

June 19 2019 Regular Meeting

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DRAFT AGENDA
NORTHERN INYO HEALTHCARE DISTRICT
BOARD OF DIRECTORS REGULAR MEETING
June 19, 2019 at 5:30 p.m.
2957 Birch Street, Bishop, CA

1. Call to Order (at 5:30 pm).
2. Introduction, Southern Mono Healthcare District Chief Executive Officer (*information item*).
3. 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*).
4. Strategic Plan update, Quality and Performance Committee report (*information item*).
5. Chief of Staff Report; Allison Robinson MD:
 - A. Medical Staff Officers and Service Chiefs for 2019/2020 (*action items*):
 1. *Chief of Staff – William Timbers, MD*
 2. *Immediate Past Chief of Staff – Allison Robinson, MD*
 3. *Chief of Emergency Room Service – Sierra Bourne, MD*
 4. *Chief of Medicine – Nickoline Hathaway, MD*
 5. *Chief of Obstetrics – Martha Kim, MD*
 6. *Chief of Pediatrics – Charlotte Helvie, MD*
 7. *Chief of Radiology – Edmund Pillsbury, MD*
 8. *Chief of Surgery – Robbin Cromer-Tyler, MD*
 9. *Member-at-Large – Stacey Brown, MD*
 - B. Policy and Procedure approvals (*action items*):
 1. *Patient Safety Attendant or 1:1 Staffing Guidelines*
 2. *High Alert Medications: Preparation, Dispensing, Storage*
 3. *Newborn Blood Glucose Monitoring*
 4. *Neonatal Death, Fetal Demise & Spontaneous Abortion Procedure*
 5. *Nursing Management of Preeclampsia*
 6. *Pediatric Standards of Care and Routines*
 7. *Removal of Placenta from Hospital per Patient’s Request*
 8. *Infection Prevention Plan*

9. *Vendor Credentialing*
10. *Aerosolized Transmissible Disease Exposure Plan/Respiratory Protection Program*
11. *Healthcare Worker Health Screening and Maintenance Requirements*
12. *Skilled Nursing Facilities*
13. *Standards of Care ICU*
14. *Definition and Limitations of Direct Access Physical Therapy Care*
15. *Standards of Care in the Outpatient Infusion Unit*
- C. Perinatal Critical Indicators 2019 - update (*action item*).
- D. Core Privilege form update (*action item*):
 1. Family Medicine
- E. Medical Staff Appointments (*action items*):
 1. Samantha Jeppsen, MD (*emergency medicine*) – Provisional Active Staff
 2. Carly Harvey, MD (*radiology*) – Provisional Consulting Staff
- F. Temporary Privileges for 60 days (*action item*):
 1. Ruhong Ma, DO (*internal medicine*) – Locums/Temporary Staff
- G. Extension of privileges for an additional 60 days (*action items*):
 1. Kristina Jong, MD (*radiology, breast imaging*) – effective 6/7/19
 2. Michael Rhodes, MD (*internal medicine/hospitalist*) – effective 6/24/19
 3. Joseph BenPerlas, MD (*internal medicine/hospitalist*) – effective 5/23/19
- H. Additional Privileges (*action item*):
 1. Uttama Sharma, MD (*family medicine*) – chemotherapy in consultation with oncologist
- I. Resignation (*action item*):
 1. Sun Kim, MD (*urology*) – effective 5/2/19
6. New Business
 - A. Operating Budget 60-day extension of 2018/2019 budget (*action item*).
 - B. District Board Resolution 19-04, *Appropriations Limit for 2019/2020* (*action item*).
 - C. District Board Resolution 19-05, *Funding of NIHD 401(a) Pension Plan* (*action item*).
 - D. RQI Master Services Agreement (*action item*).
 - E. Employee Engagement Survey results (*information item*).
 - F. Pharmacy update (*information item*).
 - G. Determination of date for Board Self-Assessment review (*information item*).
 - H. Ad Hoc Committee report and appointment of Board member for District Zone 1 (*action item*).

7. Old Business
 - A. Athena update (*information item*).
 - B. Phase III budget management (*information item*).

Consent Agenda (action items)

8. Approval of minutes of the May 15 2019 regular meeting
9. Approval of minutes of the May 28 2019 special meeting
10. Policy and Procedure annual approvals

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11. Reports from Board members (*information items*).
 12. Adjournment to closed session to/for:
 - A. Discuss trade secrets, new programs and services (estimated public session date for discussion yet to be determined) (*Health and Safety Code Section 32106*).
 - B. Conference with Labor Negotiators; Agency Designated Representative: Irma Moisa; Employee Organization: AFSCME Council 57 (*pursuant to Government Code Section 54957.6*).
 - C. Conduct Public employee performance evaluation, Chief Executive Officer (*pursuant to Government Code Section 54957*).
 13. Return to open session and report of any action taken in closed session.
 14. 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.

Stacey Brown
Robin Christensen
Scott Hooker
Jeff Kneip
**Jannalyn
Lawrence**
Richard Mears
Justin Nott
Wendy Runley
Lynda Vance

Quality Improvement Operational Team

NIHD Health Care Worker Vaccination Rate 2018-2019 Influenza Season

Personnel Type	Declinations	Contraindicated	Vaccinated Else-ware	Vaccinate Here	Working	Percent Vaccinate
Employee	10	1	14	481	536	99%
Licensed Independent Practitioner	2	0	25	46	73	97%
Adults students trainees and volunteers	2	0	10	32	44	95%
All health Care Workers	14	1	49	559	623	98%

Sepsis is the body's overwhelming and life-threatening response to infection that can lead to tissue damage, organ failure, and death. In other words, it's the body's overactive and toxic response to an infection

Sepsis Definition

Retrieved from Sepsis Alliance. (2019). <https://www.sepsis.org/sepsis/definition/>

Who is at Risk for Sepsis?

Anyone can get an infection and any infection can lead to sepsis. Certain people are at higher risk:

- Adults 65 or older
- People with chronic medical conditions such as diabetes, lung disease, cancer, and kidney disease
- People with weakened immune systems
- Children younger than one
- Implanted medical device or recent surgical procedure

Common
infections
that can
lead to
sepsis

Urinary tract infection

Pneumonia

Flu

MRSA

Team Goal



Raise community awareness on “early warning signs” of sepsis



Improve patient outcomes by:



Decrease patients presenting to hospital in “severe sepsis” or “septic shock”



Decrease inpatient mortality



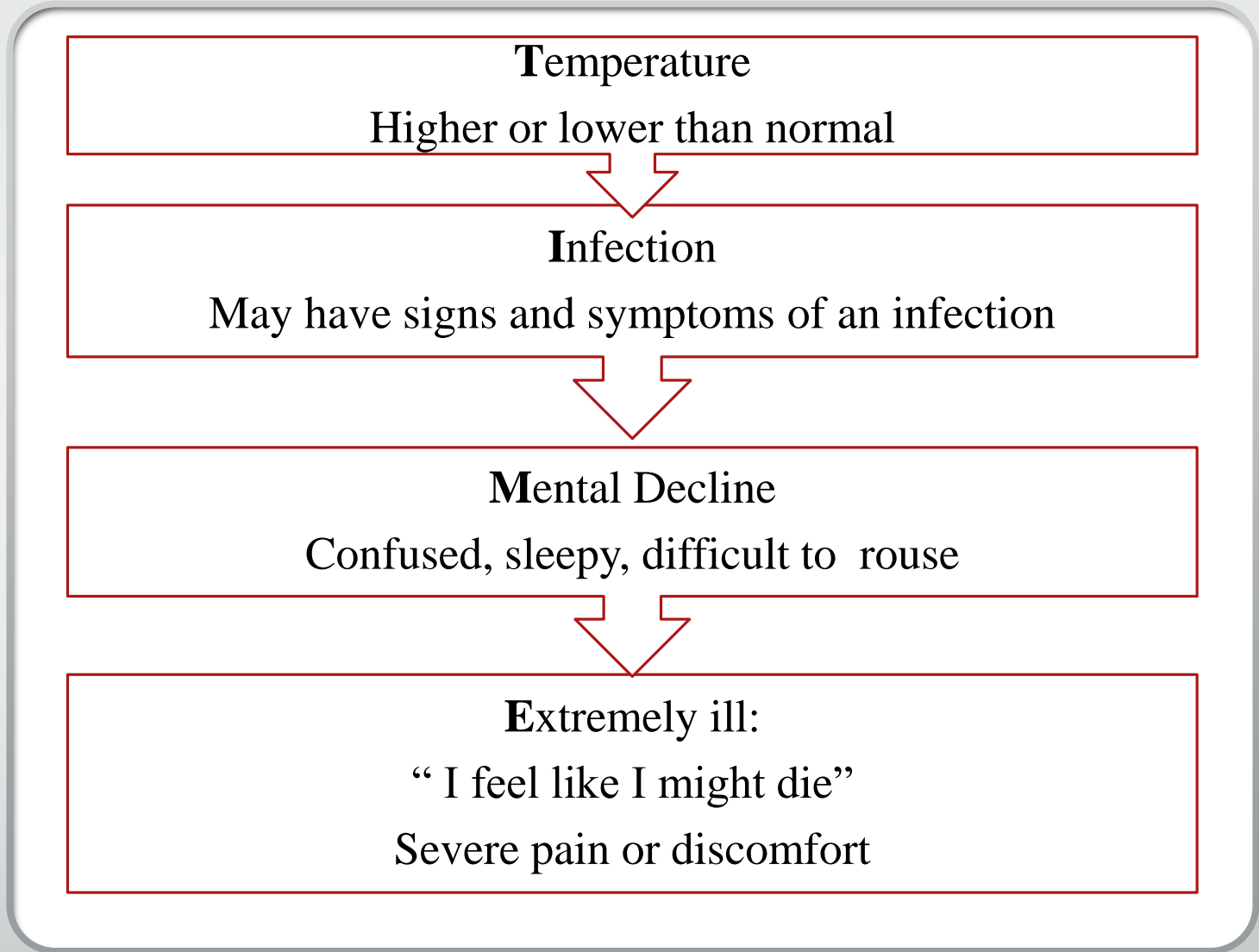
Decrease hospital length of stay

Community Awareness

- Education material distributed (English and Spanish)
- Posters around NIHD on campus
- Vons Shopping cart insert
- Newspaper article & radio announcements
- Public education
 - Bishop Care Center, Sterling Heights, Senior Center
- Dr. Brown to focus on sepsis with “Healthy Lifestyle Talk”

TIME

Combination of these symptoms



When it comes to sepsis, remember
IT'S ABOUT TIME™. Watch for:



TEMPERATURE
higher or lower
than normal

INFECTION
may have signs
and symptoms of
an infection

MENTAL DECLINE
confused, sleepy,
difficult to rouse

EXTREMELY ILL
"I feel like I might
die," severe pain
or discomfort

Watch for a combination of these symptoms. If you suspect sepsis, see a doctor urgently, CALL 911 or go to a hospital and say, "I AM CONCERNED ABOUT SEPSIS."

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SEPSIS.ORG



SEPSIS ALLIANCE

Example of public education material/card

Next Quarter Goals & Metric

Review last 10 adult patients charts that presented in severe sepsis or septic shock to obtain baseline

Review number of adult patients diagnosed with sepsis before and after community education campaign

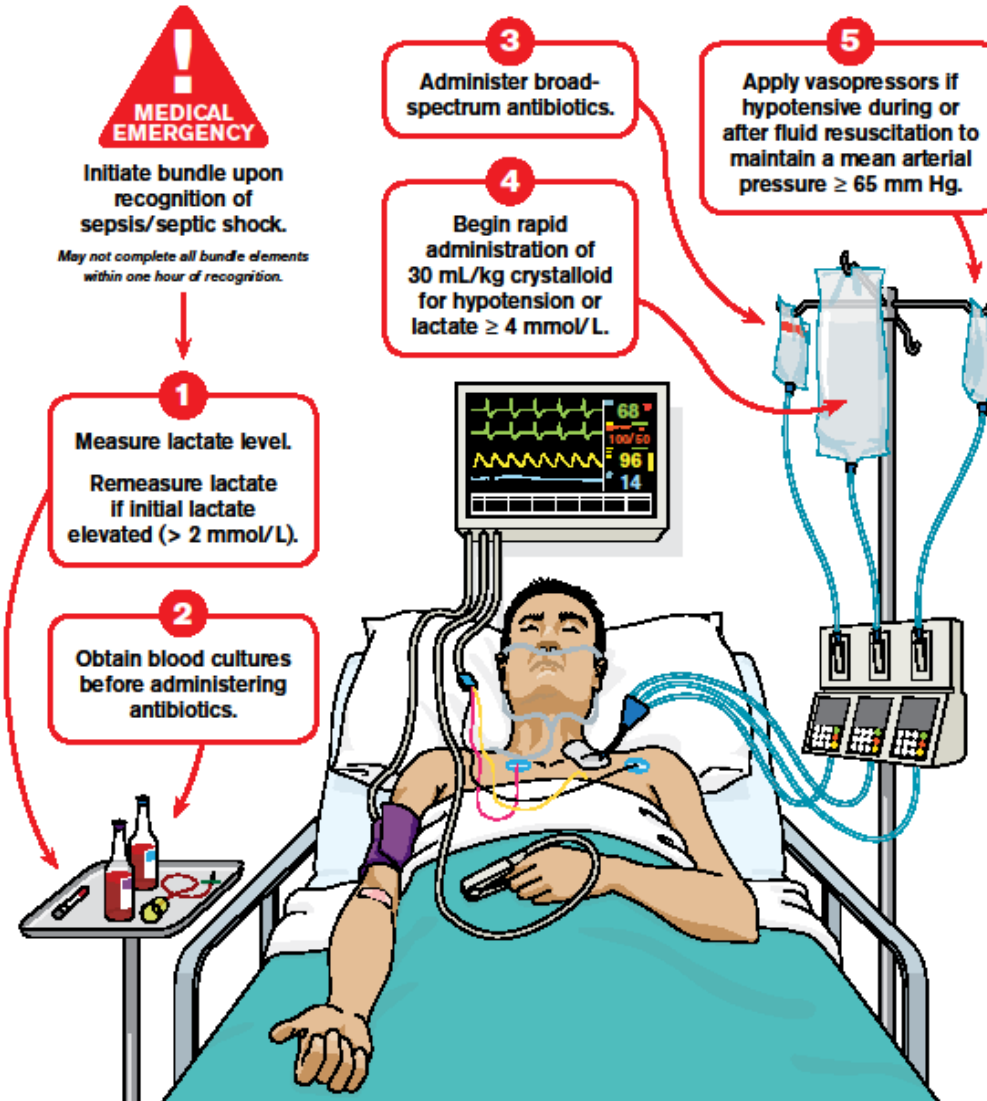
Follow CMS Inpatient Quality Reporting (IQR) reporting algorithm* (see next slide)

Numerator: # of adult patients who meet IQR criteria (best practice)

Denominator: # of adult patients with diagnosis of Severe Sepsis and/or Septic Shock

Hour-1 Bundle

Initial Resuscitation for Sepsis and Septic Shock



Bundle: SurvivingSepsis.org/Bundle

Complete Guidelines: SurvivingSepsis.org/Guidelines

References

Centers for Disease Control and Prevention. (2018). What is sepsis?.

Downloaded 6/11/19 from <https://www.cdc.gov/sepsis/what-is-sepsis.html>

Sepsis Alliance. (2019). Suspect Sepsis. Save Lives. Downloaded 6/11/19 from

<https://www.sepsis.org/>

Surviving Sepsis Campaign. Downloaded 6/11/19 from

<https://www.survivingsepsis.org>

**NORTHERN INYO HOSPITAL
POLICY AND PROCEDURE**

Title: Patient Safety Attendant or 1:1 Staffing Guidelines*	
Scope: Nursing Services	Manual: CPM - Patient Safety (PS)
Source: Chief Nursing Officer	Effective Date: 4/1/16

PURPOSE:

The purpose of a Patient Safety Attendant (SA) is to help keep the patient oriented to place and/or help assure the patient's safety by one-to-one observation.

POLICY:

1. A Medical Staff Practitioner may write an order for a patient safety attendant however a nurse may also initiate the use of a SA through assessment and by collaboration with other team members. Patient safety attendant criteria include:
 - a. Suicide precaution (All patients on suicide precautions will have a safety attendant until a physician has cleared the patient from such precautions.)
 - b. Protecting patients from harm when they are at high risk for falls
 - c. Patient disorientation/non cooperative
2. With the exception of a patient placed on suicide precautions (one-to-one observation), the patient's family may serve as a patient safety attendant.
3. Patient safety attendant may be from different levels of care providers, including LVN, CNA, Clerk, Security, Environmental Services, etc.
4. Performance standards of a patient safety attendant (what the patient safety attendant may do for and with the patient) will be based on the patient safety attendant's job description.

PROCEDURE:

1. When a patient safety attendant is deemed necessary for the safety of the patient, the RN or designee will notify the House Supervisor (HS) for coverage. The HS will find staffing coverage.
 - a. Patient Safety Attendants are usually not provided in ICU or when staffing meets 1-2 patient ratio
2. If a patient's family member chooses to sit with the patient, instructions will be given that the family member is to:
 - a. Call for assistance as needed using the call bell
 - b. Not to leave the patient unattended
3. A guest tray may be ordered for the family member who is sitting with the patient.
4. All patient care is under the direction of the RN assigned to the patient. The RN will:
 - a. Give direction to the SA based on the SA's job description performance standards
 - b. Check on the SA when completing hourly rounding every hour from 0800-2200 and every two hours from 2200-0800
5. The patient SA will be located in the room with the patient. The patient SA will:
 - a. Not leave the room (i.e. breaks and meals unless relieved by another person)
 - b. Notify the RN of any assistance needed or concerns
 - c. Document utilizing the 'close observation' form every 15 minutes for patients requiring SA (see attached document)
 - d. Follow the 'Safety Attendant Guidelines' (see attached document)
6. The patient need for a patient safety attendant should be re-assessed on an ongoing basis but not less than every 24 hours.
 - a. Patient Safety Attendant continuation will be reviewed at the daily interdisciplinary team meeting.

**NORTHERN INYO HOSPITAL
POLICY AND PROCEDURE**

Title: Patient Safety Attendant or 1:1 Staffing Guidelines*	
Scope: Nursing Services	Manual: CPM - Patient Safety (PS)
Source: Chief Nursing Officer	Effective Date: 4/1/16

REFERENCES:

1. McFarlane-Kolb, H. (2004) Falls Risk assessment, Multitargeted Interventions and Impact on Hospital Falls. International Journal of Nursing Practice 10: 199-206
2. NCPS Falls Toolkit; 2004 National Center for Patient Safety. <http://www.patientsafety.gov/SafetyTopics/fallstoolkit/notebook/completebooklet.pdf>.
3. Care of the Psychiatric Patient in the Emergency Department, ACEP Emergency Medicine Practice Committee (2014)
4. Sentinel Event Alert: New Alert Focuses on Suicidal Ideation, The Joint Commission Perspectives, (2016)

CROSS REFERENCE P&P:

1. Management of the Behavioral Health Patient (5150 and non-5150)
2. Fall prevention and management

Approval	Date
CCOC	5/14/19
MEC	6/10/19
Board of Directors	
Last Board of Director review	4/18/18

Developed: 12/92
 Reviewed: 10/97, 3/06, 5/09, 5/11, 9/12, 4/18ta
 Revised: 1/16, 4/19ta

Replaces 1:1 Staffing (Sitter)

**NORTHERN INYO HOSPITAL
POLICY AND PROCEDURE**

Title: High Alert Medications: Preparation, Dispensing, Storage*	
Scope: Pharmacy, Nursing Services	Manual: CPM - Medication (MED), Pharmacy
Source: Pharmacy Director	Effective Date: 9/15/17

PURPOSE:

To ensure that the preparation, dispensing, and storage of high alert medications occurs safely

POLICY:

1. High Alert medications are cancer chemotherapy drugs, monoclonal antibody drugs, concentrated electrolytes solutions, insulin, heparin, PCA narcotics, neuromuscular blocking agents and any medications designated as High Alert by the Pharmacy and Therapeutics Committee.
2. High Alert medications will not be dispensed or prepared for dispensing without a Provider order.
3. Prior to preparation or dispensing, the pharmacist will check the diagnosis, indications, contraindications, precautions, adverse effects, dose, route of administration in an FDA sanctioned publication (e.g.: the package insert), or in a industry-recognized compendium such as the American Hospital Formulary Service, Facts and Comparisons Chemotherapy Manual, or in a peer-reviewed article in a recognized medical journal. This step may be skipped if the pharmacist is sufficiently familiar with the drug to judge the safety and appropriateness of the order.
4. The drug will only be prepared and dispensed if the pharmacist is satisfied of the safety and appropriateness of the drug and dose.
5. For cancer chemotherapy orders and for orders written on a Chemotherapy Orders sheet, the pharmacy Chemotherapy Policy and Procedure will be followed.
6. Prior to the final mixing of non-chemotherapy High Alert medication, the prepared dose of the medication will be double checked by another pharmacist, a pharmacy technician, or a registered nurse.

Department specific actions for High Alert Medications:

Class of Medication	Pharmacy	Nursing
Chemotherapy	Segregated in pharmacy Double check	Double check
Monoclonal Antibody	Segregated in Pharmacy Double check	Double check
Concentrated Electrolyte Sol.	Alert Note in Pharmacy Double check	3% Sodium Chloride 500ml in ED only, witness required.
Insulin	Double check	Double check
Heparin	Pre-mix sol (excludes Heparin Flush for line integrity)	Double check
PCA Narcotics	Double check	Double check Alert packaging
Neuro-Muscular Blocking Agent	Alert Note in Pharmacy	Alert packaging
Oxytocin	Double check	Double check Alert packaging

**NORTHERN INYO HOSPITAL
POLICY AND PROCEDURE**

Title: High Alert Medications: Preparation, Dispensing, Storage*	
Scope: Pharmacy, Nursing Services	Manual: CPM - Medication (MED), Pharmacy
Source: Pharmacy Director	Effective Date: 9/15/17

OB Premixed Epidural	Mixed by Pharmacist Only	Lock Box in Refrigerator Alert packaging Double check
Thrombolytics (Alteplase, TNKase)	Double check	Double check

Double check means that medication and dose are independently checked by 2 licensed practitioners.

Approval	Date
CCOC	11/19/18
Pharmacy and Therapeutics Committee	2/21/19
Medical Executive Committee	6/10/19
Board of Directors	
Last Board of Director Review	7/19/17

Revised: 2/04, 12/09, 11/18jk

Reviewed: 10/05, 9/10, 9/11, 9/12, 11/13, 4/14, 3/15/17

Supersedes:

Index Listing

**NORTHERN INYO HEALTHCARE DISTRICT
POLICY AND PROCEDURE**

Title: Newborn Blood Glucose Monitoring	
Scope: Perinatal	Manual: Perinatal
Source: Manager of Perinatal Department	Effective Date:

PURPOSE:

Blood glucose monitoring is done to ensure stable blood glucose levels in neonates at risk.

POLICY:

1. All newborns will be assessed for the need to monitor blood glucose levels.
2. Only infants with risk factors for hypoglycemia (asymptomatic) or clinical signs consistent with hypoglycemia (symptomatic) will undergo routine glucose screening.
3. All testing will be done by heelstick blood sugar (HSBS) unless otherwise indicated.

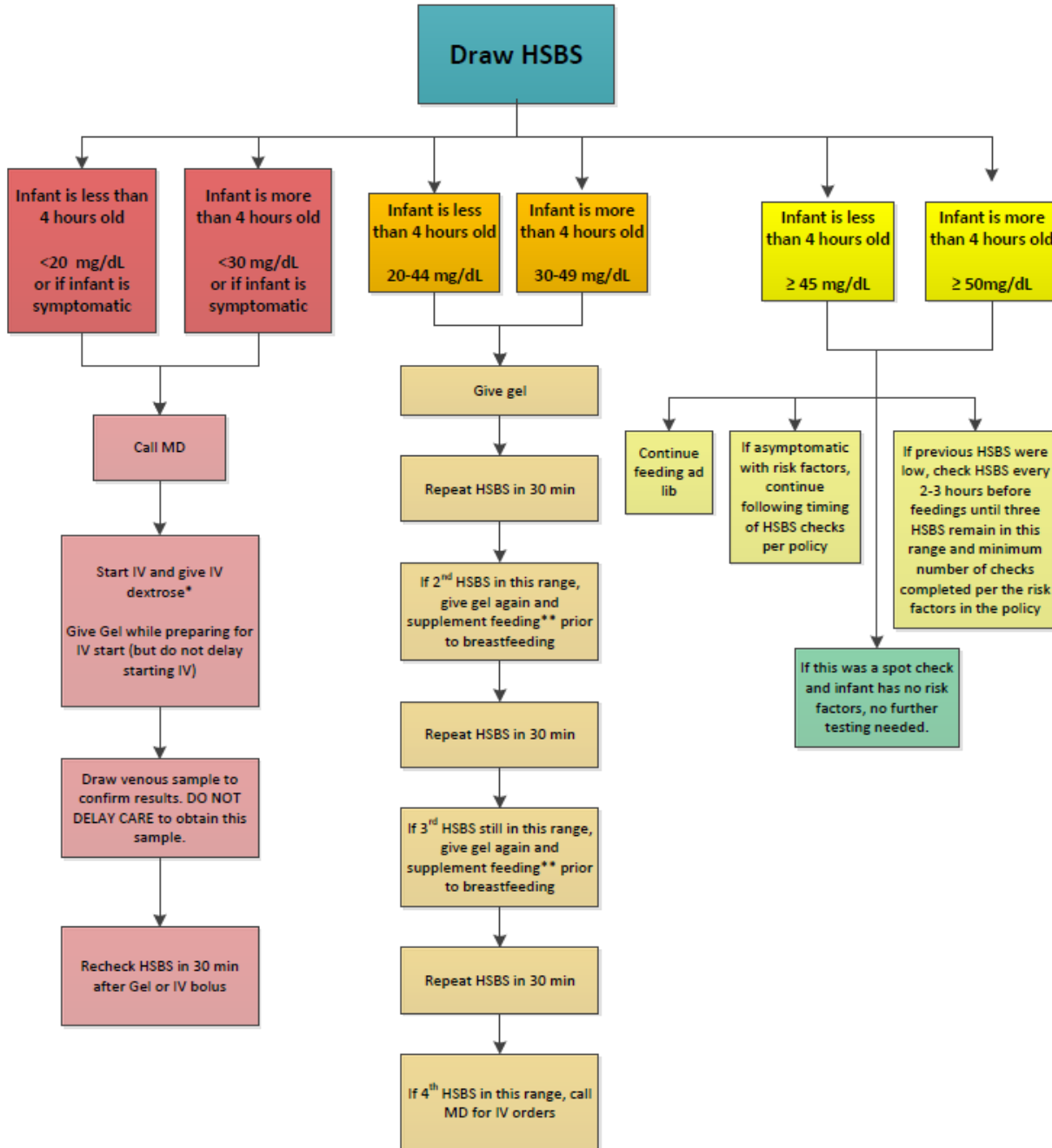
PROCEDURE:

1. Assess all newborns for hypoglycemia risk factors (see below)
2. **INITIAL** feed: All infants should be fed within the first hour of life and prior to the first blood glucose check, unless unstable.
3. Screen all at risk infants within 2 hours of birth. See below for risk factors
4. Screen all symptomatic newborns immediately.
 - o Symptoms include irritability, exaggerated Moro reflex, high pitched cry, decreased suck, temperature instability, jitteriness, tachypnea, apnea, lethargy, decreased tone, or seizures.
5. Screen all asymptomatic newborns with risk factors at the times described below:
 - Screen for **24 hours** (Check blood glucose at 1 hour of age, and then at approximately 4, 7, 13 and 19 hours of age. Check blood glucose prior to feeds whenever possible. Further screening needed if any of the last three blood glucose results are <45. Recheck blood glucose immediately if infant becomes symptomatic.
 - o PRETERM (less than 37 weeks gestation)
 - o SGA (*UpToDate chart attached*)
 - o Trisomy 21
 - o Endocrine/metabolism disorders, or midline defect or microphallus
 - o Maternal intrapartum dextrose infusion or maternal hypoglycemia
 - Screen for **12 hours** Check blood glucose at 1 hour of age then approximately 4 and 7 hours of age. Check blood glucose prior to feeds whenever possible. Further screening needed if any blood glucose results are <45. and Recheck blood glucose immediately if infant becomes symptomatic.
 - o LGA \geq 4000 grams
 - o Infant of diabetic mother (IDM)
 - o Postdates (>42 weeks gestation)
 - o Discordant twin (weight is 10% less than twin)
 - o Perinatal stress (arterial cord pH <7, 5 minute Apgar score <7)
 - o Suspected sepsis, maternal infection or maternal fever > 38.3°C
 - o Prolonged respiratory distress for greater than 30 minutes (Respiratory rate >60 rpm or infant requiring oxygen)
 - o Infants requiring continuous IV fluids at greater than 5mL/hr
 - o Maternal treatment with terbutaline, propranolol, or labetalol within 48 hours prior to delivery
 - o Congenital cardiac malformations

**NORTHERN INYO HEALTHCARE DISTRICT
POLICY AND PROCEDURE**

Title: Newborn Blood Glucose Monitoring	
Scope: Perinatal	Manual: Perinatal
Source: Manager of Perinatal Department	Effective Date:

- Hyperviscosity/polycythemia (Hct >65%)



Orders required for the following:

*IV Dextrose: D10W 2ml/kg over 1-2 minutes then continuous D10W at 80ml/kg/day.

**Gel: Dextrose gel 40%. Rub into dry buccal surface. Breast feed immediately after giving gel whenever possible.

***Supplemental feeding: Give at least 8 ml (and up to 30ml if tolerated) of expressed breast milk or formula.

**NORTHERN INYO HEALTHCARE DISTRICT
POLICY AND PROCEDURE**

Title: Newborn Blood Glucose Monitoring	
Scope: Perinatal	Manual: Perinatal
Source: Manager of Perinatal Department	Effective Date:

SGA Chart (per *UpToDate*)

Gestation	Male	Female
36	≤2407	≤ 2300
37	≤ 2596	≤ 2484
38	≤ 2769	≤ 2657
39	≤ 2908	≤ 2796
40	≤ 2986	≤ 2872
41	≤ 3007	≤ 2891
42	≤ 2998	≤ 2884

REFERENCES:

1. *Overview of the routine management of the healthy newborn infant*, UpToDate
2. *Management and outcome of neonatal hypoglycemia*, UpToDate
3. *AWHONN Templates for Protocols and Procedures for Maternity Services*, 2nd edition, Patti Besuner, RN, MN, CNS Washington, DC 2010 P123-124

CROSS REFERENCE P&P:

1. Admission, Care, Discharge and Transfer of the Newborn

Approval	Date
CCOC	7/16/18
PeriPeds	5/14/19
Medical Executive Committee	6/10/19
Board of Directors	
Last Board of Directors Review	

Developed: 4/1/2018

Reviewed: 3/2019AF

Revised: : 3/2019AF

Supersedes: Newborn Blood Glucose Monitoring

Index Listings:

**NORTHERN INYO HOSPITAL
POLICY AND PROCEDURE**

Title: Neonatal Death, Fetal Demise & Spontaneous Abortion Procedure	
Scope: Perinatal	Manual: Perinatal
Source: Perinatal Nurse Manager	Effective Date:

PURPOSE: To provide guidelines for nursing personnel in the care of neonatal death, fetal demise or spontaneous abortion.
To provide emotional support to the parents/family experiencing a fetal/neonatal death.

POLICY:

1. Every neonatal death and/or fetal demise (stillborn) shall be processed in a legal manner.
2. Every effort shall be made to facilitate this process in a caring, sensitive manner.
3. The attending physician will determine the gestational age of the infant/fetus.
4. “Products of conception” that meet the “Live Birth” definition must have a birth certificate.
5. The fetus born at less than 20 weeks gestation will be sent to Pathology as a tissue specimen.
6. A physician will be called to examine any “Live Birth” under 20 week’s gestation.
7. Infant/fetal death following a “Live Birth” requires disposition of the remains by a mortician and issuance of a death certificate.
8. Social Service will be notified of any fetal/neonatal death.
9. The family is responsible for making funeral arrangements.
10. All neonatal/fetal deaths that qualify as a coroner’s case will be reported as required.
11. Neonatal resuscitation procedures will be followed for any “Live Birth” unless/until “No Code” order given/written by physician. A medical record number will be issued for any fetus born live. If a fetus is stillborn, no medical record number will be issued.
12. It is the responsibility of the physician to obtain consent from the family for an autopsy.
13. For any of the below status, please hang the butterfly picture on the outside of mom’s room so to alert staff (including EVS, dietary, lab, etc.) that this mom is experiencing a loss.

DEFINITIONS:

Birth is defined as the complete expulsion or extraction from its mother the product of conception (irrespective) of the duration of, or viability of the pregnancy

Adherence to the following definitions is required:

Live birth: means the complete expulsion or extraction from its mother of a product of conception which breathes, has a heartbeat, pulsating umbilical cord or definite movement of voluntary muscles before or after cutting of umbilical cord or placental separation.

Fetal death/stillborn: means death prior to birth, as defined as the complete expulsion or extraction of a product of conception which does not breathe, have beating heart, pulsating umbilical cord or definite movement of voluntary muscles, at any time. (Before or after the umbilical cord is cut or placenta separates).

Abortus: A fetus or embryo expelled from the uterus before the 20th week of gestation and showing no signs of life.

Neonatal death: Death of an infant that was born live. (called a neonate from birth through the first 27 days).

**NORTHERN INYO HOSPITAL
POLICY AND PROCEDURE**

Title: Neonatal Death, Fetal Demise & Spontaneous Abortion Procedure	
Scope: Perinatal	Manual: Perinatal
Source: Perinatal Nurse Manager	Effective Date:

PROCEDURE:

- A. Neonatal Death: Care at delivery of “Live Birth” of a non-viable fetus, due to immaturity or anomalies incompatible with life.
 1. Dry infant with blankets.
 2. If physician not present, cut and clamp the cord.
 3. Assess Apgar score.
 4. Assign medical record number.
 5. Follow neonatal resuscitation procedures unless/until order by physician for “no code” is given or until physician has pronounced infant death.
 6. After no code order given or infant pronounced dead by physician:
 - a. wrap infant in dry blanket, use stockinet cap to cover cranial deformities, if appropriate
 - b. allow parents to hold infant for as long as desired
 - c. Assist the family in Spiritual, Cultural, or Family traditions
 - d. place completed baby identification bands on infant
 - e. weigh and measure infant
 - f. if infant still has any signs of life, keep infant warm and provide comfort care as ordered.
 - g. note Apgars per protocol, and note the time of birth and death in the newborn and mothers charts (any live birth requires an infant chart to be generated)
- B. Memory Box Preparation
 - a. take Digital picture of infant, label it with mother’s name, date and time of birth, and offer to parents with other mementos (lock of hair, footprints etc.) in memory box describing the memory box and its contents and its present location (follow instructions on memory box)—camera and other necessary equipment for compiling mementos for the family are in the “grief” bag located in the utility room. Label a zip lock bag (with the addressograph card stamped on the label) and place it in the Memory box containing their mementos. If the parents are not interested in the memory box at the time of discharge, the box can be stored in OB Nurse Managers office or after 1 year to be stored in Medical Records. Place a patient belonging envelope in the Medical Record.
 - b. Offer these to the family--if they do not wish to have these at this time, leave memento’s in a zip-lock bag in chart so the parents may have them available at a later date.
- C. Care at delivery of “Fetal Death”/Stillborn
 1. Dry infant with blankets
 2. If the physician is not present, clamp and cut the cord
 3. Follow procedures outlined in 5a-5g above
 4. All chart entries are made on the mothers chart--no separate infant chart is generated if the infant is stillborn
- D. Care and disposition of remains of “Fetal Death” under 20 weeks (does not include “Live Birth” under 20 weeks with subsequent death)
 1. Weigh and measure fetus, record on delivery record

**NORTHERN INYO HOSPITAL
POLICY AND PROCEDURE**

Title: Neonatal Death, Fetal Demise & Spontaneous Abortion Procedure	
Scope: Perinatal	Manual: Perinatal
Source: Perinatal Nurse Manager	Effective Date:

2. Place fetus and placenta in specimen bucket with formalin (various sizes of specimen containers are located in the cabinet with the “grief bag”) unless for genetic studies then place in normal saline
 3. Label side of bucket with patient identification sticker. Complete pathology request form (include all relevant information on pathology requisition, i.e. gravida/para, date and time of delivery, gestational age, etc)
 4. Take fetus to pathology, place in the Lab refrigerator on A Floor if after hours, or give to supervisor to take to pathology refrigerator after hours.
 5. Parents have the right to take the fetus and placenta with them if they so desire.
- E. Care and disposition of remains of “Fetal Death” 20 weeks and over or live birth with subsequent death
1. Weigh and measure fetus, record on delivery record.
 2. Wrap the body in blue underpad. Place identa-band on arm or leg of body. For fetus too small or macerated to put arm or leg bands on, place the band across the body inside the underpad. Wrap the baby in a clean blanket and pin the second identa-band to outside of blanket.
 3. Send placenta to pathology in the usual manner:
 - a) if no genetic work-up required, then placenta is placed in formalin and sent to pathology
 - b) if genetic work-up is required, then placenta is placed in normal saline and sent to pathology
 4. Notify the supervisor that the baby is ready to be sent to the mortuary (all paperwork must be filled out and given to the mortuary at the time they arrive to take the body); all babies 20 weeks and over are sent to the mortuary regardless of whether an autopsy is to be done or not
- F. Genetic Workup
1. If genetic workup is requested, provider will obtain 1x1 segment of placenta and place in normal saline. Collection of specimen can be performed by an RN. Provider order is required.

G. Checklist:

ALL INFANTS

- _____ Spiritual, Cultural or Family traditions included in patient wishes
- _____ Weight and length of infant documented
- _____ Momentos given to family: complete and follow directions in memory box
- _____ “No Code” order by MD when appropriate
- _____ Social Services contacted
- _____ Copy of face sheet to mortuary with fetus if indicated
- _____ Autopsy consent signed if indicated
- _____ Release of body consent signed by mortician if indicated
- _____ Birth certificate information completed and signed by parent if live birth occurred
- _____ High risk referral sent to Health Department

**NORTHERN INYO HOSPITAL
POLICY AND PROCEDURE**

Title: Neonatal Death, Fetal Demise & Spontaneous Abortion Procedure	
Scope: Perinatal	Manual: Perinatal
Source: Perinatal Nurse Manager	Effective Date:

Less Than 20 Weeks

- ___ MD statement of gestational age
- ___ Contact mortuary for any fetus \geq 20 weeks
- ___ Contacted MD if gestational age not documented

- ___ Place in formalin and send to pathology,
or if genetic work-up is ordered, then specimens sent in normal saline

Greater Than 20 Weeks

- ___ Notify MD that death certificate is required

- ___ Paperwork completed and ready for mortician

- ___ L&D record completed and signed

Genetic Workup

- ___ Pathology slips completed and attached
- ___ Placenta 1x1 sample placed in Normal Saline
- ___ 20 weeks or less: fetus and placenta in normal saline, then refrigerated
- ___ Provider order for workup

CROSS REFERENCE P&P:

1. Pathology Department Policy “Handling of Pregnancy Loss Specimens for Cytogenetic Analysis Only” for additional information for specimens to be sent for genetic work-up)

Committee Approval	Date
CCOC	
Perinatal/Pediatrics Committee	3/5/19
Medical Executive Committee	6/10/19
Board of Directors	
Last Board of Directors Review	2/15/17

Developed:

Reviewed: 01/01, 03/04 JK, 9/09jk, 9/12jk

Revised: 3/98

Supersedes:

**NORTHERN INYO HOSPITAL
POLICY AND PROCEDURE**

Title: Nursing Management of Preeclampsia	
Scope:	Manual: Perinatal
Source: OB Nurse Manager	Effective Date: 11/97

PURPOSE:

To outline the nursing management of inpatients who have preeclampsia including special considerations for management of patients on magnesium sulfate, patients on antihypertensive medications and management of eclampsia.

BACKGROUND:

Preeclampsia is a hypertensive disorder of pregnancy characterized by vasospasm and endothelial damage, which may impact the cardiovascular, renal, hematological, neurologic, and hepatic systems as well as the uteroplacental unit. It is of unknown etiology. Preeclampsia is characterized by new onset of hypertension and proteinuria after 20 weeks' gestation in a previously normotensive woman.

Diagnostic Criteria for Preeclampsia

- Hypertension: Systolic blood pressure ≥ 140 mmHg or diastolic blood pressure ≥ 90 mmHg on at least two occasions at least four hours apart.
- Proteinuria: ≥ 0.3 g of protein in a 24-hour urine specimen or protein/creatinine ratio ≥ 0.3 in a random urine specimen or dipstick $\geq 2+$ if a quantitative measurement is unavailable.

Diagnostic Criteria for Preeclampsia with Severe Features

- Systolic blood pressure ≥ 160 mmHg or diastolic blood pressure ≥ 110 mmHg and proteinuria (with or without signs and symptoms of significant end-organ dysfunction).
- Systolic blood pressure ≥ 140 mmHg or diastolic blood pressure ≥ 90 mmHg (with or without proteinuria) and one or more of the following signs and symptoms of significant end-organ dysfunction:
 - New-onset cerebral or visual disturbance, such as:
 - Photopsia (flashes of light) and/or scotomata (dark areas or gaps in the visual field).
 - Severe headache (ie, incapacitating, "the worst headache I've ever had") or headache that persists and progresses despite analgesic therapy.
 - Altered mental status.
 - Severe, persistent right upper quadrant or epigastric pain unresponsive to medication and not accounted for by an alternative diagnosis or serum transaminase concentration ≥ 2 times upper limit of normal for a specific laboratory, or both.
 - $< 100,000$ platelets/microL.
 - Progressive renal insufficiency (serum creatinine > 1.1 mg/dL [97.3 micromol/L]; some guidelines also include doubling of serum creatinine concentration in the absence of other renal disease).
 - Pulmonary edema.

REPORTABLE CONDITIONS:

Notify provider for:

1. Repeated blood pressure greater than 160 systolic OR greater than 105-110 diastolic (taken at least 15 minutes apart).

**NORTHERN INYO HOSPITAL
POLICY AND PROCEDURE**

Title: Nursing Management of Preeclampsia	
Scope:	Manual: Perinatal
Source: OB Nurse Manager	Effective Date: 11/97

2. New or worsening complaint of any of the following:
 - a. Headache
 - b. Visual changes
 - c. Right Upper Quadrant (RUQ) or epigastric pain
3. Abnormal lab values

PROCEDURE:

ADMISSION:

1. Assess for absence or presence of:
 - a. Headache
 - b. Visual changes
 - c. Right upper quadrant or epigastric pain
 - d. Nausea/vomiting
 - e. General malaise
2. Assess upper or lower deep tendon reflexes.
3. Auscultate for lung sounds, noting any presence of rales, rhonchi, wheezing, etc.
4. Assess for generalized edema and significant, rapid weight gain.
5. Assess blood pressure using an appropriately sized blood pressure cuff with patient sitting or in the upright position with the patient's arm at the level of the heart. Do not reposition the patient to her left side and retake blood pressure. It will give a false lower reading.
6. Apply external fetal monitor (if viable fetus).
7. Prepare to obtain IV access as ordered by provider.
8. Prepare to administer medications to lower blood pressure and prevent seizure activity.
9. Maintain activity as ordered by provider. If on bedrest, maintain side-lying position as much as possible, avoiding supine position, and change position every two hours or more often as needed.
10. Provide emotional support and opportunity for patient family to verbalize questions, concerns and/or fears.
11. Assess maternal vital signs including: blood pressure as described above, respiratory rate, heart rate, temperature, and oxygen saturation as ordered by provider.
12. Prepare to assess lab values as ordered.
13. Ensure oxygen and suction equipment are present and functioning.
14. Implement measures to decrease stress level, such as provision of a quiet environment and low lighting.
15. Monitor temperature per department protocol.
16. Assess intake and output every 1 hour.

ANTEPARTUM ONGOING ASSESSMENT:

Goals of patient management are:

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Title: Nursing Management of Preeclampsia	
Scope:	Manual: Perinatal
Source: OB Nurse Manager	Effective Date: 11/97

1. Early recognition of severe or worsening preeclampsia or development of eclampsia.
2. Prolongation of pregnancy to optimize fetal maturation must be weighed against risks of pregnancy continuation.

Preeclampsia without severe features (mild):

1. Obtain blood pressure, pulse, respirations, and oxygen saturation hourly until DC'd by physician order.
2. Assess lung sounds every 4 hours.
3. Assess deep tendon reflexes, clonus, edema, level of consciousness, headache, visual disturbances epigastric pain every 8 hours.
4. Obtain NST or monitor FHT's with uterine activity for 30 minutes every shift or as condition warrants.
5. Assess fetal movement every shift.
6. Hourly intake and output

Severe Preeclampsia:

1. Obtain blood pressure, pulse, respirations, and oxygen saturation hourly.
2. Assess lung sounds every 2 hours.
3. Assess deep tendon reflexes, clonus, edema, level of consciousness, headache, visual disturbances epigastric pain every 4 hours.

INTRAPARTUM ONGOING ASSESSMENT:

Preeclampsia without severe features (mild):

1. Obtain blood pressure, pulse, respirations, and oxygen saturation every 60 minutes.
2. Assess lung sounds every 4 hours.
3. Assess deep tendon reflexes, clonus, edema, level of consciousness, headache, visual disturbances epigastric pain every 8 hours.
4. Monitor FHR and uterine activity continuously.
5. Hourly Intake and Output

Severe Preeclampsia:

1. Obtain blood pressure, pulse, respirations, and oxygen saturation every 30 minutes.
2. Assess lung sounds every 2 hours.
3. Assess deep tendon reflexes, clonus, edema, level of consciousness, headache, visual disturbances epigastric pain every 4 hours.
4. Monitor FHR and uterine activity continuously.
5. Hourly Intake and Output

POSTPARTUM TO DISCHARGE ONGOING ASSESSMENT:

Preeclampsia without severe features (mild):

1. Obtain blood pressure, pulse, respirations, and oxygen saturation hourly until DC'd by physician order.
2. Assess lung sounds every 4 hours.

**NORTHERN INYO HOSPITAL
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Title: Nursing Management of Preeclampsia	
Scope:	Manual: Perinatal
Source: OB Nurse Manager	Effective Date: 11/97

3. Assess deep tendon reflexes, clonus, edema, level of consciousness, headache, visual disturbances epigastric pain every 8 hours.
4. Hourly Intake and Output

Severe Preeclampsia:

1. Obtain blood pressure, pulse, respirations, and oxygen saturation every 60 minutes for first 24 hours after delivery then every 4 hours.
2. Assess lung sounds every 2 hours for first 24 hours after delivery then every 4 hours.
3. Assess deep tendon reflexes, clonus, edema, level of consciousness, headache, visual disturbances epigastric pain every 4 hours.
4. Hourly Intake and Output

Approval	Date
CCOC	5/21/19
Perinatal-Pediatrics Committee	5/14/19
Medical Executive Committee	6/10/19
Board of Directors	
Last Board of Director review	3/21/18

Responsibility: Perinatal Unit Nurse Manager

Index listings: CMQCC Preeclampsia Care Guidelines and Toolkit: Nursing management of Preeclampsia Policy and Procedure 12/20/13

Revised: 11/97, 8/11jk, 5/19ss

Reviewed: 01/01, 8/11jk-ab

Last Board of Director review: 3/21/18

**NORTHERN INYO HOSPITAL
POLICY AND PROCEDURE**

Title: Pediatric Standards of Care and Routines	
Scope: Pediatric	Manual:
Source:	Effective Date: 3/16/16

POLICY STATEMENT:

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

PROCEDURE:

The Pediatric patient and family can expect:

ON ADMISSION/TRANSFER INTO DEPARTMENT:

1. To be greeted immediately upon arrival to the unit including:
 - a. Introduction of nursing and ancillary staff.
 - b. Explanation of what to expect within the next hour.
 - c. Clean patient room with pediatric-appropriate supplies and equipment.
 - d. Assessment of level of assistance required to complete activities of daily living, including transferring, ambulation, self-care, and feeding; support provided to meet identified need.
 - e. Orientation to room including call light use, bed operation, TV and light controls, phone, bathroom location and options for patient and family members, safety procedures, equipment in use, and unit routine.
 - f. Pain, potty, and position addressed.
 - g. Additional comfort needs such as fluids, blankets, IV site, traction, safety devices, and communication devices addressed.
2. To receive information about the patient/family's Speak Up Program, Patient Rights, Patient Safety, Pediatric Letter to Family, Patient Advocate, Advance Directives, Infection Control, and Rapid Response.
3. To have an RN assess his/her admitting or transfer condition (quick check) within 30 minutes of arrival.
4. To have an RN initiate a nursing assessment within 4 hours of admission, to be completed within 12 hours, including:
 - a. Physical and social assessment.
 - b. Assessment of communication methods, dietary practices, home environment.
 - c. Patient profile, to include home medications, pre-arrival medications, reported problems and procedures, implants, allergies, immunizations, family history, education, occupation, use of alcohol, tobacco, and other drugs.
 - d. Interdisciplinary referral based on functional screens within the nursing assessment.
 - e. Nursing plan of care individualized for patient.
5. To have an RN review and initiate Physician Admitting Orders within 4 hours of admission, including review of physician plan of care as written.

**NORTHERN INYO HOSPITAL
POLICY AND PROCEDURE**

Title: Pediatric Standards of Care and Routines	
Scope: Pediatric	Manual:
Source:	Effective Date: 3/16/16

6. To have an RN initiate discharge planning at time of admission, to be readdressed throughout stay, including:
 - a. Patient and family goals for hospitalization
 - b. Referral to interdisciplinary team, including Dietary, Social Services, Physical Therapy, Speech Therapy, and Pharmacy.

THROUGHOUT STAY:

1. To be treated in accordance with NIH’s policy entitled “Patients’ Rights”.
2. To be kept informed of and involved in the plan of care including medications, procedures, and discharge needs.
3. To have care delivered based on standards of practice for the diagnosis identified.
4. To have a Physician (Attending Physician) oversee care with site visit every 24 hours.
5. To have Physician consultations completed within 24 hours of referral.
6. To have an RN monitor and assess his/her health status a minimum of every 12 hours, and as the patient’s condition warrants (0800, 2000).
7. To have the physician updated and informed of response to care and/or significant changes as demonstrated by:
 - a. Abnormal or worsening critical signs specific to patient’s baseline.
 - b. Abnormal or worsening lab values.
 - c. Significant change in Level of Consciousness (LOC).
 - d. Significant or worsening change in physical assessment.
 - e. Significant change or imbalance in Input and Output (I&O).
 - f. Any adverse drug and/or blood reactions, or untoward change as a response to treatment.
 - g. Inability to control pain or obtain pain relief.
 - h. Any untoward occurrence/event occurring in the hospital.
8. To receive prompt identification of and intervention for potential and actual complications/side effects, including Rapid Response team initiation.
9. To have parent, if not present, informed of any of above circumstances or occurrences.
10. To have pain assessed and managed in a systematic way to achieve optimal relief.
11. To have hourly rounding 0800 to 2400 and every 2 hour rounding 2400 to 0800 to address:
 - a. Pain, potty, position.
 - b. Comfort needs.
 - c. Environment assessment, to include maintenance of quiet, therapeutic atmosphere.
12. To have safety measures identified specific to each patient including:
 - a. Patient identification band in place on patient and parent; staff to use at least two patient identifiers for medications and procedures.
 - b. Pediatric security tag in place with alarm activated, Code Amber information sheet completed.
 - c. 5 rights of medication administration practiced; all pediatric medication dosages double-checked with second RN, LVN, or RPh; emergency medications

**NORTHERN INYO HOSPITAL
POLICY AND PROCEDURE**

Title: Pediatric Standards of Care and Routines	
Scope: Pediatric	Manual:
Source:	Effective Date: 3/16/16

- calculated based on admission weight and Broselow-Hinkle Pediatric emergency system.
- d. Time out as appropriate for identified invasive procedures.
 - e. Fall risk assessment every 12 hours and with change of condition.
 - i. Interventions in place specific to the patient.
 - ii. High risk patient to be awoken at agreed-upon time for toileting.
 - iii. Patients ages 4 and under in crib with side rails raised to full height, unless patient sleeps in regular bed at home.
 - iv. Infants in bassinet.
 - f. Skin assessment every 12 hours
 - i. Interventions in place specific to patient to prevent new breakdown, and to treat existing skin breakdown.
 - g. IV site assessment every hour
 - h. Restraint-free environment emphasizing alternatives to restraint:
 - i. Comfort measures.
 - ii. Patient orientation techniques.
 - iii. Patient safety alert devices.
 - iv. Patient location.
 - v. Sitter in room.
 - vi. Restraints only used if less restrictive measure have not succeeded or are clearly not likely to succeed in preventing injury to the patient.
 - i. Smoke-free environment.
 - j. Assessment for suicidal risk.
13. To have preventative measures followed to avoid patient infections, pneumonia, and blood clots.
 14. To be educated throughout the admission to support understanding of:
 - a. Health status, current diagnosis, and plan of care.
 - b. Self-care needed to maintain and improve health status.
 - c. Basic health and safety practices, including opportunity to communicate concerns about safety issues before, during, and after care is received.
 - d. Oral health.
 - e. Nutrition interventions.
 - f. Habitation or rehabilitation techniques to help patient reach maximum independence.
 - g. Equipment usage during stay and equipment needs for discharge.
 - h. Fall reduction strategies.
 - i. Pain, risk for pain, and methods of pain management.
 - j. Medication name, dosage, route, timing, and reason for receiving.
 15. To have continuity of care maintained between caregivers and departments through appropriate sharing of information (SBAR-QC).
 16. To have confidentiality and privacy maintained in accordance with policy on Patient Rights, State Law, and Federal Law.

**NORTHERN INYO HOSPITAL
POLICY AND PROCEDURE**

Title: Pediatric Standards of Care and Routines	
Scope: Pediatric	Manual:
Source:	Effective Date: 3/16/16

17. To have nutritional needs assessed, and nutrition provided that meets the patient's special diet, including developmental status, and cultural, religious, or ethnic preferences.
 - a. To be provided with storage for pumped breastmilk, if needed.
 - b. To be provided with formula, bottles, and nipples for feeding, if needed.
18. To have services that support family time, schoolwork and education, social work, nursing care, dental care, rehabilitation, and discharge needs.
19. To have palliative and terminal care as required.

ON TRANSFER WITHIN NIH:

1. To have transfer assessment completed by transferring RN.
2. To have patient assessment completed by receiving RN.
3. To have transferring RN provides report of patient condition (SBAR-QC) to receiving RN.
4. To have patient/family updated on reason for transfer, location moved, and change in plan of care.
5. To be transferred with all belongings.
6. To have medications/orders reconciled upon transfer by receiving RN/Pharmacy.

ON DISCHARGE/TRANSFER TO ANOTHER FACILITY:

1. To have discharge transfer orders reviewed with patient/family.
2. To have discharge transfer assessment completed by RN and report called to receiving facility RN.
3. To have transportation arranged including:
 - a. Medical condition.
 - b. Orders for care level during transport.
 - c. IV/Medication maintenance as appropriate.
 - d. Record of care transported with patient.
4. To have discharging transfer RN give report to transport team, MD/RN/Paramedic/EMT as appropriate.
5. To be transferred with all personal belongings and medications.

ON DISCHARGE:

1. To have discharge assessment completed by RN.
2. To have written discharge instructions provided to patient/family member by RN, including clarification of:
 - a. Who to call for questions.
 - b. Nature of medical condition and what symptoms to report to MD.
 - c. Medications to take, list of medications already given that day, new prescriptions.
 - d. Follow-up appointment, including outpatient diagnostic test and lab work orders.
 - e. Medical equipment needed at home, including vendor to call for assistance.
 - f. Home Health/Hospice/Meals on Wheels contact information as ordered.

**NORTHERN INYO HOSPITAL
POLICY AND PROCEDURE**

Title: Pediatric Standards of Care and Routines	
Scope: Pediatric	Manual:
Source:	Effective Date: 3/16/16

- g. Activity level and return to work.
- h. Dietary restrictions.
- 3. To be provided with “Release of a Child Under 8 Years of Age” form indicating awareness of federally required child passenger restraint systems, if applicable for age of patient.
- 4. To be discharged with all belongings and medications.
- 5. To receive hospital follow-up call.

ON EXPIRATION:

- 1. To have Family Member/Significant Other/Power of Attorney/Health Care Surrogate, Nursing Home, and Organ Procurement agency notified of impending death.
- 2. To have all Medical Staff assigned to the case, Family Member/Significant Other/Power of Attorney/Health Care Surrogate, Nursing Home, and Organ Procurement agency notified of death.
- 3. To have all belongings returned to family or sent with body to Funeral Home.
- 4. To have post-mortem care completed and body released to Funeral Home or Medical Examiner.

REFERENCE(S):

- 1. General Acute Care Hospitals, 22 CCR Div.5, 2014.
- 2. ANA. (2010). *Nursing Scope and Standards of Practice*. Silver Spring, MD: Nursesbooks.org

CROSS REFERENCE HOSPITAL P&P:

- 1. A Quick Check
- 2. Admission of a Pediatric Patient
- 3. Hand Off; Standardized Nursing Communications Policy
- 4. Obtaining Consent for Organ and Tissue Donation
- 5. Patients’ Rights
- 6. Patient Transfer/Discharge to Another Facility
- 7. Pediatric Emergency Code System (Broselow-Hinkle)
- 8. Pediatric Letter to Family
- 9. Pediatric Service

Approval	Date
NEC	03/20/19
Peri-peds Committee	5/14/19
Medical Executive Committee	6/10/19
Board of Directors	
Last Board of Directors Review	

Developed: 6/14
 Reviewed: 1/17 la
 Revised: 3/19 sem

**NORTHERN INYO HEALTHCARE DISTRICT
POLICY AND PROCEDURE**

Title: Removal of Placenta from Hospital per Patient's Request	
Scope:	Manual: Emergency Dept, ICU/CCU, Medical/Surgical, Nursing Administration, Perinatal, Surgery
Source: Manager of Perinatal Department	Effective Date:

PURPOSE: The purpose of this policy is to provide guidance for the staff in honoring a patient's request to remove her placenta from the hospital after birth.

POLICY:

1. The placenta will be placed in a plastic container provided by the Perinatal Department
2. If the provider determines the need for placenta to go to pathology for further examination, the patient will not be permitted to take it home.
3. If the patient has a communicable disease including, but not limited to, one of the following, the placenta may not be released from the hospital:
 - Hepatitis B, C, D
 - HIV
4. The patient is responsible for bringing a container (ie: cooler) in which to transport the placenta from the hospital.
5. No storage will be made available for the placenta, and the patient's family/significant other will be required to take the placenta home immediately upon receipt.

PROCEDURE:

1. Don Personal Protective Equipment (PPE)
2. Ensure that the provider has assessed the placenta for intactness and that there is no indication for it to be sent to Pathology.
3. Ensure that there is no maternal disease process.
4. Place the placenta, membranes and cord in the designated plastic container.
5. Place a patient label on the plastic container.
6. Obtain Release of Liability for Removal of Placenta and have patient sign the release.
7. Instruct the patient's family or significant other on the following:
 - Placenta must be taken home immediately from the hospital.
 - Storage is not available anywhere in the hospital.
 - The placenta cannot be returned to the hospital.
8. Document hand over of placenta to family or significant other in patient's electronic medical record, including instructions as mentioned above.

REFERENCES:

- 1.

CROSS REFERENCE P&P: Disposal of Placenta

**NORTHERN INYO HEALTHCARE DISTRICT
POLICY AND PROCEDURE**

Title: Removal of Placenta from Hospital per Patient's Request	
Scope:	Manual: Emergency Dept, ICU/CCU, Medical/Surgical, Nursing Administration, Perinatal, Surgery
Source: Manager of Perinatal Department	Effective Date:

Approval	Date
Compliance Committee	
Perinatal/Pediatrics Committee	5/14/19
Medical Executive Committee	6/10/19
Board of Directors	
Last Board of Directors Review	

Developed:
Reviewed:
Revised:
Supersedes:
Index Listings:



RELEASE OF PLACENTA FOR RELIGIOUS, ETHNIC OR CULTURAL REASONS

Patient Name: _____

Date of Delivery: _____ Date of Release _____

I have requested the release of my placenta from **Northern Inyo Healthcare District** to me for religious, ethnic or cultural reason(s). I understand that the release of my placenta is subject to an order for release issued by my **attending physician**.

I have been informed and understand that there may be multiple health and other risks associated with taking my placenta home, including but not limited to:

1. Illness or injury to myself or others, due to ingestion or physical exposure.
2. Illness or injury to myself or animal/ plant life or environment resulting from the improper handling, disposal or other use which may be made of the placenta.
3. I understand that this list of dangers is not complete and that a more detailed list of recommendations can be provided by the hospital upon my request.
4. I have been advised that the placenta should be handled in a responsible way to minimize the risks associated with taking my placenta out of the hospital.

Recommended procedures to handle the placenta include, but are not limited to the following:

1. Keep the placenta in a leak proof container to prevent contact with persons, animals, plants, or objects.
2. The used container should be washed thoroughly, not used for any other purpose thereafter, and then discarded in the trash.
3. Wear disposable protective gloves when handling the placenta and discard the used gloves in the trash after use and before touching anything else.
4. After removing the gloves immediately wash hands thoroughly with disinfectant soap and water.

I assume the risks and accept any and all consequences of receiving, storing, and disposing of my placenta. I understand that the usual, and safest, method of placenta disposal is through established hospital procedures, as local ordinances set forth specific requirements for the disposal.

I hereby release and discharge **Northern Inyo Healthcare District**, and its parent, subsidiaries, employees and agents from all claims, demands, actions, causes of action, rights or damages of whatever nature, whether known or unknown, arising out of or in any way connected with my taking custody of my placenta.



I understand and agree that I waive rights and benefits which I may have, or in the future may have, under and by virtue of the terms of Section 1542 of the California Civil Code which reads as follows:

“A general release does not extend to the claims, which the creditor does not know or suspect to exist in his favor at the time of executing the release which if known by him/her must have materially affected his settlement with the debtor.”

I further agree to indemnify and hold harmless **Northern Inyo Healthcare District** and its parent, employees and agents from and against any and all claims, causes of action, liabilities, losses, damages, penalties, assessments, judgments, awards or costs, including reasonable attorneys’ fees and costs, arising out of, resulting from, or relating to any claim, lawsuit, or other action brought against **Northern Inyo Healthcare District** by any individual, or by any governmental, corporate, or other entity as a result of my taking custody of my placenta.

I have read and fully understand the information and the terms of this document. All of my questions have been answered to my satisfaction.

Patient’s Signature

Date

NIHD Representative Signature

Date

Interpreter name/number, if needed:

Name: _____

Statement of Non-discrimination

Northern Inyo Healthcare District complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex.

Spanish

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 760-873-5811 (TTY: 711).

Chinese

注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 760-873-5811（TTY：711）。

**NORTHERN INYO HOSPITAL
POLICY AND PROCEDURE**

Title: Infection Prevention Plan*	
Scope: Hospital Wide	Manual: CPM - Infection Control- Patient Care (ICP)
Source: Quality Nurse/Infection Control Preventionist	Effective Date: 4/1/2015

INFECTION CONTROL MISSION STATEMENT

To improve the quality of health by identifying, preventing and controlling the risks of acquiring and transmitting infections among patients, visitors, team members, volunteers and all other healthcare providers, while utilizing evidence based practices and principles.

The Infection Control (IC) Program incorporates Administrative support to ensure adherence to the program standards.

Through orientation and an ongoing continuing education program, Northern Inyo Healthcare District (NIHD) ensures that all team members are effectively trained and educated on infection control issues and procedures. The IC Program ensures that all team members safely interact with our customers.

Adherence to the established IC Program standards is continuously monitored through surveillance. Problems identified through surveillance are analyzed, evaluated, and monitored for resolution. Surveillance is used to identify opportunities to improve care while playing an integral role in continuous quality improvement effort.

The continuously developing Infection Control Program is part of (NIHD) ongoing commitment to provide high quality healthcare. Through the Infection Control Program, (NIHD) systematically involves each team member in the process of maintaining a safe environment for our patients, visitors, team members and other healthcare providers.

The driving force behind every recommendation and action of the Infection Control Program is:

- To protect the patient/family/community
- To protect the Health Care Worker (HCW), and others in the Health Care environment
- Provide the same high level of precautions for all patients, visitors and employees
- To accomplish this in a cost-effective manner whenever possible.

SUMMARY OF THE INFECTION CONTROL COMMITTEE DUTIES

Northern Inyo Healthcare District Infection Control Committee has a wide scope of responsibilities and duties. Some of these responsibilities are advisory in nature. The Infection Control Plan delineates the full scope of responsibilities and duties by frequency as listed:

ANNUAL:

- Infection Control Program Evaluation
- Evaluation of Infection Control Goals
- Approve new FY Infection Prevention Pillars of Excellence
- Approve required Policy and Procedures
- Approve Employee Health yearly goals
- Approve new FY Employee Health Pillars of Excellence
- Evaluate Employee Health Goals

**NORTHERN INYO HOSPITAL
POLICY AND PROCEDURE**

Title: Infection Prevention Plan*	
Scope: Hospital Wide	Manual: CPM - Infection Control- Patient Care (ICP)
Source: Quality Nurse/Infection Control Preventionist	Effective Date: 4/1/2015

QUARTERLY

1. Infection Control Committee Meeting
2. Submit Quarterly Infection Prevention and Employee Health Pillars of Excellence to
 - Infection Control Committee
 - Nurse Executive Committee
 - Quality Assurance and Performance Improvement

CONTINUOUS

- Identify, Correct, Address Problems or Issues
- Monitor and Evaluate Outstanding Problems or Issues
- Issue Recommendations to leadership as needed
- Development and Implementation of Infection Control Policies
- Healthcare – Team Member Education
- Orientation Education
- Nursing Education
- Surveillance Activities

STATEMENT OF PURPOSE

- A. All hospitals run the risk of Health Care Facility Associated Infections (HAI's), meaning infections acquired in the hospital. These infections may be endemic or epidemic which may affect patients, team members, and others who come into contact with patients.
- B. Northern Inyo Healthcare District is committed to providing an effective hospital wide program for the surveillance, prevention and control of infection. The infection control process is designed to lower the risks and to improve the rates or trends of epidemiologically significant infections. The surveillance, prevention and control of infection includes processes and activities both in direct patient care and in patient care support coordinated and carried out by the hospital. It also links with external organizational support systems to reduce the risk of infection from the environment, and the community.
- C. The infection control process and its supporting mechanisms are based on current scientific knowledge, acceptable practice guidelines, applicable laws and regulations, sound epidemiologic principles and research on HAI's It takes into consideration the following factors: the facility's geographic location, patient volume, patient population served, the hospital's clinical focus and number of team members.
- D. The Infection Control Program addresses and prioritizes issues defined by the hospital to be epidemiologically important to the hospital. Information regarding risk, rates and trends in HAI's is used to improve prevention and control activities and to reduce HAI's rates to the lowest possible level. The Infection Control Program is connected with the Inyo County Health Department to ensure appropriate follow-up of infection is implemented within the communities and rural areas served by Northern Inyo Healthcare District.

LEADERSHP AND RESPONSIBILITY

**NORTHERN INYO HOSPITAL
POLICY AND PROCEDURE**

Title: Infection Prevention Plan*	
Scope: Hospital Wide	Manual: CPM - Infection Control- Patient Care (ICP)
Source: Quality Nurse/Infection Control Preventionist	Effective Date: 4/1/2015

A. Board of Directors

The Board of Directors has the final authority and oversight of the Infection Control Program. The Board monitors and supports organizational efforts to continuously improve the quality of patient care services and customer satisfaction. The Board ensures the necessary resources and education for the hospital to achieve these goals. The Board delegates the responsibility of maintenance of the Infection Control Program to the Medical Executive Committee and Chief Executive Officer.

B. Medical Executive Committee

The Medical Executive Committee is responsible for overseeing the Infection Control Program and delegates the development and monitoring of infection surveillance, prevention and control processes to the Infection Control Committee. The Medical Executive Committee receives information related to actions taken to resolve issues of infection control and, if necessary, acts upon any issues related to infection control. The Medical Executive Committee grants the Infection Preventionist Manager authority, under the direction of the Infection Control Committee Chair or his/her designee, to institute surveillance, prevention and control measures of studies, when there is reason to believe that any patient or team member may be in danger. In the absence of the Infection Preventionist Manager, nursing staff trained in Infection Prevention practices assumes the Infection Control responsibilities and are able to take appropriate actions as outlined in Infection Control Policies.

C. Chief Executive Officer

The Chief Executive Officer of the Hospital serves as a liaison between the Board of Directors and the Medical Executive Committee. He/she ensures that all hospital departments, programs, and disciplines participate in and provide support for the Infection Control Program.

D. Infection Control Committee

(See attached structure appendix 1)

E. Infection Control Medical Staff Chairperson

The Infection Control Medical Staff Chairperson acts as a resource for the Infection Control Manager. This person will have training and/or experience in infection control as stated in *Senate Bill 158* (Attachment 1) and will review the Infection Control Program, including rates, make recommendations as needed and have input into policies and procedures.

F. Infection Preventionist Manager

The Infection Preventionist Manager assumes the responsibility of managing and carrying out the infection surveillance, prevention and control functions within NIHD. This person has training in infection surveillance, prevention and control as well as knowledge and job experience in the areas of epidemiological principles and infectious disease, sterilization, sanitation and disinfection practices.

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This individual also is knowledgeable in adult education principles and patient care practice. This person maintains records and logs of incidents related to infections and communicable disease. The Infection Preventionist Manager and/or designee reviews culture and sensitivity testing, reviews antibiotic usage reports, reports suspected infections, conducts department specific periodic rounding, infection control annual risk assessment and implements isolation procedures in accordance with hospital policy, maintain policies and procedures that are specific to patient care activities and are based on recognized guidelines and applicable laws and regulations. The Infection Preventionist Manager has input into staff education to ensure all team members are competent to participate in infection monitoring, prevention and control activities. The Infection Preventionist Manager refers cases for physician review and communicates pertinent clinical infection control information to the Infection Control Committee.

SCOPE AND INTEGRATION:

Surveillance prevention and control of infection covers a broad range of processes and activities that are coordinated and carried out by the hospital: (1) in direct patient care and in patient care support and (2) health care team members. The Infection Control Program also links with external organizational support systems to reduce the risk of infection from the environment, including air, food and water sources. The Infection Control Program is a coordinated process to reduce the risk of endemic and epidemic HAI's in patients and team members. It is adopted by the NIHD Administration, Medical Staff, and team members of NIHD to provide for the surveillance and control of infections. The infection control process is integrated with the hospital's overall process for assessing and improving organizational performance. The hospital tracks risks, rates and trends of HAI's. It uses this information to improve prevention and control activities and to reduce HAI's rates to the lowest possible levels. Special monitoring of the environment, continuous evaluation of infection control policies and procedures, and periodic review of the clinical use of antibiotics is utilized. The Infection Control Program also interfaces with the local health department to ensure continuation of care, appropriate follow-up and control of infection as appropriate.

The hospital wide Infection Control Program for surveillance, prevention and control of infection is defined to include the following:

A. Inpatient and outpatient areas

All areas with inpatient beds and all areas where patient care services are provided on an outpatient basis:

- Acute/Subacute
- Swing
- Inpatient Hospice
- Intensive Care Unit
- Perinatal Services
- Emergency Department
- Peri-operative Services
- Outpatient Infusion Center

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- Rural Health Clinic and other clinics

B. Service/Diagnostic Areas

All areas that provide specialized patient treatment or diagnostic services. The nature of these services forces practitioners to put infection control principles into practice:

- Laboratory
- Diagnostic Imaging
- Cardiopulmonary
- Rehabilitation Services

C. Support Services

All hospital departments/services that support diagnostic or therapeutic patient care activities and have an identified role in infection control:

- Admission Services
- Biomedical Engineering
- Case Management
- Environmental Services
- Dietary
- Health Information Services (Medical Records)
- Laundry Services
- Plant Operations
- Materials Management
- Security
- Volunteer Services
- Quality Assurance/Performance Improvement

D. Employee Health Services

Employee Health and Infection Control functions collaborate with the Medical Staff to reduce the transmission of infections, including vaccine preventable diseases, from patients to health care team members or from health care members to patients. Mechanisms or processes designed to reduce the risk of endemic and epidemic HAI's are in patient care and health care team member health activities.

These mechanisms include:

- Case findings and identification of demographically important HAI's, to provide surveillance data for the hospital
- Reporting of information about infections internally and, as indicated, to public health agencies.
- Implementation of strategies to prevent or reduce the risk of HAI's in patients, team members and visitors.
- Implementation of strategies to control outbreaks of HAI's when such are identified.

METHODOLOGY

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- A. Case findings and identification of demographically important HAI's provide surveillance data. Nosocomial infection data, using, as appropriate, rates stratified by infection risk or focused infection studies, are collected on an ongoing basis.
- B. In addition to the use of planned surveillance methods, special studies may be conducted that include:
- The investigation of clusters of infections above expected levels.
 - The investigation of single cases of unusual or epidemiologically significant HAI's
 - A focus on procedures with significant potential for HAI's, particularly when the procedure is new or substantially changed.
 - The comparison of a group of infected patients with an uninfected control group to detect statistically significant risk factors for which control measures can be developed.
- C. The Infection Control Manager or designee will conduct outbreak investigations whenever appropriate by following any or all of the below steps if indicated:
1. Verify the diagnosis and confirm possible outbreak
 2. Implement immediate control measures if needed
 3. Define the outbreak; refine as the outbreak investigation progresses
 4. Conduct case findings by making a line listing that may contain:
 - i. Name and Medical Record Number
 - ii. Age, sex, diagnosis
 - iii. Unit or location
 - iv. Date of Admission
 - v. Date of Symptom Onset
 - vi. Procedures
 - vii. Symptoms
 - viii. Positive Cultures and pertinent labs
 5. Form Outbreak Control Team, if preliminary assessment suggests actual outbreak. The team may include all or some of the following:
 - i. Infection Preventionist
 - ii. Infection Control Medical Staff Chairperson
 - iii. Microbiologist
 - iv. Lab Manager
 - v. Administrator on call
 - vi. Inyo County Health Officer
 - vii. Strategic Communications Specialist
 - viii. Administrative Assistant
 6. Hospital Incident Command Center will be followed as necessary.
 7. Evaluate control case (ex: any new cases)
 8. Communicate findings with leadership.
 9. Keep record of all data and communication.
 10. Contact CDC or other agencies for advice or assistance if deemed appropriate or necessary.
- D. Interventions to reduce infections risks other than those directly related to prevention of transmission may include the following strategies

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- The Surveillance function itself.
- Review positive microbiology/Lab results
- Institution of prevention and control measure as indicated (e.g. isolation, improved hand hygiene, active surveillance of cultures, and environmental cleaning)
- Perform Surveillance for healthcare –associated infection
 - Follow CDC National Healthcare Safety Network (NHSN) definitions
 - Prospective surveillance: Monitor patients during hospitalization and post discharge
 - Retrospective surveillance: Identify infections via chart reviews
- Monitored incidence of healthcare-associated device-related or procedure-related infections
 - Central catheter-associated bloodstream infections
 - Ventilator -associated events
 - Surgical site infections
 - Catheter-associated urinary tract infections
- Conduct periodic tracer activity
- Ensure compliance with The Joint Commission Critical Access Hospital requirements and the California Department of Public Health regulations.

- E. The assessment of reasons for infection rates not being reduced by surveillance alone and interventions undertaken to address problems in the following areas:
- Knowledge – innovative educational approaches beyond the routine or standard in services.
 - Behavior – activities by managers to change behavior.
 - Systems – such as staffing, sink number and placement, control of over-crowding, lack of proper equipment and supplies.

NOTE: NIHD is prepared to respond to an influx, or the risk of an influx, of infectious patients.
See *Infection Control: Northern Inyo Healthcare District Surge Plan*

POLICIES AND PROCEDURES

- A. Policies and procedures are based on recognized guidelines and applicable law and regulations. Policies and procedures address prevention and control mechanisms used in all patient care and service areas to prevent the transmission of infection among patients, team members, medical staff, contractors, volunteers and visitors; and also, address specific environmental issues.
- B. Policies and procedures address the following:
- Measures that is scientifically valid, applicable in all seeing, and practical to implement.
 - The relationship between team member activities and the infection prevention and control program.
 - Various methods used to reduce the risk of transmission of infection between or among team members and patients.
 - Appropriate patient care practices, sterilization, disinfection and antisepsis, and pertinent environmental controls.
 - Educational and consultative roles of the Infection Preventionist.

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- C. ~~All~~ Infection control policies and procedures will be reviewed/revised annually **or every three years** as needed by the Infection Preventionist Manager with approval of the **Clinical Consistency Oversight Committee (CCOC) and Infection Control Committee** ~~Infectious Control Medical Staff Chairperson~~ and prior to submission to the Medical Executive Committee.

REPORTING AND COMMUNICATION

- A. Information about infections is reported both internally and to public health agencies, providing clinical practitioners with valid epidemiological measures of the risk of infection in their patients. This will allow them to take action to reduce those risks and decrease infection rates.
- B. When the hospital becomes aware that it received a patient from another organization who has an infection requiring action and the infection was not communicated by the referring organization, the Infection Preventionist Manager will inform the referring organization. Upon discharge, the case manager and/or nurse caring for the patient will inform the accepting facility of any infections the patient may have, site treatment and any special precautions. If the patient is transferred to another facility and there are pending laboratory results the transfer form will be completed indicating “Pending Lab Culture and the ordering physician will be notified via telephone and fax with laboratory results. If the ordering physician is no longer caring for the patient, the ordering physician will inform the laboratory technician of the physician or facility caring for the patient.
- C. Donor/Tissue postoperative infections/complications identified through surveillance activities that are suspected of being directly related to the use of the tissue will be investigated promptly. Notification of the post-transplant infection or adverse event will be reported to the tissue supplier by the Infection Preventionist Managers as soon as the hospital becomes aware of the event.
- D. Infection Control committee meetings will be conducted not less than quarterly and more often as needed. Minutes will be recorded by the Medical Staff Office.
- E. Findings, quality assessment activities, performance improvement recommendations, actions and follow-up evaluations will be forwarded to Infection Control Committee members, other medical staff committees as appropriate, Medical Executive Committee and the Board of Directors.
- F. Review of infections-and surveillance data within the hospital will be completed quarterly through Infection Prevention Pillars and Infection Committee Database.

EDUCATION

- A. Education is conducted based on the employee’s job description and/or status with Northern Inyo Healthcare District. Education in infection control measures is conducted upon hire and annually.
- B. Infection Control Education is based upon:
- Ongoing review and analysis of HAI’s data and risk factors.
 - Notifications from the Inyo County Health Department, Centers for Disease Control and Prevention(CDC) and California State Department of Public Health (CDPH) regarding emerging issues, trends or communicable diseases.
 - Regulatory requirements. Refer to the *Senate Bill 158*, Attachment 1.

CONFIDENTIALITY

- A. NIHD has written policies and procedures related to the release of information which are intended to protect the privacy of patients. Confidentiality of infection control data and reports shall be in

**NORTHERN INYO HOSPITAL
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accordance with established hospital policy, Medical Staff Bylaws, state law and federal regulations and shall be maintained as “confidential and protected.”

- B. Members of the Medical Staff, clinical staff, appointed members of the organizational committee and project teams with delegated responsibilities for assessing and evaluating organizational performance improvement shall be granted authority to access health care records to perform quality review functions.

RESOURCES

1. There are multiple resources for information about infection prevention and control. Although not an exhaustive list, several professional associations and governmental websites are listed below. In addition, local and health state departments offer a wealth of information.

- Center for Disease Control and Prevention
www.cdc.gov
- HICPAC
Healthcare Infection Control Practices Advisory Committee
www.cdc.gov/ncidod/hip/HICPAC/factsheet.htm
- U.S. Department of Labor – Occupational Safety & Health Administration
www.osha.gov
- U.S. Food and Drug Administration
www.fda.gov
- American Public Health Association
www.apha.org
- American Society for Healthcare Engineering
www.ashe.org
- Association for Professionals in Infection Control, Inc.
www.apic.org
- The Society for Healthcare Epidemiology of America, Inc.
www.shea-online.org
- The Infectious Disease Society of America
www.idsociety.org
- International Sharps Injury Prevention Society (ISIPS)
<http://www.isips.org/>
- World Health Organization (WHO)
<http://www.who.int/en/>

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- Occupational Health and Safety Administration
<https://www.osha.gov/>

CROSS REFERENCE:

1. NIH Medical Staff Bylaws and Rules Amendment, (6/18/2003), Infection Control Committee p. 7 &8.
2. Infection Control: Northern Inyo Healthcare District Surge Plan
3. Scope of Service –Infection Prevention
4. Scope of Service Employee Health

REFERENCE:

1. All Facilities Letter 14-36 California Department of Public Health, 12/19/2014, Regarding SB 1311: Antimicrobial Stewardship Programs.
2. APIC - “Infection Prevention Program in Critical Access Hospitals” Teresa Fulton, RN, MSN, CIC, Chief Quality Officer, Whidbey General Hospital, 2013, http://www.apic.org/.../Day_1-_Infection_Prevention_for_CAH-_Web.pdf
3. APIC . (2016). Outbreaks and Infection Emergencies. Retrieved from https://www.cdph.ca.gov/programs/hai/Documents/15Outbreaks_Final051115.pdf
4. Centers for Disease Control and Prevention. (2016). Infection Control in Health Care Facilities. Retrieved from <https://www.cdc.gov/flu/professionals/infectioncontrol/>
5. Centers for Disease Control and Prevention. (2017). Infection Control Assessment Tools. Retrieved from <https://www.cdc.gov/hai/prevent/infection-control-assessment-tools.html>
6. Centers for Disease Control and Prevention. (2016). Infection Prevention and Control Assessment Tool for Acute Care Hospitals. Retrieved from <https://www.cdc.gov/infectioncontrol/pdf/icar/hospital.pdf>
7. Centers for Disease Control and Prevention. (2016). Principles of Epidemiology in Public Health Practice, Third Editions an Introduction to applied epidemiology and biostatistics Lesson 6: Investigating an outbreak. Retrieved from <https://www.cdc.gov/ophss/csels/dsepd/ss1978/lesson6/section2.html>
8. *Senate Bill No. 158, Florez.* Sept. 25, 2008, *California*. Retrieved from https://www.cdph.ca.gov/services/boards/Documents/SB158chaptered09_25_08.pdf
9. The Joint Commission (January 2017) Critical Access Hospital: Infection Prevention and Control (IC) IC01.05.01.

Approval	Date
CCOC	03/26/2018
Infection Control Committee	6/3/19
MEC	6/10/19

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Title: Infection Prevention Plan*	
Scope: Hospital Wide	Manual: CPM - Infection Control- Patient Care (ICP)
Source: Quality Nurse/Infection Control Preventionist	Effective Date: 4/1/2015

Board of Directors	6/20/18
Last Board of Director Review	6/20/18

Developed: 2/13/99

Reviewed: 1/11

Revised: 6/03, 9/05, 1/08, 1/09, 1/10, 2/15, 4/17rc, 3/18rc

Replace: Goals of the Infection Control Program dated 2/22/2011
Infection Control Committee Responsibilities

Draft

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APPENDIX 1

Northern Inyo Healthcare District
Medical Staff Committee
Infection Control Committee
Per Bylaws amended 2/17/2016

Reports to: Medical Executive Committee

Chairperson: Member of the Medical Staff with CME in Infection surveillance, prevention and control

Membership: Two active Medical Staff members representing other services

- Nurse Manager Infection Prevention or other designee of the Director of Nursing
- Employee Health/Infection Prevention Specialist Nurse

Without vote:

- CEO or Designee
- Chief Performance Excellence Officer
- Inyo County Public Health Officer
- Coordinator Laboratory Microbiology
- Cardiopulmonary Director
- Environmental Services Manager
- Dietary
- Other departments as designated in the Bylaws

Convenes: Quarterly

PURPOSE:

1. The Infection Control Committee selects, designs, evaluates, revises and approves the type and scope of surveillance activities.
2. Action to prevent or reduce the risk of HAI's in patients, team members and visitors will be initiated.
3. Action to control outbreaks of HAI's will be initiated as soon as identified.
4. Ongoing review and analysis of nosocomial infection data, risk factors, and, as needed, special studies that related to infection prevention and control will be conducted.
5. The Infection Control Committee members are responsible for bringing clinical, administrative and epidemiological expertise to the committee, participating in data evaluation and reviewing/approving infection control policies and procedures.

Dev. 11/2014, Revised 2/2015, 2/19 rc
Appendix 1: Reviewed 5/17 RC, 3/18 rc

**NORTHERN INYO HOSPITAL
POLICY AND PROCEDURE**

Title: Vendor Credentialing	
Scope:	Department: Purchasing
Source: Director of Purchasing	Effective Date:

Policy:

Northern Inyo Healthcare District credentials all vendors and representatives according to state and federal guidelines, and Joint Commission recommendations. Credentialing requirements promote patient health, safety, confidentiality, and conformance with regulatory guidelines for the District.

Definition(s)

Healthcare Industry Representatives (HCIR) are defined as individuals seeking access to a healthcare organization (HCO) and who are employed by a third party or are independent contractors. These individuals may or may not be seeking access to patient care and/or procedural areas within the organization. Examples of HCIR’s include, however are not limited to, clinical education specialist, supplier executive, construction worker, homecare provider, social services, delivery personnel, durable medical equipment staff, supplier sales representative, non-employee maintenance, biomedical technician, and contract labor.

Contracted Labor, Clinical and Collaborative Partners – described as contract employees/vendors that may provide direct patient care and/or services on behalf of an organization; typically, a contractual relationship exists between the HCO and the vendor/service provider. All non-clinical contract labor also falls within this category. Examples – patient care personnel can include, but are not limited to, nursing, therapy, pharmacy, dietary, activities staff, drug/alcohol counselors, patient care technicians

Requirements; credentialing for these individuals, as with all contracted vendors, should be addressed in Human Resources processes. Credentialing of these individuals is not within the scope of this document and the proposed recommendations outlined herein.

Referrals or Care Continuum HCIRs – individuals who primarily serve in a clinical support role and most often receive patients or provide equipment for patient use in the next site of care. Their role requires them to work in patient care areas and/or provide assistance to or consult with patient care staff. Examples may include, but are not limited to, assisted living, hospice, rehabilitation facilities’ staff, home care representatives, long-term care staff, etc.

- *Requirements*; required to meet specific requirements within their organizations equivalent to credentialing requirements. At a minimum these HCIRs would be required to wear a name tag identifying their company and personal name. Proof of credentialing and immunizations should be made available to the HCO upon request of the HCIRs’ employer within 24 hours.

Level I – HCIR Guests – individuals who may seek access to an HCO’s facility, however do not have access to clinical areas, do not provide technical assistance, do not operate equipment, do not enter patient care areas and do not provide assistance or consult with patient care staff or clinicians. These may include company representatives that visit less than three times per year, are accompanied by a credentialed HCIR and are not entering patient care areas. May include, but are not limited to, delivery vendors, construction labor, non-clinical contract vendor, and vendor’s management or non-clinical implementation specialists. If guest is a frequent visitor to the HCO and is not a contracted or referral HCIR he or she should be elevated to a Level II. Level I HCIR should be accompanied in the facility.

Level II – Tech Support and Sales HCIR –Primarily serve in a technical support role or product and service sales role. They may provide technical assistance, assist with operation of equipment, and be in patient care environment that is not defined as restricted or sterile procedure area. Their role requires them to often work in patient care areas where other visitors may be present and/or provide assistance to or consult

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Scope:	Department: Purchasing
Source: Director of Purchasing	Effective Date:

with patient care staff. This also includes vendor and supplier sales representatives that interact with care providers for the purpose of sales, education, and technical support. Examples may include, but are not limited to, durable medical equipment providers, medical device sales and pharmacy representatives, representatives calling on departments such as laboratory and radiology, as well as diagnostic representatives.

Level III – Clinical Support and Sales HCIR – Individuals who serve primarily in a clinical support or product sales/service role while attending or observing patient procedures (including sterile or restricted areas). Often provide technical information and serve as a resource for the medical professional, by responding to questions regarding the appropriate operation of the medical equipment. **These representatives may not scrub in on a procedure, touch patients, or operate, control or touch any equipment being used on a patient, except at the request of the attending physician, and for the sole purpose of ensuring patient safety. They may troubleshoot and offer technical assistance; calibrate or program equipment; and provide other technical support needed to ensure that the respective equipment functions safely.**

Requirements:

The following chart outlines the credentialing requirements managed within the supplier representative registration system (excluded activities managed with HCO’s security and HR systems):

Administrative Credentials	Levels		
	III	II	I
HCO Name Tag; name tag produced by an automated vendor credentialing system or the HCO or equivalent as determined by HCO	X	X	X
Employment Verification: memo or letter on the supplier’s letterhead will serve as acceptable documentation	X	X	
Proof of Liability Insurance: A general Acord Certificate of Liability Insurance or letter of attestation on HCIR’s company’s letterhead as evidence that the company maintains insurance necessary to protect itself, its employees, directors and officers from liability in acceptable forms and limits. This document should not specify a certificate holder (e.g., healthcare system or customer name). Specifically, the vendor will maintain commercial general liability in minimum amounts of One Million Dollars (\$1,000,000) per occurrence and Three Million Dollars (\$3,000,000) in the annual aggregate. The vendor will notify the customer within ten (10) days of any substantial reduction, cancellation or termination of any insurance coverage. The vendor will provide evidence of insurance coverage	X	X	

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Title: Vendor Credentialing	
Scope:	Department: Purchasing
Source: Director of Purchasing	Effective Date:

Administrative Credentials (cont)	Levels		
	III	II	I
Proof of Criminal Background Check	X	X	
Code of Ethics and Professional Conduct Policy	X	X	
Corporate Policy Manual	X	X	
Employee Awareness and Understanding of False Claims	X	X	
Vendor Privacy Form -	X	X	
Sanctions Checklist: Including OFAC (terrorism), GSA (failed contracts) , OIG (Medicare/aid), DEA (drug enforcement), FDA (food/drug), TRICARE, PHS (public health) Federal Register, State	X	X	X

Training Credentials	Levels		
	III	II	I
Vendor Orientation Manual	X	X	
Operating Room Protocols (Sterile/Aseptic Controls)	X		
HIPAA Training	X	X	
Product Training/Competency & Medical Device Reporting (MDR) Requirements Training (as applicable) per FDA guidelines	X	X	
Ethics/Conduct Policy and Procedure	X	X	
HCO Specific Policies: organization specific policies that are relevant to all HCIR's may be placed in the credentialing system for the HCIRs to indicate they have read the documents (policy content required to be known by the HCIR may be placed in the Vendor Orientation manual)	X	X	
Hand Hygiene	X	X	X
Infection Control Reference Guide	X	X	
Bloodborne Pathogens	X	X	

Immunization Credentials	Levels		
	III	II	I
Tuberculosis Testing per CDC Guidelines	X	X	
Influenza Immunization following NIHD Policy and Procedure	X	X	X
MMR	X	X	
Hepatitis B	X	X	

Enforcement:

Northern Inyo Healthcare District, the HCIR, and their employer have a responsibility to enforce requirements and practices that are in the best interest of the patients and the organization. Clear and effective communication and corrective escalation processes should be articulated within the HCO and with the HCIR's employer to facilitate rapid resolution of any violations or issues that may need to be addressed by any of the parties. Infractions will be classified as follows (dependent on severity NIHD reserves the right to move directly to actions outlined in Type 3 Infraction):

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Title: Vendor Credentialing	
Scope:	Department: Purchasing
Source: Director of Purchasing	Effective Date:

1. **Type 1 Infraction** – non-compliance with requirement or violation of a requirement; action will be direct communication with the HCIR and written communication to his or her manager.
2. **Type 2 Infraction** – non-compliance or violation has not been resolved, and additional violation has occurred; or patient safety and/or confidentiality have been compromised; action will be written notification to the HCIR and his or her manager, as well as potential suspension dependent on the nature of the seriousness of the violation or non-compliance.
3. **Type 3 Infraction** - Situation has not been rectified, there has been a repeated violation subsequent to a second notice, or business operations, patient safety, and/or confidentiality have been severely compromised/impacted; action will be written notice to the HCIR, his or her manager and the employer that the HCIR is suspended from access to the facility until appropriate resolution of the infraction(s) or the HCIR’s employer and the HCO can come to a resolution of the situation. Departments will be notified if a respective HCIR is no longer permitted in the facility.

In all instances, the HCIR employer should take responsibility for assuring continuity and quality of service and patient care safety in the event an HCIR is unable to perform their duties.

References:

1. Joint Commission standards
 - a. EC.02.01.01
 - b. RI.01.01.01
 - c. IC.02.01.01
 - d. LC.02.02.05, EPs 1, 3, 4

Committee Approval	Date
CCOC	4/8/19
Infection Control Committee	6/3/19
Executive Team	
Compliance and Business Ethics Committee	4/29/19
Medical Executive Committee	6/10/19
Board of Directors	
Last Board of Directors Review	

Responsibility for review and maintenance: Director, Materials Management

Index Listings:

Developed: 04/2018nl

Revised: 2/2019pd

Reviewed:

**NORTHERN INYO HOSPITAL
POLICY AND PROCEDURE**

Title: Aerosolized Transmissible Disease Exposure Plan/Respiratory Protection Program*	
Scope: Hospital Wide	Manual: CPM - Infection Control- Patient Care (ICP)
Source: Quality Nurse/Infection Control Preventionist	Effective Date: 11/14/17

PURPOSE:

Title 8, California Code of Regulations, General Industry Safety Orders, Section 5199 (CCR, GSO, Title 8, 5199) requires that employers' procedures for complying with the regulation be documented in writing and made available to all employees for review and training.

PLAN:

Northern Inyo Healthcare District (NIHD) will provide a safe and healthy workplace environment by implementing an effective Aerosolized Transmissible Diseases (ATD) Exposure Control Plan. This ATD Exposure plan applies to the control of exposures to ATD's for high risk employees that may have a potential to an ATD exposure due to work environment and job tasks. This plan focuses on safe work practices, personal protective equipment (PPE), engineering and administrative controls, and vaccinations of employees.

OVERVIEW:

The goal of the respiratory protection program for Aerosolized Transmissible Disease (ATD) is to eliminate or minimize health care worker (HCW) exposure to any respiratory aerosol transmissible diseases, which are particles of respiratory secretions from the nose or mouth. Some diseases that are transmitted by respiratory aerosols may or may not manifest primarily with respiratory symptoms. Although there are many infectious diseases that may be transmitted by respiratory aerosols, this standard is meant to address diseases that cause significant morbidity and mortality and represent a significant threat to HCWs and to the health of the community. Examples of diseases in this category include:

- Pandemic Influenza
- Tuberculosis
- Pneumonic Plague
- Severe Acute Respiratory Syndrome (SARS)
- Middle East Respiratory Syndrome (MERS)
- Smallpox
- New diseases (novel) or syndromes not previously recognized
- Measles
- Chicken Pox

POLICY:

Northern Inyo Hospital will establish, implement, and maintain an effective, written ATD Exposure Control Plan as specified by Cal/OSHA's State Standard, Title 8, and Chapter 4. This plan will be followed by all Northern Inyo Healthcare District HCWs and others working within this facility who may be potentially exposed to respiratory aerosol transmissible [disease](#)

AEROSOLIZED TRANSMISSIBLE DISEASES EXPOSURE CONTROL PLAN:

The Infection Preventionist will be responsible for administering this plan and maintenance of infection control procedures to control the risk of transmission of ATDs. The Employee Health Nurse and the Infection Preventionist will do this with the collaboration of Directors of Maintenance, Nursing, Environmental Services [Manager](#), [Director of Cardiopulmonary](#), [Director of Diagnostic Services](#) and Safety. The plan will be reviewed annually by the program administrator, and by employees in their respective work areas. The changes and review will be documented. [The Medical Laboratory Director will review annually the Biosafety Plan and potential Aerosolized Transmissible Disease organisms.](#)

**NORTHERN INYO HOSPITAL
POLICY AND PROCEDURE**

Title: Aerosolized Transmissible Disease Exposure Plan/Respiratory Protection Program*	
Scope: Hospital Wide	Manual: CPM - Infection Control- Patient Care (ICP)
Source: Quality Nurse/Infection Control Preventionist	Effective Date: 11/14/17

EXPOSURE RISK PERSONNEL THAT REQUIRE FIT TESTING

1. Admission Services (Outpatient Clerks, e.g. ED, RHC) Exceptions: Admission Services Director; Insurance Verifier; Radiology Clerks	8. Pharmacy (In case of a surge; pharmacy staff normally doesn't have direct patient care)
2. Nursing Department (RNs, LVNs, CNAs, Medical Office Assistants) Case Managers- RNs	9. Rehabilitation Department
3. Environmental Services	10. Cardiopulmonary
4. Physicians	11. Radiology Department
5. Laboratory Clinical Staff	12. Security
6. Language Services- Director and Interpreters	13. Social Services
7. Maintenance/Plant Operations	14. Students (if there is potential for patient contact)

FIT Test (N95 mask/PAPR) COMPLIANCE:

- Fit testing will be completed annually and within three weeks of hire.
- Annual fit testing will be completed during the months that the department is assigned. The employee will be re-fit tested during their assigned month; example ICU nurse gets hired in January he/she will be fit tested within three weeks of hire and re-fit tested again in April.
- Failure to be fit tested by the last day of your departments assigned month will result in the inability to work the first day of the following month until you have been fit tested.
- Employees that are on leave of absence during the month of their scheduled department fit testing must be completed within five days of their return to work.
- Notification of annual department fit testing will occur a month prior via email.

DEFINITIONS: See Attachments

HIGH HAZARD PROCEDURES:

On patients suspected or known to be infected with an illness or pathogen requiring Airborne Precautions, the following procedures are considered high hazard procedures for risk of exposure to Aerosolized Transmissible Disease, requiring the use of Personal Protective Equipment (PPE) during the procedure. At minimum an N-95/Purified Air Powered Respirator (PAPR) and eye protection is indicated. Staff is expected to follow recommendations for additional PPE as indicated for specific disease processes under transmission-based precautions this list includes, but is not limited to:

1. Sputum Induction/collection
2. Open suctioning of airways
3. Endotracheal intubation and extubation
4. Bronchoscopy
5. Aerosolized administration of medications when patient is in Droplet or Airborne Isolation
6. Cardiopulmonary resuscitation
7. Laboratory procedures that may aerosolize pathogens
8. Obtaining a nasal swab or throat culture

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NOTE: NIHD has PAPRs available - see policy for use and maintenance.

Bronchoscopy and other similar high hazard procedures will be done in an AII room or area. Lesser procedures, like obtaining a nasal swab will be done with a minimally a surgical mask or N-95 mask if atypical respiratory illness such as novel avian flu is suspected, face shield, gloves must be worn. A gown is donned if patient unable has poor respiratory etiquette and/or poor hand hygiene. Persons not performing the procedures are to be excluded from the area.

Exception: Where no AIIR or area is available and the treating physician determines that it would be detrimental to the patient's condition to delay performing the procedure, high hazard procedures may be conducted in other areas. In that case, employees working in the room or area where the procedure is performed shall use respiratory protection and shall use all necessary personal protective equipment

EMPLOYEE IMMUNIZATIONS:

NIHD will comply with the "Mandatory Vaccination Recommendations for Susceptible Health Care Workers" as listed in Appendix below of the Cal/OSHA ATD Standard. Employee Health, during the pre-employment physical process, obtains titers for the illnesses listed below- if the prospective employee does not have documented proof of the vaccinations. Vaccinations are provided free of charge when necessary for negative titers. Declinations must be signed by the HCW in lieu of the vaccination after education on the vaccine and NIHD's commitment to safety for the patients, the employee, and his or her family.

Appendix: Aerosol Transmissible Disease Vaccination Recommendations for Susceptible Health Care Workers (Mandatory)

Vaccine	Schedule
Influenza	One dose annually
Measles	Two doses
Mumps	Two doses
Rubella	One dose
Tetanus, Diphtheria, and Acellular Pertussis (Tdap)	One dose, booster as recommended
Varicella-zoster (VZV)	Two doses or lab evidence of immunity

Source: California Department of Public Health, Immunization Branch. Immunity should be determined in consultation with *Epidemiology and Prevention of Vaccine-Preventable Diseases 13th edition or later by the Centers for Disease Control and Prevention*

WORK PRACTICE CONTROLS:

SOURCE CONTROL MEASURES: Measures to prevent patients, staff, or visitors from spreading illness inside of the hospital.

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On Arrival to the Hospital:

1. Hand hygiene stations and Respiratory Hygiene/Cough Etiquette are at every entrance to the hospital with signs encouraging their use.
 2. If indicated, warning/education signs may also be placed at entrances explaining any special concerns or limitations regarding entrance to the hospital e.g. with outbreak of influenza.
 3. Patients, visitors, and caregivers will be instructed on Respiratory Hygiene/ Cough Etiquette measures by the hospital staff, with easy access to all the necessary sanitation supplies.
 - a. Cover mouth and nose for coughs and sneezes with Kleenex, linen, or elbow.
 - b. To use the available surgical masks as soon as possible if actively coughing.
 - c. To perform hand hygiene frequently and after handling their secretions.
 - d. To dispose of contaminated tissues, napkins, linens into “no-touch” receptacles.
 4. Entry may be denied to visitors if they already know they have suspected or confirmed influenza, another known serious respiratory illness, tuberculosis, and/or possibly others on a case by case basis.
 5. Elective procedures may also be postponed for patients with suspected or confirmed influenza until they are no longer infectious.
- 5-6. NIHD prohibits misters for human comfort (eg. Patio misters) anywhere on the campus this includes employee break areas.

On arrival to the Emergency Department (ED) Area:

1. Same entry procedures as above. Hand hygiene station is at the Emergency Department entrance.
2. The Emergency Department personnel may have the patients mask immediately if the complaint is an Influenza-like-Illness (ILI) or cough.
3. A separate waiting room was developed so that those with ILI can potentially be segregated from those without.
4. ILI patients are isolated to an Emergency Department single room or kept masked and physically located ≥ 3 feet from other patients. Friends and family are instructed in the use of surgical masks and any other necessary PPE being used. They are encouraged to follow instructions and to ask for clarification, so that they have the understanding of why the isolation procedures are used.
5. Appropriate isolation signage will be posted outside the room visible to hospital staff and visitors

On Arrival to Another Hospital Unit:

1. Same entry procedures as above with access to hand hygiene stations and necessary sanitation supplies.
2. Notify the Infection Control Nurse, via House Supervisor 12-hour shift report of all patients admitted with suspected airborne illnesses.
3. Sever Acute Respiratory Syndrome has its own assessment/screening form that is found on the hospital Intranet.
4. Source patients from any department, including the Emergency Department, are put into single rooms when available and the door is closed. Airborne precautions will be initiated, when appropriate. Visitors are instructed in the use of PPE and restricted to those most crucial to the patient’s well-being.

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Room Placement:

Airborne infection isolation rooms units will be used for patients who are suspected of having airborne transmissible disease, e.g. TB, SARS, Smallpox, Avian Flu, and Pneumonic Plague. Airborne isolation rooms are private rooms that have monitored negative air pressure in relation to the exterior surrounding areas, so that air does not come out from under the door because the pressure outside the door is > than inside the room. See the section under *Engineering Controls* related to Air Exchanges per hour and other specifics. Our current best options for any patient include:

- Option 1: Room 5 on the Acute/Subacute and ICU RM 1, ~~and Infusion Room 6 unit is an Airborne Infection Isolation room, vented to the outside with filters and an antechamber.~~
- Option 2: If no Airborne Infection Isolation Room available put patient in surgical mask, use Hospi-gard Portable Filtration Unit, keep door closed, ~~and~~ staff and visitors to wear a N95 or PAPR

Source Patient Control:

1. The patient will remain in the room, unless transport is necessary for a diagnostic procedure. The patient will be kept masked with a surgical mask and the transport team will wear a fit-tested N-95 mask.
2. Information about patients who have or may have an ATD is shared with appropriate personnel before transferring or transporting the patient to other departments or other facilities using SBAR/Ticket to Ride or Handoff report.
3. Personal Protective Equipment and Isolation Precautions implemented by staff may be discontinued based on documented, negative laboratory studies. This should be decided with input from any one or more of the following: Infection Preventionist or designee, Infection Control Medical Staff Chairperson, the unit's Nursing Director manager and the patient's physician, Inyo County Health Officer, or California State Health Department official.
4. Visitors should be limited to only family or friends crucial to the patient's well-being.
5. Patient care equipment:
 - a. Equipment (e.g. designated computer, vital sign equipment, stethoscopes, and commodes) should be kept in the patient's room. Use disposable equipment as much as possible.
 - b. Any reusable equipment has to be cleaned per hospital protocol before re-use.
6. Linens, waste, and room cleaning as per policy under Contact Precautions.

Precautions Required for SARS, Avian, And Other Serious Airborne Illnesses:

1. Standard
2. Airborne and Droplet
3. Contact

PPE Required When Entering an Airborne Isolation Room:

1. Fit-tested N-95 Mask or PAPR
2. Face shields or Eye Protectors
3. Disposable Gowns: For substantial contact with the patient or environmental surfaces.
4. Gloves

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Reporting the Illness:

Report all airborne illnesses to the county. The Confidential Morbidity Report form is on the NIH Intranet. The back of the form tells you by which method and how quickly to report each reportable illness. For example, with SARS you are to call the county health department immediately.

Procedure If NIH Has Insufficient Isolation Rooms:

If the patient needs an airborne isolation room and there is not one available, the patient should be a transfer to another facility in a timely manner.

1. Transfers to other facilities: Transfer should occur within **5** hours of identification, unless the-physician documents, at the end of the 5-hour period, and at least every 24 hours thereafter, one of the following:
 - a. The Physician, Infection Preventionist, ~~or~~ House Supervisor, Administrator On Call (AOC) or designee has contacted the local health officer.
 - b. There is no room or area available within that jurisdiction.
 - c. Reasonable efforts have been made to contact establishments outside of that jurisdiction.
 - d. Applicable measures recommended by the local health officer and the Physician or other licensed health care professional

Exception to above: The patient need not be transferred if the treating physician determines that the transfer would be detrimental to the patient’s condition. In that case, the employees will use all necessary respiratory protection when entering the patient’s room. The patient’s condition has to be reviewed at least every 24 hours. Once transfer is safe, then it should still occur in the timeframe above.

Employee Control Measures:

1. Keeping personnel at home while they are ill to reduce the risk of spreading influenza or other airborne illnesses is essential
2. Continuing monitoring of hand hygiene and PPE compliance.
3. Continue the yearly influenza vaccination policy. (Covered under Vaccination Section)
4. Monitor any employee with an airborne exposure. (Covered under Exposure Evaluation Section)
5. Annual education on Aerosolized Transmissible Disease for employees that have exposure risk.

PATIENT SCREENING: Patients will be screened during the triage period in the Emergency Department during the admission assessment for inpatients, as appropriate, to evaluate for any symptoms of Aerosolized Transmissible Disease infections.

1. For **tuberculosis** this would include:
 - a. Cough for more than 3 weeks not explained by non-infectious conditions
 - b. Hemoptysis
 - c. Unexplained significant weight loss
 - d. Fatigue
 - e. Night sweats
 - f. Known exposure to a TB patient
2. For **influenza-like illness (ILI)** signs and symptoms would include:
 - a. Fever > 100 F with cough and/or sore throat and headache;

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- b. Body aches, nasal congestion or discharge, chills and fatigue;
- c. Nausea, vomiting, diarrhea or other GI symptoms may also be present

- 3. For **SARS: Screening form on Hospital Intranet>Forms>Infection Control**
- 4. Patient statement that they have a transmissible respiratory disease, excluding the ~~common cold~~common cold.

CLEANING AND DISINFECTION:

- 1. Routine cleaning and disinfection strategies used during influenza season can be applied to the environmental management of Influenza
- 2. Dedicated disposable equipment is to be used whenever possible.
- 3. Non-disposable equipment is to be cleaned and disinfected according to established agency policies - "Infectious and Noninfectious Waste Disposal Procedure."
- 4. Management of laundry, utensils, and medical waste should also be performed in accordance with procedures followed for seasonal influenza.

PERSONAL PROTECTIVE EQUIPMENT/RESPIRATORY PROTECTION

- 1. Adherence to Standard Precautions and Transmission Based Precautions, as appropriate for the patient's disease status, is mandatory for all NIHD employees and departments.
- 2. Droplet Precautions: Permit the use of surgical masks rather than respiratory protection, i.e., use of respirators. Recognizing that surgical masks do not provide protection against inhalation of airborne infectious aerosols, NIHD will allow health care personnel to use N-95 masks for contact with influenza patients should they prefer that level of protection.
- 3. Clinical staff who are assigned to patients with suspected or confirmed infectious Pulmonary TB, or other aerosol transmissible disease requiring use of respirator will be provided and fitted with a National Institute for Occupational Safety and Health approved (at least N95) Respirator Mask for individual, personal protection prior to providing care. Trained personnel will instruct the clinical staff members on proper respirator use and fit-check, in accordance with the manufacturer's instructions and guidelines.
 - a. ~~Instructions on putting on and taking off N-95 masks is also available on the hospital Intranet. The staff has been instructed to watch this video. Handouts detailing reuse procedure have also been made available.~~
 - b. Every attempt will be made to have an adequate supply of all types of N-95 masks we currently use for fit tests.
 - c. The standard is to use a mask if needed and discard it after- *not to re-use*. They should be discarded after each patient encounter. **EXCEPTION: During times of shortage NIHD will follow CDC current guidelines for extended and re-use of masks**
 - d. The Purchasing Department Manager is responsible for monitoring mask numbers and will work in conjunction with the Infection Preventionist, if a disaster and surge make mask availability an issue.
- 4. Clinical staff that cannot be adequately fitted with the National Institute for Occupational Safety and Health approved respirators will not be assigned to these patients, unless they have been trained to use the PAPR and a PAPR is available.
- 5. Personnel with histories of respiratory problems/compromise or those with known lack of immunity to the organism (e.g.: chickenpox) should not be assigned to these patients.

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6. Unprotected employees should be prevented from entering areas where aerosol generation procedures were performed until the required clearance time has elapsed.
7. When respirators are necessary to protect the HCW from other hazards, including the uncontrolled release of microbiological spores or exposure to chemical or radiologic agents, respirator selection shall be made in accordance with the anticipated risk.
8. In summary, NIHD provides, and ensures that employees use, a fit-tested N-95 respirator or PAPR when the employee:
 - a. Enters an Airborne infection isolation room or area or an Airborne infection isolation area in use for Airborne Infection Isolation;
 - b. Present during the performance of procedures or services for an Airborne infectious disease case or suspected case;
 - c. Takes part in aerosol generating procedures on patient suspected or known to be infected with an illness or pathogen requiring airborne precautions such as sputum induction, bronchoscopy, open suctioning, CPR, intubation or extubation Pulmonary function testing, collection of nasal pharyngeal lab specimens for RSV or Pertussis
 - d. Repairs, replaces, or maintains air systems or equipment that may contain or generate aerosolized pathogens;
 - e. Is working in an area occupied by an airborne infectious disease case or suspected case, during decontamination procedures after the person has left the area and as required.
 - f. Is performing a task for which the Biosafety Plan or Exposure Control Plan requires the use of respirators; or
 - g. Transports an Airborne infectious disease case or suspected case within the facility or in an enclosed vehicle (e.g., van, car, ambulance or Air transport when the patient is not masked).
9. Medical Evaluation for Fit Testing:
 - a. NIHD provides a medical evaluation by the Medical Director of the Respiratory Therapy Department. This is done to determine the employee’s ability to use a respirator before the employee is fit tested or required to use the respirator. This form is the OSHA approved form for respirator fit testing.
 - b. The employee’s supervisor provides the employee a copy of the Medical Evaluation Questionnaire. The questionnaire is confidential. A sealable envelope must be provided to the employee, in which to return the questionnaire.
 - c. After completion it is returned to the employee’s supervisor who forwards it to the head of the Respiratory Therapy Department, who then has the Medical Director review it for any problems or concerns.
 - d. The record is stored in the employee’s confidential employee health records.
 - e. After the medical evaluation, the employee can have the fit test scheduled.
10. Fit Testing: “N95 Mask Fit Testing Using the Portacount Pro Policy”
 - a. NIHD Cardiopulmonary RT staff performs quantitative fit tests. The fit tests are performed on the same size, make, model and style of respirator as the employee will use. When fit testing single use respirators, a new respirator shall be used for each employee.
 - b. The employer shall ensure that each employee who is assigned to use a filtering face piece or other tight-fitting respirator passes a fit test:
 1. At the time of initial fitting;
 2. When a different size, make, model or style of respirator is used; and

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3. At least annually thereafter.

- c. NIHD requires an additional fit test when the employee reports, or the employer, **physician or other licensed health care professional**, supervisor, or program administrator makes visual observations of changes in the employee's physical condition that could affect respirator fit. Such conditions include, but are not limited to, facial scarring, dental changes, cosmetic surgery, or an obvious change in body weight.
- d. If, after passing a fit test, the employee subsequently notifies the employer, program administrator, supervisor, or Physician or other licensed health care professional that the fit of the respirator is unacceptable, the employee shall be given a reasonable opportunity to select a different respirator face piece and to be retested.
- e. NIHD will ensure that each respirator user is provided with initial and annual training in accordance with Section 5144, Respiratory Protection of these orders.

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- 11. PAPR Orientation: Shall be provided for:
 - a. Staff who fails N-95 mask fit testing for whatever reason
 - b. High hazard procedures where it is the safer option.

MEDICAL SERVICES

- 1. NIHD provides any employee with *occupational exposure* medical services for tuberculosis and other ATDs, and infection with Aerosol transmissible pathogen and Aerosol transmissible pathogen -- laboratory, in accordance with applicable public health guidelines, for the type of work setting and disease. NIHD also acts as the evaluating health care professional through our Emergency Room. Following an exposure incident, the employee may request follow-up medical care from another health care provider. When this occurs, NIH will ensure that a medical follow-up is arranged from a Physician or other licensed health care professional other than through our Emergency Room.
- 2. Medical services, including vaccinations, tests, examinations, evaluations, determinations, procedures, and medical management and follow-up, shall be:
 - a. Performed by or under the supervision of the Emergency Room Physician or designee.
 - b. Provided according to applicable public health guidelines; and
 - c. Provided in a manner that ensures the confidentiality of employees and patients. Test results and other information regarding exposure incidents and TB conversions shall be provided without providing the name of the source individual.
- 3. For questions related to Tuberculosis refer to NIHD's Tuberculosis policies Aerosolized Transmissible Disease Exposure Plan/Respiratory Protection Program* and the Employee Tuberculosis Surveillance Program.
- 4. Unless it is determined that the TB test conversion is not occupational, the Infection Preventionist and the Employee Health nurse shall investigate the circumstances of the conversion, and correct any deficiencies found during the investigation.

Vaccinations:

- 1. Recommended vaccinations are made available to all employees who have occupational exposure during the pre-employment physical unless:
 - a. The employee has previously received the recommended vaccination(s) and is not due to receive another vaccination dose; or
 - b. It is determined that the employee is immune in accordance with applicable public health guidelines;
 - c. The vaccine(s) is contraindicated for medical reasons.

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2. Employee Health Nurse makes additional vaccine doses available to employees within 120 days of the issuance of new applicable public health guidelines recommending the additional dose as approved by NIHD in the vaccination policies.
3. Employee Health Nurse does not make participation in a prescreening serology program a prerequisite for receiving a vaccine, unless applicable public health guidelines recommend this prescreening prior to administration of the vaccine. However, titers are routinely tested at time of hire, with each new employee's consent, to determine eligibility for each indicated vaccine when the vaccination/immune status is not known.
4. If the employee initially declines a vaccination but at a later date, while still covered under the standard, decides to accept the vaccination, the employer shall make the vaccination available within 10 working days of receiving a written or verbal request from the employee.
5. Employee Health ensures that employees who decline to accept a recommended and offered vaccination sign the statement in 1 for each declined vaccine.
6. Employee Health requests the responsible Physician or other licensed health care professional or specific agency (when applicable, e.g.; travelers) administering a vaccination or determining immunity to provide only the following information to the employer:
 - a. The employee's name and employee identifier;
 - b. The date of the vaccine dose or determination of immunity;
 - c. Whether the employee is immune to the disease, and whether there are any specific restrictions on the employee's exposure or ability to receive vaccine;
 - d. (D)Whether an additional vaccination dose is required, and if so, the date the additional vaccination dose should be provided.
7. Employee Health makes available seasonal influenza vaccine to all NIHD employees. In times of shortage it is offered first to those with the most occupational exposure. Each employee who declines to accept the seasonal influenza vaccine signs a declination statement
 - a. EXCEPTION 1: Seasonal influenza vaccine shall be provided during the period designated by the CDC (Oct 1 through March 30)
 - b. For administration, and need not be provided outside of those periods.
 - c. EXCEPTION 2: In lieu of the statement in, the employer may utilize an influenza vaccine declination statement acceptable to the CDPH.

Exception for vaccine policies: When Employee Health cannot implement these procedures because of the lack of availability of vaccine, efforts made to obtain the vaccine in a timely manner and inform employees of the status of the vaccine availability, including when the vaccine is likely to become available will be documented. The employer shall check on the availability of the vaccine at least every 60 calendar days and inform employees when the vaccine becomes available.

EXPOSURE EVALUATION AND FOLLOW-UP

1. A health care provider or the employer of a health care provider who determines that a person (patient or NIHD employee) is a Reportable aerosol transmissible disease case or suspected case shall report, or ensure that the health care provider reports, the case to the local health officer, in accordance with Title 17. The official **CDPH Severe Influenza Case History Form (ICU and Fatal Cases Age 0-64 Years)** is located under NIHD Intranet> forms> Employee Health and Infection Prevention "Attachments" on the left sidebar and can be printed for use when appropriate.

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2. Any Healthcare worker who has unprotected direct contact with an airborne illness must report the exposure to Employee Health, or Infection Prevention Nurse as soon as possible, either directly or with the assistance of the unit manager or House supervisor. The Employee Health Nurse, Infection Preventionist, or House Supervisor will complete the form "HCW Contact with Case of an Aerosolized Transmissible Disease in conjunction with the exposed employee. It is critical it report exposures immediately when the source is a known life-threatening illness, such as SARS, Avian flu, Smallpox, etc.
3. An Exposure Incident: Significant exposure- exposure to a source of Aerosolized Transmissible Pathogens in which the circumstances make disease transmission sufficiently likely that the employee requires further evaluation by a physician or other physician or other licensed health care provider. The likelihood of transmission is determined by:
 - a. Exposure scenario including distance, time, PPE used
 - b. Specific pathogen
 - c. Infectivity of the source
 - d. Susceptibility of the host (vaccination status is one component)-
Refer for a medical evaluation if the susceptibility is unknown.
4. In addition to the report required, NIH's Infection Preventionist and/or Employee Health Nurse shall, to the extent that the information is available:
 - a. Decide what the affected employee needs to receive effective medical intervention to prevent disease or mitigate the disease course.
 - b. Instruct the HCW to monitor their temperature in the morning and the evening for at least 10 days
 - c. If a cough or fever develops; the HCW must seek medical evaluation immediately and notify the Infection Control nurse.
 - d. Assess whether employees in other agencies may be affected. There is an Aerosolized Transmissible Disease notification form to be filled out in the Emergency Department to help track employees outside of NIHD who may have been exposed.
 - e. Initiate a prompt investigation to identify exposed employees. In no case, shall the notification be longer than 72 hours after the report to the local health officer and/or public health department. The notification shall include the date, time, and nature of the potential exposure, and provide any other information that is necessary for the other employer(s) to evaluate the potential exposure of his or her employees. The notifying NIHD provider shall not reveal the identity of the source patient to the other employers.

NOTE 1: These potentially exposed employees may include, but are not limited to, paramedics, emergency medical technicians, emergency responders, home health care personnel, homeless shelter personnel, personnel at referring health care facilities or agencies, and corrections personnel.

NOTE 2: Some diseases, such as meningococcal disease, require prompt prophylaxis of exposed individuals to prevent disease. Some diseases, such as varicella, have a limited window in which to administer vaccine to non-immune contacts. Exposure to some diseases may create a need to temporarily remove an employee from certain duties during a potential period of communicability as determined by the local health officer for that jurisdiction of the potentially exposed employees. For other diseases such as tuberculosis there may not be a need for immediate medical intervention, however prompt follow up is important to the success of identifying exposed employees.

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5. When NIHD becomes aware that employees may have been exposed to a reportable aerosol transmissible disease case or suspected case, or to an exposure incident involving an Aerosol transmissible pathogen – laboratory shall do all of the following:
 - a. Within a timeframe that is reasonable for the specific disease, but in no case later than 72 hours following, as applicable, conduct an analysis of the exposure scenario to determine which employees had significant exposures. This analysis shall be conducted by the Infection Preventionist with assistance from Inyo County Health Department when indicated. This analysis will include the employee names and shall also record the basis for any determination that an employee need not be included in post-exposure follow-up because the employee did not have a significant exposure or because Employee Health or a Physician or other licensed health care professional determined that the employee is immune to the infection in accordance with applicable public health guidelines. The exposure analysis shall be made available to the local health officer upon request. The name of the person making the determination, and the identity of any Physician or other licensed health care professional or local health officer consulted in making the determination shall be recorded.
 - b. Within a timeframe that is reasonable for the specific disease, but in no case later than 96 hours of becoming aware of the potential exposure, notify employees who had significant exposures of the date, time, and nature of the exposure.
 - c. Provide post-exposure medical evaluation to all employees who had a significant exposure as soon as feasible. The evaluation shall be conducted by a Physician or other licensed health care professional knowledgeable about the specific disease, including appropriate vaccination, prophylaxis and treatment. For *M. tuberculosis*, and for other pathogens where recommended by applicable public health guidelines, this shall include testing of the isolate from the source individual or material for drug susceptibility, unless that it is not feasible.
 - d. Obtain from the Physician or other licensed health care professional or Inyo County Health Department a recommendation regarding precautionary removal as in a medical leave of absence following the exposure and a written opinion.
 - e. Determine to the extent that the information is available, whether employees of any other employers may have been exposed to the case or material.-NIHD shall notify these other employers within a time frame that is reasonable for the specific disease, but in no case later than 72 hours of becoming aware of the exposure incident of the nature, date, and time of the exposure, and shall provide the contact information for the local public health department. NIHD shall not provide the identity of the source patient to other employers.
6. Information provided to the Physician or Other Licensed Health Care Professional.
 - a. NIH will ensure that all Physicians or other licensed health care professional responsible for making determinations and performing procedures as part of the medical services program are provided a copy of this standard and applicable public health guideline. For respirator medical evaluations, the employer shall provide information regarding the type of respiratory protection used, a description of the work effort required, any special environmental conditions that exist (e.g., heat, confined space entry), additional requirements for protective clothing and equipment, and the duration and frequency of respirator use.
 - b. Each employer shall ensure that the Emergency Department physician or physician or other licensed health care professional who evaluates an employee after an exposure incident is provided the following information:
 - i. A description of the exposed employee's duties as they relate to the exposure incident;
 - ii. The circumstances under which the exposure incident occurred;

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- iii. Any available diagnostic test results, including drug susceptibility pattern or other information relating to the source of exposure that could assist in the medical management of the employee;
 - iv. All of the employer’s medical records for the employee that are relevant to the management of the employee, including tuberculin skin test results and other relevant tests for ATP infections, vaccination status, and determinations of immunity.
- 7. Precautionary removal recommendation from the emergency room physician, other physician or other licensed health care professional Inyo County Health Department, or NIHD’s Infection Control Committee Physician Director.
 - a. NIHD, when necessary, shall request from the above an opinion regarding whether precautionary removal from the employee’s regular assignment is necessary to prevent spread of the disease agent by the employee and what type of alternate work assignment may be provided. This recommendation will be documented in writing and provided to Human Resources and to the employee.
 - b. Where precautionary removal is recommended, NIHD shall maintain until the employee is determined to be noninfectious, the employee’s earnings, seniority, and all other employee rights and benefits, including the employee's right to his or her former job status, as if the employee had not been removed from his or her job or otherwise medically limited.

EXCEPTION: Precautionary removal provisions do not extend to any period of time during which the employee is unable to work for reasons other than precautionary removal.
- 8. Written opinion from the physician or other licensed health care professional.
 - a. NIHD will obtain, and provide the employee with a copy of, the written opinion within 15 working days of the completion of all medical evaluations required by this section.
 - b. For TB conversions and all Reportable aerosol transmissible disease and Aerosol transmissible pathogen – laboratory exposure incidents, the written opinion shall be limited to the following information:
 - i. The employee's TB test status or applicable Reportable aerosol transmissible disease test status for the exposure of concern;
 - i. The employee's infectivity status;
 - ii. A statement that the employee has been informed of the results of the medical evaluation and has been offered any applicable vaccinations, prophylaxis, or treatment;
 - iii. A statement that the employee has been told about any medical conditions resulting from exposure to TB, other Reportable aerosol transmissible disease, or Aerosol transmissible pathogen – laboratory that require further evaluation or treatment and that the employee has been informed of treatment options; and
 - iv. Any recommendations for precautionary removal from the employee’s regular assignment.
 - c. All other findings or diagnoses shall remain confidential and shall not be included in the written report.

TRAINING:

- 1. NIHD will provide that all employees, with occupational exposure, participate in training program.
- 2. The Aerosolized Transmissible Disease training will occur as stated below:
 - a. At the time of initial assignment to tasks where occupational exposure may take place;
 - b. At least annually thereafter, not to exceed 12 months from the previous training;

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- c. For employees who have received training on aerosol transmissible diseases in the year preceding the effective date of the standard, only training with respect to the provisions of the standard that were not included previously need to be provided.
- d. When changes, such as introduction of new engineering or work practice controls, modification of tasks or procedures or institution of new tasks or procedures, affect the employee's occupational exposure or control measures. The additional training may be limited to addressing the new exposures or control measures.
- 3. Training material appropriate in content and vocabulary to the educational level, literacy, and language of employees shall be used.
- 4. The training program shall contain at a minimum the following elements:
 - a. An accessible copy of the regulatory text of this standard and an explanation of its contents.
 - b. A general explanation of Aerosolized Transmissible Diseases including the signs and symptoms of that require further medical evaluation.
 - c. An explanation of the modes of transmission of Aerosol transmissible pathogen – or Aerosol transmissible pathogen – laboratory and applicable source control procedures.
 - d. An explanation of the employer's ATD Exposure Control Plan and/or Respiratory Protection Program and Biosafety Plan, and the means by which the employee can obtain a copy of the written plan and how they can provide input as to its effectiveness.
 - e. An explanation of the appropriate methods for recognizing tasks and other activities that may expose the employee to Aerosol transmissible pathogen or Aerosol transmissible pathogen – laboratory
 - f. An explanation of the use and limitations of methods that will prevent or reduce exposure to Aerosol transmissible pathogen or Aerosol transmissible pathogen laboratory including appropriate engineering and work practice controls, decontamination and disinfection procedures, and personal and respiratory protective equipment.
 - g. An explanation of the basis for selection of personal protective equipment, its uses and limitations, and the types, proper use, location, removal, handling, cleaning, decontamination and disposal of the items of personal protective equipment employees will use.
 - h. A description of the employer's TB surveillance procedures, including the information that persons who are immune-compromised may have a false negative test for Latent TB infection
 - i. Training meeting the annual requirements for employees whose assignment includes the use of a respirator.
 - j. Information on the vaccines made available by Employee Health, including information on their efficacy, safety, method of administration, the benefits of being vaccinated, and that the vaccine and vaccination will be offered free of charge.
 - k. An explanation of the procedure to follow if an exposure incident occurs, including the method of reporting the incident, the medical follow-up that will be made available, and post-exposure evaluation.
 - l. Information on the employer's surge plan as it pertains to the duties that employees will perform. As applicable, this training shall cover the plan for surge receiving and treatment of patients, patient isolation procedures, surge procedures for handling of specimens, including specimens from persons who may have been contaminated as the result of a release of a biological agent, how to access supplies needed for the response including personal protective equipment and respirators, decontamination facilities and procedures, and how to coordinate with emergency response personnel from other agencies.

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5. Every training program shall include an opportunity for interactive questions and answers with a person who is knowledgeable in the subject matter of the training as it relates to the workplace that the training addresses and who is also knowledgeable in the employer's ATD exposure control Respiratory Protection Program and Biosafety plan. Training not given in person fulfills all the subject matter required and allows for interactive questions to be answered within 24 hours by a knowledgeable person as described above.

ENGINEERING CONTROLS

1. Specific requirements for Airborne Infection Isolation Rooms and areas. Hospital isolation rooms constructed in conformance with Title 24, California Code of Regulations, Section 417, et seq., and which are maintained to meet those requirements.
2. Negative pressure shall be maintained in Airborne Infection Isolation Rooms or areas. The ventilation rate shall be 12 or more air changes per hour (ACH). The required ventilation rate may be achieved in part by using in-room high efficiency particulate air (HEPA) filtration or other air cleaning technologies, but in no case shall the outdoor air supply ventilation rate be less than six ACH. Hoods, booths, tents and other local exhaust control measures shall comply with Guidelines for Preventing the Transmission of *Mycobacterium tuberculosis* in Health-Care Settings.
- ~~3. Negative pressure is demonstrated by smoke trails or equally effective means daily while a patient is in Infusion Room 6 Refer to Airborne Infection Isolation Rooms (AIIR) policy.~~
4. Engineering controls shall be maintained, inspected and performance monitored for exhaust or recirculation filter loading and leakage at least annually, whenever filters are changed, and more often if necessary to maintain effectiveness. NIHD's maintenance department does check at least quarterly. NIHD Plant Maintenance has an aggressive filter checking program that is managed with a software program for this purpose. If a problem(s) prevent the room from providing effective AII, then the room shall not be used for that purpose until the condition is corrected.
5. Ventilation systems for AII rooms or areas shall be constructed, installed, inspected, operated, tested, and maintained in accordance with Section 5143, General Requirements of Mechanical Ventilation Systems, of these orders. Inspections, testing and maintenance shall be documented in writing.
6. Air from Airborne Infection Isolation Rooms or areas, and areas that are connected via plenums or other shared air spaces shall be exhausted directly outside, away from intake vents, employees, and the general public. Air that cannot be exhausted in such a manner or that must be recirculated must pass through HEPA filters before discharge or recirculation.
7. Ducts carrying air that may reasonably be anticipated to contain aerosolized *M. tuberculosis* or other airborne infectious pathogen shall be maintained under negative pressure for their entire length before in-duct HEPA filtration or until the ducts exit the building for discharge.
8. Doors and windows of Airborne Infection Isolation Rooms or areas shall be kept closed while in use for airborne infection isolation, except when doors are opened for entering or exiting.
9. When a case or suspected case vacates an Airborne Infection Isolation Rooms or area, the room or area shall be ventilated according to Table 1 in the Guidelines for Preventing the Transmission of *Mycobacterium tuberculosis* in Health-Care Settings for a removal efficiency of 99.9 % before permitting employees to enter without respiratory protection.

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TABLE 1 Air Exchange Within NIHD Departments:

Department Name	Air exchange per Hour (ACH)	Minutes Required for Removal efficiency †	
		99%	99.9%
Emergency Department	6 ACH	46	69
Emergency Department Triage	12 ACH	23	35
Med-Surg Non AIIR	6 ACH	46	69
ICU Non AIIR	6 ACH	46	69
OB	6 ACH	46	69
Pre-op/PACU	6 ACH	46	69
OR	25 ACH	14	21
Outpatient Infusion Clinics	2	138	207

* This table can be used to estimate the time necessary to clear the air of airborne *Mycobacterium tuberculosis* after the source patient leaves the area or when aerosol-producing procedures are complete.

† Time in minutes to reduce the airborne concentration by 99% or 99.9%.

LABORATORIES

1. The biological safety officer at NIHD is the Medical Director of Laboratory Services.
2. The biological safety officer performs a risk assessment in accordance with accepted methodology for each agent and procedure involving the handling of aerosolized transmissible disease pathogens in the lab Aerosol transmissible pathogen laboratory
3. Our laboratory has feasible engineering and work practice controls, in accordance with the risk assessment to minimize the employee exposures to Aerosol transmissible pathogen – laboratory. If exposure still remains after the institution of engineering and work practice controls, then the employees will use the appropriate PPE when and where necessary.
4. Biosafety Plan: Titled Chemical Hygiene Plan: The employer shall establish, implement, and maintain an effective written Biosafety Plan to minimize employee exposures to Aerosol transmissible pathogen – laboratory that may be transmitted by laboratory aerosols. The Biosafety Plan is kept in the laboratory’s safety manual and includes the following:
 - a. Identifies a biological safety officer(s) with the necessary knowledge, authority and responsibility for implementing the Biosafety Plan
 - b. Establishes safe handling procedures and prohibit practices, such as sniffing *in vitro* cultures that may increase employee exposure to infectious agents.
 - c. Identifies any operations or conditions in which respiratory protection will be required.
 - d. Establishes emergency procedures for uncontrolled releases within the laboratory facility and untreated releases outside the laboratory facility. These procedures shall include effective means of reporting such incidents to the local health officer.
 - e. Includes procedures for communication of hazards and employee training. This shall include training in the Biosafety Plan and emergency procedures.

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- f. Includes an effective procedure for obtaining the active involvement of employees in reviewing and updating the Biosafety Plan with respect to the procedures performed by employees in their respective work areas or departments on an annual (or more frequent) basis.
 - g. Includes procedures for the biological safety officer(s) to review plans for facility design and construction that will affect the control measures for Aerosol transmissible pathogen – laboratory.
 - h. Includes procedures for inspection of laboratory facilities, including an audit of Biosafety procedures. These inspections shall be performed at least annually. Hazards found during the inspection, and actions taken to correct hazards, shall be recorded.
5. Recordkeeping will be done by the biological safety officer.

SURGE PROCEDURES

- 1. In the event of a surge of patients due to infectious disease, NIHD staff will follow established policies for Disaster Preparedness.
- 2. NIHD will participate in a multi-agency management plan, and will be directed by the Incident Command System and the county Emergency Operations Center.
- 3. Respiratory and personal protective equipment may be stockpiled and distributed by the Inyo County Health Department for use during a public health surge.

RECORDKEEPING

- 1. Medical records.
 - a. Employers are responsible for recording cases of Aerosolized Transmissible Diseases for occupational exposures, and if it involves days away from work and/or medical treatment. This record may not be combined with non-medical personnel records.
 - b. This record shall include:
 - i. The employee’s name and any other employee identifier used in the workplace;
 - ii. The employee’s vaccination status for all vaccines required by this standard, including the information provided by Employee Health, any vaccine record provided by the employee, and any signed declination forms;
- EXCEPTION: As to seasonal influenza vaccine, the medical record need only contain a declination form for the most recent seasonal influenza vaccine.
- iii. A copy of all written opinions provided by a Physician or other licensed health care professional in accordance with this standard, and the results of all TB assessments; and
 - iv. A copy of the information regarding an exposure incident that was provided to the Physician or other licensed health care.
- c. Confidentiality. The employer shall ensure that all employee medical records required by this section are:
 - i. Kept confidential; and
 - ii. Not disclosed or reported without the employee’s express written consent to any person within or outside the workplace except as permitted by this section or as may be required by law.

NOTE: These provisions do not apply to records that do not contain individually identifiable medical information, or from which individually identifiable medical information has been removed.

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- d. The employer shall maintain the medical records required by this section for at least the duration of employment plus 30 years in accordance with Section 3204, Access to Employee Exposure and Medical Records, of these orders.
- 2. Training records.
 - a. Training records shall include the following information:
 - i. The date(s) of the training session(s);
 - ii. The contents or a summary of the training session(s);
 - iii. The names and qualifications of persons conducting the training or who are designated to respond to interactive questions; and
 - iv. The names and job titles of all persons attending the training sessions.
 - b. Training records shall be maintained for 3 years from the date on which the training occurred.
- 1. Records of implementation of Aerosolized Transmissible Disease Plan and/or Biosafety Plan.
 - a. Records of annual review of the ATD Plan and Respiratory Protection Program Biosafety Plan shall include the name(s) of the person conducting the review, the dates the review was conducted and completed, the name(s) and work area(s) of employees involved, and a summary of the conclusions. The record shall be retained for three years.
 - b. Records of exposure incidents shall be retained and made available as employee exposure records in accordance with Section 3204. These records shall include:
 - i. The date of the exposure incident;
 - ii. The names, and any other employee identifiers used in the workplace, of employees who were included in the exposure evaluation;
 - iii. The disease or pathogen to which employees may have been exposed;
 - iv. The name and job title of the person performing the evaluation;
 - v. The identity of any local health officer and/or Physician or other licensed health care consulted;
 - vi. The date of the evaluation; and
 - vii. The date of contact and contact information for any other employer notified by NIHD regarding potential employee exposure.
 - c. Records of the unavailability of vaccine shall include the name of the person who determined that the vaccine was not available, the name and affiliation of the person providing the vaccine availability information, and the date of the contact. This record shall be retained for three years.
 - d. Records of the unavailability of Airborne Infection Isolation Rooms or areas shall include the name of the person who determined that an Airborne Infection Isolation Room or area was not available, the names and the affiliation of persons contacted for transfer possibilities, and the date of the contact, the name and contact information for the local health officer providing assistance, and the times and dates of these contacts. This record, which shall not contain a patient's individually identifiable medical information, shall be retained for three years.
 - e. Records of decisions not to transfer a patient to another facility for Airborne Infection Isolation Room for medical reasons shall be documented in the patient's chart, and a summary shall be provided to the Plan administrator providing only the name of the physician determining that the patient was not able to be transferred, the date and time of the initial decision and the date, time and identity of the person(s) who performed each daily review. The summary record, which shall not contain a patient's individually identifiable medical information, shall be retained for three years.
 - f. Records of inspection, testing and maintenance of non-disposable engineering controls including ventilation and other air handling systems, air filtration systems, containment equipment, biological

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safety cabinets, and waste treatment systems shall be maintained for a minimum of five years and shall include the name(s) and affiliation(s) of the person(s) performing the test, inspection or maintenance, the date, and any significant findings and actions that were taken. Plant operation uses a computer-based work system for documentation of records.

- g. Records of the respiratory protection program shall be established and maintained. Fit-test screenings will be retained for two years.
2. Availability.
 - a. The employer shall ensure that all records, other than the employee medical records more specifically dealt with in this subsection, required to be maintained by this section shall be made available upon request to the Chief Operations Officer and National Institute for Occupational Safety and Health and the local health officer for examination and copying.
 - b. Employee training records, the exposure control plan and/or Biosafety plan, and records of implementation of the Aerosolized Transmissible Disease exposure control plan and Respiratory Protection Program and the Biosafety-plan (Chemical Hygiene Plan), other than medical records containing individually identifiable medical information, shall be made available as employee exposure records in accordance to employees and/or employee representatives.
 - c. Employee medical records required by this subsection shall be provided upon request to the subject employee, anyone having the written consent of the subject employee, the local health officer, and to the Chief Operations Officer and National Institute for Occupational Safety and Health for examination and copying.
 3. Transfer of Records.
 - a. NIHD will comply with the requirements involving the transfer of employee medical and exposure records.
 - b. If the employer ceases to do business and there is no successor employer to receive and retain the records for the prescribed period, the employer shall notify the Chief Operations Officer and National Institute for Occupational Safety and Health, at least three months prior to the disposal of the records and shall transmit them to National Institute for Occupational Safety and Health, if required by National Institute for Occupational Safety and Health to do so, within that three-month period. NOTE: Authority cited: Sections 142.3 and 6308; Labor Code. Reference: Sections 142.3 and 6308, Labor Code, and 8 CCR 332.3.

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2. California Department of Public Health. (2017). ATD Standard Appendix D: Aerosol Transmissible Pathogens-Laboratory. Retrieved from <https://www.dir.ca.gov/title8/5199d.html>
3. Guidelines for Preventing the Transmission of Mycobacterium Tuberculosis in Health-Care Settings. (2005) CDC page last updated 2012 and page last reviewed 2016. published by the Centers for Disease Control.
4. California Department of Public Health. (2017). Respiratory Protection in the Workplace: Cal?OSHA Respiratory Protection Standard. Retrieved from <https://www.cdph.ca.gov/programs/ohb/Pages/RespStd.aspx>

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13. Implementing Respiratory Protection Programs in Hospitals a Guide for Respirator Program Administrators, California Department of Public Health, Occupational Health Branch, August 2015
14. California Department of Public Health (CDPH). (2012). Respirator Use in Health Care Workplaces: Cal/OSHA Aerosol Transmissible Disease Standard. Retrieved from <https://www.cdph.ca.gov/programs/ohb/Pages/ATDStd.aspx>

CROSS REFERENCE POLICIES:

1. Airborne Infection Isolation Room (AIIR)
2. N95 Mask Fit Testing Using Porta Count Pro
3. Employee Health Surveillance Program
4. Adult Immunization in the Healthcare Worker
5. Work Related Accidents/Exposures
6. Initial Evaluation of Exposure Incident
7. Lippincott Procedures: Airborne Precautions, Contact Precautions, Droplet Precautions, Standard Precautions, Respiratory Hygiene and Cough Etiquette ambulatory care.
8. Admission of a Patient with a Communicable Disease
9. Avian Influenza-H5N1 Flu Hospitalized Patients Infection Control
10. Infectious/Non Infectious Waste Disposal Procedure
11. Severe Acute Respiratory Syndrome Coronavirus (SARS-CoV) Middle East Respiratory Syndrome (MERS-CoV) Infection Control Recommendations Hospitalized Patients
12. PAPR Respirator Inspection Record

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- 13. Care and Donning of a Powered Air Purifying Respirator
- 14. Northern Inyo Healthcare District Surge Plan
- 15. Chemical Hygiene Plan
- 16. Hospi-Gard Portable Filtration Unit (HGU)
- 17. NIHD Water Management Plan

Approval	Date
CCOC	4/8/19
<u>Safety Committee</u>	
Infection Control Committee	6/3/19
MEC	6/10/19
Board of Directors	
Last Board of Directors Review	

Developed: 11/09/10 LA

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Appendix A – Aerosol Transmissible Diseases/Pathogens (Mandatory)

This appendix contains a list of diseases and pathogens which are to be considered aerosol transmissible pathogens or diseases for the purpose of Section 5199. Employers are required to provide the protections required by Section 5199 according to whether the disease or pathogen requires airborne infection isolation or droplet precautions as indicated by the two lists below.

Diseases/Pathogens Requiring Airborne Infection Isolation

- Aerosolizable spore-containing powder or other substance that is capable of causing serious human disease, e.g. *Anthrax/Bacillus anthracis*.
- Avian influenza/Avian influenza A viruses (strains capable of causing serious disease in humans)
- Varicella disease (chickenpox, shingles)/Varicella zoster and Herpes zoster viruses, disseminated disease in any patient. Localized disease in immunocompromised patient until disseminated infection ruled out
- Measles (rubeola)/Measles virus
- Monkeypox/Monkeypox virus
- Novel or unknown pathogens
- Severe acute respiratory syndrome (SARS)
- Smallpox (variola)/Variola virus
- Tuberculosis (TB)/*Mycobacterium tuberculosis* -- Extrapulmonary, draining lesion; Pulmonary or laryngeal disease, confirmed; Pulmonary or laryngeal disease, suspected
- Any other disease for which public health guidelines recommend airborne infection isolation

Diseases/Pathogens Requiring Droplet Precautions

- Diphtheria pharyngeal
- Epiglottitis, due to *Haemophilus influenzae* type b
- Haemophilus influenzae* Serotype b (Hib) disease/*Haemophilus influenzae* serotype b -- Infants and children
- Influenza, human (typical seasonal variations)/influenza viruses
- Meningitis
- Haemophilus influenzae*, type b known or suspected
- Neisseria meningitidis* (meningococcal) known or suspected
- Meningococcal disease sepsis, pneumonia (see also meningitis)
- Mumps (infectious parotitis)/Mumps virus
- Mycoplasmal pneumonia
- Parvovirus B19 infection (erythema infectiosum)
- Pertussis (whooping cough)
- Pharyngitis in infants and young children/Adenovirus, Orthomyxoviridae, Epstein-Barr virus, Herpes simplex virus,
- Pneumonia
- Adenovirus
- Haemophilus influenzae* Serotype b, infants and children
- Meningococcal
- Mycoplasma, primary atypical*
- Streptococcus Type A
- Pneumonic plague/*Yersinia pestis*
- Rubella virus infection (German measles)/Rubella virus

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Severe acute respiratory syndrome (SARS)
 Streptococcal disease (group A streptococcus)
 Skin, wound or burn, Major
 Pharyngitis in infants and young children; Scarlet fever in infants and young children
 Pneumonia
 Serious invasive disease
 Viral hemorrhagic fevers due to Lassa, Ebola, Marburg, Crimean-Congo fever viruses (airborne infection isolation and respirator use may be required for aerosol-generating procedures)
 Any other disease for which public health guidelines recommend droplet precautions

Note: The Biosafety officer reviewed all of the pathogens listed above and listed the few that may pertain to our laboratory.

Airborne: All bioterrorism bacteria- sent to the state lab immediately, without work here

Droplet: Streptococcus Type A

Haemophilus influenza, type b known or suspected- Do not type it here, but may work with it
 Neisseria meningitis, known or suspected- Any work with this is done under the hood.

Draft

**NORTHERN INYO HEALTHCARE DISTRICT
POLICY AND PROCEDURE**

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

PURPOSE:

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

POLICY:

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

DEFINITIONS

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

GUIDELINES

1. Center for Disease Control (CDC) current year Immunization Schedule and recommendations for Health Care Personnel.
2. Current edition of CDC Epidemiology and Prevention of Vaccine Preventable Diseases.
3. CDPH and Cal/OSHA mandatory vaccinations against aerosol transmissible infections.
4. OSHA requirements for Blood Borne Pathogen vaccination.

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5. Legal declination documentation as described in CDC, CDPH, and Cal OSHA.
6. Forms attached are based on State and Federal requirements.

PROCEDURE:

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

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7. TUBERCULOSIS SCREENING

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

8. IMMUNIZATIONS:

- a. Employee Health vaccine screening, monitoring and administering is limited to these vaccines: Influenza, MMR, Varicella, Tdap, Hepatitis B, and Meningococcal, Hepatitis A, and TB Skin Tests. If the HCW wishes to receive other vaccinations, they will be directed to contact their primary care practitioner.
- b. Initial immunization screening is required of all HCW’s prior to the start date.
- c. Annual Influenza vaccinations will be overseen by the Employee Health Nurse Specialists in collaboration with all department managers.
- d. Employee Health Standing Orders for Vaccine administration to HCW’s are based on the CDC/ACIP Recommendations. They will be approved by the Medical Director annually using the CDC/ACIP order templates. Standing Orders will be stored in the Employee Health Office and on the Employee Health shared drive or Intranet.
- e. A signed consent with CDC screening questionnaire will be completed for all immunizations.
- f. Immunizations:

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- i. **Influenza**
 - 1. Applies to all HCW’s on campus during the influenza season.
 - 2. Required by CDPH.
 - 3. Annually, during each flu season, one dose of influenza vaccine is required if there is no documentation for that season.
- ii. **MMR**
 - 1. Applies to all HCW’s on campus: except volunteers and auxiliary.
 - 2. Required by Cal OSHA.
 - 3. Immune titers to all 3 or documentation of 2 doses.
 - 4. Birthdate prior to 1957 does require documentation of IgG immunity to Rubella, Rubeola, and Mumps.
 - 5. If immunity or vaccination history is unknown, an IgG will be drawn for Rubella, Rubeola, and Mumps.
 - 6. Follow CDC recommendations/Standing Orders for booster dose or re-vaccination if the results demonstrate non-immunity or equivocal.
- iii. **Varicella (chickenpox)**
 - 1. Applies to all HCW’s on campus: except volunteers and auxiliary.
 - 2. Required by Cal OSHA.
 - 3. Serologic proof of immunity, documentation of 2 dose vaccination, or verification of a history of varicella or herpes zoster (shingles) by a healthcare provider are evidence of immunity.
 - 4. If disease of vaccination history is undocumented or incomplete documentation, an IgG will be drawn for Varicella. Follow CDC recommendations/Standing Orders for booster dose or re-vaccination if the results demonstrate non-immunity or equivocal.
- iv. **Tetanus, diphtheria, pertussis**
 - 1. Applies to all HCW’s on campus, no exceptions.
 - 2. Required by Cal OSHA
 - 3. Documentation of one dose of Tdap at or after the age of 11.
 - 4. Booster doses would be provided by the person’s primary care practitioner.
- v. **Meningococcal**
 - 1. Both MenACWY and MenB are recommended only for microbiologists who are routinely exposed to isolates of Neisseria meningitides.
 - 2. CDC Recommended.
 - 3. Every 5 years boost with MenACWY if risk continues.
 - 4. When offered and refused, a declination will be required.
- vi. **Hepatitis B**
 - 1. Required by CAL/OSHA.
 - 2. Applies to NIHD HCW’s who will be working in these departments/roles: Activities Director, Admission Services, Biomedical, Case Management, Central Supply, Diagnostic Imaging Techs and Radiologists, Dietary, Environmental Services, EKG/EEG, Laboratory, Language Services, Laundry, Maintenance/Plant Operations, Nursing, Medical Assistant,

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Pharmacy, Physical Therapy, Occupational Therapy, Respiratory Therapy, Security, Social Services.

3. Documentation of the 2-dose (HepB-B) or 3-dose (Engerix-B or Recombivax HB) series is required for HCW's who perform tasks that may involve exposure to blood or body fluids.
4. Request a HepBsAb titer to check for immune reactivity if there is documentation of a full series of Hep B vaccines.
5. If no documentation of immunizations, then the series will be restarted.
6. Follow CDC recommendations/Standing Orders for HCW boosters and follow up HepBsAb titers. The HCW is allowed to work at NIHD while completing Hepatitis B initial series, boosters, and titers. In this case, the HCW will also sign the Hep B declination form as an acknowledgement of risk while receiving the series or boosters.

vii. Hepatitis A

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

9. VACCINE DECLINATIONS

- a. NIHD strives to ensure the safety of our patients and HCW's through vaccinations. Should a HCW decline any of the required vaccines a declination must be signed, acknowledging awareness of risk.
- b. OSHA requires signed declination for refusal of Hepatitis B vaccine. Attached.
- c. California law requires signed declination for refusal of vaccines to prevent aerosol transmissible diseases. Attached.
- d. Declinations are specific to the vaccine, for NIHD, and attached to this policy.

10. EXCEPTIONS:

- a. Volunteers and auxiliary members Health Screening Requirements are limited to the following:
 - i. Tdap once at or after age 11
 - ii. Influenza immunization annually
 - iii. TB screening per policy
- b. Travelers are required to submit a pre-hire Drug Screen. This is monitored by Human Resources and Employee Health.
- c. Vendors are not screened through Employee Health. Vendormate is used in this instance.

11. COSTS

- a. Initial required exams, immunizations, titers, and Tuberculosis testing is offered at no cost to NIHD employees, contracted physicians, contracted mid-level providers, volunteers, and auxiliary members upon hire.

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- b. Travelers and all students will need to meet their initial requirements through a primary health care provider at their cost.
- c. Annual influenza immunization is offered to all HCW during influenza season at no cost.
- d. TB testing is offered at no cost to all HCW every two years, except for students.

12. DOCUMENTATION

- a. Documentation related to vaccinations, titers, TB screening, medical history and Physical Exam will be kept in the Employee Health files and database.
- b. Vaccine's provided by NIHD require a consent which includes a screening questions, the manufacturer, lot, expiration date, and date of published VIS that was provided. This data will be documented in the database where required and the form will be stored in the HCW's health record.
- c. Current and former NIHD employees may request a copy of their vaccine, titer, and TB Screening records from the Employee Health Nurse Specialist by completing an *NIHD Authorization to Disclose Health Information*.
- d. Travelers that may receive an influenza vaccine at NIHD are responsible to ensure a copy is stored in Medical Solutions or with their clinical staffing company.
- e. HCW Employee Health records include the screening documentation as defined in this policy per role/department: The Health History, Physical Exam as described, immunization records, database vaccine administration record, immunization consents and declinations, lab reports/titers, all Tuberculosis Screening documentation, chest rays for positive PPD, and CAL/OSHA Fit Testing Medical Questionnaire (if fit tested), Employee Health Clearance to work, and Date of Termination.

REFERENCES:

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

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ATTACHED:

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

CROSS REFERENCE P&P:

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

SUPERCEDES

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

Approval	Date
Clinical Consistency Oversight Committee	5/21/2019
Infection Control Committee	6/3/19
MEC	6/10/19
Board of Directors	
Last Board of Directors Review	

Developed: 5/19

Reviewed:

Revised:

Supersedes:

Index Listings:

NORTHERN INYO HEALTHCARE DISTRICT

Onboarding Healthcare Screening and Plan

INFORMATIONAL HANDOUT TO ALL HEALTHCARE WORKERS ABOUT NIHD HEALTH SCREENING

Prior to beginning your agreement with NIHD, the Employee Health Specialist will need to review the following documents based on NIHD policy and CDC Guidelines.

You are encouraged to contact the Employee Health Nurse Specialist at least 2 weeks prior to your expected start date and submit copies of all your vaccines, titers, and prior TB screenings. Please acquire prior immunization, titer and TB screening documents from former employer's Employee Health, clinics, and hospital medical records and gather as much as you can and email to: employeehealth2@nih.org phone: 760-873-5811 ext 3343

Volunteers, Auxiliary, Shadows Do not need a health history or physical exam. You only need:

- 2-step TB skin test, then every two years per policy.
- One Tdap immunization at or after age 11
- Seasonal Influenza vaccine by Nov 1 or sign a declination and wear a mask as per policy.
- It is likely you have had your immunizations already, please request records from your provider prior to meeting with the Employee Health Nurse.

Physicians and all Students:

- You do not need to provide a Health History and Physical Exam.
- **TB Screening** and all **Immunization and Titer** requirements below applies to you (ALL HEALTHCARE WORKERS).
- Please provide screening documentation from other facilities you have been associated with to Medical Staff Administration or Employee Health.
- You may be requested by Employee Health to complete further titers and immunizations that are not documented following the CDC guidelines for Healthcare Workers.

Travelers: are required to submit a pre-hire Drug Screen. All requirements below apply to you.

ALL HEALTHCARE WORKERS:

1. **Health History**
2. **Physical Exam with Clearance to work in this role.**
Allergies including latex, Audiometry, Vision Test, Infectious Disease Exposure Screening
Color vision: Ishihara 14 plates with color failure identification
3. **TB Screening:** TST documentation within the last 12 months or QuantiFERON lab test or 2 step TST or no prior documentation of testing
4. **Immunizations and Titers**

NIHD Follows the current CDC Guidelines for Healthcare Workers, you may be requested to complete titers and further immunizations. Submit all documentation for the following:

Influenza annual by Nov 1 until the season is cleared by Inyo County Health Officer: immunization documentation or declination with agreement to wear a mask on campus.

MMR 2 MMR documented vaccines, or documentation of immunity with IgG blood test of each: Rubella, Rubeola, Mumps.

Varicella 2 Varicella documented vaccines, or documentation of immunity with IgG blood test for Varicella.

Tdap 1 documented dose at or after age 11

Hepatitis B: Documentation of the 2-dose (HepIsav-B) or 3-dose (Engerix-B or Recombivax HB) series is required for HCW's who perform tasks that may involve exposure to blood or body fluids.

- If there is documentation of a full series please provide a reactive HepBsAb titer.
- CDC recommends repeating the series if there is no immunization documentation despite a HepBsAb reactive titer. NIHD will request the HCW to follow this recommendation.

Hepatitis A: Dietary/Food service only: If you have documentation please provide it.

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HEALTH HISTORY FORM

Employee: _____ Date: _____

Do you have any present symptoms or known medical conditions that may affect how you would perform your job? **Examples: anemia, insomnia, pain, diabetes, respiratory problems, joint or extremity injuries, etc** *If yes, please list:*

Do you take any medications regularly? Yes No *If yes, what are they?*

Do you have any allergies to **including latex**? Yes No

If yes, to what? _____

Do you have a history of or recent exposure to Infectious Diseases such as Hepatitis B, Hepatitis C, HIV, measles, other.

If yes, please list or describe

Have you had any operations that may affect how you would perform your job? Yes No *If yes, please list:*

In previous employment, have you been exposed to: Chemical fumes Heavy lifting
 Repetitive motion Loud noises Other occupational *If yes, explain:*

The above information is true to the best of my knowledge. I understand that any concealment or falsification discovered after employment is grounds for termination:

Signature: _____ Date: _____

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PHYSICAL EXAMINATION FORM

Name: _____ **Date of Birth:** _____ **Age:** _____

Vital Signs: _____ **Ht:** _____ **Wt:** _____

GENERAL APPEARANCE	Normal
	Abnormal

FACE	Normal
	Abnormal

EYES	Normal	Vision: _____ Corrected _____ Uncorrected Rt: _____ Lt: _____
	Abnormal	Color Vision Ishihara 14 plates: Pass _____ Fail (<12) _____ identify color deficiency _____

EARS	Normal	Whisper test: _____ Normal _____ Abnormal
	Abnormal	Audiogram: _____ Normal _____ Abnormal

NOSE	Normal
	Abnormal

MOUTH	Normal
	Abnormal

THROAT	Normal
	Abnormal

NECK	Normal
	Abnormal

CHEST	Normal
	Abnormal

HEART	Normal
	Abnormal

ABDOMEN	Normal
	Abnormal

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MUSCULOSKELETAL	Normal	
	Abnormal	
PERIPHERAL VASCULAR	Normal	
	Abnormal	
NEUROLOGICAL	Normal	
	Abnormal	
MENTAL AND PSYCHOLOGICAL	Appears Normal	Able to handle the stress associated with the position: Yes / No (Circle)
	Abnormal	
SKIN	Normal	
	Abnormal	

DIAGNOSTIC IMPRESSIONS			

INFORMATION FOR MANAGEMENT	RECOMMEND For Employment <input type="checkbox"/> Against Employment <input type="checkbox"/> Employment With Restrictions Specified Below <input type="checkbox"/>	Class A <input type="checkbox"/> Suitable for any type of work Class B <input type="checkbox"/> Suitable for any type of work but has minor defects Class C <input type="checkbox"/> Suitable for work within specific limits Class D <input type="checkbox"/> Not suited for employment
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Comments:

Signature

NORTHERN INYO HEALTHCARE DISTRICT

Onboarding Healthcare Screening and Plan

Name _____

Start Date: _____

Department/Role: _____

Birth Date: _____

VACCINE EVALUATION By Employee Health Specialist

MEASLES (RUBEOLA), MUMPS, RUBELLA (German Measles) mandatory CDPH/CalOSHA:

- Born Before 1957 _____ titers are needed
- MMR Vaccinations: #1 _____; #2 _____
- MMR Titers only if incomplete documentation
 - Measles (Rubeola) Titer Date/Result _____
 - Mumps Titer Date/Result _____
 - Rubella Titer Date/Result _____
- MMR x1 Booster if any titer is negative Date _____

VARICELLA mandatory CDPH/CalOSHA:

- Varicella Vaccination #1 _____ # 2 _____ Booster _____
- Varicella Titer if no documentation of Vaccination Date/Result _____
- Documented of history of disease _____ (don't vaccinate, draw a titer and follow CDC guidelines if negative)

Tdap mandatory CDPH/CalOSHA:

- One documented dose over the age of 11 Date: _____ then every 10 years seek Td update from primary care provider.

HEPATITIS B SERIES (see policy)

- Dates: #1 _____ #2 _____ #3 _____ (Engerix-B or Recombivax HB)
Or Heplisav Hepatitis B, Dates: #1 _____ #2 _____
- If documented complete series then draw Hepatitis B Titer: Date _____ Result: _____
- If incomplete series or no documentation, series needs to be completed, followed by a titer
- Non-reactive result after complete series: provide booster Date: _____
- Recheck titer in 1-2 months after series completed Date/Result _____
- If still negative, complete the second series Date (type) _____ Date (type) _____
repeat titer 1-2 months after completing second series Date _____ Result _____
- If remains non-reactive after 2 complete series, refer to primary physician. _____

HEPATITIS A Dietary/Food Handlers only

- Hepatitis A vaccine series Date #1 _____ Date #2 _____

SEASONAL FLU VACCINE mandatory CDPH:

- Consent or declination during flu season. Need proof of documentation if received elsewhere
Date received _____ NIHD _____ Other Location _____ Declination _____
- Declination includes received elsewhere (separate declination from other vaccines)

TB SCREENING mandatory CDPH:

- Date/result of last TST within past 12 months _____ Result _____
- 2 Step necessary (if no previous TST or > 1 year since last TST)
First Step TST Date placed _____ Date read _____ mm result _____
Second Step TST Date placed _____ Date read _____ mm Result _____ N/A _____
- History of a positive TST or recent exposure:
 - Complete Prior (+) TST History _____
 - Complete Symptom Questionnaire _____
 - Date and copy of last chest xray (if possible) _____
 - Order Chest Xray _____ (even if asymptomatic)
- QuantiFERON Gold TB Blood test (QFT-G): documentation of negative result in prior 12 months is an acceptable alternative to TST; although not provided by NIHD during onboarding unless TST positive Date _____ Result _____

Cleared by Employee Health Specialist Signature _____ Date _____
--

Name _____

Birth Date: _____

NORTHERN INYO HEALTHCARE DISTRICT

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HEALTH HISTORY completed Date _____ Location _____

PHYSICAL EXAM completed Date _____ Location _____

- **ALLERGIES** Latex _____ Other _____
- **Audiometry Completed** _____ **Abnormal reported to Manager** _____ **HR** _____
- **Vision Test Completed** _____ **Abnormal reported to Manager** _____ **HR** _____
- **COLOR SCREENING:**
 - Ishihara 14-plate Score _____ Pass _____ Fail _____ (<12/14)
 - Color fail _____ If failed Notify Manager _____ Notify HR _____

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Name _____

Department/Role: _____ Birth Date: _____

LAB TESTS:

Rubella Ab, IgG _____

Hepatitis B Surface Ab _____

Rubeola Ab, IgG _____

QuantiFERON Gold _____

Varicella Ab, IgG _____

Flu Swab _____

Mumps Ab, IgG _____

Other _____

RADIOLOGY

2-view Chest X-Ray R/O TB (+) TST or QuantiFERON _____

HCW Signature _____	Date _____
Employee Health Nurse Specialist Ordering Signature _____	Date _____

NORTHERN INYO HEALTHCARE DISTRICT Onboarding Healthcare Screening and Plan

Name _____ Date of Birth _____

The following questions will help us determine which vaccines you can be given today. If you answer “yes” to any question, it does not necessarily mean you should not be vaccinated. It just means additional questions must be asked. Please ask for clarification if a question is unclear.

	Questions	yes	no	don't know
1.	Are you sick today?			
2.	Do you have allergies to medications, food, a vaccine component, or latex?			
3.	Have you ever had a serious reaction after receiving a vaccination?			
4.	Have you had a seizure or a brain or other nervous system problem?			
5.	For women: Are you pregnant or is there a chance you could become pregnant during the next month?			
If you will be receiving a live vaccine: MMR or Varicella please also answer the following questions:				
6.	Do you have a long-term health problem with heart, lung, kidney or metabolic disease (e.g., diabetes), asthma a blood disorder, no spleen, complement component deficiency, a cochlear implant, or a spinal fluid leak? Are you on long-term aspirin therapy?			
7.	Do you have cancer, leukemia, HIV/AIDS, or any other immune system problem?			
8.	In the past 3 months, have you taken medications that affect your immune system, such as prednisone, other steroids, or anticancer drugs; drugs for the treatment of rheumatoid arthritis, Crohn's disease, or psoriasis; or have you had radiation treatments?			
9.	During the past year, have you received a transfusion of blood or blood products, or been given immune (gamma) globulin or an antiviral drug?			
10.	Have you received any vaccinations in the past 4 weeks?			

I have received, read, and understand the information in the following Vaccine Information Statements (VIS) and my questions have been answered satisfactorily. I agree to receive the following vaccines today.

___ Hepatitis B (VIS Date _____) ___ Measles, Mumps, Rubella (VIS Date _____)
 ___ Tdap (VIS Date _____) ___ Varicella (VIS Date _____) ___ Hepatitis A (VIS Date _____)

Signature _____ Date _____ Time _____

VACCINE ADMINISTRATION DOCUMENTATION

Vaccine	Extremity	Site	Route	Manufacturer	Lot #	Exp. Date
Hepatitis B #1 #2 #3 1st series 2 nd series	Right Left	Deltoid	IM			
Tdap once	Right Left	Deltoid	IM			
Measles, Mumps, Rubella #1 #2 Booster	Right Left	Fatty tissue over tricep	SC			
Varicella #1 #2	Right Left	Fatty tissue over tricep	SC			
Hepatitis A #1 #2	Right Left	Deltoid	IM			

Signature/Credentials of Vaccine Administrator _____ Date _____ Time _____

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VACCINE DECLINATIONS

DECLINATION OF VACCINATION AGAINST AEROSOL TRANSMISSIBLE DISEASES

California Code of Regulations, Title 8 Section 5199, Appendix E

I understand that due to my occupational exposure to aerosol transmissible diseases I may be at risk of acquiring the following infections: Rubeola, Rubella, Mumps, Varicella, Pertussis.

I understand that by declining this vaccine, I continue to be at risk of acquiring these infections. Should I choose to change my mind, I will provide the Employee Health Nurse Specialist with a copy of the vaccine (s). I understand the vaccine and titers are available and free of charge to NIHD employed HCW's and contracted physicians through the Employee Health Nurse Specialist. I decline the following vaccination at this time.

I decline (Please circle as appropriate): Rubeola Rubella Mumps Varicella Tdap

Employee Name (Print) _____ Employee Signature _____ Date _____

HEPATITIS B DECLINATION OF VACCINATION

OSHA Chapter 296-823 WAC, Occupational Exposure to Blood borne Pathogens

I understand that due to my occupational exposure to blood or other potentially infectious materials (OPIM), I may be at risk of acquiring Hepatitis B virus (HBV) infection.

_____ My Hepatitis immunization series, boosters, and reactive titers are in progress. I understand my risk of acquiring HBV is significantly higher than after completion of the vaccine series. I understand the vaccines and titers are available and free of charge to NIHD employed HCW's and contracted physicians through the Employee Health Nurse Specialist.

Employee Name (Print) _____ Employee Signature _____ Date _____

_____ I decline Hepatitis B Vaccine at this time. I understand that by declining this vaccine (s), I continue to be at risk of acquiring Hepatitis B, a serious disease. Should I choose to change my mind, and continue to have occupational exposure potential, I will provide the Employee Health Nurse Specialist with a copy of the vaccines and follow-up titer. I understand the vaccines and titers are available and free of charge to NIHD employed HCW's and contracted physicians through the Employee Health Nurse Specialist.

Employee Name (Print) _____ Employee Signature _____ Date _____

MENINGOCOCCAL DECLINATION OF VACCINATION

I understand that due to my occupational exposure to potentially infectious materials (OPIM), I may be at risk of acquiring Meningococcal infection.

I understand by declining the vaccine, I continue to be at risk of acquiring the disease. Should I choose to change my mind, I will provide the Employee Health Nurse Specialist with a copy of the vaccine (s). I understand the vaccine is available and free of charge to NIHD employed HCW's and contracted physicians through the Employee Health Nurse Specialist. I decline the vaccine at this time.

Employee Name (Print) _____ Employee Signature _____ Date _____

HEPATITIS A DECLINATION OF VACCINATION

I have been offered the Hepatitis A vaccine and understand my risk. However, I decline the vaccine at this time. I understand by declining the vaccine, I continue to be at risk of acquiring the disease. Should I choose to change my mind, I will provide the Employee Health Nurse Specialist with a copy of the vaccines and follow-up titer. I understand the vaccines are available and free of charge to NIHD employed HCW's through the Employee Health Nurse Specialist.

Employee Name (Print) _____ Employee Signature _____ Date _____

**NORTHERN INYO HOSPITAL
POLICY AND PROCEDURE**

Title: SKILLED NURSING FACILITIES	
Scope: Case Management	Manual: Social Services, Swing Bed
Source: Chief Nursing Officer	Effective Date:

PURPOSE:

To assure appropriate discharge for patients that may be unable to care for themselves, have appropriate care at home, are in need of short term rehabilitation or need of long term custodial care.

POLICY:

1. A patient can be referred to a Skilled Nursing Facility (SNF) for short term rehabilitation or for long term custodial care.
2. Arrangements for patients to transition from acute care to SNF are generally made by the Case Manager (CM) or the Social Worker (LCSW). In the absence of the CM or LCSW, the House Supervisor assumes this responsibility.
3. Transition of care will be discussed with the patient and/or their family-caregiver. Arrangements to the appropriate SNF is dependent on bed availability, patient's specific needs, services available and coverage of costs at the SNF facility. The patient and family will be encouraged to participate as fully as possible in the arrangements.
4. The patient will be encouraged, as his conditions allow, to fully participate in this decision for placement in a SNF.
5. The patient's rights will be protected in this matter. If the patient is unwilling to enter any facility as recommended and it appears that the patient may be unable to make appropriate decisions, the physician will be notified. The physician may choose to discharge the patient to their home or the physician may choose to recommend the patient be evaluated for conservatorship, with L.P.S. or Probate, depending on the specific circumstances and medical condition of the patient.
6. When a skilled nursing referral is recommended or deemed appropriate by the physician, the CM or LCSW will make referrals to appropriate skilled nursing facilities.
7. The CM or LCSW will explore the patient's financial condition when transition to a SNF is necessary for the patient. The financial impact of a skilled nursing facility will be explained to the patient, his family and referral made for Medi-Cal, whenever appropriate.
8. A Non-Emergent Transfer form will be completed and medical records provided to the SNF, including discharge summary and admission orders. This will include reason for SNF admission, physical and psychosocial status, summary of care, patient's progress toward goals.
9. Verbal hand-off from the RN transitioning the patient from the District to the receiving nurse at the SNF will be provided. Documentation of the hand-off will be placed into the patient's medical record.

REFERENCES:

1. Department of Health and Human Services, Centers for Medicare & Medicaid Services; CMS Manual, Conditions of Participation 482.43(a) – 482.43 (e)
2. California Department of Public Health, Senate Bill 675: Hospital Discharge Planning and Family Caregivers; Health and Safety Code section 1262.5, Chapter 494
3. The Comprehensive Accreditation Manual for Critical Care Access Hospitals (2019) as published by The Joint Commission; Standards PC.04.01.03; PC.04.02.01; PC.04.01.05

CROSS REFERENCE P&P:

1. Documentation of Case Management Services
2. SKILLED NURSING FACILITIES

**NORTHERN INYO HOSPITAL
POLICY AND PROCEDURE**

Title: SKILLED NURSING FACILITIES	
Scope: Case Management	Manual: Social Services, Swing Bed
Source: Chief Nursing Officer	Effective Date:

Approval	Date
CCOC	3/25/19
Utilization Review Committee	
Medical Executive Committee	
Board of Directors	
Last Board of Director review	

Developed:3/19ta
 Revised:
 Reviewed:
 Supersedes:
 Index Listings:

Draft

**NORTHERN INYO HOSPITAL
POLICY AND PROCEDURE**

Title: Standards of Care in ICU	
Scope: ICU	Manual: ICU - Standards of Care (S of C)
Source: Manager - ICU Acute/Subacute	Effective Date: 3/31/18

POLICY STATEMENT:

1. Intensive Care Unit (ICU) nursing is provided using an interdisciplinary team approach, based on a holistic assessment of patient needs, capabilities, and limitations; nursing diagnosis; planning; interventions; and evaluation of patient response.
2. The patient age-specific population served is:
 - a. Adult: 18 years of age to 65 years of age
 - b. Geriatric: > 65 years of age

PROCEDURE:

The ICU patient and/or family-caregiver can expect:

1. ON ADMISSION OR TRANSFER INTO THE DEPARTMENT:

- A. To be greeted immediately upon arrival to the unit including:
 - a. Introduction of nursing and ancillary staff
 - b. Explanation of what to expect within the next hour
 - c. A clean patient room with appropriate supplies and equipment
 - d. Assessment of level of assistance required to complete activities of daily living, including transferring, ambulation, self-care, and feeding; support provided to meet identified need.
 - e. Orientation to room including, but not limited to the operation of:
 - i. Call light use
 - ii. Bed controls
 - iii. TV and light controls
 - iv. Phone
 - v. Bathroom location and toileting options
 - vi. Safety procedures
 - vii. Equipment in use
 - viii. Department routine
 - f. Pain, potty, and positioning addressed
 - g. Additional comfort needs including but not limited to:
 - i. Fluids
 - ii. Food and nutrition
 - iii. Blankets
 - iv. IV site
 - v. Traction
 - vi. Safety devices
 - vii. Environmental assessment to ensure items such as Kleenex and trash bag are within reach
 - viii. Personal hygiene supplies provided, including hand sanitizer, soap, lotion, toothbrush, toothpaste; other supplies such as razor, shaving cream, denture care available on request
 - ix. Patient personal equipment checked prior to usage
- B. To receive information about the patient/family's Speak Up Program, Patient Rights, Patient Safety, Patient Advocate, Advance Directives, Infection Control, and Rapid Response.
- C. To have an RN assess his/her admitting or transfer condition (quick check) within 30 minutes of arrival.

**NORTHERN INYO HOSPITAL
POLICY AND PROCEDURE**

Title: Standards of Care in ICU	
Scope: ICU	Manual: ICU - Standards of Care (S of C)
Source: Manager - ICU Acute/Subacute	Effective Date: 3/31/18

- D. To have an RN initiate a nursing assessment within 4 hours of admission, to be completed within 12 hours, including:
 - a. Physical and social assessment.
 - b. Patient profile, to include home medications, pre-arrival medications, reported problems and procedures, implants, allergies, immunizations, family history, education, occupation, use of alcohol, tobacco, and other drugs, patient education provided
 - c. Interdisciplinary referral based on functional screens within the nursing assessment.
 - d. Nursing plan of care individualized for patient.
 - e. The nursing care of patients will be supervised by nurses adept in skills and knowledge of a critical care patient. The priority of data collection activities is driven by the patient's immediate condition and/or anticipated needs.
- E. To have an RN review and initiate physician admitting orders within 4 hours of admission, including review of medical staff plan of care as written
- F. To have an RN initiate discharge planning at time of admission, to be readdressed throughout stay, including:
 - a. Patient goals for hospitalization
 - b. Referral to interdisciplinary team, including but not limited to: dietary, social services, physical therapy, speech therapy, and pharmacy.
- G. To have pharmacy review the medication list for appropriateness within 24 hours of admission/transfer.
- H. The ICU/CCU RN's practice is guided by the ANA's Code for Nurses, AACN's Ethic of Care, and ethical principles.
- I. The AHA ACLS protocol will be instituted when necessary for all ICU patients, older than 13 years of age.

2. THROUGHOUT THE STAY:

- A. To be treated in accordance with NIH's policy entitled "Patients' Rights"
- B. To be kept informed of and involved in the plan of care including medications, procedures, and discharge needs.
- C. To have care delivered based on standards of practice for the diagnosis identified.
- D. To have a Physician oversee care with site visit every 24 hours.
- E. To have Medical Staff consultations completed within 24 hours of referral.
- F. To have an RN monitor and assess the patient's health status at the beginning of each shift and as the patient's condition warrants.
- G. All patients will have continuous cardiac monitoring in the most appropriate leads. Monitor strips will be placed on the chart at the beginning of each 12-hour shift and PRN. A 6-lead printout will be documented every 12 hours. Changes in rate, rhythm, or morphology will be documented PRN. Monitoring leads, PR, QRS, and QT interval measurements will be noted. Interpretation of the cardiac rhythm will be documented on the strip by the RN or the ICU technician at the beginning of each shift and PRN changes or dysrhythmias.
- H. Monitor alarms will be set and reviewed at the beginning of each shift and changed, as needed based on patient condition. Changes in the alarms will be made **only** by the nurse in charge of the patient or in consultation with that nurse.
- I. All patients will be on intake and output monitoring. I&O's will be recorded every 2 hours.

**NORTHERN INYO HOSPITAL
POLICY AND PROCEDURE**

Title: Standards of Care in ICU	
Scope: ICU	Manual: ICU - Standards of Care (S of C)
Source: Manager - ICU Acute/Subacute	Effective Date: 3/31/18

- J. All patients will be weighed daily. Bed scale weights will ideally be done on the evening shift around 10 PM to correlate more accurately to the 24 hour I&O.
- K. All patients will have a complete assessment completed every shift and as the condition dictates. Vital signs including Blood Pressure, Pulse, Respiratory rate and O2 saturation will be completed a minimum of every 2 hours and as the condition dictates. A temperature will be obtained every 8 hours or as the condition dictates. All completed assessments will be documented in the EHR in a timely manner.
- L. All patients will have an IV of NS at a 'to keep open rate' for the first 8 hours unless otherwise ordered by the physician. After that, the IV may be saline locked according to P&P, if the patient remains stable.
- M. An intravenous infusion pump will be used on all patients receiving intravenous fluids or drugs..
- N. All patients will have suctioning performed whenever indicated. This includes oral/naso pharyngeal and endotracheal suctioning.
- O. The Ventilator Associated Pneumonia (VAP) policy will be followed as indicated.
- P. In the event that the patient's respiratory status deteriorates, the nurse may order arterial blood gases and /or Chest x-ray and notify physician.
- Q. Blood may be withdrawn by the ICU R.N. from the central or arterial line for laboratory analysis. Respiratory Therapists may withdraw blood from the arterial line for ABGs according to P&P.
- R. Blood drawn from arterial lines prior to lab withdrawal will be discarded, not re-infused. Exceptions to this will be: if specifically ordered by attending physician or if there is a venous arterial blood management protection (VAMP) system attached to the arterial or central line. This is a closed system allowing for reinfusion.
- S. In the event of inability to access an IV line in the upper extremities, IV venipuncture may be performed in the lower extremities after notifying the attending Physician. The Physician must be notified of difficult IV access so He or She can arrange for insertion of a central line.
- T. Monitoring electrodes will be checked each day and replaced as necessary. The skin will be prepped with alcohol to remove excess skin oils. Excess hair may be clipped or shaved for good contact.
- U. Care of the adult ICU/CCU patient will be guided by the policies and procedures at Northern Inyo Hospital.
- V. Per MD/Advanced Practice Provider (APP) order, A FSBS may be performed by the RN or LVN if the patient is demonstrating signs or symptoms suspicious for hypo/hyperglycemia. The physician will be informed of all abnormal results.
- W. In the event of medication incompatibility, an IV at TKO rate or saline lock may be inserted.
- X. Nursing staff will be responsible for knowledge of medication given and utilizing appropriate resources to gain that knowledge.
- Y. All patients receiving vasoactive and antidysrhythmic agents will have their BP, heart rate and appropriate EKG intervals measured prior to administration; notify physician of significant changes and have parameters for drug administration.
- Z. All sedation/analgesia will be given according to the IV sedation analgesia guidelines.
- AA. Per MD/APP order, the ICU R.N. may discontinue arterial lines and central lines and remove the sutures that retain them if they become dislodged or show signs of site infiltration.

**NORTHERN INYO HOSPITAL
POLICY AND PROCEDURE**

Title: Standards of Care in ICU	
Scope: ICU	Manual: ICU - Standards of Care (S of C)
Source: Manager - ICU Acute/Subacute	Effective Date: 3/31/18

- BB. Per MD/APP order, the nurse may obtain a 12-lead EKG in the event of:
 - a. Chest pain unrelieved by ordered medications such as Nitroglycerine or Morphine Sulfate.
 - b. New onset of chest pain.
 - c. Significant changes in the cardiac rhythm.
- CC. To have the physician updated and informed of response to care and/or significant changes as demonstrated by:
 - a. Abnormal or worsening critical signs specific to patient's baseline
 - b. Abnormal or worsening lab values
 - c. Significant change in Level of Consciousness (LOC)
 - d. Significant or worsening change in physical assessment
 - e. Significant change or imbalance in Input and Output (I&O)
 - f. Any adverse drug and/or blood reactions, or untoward change as a response to treatment
 - g. Inability to control pain or obtain pain relief
 - h. Any untoward occurrence/event occurring in the hospital
 - i. Significant change in cardiac rhythm
- DD. To receive prompt identification of and intervention for potential and actual complications/side effects, including Rapid Response Team initiation
- EE. To have pain assessed and managed in a systematic way to achieve optimal relief.
- FF. To have hourly rounding from 0800 to 2400 and every 2 hour rounding from 2400 to 0800 to address:
 - a. Pain, potty, positioning.
 - b. Comfort needs.
 - c. Environment assessment, to include maintenance of quiet, therapeutic atmosphere.
- GG. To have safety measures identified specific to each patient including:
 - a. Patient identification band in place; staff to use at least two patient identifiers for medications and procedures.
 - b. 5 rights of medication administration practiced.
 - c. Time out as appropriate for identified invasive procedures.
 - d. Fall risk assessment completed at the beginning of every shift and with change of condition.
 - i. Interventions in place specific to the patient
 - ii. High risk patient to be awoken at agreed-upon time for toileting
 - e. Skin assessment at the beginning of every shift
 - i. Interventions in place specific to patient to prevent new breakdown, and to treat existing skin breakdown
 - f. Restraint-free environment emphasizing alternatives to restraint:
 - i. Comfort measures
 - ii. Patient orientation techniques
 - iii. Patient safety alert devices
 - iv. Patient location
 - v. Safety attendant in room
 - g. Restraints only used if less restrictive measures not successful and the patient is at risk for injury of self. Smoke-free environment
 - h. Assessment for suicidal risk
- HH. To have preventative measures followed to avoid patient infections, pneumonia, and blood clots.

**NORTHERN INYO HOSPITAL
POLICY AND PROCEDURE**

Title: Standards of Care in ICU	
Scope: ICU	Manual: ICU - Standards of Care (S of C)
Source: Manager - ICU Acute/Subacute	Effective Date: 3/31/18

- II. To be educated throughout the admission to support understanding of:
 - a. Health status, current diagnosis, and plan of care.
 - b. Self-care needed to maintain and improve health status.
 - c. Basic health and safety practices, including opportunity to communicate concerns about safety issues before, during, and after care is received.
 - d. Oral health.
 - e. Nutrition interventions.
 - f. Habitation or rehabilitation techniques to help patient reach maximum independence.
 - g. Equipment usage during stay and equipment needs for discharge.
 - h. Fall reduction strategies.
 - i. Pain, risk for pain, and methods of pain management.
 - j. Medication name, dosage, route, timing, and reason for receiving
- JJ. To have continuity of care maintained between caregivers and departments through appropriate sharing of information (SBAR-QC).
- KK. To have confidentiality and privacy maintained in accordance with policy on Patient Rights, State Law, and Federal Law.
- LL. To have nutritional needs assessed, and nutrition provided that meets the patient’s special diet, including cultural, religious, or ethnic preferences. To have services that support family time, social work, nursing care, dental care, rehabilitation, and discharge needs.
- MM. To have palliative and terminal care as required The ICU/ CCU RN and physician address the wishes of patients related to end-of-life decisions.
- NN. Patients have the right to refuse care, treatment and services in accordance with the law and regulation
- OO. All admitted patients will be entered in the ICU logbook.

3. ON TRANSFER WITHIN NIH:

- A. To have discharge transfer assessment completed by transferring RN.
- B. To have patient assessment completed by receiving RN.
- C. To have transferring RN provides report of patient condition (SBAR-QC) to receiving RN.
- D. To have patient/family updated on reason for transfer, location moved, and change in plan of care.
- E. To be transferred with all belongings.
- F. To have medications/orders reconciled upon transfer by receiving RN/Pharmacy.

4. ON DISCHARGE/TRANSFER TO ANOTHER FACILITY:

- A. To have discharge transfer orders reviewed with patient/family.
- B. To have discharge transfer assessment completed by RN and report called to receiving facility RN.
- C. To have transportation arranged including:
 - a. Medical condition.
 - b. Orders for care level during transport.
 - c. IV/Medication maintenance as appropriate.
 - d. Record of care transported with patient.
- D. To have discharging transfer RN give report to transport team, MD/RN/Paramedic/EMT as appropriate.

**NORTHERN INYO HOSPITAL
POLICY AND PROCEDURE**

Title: Standards of Care in ICU	
Scope: ICU	Manual: ICU - Standards of Care (S of C)
Source: Manager - ICU Acute/Subacute	Effective Date: 3/31/18

- E. To be transferred with all personal belongings and medications.

5. ON DISCHARGE:

- A. To have discharge assessment completed by RN.
- B. To have written discharge instructions provided to patient/family member by RN, including clarification of:
 - a. Who to call for questions.
 - b. Nature of medical condition and what symptoms to report to MD.
 - c. Medications to take, list of medications already given that day, new prescriptions.
 - d. Follow-up appointment, including outpatient diagnostic test and lab work orders.
 - e. Medical equipment needed at home, including vendor to call for assistance.
 - f. Home Health/Hospice/Meals on Wheels contact information as ordered.
 - g. Activity level and return to work.
 - h. Dietary restrictions.
- C. To be discharged with all belongings and medications.
- D. To receive hospital follow-up call.

6. ON EXPIRATION:

- A. To have Family Member/Significant Other/Power of Attorney/Health Care Surrogate, Nursing Home, and Organ Procurement agency notified of impending death.
- B. To have all Medical Staff assigned to the case, Family Member/Significant Other/Power of Attorney/Health Care Surrogate, Nursing Home, and Organ Procurement agency notified of death.
- C. To have all belongings returned to family or sent with body to Funeral Home.
- D. To have post-mortem care completed and body released to Funeral Home or Medical Examiner.

REFERENCE(S):

1. General Acute Care Hospitals. (2016). 22 CCR §§ 70211-70217
2. American Nurses Association. (2010). *Nursing Scope and Standards of Practice*. Silver Spring, MD: Nursesbooks.org
3. JCAHO NC3.1.2 1992

CROSS REFERENCE HOSPITAL P&P:

1. A Quick Check
2. Definition of Nursing Practice
3. Hand Off; Standardized Nursing Communications Policy
4. Obtaining Consent for Organ and Tissue Donation
5. Patients' Rights
6. Patient Transfer/Discharge to Another Facility

Approval	Date
Nurse Executive Committee (NEC)	3/20/19
Med Services/ICU	6/6/19
Medical Executive Committee (MEC)	6/10/19

**NORTHERN INYO HOSPITAL
POLICY AND PROCEDURE**

Title: Standards of Care in ICU	
Scope: ICU	Manual: ICU - Standards of Care (S of C)
Source: Manager - ICU Acute/Subacute	Effective Date: 3/31/18

Board of Directors	
Last Board of Director review	

Developed: 3/96

Reviewed:

Revised: 01/01, 02/2004, 11/07 jk, 02/09rs, 04/09 FM, 9/12jk 6/17la, 2/18ta. 2/19jn

Last Board of Director review: 4/19/17

Index Listings: Standards of Care, ICU; ICU Standards of Care; Patient Care, Standards in ICU

**NORTHERN INYO HEALTHCARE DISTRICT
POLICY AND PROCEDURE**

Title: Definition and Limitations of Direct Access Physical Therapy Care	
Scope: Outpatient Rehabilitation	Manual: Rehabilitation Services
Source: Rehabilitation	Effective Date: draft

PURPOSE: To establish direct access physical therapy services at Northern Inyo Healthcare District.

POLICY:

Per the Physical Therapy Practice Act of California all patients seeking Physical Therapy services may initiate physical therapy treatment directly from a licensed physical therapist actively employed by Northern Inyo Healthcare District if the treatment is within the scope of practice of physical therapists, as defined in Section 2620 of the Physical Therapy Practice Act of California. Furthermore, a person may initiate physical therapy treatment directly if all of the following conditions are met:

- (1) If, at any time, the physical therapist has reason to believe that the patient has signs or symptoms of a condition that requires treatment beyond the scope of practice of a physical therapist or the patient is not progressing towards documented treatment goals as demonstrated by objective, measurable, or functional improvement, the physical therapist shall refer the patient to a person holding a physician and surgeon’s certificate issued by the Medical Board of California or by the Osteopathic Medical Board of California or to a person licensed to practice dentistry, podiatric medicine, or chiropractic.
- (2) The physical therapist shall comply with Section 2633 of the Physical Therapy Practice Act of California, and shall disclose to the patient any financial interest he or she has in treating the patient and, if working in a physical therapy corporation, shall comply with Article 6, Section 650 of Chapter 1 of the Physical Therapy Practice Act of California.
- (3) With the patient’s written authorization, the physical therapist shall notify the patient’s physician and surgeon, if any, that the physical therapist is treating the patient.
- (4) The physical therapist shall not continue treating the patient beyond 45 calendar days or 12 visits, whichever occurs first, without receiving, from a person holding a physician and surgeon’s certificate from the Medical Board of California or the Osteopathic Medical Board of California or from a person holding a certificate to practice podiatric medicine from the California Board of Podiatric Medicine and acting within his or her scope of practice, a dated signature on the physical therapist’s plan of care indicating approval of the physical therapist’s plan of care. Approval of the physical therapist’s plan of care shall include an in-person patient examination and evaluation of the patient’s condition and, if indicated, testing by the physician and surgeon or podiatrist.
- (5) The conditions in paragraph (4) do not apply to a physical therapist when he or she is only providing wellness physical therapy services to a patient as described in the Physical Therapy Practice Act section 2620, subdivision (a).

Procedure:

1. Upon initiation of physical therapy treatment under direct access care the physical therapist shall not perform physical therapy treatment services without first providing the Direct Physical Therapy Treatment Services notice to the patient, orally and in writing.
2. Initiation of direct access care from a physical therapist does not guarantee a health care service plan, insurer, worker’s compensation insurance plan, employer, or state program will provide coverage for

**NORTHERN INYO HEALTHCARE DISTRICT
POLICY AND PROCEDURE**

direct access to treatment by a physical therapist. Patients will be responsible for denied insurance claims.

3. Direct access services also do not restrict or alter the scope of practice of any other health care professional at Northern Inyo Healthcare District.
4. Direct access services do not expand or modify the scope of practice for physical therapists set forth in Section 2620 of the Physical Therapy Practice Act of California, including the prohibition on a physical therapist diagnosis of disease.

References: California Laws and Regulations Related to the Practice of Physical Therapy 2017: Article 2, §2620.1

Cross Reference Policies or Plans: None

Committees: Required Hospital Committee where policy is approved. Include month/year of approval at committee.

Developed: 2/28/19

Reviewed: pending

Revised: 4/19/19

Retired:

Competency Sheet:

Medbridge Courses:

- Indications for Musculoskeletal Imaging by Robert Boyles, PT, DSc, OCS, FAAOMPT
- Medical Screening and Differential Diagnosis nine part course series by Michael Fink, PT, DSc, SCS, OCS

Approval	Date
Medicine/Intensive Care Committee	6/6/19
Medical Executive Committee	6/10/19
Board of Directors	
Last Board of Directors Review	

Developed:

Revised:

Reviewed:

Supersedes:

**NORTHERN INYO HEALTHCARE DISTRICT
STANDARD OF CARE**

Title: Standards of Care in the Perioperative Unit	
Scope: Perioperative Unit	Manual: Infusion – Standards of Care (S of C)
Source: DON Perioperative Services	Effective Date:

POLICY STATEMENT:

1. The Outpatient Infusion Unit nursing is provided using an interdisciplinary team approach, based on a holistic assessment of patient needs, capabilities, and limitations; nursing diagnosis; planning; interventions; and evaluation of patient response.
2. The patient age-specific population served is:
 - Pediatric: 28 days of age to 13 years of age
 - Adult: 13 years of age to 65 years of age
 - Geriatric: > 65 years of age

PROCEDURE:

The Outpatient Infusion patient and/or family-caregiver can expect:

1. THROUGHOUT THE STAY

- a. To be treated in accordance with NIHD’s policy entitled “Patients’ Rights”
- b. To be kept informed of and involved in the plan of care including medications, procedures, and discharge needs.
- c. To have care delivered based on standards of practice for the diagnosis identified.

2. PRIOR TO ADMISSION

- A. The patient will be scheduled for the infusion or other Outpatient service (injection, transfusion, wound care, central line care, therapeutic phlebotomy) after the provider orders have been received, insurance authorization has been obtained, and the NIHD Pharmacy has verified that any needed medication is available.

3. ON ADMISSION OR TRANSFER INTO THE DEPARTMENT:

- A. To be greeted immediately upon arrival to the unit including:
 - a. Introduction of nursing and ancillary staff
 - i. Explanation of what to expect during the Outpatient stay
 - ii. Expected timing of the procedure
 - b. A clean patient cubicle with appropriate supplies and equipment and orientation to:
 - i. Call light use and TV controls
 - ii. Bathroom location
 - iii. Equipment in use including IV pumps or wound care equipment
- B. ~~Assessment and initiation of the procedure by an RN within 30 minutes of arrival~~ **Within 30 minutes of arrival the RN will assess the patient and initiate the procedure. As appropriate to diagnosis and MD/APP orders the following will be provided:**
 - a. Vital signs taken and recorded as well as height / weight if needed
 - b. Physical assessment (skin, lungs, heart)
 - c. IV access obtained if needed for the procedure
 - d. Informed consent for an initial chemotherapy administration, any blood product administration and therapeutic phlebotomy reviewed / signed per policy
 - e. Review of post-procedure appointments or equipment if needed

**NORTHERN INYO HEALTHCARE DISTRICT
STANDARD OF CARE**

Title: Standards of Care in the Perioperative Unit	
Scope: Perioperative Unit	Manual: Infusion – Standards of Care (S of C)
Source: DON Perioperative Services	Effective Date:

- f. Documentation of the care given will be completed in the electronic health record and patient assessments will be used to formulate an ongoing plan of care which will be documented in the EHR
- C. The nursing care of patients will be supervised by RNs adept in skills and knowledge of the outpatient procedures performed in the Infusion Unit.
 - a. **RN will** review and ~~initiation~~ **initiate** of the procedure orders ~~by the RN~~
 - b. ~~To have an~~ **RN will** initiate discharge planning at time of admission, to be readdressed throughout stay including:
 - i. Patient goals for outpatient procedure
 - ii. Referral to interdisciplinary team, including but not limited to: dietary, social services, physical therapy, speech therapy, and pharmacy **as needed.**
 - c. The Outpatient Infusion RN’s practice is guided by the Infusion Nurses Society, and the Oncology Nursing
 - d. The AHA ACLS protocol will be instituted when necessary for all **PACU Outpatient and Infusion** patients, older than 13 years of age, and the AHA PALS protocol instituted when necessary for all patients younger than 13 years of age.
 - a. Medication will be labeled and bar code scanned
 - b. Aseptic technique will be implemented and maintained for central line care and IV access
- D. Universal Protocol will be followed.
- E. The patient will be monitored throughout the procedure by an RN. Patients will receive nursing care based on an assessment of their needs.
- A. Vital signs including Blood Pressure, Pulse, Respiratory rate and O2 saturation will be completed per policy. A temperature will be obtained on unit admission and as the condition / procedure dictates.
- B. All completed assessments will be documented in the EHR in a timely manner
- C. An intravenous infusion pump will be used on all patients receiving IV drugs.
- D. In the event that the patient's status deteriorates, the Infusion RN will immediately notify the primary care physician or hospitalist.
 - a. Abnormal or worsening critical signs specific to patient’s baseline
 - b. Abnormal or worsening lab values
 - c. Significant change in Level of Consciousness (LOC)
 - d. Significant or worsening change in physical assessment
 - e. Significant change or imbalance in Input and Output (I&O)
 - f. Any adverse drug and/or blood reactions, or untoward change as a response to treatment
 - g. Inability to control pain or obtain pain relief
 - h. Any untoward occurrence/event occurring in the hospital
 - i. Significant change in cardiac rhythm
- E. To receive prompt identification of and intervention for potential and actual complications/side effects, including Rapid Response Team initiation.

**NORTHERN INYO HEALTHCARE DISTRICT
STANDARD OF CARE**

Title: Standards of Care in the Perioperative Unit	
Scope: Perioperative Unit	Manual: Infusion – Standards of Care (S of C)
Source: DON Perioperative Services	Effective Date:

- F. Care of the Infusion patient will be guided by the policies and procedures at Northern Inyo ~~Hospital~~ **Healthcare District**.
- G. A FSBS may be performed by the RN if the patient is demonstrating signs or symptoms suspicious for hypo/hyperglycemia. The physician will be informed of all abnormal results.
- H. Nursing staff will be responsible for knowledge of medication given and utilizing appropriate resources to gain that knowledge.
- I. All sedation/analgesia will be given according to the Procedural Sedation guidelines.
- J. To have pain assessed and managed in a systematic way to achieve optimal relief.
- K. Environment assessment, to include maintenance of clean, quiet, and therapeutic atmosphere.
- L. To have safety measures identified specific to each patient including:
 - a. Patient identification band in place; staff to use ~~at least~~ two patient identifiers (**name and date of birth**) for medications and procedures.
 - b. 5 rights of medication administration practiced.
 - c. Fall risk assessment completed at admission (pre-operatively) and discharge from hospital.
 - d. Smoke-free environment
- M. To have confidentiality and privacy maintained in accordance with policy on Patient Rights, State Law, and Federal Law.
- N. Patients have the right to refuse care, treatment and services in accordance with the law and regulation
- O. All Outpatient Procedure patients will be entered in the Outpatient Procedure logbook.

4. ON TRANSFER WITHIN NIH:

- A. To have patient assessment completed by receiving RN.
- B. To have transferring RN provides report of patient condition (SBAR-QC) to receiving RN.
- C. To have patient/family updated on reason for transfer, location moved, and expected time of transfer.
- D. To be transferred with all belongings.

5. ON DISCHARGE:

- A. To have written discharge instructions provided to patient/family member by RN, including clarification of:
 - a. Who to call for questions.
 - b. Nature of medical condition and what symptoms to report to MD.
 - c. Follow-up appointment, including outpatient diagnostic test and lab work orders.
 - d. Medical equipment needed at home, including vendor to call for assistance.
- B. To be discharged with all belongings and medications.

REFERENCE(S):

**NORTHERN INYO HEALTHCARE DISTRICT
STANDARD OF CARE**

Title: Standards of Care in the Perioperative Unit	
Scope: Perioperative Unit	Manual: Infusion – Standards of Care (S of C)
Source: DON Perioperative Services	Effective Date:

1. *American Nurses Association. (2010). Nursing Scope and Standards of Practice. Silver Spring, MD: Nursesbooks.org*
2. *CA Code of Regulations Div. 5, Title 22: 70211, 70213, 70215, 70217 (2018)*
3. *Journal of Infusion Nursing: Infusion Therapy Standards of Practice, 2016*
4. *ONS (Oncology Nursing Society) Chemotherapy and Biotherapy Guidelines Fourth Edition (2014)*

CROSS REFERENCE HOSPITAL P&P:

1. Chemotherapy Administration and Precautions
2. Nursing Care of the Interventional Radiology Patient
3. Staffing Plan OP/PACU
4. Patients' Rights
5. Universal Protocol

Approval	Date
Clinical Consistency Oversight Committee (CCOC)	4/8/19
Med Services/ICU	6/6/19
Medical Executive Committee (MEC)	6/10/19
Board of Directors	
Last Board of Director review	1/16/19

Developed: 7/15

Reviewed:

Revised: 02/01, 08/11 bs, 08/12bs, 02/19aw

Last Board of Director review: 1/16/19

Index Listings: Standards of Care, Outpatient Infusion

Perinatal Critical Indicators

2019

1. Maternal death or resuscitation
2. Fetal demise beyond 20 weeks gestation
3. Transfer to a higher level of care
4. Apgar score below 7 at 5 minutes
5. Neonatal trauma
6. Maternal seizure
7. Vaginal deliveries coded with shoulder dystocia
8. 3rd and 4th degree lacerations
9. Postpartum hemorrhage requiring transfusion
10. Postpartum readmission
11. Disruption or infection of obstetrical wound
12. Delivery of infant less than 36 weeks gestation
13. Maternal admission to ICU
14. Maternal induction of labor less than 39 weeks without documented indication
- 14,15. Staff concerns.

Approvals:

Peri-Peds Committee: 5/14/19

Medical Executive Committee: 6/10/19

Board of Directors:

Practitioner Name: _____ Date: _____
Please Print

FAMILY MEDICINE

Instructions: Please check box next to each core privilege/special privilege requested.

INITIAL CRITERIA

Education/Formal Training:

- Completed accredited residency training in family medicine.
- Board Certified/Board Eligible by the American Board of Family Medicine **OR** equivalent (AOA).

OUTPATIENT CORE PRIVILEGES

****Current BLS or ACLS required****

- Assess, evaluate, stabilize and/or provide treatment to patients of any age who present to the outpatient environment with any illness, condition or symptom.
- Evaluate, diagnose, perform H&P, consult, and provide non-surgical treatment to a patient of any age.

Primary Care

- Incision and drainage of abscess, excluding peri-rectal
- Allergy immunotherapy
- Anoscopy
- Arthrocentesis/joint injections
- Incision and drainage of Bartholin's cyst/abscess
- Bladder catheterization
- Burn management, 1st and 2nd degree
- Aspiration of breast cyst
- Application of cast/splint
- Cancer chemotherapy(in consultation with oncologist)
- Cerumen impaction removal
- Cervical dilation (mechanical)
- Removal of cervical polyps, simple
- Circumcision with clamp, pediatric only
- Colposcopy, with or without cervical biopsy
- Cryotherapy, skin
- Cryotherapy, cervix
- Dermoscopy
- Endometrial biopsy
- Foreign body removal (skin, superficial corneal/conjunctival, nose and ear)
- Ganglion cyst aspiration/injection
- Incision of thrombosed external hemorrhoid, simple
- Insertion/removal of implanted contraceptive device (eg, Nexplanon)
- Insertion/removal of intrauterine device (IUD)
- Laceration repair, simple
- Lumbar puncture

Primary Care (continued)

- Microscopic examination (urine, vaginal wet mount and skin preparations) – *Provider Performed Microscopy (PPM) competency required*
- Nail removal
- Paracervical block
- Pessary placement
- Digital nerve/ring block anesthesia
- Skin biopsy (excisional, shave, or punch)
- Soft tissue injections/trigger point injections
- Drainage of subungual hematoma
- Tonometry
- Tympanometry
- Application of Unna paste boot
- Vasectomy
- Uncomplicated wound debridement

Obstetrics/Gynecology

- Endocervical curettage
- Vulvar/vaginal biopsy
- Abdominal/transvaginal OB/GYN ultrasonography
- Saline infusion hysterosonography

Physical Examinations

- Pre-employment physicals
- Commercial driving medical exams (DOT Medical Examiner's Certificate required)
- Disability evaluations
- Independent medical evaluations (Workman's Compensation)
- Return to work evaluations

ADULT INPATIENT CORE PRIVILEGES

Requires inpatient experience within the last 2 years, current ACLS certification, and recommendation by Hospitalist Director.

- Admit, evaluate, diagnose, perform H&P, consult and provide nonsurgical treatment to adult patients presenting with general medical problems.
- Admit, evaluate, diagnose, perform H&P, consult and provide nonsurgical treatment to adult patients presenting with critical illnesses, needing ICU care.
- Ventilator management.



Northern Inyo Hospital Medical Staff
Clinical Privilege Request Form

Appointment cycle _____
(Office use only)

Practitioner Name: _____ Date: _____

Please Print

SPECIAL PRIVILEGES	
<i>All require experience within last 2 years</i>	
<input type="checkbox"/> Well newborn care/admit to nursery (NRP required, STABLE preferred; approval by Chief of Pediatrics) <input type="checkbox"/> Pediatric consultation and admission (advanced experience managing peds/newborns; PALS & NRP required; approval by Chief of Pediatrics) <input type="checkbox"/> Conscious sedation (requires tutorial and current ACLS certificate per Procedural Sedation policy) <input type="checkbox"/> Surgical first assist (requires experience in last 2 years and recommendation by Chief of Surgery)	Special Privileges in Obstetrics: require experience in last 2 years and recommendation by Chief of OB/GYN <input type="checkbox"/> Vaginal delivery; spontaneous <input type="checkbox"/> Vacuum-assisted vaginal delivery <input type="checkbox"/> Episiotomy and repair of vaginal lacerations (1 st and 2 nd degree only; 3 rd /4 th degree must consult OB) <input type="checkbox"/> Manual extraction of the placenta <input type="checkbox"/> FSE application/IUPC insertion <input type="checkbox"/> Induction of labor/cervical ripening

Acknowledgment of Practitioner:

I have requested only those privileges for which by education, training, health status, current experience and demonstrated performance I am qualified to perform and for which I wish to exercise and I understand that:

- (a) In exercising any clinical privileges granted, I am constrained by any Medical Staff Bylaws, Rules and Regulations, and policies and procedures applicable.
- (b) Any restriction on the clinical privileges granted to me is waived in an emergency situation and in such situation my actions are governed by the applicable section of the Medical Staff Bylaws or related documents.

Practitioner Signature

Date

APPROVALS

COMMENTS/MODIFICATIONS TO REQUESTED PRIVILEGES:

RHC/Outpatient Clinic Medical Director Date

Chief of Medicine Date

Chief of Pediatrics Date

Chief of Surgery Date

Chief of Obstetrics Date

Hospitalist Director Date

<i>Approvals</i>	<i>Committee Date</i>
Credentials Committee	
Medical Executive Committee	
Board of Directors	

(Office use only)



NORTHERN INYO HOSPITAL
Northern Inyo Healthcare District
150 Pioneer Lane, Bishop, California 93514

Medical Staff Office
(760) 873-2136 voice
(760) 873-2130 fax

TO: NIHD Board of Directors
FROM: Allison Robinson, MD, Chief of Medical Staff
DATE: June 10, 2019
RE: Medical Executive Committee Report

The Medical Executive Committee met on this date. Following careful review and consideration, the Committee agreed to recommend the following to the NIHD Board of Directors:

- A. Medical Staff Officers and Service Chiefs 2019 – 2020 (*action item*)
 - 1. Chief of Staff – William Timbers, MD
 - 2. Immediate Past Chief of Staff – Allison Robinson, MD
 - 3. Chief of Emergency Room Service – Sierra Bourne, MD
 - 4. Chief of Medicine – Nickoline Hathaway, MD
 - 5. Chief of Obstetrics – Martha Kim, MD
 - 6. Chief of Pediatrics – Charlotte Helvie, MD
 - 7. Chief of Radiology – Edmund Pillsbury, MD
 - 8. Chief of Surgery – Robbin Cromer-Tyler, MD
 - 9. Member-at-large – Stacey Brown, MD

- B. Policies and Procedures (*action items*)
 - 1. *Patient Safety Attendant or 1:1 Staffing Guidelines*
 - 2. *High Alert Medications: Preparation, Dispensing, Storage*
 - 3. *Newborn Blood Glucose Monitoring*
 - 4. *Neonatal Death, Fetal Demise & Spontaneous Abortion Procedure*
 - 5. *Nursing Management of Preeclampsia*
 - 6. *Pediatric Standards of Care and Routines*
 - 7. *Removal of Placenta from Hospital per Patient's Request*
 - 8. *Infection Prevention Plan*
 - 9. *Vendor Credentialing*
 - 10. *Aerosolized Transmissible Disease Exposure Plan/Respiratory Protection Program*
 - 11. *Healthcare Worker Health Screening and Maintenance Requirements*
 - 12. *Skilled Nursing Facilities*
 - 13. *Standards of Care ICU*
 - 14. *Definition and Limitations of Direct Access Physical Therapy Care*
 - 15. *Standards of Care in the Outpatient Infusion Unit*

- C. Perinatal Critical Indicators 2019 – update (*action item*)

- D. Core Privilege form updates (*action items*)
 - 1. Family Medicine

- E. Medical Staff Appointments (*action items*)
 - 1. Samantha Jeppsen, MD (*emergency medicine*) – provisional active staff
 - 2. Carly Harvey, MD (*radiology*) – provisional consulting staff

- F. Temporary Privileges for 60 days (*action item*)
 - 1. Ruhong Ma, DO (*internal medicine*) – locums/temporary staff

- G. Extension of privileges for an additional 60 days (*action items*)
 - 1. Kristina Jong, MD (*radiology, breast imaging*) – effective 6/7/19
 - 2. Michael Rhodes, MD (*internal medicine/hospitalist*) – effective 6/24/19
 - 3. Joseph BenPerlas, MD (*internal medicine/hospitalist*) – effective 5/23/19

- H. Additional Privileges (*action item*)
 - 1. Uttama Sharma, MD (*family medicine*) – chemotherapy in consultation with oncologist

- I. Resignations (*action items*)
 - 1. Sun Kim (*urology*) – effective 5/2/19

**RESOLUTION NO. 4
OF THE
NORTHERN INYO HEALTHCARE DISTRICT
BOARD OF DIRECTORS**

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

WHEREAS, using data provided by the State of California Department of Finance, on June 20, 2018, the Board of Directors of Northern Inyo Healthcare District established an appropriations limit of \$626,906.98 for the year July 1, 2018 to June 30, 2019 fiscal year; and

WHEREAS, using the attached data provided by the State of California Department of Finance and the County of Inyo, an appropriations limit of \$651,078.09 has been calculated for the July 1, 2019 to June 30, 2020 fiscal year.

NOW, THEREFORE, BE IT RESOLVED by this Board of Directors of Northern Inyo Healthcare District, meeting in regular session this 19th day of June, 2019 that an appropriations limit of \$651,078.09 be established for the Northern Inyo Healthcare District for the 2019-2020 fiscal year; and

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

President

Attest:

Secretary



May 2019

Dear Fiscal Officer:

Subject: Price Factor and Population Information

Appropriations Limit

California Revenue and Taxation Code section 2227 requires the Department of Finance to transmit an estimate of the percentage change in population to local governments. Each local jurisdiction must use their percentage change in population factor for January 1, 2019, in conjunction with a change in the cost of living, or price factor, to calculate their appropriations limit for fiscal year 2019-20. Attachment A provides the change in California's per capita personal income and an example for utilizing the price factor and population percentage change factor to calculate the 2019-20 appropriations limit. Attachment B provides the city and unincorporated county population percentage change. Attachment C provides the population percentage change for counties and their summed incorporated areas. The population percentage change data excludes federal and state institutionalized populations and military populations.

Population Percent Change for Special Districts

Some special districts must establish an annual appropriations limit. California Revenue and Taxation Code section 2228 provides additional information regarding the appropriations limit. Article XIII B, section 9(C) of the California Constitution exempts certain special districts from the appropriations limit calculation mandate. The code section and the California Constitution can be accessed at the following website: <http://leginfo.legislature.ca.gov/faces/codes.xhtml>.

Special districts required by law to calculate their appropriations limit must present the calculation as part of their annual audit. Any questions special districts have on this requirement should be directed to their county, district legal counsel, or the law itself. No state agency reviews the local appropriations limits.

Population Certification

The population certification program applies only to cities and counties. California Revenue and Taxation Code section 11005.6 mandates Finance to automatically certify any population estimate that exceeds the current certified population with the State Controller's Office. **Finance will certify the higher estimate to the State Controller by June 1, 2019.**

Please Note: The prior year's city population estimates may be revised.

If you have any questions regarding this data, please contact the Demographic Research Unit at (916) 323-4086.

KEELY BOSLER
Director
By:

Vivek Viswanathan
Chief Deputy Director

Attachment

- A. **Price Factor:** Article XIII B specifies that local jurisdictions select their cost of living factor to compute their appropriation limit by a vote of their governing body. The cost of living factor provided here is per capita personal income. If the percentage change in per capita personal income is selected, the percentage change to be used in setting the fiscal year 2019-20 appropriation limit is:

Per Capita Personal Income	
Fiscal Year (FY)	Percentage change over prior year
2019-20	3.85

- B. Following is an example using sample population change and the change in California per capita personal income as growth factors in computing a 2019-20 appropriation limit.

2019-20:

Per Capita Cost of Living Change = 3.85 percent
 Population Change = 0.47 percent

Per Capita Cost of Living converted to a ratio: $\frac{3.85 + 100}{100} = 1.0385$

Population converted to a ratio: $\frac{0.47 + 100}{100} = 1.0047$

Calculation of factor for FY 2019-20: $1.0385 \times 1.0047 = 1.0434$

Fiscal Year 2019-20

Attachment B
Annual Percent Change in Population Minus Exclusions*
January 1, 2018 to January 1, 2019 and Total Population, January 1, 2019

County City	Percent Change 2018-2019	-- Population Minus Exclusions --		Total Population
		1-1-18	1-1-19	1-1-2019
Inyo				
Bishop	-0.03	3,900	3,899	3,899
Unincorporated	0.01	14,601	14,603	14,694
County Total	0.01	18,501	18,502	18,593

*Exclusions include residents on federal military installations and group quarters residents in state mental institutions, state and federal correctional institutions and veteran homes.

**ATTACHMENT A
STATEMENT OF INYO COUNTY GANN LIMIT CALCULATIONS
FOR THE TAX YEAR 2018-2019**

Updated to Include Northern Inyo Healthcare District

	2016-2017 Limit	Population Change	Per Capita Change	2017-2018 Limit	Population Change	Per Capita Change	2018-2019 Limit
Big Pine Lighting	51,595.94	1.0001	1.0369	53,505.18	0.9990	1.0367	55,413.35
Independence Lighting	51,437.49	1.0001	1.0369	53,340.87	0.9990	1.0367	55,243.18
Lone Pine Lighting	73,988.18	1.0001	1.0369	76,726.02	0.9990	1.0367	79,462.32
Big Pine Fire	333,703.75	1.0001	1.0369	346,052.02	0.9990	1.0367	358,393.38
Bishop Fire	524,235.26	1.0001	1.0369	543,633.90	0.9990	1.0367	563,021.68
Independence Fire	229,073.97	1.0001	1.0369	237,550.55	0.9990	1.0367	246,022.39
Lone Pine Fire	285,471.19	1.0001	1.0369	296,034.67	0.9990	1.0367	306,592.25
Big Pine Cemetery	70,794.73	1.0001	1.0369	73,414.40	0.9990	1.0367	76,032.60
Independence Cemetery	163,704.33	1.0001	1.0369	169,762.00	0.9990	1.0367	175,816.27
Mt. Whitney Cemetery	113,851.27	1.0001	1.0369	118,064.19	0.9990	1.0367	122,274.75
Pioneer Cemetery	423,814.79	1.0001	1.0369	439,497.50	0.9990	1.0367	455,171.43
Tecopa Cemetery	11,882.42	1.0001	1.0369	12,322.11	0.9990	1.0367	12,761.56
Darwin CSD	17,433.65	1.0001	1.0369	18,078.76	0.9990	1.0367	18,723.51
Olancho CSD	141,435.45	1.0001	1.0369	146,669.08	0.9990	1.0367	151,899.79
Westridge CSD	88,824.82	1.0001	1.0369	92,111.66	0.9990	1.0367	95,396.67
Southern Inyo Emergency	118,564.27	1.0001	1.0369	122,951.58	0.9990	1.0367	127,336.44
INYO COUNTY	41,031,142.54	1.0001	1.0369	42,549,446.22	0.9990	1.0367	44,066,899.88
Northern Inyo Healthcare	583,719.53	1.0001	1.0369	605,319.30	0.9990	1.0367	626,906.99
Estimated 2020 Limit							
Northern Inyo Healthcare	\$ 626,906.98	1.0001	1.0385	\$ 651,078.09			

**RESOLUTION NO. 19-05
OF THE
NORTHERN INYO HEALTHCARE DISTRICT
BOARD OF DIRECTORS**

WHEREAS, the Board of Directors (“Board”) of the Northern Inyo Healthcare District (“District”) established the Northern Inyo Healthcare District 401(a) Retirement Plan effective January 1, 2013 (the “Retirement Plan”), and subsequently restated the Plan effective January 1, 2016: and

WHEREAS, Section 5.1 of the Plan permits the District to determine the contribution amount to the Plan; and

WHEREAS, the Board previously approved a contribution to the Plan equal to 7% of the eligible Compensation on behalf of each Participant (as defined by the Plan) as part of the District’s 2017/2018/2019 budgets.

NOW, THEREFORE, be it resolved, determined, and ordered by the Board of Directors of the Northern Inyo Healthcare District as follows:

SECTION 1. That, effective January 1, 2018 the District hereby ratifies and approves a 7% contribution to the Northern Inyo Healthcare District 401(a) Retirement Plan on behalf of each eligible Participant, as contemplated by the approved 2017/2018 and 2018/2019 budgets.

BE IT FURTHER RESOLVED that this Resolution be made a part of the minutes of this meeting. ADOPTED this 19th day of June, 2019.

President

Attest:

Secretary

RQI Program Master Services Agreement



RQI Master Services Agreement - Important Background Information

Thank you for your interest in adopting the RQI Program, the American Heart Association and Laerdal Medical's paradigm shift towards competency-based learning to sustain high quality CPR. We would like to offer some key points and tips to promote a smooth transition through the Master Service Agreement process. If you have any questions or concerns, please feel free to contact your local RQI Partners Territory Manager/Regional Manager or send questions/request help at RQIQuestions@rqipartners.com

Resuscitation Quality Improvement Program
RQI Partners LLC
7272 Greenville Avenue
Suite P2020
Dallas, TX 75231

Key Points when completing a RQI Master Service Agreement:

- Where should I submit the MSA once I have completed my assigned portion?
 - The MSA should be sent to your RQI Partners Regional or Territory Manager – or to RQIQuestions@rqipartners.com. It will then be routed to the appropriate RQI personnel for review and prepare it for execution.
- Please do not complete the Implementation Sign-Off Form. This portion will be finalized by RQI team members when your implementation is complete.
- Please gather the information necessary to complete the RQI: New Vendor Set Up form which is located on the last page of the MSA. This allows RQI Finance to set up billing and begin issuing statements for payment.
- The Total Contract Amount listed on the Order Form is not due upon program implementation, but all implementation fees will be invoiced at that time. RQI Subscription Services may be invoiced on an annual/semi-annual/quarterly basis commencing on the first subscription being activated.
- **Important Reminder:** Insert the “Effective Date” into the contract. There are two areas on the contract where this information needs to be entered.
 - Page 1, introduction segment
 - Page 11, section 13.1

RESUSCITATION QUALITY IMPROVEMENT PROGRAM MASTER SERVICES AGREEMENT

This Resuscitation Quality Improvement (“RQI”) Master Services Agreement (“Agreement”) is entered into and effective as of [Click here to enter a date.](#) (“Effective Date”) by and between **RQI Partners, LLC** (“RQIP”), a Delaware Limited Liability Company with its principal place of business at 7272 Greenville Ave., Suite P2020, Dallas, Texas, 75231 and **Northern Inyo Healthcare District**, having its principal place of business at 150 Pioneer Ln, Bishop, CA 93514 (“Customer”). **RQIP is a joint venture between the American Heart Association and Laerdal Medical**, specifically established to sell, service and support their Resuscitation Quality Improvement Program for customers on their behalf.

1. Definitions

“Program” or “RQI” means the Program as described in Section 2 and the subject of this Agreement.

“Order Form” means the ordering document representing the initial purchase of any Services as well as any subsequent purchases agreed to between the parties in writing, that are signed under this Agreement. The initial style of the Order Form for the Services to be delivered under this Agreement is included as [Exhibit A](#). The Order Form shall specify, among other things: the number of subscriptions ordered, type of project or product; the subscription, project, or project term; and the applicable fees, as applicable to the respective Service(s) ordered. The term “Order Form” also includes any subsequent document intended by the Parties to effect a change to the Service, such as a Change Request Form or Order Modification Form.

“Service” means all services specified at the time of ordering to be included in RQI which is the subject of this agreement. Service may also include equipment or other tangible assets as deemed appropriate by RQIP, depending on the type of Service agreed between the parties under this Agreement. The equipment will have no effect on the subscription fees unless agreed to by the parties in writing.

“Users” means Customer's employees, consultants, contractors, clients or agents who are authorized to use the Service and have been supplied user identifications and passwords by Customer (or by RQIP at Customer's request).

2. Program Description – Resuscitation Quality Improvement (RQI)

RQI is a system developed jointly by the American Heart Association and Laerdal Medical AS to assist in the continuous improvement of resuscitation skills provided by healthcare workers. RQI Partners, LLC, is a joint venture of the American Heart Association and Laerdal Medical Corporation established to sell, service and support the RQI Program.

RQI Program Master Services Agreement

The Program utilizes a variety of learning tools to assist in the maintenance of competency through frequent, small quantities of learning activities, including performance feedback and measurement, as well as capability to credit actual skill application in real medical situations. The Program may include some or all the following as specified in an Order Form agreed to and executed by the parties:

- **Skills learning activities** for the practice of resuscitation skills using special simulation learning stations deployed at locations
- **Simulation Learning Stations** that include all necessary equipment to ensure completion of specified skills learning activities
- **Knowledge and decision-making activities** to develop the application of resuscitation skills and may include interactive web-based and video content
- **Learning management system** to ensure the suitable management of learning activities within, reporting and administration of the Program. The system will include reporting and ability to export electronic records for the administration of the Program.
- **Rolling electronic credential maintenance** system that maintains the electronic course completion information, compliance documents for the Customer, and the validity period based upon the satisfactory completion of a skills learning session.

3. Service

3.1. Provision of Service. Customer agrees that its purchase of User subscriptions for Service is not contingent upon the delivery of any future functionality or features nor is it dependent upon any oral or written public comments made by RQIP with respect to future functionality or features.

3.2. Additional Users. User subscriptions for the Service are for named Users and cannot be shared or used by more than one User but may be reassigned by Customer to new Users replacing former Users who have separated from employment or some other prior relationship with Customer, changed job status or function, or otherwise no longer require ongoing use of the Service. Customer acknowledges that RQIP may conduct usage audits and invoice Customer, and Customer agrees to pay, for any usage above the number of subscriptions specified in Customer's Order Forms as well as adjust future billing rates to the new subscription level indicated by Customer's actual usage. Unless otherwise specified in the relevant Order Form:

- (a) the term of the additional User subscriptions shall be coterminous with the expiration of the then current subscription term; and
- (b) pricing for the additional User subscriptions shall be the same as that for the pre-existing subscriptions, prorated for the remainder of the then current subscription term.

3.3. Administrative Users. Each subscription will include one or more User accounts that include limited system administration and reporting features. The number of Administrative User accounts will be determined based on the number of regular User accounts in the subscription and may be adjusted as the number of regular User accounts, number and deployment strategies for training equipment and other factors change during the term.

3.4. Authorized Support Contacts. Customer will designate one or more Administrative Users who are authorized to invoke technical support and permit technical support technicians to access and make changes to Customer's Services as determined necessary to resolve Customer's technical support service request. The number of Authorized Support Contacts cannot exceed the number of Administrative Users. Customer is responsible for updating the list of Authorized Support Contacts with RQIP when any changes occur.

4. Use of the Service.

The Service included in the fees stated on the Order Form may include:

4.1. Training equipment - all training equipment for psychomotor skills as provided on the Order Form (not including the use of any consumables required to operate the equipment). Except in the case of an out of box failure or product defect, Customer is responsible for replacing manikin faces and lungs, wipes, adult and infant bag, adult and infant clothing. Customer acknowledges that in receiving the Service it does not take title or ownership to any of the equipment provided for the Services under this Agreement.

4.2. Installation and Administration Support – services to ensure that equipment installed at the Customer's site is operational and that site administrators are able to manage and operate the provided systems. An installation fee shall be included on the Order Form to cover such establishment charges.

4.3. Training Equipment Support – services to ensure that the training equipment remains operational and functional to perform the Services. In the case of failure of equipment RQIP will, as far as commercially reasonable, undertake to repair or replace at its own discretion and expense within five working days of the reported failure. RQIP shall maintain the equipment by means of replacement product, loaned equipment, shipping and repair, or on-site service.

4.4. Customer Support - standard telephone and online support to Customer's Authorized Support Contacts during normal RQIP Support Hours (generally Monday-Friday, 8 a.m. to 8 p.m. and Saturday 10 a.m. to 6 p.m. Eastern time, except holidays), which are subject to change.

4.5. Software and Data Handling - use of commercially reasonable efforts to make the Service generally available 24 hours a day, 7 days a week, except for: (i) planned downtime; or (ii) any unavailability caused by circumstances beyond RQIP's reasonable control, including without limitation, acts of God, acts of government, flood, fire, earthquakes, civil unrest, acts of terror, strikes or other labor problems (other than those involving RQIP employees), computer, telecommunications, internet service provider or hosting facility failures or delays involving hardware, software or power systems not within RQIP possession or reasonable control, and network intrusions or denial of service attacks.

4.6. Utilization Optimization Services – services provided at RQIP's sole discretion to assess Customer's needs and program goals, then configure and reconfigure some or all of the Service and included equipment in an effort to improve system performance and effectiveness based upon information such as Customer feedback, user experiences, results of a usage audit, environmental suitability factors and proximity of Customer's staff in the location.

5. Customer Responsibilities. Customer is responsible for all activities that occur under Customer's User accounts. Customer shall: (a) have sole responsibility for the accuracy, quality, integrity, legality, reliability, and appropriateness of all Customer Data; (b) use commercially reasonable efforts to preserve and care for the Simulation Learning Stations and prevent unauthorized access to, or use of, the Service, and notify RQIP promptly of any unauthorized use; (c) comply with all applicable local, state, federal, and foreign laws in using the Service and not use the Service in a manner that would violate any federal or state laws of the United States if conducted in the United States; and (d) not move beyond the designated facility where the equipment was installed, modify, dispose of, transfer or otherwise devalue the Simulation Learning Stations without prior written approval by RQIP. If Customer elects to have RQIP perform changes or repairs to the Service (including equipment) that Customer's Authorized Support Contact(s) could have performed, either with or without telephone or online Customer Support, Customer agrees to pay all costs associated with the elected additional services, including reasonable travel time and expenses.

6. Fees & Payment.

6.1. Fees. Customer shall pay all fees specified in all executed Order Forms. Except as otherwise provided, all fees are quoted in United States dollars. In the case of the Service and except for installation fees and as otherwise provided:

- (a) fees are based on the number of User subscriptions purchased in the relevant Order Form, not the extent of actual usage;

RQI Program Master Services Agreement

(b) fees are non-refundable; and

(c) the number of User subscriptions purchased cannot be decreased during the relevant subscription term stated on the Order Form.

6.2. Customer Invoicing & Payment. Customer shall provide complete and accurate billing and contact information to RQIP and notify RQIP of any change to such information. Fees for the Service will be invoiced in advance and otherwise in accordance with the terms set forth in the relevant Order Form. Unless otherwise stated in the Order Form, charges are due net thirty (30) days from the invoice date. Unless otherwise stated in the Order Form, all payments made under this Agreement shall be in United States dollars. Any payment not received from Customer by the due date may accrue (except with respect to charges then under reasonable and good faith dispute), at RQIP's discretion, late charges at the rate of 1.5% of the outstanding balance per month, or the maximum rate permitted by law, whichever is lower, from the date the payment was due until the date paid.

6.3. Initiation of Implementation and Subscription Fees. As RQIP completes delivery and implementation of the Service ordered by Customer, Customer will acknowledge receipt of the installation using a communication substantially similar to the example form attached as Exhibit B, "Implementation Sign-off Document," for each phase of delivery ("Implementation Date"). Customer's acknowledgement of receipt of installation will initiate immediate billing for the implementation fees. The fees for the subscription, and associated billing for related fees, on the service shall commence on the initiation of the first subscription being activated.

6.4. Taxes. Unless otherwise stated, RQIP's fees do not include any local, state, federal or foreign taxes, levies or duties of any nature ("Taxes"). Customer is responsible for paying all Taxes, excluding only taxes based on RQIP's income. If RQIP has the legal obligation to pay or collect Taxes for which Customer is responsible under this section, the appropriate amount shall be invoiced to and paid by Customer unless and to the extent that Customer qualifies for exemption of some or all of the Taxes and Customer provides RQIP with a valid tax exemption certificate authorized by each appropriate taxing authority.

6.5. Suspension of Service. If Customer's account is thirty (30) days or more overdue (except with respect to charges then under reasonable and good faith dispute), in addition to any of its other rights or remedies, RQIP reserves the right to suspend the Service provided to Customer, without liability to Customer, until the overdue amounts are paid in full.

7. Proprietary Rights

- 7.1. Reservation of Rights.** Customer acknowledges that in providing the Service, RQIP utilizes (a) trademarks and service marks; (b) certain audio and visual information, documents, software and other works of authorship; and (c) other technology, software, hardware, products, processes, algorithms, user interfaces, know-how and other trade secrets, techniques, designs, inventions and other tangible or intangible technical material or information, and other intellectual property licensed to RQIP (collectively, "RQIP Licensed IP") and that the RQIP Licensed IP is covered by intellectual property rights licensed by RQIP to Customer under this Agreement (collectively, "RQIP IP Rights"). Other than as expressly stated in this Agreement, no license or other rights in or to the RQIP Licensed IP or RQIP IP Rights are granted to Customer, and all licenses and rights are expressly reserved.
- 7.2. License Grant.** To the extent Customer orders Services under this Agreement, RQIP grants Customer and its Users a worldwide, non-exclusive, non-transferable, non-sublicenseable right to access and use the Service in accordance with the terms of this Agreement.
- 7.3. Restrictions.** Customer shall not (a) modify, copy or create derivative works based on the Service or RQIP Licensed IP; (b) create Internet "links" to or from the Service, or "frame" or "mirror" any content forming part of the Service, other than on Customer's own intranets or otherwise for its own internal business purposes; (c) disassemble, reverse engineer, or decompile the Service or RQIP Licensed IP, or access it in order to (i) build a competitive product or service; (ii) build a product or service using similar ideas, features, functions or graphics of the Service; or (iii) copy any ideas, features, functions or graphics of the Service; or (d) permit any use, removal or changes to any branding marks or logos on any components of the Service that are not authorized by RQIP in writing in advance.

8. Customer Data.

- 8.1. General.** As between RQIP and Customer, all data obtained by RQIP from Customer through the provision of the Service, including all data results compiled by RQIP in providing the Service ("Customer Data") is owned exclusively by Customer. Customer Data shall be considered Confidential Information subject to the terms of this Agreement. Customer grants RQIP, the American Heart Association and Laerdal Medical, an unrestricted, royalty-free, irrevocable license to maintain and distribute aggregated compilations of Customer Data ("Aggregated Data") and to use such Aggregated Data for future studies and reports; provided, that the Aggregated Data will not reveal any personal information or the identity of Customer or any information in violation of FERPA (as defined below).

8.2. Learning Service Data. RQIP may access Customer's User accounts, including Customer Data, solely to respond to service or technical problems or at Customer's request. At Customer's request, when included as part of the Service, Customer agrees that RQIP may distribute certain Customer Data to support service, licensing and accreditation organizations for the benefit of Users. RQIP will release the minimum data required to adequately credit Users for educational activities completed.

9. Confidentiality.

9.1. Definition of Confidential Information. As used in this Agreement, "**Confidential Information**" means all confidential and proprietary information of a party ("**Disclosing Party**") disclosed to the other party ("**Receiving Party**"), whether orally or in writing, that is designated as confidential at the time of disclosure or that reasonably should be understood to be confidential given the nature of the information and the circumstances of disclosure, including the terms and conditions of this Agreement (including pricing and other terms reflected in all Order Forms under this Agreement), the Customer Data, the Service, the RQIP Licensed IP and RQIP IP Rights, business and marketing plans, technology and technical information, product designs, and business processes. Confidential Information expressly includes all proprietary information and details that are generally considered "trade secrets" in the medical training services, medical and health-related technology and resuscitation technology industries. Confidential Information (except for Customer Data) shall not include any information that: (a) is or becomes generally known to the public without breach of any obligation owed to the Disclosing Party; (b) was known to the Receiving Party prior to its disclosure by the Disclosing Party without breach of any obligation owed to the Disclosing Party; (c) was independently developed by the Receiving Party without breach of any obligation owed to the Disclosing Party; or (d) is received from a third party without breach of any obligation owed to the Disclosing Party.

9.2. Confidentiality. The Receiving Party shall not disclose or use any Confidential Information of the Disclosing Party for any purpose outside the scope of this Agreement, except with the Disclosing Party's prior written permission. Each party agrees to protect the confidentiality of the Confidential Information of the other party in the same manner that it protects the confidentiality of its own proprietary and confidential information of like kind, but in no event shall either party exercise less than reasonable care in protecting the Confidential Information. If the Receiving Party is compelled by law to disclose Confidential Information of the Disclosing Party, it shall provide the Disclosing Party with prior notice of the compelled disclosure (to the extent legally permitted) and reasonable assistance, at Disclosing Party's cost, if the Disclosing Party wishes to contest the disclosure.

RQI Program Master Services Agreement

9.3. Remedies. If the Receiving Party discloses or uses (or threatens to disclose or use) any Confidential Information of the Disclosing Party in breach of this Section 9, the Disclosing Party shall have the right, in addition to any other remedies available to it, to seek injunctive relief to enjoin the acts, it being specifically acknowledged by the parties that any other available remedies may be inadequate.

10. Warranties.

10.1. General. Each party represents and warrants that it has the legal power to enter into this Agreement. RQIP represents and warrants that (i) it will provide the Service in a manner consistent with general industry standards reasonably applicable to the provision of the Service; (ii) it owns or otherwise has sufficient rights to the Service and the RQIP Licensed IP to grant the rights and licenses granted in this Agreement; and (iii) the Service, RQIP Licensed IP and RQIP Licensed Rights do not infringe any intellectual property rights of any third party.

10.2. Non-Exclusion. RQIP represents and warrants that RQIP, its officers, directors, and employees (i) are not currently excluded, debarred, or otherwise ineligible to participate in the federal healthcare programs as defined in 42 U.S.C. §1320a-7b(f) (the “federal healthcare programs”), (ii) have not been convicted of a criminal offense related to the provision of healthcare items or services and have not been excluded, debarred, or otherwise declared ineligible to participate in the federal healthcare programs, and (iii) are not, to the best of its knowledge, under investigation or otherwise aware of any circumstances which may result in RQIP being excluded from participation in the federal healthcare programs. This shall be an ongoing representation and warranty and RQIP shall immediately notify Customer of any change in the status of the representations and warranty set forth in this section. Any breach of this section shall give Customer the right to terminate this Agreement immediately for cause.

10.3. FERPA. RQIP represents and warrants that it will not disclose any information in violation of the Family Educational Rights and Privacy Act (20 U.S.C. 1232g) and the Family Educational Rights and Privacy Act Regulations (34 CFR Part 99), as amended or otherwise modified from time to time, and that Education Records, as defined by FERPA, shall remain in the ownership of Customer.

10.4. Disclaimer. EXCEPT AS EXPRESSLY PROVIDED IN THIS AGREEMENT, RQIP MAKES NO WARRANTY OF ANY KIND, WHETHER EXPRESS, IMPLIED, STATUTORY, OR OTHERWISE. RQIP SPECIFICALLY DISCLAIMS ALL IMPLIED WARRANTIES, INCLUDING ANY WARRANTY OF MERCHANTABILITY OR FITNESS FOR A PARTICULAR PURPOSE, TO THE MAXIMUM EXTENT PERMITTED BY APPLICABLE LAW.

