Northern Inyo Hospital

January 18 2017 Regular Meeting

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AGENDA

NORTHERN INYO HEALTHCARE DISTRICT
BOARD OF DIRECTORS REGULAR MEETING
January 18, 2017 at 5:30 p.m.
In the Northern Inyo Hospital Board Room at 2957 Birch Street, Bishop, CA

1. Call to Order (at 5:30 pm).
2. At this time persons in the audience may speak on any items not on the agenda on any matter within the jurisdiction of the District Board. (*Members of the audience will have an opportunity to address the Board on every item on the agenda. Speakers are limited to a maximum of three minutes each.)*

Consent Agenda (action items)

3. Approval of minutes of the December 14, 2016 regular meeting
4. Financial and Statistical reports for November 2016
5. 2013 CMS Validation Survey Monitoring, January 2017

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6. Workforce Experience Committee Report (*information item*).
7. Patient Experience Committee Report (*information item*).
8. Chief of Staff Report; Joy Engblade, MD
   A. Policies/Procedures/Protocols/Order Set approvals (*action items*):
      - *Management of Discharge Disputes from Medicare Patients*
      - *Utilization Review Plan* (annual approval)
      - *Pitocin Administration* (superseding: *Pitocin Induction or Augmentation of Labor*)
      - *Certified Nurse Midwife Standardized Procedures*
      - *Procedural Sedation*
      - *Patient Restraints (Behavioral and Non-Behavioral)* – Addition of Safety Vests
      - *Swing Bed Patient Restraints* – Addition of Safety Vests

   B. Medical Staff Appointments/Privileging (*action items*):
      - Jennifer McKinley, PA-C (*RHC Family Practice*)

   C. Focused Professional Practice Evaluation (FPPE) – Recommendation Form (*action item*):

- Amy Saft, CRNA (Nurse Anesthesia) – Recommendation for completion of FPPE based on six proctored cases and discussion with peers

9. Hospital Wide Policy and Procedure annual approvals (*action items*); Attachment A to agenda.
10. Old Business
    - *None*
11. New Business
    A. Collaboration with Ridgecrest Hospital on review of Electronic Health Record/s (*action item*).
    B. Occupational Health Clinic (*action item*).
    C. BUHS School Clinic (*action item*).
    D. Options for expansion of physician recruiting (*action item*).
    E. Healthcare Cost Solutions audit results and agreement (*action item*).
    F. Nursing Department Policy and Procedure approvals (*action items*):
        1. *Community Skills Session; Reservation, No Show or Cancellation Policy*
        2. *Cross-Training RN Staff*
        3. *Orientation-Cross Training Time Frame*
        4. *Nursing Assessment and Reassessment*
            a. *Nursing Assessment Reassessment Chart Time Frames*
        5. *Nursing Care Plan*
    G. Reach Air Medical/Services Agreement (*action item*).
12. Reports from Board members (*information items*).
13. Adjournment to closed session to/for:
    A. Hear reports on the hospital quality assurance activities from the responsible department head and the Medical Staff Executive Committee (*Section 32155 of the Health and Safety Code, and Section 54962 of the Government Code*).
    B. Confer with Legal Counsel regarding pending and threatened litigation, existing litigation and significant exposure to litigation (*pursuant to Government Code Section 54956.9*).
    C. Confer with Legal Counsel regarding pending and threatened litigation, existing litigation and significant exposure to litigation, 2nd case (*pursuant to Government Code Section 54956.9*).
    D. Confer with Legal Counsel regarding pending and threatened litigation, existing litigation and significant exposure to litigation, 3rd case (*pursuant to Government Code Section 54956.9*).
    E. Discuss trade secrets, new programs and services (estimated public session date for

discussion yet to be determined) (*Health and Safety Code Section 32106*).

G. Discussion of a personnel matter (*pursuant to Government Code Section 54957*).

14. Return to open session and report of any action taken in closed session.
15. 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.

ATTACHMENT A

POLICY AND PROCEDURE APPROVALS LIST

JANUARY 2017

POLICIES TO THE BOD
DIAGNOSTIC SERVICES

POLICIES TO THE BOARD				
DIAGNOSTIC SERVICES				
	TITLE	TO BOD	APPROVED	COMMENTS
1	MRI SAFETY MANUAL	1/18/2017		
	a) Magnetic Resonance Imaging (MRI) Gadolinium Injection P&P	1/18/2017		
	b) DI - MRI Safety - Magnet Room Safety	1/18/2017		
	c) DI - MRI Safety - Ear Protection	1/18/2017		
	d) Anxiolysis in the MRI Unit	1/18/2017		
2	RADIATION SAFETY MANUAL	1/18/2017		
	a) ALARA Program	1/18/2017		
	b) Dosimetry Program - Occupational Radiation Exposure Monitoring Program	1/18/2017		
	c) Responsibilities and Duties of Radiation Safety Officer	1/18/2017		
	d) Radiation Safety Committee	1/18/2017		
	e) Responsibilities and Duties of Radiation Safety Committee (RSC)	1/18/2017		
	f) Emergency Response Procedures	1/18/2017		
	g) Emergency Call List	1/18/2017		
	h) Radiology Equipment Registration	1/18/2017		
	i) Radioactive Materials Training for Ancillary Staff	1/18/2017		
	j) Department Specific New/Annual Employee Orientation	1/18/2017		
	k) Radiology Personnel Orientation/Annual Review	1/18/2017		
	l) Radiology Personnel Certification	1/18/2017		
	m) Patient Radiation Exposure	1/18/2017		
	n) Protective Clothing Storage	1/18/2017		
	o) Pregnant Personnel	1/18/2017		
	p) Fluoroscopic Unit Monitoring	1/18/2017		
	q) Safe Use of C-Arms	1/18/2017		
	r) Mobile Radiography	1/18/2017		

POLICIES TO THE BOD
DIETARY

POLICIES TO THE BOARD				
DIETARY DEPT.				
	TITLE	TO BOD	APPROVED	COMMENTS
1	Cleaning and Washing of Dishes and other untensils	1/18/2017		
2	Cooling Potential Hazardous Foods	1/18/2017		
3	Dietary Dept. Refrigerator and Freezer Temperature Alarms	1/18/2017		
4	Dietary Dress, Health and Safety Policies	1/18/2017		
5	Dietary Refrigerator/Freezer Temperature Monitoring & Documentation	1/18/2017		
6	Meal Assembly, Delivery, and Dishwashing Methods for Patients	1/18/2017		
7	Meals to Patients and Visitors Policy	1/18/2017		
8	Ordering Dietary Supplements	1/18/2017		
9	Refrigerator Monitoring and Documentation	1/18/2017		
10	Storage of Frozen Foods	1/18/2017		
11	Temperatur Monitoring of Storage Devices and Units	1/18/2017		
12	Test Tray Temperature Taking	1/18/2017		

HUMAN RESOURCES
POLICY AND PROCEDURES APPROVAL LIST
JANUARY 2017

1. *YOUR JOB*
2. *ORIENTATION*
3. *PERSONNEL CLASSIFICATIONS*
4. *INTRODUCTORY PERIOD*
5. *LOCKERS*
6. *EMPLOYMENT OF MINORS*
7. *TIME OFF*
8. *OVERTIME*
9. *STANDBY*
10. *PAYROLL DEDUCTIONS*

POLICIES TO THE BOD
MEDICAL RECORDS

POLICIES TO THE BOARD				
MEDICAL RECORDS				
	TITLE	TO BOD	APPROVED	COMMENTS
1	Entries in the Medical Record	1/18/2017		
2	Forms Development and Control Policy	1/18/2017		
3	Information Security and Data Integrity	1/18/2017		
4	Legal Health Record	1/18/2017		
5	Responsibility and Process for Releasing PHI	1/18/2017		
6	Sending Protected Health Information byFax	1/18/2017		

POLICIES TO THE BOD
PHARMACY

POLICIES TO THE BOARD				
PHARMACY DEPT.				
	TITLE	TO BOD	APPROVED	COMMENTS
1	Administration of Drugs & Biologicals	1/18/2017		
2	340B Contract Pharmacy Policy & Procedure	1/18/2017		
3	Access to Medications in the Absence of the Pharmacist	1/18/2017		
4	Administration of Drugs: Patient's Own Drugs	1/18/2017		
5	340B Hospital Administered Drugs Covered Entity Policy	1/18/2017		

POLICIES TO THE BOARD				
REHABILITATION				
	TITLE	TO BOD	APPROVED	COMMENTS
1	Goals and Objectives	1/18/2017		
2	Rehabilitation Services Department Definitions	1/18/2017		
3	Standard of Care - Outpatient	1/18/2017		
4	Progress Notes and General Charting Policy	1/18/2017		

POLICIES TO THE BOD
RESPIRATORY

POLICIES TO THE BOARD				
RESPIRATORY				
	TITLE	TO BOD	APPROVED	COMMENTS
1	Adult Oxygen Protocol	1/18/2017		
2	Drawing of Arterial Blood Gases	1/18/2017		
3	Infant Oxygen Protocol	1/18/2017		
4	Liberation from Mechanical Ventilation-Weaning Protocol	1/18/2017		
5	BiPAP/Non-invasive Ventilation	1/18/2017		
6	Initial Adult or Pediatric Ventilator Settings	1/18/2017		
7	Aerobika OPEP Therapy (Bronchopulmonary Hygiene)	1/18/2017		
8	Patient - Ventilatory System Checks	1/18/2017		
9	EzPAP	1/18/2017		
10	Vapotherm	1/18/2017		

Ref #	Title	Status
1272	Adult Immunization in the Healthcare Worker	Approved
1101	Aerosolized Transmissible Disease Plan	Approved
1196	Employee Tuberculosis Surveillance Program	Approved
1253	Health Care Workers with Influenza like Illness	Approved
2016	Influenza Vaccination Policy	Approved
155	Initial Evaluation of Exposure Incident	Approved
2289	Injury and Illness Prevention Program	Approved
2170	Post-Offer Physical Examinations for New Hires	Approved
3839	Post-Offer Physical Requirements	Approved
2212	Prevention and Treatment of Pertussis in Hospital Employees	Approved
1151	Recommendation for Prophylaxis After Occupational Exposure to HIV	Approved
3830	Scope of Service - Employee Health	Approved
3838	Work Related Accidents/Exposures	Approved
630	Breastfeeding the Term Infant*	Approved
3823	Standards of Care- The NEST	Approved
3667	Standards of Practice- The NEST	Approved
3901	3M Attest 3 Hour Steam-Plus Challenge Pack	Approved
829	Airway Management	Approved
197	Alteplase Administration For Declotting Central Venous Catheters	Approved
908	Anesthesia Apparatus Checkout	Approved
931	Anesthesia Clinical Standards and Professional Conduct	Approved
626	Anesthesia in Ancillary Departments	Approved
920	Anesthesia Philosophy	Approved
921	Anesthesia Privileges for Staff Physicians	Approved
924	Anesthesia Record	Approved
1684	Anxiolysis in the MRI Unit	Approved
884	Argon Laser Therapy (Ophthalmic)	Approved
830	Arterial Monitoring in PACU	Approved
967	Basic Principles of Sterilization	Approved
871	BCG (Intravesical Therapy with Bacillus Calmette-Guerin) for Bladder Cancer	Approved
935	Biological Monitoring System for Steam Sterilizers	Approved
977	Bone Graft Tissue Bank	Approved
3902	Bubble Study	Approved
909	Cardiac Arrest in the OR	Approved
211	Central Line Care and Maintenance	Approved
831	Central Venous Pressure Monitoring in PACU	Approved
832	Changing Patient Status	Approved
833	Charge Sheet and Charge Description in the PACU	Approved
872	Charge Sheet and Charge Descriptions in the OPD	Approved
991	Chemotherapeutic Agents in the OR	Approved
300	Chemotherapy Administration And Precautions	Approved
177	Chemotherapy Extravasation Management	Approved
215	Chemotherapy Spill Protocol	Approved
3733	Cleaning & Sterilization of NeuroTherm Probes	Approved
940	Cleaning / Sterilization or High Level Disinfection of Equipment	Approved
937	Cleaning and Care of Surgical Instruments	Approved
987	Collection of Anaerobic and Anaerobic Cultures	Approved
997	Completion Dilatation and Curettage Using Berkley Suction Under Sedation	Approved

252	Cosyntropin Stimulation Test	Approved
4021	daVinci Robot Si Cleaning and Maintenance	Approved
995	Death in the Operating Room	Approved
304	Dialysis Access Catheter: Blood Draw/Infusion/Dressing Change	Approved
998	Disaster Plan Perioperative Unit	Approved
1456	Down Time Procedures for OP/PACU	Approved
1001	Draping for Surgical Procedures	Approved
874	Dress Code for the Outpatient Department	Approved
839	Dress Code in the Post Anesthesia Care Unit	Approved
982	Electrosurgical Cautery	Approved
1004	Emergency Supplies in Surgery	Approved
913	Environmental and Infection Control OR/PACU	Approved
2118	Environmental and Infection Control PACU	Approved
846	Environmental Infection Control in the PACU	Approved
1009	Eye Wash Stations in the Perioperative and Sterile Processing Units	Approved
844	Fire / Safety PACU	Approved
1010	Fire Safety in Surgery	Approved
2120	Fire Safety in the OP Infusion Unit	Approved
880	Floating Guidelines for OPD/PACU	Approved
1011	Formalin Use and Spill Management	Approved
175	Groshong Catheter, Dressing Change, Flush, Cap Change, Blood Draw	Approved
1055	Handling of Infants/Fetus/Stillborns and Genetic Workup	Approved
962	Heat Sealer	Approved
947	Immediate Use Sterilization Procedure (IUS)	Approved
1156	Implantation of Medical Devices	Approved
948	Infection Control Sterile Processing Policy	Approved
2351	Instrument Cleaning Process	Approved
1041	Intraoperative Nursing Care for the Pediatric Patient	Approved
503	Iron Dextran (Imferon) Administration	Approved
255	IVIG (Intravenous Immune Globulin)	Approved
847	Laryngeal Mask Airway Removal	Approved
339	Latex Precautions	Approved
268	Lidocaine Anesthetic For Local Infiltration Prior To Peripheral Catheter Placement	Approved
1441	Lithotripsy	Approved
1459	Loaner instruments Care	Approved
915	Malignant Hyperthermia	Approved
2277	Malignant Hyperthermia Cart Check	Approved
1024	Manufacturer's Information on Hardware/Equipment	Approved
951	Manufacturer's Recall Sterile Processing	Approved
1002	Medical Device Tracking	Approved
1219	Medical Students in the OR	Approved
3705	Medication/Solution Transfer to the Sterile Field	Approved
988	Microbiological Specimen Handling	Approved
853	Mitomycin Bladder Instillation	Approved
347	Monitoring The Patient In The MRI Unit	Approved
423	Myocardial Perfusion Stress Test: Nuclear	Approved
217	Neupogen / Procrit Administration	Approved
401	NPO Guidelines	Approved
845	Nursing Care Guidelines in PACU	Approved

914	Nursing Management of the Patient Receiving Local Anesthesia for Procedures	Approved
889	Observation Following a Myelogram	Approved
919	Observation in the Operating Room	Approved
647	Observation of the Lung or Liver Biopsy Outpatient	Approved
837	OPD/PACU Discharge Instructions	Approved
975	Operating Room Attire	Approved
1030	Operating Room Orientation For the Perioperative Nurse	Approved
1059	Operating Room Sanitation	Approved
985	Operative Consents	Approved
1008	OR Electrical Safety	Approved
3810	Organ/Tissue/Eye Donation*	Approved
918	Organization of Surgical/Anesthesia Services	Approved
842	Orientation and Cross Training to OPD/PACU	Approved
954	Orientation to Sterile Processing	Approved
1029	Orientation To The Perioperative Unit For New Nursing Personnel	Approved
885	Outpatient Department Medication and Solution Policy	Approved
879	Outpatient Facilities	Approved
882	Outpatient Intermittent Infusion Administration	Approved
512	PACU Discharge Criteria	Approved
841	PACU Equipment	Approved
868	PACU Visitation	Approved
386	Pain Assessment/Management	Approved
2119	Paragon, Use of in Pre-op and PACU	Approved
1033	Pathology Specimens In The Operating Room	Approved
455	Patient Warmer (Warm Air Hyperthermia System)	Approved
855	Pediatric Standards of Care in the OPD/PACU	Approved
527	Pentax Emergency Bedside Intubating Laryngoscope	Approved
1726	Performance Improvement - Outpatient Unit	Approved
858	Performance Improvement Post Anesthesia Care Unit	Approved
923	Performance Improvement Program Anesthesia Service	Approved
1042	Performance Improvement Program Perioperative Unit	Approved
126	Performance Improvement Program Sterile Processing	Approved
1046	Performance Improvement Program Surgical Service Physicians	Approved
930	Perioperative Scope of Practice	Approved
100	Perioperative Unit Performance Improvement Program	Approved
1036	Philosophy of Perioperative Nursing Practice	Approved
178	PICC Peripherally Inserted Central Catheters	Approved
1061	Pneumatic Tourniquet	Approved
856	Point of Care Testing (Blood Glucose, Urine Dipsticks) OPD/PACU	Approved
294	Portacath Vascular Access System	Approved
922	Positioning of the Surgical Patient	Approved
910	Post Anesthesia Recovery	Approved
843	Post Operative Follow-up Phone Calls	Approved
866	Postoperative Teaching	Approved
857	Postpartum Patient Care in the PACU	Approved
932	Pre and Post Operative Anesthesia Visits	Approved
627	Pre-Anesthesia Protocol for All Obstetrical Patients	Approved
3804	Precleaning of Soiled Instruments	Approved
1039	Pregnant Personnel in the Peri-Operative Unit	Approved

1074	Preoperative EPT Testing Protocol	Approved
1374	Preoperative Instruction Sheet	Approved
881	Preoperative Interview	Approved
888	Preoperative Medication Guidelines	Approved
887	Preoperative Medications	Approved
2314	Preoperative Preparation and Teaching	Approved
890	Preoperative Skin Preparation	Approved
974	Principles of Asepsis in the Operating Room	Approved
2008	Procedural Sedation	Approved
1363	Quick Rinse	Approved
2124	Rabies Vaccination	Approved
1043	Radiation Protection in the OR	Approved
1023	Rapid Fluid/Blood Infuser	Approved
1044	Records and Reports Surgery	Approved
917	Refrigerated Neuromuscular Blocking Agents in OR Carts	Approved
961	Reprocessing Single Use Items	Approved
926	Responsibility of Service Perioperative	Approved
912	Restocking and Maintenance of Anesthesia Equipment	Approved
3843	Returning of Instrument to Central Sterile Processing	Approved
1049	RN First Assistant, RNFA	Approved
927	Safety in the Operating Room	Approved
416	Scheduling Emergency Surgical Cases	Approved
929	Scheduling Surgical Procedures	Approved
2012	Scope of Anesthesia Practice	Approved
1050	Scope of Perioperative Nursing Practice	Approved
892	Secretin Test	Approved
957	Selection and Use of Packaging Systems	Approved
1302	Sestamibi Stress Test (Nuclear Myocardial Perfusion Stress Test)	Approved
1060	Shoulder Arthroscopy Traction Device	Approved
1052	Skin Preparation in the Perioperative Unit	Approved
971	Special Procedure Trays	Approved
986	Sponge, Sharps, and Instrument Counts	Approved
928	Staffing Patterns Anesthesia	Approved
1053	Staffing Plan in the Operating Room*	Approved
863	Staffing Plan OP/PACU*	Approved
865	Standards of Care OPD	Approved
864	Standards of Care PACU	Approved
1054	Standards of Care Perioperative Unit	Approved
944	Sterile Processing Disaster Plan	Approved
956	Sterile Processing Philosophy	Approved
953	Sterile Processing Objectives and Functions	Approved
963	Sterile Processing Staffing of Unit	Approved
964	Sterile Processing Standards of Practice	Approved
958	Sterilization Recall Policy	Approved
965	Sterilization of CMI Vacuum Pump	Approved
955	Sterilizing of Orthopedic Implants	Approved
1702	Steris Century Medium Steam Sterilizer	Approved
1701	Steris Prevacuum Sterilizer Surgery	Approved
1706	Steris System 1E Processor	Approved

1699	Steris Vision Single Chamber Washer Disinfector	Approved
1704	Steris V-Pro 1 Low Temperature Sterilizer System	Approved
966	Storage Requirements for Sterile and Clean Items	Approved
969	Supplies After Hours Sterile Processing	Approved
979	Surgeries Requiring an Assistant	Approved
1005	Surgery Emergency Generator Power	Approved
1007	Surgery Equipment and Routine Supplies	Approved
916	Surgery Medication and Solution Policy	Approved
978	Surgery Tissue / Bone Graft "Look Back" Policy	Approved
1037	Surgical Anesthesia Privileges and Limitations	Approved
990	Surgical Charges	Approved
14	Surgical Drains Care of	Approved
1051	Surgical Hand Hygiene and Hand Scrub	Approved
1038	Surgical Procedures	Approved
253	Taxol (Paclitaxel) Administration OPD	Approved
257	Therapeutic Phlebotomy	Approved
487	Transfer of Evidence	Approved
867	Ulnar Nerve Check	Approved
3883	Universal Protocol	Approved
895	VCUG: Assisting with a Voiding Cystourethrogram	Approved
456	Warming Cabinet for Blankets/Solutions	Approved
311	Wound Care Product Suggestions For Specific Types Of Wounds	Approved
457	Wound Vac - Vacuum Assisted Closure System ATS	Approved
972	Wrapping and Dating of Supplies and Instruments	Approved
3920	American Heart Association Training Center Faculty and Course Instructor Roles and Training	Approved
1098	American Heart Association Training Center Policies and Procedures	Approved
3919	American Heart Association Training Center QAPI	Approved
900	Course Evaluation	Approved
905	Ensuring Compliance with Continuing Education Guidelines at NIH	Approved
904	Instructor/Course Concern Form	Approved
897	Nursing Education Department Plan	Approved
2011	Nursing Instructor Policy	Approved
903	Staff Development Dispute Resolution Policy	Approved

NORTHERN INYO HEALTHCARE DISTRICT

Restricted and Specific Purpose Fund Balances
for period ending November 30, 2016

	Current Month	Prior Month	Change
Board Designated Funds:			
Tobacco Fund Savings Account	$ 1,097,944	$ 1,097,899	45
Equipment Fund Savings Account	$ 26,723	$ 26,723	-
Total Board Designated Funds:	**$ 1,124,667**	**$ 1,124,622**	**$ 45**
Specific Purpose Funds:			
* Bond and Interest Savings Account	$ 110,702	$ 89,118	$ 21,584
Nursing Scholarship Savings Account	$ 29,767	$ 29,767	$ -
Medical Education Savings Account	$ 76	$ 76	$ -
Joint NIHD/Physician Group Savings Account	$ 100,000	$ -	$ 100,000
Total Specific Purpose Funds:	**$ 240,546**	**$ 118,962**	**$ 121,584**
Grand Total Restricted and Specific Purposes Funds:	**$ 1,365,213**	**$ 1,243,584**	**$ 121,630**

NORTHERN INYO HEALTHCARE DISTRICT

OPERATING STATISTICS

for period ending November 30, 2016

		FYE 2017	FYE 2016		Variance %
	Month to Date	Year-to-Date	Year-to-Date	Variance from PY	
Licensed Beds	25	25	25		
Total Patient Days with NB	274	1,550	1,701	(151)	-9%
Total Patient Days without NB	246	1,396	1,552	(156)	-10%
Swing Bed Days	42	242	275	(33)	-12%
Discharges without NB	86	461	480	(19)	-4%
Swing Discharges	6	34	45	(11)	-24%
Days in Month	30	153	153		
Occupancy without NB	8.20	9.12	10.14	(1.0)	-10%
Average Stay (days) without NB	2.86	3.03	3.23	(0.2)	-6%
Average LOS without NB/Swing	2.55	2.70	2.94	(0.2)	-8%
Hours of Observation (OSHPD)	650	3,412	2,502	910	36%
Observation Adj Days	27	142	104	38	36%
ER Visits All Visits	709	4,049	3,583	466	13%
RHC Visits (OSHPD)	2,198	10,216	10,042	174	2%
Outpatient Visits (OSHPD)	3,901	16,000	15,793	207	1%
IP Surgeries (OSHPD)	20	121	136	(15)	-11%
OP Surgery (OSHPD)	101	474	516	(42)	-8%
Worked FTE's	298.00	318.00	319.00	(1)	0%
Paid FTE's	373.00	362.00	363.00	(1)	0%
Hours Worked to Hours Paid%	79.9%	87.8%	87.9%	0.0%	0%
Payor %					
Medicare		40%	40%	0%	
Medi-Cal		23%	24%	-1%	
Insurance, HMO & PPO		34%	35%	-1%	
Indigent (Charity Care)		1.2%	0.3%	0.9%	
All Other		2%	2%	1%	
Total		100%	100%		

NORTHERN INYO HEALTHCARE DISTRICT

BUDGET VARIANCE ANALYSIS

Nov-16 *Fiscal Year Ending June 30, 2017*

Year to date for the month ending November 30, 2016

-151	or	-9%	less IP days than in the prior fiscal year
$ (1,971,081)	or	-10.41%	under budget in Total IP Revenue and
$ (773,795)	or	-2.1%	under budget in OP Revenue resulting in
$ (2,744,875)	or	-4.9%	under budget in gross patient revenue &
$ (423,073)	or	-1.3%	under budget in net patient revenue

Year-to-date Net Revenue was		$	32,570,373
Total Operating Expenses were:		$	30,276,607
			for the fiscal year to date
$ (294,544)	or	-1.0%	under budget. Salaries and Wages were
$ (1,457,303)	or	-13.5%	under budget and Employee Benefits
$ 79,305	or	1.1%	over budget.
		65%	Employee Benefits Percentage of Wages

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

$ 906,545	or	25.5%	Professional Fees due to Contract Employees and reflected in salaries and wages being under budget
$ 77,078	or	3.6%	Depreciation Expense continues to run high based on capital purchases
$ 17,180	or	1.1%	Other Expenses are running high due to travel/education that has happened in the first two months of fiscal year; should even out over year

Other Information:

$ 2,468,536		Operating Income, less
$ (1,464,502)		loss in non-operating activities created a net income of;
$ 1,004,034	$ 452,322	over budget.
	38.75%	Contractual Percentages for Year and
	41.00%	Budgeted Contractual Percentages including

$ 1,890,205 in prior year cost report settlement activity for Medicare & Medi-Cal including Intergovernment Transfer Funds (IGT) from Managed Care Medi-Cal & Contractuals are also reduced for the PRIME IGT of $1,490,000

Non-Operating actives included:

$ (1,707,843) loss	$ (30,110)	under budget in Medical Office Activities
$ (51,378)	$ (112,157)	under budget in 340B Pharmacy Activity

Northern Inyo Healthcare District

Financial Indicators as of November 30, 2016

	Target	Nov-16	Oct-16	Sep-16	Aug-16	Jul-16	Jun-16	May-16	Apr-16	Mar-16
Current Ratio	>1.5-2.0	2.85	2.95	2.60	2.15	2.05	1.98	2.92	2.96	3.03
Quick Ratio	>1.33-1.5	2.46	2.41	2.20	1.83	1.74	1.71	2.57	2.56	2.58
Days Cash on Hand prior method	>75	160.86	145.43	157.98	168.91	162.64	161.90	177.01	167.60	163.33
Days Cash on Hand Short Term Sources	>75	85.97	67.02	77.60	86.56	91.08	96.57	96.43	91.56	84.50
Debt Service Coverage	>1.5-2.0	2.46	2.30	2.80	3.18	2.03	1.95	2.48	2.30	2.38
Operating Margin		7.48	6.43	8.37						
Outpatient Revenue % of Total Revenue		68.11	67.48	67.03						
Cash flow (CF) margin (EBIDA to revenue)		5.43	4.53	7.01						
Days in Patient Accounts Receivable	<60 Days	75.60	75.00	77.80	78.50	73.10	63.20	68.60	65.90	68.80

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

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

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

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

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

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

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

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

Accounts Receivable Days are pulled from the AR Aging report

NORTHERN INYO HEALTHCARE DISTRICT

Investments as of November 30, 2016

ID	Purchase Date	Maturity Dat	Institution	Broker	Rate		Principal Invested
2	30-Nov-16	01-Dec-16	Local Agency Investment Fund	Northern Inyo Hospital	0.68%	$	13,435,432.98
3	13-Jun-14	13-Jun-18	Synchrony Bank Retail-FNC	Financial Northeaster Corp.	1.60%	$	250,000.00
				SHORT TERM INVESTMENTS		$	13,685,432.98
4	28-Nov-14	28-Nov-18	American Express Centurion Bank	Financial Northeaster Corp.	2.00%	$	150,000.00
5	02-Jul-14	02-Jul-19	Barclays Bank	Financial Northeaster Corp.	2.05%	$	250,000.00
6	02-Jul-14	02-Jul-19	Goldman SachsBank USA NY CD	Financial Northeaster Corp.	2.05%	$	250,000.00
7	20-May-15	20-May-20	American Express Centurion Bank	Financial Northeaster Corp.	2.05%	$	100,000.00
8	26-Sep-16	27-Sep-21	Comenity Capital Bank	Multi-Bank Service	1.70%	$	250,000.00
9	02-Sep-16	28-Sep-21	Capital One Bank	Gemini Financial Services, LL	1.70%	$	250,000.00
10	28-Sep-16	28-Sep-21	Capital One National Assn	Multi-Bank Service	1.70%	$	250,000.00
11	28-Sep-16	28-Sep-21	Wells Fargo Bank NA	Multi-Bank Service	1.70%	$	250,000.00
				LONG TERM INVESTMENTS		$	1,750,000.00
				TOTAL INVESTMENTS		$	15,435,432.98
1	31-Oct-16	01-Nov-16	LAIF Defined Cont Plan	Northern Inyo Hospital	0.65%	$	868,771.46
				DEFINED CONTRIBUTION ACCRUA		$	868,771.46
							16,304,204.44

NORTHERN INYO HEALTHCARE DISTRICT
STATEMENT OF OPERATIONS
for period ending November 30, 2016

	ACT MTD	BUD MTD	VARIANCE	ACT YTD	BUD YTD	VARIANCE
Unrestricted Revenues, Gains & Other Support						
Inpatient Service Revenue						
Routine	720,342	862,603	(142,261)	3,733,736	4,399,253	(665,517)
Ancillary	2,410,190	2,849,476	(439,286)	13,226,747	14,532,311	(1,305,564)
Total Inpatient Service Revenue	3,130,532	3,712,079	(581,547)	16,960,483	18,931,564	(1,971,081)
Outpatient Service Revenue	7,510,915	7,252,844	258,071	36,215,741	36,989,536	(773,795)
Gross Patient Service Revenue	**10,641,447**	**10,964,923**	**(323,476)**	**53,176,225**	**55,921,100**	**(2,744,875)**
Less Deductions from Revenue						
Patient Service Revenue Deductions	405,057	169,290	235,767	796,562	863,379	(66,817)
Contractual Adjustments	3,928,869	4,326,329	(397,460)	21,699,495	22,064,275	(364,780)
Prior Period Adjustments	(66,055)	-	(66,055)	(1,890,205)	-	(1,890,205)
Total Deductions from Patient Service Revenue	**4,267,870**	**4,495,619**	**(227,749)**	**20,605,851**	**22,927,654**	**(2,321,803)**
Net Patient Service Revenue	**6,373,577**	**6,469,304**	**(95,727)**	**32,570,373**	**32,993,446**	**(423,073)**
Other revenue	33,961	52,083	(18,122)	174,770	265,626	(90,856)
Total Other Revenue	**33,961**	**52,083**	**(18,122)**	**174,770**	**265,626**	**(90,856)**
Expenses:						
Salaries and Wages	1,779,155	2,118,240	(339,085)	9,345,727	10,803,030	(1,457,303)
Employee Benefits	1,278,543	1,377,986	(99,443)	7,106,980	7,027,675	79,305
Professional Fees	788,908	695,784	93,124	4,455,050	3,548,505	906,545
Supplies	829,249	550,295	278,954	3,129,474	2,806,504	322,970
Purchased Services	203,173	331,158	(127,986)	1,354,825	1,688,895	(334,070)
Depreciation	446,157	414,340	31,817	2,190,214	2,113,136	77,078
Bad Debts	90,665	192,100	(101,435)	1,073,461	979,709	93,752
Other Expense	231,192	314,449	(83,257)	1,620,877	1,603,697	17,180
Total Expenses	**5,647,041**	**5,994,352**	**(347,311)**	**30,276,607**	**30,571,151**	**(294,544)**
Operating Income (Loss)	**760,497**	**527,035**	**233,462**	**2,468,536**	**2,687,921**	**(219,385)**
Other Income:						
District Tax Receipts	48,644	47,978	666	243,220	244,687	(1,467)
Tax Revenue for Debt	150,920	70,719	80,201	754,600	360,666	393,934
Partnership Investment Income		-	-		-	-
Grants and Other Contributions Unrestricted	-	8,219	(8,219)	531,531	41,917	489,614
Interest Income	14,066	17,965	(3,899)	83,817	91,619	(7,802)
Interest Expense	(263,771)	(237,024)	(26,747)	(1,326,857)	(1,208,823)	(118,034)
Other Non-Operating Income	2,038	2,137	(99)	8,408	10,898	(2,490)
Net Medical Office Activity	(277,149)	(340,775)	63,626	(1,707,843)	(1,737,952)	30,110
340B Net Activity	(9,219)	11,917	(21,136)	(51,378)	60,779	(112,157)
Non-Operating Income/Loss	**(334,471)**	**(418,864)**	**84,393**	**(1,464,502)**	**(2,136,209)**	**671,707**
Net Income/Loss	**426,026**	**108,171**	**317,855**	**1,004,034**	**551,712**	**452,322**

Northern Inyo Healthcare District
Balance Sheet
Period Ending November 30, 2016

Assets:	Current Month	Prior Month	Change
Current Assets			
Cash and Equivalents	4,129,245	592,437	3,536,808
Short-Term Investments	12,883,290	12,938,139	(54,849)
Assets Limited as to Use	-	-	-
Plant Replacement and Expansion Fund	2	2	-
Other Investments	845,660	845,660	-
Patient Receivable	55,111,728	55,052,395	59,333
Less: Allowances	(42,285,512)	(41,276,510)	(1,009,001)
Other Receivables	306,691	1,651,798	(1,345,107)
Inventories	3,381,843	3,549,322	(167,479)
Prepaid Expenses	1,147,107	1,206,678	(59,572)
Total Current Assets	**35,520,055**	**34,559,922**	**960,133**
Internally Designated for Capital Acquisitions	1,124,667	1,124,622	46
Special Purpose Assets	240,545	118,961	121,584
Limited Use Asset; Defined Contribution Pension	868,771	813,922	54,849
Limited Use Assets Defined Benefit Plan	14,144,525	14,144,525	-
Revenue Bonds Held by a Trustee	3,526,538	3,344,470	182,069
Less Amounts Required to Meet Current Obligations	-	-	-
Assets Limited as to use	**19,905,047**	**19,546,500**	**358,548**
Long Term Investments	2,552,143	2,552,143	-
			-
Property & equipment, net Accumulated Depreciation	82,219,872	82,198,352	21,520
Unamortized Bond Costs	33	-	33
Total Assets	**140,197,149**	**138,856,916**	**1,340,233**

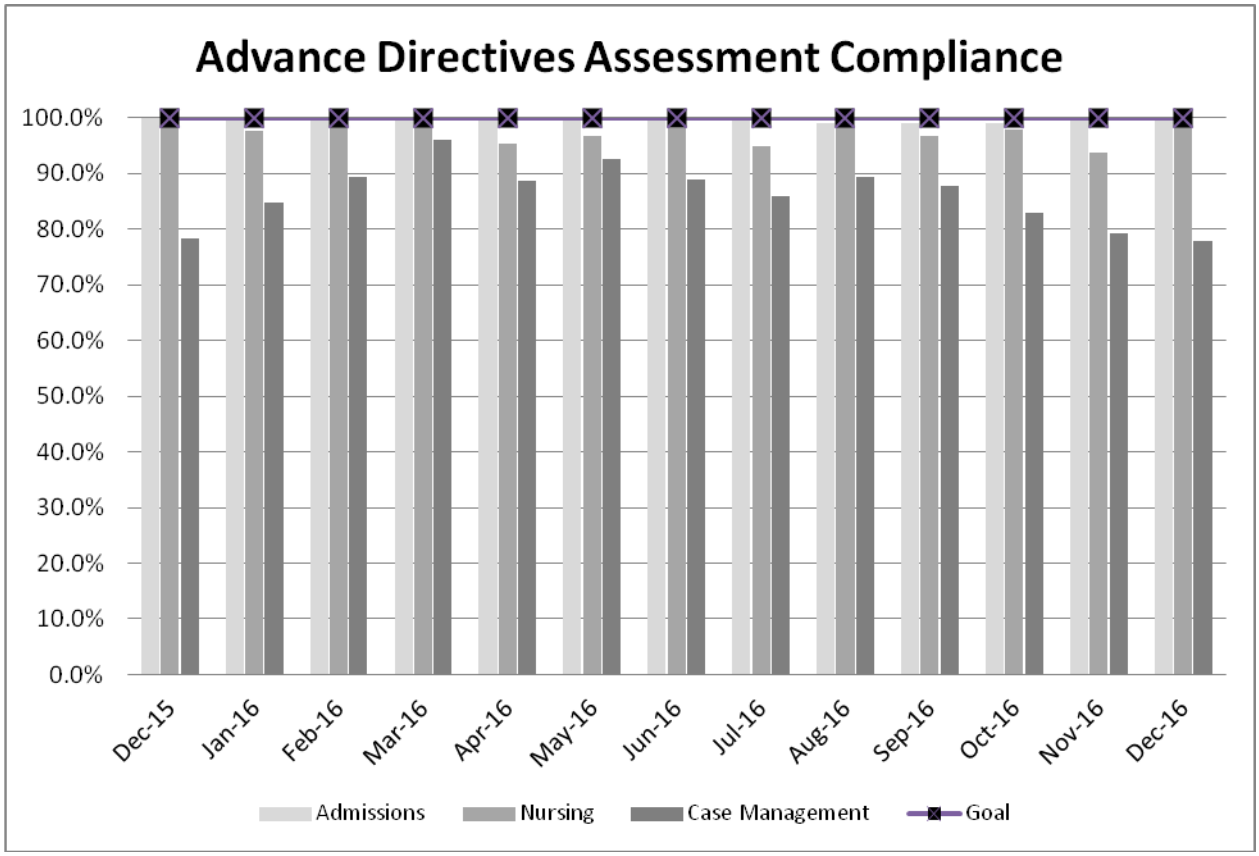
Northern Inyo Healthcare District
Balance Sheet
Period Ending November 30, 2016

Liabilities and Net Assets	Current Month	Prior Month	Change
Current Liabilities:			
Current Maturities of Long-Term Debt	1,757,878	1,845,365	(87,487)
Accounts Payable	2,121,181	1,552,137	569,044
Accrued Salaries, Wages & Benefits	5,244,769	5,167,486	77,282
Accrued Interest and Sales Tax	328,873	176,692	152,181
Deferred Income	340,508	389,152	(48,644)
Due to 3rd Party Payors	1,262,688	1,123,572	139,116
Due to Specific Purpose Funds	-	21,584	(21,584)
Other Deferred Credits; Pension	1,427,520	1,427,520	-
Total Current Liabilities	**12,483,417**	**11,703,508**	**779,909**
Long Term Debt, Net of Current Maturities	46,012,756	46,012,756	-
Bond Premium	727,611	728,865	(1,254)
Accreted Interest	10,093,253	9,982,704	110,549
Other Non-Current Liabilities; Pension	33,492,468	33,492,468	-
Total Long Term Debt	**90,326,088**	**90,216,794**	**109,294**
Net Assets			
Unrestricted Net Assets less Income Clearing	36,243,065	35,157,463	1,085,602
Temporarily Restricted	140,545	1,202,502	(1,061,957)
Net Income (Income Clearing)	1,004,034	576,650	427,384
Total Net Assets	**37,387,644**	**36,936,614**	**451,030**
Total Liabilities and Net Assets	**140,197,149**	**138,856,916**	**1,340,233**

2013 CMS Validation Survey Monitoring-January 2017

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

    a. Advance Directives Monitoring.

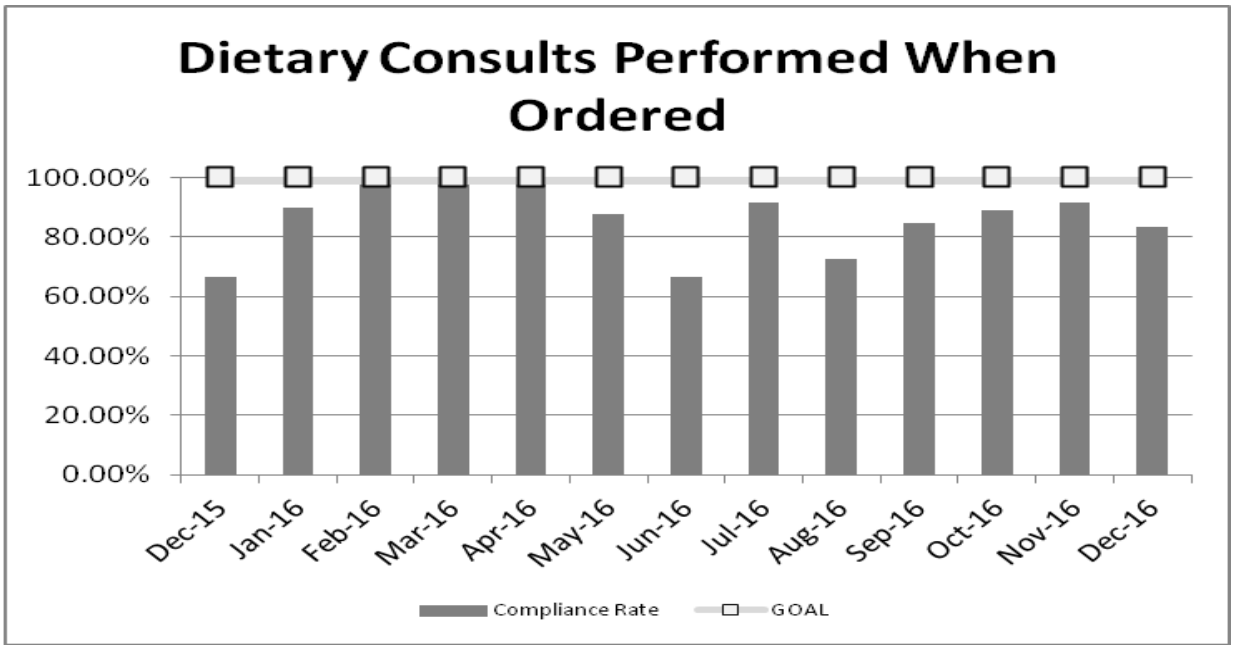


    b. Positive Lab Cultures are being routed to Infection Prevention and each positive is being investigated as to source. Monitoring has been ongoing and reported through Infection Control Committee. QAPI receives data.

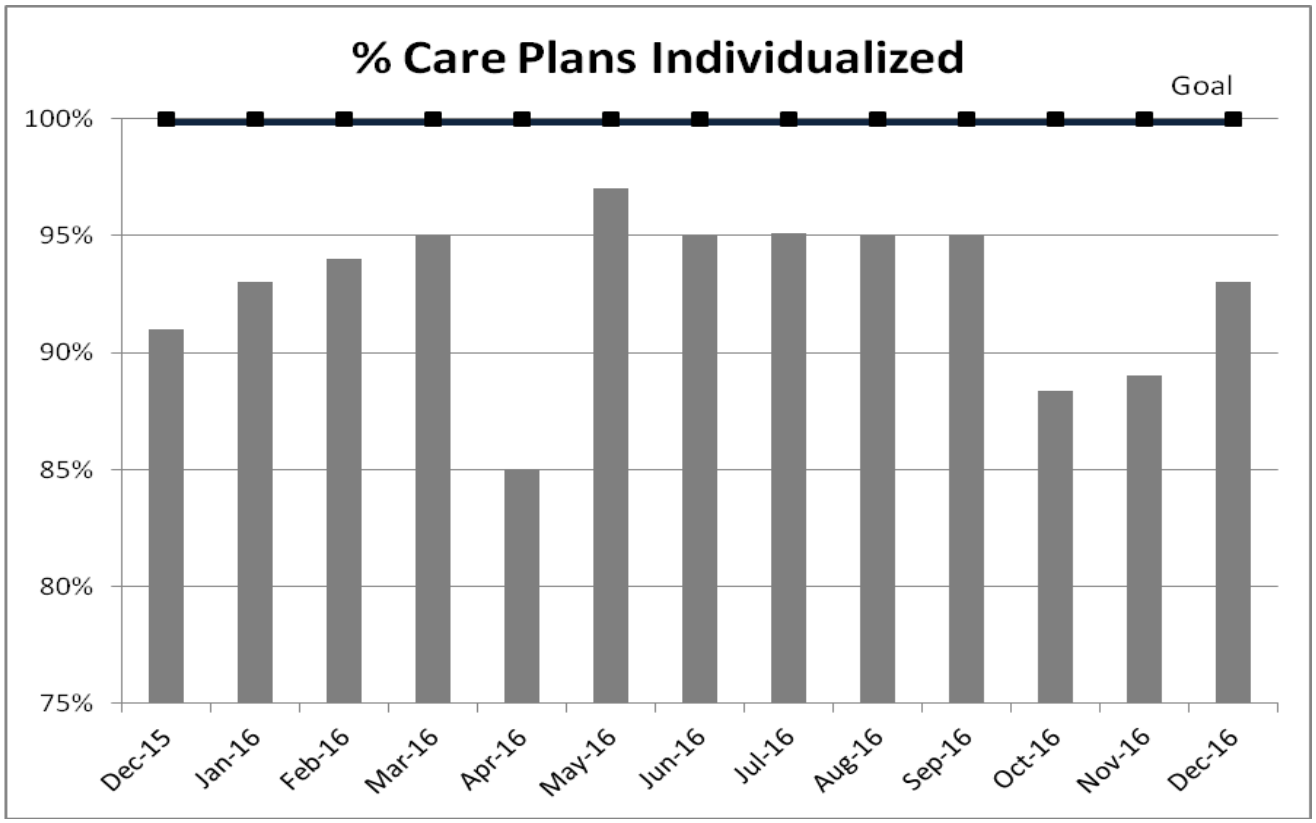
    c. Safe Food cooling monitored for compliance with approved policy and procedure. 100% compliance since May 6, 2013.

    d. Dietary hand washing logs have been reported and are at 100% compliance since May 6, 2013.

    e. QAPI continues to monitor dietary referrals and the number of consults completed within 24 hours.

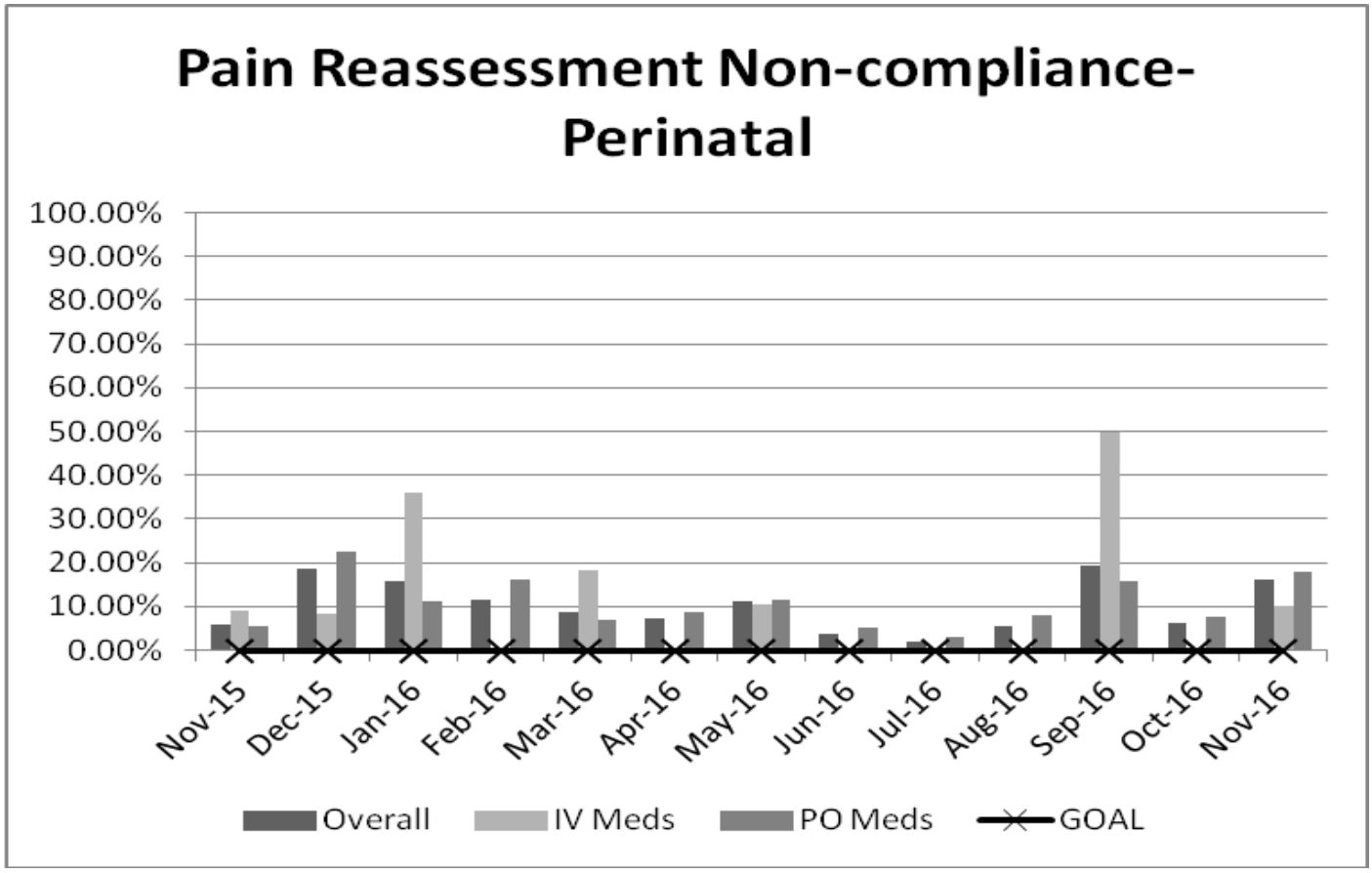


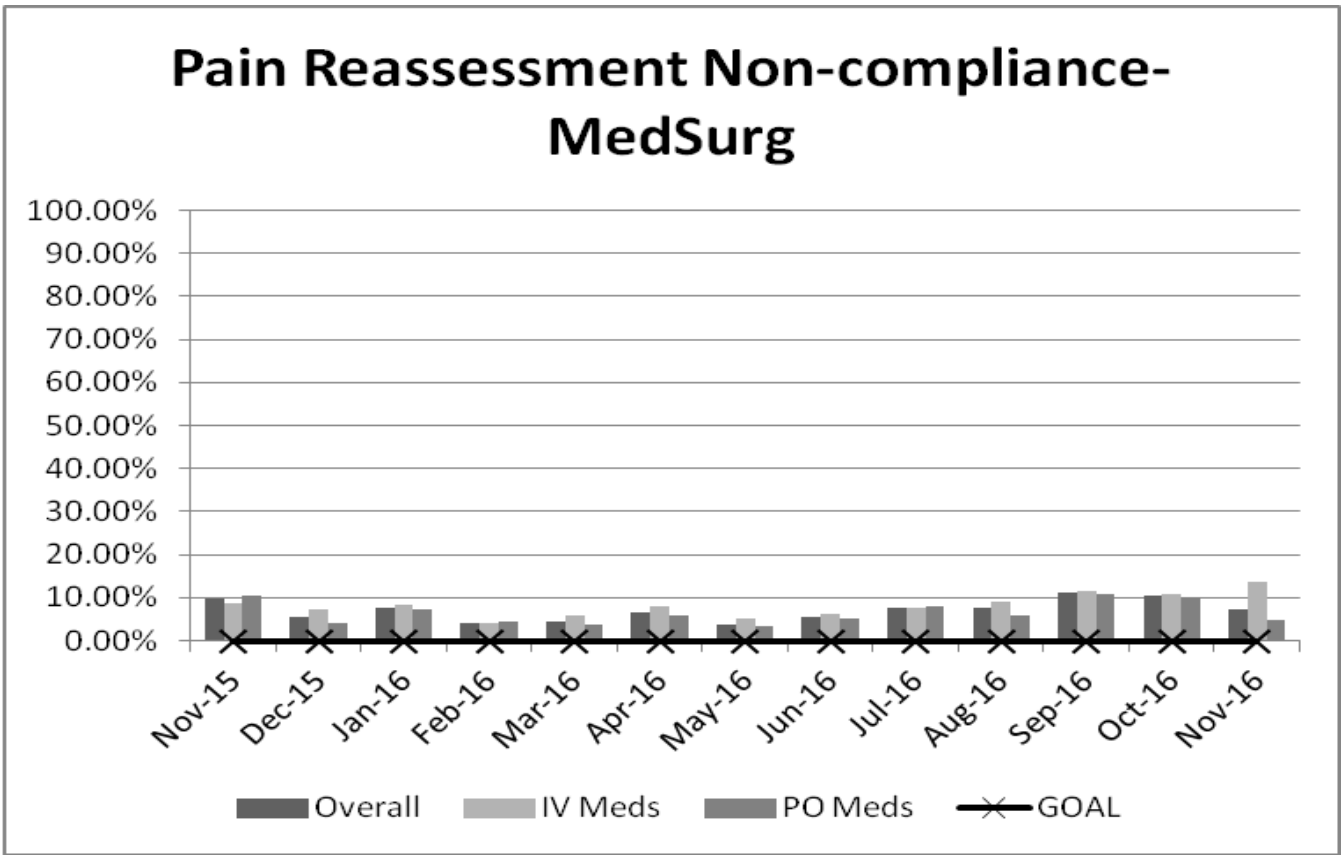
f. Care plans reviewed by Case Management and interventions made to produce care plans. Progress has been made in developing individualized care plans.

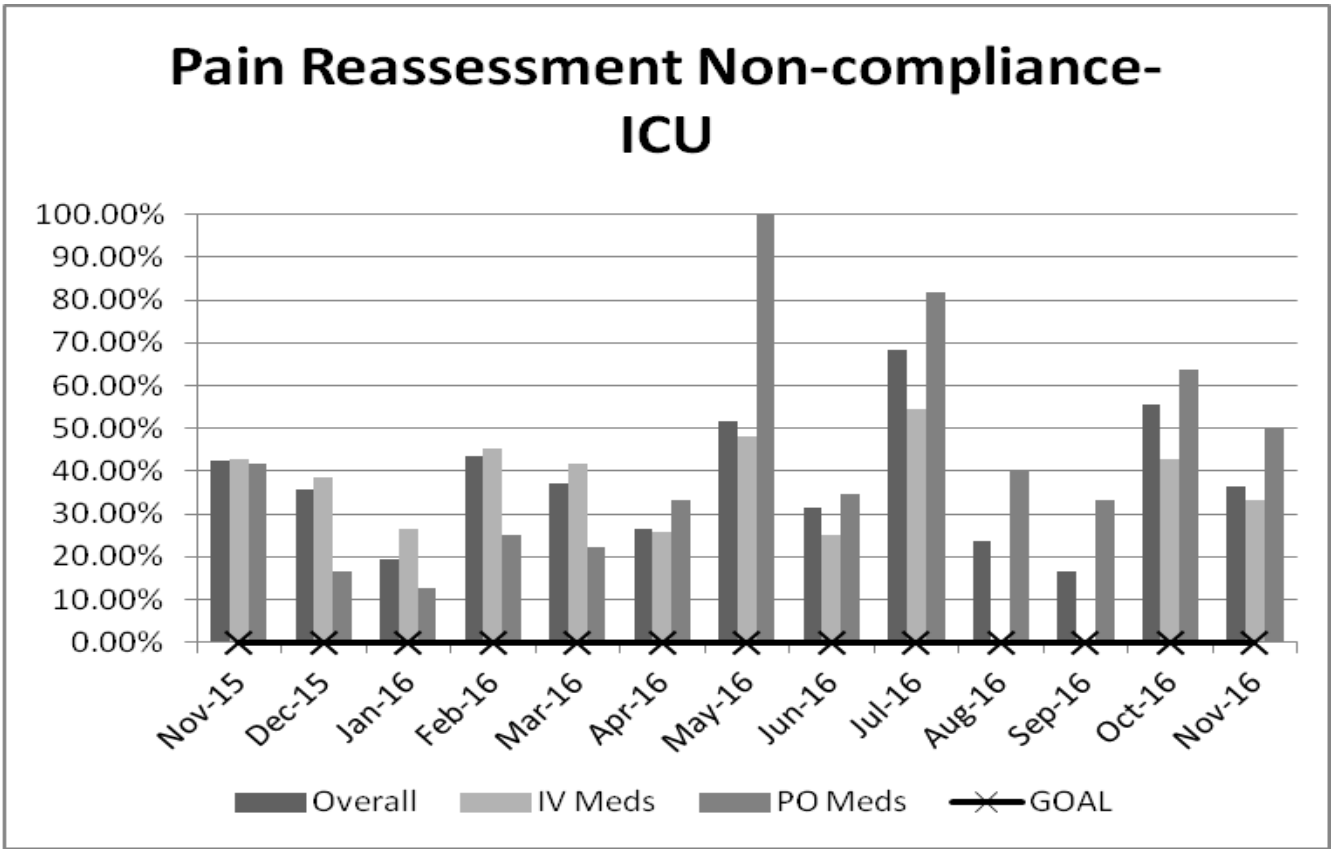


g. Fire drill date, times, attendance and outcomes, smoke detector tests, and fire extinguisher test grids have been approved. All fire drills were complete and compliant from May 6, through present.

h. Pain Re-Assessment. NIH conducts pain re-assessment after administering pain medications and uses a 1-10 scale.







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

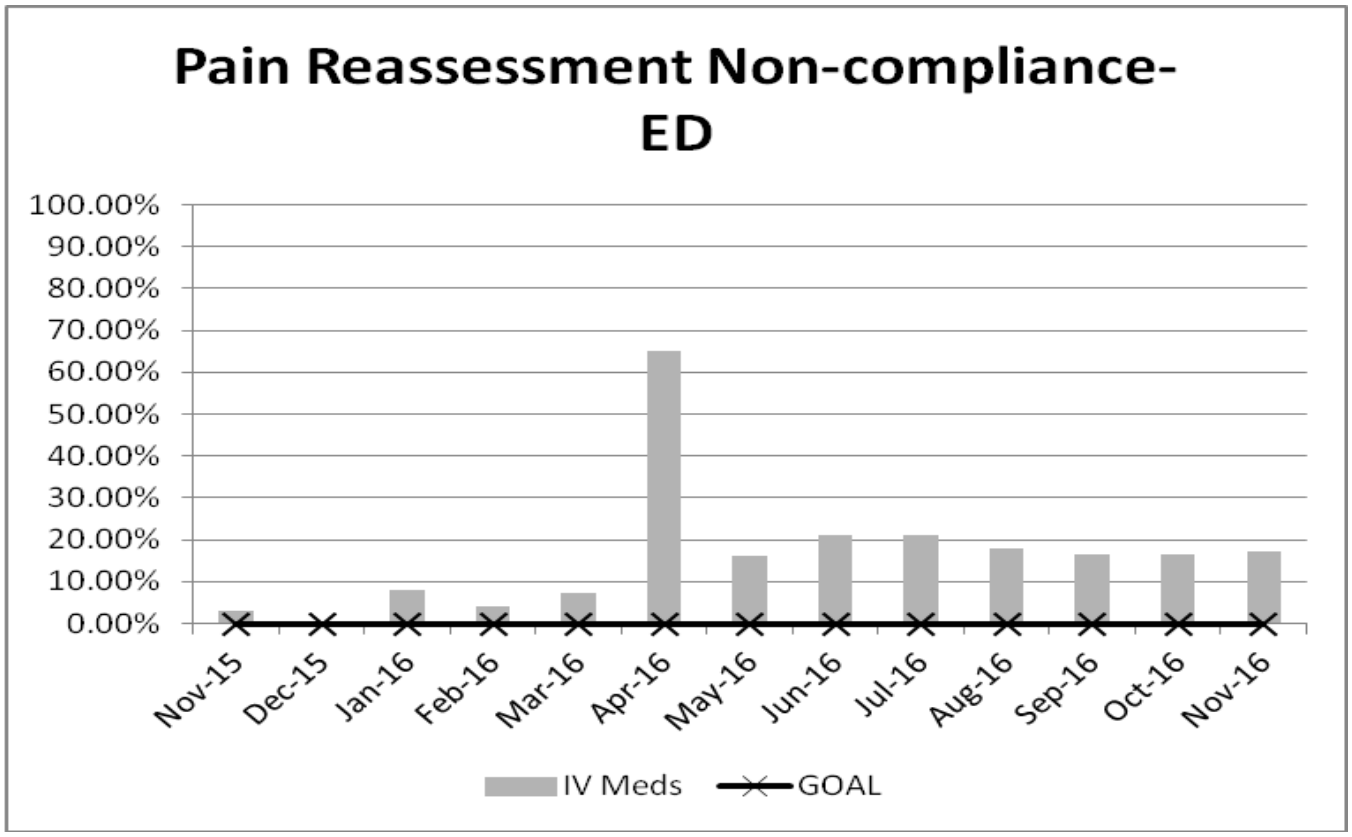


Table 6. Restraint chart monitoring for legal orders.

	April 2016	***May 2016***	***June 2016***	***July 2016***	***Aug 2016***	***Sept 2016***	***Oct 2016***	***Nov 2016***	***Dec 2016***	***Goal***
Restraint verbal/written order obtained within 1 hour of restraints	0/2 (0%)	1/1 (100%)	2/3 (66%)	2/2 (100%)	1/1 (100%)	1/1 (100%)	1/2 (50%)	1/1 (100%)	2/2 (100%)	100%
Physician signed order within 24 hours	0/2 (0%)	1/1 (100%)	3/3 (100%)	1/2 (50%)	1/1 (100%)	1/1 (100%)	1/2 (50%)	0/1 (0%)	2/2 (100%)	100%
Physician Initial Order Completed (all areas completed and form/time/date noted/signed by MD and RN)	0/2 (0%)	1/1 (100%)	1/3 (33%)	1/2 (50%)	0/1 (0%)	0/1 (0%)	0/2 (0%)	0/1 (0%)	2/2 (100%)	100%
Physician Re-Order Completed (all areas completed and form time/date/noted/signed by MD and RN)	3/4 (75%)	1/1 (100%)	2/6 (33%)	N/A	0/1 (0%)	N/A	2/4 (50%)	1/3 (33%)	2/2 (100%)	100%
Orders are for 24 hours	5/6 (83%)	2/2 (100%)	9/9 (100%)	2/2 (100%)	2/2 (100%)	1/1 (100%)	5/6 (83%)	4/4 (100%)	4/4 (100%)	100%
Is this a PRN (as needed) Order	1/6 (16%)	0/2 (0%)	0/9 (0%)	0/2 (0%)	0/2 (0%)	0/1 (0%)	0/6 (0%)	0/4 (0%)	0/4 (0%)	0%

*No restraint orders for this time interval

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CALL TO ORDER	The meeting was called to order at 5:30 pm by Peter Watercott, Vice President.
PRESENT	Peter Watercott, President John Ungersma MD, Vice President M.C. Hubbard, Secretary Mary Mae Kilpatrick, Treasurer Phil Hartz, Member at Large Joy Engblade MD, Chief of Staff
ALSO PRESENT	Kevin S. Flanigan MD, MBA, Chief Executive Officer Kelli Huntsinger, Chief Operating Officer Maria Sirois, Chief Performance Excellence Officer Alison Murray, Interim Chief Human Relations Officer Tracy Aspel RN, Interim Chief Nursing Officer Sandy Blumberg, Executive Assistant
ABSENT	Carrie Petersen, Chief of Fiscal Services
INTRODUCTION OF NEWLY APPOINTED BOARD MEMBERS	Chief Executive Officer Kevin S. Flanigan MD, MBA introduced the following Board members who have recently been elected for four year terms: - John Ungersma MD, District Zone 1 - Phil Hartz, District Zone 2 - Mary Mae Kilpatrick, District Zone 4
ELECTION OF BOARD OFFICERS	Mr. Watercott announced at this time the Board would entertain nominations for Board officers for the next twelve month period. John Ungersma, MD moved that the Board of Directors elect the following slate of officers for the next twelve months: - President, Peter Watercott - Vice President, John Ungersma MD - Secretary, M.C. Hubbard - Treasurer, Mary Mae Kilpatrick - Member At Large, Phil Hartz The motion was seconded by Phil Hartz, and it was unanimously passed to approve the proposed slate of Board Officers as presented.
OPPORTUNITY FOR PUBLIC COMMENT	Mr. Watercott announced at this time persons in the audience may speak on any items not on the agenda on any matter within the jurisdiction of the District Board. Members of the audience will have an opportunity to address the Board on every item on the agenda and speakers will be limited to a maximum of three minutes each. No comments were made.
CONSENT AGENDA	Mr. Watercott called attention to the Consent Agenda for this meeting which contained the following items: - Approval of minutes of the November 16 2016 regular meeting

- Financial and statistical reports for October 2016

It was moved by M.C. Hubbard, seconded by Doctor Ungersma, and unanimously passed to approve both Consent Agenda items as presented.

CHIEF OF STAFF REPORT

Chief of Staff Joy Engblade MD reported following careful review, consideration, and approval by the appropriate Committees the Medical Executive Committee recommends approval of the following hospital wide policies and procedures:

POLICY AND PROCEDURE APPROVALS

1. *Newborn and Pediatric Abduction Prevention Safety and Security and Code Amber Form*
2. *HUGS/PEDZ Policy*
3. *Surgeries Requiring an Assistant*
4. *Diagnostic Imaging - Reportable/Recordable Events in CT, Fluoroscopy and Nuclear Medicine*
5. *Patients under Legal or Correctional Restriction*
6. *Forensics Staff Orientation*
7. *Just in Time Training: Law Enforcement Officer with Prisoner Patient*
8. *Infection Control Policy - Perinatal*
9. *da Vinci Robot Si Cleaning and Maintenance*
10. *Policy and Procedure for EVS for Cleaning the Pharmacy Clean Room*
11. *Toy Cleaning*
12. *Infection Control Risk Assessment (ICRA) for Demolition, Renovation or New Construction Projects (2 attachments)*
    - *NIHD Construction Rounds Compliance Forms*
    - *Contracted Workers Education Form*

It was moved by Doctor Ungersma, seconded by Ms. Hubbard and unanimously passed to approve policies 1 through 12 as presented.

MEDICAL STAFF REAPPOINTMENTS AND RECREDENTIALING FOR 2017 AND 2018

Doctor Engblade also stated following careful review and consideration the Medical Executive Committee recommends approval of the following Medical Staff/Allied Health Professional (AHP) reappointments and re-credentialing for 2017 and 2018:

1. *Lara Jeanine Arndal, MD (OB/Gyn)*
2. *Ryan Berecky, MD (Emergency Medicine)*
3. *Peter Bloomfield, MD (Family Practice)*
4. *Thomas Boo, MD (Family Practice)*
5. *Sierra Bourne, MD (Emergency Medicine)*
6. *John Daniel Cowan, MD (Anesthesiology)*
7. *Robbin Cromer-Tyler, MD (Surgery)*
8. *Tracy Drew, FNP (Family Practice)*
9. *Joy Engblade, MD (Internal Medicine)*
10. *Anne Gasior, MD (Family Practice)*
11. *Anne Goshgarian, MD (Emergency Medicine)*
12. *Charlotte C. Helvie, MD (Pediatrics)*
13. *Kristina Jong, MD (Radiology)*
14. *Mohammad Kanakriyeh, MD (Pediatric Cardiology)*

15. *Catherine Leja, MD (Family Practice)*
16. *Gregg McAninch, MD (Radiology)*
17. *Colleen McEvoy, PNP (Pediatrics)*
18. *Edmund Pillsbury, MD (Radiology)*
19. *Allison Robinson, MD (Surgery)*
20. *Mark K. Robinson, MD (Orthopedics)*
21. *Jeanette Schneider, PhD, MD (Psychiatry)*
22. *Stuart Souders, MD (Radiology)*
23. *William Timbers, MD (Emergency Medicine)*
24. *Jennie G. Walker, MD (Emergency Medicine)*
25. *John Williamson, MD (Cardiology)*
26. *Matthew Wise, MD (OB/Gyn)*
27. *Mara Yolken, ANP (Family Practice)*

It was moved by Ms. Hubbard, seconded by Mr. Hartz, and unanimously passed to approve all Medical Staff/AHP reappointments and re-credentialing for 2017 and 2018 as presented.

MEDICAL STAFF APPOINTMENTS, PRIVILEGING, RESIGNATIONS, AND FPPE PLANS AND COMPLETION

Doctor Engblade also reported following careful review and consideration the Medical Executive Committee recommends Medical Staff Appointments/Privileging for the following:

- *Amy Saft, CRNA*
- *David Nicholson, CRNA (locum tenens)*

Additionally, the Medical Executive Committee recommends the following Medical Staff advancement; resignations; and Focused Professional Practice Evaluation (FPPE) Plans, recommendation, and form:

- *David Pomeranz, MD (Emergency Medicine), advancement from Provisional Active to Active Medical Staff*
- *Medical Staff Resignation, Sarah Starosta, PA-C (Rural Health Clinic Family Medicine), Effective 11/30/16 (relocated out of this area)*
- *Medical Staff Resignation, James Englesby, MD (Internal Medicine), Effective 12/31/16 (retirement)*
- *FPPE Performance Monitoring Plan for Manish Pandya, MD (Hospitalist), Evaluation to include concurrent and follow-up of his patients' wounds for 5 procedures, as proposed by Robbin Cromer-Tyler, MD*
- *FPPE Performance Monitoring Plan for Jay Harness, MD (Breast Surgery), evaluation to include concurrent and follow-up of his patients' wounds for 5 procedures, as proposed by Robbin Cromer-Tyler, MD*
- *FPPE Performance Monitoring Plan for Amy Saft, CRNA (Anesthesiology), Evaluation to include concurrent, prospective, retrospective, and discussion with peers as proposed by Curt Schweizer, MD*
- *FPPE Recommendation form for Carolyn Saba, MD (Anesthesiology), Completion of FPPE and release from proctorship*

It was moved by Mary Mae Kilpatrick, seconded by Doctor Ungersma, and unanimously passed to approve the Medical Staff Appointments and Privileging; resignations; and FPPE Monitoring Plans and recommendation form as recommended.

Doctor Engblade also introduced Dianne Picken, Northern Inyo Healthcare District (NIHD) Medical Staff Coordinator, who was present at this meeting.

CHIEF EXECUTIVE OFFICER REPORT

Doctor Flanigan provided a monthly Chief Executive Officer report which included the following:

- NIHD has entered into a Memorandum of Understanding (MOU) with Toiyabe Indian Health Project and Inyo Country. The MOU will enhance agency collaboration and efforts to expand patient services in this area, including cardiology, telehealth, and Behavioral Health.
- The District recently held a robotic surgery open house for healthcare providers in this community. The event was well received and an open house for the general public has been scheduled for December 20.
- The NIHD management team will bring one twelfth of hospital wide Policies and Procedures to the Board of Directors for approval at regular monthly meetings. This will prevent the Board from having to review all policies and procedures en masse once a year, in order to accomplish required annual approval.
- The District is pleased to welcome incoming Director of Pharmacy Michael Cipriano to the NIHD management team. Mr. Cipriano brings a wealth of knowledge with him which will assist in completion of several key projects currently underway in the Pharmacy Department.
- Doctor Flanigan also stated that beginning in January 2017 the format for Board meetings will be changed to allow for regular reports/updates on progress made toward achieving the goals of the District's Strategic Plan. This will include receiving bi-monthly reports from the Patient Experience Committee; the Employee Experience Committee; and the Data and Information Committee. Quality; Finance, and Compliance reports will also be provided on a quarterly basis moving forward.
- Doctor Flanigan acknowledged the achievements of Compliance Officer Patty Dickson (who has earned Certification in Healthcare Compliance); and Accounting Technician Genifer Owens (who recently earned her Bachelor of Science degree in Business Administration with a focus in Public Accounting).
- Doctor Flanigan additionally extended congratulations to Doctor Ungersma and to Mr. Hartz for their successful campaigns and election to the District Board, and to Ms. Kilpatrick who ran for the Board uncontested. Doctor Flanigan and the NIHD management team look forward to working with each of the Directors for the next four years.
- District Legal Counsel Colin Coffey will be present at a special meeting of the District Board in the month of January in order to

provide Compliance, Brown Act, and governance training.
- Doctor Flanigan additionally reported that the District's incoming Rural Health Clinic (RHC) Director has accepted another position and will no longer be joining the NIHD team. Doctor Flanigan will continue to provide leadership for the Clinic until such time as a new Director has been selected.
- Doctor Flanigan also stated that contracts have been distributed to physicians who may become part of the Robbin Cromer-Tyler MD Inc. physician group, and if additional time past the end of this calendar year is needed in order to finalize the contracting process short-term extensions may be entered into with some of the existing physicians.

CHIEF PERFORMANCE EXCELLENCE OFFICER REPORT

Chief Performance Excellence Officer Maria Sirois provided an update on Performance Excellence projects which included the following:
- Patient access improvement efforts at the RHC continue
- Process analysis at the RHC continues in an effort to further streamline patient services
- The new staffing model for the RHC is being implemented, and data collection on patient service needs is also underway

CHIEF NURSING OFFICER REPORT

Interim Chief Nursing Officer Tracy Aspel RN reported Northern Inyo Hospital (NIH) has been recognized for achievement in low-risk C-Section deliveries. She additionally noted that four NIHD staff RN's have been sent to certified childbirth educator training.

CHIEF HUMAN RELATIONS OFFICER REPORT

Interim Chief Human Relations Officer Alison Murray called attention to a proposed hospital wide policy and procedure titled *Personnel File Inspection Policy (and form)*. It was moved by Doctor Ungersma, seconded by Ms. Kilpatrick, and unanimously passed to approve the proposed *Personnel File Inspection Policy (and form)* as presented.

NEW BUSINESS

POLICY AND PROCEDURE MANUAL ANNUAL APPROVALS

Doctor Flanigan called attention to the following list of hospital wide Policy and Procedure manuals being presented for annual approval:

1. AHA Training Center Manual
2. Anesthesia
3. Biomedical Engineering Operations Manual
4. Case Management Manual
5. Central Supply
6. Clinical Practice Manual (Interdisciplinary Direct Care)
7. Compliance Manual
8. Construction Activities
9. Dietary
10. EKG
11. Emergency Department Manual
12. Emergency Management Manual
13. Employee Health Manual
14. Environmental Services

15. Fiscal Services Manual
16. Human Resources - Employee Handbook
17. ICU Unit
18. Infection Control
19. Infusion Center Manual
20. Laboratory Manual
21. Language Services
22. Lippincott Procedure Manual
23. Mammography & MSQA
24. Med-Surg Unit
25. Medical Records
26. Medical Staff Office Manual
27. MRI Safety
28. Nuclear Medicine
29. Nursing Administration
30. OB Unit
31. Outpatient Unit
32. PACU Unit
33. Pediatric Unit
34. Pharmacy
35. Quality Assurance & Performance Improvement
36. Radiology Policy & Procedures Manual
37. Radiation Safety
38. Rehabilitation Services Manual
39. Respiratory and PFT Manual
40. Rural Health Clinic
41. Safety Manuals (10)
42. Social Services
43. Staff Development
44. Surgical Services Unit
45. Surgery Lithotripsy Service
46. Swing Bed Manual
47. Utility Systems

It was moved by Ms. Hubbard, seconded by Ms. Kilpatrick, and passed to approve hospital wide Policy and Procedure manuals 1 through 47 as presented, with Director Hartz abstaining from the vote.

BOARD MEMBER COMMITMENT LETTER

Mr. Watercott called attention to a proposed *Board Member Commitment Letter* which was presented for consideration at the last meeting of the District Board. Director Kilpatrick provided suggestions for additional language for the letter as included in Association of California Healthcare Districts (ACHD) recommendations. Director Hartz distributed a list of questions about the proposed Commitment Letter, and following brief discussion it was decided that the Board will receive additional input on this topic during the January special meeting at which legal counsel will be present. Possible approval of the *Board Member Commitment Letter* was tabled to a future meeting.

NOTARY POLICY AND PROCEDURE	Doctor Flanigan called attention to an updated *Notary Policy and Procedure* which provides additional guidelines for the District's provision of notary services. It was moved by Doctor Ungersma, seconded by Ms. Kilpatrick, and unanimously passed to approve the updated *Notary Policy and Procedure* as presented.
AGREEMENT WITH NICKOLINE HATHAWAY MD	Doctor Flanigan called attention to a draft *Internal Medicine Service Agreement* with Nickoline Hathaway MD. Doctors Hathaway and Flanigan will meet later this week to finalize details of the draft agreement, and it is possible that minor changes may be made to the draft version. It was moved by Mr. Hartz, seconded by Ms. Kilpatrick, and unanimously passed to approve a proposed agreement for internal medicine services with Doctor Hathaway as requested.
BOARD MEMBER REPORTS	Mr. Watercott asked if any members of the Board wished to report on any items of interest. Director Kilpatrick praised the District's robotic surgery provider presentation, stating her belief that the addition of robotic surgery is a tremendous benefit for this community. Director Hartz suggested a possible change to the setup of the Board room for future Board meetings. Suggestions were also made regarding improving the sound system in the Board Room for future meetings. No other comments were heard.
CLOSED SESSION	At 7:29 pm Mr. Watercott announced the meeting would adjourn to closed session to allow the Board of Directors to: A. Hear reports on the hospital quality assurance activities from the responsible department head and the Medical Staff Executive Committee (*Section 32155 of the Health and Safety Code, and Section 54962 of the Government Code*). B. Confer with Legal Counsel regarding pending and threatened litigation, existing litigation and significant exposure to litigation (*pursuant to Government Code Section 54956.9*). C. Confer with Legal Counsel regarding pending and threatened litigation, existing litigation, and significant exposure to litigation (2nd case) (*pursuant to Government Code Section 54956.9*). D. Confer with Legal Counsel regarding pending and threatened litigation, existing litigation, and significant exposure to litigation (3rd case) (*pursuant to Government Code Section 54956.9*). E. Discuss trade secrets, new programs and services (estimated public session date for discussion yet to be determined) (*Health and Safety Code Section 32106*). F. Discussion of a personnel matter (*pursuant to Government Code Section 54957*).
RETURN TO OPEN SESSION AND REPORT OF ACTION TAKEN	At 8:20 pm the meeting returned to open session. Mr. Watercott reported that the Board took no reportable action.
ADJOUNRMENT	The meeting was adjourned at 8:21 pm.

Peter Watercott, President

Attest:

M.C. Hubbard, Secretary

As to all of these, I would like to know who made up these rules? Are they from some legal code or statute concerning hospital boards? Are they from some model code from some hospital organization? Were they adopted by the existing board or some past board.? Are they restating some bylaw? Are they just some individual's idea of a good idea?

Who dratted this commitment letter?

As to number 3, this idea of maintaining confidentiality obviously has plusses and minuses. This obviously violates most notions of transparency although it may be desirable in some instances.

In short, I would like to know from where the rule comes and the reason for it .Does it apply in all circumstances or only a select few such as pending or prospective litigation where it might be appropriate.

As to number 8 regarding refraining from intruding on the administration in areas for which it is responsible, one would have to have a clearly delineated structure of where the responsibilities of the board begin and end and where management's responsibilities begin and end. Without knowing the lines of demarcation, I don't see how one can be expected to commit to this.

To what extent should the board be overseeing the management?

To what extent do their responsibilities overlap?

I suppose management should be fostering good health care within its budget. If it is not doing this, shouldn't the elected board intrude in the areas of responsibility delegated by the board to its manager?

What if the CEO wants to fire a competent and well liked doctor or nurse or manager over a personality dispute or for some clearly illegal reasons which will invite or guarantee a lawsuit and or negative publicity?

As to number 10 about supporting all decisions even you are in the minority, I suppose this would be appropriate in most instances, but clearly not always. There might be circumstances where going public with one's minority position might be appropriate and maybe even the ethical or moral duty of the board member if he or she saw corruption, dishonesty or self dealing or something harmful to healthcare or the community.

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: Joy Engblade, MD, Chief of Medical Staff
DATE: January 3, 2017
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:

1. **Policy/Procedure/Protocols/Order Sets (Action Items)**
   - *Management of Discharge Disputes from Medicare Patients*
   - *Utilization Review Plan* (annual approval)
   - *Pitocin Administration* (superseding: *Pitocin Induction or Augmentation of Labor*)
   - *Certified Nurse Midwife Standardized Procedures* (changes highlighted)
   - *Procedural Sedation* (changes highlighted)
   - *Patient Restraints (Behavioral and Non-Behavioral)* – Addition of Safety Vests
   - *Swing Bed Patient Restraints* – Addition of Safety Vests

2. **Medical Staff Appointments/Privileging (Action Items):**
   - Jennifer McKinley, PA-C (RHC Family Practice)

3. **Focused Professional Practice Evaluation (FPPE) – Recommendation Form**
   - Amy Saft, CRNA (Nurse Anesthesia) – Recommendation for completion of FPPE based on six proctored cases and discussion with peers.

_____
Joy Engblade, MD, Chief of Staff

NORTHERN INYO HOSPITAL
POLICY AND PROCEDURE

Title: Management of Discharge Disputes from Medicare Patients	
Scope: Case Management	Manual: Case Management, Utilization Review
Source: Director of Nursing Practice	Effective Date:

This policy is to provide direction and guidelines for the physicians and case managers when a Medicare patient and/or their family does not agree with the discharge date, and believe the patient needs to continue receiving care in an acute care setting. This policy DOES NOT address dispute over the actual discharge plan, only the anticipated date of discharge.

POLICY:

It is the policy of Northern Inyo Hospital District that all Medicare patients admitted to the hospital for medical services have the right to file an appeal with the Department of Health and Human Services Centers for Medicare and Medicaid Services (CMS) if they and/or their family believe they should not be discharged on the date proposed by the physician and care team and, instead, need to continue to receive medical care in an acute care setting. The patient and their family/caregivers have the right to have their discharge date dispute reviewed by the Beneficiary and Family Centered Care Quality Improvement Organization (BFCC-QIO) reviewer, hired by Medicare to decide discharge dispute appeals.

This policy is to ensure that NIHD is adhering to the **Important Message from Medicare About Your Rights standard CMS-R-193**, which is intended to inform all hospitalized Medicare patients of their Hospital Discharge Appeal Rights (CMS-4105-F). This policy also supports NIHD policies to coordinate all discharge plans with the patients and their family/caregivers. The following procedures are congruent and aligned with CMS as described and outlined in form OMB Approval No. 0938-0692.

PROCEDURE:

1. Upon admission to NIHD all Medicare patients and their family/caregiver will be provided education and information about the Discharge Dispute Appeal process and asked to sign **Important Message form CMS-R-193**. This form describes the steps that patient/family/caregiver can take if they do not think the patient is ready for discharge. This dispute process is based upon the patients need for acute in-patient medical care. This form is provided by admission services.
2. If the patient or family/caregiver believes that the patient needs to remain in the hospital for acute medical care, they will inform the patient's physician or another member of the healthcare team.
3. The patient's physician and case manager will then meet with the patient and family/caregiver to discuss their concerns.
4. If the physician still believes that the patient is ready for discharge and no longer meets the criteria for acute in-patient care, the physician will then seek the opinion of the UR Physician Advisor.
5. If the physician and UR Physician Advisor are in agreement with the discharge date, then the case manager will review with the patient and family the steps to complete the Discharge Appeal process as outlined in the Important Message from Medicare About Your Rights, form 0938-0692.
6. The patient and family/caregiver must contact the Medicare Quality Improvement Organization (QIO) at the phone number provided on form 0938-0692 PRIOR to being discharged.

7. Once the patient or family/caregiver speak to somebody or leave a message with QIO, the appeal process has begun and **the patient cannot be discharged until the physician and NIH have been informed of QIO's decision**.
8. The patient should be reminded that if they do not engage in the formal appeal process, but decide to stay in the hospital past the planned discharge date, they may have to pay for any hospital services they receive past the discharge date. If this is the case, the physician and case manager will present the patient and family/caregiver with a Notice of Non-Coverage Continued Stay letter (see Discharge forms). The physician and case manager will explain the letter and a representative from admitting and/or billing will be available to answer additional questions.
9. In addition, the patient will be given a copy of form 0938-1019 entitled Detailed Notice of Discharge. This form discloses to the patient and family/caregiver the medical conditions that are related to the decision to discharge and is sent to QIO for the appeal process.
10. The QIO reviewer will contact NIHD Health Information Management and, using our provider identification number, request the patient's medical records be sent to them for review. This is usually done within 24 hours of initiating the appeal process.
11. The QIO will review the medical records and notify the patient and NIH of their decision within 1 day after receiving all necessary information
12. If the QIO finds that the patient is not ready to be discharged, Medicare will continue to cover the patient's hospital stay.
13. If the QIO finds that the patient is ready for discharge, Medicare will continue to cover the patient's hospital services until noon the day after the QIO notifies the patient of its decision.
14. If the QIO finds that the patient is not ready for discharge, the patient's physician and the interdisciplinary care team will meet to re-evaluate the discharge date and plan.
15. Every effort should be made to provide support and assistance in preparing the patient and family/caregiver for the revised discharge date.

REFERENCES:

1. Department of Health and Human Services Centers for Medicare and Medicaid Services; CMS-R-193
2. CMS-4104-F
3. CMS Form#0938-0692
4. CMS Form#093-1019

CROSS REFERENCE P&P:

1. Discharge Plan
2. UR Plan

Approval	**Date**
CCOC	4/11/16
UR	12/1/2016
MEC	1/3/2017
BOD	

Developed: 4/2016
Reviewed: 12/2016
Revised: 11/2016
Supersedes:

NORTHERN INYO HOSPITAL
POLICY AND PROCEDURE

Title: **Utilization Review Plan**	
Scope: Hospital Wide	Manual: Case Management, Utilization Review
Source: Director of Nursing Practice	Effective Date:

PURPOSE:

The purpose of this plan is to identify the elements of a comprehensive utilization review management plan which is necessary to satisfy Medicare Conditions of Participation. This plan is coordinated to support Northern Inyo Healthcare District (NIHD) mission and vision by collecting and reviewing data that assures the appropriate allocation of hospital resources and specifically monitoring the necessity for appropriateness of hospitalization extended length of stay and the quality of this interaction. This plan provides framework for addressing under and over utilization of resources as well as the review of treatment to determine that the care provided meets professionally recognized standards of care.

POLICY:

1. Northern Inyo Hospital's (NIH's) UR plan applies to all patients regardless of payment source and all admissions are reviewed in accordance with federal and state regulations governing Utilization review.
2. Findings and recommendations of the Utilization Review Committee are reported to the Medical Executive Committee. Additional issues can be referred to Billing Coding Compliance Committee.
3. The UR plan shall be reviewed and evaluated by the Utilization Review Committee and the Medical Executive Committee at least once a year and revised as needed.

DEFINITIONS:

1. **Utilization Management Plan** means the organizational plan that contains the essential requirements for the establishment and implementation of a utilization management process to ensure the quality, appropriateness and efficiency of care and resources furnished by the facility and medical staff. The purpose of this plan is to ensure that patients at Northern Inyo Hospital receive medically necessary and appropriate care at the appropriate time and in the appropriate setting.
2. **INTERQUAL Criteria** means clinical decision support guidelines licensed for use by hospitals to evaluate the appropriateness of medical interventions and level of care based on clinical criteria and standards.
3. **Secondary Review** means a clinical review performed by a physician member of the Utilization Review Committee or a Physician Advisor when INTERQUAL guidelines suggest a different patient status or level of care than that ordered by the patient's Physician and/or a potential quality concern.

PROCEDURE:

Overview:

A developed plan that contains

- Delineation of responsibilities and authority of personnel for conducting internal utilization review.

- Establishes procedures to review the medical necessity of admissions, extended stays, and professional services, and appropriateness of settings.
- Establish procedures for coverage determinations, denials, appeals, and peer review within the organization.
- Establishes reporting, corrective action and documentation requirements for the utilization management process.

Plan Requirements

- Commitment and cooperation from the hospital administration and Medical/Hospital staff.
- Objective Review Criteria
- Maintenance of appropriate data
- Integration of UR findings into quality improvement activities
- Patient record access appropriate for Utilization review

Composition – See ***Medical Staff bylaws***

- The Utilization Review committee is a standing committee of the medical staff and is responsible to the Medical Staff Executive Committee. The committee shall be comprised of two or more physicians and other practitioners to perform the utilization management function. The other members may be any of the other types of practitioners specified in 482.12(c) (1). The Utilization Review and Medical Records Committee shall consist of at least 4 active staff members selected on a basis that will ensure insofar as feasible, representation of the services and the major clinical specialties which are routinely practiced by Practitioners at Northern Inyo Hospital.
    - The Quality Improvement Coordinator, the Utilization Review/Infection Control Coordinator, the Director of Nursing, Billing Department Supervisor, Director of Medical Records, DRG Coordinator, the Hospital's Patient Representative, and Social Service Director shall serve as Ex Officio non-voting members.
- The UR committee may be supported by representatives from Case Management and Administration, but only physicians and other practitioners are members for regulatory purposes.
- No person with a direct financial interest may participate in reviews conducted by the Committee.

Meetings

- The UR committee shall meet as a separate and distinct committee with its own agenda and minutes. The committee shall meet as often as necessary to accomplish primary functions, but no fewer that quarterly.
- Committee minutes shall be maintained according to hospital policy and include the date/time of the meeting, attendees, standard reports, action item follow-up, focused reviews, audits, and action to be taken. The minutes shall exclude patient or physician names from charts reviews.

Standard Reports

- Length of Stay
- Avoidable Days
- Appeal Outcomes
- Denials

- INTERQUAL review results (Cases or number of days that do not satisfy criteria for admission, continued stay and/or level care, and secondary reviews results)
- # of Admission Hospital Issued Notice of Non-coverage (HINN) letters issued
- Observation information, including the number of observation stays converted to inpatient, average length of stay (hours) and the number exceeding 48 hours.
- Condition Code 44

Authority and Responsibility

- **UR (Case Management) Committee Chair**
  - Assigns responsibility for medical necessity secondary review process
  - Evaluates the effectiveness of utilization management activities
  - Reports evaluation results and/or issues to appropriate committees.
- **Utilization Review Committee**
  - Provides oversight to assure that health care furnished at Northern Inyo Hospital is consistent with professionally recognized quality standards.
  - Provides oversight to assure consistently appropriate and medically necessary treatment for patients.
  - Evaluates and acts upon peer review information related to medical necessity, appropriateness of treatment and quality of care.
  - Provides for confidentiality of the peer review process and findings.
  - Provides focused review and reporting mechanisms or identified utilization management problems
  - Arrange for two or more appropriate practitioners to perform UR functions
  - Schedule meetings with appropriate minutes and committee activity.
  - Provides annual review, evaluation and approval of the plan by both the UR and Medical Executive Committee.
- Duties: The Utilization Review and Medical Records Committee shall perform the following functions:
    - Delineate the scope of utilization review provided within the hospital
    - Develop critical indicators to be used as screening devices in reviewing the utilization of Hospital Services.
    - Establish thresholds used to trigger physician review.
    - After cases have been isolated using the critical indicators, evaluate the quality and appropriateness of care administered and identify areas for improvement.
    - Review patient care services to ascertain if quality care within the standards of the Hospital and Medical Staff is being provided in the most cost-effective manner, address overutilization, underutilization, and inefficient scheduling of care and resources.
- **Case Management Staff**
  - **Director**: The Director of Case Management, under the direction of the Utilization Review Committee, has responsibility for the following activities:
    - Delegates responsibilities to appropriate personnel to ensure coverage for determining appropriate patient status.
    - Provides guidance to the medical staff and hospital personnel regarding medical necessity criteria and appropriate service determinations
    - The process of measuring and assessing the use of professional care, services, procedures, and facilities, including the medical necessity and appropriateness of:

- Necessity of admission
- Level of care
- Appropriate utilization of resources
- Continued stay
- Discharge/post hospital referrals
- Readmissions
- Performance improvement team activities to improve systems and processes associated with inefficient or inappropriate delivery of care and services.

- **Case Manager:**
  - Reviews medical record documentation to obtain information necessary for UR determinations
  - Screens patients from time of admission for potential discharge and aftercare needs
  - Applies utilization review criteria objectively regarding level of care using INTERQUAL guidelines on all admissions and continued stays regardless of payer.
  - Reviews all continued stays and addresses all concerns with attending physician/hospitalist
  - If admission criteria are not satisfied, the reviewer shall contact the attending physician for additional information. If additional information is provided to support the admission satisfies admission criteria, the admission shall be approved.
    - If additional information is not provided or the case still fails to satisfy admission criteria, an alternate level of care (ALOC) shall be discussed with the attending physician. If the attending physician agrees that an ALOC is appropriate, the Case Manager shall facilitate the transfer. If the attending does not agree to transfer to an ALOC, the case shall be referred for secondary review.

- **Secondary Review Process**
  - When an admission or continued stay case is referred by the Case Manager to a member of the committee for secondary review, the reviewer shall review the case based on the documentation in the medical record and discussions with the attending physician in order to determine medical judgment. Secondary review determinations shall be documented and supported with clinical rationale.
  - If the physician member of the UR committee determines that an admission or a continued stay is not medically necessary, the Case Manager will be contacted and provided instructions on the appropriate level of care. Any determination to transfer a patient from the inpatient level of care to the observation level of care resulting from the secondary review process must involve a physician of the UR committee and must also comply with the requirements of Condition Code 44.
  - If the UR committee or designee decides that continued stay in the hospital is not medically necessary, the designee must give written notification to the hospital, the patient, and the practitioner responsible for the care no later than two (2) days after the determination. (*See Management of Discharge Disputes from Medicare Patients)*

REFERENCES:

1. A-0308
    a. **§482.30 Condition of Participation: Utilization Review**
2. A-309
    a. **§482.30(a) Standard: Applicability**
3. A-0310
    a. **§482.30(b) Standard: Composition of Utilization Review Committee**
4. A-0311
    a. **§482.30(c) Standard: Scope and Frequency of Review**
5. A-3012
    a. **§482.30(d) Standard: Determination Regarding Admissions or Continued Stays**
6. A-0313
    a. **§482.30(e) Standard: Extended Stay Review**
7. A-0314
    a. **§482.30(f) Standard: Review of Professional Services**
8. TENET Utilization Management Plan

CROSS REFERENCE P&P:

1. Management of Discharge Disputes from Medicare Patients
2. Discharge Planning

Approval	**Date**
UR Committee	**12/1/2016**
MEC	1/3/2017
Board of Directors	

Developed: 2/15
Reviewed:
Revised: 11/2016, 12/2016
Supersedes:

Responsibility for review and maintenance:
Index Listings:

NORTHERN INYO HOSPITAL
POLICY AND PROCEDURE

Title: Pitocin Administration	
Scope: Perinatal Services / Surgical/PACU	Manual: **CPM - Medication (MED)**
Source: Manager of Perinatal Department	Effective Date:

PURPOSE:

To provide guidelines for administration of Pitocin (Oxytocin) for induction, augmentation of labor, or postpartum administration to Perinatal Unit RNs

I. INDUCTION/AUGMENTATION PITOCIN POLICY:

1. A qualified Perinatal Unit RN may initiate a Pitocin infusion for induction or augmentation of labor when ordered by the attending physician.
2. The physician must be within 15 minutes of the hospital and available immediately by phone.
3. A category I baseline fetal monitoring strip must be obtained prior to the beginning of the induction or augmentation of labor. Induction or augmentation may be appropriate and occur with a Category II strip by specific MD order.
4. Patients must be on continuous fetal monitoring while on Pitocin unless there is a Category I strip and the infusion rate is stable.
5. If internal monitoring is requested refer to "Internal Fetal Monitoring" policy.
6. Pitocin is required to be double checked with another RN, according to high alert medication policy, prior to connecting the Pitocin to the patient.
7. The nurse must inform the physician if any of the following occur:
    a. Abnormal FHR
    b. Uterine tetany
    c. Uterine Hypertonus: When using an IUPC and uterine baseline is >20mmHg or contractions do not return to baseline.
    d. Tachysystole: A series of single contractions lasting 2 minutes or more, a contraction frequency of more than 5 in 10 minutes averaged over a 30 minute period, or contractions of normal duration occurring within 1 minute of each other.
    e. Inability to adequately monitor the patient
    f. Maternal sequelae:
        - increased BP
        - increased temperature
        - excessive bleeding
    g. Signs and symptoms of water intoxication, (e.g., Drowsiness, Listlessness, Headache, Confusion, Shortness of Breath, Edema, Decreased BP, Urinary Output <30ml/hr, Anuria)
    h. Failure to progress
    i. If at any time the nurse feels it is not safe to start or continue the induction or augmentation.

8. Pitocin must be administered through appropriate pump tubing on an IV pump.
9. The MD will order the rate for IV maintenance fluids.

SPECIAL CONSIDERATIONS: Special education required in order for a RN to perform the procedure

1. Physician order is required.
2. Procedure must only be performed by a RN who has a minimum of six months experience in Perinatal Nursing.

3. Completion of Gnosis APS (Advanced Practice Strategies) including fetal assessment and monitoring modules.
4. Must be fetal monitoring certified.
5. Must be observed at the bedside in the performance of induction/augmentation using an intravenous Pitocin infusion, under the guidance and direction of the Perinatal Unit Nurse Manager or designee.

Age specific considerations should be evaluated and education needs addressed.

PRECAUTIONS:

1. Contraindications for use of Pitocin include: CPD, fetal malpresentations, prolapsed cord, macrosomia, placenta previa or abruption, prior cesarean section, Category III strip, or active genital herpes.
2. Dependent on individual patient responses, a 1:1 nurse to patient ratio may be required.

PROCEDURE:

1. Prior to starting Pitocin, the risks and benefits of the medication must be discussed with the patient, and written consent obtained.
2. Prior to starting Pitocin, obtain and assess maternal vital signs, obtain a 20-minute baseline fetal monitor strip, and complete a vaginal exam to confirm presentation and dilation, except in patients with Premature Rupture of Membranes (PROM).
3. Place an 18-gauge (preferred) or 20-guage catheter IV and ensure a multi-flow clave extension is placed prior to beginning a mainline IV.
4. Using appropriate pump IV Tubing and on the IV pump, start a mainline IV with a 1000L bag of LR or solution ordered by physician and infuse as ordered.
5. Obtain a pre-mix bag of Pitocin 30 units in 0.9% NaCL 500mL and ensure IV Pitocin Rate Label is on the bag, as well as the high-alert medication sticker.
6. IV Pitocin stickers are required in 3 places prior to beginning administration. The IV pump, on the Pitocin tubing at the patient hub attachment port, and in the middle of the IV tubing.
7. Using separate appropriate pump IV tubing and a second IV pump, connect the Pitocin piggyback to the mainline IV tubing using the port nearest the patient's catheter site.
8. The Pitocin infusion rate will be ordered by the physician. The concentration is 1 milliunit (mU) per minute = 1 ml per hour.
9. The starting rate of Pitocin and interval for rate change will be specifically ordered by the physician and titrated by the Perinatal Unit RN assessing fetal response and uterine activity/labor progress.
10. Increases and decreases in the amount of Pitocin being infused are to be done with discretion of the Perinatal Unit RN and will be based on each patient's individual sensitivities and responses. These changes may be done in 0.5 mU/min increments if needed.
11. Nursing assessments and documentation must be charted as specified under documentation heading in this Pitocin policy, or more often if the patient's condition requires more frequent intervention.
12. Crisis Intervention:
    a. Category III fetal heart pattern:
        1. Turn Pitocin infusion off and notify physician.
        2. Turn patient to her side, and slightly elevate the legs.
        3. Give the mother oxygen at 10 liters per minute with a non re-breather facemask.

4. Turn primary IV on and give a 200 ml fluid bolus unless contraindicated due to maternal diseases.
5. Have Tocolytics (Terbutaline 0.25 mg SQ) readily available for administration

b. Maternal Shock:
1. Turn Pitocin infusion off and notify physician.
2. Turn patient to her side and keep her flat.
3. Give oxygen at 10 liters/min with a non re-breather facemask
4. Increase her mainline IV to wide open and use a pressure bag if needed to maintain maternal BP until further help arrives and or further orders by the physician have been obtained
5. Observe for hemorrhage.
6. Keep patient warm.
7. Try to keep patient reassured and comfortable.

b. Tachysystole or Tetanic Uterine Contractions:
1. Assess fetal pattern and treat as outlined
    a. Category I FHR Tracing: Decrease Pitocin
    b. Category II and III FHR tracings:
        - Decrease or stop the Pitocin infusion and initiate intrauterine resuscitative measures (see Intrauterine Resuscitation Measures chart)
        - Notify physician in a timely manner
        - Pitocin should not be restarted without a physicians order

c. If no response to the above interventions, the mother may need to be prepared for emergency c-section

DOCUMENTATION:

1. Frequency of assessments should always take into consideration maternal-fetal condition and at times will need to occur <u>more often</u> if the maternal-fetal clinical needs change:

2. Maternal vital signs:
    a. Temperature q4 hours with intact membranes
    b. Temperature q2 hours with ruptured membranes
    c. Temperature q1 hr with ≥100°F
    d. Temperature q30 minutes ≥101°F
    e. Pulse and respirations q1 hour
    f. BP q10-15 minutes with each rate change
    g. BP q30 minutes when Pitocin rate is stable

3. Fetal Heart Rate, Variability, and Uterine Activity:
    a. Record with each rate change
    b. First stage: FHR q15 minutes at a minimum
    c. Second stage: FHR q5 minutes

4. Observe for, document, and notify physician of the occurrence of the following potential side effects:

a. Maternal hypotension
b. Maternal tachycardia
c. Nausea and vomiting
d. Water Intoxication (e.g., Drowsiness, Listlessness, Headache, Confusion, Shortness of Breath, Edema, Decreased BP, Urinary Output <30ml/hr, Anuria)
e. Uterine Tetany: Contractions that plateau and do not return to baseline within two contraction cycles or five minutes or one such contraction which lasts longer than three min.
f. Tachysystole: A series of single contractions lasting 2 minutes or more, a contraction frequency of more than 5 minutes averaged over a 30 minute period, or contractions of normal duration occurring within 1 minute of each other
g. Uterine Hypertonus: When using an IUPC and uterine baseline is >20mmHg or contractions do not return to baseline
h. Fetal Tachycardia: FHR ≥ 160 bpm for 10 minutes or longer
i. Fetal Bradycardia: FHR ≤110 bpm for 10 minutes or longer
j. Late decelerations
k. Prolonged or recurrent variable decelerations
l. Rapid labor progression
m. Failure to progress: Lack of labor progression with demonstration of > 2 hours of an adequate contraction pattern
n. Category III strip
o. Nursing interventions and any provided treatments, including the results
p. Time of occurrence
q. Time of physician notification

II. POSTPARTUM PITOCIN POLICY:

1. A qualified RN may initiate postpartum Pitocin, after delivery of the baby, as ordered by physician.
2. The pre-mixed Pitocin will not be connected to the patient (or rate changed to postpartum rate) until it is double checked with a second RN, or a verbal timeout is performed and documented in the MAR if second RN is not immediately available to witness administration on the MAR.
3. The pre-mixed Pitocin will be started as ordered for standard postpartum Pitocin administration, unless otherwise ordered by physician.

PROCEDURE:

1. A qualified RN may obtain the pre-mixed Pitocin, prime the tubing, ensure proper labeling of each port program the IV pump (if patient is not currently on Pitocin for augmentation/induction), but will not connect Pitocin to the patient.
2. RN will program the Pitocin pump in anticipation for delivery:
   a. Prime the tubing with the pre-mixed Pitocin 30 mU in 0.9% NaCL 500 ml.
   b. Program pump to run at 200 ml/hr with a VTBI (volume to be infused) of 333 ml to give the patient a total of 20 mU of Pitocin as standard postpartum Pitocin ordered by physician.
   c. Push start (not connected to patient), then push "A", then push "Program/Options", when it asks if you want to put the pump in "Standby Mode", push yes (do not need to set a time, it will stay in standby until you start the pump or turn it off). It will stay in standby mode without alarming, until you are ready to connect the Pitocin to the patient.

Title: Pitocin Administration	
Scope: Perinatal Services / Surgical/PACU	Manual: **CPM - Medication (MED)**
Source: Manager of Perinatal Department	Effective Date:

3. After patient has delivered the baby, confirm the dose of Pitocin with another RN, or if another RN is not immediately available, perform a verbal timeout with physician. Document in the MAR, connect to the patient, and push "A" on the pump that is pre-programmed with postpartum Pitocin, push "no" to not put in standby mode, and push "start" and "yes" to confirm. The postpartum Pitocin is now running according to the ordered postpartum Pitocin concentration.
4. According to the postpartum Pitocin physician standing orders, the LR is to be running concurrently at 400 ml/hr on the second IV pump.

Committee Approval	**Date**
Peri-Peds	**11-7-16**
P&T	**12/15/16**
CCOC	**11/14/16**
MEC	1/3/2017
Board	

Responsibility for review and maintenance: Perinatal Nurse Manager
Revised: 11/97; 07/06: 08/10: 9/12jk: 4/2014jk; 8/2016 SG

NORTHERN INYO HOSPITAL
POLICY AND PROCEDURE

Title: **Certified Nurse Midwife Standardized Procedures**	
Scope:	Department:
Source: OB Nurse Manager	Effective Date:

I. POLICY

A. Definition and Purpose:
The nurse midwife, by virtue of added knowledge and skill gained through an organized program of study and clinical experience recognized by the American College of Nurse-Midwives, practices in the area of management of care of mothers, so long as progress meets the criteria accepted as normal. Nurse-Midwives are educationally prepared to recognize the deviations from normal at a time when medical care can be instituted to safeguard the well being of the mother and baby. The practice of nurse-midwifery is recognized as an extended role for specially trained nurses under the Nursing Practice Act, as used in the following policies and protocols:

1. Nurse-midwife, means a registered nurse certified to practice nurse-midwifery pursuant to the Nursing Practice Act (Art. 2.5, Ch 6, Div. 2 Secs 2746-2746.51, business and professional Code and related to regulations (Sections 1460-1466 Title 16 California Adm. Code)).
2. Supervising Physician, means a physician who is an active member of the medical staff at Northern Inyo Hospital and who has current obstetrical privileges. This individual must contract with the practicing nurse-midwife to supervise normal obstetrical patient care. All patients will be admitted to the supervising physicians service.
3. "Normal delivery" means vertex presentation, vaginal birth of a child, completed by the natural efforts of the mother. Criteria and Exclusions: refer to addendum A attached.

B. Experience, training and/or education criteria for Nurse Midwives:
Criteria: Applicants for membership and privileges as a nurse-midwife shall meet the following criteria:

1. Licenses: Possession of a valid California license as a registered nurse. Possession of a valid California license as a certified nurse midwife. Board certified by the American Midwifery Certification Board (AMCB) within one year of graduation from an accredited school of nurse-midwifery.
2. Education: Graduation from an accredited certified nurse midwife program.
3. Experience:
    a. New Graduates: Completion of a post graduate internship in a university affiliated setting or in a setting approved by the chief of obstetric services. If more than 24 months since graduation, CNM may be required to fulfill a remediation course.
    b. Experienced CNM: In lieu of the required internship, an experienced CNM may furnish documentation of 1-2 years of recent hospital based intrapartum management experience in either a university setting or in affiliation with a board certified obstetrician/gynecologist or family practice physician.
5. Maintain American Midwifery Certification Board Continuing Competency and Assessment (CCA). Verification in the Certified Nurse Midwife credential file.
6. Perinatal Committee meeting attendance
7. CNM's who request privileges to assist at Cesarean Section Deliveries must meet the following educational and performance criteria:

a. Successful completion of a course in CNM First Assisting for Cesarean Sections through an accredited college, or a program approved by the ACNM or Chief of Obstetrical Services, that incorporates didactic and clinical performance sections.
b. The CNM will be proctored for minimum of 2 second assists and 3 first assists at Cesarean Sections and/or for a minimum of 3 months, at which time the Chief of Obstetric Services will recommend either an extension of the proctoring period or approval for Cesarean Section First Assistant privileges to the Interdisciplinary Practice Committee.
c. Continued competency will be reviewed by the Chief of Obstetrical Services on an annual basis by direct observation of performance and he/she will then make a recommendation for approval or denial of continued privileges through the credentialing process to the Interdisciplinary Practice Committee.
d. Refer to appendix B for complete description of CNMFA scope and qualifications.

8. Application requirements for staff privileges, in addition to the above will include
   a. The certified nurse-midwife will be required to carry liability insurance
   b. The certified nurse-midwife will agree not to participate in out of hospital births
9. Successful completion of CPR and neonatal resuscitation are required; successful completion of ACLS and PALS is preferred.

C. Probationary/Proctoring Period.
1. The period of observation will be no less than 3 months and will be used for evaluation of midwifery skills. A new graduate will be required to have a total of 10 supervised deliveries by a designated proctor to receive hospital privileges. A midwife with greater than 2 years of documented experience will be required to have 5 supervised deliveries.
2. Observation will be performed by: supervising physician, other CNMs with current staff privileges, chart review, as well as assessment of obstetrician/gynecologists.
3. CNM Cesarean Section First Assistant: proctoring period as described under section "B" above

D. Nurse Midwife Functions:
1. Function as member of the obstetrical team under supervision and guidance of a supervising physician. Arrange for alternate consultation if supervising physician not available
2. Manage labor, delivery and postpartum course of normal obstetrical patients and deliver care to normal newborn under the auspices of supervising physician and may co-manage exclusions with physician present
3. Function in the role as First Assistant for Cesarean Sections when requested by an obstetrician-see complete description under appendix B.

NORTHERN INYO HOSPITAL
POLICY AND PROCEDURE

Title: **Certified Nurse Midwife Standardized Procedures**	
Scope:	Department:
Source: OB Nurse Manager	Effective Date:

II GUIDELINES:

A. Intrapartum Care by Nurse Midwife:
   1. A Certified Nurse Midwife may function under the confines of their own "Scope of Practice" as defined by the American Midwifery Certification Board. All of the above functions are to be performed within the parameters of normal. If problems arise, the supervising physician is to be notified immediately, as well as the pediatrician, if indicated.
   2. Medication orders are to be signed by the supervising physician unless prescribed under the approved medication listed. "see list"

B. Resuscitation of newborn:
   1. Routine stabilization/care of the newborn at delivery following the guidelines of the American Heart Association/Academy of Pediatrics Neonatal Resuscitation Program.
   2. The CNM will communicate with the on call Pediatrician about any newborn needing additional assistance after delivery and as needed.
   3. Newborn Care: The nurse-midwife may perform and enter the initial physical examination and discharge exam on the newborn record and write admission orders. Complications or abnormalities will be promptly reported to the supervising physician. The supervising physician must countersign medications orders (unless prescribed under the approved medications listed) and will examine infant(s) when requested to do so by CNM or at the physician's discretion.

III RECORDS:
Documentation shall be sufficiently complete to include: an appropriate database, differential diagnosis, management plans and final disposition of the patient. Information shall be recorded on the patient record, which is centrally filed and available to all care providers.

IV FORMULARY OF APPROVED MEDICATIONS:
The following medications may be prescribed by the CNM without the need for physician co-signing; the CNM may prescribe other medications with the appropriate consultation and according to state licensure guidelines but these medications must be countersigned by the physician.

A. Ordering other medications for use in the antepartum, intrapartum and postpartum periods; Caboprost Tromethamine, (Hemabate) 250 mcg. IM or IU to uterine atony/bleeding after delivery
   - Docusate Sodium 250 mg at HS for use as stool softener after delivery.
   - Methergine 0.2 mg PO q 8 hours for treatment/prevention of uterine atony after delivery.
   - Methergine 0.2 mg IM post delivery for treatment of uterine atony after delivery.
   - IV fluids: LR, D5LR, NS, D5W, D5 ½ NS for hydration and for administration of medications.
   - Medroxyprogesterone acetate 150 mg IM postpartum method of birth control
   - Methergine 0.2 mg IM or IV for treatment of uterine atony after delivery.
   - Naloxone 0.4 mg for reversal of respiratory depression.

- Oxytocin 10-20 units in IV fluid post delivery for the treatment/prevention of uterine atony.
- Pen G IVPB 5 million units followed by 2.5 million units q 4 hr. for positive b-strep until delivery. (May use Ampicillin If Pen G not available)
- Rubella Vaccine: 0.5cc sq for non-immune mothers after delivery.
- Rh immune globulin 300 mcg IM for Rh-negative mothers to prevent sensitization.
- Saline or Heparin locks to maintain IV access as precaution or for the administration of meds.
- Terbutaline 0.25 mg sub-q for the immediate management of preterm labor until consultation obtained.
- Initiate Magnesium protocol for pregnancy-related hypertensive disorders and/or preterm labor
- Phenergan ≤50 mg IM or IV, may repeat X 1
- Vistaril ≤ 100 mg IM, may repeat X 1
- Nubain ≤ 20 mg sub-q or ≤ 10 mg IV or IM, may repeat X 1
- Motrin 600 mg. PO Q 6 hours
- Morphine Sulfate 2 mg IV every 15 minutes PRN
- Pitocin (during co-management with supervising attending) 2mU/min IV, may increase by 2mU/min every 15 min to max of 32 mU
- Pitocin 10 mU IM as needed post placenta delivery if needed.
- Fentanyl 50-100mcg IVP as needed for pain analgesia.
- Nitrous Oxide per protocol as needed for pain analgesia.

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B. Ordering neonatal medications

- Erythromycin ophthalmic ointment for prophylactic eye treatment
- Phytonadione 0.5-1.0 mg IM for prevention of neonatal bleeding disorders
- HBIG 0.5cc IM for treatment/prevention of Hepatitis B in newborn
- Hepatitis B vaccine – pediatric dose- for infants born of Hb_sAG negative mothers
- Hepatitis B vaccine –pediatric dose- IM for infants born of Hb_sAG positive mothers
- Hydrogen peroxide for routine care of circumcision site
- Naloxone 0.4 or 1.0 mg for the treatment of respiratory depression in the newborn
- Epinephrine 1:10,000 0.1-0.3 ml/kg IV or ET for use in resuscitation, according to the guidelines in the AHA/AAP neonatal resuscitation program
- Volume expanders (Whole blood, 5% albumin, Normal saline, LR) 10ml/kg IV for use in resuscitation according to the guidelines in the AHA/AAP neonatal resuscitation program

NORTHERN INYO HOSPITAL
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Title: **Certified Nurse Midwife Standardized Procedures**	
Scope:	Department:
Source: OB Nurse Manager	Effective Date:

APPENDIX A: CRITERIA FOR CO-MANAGEMENT, COLLABORATION, EXCLUSIONS AND MEDICAL MANAGEMENT.

Criteria for Certified Nurse Midwife delivery will include:

Gestational age > 36 to < 42 weeks
EFW > 2500 - <4000 grams
Normal prenatal care and low risk factors, gestational diabetes diet-controlled

Exclusions – Any patient that does not meet the criteria above will be co-managed with the Atending Physician.

Medical Management of the patient may be transferred to the Physician during the course of the hospitalization by agreement between the CNM and physician.

APPENDIX B: CERTIFIED NURSE MIDWIFE FIRST ASSISTANT (CNMFA)

I. POLICY:
A. The Certified Nurse Midwife First Assistant (CNMFA) assists the attending obstetrician during a Cesarean Section by providing aid in exposure and other technical functions, which will help the surgeon, carry out a safe operation with optimal results for the patient.
B. Only a CNM currently licensed in California, who meets all the criteria specified within this procedure may perform as a CNMFA.
C. The CNMFA may function under this standardized procedure when the attending obstetrician has determined that the CNMFA can provide the type of assistance needed during the specific surgery.

II. PROTOCOL:
A. The CNMFA may assist with the positioning and draping of the patient, or perform these actions independently, if so directed by the physician

B. The CNMFA will provide retraction by:
1) closely observing the operative field at all times
2) managing all instruments in the operative field to prevent obstruction of the surgeon's view
3) anticipating retraction needs with knowledge of the surgeon's preferences and anatomical structures

C. The CNMFA may provide hemostasis by:
1) sponging and utilizing pressure as necessary
2) utilizing suctioning techniques
3) applying clamps on superficial vessels and tying or electro-coagulation of them as directed by the physician

D. The CNMFA may perform knot tying by using basic techniques of knot tying to include two-handed tie, one-handed tie and instrument tie

E. The CNMFA may provide closure of layers by approximating tissue layers under the direct supervision of the physician

F. The CNMFA will assist the physician at the completion of the surgical procedure by:
   1) affixing and stabilizing all drains
   2) cleaning the wound and applying the dressing

III. QUALIFICATIONS:

A. A CNM who is approved as a CNMFA at NIH may function as first assistant if all the following conditions exist:
   1. currently licensed as a CNM in California
   2. successful completion of a course in CNM First Assisting as noted in the above procedure- refer to section B-5 (a copy of the certificate of completion will be placed in the CNMFA's credentialing file)
   3. demonstrated knowledge and skill in applying principles of asepsis and infection control and demonstrated skill in behaviors that are unique to functioning as a CNMFA
   4. demonstrated knowledge of surgical anatomy, physiology and operative procedures encountered in a Cesarean delivery
   5. demonstrated ability to function effectively and harmoniously as a team member
   6. able to perform CPR, completion of ACLS preferred
   7. able to perform effectively in stressful and emergency situations

APPENDIX C: APPROVALS

A. The following CNM's who have been approved to function as Certified Nurse Midwives under this standardized procedure are:

Name:	Approval Date:
_____	_____
_____	_____

B. The following CNM's who have been approved to function as a CNMFA under this standardized procedure are:

Name:	Approval Date:
_____	_____
_____	_____

NORTHERN INYO HOSPITAL
POLICY AND PROCEDURE

Title: **Certified Nurse Midwife Standardized Procedures**	
Scope:	Department:
Source: OB Nurse Manager	Effective Date:

C. This standardized procedure has been approved for use at Northern Inyo Hospital by:

Chairman, Committee on Interdisciplinary Practice	Date	Chief of Staff	Date
President, Board of Directors	Date		

Index Listing: Midwife Policy
Revised: 3/98, 3/09, 6/09, 9/16SG

Committee Approval	**Date**
Peri-Peds	**11/7/16**
Interdisciplinary Practice	**11/11/16**
P&T	**12/15/16**
MEC	1/3/2017
Board	

NORTHERN INYO HOSPITAL
POLICY AND PROCEDURE

Title: **Procedural Sedation**	
Scope: Clinical Services	Manual: **Anesthesia**
Source: DON Perioperative Services	Effective Date: 2/1/16

PURPOSE:

To provide a consistent standard for the administration of sedation during procedures performed at Northern Inyo Hospital

DEFINITIONS:

1) Minimal Sedation – A drug-induced state in which patients respond normally to verbal commands. Although cognitive function and coordination may be impaired, ventilator and cardiovascular functions are unaffected. 'Minimal Sedation' includes analgesia, anxiolysis and/or the use of a soporific for the purpose of performing a procedure.
    a. Analgesia – Pain control, often with a narcotic, which is expected to have no significant effect on the patient's level of consciousness.
    b. Anxiolysis – Control of anxiety, most commonly with a benzodiazepine, which is expected to have no effect on a patient's level of consciousness.
    c. Soporific – A sleeping agent, which, at the usual dose and route, is expected to induce sleep from which a patient can be easily aroused.
2) Dissociative Sedation – A trance-like state of unconsciousness in which the patient is unresponsive to pain and of which the patient will have no memory. Airway reflexes are maintained and vital signs remain stable. This state is unique to Ketamine in appropriate doses.
3) Moderate Sedation – A drug-induced depression of consciousness during which the patient responds purposefully to verbal commands, either alone or with light tactile stimulation. No interventions are required to maintain a patent airway and spontaneous ventilation is adequate. Cardiovascular function is usually maintained. Medications to be used may include, but are not limited to, benzodiazepines, narcotics and barbiturates.
4) Deep Sedation - A drug-induced depression of consciousness during which patients are not easily aroused, but respond purposely after repeated or painful stimulation. The ability to independently maintain ventilatory function may be impaired. Patients may require assistance in maintaining a patent airway and spontaneous ventilation may be inadequate. Cardiovascular function is usually maintained. Medications to be used may include, but are not limited to, all of the above plus propofol and etomidate.
5) General Anesthesia – A drug-induced unconsciousness during which it is expected that respirations, motor tone and protective airway reflexes may be abolished, requiring complete airway and respiratory support. General anesthesia may only be administered by an Anesthesiologist or a Certified Registered Nurse Anesthetist (CRNA) with appropriate clinical privileges. ED physicians may induce general anesthesia only when the goal is endotracheal intubation, as in Rapid Sequence Intubation, and as delineated in their Hospital privileges.

POLICY:

1) Procedural sedation in the hospital shall be monitored and evaluated by the Surgery, Tissue, Transfusion and Anesthesia Committee according to the policy and performed to assure optimal patient outcomes. The physician providing sedation must be thoroughly familiar with the use and potential complications of the drugs used.

Title: **Procedural Sedation**	
Scope: Clinical Services	Manual: **Anesthesia**
Source: DON Perioperative Services	Effective Date: 2/1/16

2) This policy applies in the hospital when patients receive, by any route, for any purpose, moderate, deep or dissociative sedation.
3) This policy does not apply to situations which do not constitute procedural sedation, such as: patients receiving medications for pain control, seizures, insomnia, preoperative medications, anxiety management, or medications given to intubated patients while on ventilatory support. This policy also does not apply to anesthesiologists or CRNAs providing General Anesthesia.
    a. Minimal sedation, as defined above, does not require any special monitoring or facilities other than maintaining verbal or visual contact with the patient until the effects of the medication have reached their peak, but continuous Pulse Oximetry may be considered.
4) Sedation may only be performed by a practitioner with the appropriate privileges at NIH. Medications ordered for the purpose of sedation may be administered by the RN; medications for moderate or deep sedation must be administered under the direct supervision of the ordering practitioner who must be present in the department.
5) The following resources shall be available in all locations where medications are administered to induce sedation:
    a. Equipment to monitor vital signs including pulse, respiratory rate and oxygenation.
    b. Appropriately sized equipment for establishing and providing airway maintenance, including a selection of laryngoscope blades with handle and endotracheal tubes.
    c. Suction and supplemental oxygen with the appropriately sized adjuncts.
    d. Crash cart equipped with a defibrillator.
    e. Appropriate selection of masks and airways.
    f. Means to administer positive-pressure ventilation (e.g. ambu bag).
    g. Pharmacologic antagonists, including naloxone and flumazenil.
6) Because deep sedation carries a high level of risk, the administration must be carefully planned. A sedation plan will be developed to meet patient needs identified through a pre-sedation assessment.
7) Practitioners providing moderate or deep sedation must have training and experience in:
    a. Evaluating patients prior to performing moderate or deep sedation.
    b. Performing the sedation, including methods and techniques required to rescue those patients who unavoidably or unintentionally slip into a deeper level of sedation than desired.
    c. Managing an unstable cardiovascular system as well as a compromised airway and inadequate ventilation.
8) All physicians requesting privileges in moderate, dissociative and deep sedation must meet the following criteria:
    a. Satisfactory completion of the sedation reading list or tutorial and completion of the post-test at least every 2 years.
    b. Documentation of 6 successful sedation procedures within 2 years.
    c. Current ACLS certification and/or Emergency Medicine Board Certification.

    EXCEPTIONS
    Anesthesiologists who have completed an anesthesiology residency and CRNAs who have completed an accredited nurse anesthesia program are considered qualified to administer moderate, dissociative, and/or deep sedation and analgesia by virtue of their training and experience. They are therefore exempt from the requirements listed in Section 8a of this document.

9) The Registered Nurse administering the medications to be used for sedation must be competent in the following areas:
    a. Basic arrhythmia recognition
    b. Airway management
    c. Current in BLS, ACLS and PALS ~~(if providing sedation for a pediatric patient)~~
    d. Clinical pharmacology and hemodynamic variables of the medications to be used and their antagonists
    e. Knowledge of the appropriate monitoring equipment.
10) Sufficient numbers of qualified personnel will be present during sedation to:
    a. Appropriately evaluate the patient prior to sedation.
    b. Provide the sedation. The sedation nurse will have no additional responsibilities during the procedure.
    c. Perform the procedure.
    d. Monitor the patient.
    e. Recover and discharge the patient from the department where sedation has been administered.
11) The patient's response to sedation and the procedure will be documented in the patient's record.
12) Outcomes of patients undergoing moderate, dissociative or deep sedation will be collected and analyzed within the Peer Review process in order to identify opportunities to improve.

PROCEDURE:

PRE-SEDATION:

The nurse will complete a pre-procedure assessment with documentation to include:

- Patient identified using 2 patient identifiers (MR#, DOB, Name or Acct#)
- Baseline vital signs including oxygen saturation
- Physical assessment including age, weight, level of consciousness and pregnancy status
- Allergies
- Current medications
- Current medical problems
- Preferred NPO status
    - May not be obtainable due to nature of emergency
    - Consider addition of Reglan or Bicitra 20-30 minutes prior to procedure for patients with a full stomach
    - Pregnancy greater than 20 weeks, obesity and prior history of reflux should always be considered a potential full stomach
    - Non-emergency NPO guidelines:

Previous 2 hours - clear liquids
Previous 4 hours – breast milk
Previous 6 hours - light meal
Previous 8 hours - heavy meal

- Signed consent for the procedure including sedation, if condition permits

- IV status (patent, running, saline lock)
- Verification that a responsible adult is available to transport the patient home
- Equipment available
- Reversal agents

Physician documentation will include:

- Focused history and physical for the chief complaint
- History of patient or family complications to sedation
- Risks, benefits and alternatives of the procedure and types of sedation have been discussed with the patient and family prior to administration.
- An immediate pre-procedure assessment including a review of vital signs and patient status.
- Airway assessment with classification based on the American Society of Anesthesiology (ASA) classification system listed below. Any patient assessed an ASA-IV or greater requires consultation from the anesthesiologist or CRNA.

SEDATION:

1) The patient will be monitored continuously throughout the procedure. Monitoring will be done by the medication/monitoring RN who will not assist with the procedure.
    a. Vital signs, including sedation scale and oxygen saturation levels will be recorded every 5 minutes throughout the procedure.
        a. For deep sedation, vital signs should be monitored more closely, at least every 3 minutes.
    b. Medications given, including dose, route and response will be documented throughout the procedure.
    c. A change of 20% or more from baseline in pulse, heart rate or oxygen saturation should be reported to the physician.
    d. Documentation should also include the patient's tolerance of the procedure, estimated blood/fluid loss, acute changes in the patient's status, interventions performed and disposition of the patient.
2) A respiratory therapist will be at the bedside for any moderate or deep sedation in the ED.
3) ETCO2 Monitoring will be used for deep sedation, if available.

POST-PROCEDURE:

1) Immediately after the procedure, the physician will document the outcome of the procedure, the patient's response to the sedation and any complications.
2) Routine nursing recovery care will include, but not be limited to:
    a. Admission Aldrete score
    b. Blood pressure, respirations and heart rate every 15 minutes
    c. Continuous monitoring of oxygen saturation, respirations, and cardiac rhythm
    d. Documentation of vital signs will continue every 15 minutes until the patient reaches discharge criteria defined as an Aldrete score of 8 for 30 minutes or achieves a score equivalent to pre-

procedure levels. If a reversal agent was administered, this monitoring time will be extended to at least one hour after the last reversal agent was administered.

3) Any abrupt deterioration of the patient's condition will be reported to the physician immediately. These include, but are not limited to:
    a. Respiratory rate greater than 20 or less than 10
    b. Oxygen saturation less than 90% or less than pre-procedure levels
    c. Stridor, wheezing or croup symptoms
    d. Shallow or inadequate tidal volumes
    e. Sudden onset of cyanosis
    f. Repeated respiratory obstruction
    g. Systolic blood pressure less than 80% under or more than 20% over preoperative values
    h. Pulse greater than 120 or less than 50
    i. Any cardiac dysrhythmias
    j. Any deterioration in mental status

DISCHARGE:

1) Patients who have received procedural sedation may be discharged when the following criteria are met:
    a. Discharge order from the physician
    b. Vital signs to within +/- 20% of pre-procedure level
    c. Level of consciousness returned to pre-procedure state
    d. Return of baseline motor function, including able to ambulate without assistance (if applicable)
    e. Able to tolerate oral fluids (unless contraindicated)
    f. Pain is manageable
    g. Oxygen saturation maintained at 94% or greater or is stable at pre-procedural level
2) Patient and family education and discharge planning is done and validation that learning took place is documented. Written discharge instructions should cover the following:
    a. Limitations of activity (including operating a motor vehicle or heavy machinery)
    b. Dietary precautions
    c. Medications
    d. Signs and symptoms of complications with a course of action to take
    e. Name and phone number of physician and hospital
    f. Follow-up instructions
3) Transportation home shall be by a responsible adult other than the patient.

Approvals	**Date**
Surgery Tissue	10/26/16
Pharmacy & Therapeutics	12/15/16
Medical Executive Committee	1/3/2017
Board of Directors	

Title: **Procedural Sedation**	
Scope: Clinical Services	Manual: **Anesthesia**
Source: DON Perioperative Services	Effective Date: 2/1/16

ASA SCORING:

American Society of Anesthesiologists grading for anesthetic assessment

1. ASA I - A normal healthy patient without medical problems
2. ASA II - A patient with mild systemic disease (that does not limit activity)
3. ASA III - A patient with moderate or multiple controlled systemic diseases (limits activity, but not incapacitating)
4. ASA IV - A patient with severe systemic disease that is incapacitating and is a constant threat to life
5. ASA V - A moribund patient who is not expected to survive with or without the operation

If any of the above categories is an emergency, it is suffixed with 'E'.

ALDRETE SCORING:

ACTIVITY
Able to move 4 extremities voluntarily or on command = 2
Able to move 2 extremities voluntarily or on command = 1
Able to move 0 extremities voluntarily or on command = 0

RESPIRATION
Able to deep breathe and cough freely = 2
Dyspnea or limited breathing = 1
Apneic = 0

CIRCULATION
BP" 20% of Preanesthetic level = 2
BP" 20-50% of Preanesthetic level = 1
BP" 50% of Preanesthetic level = 0

CONSCIOUSNESS
Fully Awake = 2
Arousable on calling = 1
Not responding = 0

COLOR
Pink = 2
Pale, dusky blotchy, jaundiced, other = 1
Cyanotic = 0

Title: **Procedural Sedation**	
Scope: Clinical Services	Manual: **Anesthesia**
Source: DON Perioperative Services	Effective Date: 2/1/16

DOSING STANDARDS:

Maximum doses are for procedures without the presence of Anesthesiologist or CRNA

Moderate Sedation Agents - Intravenous Administration

Trade Name	Generic Name	Initial Dose	Repeat Dose	Minimal Repeat Dose Interval	Maximum Dose Per Hour
Morphine	morphine sulfate	0.025mg/kg-0.1mg/kg	0.025mg/kg	2 minutes	20 mg
Sublimaze	fentanyl	0.5-1mcg/kg	0.5mcg/kg	2 minutes	500 mcg
Demerol	Meperidine	25-50mg		5-10 minutes	100mg
Versed	midazolam hydrochloride	0.025mg/kg-0.05mg/kg	0.025mg/kg	2 minutes	10mg*

Midazolam (Versed)

*The Physician may exceed the upper dose limit of midazolam (10mg) if in his/her judgement a higher upper limit dose is indicated and the physician remains at the bedside until the patient is transferred to an appropriate level of care.

For Midazolam and Fentanyl given together:

- Use smaller doses and longer intervals between doses in the elderly and patients with compromised hepatic or renal function
- Fentanyl may cause chest wall rigidity, apnea, respiratory depression or hypotension; elicits minimal cardiovascular depression; may cause dysphoria, nausea or vomiting, reversed by naloxone
- Midazolam may cause respiratory depression or hypotension, particularly when administered with a narcotic, reversed by flumazenil

Pediatric Moderate Sedation Agents

Name/Route	Initial Dose	Repeat Dose	Minimal Repeat Dose Interval	Onset/Duration	MAX Dose Per Procedure
Morphine IV	0.05-0.1mg/kg	0.05mg/kg	2 minutes	Duration 60 minutes	0.3mg/kg
Fentanyl IN	2mcg/kg			Onset 10 min	
Fentanyl IV	0.5-1mcg/kg	0.5mcg/kg	2 minutes		5mcg/kg
Versed Oral	0.5-1mg/kg	0.5mg/kg	*	Onset 20-30 minutes Duration 60-90 min	20 mg
Versed IN	0.2-0.4mg/kg	0.2mg/kg	*	Onset 10 min Duration 60 min	*
Versed IV	0.025-0.05mg/kg	0.025-0.05mg/kg	2 minutes	Onset 1-2 minutes Duration 30-60min	*

Title: **Procedural Sedation**	
Scope: Clinical Services	Manual: **Anesthesia**
Source: DON Perioperative Services	Effective Date: 2/1/16

***Check current pediatric sedation references**

Reversal Agents - Intravenous or Intranasal Administration

Trade Name	Generic Name	Initial Dose	Repeat Dose	Minimal Repeat Dose Interval	MAX Dose Per Procedure
Narcan	naloxone	0.1- 0.4 mg SC/IM/IV	0.4mg	3 minutes	2mg/dose May need continuous drip
Romazicon	flumazenil	0.2 mg IV over 15 seconds	0.2mg	1 minute	1mg/dose & 3mg/hr Repeat doses may be given at 20-minute intervals

- Rebound sedation can occur with either reversal agent and may require repeat doses.
- Naloxone can precipitate acute withdrawal symptoms in chronic opioid users.
- Flumazenil can precipitate acute withdrawal seizures in chronic benzodiazepine users which are unresponsive to benzos.

Dissociative Sedation Agent - Ketamine

Route	Initial Dose	Repeat Dose	Minimal Repeat Dose Interval	Onset/Duration	MAX Dose Per Procedure
IM	4-5mg/kg	2mg/kg	5 minutes	5-10 minutes 30 minutes	
IV	1-1.5mg/kg over 1-2 minutes	0.5mg/kg	3 minutes	1-2 minutes 20 minutes	

- Increases bronchial and salivary secretions, heart rate, blood pressure and intracranial pressure, emergence hallucinations observed >15 yo, NOT reversible
- May add atropine 0.01mg/kg (min 0.1mg, max 0.5mg) to same syringe to decrease salivation
- May add midazolam 0.1mg/kg IM or 0.05mg/kg IV for emergence reactions or agitation, will slow recovery time.
- May cause vomiting during recovery

Deep Sedation Agents

Trade Name	Generic/Route	Initial Dose	Repeat Dose	Min Interval	Onset/Duration	MAX Dose Per Procedure
Brevital	Methohexital -Rectal	25mg/kg			Onset 15 min	500mg
	Methohexital -IV	1-1.5mg/kg slow IVP	0.5mg/kg	3 minutes	Duration 5-7 min	

Amidate	Etomidate -IV	0.1-0.2mg/kg	0.1mg/kg	2 minutes	Onset <1 min Duration 5-10 min	
Diprivan	Propofol IV	0.5-1mg/kg	0.5mg/kg	1 minute	Onset <1 min Duration 5-10 min	4mg/kg

- Methohexital is an ultra-short-acting barbiturate providing good immobilization and hypnosis, paradoxical excitation may occur, NOT reversible
- Etomidate commonly causes myoclonus and pain upon injection; may cause adrenal suppression, nausea, vomiting, or lower the seizure threshold; no hemodynamic effect; causes a slight to moderate decrease in intracranial pressure for several minutes; useful for patients with trauma and hypotension, NOT reversible
- Propofol provides rapid onset and recovery phase of deep sedation with brief duration of action, has anticonvulsant properties; causes cardiovascular depression and hypotension, NOT reversible
    - Requires one physician dedicated to the airway while another provider performs the procedure

Reviewed: AW 9/12, 10/16 AW

NORTHERN INYO HOSPITAL
POLICY AND PROCEDURE

Title: Patient Restraints	
Scope: NIH	Manual: CPM - Patient Safety (PS), Nursing Administration Manual (NAM)
Source: DON ACUTE & SUBACUTE	Effective Date: 2/18/16

PURPOSE:

To delineate standards of care for the patient who is restrained which promotes an environment conducive to maintaining patient dignity, while protecting patient safety.

POLICY:

A. It is the policy of Northern Inyo Hospital (NIH) to create a physical, social and cultural environment that limits the use of restraint to appropriate and justified situations, and, to reduce restraint use through preventive or alternative methods which focus on the patient's rights, dignity and well-being. Patients have the right to be free from restraints of any form that are not medically necessary. Restraint may only be imposed to ensure the immediate physical safety of the patient, staff, or others and must be discontinued at the earliest possible time.

B. The decision to use a restraint is not driven by diagnosis. Comprehensive assessment of the patient and environment, in conjunction with individualized patient care planning, should be used to determine those interventions that will best ensure the patient's safety and well-being with the least risk. The comprehensive assessment should include a physical assessment to identify medical problems that may be causing behavior changes in the patient. Restraint may only be used if needed to improve the patient's well being when less restrictive interventions have been determined to be ineffective in protecting the patient and others from harm. Restraints, if deemed appropriate, are implemented using safe techniques identified in this policy and reinforced during annual staff education. The restraint shall be discontinued at the earliest possible time, regardless of the scheduled expiration of the order.

C. Patient's rights, dignity and well-being are protected during restraint use to assure the following:

   1. Respect for the patient as an individual

   2. Safe and clean environment

   3. Protection of the patient's modesty, visibility and body temperature

D. The hospital does not permit restraint for management of violent or self-destructive behavior to be used for the purpose of coercion, discipline, convenience, or staff retaliation. Restraints are never a substitute for adequate staffing.

E. The patient and family will be informed of the organization's policy/procedure on the use of restraints.

   1. Staff will explain the need for the use of restraint to the patient/family/ significant other to increase their understanding and decrease their fears about the use of restraint.

   2. Patient and/or family will be encouraged to be involved in decision-making. Incorporating patient/family preferences in the care process may help minimize restraint use.

   3. The patient/family/significant other are assured that the least restrictive device will be utilized, that restraints are discontinued as soon as possible, and that the patient's basic needs for nutrition, personal care, and exercise are met during the use of the restraint.

4. In the event that the patient chooses not to include the family/significant other, or that participation would have a detrimental effect on the patient, family/significant other involvement would not be applicable.

5. Staff will attempt to promptly contact the family to notify them when restraints are used as appropriate.

F. The use of restraints must be in accordance with the telephone order or written order of a physician.

G. A Registered Nurse (RN) may make the decision to initiate a restraint in an emergent situation when the risk to the patient is such that an order from a physician cannot be obtained before restraining the patient.

H. Per the restraint orders, the RN may discontinue restraints prior to the expiration of the order when the action/behavior leading to the need for restraints is no longer evident. If the restraints must be re-initiated, another order must be obtained.

DEFINITIONS:

A. Physical Restraints: Physical restraint is any manual or physical method or mechanical device, material, or equipment that immobilizes or reduces the ability of a patient to move his or her arms, legs, or head freely.

1. Bed side rails: Side rails present an inherent safety risk, particularly when the patient is elderly or disoriented. Even when they are not used intentionally as a restraint, patients may become trapped between the mattress or bed frame and the side rail.

   a. Side rails used to physically restrict a person's freedom of movement or physical activity in order to protect the patient or others from injury is considered restraint. Therefore, when all four side rails of a four rail system are raised, it is considered a restraint.

   b. Individual patient needs are assessed for the use of side rails.

   c. Infants and children will have crib rails and side rails up at all times which are not considered restraint.

   d. The upper two side rails of a four rail system may be placed in the up position to provide patient access to bed control, the nurse call system, or to assist the patient in turning in bed and are not considered restraint.

   e. The upper two side rails and one lower side rail of a four-rail system or one side of a two-rail system may be up for patient protection and comfort as long as the patient's ability to get out of bed is not restricted and are not considered restraint.

   f. The upper and lower two side rails of a four rail system on specialty beds (i.e. lateral rotation beds) may be up for patient protection and in order for the bed to properly operate and are not considered restraint.

2. Devices and Immobilization

   a. Devices, which serve multiple purposes when they have the effect of restricting a patient's movement and cannot be easily removed by the patient, constitute a restraint. (e.g. Geri chair, elbow immobilizers to prevent the patient from reaching tubes, etc.)

b. Patient assessment for the use of the device should be based on the least risk for the patient and the risk of what might happen if the device is not used versus the risk it poses as a restraint.

B. Drugs used as a restraint: Chemical restraint is defined as medication used as a restriction to manage the patient's behavior or restrict the patient's freedom of movement and is not standard treatment for the patient's medical or psychological condition. These are medications used in addition to or in replacement of the patient's regular drug regimen to control aggressive and/or violent behavior during an emergency.

1. A standard treatment for a medication used to address a patient's condition would include all of the following:

   a. The use of the medication follows national practice standards established or recognized by the medical community and/or professional medical association or organization.

   b. The use of the medication to treat a specific patient's clinical condition is based on that patient's symptoms, overall clinical situation, and on the physician's knowledge of that patient's expected and actual response to the medication.

   c. If the overall effect of a medication is to reduce the patient's ability to effectively or appropriately interact with others, then the medication is not being used as a standard treatment for the patient's condition.

   d. Whether or not the use of a medication is voluntary, or even whether the drug is administered as a one-time dose or PRN are not factors in determining if a drug is being used as a standard treatment. The use of PRN medications is only prohibited if the drug is being used as restraint.

2. NIH does not use chemical restraints as a means of coercion, discipline, convenience or retaliation by staff. Medications that comprise the patient's regular medical regimen (including PRN medications) are not considered drug restraints, even if their purpose is to control ongoing behavior.

C. Seclusion: Seclusion of an individual is involuntarily confining an individual alone in a room or area where he/she is physically prevented from leaving. NIH's policy and practice prohibits the use of seclusion.

D. NIH prohibits the use of restraints when the patient is in a prone position.

E. Exceptions: Therapeutic or protective interventions that, although they may restrict activity, are ***not*** considered restraint interventions include:

1. A restraint does not include devices, such as prescribed orthopedic devices, surgical dressings or bandages, protective helmets, or methods that involve the physical holding of a patient for the purpose of conducting routine physical examinations or tests.

2. A restraint does not include methods that protect the patient from falling out of bed.

   a. Examples include raising the side rails when a patient is on a stretcher; recovering from anesthesia; sedated; on seizure precautions, experiencing involuntary movement; or on certain types of therapeutic beds to prevent the patient from falling out of the bed.

3. Age or developmentally appropriate protective safety interventions (such as stroller safety belts, swing safety belts, highchair lap belts, raised crib rails and crib covers) that a safety-conscious child care provider outside a

healthcare setting would utilize to protect an infant, toddler or preschool-aged child would not be considered restraint or seclusion for the purposes of this regulation.

4. A physical escort would include a "light" grasp to escort the patient to a desired location

    a. If the patient can easily remove or escape the grasp, this would not be considered physical restraint. However, if the patient cannot easily remove or escape the grasp, this would be considered physical restraint and all the requirements would apply.

5. A voluntary mechanical support used to achieve proper body position, balance, or alignment so as to allow greater freedom of mobility than would be possible without the use of such a mechanical support is not considered a restraint (e.g. knee immobilizers for medical clinical purposes, abductor pillow, postural support, or orthopedic devices).

6. A position or securing device used to maintain the position, limit mobility or temporarily immobilize the patient during medical, dental, diagnostic or surgical procedures.

7. The use of handcuffs or other restrictive devices applied by law enforcement officials for custody, detention, and public safety reasons is not considered restraint.

8. Placing hand mitts on a patient to prevent the patient from pulling on tubes or scratching him or herself would not be considered a restraint. However, pinning or otherwise attaching those same mitts to bedding or using a wrist restraint in conjunction with the hand mitts would meet the definition of restraint and the requirements would apply. In addition, if the mitts are applied so tightly that the patient's hand or fingers are immobilized, this is considered a restraint and the requirements would apply.

9. A medication used to control a patient's behavior that is standard treatment for the patient's medical or psychiatric conditions (i.e. drug or alcohol withdrawal, psychiatric diagnosis) is not considered chemical restraint.

10. If the patient is on a stretcher, there is an increased risk of falling from a stretcher without raised side rails due to its narrow width and high center of gravity. Additionally, since stretchers are elevated platforms, the risk of patient injury due to a fall is significant. Therefore, the use of raised side rails are not considered restraint but a prudent safety intervention.

F. The following functional guidelines should be considered when defining an intervention as a physical restraint:

1. Does the patient have the ability and skill to easily remove the intervention? (If the answer is no, then intervention is a restraint).

2. Is the patient's freedom to move when the intervention is in place less than their freedom to move without the intervention, or is the patient's access to their body when the intervention is in place less than their access to their body without the interventions? (If the answer is yes, then intervention is a restraint).

3. Utilization of a functional assessment allows for individual assessment of each device and situation that could potentially be used to inhibit an individual's movement. Therefore, if the effect of using an object fits the definition of restraint for a patient at a specific point in time, then for that patient, the device is a restraint.

NORTHERN INYO HOSPITAL
POLICY AND PROCEDURE

Title: Patient Restraints	
Scope: NIH	Manual: CPM - Patient Safety (PS), Nursing Administration Manual (NAM)
Source: DON ACUTE & SUBACUTE	Effective Date: 2/18/16

APPROVED TYPES OF RESTRAINTS

A. **Soft limb restraints**
B. **Four (4) siderails up (See definitions)**
C. **Mitts**
D. **Safety vest**

ALTERNATIVES TO RESTRAINTS/LEAST RESTRICTIVE DEVICE

A. Alternatives to restraints do not always need to be tried, but prior to the use of restraints; alternative interventions must be determined to be ineffective to protect the patient or others from harm.

B. Alternatives attempted or rationale for not attempting alternatives must be documented.

C. Efforts are taken to develop and promote preventive strategies and use safe and effective alternatives when appropriate as follows:

1. Identify and treat the cause of the behavior (e.g. medical re-evaluation, reposition, put to bed if fatigued, change environmental noise level, lighting, furnishings, or equipment, or if possible, change or eliminate bothersome treatments).

2. Increase observation/supervision.

3. Involve the family and significant others.

4. Provide diversionary measures (e.g. formal activities, visitors, exercise, reorganize the ADLs).

5. Consider and eliminate barriers; manipulate the environment (e.g. increase the lighting, leave side rails down, decrease noise, call bell accessible).

6. Re-orient patients/provide reality orientation.

7. Evaluate medication regimen (e.g. pain, agitation, and initiation).

D. The use of restraints may only be used when less restrictive interventions have been determined to be ineffective to protect the patient or others from harm.

Examples of Alternatives to Physical Restraints

All behaviors can be viewed as a symptom and each may arise from a variety of causes or be indicative of an array of unmet needs. Medical re-evaluation is always appropriate. Involvement of the interdisciplinary team (i.e. OT/PT assessment) may identify additional alternatives.

Observe the patient's behavior, investigate its meaning, and develop creative and individualized alternatives. Educate the patient and family to reduce the use of physical restraints.

Behavior Exhibited	Suggested Options, if available

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Falls	Bathroom rounds Grab rails and raised toilet seats Side rails kept down Bed in low position Increase the light in the room Eliminate hazards, clear a path Ambulate frequently / supervised ambulation Bed Alarm / Chair Alarm Family supervision Call bell within reach Wear supportive shoes Gripping rubber mats / nonslip surface in chairs Keep patient in view of staff Wedge cushions Adequate pain medication Place commode at bedside Provide glasses, hearing aid, dentures, purse, etc. If fatigued and in the chair, transfer to the bed Place pillow or rolled blanket under mattress to create lip at edge Evaluate meds to decrease the possibility of side effects Make sure clothing, tubing, etc. not interfering with walking Consult with PT for alternatives
Scratching	Eliminate itch and treat the cause Diversional activities
Pulling at Tubes	Wear Briefs over Foley catheter Hide or camouflage IV tubing Get tubes out as soon as possible Provide patient something else to "fiddle" with Consider alternatives for NG tubes
Pulling at wounds or dressings	Overdress wounds Hide or camouflage dressings Medicate for pain Supervise confused patients carefully Use abdominal binders when possible Evaluate to see if tape or dressing is itching Try calming music / distract the patient with TV, activities, etc. Consult with school program for learning activities If active play activities are not available, provide stimulation

	with music, audio books, and mobiles. colorful surroundings, etc.
Wandering	Determine where the patient is going and why Anticipate needs; learn past patterns and coping styles Have hearing aid and glasses available Use STOP signs Decrease stimuli (ex. light, noise, interruptions) Exercise patient or walk them frequently Reminisce and validation Use alarms Family / friend / volunteer supervision Test for urinary tract infections (UTI) and treat as indicated and ordered Assess pain level. Treat as indicated and ordered Place bed in lowest position Reality orientation / psychosocial intervention Offer interesting TV program, game or activity Consult with OT / PT for alternatives
Rummaging and Scavenging	Busy boxes Reorientation Family / friend / volunteer supervision
Combative	Control for visual and auditory stimuli Music therapy and relaxation tapes Assess pain level or medication side effects Explain slowly what you are trying to do and move slowly Rest periods Contracting, when appropriate Consistent personnel Family / friend / volunteer involvement Provide reality links: TV, radio, calendar, clock Explain procedures to reduce fear and convey a sense of calm Involve the patient in conversation, don't talk over them Use active listening to elicit the patient's perspective Allow patient I family as much control over daily routine as possible

E. When an individual patient's assessed needs indicate the use of restraint, the least restrictive means should be chosen. For example, hand mittens for a patient who is scratching an irritated skin rash may be effective instead of the more restrictive soft wrist restraints.

F. Less restrictive measures may still constitute a restraint for which an order must be obtained if the patient cannot readily remove the device.

RESTRAINTS TO PREVENT INTERFERENCE WITH MEDICAL AND SURGICAL CARE

A. Definition of Restraints used for non-behavioral health patients (Non-violent and non-self destructive behavior) purposes

1. The patient is performing some action that interferes or has the potential to interfere with medical and /or surgical healing.

a. The patient pulls at, attempts to remove, actually removes, or dislodges IVs, drains, tubes, surgical dressings or other therapies or treatments.

b. The patient gets out of bed unassisted when assessed as unstable or when activity may be detrimental to the patient.

B. Clinical Justification

1. After assessing/evaluating a patient's physical or emotional condition, and despite attempts at alternative solutions, the documented continuance of a patient activity that will interfere with medical therapy justifies initiation or continued use of restraints.

2. If, based on a complete nursing assessment/evaluation, an RN assesses a patient to need a restraint to prevent interference with medical and surgical care, then that RN shall notify the patient's treating physician who may give an order for restraints.

C. Initiation of Restraints

1. If the patient is not in immediate danger, the RN may obtain an order for the restraint prior to applying restraints.

2. The RN may only apply restraints to prevent interference with medical and surgical care without receiving a physician's order if the patient's safety will be jeopardized without immediate use. The RN, after appropriate assessment, may make the decision to initiate and apply a restraint if the physician is not immediately available.

a. The RN who determines that the patient requires restraints will notify the physician and obtain a telephone order or written order. The order must be obtained immediately (within 1 hour) after the initiation of restraints. If the episode that led to restraints is a significant change for the patient, the physician will be notified immediately.

b. A physician will examine the patient within 24 hours of initiation of restraint used to prevent interference with medical or surgical care, and will enter a written order into the patient's medical record.

D. Physician's Order

1. A physician's order for the management of non-behavioral health patients (Non-violent and non-self destructive behavior) must be obtained for each restraint episode.

2. Restraint orders must include:

   a. Date and time order was written

   b. Restraint category: Non-behavioral health patients (Non-violent and non-self destructive behavior)

   c. The type of restraint to be used

   d. Time specific

   e. The reason for restraint (i.e. patient's behavior and staff concerns regarding safety risks to the patient, staff, and others that necessitated the use of restraint).

   f. Signature of a physician in the appropriate time frame.

   g. Cannot be written as “PRN."

3. Each written order for a physical restraint to prevent interference with medical and surgical care is to be renewed no less often than every twenty four (24) hours.

4. Example of Physician order

   a. Restrain wrists for up to twenty-four hours using soft wrist restraints to prevent dislodging IV tubes.

E. Physician Assessment and Continuation of Restraint orders

Continued use of restraints beyond the first 24 hours is authorized by a physician renewing the original order or issuing a new order if restraint continues to be clinically justified.

1. Such renewal or new order is issued no less often than every 24 hours and is based on a documented face-to-face examination of the patient by the physician. The physician reevaluates the efficacy of the patient's treatment plan and works with the patient to identify ways to help him or her regain control.

2. If the patient's attending physician is not the physician who has ordered the restraint, then the patient's attending physician should be notified of the initiation of the restraint order as soon as possible.

F. Early Termination

1. The restraint will be terminated as soon as possible when the initial action is no longer evident or alternatives are effective.

2. The physician may make the decision to discontinue the restraint based on current assessment and evaluation of the patient's condition. CMS 482.13(e)

G. Re-application

1. If a patient was recently released from interference with medical and surgical care restraint due to non-behavioral health (Non-violent and non-self destructive behavior) and exhibits behavior that can only be handled by the reapplication of restraint, a new order is required.

2. Staff cannot discontinue an order and re-start it under the same order because that would constitute a PRN order. Each episode of restraint use must be initiated in accordance with the order of a physician.

3. A temporary release that occurs for the purpose of caring for a patient's needs-for example toileting, feeding, and range of motion or assessing whether restraints can be discontinued is not considered a discontinuation of restraint.

H. Observation/ Ongoing Assessment of the Patient

1. An RN/LVN/CNA who has demonstrated competency in the application and monitoring of restraints may apply and monitor the restraints.

2. The RN is responsible to assess the patient on an ongoing basis and determine whether restraints should be continued or terminated.

3. After applying restraints, immediately perform an initial assesment to ensure the well being of the patient, safe and proper application, , and that there is no evidence of injury. If the patient's response is negative, make immediate changes.

4. During the period of restraint, the patient must be monitored and assessed at a frequency that is determined by the needs of the patient, his/her condition, and the type of restraint used. This can be accomplished by observation, interaction with the patient, or direct assessment and will be done at a minimum of every 2 hours. Documentation of assessment will include relevant orders for use, results of patient monitoring, reassessment, and significant changes in patient's condition.

   a. Assessment for patients who are restrained with soft limb restraints, mitts, or side rails, will be documented at least every 2 hours.

5. The RN assessment includes the following:

   a. Skin Integrity (e.g. dry & intact, redness or swelling, abrasions)

   b. Circulation/sensation/movement (CSM) of affected extremities

   c. Well-being - the patient's physical and emotional well-being is addressed

   d. Application: the restraint is safely and properly applied

   e. Signs of injury associated with applying restraint

f. Vital Signs: Done if per patient physical/emotional status the RN assesses the need for vital signs

g. Release and ROM to restrained extremity every 2 hours

h. Whether less restrictive methods are possible

i. If the patient's behavior or clinical condition is appropriate to need continuation of restraints or if termination is possible.

j. Dignity and rights are maintained. Attention is given and interventions are provided to meet the patient's physical needs including but not limited to:

1) Hydration

2) Nutrition

3) Elimination

4) Hygiene

RESTRAINTS FOR MANAGEMENT OF VIOLENT AND/OR SELF-DESTRUCTIVE BEHAVIOR

A. Definition: Behavioral health (Violent and/or self destructive behavior) Restraint

1. The patient is displaying assaultive/ aggressive behavior that poses imminent risk of physical harm to him/her, the staff and/or others.

2. Restraints for management of violent or self-destructive behavior is an emergency measure that should be reserved for those occasions when unanticipated aggressive or destructive behavior places the patient or others in imminent danger and nonphysical intervention would not be effective.

3. The use of restraints for the management of violent or self-destructive behavior is not based on a patient's restraint history or solely on a history of dangerous behavior.

4. Whenever possible, non-physical interventions are used to avoid the use of restraints for the management of violent or self-destructive behavior through de-escalation techniques. when there is an imminent risk of physical harm, physical interventions will need to be applied.

B. Clinical Justification

1. After assessing/evaluating a patient's emotional condition, and after consideration or trial of alternative solutions, the documented continuance of a patient behavior that gives reasonable probability of harm to self or others justifies the initiation or continued use of restraints.

2. The RN must justify the use of the restraint in the patient's medical record. This includes the specific behavior that placed the patient or others at risk and the alternatives attempted.

NORTHERN INYO HOSPITAL
POLICY AND PROCEDURE

Title: Patient Restraints	
Scope: NIH	Manual: CPM - Patient Safety (PS), Nursing Administration Manual (NAM)
Source: DON ACUTE & SUBACUTE	Effective Date: 2/18/16

C. Initiation of Restraints

1. In an emergent condition when the RN has assessed the patient and evaluates that the behavior is aggressive/assaultive then the RN may make the decision to restrain the patient.

2. The RN must inform the physician for the need for restraints for the management of violent or self-destructive behavior, obtain a telephone order or written order, and consult with the physician about the patient's physical and psychological condition immediately (within 1 hour) after initiation of the restraint.

3. The in-person evaluation and documentation by the physician, conducted within 1 hour of the initiation of restraint for the management of violent or self-destructive behavior that jeopardizes the physical safety of the patient, staff or others, includes the following:

   a. An evaluation of the patient's immediate situation.

   b. The patient's condition or symptom(s) that warranted the use of the restraint.

   c. Alternatives or less restrictive interventions attempted (as applicable).

   d. The patient's medical and behavioral condition.

   e. A description of the intervention used.

   f. The patient's response to the intervention used, including the need to continue or terminate use of restraint.

D. Physician Order

1. A physician's order for a restraint for management of behavioral health restraints (violent and/or self-destructive behavior) must be obtained for each restraint episode.

2. Restraint orders must include:

   a. Date and time order was written.

   b. Restraint category: Behavioral Health (Management of Violent and/or Self-Destructive Behavior).

   c. Type of restraint to be used.

   d. Time specific.

   e. Reason for restraint; description of the patient's behavior'

   f. Signature of a physician within the appropriate period of time.

   g. Cannot be written as "PRN."

3. Verbal and written orders for restraints used for the management of behavioral health (violent and/or self-destructive behavior) are time-limited as indicated below. Orders may be renewed according to the time limits for a maximum of 24 consecutive hours.

    a. 4 hours for adults ages 18 and older

    b. 2 hours for children and adolescents ages 9-17

    c. 1 hour for children under 9 years of age.

E. Physician Assessment and Continuation of Restraints

1. The physician must complete a face-to-face evaluation of the patient and evaluate the need for restraint within one hour after the initiation of the restraint. A telephone call is not adequate.

2. Upon initiation of restraints for management of violent or self-destructive behavior and on an ongoing basis, the physician will provide the following:

    a. Reviews with staff the physical and psychological status of the patient and supplies staff with guidance in identifying ways to help the patient regain control so that restraints can be discontinued.

    b. Reevaluates the efficacy of the patient's plan of care, treatment, and services and determines whether restraints should be continued.

    c. Works with the patient to identify ways to help regain control.

    d. Supplies the order.

3. When restraint is continued for management of violent or self-destructive behavior and the individual providing the order is someone other than the patient's physician, the patient's responsible physician is notified of the patient's status.

4. The physician reevaluates the efficacy of the patient's treatment plan and works with the patient to identify ways to help him or her regain control.

5. Every 24 hours, the physician primarily responsible for the patient's ongoing care evaluates the patient in person before writing a new restraint order for management of violent or self-destructive behavior that jeopardizes the immediate physical safety of the patient, staff, or others.

6. If the patient is released from restraint used for management of violent or self-destructive behavior prior to the expiration of the original order, the physician still has to conduct an in-person evaluation of the patient within 24 hours of the initiation of restraint and original order.

F. Early Termination

1. The use of physical restraint must be limited to the duration of the emergency safety situation regardless of the length of the order. The physician has the discretion to decide that the order should be written for a shorter

period of time. Staff should assess, monitor, and assist the patient to regain control, and re-evaluate the patient so that he or she is released from the restraints at the earliest possible time.

2. The physician may make the decision to discontinue the restraint based on current assessment and evaluation of the patient's condition. CMS 482.13(F)

G. Reapplication of Restraints

1. If the patient was recently released from restraints for the management of violent or self-destructive behavior and exhibits behavior that can only be handled by the reapplication of restraint, a new order is required.

2. Staff cannot discontinue an order and re-start it under the same order if the patient's behavior escalates again after he or she has been released. Each episode of restraint use must be initiated in accordance with the order of a physician; PRN orders are prohibited

3. A temporary release that occurs for the purpose of caring for a patient's needs - for example toileting, feeding, and range of motion - or assessing whether restraints can be discontinued is not considered a discontinuation of restraint.

H. Observation/Ongoing Assessment of Patients

1. During the time of restraint use for the management of violent or self-destructive behavior, there will be continuous in-person observation by an assigned staff member who is competent in the use of restraints.

2. During the period of restraint use for management of violent and/or self-destructive behavior, all patients must be monitored and assessed at a frequency that is determined by the needs of the patient, his/her condition, and the type of restraint used. This can be accomplished by observation, interaction, or direct assessment.

3. After applying restraints, the RN will immediately perform an initial assessment to ensure the well being of the patient, safe and proper application, and that there is no evidence of injury. If the patient's response is negative, make immediate changes.

a. Assessment of the patient in restraints for management of violent or self-destructive behavior is performed at the initiation of restraints and minimally every 15 minutes thereafter. This assessment includes the following:

b. Skin Integrity (e.g. dry & intact, redness or swelling, abrasions)

c. Circulation/sensation/movement (CSM) of affected extremities

d. Well-being. The patient's physical and emotional well-being is addressed

e. Application: the restraint is safely and properly applied

f. Signs of injury associated with applying restraint

g. Vital Signs: Completed if the RN’s assessment warrants the need for vital signs

h. Release and range of motion (ROM) to restrained extremity every 15 minutes

i. Whether less restrictive methods are possible

j. If the patient's behavior or clinical condition is appropriate to need continuation of restraints or if termination is possible

k. Dignity and rights are maintained. Attention is given to the patient's needs including but not limited to:

1) Hydration

2) Nutrition

3) Elimination

4) Hygiene

5) Physical or psychological status and comfort.

4. If the patient is in a physical hold for management of violent or self-destructive behavior, another staff person who is competent in the use of restraint and who is not involved in the physical hold is assigned to observe the patient.

5. Staff members help patients meet behavior criteria for discontinuing restraints for management of violent or self-destructive behavior by attempting alternatives and providing for less restrictive measures whenever possible.

a. Assisting to meet behavior criteria for discontinuing restraints for management of violent or self-destructive behavior can include the following interventions:

1) Appropriate implementation of medical plan of care to stabilize the disease process causing the aggressive/assaultive behavior

2) Decrease environmental stimuli to a minimum

3) Set clear, consistent, and enforceable limits on behavior

4) Attend and respond positively to patient anxiety or anger with active listening and validation of patient distress

5) Work with patient to identify the internal and interpersonal factors that provoke violence/aggression

6) Work with patient to identify what supports are lacking and problem-solve ways to achieve needed support

7) Role-play alternative behaviors with patient that they can use in stressful and overwhelming situations

8) Work with patient to set goals for their behavior

9) Provide patient with other outlets for stress and anxiety

10) Provide patient and family/significant other with community resources that teach anger management and stress reduction techniques

11) Utilize de-escalation techniques for staff who are trained in this

:

RESTRAINT APPLICATION

A. Competent staff applies restraint corr.ctly and appropriately to protect patient safety.

~~B.~~ Please reference Lippincott for limb and vest restraint application.

~~C. Restraint devices are attached to the bed frame using a slipknot. If the bed is adjustable, secure the restraint to the parts of the bed that move with the patient, except the side rails, to avoid constricting the Patient.~~

B.

~~D. Maintain patient's proper body alignment.~~

~~E.~~C. If a patient must be restrained in the supine position, ensure that the head is free to rotate to the side and, when possible, the head of the bed is elevated to minimize the risk of aspiration.

~~F.~~D. Secure Restraint so that it may be released immediately in emergency situations.

~~G.~~E. Verify that the order for restraint includes rationale for restraint, length of time and type of restraints to be used, and extremity or body part(s) to be restrained

~~H.~~F. All limb restraints are to be kept in full view and not covered with sheet or bedspread.

DOCUMENTATION

A. Documentation of restraint application for non-behavioral health (non-violent, non-self destructive behavior), or for behavioral health (violent and/or self-destructive behavior) includes the following:

1. In the Electronic Health Record (EHR)

   a. Initial assessment/clinical justification that includes the patient's behavior or actions that led to the use of the restraint.

   b. Alternatives/Interventions attempted before use of restraint or rationale on why these were not appropriate with this patient.

   c. Choice of less restrictive means as applicable.

   d. Time of application and termination.

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e. Family notification of restraint application, if appropriate

f. When the patient no longer needs to be restrained, documentation must include the time and rationale for removal from restraints

g. Physician's order, which includes type of restraint, time limit and reason for restraint.

2. Patient family teaching is documented on the Restraint Education section.

CARE PLANNING

A. A modification to the patient's plan of care must accompany the use of restraints for either Non-behavioral health (Non-violent, non-self destructive behavior) or management of behavioral health (violent and/or self-destructive behavior)

B. Nursing documentation will reflect assessment intervention, evaluation, and re-intervention process with a focus on utilizing the restraint for the shortest period of time and the least restrictive measures

C. Care plan modifications may include but are not limited to the following:

1. Patient care problem

2. Outcome-oriented goal

3. Restraint intervention used

4. The Nursing documentation will reflect the date the restraint was initiated and discontinued and appropriate interventions taken to ensure patient safety

EDUCATION

A. Physicians and other licensed independent practitioners authorized to order restraints are educated on the policy during their orientation. Education on policy changes occurs during policy review and approval at medical department meetings

B. Education and training in the proper and safe use of restraints shall be provided as part of the employee's initial orientation and before participating in the use of restraints. Competency will be evaluated during orientation and annually. The nursing department education plan will include annual restraint education.

C. Education and training of staff with direct patient contact shall include but not be limited to:

1. Hospital policy on restraints

2. Understanding that behaviors are sometimes related to the patient's medical condition

3. The use of alternative interventions and least restrictive measures

4. The initiation, safe application, and removal of all types of restraints used including monitoring and reassessment criteria. Training includes how to recognize and respond to signs of physical and psychological distress, and patient monitoring/observation/assessment and reassessment parameters.

5. Monitoring the physical and psychological well-being of the patient who is restrained, including, but not limited to, respiratory and circulatory status, skin integrity, vital signs, and any special requirements specified by hospital policy associated with the in-person physician evaluation conducted within one hour of initiation of behavioral health (Violent and/or self destructive behavior) restraints.

6. Patient comfort, modesty, well being, dignity, rights and respect, hygiene, psychological status, elimination, nutrition, hydration needs and to recognize signs of physical distress in restrained patients.

7. Strategies to identify staff and patient behaviors, events, and environmental factors that may trigger circumstances that require the use of behavioral restraints.

8. Determination of underlying causes of behavior that may be related to a medical condition. (i.e. hypoglycemia, DTs, delirium and how that may be related to the patient's emotional condition).

9. Recognition of how age, developmental considerations, gender issues, ethnicity, and history of sexual or physical abuse may affect the way an individual reacts to physical contact and restraints.

10. Use of nonphysical intervention skills

11. Methods for choosing the least restrictive interventions based on an assessment of the patient's medical or behavioral status or condition

12. Use of first aid techniques and certification in the use of cardiopulmonary resuscitation, including required periodic recertification.

13. Clinical justification of specific behavioral changes that indicate that restraints are no longer necessary

PERFORMANCE IMPROVEMENT

REPORTING OF PATIENT DEATHS ASSOCIATED WITH RESTRAINT

NIH must report deaths associated with restraint to its CMS regional office no later than the close of business the next business day following knowledge of the patient's death. [CMS 482.13(f)(7)]

NIH must report to its CMS Regional Office each death that occurs:

1. While a patient is in restraint, except when no seclusion has been used and the only restraint used was a soft, cloth-like 2-point wrist restraint.

    a. Deaths occurring during or within 24 hours of discontinuation of 2-point soft, cloth-like non-rigid wrist restraints used in combination with any other restraint device must be reported to CMS.

    b. Death associated with the use of other types of wrist restraints, such as 2-point rigid or leather wrist restraints must be reported to CMS.

2. Within 24 hours after the patient has been removed from restraint or seclusion, except when no seclusion has been used and the only restraint used was a soft, 2-point wrist restraint

3. Within one (1) week after use of restraint or seclusion where the death is known to the hospital and it is reasonable to assume that the use of restraint or seclusion contributed directly or indirectly to the patient's death, regardless of the type(s) of restraint used on the patient during this time

Patient Death Reporting- Only in 2-Point Soft Wrist Restraints and no seclusion:

NIH must maintain an internal log or other type of tracking system for recording information within seven (7) days of a patient's death that occurs:

1. While a patient is only in 2-point soft, cloth-like non-rigid wrist restraints and there is no use of seclusion; and

2. Within 24 hours of the patient being removed from 2-point soft, cloth-like non-rigid wrist restraints where there was no use of any other type of restraint or seclusion

This log must be made readily available to CMS immediately upon request.

It is the responsibility of the Chief Performance Excellence Officer or his/her designee to report the incident to CMS after notification of hospital group administration and document in the patient's medical record the date and time the death was reported to CMS.

REFERENCES

- Centers for Medicare and Medicaid Services (CMS). Federal Register Part IV: Department of Health and Human Services. Medicare and Medicaid Programs; Hospital Conditions of Participation: Patient's Rights; Final Rule. December 8, 2006. 42 CFR Part 482: (pp.71378-71428).
- Centers for Medicare and Medicaid Services (CMS). Restraint Rate per 1000 LTCH Days Measure Specifications*. June 11, 2012. https://www.cms.gov/medicare/quality-initiatives-patient-assessment-instruments/ltch-quality-reporting/downloads/restraintrateper1000-ltchdaysmeasurespecifications.pdf
- Centers for Medicare and Medicaid Services (CMS), State Operations Manual, Appendix A-Survey Protocol, Regulations and Interpretive Guidelines for Hospitals, 04-01-2015
- California Department of Public Health, Licensing and Certification Program, General Acute Care Hospital Memorandum, Subject: Centers for Medicare and Medicaid (CMS) Death Reporting Requirements, August 3, 2009.
- Joint Commission on Accreditation of Healthcare Organizations. Comprehensive Accreditation Manual for Hospitals Update 1, June 2010(pp. PC.03.02.01-PC.03.02.11) Oakbrook Terrace, IL: Joint Commission Resources, Inc.
- Management of Aggressive Behavior. MOAB Training International, Inc. 2007. Kulpsville, PA: Cricket Press, Inc.
- Title 22, California Code of Regulations, Division 5. Licensing and Certification of Health

NORTHERN INYO HOSPITAL
POLICY AND PROCEDURE

Title: Patient Restraints	
Scope: NIH	Manual: CPM - Patient Safety (PS), Nursing Administration Manual (NAM)
Source: DON ACUTE & SUBACUTE	Effective Date: 2/18/16

Facilities, Home Health Agencies, Clinics, and Referral Agencies, section 73095, 73403-73409.2005. State of California, Office of Administrative Law.
- Varcarolis, EM. Manual of Psychiatric Nursing Care Plans: Diagnoses, Clinical Tools, and
- Psychopharmacology, 3rd edition. 2006. (pp. 497-517). St Louis, MO: Saunder Elsevier.

CROSS REFERENCE P&P:
1. Forensics
2. Lippincott limb restraint application
3. Lippincott vest restraint application

Committee Approval	Date
CCOC	**1/11/16**
NEC	**12/16/15**
Med/ICU	**1/28/2016**
Peri-Peds	**2/1/2016**
Medical Executive Committee	**2/2/16**
Board of Directors	**2/17/16**

Developed: 1/10/2015
Reviewed:
Revised: **12/5/2016**
Supercedes:

NORTHERN INYO HOSPITAL
POLICY AND PROCEDURE

Title: Swing Bed Patient Restraints	
Scope: Acute/Subacute Services	Manual: CPM- Patient Safety (PS), Nursing Administration Manual (NAM)
Source: DON ACUTE & SUBACUTE	Effective Date: 5/18/16

PURPOSE:

To delineate standards of care for the patient who is restrained which promotes an environment conducive to maintaining patient dignity, while protecting patient safety. All swing bed patients will be advised of their right for freedom from restraints used in the provision of swing bed care unless clinically necessary, and of their right to freedom from restraints used in behavioral management unless clinically necessary. These are included in the "*Patient's Bill of Rights"* given to the patient on admission to Swing Bed Status.

POLICY:

A. It is the policy of Northern Inyo Hospital (NIH) to create a physical, social and cultural environment that limits the use of restraint to appropriate and justified situations, and, to reduce restraint use through preventive or alternative methods which focus on the patient's rights, dignity and well-being. Patients have the right to be free from restraints of any form that are not medically necessary. Restraint may only be imposed to ensure the immediate physical safety of the patient, staff, or others and must be discontinued at the earliest possible time.

B. The decision to use a restraint is not driven by diagnosis. Comprehensive assessment of the patient and environment, in conjunction with individualized patient care planning, should be used to determine those interventions that will best ensure the patient's safety and well-being with the least risk. The comprehensive assessment should include a physical assessment to identify medical problems that may be causing behavior changes in the patient. Restraint may only be used if needed to improve the patient's well being when less restrictive interventions have been determined to be ineffective in protecting the patient and others from harm. Restraints, if deemed appropriate, are implemented using safe techniques identified in this policy and reinforced during annual staff education. The restraint shall be discontinued at the earliest possible time, regardless of the scheduled expiration of the order.

C. Patient's rights, dignity and well-being are protected during restraint use to assure the following:

   1. Respect for the patient as an individual

   2. Safe and clean environment

   3. Protection of the patient's modesty, visibility and body temperature

D. The hospital does not permit restraint for management of violent or self-destructive behavior to be used for the purpose of coercion, discipline, convenience, or staff retaliation. Restraints are never a substitute for adequate staffing.

E. The patient and family will be informed of the organization's policy/procedure on the use of restraints.

   1. Staff will explain the need for the use of restraint to the patient/family/ significant other to increase their understanding and decrease their fears about the use of restraint.

   2. Patient and/or family will be encouraged to be involved in decision-making. Incorporating patient/family preferences in the care process may help minimize restraint use.

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3. The patient/family/significant other are assured that the least restrictive device will be utilized, that restraints are discontinued as soon as possible, and that the patient's basic needs for nutrition, personal care, and exercise are met during the use of the restraint.

4. In the event that the patient chooses not to include the family/significant other, or that participation would have a detrimental effect on the patient, family/significant other involvement would not be applicable.

5. Staff will attempt to promptly contact the family to notify them when restraints are used as appropriate.

F. The use of restraints must be in accordance with the telephone order or written order of a physician.

G. A Registered Nurse (RN) may make the decision to initiate a restraint in an emergent situation when the risk to the patient is such that an order from a physician cannot be obtained before restraining the patient.

H. Per the restraint orders, the RN may discontinue restraints prior to the expiration of the order when the action/behavior leading to the need for restraints is no longer evident. If the restraints must be re-initiated, another order must be obtained.

DEFINITIONS:

A. Physical Restraints: Physical restraint is any manual or physical method or mechanical device, material, or equipment that immobilizes or reduces the ability of a patient to move his or her arms, legs, or head freely.

1. Bed side rails: Side rails present an inherent safety risk, particularly when the patient is elderly or disoriented. Even when they are not used intentionally as a restraint, patients may become trapped between the mattress or bed frame and the side rail.

a. Side rails used to physically restrict a person's freedom of movement or physical activity in order to protect the patient or others from injury is considered restraint. Therefore, when all four side rails of a four rail system are raised, it is considered a restraint.

b. Individual patient needs are assessed for the use of side rails.

c. Infants and children will have crib rails and side rails up at all times which are not considered restraint.

d. The upper two side rails of a four rail system may be placed in the up position to provide patient access to bed control, the nurse call system, or to assist the patient in turning in bed and are not considered restraint.

e. The upper two side rails and one lower side rail of a four-rail system or one side of a two-rail system may be up for patient protection and comfort as long as the patient's ability to get out of bed is not restricted and are not considered restraint.

f. The upper and lower two side rails of a four rail system on specialty beds (i.e. lateral rotation beds) may be up for patient protection and in order for the bed to properly operate and are not considered restraint.

2. Devices and Immobilization

a. Devices, which serve multiple purposes when they have the effect of restricting a patient's movement and cannot be easily removed by the patient, constitute a restraint. (e.g. Geri chair, elbow immobilizers to prevent the patient from reaching tubes, etc.)

b. Patient assessment for the use of the device should be based on the least risk for the patient and the risk of what might happen if the device is not used versus the risk it poses as a restraint.

B. Drugs used as a restraint: Chemical restraint is defined as medication used as a restriction to manage the patient's behavior or restrict the patient's freedom of movement and is not standard treatment for the patient's medical or psychological condition. These are medications used in addition to or in replacement of the patient's regular drug regimen to control aggressive and/or violent behavior during an emergency.

1. A standard treatment for a medication used to address a patient's condition would include all of the following:

a. The use of the medication follows national practice standards established or recognized by the medical community and/or professional medical association or organization.

b. The use of the medication to treat a specific patient's clinical condition is based on that patient's symptoms, overall clinical situation, and on the physician's knowledge of that patient's expected and actual response to the medication.

c. If the overall effect of a medication is to reduce the patient's ability to effectively or appropriately interact with others, then the medication is not being used as a standard treatment for the patient's condition.

d. Whether or not the use of a medication is voluntary, or even whether the drug is administered as a one-time dose or PRN are not factors in determining if a drug is being used as a standard treatment. The use of PRN medications is only prohibited if the drug is being used as restraint.

2. NIH does not use chemical restraints as a means of coercion, discipline, convenience or retaliation by staff. Medications that comprise the patient's regular medical regimen (including PRN medications) are not considered drug restraints, even if their purpose is to control ongoing behavior.

C. Seclusion: Seclusion of an individual is involuntarily confining an individual alone in a room or area where he/she is physically prevented from leaving. NIH's policy and practice prohibits the use of seclusion.

D. NIH prohibits the use of restraints when the patient is in a prone position.

E. Exceptions: Therapeutic or protective interventions that, although they may restrict activity, are ***not*** considered restraint interventions include:

1. A restraint does not include devices, such as prescribed orthopedic devices, surgical dressings or bandages, protective helmets, or methods that involve the physical holding of a patient for the purpose of conducting routine physical examinations or tests.

2. A restraint does not include methods that protect the patient from falling out of bed.

a. Examples include raising the side rails when a patient is on a stretcher; recovering from anesthesia; sedated; on seizure precautions, experiencing involuntary movement; or on certain types of therapeutic beds to prevent the patient from falling out of the bed.

3. Age or developmentally appropriate protective safety interventions (such as stroller safety belts, swing safety belts, highchair lap belts, raised crib rails and crib covers) that a safety-conscious child care provider outside a healthcare setting would utilize to protect an infant, toddler or preschool-aged child would not be considered restraint or seclusion for the purposes of this regulation.

4. A physical escort would include a "light" grasp to escort the patient to a desired location

a. If the patient can easily remove or escape the grasp, this would not be considered physical restraint. However, if the patient cannot easily remove or escape the grasp, this would be considered physical restraint and all the requirements would apply.

5. A voluntary mechanical support used to achieve proper body position, balance, or alignment so as to allow greater freedom of mobility than would be possible without the use of such a mechanical support is not considered a restraint (e.g. knee immobilizers for medical clinical purposes, abductor pillow, postural support, or orthopedic devices).

6. A position or securing device used to maintain the position, limit mobility or temporarily immobilize the patient during medical, dental, diagnostic or surgical procedures.

7. The use of handcuffs or other restrictive devices applied by law enforcement officials for custody, detention, and public safety reasons is not considered restraint.

8. Placing hand mitts on a patient to prevent the patient from pulling on tubes or scratching him or herself would not be considered a restraint. However, pinning or otherwise attaching those same mitts to bedding or using a wrist restraint in conjunction with the hand mitts would meet the definition of restraint and the requirements would apply. In addition, if the mitts are applied so tightly that the patient's hand or fingers are immobilized, this is considered a restraint and the requirements would apply.

9. A medication used to control a patient's behavior that is standard treatment for the patient's medical or psychiatric conditions (i.e. drug or alcohol withdrawal, psychiatric diagnosis) is not considered chemical restraint.

10. If the patient is on a stretcher, there is an increased risk of falling from a stretcher without raised side rails due to its narrow width and high center of gravity. Additionally, since stretchers are elevated platforms, the risk of patient injury due to a fall is significant. Therefore, the use of raised side rails are not considered restraint but a prudent safety intervention.

F. The following functional guidelines should be considered when defining an intervention as a physical restraint:

1. Does the patient have the ability and skill to easily remove the intervention? (If the answer is no, then intervention is a restraint).

2. Is the patient's freedom to move when the intervention is in place less than their freedom to move without the intervention, or is the patient's access to their body when the intervention is in place less than their access to their body without the interventions? (If the answer is yes, then intervention is a restraint).

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3. Utilization of a functional assessment allows for individual assessment of each device and situation that could potentially be used to inhibit an individual's movement. Therefore, if the effect of using an object fits the definition of restraint for a patient at a specific point in time, then for that patient, the device is a restraint.

APPROVED TYPES OF RESTRAINTS

A. **Soft limb restraints**
B. **Four (4) side rails up (See definitions)**
C. **Mitts**
D. **Safety Vest**

ALTERNATIVES TO RESTRAINTS/LEAST RESTRICTIVE DEVICE

A. Alternatives to restraints do not always need to be tried, but prior to the use of restraints; alternative interventions must be determined to be ineffective to protect the patient or others from harm.

B. Alternatives attempted or rationale for not attempting alternatives must be documented.

C. Efforts are taken to develop and promote preventive strategies and use safe and effective alternatives when appropriate as follows:

1. Identify and treat the cause of the behavior (e.g. medical re-evaluation, reposition, put to bed if fatigued, change environmental noise level, lighting, furnishings, or equipment, or if possible, change or eliminate bothersome treatments).

2. Increase observation/supervision.

3. Involve the family and significant others.

4. Provide diversionary measures (e.g. formal activities, visitors, exercise, reorganize the ADLs).

5. Consider and eliminate barriers; manipulate the environment (e.g. increase the lighting, leave side rails down, decrease noise, call bell accessible).

6. Re-orient patients/provide reality orientation.

7. Evaluate medication regimen (e.g. pain, agitation, and initiation).

D. The use of restraints may only be used when less restrictive interventions have been determined to be ineffective to protect the patient or others from harm.

Examples of Alternatives to Physical Restraints

All behaviors can be viewed as a symptom and each may arise from a variety of causes or be indicative of an array of unmet needs. Medical re-evaluation is always appropriate. Involvement of the interdisciplinary team (i.e. OT/PT assessment) may identify additional alternatives.

Observe the patient's behavior, investigate its meaning, and develop creative and individualized

alternatives. Educate the patient and family to reduce the use of physical restraints.

Behavior Exhibited	Suggested Options, if available
Falls	Bathroom rounds Grab rails and raised toilet seats Side rails kept down Bed in low position Increase the light in the room Eliminate hazards, clear a path Ambulate frequently / supervised ambulation Bed Alarm / Chair Alarm Family supervision Call bell within reach Wear supportive shoes Gripping rubber mats / nonslip surface in chairs Keep patient in view of staff Wedge cushions Adequate pain medication Place commode at bedside Provide glasses, hearing aid, dentures, purse, etc. If fatigued and in the chair, transfer to the bed Place pillow or rolled blanket under mattress to create lip at edge Evaluate meds to decrease the possibility of side effects Make sure clothing, tubing, etc. not interfering with walking Consult with PT for alternatives
Scratching	Eliminate itch and treat the cause Diversional activities
Pulling at Tubes	Wear Briefs over Foley catheter Hide or camouflage IV tubing Get tubes out as soon as possible Provide patient something else to "fiddle" with Consider alternatives for NG tubes
Pulling at wounds or dressings	Overdress wounds Hide or camouflage dressings Medicate for pain Supervise confused patients carefully Use abdominal binders when possible Evaluate to see if tape or dressing is itching Try calming music / distract the patient with TV, activities, etc. Consult with school program for learning activities

	If active play activities are not available, provide stimulation with music, audio books, and mobiles. colorful surroundings, etc.
Wandering	Determine where the patient is going and why Anticipate needs; learn past patterns and coping styles Have hearing aid and glasses available Use STOP signs Decrease stimuli (ex. light, noise, interruptions) Exercise patient or walk them frequently Reminisce and validation Use alarms Family / friend / volunteer supervision Test for urinary tract infections (UTI) and treat as indicated and ordered Assess pain level. Treat as indicated and ordered Place bed in lowest position Reality orientation / psychosocial intervention Offer interesting TV program, game or activity Consult with OT / PT for alternatives
Rummaging and Scavenging	Busy boxes Reorientation Family / friend / volunteer supervision
Combative	Control for visual and auditory stimuli Music therapy and relaxation tapes Assess pain level or medication side effects Explain slowly what you are trying to do and move slowly Rest periods Contracting, when appropriate Consistent personnel Family / friend / volunteer involvement Provide reality links: TV, radio, calendar, clock Explain procedures to reduce fear and convey a sense of calm Involve the patient in conversation, don't talk over them Use active listening to elicit the patient's perspective Allow patient I family as much control over daily routine as possible

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E. When an individual patient's assessed needs indicate the use of restraint, the least restrictive means should be chosen. For example, hand mittens for a patient who is scratching an irritated skin rash may be effective instead of the more restrictive soft wrist restraints.

F. Less restrictive measures may still constitute a restraint for which an order must be obtained if the patient cannot readily remove the device.

RESTRAINTS TO PREVENT INTERFERENCE WITH MEDICAL AND SURGICAL CARE

A. Definition of Restraints used for non-behavioral health patients (Non-violent and non-self destructive behavior) purposes

1. The patient is performing some action that interferes or has the potential to interfere with medical and /or surgical healing.

a. The patient pulls at, attempts to remove, actually removes, or dislodges IVs, drains, tubes, surgical dressings or other therapies or treatments.

b. The patient gets out of bed unassisted when assessed as unstable or when activity may be detrimental to the patient.

B. Clinical Justification

1. After assessing/evaluating a patient's physical or emotional condition, and despite attempts at alternative solutions, the documented continuance of a patient activity that will interfere with medical therapy justifies initiation or continued use of restraints.

2. If, based on a complete nursing assessment/evaluation, an RN assesses a patient to need a restraint to prevent interference with medical and surgical care, then that RN shall notify the patient's treating physician who may give an order for restraints.

C. Initiation of Restraints

1. If the patient is not in immediate danger, the RN may obtain an order for the restraint prior to applying restraints.

2. The RN may only apply restraints to prevent interference with medical and surgical care without receiving a physician's order if the patient's safety will be jeopardized without immediate use. The RN, after appropriate assessment, may make the decision to initiate and apply a restraint if the physician is not immediately available.

a. The RN who determines that the patient requires restraints will notify the physician and obtain a telephone order or written order. The order must be obtained immediately (within 1 hour) after the initiation of restraints. If the episode that led to restraints is a significant change for the patient, the physician will be notified immediately.

b. A physician will examine the patient within 24 hours of initiation of restraint used to prevent interference with medical or surgical care, and will enter a written order into the patient's medical record.

D. Physician's Order

1. A physician's order for the management of non-behavioral health patients (Non-violent and non-self destructive behavior) must be obtained for each restraint episode.

2. Restraint orders must include:

   a. Date and time order was written

   b. Restraint category: Non-behavioral health patients (Non-violent and non-self destructive behavior)

   c. The type of restraint to be used

   d. Time specific

   e. The reason for restraint (i.e. patient's behavior and staff concerns regarding safety risks to the patient, staff, and others that necessitated the use of restraint).

   f. Signature of a physician in the appropriate time frame.

   g. Cannot be written as "PRN."

3. Each written order for a physical restraint to prevent interference with medical and surgical care is to be renewed no less often than every twenty four (24) hours.

4. Example of Physician order

   a. Restrain wrists for up to twenty-four hours using soft wrist restraints to prevent dislodging IV tubes.

E. Physician Assessment and Continuation of Restraint orders

Continued use of restraints beyond the first 24 hours is authorized by a physician renewing the original order or issuing a new order if restraint continues to be clinically justified.

1. Such renewal or new order is issued no less often than every 24 hours and is based on a documented face-to-face examination of the patient by the physician. The physician reevaluates the efficacy of the patient's treatment plan and works with the patient to identify ways to help him or her regain control.

2. If the patient's attending physician is not the physician who has ordered the restraint, then the patient's attending physician should be notified of the initiation of the restraint order as soon as possible.

F. Early Termination

1. The restraint will be terminated as soon as possible when the initial action is no longer evident or alternatives are effective.

2. The physician may make the decision to discontinue the restraint based on current assessment and evaluation of the patient's condition. CMS 482.13(e)

G. Re-application

1. If a patient was recently released from interference with medical and surgical care restraint due to non-behavioral health (Non-violent and non-self destructive behavior) and exhibits behavior that can only be handled by the reapplication of restraint, a new order is required.

2. Staff cannot discontinue an order and re-start it under the same order because that would constitute a PRN order. Each episode of restraint use must be initiated in accordance with the order of a physician.

3. A temporary release that occurs for the purpose of caring for a patient's needs-for example toileting, feeding, and range of motion or assessing whether restraints can be discontinued is not considered a discontinuation of restraint.

H. Observation/ Ongoing Assessment of the Patient

1. An RN/LVN/CNA who has demonstrated competency in the application and monitoring of restraints may apply and monitor the restraints.

2. The RN is responsible to assess the patient on an ongoing basis and determine whether restraints should be continued or terminated.

3. After applying restraints, immediately perform an initial assessment to ensure the well being of the patient, safe and proper application, and that there is no evidence of injury. If the patient's response is negative, make immediate changes.

4. During the period of restraint, the patient must be monitored and assessed at a frequency that is determined by the needs of the patient, his/her condition, and the type of restraint used. This can be accomplished by observation, interaction with the patient, or direct assessment and will be done at a minimum of every 2 hours. Documentation of assessment will include relevant orders for use, results of patient monitoring, reassessment, and significant changes in patient's condition.

   a. Assessment for patients who are restrained with soft limb restraints, mitts, or side rails, will be documented at least every 2 hours.

5. The RN assessment includes the following:

   a. Skin Integrity (e.g. dry & intact, redness or swelling, abrasions)

   b. Circulation/sensation/movement (CSM) of affected extremities

   c. Well-being - the patient's physical and emotional well-being is addressed

   d. Application: the restraint is safely and properly applied

   e. Signs of injury associated with applying restraint

   f. Vital Signs: Done if per patient physical/emotional status the RN assesses the need for vital signs

   g. Release and ROM to restrained extremity every 2 hours

h. Whether less restrictive methods are possible

i. If the patient's behavior or clinical condition is appropriate to need continuation of restraints or if termination is possible.

j. Dignity and rights are maintained. Attention is given and interventions are provided to meet the patient's physical needs including but not limited to:

1) Hydration

2) Nutrition

3) Elimination

4) Hygiene

RESTRAINTS FOR MANAGEMENT OF VIOLENT AND/OR SELF-DESTRUCTIVE BEHAVIOR

A. Definition: Behavioral health (Violent and/or self destructive behavior) Restraint

1. The patient is displaying assaultive/ aggressive behavior that poses imminent risk of physical harm to him/her, the staff and/or others.

2. Restraints for management of violent or self-destructive behavior is an emergency measure that should be reserved for those occasions when unanticipated aggressive or destructive behavior places the patient or others in imminent danger and nonphysical intervention would not be effective.

3. The use of restraints for the management of violent or self-destructive behavior is not based on a patient's restraint history or solely on a history of dangerous behavior.

4. Whenever possible, non-physical interventions are used to avoid the use of restraints for the management of violent or self-destructive behavior through de-escalation techniques. when there is an imminent risk of physical harm, physical interventions will need to be applied.

B. Clinical Justification

1. After assessing/evaluating a patient's emotional condition, and after consideration or trial of alternative solutions, the documented continuance of a patient behavior that gives reasonable probability of harm to self or others justifies the initiation or continued use of restraints.

2. The RN must justify the use of the restraint in the patient's medical record. This includes the specific behavior that placed the patient or others at risk and the alternatives attempted.

C. Initiation of Restraints

1. In an emergent condition when the RN has assessed the patient and evaluates that the behavior is aggressive/assaultive then the RN may make the decision to restrain the patient.

2. The RN must inform the physician for the need for restraints for the management of violent or self-destructive behavior, obtain a telephone order or written order, and consult with the physician about the patient's physical and psychological condition immediately (within 1 hour) after initiation of the restraint.

3. The in-person evaluation and documentation by the physician, conducted within 1 hour of the initiation of restraint for the management of violent or self-destructive behavior that jeopardizes the physical safety of the patient, staff or others, includes the following:

   a. An evaluation of the patient's immediate situation.

   b. The patient's condition or symptom(s) that warranted the use of the restraint.

   c. Alternatives or less restrictive interventions attempted (as applicable).

   d. The patient's medical and behavioral condition.

   e. A description of the intervention used.

   f. The patient's response to the intervention used, including the need to continue or terminate use of restraint.

D. Physician Order

1. A physician's order for a restraint for management of behavioral health restraints (violent and/or self-destructive behavior) must be obtained for each restraint episode.

2. Restraint orders must include:

   a. Date and time order was written.

   b. Restraint category: Behavioral Health (Management of Violent and/or Self-Destructive Behavior).

   c. Type of restraint to be used.

   d. Time specific.

   e. Reason for restraint; description of the patient's behavior'

   f. Signature of a physician within the appropriate period of time.

   g. Cannot be written as "PRN."

3. Verbal and written orders for restraints used for the management of behavioral health (violent and/or self-destructive behavior) are time-limited as indicated below. Orders may be renewed according to the time limits for a maximum of 24 consecutive hours.

   a. 4 hours for adults ages 18 and older

   b. 2 hours for children and adolescents ages 9-17

c. 1 hour for children under 9 years of age.

E. Physician Assessment and Continuation of Restraints

1. The physician must complete a face-to-face evaluation of the patient and evaluate the need for restraint within one hour after the initiation of the restraint. A telephone call is not adequate.

2. Upon initiation of restraints for management of violent or self-destructive behavior and on an ongoing basis, the physician will provide the following:

   a. Reviews with staff the physical and psychological status of the patient and supplies staff with guidance in identifying ways to help the patient regain control so that restraints can be discontinued.

   b. Reevaluates the efficacy of the patient's plan of care, treatment, and services and determines whether restraints should be continued.

   c. Works with the patient to identify ways to help regain control.

   d. Supplies the order.

3. When restraint is continued for management of violent or self-destructive behavior and the individual providing the order is someone other than the patient's physician, the patient's responsible physician is notified of the patient's status.

4. The physician reevaluates the efficacy of the patient's treatment plan and works with the patient to identify ways to help him or her regain control.

5. Every 24 hours, the physician primarily responsible for the patient's ongoing care evaluates the patient in person before writing a new restraint order for management of violent or self-destructive behavior that jeopardizes the immediate physical safety of the patient, staff, or others.

6. If the patient is released from restraint used for management of violent or self-destructive behavior prior to the expiration of the original order, the physician still has to conduct an in-person evaluation of the patient within 24 hours of the initiation of restraint and original order.

F. Early Termination

1. The use of physical restraint must be limited to the duration of the emergency safety situation regardless of the length of the order. The physician has the discretion to decide that the order should be written for a shorter period of time. Staff should assess, monitor, and assist the patient to regain control, and re-evaluate the patient so that he or she is released from the restraints at the earliest possible time.

2. The physician may make the decision to discontinue the restraint based on current assessment and evaluation of the patient's condition. CMS 482.13(F)

G. Reapplication of Restraints

Title: Swing Bed Patient Restraints	
Scope: Acute/Subacute Services	Manual: CPM- Patient Safety (PS), Nursing Administration Manual (NAM)
Source: DON ACUTE & SUBACUTE	Effective Date: 5/18/16

1. If the patient was recently released from restraints for the management of violent or self-destructive behavior and exhibits behavior that can only be handled by the reapplication of restraint, a new order is required.

2. Staff cannot discontinue an order and re-start it under the same order if the patient's behavior escalates again after he or she has been released. Each episode of restraint use must be initiated in accordance with the order of a physician; PRN orders are prohibited

3. A temporary release that occurs for the purpose of caring for a patient's needs - for example toileting, feeding, and range of motion - or assessing whether restraints can be discontinued is not considered a discontinuation of restraint.

H. Observation/Ongoing Assessment of Patients

1. During the time of restraint use for the management of violent or self-destructive behavior, there will be continuous in-person observation by an assigned staff member who is competent in the use of restraints.

2. During the period of restraint use for management of violent and/or self-destructive behavior, all patients must be monitored and assessed at a frequency that is determined by the needs of the patient, his/her condition, and the type of restraint used. This can be accomplished by observation, interaction, or direct assessment.

3. After applying restraints, the RN will immediately perform an initial assessment to ensure the well being of the patient, safe and proper application, and that there is no evidence of injury. If the patient's response is negative, make immediate changes.

   a. Assessment of the patient in restraints for management of violent or self-destructive behavior is performed at the initiation of restraints and minimally every 15 minutes thereafter. This assessment includes the following:

   b. Skin Integrity (e.g. dry & intact, redness or swelling, abrasions)

   c. Circulation/sensation/movement (CSM) of affected extremities

   d. Well-being. The patient's physical and emotional well-being is addressed

   e. Application: the restraint is safely and properly applied

   f. Signs of injury associated with applying restraint

   g. Vital Signs: Completed if the RN’s assessment warrants the need for vital signs

   h. Release and range of motion (ROM) to restrained extremity every 15 minutes

   i. Whether less restrictive methods are possible

   j. If the patient's behavior or clinical condition is appropriate to need continuation of restraints or if termination is possible

k. Dignity and rights are maintained. Attention is given to the patient's needs including but not limited to:

1) Hydration

2) Nutrition

3) Elimination

4) Hygiene

5) Physical or psychological status and comfort.

4. If the patient is in a physical hold for management of violent or self-destructive behavior, another staff person who is competent in the use of restraint and who is not involved in the physical hold is assigned to observe the patient.

5. Staff members help patients meet behavior criteria for discontinuing restraints for management of violent or self-destructive behavior by attempting alternatives and providing for less restrictive measures whenever possible.

a. Assisting to meet behavior criteria for discontinuing restraints for management of violent or self-destructive behavior can include the following interventions:

1) Appropriate implementation of medical plan of care to stabilize the disease process causing the aggressive/assaultive behavior

2) Decrease environmental stimuli to a minimum

3) Set clear, consistent, and enforceable limits on behavior

4) Attend and respond positively to patient anxiety or anger with active listening and validation of patient distress

5) Work with patient to identify the internal and interpersonal factors that provoke violence/aggression

6) Work with patient to identify what supports are lacking and problem-solve ways to achieve needed support

7) Role-play alternative behaviors with patient that they can use in stressful and overwhelming situations

8) Work with patient to set goals for their behavior

9) Provide patient with other outlets for stress and anxiety

10) Provide patient and family/significant other with community resources that teach anger management and stress reduction techniques

11) Utilize de-escalation techniques for staff who are trained in this

NORTHERN INYO HOSPITAL
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Title: Swing Bed Patient Restraints	
Scope: Acute/Subacute Services	Manual: CPM- Patient Safety (PS), Nursing Administration Manual (NAM)
Source: DON ACUTE & SUBACUTE	Effective Date: 5/18/16

:

RESTRAINT APPLICATION

A. Competent staff applies restraint corr.ctly and appropriately to protect patient safety.

B. Please reference Lippincott for limb and vest restraint application.

~~B. Restraint devices are attached to the bed frame using a slipknot. If the bed is adjustable, secure the restraint to the parts of the bed that move with the patient, except the side rails, to avoid constricting the Patient.~~

~~C. Maintain patient's proper body alignment.~~

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~~D.~~C. If a patient must be restrained in the supine position, ensure that the head is free to rotate to the side and, when possible, the head of the bed is elevated to minimize the risk of aspiration.

~~E.~~D. Secure Restraint so that it may be released immediately in emergency situations.

~~F.~~E. Verify that the order for restraint includes rationale for restraint, length of time and type of restraints to be used, and extremity or body part(s) to be restrained

~~G.~~F. All limb restraints are to be kept in full view and not covered with sheet or bedspread.

DOCUMENTATION

A. Documentation of restraint application for non-behavioral health (non-violent, non-self destructive behavior), or for behavioral health (violent and/or self-destructive behavior) includes the following:

1. In the Electronic Health Record (EHR)

   a. Initial assessment/clinical justification that includes the patient's behavior or actions that led to the use of the restraint.

   b. Alternatives/Interventions attempted before use of restraint or rationale on why these were not appropriate with this patient.

   c. Choice of less restrictive means as applicable.

   d. Time of application and termination.

   e. Family notification of restraint application, if appropriate

   f. When the patient no longer needs to be restrained, documentation must include the time and rationale for removal from restraints

   g. Physician's order, which includes type of restraint, time limit and reason for restraint.

2. Patient family teaching is documented on the Restraint Education section.

CARE PLANNING

NORTHERN INYO HOSPITAL
POLICY AND PROCEDURE

Title: Swing Bed Patient Restraints	
Scope: Acute/Subacute Services	Manual: CPM- Patient Safety (PS), Nursing Administration Manual (NAM)
Source: DON ACUTE & SUBACUTE	Effective Date: 5/18/16

A. A modification to the patient's plan of care must accompany the use of restraints for either Non-behavioral health (Non-violent, non-self destructive behavior) or management of behavioral health (violent and/or self-destructive behavior)

B. Nursing documentation will reflect assessment intervention, evaluation, and re-intervention process with a focus on utilizing the restraint for the shortest period of time and the least restrictive measures

C. Care plan modifications may include but are not limited to the following:

1. Patient care problem
2. Outcome-oriented goal
3. Restraint intervention used
4. The Nursing documentation will reflect the date the restraint was initiated and discontinued and appropriate interventions taken to ensure patient safety

EDUCATION

A. Physicians and other licensed independent practitioners authorized to order restraints are educated on the policy during their orientation. Education on policy changes occurs during policy review and approval at medical department meetings

B. Education and training in the proper and safe use of restraints shall be provided as part of the employee's initial orientation and before participating in the use of restraints. Competency will be evaluated during orientation and annually. The nursing department education plan will include annual restraint education.

C. Education and training of staff with direct patient contact shall include but not be limited to:

1. Hospital policy on restraints
2. Understanding that behaviors are sometimes related to the patient's medical condition
3. The use of alternative interventions and least restrictive measures
4. The initiation, safe application, and removal of all types of restraints used including monitoring and reassessment criteria. Training includes how to recognize and respond to signs of physical and psychological distress, and patient monitoring/observation/assessment and reassessment parameters.
5. Monitoring the physical and psychological well-being of the patient who is restrained, including, but not limited to, respiratory and circulatory status, skin integrity, vital signs, and any special requirements specified by hospital policy associated with the in-person physician evaluation conducted within one hour of initiation of behavioral health (Violent and/or self destructive behavior) restraints.
6. Patient comfort, modesty, well being, dignity, rights and respect, hygiene, psychological status, elimination, nutrition, hydration needs and to recognize signs of physical distress in restrained patients.

7. Strategies to identify staff and patient behaviors, events, and environmental factors that may trigger circumstances that require the use of behavioral restraints.

8. Determination of underlying causes of behavior that may be related to a medical condition. (i.e. hypoglycemia, DTs, delirium and how that may be related to the patient's emotional condition).

9. Recognition of how age, developmental considerations, gender issues, ethnicity, and history of sexual or physical abuse may affect the way an individual reacts to physical contact and restraints.

10. Use of nonphysical intervention skills

11. Methods for choosing the least restrictive interventions based on an assessment of the patient's medical or behavioral status or condition

12. Use of first aid techniques and certification in the use of cardiopulmonary resuscitation, including required periodic recertification.

13. Clinical justification of specific behavioral changes that indicate that restraints are no longer necessary

PERFORMANCE IMPROVEMENT

REPORTING OF PATIENT DEATHS ASSOCIATED WITH RESTRAINT

NIH must report deaths associated with restraint to its CMS regional office no later than the close of business the next business day following knowledge of the patient's death. [CMS 482.13(f)(7)]

NIH must report to its CMS Regional Office each death that occurs:

1. While a patient is in restraint, except when no seclusion has been used and the only restraint used was a soft, cloth-like 2-point wrist restraint.

    a. Deaths occurring during or within 24 hours of discontinuation of 2-point soft, cloth-like non-rigid wrist restraints used in combination with any other restraint device must be reported to CMS.

    b. Death associated with the use of other types of wrist restraints, such as 2-point rigid or leather wrist restraints must be reported to CMS.

2. Within 24 hours after the patient has been removed from restraint or seclusion, except when no seclusion has been used and the only restraint used was a soft, 2-point wrist restraint

3. Within one (1) week after use of restraint or seclusion where the death is known to the hospital and it is reasonable to assume that the use of restraint or seclusion contributed directly or indirectly to the patient's death, regardless of the type(s) of restraint used on the patient during this time

Patient Death Reporting- Only in 2-Point Soft Wrist Restraints and no seclusion:

NIH must maintain an internal log or other type of tracking system for recording information within seven (7) days of a patient's death that occurs:

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1. While a patient is only in 2-point soft, cloth-like non-rigid wrist restraints and there is no use of seclusion; and

2. Within 24 hours of the patient being removed from 2-point soft, cloth-like non-rigid wrist restraints where there was no use of any other type of restraint or seclusion

3.

This log must be made readily available to CMS immediately upon request.

It is the responsibility of the Chief Performance Excellence Officer or his/her designee to report the incident to CMS after notification of hospital group administration and document in the patient's medical record the date and time the death was reported to CMS.

REFERENCES

- Centers for Medicare and Medicaid Services (CMS). Federal Register Part IV: Department of Health and Human Services. Medicare and Medicaid Programs; Hospital Conditions of Participation: Patient's Rights; Final Rule. December 8, 2006. 42 CFR Part 482: (pp.71378-71428).
- Centers for Medicare and Medicaid Services (CMS). Restraint Rate per 1000 LTCH Days Measure Specifications*. June 11, 2012. https://www.cms.gov/medicare/quality-initiatives-patient-assessment-instruments/ltch-quality-reporting/downloads/restraintrateper1000-ltchdaysmeasurespecifications.pdf
- Centers for Medicare and Medicaid Services (CMS), State Operations Manual, Appendix A-Survey Protocol, Regulations and Interpretive Guidelines for Hospitals, 04-01-2015
- California Department of Public Health, Licensing and Certification Program, General Acute Care Hospital Memorandum, Subject: Centers for Medicare and Medicaid (CMS) Death Reporting Requirements, August 3, 2009.
- Joint Commission on Accreditation of Healthcare Organizations. Comprehensive Accreditation Manual for Hospitals Update 1, June 2010(pp. PC.03.02.01-PC.03.02.11) Oakbrook Terrace, IL: Joint Commission Resources, Inc.
- Management of Aggressive Behavior. MOAB Training International, Inc. 2007. Kulpsville, PA: Cricket Press, Inc.
- Title 22, California Code of Regulations, Division 5. Licensing and Certification of Health Facilities, Home Health Agencies, Clinics, and Referral Agencies, section 73095, 73403-73409.2005. State of California, Office of Administrative Law.
- Varcarolis, EM. Manual of Psychiatric Nursing Care Plans: Diagnoses, Clinical Tools, and
- Psychopharmacology, 3rd edition. 2006. (pp. 497-517). St Louis, MO: Saunder Elsevier.

CROSS REFERENCE P&P:

1. Forensics
2. Lippincott limb restraint application
3. Lippincott vest restraint application

Approval	**Date**
CCOC	**3/08/16**
Med/ICU	**4/28/16**
MEC	**5/03/16**

NORTHERN INYO HOSPITAL
POLICY AND PROCEDURE

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Source: DON ACUTE & SUBACUTE	Effective Date: 5/18/16

Board of Directors	**5/18/16**

Developed: 1/10/2015
Reviewed:
Revised: 3/16la, 12/2016 la
Supercedes:

REMOTE BACKLOG CODING
SERVICE AGREEMENT
BETWEEN
NORTHERN INYO HEALTHCARE DISTRICT
AND
HEALTHCARE COST SOLUTIONS, INC.

INTRODUCTION

Healthcare Cost Solutions, Inc. is a recognized leader in the Health Information Management field providing Coding, Auditing and HIM Consultative Services to hospitals, ambulatory surgery centers and physician providers nationwide.

Healthcare Cost Solutions has been in the forefront of the transition to the EMR and the IT infrastructure development that supports it. In response to the ever-changing audit environment and increased government scrutiny, ***Healthcare Cost Solutions has developed HART (Healthcare Audit Resource Technology), proprietary software, to optimize your reviewed data.*** Our services are offered on-site or remotely.

Healthcare Cost Solutions provides free online tutorials and physician query forms to clients.
Access the online library of coding and ICD-10 tutorials via the HCS website:
http://www.hcsstatexam.com/training/coursemenu.htm

This agreement between Northern Inyo Healthcare District ("Facility") and Healthcare Cost Solutions, Inc. ("HCS") is entered into as of January 5, 2017 and outlines the process by which HCS will provide Remote Backlog Coding services.

1. HCS Role – Remote Coding

1.1 Coding will be performed according to the official coding principles and guidelines as put forth by the American Hospital Association (Coding Clinic), the American Medical Association (CPT Assistant), and Centers for Medicare and Medicaid Services (CMS).

1.2 Coding turnaround time is 24 hours or less for fulltime outsourced positions; 48 hours or less for 'as-needed' coding support.

1.3 HCS shall provide experienced, credentialed coding professionals to assist Facility with coding Inpatient, Outpatient, Emergency Room and/or Ancillary medical records.

1.4 HCS shall make the following documents available to the Facility upon request:

- Resume with brief bio
- Proof of AHIMA and/or AAPC certification (CCS, CCS-P, CPC-H, CPC, and/or RHIT, RHIA, CDIP)
- Evidence of continuing education units for past twelve (12) months.

1.5 HCS shall conduct testing and screening of all applicants prior to placement (references, criminal background checks, OIG exclusion search, etc.). Coders are tested on their productivity and accuracy.

1.6 HCS conducts internal quality reviews to maintain a 95% or above accuracy rate.

1.7 HCS will provide each Coder with dual monitors to optimize remote coding efficiency.

1.8 HCS shall provide evidence of existing Internal Compliance Plan to Hospital upon request.

1.9 HCS shall provide IT support to HCS coders to assure proper compatibility with Facility EMR and systems as warranted.

2. Hospital Role – Remote Coding

2.1 Hospital will provide HCS with facility coding guidelines in writing.

2.2 Hospital shall provide HCS Coders with:

- Orientation to coding/abstracting systems
- Hospital coding policies and procedures
- Complete medical records for coding

2.3 Hospital retains the right to accept or decline each HCS coder prior to or during course of assignment.

2.4 Hospital shall provide remote access to EMR in whichever method(s) deemed appropriate (EPIC, etc.) by the Hospital IS department.

2.5 Hospital shall provide HCS with 30 days advance notice for cancellation of regularly scheduled, fulltime remote coding services.

3. Fees

Complimentary Physician Queries, coding assistance between audits, and access to the HCS Online Library of HIM and ICD-10 interactive Tutorials is provided to all HCS clients:
http://www.hcsstatexam.com/training/coursemenu.htm

Coding Services		
ICD-10-CM/CPT		
Chart Type	**Per Hour Productivity**	**Per Hour Coding Fee**
Professional Fee – Clinic Visits	7 - 10	$76
Professional Fee – Clinic / Hospital E&M	5 – 10	$76
Professional Fee – Surgical Encounters	4 - 8	$76
Professional Fee – Hospital E&M	5 – 8	$76
ICD-10-CM/PCS		
Chart Type	**Per Hour Productivity**	**Per Hour Coding Fee**
Inpatient	1.75 - 3	$76
ICD-10-CM		
Chart Type	**Per Hour Productivity**	**Per Hour Coding Fee**
Outpatient Surgery	3 - 4	$76
Observation	3 – 4	$76
Observation w/Injections and Infusions	1 – 2	$76
Emergency	8 - 12	$76
Diagnostic/Clinic/Ancillary	12 - 15	$76

Productivity is presented as an estimate only. These are approximate numbers and may be affected by the speed of the facility abstracting system and/or remote connections. Actual benchmarks are achieved after individual facility testing. Outpatient PCS codes will not be assigned unless requested.
(Assignment of PCS codes will further impact productivity)

Other Services	
Type	**Hourly Rate**
Claim Reviews and Appeals	$145
PACT Validation	18% Contingency
Medical Necessity Review	$145
Physician Education	$195
Coding Staff Education	TBD
Interim HIM Staffing at all levels	TBD

No up-front or advance fees. Invoicing shall occur bi-weekly. Payment terms shall be net 30 days.

3.1 Overtime rates are charged for all hours worked in excess of forty (40) per week or according to applicable state law. Overtime must have Hospital supervisory approval. The overtime rate is one and one-half (1 ½) times the regular billing rate for such hours (or at two (2) times the regular billing rate if that is the applicable state law overtime rate).

3.2 Reimbursement for travel time exceeding one hour per day shall be paid at $50 per hour. Mileage shall be paid at the prevailing rate as set forth by the Internal Revenue Service. The allowance for overnight stays will generally range from $125-$165 per night depending upon the geographical location. Overnight stays will include a per diem meal allowance of $45 per day, unless the geographical location dictates otherwise.*

*Travel time mileage, and expenses are not applicable for services performed remotely.

3.3 Holiday rates will apply to shifts beginning at 11 p.m. the night before the holiday through 11 p.m. the night of the holiday. Time and one-half will be charged for the following holidays:

- New Year's Day
- Memorial Day
- July 4th (Independence Day)
- Labor Day
- Thanksgiving Day
- Christmas Eve
- Christmas Day
- New Year's Eve

3.4 In case of delayed payment, HCS shall have the right to charge interest not to exceed one (1%) percent per month, or the maximum amount permitted by applicable law, whichever is less on any unpaid amount for each calendar month or fraction thereof that any payments to HCS that are in arrears. This late fee does not attach to any disputed amount claimed by Hospital. Hospital agrees to provide HCS with prompt notice, within ten (10) days after receipt of the invoice, of any disputed claims to HCS.

3.5 Visit the Healthcare Cost Solutions website at www.hcsstat.com for additional services that we offer.

4. HIPAA – Confidentiality, Privacy, Data Security

HCS acknowledges that medical record and billing information is highly confidential and agrees not to disclose or use information for any purpose except as permitted or required to perform the services contained in this agreement or as required by law.
Medical files and all documents of the Hospital that may be used by HCS shall remain the exclusive property of the Hospital.

HCS maintains compliance with federal requirements *(Health Insurance Portability and Accountability Act, 1996)* governing the protection of individually identifiable protected health information (PHI) applicable to Hospital Business Associates, including, but not limited to:

- Using appropriate safeguards to prevent use or disclosure of information other than as provided for by this agreement.
- Reporting to Hospital any use or disclosure of the information not provided for by this contract of which it becomes aware.
- Making available the information required to provide an accounting of disclosures.
- Maintaining and making available on request documents demonstrating compliance with standards of data security, integrity and availability.

5. Termination/Agreement Not to Employ

Should either party wish to terminate this agreement, 30 days written notice will be provided. Notwithstanding the above, HCS shall have the option to immediately terminate this Agreement without notice if Hospital fails to pay any HCS invoice within 60 days of issuance, Hospital files for bankruptcy or takes any other action indicating that it may not be able to pay for past or future HCS services, or Hospital otherwise breaches any of its obligations under this Agreement.
Both the Hospital and HCS agree that during the course of this Agreement and for a period of one (1) year after the termination of this Agreement, each entity will not solicit or attempt to encourage any staff member of the Hospital or HCS to cease employment with their current employer to commence employment with the other entity. If either the Hospital or HCS hires any current employee of the other during the course of the Agreement or during one (1) year after the termination of this Agreement, the entity hiring the employee shall pay the other entity a recruitment fee equal to 50% of the employee's annualized compensation. Any exception to the non-solicitation and/or recruitment fee provisions above must be by mutual agreement in writing and signed by both Hospital and HCS.

6. Attorney's Fees/Governing Law

If any action at law or in equity is necessary to enforce the terms of this Agreement, the prevailing party shall be entitled to reasonable attorney's fees, costs and necessary disbursements.

This Agreement shall be governed by the laws of the State of California. It constitutes the entire agreement between both parties. If any provision of the agreement is held by any court to be invalid, void or unenforceable, the remaining provisions shall nevertheless continue in force.

7. Access to Books and Records

Each party shall make available this Agreement and its books, documents and records to the Secretary of Health and Human Services, to the Controller General, or to their duly authorized representatives, to the extent required by Section 952 of the Omnibus Reconciliation Act of 1980 ("Section 952").

8. Compliance With Safety, Health and Employment Laws and Regulations

Hospital represents and agrees that it is and will remain in compliance with all safety, health and employment laws and regulations applicable to persons employed at the Hospital, and that Hospital will make its best efforts to ensure that employees of HCS are not subjected to any unfair labor practices, discrimination or harassment by Hospital personnel. Hospital agrees that it will defend and indemnify HCS for any costs or liability to HCS which is caused by any unlawful act by an employee of Hospital or any breach by Hospital of this Agreement.

Approved:

Northern Inyo Healthcare District
150 Pioneer Lane
Bishop, CA 93514
760-873-5811

Name: Kevin S. Flanigan, MD, MBA

Title: Chief Executive Officer

Date: 1-5-17

Healthcare Cost Solutions, Inc.
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Telephone: (949) 721-2795
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Name: Bridget T. Gallagher

Title: Chief Executive Officer

Date: January 5, 2017

HEALTHCARE COST SOLUTIONS

Remittance Advice

Company Name	NIHD
Attention	KS FRANZEEN, MD MBA
Address	
	150 PIONEER LANE
City, State, Zip Code	BISHOP, CA 93514
Email Address	KEVIN.FRANZEEN@NIH.ORG
Telephone Number	760-873-2838
Fax Number	
Preference	Send invoice by ✓ Email ___ Mail
PO Required	Yes (No)

REVENUE CYCLE INC.
HIPAA BUSINESS ASSOCIATE AGREEMENT

This Agreement is incorporated into the Service Agreement between Healthcare Cost Solutions, Inc., ("HCS"), and Northern Inyo Healthcare District, hereafter known as "Business Associate."

Whereas, it is the mutual intent of HCS and Business Associate to comply with the applicable provisions of the Health Insurance Portability and Accountability Act Standards for Privacy of Individually Identifiable Health Information, 45 C.F.R. Parts 160 and 164 (the "Privacy Standards"); and

Whereas, it is the mutual intent of HCS and Business Associate to comply with the applicable provisions of the Health Insurance Portability and Accountability Act Standards for Security of Electronic Protected Health Information, 45 C.F.R. Parts 160, 162 and 164 (the "Security Standards") as well as the applicable provisions of the Health Information Technology for Economic and Clinical Health Act ("HITECH Act") (the Privacy Standards, Security Standards, and HITECH Act are hereinafter collectively referred to as the "HIPAA Rules"); and

Whereas, HCS, has access to Protected Health Information from Business Associate, is a "Business Associate" as that term is defined in the "Privacy Rule";

Whereas, pursuant to the "Privacy Rule", all Business Associate of Covered Entities must agree in writing to certain mandatory provisions regarding the use and disclosure of PHI; and

Whereas, the purpose of this Agreement is to comply with all applicable federal, state and local regulations, including but not limited to the requirements of the "Privacy Rule" (45 CFR 164.501), California Confidentiality of Medical Information Act, (California Civil Code x56 et Seq, and the Federal Health Insurance Portability and Accountability Act of 1996, (104 PL. 191, Subtitle F).

1. Obligations of HCS. HCS agrees:
    a. To not use or disclose Protected Health Information, (PHI), other than as permitted or required by the Agreement or as Required By Law.
    b. To use appropriate safeguards to prevent use or disclosure of the PHI other than as provided for by this Agreement.
    c. To mitigate, to the extent practicable, any harmful effect that is known to HCS of a use or disclosure of PHI by HCS in violation of the requirements of this Agreement.
    d. To report to the Business Associate any use or disclosure of the PHI not provided for by this Agreement of which it becomes aware.

e. To ensure that any agent, including a subcontractor, to whom it provides PHI received from, or created or received by HCS on behalf of the Business Associate agrees to the same restrictions and conditions that apply through this Agreement to HCS with respect to such information.
f. To provide access, at the request of the Business Associate, to PHI in a Designated Record Set, to the Business Associate or as directed by the Business Associate, to an Individual in order to meet the requirements under 45 CFR 164.524.
g. To make any amendment(s) to PHI in a Designated Record Set that the Business Associate, directs or agrees to pursuant to 45 CFR 164.526 at the request of the Business Associate, or an Individual.
h. To make internal practices, books, and records, including policies and procedures and PHI, relating to the use and disclosure of PHI received from or created or received by HCS on behalf of, the Business Associate, to the Business Associate, or to the Secretary of the Department of Health and Human Services or his designee, for the purposes of the Secretary determining the Business Associate's compliance with the Privacy Rule.
i. To document such disclosures of PHI and information related to such disclosures as would be required for the Business Associate to respond to a request by an Individual for an accounting of disclosures of PHI in accordance with 45 CFR 164.528.
j. To provide to the Business Associate or an Individual information collected in accordance with this agreement, to permit the Business Associate to respond to a request by an Individual for an accounting of disclosures of PHI in accordance with 45 CFR 164.528.
k. To comply with Electronic Code Set Standards as set forth in the Electronic Code Sets and Electronic Transaction Regulations, 45 C.F. R. parts 160 and 162, issued pursuant to HIPAA and published in the Federal Register on August 17, 2000, and the Standards for Privacy of Individually Identifiable Health information, 45 C.F. R. part 164 published in the Federal Register on December 28, 2000 and August 14, 2002.

2. Permitted Uses and Disclosures by HCS.
   a. Except as otherwise limited in this Agreement, HCS may disclose PHI for the proper management and administration of HCS, provided that disclosures are required by law, or HCS obtains reasonable assurances from the person to whom the information is disclosed that it will remain confidential and used or further disclosed only as required by law or for the purpose for which it was disclosed to the person, and the person notifies HCS of any instances of which it is aware in which the confidentiality of the information has been breached.
   b. Except as otherwise limited in this Agreement, HCS may use PHI to provide data aggregation to the Business Associate as permitted by 42 CFR164.504(e)(2)(1)(B).
   c. HCS may use PHI to report violations of law to appropriate Federal and State authorities, consistent with Sec. 164.502(j)(l).
   d. Business Associate will implement appropriate safeguards to prevent use or disclosure of Protected Health Information other than as permitted in this

Agreement. Business Associate will implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of any Electronic Protected Health Information that it creates, receives, maintains, or transmits on behalf of Covered Entity as required by the HIPAA Rules.

e. Covered Entity agrees to limit the disclosure of Protected Health Information to Business Associate to Protected Health Information that is specifically requested by Business Associate. Neither Party will transmit unencrypted Protected Health Information to the other over the Internet that is not secured through the use of a technology or methodology specified by the HIPAA Security Standards.

3. Obligations of the Business Associate shall:
   a. Notify HCS of any limitation(s) in its notice of privacy practices in accordance with 45 CFR 164.520, to the extent that such limitation may affect HCS's use or disclosure of PHI.
   b. Notify HCS of any changes in, or revocation of, permission by an Individual to use or disclose PHI, to the extent that such changes may affect HCS's use or disclosure of PHI.
   c. Notify HCS of any restriction to the use or disclosure of PHI that the Business Associate has agreed to in accordance with 45 CFR 164.522, to the extent that such restriction may affect HCS's use or disclosure of PHI.
   d. Not request HCS to use or disclose PHI in any manner that would not be permissible under the Privacy Rule.

4. Access and Availability of Protected Health Information
   a. Upon receipt of a request by Covered Entity for access to Protected Health Information about an individual contained in a Designated Record Set, Business Associate shall make such Protected Health Information available to Covered Entity. In the event any individual requests access to Protected Health Information directly from Business Associate, Business Associate shall forward such request to Covered Entity.
   b. Upon receipt of a request from Covered Entity for the amendment of an individual's Protected Health Information or a record regarding an individual contained in a Designated Record Set, Business Associate shall provide such information to Covered Entity for amendment and/or incorporate any such amendments in the Protected Health Information as required by 45 C.F.R. §164.526.
   c. Business Associate shall make available to Covered Entity such information as is in Business Associate's possession and is required for Covered Entity to make the accounting required by 45 C.F.R. §164.528. In the event the request for an accounting is delivered directly to Business Associate, Business Associate shall forward such request to Covered Entity.

5. Term and Termination
    a. Term. The Term of this Agreement shall be effective as of January 5, 2017, and shall terminate when all of the PHI provided by the Business Associate to HCS, or created or received by HCS on behalf of the Business Associate, is destroyed or returned to the Business Associate, or, if it is infeasible to return or destroy PHI, protections are extended to such information, in accordance with the termination provisions in this Section, Termination for Cause. Upon the Business Associate's knowledge of a material breach by HCS, the Business Associate shall either:

        (1) Provide an opportunity for HCS to cure the breach or end the violation and terminate this Agreement if HCS does not cure the breach or end the violation within the time specified by the Business Associate.
        (2) Immediately terminate this Agreement if HCS has breached a material term of this Agreement and cure is not possible; or
        (3) If neither termination nor cure is feasible, the Business Associate shall report the violation to the Secretary of the Department of Health and Human Services.

    b. Effect of Termination.
        (1) Except as provided in paragraph (2) of this section, upon termination of this Agreement, for any reason, HCS shall return or destroy all PHI received from the Business Associate, or created or received by HCS on behalf of the Business Associate. This provision shall apply to PHI that is in the possession of subcontractors or agents of HCS. HCS shall retain no copies of the PHI.
        (2) In the event that HCS determines that returning or destroying the PHI is infeasible, HCS shall provide to the Business Associate notification of the conditions that make return or destruction infeasible. Upon that return or destruction of PHI is infeasible, HCS shall extend the protections of this Agreement to such PHI and limit further uses and disclosures of such PHI to those purposes that make the return or destruction infeasible, for so long as HCS maintains such PHI.

5. Miscellaneous
    a. Regulatory References. A reference in this Agreement to a section in the Privacy Rule means the section as in effect or as amended.
    b. Amendment. The Parties agree to take such action as is necessary to amend this Agreement from time to time as is necessary for the Business Associate to comply with the requirements of the Privacy Rule and the Health Insurance Portability and Accountability Act of 1996, Pub. L. No. 104-191.
    c. Survival. The respective rights and obligations of HCS under this Agreement shall survive the termination of this agreement.
    d. Interpretation. An ambiguity in this Agreement shall be resolved to permit the Business Associate to comply with the Privacy Rule.
    e. This Agreement will be governed by the laws of the State of California.

f. No change, waiver or discharge of any liability or obligation hereunder on any one or more occasions shall be deemed a waiver of performance of any continuing or other obligation, or shall prohibit enforcement of any obligation, on any other occasion.

g. In the event that any provisions of this Agreement are held by a court of competent jurisdiction to be invalid or unenforceable, the remainder of the provisions of this Agreement will remain in full force and effect. In addition, in the event a Party believes in good faith that any provision of this Agreement fails to comply with the then-current requirements of the HIPAA Rules including the HITECH Act, such Party shall notify the other Party in writing. For a period of up to thirty days, the parties shall address in good faith such concern and amend the terms of this Agreement, if necessary to bring it into compliance. If, after such thirty-day period, the Agreement fails to comply with the HIPAA Rules, then either Party has the right to terminate this Agreement upon written notice to the other Party.

Healthcare Cost Solutions IT Infrastructure

Healthcare Cost Solutions provides a comprehensive and secure means of auditing/coding patient information, and transmission of that information to HCS's data center. Our goal is to work with the client in order to leverage our solution to meet the client's needs. The manner in which this is performed is as follows:

1) All HCS remote auditors/coders are required to have a broadband connection, with a computer running an updated version of Microsoft Windows and an industry leading corporate anti-virus solution that includes firewall protection. Windows updates are performed regularly and HCS Corporate employees monitor the status of updates and anti-virus subscriptions.

2) HCS Corporate employees will access the client's network in whatever manner deemed appropriate by the client's IT department (Citrix, IPSEC VPN, etc.). HCS will work with the client to ensure that the standards and procedures in place to protect data integrity are maintained. If Remote Auditors/Coders are required to manually move patient charts from the client's network to the HCS data center, this will be done via a secure FTP program that utilizes SSH-2 encryption/negotiation. The patient information will be uploaded to an HCS secure server, and then be moved automatically over to an HCS server network.

3) Remote auditors/coders will code the patient information, while connected via a Remote Desktop (128-bit encryption) connection to the HCS data center. HCS monitors and logs all Terminal Service connections to the HCS network. The TCP/UDP ports used to access the HCS network are customized to avoid unsolicited login attempts. Password standards are enforced and maintained by HCS Corporate employees. The Remote Desktop connection will terminate and block after a set amount of login attempts. Also all connections are disconnected after 20 minutes of inactivity.

4) The HCS data center is protected by a comprehensive and multi-layered security methodology. HCS utilizes a cutting edge firewall server that performs deep packet inspection on all incoming data traffic. It also performs Intrusion Prevention, Gateway Anti-Virus, and Anti-Spam functions. These features are regularly updated and monitored. In addition to the powerful firewall, HCS utilizes TCP/UDP port redirection to stop known port attacks against the HCS network. HCS utilizes a network attached device that backs up critical data, which is fully configurable to protect HCS and HCS client data. All PC's in the Data Center are running new versions of Windows that are kept up-to-date with service packs and Windows updates. All computers have advanced corporate anti-virus protection that are vigorously maintained and updated. All HCS servers run a stable version of Windows and Server editions that are kept up-to-date with all Windows updates and anti-virus update. HCS logs all server/network activity and monitors all traffic regularly.

5) HCS has a 24/7 network, with planned/scheduled maintenance performed as needed. All network issues are monitored and dealt with promptly by the HCS IT department.

NORTHERN INYO HOSPITAL
POLICY AND PROCEDURE

Title: Community Skills Session; Reservation, No Show or Cancellation Policy	
Scope: Nursing Education, Admissions Services, Accounts Payable	Manual: Nursing Education
Source: Nursing Education	Effective Date: 5/1/2016

PURPOSE: To establish a set plan for community members who sign up for a Northern Inyo Healthcare District (NIHD)/AHA Training Center skills session in regards to reservation, cancellation and "No Show". "No Show" is in reference to individuals who do not cancel or attend their scheduled skills session.

POLICY:

1. Community members have 5 days to submit payment from time session registration confirmation letter is sent. If payment is not received within 5 days, skills session registration will be cancelled and the slot will be reopened to additional community members.

2. Community members who have registered for a skills session and cancel no later than 5 days prior to session scheduled date will have the opportunity for refund or registration into another skills session. Registration fee will be forfeited should cancellation be less than 5 days.

3. Cancellations prior to the 5 day deadline will be refunded or the community member will be given the option to register for the next course.

4. Community members who "No Show" their scheduled skills session forfeit their registration payment.

PROCEDURE:

1. Payments will be submitted at NIHD's front admission desk, community members will receive a receipt and an email confirming payment will be sent to Nursing Education.

2. Community members seeking to cancel their session registration will email the staff member in Nursing Education who scheduled their session no later than 5 days prior to their scheduled session. Cancellations abiding by the 5 day requirement will be eligible for refund or may register for another skills session.

3. Refunds will be requested from accounts payable via Nursing Education. Email confirmation of payment will be forwarded at time of request along with community member's address.

REFERENCES:

1. N/A

CROSS REFERENCE P&P:

1. American Heart Association Training Center Policies and Procedures
2. American Heart Association Training Center QAPI
3. American Heart Association Training Center Faculty and Course Instructor Roles and Training

NORTHERN INYO HOSPITAL
POLICY AND PROCEDURE

Title: Community Skills Session; Reservation, No Show or Cancellation Policy	
Scope: Nursing Education, Admissions Services, Accounts Payable	Manual: Nursing Education
Source: Nursing Education	Effective Date: 5/1/2016

Approval	**Date**
CCOC	12/12/16
Board of Directors	

Developed: 4/2016
Reviewed:
Revised: 12/16 NW
Supercedes:

Responsibility for review and maintenance:
Index Listings:

NORTHERN INYO HOSPITAL
POLICY AND PROCEDURE

Title: Cross-Training of RN Staff	
Scope: Nursing Services	Manual: Nursing Administration
Source: CNO	Effective Date:

PURPOSE:
To describe the method for cross-training nursing staff.

POLICY:

1. Employees in a Cross Trained position shall receive orientation to that department. This does not apply to staff who may occasionally be assigned to a different department working within their competency or staff working under the direct supervision of an RN oriented to that department.
2. Cross trained positions will be posted based on the Staffing Management Plan Position Control.
3. Any cross-trained staff will:
   a. Receive an orientation to the cross-trained position
   b. Receive an annual feedback to the cross-trained department job skill performance standards or position.
   c. Complete the annual competency plan to the department job skill or position.
4. Staff may be hired into a position that requires cross-training to another department or role as part of the position.
5. Orientation will be completed to the main position hired prior to orientation to a cross-trained position. The employee shall work in the main position hired until deemed appropriate by their Director of Nursing/manager before cross-training to another department or role. Should a Director/manager determine an employee is not ready for cross training, they will develop a readiness plan for cross training.
6. The department Position Control will indicate staff currently cross-trained to another department or role.
   a. Staff who are cross trained to another position or role within the department will also be listed on the position control
7. Staff will generally only cross train to two departments and/or positions.
8. An annual feedback and on-going Competency Plan is maintained on the cross-trained employee.

DEFINITIONS:

1. **Cross-trained Staff**: Staff member has completed skills checklist and annual competencies to the cross trained department. .
2. **Floating**: A non cross trained staff person who is assigned to work in an alternate department. The person functions within the performance standards in which they are competent. In some situations, the floated RN works under the care coordination of another RN in the department to which they have been floated. i.e., Med-Surg RN floated to ICU.
3. **Cross-trained for a Skill**: Employees are provided orientation to a particular skill to be performed in another department on a per diem basis, i.e., a Scrub Tech has been trained to wrap instrument pans and can be floated to CSP. A Skills Checklist for wrapping instruments is present in the employee file. Another example is a sitter. A CNA, or Security, can be cross-trained to be a sitter.

PROCEDURE:

1. The department Position Control will indicate the number of cross trained positions within each unit. Open cross trained positions will be posted with inclusion of the job requirements within the job description for internal applicants only. Staff who are cross-trained to another department or

Title: Cross-Training of RN Staff	
Scope: Nursing Services	Manual: Nursing Administration
Source: CNO	Effective Date:

role will be the first person selected to work in the cross-trained department or role if a need exists.

2. The Director of the cross-trained department will complete an annual review of the job skills performance standards (use Annual Alternate RN review).
   a. The staff member's core position department Director will complete the annual feedback and include the cross trained department Alternate RN Review.
   b. Formal evaluation will be provided by alternate department director, should cross trained employee fail to meet performance standards.
3. Staff must work a minimum of 2 shifts per year to maintain competency in the department or position cross-trained.

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REFERENCES:

1. TJC(2016)Nursing Functional Chapter Standard NR 02.03.01

CROSS REFERENCE P&P:

1. Fixed Staff Floating
2. Staffing Management Plan
3. Orientation-Cross Training Time Frame

Committee Approval	**Date**
Orientation Competency Committee	**10/2016**
NEC	**12/2016**
Board of Directors	

Developed: 10/21/13,
Revised: 2/16, 10/16
Supercedes:

Responsibility for review and maintenance:
Index Listings:

NORTHERN INYO HOSPITAL
POLICY AND PROCEDURE

Title: Orientation/Cross Training Time Frames	
Scope: Nursing Services	Manual: NAM
Source: CNO	Effective Date:

PURPOSE:
To set a time frame on the number of hours paid to orientees to become competent in a job position hired or cross trained.

POLICY:
1. Time Frames will be established as a guide for orientation/cross training to positions within Nursing Services.
2. Exceptions to the established time frames must be approved by the manager of the department where the employee is hired.
3. Each department will track/monitor the orientation /cross training time frames of all non-exempt direct care staff including but not limited to: Registered Nurse (RN), Licensed Vocational Nurse (LVN), Certified Nursing Assistants (CNA), and Department Clerks.
4. Staff members whose orientation is 12-24 weeks are expected to work a minimum of one year or repay the cost of orientation and will sign a contract at the beginning of their orientation acknowledging this agreement.
5. Staff members whose orientation is greater than 24 weeks are expected to work a minimum of two years or repay the cost of orientation and will sign a contract at the beginning of their orientation acknowledging this agreement.
6. Staff that complete training set up at another facility to develop competency will be expected to work a minimum of two years or pay the cost of the training and will sign a contract at the beginning or their orientation acknowledging this agreement.
7. RN staff hired into specialty care areas should have at least 3 months experience as a medical surgical nurse. The CNO may approve exceptions to the medical surgical experience requirement.
8. Cross Training requires the staff member to complete annual competency validations for the department in order to maintain cross trained status. Minimum hour requirements must be met. (See Union Contract for RN union eligible nurses.) Annual performance appraisals for the cross trained position are required and will be performed by the manager/director of the department to which they are cross trained.
9. RN Staff floating to a department who are not cross trained will be given a float orientation to the department including an RN resource.

DEFINITIONS:
1. Orientation: The process of assisting new and/or transferring personnel in gaining the knowledge and skills (competency verification/validation) to function in a particular position at NIH.
2. Cross Training: The process of assisting an employee who has completed orientation in one department to gain knowledge and skills (competency verification/validation) to function in another department and/or position. Cross Training only occurs after the employee is competent to function in their hired role.
3. Float Training: The process of assisting an employee to gain knowledge of shift activity with the support of a resource RN. Staff will function within the competencies of their Job Description.

NORTHERN INYO HOSPITAL
POLICY AND PROCEDURE

Title: Orientation/Cross Training Time Frames	
Scope: Nursing Services	Manual: NAM
Source: CNO	Effective Date:

PROCEDURE:

1. The following time frames are to be used as a guideline by the Director and/or the designated education coordinator (Clinical Staff Educator, Coordinator) to complete the orientation process.

Category of employee	Time Frame
a. Employee with experience in clinical area	2-3 weeks
b. Experienced employee entering new clinical area	3-6 weeks
c. Recently graduated nurse (less than one year experience as an RN/LVN)	7 weeks
d. Department Clerk with experience	2 weeks
e. Certified Nursing Assistant/Tech/Dept. Clerk	3-4 weeks
f. Nursing Assistant/ERT/CSP Tech with experience	2-3 weeks
g. Coordinator/Manager/Director	90 days
h. House Supervisor without management experience	2-3 weeks
i. House Supervisor without management experience new to NIH	3-4 weeks
j. House Supervisor with management experience	2-3 shifts
k. Surgery RN/ST without experience	6-9 months
l. Surgery RN/ST with experience	6-8 weeks
m. OB RN without experience	6-9 months
n. OB RN with experience	2-3 weeks

REFERENCES:

1. TJC (October 2013) CAMCAH Human Resources Chapter. Standard HR01.04.01 The critical access hospital provides orientation to staff. Joint Commission Resources, Oakbrook, Illinois.

CROSS REFERENCE P&P:

1. Nursing Competency Plan
2. Competency Notebook
3. Cross-Training RN Staff

Approval	**Date**
OCC	**10/2016**
NEC	**12/2016**
Board of Directors	

Developed: 6/3/2015
Reviewed:
Revised: 10/16

NORTHERN INYO HOSPITAL
POLICY AND PROCEDURE

Title: Nursing Assessment & Reassessment	
Scope: Nursing Services	**Manual:** CPM - Admission, Discharge, Transfer Documentation (ADT)
Source: Director of Nursing Practice	**Effective Date:**

PURPOSE:

To determine the care, treatment and services that will meet the patient's needs based on the initial RN assessment. To determine the RN reassessment of the patient's needs throughout the course of care, treatment and services.

POLICY:

1. At the time of patient admission, all patients will have an initial nursing assessment (which includes physical, psychological, and social status parameters), completed by an RN based on the patient's age and population specific needs.

2. The time of admission is defined by each nursing patient care department, outlining specific time frames for completion of assessment with time frames established based on that department's Scope of Service (see attached chart time frames).
    a. Immediately upon arrival, to nursing patient care department, vital signs will be obtained and a Quick Check assessment will be performed. Refer to A Quick Check policy and procedure. If the Quick Check assessment reveals the patient to be severely compromised, a complete and thorough assessment will be performed immediately. This may include the calling of the Rapid Response Team.

3. As appropriately determined by the RN performing the initial assessment and/or as indicated by the Admission Medical Staff Practitioner Orders, other disciplines will be contacted to assess the patient.

4. Based on the Initial Nursing Assessment, patient needs are prioritized and an individualized nursing plan of care is developed for the patient.

5. The Interdisciplinary Plan of Care is developed based on the collaborative interdisciplinary team's assessment and goals established.
    a. The House Supervisor (HS) monitors the Interdisciplinary Plan of Care for Perinatal Services, ICU and Acute/Subacute Services.
    b. The caseload RN monitors the Interdisciplinary Plan of Care in departments that practice Primary Nursing.

6. Reassessment will be determined by the patient's diagnosis, nursing department admitted, complexity of care, duration of care, and patient response to care and treatment.

7. Discharge planning begins on the day of admission as a collaborative effort by the RN with other disciplines. Case Management develops the discharge plan.

PROCEDURE:

1. The RN chooses the initial nursing assessment specific to the age of the patient and department.

2. The initial nursing assessment will include identification of the patient, the reason for admission, patients known allergies, history and physical exam, function health pattern's as defined using the McKesson clinical practice model, advanced directive, medication history, and content specific to the population and individual needs of the patient.

3. Based on the initial nursing assessment, clinical screens have been established that generate automatic referrals to the following interdisciplinary team members:
    a. Rehabilitation Services Screen

Title: Nursing Assessment & Reassessment	
Scope: Nursing Services	**Manual:** CPM - Admission, Discharge, Transfer Documentation (ADT)
Source: Director of Nursing Practice	**Effective Date:**

b. Cardiopulmonary Services Screen
c. Nutritional Services Screen
d. Social Services Screen

4. The RN will complete a reassessment according to time frames established for the departments, usually in correlation with the start of each shift on the daily assessment record.
    a. The depth and frequency of reassessment is dependent on the patient's response to care, treatment and services provided, (See attached time frames).

REFERENCES:

1. TJC Comprehensive Accreditation Manual for Hospitals. Functional Chapter Provision of care PC01.02.03 EPI, and Record of Care treatment Services 01.03.01 EPI

CROSS REFERENCE P&P:

1. Organization Wide Assessment and Reassessment of Patients
2. Nursing Patient Profile and Admission Assessment
3. Nursing plan of Care
4. Quick Check
5. Rapid response Team
6. Interdisciplinary Plan of Care

Approval	**Date**
NEC	12/16
Board of Directors	

Developed: 11/16
Reviewed:
Revised:
Supercedes:

Nursing Assessment/Reassessment

Department	Initial Assessment Completion	Initial Assessment Plan of Care Completion	Update Plan of Care	Reassessment	Interdisciplinary Plan of Care update
Acute/Subacute					
Second Floor Medical/Surgical Telemetry	Quick Check 30 min 12 hours	12 hours	Review Every 12 hours and update as needed	• Head to Toe every 12 hours • VS every 12 hours and systems not WNL or more often based on condition.	Every 24 hours.
Second Floor Medical/Surgical Pediatrics	Quick Check 30 min 12 hours	12 hours	Review Every 12 hours and update as needed	• Head to Toe every 12 hours • VS every 8 hours and systems not WNL or more often based on condition.	Every 24 hours.
Swing	Quick Check 30 min 12 hours	12 hours	Review Every 12 hours and update as needed	• Head to Toe every 12 hours • VS every 12 hours and systems not WNL or more often based on condition.	Every 24 hours.
Observation	Quick Check 30 min 12 hours	12 hours	Each Visit as needed	• Head to Toe every 12 hours • VS every 12 hours and systems not WNL or more often based on condition.	Every 24 hours.
Specialty Care					
ED	See Emergency Department Standards of Care				
ICU	Quick Check upon arrival 4 hours initial	12 hours	Review every 12 hours and update as needed	• Head to Toe every 12 hours (4 and 1600) • VS every 4 hours and systems not WNL	Every 24 hours.
Perioperative Services					
Department	Initial Assessment Completion	Initial Assessment Plan of Care Completion	Update Plan of Care	Reassessment	Interdisciplinary Plan of Care update
PAT	Phone Visit	Phone Visit	SDS	• SDS	May do referral
SDS	If no PAT, Day of Surgery, Prior to Surgery	Prior to Surgery	Day of Surgery as needed	• Prior to Surgery • Upon return • At disposition	May do referral
Surgery	Upon Arrival	Upon Arrival	As needed	• Based on Condition • End of Case	———

Nursing Assessment/Reassessment

Department	Initial Assessment Completion	Initial Assessment Plan of Care Completion	Update Plan of Care	Reassessment	Interdisciplinary Plan of Care update
PACU - Adult	Upon Arrival 30 min	30 min	As needed	• As clinically indicated • At disposition	May do referral
PACU - Peds	Upon Arrival	15 min	As needed	• As clinically indicated • At disposition	May do referral
Endo/Special Procedures	Day of Procedure Prior to Procedure	Prior to Procedure	Day of procedure as needed	• Prior to Surgery • End of case • At disposition	May do referral
Interventional Radiology	If no PAT, Day of Procedure Prior to Procedure	———	———	• Prior to Surgery • End of case • At disposition	May do referral
Outpatient Services					
Infusion Center	Upon Arrival 30 min	———	———	• Each visit or clinically indicated • At disposition	May do referral May do transfer or admit
Perinatal Services					
L&D: Triage	Upon arrival Within 30 min	N/A	N/A	• Every hour • At disposition	May do referral May transfer or admit
L&D Ante partum Visit	Upon Arrival Within 60 min	During Visit	Each Visit	• Based on procedure • At disposition	May do referral
L&D	Upon Arrival Within 60 min	Within 60 min	Review every 12 hours and update as needed	• Head to Toe every 12 hours • Reassessment more frequent if condition dictates.	Every 24 hours
Normal Newborn	Upon Birth	12 hours	Review every 12 hours and update as needed	• Every 12 hours, more frequent if condition dictates.	Every 24 hours
Post Partum Mom	• Every 15 min for initial 1 hour recovery, then 30 min for 1 hour additional recovery. • Every 12 hours at beginning of shift, within 60 min.	12 hours	After Delivery review every 12 hours and update as needed	• Head to Toe after delivery	Every 24 hours
Peds Neonate Inpatient	Upon Arrival within 60 min	12 hours	Review every 12 hours and update as needed	• Head to Toe every 12 hours and update as needed.	Every 24 hours
Peds Neonate Outpatient (NEST)	Upon Arrival within 60 min.	First Visit	As needed.	• Follow/up visits as needed	May do referral

NORTHERN INYO HOSPITAL
POLICY AND PROCEDURE

Title: Nursing Care Plan	
Scope: Nursing Services	Manual: CPM
Source: CNO	Effective Date:

PURPOSE:

1. Nursing care plans are designed to:
    a. Allow nursing staff to provide patients with individualized safe and quality care by carrying out the nursing process in a systematic fashion.
    b. Identify the planning process when patient goals and expected outcomes are established and nursing interventions selected.
2. After the RN completes the initial nursing assessment, appropriate plans of care are developed.
3. Nursing Care plans have been incorporated into the electronic health record to facilitate report and continuity of care through ease of access.
4. Nursing care plans shall also be considered when determining patient acuity.

POLICY:

1. The nursing care plan is developed incorporating information from the initial nursing assessment, Physician History & Physical (H&P) and physician order sets.
    a. The care plan gives direction in providing care for the patient/family and is used as a means of communication that allows for the continuity and consistency of care.
    b. Care planning and the development of an individualized plan of care will be based on established nursing standards of care and standards of practice that reflect patient needs identified through the assessment process.
    c. The plan of care will be consistent with therapies of other disciplines, patient/family needs and will be focused on collaborating with other disciplines.
2. The initial nursing assessment is completed by the RN within time frames established for each nursing department. (See Nursing Assessment and Reassessment chart time frames)
    a. Referrals to the interdisciplinary team are generated based on patient's answers to clinical screen questions within the initial nursing assessment.
    b. Patient problems are identified and prioritized in the selection of a medical problem or nursing diagnosis with the development of a plan of care.
3. The evaluation of the patient's response to the plan of care is reviewed and evaluated each shift. The plan of care is updated each shift when patient condition changes.
4. The patient progress towards the goal is evaluated as part of the daily interdisciplinary care conference.
5. The framework for nursing practice is the nursing process which reflects the delivery of care based on the following steps:
    a. Assessment
    b. Identification and prioritization of patient problems or needs
    c. Mutual planning and establishment of goals and interventions
    d. Implementation of interventions by nursing and the health care team

PROCEDURE:

1. After completing the initial nursing assessment, the RN identifies patient needs or problems.
    a. Automatic referrals triggered by clinical screens built into the initial nursing assessment are sent to members of the interdisciplinary team.
    b. Those interdisciplinary team members who receive a referral, complete an assessment, and when appropriate, contact the medical staff practitioner and/or initiate a care/treatment plan.
2. The RN develops the plan of care in collaboration with the patient/family-caregiver from the identified initial nursing assessment patient needs or problems (see references below).

3. The plan of care and patient response, including progress toward goals/outcomes and discharge, are reviewed as part of the shift report hand off using SBAR-QC.

REFERENCES:

1. TJC Comprehensive Accreditation Manual for Critical Access Hospitals. Function Chapter Provision of Care. RC.02.01.01, EP 2
2. Gulanick & Myers (2014) Nursing Care Plans Diagnoses Interventions and Outcomes. Elsivier: Philadelphia.

CROSS REFERENCE P&P:

1. Initial Nursing Assessment
2. Nursing Admission/Reassessment Interdisciplinary Team
3. Clinical Screens Built into Initial Assessment
4. Nursing Standards 6010 I VD in NAM
5. Interdisciplinary Plan of Care 6265 IA

Approval	**Date**
CCOC	2/2016
NEC	12/2016
Board of Directors	

Developed: 7/94
Reviewed: 2/95, 4/96, 8/2000, 2/2006, 4/09, 5/11, 9/12
Revised: 1/16, 12/16

REACH℠ Air Medical Services

Above & Beyond

Date: _____
Hospital: _____
Name: _____
Address: _____

Re: **Air Medical Transportation Services – Preferred Provider Agreement**

Dear _____,

_____ ("**Hospital**"), requires access to fixed wing air medical transportation services to transfer certain patients to other medical facilities. It is important for the care of Hospital's patients that such services be provided in a professional, quality and timely manner. It also is beneficial to Hospital's patients that such services be provided in a cooperative, consistent and seamless manner. Hospital believes that it can best achieve these goals by being proactive and by pre-selecting and maintaining a relationship with a preferred provider of air medical transportation services.

REACH Air Medical Services, LLC, d/b/a Sierra Life Flight, a California limited liability company ("**Company**"), is a well-established and respected provider of 24-hour, 365 day-a-year, emergency air medical transportation services for critically ill or injured patients, with a team of specially trained flight nurses, paramedics and pilots. Company desires to work closely with Hospital to meet the goals of providing the best air medical transportation services for Hospital's patients.

Accordingly, Hospital agrees that:

- It will make its medical personnel available for appropriate training to be provided by Company.
- It will (a) request Services first from Company when Hospital is the sending facility and one of its patients has a need for fixed wing air medical transportation services (hereinafter referred to as "**air medical transportation services**"), and (b) it will recommend Company Services upon the request of any third party; provided that the obligations of Hospital set forth in the foregoing clauses (a) and (b) shall not apply and Hospital may use or recommend the services of another air medical transport service provider (i) during any period of time when the Company aircraft are unavailable (whether because they are out of service, in the process of responding to a mission or otherwise) or out of position to respond to a specific call in an appropriate and timely manner (i.e., patient care dictates that a different service be used), (ii) based on specific patient or independent physician request, or (iii) with Company's prior written consent.
- It will not enter into, directly or indirectly, formally or informally, any first call, preferred provider or similar agreement or arrangement (including the use of direct dial telephones or other direct communication devices) with any person or entity to provide or arrange for air medical transportation services into or out of any Hospital location for the Hospital or any patient.

Company agrees that:

- It will provide appropriate training to Hospital personnel in connection with the assessment and preparation of patients to be transported by Company.

- It will use reasonable efforts to increase community awareness regarding the benefits of "REACH for Life Membership" on out-of-pocket copayments for emergency air medical transports.
- It will strive to make its aircraft and crews available on a 24 hours a day, seven days a week basis; provided, however, Hospital understands and acknowledges that availability may be limited (in Company's sole and absolute discretion) based upon weather conditions, weight limitations, current use of the aircraft for other missions, aircraft maintenance, or other conditions; provided, further, if Company aircraft are unavailable, Company will assist Hospital in locating an alternative provider of the services.
- When it accepts a request for services, Company will:
    - provide a reasonable estimate of timely response to Hospital, considering the geographic proximity of the responding aircraft;
    - be responsible for all expenses associated with the provision of its air medical transport services;
    - not inquire into the prospect of receiving payment prior to furnishing services; but Company will directly bill and look solely to the transported patient and/or the patient's third party payor or responsible party for payment of all transportation, medical care, supplies, drugs or other services described herein; and
    - collect all patient care information and billing information as it would in its usual business practice.
- It will strive to minimize response time through early activation of crews allowing for dispatching and response of aircraft prior to confirmation of receiving facility when possible.
- It will provide quarterly data reporting of service data to designated Hospital personnel, such as flight volumes, requests, transports, and response times.
- Company will obtain and maintain general liability insurance, in an amount consistent with industry standards, and be solely responsible for and defend, save and hold harmless Hospital from any and all liability for the negligent acts or omissions of Company or its personnel; and
- Company provides outreach education as a general service to support the needs of local communities in which it operates. Company desires to work collaboratively with Hospital to provide such outreach education, either as a co-sponsor and/or by having its employees attend.

Both Hospital and Company agree that:

- The referring physician at the Hospital will decide when a patient is to be transferred. Such referring physician will also decide to which institution the patient will be transferred, depending on the patient's preference, needs, and the availability of resources to meet those needs and shall certify that the patient requires airborne emergency medical service transport. Such referring physician shall be responsible for arranging with the appropriate receiving physician at the designated receiving hospital to assure the continuity of medical care, and assuring that proper arrangements have been made to provide an efficient transfer of the patient. Patient preparation prior to transfer by Company will be the responsibility of the referring physician in consultation with the Company medical team. Patient care en route will be guided by such protocols, policies and procedures regarding patient safety and care by Company personnel as established by Company.

- HIPAA Compliance. The parties agree that, in the performance of its duties under this Agreement, Company is acting as a covered entity as described in the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") and regulations promulgated hereunder by the U.S. Department of Health and Human Services ("HIPAA Regulations"). Each party, as a covered entity shall comply with its obligations with respect to the confidentiality, privacy and security of patients' medical information and shall take the required steps to preserve the confidentiality of this information, including the training of staff and the establishment of proper procedures for the release of such information, as required by HIPAA and the HIPAA regulations and other applicable laws and regulations.
- Neither party shall exercise any control or direction over the other party or the services that each other renders and nothing in this letter agreement is intended to create any right of either party to intervene in any manner in the methods or means by which either party shall render medical or transportation services. Further, the parties are independent contractors, and are not partners, agents, or parties in a joint venture.
- They intend to comply fully with all applicable state and federal laws and regulations, including but not limited to The Social Security Act, the federal Anti-Kickback Statute, the federal False Claims Act, and all applicable state and federal fraud and abuse laws and rules. If any terms or conditions of this letter agreement are determined by any court or by the OIG of the Department of Health and Human Services to be contrary to any such statutes or regulations, the parties agree to promptly and in good faith confer and resolve any issues so as to make the performance of this letter agreement consistent with all applicable statutes and regulations. Additionally, both parties hereto agree that any patient transfers shall be in compliance with EMTALA, 42 U.S.C. 1395dd et seq. and any amendments thereto, and such other requirements as may be imposed by the Secretary of Health and Human Services, and any applicable State transfer laws.
- This letter agreement shall be binding on the Hospital and Company and be in effect for a term of 36 months from the date of this letter. Notwithstanding the foregoing, this letter agreement may be terminated prior to normal expiration, (i) if both parties agree in writing, (ii) by a non-breaching party, if the breaching party does not cure a material breach within 30 days following written notice thereof by the non-breaching party, (iii) after the initial term, by either party for any reason providing the other party with at least 90 days advance written notice of intent to terminate or (iv) by Company giving Hospital at least 60 days advance written notice of intent to terminate due to adverse changes in flight volumes, reimbursement rates or other business prospects or circumstances which the parties are not able to resolve in a mutually acceptable manner within 30 days following such notice.

Please acknowledge your agreement with the foregoing by returning to me a copy of this letter agreement signed by you in the space provided below.

Sincerely,

_____

Anna Blair
Vice President Business Relations and Development
REACH Air Medical Services, LLC d/b/a Sierra Life Flight
451 Aviation Boulevard, Suite 101
Santa Rosa, CA 95403
Phone: 707.324.2400
Fax: 707.324.2478
Email: anna.blair@reachair.com

AGREED BY HOSPITAL:

By: _____

Name: _____
Title: _____
Date: _____