Northern Inyo Hospital

June 16 Regular Meeting

June 16 Regular Meeting - June 16 Regular Meeting

AGENDA

NORTHERN INYO HEALTHCARE DISTRICT
BOARD OF DIRECTORS REGULAR MEETING
June 16th, 2021 at 5:30 p.m.

Northern Inyo Healthcare District invites you to attend this Zoom meeting:

TO CONNECT VIA **ZOOM**: (*A link is also available on the NIHD Website*)
https://zoom.us/j/213497015?pwd=TDlIWXRuWjE4T1Y2YVFWbnF2aGk5UT09
Meeting ID: 213 497 015
Password: 608092

PHONE CONNECTION:
888 475 4499 US Toll-free
877 853 5257 US Toll-free
Meeting ID: 213 497 015

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1. Call to Order (at 5:30 pm).
2. ***Public Comment***: The purpose of public comment is to allow members of the public to address the Board of Directors. Public comments shall be received at the beginning of the meeting and are limited to three (3) minutes per speaker, with a total time limit of thirty (30) minutes for all public comment unless otherwise modified by the Chair. Speaking time may not be granted and/or loaned to another individual for purposes of extending available speaking time unless arrangements have been made in advance for a large group of speakers to have a spokesperson speak on their behalf. Comments must be kept brief and non-repetitive. The general Public Comment portion of the meeting allows the public to address any item within the jurisdiction of the Board of Directors on matters not appearing on the agenda. Public comments on agenda items should be made at the time each item is considered.
3. New Business:

   A. NIHD and Inyo County Covid-19 update (*information item*).

   B. Cerner Project Update *(information item)*

   C. Colombo Construction Project Update *(information item)*

   D. 2021 NIHD Strategic Plan Presentation *(action item)*

   E. Policy and Procedure approval, *Password Policy (action item)*

   F. Policy and Procedure approval, *Cell Phone Procurement and Issuance (action item)*

   G. Policy and Procedure approval, *Lost and Found Items (action item)*

H. Policy and Procedure approval, *Environmental Services Radio Procedure (action item)*

I. Policy and Procedure approval, *Development Review and Revision of Policies and Procedures (action item)*

J. Compliance Department Quarterly Report, *(action item)*

K. Approval of District Board Resolution 21-05, Appropriations Limit (action item)

L. Board Meeting Venue Discussion *(discussion item)*

4. Chief of Staff Report, Sierra Bourne MD:

A. Medical Staff Appointments *(action item)*
   1. Kevin Efros, MD (*anesthesiology*) – Active Staff
   2. Michael Santomauro, MD (*urology*) – Courtesy Staff
   3. Andrew Tang, MD (*internal medicine/hospitalist*) – Courtesy Staff

B. Change in Staff Category (*action item*)
   1. Michael Phillips, MD (*emergency medicine*) – change from Active Staff to Honorary Staff

C. Policies and Procedures (*action items*)
   1. *Dilation and Curettage or modified suction curettage procedures in the Emergency Department*
   2. *Bloodborne Pathogen Exposure Control Plan*
   3. *Nursing Care Guidelines in the PACU*
   4. *Local Anesthesia in Surgery*
   5. *PACU Discharge Criteria*
   6. *Pathology Specimens in the Operating room*
   7. *Patient Warmer (Warm Air Hyperthermia System)*
   8. *Standards of Care in the Perioperative Unit: Pediatric Patient*
   9. *Preoperative Preparation and Teaching*
   10. *Scheduling Surgical Procedures*
   11. *Scope of Service PACU*
   12. *Sponge, Sharps, and Instrument Counts*
   13. *Surgery Equipment and Routine Supplies*

D. Medical Executive Committee Meeting Report (*information item*)

Consent Agenda (action items)

5. Approval of minutes of the May 19 2021 regular meeting
6. Financial and Statistical reports as of April 30 2021

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7. NIHD Committee updates from Board members (*information items*).
8. Reports from Board members (*information items*).
9. Adjournment to Closed Session to/for:

A. Conference with legal counsel, existing litigation (*pursuant to Gov. Code 54956.9(d)(1*)). One case: NIHD v. SMHD.

B. Conference with legal counsel, anticipated litigation. Significant exposure to litigation (*pursuant to paragraph (2) of subdivision (d) of Government Code Section 54956.9*) three cases.

C. Conference with legal counsel, existing litigation (*pursuant to Gov. Code Section 54956.9 (d)(1).*

10. Return to Open Session and report of any action taken (*information item*).
11. 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
POLICY AND PROCEDURE

Title: **Password Policy**	
Scope: District Wide	Department: **District Information Security**
Source: Director of Information Technology Services	Effective Date: 4/14/2021

PURPOSE:

Passwords are an important aspect of computer security. They are the front line of protection for user accounts. A poorly chosen password may result in the compromise of NIHD's entire network. As such, all NIHD workforce members including but not limited to- employees, members of the Board of Directors, contractors and vendors with access to NIHD systems are responsible for taking the appropriate steps, as outlined below, to select and secure their passwords.

The purpose of this policy is as follows:

1. To establish a standard for creation of strong passwords
2. To establish a standard for the protection of those passwords
3. To establish a standard for the frequency of change of those passwords.

SCOPE:

The scope of this policy includes all NIHD workforce members (as described above) who have or are responsible for an account (or any form of access that supports or requires a password) on any system that resides at any NIHD facility, has access to the NIHD network, or stores any non-public NIHD information.

POLICY:

1. All passwords must be changed every 90 days.
2. Password history will remember the last 3 passwords that cannot be reused.
3. Accounts will be locked out after 8 failed attempts to prevent password spraying attempts.
4. Passwords must not be inserted into email messages or other forms of electronic communication.
5. All user-level and system-level passwords must conform to the guidelines described below.
    a. Password must contain a minimum of 8 characters and maximum of 15 characters
    b. Passwords must contain a combination of capital and lowercase letters ,numbers and symbols
    c. Passwords should not contain easily recognizable words (i.e. Bishop, Inyo, NIH)
    d. ***Password exception for DMS***– Passwords can **only** contain capital or lowercase and not in combination. Example – "TgAgm487&" the password would have to be "tgagm4878&" or "TGAGM4878&"
6. Passwords are not to be shared with anyone, including administrative assistants.
7. If a password is suspected to have been compromised, report the incident immediately to the Information Technology Services Department or the District Information Security Officer.
8. NIHD workforce members cannot use the same password for NIHD accounts as they use for other non-NIHD access (e.g., personal ISP account, shopping sites, benefits, etc.).
    a.) If an employee's NIHD account(s) is compromised the ITS department will then investigate the public password breaches to verify that an employee's password(s) are not in the public domain.
    b.) During an investigation of a security breach an employee may be asked - do you use the same password for any other accounts whether private or public?
9. NIHD workforce members cannot use the "Remember Password" feature of applications (e.g., Internet, Outlook OWA, etc.).

REFERENCES:

1. HIPAA Security - Security Awareness and Training Standard 164.308(a)(5)(ii)(D)
   NIST SP: 800-118, 800-12, 800-82 Rev 2, 800-53 Rev 4, 800-63-2, 800-66 4.5.3

CROSS REFERENCE P&P:

1. Password Management

Committee Approval	Date
Executive Team	4/5/2021

NORTHERN INYO HOSPITAL
POLICY AND PROCEDURE

Title: **Password Policy**	
Scope: District Wide	Department: **District Information Security**
Source: Director of Information Technology Services	Effective Date: 4/14/2021

Board of Directors	5/20/2020
Board of Directors Last Review	5/20/2020

Developed: 1/1/2004
Reviewed:
Revised: 6/3/2019 bh
Supersedes: Password Policy
Responsibility for review and maintenance: District Information Security Officer
Index Listings:
NIST Guidelines- https://pages.nist.gov/800-63-3/sp800-63b.html

NORTHERN INYO HEALTHCARE DISTRICT
POLICY AND PROCEDURE

Title: Cell Phone Procurement and Issuance	
Scope: District Wide	Manual: Information Technology
Source: Information Technology	Effective Date:

PURPOSE: Northern Inyo Healthcare District obtains and manages cell phones for use by district staff members in order to maintain appropriate privacy for hospital communications. This policy is to outline the process for issuance of cell phones to meet the needs of the hospital team.

POLICY:

1. **Northern Inyo Healthcare District has outlined cell phone usage policies as defined in the referenced policies below. The purposes of this policy is to assure the compliance of all team members regarding the procurement and issuance of cell phones.**

PROCEDURE:

1. Approved Cell Phones are requested by the manager of the staff member by submitting an IT (Information Technology) Service Desk request.
2. IT orders, manages and configures all smart phones.
3. Accounting reconciles the new phone charge to the monthly statement and completes the Purchase Order process.
4. Managers or Human Resources returns all phones to IT for re-deployment and updating of cost center information through the Verizon management console by either suspending the service as required by the carrier or reissuing to a new user. All phones returned must have the screen lock pin disabled before returning.

REFERENCES:

1. N/A

CROSS REFERENCE P&P:

1. Hospital Cell Phone Use
2. Hospital Issued Cell Phone/Electronic Communication Device Use By Employees

Approval	**Date**
NCOC	**6/2/2021**
Executive Committee	**6/7/2021**
Board of Directors	
Board of Directors Last Review	

Developed: 5/21kp
Reviewed:
Revised:

NORTHERN INYO HEALTHCARE DISTRICT
POLICY AND PROCEDURE

Title: Cell Phone Procurement and Issuance	
Scope: District Wide	Manual: Information Technology
Source: Information Technology	Effective Date:

NORTHERN INYO HEALTHCARE DISTRICT
PROCEDURE

Title: Lost and Found Items	
Scope: District Wide	Manual: Admissions Services
Source: Admission Services Manager	Effective Date:

PURPOSE: Northern Inyo Healthcare District will make reasonable attempts to safeguard patient and staff personal belongings and to assist in their recovery when loss or misplacement claims are made in order to reunite lost and found items with their owners.

PROCEDURE:

1 Found Items

A. Attach identifying information to the article:

1. Name
2. Date
3. Location lost and found
4. Patient/visitor or employee information, if known
5. Other pertinent information

2. Items to be turned in

l. Give items to admitting office
2. Admitting staff will put in lost and found box
3. Admission Services Department will check box every day and pick up any item(s)
4. If Admission Services Department is out of the hospital an alternate will be assigned to pick up item(s) and log item(s) in

3. Item(s) logged in and ID Number Given

l. The Admission Services Department will attempt to contact the owner

4. The Admission Services Department will:

l. Hold the item for 90 days; if unclaimed then
2. Disposal would then be,
   a. Donate to a Thrift store, or
   b. Offer to finder

5. Reporting Lost Items

A. When a patient believes that the hospital has misplaced an item that needs replacing, the Community Relations Department will:

1. Assess the hospital's responsibility with hospital administration and
2. Replace the item, if appropriate

B. Calls regarding lost item(s)

l. Take information about lost item from caller
2. Check lost and found, if not found
3. Do a search of the area were items was said to be lost
4. Found item(s) will be entered into log and owner contacted

DOCUMENTATION:

The Community Relations log of lost and found items shall document:

NORTHERN INYO HEALTHCARE DISTRICT
PROCEDURE

Title: Lost and Found Items	
Scope: District Wide	Manual: Admissions Services
Source: Admission Services Manager	Effective Date:

1. Name of person, if known
2. Description of Item(s)
3. Date found and /or date lost
4. Name of reporting party
5. Location item(s) lost/found
6. Actions taken to find item(s)owner
7. Final disposition

REFERENCES:

1. N/A

CROSS REFERENCE P&P:

1. N/A

RECORD RETENTION:

1. N/A

Approval	**Date**
NCOC	6/2/2021
Executive Committee	6/7/2021
Board of Directors	
Last Board of Directors Review	

Developed:
Reviewed:
Revised: 6/21ta
Supersedes:

NORTHERN INYO HOSPITAL
PROCEDURE

Title: Environmental Services Radio Procedure	
Scope: Environmental Services	Manual: Environmental Services
Source: MANAGER OF ENVIRONMENTAL SERVICES	Effective Date:

PURPOSE:
To provide constant communication within the E.S. Department and between the E.S. Department and other departments.

PROCEDURE:

1. Each employee will carry a radio throughout their shift.
2. Staff should radio out to the team they are here when they come on shift.
3. All conversations must be brief and each call must be responded to with a brief response.
4. Conversations should be kept discreet, including only vital information, over the radio.
5. Staff will turn on the radio, turn dial to channel #2 for ES Department, press the button on the side of the radio and wait two seconds before speaking, release button to hear the response.
6. If using the earpiece, hook the piece to ear and clip microphone to shirt. To respond to calls, press button on microphone wait two seconds before speaking and release button for response. If the earpiece or radio is not working, report it to the coordinator or manager.
7. At the end of the shift, turn radio off, disconnect ear piece, and dock the radio in the provided charger.

Approval	**Date**
NCOC	**6/2/2021**
Executive Committee	**6/7/2021**
Board of Directors	

Developed: 2/18/2017 AD
Reviewed:
Revised: 4/27/21 AS
Supersedes:

NORTHERN INYO HOSPITAL
POLICY AND PROCEDURE

Title: Development, Review and Revision of Policies and Procedures	
Scope: District Wide	Manual: Administration
Source: Policy Tech Project Analyst	Effective Date:

PURPOSE:

1. Policies and Procedures are developed to create a framework that describe and guide workforce in meeting the standards and expected action which have been adopted and approved by the Board of Directors of Northern Inyo Healthcare District (NIHD).
2. To provide direction on the required elements of policies and procedures and the required approval process.
3. To assist with determination on when to create a policy and when not to; to determine when a policy is essential and when it isn't.
4. Policy helps NIHD to accomplish its mission; maintain accountability; provide workforce and students with clear, concise tools; and clarify how the District does business.

POLICY:

NIHD workforce will have access to well-articulated and understandable policies and related procedures. These policies and procedures will be:

1. Presented in common format,
2. Formally approved,
3. Centrally maintained,
4. Kept current within the framework of an organized system of change control, and
5. Distributed to all relevant units in a timely manner.

DEFINITIONS

1. Clinical Consistency Oversight Committee (CCOC) – Multidisciplinary team, represented by clinical staff that reviews all clinical policies and procedures, once approved by CCOC, sends to appropriate medical staff committees and board of directors for final approval.
2. Forms – approve documents that are utilized for operations at the District. Stored on the NIHD Intranet and as attachments to procedures when appropriate.
3. Guideline – Statements that include recommendations intended to optimize patient care that are informed by a systematic review of evidence and assessment of the benefits and harms of alternative care options.
4. Policy – The clear, concise statements of the parameters by which an organization conducts its business. Policies are the rules that workforce abide by as they carry out their various responsibilities.
    A. Must be approved by governing body (Board of Directors) every 2 years at minimum.
5. Non-Clinical Consistency Oversight Committee (NCOC) – Multidisciplinary team, represented by non-clinical staff, operations team and clinical workforce, who review non-clinical policies and procedures. NCOC reviews and once approved sends policy on to other committees as appropriate prior to final approval at the board of directors.
6. Policy and Procedure Management Software (PPM) – Repository for NIHD policies and procedures, excluding the procedures in Lippincott Procedures. PPM allows for tracking of current and past policies and procedures, while maintaining access for workforce review.
7. Procedures – The instructions or steps that describe how to complete a task or do a job.

Title: Development, Review and Revision of Policies and Procedures	
Scope: District Wide	Manual: Administration
Source: Policy Tech Project Analyst	Effective Date:

   A. Clinical procedures require approval via the medical staff committee process; ultimately approved by the Medical Executive Committee.
   B. Lippincott Procedure Manual is utilized by NIHD for Clinical Procedures.
8. Protocols – An algorithm or recipe for managing a disease or condition. This sets a specific standard for process. (Example – wrist x-ray = 3 views)
   A. Require approval via medical staff committee(s) of departments where the protocol is utilized; ultimately approved by the Medical Executive Committee.
   B. Protocols followed by RN staff that cross from nursing into medical process require a standardized procedure per the California Board of Registered Nursing. These must be approved by the Interdisciplinary Practice Committee, Medical Staff Committee with department oversight and ultimately by the Medical Executive Committee
9. Workforce - Persons whose conduct, in the performance of their work for NIHD, is under the direct control of NIHD or have an executed agreement with NIHD, whether or not NIHD pays them. The Workforce includes employees, NIHD contracted and subcontracted staff, NIHD clinically privileged Physicians and Advanced Practice Providers (APPs), and other NIHD health care providers involved in the provision of care of NIHD's patients.
10. Board of Directors Policy – Policy designed for organizational governance that sets direction for the District, defines and guides appropriate relationships between the board and the chief executive, and sets the duties and responsibilities of the board. These documents do not go to the NCOC or CCOC committees and are managed by the Board Administrative Assistant.

PROCEDURE:

1. Establishing need for a new policy or procedure:

   A. Determine a policy or procedure is necessary;
      I. When the cost of a mistake is high. (High Risk, High Volume or Problem Prone)
      II. When process is outside of common sense and must be prescribed.
      III. When consistent poor results across a number of departments or employees is demonstrated.
      IV. When required by regulatory agencies, including but not limited to: California Department of Public Health (CDPH), The Joint Commission (TJC), Title 22, or Centers for Medicare/Medicaid Service (CMS) Condition of Participation.

   B. Determine a policy or procedure is not necessary.
      I. Simple tasks that are able to done a variety of ways to achieve the same outcome.
      II. Processes that are able to be resourced via other manuals, such as One Source, Lippincott Procedure, etc.
      III. Guidelines are recommendations and although they may be adopted by clinical teams, they do not need to be approved at the Board of Directors level. They are generally created after studies lead to conclusion of best practice. They are not mandated as a policy. Clinical

Title: Development, Review and Revision of Policies and Procedures	
Scope: District Wide	Manual: Administration
Source: Policy Tech Project Analyst	Effective Date:

Guidelines must be adopted by the Medical Staff Committee with oversight of the area where the Guideline is being utilized; ultimately approved by the Medical Executive Committee.
IV. Clinical procedures that are separated from policy may be contained within the District's Procedure Resource (Lippincott Procedures), which is based on best practice and updated routinely. This precludes the necessity of duplicate procedures in most instances. Critical notes are added within the Lippincott procedure to customize for NIHD practices. These must be approved via Medical Staff Committee, but do NOT require Board of Directors review or approval. Included in this document type are Standard Operating Procedures.

2. Policy/Procedure Development or Review/Revision

A. Policy owner or their designee (writer within PPM) may develop or review and update existing policy.

B. New policy development is done in *document>draft* within PPM by policy owner.

I. Policy Wizard is utilized to input policy title, owner, and department by policy owner and Approver. NCOC or CCOC will review the Policy Wizard at the time of approval to support the Policy Owner in making correct build, including assignee (reader group) and frequency of policy review by workforce and owners.
   a. Template is chosen based upon type of document.
   b. Search features are tied to Owner, Department, Writer, Template, Approver and Category.
   c. Writers, Reviewers and approvers are assigned by the Owner, with support and review by the NCOC or CCOC.

II. Research is conducted. Collaboration with subject matter experts and team members impacted by the policy or procedure is best practice during development. Collaborators may include but is not limited to:
   a. Compliance Officer
   b. Legal Counsel (with approval of Executive)
   c. Director of Human Resources
   d. Director or Chief within chain of command

III. References from valid sources and/or regulatory agencies is generally required. Occasionally "not applicable" (N/A) will be appropriate.
IV. Cross Reference P&P – requires review of policies or procedures that may impact the new policy being developed. These are listed as a reference to the end user and to assure the documents are aligned. Other cross reference documents can be located by use of key words via the search feature within PPM.

C. Revision or Review of existing policy or procedure in PPM:

I. Published document within PPM is opened.

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II. Create New Version (blue box/top of screen) drop down list allows:
   a. All assignees - A user given the Assignee role can see all documents and assessment they're assigned to plus all published documents whose security is set to All Users.
   b. Administrators will have exclusive ability to Edit in Current State within published documents.
   a. Owners to Submit for Periodic Review or determine No Revision Necessary
   b. Task Completion by Proxy (Allows policy owner to assign a proxy author to create a specific document, access and edit all draft documents for the owner, request review of edited or newly written document by the owner, can assign review and approval process and can revise owner's documents in review or approval status-placing them back into draft status.)

III. Create New Version (blue box/top of screen) may be checked to create draft of current policy for revision. This does the following:
   a. Automatically archives the current published version upon final approval of the revised version
   b. Maintains current Property Wizard settings, unless revision of these settings is required
   c. Allows for revisions within the draft version

3. Template development

A. Policy Steering Committee will have authority to develop and approve new templates.
   I. Owners and writers may present ideas for new templates to the Policy Steering Committee, but may not create templates.
   II. Templates will have standardized information contained within the header.

B. Templates will be developed for various document types
   I. Policy/Procedure
   II. Standards of Care
   III. Guidelines
   IV. Protocols
   V. Standardized Procedures
   VI. Standard Operating Procedures
   VII. Committee Charters
   VIII. Clinical Guidelines

C. Policy and or procedure templates will contain some or all of the following elements:
   I. Purpose
   II. Policy Statement (All documents that contain policy MUST be initially approved and reviewed every two years by the Board of Directors.)
   III. Definitions

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IV. Procedural steps
V. Record retention and destruction
   a. California Hospital Association reference may be found on the NIHD Intranet>Information>Compliance>Record Retention.
   b. If record retention is not applicable (N/A) must be inserted within this section.
   c. Destruction of record – Confidential records and those with PHI will be shredded or destroyed in compliance with Information Technology Services standards.
VI. References are required using the American Psychological Association (APA) format.
VII. Cross-referenced policies
   a. Use "search" function within PPM to find key words.
   b. Review policies identified by search for potential cross-reference.
   c. Assure policies align with new policy/procedure; if not determine if further revision is required of either or both policy/procedure.
VIII. Header will Contain:
   a. Northern Inyo Healthcare District
   b. Document Type
   c. Title of Document
   d. Source (What part of the Workforce will utilize the document- all departments where the document applies)
   e. Owner of the document (title of the role)
   f. Department (of the document Owner)
   g. Effective date and version number for the document
IX. Page numbers for each page in every document.

4. Committee Approval Process

A. Clinical Policies/Procedures:

I. Clinical Consistency Oversight Committee (CCOC) is the first committee to review and determine if a clinical Policy/Procedure document is ready for approval. They make the following determinations:

   a. Frequency of required review/revision (if necessary)
   b. Assignee by role (who needs to read the document and how often.)
   c. Effective date time line is established to allow workforce education on policy/procedure new documents and for revisions of significance.
   d. Medical Staff Committee(s) referral for approval (Medical Staff Office builds committees into Property Wizard, sequenced by upcoming meeting dates). Final Medical Staff Meeting is Medical Executive Committee (MEC).
   e. Board of Directors review approval is required on all policy and procedure documents prior to implementation.
   f. Final approver, generally at Chief Executive level (may be a designee of the Chief).
   g. Clinical documents recommended for archival by owner must be approved by CCOC prior to archival.

h. After final required approval by Board of Directors or MEC, the Nursing Administrative Assistant is responsible to assure the document is published.

B. Non-Clinical Policies/Procedures

I. Non-Clinical Consistency Oversight Committee (NCOC) is the first committee to review and determine if a Non-Clinical Policy/Procedure document is ready for approval. They make the following determinations:

a. Frequency of required review/revision (if necessary)
b. Assignee by role (who needs to read the document, how often and in what timeframe)
c. Effective date time line is established to allow for workforce education on policy/procedure new documents and for revisions of significance.
d. What other committee(s) need to review and approve the document prior to sending to the Board of Directors.
e. Board of Directors review approval is required on all policy documents prior to implementation and every two years.
f. Executive Committee review/approval is required on all procedure documents prior to implementation and every two years.
g. Non-Clinical documents recommended for archival by owner must be approved by NCOC prior to archival.
h. After final required approval via committees, the COO Administrative Assistant is responsible to assure the document is published.

C. Clinical Guidelines tools developed as best practice (generally utilized for specific diagnosis or situations).

I. Medical Staff Committee will approve Clinical Guideline for use within their department and assure education of peers.
II. Medial Executive Committee approval is required prior to implementation
III. Board of Director approval is not required.
IV. Frequency of review of Clinical Guideline will be determined at Medical Department level.

D. Board of Director policy and procedure will be developed and approved at the Board level.

I. Board may request Board Legal Counsel or Compliance review
II. Board Policy/Procedure will be maintained within PPM and the following will be established:

a. Frequency of required review/revision (if necessary)
b. Assignee by role (who needs to read the document, how often and in what timeframe)
c. Effective date time line is established to allow for workforce education on policy/procedure new documents and for revisions of significance.

5. Periodic Review of documents:

A. This is the responsibility of the document owner, who may delegate by assigning writer(s)

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Source: Policy Tech Project Analyst	Effective Date:

B. The PPM will be set up to notify the owner of items due for review or revision via email and task list within PPM. This process will be under the direction of the Policy Steering Committee.

6. Implementation and effective dates:

A. Workforce education to the new processes and polices must be considered when determining the effective date for each document.

B. During CCOC or NCOC approval process the following decision will be documented:
I. Effective date in relationship to final approval date. (Last Committee or Board of Directors required to approve document)
II. Is workforce required to read the new document? If so, what roles are required to read the document and how often.
III. Will a different education process be utilized to train workforce to the new document?

7. Discarding of documents versus Archival of document

A. Published documents are moved to archives when revised or if they become obsolete. This does require NCOC or CCOC approval for obsolete documents.
B. Draft documents that are found to be unnecessary may be discarded; becoming irretrievable. This may only be done by the policy owner or their designee and does not require committee approval.

8. General Information for document development for PPM.

A. Acronyms must be spelled out prior to being utilized in all documents.
B. May/must are preferred to use of should/shall.

REFERENCES:

1. Center for Medicare/Medicaid Services- **§485.627 Condition of Participation: Organizational Structure C-0241; Interpretive Guidelines §485.635(a)(2) & (4); -§485.627(a) Standard: Governing Body or Responsible Individual; (**Rev. 200, 02-21-20**).** https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/som107ap_w_cah.pdf
2. American Psychological Association (APA) Format web site: https://owl.purdue.edu/owl/research_and_citation/apa_style/apa_formatting_and_style_guide/general_format.html
3. California Hospital Record and Data Retention Schedule, 2018.

CROSS REFERENCE P&P:

1. Pathways for development, Review and Revision of Nursing Standards

NORTHERN INYO HOSPITAL
POLICY AND PROCEDURE

Title: Development, Review and Revision of Policies and Procedures	
Scope: District Wide	Manual: Administration
Source: Policy Tech Project Analyst	Effective Date:

RECORD RETENTION:
All policy, procedure, scope of practice, standards of care, care guidelines and bylaw documents will be maintained for the life of the document, plus 6 years.

Approval	**Date**
NCOC	6/2/2021
CCOC	6/1/2021
Executive Committee	6/7/2021
Medical Executive Committee	6/1/2021
Board of Directors	
Board of Directors Last Review	

Developed: 5/2021ta
Reviewed:
Revised:

Responsibility for review and maintenance:
Index Listings:

https://www.pnwu.edu/inside-pnwu/about-us/policies-and-procedures/procedure-policy-development-and-approval

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

Northern Inyo Healthcare District

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Bishop, CA 93514
(760) 873-5811
www.nih.org

Compliance Report
June 2021

1. **Compliance Department Team**
    a. The Compliance team is pleased to announce that Paige Wagoner has moved from the RHC to the Compliance Team. She is fantastic to work with and is already making great contributions.
    b. The Compliance team is also pleased to announce that Tracy Aspel returned from retirement as the Compliance Policy Project Analyst. Tracy is making great progress preparing the new software, our policies, and training for our leadership team.
2. **Comprehensive Compliance Program review –** no update since Annual Compliance Report of November 2020.
3. **Potential Breaches** and privacy concerns
    a. The Compliance Department has investigated 12 privacy concerns between January 1, 2021 and May 31, 2021.
        i. Investigations closed with no external reporting required – 7
        ii. Investigations still active – 2
        iii. Reported to CDPH/OCR – 3
            1. No determinations received from CDPH
    b. The Compliance Department has investigated 69 alleged breaches in CY 2020.
        i. Investigations closed with no external reporting required – 50
        ii. Investigations still active – 0
        iii. Reported to CDPH/OCR – 19
            1. 3 CDPH cases closed as substantiated without deficiencies
            2. 16 are pending determination by CDPH
    c. Outstanding breaches reported to CDPH between 2016-2019
        i. 2016
            1. 1 case is still in progress
        ii. 2017
            1. 15 cases are in submitted status
            2. 1 case is still in progress
        iii. 2018
            1. 9 cases are in submitted status

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iv. 2019
    1. 3 cases are in submitted status
    2. 1 case is in progress

4. Issues and Inquiries

a. The Compliance Team researches regulatory concerns, ever-changing COVID regulations and guidance, and internal policy as requested by NIHD workforce.
b. Compliance has assisted with more than 50 research requests since the beginning of January 2021.

5. Audits

a. Employee Access Audits
    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.
        1. The Compliance Department Analyst manually completes audits for access of previous patient information systems (Athena, Centricity, Paragon, Redoc, Orchard, etc) to ensure employees' access records only on a work-related, "need to know," and "minimum necessary" basis.
            a. Compliance performs hundreds audits monthly. **This will continue for the legacy systems as long as they are accessed.**
            b. Each audit ranges from hundreds of lines of data to thousands of lines of data.
            c. A "flag" is created when any access appears unusual.
            d. Flags are reviewed and resolved by comparison audits, workflow review, discussions with workforce, and discussions with leadership.
            e. See attachment A
    iii. Cerner has a more automated system for auditing. Cerner has a dashboard that displays the data the program monitors on an on-going basis.
        1. Compliance has a dashboard and can review flags for the following event types regularly

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a. User ID matches patient name
b. User has same last name as patient
c. Chart access is unusual pattern for user.
d. Excessive printing or excessive charts being opened for job role.

2. We have only had the new auditing software for two months, and so are still working on how to incorporate executive overview style reports for the Board of Directors. See some sample data
    a. attachment B

b. Business Associates Agreements (BAA) audit
    i. We currently have approximately 160 Business Associates Agreements.
    ii. We have executed around 1 BAAs since January 1, 2021.
c. Vendor Contract reviews
    i. 39 contracts currently in the review process
    ii. More than 100 agreements or contracts have been reviewed and executed since January 2021
d. PACS (Picture Archival and Communication System) User Access Agreements - No update since previous quarterly report
e. HIMS scanning audit – Deferred to Q3 CY 2021 to include Cerner EHR
f. Language Access Services Audit – Deferred to Q3 to ensure documentation in Cerner
    i. Audits for Language Access Services to ensure Limited English Proficiency (LEP) patients are provided with the appropriate access to ensure safe, quality healthcare.
    ii. Audits review documentation of language assistance provided to LEP patients
    iii. Action items from audits allow the Compliance team to work with Language Access Services Manager, Jose Garcia, to develop tools for the workforce to ensure all proper steps are followed.
    iv. Language Access regulations are enforced by the HHS Office of Civil Rights.
g. HIPAA Security Risk Assessment – Due November 2021 (requires collaboration between Compliance Officer and Security Officer)
    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.

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1. Periodic update and assessment to be completed in Q3 of CY2021 with system changes of EHR, Time keeping system, Employee badge process, and other technological update.

ii. NIHD is now using 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.
   1. We have over 70 Vendor Companies registered.
   2. We have over 127 Representatives registered.

h. 340B audit – Annual external audit and response plan in progress
i. An audit of NIHD Board of Directors Agendas, Minutes, and Resolutions is in progress.

6. CPRA (California Public Records Act) Requests

a. The Compliance office has responded to two CPRA requests to date in 2021.

7. Compliance Workplan - – no update since previous quarterly report

8. Unusual Occurrence Reports (UOR) - UORs have transitioned to the Compliance Department. ** We continue to update the confusing or missing labeling on the reports.

a. See attached 2020 Summary of Unusual Occurrence Reports (14 pages)
   i. attachment C
b. See attached Q1 CY2021 Summary of Unusual Occurrence Reports (14 pages)
   i. Attachment D

9. Compliance Committees

a. Business Compliance Team
   i. 2021 Conflict of Interest (COI) questionnaires were distributed approximately 2 weeks ago.
   ii. We have received greater than 40% of completed questionnaires from our workforce
   iii. Business Compliance Team will be meeting no less than monthly until all conflicts of interest have been addressed.
b. Billing and Coding Compliance Committee
   i. Sporadic meetings during the Cerner build and go-live. Has now been set for weekly meetings to address coding, provider enrollment, billing, productivity, coding audit information, new services or service lines and similar information
c. Compliance and Business Ethics

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i. Members of committee have been reassessed. Update to Compliance Program to the Board anticipated in July and then we will re-establish regular quarterly meetings.

10. Optimization, update, and audit of Policy Management software

a. Proper policies and policy management is a large component of an effective Compliance Program.
b. A small team comprised of nursing, operations, compliance, and ITS representatives have been completing work on the policy management software optimization. Tracy Aspel has compiled all of this information and we are hoping to bring the steering policy to the Board either in June or July.
c. Tracy, Policy Project Analyst, has reviewed and updated more than 600 policies, ensured the correct version in correct formats are in both the currently published version and the version to be released later this year.
d. Tracy has also provided one-on-one training for the policy software and policy writing with many new and no-so-new members of the District leadership team.

11. Optimization, update, and audit of Contract Management software

a. Approximately 75% of active contracts have been updated to utilize additional features available in the updated software.
b. Paige, Compliance Clerk, is working to update all contracts, standardize entries and include key data for the end users of the system.
c. All historic contracts in the system will still be available for review.

NORTHERN INYO HEALTHCARE DISTRICT
DISTRICT BOARD RESOLUTION 21-05

WHEREAS, the Northern Inyo Healthcare District is required to establish an annual appropriations limit in accordance with Article XIIIB of the California Constitution; and

WHEREAS, using data provided by the State of California Department of Finance, letter dated May 2020, the Board of Directors of Northern Inyo Healthcare District established an appropriations limit of $677,524.23 for the July 1, 2020 to June 30, 2020 fiscal year; and

WHEREAS, using the attached data provided by the State of California Department of Finance and the County of Inyo, an appropriations limit of $716,632.91 has been calculated for the July 1, 2021 to June 30, 2022 fiscal year.

NOW, THEREFORE, BE IT RESOLVED by this Board of Directors of Northern Inyo Healthcare District, meeting in regular session this 16th day of June, 2021 that an appropriations limit of $716,632.91 be established for the Northern Inyo Healthcare District for the 2021-2022 fiscal year; and

BE IT FURTHER RESOLVED that this Resolution be made a part of the minutes of this meeting.

Adopted, signed and approved this 16th day of June, 2021.

_____
District Board Chair

_____
District Board Secretary

Appropriation calculation:

Per capita personal income 3.73

Per capital cost of living converted to a ratio: $\frac{3.73+100}{100} = 1.0373$

Population minus exclusion: +0.10

Population converted to ratio: $\frac{0.22+0.10+100}{100} = 1.0032$

Calculation of factor for FY 2018-19: 1.0373x1.0032=1.040619

Prior year appropriation limit: $604,858.24

Calculation of appropriation limit for FY 2019-20: $651,078.09x1.040619=$677,524.23

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: Sierra Bourne, MD, Chief of Medical Staff
DATE: June 1, 2021
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. Medical Staff Appointments *(action item)*
    1. Kevin Efros, MD (*anesthesiology*) – Active Staff
    2. Michael Santomauro, MD (*urology*) – Courtesy Staff
    3. Andrew Tang, MD (*internal medicine/hospitalist*) – Courtesy Staff

B. Change in Staff Category (*action item*)
    1. Michael Phillips, MD (*emergency medicine*) – change from Active Staff to Honorary Staff

C. Policies and Procedures (*action items*)
    1. *Dilation and Curettage or modified suction curettage procedures in the Emergency Department*
    2. *Bloodborne Pathogen Exposure Control Plan*
    3. *Nursing Care Guidelines in the PACU*
    4. *Local Anesthesia in Surgery*
    5. *PACU Discharge Criteria*
    6. *Pathology Specimens in the Operating room*
    7. *Patient Warmer (Warm Air Hyperthermia System)*
    8. *Standards of Care in the Perioperative Unit: Pediatric Patient*
    9. *Preoperative Preparation and Teaching*
    10. *Scheduling Surgical Procedures*
    11. *Scope of Service PACU*
    12. *Sponge, Sharps, and Instrument Counts*
    13. *Surgery Equipment and Routine Supplies*

D. Medical Executive Committee Meeting Report (*information item*)

NORTHERN INYO HEALTHCARE DISTRICT
POLICY AND PROCEDURE

Title: Dilation and Curettage in the Emergency Department	
Scope: Emergency Department	Manual: Emergency Department
Source: MNGR ED DISASTER PLANNING	Effective Date:

PURPOSE: To establish appropriate guidelines regarding initiation of a Dilation and Curettage (D&C) or a modified suction curettage procedure in the Emergency Department (ED).

POLICY:

1. Dilation and Curettage or modified suction curettage procedures are to be scheduled and performed in an outpatient ambulatory clinic or in the Operating Room (OR).

2. A Dilation and Curettage or modified suction curettage procedure will **NOT** be performed in the Emergency Department unless the procedure is deemed emergent and a collaborative conversation has taken place to ensure adequate resources are available to safely support the procedure in the ED.

PROCEDURE:

1. The OB/GYN physician will be notified immediately by the ED physician of any hemodynamically unstable patients in the ED that may be in need of a D&C or modified suction curettage procedure.
2. Every attempt will be made to transfer the patient to the OR.
3. If the patient is unable to transfer to the OR and the OB/GYN physician deems the D&C or modified suction curettage emergent, the OB/GYN will perform the D&C or modified suction curettage in the ED.
4. A collaborative conversation will occur between the ED physician, OB/GYN physician, and the House Supervisor to meet the following needs:
    a. Staffing – An OR RN/Scrub Tech or an ED RN may assist the OB/GYN physician during the procedure only if staffing allows and a plan is in place to accommodate emergencies that may arrive to the ED or OR.
    b. Equipment – All necessary equipment will be obtained by the OB/GYN physician or House Supervisor prior to start of procedure.
    c. If procedural sedation is required, policies related to administration must be followed.

5. If an ED RN is utilized during the procedure, the House Supervisor will be made aware and on standby in case the ED volume increases or critical patients arrive needing assistance.

REFERENCES:

1. Lippincott Procedures

CROSS REFERENCE P&P:

1. Evaluation and Screening of Patients Presenting to Emergency Department.

NORTHERN INYO HEALTHCARE DISTRICT
POLICY AND PROCEDURE

Title: Dilation and Curettage in the Emergency Department	
Scope: Emergency Department	Manual: Emergency Department
Source: MNGR ED DISASTER PLANNING	Effective Date:

Approval	**Date**
CCOC	2/11/2021
ED Services Committee	3/11/2021
Surgery Tissue Committee	5/12/2021
Peri-peds Committee	2/23/2021
Infection Prevention	4/21/2021
MEC	6/01/2021
Board of Directors	
Last Board of Directors Review	

Developed: 12/1/20jb
Reviewed:

NORTHERN INYO HOSPITAL
POLICY AND PROCEDURE

Title: Bloodborne Pathogen Exposure Control Plan	
Scope: NIHD	Manual: CPM Infection Control Patient Care (ICP)
Source: Quality Informatics Nurse/Infection Preventionist Manager	Effective Date: 9/1/17

PURPOSE:

The goal is of this plan is to minimize or eliminate health care worker exposure to bloodborne pathogens. This plan focuses on safer work practices, personal protective equipment, and engineering and administrative controls. Adhering to this plan ensures compliance with all applicable laws and regulations relating to bloodborne pathogens exposure, and is in accordance with Cal/OSHA's Bloodborne Pathogens Standard (Title 8, California Code of Regulations, Section 5193). This plan continues our commitment to providing a safe and healthy environment in which to deliver patient care.

POLICY

Northern Inyo Healthcare District is committed to providing a safe and healthy environment for its entire staff. This policy and procedure will be followed by all employees and physicians working within this facility who may be potentially exposed to bloodborne pathogens. Failure to follow this policy and procedure may result in disciplinary actions.

DEFINITIONS

Bloodborne pathogens – Pathogenic microorganisms that may be present in human blood and can cause disease in humans. These pathogens include, but are not limited to, hepatitis B virus (HBV), hepatitis C virus (HCV) and human immunodeficiency virus (HIV).

Contaminated – The presence or the reasonably anticipated presence of blood or other potentially infectious materials on a surface or in or on an item.

Decontamination – The use of physical or chemical means to remove, inactivate or destroy bloodborne pathogens on a surface or item to the point where they are no longer capable of transmitting infectious particles and the surface or item is rendered safe for handling, use or disposal.

Engineering controls – Controls such as sharps disposal containers, needleless systems and sharps with engineered sharps injury protection that isolate or remove the bloodborne pathogens hazard from the workplace.

Engineered sharps injury protection – A physical attribute built into a needle device used for withdrawing other potentially infectious materials accessing a vein or artery, or administering medications or other fluids, which effectively reduces the risk of an exposure incident by a mechanism such as barrier creation, blunting, encapsulation, withdrawal or other effective mechanisms; or a physical attribute built into any other type of needle device, or into a non-needle sharp, which effectively reduces the risk of an exposure incident.

Exposure incident – A specific eye, mouth, or other mucous membrane, non-intact skin, or parenteral contact with blood or other potentially infectious materials that results from the performance of an employee's duties.

Title: Bloodborne Pathogen Exposure Control Plan	
Scope: NIHD	Manual: CPM Infection Control Patient Care (ICP)
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Needleless system: A device that does not use a needle and is used to withdraw body fluids after initial venous or arterial access is established; to administer medication or fluids; or for any other procedure involving the potential for an exposure incident

Occupational exposure – A job category where skin, eye, mucous membrane, or parenteral contact with blood or other potentially infectious materials could be reasonably anticipated.

Other potentially infectious materials (OPIM) –

- Human body fluids: semen, vaginal secretions, cerebrospinal fluid, synovial fluid, pleural fluid, pericardial fluid, peritoneal fluid, amniotic fluid, saliva in dental procedures, any other body fluid that is visibly contaminated with blood such as saliva or vomitus, and all body fluids in situations where it is difficult or impossible to differentiate between body fluids such as in an emergency response
- Any unfixed tissue or organ (other than intact skin) from a human (living or dead)
- Any of the following, if known or reasonably likely to contain or be infected with HIV, HBV or HCV:
  - –Cell, tissue, or organ cultures from humans or experimental animals
  - –Blood, organs or other tissues from experimental animals
  - –Culture medium or other ~~solutions~~solutions

Personal Protective Equipment (PPE): PPE is specialized clothing or equipment worn by an employee to minimize exposure to a variety of hazards.

Source individual – Any individual, living or dead, whose blood or other potentially infectious materials may be a source of occupational exposure to the employee. Examples include, but are not limited to, hospital and clinic patients; clients in institutions for the developmentally disabled; trauma victims; clients of drug and alcohol treatment facilities; residents of hospices and nursing homes; human remains; and individuals who donate or sell blood or blood components.

Standard precautions – An approach to infection control. Standard precautions expand the universal precautions concept *(see below)* to include all other potentially infectious materials with the intent of protecting employees from any disease process that can be spread by contact with a moist body substance. This isolation technique includes substances such as feces, urine, saliva and sputum that were not included in Standard universal precautions unless they contained visible blood.

Universal precautions – Is an approach to infection control to treat all human blood and certain human body fluids as if they were known to be infectious for HIV, HBV and other bloodborne pathogens. Universal Precautions emphasizes the use of Personal Protective Equipment (PPE) barrier to prevent contact with blood and other potentially infectious materials Precautions apply to blood, semen, and vaginal secretions; amniotic, cerebrospinal, pericardial, peritoneal, pleural, and synovial fluids; and any other body fluid visibly contaminated with blood.

Title: Bloodborne Pathogen Exposure Control Plan	
Scope: NIHD	Manual: CPM Infection Control Patient Care (ICP)
Source: Quality Informatics Nurse/Infection Preventionist Manager	Effective Date: 9/1/17

Work Practice Controls: Are controls that reduce the likelihood of exposure be altering the in manner in which a task is performed.

EXPOSURE DETERMINATION

The exposure determination looks at all job classifications to determine the potential for occupational exposure to blood or other potentially infectious materials. Health care worker job classifications listed below have been determined to be at risk for occupational exposure. This list includes those job classifications in which only some employees have occupational exposure. All elements of this exposure control plan apply to all employees in these jobs.

- Admission Services
- Biomedical engineers
- Central Supply
- Diagnostic Imaging Technologists
- ~~EEG /~~ EKG technicians
- Environmental Services
- Laboratory employees
- Language Services
- Laundry
- Maintenance/Plant Operations
- Nursing- All
- Pharmacy
- Physicians
- Rehab Department
- Respiratory therapists
- Security
- Social Services
- Dietary

METHODS OF COMPLIANCE

This section reviews the numerous work practices and procedures necessary to minimize or eliminate un-protected exposure to bloodborne pathogens. Compliance with these practices and procedures is MANDATORY and is a condition of employment.

Title: Bloodborne Pathogen Exposure Control Plan	
Scope: NIHD	Manual: CPM Infection Control Patient Care (ICP)
Source: Quality Informatics Nurse/Infection Preventionist Manager	Effective Date: 9/1/17

Standard Precautions

Refer to Lippincott Procedures Standard Precautions.

Standard precautions are used in all patient care to prevent contact with blood and OPIM. The following body fluids are always treated as if infectious for HBV, HCV or HIV:

* Human blood, blood components and products made from human blood

* **Other potentially infectious materials (OPIM)**

  –semen

  –vaginal secretions

  –cerebrospinal fluid

  –synovial fluid

  –pleural fluid

  –pericardial fluid

  –peritoneal fluid

  –amniotic fluid

  –any other body fluid contaminated with blood such as saliva or vomitus

  –any unfixed tissue or organ from a human

In circumstances where it is difficult or impossible to differentiate between body fluid types, those fluids are assumed to be potentially infectious.

The Infection Preventionist of Northern Inyo Healthcare District (NIHD) and leadership is responsible for overseeing the use of standard precautions by all health care workers in this setting.

Engineering Controls:

Engineering controls are used to minimize or eliminate HCW occupational exposures to bloodborne pathogens. These controls include, but are not limited to:

- Devices with engineered sharps injury protection
- ~~Sharps with engineering controls, such as~~ Nneedleless systems
- Safety design devices

~~Needle devices and non-needle sharps~~

- Hand washing facilities

~~Leak proof specimen containers~~ Sharps containers

-
- Laboratory safety hoods where appropriate
- Pneumatic Tube Safety
- Specimen containers
- Protective shields

Use of Needleless Systems, Needle Devices, Non-needle Sharps

When feasible, needless system(s) will be used for:

- Withdrawing OPIM after initial venous or arterial access is established.
- Administering medications or fluids
- Any other procedure involving the potential exposure incident for which a needle device with engineered sharps injury protection is available

When feasible, devices with engineered sharp injury protection will be used for:

- ~~d~~Withdrawing OPIM
- Accessing a vein or artery
- Administering medication or fluid
- Any other procedure involving the potential for an exposure incident for which a needle device with engineered sharps injury protection is available.

Non-needle sharps (e.g., scalpels, lancets) shall have engineered sharps injury protection mechanisms

Employees with potential occupational exposure to blood and OPIM will be trained in the use of engineering controls provided for their use. Additional training will be provided as necessary when new engineering controls are adopted.

~~These devices represent a very effective means of reducing potential staff injuries. The following systems/devices are in place:~~

~~The *CLAVE CONNECTOR* needleless system(s) will be used for:~~

- ~~Administering fluids or medications~~

- ~~Any other procedures involving the potential for an exposure incident for which a needleless system is available as an alternative to using a needle device~~

~~When a needle or sharp is required, engineered sharps injury protection such as~~

~~**AUTOGARD IV CATHS*~~

~~**MONOJECT SAFETY SYRINGES*~~

~~**VACUTAINER BUTTERFLY / PUNCTURE GUARD / NEEDLE-PRO*~~

~~**SAFETY TIP NEEDLES*~~

~~**NEEDLE-PRO BLOOD GAS KIT*~~

~~**BLOOD TRANSFER SETS*~~

~~**TIP PROTECTORS*~~

~~**EDGE SAFETY DEVICE*~~

~~**HYPODERMIC NEEDLE-PRO*~~

~~**SAF-T HOLDER DEVICE*~~

NIHD Sharps Protection Injury Committee evaluates engineering control on an as needed basis and determines which ones provide the best protection without compromising patient care.

~~**WILL BE USED FOR:**~~

- ~~Withdrawing other potentially infectious materials~~
- ~~Accessing a vein or artery~~
- ~~Administering medications or fluids~~
- ~~Any other procedure involving the potential for an exposure incident for which a needle device with engineered sharps injury protection is available.~~

~~Non-needle sharps (e.g., scalpels, lancets) shall have engineered sharps injury protection mechanisms. The following non-needle safer devices are in use:~~

~~**TENDERLETT LANCETTS*~~

~~**DISPOSABLE SCALPELS*~~

Engineered sharps injury protection devices are not required in the following situations only:

- An engineering control is not available in the marketplace during a pandemic or during a national shortage.

Title: Bloodborne Pathogen Exposure Control Plan	
Scope: NIHD	Manual: CPM Infection Control Patient Care (ICP)
Source: Quality Informatics Nurse/Infection Preventionist Manager	Effective Date: 9/1/17

- A licensed health care professional, directly involved in a patient's care, determines in the reasonable exercise of clinical judgment, that the use of the engineering control will jeopardize the patient's safety or the success of a medical or nursing procedure involving the patient. In such cases, the use of this exception shall be investigated and documented by the Infection Preventionist or designee, and must be approved by the NIHD Infection Committee.
- The employer can demonstrate by means of objective product evaluation criteria that the engineering control is not more effective in preventing incidents than the alternative used by the employer.
- There is no reliable or specific safety performance information available on the safety performance of the safety control for this facility's procedures. NIHD ~~This facility is~~ actively determin~~es~~~~ing~~ whether the use of engineering controls lacking reliable or specific safety performance information will reduce the risk of exposure incidents occurring in this facility.
- The use of engineering controls will be re-evaluated annually during the yearly review of this exposure control plan. Additions or deletions will be made at that time or as indicated by ongoing monitoring activities.

  ~~Evaluations of effective engineered sharps injury protection devices will follow the Safer *Sharps and Work Practices Evaluation Process*. New devices will be evaluated annually as available, and otherwise as needed.~~

Work Practice Controls:

The use of standard precautions is an integral part of this exposure control plan and of NIHD infection prevention program. Standard precautions will be practiced whenever exposure to blood or OPIM is anticipated. When differentiation between body fluid types is difficult or impossible, all other potentially infectious materials will be considered potentially infectious materials.

Work practice controls/procedures have been implemented to minimize exposure to bloodborne pathogens. Each department manager/supervisor is responsible for implementing, evaluating and monitoring compliance with these work practices. Infection Preventionist, department designee, and Department Safety Officers will monitor work practices as part of routine rounds through each area.

Specific infection control policies and procedures are in place to address work practices and procedures centered on the concept of standard precautions. The minimization and elimination of exposure to blood and OPIM is the primary goal.

The following is a summary of work practice controls:

- Hands will be washed with soap and water or alcohol based hand rub (ABHR) before patient contact, after the removal of gloves or other personal protective equipment and immediately following contact or exposure to blood or Other potentially infectious materials before clean/aseptic procedure, and after

touching patient surroundings. *Hands must be washed with soap and water if there is any visible contamination with blood or other fluids.*

- Mucous membranes and eyes will be immediately flushed with water following exposure to blood or other potentially infectious materials.
- Eating, drinking, smoking, applying cosmetics or lip balm, and handling contact lenses are prohibited in work areas where there is reasonable likelihood of occupational exposure (e.g., nurses' station).
- Food, drink and oral medications will not be kept in refrigerators, freezers, shelves, cabinets or on countertops or bench tops where blood or other potentially infectious materials may be present.
- All procedures involving blood or other potentially infectious materials will be performed in such a manner as to minimize splashing, spraying, spattering and generation of droplets.
- ~~Mouth pipetting/suctioning of blood or other potentially infectious materials is prohibited.~~
- Specimens of blood or other potentially infectious materials will be placed in containers that prevent leakage during collection, handling, processing, storage, transportation or shipping. Syringes containing blood or other potentially infectious materials will not be transported with needles attached unless an engineered safety device is in place permanently shielding the needle.
- The container for storage, transport or shipping to outside of the facility will be labeled or color-coded with the legend "biohazard." These labels shall be fluorescent orange or orange-red, with lettering and symbols in a contrasting color. The surgery department labels are blue for specimens.
- If outside contamination of the primary container occurs, the primary container will be placed within a second container that prevents leakage during handling, processing, storage, transport or shipping and is properly labeled. If specimen could puncture the primary container, the primary container will be placed within the secondary container that is also puncture-resistant.
- Equipment that may be contaminated with blood or other potentially infectious materials will be decontaminated prior to servicing or shipping. If decontamination is not feasible, a biohazard-warning label (that meets the Cal/OSHA requirements) will be attached to the equipment identifying the contaminated portions. Information will be conveyed to all affected employees, servicing people and/or the manufacturer prior to handling to ensure that appropriate precautions are taken.
- Pneumatic Tube System: In case of a biohazard spill in the system:
  - The employee should immediately dial "911 and hit the "Special Function" key. This disables the system and prevents other tubes from becoming contaminated.
  - During the day notify maintenance and during off hours notify the Nursing Supervisor.
  - To prevent this problem, all employees who may place either blood or urine in the tube, need to remember how important it is to carefully seal every biohazard bag.

- To prevent possible hand contamination, open all tubes slowly and carefully.
    - Pneumatic Tube educational video available on NIHD Intranet~~>Education>Clinical Equipment Videos.~~ \\root.nih.org\home\Public\Video\EQUIPMENT-VIDEOS\PneumaticTube.wmv

Managing Blood/OPIM Spills.

- Basic principles
    - Standard precautions apply, including use off PPE as applicable
    - Spills should be cleaned before the area is cleaned (adding liquid to spills increase the size of the spill and should be avoided)
- Management small spill < 10cm
    - Secure the spill area notify appropriate personnel
    - Wipe the area immediately with paper toweling
    - Clean with approved hospital disinfectant
- Management of large spill > 10cm
    - Secure the spill area and notify appropriate personnel
    - Contain the spill using spill kit
    - Remove absorbed material with a scraper and pan and place in a biohazard bag
    - Clean with approved hospital disinfectant
-

Handling Contaminated Sharps

All procedures involving the use of sharps in connection with patient care will be performed using the following effective patient-handling techniques and other methods designed to minimize risk of a sharps injury:

- Contaminated needles and syringes, and other sharps will not be bent, broken, recapped or otherwise manipulated and will be disposed of in rigid-walled disposable sharps containers. ***Exception***: Syringes that contain radioactive pharmaceuticals that must be returned to the pharmaceutical company for disposal may be recapped using a safety device designed for this purpose or by the "one-handed" method.
- Reusable sharps will be placed in labeled, puncture resistant, leak-proof containers for appropriate cleaning and sterilization. Cleaning of such sharps will not require employees to reach their hands into sharps containers.

- Disposable sharps will not be reused under any circumstances.
- Contaminated sharps will be immediately, or as soon as possible after use, disposed of in rigid, puncture-resistant, leak proof containers which are labeled "Sharps Waste" or with the international biohazard symbol and the word "Biohazard."
- Sharps container seals must be leak resistant and difficult to reopen.
- Sharps containers will be readily available and easily accessible for all situations in which sharps are used or can be anticipated to be found, including dietary trays and laundry, if applicable.
- Sharps containers will be maintained in the upright position and will be replaced when reaches the fill line (2/3 full) to avoid overfilling.
- Broken glassware that may be contaminated will not be picked up by hand, but by mechanical means such as a brush and dustpan, tongs or forceps.
- No items shall be placed on top of the sharps container (e.g. germicidal wipes, Kleenex boxes
- Staff must ensure that no items are sticking out and/or stuck in the opening of sharps containers
- A safety device will be used (ex point lock) if there is no engineered safety device.

Personal Protective Equipment:

Personal protective equipment is an essential component of a plan to reduce or eliminate exposure to bloodborne pathogens. The following policies and procedures will be adhered to:

- Personal protective equipment will be used in conjunction with engineered controls and work practice controls.
- Where the potential for occupational exposure exists, staff will be provided, at no cost to the employee, appropriate personal protective equipment such as gloves, gowns, aprons, laboratory coats, splash goggles, glasses, face shields, masks, mouthpieces, resuscitation bags, pocket masks, hoods, shoe covers, etc.
- Appropriate personal protective equipment will not permit blood or other potentially infectious materials to pass through (e.g., impervious gowns) or to reach the employee's work clothes, street clothes, undergarments, skin, eyes, mouth or other mucus membranes under normal conditions of use.
- Hypoallergenic gloves, glove liners, powderless gloves, and other similar alternatives will be readily available to those employees who experience allergenic problems with the standard gloves.

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- Department managers will insure that personal protective equipment in the appropriate size is readily available and utilized when necessary to provide the needed level of protection from anticipated exposure.
- The Infection Preventionist will monitor compliance by checking use of personal protective equipment as part of the environmental rounds, and department managers will monitor compliance on a day-to-day basis.
- Employees will be provided training on the appropriate use of personal protective equipment. Training will be completed at the time of initial assignment to a job classification or task/procedure that presents the potential for blood, body fluid or other potentially infectious material exposure.
- A staff member may temporarily and briefly decline to use personal protective equipment only under rare and extraordinary circumstances. If he/she believes, based on their own professional judgment, that its use would prevent the delivery of health care or public safety services or would pose an increased hazard to worker safety, then they may decline to use the personal protective equipment. If this occurs, the Infection Preventionist will investigate and document the circumstances to determine whether changes should be implemented to prevent a similar occurrence in the future. NIHD encourages employees to report all such instances.
- NIHD will be responsible for the cleaning, laundering, repairing, replacing and disposing of personal protective equipment as needed to maintain effectiveness at no cost to the employee.
- Any garment(s) penetrated by blood or other potentially infectious materials will be removed immediately or as soon as feasible, and placed in the designated area or container for storage until washed or disposed of by the facility.
- All personal protective equipment will be removed prior to leaving the work area and patients room
- Employees are responsible for placing their personal protective equipment, after removal, in a designated area or container for storage, washing, decontamination or disposal.
- Employees will wear gloves when it is reasonably anticipated that they will have hand contact with blood or other potentially infectious materials, mucous membranes and non-intact skin when performing vascular access procedures, and when handling or coming into contact with contaminated items or surfaces.
- Disposable gloves will be replaced, as soon as practical when contaminated, torn or punctured or when their ability to function as a barrier has been compromised.
- Disposable gloves will not be washed or decontaminated for reuse.
- Heavy duty, utility gloves may be decontaminated for reuse; however, they must be discarded if cracked, peeling, torn or exhibit any signs of deterioration that would compromise their barrier protection.

- Employees will wear masks in combination with eye protective devices such as glasses with solid sidepieces, goggles or face shields whenever splashes, spray, spatter or droplets of blood or other potentially infectious materials may be generated and eye, nose or mouth contamination can be reasonably anticipated.
- Gowns, aprons, lab coats or similar outer garments will be worn whenever the potential for exposure to blood or other potentially infectious materials is likely.
- Surgical caps or hoods, and impermeable shoe covers or boots will be worn in instances where "gross contamination" is anticipated (e.g., autopsies, orthopedic surgery, labor and delivery).

Cleaning and Decontaminating the Work Site:

Listed below are cleaning and decontaminating policies and procedures that must be followed:

- Environmental Services is responsible for maintaining the facility in a clean and sanitary manner. Policies and procedures have been developed and implemented to ensure that cleaning is scheduled appropriately and proper methods for cleaning and decontaminating are followed. A written schedule for cleaning and decontaminating the worksite has been developed and is posted in Environmental Services work stations and in the Environmental Services manual.
- All dirty linen is handled in compliance with standard precautions. All appropriate steps are taken to minimize or eliminate potential exposures. If the soiled linen is wet and presents the likelihood of causing exposure, a plastic bag will be used to prevent leakage or exposure.
- Linen will be bagged or containerized at the point of use and will not be sorted or rinsed in this location.
- The Infection Control Committee is responsible for reviewing and approving policies and procedures that address proper cleaning, disinfection, and/or sterilization of equipment or environmental surfaces that become contaminated.

A summary of cleaning requirements follows:

- All equipment and environmental and work surfaces will be cleaned and decontaminated as soon as possible after contact with blood or other potentially infectious materials.
- Contaminated work surfaces, or surfaces that come into contact with the hands, will be cleaned and decontaminated immediately or as soon as feasible in the event they become overtly contaminated, when blood or other potentially infectious materials fluid spills occur, or when procedures are completed, using a disinfectant with a hepatitis B or tuberculocidal claim.
- All bins, pails, cans and similar receptacles that become contaminated with blood or other potentially infectious materials will be cleaned and decontaminated immediately or as soon as feasible, no later than at the end of the work shift.

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- Protective coverings such as plastic wrap, aluminum foil, or imperviously-backed absorbent paper used to cover equipment or environmental surfaces will be removed, replaced and appropriately disposed of at the end of each work shift. If such covering becomes overtly contaminated, it will be removed and disposed of immediately or as soon as feasible.

Waste Disposal

The California Medical Waste Management Act, in conjunction with this plan, will provide direction on the proper disposal of biohazardous waste to include sharps waste and wastes contaminated with blood or OPIM. The following will be placed in red plastic bags marked with the word and symbol for "biohazard" and disposed of using the biohazard waste pathway:

- Liquid or semi-liquid blood or other potentially infectious materials
- Contaminated items that contain liquid or semi-liquid blood or are caked with dried blood and are capable of releasing these materials when handled or compressed
- Contaminated sharps
- Pathological and microbiological wastes containing blood or other potentially infectious materials

Hepatitis B Vaccination Program:

In an effort to provide maximum protection from hepatitis B infection, NIHD offers a vaccination program, at no employee cost, to all staff that has potential occupational exposure to bloodborne pathogens. Components of the program are outlined below:

- The vaccination program will be discussed with applicable staff following the training outlined in this plan and within 10 days of initial assignment and annually during the bloodborne pathogens training program. The safety of the vaccine and the advantages of receiving the vaccine will be reviewed with all applicable staff. Details for receiving the vaccine also will be included.
- Vaccine will be provided when indicated by Employee Health as part of the initial employment physical for all new employees with potential exposure to blood or other potentially infectious materials. Employee Health follows up with each employee until the vaccination series is complete.
- Current employees also will be offered the HBV vaccine free of charge from Employee Health. The vaccine is offered to physicians ~~and other individuals who are not employees (i.e. students, volunteers, contract employees).~~ and non-licensed contracted employees with potential exposure to blood free of charge.

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- All employees have the right to decline immunization and are required to complete and sign the declination statement. If the employee subsequently changes his/her mind and requests the vaccine, it will be provided at no cost to the employee.

Post-Exposure Evaluation and Follow-Up: **Follow P&P Exposure Evaluation-Blood Borne Pathogen**

A bloodborne pathogen exposure prophylaxis protocol has been implemented to provide an immediate, confidential medical evaluation and follow-up of employees exposed to blood or other potentially infectious materials. This protocol is in accordance with the most recent recommendations of the U.S. Public Health Service.

Note: *The Standard requires providers to follow procedures as recommended by the U.S. Public Health Service. The Centers for Disease Control and Prevention periodically issue new recommendations. Providers, and in particular, medical professionals who conduct post-exposure evaluations, need to keep updated on the CDC's recommendations.* Current recommendations and checklists are incorporated into packets and outlined below to ensure comprehensive and appropriate treatment.

- The protocol and information packets are available from the infection policies and procedures manual. Detailed instructions and all necessary forms are included in the packet for the employee, supervisor and physician, to ensure the evaluation is comprehensive and thorough.
- ~~Medical evaluation, counseling and follow-up will be conducted by the Nursing Supervisor, Emergency Department, and Infection Preventionist, and Employee Health.~~
- Initial Medical Evaluation of the exposed healthcare worker is conducted by the Emergency Department Physician. The initial workflow is conducted by Nursing Supervisor, Emergency Department Nurses, Infection Prevention Nurse, or Employee Health Nurse Specialist. Follow up labs are conducted by Employee Health Nurse Specialist or Infection Prevention Nurse. Follow up medical care is conducted by a primary care physician.
- If the healthcare worker refuses post-exposure medical evaluation and laboratory testing, "refusal of care document" will be signed, and healthcare worker is encouraged to follow up with their primary care as soon as possible.
- Medical evaluation and laboratory tests will be provided at no cost to the employee.
- All medical records will be maintained in the patient's confidential employee health file.

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- The treating health care professional will provide to the employee, within 15 days, a copy of his/her written opinion following the post-exposure evaluation and follow-up.
- ~~The Infection Preventionist, Employee Health, or designee will advise the employee-patient of the right to refuse consent of post-exposure evaluation and follow-up from his/her health care employer. If consent is refused, a confidential medical evaluation and follow-up will be made immediately available by an outside health care professional. Medical evaluation and laboratory tests will be provided at no cost to the employee.~~

Reporting and Documenting Sharps Injuries:

All sharps related injuries will be reported as an occupational injury following the facility's Occupational Injury and Illness Reporting procedure. All sharps devices used within the facility will be available and displayed to assist the employee in identifying the device that caused the injury. A report denoting the frequency of use of the types and brands of sharps involved in exposure incidents will be generated and reported to the Safety and Infection Control Committees annually. Frequency of use will be approximated by product ordering trends. All sharps devices used within the facility will be available and displayed to assist the employee in identifying the device that caused the injury.

In addition, all sharps injuries will be recorded on the sharps injury log within 14 working days of the date the incident was reported. The log will be maintained for a minimum of five years by Employee Health.

The log will include the following information

- Job classification of the exposed employee.
- Date and time of the exposure incident.
- Type and brand of the sharp involved, if known.
- A description of the exposure incident which must include:
    - Job classification of the exposed employee.
    - Department or work area where the exposure incident occurred.
    - The procedure the exposed employee was performing at the time of the incident.
    - How the incident occurred.
    - The body part involved in the exposure incident.
    - If the sharp had engineered sharps injury protection, whether the protective mechanism was activated, and whether the injury occurred before the protective mechanism was activated, during activation, or after activation.

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- If the sharp had no engineered sharps injury protection, the injured employee's opinion as to whether and how such a mechanism could have prevented the injury.
- The employee's opinion about whether any other engineering, administrative or work practice control could have prevented the injury.

Communicating Hazards to Employees:

In addition to the provisions of standard precautions, the following hazard communication provisions are implemented as part of the exposure control plan:

- Biohazardous waste will be collected in red bags pre-printed with both the word **BIOHAZARD** and the biohazard symbol.
- Warning labels with the legend **BIOHAZARD** will be affixed to refrigerators and freezers containing blood or other potentially infectious materials-and all other containers used to store, transport or ship blood or other potentially infectious materials.
- Biohazardous wastes will be labeled with the legend **BIOHAZARDOUS WASTE** or **SHARPS WASTE** as appropriate. Labels shall be fluorescent orange or orange-red, with lettering and symbols in a contrasting color.
-

The following items *do not* require hazard labels/signs:

- Containers of blood or blood products already labeled as to their contents and released for transfusion or other clinical use.
- Individual containers, tubes and specimen cups of blood or other potentially infectious materials placed in biohazard labeled bags or containers for storage, transport, shipment or disposal.
- Primary specimen containers, as all staff are trained to use standard precautions when handling patient specimens.
- Laundry bags and containers, as both staff and laundry workers are trained in standard precautions.
- Biohazardous (regulated) waste which has been decontaminated (e.g., processed in a sterilizer) prior to disposal.

Note: *The California Medical Waste Management Act also requires hazard-warning signs/labels of biohazardous waste. The requirements of this exposure plan are not intended to supersede these requirements but augment them.*

Information and Training:

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All employees and physicians covered by this plan will be provided training at the time of initial assignment to an at-risk job classification.

Training will be provided by the Infection Preventionist or assigned training. Training will be provided in the language and vocabulary appropriate to the employee's education, literacy and language background.

Training will occur:

- At the time of initial assignment to an at-risk job classification.
- Annually, within 12 months of the previous training.
- When changes affect the employee's occupational exposure, such as new engineering, administrative or work practice controls, modifications of tasks/procedures or institution of new tasks/procedures. This training may be limited to these changes.

The training program will contain, at a minimum, the following elements:

- Copy and explanation of the Standard – A copy of Cal/OSHA's Bloodborne Pathogens Standard is available for review in the Infection Prevention department and this plan.
- Epidemiology and symptoms – A general explanation of the epidemiology and symptoms of bloodborne pathogens.
- Modes of transmission – A general explanation of the modes of transmission of bloodborne pathogens.
- Employer's exposure control plan – An explanation of the plan and how an employee can obtain a copy.
- Risk identification – An explanation of the appropriate methods for recognizing tasks and other activities that may involve exposure to blood and other potentially infectious materials.
- Methods of compliance – An explanation of the use and limitations of methods to prevent or reduce exposure, including appropriate engineering controls, administrative or work practice controls, and personal protective equipment.
- Personal protective equipment – Information on the types, proper use, location, removal and an explanation of the basis for selecting personal protective equipment.
- Decontamination and disposal – Information on handling and the decontamination and disposal of personal protective equipment.
- Hepatitis B vaccination – Information on the hepatitis B vaccine, including its efficacy, safety, method of administration, the benefits of being vaccinated, and that it will be offered free of charge.
- Emergencies – Information on the appropriate actions to take and persons to contact in an emergency involving blood or other potentially infectious materials.

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- Exposure incident – An explanation of the procedure to follow if an exposure incident occurs, including how the incident should be reported, the medical follow-up available and the procedure for recording the incident on the sharps injury log.
- Post-exposure evaluation and follow-up – Information on the post-exposure evaluation and follow-up that will be provided to the employee after an exposure incident.
- Signs and labels – An explanation of the signs, labels and/or color coding used to identify hazards.
- Interactive questions and answers – An opportunity for interactive questions and answers with the trainer.

Recordkeeping:

Records covered in this section are available through Human Resources, Employee Health, and Infection Prevention. Records must be made available under these circumstances:

- All records (training records, medical records and sharps injury log) will be provided upon request to Cal/OSHA and NIOSH for examination and copying.
- Employee training records will be provided upon request to employees and employee representatives.
- Employee medical records will be provided to the subject employee upon request for examination and photocopying. Anyone with written consent from this employee may also request the medical records.
- The sharps injury log is available upon request to examine and photocopy, and will be made available to employees and to employee representatives upon request.
- The sharps injury log will be maintained in by Employee Health for a minimum of five years.

Medical Records

A medical record for each employee who performs duties that may result in an exposure incident will be maintained by Employee Health. These records will include the following information:

- The name and social security number of the affected employee.
- A copy of the employee's hepatitis B vaccination status including the dates of all hepatitis B vaccinations and any medical records relative to the employee's ability to receive vaccination.
- A copy of all examination and medical testing results, and follow-up procedures.
- The employer's copy of the health care professional's written opinion.
- A copy of the information provided to the health care professional.

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These records will be kept confidential and will not be disclosed or reported without the employee's expressed written consent except as required by Title 8, California Code of Regulations, Section 3204, and other applicable laws. These records will be maintained within the above listed departments for at least the duration of employment plus 30 years.

Training Records

Full documentation of training must be completed for all employees trained. Documentation will be maintained by, and be the responsibility of, department managers and the Infection Preventionist. Documentation will be maintained for a minimum of three years from the date of training and then transferred to permanent storage.

Training records must include, at a minimum, the following:

Date of training session

Summary of content

Names and job titles of attendees

Names and qualifications of trainers

Annual Review:

A review of bloodborne pathogens is conducted each year. This review will be conducted by the Infection Preventionist and Sharps Injury Prevention Committee members. Frontline health care workers—those who have contact with patients and use sharps frequently—will be included in this review. As part of the review process, the committee will consider the effectiveness of the program in preventing "exposure incidents" and will include a review of current engineering controls and work practice. The Infection Preventionist Manager is responsible for reviewing and updating the Bloodborne Pathogen Exposure Control Plan annually or more frequently if necessary to reflect any new or modified tasks and procedures that affect occupational exposure. The annual review process will include soliciting input from frontline healthcare workers who have contact with patients and use sharps frequently.

~~The actual CAL/OSHA Standard for Bloodborne Pathogens can be found in the following 3 links:~~

- ~~Link to Standard 5193 Bloodborne Pathogens: https://www.dir.ca.gov/title8/5193.html~~

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- ~~Link to Revisions to above (also needs to be included as the 2nd link related to a complete bloodborne pathogen standard)~~
  ~~http://www.dir.ca.gov/oshsb/bloodpathapprvdtxt.pdf~~

- ~~3rd Link related to bloodborne pathogen's standard:~~
  ~~http://www.osha.gov/pls/oshaweb/owadisp.show_document?p_table=STANDARDS&p_id=10051~~

CROSS REFERENCE P&P

1. Handling of Soiled Linen
2. Exposure Evaluation
3. Handling and Disposal of Needle/Sharps
4. Handling of Infectious/Non-Infectious Waste
5. Hepatitis Prophylaxis/Needles Stick Policy
6. Injury and Illness Prevention Program
7. Lippincott Standard Precautions
8. Personal Protective Equipment (PPE's) Putting On
9. Personal Protective Equipment (PPE's) Removing with critical notes
10. Personal Protective Equipment (PPE's) and Supplies
11. Pneumatic Tube Use
12. NIHD Sharps Injury Prevention Program
13. Adult Immunization in the Healthcare Worker
14. Recommendation for Prophylaxis after Occupational Exposure to HIV
15. Waste Management Plan

REFERENCES:

Title: Bloodborne Pathogen Exposure Control Plan	
Scope: NIHD	Manual: CPM Infection Control Patient Care (ICP)
Source: Quality Informatics Nurse/Infection Preventionist Manager	Effective Date: 9/1/17

~~1. Centers for Disease Control and Prevention (2013). Infection Control: Frequently asked questions-Bloodborne Pathogens-Occupational Exposure. Retrieved from https://www.cdc.gov/oralhealth/infectioncontrol/faq/bloodborne_exposures.htm~~

~~2.~~1. The Joint Commission (~~2018~~ 2021). Infection Prevention and Control IC.02.03.01. Retrieved from https://e-dition.jcrinc.com/MainContent.aspx

~~3.~~2. State of California: Department of Industrial Relations (Last accessed 3-15-21 ~~2/20/2017~~). Exposure control plan for Bloodborne Pathogens. Retrieved from https://www.dir.ca.gov/dosh/dosh_publications/expplan2.pdf

3. United States Department of Labor: Occupational Safety and Health Administration (OSHA) (Last accessed ~~2/20/2017~~ 3/15/21). Bloodborne Pathogens and Needlestick Prevention. Retrieved from https://www.osha.gov/SLTC/bloodbornepathogens/evaluation.html

4. California Code of Regulations. (Site accessed 5/25/2020). § 5193. Blood borne Pathogens. Retrieved from https://www.dir.ca.gov/title8/5193.html

~~4.~~5. Centers for Disease Control and Prevention. (2014). Bloodborne Pathogen Exposure. Retrieved from https://www.cdc.gov/niosh/docs/2007-157/default.html

Approval	Date
CCOC	~~03/26/2018~~3/30/2021
Sharps Committee	2/23/2021
Infection Control Committee	~~5/22/18~~5/10/2021
Emergency Services Committee	5/13/2021
MEC	~~6/5/18~~06/01/2021
Board of Directors	6/20/18
Last Board of Director Review	1/16/19

Initiated: 1/2010
Revised: 5/17 RC, 3/18 RC, ~~5/2020~~03/2021 RC/Sharps Injury Committee
Reviewed: 5/10, 8/11LA; 2/12; 9/12LA; 12/15 NH, 1/16/2019 NIHD;

Index Listings: Exposure Control Plan, Needlestick, Exposure

NORTHERN INYO HEALTHCARE DISTRICT
POLICY AND PROCEDURE

Title: Nursing Care Guidelines in PACU	
Scope: PACU	Manual: PACU Section III
Source: OP/PACU Manager	Effective Date:

PURPOSE:
These guidelines outline the nursing care that will be given to the PACU patient.

POLICY:
The following care guidelines will be followed for inpatients and outpatients in the PACU. The PACU nurse will be an RN who has completed BLS, ACLS, and PALS in the last two years and is fully oriented to the PACU.
Utilizing the PACU Discharge Criteria as a guideline, PACU Phase I is care that is focused on providing postanesthesia nursing care to the patient in the immediate postanesthesia period and transitioning the patient to Phase II level of care in which the focus is preparing the patient / family / significant other for care in the home or Extended Care. Staffing in PACU Phase I can be: 2 nurses to 1 patient, 1 nurse to 1 patient, or 1 nurse to 2 patients. Vital signs are generally taken every 5 minutes X 3, then every 15 minutes or more often as needed. Staffing in Phase II PACU can be: 1 nurse to 1 patient, or 1 nurse to 2, or 1 nurse to 3 patients. Vital signs are generally taken every 15 to 30 minutes.

GUIDELINE 1: The PACU nurse will assess and maintain ventilation of the patient.
Criteria

1. Maintain the airway.
   - 1.1. Determine patency. If upper airway obstruction is present
     - 1.1.1. Reposition head.
     - 1.1.2. Apply jaw thrust and/or chin lift as needed.
     - 1.1.3. Insert oral airway or nasal airway as needed.
     - 1.1.4. Suction as needed: oral, nasal or endotracheal tube.
     - 1.1.5. Notify anesthesia provider of airway obstruction.
   - 1.2. Position patient on side if not reactive.
   - 1.3. Elevate head of bed 30 degrees if not contraindicated.
   - 1.4. Encourage patient to take deep breaths and cough every 15 minutes.

2. Monitor respirations.
   - 2.1. Obtain respiratory rate on admission to the PACU and continue to document rate every 5 minutes, three times, and then, if stable, every 15 minutes.
   - 2.2. Document chest expansion; observe for use of auxillary muscles.
   - 2.3. Auscultate bilateral breath sounds and document; note depth of respirations.
   - 2.4. Notify anesthesiologist if respiratory rate drops below 10/min and encourage patient to breathe deeply; have reversal agents available.

3. Observe the skin.
   - 3.1. Note color of lips, nailbeds, and extremities.
   - 3.2. Note temperature of skin.

4. Maintain the oxygen delivery system.
   - 4.1. Apply oxygen mask at 6-10 liters/minutes or nasal prongs at 2-6 L/minutes or "blow by" nebulized oxygen as requested by the anesthesiologist.

5. Monitor arterial oxygen saturation.
   5.1. Apply pulse oximeter until PACU discharge criteria has been met.

GUIDELINE 2: The PACU nurse will assess and maintain hemostasis and circulation.
Criteria

1. Obtain heart rate on admission to the PACU, and continue to document rate every 5 minutes three times, and then, if stable, every 15 minutes.

2. Place every patient on a cardiac monitor. Lead II will be monitored unless requested otherwise by the anesthesiologist.

3. Document heart rhythm on arrival to the PACU. Document any change in rhythm while in the PACU; notify anesthesia provider of any change while in the PACU, or if the initial rhythm is different from the patient's preoperative status.

   3.1. ACLS Guidelines (established by the American Heart Association) will be followed when treating a dysrhythmia in the PACU. A current ACLS and PALS manual will be kept in the PACU.
   3.2. PALS protocols may need to be initiated if the patient is age 13 or under.
   3.3. The patient's physician will be notified whenever the ACLS protocols are initiated.

4. Obtain blood pressure (BP) on admission to the PACU (via cuff or A-line) and continue to document BP every 5 minutes three times, and then, if stable, every 15 minutes.

5. If the patient is hypertensive or hypotensive on admission to the PACU (determined by comparison with preoperative and/or intraoperative BP), continue to document BP every 5 minutes until stable and acceptable, and then every 15 minutes.

6. If the patient is receiving intravenous (IV) vasoactive drugs, document the BP every 5 minutes until stable and acceptable by the anesthesiologist.

7. If central venous pressure is being monitored, document reading every 15 minutes.

8. If pulmonary artery pressure is being monitored, document reading every 15 minutes.

9. Document urine output every hour (if Foley catheter in place).

10. Document urine color on arrival to the PACU; if any change occurs; and on discharge.

11. Check peripheral pulses when indicated (e.g., extremity surgery, vascular surgery, spinal cord surgery), and document on arrival to PACU, every hour, if any change occurs, and on discharge.

12. Report the presence of the following to the anesthesiologist or surgeon:

12.1. Decreased urine output - less than 0.5cc/kg per hour.
12.2. Cyanosis.
12.3. Excessive perspiration.
12.4. Any sign of hemorrhage.

13. Maintain IV fluids as ordered

14. Observe dressings for amount of bleeding or drainage every 30 minutes if dry or every 15 minutes if drainage is present. Reinforce dressing or change as needed. Carefully estimate and document amount *of* bleeding.

15. Make sure all drains and/or tubes are patent. Document amount and characteristics of drainage on admission to and discharge from the PACU. Empty hemovacs, J-P drains, etc. as necessary. Connect hemovacs and nasogastric tubes as ordered.

16. If patient becomes hypotensive and is symptomatic, position patient flat, infuse IV fluid rapidly (unless contraindicated), administer oxygen, notify the anesthesia provider and surgeon, and continue to monitor BP every 3 to 5 minutes. Have emergency drugs available.

17. If patient becomes bradycardic (heart rate 50 and is symptomatic, notify the anesthesia provider and surgeon, administer oxygen (40% face mask or 3 L nasal prongs), have medications (atropine and ephedrine) available, and continue to monitor vital signs every 3 to 5 minutes.

18. Vital signs on an outpatient are taken as directed in 2.1 and 2.4 until patient is ready for discharge. Vital signs are taken at least once after the patient has ambulated prior to his/her discharge home.

GUIDELINE 3: The PACU nurse will assess level of consciousness and promote reactivity.
Criteria

1. Frequently orient the patient to surroundings and to the fact that surgery is over.

2. Assess level of consciousness; document every 15 minutes until oriented to preoperative level.
   2.1. Assess verbal response by asking the patient "Where are you," What is your name," What (day) (month) (year) is it?"
   2.2. Assess eye opening by noting if the patient opens eyes spontaneously or only when asked.
   2.3. Assess motor response by asking the patient "squeeze my hand" (do this bilaterally), and "move your feet."

3. Assess and document level of spinal or epidural anesthesia.
   3.1. Level will be assessed and documented on arrival to the PACU and reported to the anesthesia provider.
   3.2. Continue to assess level every 30 minutes. Document *if* there is a change; if no change, document level every 1 hour.
   3.3. Assessment will include bilateral sensory and motor level.

4. Assess and document pupillary response every 30 minutes when indicated (e.g., carotid endarterectomy).

5. Reduce anxiety by giving reassurance and support.

6. Be familiar with anesthetic agents used and special considerations in doing this (e.g. Ketamine).

GUIDELINE 4: The PACU nurse will assess and promote fluid and electrolyte balance.
Criteria

1. Document bottle number, solution, and additives of parenteral infusions on arrival to the PACU.

2. Note intravenous system patency on arrival to the PACU and every 15 minutes.

3. Maintain the IV rate ordered by the anesthesia provider.

   3.1. Use a pump to deliver IV infusion except for maintenance fluids as ordered
   3.2. Apply pump tubing to IV's on inpatients.

4. Apply stabilizing device for IVs as needed (armboards, restraints).

5. Keep the inpatient NPO unless otherwise ordered. Advance diet as tolerated for the outpatient as ordered, start with ice chips.

6. Report results of any abnormal values of emergency laboratory work to the anesthesiologist. Document the laboratory results and that the appropriate person was notified. Document any action taken as the result of the laboratory findings.

7. Continuously observe for signs of hemorrhage.

8. Observe for bladder distention and discomfort, if Foley catheter not present. If Foley catheter present, proceed as directed in Standard 2, 9.0, 10.0 and 12.1.

9. Document amount and character of any emesis. Notify the anesthesia provider of persistent nausea and/or vomiting. Medicate patient as directed by the anesthesia provider. Document medication administration and effect.

10. Record intake and output on PACU record and complete 24-hour Intake and output sheet on Inpatients.

GUIDELINE 5: The PACU nurse will ensure the safety of the postoperative patient.
Criteria

1. Have siderails up constantly when not at bedside.

2. Use bumper pads for protection of a restless or combative patient.

3. Notify the anesthesia provider if restraints are necessary.

4. Use all electrical equipment in the proper manner.

5. Properly label any IV additives and document medications administered.

6. Transport patients with safety equipment as needed (Vaseline gauze and chest tube clamp for patients with closed chest drainage, tracheotomy kit for patient's s/p neck surgery).

7. With same-day surgery patients, lock all four wheel brakes on the stretcher before helping the patient to get up. Have a step stool available for the patient to use.

8. Make sure all equipment is in proper working order. If not, take the equipment out of service and notify the appropriate person for repair.
   8.1. The oxygen supply, suction supply and defibrillator will be checked daily.
   8.2. Expiration dates on drugs and IV solutions will be checked monthly by the Pharmacy.
   8.3. All overbed shelves will be stocked daily with oxygen masks, oxygen cannulas, emesis basins, tissues, lidocaine jelly and bit blocks. Presence of IV poles, oxygen tank, ventilator, supply cart, IBP monitors, oximeters, gurneys will be noted as well.
   8.4. Supplies will be checked/reordered. Laryngoscope handle/blades checked weekly.

GUIDELINE 6: The PACU nurse will provide for assistance with emotional and spiritual needs.
Criteria

1. Provide for the patient's right to privacy, including use of curtains and enforcement of traffic control policy.

2. Provide emotional support with positive and encouraging verbal and nonverbal communication.

3. Maintain a calm, confident manner when caring for the patient.

4. Explain all procedures before performing them.

5. Respect the patient's religious beliefs and preferences.

GUIDELINE 7: The PACU nurse will promote the comfort of the postoperative patient.
Criteria

1. Turn and reposition patient as indicated. Document patient's position on arrival as well as any position changes in the PACU.

2. Check for restrictive dressings.

3. Provide for hygiene as needed.

4. Keep patient well covered, using warmed blankets unless contraindicated.

5. Document patient's temperature on arrival to the. PACU.
   5.1. If temperature < 96 degrees F, apply patient warmer per anesthesia provider's order. Document temperature every 15 minutes until temperature is 96 degrees F and then again prior to discharge. Discontinue patient warmer when patient reaches 96 degrees F and patient is comfortable.
   5.2. If temperature is > 96 degrees F document again on discharge. Apply warmed blankets as patient requests.
   5.3. Temperatures will be taken tympanically on all patients including children unless otherwise ordered.

6. Assess the patient's level of pain using a scale of 0 - 10 if indicated.

7. Administer analgesic as ordered by the anesthesia provider or surgeon.
   7.1. Analgesic will be administered IV or as ordered by anesthesiologist or surgeon.
   7.2. Analgesic will be titrated to the desired level of comfort while monitoring side effects, (heart rate, BP, airway obstruction, respiratory rate, nausea, vomiting).
   7.3. Administration of analgesia will be documented including reason for administration and effect of the medication.
   7.4. If the patient is to use patient-controlled analgesia postoperatively, the PACU nurse will set up the pump, prepare the IV site to accept the infusion, and explain the use of the pump to the patient (This explanation will be reinforced by the unit nurse, who will initiate use of the pump.)
   7.5. Outpatient prescriptions are called to desired pharmacy.

GUIDELINE 8: The PACU nurse will promote continuity of care for the postoperative patient.
Criteria

1. Obtain a complete intraoperative report from the anesthesia provider including, but not limited to the following:

   1.1. Identify the patient.
   1.2. Review of the patient's general health and any problems such as chronic disease or addiction.
   1.3. Actual surgical procedure.
   1.4. Anesthetic agents used and the patient's tolerance.
   1.5. Any surgical or anesthetic complications.
   1.6. Replacement of fluids (type and amount).
   1.7. Urinary output.
   1.8. Presence of drains, etc.

2. Initiate physician's orders promptly and document them. Notify Pharmacy of any medication needed in PACU and time of antibiotics administered in O.R.

3. Give the receiving nurse a call re: equipment needed and patient's time of arrival so preparations for care of the patient may be made (Inpatients) or notify responsible adult of patient's potential discharge time and needed equipment or medication (Outpatients).

4. Document the patient's status at time of discharge, including:

   4.1. Level of consciousness.
   4.2. Level of comfort.
   4.3. Conditions of dressings(s).
   4.4. Patency of tubes, drains, catheters, IV lines.
   4.5. Intake and output.
   4.6. Skin color.
   4.7. Nerve and circulation status including radial and ulnar nerve check.

5. Transport the patient to room and assist in transfer into bed, when patient meets discharge criteria (Inpatients) or discharge patient to car with responsible adult (Outpatients).
   5.1. Document to whom report was given.
   5.2. Document initial vital signs taken by the nursing person receiving the patient.
   5.3. If the PACU nurse Is unavailable to transport the patient due to staffing needs in the PACU, arrange for a unit nurse to transport the patient. Instruct the unit nurse to notify the PACU of the patient's initial vital signs on arrival to the unit, and arrange for their documentation.

6. Give the receiving registered nurse a complete report so that continuity of patient care is assured.
   6.1. Identify the patient.
   6.2. Surgical procedure.
   6.3. Type of anesthesia and any particulars of which the nurse should be aware in caring for the patient (e.g., indwelling epidural catheter and naloxone).
   6.4. Any surgical or anesthetic complication.
   6.5. Replacement of fluids and/or blood in the OR and the PACU.
   6.6. Urinary output in the OR and the PACU.
   6.7. Status of dressing(s) and amount and type of drainage.
   6.8. Output from drainage tubes and devices.
   6.9. Respiratory status.
   6.10. Vital signs
   6.11. Neurological status.
   6.12. Review of postoperative orders.
   6.13. Review of any medications administered in the PACU including their indications and effects.
   6.14. Level of comfort.

7. Written discharge instructions will be sent home with outpatients.
   7.1. The instructions will include a way to access the physician and the hospital for questions and problems: (excessive bleeding, temperature elevation of 101 degrees or greater, any signs of infection (review these), difficulty voiding, unrelieved pain, nerve/circulation problems).
   7.2. Discharge instructions should include:
      - No driving / operating dangerous machinery for 24 hours after receiving anesthesia / sedation
      - Specific instructions for exercise, bathing, and wound care.
      - Medications if ordered and the name of the pharmacy on the discharge instruction sheet.
      - Pain relief measures that have been ordered.

- Appointments that have been made or need to be made with the surgeon, physical therapy, or other health care professionals.
- Exercises, icing and equipment as ordered.
- Diet instructions
- The patient will be called the next weekday by the PACU nursing staff to check on status.
- Nausea/vomiting as well as headaches/muscle pain/sore throats (with general anesthesia) are not uncommon following surgery but these problems should be reported if they are severe or persist after 2 days.

7.3. Document the person(s) receiving the discharge instructions in the PACU record
7.4. Document additional educational material sent home with the patient on the discharge instruction sheet and PACU record
7.5. Minors are to be discharged to the care of a responsible parent/guardian.

8. Discharge outpatients home per physician order after they have met the discharge criteria.
8.1. Document person(s) receiving the discharge instruction review.
8.2. Document how and with whom the outpatient was discharged.
8.3. Document items with which the outpatient was discharged (Rx, instructions, personal belongings, equipment, etc.).

REFERENCES:

1. TJC PC 03.01.07, Title 22 CA Code Regulations 76235 d-f
2. ASPAN 2017-2018 Perianesthesia Nursing: Standards, Practice Recommendations and Interpretive Statements, Standard IV, Practice Recommendations 2-6

CROSS REFERENCE P&P:

1. Standards of Care PACU, PACU Discharge Criteria

Approval	**Date**
CCOC	5/4/2021
STTA	5/12/2021
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Board of Directors	
Last Board of Directors Review	

Developed: 3/98
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Supersedes:
Index Listings: Guideline, Nursing, PACU; Nursing Care Guidelines, PACU; Care, Nursing Guidelines, PACU; PACU Nursing Guidelines

NORTHERN INYO HEALTHCARE DISTRICT
POLICY AND PROCEDURE

Title: Local Anesthesia in Surgery	
Scope: Perioperative	Manual: Anesthesia, Outpatient, PACU, Surgery
Source: Surgery / Sterile Processing Manager	Effective Date:

PURPOSE: To outline the nursing management required for patients receiving local anesthesia.

POLICY: If the patient has sedation administered in addition to local anesthesia, the "Procedural Sedation" Policy shall be followed.

The following criteria will be met for management of surgical cases performed under local anesthesia without an anesthesiologist:

1. Appropriate preoperative evaluation by the physician including:

   a) Physician documentation will include:
      - Focused history and physical for the chief complaint
      - History of other current medical problems
      - Previous operative and anesthesia experience
      - History of current medications and adverse medication reactions
      - Risks, benefits and alternatives of the procedure and types of local anesthesia have been discussed with the patient and family prior to administration.
      - An immediate pre-procedure assessment including vital signs and patient status
      - Airway assessment with classification based on the American Society of Anesthesiology (ASA) classification system. Any patient assessed an ASA-IV or greater requires consultation from the anesthesiologist.

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   b) There is no specific requirement for laboratory, radiologic or cardiographic studies except in those disease processes that may be adversely affected by operative stress.

2. Informed consent for the proposed procedure by the operating physician and operative consent form signed by the patient.

3. The patient should be able to verify that he/she has been given pre-hospital care instructions and has complied with these.

4. The physician shall be responsible for the administration of the local anesthesia.

5. The RN designated to monitor the patient receiving local anesthesia will have no other responsibilities.

6. The Registered Nurse designated to monitor the patient must be competent in the following areas:
   - Current in BLS, ACLS and PALS.
   - Basic arrhythmia recognition
   - Clinical pharmacology and hemodynamic variables of the medications to be used and of the function, use and interpretation of the monitoring equipment and is able to recognize the normal physiologic baseline for the patient.

EQUIPMENT: Pulse oximeter /cardiac monitor, and NIBP

NORTHERN INYO HEALTHCARE DISTRICT
POLICY AND PROCEDURE

Title: Local Anesthesia in Surgery	
Scope: Perioperative	Manual: Anesthesia, Outpatient, PACU, Surgery
Source: Surgery / Sterile Processing Manager	Effective Date:

Emergency Resources: The following resources shall be immediately available:

- Equipment to monitor vital signs including pulse, respiratory rate and oxygenation.
- Appropriately sized equipment for establishing and providing airway maintenance, including a selection of laryngoscope blades with handle and endotracheal tubes.
- Suction and supplemental oxygen with the appropriately sized adjuncts.
- Crash cart equipped with a defibrillator.
- Appropriate selection of masks and airways.
- Means to administer positive-pressure ventilation (e.g. ambu bag).
- Intra-lipid Rescue Kit and dosing protocol for all patients receiving local and regional anesthesia.

PROCEDURE:

1. All patients will have baseline blood pressure, heart rate, respiratory rate, level of consciousness, pain level and oxygen saturation documented prior to initiation of local anesthesia**. EKG and oxygen saturation will be monitored continuously** during the procedure per the sedation for procedure policy. Alarm limits will be set by the operating surgeon or by the monitoring RN at the discretion of the physician.

2. Once the anesthesia is initiated, the patient's blood pressure, pulse and respirations, oxygen saturation level of consciousness and pain level will be documented at least every 5 minutes until the procedure is completed.

3. Any changes in the patient's condition (physical, mental or emotional) will be reported promptly to the physician.

4. Oxygen may be administered by the Registered Nurse as ordered.

5. At the completion of the procedure the patient will be returned to his/her room, PACU or the outpatient area as designated by the physician performing the procedure.

6. Discharge of the patient will be determined by the same physician who will also complete a discharge note.

7. Written discharge instructions will be reviewed with and given to the patient and/or the responsible adult with the patient prior to discharge.

DOCUMENTATION:

- The "Procedural Sedation Record" will be used for documentation.
- A patient assessment is made at the top of the record.
- Intraoperative vital signs at intervals no less than every five minutes are documented.
- Procedure performed, oxygen, IV solutions and medications given
- Patient response to medications administered shall be noted.

NORTHERN INYO HEALTHCARE DISTRICT
POLICY AND PROCEDURE

Title: Local Anesthesia in Surgery	
Scope: Perioperative	Manual: Anesthesia, Outpatient, PACU, Surgery
Source: Surgery / Sterile Processing Manager	Effective Date:

- A surgical checklist and a Surgical Safety Checklist shall be completed on all surgical patients.
- Appropriate charges shall be documented.

REFERENCES:

- Title 22: 70223
- TJC: PC.03.01.03, PC.03.01.05
- AORN 2018 Guidelines for Perioperative Practice: Guideline for Care of the Patient Receiving Local Anesthesia

Approval	**Date**
CCOC	5/4/2021
STTA	5/12/2021
MEC	6/1/2021
Board of Directors	
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Index Listings: Anesthesia, Local, Local Anesthesia, Monitoring Patients Receiving Local Anesthesia
Developed:
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NORTHERN INYO HEALTHCARE DISTRICT
POLICY AND PROCEDURE

Title: PACU Discharge Criteria	
Scope: PACU	Manual: Anesthesia, PACU and ICU
Source: OP/PACU Manager	Effective Date:

PURPOSE:
To ensure that patients are discharged and released safely from procedures during which patients were under conscious sedation or anesthesia.

POLICY:
The patient can be discharged from the PACU by discharge criteria however a post-anesthesia evaluation must be completed by a practitioner who is qualified to administer anesthesia. within 48 hours of PACU admission and will include: (respiratory function, cardiovascular function, temperature, pain, nausea / vomiting, and postoperative hydration)

The following criteria (1-10) are generally met in PACU Phase I. The patient may be moved into PACU Phase II (preparation for discharge home) where criteria 11-17 are addressed.

PACU Discharge Criteria:
1. Patient must have recovered from anesthetic sufficiently to be aware of his/her surroundings and able to call a nurse if necessary. Age specific orientation and activity level for pediatric patients will be utilized.
2. Patient must be able to maintain a clear airway and handle his own secretions and emesis.
3. Patient's blood pressure and heart rate shall be within 20% of patient's pre-operative average range or no lower than 90/40 or higher than 170/100 for a minimum of 45 minutes unless otherwise stated by physician.
4. Any untoward symptoms or temperature less than 96 or over 100.5 degrees F will have been reported to the surgeon and/or anesthesiologist with appropriate treatment initiated.
5. The patient must have an Aldrete score of 9-10 unless otherwise specified by the anesthesiologist.
6. The last dose of IM narcotic was administered one-half hour before discharge, last dose of IV narcotic 10 minutes before discharge. The exception is a PCA; if a patient has used the PCA, he or she may be discharged from the PACU without the 10-minute observation as long as the other PACU discharge criteria have been met.
7. The last dose of narcotic antagonist or benzodiazepine antagonist was administered more than one hour before discharge unless the patient is being admitted to the ICU. Patients going to the ICU are not required to have the one-hour observation after a reversal agent has been given.
8. In regional, spinal or epidural anesthesia, the level of anesthesia should be at least below the umbilicus and the Aldrete score may be 9. Exception to this is when long -acting, local anesthetics are used for the specific purpose of post-op analgesia.
9. Patient will have a SpO2 of 92% or better or the surgeon/anesthesiologist will be notified.
10. Hydration, as evidenced by urine output and blood pressure, will be adequate.

In addition to the above guidelines (1-10), patients to be discharged home must also meet the following guidelines:

Title: PACU Discharge Criteria	
Scope: PACU	Manual: Anesthesia, PACU and ICU
Source: OP/PACU Manager	Effective Date:

11. Patient shall have urinated in postoperative period, or have specific instructions to call physician if signs of urinary retention are encountered. (Urology patients to follow Urologist's orders).
12. Patient must be able to ambulate with minimum of assistance unless prohibited from doing so by the surgical procedure or pre-existing conditions. Patients who have received a spinal or regional anesthetic must have complete return of motor control and signs of progressive sensation return.
13. Postoperative pain shall have been brought under control with analgesics and the patient should be reasonably comfortable.
14. Patient should be experiencing minimal, if any, nausea, light-headedness, or dizziness.
15. Any surgical wound must be in stable condition.
16. The patient must be able to tolerate oral clear liquids unless otherwise ordered by the surgeon.
17. The patient must have a responsible adult present to drive them home, and be told not to drive, operate machinery, or make any important decisions for at least 24 hours.

DOCUMENTATION:

Appropriate documentation reflecting patient condition shall be made on the PACU record or the "Local Anesthesia/Procedure Record" utilizing the designated space for the PARGAR score.

REFERENCES:

1. ASPAN 2012-2014 Perianesthesia Nursing Standards: Practice Recommendations and Interpretive Statements: Standards for Postanesthesia Care
2. TJC PC 03.01.07, PC 04.01.03, PC 04.01.05
3. Department of Health and Human Services CMS Interpretive Guideline 482.52

CROSS REFERENCE P&P:

1. Standards of Care in the PACU, PACU Discharge Criteria
2. Nursing Care Guidelines in PACU

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CCOC	5/4/2021
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NORTHERN INYO HEALTHCARE DISTRICT
POLICY AND PROCEDURE

Title: PACU Discharge Criteria	
Scope: PACU	Manual: Anesthesia, PACU and ICU
Source: OP/PACU Manager	Effective Date:

NORTHERN INYO HEALTHCARE DISTRICT
POLICY AND PROCEDURE

Title: Pathology Specimens In The Operating Room*	
Scope: Perioperative Unit	Manual: Infection Control Blue Manual, Surgery
Source: Surgery / Sterile Processing Manager	Effective Date:

PURPOSE:
To define the types of specimens to be sent to Pathology and assure specimens are properly handled, labeled and recorded.

POLICY:
All anatomical parts, tissues and foreign objects removed during surgical procedures will be sent to the pathology laboratory for verification of diagnosis <u>including orthopedic hardware</u>. The exceptions are cataract tissue, C-Section placentas as designated by Surgeon and arthroscopy shavings. ***If the surgeon asks to have cataract tissue, arthroscopy shavings, or placenta sent to pathology, the specimen will be sent to Pathology per this policy / procedure.***

The Pathologist has the ultimate responsibility for making decisions about the extent of the examination of the tissue.

It is a joint responsibility of both the circulating and scrub personnel to assure that each specimen is properly handled and labeled for each surgical procedure. It is the responsibility of the perioperative RN to verify the name of each specimen with the surgeon, to enter the specimen in the patient record and submit the electronic pathology order. If the electronic system is down, follow down time procedure, creating a paper record. A physician order is not required.

EQUIPMENT:
1. Printed Patient identification labels.
2. Containers and or plastic bags appropriate for size of specimen.
3. Biohazard bags for all specimens
4. TranSpec Plastic containers for breast biopsy with needle localization (x-ray)

SPECIAL INSTRUCTIONS:
1. Placentas not going to Pathology will be placed in a leak-proof plastic container, fluid solidifier will be added and the container will be placed in a double red-bag for disposal.

2. All specimens will be placed in **Formalin <u>EXCEPT</u>** those specified for **<u>FROZEN SECTIONS</u>** which will be taken to pathology **<u>IMMEDIATELY</u>** for processing.
   Exemptions to this rule:
   - Muscle biopsies will be processed per reference lab instructions.
   - Crystal analysis specimen is sent fresh.

3. Breast tissue specimens for **<u>LOCALIZATION</u>** will be taken in a labeled **TranSpec Plastic container** to x-ray for confirmation that specimen contains lesion and that the localization wire is intact before specimen is taken to pathology. **<u>Note on operating room record that the wire is included or separate from specimen when it goes to x-ray or pathology.</u>**
   If lesion is not present, physician will be notified so more specimen can be obtained.

<u>Procedure for transporting breast tissue Frozen Sections</u>;

- Surgical Registered Nurse or Surgical Technician will transport the labeled specimen to the Radiology Unit and hand the specimen in its container to the Mammography Technician along with the patient's x-rays. The extension for the OR Suite will be included on the specimen label.
- Surgical Registered Nurse or Surgical Technician will remain in the Radiology Unit and wait for the specimen.
- Surgical Registered Nurse or Surgical Technician will ask the Radiologist to call the operating room where patient is located and notify the surgeon if the calcification/lesion is in the specimen.
- Surgical Registered Nurse or Surgical Technician will transport the specimen and the new mammography film to Pathology and hand it to the Pathology personnel **indicating that the specimen is for a frozen section**. After handing the specimen to pathology personnel, the transport person will call the operating room where the patient is located and notify the surgeon that the specimen is in pathology. **DO NOT LEAVE THE SPECIMEN WITHOUT THE PRESENCE OF PATHOLOGY PERSONNEL – MUST PHYSICALLY HAND THE SPECIMEN TO PATHOLOGY PERSONNEL.**

PROCEDURE FOR ROUTINE SPECIMENS:

- Specimen identification should be confirmed verbally between the surgeon and the registered nurse circulator and should include a read back verification, and be documented on the appropriate forms. (See policy Identification of Surgical Specimens)

- All specimens will be placed in a specimen container appropriate for the size of the specimen. Containers should;
  - Be large enough to safely secure the specimen and fluids.
  - Be of a size appropriate to allow preservatives or solutions, to contact all surfaces of the specimen.
  - Be sterile or clean, depending on collection requirements.
  - Be labeled with patient identification, specimen type, site and date of surgery. Surgeons name should be included if different from patient identification label.
- Specimens secured on the sterile field before transfer should be maintained in a manner to prevent misidentification or mishandling.
- The specimen should be contained and labeled immediately to prevent mishandling and errors.
- If more than one specimen per patient, place each specimen in a separate container and designate with a number and label as above.
- Labeled specimen containers should be placed in a designated area on the back table to keep them separated.
  - The specimen containers will be on the top of the back table after labeling for scope procedures.
  - The specimen containers will be on the bottom of the back table after labeling for sterile procedures.
- A list of each specimen should be made on the pathology order and operating room record with numbers that co-ordinate with specimen container.

NORTHERN INYO HEALTHCARE DISTRICT
POLICY AND PROCEDURE

Title: Pathology Specimens In The Operating Room*	
Scope: Perioperative Unit	Manual: Infection Control Blue Manual, Surgery
Source: Surgery / Sterile Processing Manager	Effective Date:

- All specimens will be considered contaminated and handled utilizing standard precautions.
- When adding formalin to specimen containers, personnel will wear appropriate protective devices;
  - Goggles or face shield
  - Gloves, and protective clothing
  - Close formalin dispenser lid when finished filling specimen container.
  - Place a label on the container indicating that formalin has been added. These labels are located next to the formalin dispenser.
  - All specimen containers will be placed in a secondary leak-proof container for transport.

SPECIMENS:

AMPUTATION SPECIMENS:

- Place amputated limb into impervious stockinet appropriate for limb size.
- Place appropriate size rigid specimen container over exposed bone to prevent accidental exposure to pathology personnel.
- Seal top of stockinet to contain the specimen.
- Place the limb into a second red bag for transport.
- This bag should be clear and appropriately **labeled with the patient identification label as described previously.**
- Make sure bag is sealed appropriately for transport.
- If during work hours walk specimen to pathology.
- If after work hours contact clinical laboratory specialist on duty and they will store specimen appropriately.

CYTOLOGY SPECIMENS:

- During regular hours, cytology specimen is to be taken **IMMEDIATELY** to pathology.
- **AFTER HOURS**: SPUTUMS, URINES, BRONCHIAL WASHINGS, PLEURAL AND ABDOMINAL FLUIDS are fixed by using **COATING FIXATIVE** (Saccammano Technique). Add equal parts of fixative and specimen. **LARGE** amount of specimens such as abdominal fluid, put 25ml of specimen into (2) 50ml containers and add equal parts of fixative. **ONCE FIXATIVE HAS BEEN ADDED ONLY CYTOLOGY TESTS CAN BE RUN.**
- **RAPID FROZEN SECTION:** Alert pathology department so pathologist is present.
- Place electronic order, label specimen, include operating room phone extension and walk specimen to pathology immediately. **DO NOT PUT SPECIMEN IN FORMALIN.**

FOREIGN BODIES

- Any foreign body that might be used as evidence in a lawsuit or criminal action is to be labeled and handled as bullets (see disposition of evidence form and policy); all other foreign bodies are sent to pathology as usual.

ORTHOPEDIC HARDWARE/IMPLANTS

- Removed from a patient **DO** have to go to pathology.

NORTHERN INYO HEALTHCARE DISTRICT
POLICY AND PROCEDURE

Title: Pathology Specimens In The Operating Room*	
Scope: Perioperative Unit	Manual: Infection Control Blue Manual, Surgery
Source: Surgery / Sterile Processing Manager	Effective Date:

- If the patient would like to have their hardware, they may call Pathology the following day to arrange pickup. Before hardware may be released to the patient, it must be cleaned and terminally processed. Please note on pathology slip if patient wishes to pick up hardware.
- **Gross Examination Only** of specimens is at the discretion of the Pathologist.

REFERENCES:

1. Title 22: 7022
2. AORN Guidelines for Perioperative Practice (2018): Specimen Management

CROSS REFERENCE P&P: Identification of Surgical Specimens and Submission of Biopsy (Tissue) Specimens

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Responsibility for review and maintenance: Perioperative Director on Nurses
Index Listings: Pathology Specimens in the Operating Room/Specimens Pathology

NORTHERN INYO HEALTHCARE DISTRICT
POLICY AND PROCEDURE

Title: Patient Warmer (Warm Air Hyperthermia System)	
Scope: Hospital Clinical Departments	Manual: Surgery
Source: Surgery / Sterile Processing Manager	Effective Date:

SURGICAL UNIT / POST ANESTHESIA CARE UNIT

PURPOSE:
The Patient Warmer (Warm Air Hyperthermia system: brand name: Bair Paws) provides a continuous flow of heated air to the peripheral areas of the patient.

It is used to treat/prevent preoperative / intraoperative / postoperative hypothermia and the discomfort associated with it.

POLICY:
In the Operating Room the anesthesia provider assumes responsibility for the warming unit and notes on his record – the circulator will note on intraoperative order sheet.
The anesthesia provider will monitor patient temperature either by core or surface monitoring for all anesthetics equal to or greater than 30 min. duration.
A temperature will be taken on each patient on admission to the PACU. The anesthesia provider will be notified of a temperature < 35.5 degrees C (96 degrees F). The warmer will be applied as ordered by the anesthesia provider. The warmer will stay in place until the patient's temperature reaches 35.5 degrees C and the patient feels comfortable or as ordered by the anesthesiologist.
Nursing documentation in the pre-operative and PACU areas should include: time warmer applied, patient's response to the warmer (temperature etc.) and the time the warmer was discontinued. The patient's temperature will be taken every 15 minutes until desired temperature has been reached.

EQUIPMENT:
Warm Air Hyperthermia System – check that the model is approved for use in the OR before using it in surgery; some models are not intended for use in the OR.
Patient warming gown and warming unit.
Warming tube / blanket of choice: Sheet or Cotton blanket

PRECAUTIONS:
1. The warm air hyperthermia system gowns/tubes/blankets are not sterile.
2. The warm air hyperthermia system gowns/tubes/blankets are designed for single patient use.
3. Monitor the temperature and cutaneous response of patients who are incapable of reacting, communicating and/ or who are without a sense of feeling every 10 -20 minutes. Monitor the patient's vital signs regularly. Adjust air temperature or discontinue therapy when the therapeutic goal is reached or if vital sign instability occurs. Notify physician of vital sign instability immediately.
4. Do not leave pediatric patients unattended during therapy.
5. Do not initiate temperature management therapy unless the temperature management unit is safely placed on a hard surface or securely mounted, otherwise injury may result.

Contraindication:

NORTHERN INYO HEALTHCARE DISTRICT
POLICY AND PROCEDURE

Title: Patient Warmer (Warm Air Hyperthermia System)	
Scope: Hospital Clinical Departments	Manual: Surgery
Source: Surgery / Sterile Processing Manager	Effective Date:

Do not apply heat to lower extremities during aortic cross-clamping. Thermal injury may occur if heat is applied to ischemic limbs.

Use of the high temperature setting is **CONTRAINDICATED** when treating patients who have:
Significant peripheral vascular disease (occlusive or diabetic)
Low cardiac output
Total immobilization

Warnings:

- Do not warm patients with the warming unit's hose alone. Thermal injury may result. Always connect the hose to a warming gown or blanket before providing patient warming.
- Do not use a forced-air warming device over transdermal medications; increased drug delivery, patient death, or injury may occur.
- Do not allow the patient to lie on the warming unit hose or allow the hose to directly contact the patient's skin during patient warming; thermal injury may result.
- Do not leave patients with poor perfusion unmonitored during prolonged warming therapy sessions. Thermal injury may result.
- **Do not** place the **non-perforated** side of the blanket on the patient. Thermal injury may result. Always place the perforated side (the side with small holes) towards the patient.
- Do not continue temperature therapy if the Over-Temp indicator light illuminates and the alarm sounds. Thermal injury may result. Unplug the unit, and contact biomed.
- Position the temperature controller cord and the hose away from the patient's neck or shoulders to avoid entanglement and/or injury.
- Equipment not suitable for use in the presence of a flammable anesthetic mixture with air or with oxygen or nitrous oxide.

PROCEDURE:

1. If using a patient warming gown, have patient dress in gown as shown on package insert.
2. Attach hose from warming unit to inlet port on gown, and give patient control unit.
3. Turn on unit, and have patient use control knob to control heat to a level of comfort.
4. If using warming tube or blanket, remove the warming tube/blanket from the package.
5. Partially unfold the warming tube/blanket at the foot of the stretcher, air inlet port away from the patient's feet.
6. Insert heater hose into air port on the warming tube. Attach clip to the bottom of the sheet to anchor tube.
7. Plug warmer in, turn switch, select desired temperature (low temperature 90 degrees F/32.2 degrees C; medium temperature 100 degrees F/37.8 degrees C; high temperature 110 degrees F/43.3 degrees C). The warming tube will fully inflate and extend towards the patient's head. The ties may be used to secure the warming tube (tie across the patient, tie to the side rails or place under the patient).
8. Cover the patient with a single sheet or cotton blanket. Any covering too heavy will impede the flow of warm air. The patient must have a sheet or blanket on to hold the air around his/her body.
9. Monitor temperature with other PACU vital signs.
10. Discontinue when temperature of 96 degrees F is reached and the patient is comfortable or otherwise ordered by anesthesiologist.

11. Patients with **poor circulation should be started on a low or medium temperature setting** (not high). See the operation and technical manual with the machine for alarms (pages 19/20). The filter should be checked every month and changed as needed.

CLEANING THE CABINET AND HOSE:

Precautions:

- Do not use alcohol or other solvents to clean the cabinet. Solvents may damage the labels and other plastic parts.
- Do not immerse the cabinet or hose while cleaning or use dripping wet cloth to clean the cabinet Moisture will damage the components, and thermal injury may result.

Method:

- Disconnect the temperature management unit from the power source before cleaning.
- Wipe the cabinet and the outside of the hose with a damp, soft cloth and a mild detergent or antimicrobial spray.
- Dry with a separate soft cloth.

REFERENCES:

AORN Guidelines for Perioperative Practice (2018): Hypothermia
Manufacturer Instructions for Use
One Source

DOCUMENTATION: Anesthesia record, preoperative record, PACU record

Approval	Date
CCOC	5/4/2021
STTA	5/12/2021
MEC	6/1/2021
Board Of Directors	
Last Board of Director review	

Index Listing: Warm Air Hyperthermia System/Warmer/Patient Warmer
Revised: 1/98 BS/AW; 05/2011BS, 10/11/11, 4/21aw
Last Board of Director review: 1/17/18; 1/16/19; 6/19/19, 3/18/2020

NORTHERN INYO HEALTHCARE DISTRICT
STANDARD OF CARE

Title: Standards of Care in the Perioperative Unit: Pediatric Patient	
Scope: Perioperative Unit	Manual: PACU
Source: OP/PACU Manger	Effective Date:

POLICY STATEMENT:

1. Pediatric nursing is provided using an interdisciplinary team approach, based on a holistic assessment of patient and family needs, capabilities and limitations, nursing diagnosis, planning, interventions, and evaluation of patient response.
2. Patient expectations as defined will be met for each patient and their family
3. The patient age-specific population served is:
   - Pediatric: age 28 days up to 13th birthday

PROCEDURE:

The Pediatric patient and family-caregiver in the Perioperative Unit can expect:

1. **THROUGHOUT THE STAY**
   a. To be treated in accordance with NIH's policy entitled "Patients' Rights"
   b. To be kept informed of and involved in the plan of care including medications, procedures, and discharge needs.
   c. To have care delivered based on standards of practice for the diagnosis identified.

2. **PRIOR TO ADMISSION**
   A. A preoperative interview initiated by a perioperative RN by phone with the patient's parent or guardian at least one day prior to the scheduled surgery. If the patient chooses to come to the hospital the day prior to surgery – the interview may be conducted in person. The preoperative interview will include:
      a. Preoperative teaching, based on individualized needs and age appropriate
      b. Description of the pre-op preparation, the OR, and the PACU (if possible, a tour of the preoperative / postoperative unit can be offered to the child and family).
      c. Review of past procedures and problems, allergies, implants, immunizations, family history, use of alcohol, tobacco, other drugs
      d. Review of current medications, medications to be taken prior to surgery
      e. Estimated times for surgery and discharge from the PACU (outpatient surgery) or transfer to inpatient unit
      f. The interview will be documented in the EHR (electronic health record).

3. **ON ADMISSION OR TRANSFER INTO THE PERIOPERATIVE DEPARTMENT:**
   A. Orientation to the surgical experience but not limited to:
      To be greeted immediately upon arrival to the unit including:
      a. Introduction of nursing and ancillary staff
         i. Explanation of what to expect within the next hour
         ii. Expected timing of the surgery
         iii. A parent will be allowed to stay with the patient in the preoperative area
      b. A clean patient cubicle with appropriate supplies and equipment and orientation to:
         i. Call light use and TV controls
         ii. Bathroom location
         iii. Equipment in use including warming measures, athrombic pumps if ordered

B. Assessment and preparation for surgery within 30 minutes of arrival by an RN (A pediatric assessment will be used)
   a. Assessment of level of assistance required to complete activities of daily living, including transferring, ambulation, self-care, and feeding; support provided to meet identified needs postoperatively
   b. Immunization history will be recorded
   c. Personal belongings checked and placed in labeled belongings bag or given to designated responsible adult accompanying patient
   d. Height, Weight and vital signs taken and recorded: weight for a child too young to stand will be taken using the pediatric gram scale)
   e. Head Circumference will be measured using a cloth or paper measuring tape for children under the age of 2.
   f. Physical assessment (skin, lungs, heart, pulses, pupils, mobility)
   g. Social and learning needs assessment (continued using information from the perioperative interview)
   h. IV access obtained – the anesthesia provider can be contacted for use of numbing creams or spray for the skin or oral sedation if needed prior to starting the IV. A pump, Soluset or other volume limiting device will be used on children under the age of 2.
   i. Informed consent for surgery reviewed / signed per policy
   j. Surgical site preparation performed if ordered / needed
   k. Review of postoperative equipment (crutches, braces, shoes, briefs)
   l. A Surgical Checklist will be completed on each preoperative patient prior to the patient going to the OR
   m. To have a surgery RN review chart, explain surgery and answer questions before going into surgery. The Surgical Checklist will be reviewed by the Circulating RN prior to the patient being moved to the OR
   n. The patient will participate in signing the surgical site per policy
   o. To speak with the surgeon and have any questions answered prior to going to the OR
   p. The consent for surgery / procedure will be signed by the patient's parent / legal guardian
   q. If anesthesia provider is assigned to the patient – the anesthesia provider will assess the patient, review the medical record, and explain anesthesia plan to patient prior to the patient entering the OR
   r. The pediatric patient will not be left unattended in the preoperative unit.

C. To receive information about the patient/family's Speak Up Program, Patient Rights, Patient Safety, Patient Advocate, Advance Directives, Infection Control, and Rapid Response.

D. The Broselow Pediatric cart will be brought to the perioperative unit during the child's stay. The child's weight will be used to determine the Broselow tape color for the child.

E. The nursing care of patients will be supervised by RNs adept in skills and knowledge of a surgery patient. The priority of data collection activities is driven by the patient's immediate condition and/or anticipated:
   a. Nursing plan of care individualized for patient. Information from the preoperative interview, medical record, preoperative checklist, and interviews done the day of surgery will be used to formulate an ongoing plan of care which will be documented in the EHR
   b. Review and initiation of preoperative orders by the RN
      i. To have an RN review and initiate ~~physician~~practitioner admitting orders within 30 minutes of admission, including review of medical staff plan of care as written
   c. To have an RN initiate discharge planning at time of admission, to be readdressed throughout stay including:
      i. Patient goals for hospitalization
      ii. Referral to interdisciplinary team, including but not limited to: dietary, social services, physical therapy, speech therapy, and pharmacy.
   d. The Perioperative RN's practice is guided by the ANA's Code for Nurses, AACN's Ethic of Care, and ethical principles, ASPAN Standards and Practice Recommendations as well as AORN Guidelines for Perioperative Practice.
   e. The AHA ACLS protocol will be instituted when necessary for all PACU patients, older than 13 years of age, and the AHA PALS protocol instituted when necessary for all patients younger than 13 years of age.

F. During the Surgical procedure the patient will be accompanied by a surgical RN (the RN will accompany the patient to surgery, a Surgical RN will be with the patient through surgery and will accompany the patient out of surgery. The Surgical nurse will ensure safety for the patient addressing:
   a. Positioning – assessing and ensuring correct alignment and tissue integrity: apply soft, non-constrictive restraints if needed, pad all pressure points, avoid hyperextension / hyperflexion of joint areas, position the IV site so it is visible.
   b. Maintain body temperature with warm blankets, warm IV fluids, or warm air system.
   c. Monitor the pediatric patient for signs of Malignant Hyperthermia throughout the surgical case.
   d. Intake / Output will be accurately measured: use of pediatric urine meter or Pedi-bag for urine collection if indicated
   e. Site mark visible after draping
   f. Risk for fire in the OR
   g. Medication labeling on and off the sterile field
   h. Aseptic technique will be implemented and maintained throughout the surgical procedure
   i. Specimens properly labeled
   j. Universal Protocol will be followed. A time-Out is performed before an incision is made and before the incision is closed

G. The patient will be accompanied from surgery by an anesthesia provider, the RN that administered sedation, or surgeon
H. The patient will be monitored continuously throughout the operative procedure by an anesthesia provider or an RN.
I. All patients undergoing operative, manipulative, or diagnostic procedures under general or regional anesthesia shall stay in the PACU before being returned to the nursing unit except those patients who, in the judgement of the surgeon and anesthesia provider should be taken directly to an in-patient hospital room. The anesthesia provider, surgeon, or responsible ~~physician~~ practitioner shall ascertain the patient is in satisfactory condition before delegating the immediate care to the PACU RN.
J. A report is given to the Postoperative RN (PACU or other unit RN) by the Surgical RN and the anesthesia provider. Such discussion shall include pre-existing medical problems, anesthetic technique used, surgery or procedure performed, any untoward reactions or unusual incidents, special orders, needs or precautions.

4. **THROUGHOUT THE PACU STAY:**
A. To have an RN monitor and assess the patient from PACU admit to PACU discharge as the patient's condition warrants. Patients will receive nursing care based on an assessment of their needs.
B. All patients will have cardiac monitoring in the most appropriate leads. Monitor strips will be placed on the chart preoperatively and postoperatively. Changes in rate, rhythm, or morphology will be documented PRN.
C. Vital signs including Blood Pressure, Pulse, Respiratory rate and O2 saturation will be completed per policy. A temperature will be obtained on PACU admission and discharge or more often as the condition dictates.
D. Oxygen may be humidified and delivered by "blow-by" method if ordered by the anesthesia provider
E. All completed assessments (vital signs, level of consciousness, nerve and circulation checks, pain scales), intravenous fluids, medications, blood and blood product administration will be documented in the EHR in a timely manner.
F. All inpatients will be on intake and output monitoring. I&O's will be recorded every 2 hours.
G. All patients will have an IV or saline lock unless otherwise ordered by the ~~physician~~licensed independent practitioner.
H. All patients will have suctioning performed whenever indicated. This includes oral/naso pharyngeal and endotracheal suctioning.
I. In the event that a patient's status deteriorates, the PACU RN will immediately notify the anesthesia provider or the surgeon. The responsibility for the PACU patient is a joint one, shared by the surgeon and the anesthesia provider. Requests for assistance by the PACU personnel shall evoke immediate and appropriate response on the part of the anesthesia provider or surgeon. In the event that the patient's status deteriorates, the PACU RN will immediately notify the anesthesia provider or surgeon. If no anesthesia provider is involved in the care of the patient, the surgeon responsible.

a. Abnormal or worsening vital signs specific to patient's baseline
b. Abnormal or worsening lab values
c. Significant change in Level of Consciousness (LOC)
d. Significant or worsening change in physical assessment
e. Significant change or imbalance in Input and Output (I&O)
f. Any adverse drug and/or blood reactions, or untoward change as a response to treatment
g. Inability to control pain or obtain pain relief
h. Any untoward occurrence/event occurring in the hospital
i. Significant change in cardiac rhythm

J. To receive prompt identification of and intervention for potential and actual complications/side effects, including Rapid Response Team initiation. All unusual incidents, untoward reactions, and notification of and response by the anesthesia provider and surgeon shall be noted in the PACU record.

K. Care of the PACU patient will be guided by the policies and procedures at Northern Inyo Hospital. The PACU is not to be used as a substitute for routine post-operative care and patients requiring prolonged observations should be admitted to a 23 hour "Observation Status".

L. If the patient is demonstrating signs or symptoms suspicious for hypo/hyperglycemia, the provider will be informed.

M. Nursing staff will be responsible for knowledge of medication given and utilizing appropriate resources to gain that knowledge. Medications will be verified with a pediatric reference before administration.

N. All sedation/analgesia will be given according to the Procedural Sedation guidelines.

O. The nurse may obtain a 12-lead EKG and will call the anesthesia provider or surgeon in the event of:
a. New onset of chest pain.
b. Significant changes in the cardiac rhythm.

P. To have pain assessed and managed in a systematic way to achieve optimal relief.

Q. Environment assessment, to include maintenance of clean, quiet, and therapeutic atmosphere. *Universal precautions will be followed*

R. To have safety measures identified specific to each patient including:
a. Patient identification band in place; staff to use at least two patient identifiers for medications and procedures.
b. 5 rights of medication administration practiced.
c. Fall risk assessment completed at admission (pre-operatively) and discharge from hospital.
d. Skin assessment at admission (pre-operatively) and discharge from hospital.
i. Interventions in place specific to patient to prevent new breakdown (positioning in the OR), and to treat existing skin breakdown
e. Restraints only used if less restrictive measures not successful and the patient is at risk for injury of self.
f. Smoke-free environment

S. To have preventative measures followed to avoid patient infections, pneumonia, and blood clots.
T. To have visitors as patient condition warrants per PACU RN, anesthesia provider, and surgeon discretion.
U. To have continuity of care maintained between preoperative RN, Surgery RN, PACU RN, and inpatient unit RN through appropriate sharing of information (SBAR-QC [Situation-Background-Assessment-Recommendation-Questions-Concerns]).
V. To have confidentiality and privacy maintained in accordance with policy on Patient Rights, State Law, and Federal Law.
W. To have nutritional needs assessed, and nutrition provided that meets the patient's special diet, including cultural, religious, or ethnic preferences.
X. Patients have the right to refuse care, treatment and services in accordance with the law and regulation
Y. All admitted patients will be entered in the PACU logbook.

5. **ON TRANSFER WITHIN NIH:**
A. To have discharge transfer assessment completed by transferring RN.
B. To have patient assessment completed by receiving RN.
C. The inpatient may be transferred from the PACU utilizing STTA (Surgery, Tissue, Transfusion, and Anesthesia) Committee approved PACU Discharge Criteria
D. To have transferring RN provides report of patient condition (SBAR-QC) to receiving RN.
E. To have patient/family updated on reason for transfer, location moved, and expected time of transfer.
F. To be transferred with all belongings.

6. **ON DISCHARGE:**
A. To have discharge assessment completed by RN.
B. A ~~physician~~ licensed independent practitioner will discharge the patient. STTA Committee approved PACU Discharge Criteria will be used to determine readiness for discharge.
C. To have written discharge instructions provided to patient/family member by RN, including clarification of:
a. Who to call for questions.
b. Nature of medical condition and what symptoms to report to ~~MD~~practitioner.
c. Medications to take, list of medications already given that day, new prescriptions.
d. Follow-up appointment, including outpatient diagnostic test and lab work orders.
e. Medical equipment needed at home, including vendor to call for assistance.
f. Activity level and return to work.
g. A responsible adult should take the patient home – driving is not permitted for 24 hours following anesthesia / sedation
h. Dietary restrictions.
D. To be discharged with all belongings and medications.

E. To be provided with "Release of a Child Under 8 Years of Age" form indicating awareness of federally required passenger restraint systems if applicable for age of patient.
F. To receive hospital follow-up call.

REFERENCE(S):

1. American Nurses Association. (2010). Nursing Scope and Standards of Practice. Silver Spring, MD: Nursesbooks.org
2. JCAHO (CAMH): UP.01.01.01, RI.01.03.01, PC.03.01.01, PC.03.01.03, PC.03.01.05, PC.03.01.07, PC.04.01.05, RC.01.03.01 Jan 2019
3. CA Code of Regulations Div. 5, Title 22: 70223, 70225, 70233 (2018)
4. CMS: 482.52 2009
5. ASPAN Perianesthesia Nursing Standards, Practice Recommendations, and Interpretive Statements (2012-2014)
6. AORN 2018 Edition Guidelines for Perioperative Practice

CROSS REFERENCE HOSPITAL P&P:

1. Preoperative Interview
2. Operative Consents
3. Hand Off; Standardized Nursing Communications Policy
4. Postoperative Teaching
5. Patients' Rights
6. Universal Protocol
7. Pain Management and Documentation
8. Obtaining Blood Bank Samples from Patients in Surgery

Approval	**Date**
CCOC	5/4/2021
STTA	5/12/2021
Perinatal/Pediatric Committee	5/25/2021
Medical Executive Committee (MEC)	6/1/2021
Board of Directors	
Last Board of Director review	

Developed: 2/98
Reviewed:
Revised: 3/06aw, 5/11aw, 4/21 aw
Index Listings: Pediatric Standards of Care, Perioperative

NORTHERN INYO HEALTHCARE DISTRICT
POLICY AND PROCEDURE

Title: Preoperative Preparation and Teaching	
Scope: PACU, Surgery	Manual: PACU
Source: OP/PACU Manager	Effective Date:

PURPOSE:
To expedite admission of surgery patients and to insure continuity of care thereby promoting patient safety and alleviating patient anxiety. Preoperative teaching is to ensure the patient's understanding of and general timing of the operative day, as well as the procedures and equipment that will be used in the Operating Room, Recovery Room and the other nursing units. This will help the patient to be as relaxed as possible and have a better pre and postoperative experience.

POLICY:

1. Do Not Resuscitate (DNR) will be suspended, unless continued by the treating physician upon review prior to going to surgery.

2. Patients selected for outpatient surgery should meet the following criteria:
   - The operation should be a procedure that is not usually accompanied by significant blood loss or physiological derangement post operatively.
   - The incidence of postoperative complications should be low.
   - The patient should be in good health or have mild systemic disease.
   - It should be understood that preoperative preparation and postoperative care can be safely accomplished in an outpatient environment.
   - The surgeon selects the patient, provides written instructions, and schedules the procedures. The instructions describe the pre-operative work-up, admission, and recovery periods.
   - Patients with BMI greater than 40 or history of O.S.A. (Obstructive Sleep Apnea) may not be a candidate for outpatient surgery requiring general anesthesia/procedural sedation.
   - Dental and podiatry patients shall be admitted under the service of a medical staff physician with a medical history and physical examination pertinent to the patient's general heath.
   - The podiatric history should justify hospital admission and include a detailed description of the examination of the foot and a preoperative diagnosis.

3. Patient teaching for elective surgery will include preoperative preparation, postoperative care, and information re: prevention of hospital acquired infection. Patients will receive teaching and handouts appropriate to their scheduled surgery (Surgical Site Infection Prevention, Central Line, Catheter Associated Urinary Tract Infection, Ventilator Associated, and information on MRSA and C-Diff). The education section of the Patient Profile will be used to document this teaching.

   The surgeon will provide written instructions for the patient at the time of the preoperative work-up appointment. The instructions describe the preoperative work-up, admission, and recovery periods. The surgeon or office staff must explain and emphasize the importance of following the instructions. The patient should be told to notify the surgeon of any change in condition prior to the day of surgery (fever, cold, flu-like symptoms)

PROCEDURE:

A. **Chart Assembly**

The chart will be put together by the PACU clerk the day before surgery. Documents include history and physical, lab, EKG and X-ray reports, doctors' orders, etc.

The outpatient nurse will review the charts the day before the surgery screening lab, x-ray, and EKG reports and notify the surgeon and/or anesthesia provider of any abnormal values.

B. Preoperative Interview

The perioperative RN will check the OR schedule noting the date / time and type of surgery, the surgeon, type of anesthesia (procedural sedation, MAC, general). Prior to starting the interview, the RN should check the patient's chart: the surgeon's orders should be reviewed. The consent should be verified and any other special orders should be noted. The RN should review the chart to ensure lab work and other preoperative testing (EKG, Diagnostic Imaging) has been completed and the values are within normal ranges.

Patients will be interviewed by a perioperative nurse on a weekday prior to surgery, no later than the day before the surgery. Interviews not completed in person should be completed the day before surgery by phone. The information is documented in the patient's medical record.

Patients requiring an urgent (unscheduled) surgery will have preoperative teaching completed by the nurse on the unit to which he/she has been admitted. Preoperative teaching should be documented in the electronic health record. The perioperative nurses are responsible for the preoperative interview for elective surgeries.

The nurse should allow adequate time for the interview (10-20 minutes unless the patient has complex needs) to assess the patient's physical and emotional status. The RN will complete the preoperative sections in the electronic health record. The RN will answer the patient's questions throughout the interview and at the end of the interview the nurse will ask the patient if he/she has any questions. A completed Anesthesia History is helpful for the nurse to review at the time of the interview. These are given to the patient by the staff at the surgeons' office and the patient should have received instructions to complete it, have it ready to use at the time of the preoperative interview, and to bring it in to the hospital the day of surgery where a copy can be scanned into the electronic health record.

Pediatric patients**:** The parents (or legal guardians) usually serve as the source of information for the preoperative interview however if the interview is done in person, the pediatric patient should be included in the interview process. Parents are a source of information for preoperative interviews and should be included.
There are coloring books available to be given to the pediatric patients; these contain illustrations of a same-day-surgery that can be given to the pediatric patients. It may alleviate anxiety to have the parents and child come into the preoperative area to see the area and some of the equipment (such as a gurney, an anesthesia mask, BP cuff, SPO2 probe, the patient monitor, thermometer, etc.), Check with the patient's parents; a brief tour along with explanations of the equipment use and the procedure for getting a patient ready for surgery may be helpful.
Adolescent patients: It may be beneficial to conduct the preoperative interview without having the parents present due to the nature of some of the assessment questions.
Parents/guardians of any pediatric or adolescent patient should be encouraged to stay in the hospital for the duration of the child's perioperative experience.

NORTHERN INYO HEALTHCARE DISTRICT
POLICY AND PROCEDURE

Title: Preoperative Preparation and Teaching	
Scope: PACU, Surgery	Manual: PACU
Source: OP/PACU Manager	Effective Date:

Preoperative teaching should include the following: Determine the patient's level of knowledge regarding his/her surgery. Any questionable aspect of the pre-op teaching should be discussed with the surgeon.

Admit time: Inform the patient of the appropriate arrival time for the day of the surgery. A first case (0730) should be told to arrive at the Admissions Desk at 0600. The patient should be told that the front Admissions Desk does not open until 0600, so arriving earlier than 0600 is not advised. The patients that are scheduled as "To Follow" will be given appropriate arrival times (0700 or later) depending on the length of the case(s) preceding the surgery. Generally, the patient is told to arrive 1 ½ hours prior to their intended surgery start time. C-sections will have a stress test done in the Perinatal Unit then be prepared for surgery in the Preoperative Unit. They are given earlier arrival times (0530).

NPO: Adults are asked to remain NPO before surgery per the NPO recommendations below. Water, Gatorade, Crystal Light, and/or bowel prep are ok up to 2 hours prior to the surgery start time if so advised by the surgeon. (See "Enhanced Recovery After Surgery" guidelines)

NPO Recommendations:

Patient's Age	Number of hours since solid food / milk / breast milk	Number of hours since clear liquids
< 6 months	4	2
6 – 36 months	6	2
> 36 months – adult	6 – 8	2

The only exception to the NPO guideline is medications specifically ordered by the surgeon or anesthesia provider (or the medication the patient is advised to take following the "Preoperative Medication Guideline" policy/procedure. Patients should be encouraged not to smoke, chew tobacco, or chew gum prior to surgery

Medications to take in the AM: The nurse conducting the preoperative interview will review current medications and allergies with the patient including any history of allergic reaction to sutures or surgical pre solutions (such as iodine). The patient will be instructed to take or hold their regular medications prior to surgery based on the current Preoperative Medication Guidelines (reviewed annually by the Surgery Tissue Committee). Medications should be taken with a small amount of water (enough for the patient to swallow the medication comfortably) If there are any questions about the patient's medications, the anesthesia provider should be contacted for advice. The patient should not drink alcoholic beverages or take medications not specifically prescribed by physician

Preoperative/Surgery Environment: The nurse will describe the preoperative unit, Surgery, and PACU environments, and describe briefly the steps taken in the preparation for surgery (changing into a gown, height/ weight, vital signs, IV, clipper prep /scrub, etc.).
The nurse should emphasize several points: Clothing-It is best to wear loose comfortable clothing that will be wide enough over the operative area to allow for a dressing. Valuables: It is best to leave all money and jewelry at home including watches. Make-up: It is suggested that no make-up be worn. Nail polish should be removed from the index finger and thumb of both hands, and from the entire hand or foot of any limb involved in the surgery. Equipment: The nurse will review any special equipment the patient might need (braces, crutches, TED hose, etc.) and encourage the patient to bring appropriate equipment he/she may

already have to the hospital the morning before surgery. The patient must bring their CPAP machine to the hospital if one is used by the patient at home.

Description of the preoperative process: inform the patient that the anesthesia provider will visit prior to surgery to discuss all aspects of anesthesia. If the anesthesia provider has already spoken with the patient, reinforce the anesthesia provider teaching. The OR environment (lights, monitors, positioning, approximate operating room time) should be described as well as the PACU environment (oxygen, monitors, approximate PACU time). Review visiting information which includes: the surgeon will talk to family following surgery, PACU visitors, routine visiting hours (for inpatients).

If patient feels uncomfortable with impending surgical procedure or has questions regarding the surgery or anesthesia the surgeon and anesthesia provider should be notified before proceeding with procedure.

Reinforce the importance of deep breathing and coughing and the use of the incentive spirometer, and splint pillow if indicated. Discuss the importance of movement in bed (i.e. improve circulation / prevent venous stasis, etc.) and early ambulation. Describe drains/tubes/catheters if applicable.

Discuss the importance of asking for pain medication to decrease pain so he/she will be able to complete above with minimal discomfort.

Discharge RX: Check with the patient for preferred pharmacy. This allows the PACU nurse to arrange for discharge medications to be dispensed as soon as possible following discharge.

Transportation: The patient must have arrangements for a responsible adult to take him/her home and stay with patient overnight as directed by the surgeon. The patient will not be allowed to drive for twenty-four hours after anesthesia. Important decision making should be delayed until 24 hrs. after general, spinal, or epidural anesthetic or procedural sedation. Minors will be discharged home with a responsible adult.

C. Assessment: The preoperative assessment should be completed electronically. This includes screening for allergies, chronic medical conditions, history of infectious diseases, previous surgeries/hospitalizations and current medications and a psycho/social history. A pediatric assessment form will be used for children age 13 and under.

DAY OF SURGERY

A. Assessment: Complete the assessment started in the Preoperative Interview. Include vital signs, height, weight, and obtain a cardiac rhythm strip for the chart

B. Patient Care Plan – A surgical care plan should be completed in the electronic health record. If a patient has any problems or potential problems not addressed in these standard care plans; the problem and plan of care should be outlined. If there are no problems other than those addressed by the generic operative care plan and the care plan for that particular surgery, "standards of care for procedure" should be written in the care plan section.

C. Surgical Checklist

- **The Surgical Checklist** must be filled out completely, all blanks must be filled in; use of N/A (not applicable) as necessary. If patient has eaten within 8 hours of the surgery the anesthesia provider and surgeon must be notified.
- Completion of surgical checklists for inpatients are the responsibility of the RN caring for that patient on that particular unit (on the shift that the patient is sent to the OR); Outpatient and AM admit checklists will be completed by the Preoperative staff.

D. Informed consent - The consent shall be written as per physician's order completely and without abbreviations. When appropriate, must include right or left (as in right leg, left eye, etc.).

- Special consents are needed for transfusion, sterilization, hysterectomy, photography, observation and breast cancer therapy.
- In emergency situations involving a minor, unconscious or incompetent patient the situation is to be fully explained on the medical record with confirmation by a second physician.

E. Other Paperwork

- Physician orders should be completed, noted and on chart.

- A copy of the patient's history & physical performed and recorded with 30 days of surgery. The history and physical is to be updated and signed by physician the morning of surgery for Outpatient procedures. For inpatient procedures, the history and physical does not have to be updated the morning of surgery. If the history and physical is older than 30 days, it must be redone. The History and Physical must be available electronically or on the patient chart prior to the patient entering the operating room. Exception to this is for a life or limb threatening emergency.

- Results of ordered **laboratory work and tests** performed must be available electronically or on the chart prior to surgery. Laboratory values and test reports should be reviewed for normal values and abnormal values reported to the anesthesiologist and surgeon.

- In order to be certain that the right type of blood and sufficient quantity is available if needed for surgery; the patient should be typed and cross-matched 3 days prior to scheduled surgery.

- For elective procedures all women of childbearing potential (from the onset of menses until the woman has not had a menstrual cycle in over a year) with intact tubo/ovarian/uterine anatomy will have an HCG (pregnancy test) unless they refuse. A copy of these records may be an acceptable substitute if the patient had these studies done elsewhere.

- The operation shall be delayed until above are complete. In any emergency, the practitioner shall make at least a comprehensive note regarding the patient's condition prior to induction of anesthesia and start of surgery. If the history and physical have been dictated, but not transcribed, the surgeon shall so state in writing on the progress notes.

- Patients whose procedures require local anesthesia involving a small area only may not require preoperative testing at the discretion of the operating surgeon.

- If ordered, the EKG should be in the chart. If no EKG ordered, pt shall have a three lead EKG monitor strip documented on chart. Do not place leads in the area of the surgical site (check with the circulating OR RN if unsure about lead placement).

Patient Prep

Dress:

- The patient will have dressed in hospital attire: gown, hair cap and foot covers. The patient must have his/her identification bracelet on. All jewelry will be removed. If jewelry cannot be removed, it can be covered with tape. All valuables will be sent home or placed in a valuables envelope and placed in the safe. All makeup should be removed.

- Valuables will be given to the patient's significant other or stored in the safe. Clothing will be put in labeled plastic bags and taken to the PACU (outpatients) or the patient's room (inpatients).

- The removal of prosthetic devices such as eye glasses, hearing aids and dentures are to be moderated by good nursing judgment in consultation with the anesthesiologist. (Example, a patient who is deaf could come to the OR with a hearing aid in place if the anesthesiologist was notified). Once removed, document location of devices jewelry, clothing, luggage, etc. on the surgical checklist and the assessment sheet.

Surgical Site Prep and Marking:

Preoperative prep will be performed routinely by the preoperative staff per physician's order.

After confirming appropriate surgical site/side, the SURGEON will mark the surgical site with his initials, designating correct site/side using a one-time use pen. Ophthalmology patients will have a colored dot placed above the operative eye. The ophthalmologist will place his initials over the patient’s eyebrow of the eye to be operated on, again using the disposable pen.
If there is any discrepancy between the surgical procedure scheduled, Surgical Consent, Physician History and Physical documentation of the site or side, or the patient’s understanding of the procedure/site or side, they must be clarified between the surgeon and the patient before the site/side is marked and the patient is transported to the operating room. Documentation of surgical site verification will be noted on the Surgical Checklist, the Surgical Safety Checklist and Intraoperative Record.

Tubing and Solution:

The patient's IV should have anesthesia tubing (gravity tubing without a filter) and a luer lock extension. Check the physician's order for solution and rate.

If there is a written/verbal order for changing the IV Solution/Tubing, this should be changed prior to the patient coming to the operating room/holding room. If there is no order, the patient will be sent to the Operating Room/Holding Room with the current IV solution/tubing hanging and they will be changed by the anesthesia provider caring for the patient. This procedure should be completed on all in-house patients scheduled for surgery since frequently there are schedule add-ons, changes and switches.

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Transfer to OR

The surgery staff will notify the unit when they are ready for the patient. The patient will be transferred to the OR by the unit staff, appropriately prepped and dressed with their completed medical record. The patient will be transported by gurney, side rails up.

Patients with a fractured hip or in traction will be transported in their unit bed with traction devices in place.
Small children may be carried to the OR by a parent upon the anesthesia provider's request. (See policy/procedure on Transfer of Patients to the O. R.)

Patients must have O_2 during transport if continuous O_2 has been ordered by the attending physician.

C-SECTIONS

C-Section patients will be told to arrive @ 0530, check in at ED registration desk and report to the Perinatal Unit. The perinatal RN will complete an NST on the patient for fetal well-being. The Family Caregiver (support person) will receive scrubs to change into and will accompany the patient to the PACU no later than 0615. The patient will be assessed and prepped for surgery in the preoperative unit (patient gown on, height, weight, vital signs, IV, etc). The patient should be ready to be taken to the OR by 0730.

If for some reason there is an issue getting the passing NST or the patient arrives late to the hospital, the PACU staff should be notified so the patient preparation can be expedited. Factors to consider:

- There must be 2 staff members in the perinatal unit when patients are present. (Depending on acuity in the unit, staff from other units could come during that time to be the second staff member)
- If needed the portable monitor can be taken to PACU to complete the NST
- A PACU RN can come to the Perinatal Unit to begin prep work in conjunction with the Perinatal staff

A surgery chart will be assembled by the PACU clerk. The OB MD will have sent the H&P to the PACU clerk along with admit orders and a Perinatal summary sheet when the C-section was scheduled. Anesthesia forms will be added to the surgery chart by the PACU clerk.

DOCUMENTATION:

- Doctor's orders (noted by the RN)
- A Surgical checklist will be completed
- Appropriate consents will be signed (and witnessed)
- Electronic assessment and care plan completed
- Medication reconciliation form (outpatients only) completed and placed in chart with H&P for the physician to complete

REFERENCES:

1. ASPAN 2012-2014 Perianesthesia Nursing (Standards, Practice Recommendations, and Interpretive Statements: Standard VI: Nursing Process

Title: Preoperative Preparation and Teaching	
Scope: PACU, Surgery	Manual: PACU
Source: OP/PACU Manager	Effective Date:

2. TJC Standards PC 02.03.01, PC 03.01.03
3. CA Code of Regulations, Title 22 Standard 70215 (c), (d)

CROSS REFERENCE P&P:

1. NPO Guidelines
2. NPO Guideline Table for children
3. Preoperative EPT testing protocol
4. Skin Preparation in the Perioperative Unit
5. Patient Visitation Rights
6. Preoperative Medication Guidelines

Approval	**Date**
CCOC	5/4/2021
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NORTHERN INYO HEALTHCARE DISTRICT
POLICY AND PROCEDURE

Title: Scheduling Surgical Procedures	
Scope: Nursing	Manual: Surgery
Source: Surgery / Sterile Processing Manager	Effective Date:

PURPOSE:
To facilitate the process of scheduling elective, after-hours, and emergency surgical procedures.

POLICY:
When scheduling surgical procedures, the following procedure will be utilized.

PROCEDURE
SCHEDULING ELECTIVE SURGERIES / PROCEDURES:
Surgical procedures will be scheduled by the perioperative clerk, or a perioperative nurse during regular working hours which start at 0700 and end at 1700 weekdays. Hospital designated holidays excluded.

Information taken upon scheduling will be:

- Patient name
- Patient date of birth
- In-patient / same-day / am admit status
- Date of procedure
- Time of procedure
- Proposed surgical procedure or procedures
- Length of surgery
- Name of Surgeon and assistant (if one has been arranged)
- Need for RNFA
- Need for special equipment (instruments, trays, implants, etc.)
- Need for imaging (C-arm, needle localization)

1. Procedures are scheduled on the date requested when possible; and surgery time is assigned as available on first come, first served basis.

2. The first procedure of the day is scheduled to start at 0730. All other procedures are scheduled to follow. Each room can accommodate a 0730 procedure unless there is no anesthesia coverage for the second room.

3. Children under seven years of age, cesarean sections, total joint replacements, and diabetic patients are given a first hour (0730) space whenever possible.

4. No elective cases should be scheduled after 1600 without consent of the Surgery Manager or Assistant Manager.

5. Procedures may be delayed for a variety of reasons. Depending on the reason for the delay or cancellation, the surgery may need to be rescheduled for the next available or appropriate time. In the event procedures run longer or shorter than anticipated, the perioperative clerk or RN should notify the surgeon and assistant and provide an approximate time when their procedure will begin. The perioperative clerk or RN should also notify the anesthesia provider of any schedule changes.

6. When two separate unrelated procedures are to be done simultaneously (by two different surgeons) on one patient, each surgeon will have a scrub nurse in attendance.

7. Patients who meet the health and procedural requirements for same-day, or AM Admit surgeries should be given the following information by the physician's office staff:
    - Date, time, and place for the preoperative testing (if ordered)
    - Date and time of the surgery
    - Anticipated arrival time at the hospital the day of the surgery (about 90 minutes prior to the procedure)
    - NPO instructions
    - Appropriate clothing
    - Arrangements for a responsible adult provide transportation / care postoperatively
    - An RN from the perioperative unit will be calling the day prior to surgery for a preoperative interview
    - Information hand-outs shall be provided relative to insurance coverage or non-coverage

8. The physician's office personnel will send the following to the preoperative unit:
    - Signed orders: which address surgical consent, preoperative testing, preoperative prep, and medications including an IV, and any other preoperative care the physician would like the patient to receive
    - H&P (completed within 30 days of the scheduled surgery)
    - Consent (witnessed)
    - Preoperative worksheet (if applicable) for equipment, instruments, implants and contact information for vendors that may provide specialized products.

PREOPERATIVE INTERVIEW

An RN from the perioperative unit will call the patient the weekday prior to the scheduled surgery to review medication use, allergies, medical history, history of prior procedures, and provide more detailed preoperative instructions and start postoperative teaching

AFTER – HOURS SCHEDULING:

1. Emergency procedures may preempt elective procedures by mutual consent of the surgeons involved or are scheduled as soon as on-call personnel are available (within 15 minutes) after normal operating room hours.

2. After hours, urgent surgeries, additions, or cancellations to the schedule that will occur in the following 24 hours will be handled by the House Supervisor who will notify the Perioperative DON or Surgery Coordinator. The DON or coordinator will instruct the House Supervisor to notify other team members if needed (Board Runner, anesthesia provider, vendors, etc.)

EMERGENCY SURGERIES/PROCEDURES

NORTHERN INYO HEALTHCARE DISTRICT
POLICY AND PROCEDURE

Title: Scheduling Surgical Procedures	
Scope: Nursing	Manual: Surgery
Source: Surgery / Sterile Processing Manager	Effective Date:

The surgeon scheduling an emergency surgery or a surgery to be done during "on call" hours should notify the House Supervisor.

The House Supervisor should ask the surgeon for the following information:

- **Type of surgery and side (for cases involving laterality –this is important for OR set-up)**
- **Patient's date of birth**
- **Physician**
- **Time of surgery**
- **If the Surgery is STAT**, urgent, or scheduled after -hours
- **Has anesthesia been called** (this should be a surgeon to anesthesia provider call for appropriate information exchange but the supervisor may need to call if the surgeon cannot do so)
- **Need for an assistant**
- **Need for radiology or imaging**
- **Any special equipment**

If this is a STAT case, the OR Team should be called in.
The Perioperative on-call staff is currently listed together on the intranet under "Code Team/Call Sheet"
The House Supervisor should relay the following information to the OR Team:

Type of surgery: _____ Side: Left Right N/A
Name of patient: _____ DOB: _____
Surgeon: _____
STAT / Urgent / "Scheduled" (timing of case)
Other: Assistant, imaging, special equipment

The House supervisor checklist:

1. **Call the circulating RN**
2. **Call the scrub tech or second RN**
3. **Make sure the anesthesia provider has been notified**
4. **Check on an assistant: is one needed? has the surgeon found one? does one need to be called?**
5. **Check with circulator – will the circulator notify PACU will the shift supervisor notify PACU?**

Usually the operating room nurse circulating the procedure will notify the PACU nurse on call when the surgeon begins to finish the procedure, allowing time to prepare the PACU before completion of the surgery.

The OR Team should be notified of any "scheduled" after-hours case (like a Saturday morning hip repair) as soon as it is scheduled by the surgeon – but there is no need to call the OR Team during usual sleeping hours for a case that is not an emergency.

Also inform the OR Team if any case that was going to be done during "On Call" is canceled.

TRANSFERRING THE PATIENT FOR EMERGENCY SURGERY

NORTHERN INYO HEALTHCARE DISTRICT
POLICY AND PROCEDURE

Title: Scheduling Surgical Procedures	
Scope: Nursing	Manual: Surgery
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On off hours, holidays and week-ends, patients are transported directly to the OR. The OR circulator will come to the department, identify the patient and transport the patient by stretcher (or bed if it is an orthopedic total joint case) to the OR. The sending department will assist with the transport to the OR elevator entrance. The sending department transport assistant will escort the patient's family to the front lobby OR waiting area.

The unit RN completes the Preoperative Checklist

The Surgeon completes the informed consent by reviewing the risks benefits and alternatives of the surgical procedure with the patient/family. If the signed consent is not on the chart, the RN may witness the consent. The RN signature on the consent indicates that the Surgeon reviewed the risks, benefits and alternatives of the surgical procedure with the patient/family and or patient representative.

The unit RN follows the Surgeon's preoperative orders. If the unit RN has questions about the surgical preparation, the RN is to call the Surgeon for orders.

If no orders are received to change the IV solution, the patient will be sent to surgery with the current IV on a pump. If the surgery is scheduled for the next day, the Surgeon will usually order NPO at 2400. If the patient does not have an IV ordered, the Surgeon should be called for IV orders.

REFERENCES:

1. Title 22 : 70225

CROSS REFERENCE P&Ps:

1. Cesarean Delivery
2. Preoperative Preparation and Teaching

Approval	**Date**
CCOC	5/4/2021
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Index listings: Scheduling Surgical Procedures
Supersedes: Scheduling Emergency Surgeries

NORTHERN INYO HEALTHCARE DISTRICT
POLICY AND PROCEDURE

Title: Scope of Service - PACU*	
Scope: PACU	Manual: PACU
Source: OP/PACU Manager	Effective Date:

I. Department Description:

The Post Anesthesia Care Unit is an 11 bay unit located in the new hospital on the first floor. There are 2 locked entrances. The entrance to the west of the unit is for ambulatory patients or visitors. The north entrance is for approved employees and patient flow to and from surgery or to inpatient care.

The department has 11 bays, 2 of which are closed rooms for isolation use, one of those currently is used as a draw room, ophthalmic (argon) laser, or for confidential interviews.

ADC is based on Monday – Friday Surgeries: 5-6 / OP Procedures: 7-9

II. Mission:

Provide perianesthesia nursing care that involves cultural, developmental, and age-specific assessment, diagnosis, intervention, and evaluation of individuals within the perianesthesia continuum. This includes care for patients in Preanesthesia Care (preadmission, day of surgery/procedure), Postanesthesia care (Phase I & II, and extended care) and procedural areas such as Interventional and Diagnostic Imaging.

III. Vision:

- Preadmission: To prepare patients for surgery / procedures. Interview and assess; identify potential or actual problems, educate and intervene to optimize positive outcomes.
- Day of Surgery / Procedure Preparation: Reinforce preoperative teaching, review discharge instructions, and complete preparation for the surgery / procedure.
- Postanesthesia Phase I: Provide postanesthesia care for patients and transition to Phase II, an inpatient setting, or ICU for continued care.
- Postanesthesia Phase II: Preparation for the home setting.
- Care of the Procedure patients in Interventional and Diagnostic Imaging: (incorporating care from all spectrums of Perianesthesia Nursing Care): Interview, assess, teach, prepare, and provide post-sedation recovery for the patients identified as needing nursing care.

IV. Scope:

The PACU unit provides elective and 24-hour emergency post anesthesia care; both ambulatory and inpatient patient care is provided. The Outpatient department is open during the day Monday through Friday and provides patient preparation for AM admit and outpatient surgeries. The outpatient department nursing staff assists with outpatient procedures, transfusions, chemotherapy etc., and provides recovery and discharge of local anesthesia and analgesia sedation patients, as well as, post recovery observation and discharge of patients who have met PACU discharge criteria and have been discharged by a physician

Patients whose acuity exceeds the criteria for discharge are transferred to the appropriate inpatient unit per MD orders.

V. Staffing:

The PACU patient is under the care of the Surgeon and Anesthesia Provider. They may consult with the hospitalist for admission to inpatient care.

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The PACU is open M-F from 6am-6pm excluding holidays. There are 2 RNs on call for all after hours 24/7, 365 days a year.

Nursing staff includes:
Manager (Infusion and PACU)
RN
Unit Clerk/CNA
Patient Navigator

VI. Customers

The PACU/Outpatient management is a joint function of the Medical Staff and Nursing Department and the nursing staff work in close cooperation with physician staff of the Medical Services Committee, Anesthesia Department, Surgical physicians and nursing staff, Pharmacy, Laboratory, Respiratory Therapy and Radiology departments.

VII. Ages Serviced:

PACU provides care across the life span
Pediatrics: 28 days to <13 years
Adult: 13 to 65 years
Geriatric: > 65 years

VIII. QA/PI:

The OP/PACU Manager integrates all nursing quality improvement functions on the unit, tracks identified problems, assist the nursing unit in the development and evaluation of effective performance improvement reviews, ensures appropriate follow up occurs, and prepares a yearly Pillar of Excellence report concerning nursing quality improvement programs for the Nurse Performance Improvement Committee. Activities of the PACU Performance Improvement program will be documented in the minutes of the unit staff meetings and will be reported to the NEC and QA/PI Department.

XI. Budgeted Staff:

Refer to Master staffing plan

Approval	**Date**
CCOC	5/4/2021
Surgery Tissue	5/12/2021
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Board of Directors	
Last Board of Directors Review	

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Reviewed:
Revised: 1/20ne, 3/21aw

NORTHERN INYO HEALTHCARE DISTRICT
POLICY AND PROCEDURE

Title: Scope of Service - PACU*	
Scope: PACU	Manual: PACU
Source: OP/PACU Manager	Effective Date:

Supersedes:
Index Listings:

NORTHERN INYO HEALTHCARE DISTRICT
POLICY AND PROCEDURE

Title: Sponge, Sharps, and Instrument Counts*	
Scope: Surgery	Manual: Surgery
Source: Surgery / Sterile Processing Manager	Effective Date:

PURPOSE:

- Provide guidance to perioperative registered nurses in preventing retained surgical items (RSI's) in patients undergoing surgical and other invasive procedures.
- To ensure patient safety by making sure that no instruments, sharps or sponges are retained in the patient.
- To institute a systematic and accurate accounting of all instruments, sharps and sponges.

POLICY:

- Sponges, sharps and other countable items (as listed below) herein referred to as sharps, must be counted at the beginning of all surgical procedures.
- Instruments (including retractors) shall be counted on all surgical procedures requiring the opening of the abdominal, retroperitoneal and thoracic cavity.

Exceptions:

- Sponges will be counted at the closure of the wound on all procedures in which the likelihood exists that a sponge could be retained.
- Sharps will always be counted.

PRECAUTIONS:

- All counts must be performed by two personnel, ideally one scrub tech or nurse and one circulating RN as they have liability for the count being correct.
- Incorrectly number packaged sponges must be isolated and not used during the procedure.

PROCEDURE:

PREOPERATIVE PHASE

While setting up the room the circulating nurse assembles the supplies and paperwork required to perform the surgical count. They include:

- Instrument count sheets from the instruments sets
- Preprinted tally sheet for miscellaneous instruments or additional instruments added during surgery
- The Count Recording Board and a marking pen to record the tally
- Plastic bags or hanging counting racks
- Personal Protective Equipment (PPE)

INTRAOPERATIVE PHASE - General Considerations:

1. Instruments that are broken or disassembled during the procedure must be accounted for in their entirety.

2. Instruments and sponges removed from the sterile field must remain in the room and are retained in the count.
3. Any "countable" items should not be removed from the operating room during the procedure. Any "countable" items from previous surgeries should be removed from the room prior to setup for another case.

Title: Sponge, Sharps, and Instrument Counts*	
Scope: Surgery	Manual: Surgery
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4. Counted sponges should not be used as postoperative packing. In certain circumstances, such as when counted sponges are intentionally used as packing and the patient leaves the OR with this packing in place, the number and types of sponges retained and the reasons for the variation should be documented in the intraoperative record as correct and confirmed by surgeon.

5. When patient returns to surgery and the packed sponges are removed, the number and types removed should be noted in the current patient's record. Sponges removed should be isolated and not included in the counts for subsequent procedure. The count on subsequent procedure should be noted as correct after all sponges have been accounted for. If the sponges are removed in an area other than the OR, the number removed should be noted on the patient's record.

6. Items considered to be sharps and are to be counted but are not limited to include:
    a. Atraumatic needles
    b. Free/eyed needles
    c. Hypodermic needles
    d. Scalpel blades
    e. Suture boots
    f. Vessel loops/umbilical tapes
    g. Cautery tips/scratch pads

7. All sponges used for surgical procedures must contain an X-Ray detectable element.

8. Any package containing an incorrect number of sponges should be removed from the field, bagged, labeled, and isolated from the rest of the sponges in the Operating Room. Containing and isolating the entire package helps reduce the potential for error in subsequent counts.

9. Counted sponges are not used for dressings.

10. Used sponges passed from the sterile field during the procedure must be contained.

11. All linen hampers and waste receptacles and their contents are in the room at the time of the initial count must remain in the room until the final count is completed.

12. Counting should not be interrupted. If uncertain about count because of interruption, fumbling or for any other reason, repeat it.

13. When a life threatening emergency occurs initial counts may be omitted due to lack of time. An X-Ray will be taken upon closure of incision and results documented on patient record.

INTRAOPERATIVE PHASE:

PROCEDURE:

NORTHERN INYO HEALTHCARE DISTRICT
POLICY AND PROCEDURE

Title: Sponge, Sharps, and Instrument Counts*	
Scope: Surgery	Manual: Surgery
Source: Surgery / Sterile Processing Manager	Effective Date:

A tally is taken of sponges, sharps, and instrumentation at the start of each surgical procedure (before the incision is made). As more items are added, they are added, and included in the tally.

Counts should be performed in the same manner throughout the surgical suite.

- A surgical count should be conducted in the same sequence each time (starting from the sterile field to the back table to the kick bucket).
- As nursing move throughout the surgical suite, uniformity of counting technique will help reduce procedural errors.
- A standardized count procedure, following the same sequence, assists in achieving accuracy, efficiency, and continuity among perioperative team members. Studies in human error have shown that errors involve some kind of deviation from routine practice.

When additional sponges are added to the field, they should be counted at that time and recorded as part of the count documentation to keep the count current and accurate.

Counts are taken:

- For sponges and instruments and sharps when a cavity is to be closed (e.g. Peritoneal and Pleural).
- At the permanent relief of the scrub or circulating nurse.
- At the start of closure: final count shall be made for sponges, sharps and instruments.
- When closure is near completion. All instrument count should not be considered complete until those instruments used in closing the wound (e.g. malleable retractors, drape/towel clamps, needle holders, forceps, and scissors) are removed from the wound and returned to the scrub person.

Additional counts of sponges and sharps:

- Whenever a hollow organ (e.g. uterus) is opened, additional count is made as the organ is closed.
- When the retro peritoneum is opened an additional count will be made upon closing of the retro peritoneum.
- When a bilateral procedure is performed, a separate count will be taken for each side.
- When a multiple stage operation is performed, a separate count will be taken for each stage.
- Whenever the scrub person or circulating nurse is relieved, the count shall be taken by the relieving person(s).
- When a member of the surgical team requests an interim count.

RESPONSIBILITIES OF THE SCRUB PERSON AND CIRCULATING NURSE:

1. Sharps, instruments and sponges must be counted simultaneously, visually and verbally by the scrub person and circulating nurse.

Title: Sponge, Sharps, and Instrument Counts*	
Scope: Surgery	Manual: Surgery
Source: Surgery / Sterile Processing Manager	Effective Date:

2. Both must verify the presence of a radiopaque element.
3. Surgical instruments sets should be reviewed frequently to streamline contents.
4. Items that can be disassembled should be accounted for in their entirety.
5. Instrument count sheets should be available for all sets.
6. Preprinted tally sheets are available and are recommended to be utilized if additional instruments are added.
7. Preprinted tally sheets must be kept up to date and available for counts.
8. Sharps broken during the procedure must be accounted for in their entirety.
9. Counts of multiple suture packages are confirmed when a package is opened at time of use.
    - Viewing each needle will help ensure an accurate needle count.
    - Needles should be counted and recorded according to the number on the outer package and verified by the scrub person when the package is open.
10. The circulating nurse is responsible for:
11. Recording all sharps, sponges and instrument counts on the Count Recording Board and instrument tally sheet.
12. Recording the results of the final count on the operative record.
13. Notifying the surgeon of the count results.

DISCREPANCIES IN INSTRUMENT, NEEDLES OR SPONGE COUNTS:

When a discrepancy is reported:

1. The surgeon is immediately notified and the procedure suspended, if patient's condition permits.
    - A thorough search is made of the following:
    - Manual inspection of the operative site by surgeon and assistants.
    - Visual inspection of the area surrounding the surgical field, including the floor, kick buckets, linens and trash receptacles and the sterile field by scrub person and the circulating nurse.

2. Recount that entire particular group of items if missing item is found.

3. When discrepancy cannot be reconciled:
    - An X-Ray of the operative site is taken before the patient leaves the room.
    - Documentation of all measures taken and outcomes of actions on patient's record.
    - Reporting of incident and review of incident or near miss for cause, effect and prevention.

DOCUMENTATION:

1. Type of count (i.e. sharps, sponges, instruments, etc.)

2. Number of counts or reason why count was done (first count, second count, change of personnel, etc.)

3. The circulating nurse will document the count result on the operative record and notify the surgeon of the results.

Title: Sponge, Sharps, and Instrument Counts*	
Scope: Surgery	Manual: Surgery
Source: Surgery / Sterile Processing Manager	Effective Date:

4. Scrub and circulating personnel participating in the sponge, sharp and instrument count must sign the operative record.

5. Instruments intentionally remaining with the patient or sponges intentionally retained as packing should be documented.

6. The operative record will become a part of the patient's chart.

7. Omitted counts due to life threatening emergency shall be documented on the operating room record by the circulating nurse.
    - An X-Ray of the surgical site may be performed at the end of the case to assure that no items were unintentionally left in the wound
    - Results of the x-ray should be included by the circulating nurse in the counts section of the operative record.

Note:
AORN recommends preprinted count sheets, identical to the standardized sets, should be used to record the counted items. Additional instruments requested by the surgeon should be counted and added to the pre-printed sheet separately.

CROSS REFERENCE P&P:
1. Universal Protocol

REFERENCES:
1. AORN Guidelines for Perioperative Practice (2018): Retained Surgical Items
2. Title 22: 70223

Approval	**Date**
CCOC	5/4/2021
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Reviewed: 4/27/16AW

NORTHERN INYO HEALTHCARE DISTRICT
POLICY AND PROCEDURE

Title: Surgery Equipment and Routine Supplies	
Scope: Surgery	Manual: Surgery
Source: Surgery / Sterile Processing Manager	Effective Date:

PURPOSE:

- To provide a par level of routine supplies and equipment.
- To communicate the introduction of new equipment /instrumentation to all members of the surgical team.
- To establish a tracking mechanism for borrowing and lending equipment.
- To communicate unavailability of equipment to the members of the surgical team.

POLICY:

Appropriate quantities of supplies and equipment will be available at all times to support quality care for the surgical patient.

PROCEDURE:

ROUTINE SUPPLIES - PAR LEVELS:

- A list of all routine supplies shall be maintained in the department. Supplies not included shall be considered specialty items.
- An appropriate par level for all routine supplies will be utilized.
- Designated staff persons shall be assigned to check par levels of routine supplies and initiate requisitions for replacements on a daily/weekly basis as appropriate.
- Requisitions for replacement of routine supplies shall be submitted to Purchasing or Pharmacy as appropriate.

SPECIALTY ITEMS:

- Requests for specialty items must be made to the Surgery Nurse Manager
- Requested items will be purchased and added to order sheets if applicable.
- Charge number is requested if item is patient chargeable and added to appropriate charge sheet and charge menu (Surgery Inventory Analyst will add charge to charge menu, when new charge is received and ready for use.)

OUTSIDE SALES:

Administration approval must be acquired before selling supplies to another institution, physician and or private patients. If a sale is approved by administration, price is determined by contacting purchasing for cost of item plus 10%. Purchasing to be billed to institution, or physician.

NEW EQUIPMENT:

- All new electrical equipment shall be examined by the Biomedical Engineering Technician before the equipment is introduced into the operating room for patient care.
- Documentation for proper care and handling of equipment, including manufacturer's recommendations shall be on file and available within the department for referral.

- Operating room staff will be in-serviced in the use, care and handling of new equipment before the equipment is used.

- Documentation for proper care and handling shall be provided to the central supply department for items requiring processing. Central Supply Staff will be in-serviced to the care and reprocessing of equipment.
- Documentation of in-service for new equipment shall be maintained within the department.

BORROWING AND LENDING OF EQUIPMENT AND SUPPLIES:

- Requests to borrow outside equipment, prostheses and/or supplies shall be coordinated through the Surgery Nurse Manager or the House Supervisor.
- Requests from other institutions, surgeons, and other sources shall be made through the Surgery Nurse Manager or the House Supervisor.
- Instruments, prosthesis, and other equipment and supplies shall be inventoried prior to lending, and shall be inventoried upon return.
- Items shall not be loaned without a pre-established agreement for return/replacement.
  - Equipment loan form is to be completed for equipment loaned to another institution or surgeon (NIHD Intranet: Forms: Administrative: Equipment Loan)
- Documentation for equipment and other items borrowed or loaned shall include:
  - Date
  - Equipment identification
  - Institution or person requesting equipment or supplies
  - Signature of person receiving and lending equipment or supplies
- Equipment is to be checked for completeness and working function before reprocessing for use.
- Electrical equipment loaned to another institution shall be inspected by Biomedical Engineering upon return and before use in the operating room. Inspection shall be documented.

EQUIPMENT REPAIR:

- All members of the surgical team shall be responsible for identification of equipment in need of repair.
- Items identified as needing repair shall be removed from service immediately and referred to Biomedical Engineering.
- Electrical equipment repaired by other than Biomedical Engineering shall be inspected by Biomedical Engineering upon return and before use in the operating room.
- Documentation of service rendered and date of repair shall be maintained.

UNAVAILABILITY OF EQUIPMENT/SUPPLIES:

- The Surgery Nurse Manager shall be informed when equipment is removed from service or essential items are low or out of stock.
- Surgeons will be notified of unavailability of essential equipment/supplies before a procedure is scheduled.
- Loaner equipment will be obtained from the manufacturer for essential equipment while repair is being performed.
- Assigned personnel will complete Inventory Control Form and log pertinent information in Log Book for repairs.
- A notation shall be placed on the “Schedule Board” noting the equipment being out for repair if there is no duplication.

Title: Surgery Equipment and Routine Supplies	
Scope: Surgery	Manual: Surgery
Source: Surgery / Sterile Processing Manager	Effective Date:

- Assure adequate insurance is applied to cover the cost of equipment and ship via FedEx or UPS depending on urgency of need for repair.

ANESTHESIA EQUIPMENT AND SUPPLIES

The list of supplies for restocking the anesthesia carts should be used by the Surgery staff checking and restocking the anesthesia carts. Pharmacy staff restocks the medications on the carts and in the main Surgery Omnicel. The anesthesia provider is responsible to check the anesthesia cart before beginning a case and the provider should restock or ask for supplies prior to starting a surgical case.
In addition to the anesthesia carts (one in each OR room) there are pediatric airway supplies on a separate cart as well as a difficult airway tray and video laryngoscopes.

There are operator manuals on all Anesthesia monitors and Drager anesthesia machines in the Surgery area for reference. It is the responsibility of the anesthesia provider to check the equipment before use (monitors, suction, anesthesia machines, oxygen and gases).

In the event an RN monitoring a Procedural Sedation patient must use the anesthesia machine oxygen the following quick oxygen flow check should be used:
At the beginning of each day the 02 sensor on the anesthesia machine is to be placed on the workspace of machine for at least two minutes, open side up for calibration, press the 21% on calibration panel, after green light comes on indicating that it Calibrated to 21%, secure the sensor into its port labeled ***OXYGEN SENSOR ONLY*** *on the inspiration side of machine. Turn oxygen flow meter to 3-4 liters to keep alarm from alarming. Check that 02 monitor displays 100% during oxygen flow.*

DOCUMENTATION:
As stated above in each section.

REFERENCES:
TJC: PC.03.01.01
Title 22: 70237
CMS: 482.52

CROSS REFERENCE POLICIES: Anesthesia Clinical Standards and Professional Conduct

Approval	**Date**
CCOC	5/4/2021
STTA	5/12/2021
MEC	6/1/2021
Board of Directors	
Last Board of Director review	

Revised: 6/11 BS, 4/21aw
Last Board of Director review: 1/17/18; 1/16/19, 3/18/2020
Index listings: Equipment and Routine Supplies/ Equipment Repair Supplies/ Equipment Loan

CALL TO ORDER	The meeting was called to order at 5:30 pm by Robert Sharp, District Board Chair.
PRESENT	Robert Sharp, Chair Jody Veenker, Vice Chair Mary Mae Kilpatrick, Secretary Topah Spoonhunter, Treasurer Kelli Davis MBA, Interim Chief Executive Officer and Chief Operating Officer Joy Engblade MD, Chief Medical Officer Allison Partridge RN, MSN, Chief Nursing Officer Sierra Bourne MD, Chief of Staff Keith Collins, General Legal Counsel (Jones & Mayer)
ABSENT	Jean Turner, Member-at-Large
OPPORTUNITY FOR PUBLIC COMMENT	Mr. Sharp announced that the purpose of public comment is to allow members of the public to address the Board of Directors. Public comments shall be received at the beginning of the meeting and are limited to three (3) minutes per speaker, with a total time limit of thirty (30) minutes being allowed for all public comment unless otherwise modified by the Chair. Speaking time may not be granted and/or loaned to another individual for purposes of extending available speaking time unless arrangements have been made in advance for a large group of speakers to have a spokesperson speak on their behalf. Comments must be kept brief and non-repetitive. The general Public Comment portion of the meeting allows the public to address any item within the jurisdiction of the Board of Directors on matters not appearing on the agenda. Public comments on agenda items should be made at the time each item is considered. Comments were heard from previous NIHD Physical Therapist, Laura Molnar.
NEW BUSINESS COVID 19 UPDATE	Interim Chief Executive Officer and Chief Operating Officer Kelli Davis, MBA, provided a monthly Covid 19 update which included the following: - Inyo County shows a decrease in Covid-19 positive cases - NIHD continues to adhere to all mandates that have been released for health care facilities, including masking and social distancing. More information is expected in June, 2021. - Incident Command continues to meet on Wednesday mornings - NIHD will be updating signage for people on campus In addition, Mr. Sharp reported that masks continue to be required when indoors as California guidelines are stricter than Federal guidelines. New guidelines are expected on June 15, 2021, but health care facilities are likely to have different regulations. Allison Partridge, CNO, commented on the county's great vaccination

rate. NIHD will be offering the Pfizer vaccine on campus next week for those aged 12-18 years.

MOMENT OF APPRECIATION FOR DISTRICT STAFF AND PROVIDERS

The District Board took a moment to appreciate NIHD staff and providers for their continued dedication during the Covid 19 pandemic. In addition, Mr. Sharp recognized the retirement of Sandy Blumberg and thanked her for her years of service to the Board of Directors.

Ms. Veenker thanked all NIHD staff for the work they have put into the Cerner project. In addition, Ms. Veenker thanked the 40 members of Cerner for being onsite to help staff, and gave a shout out to Vinay Behl, Financial Consultant, for being onsite as well.

Ms. Davis thanked the NIHD team as well.

Ms. Kilpatrick commented that she is sorry to see Laura Molnar go as she was an outstanding Physical Therapist. She wishes Laura the best in her endeavors.

NIHD STRATEGIC PLAN UPDATE

David Sandberg reviewed the 5 areas of the Strategic Plan which utilizes the Action Strategy platform. Work began on April 10, 2021. More information will be presented as the project moves forward.

CERNER IMPLEMENTATION UPDATE

Daryl Duenkel of Wipfli provided an update on the Cerner Go Live Project which kicked off on May 17 at 12:01am. Mr. Duenkel thanked the Board of Directors for their warm expressions of appreciation to the Cerner team. Overall, the transition from Athena to Cerner has gone very well.

CONSTRUCTION PROJECT UPDATES

Louis Varga, Colombo Construction, provided updates on the Building Separation Project, Pharmacy Project, Omnicell Project and Condenser Replacement Project. More updates will be provided in June, 2021.

BILLING SERVICES AGREEMENT WITH OUTSOURCE, INC

Kelli Davis and Vinay Behl presented the OutSource, Inc. agreement along with a historical perspective pertaining to the need. It was moved by Ms. Kilpatrick, seconded by Mr. Spoonhunter, and unanimously passed to approve the OutSource Billing Services agreement as presented.

POLICY & PROCEDURE APPROVAL

Sanctions for Breach of Patient Privacy Policies was presented by Compliance Office Patty Dickson. It was moved by Mr. Spoonhunter, seconded by Ms. Kilpatrick, and unanimously passed to approve this policy.

Funding Requests of NIH Foundation and *Grant Program Activities* was presented by Greg Bissonette, Executive Director of the NIH Foundation. It was moved by Ms. Kilpatrick, seconded by Ms. Veenker, and

unanimously passed to approve these 2 policies.

CHIEF OF STAFF REPORT

Chief of Staff Sierra Bourne, MD reported following careful review and consideration the Medical Executive Committee recommends Medical Staff re-appointment for Calendar Years 2021-2022 for the following

MEDICAL STAFF REAPPOINTMENT

1. John Daniel Cowan, MD (*anesthesiology*) – Active Staff

It was moved by Ms. Kilpatrick, seconded by Mr. Spoonhunter and unanimously passed to approve the Medical Staff re-appointment of John Daniel Cowan, MD as requested.

POLICY AND PROCEDURE APPROVALS

Doctor Bourne also reported after careful review, consideration, and approval by the appropriate Committees, the Medical Executive Committee's recommendation to approve the following District-Wide Policies and Procedures:

1. *DI-Radiation Protection for the Patient*
2. *Nursing Bedside Swallow Screen*
3. *District-Wide Quality Assurance and Performance Improvement (QAPI) Plan FY 2021*
4. *MERP: Plan to Eliminate or Substantially Reduce Medication-Related Errors*
5. *Infection Control Risk Assessments (ICRA) for Demolition, Renovation, Remediation, or New Construction Projects*
6. *Cleaning and Care of Surgical Instruments*
7. *Packaging, Wrapping, and Dating Trays and Instruments*
8. *Precleaning and Returning Instruments to Sterile Processing*
9. *Medical Staff Department Policy – Outpatient Medicine*

It was moved by Ms. Veenker, seconded by Mr. Spoonhunter, and unanimously passed to approve all nine District-Wide Policies and Procedures as presented.

OUTPATIENT MEDICINE CRITICAL INDICATORS

Doctor Bourne additionally reported the Medical Executive Committee recommends approval of:

- Outpatient Medicine Critical Indicators

It was moved by Ms. Kilpatrick, seconded by Mr. Spoonhunter, and unanimously passed to approve the Outpatient Medicine Critical Indicators as presented.

EMERGENCY DEPARTMENT PRIVILEGE FORM

Doctor Bourne also reported the Medical Executive Committee recommend approval of:

- Emergency Department Privilege Form

It was moved by Ms. Kilpatrick, seconded by Mr. Spoonhunter, and unanimously passed to approve the Emergency Department Privilege Form as presented.

MEDICAL EXECUTIVE COMMITTEE REPORT

Doctor Bourne also provided a review of the report on the Medical Executive Committee meeting for the month of May.

CONSENT AGENDA

Mr. Sharp called attention to the Consent Agenda for this meeting which contained the following items:

1. Approval of minutes of the April 21 2021 regular meeting
2. Approval of minutes of the April 28 2021 special meeting
3. Interim Chief Executive Officer report
4. Chief Medical Officer report
5. Chief Nursing Officer report
6. Financial and Statistical reports as of March 31 2021
7. Policy and Procedure annual approvals

It was moved by Ms. Veenker, seconded by Mr. Spoonhunter, and unanimously passed to approve Consent Agenda items 1 through 7 as presented.

Ms. Kilpatrick mentioned that Dr. Will Timbers did a great job recruiting physicians, and believes the new Finder's Fee Program could be a great incentive for acquiring physicians.

BOARD MEMBER REPORTS ON COMMITTEE MEETINGS

Mr. Sharp also asked if any members of the Board of Directors wished to report on their attendance at any NIHD Committee meetings.

Ms. Kilpatrick reported on her attendance at the Medical Executive Committee meeting, NIH Foundation Board meeting and the Pioneer Home Health Board meeting.

Mr. Spoonhunter reported on his attendance at the Physician Compensation Sub-Committee meeting

BOARD MEMBER REPORTS ON ITEMS OF INTEREST

Mr. Sharp additionally asked if any members of the Board of Directors wished to report on any items of interest. Nothing was reported.

ADJOURNMENT TO CLOSED SESSION

At 6:45pm Mr. Sharp reported the meeting would adjourn to Closed Session to allow the District Board of Directors to:

A. Conference with Legal Counsel, existing litigation (*pursuant to Paragraph (1) of subdivision (d) of Government Code Section 54956.9*). Name of case: Inyo County LAFO and NIHD v. SMHD, Case No. 3-2015-8002247-CY-WM-GDS-Sacramento County.
B. Conference with legal counsel, anticipated litigation. Significant exposure to litigation (*pursuant to paragraph (2) of subdivision (d) of Government Code Section 54956.9*) two cases.
C. Public Employee Performance Evaluation (*pursuant to Government Code Section 54957 (b*)) title: Interim Chief Executive Officer.

Mr. Sharp additionally noted that it was not anticipated that any action

would be reported out following the conclusion of Closed Session.

RETURN TO OPEN SESSION AND REPORT OF ACTION TAKEN	At 8:06pm the meeting returned to Open Session. Mr. Sharp reported that the Board took no reportable action.
ADJOURNMENT	The meeting adjourned at 8:07pm.

_____
Robert Sharp, Chair

Attest: _____
Mary Mae Kilpatrick, Secretary

Overview: April billed charges were over budget by $7.4M.

April YTD is $142M compared to budget of $111M.

	Charges	Budget
January 2020	16,271,574	14,095,678
February 2020	13,886,140	13,186,280
March 2020	12,141,181	14,095,678
April 2020	6,887,085	13,640,980
May 2020	10,687,793	14,095,678
June 2020	13,443,103	13,640,980
July 2020	14,939,822	11,862,737
August 2020	13,989,077	11,533,455
September 2020	14,652,230	10,715,581
October 2020	14,539,677	12,487,777
November 2020	12,978,658	11,166,411
December 2020	15,139,508	11,863,789
January 2021	13,060,873	13,778,625
February 2021	12,879,445	11,639,016
March 2021	15,505,494	9,383,779
April 2021	14,266,929	6,870,945

Gross Accounts Receivables in Athena total $34.2M in April, down from $36.7M at the end of March.

Gross Legacy AR is at $1,9M, Totally reserved for as Uncollectable.

Salaries and Wages for hospital operations were down from March.

Actual Salaries percentage is 30% compared to Budget of 34% of Net Patient Revenues.

	Salaries & Wages	Cost Per Day
January 2020	2,169,008	69,968
February 2020	2,144,412	73,945
March 2020	2,306,958	74,418
April 2020	1,999,126	66,638
May 2020	2,082,141	67,166
June 2020	2,130,598	71,020
July 2020	2,244,335	72,398
August 2020	2,263,144	73,005
September 2020	2,142,762	71,425
October 2020	2,227,959	71,870
November 2020	2,161,607	72,054
December 2020	2,596,191	83,748
January 2021	2,096,158	67,618
February 2021	2,104,702	75,168
March 2021	2,316,452	74,724
April 2021	2,260,211	72,910

April 2021 Financial Results: Revenues trended higher than budget in April

Direct costs were higher than budget due to pharmacy charges trending 150k higher per month,
Athena costs were up 144k vs 97k monthly average, Pensions costs in total 200k higher than budget.
Medical, Dental, Vision expense was up by 500k for April. Will have similar monthly expense for rest of year.
Labcorp testing of 200-400k per month, and G&A costs were 128k higher than budget-professional fees.

FY2021

Unit of Measure	July 2020	August 2020	September 2020	October 2020	November 2020	December 2020	January 2021	February 2021	March 2021	April 2021
Cash, CDs & LAIF Investments	56,272,847	55,214,586	52,965,190	53,539,618	50,491,090	47,413,188	44,556,758	42,840,110	48,843,100	45,968,807
Days Cash on Hand	226	225	220	218	153	143	162	150	166	139
Gross Accounts Receivable	46,949,619	48,287,230	45,195,462	39,988,328	38,951,324	41,570,823	39,066,151	38,262,376	36,741,318	34,157,246
Average Daily Revenue	481,930	466,595	473,708	472,527	464,702	468,886	462,027	461,791	466,134	417,921
Gross Days in AR	97.42	103.49	95.41	84.63	83.82	88.66	84.55	82.86	78.82	81.73
Key Statistics										
Acute Census Days	263	275	232	203	210	310	246	198	216	178
Swing Bed Census Days	42	44	34	8	20	8	16	28	15	7
Total Inpatient Utilization	305	319	266	211	230	318	262	226	231	185
Avg. Daily Inpatient Census	9.8	10.3	8.9	6.8	7.7	10.3	8.5	8.1	7.5	6.2
Emergency Room Visits	691	639	581	624	516	504	524	480	583	608
Emergency Room Visits Per Day	22	21	19	20	17	16	17	15	19	20
Operating Room Inpatients	31	26	39	23	27	18	21	12	10	17
Operating Room Outpatient Cases	81	74	74	74	79	90	38	68	89	112
Observation Days	44	32	46	48	39	28	37	37	68	63
RHC Clinic Visits	2,670	2,614	2,535	2,730	2,490	2,758	2,954	3,282	3,533	2,557
NIA Clinic Visits	1,792	1,794	1,918	1,681	1,555	1,642	1,290	1,408	1,640	1,604
Outpatient Hospital Visits	4,431	3,558	4,139	3,560	3,531	3,837	4,140	4,188	5,139	4,903
Hospital Operations										
Inpatient Revenue	3,201,903	3,105,168	3,469,234	2,495,776	2,626,028	4,084,113	3,318,446	2,323,227	2,335,831	2,270,420
Outpatient Revenue	10,836,050	10,143,216	10,036,379	10,848,725	9,124,901	10,195,061	8,853,180	9,762,269	12,073,580	11,070,780
Clinic (RHC) Revenue	901,868	740,693	1,146,616	1,195,178	1,227,729	896,334	889,247	793,949	1,096,083	925,729
Total Revenue	14,939,822	13,989,076	14,652,230	14,539,679	12,978,658	15,175,508	13,060,873	12,879,445	15,505,494	14,266,929
Revenue Per Day	481,930	451,261	488,408	469,022	432,622	489,533	421,318	459,980.18	500,177.23	475,564.29
% Change (Month to Month)		-6.36%	8.23%	-3.97%	-7.76%	13.15%	-13.93%	9.18%	8.74%	-4.92%
Salaries	2,244,335	2,263,143	2,142,762	2,227,959	2,161,607	2,596,191	2,096,158	2,104,702	2,316,452	2,260,211
PTO Expenses	221,460	234,078	225,291	249,855	258,672	124,932	370,227	234,842	248,272	259,667
Total Salaries Expense	2,465,795	2,497,221	2,368,053	2,477,814	2,420,279	2,721,123	2,466,385	2,339,544	2,564,724	2,519,878
Expense Per Day	79,542	80,556	78,935	79,929	80,676	87,778	79,561	83,555	82,733	83,996
% Change		1.27%	-2.01%	1.26%	0.93%	8.80%	-9.36%	5.02%	-0.98%	1.53%
Operating Expenses	6,681,333	6,598,376	6,443,189	6,700,067	7,141,845	9,200,728	6,985,656	6,779,565	7,892,831	7,801,114
Operating Expenses Per Day	215,527	212,851	214,773	216,131	238,062	296,798	225,344	242,127.32	254,607	260,037
Capital Expenses	118,728	243,872	146,626	47,518	24,398	47,743	1,042,766	27,227	13,867	196,773
Capital Expenses Per Day	3,830	7,867	4,888	1,533	813	1,540	33,638	972.39	447.33	6,559
Total Expenses	8,056,147	7,962,211	7,811,638	7,971,619	8,554,701	10,596,071	8,359,968	7,899,803	9,134,536	9,586,642
Total Expenses Per Day	259,876	256,846	260,388	257,149	285,157	341,809	269,676	282,136	294,662	319,554.74
Gross Margin	2,200,258	1,770,841	1,569,390	1,411,167	667,943	(182,482)	699,801	225,290	941,939	7,839,446
Debt Compliance										
Current Ratio (ca/cl) > 1.50	1.51	1.49	1.47	1.47	1.53	1.52	1.42	1.36	1.43	1.51
Quick Ratio (Cash + Net AR/cl) > 1.33	1.41	1.38	1.36	1.37	1.41	1.39	1.29	1.23	1.33	1.41
Days Cash on Hand > 75	226	225	220	218	185	143	162	150	166	139

	July 2020	August 2020	September 2020	October 2020	November 2020	December 2020	January 2020	February 2021	March 2021	April 2021	YTD
Total Net Patient Revenue	8,881,591	8,369,217	8,239,709	8,111,234	7,809,788	7,318,246	7,685,457	7,004,855	8,834,770	7,429,719	79,684,586
IGT Revenues										8,210,841	8,210,841
Total Patient Revenue	8,881,591	8,369,217	8,239,709	8,111,234	7,809,788	7,318,246	7,685,457	7,004,855	8,834,770	15,640,560	87,895,427
Cost of Services											
Salaries & Wages	2,244,335	2,263,143	2,142,762	2,227,958	2,161,607	2,596,191	2,096,158	2,104,702	2,316,452	2,260,211	22,413,519
Benefits	1,285,813	1,444,212	1,418,815	1,486,044	1,593,888	1,473,236	1,676,074	1,403,697	1,733,968	2,126,588	15,642,336
Professional Fees	1,729,883	1,641,804	1,519,996	1,734,533	1,989,323	2,046,081	2,153,241	1,928,594	2,092,969	1,982,469	18,818,894
Pharmacy	176,452	304,490	373,754	268,114	263,434	403,646	333,834	343,360	474,852	347,263	3,289,198
Medical Supplies	373,322	237,452	307,119	362,431	784,257	284,134	198,902	445,225	418,016	426,798	3,837,656
Hospice Operations	-	-	-	-	-	-	-				-
Athena EHR System	85,401	86,356	129,219	145,890	103,674	89,294	70,400	68,680	228,428	143,678	1,151,020
Other Direct Costs	592,164	492,312	420,847	475,097	521,573	608,146	457,047	485,307	628,147	514,106	5,194,745
Total Direct Costs	6,487,371	6,469,769	6,312,511	6,700,067	7,417,757	7,500,728	6,985,656	6,779,565	7,892,831	7,801,114	70,347,369
Gross Margin	2,394,220	1,899,448	1,927,198	1,411,167	392,031	(182,482)	699,801	225,290	941,939	7,839,446	17,548,058
Gross Margin %	26.96%	22.70%	23.39%	17.40%	5.02%	-2.49%	9.11%	3.22%	10.66%	50.12%	19.96%
General and Administrative Overhead											
Salaries & Wages	341,944	326,215	323,043	340,706	348,981	335,953	331,284	299,846	356,050	344,356	3,348,379
Benefits	280,576	230,351	242,620	273,351	315,017	235,101	253,272	225,528	(5,740)	395,643	2,445,719
Professional Fees	182,344	187,479	170,202	172,012	230,121	263,864	324,397	150,882	437,286	790,953	2,909,540
Depreciation and Amortization	348,949	350,898	350,981	351,061	351,070	351,786	332,743	333,225	322,062	329,298	3,422,072
Other Administrative Costs	196,201	195,246	152,383	134,422	174,792	208,639	132,616	110,757	132,047	(74,722)	1,362,382
Total General and Administrative Overhea	1,350,014	1,290,188	1,239,230	1,271,552	1,419,981	1,395,343	1,374,312	1,120,238	1,241,705	1,785,528	13,488,092
Net Margin	1,044,206	609,260	687,968	139,614	(1,027,950)	(1,577,825)	(674,511)	(894,948)	(299,766)	6,053,918	4,059,966
Net Margin %	11.76%	7.28%	8.35%	1.72%	-13.16%	-21.56%	-8.78%	-12.78%	-3.39%	38.71%	4.62%
Financing Expense	121,150	119,676	114,676	134,694	146,215	115,920	111,327	113,408	115,513	109,058	1,201,636
Financing Income	56,337	56,337	56,337	56,337	1,076,210	56,337	56,337	56,337	56,337	56,337	1,583,243
Investment Income	49,812	29,010	34,393	52,775	23,405	31,044	29,189	20,452	15,723	21,543	307,346
Miscellaneous Income	91,226	52,266	51,822	35,727	310,748	88,180	28,264	147,902	123,663	58,280	988,079
Net Surplus	1,120,431	627,196	715,844	149,759	236,198	(1,518,184)	(672,048)	(783,665)	(219,555)	6,081,020	5,736,997

	April 2021
Assets	
Current Assets	
Cash and Liquid Capital	7,054,105
Short Term Investments	36,962,214
PMA Partnership	563,924
Accounts Receivable, Net of Allowance	31,901,889
Other Receivables	-
Inventory	3,068,251
Prepaid Expenses	1,344,836
Total Current Assets	80,895,219
Assets Limited as to Use	
Internally Designated for Capital Acquisitions	1,193,799
Short Term - Restricted	668,978
Limited Use Assets	
LAIF - DC Pension Board Restricted	1,132,902
DB Pension	18,895,468
PEPRA - Deferred Outflows	8,320
PEPRA Pension	79,568
Total Limited Use Assets	20,116,258
Revenue Bonds Held by a Trustee	3,073,608
Total Assets Limited as to Use	25,052,642
Long Term Assets	
Long Term Investment	1,508,039
Fixed Assets, Net of Depreciation	75,527,029
Total Long Term Assets	77,035,068
Total Assets	182,982,929
Liabilities	
Current Liabilities	
Current Maturities of Long-Term Debt	1,475,612
Accounts Payable	4,858,215
Accrued Payroll and Related	10,811,324
Accrued Interest and Sales Tax	301,628
Notes Payable	8,927,628
Unearned Revenue	21,142,074
Due to 3rd Party Payors	3,121,005
Due to Specific Purpose Funds	(25,098)
Other Deferred Credits - Pension	3,045,352
Total Current Liabilities	53,657,741
Long Term Liabilities	
Long Term Debt	37,634,947
Bond Premium	429,098
Accreted Interest	14,244,849
Other Non-Current Liability - Pension	39,799,580
Total Long Term Liabilities	92,108,474
Suspense Liabilities	(1,766,067)
Uncategorized Liabilities	463,065
Total Liabilities	144,463,213
Fund Balance	
Fund Balance	31,769,755
Temporarily Restricted	668,940
Net Income	6,081,020
Total Fund Balance	38,519,716
Liabilities + Fund Balance	182,982,929

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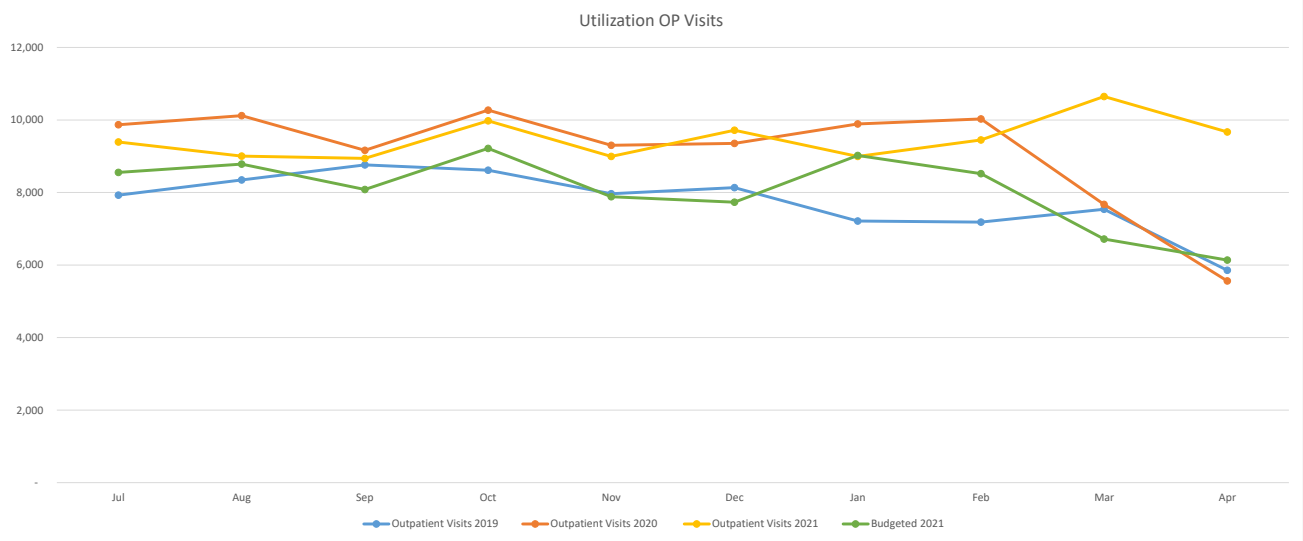
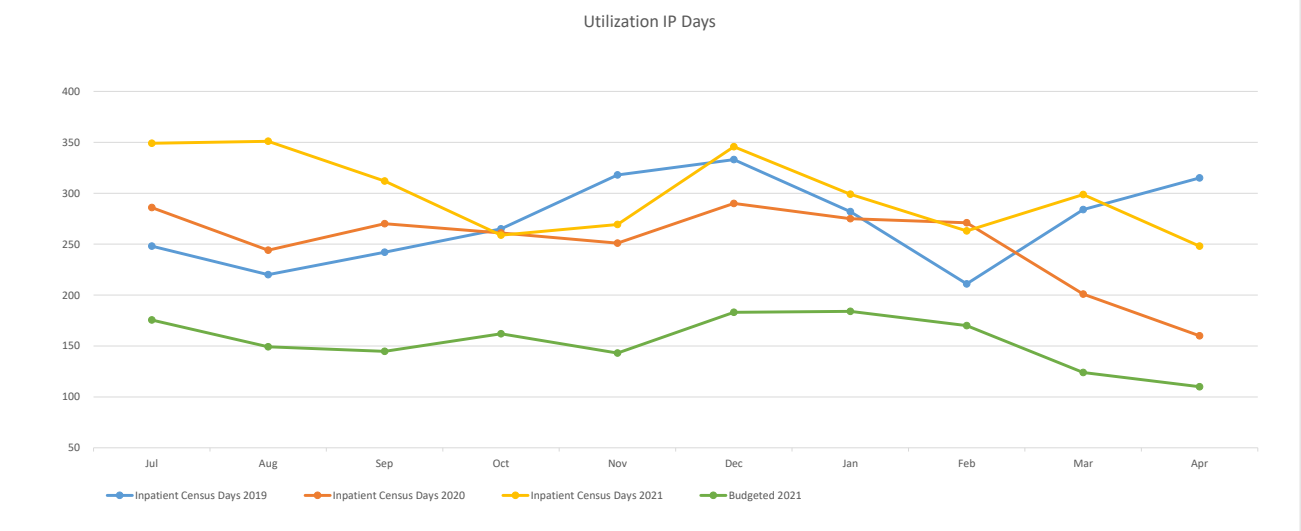
	Budget 4/30/2021	Actual 4/30/2021	Budget Expense as a % of Revenue 4/30/2021	Actual Expense as a % of Revenue 4/30/2021
Total Net Patient Revenue	3,779,019	15,640,560		
Cost of Services				
Salaries & Wages	1,273,673	2,260,211	33.70%	14.45%
Benefits	804,070	2,126,588	21.28%	13.60%
Professional Fees	883,535	1,982,469	23.38%	12.68%
Pharmacy	107,158	347,263	2.84%	2.22%
Medical Supplies	196,199	426,798	5.19%	2.73%
Hospice Operations	24,537	-	0.65%	0.00%
Athena EHR System	67,267	143,678	1.78%	0.92%
Other Direct Costs	107,702	514,106	2.85%	3.29%
Total Direct Costs	3,464,140	7,801,114	91.67%	49.88%
Gross Margin	314,880	7,839,446		
Gross Margin %	8.33%	50.12%		
General and Administrative Overhead				
Salaries & Wages	263,883	344,356	6.98%	2.20%
Benefits	204,008	395,643	5.40%	2.53%
Professional Fees	138,996	790,953	3.68%	5.06%
Depreciation and Amortization	217,805	329,298	5.76%	2.11%
Other Administrative Costs	37,355	(74,722)	0.99%	-0.48%
Total General and Administrative Overhead	862,048	1,785,528	22.81%	11.42%
Net Margin	(547,168)	6,053,918		
Net Margin %	-14.48%	38.71%		
Financing Expense	128,572	109,058	3.40%	0.70%
Financing Income	110,328	56,337	2.92%	0.36%
Investment Income	23,890	21,543	0.63%	0.14%
Miscellaneous Income	15,203	58,280	0.40%	0.37%
Net Surplus	(526,319)	6,081,020		


Utilization OP Visits
12,000
10,000
8,000
6,000
4,000
2,000
-
Jul
Aug
Sep
Oct
Nov
Dec
Jan
Feb
Mar
Apr
Outpatient Visits 2019
Outpatient Visits 2020
Outpatient Visits 2021
Budgeted 2021


Utilization IP Days
400
350
300
250
200
150
100
50
Jul
Aug
Sep
Oct
Nov
Dec
Jan
Feb
Mar
Apr
Inpatient Census Days 2019
Inpatient Census Days 2020
Inpatient Census Days 2021
Budgeted 2021

Management Discussion and Analysis

Revenue continues to be robust given strong inpatient days and outpatient visits.

- Inpatient days in April were 185 compared to budgeted of 110.
- Outpatient visits in April were 9,847 compared to 6,137 budgeted for the month.
- Salaries are in line with budget 34% to actual of 30%.
- Gross margins are considerably higher due to IGT being recorded.
- AR continues with clean up efforts and contractuals and bad debt reserves are starting to stabalize.
- Cash balances have stabilized due to good collections at $ 72 Million year to date.
- AR days trending lower with increased collection efforts and new Rev Cycle Director in place.
- Recorded 8.2M for IGT FY2020 revenues