

June 20 2018 Regular Meeting

June 20 2018 Regular Meeting - June 20 2018 Regular Meeting

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AGENDA

NORTHERN INYO HEALTHCARE DISTRICT BOARD OF DIRECTORS REGULAR MEETING

June 20, 2018 at 5:30 p.m.

In the Northern Inyo Hospital Board Room at 2957 Birch Street, Bishop, CA

1. Call to Order (at 5:30 pm).
2. At this time persons in the audience may speak on any items not on the agenda on any matter within the jurisdiction of the District Board (*Members of the audience will have an opportunity to address the Board on every item on the agenda. Speakers are limited to a maximum of three minutes each.*)
3. New Business
 - A. District Board Resolution 18-03, *Consolidation of Election (action item).*
 - B. District Board Resolution 18-04, *Appropriations Limit for 2018 (action item).*
 - C. Operating budget for 2018/2019 Fiscal Year (*action item*).
 - D. Recommended Funding for NIHD Retirement Plan, 2018/2019 Fiscal Year (*action item*).
 - E. Board of Directors Policy and Procedure approval, *NIHD Board Meeting Minutes (action item).*
 - F. Board of Directors Policy and Procedure Approval, *NIHD Board of Director Meetings/Brown Act Compliance (action item).*
 - G. Process for appointing Board members to vacant seats (*discussion item*).
 - H. Telework Program Policy (*action item*).
 - I. Workplace Violence Prevention Policy (*action item*).
 - J. Emergency Department Level of Care Assessment Policy and Procedure (*action item*).
 - K. Carrier Chiller Replacement (*action item*).
 - L. Grant application for adolescent and reproductive health education (*action item*).
 - M. Strategic Plan presentation format for Fiscal Year 2018/2019 (*information item*).
 - N. 2013 CMS Survey Validation Monitoring quarterly report (*action item*).

Consent Agenda (action items)

4. Approval of minutes of the May 16 2018 regular meeting
5. Financial and Statistical reports as of April 30 2018
6. Policy and Procedure annual approvals

7. Chief of Staff Report; Richard Meredick, MD:

A. Policies/Procedures/Protocols/Order Sets (*action items*):

1. *Medical Ethics Referrals and Consultations*
2. *Medical Staff and Allied Health Professional Educational Requirements*
3. *Adult Immunization in the Healthcare Worker*
4. *Aerosolized Transmissible Disease Exposure Plan/Respiratory Protection Program*
5. *Bloodborne Pathogen Exposure Control Plan*
6. *Emergency Management Plan*
7. *Emergency Room Overcrowding*
8. *Evaluation of Pregnant Patients in the Emergency Department*
9. *Infection Prevention Plan*
10. *Process for Amendment to Protected Health Information*
11. *Process for Auditing of Physician In-house/Office Records*
12. *Record Retention, Destruction and Disposal of Protected Health Information*
13. *Rejected Specimens Acceptability and Rejection*
14. *Role of Microbiology n Infectious Disease Control*
15. *Safe Injection Practices*
16. *Scope of Anesthesia Practice*
17. *Toy Cleaning*
18. *Trauma Patient Care in the Emergency Department*
19. *Trophon Environmental Probe Reprocessor (EPR)*
20. *Wild Iris Services (Victims Services)*
21. *DI – CT Contrast Administration*
22. *DI – CT Radiation Safety Policy*
23. *DI – Monitoring and Minimizing Radiation Exposure for the Occupation*
24. *DI NM Daily Area Surveys*
25. *DI NM General Rules for the Safe Use of Radioactive Materials*
26. *DI NM Radioactive Package Receipt*
27. *Diagnostic Imaging – Monitoring and Documentation of Fluoroscopic Quality Control*
28. *Diagnostic Imaging – Scope of Services*
29. *Diagnostic Imaging – Ultrasound, Intimate Exams*

30. *Diagnostic Imaging Department Orientation and Competency*

31. *Diagnostic Imaging X-Ray Protocols Procedure*

32. *Diagnostic Mammography – 3D*

33. *Premedication for Radiographic Contrast Sensitivity*

34. *Ultrasound – Scope of Practice Procedure*

B. Nurse Practitioner and Certified Nurse Midwife Standardized Procedures (*action items*):

1. General Policy
2. Adult Health Maintenance Policy
3. Management of Acute Illness Policy
4. Management of Chronic Illness Policy
5. Emergency Care Policy
6. Laboratory and Diagnostic Testing Policy
7. Minor Surgical Procedures Policy
8. Management of Minor Trauma Policy
9. Well Child Care Policy for the Nurse Practitioner

C. Service Chiefs and Medical Staff Officers for the 2018-2019 Medical Staff year (*action items*):

1. Chief of Staff – *Allison Robinson, MD*
2. Vice Chief of Staff – *Will Timbers, MD*
3. Immediate Past Chief of Staff – *Richard Meredick, MD*
4. Member-at-Large – *Joy Engblade, MD*
5. Chief of Emergency Room Service – *Sierra Bourne, MD*
6. Chief of Medicine/Intensive Care Service – *Nickoline Hathaway, MD*
7. Chief of Obstetrics – *Martha Kim, MD*
8. Chief of Pediatrics – *Charlotte Helvie, MD*
9. Chief of Radiology – *Edmund Pillsbury, MD*
10. Chief of Surgery – *Jeanine Arndal, MD*

D. Rural Health Clinic Critical Indicators 2018 (*action item*):

E. Medical Staff Appointments/Privileges (*action items*):

1. Daniel K. Davis, MD (*orthopedic surgery*) – Provisional Consulting Staff
2. John Adam Hawkins, DO (*emergency medicine*) – Provisional Active Staff

F. Temporary Privileges – Locum Tenens (*action items*)

1. Akash Rusia, MD (*internal medicine*) – temporary privileges
2. Chibao Nguyen, DO (*internal medicine*) – temporary privileges

3. Chivonne Harrigal, MD (*breast imaging*) – temporary privileges

G. Additional Privileges (*action items*):

1. Robert Nathan Slotnick, MD (*perinatology*) – addition of cervical cerclage privileges
2. Thomas Boo, MD (*family medicine*) – addition of outpatient family medicine privileges to work in the RHC.

H. Telemedicine Staff Appointment/Privileges – Proxy Credentialing (*action item*):

As per the approved Telemedicine Physician Credentialing and Privileging Agreement, and as outlined and allowed by 42CFR 482.22, the Medical Staff have chosen to recommend the following practitioners for Telemedicine privileges relying upon Adventist Health's credentialing and privileging decisions.

1. Sheila Lezcano, MD (*Endocrinology*) – Adventist Health, Telemedicine Staff

8. Reports from Board members (*information items*).

9. Adjournment to closed session to/for:

- A. Discussion of Labor Negotiations; Agency Designated Representative: Kevin Dale; Employee Organization: AFSCME Council 57 (*pursuant to Government Code Section 54957.6*).
- B. Discuss trade secrets, new programs and services (estimated public session date for discussion yet to be determined) (*Health and Safety Code Section 32106*).
- C. Confer with Legal Counsel regarding pending and threatened litigation, existing litigation and significant exposure to litigation, 4 matters pending (*pursuant to Government Code Section 54956.9*).
- D. Discussion of a personnel matter (*pursuant to Government Code Section 54957*).
- E. Discussion of real estate negotiation (*pursuant to Government Code Section 54956.8*).

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

11. Adjournment.

In compliance with the Americans with Disabilities Act, if you require special accommodations to participate in a District Board meeting, please contact administration at (760) 873-2838 at least 48 hours prior to the meeting.

RESOLUTION NO. 18-03

**RESOLUTION OF THE BOARD OF DIRECTORS OF THE
NORTHERN INYO HEALTHCARE DISTRICT
REQUESTING CONSOLIDATION OF ELECTION**

WHEREAS, it is necessary that two (2) directors be elected to the Board of Directors of Northern Inyo Healthcare District, one each from Zones III and V of said District; and

NOW, THEREFORE, BE IT RESOLVED by the Board of Directors of Northern Inyo Healthcare District that it request that the Board of Supervisors of the County of Inyo, State of California, consolidate said election of directors with the statewide election to be held on November 6, 2018; and,

BE IT FURTHER RESOLVED THAT THE Hospital Chief Executive Officer be, and is hereby directed to file copies of this Resolution with said Board of Supervisors of the County of Inyo, State of California, and the County Clerk-Recorder, Registrar of Voters of said County.

Adopted, signed and approved this 20th day of June, 2018.

John Ungersma, President

Attest: _____
M.C. Hubbard, Secretary

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

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

WHEREAS, using data provided by the State of California Department of Finance, on June 21, 2017, the Board of Directors of Northern Inyo Healthcare District established an appropriations limit of \$604,858.24 for the July 1, 2017 to June 30, 2018 fiscal year; and

WHEREAS, using the attached data provided by the State of California Department of Finance and the County of Inyo, an appropriations limit of \$626,906.98 has been calculated for the July 1, 2018 to June 30, 2019 fiscal year.

NOW, THEREFORE, BE IT RESOLVED by this Board of Directors of Northern Inyo Healthcare District, meeting in regular session this 20th day of June, 2018 that an appropriations limit of \$626,906.98 be established for the Northern Inyo Healthcare District for the 2018-2019 fiscal year; and

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

President

Attest:

Secretary

ATTACHMENT A
STATEMENT OF INYO COUNTY GANN LIMIT CALCULATIONS
FOR THE TAX YEAR 2017-2018

Updated to Include Northern Inyo Healthcare District

	2015-2016 Limit	Population Change	Per Capita Change	2016-2017 Limit	Population Change	Per Capita Change	2017-2018 Limit
Big Pine Lighting	48,888.22	1.0016	1.0537	51,595.94	1.0001	1.0369	53,505.18
Independence Lighting	48,738.09	1.0016	1.0537	51,437.49	1.0001	1.0369	53,340.87
Lone Pine Lighting	70,105.34	1.0016	1.0537	73,988.18	1.0001	1.0369	76,726.02
	-						
Big Pine Fire	316,191.21	1.0016	1.0537	333,703.75	1.0001	1.0369	346,052.02
Bishop Fire	496,723.76	1.0016	1.0537	524,235.26	1.0001	1.0369	543,633.90
Independence Fire	217,052.33	1.0016	1.0537	229,073.97	1.0001	1.0369	237,550.55
Lone Pine Fire	270,489.86	1.0016	1.0537	285,471.19	1.0001	1.0369	296,034.67
	-						
Big Pine Cemetery	67,079.47	1.0016	1.0537	70,794.73	1.0001	1.0369	73,414.40
Independence Cemetery	155,113.24	1.0016	1.0537	163,704.33	1.0001	1.0369	169,762.00
Mt. Whitney Cemetery	107,876.44	1.0016	1.0537	113,851.27	1.0001	1.0369	118,064.19
Pioneer Cemetery	401,573.28	1.0016	1.0537	423,814.79	1.0001	1.0369	439,497.50
Tecopa Cemetery	11,258.84	1.0016	1.0537	11,882.42	1.0001	1.0369	12,322.11
	-						
Darwin CSD	16,518.75	1.0016	1.0537	17,433.65	1.0001	1.0369	18,078.76
Olancha CSD	134,013.01	1.0016	1.0537	141,435.45	1.0001	1.0369	146,669.08
Westridge CSD	84,163.35	1.0016	1.0537	88,824.82	1.0001	1.0369	92,111.66
	-						
Southern Inyo Emergency	112,342.10	1.0016	1.0537	118,564.27	1.0001	1.0369	122,951.58
INYO COUNTY	38,877,856.68	1.0016	1.0537	41,031,142.54	1.0001	1.0369	42,549,446.22
Northern Inyo Healthcare	553,086.33	1.0016	1.0537	583,719.53	1.0001	1.0369	605,319.30
Estimated 2019 Limit							
Northern Inyo Healthcare	605,319.30	0.9990	1.0367	\$ 626,906.98			



May 2018

Dear Fiscal Officer:

Subject: Price Factor and Population Information

Appropriations Limit

California Revenue and Taxation Code section 2227 requires the Department of Finance to transmit an estimate of the percentage change in population to local governments. Each local jurisdiction must use their percentage change in population factor for January 1, 2018, in conjunction with a change in the cost of living, or price factor, to calculate their appropriations limit for fiscal year 2018-19. Attachment A provides the change in California's per capita personal income and an example for utilizing the price factor and population percentage change factor to calculate the 2018-19 appropriations limit. Attachment B provides the city and unincorporated county population percentage change. Attachment C provides the population percentage change for counties and their summed incorporated areas. The population percentage change data excludes federal and state institutionalized populations and military populations.

Population Percent Change for Special Districts

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

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

Population Certification

The population certification program applies only to cities and counties. California Revenue and Taxation Code section 11005.6 mandates Finance to automatically certify any population estimate that exceeds the current certified population with the State Controller's Office. **Finance will certify the higher estimate to the State Controller by June 1, 2018.**

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

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

MICHAEL COHEN
Director
By:

AMY M. COSTA
Chief Deputy Director

Attachment

- A. **Price Factor:** Article XIII B specifies that local jurisdictions select their cost of living factor to compute their appropriation limit by a vote of their governing body. The cost of living factor provided here is per capita personal income. If the percentage change in per capita personal income is selected, the percentage change to be used in setting the fiscal year 2018-19 appropriation limit is:

Per Capita Personal Income

Fiscal Year (FY)	Percentage change over prior year
2018-19	3.67

- B. Following is an example using sample population change and the change in California per capita personal income as growth factors in computing a 2018-19 appropriation limit.

2018-19:

Per Capita Cost of Living Change = 3.67 percent
 Population Change = 0.78 percent

Per Capita Cost of Living converted to a ratio: $\frac{3.67 + 100}{100} = 1.0367$

Population converted to a ratio: $\frac{0.78 + 100}{100} = 1.0078$

Calculation of factor for FY 2018-19: $1.0367 \times 1.0078 = 1.0448$

Fiscal Year 2018-19

Attachment B
Annual Percent Change in Population Minus Exclusions*
January 1, 2017 to January 1, 2018 and Total Population, January 1, 2018

County City	<u>Percent Change</u> 2017-2018	<u>--- Population Minus Exclusions ---</u>		<u>Total Population</u> 1-1-2018
		1-1-17	1-1-18	
Inyo				
Bishop	-0.38	3,937	3,922	3,922
Unincorporated	-0.03	14,561	14,557	14,655
County Total	-0.10	18,498	18,479	18,577

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

The logo is a square gold emblem with a circular seal inside. The seal features a stylized plant with three leaves and a central stem topped with a small circle. The background of the slide has a vertical gold bar on the left with diagonal hatching.

2019 Fiscal Budget for Northern Inyo Healthcare District

June 20, 2018

Overview of 2019 Budget

- **Patient Volumes & Services**
- **Salaries & FTEs**
- **Supplies & Purchased Services**
- **Capital**
- **Net Revenues**
- **Policies for Consideration**
- **Management Request**

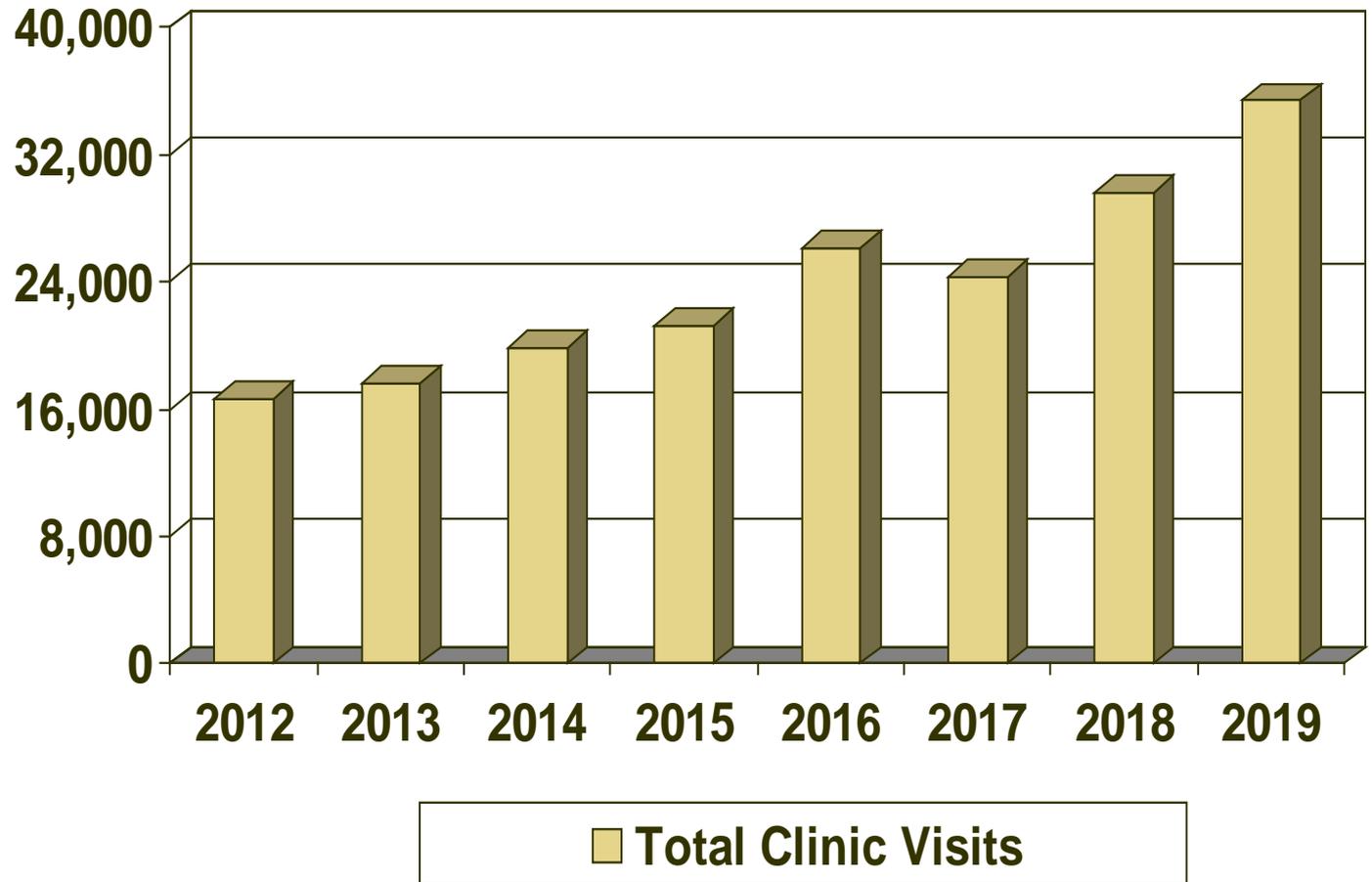
2018/19 Expansion of Services

- **Add Physician Assistant to add Same Day Services to be six days a week.**
- **Added Dr. Boo and new PA**
- **Adding Dr. Wakamiya and new NP**
- **Expand Telemedicine to 8 specialties**
- **Urology to be 8 days a month on site**
- **Requests for added: Charge Coordinator, Outpatient coder, RHC Desk staff, RHC Medical Assistants, RHC Care Coordinator, Lab and Surgery Manager and NIA Internal Med LVN and MA.**
- **Outpatient revenues increases to 69.7% of Gross Patient Revenues**

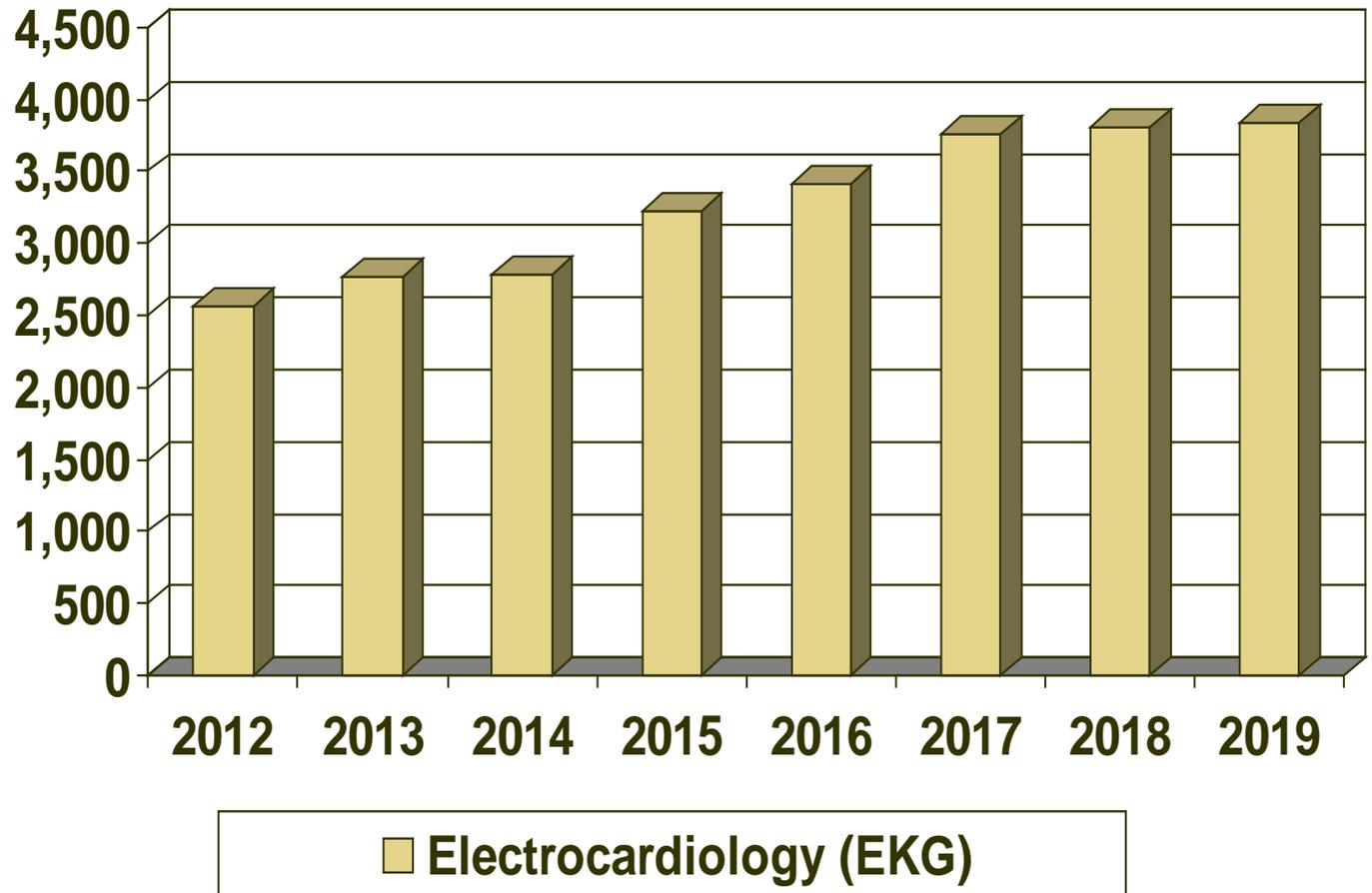
2018/2019 Recruitment Request

- **1 Physician Assistant for Same Day Clinic hours (days) expansion**
- **1 Registered Dietician**
- **2 Physical Therapists**
- **1 Occupational Therapist**
- **2 Speech Language Therapists**
- **2 Interpreters for Language Line**

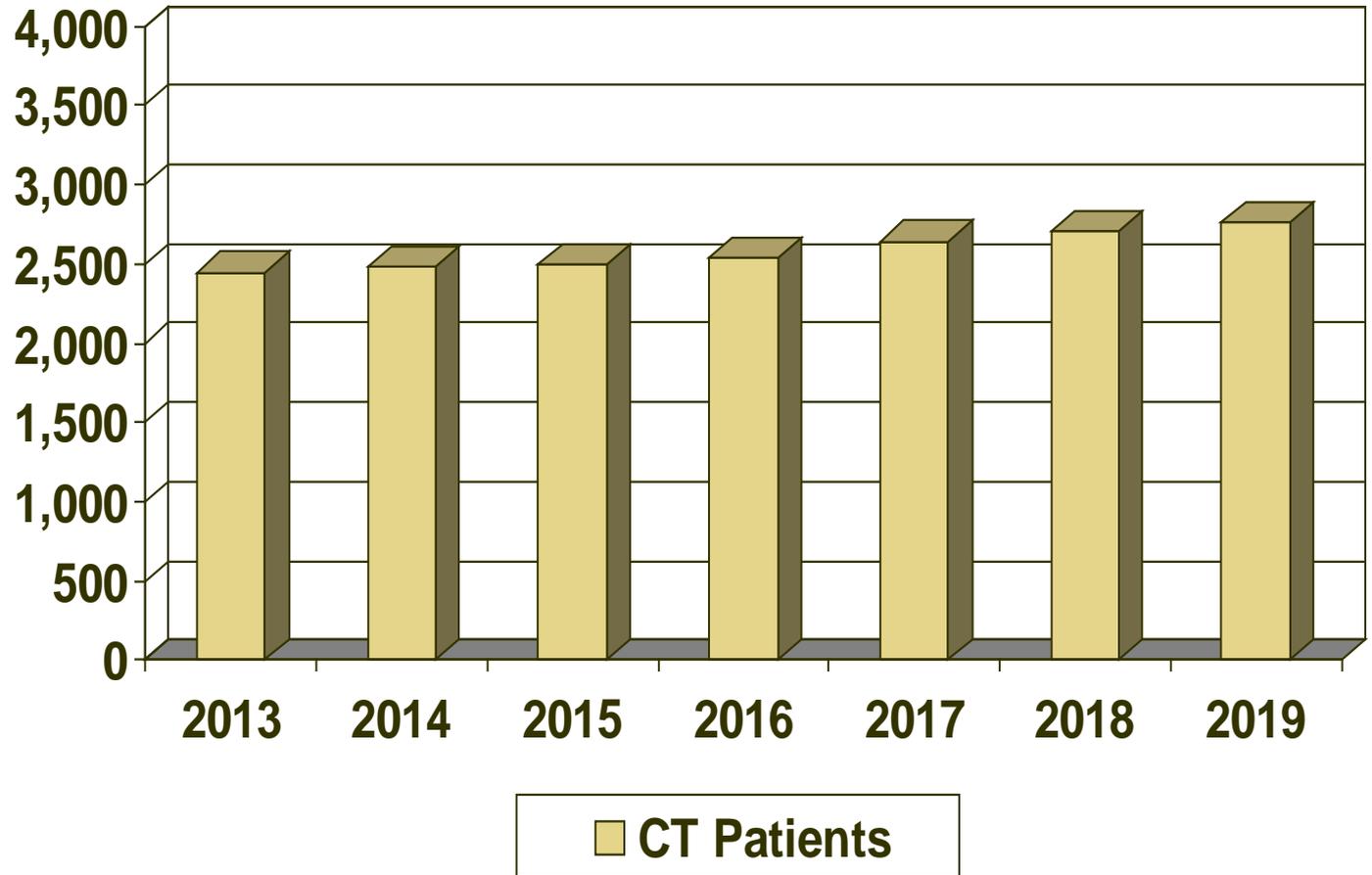
Rural Health Clinic



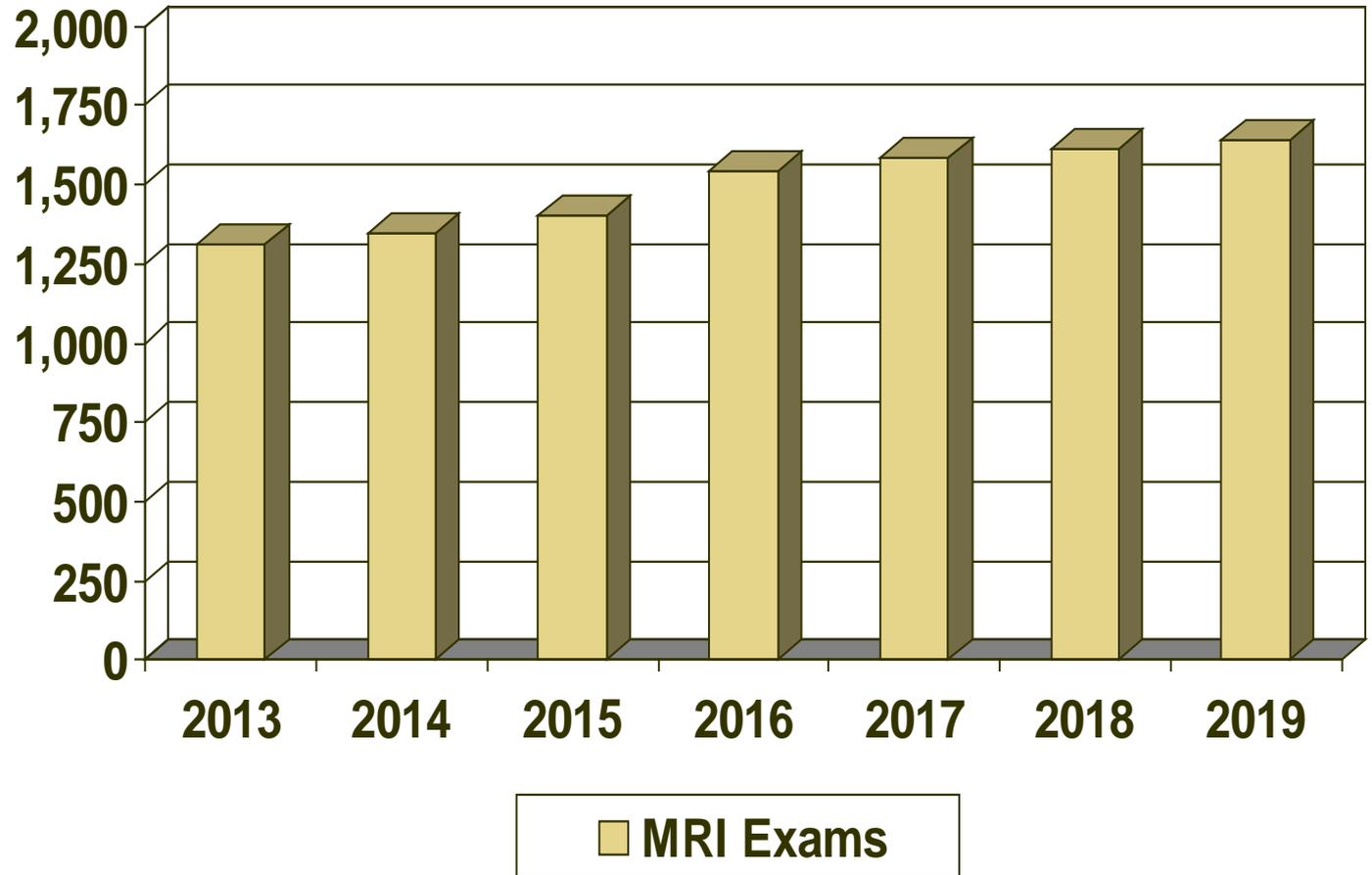
Cardiology



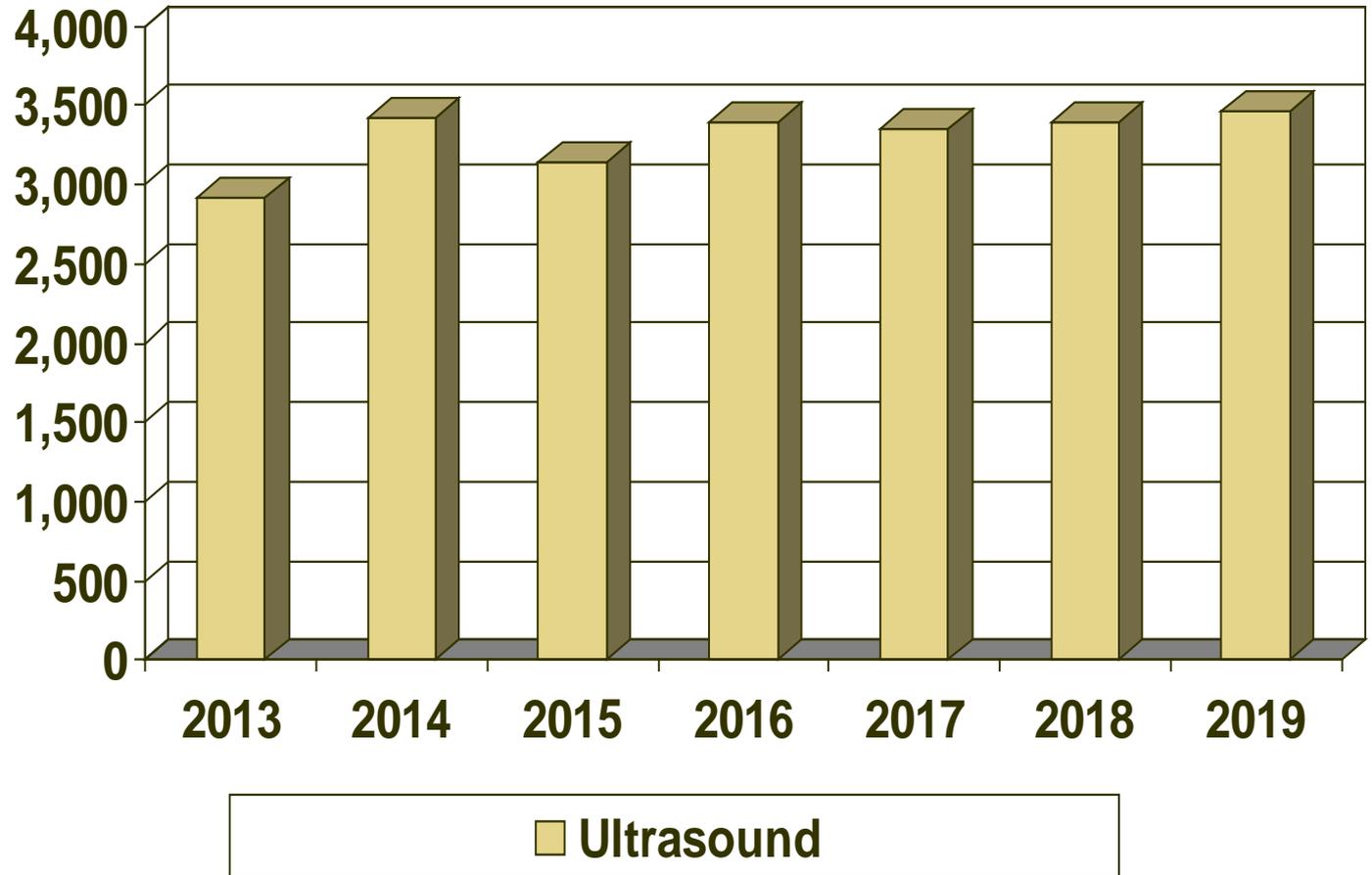
Diagnostic Imaging



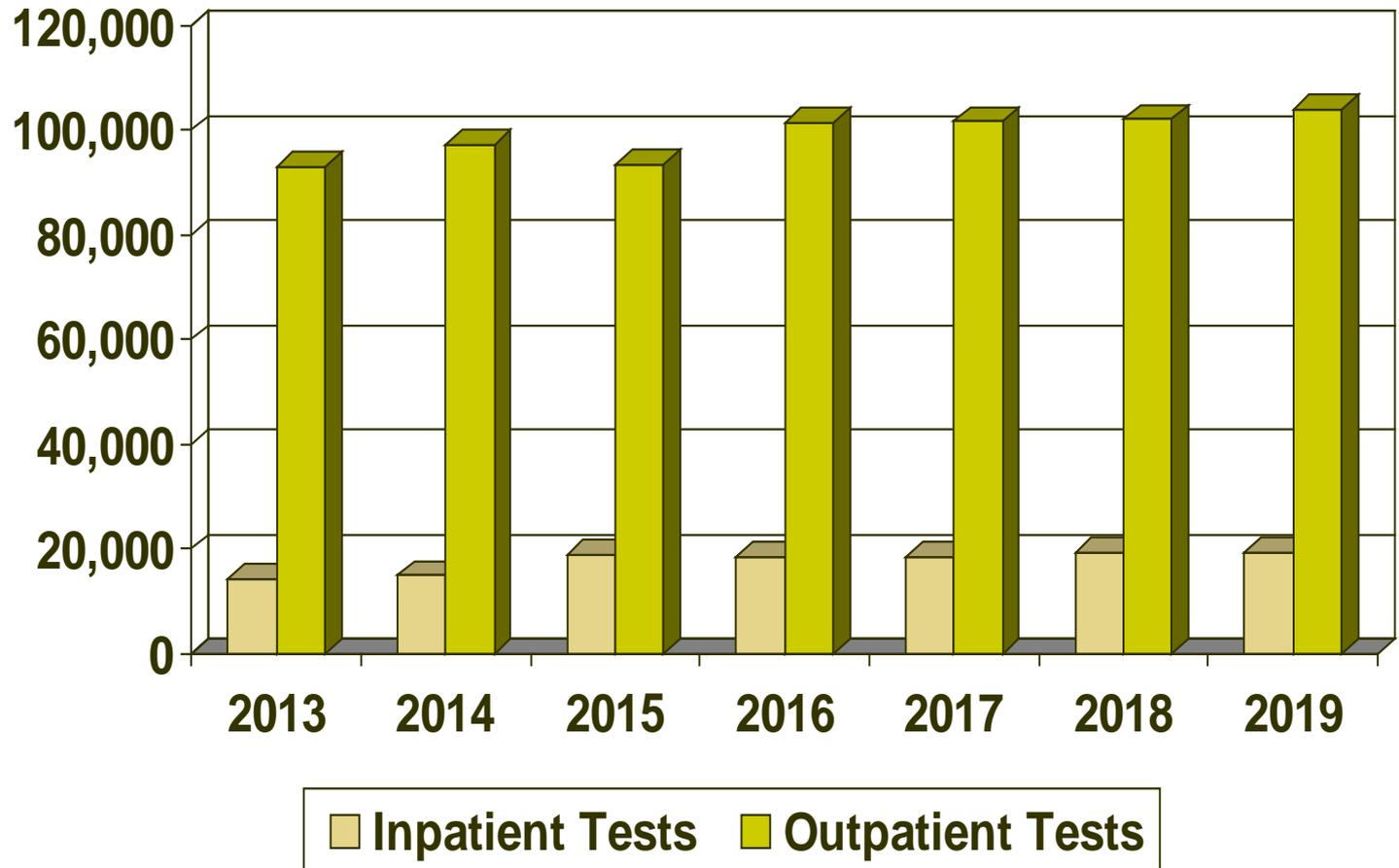
Diagnostic Imaging



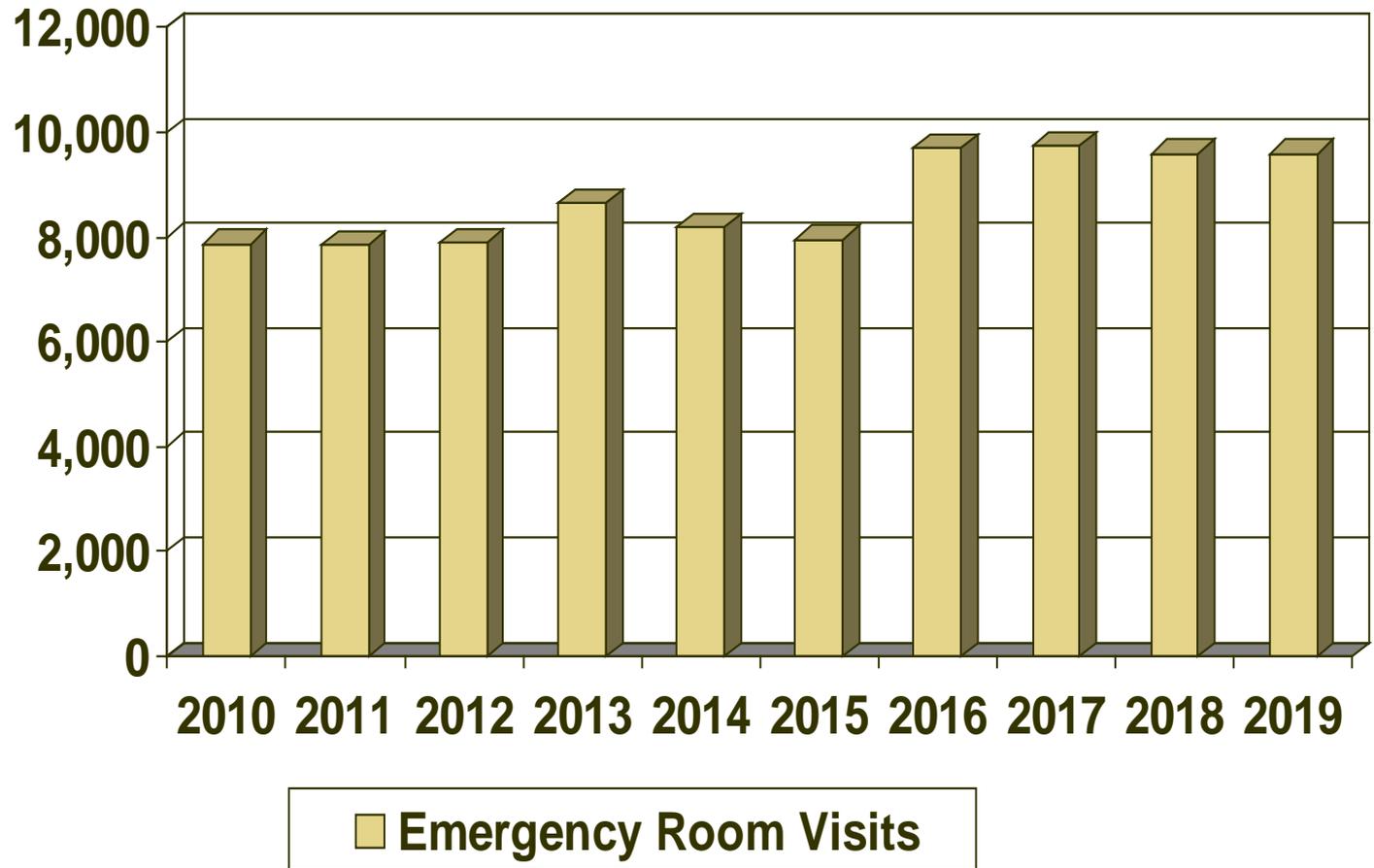
Diagnostic Imaging



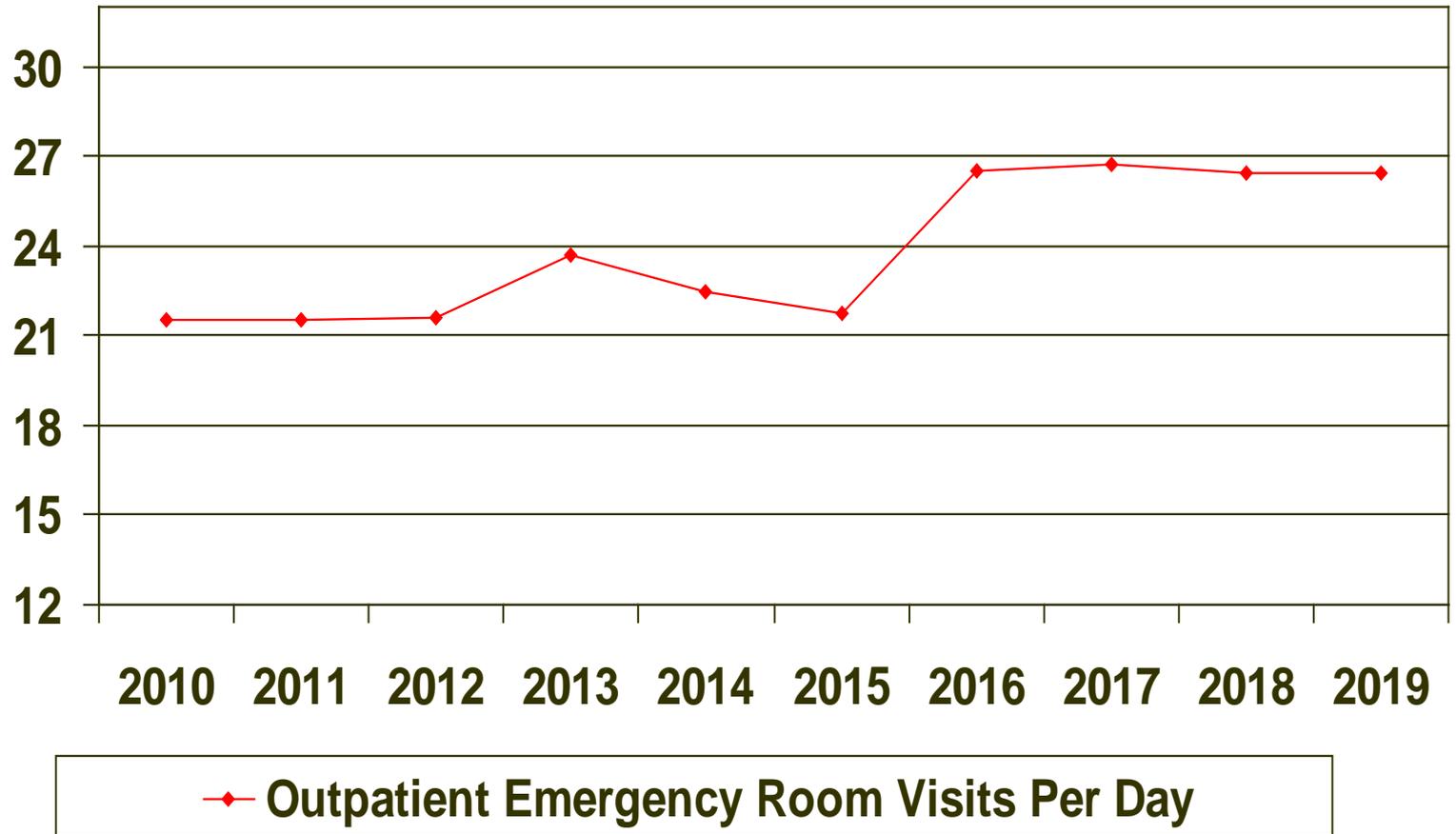
Laboratory Services



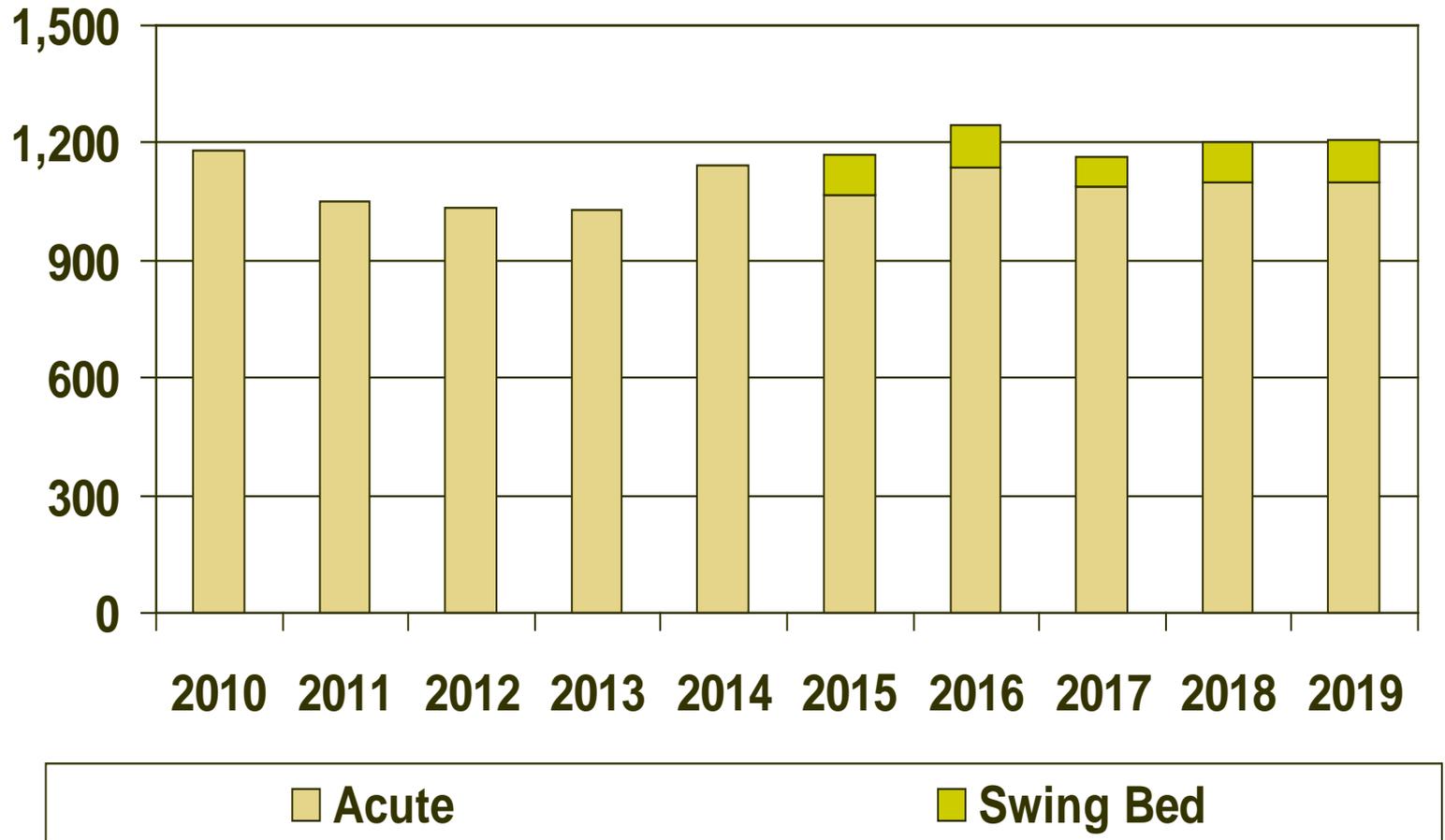
Emergency Room - Visits



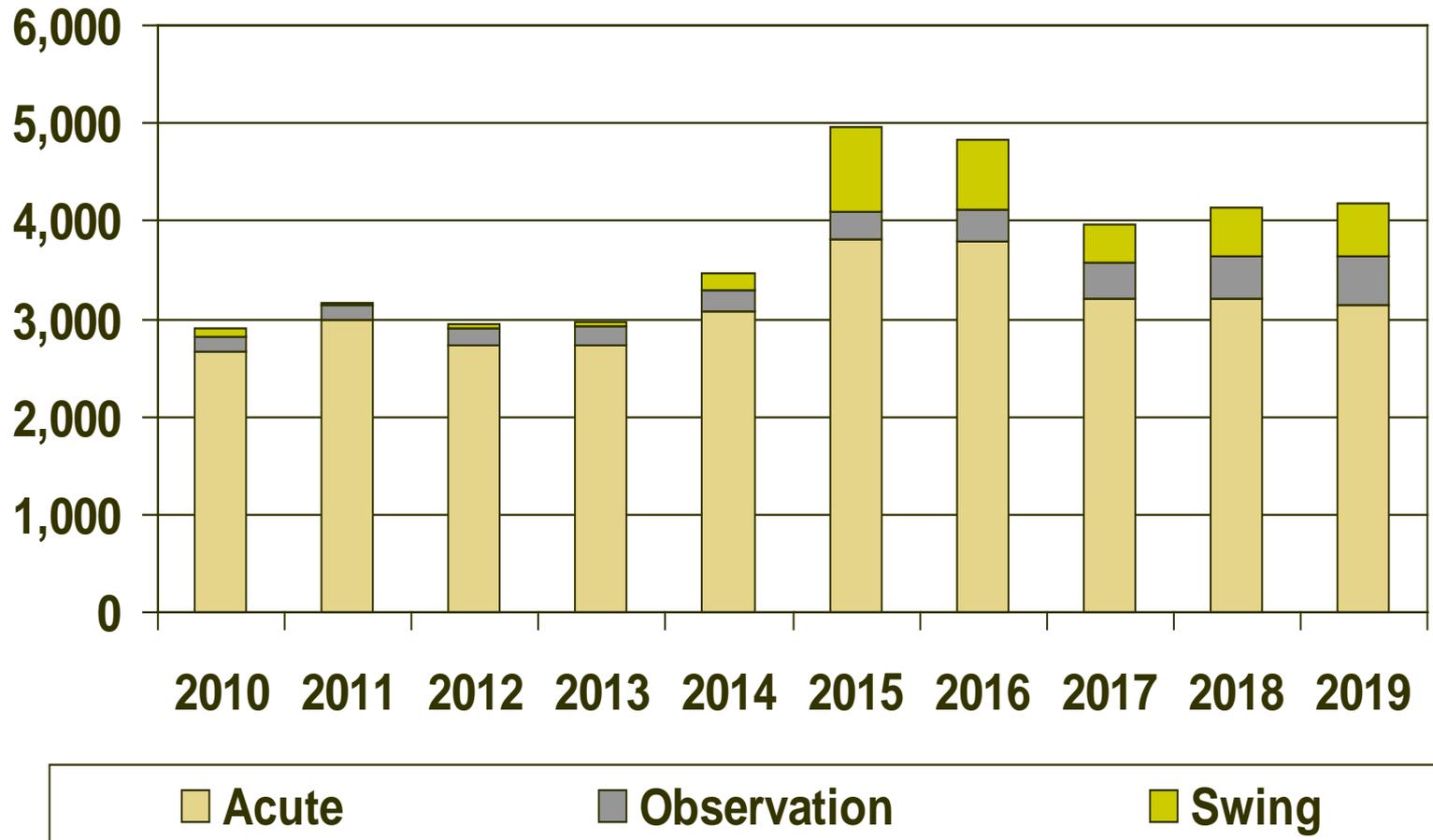
Emergency – Visits Per Day



Inpatient – Discharges

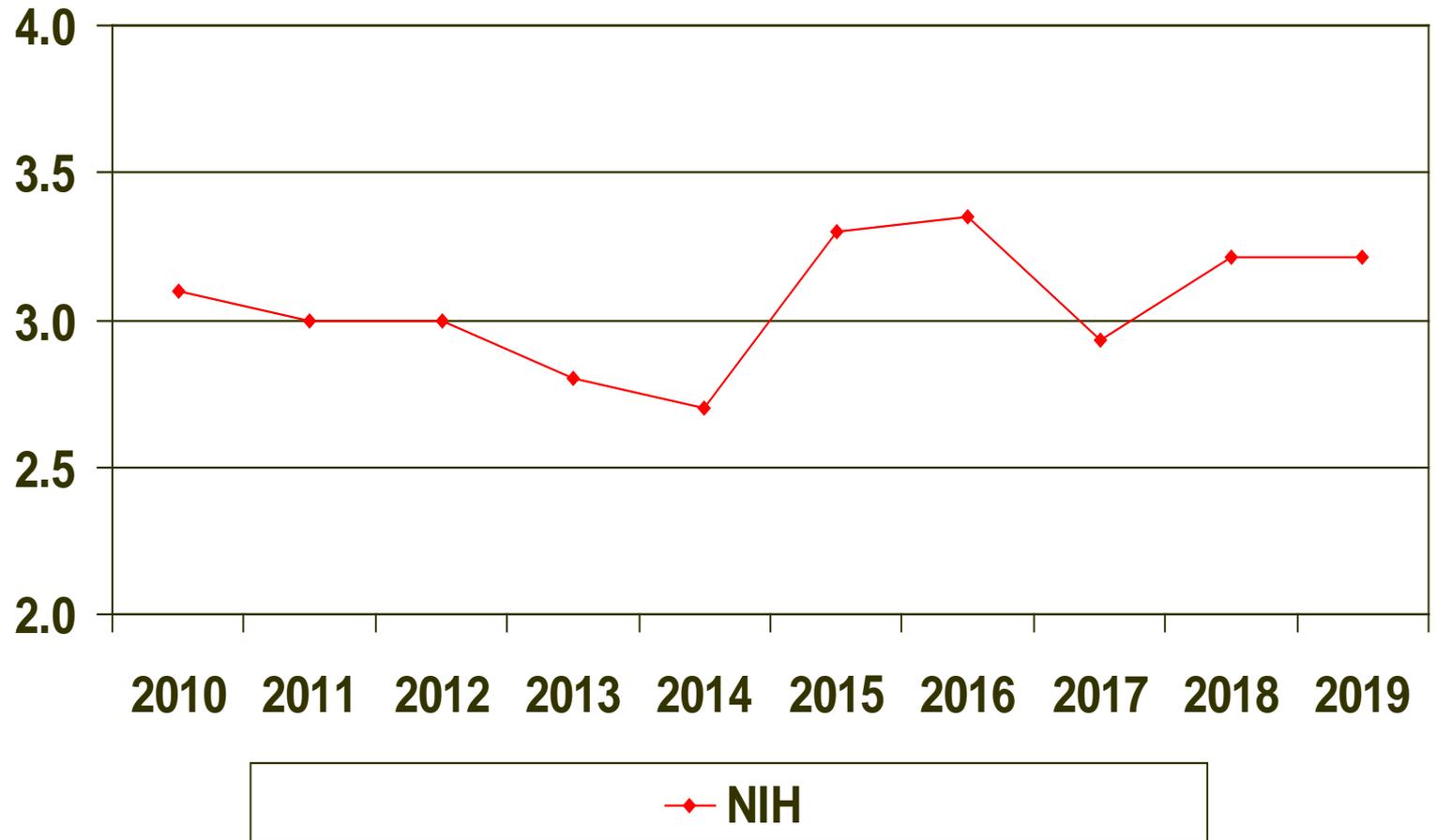


Inpatient Days

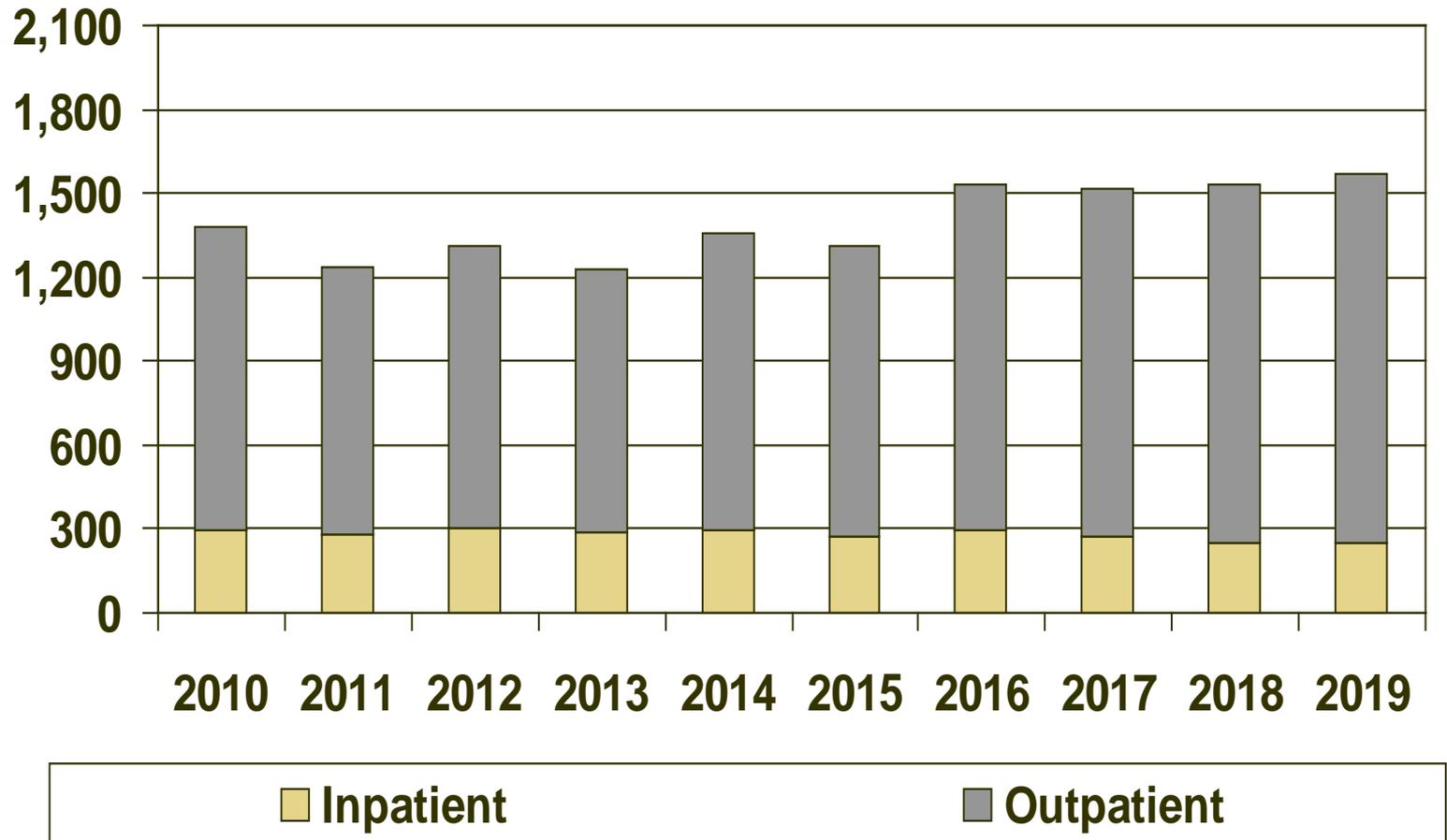


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Inpatient - Length of Stay

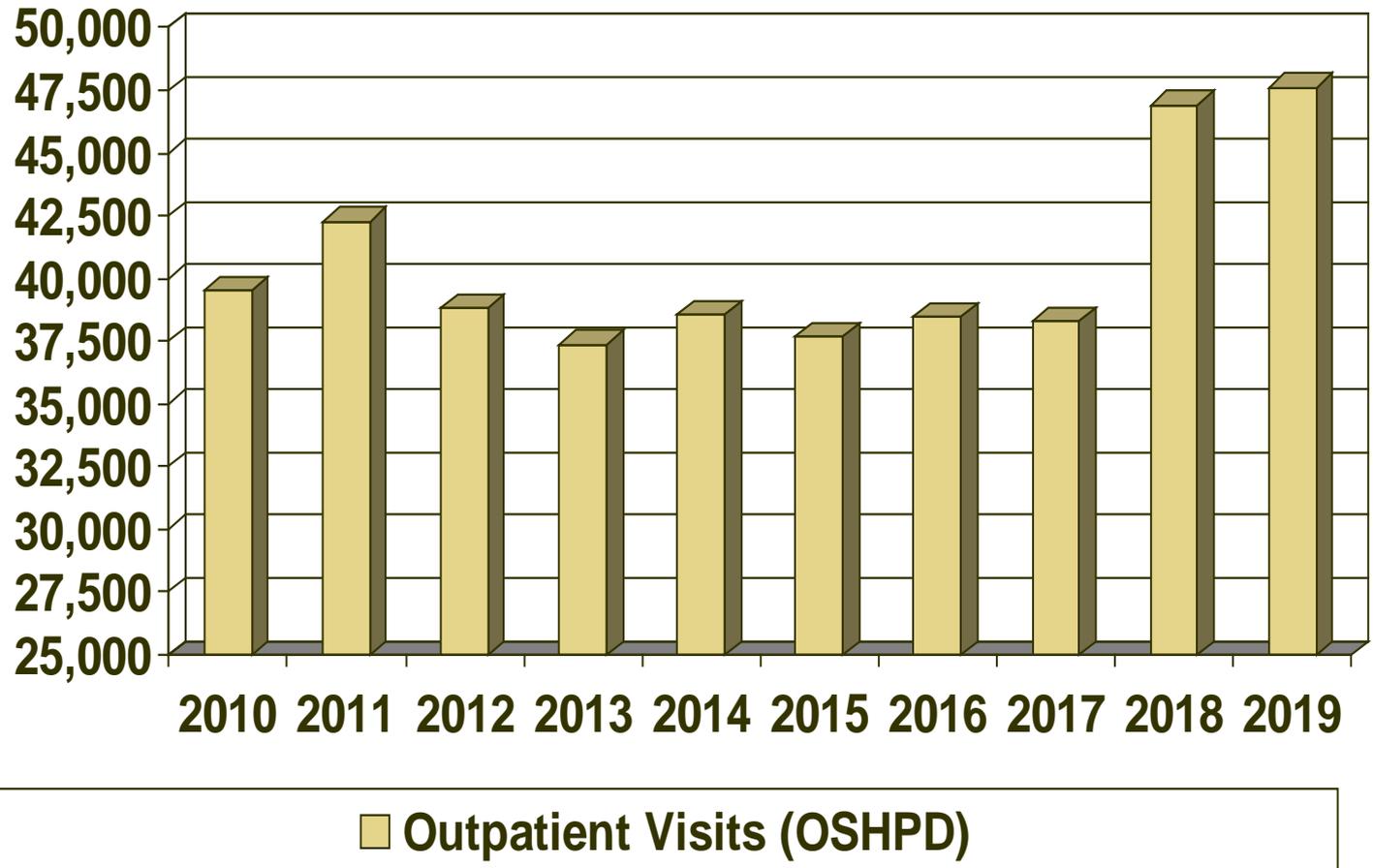


Surgical Cases



Budget includes 36²⁸ Urology cases

Outpatient Visits



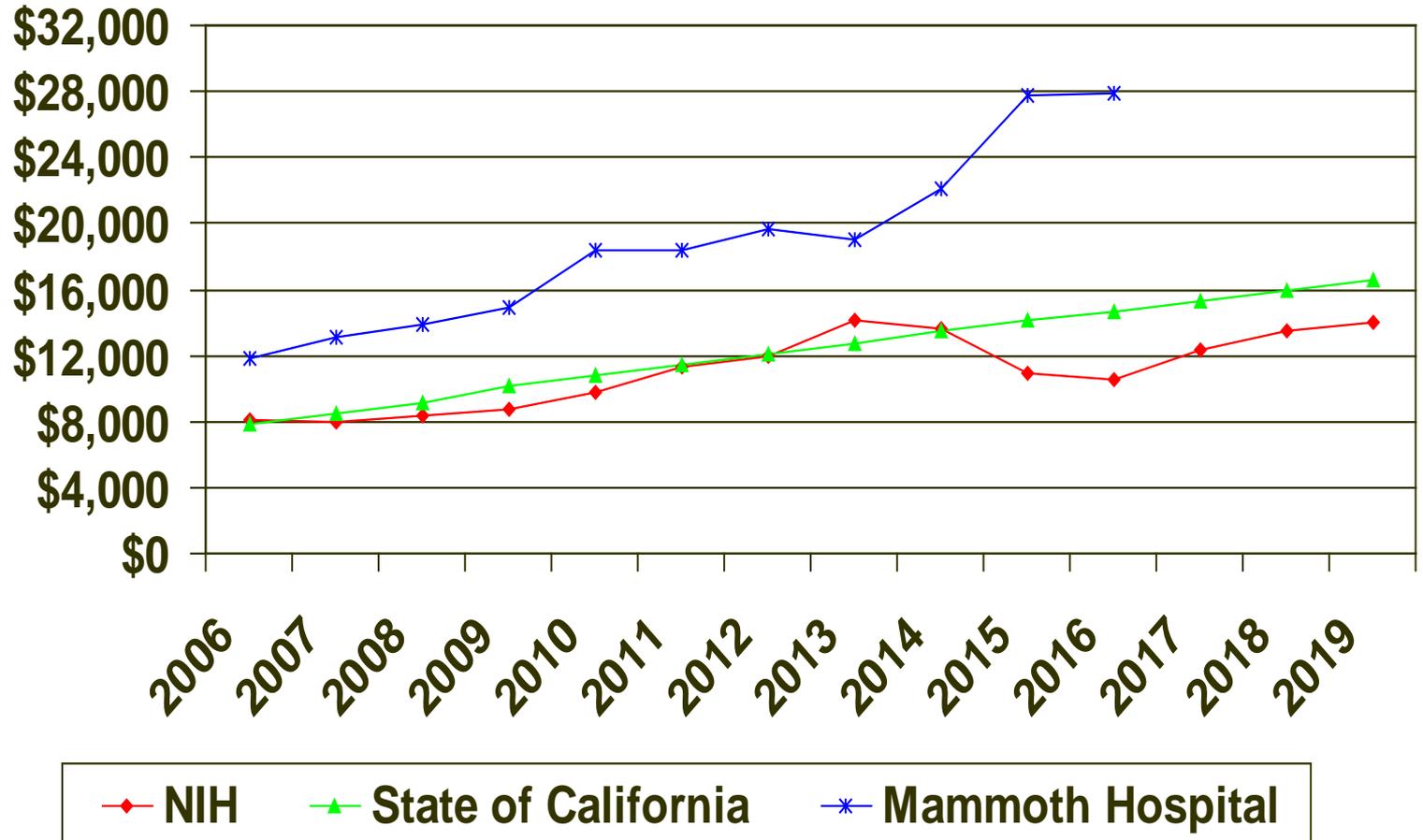
2019 Budget Challenges

- **Low growth in traditional services, particularly inpatient, obstetrics, general surgery, imaging, laboratory and procedures**
- **Increase in base wages without more growth is increasing our cost per day**
- **Full year commitments in nursing management, quality, other formerly vacant positions adds expense without added revenue**
- **ER Physician & Anesthesia new contract rates**
- **Ramped up costs with more Providers**
- **No expectation of Athena Net Cash Flow Add**

2018/2019 Revenues

- **Assumes 2017/2018 outpatient visit growth is permanent**
- **Does not account for any departures from the medical staff**
- **Requesting 4.0% overall increase in fees (excluding xray facility) and 60% increase in swing bed per day rate. (in response to Medicare inquiry)**

Average Daily Inpatient Charge



Assumes 4% Rise for California 2017 -2019

Intergovernmental Transfers

Intergovernmental Transfers are playing an ever increasing part of the payments for serving Medi-Cal patients and supporting District Hospitals in California.

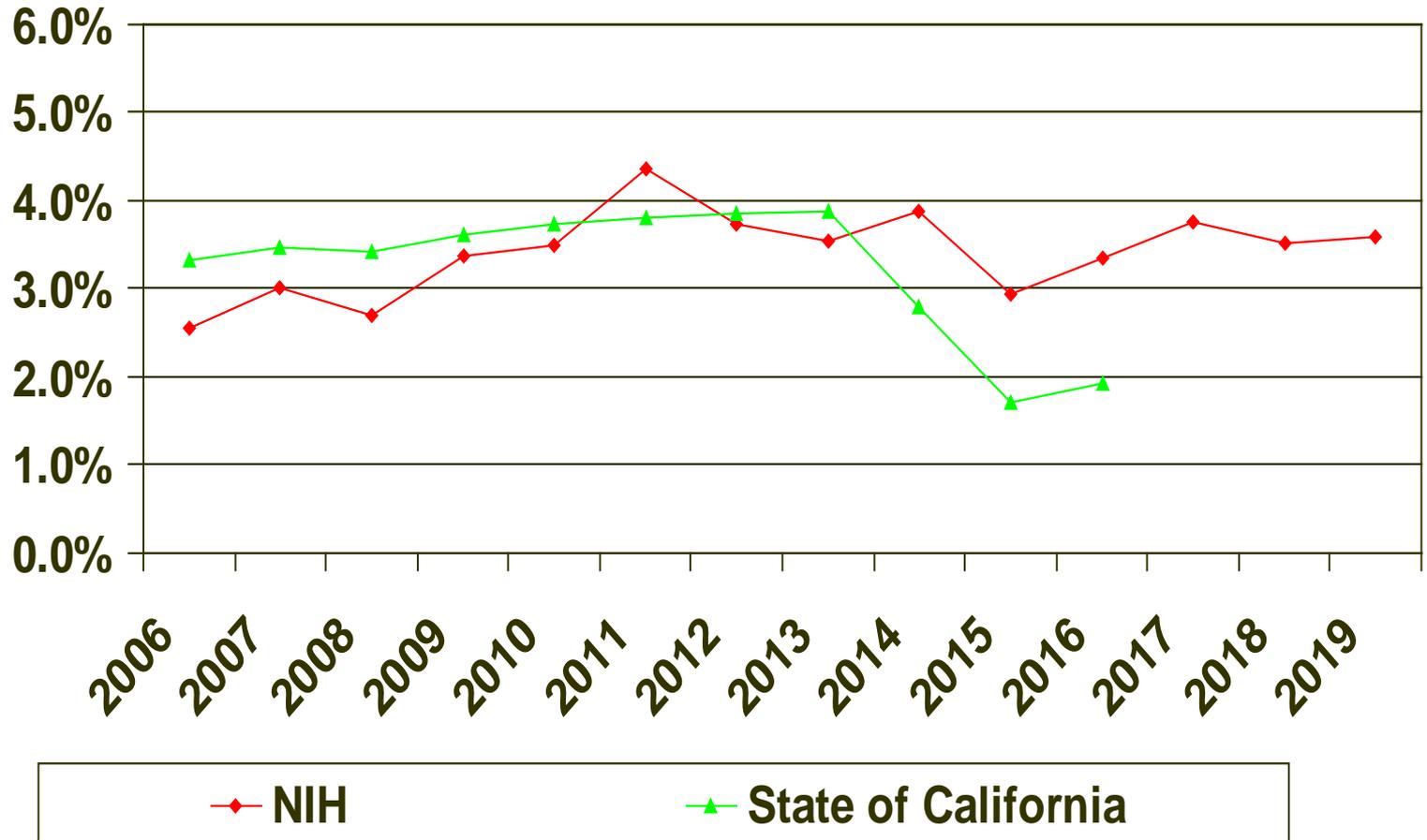
- General support from the State will be \$131,940.
- Annual Medicaid IGT net grant of \$266,877.
- Total Direct Grant of \$1,051,127 for District Hospitals.
- Medi-Cal Managed IGT increases to \$7,570,000 from \$5,414,000 in the fall of 2018.

- Prime Incentive program (Non-Operating Donation) increases to \$1,980,000 in October, 2018. Reduces to \$1,782,000 in October, 2019 and \$1,514,000 in October, 2020.

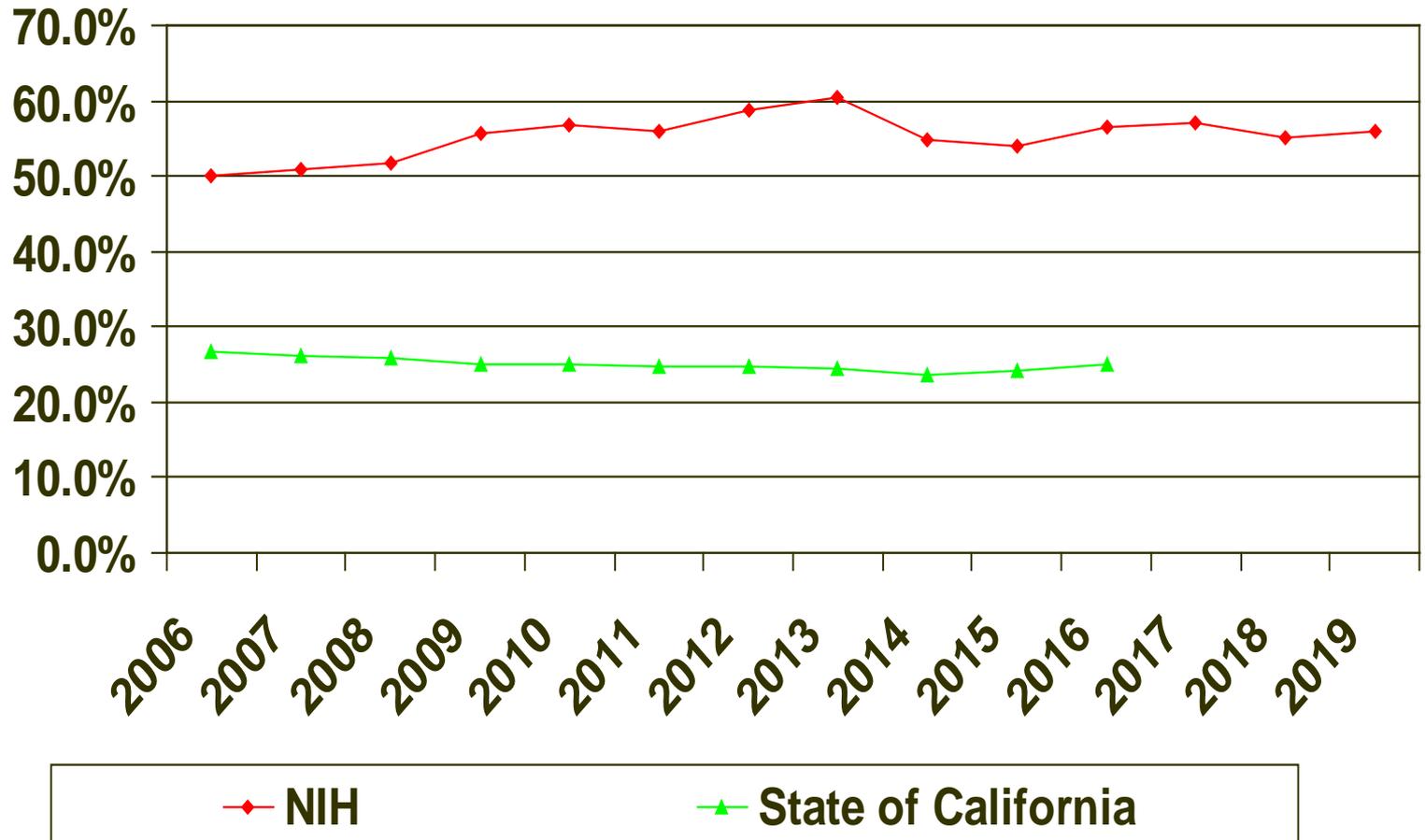
Policies for Fiscal 2019

- Continuation of the California mandated Charity Care for patients whose income is less than 300% of Federal Poverty Guidelines is budgeted for \$1,959,000 including Medicaid unpaid Medicare deductibles and coinsurances
- Continuation of the 25% discount for residents of the District who pay their first statement within 30 days – (Budget value of \$360,000)
- Continuation of the 50% discount for employees for their non-insurance covered portion of services from NIHD paid within 30 days of statement date (Budget value of \$108,000)
- Continuation of General Discount (Budget value of \$132,000)
 - 20% discount for private pay portion of bill paid with first statement for non-District patients
 - 30% discount for patients without insurance who pay promptly
- Total Charity Care & Voluntary Discounts of \$2,559,000

Uncompensated Care Costs



Overall Cost to Charge Ratio



2019 rate³⁶ is 55.85%

Salary and Benefits

Salary Increases of 2.0% (Merit, CA Minimum and Technical)
CPI from April 2017 to May 2018 is up 2.8%.

Benefits

Continuation of Health Plan as is for 2019.

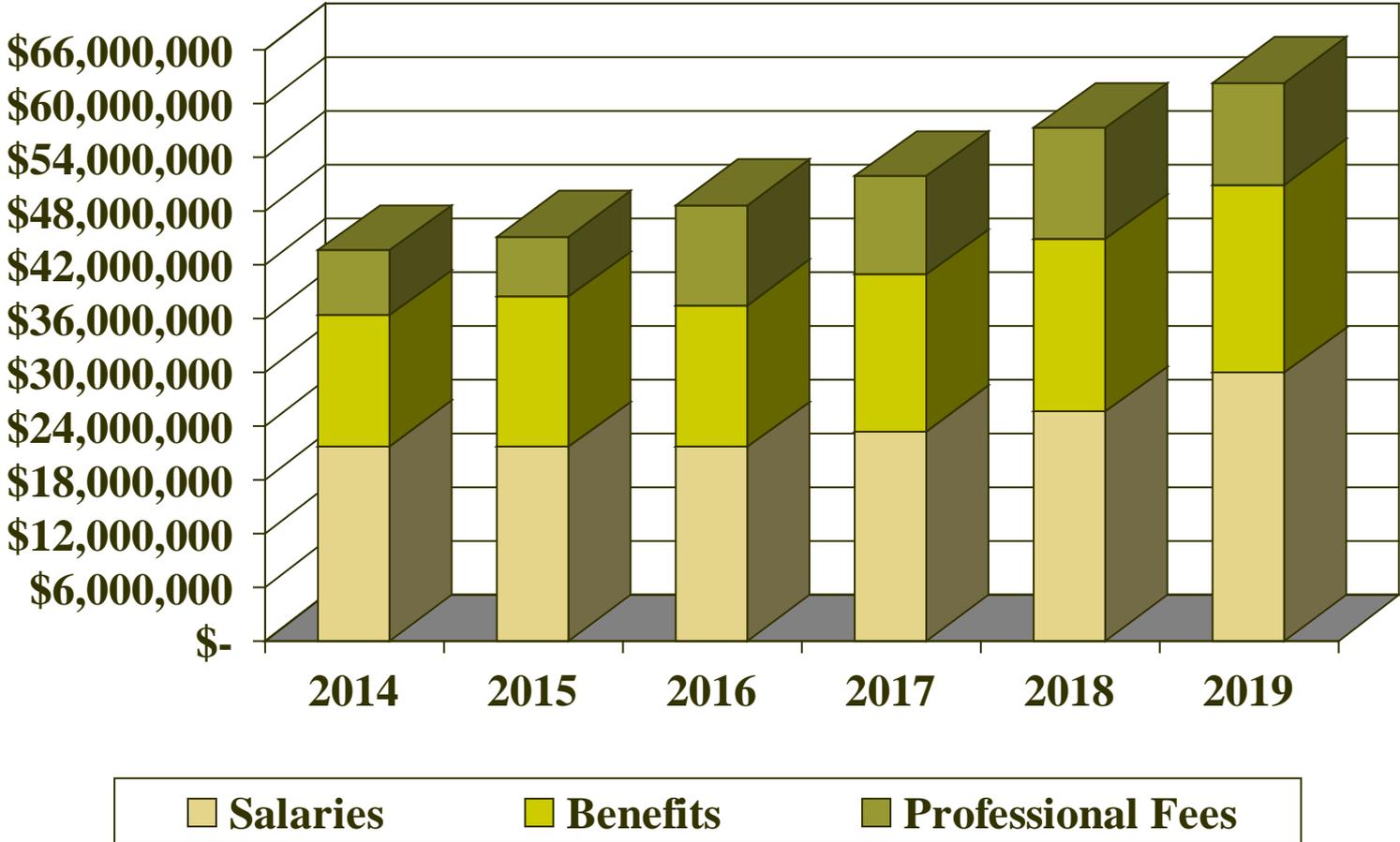
Other benefits (dental, life & pension) will remain at current levels. Monthly contribution of \$457,000 into the Defined Benefit retirement plan. Worker's compensation costs are increasing 6%.

As employee turnover occurs, the percentage of employees on the defined benefit pension plan decreases and is expected to drop to under 60% during 2019. Defined Contribution rate to remain at 7%.

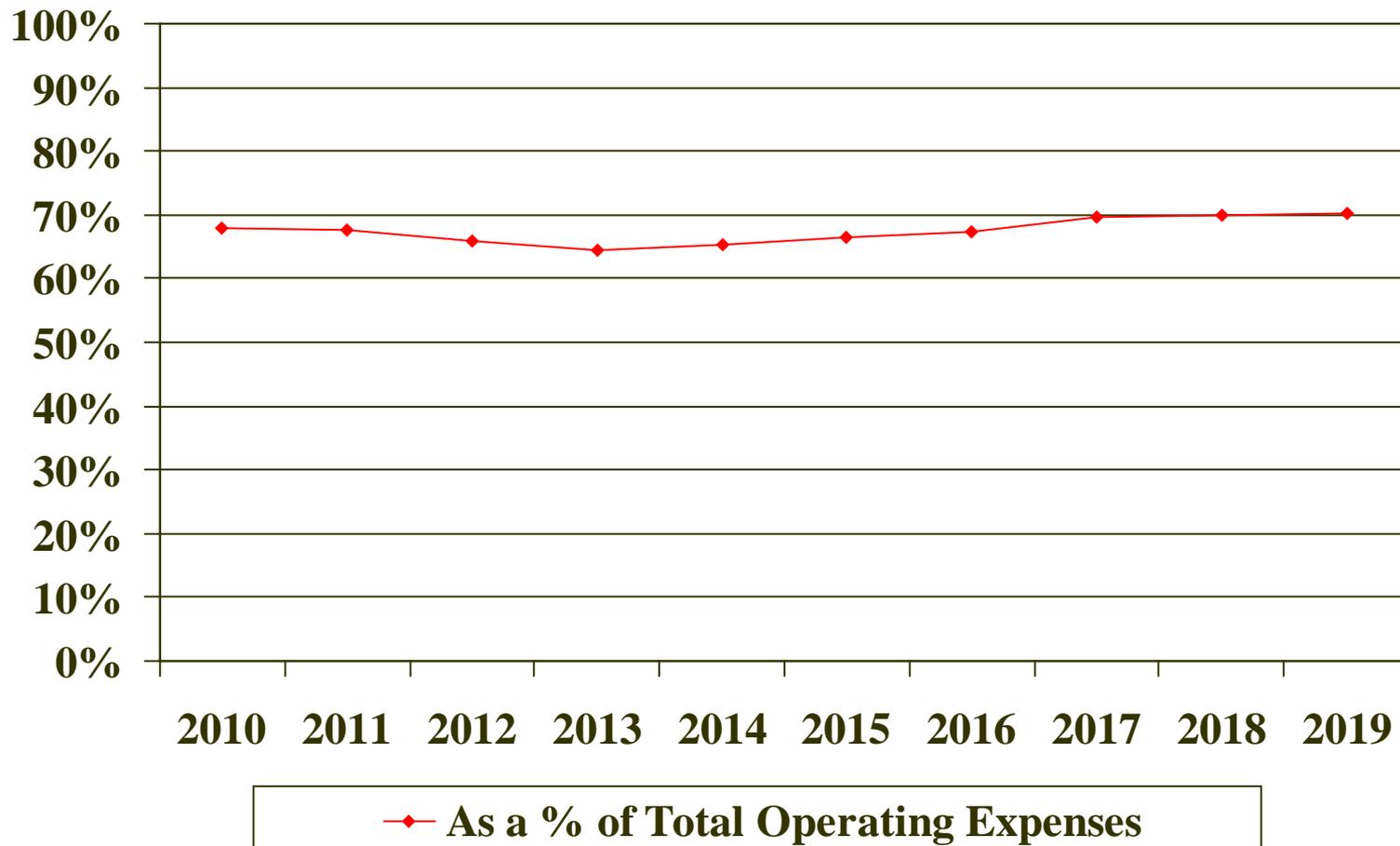
FTEs

Total FTEs including contracted staff of 446.70, 15.1 per adjusted patient day.

Salaries & Benefits



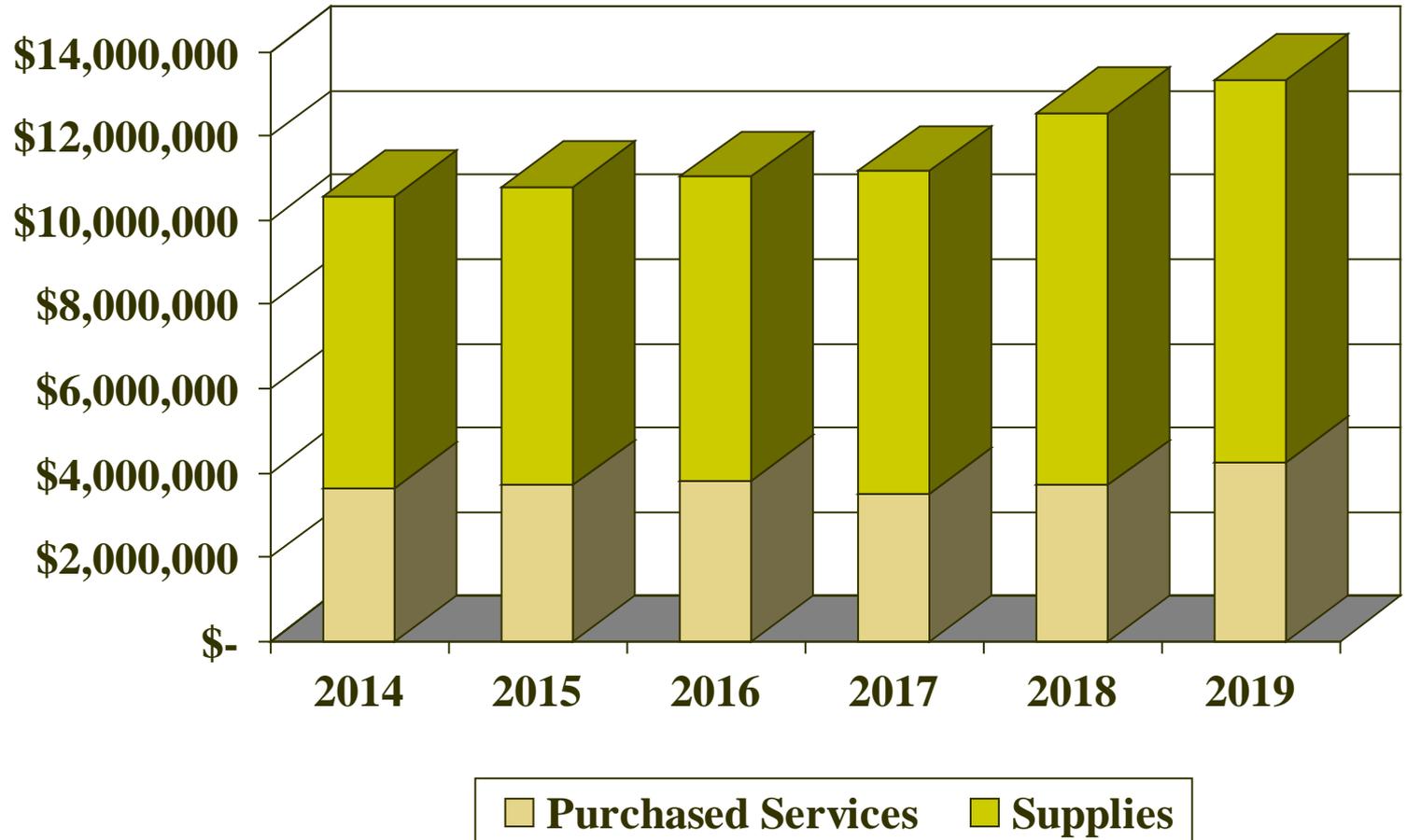
Salaries, Benefits & Professional Fees



Purchased Services

- **Athena added for 215 days of net AR at 1.6% of net revenue**
- **Continues Paragon service contract for half of the fiscal year with other IT contract expiring as use decreases and contracts allow**
- **Other service contracts budgeted by month of implementation**

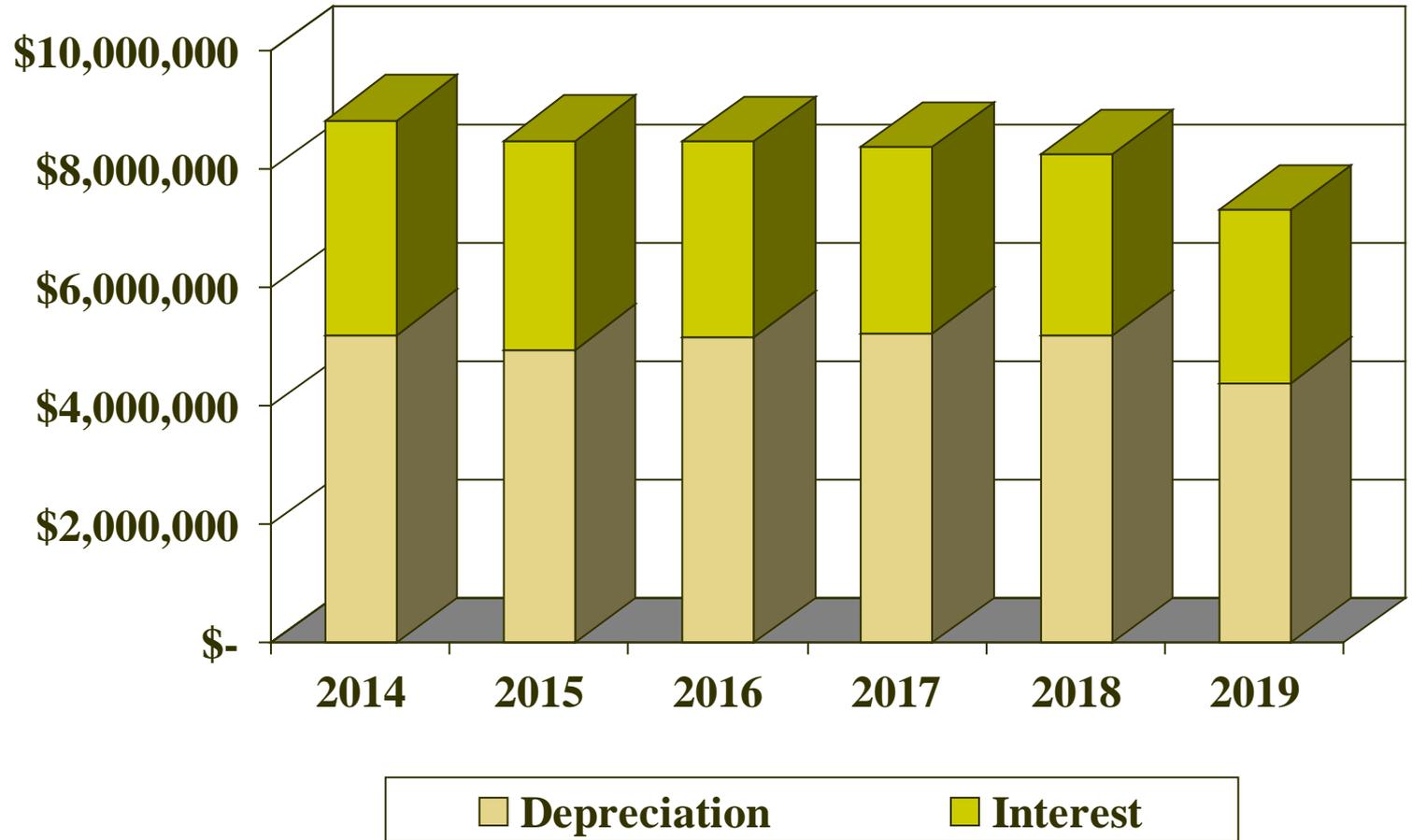
Purchased Services & Supplies



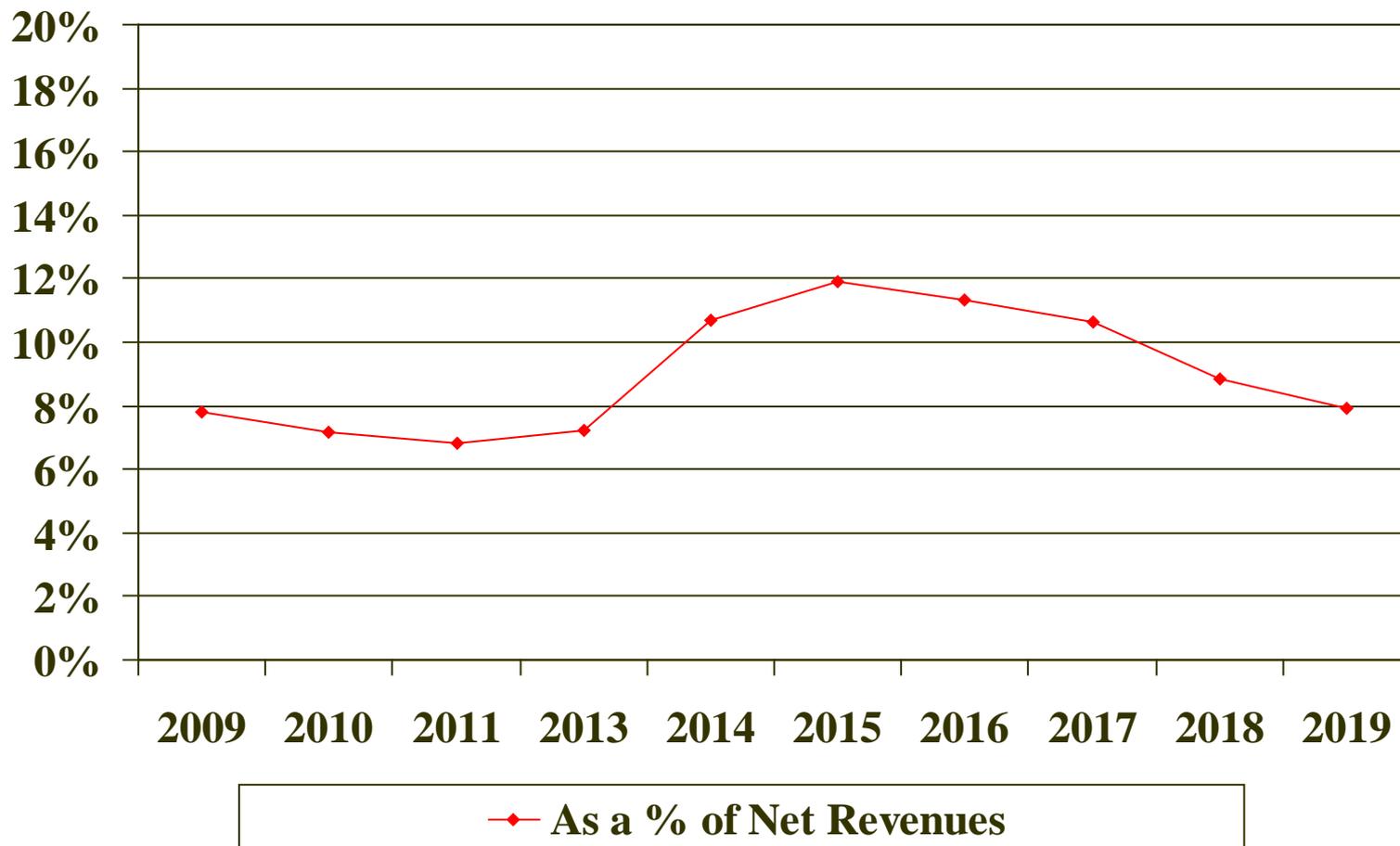
Capital

- **New expenditures of \$3,150,000 budgeted in depreciation and limited capital associated with the new EHR**
- **No gain or loss on disposal of fixed assets budgeted in 2019**

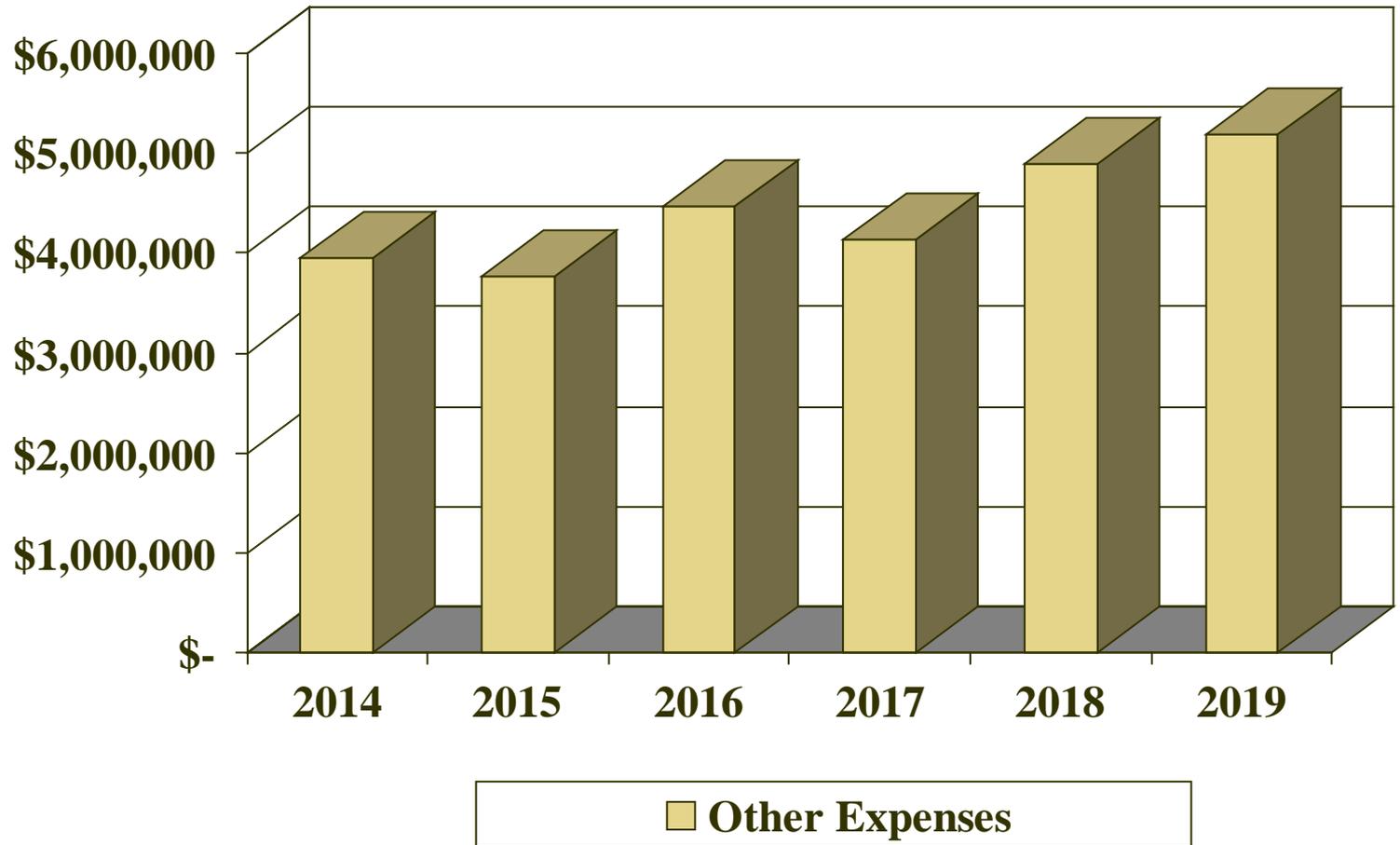
Depreciation, Amortization & Interest Expense



Depreciation, Amortization & Interest Expense



Other Expenses



Includes \$332,000 of staff development (1.1% of wages)⁴⁶

Other Change/Policy Requests

- All employee payments will be made exclusively via ADP Payroll. Pay as well as travel, tuition and other reimbursements.
- NIHD to adopt a new meals reimbursement policy of actual cost;but not more than \$50 per day versus the current automatic \$50 per diem practice.
- NIHD to change the mileage policy to automatically match the Federal allowable limit as it changes from time to time.

2018/19 Revenues

	Budget 2019	Annualized 2018	Budget 2018	Fiscal 2017
Inpatient Revenue	46,182,472	41,945,968	38,371,449	37,896,768
Price Change	<u>1,847,299</u>	<u>3,355,677</u>	<u>3,069,716</u>	<u>1,136,903</u>
Gross Inpatient Revenue	48,029,771	45,301,646	41,441,165	39,033,671
Revenue Per IP Patient Day	\$ 14,708	\$ 14,909	\$ 12,010	\$ 12,217
Patient Days without newborns	3,140	3,039	3,195	3,195
Average Daily Acute Census	8.60	8.32	8.75	8.75
Outpatient Revenue	106,185,037	95,542,608	89,336,761	87,857,800
Price Change	<u>4,247,400</u>	<u>7,643,409</u>	<u>7,146,941</u>	<u>2,635,734</u>
Gross Outpatient Revenue	110,432,437	103,186,017	96,483,702	90,493,534
Observation Adj. Days	500	445	372	393
ER Visits (all visits)	9,860	9,605	9,860	9,750
Outpatient Visits	47,520	46,949	40,100	38,829
Revenue Per OP Visit	\$ 2,324	\$ 2,198	\$ 2,406	\$ 2,331
All Surgeries	1,556	1,531	1,520	1,513
RHC Encounters	35,400	30,508	29,960	24,362
Total Gross Patient Revenues	158,462,208	148,487,663	137,924,867	129,527,205
Total Adjusted Patient Days	10,774	9,960	11,484	
Adjusted Average Daily Census	29.5	27.3	31.5	
Paid FTEs Per Adjusted Patient Day	15.1	14.3	13.1	
Equivalent FTEs Per Adj Patient Day	18.4	18.1	15.6	
Total Customers Served				
(Less) Uncollectible/Bad Debts	(3,000,000)	(2,977,485)	(2,763,678)	(2,956,426)
(Less) Payor Discounts	<u>(66,051,662)</u>	<u>(62,275,963)</u>	<u>(55,602,248)</u>	<u>(51,475,123)</u>
Net Patient Service Revenue	89,410,546	83,234,215	79,558,941	75,095,656
Other Revenue	748,000	592,615	904,487	452,015
Transfers from Restricted	<u>1,604,000</u>	<u>1,542,353</u>	<u>1,948,472</u>	<u>1,304,781</u>
Total Hospital Net Revenues	91,762,546	⁴⁷ 85,369,183	82,411,900	76,852,452
Net Revenue Per Adj. Pt. Day	\$ 8,517	\$ 8,572	\$ 7,176	

2018/19 Expenses

	Budget 2019	Annualized 2018	Budget 2018	Fiscal 2017
Salaries & Wages	29,915,904	25,542,117	27,417,080	23,374,754
Paid FTEs	447	389	413	373
Cost Per Paid FTE	\$ 66,971	\$ 65,661	\$ 66,385	
Employee Benefits	20,935,712	19,288,397	18,725,144	17,531,466
Benefit Cost Per Paid FTE	\$ 50,815	\$ 52,701	\$ 45,449	
% Benefits Cost	70%	76%	68%	75%
Professional Fees	11,387,248	12,341,913	8,530,525	10,912,133
Pro Fees as % of Expenses	13%	15%	11%	15%
Equivalent FTEs in Pro Fees	96.68	105.29	76.28	
Salaries, Benefits & Pro Fees	62,238,864	57,172,426	54,672,749	51,818,353
Salary, Benefit, Pro per Pt. Day	\$ 5,776.75	\$ 5,740.41	\$ 4,760.64	
Salary, Benefits & Pro Fees as %	70%	70%	70%	70%
SBP as a % of Net Pat. Revenues	70%	69%	69%	69%
Supplies	9,051,180	8,823,347	7,635,412	7,296,329
Supply Cost Per Adj Pat. Day	840	886	665	
Purchased Services	4,269,368	3,717,167	3,910,569	3,529,165
Athena Fee	885,000	-	-	-
Depreciation	4,380,000	4,581,884	5,186,752	5,028,944
Interest Income	(420,000)	(353,283)	(198,339)	(313,502)
Interest Expense	2,904,335	2,969,375	3,067,772	2,959,005
Other Expense	<u>5,184,517</u>	<u>4,891,350</u>	<u>4,152,769</u>	<u>4,127,468</u>
Total Operating Expenses	88,493,264	81,802,267	78,427,684	74,445,762
Cost Per Adjusted Patient Day	8,214	48 8,213	6,829	
Cost to Charge Ratio	55.85%	55.09%	56.86%	57.48%

2018/19 Net Revenues

	Budget 2019	Annualized 2018	Budget 2018	Fiscal 2017
Operating Income (Loss)	3,269,282	3,566,916	3,984,216	2,406,691
Operating Margin %	3.6%	4.2%	4.8%	3.1%
Oper, Margin Per Adj Pat. Day	303	358	347	
District Taxes Receipts	624,000	526,979	578,071	583,727
Athena Installation Costs	(720,000)	-	-	-
Grants & Gifts Received	2,080,000	1,549,932	500,000	250,200
Other Non Operating	48,000	52,982	28,517	73,853
Medical Office Building (Net)	(4,941,282)	(4,453,706)	(4,670,804)	(4,060,873)
340B Net Activity	<u>240,000</u>	<u>(3,251)</u>	<u>200,000</u>	<u>(26,454)</u>
Non-Operating Income (Loss)	(2,669,282)	(2,327,064)	(3,364,216)	(3,179,547)
Net Income (Loss)	600,000	1,239,852	620,000	(772,856)
Net Margin %	0.7%	1.5%	0.8%	-1.01%
Net Income Per Adj Pat. Day	55.69	124.49	53.99	

Net Operations

- **Net Income of \$600,000, .7 % net margin after one time Athena implementation expenses of \$720,000.**
- **Positive cash flow of \$2,150,000**
- **Adequate Financial Ratios**
- **Reduce A/R Days to below 72**
- **Days Cash on Hand at a minimum of 90 days at go live (September 25th)**
- **Cost of Capital equal to 5.15%**

Request from Management

- **Approve the Operating Budget for 2018/19**
- **Authorize the increase in prices by 4% as of August 1, 2018 with 60% increase in swing bed rate**
- **Authorize the creation of any other appropriate documents and resolutions as required to implement the Operating Budget**



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June 4, 2018

Mr. John Tremble
Chief Financial Officer
Northern Inyo Healthcare District
150 Pioneer Lane
Bishop, California 93514-2599

***Northern Inyo County Local Hospital District Retirement Plan
Recommended Funding for 2018-19 Fiscal Year***

Dear John:

We have completed the first phase of our actuarial valuation of the Northern Inyo County Local Hospital District Retirement Plan as of January 1, 2018, where we determine the recommended annual contribution for the fiscal year ending June 30, 2019.

The recommended annual contribution for the 2018-19 fiscal year is \$4,896,000. This means the current monthly contribution rate of \$393,000 should be increased to \$408,000, effective July 1, 2018, as shown in the funding schedule in Exhibit 1. The details of the calculation of the recommended contribution are shown in Exhibit 2.

Despite the decrease in covered payroll, the recommended contribution increased by \$180,000 this year (from \$4,716,000 to \$4,896,000), primarily due to a lower return on assets of 1.0% for 2017 than the 5.0% that is assumed in the valuation, and also due to other actuarial losses on Plan liabilities.

This year we updated the mortality assumption to incorporate the MP-2017 projection scale that was recently published by the Society of Actuaries in October 2017. The effect of this change was not material, resulting in only a very slight lowering of Plan liabilities and costs from what they would have been without the change.

Please refer to Appendices A, B, and C for summaries of the Plan provisions, actuarial assumptions, and participant data, respectively, that were used to determine the valuation results shown herein.

The full actuarial valuation report will be completed in August and will include the accounting information required by GASB 67 and 68 for the fiscal year ending June 30, 2018.

Note

In preparing this report, we have relied without audit on information (some oral and some in writing) provided by New York Life Insurance Company and the Healthcare District. This information includes, but is not limited to, financial information, census data, and plan provisions. We found this information to be reasonably consistent and comparable with information used for other purposes. The valuation results depend on the integrity of this information. If any of this information is inaccurate or incomplete the results may be different and the calculations may need to be revised.

All costs, liabilities, rates of interest, and other factors for the Fund have been determined on the basis of actuarial assumptions and methods which are individually reasonable (taking into account the experience of the Plan and reasonable expectations); and which, in combination, offer our best estimate of anticipated experience affecting the Fund.

This valuation report is only an estimate of the Plan's financial condition as of a single date. It can neither predict the Plan's future condition nor guarantee future financial soundness. Actuarial valuations do not affect the ultimate cost of Plan benefits, only the timing of Plan contributions. While the valuation is based on an array of individually reasonable assumptions, other assumption sets may also be reasonable and valuation results based on those assumptions would be different. No one set of assumptions is uniquely correct. Determining results using alternative assumptions is outside the scope of our engagement.

Future actuarial measurements may differ significantly from the current measurements presented in this report due to such factors as the following: plan experience differing from that anticipated by the economic or demographic assumptions; changes in economic or demographic assumptions; increases or decreases expected as part of the natural operation of the methodology used for these measurements (such as the end of an amortization period or additional cost or contribution requirements based on the Fund's funded status); and changes in plan provisions or applicable law. Due to the limited scope of our assignment, we did not perform an analysis of the potential range of future measurements. The Healthcare District has the final decision regarding the appropriateness of the assumptions and actuarial cost methods.

The calculations reported herein have been made in accordance with the applicable provisions of the Internal Revenue Code. The results of this valuation are applicable only for the current year and are intended to be used only by the plan sponsor for the specific purposes described herein.

Milliman's work is prepared solely for the internal business use of the Healthcare District. To the extent that Milliman's work is not subject to disclosure under applicable public records laws, Milliman's work may not be provided to third parties without Milliman's prior written consent. Milliman does not intend to benefit or create a legal duty to any third party recipient of its work product. Milliman's consent to release its work product to any third party may be conditioned on the third party signing a Release, subject to the following exception(s):

- (a) The Healthcare District may provide a copy of Milliman's work, in its entirety, to the Healthcare District's professional service advisors who are subject to a duty of confidentiality and who agree to not use Milliman's work for any purpose other than to benefit the Healthcare District.
- (b) The Healthcare District may provide a copy of Milliman's work, in its entirety, to other governmental entities, as required by law.

No third party recipient of Milliman's work product should rely upon Milliman's work product. Such recipients should engage qualified professionals for advice appropriate to their own specific needs.

The consultants who worked on this assignment are pension actuaries. Milliman's advice is not intended to be a substitute for qualified legal or accounting counsel.

On the basis of the foregoing, we hereby certify that, to the best of our knowledge and belief, this report is complete and accurate and has been prepared in accordance with generally accepted actuarial principles and practices which are consistent with the applicable Actuarial Standards of Practice of the American Academy of Actuaries. The undersigned is a member of the American Academy of Actuaries and meets the Qualification Standards of the American Academy of Actuaries to render the actuarial opinion contained herein.

If you'd like to discuss, please call me at (415) 394-3716.

Sincerely,

A handwritten signature in black ink that reads 'Richard A. Wright' in a cursive style.

Richard A. Wright

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enc.
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EXHIBIT 1. MONTHLY CONTRIBUTIONS

To satisfy the funding requirement for the 2018 plan year, we recommend the schedule of contributions shown below. Contributions for a fiscal year (July 1 to June 30) are being applied to the plan year (January 1 to December 31) ending within the fiscal year.

Approximate Date of Contribution	Contributions for the 2018 Plan Year
07/15/2018	\$ 408,000
08/15/2018	408,000
09/15/2018	408,000
10/15/2018	408,000
11/15/2018	408,000
12/15/2018	408,000
01/15/2019	408,000
02/15/2019	408,000
03/15/2019	408,000
04/15/2019	408,000
05/15/2019	408,000
06/15/2019	<u>408,000</u>
Total	\$ 4,896,000

EXHIBIT 2. RECOMMENDED CONTRIBUTION

The recommended contribution targets a funding level of 110% of the Accumulated Benefit Obligation (ABO). Since the plan is currently funded less than 110% of ABO, the deficit is amortized over a 20 year period starting from January 1, 2012 (i.e. 14 years remaining as of January 1, 2018). The recommended contribution is reduced, if necessary, to the Full Funding Limitation.

	PLAN YEAR ENDING	
	December 31, 2018	December 31, 2017
Target Surplus		
Accumulated Benefit Obligation (ABO)	\$ 42,680,430	\$ 43,010,196
Funding Target %	<u> x 110%</u>	<u> x 110%</u>
Funding Target (110% of ABO)	\$ 46,948,473	\$ 47,311,216
Actuarial Assets	<u>26,405,455</u>	<u>28,484,086</u>
Excess / (deficit)	\$ (20,543,018)	\$ (18,827,130)
Recommended Contribution		
ABO Normal Cost	\$ 2,688,877	\$ 2,768,306
Amortization of (Excess) / Deficit	<u>1,976,512</u>	<u>1,727,475</u>
Total as of beginning of year	\$ 4,665,389	\$ 4,495,781
Interest	<u>233,269</u>	<u>224,789</u>
Total as of end of year	\$ 4,898,658	\$ 4,720,570
Full Funding Limitation, end of year	\$ 33,719,534	\$ 32,365,129
Recommended Contribution	\$ 4,898,658	\$ 4,720,570

APPENDIX A. SUMMARY OF PENSION PLAN

The following paragraphs are only a brief summary of the more important provisions of the plan. In the event there are any inconsistencies between statements contained in this Appendix and the plan document, the provisions of the plan document shall control.

Effective Date: March 1, 1975; last restatement January 1, 2009; amended January 1, 2008; and amended January 1, 2013.

Plan Eligibility: An employee becomes a participant of the plan on the earliest January 1 or July 1 following the later of attainment of age 21 and completion of 1 year of service. The Plan was closed to new entrants effective January 1, 2013.

Vesting: 50% vesting after 5 years of Credited Service increasing 10% per year until 100% vested after 10 years of service. Active participants automatically become 100% vested upon attainment of normal retirement age or if they become totally and permanently disabled.

Normal Retirement Date: The first day of the month coinciding with or following the later of Participant's attainment of age 65 or completion of 5 years of plan participation. However, the Normal Retirement Date shall not be later than age 70.

Normal Retirement Benefit: 2.50% of Average Annual Compensation multiplied by years of Credited Service, but not less than \$600.

Average Annual Compensation: Average of annual compensation for the highest consecutive 36-month period preceding the determination date. Compensation includes wages, shift differential, standby pay, and 50% of the value of any unused and unpaid sick leave existing at the time of termination of employment, and accrued after April 26, 1997.

Accrued Benefit: Normal Retirement Benefit prorated on credited service.

Normal Form of Retirement Benefit: Life Annuity.

Early Retirement: The first day of the month coinciding with or following the Participant's attainment of age 55 and completion of at least 5 years of credited service. Then the normal retirement benefit will be reduced by 5/9% for each of the first 60 months and 5/18% for each additional month that payment starts before normal retirement age.

Pre-Retirement Death Benefit: If a vested participant dies prior to retirement, his or her beneficiary will receive the actuarially determined present value of his or her accrued benefit.

APPENDIX B. ACTUARIAL COST METHOD AND ASSUMPTIONS

The following cost method and assumptions were used in valuing the benefits of all participants.

	January 1, 2018	January 1, 2017
Actuarial Cost Method	Entry Age Normal Cost Method	Entry Age Normal Cost Method
Form of Payment Election	60% of retiring participants are assumed to elect a lump sum, and 40% are assumed to elect an annuity.	60% of retiring participants are assumed to elect a lump sum, and 40% are assumed to elect an annuity.
Interest Rate		
<i>Pre-retirement</i>	5.00%	5.00%
<i>Post-ret. (Annuity elected)</i>	5.00%	5.00%
<i>Post-ret. (Lump Sum elected)</i>	<u>Based on Date of Participation</u> DOP Before 7/1/2009: 8.00% DOP On/After 7/1/2009: 6.50%	<u>Based on Date of Participation</u> DOP Before 7/1/2009: 8.00% DOP On/After 7/1/2009: 6.50%
Mortality		
<i>Pre-retirement</i>	RP-2014 Healthy Mortality with Generational Projection from 2006 Base Year using Scale MP-2017	RP-2014 Healthy Mortality with Generational Projection from 2006 Base Year using Scale MP-2016
<i>Post-ret. (Annuity elected)</i>	RP-2014 Healthy Mortality with Generational Projection from 2006 Base Year using Scale MP-2017	RP-2014 Healthy Mortality with Generational Projection from 2006 Base Year using Scale MP-2016
<i>Post-ret. (Lump Sum elected)</i>	<u>Based on Date of Participation</u> DOP Before 7/1/2009: 1984 UP Mortality Table set back 4 years. DOP On/After 7/1/2009: RP-2000 Table for Males set back 4 years.	<u>Based on Date of Participation</u> DOP Before 7/1/2009: 1984 UP Mortality Table set back 4 years. DOP On/After 7/1/2009: RP-2000 Table for Males set back 4 years.
Salary Scale	4.00%	4.00%
Disability		
<i>Disablement Rate</i>	None.	None.
<i>Disabled Annuitants Mortality</i>	None.	None.
Withdrawal Rates	Table T-8, <u>The Actuary's Pension Handbook</u> , Crocker-Sarason-Straight.	Table T-8, <u>The Actuary's Pension Handbook</u> , Crocker-Sarason-Straight.
Retirement Age	The later of age 65 or the 5 th anniversary of date of participation; or age 70, if earlier.	The later of age 65 or the 5 th anniversary of date of participation; or age 70, if earlier.
Asset Valuation Method	Market value	Market value

APPENDIX C. SUMMARY OF PARTICIPANT DATA

The plan was closed to new entrants effective January 1, 2013.

Active Participants as of January 1, 2018

Age	NUMBER OF PARTICIPANTS			ANNUAL SALARIES		
	Males	Females	Total	Males	Females	Total
Under 25	0	0	0	\$ 0	\$ 0	\$ 0
25 - 29	2	2	4	123,340	80,649	203,989
30 - 34	3	9	12	219,831	598,908	818,739
35 - 39	5	16	21	549,667	971,124	1,520,791
40 - 44	4	8	12	370,788	518,419	889,207
45 - 49	5	9	14	367,665	619,769	987,434
50 - 54	3	19	22	296,911	1,414,955	1,711,866
55 - 59	9	36	45	745,901	2,377,123	3,123,024
60 - 64	7	35	42	626,555	2,837,109	3,463,664
65 - 69	0	3	3	0	135,145	135,145
70 & Over	<u>0</u>	<u>2</u>	<u>2</u>	<u>0</u>	<u>86,146</u>	<u>86,146</u>
Total	38	139	177	\$ 3,300,658	\$ 9,639,347	\$ 12,940,005

Other Participants as of January 1, 2018

Participant Status	NUMBER OF PARTICIPANTS			ANNUAL BENEFITS		
	Males	Females	Total	Males	Females	Total
Part-time	0	2	2	\$ 0	\$ 94,728	\$ 94,728
Disabled	0	1	1	0	3,885	3,885
Terminated Vested	18	52	70	249,672	698,779	948,451
Retired	<u>0</u>	<u>0</u>	<u>0</u>	<u>0</u>	<u>0</u>	<u>0</u>
Total	18	55	73	\$ 249,672	\$ 797,392	\$ 1,047,064

APPENDIX C. SUMMARY OF PARTICIPANT DATA (cont'd)

Active Participants as of January 1, 2018

Age	YEARS OF SERVICE							Total
	0-4	5-9	10-14	15-19	20-24	25-29	30+	
Under 25	0	0	0	0	0	0	0	0
25 - 29	0	4	0	0	0	0	0	4
30 - 34	0	6	6	0	0	0	0	12
35 - 39	0	10	10	1	0	0	0	21
40 - 44	0	4	7	1	0	0	0	12
45 - 49	0	6	3	5	0	0	0	14
50 - 54	0	7	7	1	3	3	1	22
55 - 59	0	6	14	10	6	4	5	45
60 - 64	0	6	13	8	5	2	8	42
65 - 69	0	1	1	1	0	0	0	3
70 & Over	<u>0</u>	<u>1</u>	<u>0</u>	<u>0</u>	<u>0</u>	<u>0</u>	<u>1</u>	<u>2</u>
Total	0	51	61	27	14	9	15	177

**NORTHERN INYO HEALTHCARE DISTRICT
POLICY AND PROCEDURE**

Title: NIHD Board Meeting Minutes	
Scope: Board of Directors	Manual: BOD Policy Manual - Administration
Source: Board of Directors	Effective Date: 06/20/2018

PURPOSE: Establish documentation policy for Northern Inyo Healthcare District (NIHD) Board of Directors (BOD) meeting minutes.

POLICY: Northern Inyo Healthcare District Board of Directors meeting minutes shall be kept in action format. The following information shall be included in each meeting's minutes:

- Date, place and type (regular or special) of meeting
- Directors and Chief Executive team members present and absent by name.
- Call to Order (including time)
- Names (if given) of public commentators, and topic commented on.
- If a Director arrives late or leaves early, the time and name shall be recorded.
- Names of Directors absent during any agenda item on which action was taken.
- BOD directives to staff.
- Motions or resolutions on which action was taken.
- Names of Directors making and seconding motions.
- Public comments made by BOD members.
- Topics included in closed session.
- Announcement by BOD President stating what action, if any, was taken during closed session.
- Time of adjournment.

PROCEDURE:

1. The clerk of the BOD shall prepare and keep minutes of all regular and special BOD meetings.
2. The draft minutes of the previous regular BOD meeting and any special meeting(s) of the BOD held since the previous regular meeting shall be distributed to Directors as part of the information packet for the next regular BOD meeting at which time the BOD shall consider approving the minutes as presented or with corrections.
3. Unapproved minutes are "preliminary drafts that are not retained by the public agency in the ordinary course of business." (CA Government Code Section 6254). Therefore, draft minutes shall not be released until the BOD has approved them.
4. Once approved by the BOD the minutes shall be posted on the District website and maintained in the District's official files.
5. After approval, the Secretary of the BOD shall sign the minutes.
6. Motions and resolutions of regular and special BOD meetings shall be recorded as having passed or failed. Individual votes for and against and abstentions shall be recorded unless the action was unanimous.
7. All resolutions adopted by the BOD shall be numbered consecutively, starting new numbering at the beginning of each calendar year.

REFERENCES:

1. (CA Government Code Section 6254) Public Records Act

**NORTHERN INYO HEALTHCARE DISTRICT
POLICY AND PROCEDURE**

Title: NIHD Board Meeting Minutes	
Scope: Board of Directors	Manual: BOD Policy Manual - Administration
Source: Board of Directors	Effective Date: 06/20/2018

Approval	Date
Board of Directors	06/20/2018
Last Board of Directors Review	06/20/2018

Developed: April 2, 2018

Reviewed:

Revised:

Supersedes:

Index Listings:

**NORTHERN INYO HEALTHCARE DISTRICT
POLICY AND PROCEDURE**

Title: Northern Inyo Healthcare District Board of Directors Meetings/Brown Act Compliance	
Scope: Board of Directors	Manual: BOD Policy Manual - Administration
Source: Board of Directors	Effective Date: 06/20/2018

PURPOSE: Establish procedures for Northern Inyo Healthcare District (NIHD) Board of Directors' (BOD) meetings.

POLICY:

1. All meetings of the NIHD BOD shall be conducted in accordance with the Ralph Brown Act, Government Code 54950 et seq. and such additional requirements as set forth in any other BOD Policy and Procedures.

PROCEDURE:

1. Meetings of the BOD shall be held at the NIHD Board Room located at 2957 Birch St. Bishop CA 93514 except as otherwise set forth in agenda notices.
2. Regular meetings shall be held the third Wednesday of each calendar month unless it is deemed necessary to cancel or hold the regular monthly meeting on a different date.
3. As the BOD encourages public participation at its meetings (whether regular, special, study sessions, or emergency) and to facilitate communications, the BOD will ensure agendas are posted in the required timeframe on the NIHD website in addition to other legal requirements. The place, date and time of the meeting shall be indicated on the agenda.
4. Each agenda shall include a time for public comment on non-agenda items as well as comment opportunity on each action agenda item when called.
5. If any Director is attending the meeting by teleconference, the location shall be posted and accessible to the public.
6. The President of the NIHD BOD shall preside at all board meetings at which they are present. In absence of the President, the Vice President shall perform the President's duties and have the President's rights. If both the President and Vice President are absent then the Secretary shall perform the President's duties and have the President's rights.
7. The President shall call the meeting to order at the time set on the agenda or as soon as a quorum is present.
8. A majority (3 of 5 members) shall constitute a quorum for transaction of business. An abstention does not count as a vote for or against.
9. If no directors are present the clerk of the board shall adjourn the meeting to a future date and time. A notice of the adjournment including the future date and time of the adjourned meeting shall be conspicuously posted on or near the door of the place where the meeting was held.
10. If the date of the adjourned meeting is within five (5) days of the original meeting, no new agenda need be posted if no additional agenda items are added. If the date of the adjourned meeting is more than five (5) days a new agenda must be posted.
11. The President of the BOD, as necessary to conduct business of the District, can call special meetings or study sessions.
12. Ordinarily, items on the agenda will be considered in the order set forth in the agenda. However, the President may alter the order of items on the agenda, as the President deems necessary for the good of the meeting.
13. The President may declare a short recess during any meeting.

**NORTHERN INYO HEALTHCARE DISTRICT
POLICY AND PROCEDURE**

Title: Northern Inyo Healthcare District Board of Directors Meetings/Brown Act Compliance	
Scope: Board of Directors	Manual: BOD Policy Manual - Administration
Source: Board of Directors	Effective Date: 06/20/2018

14. The President shall have the same rights as the other Board members in voting, introducing or seconding motions and resolutions as well as participating in discussions.
15. No action may be taken by secret ballot. (Government Code Section 54953(c).)
16. All votes taken during a teleconferenced meeting shall be by roll call. (Government Code Section 54953(b)(2).)
17. Directors shall observe all applicable conflict of interest rules. If a financial interest is determined by any board member they must abstain from any vote that may be in violation of Government Code 1090. The director shall leave the meeting room during any discussion and the vote and shall state the reason for abstention.
18. The annual organizational meeting shall be the regular BOD meeting held in December or at an earlier meeting if called. At that meeting officers shall be elected.

REFERENCES:

1. Ralph Brown Act, Government Code 54950 et seq.
2. Government Code Section 54953(c)
3. Government Code Section 54953(b)(2)
4. Government Code 1090

Approval	Date
Board of Directors	06/20/2018
Last Board of Directors Review	06/20/2018

Developed: March 31, 2018
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**NORTHERN INYO HEALTHCARE DISTRICT
EMPLOYEE HANDBOOK – PERSONNEL POLICY**

Title: TELEWORK PROGRAM POLICY	
Scope: District Wide	Department: Human Resources – Employee Handbook
Source: Human Resources	Effective Date: 6/20/2018

POLICY:

The Northern Inyo Healthcare District (District) believes that its ability to meet the needs of the District’s customers is related to its ability to attract and retain adequate numbers of qualified, competent and diverse employees who provide high quality service in a healthcare setting. To accomplish this, the District determines how employees function within the organization by establishing and maintaining programs that facilitate recruitment, orientation, competency, continuing education, evaluation and a positive work environment to promote employee retention. It is, therefore, the District policy to establish and encourage the use of a telework program whose primary purpose is to meet the District’s mission and operational needs.

In accordance with this policy, the employee/teleworker and management must agree that the telework arrangement is mutually beneficial and the telework arrangement can be terminated by either or both parties when no longer mutually beneficial. Telework means working one or more days away from the District’s assigned space, either at their place of residence (home) or at an alternate worksite. Home-based telework is where the employee/teleworker works in a space specifically set aside as an office in an employee’s residence. Telecenter-based telework is where the employee/teleworker works in an office or other space near the employee’s home to which the employee regularly reports to work. Either option is available to maximize management flexibility in planning and managing eligible employee participation in this telework program.

The objectives of the District’s telework program include (1) improving continuity of operations by using telework as a strategy to keep the District operational during inclement weather, disaster recovery, or other emergency situation; (2) improving air quality and reducing traffic congestion, parking challenges, and commuter costs; (3) promoting management effectiveness by using telework to target reductions in management costs related to employee turnover and absenteeism and to real estate costs associated with all staff reporting to District assigned space for work; (4) enhancing work-life balance for employees by using telework flexibly so that employees may better manage their work and family obligations thereby retaining a more resilient District workforce capable of meeting organizational goals; and, (5) enhancing employee engagement by increasing work options for employees with or without mobility restrictions, increasing return-to-work options for employees who are on temporary limited duty, and improving employee morale overall.

PROCEDURES:

- A. District Chiefs, during the annual budget cycle, will designate Full Time Equivalent (FTE) position(s) that they deem appropriate for telework arrangements.

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- B. Each FTE position deemed appropriate for telework arrangements will be posted internally so as to afford incumbent employees the opportunity to compete for the available position(s) if applicable.
1. Only the best qualified internal candidates will be selected for participation in the telework program.
 2. Once selected for the telework program, District Chiefs will determine appropriate employees for annual participation in the telework program based on the date the qualified application was received, the last most recent overall performance rating, the length of time performing current duties, and the expected contributions of the applicant to the District’s mission, vision, values, and goals of the District. In the event of a tie between applicants, a random selection process will be implemented.
- C. Participating employees and the District shall enter into an annual (after successful completion of a pilot) written telework arrangement governing responsibilities of both parties during the course of the telework arrangement that will include, but not limited to, equipment, expenses, hours of work (employees must choose either a telework arrangement or an alternative work schedule but not both), overtime, safety, adherence to District policies, and termination of the arrangement.
- D. Employees who are currently participating in a performance improvement plan, who have participated in a performance improvement plan (PIP) within the last 12 months, who are in their probationary period (or any extension thereof), and/or who have a record of disciplinary action within the last 12 months, are not eligible to apply for telework. Employees who participate in a PIP and/or are issued a disciplinary action during the course of a telework arrangement are ineligible to continue the telework arrangement.

RESPONSIBILITIES:

- A. Chief
1. Oversight of the telework arrangements in their work area.
 2. Designate appropriate FTE(s) prior to the commencement of each fiscal year as telework eligible and include this designation in each fiscal year’s budget.
 3. Approve or discontinue telework arrangements for District employees in their areas and serve as the final signature authority on the selected employee’s telework arrangement. This approval authority may be delegated to appropriate management officials.

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B. Director/Department Head/Manager/Assistant Manager

1. Encourage the use of telework arrangements for the designated position with relevant employees including all requirements and expectations regarding the telework arrangement.
2. Facilitate the submission of all required documents to their Chief or designated approving official once employee has signed the arrangement.
3. Provide teleworkers with specific, measurable, and attainable assignments, just as they would non-teleworking employees.
4. Foster an inclusive work environment for all types of workers by communicating general office updates and related information to teleworkers and ensuring employees who remain in the District's assigned work areas are not negatively impacted by handling the teleworker's regular assignments (answering telephone calls, dispensing information, etc.).
5. Conduct periodic reviews, virtually if needed, of telework arrangements to determine ongoing compliance, effectiveness and impact on work operations and employee productivity.

C. District Telework Coordinator

1. Coordinate, in partnership with the Chiefs, the District's Telework Program.
2. Oversee implementation of the program, providing guidance as needed.
3. Serve as a resource for information and/or training to District employees on the program.
4. Retain appropriate documentation on the program including each employee's signed telework arrangement.
5. As a part of a cycle of continuous improvement, annually assess the program and makes recommendations for improvement, if warranted.

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D. Employees

1. Apply for designated FTE(s) that are approved for telework arrangements as desired and submit required documentation timely.
2. Review and understand all expectations regarding the telework arrangement including, but not limited to, maintenance of telephone and internet connectivity.
3. Comply with all District policies or procedures as they apply to a teleworker, including but not limited to, check in/out procedures, productivity and safety standards, hours of work and overtime request requirements.
4. Protect and preserve District assets, information and property at all times while under a telework arrangement.
5. Participate and cooperate as needed in the District’s ongoing and annual assessment(s) of the viability of the District’s Telework Program.

REFERENCES:

The Joint Commission Standards: HR.01.01.01 - HR.01.07.01 and PI.03.01.01

Approvals	Date
Human Resources	6/1/2018
Senior Leadership	6/4/2018
Board of Directors	6/20/2018

**NORTHERN INYO HEALTHCARE DISTRICT
EMPLOYEE HANDBOOK – PERSONNEL POLICY**

Title: Workplace Violence Prevention Policy	
Scope: Hospital-District Wide	Manual: Human Resources
Source: Chief of Human Resources	Effective Date: 6/22/2017

POLICY:

Northern Inyo Healthcare District (~~NIHD~~~~District~~) is committed to providing a safe and healthful work environment for ~~our~~~~the District's~~ patients, visitors, employees, volunteers, contractors, suppliers, members of the medical staff and members of the public. ~~NIHD-The District~~ has zero tolerance for any act of violence or any threat of violence that occurs on ~~NIHD-District~~ property. This prohibition against threats or acts of violence applies to all ~~NIHD-District~~ patients, visitors, employees, volunteers, and members of the medical staff, contractors, suppliers, and members of the public.

NOTE: This is a ZERO-TOLERANCE policy, meaning that ~~NIHD-the District~~ shall take appropriate action to correct any violation of this policy, after an investigation into the facts and circumstances of each reported incident.

~~NIHD-The District~~ prohibits retaliation against an individual who has alleged that a workplace violence incident has occurred, who has participated in an investigation of a workplace violence incident or who has reported an incident of workplace violence to law enforcement.

PROCEDURES:

I. Workplace Violence includes, but is not limited to, the following:

A. Any act of violence or threat of violence that occurs at or towards any District worksite or District employee. Some examples of behavior that exhibit aggression/violence include, but are not limited to, the following:

1. Intimidation, including verbal attacks, humiliation in front of others, using a sincere tone to get what is wanted
2. Offensive language and/or sexual innuendos in the form of words, expressions, gestures and other social behaviors that are perceived as disrespectful
3. Verbal abuse in the form of shouting, insulting, intimidating, threatening, shaming, demeaning, or derogatory language
4. Verbal assault in the form of negative defining statements told to the person or told about a person intended to cause injury or harm that includes verbal, vocalized threats; threatening body language, and written threats
5. Physical Assault which is an intentional action by a person that creates an apprehension in another of an imminent, harmful or offensive contact and includes slapping, pushing, and shoving as

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EMPLOYEE HANDBOOK – PERSONNEL POLICY**

Title: Workplace Violence Prevention Policy	
Scope: Hospital-District Wide	Manual: Human Resources
Source: Chief of Human Resources	Effective Date: 6/22/2017

well as assaults involving weapons and the risk of serious bodily injury.

~~A.~~ B. The use of physical force against a ~~NIHD-District~~ employee by a patient or a person accompanying a patient that results in, or has a high likelihood of resulting in, injury, psychological trauma, or stress, regardless of whether the employee sustains an injury.

~~B.~~ C. An incident involving the use of a firearm or other dangerous weapon, regardless of whether the employee sustains an injury.

~~C.~~ D. The following are the four (4) workplace violence types:

1. “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.
2. “Type 2 violence” means workplace violence directed at employees by customers, clients, patients, students, inmates, or visitors or other individuals accompanying a patient.
3. “Type 3 violence” means workplace violence against an employee by a present or former employee, supervisor, or manager.
4. “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.

II. Identifying and responding to risks:

A. Workplace Violence Prevention Assessment Team (V-PAT). ~~NIHD-The District~~ has established the V-PAT, which shall convene on an ad hoc basis, consisting of the following, or their designee:

- Chief Operating Officer
- Chief Nursing Officer
- Chief, ~~Accounting-Finance~~ Officer
- Chief Human Resources Officer
- Director, Human Resources
- Director, Project/Property Management (includes Safety Officer and Security professionals)

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Director of Maintenance
 Director, Administrative Staff, RHC/NIA
Security Officer
House Supervisor
Director of Nursing
 Manager, Emergency Department/Disaster Planning
 Employee Health professional
Maintenance professional
District Education Coordinator
Director, Quality and RiskQuality Assurance and Performance
~~Improvement Assistant~~
 Others as determined appropriate

- B. The V-PAT is responsible for:
1. Hazard assessment
 2. Workplace safety and security assessment
 3. Hazard correction, control and prevention
 4. Development and implementation of a Workplace Violence Prevention Plan
 5. Annual evaluation of the Workplace Violence Prevention Plan
- C. Hazard Assessment. A Hazard Assessment shall include a review of the following records:
1. OSHA logs
 2. Quality Review Reports (QRR)
 3. Worker's Compensation reports
 4. Environment of Care reports
 5. Human Resources Department records
 6. Workplace Violence Incident Reports
 7. Workplace Violence Incident Response and Investigation Forms
 8. Area crime statistics
- D. Workplace Safety and Security Assessment: A workplace safety and security assessment shall be conducted to identify and evaluate safety and security risks, nature and extent of hazards, conditions, and/or situations that may exist that could place an individual in danger of violence.

NOTE: The V-PAT may seek assistance and/or input from sources to include; local law enforcement, employee assistance program counselors, NIHD liability insurance carrier, and/or a security/safety specialist.

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E. Hazard Correction, Control and Prevention. Based upon information gathered during the Hazard Assessment and the Workplace Safety and Security Assessment, the V-PAT shall implement appropriate hazard corrections which may include engineering controls, new equipment, workplace design, and/or policy/procedure development.

F. Development, ~~and~~ Implementation, and Annual Evaluation of a Workplace Violence Prevention Plan. The V-PAT shall lead the development and implementation of a Workplace Violence Prevention Plan. Once developed, the V-PAT shall lead an evaluation of the Workforce Violence Prevention Plan at least annually. Such evaluation shall be documented.

~~G. Annual Evaluation of the Workplace Violence Prevention Plan. The V-PAT shall undergo an evaluation of the Workplace Violence Prevention Plan annually. Such evaluation shall be documented.~~

III. Training and Communication

All employees, and others as determined by the District, shall receive training at new employee orientation and annually thereafter and this training shall be documented. Certain employees and others may receive specific training depending upon their particular job and/or work location and such training shall also be documented. When there is a change to equipment, work practices or the work environment due to hazard correction, affected employees and others shall be trained thereon and such training shall be documented.

IV. Incident Reporting and Investigations

A. All incidents under this policy shall be documented immediately using the Workplace Violence Incident Report Form available online and in the Quality Assurance and Performance Improvement Department.

B. All incidents under this policy shall be reported to any of the following: Security Officer, Department Head, House Supervisor, Director, Human Resources Department, any Chief, the Administrator on Call (AOC), or the Chief Executive Officer (CEO). Incidents of workplace violence may also be reported to law enforcement and/or any relevant regulatory agency.

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- C. All Workplace Violence Incident Report Forms are to be submitted to the Quality Assurance and Performance Improvement Department during business hours (Monday through Friday, 8 am – 4:30 pm). Outside of these business hours, all such report forms are to be submitted to the House Supervisor or the AOC.
- D. All post-incident responses including any investigation shall be documented using the Workplace Violence Incident Response and Investigation Form available online and in the Quality Assurance and Performance Improvement Department.

V. Support for Victims of Violence

Victims of incidents under this policy may have to contend with a variety of medical, psychological, and legal consequences. NIHD shall assist victims by:

- A. Referring victims to appropriate medical care
- B. Referring victims to appropriate community resources.
- C. Providing flexible work hours or short-term or extended leave as appropriate.
- D. Cooperating with law enforcement personnel in the investigation of any crime.

VI. Record Keeping

The Quality Assurance and Performance Improvement Department shall maintain records of all Workplace Violence Incident Report forms and all Workplace Violence Incident Response and Investigation forms under this policy. Access to such records shall be limited to a need to know basis as determined jointly by the Director, Human Resources and the applicable Chief. Records of employee injuries shall be maintained in Human Resources in accordance with OSHA requirements. Confidentiality of patient information and employee records shall be maintained.

VII. Responsibility

- A. The Chief Human Resources Officer is responsible for administering the Workplace Violence Prevention Plan and ensuring that this Plan is communicated to all relevant persons including other employers of employees working at a ~~NIHD-District~~ facility.
- B. Chiefs, Department Heads, and supervisory personnel are responsible for the enforcement of this policy. Chiefs, Department Heads and supervisory

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Title: Workplace Violence Prevention Policy	
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Source: Chief of Human Resources	Effective Date: 6/22/2017

personnel are required to report, in writing using the Workplace Violence Incident Report form, any incidents of workplace violence without delay.

- C. All persons including members of the medical staff, employees, suppliers, contractors, visitors, patients, and volunteers are expected to follow all policies and procedures and to report acts of violence immediately.

REFERENCES:

Workplace Violence Prevention in Health Care Regulation (Title 8, CCR, Section 3342)
Occupational Safety and Health Act of 1970
[Injury and Illness Prevention Policy](#)
The Joint Commission Standards: EC.01.01.01, EC.02.01.01, EC.02.06.01, EC.03.01.01, and EC.04.01.01

Committee Approval	Date
Human Resources	6/2/2017
Safety Committee	7/12/2017
Executive Team	6/5/2017
Board of Directors	6/22/2017
<u>Last Board of Directors Review</u>	<u>6/20/2018</u>

**NORTHERN INYO HOSPITAL
POLICY AND PROCEDURE**

Title: Emergency Department Level of Care Worksheet	
Scope: Emergency Department	Manual: Emergency Department
Source: Emergency Department Director	Effective Date: 11/01/2013

PURPOSE: To define the methodology to assign the Facility Level of Care based on an acuity system determined by points assigned to the nursing interventions, complexity of the service, resource utilization and the time spent on the episode. The Level of Care Worksheet is to be completed by the RN on duty for every ED patient who presents to our ED. (See Attachment A)

The intent is to capture nursing procedures/processes that are not separately chargeable as procedures. Patients are charged based upon the amount of nursing time and resources necessary to care for them. All assigned points must be supported by the nursing documentation.

POLICY:

1. INITIAL ASSESSMENT

Current Procedural Terminology defines the following as recognized body systems:

- Eyes
 - Ears, nose, mouth and throat
 - Cardiovascular
 - Respiratory
 - Gastrointestinal
 - Genitourinary
 - Musculoskeletal
 - Skin
 - Neurologic
 - Psychiatric
 - Hematologic/Lymphatic/Immunologic
- a. Triage: Each ED patient is initially triaged by an RN. Documentation of the chief complaint, arrival status, initial vital signs and a focused nursing assessment is to be included. Additional information may also be included. A point value of 10 will be assigned for this assessment.
 - b. ED Visit for Recheck only: Assigned for a return patient who is following-up for a recheck of an established diagnosis from a previous encounter. There can be no new symptoms or problems at this recheck. A point value of 5 will be assigned for this assessment.
 - c. Brief Focused Assessment of One (1) System: Assigned for the assessment and documentation of one (1) body system. A point value of 5 will be assigned for this assessment.
 - d. Limited Assessment 2 – 3 Systems or Reassessment (with new findings): Assigned for the assessment and documentation of 2 – 3 body. A point value of 10 will be assigned for this assessment.
 - e. Multi-System Assessment or Reassessment 4 or more body systems (with new findings): Assigned for the assessment and documentation of 4 or more body systems. A point value of 15 will be assigned for this assessment.
 - f. Leaving against Medical Advise (AMA): Assigned for the patient who, against the advice of their medical provider (which included elopement), checks themselves out of

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the ED. This is with or without the patient's signature. A point value of 25 will be assigned for this situation.

2. MODE OF ARRIVAL / DISCHARGE

- a. Arrival via Ambulance: Assigned for the patient who is transported to the Emergency Department by an Emergency Medical Services provider and care is assumed by the ED staff. A point value of 10 is assigned.
- b. Admission to Hospital: Assigned for the patient who is admitted through the Emergency Department to the hospital. A point value of 15 is assigned.
- c. Transfer to Acute Care, SNF or Psychiatric Facility: Assigned for the patient who is transported to another Acute Care, Skilled Nursing Facility or Psychiatric Facility where a higher level of care can be performed. A point value of 20 is assigned.

3. DISCHARGE INSTRUCTIONS

- a. Simple: Assigned when there is 0 - 1 item documented in each of the following categories on the discharge instructions given to the patient; Illness, medication, follow-up and/or medical supply. A point value of 5 is assigned for this discharge.
- b. Complex: Assigned when there are 2 or more items documented in any of the following categories on the discharge instructions; Illness, medication(s), follow-up instructions and/or medical supplies. (An example would be 2 medical illnesses, 1 medication and a follow-up instruction). A point value of 10 is assigned for this discharge.
- c. Discharge Instructions Requiring Return Demonstration: Assigned for the patient who is being discharge that has learned and demonstrated a new skill set required to continue their care at home. (An example of this would be crutch fitting & training with return demonstration). A point value of 15 is assigned for this discharge.
- d. Involved Teaching Needs: Assigned when documented that a nurse has utilized additional time and/or resources educating a patient about a new diagnosis, intervention or procedure that the patient or patient's family needs to learn to care for the patient. An example would be a new diagnosis of diabetes, or the use of anticoagulants. A point value of 20 is assigned to this service.

4. MONITORING

- a. Vital Signs 1 – 2 Readings: Assigned for each vital sign check that is documented in the patient's medical record. A patient should receive a vital sign check at admission and upon discharge; therefore each patient should receive this credit. A point value of 5 is assigned.
- b. Orthostatic Vital Signs: Assigned each time a patient receives an orthostatic vital sign assessment and is documented in the medical record. An MD order is required for points to be assigned. A point value of 10 is assigned.
- c. Pulse Oximetry (3 or more readings, or is continuous): Assigned when 3 or more readings are documented or there is continuous monitoring of a patient's O2 saturation. A point value of 10 is assigned.
- d. Multiple Blood Pressure Checks (3 or more): Assigned when 3 or more readings are documented either by the nurse or continuous monitoring via a trend sheet. A point value of 15 is assigned.
- e. Multiple Temperature Checks (3 or more): Assigned when 3 or more readings are documented either by the nurse or continuous monitoring via a trend sheet. A point value of 10 is assigned.

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- f. Multiple Glasgow Coma Scale checks (3 or more): Assigned when 3 or more readings are documented. A point value of 15 is assigned.
 - g. Cardiac Monitoring: Assigned for documentation of and a physician order for cardiac monitoring. A point value of 25 is assigned.
5. **ROUTINE SUTURE/STAPLE REMOVAL AND WOUND CHECK**
When completing this section, no other section will be used, and no other point values from other sections will be added. This is only for removal or checks for procedures completed at our facility.
- a. Triage: Each ED patient is initially triaged by an RN. Documentation of the chief complaint, arrival status, initial vital signs and a focused nursing assessment is to be included. Additional information may also be included. A point value of 0 will be assigned for this assessment.
 - b. Wound Cleaning: Assigned when documented that a wound is cleaned, not requiring additional time and/or resources other than the basic supplies and is not associated with a procedure, suturing or other wound closures, performed by the MD. A point value of 0 is assigned for this service.
 - c. Suture/Staple Removal: Assigned when documented that a patient comes in for the removal of sutures/staples that were placed at our facility. A point value of 0 is assigned to this service.
 - d. Simple Discharge Instructions: Assigned when there is 0 - 1 item documented in each of the following categories on the discharge instructions given to the patient; Illness, medication, follow-up and/or medical supply. For routine wound closure removal or wound check, this should reinforcement of initial visit discharge instructions. A point value of 0 is assigned for this discharge.
6. **WOUND CARE, SPRAINS AND FRACTURES**
- a. Suture/Staple Removal: Assigned when documented that a patient comes in for the removal of sutures/staples that were placed at another facility. A point value of 10 is assigned to this service.
 - b. Wound Cleaning: Assigned when documented that a wound is cleaned, not requiring additional time and/or resources other than the basic supplies and is not associated with a procedure, suturing or other wound closures, performed by the MD. A point value of 10 is assigned for this service.
 - c. Laceration Repair with Steri-Strips: Assigned when documented that a laceration is repaired using steri-strips only. A point value of 10 is assigned for this service.
 - d. Dressing Small: Assigned when documented that a wound is dressed and the size of the dressing is designated as small. (An example would be a Band-Aid or a 2 X 2 dressing.) The application of dressings is credited when not associated with a procedure performed by the MD. A point value of 5 is assigned.
 - e. Dressing Medium: Assigned when documented that a wound is dressed and the size of the dressing is designated as medium. (An example would be a 4 X 4 dressing.) The application of dressings is credited when not associated with a procedure performed by the MD. A point value of 10 is assigned.
 - f. Dressing Large: Assigned when documented that a wound(s) is dressed and the size of the dressing is designated as large. (An example would be a head wound requiring a head wrap and/or there are multiple dressings applied. The application of dressings is credited when not associated with a procedure performed by the MD. A point value of 15 is assigned.

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- g. Placement of Aces, Slings and all Pre-Made Splints: Assigned when documented that the nurse applies an ace, sling or any pre-made splint to a patient. A point value of 15 is assigned.
- h. C-Spine Stabilization: Assigned when documented that the nurse initially applies, or confirms proper placement of a cervical collar when received from EMS. A point value of 30 is assigned.

7. MEDICATIONS AND IV'S

- a. Medications – Oral, Suppository, Topical and Drops (not IV or Injections SQ or IM): Assigned when documented that an oral, suppository, topical and/or dropped medication is administered to the patient. This does not include IV, IVP, SQ or IM administration of medication. A point value of 5 for each medication administered is assigned.
- b. IV Start or Saline Lock Start: Assigned when documented that an IV or saline lock is started but there is no medication or fluid given through this site. Credit is given when a blood draw is done through the site. A point value of 10 is assigned for each new site started. A point value of 10 is assigned.
- c. Each Additional IV Attempt: Assigned when documented for each attempt that is made to start an IV or saline lock prior to the successful intervention. A point value of 5 for each additional attempt is assigned.

8. TREATMENTS

- a. Simple Eye Irrigation: Assigned when documented that the nurse irrigates the eye when not associated with a procedure performed by the MD. A point value of 5 is assigned to this service.
- b. Eye Irrigation with Morgan Lenses: Assigned when documented that the nurse irrigates the eye in conjunction with the use of the Morgan Lenses. A point value of 15 is assigned to this service.
- c. Eye Exam (Stain/slit lamp), w/o FB removal: Assigned when documented that there is an examination of the eye using medication and/or a slit lamp. Credit is given when it is not associated with a foreign body removal. A point value of 15 is assigned to this service.
- d. Suction / Irrigation: Assigned when documented that the nurse performs suction or irrigation, by any route. This is assigned each time either of these interventions is performed. A point value of 20 is assigned to either/each of these services.
- e. Enema administration (other than Fleets enema): Assigned when documented that the nurse administers an enema, that is not a Fleets enema. A point value of 20 is assigned to this service.
- f. Preparation for Surgery: Assigned when documented that the nurse performed duties specific to preparing the patient for surgery. A point value of 20 points is assigned to this service.
- g. Cerumen Removal: Assigned when documented that the nurse removed cerumen from the ear. This is assigned for each time or location (right or left ear) the process is performed. A point value of 20 is assigned to this service.

9. OB / GYN

- a. Fetal Heart Tones: Assigned when documented that a nurse monitors the fetal heart tones on an OB patient. A point value of 10 is assigned to this service.
- b. Pelvic Exam: Assigned when documented that the nurse attends during a pelvic exam of an OB patient. A point value of 20 is assigned to this service.

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10. TESTS

- a. X-Ray Simple: Assigned when documented that the nurse coordinates X-rays for the patient. This is assigned each time a patient is taken to X-Ray or a portable unit is brought to the patients' bedside. It is not assigned for each X-Ray taken at a single sitting. A point value of 5 is assigned to this service.
- b. X-ray Complex or requiring Nurse Accompany: Assigned when documented that the nurse coordinates a complex X-Ray procedure (example would be an MRI or tests requiring preps), or the nurse is required to accompany the patient to have the X-Ray performed. This is assigned each time the nurse coordinates a separate test/sitting or accompanies the patient for the test, not for each test performed at one sitting. A point value of 15 is assigned to this service.
- c. Lab Draw and/or Specimen Pick-Up: Assigned when documented each time that a lab was drawn by the nurse and sent to the lab, or the lab comes to the ER department to perform the draw. It is also assigned each time any specimen that has been collected, is documented that it was sent to the lab. A point value of 5 is assigned for time this service is performed.
- d. Specimen Collection – Urine, Sputum, Wound, Slides and/or Swabs: Assigned each time it is documented that a specimen (of any sort) is collected by the nurse. A point value 10 is assigned to each service performed.
- e. Breathing Treatment by RT or ABG's: Assigned each time it is documented that the nurse coordinated one of these RT services. A point value of 5 is assigned to each of these services.
- f. Visual Acuity: Assigned when documented that a visual acuity test is performed by the nurse. A point value of 5 is assigned to this service.
- g. Hemocult / Gastrocult / Chemstix / Accu-check: Assigned when documented each time one of these tests is performed by the nurse. Points are assigned for each test done or multiple tests of the same type at different times. A point value of 5 is assigned to this service.
- h. Bladder Scan: Assigned when documented that the nurse performs a bladder scan. Points are awarded each time a scan is performed. A point value of 10 is assigned to this service.
- i. 12 Lead ECG: Assigned each time there is a physician order for and documentation that the nurse has performed or coordinated the ECG ordered test. A point value of 15 is assigned to this service.

11. SPECIAL NEEDS / EDUCATION

- a. Emotional Needs Pediatric (Age 14 and Under): Assigned when documented that there was additional time and/or resources required by the nursing staff to take care of the needs of the patient or patient's family. This does not include involved teaching requirements (which are addressed separately). It also does not include the use of interpreters. A point value of 10 is assigned to this service.
- b. Emotional Needs Adult: Assigned when documented that there was additional time and/or resources required by the nursing staff to take care of the needs of the patient or patient's family. This does not include involved teaching requirements (which are addressed separately). It also does not include the use of interpreters. A point value of 10 is assigned to this service.
- c. Social Service or Mental Health Intervention (Non-5150): Assigned when documented that a nurse has coordinated an intervention by Social Services or the Mental Health

**NORTHERN INYO HOSPITAL
POLICY AND PROCEDURE**

Title: Emergency Department Level of Care Worksheet	
Scope: Emergency Department	Manual: Emergency Department
Source: Emergency Department Director	Effective Date: 11/01/2013

Department. Mental Health intervention would not be for an Involuntary Psychiatric Hold (5150). A point value of 10 is assigned to this service.

- d. Combative, Confused, Coordination with Mental Health (5150), Security, Police Involvement or Comatose: Assigned when documented that a nurse has specifically dealt with one of the conditions listed above or has coordinated intervention for any of the above mentioned services or conditions. This would include Mental Health intervention for an Involuntary Psychiatric Hold (5150). A point value of 15 is assigned to this service.
- e. Hospice, Home Health, Oxygen / Airway Referral: Assigned when documented that a nurse has coordinated the services of or a referral for hospice care, home health, and oxygen or airway agency. A point value of 15 is assigned to this service.

12. ASSISTS OR OBSERVATION TIME NOT COVERED IN PROCEDURES

Assists and Observation time are combined to account for the cumulative time a nurse spends at a patients' bedside administering to a patient, and that time is not separately covered under other methods of care. The time may be continuous or frequent in nature, and must be documented as time assisting or observing the patient. (Examples of this time would be assisting the patient to the bathroom, stand by assists for ambulation or feeding the patient). It would not include services that by their very nature are standard nursing duties or when assisting an MD in a procedure.

- a. Assists (1 – 15 minutes): Assigned when documented that a nurse has assisted/observed the patient for a period of time of 1 – 15 minutes in duration. A point value of 10 is assigned for this service.
- b. Assists (16 – 30 minutes): Assigned when documented that a nurse has assisted/observed the patient for a period of time of 16 – 30 minutes in duration. A point value of 15 is assigned for this service.
- c. Assists (31 – 60 minutes): Assigned when documented that a nurse has assisted/observed the patient for a period of time or 31 – 60 minutes in duration. A point value of 20 is assigned for this service.
- d. Each Additional Hour: Assigned when documented that a nurse has assisted/observed the patient for each additional hour beyond the first hour. A point value of 20 is assigned for this service.

13. TOTALS

- a. Initial Assessment: Total of the points in this category
- b. Mode of Arrival / Discharge: Total of the points in this category
- c. Discharge Instructions: Total of the points in this category
- d. Monitoring: Total of the points in this category
- e. Wound Care, Sprains and Fractures: Total of the points in this category
- f. Medications and IV's: Total of the points in this category
- g. Treatments: Total of the points in this category
- h. OB / GYN: Total of the points in this category
- i. Tests: Total of the points in this category
- j. Special Needs / Education: Total of the points in this category
- k. Assists Not Covered in Procedures: Total of the points in this category

**NORTHERN INYO HOSPITAL
POLICY AND PROCEDURE**

Title: Emergency Department Level of Care Worksheet	
Scope: Emergency Department	Manual: Emergency Department
Source: Emergency Department Director	Effective Date: 11/01/2013

14. **CRITICAL CARE SERVICES:** Per the current CPT Manual, Critical Care is defined as ‘... the direct delivery by the medical and nursing staff in the care for a critically ill or critically injured patient. A critical illness or injury acutely impairs one or more vital organ systems resulting in a high probability of imminent or life threatening deterioration in the patient’s condition. This requires high complexity decision making to assess, manipulate and support vital system function(s) to treat single or multiple vital organ system failure and/or to prevent further life threatening deterioration of the patient’s condition. Although critical care typically requires interpretation of multiple physiologic parameters and/or application of advanced technology(s), critical care may be provided in life threatening situations when these elements are not present.’ For the determination on charging for the facility fees, and based upon this description, it is at the nurse’s discretion whether the care of a patient falls under this description or not. If critical care is charged, then there is no other Level of Care determination or charge. There may be other charges for procedures performed in the care of this critical patient.

15. Level of Care

- | | |
|------------------|---|
| a. Level I | 0 – 25 Points |
| b. Level II | 26 – 55 Points |
| c. Level III | 56 – 85 Points |
| d. Level IV | 86 – 125 Points |
| e. Level V | > 125 Points |
| f. Critical Care | Critical Care up to 74 Minutes |
| g. Critical Care | Critical Care: Each additional 30 Minutes |

16. Done by: The initials of the nurse initially completing the Level of Care Worksheet should be placed on this line.

17. Checked by: The initials of the person reviewing or auditing the initial review should be placed on this line.

Approval	Date
CCOC	5/21/18
Business, Coding and Compliance Committee	5/8/18
Board of Directors	
Last Board of Director review	6/21/17

Responsibility for review and maintenance: Emergency Department Director

Index Listings:

Developed: 10/13

Revised:

Retired: Charge Policy, Emergency Department

Reviewed: 04/17gr



Northern Inyo Healthcare District

150 Pioneer Lane
Bishop, CA 93514
(760) 873-2832
Danny.webster@nih.org

May 6, 2018

To: Board of Directors

From: Danny Webster, Director of Plant Operations
Robert Ralston, Maintenance Project Coordinator

Re: 80 Ton Carrier Chiller

On May 8, 2018, maintenance experienced a catastrophic failure of several components of the McQuay Chiller, which cools and maintains the temperature within the Support Building. Over the life of this chiller there have been many changes within the Support Building that have increased the heat load, for example 3 equipment upgrades in the Lab, and extended work load in the Laundry Department.

The current McQuay Chiller can be repaired for approximately \$39,541.00, however that still leaves us with a subpar device unable to keep up with the current demands. On the advice of our HVAC Representative with Carrier we are recommending a full replacement with an 80 ton Carrier Chiller (see attached Carrier Submittal.) This will accommodate current and future needs of the District.

We appreciate your consideration in this matter,

Thank You!

Danny Webster, Director of Plant Operations



Carrier Commercial Service
 1170 W National Drive Suite 50
 Sacramento, CA 95834
 916-928-9500 24/7/365 Service
 License #499642

May 23, 2018

Northern Inyo Hospital
 150 Pioneer Lane
 Bishop, CA 93514
 Attn: Robert Ralston

RE: McQuay Chiller Repair/Rental/Replacement

Upon request, we completed the installation of an emergency 100-ton rental chiller at your facility. After troubleshooting the existing McQuay air-cooled chiller we found a failed #2 compressor, bad contactors, a bad condenser fan motor and VFD. These repairs will also require new refrigerant and oil. It is our understanding that the chiller struggles to handle the load during the summer months; therefore, due to the history, current condition and costs along with potential energy savings we recommend replacing the 70-Ton McQuay chiller with a new 80-Ton Carrier RB chiller.

The new Carrier chiller will be more efficient and increase your overall reliability. Your system currently operates with R-407C refrigerant and the new chiller will be factory charged with R410A, which runs approximately 22 – 26% more efficient than 407C. The Carrier chiller has Greenspeed intelligence with variable speed condenser fans along with a VFD for the pump.

*AquaSnap® 30RB: Best-In-Class For Both Efficiency & Quiet Operation The Carrier AquaSnap® 30RB air-cooled scroll chiller with Greenspeed® Intelligence is best-in-class in multiple categories, including part-load efficiency and sound levels during operation.

Below is a cost summary of costs incurred and future costs. The McQuay repairs are per quote 00416174 in the amount of \$39,541 this quote is repair the deficiencies found during our recent visit. The rental charges summarized below consists of existing and future costs. The monthly rental is a per month fee and will be invoiced appropriately per the number of months on rental. The new chiller cost breaks down the costs associated with a new chiller, excluding electrical and any OSHPOD or engineering services.

McQuay Repairs	\$39,541
----------------	----------

Rental Charges	
Monthly Rental:*	\$9,268
Freight In:	\$3,730
Freight Out:	\$1,599
Install/Startup Labor:	\$5,765
Demo:	\$3,000

New Chiller Costs	
New Chiller	\$64,571
Pump Package	\$12,504
Budget Install	\$39,000
Turkey Chiller Price	\$116,075



Carrier Commercial Service
1170 W National Drive Suite 50
Sacramento, CA 95834
916-928-9500 24/7/365 Service
License #499642

Although you will invest more money upfront to replace the air-cooled chiller, in the long run you will reap the benefits of less maintenance, repairs, and increased operating efficiency. Please let me know if you need anything further or have any questions. Thank you for the opportunity to partner with you in this project.

Sincerely,

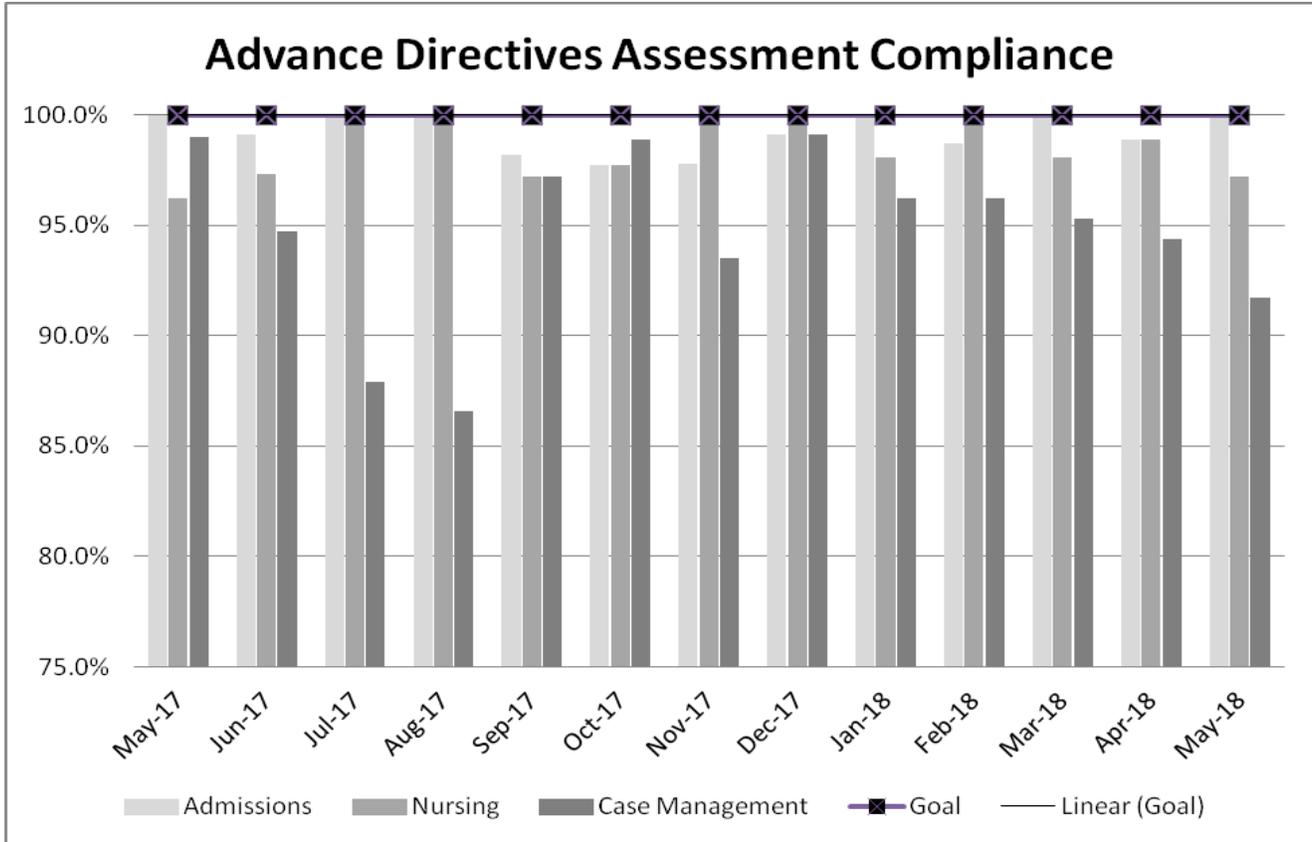
Cristian Saldivar

Cristian Saldivar
Account Executive
Cell: 707.974.8420

2013 CMS Validation Survey Monitoring-June 2018

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

a. Advance Directives Monitoring.

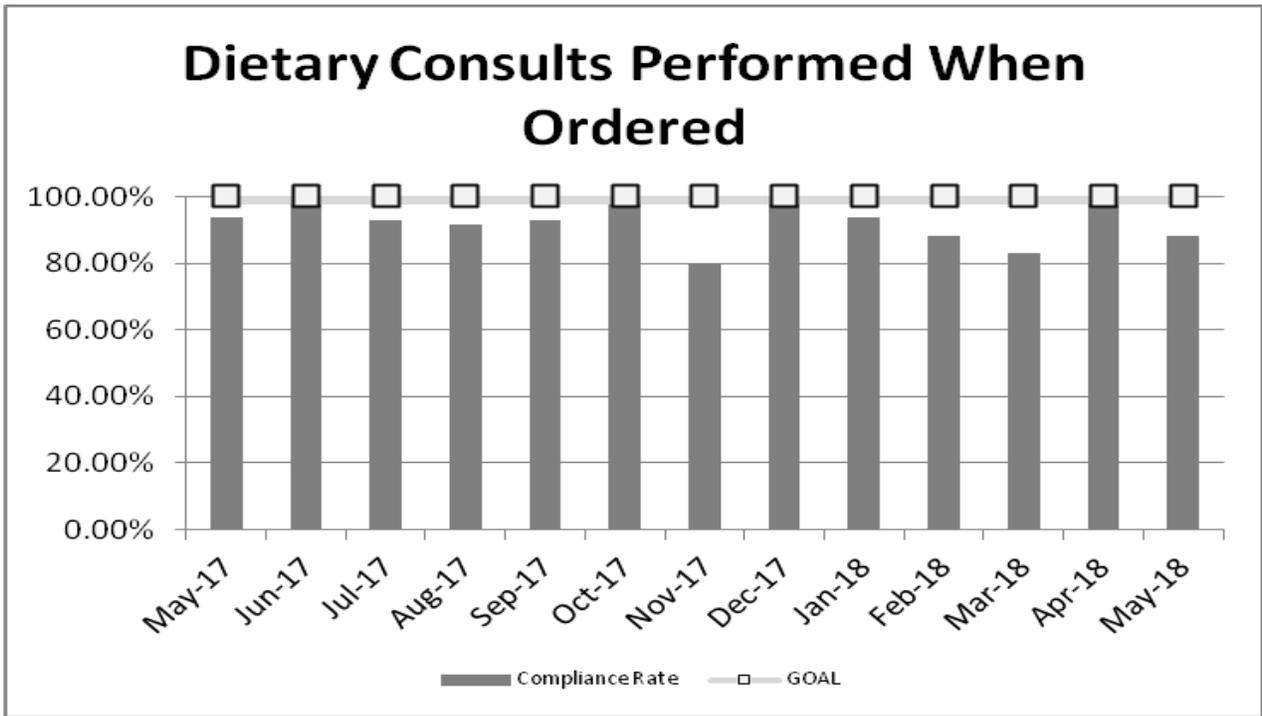


b. Positive Lab Cultures are being routed to Infection Prevention and each positive is being investigated as to source. Monitoring has been ongoing and reported through Infection Control Committee. QAPI receives data.

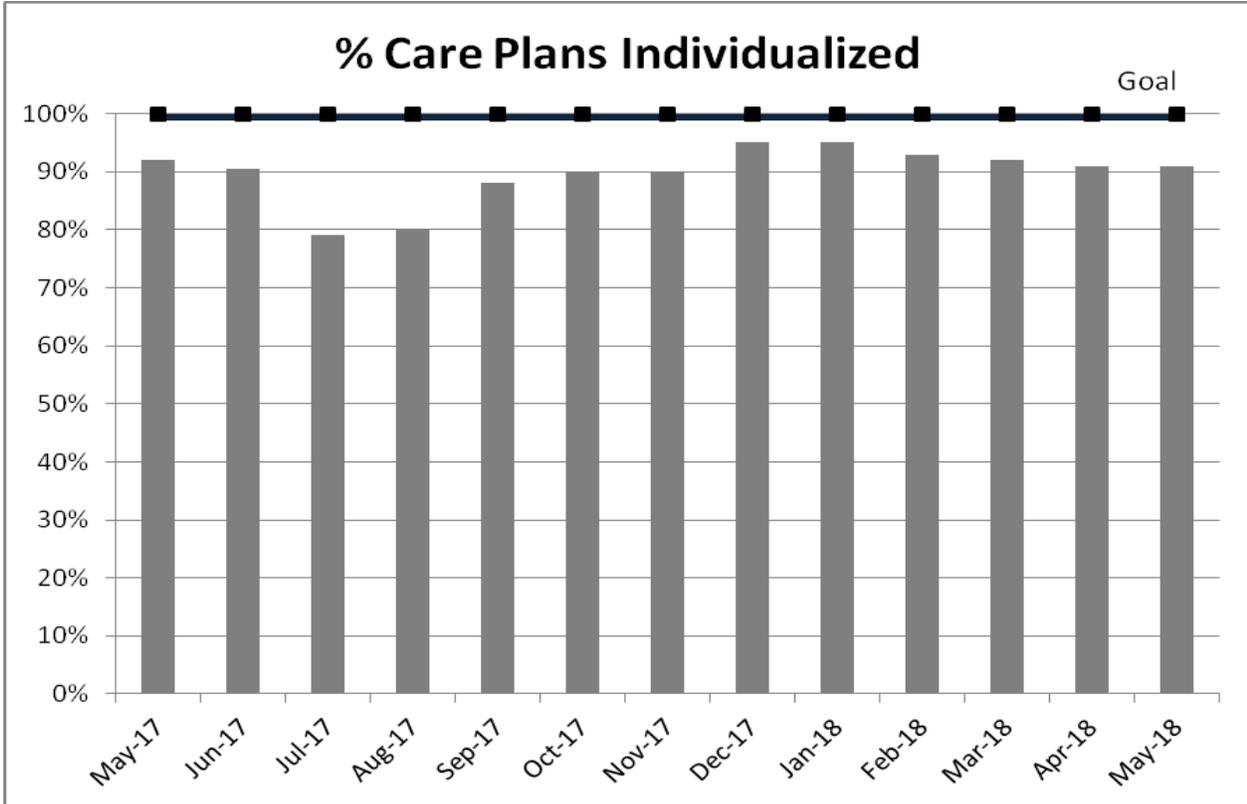
c. Safe Food cooling monitored for compliance with approved policy and procedure. 100% compliance since May 6, 2013.

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

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

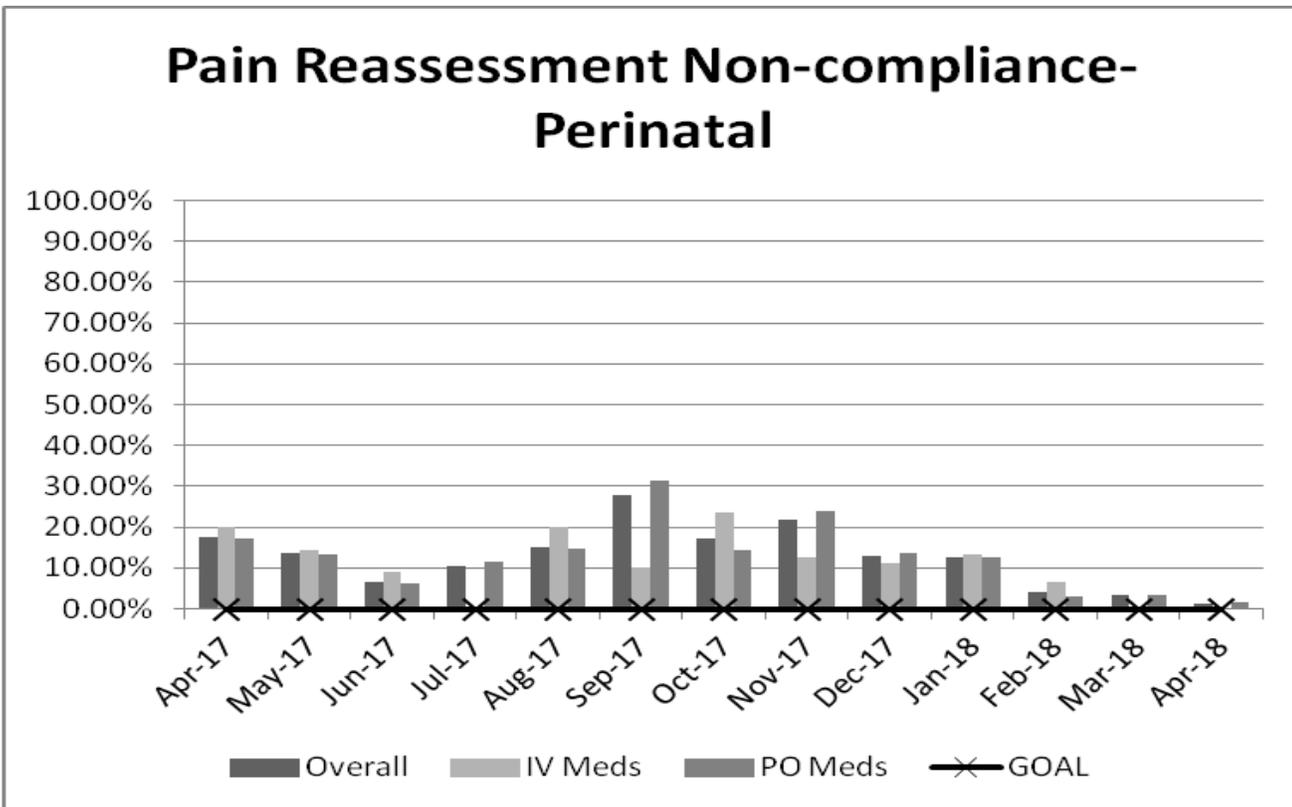


f. Care plans reviewed by Case Management and interventions made to produce care plans. Progress has been made in developing individualized care plans.

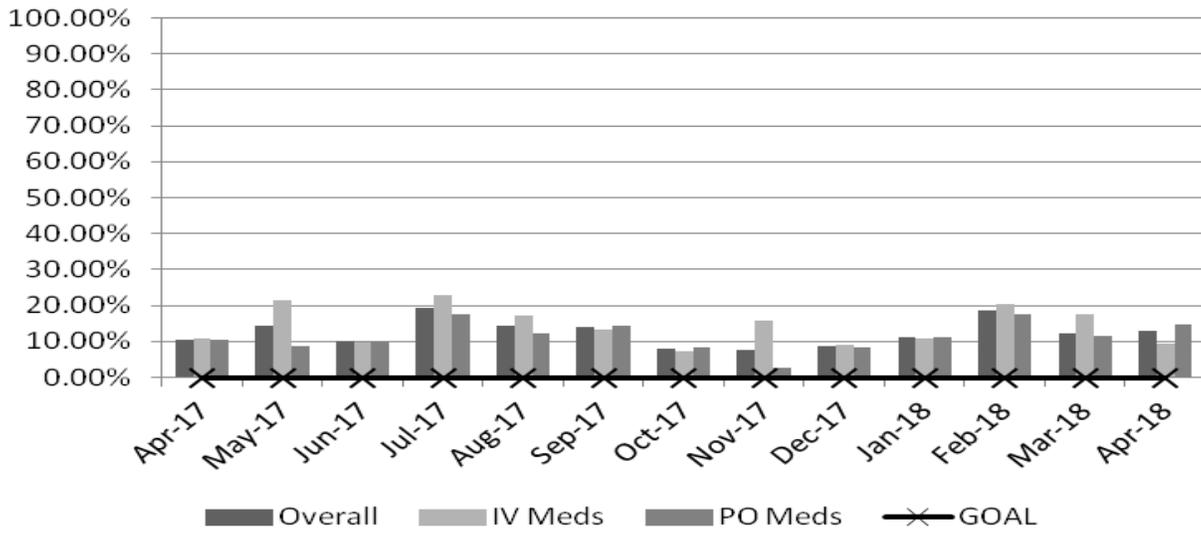


g. Fire drill date, times, attendance and outcomes, smoke detector tests, and fire extinguisher test grids have been approved. All fire drills were complete and compliant from May 6, through present.

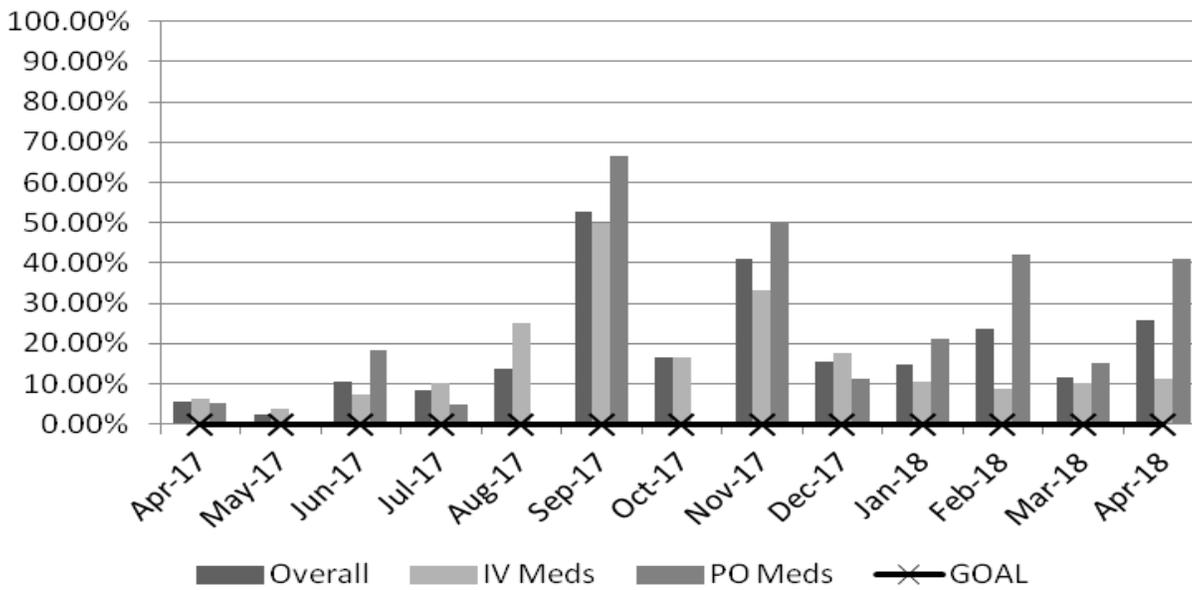
h. Pain Re-Assessment. NIH conducts pain re-assessment after administering pain medications and uses a 1-10 scale.



Pain Reassessment Non-compliance- MedSurg



Pain Reassessment Non-compliance- ICU



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

Pain Reassessment Non-compliance- ED

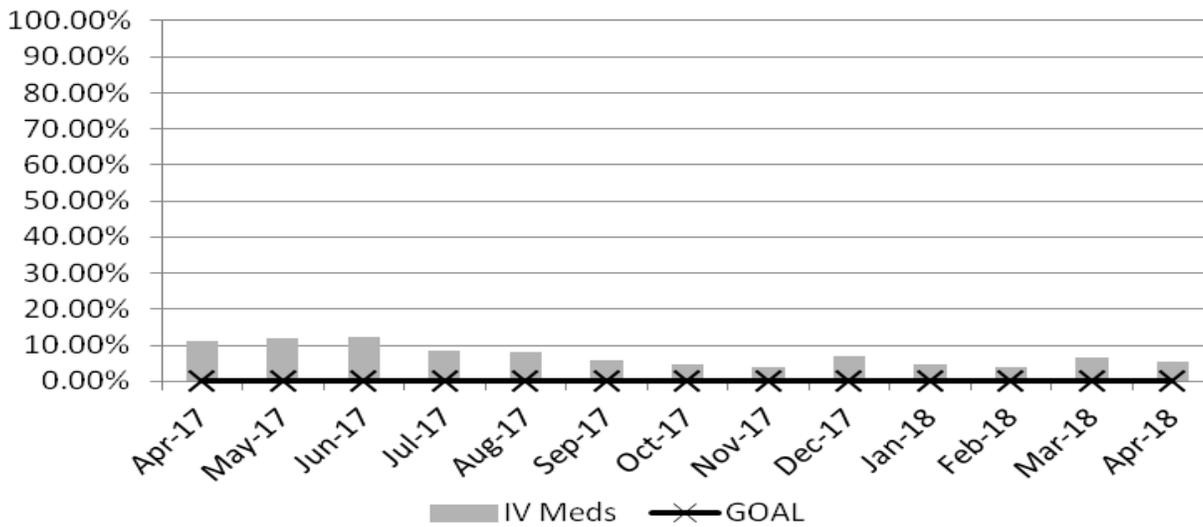


Table 6. Restraint chart monitoring for legal orders.

	<i>Oct 2017</i>	<i>Nov 2017</i>	<i>Dec 2017</i>	<i>Jan 2018</i>	<i>Feb* 2018</i>	<i>Mar 2018</i>	<i>April 2018</i>	<i>May 2018</i>	<i>Goal</i>
Restraint verbal/written order obtained within 1 hour of restraints	3/3 (100%)	1/1 (100%)	3/3 (100%)	1/1 (100%)		2/2 (100%)	1/1 (100%)	1/2 (50%)	100%
Physician signed order within 24 hours	2/3 (66%)	1/1 (100%)	2/3 (66%)	0/1 (0%)		2/2 (100%)	1/1 (100%)	1/2 (50%)	100%
Physician Initial Order Completed (all areas completed and form/time/date noted/signed by MD and RN)	2/3 (66%)	1/1 (100%)	1/3 (33%)	0/1 (0%)		1/2 (50%)	0/1 (0%)	1/2 (50%)	100%
Physician Re-Order Completed (all areas completed and form time/date/noted/signed by MD and RN)	1/2 (50%)	N/A	2/6 (33%)	N/A		3/6 (50%)	N/A	N/A	100%
Orders are for 24 hours	5/5 (100%)	1/1 (100%)	9/9 (100%)	1/1 (100%)		8/8 (100%)	1/1 (100%)	2/2 (100%)	100%
Is this a PRN (as needed) Order	0/5 (0%)	0/1 (0%)	0/9 (0%)	0/1 (0%)		0/8 (0%)	0/1 (0%)	0/2 (0%)	0%

- CALL TO ORDER** The meeting was called to order by M.C. Hubbard, Vice President, at 5:30 pm in the Northern Inyo Healthcare District Board Room at 2957 Birch Street, in Bishop California.
- PRESENT** M.C. Hubbard, Vice President
Mary Mae Kilpatrick, Secretary
Jean Turner, Treasurer
Robert Sharp, Member at Large
Kevin S. Flanigan MD, MBA, Chief Executive Officer
Kelli Huntsinger, Chief Operating Officer
John Tremble, Chief Financial Officer
Tracy Aspel RN, Chief Nursing Officer
Evelyn Campos Diaz, Chief Human Resources Officer
Allison Robinson MD, Vice Chief of Staff
Sandy Blumberg, Executive Assistant
- ABSENT** John Ungersma MD, President
Richard Meredick MD, Chief of Staff
- OPPORTUNITY FOR PUBLIC COMMENT** Ms. Hubbard announced at this time persons in the audience may speak on any items not on the agenda on any matter within the jurisdiction of the District Board (*members of the audience will have an opportunity to address the Board on every item on the agenda, and speakers will be limited to a maximum of three minutes each*). On behalf of the American Association of Retired Persons (AARP) Melissa Best-Baker thanked Northern Inyo Healthcare District (NIHD) for allowing AARP to use the Board room in order to provide tax preparation assistance for members of the community. No other comments were heard.
- AD HOC COMMITTEE REPORT AND ELECTION OF NEW BOARD MEMBER** Jean Turner was pleased to report that the NIHD Board of Directors Ad Hoc Committee established for the purpose of filling the District Zone III Board vacancy recommends the appointment of Mr. Robert Sharp to fill that vacancy. It was moved by Ms. Turner, seconded by Ms. Hubbard, and unanimously passed to approve appointing Mr. Robert Sharp to fill the Northern Inyo Healthcare District Zone III Board vacancy. Former Zone III representative Peter Watercott thanked Mr. Sharp for stepping forward to serve, stating his belief that Mr. Sharp will find serving on the NIHD Board to be a very rewarding experience. Mr. Sharp was then sworn into office by District Secretary Sandra Blumberg.
- CHIEF EXECUTIVE OFFICER REPORT** Chief Executive Officer (CEO) Kevin S. Flanigan MD, MBA provided a Chief Executive Officer report which included the following:
- After a lengthy period of intensive physician recruitment the District has extended a contract offer to Anne Wakamiya MD, who specializes in internal medicine with an emphasis in geriatric care. A response to the contract offer is expected soon, and it is

hoped that Dr. Wakamiya will join the practice of Nickoline Hathaway MD.

- The District has contracted with Colombo Construction Inc. to work on decommissioning the 1967 hospital building, and to begin work on the NIHD Pharmacy upgrade project. Kevin Boots with RBB Architects is also collaborating with NIHD on this project.
- Hospital Week was celebrated in the month of May, and the events that took place proved to be a positive and bonding experience for District staff. Both Doctor Flanigan and Director Hubbard complimented the NIHD Dietary Department in particular for their hard work and many contributions to the success of Hospital Week.

MEDICAL STUDENT HOUSING

Doctor Flanigan reported there is a need for housing accommodations for medical students rotating to this community. The District has reduced its number of contracted rental properties, so any Board members, physicians, staff members, or community members interested in providing housing for healthcare professional students are asked to contact Doctor Flanigan or Dianne Picken in the NIHD Medical Staff Office for more information.

GAP IN ACCESS TO CARE

Doctor Flanigan also reported that until an additional practitioner is added to the Internal Medicine Office, and during the summer months when NIHD providers may schedule vacations, we can expect to experience a gap in access to primary care providers. Joy Engblade MD has stepped up to help provide patient coverage on her Hospitalist Director administrative days, and recruitment efforts continue to bring additional primary care providers on board as soon as possible.

BI-ANNUAL REVIEW OF CONFLICT OF INTEREST CODE

Doctor Flanigan called attention to the NIHD Conflict of Interest Code which is required to be reviewed on a bi-annual basis. He noted that the purpose of the Code is to ensure that financial conflicts of interest do not exist relating to the handling of District funds. It was moved by Mary Mae Kilpatrick, seconded by Ms. Turner, and unanimously passed to approve the bi-annual review of the NIHD Conflict of Interest Code as presented.

QUARTERLY COMPLIANCE REPORT

On behalf of Compliance Officer Patricia Dickson, Doctor Flanigan called attention to the Quarterly Compliance Report as of May 2 2018, which included the following:

- A report of breaches for calendar year 2018
- A report on the number of issues and inquiries received year-to-date
- Review of access to information audits and contract reviews
- Information on District HIPAA Security Risk assessments; CPRA Requests made; District employee compliance with completion of Compliance trainings and education; and progress made toward achieving the goals of the Compliance Department annual

Workplan

Doctor Flanigan additionally reported that the District will soon implement software for electronic auditing of access to patient charts.

NIHD AGREEMENT
WITH INYO COUNTY
FIRST 5 (NEST)

Doctor Flanigan asked to address agenda item 3.K (approval of the *Inyo County First Five Childbirth Education and Breastfeeding Support Services Agreement*) out of order, in order to allow persons present only for that agenda item to leave following discussion. The proposed Inyo County First 5 Grant Proposal would provide funding to expand upon and improve the District's Newborn Evaluation Support & Teaching (NEST) program established in 2015, which promotes best practices and education for pregnancy preparation, labor, and breastfeeding support for local families. Future expansion of the NEST program will include additional training and education for nurses, and establishing a safe sleeping program for newborn babies. It was moved by Ms. Turner, seconded by Robert Sharp, and unanimously passed to approve the agreement with the County of Inyo to expand the NIHD NEST program as requested.

CHIEF OPERATING
OFFICER REPORT

Chief Operating Officer (COO) Kelli Huntsinger provided a bi-monthly COO report which included updates on operations in the following departments: Diagnostic Imaging; Dietary; Environmental Services; Cardiopulmonary; Laboratory; Laundry; Pharmacy; Health Information Management; and Quality and Performance Improvement. Ms. Huntsinger noted the following during her report:

- All departments continue to work on survey readiness
- The District's safety and security programs are being expanded
- NIHD is working on developing employee talent pools, and on expanding educational opportunities to train staff for hard-to-fill positions
- Macrohelix software has been implemented to support the Pharmacy's 340B discounted drug program
- Medical records coding personnel are working hard to keep up with volume, and are providing coding education for physicians
- All hospital departments continue to prepare for implementation of the Athena Health Information System

CHIEF HUMAN
RESOURCES OFFICER
REPORT

Chief Human Resources Officer Evelyn Campos Diaz provided a Human Resources Department update which included the following:

- The District continues to expand its leadership development program
- The NIHD Workforce Council continues to develop new opportunities for District employees and improve upon the overall workforce experience
- Staff development opportunities and trainings continue to be expanded upon
- Budget education for District leadership continues
- Ongoing development of HR office staff continues
- Review and updating of HR policies and procedures continues

- ADP software will soon be implemented for the Human Resources Department

POLICY AND
PROCEDURE
APPROVAL
HOSPITAL ACCOUNTS

Ms. Campos Diaz also called attention to an updated Policy and Procedure titled *Hospital Accounts*, which clarifies that District employees are offered the same payment terms on accounts as members of the public. It was moved by Ms. Kilpatrick, seconded by Ms. Hubbard, and unanimously passed to approve the updated *Hospital Accounts* Policy and Procedure as presented.

CHIEF NURSING
OFFICER REPORT

Chief Nursing Officer Tracy Aspel RN provided a Nursing Department update which included the following:

- The Emergency Department is working to speed up the patient triage process in order to decrease the number of patients who leave the hospital without being seen
- The Medical Surgical team is working on decreasing the noise level in their unit, and improvement has been seen in that area already
- An ICU RN training program with Adventist Health will soon be up and running
- The Skytron system in the Operating Rooms is being replaced
- The District's Urology program will be up and running soon, and nursing staff is being trained on the use of new urology equipment
- Clinical Informatics continues to prepare for the Athena Health Information System implementation
- Work is underway to improve the District's water safety program
- Inspectors will come on site in the next several weeks for the purpose of certifying NIHD as a Baby Friendly facility
- Abel Jones RN is the most recent recipient of the Daisy Award for excellence in nursing

DE-ESCALATION TEAM
POLICY AND
PROCEDURE

Ms. Aspel called attention to a proposed Policy and Procedure titled *De-escalation Team*, which defines District response to situations involving individual(s) displaying escalating, aggressive, hostile, or potentially dangerous behavior. It was moved by Ms. Turner, seconded by Mr. Sharp, and unanimously passed to approve the *De-escalation Team* Policy and Procedure as presented.

CHIEF FINANCIAL
OFFICER REPORT

Chief Financial Officer John Tremble provided a financial and Accounting Department update which included the following:

- Accounting, Admitting, and Purchasing staff are working on the Athena project software build, and Purchasing is building a master list of approximately 4,800 products
- The Payroll Department is in the final stages of ADP system implementation
- Accounting is working on the Athena Chargemaster build, and that department will soon be using 5 different software systems
- Patient volume for the 3rd quarter of this fiscal year is up, however

- operating expenses are up as well
- Cash on hand is lower than usual but will increase in June with the of receipt of an Intergovernmental Transfer

Mr. Tremble additionally noted the operating budget for the upcoming fiscal year will be presented for approval at the June regular meeting.

ADOPTION OF
DISTRICT VALUES

Doctor Flanigan called attention to the following (proposed) District Values statement, which is being established in support of the District Mission and Vision Statements:

VALUES

The members of Northern Inyo Healthcare District Board of Directors are guided by these values in fulfilling our mission and achieving our vision:

- INTEGRITY - We believe in maintaining the highest standards of behavior encompassing honesty, ethics, loyalty, and doing the right thing for the right reason.
- INNOVATIVE VISION - We strive to be capable of extraordinary creativity and are willing to explore new approaches to improving quality of life for all persons.
- STEWARDSHIP – We are dedicated to be responsible stewards of our team, assets and financial resources, and to community service.
- TEAMWORK – We have an abiding respect for others, and a sustaining commitment to work together.

It was moved by Ms. Kilpatrick, seconded by Mr. Sharp, and unanimously passed to approve the proposed NIHD Values Statement as presented.

BOARD OF DIRECTORS
POLICY AND
PROCEDURE
APPROVALS

Ms. Hubbard called attention to the following proposed Board of Directors Policies and Procedures, which are being established in the interest of defining best governance practices for the NIHD Board:

1. *Use by NIHD Directors of District Email Accounts*
2. *Appointments to the NIHD Board of Directors*
3. *Compensation of the Chief Executive Officer*
4. *Requests For Public Funds, Community Grants, Sponsorships*
5. *Authority of the Chief Executive Officer for Contracts and Bidding*
6. *Officers and Committees of the Board of Directors*
7. *Public Records Requests*
8. *Northern Inyo Healthcare District Board of Directors Conflicts of Interest*

It was noted that a ninth Policy and Procedure titled *NIHD Board Meeting Minutes* will be tabled and addressed at the June regular meeting, due to the fact that it was not included in the Board packet for this meeting. It was moved by Mr. Sharp, seconded by Ms. Kilpatrick, and unanimously passed to approve Board Policies and Procedures 1 through 8 as presented, with housekeeping changes being made to the content.

OLD BUSINESS

ATHENA
IMPLEMENTATION
UPDATE

Information Technology Services (ITS) Director Robin Cassidy provided an update on the progress of the Athena Health project, including a timeline for upcoming software implementations (including Orchard; Jump; ADP Human Resources; GeauTech; Athena Health; Centricity for Perinatal; 7 Medical; Intacct; Dragon Medical One; and the Protenuis privacy solution product). Ms. Cassidy additionally provided an overview of the various teams working on the Athena implementation project, and defined the roles of Subject Matter Experts (SME's); Stakeholders; implementation Committees; and the Chiefs. She additionally reported that ITS is focusing on change management, vendor management, communication, and on identifying potential project challenges. The Go Live date for Athena Health will be September 25 2018.

CONSENT AGENDA

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

- Approval of minutes of the April 12 2018 special Board meeting
- Approval of minutes of the April 18 2018 regular Board meeting
- Approval of minutes of the April 20 2018 special Board meeting
- Financial and Statistical reports as of March 31, 2018
- 2013 CMS Survey Validation Monitoring
- Policy and Procedure annual approvals

It was moved by Ms. Turner, seconded by Ms. Kilpatrick, and unanimously passed to approve all six Consent Agenda items as presented, with 2 corrections being made to the minutes for the April 18 2018 regular meeting.

CHIEF OF STAFF
REPORT

On behalf of Chief of Staff Richard Meredith MD, Vice Chief of Staff Allison Robinson MD reported following careful review, consideration, and approval by the appropriate Committees, the Medical Executive Committee recommends approval of the following Policies, Procedures, Protocols, and Order Sets:

POLICIES,
PROCEDURES,
PROTOCOLS, AND
ORDER SETS

1. *Code Blue Procedure – Code Blue Team*
2. *Color-Coded Wristband Use*
3. *Evaluation and Medical Screening of Patients Presenting to the Emergency Department*
4. *Laser Safety*
5. *Leaving Hospital Against Medical Advice, Refusal of Treatment or Transfer*
6. *Management of the Behavioral Health Patient (5150 and non-5150)*
7. *Medical Screening Examination for Emergency Department Physician Assistant – Standardized Protocol*
8. *Medical Waste Management*
9. *Medication/Solution Transfer to the Sterile Field*
10. *Nursing Care Guidelines in the PACU*
11. *Preoperative Preparation and Teaching*
12. *Standards of Care PACU*

It was moved by Ms. Kilpatrick, seconded by Mr. Sharp, and unanimously passed to approve Policies, Procedures, Protocols, and Order Sets 1 through 12 as presented.

ANNUAL REVIEWS

Doctor Robinson reported the Medical Executive Committee also recommends approval of the following Annual Reviews:

1. *Surgical Critical Indicators 2018*
2. *Anesthesia Critical Indicators 2018*
3. *Perinatal Critical Indicators 2018*
4. *Neonatal Critical Indicators 2018*

It was moved by Ms. Turner, seconded by Mr. Sharp, and unanimously passed to approve Annual Reviews 1 through 4 as presented.

OB CORE PRIVILEGE
FORM

Doctor Robinson also reported the Medical Executive Committee recommends approval of the updated *OB/GYN Core Privilege Form*. It was moved by Ms. Turner, seconded by Ms. Kilpatrick, and unanimously passed to approve the updated *OB/GYN Core Privilege Form* as requested.

INTERIM CHIEF OF
RADIOLOGY

Doctor Robinson requested Board approval of the appointment of Edmund Pillsbury MD to act as Interim Chief of Radiology Services. It was moved by Mr. Sharp, seconded by Ms. Hubbard, and unanimously passed to approve the appointment of Edmund Pillsbury MD as Interim Chief of Radiology Services as requested.

MEDICAL STAFF
APPOINTMENTS /
PRIVILEGES

Doctor Robinson also reported following careful review, consideration, and approval by the appropriate Committees the Medical Executive Committee recommends approval of the following Medical Staff Appointments and Privileges:

1. Steve N. Dong MD (*Urology*) – Provisional Consulting Staff
2. Sheldon M. Kop MD (*Radiology, Tahoe Carson Radiology*) – Consulting Staff
3. Ian K. Tseng MD (*Teleradiology, Quality Nighthawk*) – Telemedicine Staff
4. Rainier A. Manzanilla MD (*interventional cardiology*) – Provisional Consulting Staff

It was moved by Ms. Turner, seconded by Ms. Kilpatrick, and unanimously passed to approve all 4 Medical Staff Appointments and Privileges as requested.

AHP PRIVILEGES

Doctor Robinson additionally reported following careful review, consideration, and approval by the appropriate Committees the Medical Executive Committee recommends the following Allied Health Professional (AHP) privileging:

1. Jennifer Figueroa PA-C – *approval to function under the following standardized protocol: Medical Screening Examination for Emergency Department Physician Assistant*

It was moved by Ms. Kilpatrick, seconded by Ms. Turner, and unanimously passed to approve the AHP privileging of Jennifer Figueroa PA-C as requested.

TELEMEDICINE STAFF
APPOINTMENTS /
PRIVILEGES

Doctor Robinson also reported following careful review, consideration, and approval by the appropriate Committees the Medical Executive Committee recommends the following:

- Telemedicine Staff Appointments/Privileges – Proxy Credentialing
 - *As per the approved Telemedicine Physician Credentialing and Privileging Agreement, and as outlined and allowed by 42CFR 482.22, the Medical Staff has chosen to recommend the following practitioner for Telemedicine privileges relying upon Adventist Health’s credentialing and privileging decisions:*
 - Zarmen Israelian MD (*Endocrinology*) – Adventist Health, Telemedicine Staff

It was moved by Ms. Turner, seconded by Ms. Kilpatrick, and unanimously passed to approve the Telemedicine Staff Appointment and Privileging of Zarmen Israelian MD, as requested.

MEDICAL STAFF
RESIGNATION

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

- John Williamson MD (*Renown Telecardiology*) – effective 1/19/18

It was moved by Ms. Kilpatrick, seconded by Mr. Sharp, and unanimously passed to approve the Medical Staff resignation of John Williamson MD, as requested.

BOARD MEMBER
REPORTS

Ms. Hubbard stated at this time members of the Board of Directors may comment on any items of interest. Director Turner praised the District’s employee Years of Service event, while Director Kilpatrick expressed her appreciation of the Daisy Award ceremony recognizing excellence in nursing. Ms. Hubbard welcomed Mr. Sharp to the NIHD Board, and praised those involved in providing an outstanding Hospital Week for District staff.

CLOSED SESSION

At 7:45 pm Ms. Hubbard announced the meeting would adjourn to closed session to allow the Board of Directors to:

- A. Discuss Labor Negotiations; Agency Designated Representative: Kevin Dale, Employee Organization: AFSCME Council 57 (*pursuant to Government Code Section 54957.6*).
- B. Discuss trade secrets, new programs and services (estimated public session date for discussion yet to be determined)(*Health and Safety Code Section 32106*).
- C. Confer with Legal Counsel regarding pending and threatened litigation, existing litigation and significant exposure to litigation,

- D. 2 matters pending (*pursuant to Government Code Section 54956.9*).
- E. Discuss a personnel matter (*pursuant to Government Code Section 54957*).

RETURN TO OPEN
SESSION AND REPORT
OF ACTION TAKEN

At 9:08 pm the meeting returned to open session. Ms. Hubbard reported the Board took action to authorize Doctor Flanigan to have District legal counsel draft an agreement to purchase Pioneer Home Health for \$300,000, noting that stipulations will be attached to the purchase agreement. Ms. Hubbard additionally noted that Director Kilpatrick abstained from the closed session vote on this matter.

ADJOURNMENT

The meeting adjourned at 9:10 pm.

M.C. Hubbard, Vice President

Attest:

Mary Mae Kilpatrick, Secretary

NORTHERN INYO HEALTHCARE DISTRICT
PRELIMINARY STATEMENT OF OPERATIONS
for period ending April 30, 2018

	ACT MTD	BUD MTD	VARIANCE	ACT YTD	BUD YTD	VARIANCE
Unrestricted Revenues, Gains & Other Support						
Inpatient Service Revenue						
Routine	862,460	778,471	83,989	9,683,756	7,888,524	1,795,232
Ancillary	2,263,786	2,700,381	(436,595)	27,449,752	27,363,845	85,907
Total Inpatient Service						
Revenue	3,126,246	3,478,852	(352,606)	37,133,509	35,252,369	1,881,140
Outpatient Service	9,048,636	7,857,438	1,191,198	86,508,824	79,622,094	6,886,730
Gross Patient Service						
Revenue	12,174,881	11,336,290	838,591	123,642,333	114,874,463	8,767,870
Less Deductions from Revenue						
Patient Service Revenue						
Deductions	189,002	227,153	(38,151)	2,301,551	2,301,802	(251)
Contractual Adjustments	4,863,242	4,348,068	515,174	51,186,545	44,060,423	7,126,122
Prior Period Adjustments	(300,989)	(12,967)	(288,022)	(1,987,214)	(131,404)	(1,855,810)
Total Deductions from						
Patient Service Revenue	4,751,255	4,562,254	189,001	51,500,882	46,230,821	5,270,061
Net Patient Service						
Revenue	7,423,626	6,774,036	649,590	72,141,450	68,643,642	3,497,808
Other revenue	277,227	74,342	202,885	722,095	753,325	(31,230)
Total Other Revenue	277,227	74,342	202,885	722,095	753,325	(31,230)
Expenses:						
Salaries and Wages	2,038,882	2,253,618	(214,736)	21,212,964	22,836,665	(1,623,701)
Employee Benefits	1,851,446	1,538,619	312,827	16,330,955	15,591,361	739,594
Professional Fees	974,411	701,142	273,269	10,329,299	7,104,876	3,224,423
Supplies	870,786	627,567	243,219	7,494,340	6,359,355	1,134,985
Purchased Services	365,683	348,470	17,213	3,156,103	3,531,168	(375,065)
Depreciation	332,906	428,731	(95,825)	3,772,457	4,344,480	(572,023)
Bad Debts	373,849	234,952	138,897	2,609,002	2,380,849	228,153
Other Expense	251,656	341,327	(89,671)	3,923,519	3,458,749	464,770
Total Expenses	7,059,618	6,474,426	585,192	68,828,639	65,607,503	3,221,136
Operating Income (Loss)	641,235	373,952	267,283	4,034,906	3,789,464	245,442
Other Income:						
District Tax Receipts	43,955	47,513	(3,558)	439,550	481,460	(41,910)
Tax Revenue for Debt	128,647	160,148	(31,501)	1,286,468	1,622,838	(336,371)
Partnership Investment Income	-	-	-	-	-	-
*Grants and Other						
Contributions	29,499	41,096	(11,598)	1,559,430	416,440	1,142,990
Interest Income	31,324	16,302	15,022	296,528	165,191	131,337
Interest Expense	(238,142)	(252,142)	14,000	(2,467,207)	(2,555,041)	87,834
Other Non-Operating Income	2,463	2,344	119	42,236	23,752	18,484
Net Medical Office	(523,563)	(383,901)	(139,662)	(3,866,893)	(3,890,189)	23,296
340B Net Activity	-	16,439	(16,439)	(3,251)	166,582	(169,833)
Non-Operating						
Income/Loss	(525,818)	(352,201)	(173,617)	(2,713,140)	(3,568,967)	855,827
Net Income/Loss	115,417	21,751	93,666	1,321,766	220,497	1,101,269

NORTHERN INYO HEALTHCARE DISTRICT

Preliminary BUDGET VARIANCE ANALYSIS

Fiscal Year Ending June 30, 2018

Year to date for the month ending April 30, 2018

	259	or	8.9%	more IP days than in the prior fiscal year
\$	1,881,140	or	5.3%	over budget in Total IP Revenue and
\$	6,886,730	or	8.6%	over budget in OP Revenue resulting in
\$	8,767,870	or	7.6%	over budget in gross patient revenue &
\$	3,497,808	or	5.1%	over budget in net patient revenue

Year-to-date Net Revenue was	\$		72,141,450	
Total Operating Expenses were:	\$		68,828,639	
for the fiscal Year To Date				
\$	3,221,136	or	4.9%	over budget. Salaries and Wages were
\$	(1,623,701)	or	-7.1%	under budget and Employee Benefits
\$	739,594	or	4.7%	over budget
			77%	Employee Benefits as Percentage of Wages

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

\$	3,224,423	or	45.4%	Professional Fees are over budget due to contract labor budgeted as employees
\$	464,770	or	13.4%	Other Expenses are over budget due to timing difference on Liability Insurance, Surgery Lease, Plant Utilities as well as Chemistry and Pharmacy spending
\$	228,153	or	9.6%	Bad Debts are over budget due to higher volume of Outpatient services provided

Other Information:

\$	4,034,906			Operating Income, less
\$	(2,713,140)			loss in non-operating activities resulted in a Net
\$	1,321,766	or	\$ 1,101,269	over budget.
			41.65%	Actual Contractual Percentages for Year versus
			40.24%	Budgeted Contractual Percentages including
\$	1,987,214	in prior year cost report favorable settlement activity for Medicare & Medi-Cal		

Non-Operating activities included:

\$	(3,866,893)	loss	\$ 23,296	favorable to budget in Medical Office Activities
\$	1,559,430		\$ 1,142,990	favorable to budget in Grants and Other Contributions

Northern Inyo Healthcare District

Preliminary Financial Indicators as of April 30, 2018

	Target	Apr-18	Mar-18	Feb-18	Jan-18	Dec-17	Nov-17	Oct-17	Sep-17	Aug-17	Jul-17	Jun-17	May-17	Apr-17
Current Ratio	>1.5-2.0	2.46	2.43	2.47	2.50	2.41	2.18	2.26	2.45	2.42	2.49	3.39	3.83	3.51
Quick Ratio	>1.33-1.5	1.63	1.66	2.06	2.09	1.99	1.83	1.84	1.82	1.81	2.05	2.84	3.23	2.96
Days Cash on Hand prior method	>75	132.72	137.59	168.44	166.36	165.72	169.35	165.31	140.47	142.06	160.31	154.70	160.60	159.55
Days Cash on Hand Short Term	>75	57.21	51.38	83.49	81.30	83.05	87.18	81.28	53.95	59.26	79.93	79.37	75.71	76.12
Debt Service Coverage	>1.5-2.0	2.49	2.52	2.68	2.73	2.67	2.74	2.78	2.79	2.87	2.34	1.81	1.96	1.91
Operating Margin		5.50	5.18	5.09	4.87	5.79	5.87	7.64	7.49	8.45	6.67	4.71	6.18	6.06
Outpatient Revenue % of Total		69.97	69.49	69.74	69.53	69.25	69.52	69.46	69.13	69.83	66.58	69.86	69.96	69.76
Cash flow (CF) margin (EBIDA to revenue)		3.43	3.53	4.17	4.31	4.05	4.30	4.69	4.82	5.62	3.68	2.48	2.84	2.59
Days in Patient Accounts Receivable	<60 Days	79.80	81.50	85.60	85.90	82.80	81.80	81.40	82.10	81.40	74.10	78.90	89.00	86.00

Debt Service Coverage as outlined in 2010 and 2013 Revenue Bonds require that the district has a debt service coverage ratio of 1.50 to 1 (can be 1:25 to 1 with 75 days cash on hand)
 Debt Service Coverage is calculated as Net Income (Profit/Loss) from the Income Statement PLUS Depreciation & Interest Expense added back divided by the Current Interest & Principle for TOTAL DEBT from the Debt Information divided by number of closed fiscal periods

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

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

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

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

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

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

Accounts Receivable Days are pulled from the AR Aging report

Northern Inyo Healthcare District
Preliminary Balance Sheet
Period Ending April 30, 2018

Assets:	Current Month	Prior Month	Change
Current Assets			
Cash and Equivalents	4,148,119	2,724,222	1,423,897
Short-Term Investments	8,805,734	8,859,199	(53,464)
Assets Limited as to Use	-	-	-
Plant Replacement and Expansion Fund	-	-	-
Other Investments	1,094,029	1,094,029	-
Patient Receivable	62,512,209	63,863,634	(1,351,425)
Less: Allowances	(48,094,152)	(47,177,291)	(916,861)
Other Receivables	8,771,184	6,999,482	1,771,701
Inventories	4,137,088	5,066,928	(929,841)
Prepaid Expenses	1,582,338	1,653,202	(70,865)
Total Current Assets	42,956,548	43,083,405	(126,857)
Internally Designated for Capital			
Acquisitions	1,125,397	1,125,397	-
Special Purpose Assets	964,558	964,558	-
Limited Use Asset; Defined Contribution			
Pension	1,371,834	1,281,570	90,264
Limited Use Assets Defined Benefit Plan	13,365,385	13,365,385	-
Limited Use Asset Defined Benefit Plan 003	13,264	11,572	1,691
Revenue Bonds Held by a Trustee	2,849,918	2,688,177	161,741
Less Amounts Required to Meet Current Obligations	-	-	-
Assets Limited as to use	19,690,355	19,436,659	253,696
Long Term Investments	1,750,000	1,750,000	-
Property & equipment, net of Accumulated			
Depreciation	77,519,383	77,685,621	(166,239)
Unamortized Bond Costs	-	-	-
Total Assets	141,916,285	141,955,685	(39,400)

*Northern Inyo Healthcare District
Preliminary Balance Sheet
Period Ending April 30, 2018*

Liabilities and Net Assets	Current Month	Prior Month	Change
Current Liabilities:			
Current Maturities of Long-Term Debt	2,110,089	2,110,089	-
Accounts Payable	2,440,224	3,487,524	(1,047,300)
Accrued Salaries, Wages & Benefits	6,741,660	5,856,011	885,649
Accrued Interest and Sales Tax	380,762	249,550	131,212
Deferred Income	165,338	494,710	(329,372)
Due to 3rd Party Payors	1,120,165	1,020,165	100,000
Due to Specific Purpose Funds	-	-	-
Other Deferred Credits; Pension	4,520,080	4,518,388	1,691
Total Current Liabilities	17,478,318	17,736,437	(258,119)
Long Term Debt, Net of Current Maturities	41,839,947	41,839,947	-
Bond Premium	548,987	556,234	(7,247)
Accreted Interest	11,972,582	11,862,033	110,549
Other Non-Current Liabilities; Pension	30,487,532	30,487,532	-
Total Long Term Debt	84,849,048	84,745,746	103,302
Net Assets			
Unrestricted Net Assets less Income	38,624,362	38,508,945	115,417
Temporarily Restricted	964,558	964,558	-
Net Income (Income Clearing)	(1,322,009)	(1,206,592)	(115,417)
Total Net Assets	39,588,920	39,473,503	115,417
Total Liabilities and Net Assets	141,916,285	141,955,685	(39,400)

NORTHERN INYO HEALTHCARE DISTRICT

Preliminary OPERATING STATISTICS

for period ending April 30, 2018

	FYE 2018		FYE 2017	Variance %	
	Month to Date	Year-to-Date	Year-to-Date	Variance from PY	
Licensed Beds	25	25	25		
Total Patient Days with NB	257	3,163	2,904	259	9%
Total Patient Days without NB	233	2,885	2,622	263	10%
Swing Bed Days	33	404	328	76	23%
Discharges without NB	79	903	891	12	1%
Swing Discharges	4	55	52	3	6%
Days in Month	31	31	31		
Occupancy without NB	7.52	93.06	84.58	8.5	10%
Average Stay (days) without NB	2.95	3.19	2.94	0.3	9%
Average LOS without NB/Swing	2.67	2.93	2.73	0.2	7%
Hours of Observation	785	8,811	7,785	1,026	13%
Observation Adj Days	33	367	324	43	13%
ER Visits All Visits	1,006	8,170	8,293	(123)	-1%
RHC Visits	2,308	25,210	23,582	1,628	7%
Outpatient Visits	3,941	39,185	36,854	2,331	6%
IP Surgeries	13	200	228	(28)	-12%
OP Surgery	106	1,068	1,013	55	5%
Worked FTE's	353.25	344.32	331.55	13	4%
Paid FTE's	385.58	388.08	370.52	18	5%
Hours Worked to Hours Paid%	91.6%	88.7%	89.5%	-0.8%	-1%
Payor %					
Medicare		43%	41%	2%	
Medi-Cal		20%	23%	-3%	
Insurance, HMO & PPO		34%	33%	1%	
Indigent (Charity Care)		0.9%	1%	-0.3%	
All Other		2%	2%	0%	
Total		<u>100%</u>	<u>100%</u>		

NORTHERN INYO HEALTHCARE DISTRICT

Restricted and Specific Purpose Fund Balances

for period ending April 30, 2018

	Current Month	Prior Month	Change
Board Designated Funds:			
Tobacco Fund Savings Account	\$ 1,098,670	\$ 1,098,670	-
Equipment Fund Savings Account	\$ 26,727	\$ 26,727	-
Total Board Designated Funds:	\$ 1,125,397	\$ 1,125,397	\$ -
Specific Purpose Funds:			
* Bond and Interest Savings Account	\$ 834,044	\$ 834,044	\$ -
Nursing Scholarship Savings Account	\$ 30,448	\$ 30,448	\$ -
Medical Education Savings Account	\$ -	\$ -	\$ -
Joint NIHD/Physician Group Savings Account	\$ 100,066	\$ 100,066	\$ -
Total Specific Purpose Funds:	\$ 964,558	\$ 964,558	\$ -
Grand Total Restricted and Specific Purposes Funds:	\$ 2,089,954	\$ 2,089,954	\$ -

NORTHERN INYO HEALTHCARE DISTRICT
Investments as of April 30, 2018

ID	Purchase Date	Maturity Date	Institution	Broker	Rate	Principal Invested
2	30-Apr-18	01-May-18	Local Agency Investment Fund	Northern Inyo Hospital	1.66%	8,555,734.23
3	13-Jun-14	13-Jun-18	Synchrony Bank Retail-FNC	Financial Northeaster Corp.	1.60%	250,000.00
Short Term Investments						8,805,734.23
4	28-Nov-14	28-Nov-18	American Express Centurion Bank	Financial Northeaster Corp.	2.00%	150,000.00
5	02-Jul-14	02-Jul-19	Barclays Bank	Financial Northeaster Corp.	2.05%	250,000.00
6	02-Jul-14	02-Jul-19	Goldman Sachs Bank USA NY CD	Financial Northeaster Corp.	2.05%	250,000.00
7	20-May-15	20-May-20	American Express Centurion Bank	Financial Northeaster Corp.	2.05%	100,000.00
8	26-Sep-16	27-Sep-21	Comenity Capital Bank	Multi-Bank Service	1.70%	250,000.00
9	02-Sep-16	28-Sep-21	Capital One Bank	Multi-Bank Service	1.70%	250,000.00
10	28-Sep-16	28-Sep-21	Capital One National Assn	Multi-Bank Service	1.70%	250,000.00
11	28-Sep-16	28-Sep-21	Wells Fargo Bank NA	Multi-Bank Service	1.70%	250,000.00
Long Term Investments						\$ 1,750,000.00
Total Investments						\$ 10,555,734.23
1	30-Apr-18	01-May-18	LAIF Defined Cont Plan	Northern Inyo Hospital	1.66%	\$ 1,371,833.74
LAIF PENSION INVESTMENTS						\$ 1,371,833.74

Human Resources Policies
June, 2018

- 1 Food Service
- 2 Theft
- 3 Community Relations
- 4 Confidentiality
- 5 Electronic Communications
- 6 Employee Requests to be Excluded From Patient Care
- 7 Patients' Rights, Patients' Responsibilities, and Process For Resolution of Patient Grievances or Complaints
- 8 Personnel File Inspection Policy
- 9 Anniversary Date
- 10 Hours, Rest and Meal Periods
- 11 Post-Offer Physical Examination and Annual Health Screening
- 12 Identification Badges
- 13 Employee Assistance
- 14 Hospital Equipment and Supplies for Personal Use
- 15 Background Screening
- 16 Vacations
- 17 Paid Time Off
- 18 Domestic Partner Recognition
- 19 Performance Improvement and Progressive Discipline
- 20 Leave Donation
- 21 Tuition Reimbursement
- 22 Paid Sick Leave
- 23 Solicitation and Distribution of Literature on Hospital Property
- 24 Leaves of Absence
- 25 Attendance
- 26 Employee Medical Expense Discount
- 27 Northern Inyo Hospital (NIH) Job Protected Leave (JPL)
- 28 Pregnancy and Lactation Accommodation
- 29 Worker Housing Policy

POLICY & PROCEDURES TO THE BOARD

Title	TO BOD
DI standards of Care	05/31/2018
Diagnostic Imaging- Method of Practice	05/31/2018
Radiation Safety Committee	05/31/2018
Responsibilities and duties of radiation safety committee	05/31/2018
Di lead Apron / Protective equipment policy	05/31/2018
Diagnostic imaging – Guidelines for use of radiology equipment in other areas	05/31/2018
Radiology services pregnant personnel	05/31/2018
ALARA Program	05/31/2018
Dosimetry Program-Occupational Radiation Exposure monitoring program	05/31/2018
Di CT Radiation Safety Policy	05/31/2018
Diagnostic Imaging- ordering privileges and procedure	05/31/2018
Diagnostic imaging – Patient Priority	05/31/2018
Di-pregnant patients for Radiological procedures	05/31/2018
Monitoring of patients in rooms with no call lights	05/31/2018
Diagnostic imaging chaperone policy	05/31/2018
Diagnostic imaging repeat rate and analysis	05/31/2018
DI – Reportable / Recordable events in CT/ Fluoroscopy and nuclear medicine	05/31/2018
Diagnostic imaging – C-Arm (fluoroscope) radiation safety	05/31/2018
DI timeliness for critical results	05/31/2018
Di- CT dose documentation	05/31/2018
Diagnostic imaging – imaging equipment quality control	05/31/2018



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

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

TO: NIHD Board of Directors
FROM: Allison Robinson, MD, Chief of Medical Staff
DATE: June 5, 2018
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/Procedures/Protocols/Order Sets (*action item*)
1. *Medical Ethics Referrals and Consultations*
 2. *Medical Staff and Allied Health Professional Educational Requirements*
 3. *Adult Immunization in the Healthcare Worker*
 4. *Aerosolized Transmissible Disease Exposure Plan/Respiratory Protection Program*
 5. *Bloodborne Pathogen Exposure Control Plan*
 6. *Emergency Management Plan*
 7. *Emergency Room Overcrowding*
 8. *Evaluation of Pregnant Patients in the Emergency Department*
 9. *Infection Prevention Plan*
 10. *Process for Amendment to Protected Health Information*
 11. *Process for Auditing of Physician In-house/Office Records*
 12. *Record Retention, Destruction and Disposal of Protected Health Information*
 13. *Rejected Specimens Acceptability and Rejection*
 14. *Role of Microbiology in Infectious Disease Control*
 15. *Safe Injection Practices*
 16. *Scope of Anesthesia Practice*
 17. *Toy Cleaning*
 18. *Trauma Patient Care in the Emergency Department*
 19. *Trophon Environmental Probe Reprocessor (EPR)*
 20. *Wild Iris Services (Victims Services)*
 21. *DI – CT Contrast Administration*
 22. *DI – CT Radiation Safety Policy*
 23. *DI – Monitoring and Minimizing Radiation Exposure for the Occupational Worker*
 24. *DI NM Daily Area Surveys*

25. *DI NM General Rules for the Safe Use of Radioactive Materials*
26. *DI NM Radioactive Package Receipt*
27. *Diagnostic Imaging – Monitoring and Documentation of Fluoroscopic Quality Control*
28. *Diagnostic Imaging – Scope of Services*
29. *Diagnostic Imaging – Ultrasound, Intimate Exams*
30. *Diagnostic Imaging Department Orientation and Competency*
31. *Diagnostic Imaging X-Ray Protocols Procedure*
32. *Diagnostic Mammography – 3D*
33. *Premedication for Radiographic Contrast Sensitivity*
34. *Ultrasound – Scope of Practice Procedure*

B. Nurse Practitioner and Certified Nurse Midwife Standardized Procedures (*action item*)

1. General Policy
2. Adult Health Maintenance Policy
3. Management of Acute Illness Policy
4. Management of Chronic Illness Policy
5. Emergency Care Policy
6. Laboratory and Diagnostic Testing Policy
7. Minor Surgical Procedures Policy
8. Management of Minor Trauma Policy
9. Well Child Care Policy for the Nurse Practitioner

C. Service Chiefs and Medical Staff Officers for the 2018-2019 Medical Staff year (*action item*)

1. Chief of Staff – Allison Robinson, MD
2. Vice Chief of Staff – Will Timbers, MD
3. Immediate Past Chief of Staff – Richard Meredick, MD
4. Member-at-Large – Joy Engblade, MD
5. Chief of Emergency Room Service – Sierra Bourne, MD
6. Chief of Medicine/Intensive Care Service – Nickoline Hathaway, MD
7. Chief of Obstetrics – Martha Kim, MD
8. Chief of Pediatrics – Charlotte Helvie, MD
9. Chief of Radiology – Edmund Pillsbury, MD
10. Chief of Surgery – Jeanine Arndal, MD

D. Rural Health Clinic Critical Indicators 2018 (*action item*)

- E. Medical Staff Appointments/Privileges (*action items*)
 - 1. Daniel K. Davis, MD (*orthopedic surgery*) – Provisional Consulting Staff
 - 2. John Adam Hawkins, DO (*emergency medicine*) – Provisional Active Staff

- F. Temporary Privileges – Locum Tenens (*action items*)
 - 1. Akash Rusia, MD (*internal medicine*) – temporary privileges
 - 2. Chibao Nguyen, DO (*internal medicine*) – temporary privileges
 - 3. Chivonne Harrigal, MD (*breast imaging*) – temporary privileges

- G. Additional Privileges (*action item*)
 - 1. Robert Nathan Slotnick, MD (*perinatology*) – addition of cervical cerclage privileges
 - 2. Thomas Boo, MD (*family medicine*) – addition of outpatient family medicine privileges to work in the RHC.

- H. Telemedicine Staff Appointment/Privileges – Proxy Credentialing (*action item*)

As per the approved Telemedicine Physician Credentialing and Privileging Agreement, and as outlined and allowed by 42CFR 482.22, the Medical Staff have chosen to recommend the following practitioners for Telemedicine privileges relying upon Adventist Health’s credentialing and privileging decisions.

 - 1. Sheila Lezcano, MD (*Endocrinology*) – Adventist Health, Telemedicine Staff

**NORTHERN INYO HOSPITAL
POLICY AND PROCEDURE**

Title: Medical Ethics Referrals and Consultations	
Scope: NIHD	Manual: Medical Staff
Source: Chief of Staff	Effective Date:

PURPOSE:

The purpose of this document is to outline the procedure for medical ethics referrals to the Northern Inyo Healthcare District (NIHD) Medical Executive Committee. The Medical Executive Committee will serve as a forum to promote and clarify medical ethics practices throughout NIHD in order to enhance the quality of patient care.

POLICY:

1. The Medical Executive Committee shall serve as the Medical Staff Ethics Committee.
2. The activities of the Medical Executive Committee in relation to ethics include:
 - a. Consultation – Consult with hospital staff regarding difficult clinical ethics cases, making recommendations when appropriate.
 - b. Education – Identify educational opportunities to educate committee members, the hospital, and the community on medical ethics issues.
 - c. Policy work – Review and create hospital policies and procedures to promote medical ethics practice guidelines and decrease future ethics conflicts.
3. Other healthcare professionals or members of the community may be asked to participate in the committee’s activities when appropriate, including, but not limited to:
 - a. Social workers
 - b. Clergy
 - c. Legal counsel

PROCEDURE:

1. Consultation Procedure (Referrals) – Inpatient or Outpatient
 - a. Requests for consultation may be initiated by the patient, family, attending physician, other health care providers, or any person having a significant relationship with the patient.
 - b. When a request arises, the House Supervisor contacts the Chief of Staff, Vice Chief of Staff, or designee to initiate the referral.
 - c. The Chief of Staff, Vice Chief of Staff, or designee reviews the request for appropriateness and urgency. If the request is appropriate, the Chief of Staff, Vice Chief of Staff, or designee contacts the Medical Staff Office to either:
 - i. Add the referral to the next regularly scheduled Medical Executive Committee agenda for discussion in closed session, or
 - ii. Convene a special meeting of the Medical Executive Committee if urgent.
 - d. The committee reviews the case and proceeds as follows:
 - i. Discusses issues that initiated the consultation including medical, family, psychosocial, spiritual, legal and ethical dilemmas.
 - ii. Clarifies options, including the ethical justification or rationale for each option.
 - iii. Selects appropriate options to recommend.
 - e. The Medical Executive Committee communicates its recommendation to the appropriate involved parties, either verbally or in writing.
 - f. A summary statement is placed in the patient’s medical record by the Chief of Staff, Vice Chief of Staff, appropriate Chief or designee.

**NORTHERN INYO HOSPITAL
POLICY AND PROCEDURE**

Title: Medical Ethics Referrals and Consultations	
Scope: NIHD	Manual: Medical Staff
Source: Chief of Staff	Effective Date:

REFERENCES:

1. Nelson, William A. and Elliot, Barbara A. (2012) *Critical Access Hospital Ethics Committee Resource Guide*. Trustees of Dartmouth College, Hanover, New Hampshire.

Approval	Date
Medical Executive Committee	6/5/18
Board of Directors	
Last Board of Directors Review	

Developed: 5/2018 dp

Reviewed:

Revised: 5/2018 je

Supersedes:

Index Listings: Ethics consultation, ethics consult, ethics referral

**NORTHERN INYO HEALTHCARE DISTRICT
POLICY AND PROCEDURE**

Title: Medical Staff and Allied Health Professional Educational Requirements	
Scope: Medical Staff and Allied Health Professionals	Manual: Medical Staff
Source: Medical Staff Support Manager	Effective Date:

PURPOSE:

The purpose of this policy is to outline the Medical Staff and non-employed Allied Health Professional (AHP) educational requirements. Employed AHP educational requirements primarily follow Human Resources policies based on the employee’s home department, although some education may be additionally assigned by the Medical Staff Office as needed.

POLICY:

1. It is the policy of the Northern Inyo Healthcare District (NIHD) Medical Staff and non-employed AHPs to comply with, at a minimum, the applicable educational requirements dictated by state regulations, federal regulations, and other accreditation bodies such as the Joint Commission.
2. Educational requirements may be met through different mechanisms, including, but not limited to:
 - a. The NIHD online learning management system;
 - b. In-person trainings offered at NIHD;
 - c. Proof of equivalent training satisfactorily completed at another facility, where exemptions are allowed (refer to Appendix 1 for more information).
3. A practitioner who has not completed the educational requirements within ninety (90) days of initial notice of noncompliance will be deemed to have voluntarily relinquished all privileges and resigned from the Medical Staff. Any such deemed resignation is not defined as a medical disciplinary cause or reason and shall not entitle the practitioner to the hearing and appeal rights outlined in the Medical Staff bylaws.
4. Additional training may be recommended by the Medical Staff, the Medical Executive Committee, or the Chief of Staff as regulations change or as identified through the peer review process. Timelines and requirements for these additional trainings will be specified upon assignment.
 - a. The Medical Staff Office will update Appendix 1 accordingly and the changes will become effective by the approval of the Medical Executive Committee.

PROCEDURE:

1. At the time of initial granting of privileges, the Medical Staff Office will assign the required educational courses outlined in Appendix 1 to all initial applicants.
2. At the time of reappointment, any education that is required as a condition of reappointment will be assigned by the Medical Staff Office (refer to Appendix 1 for necessary courses).
3. Privilege-specific education, such as moderate sedation education, will be assigned to practitioners requesting the privilege and will be required as a condition for granting the privilege. For more information on sedation education and frequency of trainings, refer to the *Procedural Sedation* policy.

REFERENCES:

1. “Medical Staff and Advanced Practice Professional (APP) Educational Requirements.” Stanford Hospital and Clinics, Policy and Procedure. Approved September 2016.

**NORTHERN INYO HEALTHCARE DISTRICT
POLICY AND PROCEDURE**

Title: Medical Staff and Allied Health Professional Educational Requirements	
Scope: Medical Staff and Allied Health Professionals	Manual: Medical Staff
Source: Medical Staff Support Manager	Effective Date:

2. California Hospital Association. CAL/OSHA Workplace Violence Prevention Training Requirements. Handbook: Section 3.1. Obtained March 2018.
3. The Joint Commission Medical Staff Standard 03.01.03 EP2 for Critical Access Hospitals. January 2018.

CROSS REFERENCE P&P:

1. *Procedural Sedation Policy*

Approval	Date
Medical Executive Committee	6/5/18
Board of Directors	
Last Board of Directors Review	

Developed: 4/2018 dp

Reviewed:

Revised:

Supersedes:

Index Listings: Medical Staff Education

**NORTHERN INYO HEALTHCARE DISTRICT
POLICY AND PROCEDURE**

Title: Medical Staff and Allied Health Professional Educational Requirements	
Scope: Medical Staff and Allied Health Professionals	Manual: Medical Staff
Source: Medical Staff Support Manager	Effective Date:

Appendix 1

Required Training	Regulatory Reference	Frequency Required by Regulation	Frequency Established at NIHD
Pain Assessment and Management	TJC MS.03.01.03 EP2	Hospital determines frequency	Once, at initial granting of privileges
Workplace Violence Prevention ^{1,2}	CCR, Title 8, Section 3342	Hospital determines frequency	Once, at initial granting of privileges.
HIPAA ²	45CFR Section 164.530(b)(1)	Hospital determines frequency	At initial granting of privileges and at each reappointment

Rev. 6/5/18

¹ Only required for regular on-site providers.

² Proof of equivalent training completed at another facility can be provided to the Medical Staff Office for determination of an exemption.

**NORTHERN INYO HOSPITAL
POLICY AND PROCEDURE**

Title: Adult Immunization in the Healthcare Worker*	
Scope: District	Manual: Employee Health
Source: Employee Health/Infection Prevention Spec.	Effective Date: 8/17/2016

It is a priority for Northern Inyo Healthcare District to provide as safe an environment as possible for both employees and the patients they serve. This includes prevention of disease transmission between health care workers (HCWs) and patients, particularly those diseases that are preventable by immunization.

PURPOSE:

1. To explain Northern Inyo Healthcare District's Immunization Program.
HCWs are at risk of acquiring several vaccine-preventable diseases with potentially devastating consequences.
HCWs also serve as vectors for transmitting disease to other staff members and patients. Outbreaks of vaccine-preventable diseases have been well documented in medical institutions. Immunizing HCWs against vaccine-preventable diseases can prevent these outbreaks.
2. To define who is included in NIHD's Immunization Program.
3. To define which immunizations are offered by Northern Inyo Healthcare District.
4. To identify the resource(s) for all decisions (unless otherwise stated) for the immunization program.

POLICY:

1. The Employee Health Specialist, supervised by the Medical Director or designee, administers the immunization program. Questions related to vaccinations and immunization status is best addressed to the Employee Health Specialist. However, in most cases the ER nursing staff is also able to help, and they are available 24 hours a day. If the ER is busy with a heavy patient load, then it may be necessary **to call or** return at a quieter time.
2. Participants in the immunization program include:
 - a. NIHD employees
 - b. Physicians
 - c. Independent contractors
 - d. Traveler contracted staff
 - e. Volunteers
 - f. Hospice staff
 - g. NIHD Student employees (with parental permission for those under age 18)
 - h. Board Members
3. The health status of all participants is assessed for:
 - a. General health status
 - b. Vaccination history
 - c. Allergy history
 - d. Documentation of infectious diseases
 - e. Documentation of past immunizations
 - f. Documentation of disease titers
4. The currently available vaccines **are: in the NIHD Employee Health Program are:**
 - a. Measles, mumps, rubella (MMR)
 - b. Varicella- If age 50 or less there should be evidence of 2 chickenpox vaccinations and/ or a positive titer
 - c. Hepatitis B- If at risk for contact with blood, blood products, or bodily secretions (eligible employees include: Activities director, Admission services, Biomedical, Case Management,

**NORTHERN INYO HOSPITAL
POLICY AND PROCEDURE**

Title: Adult Immunization in the Healthcare Worker*	
Scope: District	Manual: Employee Health
Source: Employee Health/Infection Prevention Spec.	Effective Date: 8/17/2016

Central Supply, Diagnostic Imaging, Environmental Services EKG/EEG, Laboratory, Language Services, Laundry, Maintenance, Nursing, LVNs, CNAs, Pharmacy, Rehabilitation, Respiratory Therapy, Dietary, Security, Social Services, Students/Volunteers, any employee that has a risk for potential patient contact).

- d. Tetanus, diphtheria, pertussis (Tdap): For all Employees
 - e. Tetanus/diphtheria (Td), if staff member has contraindication to Tdap
 - f. Influenza- Offered yearly to all Employees
 - g. Meningococcal- For laboratory technicians whose work in microbiology puts them at a higher risk
 - h. Hepatitis A- If at risk for contact with blood, blood products, or bodily secretions (eligible employees include: Activities director, Admission services, Biomedical, Case Management, Central Supply, Diagnostic Imaging, Environmental Services EKG/EEG, Laboratory, Language Services, Laundry, Maintenance, Nursing, LVNs, CNAs, Pharmacy, Rehabilitation, Respiratory Therapy, Dietary, Security, Social Services, Students/Volunteers, any employee that has a risk for potential patient contact).
5. All aspects of the immunization program will follow the CDC guidelines in the current edition of **Epidemiology and Prevention of Vaccine-Preventable Diseases.** Published by the Department of Health and Human Services Centers for Disease Control and Prevention (CDC) This resource is published yearly. **so all recommendations will stay current.**
6. Interim recommendations will be based on the CDC recommendations and the American Committee on Immunization Practices (ACIP). The CDC website, www.cdc.gov, reflects any interim recommendations.

PROCEDURE:

1. All participants will be notified of available vaccinations and determination will be made if a specific vaccination is appropriate, based on individual history.
2. The vaccinations are primarily given by the Employee Health Specialist and also in the ER, as staffing and time permits, providing 24-hour availability.
3. The vaccines are all free of charge, as are any necessary titers done before or after the vaccinations.
4. When participants receive notice of a vaccination being due or a question related to vaccination status, it is appreciated if there is a prompt response. It should be considered a priority and repeated requests should not have to be necessary.
5. It is preferred that vaccinations not be delayed or refused. However, all employees have a right to refuse any vaccination after being informed of risks and benefits. There is a vaccination declination that needs to be signed after the employee is fully informed.
6. Documentation is completed by the Employee Health Specialist and is kept in the employee health files and database. The Employee Health Specialist is responsible for the maintenance of these records.
7. Copies of health records are available from the Employee Health Specialist.

**NORTHERN INYO HOSPITAL
POLICY AND PROCEDURE**

Title: Adult Immunization in the Healthcare Worker*	
Scope: District	Manual: Employee Health
Source: Employee Health/Infection Prevention Spec.	Effective Date: 8/17/2016

8. Standing orders for immunizations to be obtained from the Medical Director on an annual basis for the Employee Health immunization program.

SPECIAL CONSIDERATIONS:

1. Employees who request immunizations not covered by the standing orders and guidelines of the Employee Health Medical Director will be referred to their private provider (i.e. Shingles and Pneumococcal vaccines).
2. The immunization program follows NIH guidelines approved by the Infection Control Committee, based on the CDC Guidelines and ACIP.
3. Age: Adults only. Employees < 18 years of age will need parental approval.

DOCUMENTATION:

All documentation relating to vaccinations and or titers will be kept in the Employee Health files and database.

With employee signed permission (*Authorization to Disclose Health Information*), vaccination records will be forwarded to the employee’s local health care provider.

The Employee Health Specialist or designee is responsible for maintenance of immunization records.

REFERENCES:

1. *Epidemiology and Prevention of Vaccine-Preventable Diseases, 13th edition*
Published by the Department of Health and Human Services
Centers for Disease Control and Prevention (CDC).
2. United States Centers for Disease Control and Prevention Website: www.cdc.gov
3. American Committee on Immunization Practices: www.immunize.org/acip
4. Marshall, G. (2012). *The Vaccine Handbook: A Practical Guide for Clinicians*.
University of Louisville School of Medicine: Professional Communications, Inc.
5. Immunization Action Coalition: www.immunize.org/catg.d/p2017.pdf

CROSS REFERENCE P&P:

1. Aerosolized Transmissible Disease Plan
2. Influenza Vaccination Policy
3. Prevention and Treatment of Pertussis in Hospital Employees
4. Employee Tuberculosis Surveillance Program

Approval	Date
Clinical Consistency Oversight Committee	3/26/18
Infection Control Committee	5/22/18
MEC	6/5/18
Board of Directors	
Last Board of Director review	1/17/18

Developed: 09/2007 la

**NORTHERN INYO HOSPITAL
POLICY AND PROCEDURE**

Title: Adult Immunization in the Healthcare Worker*	
Scope: District	Manual: Employee Health
Source: Employee Health/Infection Prevention Spec.	Effective Date: 8/17/2016

Reviewed: 08/2011 la; 5/15 NH; 1/17 NH
Revised: 03/2014 la; 6/15 NH; 4/16 NH; 5/18CO
Supersedes:

Draft

**NORTHERN INYO HOSPITAL
POLICY AND PROCEDURE**

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

PURPOSE:

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

PLAN:

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

OVERVIEW:

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

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

POLICY:

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

AEROSOLIZED TRANSMISSIBLE DISEASES EXPOSURE CONTROL PLAN:

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

**NORTHERN INYO HOSPITAL
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EXPOSURE RISK PERSONNEL THAT REQUIRE FIT TESTING

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

DEFINITIONS:

Accredited laboratory. A laboratory that is licensed by the CDPH pursuant to Title 17 of the California Code of Regulations (CCR), or which has received a certification of competence based on participation in a quality assurance program administered by a governmental or private organization that tests and certifies laboratories.

Aerosol transmissible disease (ATD) or aerosol transmissible pathogen (ATP). A disease or pathogen for which droplet or airborne precautions are required, as listed in Appendix A.

Aerosol transmissible pathogen -- laboratory (ATP-L). A pathogen that meets one of the following criteria: (1) the pathogen appears on the list in Appendix D, (2) the Biosafety in Microbiological and Biomedical Laboratories (BMBL) recommends Biosafety level 3 or above for the pathogen, (3) the biological safety officer recommends Biosafety level 3 or above for the pathogen, or (4) the pathogen is a novel or unknown pathogen.

Airborne infection isolation (AII). Infection control procedures as described in Guidelines for Preventing the Transmission of *Mycobacterium tuberculosis* in Health-Care Settings. These procedures are designed to reduce the risk of transmission of airborne infectious pathogens, and apply to patients known or suspected to be infected with epidemiologically important pathogens that can be transmitted by the airborne route.

Airborne infection isolation room or area (AIIR). A room, area, booth, tent, or other enclosure that is maintained at negative pressure to adjacent areas in order to control the spread of aerosolized *M. tuberculosis* and other airborne infectious pathogens and that meets the requirements stated in subsection (e)(5)(D) of this standard.

Airborne infectious disease (AirID). Either: (1) an aerosol transmissible disease transmitted through dissemination of airborne droplet nuclei, small particle aerosols, or dust particles containing the disease agent for which AII is recommended by the CDC or CDPH, as listed in Appendix A, or (2) the disease process caused by a novel or unknown pathogen for which there is no evidence to rule out with reasonable certainty the possibility that the pathogen is transmissible through dissemination of airborne droplet nuclei, small particle aerosols, or dust particles containing the novel or unknown pathogen.

Airborne infectious pathogen (AirIP). Either: (1) an aerosol transmissible pathogen transmitted through dissemination of airborne droplet nuclei, small particle aerosols, or dust particles containing the infectious agent, and for which the CDC or CDPH recommends Airborne Infection Isolation, as listed in Appendix A, or (2) a novel or unknown pathogen for which there is no evidence to rule out with reasonable certainty the possibility

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that it is transmissible through dissemination of airborne droplet nuclei, small particle aerosols, or dust particles containing the novel or unknown pathogen.

Biological safety officer(s). A person who is qualified by training and/or experience to evaluate hazards associated with laboratory procedures involving **Aerosol transmissible pathogen -- laboratory**, who is knowledgeable about the facility Biosafety plan, and who is authorized by the employer to establish and implement effective control measures for laboratory biological hazards.

Biosafety level 3. Compliance with the criteria for laboratory practices, safety equipment, and facility design and construction recommended by the CDC in Biosafety in Microbiological and Biomedical Laboratories for laboratories in which work is done with indigenous or exotic agents with a potential for aerosol transmission and which may cause serious or potentially lethal infection.

Biosafety in Microbiological and Biomedical Laboratories (BMBL). Biosafety in Microbiological and Biomedical Laboratories, Fifth Edition, CDC and National Institutes for Health, 2007, which is hereby incorporated by reference for the purpose of establishing Biosafety requirements in laboratories.

CDC. United States Centers for Disease Control and Prevention.

CDPH. California Department of Public Health and its predecessor, the California Department of Health Services (CDHS).

Case. Either of the following:

- (1) A person who has been diagnosed by a health care provider who is lawfully authorized to diagnose, using clinical judgment or laboratory evidence, to have a particular disease or condition.
- (2) A person who is considered a case of a disease or condition that satisfies the most recent communicable disease surveillance case definitions established by the CDC and published in the Morbidity and Mortality Weekly Report (MMWR) or its supplements.

Chief. The Chief of the Division of Occupational Safety and Health of the Department of Industrial Relations, or his or her designated representative.

CTCA. The California Tuberculosis Controllers Association.

Droplet precautions. Infection control procedures as described in Guideline for Isolation Precautions designed to reduce the risk of transmission of infectious agents through contact of the conjunctivae or the mucous membranes of the nose or mouth of a susceptible person with large-particle droplets (larger than 5 mm in size) containing microorganisms generated from a person who has a clinical disease or who is a carrier of the microorganism.

Emergency medical services. Medical care provided pursuant to Title 22, Division 9, by employees who are certified EMT-I, certified EMT-II, or licensed paramedic personnel to the sick and injured at the scene of an emergency, during transport, or during inter-facility transfer.

Epidemiology and Prevention of Vaccine-Preventable Diseases. Epidemiology and Prevention of Vaccine-Preventable Diseases. Centers for Disease Control and Prevention, Atkinson W, Hamborsky J, McIntyre L, Wolfe S, eds. 10th ed. 2nd printing, including chapters from the 9th edition on Anthrax and Smallpox, Washington DC: Public Health Foundation, 2008, which is hereby incorporated by reference.

Exposure incident. An event in which all of the following have occurred: (1) An employee has been exposed to an individual who is a case or suspected case of a reportable ATD, or to a work area or to equipment that is reasonably expected to contain ATPs associated with a reportable ATD; and (2) The exposure occurred without the benefit of applicable exposure controls required by this section, and (3) It reasonably appears from the circumstances of the exposure that transmission of disease is sufficiently likely to require medical evaluation.

Exposure incident (laboratory). A significant exposure to an aerosol containing an ATP-L, without the benefit of applicable exposure control measures required by this section.

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Field operation: An operation conducted by employees that is outside of the employer’s fixed establishment, such as paramedic and emergency medical services or transport, law enforcement, home health care, and public health.

Guideline for Isolation Precautions. The Guideline for Isolation Precautions: Preventing Transmission of Infectious Agents in Healthcare Settings, June 2007, CDC, which is hereby incorporated by reference for the sole purpose of establishing requirements for droplet and contact precautions.

Guidelines for Preventing the Transmission of *Mycobacterium tuberculosis* in Health-Care Settings. The Guidelines for Preventing the Transmission of *Mycobacterium tuberculosis* in Health-Care Settings, December 2005, CDC, which is hereby incorporated by reference for the sole purpose of establishing requirements for airborne infection isolation.

Health care provider. A physician and surgeon, a veterinarian, a podiatrist, a nurse practitioner, a physician assistant, a registered nurse, a nurse midwife, a school nurse, an infection control practitioner, a medical examiner, a coroner, or a dentist.

Health care worker. A person who works in a health care facility, service or operation, or who has occupational exposure in a public health service described in subsection (a)(1)(D).

High hazard procedures. Procedures performed on a person who is a case or suspected case of an aerosol transmissible disease or on a specimen suspected of containing an ATP-L, in which the potential for being exposed to aerosol transmissible pathogens is increased due to the reasonably anticipated generation of aerosolized pathogens. Such procedures include, but are not limited to, sputum induction, bronchoscopy, aerosolized administration of pentamidine or other medications, and pulmonary function testing. High Hazard Procedures also include, but are not limited to, autopsy, clinical, surgical and laboratory procedures that may aerosolize pathogens.

Individually identifiable medical information. Medical information that includes or contains any element of personal identifying information sufficient to allow identification of the individual, such as the patient's name, address, electronic mail address, telephone number, or social security number, or other information that, alone or in combination with other publicly available information, reveals the individual's identity.

Infection control PLHCP. A **Physician or other licensed health care professional** who is knowledgeable about infection control practices, including routes of transmission, isolation precautions and the investigation of exposure incidents.

Influenza like illness (ILI). Signs and symptoms would include:

- a. Fever > 100 F with cough and/or sore throat and headache;
- b. Body aches, nasal congestion or discharge, chills and fatigue;
- c. Nausea, vomiting, diarrhea or other GI symptoms may also be present

Initial treatment. Treatment provided at the time of the first contact a health care provider has with a person who is potentially an **Airborne infectious disease** case or suspected case. Initial treatment does not include high hazard procedures.

Laboratory. A facility or operation in a facility where the manipulation of specimens or microorganisms is performed for the purpose of diagnosing disease or identifying disease agents, conducting research or experimentation on microorganisms, replicating microorganisms for distribution or related support activities for these processes.

Latent TB infection (LTBI). Infection with *M. tuberculosis* in which bacteria are present in the body, but are inactive. Persons who have **Latent TB infection** but who do not have TB disease are asymptomatic, do not feel sick and cannot spread TB to other persons. They typically react positively to TB tests.

Local health officer. The health officer for the local jurisdiction responsible for receiving and/or sending reports of communicable diseases, as defined in Title 17, CCR.

**NORTHERN INYO HOSPITAL
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NOTE: Title 17, Section 2500 requires that reports be made to the local health officer for the jurisdiction where the patient resides.

M. tuberculosis. *Mycobacterium tuberculosis* complex, which includes *M. tuberculosis*, *M. bovis*, *M. africanum*, and *M. microti*. *M. tuberculosis* is the scientific name of the group of bacteria that cause tuberculosis.

Negative pressure. A relative air pressure difference between two areas. The pressure in a containment room or area that is under negative pressure is lower than adjacent areas, which keeps air from flowing out of the containment facility and into adjacent rooms or areas.

NIOSH. The Director of the National Institute for Occupational Safety and Health, CDC, or his or her designated representative.

Non-medical transport. The transportation by employees other than health care providers or emergency medical personnel during which no medical services are reasonably anticipated to be provided.

Novel or unknown aerosol transmissible pathogen. A pathogen capable of causing serious human disease meeting the following criteria:

1. There is credible evidence that the pathogen is transmissible to humans by aerosols; and
2. The disease agent is:
 - a. A newly recognized pathogen, or
 - b. A newly recognized variant of a known pathogen and there is reason to believe that the variant differs significantly from the known pathogen in virulence or transmissibility, or
 - c. A recognized pathogen that has been recently introduced into the human population, or
 - d. A not yet identified pathogen.

NOTE: Variants of the human influenza virus that typically occur from season to season are not considered novel or unknown Aerosol transmissible pathogens if they do not differ significantly in virulence or transmissibility from existing seasonal variants. Pandemic influenza strains that have not been fully characterized are novel pathogens.

Occupational exposure. Exposure from work activity or working conditions that is reasonably anticipated to create an elevated risk of contracting any disease caused by Aerosol transmissible pathogen or Aerosol transmissible pathogen -laboratory if protective measures are not in place. In this context, “elevated” means higher than what is considered ordinary for employees having direct contact with the general public outside of the facilities, service categories and operations listed in subsection (a)(1) of this standard. Occupational exposure is presumed to exist to some extent in each of the facilities, services and operations listed in subsection (a)(1)(A) through (a)(1)(I). Whether a particular employee has occupational exposure depends on the tasks, activities, and environment of the employee, and therefore, some employees of a covered employer may have no occupational exposure. For example, occupational exposure typically does not exist where a hospital employee works only in an office environment separated from patient care facilities, or works only in other areas separate from those where the risk of Aerosolized Transmissible Disease transmission, whether from patients or contaminated items, would be elevated without protective measures. It is the task of employers covered by this standard to identify those employees who have occupational exposure so that appropriate protective measures can be implemented to protect them as required. Employee activities that involve having contact with, or being within exposure range of cases or suspected cases of Aerosolized Transmissible Disease, are always considered to cause occupational exposure. Similarly, employee activities that involve contact with, or routinely being within exposure range of, populations served by facilities identified are considered to cause occupational exposure. Employees working in laboratory areas in which Aerosol transmissible pathogen -laboratory are handled or reasonably anticipated to be present are also considered to have occupational exposure.

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Physician or other licensed health care professional (PLHCP) means an individual whose legally permitted scope or practice (i.e., license, registration, or certification) allows him or her to independently provide, or be delegated the responsibility to provide, some or all of the health care services required by this section.

Public health guidelines. (1) In regards to tuberculosis, applicable guidelines published by the Californian Tuberculosis Controllers Association and/or California Department Public Health. Refer to below reference number 3

Referral. The directing or transferring of a possible ATD case to another facility, service or operation for the purposes of transport, diagnosis, treatment, isolation, housing or care.

Referring employer. Any employer that operates a facility, service, or operation in which there is occupational exposure and which refers Airborne infectious disease cases and suspected cases to other facilities. Referring facilities, services and operations do not provide diagnosis, treatment, transport, housing, isolation or management to persons requiring Airborne infection isolation. General acute care hospitals are not referring employers. Law enforcement, corrections, public health, and other operations that provide only non-medical transport for referred cases are considered referring employers if they do not provide diagnosis, treatment, housing, isolation or management of referred cases.

Reportable aerosol transmissible disease (RATD). A disease or condition which a health care provider is required to report to the local health officer, in accordance with Title 17 CCR, Division 1, Chapter 4, and which meets the definition of an aerosol transmissible disease (ATD).

Respirator. A device which has met the requirements of 42 CFR Part 84, has been designed to protect the wearer from inhalation of harmful atmospheres, and has been approved by National Institute for Occupational Safety and Health for the purpose for which it is used.

Respirator user. An employee who in the scope of their current job may be assigned to tasks which may require the use of a respirator, in accordance with subsection (g).

Respiratory Hygiene/Cough Etiquette in Health Care Settings. To prevent the transmission of all respiratory infections in healthcare settings, including influenza, the following infection control measures should be implemented at the first point of contact with a potentially infected person. They should be incorporated into infection control practices as one component of Standard Precautions

Screening (health care provider). The initial assessment of persons who are potentially Airborne infectious disease or Aerosolized Transmissible Disease cases by a health care provider in order to determine whether they need airborne infection isolation or need to be referred for further medical evaluation or treatment to make that determination. Screening does not include high hazard procedures.

Screening (non health care provider). The identification of potential Aerosolized Transmissible Disease cases through readily observable signs and the self-report of patients or clients. Screening does not include high hazard procedures.

Significant exposure. An exposure to a source of Aerosol transmissible pathogen or Aerosol transmissible pathogen -- laboratory in which the circumstances of the exposure make the transmission of a disease sufficiently likely that the employee requires further evaluation by a Physician or other licensed health care professional

Source control measures. The use of procedures, engineering controls, and other devices or materials to minimize the spread of airborne particles and droplets from an individual who has or exhibits signs or symptoms of having an Aerosolized Transmissible Disease, such as persistent coughing.

Surge. A rapid expansion beyond normal services to meet the increased demand for qualified personnel, medical care, equipment, and public health services in the event of an epidemic, public health emergency, or disaster.

Susceptible person. A person who is at risk of acquiring an infection due to a lack of immunity as determined by a PLHCP in accordance with applicable public health guidelines.

Suspected case. Either of the following:

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1. A person whom a health care provider believes, after weighing signs, symptoms, and/or laboratory evidence, to probably have a particular disease or condition listed in Appendix A.
2. A person who is considered a probable case, or an epidemiologically-linked case, or who has supportive laboratory findings under the most recent communicable disease surveillance case definition established by CDC and published in the Morbidity and Mortality Weekly Report (MMWR) or its supplements as applied to a particular disease or condition listed in Appendix A.

TB conversion. A change from negative to positive as indicated by TB test results, based upon current CDC or CDPH guidelines for interpretation of the TB test.

Test for tuberculosis infection (TB test). Any test, including the tuberculin skin test and blood assays for *M. Tuberculosis* (BAMT) such as interferon gamma release assays (IGRAs) which: (1) has been approved by the Food and Drug Administration for the purposes of detecting tuberculosis infection, and (2) is recommended by the CDC for testing for TB infection in the environment in which it is used, and (3) is administered, performed, analyzed and evaluated in accordance with those approvals and guidelines.

NOTE: Where surveillance for LTBI is required by Title 22, CCR, and the TB test must be approved for this use by the CDPH. The tool used to identify asymptomatic adults for Latent Tuberculosis Infection is the California Tuberculosis Risk Assessment Adults.

<http://www.cdph.ca.gov/programs/tb/Documents/TBCB-CA-TB-Risk-Assessment-and-Fact-Sheet.pdf>

Tuberculosis (TB). A disease caused by *M. tuberculosis*.

UVGI. Ultraviolet germicidal irradiation.

HIGH HAZARD PROCEDURES:

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

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

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

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

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Exception: Where no airborne infection isolation room or area is available and the treating physician determines it would be detrimental to the patient’s health to delay performing the procedure, high hazard procedures may be conducted in other areas with personnel using appropriate PPE.

EMPLOYEE IMMUNIZATIONS:

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

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

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

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

WORK PRACTICE CONTROLS:

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

On Arrival to the Hospital:

1. Hand hygiene stations and Respiratory Hygiene/Cough Etiquette are at every entrance to the hospital with signs encouraging their use.
2. If indicated, warning/education signs may also be placed at entrances explaining any special concerns or limitations regarding entrance to the hospital e.g. with outbreak of influenza.
3. Patients, visitors, and caregivers will be instructed on Respiratory Hygiene/ Cough Etiquette measures by the hospital staff, with easy access to all the necessary sanitation supplies.
 - a. Cover mouth and nose for coughs and sneezes with Kleenex, linen, or elbow.

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- b. To use the available surgical masks as soon as possible if actively coughing.
 - c. To perform hand hygiene frequently and after handling their secretions.
 - d. To dispose of contaminated tissues, napkins, linens into “no-touch” receptacles.
4. Entry may be denied to visitors if they already know they have suspected or confirmed influenza, another known serious respiratory illness, tuberculosis, and/or possibly others on a case by case basis.
5. Elective procedures may also be postponed for patients with suspected or confirmed influenza until they are no longer infectious.
- 5-6. NIHD prohibits misters for human comfort (eg. Patio misters) anywhere on the campus this includes employee break areas.

On arrival to the Emergency Department (ED) Area:

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

On Arrival to Another Hospital Unit:

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

Room Placement:

Airborne infection isolation rooms units will be used for patients who are suspected of having airborne transmissible disease, e.g. TB, SARS, Smallpox, Avian Flu, and Pneumonic Plague.

Airborne isolation rooms are private rooms that have monitored negative air pressure in relation to the exterior surrounding areas, so that air does not come out from under the door because the pressure outside the door is > than inside the room. See the section under *Engineering Controls* related to Air Exchanges per hour and other specifics. Our current best options for any patient include:

- Option 1: Room 5 on the Acute/Subacute ICU RM 1, and Infusion Room 6 unit is an Airborne Infection Isolation room, vented to the outside with filters and an antechamber.

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- Option 2: If no Airborne Infection Isolation Room available put patient in surgical mask, keep door closed, ~~and~~ staff and visitors to wear a N95 or PAPR

Source Patient Control:

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

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

1. Standard
2. Airborne and Droplet
3. Contact

PPE Required When Entering An Airborne Isolation Room:

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

Reporting the Illness:

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

Procedure If NIH Has Insufficient Isolation Rooms:

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

1. Transfers to other facilities: Transfer should occur within **5** hours of identification, unless the- physician documents, at the end of the 5 hour period, and at least every 24 hours thereafter, one of the following:

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- a. The Physician, Infection Preventionist, ~~or~~ House Supervisor, Administrator On Call (AOC) or designee has contacted the local health officer.
- b. There is no room or area available within that jurisdiction.
- c. Reasonable efforts have been made to contact establishments outside of that jurisdiction.
- d. Applicable measures recommended by the local health officer and the Physician or other licensed health care professional

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

Employee Control Measures:

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

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

1. For **tuberculosis** this would include:
 - a. Cough for more than 3 weeks not explained by non-infectious conditions
 - b. Hemoptysis
 - c. Unexplained significant weight loss
 - d. Fatigue
 - e. Night sweats
 - f. Known exposure to a TB patient
2. For **influenza-like illness (ILI)** signs and symptoms would include:
 - a. Fever > 100 F with cough and/or sore throat and headache;
 - b. Body aches, nasal congestion or discharge, chills and fatigue;
 - c. Nausea, vomiting, diarrhea or other GI symptoms may also be present
3. For **SARS: Screening form on Hospital Intranet>Forms>Infection Control**
4. Patient statement that they have a transmissible respiratory disease, excluding the ~~common cold~~common cold.

CLEANING AND DISINFECTION:

1. Routine cleaning and disinfection strategies used during influenza season can be applied to the environmental management of Influenza

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2. Dedicated disposable equipment is to be used whenever possible.
3. Non-disposable equipment is to be cleaned and disinfected according to established agency policies - "Infectious and Noninfectious Waste Disposal Procedure."
4. Management of laundry, utensils, and medical waste should also be performed in accordance with procedures followed for seasonal influenza.

PERSONAL PROTECTIVE EQUIPMENT/RESPIRATORY PROTECTION

1. Adherence to Standard Precautions and Transmission Based Precautions, as appropriate for the patient's disease status, is mandatory for all NIHD employees and departments.
2. Droplet Precautions: Permit the use of surgical masks rather than respiratory protection, i.e., use of respirators. Recognizing that surgical masks do not provide protection against inhalation of airborne infectious aerosols, NIHD will allow health care personnel to use N-95 masks for contact with influenza patients should they prefer that level of protection.
3. Clinical staff who are assigned to patients with suspected or confirmed infectious Pulmonary TB, or other aerosol transmissible disease requiring use of respirator will be provided and fitted with a National Institute for Occupational Safety and Health approved (at least N95) Respirator Mask for individual, personal protection prior to providing care. Trained personnel will instruct the clinical staff members on proper respirator use and fit-check, in accordance with the manufacturer's instructions and guidelines.
 - a. Instructions on putting on and taking off N-95 masks is also available on the hospital Intranet. The staff has been instructed to watch this video. Handouts detailing reuse procedure have also been made available.
 - b. Every attempt will be made to have an adequate supply of all types of N-95 masks we currently use for fit tests.
 - c. The standard is to use a mask if needed and discard it after- *not to re-use*. They should be discarded after each patient encounter.
 - d. The Purchasing Department Manager is responsible for monitoring mask numbers and will work in conjunction with the Infection Preventionist, if a disaster and surge make mask availability an issue.
4. Clinical staff that cannot be adequately fitted with the National Institute for Occupational Safety and Health approved respirators will not be assigned to these patients, unless they have been trained to use the PAPR and a PAPR is available.
5. Personnel with histories of respiratory problems/compromise or those with known lack of immunity to the organism (e.g.: chickenpox) should not be assigned to these patients.
6. Unprotected employees should be prevented from entering areas where aerosol generation procedures were performed until the required clearance time has elapsed.
7. When respirators are necessary to protect the HCW from other hazards, including the uncontrolled release of microbiological spores or exposure to chemical or radiologic agents, respirator selection shall be made in accordance with the anticipated risk.
8. In summary, NIHD provides, and ensures that employees use, a fit-tested N-95 respirator or PAPR when the employee:
 - a. Enters an Airborne infection isolation room or area or an Airborne infection isolation area in use for Airborne Infection Isolation;
 - b. Present during the performance of procedures or services for an Airborne infectious disease case or suspected case;

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- c. Takes part in aerosol generating procedures on patient suspected or known to be infected with an illness or pathogen requiring airborne precautions such as sputum induction, bronchoscopy, open suctioning, CPR, intubation or extubation Pulmonary function testing, collection of nasal pharyngeal lab specimens for RSV or Pertussis
 - d. Repairs, replaces, or maintains air systems or equipment that may contain or generate aerosolized pathogens;
 - e. Is working in an area occupied by an airborne infectious disease case or suspected case, during decontamination procedures after the person has left the area and as required.
 - f. Is performing a task for which the Biosafety Plan or Exposure Control Plan requires the use of respirators; or
 - g. Transports an Airborne infectious disease case or suspected case within the facility or in an enclosed vehicle (e.g., van, car, ambulance or Air transport when the patient is not masked).
9. Medical Evaluation for Fit Testing:
- a. NIHD provides a medical evaluation by the Medical Director of the Respiratory Therapy Department. This is done to determine the employee’s ability to use a respirator before the employee is fit tested or required to use the respirator. This form is the OSHA approved form for respirator fit testing.
 - b. The employee’s supervisor provides the employee a copy of the Medical Evaluation Questionnaire. The questionnaire is confidential. A sealable envelope must be provided to the employee, in which to return the questionnaire.
 - c. After completion it is returned to the employee’s supervisor who forwards it to the head of the Respiratory Therapy Department, who then has the Medical Director review it for any problems or concerns.
 - d. The record is stored in the employee’s confidential employee health records.
 - e. After the medical evaluation, the employee can have the fit test scheduled.
10. Fit Testing: “N95 Mask Fit Testing Using the Portacount Pro Policy”
- a. NIHD Cardiopulmonary RT staff performs quantitative fit tests. The fit tests are performed on the same size, make, model and style of respirator as the employee will use. When fit testing single use respirators, a new respirator shall be used for each employee.
 - b. The employer shall ensure that each employee who is assigned to use a filtering face piece or other tight-fitting respirator passes a fit test:
 - i.1. At the time of initial fitting;
 - ii.2. When a different size, make, model or style of respirator is used; and
 - iii.3. At least annually thereafter.
 - c. NIHD requires an additional fit test when the employee reports, or the employer, **physician or other licensed health care professional**, supervisor, or program administrator makes visual observations of changes in the employee’s physical condition that could affect respirator fit. Such conditions include, but are not limited to, facial scarring, dental changes, cosmetic surgery, or an obvious change in body weight.
 - d. If, after passing a fit test, the employee subsequently notifies the employer, program administrator, supervisor, or Physician or other licensed health care professional that the fit of the respirator is unacceptable, the employee shall be given a reasonable opportunity to select a different respirator face piece and to be retested.

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- e. NIHD will ensure that each respirator user is provided with initial and annual training in accordance with Section 5144, Respiratory Protection of these orders.
- 11. PAPR Orientation: Shall be provided for:
 - a. Staff who fails N-95 mask fit testing for whatever reason
 - b. High hazard procedures where it is the safer option.

MEDICAL SERVICES

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

Vaccinations:

1. Recommended vaccinations are made available to all employees who have occupational exposure during the pre-employment physical unless:
 - a. The employee has previously received the recommended vaccination(s) and is not due to receive another vaccination dose; or
 - b. It is determined that the employee is immune in accordance with applicable public health guidelines;
 - c. The vaccine(s) is contraindicated for medical reasons.
2. Employee Health Nurse makes additional vaccine doses available to employees within 120 days of the issuance of new applicable public health guidelines recommending the additional dose as approved by NIHD in the vaccination policies.
3. Employee Health Nurse does not make participation in a prescreening serology program a prerequisite for receiving a vaccine, unless applicable public health guidelines recommend this prescreening prior to administration of the vaccine. However, titers are routinely tested at time of hire, with each new employee's consent, to determine eligibility for each indicated vaccine when the vaccination/immune status is not known.

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

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

EXPOSURE EVALUATION AND FOLLOW-UP

1. A health care provider or the employer of a health care provider who determines that a person (patient or NIHD employee) is a Reportable aerosol transmissible disease case or suspected case shall report, or ensure that the health care provider reports, the case to the local health officer, in accordance with Title 17. The official **CDPH Severe Influenza Case history Form (ICU and Fatal Cases Age 0-64 Years)** is located under NIHD Intranet> forms> Employee Health and Infection Prevention "Attachments" on the left sidebar and can be printed for use when appropriate.
2. Any Healthcare worker who has unprotected direct contact with an airborne illness must report the exposure to Employee Health, or Infection Prevention Nurse as soon as possible, either directly or with the assistance of the unit manager or House supervisor. The Employee Health Nurse, Infection Preventionist, or House Supervisor will complete the form "HCW Contact with Case of an Aerosolized Transmissible Disease in conjunction with the exposed employee. It is critical it report exposures immediately when the source is a known life-threatening illness, such as SARS, Avian flu, Smallpox, etc.
3. An Exposure Incident: Significant exposure- exposure to a source of Aerosolized Transmissible Pathogens in which the circumstances make disease transmission sufficiently likely that the employee requires further

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evaluation by a physician or other Physician or other licensed health care provider. The likelihood of transmission is determined by:

- a. Exposure scenario including distance, time, PPE used
- b. Specific pathogen
- c. Infectivity of the source
- d. Susceptibility of the host (vaccination status is one component)-

Refer for a medical evaluation if the susceptibility is unknown.

4. In addition to the report required, NIH's Infection Preventionist and/or Employee Health Nurse shall, to the extent that the information is available:
 - a. Decide what the affected employee needs to receive effective medical intervention to prevent disease or mitigate the disease course.
 - b. Instruct the HCW to monitor their temperature in the morning and the evening for at least 10 days
 - c. If a cough or fever develops; the HCW must seek medical evaluation immediately and notify the Infection Control nurse.
 - d. Assess whether employees in other agencies may be affected. There is an Aerosolized Transmissible Disease notification form to be filled out in the Emergency Department to help track employees outside of NIHD who may have been exposed.
 - e. Initiate a prompt investigation to identify exposed employees. In no case, shall the notification be longer than 72 hours after the report to the local health officer and/or public health department. The notification shall include the date, time, and nature of the potential exposure, and provide any other information that is necessary for the other employer(s) to evaluate the potential exposure of his or her employees. The notifying NIHD provider shall not reveal the identity of the source patient to the other employers.

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

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

5. When NIHD becomes aware that employees may have been exposed to a reportable aerosol transmissible disease case or suspected case, or to an exposure incident involving an Aerosol transmissible pathogen – laboratory shall do all of the following:
 - a. Within a timeframe that is reasonable for the specific disease, but in no case later than 72 hours following, as applicable, conduct an analysis of the exposure scenario to determine which employees had significant exposures. This analysis shall be conducted by the Infection Preventionist with assistance from Inyo County Health Department when indicated. This analysis will include the employee names and shall also record the basis for any determination that an employee need not be included in post-exposure follow-up because the employee did not have a significant exposure or because Employee Health or a Physician or other licensed health care professional determined that the

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- employee is immune to the infection in accordance with applicable public health guidelines. The exposure analysis shall be made available to the local health officer upon request. The name of the person making the determination, and the identity of any Physician or other licensed health care professional or local health officer consulted in making the determination shall be recorded.
- b. Within a timeframe that is reasonable for the specific disease, but in no case later than 96 hours of becoming aware of the potential exposure, notify employees who had significant exposures of the date, time, and nature of the exposure.
 - c. Provide post-exposure medical evaluation to all employees who had a significant exposure as soon as feasible. The evaluation shall be conducted by a Physician or other licensed health care professional knowledgeable about the specific disease, including appropriate vaccination, prophylaxis and treatment. For *M. tuberculosis*, and for other pathogens where recommended by applicable public health guidelines, this shall include testing of the isolate from the source individual or material for drug susceptibility, unless that it is not feasible.
 - d. Obtain from the Physician or other licensed health care professional or Inyo County Health Department a recommendation regarding precautionary removal as in a medical leave of absence following the exposure and a written opinion.
 - e. Determine to the extent that the information is available, whether employees of any other employers may have been exposed to the case or material.-NIHD shall notify these other employers within a time frame that is reasonable for the specific disease, but in no case later than 72 hours of becoming aware of the exposure incident of the nature, date, and time of the exposure, and shall provide the contact information for the local public health department. NIHD shall not provide the identity of the source patient to other employers.
6. Information provided to the Physician or Other Licensed Health Care Professional.
- a. NIH will ensure that all Physicians or other licensed health care professional responsible for making determinations and performing procedures as part of the medical services program are provided a copy of this standard and applicable public health guideline. For respirator medical evaluations, the employer shall provide information regarding the type of respiratory protection used, a description of the work effort required, any special environmental conditions that exist (e.g., heat, confined space entry), additional requirements for protective clothing and equipment, and the duration and frequency of respirator use.
 - b. Each employer shall ensure that the Emergency Department physician or physician or other licensed health care professional who evaluates an employee after an exposure incident is provided the following information:
 - i. A description of the exposed employee's duties as they relate to the exposure incident;
 - ii. The circumstances under which the exposure incident occurred;
 - iii. Any available diagnostic test results, including drug susceptibility pattern or other information relating to the source of exposure that could assist in the medical management of the employee;
 - iv. All of the employer's medical records for the employee that are relevant to the management of the employee, including tuberculin skin test results and other relevant tests for ATP infections, vaccination status, and determinations of immunity.
7. Precautionary removal recommendation from the emergency room physician, other physician or other licensed health care professional Inyo County Health Department, or NIHD's Infection Control Committee Physician Director.

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- a. NIHD, when necessary, shall request from the above an opinion regarding whether precautionary removal from the employee's regular assignment is necessary to prevent spread of the disease agent by the employee and what type of alternate work assignment may be provided. This recommendation will be documented in writing and provided to Human Resources and to the employee.
- b. Where precautionary removal is recommended, NIHD shall maintain until the employee is determined to be noninfectious, the employee's earnings, seniority, and all other employee rights and benefits, including the employee's right to his or her former job status, as if the employee had not been removed from his or her job or otherwise medically limited.

EXCEPTION: Precautionary removal provisions do not extend to any period of time during which the employee is unable to work for reasons other than precautionary removal.

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

TRAINING:

1. NIHD will provide that all employees, with occupational exposure, participate in training program.
2. The Aerosolized Transmissible Disease training will occur as stated below:
 - a. At the time of initial assignment to tasks where occupational exposure may take place;
 - b. At least annually thereafter, not to exceed 12 months from the previous training;
 - c. For employees who have received training on aerosol transmissible diseases in the year preceding the effective date of the standard, only training with respect to the provisions of the standard that were not included previously need to be provided.
 - d. When changes, such as introduction of new engineering or work practice controls, modification of tasks or procedures or institution of new tasks or procedures, affect the employee's occupational exposure or control measures. The additional training may be limited to addressing the new exposures or control measures.
3. Training material appropriate in content and vocabulary to the educational level, literacy, and language of employees shall be used.
4. The training program shall contain at a minimum the following elements:
 - a. An accessible copy of the regulatory text of this standard and an explanation of its contents.

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- b. A general explanation of Aerosolized Transmissible Diseases including the signs and symptoms of that require further medical evaluation.
 - c. An explanation of the modes of transmission of Aerosol transmissible pathogen – or Aerosol transmissible pathogen – laboratory and applicable source control procedures.
 - d. An explanation of the employer's ATD Exposure Control Plan and/or Respiratory Protection Program and Biosafety Plan, and the means by which the employee can obtain a copy of the written plan and how they can provide input as to its effectiveness.
 - e. An explanation of the appropriate methods for recognizing tasks and other activities that may expose the employee to Aerosol transmissible pathogen or Aerosol transmissible pathogen – laboratory
 - f. An explanation of the use and limitations of methods that will prevent or reduce exposure to Aerosol transmissible pathogen or Aerosol transmissible pathogen laboratory including appropriate engineering and work practice controls, decontamination and disinfection procedures, and personal and respiratory protective equipment.
 - g. An explanation of the basis for selection of personal protective equipment, its uses and limitations, and the types, proper use, location, removal, handling, cleaning, decontamination and disposal of the items of personal protective equipment employees will use.
 - h. A description of the employer's TB surveillance procedures, including the information that persons who are immune-compromised may have a false negative test for Latent TB infection
 - i. Training meeting the annual requirements for employees whose assignment includes the use of a respirator.
 - j. Information on the vaccines made available by Employee Health, including information on their efficacy, safety, method of administration, the benefits of being vaccinated, and that the vaccine and vaccination will be offered free of charge.
 - k. An explanation of the procedure to follow if an exposure incident occurs, including the method of reporting the incident, the medical follow-up that will be made available, and post-exposure evaluation.
 - l. Information on the employer's surge plan as it pertains to the duties that employees will perform. As applicable, this training shall cover the plan for surge receiving and treatment of patients, patient isolation procedures, surge procedures for handling of specimens, including specimens from persons who may have been contaminated as the result of a release of a biological agent, how to access supplies needed for the response including personal protective equipment and respirators, decontamination facilities and procedures, and how to coordinate with emergency response personnel from other agencies.
5. Every training program shall include an opportunity for interactive questions and answers with a person who is knowledgeable in the subject matter of the training as it relates to the workplace that the training addresses and who is also knowledgeable in the employer's ATD exposure control Respiratory Protection Program and Biosafety plan. Training not given in person fulfills all the subject matter required and allows for interactive questions to be answered within 24 hours by a knowledgeable person as described above.

ENGINEERING CONTROLS

1. Specific requirements for Airborne Infection Isolation Rooms and areas. Hospital isolation rooms constructed in conformance with Title 24, California Code of Regulations, Section 417, et seq., and which are maintained to meet those requirements.

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

LABORATORIES

1. The biological safety officer at NIHD is the Medical Director of Laboratory Services.
2. The biological safety officer performs a risk assessment in accordance with accepted methodology for each agent and procedure involving the handling of aerosolized transmissible disease pathogens in the lab Aerosol transmissible pathogen laboratory
3. Our laboratory has feasible engineering and work practice controls, in accordance with the risk assessment to minimize the employee exposures to Aerosol transmissible pathogen – laboratory. If exposure still remains after the institution of engineering and work practice controls, then the employees will use the appropriate PPE when and where necessary.
4. Biosafety Plan: Titled Chemical Hygiene Plan: The employer shall establish, implement, and maintain an effective written Biosafety Plan to minimize employee exposures to Aerosol transmissible pathogen – laboratory that may be transmitted by laboratory aerosols. The Biosafety Plan is kept in the laboratory’s safety manual and includes the following:

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- a. Identifies a biological safety officer(s) with the necessary knowledge, authority and responsibility for implementing the Biosafety Plan
 - b. Establishes safe handling procedures and prohibit practices, such as sniffing *in vitro* cultures that may increase employee exposure to infectious agents.
 - c. Identifies any operations or conditions in which respiratory protection will be required.
 - d. Establishes emergency procedures for uncontrolled releases within the laboratory facility and untreated releases outside the laboratory facility. These procedures shall include effective means of reporting such incidents to the local health officer.
 - e. Includes procedures for communication of hazards and employee training. This shall include training in the Biosafety Plan and emergency procedures.
 - f. Includes an effective procedure for obtaining the active involvement of employees in reviewing and updating the Biosafety Plan with respect to the procedures performed by employees in their respective work areas or departments on an annual (or more frequent) basis.
 - g. Includes procedures for the biological safety officer(s) to review plans for facility design and construction that will affect the control measures for Aerosol transmissible pathogen – laboratory.
 - h. Includes procedures for inspection of laboratory facilities, including an audit of Biosafety procedures. These inspections shall be performed at least annually. Hazards found during the inspection, and actions taken to correct hazards, shall be recorded.
5. Recordkeeping will be done by the biological safety officer.

SURGE PROCEDURES

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

RECORDKEEPING

1. Medical records.
 - a. Employers are responsible for recording cases of Aerosolized Transmissible Diseases for occupational exposures, and if it involves days away from work and/or medical treatment. This record may not be combined with non-medical personnel records.
 - b. This record shall include:
 - i. The employee’s name and any other employee identifier used in the workplace;
 - ii. The employee’s vaccination status for all vaccines required by this standard, including the information provided by Employee Health, any vaccine record provided by the employee, and any signed declination forms;

EXCEPTION: As to seasonal influenza vaccine, the medical record need only contain a declination form for the most recent seasonal influenza vaccine.

- iii. A copy of all written opinions provided by a Physician or other licensed health care professional in accordance with this standard, and the results of all TB assessments; and

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- iv. A copy of the information regarding an exposure incident that was provided to the Physician or other licensed health care.
- c. Confidentiality. The employer shall ensure that all employee medical records required by this section are:
 - i. Kept confidential; and
 - ii. Not disclosed or reported without the employee's express written consent to any person within or outside the workplace except as permitted by this section or as may be required by law.

NOTE: These provisions do not apply to records that do not contain individually identifiable medical information, or from which individually identifiable medical information has been removed.
- d. The employer shall maintain the medical records required by this section for at least the duration of employment plus 30 years in accordance with Section 3204, Access to Employee Exposure and Medical Records, of these orders.
- 2. Training records.
 - a. Training records shall include the following information:
 - i. The date(s) of the training session(s);
 - ii. The contents or a summary of the training session(s);
 - iii. The names and qualifications of persons conducting the training or who are designated to respond to interactive questions; and
 - iv. The names and job titles of all persons attending the training sessions.
 - b. Training records shall be maintained for 3 years from the date on which the training occurred.
- 3. Records of implementation of Aerosolized Transmissible Disease Plan and/or Biosafety Plan.
 - a. Records of annual review of the ATD Plan and Respiratory Protection Program Biosafety Plan shall include the name(s) of the person conducting the review, the dates the review was conducted and completed, the name(s) and work area(s) of employees involved, and a summary of the conclusions. The record shall be retained for three years.
 - b. Records of exposure incidents shall be retained and made available as employee exposure records in accordance with Section 3204. These records shall include:
 - i. The date of the exposure incident;
 - ii. The names, and any other employee identifiers used in the workplace, of employees who were included in the exposure evaluation;
 - iii. The disease or pathogen to which employees may have been exposed;
 - iv. The name and job title of the person performing the evaluation;
 - v. The identity of any local health officer and/or Physician or other licensed health care consulted;
 - vi. The date of the evaluation; and
 - vii. The date of contact and contact information for any other employer notified by NIHD regarding potential employee exposure.
 - c. Records of the unavailability of vaccine shall include the name of the person who determined that the vaccine was not available, the name and affiliation of the person providing the vaccine availability information, and the date of the contact. This record shall be retained for three years.
 - d. Records of the unavailability of Airborne Infection Isolation Rooms or areas shall include the name of the person who determined that an Airborne Infection Isolation Room or area was not available, the names and the affiliation of persons contacted for transfer possibilities, and the date of the contact, the name and contact information for the local health officer providing assistance, and the times and dates

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of these contacts. This record, which shall not contain a patient’s individually identifiable medical information, shall be retained for three years.

- e. Records of decisions not to transfer a patient to another facility for Airborne Infection Isolation Room for medical reasons shall be documented in the patient’s chart, and a summary shall be provided to the Plan administrator providing only the name of the physician determining that the patient was not able to be transferred, the date and time of the initial decision and the date, time and identity of the person(s) who performed each daily review. The summary record, which shall not contain a patient’s individually identifiable medical information, shall be retained for three years.
 - f. Records of inspection, testing and maintenance of non-disposable engineering controls including ventilation and other air handling systems, air filtration systems, containment equipment, biological safety cabinets, and waste treatment systems shall be maintained for a minimum of five years and shall include the name(s) and affiliation(s) of the person(s) performing the test, inspection or maintenance, the date, and any significant findings and actions that were taken. Plant operation uses a computer-based work system for documentation of records.
 - g. Records of the respiratory protection program shall be established and maintained. Fit-test screenings will be retained for two years.
4. Availability.
- a. The employer shall ensure that all records, other than the employee medical records more specifically dealt with in this subsection, required to be maintained by this section shall be made available upon request to the Chief Operations Officer and National Institute for Occupational Safety and Health and the local health officer for examination and copying.
 - b. Employee training records, the exposure control plan and/or Biosafety plan, and records of implementation of the Aerosolized Transmissible Disease exposure control plan and Respiratory Protection Program and the Biosafety-plan (Chemical Hygiene Plan), other than medical records containing individually identifiable medical information, shall be made available as employee exposure records in accordance to employees and/or employee representatives.
 - c. Employee medical records required by this subsection shall be provided upon request to the subject employee, anyone having the written consent of the subject employee, the local health officer, and to the Chief Operations Officer and National Institute for Occupational Safety and Health for examination and copying.
5. Transfer of Records.
- a. NIHD will comply with the requirements involving the transfer of employee medical and exposure records.
 - b. If the employer ceases to do business and there is no successor employer to receive and retain the records for the prescribed period, the employer shall notify the Chief Operations Officer and National Institute for Occupational Safety and Health, at least three months prior to the disposal of the records and shall transmit them to National Institute for Occupational Safety and Health, if required by National Institute for Occupational Safety and Health to do so, within that three-month period. NOTE: Authority cited: Sections 142.3 and 6308; Labor Code. Reference: Sections 142.3 and 6308, Labor Code, and 8 CCR 332.3.

REFERENCES:

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1. 2009, California Occupational Safety & Health Standards Board (OSHSB), General Industry Safety Orders, Aerosolized Transmissible Diseases, Title 8, Chapter 4, Subchapter 7, Article 109, Section 5199 <http://www.dir.ca.gov/title8/5199.HTML>
2. California Department of Public Health. (2017). ATD Standard Appendix D: Aerosol Transmissible Pathogens-Laboratory. Retrieved from <https://www.dir.ca.gov/title8/5199d.html>
3. Guidelines for Preventing the Transmission of Mycobacterium Tuberculosis in Health-Care Settings. (2005) CDC page last updated 2012 and page last reviewed 2016. published by the Centers for Disease Control.
4. California Department of Public Health. (2017). Respiratory Protection in the Workplace: Cal?OSGA Respiratory Protection Standard. Retrieved from <https://www.cdph.ca.gov/programs/ohb/Pages/RespStd.aspx>
5. California Tuberculosis Controllers Association. (2015). Current CDPH-CTCA Joint Guidelines. Retrieved from <http://www.ctca.org/menus/cdph-ctca-joint-guidelines.html>
http://www.ctca.org/filelibrary/Scrnimg_Trtnmt-Patients_with_ChronicKidneyDisease..._.pdf
http://www.ctca.org/filelibrary/CTCA_CDPH_Actions_and_Best_Practices_For_TB_Approved.pdf
<http://www.cdph.ca.gov/programs/tb/Documents/TBCB-CA-TB-Risk-Assessment-and-Fact-Sheet.pdf> (Oct 2016)
6. California Health & Safety Code, Title 22, Division 5, Chapter 6, Article 4, §74723 (c)(4), <http://www.dtsc.ca.gov/LawsRegsPolicies/Title22/index.cfm> (go to the Official CCR via link from this site)
7. Centers for Disease Control and Prevention. *Epidemiology and Prevention of Vaccine-preventable Diseases*, Hamborsky J, Kroger A, Wolfe S, eds. 13th ed. 2009, Washington D.C. Public Health Foundation, 2015.
8. Centers for Disease Control and Prevention. (2012) Respiratory Hygiene/Cough Etiquette in Healthcare Settings. Retrieved from <https://www.cdc.gov/flu/professionals/infectioncontrol/resphygiene.htm>
9. Centers for Disease Control and Prevention. (2016). The National Personal Protective Technology Laboratory (NPPTL). Retrieved from <https://www.cdc.gov/niosh/npptl/hospresptoolkit/default.html>
10. APIC Position Paper” Recommendations for Extending Use and/or Reusing Respirators” December 2009 (Placed at the end of this policy for referencing).
11. *Implementing Respiratory Protection Programs in Hospitals A Guide for Respirator Program Administrators*, California Department of Public Health, Occupational Health Branch, August 2015
12. California Department of Public Health (CDPH). (2012). Respirator Use in Health Care Workplaces: Cal/OSHA Aerosol Transmissible Disease Standard. Retrieved from <https://www.cdph.ca.gov/programs/ohb/Pages/ATDStd.aspx>

CROSS REFERENCE POLICIES:

1. Airborne Infection Isolation Room (AIIR)
2. N95 Mask Fit Testing Using Porta Count Pro
3. Employee Health Surveillance Program
4. Adult Immunization in the Healthcare Worker
5. Work Related Accidents/Exposures
6. Initial Evaluation of Exposure Incident
7. Lippincott Procedures: Airborne Precautions , Contact Precautions, Droplet Precautions, Standard Precautions, Respiratory Hygiene and Cough Etiquette ambulatory care.
8. Admission of a Patient with a Communicable Disease

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- 9. Avian Influenza-H5N1 Flu Hospitalized Patients Infection Control
- 10. Infectious/Non Infectious Waste Disposal Procedure
- 11. Severe Acute Respiratory Syndrome Coronavirus (SARS-CoV) Middle East Respiratory Syndrome (MERS-CoV) Infection Control Recommendations Hospitalized Patients
- 12. PAPR Respirator Inspection Record
- 13. Care and Donning of a Powered Air Purifying Respirator
- 14. Northern Inyo Healthcare District Surge Plan
- [15. Chemical Hygiene Plan](#)
- [16. Hospi-Gard Portable Filtration Unit \(HGU\)](#)
- ~~15-17.~~ [NIHD Water Management Plan](#)

Approval	Date
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Safety Committee	
Infection Control Committee	5/22/18
MEC	6/5/18
Board of Directors	
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Appendix A – Aerosol Transmissible Diseases/Pathogens (Mandatory)

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

Diseases/Pathogens Requiring Airborne Infection Isolation

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

Diseases/Pathogens Requiring Droplet Precautions

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

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

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

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

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

Droplet: Streptococcus Type A

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

Draft

**NORTHERN INYO HOSPITAL
POLICY AND PROCEDURE**

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

PURPOSE:

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

POLICY

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

DEFINITIONS

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

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

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

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

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

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

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

Other potentially infectious materials (OPIM) –

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

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

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

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

EXPOSURE DETERMINATION

The exposure determination looks at all job classifications to determine the potential for occupational exposure to blood or other potentially infectious materials. Health care worker job classifications listed below have been determined to be at risk for occupational exposure. This list includes those job

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classifications in which only some employees have occupational exposure. All elements of this exposure control plan apply to all employees in these jobs.

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

METHODS OF COMPLIANCE

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

Standard Precautions

Refer to Lippincott Procedures Standard Precautions.

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

- * Human blood, blood components and products made from human blood
- * **Other potentially infectious materials**
 - –semen
 - –vaginal secretions

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- –cerebrospinal fluid
- –synovial fluid
- –pleural fluid
- –pericardial fluid
- –peritoneal fluid
- –amniotic fluid
- –any other body fluid contaminated with blood such as saliva or vomitus
- –any unfixated tissue or organ from a human

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

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

Engineering Controls:

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

- Sharps with engineering controls, such as needleless systems
- Needle devices and non-needle sharps
- Handwashing facilities
- Leak proof specimen containers
- Laboratory safety hoods where appropriate
- Pneumatic Tube Safety

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

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

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

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

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

- **AUTOGARD IV CATHS*
- **MONOJECT SAFETY SYRINGES*
- **VACUTAINER BUTTERFLY / PUNCTURE GUARD / NEEDLE-PRO*
- **SAFETY TIP NEEDLES*
- **NEEDLE-PRO BLOOD GAS KIT*
- **BLOOD TRANSFER SETS*
- **TIP PROTECTORS*
- **EDGE SAFETY DEVICE*
- **HYPODERMIC NEEDLE-PRO*
- **SAF-T HOLDER DEVICE*

WILL BE USED FOR:

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

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

- **TENDERLETT LANCETTS*
- **DISPOSABLE SCALPELS*

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

- An engineering control is not available in the marketplace.
- A licensed health care professional, directly involved in a patient's care, determines in the reasonable exercise of clinical judgment, that the use of the engineering control will jeopardize the patient's safety or the success of a medical or nursing procedure involving the patient. In such cases, the use of this exception shall be investigated and documented by the Infection Preventionist or designee, and must be approved by the NIHD Infection Committee.

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- The employer can demonstrate by means of objective product evaluation criteria that the engineering control is not more effective in preventing incidents than the alternative used by the employer.
- There is no reliable or specific safety performance information available on the safety performance of the safety control for this facility's procedures. This facility is actively determining whether the use of engineering controls lacking reliable or specific safety performance information will reduce the risk of exposure incidents occurring in this facility.
- The use of engineering controls will be re-evaluated annually during the yearly review of this exposure control plan. Additions or deletions will be made at that time or as indicated by ongoing monitoring activities.

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

Work Practice Controls:

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

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

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

The following is a summary of work practice controls:

- Hands will be washed with soap and water or alcohol based hand rub (ABHR) before patient contact, after the removal of gloves or other personal protective equipment and immediately following contact or exposure to blood or Other potentially infectious materials before clean/aseptic procedure, and after touching patient surroundings. *Hands must be washed with soap and water if there is any visible contamination with blood or other fluids.*
- Mucous membranes and eyes will be immediately flushed with water following exposure to blood or other potentially infectious materials.
- Eating, drinking, smoking, applying cosmetics or lip balm, and handling contact lenses are prohibited in work areas where there is reasonable likelihood of occupational exposure (e.g., nurses' station).

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- Food, drink and oral medications will not be kept in refrigerators, freezers, shelves, cabinets or on countertops or bench tops where blood or other potentially infectious materials may be present.
- All procedures involving blood or other potentially infectious materials will be performed in such a manner as to minimize splashing, spraying, spattering and generation of droplets.
- Mouth pipetting/suctioning of blood or other potentially infectious materials is prohibited.
- Specimens of blood or other potentially infectious materials will be placed in containers that prevent leakage during collection, handling, processing, storage, transportation or shipping. Syringes containing blood or other potentially infectious materials will not be transported with needles attached unless an engineered safety device is in place permanently shielding the needle.
- The container for storage, transport or shipping to outside of the facility will be labeled or color-coded with the legend “biohazard.” These labels shall be fluorescent orange or orange-red, with lettering and symbols in a contrasting color.
- If outside contamination of the primary container occurs, the primary container will be placed within a second container that prevents leakage during handling, processing, storage, transport or shipping and is properly labeled. If specimen could puncture the primary container, the primary container will be placed within the secondary container that is also puncture-resistant.
- Equipment that may be contaminated with blood or other potentially infectious materials will be decontaminated prior to servicing or shipping. If decontamination is not feasible, a biohazard-warning label (that meets the Cal/OSHA requirements) will be attached to the equipment identifying the contaminated portions. Information will be conveyed to all affected employees, servicing people and/or the manufacturer prior to handling to ensure that appropriate precautions are taken.
- Pneumatic Tube System: In case of a biohazard spill in the system:
 - The employee should immediately dial “911 and hit the “Special Function” key. This disables the system and prevents other tubes from becoming contaminated.
 - During the day notify maintenance and during off hours notify the Nursing Supervisor.
 - To prevent this problem, all employees who may place either blood or urine in the tube, need to remember how important it is to carefully seal every biohazard bag.
 - To prevent possible hand contamination, open all tubes slowly and carefully.
 - Pneumatic Tube educational video available on NIHD Intranet>Education>Clinical Equipment Videos.

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Handling Contaminated Sharps

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

- Contaminated needles and syringes, and other sharps will not be bent, broken, recapped or otherwise manipulated and will be disposed of in rigid-walled disposable sharps containers. **Exception:** Syringes that contain radioactive pharmaceuticals that must be returned to the pharmaceutical company for disposal may be recapped using a safety device designed for this purpose or by the “one-handed” method.
- Reusable sharps will be placed in labeled, puncture resistant, leak-proof containers for appropriate cleaning and sterilization. Cleaning of such sharps will not require employees to reach their hands into sharps containers.
- Disposable sharps will not be reused under any circumstances.
- Contaminated sharps will be immediately, or as soon as possible after use, disposed of in rigid, puncture-resistant, leak proof containers which are labeled “Sharps Waste” or with the international biohazard symbol and the word “Biohazard.”
- Sharps container seals must be leak resistant and difficult to reopen.
- Sharps containers will be readily available and easily accessible for all situations in which sharps are used or can be anticipated to be found, including dietary trays and laundry, if applicable.
- Sharps containers will be maintained in the upright position and will be replaced when reaches the fill line (2/3 full) to avoid overfilling.
- Broken glassware that may be contaminated will not be picked up by hand, but by mechanical means such as a brush and dustpan, tongs or forceps.
- No items shall be placed on top of the sharps container (e.g. germicidal wipes, Kleenex boxes
- Staff must ensure that no items are sticking out and/or stuck in the opening of sharps containers
- A safety device will be used (ex point lock) if there is no engineered safety device.

Personal Protective Equipment:

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

- Personal protective equipment will be used in conjunction with engineered controls and work practice controls.

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- Where the potential for occupational exposure exists, staff will be provided, at no cost to the employee, appropriate personal protective equipment such as gloves, gowns, aprons, laboratory coats, splash goggles, glasses, face shields, masks, mouthpieces, resuscitation bags, pocket masks, hoods, shoe covers, etc.
- Appropriate personal protective equipment will not permit blood or other potentially infectious materials to pass through (e.g., impervious gowns) or to reach the employee’s work clothes, street clothes, undergarments, skin, eyes, mouth or other mucus membranes under normal conditions of use.
- Hypoallergenic gloves, glove liners, powderless gloves, and other similar alternatives will be readily available to those employees who experience allergenic problems with the standard gloves.
- Department managers will insure that personal protective equipment in the appropriate size is readily available and utilized when necessary to provide the needed level of protection from anticipated exposure.
- The Infection Preventionist will monitor compliance by checking use of personal protective equipment as part of the environmental rounds, and department managers will monitor compliance on a day-to-day basis.
- Employees will be provided training on the appropriate use of personal protective equipment. Training will be completed at the time of initial assignment to a job classification or task/procedure that presents the potential for blood, body fluid or other potentially infectious material exposure.
- A staff member may temporarily and briefly decline to use personal protective equipment only under rare and extraordinary circumstances. If he/she believes, based on their own professional judgment, that its use would prevent the delivery of health care or public safety services or would pose an increased hazard to worker safety, then they may decline to use the personal protective equipment. If this occurs, the Infection Preventionist will investigate and document the circumstances to determine whether changes should be implemented to prevent a similar occurrence in the future. NIHD encourages employees to report all such instances.
- NIHD will be responsible for the cleaning, laundering, repairing, replacing and disposing of personal protective equipment as needed to maintain effectiveness at no cost to the employee.
- Any garment(s) penetrated by blood or other potentially infectious materials will be removed immediately or as soon as feasible, and placed in the designated area or container for storage until washed or disposed of by the facility.
- All personal protective equipment will be removed prior to leaving the work area and patients room
- Employees are responsible for placing their personal protective equipment, after removal, in a designated area or container for storage, washing, decontamination or disposal.
- Employees will wear gloves when it is reasonably anticipated that they will have hand contact with blood or other potentially infectious materials, mucous membranes and non-intact skin when performing

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vascular access procedures, and when handling or coming into contact with contaminated items or surfaces.

- Disposable gloves will be replaced, as soon as practical when contaminated, torn or punctured or when their ability to function as a barrier has been compromised.
- Disposable gloves will not be washed or decontaminated for reuse.
- Heavy duty, utility gloves may be decontaminated for reuse; however, they must be discarded if cracked, peeling, torn or exhibit any signs of deterioration that would compromise their barrier protection.
- Employees will wear masks in combination with eye protective devices such as glasses with solid sidepieces, goggles or face shields whenever splashes, spray, spatter or droplets of blood or other potentially infectious materials may be generated and eye, nose or mouth contamination can be reasonably anticipated.
- Gowns, aprons, lab coats or similar outer garments will be worn whenever the potential for exposure to blood or other potentially infectious materials is likely.
- Surgical caps or hoods, and impermeable shoe covers or boots will be worn in instances where “gross contamination” is anticipated (e.g., autopsies, orthopedic surgery, labor and delivery).

Cleaning and Decontaminating the Work Site:

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

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

A summary of cleaning requirements follows:

- All equipment and environmental and work surfaces will be cleaned and decontaminated as soon as possible after contact with blood or other potentially infectious materials.
- Contaminated work surfaces, or surfaces that come into contact with the hands, will be cleaned and decontaminated immediately or as soon as feasible in the event they become overtly contaminated, when

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blood or other potentially infectious materials fluid spills occur, or when procedures are completed, using a disinfectant with a hepatitis B or tuberculocidal claim.

- All bins, pails, cans and similar receptacles that become contaminated with blood or other potentially infectious materials will be cleaned and decontaminated immediately or as soon as feasible, no later than at the end of the work shift.
- Protective coverings such as plastic wrap, aluminum foil, or imperviously-backed absorbent paper used to cover equipment or environmental surfaces will be removed, replaced and appropriately disposed of at the end of each work shift. If such covering becomes overtly contaminated, it will be removed and disposed of immediately or as soon as feasible.

Waste Disposal

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

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

Hepatitis B Vaccination Program:

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

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

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

Post-Exposure Evaluation and Follow-Up:

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

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

- The protocol and information packets are available from the infection policies and procedures manual. Detailed instructions and all necessary forms are included in the packet for the employee, supervisor and physician, to ensure the evaluation is comprehensive and thorough.
- Medical evaluation, counseling and follow-up will be conducted by the Nursing Supervisor, Emergency Department, and Infection Preventionist, and Employee Health.
- All medical records will be maintained in the patient's confidential employee health file.
- The treating health care professional will provide to the employee, within 15 days, a copy of his/her written opinion following the post-exposure evaluation and follow-up.
- The Infection Preventionist, Employee Health, or designee will advise the employee-patient of the right to refuse consent of post-exposure evaluation and follow-up from his/her health care employer. If consent is refused, a confidential medical evaluation and follow-up will be made immediately available by an outside health care professional. Medical evaluation and laboratory tests will be provided at no cost to the employee.

Reporting and Documenting Sharps Injuries:

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

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

The log will include the following information

- Job classification of the exposed employee.
- Date and time of the exposure incident.
- Type and brand of the sharp involved, if known.
- A description of the exposure incident which must include:
 - Job classification of the exposed employee.
 - Department or work area where the exposure incident occurred.
 - The procedure the exposed employee was performing at the time of the incident.
 - How the incident occurred.
 - The body part involved in the exposure incident.
 - If the sharp had engineered sharps injury protection, whether the protective mechanism was activated, and whether the injury occurred before the protective mechanism was activated, during activation, or after activation.
 - If the sharp had no engineered sharps injury protection, the injured employee's opinion as to whether and how such a mechanism could have prevented the injury.
 - The employee's opinion about whether any other engineering, administrative or work practice control could have prevented the injury.

Communicating Hazards to Employees:

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

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

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

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

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

Information and Training:

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

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

Training will occur:

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

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

- Copy and explanation of the Standard – A copy of Cal/OSHA’s Bloodborne Pathogens Standard is available for review in the Infection Prevention department and this plan.
- Epidemiology and symptoms – A general explanation of the epidemiology and symptoms of bloodborne pathogens.
- Modes of transmission – A general explanation of the modes of transmission of bloodborne pathogens.
- Employer’s exposure control plan – An explanation of the plan and how an employee can obtain a copy.

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- Risk identification – An explanation of the appropriate methods for recognizing tasks and other activities that may involve exposure to blood and other potentially infectious materials.
- Methods of compliance – An explanation of the use and limitations of methods to prevent or reduce exposure, including appropriate engineering controls, administrative or work practice controls, and personal protective equipment.
- Personal protective equipment – Information on the types, proper use, location, removal and an explanation of the basis for selecting personal protective equipment.
- Decontamination and disposal – Information on handling and the decontamination and disposal of personal protective equipment.
- Hepatitis B vaccination – Information on the hepatitis B vaccine, including its efficacy, safety, method of administration, the benefits of being vaccinated, and that it will be offered free of charge.
- Emergencies – Information on the appropriate actions to take and persons to contact in an emergency involving blood or other potentially infectious materials.
- Exposure incident – An explanation of the procedure to follow if an exposure incident occurs, including how the incident should be reported, the medical follow-up available and the procedure for recording the incident on the sharps injury log.
- Post-exposure evaluation and follow-up – Information on the post-exposure evaluation and follow-up that will be provided to the employee after an exposure incident.
- Signs and labels – An explanation of the signs, labels and/or color coding used to identify hazards.
- Interactive questions and answers – An opportunity for interactive questions and answers with the trainer.

Recordkeeping:

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

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

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Medical Records

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

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

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

Training Records

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

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

- Date of training session
- Summary of content
- Names and job titles of attendees
- Names and qualifications of trainers

Annual Review

A review of bloodborne pathogens is conducted each year. This review will be conducted by the Infection Preventionist. Frontline health care workers—those who have contact with patients and use sharps frequently—will be included in this review. As part of the review process, the committee will consider the effectiveness of the program in preventing “exposure incidents” and will include a review of current

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engineering controls and work practice. The Infection Preventionist Manager is responsible for reviewing and updating the Bloodborne Pathogen Exposure Control Plan annually or more frequently if necessary to reflect any new or modified tasks and procedures that affect occupational exposure. The annual review process will include soliciting input from frontline healthcare workers who have contact with patients and use sharps frequently.

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

- Link to Standard 5193 Bloodborne Pathogens:
<https://www.dir.ca.gov/title8/5193.html>
- Link to Revisions to above (also needs to be included as the 2nd link related to a complete bloodborne pathogen standard)
<http://www.dir.ca.gov/oshsb/bloodpathapprvdtxt.pdf>
- 3rd Link related to bloodborne pathogen's standard:
http://www.osha.gov/pls/oshaweb/owadisp.show_document?p_table=STANDARDS&p_id=10051

CROSS REFERENCE P&P

1. Handling of Soiled Linen
2. Exposure Evaluation
3. Handling and Disposal of Needle/Sharps
4. Handling of Infectious/Non-Infectious Waste
5. Hepatitis Prophylaxis/Needles Stick Policy
6. Injury and Illness Prevention Program
7. Lippincott Standard Precautions
8. Personal Protective Equipment (PPE's) Putting On
9. Personal Protective Equipment (PPE's) Removing with critical notes
10. Personal Protective Equipment (PPE's) and Supplies
11. Pneumatic Tube Use

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12. NIHD Sharps Injury Prevention Program

- 13. Adult Immunization in the Healthcare Worker
- 14. Recommendation for Prophylaxis after Occupational Exposure to HIV
- 15. Waste Management Plan

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REFERENCES:

- Centers for Disease Control and Prevention (2013). Infection Control: Frequently asked questions-Bloodborne Pathogens-Occupational Exposure. Retrieved from https://www.cdc.gov/oralhealth/infectioncontrol/faq/bloodborne_exposures.htm
- The Joint Commission (2018). Infection Prevention and Control IC.02.03.01. Retrieved from <https://edition.jcrinc.com/MainContent.aspx>
- State of California: Department of Industrial Relations (Last accessed 2/20/2017). Exposure control plan for Bloodborne Pathogens. Retrieved from https://www.dir.ca.gov/dosh/dosh_publications/expplan2.pdf
- United States Department of Labor: Occupational Safety and Health Administration (OSHA) (Last accessed 2/20/2017). Bloodborne Pathogens and Needlestick Prevention. Retrieved from <https://www.osha.gov/SLTC/bloodbornepathogens/evaluation.html>

Approval	Date
CCOC	03/26/2018
Infection Control Committee	5/22/18
MEC	6/5/18
Board of Directors	
Last Board of Director Review	6/21/2017

Initiated: 1/2010
 Revised: 5/17 RC, 3/18 RC
 Reviewed: 5/10, 8/11LA; 2/12; 9/12LA; 12/15 NH,

Index Listings: Exposure Control Plan, Needlestick, Exposure

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POLICY

Northern Inyo Healthcare District Emergency Operations Plan (EOP) follows the HICS format. Northern Inyo Healthcare District (NIHD) will manage all emergency incidents, exercises and preplanned (reoccurring/special) events in accordance with the incident command system (ICS) design of the Hospital Incident Command System (HICS). HICS provides for an “All Hazards” approach to manage emergencies. HICS has a defined organization and job action sheets to accommodate as many positions as needed, depending on the disaster. Northern Inyo Healthcare District has identified nine leadership positions that may be activated when activate HICS plan. These include Incident Commander, Liaison, Safety Officer, Public Information officer (PIO), Medical Tech/Specialist, Operations Section Chief, Planning, Logistics and Finance Administrator. These positions will be filled with most appropriate staff member on duty when Hospital Incident Command System (HICS) is activated. These people will be relieved when senior healthcare district staff becomes available.

HICS materials including job action sheets, vests (found only on Disaster Cart), organization chart and documentation forms are located in the Disaster Manual and Disaster Cart and brought to the Incident Command Center (ICC) upon activation of Code Triage.

An emergency incident is defined as natural or manmade events which cause major disruption in the environment of care such as damage to the organization’s buildings and grounds due to severe wind storms, tornadoes, hurricanes, earthquakes, fires, floods, explosions; or, the impact on patient care and treatment activities due to such things as the loss of utilities (power, water, and telephones), riots, accidents or emergencies within the organization or in the surrounding community that disrupt the organization’s ability to provide care.

This Emergency Operations Plan (EOP) is designed to outline the basic infrastructure and operating procedures utilized to mitigate, prepare for, respond to, and recover from emergency situations that tax the routine operating capabilities of the healthcare district. Northern Inyo Hospital District (NIHD) has adopted the National Incident Management System (NIMS) at an organization level. NIMS uses a system approach to integrate the best of existing processes and methods for a unified national framework for incident management. NIHD has incorporated the 17 elements of NIMS compliance into this Emergency Operations Plan.

NIHD has established mutual-aid agreements with Mammoth Hospital, Southern Inyo Hospital and the Public Health Department. NIHD works in conjunction with hazardous materials response teams, local fire department, local law enforcement, area pharmacies and/or medical supply vendors. Established Memorandums of Understanding (MOU) and/or Agreement (MOA) will be shared with local emergency management prior to an incident occurring.

NIHD will participate in local, regional, and or state multidiscipline and multi-agency drills twice per year. Exercise activities will address internal and external communications, receiving, triage, treatment, and transfer of mass casualties, progression of causalities through the healthcare district system, resource management, security procedures, specialty lab testing, and or site/facility safety. Exercise will be conducted through drills, tabletop, functional, and or full scale exercises.

SCOPE

The Emergency Operations Plan is designed to assure appropriate, effective response to a variety of emergency situations that could affect the safety of patients, staff, and visitors, or the environment of NIHD, or adversely impact upon the healthcare district’s ability to provide healthcare services to the community based upon the Hazard Vulnerability Analysis. The Program is also designed to assure compliance with applicable codes and regulations.

This plan covers all healthcare district facilities (Main and All outbuildings and clinics) and its implementation is the responsibility of all personnel.

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GOALS

1. Adhere to the NIHD's mission statement.
2. Prevent or lessen the impact that an emergency may have on the institution and the community (mitigation).
3. Identify resources essential to emergency response and recovery and facilitate their access and utilization (preparedness).
4. Prepare staff to respond effectively to emergency situations that affect the environment of care (response) and test response mechanisms.
5. Plan processes for reestablishing operations after the incident (recovery).

OBJECTIVES:

EM 01.01.01

The critical access hospital engages in planning activities prior to developing its written Emergency Operations Plan. Note: An emergency is an unexpected or sudden event that significantly disrupts the organization's ability to provide care, or the environment of care itself, or that results in a sudden, significantly changed or increased demand for the organization's services. Emergencies can be either human-made or natural (such as an electrical system failure or a tornado), or a combination of both, and they exist on a continuum of severity. A disaster is a type of emergency that, due to its complexity, scope, or duration, threatens the organization's capabilities and requires outside assistance to sustain patient care, safety, or security functions

EM .02.01.01

The critical access hospital has an Emergency Operations Plan. This "all hazards" approach supports a general response capability that is sufficiently nimble to address a range of emergencies of different duration, scale, and cause. For this reason, the plan's response procedures address the prioritized emergencies but are also adaptable to other emergencies that the organization may experience.

EM. 02.02.01

As part of its Emergency Operations Plan, the hospital has a plan for how it will communicate during emergencies

EM. 02.02.03

As part of its Emergency Operations Plan, the healthcare district prepares for how it will manage resources and assets during emergencies.

EM. 02.02.05

As part of its Emergency Operations Plan, the critical access hospital prepares for how it will manage security and safety of staff, patients, visitors, volunteers and other individuals during an emergency.

EM. 02.02.07

As part of its Emergency Operations Plan, the critical access hospital prepares for how it will manage staff during an emergency.

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EM.02.02.09

As part of its Emergency Operations Plan, the critical access hospital prepares for how it will manage utilities during an emergency.

EM.02.02.13

During disasters, the critical access hospital may grant disaster privileges to volunteer licensed independent practitioners. Note: A disaster is an emergency that, due to its complexity, scope, or duration, threatens the organization's capabilities and requires outside assistance to sustain patient care, safety, or security functions. [Refer to Medical Staff bylaws for further information regarding disaster credentialing.](#)

EM.02.02.15

During disasters, the critical access hospital may assign disaster responsibilities to volunteer practitioners who are not licensed independent practitioners, but who are required by law and regulation to have a license, certification, or registration. Note: While this standard allows for a method to streamline the process for verifying identification and licensure, certification, or registration, the elements of performance are intended to safeguard against inadequate care during a disaster. [Refer to Medical Staff bylaws for further information regarding disaster credentialing.](#)

EM.03.01.01

The critical access hospital evaluates the effectiveness of its emergency management planning activities.

EM.03.01.03

The critical access hospital evaluates the effectiveness of its Emergency Operations Plan.

EM.04.01.01

If the critical access hospital is part of a health care system that has an integrated emergency preparedness program, and it chooses to participate in the integrated emergency preparedness program, the critical access hospital participates in planning, preparedness, and response activities with the system.

ORGANIZATION AND RESPONSIBILITY

Medical Staff: The Emergency Department Physician on duty at the time of the emergency will be responsible for providing medical services for the "Immediate Care" area. Additional physicians may be called in depending on the number of casualties and the nature of their injuries. If "Delayed Care" and/or "Minor Care" areas are established, a physician will be asked to coordinate medical efforts for these functions. The Medical Staff reviews the EOP Plan at the Department and MEC.

Quality Improvement Committee receives regular reports of the current status of the Emergency Management Program through the Safety Committee. Quality Improvement Committee reviews the reports and, as necessary, communicates concerns about key issues and regulatory compliance to the Safety Committee Chair. The MEDDM makes recommendations to Senior Leadership for purchase of supplies and equipment necessary for the improvement of the emergency response capability.

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The Manager of Emergency Department and Disaster Planning (MEDDP) works under the general direction of the Chief Nursing Officer (CNO) and the Administrator. The MEDDP, in collaboration with the Resuscitation Committee is responsible for managing all aspects of the Emergency Management Program. The MEDDMP advises the Safety Committee regarding emergency management issues which may necessitate changes in policies and procedures, orientation or education of personnel and/or purchase of equipment.

Individual personnel are responsible for learning and following job and task specific procedures for emergency response and for participation in emergency activities as appropriate to their jobs.

All Healthcare district personnel are considered essential to the operation of the healthcare district. HICS allows for easy expansion of the basic incident command structure to include additional personnel assignments designed to accommodate the needs of specific disaster situations. Designated staff have been assigned to fill HICS positions and trained to assume these rolls. In some emergencies, the Healthcare district may establish a personnel pool to supplement or staff essential response or operating functions. In those situations, employees may be assigned responsibilities commensurate with their abilities but outside their normal job responsibilities. Employees who are assigned key roles in the HICS are issued identification vests and name badges, designed to clearly identify their role in the response effort.

Department Directors are responsible to implement their departmental emergency duties and take whatever actions are necessary to maintain needed services including maintaining a current emergency call-back telephone list. Depending on the scope and nature of the emergency some departments may be asked to close and send all available employees to the labor pool to assist with more acute needs. Department Directors are also responsible for educating their staff regarding emergency procedures. In addition they are responsible to be familiar with the specific roles which may be assigned to them or their department should the function(s) be activated by the Incident Commander. Each department must complete and submit a status report to the Incident Command Center (ICC) immediately following Code Triage. General guidance for emergency incidents is provided in the Management of the Environment of Care Manual for the immediate situation, i.e. Civil Disturbance, Bomb Threat, Earthquake Protocol, Utility Failures, etc. The Department Director will notify the Incident Command Center of additional staffing needs and request approval to utilize the call-back list to provide personnel necessary to cover necessary staff positions. Department Directors are responsible for determining the department level of response needed for the emergency, based upon such information as:

- The nature and severity of the emergency;
- Direction from the Incident Commander;
- Number of victims;
- Types of injuries;
- Time of day;
- Current staffing;
- Conditions and availability of the healthcare district, its equipment and materials available.

Volunteers are responsible for knowing the overhead page, CODE TRIAGE, for the activation of the Emergency Preparedness Plan. Those volunteers assigned to specific departments are responsible to return to their assigned department, unless released to the labor pool. All other volunteers are responsible for reporting to the labor pool, if activated.

HAZARD VULNERABILITY ANALYSIS (HVA)

The Resuscitation Committee, with the assistance of other pertinent personnel will conduct an HVA of the operations and environment of NIH. The result of the HVA will be reviewed with Healthcare Coalition and a county HVA will also be developed. Both of these processes will be completed annually. Results will be shared with the Safety Committee, Department Heads, and the Board of Directors.

MITIGATION, PLANNING, RESPONSE AND RECOVERY

The job action sheet of HICS includes sections addressing mitigation, planning, response, and recovery.

- **The Mitigation Section** describes equipment and human activity designed to be put in place in

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advance to minimize the impact of an emergency.

- **The Planning Section** describes the training, supplies, and equipment required to initiate full effective response at the time of an emergency. These planning descriptions include a list of available supplies and equipment and any required maintenance or inspection.
- **The Response Section** describes the command structure required to manage the plan after initiation, during the emergency situation, and sustaining operations during protracted disruptions.
- **The Recovery Section** describes the processes for moving from emergency operations back to normal operations, and the process for assessing and implementing a full recovery of the structure and all internal components and systems.

COMMUNICATIONS SYSTEMS

Several alternate communication systems are available for use during emergency responses. The systems include the regular phone system, an emergency phone system, public and satellite telephones, two-way radios, Ham radios, and cellular phones. The implementation of the emergency plan focuses on maintaining vital patient care communications.

NIHD has established common equipment, communications and data interoperability resources with emergency medical services (EMS), public health, and emergency management that will be used during incident response. This element will be part of the annual evaluation of NIMS compliance.

NIHD will establish common language that is consistent with language to be used by local emergency management, law enforcement, emergency medical services, fire department, and public health personnel. Plan language will be used in training and tested during drill exercises.

COMMUNITY-WIDE RESPONSE INVOLVEMENT

NIHD is part of Section VI (6). The Emergency Response Group works with local, county and state planning agencies to define the role each provider will play during an emergency. The anticipated role of NIHD is to function as an acute medical care facility capable of effectively treating many levels of injury/illness. This role might be reduced if environmental circumstances affect the integrity of the campus or the utility systems essential to providing care.

COMMAND STRUCTURE

NIHD has chosen to use the ICS (Incident Command System) model to manage the implementation of emergency responses and to integrate the facility response with the community and other health care providers. The ICS model plan is developed to manage emergency responses that have unpredictable elements. These are determined as part of the HVA and priority analysis. Plans that stand alone are designed to allow immediately available staff to effect instant activation and to manage the consequences. Most others are designed to use the ICS for emergency management.

COMMUNITY PLANNING

NIHD participates in the Inyo County Emergency Planning through the Unified Command and the Healthcare Coalition. The groups are made up of representatives of community emergency response agencies, health care organizations, and other organizations interested in developing coordinated regional emergency response plans. The discussions of the group are used to guide the development of the NIHD Emergency Operations Plan and planning.

INITIATION OF EMERGENCY

The Administrator or Administrator on Call, and the Nursing Supervisor on Duty, have authority to activate the Incident Command Center (ICC) and initiate CODE TRIAGE, or other portions of the emergency plan whenever a defined emergency exists. The person activating the emergency plan and/or the EOC, serves as the Incident Commander until relieved by a senior Administrator, or relinquishes responsibility to another individual for breaks or rest periods. It is always better to activate the EOC, and close it soon thereafter, then to delay activation and try to catch up with rapidly moving events. Each Emergency Operations Plan (HICS) clearly states the process for implementation of the plan. The description includes the command

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structure for the plan, the conditions, or criteria requiring activation of the plan, and the individual(s) responsible for implementation of the plan. The simplest implementation procedure is immediate activation of the response using an equipment-activated alarm for the fire plan. More complex response procedures involving setting up a command center and ICS response team are required for most emergencies, including major utility failures and community-based emergencies.

The healthcare district may receive three principle notifications: Advisory, Alert and or Activation.

- **An Advisory** is given when no system response is needed but the potential for a response exists.
- **An Alert** is given when a response is likely or imminent and should prompt an elevated level of response preparedness.
- **An Activation** is given when a response is required.

The local Public Health Department or emergency management office will usually receive these notifications.

Important information to obtain as soon as possible should include but not be limited to:

- type of incident, including specific hazard/agent, if known
- location of incident
- number and types of injuries
- special actions being taken (e.g., decontamination, transporting persons)
- estimated time of arrival of first-arriving Emergency Medical Service units.

NIHD and local law enforcement will maintain access, crowd and traffic control. Volunteers from the labor pool would be used to expand the security force if needed.

NOTIFICATION OF CIVIL AUTHORITY

Whenever a situation adversely affects the Healthcare district’s ability to provide services to the community, the Healthcare District notifies appropriate authorities and city-county agencies and coordinates mutual aid and other response activities through the county Emergency Operations Center (EOC), if appropriate, or directly with receiving hospitals.

Several local agencies may play a role in managing an emergency. NIH maintains a current list of these agencies and key contacts for various kinds of emergency situations. Contacts on the list include police, fire, Emergency Medical Services, local emergency management offices, and the Red Cross. The Incident Commander, or designee, notifies agencies as appropriate as soon as possible after an emergency response is initiated.

California Dept of Health Services requires that all emergency/disaster related occurrences, which threaten the welfare, safety, or health of patients, must be reported to the Dept of Health Services, Licensing and Certification Program.

STAFF NOTIFICATION

Staff is notified of EOP plan implementation in several ways: overhead page, landline telephone, cellular phones, pagers, or runners in the healthcare district. Telephone trees, electronic computer notification, cellular phones, social media, pagers and other means of communication are used to notify staff that are away from the healthcare district.

STAFF IDENTIFICATION

NIHD uses the regular staff identification badge to identify caregivers and other employees during mass casualty or major environmental disasters. Everyone coming into the facility needs to have a visible NIH ID in order to enter. Staff without ID’s must go through Labor pool, be positively identified, and receive a temporary badge or other approved alternate.

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Key members of the Incident Command team are issued a vest with the ICS Command Title visible to identify their role in the response. These vests move with the job title and as more senior staff become available, and during longer incidents, jobs are handed from staff to staff. The Liaison Officer from the Incident Command team is assigned to work with law enforcement, fire services, emergency management agencies, contractors, the media, and volunteer responders to issue NIH emergency identification or to determine what form of identification to each responding group will display.

STAFF COVERAGE OF CRITICAL POSITIONS

The Emergency Operations Plan includes processes for the Incident Commander and Department heads to communicate to determine staffing needs and to assign available staff to critical responder positions. Some response procedures assign departments or individuals specific roles automatically to assure timely and effective implementation. HICS includes organizational charts and processes to assure staff coverage.

MANAGEMENT OF PATIENT CARE ACTIVITY

There is an Emergency Operations Plan that addresses management of patient care activities. The plans include procedures for discontinuation of elective treatment, for evaluation of patients for movement to other units, release to home or transfer to other facilities as space is needed, management of information about incoming patients and about current patients for planning, patient management, and informing relatives and other; and for transport of patients.

Victims will be admitted through the Emergency Department for initial triage and disposition to appropriate area as their condition warrants. Outpatient and elective procedures may need to be canceled and rescheduled, depending on resource allocation and facility status (i.e. condition of department, availability of staff & supplies) as a result of the emergency. Inpatients will be assessed on admission and placed in the following categories for discharge or transfer:

1. **very high-risk** – could only be cared for in an acute facility
2. **high risk** – could be transferred to an acute care facility
3. **moderate risk** – would be transferred to another facility
4. **low risk** – could be transferred home
5. **minimum risk** – could be discharged immediately

DISASTER CREDENTIALING (See Healthcare District Policy)

EMERGENCY LOCATIONS FOR PATIENT CARE

All patients will enter through Emergency Department, after triage outside, as appropriate. Patient Treatment Areas will be assigned as follows unless otherwise stated at the time of the Code.

- o **Triage Area** - Emergency Parking Lot beside Emergency Department
- o **Immediate Care Area** - Emergency Department
- o **Delayed Care Area** – Rural Health Clinic
- o **Minor Care Area** – Pioneer Medical Building
- o **MORGUE** – To be determined at the time of emergency

EMERGENCY LOCATIONS FOR NON-PATIENT CARE

Pre-assigned locations of various functions (if activated) are as follows unless otherwise stated at the time of the Code Triage:

- o **Healthcare District Command Center** – 2nd floor Conference Room
- o **Labor Pool** – Main Lobby
- o **Family Center/Human Services Center** – Rehabilitation Building
- o **Press Center** – Administration Meeting Room
- o **Dependent Adult/Child Care Center** – Rehabilitation Building

Procedures also address the transportation and housing of staff that may not be able to get to or from the facility during an emergency or who may need housing and other services for their families to be available for service. A procedure is in place for incident stress debriefing. Staff who are involved in emergency

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operations are offered an opportunity to address incident related issues with qualified behavioral health professionals, social services or chaplain.

Arrangements are made with vendors and other services to assure availability of supplies, materials, food and water in a timely fashion.

Release of information to the news media follows the procedures developed by the Public Information Officer (PIO)⁴ who would act as spokes persons for the organization. The PIO, along with information Technology can give updates through social media. The Incident Commander will release information as appropriate to the situation. In larger incidents, the local Emergency Operations Center of Inyo County may act as spokesperson for the overall emergency and healthcare district information.

STAFF AND FAMILY SUPPORT

Because all Healthcare district personnel are considered essential during emergency response situations, the Healthcare district recognizes its responsibility to provide meals, rest periods, psychological, and other personnel support. In addition, the Healthcare district recognizes that providing support, such as communication services and dependent care, to employees' families during emergency situations allows employees to respond in support of the essential functions of the Healthcare district. The Operations Chief, working through the Human Service Director and his/her unit leaders will initiate support programs and activities, based on the demands of the specific emergency including but not limited to:

- Emergency child care
- Emergency transportation
- Staff/family lodging and meals
- Psychological and bereavement counseling
- Staff/family prophylaxis or immunization
- Animal and pet care

ETHICAL OPERATING PROCEDURES

In emergency situations, certain standing policies and procedures of the Healthcare district and rules and regulations of the Medical Staff may be waived by the Incident Commander, the Medical Care Director or the other first-tier incident command center staff to ensure that essential patient care can be rendered and that the facility can be secured.

EVACUATION

A facility evacuation plan is in place and can be implemented in phases. Relocation of staff away from the area of emergency may be undertaken by staff on the spot, moving to areas in adjacent zones. A full evacuation would be implemented if the impact of an emergency renders the healthcare district inoperable or unsafe for occupancy, and would be implemented with the involvement of the CEO or senior leadership available.

SURGE AND ALTERNATE CARE SITES

Surge tent may be utilized for alternate care site. Other care sites may include Jill Kinmont Boothe School; City Hall, Pine Street School Gym; and the Fairgrounds.

The Incident command Center works with Operations, Planning and Logistics Chiefs to coordinate appropriate staff to assure required equipment, medication, medical records, staffing communications and transportation are mobilized to support relocation and management of patients at remote sites.

RECOVERY PLANS

NIHD has recovery plans to return operations to normal functions after most emergencies. The recovery plans are activated near the completion of the Emergency Operations Plan (HICS). The Incident Commander will determine the degree of activity required. Preset activity that is activated by the "all clear" includes action by medical records to capture the records of emergency services, capture of costs by

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patient billing, and return of facilities to their original and normal use. The plans also call for resetting and recovering emergency equipment and supplies, and documentation of the findings of the after the event debriefing. If substantial damage has been done to the facility, plans for reconstruction and renovation will be developed at that point. Documentation of current assets (buildings, equipment, etc) has been recorded for baseline

Documentation for ~~FMEA-FEMA~~ assistance will be based on pictures of damages and repairs, documentation and notes on damages and repairs, newspaper reports and stories, video footage from television stations, and records of all expenditures, receipts, and invoices. Short- term recovery frequently overlaps with response.

ALTERNATE SOURCES OF UTILITY SYSTEMS

Alternate plans for supply of utilities for patient care are maintained for these contingencies. Plans include use of the emergency power, backup systems for water, fuel for heating and power, HVAC, and ventilation systems with alternate power sources. Managers and staff in all departments affected by the plans are trained as part of organization wide and department specific education. The plans are tested from time to time as part of the regularly scheduled drills of the Emergency Operations Plan (HICS), and actual outages of utility systems.

CHEMICAL AND RADIOACTIVE ISOLATION AND DECONTAMINATION

The management of situations involving nuclear, biological, or chemical contamination is a joint effort between national, state, and local officials and the health care community. NIH is prepared to manage a limited number of individuals contaminated with hazardous materials and to meet the care needs of others who have been decontaminated by other agencies.

If the facility is contaminated, a contractor experienced in the isolation and decontamination process will be contacted by the Incident Command staff. The Safety Officer, with Public Safety assistance, will assure isolation of the affected area until it is declared safe by appropriate experts.

EDUCATION AND TRAINING

Each new staff member of NIHD participates in a general orientation that includes information related to the Emergency Operations Plan. Examples of such information include: the Emergency Operations Plan (HICS)s, job-specific roles, emergency communication plans, location of emergency supplies and equipment, and disaster management procedures.

The Human Resources Department conducts the general orientation program. The general orientation program is scheduled by the Human Resources Department, and records attendance for staff members who complete the general orientation program. They also track and reschedule staff members who did not to attend the general orientation program.

New staff members also receive a department-specific orientation. Each department manager provides new staff members with a department-specific orientation to their role in the Emergency Management Program. All staff members of NIH participate at least once each year in a continuing education Program. Information specific to the Emergency Management Program is included in the continuing education Program. The Safety Officer collaborates with individual department heads to develop content and supporting materials for general and department-specific orientation and continuing education programs.

Independent Study (IS) IS-100, IS-200, IS-700 and IS-800 will be available to all healthcare district personnel likely to have a leadership role in emergency preparedness, incident management, and or emergency response during an incident; all directors and nursing supervisors. ¹

PERFORMANCE OF DRILLS/EXERCISES

**NORTHERN INYO HEALTHCARE DISTRICT
POLICY AND PROCEDURES**

Title: Emergency Management Plan	
Scope: Hospital Wide	Manual: Safety
Source: Disaster Planning/Safety	Effective Date: 8/2008

NIHD is a healthcare district that offers emergency services and has a defined role in community-wide emergency management therefore the emergency management plan is tested twice a year, in response to and actual or in a planned exercise. One exercise a year includes a communitywide exercise and an influx of actual or simulated patients.

During planned exercises, an individual(s) is designated whose sole responsibility is to monitor performance and who is knowledgeable in the goals and expectations of the exercise, documents opportunities for improvement.. The following core performance areas are monitored during planned exercises: event notification including processes related to notification of external authorities, communication including the effectiveness of communication both within the healthcare district as well as with response entities outside of the healthcare district such as local governmental leadership, police, fire, public health, and other healthcare organizations within the community, resource mobilization and allocation including responders, equipment, supplies, personal protective equipment, transportation, and security, patient management including provision of both clinical and support care activities, processes related to triage activities, patient identification and tracking processes.

All exercises are critiqued by a multi-disciplinary process that includes administration, clinical (including physicians), and support staff to identify deficiencies and opportunities for improvement based upon all monitoring activities and observations during the exercise.

After a drill or exercise, a corrective action report will be created. In the corrective after ction report, the following points will be addressed for each identified issue:

- The identified action to correct the issue or deficiency
- The responsible person or group of people to implement the action,
- The due date for completion of the action, and
- The resulting corrective action will be incorporated into plans and procedures once completed.

The EOP is modified in response to critiques of exercises. Future planned exercises evaluate the effectiveness of improvements that were made in response to critiques of the previous exercise. Note: When improvements require substantive resources that cannot be accomplished by the next planned exercise, interim improvements are put in place until final resolution. The strengths and weaknesses identified during exercises are communicated to the multidisciplinary improvement team responsible for monitoring environment of care issues.

The MEDDP maintains performance indicators to objectively measure the effectiveness of the Emergency Management Program. The MEDDP determines appropriate data sources, data collection methods, data collection intervals, analysis techniques and report formats for the performance improvement standards. Personnel, equipment, and management performance are evaluated to identify opportunities to improve the Emergency Management Program. The performance measurement process is one part of the evaluation of the effectiveness of the Emergency Management Program. A performance indicator is established to measure at least one important aspect of the Emergency Management Program. The current performance indicators for the Emergency Management Program are:

HI1.25

1. # Drills
2. # actual implementation of HICS
3. # pts treated in ED requiring decontamination
4. # incidents of mass causality

In addition, all the objectives listed at the beginning of this plan are evaluated for effectiveness during the annual evaluation.

ANNUAL EVALUATION

NORTHERN INYO HEALTHCARE DISTRICT POLICY AND PROCEDURES

Title: Emergency Management Plan	
Scope: Hospital Wide	Manual: Safety
Source: Disaster Planning/Safety	Effective Date: 8/2008

The MEDEP is responsible for coordinating the annual evaluation of the seven functions associated with Management of the EC. The MEDEP is responsible for performing the annual evaluation of the Emergency Management Program.

The annual evaluation examines the objectives, scope, performance, and effectiveness of the Emergency Management Program and the Hazardous Vulnerability Analysis. The annual evaluation uses a variety of information sources including the reports from internal policy and procedure review, incident report summaries, Safety Committee Meeting minutes, Safety Committee reports, and summaries of other activities. In addition, findings by outside agencies, such as accrediting or licensing bodies or qualified consultants, are used. The findings of the annual evaluation are presented in a narrative report supported by relevant data. The report provides a balanced summary of the Emergency Management Program's performance over the preceding 12 months. Strengths are noted and deficiencies are evaluated to set goals for the next year or longer term future.

The annual evaluation is presented to the Safety Committee who reviews and approves the report. The deliberations, actions, and recommendations of the Committee are documented in the minutes. The annual evaluation is also distributed to the Chief Executive Officer, the Performance Improvement Committee, and other Department Heads as appropriate. Once the review is finalized, the DONCCDM is responsible for implementing the recommendations in the report as part of the performance improvement process.

DEFINITIONS

- a. **Hospital Incident Command System (HICS)** – The “All Hazards” plan used to manage emergencies. This describes a management method that may be adapted to most emergency situations, both internal and external.
- b. **Incident Planning Guides (IPGs)**: Plans that describe the specifics of how the organization plans to respond to specific emergency situations as identified by HVA and other analysis.
- c. **Emergency Operations Plan (EOP)** – The Program to identify, plan for, prepare for, drill, recover from, and evaluate the response to the drills and actual emergencies, and to identify processes and elements that may be improved with better planning, equipment, or training.
- d. **Emergency** - Emergencies are defined as natural or manmade events which cause major disruption in the environment of care such as damage to the organization's buildings and grounds due to severe wind storms, tornadoes, hurricanes, earthquakes, fires, floods, explosions; or, the impact on patient care and treatment activities due to such things as the loss of utilities (power, water, and telephones), riots, accidents or emergencies within the organization or in the surrounding community that disrupt the organization's ability to provide care.
- e. **Hazard Vulnerability Analysis (HVA)**: a structured process to evaluate the potential for conditions or events that are likely to have a significant adverse impact on the health and safety of the patients, staff, and visitors of NIH or on the ability of NIH to conduct normal patient care and business activities.

REFERENCES

1. National Incident Management System (NIMS)
http://www.dhs.gov/dhspublic/interapp/editorial/editorial_0566.xml
2. Appendix 1. NIMS Implementation Activities for Hospitals and Healthcare Systems
3. National Bioterrorism Hospital Preparedness Program (NBHPP)
4. Hospital Incident Command System (HICS) Manual <http://www.emsa.ca.gov>
5. LA County Hospital Regional Response Plan
6. Emergency Management (EM) Principles and Practices for Healthcare Systems
7. Training of Hospital Staff to Respond to a Mass Casualty Incident

**NORTHERN INYO HEALTHCARE DISTRICT
POLICY AND PROCEDURES**

Title: Emergency Management Plan	
Scope: Hospital Wide	Manual: Safety
Source: Disaster Planning/Safety	Effective Date: 8/2008

8. IS-242 Effective Communication
9. IS-702 National Incident Management System
10. CAMH's Manual EC 4.10 and EC 4.20
11. Los Angeles County Hospital Regional Response Plan Umbrella Health Care Entities agreement
12. Federal Emergency Management Agency, FEMA, Higher Education Project (Appendix: Select Emergency Management-Related Terms and Definitions - 501KB MS Word):
<http://training.fema.gov/EMIWeb/edu/hazdisusems.asp>
13. Federal Emergency Management Agency, FEMA, State and Local Guide (SLG) 101: Guide for All-Hazard Emergency Operations Planning: <http://www.fema.gov/plan/gaheop.shtm>
14. Department of Veterans Affairs. Emergency Management Program Guidebook. 2005:
<http://www1.va.gov/emshg/page.cfm?pg=114>
15. NFPA 1600, Standard on Disaster/Emergency Management and Business Continuity Programs 2004 Edition: <http://www.nfpa.org/assets/files/pdf/nfpa1600.pdf>

CROSS REFERENCES:

1. Evacuation Policy
2. HICS Organization Chart
3. Emergency: Internal/ External Disaster Plan
4. Credentialing Health Care Practitioners in the Event of a Disaster
5. Disaster Plan Perioperative Unit
6. Sterile Processing Disaster Plan
7. Overcrowding in the Emergency department

Approval	Date
CCOC	1/29/18
Safety Committee	4/11/18
Resuscitation Committee	4/4/18
Emergency Services Committee	<u>5/16/18</u>
Medical Executive Committee	<u>6/5/18</u>
Board of Directors	
Last Board of Director review	

Developed:
 Reviewed: 8/08; 8/09; 8/2010; 7/2011as
 Revised: 10/07; 8/09; 7/2011as, 1/2018 gr
 Supersedes: HI – HICS_ Emergency Management Plan

**NORTHERN INYO HOSPITAL
POLICY AND PROCEDURE**

Title: Emergency Room Overcrowding	
Scope: Dept. Specific	Department: Emergency Dept
Source: Emergency Dept Nurse Manager	Effective Date:

PURPOSE:

As ambulance diversion in the 911 System is not an option under general circumstances since the closest hospital is 45 miles away, this policy will address the issue of Emergency Department (ED) overcrowding, indicators and possible solutions.

POLICY:

Each patient will be triaged on arrival for care and the approximate wait time will be projected.

Indicators of reduced capacity include:

- 1) Large volume of ED patients awaiting medical screening.
- 2) High acuity patients currently receiving treatment.
- 3) Increase patient to nurse ratio.
- 4) Decreased bed availability in-house.
- 5) Decreased bed availability at receiving specialty hospitals.
- 6) Patients leaving without being seen (LWBS) during periods of long wait.
- 7) Patients waiting transfer to specialty facility.

Procedures and Strategies to relieve overcrowding should include:

- 1) Notify House Supervisor of overcrowding.
- 2) Request additional physician or qualified medical provider coverage for medical screening.
- 3) Nursing staff called in “on-call” to improve ratios and efficiency.
- 4) Patients in waiting room should be updated as to the time frame when they may be seen and reassessed every hour and as needed.
- 5) Using chairs and hallways for lower level acuity patients.
- 6) Establish a “results” waiting and pending discharge area.
- 7) During full surge capacity with no relief, notify all nurse managers and on-call administrator and establish Hospital Incident Command.
 - a) Mobilize Emergency Management Plan.
 - b) Utilize surge tent when needed.
- 8) House supervisor to obtain information on potential receiving hospitals.
- 9) In disaster situations, working with public health for additional triage and medical screening sites.

REFERENCES:

1. Emergency Nurses Association. (2017), ENA Topic Brief: *Emergency Department Throughput*. Retrieved from: https://www.ena.org/docs/default-source/resource-library/practice-resources/topic-briefs/ed-throughput.pdf?sfvrsn=ceeb57fb_8
2. National Center for Biotechnology Information (NCBI) 2012. *Emergency Room Crowding: A Marker of Hospital Health*. Available at: <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3540619/>

CROSS REFERENCES:

1. Emergency Management Plan

**NORTHERN INYO HOSPITAL
POLICY AND PROCEDURE**

Title: Emergency Room Overcrowding	
Scope: Dept. Specific	Department: Emergency Dept
Source: Emergency Dept Nurse Manager	Effective Date:

Committee Approval	Date
Clinical Consistency Oversight Committee	11/6/17
Emergency Services Committee	5/16/18
Medical Executive Committee	6/5/18
Board of Directors	
Last Board of Directors Review	

Developed:

Reviewed: 10/2017 gr

Revised: 04/2018 gr

Supersedes:

Index Listings:

**NORTHERN INYO HOSPITAL
POLICY AND PROCEDURE**

Title: Evaluation of Pregnant Patients in the Emergency Department	
Scope:	Department: Emergency Dept, OB/Gyn
Source: Emergency Dept Nurse Manager	Effective Date: 1/9/2004

PURPOSE:

To ensure quality care for pregnant patients presenting in the Emergency Department for evaluation and potential treatment

POLICY:

1. All pregnant patients presenting to the Emergency Department will initially be seen in accordance with ER medical screening policies and procedures.
2. Stable patients at 20 weeks or greater gestation will be sent to the Perinatal Department for evaluation. The on-call OB provider will be consulted by the Perinatal RNs, and will see the patient as necessary (in accordance with EMTALA and patient condition). If the patient is cleared (discharged) from the Perinatal Department by the OB provider and has non-OB complaints that were not addressed by the OB provider, the patient shall return to the ED to be evaluated by the ER physician.
3. Patients who are unstable will not be transferred to the Perinatal Department until stabilized.
4. Patients at less than 20 weeks gestation will be evaluated by the ER physician who will consult, as needed, with the OB physician on-call.
5. For patients at 20 weeks or greater gestation who are not immediately transferred to the Perinatal Department, the ER physician will consult with the on-call OB provider.
6. If patient appears to be in active labor or delivery appears imminent, notify Perinatal Department to prepare for the patient and accompany patient to Perinatal Department.
7. If delivery in progress, patient will be cared for by the ER MD until the on-call OB provider arrives. Perinatal RNs may be requested to assist in the ED if available.
8. The decision to admit or discharge a patient at 20 weeks or greater gestation will be at the discretion of the OB provider evaluating the patient for pregnancy-related problems. If not pregnancy-related, then ER procedures will be followed.
9. For patients at 20 weeks or greater gestation who are not immediately transferred to the Perinatal Department, a Perinatal RN may evaluate the patient in the ED if staffing allows and both departments are agreeable. If in doubt, the OB evaluation should take place on the Perinatal Department.

**NORTHERN INYO HOSPITAL
POLICY AND PROCEDURE**

Title: Evaluation of Pregnant Patients in the Emergency Department	
Scope:	Department: Emergency Dept, OB/Gyn
Source: Emergency Dept Nurse Manager	Effective Date: 1/9/2004

REFERENCES:

1. EMTALA; California Hospital EMTALA Manual; A guide to patient anti-dumping laws. Lipton, M.S. 2018.

CROSS REFERENCES:

1. Emergency Department Triage Protocols
2. EMTALA Policy

Committee Approval	Date
CCOC	4/23/18
Emergency Services Committee	5/16/18
Perinatal-Pediatrics Committee	4/20/18
Medical Executive Committee	6/5/18
Board of Directors	
Last Board of Directors Review	

Developed:

Revised: 2/2018af

Reviewed

Supersedes: 2/02

Index Listing: OB Patients, Evaluation of Pregnant Patients in Emergency Department

**NORTHERN INYO HOSPITAL
POLICY AND PROCEDURE**

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

INFECTION CONTROL MISSION STATEMENT

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

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

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

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

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

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

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

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SUMMARY OF THE INFECTION CONTROL COMMITTEE DUTIES

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

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ANNUAL:

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

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

QUARTERLY

Infection Control Committee Meeting

Submit Quarterly Infection ~~Prevention~~ Prevention and Employee Health Pillars of

Excellence to

- Infection Control Committee
- Nurse Executive Committee
- Quality Assurance and Performance Improvement

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CONTINUOUS

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

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STATEMENT OF PURPOSE

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

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**NORTHERN INYO HOSPITAL
POLICY AND PROCEDURE**

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

LEADERSHP AND RESPONSIBILITY

A. Board of Directors

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

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B. Medical Executive Committee

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

C. Chief Executive Officer

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

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D. Infection Control Committee

(See attached structure appendix 1)

E. Infection Control Medical Staff Chairperson

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

F. Infection Preventionist Manager

The Infection Preventionist Manager assumes the responsibility of managing and carrying out the infection surveillance, prevention and control functions within NIH. This person has training in

**NORTHERN INYO HOSPITAL
POLICY AND PROCEDURE**

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

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

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~~G. Clinical Informatics Nurse Specialist supports the infection control process, including data collection, data analysis, interpretation and presentation of findings and helps the hospital achieve program objectives.~~

SCOPE AND INTEGRATION:

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

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

A. Inpatient and outpatient areas

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

- Acute/Subacute
- Swing
- Inpatient Hospice

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- Intensive Care Unit
- Perinatal Services
- Emergency Department
- Peri-operative Services
- Outpatient Infusion Center
- Rural Health Clinic and other clinics

B. Service/Diagnostic Areas

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

- Laboratory
- Diagnostic Imaging
- Cardiopulmonary
- Rehabilitation Services

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C. Support Services

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

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

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D. Employee Health Services

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

- Case findings and identification of demographically important ~~nosocomial infections~~ HAI's, to provide surveillance data for the hospital

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**NORTHERN INYO HOSPITAL
POLICY AND PROCEDURE**

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- Reporting of information about infections internally and, as indicated, to public health agencies.
- Implementation of strategies to prevent or reduce the risk of ~~nosocomial infections-~~HAI's in patients, team members and visitors.
- Implementation of strategies to control outbreaks of ~~-nosocomial infections-~~ HAI's when such are identified.

METHODOLOGY

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

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POLICY AND PROCEDURE**

Title: Infection Prevention Plan*	
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Source: Quality Nurse/Infection Control Preventionist	Effective Date: 4/1/2015

7. Evaluate control case (ex: any new cases)
8. Communicate findings with leadership.
9. Keep record of all data and communication.
10. Contact CDC or other agencies for advice or assistance if deemed appropriate or necessary.

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D. Interventions to reduce infections risks other than those directly related to prevention of transmission may include the following strategies

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

E. The assessment of reasons for infection rates not being reduced by surveillance alone and interventions undertaken to address problems in the following areas:

- Knowledge – innovative educational approaches beyond the routine or standard in services.
- Behavior – activities by managers to change behavior.
- Systems – such as staffing, sink number and placement, control of over-crowding, lack of proper equipment and supplies.

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

POLICIES AND PROCEDURES

- A. Policies and procedures are based on recognized guidelines and applicable law and regulations. Policies and procedures address prevention and control mechanisms used in all patient care and service areas to prevent the transmission of infection among patients, team members, medical staff, contractors, volunteers and visitors; and also, address specific environmental issues.
- B. Policies and procedures address the following:

**NORTHERN INYO HOSPITAL
POLICY AND PROCEDURE**

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

- Measures that is scientifically valid, applicable in all seeing, and practical to implement.
 - The relationship between team member activities and the infection prevention and control program.
 - Various methods used to reduce the risk of transmission of infection between or among team members and patients.
 - Appropriate patient care practices, sterilization, disinfection and antisepsis, and pertinent environmental controls.
 - Educational and consultative roles of the Infection Preventionist.
- C. All infection control policies and procedures will be re viewed/revise~~d~~ ~~tri-annually~~ annually or as needed by the Infection Preventionist Manager with approval of the Infectious Control Medical Staff Chairperson and prior to submission to the Medical Executive Committee.

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REPORTING AND COMMUNICATION

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

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EDUCATION

- A. Education is conducted based on the employee's job description and/or status with Northern Inyo Healthcare District. Education in infection control measures is conducted upon hire and annually.
- B. Infection Control Education is based upon:
- Ongoing review and analysis of ~~nosocomial infection~~ HAI's data and risk factors.

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**NORTHERN INYO HOSPITAL
POLICY AND PROCEDURE**

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

- Notifications from the Inyo County Health Department, Centers for Disease Control and Prevention(CDC) and California State Department of Public Health (CDPH) regarding emerging issues, trends or communicable diseases.
- Regulatory requirements. Refer to the *Senate Bill 158*, Attachment 1.

CONFIDENTIALITY

- NIHD has written policies and procedures related to the release of information which are intended to protect the privacy of patients. Confidentiality of infection control data and reports shall be in accordance with established hospital policy, Medical Staff Bylaws, state law and federal regulations and shall be maintained as “confidential and protected.”
- Members of the Medical Staff, clinical staff, appointed members of the organizational committee and project teams with delegated responsibilities for assessing and evaluating organizational performance improvement shall be granted authority to access health care records to perform quality review functions.

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RESOURCES

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

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- Center for Disease Control and Prevention
www.cdc.gov
- HICPAC
Healthcare Infection Control Practices Advisory Committee
www.cdc.gov/ncidod/hip/HICPAC/factsheet.htm
- U.S. Department of Labor – Occupational Safety & Health Administration
www.osha.gov
- U.S. Food and Drug Administration
www.fda.gov
- American Public Health Association
www.apha.org
- American Society for Healthcare Engineering
www.ashe.org
- Association for Professionals in Infection Control, Inc.
www.apic.org
- The Society for Healthcare Epidemiology of America, Inc.

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**NORTHERN INYO HOSPITAL
POLICY AND PROCEDURE**

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

www.shea-online.org

- The Infectious Disease Society of America
www.idsociety.org
- **International Sharps Injury Prevention Society (ISIPS)**
<http://www.isips.org/>
- **World Health Organization (WHO)**
<http://www.who.int/en/>
- **Occupational Health and Safety Administration**
<https://www.osha.gov/>

CROSS REFERENCE:

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

REFERENCE:

1. All Facilities Letter 14-36 California Department of Public Health, 12/19/2014, Regarding SB 1311: Antimicrobial Stewardship Programs.
2. APIC - “Infection Prevention Program in Critical Access Hospitals” Teresa Fulton, RN, MSN, CIC, Chief Quality Officer, Whidbey General Hospital, 2013, http://www.apic.org/.../Day_1-_Infection_Prevention_for_CAHA_Web.pdf
3. APIC . (2016). Outbreaks and Infection Emergencies. Retrieved from https://www.cdph.ca.gov/programs/hai/Documents/15Outbreaks_Final051115.pdf
4. Centers for Disease Control and Prevention. (2016). Infection Control in Health Care Facilities. Retrieved from <https://www.cdc.gov/flu/professionals/infectioncontrol/>
5. Centers for Disease Control and Prevention. (2017). Infection Control Assessment Tools. Retrieved from <https://www.cdc.gov/hai/prevent/infection-control-assessment-tools.html>
6. Centers for Disease Control and Prevention. (2016). Infection Prevention and Control Assessment Tool for Acute Care Hospitals. Retrieved from <https://www.cdc.gov/infectioncontrol/pdf/icar/hospital.pdf>
7. Centers for Disease Control and Prevention. (2016). Principles of Epidemiology in Public Health Practice, Third Editions an Introduction to applied epidemiology and biostatistics Lesson 6: Investigating an outbreak. Retrieved from <https://www.cdc.gov/ophss/csels/dsepd/ss1978/lesson6/section2.html>

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

8. *Senate Bill No. 158, Florez. Sept. 25, 2008, California.* Retrieved from https://www.cdph.ca.gov/services/boards/Documents/SB158chaptered09_25_08.pdf

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9. The Joint Commission (January 2017) Critical Access Hospital: Infection Prevention and Control (IC) IC01.05.01.

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Approval	Date
CCOC	3/13/2017 <u>03/26/2018</u>
Infection Control Committee	5/22/18
MEC	6/5/18
Board of Directors	
Last Board of Director Review	6/21/17

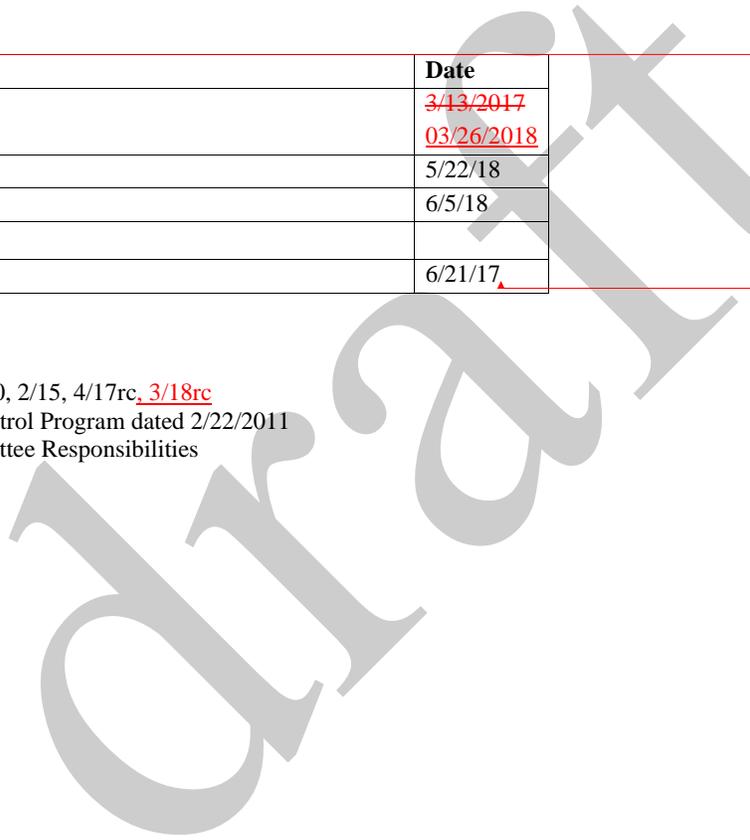
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Developed: 2/13/99

Reviewed: 1/11

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

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



**NORTHERN INYO HOSPITAL
POLICY AND PROCEDURE**

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

APPENDIX 1

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

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Reports to: Medical Executive Committee
Chairperson: Member of the Medical Staff with CME in Infection surveillance, prevention and control
Membership: Two active Medical Staff members representing other services

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

Comment [RC2]: Not sure if Cindy is considered membership or without vote

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Without vote:

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

Convenes: Quarterly

PURPOSE:

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

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

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**NORTHERN INYO HOSPITAL
POLICY AND PROCEDURE**

Title: Process for Amendment to Protected Health Information	
Scope: Hospital Wide	Manual: Medical Records, Quality/Risk
Source: Manager of HIM	Effective Date:

PURPOSE: To ensure that any request for amending of Protected Health Information (“PHI”) is properly addressed.

POLICY: Northern Inyo Healthcare District (NIHD) will ensure the privacy, security, and accuracy of protected health information. All amendments to patient’s (PHI) protected health information will be carried out in accordance with federal and state law.

The Health Information Management (HIM) Department is responsible for maintaining a legal medical record for each inpatient and outpatient. Agreement to amend a patient’s medical record will be granted only upon consent of the provider on date of service.

PROCEDURE: This policy shall apply to health information that is generated during provisions of health care to patients in any of NIHD’s patient care units, departments and clinics.

1. Request for Amendment
 - a. Request for an amendment is received by the Health Information Management department.
 - b. HIM Manager will contact patient to send the “Request to Amend Protected Health Information” to them for completion.
 - c. Upon receipt of filled out “Request to Amend Protected Health Information”, (HIM) Health Information Management Manager shall copy form, encounter requesting to be amended, and send meeting request to Quality/Risk Director and the Provider of said encounter.
 - d. At conclusion of the meeting, decision will be made to approve or decline the patient’s request.
 - a. If approved, physician will document the change and HIM staff shall scan into the legal medical record.
 - e. HIM Manager will send final decision to the patient utilizing the “Response to your request to amend Protected Health Information” form.
 - a. If request was denied, HIM Manager will forward the form, “ Statement of Disagreement” to the patient.
 - b. Patient may mail form back to be included in medical record.

**NORTHERN INYO HOSPITAL
POLICY AND PROCEDURE**

Title: Process for Amendment to Protected Health Information	
Scope: Hospital Wide	Manual: Medical Records, Quality/Risk
Source: Manager of HIM	Effective Date:

Committee Approval	Date
UR/ Medical Records Committee	5/31/18
Medical Executive Committee	6/5/18
Board of Directors	

Developed: May 15, 2018

Reviewed:

Revised:

Responsibility for review and maintenance: Manager of Health Information Management,
Director Quality/Risk, Chief Operation Officer

Index Listings:

**NORTHERN INYO HOSPITAL
POLICY AND PROCEDURE**

Title: Process for Auditing of Physician In-house/ Office Records	
Scope: Hospital Wide	Manual: Medical Records
Source: Manager of HIM	Effective Date:

PURPOSE: To ensure the accuracy and integrity of the (PHI) protected health information stored in the Health Information Management (HIM) Department.

POLICY: Northern Inyo Healthcare District (NIHD) will provide audits on providers for documentation consistency and accuracy of the medical record.

PROCEDURE: This policy shall apply to health information that is generated during provisions of health care to patients in any of NIHD’s patient care units, departments and clinics.

1. Annual Schedule will be created and sent to heads of NIHD’s Medical Staff Department.
2. Upon the beginning of the month scheduled for an audit, a list of 20 random patients per provider will be reviewed by the HIM Manager. Encounters are to be no older than six months.
3. Audit will entail the checking of :
 - a. Outpatient/Clinic review:
 - i. correct E/M level,
 - ii. Primary diagnosis, and
 - iii. Primary procedures performed.
 - b. Inpatient review:
 - i. Principle Diagnosis
 - ii. Secondary Diagnoses
 - iii. Principle Procedure
 - iv. Secondary Procedures
 - v. DRG assignment
4. Rationale of results will be listed per finding, giving the coding guideline or Coding Clinic that supports the auditor’s findings and given to the Director/Manager of that entity.
 - a. If provider disagrees with audit findings, he/she may submit a rebuttal for consideration.
 - b. If auditor stands by first decision, escalation to 3M Nosology for final decision.
5. An educational session will be given to the providers at final closure of the audit.

Committee Approval	Date
UR/ Medical Records Committee	5/31/18
Medical Executive Committee	6/5/18
Board of Directors	

Developed: May 15, 2018

Reviewed:

Revised:

Responsibility for review and maintenance: Manager of Health Information Management, Director Medical Staff, Chief Operation Officer

**NORTHERN INYO HOSPITAL
POLICY AND PROCEDURE**

Title: Record Retention, Destruction and Disposal of Protected Health Information	
Scope: Hospital Wide	Manual: Medical Records, Compliance, Information Technology
Source: Manager of HIM	Effective Date:

PURPOSE: To ensure that any medium containing Protected Health Information (“PHI”) is properly retained and destroyed

POLICY: Northern Inyo Healthcare District (NIHD) will ensure the privacy and security of protected health information in the maintenance, retention, eventual destruction and disposal of such media. Destruction and disposal of protected health information will be carried out in accordance with federal and state law, and as defined in NIHD’s policy. The schedule for destruction and disposal shall be suspended for records involved in any open investigation, audit or litigation.

The Health Information Management (HIM) Department is responsible for maintaining a legal medical record for each inpatient and outpatient. These records will be properly maintained and accessible. After the retention requirements have been met, destruction of the legal medical record will be carried out by designated members of the HIM Department in a method that ensures no possibility to reconstruct the contents of the record.

PROCEDURE: This policy shall apply to health information that is generated during provisions of health care to patients in any of NIHD’s patient care units, departments and clinics.

1. Record Retention

- a. Record retention may take the form of electronic medical record, paper documents, microfilm, electronic data storage, etc, but must be maintained in such a way that the information is available for clinical reference upon request.
- b. Medical record documents that are scanned and stored in the facilities legal electronic medical record will be available in electronic image format according to the guidelines listed above. The paper copy will be maintained for 180 days and destroyed according to policy.
- c. Original x-ray images will be kept for 10 years for patients over 18 years old, and for patients less than 18 years old kept until patient’s 28th birthday. Electronic radiographic images will be kept permanently.
- d. Employee health records will be kept separate from NIHD patient records and will be kept for 30 years after termination of employment.
- e. Other acquired documentation from outside resources used for clinic decision making and treatment planning will be scanned and stored in the facilities legal electronic medical record and will be available in electronic image format according to the guidelines listed above. The paper copy or electronic data storage device received from outside facilities can be destroyed once appropriately (readable) scanned into the facilities legal electronic medical record.

**NORTHERN INYO HOSPITAL
POLICY AND PROCEDURE**

Title: Record Retention, Destruction and Disposal of Protected Health Information	
Scope: Hospital Wide	Manual: Medical Records, Compliance, Information Technology
Source: Manager of HIM	Effective Date:

2. Record Destruction and Disposal

The destruction and disposal of protected health information will be carried out in accordance with the Health Insurance Portability and Accountability Act (HIPAA), CFR 164.310(d)(2)(i), federal and state regulations.

- a. No PHI will be destroyed before the minimum retention period has been met as indicated above.
- b. Confidential information includes that which contains protected health information of a patient, relative or household member of a patient. All documents containing protected health information must be destroyed in a manner that prevents reconstruction. Destruction will occur in one of the following manners:

Paper	Shredding, incinerating or pulverizing
Computerized Data	As per NIH Policy “Data Storage Media – Destruction” Policy
Radiology Films	Shredding or pulverizing
Laser Disks	Pulverizing
Microfilm/Fiche	Shredding or pulverizing
Patient Labels	Shredding

- c. Any documentation containing PHI must be personally shredded or placed in a secure recycling containing. PHI must not be discarded in trash bins, unsecured recycle containers and other publicly accessible locations.
- d. Information Technology must be contacted to coordinate the destruction of any computerized media.
- e. Destruction of the legal medical record must be documented and maintained permanently and include the following:
 - Date of destruction;
 - Method of destruction;
 - Description of the destroyed documents;
 - Signature of the individuals supervising and witnessing the destruction.

If destruction services are contracted, the contract must meet the requirements of the HIPAA privacy and security rules and a Business Associate Agreement must be executed with the contractor through the NIHD Privacy Officer or designated individual.

REFERENCES:

1. 45 CFR 164.310(d)(2)(i)
2. 45 CFR 164.530(c)

CROSS REFERENCE P&P:

1. NIH “Data Storage Media – Destruction” Policy
2. NIH “Business Associate Agreement Establishment and Maintenance” Policy

**NORTHERN INYO HOSPITAL
POLICY AND PROCEDURE**

Title: Record Retention, Destruction and Disposal of Protected Health Information	
Scope: Hospital Wide	Manual: Medical Records, Compliance, Information Technology
Source: Manager of HIM	Effective Date:

Committee Approval	Date
UR/ Medical Records Committee	5/31/18
Medical Executive Committee	6/5/18
Board of Directors	

Developed:

Reviewed:

Revised:

Supersedes: NIH “Scanning and Destruction of Medical Records” Policy

Responsibility for review and maintenance: Director of Compliance, Manager of Health Information Management, Chief Information Officer, Chief Operation Officer

Index Listings:

**NORTHERN INYO HEALTHCARE DISTRICT
POLICY AND PROCEDURE**

Title: Rejected Specimens acceptability and rejection	
Scope: NIHD, Outpatient Offices	Manual: Laboratory
Source: Director of Diagnostic Services	Effective Date:

I. PURPOSE:

According to both Clinical Laboratory Improvement Amendment (CLIA) regulations and the Joint Commission (TJC) Accreditation Standards for Laboratory and Pathology Services, the laboratory must establish and follow written policies and procedures for specimen labeling and specimen acceptability and rejection. Included in these policies and procedures will be criteria for the disposition of rejected specimens.

The primary focus for a specimen rejection policy is to insure patient specimen identification and specimen integrity in order to maintain patient safety and accurate test results. Mislabeled specimens can lead to morbidity and even death.

It is the responsibility of all departments involved with the collection of specimens that the system affords no opportunity for specimen misidentification or inadequate preservation. It is the responsibility of the laboratory to reject patient specimens which are compromised by incorrect or incomplete identification, inadequate sampling, improper storage, delayed transportation, or any other factor which impinges upon specimen integrity.

II. SPECIMEN REQUIREMENTS

A. Specimen Labeling

1. All Specimens must be properly labeled **in the presence of the patient**.
2. Label must be a pre-printed label or hand labeled using legible handwriting and **must include**:
 - a. Patient's first and last name
 - b. Patients date of birth (DOB)
 - c. Date and time of collection
 - d. Collectors initials
3. **TRANSFUSION SPECIMENS:** All blood bank specimens collected for transfusion work-up must include all items under section II.A.2 and also include
 - a. The patient's medical record number
 - b. The patient's unique blood bank band number
4. **NON BLOOD SPECIMENS:** All non-blood specimens (Microbiology, Serology and Histology / Pathology) must include all items in section II.A.2 and also include:
 - a. The specimen source
5. **PATHOLOGY SPECIMENS:** All Pathology specimens must also include all items in Section II.A.2 and also include the following:
 - a. The specimen source
 - b. The type of tissue being submitted.

**NORTHERN INYO HEALTHCARE DISTRICT
POLICY AND PROCEDURE**

Title: Rejected Specimens acceptability and rejection	
Scope: NIHD, Outpatient Offices	Manual: Laboratory
Source: Director of Diagnostic Services	Effective Date:

B. Outpatient Specimens

All outpatient specimens must be properly labeled as indicated above (II.A) and include an order for the requested test which includes:

- Patient's first and last name
- DOB
- Ordering physician signature or Electronic Signature
- Test(s) requested
- An applicable Diagnosis code for test being ordered

C. Specimen Integrity

The specimen must meet criteria specified in the specimen requirements attachment that includes the following standards:

- Collected in the appropriate, non-expired, intact container, device, test tube or transport media as designated by the laboratory
- Stored / transported under the correct conditions
- Processed and handled according to approved laboratory procedures
- Sufficient in quantity to perform testing
- Received within acceptable time limitation as specified by the laboratory

III. SPECIMEN REJECTION

A. Unlabeled or Mislabeled Specimens

Because of the potential for serious patient harm, unlabeled or mislabeled specimens must be rejected by the laboratory and re-collected unless the patient's ordering health care provider deems the specimen irretrievable.

- An unlabeled specimen is defined as a patient specimen that does not have the required forms of identification directly on the specimen container as required in section II.A of this policy.

Note: Identification on the bag holding the specimen is not acceptable, since the specimen can get separated from the bag.

- A mislabeled specimen is defined as a patient specimen where the two legible forms of identification (Patient's first and last name and Patient date of birth) on the specimen container does not match the identification on the request form, or does not correctly identify the patient from whom the specimen was collected.

1. It is the laboratory's responsibility to **promptly notify** the authorized person (e.g. physician, nurse, office) when a specimen meets its rejection criteria and may be unsuitable for testing. Accordingly, if a specimen is received that is not labeled with the minimum required documentation (see section II.A), the laboratory will notify the sending location that, unless the patient's ordering health care provider deems the specimen irretrievable (Section III.B.1), it will be discarded and a properly labeled, recollected specimen will be required.
2. Documentation of all unlabeled or mislabeled specimens will be maintained by the laboratory as specified below (see section IV.C).

B. Irretrievable Unlabeled or Mislabeled Specimens

**NORTHERN INYO HEALTHCARE DISTRICT
POLICY AND PROCEDURE**

Title: Rejected Specimens acceptability and rejection	
Scope: NIHD, Outpatient Offices	Manual: Laboratory
Source: Director of Diagnostic Services	Effective Date:

1. In order to deem the specimen irretrievable the following steps must occur:
 - Lab personnel contacts ordering department that the specimen is being rejected and the reason the specimen is being rejected.
 - The ordering physician for the test must communicate directly to the Clinical Lab Scientist whom is rejecting the specimen that the specimen is irretrievable and that the specimen must be used for testing.
 - The person who originally collected the specimen, or authorized staff member, must go to the lab and correct the cause of the rejected specimen. The rejected specimen must remain in the lab at all times after being rejected.
2. A rejected specimen that is deemed irretrievable will have the following qualifying statement accompanying the results of the test.
 - Specimen received unlabeled / mislabeled and was deemed irretrievable by ordering physician and relabeled / corrected labeling of specimen occurred by collector or other authorized staff.

C. Other Reasons for Specimen Rejection

There are many reasons why a specimen could potentially be rejected by the laboratory. The following section is intended as a guide and is not a complete list of rejection criteria.

1. Collection errors
 - Wrong preservative or anticoagulant for requested test(s)
 - Improper ratio of anticoagulant or preservative to specimen e.g. “short-fills”, “over-fills”
 - Wrong specimen type collected for requested test
 - Clots in specimen that require non-clotted blood
 - Hemolyzed specimens where hemolysis will influence test results
 - Insufficient quantity for requested analysis (QNS)
 - Unacceptable specimen container submitted (e.g. broken or leaking container, needle attached to syringe)
2. Handling errors
 - Specimens that should have been separated or should not have been separated
 - Specimens that should have been frozen, refrigerated, or held at room temperature
 - Specimens that should have been protected from light
 - Excessive delay in specimen transport (too old to give reliable results)
3. Contaminated specimen
 - Cross-contamination of specimens with other body fluids
 - Non-sterile technique used in obtaining the specimen
4. Clerical errors
 - Specimen received without proper order if the laboratory is unable to receive one
 - Inadequate clinical data (e.g. specimen source and patient history)

Note: All discrepant or questionable laboratory results may require a recollection to ensure patient safety. At all times, the clinical lab scientist (CLS) on duty has responsibility to ensure accurate test results and due to this has full authority to reject any specimen that, in their opinion, could lead to inaccurate results. When a specimen is rejected, only the authorization of the

**NORTHERN INYO HEALTHCARE DISTRICT
POLICY AND PROCEDURE**

Title: Rejected Specimens acceptability and rejection	
Scope: NIHD, Outpatient Offices	Manual: Laboratory
Source: Director of Diagnostic Services	Effective Date:

ordering physician stating the specimen is irretrievable will permit the lab to use the rejected specimen for testing.

IV. REMEDIAL ACTION

A. Notification

Laboratory staff will notify the ordering physician/provider/nurse/office or submitting laboratory of a rejected specimen and the reason why the specimen was unacceptable. Lab will inquire as to the intended resolution. Details for specimen recollection will be provided at this time, if request is to resubmit the specimen.

B. Handling of rejected specimens

- Questionable specimens will be quarantined within the lab until the issue is resolved
- Specimens that are deemed by the CLS as unacceptable will be discarded

C. Documentation

Documentation of all unacceptable/rejected specimens will be maintained in the laboratory. It will include the following:

- Date and time of specimen receipt
- Test(s) affected by rejected specimen
- Ordering physician
- Patient name and Date of Birth
- Name of CLS that rejected specimen
- Name of staff member that reported the rejected specimen
- Person notified of rejected specimen
- Time and date of notification
- Reason for rejection
- Disposition of specimen

Approval	Date
CCOC	3/26/18
Emergency Service Committee	5/16/18
Medical Services/ICU Committee	4/26/18
Perinatal/Pediatric Committee	4/20/18
Medical Executive Committee	6/5/18
Board of Directors	
Last Board of Directors Review	

Developed: 03-15-2018

Reviewed:

Revised:

Supersedes: N/A

**NORTHERN INYO HOSPITAL
POLICY AND PROCEDURE**

Title: Role of Microbiology in Infectious Disease Control	
Scope: NIHD	Department: CPM: Infection Control & Laboratory
Source: Quality Informatics Nurse Specialist/Infection Preventionist Manager & Laboratory Director	Effective Date:

PURPOSE: To partner with the Infection Preventionist, clinical staff, physicians, and pharmacy in monitor, surveillance and preventing health care associated infections. Clinical Microbiology Laboratory Specialists plays a pivotal role in patient care providing information on a variety of microorganisms with clinical significance and is an essential component of an effective infection control program and Hospital Acquired Infections (HAI's) control and prevention

DEFINITIONS:

1. **Antibiogram:** Overall profile of antimicrobial susceptibility testing results of specific microorganisms to a battery of antimicrobial drugs. Results should only include antimicrobial drugs that are routinely tested and clinically useful to clinicians
2. **Antibiotic Stewardship:** A coordinated program that promotes the appropriate use of antibiotics, improve patient outcomes, reduces microbial resistance, and decrease the spread of infections caused by multi-drug resistant organisms (MDRO's)
3. **Hospital Acquired Infections (HAI's):** Also known as nosocomial infection is an infection that is acquired in a hospital or healthcare facility that spread to a susceptible patient in the clinical setting
4. **Outbreak:** An incident in which two or more people experiencing a similar illness are linked in time or place.
5. **Reportable Disease:** Disease that are considered to be a public health concern. These diseases are reported locally, state and national level.
6. **Surveillance:** The ongoing, systematic collection, analysis, and interpretation of health data that is essential to the planning, implementation and evaluation of data.

MICROBIOLOGY ROLE IN INFECTION CONTROL:

1. Apply evidenced-based practices
2. Accurate identification and susceptibility testing
3. Active and post discharge surveillance
4. Rapid diagnostic testing
5. Reporting of laboratory data
6. Outbreak detection and management
7. Specimen handling and transport
8. Antibiogram for antimicrobial stewardship
9. Participates on the Infection Control Committee
10. Partners with the Infection Preventionist
11. Delivers annual blood culture contamination rate
12. Provide education to technologist, phlebotomy technicians, Infection Prevention and other healthcare personnel
13. Reject improper specimens
14. Report Multi-Drug Resistant Organisms to appropriate healthcare workers
15. Report positive cultures to receiving facilities.
16. Report to County Health Department "reportable disease" per title 17
17. Point of Care Testing for microbiology tests

PROCEDURE FOR REPORTING:

**NORTHERN INYO HOSPITAL
POLICY AND PROCEDURE**

Title: Role of Microbiology in Infectious Disease Control	
Scope: NIHD	Department: CPM: Infection Control & Laboratory
Source: Quality Informatics Nurse Specialist/Infection Preventionist Manager & Laboratory Director	Effective Date:

1. Report to House Supervisor, physician and nursing department all positive MRSA, VRE, ESBL and C-diff positive culture or test.
2. Report all positive cultures to transfer facility if final results are not resulted prior to transfer or discharge to another facility and document in patient medical record
3. Notify Inyo County Health Department for reportable diseases

REFERENCES:

1. California Code of Regulations. (2018). Title 17, Public Health. Retrieved from [https://govt.westlaw.com/calregs/Browse/Home/California/CaliforniaCodeofRegulations?guid=I38842B20D60511DE88AEDDE29ED1DC0A&originationContext=documenttoc&transitionType=Default&contextData=\(sc.Default\)](https://govt.westlaw.com/calregs/Browse/Home/California/CaliforniaCodeofRegulations?guid=I38842B20D60511DE88AEDDE29ED1DC0A&originationContext=documenttoc&transitionType=Default&contextData=(sc.Default))
2. Journal of Clinical Microbiology (2018). Clinical Microbiology and Infection Prevention. Retrieved from http://jcm.asm.org/content/49/9_Supplement/S57.full?utm_source=TrendMDJClinMicrobiol&utm_medium=TrendMDJClinMicrobiol&utm_campaign=TrendMD_JCMCLIN_0
3. Kalenic, S., (2016). Chapter 7: The Role of Microbiology Laboratory. International Federation of Infection Control (IFIC) Basic Concepts of Infection Control 3rd edition. Retrieved from http://theific.org/wp-content/uploads/2016/04/7-micro_2016.pdf
4. Luther, V., (2015). The essential Role of Clinical Microbial Laboratories in Antimicrobial Stewardship. *American Association for Clinical Chemistry (AACC)* Retrieved from <https://www.aacc.org/publications/cln/articles/2015/august/stewardship>.
5. Simone, A., et al., (2016). Prevention and Control of Antimicrobial Resistant Healthcare-Associated Infections: The Microbiology Laboratory Rocks! *Frontiers in Microbiology*, Volume 7, pg. 855. doi: 10.3389/fmicb.2016.00855. Retrieved from the University of Phoenix Library

CROSS REFERENCE P&P:

1. Infection Control Plan
2. Multi-Drug Resistant Organism (MDRO) Control Plan
3. Lippincott Procedures: Reportable Disease

Approval	Date
CCOC	04/23/2018
Infection Control Committee	5/22/18
Director Of Laboratory	
MEC	6/5/18
Board of Directors	
Last Board of Directors Review	

Developed: 4/17/2018 RC

Reviewed:

Revised:

**NORTHERN INYO HOSPITAL
POLICY AND PROCEDURE**

Title: Role of Microbiology in Infectious Disease Control	
Scope: NIHD	Department: CPM: Infection Control & Laboratory
Source: Quality Informatics Nurse Specialist/Infection Preventionist Manager & Laboratory Director	Effective Date:

Supersedes:
Index Listings:

Draft

**NORTHERN INYO HEALTHCARE DISTRICT
POLICY AND PROCEDURE**

Title: Safe Injection Practices	
Scope: NIHD	Manual: CPM: Infection Control
Source: Quality Nurse/Infection Control Preventionist	Effective Date:

PURPOSE:

To prevent the spread of bloodborne pathogens and bacterial infections through the use of safe injection practices

POLICY:

All members of the healthcare team will follow best practice guidelines that are current with The Centers for Disease Control and Prevention (CDC) and the Institute for Safe Medication Practices for safe injection practices.

PROCEDURE: The following procedures apply to the use of needles, cannulas that replace needles, and intravenous delivery systems.

1. Follow standard precautions and hand hygiene during the preparation and administration of medications and when placing intravascular access.
2. Needles, cannulae and syringes are sterile, single-use items. They should never be reused for another patient or to access a medication or solution that might be used for a subsequent patient.
3. Use aseptic technique to avoid contamination of sterile injection equipment. Never enter a vial with a used syringe or needle-even when obtaining additional doses for the same patient.
4. Wipe the rubber septum with alcohol prior to piercing.
5. Do not administer medications from a syringe to multiple patients, even if the needle or cannula on the syringe is changed.
6. Use fluid infusion and administration sets (i.e., intravenous bags, tubing and connectors) for one patient only and dispose appropriately after use. Once it has been used to enter or connect to a patient's intravenous infusion bag or administration set, consider a syringe or needle/cannula contaminated.
7. Use single-dose vials for parenteral medications whenever possible.
8. Do not administer medications from single-dose vials or ampules to multiple patients or combine leftover contents for later use.
9. If multidose vials must be used, both the needle or cannula and syringe used to access the multidose vial must be sterile. Date multi-dose vials when they are first opened and discarded within 28 days unless the manufacturer specifies a different date when opened.
10. Do not keep multidose vials in the immediate patient treatment area. Store multidose vials in accordance with the manufacturer's recommendations. Discard multidose vials if sterility is compromised or questionable.
11. Multi-dose vials are dedicated to individual patients whenever possible.

**NORTHERN INYO HEALTHCARE DISTRICT
POLICY AND PROCEDURE**

Title: Safe Injection Practices	
Scope: NIHD	Manual: CPM: Infection Control
Source: Quality Nurse/Infection Control Preventionist	Effective Date:

12. If Multi-dose vials are to be used for more than one patient they are kept in a centralized medication area and do not enter the immediate patient treatment area (e.g. operating room, patient room)
13. Do not use bags or bottles of intravenous solution as a common source of supply for multiple patients.
14. Discard the needle and syringe, intact, with the safety device activated in appropriate sharps container.
15. Prefilled saline flushes can only be used for flushing and locking vascular devices.
16. Pre-drawn medications must be labeled properly
17. Point of care devices (e.g. glucometers) are cleaned between each patient use with approved germicidal wipe per manufactures instructions
18. Wear surgical mask when placing a catheter or injecting material into the spinal canal or subdural space.

REFERENCES:

1. ASC Quality Collaboration (2018). Safe Injection Practices Toolkit. Retrieved from <http://www.ascquality.org/safeinjectionpracticestoolkit.cfm#training>
2. Centers for Disease Control and Prevention. (2016). Injection Safety. Retrieved from <https://www.cdc.gov/injectionsafety/>
3. Centers for Medicare and Medicaid Services. (2015). State Operations Manual 42 CFR 416.51 (a). Retrieved from https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/som107ap_1_ambulatory.pdf
4. Institute for Safe Medication Practices (ISMP). (2018). Education & Awareness & Medication Safety Tools & Resources. Retrieved from <http://www.ismp.org/default.asp>
5. The Joint Commission (2018). Infection Control 01.05.01. EP1 and Infection Control 02.01.01 EP 2 Retrieved from <https://edition.jcrinc.com/MainContent.aspx>

CROSS REFERENCE P&P:

1. Administration of Drugs and Biologicals
2. Bloodborne Pathogen Exposure Control Plan
3. Intravenous Medication Policies
4. Medication/Solution Transfer to Sterile Field
5. Medical/Biohazardous Waste Management Plan
6. Sharps Injury Protection Plan
7. Standard Precaution Lippincott Procedures

**NORTHERN INYO HEALTHCARE DISTRICT
POLICY AND PROCEDURE**

Title: Safe Injection Practices	
Scope: NIHD	Manual: CPM: Infection Control
Source: Quality Nurse/Infection Control Preventionist	Effective Date:

Approval	Date
CCOC	03/26/2018
Infection Control Committee	5/22/18
STTA	4/25/18
Emergency Services Committee	5/16/18
Medical/ICU Services	4/26/18
Perinatal/Pediatric Committee	4/20/18
Director of Laboratory	
Radiology Services Committee	5/8/18
Pharmacy and Therapeutics	4/19/18
Medical Executive Committee	6/5/18
Board of Directors	
Last Board of Directors Review	

Developed: 03/20/2018 RC

Reviewed:

Revised:

Supersedes:

Index Listings: Medications, Injection Practices, Safe Injection Practices

**NORTHERN INYO HEALTHCARE DISTRICT
POLICY AND PROCEDURE**

Title: Scope of Anesthesia Practice	
Scope: Anesthesia	Manual: Anesthesia
Source: Chief of Surgery	Effective Date:

PURPOSE:

To delineate the practice of anesthesia, which is a recognized medical and advanced practice nursing specialty unified by the same standard of care.

POLICY:

1. The scope of anesthesia practice at Northern Inyo Healthcare District (NIHD) includes, but is not limited to: Anesthesiology is a discipline within the practice of medicine dealing with but not limited to, and specializing in
 - A. The preoperative, intraoperative and postoperative evaluation and treatment of patients who are rendered unconscious and/or insensible to pain and emotional stress during surgical, obstetrical, radiological therapeutic and diagnostic or other medical procedures and participation in the overall coordination of care;
 - B. The protection and maintenance of life functions and vital organs (e.g., brain, heart, lungs, kidneys, liver, endocrine, skin integrity, nerve [sensory and muscular]) under the stress of anesthetic, surgical and other medical procedures;
 - C. Monitoring and maintenance of ~~normal~~ acceptable physiology during the perioperative period;
 - D. Diagnosis and treatment of acute, chronic and cancer-related pain;
 - E. Clinical management of cardiac and pulmonary resuscitation;
 - F. Evaluation of respiratory function and application of respiratory therapy;
 - G. Management of critically ill patients;
 - H. Conduct of clinical, translational, ~~and~~ basic science and outcomes/best practice research;
 - I. Supervision, teaching and evaluation of performance of both medical and paramedical personnel involved in perioperative care and cardiac and pulmonary resuscitation-;
 - J. Management and preservation of patient safety;
 - I.K. Communication of patient-care concerns with the surgeon/proceduralist and other members of the healthcare team whenever indicated.
2. The anesthesia provider's Anesthesiologist's responsibilities to patients include:
 - A. Assessment of, consultation for and preparation of patients for anesthesia;
 - B. ~~Medical Mm~~ management of patients and the anesthetic for the planned procedures;
 - C. Post anesthetic evaluation and treatment;
 - D. Perioperative pain management.

**NORTHERN INYO HEALTHCARE DISTRICT
POLICY AND PROCEDURE**

Title: Scope of Anesthesia Practice	
Scope: Anesthesia	Manual: Anesthesia
Source: Chief of Surgery	Effective Date:

REFERENCES:

1. [“Guidelines for Patient Care in Anesthesiology.” American Society of Anesthesiologists. October 26, 2016 edition.](#)
2. [“Scope of Nurse Anesthesia Practice.” American Association of Nurse Anesthetists 2013.](#)

Approval	Date
Surgery/Tissue/Transfusion/Anesthesia Committee	<u>4/25/18</u>
Medical Executive Committee	
Board of Directors	
Last Board of Directors Review	1/17/18

Developed:

Reviewed:

Revised: 01/01 1/3/2011 BS, 10/21/12 PM [3/20/18 DP](#)

Supersedes:

Index Listings: Anesthesia Scope of Practice, Scope of Practice Anesthesia

**NORTHERN INYO HOSPITAL
POLICY AND PROCEDURE**

Title: Toy Cleaning	
Scope: NIHD	Manual: CPM - Infection Control-Environmental (ICE)
Source: Quality Nurse/Infection Control Preventionist Manager	Effective Date: 1/31/2017

PURPOSE:

To prevent transmission of microorganisms associated with soiled or used toys.

POLICY:

1. Each age group of pediatric patients shall have their own developmentally appropriate toys.
2. Toys that can be easily cleaned and disinfected shall be selected.
3. Stuffed, furry toys may not be shared.
4. Toys shall not be shared between age groups.
5. All toys are to be clean and in good repair
6. Hand hygiene is performed prior to handling toys and books
7. Water containing bath toys are prohibited

DEFINITIONS:

1. Hospital-approved detergent disinfectant: EPA-registered disinfectants approved by the institution's Infection Control Committee to meet the overall needs of the healthcare facility for routine cleaning and disinfection; used according to the manufacturer's recommendations for amount, dilution, and contact time sufficient to remove pathogens from surfaces of rooms where colonized or infected individuals are housed.
2. Moveable toys: Moveable toys (e.g. books, blocks, dolls, etc.) are discouraged for communal use. Provide toys/items that the patient can take home. Therapeutic items used for distraction, instruction, etc. must be cleaned after each use.
3. Stationary toys: Toys affixed to tables, walls, ceilings, floors, casework, or that are not easily moveable by the patient

PROCEDURE:

1. Toys are to be examined before and after use. Any toy that is cracked, broken or unable to be cleaned is to be discarded.
2. After use by patient use Hospital-approved detergent/disinfectant
 - Clean toy with disinfectant
 - Follow approved detergent/disinfectant label directions for contact time, and allow drying to air.
3. Use soap and water for cleaning visibly soiled toys
 - Wash with soap and water using friction
 - Rinse with water and dry
4. If toy has crevices use brush to clean
5. Toys used in isolation rooms will remain with the patient throughout hospitalization, then cleaned using appropriate hospital-approved detergent/disinfectant according to the type of organism that the patient is being isolated for
6. Clean stationary toy in Northern Inyo Associated Pediatric/Allergy with hospital approved detergent/disinfectant at least once per day when in use.
7. Books:
 - Rehab Services paperback books will be stored and used for children that can follow appropriate hand hygiene.
 - Northern Inyo Associated Pediatric/Allergy books will remain on the well-child side and be wiped down daily.
8. If toys are assigned to patients for therapy, place in plastic bag and label bag with at least 2 patient identifiers.
9. If unassigned toys are used during therapy session after use, place in bin that is labeled "To be cleaned." After toys have been cleaned place toys in the bin that is labeled "Cleaned Toys".

**NORTHERN INYO HOSPITAL
POLICY AND PROCEDURE**

Title: Toy Cleaning	
Scope: NIHD	Manual: CPM - Infection Control-Environmental (ICE)
Source: Quality Nurse/Infection Control Preventionist Manager	Effective Date: 1/31/2017

REFERENCES:

- Centers for Disease Control and Prevention (2011). 2007 Guidelines for Isolation Precautions: *Guideline for Isolation Precautions: Preventing Transmission of Infectious Agents in Healthcare Settings (Section IV.F.4)*. Retrieved from http://www.cdc.gov/hicpac/2007ip/2007ip_part4.html
- Siegel JD, Rhinehart E, Jackson M, Chiarello L, and the Healthcare Infection Control Practices Advisory Committee. (2010). *Guideline for Isolation Precautions: Preventing Transmission of Infectious Agents in Healthcare Settings*. Retrieved from <http://www.cdc.gov/hicpac/2007ip/2007isolationprecautions.html>

CROSS REFERENCE P&P:

- Disinfection, noncritical patient care equipment, ambulatory care
<http://procedures.lww.com/lmp/view.do?pid=3358992&hits=noncritical&a=false&ad=false>
- Northern Inyo Hospital Water Management Plan (7/19/2017)**

Approval	Date
CCOC	3/26/18
Infection Control Committee	5/22/18
MEC	6/5/18
Board of Directors	
Last Board of Director review	5/17/17

Developed: 10/27/2016 RC
 Reviewed:
 Revised: 3/6/18 RC
 Supersedes: Toy Cleaning
 Index Listings:

**NORTHERN INYO HOSPITAL
POLICY AND PROCEDURE**

Title: Trauma Patient Care in the Emergency Department	
Scope: Emergency Department	Manual: Emergency Dept
Source: Emergency Dept Nurse Manager	Effective Date: 03/2004

PURPOSE: Guideline for the care of the trauma patient in the Emergency Department (ED)

MAJOR TRAUMA CRITERIA:

1. Physiologic Indicators

- a. Glasgow Coma Scale (GCS)
 - At or less than 13 (Adult & Pediatric)
- b. Respiratory Rate
 - Less than 10 or greater than 29 (Adult and Pediatric)
 - Less than 20 (infants less than a year old) or need for ventilator support
- c. Hypotension
 - Adult
 - Less than 90 mmHg
 - Tachycardia
 - Pediatric
 - Exhibits inadequate tissue perfusion
 - Abnormal vital signs according to age

2. Anatomic Indicators:

- a. Penetrating injuries to head, neck, torso and extremities proximal to the knee or elbow
- b. Blunt chest trauma resulting in chest wall instability or deformity (e.g. **3 or more broken ribs**)
- c. Two or more proximal long bone fractures (femur, humerus)
- d. Crushed, degloved, mangled or pulseless extremity
- e. Amputation proximal to wrist and ankle
- f. **Unstable** pelvic fractures
- g. Paralysis

3. Mechanism of injury

- a. Falls
 - Adults: greater than 20 feet (one story = 10 feet)
 - Pediatric: greater than 10 feet or 2-3x the child's height
- b. High risk auto crash
 - Intrusion, including roof greater than 12 inches on occupants site
 - Ejection (partial or complete) from vehicle
 - Death in the same passenger compartment
 - Vehicle telemetry data consistent with high risk injury
 - Auto vs. pedestrian thrown, run over, or with significant impact (> 20 mph)
 - Motorcycle crash with greater than 20 mph speed

POLICY:

1. All patients will be triaged according to the Emergency Severity Index 5-level triage system.
 - a. Care will be determined by the severity of their injuries, mechanism of injury and first responder report.

**NORTHERN INYO HOSPITAL
POLICY AND PROCEDURE**

Title: Trauma Patient Care in the Emergency Department	
Scope: Emergency Department	Manual: Emergency Dept
Source: Emergency Dept Nurse Manager	Effective Date: 03/2004

2. The Emergency Nurse Association's Trauma Nurse Core Course (TNCC)“A through I Algorithm” will serve as a guideline for trauma assessment.
 - a. Primary Survey
 - A- Airway
 - B- Breathing
 - C- Circulation
 - D-Disability
 - E- Exposure/Environment
 - b. Secondary Survey
 - F- Full set of Vitals/ Family
 - G- Give Comfort Measures
 - H- Head to Toe Exam
 - I- Inspect Posterior Surface
3. Trauma team will consist of:
 - a. Emergency Department Physician
 - b. Trauma 1 RN (TN 1)
 - Coordinates / treatment plan with physician
 - Provides direct patient care
 - Responsible for **documentation of** primary and secondary surveys and re-evaluations
 - Places monitoring devices such as cardiac monitor, pulse oximeter and blood pressure cuff
 - Assist with airway management
 - Ensures that 2 large bore IV's are in place
 - Administers medications
 - May delegate other duties to other team members.
 - c. Trauma 2 RN (TN 2)
 - Assist Trauma 1 RN with above duties
 - Insert NG/ OG tube, foley catheter
 - Set up and assist Physician with chest tube insertion, needle decompression, central line placement, arterial line placement.
 - TN 1 and TN 2 may change or delegate roles as necessary according to individual skills except for assessments and re-evaluations.
 - d. Trauma 3 RN (if available or if needed) (TN3)
 - Undresses patient as able
 - General runner/helper
 - Provide CPR if necessary
 - e. Trauma 4 RN
 - Record all information on trauma sheet
 - Obtains signatures from team members
 - Reviews with TN 1 assessments and treatments/interventions

**NORTHERN INYO HOSPITAL
POLICY AND PROCEDURE**

Title: Trauma Patient Care in the Emergency Department	
Scope: Emergency Department	Manual: Emergency Dept
Source: Emergency Dept Nurse Manager	Effective Date: 03/2004

- f. ED Tech/Clerk
 - Call ancillary department staff as needed.
 - Run monitor strips in central monitor as indicated
 - Push CPOE orders as needed
- 4. ED Trauma CPOE orders may be used as directed by Physician.
- 5. Consultations with on-call physicians or transferring facility physicians are the responsibility of the ED physician.
- 6. The House Supervisor will then initiate contact with an air transport company as well as the bed control person at the accepting facility. This should be done as soon as possible to avoid delays.

For Major Trauma Victims:

1. Have portable ultrasound ready at bedside.
2. Notify Lab and Radiology of patient arrival.
3. Notify House Supervisor immediately of patient arrival and need for flight crew. This should be considered as soon as the MICN receives the radio report triaging the patient as a major trauma patient.
4. Lab should be notified to deliver four units of uncross-matched O-negative blood. Have Hotline warmer ready at bedside.

REFERENCE:

1. Emergency Severity Index (ESI) A Triage Tool for Emergency Department Care Version 4, 2012 Edition.
2. Emergency Nurses Association, Trauma Nurse Core Course 2012
3. EMTALA: A Guide to Patient Anti-dumping Laws 2009
4. Trauma Triage Criteria: ICEMA Policy and Procedures Protocol Manual, Reference 15030

CROSS- REFERENCE:

1. EMTALA Policy
2. Triage Policy
3. Evaluation and Medical Screening of Patients Presenting to the Emergency Department
4. Standards of Care in the Emergency Department

Committee (s) Approval:	Date:
CCOC	1/29/18
Emergency Services Committee	5/16/18
Medical Executive Committee	6/5/18
Board of Directors	
Last Board of Director's Review	

Developed:

Revised: 1/2005, 09/07 AS, 08/11 AS 01/2018gr

Reviewed:

**NORTHERN INYO HEALTHCARE DISTRICT
POLICY AND PROCEDURE**

Title: Trophon® Environmental Probe Reprocessor (EPR)*	
Scope: Diagnostic Imaging, RHC Women's	Manual: CPM - Infection Control-Environmental (ICE)
Source: Quality Nurse/Infection Control Preventionist	Effective Date: 10/15/17

PURPOSE:

Provide guidance for achieving high level disinfection (HLD) using the Trophon® EPR in accordance with the manufacturer's recommendations and infection control guidelines. The sole purpose of the Trophon® EPR is to provide high level disinfect on all ultrasound transducers.

POLICY:

1. High Level Disinfection of the ultrasound probes will be preformed after each patient use to ensure it is properly sanitized for the next patient.
2. Trophon EPR system will be used only by trained healthcare professionals.
3. The Trophon EPR system will be used according to manufacturer's safe operation
4. Trophon EPR system and user training will be completed upon hire and annually
5. Personal Protective Equipment (PPE) required: gloves and standard precautions
6. The Chemical indicator chart and Trophon EPR user chart must be posted where the Trophon is being utilized.
7. The Trophon® EPR must be left connected to power and switched ON at all times.

DEFINITION:

High-Level Disinfection: Destruction/removal of all microorganisms except bacterial spores

BACKGROUND:

High level disinfection is the minimal requirement for semi-critical items as outlined by the Spaulding Classification System and the Centers for Disease Control and Prevention (CDC). Semi-critical items are those items that have been exposed to non-intact skin or mucous membranes and should receive a minimum of HLD. High level disinfection must be performed by staff members who have had appropriate training and can demonstrate competency in performing HLD.

DISINFECTION PROCESS:

At the beginning of the cycle, the Trophon® EPR creates an aerosol of concentrated hydrogen peroxide. This is quickly and evenly distributed over the surface of the probe, including very small crevices. This process provides thorough, high level disinfection of the shaft and the handle of the probe. The device breaks down the hydrogen peroxide into small particles of water and oxygen, and then safely vents them into the external environment. The only required personal protective equipment for this HLD process is clean gloves.

PROCEDURE:

1. PREPARING AND POSITIONING THE PROBE:
 - Don gloves
 - The probe must be pre-cleaned and dried BEFORE the HLD process can commence in the Trophon® EPR. Use a hospital approved alcohol-free cleaning disinfecting

**NORTHERN INYO HEALTHCARE DISTRICT
POLICY AND PROCEDURE**

Title: Trophon® Environmental Probe Reprocessor (EPR)*	
Scope: Diagnostic Imaging, RHC Women's	Manual: CPM - Infection Control-Environmental (ICE)
Source: Quality Nurse/Infection Control Preventionist	Effective Date: 10/15/17

wipe, following directions of cleaning and disinfecting product being used, and ensure the cleaner being used is approved by the probe manufacturer.

- A chemical indicator must be used for each disinfection cycle and can only be used one time. A chemical indicator shall be placed into the holder on the floor of the device chamber.
- *Load Probe and Indicator* screen message will be displayed when Trophon EPR system is ready.
- Open chamber door, and use the two clamps to hold the probe securely to the chamber
- After correctly loading the probe into the chamber the door will automatically lock at the start of the HLD cycle. Note: If door not properly closed a "Close Chamber Door" message will be displayed.

2. DISINFECTING THE PROBE SCREEN MESSAGE

- If the probe has been pre-cleaned and dried press YES and then Press Start
- If the probe has not been pre-cleaned and dried press NO, remove probe, clean and dry with approved alcohol-free cleaning disinfecting wipe. Reload probe into chamber
- High Level Disinfection process will take 7 minutes to complete.

3. REMOVING THE PROBE:

- When the cycle has been completed, the trophon will sound an audible alarm. Put on gloves and follow the screen instruction message
 - Message 1 Cycle complete, remove and wipe probe
 - Message 2: Attention wear gloves and wipe probe. (This message indicates that some hydrogen peroxide may not be broken down and extra care should be taken when removing the probe.
 - Immediately remove the used Chemical Indicator from the trophon and verify the color change against the chart on the Chemical Indicator carton. Discard Indicator. Record the result using the printer and label.
 - Record patient medical record number next to trophon cleaning label to trace a particular probe to an individual patient

Sample label:

		
15/05/2014 15:24	SN: 18333-024	
Disinfection: FAIL	Cycle#: 15000	
Error: XXXX		
Operator: _____		1. trophon logo
Probe: _____		2. Date and time
Notes: _____		3. trophon EPR serial number
		4. Disinfection result (PASS)
		5. trophon cycle number
		6. Chemical indicator result
		7. Error code
		8. Operator name ID (manual entry field)
		9. Probe information ID (manual entry field)
		10. Notes (manual entry field)

**NORTHERN INYO HEALTHCARE DISTRICT
POLICY AND PROCEDURE**

Title: Trophon® Environmental Probe Reprocessor (EPR)*	
Scope: Diagnostic Imaging, RHC Women's	Manual: CPM - Infection Control-Environmental (ICE)
Source: Quality Nurse/Infection Control Preventionist	Effective Date: 10/15/17

- Remove the probe carefully using minimal contact after the cycle is complete. Avoid touching the probe against the chamber's hot surface.
- Wipe the probe with a clean, low lint, absorbent, single-use, dry cloth/ wipe. Visually inspect the probe and ensure any disinfectant residue present is removed.
- If a pass was verified by the Chemical Indicator color AND the trophon screen displayed *cycle complete*, the HLD has been successful. If one or both of these items do not occur, repeat HLD cycle beginning at procedure Step 1

***NOTE:** After HLD cycle completion, the trophon performs a rapid cooling cycle until the probe is removed from the chamber to prevent overheating of the probe. If the probe is not removed immediately this will increase the warm-up time required by the subsequent cycle. It is therefore recommended to remove the probe as soon as possible after HLD cycle has been completed.*

4. REMOVING AND DISPOSING OF USED DISINFECTANT CARTRIDGES

***NOTE:** Cartridges are punctured at the top and on the side near the bottom when the cartridge door is closed and locked. A small amount of disinfectant may remain in the cartridge, even when it has been fully used. Follow the instructions carefully to avoid injury.*

1. Removing the Cartridge

- Wear gloves

Screen message: REPLACE THE CARTRIDGE AND CLOSE CARTRIDGE DOOR

***NOTE:** Cartridge door opens automatically. DO NOT Force the cartridge door open.*

- Lift the cartridge out by touching the areas exposed while the bottle is in the holder and avoid touching pierced area
- DO NOT shake or change the orientation of the cartridge
- Refer to IFU enclosed with the trophon NanoNebulant for detailed instructions on how to install a new cartridge

2. Disposing of Empty Cartridge

Empty used cartridges should be disposed of in the nearest waste receptacle or according to the disposal guidelines of your institution

***NOTE:** DO NOT insert empty cartridges into the device*

3. Expired Cartridge containing disinfectant

- Environmental Services will take to Maintenance Department for disposal.
- Maintenance Department will follow NIHD procedure for the disposal of corrosive or oxidizing materials.

4. Deformed Cartridge

**NORTHERN INYO HEALTHCARE DISTRICT
POLICY AND PROCEDURE**

Title: Trophon® Environmental Probe Reprocessor (EPR)*	
Scope: Diagnostic Imaging, RHC Women's	Manual: CPM - Infection Control-Environmental (ICE)
Source: Quality Nurse/Infection Control Preventionist	Effective Date: 10/15/17

- Turn disinfectant cartridge the right way up, to allow the cartridge to degas.
- Contact your customer service representative.

Note: After completion of a successful high level disinfection cycle, the ultrasound probe and chamber may have surface temperatures up to 45°C/ 113°F and 60°C/ 140°F respectively.

5. SLEEP MODE AND SHUTDOWN PROCEDURES

- The trophon is not used for 120 minutes or a probe has been left inside the trophon for an extended amount of time, it will automatically enter sleep mode in order to save power. To restart the trophon from sleep mode press *Restart*.
- While the trophon is in sleep mode it will perform self-maintenance functions and will display the messages: *Warming Up* or *System Refresh*. Do not switch the trophon off during these processes.
- System refresh during sleep will only occur for low use customers and does not impact the number of disinfection cycles that can be performed per cartridge. This process will typically take 13 minutes.

6. WARM-UP CYCLE:

The warm up cycle prepares the trophon for operation and will begin automatically when the machine is powered on or restarted from sleep.

Screen Message	Approximate Warm Up Time (minutes)
<i>Quick Warm Up</i>	< 2
<i>Warming Up</i>	2-30
<i>Extended Warm Up</i>	> 30

7. PURGE CYCLE:

- Removes any remaining disinfectant from the cartridge and inside the device, this process will take about 35 minutes.
- After completion, remove waste container and empty contents into sink, rinse and dry with a clean cloth.

8. INCOMPLETE OR FAILED CYCLES

**NORTHERN INYO HEALTHCARE DISTRICT
POLICY AND PROCEDURE**

Title: Trophon® Environmental Probe Reprocessor (EPR)*	
Scope: Diagnostic Imaging, RHC Women's	Manual: CPM - Infection Control-Environmental (ICE)
Source: Quality Nurse/Infection Control Preventionist	Effective Date: 10/15/17

- Refer to manual page 19 titled Part D- Troubleshooting

9. ROUTINE CARE AND MAINTENANCE

- Wipe all accessible surfaces of the trophon with a hospital approved Quat disinfectant.
- Store disinfected probe with an ultrasound probe cover. Ensure that nothing is touching the probe.
- 10. If a Trophon system was to require maintenance the backup process will be to use the other Trophon system located at the RHC Women's Clinic or Diagnostic Imaging. For transportation follow the policy titled "Endovaginal ultrasound probe storage, transportation and disinfection"

Formatted: Numbered + Level: 1 +
Numbering Style: 1, 2, 3, ... + Start at: 7 +
Alignment: Left + Aligned at: 0.19" + Indent
at: 0.44"

REFERENCES:

1. AHRA Connect: The Community for AHRA Members. (2018). Topic: Joint Commission Survey Experience. Retrieved from <https://connect.ahra.org/home>
2. American Institute of Ultrasound in Medicine. (2017). Guidelines for Cleaning and Preparing External-and Internal-Sue Ultrasound Probes Between Patients, Safe Handling, and use of Ultrasound Coupling Gel. Retrieved from <http://www.aium.org/officialStatements/57>
3. Centers for Disease Control and Prevention. (2016). Disinfection and Sterilization, <https://www.cdc.gov/infectioncontrol/pdf/guidelines/disinfection-guidelines.pdf> (2008)
4. General Electric Healthcare. (2017). Trophon EPR for High Level Disinfection for Ultrasound Probes. Retrieved from http://www3.gehealthcare.com/en/products/categories/ultrasound/trophon_cpr
5. Infection Control Today. (2015) Human Papilloma Virus the New Challenge ~~For~~ Infection Prevention. Retrieved from <https://www.infectioncontroltoday.com/immersion-centers/2015/05/~media/DF602B3687504B6E8A9FF975329C739F.ashx>
6. Joint Commission E-dition. (2017). Infection Prevention and Control (IC.02.02.01 EP 2) The Critical Access hospital reduces the risk of infections associated with the medical equipment, devices and supplies. Retrieved from <https://e-dition.jcrinc.com/MainContent.aspx>

CROSS REFERENCE P&P:

1. Endovaginal Ultrasound Probe Storage Transportation and Disinfection
2. Gluteraldehyde Use Station GUS – STATION HIGH-LEVEL DISINFECTION DEVICE

Approval	Date
CCOC	7/17/17
Infection Control Committee	8/22/17
MEC	9/5/17

**NORTHERN INYO HEALTHCARE DISTRICT
POLICY AND PROCEDURE**

Title: Trophon® Environmental Probe Reprocessor (EPR)*	
Scope: Diagnostic Imaging, RHC Women's	Manual: CPM - Infection Control-Environmental (ICE)
Source: Quality Nurse/Infection Control Preventionist	Effective Date: 10/15/17

Board of Directors	9/20/18
Last Board of Directors Review	

Developed: 5/2017 KA/RC

Reviewed:

Revised: 5/2018RC

Supersedes: GLutaraldehyde Use Station GUS-Station High Level Disinfection

Index Listings: Trophon, endovaginal probes, High Level Disinfection, Ultrasound Probes

Draft

**NORTHERN INYO HOSPITAL
POLICY AND PROCEDURE**

Title: Wild Iris Services (Victims Services)	
Scope: District	Manual: HOSPITAL WIDE, Social Services
Source: Licensed Clinical Social Worker	Effective Date: 1/1/1995

POLICY:

Wild Iris is committed to helping victims and survivors affected by domestic violence, child abuse and sexual assault from all cultures including race, gender, religion, age, class, disability status, immigration status, education and geographic location within Inyo and Mono counties.

Prevention and Intervention Services Include:

24-Hour Crisis Line: 1-877-873-7384 - Available 24/7 for times of crisis. Trained peer crisis counselors are available to provide immediate counseling, information and resources.

Emergency Shelter: Available for individuals who are fleeing unsafe situations.

Safety Planning: Trained peer counselors are available to assist in safety planning and provide you with valuable information to consider when you are in a dangerous situation, or are planning to leave an abusive relationship.

Restraining Order: Wild Iris peer counselors are trained to help you prepare and obtain an order of protection, or to answer questions about restraining orders and criminal protective orders.

Advocacy & Accompaniment: Wild Iris peer counselors can provide support during your time of crisis. At your request, a counselor can attend court dates, or appropriate appointments such as medical, social services, mental health, etc. Their role during advocacy and accompaniment is to support you emotionally, prepare you for what to expect in the courtroom or during a medical exam, and to help you understand what is happening and why. With your permission, a peer counselor may also speak-up on your behalf to make sure that your rights are not being overlooked.

Crisis Counseling & Support: One-on-one peer counseling is available and is designed to support you while you are working through a crisis or an abusive situation. Topics to cover in these sessions are your choice, but may include rebuilding self esteem, creating healthy boundaries, understanding the cycle of violence, how to move on after a violent relationship, healthy coping strategies, stress management, becoming self-sufficient, or recreating yourself and achieving your goals. Support groups are also available.

Information & Referrals: Peer counselors can help locate community programs and resources which may be of benefit during times of need. These may include referrals to medical services, children's services, long-term mental health services, food banks, parenting classes, employment and education, faith based services, legal services, transportation services, recovery services and long term shelter services.

Emergency Food & Clothing: Emergency food and clothing are available for clients who are in need due to violence and abuse.

Housing Establishment & Relocation: Through the generous donations of our supporters and local community, Wild Iris is often able to assist with providing items needed to establish a new home after

**NORTHERN INYO HOSPITAL
POLICY AND PROCEDURE**

Title: Wild Iris Services (Victims Services)	
Scope: District	Manual: HOSPITAL WIDE, Social Services
Source: Licensed Clinical Social Worker	Effective Date: 1/1/1995

fleeing an abusive relationship. This help may include temporary assistance with utility services and locating furniture and essential household items. In some instances, Wild Iris may be able to assist with relocating you to another, safer community.

Youth Violence Prevention: Wild Iris offers programs to assist the youth in our community to understand what a healthy relationship looks like, how to set healthy boundaries, the importance of respecting themselves and others, and how to build self-esteem.

The social worker will refer individuals to this program as needed, including providing referral and support during the initial interview if necessary.

Bishop Office 760 873-6601
386 West Line Street
Bishop, CA 93515

Mammoth Lakes Office 760-934-2491
Sierra Center Mall, Third Floor
Mammoth Lakes, CA 93546

Lone Pine Office 760-876-4740
120 South Main St. Unit 5
Lone Pine, CA 93546

Coleville/Walker Office: 530-495-1500
24-Hour Crisis Hotline 1-877-873-7384

Approval	Date
CCOC	3/26/18
Utilization Review Committee	5/31/18
Medical Executive Committee	6/5/18
Board of Directors	
Last Board of Director review	3/15/17

Initiated:
Revised:
Reviewed: 2/18hf
Supersedes:
Index Listings:

**NORTHERN INYO HOSPITAL
POLICY AND PROCEDURE**

Title: DI - CT Contrast administration	
Scope:	Manual: Diagnostic Imaging
Source: Operations - Director of Diagnostic Services (DI & Lab)	Effective Date:

PURPOSE: To maintain safety in regards to performing contrast enhanced CT examinations and address issues relating to the administration of contrast material

POLICY:

1. Intravenous iodinated contrast may be administered by authorized personnel who are in compliance with all applicable state laws and have been educated patient screening for potential contrast sensitivity and renal insufficiency, recognition of minor and major contrast reactions, and emergency procedures of minor and major contrast reactions. Personnel starting intravenous access must have education and training in venipuncture.
2. Intravenous (IV) iodinated contrast may only be administered only when the appropriate supervising physician has been informed.
3. All patients having IV contrast enhanced imaging studies must read, complete, and sign the contrast administration consent form. The technologist shall review and complete the patient history form with the patient. These forms will be entered as a part of the patient's medical record.
4. Any patients noting multiple reactions to medications, iodinated contrast, or foods containing iodine will have their information reviewed by the technologist and supervising physician. Information will be evaluated for increased risk of an IV contrast reaction.
5. The patient's medical record will be checked for prior IV contrast reactions or other contraindications to iodinated contrast.
 - a. If a significant potential for an IV contrast reaction exists, the supervising physician shall be notified and he/she may request the study be delayed so the patient may be pre-medicated.
 - b. If the patient states there is a history of renal insufficiency, renal cancer, or diabetes, or is over the age of 50, a creatinine blood test that has been performed within the last 30 days must be obtained and reviewed.
 - c. Creatinine values that are abnormal shall be reviewed by the supervising physician. The supervising physician must determine whether contrast shall be administered.
6. Unless otherwise directed by the ordering or supervising physician, contrast will be delivered per the CT contrast Protocol section of this policy.

ACUTE MEDICAL EMERGENCIES:

1. All staff involved directly with patient care will be Basic Life Support (BLS) certified.
2. Emergency phone numbers are posted by each phone in the Imaging suite (2400).
3. Emergency equipment (crash cart) is available.
4. In the event of an emergency, staff will call a "Code Blue" or "Rapid Response" in the CT suite.
5. The supervising physician will be notified immediately.

**NORTHERN INYO HOSPITAL
POLICY AND PROCEDURE**

Title: DI - CT Contrast administration	
Scope:	Manual: Diagnostic Imaging
Source: Operations - Director of Diagnostic Services (DI & Lab)	Effective Date:

CT Contrast Protocols:

CT PROCEDURE	IV CONTRAST TYPE	VOLUME (ml)	RATE (ml/sec)	RECOMMENDED NEEDLE SIZE (ga)	MAX INJECTION PRESSURE (psi)
ABDOMEN	ISOVUE 300	95	2.5	20/22	300
ABDOMEN/PELVIS	ISOVUE 300	95	2.5	20/22	300
PELVIS	ISOVUE 300	95	2.5	20/22	300
BRAIN	ISOVUE 300	75	2.5	20/22	300
FACIAL, TEMPORAL, IAC	ISOVUE 300	75	2.0	20/22	300
CHEST	ISOVUE 300	95	2.5	20/22	300
CHEST/ABDOMEN/PELVIS	ISOVUE 300	95	2.5	20/22	300
TRAUMA CHEST/ABDOMEN/PELVIS	ISOVUE 300	95	1.8	20/22	300
ENTEROGRAPHY	ISOVUE 370	95	4.0	20	300
UROGRAM/DUAL INJECTION	ISOVUE 300	50/80	2.5	20/22	300
SOFT TISSUE NECK	ISOVUE 300	75	2.0	20/22	300
SOFT TISSUE NECK CHEST/ABDOMEN/PELVIS	ISOVUE 300	75/75	2.5	20/22	300
CERVICAL SPINE	ISOVUE 300	95	2.0	20/22	300
THORACIC SPINE	ISOVUE 300	95	2.0	20/22	300
LUMBAR SPINE	ISOVUE 300	95	2.0	20/22	300
VENOGRAM	ISOVUE 370	150	3.0	20	300
CTA CHEST	ISOVUE 370	95	4.0	20	300
CTA CAROTID	ISOVUE 370	75	4.0	20	300
CTA BRAIN (COW)	ISOVUE 370	75	4.0	20	300
CTA BRAIN/CAROTID	ISOVUE 370	75	4.0	20	300
CTA ABDOMEN	ISOVUE 370	95	4.0	20	300
CTA ABDOMEN W RUNOFF	ISOVUE 370	125	4.0	20	300
CTA CARDIAC	ISOVUE 370	75	5.0	20	300
CTA EXTREMITY	ISOVUE 370	95	4.0	20	300
PEDS BRAIN	ISOVUE 300	1ml per kg	2.0	22	300
PEDS CHEST	ISOVUE 300	1ml per kg	2.0	22	300
PEDS ABDOMEN	ISOVUE 300	1ml per kg	2.0	22	300

**NORTHERN INYO HOSPITAL
POLICY AND PROCEDURE**

Title: DI - CT Contrast administration	
Scope:	Manual: Diagnostic Imaging
Source: Operations - Director of Diagnostic Services (DI & Lab)	Effective Date:

REFERENCES:

1. ACR Contrast Manual

Approval	Date
Radiology Services Committee	5/22/18
Medical Executive Committee	6/5/18
Administration	
Board of Directors	

Developed: 4/17/2018

Reviewed:

Revised:

Supersedes:

Index Listings:

**NORTHERN INYO HOSPITAL
POLICY AND PROCEDURE**

Title: DI CT Radiation Safety Policy*	
Scope: Departmental	Manual: Administrative, CT
Source: Operations - Director of Diagnostic Services (DI & Lab)	Effective Date:

PURPOSE: To establish and maintain safe practice at all times in our CT department

POLICY: Computed tomography will be performed by appropriately licensed and trained technologists in accordance with the ALARA program, and Image Gently ® /Image Wisely ® training.

1. All technologists operating the CT scanner will meet the requirements as determined by CMS, ACR, and The Joint Commission.
2. All technologists operating the CT scanner shall have a thorough understanding of the CT radiation dose, including dose index and “optimal” dose index ranges.
3. Staff involved with CT imaging procedures will be issued radiation monitoring occupational exposure badges. The badge readings will be reviewed by the Radiation Safety Officer. Any readings that are deemed excessive will be addressed by the Radiation Safety Officer directly to the staff member.
4. Public access to the CT suite is restricted. Appropriate signs are posted when radiation is in use.
5. Pediatric specific protocols that have been established based on patient age and/or weight will be utilized whenever possible and kept on file on the unit console.
6. All staff will comply with published ALARA recommendations.
7. All staff will make every effort to conform to Image Gently ® /Image Wisely ® standards.
8. A remotely operated flow-rate injector will be utilized for all intravenous contrast injections.
9. All standards set forth by the Occupational Safety and Health Administration and the Joint Commission will be followed.
10. All patients will be appropriately shielded for all CT imaging studies.
11. Dose reduction (optimization) techniques will be utilized whenever possible. The radiation dose will be set at the lowest values possible while still maintaining appropriate diagnostic imaging quality and;
12. Modifications which will increase patient dose will not be made to physicist-approved default protocols without review by the facility’s physicist.
13. Documentation will be made of any changes to the default protocols to include details of the protocol change (technical parameters and the rationale for the change. Any adverse effect on patient dose shall trigger a review by the facility’s physicist.
14. Deviations from approved procedures require approval of the ordering physician or radiologist. Protocol deviations may be given by verbal order, but require a physician signature within 48 hours.

REFERENCES:

1. American College of Radiology
2. Intersocietal Accreditation Commission – Computer Tomography Laboratories

Approval	Date
Radiology Services Committee	5/8/18
Medical Executive Committee	6/5/18
Board of Directors	
Last Board of Directors Review	

Developed: 2/3/2016, PD

**NORTHERN INYO HOSPITAL
POLICY AND PROCEDURE**

Title: DI CT Radiation Safety Policy*	
Scope: Departmental	Manual: Administrative, CT
Source: Operations - Director of Diagnostic Services (DI & Lab)	Effective Date:

Reviewed:05-01-2018

Revised:05-01-2018

Supersedes:03-16-2016

Index Listings:

**NORTHERN INYO HOSPITAL
POLICY AND PROCEDURE**

Title: DI - Monitoring and Minimizing Radiation Exposure for the Occupational Worker	
Scope:	Manual: Diagnostic Imaging
Source: Operations - Director of Diagnostic Services (DI & Lab)	Effective Date:

PURPOSE: To provide guidelines that ensure occupational exposure is monitored, documented and ALARA (As Low As Reasonably Achievable).

POLICY:

1. All technologists shall wear personal radiation dosimetry badges at all times while on duty, as required by 10 CFR 20, 20.1101.
1. Badges shall be worn at the collar or waist level.
2. Badges are to be changed monthly
3. The NIH Radiation Safety Officer (RSO) shall be responsible for review of all dosimetry results monthly. Reports shall be submitted and discussed at the Radiation Safety Committee, quarterly.
4. The Department of Public Health, Radiologic Health Branch shall be notified by the RSO in the event of an overexposure, in accordance with the NIH ALARA program
5. Radiologist shall be notified of any exposure level of concern to the technologists.
6. During radiology examinations, employees shall remain behind protective barriers as much as possible. If an employee must remain in the room during radiation exposure, he/she must wear a lead apron and not have any body part in the primary beam. Thyroid shields and protective eyewear should be worn, if appropriate. Every effort must also be made to maximize the distance between the employee and the radiation source.
7. Lead gloves shall be worn any time someone's hand is placed in the primary radiation beam.
8. Non-compliance with proper personnel protective equipment or radiation monitoring badge use shall be communicated to the RSO.
9. When using patient restraints, mechanical devices shall be used as much as possible.

REFERENCES:

1. US Nuclear Regulatory Commission (USNRC), NRC Library, Document Collections, NRC Regulations (10 CFR), *Part 20 - Standards for Protection Against Radiation*,, <http://www.nrc.gov/reading-rm/doc-collections/cfr/part020/>
2. U.S. Nuclear Regulatory Commission Regulatory Guide 8.13, Rev. 3, June 1999

CROSS REFERENCE P&P:

1. ALARA Program
2. Dosimetry Program
3. DI – Patient holding/Patient Restraint

**NORTHERN INYO HOSPITAL
POLICY AND PROCEDURE**

Title: DI - Monitoring and Minimizing Radiation Exposure for the Occupational Worker	
Scope:	Manual: Diagnostic Imaging
Source: Operations - Director of Diagnostic Services (DI & Lab)	Effective Date:

Approval	Date
Radiology Services Committee	5/8/18
Medical Executive Committee	6/5/18
Administration	
Board of Directors	

Developed:

Reviewed:

Revised:

Supersedes:

Index Listings:

Draft

**NORTHERN INYO HOSPITAL
POLICY AND PROCEDURE**

Title: DI NM Daily Area Surveys	
Scope: Departmental	Manual: Nuclear Medicine
Source: Operations - Director of Diagnostic Services (DI & Lab)	Effective Date:

PURPOSE:

To provide guidance to the technologist to ensure that radiation exposure levels, in areas used by nuclear medicine, are checked daily.

POLICY:

Daily surveys shall be done, with a GM survey meter, at the end of each normal workday, when radioactive materials are in use, to check for areas of contamination.

REFERENCES:

1. Guide for the Preparation of an Application for a Radioactive Materials License Authorizing Medical Use, Retrieved from:
<http://www.cdph.ca.gov/pubsforms/Guidelines/Documents/RHB-MedicalGuide.pdf>,
2. 10 CFR 35

Approval	Date
Radiology Services Committee	5/8/18
Medical Executive Committee	6/5/18
Board of Directors	

Developed: 12-03-2015

Reviewed: 05-01-2018

Revised: 05-01-2018

Supercedes:

**NORTHERN INYO HOSPITAL
POLICY AND PROCEDURE**

Title: DI NM General Rules for the Safe Use of Radioactive Materials	
Scope: Departmental	Manual: Nuclear Medicine
Source: Operations - Director of Diagnostic Services (DI & Lab)	Effective Date:

Purpose:

The purpose of this guideline is to provide general rules for the safe use of radioactive materials.

POLICY:

The general rules listed below shall be followed at all times in the nuclear medicine department.

1. Wear laboratory coats or other protective clothing at all times in areas where radioactive materials are used.
2. Wear disposable gloves at all times while handling radioactive materials.
3. Monitor hands and clothing for contamination before leaving the area.
4. Use syringe shields for preparation of patient doses and administration to patients except in circumstances such as pediatric cases when their use would compromise the patient's well being.
5. Do not eat, drink, smoke, or apply cosmetics in any area where radioactive material is stored or used.
6. Do not store food, drink or personal items in areas where radioactive material is stored or used.
7. Wear personnel monitoring devices at all times while in areas where radioactive materials are used or stored. These devices should be worn at chest level or at waist level when device is not shielded by workbenches, etc.
8. Wear TLD finger badges during elution of generator and preparation, assay, and injection of radiopharmaceuticals.
9. Dispose of radioactive waste only in specifically designated receptacles.
10. Never pipette by mouth.
11. Survey generator, kit preparation, and injection areas for contamination at the end of the day. Decontaminate in necessary.
12. Confine radioactive solutions in covered containers plainly identified and labeled with the name of the compound, radionuclide, date, activity, and radiation level, if applicable.
13. Always label syringes to indicate the radiopharmaceutical, activity, type of study and name of patient.
14. Assay each patient dose in the dose calibrator prior to administration. Do not use any doses that differ from the prescribed dose by more than 10%.
15. Do not use radiopharmaceutical containing more than 0.15 microcurie of Mo-99 per 1.0 millicurie of Tc99m.
16. Always transport radioactive material in shielded containers.

REFERENCES:

1. Guide for the Preparation of an Application for a Radioactive Materials License Authorizing Medical Use, Retrieved from: <http://www.cdph.ca.gov/pubsforms/Guidelines/Documents/RHB-MedicalGuide.pdf>,
2. 10 CFR 35

**NORTHERN INYO HOSPITAL
POLICY AND PROCEDURE**

Title: DI NM General Rules for the Safe Use of Radioactive Materials	
Scope: Departmental	Manual: Nuclear Medicine
Source: Operations - Director of Diagnostic Services (DI & Lab)	Effective Date:

Approval	Date
Radiology Services Committee	5/8/18
Medical Executive Committee	6/5/18
Board of Directors	

Developed: 2004

Reviewed: 05-01-2018

Revised: 05-01-2018

Supercedes: 01-19-2016

Index Listings:

**NORTHERN INYO HOSPITAL
POLICY AND PROCEDURE**

Title: DI NM Radioactive Package Receipt*	
Scope: Departmental	Manual: Nuclear Medicine
Source: Operations - Director of Diagnostic Services (DI & Lab)	Effective Date: 2/1/16

PURPOSE:

The purpose of this guideline is to provide instructional procedures for the safe receipt and handling of radioactive materials and to prevent an accident involving these materials.

POLICY:

A nuclear medicine technologist, security officer on duty or trained purchasing/materials management personnel, may receive packages containing radioactive materials. Deliveries will be immediately directed to the Nuclear Medicine area of the Diagnostic Imaging Building. The package should be placed inside the hot lab on the floor. The hot lab door should be re-locked upon exit, unless supervised by authorized hot lab personnel. Nuclear Medicine technologist shall visually inspect, survey external surface radiation exposure levels, and perform wipe test for removable radioactive contamination for each radioactive materials package received.

REFERENCES:

1. Guide for the Preparation of an Application for a Radioactive Materials License Authorizing Medical Use, Retrieved from: <http://www.cdph.ca.gov/pubsforms/Guidelines/Documents/RHB-MedicalGuide.pdf>,
2. 10 CFR 35

CROSS REFERENCE POLICY

1. Diagnostic Imaging - Radioactive Materials Delivery After-hours Policy/Procedure

Approval	Date
Radiology Services Committee	5/8/18
Medical Executive Committee	6/5/18
Board of Directors	
Last Board of Director review	

Developed: 01-19-2016
 Reviewed: 05-01-2018
 Revised:05-01-2018
 Supersedes:01-19-2016
 Index Listings:

**NORTHERN INYO HOSPITAL
POLICY AND PROCEDURE**

Title: Diagnostic Imaging - Monitoring and Documentation of Fluoroscopic Quality Control*	
Scope: Departmental	Manual: Administrative, Radiology
Source: Operations - Director of Diagnostic Services (DI & Lab)	Effective Date:

PURPOSE:

Ensures that fluoroscopic quality control is completed and documented weekly, in accordance with Title 17, Section 30307

POLICY:

1. Monitoring fluoroscopic tube current (mA) and potential (kVp) shall be performed and documented weekly on quality control logs provided by the medical physicist.
2. Any technologists with a fluoroscopic license may be responsible for performing the weekly quality control.
3. Responsibility and accountability for performance of weekly fluoroscopic quality control shall be assigned and maintained by Diagnostic Imaging Coordinator.

Approval	Date
Radiology Services Committee	5/8/18
Medical Executive Committee	6/5/18
Administration	
Board of Directors	
Last Board of Director review	

Developed: 7/20/2014 PDickson

Reviewed:05-01-2018

Revised:

Supersedes:04-15-2015

**NORTHERN INYO HOSPITAL
POLICY AND PROCEDURE**

Title: Diagnostic Imaging - Scope of Services*	
Scope: Departmental	Manual: Administrative
Source: Operations - Director of Diagnostic Services (DI & Lab)	Effective Date: 6/16/16

Department Organization

The Diagnostic Imaging (DI) department head is the Director of Diagnostic Imaging (DDI) who reports to the Chief Executive Officer (CEO) and has 24-hour responsibility for the DI department. The people in the following positions report directly to the DDI: imaging department managers, imaging technologist coordinators, imaging technologists, radiology file/scan clerks.

Imaging services at Northern Inyo Healthcare District are supervised by the contracted Radiologist Operator and Supervisor. The Radiologist has responsibility and authority for quality oversight, quality of images, protocols under which technologists practice and the case by case clinical decisions affecting any study performed. The Radiologist informs the DDI of study quality issues requiring training, re-training, changes to protocols or any other technologist practices that should be improved or modified. The Radiologist may provide feedback to DDI on potential candidates to become members of the DI team. The Radiologist instructs and communicates case by case, as needed, with technologists in order to insure the quality of images needed is produced for interpretation by the Radiologist. The Radiologist is responsible for determining what modalities, studies and interventional procedures are offered by the hospital within the budgetary capabilities of the hospital as agreed to by hospital administration.

NIHD Radiation Safety Officer (RSO), Radiation Safety Committee (RSC) or designee, provides oversight or the radiation program. The RSO ensures enforcement of radiation safety policies and procedures.

DI is composed of general radiography, fluoroscopic special/interventional procedures, computed tomography (CT), ultrasound (US), Nuclear Medicine (NM), magnetic resonance imaging (MRI), bone densitometry (Dexa), and breast imaging services.

The DDI attends the following meetings: Radiation Safety Committee, Radiology Services Committee, Medical Staff, Ancillary Services, and Safety Committee. The DDI also attends Hospital Board, Billing, Coding and Compliance, and other Medical staff meetings as required or requested.

The DDI prepares the annual budget for the Diagnostic Imaging cost centers and submits it to the CEO. The DDI monitors the budget for these cost centers.

The CEO or DDI designee provides oversight and direction for the DI department when the DDI is unable.

Scope of Services

The Diagnostic Imaging department offers fully digital imaging services to all age groups from neonate to geriatric in accordance with CA state/federal regulations, the standards of the Joint Commission (TJC) and the American College of Radiology (ACR).

The Diagnostic Imaging department provides outpatient imaging services in all modalities from 1000-1730 Monday, Tuesday through Thursday 0800-1730 and Friday 0800-1230, excluding hospital holidays.

**NORTHERN INYO HOSPITAL
POLICY AND PROCEDURE**

Title: Diagnostic Imaging - Scope of Services*	
Scope: Departmental	Manual: Administrative
Source: Operations - Director of Diagnostic Services (DI & Lab)	Effective Date: 6/16/16

The DI department provides emergency and inpatient diagnostic radiography, CT and US services 24 hours per day, seven days per week via on-site or on-call technologists. Urgent outpatient procedures are addressed within the capabilities of the department.

Board certified radiologists are accessible on-site between the hours of 1000-1730 Monday, Tuesday through Thursday 0800-1730 and Friday 0800-1230, for interpretative, interventional and consultative purposes. After normal hours, imaging studies are sent via secure network to a board certified or eligible tele-radiologist for preliminary interpretation. Radiologists are appropriately credentialed appointees of the medical staff with delineated privileges.

Radiological and imaging procedures are performed in the imaging department, surgical suites, and portably where required. Services offered by the DI department range from general radiography and fluoroscopy to new and advanced interventional and pain management procedures, contrast imaging in CT, MRI, and radiological procedures. Other procedures provided are ultrasound color Doppler, nuclear medicine SPECT-CT, 3D CT, CT and MR angiography, cardiac CT, coronary artery CT, Nuclear Cardiology, automated whole-breast ultrasound (ABUS), Mammography including Digital Breast Tomosynthesis (3D) and stereotactic breast biopsy.

Contrast agent administration is performed or supervised by an IV certified radiologic, CT, MRI, or nuclear medicine technologist, with general supervision by a radiologist or other qualified physician.

The DI department holds ACR accreditation in the following areas: Mammography, MRI, CT, US, Nuclear Medicine and Nuclear Cardiology.

Types of Services

Radiological Imaging

- 1) General radiography of the head, body and extremities
- 2) Fluoroscopic examinations
- 3) Invasive procedures including guided biopsy, drainage, injections and pain management procedures

CT (ACR accredited)

- 1) Diagnostic studies of the head, body and extremities, including vascular and cardiac studies
- 2) Invasive procedures including guided biopsy, drainage, injections and pain management procedures

Ultrasound (ACR accredited)

- 1) Diagnostic studies of the head, body and extremities and superficial lesions, including vascular studies
- 2) Ultrasound guided biopsy, drainages and venous access

Nuclear Medicine and Nuclear Cardiology (ACR accredited)

- 1) Radionuclide studies
- 2) Cardiac imaging including Myocardial Perfusion Imaging

**NORTHERN INYO HOSPITAL
POLICY AND PROCEDURE**

Title: Diagnostic Imaging - Scope of Services*	
Scope: Departmental	Manual: Administrative
Source: Operations - Director of Diagnostic Services (DI & Lab)	Effective Date: 6/16/16

Magnetic Resonance Imaging (ACR accredited)

- 1) Diagnostic studies of the head, body and extremities, including vascular studies

Breast Imaging Services (ACR accredited)

- 1) Mammography with Digital Breast Tomosynthesis (3D), including screening and diagnostic studies
- 2) Breast sonography, including automated whole breast US and handheld targeted US
- 3) Breast MRI, including MRI guided breast biopsy
- 4) Guided Breast biopsy and wire localization for surgical excision or biopsy

DI also provides services related or pertaining to imaging including: quality assessment monitoring and evaluation, quality control, performance excellence evaluation and improvement, infection control, image interpretation, dictation, record filing and management, equipment purchasing, marketing, continuing staff education, and customer support.

Staffing

All diagnostic imaging and therapeutic procedures are performed by or under the supervision of board certified or eligible radiologists.

Radiologic technologists are licensed by the California State Radiologic Health Branch (CA-RHB) and registered or registry-eligible by the American Registry of Radiologic Technologists (ARRT).

Nuclear medicine procedures are performed by or supervised by technologists registered by the Nuclear Medicine Technology Certification Board (NMTCB) or the ARRT. Nuclear Medicine technologists are licensed by the CA-RHB.

Ultrasound procedures are performed or supervised by sonographers registered by the American Registry of Diagnostic Medical Sonographers (ARDMS).

Magnetic Resonance imaging is performed or supervised by technologists registered by the ARRT.

Daily Staffing

DDI, or designee, is responsible for appropriate completion of a 2-week (pay period) schedule that is electronically posted no later than two weeks before the schedule period. In order to provide employees time to plan around scheduled work hours, every effort is made to post 2 pay periods of schedules (4 weeks) ahead of the scheduled time. Employee hours are listed on the schedule master. Qualified employees rotate call in designated areas as assigned. Scheduled shifts are in 8, 9, 10, and 12 hour segments. There are no guaranteed employee hours, days, or schedules except as published on the 2-week master schedules.

Employees' requests for special time off must be submitted at least two weeks in advance of requested time off, whenever possible. Time-off requests submitted for posted schedules will not be approved unless the

**NORTHERN INYO HOSPITAL
POLICY AND PROCEDURE**

Title: Diagnostic Imaging - Scope of Services*	
Scope: Departmental	Manual: Administrative
Source: Operations - Director of Diagnostic Services (DI & Lab)	Effective Date: 6/16/16

requesting employee has arranged a “trade/swap” of shifts with a similarly licensed/skilled technologist. DDI, or designee, must approve any coverage/schedule “trades.” The DDI, or designee, makes every effort not to change employee hours after the schedule has been published. Time-off requests will be approved following hospital policy and in accordance with department staffing needs. All staffing changes will be documented on the master schedule.

REFERENCES:

AHRA Radiology Policy & Procedure Manual: Third Edition. 2012. The Association for Medical Imaging Management. Sudbury, MA.

Approval	Date
Radiology Services Committee	5/8/18
Medical Executive Committee	6/5/18
Board of Directors	
Last Board of Director review	

Developed: 7/16/2014, DDI

Reviewed: 05-01-2018

Revised 5/1/2018

Supersedes:

**NORTHERN INYO HOSPITAL
POLICY AND PROCEDURE**

Title: Diagnostic Imaging - Ultrasound, Intimate Exams	
Scope: Departmental	Manual: Ultrasound
Source: Operations - Director of Diagnostic Services (DI & Lab)	Effective Date: 5/1/2018

PURPOSE: To ensure patient privacy and comfort during ultrasound (US) examinations of an intimate nature

DEFINITIONS:

Intimate examination – exam involving the breasts, genitalia, pelvis, or buttocks. The definition of an intimate examination may differ between individual patients for ethnic, religious or cultural reasons.

POLICY:

1. Technologists of the same gender as the patient will perform US intimate examinations during regular business hours. This policy applies to OB US on patients that are less than 14 weeks gestation.
2. In the event that a technologist of the same gender is unavailable, the patient will be informed and given the option of a technologist of the opposite gender with a chaperone or to reschedule the exam if they prefer.
3. Intimate US exams after regular business hours (emergencies, Stats and urgent add-ons) will be performed by the technologist on-call. A chaperone will be present if the patient is not the same gender as the technologist.

Committee Approval	Date
Radiology Services Committee	5/8/18
Medical Executive Committee	6/5/18
Administration	8/19/2014
Board of Directors	9/17/2014

Developed: 7/30/2014 PDickson

Reviewed:05-01-2018

Revised:

Supercedes:09-17-2014

Responsibility for review and maintenance: DDI

**NORTHERN INYO HOSPITAL
POLICY AND PROCEDURE**

Title: Diagnostic Imaging Department Orientation and Competency*	
Scope: Departmental	Manual: Administrative
Source: Operations - Director of Diagnostic Services (DI & Lab)	Effective Date:

PURPOSE:

To provide guidelines for orientation of Diagnostic Imaging Department personnel and to confirm staff are competent to perform the tasks associated with their job.

POLICY:

All new employees to the Diagnostic Imaging Department will be afforded appropriate orientation, in-service training and continuing education programs. All new employees will be directly observed by a proctor, who has been deemed competent on the task being observed, and evaluated as to their competency. Both the employee and the proctor must attest to competency prior to the staff being able to perform the task with indirect supervision.

At any point after competency is confirmed the staff member or leadership of the department may request additional training on a specific task or procedure, The employee will be assigned a proctor and will not perform the task or procedure until both the employee and the assigned proctor confirm staff is competent to perform the task or procedure and both attest to the staff's competency.

When staff are required to perform additional tasks or new procedures, or asked to perform current tasks or procedures with new equipment, the staff must receive training and be deemed competent prior to performing the new task or procedure or using the new equipment under indirect supervision.

As part of the employee's annual performance evaluation, each employee will be evaluated as to their continued competency to perform all tasks and procedures associated with their job assignments. If either the leader or the employee question competency on a specific task or procedure, the employee will be assigned a proctor for the task or procedure until competency is attested to by both the staff and the proctor.

General Orientation checklist for Imaging includes the following documents (attached):

1. Imaging Services Overview
2. DI Competency Plan
3. Systems
4. Processes
5. Equipment
6. Imaging Procedures

Approval	Date
Radiology Services Committee	5/8/18
Medical Executive Committee	6/5/18
Board of Directors	
Last Board of Director review	

Developed: 1997

Reviewed:

Revised: 04-17-2018

Supersedes: 11/11/2015 DDI

**NORTHERN INYO HEALTHCARE DISTRICT
POLICY AND PROCEDURE**

Title: Diagnostic Imaging X-ray Protocols Procedure	
Scope: Departmental	Manual:
Source: Operations –Operations - Director of Diagnostic Services (DI & Lab)	Effective Date:

PURPOSE: To provided a reference to the Radiologic Technologist when performing routine and emergent imaging.

POLICY:

1. Technologists will perform exams as indicted: See attached document.
2. Alternate views will be obtained if indicated by the Interpreting Radiologist or Ordering Physician.

Approval	Date
Radiology Services Committee	5/8/18
Medical Executive Committee	6/5/18
Board of Directors	
Last Board of Directors Review	

Developed: 12-02-2015

Reviewed:05-01-2015

Revised: 05-01-2015

Supersedes:12-02-2015

**NORTHERN INYO HOSPITAL
POLICY AND PROCEDURE**

Title: Diagnostic Mammography - 3D	
Scope:	Manual: Breast Imaging
Source: Operations - Director of Diagnostic Services (DI & Lab)	Effective Date:

PURPOSE: To define the procedure steps to achieve high quality diagnostic mammography utilizing a dedicated, low-dose digital mammography unit with 3D tomosynthesis capability.

PROCEDURE:

1. Perform Diagnostic Mammography only when the Mammographer is onsite.
2. Review the patient’s mammography history with the patient.
3. Requests on patients under 30 shall be reviewed with the radiologist prior to being performed.
4. Explain the exam, including the importance of compression for high quality studies.
5. Position gonadal shielding on patients that are of child-bearing age.
6. Position the patient to obtain views as directed by the Mammographer and according to the “Work-up Procedures” on the following page.
7. Select the proper techniques and compression for the view(s) being performed.
8. Route images, with prior mammography studies for comparison, to the CAD (computer assisted diagnosis) enabled radiologist workstation for review by the Mammographer.
9. Release the patient when no further mammography images are needed by the Mammographer for interpretation of the exam.

REFERENCES:

1. ACR

Approval	Date
Radiology Services Committee	5/8/18
Medical Executive Committee	6/5/18
Board of Directors	
Medical Director, Breast Imaging Services	

Developed: 02-21-2012
Reviewed:05-01-2018
Revised:
Supersedes: 09-24-2015

Index Listings:

**NORTHERN INYO HOSPITAL
POLICY AND PROCEDURE**

Title: Premedication for Radiographic Contrast Sensitivity	
Scope:	Department: Diagnostic Imaging, PACU
Source: Radiology Director	Effective Date:

PURPOSE: To ensure patient safety

POLICY: Patients that have had previous reactions to contrast material may be pre-medicated upon orders of the Radiologist or the patient’s referring physician.

Procedure:

1. At the time of scheduling a contrast study, the patient discloses they have had a significant allergy to iodine or have had a previous contrast reaction. Reactions necessitating pre-medication:
 - a. Shortness of breath
 - b. Drop in blood pressure
 - c. Reaction resulting in hospitalization
 - d. History of previous anaphylactic reaction
2. Pharmacy shall be informed of patient name, date of birth, allergy and reaction type.
3. Patients receiving pre-medication for contrast should be informed to show up 45 minutes prior to scheduled exam time. Patients should be informed that they will need to wait 45 minutes after the exam to leave the facility.
4. Patients receiving pre-medication for contrast sensitivity require a ride home following the exam.
5. Pre-medication protocol:
 - a. Solucortef – 100 mg IV push
 - b. Diphenhydramine- 25-50 mg IV push
6. Contrast exam should be performed within 30 minutes of administration of medications.

Committee Approval	Date
Radiology Services Committee	5/8/18
Medical Executive Committee	6/5/18
Administration	
Board of Directors	

Responsibility for review and maintenance:

Index Listings:

Developed:04-15-2015

Revised:05-01-2015

Reviewed:

Supercedes: 04-15-2015

**NORTHERN INYO HEALTHCARE DISTRICT
POLICY AND PROCEDURE**

Title: Ultrasound - Scope of Practice Procedure	
Scope: Departmental	Manual:
Source: Operations –Operations - Director of Diagnostic Services (DI & Lab)	Effective Date: 5/1/2018

PURPOSE: Outline protocols following American Institute of Ultrasound in Medicine (AIUM) Practice Parameters

POLICY:

1. Sonographers will adhere to the AIUM guidelines when performing exams.
2. Protocols are in alignment with these guidelines: see link below.

REFERENCES:

1. <http://www.aium.org/resources/guidelines.aspx>

Approval	Date
Radiology Services Committee	5/8/18
Medical Executive Committee	6/5/18
Board of Directors	
Last Board of Directors Review	

Developed: 05-01-2018

Reviewed:

Revised:

Supersedes:N/A

**NORTHERN INYO HOSPITAL
POLICY AND PROCEDURE**

Title: Responsibility for Patient Care	
Scope:	Manual: Nursing Administration
Source: Director of Nursing	Effective Date:

Responsibility for Patient Care

“A member of the Medical Staff shall be responsible for the medical care and treatment of each patient in the Hospital, for the prompt completeness and accuracy of the medical record, for necessary special instructions, and for transmitting reports of the condition of the patient to the referring Practitioner and to relatives to the patient. Whenever these responsibilities are transferred to another Staff member, a note covering the transfer of responsibility shall be entered on the order sheet of the medical record.”

From NIH Medical Staff Rules and Regulations, page 1, #2, 7/19/95.

“A Practitioner who will be out of town should, on the order sheet of the chart of each of his patients, indicate in writing the name of the Practitioner who will be assuming responsibility for the care of the patient during his absence. Upon failure to do so, the Chief of Staff or the Administrator may call in another member of the Medical Staff to assume responsibility for the patient.”

From NIH Medical Staff Rules and Regulations, page 2, #6, 07/19/95

Revised: 07/95

Reviewed: 08/03

Last Board of Director review: 4/18/18

Index Listings: Responsibility for patient care; Patient care, responsibility for

**NORTHERN INYO HOSPITAL-RURAL HEALTH CLINIC
STANDARDIZED PROCEDURE**

OBSTETRIC CARE

Scope: Nurse Practitioner

I. POLICY

A. Function: Management of Obstetric Care

B. Circumstances:

- 1. Patient population: pregnant patients of the Rural Health Clinic.**
- 2. Setting: Rural Health Clinic.**
- 3. Supervision: Rural Health Clinic physician as indicated in the General Standardized Procedure statement.**
- 4. Specialized education to provide OB care will consist of one of the following:**
 - a. Certification as a Nurse Practitioner with a specialty which includes OB training**
 - b. Education by the physician provider of OB care in clinic both by didactic proctoring and attending at least 2 hours of continuing education in the field of obstetrics**

II. PROTOCOL

A. Definition: This standardized procedure establishes guidelines for antepartum care and postpartum care of pregnant patients presenting at the Rural Health Clinic for Obstetric care.

Prenatal visits may include but are not limited to documentation of gestational age, maternal uterine growth and weight gain, urinalysis by dipstick, blood pressure monitoring, patient teaching, fetal heart rate, fetal activity, identification of high risk conditions (see list), and referral to community resources or the supervising physician as necessary.

The NPs shall consult with the supervising physician on any prenatal female with a potential or obvious high-risk condition.

B. Data Base: Data shall include but not be limited to:

- 1. Subjective:**
 - a. Relevant health history**
 - b. Family medical/genetic history**
 - c. Medications and sensitivities**
 - d. Self-care practices-sexual, nutritional, exercise, use of drugs, alcohol and tobacco**
 - e. Current issues and problems with pregnancy-nausea, vomiting, edema, abdominal pain, vaginal discharge/bleeding, urinary symptoms**
 - f. Assess for HIV risk factors**

2. Objective:

- a. Physical examination as soon as possible after determination of pregnancy
 - b. Laboratory and diagnostic tests appropriate to the gestational age.
 - c. Measurement of fundal height and fetal heart tones appropriate to presenting gestational age.
 - 3. **Assessment:** Maternal and fetal diagnosis consistent with subjective and objective findings. Notation of risk factors for possible referral or consultation.
 - 4. **Plan:**
 - a. Plan of care initiated based on objective findings and assessment. Treatment regimens to include, but not limited to: monitoring diet, exercise, employment, medication, psycho/social issues, baby and child safety and common complaints in pregnancy.
 - b. Medications shall be ordered as appropriate according to Drugs in Pregnancy and Lactation.
- C. Patient Education:**
- 1. Provide client with information on course of pregnancy, utilizing the Pregnancy handout created by Dr. Arndal.
 - 2. Provide counseling and approximate schedule of follow-up prenatal visits (see schedule C).
- D. Consultation and/or Referral:** Provide consultation and referral as indicated in General Policy Statement. Additional reference text resource for management guidelines: Management Guidelines for Nurse Practitioners Working with Women, 2nd edition, 2004 Chapters 12-13 (Antepartum and Postpartum Care)

POTENTIAL HIGH RISK CONDITIONS

Anemia: Hct 30%/Hgb 10 gm/dl unresponsive to iron replacement.

Abnormal QUAD screen

Drug/Alcohol abuse

Diabetes Mellitus or history of gestational diabetes

Habitual spontaneous abortions

Hemoglobinopathies

Rh isoimmunization or positive antibody screen

Multiple gestation

Maternal cardiac disease

Maternal hypertensive disease

Maternal hepatic disease

Maternal cancer

Maternal collagen vascular disease

Maternal renal disease

Maternal seizure disorder

Other maternal Gyn, endocrine, GI, neuromuscular, infectious, or pulmonary disease.

Previous pre-term labor or pre-term delivery

Pregnancy induced hypertension

Post maturity 41 weeks gestation

Positive HIV, Herpes, Hep B, Hep C

Psychiatric illness

Premature rupture of membranes

Bleeding at any time during pregnancy

Maternal age over 35 years or under 16 years

Fetal malpresentation after 36 weeks gestation

Maternal/paternal or family history of congenital anomalies

Grand multiparity ≥ 6

Late presentation for prenatal care (≥ 16 weeks)

Source: The Journal of Family Practice 28(i)

SCHEDULE

Prenatal Visit Schedule: **Every 4 weeks up to 28 weeks**
 Every 2 weeks from 28-36 weeks
 Weekly from 36 weeks to delivery

Estimated Schedule of Care

Initial visit:

Labs, Studies, Referrals

Schedule or perform complete physical examination to include Pap smear, Chlamydia and Gc

Prenatal Lab Panel: CBC Rubella
 Type and Rh HepBsAg
 RPR PPD
 UA & Pregnancy test
 HIV
 Cystic Fibrosis Screen optional

QUAD Screen at 12-18 weeks

1 hour GTT – 50 grams glucola at 20-28 weeks gestation

U/S @ 15-24 weeks

Group B Strep perineal culture @ 36 weeks

Education

Outline prenatal care

Diet, psychosocial, exercise

Risks

Prenatal vitamins

12-18 weeks: QUAD Screen

Review diet, exercise, habits

15-24 weeks: Ultrasound

OB Ultrasound for size dates, AFI, Anatomy

**24-28 weeks: 1-hour GTT Hct/Hgb
 Rhogam @ 28 weeks if
 Negative**

**Discuss scheduling prenatal classes
Discuss BTL/Family Planning**

32 weeks: BTL consent signed

**Discuss labor precautions
Breast Feeding options
Circumcision options**

34-36 weeks: Begin Fetal Activity Studies

Review procedure for fetal activity studies

36 weeks: GBS Swab

Discuss episiotomy, vacuum, forceps, C-Section

38 weeks:

Review labor precautions

**39-41 weeks: Vaginal exam
NST by 41 weeks**

**Postpartum: car seat, WCC,
Discuss induction if indicated**

**Post-dates: NST/CST after 41 weeks (2x/week)
NST for decreased fetal movement**

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

Chairman, Interdisciplinary Practice Committee

Date

Administrator

Date

Chief of Staff

Date

President, Board of Directors

Date

Registered Nurses authorized to perform this standardized procedure and date of authorization:

1. _____

2. _____

3. _____

4. _____

5. _____

6. _____

**NORTHERN INYO HOSPITAL
POLICY AND PROCEDURE**

Title: General Policy for the Rural Health Clinic Nurse Practitioner or Certified Nurse Midwife – Standardized Procedure	
Scope: Nurse Practitioner, Certified Nurse Midwife	Manual:
Source:	Effective Date:

PURPOSE:

To outline the general policy for the development of standardized procedures and the evaluation of those authorized to perform the standardized procedure functions, as promulgated by the guidelines of the Medical Board of California and the Board of Registered Nursing.

DEFINITIONS:

1. **Nurse Practitioner** (ANP, FNP, or PNP) is licensed by the State of California Board of Registered Nursing and possesses additional preparation and skills in physical diagnosis, psychosocial assessment, and management of health-illness needs in primary health care, and who has been prepared in a program that conforms to board standards.

2. **Certified Nurse Midwife** (CNM) encompasses a full range of primary health care services for women from adolescence beyond menopause. These services include primary care, gynecologic and family planning services, preconception care, care during pregnancy, childbirth and the postpartum period, care of the normal newborn during the first 28 days of life, and treatment of male partners for sexually transmitted infections. Midwives provide initial and ongoing comprehensive assessment, diagnosis, and treatment. They conduct physical examinations; prescribe medications; admit, manage and discharge patients; order and interpret laboratory and diagnostic tests and order the use of medical devices. Midwifery care also includes health promotion, disease prevention, and individualized wellness education and counseling.

POLICY:

1. Development and Review of Standardized Procedures
 - a. All standardized procedures are developed collaboratively and approved by the **Northern Inyo Healthcare District (NIHD)** Interdisciplinary Practice Committee (IDPC) and must conform to all 11 steps of the standardized procedure guidelines as specified in Title 16, CCR Section 1474.

 - b. All standardized procedures will be kept in a manual that includes dated and signed approval sheets of the persons covered by the standardized procedures.

 - c. All standardized procedures are to be reviewed every 3 years at minimum by the NP(s), **Medical Director of the setting the NP(s) function(s) in**, and then by the IDPC. Standardized procedures will be updated ~~by the Nurse Practitioner(s), RHC Director of Nursing, or RHC Medical Director~~ as practice changes.

 - d. All changes or additions to the standardized procedures are to be approved by the IDPC. All standardized procedures approved by the IDPC will be sent to the Medical Staff Executive Committee and, if so approved, to the **NIHD** Board of Directors.

**NORTHERN INYO HOSPITAL
POLICY AND PROCEDURE**

Title: General Policy for the Rural Health Clinic Nurse Practitioner or Certified Nurse Midwife – Standardized Procedure	
Scope: Nurse Practitioner, Certified Nurse Midwife	Manual:
Source:	Effective Date:

2. Setting of Practice

- a. Any of the following outpatient locations, as appropriate for specialty:
 - i. Rural Health Clinic (RHC)
 - ii. Rural Health Women’s Health Clinic (RHWC)
 - iii. Bishop Pediatrics and Allergy
 - iv. Northern Inyo Associates (NIA) Clinic

3. Scope of Practice

- a. The NP & CNM may perform the following functions within his/her specialty area and consistent with their experience and credentialing: assessment, management, and treatment of episodic illness, chronic illness, contraception, and the common nursing functions of health promotion, and general evaluation of health status (including but not limited to ordering laboratory procedures, x-rays, and physical therapies as well as recommending diets, and referring to specialty services when indicated).
- b. Standardized procedure functions, such as managing medication regimens, are to be performed at the ~~NIH RHC, Women’s Health Clinic or Bishop Pediatric and Allergy office~~ approved setting of practice. The ~~consulting Medical Director supervising~~ physician, or his/her relief, will be available ~~to the ANP(s) & FNP(s)~~ in person or by phone. PNP(s) will consult the Pediatrician supervisor on call. CNM(s) will consult OB/GYN Physician on call.
- c. Physician consultation is to be obtained under the following circumstances:
 - i. Emergent conditions requiring prompt medical intervention after the initial stabilizing care has been started.
 - ii. Acute decompensation of patient situation.
 - iii. Problem which is not resolving as anticipated.
 - iv. History, physical, or lab finding inconsistent with the clinical picture.
 - v. Upon request of patient, nurse, or supervising physician.
- d. Medical Records: Medical record entries by the NP or CNM shall include, for all problems addressed: the patients’ statement of symptoms, the physical findings, results of special studies, the NP’s or CNM’s assessment and management plan including further studies ordered, medication or procedures, information given patient and the names of any physicians consulted.

4. Qualifications and Evaluations

- a. Each nurse performing standardized procedure functions must have a current California registered nursing license, be a graduate of an approved Nurse Practitioner or Certified Nurse Midwife program, and have current certification as a NP or CNM by the California Board of Registered Nursing.

**NORTHERN INYO HOSPITAL
POLICY AND PROCEDURE**

Title: General Policy for the Rural Health Clinic Nurse Practitioner or Certified Nurse Midwife – Standardized Procedure	
Scope: Nurse Practitioner, Certified Nurse Midwife	Manual:
Source:	Effective Date:

- b. Evaluation of competence in performance of standardized procedure functions will be done in the following manner:
 - i. Initial: at 3 months, 6 months and 12 months by the Supervising Physician, and other physicians and colleagues, and review of charting completed during performance period being evaluated.
 - ii. Routine: ~~annually after the first year~~ every 6 months thereafter, in accordance with the Medical Staff Ongoing Professional Practice Evaluation (OPPE) policy.
 - iii. Follow-up: areas requiring increased proficiency, as determined by the initial or routine evaluation, will be reevaluated by the supervising physician at appropriate intervals until acceptable skill level is achieved.
- c. Medical Record Review shall consist of audit by the supervising physician(s) of at least 5% of patients seen by the NP or CNM.
- d. Further requirements shall be regular continuing education in primary care, including reading of appropriate journals and new text books, attending conferences in primary care sponsored by hospitals, professional societies, and teaching institutions equaling 15 hours a year, minimum.
 - i. A record of continuing education must be submitted to the Medical Staff Office every other year at re-credentialing.
 - ii. Continuing education information will remain on file in the NP/CNM’s competency notebook. A copy of the competency assurance documents will be submitted to Human Resources (HR) at the end of each calendar year to be stored in the employee HR file.

5. Protocols

- a. The standardized procedure protocols developed for the use by the NP and CNM are designed to describe the steps of medical care for given patient situations. They are to be used in the following circumstances: health promotion exams, contraception, routine gynecological problems, trauma, infectious disease contacts, management of acute/episodic or chronic conditions, and furnishing of medications.

REFERENCES:

- 1. 16 CCR §1474. Standardized Procedure Guidelines. Retrieved 16 Apr 2018.

Approval	Date
Interdisciplinary Practice Committee	5/30/18
Medical Executive Committee	6/5/18
Board of Directors	
Last Board of Directors Review	

**NORTHERN INYO HOSPITAL
POLICY AND PROCEDURE**

Title: General Policy for the Rural Health Clinic Nurse Practitioner or Certified Nurse Midwife – Standardized Procedure	
Scope: Nurse Practitioner, Certified Nurse Midwife	Manual:
Source:	Effective Date:

APPROVALS

Chairman, Interdisciplinary Practice Committee Date _____

Administrator Date _____

Chief of Staff Date _____

President, Board of Directors Date _____

Developed:
Reviewed: 5/2018 dp
Revised: 5/2018 dp
Supersedes: *General Policy for the Rural Health Clinic Nurse Practitioner or Certified Nurse Midwife*
Index Listings:

**NORTHERN INYO HOSPITAL
POLICY AND PROCEDURE**

Title: General Policy for the Rural Health Clinic Nurse Practitioner or Certified Nurse Midwife – Standardized Procedure	
Scope: Nurse Practitioner, Certified Nurse Midwife	Manual:
Source:	Effective Date:

ATTACHMENT 1 – LIST OF AUTHORIZED NP’s or CNM’s

1. _____
NAME DATE
2. _____
NAME DATE
3. _____
NAME DATE
4. _____
NAME DATE
5. _____
NAME DATE
6. _____
NAME DATE
7. _____
NAME DATE
8. _____
NAME DATE
9. _____
NAME DATE
10. _____
NAME DATE

**NORTHERN INYO HOSPITAL
POLICY AND PROCEDURE**

Title: Adult Health Maintenance Policy for the Nurse Practitioner or Certified Nurse Midwife – Standardized Procedure	
Scope: Nurse Practitioner, Certified Nurse Midwife	Manual:
Source:	Effective Date:

PURPOSE:

This standardized procedure developed for the use by the Nurse Practitioner (NP) and the Certified Nurse Midwife (CNM) is designed to establish guidelines for the management of adult health maintenance (specific chronic diseases – protocols i.e. HTN, DM).

POLICY:

1. This standardized procedure and those authorized to work through this standardized procedure will meet all guidelines as outlined in the *General Policy for the Outpatient Nurse Practitioner or Certified Nurse Midwife*.
2. Function: management of adult health maintenance.
3. Circumstances:
 - a. Patient Population: adult patients
 - b. Settings:
 - i. Rural Health Clinic (RHC)
 - ii. Rural Health Women’s Health Clinic (RHWC)
 - iii. Bishop Pediatrics and Allergy
 - iv. Northern Inyo Associates (NIA) Clinic
 - c. Supervision: Physicians indicated in the supervisory agreements for the NP or CNM.

PROTOCOL:

1. Definition: health maintenance, health promotion and prevention activities which promote the physical, psychosocial and developmental well-being of adults.
 - a. Includes health assessment and disease prevention utilizing:
 - i. physical exam
 - ii. diagnostic testing
 - iii. immunizations
 - iv. health education
2. Data base:
 - a. Subjective:
 - i. Obtain complete histories on all first-time patients; interval histories on subsequent visits.
 - b. Objective:
 - i. At each visit obtain vital signs, weight, allergy history and pain assessment.
 - ii. Risk assessment when establishing care and as indicated.
 - iii. Perform complete physical examinations as indicated.
 - iv. Perform appropriate psychosocial assessment.
 - v. Laboratory/diagnostic testing as needed.
3. Plan:
 - a. Diagnosis established utilizing current coding standards in CPOE format.
 - i. Health maintenance
 - ii. Acute illness

**NORTHERN INYO HOSPITAL
POLICY AND PROCEDURE**

Title: Adult Health Maintenance Policy for the Nurse Practitioner or Certified Nurse Midwife – Standardized Procedure	
Scope: Nurse Practitioner, Certified Nurse Midwife	Manual:
Source:	Effective Date:

- iii. Current assessment of chronic illness
 - b. Therapeutic regimen
 - i. Diet as appropriate for age/nutritional status
 - ii. Medications
 - 1. Vitamins/mineral supplements
 - 2. Immunizations as indicated
 - 3. Hormonal replacement as indicated
 - 4. Medications appropriate to address acute and chronic health problems.
 - iii. Activity/exercise as appropriate for age/health status
 - iv. Health education related to age/health status, preventative health behaviors.
 - v. Interventions appropriate to address acute and chronic health problems.
 - c. Consultation/referral
 - i. Physician consult to be obtained under the circumstances:
 - 1. Emergent conditions requiring prompt medical intervention after the initial stabilizing care has been started.
 - 2. Acute decompensation of patient situation.
 - 3. Problem which is not resolving as anticipated.
 - 4. History, physical, or lab finding inconsistent with the clinical picture.
 - 5. Upon request of patient, nurse, or supervising physician.
 - 6. Refer to specialist or other community resource indicated.
 - d. Follow-up
 - i. According to adult health maintenance schedule, sooner as indicated.
 - e. Record keeping
 - i. Appropriate documentation to be maintained [in](#) patient’s chart.
 - ii. Allergic reaction to vaccine/medication
- 4. Contraindications to immunization
 - a. Live virus vaccines contraindicated (consult with physician first):
 - i. Patient with disorder of immune system
 - ii. Household member of patient with disorder of immune system
 - iii. Patient who received immune globulin in last 3 months
 - iv. During pregnancy
 - v. PPD should not be administered for 3 months following MMR
- 5. Management of anaphylactic reactions to immunizations
 - a. Mild anaphylaxis involving skin (immediate):
 - i. Pruritus, flush, urticaria, angioedema
 - ii. Emergency treatment
 - 1. Maintain patient airway
 - 2. Administer 1:1000 (aqueous) Epinephrine SQ or IM 0.01 ml/kg.
 - 3. Repeat dose every 15-20 minutes.
 - 4. Consult with physician.

**NORTHERN INYO HOSPITAL
POLICY AND PROCEDURE**

Title: Adult Health Maintenance Policy for the Nurse Practitioner or Certified Nurse Midwife – Standardized Procedure	
Scope: Nurse Practitioner, Certified Nurse Midwife	Manual:
Source:	Effective Date:

- b. Systemic – in addition to skin rash, rhinitis, redness, tearing of eyes, bronchospasm, laryngeal spasm, shock with cardiovascular collapse.
 - i. Treatment
 - 1. Maintain patient airway, administer CPR if necessary.
 - 2. Administer 1:1000 (aqueous) Epinephrine SQ or IM 0.01 ml/kg.
 - 3. Refer to M.D.
 - 4. Call Code Blue if indicated
 - 5. Report adverse reaction to local health department/manufacture of vaccine.

CROSS REFERENCE P&P:

- 1. *General Policy for the Nurse Practitioner or Certified Nurse Midwife – Standardized Procedure*

Approval	Date
Interdisciplinary Practice Committee	5/30/18
Medical Executive Committee	6/5/18
Board of Directors	
Last Board of Directors Review	

Developed:
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 Revised: 05/2018 dp
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 Index Listings:

**NORTHERN INYO HOSPITAL
POLICY AND PROCEDURE**

Title: Adult Health Maintenance Policy for the Nurse Practitioner or Certified Nurse Midwife – Standardized Procedure	
Scope: Nurse Practitioner, Certified Nurse Midwife	Manual:
Source:	Effective Date:

APPROVALS

Chairman, Interdisciplinary Practice Committee Date _____

Administrator Date _____

Chief of Staff Date _____

President, Board of Directors Date _____

**NORTHERN INYO HOSPITAL
POLICY AND PROCEDURE**

Title: Adult Health Maintenance Policy for the Nurse Practitioner or Certified Nurse Midwife – Standardized Procedure	
Scope: Nurse Practitioner, Certified Nurse Midwife	Manual:
Source:	Effective Date:

ATTACHMENT 1 – LIST OF AUTHORIZED NP’s or CNM’s

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**NORTHERN INYO HOSPITAL
POLICY AND PROCEDURE**

Title: Management of Acute Illness Policy for the Nurse Practitioner or Certified Nurse Midwife – Standardized Procedure	
Scope: Nurse Practitioner, Certified Nurse Midwife	Manual:
Source:	Effective Date:

PURPOSE:

This standardized procedure developed for the use by the Nurse Practitioner (NP) and the Certified Nurse Midwife (CNM) is designed to establish guidelines that will allow the NP or CNM to medically manage acute illness and conditions.

POLICY:

1. This standardized procedure and those authorized to work through this standardized procedure will meet all guidelines as outlined in the *General Policy for the Outpatient Nurse Practitioner or Certified Nurse Midwife*.
2. This standardized procedure covers the medical management of acute illness, allergies, symptomatic complaints, minor trauma and emergencies in children and adults in the family-practice ambulatory care setting.
3. Circumstances:
 - a. Patient population: neonates, pediatrics, adults and geriatrics – as appropriate for specialty.
 - b. Settings:
 - i. Rural Health Clinic (RHC)
 - ii. Bishop Pediatrics and Allergy
 - iii. Rural Health Women’s Health Clinic (RHWC)
 - iv. Northern Inyo Associates (NIA) Clinic
 - c. Supervision: Physicians indicated in the supervisory agreements for the NP or CNM.

PROTOCOL:

1. Data Base
 - a. Subjective:
 - i. Historical information relevant to the acute illness.
 - ii. Historical information regarding concurrent problems.
 - iii. Historical information regarding relevant past medical problems.
 - iv. Patient’s/family’s efforts to treat the illness/condition.
 - v. History of allergic/adverse reactions to medications.
 - vi. Status of patient’s functional and instrumental abilities.
 - b. Objective:
 - i. Perform physical exam pertinent to presenting symptoms.
 - ii. Evaluate severity of complaint (i.e., vital sign changes, level of consciousness, unusual or unexpected symptoms).
 - iii. Order laboratory testing and diagnostic procedure as indicated.
 - c. Assessment
 - i. Diagnosis consistent with subjective and objective findings.
 - ii. Record data on appropriate areas on patient’s chart.
 - d. Plan
 - i. Medications as indicated (see *Furnishing of Medications/Devices Standardized Procedure*).

**NORTHERN INYO HOSPITAL
POLICY AND PROCEDURE**

Title: Management of Acute Illness Policy for the Nurse Practitioner or Certified Nurse Midwife – Standardized Procedure	
Scope: Nurse Practitioner, Certified Nurse Midwife	Manual:
Source:	Effective Date:

- ii. Order further diagnostic testing as indicated.
- iii. Patient education appropriate to acute illness and any procedures, diagnostic testing, or medications ordered.
- iv. Order/perform therapeutic procedures as appropriate.
- v. Order medical supplies and necessary equipment for treatment.
- vi. Consult with and/or refer to supervising M.D. for:
 - 1. Presence of unexpected or ambiguous historical, physical or diagnostic findings.
 - a. Signs of sepsis/toxic patient.
 - b. Alteration in level of consciousness (i.e., seizure, etc.).
 - c. Emergency situations which may be life threatening.
 - d. Any patient whose condition warrants hospitalization.
 - e. Unresolving problems.
 - f. Any needs of the NP or CNM requiring information/confirmation of management plans.
 - g. Upon request of patient/family.
- vii. Refer as indicated to other services/specialties.
- viii. Follow-up as indicated.

CROSS REFERENCE P&P:

1. *General Policy for the Nurse Practitioner or Certified Nurse Midwife – Standardized Procedure*
2. *Furnishing Medications/Devices Policy for the Nurse Practitioner or Certified Nurse Midwife – Standardized Procedure*

Approval	Date
Interdisciplinary Practice Committee	5/30/18
Medical Executive Committee	6/5/18
Board of Directors	
Last Board of Directors Review	

Developed:
 Reviewed:
 Revised: 05/2018 dp
 Supersedes:
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**NORTHERN INYO HOSPITAL
POLICY AND PROCEDURE**

Title: Management of Acute Illness Policy for the Nurse Practitioner or Certified Nurse Midwife – Standardized Procedure	
Scope: Nurse Practitioner, Certified Nurse Midwife	Manual:
Source:	Effective Date:

APPROVALS

Chairman, Interdisciplinary Practice Committee Date _____

Administrator Date _____

Chief of Staff Date _____

President, Board of Directors Date _____

**NORTHERN INYO HOSPITAL
POLICY AND PROCEDURE**

Title: Management of Acute Illness Policy for the Nurse Practitioner or Certified Nurse Midwife – Standardized Procedure	
Scope: Nurse Practitioner, Certified Nurse Midwife	Manual:
Source:	Effective Date:

ATTACHMENT 1 – LIST OF AUTHORIZED NP’s or CNM’s

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NORTHERN INYO HOSPITAL POLICY AND PROCEDURE

Title: Management of Chronic Illness Policy for the Nurse Practitioner or Certified Nurse Midwife – Standardized Procedure	
Scope: Nurse Practitioner, Certified Nurse Midwife	Manual:
Source:	Effective Date:

PURPOSE:

This standardized procedure **developed for the use by the Nurse Practitioner (NP) and the Certified Nurse Midwife (CNM)** is designed to establish guidelines that will allow the NP or CNM to manage chronic illness.

POLICY:

1. This standardized procedure and those authorized to work through this standardized procedure will meet all guidelines as outlined in the *General Policy for the Outpatient Nurse Practitioner or Certified Nurse Midwife*.
2. This standardized procedure covers the management of chronic illness in children and adults in the ambulatory **primary care** setting.
3. Circumstances:
 - a. Patient population: neonates, pediatrics, adults and geriatrics – **as appropriate for specialty.**
 - b. Settings:
 - i. Rural Health Clinic (RHC)
 - ii. Bishop Pediatrics and Allergy
 - iii. Rural Health Women’s Health Clinic (RHWC)
 - iv. **Northern Inyo Associates (NIA) Clinic**
 - c. **Supervision: Physicians indicated in the supervisory agreements for the NP or CNM.**

PROTOCOL:

1. Data Base
 - a. Subjective:
 - i. Pertinent history including symptoms related to the chronic illness.
 - ii. Present state of chronic illness (worse, better, stable).
 - iii. Historical information regarding relevant past medical problems.
 - iv. Effects of chronic illness on activities of daily living, psychological, physical and financial status.
 - v. Patient’s attitude and behaviors regarding the chronic illness.
 - vi. Patient’s physical, social, financial support systems.
 - vii. Documentation of complete history updated minimally on an annual basis.
 - b. Objective:
 - i. Complete pediatric WCC or adult HME annually.
 - ii. Physical assessment pertinent to chronic illness.
 - iii. Laboratory/diagnostic testing as indicated.
 - c. Assessment
 - i. Qualification/quantification of chronic illness status.
 - ii. Record appropriately on patient chart.
 - d. Plan
 - i. Medications as indicated (see *Furnishing of Medications/Devices Standardized Procedure*).

**NORTHERN INYO HOSPITAL
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Title: Management of Chronic Illness Policy for the Nurse Practitioner or Certified Nurse Midwife – Standardized Procedure	
Scope: Nurse Practitioner, Certified Nurse Midwife	Manual:
Source:	Effective Date:

- ii. Laboratory/diagnostic testing as indicated.
- iii. Patient education appropriate to chronic illness and any procedures, diagnostic testing, or medications ordered.
- iv. Order/perform therapeutic procedures as appropriate.
- v. Order medical supplies and necessary equipment for treatment.
- vi. Consult with and/or refer to supervising M.D. or patient’s specialist for:
 - 1. Acute decompensation of chronic stable illness.
 - 2. Ambiguous diagnostic, physical or historical findings.
 - 3. Any needs of the NP and CNM requiring information/confirmation of management plans.
 - 4. Upon request of patient/family
- vii. Refer as indicated to other services/specialties.
- viii. Follow-up as indicated.

CROSS REFERENCE P&P:

1. *General Policy for the Nurse Practitioner or Certified Nurse Midwife – Standardized Procedure*
2. *Furnishing Medications/Devices Policy for the Nurse Practitioner or Certified Nurse Midwife – Standardized Procedure*

Approval	Date
Interdisciplinary Practice Committee	5/30/18
Medical Executive Committee	6/5/18
Board of Directors	
Last Board of Directors Review	

Developed:
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**NORTHERN INYO HOSPITAL
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Title: Management of Chronic Illness Policy for the Nurse Practitioner or Certified Nurse Midwife – Standardized Procedure	
Scope: Nurse Practitioner, Certified Nurse Midwife	Manual:
Source:	Effective Date:

APPROVALS

Chairman, Interdisciplinary Practice Committee Date _____

Administrator Date _____

Chief of Staff Date _____

President, Board of Directors Date _____

**NORTHERN INYO HOSPITAL
POLICY AND PROCEDURE**

Title: Management of Chronic Illness Policy for the Nurse Practitioner or Certified Nurse Midwife – Standardized Procedure	
Scope: Nurse Practitioner, Certified Nurse Midwife	Manual:
Source:	Effective Date:

ATTACHMENT 1 – LIST OF AUTHORIZED NP’s or CNM’s

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**NORTHERN INYO HOSPITAL
POLICY AND PROCEDURE**

Title: Emergency Care Policy for the Nurse Practitioner or Certified Nurse Midwife – Standardized Procedure	
Scope: Nurse Practitioner, Certified Nurse Midwife	Manual:
Source:	Effective Date:

PURPOSE:

This standardized procedure developed for the use by the Nurse Practitioner (NP) and the Certified Nurse Midwife (CNM) is designed to establish guidelines for the management of emergency care conditions.

POLICY:

1. This standardized procedure and those authorized to work through this standardized procedure will meet all guidelines as outlined in the *General Policy for the Outpatient Nurse Practitioner or Certified Nurse Midwife*.
2. Circumstances:
 - a. Patient population: neonates, pediatrics, adults and geriatrics – as appropriate for specialty.
 - b. Settings:
 - i. Rural Health Clinic (RHC)
 - ii. Bishop Pediatrics and Allergy
 - iii. Rural Health Women’s Health Clinic (RHWC)
 - iv. Northern Inyo Associates (NIA) Clinic
 - c. Supervision: Physicians indicated in the supervisory agreements for the NP or CNM.

PROTOCOL:

1. Database:
 - a. Subjective:
 - i. Obtain pertinent history related to emergency symptoms
 - ii. Collect appropriate information, including past medical history, review of systems, allergies, immunizations, and medications.
 - b. Objective:
 - i. Perform limited physical examination pertinent to the emergency illness or injury, including any possible involved organ systems.
 - ii. Obtain appropriate evaluative studies, including but not limited to, lab work and x-rays. (See *Laboratory and Diagnostic Testing Policy for the Nurse Practitioner or Certified Nurse Midwife – Standardized Procedure*).
2. Assessment:
 - a. Formulate diagnosis consistent with the data base collected.
 - b. Document diagnosis in the patient chart.
3. Treatment Plan – Medical Regimen:
 - a. Patients requiring emergency care will be stabilized to the best of the capabilities of the ~~NIH RHC~~ Northern Inyo Healthcare District (NIHD) setting and transferred to or referred to an appropriate provider. These patients shall become the responsibility of the accepting physician and/or NIHD-Base Hospital during ambulance transport.
 - b. The NP or CNM may, whenever necessary, attempt to sustain life. This includes, but is not limited to:

**NORTHERN INYO HOSPITAL
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Title: Emergency Care Policy for the Nurse Practitioner or Certified Nurse Midwife – Standardized Procedure	
Scope: Nurse Practitioner, Certified Nurse Midwife	Manual:
Source:	Effective Date:

- i. Establishing and maintaining an airway
- ii. Cardiopulmonary resuscitation
- iii. Control of hemorrhage by external pressure or tourniquet
- iv. Establishing an intravenous line
- v. Injection of epinephrine for asthma, anaphylactic shock or laryngeal edema
- vi. Administration of oxygen for acute dyspnea
- vii. Splint skeletal injuries
- viii. Irrigate wounds
- ix. Apply heat or cold for exposure
- x. Administration of Narcan for suspected narcotic overdose
- xi. Administration of intravenous glucose for suspected insulin reaction
- xii. Follow Advanced Cardiac Life Support Guidelines
- c. Physician Consultation: As described in the *General Policy Standardized Procedure*.
- d. Referral to Physician or Specialty Clinic: Conditions for which diagnosis and/or treatment are beyond the scope of the NP’s or CNM’s knowledge and/or skills, or for those conditions that require consultation.
 - i. Emergent referral will usually require transport to NIHD emergency department. This may be accomplished by use of the 911 system and ALS ambulance if indicated by the patient condition. If in the opinion of the NP or CNM the patient can tolerate transfer by wheel chair, an RN must accompany the patient to the emergency department.
 - ii. Emergent referrals to facilities other than NIHD will be managed per NIHD ~~Emergent Transfer~~ policy.
- e. Furnishing Medications – Medical Regimen:
 - i. Follow *Furnishing Medications/Devices Standardized Procedure*, utilizing formulary.
- 4. Documentation:
 - a. All emergency care provided will be recorded in the ~~RHC~~ patient chart.

CROSS REFERENCE P&P:

1. *General Policy for the Nurse Practitioner or Certified Nurse Midwife – Standardized Procedure*.
2. *Laboratory and Diagnostic Testing Policy for the Nurse Practitioner or Certified Nurse Midwife – Standardized Procedure*
3. *Furnishing Medications/Devices Policy for the Nurse Practitioner or Certified Nurse Midwife – Standardized Procedure*

**NORTHERN INYO HOSPITAL
POLICY AND PROCEDURE**

Title: Emergency Care Policy for the Nurse Practitioner or Certified Nurse Midwife – Standardized Procedure	
Scope: Nurse Practitioner, Certified Nurse Midwife	Manual:
Source:	Effective Date:

Approval	Date
Interdisciplinary Practice Committee	5/30/18
Medical Executive Committee	6/5/18
Board of Directors	
Last Board of Directors Review	

Developed:
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 Index Listings:

**NORTHERN INYO HOSPITAL
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Title: Emergency Care Policy for the Nurse Practitioner or Certified Nurse Midwife – Standardized Procedure	
Scope: Nurse Practitioner, Certified Nurse Midwife	Manual:
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APPROVALS

Chairman, Interdisciplinary Practice Committee Date _____

Administrator Date _____

Chief of Staff Date _____

President, Board of Directors Date _____

**NORTHERN INYO HOSPITAL
POLICY AND PROCEDURE**

Title: Emergency Care Policy for the Nurse Practitioner or Certified Nurse Midwife – Standardized Procedure	
Scope: Nurse Practitioner, Certified Nurse Midwife	Manual:
Source:	Effective Date:

ATTACHMENT 1 – LIST OF AUTHORIZED NP’s or CNM’s

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**NORTHERN INYO HOSPITAL
POLICY AND PROCEDURE**

Title: Laboratory and Diagnostic Testing Policy for the Nurse Practitioner or Certified Nurse Midwife – Standardized Procedure	
Scope: Nurse Practitioner, Certified Nurse Midwife	Manual:
Source:	Effective Date:

PURPOSE:

This standardized procedure developed for the use by the Nurse Practitioner (NP) and the Certified Nurse Midwife (CNM) is designed to establish guidelines for the ordering of laboratory and diagnostic tests.

POLICY:

1. This standardized procedure and those authorized to work through this standardized procedure will meet all guidelines as outlined in the *General Policy for the Outpatient Nurse Practitioner or Certified Nurse Midwife*.
2. Laboratory and diagnostic tests may be ordered by the NP or CNM under the following conditions:
 - a. As an appropriate adjunct to the determination of diagnosis.
 - b. When necessary, to implement, monitor or adjust treatment.
3. Circumstances:
 - a. Patient population: neonates, pediatrics, adults and geriatrics – as appropriate for specialty.
 - b. Settings:
 - i. Rural Health Clinic (RHC)
 - ii. Bishop Pediatrics and Allergy
 - iii. Rural Health Women’s Health Clinic (RHWC)
 - iv. Northern Inyo Associates (NIA) Clinic
 - c. Supervision: Physicians indicated in the supervisory agreements for the NP or CNM.

PROTOCOL:

1. Conditions
 - a. The following diagnostic tests can be initiated by the ~~Mid-level Provider~~NP or CNM without prior consultation with M.D.:
 - i. Any blood work
 - ii. Urine: any urine test
 - iii. Cultures: any culture
 - iv. Radiologic/Sonographic: any radiologic/sonographic exam including CT scans and MRI examinations
 - v. Audiometric testing/speech evaluation
 - vi. Pregnancy Tests
 - vii. Cardiac Testing
 - viii. EEG
 - b. All other diagnostic tests will be ordered by the ~~FNP~~ NP or CNM in consultation with the physician, including:
 - i. When diagnostic test of choice is in doubt.

**NORTHERN INYO HOSPITAL
POLICY AND PROCEDURE**

Title: Laboratory and Diagnostic Testing Policy for the Nurse Practitioner or Certified Nurse Midwife – Standardized Procedure	
Scope: Nurse Practitioner, Certified Nurse Midwife	Manual:
Source:	Effective Date:

CROSS REFERENCE P&P:

1. *General Policy for the Nurse Practitioner or Certified Nurse Midwife – Standardized Procedure*

Approval	Date
Interdisciplinary Practice Committee	5/30/18
Medical Executive Committee	6/5/18
Board of Directors	
Last Board of Directors Review	

Developed:
 Reviewed:
 Revised: 05/2018 dp
 Supersedes:
 Index Listings:

**NORTHERN INYO HOSPITAL
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Title: Laboratory and Diagnostic Testing Policy for the Nurse Practitioner or Certified Nurse Midwife – Standardized Procedure	
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Source:	Effective Date:

APPROVALS

Chairman, Interdisciplinary Practice Committee

Date

Administrator

Date

Chief of Staff

Date

President, Board of Directors

Date

**NORTHERN INYO HOSPITAL
POLICY AND PROCEDURE**

Title: Laboratory and Diagnostic Testing Policy for the Nurse Practitioner or Certified Nurse Midwife – Standardized Procedure	
Scope: Nurse Practitioner, Certified Nurse Midwife	Manual:
Source:	Effective Date:

ATTACHMENT 1 – LIST OF AUTHORIZED NP’s or CNM’s

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**NORTHERN INYO HOSPITAL
POLICY AND PROCEDURE**

Title: Minor Surgical Procedures Policy for the Nurse Practitioner or Certified Nurse Midwife – Standardized Procedure	
Scope: Nurse Practitioner, Certified Nurse Midwife	Manual:
Source:	Effective Date:

PURPOSE:

This standardized procedure developed for the use by the Nurse Practitioner (NP) and the Certified Nurse Midwife (CNM) is designed to establish guidelines that will allow the NP or CNM to manage minor surgical procedures.

POLICY:

1. This standardized procedure and those authorized to work through this standardized procedure will meet all guidelines as outlined in the *General Policy for the Outpatient Nurse Practitioner or Certified Nurse Midwife*.
2. This standardized procedure is designed to establish guidelines that will allow NP and CNM to perform minor surgical procedures incidental to the provision of routine primary care to ambulatory patients presenting to the listed settings.
3. Circumstances:
 - a. Patient population: neonates, pediatrics, adults and geriatrics – as appropriate for specialty.
 - b. Settings:
 - i. Rural Health Clinic (RHC)
 - ii. Bishop Pediatrics and Allergy
 - iii. Rural Health Women’s Health Clinic (RHWC)
 - iv. Northern Inyo Associates (NIA) Clinic
 - c. Supervision: Physicians indicated in the supervisory agreements for the NP or CNM.

PROTOCOL:

1. Conditions
 - a. After appropriate training and experience, minor procedures that can be performed by the NP or CNM without direct physician supervision include:
 - i. Pessary placement
 - ii. Electrocautery of external, non-malignant lesions, e.g. warts
 - iii. Epidermal cyst removal
 - iv. Incision and drainage of abscess (excluding peri-rectal abscesses)
 - v. Suture laceration without nerve or tendon involvement
 - vi. Mole removal (non-facial)
 - vii. Punch or shave biopsy
 - viii. Toe nail removal
 - ix. Cryotherapy
 - x. IUD insertion and removal
 - xi. Excision of simple lesions
 - xii. Simple foreign body removal
 - xiii. Endometrial biopsy
 - xiv. Arthrocentesis/Steroid joint injection
 - xv. Excision of hemorrhoid thrombus
 - xvi. Nexplanon insertion/removal
 - xvii. Circumcision of newborn

**NORTHERN INYO HOSPITAL
POLICY AND PROCEDURE**

Title: Minor Surgical Procedures Policy for the Nurse Practitioner or Certified Nurse Midwife – Standardized Procedure	
Scope: Nurse Practitioner, Certified Nurse Midwife	Manual:
Source:	Effective Date:

2. Data Base

a. Subjective

- i. Obtain pertinent history including involved organ system, injury, trauma, dermatology problems, etc.
- ii. Obtain information regarding review of system, risk taking behaviors, prior surgery, allergies, and immunizations.

b. Objective

- i. Perform physical examination pertinent to assessment of the problem.
- ii. Collect appropriate diagnostic/radiological studies.

c. Assessment

- i. Formulate diagnosis consistent with the above data base.

d. Plan

- i. Develop therapeutic regimen
- ii. Provide informed consent. Utilize universal ~~precaution~~ protocol; “Time Out” prior to all invasive procedures.
- iii. Perform appropriate procedure utilizing standard aseptic technique.
- iv. Obtain additional diagnostic studies as indicated.
- v. Physician consultation/assistance in performing the procedure as per policy statement or above conditions.
- vi. Patient education and self-care techniques.
- vii. Development of appropriate follow-up care plan.
- viii. Update problem list.

CROSS REFERENCE P&P:

1. *General Policy for the Nurse Practitioner or Certified Nurse Midwife – Standardized Procedure*

Approval	Date
Interdisciplinary Practice Committee	5/30/18
Medical Executive Committee	6/5/18
Board of Directors	
Last Board of Directors Review	

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Title: Minor Surgical Procedures Policy for the Nurse Practitioner or Certified Nurse Midwife – Standardized Procedure	
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Chairman, Interdisciplinary Practice Committee Date _____

Administrator Date _____

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**NORTHERN INYO HOSPITAL
POLICY AND PROCEDURE**

Title: Minor Surgical Procedures Policy for the Nurse Practitioner or Certified Nurse Midwife – Standardized Procedure	
Scope: Nurse Practitioner, Certified Nurse Midwife	Manual:
Source:	Effective Date:

ATTACHMENT 1 – LIST OF AUTHORIZED NP’s or CNM’s

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**NORTHERN INYO HOSPITAL
POLICY AND PROCEDURE**

Title: Management of Minor Trauma Policy for the Nurse Practitioner or Certified Nurse Midwife – Standardized Procedure	
Scope: Nurse Practitioner, Certified Nurse Midwife	Manual:
Source:	Effective Date:

PURPOSE:

This standardized procedure developed for the use by the Nurse Practitioner (NP) and the Certified Nurse Midwife (CNM) is designed to establish guidelines that will allow the NP or CNM to manage minor trauma.

POLICY:

1. This standardized procedure and those authorized to work through this standardized procedure will meet all guidelines as outlined in the *General Policy for the Outpatient Nurse Practitioner or Certified Nurse Midwife*.
2. This standardized procedure is designed to establish guidelines that will allow NP and CNM to manage ambulatory clients presenting with minor traumatic injuries.
3. Circumstances:
 - a. Patient population: neonates, pediatrics, adults and geriatrics – as appropriate for specialty.
 - b. Settings:
 - i. Rural Health Clinic (RHC)
 - ii. Bishop Pediatrics and Allergy
 - iii. Rural Health Women’s Health Clinic (RHWC)
 - iv. Northern Inyo Associates (NIA) Clinic
 - c. Supervision: Physicians indicated in the supervisory agreements for the NP or CNM.

PROTOCOL:

1. Data Base
 - a. Subjective:
 - i. Obtain pertinent history related to the injury or traumatic event.
 - ii. Collect appropriate information, including past medical history, review of systems, allergies, immunizations, and medications.
 - b. Objective:
 - i. Perform limited physical examinations pertinent to the injury, including any possible involved organ system.
 - ii. Obtain appropriate evaluative studies, including but not limited to, lab work and x-rays (see *Laboratory and Diagnostic Testing Standardized Procedure*).
 - c. Assessment
 - i. Formulate a working diagnosis consistent with data base collected.
 - d. Plan
 - i. If indicated, develop or initiate a therapeutic regimen including, but not limited to, the following:
 1. Physician consultation prior to management as per policy statement or in the following cases:
 - a. Any injury threatening to life or limb.

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- b. Any laceration requiring complicated suture closure (see *Minor Surgical Procedures – Standardized Procedure*).
 - c. Any fracture or injury requiring immobilization by full casting.
 - d. Complicated or extensive burns.
 - e. Injury that may involve litigation or compensation.
 - f. Any case where surgical intervention may be needed.
2. Further diagnostic tests.
3. Skin/wound care appropriate to injury.
4. Apply or furnish appropriate medications and/or immunizations.
5. Refer to appropriate support services which may include Rehabilitative services.
6. Develop appropriate follow-up care plan to maximize healing and rehabilitation.
 - a. Provide appropriate health education materials including, but not limited to, cast care and precautions, head trauma, suture care, and use of oral or topical medications.
 - b. Schedule follow-up appointments as appropriate.
7. Update problem list.

CROSS REFERENCE P&P:

1. *General Policy for the Nurse Practitioner or Certified Nurse Midwife – Standardized Procedure*
2. *Laboratory and Diagnostic Testing Policy for the Nurse Practitioner or Certified Nurse Midwife – Standardized Procedure*
3. *Minor Surgical Procedures Policy for the Nurse Practitioner or Certified Nurse Midwife – Standardized Procedure*

Approval	Date
Interdisciplinary Practice Committee	5/30/18
Medical Executive Committee	6/5/18
Board of Directors	
Last Board of Directors Review	

Developed:
 Reviewed:
 Revised: 05/2018 dp
 Supersedes:
 Index Listings:

**NORTHERN INYO HOSPITAL
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Title: Management of Minor Trauma Policy for the Nurse Practitioner or Certified Nurse Midwife – Standardized Procedure	
Scope: Nurse Practitioner, Certified Nurse Midwife	Manual:
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APPROVALS

Chairman, Interdisciplinary Practice Committee Date _____

Administrator Date _____

Chief of Staff Date _____

President, Board of Directors Date _____

**NORTHERN INYO HOSPITAL
POLICY AND PROCEDURE**

Title: Management of Minor Trauma Policy for the Nurse Practitioner or Certified Nurse Midwife – Standardized Procedure	
Scope: Nurse Practitioner, Certified Nurse Midwife	Manual:
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ATTACHMENT 1 – LIST OF AUTHORIZED NP’s or CNM’s

1. _____
NAME DATE
2. _____
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**NORTHERN INYO HOSPITAL
POLICY AND PROCEDURE**

Title: Well Child Care Policy for the Nurse Practitioner – Standardized Procedure	
Scope: Nurse Practitioner, Certified Nurse Midwife	Manual:
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PURPOSE:

This standardized procedure developed for the use by the Family Nurse Practitioner (FNP) or Pediatric Nurse Practitioner (PNP) is designed to establish guidelines that will allow the FNP or PNP to manage well child care.

POLICY:

1. This standardized procedure and those authorized to work through this standardized procedure will meet all guidelines as outlined in the *General Policy for the Outpatient Nurse Practitioner or Certified Nurse Midwife*.
2. This standardized procedure is designed to establish guidelines that will allow the PNP or FNP to perform health maintenance, health promotion and disease prevention activities which promote the physical, psychosocial and developmental well-being of children.
3. Circumstances:
 - a. Patient population: neonatal and pediatric patients
 - b. Settings:
 - i. Rural Health Clinic (RHC)
 - ii. Bishop Pediatrics and Allergy
 - c. Supervision: Physicians indicated in the supervisory agreements for the NP

PROTOCOL:

1. Data Base
 - a. Subjective
 - i. Obtain complete histories on all first time patients; interval histories on subsequent visits.
 - b. Objective
 - i. See schedule of well child care. Gather and review information as indicated on periodicity schedule.
2. Plan
 - a. Diagnosis
 - i. Well child
 - ii. Acute illness
 - iii. Current assessment of chronic illness
 - b. Therapeutic regimen
 - i. Diet as appropriate for age/nutritional status
 - ii. Medications
 1. Vitamins/mineral supplements
 2. Immunizations as indicated
 3. Medication as indicated for chronic or acute illness
 - iii. Activity/exercise as appropriate for age
 - iv. Health education and anticipatory guidance related to developmental level
 - v. Treatment of acute illness as indicated (see *Management of Acute Illness Standardized Procedure*).
 - c. Consultation/referral
 - i. Physician consult to be obtained under the following circumstances:

**NORTHERN INYO HOSPITAL
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Title: Well Child Care Policy for the Nurse Practitioner – Standardized Procedure	
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1. Unexplained history, physical or laboratory finding
2. Emergency conditions requiring prompt medical intervention
3. Upon request of patient/family
 - ii. Refer to specialist or other community resource as indicated.
- d. Follow-up
 - i. According to well child schedule or sooner as indicated
- e. Record keeping
 - i. Appropriate documentation to be maintained in patient’s chart.
 - ii. Allergic reaction to vaccine
3. Contraindications to immunization
 - a. Pertussis is contraindicated in child with evolving neurological disorder (consult with physician first).
 - b. Live virus vaccines contraindicated (consult with physician first):
 - i. Patient with disorder of immune system
 - ii. Household member of patient with disorder of immune system
 - iii. Patient who received immune globulin in last 3 months
 - iv. During pregnancy
 - v. PPD should not be administered for 3 months following MMR
4. Management of anaphylactic reactions to immunizations includes but not limited to:
 - a. Mild anaphylaxis involving skin (immediate):
 - i. Pruritus, flush, urticaria, angioedema
 - ii. Emergency treatment
 1. Maintain patient airway
 2. Benadryl IM in appropriate doses
 3. Administer [antihistamine, albuterol, steroids](#), 1:1000 (aqueous) Epinephrine SQ or ~~IM~~ [IM](#) 0.01 ml/kg. Repeat dose ~~q-15-20~~ [minutes as indicated. Monitor vital signs](#)
 4. Usual dose: infants 0.05-0.10 ml, children 0.10-0.30 ml
 5. Consult with physician.
 - b. Systemic – in addition to skin rash, rhinitis, redness, tearing of eyes, bronchospasm, laryngeal spasm, shock with cardiovascular collapse.
 - i. Treatment:
 1. Maintain patient airway, administer CPR if necessary.
 2. Administer Epinephrine as outlined above.
 3. Refer to M.D. Call 911
 4. Report adverse reaction to local health department/manufacturer of vaccine.

CROSS REFERENCE P&P:

1. *General Policy for the Nurse Practitioner or Certified Nurse Midwife – Standardized Procedure*
2. *Management of Acute Illness Policy for the Nurse Practitioner or Certified Nurse Midwife – Standardized Procedure*

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Scope: Nurse Practitioner, Certified Nurse Midwife	Manual:
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Approval	Date
Interdisciplinary Practice Committee	5/30/18
Medical Executive Committee	6/5/18
Board of Directors	
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**NORTHERN INYO HOSPITAL
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Source:	Effective Date:

APPROVALS

Chairman, Interdisciplinary Practice Committee Date _____

Administrator Date _____

Chief of Staff Date _____

President, Board of Directors Date _____

**NORTHERN INYO HOSPITAL
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Title: Well Child Care Policy for the Nurse Practitioner – Standardized Procedure	
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NORTHERN INYO HEALTHCARE DISTRICT MEDICAL STAFF
OFFICERS, SERVICE CHIEFS, AND COMMITTEES

July 1, 2018 – June 30, 2019

OFFICERS

CHIEF OF STAFF	Allison Robinson, M.D.
VICE CHIEF OF STAFF	William Timbers, M.D.
IMMEDIATE PAST CHIEF OF STAFF	Richard Meredick, M.D.

SERVICE CHIEFS

CHIEF OF EMERGENCY ROOM SERVICE	Sierra Bourne, M.D.
CHIEF OF MEDICINE/INTENSIVE CARE	Nickoline Hathaway, M.D.
CHIEF OF OBSTETRICS	Martha Kim, M.D.
CHIEF OF PEDIATRICS	Charlotte Helvie, M.D.
CHIEF OF RADIOLOGY	Edmund Pillsbury, M.D.
CHIEF OF SURGERY	L. Jeanine Arndal, M.D.

Member-at-Large, [Medical] Executive and Quality Improvement Committees: Joy Engblade MD

Rural Health Clinic Critical Indicators

2018

1. Transfer to NIH for emergency care.
2. All admissions of RHC patients.
3. All deaths of RHC patients.
4. Documented specific procedure complication, such as:
 - a. Hemorrhage
 - b. Poor healing
 - c. Impairment of body function to a level less than that prior to the procedure and less than commonly expected as a result of the procedure
5. Cardiac or respiratory arrest.
6. Consultation with the physician in the following circumstance:
 - a. Emergent conditions requiring prompt medical intervention after the stabilization has been initiated
 - b. Any injury threatening life or limb
 - c. Any laceration requiring complicated suture close
 - d. Any fracture or injury requiring immobilization by full casting
 - e. Complicated or extensive burns
7. Upon request of the patient/family, provider staff, nursing or ancillary RHC staff, or Medical Staff member.

Approvals:

Medicine/Intensive Care Service Committee: 4/26/18

Medical Executive Committee: 6/5/18

Board of Directors: