NORTHERN INYO HEALTHCARE DISTRICT
Improving our communities, one life at a time.
One Team. One Goal. Your Health.

150 Pioneer Lane
Bishop, California 93514
(760) 873-5811 Ext. 3415

DATE: June 2024
TO: Board of Directors, Northern Inyo Healthcare District
FROM: Allison Partridge COO-CNO
RE: District Updates

REPORT DETAIL

The Department Leaders have contributed to this report with an overview of the ongoing work in their areas of oversight.

NIHD celebrated Nurses Week May 6 through 12th and Hospital Week May 12 through 18th. Activities were scheduled throughout these periods to celebrate our outstanding District team.

Acute/Subacute and ICU

- The Medical-Surgical unit is excited to welcome three new CNAs starting 5/13/2024. Additionally, a full-time Medical-Surgical RN and two per diem Medical-Surgical RNs joined our team in early May. As of 5/6/2024, the Medical-Surgical unit has no travel RNs.
- The My Child 6 infant/pediatric security system went live in March. We have utilized it often, including the integrated Code Amber Alert, for increased child safety.

Perinatal

- The Perinatal unit has established a Perinatal Professional Practice Committee. This committee will focus on improving nursing practice, workflow efficiency, and specialty education for the Perinatal team utilizing a shared governance approach. Subcommittees include:

- PPPC – Evidence-Based Practice Subcommittee: This subcommittee meets monthly to evaluate and update our department policies based on current research and literature.
- PPPC—Education Subcommittee: This subcommittee meets monthly and aims to provide department-specific education and skills through drills, skills training, and, hopefully, lunch-and-learn lectures in the near future.
- PPPC—Workflow Subcommittee: This subcommittee meets monthly to examine specific workflows with the intention of improving efficiencies. Medication and Lab barcode scanning are two of the high-priority projects.

Emergency Department

- On 04/22/24, five ED nurses and two ED physicians were recognized at the Bishop City Council meeting for having participated in the life-saving measures of two cardiac arrest patients, both of whom survived. Both patients were present at the meeting to share their heartfelt stories of survival and thank ED staff and first responders in person for their quick thinking and decisive life-saving actions.
- ED Leadership met with Beta Healthcare Group-Quest for Zero representatives on May 2, 2024, to present Tier I (Sepsis) & Tier 2 (ED High-Risk Callback Log) projects and respective data. We are pleased to announce the ED will again earn credit for both tiers.

Infection Prevention

- Continuation of best practices review and policy updates in alignment with national/state guidelines and requirements.
- Ongoing monthly reporting of Infection Prevention Quality reporting to CMS, Joint Commission, CDPH including:
  - Multi-drug Resistant reporting for inpatient and ED
  - Hospital-Acquired Infection reporting for Q4 (Jan-March)
  - Antibiotic Use and Resistance reporting for Promoting Interoperability
- CMS and CDPH have discontinued daily and weekly COVID-19 reporting requirements, proposing new electronic reporting standards starting October 2024. HCW COVID-19 vaccine rate reporting will continue through December 2024.

- Infection prevention continues to play a critical role in ensuring patient safety and quality of care through surveillance, interventions, and compliance with regulatory standards.

Employee Health:

- **Submitted reporting for 2023-2024 HCW Influenza rates to CMS & CDPH**
    - Healthcare worker influenza vaccine rates 2023-2024 season **(Goal >= 72%).**
        - Percentage of HCW vaccinated **69%**
        - Percentage of HCW with Documented declination **24%**
        - Number of HCW with Unknown Status **7%**
- Preparations for the upcoming influenza season will begin in August with a goal of achieving a vaccination rate greater than **72%.**
- Ongoing review and updating of policies to align with national/state guidelines, including Injury Illness Prevention Plan (IIPP) and Musculoskeletal Injury Prevention Plan (MIPP) in accordance with Cal/OSHA regulations.
- The Employee Health and Infection Prevention team is taking a proactive approach to enhance preparedness for a potential increase in measles.
    - **Review of Immunity Status**: The Employee Health team has initiated a review of the immunity status of high-risk frontline staff to ensure preparedness and minimize the potential spread of the disease within our organization. Once completed, we will review the status of all current workforce members' immunity.
    - **Vaccination**: Vaccines will be available through employee health for persons identified as non-immune.
    - **Education:** Education has been completed, including infection prevention practices, isolation, personal protective equipment, cleaning & disinfecting, reporting, outbreak investigation, and return to work guidance.
    - **Surveillance & Monitoring**: Infection Prevention and Employee Health will continue to monitor for updated information from local, state, and federal agencies.

Facilities Department Update

Project Updates:

- Pharmacy / Infusion Project
    - Electrical Panels, waiting on ETA.
    - Lighting, waiting on ETA.
    - Temporary fencing for the project has been removed.
- SB 1882 Seismic Update
    - On track
- RHP onsite for annual preventative maintenance of all rooftop units and building management system.
- HVAC work has been completed in the PMA building servicing the pediatric clinic.
- Work is underway to optimize clinical space throughout the PMA building.
- The security camera system installation project is complete (ITS is working to bring the new cameras online). This is a security enhancement for our campus.
- The Birch Street re-roofing project is complete.
- Planning for work to begin in the Women's Clinic, including updating the exam rooms and replacing the flooring.
- Planning for work to begin in the PMA building, including general repair and maintenance of the main corridor
- Planning for work to begin to transition the old Rehab building site into additional parking

Dietary Department Update

- Our County inspection was completed the week of May 6. It went very well, and the inspector noted that the "Facility is organized and well maintained."
- Our Dietary team has supported Nurses Week and Hospital Week with excellent treats, including cinnamon rolls, breakfast burritos, and an ice cream social.

Cardiopulmonary:

- Our Cardiopulmonary department has seen an increase in volume; Echocardiogram volume is up 37% this year compared to last. We are monitoring the current capacity in all cardiopulmonary service areas compared to the demand for those services and expanding capacity as necessary to facilitate timely appointments.

- Adam Wills, our echocardiography trainee, passed his ultrasound physics exam. He is on track to obtain his Registered Diagnostic Medical Sonographer (RDMS).

- Our department has four new respiratory therapists who will begin NICU training in Pomona on May 20. This training supports our Respiratory Therapist's knowledge and skills in caring for newborns at NIHD.

Diagnostic Imaging:

- Our Diagnostic Imaging Department recently received re-accreditation by the American College of Radiology (ACR) for CT, MRI, Breast, Nuclear Medicine, and Ultrasound. The department will be working on a submission for Mammography this month.

- We are pleased to announce that two techs have accepted CT/XR positions and will start in June.

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

Medical Staff Office
(760) 873-2174 voice
(760) 873-2130 fax

TO: NIHD Board of Directors
FROM: Sierra Bourne, MD, Chief of Medical Staff
DATE: June 4, 2024
RE: Medical Executive Committee Report

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

A. Policies (*action item*)
    1. Health Care Worker (HCW) Influenza Vaccination
    2. Injury and Illness Prevention Program
    3. Safe Handling and Disposal of Occupationally Hazardous Drugs and Environmentally Hazardous Drugs
    4. Safe Patient Handling – Minimal Lift Program
    5. Cesarean Delivery
    6. Induction of Labor Including Cervical Ripening
    7. Newborn & Pediatric Security and Abduction Policy
    8. Standards of Care for the Neonate in the Perinatal Department

B. Extension of Temporary Privileges for Good Cause (*action item*)
    1. Talia Luc, PMHNP (*psychiatric mental health nurse practitioner*) – 60 day extension to allow for coverage of the mental health service line

C. Medical Executive Committee Meeting Report (*information item*)
    1. Notable topics from the June MEC include:
        a) The Medical Staff Office has been working hard to approve individual credentials for a new Radiology group that will fulfill our nighttime STAT reads. This change is expected to increase the quality and timeliness of off-hours radiology reads.
        b) Dr. Hawkins likely already mentioned this in his report, but the ED group will welcome a new physician, Dr. Jack Kornfeld, in July. He has recently completed his emergency physician residency at UC Davis.
        c) Coding update: based on feedback from the Provider Coding Workshops, the physician leaders and myself have engaged UASI and have received many specific answers to our questions including clarifying therapies such as "rigid musculoskeletal immobilization" (splinting/casting), which warrants a higher level of code than previously thought for some providers.
        d) The Med Staff is hosting a summer Provider Social at Cardinal Village in July. This is part of an initiative to foster closer relationships in the provider staff, improve resilience, and reduce burnout.
        e) Thank you for accepting my report, I look forward to attending the July board meeting in person.

NORTHERN INYO HEALTHCARE DISTRICT
CLINICAL POLICY AND PROCEDURE

Title: Health Care Worker (HCW) Influenza Vaccination		
Owner: Manager Employee Health & Infection Control	Department: Employee Health	
Scope: Northern Inyo Healthcare District (NIHD)		
Date Last Modified: 05/28/2024	Last Review Date: No Review Date	Version: 7
Final Approval by: NIHD Board of Directors	Original Approval Date:	

PURPOSE:
Health and Safety Code section 1288.7(a) requires California acute care hospitals to offer influenza vaccine free of charge to all Health Care Workers (HCWs) or sign a declination form if an HCW chooses not to be vaccinated. The purpose is to:

1. To help minimize the risk of influenza illness to patients, health care personnel, and their friends/family.
2. To prevent influenza transmission from personnel to persons at high risk for complications. Higher influenza vaccination coverage among HCWs is associated with reduced nosocomial influenza among hospital patients.
3. To reduce personnel absenteeism during community outbreaks.

POLICY:

1. Free influenza vaccinations will be offered once from when they become available in September or October, at least through March 31 of the following year or through the end of the influenza season as declared by Inyo County Health Officer.
2. If a national vaccine shortage occurs or the CDC recommendations are altered, the Inyo County Health Officer and NIHD Employee Health Medical Director may suspend or revoke all parts of this policy and procedure.
3. Data will be collected and reported to the National Health and Safety Network (NHSN) to determine rates of vaccinations and declinations.
4. All efforts will be made to improve our program and our vaccination rates.

PROCEDURE:

1. Northern Inyo Healthcare District (NIHD) requires annual influenza vaccinations for all NIHD workforce members or a signed declination. If no declination on file, it would be considered as unknown vaccination status for data reporting. Employee Health will make all attempts to collect data.
2. NIHD workforce includes:
    a. Employees who receive a direct paycheck from NIHD
    b. Licensed Independent Practitioners (LIP) who work on-site in any of the patient care buildings
    c. Travelers
    d. Contract workers
    e. Volunteers and Auxiliary on NIHD campus
    f. Students/Trainees

    Note: Vendors will upload their influenza vaccination status within Vendormate portal

3. Education will be provided to NIHD workforce. Education topics will include:
    a. Education on the influenza vaccine and the different types offered. Education will involve information on the ingredients-and health concerns.
    b. Ongoing education related to non-vaccine control and prevention measures is also provided through several policies, emails, and Talking Points. Topics include information on how flu is transmitted, respiratory hygiene/cough etiquette, hand hygiene, personal protective equipment, and not coming to work ill.
4. The influenza vaccine is free of charge to all healthcare workers on NIHD campus. It is freely accessible to prevent any perceived difficulty. It is available through Employee Health, House Supervisors, and department rounding and meetings.
    a. Influenza vaccinations will typically begin when they become available in September or October.
    b. All HCWs must either receive the vaccination or sign a declination.
    c. Acceptable forms of proof of influenza vaccine **must** include first and last name, date of birth, and **at least one** of the following:
        i. Singed NIHD influenza consent form
        ii. Vaccine card or immunization registry
        iii. Receipt or other proof of purchase from pharmacy or other vaccinator
        iv. Insurance claim for receipt of influenza vaccination indicating where vaccine was received
        v. Note from person or organization that administered the vaccination stating that HCW received the influenza vaccine at that location
        vi. Written signed statement, or electronic form, or e-mail from HCW indicating date and where they received the influenza vaccines
        vii. Signature of healthcare worker on NIHD standard declination form
    d. Mask mandates will be determined annually and throughout respiratory illness season per local, state, and federal guidelines. NIHD Employee Health and leadership will monitor regulatory guidelines with the local county public health department. Information related to mask mandates will be communicated annually and with any changes.
    e. NIHD strongly recommends that any employee who declines influenza vaccine wear a tight-fitting surgical mask during influenza season.
5. NIHD strives to improve vaccination rates and see a decrease in declinations through:
    a. Education
        i. regarding the benefit/risk profile of the vaccination
        ii. myths and realities- via CDC flyers, posters, emails
        iii. on the seriousness of influenza-especially for high-risk populations
    b. Annual consideration of mask use
    c. Strategies to promote/enhance vaccination
    d. Methods to deliver vaccine to NIHD HCW's
6. Influenza vaccine administration and declination data will be collected and entered into the NHSN database.
7. Employee Health will annually provide influenza rate and declination data to those leaders and managers who have a stake in the influenza vaccination rate of the hospital staff and Licensed LIPs.
    a. Infection Control Committee
    b. Nurse Executive Team
    c. Quality Improvement
    d. Department Heads
    e. Medical Staff via the medical staff office.
    f. Board of Directors

REFERENCES:

1. California Health and Human Service (CalHHS). August 30, 2023. Health Care Personnel Influenza Vaccination. Retrieved from https://data.chhs.ca.gov/dataset/cdph-health-care-personnel-influenza-vaccination.
2. California Hospital Association. 2018. California Hospital Record and Data Retention. Retrieved from file:///H:/Public/CHA/CHA%20Record%20and%20Data%20Retention%20Schedule%202018.pdf.
3. CalOSHA. June 2023. The California Workplace Guide to Aerosol Transmissible Disease. Retrieved from https://data.chhs.ca.gov/dataset/cdph-health-care-personnel-influenza-vaccination
4. Centers for Disease Control and Prevention. May 2021. Prevention Strategies for Seasonal Influenza in Healthcare Settings. Retrieved from https://www.cdc.gov/flu/professionals/infectioncontrol/healthcaresettings.htm
5. Centers for Disease Control and Prevention. August 30, 2023. Healthcare Personnel (HCP) Flu Vaccination. Retrieved from https://www.cdc.gov/nhsn/hps/vaccination/index.html
6. Centers for Disease Control and Prevention. (September 2023). HCP Influenza Vaccination Summary Reporting FAQs. Retrieved from https://www.cdc.gov/nhsn/faqs/vaccination/faq-influenza-vaccination-summary-reporting.html#anchor_1583347515617

RECORD RETENTION AND DESTRUCTION:

Duration of employment plus 30 years.

CROSS REFERENCE POLICIES AND PROCEDURES:

1. Employee Health NIHD Workforce Onboarding
2. Health Care Workers with Influenza like Illness
3. Aerosolized Transmissible Disease Exposure Plan/Respiratory Protection Program
4. Infection Prevention Recommendations for Avian Influenza, Novel Influenza, and Seasonal Flu

Supersedes: v.6 Health Care Worker (HCW) Influenza Vaccination

NORTHERN INYO HEALTHCARE DISTRICT

ANNUAL PLAN

Title: Injury and Illness Prevention Program		
Owner: Manager Employee Health & Infection Control	Department: Infection Prevention	
Scope: District Wide		
Date Last Modified: 05/28/2024	Last Review Date: No Review Date	Version: 3
Final Approval by: NIHD Board of Directors	Original Approval Date: 11/01/2023	

PURPOSE

The intent of the Northern Inyo Healthcare District (NIHD) Injury and Illness Prevention Program (IIPP) is to prevent and/or minimize the probability of injuries and illness to our workforce. The IIPP is a guide to comply with all applicable state, federal, and local health and safety codes required of acute care hospitals.

NIHD is committed to providing its workforce with a safe and healthful workplace that supports and encourages teamwork and collaboration with a goal to be proactive and learn from accidental incidents.

POLICY

NIHD IIPP contains the following nine elements as required by Title 8 of the California Code of Regulations, Section 3203 (T8 CCR 3203) to establish, implement and maintain an effective written Injury and Illness Prevention Program.

- Responsibility
- Compliance
- Communication
- Hazard Assessment
- Accident/Exposure Investigation
- Hazard Correction
- Training and Instruction
- Employee Access to the IIPP
- Recordkeeping

NIHD is identified as a high-hazard employer through the California Department of Industrial Relations. Federal Fiscal Year 2023-2024 High Hazard Industry List Healthcare and Social Assistance North American Industry Classification System (NAICS) 6221 and 6219. This plan is adapted from the Cal/OSHA Workplace Injury and Illness Prevention Model Program for High Hazard Employers, August 2023. The IIPP will be reviewed annually and as needed per regulatory guidelines.

Elements of the Musculoskeletal Injury Prevention Plan (MIPP) are integrated throughout the IIPP Policy.

RESPONSIBILITY:

1. The Safety Committee will have oversight and implement the IIPP, with reporting from Safe Patient Handling Committee, Sharps Committee, and Human Resources injury and illness reporting. The Safety Committee is a multi-disciplinary team that consists of representation from the following departments:

- Administration
- Safety Officer
- Environmental Services
- Security
- Emergency Services
- Human Resources
- Employee Health
- Rehabilitation Services
- Infection Prevention
- Maintenance
- Quality team member
- Bio-Medical
- Purchasing
- Nursing Leadership
- Diagnostic Imaging
- Compliance
- Union labor representative

2. Employee Health will update the IIPP plan as determined by regulations and the Safety Committee.
3. All Leadership is responsible for implementing the IIPP in their work areas and for answering employee questions about it. The IIPP is located in the Policy Tech.
4. All workforce is responsible for:
   a. Working safely, following all safety guidelines and rules for their own protection and that of visitors and patients.
   b. Following the IIPP contents,
   c. Attending trainings, and
   d. Asking questions if unclear on understanding or ability to comply with IIPP from the instructor and/or department leadership.
5. Chief Executive Officers support injury illness prevention financially to help prevent and mitigate employee injuries or illnesses.

COMPLIANCE

1. Leadership and Chief Executives, are responsible for providing safe and healthful work practices and a workplace free from serious recognized hazards that comply with the standards, rules and regulations of OSHA. This includes properly maintained safe tools and equipment, color codes, posters, labels, or signs warning workers of potential hazards, and safety training and instruction in a language and vocabulary workers can understand.
2. All workforce, including Leadership and Chief Executives, are responsible for complying with safe and healthful practices, identifying and reporting of potential hazards, which in turn, need to be remedied by Leadership to mitigate potential injuries.
3. All workforce is assigned to read the IIPP upon hire, annually and with any revisions.
4. Senior Leadership has assured employee understanding through the individual attestation within Policy Manager upon completing the review by selecting “Mark as Read”.
5. Management is responsible for ensuring that all safety and health policies and procedures are clearly communicated and understood by all employees. Managers and supervisors are expected to enforce the rules fairly and uniformly, and address any hazardous conditions when discovered.

a. Assist the workforce in completing an Unusual Occurrence Report (UOR) or properly reporting findings and completing UOR's.
b. Correct unsafe conditions timely, including ergonomic safety round findings.
c. Ensure safety trainings are complete during initial orientation and annually as required such as Safe Patient Handling equipment, de-escalation, ergonomics, and assigned NIHD Learning Management System education.
d. Ensure training is provided to workers whose safety performance is deficient, as well as recognizing employees who perform safe practices through their annual evaluations and individual department processes.
e. Recognize workers who perform safe, healthful, and preventative work practices, such as the Good Catch Safety Award.

6. All workforce is responsible in helping to maintain a safe and healthy workplace through these practices:
   a. Take action to reduce accidents and injuries
   b. Report incidents or unsafe conditions as soon as possible
   c. Report to the Emergency Department (ED) if exposed to blood, or are injured on campus, as soon as possible
   d. Attend de-escalation annual trainings
   e. Attend Safe Patient Handling annual trainings and follow related policies,
   f. Complete employee health requirements timely
   g. Complete annual assigned competency via NIHD Learning Management System and Policy Tech assignments
   h. Participation in department Ergonomic Safety Rounds.
   i. Refuse to work in a situation in which the worker believes they would be unprotected from a hazard that could result in injury.
3. Completion of a safety related disciplinary action is through Department Leadership under the direction of Human Resources.

COMMUNICATION

1. NIHD recognizes that open, two-way communication between management and the workers on health and safety issues is essential to an injury-free, productive workplace. All Leadership is responsible for communicating with all workers about occupational safety and health in a form readily understandable by all workers.
2. Our communication system encourages all workers to inform their Department Leadership about workplace hazards or injury reporting without fear of retaliation. If a worker has been retaliated against for using their rights, the worker must file a Whistleblower Complaint with OSHA as soon as possible, but no later than 30 days.
3. Refer to Accident/Exposure Investigation section for workplace injuries reporting.
4. The following system of communication is designed to facilitate a continuous flow of safety and health information between management and staff in a form that is readily understandable and consists of one or more of the following checked items:
   a. Workers are encouraged to report safety or health concerns verbally, written, or in an email.
   b. Some methods NIHD uses to communicate safety and health information between leadership and worker, including staff feedback, is accomplished through:
      i. Communication with their department Leadership and/or House Supervisor
      ii. Informing the Safety Officer

iii. Maintenance Work Request System
iv. Notify Bio Med
v. Communication with Employee Health, Human Resources or Compliance.
vi. Unusual Occurrence Reports: can be anonymous
vii. Suggestions can be submitted via NIHD intranet, or placed in Infection Prevention or Employee Health box outside their offices with an anonymous option.
viii. Safety Committee meeting not less than quarterly
ix. Infection Control Committee
x. Safe Patient Handling Subcommittee
xi. Professional Practice Committee
xii. Monthly Department Safety Rounds completed by department safety resource person
xiii. Sharps Committee
xiv. Talking Points sent out to address any safety health and wellness information updates
xv. Suggestions from staff to the Safety Committee
xvi. Ergonomic Safety Rounds
xvii. Posted Safety and Health Information
xviii. Daily Safety Huddles
xix. Department Staff Meetings and Huddles
xx. NIHD Learning Management System
xxi. Recognizing workers who perform safe, healthful and preventative work practices, such as the Good Catch Safety Award
xxii. Annual Employee Assessment
xxiii. Effective communication of safety and health concerns between workers and supervisors including translation where appropriate.

HAZARD ASSESSMENT

1. Periodic inspections to identify and evaluate workplace hazards shall be performed by a competent observer, with departmental and specific hazard knowledge. The hazard assessment process varies depending on the hazard. There are processes in place that utilize the following:
   a. Project Management
   b. EOC Rounding
   c. Security Officer Rounding
   d. Work Orders
   e. UOR
   f. Compliance Reporting
   g. Service Desk
   h. Quality
   i. Department Huddles
   j. Safety Committee
   k. Department Leadership
   l. Maintenance
   m. Environmental Services
   n. Ergonomic Assessments
   o. Human Resources
   p. Biomedical
   q. Information Technology
   r. Employee Health
   s. Infection Prevention
2. Inspections are performed according to the following schedule:

a. When new substances, processes, procedures or equipment which present potential new hazards are introduced into our workplace,
    i. Hazard mitigation and education is based on the Manufacturer recommendations
    ii. Follow up is completed to ensure expected function/outcome.
b. When new or previously unidentified hazards are recognized.
c. When occupational injuries occur,
    i. When immediate supervisor or house supervisor is notified of an injury
    ii. Based on the Supervisor Occupational Report of Injury (SORI) and
    iii. UOR
d. When occupational illnesses occur,
    i. NIHD Employees will follow the Aerosolized Transmissible Disease Exposure Plan/Respiratory Protection Program (ATD) in the event of an infectious disease or special pathogens that are highly infectious with major consequences, ie Covid-19 or measles
e. Whenever workplace conditions warrant an inspection.
    i. May be alerted from staff reported in morning department Safety Huddles
    ii. Reporting among Leadership and Safety in Monday-Friday Safety Huddle Committee
    iii. Follow up of corrections that the improvement is safe and functioning per manufacturer expectations.

3. The OSHA Hazard Assessment Checklist may be referenced as a tool for evaluating current or new equipment, policy/procedure updates, and just-in-time hazard training.
4. Several Agencies conduct random, regular, or periodic inspections to assist NIHD in achieving safety inspection responsibilities. These include:
    a. Fire Marshall
    b. Fire Department
    c. County Environmental Health Department
    d. Cal/OSHA
    e. California Department of Public Health
    f. BETA Healthcare Group
    g. Board of Pharmacy
    h. Local County Agencies
    i. City of Bishop
5. Ergonomic Repetitive Stress Injury Hazards including cumulative trauma of the muscles, tendons, ligaments, bursa, peripheral nerves, joints, bone or blood vessels, Safe Patient Handling Hazards, and acute musculoskeletal injury hazards must be identified, communicated, and resolved.
    a. New hire and annual ergonomic safety training in the learning management system is assigned to workforce.
    b. Annual Ergonomic rounding with Occupational Therapy and Employee Health in clinical departments and select non-patient care departments at risk. Leadership is notified and timely resolution is documented and presented to the Safety Committee.
    c. Workforce may request an ergonomic evaluation of their workstation or workspace, through their manager, upon hire, or at any time, to prevent acute or chronic stress injury. A process is in place to assess, educate, and correct potential hazards with Occupational Therapy, Purchasing, Human Resources, and Information Technology.
    d. Policies in place for Fall Prevention Management for inpatient departments, Emergency Services, and Perinatal Department.
    e. Reference the Safe Patient Handling - Minimal Lift Policy for mitigating Safe Patient Handling Hazards.

6. All departments complete an Environment of Care Safety inspection report every other month with risk findings submitted to appropriate department for correction.
7. Personal protective equipment is maintained in safe and good working condition. Workforce is to report to leadership any concerns with Personal Protective Equipment (PPE).
8. Workplace Violence: Reference the Workplace Violence Plan for details of identification, communication, and resolution. The four Types of Workplace Violence are:
    a. "Type 1 violence" means workplace violence committed by a person who has no legitimate business at the work site, and includes violent acts by anyone who enters the workplace with the intent to commit a crime.
    b. "Type 2 violence" means workplace violence directed at employees by customers, clients, patients, students, inmates, visitors, or other individuals accompanying a patient.
    c. "Type 3 violence" means workplace violence against an employee by a present or former employee, supervisor, or manager.
    d. "Type 4 violence" means workplace violence committed in the workplace by someone who does not work there, but has or is known to have had a personal relationship with an employee.

ACCIDENT/EXPOSURE INVESTIGATIONS

1. Investigations of accidents, exposures, and near-miss incidents may be initiated by Administrator, Human Resources, Employee Health, Infection Prevention, Compliance, Facilities Manager, Safety Officer, or the Medical Director.
2. The employee should notify the management on site at the time of the accident or exposure. Reporting all accidents provides NIHD with an accurate record of its accidents or exposures experience and can be used in determining the most efficient use of resources in accident prevention strategies. The main purpose of the investigation is not to determine who was at fault, but to understand what occurred and to prevent it from happening again. Investigation of the accident scene or any hazardous substance exposure will be visited as soon as possible by the department leader or House Supervisor, prioritized by the severity of the incident.
3. Procedures for investigating workplace accidents and hazardous substance exposures include:
    a. Interview injured workers and witnesses about the incident and how it occurred;
    b. Examine the workplace for factors associated with the accident/exposure;
    c. Determine the cause of the accident/exposure;
    d. Take corrective action to prevent the accident/exposure from reoccurring;
    e. Record the findings and corrective actions taken.
4. Reference Policy Health and Safety - Work Related Accidents or Exposures to Blood or Other Potentially Infectious Materials

HAZARD CORRECTION

Unsafe or unhealthy work conditions, practices or procedures shall be corrected in a timely manner. Hazards shall be corrected according to the following procedures:

1. When observed or discovered.
2. When an imminent hazard exists, which cannot be immediately abated without endangering workers and/or property, we will remove all exposed workers from the area except those necessary to correct the existing condition. Workers who are required to correct the hazardous condition will be provided with the necessary protection.
3. Hazard mitigation and education is based on the Manufacturer recommendations
4. All such actions taken and dates they are completed shall be documented.
5. Reporting person, if known, may receive feedback or inquire about the hazard mitigation.

6. Completed investigations and corrections are presented to the Safety Committee for review and use in injury prevention efforts.

TRAINING AND INSTRUCTION

All workers, including leadership, shall have training and instruction on general and job-specific safety and health practices in a language and vocabulary workers can understand. During trainings staff are encouraged to ask questions. Leadership and Safety Committee is available to answer questions. Training will include the Manufacturer recommendations. Some examples of our training and instruction are the following:

1. When the IIPP is revised.
2. To all new workers.
3. To all workers given new job assignments for which training has not previously provided.
4. Whenever new substances, processes, procedures or equipment are introduced to the workplace and represent a new hazard.
5. Whenever the employer is made aware of a new or previously unrecognized hazard.
6. To Department Leadership in order to familiarize them with the safety and health hazards to which workers under their immediate direction and control may be exposed; and
7. To all workers with respect to hazards specific to each employee's job assignment. Department managers are responsible to provide additional training on additional hazards as identified by the manufacturer of certain equipment or those performing high-hazard tasks in their job assignment, such as, but not limited to, Environmental Services, Maintenance, Operating Room, Diagnostic Imaging, and Nuclear Medicine.
8. General workplace safety and health trainings include, but are not limited to, the following:
    a. Workplace Violence training.
    b. Emergency action and fire prevention plan.
    c. Provisions for medical services and first aid including emergency procedures.
    d. Reporting of hazards and accidents to Department Leadership.
    e. Physical Hazard communication, including worker awareness of potential chemical hazards, and proper labeling of containers.
    f. Ergonomic training for all staff
    g. Slips, trips and fall prevention
    h. Electrical Hazards
    i. Personal Protective Equipment (PPE)
9. Appropriate PPE is describe within department policies where specialized equipment and hazardous materials are utilized.
10. Access to hand sanitation, drinking water and toileting:
    a. During an emergency NIHD workers will follow the Emergency Management Plan. Communication will be distributed on how to access these items.
    b. For NIHD employees working outside, access to these items would be provided during orientation.

EMPLOYEE ACCESS TO THE IIPP

1. NIHD workforce has unobstructed access to the IIPP at all times in the Policy Manager including printing at no charge. When the system is down, a hard copy may be obtained from Employee Health, Infection Prevention, or Human Resources.
2. The provision of the plan, in and of itself meets the requirements; thus no other records will be provided.

RECORDKEEPING

Our establishment is on a designated high-hazard industry list. We have taken the following steps to implement and maintain our IIPP:

1. Records of hazard assessment inspections, including the person(s) or persons conducting the

inspection, the unsafe conditions and work practices that have been identified and the action taken to correct the identified unsafe conditions and work practices, are recorded on a hazard assessment and correction form; and

2. Documentation of safety and health training for each worker, including the worker's name or other identifier, training dates, type(s) of training, and training providers is recorded on a worker training and instruction form. We also include the records relating to worker training provided by a construction industry occupational safety and health program approved by Cal/OSHA.
3. Inspection records and training documentation will be maintained for one year, except for training records of employees who have worked for less than one year that are provided to the worker upon termination of employment.

OTHER

1. Covid-19 Emergency Regulations: NIHD Employees will follow the Aerosolized Transmissible Disease Exposure Plan/Respiratory Protection Program (ATD).

REFERENCES

1. California Code of Regulations, Title 8, Section 3203 (T8 CCR 3203) https://www.dir.ca.gov/title8/3203.html
2. Cal OSHA Model Programs: Injury and Illness Prevention Program High-Hazard Employers: https://trainingacademy.dir.ca.gov/page/iipp-model
3. Cal/OSHA Department of Industrial Relations. Division of Occupational Safety and Health. Guide to Developing Your Workplace Injury and Illness Prevention Program. (August 2020) https://www.dir.ca.gov/dosh/dosh_publications/iipp.pdf
4. California Department of Industrial Relations. FFY 2023-2024 High Hazard Industry List, p. 4 https://www.dir.ca.gov/dosh/documents/hhu-list-2023-2024.pdf
5. California Hospital Association. (2018). CHA Record and Data Retention. Retrieved from file:///H:/Public/CHA/CHA%20Record%20and%20Data%20Retention%20Schedule%202018.pdf
6. OSHA Workers Rights and Protections Retrieved 2/28/24 from https://www.osha.gov/workers
7. OSHA laws and Regulations Retrieved 2/28/24 from https://www.osha.gov/laws-regs
8. U.S. Department of Labor. (2021). OSHA Online Whistleblower Complain Form. Retrieved from
9. https://www.osha.gov/whistleblower/WBComplaint

RECORD RETENTION AND DESTRUCTION:

Inspection records and training documentation will be maintained per regulatory requirements of the bodies of oversight.

CROSS-REFERENCE POLICIES AND PROCEDURES:

1. Medical Equipment Management Plan
2. Care and Donning of a Powered Air Purifying Respirator (PAPR)
3. Fire Safety Management Plan (FSMP) EC.01.01.01 EP 7
4. Health and Safety - Work Related Accidents or Exposures to Blood or Other Potentially Infectious Materials (17-01)
5. Workplace Violence Prevention Plan
6. Safe Patient Handling – Minimal Lift Program
7. Safe Patient Handling Subcommittee Charter

8. Security Management Plan
9. Exposure Evaluation*
10. Aerosolized Transmissible Disease Exposure Plan/Respiratory Protection Program
11. Sharps Injury Protection Plan
12. Fall Prevention and Management*
13. Fall Risk Prevention - Perinatal*

Supersedes: v.2 Injury and Illness Prevention Program*

NORTHERN INYO HEALTHCARE DISTRICT
CLINICAL POLICY AND PROCEDURE

Title: Safe Handling and Disposal of Occupationally Hazardous Drugs and Environmentally Hazardous Drugs*		
Owner: PHARMACY DIRECTOR	Department: Pharmacy	
Scope: District Wide		
Date Last Modified: 01/11/2024	Last Review Date: No Review Date	Version: 2
Final Approval by: NIHD Board of Directors	Original Approval Date: 07/01/2017	

PURPOSE:

The provide guidelines for Northern Inyo Healthcare District (NIHD) activities in controlling occupational exposures to hazardous drugs as defined by the American Society of Health-System Pharmacists[1] and the National Institute for Occupational Safety and Health (NIOSH)[2] and in managing disposal of drugs classified as hazardous per the Resource Conservation and Recovery Act (RCRA).

This policy will cancel the NIHD Policy titled: "Pharmaceutical and Medical Waste Management"

SCOPE: This policy will apply to setting where personnel may be exposed to occupationally hazardous drugs (OHDs) in the workplace and to areas generating waste containing environmentally hazardous drugs (EHDs)

BACKGROUND:

1. Preparation, transportation, administration and disposal of OHDs and certain EHDs may expose pharmacy personnel, nurses, physicians, environmental service employees and other health care workers or facility staff to potentially hazardous levels of the chemicals through acute and chronic workplace exposure. Routes of exposure include inhalation of dusts or aerosols, dermal absorption, ingestion, self-inoculation and contact with excreta or body tissue from patients treated with these drugs.
2. OHDs are characterized by genotoxicity, carcinogenicity, teratogenicity, reproductive toxicity or serious organ toxicity at low doses.[1] Lists of OHDs have been compiled by OSHA[2] and are updated biennially. These lists serve as references for NIHD in creating a district-wide list of OHDs. (Appendix A)
3. A number of pharmaceutical are identified as pharmaceutical waste that is hazardous to the environment (EHDs) and their management and disposal are regulated by the Environmental Protection Agency (EPA) and the California Medical Waste Management Act (CAMWMA). These drugs are classified as hazardous waste under the applicable regulations and while they may or may not pose an occupational hazard to workers, they do have additional regulations regarding their management and disposal. While there is overlap between lists of IHDs and EHDs, there are many pharmaceuticals that fall only into one category.

POLICY:

It is the policy of NIHD to eliminate or, when elimination is not feasible, to minimize employee exposure to OHDs and to properly manage and transfer EHDs and OHDs for hazardous waste disposal. It is also the policy

of NIHD to manage all non-hazardous pharmaceutical waste in a manner consistent with the CAMWMA in a manner to prevent it from entering sewers or landfills untreated.

1. NIHD will implement a comprehensive program to eliminate or minimize employee exposure to OHDs per USP 800 guidance[3]. Further, NIHD will implement a comprehensive program to appropriately manage disposal of EHDs per RCRA and CAMWMA requirements.
2. NIHD will appoint a pharmacist as the Hazardous Drug Officer and establish a multi-disciplinary hazardous drug committee. The Committee will be chaired by the Hazardous Drug Officer (HDO) and will consist of representatives from safety, employee health, pharmacy, nursing, environmental services and others, as appropriate. The Committee will develop an OHD safety and health plan as described in USP 800 guidance. A key element of this plan will be to perform and document multi-disciplinary risk assessments to determine which employees will be enrolled in the OHD medical surveillance program.
3. NIHD will appoint a member of the Pharmacy staff as the primary point of contact (POC) for the management of pharmaceutical waste. The pharmaceutical waste POC will have oversight for each area in which pharmaceutical waste in generated and the responsibility to ensure written procedures are developed, implemented and maintained.

PROCEDURE: PHARMACEUTICAL WASTE MANAGEMENT

Scope: This policy applies to all categories of pharmaceuticals used within NIHD. It includes but is not limited to OHDs, EHDs, controlled substances (CS) and Non-regulated pharmaceuticals (NRPs). Non-regulated pharmaceuticals include all medications not listed as an OHD, EHD, or CS.

Background: Many pharmaceuticals meet the definition of hazardous waste. The EPA, California Department of Public Health (CADPH), and Drug Enforcement Administration (DEA) address the management of pharmaceutical waste generated from health care facilities. Surveyors from The Joint Commission (JC) include pharmaceutical waste management in their surveys. Because of the risks associated with the improper disposal of both regulated and non-regulated pharmaceutical waste, a program to properly manage and dispose of these **wastes is required.**

Classification: There are six categories of pharmaceutical waste that require management as part of this pharmaceutical waste management program:

1. Non-regulated pharmaceutical waste: Pharmaceuticals that must be disposed of properly but that are not classified as OHD, EHD or CS
2. RCRA Hazardous waste
    a. P Listed waste (acutely hazardous)
    b. U Listed waste (toxic but not acutely so)
3. Trace chemotherapy waste: empty (less than 3% of original volume) containers used in the preparation or delivery of antineoplastics
4. Bulk chemotherapy: Full or partially full (greater than 3% of original volume) containers or equipment used in preparation or delivery of antineoplastics.
5. Dual waste: A mixture of both hazardous and non-regulated pharmaceutical waste.
6. Controlled substance waste: Includes controlled substances that remain after administration of the appropriate dose to the patient, a damaged, partially used or a controlled substance that is otherwise not-returnable.

Pharmaceutical Waste Determination: Each medication within the facility must have a dedicated waste determination and for hazardous medications, a hazard determination. Each medication non included on the NIHD Hazardous drug list will be handled as non-regulated pharmaceutical waste or as a controlled substance if so classified by the DEA.

1. Common P-listed pharmaceuticals (not an inclusive list):
    a. P001 – Warfarin
    b. P012 – Arsenic Trioxide
    c. P042 – Epinephrine
    d. P075 – Nicotine
    e. P081 – Nitroglyerin
    f. P204 – Physostigmine
2. Common U-listed pharmaceuticals (not an inclusive list):
    a. U058 – Cyclophosphamide
    b. U059 – Daunomycin
    c. U150 – Melphalan
    d. U151 – Mercury
    e. U010 – Mitomycin C
3. The determination of which wastes are hazardous is listed in the NIHD Hazardous drug list which will be updated annually or when a new medication is added to the formulary.
4. Hazardous Waste Profiles
    a. Any pharmaceutical waste requiring management as a hazardous waste must be profiled for proper disposal. Manifesting and profiling will be completed with the hazardous waste hauler as well as facilities and pharmacy personnel.
    b. The contracted hazardous waste hauler will identify proper manifesting procedures as part of the contractual relationship with NIHD.
5. Informing Staff who handle EHDs and OHDs. Healthcare staff who handle EHDs and OHDs must be made aware of the proper mechanisms by which to dispose of their pharmaceutical wastes. These staff must be trained at time of assignment and annually thereafter and this training must be documented in writing. In addition to the management and disposal requirements of this policy, other best management practices may be employed to further streamline the process for the user. Recommended practices include:
    a. Placing stickers or labels on shelves and on the product, where possible, to identify the disposal mechanism for pharmaceuticals.
    b. Removal warnings will be placed in the automated dispensing cabinets to remind users that the pharmaceutical being removed is hazardous and must be disposed of as hazardous waste.
    c. All medications prepared in the pharmacy that are hazardous will be identified as such.
6. Container Selection and Management
    a. The color-coding system established in this policy is designed to standardize the management of the various categories of pharmaceutical waste. This system is modeled after current industry practice and appropriate containers are readily available through various supply chains.
        i. Blue and white: non-regulated pharmaceutical waste for incineration
        ii. Yellow: Trace chemotherapy waste for incineration
        iii. Black: RCRA hazardous, Bulk chemotherapy and Best management practices hazardous wastes (many OHDs)
    b. Containers must meet applicable regulatory standards (EPA, CAMWMA, Department of Transportation (DOT).
    c. Containers must be properly labeled per applicable regulatory standards (EPA, DOT, OSHA, CAMWMA, etc). Labels must be readily visible to personnel in those areas.

7. Accumulation Points:
    a. NIHD will identify an accumulation site for storage of pharmaceutical waste once it leaves the pharmacy or patient care areas. The accumulation site will be the central location for eventual transport off-site for processing.
    b. Non-regulated waste and controlled substance waste will be stored separately from hazardous waste. The accumulation site will conform to all applicable regulatory standards.
    c. The accumulation site will be under the control of Facilities personnel
8. Inspections:
    a. Collection of hazardous waste may present a significant risk of non-compliance. Therefore the accumulation site will be inspected monthly by representatives of Pharmacy, Facilities, and Safety.
    b. The monthly inspection will note the following:
        i. Condition of containers
        ii. Appropriate placement of waste containers throughout the facility
        iii. Proper segregation of wastes
        iv. Proper container labeling
        v. Appropriate dates on the containers for accumulation and removal
        vi. Appropriate completion and maintenance of log sheets
        vii. Training documentation
9. Disposal of Controlled Substances:
    a. Requirements for the disposal of controlled substances are delineated in guidance from the DEA. The DEA requires that controlled substances by disposed of so they are non-retrievable. Disposing of controlled substances via the drain, toilet or sewer is not environmentally appropriate or legal in California. Partially used or contaminated controlled substances must be waste and the wastage documented by two licensed health care providers.
    b. NIHD has elected to adopt a separate waste pathway for the disposal of controlled substances.
        i. NIHD will place separate containers for the disposal of controlled substances throughout patient care areas.
        ii. These containers will be provided by pharmacy and contain a chemical that immediately destroys the controlled substance once it is placed within the container.
        iii. The waste of controlled substances will still need to be documented and witnessed by two licensed providers.
        iv. Once filled, the containers will be shipped off-site by a separate pathway from non-regulated and hazardous wastes.

PROCEDURE: PROCEDURES FOR SAFE HANDLING OF OCCUPATIONALLY HAZARDOUS DRUGS (OHDs) AND ENVIRONMENTALLY HAZARDOUS DRUGS (EHDs)

1. **Safety Data Sheets (SDS).** SDSs for OHDs and EHDs used within NIHD will be readily available to employees. NIHD will maintain these SDSs via links on the intranet home page.
2. **OHD Preparation Precautions**
    a. OHD preparation must be performed in an area with access limited to authorized personnel only. OHDs may contaminate surfaces in preparation areas. Eating, drinking, smoking, chewing gum, taking or administering medications, applying cosmetics and storing food in the preparation area is prohibited. Procedures for spills and emergencies must be posted in or adjacent to the preparation area. Appropriate personal protective equipment must be worn during the preparation, administration and disposal of OHDs as defined in the NIHD Hazardous Drug List (NIHD-HDL).

b. Preparation of parenteral OHDs as well as any compounding of non-parenteral OHDs must be done in a Class II, Type B or Class III Biological Safety Cabinet (BSC) that meet the current National Sanitation Foundation Standard, or a negative pressure Compounding Aseptic Containment Isolator (CACI) that meets International Standards Organization (ISO) Class 5 Air Quality Standards. Internal and External exhausts for the hoods must have high efficiency particulate air (HEPA) filters. All hoods used for the preparation of OHDs must be externally vented. Commercially available oral OHD products which only require unit dosing will not need to be prepared in a containment device but do require preparation in a segregated area with appropriate PPE use as defined in the NIHD Hazardous Drug List.
c. The exhaust fan or blower in the hood must be on at all times except when the hood is being mechanically repaired or moved or if required for cleaning or decontamination. If the blower is turned off, the hood must be decontaminated and cleaned before use. Each hood must be equipped with a continuous monitoring device to allow confirmation of adequate airflow. The outside exhaust of these hoods must clear of and vented away from air intake units. The hoods and exhaust systems must be connected to backup emergency power.
d. All hoods and BSCs used for the preparation of OHDs will be placed within negative pressure rooms, connected to positive pressure anterooms per USP 797 and USP 800 requirements.
e. The cabinet must be cleaned and decontaminated as required by UPS 797 and 800 standards as well as internal pharmacy procedure consistent with hood manufacturer standards. Decontamination must consist of surface cleaning with water and detergent followed by through rinsing. Spray cleaners or germicidal agents are prohibited. During cleaning and contamination, all personnel will wear appropriate PPE as required by pharmacy policy and the NIHD hazardous drug list. A NIOSH approved respirator, gown and gloves will be worn by the worker during the cleaning. Cleaning will proceed from most contaminated to least contaminated areas and the drain/spillage areas will be cleaned twice. All materials from the decontamination process must be handled as hazardous waste and disposed of as such.
f. All hoods must be serviced and certified by a qualified and certified technicians at least every 6 months. HEPA filters must be changed per manufacturer instruction or when contaminated by accidental spill or otherwise damaged. Used filters must be disposed of properly depending upon the location from where they were taken.
g. All contaminated needles, syringes and IV tubing used to prepare OHDs will be disposed of intact. Clipping or capping of needles is prohibited. Priming IV sets or expelling air from syringes must be carried out in the designated hood. If done at the site of administration to the patient, the IV line will be primed with a non-drug containing solution or a back flow closed system must be used..
h. NIHD mandates the use of a closed system transfer device (CSTD) for preparation and administration of certain OHDs as defined by the CSTD policy.
i. Handling of OHD tablets and other oral dosage forms must follow USP 800 guidance.

3. **Transporting and Storage**
   a. In addition to standard pharmacy labeling practices, all syringes and IV bags containing OHDs must be labeled with a distinctive warning label identifying it as an OHD.
   b. Access to areas where OHDs are stored are limited to authorized personnel within the pharmacy. Storage in patient care areas will clearly identify the medication as an OHD.
   c. Transport will occur in sealed plastic bags and/or containers to avoid breakage. Personnel involved in transporting OHDs and EHDs within the hospital will be trained in spill procedures.
4. **Drug Administration.** Only appropriately qualified/certified personnel will administer OHDs.
   a. Personnel administering OHDs must wear appropriate PPE as defined in the NIHD Hazardous Drug List. Preparation for administration of OHDs on the ward or clinic will be carried out on

trays lined with a plastic-backed absorbent pad so the plastic can be gathered as waste for appropriate disposal at the end of the procedure.

b. Contaminated needles, syringes and IV tubing/bags will be disposed of intact. Needles will not be capped, cut or crushed. In rare instances where recapping of a needle is required, only the one handed method will be used.

c. The administration of aerosolized OHDs (e.g. Pentamidine) requires special engineering controls (negative pressure) in addition to appropriate PPE.

5. PPE.
   a. Gloves. Gloves will be powder free and will be specifically designated for handling OHDs. Gloves for handling OHDs will conform to the American Society of Testing and Materials (ASTM) standard D6978 or its successor. Certain activities may require double gloving as assessed by the HDC and NIHD-HDL. Because all gloves are permeable to some extent, they will be changed every 30 minutes during use or immediately if punctured, torn or contaminated with a spill. Hands must be washed with soap and water before gloves are put on and after they are removed.
   b. Gowns. Gowns must be selected and worn based upon the OHDs being handled. A Protective disposable gown made of ployethelene-coated polypropylene or other laminate material with a closed front, long sleeves and elastic or know-closed cuffs will be worn. The cuffs will be tucked under the gloves unless double gloving is specified. If double gloves are worn, the outer glove will be worn over the gown cuff and the inner glove under the gown cuff. Gowns and gloves used in the preparation area will not be worn outside the OHD preparation area.
   c. Chemical Goggles and Face Shields. Whenever splashes, sprays or aerosols of OHDs may be generated, chemical barrier face and eye protection will be used. Eyewash facilities must also be available in the OHD preparation area.
   d. Respirator. Personnel administering aerosolized OHDs must wear a NIOSH-approved respirator appropriate for each OHD as determined by the HDC. Fitting of the respirator is personnel specific and must be certified by the employee health department.
6. **Caring for Patients Receiving OHDs**. Per the NIHD-HDL and existing NIHD Blood-Borne Pathogen exposure policy, appropriate precautions must be observed to prevent contact with blood or other potentially infectious materials.
   a. Personnel dealing with any blood, body fluids, urine or excreta from patients who have received OHDs within the last 48 hours must wear appropriate PPE per the NIHD-HDL and risk assessment by the HDC. Hands must be washed thoroughly after contact with the above substances.
   b. Linen contaminated with OHDs, urine or excreta from patients who have received OHDs within the last 48 hours must be placed in specially marked impervious plastic laundry bags. Linen soiled with blood or other potentially infectious materials as well as contaminated with urine or excreta must also be managed per NIHD soiled linen policy.
7. **Medical Surveillance**
   a. Personnel with potential exposure to OHDs will be considered for placement in the medical surveillance program (MSP) based upon the recommendations of the HDC. Selection of individuals for medical surveillance must be based on exposure assessment performed by the HDC.
      i. All personnel who directly handle OHDs, including nurses, pharmacists and pharmacy technicians at a minimum will be enrolled in the MSP. Other personnel will be enrolled based upon a determination of the HDC.
      ii. Medical surveillance consists of pre-placement, periodic and termination examinations. Employee health status, medical history and collection of data elements including a medical (including reproductive) history and work history to assess exposure to HDs,

physical examination, and laboratory testing. Methods used to assess exposure history include a review of:

1. Records of HDs handled, with quantities & dosage forms
2. Estimated number of HDs handled per week
3. Estimates of hours spent handling HDs per week and/or per month
4. Performance of a physical assessment and laboratory studies linked to target organs of commonly used HDs such as a baseline complete blood count.

iii. All personnel who are exposed to OHDs will receive training, including written documentation of the risks of exposure to OHDs and will sign a statement of understanding regarding training and compliance with PPE and safety requirements.

b. Pregnant, attempting to become pregnant or breastfeeding women must be informed of the hazards that OHDs may pose to the health of their children. Staff members identified above with be offered a transfer to duties that do not involve preparation of administration of OHDs.

8. **Post Exposure Actions**.
   a. In case of skin contact with OHDs, follow the manufacturer's instructions per the SDS. This generally involves immediately removing contaminated clothing, flushing the affected area with water and washing the area with soap or other inactivator as specified by the manufacturer.
   b. In case of eye contact with OHDs, flush with water for a minimum of 15 minutes. Continue irrigation until ophthalmologic examination is obtained.
   c. Report to the Emergency department for additional treatment and documentation of the exposure. Particular attention to the eyes, mouth, nasal mucous membranes and skill will be included in the physical examination for acute exposure.
   d. Personnel who do not routinely work with OHDs that have a situational exposure to OHDs should be evaluated and followed on an individual basis. The employee health nurse will make the determination about the need for further follow-up past acute treatment.

9. Spill Control
   a. A spill clean-up kit, clearly labeled, will be kept in each area where OHDs are prepared, administered or accumulated for disposal or transport. When transporting OHDs or patients under active treatment with OHDs, a spill kit must transport with the patient.
   b. Clean –up of spills. The American Society of Health System Pharmacists considers a small spill to be less than 5ml. The 5ml threshold should be used to categorize spills as large or small. Small spills, large spills and spills in BSCs must be cleaned following hood cleaning and decontamination protocol. When a large spill occurs, the area should be isolated and aerosol generation avoided. Clean-up personnel should wear appropriate PPE, as noted above, including a NIOSH-approved respirator if there is any suspicious of airborne powder or that an aerosol has or will be generated. Clean-up personnel must be trained to clean up large spills. Materials used during a spill clean-up of any size must be coordinated with the HDO to ensure compliance with applicable regulations and policies.

10. **Training and Information Dissemination**.
   a. All personnel involved in any aspect of the handling of covered OHDs will receive training on the hazards, appropriate handling and disposal procedures of OHDs present in the work area. This training will cover topics including the use of appropriate PPE, medical surveillance, post-exposure actions, spill control, etc. Such information will be provided at time of an employee's initial assignment to a work area where OHDs are present. Annual training is required. All training must be documented in writing. Employees must acknowledge training completion and also acknowledge the risks of failure to follow the standards outlined in this policy and in USP 800.
   b. This policy will be made available to all users, the HDO in conjunction with the HDC must ensure appropriate personnel are properly trained on the requirements.

REFERENCES:

1. United States Environmental Protection Agency. (2023). Management of Hazardous Waste Pharmaceuticals. Retrieved from https://www.epa.gov/hwgenerators/management-hazardous-waste-pharmaceuticals
2. The Joint Commission. (January 2024). EC.01.01.01 Element 6. The Critical Access hospital plan activities to minimize risks to the environment of care. Retrieved from https://e-dition.jcrinc.com/MainContent.aspx.
3. NIOSH List of Hazardous drugs in healthcare settings, 2020 from : https://www.cdc.gov/niosh/docket/review/docket233c/pdfs/DRAFT-NIOSH-Hazardous-Drugs-List-2020.pdf

RECORD RETENTION AND DESTRUCTION:

3 years

CROSS REFERENCE POLICIES AND PROCEDURES:

1. MEDICAL WASTE MANAGEMENT PLAN

Supersedes: v.1 Safe Handling and Disposal of Occupationally Hazardous Drugs and Environmentally Hazardous Drugs*

NORTHERN INYO HEALTHCARE DISTRICT
CLINICAL POLICY AND PROCEDURE

Title: Safe Patient Handling – Minimal Lift Program		
Owner: Manager Employee Health & Infection Control	Department: Infection Prevention	
Scope: Clinical Staff District Wide		
Date Last Modified: 05/28/2024	Last Review Date: No Review Date	Version: 5
Final Approval by: NIHD Board of Directors	Original Approval Date: 10/01/2014	

PURPOSE:

Northern Inyo Healthcare District (NIHD) wants to ensure that patients are cared for safely, while maintaining a safe work environment for employees. This document describes the practices at NIHD to ensure employees use safe patient handling and movement techniques for patients in patient care areas.

POLICY:

1. Patient care areas include all areas of the District where care and treatment of services are rendered directly to the District's patient population and include, but are not limited to Rural Health Clinics, Nursing Services, Diagnostic Imaging Services, Cardiopulmonary, NIA Clinics, Lab and Rehabilitation Services.
2. Direct patient care staff members in all patient care areas will assess all patient handling tasks in advance to determine the safest way to accomplish the tasks.
    a. Mechanical lift aids will be used as appropriate for the patient and all direct patient care employees are expected to assist each other in the execution of safe patient handling matters.
    b. District leaders are required to ensure that employees have appropriate assistance in implementing this policy on a task by task basis and have trained their staff members on appropriate safe patient handling matters.
3. For patients admitted to the hospital, an RN will serve as the coordinator of care assessing the patient's mobility needs and the level of assistance required and mechanical device usage.
    a. If indicated asn order will be generated to Rehabilitation Services by a physician for additional patient assessment and care planning.
4. An inventory of mechanical device equipment for patient care areas will be maintained by the department management or designee.
5. Staff training will be provided on the use of mechanical device equipment as appropriate to the position upon hire, annually, and with new equipment.
6. Mechanical lift devices are to be used on patients requiring assistance. Manual lifting without a mechanical lift device is discouraged.
    a. If some degree of lifting is required, caregivers should seek assistance from other staff members and/or employ mechanical aids, and assistive devices whenever possible.
7. Employees who do not utilize proper safe patient handling practices may be subject to corrective action. Discipline will not occur with respect to a health care worker who refuses to lift, reposition, or transfer a patient due to concerns about patient or worker safety or lack of equipment or trained lift personnel.

8. Any injury resulting from patient lifting or positioning, including strains, sprains, or any other muscular skeletal injury must be handled according to the Health and Safety- Work Related Accidents or Exposures to Blood or Other Potentially Infectious Materials. .
9. If a patient is unable to assist the HCW with repositioning or transfers, then the lifting and moving of the patient will be done with minimum of two person assist with or without the use of an assistive device. Transferring patients out of any inpatient unit, and/or ED, on a non-propelled gurney or bed, to and from the Imaging Department will be done with a minimum of two-person assistance. One person will act as the lead directing the second person for any assistance needed throughout the transport. One person can transfer to Imaging Department if using a self-propelled gurney. If a patient is being transferred on a gurney, on a level surface to any inpatient unit or PACU/OR, it is permissible for one person to perform the transport.

DEFINITIONS:

1. Manual Lifting: Lifting, transferring, repositioning, and moving patients using a caregiver's body strength without the use of lifting equipment/aids that reduce forces on the worker's muscular skeletal structure.
2. Patient Handling Equipment and Aids: Equipment or aids used to decrease the risk of injury from patient handling activities and includes, but is not limited to the following:
    a. **Lifting Equipment** includes portable/floor-based designs and their accompanying slings that function to assist in lifting and transferring patients, ambulating patients, repositioning patients, and other patient handling tasks.
    b. **Lateral Transfer Devices** Provide assistance in moving patients horizontally from one surface to another (e.g., transfers from bed to stretcher).
    c. **Beds** that provide assistance with patient handling tasks such as lateral rotation therapy, transportation, percussion, bringing patients to sitting positions, etc.
    d. **Repositioning Aids** provide assistance in turning patients and pulling patients up to the head of the bed and up in chairs.
    e. **Equipment/bed/wheelchair transport assistive devices** assist caregivers in pushing heavy equipment.
    f. **Patient Handling Aids:** Non-mechanical equipment used to assist in the lift or transfer process. Examples include stand assist aids, sliding boards, and surface friction-reducing devices.
    g. **Powered Height-adjustable exam tables** assist in transfer of patients onto exam tables and in bringing patients to sitting position, and raise the table surface to a more ergonomically safe working level.
3. High Risk Patient Handling Tasks: Patient handling tasks that have a high risk of musculoskeletal injury for staff performing the tasks. These include but are not limited to transferring and lifting tasks, repositioning tasks, bathing patients in bed, making occupied beds, ambulating and dressing patients, turning patients in bed, tasks with long durations, standing for long periods of time, bariatric, and other patient handling tasks.
4. Designated Health Care Worker: NIHD staff who have been specifically trained to handle patient lifts, repositioning, and transfers using patient transfer, repositioning, or lifting devices as appropriate for the specific patient.

PROCEDURE:

A. Direct Patient Care Employee Responsibility
    1. Take responsibility for their own health and safety, as well as that of their co-workers and their patients during patient handling activities.

2. Complete initial training and annual training as required.
    a. Complete additional training to correct improper use/understanding of safe patient handling and movement.
    b. Notify manager of need for re-training in the use of patient handling equipment and aids.
3. Assess patient for condition and ability to cooperate with transfer and appropriate level of patient assist. Identify and avoid hazardous manual patient handling and movement tasks whenever possible.
4. Use proper techniques, mechanical lifting devices, and other approved equipment and/or aids during performance of high risk patient handling tasks.
5. Promptly report to manager or shift supervisor any injury without fear of negative consequence.
6. Follow procedures for reporting patient handling equipment in need of repair.

B. RN Coordinator of Care Admitted Patients.
1. The designated registered nurse, as the coordinator of care, will assess the mobility needs of each patient (regardless of weight, mobility or other health issues) to determine the appropriate patient handling procedures based on the nurse's professional judgment using assessment tools, decision trees, algorithms or other effective means, and prepare safe patient handling instructions for the patient.
2. Information is disseminated in department huddles, during patient care, and hand-off.

C. Department Leadership:
1. Be educated and remain up-to-date in the use of mechanical lifts and transfer aids. Be aware of department worker's compensation costs and injury rates and continue to make efforts to reduce the number of incidents in all areas of responsibility.
2. Through employee observation, documentation review and other means, make sure that all employees are assessing the patient prior to any movement and that all patient handling tasks are completed safely, using mechanical lifting devices and other approved handling aids.
3. Department inventory of mechanical lifting devices/aids are available in proper working order, maintained regularly and stored readily accessible in the clinical areas.
4. Review orientation checklists to make sure that employees complete initial training; ensure employees demonstrate competency; provide re-training when employees are non-compliant with safe patient handling practices; maintain training records for a period of three years.
5. Refer all staff reporting patient handling injuries to the Shift Supervisor and/or Emergency Department for immediate evaluation and treatment.

D. Clinical Staff Educators or designee will:
1. Complete training of newly hired staff members on the use of the lift equipment/aids and assist with ongoing training for unit staff members. Provide reference materials with the information needed for troubleshooting.
2. Training will include use of lifting deices and equipment to handle patient safety and the five areas of body exposure: vertical, lateral, bariatric, repositioning, and ambulation.

E. Rehabilitation Services and Employee Health:
1. Annual ergonomic rounds will be conducted in patient care areas and select departments to interact with staff on ergonomic/musculoskeletal knowledge and acquire feedback on new safety issues in the departments and or workstations, discuss options to remedy perceived unsafe situations. Reports are sent to department leadership and actions to mitigate hazards are reported to Safety Committee. Documentation is stored in Safety committee minutes and Employee Health

F. Biomedical Engineering
1. Shall maintain patient care equipment in proper working order.

2.Consult with equipment manufacturers to provide safe equipment installations.

G. Reporting of Injuries:

1. Employees are required to follow the Health and Safety - Work Related Accidents or Exposures to Blood or Other Potentially Infectious Materials (17-01)
2. Employees who are non-compliant must be re-trained and demonstrate competency in equipment use before returning to work. Continued failure to use proper patient handling practices may result in corrective action up to and including termination.

REFERENCES:

1. ANA (2013) Safe Patient Handling and Mobility: Inter-professional National Standards. Nursebooks.org.
2. California Hospital Association. (2014). The Cal/OSHA Safe Patient Handling Regulation: Health Care Worker Back and Musculoskeletal Injury Prevention Law. Retrieved from https://calhospital.org/wp-content/uploads/2019/11/safepatienthandling_epubapp.pdf
3. California Code of Regulations (2013) Safe Patient Handling Bill (AB1136). Retrieved from http://www.leginfo.ca.gov/pub/11-12/bill/asm/ab_1101-1150/ab_1136_bill_20111007_chaptered.pdf
4. TJC (2012) Improving Patient and Worker Safety: Opportunities for Synergy, Collaboration and Innovation. Oakbrook Terrace, Illinois. Retrieved from https://www.jointcommission.org/-/media/tjc/documents/resources/patient-safety-topics/work-place-violence-prevention/updated-wsps-monograph-final-42020.pdf

RECORD RETENTION AND DESTRUCTION:

Training records will be maintained for a minimum of 1 year per Cal/OSHA requirement (2014 regulation).

CROSS REFERENCED POLICIES AND PROCEDURES:

1. Unusual Occurrence Reporting
2. Employee Request to be Excluded from Patient Care
3. Fall Prevention and Management* Fall Risk Prevention - Perinatal*
4. Health and Safety - Work Related Accidents or Exposures to Blood or Other Potentially Infectious Materials (17-01)
5. Injury and Illness Prevention Program*

Supersedes: v.4 Safe Patient Handling – Minimal Lift Program

NORTHERN INYO HEALTHCARE DISTRICT

CLINICAL POLICY

Title: Cesarean Delivery		
Owner: PERINATAL NURSE MANAGER	Department: Perinatal	
Scope: Perioperative and Perinatal		
Date Last Modified: 06/05/2024	Last Review Date: No Review Date	Version: 4
Final Approval by: NIHD Board of Directors	Original Approval Date: 11/15/2009	

PURPOSE: To provide guidelines for the preparation and delivery of a patient undergoing a cesarean section.

DEFINITIONS:

Levels of Priority

- **Scheduled** – pre-planned date and time, no maternal or fetal compromise.
- **Unscheduled, Non-Urgent** – as soon as possible, no maternal or fetal compromise.
- **Urgent** – Decision to incision expected within 60 minutes. Maternal or fetal compromise where delivery cannot be delayed.
- **Emergent** – Decision to incision expected within 30 minutes. Immediate delivery required due to severe or life-threatening maternal or fetal condition.

Resuscitative Hysterotomy (Perimortem Cesarean Delivery): delivery of the fetus via cesarean section initiated within four minutes of maternal cardiac arrest, and intended to increase the chance of maternal and/or neonatal survival.

Nulliparous, Term, Singleton, Vertex (NTSV) Cesarean Birth Rate: the proportion of live babies born at or beyond 37.0 weeks gestation to a pregnant person in their first pregnancy, that are singleton (no twins or beyond) and in the vertex presentation (no breech or transverse positions), via cesarean birth.

Arrest of active stage: All 3 of the following criteria must be met: 1) Cervix >6 cm, 2) rupture of membranes (ROM), 3) no cervical change after at least 4 hours of adequate uterine activity (e.g. strong to palpation or MVUs > 200), or at least 6 hours of oxytocin administration with inadequate uterine activity.

Arrest of second stage: No or minimal fetal descent noted after good pushing effort for >3 hours without epidural or >4 hours with epidural for nulliparas and good pushing effort >2 hours without epidural and >3 hours with epidural for multiparas.

Failed induction: The point at which a vaginal delivery cannot reasonably and safely be expected following attempts to induce labor.

Category I fetal heart tracing: Normal baseline fetal heart rate (FHR), with moderate variability and a lack of concerning decelerations. Category I tracings are strongly predictive of normal fetal acid-base status at the time of observation.

Category II fetal heart tracing: Category II FHR tracings include all tracings not categorized as Category I or Category III. Tracings in this category are not predictive of abnormal acid-base status. Category II tracings warrant increased frequency of monitoring, assessment, and intervention.

Category III fetal heart tracing: Absent baseline FHR variability with recurrent late and/or variable decelerations and/or bradycardia, or with a sinusoidal pattern. Category III tracings warrant immediate intervention to effect delivery.

POLICY:

For all cesarean deliveries (scheduled, unscheduled, urgent, and emergent):

1. The provider will provide informed consent for procedure. If patient desires a tubal ligation/salpingectomy/sterilization, appropriate consents will be obtained.
2. A Perinatal RN will review pre-operative labs, consents, and pertinent patient history. The Perinatal RN will verify that intravenous access is in place and will verify that appropriate supplies, equipment, and medications accompany patient.
3. A qualified healthcare professional with current certification in neonatal resuscitation (NRP) will be present at delivery and solely responsible for the care and resuscitation of the neonate.
4. A qualified healthcare professional will ensure that appropriate neonatal equipment is present in the OR, including neonatal warmer and neonatal resuscitation equipment.
5. To more accurately measure blood loss, Quantitative Blood Loss (QBL) measurement by qualified staff is recommended and will be documented in the medical record.
6. A qualified healthcare professional will facilitate infant bonding, skin to skin, and breastfeeding, if desired and clinically appropriate, in the OR and PACU. Surgical staff, in collaboration with Perinatal staff, will facilitate the presence of patient's support person while in the OR. If the patient undergoes general anesthesia and a support person is not present at delivery, a qualified staff member will assist them to the recovery area until the patient and neonate are stable.
7. Post-procedure handoff and communication between the PACU RN and the Perinatal RN will include:
    a. Medications administered preoperatively, intraoperatively, and during recovery in PACU
    b. Total blood loss
    c. Total volume of fluid administered
    d. Vital signs, pain, sensation and movement
    e. Assessment of IV site and urinary catheter
    f. Fundal assessments since delivery and visual assessment of surgical site
    g. Handoff will be documented in the medical record
8. Vital Signs and postpartum assessments will be documented as outlined in the policy "Standards of Patient Care in the Perinatal Unit".
9. Enhanced Recovery After Surgery (ERAS) strategies will be implemented during perioperative care, including when the patient returns to the Perinatal unit for postpartum recovery. These strategies may include and are not limited to: early mobilization, appropriate thromboprophylaxis, advancing diet as tolerated, and early discontinuation of urinary catheterization.

For urgent and emergent cesarean deliveries:

1. The Perinatal Unit will notify House Supervisor who will communicate with surgical staff and facilitate OR availability. The House Supervisor will communicate Level of Priority of case to surgical team.
2. The pediatrician will be notified of the decision for cesarean, the level of priority, and will and will make all attempts to be present at delivery.
3. Respiratory Therapy (RT) will be notified of the decision for cesarean, the level of priority, and will be present at delivery.
4. A qualified staff member will ensure that pre-operative preparation, fetal monitoring, and medication administration is completed as appropriate, based on clinical condition of pregnant person and/or fetus.
5. The Perinatal RN will ensure that appropriate neonatal resuscitation equipment is present in the OR, including neonatal warmer and the neonatal resuscitation cart.
6. A qualified staff member will confirm that supplies, equipment, and instrumentation for urgent and emergent cesarean deliveries are present in the OR.
7. Documentation for urgent and emergent cesarean deliveries includes:
    a. Decision time for cesarean
    b. Pre-operative care and preparation
    c. Arrival times of all providers and support staff
    d. Time of arrival in OR
    e. The Perinatal RN will complete all required documentation for delivery and postpartum

Fetal Monitoring

- For scheduled cesarean sections, the Perinatal RN will perform a non-stress test (NST) during pre-operative preparation. For unscheduled, non-urgent cesarean sections, monitoring will continue per provider order and status of tracing. The RN will notify the provider if the NST is not reactive.

- For scheduled and unscheduled, non-urgent cesarean sections, the RN will assess fetal heart tones (FHTs) after spinal is placed, and prior to sterile abdominal prep. The RN will notify the provider if FHTs are outside of normal range.

- For urgent and emergent cesarean sections, fetal monitoring should continue when technically feasible, until sterile prep has begun. If fetal spiral electrode is in place, continue to monitor until immediately prior to draping.

Special Considerations for Failed Induction of Labor and/or Labor Dystocia:

- If primary cesarean section is considered for a Nulliparous, Term, Singleton pregnancy, the definitions in this document, the policy “Induction and Augmentation of Labor Including Cervical Ripening” as well as Appendix A: CMQCC Pre-Cesarean Checklist for Labor Dystocia or Failed Induction and Appendix B: CMQCC Labor Dystocia Checklist will be used to determine if criteria has been met to proceed.
- Fetal intolerance to labor will be evaluated using Appendix C: CMQCC Example Algorithm for the Management of Intrapartum Fetal Heart Rate Tracings.
- Primary cesarean may be considered if:

1. Criteria for primary cesarean section has been met.
2. If criteria has not been met according to the checklist, documentation of indication, circumstances and informed consent will be provided in the patients' medical record by the provider.

REFERENCES:

American Academy of Pediatrics and The American College of Obstetricians and Gynecologists. (2017) Guidelines for Perinatal Care 8th edition.

Association of Women's Health Obstetric and Neonatal Nurses (AWHONN). (2014). Quantification of blood loss: AWHNONN Practice Brief Number 1, JOGNN, 00, 1-3.

Boehm, F. H. (2012). Decision to incision: Time to reconsider. *American Journal of Obstetrics and Gynecology*, *206*(2), 97–98. https://doi.org/10.1016/j.ajog.2011.09.009

Perioperative pathways: Enhanced recovery after surgery. ACOG. (September 2018). https://www.acog.org/clinical/clinical-guidance/committee-opinion/articles/2018/09/perioperative-pathways-enhanced-recovery-after-surgery

Simpson, K. R., Creehan, P. A., O'Brien-Abel, N., Roth, C. K., & Rohan, A. J. (2021). AWHONN *Perinatal Nursing* (5th ed.). Wolters Kluwer.

Toolkit to Support Vaginal Birth and Reduce Primary Cesareans. California Maternal Quality Care Coalition. (2022). https://www.cmqcc.org/sites/default/files/Vbirth-Toolkit-with-Supplement_Final_11.30.22_2.pdf

CROSS REFERENCED POLICIES AND PROCEDURES:
Induction and Augmentation of Labor Including Cervical Ripening

Supersedes: v.3 Cesarean Delivery*

Appendix A: CMQCC Pre-Cesarean Checklist for Labor Dystocia or Failed Induction

Pre-cesarean Checklist for Labor Dystocia or Failed Induction

Patient Name:_____ MR#: _____

Gestational Age: _____ Date of C-section: _____;

Time: _____

Obstetrician: _____ ; Initial:_____

Bedside Nurse: _____ ; Initial:_____

Indication for Primary Cesarean Delivery:

____ Failed Induction (must have both criteria if cervix unfavorable, Bishop Score < 8 for nullips and <6 for multips)

___ Cervical Ripening used (when starting with unfavorable Bishop scores as noted above). Ripening agent used: _____Reason ripening not used if cervix unfavorable: _____

AND

___ Unable to generate regular contractions (every 3 minutes) and cervical change after oxytocin administered for at least 12-18 hours after membrane rupture." *Note: at least 24 hours of oxytocin administration after membrane rupture is preferable if maternal and fetal statuses permit

____ Latent Phase Arrest <6 cm dilation (must fulfill one of the two criteria)

___ Moderate or strong contractions palpated for > 12 hours without cervical change

OR

___ IUPC > 200 MVU for > 12 hours without cervical change

*As long as cervical progress is being made, a slow but progressive latent phase e.g. greater than 20 hours in nulliparous women and greater than 14 hours in multiparous women is not an indication for cesarean delivery as long as fetal and maternal statuses remain reassuring. Please exercise caution when diagnosing latent phase arrest and allow for sufficient time to enter the active phase.

____ Active Phase Arrest ≥ 6 cm Dilation (must fulfill one of the two criteria)

Membranes ruptured (if possible), then:

___ Adequate uterine contractions (e.g. moderate or strong to palpation, or ≥ 200 MVU, for ≥ 4 hours) without improvement in dilation, effacement, station or position

OR

___ Inadequate uterine contractions (e.g. < 200 MVU) for ≥ 6 hours of oxytocin administration without improvement in dilation, effacement, station or position

____ Second Stage Arrest (must fulfill any one of four criteria)

___ Nullipara with epidural pushing for at least 4 hours

OR

___ Nullipara without epidural pushing for at least 3 hours

OR

___ Multipara with epidural pushing for at least 3 hours

OR

___ Multipara without epidural pushing for at least 2 hours

____ Although not fulfilling contemporary criteria for labor dystocia as described above, my clinical judgment deems this cesarean delivery indicated

___ Failed Induction: Duration in hours: _____
Latent-Phase Arrest: Duration in hours: _____
Active-Phase Arrest: Duration in hours:_____
Second-Stage Arrest: Duration in hours: _____

Comments:

Adapted with permission from Miller Children's and Women's Hospital.

Appendix B: CMQCC Labor Dystocia Checklist

Appendix K

CMQCC Labor Dystocia Checklist (ACOG/SMFM Criteria)

CMQCC
California Maternal
Quality Care Collaborative

CMQCC Labor Dystocia Checklist (ACOG/SMFM Criteria)

1. Diagnosis of Dystocia/Arrest Disorder (all 3 should be present)

- ☐ Cervix 6 cm or greater
- ☐ Membranes ruptured, then
- ☐ No cervical change after at least 4 hours of adequate uterine activity (e.g. strong to palpation or MVUs > 200), or at least 6 hours of oxytocin administration with inadequate uterine activity

2. Diagnosis of Second Stage Arrest (only one needed)

No descent or rotation for:

- ☐ At least 4 hours of pushing in nulliparous woman with epidural
- ☐ At least 3 hours of pushing in nulliparous woman without epidural
- ☐ At least 3 hours of pushing in multiparous woman with epidural
- ☐ At least 2 hour of pushing in multiparous woman without epidural

3. Diagnosis of Failed Induction (both needed)

- ☐ Bishop score ≥6 for multiparous women and ≥ 8 for nulliparous women, before the start of induction (for non-medically indicated/elective induction of labor only)
- ☐ Oxytocin administered for at least 12-18 hours after membrane rupture, without achieving cervical change and regular contractions. *Note: At least 24 hours of oxytocin administration after membrane rupture is preferable if maternal and fetal statuses permit

American College of Obstetrics and Gynecology, Society for Maternal-Fetal Medicine. Obstetric care consensus no. 1: safe prevention of the primary cesarean delivery. Obstet Gynecol. 2014;123(3):693-711.

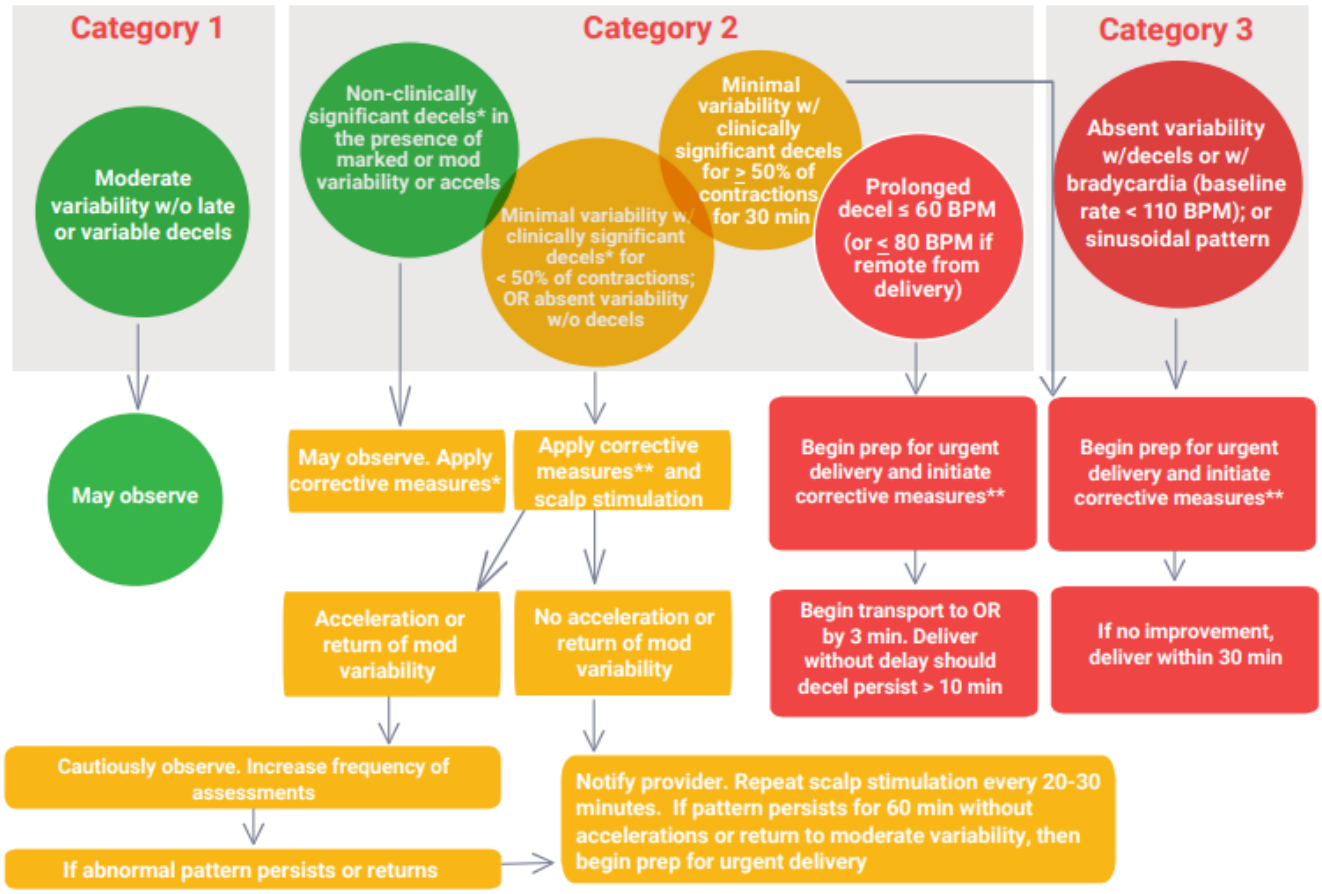
Spong CY, Berghella V, Wenstrom KD, Mercer BM, Saade GR. Preventing the first cesarean delivery: summary of a joint Eunice Kennedy Shriver National Institute of Child Health and Human Development, Society for Maternal-Fetal Medicine, and American College of Obstetricians and Gynecologists Workshop. Obstet Gynecol. 2012;120(5):1181-1193.

Appendix C: CMQCC Example Algorithm for the Management of Intrapartum Fetal Heart Rate Tracings

Appendix Q

Example Algorithm for the Management of Intrapartum Fetal Heart Rate Tracings

CMQCC
California Maternal Quality Care Collaborative



***Clinically significant decelerations include:**

- Variable decels lasting > 60 sec with a nadir > 60 BPM below baseline
- Variable decels > 60 sec with a nadir < 60 BPM regardless of baseline
- Late decels of any depth
- Any prolonged decel as defined by NICHD

(Clark et al. *Am J Obstet Gynecol.* 2013;209(2):89-97)

****Corrective measures include:**

- Oxygen administration
- Maternal position change
- Fluid bolus
- Reduction or discontinuation of pitocin
- Administration of terbutaline for tetanic contraction or tachysystole
- Administration of pressors, if hypotension present
- Amnioinfusion for deep, repetitive variable decelerations

(Miller LA, Miller DA. *J Perinat Neonatal Nurs.* 2013;27(2):126-133.)

This is an example of one possible algorithm to assist the nurse and provider in the management of intrapartum fetal heart rate patterns. It does not cover all possible clinical situations. The algorithm assumes that the abnormal fetal heart rate pattern has been recently recognized, and that the preceding tracing is not already associated with the potential for significant acidemia. The algorithm also assumes the presence of active labor with normal labor progress. If the preceding tracing is already associated with the potential for significant acidemia, or if vaginal delivery is unlikely before significant acidemia occurs (e.g. as with a protraction disorder of the active phase or if the patient is still in the latent phase of labor), then sound clinical judgment dictates that the algorithm should be abandoned and delivery should be expedited.

NORTHERN INYO HEALTHCARE DISTRICT
CLINICAL POLICY AND PROCEDURE

Title: Induction of Labor Including Cervical Ripening		
Owner: PERINATAL NURSE MANAGER	Department: Perinatal	
Scope: Perinatal Unit		
Date Last Modified: 05/15/2024	Last Review Date: No Review Date	Version: 1
Final Approval by: NIHD Board of Directors	Original Approval Date:	

PURPOSE:
To provide guidelines for the nursing care of a pregnant patient that support vaginal birth and reduce primary cesarean section during the induction of labor including mechanical and pharmacological cervical ripening as well as artificial rupture of membranes and administration of oxytocin (Pitocin) when delivery is indicated and a vaginal delivery is desired.

DEFINITIONS:
Induction of labor (IOL): The use of medications or other methods to start labor.

Favorable cervix: Bishop score of ≥8 for nulliparous patients and ≥6 for multiparous patients.

First stage of labor: This initial stage of labor begins with cervical change and ends with complete cervical dilatation and effacement.

Latent labor: The period of labor when cervical dilatation is measured as 0cm-5cm. Contractions may be irregular and/or shorter in length with more time between each contraction.

Prolonged latent stage: Latent labor lasting >18 hours for nulliparas with cervical dilatation from 3 cm - 6 cm and >11 hours for multiparas with cervical dilatation from 4 cm – 6 cm.

Active labor: Regular contractions that cause cervical change; a patient is typically considered active once cervix has reached 6cm dilation.

Prolonged active stage: When slow progress from 6cm – 10cm is made (≥7 hours in a nullipara, or ≥5 hours in a multipara.

Arrest of active stage: All 3 of the following criteria must be met: 1) Cervix ≥6 cm, 2) rupture of membranes (ROM), 3) no cervical change after at least 4 hours of adequate uterine activity (e.g. strong to palpation or MVUs > 200), or at least 6 hours of oxytocin administration with inadequate uterine activity.

Second stage of labor: Complete cervical dilatation to birth of the neonate. Normal duration for nulliparas is <3 hours without epidural and <4 hours with epidural. Normal duration for multiparas is <2 hours without epidural and <3 hours with epidural.

Prolonged second stage: Presence of fetal descent, but duration outside the normal range.

Arrest of second stage: No or minimal fetal descent noted after good pushing effort for >3 hours without epidural or >4 hours with epidural for nulliparas and good pushing effort >2 hours without epidural and >3 hours with epidural for multiparas.

Failed induction: The point at which a vaginal delivery cannot reasonably and safely be expected following attempts to induce labor.

Category I fetal heart tracing: Normal baseline fetal heart rate (FHR), with moderate variability and a lack of concerning decelerations. Category I tracings are strongly predictive of normal fetal acid-base status at the time of observation.

Category II fetal heart tracing: Category II FHR tracings include all tracings not categorized as Category I or Category III. Tracings in this category are not predictive of abnormal acid-base status. Category II tracings warrant increased frequency of monitoring, assessment, and intervention.

Category III fetal heart tracing: Absent baseline FHR variability with recurrent late and/or variable decelerations and/or bradycardia, or with a sinusoidal pattern. Category III tracings warrant immediate intervention to effect delivery.

POLICY:

A. A physician and or Certified Nurse Midwife (CNM) order is required prior to induction of labor (IOL) including cervical ripening.
B. The patient will be located in the Perinatal Unit.
C. A 30-minute fetal heart rate and uterine activity assessment are required prior to the administration of all pharmacological cervical ripening, augmentation, induction agents.
    a. In the case of fetal demise, uterine activity assessment only is required prior to administration of pharmacological cervical ripening or induction agents.
D. Informed consent by physician and/or CNM for cervical ripening and/or IOL must be documented in the patient's medical record, and the Consent for Induction or Augmentation of Labor must be signed by the patient and either the Perinatal RN or provider as witness.
E. IV access must be established prior to administration of pharmacological agents. If the patient refuses IV access, the provider must be notified prior to administration of IOL agents.
F. A qualified Perinatal RN who is familiar with the effects of pharmacological induction agents and is able to identify both maternal and fetal complications will be responsible for the delivery of care during the cervical ripening and/or IOL.
G. Gestational age for non-medically indicated inductions must be confirmed in the electronic medical record prior to beginning cervical ripening and/or IOL.
H. Elective (non-medically indicated) induction may be performed at or after 39 weeks gestation.
I. Fetal presentation will be confirmed prior to proceeding with cervical ripening/induction/augmentation via ultrasound or cervical exam.
J. Prior to initiation of oxytocin for IOL or Augmentation, the RN must document in the medical record that the patient meets established criteria for IOL/Augmentation. A pre-induction/pre-augmentation

checklist will be utilized for this process. If checklist criteria cannot be met, induction/augmentation will not be initiated. Notify the physician/CNM immediately.

K. Second nurse verification is required prior to initiating oxytocin. Both Perinatal RNs will verify the oxytocin order against the pump settings, and will visually confirm that the line is correctly attached to the patient. Verification will be documented in the medical record.
L. Once an oxytocin infusion is started, the physician must be readily available to manage any complications, including an emergency cesarean delivery.
M. Oxytocin for induction/augmentation may be initiated 4 hours after the last dose of misoprostol (Cytotec) administration.
N. The Induction of Labor Algorithm (Appendix A) will be referenced as a guide when making decisions regarding progression of IOL and/or labor.

NOTE: THE FOLLOWING GUIDELINE WILL BE USED TO TREAT THE PREGNANT PATIENT DURING CERVICAL RIPENING AND/OR INDUCTION OF LABOR. ALL INTERVENTIONS MUST BE SUPPORTED BY PROVIDERS' ORDERS AND WITHIN THE LICENSED PERSONNELS' SCOPE OF PRACTICE.

Fetal Intrauterine Resuscitation will involve:

A. Notify provider or CNM immediately.
B. Assist patient to lateral position or positions identified to be safe for the patient and that result in improved fetal tracing.
C. Give 500mL fluid bolus of LR as ordered by provider.
D. If patient is receiving an oxytocin infusion, the Perinatal RN may reduce the rate by ½ and/or discontinue the infusion.
E. Terbutaline 0.25mg SQ readily available for administration as ordered by provider.
F. For pregnant patients with normal Sp02 readings ≥95%, oxygen supplementation is not recommended. If SpO2 <95%, supplement with 10L SpO2 via non-rebreather mask as ordered by provider. Discontinue oxytocin administration if oxygen supplementation is required.
G. Document all measures implemented and maternal-fetal response.

Indications for Cervical Ripening:

A. Unfavorable cervix at term gestation.
B. Unfavorable cervix in the presence of or with a high probability of severe maternal morbidity requiring delivery.

Indications for IOL:

A. To achieve a vaginal delivery at term gestation before the spontaneous onset of labor.

Indications for Augmentation of Labor:

A. In the presence of inadequate uterine contractions that are not causing cervical change.
B. For a patient in active labor with dystocia, including either prolonged or arrest of labor.

Contraindications for Cervical Ripening with Pharmacologic Agents:

A. Non-vertex presentation or unknown presentation.
B. Known hypersensitivity to prostaglandins or known patient allergy to misoprostol.

C. Placenta Previa, Placental Abruption, or unexplained vaginal bleeding.
D. Patients currently receiving Pitocin:
    a. Wait until Pitocin has been discontinued for a minimum of 30 minutes prior to administering misoprostol.
    b. Pitocin should not be initiated until a minimum of 4 hours has passed since the last dose of misoprostol was administered.
E. **Use with caution** in obstetric conditions that are not contraindications to induction but may require special attention:
    a. Prior uterine tachysystole and/or prolonged contractions
    b. Unstable vertex presentation
    c. Multiple gestation
    d. Maternal cardiac, renal or hepatic disease
    e. Severe hypertension
    f. Polyhydramnios
    g. Fever
    h. Chorioamnionitis
    i. IUGR
    j. The use of pharmacologic cervical ripening agents in patients with previous Cesarean Section or certain uterine surgeries will be evaluated on a case by case basis.

Contraindications for IOL:

A. Placenta Previa
B. Unfavorable fetal positions or presentations which are undeliverable without conversion prior to delivery i.e. transverse lie, breech presentation.
C. Umbilical cord prolapse.
D. Previous uterine surgery (per provider order).

Equipment for Cervical Ripening:

A. Electronic Fetal Monitor.
B. Primary IV solution per provider order.
C. Automatic infusion pump(s).
D. Pharmacologic or mechanical ripening agent as ordered by provider in the electronic medical record for cervical ripening.
E. IV insertion supplies
F. Sterile exam gloves
G. Sterile saline

Equipment for IOL:

A. Electronic Fetal Monitor.
B. Primary IV solution per provider order.
C. IV solution with Pitocin (oxytocin) induction/augmentation.
D. Automatic infusion pump(s).
E. IV insertion supplies
F. Sterile exam gloves

Procedure for Cervical Ripening, IOL or Augmentation:

A. The Perinatal RN will confirm the following before initiation of cervical ripening, IOL, or augmentation:
    a. The provider discussed the plan of care regarding the cervical ripening/induction/augmentation process and provided and documented informed consent in the electronic medical record.
    b. The order set "OB Induction/Augmentation Subphase" is activated.
    c. Gestational age of ≥39 weeks if non-medically indicated/elective.
    d. Vertex presentation.
B. Complete assessment to obtain baseline values of pregnant patient and fetus as follows:
    a. Determine baseline blood pressure, pulse, respirations and temperature for pregnant patient.
    b. Determine baseline fetal heart rate via electronic fetal monitoring; documenting baseline FHR, variability, the presence or absence of accelerations and decelerations, and uterine contraction pattern.
    c. Monitor for a minimum of 30 minutes to assess fetal well-being prior to administration of pharmacologic or mechanical agents. RN must document in the medical record that the fetal status and contraction pattern is appropriate for IOL/augmentation. RN will notify provider if IOL/augmentation cannot be initiated due to fetal status or contraction pattern.
C. Insert 18g or 20g intravenous catheter and begin infusion of mainline IV solution as ordered by physician/CNM.
D. A sterile vaginal exam may be performed with patient's consent prior to administration or titration of induction agents per provider order.

Procedure for Pharmacologic Cervical Ripening:

A. Review administration with the patient, including intended effects of medication and possible adverse effects. Advise the patient to inform the RN of any of the following:
    a. Patient reports more than 3 UCs strong to palpation in a 10-minute period
    b. Prolonged UC (1 UC greater than 120 seconds)
    c. SROM
    d. Change in color of vaginal fluid (presence of meconium or signs of bleeding)

B. Continuous EFM is required for at least 2 hours after administration. Following the initial 2 hours, frequency of fetal monitoring surveillance and uterine activity monitoring are as follows, unless otherwise specified by the provider:
    a. **If Category I interpretation**: Resume EFM every 4 hours for 30 minutes to assess FHR and uterine activity patterns. A 30-minute fetal heart rate tracing must be obtained prior to administering any additional doses of cervical ripening agents. If after 30-60 minutes of monitoring, tracing is not Category I, notify provider prior to administration of additional doses.
    b. **If Category II interpretation:** Begin continuous EFM and notify managing provider to obtain additional orders for fetal surveillance. Begin intrauterine resuscitation if indicated.
    c. **If Category III interpretation**: Continuous EFM, notify managing provider and begin intrauterine resuscitation.

Continuous fetal monitoring is required for the presence of any of the following:

A. More than 2 contractions greater than 120 seconds in a 30-minute period
B. Presence of uterine tachysystole
C. Any FHR tracing that evolves into Category II
D. SROM:
    - Continuous EFM x 2 hours from identification of SROM

- Do not administer subsequent doses of pharmacologic ripening agents for up to 2 hours after SROM as patient may enter active labor. Consider SVE prior to additional doses after ROM.
- Notify provider

E. Vital signs (BP, HR, RR, Temp, Pain Score) frequency:
- Prior to placement
- Every 4 hours in early labor. If membranes are ruptured, obtain and document temperature every hour.
- Vital Signs hourly in active labor and or if febrile (>100.4 F/38 C), regardless of labor stage.

Routes of Administration for Pharmacologic Cervical Ripening:

Vaginal:

A. Position patient for vaginal exam. Assist patient into the lithotomy position.
B. Do not remove tablet from capsule. Do not use lubricant jelly.
C. The provider or Perinatal RN will insert misoprostol into the posterior vaginal fornix with sterile glove and sterile saline.
D. Maintain patient in bed for 30 minutes after administration in low semi-fowlers or lateral position. Patient may ambulate after 30 minutes.
E. Continuous EFM for 2 hours after initial administration.
F. Diet per provider order.

Sublingual:

A. RN can offer fluid prior to administration.
B. Instruct patient not to swallow tablet.
C. Remove tablet from capsule and place under the patient's tongue. Administer misoprostol sublingually.
D. Keep under tongue for 15 minutes or until fully dissolves.
E. NPO x1 hour after first dose administration. Subsequent doses, patient to remain NPO x15minutes following administration. Diet per provider order.
F. Continuous EFM for 2 hours after initial administration.

Withhold subsequent doses following and notify provider in the presence of any of the following:
- 3 or more painful uterine contractions (UCs) in 10 minutes, averaged over 30-minute window.
- 2 or more contractions greater than 120 seconds within 30 minutes prior to administration of dose.
- Uterine tachysystole.
- Category II or III fetal heart tracing.
- Favorable cervix by vaginal exam.
- Active labor.

Procedure for Mechanical Cervical Ripening:

A. Provide pre-procedure patient education.
B. Assemble all equipment and supplies for placement. A sterile speculum may be used if provider cannot digitally insert the balloon.
C. Assist provider with placement. Once balloon is in place, inflate according to manufacturer's recommendations.

D. Observe patient and FHR for 20 minutes post procedure. A reactive NST must be obtained prior to intermittent monitoring. Intermittent monitoring may be utilized per provider order.
E. If mechanical ripening is used in conjunction with pharmacologic agents, refer to the monitoring and assessment of those agents.
F. If the catheter has not fallen out by 12 hours, the balloon(s) will be deflated and removed by the RN or provider.
G. Document procedure in the EMR under "Mechanical Cervical Ripening".
H. Notify provider and consider orders to discontinue use of mechanical cervical ripening balloon in the presence of rapid onset of severe abdominal pain, sudden increase or new onset of heavy bleeding, or rupture of membranes

---

Oxytocin infusion for induction or augmentation:

A. Verify informed consent for induction or augmentation of labor.
B. Review the patient's chart for induction indications, medical and nursing assessment of fetal/maternal status and clarity of physician/CNM orders.
C. Confirm gestational age.
D. Confirm vertex presentation prior to initiating oxytocin infusion.
E. Obtain a 30-minute fetal heart rate tracing and assess uterine activity prior to oxytocin administration.
F. Complete the "Pre-Induction Checklist" and the "Oxytocin in Use Checklist" in the EMR with initiation of oxytocin infusion. Complete the "Oxytocin in Use Checklist" prior to every subsequent increase in dose. Notify provider if criteria for oxytocin initiation or titration are not met.
G. Obtain premixed infusion of 30 units Oxytocin in 500 mL 0.9% Normal Saline Solution.
H. Load the IV tubing into the automatic infusion pump.
I. Label tubing with Oxytocin label at point of insertion site and at pump. Connect Oxytocin infusion at port closest to patient.
    a. Oxytocin is a high risk medication and requires a double check prior to administration. Before administering the oxytocin infusion, a 2nd Qualified Perinatal RN is required to perform independent double-check to verify administration is safe for the patient, the pump settings are correct, and the infusion line is attached to the correct port.
    b. If no discrepancies exist from the 2nd RN medication validation, begin oxytocin at 2 milliunits/minute (mU/min) via infusion pump per OB Induction/Augmentation Subphase Order Set.
J. Vital Sign assessment and documentation every hour while oxytocin is infusing.
K. Titrate per OB Induction/Augmentation Subphase Order Set: Titration increases may occur every 30 minutes by 2 mU/min based on provider order, not to exceed maximum dose of 20 mU/min; until adequate contraction pattern is achieved.
    a. An adequate contraction pattern may be evidenced by:
        i. Contractions every 2-3 minutes and no more than 5 contractions in 10 minutes, with;
        ii. Duration of contractions of 40-90 seconds; and
        iii. Contraction strength of moderate to strong by palpation, or Montevideo Units as measured by Intrauterine Pressure Catheter (IUPC) are greater than or equal to 200 in a 10 minute window.
        iv. Adequate resting tone by palpation that is soft and non-tender, or IUPC reading of less than or equal to 25mmHg.