RQI Program Master Services Agreement

10.5. Tobacco. Customer warrants and represents that neither it nor its parent or subsidiaries is a tobacco company or tobacco company corporate subsidiary or parent. For the purpose of this paragraph, the terms “subsidiary” and “parent” are defined as an entity in which there exists a five percent (5%) or greater ownership by or of a tobacco company.

11. Mutual Indemnification.

11.1. Indemnification by RQIP. Subject to this Agreement, RQIP shall defend, indemnify and hold Customer harmless against any loss or damage (including reasonable attorneys' fees) incurred in connection with claims, demands, suits, or proceedings ("**Claims**") made or brought against Customer by a third party alleging that the Service or use of the Service as contemplated under this Agreement infringes the intellectual property rights of a third party; provided that Customer (a) promptly gives written notice of the Claim to RQIP; (b) gives RQIP sole control of the defense and settlement of the Claim (provided that RQIP may not settle or defend any Claim unless it unconditionally releases Customer of all liability); and (c) provides to RQIP, at RQIPs' cost, all reasonable assistance.

11.2. Indemnification by Customer. Subject to this Agreement, Customer shall defend, indemnify and hold RQIP harmless against any loss or damage (including reasonable attorneys' fees) incurred in connection with Claims made or brought against RQIP by a third party alleging that the Customer Data or Customer's unapproved use of the Service (as opposed to the Service itself) infringes the intellectual property rights of, or has otherwise harmed, a third party; provided that RQIP (a) promptly gives written notice of the Claim to Customer; (b) gives Customer sole control of the defense and settlement of the Claim (provided that Customer may not settle or defend any Claim unless it unconditionally releases RQIP of all liability); and (c) provides to Customer, at Customer's cost, all reasonable assistance.

12. Limitation of Liability.

12.1. Limitation of Liability. EXCEPT FOR LIABILITY ARISING UNDER SECTIONS 6 (PAYMENT OF FEES), 7.3 (RESTRICTIONS), 9 (CONFIDENTIALITY), and 11 (INDEMNIFICATION), IN NO EVENT SHALL EITHER PARTY'S AGGREGATE LIABILITY ARISING OUT OF OR RELATED TO THIS AGREEMENT, WHETHER IN CONTRACT, TORT OR UNDER ANY OTHER THEORY OF LIABILITY, EXCEED THE LESSER OF \$50,000 OR THE AMOUNTS ACTUALLY PAID BY AND DUE FROM CUSTOMER UNDER THIS AGREEMENT FOR THE SERVICE.

12.2. Exclusion of Consequential and Related Damages. EXCEPT FOR LIABILITY ARISING UNDER SECTIONS 9 (CONFIDENTIALITY) and 11 (INDEMNIFICATION), IN NO EVENT SHALL EITHER PARTY HAVE ANY LIABILITY TO THE OTHER PARTY FOR ANY LOST

PROFITS, LOSS OF USE, COSTS OF PROCUREMENT OF SUBSTITUTE GOODS OR SERVICES, OR FOR ANY INDIRECT, SPECIAL, INCIDENTAL, PUNITIVE, OR CONSEQUENTIAL DAMAGES HOWEVER CAUSED AND, WHETHER IN CONTRACT, TORT OR UNDER ANY OTHER THEORY OF LIABILITY, WHETHER OR NOT THE PARTY HAS BEEN ADVISED OF THE POSSIBILITY OF THE DAMAGE.

- 12.3. *Limitation of Action.*** Except for actions for non-payment or breach of either party's intellectual property rights, no action (regardless of form) arising out of this Agreement may be commenced by either party more than two (2) years after the cause of action has accrued.

13. Term & Termination.

- 13.1. *Term of Agreement.*** The Initial Term of this Agreement begins on the Effective Date and continues for Enter Term months from the Date of the commencement of the first subscription. Unless earlier terminated pursuant to the terms of this Agreement, this Agreement will, unless either party gives the other at least 90 days' notice of intent to not renew, automatically renew for successive 12-month periods and continue until the later of the date when (a) all User subscriptions granted in accordance with this Agreement have expired or been terminated and (b) no Service has been provided by RQIP for at least 15 business days

- 13.2. *Term of User Subscriptions.*** User subscriptions for Services, to the extent applicable to the Service, commence on the start date of the first subscription commences and continues for the subscription term specified in the Order Form. The parties may agree to extend the Term of this Agreement, providing that the extension is approved writing by both parties and states the conclusion date of the extended term and the price for the respective subscriptions and services.

- 13.3. *Termination for Cause.*** A party may terminate this Agreement for cause: (a) upon thirty (30) days written notice of a material breach to the other party if the breach remains uncured at the expiration of the cure period; or (b) if the other party becomes the subject of a petition in bankruptcy or any other proceeding relating to insolvency, receivership, liquidation or assignment for the benefit of creditors. Upon any termination for cause by Customer, RQIP shall refund Customer any prepaid fees for the Service for the remainder of the User subscription term after the date of termination. Termination shall not relieve Customer of the obligation to pay any fees accrued or payable to RQIP prior to the effective date of termination.

- 13.4. *Effect of Termination.***

- (a) No Release. The expiration or termination of this Agreement, for any reason, shall not release either Party from any obligation or liability to the other party under this Agreement that has already accrued, including any payment

RQI Program Master Services Agreement

obligation, or that accrues between notice of termination and the effective date of termination. Following the termination of this Agreement, RQIP will invoice the Customer for any outstanding fees and expenses due and owing under this Agreement, and the Customer shall pay all such amounts to RQIP in accordance with the payment terms set forth in Section 6.

- (b) **Return of Materials.** Upon termination of this Agreement, Customer shall:
- (i) in accordance with instructions given by either RQIP or its Service Provider, use reasonable care to remove any RQIP Equipment located at the Customer's premises, package all items, and insure and safely return such equipment to the address specified at the expense of the customer;
 - (ii) provide reasonable cooperation and assistance to and appropriate access by RQIP or its Service Provider for deactivating the Services; and, if applicable, removing equipment; and
 - (iii) if termination was by RQIP for cause or for convenience by Customer, pay all reasonable fees and expenses related to the deactivation, removal, packaging, shipping and delivery of, and any tangible items related to, the Services, including travel costs if work at Customer's location(s) is required.

13.5. *Surviving Provisions.* The following provisions shall survive any termination or expiration of this Agreement: Sections 5 through 9, 11, 12, and 16 and paragraph 13.4.

14. General Provisions.

- 14.1. *Relationship of the Parties.*** This Agreement does not create a partnership, franchise, joint venture, agency, fiduciary or employment relationship between the parties.
- 14.2. *Notices.*** All notices under this Agreement shall be in writing and shall be deemed to have been given, unless returned due to delivery problems, upon the earliest of: (a) personal delivery; (b) written confirmation of receipt by the other party; (c) the second business day after mailing; (d) the second business day after sending by confirmed facsimile; or (e) the second business day after sending by email.
- 14.3. *Publicity.*** Neither party may issue press releases relating to this Agreement without the other party's prior written consent. Either party may include the name and logo of the other party in lists of customers or vendors in accordance with the other party's standard guidelines.
- 14.4. *Waiver and Cumulative Remedies.*** No failure or delay by either party in exercising any right under this Agreement shall constitute a waiver of that right. Other than as expressly stated in this Agreement, the remedies provided in the Agreement are in addition to, and not exclusive of, any other remedies of a party at law or in equity.

RQI Program Master Services Agreement

- 14.5. Severability.** If any provision of this Agreement is held by a court of competent jurisdiction to be contrary to law, the provision shall be modified by the court and interpreted so as best to accomplish the objectives of the original provision to the fullest extent permitted by law, and the remaining provisions of this Agreement shall remain in effect.
- 15. Assignment.** Neither party may assign any of its rights or obligations under this Agreement, whether by operation of law or otherwise, without the prior express written consent of the other party. Notwithstanding the foregoing, either party may assign this Agreement together with all rights and obligations under this Agreement, without consent of the other party, in connection with a merger, acquisition, corporate reorganization, or sale of all or substantially all of its assets not involving a direct competitor of the other party nor a tobacco company or tobacco company's parent or subsidiary entity, as defined above in paragraph 10.5. Any attempt by a party to assign its rights or obligations under this Agreement in breach of this section shall be void and of no effect. Subject to the foregoing, this Agreement shall bind and inure to the benefit of the parties, their respective successors and permitted assigns.
- 16. Governing Law and Venue.** This Agreement shall be governed exclusively by the internal laws of the State of New York, without regard to its conflicts of laws rules. The state and federal courts located in the City of New York, New York shall have exclusive jurisdiction to adjudicate any dispute arising out of or relating to this Agreement. Each party consents to the exclusive jurisdiction of these courts. Each party also waives any right to jury trial in connection with any action or litigation in any way arising out of or related to this Agreement.
- 17. Entire Agreement.** This Agreement, including all exhibits and addenda to this Agreement and all Order Forms signed under this Agreement, constitutes the entire agreement between the parties, and supersedes all prior and contemporaneous agreements, proposals or representations, written or oral, concerning its subject matter. No modification, amendment, or waiver of any provision of this Agreement shall be effective unless in writing and signed by the party against whom the modification, amendment or waiver is to be asserted. In the event of any conflict between the provisions in this Agreement and any exhibit or addendum to this Agreement, or Order Form signed under this Agreement, the terms of the exhibit, addendum or Order Form shall prevail to the extent of any inconsistency. Notwithstanding any language to the contrary within it, no terms or conditions stated in a Customer purchase order or in any other Customer order

RQI Program Master Services Agreement

documentation (excluding Order Forms) shall be incorporated into or form any part of this Agreement, and all such terms or conditions shall be null and void.

18. Counterparts. This Agreement may be executed in counterparts, either in physical or digital form, which, taken together, shall form one legal instrument.

AGREED:

RQI Partners, LLC

**NORTHERN INYO HEALTHCARE
DISTRICT**

By: _____

By: _____

Print Name: _____

Print Name: _____

Title: _____

Title: _____

Date: _____

Date: _____

EXHIBIT A - ORDER FORM

<EMBED ORDER FORM DOC>

RQI Program Master Services Agreement

1. General Terms Regarding the Order Form

- 1.1. This Order Form and the use of the Service(s) ordered shall be governed in all cases by the Master Services Agreement (the "Agreement") between RQIP and Customer dated SS.
- 1.2. Any additional terms and conditions specific to the Service(s) shall be attached to this Order Form but will not be effective until the Order Form is signed by authorized representatives of both parties. The number of active users in the Program subscriptions may be assessed on the first day of each calendar quarter, and additional users beyond the quantity in the Master Services Agreement (MSA) and/or any Order Form(s) shall be added to such MSA and Order Form(s) and subject to billing at the point assessed.
- 1.3. This Order is intended by both parties to run for the full term for each Service in the Order Details table above, and the parties acknowledge they are aware of the current expiration date of the Agreement and the provisions for renewal and termination. In the event the Agreement expires prior to the expiration of the full term set forth above for each Service, the term of each Service license shall expire at the end of the specific Service license. In the event the Agreement is terminated prior to the expiration of the full term set forth above for each Service, the term of each Service license shall also expire at that time and the Client will not recover any fees paid in advance for the Product(s) for any part of the term or quantity for that Product or those Products that go unused.
- 1.4. RQIP, in its sole discretion, will determine and adjust the best number of simulation stations and locations in proximity to trainees based on an agreement with the Customer and other factors including suitability of the desired locations, user experience and program effectiveness.

AGREED:

RQI Partners, LLC

By: _____
Print Name: _____
Title: _____
Date: _____

NORTHERN INYO HEALTHCARE DISTRICT

By: _____
Print Name: _____
Title: _____
Date: _____

EXHIBIT B – IMPLEMENTATION SIGN-OFF DOCUMENT
Implementation Sign-off Document

Our goal is to provide the highest-level of quality assurance. To ensure that your expectations have been met, we ask that your organization’s representative(s) sign off on the following items. Please complete the form below and email it to your RQI Implementation Specialist. This signed form verifies you confirm that all agreed upon deliverables per the RQI Quotation and RQI Master Services Agreement have been received and activated, including but not limited to:

1. The Simulation Stations listed in the Quotation have been delivered and installed
2. Your local administrator(s) has received initial training on the Program

Contact & Site Information	
Organization:	
Name:	
E-mail:	
Phone Number:	() ext.
Web Address (URL):	

Approved by Name (print)	Approved by Title, Department	Signature	Date

RQI Program Master Services Agreement

Customer Information for RQI: New Vendor set up

Customer Name:

Target Go-Live Date:

Bill To:

Street 1

Street 2

Street 3

City

State

Zip

Business Phone:

Area code + number

Extension

AP CONTACT:

Name

Email

Email for Invoices *

Area Code

Phone # and Ext

This agreement will be paid by customer on an **Annual / Semi-Annual** basis. *(Please select one)*

Tax Exempt Certificate?

YES _____ No _____

If yes, please attach copy and return to RQIP.

RQI remit to address:

ACH Funds to:

Bank of America Merrill Lynch

Account Number: 488061561171

Routing Number: 111000025

Mail Checks to:

RQI Partners, LLC

P.O. Box 841213

Dallas, TX 75284-1213

Please note that it is important to include the invoice number and/or customer # so that your payment is applied promptly! Your Customer # is on your invoice, in the upper right-hand corner.

Questions?

Please direct email questions to _____

Please return completed form and tax-exempt certificate (if applicable) to _____



An American Heart Association®
and Laerdal® Program

QuickQuote 2019

June 2, 2019

Northern Inyo Medical Center
150 Pioneer Lane
Bishop, CA 93514

Quote type	New
Term (months)	36
LMS	3rd Party LMS
Total Individual Learners	250
Number of Trainings	

ANNUAL SUBSCRIPTIONS & FEES					
P/N	Description	Units	Unit Price	Disc Price	Ext Price
15-3232	RQI Healthcare Provider Subscription	250	\$73.00	\$64.24	\$16,060.00
15-3231	RQI Healthcare Provider ALS Subscription	106	\$80.00	\$67.20	\$7,123.20
15-3230	RQI Healthcare Provider PALS Subscription	102	\$80.00	\$67.20	\$6,854.40
15-3229	RQI Responder Subscription		\$25.00	\$0.00	\$0.00
15-3244	RQI Transportable Simulation Station (Requires Approval)	1			
15-3248	RQI Simulation Skills Station			Your subscriptions include 1 Station(s)	
15-3242	Additional per Station Fee	0	\$150.00 /mo/Add'l Station		\$0.00
TOTAL ANNUAL SUBSCRIPTION (excluding Initial & Implementation fees)					\$30,037.60
Approved Subscriptions Only Discount (%)					\$0.00
Adjusted Total Annual Subscriptions					\$30,037.60
Minimum Engagement Fee					\$ -

IMPLEMENTATION & INITIAL FEES					
P/N	Description	Units	Unit Price	Disc Price	Ext Price
15-3238	New Implementation Fee, incl Stations above & below	1	\$3,400.00		\$0.00
					\$0.00
					\$0.00
TOTAL IMPLEMENTATION & INITIAL FEES (Paid on completion of Installation)					\$0.00

LICENSES & STATIONS FOR LICENSES					
P/N	Description	Units	Unit Price	Disc Price	Ext Price
15-3241	HeartCode BLS Complete License		\$59.50	\$59.50	\$0.00
15-3240	HeartCode ACLS Complete License		\$156.00	\$156.00	\$0.00
15-3239	HeartCode PALS Complete License		\$166.00	\$166.00	\$0.00
15-3254	HeartCode BLS Online Part 1 (Add-On Item)		\$28.50	\$28.50	\$0.00
15-3253	HeartCode ACLS Online Part 1 (Add-On Item)		\$132.00	\$132.00	\$0.00
15-3252	HeartCode PALS Online Part 1 (Add-On Item)		\$132.00	\$132.00	\$0.00
15-3248	RQI Simulation Skills Station (for HC Licenses)	0			
15-3242	Additional Simulation Stations, for licenses		\$150.00	\$150.00	\$0.00
TOTAL LICENSES & STATIONS FOR LICENSES					\$0.00
Approved Licenses Only Discount (%)					\$0.00
Adjusted Licenses & Stations for Licenses					\$0.00

Total First Year Amount, including annualized licenses	\$ 30,037.60
Total Contract Amount	\$ 90,112.80

*Sales Tax is State-dependent and will be added to invoice as required.
This QuickQuote provides an estimate only; refer to the formal Quote for actual pricing.*

CALL TO ORDER The meeting was called to order at 10:18 am by Mary Mae Kilpatrick, President.

PRESENT Mary Mae Kilpatrick, President
Jean Turner, Vice President
Robert Sharp, Secretary
M.C. Hubbard, Member at Large

OPPORTUNITY FOR
PUBLIC COMMENT Ms. Kilpatrick announced at this time persons in the audience may speak on any items listed on the Notice for this meeting, and speakers will be limited to a maximum of 3 minutes each. No comments were heard.

ADJOURNMENT TO
CLOSED SESSION At 10:18am Ms. Kilpatrick announced the meeting would adjourn to Closed Session to allow the Board of Directors to:

- Conduct public employee performance evaluation, Chief Executive Officer (*pursuant to Government Code Section 54957*).

RETURN TO OPEN
SESSION AND REPORT
OF ACTION TAKEN At 12:51 pm the meeting returned to Open Session. Ms. Kilpatrick reported the Board took no reportable action.

ADJOURNMENT The meeting was adjourned at 12:51 pm.

Mary Mae Kilpatrick, President

Attest: _____
Robert Sharp, Secretary

CALL TO ORDER The meeting was called to order at 5:30 pm by Mary Mae Kilpatrick, President.

PRESENT Mary Mae Kilpatrick, President
Jean Turner, Vice President
Robert Sharp, Secretary
M.C. Hubbard, Member at Large
Allison Robinson MD, Chief of Staff
Kevin S. Flanigan MD, MBA, Chief Executive Officer
Kelli Davis MBA, Chief Operating Officer
John Tremble, Chief Financial Officer
Tracy Aspel RN, BSN Chief Nursing Officer

OPPORTUNITY FOR PUBLIC COMMENT Ms. Kilpatrick stated at this time persons in the audience may speak on any items not on the agenda for this meeting on any matter within the jurisdiction of the District Board. Speakers will be limited to a maximum of three minutes each, and members of the audience will have an opportunity to address the Board on every item on the agenda. The following persons commented on negotiations between Northern Inyo Healthcare District (NIHD) and the American Federation of State, County, and Municipal Employees (AFSCME) (*in order of appearance*):

- Eva Judson, RN
- Heleen Welvaart, RN
- Julie Carter, RN
- Laurie Archer, RN
- Lauren Ricksecker, RN
- Rhonda Aihara, RN
- Anneke Bishop, RN
- Cynthia McCarthy, RN
- (*a statement submitted by Montana Bazzell, RN was read aloud by Cynthia McCarthy, RN*)
- Andrew Stevens, RN
- Robyn Lee, RN
- Michelle Thomas, RN
- Christine Hanley, RN

ADJOURNMENT TO CLOSED SESSION At 6:02 pm Ms. Kilpatrick announced the meeting would adjourn to Closed Session to allow the Board of Directors to:

- Conference with Labor Negotiators; Agency Designated representative: Irma Moisa; Employee Organization: AFSCME Council 57 (*pursuant to Government Code Section 54957.6*).

RETURN TO OPEN SESSION AND REPORT OF ACTION TAKEN At 6:50 pm the meeting returned to Open Session. Ms. Kilpatrick reported that the Board took no reportable action.

NIHD AUXILIARY
REPORT OF HOURS

Northern Inyo Healthcare District Auxiliary President Judy Fratella provided an Auxiliary members hours of service annual report. Members of the Auxiliary recorded a total of 11,990 hours for the year, which represents a 3,937 hour increase over the prior year.

STRATEGIC PLAN
UPDATE, PATIENT
EXPERIENCE
COMMITTEE

The NIHD Patient Experience Committee provided an update on progress made toward achieving the patient experience-related goals of the District's Strategic Plan. The Committee's report included the following:

- Overview of the Committee's areas of focus (access to care and customer service)
- Current action plans and goals, including reinforcement of the use of the AIDET customer service tool and efforts to improve communications with patients
- Identification of successes and opportunities for improvement in the area of customer service
- Specific action plans in place to improve the NIHD patient experience
- Review of patient experience survey results

The Committee noted that an increased number of limited English Proficiency (Spanish speaking) patients participated in the recent patient satisfaction survey.

CHIEF OF STAFF
REPORT

Chief of Staff Allison Robinson MD reported following careful review and consideration the Medical Executive Committee recommends approval of the following District-Wide Policies and Procedures:

POLICY AND
PROCEDURE
APPROVALS

1. *Athena Designated Field Documentation*
2. *Standards of Care in the Perioperative Unit*
3. *Malignant Hyperthermia*
4. *Recommendation for Patients Identified at Risk for Transfusion Associated Circulatory Overload (TACO)*
5. *Opioid Sedation Scale*

It was moved by Robert Sharp, seconded by M.C. Hubbard, and unanimously passed to approve all five Policies and Procedures as presented.

MEDICAL STAFF
APPOINTMENTS

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

1. Monika Mehrens, DO (*family medicine/hospitalist*) – Locums/Temporary Staff
2. Tamara McBride, MD (*family medicine/hospitalist*) – Locums/Temporary Staff
3. Earl Landrito, MD (*radiology*) Provisional Consulting Staff

It was moved by Ms. Hubbard, seconded by Jean Turner, and unanimously passed to approve all three Medical Staff appointments as requested.

TELEMEDICINE STAFF
APPOINTMENTS

Doctor Robinson additionally reported that the Medical Executive Committee recommends approval of the following Telemedicine Staff

appointments, credentialing by proxy (*action items*):

1. Tanya Scurry, MD (*psychiatry*) – Adventist Health (St. Helena)
2. Arrash Fard, MD (*cardiology*) – Adventist Health (Simi Valley)

It was moved by Ms. Turner, seconded by Mr. Sharp, and unanimously passed to approve both Telemedicine Staff appointments as requested.

ADDITIONAL PRIVILEGES

Doctor Robinson also stated the Medical Executive Committee recommends granting additional privileges for the following:

1. Anne Wakamiya, MD (*internal medicine*) – addition of inpatient core privileges

It was moved by Mr. Sharp, seconded by Ms. Hubbard, and unanimously passed to approve additional privileges for Anne Wakamiya, MD as requested.

MEDICAL STAFF RESIGNATIONS

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

1. Doris Lin, MD (*Family Practice/Emergency Medicine*) – effective March 23, 2019
2. Keith Shonnard, MD (*Radiology* – Tahoe Carson Radiology Group) – effective March 28, 2019
3. Navid Ezra, MD (*Dermatology*) effective March 20, 2019
4. Talha Khawar, MD (*Rheumatology*) – effective March 1, 2019

It was moved by Ms. Turner, seconded by Ms. Hubbard, and unanimously passed to approve all four Medical Staff resignations as requested.

CHIEF EXECUTIVE OFFICER REPORT

Chief Executive Officer Kevin S. Flanigan, MD, MBA provided a Chief Executive Officer's report which included the following:

- Northern Inyo Healthcare District, Southern Mono Healthcare District, and Toiyabe Indian Health Project recently met and agreed to submit a singular grant proposal for funding for treatment of substance use disorders
- The Bishop City Council has issued a Proclamation declaring May 2019 to be Northern Inyo Healthcare District month
- Peter Tracy, NIHD Board trustee representing District Zone 1 has resigned from the Board of Directors for personal reasons

SHIP GRANT RENEWAL

Doctor Flanigan also informed the Board of Directors that NIHD has successfully submitted a renewal request for continuation of the Small Rural Hospital Improvement Program (SHIP) Grant, for approximately \$10,000.

JOINT COMMISSION CORRECTIVE ACTION PLAN SUBMISSION

Doctor Flanigan additionally reported that NIHD successfully passed a full accreditation survey by the Joint Commission and was granted re-accreditation for the next 3 years. The District has also submitted a Corrective Action Plan to address all deficiencies noted by the Joint Commission surveyors.

CHIEF OPERATING
OFFICER REPORT

Chief Operating Officer Kelli Davis, MBA provided a Chief Operating Officer's report which included the following:

JOINT COMMISSION
LABORATORY
ACCREDITATION

- Updates on all Operations departments within NIHD
- A Joint Commission survey of the NIHD Laboratory Department took place in the month of April, and as a result the Laboratory was granted re-accreditation for the next 3 years
- The Diagnostic Imaging department underwent a CDPH Mammography Inspection and passed that inspection at 100 percent, with zero deficiencies noted
- NIHD Food Services were also recently inspected by the County of Inyo, and the department passed that inspection with flying colors
- NIHD continues to participate with other local agencies as part of the Community Workplace Safety Taskforce
- Safety and Workplace Violence Prevention continue to be areas focus for the Healthcare District

CHEF NURSING
OFFICER REPORT

Chief Nursing Officer Tracy Aspel RN, BSN provided a Nursing Department report which included the following:

- Updates on NIHD Language Services; Case Management; District Education; Perioperative Services; PACU/Outpatient Services; ED & Inpatient Services; ICU and Medical Surgical Services; Perinatal Services; Infection Control; Quality Reporting and Clinical Informatics; and Employee Health
- NIHD has participated with other local agencies in a collaborative meeting on the topic of area homelessness and affordable housing
- Seven NIHD staff members have been certified as dual role interpreters for the District
- The District continues in its efforts to "grown its own" future leaders internally, and to provide further education and training for interested District staff members

CHIEF FINANCIAL
OFFICER REPORT

Chief Financial Officer John Tremble provided a financial report which included the following:

- Progress has been made with the Finance departments' newly implemented computer systems, yet completion of mandated reports and financial statements continues to be a challenge
- Recent growth in accounts receivables and capital expenditures have been offset by the receipt of an Intergovernmental Transfer received from California Health and Wellness
- MediCal billing concerns with the Athena system continue
- Collections processing is going well with the new accounting computer systems
- Cash flows are currently neutral
- There is a nationwide movement underway to address "Surprise Billing" following hospital care, particularly in regard to Emergency Room Care

FINANCIAL AND
STATISTICAL REPORTS
AS OF FEBRUARY 28
2019

Mr. Tremble additionally provided Financial and Statistical reports as of February 28, 2019, which revealed the following:

- Overall the Balance Sheet looks good, with Assets and Liabilities totaling \$146,743,241
- Year-to-Date Total Gross Patient Service Revenue at February 28 2019 is \$100,505,217
- Year-to-date net income as of February 28 is a positive \$78,980.15

Mr. Tremble stated the Finance Department is working hard to meet reporting guidelines relating to the District's General Obligation bonds. It was moved by Ms. Hubbard, seconded by Ms. Turner, and unanimously passed to approve the financial and statistical report as of February 28, 2019 as presented.

CAPITAL BUDGET
OVERVIEW FOR
2019/2020

Mr. Tremble also called attention to recommendations for the 2019/2020 Capital Budget, noting capital requests are currently in the process of being vetted for compatibility, resource capacity, OSHPD requirements, and Medical Staff agreement with recommendations. Analysis of projected cash flows indicate an expected 102.7 days of cash on hand at year end, with a projected end-of-year cash balance of \$24,333,700. This projection means that the District could spend \$3,000,000 on capital budget items during the next fiscal year and remain at or above the goal of 90 days of cash and investments on hand. District leadership therefore requests approval of \$3,000,00 in capital expenditures for the upcoming fiscal year. It was moved by Ms. Hubbard, seconded by Ms. Turner, and unanimously passed to approve \$3,000,000 in capital expenditures for the 2019/2020 fiscal year.

COMPLIANCE OFFICER
QUARTERLY REPORT

Compliance Officer Patty Dickson presented an NIHD quarterly Compliance report as of May 2019. Ms. Dickson's report reviewed:

- Breaches of Protected Health Information (PHI) for the 2019 calendar year
- Report on issues and inquiries received
- Review of audits of access to patient information systems
- Compliance with mandated reporting and California Public Records requests
- NIHD's Compliance Workplan for 2019
- Survey monitoring and responses
- Unusual Occurrence reporting

It was moved by Mr. Sharp, seconded by Ms. Turner, and unanimously passed to approve the Compliance Officer Quarterly report as presented.

DETERMINATION OF
DATE FOR THE NEXT
NIHD STRATEGIC
PLANNING SESSION

Ms. Kilpatrick opened discussion on potential dates for the District's next Strategic Planning Session, with the intent of picking a date convenient for the Board of Directors, the NIHD Medical Staff, and the Chief Officers. It was determined that the next Strategic Session will be scheduled for Saturday August 3 2019, with July 24 2019 being the

backup date in the event that a significant number of participants are unable to attend on August 3.

CONSENT AGENDA

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

- Approval of minutes of the April 17 2019 regular meeting
- Policy and Procedure annual approvals

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

BOARD MEMBER
REPORTS

Ms. Kilpatrick asked if any members of the Board of Directors wished to report on any items of interest. Director Turner commented that she routinely receives compliments, not complaints, about the Healthcare District from her constituents. Director Hubbard expressed kudos regarding the recently held District Appreciation weeks, stating she enjoyed participating in the many events scheduled in appreciation of District staff. Director Kilpatrick also praised the District appreciation weeks, and Director Sharp stated he enjoyed attending the annual Daisy Award presentation which acknowledges excellence in nursing. Director Kilpatrick also thanked District staff for improvements made to the sound system in the NIHD Board room, and noted that the Ad Hoc Committee established to interview potential candidates for the Zone 1 District Board vacancy will be Directors Turner and Sharp.

ADJOURNMENT TO
CLOSED SESSION

At 9:29 pm Ms. Kilpatrick reported the meeting would adjourn to Closed Session to allow the Board of Directors to:

- A. Discuss trade secrets, new programs and services (estimated public session date for discussion yet to be determined) (*Health and Safety Code Section 32106*).
- B. Conference with Legal Counsel regarding anticipated litigation or significant exposure to litigation (*pursuant to Government Code Section 54956.9(b)*), 1 potential case.
- C. Conduct Public employee performance evaluation, Chief Executive Officer (*pursuant to Government Code Section 54957*).

RETURN TO OPEN
SESSION AND REPORT
OF ACTION TAKEN

At 11:52 pm the meeting returned to Open Session. Ms. Kilpatrick reported the Board took no reportable action.

ADJOURNMENT

The meeting was adjourned at 11:52 pm.

Mary Mae Kilpatrick, President

Attest:

Robert Sharp, Secretary

Emergency Room and Disaster Policies

For BOD Review June, 2019

Handling of Infants/Fetus/Stillborns and Genetic Workup
In-House Transport of Ventilator Dependent Patients
Interfacility Transfer Guidelines
Intermittent Oximetry Checks
Intubation Tray Adult/Pediatric
Intubation Tray Infant
Iron Dextran (Imferon) Administration
Latex Precautions
Leaving Hospital Against Medical Advice Refusal of Treatment or Transfer
Legal Blood Alcohol Intake Form Completion of the
Lidocaine Anesthetic For Local Infiltration Prior To Peripheral Catheter Placement
Medications Emergency Department
Mentally Ill Patients Detention of
MICN Guidelines
Myocardial Perfusion Stress Test: Nuclear
Neupogen / Procrit Administration
NPO Guidelines
Nursing Care of Outpatient Interventional Radiology Patient
Nutritional IV
OmniCell Automated Dispensing Unit (ADU)
Oxygen Therapy
Pap Smear Specimen Handling and Collections
PAPR Respirator Inspection Record
Patient Valuables and Personal Effects in the Emergency Room
Patient Warmer (Warm Air Hyperthermia System)
Patients Under the Influence of Drugs Management of
Pediatric Order Verification Overnight
Pentax Emergency Bedside Intubating Laryngoscope
Photo Documentation Policy
Physician Orders Thrombolytic Therapy for Acute Ischemic Stroke with Alteplase
Physician Request for Consult
Poison and Drug Overdose Information
Portacath Vascular Access System
Potassium Intravenous Administration
Pre-Hospital Care Policy
Pregnancy Loss Specimens
Propofol Use In Critical Care Areas
Quality Assurance Review Daily Chart Review
Quality Improvement Program Pre-Hospital
Quality Management Program Emergency Service

Radiation Policy for Management of Patients with Excessive Exposure
Recommendation for Prophylaxis After Occupational Exposure to HIV
Safely Surrendered Baby Policy and Procedure
Saline Lock For Blood Draw
Scope of Service for the Emergency Department
Sexual Assault Exam Policy*
Standardized Protocol – Medical Screening Examination for the Emergency Department Physician Assistant
Thrombolytic Therapy Focus Review
Thrombolytic Therapy for Acute Myocardial Infarction
Transfer & Transportation for Patients
Transfer of Evidence
Trauma Patient Care in the Emergency Department
Warming Cabinet for Blankets/Solutions
EMTALA Policy
Medication Reconciliation
Responding to Ventilator, BiPAP, Vapotherm, EtCO2 and SpO2 Alarms
Bite Guidelines, Animals
Code Blue (Cardiac Arrest) Documentation
Communicable Disease Prevention Of Pre Hospital Care Worker
Computer Downtime Emergency Department
Computer Interface Down Time Emergency Department
Consent for Medical Treatment
Coroner's Cases
Dead on Arrival*
Dental Emergencies in the Emergency Department
Discharge Instructions Emergency Department
Discharge Planning for Homeless Patients
Emergency Department Level of Care Assessment
Emergency Department Telephone Advice Information
Emergency Department Triage Protocols
Emergency Medical Screening of Patients on Hospital Property
Emergency Medication and Code Blue Crash Cart Policy
Emergency Room Overcrowding
Entering an ED Admission (observation, surgery, inpatient status) into Health Information System
Evaluation and Medical Screening of Patients Presenting to the Emergency Department
Evaluation of Pregnant Patients in the Emergency Department