
b. Chills/rigors
c. DIC
d. Epistaxis
e. Fever
f. Hematuria (gross visual hemolysis)
g. Hypotenson
h. Oliguria;anuria

i. Pain and/or oozing at IV site
j. Renal failure

AND 2 or more of the following:

a. Decreased fibrinogen
b. Decreased haptoglobin
c. Elevated bilirubin
d. Elevated LDH
e. Hemoglobinemia
f. Hemoglobinuria
g. Plasma discoloration c/w hemolysis
h. Spherocytes on blood film

AND EITHER (IMMUNE-MEDIATED): Positive DAT for anti-IgG or anti-C3 and positive elution test
OR (NON-IMMUNE MEDIATED): Serologic testing is negative and physical cause (thermal, osmotic, mechanical, chemical) is confirmed

8. Delayed hemolytic transfusion reaction (DHTR)
   a. Positive DAT for antibodies developed between 24 hours and 28 days after cessation of transfusion
   b. AND EITHER: positive elution test with alloantibody present on the transfused RBCs
      OR newly-identified RBC alloantibody in recipient serum
   c. AND EITHER: inadequate rise of post-transfusion hemoglobin level or rapid fall in hemoglobin back to pre-transfusion levels
      OR: Otherwise unexplained appearance of spherocytes
9. Delayed serologic transfusion reaction (DSTR)
   Absence of clinical signs of hemolysis and demonstration of new clinically-significant antibodies against RBCs by either a positive DAT or a positive antibody screen with newly identified RBC alloantibody.
10. Transfusion-associated graft vs. host disease (TAGVHD)
    A clinical syndrome occurring from 2 days to 6 weeks after cessation of transfusion characterized by:
    a. Characteristic rash: erythematosus, maculopapular eruption centrally that spreads to extremities and may, in severe cases, progress to generalized erthroderma and hemorrhagic bullous formation
    b. Diarrhea
    c. Fever
    d. Hepatomegaly
    e. Liver dysfunction
    f. Marrow aplasia
    g. Pancytopenia

Title: Classifying Adverse Transfusion Reactions	
Scope: Hospital-wide	Department: Laboratory
Author: Immunology Coordinator	Effective Date: July 2016
Copy Location:	Revised Date:

h. Characteristic histological appearance of skin or liver biopsy

11. Post transfusion purpura (PTP)
    Alloantibodies in the patient directed against HPA or other platelet specific antigen detected at or after development of thrombocytopenia AND thrombocytopenia to less than 20% of pre-transfusion count.
12. Transfusion-transmitted infection (TTI)
    Laboratory evidence of a pathogen is demonstrated in the transfusion recipient with no other explanation. Pathogen can be bacterial, viral (HIV, hepatitis, West Nile Virus, HTLV-1), parasitic (Babesia, Trypanosoma cruzi, Malaria), or other (Creutzfeldt-Jakob disease)

Evaluating the Severity of Adverse Reactions:

The following are degrees of severity as defined by the CDC:

1. Non-severe:
   Medical intervention (e.g. symptomatic treatment) is required but lack of such would not result in permanent damage or impairment of a bodily function.
2. Severe:
   Inpatient hospitalization or prolongation of hospitalization is directly attributable to the adverse reaction, persistent or significant disability or incapacity of the patient occurs as a result of the reaction, or a medical or surgical intervention is necessary to preclude permanent damage or impairment of a body function.
3. Life-threatening:
   Major intervention required following the transfusion (e.g. vasopressors, intubation, transfer to intensive care) to prevent death.
4. Death:
   The recipient died as a result of the adverse transfusion reaction. Death should be used if death is possibly, probably or definitely related to transfusion. If the patient died of a cause other than the transfusion, the severity of the reaction should be graded as appropriate given the clinical circumstances related to the reaction
5. Not Determined:
   The severity of the adverse reaction is unknown or not stated.

Determining the Degree that Transfusion Contributed to Adverse Reactions:

The following are levels of imputability as defined by the CDC:

1. Definite:
   No other explanations for the reaction are possible
2. Probable:

Title: Classifying Adverse Transfusion Reactions	
Scope: Hospital-wide	Department: Laboratory
Author: Immunology Coordinator	Effective Date: July 2016
Copy Location:	Revised Date:

Transfusion is a likely contributor to the reaction but there are other potential causes that could explain the symptoms

3. Possible:
   Other present causes are most likely, but transfusion cannot be ruled out
4. Doubtful:
   Evidence is clearly in favor of a cause other than the transfusion, but transfusion cannot be excluded
5. Ruled Out:
   There is conclusive evidence beyond reasonable doubt of a cause other than the transfusion
6. Not Determined:
   The relationship between the adverse reaction and the transfusion is unknown or not stated.

Reporting:

1. Adverse transfusion reactions are fully reported in the patient's chart and include a copy of the "Transfusion Investigation" document
2. Adverse reactions can be reported to the National Healthcare Safety network (NHSN) biovigilance component, part of the CDC. (http://www.cdc.gov/nhsn/PDFs/Biovigilance/BV-HV-protocol-current.pdf.)
3. Transfusion reactions, whether fatal or not, due to errors such as patient misidentification, unit misidentification, or errors in ABO testing are reported to the State Health Department.
    a. State of Calif Dept Health Services Epidemiology Branch: 916-324-2833
4. Fatal transfusion reactions are reported to the FDA. Notification of the Director of the Office of Compliance and Biologics Quality for the Center for Biologics Evaluation and Research must take place as soon as possible by telephone, followed by a written report within seven days.
    a. The telephone number for this office is 301-827-6220
    b. The address for this office is:
        i. Office of Compliance and Biologics Quality/CBER
        ii. Attn: Fatality Program Manager (HFM-650)
        iii. 1401 Rockville Pike, Suite 200N
        iv. Rockville, MD 20852-1448

Reference:

U.S. Centers for Disease Control and Prevention. The National Healthcare Safety Network (NHSN) Manual: Biovigilance Component v2.2. Atlanta, GA: Division of Healthcare Quality Promotion, National Center for Emerging and Zoonotic Infectious Diseases. Available at: http://www.cdc.gov/nhsn/PDFs/Biovigilance/BV-HV-protocol-current.pdf. Accessed [enter date].

Reviewed by	Date
CCOC	5/14/19
STTA	7/24/19

NORTHERN INYO HOSPITAL
POLICY AND PROCEDURE

Title: Classifying Adverse Transfusion Reactions	
Scope: Hospital-wide	Department: Laboratory
Author: Immunology Coordinator	Effective Date: July 2016
Copy Location:	Revised Date:

Medical Executive Committee	9/3/19
Board of Directors	
Board of Directors Last Review	

NORTHERN INYO HEALTHCARE DISTRICT

POLICY AND PROCEDURE

Title: **Standardized Procedure for Admission of the Well Newborn**	
Scope: Perinatal	Manual: Perinatal
Source: Manager of Perinatal Department	Effective Date:

PURPOSE

To ensure well newborns receive immediate and short-term ongoing assessment, care, and timely administration of prophylactic ophthalmic erythromycin to prevent opthalmia neonatorum, intramuscular Hepatitis B vaccine for perinatal Hepatitis B prevention, and intramuscular Vitamin K to prevent Vitamin K deficient bleeding (VKDB) pending notification of the pediatrician and receipt of physician orders for continuing care.

POLICY

It is the policy of Northern Inyo Healthcare District (NIHD) that all well newborns will be assessed and provided care upon admission under the direction of a Registered Nurse (RN) with annual documented competencies following this Standardized Procedure. All well newborns will receive prophylactic administration of erythromycin ophthalmic ointment, Hepatitis B vaccine, and Vitamin K by an RN, unless there is a documented refusal by the parent, under this Standardized Procedure.

PROCEDURE

1. Experience, Training, and/or Education Requirements of the RN
    a. Current California RN licensure
    b. Current Neonatal Resuscitation Program (NRP) card
    c. Successful completion of orientation to newborn care at NIHD
2. Method of Initial and Continued Evaluation of Competence
    a. Initial evaluation: successful completion and demonstration of competency and clinical decision making in assessment of the newborn, as documented in the unit-specific clinical competency orientation checklist.
    b. Ongoing evaluation: annual completion of education activity on newborn assessment and administrations of prophylactic medications to a neonate.
3. Maintenance of Records of those authorized in Standardized Procedure
    a. A list of RNs competent to perform this standardized procedure is maintained with the Chief Nursing Officer and is updated annually.
4. Settings where Standardized Procedure may be preformed
    a. Admission of a well newborn and administration of prophylactic medications may take place in the Perinatal unit at the mother's bedside, newborn nursery, or in the Post Anesthesia Care Unit.
5. Standardized Procedure
    a. Circumstance under which Standardized Procedure may be performed:
        i. Well newborn delivered at NIHD

Title: **Standardized Procedure for Admission of the Well Newborn**	
Scope: Perinatal	Manual: Perinatal
Source: Manager of Perinatal Department	Effective Date:

b. Procedure

i. The RN will perform an admission assessment according to policy

ii. The RN will initiate the Newborn Admission Orders:

- Code Status:
  - Full Code
- When to call Pediatrician:
  - Call Peds at 7:30am to inform them of any delivery after 5pm the previous day
  - If born before 5pm, call Peds ASAP
- Please call Pediatrician immediately, at any hour, in the event of:
  - Maternal Chorioamnionitis
  - Maternal GBS positive without adequate maternal antibiotic coverage if infant is <37 weeks or ROM ≥18 hours even if otherwise well
  - Immediately for infant fever ≥100.4°F
  - Immediately for other concerns that cannot wait until normal rounding time
  - If indicated per Pulse Ox Screening, Hyperbilirubinemia, or Hypoglycemia policies
- Vital signs every hour times 2
- Vital signs every 8 hours and PRN
- Infant diet: Breastfeed only unless maternal refusal or medical need per policy
  - Breastfeed on demand.
- Oximetry per protocol
- Drugs of abuse screen
  - Urine collection for drug screen if mother's drug screen is positive
- Newborn hearing screening before discharge
- Newborn Screening Test before discharge
- Bili scan at 24 hours or earlier, then daily until discharge
- Bili Scan PRN for worsening jaundice or any jaundice prior to 24 hours of age
- Congenital heart defect screen at 24 hours
- Sweet Ease for pain control only

Title: **Standardized Procedure for Admission of the Well Newborn**	
Scope: Perinatal	Manual: Perinatal
Source: Manager of Perinatal Department	Effective Date:

- Pacifier use for pain control only unless requested by parent and pacifier use education provided
- Collect cord blood workup specimen
- Erythromycin Ophthalmic Ointment 0.5 % 1 application within 2 hours of delivery
- Phytonadione IM (Vitamin K1) Give 1 mg. Give within 2 hours of delivery
- Heel Stick Blood Sugar per policy
- Hepatitis B Virus Vaccine (PF) IM (Engerix-B) 0.5 mL within 24 hours if mother is Hepatitis B negative. Give as soon as possible within 12 hours of age if mother is Hep B positive or unknown
- Cholecalciferol Oral Drops 400 unit every day. Start day of discharge
    - 400 IU = 1 DROP Q day to start on the day of discharge.

6. Other specialized circumstances requiring RN to contact physician
    a. 10 minute APGAR score less than 7
7. Review of Standardized Procedure
    a. Standardized procedures are reviewed and approved annually by the Interdisciplinary Practice Committee.

REFERENCES:

1. American Academy of Pediatrics & College of Obstetricians and Gynecologist (2017*). Guidelines for Perinatal Care (8th ed.).* Elk Grove Village, IL: Author
2. Association of Women's Health, Obstetric and Neonatal Nurses (2009). *Standards & Guidelines for Professional Nursing Practice in the Care of Women and Newborns (7th ed.).* Washington DC: Author

CROSS REFERENCE P&P:

1. Admission, Care, Discharge and Transfer of the Newborn
2. Breastfeeding the Term Infant
3. Drugs of Abuse Maternal and Infant
4. BiliChek Transcutaneous Bilirubin Testing
5. Newborn Pulse Oximetry Screen
6. Newborn Hearing Screening Program
7. Newborn Blood Glucose Monitoring

NORTHERN INYO HEALTHCARE DISTRICT

POLICY AND PROCEDURE

Title: **Standardized Procedure for Admission of the Well Newborn**	
Scope: Perinatal	Manual: Perinatal
Source: Manager of Perinatal Department	Effective Date:

Approval	**Date**
Interdisciplinary Practice Committee	8/6/19
PeriPeds Committee	7/25/19
Medical Executive Committee	9/3/19
Board of Directors	
Last Board of Directors Review	

Developed: 12/21/2018
Reviewed:
Revised:
Supersedes:
Index Listings:

NORTHERN INYO HOSPITAL
POLICY AND PROCEDURE

Title: ED: Initiation of Buprenorphine in the Emergency Department	
Scope: Emergency Department	Manual: Emergency Department
Source: ED Manager	Effective Date:

PURPOSE:

To begin initiation of Medication Assisted Treatment (MAT) for opioid addiction using Buprenorphine in the Emergency Department (ED).

KEY POINTS:

Opioid addiction is a disease. Medication-assisted treatment improves survival and can be implemented successfully in the ED setting using buprenorphine.

Buprenorphine induces analgesia through partial agonist activity at the mu-opioid receptor. It is a high affinity, slow receptor dissociating opioid that partially activates the receptor causing a "ceiling effect", which reduces the risk of respiratory depression with overdose. Buprenorphine is used in MAT for opioid dependency and has lower abuse potential compared to other medications used for MAT. Patients must be in withdrawal before buprenorphine is administered. Physicians can administer buprenorphine in the ED, for up to 72 hours, but cannot prescribe for outpatient use without a DEA-X license waiver. Patients must meet certain criteria and be screened for opioid withdrawal prior to receiving a dose of buprenorphine. Patients will then be referred to Care Coordination for ongoing MAT.

DEFINITIONS:

Buprenorphine Facts

- A partial agonist at the mu-opioid receptor.
- Compared to full agonists (i.e. morphine, methadone, oxycodone), buprenorphine only partially activates the receptor causing a “ceiling effect”, minimizing risk of respiratory depression with overdose.
- Has a very high affinity for the mu-receptor so patients must be in withdrawal before buprenorphine is administered.
- Physicians can administer buprenorphine in the ED, but cannot prescribe without a DEA-X license waiver.

POLICY AND PROCEDURE:

1. ED Provider will screen patient for an opioid use disorder and offer treatment
2. ED RN will assess patient for opioid withdrawal
3. If the patient is interested in initiating MAT, Buprenorphine will be initiated by the ED provider (Reference: Buprenorphine Hospital Quickstart Guidelines)
4. The ED Provider will consider adjunctive treatment to ease withdrawal symptoms such as ibuprofen, ondansetron, clonidine, and loperamide

5. At discharge, the ED Provider will refer the patient to care coordination for ongoing MAT

6. Upon Discharge ED Provider will offer prescription for Naloxone

REFERENCES:

1. San Francisco General Hospital MAT Protocols
2. Community Hospital of Monterey Peninsula MAT Protocols
3. J Gen Intern Med 2017 Jun - Emergency Department-Initiated Buprenorphine for Opioid Dependence with Continuation in Primary Care: Outcomes During and After Intervention.
4. D'Onofrio G, O'Connor PG, Pantalon MV, et al. Emergency department initiated buprenorphine/naloxone treatment for opioid dependence. JAMA 2015; 313:1636-1644.
5. Addiction. 2017 Nov; 112(11):2002-2010. doi: 10.1111/add.13900. Epub 2017 Aug 16. Cost-effectiveness of emergency department-initiated treatment for opioid dependence.

CROSS REFERENCE P&P:

1.
2.

Committee Approval	**Date**
CCOC	6/24/19
Emergency Services Committee	7/10/19
Pharmacy & Therapeutics Committee	8/15/19
Medical Executive Committee	9/3/19
Board of Directors	
Board of Directors Last Review	

Developed: 5/8/2019ap
Reviewed:
Revised:
Supercedes:

NORTHERN INYO HOSPITAL
POLICY AND PROCEDURE

Title: Opioid Administration*	
Scope: Nursing Services	Manual: CPM - Medication (MED)
Source: Manager - ICU Acute/Subacute	Effective Date: 11/16/16

PURPOSE:
To provide safe and appropriate opioid pain relief to patients.

POLICY:
1. A thorough assessment of a patient is to be completed by a licensed RN prior to opioid administration (see procedure below for more detailed information).
2. An opioid can be administered by a Registered Nurse or Physician. A licensed Vocational Nurse (LVN) may administer opioids excluding IV opioid administration.
3. A physician's order has to be obtained prior to any opioid administration.

DEFINITION:
Acute pain – is a normal sensation that alerts us to possible injury.
Chronic pain – any pain lasting more than 12 weeks; may arise from an initial injury, or there may be an ongoing cause, such as illness.
Opioid – a medicine possessing some properties characteristic of opiate narcotics but not derived from opium. Some examples include: Hydrocodone (Vicodin), Tramadol (Ultram), Oxycodone (Percocet), Meperidine (Demerol), Morphine, Hydromorphone (Dilaudid), Methadone, Fentanyl, Refer to UpToDate for detailed drug information.
Opioid naïve – implies patients are not chronically receiving opioids on a daily basis.
Opioid tolerant – implies patients are chronically receiving opioids on a daily basis.

PROCEDURE:
1. Assessment: Upon admission, a thorough assessment should be performed on a patient by a licensed RN prior to any opioid administration. To ensure patient safety, this should be reviewed and updated as needed with each shift as necessary. This assessment includes, but is not limited to:
   - Assessing cognitive abilities to ensure an appropriate pain scale (e.g. 0-10 numeric scale, FACES, or FLACC) and pain goal is applied. This pain goal should be decided upon admission and charted on EHR.
     a) Is the patient alert and oriented?
     b) Are they able to appropriately describe their pain?
     c) What pain scale should be used and what is the patient's desired pain goal if not all pain can be eliminated?
     d) Are they age appropriate to be receiving the ordered dose and route prescribed?
   - Asking about history and current medication use
     a) Does the patient have acute or chronic pain?
     b) Do they take any opioid pain medications and for how long?
     c) Does the patient have history of Substance Use Disorder (SUD)?
2. Education: Prior to opioid administration, education for the medical personnel and for the patient is imperative.
   - Education for the personnel pertains to understanding the potential effects of opioid administration and what to monitor, such as:
     a) Sedation level - see 'Opioid Sedation Scale' policy.
     b) Drug interactions
     c) Drug compatibility

d) Side effects - constipation, nausea and vomiting, respiratory depression, risk of falls, CNS depression, impact on psychomotor and cognitive function
e) Potential for addiction, tolerance, physical dependency, and withdrawal

- Education for the patient should include:
  a) Understanding the use of the medications, the desired effects, the potential adverse effects, how the medication will be administered
  b) Pain scale and pain goal and how it relates to what type of pain relief measures can be provided
  c) Onset of action and duration to expect effect of medication

3. Administration: When considering the use of an opioid, a series of checks should be completed:
   - A multimodal approach should be taken when treating pain and trialed prior to ultimately giving an opioid:
     a) Psychosocial support
     b) Coordination of care
     c) Promotion of healthful behaviors
     d) Non-pharmacological approaches
        i. Distraction
        ii. Relaxation techniques
        iii. Positioning
        iv. Cool or warm packs
     e) Non-opioid medications
        i. Non-steroidal anti-inflammatory agents
        ii. Muscle relaxants
   - If after doing the above and an opioid is needed, a physician order must be obtained
     a) If written as a PRN order, there should be parameters according to a pain scale (e.g. Morphine 2 mg IV as needed for severe pain 7-10)
   - Timely assessment and appropriate monitoring is essential when opioids are administered to permit intervention to counteract an adverse reaction should it occur – refer to 'Patient Controlled Analgesia (PCA)' and 'Opioid Sedation Scale' policies for monitoring guidelines and interventions.
     a) Patients are at high risk of respiratory depression and over-sedation, and are more prevalent in patients with/who:
        i. Sleep apnea or sleep disorders
        ii. Morbid obesity
        iii. Snoring
        iv. Older age (over 61 years old)
        v. Opiate Naïve (no recent opioid use)
        vi. Post-surgery (particularly upper abdominal surgery)
        vii. Increased opioid dose requirement (Above 60mg MS Equivalent greatly increases risk)
        viii. Receiving other sedating drugs (benzodiazepines, CNS depressants, etc.)
        ix. Preexisting pulmonary or cardiac disease or other major organ dysfunction
        x. Smoker

   - Continually assess the need for opioid administration and advocate for its discontinuation as prompt as able to per patient's condition
   - Educate other staff members within the multi-disciplinary team to take extra precautions with the patient

Title: Opioid Administration*	
Scope: Nursing Services	Manual: CPM - Medication (MED)
Source: Manager - ICU Acute/Subacute	Effective Date: 11/16/16

4. Wasting of opioids:
   - Follow the Opioid Waste policy

DOCUMENTATION:

- Documentation for opioid administration should be performed as per 'Barcode Medication Administration' policy on the MAR.
- Documentation for monitoring and assessment of pain and sedation scale should be performed ~~on~~ in the EHR. See 'Patient Controlled Analgesia (PCA)' policy for appropriate monitoring of an administered opioid and the 'Opioid Sedation Scale' policy for sedation scale monitoring.
- Documentation of opioid waste per the Opioid Waste Policy

REFERENCES:

1. Centers for Medicare and Medicaid Services. (2014). *Requirements for hospital medication administration, particularly intravenous (IV) medications and post-operative care of patients receiving IV opioid*.
2. Curtis, Mitchell. (2015). *Hospital accreditation: CMS and IV opioid administration.* Retrieved from http://blog.cihq.org/cms-and-iv-opioid-administration
3. Medline Plus. Retrieved April 30, 2016 from https://www.nlm.nih.gov/medlineplus/mplusdictionary.html
4. The Joint Commission. (2012). *Safe use of opioids in hospital, 49*, pp. 1-5.
5. UpToDate. (2016). Drug search engine found on http://www.uptodate.com/contents/search

CROSS REFERENCE P&P:

1. Barcode Medication Administration
2. Opioid Sedation Scale
3. Patient Controlled Analgesia (PCA)
4. Safe medication administration practices, ambulatory care. (April, 2016). *Lippincott Procedures*. Retrieved on May 1, 2016 from http://procedures.lww.com
5. Opioid Waste policy

Approval	**Date**
CCOC	2/25/19
Med Services/ICU	3/28/19
STTA	5/20/19
Emergency Services Committee	3/6/19
Perinatal/Pediatrics Committee	3/5/19
Pharmacy and Therapeutics	5/3/19
MEC	9/3/19
Board of Directors	11/16/16
Last Board of Director review	4/18/18

Developed: 6/16 la
Reviewed: 1/17 la

NORTHERN INYO HOSPITAL
POLICY AND PROCEDURE

Title: Opioid Administration*	
Scope: Nursing Services	Manual: CPM - Medication (MED)
Source: Manager - ICU Acute/Subacute	Effective Date: 11/16/16

Revised: 2/19ta
Supercedes:
Index Listings:

NORTHERN INYO HOSPITAL
POLICY AND PROCEDURE

Title: **Controlled Substance**	
Scope: Hospital Wide	Department: Pharmacy
Source: Director of Pharmacy	Effective Date: 03/20/03

PURPOSE:

To ensure compliance with Federal (Title 21 U.S.C., Controlled Substances Act and Food, Drug, and Cosmetics Act), State (Health & Safety Code, Uniform Controlled Substances Act) (Chapter 9, Division 2, Business and Professions Code)

POLICY:

1. Controlled substances will be procured, stored and distributed by the pharmacy department.
2. The pharmacy department will maintain a perpetual inventory of controlled substances in Class II-V.
3. Each addition or removal will be recorded as follows:
    a. Additions will be recorded with the source, the invoice number (if applicable), the C222 number if a C-II addition, the actual count after the addition of the drug to the inventory, the initials of the recording pharmacist or technician, and the initials of the inventorying pharmacist.
    b. Removals will be recorded with ~~the requisition number,~~ the initials of the pharmacist or technician recording the transaction, the amount removed, and actual remaining inventory and the initials of the inventorying pharmacist.
4. The pharmacy department will maintain the controlled substance inventory under separate lock within the pharmacy.
5. A physical inventory of controlled substances will be taken ~~each year~~ quarterly at approximately the same time. Such inventory will be taken with two pharmacists and will be recorded in the perpetual inventory sheets for each item.
6. Biennially, the physical inventory of all controlled substances in the hospital will be recorded, printed, signed, dated and timed by the Pharmacist-in-charge (PIC). The biennial inventory will be kept for 3 years and will be available for inspection by any government agency.
7. Controlled substances will be stored on nursing units in Automated Dispensing Cabinets only utilizing secure locked bins or a secure dispensing unit.
8. Controlled substances will be distributed to automated dispensing units in quantities set by the director of pharmacy through the automated dispensing cabinet software.
9. Each controlled drug transaction will be recorded by the dispensing cabinet software and will be printed or exported to a retrievable document which will be stored ~~electronically~~ for a minimum of 3 years.
10. Returns and wastes will be documented in the automated dispensing system by two licensed persons with access to the automated dispensing cabinet through secure identification and passwords.
11. Removals from the dispensing cabinet of controlled substances will be made by a single user only upon sign in to the cabinet using secure identification and password and selection of an individual active patient.
~~12.~~ A pharmacist on duty may dispense a controlled substance directly from the pharmacy only in the case of immediate need for administration and only upon recording the removal of the controlled substance from the pharmacy's controlled substance perpetual inventory. ~~Such record must include the patient to whom the controlled substance was administered with the patient's encounter or account number of the active visit.~~
13. Verification of administration will be done by the pharmacy department by reconciling every removal with documentation of administration. Such verification will be performed daily. Discrepancies will be reconciled by contacting the administering professional in writing of the discrepancy. The Director of Pharmacy will be responsible for obtaining resolution by licensed personnel. Lack of reconciliation by professional personnel could subject the professional to potential loss of controlled substance privileges,

report to nursing administration for disciplinary action, report to medical staff, report to the professional's licensing agency, or report to local law enforcement at the discretion of the Director of Pharmacy.

REFERENCES:

1. The Comprehensive Drug Abuse Prevention and Control Act of 1970, Pub.L. 91–513, 84 Stat. 1236, enacted October 27, 1970
2. 4021. "Controlled substance" means any substance listed in Chapter 2 (commencing with Section 11053) of Division
   10 of the Health and Safety Code.

CROSS REFERENCE

1. The Comprehensive Drug Abuse Prevention and Control Act of 1970, Pub.L. 91–513, 84 Stat. 1236, enacted October 27, 1970

Committee Approval	**Date**
CCOC	7/9/2019
Pharmacy and Therapeutics Committee	8/15/19
Medical Executive Committee	9/3/19
Board of Directors	
Board of Directors Last Review	

Revised 9/04,10/05, 9/12, 7/19fl
Reviewed 10/07, 9/08, 9/10, 3/15/17
Supersedes

NORTHERN INYO HEALTHCARE DISTRICT
POLICY AND PROCEDURE

Title: Health Care Worker Health Screening and Maintenance Requirements	
Scope: NIHD	Manual: Employee Health
Source: Employee Health Specialist	Effective Date: 5/1/19

PURPOSE:
Health Screening for Health Care Workers (HCW's) occurs to ensure the worker is able to perform in the position offered and a plan has been developed for necessary documentation of immunity against specific diseases throughout the working relationship. HCW's reduce the personal risk of infection and reduce the spread of vaccine-preventable infections by receiving appropriate vaccines.