L. Once an effective contraction pattern is established and maintained as defined above, do not increase oxytocin until progression of cervical change can be determined.
M. Oxytocin infusion may be turned off if patient demonstrates that they are in active labor (at least 5-6 cm dilated and/or regular contractions that cause cervical change). If adequate cervical change is not made after 2 hours after oxytocin has been turned off, notify managing provider to determine plan of care
N. When 20 mU/min has been reached, and the patient is not making cervical change, notify provider. Oxytocin infusion may be increased beyond 20 mU/ min, to a maximum dose of 32 mU/min, with a provider order. A bedside provider assessment is recommended for infusions greater than 20 mU/min. A provider with cesarean privileges must be readily available for Oxytocin infusions >20mU/min.
O. The fetal heart rate and contraction pattern will be assessed and documented as follows:
    a. When starting Oxytocin infusion
    b. First Stage: Assessed every 15 minutes and documented every 30 minutes for the duration of the infusion.
    c. Second Stage (Active pushing): Assessed every 5 minutes and documented every 15 minutes with continuous bedside presence by Perinatal RN.
P. Diet order will be determined by the provider and order will be placed on in the EMR.

<u>Oxytocin will be managed as follows:</u>

a) <u>Category II tracing</u> with recurrent variable or late decelerations with **moderate variability**:
    a. Begin intrauterine resuscitation and notify provider. Intrauterine resuscitation may include:
        i. Reduce oxytocin infusion rate by ½.
        ii. Reposition patient to lateral recumbent or positions identified to be safe for the patient and that result in improved fetal tracing.
        iii. Administer IV bolus of primary infusion, per provider order.
        iv. Observe for 15 minutes. If no improvement, discontinue oxytocin infusion and notify provider.

b) <u>Category II tracing</u> with recurrent variable or late decelerations with **minimal variability**:
    a. Begin intrauterine resuscitation and notify provider. Intrauterine resuscitation may include:
        i. Discontinue oxytocin infusion.
        ii. Reposition to lateral recumbent or positions identified to be safe for the patient and that result in improved fetal tracing.
        iii. Administer IV bolus of primary infusion, per provider order.
        iv. Observe for 15 minutes. If no improvement, consider administration of a tocolytic medication (Terbutaline 0.25 mg SQ X 1) with provider order.

c) <u>Category III tracing:</u>
    a. Begin intrauterine resuscitation and notify provider immediately to evaluate the patient. Intrauterine resuscitation may include:
        i. Discontinue oxytocin, if infusing.
        ii. Anticipate rapid delivery.

d) <u>Uterine Tachysystole</u>:
    In the presence of a Category I Tracing:
        1. Reposition to lateral recumbent or positions identified to be safe for the patient and that result in improved fetal tracing.
        2. Administer 500 mL IV bolus of primary infusion, with provider order.
        3. Observe for 15 minutes.

4. If Uterine Tachysystole remains unresolved 15 minutes after above interventions, decrease oxytocin rate by ½ and observe for additional 15 minutes.
5. If tachysystole remains unresolved after a total of 30 minutes, discontinue oxytocin and notify provider.

After stopping oxytocin for intrauterine resuscitation and/or uterine tachysystole, the oxytocin infusion may be resumed when the criteria for oxytocin initiation have been met. The Perinatal RN will review the fetal monitor tracing and complete the "Oxytocin in Use Checklist" in the EMR. The provider will be informed if the tracing does not meet the criteria to restart oxytocin.

1. If oxytocin has been off less than 30 minutes, restart at ½ the rate of administration when discontinued.
2. If oxytocin has been off longer than 30 minutes, restart at 2 milliunits/minute and increase per induction/augmentation orders.

The Perinatal RN will document any communication with the provider in the medical record as well as any interventions taken. Any deviation from this procedure will be documented by the provider in the MAR, including rationale and patient's informed consent.

Documentation:

During augmentation or induction of labor with oxytocin, the FHR should be evaluated and documented before dosing changes. Assessment of FHR will occur every 15 minutes, and documentation will occur every 30 minutes, for the duration of the oxytocin infusion. Assessment of FHR includes documentation that a qualified Perinatal RN has reviewed the FHR and can be annotated directly on the fetal strip. Documentation of FHR requires a comprehensive assessment in the EMR. In addition, document the following in the electronic medical record:

- Dosage of oxytocin in mU/min in the MAR, including rate changes.
- A systematic admission assessment as well as ongoing assessments of the pregnant patient and fetus. Refer to policy on Standards of Care in the Obstetrical Unit for care guidelines.
- Interventions provided and evaluation to responses;
- Communication with the pregnant patient and their support person(s);
- Communication with providers; and
- Communication related to escalation of concerns.
- Prior to administration and with every increase in Oxytocin rate, complete the "Oxytocin in Use Checklist" in the EMR.

Failed Induction of Labor and/or Labor Dystocia:

A. If primary cesarean section is considered, the definitions in this document and the Labor Duration Guidelines in Appendix C, as well as the Pre-Cesarean Checklist in Appendix B will be used to determine if criteria has been met.
B. Primary cesarean may be considered
    a. If criteria for primary cesarean section has been met.
    b. If criteria has not been met according to the checklist, refer back to the Induction of Labor Algorithm in Appendix A.

i. If primary cesarean delivery proceeds, documentation of indication, circumstances and informed consent will be provided in the patients' medical record by the provider.

REFERENCES:

Agency for Healthcare Research and Quality. (n.d.). *AHRQ Safety Program for Perinatal Care: Safe Medication Administration*. https://www.ahrq.gov/sites/default/files/wysiwyg/professionals/quality-patient-safety/hais/tools/perinatal-care/modules/strategies/medication/tool_safe-oxytocin.docx

American College of Obstetrics and Gynecologists. Practice Bulletin: Clinical Management Guidelines for Obstetrician-Gynecologists. Number 107. (2009, reaffirmed 2019). *Induction of Labor.*

ACOG (2019) *Practice Bulletin Number 205. Vaginal birth after cesarean delivery. The American College of Obstetricians and Gynecologists. Washington DC.*

ACOG/SMFM. (2014, reaffirmed 2019). Safe prevention of the primary cesarean section delivery. American Journal of Obstetrics and Gynecology. (123) 693-711.

Clark, S., Belfort, M., Saade, G., Hankins, G., Miller, D & Frye, D. (2007) *Implementation of a conservative checklist-based protocol for oxytocin administration: maternal and newborn outcomes.* AM J Obstet Gynecol 2007; 197:480.e1-480.e5.

Grobman, W. (2022). Induction of labor with oxytocin. In: *UpToDate*, Lockwood, C. J. (Ed.). UpToDate Full text.

Macones A, Hankins G, Spong C, Hauth J, Moore T. *The 2008 National Institute of Child Health and Human Development Workshop Report on Electronic Fetal Monitoring. Update on Definitions, Interpretation, and Research Guidelines*. American College of Obstetricians and Gynecologists September 2008, Vol. 112, No.3.

Simpson, K. and Creehan, P. (2021). *Perinatal Nursing. AWHONN.* (5th Edition). Lippincott: Philadelphia.

Simpson, K. R. *(2020). Cervical ripening and induction and augmentation of labor.* (5th edition). Association of Women's Health and Neonatal Nurses: Washington DC.

Smith H, Peterson N, Lagrew D, Main E. (2016). *Toolkit to Support Vaginal Birth and Reduce Primary Cesareans: A Quality Improvement Toolkit*. California Maternal Quality Care Collaborative.

Toolkit to Support Vaginal Birth and Reduce Primary Cesareans. California Maternal Quality Care Coalition. (2022). https://www.cmqcc.org/sites/default/files/Vbirth-Toolkit-with-Supplement_Final_11.30.22_2.pdf

RECORD RETENTION AND DESTRUCTION:

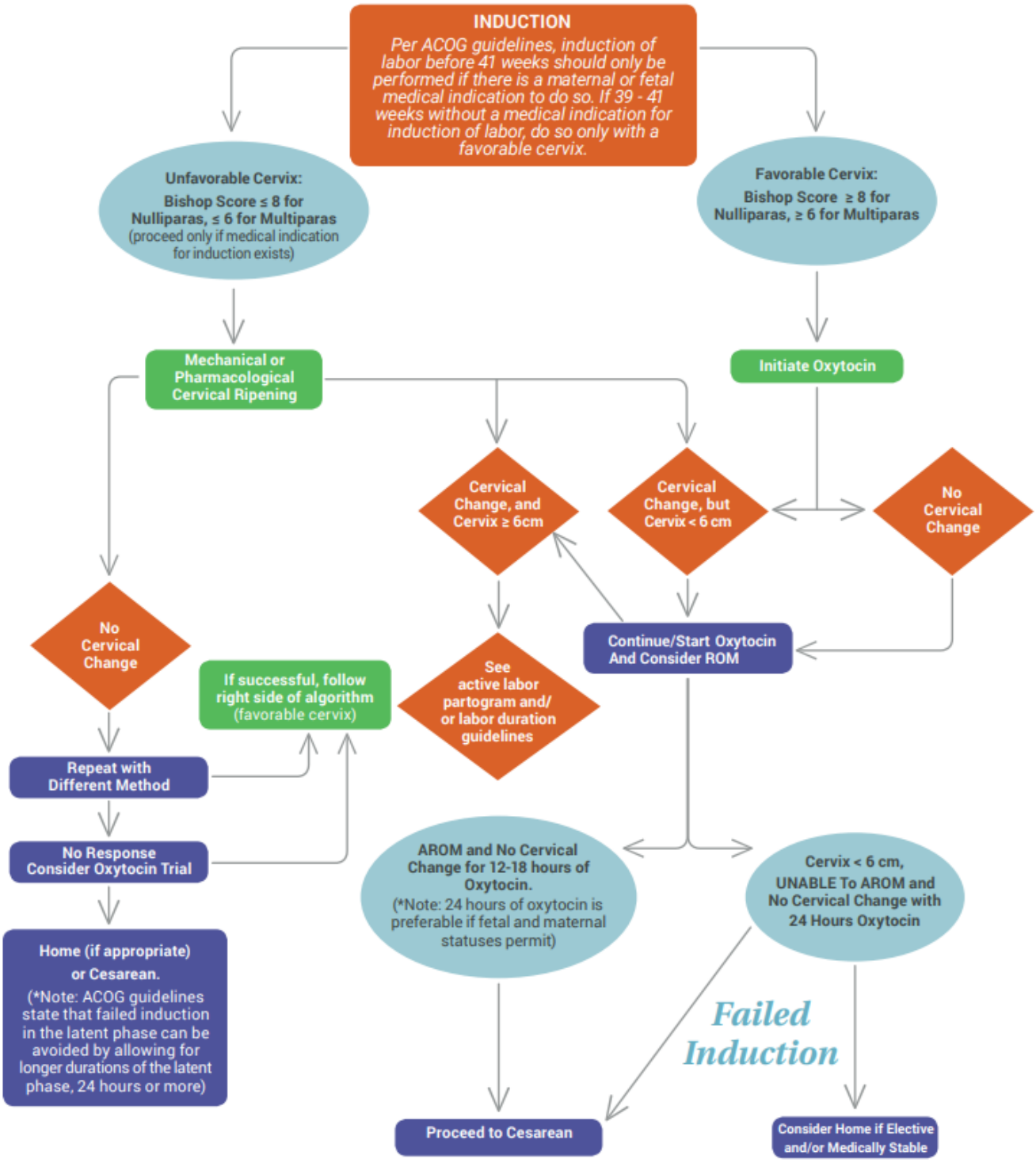
Documentation is maintained within the patient and medical record, which is managed by the NIHD Medical Records Department.

CROSS REFERENCED POLICIES AND PROCEDURES:

1. Standards of Care in the Obstetrical Unit

Supersedes: Not Set; v.6 Misoprostol for Cervical Ripening

Appendix A: CMQCC Induction of Labor Algorithm



Adapted with permission from Washington State Hospital Association

CMQCC Toolkit to Support Vaginal Birth and Reduce Primary Cesareans

Appendix B: CMQCC Pre-Cesarean Checklist for Labor Dystocia or Failed Induction

Pre-cesarean Checklist for Labor Dystocia or Failed Induction

Patient Name:_____ MR#: _____

Gestational Age: _____ Date of C-section: _____;

Time: _____

Obstetrician: _____ ; Initial:_____

Bedside Nurse: _____ ; Initial:_____

Indication for Primary Cesarean Delivery:

____ Failed Induction (must have both criteria if cervix unfavorable, Bishop Score < 8 for nullips and <6 for multips)

___ Cervical Ripening used (when starting with unfavorable Bishop scores as noted above). Ripening agent used: _____Reason ripening not used if cervix unfavorable: _____

AND

___ Unable to generate regular contractions (every 3 minutes) and cervical change after oxytocin administered for at least 12-18 hours after membrane rupture." *Note: at least 24 hours of oxytocin administration after membrane rupture is preferable if maternal and fetal statuses permit

____ Latent Phase Arrest <6 cm dilation (must fulfill one of the two criteria)

___ Moderate or strong contractions palpated for > 12 hours without cervical change

OR

___ IUPC > 200 MVU for > 12 hours without cervical change

*As long as cervical progress is being made, a slow but progressive latent phase e.g. greater than 20 hours in nulliparous women and greater than 14 hours in multiparous women is not an indication for cesarean delivery as long as fetal and maternal statuses remain reassuring. Please exercise caution when diagnosing latent phase arrest and allow for sufficient time to enter the active phase.

____ Active Phase Arrest ≥ 6 cm Dilation (must fulfill one of the two criteria)

Membranes ruptured (if possible), then:

___ Adequate uterine contractions (e.g. moderate or strong to palpation, or ≥ 200 MVU, for ≥ 4 hours) without improvement in dilation, effacement, station or position

OR

___ Inadequate uterine contractions (e.g. < 200 MVU) for ≥ 6 hours of oxytocin administration without improvement in dilation, effacement, station or position

____ Second Stage Arrest (must fulfill any one of four criteria)

___ Nullipara with epidural pushing for at least 4 hours

OR

___ Nullipara without epidural pushing for at least 3 hours

OR

___ Multipara with epidural pushing for at least 3 hours

OR

___ Multipara without epidural pushing for at least 2 hours

____ Although not fulfilling contemporary criteria for labor dystocia as described above, my clinical judgment deems this cesarean delivery indicated

___ Failed Induction: Duration in hours: _____
Latent-Phase Arrest: Duration in hours: _____
Active-Phase Arrest: Duration in hours:_____
Second-Stage Arrest: Duration in hours: _____

Comments:

Adapted with permission from Miller Children's and Women's Hospital.

Appendix C: CMQCC Labor Duration Guidelines

FIRST STAGE LATENT LABOR: Cervical dilation of 0-6 cm

NORMAL	Difficult to define due to challenge of determining the onset of labor • No range exists for the new latent labor definition of 0-6 cm per Zhang o Nulliparas (data exists only for 3-6cm): Median duration of 3.9 hours; 95th percentile 17.7 hours o Multiparas (data exists only for 4-6cm): Median duration of 2.2 hours; 95th percentile 10.7 hours • Per Friedman: <20 hours in the nullipara, and <14 hours in the multipara from 0-3cm
PROLONGED	• No range exists for the new latent labor definition of 0-6 cm o Nulliparas: >18 hours from 3-6cm o Multiparas: >10.7 hours from 4-6cm • Per Friedman: >20 hours in the nullipara, >14 hours in the multipara from 0-3 cm

FIRST STAGE ACTIVE LABOR: Cervical dilation of 6-10 cm

NORMAL	• Nulliparas: Median duration of 2.1 hours; 95th percentile 7 hours • Multiparas: Median duration of 1.5 hours; 95th percentile 5.1 hours
PROLONGED/ SLOW SLOPE	• Slow progress from 6-10cm: Presence of labor progress, but duration outside the 95th percentile range of normal (> 7 hours in a nullipara, or > 5 hours in a multipara)
ARREST	Dilation of 6 cm or more, with membrane rupture and absence of cervical change for: • 4 hours OR MORE of adequate UCs (MVUs >200) OR • 6 hours OR MORE with Pitocin if UCs inadequate

SECOND STAGE LABOR: Complete dilation to birth of the neonate

NORMAL	• Nulliparas: <3 hours WITHOUT epidural, <4 hours WITH epidural • Multiparas: <2 hours WITHOUT epidural, <3 hours WITH epidural
PROLONGED	Presence of descent, but duration outside normal range. • Nulliparas: >3 hours without epidural, >4 hours with epidural • Multiparas: >2 hours without epidural, >3 hours with epidural
ARREST	No (or minimal) descent after good pushing efforts for: • Nulliparas: >3 hours without epidural, >4 hours with epidural •Multiparas: >2 hours without epidural, >3 hours with epidural *NOTE: According to a 2014 retrospective cohort study by Cheng and colleagues, of 42,268 women who delivered vaginally and had normal neonatal outcomes, the 95th percentile duration of second stage labor with epidural anesthesia is more than two hours greater for both nullips and multips (as opposed to one hour) when compared to women in second stage labor without epidural use. Additionally, according to the ACOG/SMFM guidelines, a specific absolute maximum amount of time for the second stage of labor has not been identified.

American College of Obstetrics and Gynecology, Society for Maternal-Fetal Medicine.Obstetric care consensus no. 1: safe prevention of the primary cesarean delivery. Obstet Gynecol. 2014;123(3):693-711.

Cheng YW, Shaffer BL, Nicholson JM, Caughey AB. Second stage of labor and epidural use: a larger effect than previously suggested. Obstet Gynecol. 2014;123(3):527-535.

Friedman EA. Pr imigravid labor; a graphicostatistical analysis. Obstet Gynecol. 1955;6(6):567-589.

Spong CY, Berghella V, Wenstrom KD, Mercer BM, Saade GR. Preventing the first cesarean delivery: summary of a joint Eunice Kennedy Shriver National Institute of Child Health and Human Development,Society for Maternal-Fetal Medicine, and American College of Obstetricians and Gynecologists Workshop.Obstet Gynecol. 2012;120(5):1181-1193

Zhang J, Landy HJ, Branch DW, et al. Contemporary patterns of spontaneous labor with normal neonatal outcomes. Obstet Gynecol. 2010;116(6):1281-1287.

Adapted with permission from the authors Ana Delgado CNM, Jyesha Wren Serbin, CNM, and Anna Yen Tran, CNM, Zuckerberg San Francisco General Hospital

CMQCC Toolkit to Support Vaginal Birth and Reduce Primary Cesareans

NORTHERN INYO HEALTHCARE DISTRICT

CLINICAL POLICY AND PROCEDURE

Title: Newborn & Pediatric Security and Abduction Policy		
Owner: PERINATAL NURSE MANAGER	Department: Perinatal	
Scope: Acute-Subacute unit, Perinatal Unit		
Date Last Modified: 04/23/2024	Last Review Date: 4/17/19	Version: 4
Final Approval by: NIHD Board of Directors	Original Approval Date: 10/2016	

PURPOSE: To provide for the security and safety of all newborns in the Perinatal Department and pediatric patients in the Acute Sub Acute Department. Additionally, to provide a guideline in the event of an infant or pediatric abduction.

DEFINITIONS:

Neonate: An infant from birth through the 28th day of life.

Pediatrics: Any patient between the ages of 29 days of life through the 12th year of life.

POLICY:

1. All newborns in the Perinatal Department will be under the direct observation of a member of the nursing staff and/or direct care giver at all times. Under no circumstances will a newborn be left unattended.
2. All newborns and pediatric patients in the Acute Sub Acute Department will be under the supervision of a member of the nursing staff and/or direct care giver at all times.
3. All newborn/pediatric patients will be banded with a security tag on admission or at birth. This tag will be activated in the infant security system.
4. The primary care giver of the patient will be informed of security precautions at the time of admission or as soon as they are available.
5. Nursing staff will document patient and family education of newborn/pediatric security on the nursing admission assessment form.
6. In the Perinatal Department, all newborns will be identified in the following manner:
    a. All mother-baby couplets will have matching ID bands placed on them either in the birthing room or O.R., prior to separating mother and infant. However, if an emergency exists, the infant will be properly banded as soon after admission to the nursery as possible.
7. All pediatric patients will be identified in the following manner:
    a. All newborn and pediatric patients and their designated legal guardian will have matching ID bands placed on them at the time of admission.
8. Hospital staff will notify and work closely with law enforcement agencies, if an abduction occurs.

PROCEDURE:

1. **Security Measures:**

a. Northern Inyo Hospital (NIH) will utilize an infant/pediatric security system for all infant and pediatric patients. Refer to Nursing Management of the Infant and Pediatric Security System policy.
b. Infant-Mother ID bands will be placed on each mother-baby as soon after delivery as possible. Indicate to the parents verbally and visually that the name bands are matching. Document the band number and time bands were applied on the Labor and Delivery Record. The mother will have one wristband, and the baby will have two bands – one applied to a wrist, and the other to an ankle. These bands must be verified as matching and include the following information:

    (i) Mom's First Name, BABY (Sex of infant), Mom's Last Name, Mom's First Name, BABY (Sex of the Infant) Example: "Smith, Jane BABY GIRL".
    (ii) Date and Time of infant's birth

c. Infant bar code scanning tag will be added once the infant has been registered and infant labels are available. Apply an infant label to the designated tag and attach it directly to the Mother-Baby band that is on the infant's ankle. Verify that all patient identification indicators are identical. This tag will be used for scanning purposes.
d. All Perinatal Department nurses wear pink accented photo ID badges.
e. Pediatric patients will utilize an activated security tag in addition to the regular hospital wristband.
f. Inform mothers in the Perinatal department of security procedures which include but are not limited to:

    i. Check for proper identification before giving the baby to anyone
    ii. Never leave the baby alone or unsupervised in the room
    iii. Place the baby's bassinet on the side of the bed that is away from the door.
    iv. All infants should remain in their cribs during transport i.e. from nursery to mother's room, thus family members and staff should not be carrying infant in hallways or outside the Perinatal Department. Each crib will have a crib card with infant's name, birth date and physician.

g. Instruct patients and family members to observe the visiting hours and rules and **NOT** to open the main security door to permit access to other visitors.
h. Only staff members should allow access to visitors according to patient privacy laws.

2. **In the event of an abduction:**
    a. Follow the CODE AMBER abduction procedure outlined in the Emergency Preparedness Procedure chart. AKA "Rainbow chart".
    b. In the event of an abduction, the downtime Code Amber form will be completed and a copy provided to law enforcement.
    c. House Supervisors, Directors of Nursing, Nurse Managers, or Administration:
        i. Consider moving the primary care giver of the abducted child to a private room off the Department and assign a staff member (preferably the nurse assigned to the mother, House Supervisor or nurse manager) to accompany them at all times protecting them from stressful contact with the media and other interference.
        ii. If the incident occurred at shift change, hold the shift scheduled to leave until excused by law enforcement.

iii. The House Supervisor or nurse manager should brief all involved staff. In turn, nurses should then explain the situation to other patients in the unit (preferably while the mother and her infant are together).
iv. Nursing Administration should be sensitive to the fact that the staff may suffer post trauma stress as a result of the abduction.
v. Protect the crime scene (area where the abduction occurred) in order to preserve the subsequent collection of any forensic evidence by law enforcement.
vi. Coordinate with the police department by involving the media search for the infant if indicated.
vii. Coordinate with the police department in notifying the Center for Missing and Exploited Children (NCMEC) at 1-800-843-5678 for technical assistance in handling on-going crisis management indicated.
viii. Any facility providing care to infants and pediatric patients in the surrounding area such as but not limited to hospitals, physician offices, clinics, should be notified about the incident and provided with a full description of the patient and the abductor.

REFERENCES:

1. National Center for Missing and Exploited Children; January, 2016, "For Healthcare Professionals: Guidelines on Prevention of and Response to Infant Abductions"

RECORD RETENTION AND DESTRUCTION:

Documentation is maintained within the patient medical record, which is managed by the NIHD Medical Records Department.

CROSS REFERENCED POLICIES AND PROCEDURES:

Supersedes: Newborn and Pediatric Security and Abduction Policy v.3

NORTHERN INYO HEALTHCARE DISTRICT
CLINICAL POLICY AND PROCEDURE

Title: Standards of Care for the Neonate in the Perinatal Department		
Owner: PERINATAL NURSE MANAGER	Department: Perinatal	
Scope:		
Date Last Modified: 04/26/2024	Last Review Date: No Review Date	Version: 1
Final Approval by: NIHD Board of Directors	Original Approval Date:	

PURPOSE:
To provide safe and thorough assessment and documentation guidelines for neonatal patients in the obstetric unit, in accordance with established evidence-based guidelines. To standardize care from admission through discharge, and to provide guidance regarding safe and timely transfer to higher level of care when required.

DEFINITIONS:

Newborn: Infant from birth though the 28th day of life.
Qualified Perinatal Unit RN: A Registered Nurse (RN) who holds current Neonatal Resuscitation Program (NRP) certification in addition to focused Perinatal Specialty training and experience with documented competency in caring for and stabilizing neonatal patients of all gestational ages in the Perinatal department.
Qualified RN or LVN: A licensed Registered Nurse (RN) or Licensed Vocational Nurse (LVN) who has been trained and competency validated to provide care to well neonatal patients in the Perinatal department, including current Neonatal Resuscitation Program (NRP) certification. All LVNs will have a Qualified Perinatal Unit RN supervising care.

POLICY:
- A qualified Perinatal Unit Registered Nurse shall be responsible for the initial assessment and ongoing stabilization of the newborn.
- Within 2 hours of life, a full head to toe physical assessment will be performed and documented and routine medications will be administered and documented.
- A functional security tag will be placed on every neonatal patient and their information will be added to the electronic system.
- A qualified Perinatal LVN, or cross trained/float trained RN or LVN may take a stable neonatal patient assignment.
- Vital signs including pain will be obtained and documented according to physician orders or hospital protocol throughout the patient stay.
- Routine neonatal screening including will be performed as ordered by physician or documented as refused.
- A qualified Perinatal RN will care for any neonate needing transfer to a higher level of care.
- Exclusive breastfeeding will be supported unless alternate feeding methods are requested by the parents or due to medical necessity.

ADMISSION POLICY & PROCEDURE:
At the time of birth, all neonates will be assessed and cared for by a qualified RN with documented competencies in the Neonatal Resuscitation Program (NRP). A designated NRP certified RN will attend every

delivery and be solely responsible for infant stabilization and transition. All resuscitation efforts will follow current Neonatal Resuscitation guidelines.

Physical Assessment: An Admission Assessment will be performed and documented within two (2) hours of birth. The admission assessment includes birth weight, length, and head and chest circumferences. Measurements are to be taken in centimeters and documented in the medical record. Ongoing assessments will be performed each shift, with change of caregiver, and with any change in clinical condition.

Obtain a 1-minute and 5-minute Apgar score (1-10). If 5-minute Apgar score is <7, obtain a 10-minute Apgar score. Scoring is as follows:

- Respiratory Effort (0-2)
- Heart Rate (0-2)
- Color (0-2)
- Reflex Irritability (0-2)
- Muscle Tone (0-2)

Vital Signs: Immediately following delivery, obtain vital signs on stable newborns every 30 minutes x4 times. The following guidelines will direct frequency of obtaining vital signs, or per provider order.

- For stable newborns born via vaginal delivery, after initial stabilization, obtain vital signs every 8 hours until discharge.
- For stable newborns born via cesarean delivery, after initial stabilization, obtain vital signs every 4 hours x 24 hours, then every 8 hours until discharge.

Pain Assessment: Pain will be assessed on admission, with change of caregiver, and when clinical condition changes using the NPASS scale. Pain will be reassessed after pain medication administration and after any non-pharmacological intervention to treat pain.

Safety: Safety measures begin on admission and are addressed each shift and as appropriate. These include, but are not limited to:

- Identification bands and infant security transponder.
- Resuscitation device and bulb syringe at the bedside.
- Safe sleep guidelines will be initiated and education will be provided to families/caregivers.
- Medication administration will follow an independent double check procedure with 2 licensed health care providers.
- Neonate will be transported in a bassinette or infant warmer when outside of patient room, with the exception of transport from OR/PACU to the Perinatal Unit, when the neonate may remain skin to skin with their birth parent, if both neonate and parent are stable.

Specimen Collection:

Cord blood will be collected for every neonate born in the hospital. For neonates born to parents with Rh negative and/or all O blood types, an order will be placed to obtain the blood type and DAT of the neonate. Cord blood samples from neonates born to parents with non O Rh positive blood types will be stored for seven (7) days, and then discarded.

Umbilical cord specimens will be obtained on all newborns at the time of delivery and will either be stored or sent for drug screening according to provider order. Prepare the specimen as follows:

1. A six-inch segment of umbilical cord will be collected from every neonate.

2. Drain and discard excess blood from cord.
3. Rinse exterior or cord with normal saline solution.
4. Package and store cord according to chain of custody protocol.

Neonates born to a birth parent with a positive urine drug screen will undergo drug testing per provider order and following state legal requirements. Testing may occur via a urine, stool, and/or umbilical cord sample.

Refer to the Newborn Blood Glucose Monitoring Policy for direction on hypoglycemia risk factors and management.

Medication Administration:
Routine Newborn Medications include:

- Erythromycin Eye Ointment
- Phytonadione (Vitamin K) Intramuscular Injection
- Hepatitis B vaccine

Newborn medications are to be administered within two (2) hour of birth, unless parent/caregiver refuses. Pediatrician should be notified of refusal. Refusal should be documented in the patient's chart and a signed refusal form placed in the patient's chart. Standard dose, newborn medications (ie. erythromycin, Vitamin K, and Hepatitis B vaccine) a second RN co-sign.

Attendance of Pediatrician at Delivery:
A pediatrician should be present at these high risk deliveries:

- Preterm delivery (<37 weeks gestation)
- Vacuum or Forceps delivery
- Worsening Category II strip (at the discretion of the RN and/or OB) and all Category III fetal strips
- Twins/multiple gestation
- Unplanned/emergency cesarean delivery (with the exception of repeat cesarean section presenting early with no other complications)

ROUTINE SCREENINGS & TESTS POLICY & PROCEDURE:

All newborns will undergo certain screenings, procedures, and tests at approximately 24 hours of life, unless contraindicated or in the case of patient transfer or parental refusal. Thorough education will be provided to parents/caregivers prior to performing the tests, and procedures will follow evidence-based guidelines. Documentation of procedures, patient/family education, and/or refusal will occur in the electronic medical record.

1. **Screening for Hyperbilirubinemia**: All neonates will be visually assessed for jaundice every shift, and transcutaneous bilirubin screening may be performed at any point if clinically indicated. Transcutaneous bilirubin (TCB) screening will be performed on all infants at 24 hours of age, and once a day at approximately the same time each day until discharge. Documentation will occur in the electronic medical record.
    a. Certain conditions may increase the risk of developing hyperbilirubinemia. These include, but are not limited to:
        i. Infants with documented ABO and/or Rh incompatibility. This includes infants with a positive Coombs' test.

ii. Gestational age of less than 38 weeks
iii. Infants with significant birth trauma, including scalp hematoma or significant bruising

b. Notify physician if TCB result is elevated, based on clinical risk factors and hours of life. Initiate serum bilirubin testing and anticipate phototherapy for infants with an elevated transcutaneous bilirubin level, following provider's orders.
c. Follow manufacturer's instructions for use when performing TCB screening.

2. **Critical Congenital Heart Defects (CCHD) Screening**: All neonates will undergo CCHD screening via pulse oximetry at approximately 24 hours of age. Qualified staff in the Perinatal Unit may perform this screening test. Refer to Appendix A: CCHD Screening Algorithm. Documentation will occur in the electronic medical record.
    a. Ensure that probe is clean, dry, and properly connected. Obtain a steady, clear signal. Pre-ductal (right hand) and post-ductal (left or right foot) oxygen saturation can be measured simultaneously or one after another.
    b. To pass, oxygen saturation must 1) be greater than or equal to 95% in both right hand and either foot, and 2) the difference between pre-ductal and post-ductal oxygen saturation be no more than 3%. Notify pediatrician and document if neonate does not pass the initial screen and anticipate rescreening, following the algorithm in Appendix A.
    c. A screen is considered failed if:
        i. Any oxygen saturation measure is <90% (in the initial screen or in repeat screens)
        ii. Oxygen saturation is <95% in the right hand and foot on three measures, each separated by one hour
        iii. A >3% absolute difference exists in oxygen saturation between the right hand and foot on three measures, each separated by one hour.
    d. Evaluate any infant who fails the CCHD screen for causes of hypoxemia. Treat hypoxemia following provider orders, and consider consulting Respiratory Therapy. Anticipate further testing/evaluation.

3. **Newborn Metabolic Screening:** The California Newborn Screening (NBS) Program requires by state law that all newborns undergo screening for genetic disorders. Screening occurs between 12 and 48 hours of life using a blood sample obtained via heel stick procedure. Documentation of screening, refusal, or transfer prior to screening will occur in the electronic medical record and on the Newborn Screen Test Request Form.
    a. If for any reason the newborn screen is collected prior to 12 hours (e.g., red blood cell transfusion, discharge earlier than 12 hours), a second blood sample collection will be required. Hospital staff will work to arrange a second screen prior to 48 hours of life.
    b. Critically ill newborns should have testing postponed until stable.
    c. Any newborn not born in the hospital will have the NBS performed within 48 hours of life.
    d. Documentation, tracking and reporting of screening results will follow state requirements.

4. **Newborn Hearing Screening:** The California Newborn Hearing Screening Program (NHSP) requires that all hospitals with licensed perinatal services provide hearing screening to newborns before discharge. Documentation of procedure results will occur in the medical record, and both the medical provider and parent(s)/caregiver(s) will be notified of the results.
    a. Screening will occur using one of two methods: Auditory Brainstem Response (ABR) and/or Otoacoustic Emissions (OAE). Follow manufacturer's instructions for use when performing hearing screening.

b. A neonate may be re-screened up to two times as an inpatient following an initial failed screen. Documentation of each attempt will occur in the medical record. A printed copy of the results will be placed in the medical record in addition to electronic documentation of procedure.
c. A neonate that fails the hearing screen as an inpatient will be scheduled for outpatient screening in a timely manner and in accordance with California NHSP procedures.
d. Screening results will be provided to parents/caregivers both verbally and in writing, in accordance with the California NHSP. Documentation, tracking and reporting of screening results - including refusal of screening - will follow state requirements.

PROCEDURE FOR NEONATAL TRANSFER:
When a patient requires transfer to a facility for a higher level of care, the pediatrician will obtain an accepting provider and facility. Once an accepting facility is confirmed, the House Supervisor will assist with transport coordination. The primary Perinatal RN will refer to the transfer checklist to complete the transfer. Documentation will include a physician order placed in the EMR.

If any routine screenings or tests were not completed prior to transfer, documentation must be made in the EHR.

- If the Newborn Hearing Screen was not performed prior to transfer, complete the appropriate reporting form(s) and indicate that inpatient screen was not done. Follow unit procedure for documentation and reporting.
- If the Newborn Metabolic Screening was not performed prior to transfer, complete California Newborn Screening Test Form and indicate that screening was not performed due to transfer. Follow unit procedure for documentation and reporting.

RE-ADMISSION OF INFANT:

- Infants up to and including 28 days shall be readmitted to the Perinatal Unit. Infant older than 28 days shall be readmitted to the Med/Surg (Pediatric) Unit. Exceptions may be made on an individual basis with consideration of diagnosis.
- A qualified RN with certification and documented competency in NRP and/or PALS will perform an admission assessment. After initial assessment a qualified LVN may assume patient care when appropriate.
- Security measures will follow hospital policy.
- All reasonable efforts will be made to accommodate the infant's parent(s) or caregivers to room-in with the infant. Parents/caregivers are to be encouraged to become involved in the child's care.

REFERENCES:

1. American Academy of Pediatrics Clinical Practice Guideline: Kemper AR, Newman TB, Slaughter JL, et al. Clinical Practice Guideline Revision: Management of Hyperbilirubinemia in the Newborn Infant 35 or More Weeks of Gestation. Pediatrics. 2022;150(3):e2022058859
2. California Department of Public Health Newborn Screening Program https://www.cdph.ca.gov/Programs/CFH/DGDS/Pages/nbs/default.aspx
3. California Newborn Hearing Screening Program https://www.dhcs.ca.gov/services/nhsp/Pages/default.aspx
4. Care of the Newborn. (2017). *Guidelines for Perinatal Care*, 347–408. https://doi.org/10.1542/9781610020886-ch10
5. Centers for Disease Control and Prevention: Critical Congenital Heart Defects Screening Methods https://www.cdc.gov/ncbddd/heartdefects/hcp.html#print

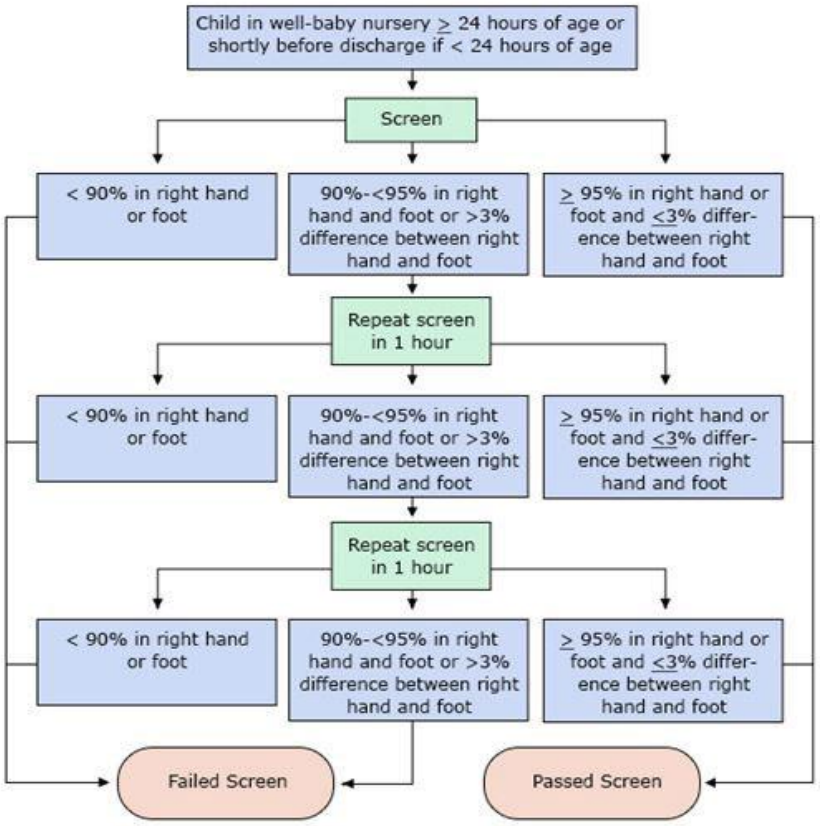
6. Kube, P. K., & Aghai, Z. H. (2021). Should we screen cord blood for ABO incompatibility? *Pediatrics*, *147*(3), 730–731. https://doi.org/10.1542/peds.147.3ma8.730
7. Moon, R. Y., Carlin, R. F., & Hand, I. (2022). Sleep-related infant deaths: Updated 2022 recommendations for reducing infant deaths in the sleep environment. *Pediatrics*, *150*(1). https://doi.org/10.1542/peds.2022-057990

CROSS-REFERENCED POLICY & PROCEDURE:

Neonatal Blood Glucose Monitoring Policy
Infant Feeding Policy
Nursing Management of the Infant and Pediatric Security System
Administration of Drugs and Biologicals

Supersedes:
Not Set
Critical Congenital Heart Disease Screening (CCHD)
Newborn Hearing Screening Program
Newborn Pulse Oximetry Screen
Newborn Screening Test
Stabilization and Resuscitation of the Newborn
Transcutaneous Bilirubin Testing (Bili Scan)
Universal Umbilical Cord Segment Procedure

Appendix A: CCHD Screening Algorithm



https://www.cdc.gov/ncbddd/heartdefects/hcp.html#print

CALL TO ORDER

Northern Inyo Healthcare District (NIHD) Board Chair Melissa Best-Baker called the meeting to order at 5:30 p.m.

PRESENT

Melissa Best-Baker, Chair
Jean Turner, Vice Chair
Ted Gardner, Secretary
Mary Mae Kilpatrick, Member at Large
Stephen DelRossi, MSA, Chief Executive Officer
Allison Partridge RN, MSN, Chief Operations Officer / Chief Nursing Officer
Adam Hawkins, DO, Chief Medical Officer
Alison Murray, MBA HRM, SHRM-CP, Chief Human Resources Officer
Sierra Bourne, MD, Chief of Staff *(Via Zoom)*

ABSENT

David McCoy Barrett, Treasurer

OPPORTUNITY FOR PUBLIC COMMENT

Chair Best-Baker reported that at this time, members of the audience may speak on any items not on the agenda on any matter within the jurisdiction of the District Board. Public comments shall be received at the beginning of the meeting and are limited to three minutes per speaker, with a total time limit of thirty minutes for all public comment unless otherwise modified by the Chair. The general Public Comment portion of the meeting allows the public to address any item within the jurisdiction of the Board of Directors on matters not appearing on the agenda. Public comments on agenda items should be made at the time each item is considered.

The following people had a public comment:

- Greg Bissonette, Foundation Executive Director/Grant Manager
- Foundation members:
  - Pete Watercott
  - Carole Wade
  - Jane Thompson

NEW BUSINESS

ANNUAL REPORT – SURGERY/TISSUE/TRANSFUSION/ANESTHESIA COMMITTEE

Chair Best-Baker called attention to the Annual Report, presented by Dr. Jeanine Arndal, Vice Chief of Staff and Chair of Surgery/Tissue/Transfusion/Anesthesia *(Information item).*

Dr. Arndal introduced herself and presented the annual report-Surgery/Tissue/Transfusion/Anesthesia Committee. Discussion ensued.

REQUEST FOR CERNER UNIFED CONSUMER COMMUNICAITONS (UCC

Chair Best-Baker called attention to the request for Cerner UCC Well Notification System for Appointments and Reminders.

WELL). A BI-DIRECTIONAL CONSUMER NOTIFICATION SYSTEM FOR APPOINTMENTS AND REMINDERS

CEO DelRossi introduced Cerner UCC Well Notification System. Discussion ensued. Mr. DelRossi also introduced Oracles representative to answer any additional questions the Board had.

Motion by: Jean Turner
Seconded by: Ted Gardner
Passed 4-0 vote

CHIEF EXECUTIVE OFFICER REPORT

Chair Best-Baker called attention to the Chief Executive Officer Report.

- Strategic Plan– Mr. DelRossi reported that he plans for a follow up meeting at the end of June.
- Nurses' week (May 6-12) & Hospital week (May 12-18) – Mr. DelRossi reported that Nurses' week was a success, and added that NIHD is excited for the upcoming Hospital week.

CHIEF FINANCIAL OFFICER REPORT

Chair Best-Baker introduced the Chief Financial Officer report.

- Financial & Statistical Reports:
  - CEO DelRossi introduced Controller Andrea Mossman to present the Financial & Statistical report. Discussion ensued.

Motion by: Ted Gardner
Seconded by: Mary Mae Kilpatrick
Passed 4-0 vote

- CFO Report – Mr. DelRossi would like to strike this item.
- Billings & Collections – Progress – Mr. DelRossi provided an update on the Billings & Collection cycle and what NIHD is doing to improve the workflow. Discussion ensued.
- Budget – Mr. DelRossi reported that he has been working on the budget with the directors and managers and will provide a report by each department at the request of Chair Best-Baker.
- Inventory – Mr. DelRossi reported that this year's inventory went a lot smoother than the 2023 inventory. Discussion ensued.

CHIEF OF STAFF REPORT

Chair Best-Baker called attention to the Chief of Staff report.

POLICIES

Chief of Staff Dr. Sierra Bourne provided an overview of the policies/procedures.

1. Communication with the Patient/Family after a Harm Event

Motion by: Ted Gardner
Seconded by: Jean Turner
Passed 4-0 vote

MEDICAL STAFF APPOINTMENTS 2024-2025

Dr. Sierra Bourne introduced appointments for 2024-2025:

1. Martin Vogel, MD *(anesthesiology)* – Courtesy Staff
2. Edward Herold, MD *(anesthesiology)* – Courtesy Staff

Motion by: Jean Turner
Seconded by: Ted Gardner
Passed 4-0 vote

CHANGE IN STAFF

Dr. Sierra Bourne introduced the following change in staff:

1. Cathy Xu, MD *(pediatrics)* – Change from Locum Tenens to Courtesy Staff with privileges effective through December 31, 2024
2. Karvier Yates, MD *(anesthesiology)* – Change from Locum Tenens to Courtesy Staff with privileges effective through December 31, 2024

Motion by: Mary Mae Kilpatrick
Seconded by: Ted Gardner
Passed 4-0 vote

MEDICAL EXECUTIVE COMMITTEE REPORT

Dr. Sierra Bourne provided the Medical Executive Committee meeting report.

Discussion ensued.

CONSENT AGENDA

Chair Best-Baker called attention to the consent agenda that contained the following items.

- *April 17, 2024 Regular Board Meeting Minutes*
- *Chief Medical Officer (CMO) Report*
- *CEO Credit Card Statements*
- *Approval of Policies and Procedures:*
    - *Leave of Absence – Leave Donation*
    - *Performance Evaluations*
    - *California Paid Sick Leave for Non-benefited Employees*
    - *Leaving without Notice*
    - *Medical Staff Department Policy – Surgery*
    - *Pre- and Post- Operative Anesthesia Visits*
    - *Scope of Anesthesia Practice*
    - *Standards of Care for the Emergency Department*
    - *Lost and Found Items*
    - *Workplace Violence Prevention Plan*

Chair Best-Baker brought attention to the consent agenda. The CMO Report was pulled from the consent agenda for further discussion. Chair Best-Baker called for a motion to approve the consent agenda as presented with the exception of the CMO Report.

Motion by: Ted Gardner

Seconded by: Mary Mae Kilpatrick
Passed 4-0 vote

Chair Best-Baker brought attention back to the CMO Report. Chief Medical Officer Dr. Hawkins provided an overview of the CMO report**.** Chair Best-Baker called for a motion to approve the CMO report as presented.

Motion by: Mary Mae Kilpatrick
Seconded by: Jean Turner
Passed 4-0 vote

GENERAL INFORMATION FROM BOARD MEMBERS

Chair Best-Baker called for information from Board Members.

Discussion ensued.

CLOSED SESSION:

PUBLIC COMMENTS ON CLOSED SESSION ITEMS

Chair Best-Baker voiced that any person in the audience may now speak on items only listed in the Closed Session portion of this meeting.

There were no public comments. Chair Best-Baker announced there would be no report out.

ADJOURNMENT TO CLOSED SESSION

At 7:04 p.m., Chair Best-Baker announced the meeting would adjourn to Closed Session to allow the District Board of Directors to discuss the following:

a. Conference with Legal Counsel – Existing Litigation (Government Code § 54956.9(d)(1)) Salazar Godina v. NIHD

ADJOURNMENT

Adjournment at 07:48 p.m.

_____
Melissa Best-Baker, Northern Inyo Healthcare District, Chair

Attest: _____
Ted Gardner, Northern Inyo Healthcare District, Secretary

JUN 11 2024

June 2024 Statement
Open Date: 05/07/2024 Closing Date: 06/05/2024

[redacted]

U.S. Bank Business Platinum Card
NORTHERN INYO HOSPITA
STEPHEN DELROSS[redacted]

Account: [redacted]

Cardmember Service [redacted]
3

New Balance	**$2,112.83**
Minimum Payment Due	**$22.00**
Payment Due Date	**07/01/2024**

Activity Summary

Previous Balance	+	$6,225.84
Payments	-	$6,225.84CR
Other Credits		$0.00
Purchases	+	$2,112.83
Balance Transfers		$0.00
Advances		$0.00
Other Debits		$0.00
Fees Charged		$0.00
Interest Charged		$0.00
New Balance	=	**$2,112.83**
Past Due		**$0.00**
Minimum Payment Due		**$22.00**
Credit Line		$37,500.00
Available Credit		$35,387.17
Days in Billing Period		30

Payment Options:

Mail payment coupon with a check

Pay online at usbank.com

[redacted]

Pay at your local U.S. Bank branch

Please detach and send coupon with check payable to: U.S. Bank [redacted]

[redacted]

24-Hour Cardmember Service: [redacted]

. to pay by phone
. to change your address

[redacted]

NORTHERN INYO HOSPITA
STEPHEN DELROSSI
150 PIONEER LN
BISHOP CA 93514-2556
[redacted]

Account Number	[redacted]
Payment Due Date	7/01/2024
New Balance	$2,112.83
Minimum Payment Due	$22.00

Amount Enclosed $_____

U.S. Bank
[redacted]

What To Do If You Think You Find A Mistake On Your Statement

If you think there is an error on your statement, please call us at the telephone number on the front of this statement, or write to us at:

[redacted]

In your letter or call, give us the following information:

- *Account information:* Your name and account number.
- *Dollar amount:* The dollar amount of the suspected error.
- *Description of Problem:* If you think there is an error on your bill, describe what you believe is wrong and why you believe it is a mistake.

You must contact us within 60 days after the error appeared on your statement. While we investigate whether or not there has been an error, the following are true:

- We cannot try to collect the amount in question, or report you as delinquent on that amount.
- The charge in question may remain on your statement, and we may continue to charge you interest on that amount. But, if we determine that we made a mistake, you will not have to pay the amount in question or any interest or other fees related to that amount.
- While you do not have to pay the amount in question, you are responsible for the remainder of your balance.
- We can apply any unpaid amount against your credit limit.

Your Rights If You Are Dissatisfied With Your Credit Card Purchases

If you are dissatisfied with the goods or services that you have purchased with your credit card, and you have tried in good faith to correct the problem with the merchant, you may have the right not to pay the remaining amount due on the purchase.

To use this right, all of the following must be true:

1. The purchase must have been made in your home state or within 100 miles of your current mailing address, and the purchase price must have been more than $50. (Note: Neither of these are necessary if your purchase was based on an advertisement we mailed to you, or if we own the company that sold you the goods or services.)
2. You must have used your credit card for the purchase. Purchases made with cash advances from an ATM or with a check that accesses your credit card account do not qualify.
3. You must not yet have fully paid for the purchase.

If all of the criteria above are met and you are still dissatisfied with the purchase, contact us in writing a[redacted]

[redacted]

While we investigate, the same rules apply to the disputed amount as discussed above. After we finish our investigation, we will tell you our decision. At that point, if we think you owe an amount and you do not pay we may report you as delinquent.

Important Information Regarding Your Account

1. **INTEREST CHARGE:** Method of Computing Balance Subject to Interest Rate: We calculate the periodic rate or interest portion of the **INTEREST CHARGE** by multiplying the applicable Daily Periodic Rate (**"DPR"**) by the Average Daily Balance (**"ADB"**) (including new transactions) of the Purchase, Advance and Balance Transfer categories subject to interest, and then adding together the resulting interest from each category. We determine the **ADB** separately for the Purchases, Advances and Balance Transfer categories. To get the **ADB** in each category, we add together the daily balances in those categories for the billing cycle and divide the result by the number of days in the billing cycle. We determine the daily balances each day by taking the beginning balance of those Account categories (including any billed but unpaid interest, fees, credit insurance and other charges), adding any new interest, fees, and charges, and subtracting any payments or credits applied against your Account balances that day. We add a Purchase, Advance or Balance Transfer to the appropriate balances for those categories on the later of the transaction date or the first day of the statement period. Billed but unpaid interest on Purchases, Advances and Balance Transfers is added to the appropriate balances for those categories each month on the statement date. Billed but unpaid Advance Transaction Fees are added to the Advance balance of your Account on the date they are charged to your Account. Any billed but unpaid fees on Purchases, credit insurance charges, and other charges are added to the Purchase balance of the Account on the date they are charged to the Account. Billed but unpaid fees on Balance Transfers are added to the Balance Transfer balance of the Account on the date they are charged to the Account. In other words, billed and unpaid interest, fees, and charges will be included in the **ADB** of your Account that accrues interest and will reduce the amount of credit available to you. To the extent credit insurance charges, overlimit fees, Annual Fees, and/or Travel Membership Fees may be applied to your Account, such charges and/or fees are not included in the ADB calculation for Purchases until the first day of the billing cycle following the date the credit insurance charges, overlimit fees, Annual Fees and/or Travel Membership Fees (as applicable) are charged to the Account. Prior statement balances subject to an interest-free period that have been paid on or before the payment due date in the current billing cycle are not included in the **ADB** calculation.
2. **Payment Information:** We will accept payment via check, money order, the internet (including mobile and online) or phone or previously established automatic payment transaction. You must pay us in U.S. Dollars. If you make a payment from a foreign financial institution, you will be charged and agree to pay any collection fees added in connection with that transaction. The date you mail a payment is different than the date we receive the payment. The payment date is the day we receive your check or money order at U.S. Bank National Associatio[redacted]

[redacted]r the day we receive your internet or phone payment. All payments by check or money order *accompanied* by a payment coupon and received at this payment address will be credited to your Account on the day of receipt if received by 5:00 p.m. CT on any banking day. Payments sent without the payment coupon or to an incorrect address will be processed and credited to your Account within 5 banking days of receipt. Payments sent without a payment coupon or to an incorrect address may result in a delayed credit to your Account, additional interest charges, fees, and/or Account suspension. The deadline for on-time internet and phone payments varies, but generally must be made before 5:00 p.m. CT to 8 p.m. CT depending on what day and how the payment is made. Please contact Cardmember Service for internet, phone, and mobile crediting times specific to your Account and your payment option. Banking days are all calendar days except Saturday, Sunday and federal holidays. Payments due on a Saturday, Sunday or federal holiday and received on those days will be credited on the day of receipt. There is no prepayment penalty if you pay your balance at any time prior to your payment due date.
3. **Credit Reporting:** We may report information on your Account to Credit Bureaus. Late payments, missed payments or other defaults on your Account may be reflected in your credit report.

[redacted]
NORTHERN INYO HOSPITA
STEPHEN DELROSSI [redacted]

Cardmember Service 1-866-485-4545

Important Messages

Paying Interest: You have a 24 to 30 day interest-free period for Purchases provided you have paid your previous balance in full by the Payment Due Date shown on your monthly Account statement. In order to avoid additional INTEREST CHARGES on Purchases, you must pay your new balance in full by the Payment Due Date shown on the front of your monthly Account statement.

There is no interest-free period for transactions that post to the Account as Advances or Balance Transfers except as provided in any Offer Materials. Those transactions are subject to interest from the date they post to the Account until the date they are paid in full.

Transactions

Payments and Other Credits

Post Date	Trans Date	Ref #	Transaction Description	Amount	Notation
05/29	05/29	[redacted]	INTERNET PAYMENT THANK YOU	$6,225.84CR	
			TOTAL THIS PERIOD	**$6,225.84CR**	

Purchases and Other Debits

Post Date	Trans Date	Ref #	Transaction Description	Amount	Notation
05/08	05/07	[redacted]	AMZN Mktp [redacted]	$26.07	Nurses Week
05/09	05/08		OPTIMUM 7715 [redacted]	$7.70	Cable
05/10	05/08		BISHOP COUNTRY CLUB [redacted]	$324.00	Auxiliary Luncheon
05/14	05/13		SQ *BREWED AWAKENING [redacted]	$1,128.68	Nurses Week
05/21	05/20		SP CA [redacted]	$53.42	Improvements
05/28	05/25		TST* WHISKEY CREEK [redacted]	$141.66	ACHD
06/03	05/31		FACEBK [redacted]	$337.52	Advertisement
06/03	06/01		OPTIMUM 7715 [redacted]	$93.78	Cable
			TOTAL THIS PERIOD	**$2,112.83**	

2024 Totals Year-to-Date

Total Fees Charged in 2024	$78.00
Total Interest Charged in 2024	$255.74

Company Approval *(This area for use by your company)*

Signature/Approval: _____ Accounting Code: _____

Continued on Next Page

NORTHERN INYO HOSPITA
STEPHEN DELROSSI [redacted]

Cardmember Service [redacted]

Interest Charge Calculation

Your Annual Percentage Rate (APR) is the annual interest rate on your account.

**APR for current and future transactions.

Balance Type	Balance By Type	Balance Subject to Interest Rate	Variable	Interest Charge	Annual Percentage Rate	Expires with Statement
**BALANCE TRANSFER	$0.00	$0.00	YES	$0.00	24.24%	
**PURCHASES	$2,112.83	$0.00	YES	$0.00	24.24%	
**ADVANCES	$0.00	$0.00	YES	$0.00	29.99%	

Contact Us

Phone [redacted]

Questions [redacted]

Mail payment coupon with a check [redacted]

Online [redacted]

End of Statement

NORTHERN INYO HOSPITA

NORTHERN INYO HEALTHCARE DISTRICT
NON-CLINICAL POLICY AND PROCEDURE

Title: Payroll Check Advances		
Owner: Chief Executive Officer	Department: Administration	
Scope:		
Date Last Modified: 03/07/2024	Last Review Date: No Review Date	Version: 2
Final Approval by: NIHD Board of Directors	Original Approval Date:	

PURPOSE: To clarify and codify the policies and procedures for granting payroll check advances.

POLICY: Payroll check advances must be requested a minimum of two weeks prior to issuance of the check for vacation advances, resignations or other routine needs.

1. In cases of extreme emergency (e.g., death in employee's family), the two-week advance request may be waived.

2. Payroll check advances must be approved by the Department Head and Administrator and must be requested on a hospital "Check Advance Request" form for both non-emergency and emergency requests.

3. Dismissed employees will receive their final paychecks immediately upon dismissal. No "Check Advance Request" is required.

4. Due to Direct Deposit-related problems with Advance Payroll Checks, up to 80% of an employee's normal take home pay will be paid from the Payroll system.

5. The advance amount paid through the Payroll system will be taken from the employee's next scheduled payroll check with the remainder going by Direct Deposit as normal into the designated bank account or **on the Employee's Pay Check.**

PROCEDURE: Fill out the "Check Advance Request"

1. Have it approved and signed by the Department Head

2. Route the form to the Administrator or Administrator on call (AOC) for approval and signature

3. Route the form to Human Resources or Payroll

Supersedes: v.1 Payroll Check Advances

NORTHERN INYO HEALTHCARE DISTRICT
NON-CLINICAL POLICY AND PROCEDURE

Title: Auditing of Workforce Access to Confidential Information		
Owner: Compliance Officer	Department: Compliance	
Scope: Compliance		
Date Last Modified: 05/15/2024	Last Review Date: No Review Date	Version: 5
Final Approval by: NIHD Board of Directors	Original Approval Date: 12/10/2013	

PURPOSE: Establishes requirements for auditing access to confidential information including protected health information in accordance with Northern Inyo Healthcare District (NIHD) policy and state and federal regulations.

Definitions:

Workforce: Persons whose conduct, in the performance of their work for NIHD, is under the direct control of NIHD or have an executed agreement with NIHD, whether or not NIHD pays them. The Workforce includes employees, NIHD contracted and subcontracted staff, NIHD clinically privileged Physicians and Allied Health Professionals (AHPs), and other NIHD health care providers involved in the provision of care of NIHD's patients.

Confidential Information - protected health information (confidential medical information), workforce and employee health information, and proprietary information related to providers, financial data, trade secrets, business information, information protected by law and any other information pertaining to NIHD unless specifically designated as not confidential. Proprietary information is generally confidential information that is developed by the District as part of its business and operations. Such information may include, but is not limited to, the business, financial, marketing, and contract arrangements associated with District services and products. It also may include computer access passwords, procedures used in producing computer or data processing records, Personnel and medical records, and payroll data. Other proprietary information may include management know-how and processes; District business and product plans with outside vendors; a variety of internal databases, and copyrighted material, such as software. (Information published by governmental agencies or the NIHD Board of Directors on public sites is not considered confidential information in the form in which it is supplied and published. NIHD is governed by and complies with all freedom of information laws, such as the California Public Records Act and the Freedom of Information Act.)

Covered Entity – (for the purpose of this policy) a healthcare provider, a health plan, or a healthcare clearinghouse who transmits any health information in electronic form.

Minimum Necessary - covered entity must make reasonable efforts to limit the use, disclosure, and/or request for protected health information, and other confidential information to the minimum necessary (lowest amount) to accomplish the intended purpose of the use, disclosure, or request.

Need-to-Know - access to only the data he or she needs to perform a particular function (role based access).

Protected Health Information (PHI) - individually identifiable health information that is transmitted or maintained in any form or medium, including electronic PHI.

Electronic Protected Health Information or ePHI*:* Is PHI that is transmitted by electronic media or is maintained in electronic media. For example, ePHI includes all data that may be transmitted over the Internet, or stored on a computer, a CD, a disk, magnetic tape, jump drive (USB) or other media.

Breach - the unauthorized acquisition, access, use or disclosure of PHI and/or confidential information which compromises the security or privacy of the PHI or other confidential information.

POLICY:
Access to information systems is granted on a need-to-know basis and is based on one's role with NIHD.

Audits will be performed which evaluate whether information accessed was based on "minimum necessary" and "need-to-know" principles and standards and appropriate corrective action is taken as applicable.

AUDIT TYPES:

1. **Routine Audits** – Routine audits can include but are not limited to:

Audit	Description
Same Last Name	Workforce who access the record of a patient with the same last name
Same Department	Workforce who access the record of a co-worker who works in the same department
Workforce Hospital Admission	When a Northern Inyo Healthcare District employee is admitted to the hospital as a patient
Confidential Document	Workforce who access "confidential" documents
New Workforce Member	All access made by new workforce members are audited within the first 30 days, and prior to the end of their 90 day introductory period
High Profile Individual	The patient is a newsworthy individual

2. **Audits for Specific Cause –** A request to audit for cause may come from various sources including but not limited to:
    a. Administration
    b. Human Resources
    c. Department Director/Manager
    d. Board of Directors
    e. Quality Assurance/Performance Improvement (QAPI) professionals
    f. Security Officer
    g. Patient or representative
    h. Community member

Audits for specific cause are conducted in all systems applicable to services provided at NIHD.

Causes or reasons for specific audits include but are not limited to:

Audit	Description
Internal Concern	Concern is expressed by a co-worker, Administration, Department Manager, Security Officer or other user
Patient Complaint	Patients request an audit of access to their medical record
Employee Family Member Admission	When a workforce member's family member is admitted as a patient
Restricted Information Patients	Users who access a patient's record who requests restricted access
Follow-Up	Workforce who have been subject to corrective action(s) for accessing records inappropriately
Disciplined Workforce	Workforce who have been disciplined for accessing records inappropriately

3. **Random Audits –** Random audits may be performed on clinical systems and may be done to determine clean-up of inactive users.

Audits Investigated and Evaluated

1. The Compliance Department will review the audit results for potential breaches of patient privacy based and confidential information on "minimum necessary" and "need-to-know" principles. When questionable access is discovered on the audit report:

    a. A member of the Compliance Department will meet with the workforce member requesting information and an explanation for accessing the patient or other information. For workforce members covered by a Memorandum of Understanding (MOU), any meeting will conform to the MOU's process. If further information is required based on the information received, meetings with additional workforce may occur. Follow up with any findings will be done with relevant workforce member(s) and leadership.

    b. If the audit findings reveal, as determined by the Compliance/Privacy Officer, activity that appears to constitute a breach of confidentiality, audit and investigation results for disciplinary determination will be reported to, at a minimum, the following:

        i. Human Resources and/or the workforce members' department manager/supervisor.
        ii. State and/or Federal agencies, in accordance with current law.
        iii. For each breach, the department manager/supervisor shall follow up with appropriate corrective action(s) as applicable to each finding and report such actions taken to the Compliance Department.
        iv. Department manager/supervisor shall submit copies of all documents for workforce corrective action(s) to the Compliance Department and the Human Resources department.

Audit Record Disposition and Retention

1. Audit reports are confidential documents. Copies of audit reports will be shared internally with Administration and management as necessary, and disclosed as required by law or for other business operations.

2. Audit for specific cause outcomes may be communicated to the requestor via mail or telephone, as determined by the Compliance/Privacy Officer.

3. Audit results will be retained according to state and federal regulations.

Availability and Retention of Documents

1. Audit documents will be made available to appropriate workforce members, as needed for review, discussion, and appropriate corrective action per NIHD policy and any applicable MOU.
2. Audit documents will be made available to state and federal investigators upon request.
3. Audit documentation shall be maintained for no less than three (3) years.
4. Policy documents will be retained for no less than six (6) years from either the creation date or the last effective date, whichever is longer.

REFERENCES:

1. 45 CFR Part 164.308(a)(8) – Administrative Safeguards
2. 45 CFR Part 164.312 (a)(1) – Technical Safeguards
3. 45 CFR Part 164.308(a)(1)(ii)(D) – Administrative Safeguards
4. 45 CFR Part 164.312(b)– Administrative Safeguards
5. 45 CFR Part 164.316 – Policies and procedures and documentation requirements
6. TJC Standard IM.01.01.01
7. TJC Standard IM.02.01.01
8. TJC Standard IM.02.01.03
9. TJC Standard PI.03.01.01

RECORD RETENTION AND DESTRUCTION:

CROSS REFERENCED POLICIES AND PROCEDURES:

1. Investigation and Reporting of Unlawful Access, Use or Disclosure of Protected Health Information
2. Minimum Necessary Access, Use and Disclosure of Protected Health Information
3. Using and Disclosing Protected Health Information for Treatment, Payment and Health Care Operations
4. Workforce Access to His or Her Own Protected Health Information
5. InQuiseek - #380 Medical Records Policy

Supersedes: v.4 Auditing of Workforce Access to Confidential Information

NORTHERN INYO HEALTHCARE DISTRICT
NON-CLINICAL POLICY

Title: District Issued Cell Phone/Electronic Communication Device Use By Employees		
Owner: Compliance Officer	Department: Compliance	
Scope: District Wide		
Date Last Modified: 05/20/2024	Last Review Date: No Review Date	Version: 3
Final Approval by: NIHD Board of Directors	Original Approval Date: 04/20/2016	

PURPOSE:

To provide guidelines for appropriate use of District owned cell phones/electronic communication devices by designated employees for District related business. To ensure the safety and security of the health care environment and to ensure patient and employee privacy and confidentiality. To provide a communication system that minimizes overhead pages and enhances communication with critical job titles for the benefit of patient care.

POLICY:

District issued mobile devices may be used during working hours for "District related business" as defined in this policy.

DEFINITIONS:

"District Related Business": to mean the pursuit of an employee's normal duties or duties as specifically directed by management.

District Issued Cell Phone Use

1. District cell phones may be assigned to employees by Management provided at least one of the following two criteria are met:
    a. The job function of the employee requires considerable time outside of their assigned office or work area and it is important to the District that they are accessible during those times.
    b. The job function of the employee requires them to be accessible to email and text as well as calls outside of scheduled or normal working hours.
2. District cell phones are to be used for "District related business".
3. District cell phones may also be assigned to specific jobs. Such cell phones will remain in the department for transfer to personnel performing the specific job to which the cell phone is assigned.
4. Managers will determine staff needs for District cell phones.
5. Managers will be responsible for:
    a. Notifying NIHD Information Technology (IT) when an employee/department needs a District cell phone.
    b. Notifying Onboarding Specialist in Human Resources of any changes affecting assignment of a district cell phone.

c. Notifying the Onboarding Specialist in Human Resources, who maintains a call list of the district cell phone numbers, with any updates/changes as appropriate.
d. Budgeting for phone costs, including replacement. Manager approval is required to replace district cell phone and phone accessories.

6. NIHD IT department will be responsible for retrieving the active log of District issued cell phones for auditing and tracking purposes from the wireless provider when needed.
7. Use of District cell phones or cameras to record or take still (photo, photography) or video pictures of the facility, employees, patients, or property is strictly prohibited without prior authorization from Management. Management must submit a written request that clearly details their department/staff need for recording or taking still or video pictures of the facility, employees, patients, or property to the Compliance Officer for approval.
8. Damaged, lost or non-functioning District cell phone:
    a. Lost District cell phone must be reported to NIHD IT Service Desk immediately upon discovery.
    b. Assistance with damaged or non-functioning District cell phones is provided via the NIHD IT Service Desk. Use of the electronic request (email) for help is preferred.
9. District cell phones are District property:
    a. Cell phones are subject to recall by the District at any time without notice and for any reason.
    b. The use of the cell phone may be revoked at any time without notice and for any reason.
    c. Upon separation of employment, District cell phones must be returned unlocked (no pin) immediately upon request.
    d. District cell phones shall not be synchronized with District cloud storage or any personal cloud storage, except by the ITS department.
    e. The District will retain control of all data stored on the cell phone.
    f. The District will retain control of the District assigned cell phone number.
10. District issued cell phones may not be used while driving.

RESPONSIBILITIES:

- All employees are required to follow this policy.
- Use of cell phones in violation of this policy may result in disciplinary action as per District policy.
- This policy is assigned to all leadership positions. Managers should assign this policy to non-management employees assigned a District cell phone.

REFERENCES:

1. Health Insurance Portability and Accountability Act of 1996
2. 45 C.F.R. Parts 160 and 164 Health Insurance Reform: Security Standards; Final Rule
3. The Joint Commission Information Management, Privacy and Security Standards IM.02.01.01 EP1-5, IM.02.01.03

RECORD RETENTION AND DESTRUCTION:

Tracking logs tie to department budgets and cost reports, therefore will be maintained for 15 years.

CROSS REFERENCED POLICIES AND PROCEDURES:

1. Personal Cell Phone/Electronic Communication Device Use by Workforce

Supersedes: v.2 District Issued Cell Phone/Electronic Communication Device Use By Employees

NORTHERN INYO HEALTHCARE DISTRICT
NON-CLINICAL POLICY AND PROCEDURE

Title: Regulatory Survey Security		
Owner: Compliance Officer	Department: Compliance	
Scope: District Wide		
Date Last Modified: 05/22/2024	Last Review Date: No Review Date	Version: 5
Final Approval by: NIHD Board of Directors	Original Approval Date: 08/17/2005	

PURPOSE: To provide a procedure for positively identifying regulatory agency personnel and guarding against imposters posing as such.

POLICY: NIHD will verify all surveyors or inspectors prior to providing them access to District facilities and restricted areas.

PROCEDURE: If any person or persons identifying themselves as regulatory surveyors [e.g. from The Joint Commission (TJC) or California Department of Public Health (CDPH)], or a federal inspector] is encountered, immediately escort the person(s) to one of the following (in order of preference):

1. Chief Executive Officer
2. Administrator-on-call
3. Chief Nursing Officer
4. Chief Medical Officer
5. Chief Human Resources Officer
6. Compliance Officer
7. House Supervisor

Administrative personnel will:

1. Collect business card or gather identification of the surveyor/inspector.
2. Call the agency from which the surveyor(s) claims to have been sent to verify their legitimacy
    a. **TJC – 630-792-5757**
    b. **CDPH – 909-383-4777**
3. Assign a hospital employee to accompany the surveyor(s) during their survey

In the event that the surveyor(s) refuse to allow verification of their identification or if the administration suspects that the surveyor is an imposter:

1. Call the local **Police – 873-5866**
2. Go to the TJC website and fill out the Homeland Security Incident Report (even if the imposters claim to be from another agency)

REFERENCES:

1. The Joint Commission (CAMCAH Manual) – The Accreditation Process (ACC); Surveyor Arrival and Preliminary Planning Session (Jan 1, 2024).
2. California Hospital Association - California Hospital Survey Manual (2021).

3. California Hospital Association – Record and Data Retention Schedule (2018).

RECORD RETENTION AND DESTRUCTION:
Records related to Accreditation/Licensing surveys and plans of correction will be maintained by NIHD for 15 years.

CROSS REFERENCED POLICIES AND PROCEDURES:
1. Security Management Plan
2. Governmental Agent Services
3. InQuiseek – Physical Plant Safety: General Policy

Supersedes: v.4 Regulatory Survey Security

NORTHERN INYO HEALTHCARE DISTRICT
NON-CLINICAL POLICY

Title: Nondiscrimination Policy		
Owner: Compliance Officer	Department: Compliance	
Scope: District Wide		
Date Last Modified: 05/20/2024	Last Review Date: 04/21/2022	Version: 3
Final Approval by: NIHD Board of Directors	Original Approval Date:09/15/2010	

PURPOSE:

To assure compliance with Title VI of the Civil Rights Act of 1964, Section 504 of the Rehabilitation Act of 1973, Title IX of the Education Amendments of 1972, and the Age Discrimination Act of 1975 and any future federal or state laws defining and prohibiting discrimination.

POLICY:

1. No person seeking services at Northern Inyo Healthcare District (NIHD) shall, on the basis or ground of race, color, sex (gender), sexual orientation, age, religion or national origin, be excluded from admission to NIHD, or excluded from any services provided by NIHD, or be otherwise subjected to discrimination in the admission to or provision of those services.

2. No persons with mental and/or physical disability shall, solely by reason of his/her disability, be excluded from admission to NIHD, or excluded from any services provided by NIHD, or be otherwise subjected to discrimination in the provision of those services, or be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any program or activity provided by NIHD.

3. NIHD employees or qualified applicants are considered for all positions without regard to race, color, religion, sex, pregnancy, childbirth, or related medical conditions, gender, gender identity, gender expression, national origin, ancestry, physical disability, mental disability, age, medical condition, genetic information, marital status, military and veteran status, sexual orientation, physical or mental disability, or any other basis protected by federal, state, or local laws.

4. Patients and Employees will be afforded reasonable accommodations within the available resources of the District in order to make the provision of services safely and conveniently accessible to an individual with the full intention that all persons be afforded the rights and benefits associated with the District.

REFERENCE:

1. California Hospital Association Record and Data Retention Schedule (2018).
2. The Joint Commission (CAMCAH Manual) (Jan. 1, 2022) RI.01.01.01 EP 4, 6, 9 & 29.
3. Patient Protection and Affordable Care Act; Section 1557 (2010).

RECORD RETENTION AND DESTRUCTION:

Employee and applicant records will be maintained by NIHD Human Resources Department for duration of employment, plus six (6) years.

Employees not entitled to pension, must have payroll records maintained for fifteen (15) years post separation.

Employees entitled to pension, must have payroll records maintained for the life of the employee plus six (6) years.

CROSS REFERENCED POLICIES AND PROCEDURES:

1. Patient Rights
2. Rights of Swing Bed Patients
3. Visitation Rights
4. InQuiseek – Non-Discriminatory Policy

Supersedes: v.2 Nondiscrimination Policy

NORTHERN INYO HEALTHCARE DISTRICT
NON-CLINICAL PROCEDURE

Title: False Claims Act Employee Training and Prevention		
Owner: Compliance Officer	Department: Compliance	
Scope: Workforce District Wide		
Date Last Modified: 03/14/2022	Last Review Date: 12/27/2021	Version: 5
Final Approval by: Executive Committee	Original Approval Date: 03/13/2014	

PURPOSE:
Consistent with our core value of Integrity, it is the policy of Northern Inyo Healthcare District (NIHD) to provide information to colleagues, contractors and agents on the False Claims Act, protections under the law, and the role of NIHD in detecting and preventing fraud, waste and abuse.

DEFINITIONS
The False Claims Act: The False Claims Act (31 USC Sections 3729-33) is a federal law that makes it a crime for any person or organization to knowingly

(1) file a false claim with the government for payment;
(2) make or use a false record or statement material to a false claim or an obligation to pay or transmit money or property to the government; and
(3) conceal and/or improperly avoid or decrease an obligation to pay or transmit money or property to the government.
   a. "Knowing" means that the person or organization:
      • Has actual knowledge that the record or claim is false, or
      • Seeks payment while deliberately ignoring whether or not the record or claim is false, or
      • Seeks payment recklessly without caring whether or not the record or claims is false.

Under certain circumstances, an inaccurate Medicare, Medicaid, VA, Federal Employee Health Plan or Workers' Compensation claim could become a False Claim.

Examples of possible False Claims include someone knowingly billing Medicare for services that were not provided, or for services that were not ordered by a physician, or for services that were provided at sub-standard quality where the government would not pay.

History of False Claims Act:
The False Claims Act has been in existence since the Civil War, and was originally passed as a way to discourage military contractors from committing fraud against the Union Army. Although the Act is still frequently utilized to combat fraud in the defense industry, it has increasingly been used as a vehicle for combating fraud and abuse in the health care industry.

Whistleblower:
A person who knows that a False Claim was filed for payment can file a lawsuit in Federal Court on behalf of the government, and in some cases, receive a reward for bringing original information about a violation to the government's attention.

Whistleblower Protections:
The federal False Claims Act protects anyone who files a False Claim lawsuit from being fired, demoted, threatened or harassed by their employer for filing the suit. An employee who was harmed by their employer for filing a False Claims lawsuit must file a lawsuit against their employer in Federal Court. If the employer retaliated, the court can order the employer to re-hire the employee, and to pay the employee twice the amount of back pay that is owed, plus interest and attorney's fees.

Workforce:
Persons whose conduct, in the performance of their work for NIHD, is under the direct control of NIHD or have an executed agreement with NIHD, whether or not NIHD pays them. The Workforce includes employees, NIHD contracted and subcontracted staff, NIHD clinically privileged Physicians and Allied Health Professionals (AHPs), and other NIHD health care providers involved in the provision of care of NIHD's patients.

PROCEDURE:
The NIHD Compliance Program includes monitoring and auditing for compliance that helps in detecting or preventing fraud waste and abuse in federal health care programs.

1) NIHD provides annual education via the learning management system (LMS) for all workforce members on the False Claims Act and its legal requirements. This will include the following:
   a. In order to violate the False Claims Act, one must knowingly and intentionally
      - Bill for services not rendered, or
      - Knowingly submit inaccurate claims for service, or
      - Take or give a kickback for a referral.
   b. California False Claims Act allows for employees to file a lawsuit against an employer who is committing fraud, theft or embezzlement with respect to government funds.
2) NIHD expects that its colleagues who are involved with creating and filing claims for payment for services that NIHD provides will use only true, complete and accurate information to make the claim.
3) NIHD expects that anyone with a concern about a possible False Claim at a NIHD will use the reporting process (either reporting to your supervisor, Compliance Officer, Chief of Service Line or via the Confidential Report Line at 1-888-200-9764) immediately so that NIHD can investigate and correct any errors. Confidential Report Line is monitored by the Compliance Department of NIHD.
4) The NIHD policy on Confidential Report Line reporting and non-retaliation protects employees from adverse action when they report, in good faith, any concern about actual or potential wrong doing.
5) NIHD will investigate any allegation of retaliation against a colleague for speaking up, and will protect and/or restore rights to anyone who raised a genuine concern in good faith.

REFERENCES:

1. The California False Claims Act (Title 2, Division 3, Part 2, Chapter 6 – 12650-12656).
2. The False Claims Act (31 USC Sections 3729-33) Federal Law.

3. California Hospital Record and Data Retention Schedule (2018).

RECORD RETENTION AND DESTRUCTION:
Compliance audits, internal investigations and Compliance Confidential Report Line logs will be maintained for a minimum of 6 years.

CROSS REFERENCES POLICIES AND PROCEDURES:
1. False Claims Act Employee Training and Prevention
2. NIHD Code of Ethics and Conduct
3. Non-Retaliation Policy
4. Workforce Investigations
5. InQuiseek – Regulatory Compliance Policy

Supersedes: v.4 False Claims Act Employee Training and Prevention Policy

NORTHERN INYO HEALTHCARE DISTRICT
NON-CLINICAL POLICY AND PROCEDURE

Title: Designated Record Set - Legal Health Record		
Owner: HIM Manager	Department: Medical Records	
Scope: HIMs and Compliance		
Date Last Modified: 05/15/2024	Last Review Date: No Review Date	Version: 1
Final Approval by: NIHD Board of Directors	Original Approval Date:	

PURPOSE: To define and identify both the Legal Health Record and Designated Record Set for business and legal purposes of Northern Inyo Healthcare District (NIHD).

SCOPE: This policy applies to all uses and disclosures of the health record for administrative, business, or evidentiary purposes.

DEFINITIONS:
Legal Health Record (LHR): The LHR is the documentation of healthcare services provided to an individual in any aspect of healthcare delivery by a healthcare provider organization. It is individually identifiable data, in any medium, collected and directly used in and/or documenting healthcare or health status. It excludes those health records not normally made and kept in the regular course of the business

Designated Record Set (DRS): A group of records maintained by or for a Covered Entity that is the medical records and billing records about an Individual; the enrollment, Payment, claims adjudication, and case or medical management record systems maintained by or for a health plan; or information used, in whole or in part, by or for the Covered Entity to make decisions about the Individual. The term Record means any item, collection, or grouping of information that includes Protected Health Information and is maintained, collected, used, or disseminated by or for a Covered Entity.

LEGAL HEALTH RECORD POLICY:
It is the policy of NIHD to create and maintain documentation of each patient for the purpose of clinical and patient care use. The said documentation will be defined as the legal heath record.

A. The Legal Health Record
The legal health record serves to support the decisions made in a patient's care; Support the revenue sought from third party payers; Documents the services provided as legal testimony regarding the patient's illness or injury, response to treatment, and caregiver decisions; Serve as the official business and legal record. Documentation is determined to be a part of the LHR based on how the information is used and whether it is reasonable to expect the information to be routinely released when a request for a complete health record is received. The legal health record excludes health records that are not official business records of NIHD.

Routine disclosures of the medical record will only include information needed to fulfill the intent of the request. It excludes information determined to not be included in the legal health record.

The legal health record is the record released upon request in accordance with applicable laws.

B. The Legal Health Record Includes:

1. Refer to APPENDIX- A Legal Health record- Designated Record Set Matrix.

2. Pre-hospitalization information that is provided to the facility by the patient is part of the LHR if the information is used to provide patient care services, document observations, actions or instructions, such as intake questionnaires and pre-procedure forms. The term includes records of care in any health-related setting used by healthcare professionals while providing patient care services, for reviewing patient data, or documenting observations, actions, or instructions. Some types of documentation that comprise the LHR may physically exist in separate and multiple paper-based or electronic databases.

C. The Legal Health Record Excludes:

- Shadow records;
- Alerts, pop-ups or reminders used as aids for clinical decision making; Administrative documents used for healthcare operations, regulatory or financial purposes;
- Working notes made by a provider to aid in completing a report;
- Derived data used in supporting, evaluating or providing patient care.

DESIGNATED RECORD SET POLICY:
To define the specific information or records that patient's may access and amend under the Health Insurance Portability and Accountability Act (HIPAA) and state privacy laws. The standards provide that individuals have the right to inspect and obtain a copy and request amendment of medical information used to make decisions about their care and billing information.

A. The Designated Record Set

NIHD is required under HIPAA to provide an Individual the right to request Access to or Amendment of the Individual's DRS. The DRS is patient specific data, in any medium, collected and directly used by Health Care Providers. The contents of the DRS may be maintained in multiple locations and in various media. The DRS includes archived, legacy, or otherwise retained components until destroyed according to the organization's retention and destruction policy. Archived documents must be reproducible in a readily accessible format and are subject to all timelines, and form and format requirements under the Patient's right to Access. Documentation is determined to be a part of the DRS based on how the information is used and whether it is reasonable to expect the information to be routinely released when a request from the individual to inspect, copy or request an amendment. The designated record set excludes health records that are not official business records of a healthcare provider.

The Designated Record Set, details elements of the HIPAA requirements for patient access. The legal health record is a component of the DRS. Generally administrative data, such as authorization forms, correspondence, nursing protocols, etc. may be part of the DRS and though not part of the LHR.

B. **The Designated Record Set Includes:**

1. The legal health record;

2. Billing record components that include Patient-specific claim information such as itemized bills, account balances, ABN letters, notice of non-coverage letters (HINN), etc.;

3. Third party Health Care Provider records that have either been scanned into electronic medical record applications maintained by the provider or that have been incorporated into the Individual's medical record in whatever format and available for future reference by the provider; or have been used in whole or in part to make Treatment decisions about the Individual;

4. Patient-submitted documentation and referral letters which have been added to the medical record;

5. Other Patient-specific information such as consents and Authorizations;

6. Wellness and disease management Patient records, unless these are duplicate and already represented in the Patient's primary medical record.

7. Records created or maintained by a Business Associate, which meet the inclusion criteria to be included in the DRS.

C. The Designated Record Set Does NOT Include:

1. Health information generated, collected, or maintained for administrative, regulatory, or other Health Care Operations purposes that is not used for Treatment decision-making of the Individual. Examples include the following:

- Research activities
- Peer review activities
- Performance improvement activities
- Risk, compliance, or privacy investigation activities
- Appointment and surgery schedules
- Birth, cancer, and death registries
- Surgery register
- Diagnostic and operative indices
- Coding indices and guidelines
- Operational documents such as narcotics count sheets, supply charging sheets.
- Duplicate copies of original source documents that may be located in the Individual's
- medical or billing record.
- Documentation used to communicate between providers and payors for submitting

- claims for payment, such as charge sheets, UB-92s, contract payment discount
- information.
- Laboratory processing documentation

2. Psychotherapy notes as defined by HIPAA

3. Employee health records

4. Source files that are interpreted or summarized in some manner in the Individual's health record either electronically or in paper, such as the following:

- Pathology slides
- Worksheets (i.e., birth certificate worksheets, coding worksheets)
- Video/audio recordings of non-patient Treatment areas such as surveillance of parking lots, entry points, and public waiting areas.

5. Information compiled under attorney client privilege in reasonable anticipation of or for use in a civil, criminal, or administrative action or proceedings.

6. Employment records, including pre-employment physicals, notice of injury or work related injury reports maintained in the employer's human resource files, fit for duty evaluations. return to work notes and forms, Americans with Disabilities Act (ADA) documents, or Family Medical Leave Act (FMLA) documents.

7. Business Associate records that duplicate information maintained by NIHD.

8. Patient information created as part of a Research study to which the Individual has temporarily waived the right to Access.

9. Records that have been destroyed pursuant to retention and destruction policies, or records rendered unusable due to fire, flood, or other circumstances.

10. Application and medical record access audit logs.

11. Alerts, pop-ups or reminders within the Electronic Health Record to complete documentation.

12. Working notes made by a Health Care Provider or practitioner to aid in daily assignment management.

REFERENCES:

1. The American Recovery and Reinvestment Act of 2009 (ARRA) (Pub.L. 111–5)
2. 45 C.F.R. § 164.300 et seq. – HIPAA Security Rule
3. 45 C.F.R. § 164.500 et seq. – HIPAA Privacy Rule
4. Guidance from HHS dated January 2016 and February 2016 regarding Patient Access to PHI
5. AHIMA. "Fundamentals of the Legal Health Record and Designated Record Set." Journal of AHIMA 82, no.2 (February 2011): expanded online version.
6. APPENDIX A- Legal Health record- Designated Record Set Matrix.

RECORD RETENTION AND DESTRUCTION:

1. 22 CCR §72543 “records shall be kept for a minimum of 7 years, with the exception of minors records that shall be kept at least until 1 year after the minor has reached the age of 18 years, but in no case less than 7 years.”

CROSS REFERENCE POLICIES AND PROCEDURES:

Supersedes: Not Set

NORTHERN INYO HEALTHCARE DISTRICT
EMPLOYEE HANDBOOK

Title: Meal and Rest Periods		
Owner: Controller	Department: Fiscal Services	
Scope: District Wide		
Date Last Modified: 05/16/2024	Last Review Date: No Review Date	Version: 5
Final Approval by: NIHD Board of Directors	Original Approval Date:	

PURPOSE:
The purpose of this policy is to outline hours, meal and rest period for NIHD non-exempt unrepresented employees.

POLICY:
Northern Inyo Healthcare District follows laws applicable to a district hospital, a political subdivision of the state of California, a public entity.

NIHD's standard pay period is 80 hours for two weeks beginning at 11:00 P.M. Saturday and ending at 11:00 P.M. the second following Saturday (at the end of the 3-11 shift). Shift agreements for 10-hour or 12-hour shifts specify differences from the standard.

Northern Inyo Healthcare District ("District") authorizes and permits non-exempt employees who work at least three and one-half (3.5) hours in a workday to take paid rest periods, which insofar as practicable shall be in the middle of each work period and during which they will be completely relieved of all duty. NIHD employees are not deducted time when they take a 10-minute break. Even if an employee clocks in and out for a break, if it is no more than 10 minutes, the break time is paid time. The authorized rest periods shall be based on the total hours worked daily at the rate of ten (10) minutes of rest time per four (4) hours or major fraction thereof worked, as indicated in the following chart:

Hours Worked in the Workday	**Number of Ten (10) Minute Periods**
3.5 to 6 hours	1
More than 6 to 10 hours	2
More than 10 to 14 hours	3
More than 14 to 18 hours	4
More than 18 to 22 hours	5
More than 22 to 24 hours	6

Rest periods may not be added to meal periods to extend the time, nor used to make up for tardiness or leaving work early. Non-exempt employees who do not receive a rest period as required by this Policy will receive one additional hour of pay at the employee's regular rate of pay for each workday during which a rest period was not provided.

Non-exempt employees who work more than five (5) hours in a workday are also provided an uninterrupted 30 minute unpaid meal period each day. During this meal period, employees are completely relieved of their work duties and the District relinquishes control over the employees' activities.

An employee's meal period must commence before the end of the fifth hour of the employee's shift, unless six (6) hours will complete the workday. If six (6) hours will complete the day, then the meal period may be waived by mutual consent of the District and the employee. An employee working more than 10 hours is provided a second unpaid, off-duty meal period of 30 minutes unless 12 hours will complete the workday. If 12 hours will complete the day, then the second meal period may be waived by mutual consent of the District and the employee, only if the first meal period was not waived. The second meal period must commence no later than before the end of the tenth hour of work.

Non-exempt employees who do not receive a meal period as required by this Policy will receive one additional hour of pay at the employee's regular rate of pay for each workday during which a meal period was not provided, unless a mutual waiver of the meal period has occurred as provided above.

The District will permit employees a reasonable opportunity to take their meal and rest periods and will do nothing to impede or discourage employees from taking their meal and rest periods. Employees may leave the premises during their meal and rest periods, and are not "on call" during their meal and rest periods. Employees are not required to check email, voicemail, or any work-related devices (cell phones, etc.) during their meal or rest period. If employees believe they have been impeded from taking their meal and rest periods, they must notify their supervisor or Human Resources immediately so the matter may be properly addressed.

You must clock in and out any time you leave hospital property other than for hospital business. You must clock in and out for all circumstances related to leaving the hospital property for personal reasons.

REFERENCE: California SB-1334
https://leginfo.legislature.ca.gov/faces/billNavClient.xhtml?bill_id=202120220SB1334

RECORD RETENTION AND DESTRUCTION:

CROSS REFERENCE POLICIES AND PROCEDURES:

- Northern Inyo Healthcare District's Payroll Policies and Guidelines
- Health and Safety - Pregnancy and Lactation Accommodations
- 10-Hour or 12-Hour Shift Agreements
- Six-Hour Shift Waiver Meal Period
- Waiver Second Meal Period

Supersedes:
Legal Review: Atkinson, Andelson, Loya, Ruud & Romo 10/30/2020

NORTHERN INYO HEALTHCARE DISTRICT
COMMITTEE CHARTER

Title: Billing and Coding Compliance Committee Charter		
Owner: HIM Manager	Department: Medical Records	
Scope: Committee Membership		
Date Last Modified: 05/14/2024	Last Review Date: No Review Date	Version: 1
Final Approval by: Executive Committee	Original Approval Date:	

COMMITTEE PURPOSE

The Billing and Coding Compliance Committee (BCCC) reports to the Compliance and Business Ethics Committee (CBEC). The BCCC ~~reports revenue data~~reviews Revenue Cycle questions, chargemaster updates and changes, and provides informative, collaborative advisory oversight, and approval to charging, billing, and coding related items and policies for Northern Inyo Healthcare District's (NIHDs) hospital and clinic services. BCCC ensures that all facility validation and recertification requirements are met based on federal, state, and local laws and regulations. This committee contributes to the compliant and successful implementation of new services lines in accordance to the New Line of Service Implementation policy.

COMMITTEE MEMBERSHIP

- Chief Financial Officer
- Compliance Officer
- Director of Revenue or designee
- Manager of Project Management
- Director of Medical Staff Support or representative
- Director of Patient Access
- Billing Office Manager (Billing Office Manager and HIMS Manager will be Co-Chairs)
- Charge Capture
- Health Information Management Services (HIMS) Manager
- Member from the following teams:
    - Billing and Coding including 3rd Party Vendors
    - Information Technology Services
    - Clinic Leadership
    - Clinical Informatics representative
    - Pharmacy
- Ad Hoc
    - Chief Executive Officer
    - Chief Nursing Officer
    - Chief Operating Officer
    - Director of Diagnostic Services or a representative
    - Finance Budget Analyst

- Additional staff as needed

FREQUENCY OF MEETINGS

Convenes ~~Weekly~~every other week or as needed

COMMITTEE GOALS

1. Ensure all charge master changes are reviewed and recommendations sent to CEO or CFO ~~approved~~ prior to being implemented across the ~~district~~ District.
2. Approve processes related to charging, billing, and coding compliance of hospital and clinical services.
3. Complete coding review, which will include the discussion of denials in order to identify ways of reducing denials in the future, if there is not a Denials Review group in the Revenue Cycle.
4. Review and discuss coding audits. Identify action items and process, as needed.
5. Ensure that all new service lines move through the appropriate channels, in accordance with the New Service Line Implementation Policy.
6. Keep all members of the committee, and appropriate NIHD team members, aware of onboarding physicians or specialists.
7. Ensure that NIHD is in compliance with facility validation requirements and recertification.
8. Other items related to billing and coding compliance, as needed.

COMMITTEE RESPONSIBILITIES

- Members will add any agenda items to the tracking system prior to the scheduled meeting for discussion.
- Members will review the agenda on the tracking system and be prepared to provide input or discuss impact in regards to their unit or department.
- Members should have an update for their action items prior to each meeting to ensure that the meeting runs smoothly and there is no time wasted.

RETENTION AND DESTRUCTION OF RECORDS

Minutes are to be maintained for a minimum of six (6) years.

Supersedes: Not Set

NORTHERN INYO HEALTHCARE DISTRICT
NON-CLINICAL POLICY

Title: Language Access Services Policy		
Owner: Compliance Officer	Department: Compliance	
Scope:		
Date Last Modified: 05/15/2024	Last Review Date: No Review Date	Version: 3
Final Approval by: NIHD Board of Directors	Original Approval Date:	

PURPOSE:

The purpose of this policy is to ensure timely and appropriate language or communication assistance is provided to Limited English Proficient (LEP), non-English speaking, or hearing impaired patients or their representatives for equal and meaningful access to high quality health care services.

DEFINITIONS:

1. **Bilingual** - a term describing a person who is "proficient" in two languages.
   There are different levels of proficiency, and being self-declared bilingual does not ensure the ability to interpret and/or provide competent health care services in a language other than English.
2. **Healthcare/Medical Interpreter** - an individual who mediates spoken communication in health care settings, between people speaking different languages. A *qualified* healthcare interpreter is someone who:
   a) Has been trained in healthcare interpreting;
   b) Adheres to a professional code of ethics and protocols for healthcare interpreters;
   c) Is knowledgeable about medical terminology in English and in the target language; and
   d) Can accurately and completely render spoken communication from one language to another without adding, omitting, or distorting meaning or editorializing.
3. **Language or Communication Barrier** – inability to effectively communicate experienced by individuals who are Limited English Proficient or non-English speaking, deaf, hearing- or speech- impaired.
4. **Limited English Proficient (LEP) or Non-English Speaking** - an individual that does not speak English well enough to take care of his/her health care needs. In most cases, these individuals do not speak English as their primary or preferred language, and have a limited ability to read, speak, write, or understand English.
5. **Preferred Language** – the language indicated by the patient as being the one in which he/she would like to communicate while receiving health care services. A patient's preferred language may/may not be the same as his/her primary language.
6. **Primary Language** – the language a person has learned from birth.
7. **Qualified Bilingual Employee** – a workforce member with assessed proficiency in a language other than English, with the ability (and approval) to directly provide services to LEP patients in their primary or preferred language.

8. **Qualified Interpreter** – a workforce member holding a primary job other than interpreting, who has completed the criteria required under NIHD's Language Access Services Program to provide interpreting services.
9. **Sight Translation** – the unprepared verbal rendering, in the target language, of a document written in a language other than the target language.
10. **Sign(ed) Language** – all different forms of communication used by interpreters for the deaf, including American Sign Language (ASL) and other sign language variants. Sign languages for the deaf are unique languages with their own syntax and are not signed versions of English or other spoken languages.
11. **Sign Language Interpreter** – An individual, who mediates signed communication for the hearing impaired or deaf, holding a certification from an accredited institution to providing Signed Language interpreting.
12. **Translation** - the conversion of a written text into a written text in a second language. *Translation refers to: written to written conversion, while interpreting refers to the conversion of spoken or verbal communication from one language into a second language.*
13. **Threshold Language** – "a language identified as the primary language, as indicated on the Medi-Cal Eligibility Data System (MEDS), of 3,000 beneficiaries or five percent of the beneficiary population, whichever is lower, in an identified geographic area."[1] The only threshold language meeting this definition in NIHD's service area, at the time this policy is reviewed is Spanish.
14. **Vital Document** – Vital Documents are those containing information for accessing services and/or benefits. Including, but not limited to:
    a) Informed Consent;
    b) Advance Directive;
    c) Intake forms with potential for important health consequences;
    d) "Notices pertaining to the denial, reduction, modification or termination of services and benefits, and the right to file a grievance or appeal;"[2] and
    e) Notices advising LEP persons of free language assistance, or applications to participate in a program or activity to receive benefits or services.[3]
15. **Workforce Member** – NIHD employees and any other person whose conduct, in the performance of work for NIHD, is under the direct control of NIHD, whether or not they are paid by NIHD. This includes Medical Staff members, including members of all Staff categories, temporary privileges holders, and allied health professionals; travelers, temporary, per-diem, full- and part-time employees, affiliates, associates, students, volunteers, and staff from third party entities providing services to NIHD.

POLICY:

1. It is the policy of Northern Inyo Healthcare District (NIHD) to provide timely and appropriate language or communication assistance to Limited English Proficient (LEP) or hearing impaired patients, and/or their representatives, who might be experiencing language or communication barriers for equal and meaningful access to high quality health care services.
2. NIHD provides language or communication assistance through the utilization of any of the resources approved under the District's Language Access Services (LAS) Program.
    a) NIHD-approved resources for language access services are workforce members qualified as:
        i. Approved Bilingual,

[1] Title 9, CCR, Section 1810.410 (a)(3).
[2] California Health and Safety Code § 1367.04(b)(1)(B)(i)-(vi)
[3] According to the Title VI Office of Civil Rights Guidance, the definition of Vital Documents "may depend upon the importance of the program, information, encounter, or service involved, and the consequences to the LEP person if the information in question is not provided accurately or in a timely manner."

ii. Medical Interpreter, or
iii. Nationally accredited as Certified Healthcare Interpreter™
iv. Contracted over the phone or video remote interpreting services, and
v. Contracted certified translation services.

b) The unavailability of a qualified workforce member to provide interpreting services, shall not cause a delay in providing health care services, in any form, and at any time. When qualified workforce members are not available to provide interpreting services, the telephone or video remote interpreting services shall be immediately utilized; these services are available 24 hours a day, seven days a week.
c) Workforce members **shall not** ask patients' family members or friends to provide interpreter services in any form and at any time.
d) Workforce members **not** qualified as Approved Bilingual, and **not approved** to provide interpreting services, shall not be asked to do so, and shall not attempt to provide direct or indirect communication (assisted with a computer, tablet, and/or Smartphone), and shall **only** use District-approved resources for language access services.

3. NIHD:
   a) Provides the assistance of trained qualified interpreters (in-person or remotely by telephone or video) to LEP, non-English speaking, and hearing impaired patients,
   b) Encourages patients **not to use friends or family** members as their interpreter, and
   c) Does not allow the utilization of anyone under the age of 18 years of age as an interpreter.
4. NIHD recognizes patients' right to self-autonomy, and their right to refuse to use the qualified interpreter services provided by the District. However, in order to **ensure communication and compliance**[4]:
   a) NIHD workforce members shall obtain a signed Waiver of Interpreter Services any and every time a patient requests to use a friend or family members (which is 18 years of age or greater) as his/her interpreter of choice. The signed waiver must be scanned as part of the medical record for that visit. **Workforce must still utilize a District-approved interpreter.**
   b) In order to ensure the accuracy and completeness of the patient's interpreter of choice, **NIHD workforce members shall have a District-approved interpreter (in-person, over the phone, or video) at the same time, during each and every time the patient is using his/her interpreter of choice.**
   c) NIHD workforce members who are requested by their friend or family member to be their interpreter of choice, are encouraged to function in the role of support-person and refrain from the interpreter role. Should the NIHD workforce member chose to interpret; an additional District-approved interpreter must be utilized.
   d) NIHD workforce members are allowed to be the patient's interpreter of choice, without the need to sign a Waiver or a second interpreter to be present, **only** when one of the following circumstances apply:
      i. The patient is a minor and the workforce member is the parent or legal guardian, or
      ii. The workforce member has been designated as the patient's legal representative, and the proper documentation is on file.
   e) NIHD workforce members obtaining the signed Waiver must complete and sign the Workforce Member Certification portion of the Waiver.
5. NIHD translates documents identified as Vital, Significant Publications, and Significant Communications into qualifying threshold languages[5].

[4] ACA § 1557: Recipients must provide a qualified interpreter.
[5] Title VI of the Civil Rights Act of 1964; Affordable Care Act § 1557; and California Health and Safety Code, Division 2, Chapter 2, Article 1, § 1259

    a) All requests for translation shall be submitted to the Compliance Department.
6. Workforce members shall provide patients the forms and information in the patient's preferred language, when they are available.
    a) When obtaining the patient's signature for a Consent for Surgery or Diagnostic Procedure, or any other form, workforce members shall use both forms, the one in English and its Spanish translation. The patient shall sign both forms, and both forms shall be scanned into the patient's medical record.
    b) NIHD maintains a translated list, in qualifying languages - Spanish, of the most frequently performed procedures at NIHD. When available, the name of the surgery or procedure shall be written in Spanish in the translated form. The form in English shall have the name of the surgery or procedure written in English.
    c) When the name of the surgery or procedure is not available in Spanish, workforce members shall write in English the name of the surgery or procedure in the Spanish form.
7. NIHD-approved resources for interpreting services nor its approved bilingual workforce members are qualified or approved to sight-translate any document.
8. NIHD develops and posts Notices informing LEP patients of their rights to language access services.
9. NIHD designs all signage to ensure qualifying LEP populations understand how to access all public areas.
10. NIHD shall comply with all federal, and state laws, and the Joint Commission's Standards related to the collection of patients' race, ethnicity, primary language, and preferred language for communicating while receiving health care services at NIHD.

REFERENCE:

This policy is in compliance with, but not limited to, the following:

1. Title VI of the Civil Rights Act of 1964;
2. The Affordable Care Act, §1557;
3. California Health and Safety Code, Division 2, Chapter 2, Article 1, §1259;
4. California Health and Safety Code § 1367.04(b)(1)(B)(i)-(vi);
5. Emergency Medical Treatment and Active Labor Act; and
6. The Joint Commission Standards on Patient-Centered Communication.

RECORD RETENTION AND DESTRUCTION:

Patients' signed Waiver of Interpreter Services are attached to the patient's medical record, which is maintained by the hospital's medical records department.

CROSS-REFERENCED POLICIES AND PROCEDURES:

Supersedes: Not Set

NORTHERN INYO HEALTHCARE DISTRICT
NON-CLINICAL PROCEDURE

Title: Subpoena and Legal Summons for Workforce		
Owner: Compliance Officer	Department: Compliance	
Scope: District Wide		
Date Last Modified: 07/19/2021	Last Review Date: 05/21/2024	Version: 1
Final Approval by: Executive Committee	Original Approval Date:	

Acceptance of Summons, Complaints and Subpoenas.

District workforce must exercise care when presented with any documents concerning legal actions in which the District or its employees are involved. Only the Office of the Compliance Officer may accept service of summons and complaints on behalf of the District. Subpoenas for District records and/or records of any patient of the District, regardless of the location of those records, must be directed to the Office of the Compliance Officer.

Subpoenas for patient or other non-District records from business affiliates of the District will be handled by the agent designated by the business affiliate and/or pursuant to any policy so adopted by the business affiliate.

Failure to appropriately handle summons, complaints or subpoenas could place the District and the workforce member at risk or disadvantage in legal proceedings. Failure to follow required procedures may be cause for discipline, up to and including termination.

Definitions.

- **Summons:** A legal document that notifies an individual or entity that a lawsuit has commenced and that the individual or entity served must respond to the complaint.
- **Complaint:** A legal document that sets forth the claims(s) in a lawsuit and the relief being sought by the plaintiff (one who commences a lawsuit to obtain a remedy for an alleged injury to his or her rights).
- **Subpoena:** An order issued by a court or attorney for the production of records or for a person to appear at a deposition (oral testimony under oath) or in court.

Summons and Complaints.

A. When the District is a party named in a Summons and Complaint.

If a marshal or other process server attempts to serve a Summons and Complaint on the District to an employee, the process server must be referred to the Office of the Compliance Officer. Only the Office of the Compliance Officer may accept service on behalf of the District.

B. When both the District and a staff member are named as parties in a Summons and Complaint.

If a marshal or other process server attempts to serve a staff member who is personally named in a complaint along with the District, the workforce member may accept service of the Summons and Complaint only on his or her own behalf. In addition, the workforce member must immediately notify Office of the Compliance Officer.

The process server must be referred to the Office of the Compliance Officer for service of the Summons and Complaint on the District. Only the Office of the Compliance Officer may accept service on behalf of the District. No other District office is authorized to accept service of process on the District's behalf.

C. When a workforce member and not the District is a party named in a Summons and Complaint.

1. A work-related complaint.

If the complaint, naming only the workforce member, is based on the workforce member's conduct within the course and scope of his or her employment with the District, the workforce member must accept the complaint and contact the Office of the Compliance Officer immediately.

2. A non-work-related complaint.

If the complaint naming the workforce member is based on conduct occurring outside the course and scope of his or her employment with the District, the workforce member shall act on his or her own behalf without involving the District. Process servers are not permitted into restricted or patient areas without express permission and an escort by District personnel.

3. Accepting service on behalf of another workforce member.

A workforce member asked by the process server to accept service of a Summons and Complaint on behalf of another workforce member should not do so. No workforce member is "apparently in charge" of any office or place of business owned by the District within the meaning of applicable State and/or Federal law. The process server must be referred to the Office of the Compliance Officer for instructions on substitute service of a workforce member in accordance with District policy and applicable law.

Subpoenas for Records.

A. Subpoenas for District records.

Other than designated personnel, workforce members must not accept subpoenas for District records. Subpoenas for District records, regardless of the location of those records, must be directed to the Office of the Compliance Officer. Thereafter, the Office of the Compliance Officer will transmit the subpoena to the District's proper Custodian of Records. District records do not include the patient or administrative records of business affiliates of the District.

B. Subpoenas for patient or non-District records from business affiliates.

Each business affiliate of the District must notify the Office of the Compliance Officer when it accepts subpoenas for patient or non-District records or for District records that may be in the possession, custody or control of the business affiliate. Prior to the production of any District records that may be in the possession, custody or control of a business affiliate, the business affiliate must notify the District.

Subpoenas for Testimony or for Testimony and Records.

A. Subpoena relating to District employment.

If a workforce member is served with a subpoena in his or her capacity as an employee or agent of the District, he or she must contact the Office of the Compliance Officer prior to accepting service or, if prior contact is not possible, he or she must contact the Office of the Compliance Officer as soon as is possible after accepting service.

B. Subpoena relating to a business affiliate employment.

A physician who is served within his or her capacity as an employee or agent of a business affiliate can either accept the subpoena personally or pursuant to the policy for accepting subpoenas set for by the District's business affiliate.

C. Subpoenas not related to District employment.

Subpoenas for individuals, served in their individual capacity and not as employees or agents of the District, must be personally served on the named individual. For example, the employee witnessed an incident (e.g., a car accident) unrelated to his or her employment and is being subpoenaed to testify as a witness.

Summons and Complaint	
Parties Named in Summons and Complaint	**Required Action**
District only	Refer process server to the Office of the Compliance Officer
District and employee	Refer process server to the Office of the Compliance Officer for service on the District. Employee may accept service only on his or her own behalf and must notify the Office of the Compliance Officer immediately.
Employee only, work-related	Employee must accept summons and complaint and contact the Office of the Compliance Officer immediately.
Employee only, non-work related	Employee must act on his or her own behalf without involving the District.
If named employee is absent	Do not accept service on behalf of another employee. Contact the Office of the Compliance Officer for instructions. Note: If, after you inform a process server that you are not authorized to accept legal documents on behalf of the District or other workforce members and the process server insists on leaving documents with you, promptly deliver any documents left with you to the Office of the Compliance Officer together with the envelope, any packaging, and an explanation of when and how you came to be in possession of the legal documents.
Subpoena for Records	
Type of Record	**Required Action**
District records	Employee must not accept subpoena. Direct the process server to Office of the Compliance Officer. Note: District

	records do not include the patient or administrative records of private faculty medical practice plans.
Patient or non-District records from District's business affiliate	District's business affiliates must notify the Office of the Compliance Officer regarding who will accept subpoenas for non-District records.
Subpoena for Testimony or for Testimony and Records	
Type of Testimony or Record	**Required Action**
Employment related	Contact the Office of the Compliance Officer prior to accepting service.
Relating to a District's business affiliate	If testimony and/or records subpoenaed are within workforce member's capacity as an employee of a business affiliate, he or she may either accept subpoena or, otherwise, pursuant to the policies of the business affiliate related to accepting service.
Non-employment related	Subpoenas for individuals served in their individual capacity and not as employees or agents of the District must be served on the named individual.

Developed: 6/21 (Legal Counsel)

Supersedes: N/A

NORTHERN INYO HEALTHCARE DISTRICT
NON-CLINICAL POLICY AND PROCEDURE

Title: Unusual Occurrence Reporting		
Owner: Compliance Officer	Department: Compliance	
Scope: Northern Inyo Healthcare District		
Date Last Modified: 05/20/2024	Last Review Date: 04/21/2022	Version: 2
Final Approval by: NIHD Board of Directors	Original Approval Date: 12/16/2015	

PURPOSE:

The purpose of the Unusual Occurrence Report (UOR) is to provide a confidential communication about events that are: unusual, unexplained, unanticipated or that affect the normal workflow, workforce, patient care or visitors.

UOR tool is utilized to facilitate an investigation of concerns or issues that may arise at Northern Inyo Healthcare District (NIHD) that will identify and/or verify opportunities for improvement in quality of service.

POLICY:

At NIHD an unusual occurrence report is to be completed for all injuries/accidents or any situation/occurrence that could pose a safety risk to patients, visitors or staff. The UOR process provides identification of areas for process or system improvement to prevent future events by identifying what happened, why it happened, and possible changes necessary to mitigate future events of the same nature. Timely completion is required as soon as is possible, but must be completed within 24 hours of discovery.

DEFINITIONS:

Close call: (or "Good Catch", "Near Miss") A patient safety event that did not reach the patient. Used to describe any process variation which did not affect the outcome, but for which a recurrence carries a significant chance of a serious adverse outcome.

Hazardous condition: A circumstance, other than the patient's own disease process, or condition, that increased the probability of an adverse event.

No-harm event: A patient safety event that reaches the patient but does not cause harm.

Patient safety event: An incident or condition that could have resulted or did result in harm to a patient. It can be the result of a defective system or process design, a system breakdown, equipment failure, or human error. Patient safety events also include adverse events, no-harm events, close calls and hazardous conditions.

Sentinel Event: An unexpected occurrence involving death or serious physical or psychological injury or the risk thereof. Serious injury specifically includes loss of limb or function. This may include "risk thereof" situations. (See Sentinel Event/Serious Harm Reporting and Prevention Policy/Procedure)

Unusual Occurrences: An incident is any unanticipated occurrence that deviates from regular District operations; injury may or may not result from the incident. At NIHD an Unusual Occurrence Report (UOR) is completed by staff aware of the unusual occurrence to allow for investigation, tracking/trending and performance improvement needs identification.

Reportable Occurrences: California Department of Public Health requires notification of events which could seriously compromise quality or patient safety. Title requires NIHD to report any occurrence, as soon as

reasonably practicable, to the local health officer and to CDPH Licensing and Certification office (San Bernardino). which includes, but is not limited to, the following:

a. An epidemic outbreak;
a. Poisoning;
b. Fire, major accident, disaster, other catastrophe or unusual occurrence which threatens the welfare, safety, or health of patients, personnel, or visitors.

Serious Injury: A serious injury is further defined as one that results in a transfer to a higher level of care, extended hospital stays or additional medical treatment.

Risk Thereof: For the purposes of this policy, the phrase "or risk thereof" is defined as an event that did not result in death or serious injury, but carries a significant chance of recurring; the recurrence of which may indeed have a more untoward outcome. In determining the risk of an event recurring, the following guidelines are used:

a. Processes involved in the event that are not well codified or standardized across the organization are more likely to result in the recurrence of the event.
b. Processes that cross multiple disciplines and department lines and involve multiple steps in the process are more likely to result in the recurrence of the event.
c. Processes that demonstrate significant variation (i.e. lack of stability) are more likely to result in the recurrence of the event.

PROCEDURES:

1. At the time of unusual incident discovery:
    a. Assists any injured or ill patient, visitor or staff member. Assure safety as the priority.
    b. Notify immediate leadership, or the House Supervisor, as soon as possible.
2. District Leaders:
    a. If significant adverse outcome, notify the Administrator-On-Call immediately.
    b. Support workforce members involved.
3. UOR is completed as soon as reasonable, but within 24 hours:
    a. By the person having the most knowledge of the occurrence.
    b. Multiple team members may choose to complete a UOR on a single incident.
4. All occurrences must be reported, even if no bodily harm or property loss resulted, utilizing the standard UOR Form. This includes: close call, hazardous condition, near miss, and risk thereof situations
5. Form location: NIHD Intranet>Quick Links>UOR.
6. Form completion instructions:
    a. Field boxes are completed (all items with asterisk * are required)
    b. Clicking within a field opens up options that allow the reporter to record data in usable format for data collection.
    c. The tool is designed to support the end user to obtain pertinent information based on the type of event.
    d. Narrative description is to be completed by the workforce member initiating the UOR who is the most involved in the event. This section describes what happened through the collection and organization of the data/facts surrounding the event.
    e. Complete recommendations for "anything that would help to avoid this in the future". This allows for workforce input on quality improvement process.
    f. Once information is documented, Click the "Submit" button in the bottom right corner.

7. Investigation of unusual occurrence:
    a. Reviews the facts and investigate further, if needed, to fully understand the sequence of events.

b. Provide all information on what was gathered in the investigation within the UOR system.
c. The UOR is electronically routed up the chain-of-command to the Chief, if necessary, over the service line or their designee.
d. Response to the unusual incident will be determined based upon needs and may include, but is not limited to:
    i. Revision of Policy and/or Procedure documents
    ii. Education of workforce
    iii. Equipment updates
    iv. Environment of care modifications

8. Data/Performance Improvement
    a. Collected data is collated quarterly, which is then analyzed for opportunities to improve processes.
    b. Data is reported to NIHD Board of Directors quarterly via the Compliance Officer Report.
    c. Environmental-related occurrences are reported at least quarterly to the Safety Committee
    d. Data is reported to Quality Council and Professional Practice Council at least annually.

REFERENCES:

1. The Joint Commission CAMCAH Manual (Jan.-2021) EC.04.01.01 EP1, 3-6, 8-11.

RECORD RETENTION AND DESTRUCTION:

Unusual Occurrence Reports will be maintained for a minimum of 10 years at NIHD.

CROSS REFERENCED POLICIES AND PROCEDURES:

1. Unusual Occurrence Reporting
2. Communication with the Patient/Family After a Harm Event
3. Patient/Customer Complaint policy
4. Unusual Occurrence Reporting

Supersedes: v.1 Occurrence Reporting EC.04.01.01EP3; v.1 Unusual Occurrence Report Instructions

NORTHERN INYO HEALTHCARE DISTRICT
NON-CLINICAL POLICY AND PROCEDURE

Title: Non-Retaliation Policy		
Owner: Human Resources Manager	Department: Human Resources	
Scope: District Wide		
Date Last Modified: 05/20/2024	Last Review Date: No Review Date	Version: 5
Final Approval by: NIHD Board of Directors	Original Approval Date: 02/01/2016	

PURPOSE:
To provide an effective process for Northern Inyo Healthcare District (NIHD) employees to express problems, concerns or opinions without fear of retaliation or retribution.

POLICY:
It is the policy of NIHD to provide and maintain a culture characterized by integrity, responsible behavior and a commitment to the highest legal and ethical standards. NIHD prohibits the taking of any retaliatory action for reporting or inquiring about alleged improper or wrongful activity.

DEFINITIONS:
Retaliation: means an adverse action taken against an employee for filing a complaint or supporting another employee's complaint under a variety of laws.

Retribution: means the act of taking revenge.

Good Faith: means honesty; a sincere intention to deal fairly with others.

ENCOURAGEMENT OF REPORTING

1. NIHD managers and staff are encouraged to report in good faith all information regarding alleged improper or wrongful activity that may constitute:
   a. Discrimination or harassment;
   b. Fraud;
   c. Unethical or unprofessional business conduct;
   d. Non-compliance with NIHD policies/procedures;
   e. Circumstances of substantial, specific or imminent danger to an employee or the public's health and/or safety;
   f. Violations of local, state or federal laws and regulations; or
   g. Other illegal or improper practices or policies.

PROTECTION FROM RETALIATION
Any NIHD staff member who, in good faith, reports such incidents as described above will be protected from retaliation, threats of retaliation, discharge, or other discrimination including but not limited to discrimination in compensation or terms and conditions of employment that are directly related to the disclosure of such information. In addition, no employee may be adversely affected because they refused to carry out a directive which constitutes fraud or is a violation of local, state, federal or other applicable laws and regulations.

REPORTING PROCEDURE:

NIHD employees should timely report evidence of alleged improper activity as described above by contacting their immediate supervisor, department director, or senior manager. Any instances of alleged retaliation or retribution should be reported in the same manner. If an employee is not satisfied with the response they receive, or is uncomfortable for any reason addressing such concerns to one of these individuals, the employee may contact the Compliance Office or Human Relations Office. For employees who do not wish to address these issues through the reporting process outlined above, the Compliance Confidential Report Line resource is available at (888)200-9764.

All reports will be handled as promptly and discreetly as possible, with facts made available only to those who need to know to investigate and resolve the matter.

REFERENCES:

1. Federal Sentencing Guidelines for Organizations, Guidelines Manual Section 8B2.1(b)(5)(C)
2. NIHD Code of Business Ethics and Conduct
3. HIPAA Administrative Simplification: Enforcement; Final Rule (45 CFR 160.316)

RECORD RETENTION AND DESTRUCTION:

CROSS REFERENCED POLICIES AND PROCEDURES:

1. Compliance Program for Northern Inyo Healthcare District
2. Employee Written Formal Complaint Form
3. Equal Employment Opportunity Procedure
4. NIHD Code of Business Ethics and Conduct
5. Practitioner Complaint Resolution Process
6. Professional Conduct, Prohibition or Discriminatory Behavior
7. Harassment by Employees
8. Workplace investigations

Supersedes: v.4 Non-Retaliation Policy

NORTHERN INYO HEALTHCARE DISTRICT
NON-CLINICAL PROCEDURE

Title: Lost and Found Items		
Owner: Director of Patient Access	Department: Patient Access	
Scope: District Wide		
Date Last Modified: 05/24/2024	Last Review Date: 05/16/2024	Version: 3
Final Approval by: Executive Committee	Original Approval Date: 07/2009	

PURPOSE:

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

PROCEDURE:

1. Found Items
   A. Attach identifying information to the article:
      1. Name
      2. Date
      3. Location lost and found
      4. Patient/visitor or employee information, if known
      5. Other pertinent information
2. Items to be turned in
      1. Give items to Patient Access workforce
      2. Patient Access staff will put in lost and found box
      3. Patient Access Department will check box every day and pick up any item(s)
      4. If Patient Access Department is unavailable an alternate will be assigned to pick up item(s) and log item(s) in
3. Item(s) logged in and ID Number is obtained
      1. The Patient Access Department will attempt to contact the owner
4. The Patient Access Department will:
      1. Hold the item for 90 days; if unclaimed then
      2. Disposal would then be,
         a. Donate to a Thrift store, or
         b. Offer to finder
5. Reporting Lost Items
   A. When a patient believes that the District has misplaced an item that needs replacing, the patient will contact Patient Access Department.
      Patient Access workforce will:
      1. Assess the District's responsibility with District Chief Executive Officer or Administrator on Call.
      2. Replace the item, if appropriate

   B. Calls regarding lost item(s)
      l. Take information about lost item from caller

2. Check lost and found, if not found
3. Do a search of the area where item was said to be lost
4. Found item(s) will be entered into log and owner contacted if owner can be identified

DOCUMENTATION:

The Patient Access lost and found item log shall document:

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

REFERENCES:

1. N/A

CROSS REFERENCE P&P:

1. Standards of Care for the Swing Bed Resident

RECORD RETENTION:

Maintain Lost and Found Log for three (3) years.

Supersedes: v.2 Lost and Found Items

NORTHERN INYO HEALTHCARE DISTRICT
NON-CLINICAL POLICY AND PROCEDURE

Title: Compliance with Information Blocking Rule		
Owner: Compliance Officer	Department: Compliance	
Scope: District Wide		
Date Last Modified: 10/20/2022	Last Review Date: 05/29/2024	Version: 1
Final Approval by: NIHD Board of Directors	Original Approval Date:	

PURPOSE:
This document applies specifically to Electronic Health Information Exchange or Use. It is a reference documents designed to support Northern Inyo Healthcare District (NIHD) workforce with understanding of the Information Blocking Rules, 45 CFR Part 171, promulgated by the Office of the National Coordinator for Health Information Technology ("ONC") in order to implement Section 4004 of the 21st Century Cures Act of 2016.

DEFINITIONS:
Access: The ability or means necessary to make Electronic Health Information (EHI) available for Exchange or Use.
Actor: A healthcare provider, Health Information Exchange (HIE), or Health Information Technology (IT) Developer of Certified Health IT.
Affiliate: Any person or entity controlling, controlled by or under common control with another person or entity.
Control: The direct or indirect power to govern the management and policies of an entity; or the power or authority through a management agreement or otherwise to approve an entity's transactions.
Electronic Health Information (EHI): Electronic protected health information (ePHI) to the extent that it would be included in a designated record set, regardless of whether the group of records are used or maintained by or for a covered entity. As of October 6, 2022, EHI includes all documents (data elements) **except** the following:

1. Psychotherapy notes;
2. Information compiled in reasonable anticipation of, or for use in, a civil, criminal or administrative action or proceeding. EHI excludes de-identified information.

Exchange: The ability for EHI to be transmitted between and among different technologies, systems, platforms or networks.
Healthcare Provider: Any hospital, health care clinic, physician, advanced practice provider (APP), home health agency, long term care facility, ambulatory surgery center, imaging and oncology center, emergency medical services provider, group practice, skilled nursing facility, nursing facility, renal dialysis center, community mental health center, federally qualified health center, pharmacist, pharmacy, laboratory, rural health clinic, therapist or Indian health service or tribe provider.
Health IT Developer of Certified Health IT: Any company business unit that develops or offers health information technology (IT) that has one or more modules certified under a voluntary certification program recognized under the ONC Health IT Certification Program. This defined term does NOT include any health IT self-developed by NIHD for their own use.

Health Information Exchange (HIE)/Health Information Network (HIN): Any NIHD business unit that determines, or has the discretion to administer any requirement, policy, or agreement that permits, enables, or requires the use of any technology or services for Access, Exchange or Use of EHI:

1. Among more than two unaffiliated individuals or entities that are enabled to exchange with each other; and
2. That is for a treatment, payment, or healthcare operations purpose.

HIPAA: The Health Insurance Portability and Accountability Act of 1996, which is included in regulations 45 CFR parts 160 and 164.
Practice: Refers to an act or omission by an Actor.
United States Core Data for Interoperability (USCDI): The standardized set of health data classes and constituent data elements set forth at www.healthit.gov/USCDI.
USCDI Data elements: The data elements represented in the USCDI standard.
Use: The ability for EHI, once Accessed or Exchanged, to be understood and acted upon.

POLICY:
NIHD workforce will support disclosure of protected health information (PHI) per HIPAA and California state privacy requirements without information blocking, unless an exception applies.
NIHD workforce will refrain from interference with Access, Exchange or Use of electronic health information (EHI), except when required to do so by law. This applies to patient, third party payor or healthcare providers requesting EHI access.

Information Blocking – means a practice that:

1. Except as required by law or covered by an Information Blocking Exception, is likely to interfere with Access, Exchange or Use of EHI; and
2. If conducted by
    A. A Healthcare Provider, such provider knows that such practice is unreasonable and is likely to interfere with Access, Exchange or Use of EHI; or
    B. A Health Information Technology (IT) Developer of Certified Health IT or Health Information Network (HIN) knows, or should know, that such practice is likely to interfere with Access, Exchange or Use of EHI.

Information Blocking Exception – refers to each of the following exceptions:

1. Preventing Harm Exception – practices that substantially reduce a risk of harm to a patient or another person;
2. Privacy Exception – practices intended to protect an individual's privacy such as obtaining an authorization that complies with HIPAA or applicable California law or honoring a patient's wishes not to share PHI;
3. Security Exception – practices that protect the security of EHI;
4. Infeasibility Exception – practices that are due to a request for EHI being infeasible, such as due to a disaster, an inability to segment data or factors such as cost;
5. Health IT Performance Exception – practices implemented to perform maintenance or improvements to health IT or to address a third-party application that is negatively impacting the health IT's performance;
6. Content and Manner Exception - practices tied to providing EHI in the manner requested or through an alternative;
7. Fees Exception – practices involving charging fees in connection with exchanging EHI; and
8. Licensing Exception – practices involving licensing interoperability elements needed to Exchange EHI.

NIHD is committed to exchanging and making EHI available and usable for authorized and permitted purposes in accordance with applicable law. We seek to avoid practices that are likely to interfere with the Access, Exchange or Use of EHI except as required by law, permitted by an information blocking exception, or otherwise permitted by the information blocking rules. If you believe an exception applies, consult with the HIMS Manager or Compliance Officer.

When a request for EHI is not being met, NIHD workforce will document the incident in an unusual occurrence report (UOR). Documentation of the reasons for the lack of Access, Exchange or Use of the EHI shall be included in the UOR. The reason for the failure of EHI access related to 'Information Blocking Exceptions' shall be specified.

HIPAA RULES	INFORMATION BLOCKING RULE
1) Specifies when protected health information (PHI) may be shared with third parties i.e., other than patient	1) Mandates that ePHI must be accessible to patients and other third parties.
2) Grants patients the right to inspect and obtain a copy of PHI (paper or electronic) in the designated record set, except for psych or therapy notes or information compiled in anticipation of litigation.	2) Grants patients and third parties access to all ePHI after 10/5/2022.
3) Provider must act on a request for access to PHI within 30 days of the request.	3) The best practice is for ePHI to be accessible at all times.
4) Provider may deny a request for access if: Such would jeopardize the health, safety or security of the patient; Record refers to a third person; and disclosure would create a risk of harm to that person.	4)Provider may deny access if one of 'eight exceptions' are satisfied.
5) Access must be allowed in the form (paper or electronic) requested by the patient "if it is readily producible in that format."	5) Access must be allowed in an electronic format that does not impose unreasonable barriers.
6) Fees: Patients- providers may charge a reasonable, cost-based fee for copies, media, labor and postage. Third Parties- providers may charge whatever they wish.	6) Fees: Patients- Providers may not charge a fee for allowing electronic access, but may still charge for copies, media, etc. Third parties- providers may only charge a reasonable, cost-based fee except for fees to "perform an export of switching health IT or to provide patients their ePHI."
7) Defines who may or must have access to PHI.	7) Provides that access must be allowed to those who are allowed access under HIPAA.
8) Specifies when a release (authorization) is or is not required to share PHI.	8) Does not address, but if sharing is allowed, with or without a release, access to ePHI must be allowed. The intent is that the information blocking provision would not conflict with the HIPAA Privacy Rule (with respect to the privacy of PHI.

9) Patient has the right to request 'confidential communications' specifying that PHI may not be shared with certain parties.	9) If provider accepts the patient's request not to share ePHI, this is not information blocking.
10) HIPAA Security Rule sets a baseline for information technology practices that must be implemented to protect ePHI.	10) Security measures are allowed, but may not unreasonably block access to authorized parties even where such measures are allowed under the HIPAA Security Rule.

PROCEDURE:

I. Record requests for EHI, will be handled primarily via the Health Information Management Service (HIMS), who will work closely with NIHD Information Technology Services (ITS) and NIHD Compliance Office.
   A. Compliance will confirm that the Access, Exchange or Use of EHI complies with applicable law, and privacy.
   B. ITS will confirm that the security and integrity of the District's Information System is maintained.
   C. Requests for EHI must comply with HIPAA, including the minimum necessary standard, where applicable.
   D. Requests to Access, Exchange or Use EHI must be evaluated promptly.
      1. Most single patient and multiple patient EHI requests will follow NIHD HIPAA procedures for receipt and processing of third-party requests for PHI, which may be sent in electronic format.
      2. Patient Portal use by patients and patients' personal representatives may be utilized when available. Patients will be offered Patient Portal set-up opportunities to increase potential for rapid access to EHI.
      3. Requests for EHI must be handled by person whose assigned job responsibilities include the disclosure, access or transmittal of the PHI at issue. Staff in the HIMS department will perform this task.

II. Requests for EHI must be handled by workforce whose assigned job responsibilities include the disclosure, access or transmittal of the PHI. These workforce members serve in the HIMS department at NIHD.
   A. In the absence of HIMS staff to complete the EHI transmission, the "infeasibility' exception may need to be utilized.
      1. Unusual Occurrence Report (UOR) shall be completed by the workforce member receiving the request when unable to transmit the EHI.
      2. Protected health information (PHI) documents may need to be transmitted via other routes such as Fax, printed and sent via mail or scanned and sent via secure email.
   B. Every effort will be made to assure records are sent timely to assure no delay in treatment.
   C. Third-parties requesting Access, Exchange or Use EHI may be asked to clarify the content, manner, and/or purpose of the request to assist NIHD affiliates with confirming:
      1. That the potential Access, use or exchange is permitted by law;
      2. Whether NIHD affiliates can furnish the requested EHI content; and

3. Whether the NIHD affiliates can provide the EHI in the manner requested. Alternative to the content and/or manner requested will be identified and offered when necessary in accordance with District guidelines.

III. Any issue that may interfere with the Access, Exchange or Use of EHI should be evaluated to determine if it is covered under the 'Information Blocking Exceptions'.
   A. If the exceptions do NOT apply, subject matter experts shall be consulted at the District. These may include:
      1. HIMS Manager;
      2. Department of service location Director or Manager;
      3. Compliance Officer; and/or
      4. Administrator-On-Call.
   B. Legal consultation may be required, but will be only done at the direction of the Compliance Officer or Administrator-On-Call.

REFERENCES:

1. 21st Century Cures Act: Interoperability, Information Blocking, and the ONC Health IT Certification Program, 45 CFR Parts 170 and 171.
2. Health Insurance Portability and Accountability Act (HIPAA), Standards for Privacy of Individually Identifiable Health Information, 45 CFR Parts 160 and 164.
3. *The New Information Blocking Rule: What it Means for Healthcare Providers*, Parsons Behle & Latimer Healthcare Law Update; August 9, 2021.

RECORD RETENTION AND DESTRUCTION:

Release of Information (ROI) related to patient medical records and/or billing are maintained for 15 years for adults and 25 years for minors.

CROSS REFERENCED POLICIES AND PROCEDURES:

1. Compliance with Information Blocking Rule
2. InQuiseek - #380 Medical Records Policy
3. Authorization for the Release of Laboratory Results to the Patient
4. Communicating Protected Health Information Via Electronic Mail (Email)
5. Disclosures of Protected Health Information Over the Telephone
6. Using and Disclosing Protected Health Information for Treatment, Payment and Health Care Operations
7. Workforce Access to His or Her Own Protected Health Information

Supersedes: Not Set

NORTHERN INYO HEALTHCARE DISTRICT
NON-CLINICAL POLICY AND PROCEDURE

Title: California Public Records Act – Information Requests		
Owner: Compliance Officer	Department: Compliance	
Scope: District Wide		
Date Last Modified: 06/22/2022	Last Review Date: 05/29/2024	Version: 4
Final Approval by: NIHD Board of Directors	Original Approval Date: 01/19/2016	

PURPOSE:

This policy establishes guidelines for the employees of Northern Inyo Healthcare District (NIHD) to follow when there has been a request for information under the California Public Records Act.

DEFINITIONS:

California Public Records Act – The fundamental precept of the California Records Act is that governmental records shall be disclosed to the public, upon request, unless there is a specific reason not to do so.
Public Record – Any writing containing information relating to the conduct of the public's business prepared, owned, used, or retained by the entity regardless of physical form or characteristics.

POLICY:

All California Public Records Act requests for NIHD related information are to be referred to the Compliance Officer.

EXEMPTIONS FROM DISCLOSURE - Key exemptions include:

- Preliminary drafts, notes, or memoranda not retained in the ordinary course of business.
- Records relating to "pending litigation". Documents that may be withheld under this section must be specifically prepared for litigation in which the Hospital is party.
- Personnel, medical, or similar files where disclosure would constitute an "unwarranted invasion of privacy".
- Police files, including investigatory or security files compiled by any state or local police agency.
- Real estate appraisals or prospective public supply and construction contracts may be withheld until the property is acquired or all of the contract agreements are obtained.
- Exemptions based on prohibitions of disclosure under federal or state law, including provisions relating to privilege. This includes:
  - Attorney-client/attorney work product and doctor-patient privileges
  - "Official Information" privilege governing "information acquired in confidence by a public employee in the course of his/her duty and not open, or officially disclosed, to the public prior to the time the claim of privilege is made".
  - "Trade Secret" privilege. "Trade Secret" is defined as "information, including a formula, pattern, compilation, program, device, method, technique, or process, that: (1) Derives independent economic value, actual or potential, from not being generally known to the public or to other persons who can obtain economic value from its disclosure or use; and (2) Is the subject of efforts that are reasonable under the circumstances to maintain its secrecy.

- Any other state or federal law protecting records, including HIPAA, FERPA, etc.

- The "Catch-all" or "Balancing Test"
  - Is applied to protect records, even when there is no other exemption that would apply, where "on the facts of the particular case the public interest served by not making the record public clearly outweighs the public interest served by disclosure of the record".
  - Includes the "Deliberative Process" privilege, to protect candid internal pre-decisional deliberations.
  - Includes "burdensomeness". A request might be so burdensome, and the public interest in the material so small, that the balancing test might allow us to deny the request.
  - Balances the public interest in disclosure against the public interest (not strictly the Hospital's interest) in withholding.

PROCEDURE:

1. Requests to inspect and copy public records should be made directly to the Compliance Office.
2. The District is entitled to review and redact records before producing them to the requester.
3. Public records are open to inspection during the normal business hours of the Compliance Office. The "open to inspection" provision does not require that an individual be given immediate access to the records upon request. In all cases, the records would first need to be located and collected, possibly from multiple locations.
4. An appointment to inspect records may be necessary under these circumstances. If the requester requests access to a large number of documents, the requester may need to make additional appointments to complete the document inspection process.
5. Upon either the completion of the inspection or the oral request of NIHD personnel, the person conducting the inspection shall relinquish physical possession of the records.
6. Persons inspecting NIHD records shall not destroy, mutilate, deface, alter, or remove any such records from the District.
7. NIHD reserves the right to have District personnel present during the inspection of records in order to prevent the loss or destruction of records.
8. The operational functions of the District will not be suspended to permit inspection of records.
9. NIHD is required to determine within 10 days (can be extended to 24 days for voluminous/complex requests) after receipt of a records request whether or not the requested records exist and/or are subject to disclosure, and to notify the person making the request of the reasons for that determination. The records themselves are not required to be released in 10 days. At the time of making a determination, NIHD will provide a good faith estimate of when the records will be available.
10. NIHD is required to "assist the member of the public in making a focused and effective request that reasonably describes an identifiable record".
11. NIHD may not consider the identity of the requester or the purpose for the request, in making its determination.
12. NIHD does not have to create new records or answer questions. The California Public Records Act simply requires access and disclosure of existing records. However, we are required to extract data from an existing database upon request.
13. Copies will be provided upon request, at a cost of $0.25 per page for scanned or paper copy or $15.00 for USB electronic format. The requester may inspect records at no cost. Staff time for searching, collecting, reviewing, and redacting documents, is not considered to fall within the "direct cost of duplication". Pre-payment for all copying/scanning, electronic format costs are required before release of public records.
14. Notification of Human Resources Leadership if the request comes from a current employee.

15. Notification of Medical Staff Office if the request involves providers (physician or advanced practice providers).

REFERENCES:

1. California Government Code §6250, 6252(f), 6253.9
2. "The ABC's of Privacy and Public Record", by Maria Shanle
3. www.thefirstamendment.org/capra.html
4. California Hospital Association – Compliance Manual (2021).
5. California Hospital Association – Record and Data Retention Schedule (2018).

RECORD RETENTION AND DESTRUCTION:

Record retention requirements vary based on the document type, legal and accreditation requirements. Destruction of relevant records will be suspended upon receipt of legal process or other notice of pending or reasonably foreseeable investigations or litigation, whether government or private.

CROSS REFERENCED POLICIES AND PROCEDURES:

1. Compliance Program for Northern Inyo Healthcare District
2. Public Records Requests (Board of Directors)

Supersedes: v.3 California Public Records Act – Information Requests

NORTHERN INYO HEALTHCARE DISTRICT
NON-CLINICAL POLICY AND PROCEDURE

Title: Development, Review and Revision of Policies and Procedures		
Owner: Compliance Officer	Department: Compliance	
Scope: PPM Document Owners, Writers and Proxy Writers		
Date Last Modified: 11/17/2022	Last Review Date: 05/29/2024	Version: 2
Final Approval by: NIHD Board of Directors	Original Approval Date: 06/16/2021	

PURPOSE:

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

POLICY:

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

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

DEFINITIONS

1. *Annual Plans* – consist of complex District programs or plans which require final approval by the NIHD Board of Directors on an annual basis.
2. *Board of Directors Policy* – Policy designed for organizational governance that sets direction for the District, defines and guides appropriate relationships between the board and the chief executive, and sets the duties and responsibilities of the board. These documents do not go to the NCOC or CCOC committees and are managed by the Board Administrative Assistant.
3. *Clinical Consistency Oversight Committee (CCOC)* – Multidisciplinary team, represented by clinical staff that reviews all clinical policies and procedures, once approved by CCOC, sends to appropriate medical staff committees and board of directors or their designee (generally the Medical Executive Committee) for final approval.
4. *Forms* – approve documents that are utilized for operations at the District. Stored on the NIHD Intranet and as attachments to procedures when appropriate. These documents are approved via the Forms Committee.
5. *Guideline* – Statements that include recommendations intended to optimize patient care that are informed by a systematic review of evidence and assessment of the benefits and harms of alternative care options. These documents receive final approval at the Medical Executive Committee.

6. *Policy* – The clear, concise statements of the parameters by which an organization conducts its business. Policies are the rules that workforce abide by as they carry out their various responsibilities.
    A. Must be approved by governing body (Board of Directors) every 2 years at minimum.
7. *Non-Clinical Consistency Oversight Committee (NCOC)* – Multidisciplinary team, represented by non-clinical staff, operations team and clinical workforce, who review non-clinical policies and procedures. NCOC reviews and once approved sends policy on to other committees as appropriate prior to final approval at the board of directors or their designee (generally the Executive Committee).
8. *Policy and Procedure Management Software (PPM)* – Repository for NIHD policies and procedures, excluding the procedures in Lippincott Procedures. PPM allows for tracking of current and past policies and procedures, while maintaining access for workforce review.
9. *Procedures* – The instructions or steps that describe how to complete a task or do a job.
    A. Clinical procedures require approval via the medical staff committee process; ultimately approved by the Medical Executive Committee.
    B. Lippincott Procedure Manual is utilized by NIHD for Clinical Procedures.
10. *Protocols* – An algorithm or recipe for managing a disease or condition. This sets a specific standard for process. (Example – wrist x-ray = 3 views)
    A. Require approval via medical staff committee(s) of departments where the protocol is utilized; ultimately approved by the Medical Executive Committee.
    B. Standardized Procedures followed by RN staff that cross from nursing into medical process require a standardized procedure per the California Board of Registered Nursing. These must be approved by the Interdisciplinary Practice Committee, Medical Staff Committee with department oversight and ultimately by the Medical Executive Committee.
    C. Standardized Protocols followed by Physician Assistants follow the process delineated by the California Medical Board.
11. *Workforce* - Persons whose conduct, in the performance of their work for NIHD, is under the direct control of NIHD or have an executed agreement with NIHD, whether or not NIHD pays them. The Workforce includes employees, NIHD contracted and subcontracted staff, NIHD clinically privileged Physicians and Advanced Practice Providers (APPs), and other NIHD health care providers involved in the provision of care of NIHD's patients.

PROCEDURE:

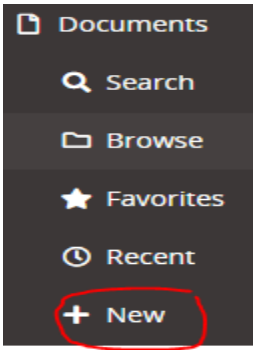
1. Establishing need for a new policy or procedure:
    A. Determine a policy or procedure is necessary;
        I. When the cost of a mistake is high. (High Risk, High Volume or Problem Prone)
        II. When process is outside of common sense and must be prescribed.
        III. When consistent poor results across a number of departments or employees is demonstrated.
        IV. When required by regulatory agencies, including but not limited to: California Department of Public Health (CDPH), The Joint Commission (TJC), Title 22, or Centers for Medicare/Medicaid Service (CMS) Condition of Participation.
    B. Determine a policy or procedure is not necessary.
        I. Simple tasks that are able to done a variety of ways to achieve the same outcome.
        II. Processes that are able to be resourced via other manuals, such as One Source, Lippincott Procedure, etc.
        III. Guidelines are recommendations and although they may be adopted by clinical teams, they do not need to be approved at the Board of Directors level. They are generally created after studies lead to conclusion of best practice. They are not mandated as a policy. Clinical Guidelines must be adopted by the Medical Staff Committee with oversight of the area where the Guideline is being utilized; ultimately approved by the Medical Executive Committee.

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

2. Policy/Procedure Development or Review/Revision

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

B. New policy development is created in *document section* within PPM by policy owner using the +New



I. Policy Wizard is utilized to input policy title, owner, and department by policy owner and Approver. NCOC or CCOC will review the Policy Wizard at the time of approval to support the Policy Owner in making correct build, including assignee (reader group) and frequency of policy review by workforce and owners.

a. Within the #1 Settings the template is chosen based upon type of document required.
b. Search features are tied to Owner, Department, Writer, Template, Approver and Category.
c. Writers, Reviewers, approvers and assignees are designated by the Owner, with support and review by the NCOC or CCOC.

II. Research is conducted. Collaboration with subject matter experts and team members impacted by the policy or procedure is best practice during development. Collaborators may include but is not limited to:

a. Compliance Officer
b. Legal Counsel (with approval of Executive)
c. Director of Human Resources
d. Director or Chief within chain of command

III. References from valid sources and/or regulatory agencies is generally required. Occasionally "not applicable" (N/A) will be appropriate.

IV. Cross Reference P&P – requires review of policies or procedures that may impact the new policy being developed. These are listed as a reference for the end user and to assure the documents are aligned. Other cross reference documents can be located by use of keywords via the search feature within PPM.

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

I. Published document within PPM is opened. Document is reviewed by owner and determination that no changes are required. If document is due for Biennial Review by the Board of Directors, Executive Committee or Medical Executive Committee the administrative assistant for the specific committee is notified to put the item onto the next agenda for "Biennial Review

without changes". This meets the Centers for Medicare and Medicaid Services (CMS) appendix W provision of care Biennial Review requirement.

III. Create New Version (blue box/top of screen) may be checked to create draft of current policy for revision. This does the following:

a. Automatically archives the current published version upon final approval of the revised version
b. Maintains current Property Wizard settings, unless revision of these settings is required (unless a new template is required).
c. Allows for revisions within the draft version

3. A. Template development

I. Compliance Office workforce will develop new templates. Owners and writers may present ideas for new templates to the Policy Steering Committee, but may not create templates.
II. Templates will have standardized information contained within the header.
III. If conflict related to new templates occurs, the Policy Steering Committee will meet to resolve issue.

B. Templates will be developed for various document types including, but not limited to:

I. Policy/Procedure
II. Standards of Care
III. Guidelines
IV. Protocols
V. Standardized Procedures
VI. Standard Operating Procedures
VII. Committee Charters
VIII. Clinical Guidelines
IX. Scope of Service

C. Policy and or procedure templates will contain some or all of the following elements:

I. Purpose
II. Policy Statement (All documents that contain policy MUST be initially approved and reviewed every two years by the Board of Directors.)
III. Definitions
IV. Procedural steps
V. Record retention and destruction
a. California Hospital Association reference may be found on the NIHD Intranet>Information>Compliance>Record Retention.
b. If record retention is not applicable (N/A) must be inserted within this section.
c. Destruction of record – Confidential records and those with PHI will be shredded or destroyed in compliance with Information Technology Services standards.
VI. References are required using the American Psychological Association (APA) format.
VII. Cross-referenced policies
a. Use "search" function within PPM to find key words.
b. Review policies identified by search for potential cross-reference.
c. Assure policies align with new policy/procedure; if not determine if further revision is required of either or both policy/procedure.
VIII. Header will Contain:
a. Northern Inyo Healthcare District
b. Document Type

c. Title of Document
d. Source (What part of the Workforce will utilize the document- all departments where the document applies)
e. Owner of the document (title of the role)
f. Department (of the document Owner)
g. Effective date and version number for the document

IX. Page numbers for each page in every document.

4. Committee Approval Process

A. Clinical Policies/Procedures:

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

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

B. Non-Clinical Policies/Procedures

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

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

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

I. Medical Staff Committee will approve Clinical Guideline for use within their department and assure education of peers.

II. Medical Executive Committee approval is required prior to implementation.

III. Board of Director approval is not required.

IV. Frequency of review of Clinical Guideline will be determined at Medical Department level.

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

I. Board may request Board Legal Counsel or Compliance review

II. Board Policy/Procedure will be maintained within PPM and the following will be established:

a. Frequency of required review/revision (if necessary)

b. Assignee by role (who needs to read the document, how often and in what timeframe)

c. Effective date time line is established to allow for workforce education on policy/procedure new documents and for revisions of significance.

5. Periodic Review of documents:

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

B. The PPM will be set up to notify the owner of items due for review or revision via email and task list within PPM.

6. Implementation and effective dates:

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

B. During CCOC or NCOC approval process the following decision will be documented:

I. Effective date in relationship to final approval date. (Last Committee or Board of Directors required to approve document)

II. Is workforce required to read the new document? If so, what roles are required to read the document and how often.

III. Will a different education process be utilized to train workforce to the new document?

7. Discarding of documents versus Archival of document

A. Published documents are moved to archives when revised or if they become obsolete. This does require NCOC or CCOC approval for obsolete documents.

B. Draft documents that are found to be unnecessary may be discarded; becoming irretrievable. This may only be done by the policy owner or their designee and does not require committee approval.

8. General Information for document development for PPM.

A. Acronyms must be spelled out prior to being utilized in all documents.

B. May/must are preferred to use of should/shall.

REFERENCES:

1. Center for Medicare/Medicaid Services- **§485.627 Condition of Participation: Organizational Structure C-0241; Interpretive Guidelines §485.635(a)(2) & (4); -§485.627(a) Standard: Governing Body or Responsible Individual; (**Rev. 200, 02-21-20**).** https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/som107ap_w_cah.pdf

2. American Psychological Association (APA) Format web site: https://owl.purdue.edu/owl/research_and_citation/apa_style/apa_formatting_and_style_guide/general_format.html
3. California Hospital Record and Data Retention Schedule, 2018.

CROSS REFERENCE P&P:

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

RECORD RETENTION:

All policy, procedure, scope of practice, standards of care, care guidelines and bylaw documents will be maintained for the life of the document, plus 6 years, within the PPM system at NIHD.

Supersedes: v.1 Development, Review and Revision of Policies and Procedures

NORTHERN INYO HEALTHCARE DISTRICT
NON-CLINICAL POLICY AND PROCEDURE

Title: Communicating Protected Health Information Via Electronic Mail (Email)		
Owner: Compliance Officer	Department: Compliance	
Scope: District Wide		
Date Last Modified: 08/19/2022	Last Review Date: 05/29/2024	Version: 4
Final Approval by: NIHD Board of Directors	Original Approval Date: 07/17/2013	

PURPOSE:

To describe the procedures governing a workforce member's use of a Northern Inyo Healthcare District (NIHD) electronic mail (email) system. It also defines the steps that must be explained to, and taken by the patients who wish to engage in email with an NIHD workforce member.

POLICY:

1. NIHD does not permit email of unencrypted Protected Health Information (PHI) outside of the NIH.org domain without patient authorization. The patient may request, verbally, via email, or in writing, that the PHI be sent to an email address provided by the patient, in an unencrypted email format. This should be confirmed via email to the patient prior to sending PHI.
2. PHI may be communicated internally following the procedures as outlined below.
3. All automatic forwarding, redirection, or other automated delivery or pickup of NIHD email, to external destinations is explicitly prohibited.

DEFINITIONS:

Access: the ability or capacity to read, write, modify, or transmit information, or otherwise make use of any system resource.

Restricted Information: Describes any confidential or personal information that is protected by law or policy and that requires the highest level of access control and security protection, whether in storage or in transit. This includes PHI (Protected Health Information)/ePHI (electronic protected health information), confidential information, and other Medical Staff and Advanced Practice Provider (APP) communication as defined in this section.

Electronic Protected Health Information or ePHI: Is PHI that is transmitted by electronic media or is maintained in electronic media. For example, ePHI includes all data that may be transmitted over the Internet, or stored on a computer, a CD, a disk, magnetic tape or other media.

Internal Email - is defined as being sent from and delivered to the NIH.org domain (both sender and recipient's email addresses end with "@nih.org").

Remote Access: the ability to access Northern Inyo Healthcare District network systems from a remote location; this includes home office users, non-Northern Inyo Healthcare District facilities, and business associates.

Workforce: Persons whose conduct, in the performance of their work for NIHD, is under the direct control of NIHD or have an executed agreement with NIHD, whether or not NIHD pays them. The Workforce includes employees, NIHD contracted and subcontracted staff, NIHD clinically privileged Physicians and Advanced Practice Providers (APPs), and other NIHD health care providers involved in the provision of care of NIHD's patients.

PROCEDURE:

1. **Communicating PHI via Email internally**
   Email of PHI will be permitted, internally, at NIHD if the following safeguards are implemented:
   a. NIHD shall use the following safeguards when communicating PHI in or attached to an internal email message:
      (1) Do not use auto-forward for NIH.org emails to a private/personal email account.
      (2) PHI should not be transmitted in the subject line of the email message.
         a. This includes the name of the patient or a medical record number. It is acceptable to have PHI in the body of the email as necessary for identification purposes for the reader.
         b. If you have an attachment, the name of the attachment file will be in the subject line. Delete any patient identifier in the subject line.
      (3) The user should verify before sending an email message that he/she has attached the proper attachment.
      (4) Before transmitting the email message, users should double-check the message and any attachments to verify that no unintended information is included.
      (5) Users who communicate PHI via email will comply with all other NIHD policies and procedures including, but not limited to, the Minimum Necessary Policy.
   b. Any user who is unsure whether an email message or attachment contains PHI should contact his/her supervisor or the HIPAA Privacy Officer before initiating the email communication.
2. **Communicating PHI with Patients**
   a. Patients have the right to request that NIHD communicate with them via email, provided NIHD can do so without compromising patient confidentiality.
   b. If a patient requests email communications containing their PHI, the individual receiving the request must document patient authorization and the email address provided.
      i. NIHD workforce MUST inform the patient that unencrypted email is not a secure format for information. It is similar to regular mail, someone can open it and get the information. The patient can choose to receive communications via encrypted (secure) email, if they prefer.
      i. Email addresses should be read back (including spelling it out) when entering the information in the EHR.
      ii. A confirmation email should be sent to the address prior to using it to communicate PHI to ensure the correct email address is used. Do not send PHI to an unverified email.
   c. Confirmation email should be sent to HIM (Health Information Management) department to be added to the patient medical record authorizations.
   d. PHI sent to patients shall meet all criteria listed in Section 3, Communicating PHI Via Email Externally.
3. **Communicating PHI via Email Externally**
   a. All email that contains PHI sent to external destinations shall be encrypted prior to delivery, in a manner adherent to NIHD Information Technology (IT) Department requirements.
      i. To encrypt (secure) an email containing PHI or sensitive information type **SECURE:** at the beginning of the subject line. The word SECURE must be in all capital letters and must be followed by a colon (:). Use caution when replying and forwarding to make certain that the SECURE: is at the beginning of the subject line.

ii. To intentionally send an unencrypted (unsecured) email type **NOENCRYPT:** at the beginning of the subject line. The word NOENCRYPT must be in all capital letters and must be followed by a colon (:). Use caution when replying and forwarding to make certain that the NOENCRYPT: is at the beginning of the subject line.

b. The email message will include the following confidentiality notice. This notice is automatically added to all emails sent outside the NIH.org domain and does not require sender interaction. **"This electronic message is intended for the use of the named recipient and may contain confidential and/or privileged information. If you are not the intended recipient, you are hereby notified that any disclosure, copying, distribution or use of the contents of this message is strictly prohibited. If you have received this message in error or are not the named recipient, please notify us immediately by contacting the sender at the electronic mail address noted above with a copy to compliance@nih.org and destroy this message"**

4. **Ownership of Electronic Mail**
   a. The email systems at NIHD, and all emails, belong to Northern Inyo Healthcare District.
   b. NIHD reserves the right to override individual passwords and access the email system at any time for valid business purposes including, but not limited to, PHI security investigations or at the request of Human Resources.

Sample text for verification email:

Greetings,

You have requested communication via email.

I am sending this email to confirm that I have your email address correct. I am attempting to reach (full name). Please reply to this email if it has correctly reached the right person.

Additionally, please let me know if you prefer to receive information encrypted (more secure, better to protect your private information) or unsecured (which is more like regular mail or a postcard).

Respectfully,

Name of employee

REFERENCES:

1. https://www.hhs.gov/hipaa/for-professionals/faq/570/does-hipaa-permit-health-care-providers-to-use-email-to-discuss-health-issues-with-patients/index.html
2. 42 CFR 164.522 (b)
3. The Joint Commission (CAMCAH Manual) Jan. 2022; Standards IM.02.02.01 EP 1 and 4.

RECORD RETENTION AND DESTRUCTION:

Release of records information received from the patient becomes a part of the patient's medical record, which is maintained by the NIHD Medical Records Department.

CROSS REFERENCED POLICIES AND PROCEDURES:

1. Sending Protected Health Information by Fax
2. Investigation and Reporting of Unlawful Access, Use or Disclosure of Protected Health Information
3. Minimum Necessary Access, use, and disclosure of PHI

4. Sanctions for Breach of Patient Privacy

Supersedes: v.3 Communicating Protected Health Information Via Electronic Mail (Email)

NORTHERN INYO HEALTHCARE DISTRICT
NON-CLINICAL POLICY AND PROCEDURE

Title: Disclosures of Protected Health Information Over The Telephone		
Owner: Compliance Officer	Department: Compliance	
Scope: District Wide		
Date Last Modified: 05/15/2024	Last Review Date: No Review Date	Version: 4
Final Approval by: NIHD Board of Directors	Original Approval Date: 07/17/2013	

PURPOSE: In certain instances, using the telephone to communicate with a patient or to respond to requests for a patient's protected health information (PHI) is necessary or more convenient for the patient than communicating via mail or e-mail, or having to come to Northern Inyo Healthcare District (NIHD) in person. In order to do so while maintaining patient privacy and minimizing workforce disclosures to incorrect parties, NIHD has certain rules in place which must be followed.

POLICY: Workforce members should attempt to limit, to the extent practical, PHI communicated over the phone. When necessary to disclose PHI over the telephone, NIHD has procedures that must be followed.

PROCEDURES:

1. **Requests from or disclosures to a caller stating he/she is a patient**
   If a caller states he/she is a patient and he/she is requesting PHI about himself/herself, the workforce member will provide the PHI when they have confirmed the caller is the patient, using two patient identifiers.

   a. The workforce member will, prior to disclosing PHI, ask specific questions that could only be answered by the patient. For example, the patient's date of birth, address, father's name, or mother's name.
   b. If the workforce member knows the patient and the patient's voice, and recognizes the voice on the telephone as being that of the patient, verification with two identifiers shall be used to ensure the workforce member is in the correct record.
   c. The workforce member may elect to place a return call to the patient using the telephone number documented in the patient's record rather than immediately disclosing the patient's PHI to a caller initiating the telephone conversation.

2. **Requests from or disclosures to a caller who is not the patient**
   If the caller states he/she is an immediate family member (e.g. father, mother, child, or sibling) of the patient, the workforce member will refer to the patient's record for documentation (Authorization for Release of Information) to determine what information may be provided to this individual.

   d. If the caller states he/she is a friend, relative, or acquaintance of the patient or if the caller is unrelated to the patient (e.g. the patient's employer, law enforcement, or a reporter) the workforce member will:
      i. Not disclose PHI without the patient's permission; or

ii. Provide only directory information about the patient. Directory information is defined as:
    1. The patient's name
    2. The patient's location
    3. The patient's condition described in general terms that do not communicate specific PHI about the patient ("good", "stable", "critical", etc.)

3. Calls to a patient's home

Workforce members may not leave messages regarding treatments or diagnostic testing information on a patient's voice mail. Individuals leaving appointment reminders may only provide the name of the provider, the office phone number, the date and time of appointment, and/or the location.

4. Documenting disclosures made over the telephone

If PHI is disclosed to a caller, the workforce member will document the disclosure in the patient's medical record.

Questions

Questions about disclosure of a patient's PHI over the telephone should be directed to the workforce member's supervisor or the HIPAA Privacy Officer.

REFERENCES:

1. The Joint Commission CAMCAH Manual (January 14, 2024) IM.01.01.01 EP 2.
2. The Joint Commission CAMCAH Manual (January 14, 2024) IM.02.01.01 EP 1, 3 & 4.

RECORD RETENTION AND DESTRUCTION:

Records related to PHI disclosure are maintained for a minimum of eight (8) years. Any documentation within the patient's medical record is maintained by the NIHD Medical Records Department.

CROSS REFERENCED POLICIES AND PROCEDURES:

1. Communicating Protected Health Information via Electronic Mail (Email)
2. Investigation and Reporting of Unlawful Access, Use or Disclosure of Protected Health Information
3. Minimum Necessary Access, Use and Disclosure of Protected Health Information
4. Sending Protected Health Information by Fax
5. Using and Disclosing Protected Health Information for Treatment, Payment and Health Care Operations

Supersedes: v.3 Disclosures of Protected Health Information Over The Telephone

NORTHERN INYO HEALTHCARE DISTRICT
CLINICAL POLICY AND PROCEDURE

Title: Medical Staff Department Policy - Emergency Medicine		
Owner: MEDICAL STAFF DIRECTOR	Department: Medical Staff	
Scope: Practitioners with Privileges in Emergency Medicine		
Date Last Modified: 05/09/2024	Last Review Date: 06/16/2022	Version: 1
Final Approval by: NIHD Board of Directors	Original Approval Date: 06/16/2022	

PURPOSE: To delineate clear expectations for practitioners in the Department of Emergency Medicine within Northern Inyo Healthcare District (NIHD).

POLICY: All practitioners (physicians and Advanced Practice Providers) granted privileges in the Department of Emergency Medicine will adhere to the following procedures. The procedures outlined in this document should reflect and be congruent with the agreements in the Emergency Room Physician Service Agreements provided by Eastern Sierra Emergency Physicians.

PROCEDURE:

1. Patient Care Responsibilities
    a. Practitioners will provide 24-hour basic emergency services for patients of all ages whose emergent medical needs can be met within the capabilities of the hospital staff and facilities.
    b. Practitioners are to be present and ready to see patients in the Emergency Department or take sign-out from the outgoing provider at the time of their scheduled shifts. Unexcused tardiness will result in disciplinary action.
    c. Practitioners performing Emergency Services are required to be in-house at all times while on shift. Practitioners are required to respond to all emergencies/codes as outlined in existing hospital policies. Practitioners first responsibility is to their patient's in the Emergency Department but every effort should be made to assist with emergencies/codes called outside of the Emergency Department but within the hospital.
    d. Practitioners will provide a medical screening exam on all patients, regardless of the ability to pay.
    e. Practitioners will be familiar with and abide by Emergency Medical Treatment and Labor Act (EMTALA) at all times and during all patient encounters.
2. Documentation:
    a. The practitioner shall be responsible for developing the ability to use the electronic health record of NIHD. It is expected that the practitioner will maintain their individual passwords and login information. It is expected that the practitioner will maintain a level of familiarity with the electronic health record that will allow them to safely and efficiently care for patients in the Emergency Department.
    b. Informed consent is to be obtained by the physician and properly documented for applicable procedures as described in the *Informed Consent – Practitioner's Responsibility* policy.
    c. Verbal and/or phone orders are to be authenticated within the timeframe specified as per the *Verbal and/or Phone Medical Staff Practitioner Orders* policy.

    d. It is a requirement for all practitioners to participate in any training provided by the District or recommend by the Emergency Department Medical Director that involves charting. This includes but is not limited to: billing, coding, electronic health record training.
    e. All patient charts are to be completed in a timely manner with the goal for patient charts to be completed within 24 hours of the patient encounter.
3. Credentialing:
    a. Physician practitioners in the Department of Emergency Medicine must be board certified or board eligible by the American Board of Emergency Medicine or the American Board of Family Medicine or AOA (American Osteopathic Association) equivalent.
4. Meeting Attendance:
    a. Practitioners are to attend meetings of the Medical Staff per Medical Staff Bylaws requirements.
5. Focused Professional Practice Evaluation (FPPE):
    a. Practitioners new to NIHD will be expected to complete FPPE as per policy and as delineated during the privileging process.
6. Ongoing Professional Practice Evaluation (OPPE):
    a. Practitioners will be expected to participate in all requirements of OPPE as per Medical Staff policy.
7. Peer Review:
    a. All charts identified by critical indicators will be peer reviewed by a physician with privileges in Emergency Medicine. Selected cases will be reviewed at the Emergency Services committee at its next scheduled meeting. Records are confidential and will be kept by the Medical Staff Office.
8. Re-Entry:
    a. Applicants to the Department of Emergency Medicine are not eligible for Re-entry.

REFERENCES:

1. N/A

RECORD RETENTION AND DESTRUCTION:

1. Life of policy, plus 6 years

CROSS REFERENCED POLICIES AND PROCEDURES:

1. Northern Inyo Healthcare District Medical Staff Bylaws
2. *Informed Consent – Practitioner's Responsibility*
3. *Verbal and/or Phone Medical Staff Practitioner Orders*
4. *Focused and Ongoing Professional Practice Evaluation Policy*
5. *Practitioner Re-Entry Policy*

Supersedes: Not Set