Northern Inyo Hospital

April 19 2017 Regular Meeting

April 19 2017 Regular Meeting - April 19 2017 Regular Meeti

AGENDA

NORTHERN INYO HEALTHCARE DISTRICT
BOARD OF DIRECTORS REGULAR MEETING
April 19, 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.).*
3. Old Business
   A. Bishop Union High School student clinic (*action item*).
4. New Business
   A. Fiscal Department Policy and Procedure Approvals (*action items*):
      1. *Remote Deposit Service*
      2. *Sales and Use Tax*
   B. Nursing Department Policy and Procedure approval, *Pain Management and Documentation* (*action item*).
   C. Compliance Department Policy and Procedure approval, *Minors with Legal Authority to Consent* (*action item*).
   D. Hospital Wide Policy and Procedure annual approvals (*action items*); Attachment A to Agenda.
   E. Approval of Northern Inyo Healthcare District Capital Budget for 2017/2018 fiscal year (*action item*).
   F. NIHD Auxiliary Bylaws review and approval (*action item*).
   G. Appoint ACHD Delegate and Alternate (*action item*).

Consent Agenda (action items)

5. Approval of minutes of the March 15, 2017 regular meeting
6. 2013 CMS Validation Survey Monitoring, April 2017
7. Financial and Statistical Reports for the period ending February 28, 2017

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8. Data and Information Committee Report (*information item*)
9. Chief of Staff Report; Joy Engblade, MD:
   A. Policies/Procedures/Protocols/Order Set approvals (*action items*):
      - *Training and Competency in Point-of-Care Testing*
      - *Point of Care Accu-Check Blood Glucose Testing*
      - *Gastric Occult Blood*
      - *Fecal Occult Blood by Beckman Coulter Card Method Hemoccult SENSA*
      - *Urine Dipstick Chemistries*
      - *Point of Care HemoCue Hbv201 + Hemoglobin Testing – (RHC)*
      - *Hemosure-One Step Immunological Fecal Occult Blood Test – (RHC)*
      - *Point of Care QuickVue hCG Urine Test – (RHC)*
      - *Point of Care QuickVue Dipstick Strep A Test – (RHC)*

   B. Radiology Services Critical Indicators 2017 (*action item*)

   C. Medical Staff Appointment/Privileges (*action items*)

   - Active Staff:
      - N. Michelle Inforzato, MD (*hospitalist*)
      - Jessica Paulson, MD (*emergency medicine*)
   - Consulting Staff:
      - Joseph Ludwick, MD (*pediatric cardiology*)
      - Katrinka Kip, MD (*pediatric cardiology*)
   - Temporary Staff:
      - Wilbur Peralta, MD (*hospitalist – temporary assignment until 8/31/17*)
      - Hung Nguyen, MD (*hospitalist – temporary assignment until 8/31/17*)

   D. Advance Practice Provider Privileging (*action item*)
      - David Nicholson, CRNA (nurse anesthesia)

   E. Extension of Privileges and Change in Staff Category (*action item*)
      - Carolyn Saba, MD (anesthesiology)
         - Change of Staff category from Temporary to Consulting Staff and extension of Privileges from 5/31/17 to 12/31/17 during the pendency of Dr. Saba's Consulting Staff reappointment application

   F. Advancement (*action item*)

- Manish Pandya, MD (hospitalist) – Request to advance from Provisional Active Staff to Active Staff. Member is in good standing.

G. Resignation (*action item*)

- Felix Karp, MD – Effective 3/31/17; privileges in effect through 12/31/17

H. Other (*information item*)

- ACLS will become a required certification for new hospitalist applicants and for current hospitalists at the time of Medical Staff reappointment

10. Chief Operating Officer Report (*information item*).
11. Chief Accounting Officer Report (*information item*).
12. Chief Nursing Officer Report (*information item*).
13. Chief Human Relations Officer Report (*information item*).
14. Reports from Board members (*information items*).
15. 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, 4 matters pending (*pursuant to Government Code Section 54956.9*).
    C. Discuss trade secrets, new programs and services (estimated public session date for discussion yet to be determined) (*Health and Safety Code Section 32106*).
16. Return to open session and report of any action taken in closed session.
17. 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" TO APRIL 19 2017 BOARD AGENDA

ANNUAL POLICY AND PROCEDURES APPROVAL LIST

POLICIES TO THE BOD
ENVIRONMENTAL SERVICES

	POLICY & PROCEDURES TO THE BOARD	APRIL, 2017			
	EVS				
	TITLE	TO BOD	APPROVED	COMMENTS	P&P UPDATED
1	Cleaning Agents: Cleaning Solutions	4/19/2017			
2	Cleaning Agents: Disposal of Cleaning Agents	4/19/2017			
3	Cleaning Agents: Identifying and Labeling Cleaning Agents	4/19/2017			
4	Cleaning Agents: Selection, Measurement, and Use of Cleaning Agents	4/19/2017			
5	Cleaning Procedure: Patient room Daily and at Discharge	4/19/2017			
6	Cleaning Procedures: Clinical Support Areas: Clinical Support & Ancillary Service Areas	4/19/2017			
7	Cleaning Procedures: Clinical Support Areas: Dietary Department	4/19/2017			
8	Cleaning Procedures: Clinical Support Areas: Pharmacy	4/19/2017			
9	Cleaning Procedures: Clinical support Areas: Protocol for Clinical Laboratory	4/19/2017			
10	Cleaning Procedures: Non Patient Care Equipment: Refrigerators	4/19/2017			
11	Cleaning Procedures: Non Paitent Areas: Conference/Meeting Rooms	4/19/2017			

POLICIES TO THE BOD
PHARMACY

	POLICY & PROCEDURES TO THE BOARD	APRIL, 2017			
	PHARMACY DEPT.				
	TITLE	TO BOD	APPROVED	COMMENTS	P&P UPDATED
1	Medication Security	4/19/2017			
2	Medication in the Absence of the Pharmacist	4/19/2017			
3	Non-Formulary Procurement of Medication	4/19/2017			
4	Medication Shortage and Outages	4/19/2017			
5	Nebulized Lidocaine	4/19/2017			

POLICIES TO THE BOD

PROPERTY MGMT, SECURITY AND MAINTENANCE

	POLICY & PROCEDURES TO THE BOARD	APRIL, 2017			
	PROPERTY MGMT, SECURITY AND MAINTENANCE				
	TITLE	TO BOD	APPROVED	COMMENTS	P&P UPDATED
1	Hazardous Chemicals	4/19/2017			
2	Hazardous Materials & Waste Inventory	4/19/2017			
3	Eyewash-Shower Stations	4/19/2017			
4	Hazardous Spill & Exposure	4/19/2017			
5	EPA SPCC Spill Prevent Ctrl & Countermeasures	4/19/2017			
6	Mercury Spills	4/19/2017			
7	Managing Hazardous Gases & Vapors	4/19/2017			
8	Formaldehyde	4/19/2017			
9	Gluteraldehyde	4/19/2017			
10	Ethylene Oxide	4/19/2017			
11	Permits, Licenses, Manifests & MSDS	4/19/2017			
12	Labeling Hazardous Material & Waste	4/19/2017			

POLICIES TO THE BOD
REHABILITATION

	POLICY & PROCEDURES TO THE BOARD	APRIL, 2017			
	REHABILITATION				
	TITLE	TO BOD	APPROVED	COMMENTS	P&P UPDATED
1	Rehab Therapy -G-Code Tests and Charges	4/19/2017			
2	Rehab Therapy Patient Management - Outpatient	4/19/2017			

Draft: Andreas, Linda (DON ICU/Acute/Subacute Services)
Area: Published

Ref #	TITLE	TO BOD	APPROVED	COMMENTS
1203	Abuse Policy for Swing Bed Patients			
3980	Acute/Sub Acute Services Standards of Care–Adult			
3806	Acute/Subacute Care Services Method of Practice: Patient Coordinated Care			
582	Admission of Pediatric Patient*			
183	Admission to the Acute Sub Acute Department*			
1081	Admission, Documentation, Assessment, Discharge, and Transfer of Swing-Bed Patients			
3939	Cardiac Monitoring*			
244	Documentation of Patient Care			
3808	Education of Swing Bed Resident and Family			
265	Emergency Paging System			
278	Falls Prevention Reminders			
3698	Gait Belt Policy			
4024	HUGS/PEDZ Policy*			
259	ICU Acuities			
299	ICU Consultation Criteria			
323	ICU Infection Control/Isolation Room Policy			
564	ICU Staffing			
335	Insulin Continuous Subcutaneous Infusion Self			
326	Intensive Care Service			
1147	Inter-disciplinary Swing Bed Care Plan			
328	IV Medications For The Control Of Pain/Anxiety			
322	LVN'S Providing Care For ICU Patients Guidelines			
648	Medical Records Requirements of Swing Bed			
4023	Newborn & Pediatric Security and Abduction			
354	Noting Physician Orders			
1083	Nutrition for Swing-Bed Patients			
3981	Opioid Administration*			
3922	Opioid Sedation Scale*			
451	Patient Valuables*			
180	Patient Acuity - Patient Care Flow Sheet*			
261	Patient Admission To ICU			
313	Patient Complications/Emergencies			
3921	Patient Controlled Analgesia (PCA)*			
243	Patient Discharge			
368	Patient Discharge Or Transfer Out Of ICU			
369	Patient Disposition In The ICU			
3774	Patient Mobility Assessment			
355	Patient Orientation To The ICU			
3898	Patient Restraints (Behavioral & Non-Behavioral)*			
443	Patient Transfer from ICU or ER to Med-Surg Unit			
584	Pediatric Admission Assessment			

615	Pediatric Emergency Code System (Broselow-			
579	Pediatric Standards of Care and Routines*			
266	Physician Guidelines For Utilizing The ICU			
390	Post Operative Patient Care In The ICU			
387	Qualifications For ICU RN			
3807	Recognizing and Reporting Swing Bed Resident			
1084	Rights of Swing Bed Patients			
277	Risk Fall Assessment-ICU			
1194	Risk-Fall assessment-Med Surg			
329	Saline Lock For Blood Draw			
3822	Scope of Service Acute/Subacute*			
4002	Scope of Service Hospice*			
3805	Scope of Service Swing Bed			
1089	Services for Swing-Bed Patients			
3681	Skin Assessment Using the Braden Scale			
3630	Standards of Care - SWING Bed Resident			
1230	Standards of Patient Care in ICU			
1142	Swing Bed Patient Restraints*			
1140	Swing Bed Patients Inter-disciplinary Care			
397	Syringe Pump			
539	Thrombolytic Therapy Consent			
431	Total Parenteral Nutrition Protocol			
561	Transducer System Procedure-vascular lines			
436	Transfer & Transportation for Patients			
385	Use Of The Peripheral Nerve Stimulator			
3940	Weights for Infant and Pediatric Patients*			
307	Withholding Resuscitative Measures In The ICU			

NORTHERN INYO HOSPITAL
POLICY AND PROCEDURE

Title: Sales & Use Tax	
Scope: District	Department: Fiscal Services
Source: Accounting	Effective Date: Not Approved Yet

Purpose:
To assess and pay sales and use taxes in accordance with respective jurisdictional law.

Policy:
Northern Inyo Healthcare District (NIHD) is in the business of providing healthcare services as defined in California Board of Equalization (BOE) Publication 45. NIHD, as a medical service facility, is considered the consumer, rather than a retailer, of tangible personal property. Sales tax is not extended to patients.
NIHD will generally pay tax to suppliers or use tax directly to the BOE for purchase of property, other than for exempt purchase of medicines, medical supplies and products as defined in BOE Publication 45.

Procedure:
1. NIHD, the consumer, will pay sales tax directly to suppliers as defined in BOE Publication 45.
2. In the event that sales tax is not collected by the supplier, NIHD will assess sales or use tax and pay the amount due directly to the BOE on a monthly basis.*
3. Suppliers who do not collect sales tax will be contacted and asked to assess in all applicable circumstances.
4. Use tax is to be assessed on the following:
    a. Tangible personal property in which sales tax was not paid to the supplier
    b. Sales of meals to employees, medical staff, and visitors
    c. Coin-operated vending machine sales
    d. Miscellaneous retail sales including medical records, central supplies, and Xerox copies
    e. Sales of fixed assets
5. Use tax is to be paid in the jurisdiction where the consumer takes possession.
6. Records of self-assessed sales tax, including vendor, invoice number, and total taxable amount, and assessed tax must be kept for a minimum of eight years.

*California recognizes reciprocity. If tax collected by the suppliers, including out-of-state retailers, is less than California state and local taxes, the *difference* should be recorded as use tax and paid to the BOE.

Committee Approval	**Date**
Fiscal Department Managers	
Administration	
Board of Directors	

Responsibility for review and maintenance:
Index Listings:
Developed:
Revised:
Reviewed:

NORTHERN INYO HEALTHCARE DISTRICT
POLICY AND PROCEDURE

Title: Remote Deposit Service	
Scope: District Wide	Department: Fiscal Services
Source: Accounting	Effective Date: Not Approved Yet

Purpose:
To process remote deposit according to bank standards and safe keep documents while reducing risk to the district.

Policy:
Northern Inyo Healthcare District (NIHD) banks with MUFG Union Bank. Remote Deposit Service is provided to reduce travel to and from the local branch, deposit funds in a more timely manner, and reduce transaction costs. It is NIHD's policy to deposit transactions by remote deposit software delivery whenever possible.

Procedure:
1. NIHD will purchase or lease a remote deposit scanner from the banking institution. The scanner is to remain on NIHD premises at all times and cannot be removed from the premise without prior written notification to the banking institution.
2. NIHD staff is prohibited from sharing his or her user ID and password with other individuals. Staff is also prohibited from using another individual's user ID and password. Sharing of confidential banking information including user ID and password is to be reported to the controller immediately.
3. Employee use of the service is subject to audit by the program administrator (CFO and/or controller).
4. Internal controls are necessary to establish procedures, reduce errors, and prevent fraud and theft. Dual control will be established as a form of internal control.
    a. Accounts receivable (AR) staff will scan the deposit to the banking institution's web delivery software using the leased or purchased scanner.
    b. Accounting staff will submit (approve) the deposit through the web delivery software once all deposit transactions are received from AR staff.

    Deposit transactions (checks) are to be transferred to accounting staff immediately following deposit scanning to prevent duplicate deposits.
5. Original checks are to be stored in a locked file cabinet or similar storage device for 90 calendar days.
    a. Only authorized staff will be provided access to the original documents.
    b. Keys to the storage device are to be kept in personal possession or accessible to authorized employees only.
    c. Keys may not be shared with unauthorized individuals.
    d. Original checks are to be destroyed after 90 days.
6. Deposits submitted Monday through Friday before 5pm PST will be processed the same business day. Deposits submitted after 5pm PST Monday through Friday or on bank holidays and/or weekends will be processed the next banking business day.

Title: Remote Deposit Service	
Scope: District Wide	Department: Fiscal Services
Source: Accounting	Effective Date: Not Approved Yet

7. In the event that the web software is unavailable or internet connectivity is not accessible for a period of at least 24 hours, physical deposits will be prepared and physically taken to the local branch by accounting staff on the date the deposit is received from AR staff.
8. Cash deposits will be transported by accounting staff to the local branch one per week *and* on the last banking business day of the month.
9. Petty cash funds may be affected by limited travel to and from the local branch. Petty cash fund increases (or decreases) will be evaluated on a case-by-case basis as necessary. Petty cash funds are to be maintained in the smallest denominations possible, including coin, to provide change to patients.
10. Bank deposits must be retained for 7 years according to the California Hospital Association. Bank deposits are available electronically from MUFG Union Bank for 7 years.

Committee Approval	**Date**
Compliance Committee	
Policy and Procedure Committee	
Medical Executive Committee	
Administration	
Board of Directors	

Responsibility for review and maintenance:
Index Listings:
Developed:
Revised:
Reviewed:

NORTHERN INYO HOSPITAL
POLICY AND PROCEDURE

Title: Sales & Use Tax	
Scope: District	Department: Fiscal Services
Source: Accounting	Effective Date: Not Approved Yet

Purpose:
To assess and pay sales and use taxes in accordance with respective jurisdictional law.

Policy:
Northern Inyo Healthcare District (NIHD) is in the business of providing healthcare services as defined in California Board of Equalization (BOE) Publication 45. NIHD, as a medical service facility, is considered the consumer, rather than a retailer, of tangible personal property. Sales tax is not extended to patients.
NIHD will generally pay tax to suppliers or use tax directly to the BOE for purchase of property, other than for exempt purchase of medicines, medical supplies and products as defined in BOE Publication 45.

Procedure:
1. NIHD, the consumer, will pay sales tax directly to suppliers as defined in BOE Publication 45.
2. In the event that sales tax is not collected by the supplier, NIHD will assess sales or use tax and pay the amount due directly to the BOE on a monthly basis.*
3. Suppliers who do not collect sales tax will be contacted and asked to assess in all applicable circumstances.
4. Use tax is to be assessed on the following:
    a. Tangible personal property in which sales tax was not paid to the supplier
    b. Sales of meals to employees, medical staff, and visitors
    c. Coin-operated vending machine sales
    d. Miscellaneous retail sales including medical records, central supplies, and Xerox copies
    e. Sales of fixed assets
5. Use tax is to be paid in the jurisdiction where the consumer takes possession.
6. Records of self-assessed sales tax, including vendor, invoice number, and total taxable amount, and assessed tax must be kept for a minimum of eight years.

*California recognizes reciprocity. If tax collected by the suppliers, including out-of-state retailers, is less than California state and local taxes, the *difference* should be recorded as use tax and paid to the BOE.

Committee Approval	**Date**
Fiscal Department Managers	
Administration	
Board of Directors	

Responsibility for review and maintenance:
Index Listings:
Developed:
Revised:
Reviewed:

NORTHERN INYO HOSPITAL
POLICY AND PROCEDURE

Title: Pain Management and documentation	
Scope: Nursing	Manual: CPM – Neurological, Sensory, Cognitive and Perceptual (NSC)
Source: DON Acute/Sub Acute Services	Effective Date: May 2, 2013

PURPOSE:

1. To provide for standardization of pain screening/assessment, management and documentation across the treatment continuum, with a particular focus on the hospital in-patient.
2. Assessment of pain for the non-verbal infant, child or adult must rely on behavioral and or physiologic parameters.

POLICY:

Pain assessment will be documented on the Admission Nursing Assessment form initially and on a regular basis on the unit patient care flow sheet or unit nursing record thereafter.

At a minimum, the following standards for pain assessment, treatment, and documentation will be followed. Additionally individual unit standards of care that pertain to pain assessment, management, and documentation will be followed.

The same numerical scale for pain assessment will be used for each individual patient If the type of pain scale is changed it will be noted.
The following scales will be used:

A. **Neonatal/Infant Pain Scale (NIPS)**
This scale may be used for *infants less than 1 year* of age.
See addendum I

B. **Facial, legs, activity, cry, consolability scale (FLACC)**
This scale can be used in *children ages 2 months to 7 years.*
FLACC Behavioral Pain Assessment Scale is a behavioral assessment that can be used to determine pain level when a child can't report his level of pain. It can be used in children ages 2 months to 7 years. Five categories are scored from 0 to 2. The categories are then totaled to obtain the child's pain score. The pain score can range from 0 to 10; the higher the score, the greater the pain.
See addendum II

C. **Wong-Baker FACES Pain Rating Scale:** This scale is used for adults and pediatric *patients older than 3 year of age.* The Wong-Baker FACES Pain Rating Scale can also be used with *patients who have mild dementia* or for those who are unable to understand a numeric pain scale.
It is a self-report tool in which the patient points to the face that corresponds to his pain intensity. NIH uses the 0 to 10 scale.
See addendum III

Title: Pain Management and documentation	
Scope: Nursing	Manual: CPM – Neurological, Sensory, Cognitive and Perceptual (NSC)
Source: DON Acute/Sub Acute Services	Effective Date: May 2, 2013

D. **Patient Self Report of Pain:** The Numeric Pain Scale may be used for patients *5 years of age or older*.
The patient must be able to count.
The patient reports pain severity on a 0-10 scale by associating with a numerical value or facial expression.
See addendum IV

E. **Observational Pain Scale for Critically Ill Adults:** May be used for patients who are unable to communicate their pain level. May be used for sedated, somnolent, sleeping, or cognitively impaired patients.
See Addendum V

STANDARDS:

1. Patients or their representatives will be informed that they have a right to be involved in their pain management as stated in the Patient Bill of Rights. This information will be included in the Conditions of Admission that the patient signs on admission to the hospital.

2. Patients or their representatives will be instructed in the use of the pain rating scale to report their pain (age-appropriate, condition appropriate, and language appropriate). The type of pain scale used will be documented on the patient care record.

3. When possible, patients will be asked to participate in setting a comfort goal. Pertinent comfort measures will be taught to the patient and family. This information will be documented on the patient care record.

4. The pain goal is set by the patient or nurse/or other clinical discipline for patients who are unable to set a goal. The goal is monitored for inpatients at a minimum of every 24 hours as part of the Interdisciplinary plan.

Pain Screening and assessment:

A. Screening:
   a. All patients will be screened for the presence of pain:
      i. On admission or initial patient encounter
      ii. Before and after a procedure
      iii. With a change in condition
      iv. With patient's self report of recurring or new pain
      v. As appropriate for patient's condition
   b. With each routine vital sign assessment. If the patient is being screened by a CNA, Tech or MA, only patient self-report of pain severity may be used. The screener will immediately report to licensed personnel using the following guidelines:
      i. Pain that is above the patient's acceptable level of pain

ii. Any chest pain
iii. Any new onset of pain above the patients acceptable level of pain

5. Upon Admission, all patients will be asked about the presence and intensity of pain at the time of initial evaluation and as clinically indicated.
6. Initial pain assessment and or new report of pain:
   A. When the patient denies pain: if the patient denies pain, document zero (0) as well as the patient's acceptable pain severity level in the electronic health record. No further pain documentation is needed at this time.
   B. Once pain has been identified, further pain assessment must be completed by a nurse or physician and includes the following elements:
      a. **Pain Severity** is determined by the patient's self-assessment or by alternative pain scales such as the FLACC or NIPS
      b. The nurse may collaborate with the family and or significant other as well as review suspected caused of pain to evaluate the patients' pain. This is especially helpful with pain assessments of the non-communicative patient.
      c. **Location** The location of pain will be assessed and documented. For patients evaluated using the FLACC or NIPS, pain location may not be assessable. The RN will use knowledge about the patients' condition, behavior and history to assist in pain location assessment.
      d. **Acceptable severity** of pain on a 0-10 scale. The patient may change the acceptable level at any time. Acceptable level cannot be obtained from the non-communicative patient and may not be assessable if using any of the recommended scales for nonverbal patients.
      e. **Additional/optional elements** that should be noted during a pain assessment and may assist with the development of a plan of care include:
         i. Quality and Character of pain
         ii. Radiation location as appropriate
         iii. Duration and frequency of pain
         iv. Effects of pain: impact on daily functioning and associated symptoms
         v. Alleviating factors, response to past interventions, what helps decrease or relieve pain, usual relief measures
         vi. Aggravating factors: what increases or triggers pain
7. Pain must always be assessed and evaluated in light of the patient's entire clinical condition. Examples of scenarios that may not require additional assessment:
   A. Pain level less than or equal to patient reported acceptable severity
   B. Patient declines additional assessment or intervention
8. Any patient declination of assessment or intervention will be documented in the health record**.**

Focused re-assessment

1. Focused pain reassessment must be completed by a nurse or trained team member as part of the shift assessment or treatment plan and in response to the patient's initial assessment. The

team member documents in the shift assessment a minimum of every shift. The assessment is documented in the EHR and includes:

A. Pain severity
B. Pain location
C. If possible, an acceptable severity of pain on a 0-10 scale will be used. If a patient denies pain it may be documented as "denies pain", or it may be documented as zero (0).
   A post intervention reassessment is conducted within a reasonable time frame after pharmacologic intervention and or other pain management interventions have occurred.
   a. After pharmaceutical intervention, the RN/LVN reassesses the patient's response: Pain shall be assessed and pain intensity documented within 60 minutes ± 15 minutes after parenteral drug therapy for inpatient and outpatient admissions. Pain shall be assessed and pain intensity documented with 90 minutes ± 15 minutes after oral drug therapy for inpatient and outpatient admissions.
   b. Post operative pain is reassessed a minimum of every 4 hours during the first 24 hours post operatively.
D. Re-assessment must be performed in light of the patient's entire clinical condition. Examples of scenarios that may not require additional assessment:
   a. Pain level less than or equal to patient reported acceptable level
   b. Patient declined additional assessment or intervention
E. Pain intensity will be assessed prior to any repeated PRN pain medication administration.

Pain management and plan of care:

The RN will begin development of the pain management plan of care in collaboration with the patient, family, significant other, medical plan of care and interdisciplinary care team. An evidence-based, individualized plan of care is created upon admission and updated as needed based on the diagnosis or patient's individual needs (Gulanick & Myers, 2011). The individualized plan of care includes nursing interventions for pain management.

1. A pain rating higher than the patient's comfort goal will elicit intervention. Interventions will be initiated as ordered. If pain persists, the physician will be notified.

DOCUMENTATION:

The following will be documented in the patient's medical record:

a. Patient/family (as applicable) teaching
b. Type of scale used
c. The comfort goal, when appropriate
d. Initial and subsequent pain assessments
e. Pain relief intervention
f. Any interdisciplinary review
g. Any modification of the treatment plan

The following records/forms may contain this documentation:

a. Admission Nursing Assessment
b. Nursing Plan of Care

c. Unit Nursing Record or Patient Care Flow Sheet
d. Medication Documentation Sheet (if applicable)
e. Discharge Instructions

REFERENCES:

1. http://wongbakerfaces.org/
2. https://www.nlm.nih.gov/research/umls/sourcereleasedocs/current/LNC_FLACC/
3. https://www.uwhealth.org/healthfacts/parenting/7711.pdf
4. https://com-jax-emergency-pami.sites.medinfo.ufl.edu/files/2015/02/Neonatal-Infant-Pain-Scale-NIPS-pain-scale.pdf
   From Hockenberry, M. J., & Wilson, D. (2016). *Wong's essentials of pediatric nursing* (10th ed.). St. Louis, MO: Mosby. Reprinted with permission.
5. *From* Merkel, S. I., et al. (1997). The FLACC: A behavioral scale for scoring postoperative pain in young children. *Pediatric Nursing, 23,* 293–297
6. McCaffery M, Pasero C: Pain: Clinical Manual, p. 410 Copyright 1999 Mosby, inc.)
7. Warden V, Hurley AC, Volicer L. Development and psychometric evaluation of the Pain Assessment in Advanced Dementia (PAINAD) scale. *J Am Med Dir Assoc. 2003;4(1):9-15.*

CROSS REFERENCE P&P's:

1. Nursing Assessment/Reassessment
2. Opioid Sedation Scale

Approval	**Date**
NEC	4/5/17
Board of Directors	
Last Board of Director Review	

Initiated: 12/99
Revised: 4/00, 8/00, 11/00, 04/02, and 02/2006 SM, 10/07, 04/10 AW, 9/12 AW 4/13, 2/17la
Reviewed: 05/11AW,

Title: Pain Management and documentation	
Scope: Nursing	Manual: CPM – Neurological, Sensory, Cognitive and Perceptual (NSC)
Source: DON Acute/Sub Acute Services	Effective Date: May 2, 2013

Addendum I:
NEONATAL INFANT PAIN SCALE (NIPS)

Use for infants less than one year of age
The Neonatal infant Pain Scale (NIPS) is a behavioral scale and can be utilized with both full-term and Pre-term infants. The tool was adapted from the CHEOPS scale and uses the behaviors that nurses have described as being indicative of infant pain or distress. It is composed of six (6) indicators:

- Facial expression
- Cry
- Breathing patterns
- Arms
- Legs
- State of arousal

Each behavioral indicator is scored with 0 or 1 except "cry" which has three possible descriptors (scored 0.1.or 2). See the NIPS Scale for the description of infant behavior in each indicator group.

Infants should be observed for one minute in order to fully asses each indicator.

Total pain scores ran from 0-7. The suggested interventions based upon the infant's level of pain are listed below.

Evaluate newborn for causes of pain versus the need for routine comfort measures.

Pain indicated by:
1. Birth injuries/trauma
2. Maternal drug history indicating potential for neonatal withdrawal symptoms
3. Painful procedures (i.e., IV starts, lab draws, tube placement, injections, circumcision, etc)

Discomfort indicated by:
1. Need for repositioning
    a. Reposition for correct body alignment, flexed midline position.
2. Need for diaper or linen change
    a. Change diapers or clothing
3. Signs of hunger (i.e., hand-mouth activity, sucking, rooting)
    a. Feed per orders or offer non-nutritive sucking

Title: Pain Management and documentation	
Scope: Nursing	Manual: CPM – Neurological, Sensory, Cognitive and Perceptual (NSC)
Source: DON Acute/Sub Acute Services	Effective Date: May 2, 2013

NEONATAL INFANT PAIN SCALE (NIPS)

Scores	0	1	2	
Facial Expression	**Relaxed Muscles** Restful face Neutral expression	**Grimace** Tight facial muscles, furrowed brow, chin, jaw (negative facial expression – nose, mouth, and brow)		
Cry	**No cry** Quiet, not crying	**Whimper** Mild moaning, intermittent	**Vigorous cry** Loud scream, rising , shrill, continuous (note: silent cry may be scored if baby is intubated, as evidenced by obvious mouth, facial movement)	
Breathing Patterns	**Relaxed** Usual pattern for this baby	**Change in breathing** In drawing, irregular, faster than usual, gagging, breath holding		
Arms	**Relaxed / Restrained** No muscular rigidity, occasional random movements of arms	**Flexed / Extended** Tense, straight arms, rigid and/or rapid extension, flexion		
Legs	**Relaxed / Restrained** No muscular rigidity, occasional random leg movement	**Flexed / Extended** Tense, straight legs, rigid and/or rapid extension, flexion		
State of Arousal	**Sleeping / Awake** Quiet, peaceful, sleeping or alert and settled	**Fussy** Alert, restless, and thrashing		
Total:				

Pain Level Intervention

0-2 = mild to no pain none
3-4 = mild to moderate pain Non-pharmacological intervention with a reassessment in 30 minutes
>4 = severe pain Non-pharmacological intervention and possibly a pharmacological intervention

Title: Pain Management and documentation	
Scope: Nursing	Manual: CPM – Neurological, Sensory, Cognitive and Perceptual (NSC)
Source: DON Acute/Sub Acute Services	Effective Date: May 2, 2013

Addendum II:

Facial, legs, activity, cry, consol ability scale (FLACC)
For children ages 2 months to 7 years.
The FLACC Behavioral Pain Assessment Scale is a behavioral assessment that can be used to determine pain level when a child can't report his level of pain. It can be used in children ages 2 months to 7 years. Five categories are scored from 0 to 2. The categories are then totaled to obtain the child's pain score. The pain score can range from 0 to 10; the higher the score, the greater the pain. See Addendum IV

FLACC Behavioral Pain Assessment Scale[19]

The FLACC Behavioral Pain Assessment Scale is a behavioral assessment that can be used to determine pain level when a child can't report his level of pain. It can be used in children ages 2 months to 7 years. Five categories are scored from 0 to 2. The categories are then totaled to obtain the child's pain score. The pain score can range from 0 to 10; the higher the score, the greater the pain.

	Scoring		
Category	**0**	**1**	**2**
Face	No particular expression or smile	Occasional grimace or frown, withdrawn, disinterested	Frequent to constant frown, clenched jaw, quivering chin
Legs	Normal position or relaxed	Uneasy, restless, tense	Kicking, or legs drawn up
Activity	Lying quietly, normal position, moves easily	Squirming, shifting back and forth, tense	Arched, rigid, or jerking
Cry	No cry (awake or asleep)	Moans or whimpers, occasional complaint	Crying steadily, screams or sobs, frequent complaints
Consol ability	Content, relaxed	Reassured by occasional touching, hugging, or being talked to, distractible	Difficult to console or comfort
Total score:			

From Merkel, S. I., et al. (1997). The FLACC: A behavioral scale for scoring postoperative pain in young children. *Pediatric Nursing, 23,* 293–297.

Title: Pain Management and documentation	
Scope: Nursing	Manual: CPM – Neurological, Sensory, Cognitive and Perceptual (NSC)
Source: DON Acute/Sub Acute Services	Effective Date: May 2, 2013

Addendum III:
Wong-Baker FACES Pain Rating Scale
For adults and pediatric patients older than 3 year of age or who have mild dementia or who do not understand the numeric pain scale.
It's a self-report tool in which the patient points to the face that corresponds to his pain intensity. NIH uses the 0 to 10 scale. Explain to the patient what each face means before having him rate his pain.
To use the FACES scale, explain to the patient that each face represents a person who feels happy because he has no pain or is sad because he has some or a lot of pain. Face 0 is very happy because he doesn't hurt. Face 1 hurts just a little bit. Face 2 hurts a little more. Face 3 hurts even more. Face 4 hurts a whole lot. Face 5 hurts as much as you can imagine, although you don't have to be crying to feel this bad. Ask the patient to choose the face that best describes how he is feeling.

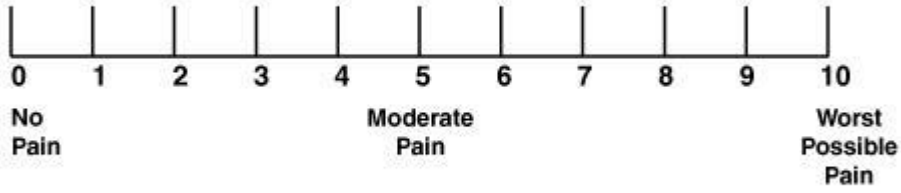
Legs	Normal position or relaxed	Uneasy, restless, tense	Kicking, or legs drawn up
Activity	Lying quietly, normal position, moves easily	Squirming, shifting back and forth, tense	Arched, rigid, or jerking
Cry	No cry (awake or asleep)	Moans or whimpers, occasional complaint	Crying steadily, screams or sobs, frequent complaints
Consol ability	Content, relaxed	Reassured by occasional touching, hugging, or being talked to, distractible	Difficult to console or comfort
Total score:			

Title: Pain Management and documentation	
Scope: Nursing	Manual: CPM – Neurological, Sensory, Cognitive and Perceptual (NSC)
Source: DON Acute/Sub Acute Services	Effective Date: May 2, 2013

Addendum IV:

Numeric Pain Scale

A numeric pain scale is a self-report tool. To use it, the patient must have a concept of numbers and their relationship to each other. The scale can be used vertically or horizontally. The numbers range from 0 to 10, where 0 is no pain and 10 is the worst possible pain. The nurse should ask the patient to pick which number corresponds to her/his pain level



Title: Pain Management and documentation	
Scope: Nursing	Manual: CPM – Neurological, Sensory, Cognitive and Perceptual (NSC)
Source: DON Acute/Sub Acute Services	Effective Date: May 2, 2013

Addendum V:
Observational Pain Scale:
Used for patients who are unable to communicate their pain level

Instructions: Observe the patient for five minutes before scoring his or her behaviors. Score the behaviors according to the following chart. The patient can be observed under different conditions (e.g., at rest, during a pleasant activity, during care giving, after the administration of pain medication).

Categories	**0**	**1**	**2**	**Score**
Face	No particular expression or smile	Occasional grimace, tearing, frowning, wrinkled forehead	Frequent grimace, tearing, frowning, wrinkled forehead	
Activity (movement)	Lying quietly, normal position	Seeking attention through movement or slow, cautious movement	Restless, excessive activity and/or withdrawal reflexes	
Guarding	Lying quietly, no positioning of hands over areas of body	Splinting areas of the body, tense	Rigid, stiff	
Physiology (vital signs)	Stable vital signs	Change in any of the following: • SBP>20 mm Hg • HR>20/min	Change in any of the following: • SBP>30 mm Hg • HR>25/min	
Respiratory	Baseline RR/SpO_2 Compliant with ventilator	RR>10 above baseline, or 5% ↓SpO_2 mild asynchrony with ventilator	RR>20 above baseline, or 10% ↓SpO_2 mild asynchrony with ventilator	
			TOTAL SCORE	

Each of the 5 categories is scored from 0-2, which results in a total score between 0 and 10. Document total score by adding numbers from each of the 5 categories.
Scores:
0-2 indicate no pain
3-6 moderate pain
7-10 severe pain

Title: Pain Management and documentation	
Scope: Nursing	Manual: CPM – Neurological, Sensory, Cognitive and Perceptual (NSC)
Source: DON Acute/Sub Acute Services	Effective Date: May 2, 2013

Addendum VI

Deep Breathing for relaxation with the option of peaceful imagery

1. Breathe in slowly and deeply.
2. As you breathe out slowly, feel yourself beginning to relax; feel the tension leaving your body.
3. Now breathe in and out slowly and regularly, at whatever rate is comfortable for you.
4. To help you focus on your breathing and breathe slowly and rhythmically:
   Breathe in as you say silently to yourself "In two three"
   Breathe out as you say silently to yourself "Out two three"
   Or
   Each time you breathe out, say silently to yourself a word such as peace or relax
5. You may imagine that you are doing this in a place you have found very calming and relaxing for you, such as laying in the sun at the beach.
6. Do steps 1 through 4 only once or repeat steps 3 and 4 for up to 20 minutes.
7. End with a slow, deep breath. As you breathe out you may say to yourself, "I feel alert and relaxed."

Additional points:

- This technique for relaxation has the advantage of being very adaptable. You may use it for only a few seconds or for up to 20 minutes. For example, you may do this regularly for 10 minutes twice a day. You may also use it for one or two complete breaths any time you need it throughout the day or when you awaken in the middle of the night.
- If you use this technique for more than a few seconds try to get in a comfortable position in a quiet environment.
- A very effective way to relax is to add peaceful images once you have performed steps 1 through 4 above. Following are some ideas about finding your own peaceful memories.

Something may have happened to you a while ago that can be of use to you now. Something may have brought you deep joy or peace. You may be able to draw on the past experience to begin you peace or comfort now. Think about these questions:

- Can you remember any situation even when you were a child, when you felt calm, peaceful, secure, hopeful, or comfortable?
- Have you ever laid back, kicked off your shoes, and daydreamed about something peaceful? What were you thinking of?
- Do you get a dreamy feeling when you listen to music? Do you have any favorite music?
- Do you have any favorite poetry that you find uplifting or reassuring? Are you now or have you ever been religiously active? Do you have favorite readings, hymns, or prayers? Even if you haven't heard or thought of them for many years, childhood religious experiences may still be very soothing.

Very likely some of the things you think of in answer to these questions can be recorded for you, such as your favorite music or a prayer read by your clergyman. Then you can listen to the recording whenever you wish. Or, if your memory is strong, you may simply close your eyes and recall the events or words.

NORTHERN INYO HOSPITAL
MEDICAL RECORDS
POLICY AND PROCEDURE

Title: Minors with Legal Authority to Consent	
Scope: District Wide	Manual: Compliance, HOSPITAL WIDE
Source: Compliance Officer	Effective Date: May 1, 2017

PURPOSE:

To provide guidance to staff for circumstances in which a minor may have the legal authority to consent to various medical procedures, diagnosis, and treatment.

DEFINITIONS:

Capacity - a person has the ability to understand the nature and consequences of a decision and to make and communicate a decision, and includes, in the case of proposed health care, the ability to understand its significant benefits, risks, and alternatives (Probate Code Section 4609)

Emancipated minor – a minor 14 years of age or older who has been granted, by the courts, release from the custody and control of his/her parent(s). Emancipated minors will have a Department of Motor Vehicles (DMV) identification card, which states the individual is emancipated, or a court order declaring emancipation

Minors – all persons under 18 years of age [Family Code Section (FCS) 6500]

Self-sufficient minor – a minor 15 years or older, living separate and apart from his/her parent(s) or legal guardian, with or without their consent, who manages his/her own financial affairs, regardless of source of income

POLICY:

1) A minor may have the legal authority to consent to medical procedures, diagnosis, and treatment without parental consent, knowledge, or liability:
   a) When he/she has been emancipated by the courts [FCS 7002 and 7050 (e)(1)]; or
   b) When, in good faith, he/she has been deemed self-sufficient (FCS 6922); or
   c) While serving on active duty with any branch of the U.S. armed services [FCS 7002 and 7050 (e)(1)]; or
   d) When he/she has entered into a valid marriage, whether or not such marriage has been terminated by dissolution or death of the spouse [FCS 7002 and 7050 (e)(1)]; or
   e) For care related to the treatment or prevention of pregnancy, regardless of age or marital status (FCS 6925); or
   f) When he/she is 12 years or older, and may have come into contact with an infectious, contagious, or communicable disease that must be reported to the local

health officer, or a related sexually transmitted disease, and prevention of sexually transmitted disease, including consent to HIV tests (FCS 6926); or

g) When the minor is 12 years or older and has allegedly been raped, including information concerning and access to the "morning after" pill, and the collection of evidence with regard to the alleged rape (FCS 6927); or

h) When he/she, of any age, has allegedly been sexually assaulted, including, but not limited to rape, sodomy, or oral copulation, and the collection of evidence with regard to the alleged assault (FCS 6928);

i) When he/she is 12 years or older and requires certain mental health treatment or counseling in specific circumstances (consult Consent Manual pp. 2.24 – 2.25);

j) When he/she is 12 years or older and requires certain drug- or alcohol- related treatment or counseling in specific circumstances (consult Consent Manual pp. 2.25 – 2.26).

2) Parents of a minor are not financially responsible for health care or related services for which the minor may legally give consent.

3) A minor has the right to privacy in health information resulting from services to which the minor is authorized to consent, and often, even when the parent or guardian gives consent (CHA 2016 Consent Manual, p 2.21).

4) Minor providing consent must have the capacity to make health care decisions. If there are basic capacity concerns, consult the primary care physician.

PROCEDURE:

1) If a minor presents with or without parent(s) or guardian, the minor may have legal authority to provide consent under circumstances listed above, including the ability to sign the Conditions of Admission.

2) If a minor is unable to produce documents proving emancipation, the determination must be made as to whether the minor is self-sufficient, by completing the Self-Sufficient Minor Information form (CHA form 2-1s).

3) California does not consider "common law marriage" to be valid.

Title: Minors with Legal Authority to Consent	
Scope: District Wide	Manual: Compliance, HOSPITAL WIDE
Source: Compliance Officer	Effective Date: May 1, 2017

4) When a minor seeks healthcare services listed below, employees should ask the minor if he/she would like the medical record, health information, and bill to be kept private from the parent(s) or guardian:
   a) Family planning services
   b) Pregnancy treatment or prevention
   c) Abortion
   d) Sexual assault
   e) Sexually transmitted diseases
   f) Mental health outpatient treatment, with some limitations
   g) Substance abuse treatment

5) All healthcare services not specifically listed in the policy section (1) (a – j) or procedure section (2) (a-g) require parent or guardian consent.

6) If the minor patient requires this restriction:
   a) The parents should not be listed as the guarantor; and
   b) The bill should not be mailed to the parent's home; and
   c) The minor patient should not be contacted at the parent's home number; and
   d) The alert code "PRIVACY" should be entered into the HIS (see procedure "Minor Privacy Procedure – NIH Admission Services" for additional procedural details).

7) If the minor does not require the legally available privacy as described in this policy, a note documenting the choice should be entered into the visit information.

REFERENCES:

1. California Hospital Association 2016 Consent Manual
2. Family Code Section (FCS) 7002 and 7050 (e)(1)
3. Family Code Section 6922
4. Family Code Section 6925
5. Family Code Section 6926
6. Family Code Section 6927
7. Family Code Section 6928
8. Probate Code Section 4609

CROSS REFERENCE P&P:

1. Minor Privacy Procedure – NIH Admissions Services
2. Guarantor Verification Procedure - NIH Admissions Services
3. Clinic Minor Privacy Procedure

NORTHERN INYO HOSPITAL
MEDICAL RECORDS
POLICY AND PROCEDURE

Title: Minors with Legal Authority to Consent	
Scope: District Wide	Manual: Compliance, HOSPITAL WIDE
Source: Compliance Officer	Effective Date: May 1, 2017

Approval	**Date**
Compliance Officer	4/6/2017
Chief Executive	
Last Board of Directors Review	

Developed: 4/5/2017
Reviewed:
Revised:
Supersedes:

POLICIES TO THE BOD
ENVIRONMENTAL SERVICES

	POLICY & PROCEDURES TO THE BOARD	APRIL, 2017			
	EVS				
	TITLE	TO BOD	APPROVED	COMMENTS	P&P UPDATED
1	Cleaning Agents: Cleaning Solutions	4/19/2017			
2	Cleaning Agents: Disposal of Cleaning Agents	4/19/2017			
3	Cleaning Agents: Identifying and Labeling Cleaning Agents	4/19/2017			
4	Cleaning Agents: Selection, Measurement, and Use of Cleaning Agents	4/19/2017			
5	Cleaning Procedure: Patient room Daily and at Discharge	4/19/2017			
6	Cleaning Procedures: Clinical Support Areas: Clinical Support & Ancillary Service Areas	4/19/2017			
7	Cleaning Procedures: Clinical Support Areas: Dietary Department	4/19/2017			
8	Cleaning Procedures: Clinical Support Areas: Pharmacy	4/19/2017			
9	Cleaning Procedures: Clinical support Areas: Protocol for Clinical Laboratory	4/19/2017			
10	Cleaning Procedures: Non Patient Care Equipment: Refrigerators	4/19/2017			
11	Cleaning Procedures: Non Paitent Areas: Conference/Meeting Rooms	4/19/2017			

POLICIES TO THE BOD
PHARMACY

	POLICY & PROCEDURES TO THE BOARD	APRIL, 2017			
	PHARMACY DEPT.				
	TITLE	TO BOD	APPROVED	COMMENTS	P&P UPDATED
1	Medication Security	4/19/2017			
2	Medication in the Absence of the Pharmacist	4/19/2017			
3	Non-Formulary Procurement of Medication	4/19/2017			
4	Medication Shortage and Outages	4/19/2017			
5	Nebulized Lidocaine	4/19/2017			

POLICIES TO THE BOD
PROPERTY MGMT, SECURITY AND MAINTENANCE

	POLICY & PROCEDURES TO THE BOARD	APRIL, 2017			
	PROPERTY MGMT, SECURITY AND MAINTENANCE				
	TITLE	TO BOD	APPROVED	COMMENTS	P&P UPDATED
1	Hazardous Chemicals	4/19/2017			
2	Hazardous Materials & Waste Inventory	4/19/2017			
3	Eyewash-Shower Stations	4/19/2017			
4	Hazardous Spill & Exposure	4/19/2017			
5	EPA SPCC Spill Prevent Ctrl & Countermeasures	4/19/2017			
6	Mercury Spills	4/19/2017			
7	Managing Hazardous Gases & Vapors	4/19/2017			
8	Formaldehyde	4/19/2017			
9	Gluteraldehyde	4/19/2017			
10	Ethylene Oxide	4/19/2017			
11	Permits, Licenses, Manifests & MSDS	4/19/2017			
12	Labeling Hazardous Material & Waste	4/19/2017			

POLICIES TO THE BOD
REHABILITATION

	POLICY & PROCEDURES TO THE BOARD	APRIL, 2017			
	REHABILITATION				
	TITLE	TO BOD	APPROVED	COMMENTS	P&P UPDATED
1	Rehab Therapy -G-Code Tests and Charges	4/19/2017			
2	Rehab Therapy Patient Management - Outpatient	4/19/2017			

Draft: Andreas, Linda (DON ICU/Acute/Subacute Services)
Area: Published

Ref #	TITLE	TO BOD	APPROVED	COMMENTS
1203	Abuse Policy for Swing Bed Patients			
3980	Acute/Sub Acute Services Standards of Care–Adult			
3806	Acute/Subacute Care Services Method of Practice: Patient Coordinated Care			
582	Admission of Pediatric Patient*			
183	Admission to the Acute Sub Acute Department*			
1081	Admission, Documentation, Assessment, Discharge, and Transfer of Swing-Bed Patients			
3939	Cardiac Monitoring*			
244	Documentation of Patient Care			
3808	Education of Swing Bed Resident and Family			
265	Emergency Paging System			
278	Falls Prevention Reminders			
3698	Gait Belt Policy			
4024	HUGS/PEDZ Policy*			
259	ICU Acuities			
299	ICU Consultation Criteria			
323	ICU Infection Control/Isolation Room Policy			
564	ICU Staffing			
335	Insulin Continuous Subcutaneous Infusion Self			
326	Intensive Care Service			
1147	Inter-disciplinary Swing Bed Care Plan			
328	IV Medications For The Control Of Pain/Anxiety			
322	LVN'S Providing Care For ICU Patients Guidelines			
648	Medical Records Requirements of Swing Bed			
4023	Newborn & Pediatric Security and Abduction			
354	Noting Physician Orders			
1083	Nutrition for Swing-Bed Patients			
3981	Opioid Administration*			
3922	Opioid Sedation Scale*			
451	Patient Valuables*			
180	Patient Acuity - Patient Care Flow Sheet*			
261	Patient Admission To ICU			
313	Patient Complications/Emergencies			
3921	Patient Controlled Analgesia (PCA)*			
243	Patient Discharge			
368	Patient Discharge Or Transfer Out Of ICU			
369	Patient Disposition In The ICU			
3774	Patient Mobility Assessment			
355	Patient Orientation To The ICU			
3898	Patient Restraints (Behavioral & Non-Behavioral)*			
443	Patient Transfer from ICU or ER to Med-Surg Unit			
584	Pediatric Admission Assessment			

615	Pediatric Emergency Code System (Broselow-			
579	Pediatric Standards of Care and Routines*			
266	Physician Guidelines For Utilizing The ICU			
390	Post Operative Patient Care In The ICU			
387	Qualifications For ICU RN			
3807	Recognizing and Reporting Swing Bed Resident			
1084	Rights of Swing Bed Patients			
277	Risk Fall Assessment-ICU			
1194	Risk-Fall assessment-Med Surg			
329	Saline Lock For Blood Draw			
3822	Scope of Service Acute/Subacute*			
4002	Scope of Service Hospice*			
3805	Scope of Service Swing Bed			
1089	Services for Swing-Bed Patients			
3681	Skin Assessment Using the Braden Scale			
3630	Standards of Care - SWING Bed Resident			
1230	Standards of Patient Care in ICU			
1142	Swing Bed Patient Restraints*			
1140	Swing Bed Patients Inter-disciplinary Care			
397	Syringe Pump			
539	Thrombolytic Therapy Consent			
431	Total Parenteral Nutrition Protocol			
561	Transducer System Procedure-vascular lines			
436	Transfer & Transportation for Patients			
385	Use Of The Peripheral Nerve Stimulator			
3940	Weights for Infant and Pediatric Patients*			
307	Withholding Resuscitative Measures In The ICU			

Northern Inyo Hospital - 2017-18 Capital Expenditure Requests

	Sum of Est Cost	Sum of Est. Depr	Priority
1	469,886	28,520	1-Patient Safety, Regulatory Compliance
2	31,127	1,462	2-Patient Satisfaction
3	753,304	66,297	3 - Strategic Purchase
4	457,439	43,722	4 - End of Life Assets
5	914,252	140,760	5- Dependent on EHR Selection
6	1,986,985	196,037	6- Future year purchase per Exec
1, 2	5,724	954	Combination
1, 2, 3	30,000	2,600	Combination
1, 2, 4	75,000	2,500	Combination
1, 3	5,000	250	Combination
1, 4	31,248	2,232	Combination
3, 4	68,562	4,898	Combination
Grand Total	**4,828,526**	**490,232**	

	Est Cost Summary	Est Depreciation	
Recommended:	1,469,850	100,083	
60% of End of Life	274,463	35,863	
Total	1,744,313	135,946	
Pharmacy Design	800,000	26,667	1/2 year of 15 years
Pharmacy Build	1,000,000	33,333	1/2 year of 15 years
No Paragon upgrade	(700,000)	(70,000)	1/2 year of 5 years
Total Net Request	**2,844,313**	**125,946**	**Total estimated additional depreciation**
With IT Dependent	**2,985,073**	**266,706**	**With IT Dependent**