POLICY:
1. HCW Health Screening is completed by the Employee Health Nurse Specialist in collaboration with Human Resources, Medical Staff Administration, the RHC Rural Health Clinic, and Department Mangers.
2. The Health Screening begins after a contract or job offer has been made, and before actual employment/relationship begins.
3. The immunization and TB screening is preferred to begin at least 2 weeks prior to start date.
4. Immunization monitoring and TB screening is an ongoing process that continues throughout the working relationship.
5. The scope of this policy, unless otherwise noted, applies to all HCW's at NIHD. Recommendations within this policy are in accordance with the United States Center for Disease Control and Prevention (CDC) guidelines for Immunization of Health-Care Personnel, Division of Occupational Safety and Health of California (CAL/OSHA), and California Department of Public Health (CDPH). All vaccination and tuberculosis monitoring policies will be consistent with state and federal standards.

DEFINITIONS
1. **Employee:** NIHD payroll employee
2. **Health Care Worker (HCW):** includes (but are not limited to) physicians, nurses, nursing assistants, therapists, technicians, emergency medical service personnel, dental personnel, pharmacists, laboratory personnel, autopsy personnel, students and trainees, contractual staff not employed by the health-care facility, and persons (e.g., clerical, dietary, housekeeping, laundry, security, maintenance, administrative, billing, and volunteers) not directly involved in patient care but potentially exposed to infectious agents that can be transmitted to and from health care workers and patients.. *(CDC)*
3. **Health Care Personnel (HCP):** an interchangeable term with Health Care Worker.
4. **Volunteer and Auxiliary:** Active members that are in contact with patients and their families on campus.
5. **Shadower:** Observing a health care role, but not physically involved in any care.

GUIDELINES
1. Center for Disease Control (CDC) current year Immunization Schedule and recommendations for Health Care Personnel.
2. Current edition of CDC Epidemiology and Prevention of Vaccine Preventable Diseases.
3. CDPH and Cal/OSHA mandatory vaccinations against aerosol transmissible infections.
4. OSHA requirements for Blood Borne Pathogen vaccination.
5. Legal declination documentation as described in CDC, CDPH, and Cal OSHA.
6. Forms attached are based on State and Federal requirements.

NORTHERN INYO HEALTHCARE DISTRICT
POLICY AND PROCEDURE

Title: Health Care Worker Health Screening and Maintenance Requirements	
Scope: NIHD	Manual: Employee Health
Source: Employee Health Specialist	Effective Date: 5/1/19

PROCEDURE:

1. Human Resources, Medical Staff Administration, Volunteer/Auxiliary Coordinator, Department Managers will provide the Screening Requirements Form to the HCW and support the importance of meeting with Employee Health Nurse Specialist preferably at least 2 weeks prior to the proposed start date.
2. Human Resources and Medical Staff Administration will provide the Employee Health Nurse Specialist with names, contact information, and current TB screening, immunizations and titer documentation of all new HCW's who have received and accepted a job offer, or other agreement. Their support is critical to success in requesting the new HCW provide all childhood and career vaccines from prior employers, clinics, and hospitals. It is preferred this process begins 2 weeks prior to start date.
3. Any HCW returning to NIHD more than 6 months from termination will be required to start the process over. If the person returns in less than 6 months after termination of employment they will be required to complete a health history form, complete a review of prior immunization records and TB screening, and a focused assessment on the physical demands of the specific position.
4. Shadowers are not cleared by Employee Health as they are observing and not in direct contact with patients.
5. To clear a new hire through the Employee Health Nurse Specialist, the nurse must be able to do the following:
   a. Review prior TB screening, immunization records, and titers
   b. Develop a plan with the new employee to meet onboarding requirements
   c. The Health History and Physical Exam is completed as defined in this policy.
   d. Then, Employee Health with send an email to Human Resources or Medical Staff Administration, stating the HCW is cleared by Employee Health.
6. **NEW HIRE HEALTH HISTORY AND PHYSICAL EXAM**
   a. The New Hire Health History and Physical Exam is required of all prospective NIHD payroll employees and Travelers only.
   b. The physical exam is to be scheduled between Human Resources, RHC, and Employee Health and completed prior to the first day of employment by the RHC Provider.
   c. A prior New Hire Health History and Physical Exam with all components is acceptable if the terminated person returns within 6 months.
   d. Documentation of the following must be included:
      i. Health History
      ii. Physical Exam
      iii. Allergies including latex
      iv. Audiometry
      v. Vision Test
      vi. Color vision: Ishihara 14 plates with color failure identification
      vii. Infectious Disease Exposure Screening

7. **TUBERCULOSIS SCREENING**
   a. TB Screening is required of all HCW's who will be on campus at NIHD.
   b. TB Screening is arranged and completed by the Employee Health Nurse Specialist.
      i. 2-step TB Skin Test is required, even if the person received a BCG vaccination in the past.

ii. If there is documentation of a negative Tuberculosis Skin Test (TST) in the last 12 months, then only 1 additional TST is required prior to start date.
iii. A QFT (QuantiFERON-TB Gold Assay) in the last 12 months is an acceptable alternative to TST.
iv. If there is a documented positive TST, reference Employee Tuberculosis Surveillance Program for direction.
v. Intervals for serial TB testing is at least every 2 years. Reference TB Screening Policy.
    1. Staff is notified 90 days prior to the need to retest allowing for adequate scheduling to make an appointment with the Employee Health Nurse for testing.
    2. If the employee work night's or only weekends:
        a. the Employee Health Nurse can notify the House Supervisors or the Infection Prevention Manager to place the PPD.
    3. If the employee works in the clinics:
        a. RHC staff is able to place and read your TST.
    4. All TST's need to be read in 48-72 hours after being placed and can be read by an RN in Employee Health, ED, RHC, Infection Prevention Manager, or a Nursing Supervisor, when provided the yellow copy with date and site of placement.
    5. Employees are responsible for returning their completed form with results (yellow copy) to the mailbox outside of Employee Health within 24 hours of the reading.
    6. If the TST is not read in time, it will need to be repeated and read before the due date.

8. **IMMUNIZATIONS:**
    a. Employee Health vaccine screening, monitoring and administering is limited to these vaccines: Influenza, MMR, Varicella, Tdap, Hepatitis B, and Meningococcal, Hepatitis A, and TB Skin Tests. If the HCW wishes to receive other vaccinations, they will be directed to contact their primary care practitioner.
    b. Initial immunization screening is required of all HCW's prior to the start date.
    c. Annual Influenza vaccinations will be overseen by the Employee Health Nurse Specialists in collaboration with all department managers.
    d. Employee Health Standing Orders for Vaccine administration to HCW's are based on the CDC/ACIP Recommendations. They will be approved by the Medical Director annually using the CDC/ACIP order templates. Standing Orders will be stored in the Employee Health Office and on the Employee Health shared drive or Intranet.
    e. A signed consent with CDC screening questionnaire will be completed for all immunizations.
    f. Immunizations:
        i. **Influenza**
            1. Applies to all HCW's on campus during the influenza season.
            2. Required by CDPH.
            3. Annually, during each flu season, one dose of influenza vaccine is required if there is no documentation for that season.
        ii. **MMR**
            1. Applies to all HCW's on campus: except volunteers and auxiliary.
            2. Required by Cal OSHA.
            3. Immune titers to all 3 or documentation of 2 doses.
            4. Birthdate prior to 1957 does require documentation of IgG immunity to Rubella, Rubeola, and Mumps.

5. If immunity or vaccination history is unknown, an IgG will be drawn for Rubella, Rubeola, and Mumps.
6. Follow CDC recommendations/Standing Orders for booster dose or re-vaccination if the results demonstrate non-immunity or equivocal.

iii. **Varicella (chickenpox)**

1. Applies to all HCW's on campus: except volunteers and auxiliary.
2. Required by Cal OSHA.
3. Serologic proof of immunity, documentation of 2 dose vaccination, or verification of a history of varicella or herpes zoster (shingles) by a healthcare provider are evidence of immunity.
4. If disease of vaccination history is undocumented or incomplete documentation, an IgG will be drawn for Varicella. Follow CDC recommendations/Standing Orders for booster dose or re-vaccination if the results demonstrate non-immunity or equivocal.

iv. **Tetanus, diphtheria, pertussis**

1. Applies to all HCW's on campus, no exceptions.
2. Required by Cal OSHA
3. Documentation of one dose of Tdap at or after the age of 11.
4. Booster doses would be provided by the person's primary care practitioner.

v. **Meningococcal**

1. Both MenACWY and MenB are recommended only for microbiologists who are routinely exposed to isolates of Neisseria meningitides.
2. CDC Recommended.
3. Every 5 years boost with MenACWY if risk continues.
4. When offered and refused, a declination will be required.

vi. **Hepatitis B**

1. Required by CAL/OSHA.
2. Applies to NIHD HCW's who will be working in these departments/roles: Activities Director, Admission Services, Biomedical, Case Management, Central Supply, Diagnostic Imaging Techs and Radiologists, Dietary, Environmental Services, EKG/EEG, Laboratory, Language Services, Laundry, Maintenance/Plant Operations, Nursing, Medical Assistant, Pharmacy, Physical Therapy, Occupational Therapy, Respiratory Therapy, Security, Social Services.
3. Documentation of the 2-dose (Heplisav-B) or 3-dose (Engerix-B or Recombivax HB) series is required for HCW's who perform tasks that may involve exposure to blood or body fluids.
4. Request a HepBsAb titer to check for immune reactivity if there is documentation of a full series of Hep B vaccines.
5. If no documentation of immunizations, then the series will be restarted.
6. Follow CDC recommendations/Standing Orders for HCW boosters and follow up HepBsAb titers. The HCW is allowed to work at NIHD while completing Hepatitis B initial series, boosters, and titers. In this case, the HCW will also sign the Hep B declination form as an acknowledgement of risk while receiving the series or boosters.

~~vii. **Hepatitis A**~~

~~1. Applies to Dietary/Food Service only.~~

2. ~~This is a 2-dose vaccine, second is due 6-12 months after the first. When the second dose is due, if the HCW changed departments within NIHD the series will be completed.~~
3. ~~When offered and refused, a declination will be required, to acknowledge risk and document the offering. The declining employee may change their mind at any time and receive the vaccine if they remain in one of the specific departments~~.

9. **VACCINE DECLINATIONS**
   a. NIHD strives to ensure the safety of our patients and HCW's through vaccinations. Should a HCW decline any of the required vaccines a declination must be signed, acknowledging awareness of risk.
   b. OSHA requires signed declination for refusal of Hepatitis B vaccine. Attached.
   c. California law requires signed declination for refusal of vaccines to prevent aerosol transmissible diseases. Attached.
   d. Declinations are specific to the vaccine, for NIHD, and attached to this policy.
10. **EXCEPTIONS:**
   a. Volunteers and auxiliary members Health Screening Requirements are limited to the following:
      i. Tdap once at or after age 11
      ii. Influenza immunization annually
      iii. TB screening per policy
   b. Travelers are required to submit a pre-hire Drug Screen. This is monitored by Human Resources and Employee Health.
   c. Vendors are not screened through Employee Health. Vendormate is used in this instance.
11. **COSTS**
   a. Initial required exams, immunizations, titers, and Tuberculosis testing is offered at no cost to NIHD employees, contracted physicians, contracted mid-level providers, volunteers, and auxiliary members upon hire.
   b. Travelers and all students will need to meet their initial requirements through a primary health care provider at their cost.
   c. Annual influenza immunization is offered to all HCW during influenza season at no cost.
   d. TB testing is offered at no cost to all HCW every two years, except for students.
12. **DOCUMENTATION**
   a. Documentation related to vaccinations, titers, TB screening, medical history and Physical Exam will be kept in the Employee Health files and database.
   b. Vaccine's provided by NIHD require a consent which includes a screening questions, the manufacturer, lot, expiration date, and date of published VIS that was provided. This data will be documented in the database where required and the form will be stored in the HCW's health record.
   c. Current and former NIHD employees may request a copy of their vaccine, titer, and TB Screening records from the Employee Health Nurse Specialist by completing an *NIHD Authorization to Disclose Health Information.*
   d. Travelers that may receive an influenza vaccine at NIHD are responsible to ensure a copy is stored in Medical Solutions or with their clinical staffing company.
   e. HCW Employee Health records include the screening documentation as defined in this policy per role/department: The Health History, Physical Exam as described, immunization records, database vaccine administration record, immunization consents and declinations, lab

reports/titers, all Tuberculosis Screening documentation, chest rays for positive PPD, and CAL/OSHA Fit Testing Medical Questionnaire (if fit tested), Employee Health Clearance to work, and Date of Termination.

REFERENCES:

1. Center for Disease Control. ACIP Vaccine Recommendations and Guidelines https://www.cdc.gov/vaccines/hcp/acip-recs/index.html
2. CAL/OSHA, Aerosol Transmissible Vaccine Declinations. Retrieved from https://www.dir.ca.gov/title8/5199e.html
3. CAL/OSHA, Title 8, Section 5193. Bloodborne Pathogens. Retrieved from https://www.dir.ca.gov/title8/5193.html
4. OSHA, Standard Number 1910.1030 App A - Hepatitis B Vaccine Declination (Mandatory) retrieved from https://www.osha.gov/laws-regs/regulations/standardnumber/1910/1910.1030AppA
5. Center for Disease Control. Prevention and Control of Influenza with Vaccines— Recommendations of ACIP at www.cdc.gov/vaccines/hcp/acip-recs/vacc-specific/flu.html
6. Center for Disease Control. Table 2 Recommended Adult Immunization Schedule by Medical Conditions and Other Indications, United States, 2019. https://www.cdc.gov/vaccines/schedules/hcp/imz/adult-conditions.html#table-conditions
7. Use of Standing Orders Programs to Increase Adult Vaccination Rates: Recommendations of the ACIP. MMWR 2000;49 (No. RR-1) at www.cdc.gov/mmwr/preview/mmwrhtml/ rr4901a2.htm.

ATTACHED:

1. CDC Health Care Personnel Immunization Recommendation (current year)
2. CDC current year complete adult immunization schedule (current year)
3. Documents
   a. Informational Handout to all Healthcare Workers about NIHD Health Screening
   b. Health History From
   c. Physical Exam Form
   d. Employee Health Worksheet for Screening HCW's
   e. Employee Health Lab and Radiology Orders
   f. Consents for Immunizations
   g. Vaccine Declinations

CROSS REFERENCE P&P:

1. Influenza Vaccination Policy
2. Employee Tuberculosis Survey Program
3. Prevention and Treatment of Pertussis in Hospital Employees

SUPERCEDES

1. Adult Immunization in the Healthcare Worker
2. Post Offer Physical Examinations for New Hires
3. Post Offer Physical Requirements

NORTHERN INYO HEALTHCARE DISTRICT
POLICY AND PROCEDURE

Title: Health Care Worker Health Screening and Maintenance Requirements	
Scope: NIHD	Manual: Employee Health
Source: Employee Health Specialist	Effective Date: 5/1/19

Approval	**Date**
Clinical Consistency Oversight Committee	5/21/19
Infection Control Committee	8/26/19
MEC	9/3/19
Board of Directors	6/19/19
Last Board of Directors Review	6/19/19

Developed: 5/19
Reviewed:
Revised:
Supersedes:
Index Listings:

NORTHERN INYO HOSPITAL
POLICY AND PROCEDURE

Title: Placenta Disposal	
Scope: Perinatal Services	Manual: OB/GYN
Source: Perinatal Nurse Manager	Effective Date:

PURPOSE: To guide nursing and staff about proper care of the placenta after delivery.

POLICY:

1. The Physician/CNM is responsible for the visual/ tactile examination of the placenta.
2. The provider determines whether or not the placenta needs to be sent to pathology.
3. If ordered, prepare and send placenta to pathology.
4. If there is no order to send the placenta to pathology, disposal of the placenta is treated as biohazardous waste.
5. The patient may request to take the placenta home. If so, please follow the "Removal of Placenta from Hospital per Patient's Request" policy. Have patient sign "Release of Placenta" form.

PROCEDURE:

1. For general disposal of a non-pathological placenta: Place placenta in the short rectangular plastic container provided on the delivery table. Use proper PPE. Add a container of Vira Sorb super solidifier to the container. Close and place in the red bag trash in the dirty utility room.
2. For a placenta that needs to go to pathology:
    a. Obtain MD/CNM order
    b. Wear proper PPE
    c. Transfer placenta into a white pathology bucket container
    d. Label the container using 2 patient identifiers at the patient bedside, as per policy
    e. Fill out "Pathology Dept Request Form".
    f. Call lab to pick the specimen up and provide the container and the request form.
3. Follow "Neonatal Death, Fetal Demise & Spontaneous Abortion" policy if you have an order for genetic workup on a placenta due to miscarriage, fetal demise, or stillbirth.

REFERENCES:

1. OSHA Standards for Medical Waste, Nov. 10, 2017

CROSS REFERENCE P&P:

1. Medical Waste Management Plan

Committee Approval	**Date**
CCOC	6/24/19
Peri/Peds Committee	7/25/19
Infection Control Committee	8/27/19
Medical Executive Committee	9/3/19
Board of Directors	
Board of Directors Last Review	

Developed: 6/19ss
Reviewed:

NORTHERN INYO HOSPITAL
POLICY AND PROCEDURE

Title: Placenta Disposal	
Scope: Perinatal Services	Manual: OB/GYN
Source: Perinatal Nurse Manager	Effective Date:

Revised:
Supersedes:

Title: da Vinci Robot ~~Si~~ Cleaning and Maintenance*	
Scope: Surgery, Environmental Services	Manual: Surgery
Source: DON Perioperative Services	Effective Date: 12/14/16

PURPOSE:
To ensure proper cleaning of the da Vinci Robot System Equipment
To prevent harm to the delicate electronics of the system

POLICY:
The environmental/surgery personnel will follow this procedure when cleaning the da Vinci Robot Console, Patient Cart, Vision Cart and System Cables.

PROCEDURE:
1. Use a soft, lint-free damp cloth and a surface disinfectant product (or a pre-moistened disinfectant wipe product) to wipe the exterior surfaces of the system components and cabling after each use of the da Vinci Robot components as designated above.
2. Examples of cleaning products include Enviroide, CaviCide, deconex S-Wipes, neoform MED rapid and 70% isopropyl alcohol.
3. If using a manufacture wipe, allow the designated exposure time. **Cavi Wipes** require a 3 minute visibly wet exposure time.
4. Do not allow cleaning solutions to get inside the system, make sure the cloth is only damp.
5. Allow components to dry before use.
6. Clean eyepieces on the Vision Cart with lens cleaner wipes and dry with soft lint free cloth.
7. Clean the Touchscreen Display with cleaning wipes approved for computer displays or a lint free cloth dampened with a diluted mixture of mild detergent and water. Make sure it is damp and not wet. Dry with another lint-free cloth. **DO NOT USE CLEANING SOLUTIONS in #2** on the Touchscreen Display.
8. Make sure you pay particular attention to the areas where the Surgeon Console Operator comes in contact with the system (such as the controller grips, the stereo viewer and the armrests.

PRECAUTIONS:
- Do not allow liquids to come in contact with electronics.
- Do not use a wet cloth only damp.
- Do not submerge the camera and camera cables in liquids.
- System Cables and their receptacles contain fiber-optics. DO NOT blow off fiber ends with oil-free canned air duster unless you have been instructed to by Intuitive Surgical Personnel.

REFERENCES:
1. daVinci Surgical System User Manual section 12.
2. Cavi-Wipes instruction for use.

Approval	**Date**
CCOC	8/26/19
Infection Control Committee	8/27/19
MEC	9/3/19

Title: da Vinci Robot ~~Si~~ Cleaning and Maintenance*	
Scope: Surgery, Environmental Services	Manual: Surgery
Source: DON Perioperative Services	Effective Date: 12/14/16

Board of Directors	
Last Board of Director review	1/17/18

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Reviewed: 6/11/19aw
Revised:
Supersedes:
Index Listings: DaVinci Robot Cleaning and Maintenance

CALL TO ORDER	The meeting was called to order at 5:30 pm by Mary Mae Kilpatrick, President.
PRESENT	Mary Mae Kilpatrick, President Jean Turner, Vice President Robert Sharp, Secretary M.C. Hubbard, Treasurer Jody Veenker, Member at Large Stacey Brown MD, Vice Chief of Staff Kevin S. Flanigan MD, MBA, Chief Executive Officer Kelli Davis, MBA, Chief Operating Officer John Tremble, Chief Financial Officer
ABSENT:	Tracy Aspel RN, BSN, Chief Nursing Officer
OPPORTUNITY FOR PUBLIC COMMENT	Ms. Kilpatrick stated at this time persons 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. Speakers will be limited to a maximum of three minutes each, and members of the audience will have an opportunity to address the Board on every item on the agenda. No comments were heard.
CARDIAC CARE CONCERNS	Community resident David Young provided an informational demonstration of a self-monitoring electrocardiogram device developed to assist cardiac patients. The device collects data that helps to identify triggers of cardiac disturbances, allowing the wearer to self-treat in order to prolong their health.
STRATEGIC PLAN UPDATE, WORKFORCE EXPERIENCE COMMITTEE	The Northern Inyo Healthcare District (NIHD) Workforce Experience Committee provided an update on progress made toward achieving the workforce experience-related goals of the District's Strategic Plan. The Committee's presentation included the following: - The group's main objectives are to address staff development and employee turnover - A behavioral interview process has been implemented as a step toward assisting the District in hiring the right people - Staff turnover statistics for 2018/2019 were compared to turnover rates for 2017/2018 - Staff churnover rates (employee movement internally within District departments, including promotions) for the last 2 years were reviewed and compared - An overview of staff development strategies were reviewed including data on completion rates of assigned competencies - Future efforts of the group will include conducting employee stay and exit interviews, and providing "Lunch and Learn" opportunities for District staff.

NEW BUSINESS

NORTHERN INYO HEALTH ARTICLES OF INCORPORATION AND NORTHERN INYO HEALTH BYLAWS

Chief Executive Officer Kevin S. Flanigan, MD, MBA called attention to proposed Articles of Incorporation to establish a nonprofit corporation by the name of *Northern Inyo Health*. The primary purposes of the corporation are to own a supplier of durable medical equipment, and to provide other healthcare services for the benefit of District residents. The corporation would support the healthcare activities of NIHD in furtherance of charitable purposes. Doctor Flanigan also called attention by proposed bylaws for *Northern Inyo Health*, which clarify that NIHD will be the sole member of the Corporation, and that it will function as a 501 C (3) as designated by the Internal Revenue Service Code. It was moved by M.C. Hubbard, seconded by Robert Sharp, and unanimously passed to approve both the Articles of Incorporation and the Bylaws for *Northern Inyo He*alth as presented, with minor edits being made to their content.

DISTRICT BOARD RESOLUTION 19-06

Doctor Flanigan also called attention to proposed District Board Resolution 19-06, which would allow for cessation of ongoing monitoring of deficiencies identified as part of the District's 2013 Centers for Medicare and Medicaid Services (CMS) survey. The deficiencies identified in 2013 were corrected 5 years ago, and the District has since passed two additional surveys with no deficiencies being noted in the same areas. It was moved by Jody Veenker, seconded by Jean Turner, and unanimously passed to approve District Board Resolution 19-06 as presented.

GROUP INTERVENTION POLICY

Stacey Brown MD, Vice Chief of Staff called attention to a policy titled *Group Intervention*, developed to identify the policy and procedure for providing Medication Assisted Treatment (MAT) Stabilization Group intervention for patients engaged in NIHD's MAT program. It was moved by Ms. Hubbard, seconded by Ms. Veenker, and unanimously passed to approve the proposed *Group Intervention* policy and procedure as presented.

DETERMINATION OF DATE FOR COMMUNITY INFORMATION NIGHT

Ms. Kilpatrick opened discussion on potential dates for a Community Information night, which will be a meeting of the NIHD Board of Directors held for the purpose of addressing a topic of interest to area residents. Constituents will have the opportunity to engage in an open discussion with the Board of Directors on that topic. Following brief discussion September 25, 2019 (at 6:30 pm) was chosen to be the date of the first Community Information night to be held by the NIHD Board of Directors.

CHIEF OF STAFF REPORT

Doctor Brown reported following careful review and consideration, the Medical Executive Committee recommends approval of the following District-wide policies and procedures:

1. *Accepting Orders from Non-Privileged Practitioners*

POLICY AND PROCEDURE APPROVALS

2. *Administration of Drugs - Patient's Own Medications*
3. *Color-Coded Wristband Use*
4. *Drugs of Abuse Test McKesson 12-Drug Panel with Adulterants*
5. *IV Service When NIHD IV Room is Closed*
6. *Medication Dosing in Renal Failure*
7. *Pharmacy Confidentiality: Storage and Destruction of PHI-Containing Documents*
8. *Point of Care QuickVue Dipstick Strep A Test*
9. *Unusable Drugs*

It was moved by Mr. Sharp, seconded by Ms. Hubbard, and unanimously passed to approve policies and procedures 1 through 9 as presented, with minor housekeeping changes being made to their content.

UPDATED EMERGENCY MEDICINE CORE PRIVILEGE FORM

Doctor Brown also reported the Medical Executive Committee recommends approval of the updated *Emergency Medicine Core Privilege* form. It was moved by Ms. Hubbard, seconded by Ms. Turner, and unanimously passed to approve the updated *Emergency Medicine Core Privilege* form as presented.

2019 CRITICAL INDICATOR UPDATES

Doctor Brown additionally reported the Medical Executive Committee recommends approval of the following 2019 Critical Indicator updates:

1. *Emergency Department*
2. *Rural Health Clinic*

It was moved by Ms. Turner, seconded by Ms. Veenker, and unanimously passed to approve both 2019 Critical Indicator updates as presented.

PHYSICIAN RECRUITMENT UPDATE

Doctor Brown also provided a physician recruitment update, noting the following:

- Urologist Colby Perkins-Souders, MD has accepted a 2-year fellowship on pelvic floor reconstruction, and she will not come on board at NIHD until the conclusion of that fellowship.
- Locums urologist Matthew Ercolani, MD is expected to begin providing urology services at the District at the start of September. Dr. Ercolani is trained in the use of robotic surgery equipment.
- Orthopedist Bo Loy, MD will begin providing orthopedic services at NIHD the first week in September.
- Hospitalists Stephan Shunk, MD and Monica Mehrens, DO both wish to increase the number of shifts that they work at NIHD.

COMMUNITY HEALTH NEEDS ASSESSMENT

Doctor Flanigan presented an overview of the District's most recently completed Community Health Needs Assessment (CHNA), and provided a history of the Districts' past CHNA efforts. Doctor Flanigan's presentation included the following:

- This year's assessment was a collaborative effort of the Inyo County Healthcare Coalition, which includes representatives from Inyo County Health and Human Services; Northern Inyo Healthcare District; Southern Inyo Healthcare District (SIHD); Wild Iris; Owens Valley Career Development Center; and Inyo

Mono Advocates for Community Action.

- The assessment was conducted for the purpose of assessing the healthcare needs of this community and developing priority focus areas for Community Health and Wellness efforts going forward.
- NIHD hired Wipfli LLP to do a financial data dive on charges and billings for NIHD and SIHD as part of the needs assessment. The County of Inyo retained the services of Kemper Consultant Group to help compile the data collected for the assessment.
- As a result of the CHNA, the Coalition has developed an *Inyo County Strategic Roadmap* to address the healthcare areas of focus identified in the assessment.
- The CHNA identified the following priority focus areas:
    1. *Behavioral Health - Mental Health and Substance Use Disorders*
    2. *Access to Patient Services*
    3. *The 3rd area of priority focus is yet to be determined*

The *Strategic Roadmap* contains strategies and next steps going forward, and identifies potential partners, funding sources, and possible barriers to future efforts. Doctor Flanigan noted that the primary focus of the NIHD September Board of Directors meeting will be Strategic Planning, with the intent of identifying what the NIHD Board of Directors and leadership wants to see the District work on in the next two years.

CONSENT AGENDA

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

- *Financial and Statistical reports as of April 30, 2019*
- *Approval of minutes of the July 13, 2019 special meeting*
- *Approval on minutes of the July 17, 2019 regular meeting*
- *Approval of minutes of the August 3, 2019 special meeting*
- *Medical Staff Services Pillars of Excellence for July 1, 2018 through June 30, 2019*
- *Policy and Procedure annual approvals*

It was moved by Mr. Sharp, seconded by Ms. Veenker, and unanimously passed to approve all 6 Consent Agenda items as presented.

BOARD MEMBER REPORTS

Ms. Kilpatrick asked if any members of the Board of Directors wished to comment on any items of interest. Director Hubbard noted that Doctor Flanigan will provide a Healthy Lifestyles talk tomorrow night, on the subject of the transition toward increased provision of outpatient services in order to meet community needs. Director Veenker commented that there was an extremely positive community response to the recently held Opioid Summit, and that the event drew approximately 200 attendees. Director Kilpatrick stated NIHD will again sponsor a booth at the Eastern Sierra Tri-County Fair, and noted that Board members are welcome to work the booth and participate in providing information for members of the community. No other comments were heard.

ADJOURNMENT TO CLOSED SESSION

At 7:45 pm Ms. Kilpatrick reported the meeting would adjourn to Closed Session to allow the Board of Directors to:

A. Discuss trade secrets, new programs and services (estimated public session date for discussion yet to be determined) (*Health and Safety Code Section 32106*).
B. Conference with Labor Negotiators; Agency Designated Representative: Irma Moisa; Employee Organization: AFSCME Council 57 (*pursuant to Government Code Section 54957.6*).
C. Confer with Legal Counsel regarding threatened litigation, 1 matter pending (*pursuant to Government Code Section 54956.9(d)(2)*).
D. Conduct Public employee performance evaluation, Chief Executive Officer (*pursuant to Government Code Section 54957*).

RETURN TO OPEN SESSION AND REPORT OF ACTION TAKEN

At 10:23 pm the meeting returned to Open Session. Ms. Kilpatrick reported that during Closed Session it was moved by Director Kilpatrick, seconded by Jody Veenker, and unanimously passed to approve appointing Directors Sharp and Hubbard to an Ad Hoc Committee to review documents and approve signing if acceptable, for the sale of 153 Pioneer Lane including a lease back of the property. Funds from the sale will be designated for the purchase back of the land. The Board took no other reportable action.

ADJOURNMENT

The meeting was adjourned at 10:24 pm.

_____
Mary Mae Kilpatrick, President

Attest: _____
Robert Sharp, Secretary

CALL TO ORDER	The meeting was called to order at 4:00 pm by Mary Mae Kilpatrick, President.
PRESENT	Mary Mae Kilpatrick, President Jean Turner, Vice President Robert Sharp, Secretary M.C. Hubbard, Member-at-Large Jody Veenker, Director Kevin S. Flanigan MD, MBA, Chief Executive Officer Tracy Aspel RN, BSN, Chief Nursing Officer
OPPORTUNITY FOR PUBLIC COMMENT	Ms. Kilpatrick announced at this time persons in the audience may speak on any 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 4:01 pm Ms. Kilpatrick announced that the meeting would adjourn to Closed Session to allow the Board of Directors to: A. Conference with Labor Negotiators; Agency Designated Representative: Irma Moisa; Employee Organization: AFSCME Council 57 (*pursuant to Government Code Section 54957.6*).
RETURN TO OPEN SESSION AND REPORT OF ACTION TAKEN	At 6:45 pm the meeting returned to Open Session. Ms. Kilpatrick reported the Board took no reportable action.
ADJOURNMENT	The meeting was adjourned at 6:46 pm.

_____
Mary Mae Kilpatrick, President

Attest: _____
Robert Sharp, Secretary

Northern Inyo Healthcare District
Income Statement - Detail
As of June 30, 2019

	Month To Date 06/30/2019	Month To Date 05/31/2019	Year To Date 06/30/2019	Year To Date 06/30/2018
Inpatient Revenue	2,642,166.98	2,390,213.95	35,770,898.63	44,157,168.62
Outpatient Revenue	9,817,974.90	10,140,516.60	110,939,676.81	98,244,395.46
RHC Clinic Revenue	525,412.08	660,025.65	6,784,060.67	7,340,812.00
Total Gross Patient Service Revenue	12,985,553.96	13,190,756.20	153,494,636.11	149,742,376.08
Deductions from Revenue	(7,272,227.37)	(8,595,664.31)	(81,919,338.01)	(69,856,157.90)
Other Patient Revenue	(69.49)	1,332,855.76	1,391,382.57	0.00
Total Net Patient Revenue	5,713,257.10	5,927,947.65	72,966,680.67	79,886,218.18
Medicare Settlement Income/Expense	354,000.00	0.00	1,829,035.00	0.00
Medicaid Settlement Income/Expense	0.00	(2,922.00)	(2,922.00)	0.00
Disproportionate Share Income/Loss	630,449.67	0.00	3,079,933.31	6,285,388.98
Total Income/Expense from Cost Reporting	984,449.67	(2,922.00)	4,906,046.31	6,285,388.98
Other Operating Revenue	1,861,184.85	2,274,857.85	13,761,793.45	1,043,052.24
Net Operating Revenue	8,558,891.62	8,199,883.50	91,634,520.43	87,214,659.40
Operating Expenses				
Repairs and Maintenance	19,721.15	22,327.72	402,995.76	2,115,416.82
Leases and Rental Expenses	68,143.98	51,374.20	817,399.83	868,173.85
Salary & Wages	2,407,740.54	2,492,331.15	29,313,247.30	25,697,885.83
Benefits	1,962,647.60	2,239,075.85	20,986,370.06	20,356,882.51
Non-Benefit Expenses	13,145.13	11,870.20	162,015.62	215,708.23
Professional Fees	909,923.37	913,010.18	10,932,226.73	13,193,098.20
Supplies	1,312,500.33	943,743.45	10,747,557.68	9,805,557.11
Contract Services	387,924.01	454,374.59	5,130,508.64	2,013,758.37
Other Department Expenses	102,707.87	98,080.47	1,206,857.62	864,872.17
Hospital Insurance Expenses	37,123.86	33,686.99	357,155.24	328,948.55
Utilities	119,484.03	102,830.25	1,461,950.87	1,335,357.75
Depreciation and Amortization	399,043.89	315,760.64	4,028,426.56	4,456,698.09
Other Fees	168,310.03	165,158.32	2,075,672.18	1,278,642.42
Interest Expense - Operating	239,702.23	231,952.23	2,809,394.77	2,892,774.64
Total Operating Expenses	8,148,118.02	8,075,576.24	90,431,778.86	85,423,774.54
Total Gross Operating Profit (Loss)	379,396.58	124,307.26	1,153,538.03	1,772,471.52
Non-Operating Revenue				
Other Income				
Tax Payer General Support	0.00	37,235.44	582,377.50	681,324.53
Bond/ Tax Payer Bond Support	137,595.79	104,355.72	1,660,197.10	1,543,645.90
Fin Chgs-Pt Ar - Int Incm-Jdgmnt	0.00	0.00	487.92	264.33
Fin Chgs-Pt Ar - Int Incm-Payors	466.70	(525.17)	20,445.17	48,138.01
Interest Income	67,702.49	45,281.85	646,116.33	311,058.11
Total Other Income	205,764.98	186,347.84	2,909,624.02	2,584,430.88
Grant Revenue	3,076.54	0.00	2,118,948.28	1,559,430.22
Other Non-Operating Income	(17,606.10)	9,340.97	24,154.76	25,349.23
Net Medical Office Activity	(495,568.47)	(453,753.63)	(6,288,117.57)	(4,800,520.64)
340b Net Activity	19,637.10	44,165.45	323,537.64	546,068.98
Donations	12,650.00	0.00	21,950.00	0.00
Rental Income	2,730.00	7,032.82	40,191.75	47,161.99
Gain - Investments - Other Income	9,758.00	1,235.00	39,203.50	(52,545.50)
Total Net Non-Operating Revenue	(259,557.95)	(205,631.55)	(810,507.62)	(90,624.84)
Other Non-Operating Expenses	328,205.74	70,000.00	398,205.74	0.00
Total Net Non-Operating Profit (Loss)	(587,763.69)	(275,631.55)	(1,208,713.36)	(90,624.84)
Total Net Income (Loss)	(176,990.09)	(151,324.29)	(5,971.79)	1,700,260.02

Northern Inyo Healthcare District
Balance Sheet
As of June 30, 2019

Assets	
Current Assets	
Cash and Liquid Capital	$ 2,312,956
Short Term Investments (LAIF & CDs)	22,762,603
PMA Partnership	379,758
Accounts Receivable, Net of Allowance	
Accounts Receivable	48,573,961
Allowances against Receivables	(28,958,257)
Total Accounts Receivable, Net of Allowance	19,615,704
Other Receivables	667,694
Inventory	2,431,341
Prepaid Expenses	1,578,582
Total Current Assets	49,748,638
Assets Limited as to Use	
Internally Designated for Capital Acquisitions - LAIF	1,193,799
Short Term - Restricted - Savings	100,128
Limited Use Assets	
LAIF - DC Pension Board Restricted	1,416,716
DB Pension (Funds Held by Trustee)	13,547,735
Total Limited Use Assets	14,964,451
Revenue Bonds Held by a Trustee	4,315,024
Total Assets Limited as to Use	20,573,402
Long Term Assets	
Long Term Investments (CDs)	1,735,695
Fixed Assets, Net of Depreciation	
Fixed Assets	125,324,288
Accumulated Depreciation	(49,779,720)
Construction in Progress	818,411
Total Fixed Assets, Net of Depreciation	76,362,978
Total Long Term Assets	78,098,673
Total Assets	$ 148,420,714
Liabilities	
Current Liabilities	
Current Maturities of Long-Term Debt	$ 3,391,089
Accounts Payable	4,806,359
Accrued Payroll and Related Benefits	8,143,497
Accrued Interest and Sales Tax	577,821
Due to 3rd Party Payors	4,517,413
Other Deferred Credits - Pension	4,059,540
Total Current Liabilities	25,495,719
Long Term Liabilities	
Long Term Debt	39,546,947
Bond Premium	481,796
Accreted Interest	13,520,264
Other Non-Current Liability - Pension	31,791,415
Total Long Term Liabilities	85,340,422
Total Liabilities	110,836,141
Fund Balance	
Fund Balance	37,490,417
Temporarily Restricted	100,128
Net Income (Loss)	(5,972)
Total Fund Balance	37,584,573
Liabilities + Fund Balance	$ 148,420,714

NORTHERN INYO HEALTHCARE DISTRICT
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Compliance Report
September 2019

1. Comprehensive Compliance Program review
    a. As September 6, 2019, 92.7% District's employee (including temporary, traveler, and contract workers) workforce have reviewed the Compliance Program. Twenty of the 39 remaining who are due to read the program are within 90 days of their first day of employment. This number fluctuates due to employee turnover.
    b. 79.5% of District workforce have completed HIPAA training for CY 2019.
2. Breaches
    a. Calendar Year (CY) 2019 – (attachment A)
        i. 51 alleged breaches of PHI (Protected Health Information) potentially affecting more than 468 patients have been investigated by the Compliance Office
        ii. 4 of the alleged breaches of PHI have been reported to California Department of Public Health (CDPH) and/or the Office of Civil Rights (OCR)
            1. CDPH has completed investigation of two cases. Both were substantiated, but assigned no deficiency.
            2. Two (2) cases are still pending CDPH investigation.
            3. Several cases from prior years are still pending letters of findings, indicating that at least several may incur some level of deficiency and penalty.
        iii. Eleven of the reported potential breaches/privacy concerns are currently under investigation by the NIHD Compliance Department.
3. Issues and Inquiries
    a. CY 2019 – Several hundred requests for research and input on a wide variety of topics have been made to the Compliance Department.
        i. Compliance and regulation research tops the list.
        ii. Policy advice and research
        iii. Potential compliance concerns that do not reach the level of a full investigation. (Usually require training and education)
    b. Compliance currently reviews all new referring physicians to verify they are not on a Federal or State exclusions list. To date in 2019, Compliance has verified several

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hundred providers. It is considered fraud to bill any government payer for diagnostic or treatment claims, if ordered by an excluded provider.

i. Compliance has identified two referring providers on an exclusions list. We have notified Administration, and have properly addressed the issues.

4. Audits
   a. Employee Access Audits (attachment B) - The Compliance Office manually completes audits for access of patient information systems to ensure that employees access records only on a work-related, "need to know," and "minimum necessary" basis.
      i. The HIPAA and HITECH Acts imply that organizations must perform due diligence by actively auditing and monitoring for appropriate use of PHI. These audits are also required by the Joint Commission and are a component of the "Meaningful Use" requirements.
      ii. Access audits monitor who is accessing records by audit trails created in the systems. These audits allow us to detect unusual or unauthorized access of patient medical records.
      iii. Compliance performs between 300-500 audits monthly.
         1. Each audit ranges from hundreds of lines of data to thousands of lines of data.
      iv. Protenus has been selected to provide semi-automated auditing software services to NIHD, however, Athena has been unable to meet its requirements for the data feeds. Protenus will be reassessed as the changes to NIHD EHR evolve.
   b. Business Associates Agreements (BAA) audit
      i. Contracts are currently under review to ensure all vendors, individuals, and entities providing services that access, disclose, retain, or transmit PHI for NIHD have an up-to-date Business Associates Agreement.
      ii. We currently have around 150 Business Associates Agreements.
   c. PACS (Picture Archival and Communication System) User Access Agreements – Compliance is now processing access agreements for external entities/providers to gain access to the NIHD PACS Portal (electronic Imaging system).
   d. HIPAA Security Risk Assessment – Due November 2019

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   i. Annual requirement to assess security and privacy risk areas as defined in 45 CFR 164.3. Review of 157 privacy and security elements performed in conjunction with Information Technology Services.
   ii. Will work with ITS (Information Technology Services) to develop and update the Risk Management plan.
   iii. NIHD is currently in a "soft roll out" of the VendorMate (GHX) vendor credentialing software. This allows us to be compliant with our Vendor Credentialing Policy, and several facility security elements of 45 CFR 164

5. Conflicts of Interest questionnaires
   a. Compliance sent the Conflict of Interest Questionnaires out in the beginning of August 2019.
   b. We have received 47% of completed questionnaires from NIHD workforce.
   c. Those received have been preliminarily processed and are awaiting review by the Business Compliance Team.
6. CPRA (California Public Records Act) Requests
   a. The Compliance office has responded to 17 CPRA request in CY 2019.
      i. 3 requests throughout the year for companies that harvest purchasing data from healthcare organizations to aid their marketing products.
      ii. 1 from Transparent California
      iii. 8 are from District resident, Ms. Freeman.
      iv. 5 requests have been from the ASCFME organizer or their legal representatives.
7. Compliance Workplan (attachment C)
   a. The Department of Health and Human Services Office of Inspector General's (OIG) creates an annual workplan for auditing, based on areas of high concern for fraud, waste, and abuse. The Centers for Medicare/Medicaid Services Medicare Administrative contractors (MACs) also create an annual audit workplan.
   b. OIG recommends that annual Compliance Department workplans are created, based on the facility Compliance Program, and the OIG and MAC workplans, along with areas of risk for the organization.
   c. The attached work plan was updated in September 2019 for progress and is scheduled for review in the Compliance and Business Ethics Committee.

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8. Unusual Occurrence Reports (UOR) (Attachment D)
    a. All unusual events are reported through the UOR system. (complaints, med errors, unusual events, Corrective Action Plan tracking items, etc)
    b. See attached reports – please note while data has been validated, we are still getting the reports "dialed in"
        i. Some labeling needs to be corrected
        ii. Some layout features need to be corrected
    c. ComplyTrack- tracking software – system went live on 4/15/2019.
9. CDPH Licensing Survey Response Monitoring (Attachment E – please note that the corrective action plan portion of the spreadsheet was printed larger and placed in front of the pages with the complete charts)
    a. Compliance has been working with Department leadership teams to follow corrective actions and monitor for sustained compliance. Those metrics will be reported here, no less than annually. (see attached spreadsheet)
        i. E 239 - Referral arrangements from non-staff ordering providers. – Monitoring in progress 09/2019
        ii. E 242 - Pediatric Consultations – Monitoring in progress 09/2019
        iii. E 276 - Code Amber drills – Goal achieved. Monitoring complete.
        iv. E 280 - RN Competency Validations – Goal achieved. Monitoring complete.
        v. E 475 - Sterile compounding area ceiling - Goal achieved. Monitoring complete.
            Refrigerator temperature monitoring – Goal achieved. Monitoring complete.
        vi. E 479 - Malignant Hyperthermia cart – Goal achieved. Monitoring complete.
        vii. E 480 - Add crash cart medication list to Crash Cart Policy – Goal achieved. Monitoring complete
        viii. E 485 - Titratable sedatives and sedation scale use – Goal achieved. Monitoring complete
        ix. E 503 - Proper storage of clove oil in ED dental box – Clove oil removed from supplies and supply list. Goal achieved. Monitoring complete
        x. E 511 - Beyond-use-date labeling of medications – Goal achieved. Monitoring complete
        xi. E1363 - Expired supply in crash cart - Monitoring in progress 09/2019

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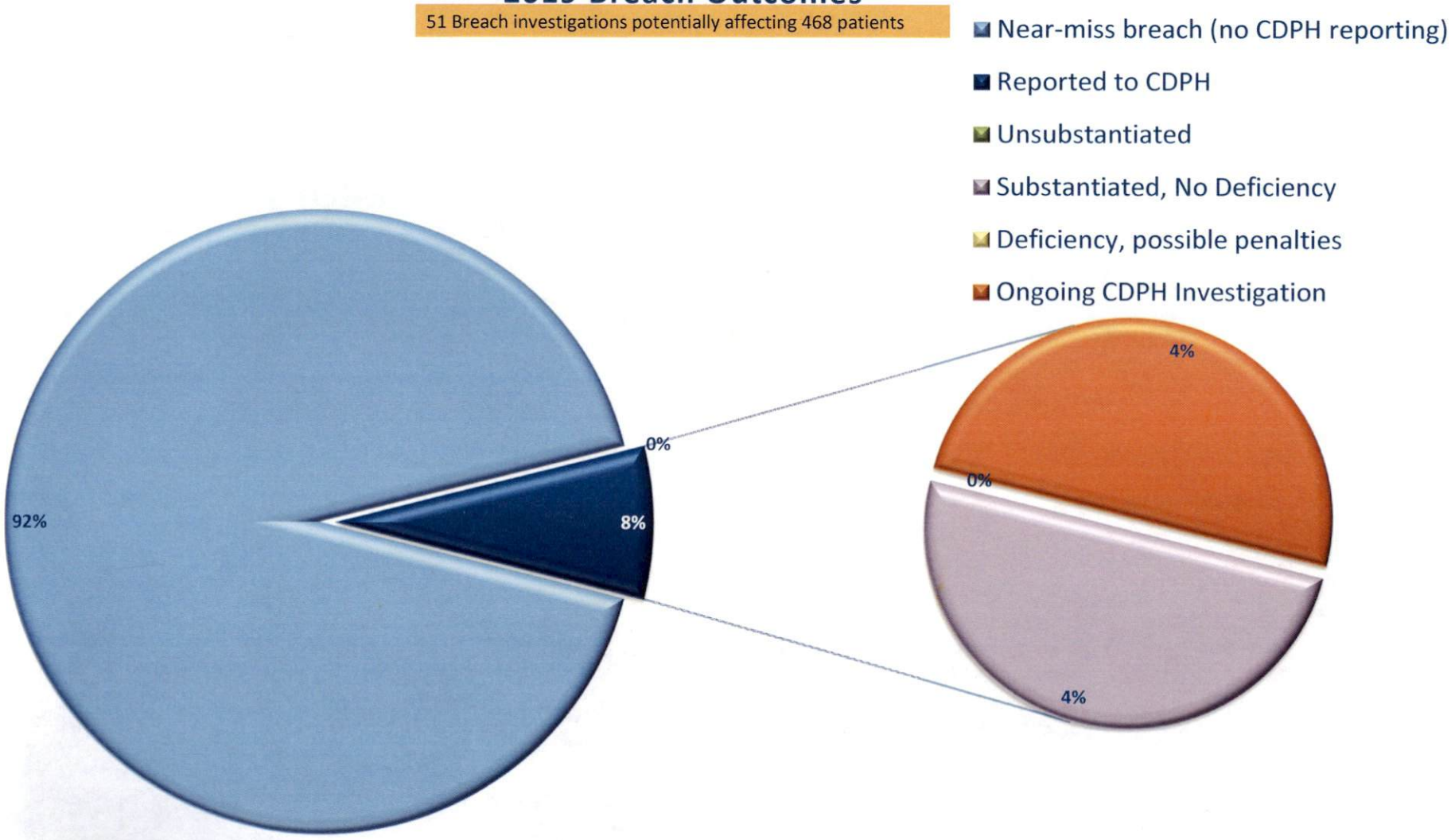
xii. E 2115 - TB Surveillance program – letter of compliance sent to CDPH. No additional monitoring is required.
xiii. E 2150 - Infection Prevention Program monitoring – Monitoring in progress 04/2019
    1. Infusion supplies - Goal achieved. Monitoring complete
    2. Cleaning Wet time – ongoing monitoring 09/2019
    3. Paper towel installed near sink – Complete
    4. Sterilized Instrument Packs - Goal achieved. Monitoring complete
    5. Crash Cart Supplies - Goal achieved. Monitoring complete
    6. Patient Refrigerators marked- Goal achieved. Monitoring complete
    7. Single Use Thickener packets - Goal achieved. Monitoring complete
xiv. E 2151 - Workforce N95 mask fit testing – Goal achieved. Quarterly monitoring for 3 additional quarters.
xv. E 2354 - Equipment preventative maintenance stickers – Goal achieved. Monitoring complete

10. The Joint Commission Survey Response
    a. Submitted and accepted
    b. Will provide monitoring in next quarterly report

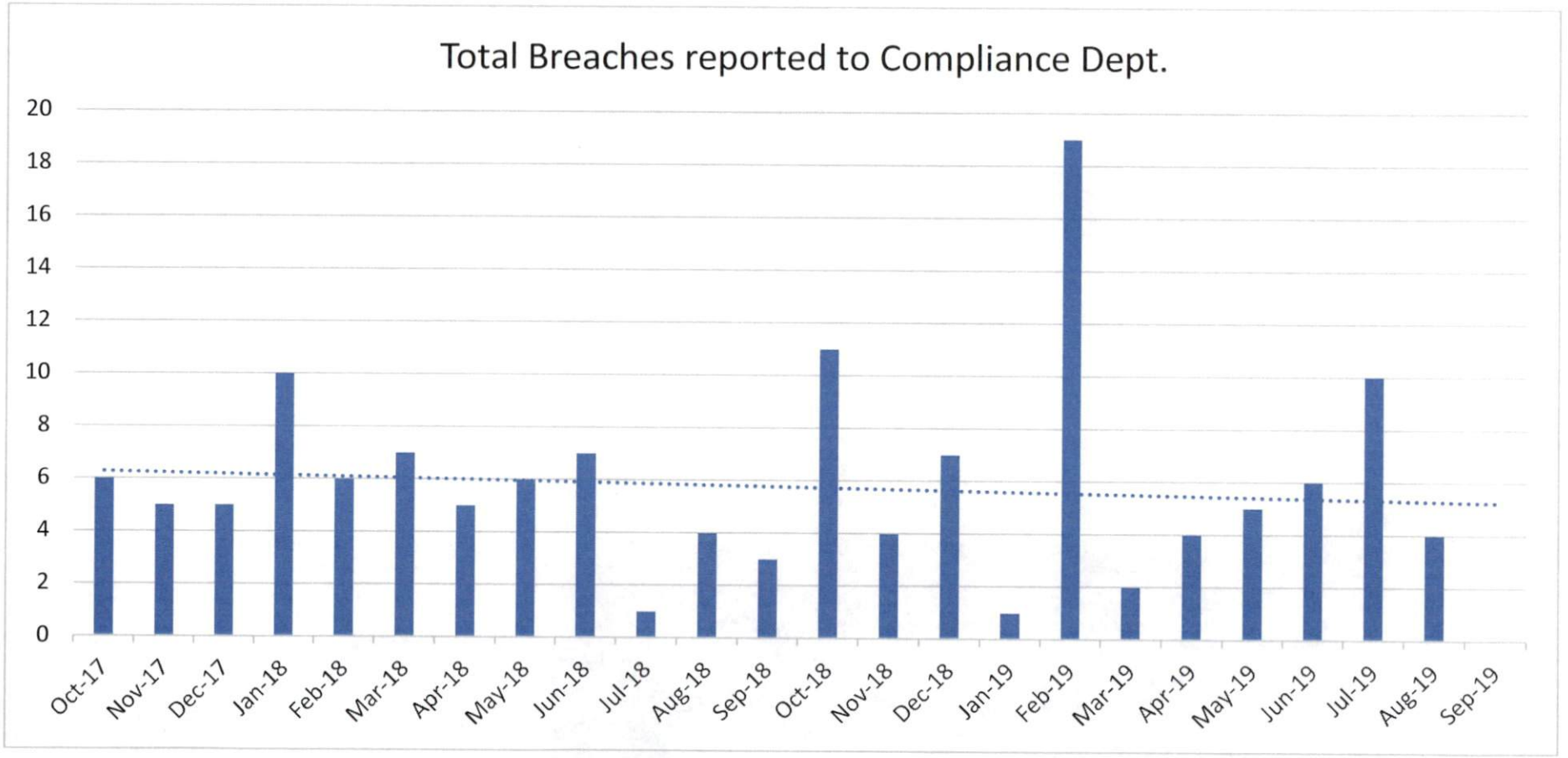
2019 Breach Outcomes

51 Breach investigations potentially affecting 468 patients



Sept 1, 2019

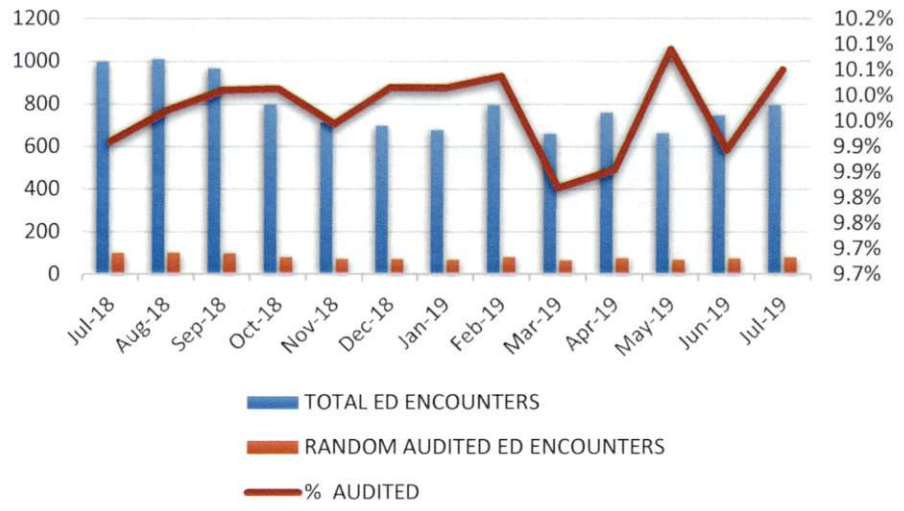
Attachment A


Total Breaches reported to Compliance Dept.
20
18
16
14
12
10
8
6
4
2
0
Oct-17
Nov-17
Dec-17
Jan-18
Feb-18
Mar-18
Apr-18
May-18
Jun-18
Jul-18
Aug-18
Sep-18
Oct-18
Nov-18
Dec-18
Jan-19
Feb-19
Mar-19
Apr-19
May-19
Jun-19
Jul-19
Aug-19
Sep-19

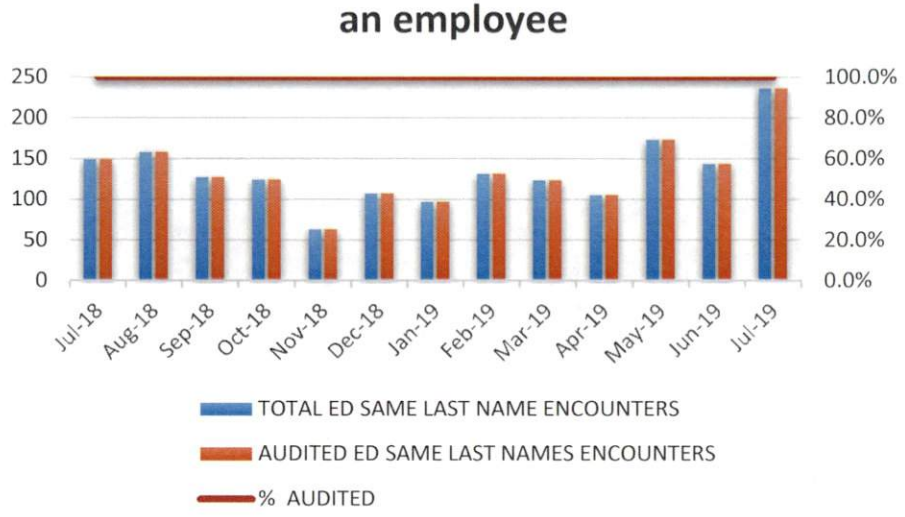
Employee EHR Access Audits

Emergency Room Encounters

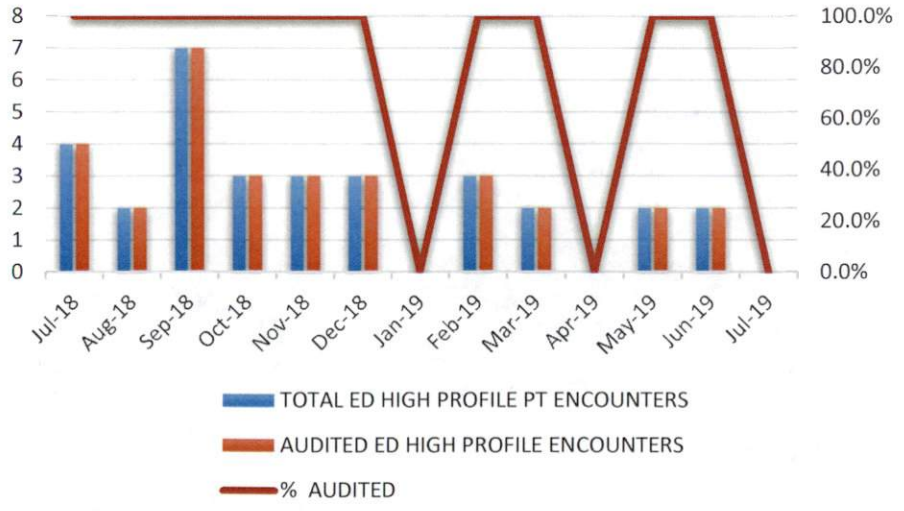
Random ED Encounter Audits



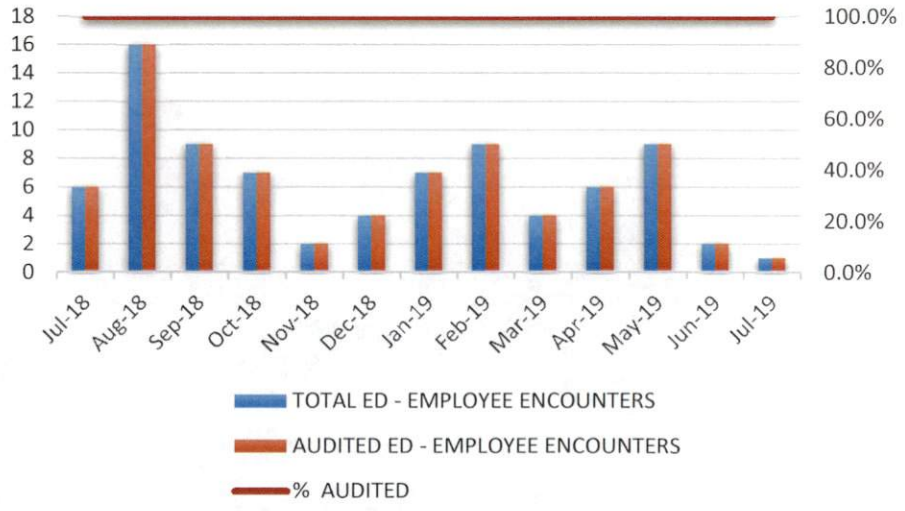
ED Patient with the same last name as an employee



HPP ED Encounters



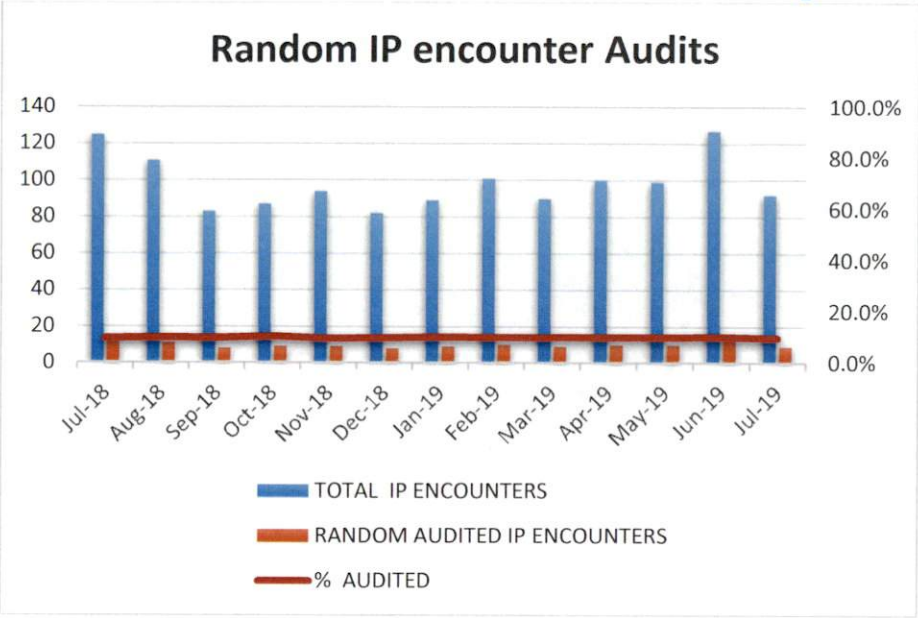
Employee ED Encounters

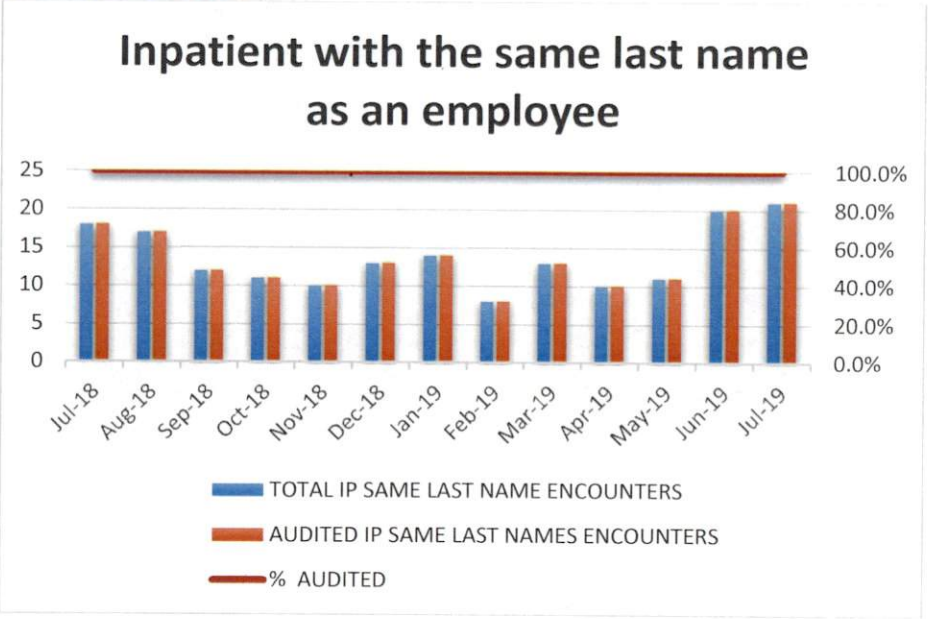


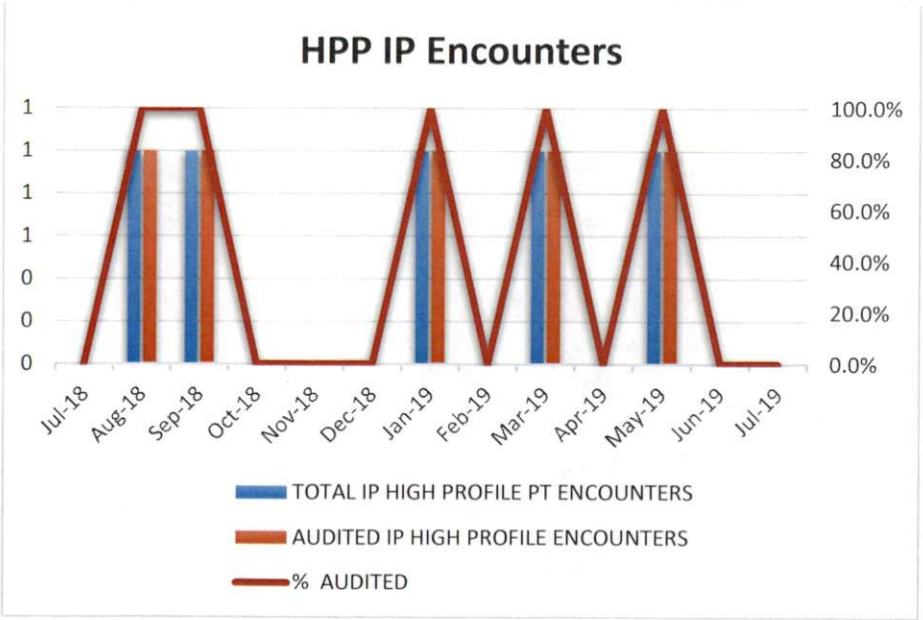
Attachment B

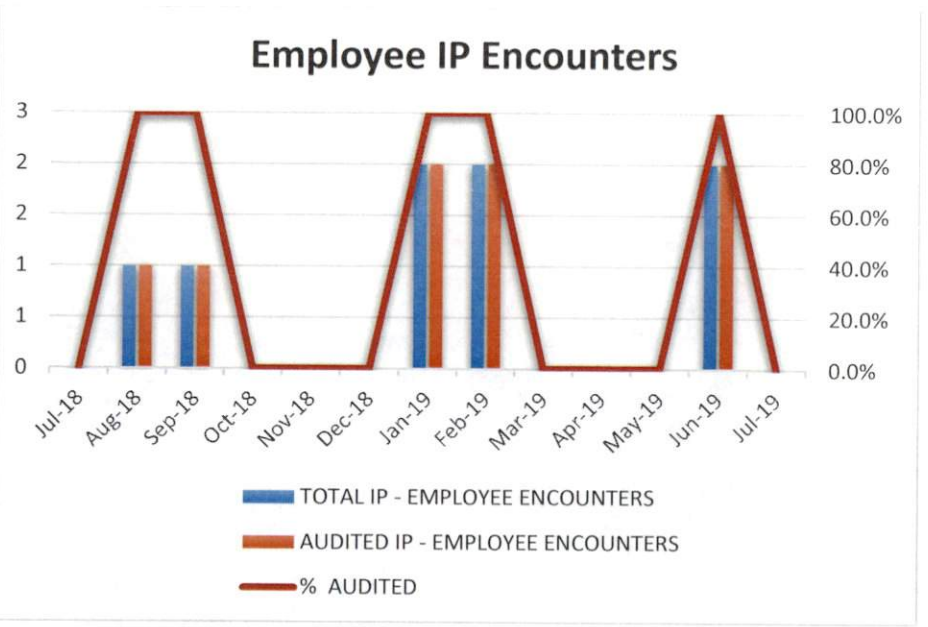
Employee EHR Access Audits

Inpatient Encounters

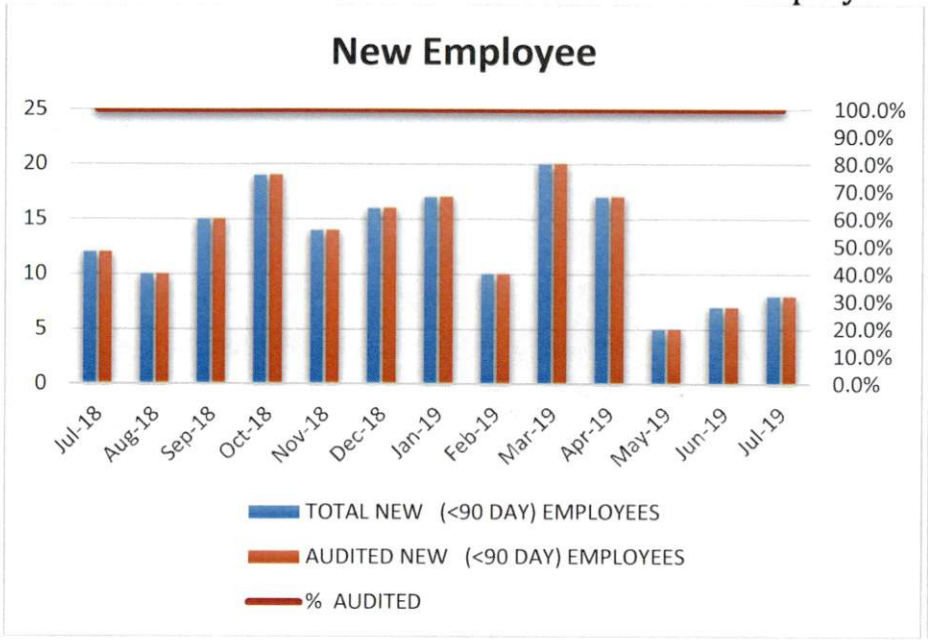


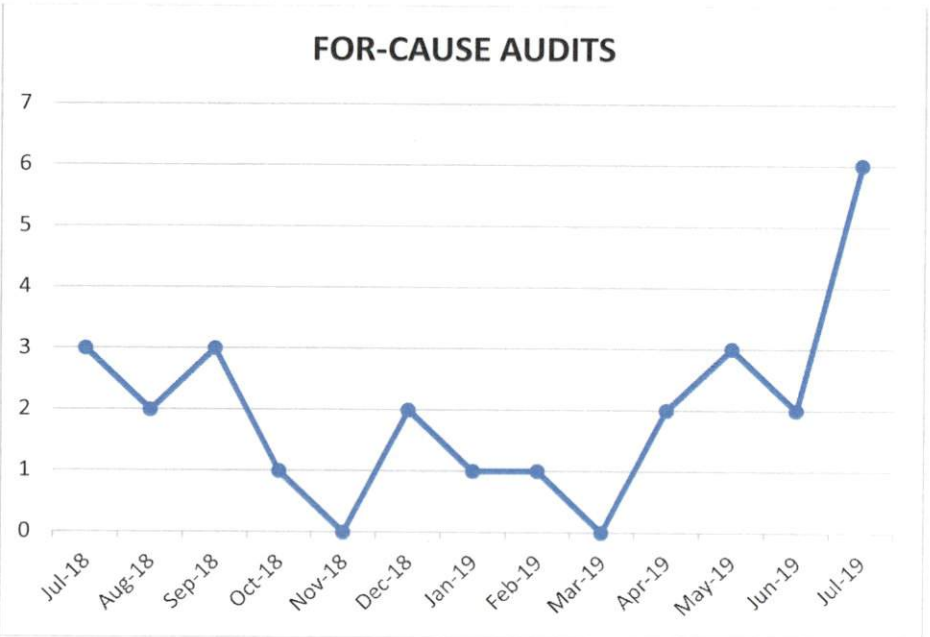


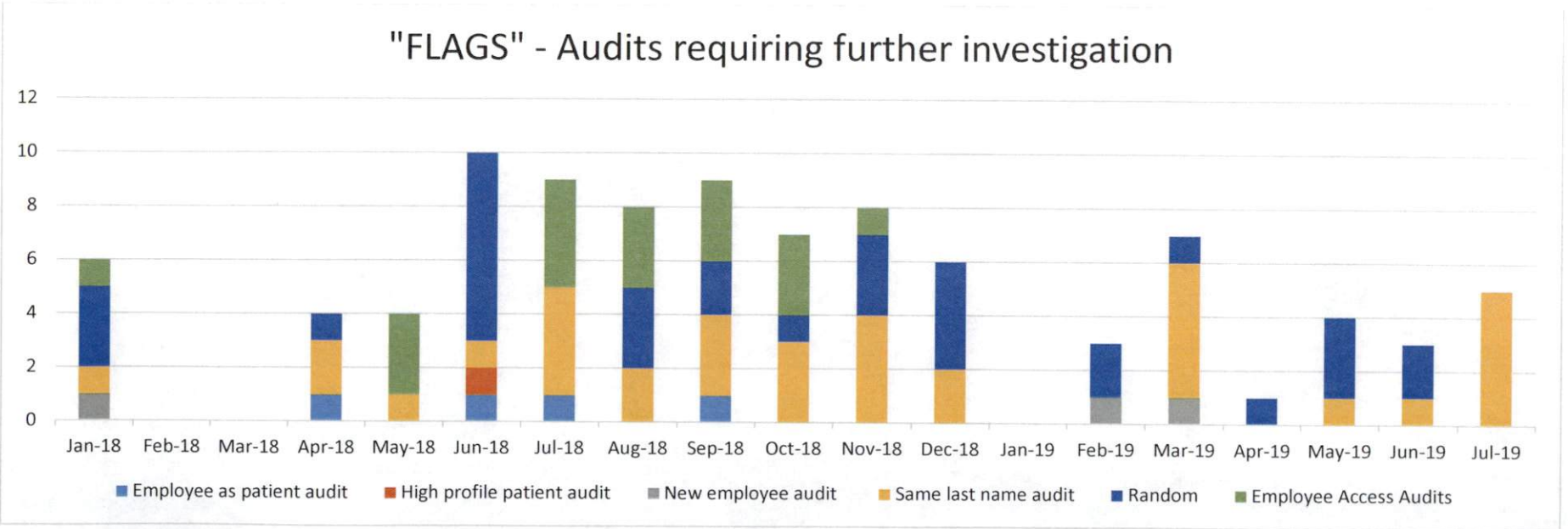




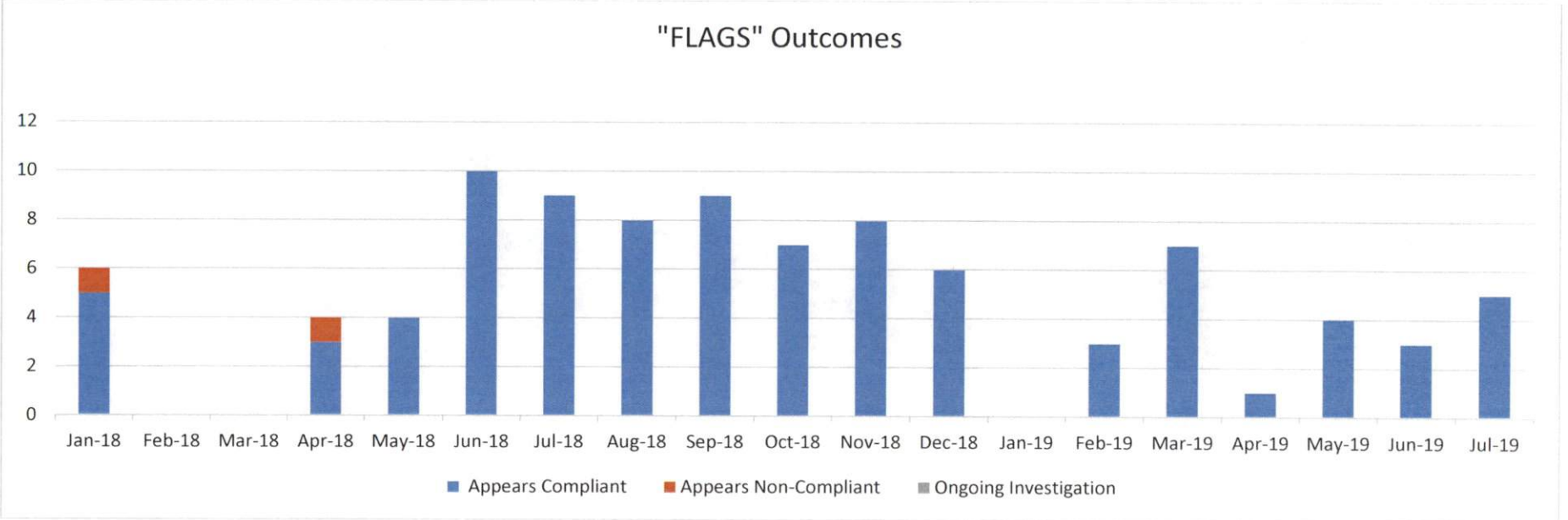
Employee EHR Access Audits







Employee EHR Access Audits

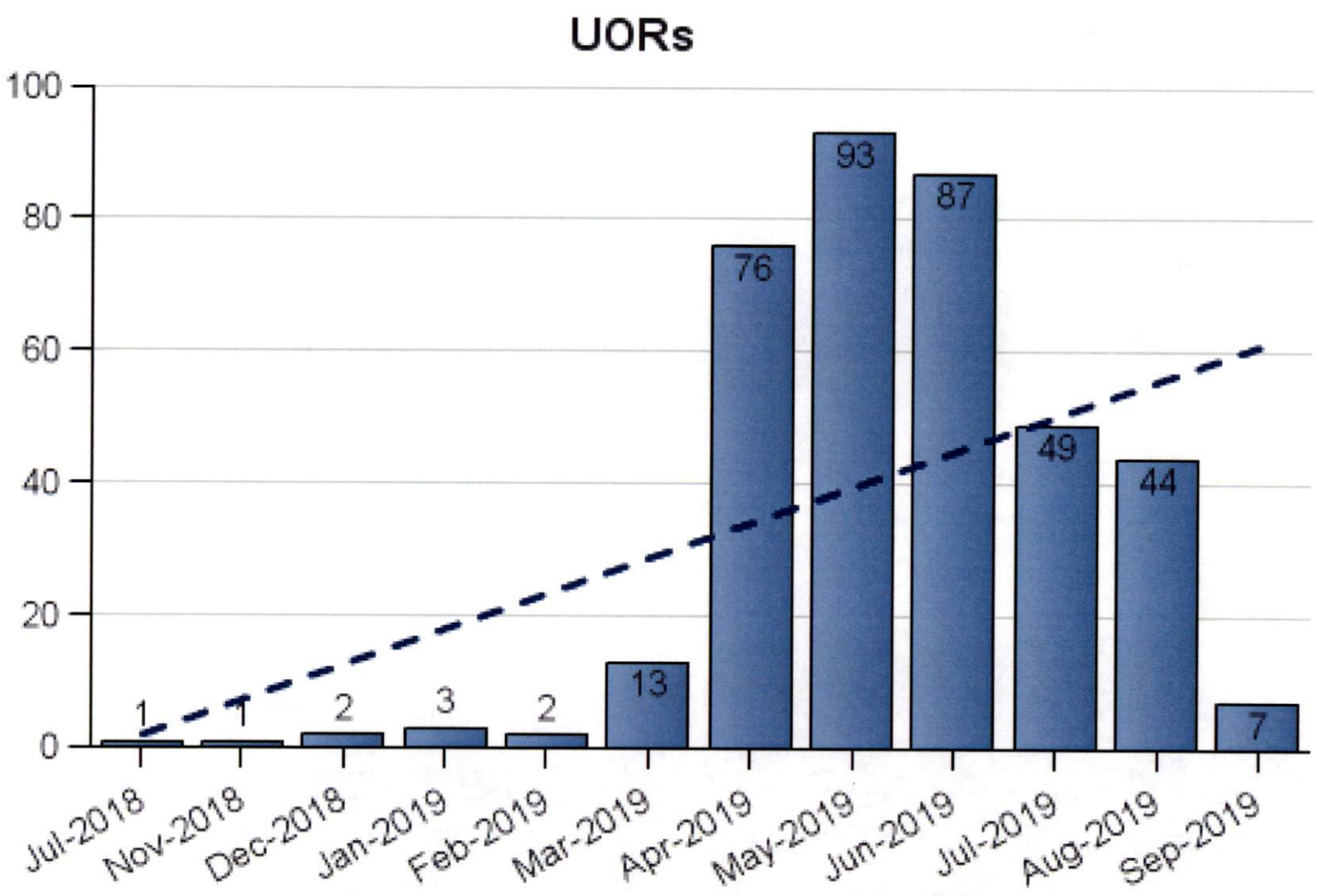


Attachment C

No.	Item	Reference	Comments
Compliance Oversight and Management			
1.	Review and update charters and policies related to the duties and responsibilities of the Compliance Committees.	NIHD Compliance Program (p.17)	Completed Jan 2019
2.	Develop and deliver the annual briefing and training for the Board on changes in the regulatory and legal environment, along with their duties and responsibilities in oversight of the Compliance Program.	NIHD Compliance Program (p.17)	Colin Coffey, Jan 2019. "Takeaways" from monthly HCCA magazine
3.	Develop a Compliance Department budget to ensure sufficient staff and other resources to fully meet obligations and responsibilities.		2019 budget pending Exec team guidance
Written Compliance Guidance			
4.	Audit of required Compliance related policies.		Annual review conducted on regular monthly schedule Throughout the year
5.	Annual review of Code of Conduct to ensure that it currently meets the needs of the organization and is consistent with current policies. (Note: Less than 12 pages, 10 grade reading level or below)		9/1/2019 - Completed
6.	Verify that the Code of Conduct has been disseminated to all new employees and workforce.		Completed Aug 2019
Compliance Education and Training			
7.	Verify all workforce receive compliance training and that documentation exists to support results. Report results to Compliance Committee.		79.33% See attached
8.	Ensure all claims processing staff receive specialized training programs on proper documentation and coding.	In progress following Athena go-live	
9.	Review and assess role-based access for EHR and partner programs. Implement/evaluate standardized process to assign role-based access.	R-BAT created 7/2018. Currently working with Athena to update RBA controls.	Stalled – Athena does not have the necessary level of granularity in security.
10.	Compliance training programs: fraud and abuse laws, coding requirements, claim development and submission processes, general prohibitions on paying or receiving remuneration to induce referrals and other current legal standards.	Completed at Orientation.	Completed at orientation – current through 9/1/2019

Compliance Communication			
11.	Review investigation log. Prepare summary report for Compliance Committee on types of issues reported and resolution		Quarterly 2019
12.	Develop a report that evidences prompt documenting, processing, and resolution of complaints and allegations received by the Compliance Department.	Complytrack	Completed April 2019
13.	Document test and review of Compliance Hotline.		Completed 09/06/2019
14.	Physically verify Compliance hotline posters appear prominently on employee boards in work areas.		Verified 9/2019
Compliance Enforcement and Sanction Screening			
15.	Verify that sanction screening of all employees/workforce and others engaged by NIHD against OIG List of Excluded Individuals and Entities has been performed in a timely manner, and is documented by a responsible party.	Ongoing – HR performs employees/travelers/temps monthly. Compliance verifies new providers. MSO verifies all medical staff. Accounting verifies all vendors.	Current through 8/31/2019
16.	Develop a review and prepare a report regarding whether all actions relating to the enforcement of disciplinary standards are properly documented.		Stalled
17.	Audits		
	a. Arrangements with physician (database)		
	b. EMTALA		
	c. Cost reports	Wipfli	
	d. Payment patterns		
	e. Bad debt/ credit balances	Will work with J. Tremble.	
	f. OPS – Home health and DME	HHS OIG target	Initial meet with P West 1/2019
	Lab services	MAC target	
	Imaging services (high cost/high usuage)	MAC target	
	Rehab services	HHS OIG workplan	
18.	Ensure that high risks associated with HIPAA and HITECH Privacy and Security requirements for protecting health information undergo a compliance review.		Due November 2019
	a. Annual Security Risk Assessment		Due November 2019
	b. Periodic update to SRA		
	c. Monthly employee access audits		Current through 09/2019
19.	Audit required signage		Completed 07/2019
20.	Audit HIMS scanned document accuracy		

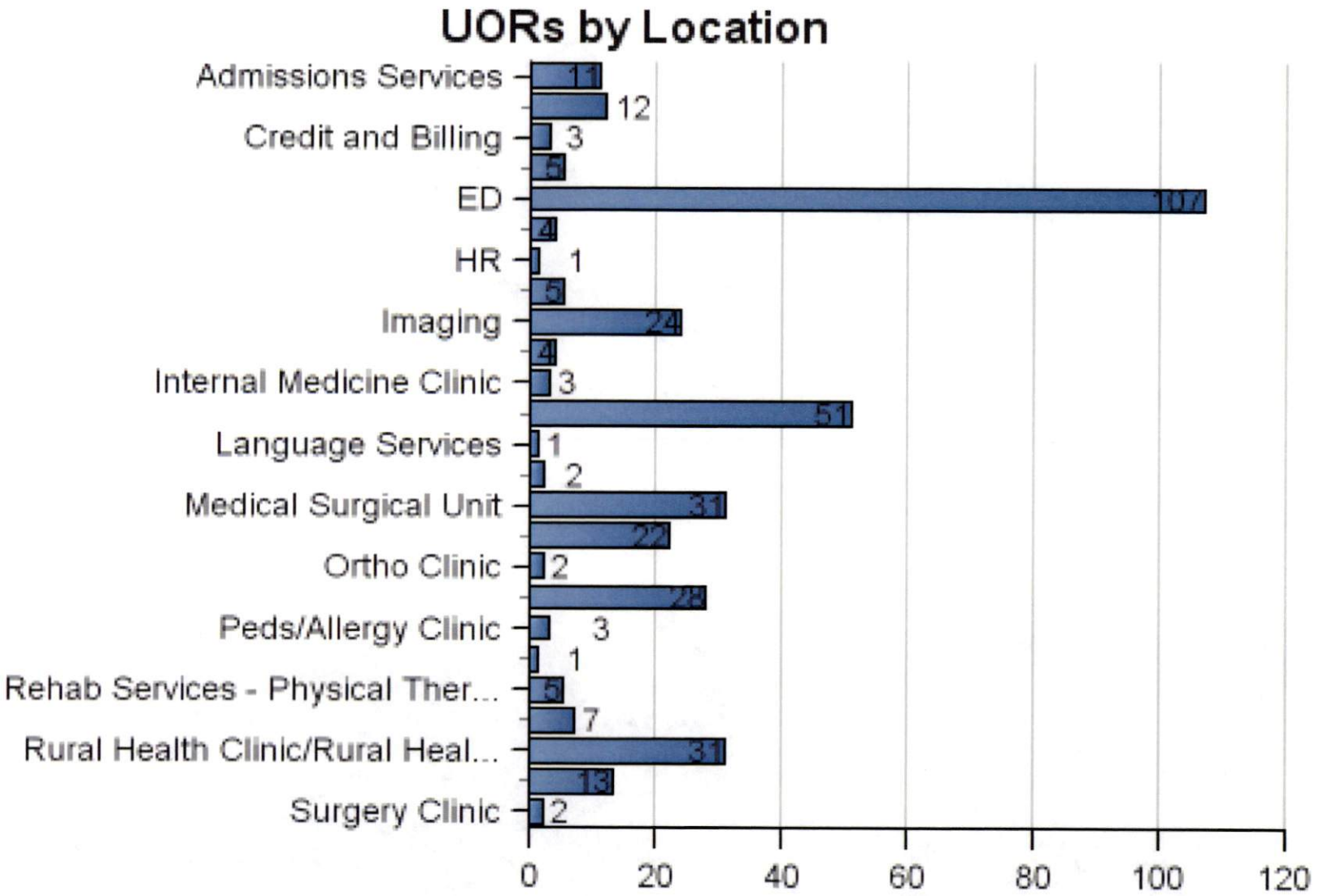
21.	Develop metrics to assess the effectiveness and progress of the Compliance Program		
22.	Implement automated access monitoring/auditing software (Protenus)		Stalled. Athena unable to complete file feeds or datalake/data warehouse
23.	~~Review CMS CoPs (CAH)~~		Delayed due to restructure
Response to Detected Problems and Corrective Action			
24.	Verify that all identified issues related to potential fraud are promptly investigated and documented		8/2019 – and ongoing
25.	Review all corrective action measures taken related to compliance to verify they have been completed and validated as being effective. Prepare a summary report for the CBEC		Monitoring for CDPH/TJC CAPS in progress
26.	Conduct a review that ensures all identified overpayments are promptly reported and repaid.	Working with WJ, MET, HIMS dept to review all audits, recoupments	7/2019
27.	UOR tracking and trending – UOR/Unusual occurrence reporting is now a function of the Compliance Department.		See UOR reporting attached to Board Report (9/2019)
	a. Provide trend feedback to leadership to allow for data driven decision-making		Quarterly (9/2019)
	I. Overall QRR process		Sept 2019
	II. Workplace Violence		Sept 2019
	III. Sharps		Sept 2019
	IV. Overweight laundry		In PDSA cycle
28.	Pioneer Home Health and Hospice of the Owens Valley Compliance Review, ACE agreement		8/2019
29.	Patient complaints	In Progress	Restructure adds these to Compliance Workplan
30.	Breach Investigations	On-going	On-going – see Compliance reports



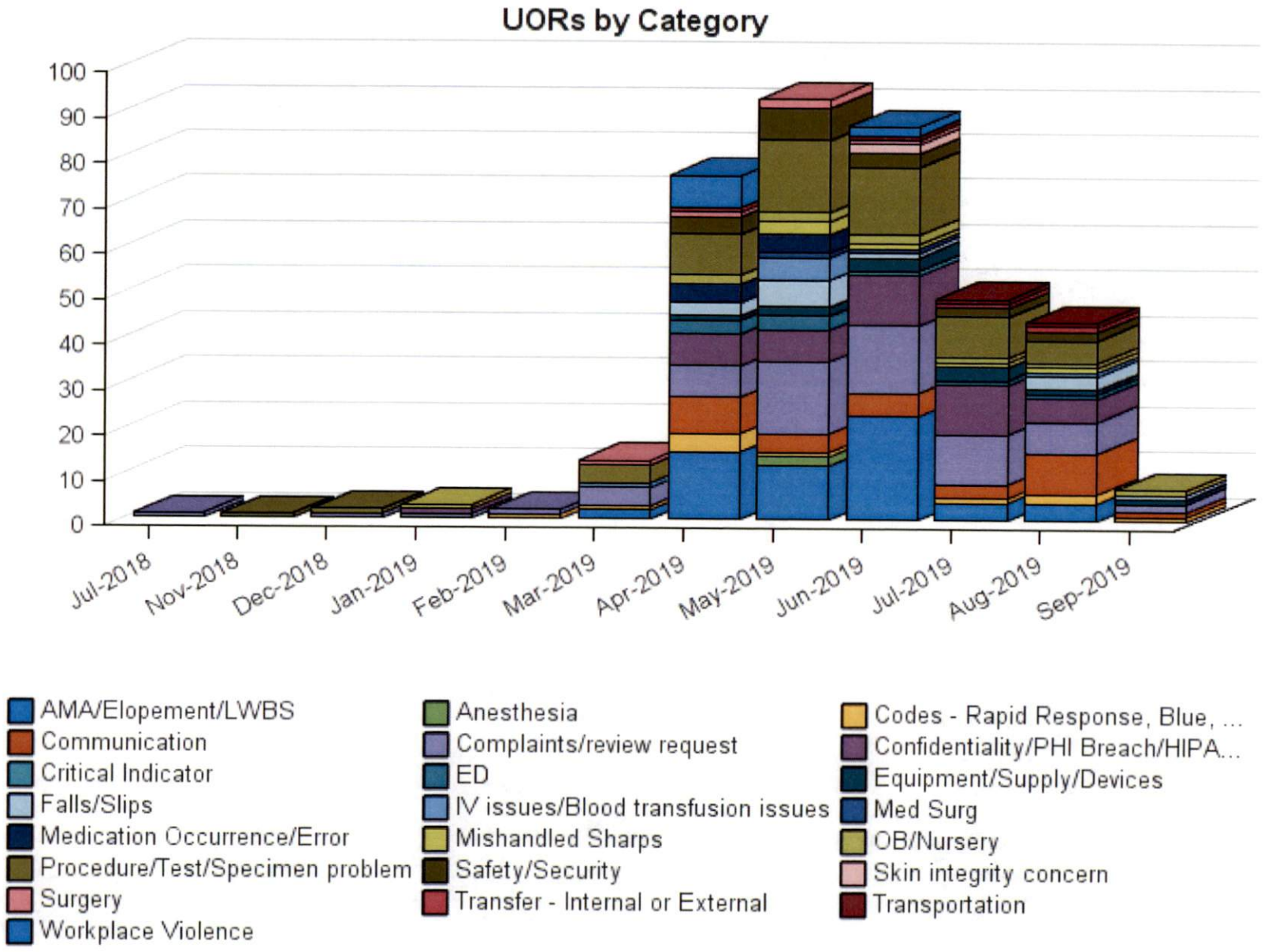
UOR reporting through the ComplyTrack System started on 04/15/2019.

Some incidents show up before this date, as they were reported after 4/15, but the incident occurred prior to that date.

Attachment D

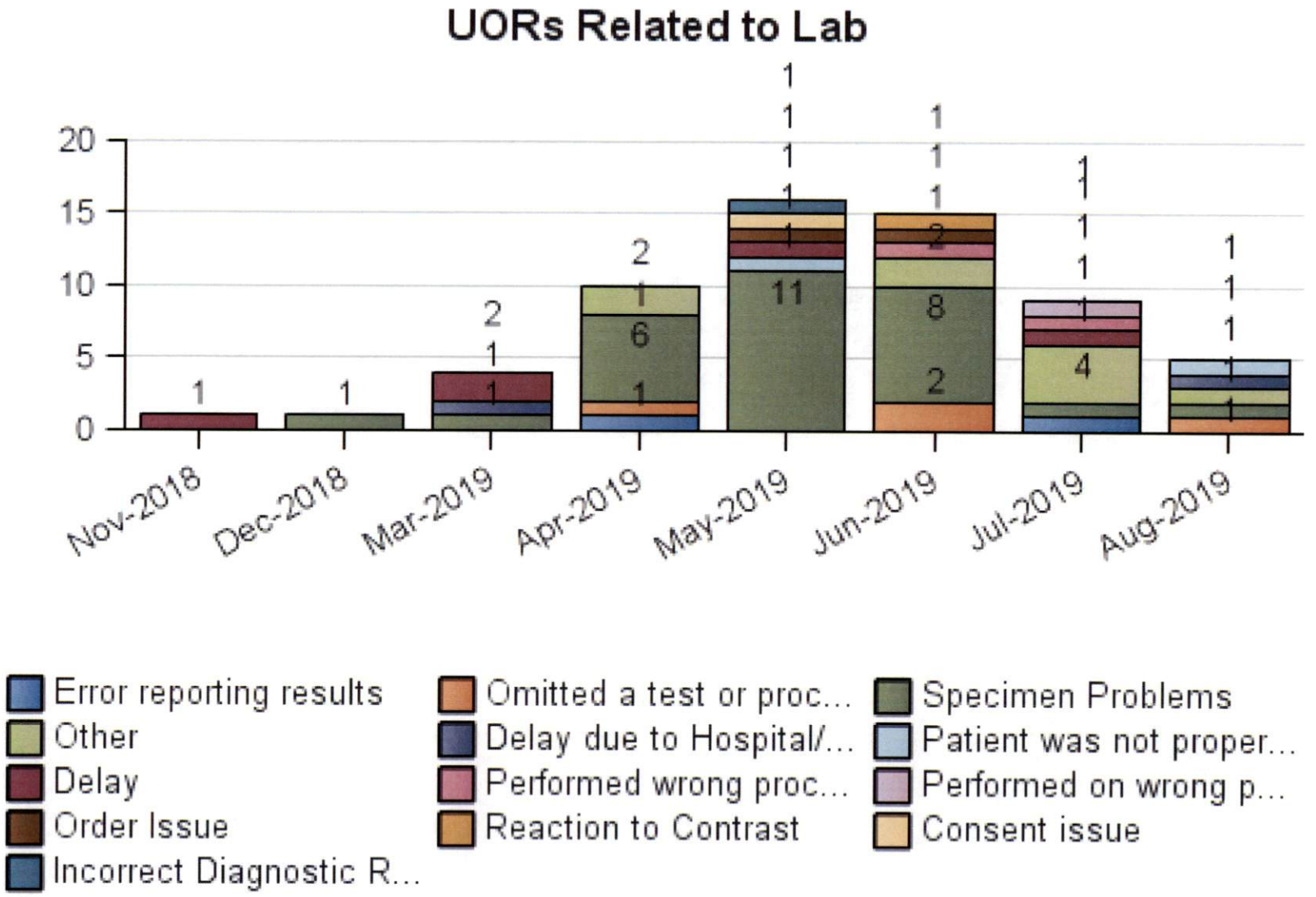


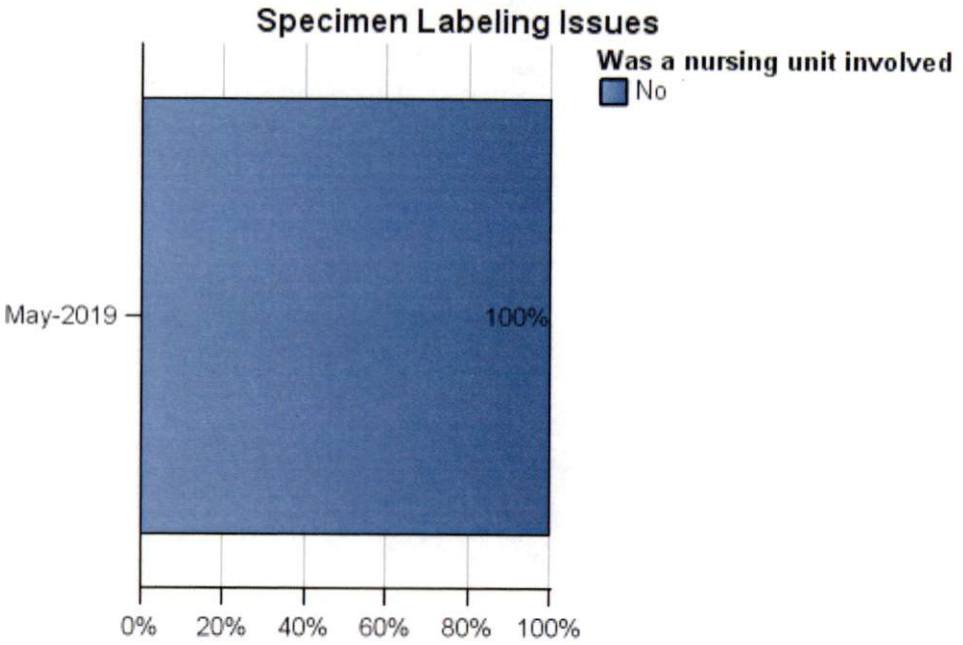
Compliance is working with report writing experts at Complytrack to ensure all labeling shows up. I currently do not have the ability to get the additional lines of information to print on the chart.

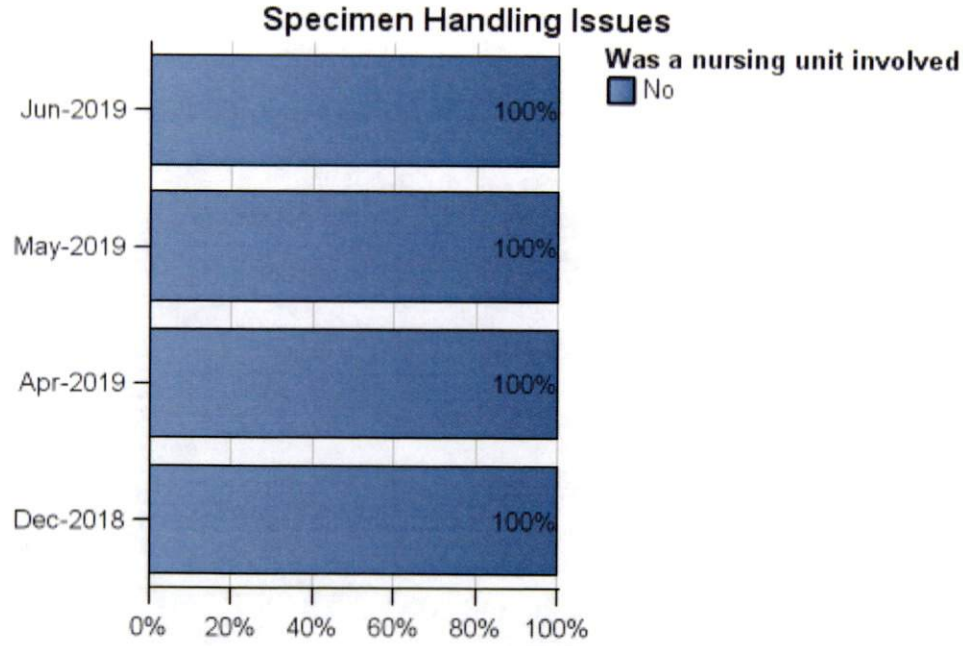


Data for chart on next page

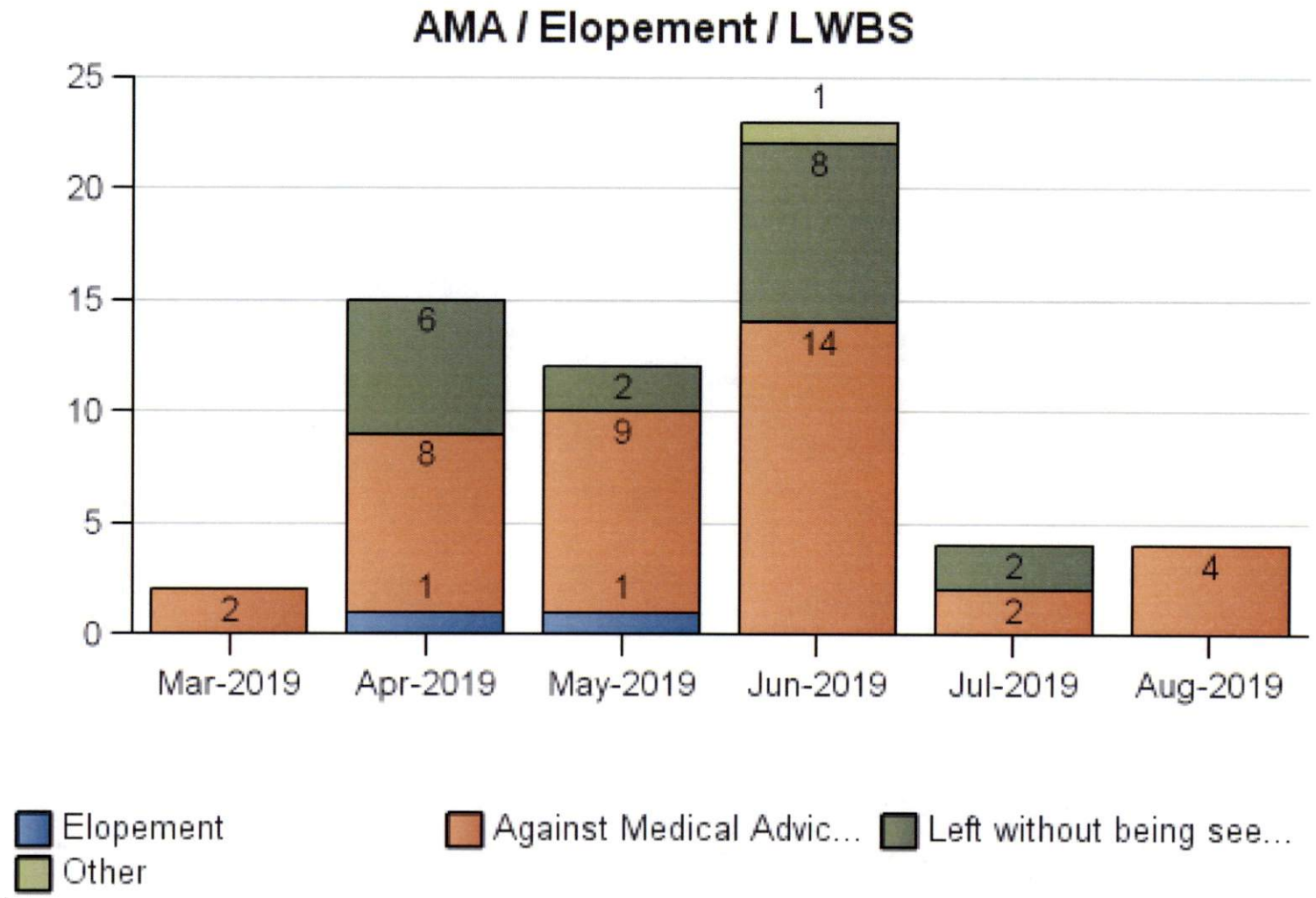
	Jul-2018	Nov-2018	Dec-2018	Jan-2019	Feb-2019	Mar-2019	Apr-2019	May-2019	Jun-2019	Jul-2019	Aug-2019	Sep-2019	Total
AMA/Elopement/LWBS						2	15	12	23	4	4		**60**
Anesthesia								2					**2**
Codes - Rapid Response, Blue, Deescalation					1	1	4	1		1	2	1	**11**
Communication							8	4	5	3	9	1	**30**
Complaints/review request	1		1	1	1	4	7	16	15	11	7	2	**66**
Confidentiality/PHI Breach/HIPAA violation				1			7	7	11	11	5		**42**
Critical Indicator									1				**1**
ED							3	3		1	1		**8**
Equipment/Supply/Devices							1	2	3	3	1	1	**11**
Falls/Slips							3	6	1		3	1	**14**
IV issues/Blood transfusion issues						1		5			1		**7**
Med Surg								1	1				**2**
Medication Occurrence/Error							4	4					**8**
Mishandled Sharps				1				3	1	1	1		**7**
OB/Nursery							2	2	2	1	1	1	**9**
Procedure/Test/Specimen problem		1	1			4	9	16	15	9	5		**60**
Safety/Security							4	7	3	2	2		**18**
Skin integrity concern									2				**2**
Surgery						1	1	2	1				**5**
Transfer - Internal or External							1			1	1		**3**
Transportation									1	1	1		**3**
Workplace Violence							7		2				**9**
Total	**1**	**1**	**2**	**3**	**2**	**13**	**76**	**93**	**87**	**49**	**44**	**7**	**378**


UORs Related to Lab
20
15
10
5
0
Nov-2018
Dec-2018
Mar-2019
Apr-2019
May-2019
Jun-2019
Jul-2019
Aug-2019
Error reporting results
Other
Delay
Order Issue
Incorrect Diagnostic R...
Omitted a test or proc...
Delay due to Hospital/...
Performed wrong proc...
Reaction to Contrast
Specimen Problems
Patient was not proper...
Performed on wrong p...
Consent issue





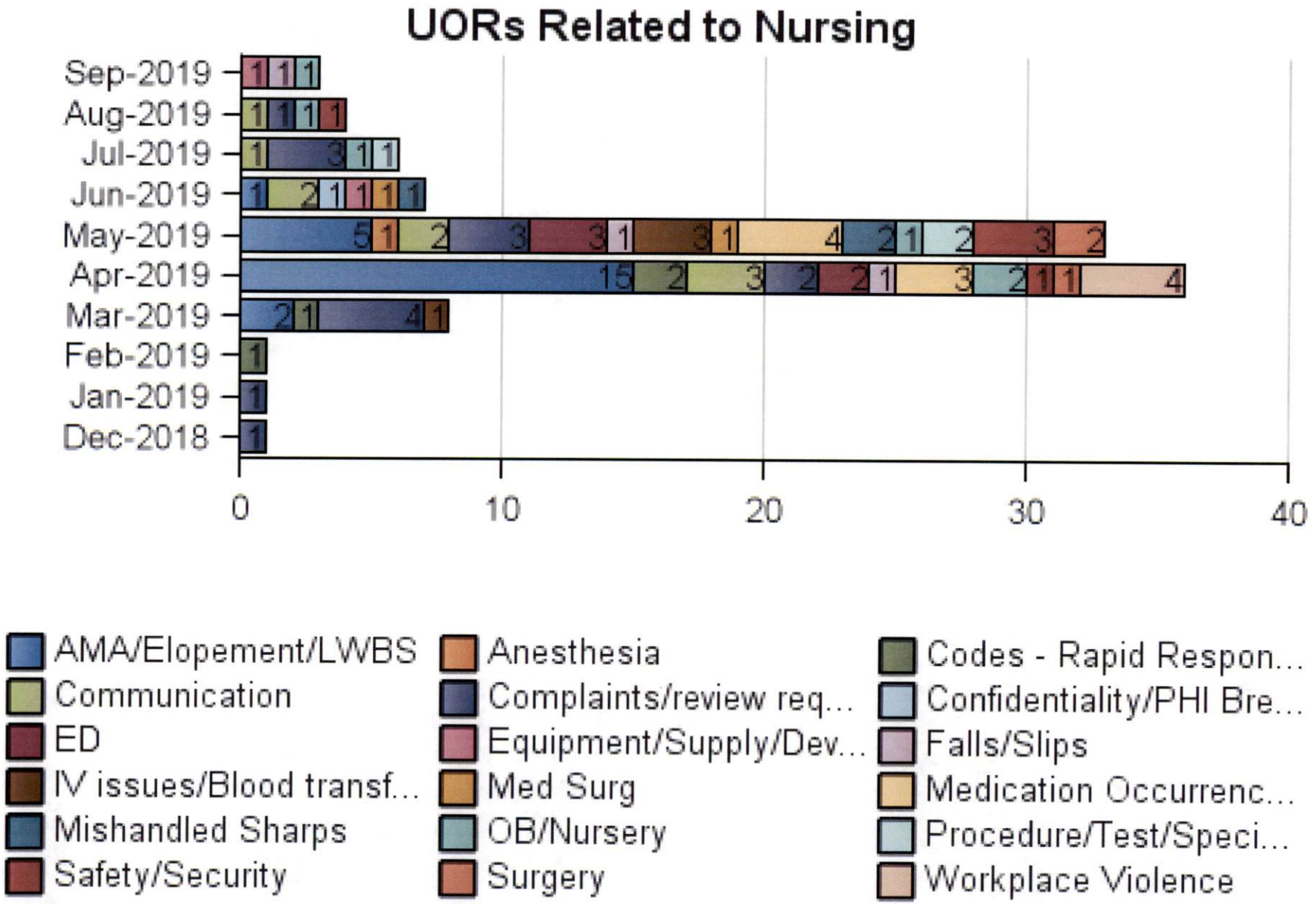
This area was a focus for the Professional Practice Council.



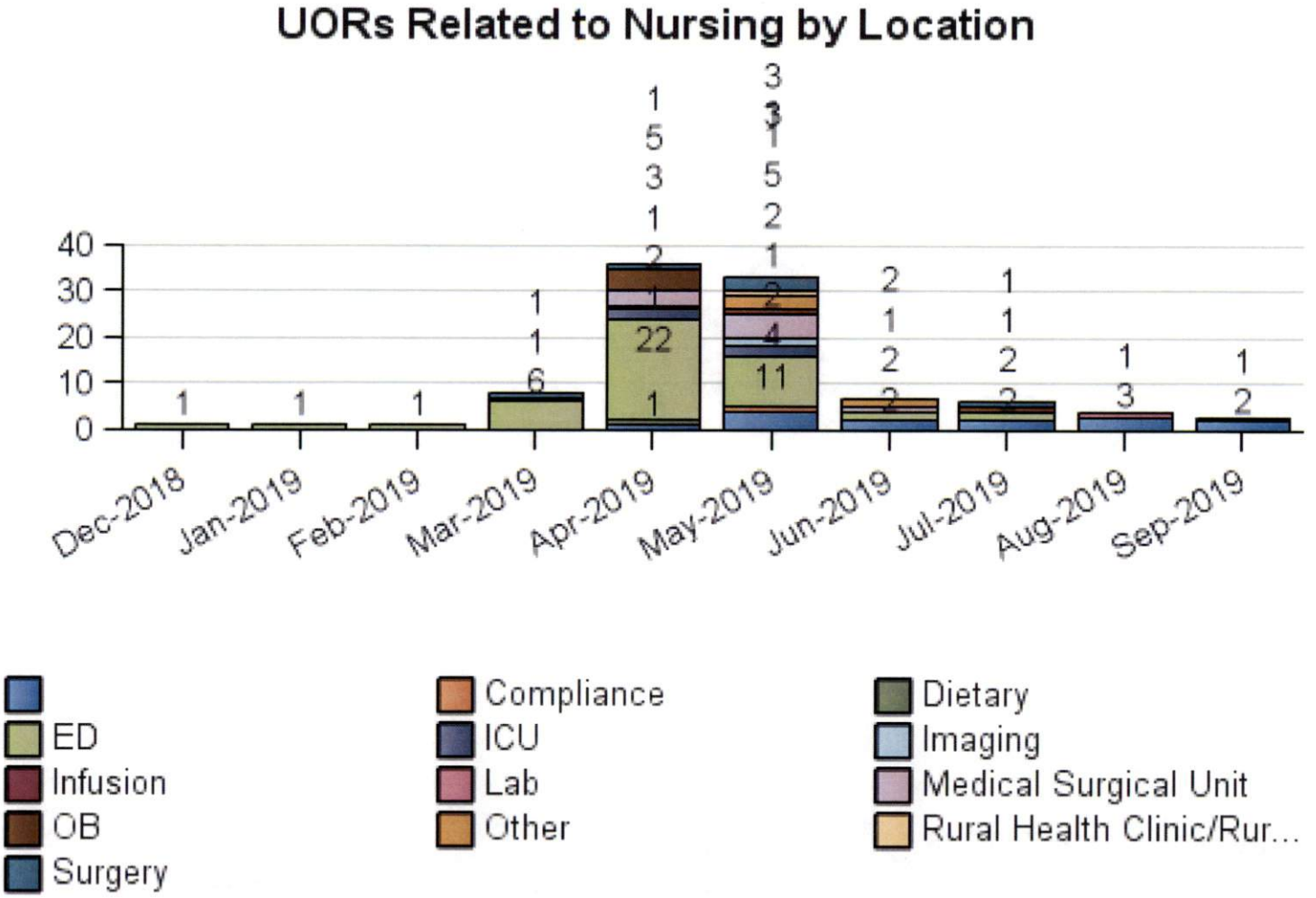
Emergency updated their critical indicators in July to no longer include Against Medical Advice.

The drop off in reported "AMA" UORs is explained by this change.

We are working to break out AMA/Left Without Being Seen/Elopements by month and by location.



The question on the UOR form asking about whether nursing was involved was rephrased to more clearly state whether "Nursing Practice" may have had an effect on the UOR in late May, with input of some of our nursing team. This greatly reduced the "UORs related to nursing" and appears to be a much better reflection of whether nursing practice may need to be reviewed.



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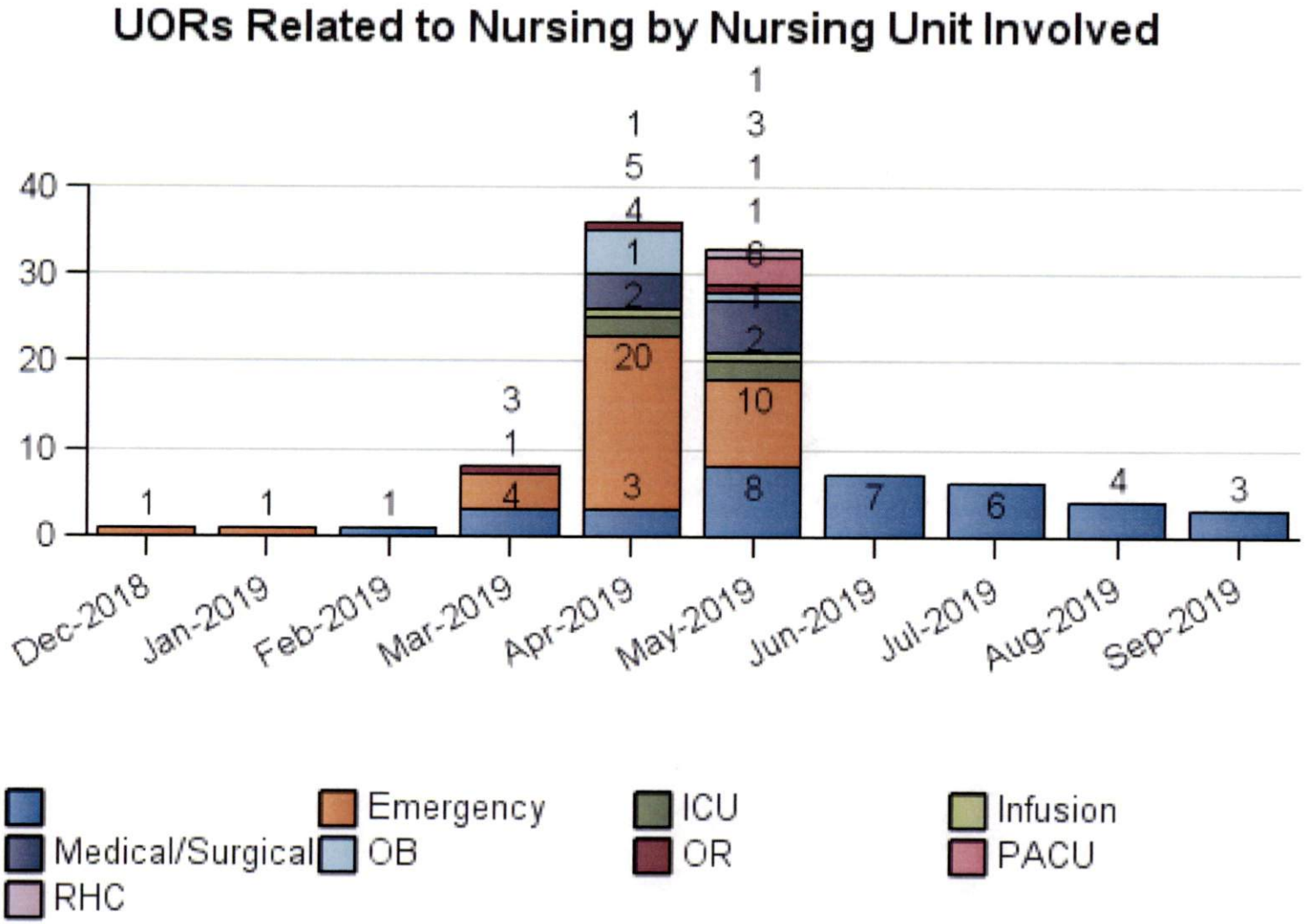

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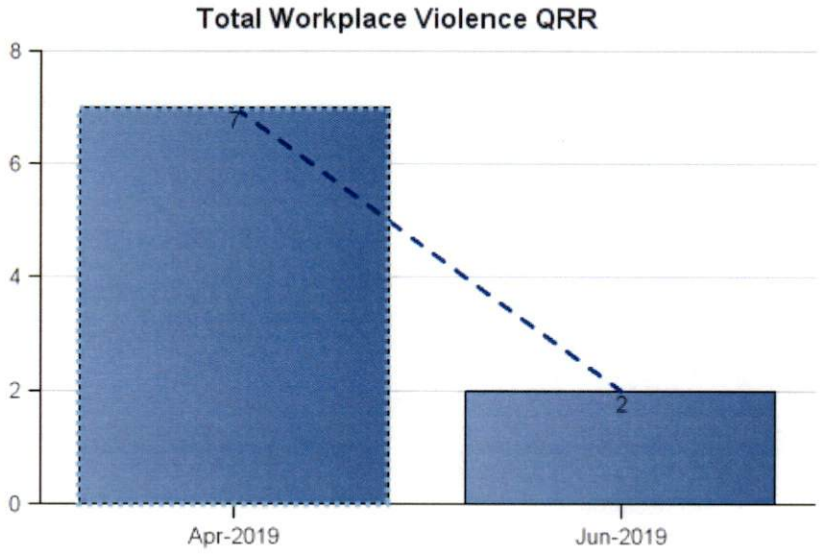
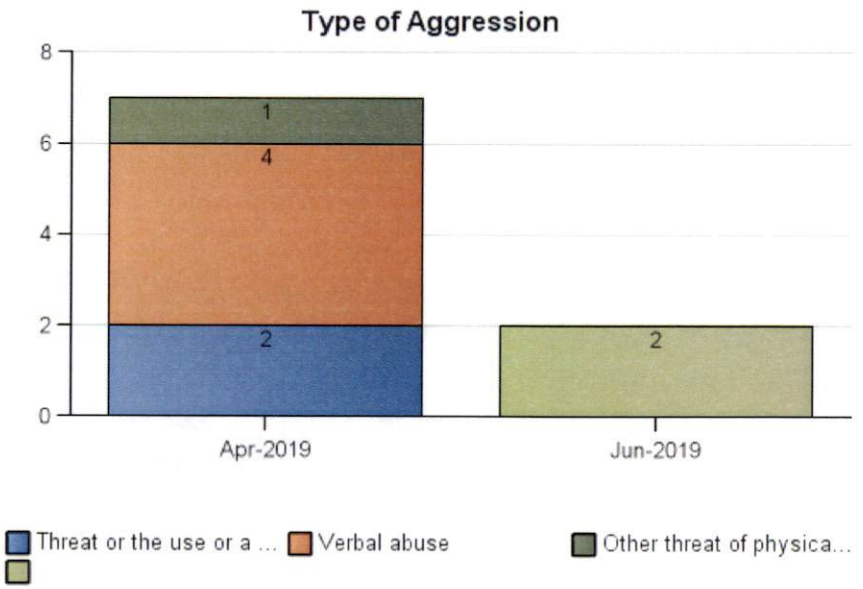
We are working with Complytrack report writing experts to fix formatting and labeling issues, as seen in this graph.





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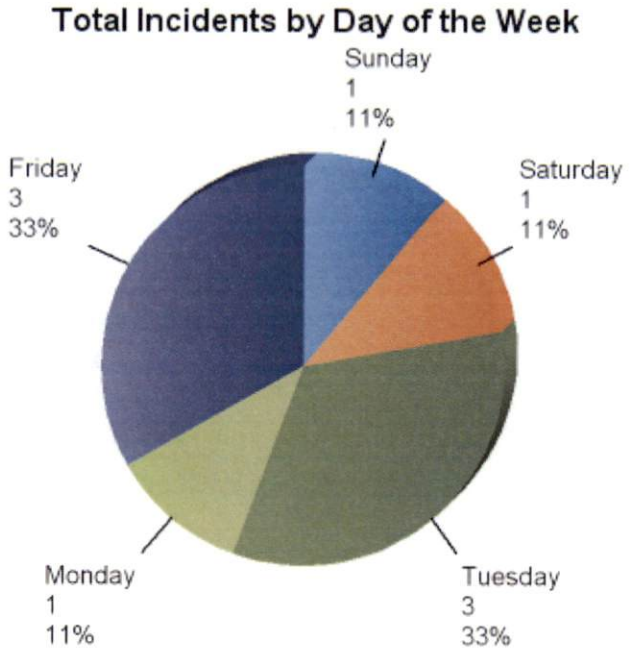

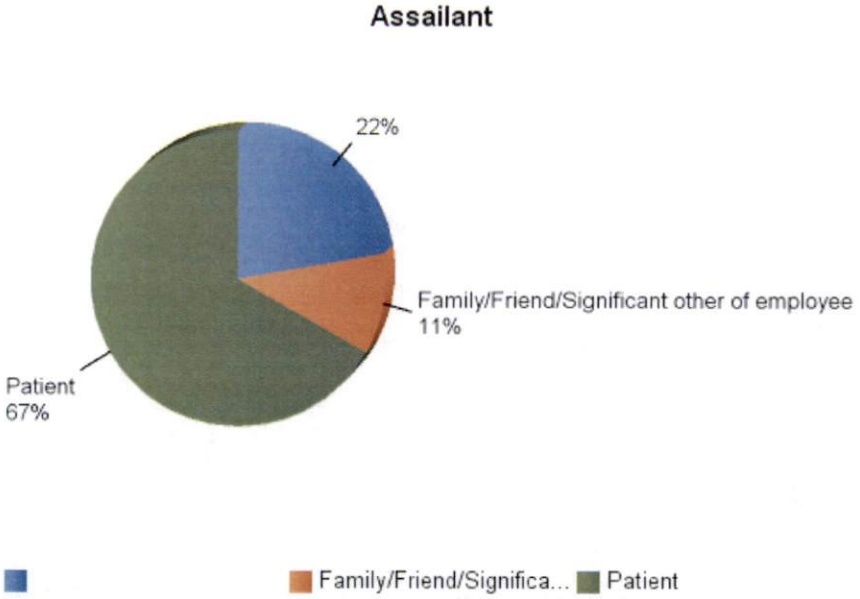

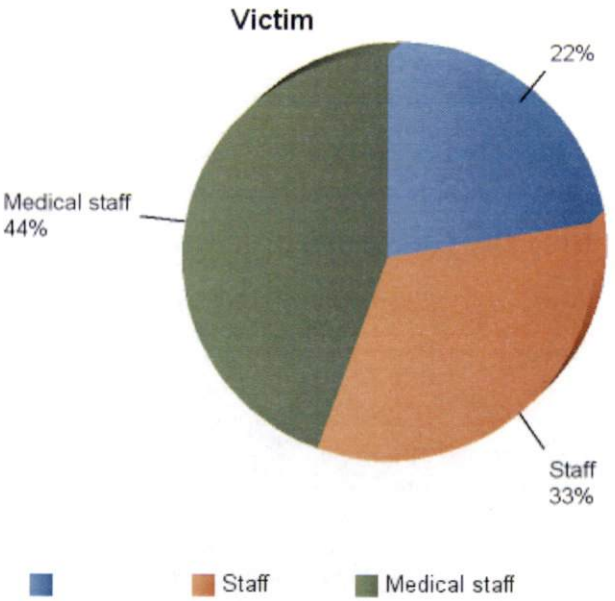

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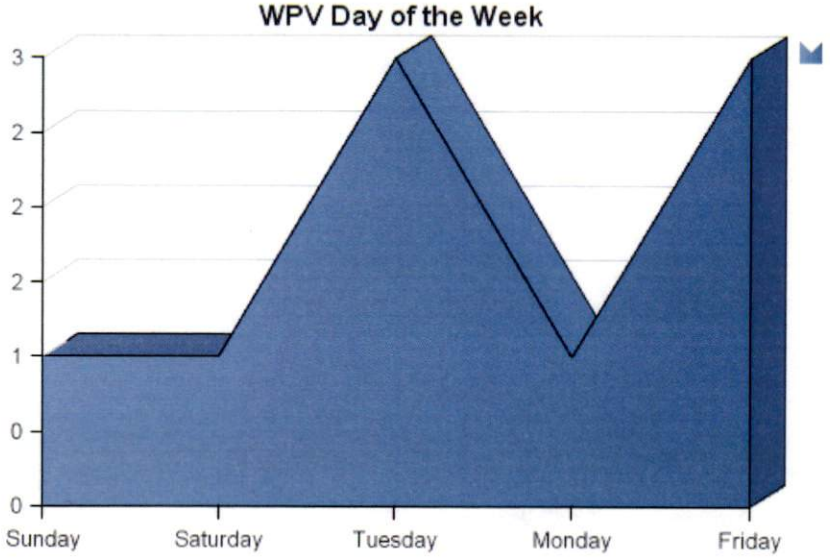

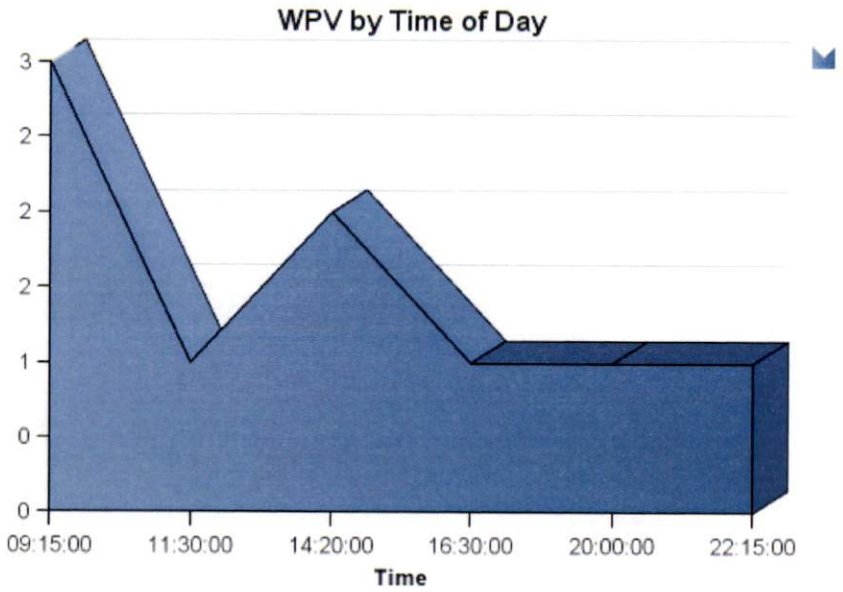

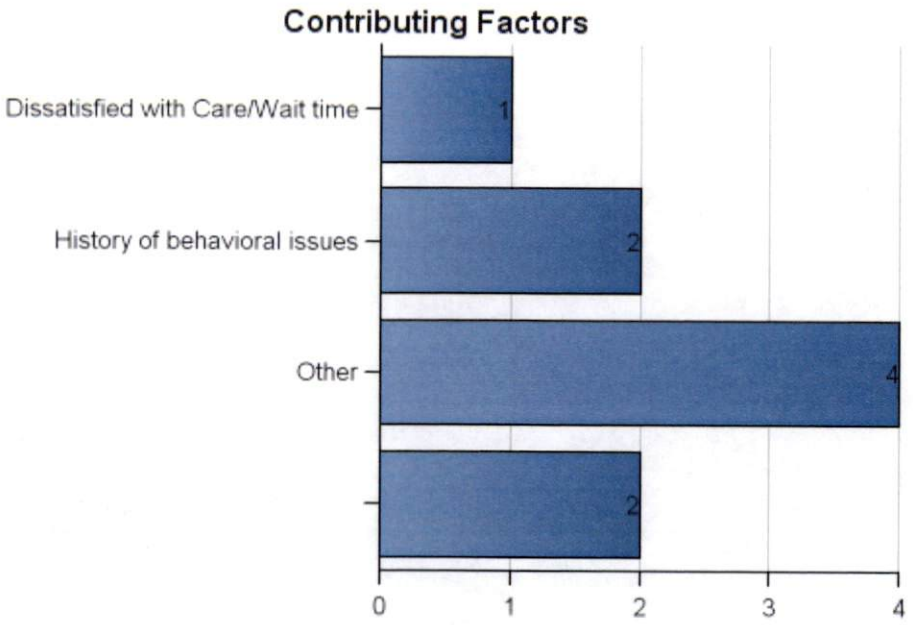

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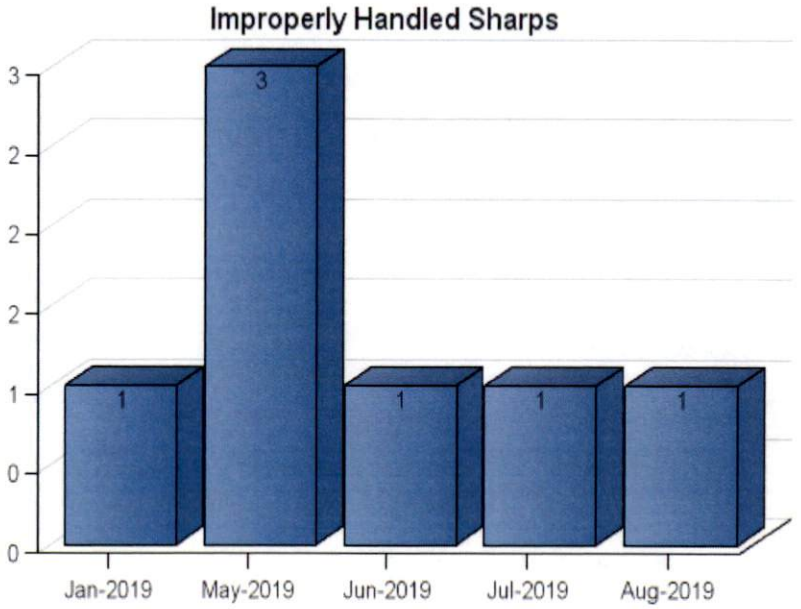
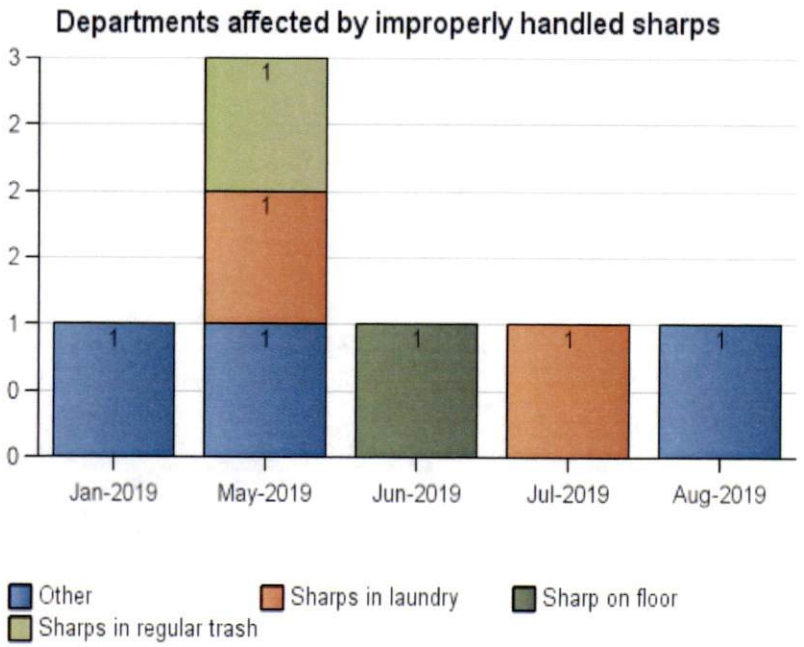
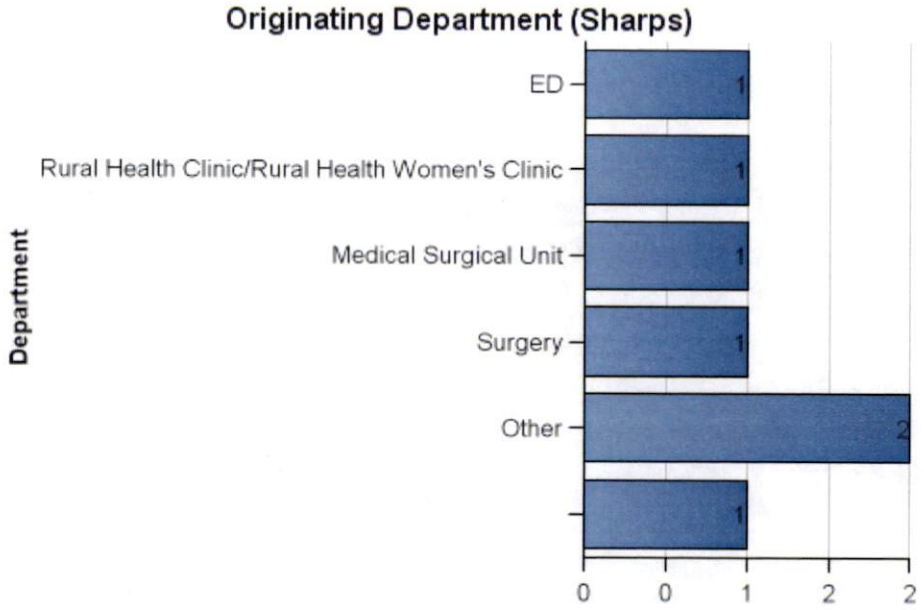
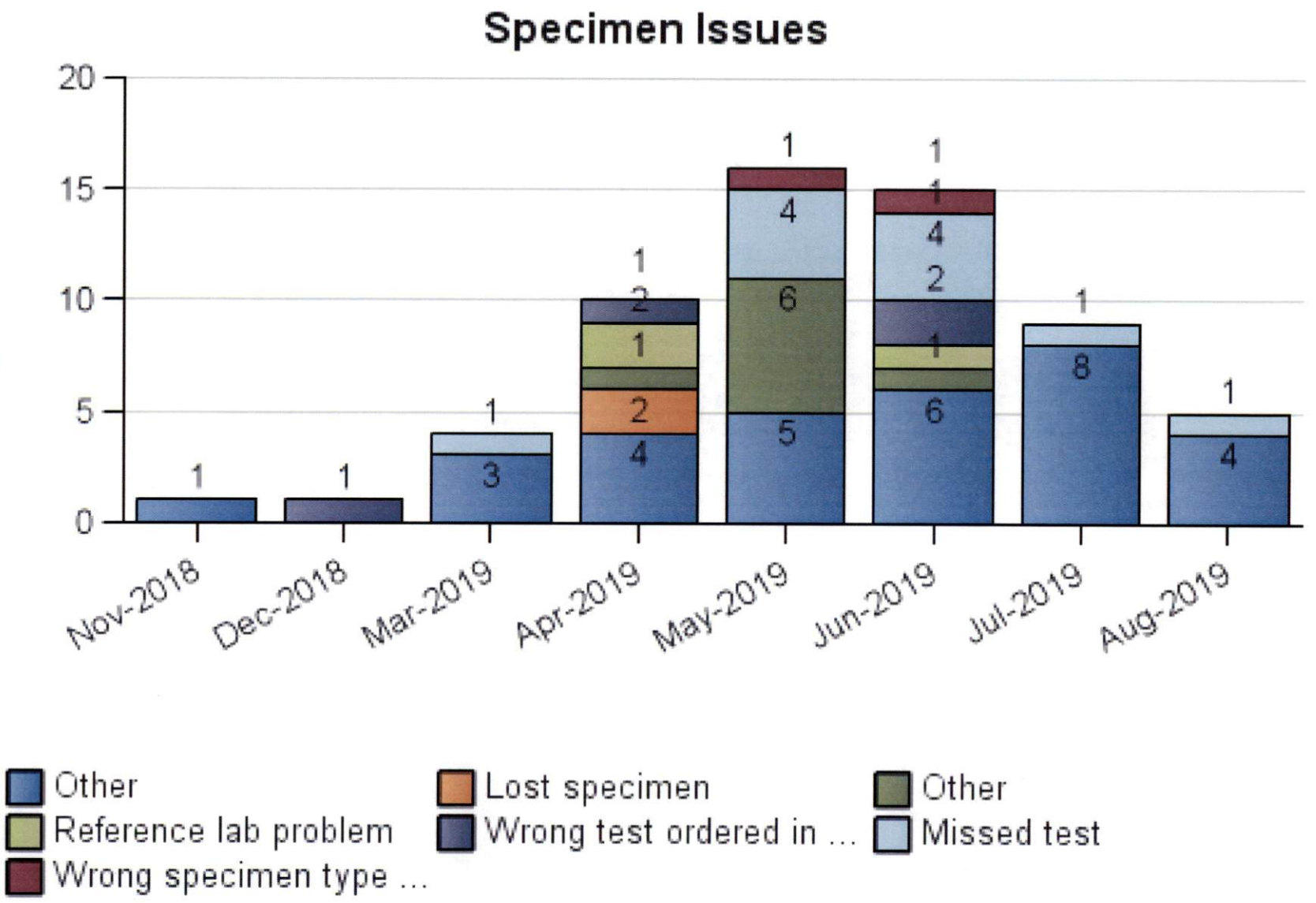
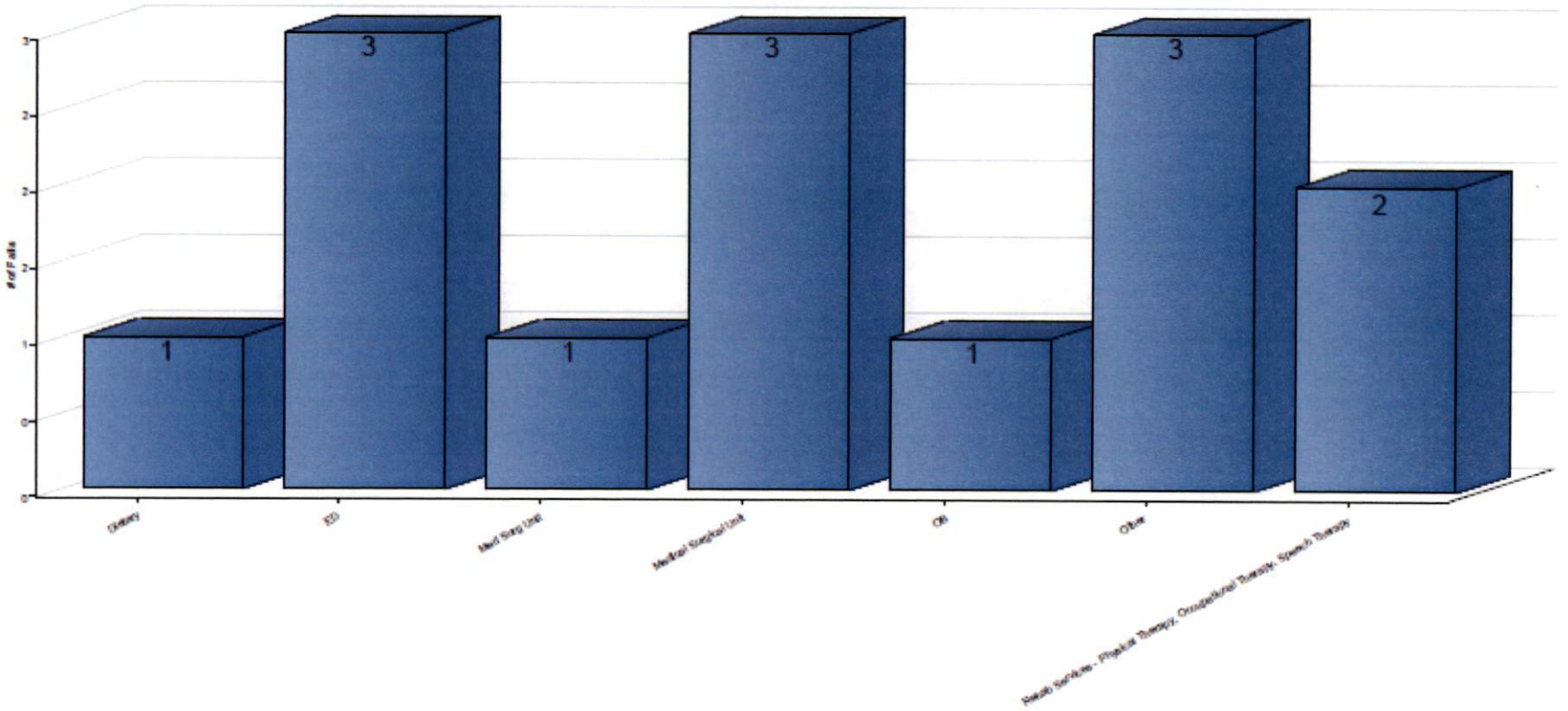

Improperly Handled Sharps
3
2
2
2
1
0
1
3
1
1
1
Jan-2019
May-2019
Jun-2019
Jul-2019
Aug-2019


Departments affected by improperly handled sharps
3
2
2
2
1
0
1
1
1
1
1
1
1
Jan-2019
May-2019
Jun-2019
Jul-2019
Aug-2019
Other
Sharps in laundry
Sharp on floor
Sharps in regular trash


Originating Department (Sharps)
Department
ED
Rural Health Clinic/Rural Health Women's Clinic
Medical Surgical Unit
Surgery
Other
1
1
1
1
2
1
0
0
1
2
2

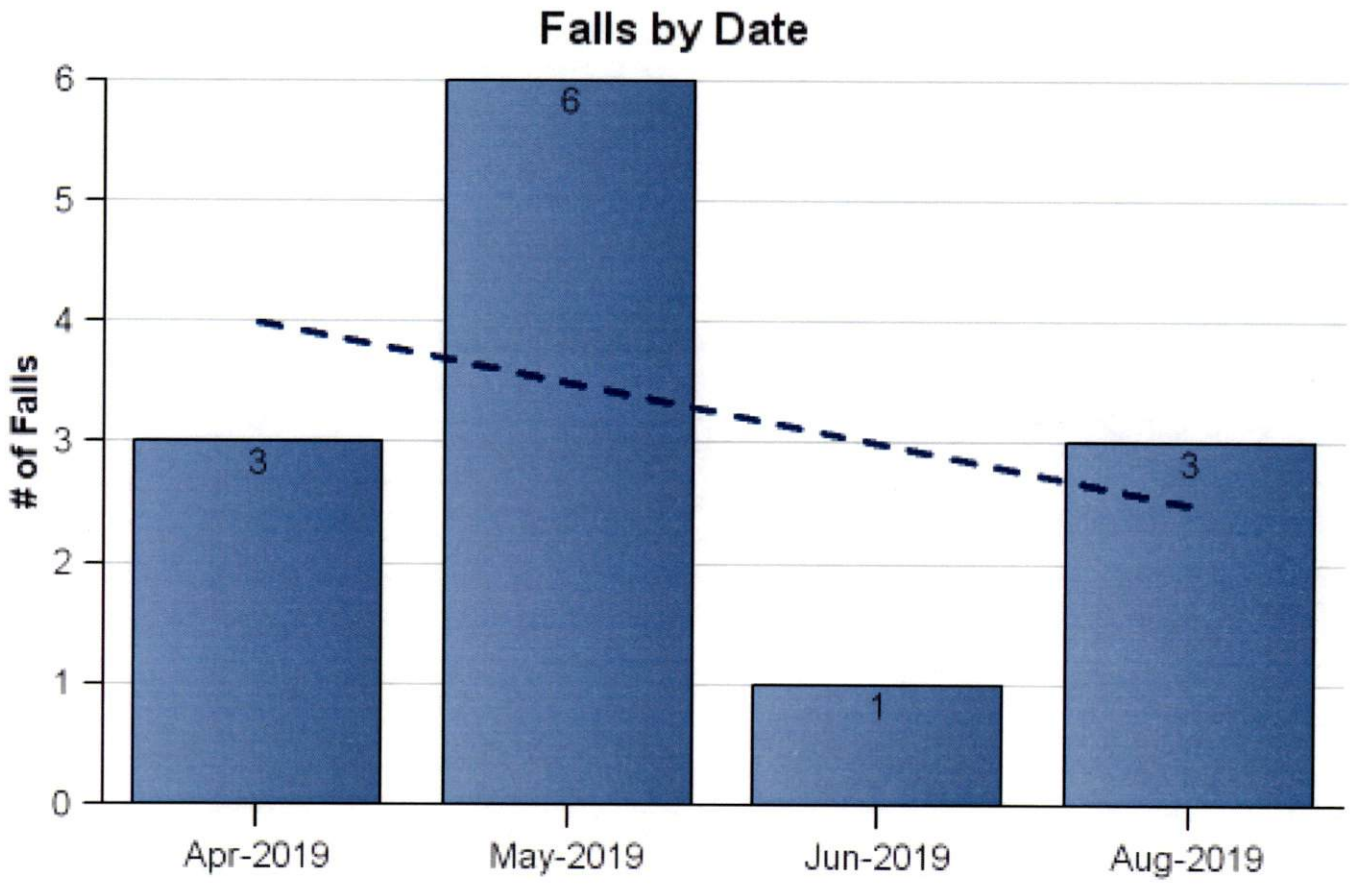

Specimen Issues
20
15
10
5
0
Nov-2018
Dec-2018
Mar-2019
Apr-2019
May-2019
Jun-2019
Jul-2019
Aug-2019
Other
Reference lab problem
Wrong specimen type ...
Lost specimen
Wrong test ordered in ...
Other
Missed test

Falls by Location



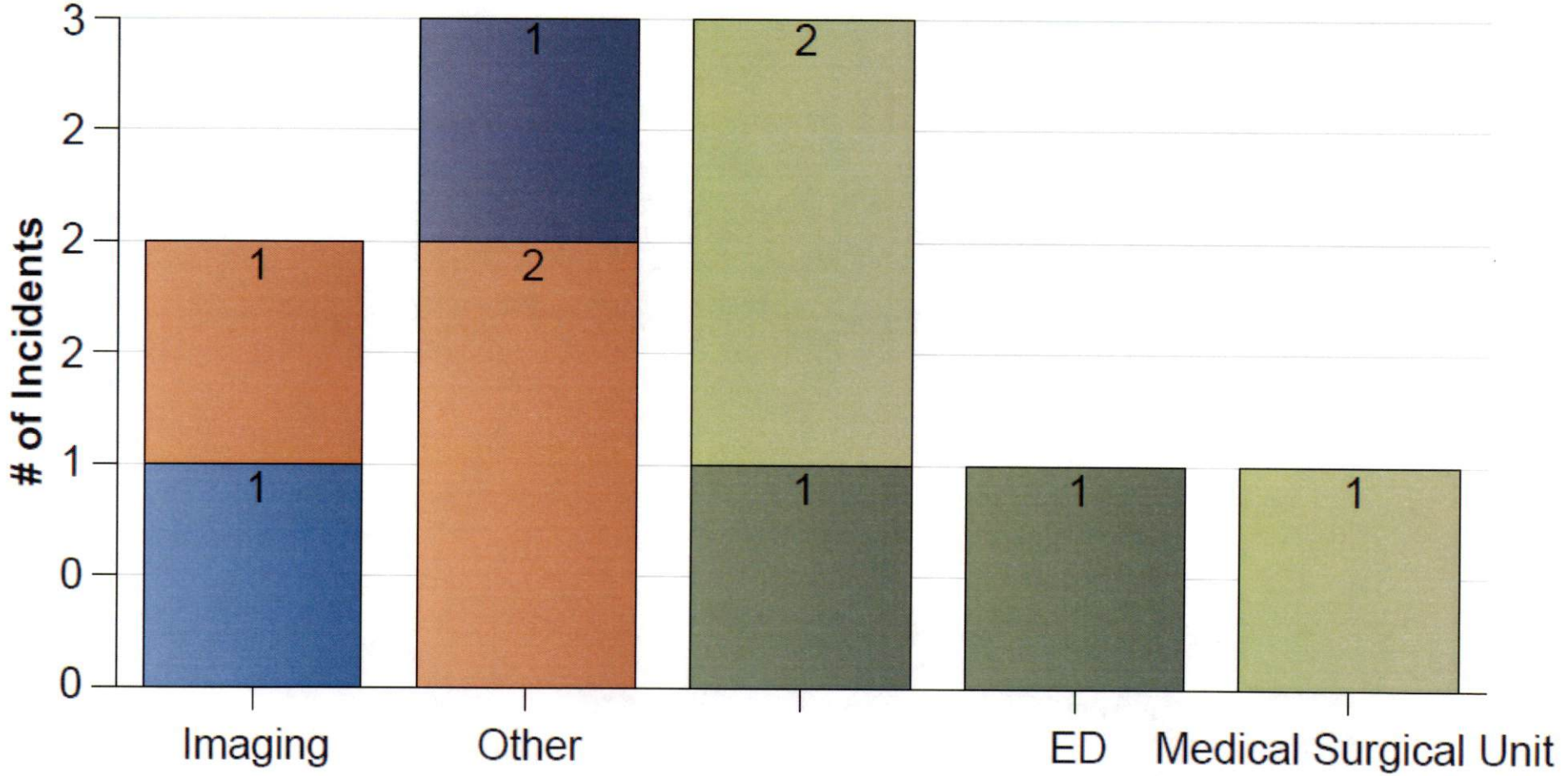
# of Falls	Falls/Slips	Total
Dietary	1	1
ED	3	3
Med Surg Unit	1	1
Medical Surgical Unit	3	3
OB	1	1
Other	3	3
Rehab Services - Physical Therapy, Occupational Therapy, Speech Therapy	2	2
Total	**14**	**14**

14 falls on this chart as it is from the beginning of reporting in ComplyTrack through 9/6/2019. 13 falls on the next chart, as it only counts falls through 88/31/2019

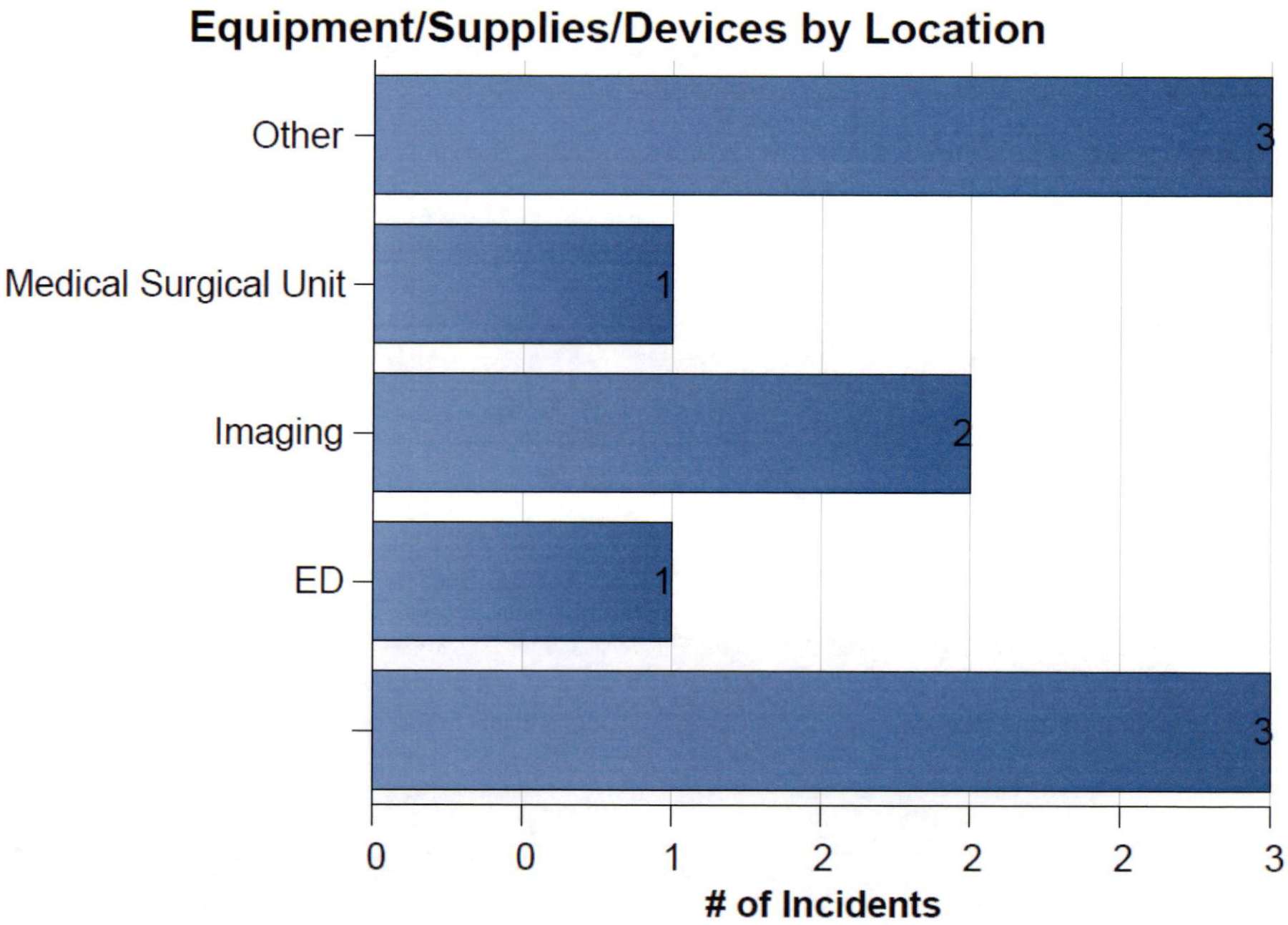


# of Falls	Apr-2019	May-2019	Jun-2019	Aug-2019	Total
Not Identified	2	4		1	7
Confused				2	2
Oriented	1	2	1		4
Total	3	6	1	3	13

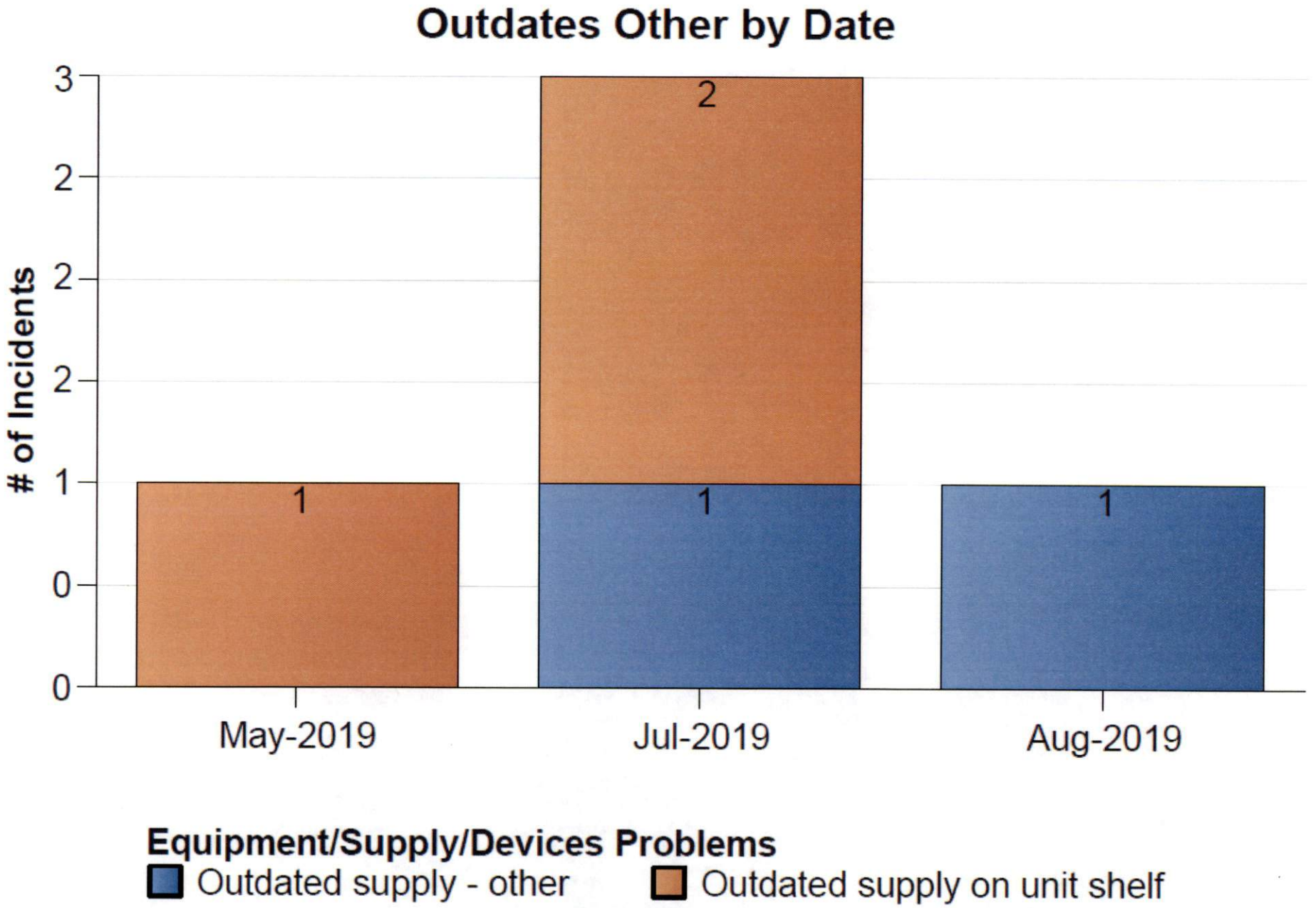
Equipment/Supplies/Devices by Incident Type/Location



We are working with Complytrack report writing experts to fix formatting and labeling issues, as seen in this graph.



We are working with Complytrack report writing experts to fix formatting and labeling issues, as seen in this graph.


Outdates Other by Date
# of Incidents
3
2
2
2
1
0
0
2
1
1
1
May-2019
Jul-2019
Aug-2019
Equipment/Supply/Devices Problems
Outdated supply - other
Outdated supply on unit shelf

CDPH 2018 Survey
Monitoring and Oversight of Corrective Action Plans

Tag	Corrective Action	Monitoring Plan	Frequency	Date Correction Completed	Oversight Responsibility	Time frame for monitoring
E239	1. Developed new policy "Accepting Orders for Outpatient Infusion Services from Non-Privileged Practitioners"	One day per month, for three months, all scheduled infusion patients' ordering provider(s) will be verified to be on the list of providers with a "documented Referral Arrangement " by a designated workforce member.	1 day/mon X 3 months; when at 100% 1 day/quarter x 3 addl quarters.	7/18/2018	DON Perioperative services to have oversight of data and report to Compliance. Compliance to report to Board of Directors (BOD) no less than annually	Monthly x 3, Quarterly x 3
	2. NIHD enters into a documented Referral Arrangement for Non-Staff Ordering Practitioners.			9/1/2018		
	3. Provided education and training to Infusion nursing staff via in-person and email.			9/1/2018		
E 242	Draft policy "Pediatric and Newborn Consultation Requirements" and obtain approval at perinatal/pediatrics medical staff committee on 10/12/2018, full approval anticipated on 11/21/2018. Education has been provided to the Medical Staff via committee process (see attached minutes).	All pediatric admissions are retrospectively reviewed by the Chief of Pediatrics on a monthly basis.	Monthly	11/23/2019	Audit data will be collected and tracked by the Medical Staff Office Manager and presented to the Chief of Pediatrics for review and presentation to the Medical Executive Committee quarterly. Once reviewed by Medical Executive Committee, aggregate data will be presented to the Board of Directors, no less than annually.	Monthly x 2 6 month OPPE periods or one year

Attachment 5

CDPH 2018 Survey
Monitoring and Oversight of Corrective Action Plans

Tag	Corrective Action	Monitoring Plan	Frequency	Date Correction Completed	Oversight Responsibility	Time frame for monitoring
E 276	Provided education and training to workforce regarding "Code Amber." "Code Amber" practice drills conducted on day and night shift.	Code Amber knowledge question added to Environment of Care monthly audit. Monthly data will be collected for trending by department for additional targeted training. Data tracking will occur until no wrong answers for 3 consecutive months, or 12 months. If goal not met, review and update plan of correction.	Monthly	10/12/2019	EOC trending, Operations?	100% correct answers for 3 consecutive months or a total of 12 months (reassess if no 3 consec month period)
E280	All contract RNs will particpate in skills days specific to their routinely assigned unit(s) during orientation.	Nursing administration and education will monitor 100% of contract RN orientation documentation for completion of competency validation routine assigned units. If 100% compliant, monitor 50% of contract RN orientation documentation for completion of competency validation routine assigned units for the following 2 months. If at 100%, sustainability goal will have been met. If not, review and update plan of correction		10/1/2019	CNO will have oversight of competency validation process for contracted RNs. Data will be reported to Nurse	3 months
	All contract RNs competency binders will contain documentation of completion of competency validations and skills validations for any unit to which they may be routinely assigned. Per policy,					
	Competency orientation plans and supporting documents for contract RNs are reviewed by nursing administration or designee prior to independent assignments.					

CDPH 2018 Survey
Monitoring and Oversight of Corrective Action Plans

Tag	Corrective Action	Monitoring Plan	Frequency	Date Correction Completed	Oversight Responsibility	Time frame for monitoring
E 475	1b. Policy "Cleaning the Pharmacy Sterile IV Preparation Area (Clean Room)" completed.	1. Pharmacist-in-charge will monitor cleaning log once a month for 3 months and then once a quarter for 2 additional quarters for 100% complete ceiling cleaning. If goal not met, review and update plan of correction.			The Infection Preventionist has oversight responsibility. Data monitoring will be sent to the Infection Prevention Medical Staff Committee, quarterly, for review. Aggregate data will be reported to the Board of Directors by the Compliance office no less than annually.	once a month X 3 months, then once/quarter for 2 additional quarters for 100% completion
	Training completed for the pharmacy department on the updated draft policy while awaiting approval process. Just-in-time training will be completed by the Clinical Engineering and Compliance as needed.	2. Pharmacist-in-charge has oversight of this process. Compliance to review log reports for daily checks of temperature monitoring software, monthly for three months.			Aggregate data reported to the Pharmacy and Therapeutics Medical Staff Committee quarterly. Aggregate data will be reported to the Board of Directors by the Compliance office no less than annually.	3 months

CDPH 2018 Survey
Monitoring and Oversight of Corrective Action Plans

Tag	Corrective Action	Monitoring Plan	Frequency	Date Correction Completed	Oversight Responsibility	Time frame for monitoring	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	CY 18 Q3	CY 18 Q4	CY 19 Q1	CY 19 Q2	
E239	1. Developed new policy "Accepting Orders for Outpatient Infusion Services from Non-Privileged Practitioners"	One day per month, for three months, all scheduled infusion patients' ordering provider(s) will be verified to be on the list of providers with a "documented Referral Arrangement " by a designated workforce member.	1 day/mon X 3 months; when at 100% 1 day/quarter x 3 addl quarters.	7/18/2018	DON Perioperative services to have oversight of data and report to Compliance. Compliance to report to Board of Directors (BOD) no less than annually	Monthly x 3, Quarterly x 3	Additional training provided			100%	100%	100%			100%							100%	100%		Monitoring is current
	2. NIHD enters into a documented Referral Arrangement for Non-Staff Ordering Practitioners.			9/1/2018																					Complete
	3. Provided education and training to Infusion nursing staff via in-person and email.			9/1/2018																					Complete
E 242	Draft policy "Pediatric and Newborn Consultation Requirements" and obtain approval at perinatal/pediatrics medical staff committee on 10/12/2018, full approval anticipated on 11/21/2018. Education has been provided to the Medical Staff via committee process (see attached minutes).	All pediatric admissions are retrospectively reviewed by the Chief of Pediatrics on a monthly basis.	Monthly	11/23/2019	Audit data will be collected and tracked by the Medical Staff Office Manager and presented to the Chief of Pediatrics for review and presentation to the Medical Executive Committee quarterly. Once reviewed by Medical Executive Committee, aggregate data will be presented to the Board of Directors, no less than annually.	Monthly x 2 6 month OPPE periods or one year							100%		100%	100%	100%								Monitoring is current
E 276	Provided education and training to workforce regarding "Code Amber." "Code Amber" practice drills conducted on day and night shift.	Code Amber knowledge question added to Environment of Care monthly audit. Monthly data will be collected for trending by department for additional targeted training. Data tracking will occur until no wrong answers for 3 consecutive months, or 12 months. If goal not met, review and update plan of correction.	Monthly	10/12/2019	EOC trending, Operations?	100% correct answers for 3 consecutive months or a total of 12 months (reassess if no 3 consec month period)							<100%	<100%				100	100	100					Completed
E280	All contract RNs will particpate in skills days specific to their routinely assigned unit(s) during orientation.	Nursing administration and education will monitor 100% of contract RN orientation documentation for completion of competency validation routine assigned units. If 100% compliant, monitor 50% of contract RN orientation documentation for completion of competency validation routine assigned units for the following 2 months. If at 100%, sustainability goal will have been met. If not, review and update plan of correction		10/1/2019	CNO will have oversight of competency validation process for contracted RNs. Data will be reported to Nurse	3 months	<100%	<100%	<100%	<100%	<100%	<100%	<100%	<100%	<100%	<100%	100%	100%	100%	100%					Completed
	All contract RNs competency binders will contain documentation of completion of competency validations and skills validations for any unit to which they may be routinely assigned. Per policy,																								
	Competency orientation plans and supporting documents for contract RNs are reviewed by nursing administration or designee prior to independent assignments.																								
E 475	1b. Policy "Cleaning the Pharmacy Sterile IV Preparation Area (Clean Room)" completed.	1. Pharmacist-in-charge will monitor cleaning log once a month for 3 months and then once a quarter for 2 additional quarters for 100% complete ceiling cleaning. If goal not met, review and update plan of correction.			The Infection Preventionist has oversight responsibility. Data monitoring will be sent to the Infection Prevention Medical Staff Committee, quarterly, for review. Aggregate data will be reported to the Board of Directors by the Compliance office no less than annually.	once a month X 3 months, then once/quarter for 2 additional quarters for 100% completion					100%	100%	100%	100%	100%	100%	100%	100%	100%	100%		100%	100%	100%	Completed
	Training completed for the pharmacy department on the updated draft policy while awaiting approval process. Just-in-time training will be completed by the Clinical Engineering and Compliance as needed.	2. Pharmacist-in-charge has oversight of this process. Compliance to review log reports for daily checks of temperature monitoring software, monthly for three months.			Aggregate data reported to the Pharmacy and Therapeutics Medical Staff Committee quarterly. Aggregate data will be reported to the Board of Directors by the Compliance office no less than annually.	3 months			100%	100%	100%														Completed

CDPH 2018 Survey
Monitoring and Oversight of Corrective Action Plans

Tag	Corrective Action	Monitoring Plan	Frequency	Date Correction Completed	Oversight Responsibility	Time frame for monitoring
E 479	1a. Posting of Signage: Sign posted in ED at past location of the Malignant Hyperthermia Cart directing staff to the new location in PACU. 1b. Email Notification of RN Staff: Current RN staff will be sent an email with reminder of current location of the Malignant Hyperthermia Cart location.	1. Added knowledge question to RN rounding form, Nursing Leadership is rounding regularly and asking a minimum of 5 RNs (17% of the workforce monthly) per week as to the location of the Malignant Hyperthermia Cart.	When 3 months of RN Rounding form documentation results in 100% knowledge of the location of the Malignant Hyperthermia Cart we will consider the knowledge of cart location to be known by the nursing team.		Data will be tracked and trended by the Nursing Administrative Team. The aggregate data will be submitted to the Nurse Executive Committee quarterly, with the Chief Nursing Officer having oversight responsibility. Chief Nurse will supply report to Compliance to be submitted to the Board of Directors no less than annually.	3 months
E480	Immediately verified the medications belonging in the crash cart and added the list to the policy.	All policies are reviewed by appropriate committees, leadership, and Board of Directors no less than once every three years. This review will ensure sustainability of this change. No additional monitoring needed.	No additional monitoring	10/17/2018	No additional monitoring	None

CDPH 2018 Survey
Monitoring and Oversight of Corrective Action Plans

Tag	Corrective Action	Monitoring Plan	Frequency	Date Correction Completed	Oversight Responsibility	Time frame for monitoring
E485	Staff were educated at Sept 2018 MS/ICU staff meeting. Staff were educated about use of appropriate sedation scales and titration orders.	100% of ICU patient charts will be audited for titratable sedative dosing per order, and the appropriate use of RASS sedation scales. This will be completed by the unit management and just in time training will be completed if a deficient practice is found.	3 months at 100% compliance is reached	10/15/2018	Audit data will be collected and tracked by the Nursing Administration Office and presented to the Chief Nursing Officer. Once reviewed aggregate data will be submitted to the Compliance department for presentation to the Board of Directors, no less than annually.	If goal not met in one year, review education and training, and update plan of correction.
E 503	1. Clove oil was removed from the Dental Box in the ED.	Dental box located in the ED will be audited once per month until 3 consecutive months of no Clove Oil. Monitoring by the nursing unit manager will be complete following 3 consecutive months of no clove oil.	3 months at 100% compliance is reached	7/20/2018	Monitoring by the nursing unit manager will be complete following 3 consecutive months of no clove oil. This data will be reported to the Compliance Dept. and the Board of Directors no less than annually.	Until 3 consecutive months of no Clove oil in the ED Dental box.
	2. Dental Box content list has been updated.			10/11/2018		
	3. Emergency Medicine Providers' group determined clove oil will no longer be used in the facility dental box			10/8/2018		
	4. Education provided to ED workforce.			9/25/2018		
E 511	1. Pharmacist in charge has directed pharmacy staff to remove AddVantage system supplies from all facility Omnicells. Pharmacy will switch to Baxter MiniBag Plus system, which comes in single use per overwrap package. Pharmacy staff has been educated on this change via email.	No additional monitoring is required.	None	7/20/2018	Pharmacist-in-charge is responsible for oversight of this change.	None

CDPH 2018 Survey
Monitoring and Oversight of Corrective Action Plans

Tag	Corrective Action	Monitoring Plan	Frequency	Date Correction Completed	Oversight Responsibility	Time frame for monitoring	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	CY 18 Q3	CY 18 Q4	CY 19 Q1	CY 19 Q2	
E 479	1a. Posting of Signage: Sign posted in ED at past location of the Malignant Hyperthermia Cart directing staff to the new location in PACU. 1b. Email Notification of RN Staff: Current RN staff will be sent an email with reminder of current location of the Malignant Hyperthermia Cart location.	1. Added knowledge question to RN rounding form, Nursing Leadership is rounding regularly and asking a minimum of 5 RNs (17% of the workforce monthly) per week as to the location of the Malignant Hyperthermia Cart.	When 3 months of RN Rounding form documentation results in 100% knowledge of the location of the Malignant Hyperthermia Cart we will consider the knowledge of cart location to be known by the nursing team.		Data will be tracked and trended by the Nursing Administrative Team. The aggregate data will be submitted to the Nurse Executive Committee quarterly, with the Chief Nursing Officer having oversight responsibility. Chief Nurse will supply report to Compliance to be submitted to the Board of Directors no less than annually.	3 months					75%	73%	62.50%		100%		100%	100%	100%				Completed
E480	Immediately verified the medications belonging in the crash cart and added the list to the policy.	All policies are reviewed by appropriate committees, leadership, and Board of Directors no less than once every three years. This review will ensure sustainability of this change. No additional monitoring needed.	No additional monitoring	10/17/2018	No additional monitoring	None	complete																		Completed
E485	Staff were educated at Sept 2018 MS/ICU staff meeting. Staff were educated about use of appropriate sedation scales and titration orders.	100% of ICU patient charts will be audited for titratable sedative dosing per order, and the appropriate use of RASS sedation scales. This will be completed by the unit management and just in time training will be completed if a deficient practice is found.	3 months at 100% compliance is reached	10/15/2018	Audit data will be collected and tracked by the Nursing Administration Office and presented to the Chief Nursing Officer. Once reviewed aggregate data will be submitted to the Compliance department for presentation to the Board of Directors, no less than annually.	If goal not met in one year, review education and training, and update plan of correction.						100%	100%	100%										Completed
E 503	1. Clove oil was removed from the Dental Box in the ED. 2. Dental Box content list has been updated. 3. Emergency Medicine Providers' group determined clove oil will no longer be used in the facility dental box 4. Education provided to ED workforce.	Dental box located in the ED will be audited once per month until 3 consecutive months of no Clove Oil. Monitoring by the nursing unit manager will be complete following 3 consecutive months of no clove oil.	3 months at 100% compliance is reached	7/20/2018 10/11/2018 10/8/2018 9/25/2018	Monitoring by the nursing unit manager will be complete following 3 consecutive months of no clove oil. This data will be reported to the Compliance Dept. and the Board of Directors no less than annually.	Until 3 consecutive months of no Clove oil in the ED Dental box.		100%	100%	100%	100%													Completed
E 511	1. Pharmacist in charge has directed pharmacy staff to remove AddVantage system supplies from all facility Omnicells. Pharmacy will switch to Baxter MiniBag Plus system, which comes in single use per overwrap package. Pharmacy staff has been educated on this change via email.	No additional monitoring is required.	None	7/20/2018	Pharmacist-in-charge is responsible for oversight of this change.	None	complete																		Completed
	2. Medication storage will be in accordance with manufacturer's specifications based on the FDA approved information in the package insert.	No additional monitoring is required.	None	10/12/2018	Pharmacist-in-charge is responsible for oversight of this change.	None	complete																		Completed

CDPH 2018 Survey
Monitoring and Oversight of Corrective Action Plans

Tag	Corrective Action	Monitoring Plan	Frequency	Date Correction Completed	Oversight Responsibility	Time frame for monitoring
	2. Medication storage will be in accordance with manufacturer's specifications based on the FDA approved information in the package insert.	No additional monitoring is required.	None	10/12/2018	Pharmacist-in-charge is responsible for oversight of this change.	None
E 1363	Spreadsheets for tracking all supplies in the crash cart had been developed by the Cardiopulmonary department. The spreadsheet was updated to include month/day/year. Additional training was provided to the Cardiopulmonary Department to review the expiry dates monthly and replace all supplies prior to expiration.	If during monthly checks, an expired supply is found, a Quality Review/Unusual Occurrence report will be completed by the staff member. Compliance will review and trend UOR/QRRs for outdated supplies in crash cart. Time: Review and trend UOR/QRRs for outdates monthly for 3 months, if no incidents of outdates, follow quarterly for 3 additional quarters. Success is less than or equal to 1 UOR during the monitoring period. THis data will be reported to the Resuscitation Medical Staff Committee quarterly and to the Board of Directors no less than annually.	monthly for 3 months, if no incidents of outdates, follow quarterly for 3 additional quarters	10/12/2018	Resuscitation Medical Staff Committee	Review and trend UOR/QRRs for outdates monthly for 3 months, if no incidents of outdates, follow quarterly for 3 additional quarters.
E 2115	Staff identified by the CDPH inspectors, and all other NIHD workforce, were within the timeframe identified by the Inyo County Health Officer, however, NIHD did not notify CDPH of this letter until the inspection. Inspectors instructed CNO to include the letter from the Inyo County Health Officer with the response to the licensing inspection.	No additional monitoring is required.		7/20/2018	Chief Nurse	None

CDPH 2018 Survey
Monitoring and Oversight of Corrective Action Plans

Tag	Corrective Action	Monitoring Plan	Frequency	Date Correction Completed	Oversight Responsibility	Time frame for monitoring
	1. Staff education that IV infusion tubing in the outpatient infusion department shall be discarded once disconnected from the patient.	1. PACU management will monitor daily for sterilely capped, patient labeled, re-used tubing in the infusion department for two months. If zero are found, no additional monitoring required.	Daily x 2 months	7/20/2018	This information will be reported to Nursing Executive Committe until two consecutive months of zero found goal is met. Compliance will report to the Board of Directors.	2 months with 100% compliance
	2. "Point of care -Accu-Chek Blood Glucose Testing" policy was reviewed and no changes regarding disinfection of the unit were required in the policy. Training and education have been provided to the NIHD staff who utilize the glucometer. Review of wet time procedures at department meetings and hospital orientation has occurred. Just-in time training is provided during rounding of unit managers and nursing leadership.	2. "Wet time" knowledge question added to Environment of Care monthly audits and Nursing Unit Rounding questions. Anyone getting the Wet-time answer wrong will receive "just-in-time" training. Monthly data will be collected for trending by department for additional targeted training.	When 3 months of RN Rounding form documentation results in 98% correct answers, we will consider the undestanding of "wet-times" to be known by the nursing team.	7/20/2018-ongoing	Data will be compiled and sent to the Nursing Administrative Team. The aggregate data will be submitted to the Nurse Executive Committee quarterly, with the Chief Nursing Officer having oversight responsibility. Chief Nurse will supply report to Compliance to be submitted to the Board of Directors no less than annually	Data tracking will occur until no wrong answers for 3 consecutive months. If goal not met, review and update plan of correction.
	3. Paper towel and soap dispenser installed near sink in supply room in the Infusion department.			9/21/2018		

CDPH 2018 Survey
Monitoring and Oversight of Corrective Action Plans

Tag	Corrective Action	Monitoring Plan	Frequency	Date Correction Completed	Oversight Responsibility	Time frame for monitoring
E 2150	4. Additional dual tip protectors were ordered to ensure all sterilized hinged instruments are more clearly in an open position and cannot move to the locked position inadvertently after sterilization. Additional education and training to ensure all staff are knowledgeable that hinged instruments must be in an open position. All staff memebers in the Central Sterile Processing will participate in the auditing of sterilized instrument packets.	Audit processed peel packs weekly: 20 / week for September and October 2018 with 100% compliance.	If at 100% Compliance, no additional monitoring requirements.	10/15/2018	DON of perioperative services	No ongoing monitoring requirements.
	5. Each area in the 3 ORs and Sterile Processing, Infusion, and PACU is assigned to a staff member who goes through and checks each item for dates. The person checking must initial the form once the check has been completed. Expired supplies will be removed. An unusual occurrence report will be completed for any expired supply found	Oversight of the Monthly outdate review is overseen by the DON of perioperative services.Compliance will trend UORs for outdated supplies.	Monthly for 3 months, if no incidents of outdates, follow quarterly for 3 additional quarters	8/1/2018	submitted to the Nurse Executive Committee quarterly, with the Chief Nursing Officer having oversight responsibility. Chief Nurse will supply report to Compliance to be submitted to the Board of Directors no less than annually.	Review and trend UORs for outdates monthly for 3 months, if no incidents of outdates, follow quarterly for 3 additional quarters
	6. Signs were placed on patient allocated refrigeration units with "For Patient Use Only" signs. Provide in-service with nursing managers to audit patient refridgeration units.	6. Nursing Managers are monitoring patient designated refrigeration units once a week for three months, and then once per quarter for three quarters to ensure no non-patient food and beverage is stored in patient designated areas.	Once per week X 3 months, Once per quarter X 3 quarters	7/25/2018	This process is overseen by the Dietary Manager. Data is reported to the Compliance Officer quarterly. The Compliance Officer will report this information to the Board of Directors no less than annually.	Once per week X 3 months, Once per quarter X 3 quarters

CDPH 2018 Survey
Monitoring and Oversight of Corrective Action Plans

Tag	Corrective Action	Monitoring Plan	Frequency	Date Correction Completed	Oversight Responsibility	Time frame for monitoring	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	CY 18 Q3	CY 18 Q4	CY 19 Q1	CY 19 Q2	
E 1363	Spreadsheets for tracking all supplies in the crash cart had been developed by the Cardiopulmonary department. The spreadsheet was updated to include month/day/year. Additional training was provided to the Cardiopulmonary Department to review the expiry dates monthly and replace all supplies prior to expiration.	If during monthly checks, an expired supply is found, a Quality Review/Unusual Occurrence report will be completed by the staff member. Compliance will review and trend UOR/QRRs for outdated supplies in crash cart. Time: Review and trend UOR/QRRs for outdates monthly for 3 months, if no incidents of outdates, follow quarterly for 3 additional quarters. Success is less than or equal to 1 UOR during the monitoring period. THis data will be reported to the Resuscitation Medical Staff Committee quarterly and to the Board of Directors no less than annually.	monthly for 3 months, if no incidents of outdates, follow quarterly for 3 additional quarters	10/12/2018	Resuscitation Medical Staff Committee	Review and trend UOR/QRRs for outdates monthly for 3 months, if no incidents of outdates, follow quarterly for 3 additional quarters.			100.0%	100.0%	100.0%	100.0%	<100% 1 UOR	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%		Will be completed 9/30/2019 if no UORs for outdated supplies in crash carts.
E 2115	Staff identified by the CDPH inspectors, and all other NIHD workforce, were within the timeframe identified by the Inyo County Health Officer, however, NIHD did not notify CDPH of this letter until the inspection. Inspectors instructed CNO to include the letter from the Inyo County Health Officer with the response to the licensing inspection.	No additional monitoring is required.		7/20/2018	Chief Nurse	None	complete																		Completed
E 2150	1. Staff education that IV infusion tubing in the outpatient infusion department shall be discarded once disconnected from the patient.	1. PACU management will monitor daily for sterilely capped, patient labeled, re-used tubing in the infusion department for two months. If zero are found, no additional monitoring required.	Daily x 2 months	7/20/2018	This information will be reported to Nursing Executive Committe until two consecutive months of zero found goal is met. Compliance will report to the Board of Directors.	2 months with 100% compliance		100%	100%															Completed
	2. "Point of care -Accu-Chek Blood Glucose Testing" policy was reviewed and no changes regarding disinfection of the unit were required in the policy. Training and education have been provided to the NIHD staff who utilize the glucometer. Review of wet time procedures at department meetings and hospital orientation has occurred. Just-in time training is provided during rounding of unit managers and nursing leadership.	2. "Wet time" knowledge question added to Environment of Care monthly audits and Nursing Unit Rounding questions. Anyone getting the Wet-time answer wrong will receive "just-in-time" training. Monthly data will be collected for trending by department for additional targeted training.	When 3 months of RN Rounding form documentation results in 98% correct answers, we will consider the undestanding of "wet-times" to be known by the nursing team.	7/20/2018-ongoing	Data will be compiled and sent to the Nursing Administrative Team. The aggregate data will be submitted to the Nurse Executive Committee quarterly, with the Chief Nursing Officer having oversight responsibility. Chief Nurse will supply report to Compliance to be submitted to the Board of Directors no less than annually	Data tracking will occur until no wrong answers for 3 consecutive months. If goal not met, review and update plan of correction.					43.8%	85.7%	75.0%	92.30%		92.3%	70.0%	100.0%	100.0%	80.0%					Monitoring is current
	3. Paper towel and soap dispenser installed near sink in supply room in the Infusion department.			9/21/2018			complete																		Completed
	4. Additional dual tip protectors were ordered to ensure all sterilized hinged instruments are more clearly in an open position and cannot move to the locked position inadvertently after sterilization. Additional education and training to ensure all staff are knowledgeable that hinged instruments must be in an open position. All staff memebers in the Central Sterile Processing will participate in the auditing of sterilized instrument packets.	Audit processed peel packs weekly: 20 / week for September and October 2018 with 100% compliance.	If at 100% Compliance, no additional monitoring requirements.	10/15/2018	DON of perioperative services	No ongoing monitoring requirements.		100%	100%	100%	100%	100%			100%			100%							Completed

CDPH 2018 Survey
Monitoring and Oversight of Corrective Action Plans

Tag	Corrective Action	Monitoring Plan	Frequency	Date Correction Completed	Oversight Responsibility	Time frame for monitoring
	7. Discard all multiple use Hormel Thick and Easy Thickener throughout NIH campus. Purchase single serving packets of Hormel Thick and Easy Thickener Powder. Provided in-service on corrective action inventory procedures with dietary staff.	Monitor invoices and unit checks once a month for three months to ensure no multi use Hormel Thick and Easy thickener is on NIH campus to ensure compliance, last purchased date of multiple use Hormel Thick and Easy Thickener to not exceed 04/27/2018.	Monitor invoices once per month for three months, if no purchases, continue to monitor once per quarter for three quarters	7/20/2018	This process is overseen by the Dietary Manager. Data is reported to the Compliance Officer quarterly. The Compliance Officer will report this information to the Board of Directors no less than annually.	once per month x 3 months, once per quarter x 3 quarters
E 2151	1. Created fit testing project team. 2.Team reviewed Aerosolized Transmissable Disease plan, which delineates job roles that require fit testing. 3. Developed tracking and reminder system for annual testing. 4. Developed process such that all new hires are tested before or within 3 weeks of hire.	A statistically significant sample of employees requiring fit-testing will have an audit of the fit test record to ensure compliance with the policy.	Auditing will occur monthly for 3 months or until 97% or greater compliance rate is achieved. Additional auditing will occur quarterly for 3 quarters with the sustainability goal of 97% or greater compliance rate is achieved.	11/1/2018	The Infection Preventionist is responsible for oversight. This data will be reported to the Infection Control Medical Staff Committee and Medical Executive Committee, quarterly. This data will be reported to the Board of Directors no less than annually.	I

CDPH 2018 Survey
Monitoring and Oversight of Corrective Action Plans

Tag	Corrective Action	Monitoring Plan	Frequency	Date Correction Completed	Oversight Responsibility	Time frame for monitoring
E 2354	1. Staff trained to look at the stickers and see if they are in compliance. **If out of date: Item to be pulled out of service**. Email to Engineering to request service. UOR completed. During transition year, staff will know that no piece of equipment is in date for greater than 1 year after inspection. 2. All equipment that can hold a PM sticker will be labeled with inspection date and expiration date to let clinical staff when a device is due for service. EOC rounds will ensure equipment is current for inspections as well as EOC reporting to the safety committee.	Unusual Occurrence Reports (UOR) will be utilized to document outdated PM Service tags, which indicate need for service, when found by the end user.	Quarterly review of the UORs will be expected to show 90% compliance of Non-High Risk Medical Equipment, and 100% complaince of High Risk Medical Equipment.	10/19/2018	Compliance Officer will provide oversight for this process. Compliance will report data to the Director of IT Services and the Board of Directors no less than annually.	After 3 concurrent Quarters of review at 90% and 100%, respectively, the audit will be complete
Results did not meet goals			Results met goals			

CDPH 2018 Survey
Monitoring and Oversight of Corrective Action Plans

Tag	Corrective Action	Monitoring Plan	Frequency	Date Correction Completed	Oversight Responsibility	Time frame for monitoring	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	CY 18 Q3	CY 18 Q4	CY 19 Q1	CY 19 Q2	
	5. Each area in the 3 ORs and Sterile Processing, Infusion, and PACU is assigned to a staff member who goes through and checks each item for dates. The person checking must initial the form once the check has been completed. Expired supplies will be removed. An unusual occurrence report will be completed for any expired supply found	Oversight of the Monthly outdate review is overseen by the DON of perioperative services.Compliance will trend UORs for outdated supplies.	Monthly for 3 months, if no incidents of outdates, follow quarterly for 3 additional quarters	8/1/2018	submitted to the Nurse Executive Committee quarterly, with the Chief Nursing Officer having oversight responsibility. Chief Nurse will supply report to Compliance to be submitted to the Board of Directors no less than annually.	Review and trend UORs for outdates monthly for 3 months, if no incidents of outdates, follow quarterly for 3 additional quarters		100%	100%	100%	100%	100%	100%	100%	100%	100%	100%				100%	100%	100%		Completed
	6. Signs were placed on patient allocated refrigeration units with "For Patient Use Only" signs. Provide in-service with nursing managers to audit patient refridgeration units.	6. Nursing Managers are monitoring patient designated refrigeration units once a week for three months, and then once per quarter for three quarters to ensure no non-patient food and beverage is stored in patient designated areas.	Once per week X 3 months, Once per quarter X 3 quarters	7/25/2018	This process is overseen by the Dietary Manager. Data is reported to the Compliance Officer quarterly. The Compliance Officer will report this information to the Board of Directors no less than annually.	Once per week X 3 months, Once per quarter X 3 quarters			75%	100%	100%		100%			100%			100%			100%	100%	100%	Completed
	7. Discard all multiple use Hormel Thick and Easy Thickener throughout NIH campus. Purchase single serving packets of Hormel Thick and Easy Thickener Powder. Provided in-service on corrective action inventory procedures with dietary staff.	Monitor invoices and unit checks once a month for three months to ensure no multi use Hormel Thick and Easy thickener is on NIH campus to ensure compliance, last purchased date of multiple use Hormel Thick and Easy Thickener to not exceed 04/27/2018.	Monitor invoices once per month for three months, if no purchases, continue to monitor once per quarter for three quarters	7/20/2018	This process is overseen by the Dietary Manager. Data is reported to the Compliance Officer quarterly. The Compliance Officer will report this information to the Board of Directors no less than annually.	once per month x 3 months, once per quarter x 3 quarters				100%	100%	100%	100%			100%			100%			100%	100%	100%	Completed
E 2151	1. Created fit testing project team. 2.Team reviewed Aerosolized Transmissable Disease plan, which delineates job roles that require fit testing. 3. Developed tracking and reminder system for annual testing. 4. Developed process such that all new hires are tested before or within 3 weeks of hire.	A statistically significant sample of employees requiring fit-testing will have an audit of the fit test record to ensure compliance with the policy.	Auditing will occur monthly for 3 months or until 97% or greater compliance rate is achieved. Additional auditing will occur quarterly for 3 quarters with the sustainability goal of 97% or greater compliance rate is achieved.	11/1/2018	The Infection Preventionist is responsible for oversight. This data will be reported to the Infection Control Medical Staff Committee and Medical Executive Committee, quarterly. This data will be reported to the Board of Directors no less than annually.	I										88.0%		98.7%	98.0%	99.7%				99.7%	Monitoring is current
E 2354	1. Staff trained to look at the stickers and see if they are in compliance. **If out of date: Item to be pulled out of service**. Email to Engineering to request service. UOR completed. During transition year, staff will know that no piece of equipment is in date for greater than 1 year after inspection. 2. All equipment that can hold a PM sticker will be labeled with inspection date and expiration date to let clinical staff when a device is due for service. EOC rounds will ensure equipment is current for inspections as well as EOC reporting to the safety committee.	Unusual Occurrence Reports (UOR) will be utilized to document outdated PM Service tags, which indicate need for service, when found by the end user.	Quarterly review of the UORs will be expected to show 90% compliance of Non-High Risk Medical Equipment, and 100% complaince of High Risk Medical Equipment.	10/19/2018	Compliance Officer will provide oversight for this process. Compliance will report data to the Director of IT Services and the Board of Directors no less than annually.	After 3 concurrent Quarters of review at 90% and 100%, respectively, the audit will be complete															100% 100%	100% 100%	100% 100%	Completed

Results did not meet goals | Results met goals | Monitoring is ongoing and current.

COMPLIANCE POLICIES, ANNUAL REVIEW
Consent Agenda, September 2019

1. False Claims Act Employee Training and Prevention Policy – non-substantive changes
2. Family Members and relatives in the workplace
3. Governmental Agent Services
4. Hospital Issued Cell Phone Electronic Communication Device Use by Employees
5. Minimum Necessary Access, Use, and Disclosure of PHI
6. Personal Cell Phone/Electronic Communication Device Use by Employees
7. PA – Patient Safety Adverse Events Disclosure Policy
8. PA – Patient Safety: Sentinel Events, Unusual Occurrences Policy/Procedure