Less than Cash Flow w/o IT:	655,687
Less than Cash Flow w/o IT:	514,927

	Northern Inyo Hospital - 2017-18 Approved Capital Budget								
		1-Patient Safety, Regulatory Compliance							
		2-Patient Satisfaction							
		3 - Strategic Purchase							
		4 - End of Life Assets							
		5- Dependent on EHR Selection			Yrs				
		6- Future year purchase per Exec		> $2000	of				
Dept ID	Department	Description	Purpose	Est Cost	Life	Req prior	note	Est. Depr	Asset Type
6010	ICU	Hospital grade patient nourishment refrigerator and freezer. One staff refrigerator	group purchase making asset	$ 4,700.00	10	1		$ 235.00	1241-1201
6010	ICU	Two Lumex Clinical Care Recliners	group purchase making asset; to support critically ill patient in recovery process	$ 2,128.00	10	1		$ 106.00	1241-1201
6400	Alternate Birthing	Portable Fetal Monitor & Cart		$ 17,000.00	4	1		$ 2,125.00	1241-1201
6400	Alternate Birthing	O2 Blender		$ 3,000.00	8	1		$ 188.00	1241-1201
7010	Emergency Department	Portable Bladder Scanner	Determine amount of urine in bladder upgrade of shared	$ 15,000.00	7	1		$ 1,071.00	1241-1201
7071	Rural Health Womens' C	Trophon Disinfection System	Disinfect endovaginal ultrasound probes	$ 9,000.00	10	1		$ 450.00	1241-1201
7630	Radiology	Automatic Door - X-Ray room in ED	Keep door open for gurneys and wheelchairs	$ 5,000.00	10	1		$ 250.00	1221-1201
7503	Lab	Automatic Door - Phleb		$ 5,000.00	10	1		$ 250.00	1221-1201
7770	Rehab Services	Pediatric Mats	Increase strength and mobility of pediatric patients	$ 3,000.00	10	1		$ 150.00	1241-1201
8390	Pharmacy	Pharmacy Relocation	Separate employee and inpatient pharmacy operations	$ 120,000.00	25	1		$ 2,400.00	1221-1201
8390	Pharmacy	Omnicell Codonics Label Printer	Securely & safely label medications in OR suite for immediate patient use (anesthesia workstation)	$ 20,000.00	5	1		$ 2,000.00	1241-1201
8410	Grounds	Repair of 4 different parking lots around campus	Main, PMA, RHC & RHC Annex parking lot repairs	$ 50,000.00	15	1		$ 1,667.00	1210-1201
8460	Maintenance	Used Pick-up Truck	Hospital usage	$ 20,000.00	4	1		$ 2,500.00	1241-1201
8460	Maintenance	Re-tube Ajax Boilers	service rep recommended replacement; used for medical waste	$ 13,058.00	10	1		$ 653.00	1225-1201
8480	IT	Software tool to help vulnerabilities within the NIHD network and system infrastructure	meet industry security and compliance requirements	$ 6,000.00	5	1		$ 600.00	1241-1201
8755	Compliance	Acrylic Pocket Display System	Framing system to allow posting/updating all required (State & Federal) in order to bring facility into compliance	$ 25,000.00	20	1		$ 625.00	1241-1201
7660	MRI	Invivo Monitor	Monitor MRI patient	$ 85,000.00	5	1		$ 8,500.00	
8462	Property Management	Environment of Care Management System	Automate process in EOC tours, project risk, deficiency, ILSM, infection control, and interim life safety to move towards continuous survey readiness	$ 12,000.00	3	1		$ 2,000.00	1241-1201
7660	MRI	Power Injector	Inject patients with contrast	$ 55,000.00	10	1		$ 2,750.00	1241-1201
				$ 469,886.00		1 Total		$ 28,520.00	
7010	Emergency Department	Gurney	Accommodate trauma, disabled & bariatric patients	$ 11,126.74	7	2		$ 795.00	1241-1201
8410	Grounds	Various Concrete Repairs or replacement	replace or repair cracked or damaged concrete due to weather, tree roots & construction	$ 20,000.00	15	2		$ 667.00	1210-1201
				$ 31,126.74		2 Total		$ 1,462.00	
7770	Rehab Services	Physical Therapy Tables	Increase number of patient treatment tables due to increased therapists & patients	$ 3,000.00	15	3		$ 100.00	1241-1201
8460	Maintenance	Motors for Surgery Air Handle Unit (AHU)	one supply and one return motor (back up)	$ 4,012.00	20	3		$ 100.00	1241-1201
8460	Maintenance	Coil for AHU in Surgery	back up stock	$ 17,598.00	20	3		$ 440.00	1241-1201
8460	Maintenance	Replace Frozen Chilled Water Cold with Factor Replacement Coil on AHU-1	Emergency Replacement of Surgery Coil if Needed; RHP recommended	$ 19,287.50	20	3		$ 482.00	1241-1201
8460	Maintenance	Intelligent Life Fire Extinguisher Training System	Hands on training	$ 6,495.00	5	3		$ 650.00	1241-1201
8480	IT	Citrix Upgrade to 7.12 from 6.5	required upgrade for servers as required by some vendors for applications such as Kronos	$ 43,712.00	5	3		$ 4,371.00	1241-1201
8480	IT	Commvault Upgrade V11 and DR Operational Testing	Upgarde Commvault 10.5 to 11 and test Updated DR	$ 8,500.00	5	3		$ 850.00	1241-1201

	Northern Inyo Hospital - 2017-18 Approved Capital Budget								
		1-Patient Safety, Regulatory Compliance							
		2-Patient Satisfaction							
		3 - Strategic Purchase							
		4 - End of Life Assets							
		5- Dependent on EHR Selection			Yrs				
		6- Future year purchase per Exec		> $2000	of				
Dept ID	Department	Description	Purpose	Est Cost	Life	Req prior	note	Est. Depr	Asset Type
8480	IT	DMS Replacement	Replace storage on non-patient centric data for AP, Payroll & HR. Cannot implement current program unless we implement Paragon v14	$ 60,000.00	3	3		$ 10,000.00	1241-1201
8492	Interpretive Services	IT/Computer/Video equipment	Call Center	$ 19,728.00	5	3		$ 1,973.00	1241-1201
8492	Interpretive Services	Remodel	Call Center	$ 11,800.00	15	3		$ 393.00	1225-1201
7420	Surgery	Stryker Power Orthopedic Equipment	Orthopedists and podiatrist to work on bones	$ 99,924.29	10	3		$ 4,996.00	1241-1201
7420	Surgery	Colonoscopes & Cabinet	Increase scopes for screening & diagnostic colonscopies to keep up with procedures	$ 90,498.75	3	3		$ 15,083.00	1241-1201
7520	Pathology	Laboratory Microscopic Camera/Upgrad	Allow remote consult and provide pathology images to the tumor board	$ 35,000.00	7	3		$ 2,500.00	1241-1201
7670	Ultrasound	Ultrasound Machine Refurbished	Diagnostic imaging	$ 75,000.00	5	3		$ 7,500.00	1241-1201
7770	Rehab Services	Pediatric Climbing Wall	Increase strength and mobility of pediatric patients	$ 4,000.00	10	3		$ 200.00	1241-1201
8440	Environmental Services	Panther Micro Scrubber	Floor scrubbing	$ 2,970.00	5	3		$ 297.00	1241-1201
8440	Environmental Services	Doodle Floor Scrubber	Floor scrubbing	$ 3,000.00	5	3		$ 300.00	1241-1201
8460	Maintenance	Back-up AC units for Laboratory	Lab equipment must be maintained at 68-74 degrees	$ 13,254.66	10	3		$ 663.00	1225-1201
8460	Maintenance	Electrical Upgrade for Lab	Lab equipment must be maintained at 68-74 degrees	$ 10,920.00	18	3		$ 303.00	1225-1201
8460	Maintenance	Storage Racks for Woodshop	for new products that need to lay flat	$ 5,000.00	15	3		$ 167.00	1225-1201
8460	Maintenance	Access Control Locks	Provide access to employees with the use of one badge	$ 40,000.00	5	3		$ 4,000.00	1225-1201
8460	Maintenance	Motorized Ergo Express Custom Platform Cart	Reduce risk of injury to employees	$ 12,249.45	10	3		$ 612.00	1241-1201
8650	Human Resources	Scanner-Refurbished	Scan paper documents into electronic filing system - OneContent	$ 4,000.00	5	3		$ 400.00	1241-1201
7070	RHC Womens Health	Scanner-Refurbished	Scan paper documents into electronic filing system - OneContent	$ 2,000.00	5	3		$ 200.00	1241-1201
8720	Nursing Administration	Clinical Informatics Training & Meeting Room	Potiental room for incident command and regulatory surveys. Used for training sessions to NIHD & general nursing orientation	$ 19,237.28	10	3		$ 962.00	1241-1201
8320	Kitchen	Remodel	Update cafeteria to improve patient and staff satisfaction	$ 45,000.00	15	3		$ 1,500.00	1221-1201
8320	Kitchen	Vending Machine	Update vending machine & allow credit card & NIH badge for purchases	$ 6,500.00	10	3		$ 325.00	1241-1201
8320	Kitchen	Dishwasher Machine	Clean dishes	$ 4,500.00	10	3		$ 225.00	1241-1201
8320	Kitchen	Counter Top Electric Steamer	Replace counter top steamer	$ 8,767.00	10	3		$ 438.00	1241-1201
8320	Kitchen	Convection Oven, Double Deck	Replace current oven	$ 7,080.00	10	3		$ 354.00	1241-1201
8320	Kitchen	Refrigerator	Replace standby kitchen refrigerator	$ 2,500.00	10	3		$ 125.00	1241-1201
8320	Kitchen	60" Electric Range	Replace current range	$ 11,305.95	10	3		$ 565.00	1241-1201
8320	Kitchen	Water Heater	Booster for dishwasher	$ 2,000.00	10	3		$ 100.00	1225-1201
8320	Kitchen	Refrigerated Salad Bar	Replace old, fully depreciated salad bar	$ 6,463.80	10	3		$ 323.00	1241-1201
8480	IT	Netapp Storage	Storage needed for growth in next 5 years	$ 28,000.00	5	3		$ 2,800.00	1241-1201
8480	IT	1 Cisco Nexus 10Gb Switches	Data Center expansion	$ 20,000.00	5	3		$ 2,000.00	
				$ 753,303.68		3 Total		$ 66,297.00	
8460	Maintenance	Replace existing steam humidifier Ultrasorb H-1-2 with exact replacement model in same location	Janitor close room H2012; RHP recommendation due to previous issues	$ 18,500.00	15	4		$ 617.00	1225-1201
8480	IT	UPS Replacement batteries	Bulk Purchase and placement of dead or dying batteries	$ 5,000.00	5	4		$ 500.00	1241-1201
8460	Maintenance	Electronic Door Replacement-PMA Building	Older door having issues and needs replacement	$ 10,000.00	10	4		$ 500.00	1221-1201

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		6- Future year purchase per Exec		> $2000	of				
Dept ID	Department	Description	Purpose	Est Cost	Life	Req prior	note	Est. Depr	Asset Type
8462	Property Management	Maintenance Management System	Track, produce and close work orders as well as keep medical equipment inventory as required by CMS.	$ 20,000.00	3	4		$ 3,333.00	1241-1201
8480/7070	IT/RHC	Replacement computers and Laptops for RHC & RHCWC	group purchase making asset	$ 17,000.00	5	4		$ 1,700.00	1241-1201
8480/9512	IT/Pediatric Clinic	Replacement PC's for Pediatric Clinic	end of life computers bulk purchase and replacement	$ 5,760.00	5	4		$ 576.00	1241-1201
8480/9515	IT/Ortho Clinic	Replacement PC's for Ortho Clinic	end of life computers bulk purchase and replacement	$ 3,100.00	5	4		$ 310.00	1241-1201
6400	Alternate Birthing	Draeger Infant Warmer		$ 19,600.00	10	4		$ 980.00	1241-1201
8740	Inservice Educ	Baby Newborn Anne	Newborn resuscitation training	$ 2,195.00	5	4		$ 220.00	1241-1201
7590	EKG	Desktop Computer x4	Replace 4 computers in bulk at end of life	$ 2,480.00	3	4		$ 413.00	1241-1201
7730	Pulmonary Function	Pulmonary Function System	Provide pulmonary function studies	$ 46,000.00	8	4		$ 2,875.00	1241-1201
8462	Propery Management	Plotter	Replace current plotter that is 9 years old	$ 18,000.00	3	4		$ 3,000.00	1241-1201
8700	Medical Records	ImageRunner Printer/Copier	Release of Information	$ 2,955.00	5	4		$ 296.00	1241-1201
8740	Staff Development	SimPad Plus with LLEAP License	Replace & upgrade current system	$ 4,080.00	5	4		$ 408.00	1241-1201
8740	Staff Development	MegaCode Kid	Training with SimPad to mimic real life emergencies	$ 5,665.00	10	4		$ 283.00	1241-1201
7420	Surgery	Skyvision System	Record surgical pictures for surgeries other than open cases	$ 248,606.40	5	4		$ 24,861.00	1241-1201
8480	IT	HP servers	reaplcement for end of life servers	$ 28,497.42	5	4		$ 2,850.00	1241-1201
				$ 457,438.82		**4 Total**		$ 43,722.00	
8480	IT	Paragon upgrade to v14	Upgrade if EHR is not replaced to keep current for support and regulatory updates	$ 700,000.00	3	5		$ 116,667.00	1241-1201
8480	IT	Targeted replacement of aging printer	replace printers that are old, are exceeding their capacity, or are associated with negative expense	$ 40,000.00	5	5		$ 4,000.00	1241-1201
8390	Pharmacy	Canon IR400if Printer	Print, scan and copy	$ 2,955.00	5	5		$ 296.00	1241-1201
8700	Medical Records	Fujitsu Scanner	Scanning of Medical Records	$ 6,200.00	5	5		$ 620.00	1241-1201
8480	IT	Offsite Storage	Storage need for growth of DR site (5 years)	$ 6,600.00	5	5		$ 660.00	1241-1201
8480	IT	1 Cisco Nexus 10Gb Switches	Data Center expansion	$ 20,000.00	5	5		$ 2,000.00	1241-1201
8480	IT	HP servers	reaplcement for end of life servers	$ 28,497.42	5	5		$ 2,850.00	1241-1201
8755	Compliance	Privacy and Security Auditing Software	Replace manual system with real-time auditing software system	$ 70,000.00	5	5		$ 7,000.00	1241-1201
7770	Rehab Services	Redoc Scheduling Software	Schedule outpatient therapy patients	$ 40,000.00	3	5		$ 6,667.00	1241-1201
				$ 914,252.42		**5 Total**		$ 140,760.00	
7427	PACU	ETCO2 Module	Monitor respiratory function for sedated or anesthetized patients	$ 4,885.00	7	6		$ 349.00	1241-1201
8460	Maintenance	MRI HVAC Back up Unit	Secondary for back-up; recommended by GE Repairman	$ 18,500.00	10	6		$ 925.00	1225-1201
7420	Surgery	Urology Equipment	Cystoscope & TURP equipment for new urologist	$ 60,000.00	3	6		$ 10,000.00	1241-1201
8410	Grounds	Energy Efficient Lighting for Parking Lot	To provide more energy efficient lighting to parking lots	$ 25,000.00	15	6		$ 833.00	1210-1201
7680	CT	Power Injector	Inject patients with contrast	$ 55,000.00	10	6		$ 2,750.00	1241-1201
7660	MRI	1.5 Tesla Magnet	Replace MRI Magnet	$ 1,800,000.00	5	6		$ 180,000.00	1241-1201
8460	Maintenance	New Roof for MRI building	weathered old and repaired multiple times; leaks	$ 23,600.00	10	6		$ 1,180.00	1221-1201
				$ 1,986,985.00		**6 Total**		$ 196,037.00	
7420	Surgery	Arthroplasty Reamer	Remove cement from femur in orthopedic surgeries	$ 5,724.00	3	1, 2		$ 954.00	1241-1201
				$ 5,724.00		**1, 2 Total**		$ 954.00	

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		6- Future year purchase per Exec		> $2000	of				
Dept ID	**Department**	**Description**	**Purpose**	**Est Cost**	**Life**	**Req prior**	**note**	**Est. Depr**	**Asset Type**
6010	ICU	Custom White Boards & Communication Board	Communicate vital information to staff, patients, and caregivers in English & Spanish	$ 6,000.00	5	1, 2, 3		$ 600.00	1241-1201
6170	Med/Surg	Custom White Boards & Communication Board	Communicate vital information to staff, patients, and caregivers in English & Spanish	$ 18,000.00	5	1, 2, 3		$ 1,800.00	1241-1201
7770	Rehab Services	Recumbent Cross Trainer	Rehab adult hips, shoulders, and knees	$ 6,000.00	15	1, 2, 3		$ 200.00	1241-1201
				$ 30,000.00		**1, 2, 3 Total**		$ 2,600.00	
7630	Radiology	Lobby Furniture/Design	Replace furniture & add privacy booths	$ 75,000.00	15	1, 2, 4		$ 2,500.00	1241-1201
				$ 75,000.00		**1, 2, 4 Total**		$ 2,500.00	
7770	Rehab Services	Stander	Increase patient tolerance of standing position and correct positioning for feeding purposes	$ 5,000.00	10	1, 3		$ 250.00	1241-1201
				$ 5,000.00		**1, 3 Total**		$ 250.00	
7520	Pathology	Microtome	Aid in microscopic pathology studies & interpretation	$ 31,247.50	7	1, 4		$ 2,232.00	1241-1201
				$ 31,247.50		**1, 4 Total**		$ 2,232.00	
7420	Surgery	Biopolar Cautery/ligasure	Surgical cautery unit to become portable for use in any OR suite	$ 20,561.80	7	3, 4		$ 1,469.00	1241-1201
7420	Surgery	Phacoemulsifier	Limit blood loss in cataract extraction/lens repair	$ 48,000.00	7	3, 4		$ 3,429.00	1241-1201
				$ 68,561.80		**3, 4 Total**		$ 4,898.00	
				$ 4,828,525.95		**Grand Total**		$ 490,232.00	

Bylaws of the
Northern Inyo Hospital Auxiliary
2/20/17

Article I
NAME

The name of this organization shall be the NORTHERN INYO HOSPITAL AUXILIARY. This organization is formed in the County of Inyo, State of California.

Article II
PURPOSE

This organization is formed exclusively for charitable, religious, educational, and/or scientific purposes, including, for such purposes, the making of distributions to organizations that qualify as exempt organizations under section 501©(3) of the Internal Revenue Code, or corresponding section of any future federal tax code.

Article III
EARNINGS RESTRICTED

No part of the net earnings of the organization shall inure to the benefit of, or be distributable to its members, trustees, officers, or other private persons, except that the organization shall be authorized and empowered to pay reasonable compensation for services rendered and to make payments and distributions in furtherance of the purposes set forth in Article II hereof.

Article IV
ACTIVITIES RESTRICTED

No part of the activities of the organization shall be the carrying on of propaganda, or otherwise attempting to influence legislation, and the organization shall not participate in, or intervene in (including the publishing or distribution of statements) any political campaign on behalf of any candidate for public office. Notwithstanding any other provision of these articles, the organization shall not carry on any other activities not permitted to be carried on (a) by an organization exempt from federal income tax under section 501 © (3) of the Internal Revenue Code, or corresponding section of any future federal tax code, or (b) by a organization, contributions to which are deductible under section 170©(2) of the Internal Revenue Code, or corresponding section of any future federal tax code.

Article V
DISSOLUTION

Upon the dissolution of the organization, assets shall be distributed for one or more if

exempt purposes within the meaning of section 501©(3) of the Internal Revenue Code, or corresponding section of any future federal tax code, or shall be distributed to the federal government, or to a state or local government, for a public purpose. Any such assets not so disposed of shall be disposed of by the Court of Common Pleas of the county in which the principal office of the organization is then located, exclusively for such purposes or to such organization or organizations.

Article VI
OFFICERS

Section 1. The elected officers of the Auxiliary shall be a President a Vice-President, a Recording Secretary, a corresponding Secretary and a Treasurer.

Section 2. Officers of the Auxiliary shall be elected for terms of one year. No officer shall be eligible for more than three consecutive terms in the same office.

a. The Treasurer may serve past the 3 year limit, as long as the person is qualified.

Article VII
TYPES OF MEMBERSHIP

Section 1. Membership in the Auxiliary shall be open to persons who are interested in Northern Inyo Hospital. All Auxiliary memberships shall be renewed annually. Prior to Active membership, a Counselor will educate and inform the prospective member as to function, purpose, and history of the Auxiliary.

Section 2. There shall be the following types of memberships:

a. ACTIVE : shall pay annual dues and participate in service programs of the Auxiliary to the extent of 50 hours minimum per year. Any Active Member in good standng shall have the right to vote, participate in meetings, and to hold office in the Auxiliary.

b. ASSOCIATE: shall be interested in the purpose of the Auxiliary, shall pay annual dues, but have no active membership responsibilities. Any Associate Member in good standing shall have the right to vote, may participate in meetings and chair Standing Committees of the Auxiliary.

c. LIFE: A Life Membership may be purchased at a one time price of $100.00. Any Life Member in good standing shall have the right to vote, participate in meetings and to hold office in the Auxiliary.

d. HONORARY LIFE: The highest honor awarded by the Auxiliary is an Honorary Life Membership. It is awarded rarely and only to those individuals`who have served over and above the normal membership requirements. These members have served in leadership roles as officers and committee chairmen. In addition, they have given countless hours participating in ALL functions of the Auxiliary. These individuals are chosen in recognition of outstanding service to the Auxiliary or the Hospital, and shall pay no dues. Any Honorary Life Member in good standing shall have the right to vote, participate in meetings, and to hold office in the Auxiliary. Those who receive this honor truly earn it, and their dedication to the Auxiliary inspires us all.

ARTICLE VIII
DUTIES OF OFFICERS

Section 1. The President shall be the chief executive officer of the Auxiliary and the Executive Board, and shall have the supervision of general management of the Auxiliary. The President shall appoint the Parliamentarian, chairmen of the standing committees, special committees as occasion may demand, and chairmen caused by vacancies. The President shall be a member ex officio of all standing committees of the Auxiliary, except the Nomination Committee. The President shall work closely with the Hospital Administrator and perform all duties pertaining to the office.

Section 2. The Vice - President shall be in charge of membership and shall be Chairman of the Membership Committee. In the absence, disability or resignation of the President, the Vice President shall have the executive powers and perform duties of the President.

Section 3. The Recording Secretary shall be responsible for keeping an accurate record of meetings of the Northern Inyo Hospital Auxiliary and of the Executive Board, in books belonging to the Auxiliary. These minutes shall be open to the inspection of any member at any reasonable time.

Section 4. The Corresponding Secretary shall be responsible for the Auxiliary's general correspondence.

Section 5. The Treasurer shall be responsible for keeping an accurate record of all financial affairs of the Auxiliary, and shall present a financial report at each General Meeting, All expenses, other than routine operating, must be approved by the members at a General Meeting, execpt for emergencies. The Treasurer's book shall be audited at the end of each financial year by three members appointed by the President.

Section 6. The Parliamentarian shall be the Chairman of the Bylaws Committee, keep a current list of the Standing Rules, and shall advise the Auxiliary board on the validity of any question of Parliamentary Law.

ARTICLE IX
THE EXECUTIVE BOARD

Section 1. The Executive Board shall consist of the Officers of the Auxiliary, the immediate past President and the chairmen of the standing committees. The Administrator of the Hospital shall be an ex officio member of the Executive Board.

Section 2. All actions of the Executive Board are subject to the approval of the Northern Inyo Hospital Board of Directors or its representative, the Hospital Administrator. With this limitation, management and control of property and funds, the affairs of the Auxiliary shall be administered by the Executive Board. The Executive Board shall adopt its own rules of procedure not inconsistent with the Bylaws of the Auxiliary.

Section 3. Regular meetings of the Executive Board are combined with the General Meetings. Special meetings of the Board may be held at any time and place determined by the President, and in addition shall be called when requested in writing by not fewer than five members of the board.

Section 4. Five members shall constitute a quorum at any meeting of the Board. In the absence of a quorum, the meeting shall be adjourned.

ARTICLE X
GENERAL MEETINGS

Section 1. There shall be regular meetings of the Auxiliary membership, the number to be determined by the Executive Board.

Section 2. The time and place of the General Meetings may be determined by the President and/or the Executive Board. Meetings are ordinarily scheduled the second Wednesday of each month. Meetings are to be held at Northern Inyo Hospital Annex, unless otherwise designated.

Section 3. The annual Meetings shall be held in May of each year for the Installation of Officers and Presentation of Awards.

Section 4. Ten voting members present shall constitute a quorum of any General Meeting of the Auxiliary.

ARTICLE XI
COMMITTEES

Section 1. Standing Committees: There shall be Standing Committees necessary to conduct the business and program of the Auxiliary. The personnel of such committees shall consist of members designated by the Chairman of the Committee with the approval of the President. The duties of each committee will be outlined in detail in the Chairman's Procedure Book. These Chairmen become members of the Executive Board of the Northern Inyo Hospital Auxiliary.

Section 2: Nominating Committee shall be put into being, and act as prescribed in Article IX.

Section 3: Special Committees may be created when necessary by the President, with the approval of the Executive Board.

ARTICLE XII
ELECTION PROCEDURES

Section 1. The Nominating Committee shall consist of three members appointed by the board.

a. Suggested nominations for Officers of the Auxiliary shall be received by the Nominating Committee from the membership. From these suggestions, and as a result of its own deliberations, the Nominating Committee shall submit to the April General Meeting a slate of candidates for officers during the ensuing year. Nominations may also be accepted from the floor.
b. Members of the Nomination Committee may be candidates for office.

Section 2. The Election of officers shall be held at the April Meeting. The new officers shall be installed at the May Meeting and take office on June 1.

ARTICLE XIII
FUNDS

Section 1. All fund-raising activities, other than regular membership dues, shall be subject to the approval of the Hospital Administration, and the funds shall be expended only for those purposes approved by the Auxiliary.

Section 2. All dues or contributions paid or made to the Auxiliary become the property of the Auxiliary and the members or contributors shall have no further claim or rights thereto.

Section 3. All documents made, accepted or executed by the Auxiliary shall be signed by the President and/or representative.

Section 4. All checks drawn against the General Funds of the Auxiliary shall be signed by two authorized signatures on file at the banking institution.

Section 5. Funds expended for gifts to Northern Inyo Hospital (NIH) shall be for life saving equipment, or other items, or facility improvements that enhance the ability of NIH to serve the needs of the overall community, as expressed by the Hospital Administration.

ARTICLE XIV
FISCAL YEAR

The fiscal year of the Auxiliary shall commence on June 1, and shall end on May 31.

ARTICLE XV
AMENDMENTS

The Bylaws of the Auxiliary may be altered, repealed, or amended by the affirmative vote of two-thirds of the members present and voting, at any regular or special meeting of the Auxiliary, provided that notice of the proposed alteration, repeal or amendment be contained in a written notice of the meeting two weeks in advance.

ARTICLE XVI
APPROVAL AND ADOPTION

These Bylaws, after approval of the Northern Inyo Hospital Board of Directors, shall be effective immediately.

Approved: _____ _____Date

Kevin Flanigan, M.D., Administrator, Northern Inyo Hospital

_____ _____Date

Peter J. Watercott, President, Northern Inyo Hospital Board of Directors

ADOPTED BY THE NORTHERN INYO HOSPITAL AUXILIARY:

Judy Fratella — 3/1/17 Date
Judy Fratella, President

Richard E Rogers — 3-1-2017 Date
Richard Rogers, Vice President

Cathryn Bahm — 3-8-2017 Date
Cathy Bahm, Recording Secretary

Carole E. Sample — 3/8/17 Date
Carole Sample, Corresponding Secretary

Sharon Moore — 3-8-2017 Date
Sharon Moore, Treasurer

NORTHERN INYO HEALTHCARE DISTRICT

BUDGET VARIANCE ANALYSIS

Feb-17 *Fiscal Year Ending June 30, 2017*

Year to date for the month ending February 28, 20017

	-486	or	-17%	less IP days than in the prior fiscal year
$	(3,906,416)	or	-12.99%	under budget in Total IP Revenue and
$	(220,832)	or	-0.4%	under budget in OP Revenue resulting in
$	(4,127,248)	or	-4.6%	under budget in gross patient revenue &
$	(1,000,250)	or	-1.9%	under budget in net patient revenue

Year-to-date Net Revenue was			$	51,401,101
Total Operating Expenses were:			$	48,223,534
				for the fiscal year to date
$	(330,631)	or	-0.7%	under budget. Salaries and Wages were
$	(2,038,342)	or	-11.9%	under budget and Employee Benefits
$	97,684	or	0.9%	over budget due to change in Pension assumptions.
			74%	Employee Benefits Percentage of Wages

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

$	1,440,676	or	25.6%	Professional Fees continue to run over budget due to contracted or registry personnel also seen in Salaries & Wages being under budget.
$	160,264	or	3.6%	Supplies running slightly over budget
$	54,258	or	1.6%	Depreciation Expense continues to be just over budget
$	261,491	or	16.8%	Bad Debt Expense running over budget
$	109,646	or	4.3%	Other Expenses are running high due to travel/education that has happened in the first half of fiscal year; should even out over year

Other Information:

$	3,561,073			Operating Income, less
$	(2,536,832)			loss in non-operating activities created a net income of;
$	1,024,241	$	147,980	Over budget.
			39.31%	Contractual Percentages for Year and
			41.00%	Budgeted Contractual Percentages including

$ 4,979,685 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 and Final for Medicare 15

Non-Operating actives included:

$	(2,703,675) loss	$	(56,599)	under budget in Medical Office Activities
$	(53,776)	$	(150,308)	under budget in 340B Pharmacy Activity

NORTHERN INYO HEALTHCARE DISTRICT
STATEMENT OF OPERATIONS
for period ending February 28, 2017

	ACT MTD	BUD MTD	VARIANCE	ACT YTD	BUD YTD	VARIANCE
Unrestricted Revenues, Gains & Other Support						
Inpatient Service Revenue						
Routine	794,575	805,090	(10,515)	5,960,343	6,987,041	(1,026,698)
Ancillary	2,281,780	2,659,510	(377,730)	20,201,009	23,080,727	(2,879,718)
Total Inpatient Service Revenue	3,076,355	3,464,600	(388,245)	26,161,352	30,067,768	(3,906,416)
Outpatient Service Revenue	6,906,353	6,769,323	137,030	58,527,259	58,748,091	(220,832)
Gross Patient Service Revenue	**9,982,707**	**10,233,923**	**(251,216)**	**84,688,611**	**88,815,859**	**(4,127,248)**
Less Deductions from Revenue						
Patient Service Revenue Deductions	133,796	158,005	(24,209)	1,641,130	1,371,250	269,880
Contractual Adjustments	4,861,847	4,037,905	823,942	36,626,065	35,043,258	1,582,807
Prior Period Adjustments	(1,342,166)	-	(1,342,166)	(4,979,685)	-	(4,979,685)
Total Deductions from Patient Service Revenue	**3,653,477**	**4,195,910**	**(542,433)**	**33,287,510**	**36,414,508**	**(3,126,998)**
Net Patient Service Revenue	**6,329,230**	**6,038,013**	**291,217**	**51,401,101**	**52,401,351**	**(1,000,250)**
Other revenue	57,184	48,611	8,573	383,505	421,877	(38,372)
Total Other Revenue	**57,184**	**48,611**	**8,573**	**383,505**	**421,877**	**(38,372)**
Expenses:						
Salaries and Wages	1,913,326	1,977,025	(63,699)	15,119,413	17,157,755	(2,038,342)
Employee Benefits	1,303,251	1,286,104	17,147	11,259,265	11,161,581	97,684
Professional Fees	857,303	649,401	207,902	7,076,540	5,635,864	1,440,676
Supplies	472,854	513,611	(40,757)	4,617,655	4,457,391	160,264
Purchased Services	300,336	309,079	(8,743)	2,266,052	2,682,360	(416,308)
Depreciation	387,332	386,717	615	3,410,415	3,356,157	54,258
Bad Debts	133,676	179,293	(45,617)	1,817,499	1,556,008	261,491
Other Expense	337,792	293,486	44,306	2,656,695	2,547,049	109,646
Total Expenses	**5,705,870**	**5,594,716**	**111,154**	**48,223,534**	**48,554,165**	**(330,631)**
Operating Income (Loss)	**680,544**	**491,908**	**188,636**	**3,561,073**	**4,269,063**	**(707,990)**
Other Income:						
District Tax Receipts	48,644	44,779	3,865	389,152	388,620	532
Tax Revenue for Debt	150,920	66,004	84,916	1,207,360	572,822	634,538
Partnership Investment Income		-	-		-	-
Grants and Other Contributions Unrestricted	42,990	7,671	35,319	597,685	66,574	531,111
Interest Income	13,731	16,767	(3,036)	130,560	145,512	(14,952)
Interest Expense	(264,017)	(221,223)	(42,794)	(2,120,923)	(1,919,896)	(201,027)
Other Non-Operating Income	2,151	1,994	157	16,787	17,308	(521)
Net Medical Office Activity	(372,526)	(318,054)	(54,472)	(2,703,675)	(2,760,274)	56,599
340B Net Activity	17,106	11,123	5,983	(53,776)	96,532	(150,308)
Non-Operating Income/Loss	**(361,001)**	**(390,939)**	**29,938**	**(2,536,832)**	**(3,392,802)**	**855,970**
Net Income/Loss	**319,543**	**100,969**	**218,574**	**1,024,241**	**876,261**	**147,980**

Northern Inyo Healthcare District
Balance Sheet
Period Ending February 28, 2017

Assets:	Current Month	Prior Month	Change
Current Assets			
Cash and Equivalents	4,083,484	4,421,769	(338,285)
Short-Term Investments	11,790,494	9,787,990	2,002,504
Assets Limited as to Use	-	-	-
Plant Replacement and Expansion Fund	2	2	-
Other Investments	779,134	779,134	-
Patient Receivable	57,361,600	57,424,503	(62,902)
Less: Allowances	(44,288,428)	(43,961,893)	(326,535)
Other Receivables	483,554	692,287	(208,732)
Inventories	3,641,965	3,633,746	8,218
Prepaid Expenses	1,449,560	1,488,644	(39,084)
Total Current Assets	**35,301,366**	**34,266,183**	**1,035,183**
Internally Designated for Capital Acquisitions	1,124,805	1,124,762	43
Special Purpose Assets	1,191,583	1,191,583	-
Limited Use Asset; Defined Contribution Pension	1,053,149	988,268	64,881
Limited Use Assets Defined Benefit Plan	14,144,525	14,144,525	-
Limited Use Asset Defined Benefit Plan 003	36,561	29,946	6,615
Revenue Bonds Held by a Trustee	2,534,820	2,375,015	159,805
Less Amounts Required to Meet Current Obligations	-	-	-
Assets Limited as to use	**20,085,443**	**19,854,099**	**231,344**
Long Term Investments	2,552,143	2,552,143	-
			-
Property & equipment, net Accumulated Depreciation	81,435,815	81,723,520	(287,705)
Unamortized Bond Costs	-	-	-
Total Assets	**139,374,767**	**138,395,945**	**978,821**

Northern Inyo Healthcare District
Balance Sheet
Period Ending February 28, 2017

Liabilities and Net Assets	Current Month	Prior Month	Change
Current Liabilities:			
Current Maturities of Long-Term Debt	523,314	611,841	(88,526)
Accounts Payable	1,291,979	1,607,788	(315,810)
Accrued Salaries, Wages & Benefits	4,927,593	4,799,334	128,259
Accrued Interest and Sales Tax	287,031	133,089	153,942
Deferred Income	194,576	243,220	(48,644)
Due to 3rd Party Payors	1,593,023	872,302	720,720
Due to Specific Purpose Funds	-	-	-
Other Deferred Credits; Pension	1,427,520	1,427,520	-
Total Current Liabilities	**10,245,036**	**9,695,095**	**549,941**
Long Term Debt, Net of Current Maturities	46,012,756	46,012,756	-
Bond Premium	723,847	725,102	(1,254)
Accreted Interest	10,424,899	10,314,350	110,549
Other Non-Current Liabilities; Pension	33,492,468	33,492,468	-
Total Long Term Debt	**90,653,971**	**90,544,676**	**109,294**
Net Assets			
Unrestricted Net Assets less Income Clearing	36,259,936	36,259,893	43
Temporarily Restricted	1,191,583	1,191,583	-
Net Income (Income Clearing)	1,024,241	704,698	319,543
Total Net Assets	**38,475,759**	**38,156,174**	**319,586**
Total Liabilities and Net Assets	**139,374,766**	**138,395,945**	**978,821**

NORTHERN INYO HEALTHCARE DISTRICT

Restricted and Specific Purpose Fund Balances

for period ending February 28, 2017

	Current Month	Prior Month	Change
Board Designated Funds:			
Tobacco Fund Savings Account	$ 1,098,082	$ 1,098,039	43
Equipment Fund Savings Account	$ 26,723	$ 26,723	-
Total Board Designated Funds:	**$ 1,124,805**	**$ 1,124,762**	**$ 43**
Specific Purpose Funds:			
* Bond and Interest Savings Account	$ 1,058,468	$ 1,058,468	$ -
Nursing Scholarship Savings Account	$ 33,036	$ 33,036	$ -
Medical Education Savings Account	$ 76	$ 76	$ -
Joint NIHD/Physician Group Savings Account	$ 100,003	$ 100,003	$ -
Total Specific Purpose Funds:	**$ 1,191,583**	**$ 1,191,583**	**$ -**
Grand Total Restricted and Specific Purposes Funds:	**$ 2,316,388**	**$ 2,316,346**	**$ 43**

NORTHERN INYO HEALTHCARE DISTRICT

OPERATING STATISTICS

for period ending February 28, 2017

		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	280	2,340	2,826	(486)	-17%
Total Patient Days without NB	248	2,112	2,562	(450)	-18%
Swing Bed Days	13	307	547	(240)	-44%
Discharges without NB	93	714	758	(44)	-6%
Swing Discharges	4	46	78	(32)	-41%
Days in Month	28	243	243		
Occupancy without NB	8.86	8.69	10.54	(1.9)	-18%
Average Stay (days) without NB	2.67	2.96	3.38	(0.4)	-12%
Average LOS without NB/Swing	2.64	2.70	2.96	(0.3)	-9%
Hours of Observation (OSHPD)	644	5,857	4,270	1,587	37%
Observation Adj Days	27	244	178	66	37%
ER Visits All Visits	726	6,421	6,189	232	4%
RHC Visits (OSHPD)	2,364	16,996	17,420	(424)	-2%
Outpatient Visits (OSHPD)	3,237	25,578	25,367	211	1%
IP Surgeries (OSHPD)	21	187	201	(14)	-7%
OP Surgery (OSHPD)	104	776	794	(18)	-2%
Worked FTE's	360.00	328.00	329.00	(1)	0%
Paid FTE's	378.00	367.00	376.00	(9)	-2%
Hours Worked to Hours Paid%	95.2%	89.4%	87.5%	1.9%	2%
Payor %					
Medicare		40%	40%	0%	
Medi-Cal		23%	24%	-1%	
Insurance, HMO & PPO		34%	35%	-1%	
Indigent (Charity Care)		1.1%	0.3%	0.9%	
All Other		2%	2%	0%	
Total		100%	100%		

NORTHERN INYO HEALTHCARE DISTRICT

Investments as of February 28, 2017

ID	Purchase Date	Maturity Dat	Institution	Broker	Rate	Principal Invested
3	28-Feb-17	01-Mar-17	Local Agency Investment Fund	Northern Inyo Hospital	0.78%	12,342,636.44
4	13-Jun-14	13-Jun-18	Synchrony Bank Retail-FNC	Financial Northeaster Corp.	1.60%	250,000.00
				SHORT TERM INVESTMENTS		$ 12,592,636.44
5	28-Nov-14	28-Nov-18	American Express Centurion Bank	Financial Northeaster Corp.	2.00%	150,000.00
6	02-Jul-14	02-Jul-19	Barclays Bank	Financial Northeaster Corp.	2.05%	250,000.00
7	02-Jul-14	02-Jul-19	Goldman SachsBank USA NY CD	Financial Northeaster Corp.	2.05%	250,000.00
8	20-May-15	20-May-20	American Express Centurion Bank	Financial Northeaster Corp.	2.05%	100,000.00
9	26-Sep-16	27-Sep-21	Comenity Capital Bank	Multi-Bank Service	1.70%	250,000.00
10	02-Sep-16	28-Sep-21	Capital One Bank	Gemini Financial Services, LL	1.70%	250,000.00
11	28-Sep-16	28-Sep-21	Capital One National Assn	Multi-Bank Service	1.70%	250,000.00
12	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		$ 14,342,636.44
1	28-Feb-17	01-Mar-17	LAIF Defined Cont Plan	Northern Inyo Hospital	0.78%	1,053,149.31
2	28-Feb-17	01-Mar-17	LAIF PEPRA DB PLAN	Northern Inyo Hospital	0.78%	36,560.99
				LAIF PENSION INVESTMENTS		$ 1,089,710.30
						15,432,346.74

Northern Inyo Healthcare District

Financial Indicators as of February 28, 2017

	Target	Feb-17	Jan-17	Dec-16	Nov-16	Oct-16	Sep-16	Aug-16	Jul-16	Jun-16
Current Ratio	>1.5-2.0	3.45	3.53	3.69	2.85	2.95	2.60	2.15	2.05	1.98
Quick Ratio	>1.33-1.5	2.90	2.93	2.92	2.46	2.41	2.20	1.83	1.74	1.71
Days Cash on Hand prior method	>75	157.10	151.40	140.37	160.86	145.43	157.98	168.91	162.64	161.90
Days Cash on Hand Short Term Sources	>75	79.99	71.85	62.90	85.97	67.02	77.60	86.56	91.08	96.57
Debt Service Coverage	>1.5-2.0	2.23	2.17	2.13	2.46	2.30	2.80	3.18	2.03	1.95
Operating Margin		6.83	6.30	5.59	7.48	6.43	8.37			
Outpatient Revenue % of Total Revenue		69.11	69.10	69.28	68.11	67.48	67.03			
Cash flow (CF) margin (EBIDA to revenue)		4.27	3.94	3.71	5.43	4.53	7.01			
Days in Patient Accounts Receivable	<60 Days	76.70	80.80	77.70	75.60	75.00	77.80	78.50	73.10	63.20

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

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

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

Quick Ratio Equals (from Balance Sheet) Current Assets;Cash and Equivalents through Net Patient Accounts 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

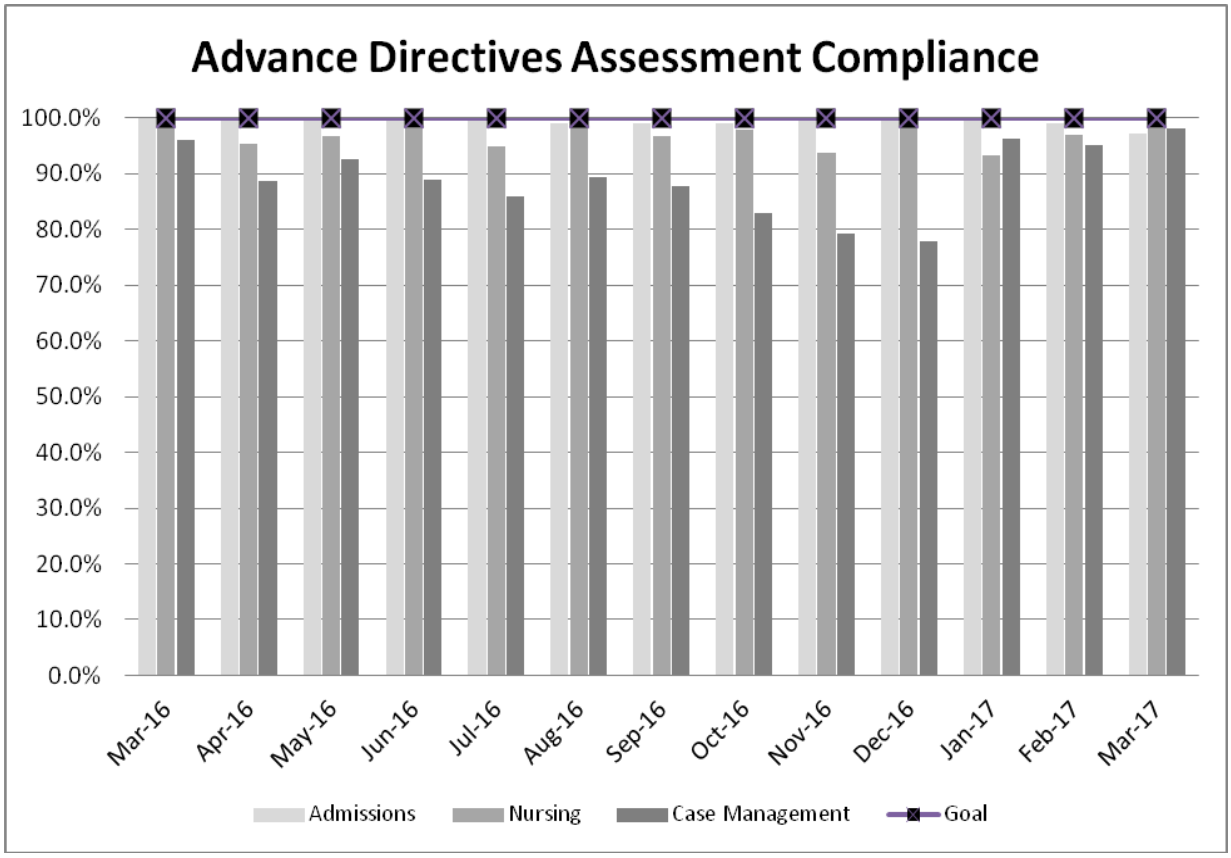
Cash Flow (CF) margin (EBIDA to revenue) Equals (from Income Statement) [Net Income+Interest+Depreciation+Amoritization(if any)/Total Revenue] x 100

Accounts Receivable Days are pulled from the AR Aging report

2013 CMS Validation Survey Monitoring-April 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.

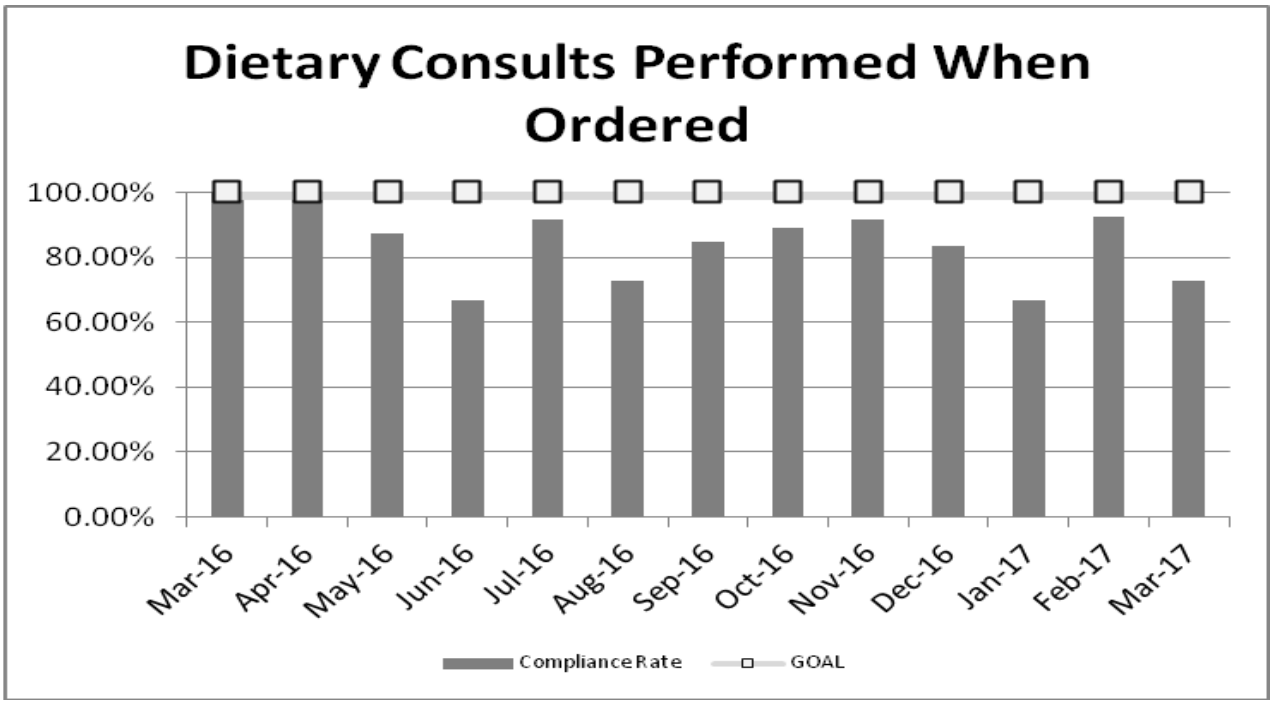


    b. Positive Lab Cultures are being routed to Infection Prevention and each positive is being investigated as to source. Monitoring has been ongoing and reported through Infection Control Committee. QAPI receives data.

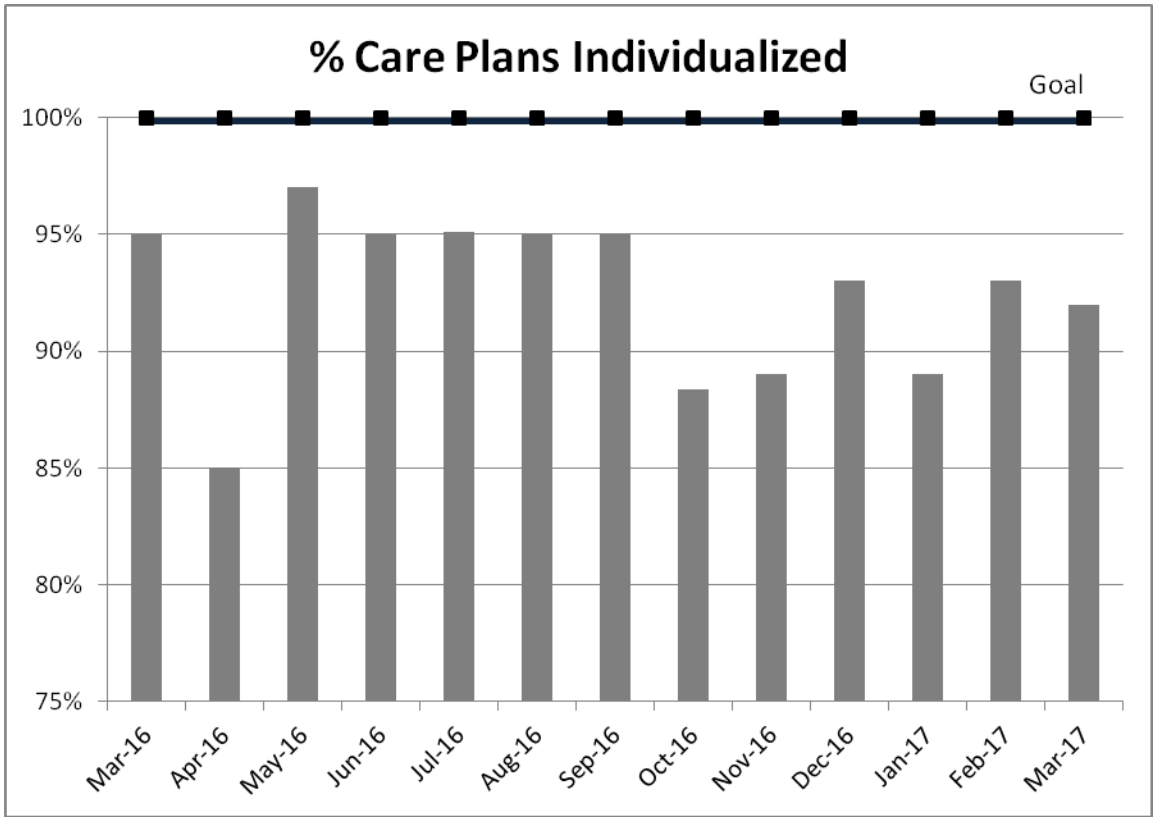
    c. Safe Food cooling monitored for compliance with approved policy and procedure. 100% compliance since May 6, 2013.

    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.

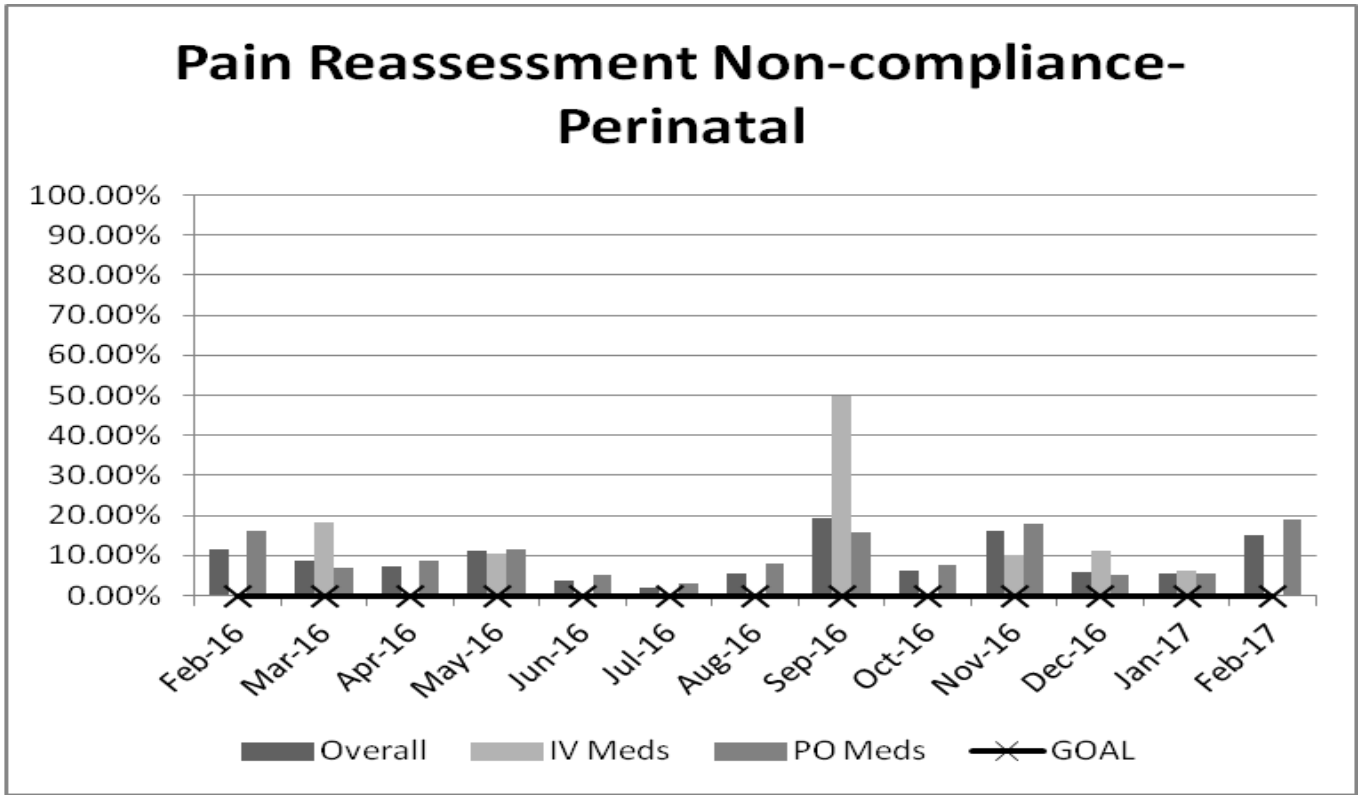


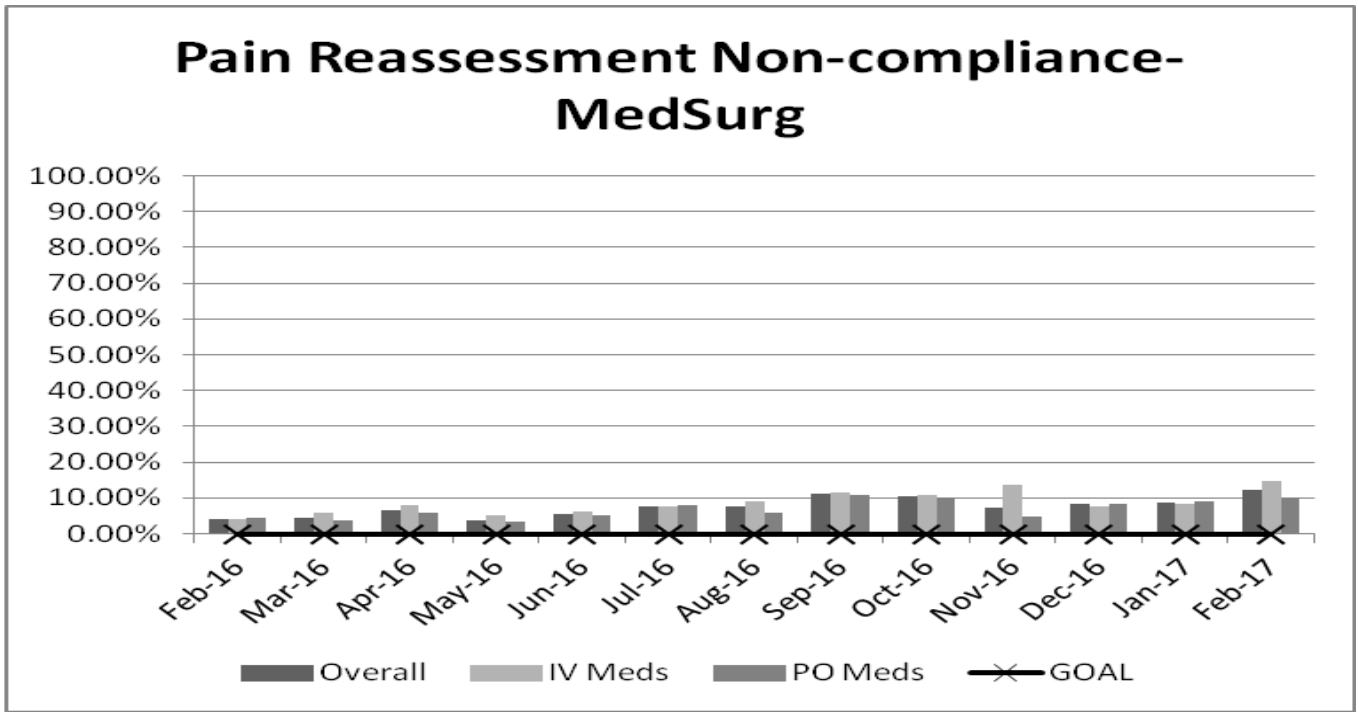
f. Care plans reviewed by Case Management and interventions made to produce care plans. Progress has been made in developing individualized care plans.

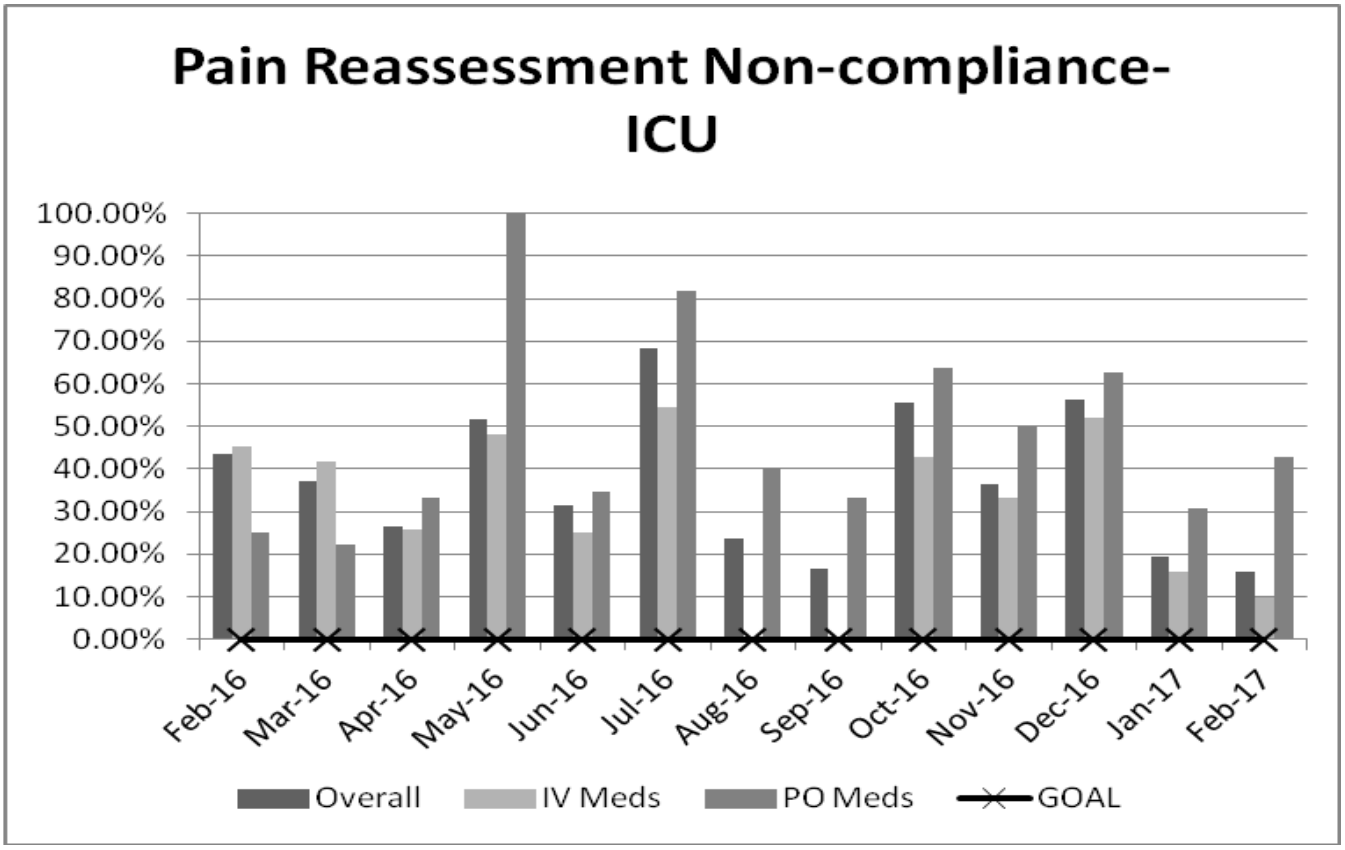


g. Fire drill date, times, attendance and outcomes, smoke detector tests, and fire extinguisher test grids have been approved. All fire drills were complete and compliant from May 6, through present.

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.

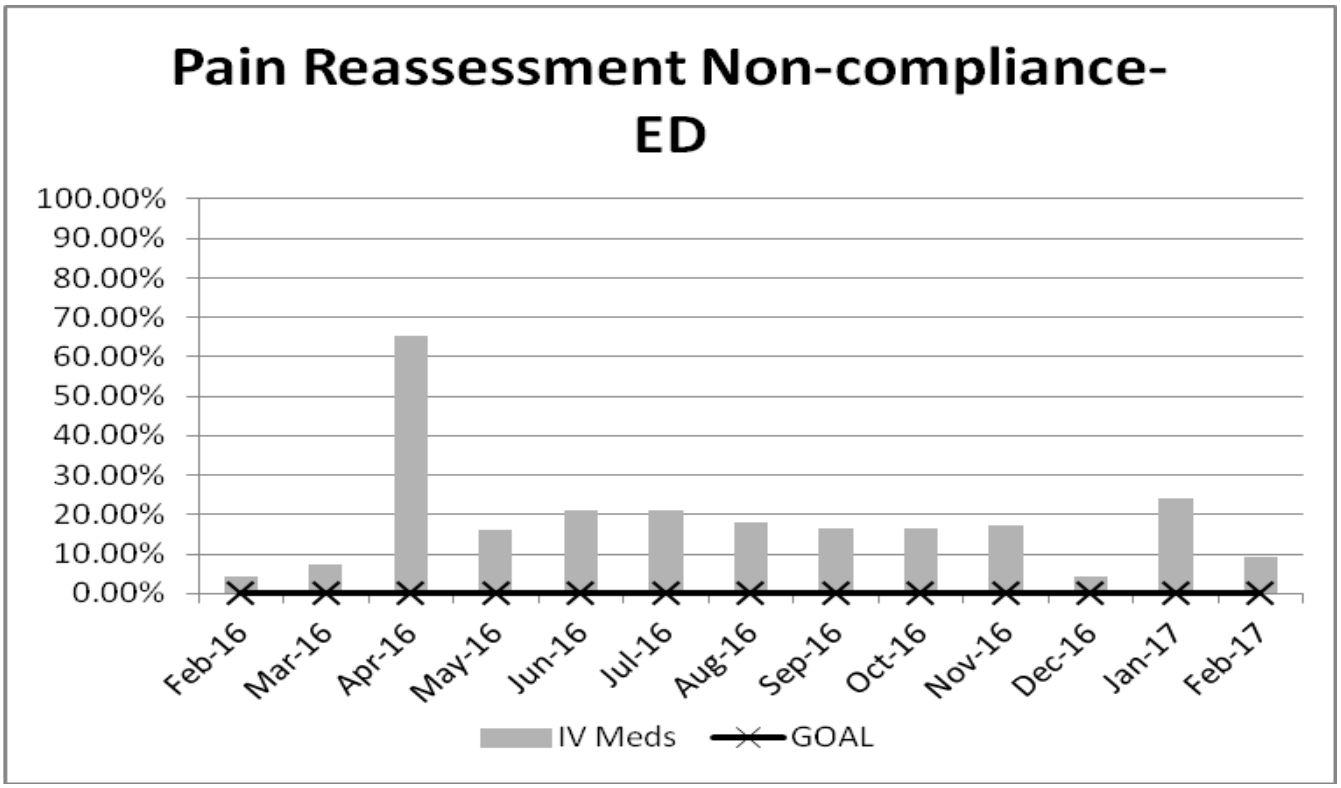


Table 6. Restraint chart monitoring for legal orders.

	Sept 2016	***Oct 2016***	***Nov 2016***	***Dec 2016***	***Jan 2017***	***Feb 2017***	***March 2017***	***Goal***
Restraint verbal/written order obtained within 1 hour of restraints	1/1 (100%)	1/2 (50%)	1/1 (100%)	2/2 (100%)	2/2 (100%	1/1 (100%)	1/1 (100%)	100%
Physician signed order within 24 hours	1/1 (100%)	1/2 (50%)	0/1 (0%)	2/2 (100%)	½ (50%)	1/1 (100%)	0/1 (0%)	100%
Physician Initial Order Completed (all areas completed and form/time/date noted/signed by MD and RN)	0/1 (0%)	0/2 (0%)	0/1 (0%)	2/2 (100%)	0/2 (0%)	1/1 (100%)	0/1 (0%)	100%
Physician Re-Order Completed (all areas completed and form time/date/noted/signed by MD and RN)	N/A	2/4 (50%)	1/3 (33%)	2/2 (100%)	3/9 (33%)	0/1 (0%)	0/1 (0%)	100%
Orders are for 24 hours	1/1 (100%)	5/6 (83%)	4/4 (100%)	4/4 (100%)	11/11 (100%)	2/2 (100%)	2/2 (100%)	100%
Is this a PRN (as needed) Order	0/1 (0%)	0/6 (0%)	0/4 (0%)	0/4 (0%)	0/11 (0%)	0/2 (0%)	0/2 (0%)	0%

CALL TO ORDER	The meeting was called to order at 5:30 pm by Peter Watercott, President.
PRESENT	Peter Watercott, President John Ungersma, MD, Vice President M.C. Hubbard, Secretary Mary Mae Kilpatrick, Treasurer Phil Hartz, Member at Large
ALSO PRESENT	Kevin S. Flanigan, MD, MBA, Chief Executive Officer Kelli Huntsinger, Chief Operating Officer Carrie Petersen, Chief Accounting Officer John Tremble, Interim CFO Maria Sirois, Chief Performance Excellence Officer Tracy Aspel, Chief Nursing Officer Sandy Blumberg, Executive Assistant
ABSENT	Joy Engblade, MD, Chief of Staff Alison Murray, Interim Chief Human Relations Officer
OPPORTUNITY FOR PUBLIC COMMENT	Mr. Watercott asked if any members of the public wished to comment 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*). No comments were heard.
OLD BUSINESS	
BISHOP UNION HIGH SCHOOL STUDENT CLINIC	Chief Executive Officer Kevin S. Flanigan, MD, MBA reported Bishop Union High School (BUHS) is moving forward to establish a student health clinic on campus. The proposed clinic would be staffed by a Northern Inyo Healthcare District (NIHD) practitioner experienced in adolescent healthcare, who would be on campus one or two days per week to provide healthcare services for students as allowed for by State law. It is likely that the School Board will approve the proposed Clinic at their March 16th meeting, and in preparation for that approval this item is listed as an action item on the agenda for this meeting as well. Discussion of the issues associated with this topic followed, which included input from NIHD practitioners and staff; Board members; the Executive Team; and members of the community. At the conclusion of discussion it was suggested that this item be tabled until it is voted on by the BUHS Board. It was moved by Phil Hartz, seconded by Mary Mae Kilpatrick, and passed to table this agenda item to a future meeting, with John Ungersma MD voting against tabling.
NEW BUSINESS	
NURSING DEPARTMENT POLICIES AND PROCEDURES	Chief Nursing Officer Tracy Aspel, RN called attention to the following Nursing Department policies and procedures being submitted for approval:

1. *Documentation of Patient Care*
2. *Orientation to Nursing Departments*
3. *Patient Valuables*
4. *Acute/Sub acute Performance Improvement*
5. *Patient Acuity*
6. *Nursing QAPI*
7. *Angel Flight*
8. *Emergency Staffing*

It was moved by Ms. Kilpatrick, seconded by Doctor Ungersma, and unanimously passed to approve Nursing Department policies and procedures 1 through 8 as presented.

ANNUAL POLICY AND PROCEDURE APPROVALS

Doctor Flanigan called attention to a list of Policies and Procedures presented for annual approval at this meeting, which were included as attachment "A" to the agenda for this meeting. It was moved by M.C. Hubbard, seconded by Mr. Hartz, and unanimously passed to approve all policies listed on Attachment A to the agenda for this meeting.

GENERAL BUDGET ASSUMPTIONS FOR FISCAL YEAR 2017/2018

Interim Chief Financial Officer John Tremble presented general budget assumptions for the 2017/2018 fiscal year, in preparation for finalizing NIHD's next fiscal year budget. The general budget assumptions included the following:

- Changes to the Affordable Care Act (ACA) will not be budgeted for, due to the fact that they are impossible to predict
- Intergovernmental Transfers will be allowed for in next year's budget
- No construction projects will be budgeted for in the upcoming fiscal year
- Increases to the price of drugs; medical supplies; food; and employee salaries will be budgeted for
- Annual depreciation for the 2017/2018 fiscal year is projected to be $4,224,900
- Accrued interest on the 2009 Bonds in the amount of $1,772,886 will be budgeted for, which will have the effect of generating cash flow

It was moved by M.C. Hubbard, seconded by Doctor Ungersma, and unanimously passed to approve the 2017/2018 fiscal year general budget assumptions as presented.

REQUEST FOR PROPOSAL (RFP) POLICY AND PROCEDURE APPROVAL

Chief Performance Excellence Officer Maria Sirois called attention to a Request for Proposal (RFP) Policy and Procedure which would establish a systematic approach for soliciting fair and impartial information and pricing from suppliers or vendors soliciting District business for products and services (for expenditures that exceed a price of $25,000). Following review of the information provided it was moved by Ms. Kilpatrick, seconded by Mr. Hartz, and unanimously passed to approve the proposed RFP Policy and Procedure process as presented.

USE OF THE NIHD HEALING GARDEN	Doctor Flanigan asked the Board for clarification regarding the intended use of the NIHD Healing Garden. The Garden was originally established as a place of sanctuary and rejuvenation for hospital patients and families, however in recent years requests have been made to use the garden for in-memoriam recognitions. Following discussion on this matter it was determined that the garden will be used as a place for healing rather than a place to recognize those who have passed on. The Board suggested that a new method for establishing memorials be considered, and that the NIHD Auxiliary be asked for input on this subject.
ELECTION OF BOARD MEMBER TO COMPLIANCE COMMITTEE	Dr. Flanigan stated that an NIHD Board Member needs to be seated on the District's *Compliance and Business Ethics Committee*, and Director Hubbard has volunteered to fill that spot. It was moved by Doctor Ungersma, seconded by Ms. Kilpatrick, and unanimously passed to approve M.C. Hubbard serving on the NIHD *Compliance and Business Ethics Committee* as suggested.
PURCHASE OF PMA PARTNERSHIP INTEREST	Dr. Flanigan then requested authorization to act on behalf of the District to purchase the Pioneer Medical Associates (PMA) Partnership interest of Nickoline Hathaway, MD and Asao Kamei, MD at a market cost not to exceed $790,000, if the opportunity to purchase arises. The proposed purchase would make NIHD the sole owner of the Pioneer Medical building located at 152 Pioneer Lane, allowing it to use the entire building for hospital business and patient care services. It was moved by Mr. Hartz, seconded by Doctor Ungersma, and unanimously passed to approve the purchase of the PMA partnership interest of Doctors Kamei and Hathaway as requested, for an amount not to exceed $790,000, if Doctors Kamei and Hathaway decide to sell at this time.
EMPLOYEE DRUG AND ALCOHOL POLICY	Doctor Flanigan called attention to a proposed *Employee Drug and Alcohol Policy* consistent with the District's commitment to maintaining a safe, healthy, and productive work environment and drug free work place for its' employees. It was moved by Ms. Kilpatrick, seconded by Ms. Hubbard, and unanimously passed to approve the proposed *Employee Drug and Alcohol Policy* as presented.
EMPLOYEE PAY SCALE UPDATE	Doctor Flanigan then called attention to a proposed update to the NIHD employee pay scale which would adjust District employee pay calculations to an average of Northern California and Rural California pay scales combined. The proposed pay scale adjustment also includes calculations to account for the upcoming escalation of the State minimum wage, and the result will be an upward shift in pay for employees who are mainly in lower pay scale categories. The fiscal impact of the update is estimated to be $674,000; 3 months of which will be realized during this fiscal year. It was moved by Doctor Ungersma, seconded by Ms. Hubbard, and unanimously passed to approve the proposed NIHD employee pay scale update as presented.

STRYKER ORTHOPEDIC SUPPLY CONTRACT

Doctor Flanigan called attention to a proposed agreement for orthopedic supply products with Stryker Corporation, which would provide for both NIHD orthopedic surgeons using the same vendor for orthopedic surgery trauma equipment, while also realizing a significant cost savings for the District. It was moved by Ms. Kilpatrick, seconded by Doctor Ungersma, and unanimously passed to approve the proposed contract with Stryker Corporation for orthopedic supply products as requested.

INTRODUCTION OF DIAGNOSTIC IMAGING AND LAB DIRECTOR

Doctor Flanigan welcomed Mr. Larry Weber, incoming Director of Diagnostic Imaging and the Laboratory to NIHD, stating that Mr. Weber's arrival has already had a profound positive effect on both departments of the hospital.

ADOPT-A-HIGHWAY PARTICIPATION

Doctor Flanigan informed the Board that NIHD has adopted two sections of Highway 395 in Bishop through the Adopt-A-Highway program, and hospital staff will volunteer and be trained to participate in quarterly cleanups of the highway in a community service effort. Cleanups will take place on Fridays, beginning in the month of April.

CONSENT AGENDA

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

- Approval of the minutes of the February 15, 2017 regular meeting
- 2013 CMS Validation Survey Monitoring, March 2017
- Financial and Statistical Reports for the period ending January 31 2017

It was moved by Mr. Hartz, seconded by Doctor Ungersma, and unanimously passed to approve all three consent agenda items as presented.

PATIENT EXPERIENCE COMMITTEE REPORT

Chief Performance Excellence Officer Maria Sirois reported that Patient Experience Committee structural role and responsibility changes will be discussed as part of the Chief of Staff Report.

WORKFORCE EXPERIENCE REPORT

Doctor Flanigan called attention to the results of the recently conducted Employee Satisfaction Survey, which on the surface indicates that our overall employee satisfaction indicators look good, however upon closer inspection the findings reveal there are areas where improvement is needed. The survey results for each Department will be reviewed with the managers, and an action plan will be developed in order to work on areas of potential improvement moving forward.

CHIEF OF STAFF REPORT

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

- *Administration of Drugs: Patient's Own Medications*
- *Closed-System Transfer Device (CSTD)*

- *Drugs of Abuse Maternal and Infant*
- *Misoprostol for Cervical Ripening*
- *Opioids Waste Policy*
- *Discharge Planning for the Hospitalized Patient*
- *Airborne Infection Isolation Rooms (AIIR)*
- *Respiratory Syncytial Virus (RSV) Policy*
- *Skin Preparation in the Perioperative*
- *Cleaning and Processing da Vinci Instruments, Accessories and Endoscopes*
- *Fern Testing*
- *Training and Competency in Fern Testing*

It was moved by Doctor Ungersma, seconded by Ms. Hubbard, and unanimously passed to approve all 12 hospital wide policies and procedures as presented.

Chief Performance Excellence Officer Maria Sirois called attention to the hospital-wide Quality Assurance and Performance Improvement (QAPI) Plan annual evaluation for calendar year 2016. She additionally called attention to the proposed hospital-wide QAPI Work Plan for Fiscal Year 2017/2018, noting that antibiotic stewardship projects will continue; identification of sepsis projects will be introduced; and the ventilator associated pneumonia project will be removed from the previous plan (due to lack of necessity). It was moved by Mr. Hartz, seconded by Doctor Ungersma, and unanimously passed to approve the QAPI Work Plan for fiscal year 2017/2018 as presented.

Ms. Sirois also called attention to a proposed revision to the hospital-wide QAPI plan which involves a change being made to the internal organizational reporting structure within the NIHD Quality Department. It was moved by Ms. Kilpatrick, seconded by Ms. Hubbard, and unanimously passed to approve the revision to the hospital-wide QAPI plan as presented. The Board also expressed their appreciation of the hard work and exemplary dedication of Ms. Sirois, who will be leaving her position with the District in order to pursue academic interests.

BOARD MEMBER REPORTS

Mr. Watercott then asked if any members of the Board of Directors wished to report on any items of interest. Director Ungersma provided an update on recent Association of California Healthcare Districts (ACHD) legislative efforts, and also stated his interest in seeing NIHD obtain ACHD certification as soon as possible. No other reports were heard.

CLOSED SESSION

At 8:16 pm Mr. Watercott reported 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, 3 matters pending (*pursuant to Government Code Section 54956.9*).
C. Discuss trade secrets, new programs and services (*estimated public session date for discussion yet to be determined)(Health and Safety Code Section 32106*).
D. Discussion of a personnel matter, CEO contract terms and discussion (*pursuant to Government Code Section 54757*).

RETURN TO OPEN SESSION AND REPORT OF ACTION TAKEN

At 9:21 pm the meeting returned to open session. Mr. Watercott reported that the Board took action to increase the salary of the Chief Executive Officer to $325,000 effective July 1, 2017.

ADJOURNMENT

The meeting was adjourned at 9:22 pm.

_____
Peter Watercott, President

Attest: _____
M.C. Hubbard, Secretary

NORTHERN INYO HOSPITAL
POLICY AND PROCEDURE

Title: Training and Competency in Point of Care Testing	
Scope: ER, ICU, Laboratory, Med Surg, Outpatient Clinics, PACU, Perinatal	Manual: Lab- Point of Care
Source: POC Coordinator	Effective Date:

I. PURPOSE

CLIA ’88, Centers for Medicare and Medicaid Services (CMS), and the State of California laboratory regulations require that all laboratories have on-going mechanisms to monitor accurate patient test management. Competency assessment is one method used to ensure that staff who performs Point of Care Testing (POCT) are proficient in test procedure(s) and reporting test result(s).
All staff performing POCT at Northern Inyo Healthcare District (NIHD) may perform waived testing once they have been trained and demonstrate initial competency. Competency must be reassessed annually thereafter or as needed.

II. PROCEDURE

All staff are trained and evaluated for competency on each Point of Care (POC) test they perform including pre-analysis, analysis and post-analysis components. When new test methodology or instrumentation is instituted, employees are retrained and reevaluated. The POCT coordinator and department supervisors will develop a program for competency assessment and acceptability standards based on the training protocol, procedure manual, and departmental policies. Supervisors and managers will evaluate common group deficiencies, review current policies and procedures, and take corrective action to improve performance.

A. Orientation and Training
   1. All trainees will read the policies and procedures on each POC test they perform
   2. Orientation/Training on the test system will be provided through video or demonstration
   3. Successful orientation will be evaluated by use of a written test and initial competency assessment
   4. Training will be provided by competent training staff
   5. Personnel qualified to perform training of waived tests are the POC coordinator and laboratory staff with at least 1 year experience in the laboratory setting and documented POCT training
   6. Orientation and training for each waived test is documented on a training checklist and filed in the POC department and kept for a minimum of 2 years; a copy of the document(s) is placed in employee personnel file

B. Waived Competency
   1. Competence for waived testing is assessed at the time of orientation and annually thereafter or as needed
   2. Competency for waived testing is assessed using the following two methods per person per test:
      a. Observation of routine work, testing a known specimen/proficiency sample or QC testing
      b. Use of a written test specific to the test assessed

3. Independent performance with no to little additional support is considered successful
4. Successful performance is equal to or greater than 80% correct for the written test
5. Competency is assessed by a qualified designee
6. Personnel qualified to observe and assess competency are the POC coordinator, laboratory staff and clinical staff with at least 1 year experience in the laboratory setting and/or POCT with documented POC training and annual reassessment
7. Competency is documented on a competency checklist and filed in the POC department and kept for a minimum of 2 years; a copy of the document(s) is placed in employee personnel file

C. Proficiency Testing

In addition to the regulatory requirements for annual competency assessment NIH has opted to follow best practice by performing proficiency testing. The POC department contracts with a CMS approved proficiency testing program that meets regulatory requirements for variety and frequency of testing.

1. Proficiency samples are received bi-annually and are rotated among the staff who perform patient testing
2. Testing personnel tests the proficiency samples the same way and the same number of times that patient samples are tested
3. The staff who perform the proficiency testing and the medical director and technical coordinator sign attestations documenting that proficiency samples were tested in the same manner as patient specimens
4. Testing personnel reports proficiency sample results the same way that patient samples are reported
5. Proficiency records are kept for two years; proficiency performance evaluations are kept for 5 years
6. Successful performance is equal to or greater than 80% correct
7. A failure is unsuccessful performance in an event and warrants an investigation using the "Proficiency Testing Checklist for Corrective Action"; the investigation is documented and records are kept for 5 years

III. CORRECTIVE ACTION

Remedial training and reassessment of employee competency must occur when problems are identified with employee performance.

A. Criteria for Remediation

Authorized training staff will perform remedial training for the following reasons:

1. When testing personnel fails an assigned proficiency test(s)
2. When confirmatory testing to validate a result is performed and the results vary significantly from each other and instrument malfunction can be excluded
3. When deficiencies are being observed during competency assessment; this will be at the discretion of the qualified designee

Title: Training and Competency in Point of Care Testing	
Scope: ER, ICU, Laboratory, Med Surg, Outpatient Clinics, PACU, Perinatal	Manual: Lab- Point of Care
Source: POC Coordinator	Effective Date:

4. When deficiencies are being observed during routine patient testing or are brought to the supervisor's attention; this will be at the discretion of the director of nursing, the education coordinator and/or qualified POC staff
5. When an individual fails to comply repeatedly with testing and/or QC requirements
6. When testing staff is non-compliant with regulatory requirement of annual competency assessment after reasonable attempts of contact have been made by the director of nursing, the education coordinator and/or POC staff

B. Retraining and Reassessment

After determination that remediation is required, the following process will be initiated:

1. Department supervisor and/or director of nursing will be notified that individual will require remedial training and that he/she is prohibited to perform waived test until remediation is complete
2. Competent POC staff will review data and determine if instrument or test malfunction may have contributed to the problem
3. Authorized training staff will conduct remediation training and will include:
    a. Review of QC logs to determine if staff performs QC correctly
    b. Review of test procedure
    c. Observation of QC testing
    d. When possible, observation of specimen collection; for example, if the waived test requires a finger-stick, the individual will perform a finger-stick on the authorized trainer, a patient, or a volunteer; if a patient collection is to be observed, all relevant NIHD policies concerning patient consent and privacy should be observed
    e. Observation of testing two specimens; if possible this will be done using specimens that the trainer observed the testing staff collect; if not possible, an unknown specimen is acceptable
    f. For qualitative testing, testing staff will perform testing under observation of one unknown specimen that is negative and one that is positive
    g. Whenever possible, a confirmatory specimen will be collected and sent to the NIHD clinical laboratory for confirmation of test results
    h. All testing privileges will be reinstated after successful retraining and reassessment
    i. Remediation will be documented and filed in the POC department and kept for a minimum of 2 years; a copy of the document(s) is placed in employee personnel file

C. Non-compliance

When it has been determined that staff is non-compliant with scheduling remediation the following steps will be taken:

Title: Training and Competency in Point of Care Testing	
Scope: ER, ICU, Laboratory, Med Surg, Outpatient Clinics, PACU, Perinatal	Manual: Lab- Point of Care
Source: POC Coordinator	Effective Date:

1. Notification of department supervisor, director of nursing and/or compliance officer that the individual may not perform any POCT effective immediately
2. Privileges to perform waived testing will stay revoked until staff has complied with retraining requirements; this includes but is not limited to revoked access to the Accu-Check Inform II system through their badge

IV. REFERENCES

1. 2017 Comprehensive Accreditation Manual of Laboratory and Point-of-Care Testing, The Joint Commission, Standard WT.03.01.01
2. Good Laboratory Practices for Waived Testing Sites, Morbidity and Mortality Weekly Report, CDC, November 11, 2005 / 54(RR13);1-25
3. U.S. Department of Health and Human Services, CLIA ’88 Final Rules, Federal Register, 1992, Sections 493.1421, 493. 1423, 493. 1425, U.S. Government Printing Office, Wash. DC, Vol. 57, No. 40. February 28, 1992
4. CADPH-Laboratory Field Services. Laws and Regulations Relating to Clinical Laboratories, Excerpts from the California Business and Professional Code and the California Code of Regulations, Berkeley, CA, January 1, 1991

Approval	**Date**
Medical Director of the Laboratory	2/28/17
CCOC	2/27/17
Emergency Medical Care Committee	3/16/17
Medical Services/ICU Committee	3/23/17
Peri/Peds Committee	3/21/17
Medical Executive Committee	4/4/17
Board of Directors	

Developed: 2/17
Reviewed:
Revised:
Supersedes:

NORTHERN INYO HOSPITAL

Point of Care Accu-Chek Blood Glucose Testing	
Scope: Procedure	Department: Laboratory
Author: POC Laboratory Team	Effective Date: March 2016
Copy Location: Nursing Work Stations	Revised Date:

I. INTENDED USE

Accu-Chek Inform II test strips are for use with the Accu-Chek Inform II meter for the quantification of glucose levels in venous whole blood, arterial whole blood, neonatal heel stick or fresh capillary whole blood samples drawn from fingertips as an aid to monitoring the effectiveness of glucose control. Blood collected in a tube should be tested within 30 minutes of drawing. This system is not intended for the use in diagnosis or screening of diabetes mellitus, nor can neonate cord blood samples be tested.

The Accu-Chek Inform II blood glucose monitoring system is approved for Waived Testing Status by the FDA. It is for in-vitro diagnostic use only and is intended for multiple patients used in healthcare settings when compliant cleaning and disinfecting recommendations of the FDA, CDC, and CMS are followed.

II. PRINCIPLE

The ACCU-CHEK Inform II system quantitatively measures glucose in whole blood. The enzyme on the test strip, mutant variant of quinoprotein glucose dehydrogenase from Acinetobacter calcoaceticus, recombinant in E. coli, converts the glucose in the blood sample to gluconolactone. This reaction creates a harmless electrical DC current that the meter interprets for a glucose result. The sample and environmental conditions are also evaluated using a small AC signal.

The system is calibrated with venous blood containing various glucose concentrations and is calibrated to deliver plasma-like results, although you always apply whole blood to the test strip. The reference values are obtained using a validated test method. This test method is referenced to the hexokinase method and is traceable to an NIST standard.

Sample size: 0.6ul
Test time: 5 seconds
System measurement range: 10-600 mg/dl

III. MATERIALS REAGENTS AND EQUIPMENT

A. Items included
   1. Accu-Chek Inform II glucose monitor
   2. Accu-Chek Inform II test strips and code Key (uploaded in the laboratory)

B. Items not included
   1. Items used to acquire blood (eg: syringe, capillary tubes, lancets etc)
   2. Appropriate disinfectant for cleansing site
   3. Bandages (optional)

IV. SPECIMEN COLLECTION

A. Acceptable specimens

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Point of Care Accu-Chek Blood Glucose Testing	
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1. Fresh whole blood sample types
   - Venous whole blood
   - Arterial whole blood
   - Capillary (non neonate fingerstick or neonate heelstick) whole blood

2. Acceptable Anticoagulants for testing with Accu-Chek
   - EDTA
   - Lithium or Sodium Heparin
   - Iodoacetate or fluoride-containing anticoagulants are NOT recommended.

B. Collection

1. Finger stick procedure.

d. Select the finger site for puncture. (Use Middle or Ring finger not recently punctured).

e. Enhance blood flow to the selected puncture site
   - Warming the site
   - Instructing the patient to flex and move the arm, wrist, hand and fingers while you are assembling your supplies and preparing the system for testing
   - Positioning the intended puncture site below heart level
   - Gently massaging in an outward (distal) direction from the palm and the base of the finger to the fingertip.

f. Cleanse the puncture site by means of appropriate cleansing product. Allow the site to air dry completely before puncturing.

g. Advise the patient of imminent puncture.

h. ***Accu-Chek Safety Pro lancet use***:
   - Twist off the protective cap of the Safe-T-Pro Plus lancet and discard
   - Choose the desired depth setting
   - Hold the Safe-T-Pro Plus lancet tip against the puncture site
   - Press the purple trigger button, dispose in sharps contalner

2. **Heelstick**

➔See diagram below for safe area of heelstick wound

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a. Baby should be in supine position with knee at the open end of a bassinet. Keep area warm.
b. Clean incision area with antiseptic and allow to air dry. Do not allow heel to come in contact with a non sterile area.
c. Remove appropriate Tenderfoot device from blister pak
d. Remove the safety clip. Once clip is removed DO NOT push trigger or touch blade slot. *Remember: prolonged exposure can compromise sterility of the site.*
e. *NEVER puncture deeper than 2.4-2.5mm.*
NEVER puncture through a previous site
NEVER on the posterior curvature of the heel or arch.
f. Place blade slot surface flush against the heel so its center point is vertically aligned with the incision site.
g. Ensure that both ends of the device have made light contact with the skin and depress the trigger. Immediately remove the device from the heel.
h. Use a dry sterile gauze to gently wipe away the first droplet of blood.
i. Taking care not to make direct contact with the collection container or Accu-Chek testing strip- allow the strip to fill by capillary action.
j. Press a dry sterile gauze to the incision until bleeding has stopped or apply a bandage.
k. Dispose of lancet in a sharps container

3. **Other blood collections**
   a. Peripheral whole blood is acceptable for use with the Accu-chek. One drop from a syringe is acceptable or anticoagulated blood can be used, refer to section IV A.2 for acceptable anticoagulants that can be used for testing.

V. STORAGE OF TEST STRIPS AND CONTROLS

1. Store strips and controls between 4-30°C (39-86° F)
2. Use strips at temperatures between 16-35°C (59-95°F)

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3. Keep strips away from dampness and humidity of >80%
4. Keep unused strips stored in original container with cap tightly closed.
5. Strips are stable until the date on the vial.
6. Strips should be used immediately after removing from the container
7. DO NOT USE expired test strips.
8. Control Reagent-pack contains 2 control solutions
   Hypoglycemic range (control solution 1, gray cap)
   Hyperglycemic range (control solution 2, white cap)
   Refer to package insert for specific ingredients of the solutions
8. Controls are stored between 4-30°C (39-86°F)
9. Use control solutions at room temperatures.
10. Control vials are stable 3 months after opening.

VI. QUALITY CONTROL

1. Must be run each day OR day of use. System locks out after 24 hrs until controls are performed.
2. Additionally controls:
   - Must be run when a new box of strips are opened .
   - Must be run If a strip container is left opened.
   - Must be run If strips were incorrectly stored.
   - Must be run If there is a question about a patient's result.
   - Must be run If the meter was dropped or to check system performance.
3. Control solution is stable for 3 months once bottle is opened. WRITE THE NEW DATE OF EXPIRATION ON THE VIAL LABEL **OR** IF THE EXPIRATION ON THE VIAL OUTDATES BEFORE THE 3 MONTHS, USE WHICH EVER COMES FIRST.

VII. ACCU-CHEK INFORM II GLUCOSE TEST

1. Remove meter from the base Unit: **Press Purple button**
   a. Wait for *"Performing Self Checks"* message to complete its process
   b. Control testing must be performed daily, at a minimum (see above conditions that warrant additional control testing).
2. Scan your ID badge (serves as operator ID)
3. TO PERFORM CONTROL TEST: Select "Control Test" on the screen
   a. *Choose Level 1 (Lo)*
   b. Scan the Lo control solution barcode at the prompt
   c. Scan the strips barcode at the prompt
   d. Insert the Glucose strip with the yellow window of the strip pointing out from the meter and the gold electrode facing inward.

e. After gently mixing the control, open cap, WIPE the tip with a lint free wipe

f. Squeeze bottle of solution until a tiny drop forms--touch drop to the front edge of the yellow window of the test strip.

g. WIPE the tip of the bottle with a lint-free wipe, then cap tightly. The result appears in the display. Remove and discard used test strip.

h. *Repeat steps a – k for Level 2 (high) solution*

i. The acceptable ranges are scanned into the glucometers with each lot number AND the ranges are found on the side of the test strips.

j. In the case that Control Results are NOT within the acceptable range

- You may not be doing the test correctly; repeat the test
- The test strip may be damaged from exposure to very high or low temperature or exposed to increased humidity. Open a fresh unexposed vial.
- Check the expiration date on the vials of test strips and control solutions. If either is out of date- TOSS- and repeat testing with in-date materials.
- Be sure the glucose control solution you are using is clear blue in color. Do not use a cloudy solution.

Control results must be within the defined acceptable ranges before patient testing is allowed. The instrument indicates a pass or fail.

4. TO PERFORM PATIENT TESTING: Carry meter to patient room or area for testing and assemble supplies.

5. Prepare the patient, with the meter on, choose patient test, scan the patient's ID bracelet, the visit number populates the patient id, OR enter the patients visit or Medical Record number manually. Verify the patient ID, and press the check button. NOTE, IN EXTREME EMERGENCY SITUATIONS, YOU CAN BYPASS THE CONTROLS. USE 911 AS THE PATIENT'S ID. The meter allows 9 stat tests by pressing Run Stat.

6. Perform the finger stick, as described in section IV B , with the strip inserted in meter, touch the strip to the drop of blood, allowing window to fill by capillary action, if there is still yellow showing, it is ok to add a second drop, the meter will sound a beep when enough blood is added.

VIII. RESULT REVIEW

1. All patient and control results are stored in the Accu-Chek meter. The lab will download all results monthly into the Roche Rals Computer, print them and store them for 2 years.
2. To access stored results, turn the meter on, press the arrow, scan your operator ID badge, select **REVIEW RESULT** button
   a. Press Patient or QC
   b. Use arrow key up and down to find needed information

NORTHERN INYO HOSPITAL

Point of Care Accu-Chek Blood Glucose Testing	
Scope: Procedure	Department: Laboratory
Author: POC Laboratory Team	Effective Date: March 2016
Copy Location: Nursing Work Stations	Revised Date:

IX. **RESULT MANAGEMENT**

1. Record the glucose in the patient's chart as instructed by your department.
2. All Results are stored in the Lab's Rals Notebook, and printed and kept for 2 years.
3. The analytical measuring range of the meter is from 10-600 mg/dl. **IF THE RESULT READS HI OR LO,** IT MAY BE ABOVE OR BELOW THE METER'S MEASUREMENT RANGE. **REPEAT THE TEST.**

3. The Critical value cutoffs are included in the table below. **REPEAT ALL CRITICAL VALUES the first time.**
4. Glucose ranges follow:

Patient Age	Normal Glucose Range	Critical Values
0-28 days	30-60 mg/dL	<30->300 mg/dL
29 days to 1 year	40-90 mg/dL	<40->400 mg/dL
1 year to 2 years	60-100 mg/dL	<50->400 mg/dL
>2 years 1 month	75-105 mg/dL	<50->400 mg/dL

5. POC CRITICAL VALUE POLICY:

a. All first time finger stick values obtained that meet the crucial cut-offs will be **REPEATED IMMEDIATELY** by the POC testing personnel.
b. Repeated results that remain critical will be reported to the provider.
c. PLEASE ADD THE FOLLOWING COMMENTS TO THE PATIENT RESULTS AT THE TIME OF TESTING

1. Test repeated and
2. MD informed

d. Once a critical value has been verified by repeat finger stick test, inform the provider of the results and the provider will make the decisions for patient follow up INCLUDING a follow up Lab Draw for POC Glucose.
e. **Any result that reads "HI" or "LO" is out of range of the meter and must be repeated. (the message means greater than 600 mg/dl or less than 10 mg/dl)**
If the ALERT "HI or LO" value repeats, the above comments must be added to the patient results in the glucometer immediately and additionally, the Nurse must

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order a POC Glucose Lab Draw to ascertain the actual level of glucose.
Note: During the same visit, if a patient has had a critical glucose by finger stick that has been repeated and verified by lab draw, the provider may decide to not repeat a lab draw on subsequent events as the patient has been shown to be unstable.

f. A total of 3 comments may be added, if desired, touch the "cloud" to enter your own comment via keypad.

6. Record the glucose in the patient's chart as instructed by your department.

X. PROCEDURAL NOTES

1. All supplies for Accu-Chek inform II are obtained from the Pharmacy OmniCell.
2. Troubleshooting the instrument is performed by the POC Team, and if necessary the manufacturer, Roche.

XI. MAINTENANCE CONSISTS OF CLEANING AND DISINFECTING.

1. *Make sure the system is turned OFF before cleaning and is sitting on a level surface.Use a soft cloth that is damp with water to remove blood or other visible organic matter .Disinfecting is accomplished with Clorox™ Germicidal Disposable Wipes (EPAreg. No. 67619). Squeeze out excess liquid, wipe surfaces three times horizontally and three times vertically and carefully wipe around the test strip port area(making sure no liquid enters port area).Allow to dry 1 minute If the patient is suspected of having or carrying Clostridium difficile allow the meter to be damp for 3 minutes..(The manufacturer suggests only 1 disinfectant be used as using more than one disinfectant interchangeably has not been evaluated.We are using the Clorox™ Wipes as stated above.) Thoroughly dry after cleaning and disinfecting with a soft dry cloth or gauze.*

- *The following parts of the meter and system components may be cleaned and disinfected:*
  - *a. The area around the test strip port*
  - ***b. Avoid getting liquid into the test strip port!***
  - *c. The meter display(touchscreen)*
  - *d. The meter housing(entire meter surface)*
  - *e. **Do Not** clean or disinfect the meter while performing a blood glucose or control test.*
  - *f. **Do not** spray anything onto the meter*
  - *g. **Do not** immerse the meter in liquid.*
  - *h. **Allow the instrument to be thoroughly dry before use.***

XI. LIMITATIONS

- Hematocrit should be between 10-65%. Patients with hematocrit outside this range should have venous blood sugars performed.
- Lipemic samples(triglycerides) in excess of 1800 mg/dl may produce elevated results.
- Blood concentrations of galactose>15 mg/dl will cause overestimation of blood glucose results.
- Intravenous administration of ascorbic acid which results in blood concentrations of ascorbic acid >3 mg/dl will cause overestimation of blood glucose results.
- If peripheral circulation is impaired, collection of capillary blood from the approved sample sites is not advised as the results might not be a true reflection of the physiological blood

glucose level. This may apply in the following circumstances: severe dehydration as a result of diabetic decompensated heart failure NYHA Class IV, or peripheral arterial occlusive disease.

- The performance of this system has not been evaluated in the critically ill.
- When comparing the meter to lab draw glucoses, ideal situation is for the patient to be fasting, as in a non fasting patient, the fingerstick may range from 20-70 mg/dl higher than the venous draw. In addition to a capillary sample, it is suggested to compare the venous blood by testing on the meter as well as on the lab chemistry analyzer.
- If there is a question about capillary results compared to venous blood tested on the chemistry analyzer, the suggestions from Roche are:
    - The goal from time of fingerstick to venous sample draw is 10 minutes.
    - The ideal time is 5 minutes
    - Use one meter, do not interchange meters
    - Expected results when there is a 10 minute time difference are as follows:
        - If the results are less than 75 mg/dl of glucose, the two samples should be within 15 mg/dl
        - If the results are greater than 75 mg/dl, the two samples should be within 20% or less different

XII. REFERENCES

Accu-chek Inform II Operator's Manual 03-2013
Accuracy Study protocol for glucose meter evaluation (www.accu-chekinformli.com)

Reviewed by	Date
Lynn Swaner MD	6/29/16

NORTHERN INYO HOSPITAL
People you know, caring for people you love.

NORTHERN INYO HOSPITAL
POLICY AND PROCEDURE

Title: Gastric Occult Blood	
Scope: Procedure for POC Testing Personnel	Department: Laboratory
Author: POC Laboratory Team	Effective Date: April 2016
Copy Location: POC Lab Procedures	Revised Date:

I. Purpose

Gastroccult is a rapid screening test (CLIA waived)designed for detecting the presence of occult blood and determining the pH of gastric aspirate or vomitus
The Gastroccult Slide Test is used as an aid in the diagnosis and management of various gastric conditions which may be encountered in intensive care areas, including ED, ICU, and MEDSURG.The identification of occult blood can be useful in the early detection of gastric trauma or deteriorating gastric condition, while pH may be of use in evaluating antacid therapy.

II. PRINCIPLE

The Gastroccult slide includes a specially buffered guaiac test for occult blood. The active component of guaiac is guaiaconic acid which reacts with hydrogen peroxide and in the presence of heme which contains a peroxidative-type of catalyst, and produces a highly conjugated blue quinone compound. When a gastric specimen containing blood is applied to Gastroccult test paper, the hemoglobin from the lysed blood cells come in contact with the guaiac. Application of Gastroccult Developer causes a peroxidase-like reaction which turns the test paper blue if blood is present. It is not to be considered conclusive evidence of the presence or absence of upper gastrointestinal bleeding, it is to be used as a preliminary screening aid and is not intended to replace other diagnostic procedures such as gastroscopic examination or X-ray studies.
The Gastroccult slide includes a pH test based on the principle that certain dyes change color with changes in hydrogen ion concentration. The occult blood test is not affected by low pH. Gastroccult is free from interferences by normal therapeutic concentrations of cimetidine(Tagamet), iron or copper salts.

III. MATERIALS/REAGENTS

A. Gastroccult Slides
B. Gastroccult Developer obtained separately
C. Both are obtained from Purchasing
D. Pipette or syringe or applicator sticks to transfer specimen to testing slide.
E. Stopwatch or timer

IV. STORAGE/STABILITY

- Do not refrigerate or freeze slides or developer
- Store in controlled room temperature of 15 - 30°C (59 - 86°F)
- Do not store items near volatile chemicals or cleaning agents
- Protect from heat and light.
- The Slides and Developer remain stable until the expiration dates which appear on each slide and developer bottle. DO NOT USE EITHER AFTER THE EXPIRATION DATE.
- Keep slides sealed in their protective packaging until use.
- The developer should be protected from heat and the bottle kept tightly capped when not in use.

V. SPECIMEN COLLECTION

A. A gastric aspirate is obtained by nasogastric intubation or vomitus .
B. Use immediately or store in a clean container either plastic or glass up to 24 hours at a controlled room temperature 15 to 30°C (59 to 86°F).

Title: Gastric Occult Blood	
Scope: Procedure for POC Testing Personnel	Department: Laboratory
Author: POC Laboratory Team	Effective Date: April 2016
Copy Location: POC Lab Procedures	Revised Date:

VI. TEST PROCEDURE

A. Open slide
B. Apply one drop of gastric sample to pH test circle and one drop to occult blood test area.
C. Determine pH of sample by visual comparison of test area to pH color chart within 30 seconds after sample application.
D. Apply 2(two) drops of Gastroccult Developer directly over the sample in the occult blood test area.
E. Read occult blood results within 60 seconds. The development of any trace of blue color in the test area is regarded as a positive result. **NOTE:** Some gastric samples may be highly colored and appear as blue or green on the test area. Test results should only be regarded as positive if additional blue is formed after the Gastroccult Developer is added. Record results on the testing form and in the patients record.
F. Add 1(one) drop of Gastroccult Developer between the positive and negative Perfomance Monitor area. A blue color will appear in the positive area within 10 seconds and remain stable for 60 seconds

VII. QUALITY CONTROL

A. The function and stability of the slides and developer are tested using the on-slide performance monitor feature located to the right of the sample testing area.
B. Quality Control should be performed only after the Patient Test has been developed, read and interpreted.
C. The positive Performance Monitor area contains a hemoglobin-derived catalyst which, upon application of developer, will turn blue within 10 seconds. The color will remain stable for at least 60 seconds.
D. The negative Performance Monitor area contains no catalyst and should not turn blue upon application of developer.
E. If the performance Monitor areas do not react as expected after application of developer, the occult blood test results should be regarded as invalid.
F. Should the QC fail, call the manufacturer for troubleshooting steps.
    a. 800-877-6242 OR 650-845-3526

VII. TEST REPORTING

A. DO NOT REPORT PATIENT RESULT IF INTERNAL CONTROLS ARE INVALID!
B. Occult Blood negative results –no detectable blue in the occult blood test area.
C. Occult Blood positive results-any trace of blue in the occult blood test area.
D. Record Results and lot numbers of cards and developer on the reporting form and in the patient chart.
E. Notify physician of result.

VIII. LIMITATIONS

A. Gastroccult tests are designed as an aid to diagnosis, and are not intended to replace other diagnostic procedures such as gastroscopic examination or X-ray studies
B. Because this test is visually read and requires color differentiation, it should not be interpreted by people who are color-blind or visually impaired.

Title: Gastric Occult Blood	
Scope: Procedure for POC Testing Personnel	Department: Laboratory
Author: POC Laboratory Team	Effective Date: April 2016
Copy Location: POC Lab Procedures	Revised Date:

C. Patient specimens and all materials that come in contact with them, should be handled as potentially infectious and disposed of with proper precautions.
D. Only use Gastroccult developing solution to develop the test.
E. It is expected that gastric aspirates from some normal individuals may give positive test results. Please see package insert for further explanation.
F. Note: Many foods(e.g. incompletely cooked meat, raw fruits and vegetables etc.) have peroxidase activity which can produce a positive Gastroccult test result. Thus, a positive test result does not always indicate the presence of human blood.
G. Gastroccult slides are designed to function reliably in the presence of low pH, high drug concentrations, metal ions or plant peroxidases in food. The interference(false-positive) from plant peroxidases, such as horseradish(HRP) **IS** reduced with the Gastroccult test over other guiac based testing cards.
H. Please see Package Insert for further details of possible interfering substances.

VII. REFERENCES

1. **Gastroccult®** Product insert, Beckman Coulter, Inc. March 2015

Reviewed by	Date
Ava S-Wasif	4/20/16

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POLICY AND PROCEDURE

Title: Fecal Occult Blood by Beckman Coulter Card Method **Hemoccult SENSA**	
Scope: POC Testing Procedure	Department: Laboratory-Point of Care
Author: POC Laboratory Team	Effective Date: March 2016
Copy Location: POC Lab Procedures	Revised Date:

I. PURPOSE

The Hemoccult test is a rapid, qualitative method for detecting fecal occult blood which may be indicative of gastrointestinal disease. It is not a test for colorectal cancer or any other specific disease. It is used as an aid in detecting gastrointestinal bleeding in patients with iron deficiency anemia or recuperating from surgery, peptic ulcer, and ulcerative colitis.

II. PRINCIPLE

The Hemoccult test is based on the oxidation of guaiac by hydrogen peroxide to a blue-colored compound. The heme portion of hemoglobin, if present in the fecal specimen, has peroxidase activity which catalyzes the oxidation of alpha guaiaconic acid (active component of guaiac paper) by hydrogen peroxide (active component of the developer) to a form a conjugated blue quinine compound.

III. MATERIALS AND REAGENTS

- Hemoccult Slides (Test Cards)(HEMOCCULT SENSA Test Cards)
- Hemoccult Developer (HEMOCCULT SENSA Developer)
- Applicator Sticks
- Obtain supplies from Purchasing

IV. STORAGE AND STABILITY

- Store slides and developer at room temp (15 to 30°C)(59 to86°F).
- Do not refrigerate or freeze
- Hemoccult slides and developer remain stable until expiration dates.
- Do not store with volatile chemicals like ammonia, bleach, bromine, iodine, household cleaners.

V. SPECIMEN COLLECTION

- A fresh stool specimen can be collected in a clean dry container.
- Fresh stool specimen can be obtained by Physician or Care Provider, during a physical exam then applied as trained.
- The following instructions are **Patient Instructions for Outpatients** who are going to be bringing the sample cards back to lab for development.
    - For accurate test results, apply samples from bowel movements collected on **three different days.**
    - Do not collect sample if blood is visible in your stool or urine(e.g. menstruation, active hemorrhoids, urinary tract infection.)
    - For the most accurate test results collect each stool sample before contact with the toilet bowl water. You may use any clean dry container.
    - Return completed slides the laboratory no later than 10 daysafter your first sample collection.
    - Protect slides from heat, light, and volatile chemicals.

Drug Guidelines

For **seven** days before and during the stool collection period, **avoid** non-steroidal anti-inflamatory drugs such as ibuprofen, naproxen or aspirin(more than one adult aspirin per day.)

Title: Fecal Occult Blood by Beckman Coulter Card Method **Hemoccult SENSA**	
Scope: POC Testing Procedure	Department: Laboratory-Point of Care
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Copy Location: POC Lab Procedures	Revised Date:

Acetaminophen (Tylenol) can be taken as needed.
For **three days** before and during the stool collection period, **avoid** vitamin C in excess of 250 mg a day from supplements and citrus fruits and juices.

Diet Guidelines

For **three** days before and during stool collection period, **avoid** red meat (beef, lamb and liver).
Eat a well balanced diet including fiber such as bran cereals, fruits, and vegetables.
Note: 100% of RDA of vitamin C for an adult is 60 mg a day. Some iron supplements contain vitamin C in excess of 250mg.
Continue with inoculating the test slides.

VI. TEST PROCEDURE

- Using the applicator stick, smear fecal material to the designated "A" and "B" windows on the front side of the testing card.
  - (i) Only a **very small amount** of fresh fecal specimen, **[thinly applied]**, is necessary in preparing the slide. With side or flattened part of applicator stick apply fresh stool – scrape most of residual stool off.
  - (ii) Select sample from two different sections of fecal specimen.
  - (iii) A fresh stool specimen slightly contaminated with urine is acceptable, **if** it is known that the **urine is negative for blood and/or hemoglobin.**
  - (iv) **DO NOT** use sample if blood is visible.
- Close the front flap.
- Wait 3 – 5 minutes after the sample application before developing test.
- Open the flap in the back and apply the 2 drops of **Hemoccult SENSA** developer over each smear. Interpret within 60 seconds.
- Any trace of blue on or at the edge of smear is positive for occult blood.

VII. QUALITY CONTROL

- Quality control areas must be developed on every slide. They are located under the sample area on the developing side of the slides.
- Perform Quality Performance (Quality Control) after patient has been developed and read.
- Apply 1 drop of Hemoccult developer between the positive and negative test areas after the test is developed, read and interpreted as negative or positive.
- Read results within 10 seconds.
- If the slide and developer are functional, a blue color will appear in the positive Performance Monitor(QC) area and no blue will appear in the negative Performance Monitor(QC) area.
- In the event that the Performance Monitor areas do not react as expected after applying developer, the test slide should be discarded and a new test slide should be obtained. If the problem persists, call the lab POC team.

Title: Fecal Occult Blood by Beckman Coulter Card Method **Hemoccult SENSA**	
Scope: POC Testing Procedure	Department: Laboratory-Point of Care
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VIII. RESULTING

- Normal results are negative-no blue color
- Any blue is considered positive.(Occasionally, a light blue discoloration may be noticed on the guaiac test paper.) This discoloration does not affect the accuracy or performance of the test when it is developed and interpreted according to the recommended procedure. When developer is added directly over the fecal smear on a discolored slide, the blue background color migrates outward. A blue ring forms at the edge of the wetted area, leaving the guaiac paper around the fecal smear off-white in color. Any blue on or at the edge of the smear is positive for occult blood.
- Obtain an occult blood testing form, add a patient label. Fill out the Patient Result, Source, Date of Completion, Initials of testor, include also, the card lot Number, Expiration Date, Developer Lot Number and expiration date. Also record the Internal Controls. Route paper to POC Team in Laboratory.
- Additionally: record the patient result in the patient chart.
- **DO NOT REPORT PATIENT RESULT IF INTERNAL CONTROLS ARE INVALID!**
- Some specimens have a high bile content which causes the feces to appear green. A distinct green color (no blue), appearing on or at the edge of the smear within 60 seconds after adding the Developer should be interpreted as negative for occult blood. A blue or blue-green color should be interpreted as positive for occult blood.

IX. LIMITATIONS/INTERFERENCES

- Substances that can cause **false-negative test** results:
  - Ascorbic acid (Vitamin C) in excess of 250 mg/day.
  - Excessive amounts of Vitamin C enriched foods(citrus fruits and juices)
- Substances that can cause **false positive test** results:
  - Red meat(beef, lamb, liver)
  - Aspirin (>325 mg/day), and other non-steroidal anti-inflamatory drugs such as ibuprofen, indomethacin and naproxen
  - Corticosteroids, phenylbutazone, reserpine, anticoagulants, antimetabolites, and cancer chemotherapeutic drugs
  - Alcohol in excess
  - The application of antiseptic preparations containing iodine(povidone/iodine mixture) to anal area.

Dietary iron supplements will not produce false-positive test results

X. EXPECTED RESULTS

In general, screening asymptomatic individuals, a positivity rate of approximately 3% -7% was obtained. The false positivity rate for colorectal disease was 1-3% depending on the compliancy to collection requirements.

XI. REFERENCES

Beckman Coulter Hemocccult SENSA Package Insert June 2015

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POLICY AND PROCEDURE

Title: Fecal Occult Blood by Beckman Coulter Card Method **Hemoccult SENSA**	
Scope: POC Testing Procedure	Department: Laboratory-Point of Care
Author: POC Laboratory Team	Effective Date: March 2016
Copy Location: POC Lab Procedures	Revised Date:

Reviewed by	Date
Eva Swaluf	4/20/16

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NORTHERN INYO HOSPITAL
POLICY AND PROCEDURE

Title: Urine DipstickChemistries	
Scope: POC Testing Procedure	Department: Laboratory-Point of Care
Author: POC Laboratory Team	Effective Date: March 2016
Copy Location: POC Lab Procedures	Revised Date:

I. PURPOSE

Rapid, semi-quantitative measurement of multiple urine chemistry parameters at the point of care. The test is useful in the initial evaluation and monitoring of renal, urinary, and metabolic disorders. Chemstrip 10 UA withSG urine test strips manufactured by Roche-Cobas are intended for use visually.

II. PRINCIPLE

The CHEMSTRIP urine test system is a multi-parameter test strip that simultaneously measures specific gravity, pH, nitrite, protein, glucose, ketones, leukocytes and blood in urine. Different reagent pads attached to inert plastic strips change color as they react with the various constituents measured. The color change provides semi quantitative measurements which are read visually against a standard color chart on the test strip container. The following analytes are included:

Specific Gravity: In the presence of cations, protons are released by a complexing agent in the test strip and produce a color change of the indicator bromthymol blue from blue to blue-green to yellow.

pH: Methyl red and bromthymol blue are indicators that give clearly distinguishable color changes (orange through yellow, green, and blue) over a pH range of 5 – 9.

Leukocytes: Leukocyte esterase, present in granulocytic leukocytes, catalyzes the hydrolysis of an indoxylcarbonic acid ester to indoxyl. The indoxyl formed reacts with a diazonium salt to produce a purple color.

Nitrite: The conversion of nitrate (derived from the diet) to nitrite by the action of gram negative bacteria in the urine. Nitrite reacts with an aromatic amine to give a deazonium salt, which couples with sulfanilamide to yield a red-azo dye to produce a pink color.

Protein: The detection of protein is based on the so-called "protein error of pH indicators", using the indicator –tetrachlorophenol-tetrabromosulfophthalein. A positive reaction is indicated by a color change from yellow to green.

Glucose: Enzymatic glucose oxidase catalyzes the formation of gluconic acid and hydrogen peroxide from the oxidation of glucose. A second enzyme, peroxidase, catalyzes the reaction of hydrogen peroxide with the chromogen tetramethylbenzidine to form a green dye complex. A positive reaction is indicated by a color change from yellow to green.

Ketones: The test principle is based on Legal's test where sodium nitroprusside and glycine react with acetoacetate and acetone in an alkaline medium to form a violet dye complex. A positive result is indicated by a color change from beige to violet.

Urobilinogen: urobilinogen couples with 4-methoxybenzene-diazonium-tetraflouroborate in an acid medium to form a red-azo dye to produce a pink-red color. This is based on a modified Ehrlich reaction.

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Bilirubin: Bilirubin is detected by the coupling reactions of a diazonium salt with bilirubin in an acid medium with an application of a chemical indicator that yields a pink to red-violet color proportional to the total bilirubin concentration.

Blood: Hemoglobin and myoglobin, if present, catalyze the oxidation of an indicator (0-tolidine) by the organic peroxidase in the test paper. Intact erythrocytes hemolyze on the test paper, and the liberated hemoglobin produces a green dot. A uniform green coloration indicates free hemoglobin, myoglobin, or hemolyzed erythrocytes. The color ranges can be from yellow with green dots (free red blood cells) to dark greens and very high levels of blood may cause the color of dark blue

For a more detailed description of the reactions, please see the package insert.

III. TESTING PERSONNEL

1. Approved Health Care Providers

IV. MATERIALS/REAGENTS/AND EQUIPMENT

A. Reagent Strips
   1. 1 vial of Chemstrips 10UA contains 100 test strips.(Order through purchasing.) Store at room temperature. Keep lid closed when not in use.
   2. Strips are stable until expiration date on vial.
   3.. Visual color comparison color scale is printed on the vial label

B. Liquid Controls by Bio-Rad. Order through purchasing.

   1. Store at 2-8°C (35.3 -46.5ºF). Open Stability is 30 days.

C. Additional equipment
   1. Timer
   2. Specimen collection containers
   3. Disposable pipettes-obtained through Lab

V. SPECIMEN COLLECTION/STORAGE/LABELING/PRECAUTIONS

A. Acceptable specimens
   1. Freshly voided urine in a clean container deep enough to allow complete immersion of the reagent pads on the test strip.
   2. The same urine tested at bedside can be submitted to the lab for complete urinalysis if it is <2 hours old and held at room temperature.
   3. When a urine has been refrigerated, bring to room temperature before testing. Urines stored from 2-8 degrees C are stable for 12 hours for urine chemistries.

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B. Unacceptable specimens
   1. Do not use preservatives
   2. Urines that are >2 hours old at room temperature.

C. Storage
   1. Store test strips at 2-30°C(35.5-86°F)
   2. Do not freeze
   3. Strips are stable in the original capped vial until listed expiration date.
   4. Avoid moisture to strips by capping the vial immediately after removal of test strip.

D. Labeling
   1. Write the patient name and a second identifier with a sharpie or attach a patient label to the specimen that has 2 unique identifiers.
   2. When the urine is sent to the lab for further testing, make sure to add the time of collection and the method of collection (ie void, clean catch, catheterized-in and out or foley cath)

E. Precautions and Warnings
   1. Universal precautions should be practiced whenever blood or body fluids are handled.
   2. Avoid contact with skin and mucous membranes, flush with copious amounts of water. Get immediate medical attention if in contact with the eyes or ingested.

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VI. QUALITY CONTROL (QC)

A. Testing
   1. Each department is required to maintain a QC logbook for QC results.
   2. QC must be performed at least once per day or day of use depending upon the frequency of testing in each department.
   3. Expiration date on the vial should be checked on a regular basis and replaced as needed. Each open vial should have the date it was opened on it.
   4. If there are questionable results, stability of test strips can be verified by retesting a specimen with a new vial and comparing the results.
   5. Take care to immerse the strip for only 1 second.
   5. Any issues or problems encountered must be recorded in the logbook along with explanation how it was resolved.

B. Control material
   1. Liquid Controls are stable for 30 days *after* opening the vial OR until the expiration date printed on the vial, if it is less than 30 days.
   2. Ranges for the Control material will vary with each new lot and is established by the manufacturer.
      - Range values for the new lot of control material must be recorded on the log.
      - The new QC lot package insert should be retained in the QC logbook after the ranges are added to the QC log. The package insert will be retained 2 years.

Title: Urine DipstickChemistries	
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3. When Corrective Action needs to be taken:

a. Check expiration dates of strips and controls.
b. Ascertain that controls and strips have been stored correctly.
c. Open new control bottle or strip container.
d. Note problem on the QC log.
e. If further troubleshooting is needed, contact the lab Point of Care Coordinator or assistant.

VII. PROCEDURE

1. Using 2 patient identifiers, verify patient's identity, and explain procedure to patient and/or family.
2. Observe universal precautions. Wear gloves and other protective equipment as needed.
3. Urine should be in a container that permits complete immersion of the test strip reagent area.
4. Mix specimen thoroughly by swirling container before testing.
5. Briefly (no longer than 1 second) dip strip into the urine. Ensure that all pads have been immersed then immediately remove the strip from the specimen.
6. Draw the edge of the test strip along the edge of the container to remove excess urine.
7. Turn the test strip on its side and press lightly against absorbent paper to remove remaining urine.
8. After 1 minute, read the strip as follows
   - Hold strip close to the color blocks and match carefully.
   - Ensure that strip is oriented properly to the color chart on the vial label
9. Read all tests at 1 minute.
   - If Leukocyte pad indicates a trace result, it should be read again at 2 minutes.
   - ***Color changes that occur after 2 minutes from immersion are not of clinical value***
   - Color changes that occur along the edge of test pad should be ignored. (removal of urine in above steps should eliminate this effect).

VIII. RESULTS

Parameter	Normal Value	Abnormal Result
Specific gravity	1.001-1.035	<1.000 or > 1.035
Leukocyte Esterase	Negative	1-3+
pH*	5-9	<5.0 or >9.0
Leukocytes	Negative	1-3+ (should repeat trace amount)
Nitrite	Negative	1-3+
Protein	Negative	1-3+
Glucose	Negative	1-4+
Ketones	Negative	1-3+

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Blood	Negative	1-3+

*on urines with a pH equal or greater than 7.0, .005 should be added to the specific gravity reading.

1. Urine dip results will be added to nurse's notes.

IX. LIMITATIONS OF THE PROCEDURE

1. Limitations-interferences are listed in the Package Insert following this procedure.
2. Extreme temperature changes outside the manufacturers' recommendations may compromise the results of the test
3. Avoid subjecting test strips to moisture when not in use.(KEEP THE LID TIGHTLY CLOSED)
4. Certain medications such as pyridium cause intense color change that make the dipstick difficult to read, send the urine to lab for a complete ua and microscopic exam.

X.. REFERENCES

1. Package Insert 03-2014 v 2.0

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POLICY AND PROCEDURE

Title: Urine DipstickChemistries	
Scope: POC Testing Procedure	Department: Laboratory-Point of Care
Author: POC Laboratory Team	Effective Date: March 2016
Copy Location: POC Lab Procedures	Revised Date:

Reviewed by	Date
Eva S. Wasef	4/20/16

NORTHERN INYO HOSPITAL

Point of Care HemoCue Hb 201+ Hemoglobin Testing	
Scope: Procedure	Department: Laboratory
Author: POC Team	Effective Date:
Copy Location: NIH Lab, RHC Lab, RHWC Lab	Revised Date:

I. INTENDED USE

The HemoCue Hb 201+ System is used for the quantitative determination of hemoglobin in blood using a specially designed analyzer, HemoCue HB 201+, and specially designed HemoCue Hb 201 Micro-cuvettes

The quantitative hemoglobin determination is indicated as a general fundamental test in acute as well as elective care. The test is used in assessing the status of a patient in such clinical situations as hemorrhage, hemolysis, dehydration, and other shifts in plasma volume—and for verifying the results of transfusion or treatment of other deficiency states such as malnutrition. The assay of hemoglobin is also used as part of a general health screen e.g., for prospective blood donors and in the assessment of womens' and childrens' health.

II. PRINCIPLE

The hemoglobin concentration in blood is determined as azidemethemoglobin utilizing a microcuvette with a dry reagent system and a dual wavelength photometer. The erythrocyte membranes are disintegrated by sodium deoxycholate, releasing the hemoglobin. Sodium nitrite converts the hemoglobin iron from the ferrous to the ferric state to form methemoglobin, which then combines with sodium azide to form azidemethemoglobin. Measurements are taken at 570 nm and 880 nm; the latter to correct for turbidity.

III. MATERIALS, EQUIPMENT, AND REAGENTS

a. Hemocue Hb 201+ Analyzer
b. Hemocue Hb 201 Microcuvettes (store at room temperature)
c. Liquid controls
d. Blood lancets, needles, syringes, blood-collection tubes
e. Gloves
f. Disinfecting solution for cleaning fingers
g. Lint-free tissue such as Kimtech Delicate Task Wipes
h. Hydrophobic material such as Parafilm
i. HemoCue Cleaner or alcohol and cotton swabs

IV. QUALIFIED PERFORMING STAFF

Any staff designated by their job description to perform CLIA Waived testing and who have been trained, oriented, and deemed competent thereafter, through annual assessment by the medical director or the qualified designees in the use and maintenance of the HemoCue instrument.

V. PROCEDURE

a. START UP PROCEDURE
   i. Pull the cuvette holder out to the loading position. Press and hold the left button until the display is activated (all symbols appear on the display).
   ii. The display shows the version number of the program, after which it will show an hourglass symbol and 'Hb.' During this time, the analyzer will automatically verify the performance of the optronic unit by performing an automatic SELFTEST.
   iii. After 10 seconds, the display will show 3 flashing dashes and the HemoCue symbol. This indicates that the analyzer has passed the SELFTEST and is ready for use. If the SELFTEST fails, an error code will be displayed.

b. QUALITY CONTROL
   i. The Hemocue Hb 201+ analyzer has an internal electronic "SELFTEST." Every time the analyzer is turned on, it will automatically verify the performance of the optronic unit of the analyzer. This test is performed every second hour if the analyzer remains switched on.
   ii. Liquid Quality Control
      1. Two levels of liquid external controls are ordered from R&D Systems and have established values. Both levels of control should be run each day that RHC is opened.
      2. The analyzer should be in the 'ready' mode prior to filling the cuvette
      3. Dispense a drop of control onto parafilm and follow steps 9-16 of capillary testing section.
      4. Record the results on a quality control log.
      5. If the results do not fall within the established range: repeat. If still out, clean monitor and retest with another individual performing the QC. Record on QC Log any problems on Out-of Range Comment Log. If still out, open new QC materials. If these steps do not resolve the issue, contact the POC team in the lab for further assistance.

c. PATIENT AND SPECIMEN TESTING

i. Capillary Testing-Finger (see figure 1)

1. To perform a test using capillary blood, the cuvette holder should be in its loading position. The display will show three flashing dashes and the HemoCue symbol.
2. The hand should be ***warm*** and ***relaxed.*** Heating the hand with warm water, or by some other means, is a good idea to increase the blood circulation. The patient's fingers should be straight but not tense, to avoid stasis. It is best to use the middle or ring finger for sampling, but fingers with rings should be avoided due to the chance of decreased circulation.
3. Remove a cuvette from the individually wrapped package. Cuvettes must be filled within 3 minutes of being removed from the package. Always avoid touching the optical eye.
4. Clean the finger with alcohol and allow it to air dry completely.
5. Using **gentle** pressure, rock your thumb from the top of the patient's distal knuckle to the fingertip. This stimulates the blood flow towards the sampling point.
6. Press the lancet firmly against the finger prior to activating the lancet to aid in obtaining a good sample.
7. While maintaining gentle pressure on the tip of the finger, perform the stick off-center on the fingertip. Discard the lancet in a sharps container.
8. Using a dry gauze, ***wipe away the first two or three drops*** of blood, applying light pressure as needed again until another drop of blood appears. This stimulates blood flow and lessens the likelihood of a dilutional effect. Avoid 'milking' the finger.
9. **Make sure that the drop of blood is big enough to fill the cuvette completely.** Hold the cuvette opposite the filling end and introduce the cuvette tip into the middle of the drop of blood. Allow the cuvette to fill upward from the tip in one continuous process. **Do not refill a partially filled cuvette**.
10. Wipe off any excess blood from the outside of the cuvette using a Kimtech wipe, taking care not to touch the open end of the cuvette.
11. Visually inspect the cuvette for air bubbles in the optical eye. If bubbles are present, the cuvette should be discarded and a new sample taken for analysis.
12. The filled cuvette should be analyzed immediately. No more than 10 minutes should pass after collection. Place the filled cuvette into the cuvette holder and gently slide the holder into the measuring position.

13. During the measurement, the hourglass symbol and three fixed dashes will be shown on the display.
14. The result will be displayed within 15 to 60 seconds and will remain on the display as long as the cuvette holder is in the measuring position. If ERROR appears, recollect and run again. Refer to pg 19, "Troubleshooting Guide," of the Hemocue manual for further assistance. Results are in mg/dL and are reported to one decimal point.
15. Record the result along with patient name and date of birth on log sheet prior to transferring result to patient's medical record
16. Pull the cuvette holder out to the loading position. Remove the cuvette and discard in sharps container.

Figure 1.

ii. Venous or Arterial Specimen from Vacuum Tubes
    1. Obtain a specimen according to NIH collection policies for venous or arterial specimens. Use fresh, well mixed, anticoagulated (EDTA, lavender top) blood specimens.
    2. Mix the sample on a mechanical mixer for at least 2 minutes or gently invert by hand 8 to 10 times.
    3. Dispense a drop of blood onto parafilm
    4. Proceed as in Steps 9-16 of the Capillary Testing – Finger section.

d. REPORTING AND INTERPRETING RESULTS
    i. Record the result along with patient name and date of birth on log sheet prior to transferring result to patient's medical record
    ii. Reference ranges are as follows and are adjusted to local altitudes:
        1. Newborns 0-21 days: 13.5-21 g/dL
        2. Infants/Children 21 days to 6 years: 10.0-15.0 g/dL
        3. 6-12 year 10.0-15.0 g/dL
        4. 12-18 yr Female 11-15 g/dL
        5. 12-18 yr Male 11-16 g/dL
        6. Adult Male: 14.0-18.0 g/dL
        7. Adult Female: 13.0-17.0 g/dL
    iii. Critical values
        1. Results of ≤7.0 g/Dl or ≥20.0 g/Dl, repeat test and notify provider immediately. If the result is the same, a confirmatory hemogram must be performed by NIH lab.
        2. Results above 25.6 g/dL will be displayed as HHH. Repeat test. If the result is the same, a confirmatory hemogram must be performed by NIH lab.

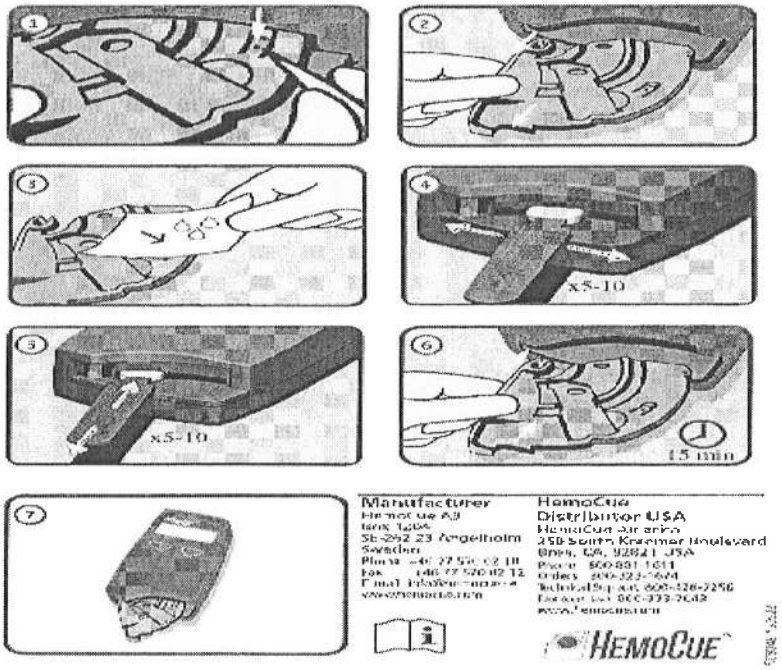
e. MAINTENANCE (see figure 2)
    i. The HemoCue unit should be cleaned each day of use using Hemocue cuvette cleaner
    ii. Check that the analyzer is turned off (the display should be blank).
    iii. Pull the cuvette holder out to the loading position. Using a pointed object or your fingertip, carefully press the small catch in the upper right hand corner of the cuvette holder.
    iv. While pressing the catch, carefully rotate the cuvette holder to the left as far as possible
    v. Using a HemoCue cleaner, push the cleaner into the analyzer and move back and forth from side to side 5 to ten times. If the swab is soiled, repeat using a new swab(s) until a new swab is no longer soiled.

vi. Clean the cuvette holder and allow to dry completely (15 minutes for both the optronic unit and the cuvette holder) before replacing it in the analyzer

vii. The exterior of the photometer may be cleaned as necessary with alcohol.

viii. If HemoCue cleaner is not available, follow steps i-vi using a cotton tipped swab(s) moistened with alcohol. Squeeze out the excess alcohol prior to use.

Figure 2



VI. PROCEDURAL NOTES

a. Microcuvettes are stored at room temperature away from any direct heat source. The individually packed microcuvettes are stable until the expiration date printed on each package.
b. Only use control solution that is assayed for the Hemocue Hb 201+.

VII. **LIMITATIONS OF THE PROCEDURE**

a. The measuring range of the Hemocue system is 0-25.6 g/dL. Values above 25.6 g/dL will be displayed as the non-numerical value of 'HHH' and must be confirmed by the NIH lab

VIII. **REFERENCES**

a. NIH Clinical Laboratory Policy and Procedure Manual
b. HemoCue Hb 201+ Operating Manual (050523)
c. HemoCue Hb 201 Microcuvette Package Insert (050523)

Reviewed By:	Date:
Eva S Wasef	3/22/16
3/22/16	

NORTHERN INYO HOSPITAL
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NORTHERN INYO HOSPITAL
POLICY AND PROCEDURE

Title: **HEMOSURE-One Step Immunological Fecal Occult Blood Test**	
Scope: POC Testing Personnel	Department: Laboratory
Author: Lab POC Team	Effective Date: June 2016
Copy Location: POC Procedure Manual	Revised Date:

I. **PRINCIPLE**

Hemosure™ one Step Immunological Fecal Occult Blood Test is a CLIA-Waived qualitative, sandwich dye conjugate immunoassay. It employs a unique combination of monoclonal and polyclonal antibodies to selectively identify hemoglobin in test samples with a high degree of sensitivity. In less than five minutes, elevated levels of human hemoglobin(hHB) as low as 50ng hHb/mL can be detected and positive results for high levels of hemoglobin can be seen in the test as early as two to three minutes. As the test sample flows up through the absorbent device, the labeled antibody-dye conjugate binds to the hemoglobin in the specimen forming an antibody-antigen complex. This complex binds to antihemoglobin antibody in the positive test reaction zone and produces a pink-rose color band. In the absence of hemoglobin, there is not line in the positive test reaction zone. The pink-rose color bands in the control reaction zone demonstrate that the reagents and devices are functioning correctly.

It is intended as a qualitative determination of Fecal Occult Blood. It is useful as an aid in determining gastrointestinal bleeding in a number of GI disorders, e.g. diverticulitis, colitis, polyps, and colorectal cancer.

II. **Materials Included With Testing Devices**

A. One test cassette individually sealed in a foil pouch

B. A corresponding fecal collection tube containing 2.0 mL of extraction buffer

III. **Materials Required But Not Supplied**

A. Clock or timing device

B. Sample collection container

C. Disposable gloves

IV. **STORAGE AND STABILITY**

A. Store test device at 36°F-86°F (2°C - 30°C)

B. The device and collection buffer are stable until the Expiration Date printed on the labels.

C. It is recommended to use the sample soon after collection, otherwise, the tube may be stored up to six(6) days at room temperature and up to thirty (30) days in refrigerator at 36°F--46°F (2° C-8°C).

V. **Sample Collection and Preparation**

A. Fecal sample should be collected using disposable gloves, preferable not to come in contact with toilet water. If that is unavoidable, make sure that the toilet is thoroughly flushed prior to collecting specimen.

B. Unscrew cap off the fecal collection tube and remove applicator stick

C. Randomly insert the applicator stick into the fecal sample from three (3) to six (6) times. Use only enough fecal material to cover the grooved portion of the stick.
Do not clump, scoop, or fill the tube(vial).

D. Secure the cap back onto the tube and shake well. Make sure the buffer solution looks discolored and hazy—(the color of weak tea)
Not grossly cloudy or a heavy mixture

E. **Instruct patients as follows for home collection:**

1. Inform the patient to collect stool sample in a clean dry container.
2. Show the patient the example of collecting the sample with the purple lid applicator stick and caution the patient TO NOT MAKE BUFFER GROSSLY CLOUDY OR TO NOT MAKE A HEAVY MIXTURE. SPECIMEN SHOULD APPEAR AS WEAK TEA.

Title: **HEMOSURE-One Step Immunological Fecal Occult Blood Test**	
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3. A specimen should not be collected from a patient with the following conditions that may interfere with the test results:
    - Menstrual bleeding
    - Constipation bleeding
    - Bleeding hemorrhoids
    - Urinary bleeding

4. Return the applicator stick into the fecal collection tube and tighten the cap thoroughly. Shake the tube to mix the sample with the extraction buffer.

VI. **TEST PROCEDURE**

A. Remove the test cassette from its foil wrapper by tearing along the slice.
B. Shake the fecal collection tube to ensure that the fecal sample is well mixed.
C. Twist off the tip of the cap on the fecal collection tube. Add three (3) drops of the extraction buffer mixture to the sample well.
D. Start timer
E. Read results within five (5) to ten (10) minutes. **DO NOT READ AFTER TEN (10) MINUTES.**

VII. **READING AND INTERPRETING RESULTS**

- **POSITIVE: One pink band appearing in the "T "region and**
  One pink band appearing in the "C" region
- **NEGATIVE: Only one pink band in the "C" Region**
- **INVALID: No bands appearing in the window at all**
  The test will have to be repeated with a new test cassette
- Positive test results may appear before 5 minutes. To verify a negative test result, be certain to wait a full 5 minutes.
    - Do not read after Ten Minutes.
      See Package insert for a visual of test interpretation

VIII. **REPORTING OF RESULTS**

A. Results are reported to the provider and recorded in the patient electronic record in Centricity.
B. Please include Lot number of kit in use, along with interpretations. C. Pink, T Pink=Pos. C pink T clear, Bkgrd(Background)Clear=Negative

IX. **QUALITY CONTROL**

A. **Internal Quality Control:**
The built-in Control feature:
    - C-LINE (Control Line) appears next to the C test window. The presence of this line indicates that an adequate sample volume was used and that the test cassette worked properly. If no C line appears the test is invalid and must be repeated.

B. **External Quality Control:**
The use of external controls assures the functionality of reagents and proper performance of the test procedure. Hemosure iFOB Control Set(Product number: T1-TC01) should be tested in the same manner as a patient, 3 drops of control material and wait 5 minutes to read. iFOB Controls are Stored between 2ºC and 8ºC and are stable until expiration date on label.

- Frequency of external QC, at a minimum, is every 30 days, or when a new lot number of testing devices are in use.

NORTHERN INYO HOSPITAL
POLICY AND PROCEDURE

Title: **HEMOSURE-One Step Immunological Fecal Occult Blood Test**	
Scope: POC Testing Personnel	Department: Laboratory
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Copy Location: POC Procedure Manual	Revised Date:

Note: If invalid results occur repeatedly or for technical assistance contact Hemosure at: 1-888-436-6787 or contact the hospital POC Team in the Laboratory.

X. **PERFORMANCE CHARACTERISTICS**

A. Sensitivity: The test is able to detect 50ng Human Hemoglobin per 1 ml of buffer or 50µg Human Hemoglobin per gram of feces.

B. Specificity: Hemosure One Step Immunological Fecal Occult Blood Test is specific for human hemoglobin. Please see package insert for detailed discussion of specificity, accuracy, and comparison studies.

XI. **LIMITATIONS.**

A. Same as other occult blood tests, Hemosure One Step may not be considered as a conclusive diagnostic for gastrointestinal bleeding or pathology. The test results can only be regarded as a preliminary screening or as an aid to diagnosis. It is not intended to replace other diagnostic procedures such as G.I. fibroscope, endoscopy, colonoscopy. Or other x-ray studies.

B. FALSE NEGATIVE- A negative result can be obtained even when a GI disorder is present. Some bowel lesions may not bleed at all or may bleed intermittently, or the blood may not be uniformly distributed in a fecal sample.

C. FALSE POSITIVE-Certain medications may cause gastrointestinal irritation resulting in occult bleeding. This may result in a false positive test result.

D. Abnormal human hemoglobins were not tested for potential cross-reactivity.

E. Color blind users may see the control and test lines as gray rather than pink-rose lines.

XII. **REFERENCE**

- Package Insert **HEMOSURE** One-step Immunological Fecal Occult Blood Test
- Effective Date: 09/05/2013

Reviewed by	Date
Eva S Wasef MD	6/29/16

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NORTHERN INYO HOSPITAL
POLICY AND PROCEDURE

Title: **HEMOSURE-One Step Immunological Fecal Occult Blood Test**	
Scope: POC Testing Personnel	Department: Laboratory
Author: Lab POC Team	Effective Date: June 2016
Copy Location: POC Procedure Manual	Revised Date:

NORTHERN INYO HOSPITAL

Point of Care QuickVue hCG Urine Test	
Scope: Procedure	Department: Laboratory
Author: POC Team	Effective Date: 6-2-16
Copy Location: NIH Lab, RHC Lab, RHWC Lab	Revised Date:

I. INTENDED USE

The QuickVue hCG Urine Test is a CLIA Waived one-step immunoassay intended for the qualitative detection of human Chorionic Gonadotropin (hCG) in urine for the early detection of pregnancy. The test is intended for use by healthcare professionals

II. PRINCIPLE

Human Chorionic Gonadotropin is a hormone produced by the placenta shortly after implantation. Since hCG is present in the urine of pregnant women, it is an excellent marker for confirming pregnancy.

The QuickVue test uses a monoclonal antibody specific to the beta subunit of hCG in a single-step technology to accurately detect hCG.

III. MATERIALS, EQUIPMENT, AND REAGENTS

- 25 individually wrapped test Cassettes containing murine monoclonal anti-hCG antibody
- 25 Disposable Pipettes
- 1 Package Insert
- 1 Procedure Card
- Sterile Collection Cups
- Gloves
- Watch or clock that measures minutes
- External urine controls

IV. STORAGE AND STABILITY

A. Kits should be kept at room temperature, 15°C to 30°C out of direct sunlight. Kits are stable until the expiration date printed on the outer box carton.

B. Specimens may be kept at room temperature for 8 hours or refrigerated at 2°C to 8°C for up to 72 hours. Samples may be frozen once at -20°C or below one time. If frozen, mix after thawing. Do not refreeze.

V. PROCEDURE

A. INTERNAL QUALITY CONTROL (IQC)

The QuickVue hCG Urine Test test provides several levels of internal procedural controls with each test run. These should be documented with each specimen tested.

- The appearance of a blue procedural Control Line is an internal positive control. This indicates that sufficient sample fluid was added for capillary flow to occur and the correct procedural technique was used. If this line does not develop, the test result is considered invalid.

- A clear background in the test result window is an internal background negative control. If the test has been performed correctly, the background should be white to light pink within 3 minutes and not interfere with the reading of that test result.

B. COLLECTION

Collect urine specimens in sterile containers. First morning specimens generally contain the highest concentrations of hCG and are recommended for early detection of pregnancy. However, any urine specimen is suitable for testing

C. ASSAY PROCEDURE

i. Gloves should be worn when handling patient specimens

ii. Remove the QuickVue test Cassettte from the foil pouch just before use and place it on a clean, dry, level surface

iii. Using one of the Disposable Pipettes supplied, collect sample and add 3 drops of urine to the Round Sample Well on the test Cassette. The test Cassette should not be handled or moved until the test is complete and ready for reading

iv. Wait 3 minutes and read.

v. Following the NIH Urine Dipstick Chemistries Policy and Procedure, determine the specimen's Specific Gravity and record the results

D. EXTERNAL QC PROCEDURE

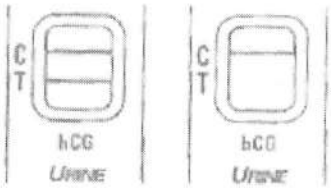
i. External QC should be run once for each new shipment of kits or once per lot. and with any new test materials.

ii. Mix controls carefully

iii. Follow the steps in C.i.-C.iv.

E. INTERPRETING RESULTS

i. Positive result: Any pink-to-red Test Line (T) along with a blue Control Line (C) is a positive result for the detection of hCG.



ii. Negative result: A blue procedural Control Line and no pink Test Line is a negative result.

iii. Invalid Result: The test is invalid if a blue Control Line (C) is not visible at 3 minutes. If this happens, retest using a new test Cassette and new sample from the patient specimen. If still no Control Line appears, contact the Lab Point of Care Team for assistance.

VI. LIMITATIONS OF THE PROCEDURE

A. The contents of this kit are for use in the qualitative detection of hCG in urine
B. Test results must always be evaluated with other data available to the physician
C. While pregnancy is the most likely reason for the presence of hCG in urine, elevated hCG concentrations unrelated to pregnancy have been reported in some patients. Conditions other than normal pregnancy may be associated with with detectable hCG, including, for example, ectopic pregnancy or molar pregnancy. Patients with trophoblastic and nontrophoblastic disease may have elevated hCG levels, therefore, the possibility of hCG secreting neoplasms should be eliminated prior to the diagnosis of pregnancy
D. hCG may remain detectable for a few days to several weeks after delivery, abortion, natural termination or hCG injections
E. Abnormal pregnancies cannot be diagnosed by qualitative hCG results. The above conditions should be ruled out when diagnosing pregnancy,.
F. Early pregnancy associated with a low level of hCG may show color development after the 3 minute procedure time. If a negative result is obtained but pregnancy is suspected, hCG levels may be too low or urine may be too dilute for detection. A low Specific Gravity may indicate that hCG levels are too dilute to detect. Another specimen, preferably a first morning void, should be collected after 48-

72 hours and tested. If waiting 48 hours is not medically advisable, the test result should be confirmed with a quantitative hCG test.

VII. REFERENCES

Northern Inyo Hospital Point of Care Manual, Urine Chemistries 2016

Northern Inyo Hospital Serology Policies/Procedures, pg 29-31

QuickVue hCG Urine Test Package insert, ref 20109 Quidel Corporation, 6/14.

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Reviewed By:	Date:
Lora S-Wasif	6/13/16

NORTHERN INYO HOSPITAL

Point of Care QuickVue Dipstick Strep A Test	
Scope: Procedure	Department: Laboratory
Author: POC Team	Effective Date:
Copy Location: NIH Lab, RHC Lab, RHWC Lab	Revised Date:

I. INTENDED USE

The QuickVue Dipstick Strep A test is intended for the rapid, qualitative detection of group A Streptococcal antigen from throat swabs. The test is to be used to aid in the diagnosis of Group A Streptococcal infection.

II. PRINCIPLE

The QuickVue Dipstick Strep A test is a lateral-flow immunoassay using Quidel's patented antibody labeled particles. The test detects either viable or nonviable organisms directly from throat swabs within five minutes.

III. MATERIALS, EQUIPMENT, AND REAGENTS

- Individually packaged Dipsticks
- Gloves
- Extraction Reagent A
- Extraction Reagent B
- Sterile throat swabs, rayon tipped on plastic shafts
- Tubes
- Positive Control
- Negative Control
- Amies gel duo swab for follow-up culture

IV. PROCEDURE

A. INTERNAL QUALITY CONTROL (IQC)

i. QuickVue Dipstick Strep A test provides three levels of internal procedural controls with each test run. For each patient specimen or External QC control tested, each level of IQC should be observed. No result should be considered valid if any IQC level does not pass.

1. The color level of the Extraction Reagent changes from clear to green as the reagents are mixed together. The color change is an internal extraction reagent control and is an indication that the reagents were mixed and functioning properly
2. The appearance of a blue Control Line is an internal control. The Dipstick must absorb the proper amount of sample and the Dipstick must be working properly for the blue Control Line to appear. Additionally, the appearance of the Control Line indicates that capillary flow occurred.
3. A clear background is an internal background negative control. If no interfering substances are in the sample and the Dipstick is working properly, the background in the Result area should be white to light pink within 5 minutes and not interfere with the reading of the test result

NORTHERN INYO HOSPITAL

Point of Care QuickVue Dipstick Strep A Test	
Scope: Procedure	Department: Laboratory
Author: POC Team	Effective Date:
Copy Location: NIH Lab, RHC Lab, RHWC Lab	Revised Date:

B. COLLECTION

i. Collect throat swab specimens by standard clinical methods. Standard Precautions and hand hygeine according to the NIH Infection Control Policy should be followed when performing any collection.

ii. Depress the tongue with a tongue blade or spoon.

iii. Use a sterile rayon tipped swab on solid plastic shaft to collect throat specimens

iv. Taking care not to touch the tongue sides, or top of the mouth, rub the swab on the back of the throat, on the tonsils and in any other area where there is redness, inflammation, or pus.

v. Process as soon as possible after collection. Swabs may be held in any clean, dry plastic tube or sleeve up to 72 hours at room temperature or refrigerated before processing (2°C-30°C). Use of charcoal or agar medium is not recommended.

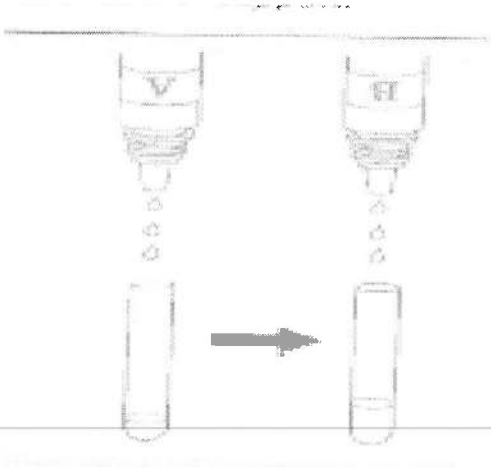
vi. If test is negative, a culture is recommended. Consult with ordering provider. Using an amies gel duo or single swab, repeat steps i-iii. Return swab(s) to the provided amies gel collection tube. Order BST and send to NIH Lab for culturing.

C. ASSAY PROCEDURE

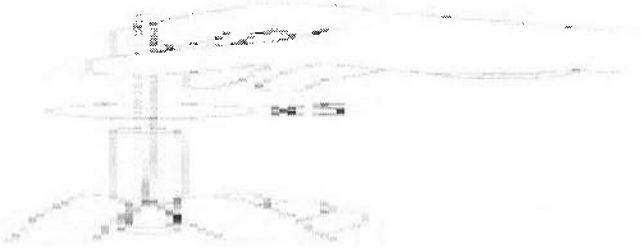
i. Gloves should be worn when handling patient specimens

ii. Add 3 drops of Reagent A and 3 drops of reagent B into a clean tube. Make sure to hold bottles vertically to form complete drops. This solution should turn GREEN.

1. Note: should Reagent B appear green prior to being mixed with Reagent A, do not use. Obtain a new Quikvue Strep A Kit to run test. Contact Lab POC Team for follow up.
2. POC Team will contact technical support, per manufacturer's recommendations.



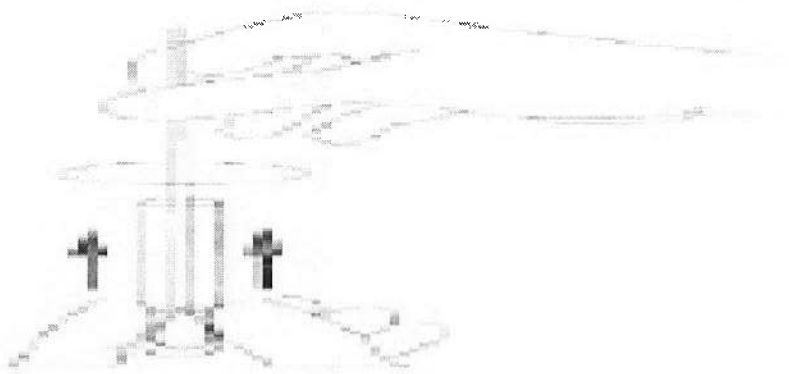
iii. Immediately add the patient swab sample to the tube. Squeeze the bottom of the tube so the



swab head is compressed. Rotate the swab a minimum of 5 times

iv. Keep swab in tube for one minute

v. Express all liquid from the swab against the inside of the tube. Squeeze the swab firmly as it is removed from the tube. Discard the swab



vi. Remove the Dipstick from the foil pouch. Place the Dipstick into the tube with the arrows of the Dipstick pointing down. Do not handle or move the Dipstick until the test is complete and ready

for reading.

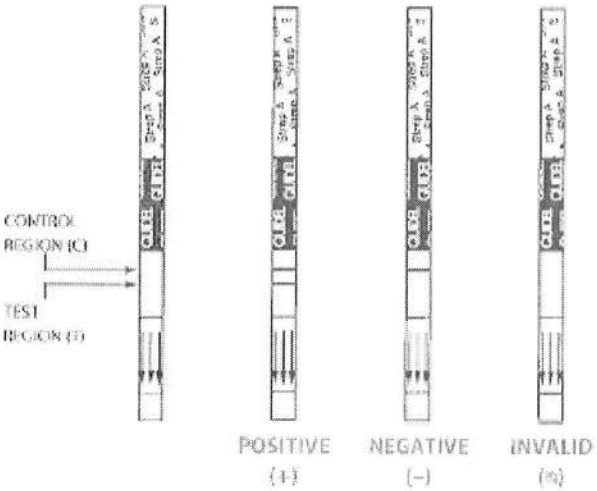
vii. Read the result at 5 minutes. Some positive results may appear sooner.

D. EXTERNAL QC PROCEDURE

i. External QC should be run once for each untrained operator and once for each new shipment of kits (or once per lot, if multiple lots are received at one time).
ii. Follow the steps in C.i.-C.ii.
iii. Vigorously mix the Positive Control Bottle. Add one drop of the control to the tube
iv. Place a clean swab in the tube
v. Follow steps C.iv-C.vii.

E. INTERPRETING RESULTS

i. Positive result: Any pink to purple Test Line along with any shade of a blue procedural Control line is a positive result for the detection of Group A Streptococcus antigen.
ii. Negative result: A blue procedural Control Line and no pink Test Line is a presumptive negative result
iii. Invalid result: The test result is invalid if a blue Control Line is not visible at 5 minutes. If this occurs, retest using a new sample and a new Dipstick.



V. LIMITATIONS OF THE PROCEDURE

A. The contents of this kit are for use in the qualitative detection of Group A Streptococcal antigen from throat swab specimens. Failure to follow the test procedure and interpretation of test results may adversely affect performance and/or produce invalid results.
B. The test detects both viable and nonviable Group A Streptococci and may yield a positive result in the absence of living organisms
C. Respiratory infections, including pharyngitis, can be caused by Streptococcus from serogroups other than Group A as well as other pathogens.

D. The QuickVue Dipstick Strep A test will not differentiate asymptomatic carriers of Group A Streptococcus from those exhibiting Streptococcal infection

E. Test results must always be evaluated with other data available to the provider. A negative test result might occur if the level of extracted antigen in a sample is below the sensitivity of the test or if a poor quality specimen is obtained. Additional follow-up testing using the culture method is recommended if the QuickVue test result is negative.

VI. REFERENCES

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Northern Inyo Hospital Point of Care Manual, 2016

Reviewed By:	Date:
Eva S-Wadey MD	6/29/16

Radiology Services Committee

Critical Indicators

2017

1. Death within 24 hours of invasive procedure.
2. Admission to ED within 24 hours of invasive procedure.
3. Severe contrast reaction.
4. Code Blue in the department
5. Patient called back for having wrong procedure performed.
6. Staff concerns with breach of protocols.

Approvals

Radiology Services Committee: 3/7/17

MEC: 4/4/17

BOD: