

# February 20 2019 Regular Meeting

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# **AGENDA**

## **NORTHERN INYO HEALTHCARE DISTRICT BOARD OF DIRECTORS REGULAR MEETING**

**February 20, 2019 at 5:30 p.m.  
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. Chief of Staff Report; Allison Robinson MD:
  - A. Policy and Procedure approvals (*action items*):
    1. *Bone Graft Tissue Bank*
    2. *Preoperative Interview*
    3. *Scheduling of Nursing Personnel*
  - B. Annual Reviews (*action items*):
    1. *Plan to Eliminate or Substantially Reduce Medication-Related Errors 2018-2019*
    2. Critical Indicators 2019
      - i. *Emergency Department Critical Indicators*
      - ii. *Surgical Critical Indicators*
      - iii. *Anesthesia Critical Indicators*
      - iv. *Neonatal Critical Indicators*
      - v. *Pediatric Critical Indicators*
      - vi. *Perinatal Critical Indicators*
      - vii. *ICU Critical Indicators*
      - viii. *Medical Services Critical Indicators*
      - ix. *RHC Critical Indicators*
3. Standardized Procedures for the Nurse Practitioner or Certified Nurse Midwife
  - i. *General Policy for the Nurse Practitioner or Certified Nurse Midwife*
  - ii. *Certified Nurse Midwife and Certified Nurse Midwife First Assistant*
  - iii. *Adult Health Maintenance*

- iv. *Emergency Care Policy*
- v. *Furnishing Medications/Devices Policy*
- vi. *Laboratory & Diagnostic Testing*
- vii. *Management of Acute Illness*
- viii. *Management of Chronic Illness*
- ix. *Management of Minor Trauma*
- x. *Minor Surgical Procedure*
- xi. *Well Child Care*

4. Standardized Protocols for the Physician Assistant

- i. *General Policy for the Physician Assistant*
- ii. *Medical Screening Examination for the Emergency Department Physician Assistant*
- iii. *Physician Assistant in the Operating Room*
- iv. *Adult Health Maintenance*
- v. *Emergency Care Policy*
- vi. *Laboratory and Diagnostic Testing*
- vii. *Management of Acute Illness*
- viii. *Management of Chronic Illness*
- ix. *Management of Minor Trauma*
- x. *Medication/Device Policy*
- xi. *Minor Surgical Policy*
- xii. *Well Child Care Policy*

C. Proposal for Expanded Chief of Staff position (*action item*).

4. New Business

A. Strategic Plan update, Quality and Performance Committee report (*information item*).

B. NIHD Rural Health Clinic report (*information item*).

C. Quarterly Compliance Department report (*action item*).

D. Policy and Procedure approval, *Authorization of Hours Worked Beyond Regularly Scheduled Shift (Including Overtime Request)* (*action item*).

E. Policy and Procedure approval, *Guidelines for Licensed Nurses Nursing Students Giving Medications* (*action item*).

F. Policy and Procedure approval, *Thrombolytic Therapy for Acute Myocardial Infarction*

*(action item).*

- G. Policy and Procedure approval, *Charge Capture Policy (action item).*
- H. Board Discussion, response to emails and letters *(information item).*
- I. Strategic Plan status report and next steps *(information item).*
- J. Phase II response to budget *(information item).*
- K. Bridge Grant award *(information item).*
- L. Office space moves *(information item).*

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***Consent Agenda***

- 5. Approval of minutes of the January 16 2019 regular meeting
- 6. Approval of minutes of the February 6 special meeting
- 7. Policy and Procedure annual approvals

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- 8. Reports from Board members *(information items).*
  - 9. Adjournment to closed session to/for:
    - A. Confer with Legal Counsel regarding potential litigation, 1 matter pending  
*(pursuant to Government Code Section 54956.9(d)(2)).*
  - 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.*



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

Medical Staff Office  
(760) 873-2136 voice  
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TO: NIHD Board of Directors  
FROM: Allison Robinson, MD, Chief of Medical Staff  
DATE: February 5, 2019  
RE: Medical Executive Committee Report

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

A. Policies and Procedures (*action items*)

1. *Bone Graft Tissue Bank*
2. *Preoperative Interview*
3. *Scheduling of Nursing Personnel*

B. Annual Reviews (*action items*)

1. *Plan to Eliminate or Substantially Reduce Medication-Related Errors 2018-2019*
2. Critical Indicators 2019
  - i. Emergency Department Critical Indicators
  - ii. Surgical Critical Indicators
  - iii. Anesthesia Critical Indicators
  - iv. Neonatal Critical Indicators
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  - i. General Policy for the Nurse Practitioner or Certified Nurse Midwife
  - ii. Certified Nurse Midwife and Certified Nurse Midwife First Assistant
  - iii. Adult Health Maintenance
  - iv. Emergency Care Policy
  - v. Furnishing Medications/Devices Policy
  - vi. Laboratory & Diagnostic Testing
  - vii. Management of Acute Illness
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  - x. Minor Surgical Procedure
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4. Standardized Protocols for the Physician Assistant
  - i. General Policy for the Physician Assistant

- ii. Medical Screening Examination for the Emergency Department Physician Assistant
- iii. Physician Assistant in the Operating Room
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    - x. Medication/Device Policy
    - xi. Minor Surgical Policy
  - xii. Well Child Care Policy

C. Proposal for Expanded Chief of Staff position (*action item*)

**NORTHERN INYO HOSPITAL  
POLICY AND PROCEDURE**

Title: Bone Graft Tissue Bank*	
Scope: Surgery, Materials Management	Manual: Invasive Procedures, Preparation and Post Op (OOP), Surgery, Surgery - Operative
Source: DON Perioperative Services	Effective Date: 11/16/2005

**PURPOSE:**

To ensure safe receipt, storage and preparation of freeze-dried and fresh-frozen human tissue or bone allograft for patient use.

**POLICY:**

1. All Tissue stored in this Tissue Bank will be purchased from a Tissue Bank Licensed in the State of California and a record of their donor screening and testing will be maintained.
2. The Perioperative Director of Nurses will be responsible for the tissue bank.
3. Freeze Dried Bone/Tissue Grafts will be stored in a designated area and maintained at ambient temperature of 15 degrees Celsius to 30 degrees Celsius, but not frozen. Temperature will be monitored and recorded daily.
4. Fresh Frozen Tissue Grafts shall be maintained in a designated bone freezer at -40 degrees Celsius to -86 degrees Celsius for long term storage; and between - 20 degrees to - 40 degrees Celsius for short term storage (fewer than six months) **except skin grafts which must be kept at -40° Celsius or colder even for short term storage.**
5. Refrigerated grafts (Graft Jacket) will be maintained in designated refrigerator at 1degree to 10 degrees Celsius or 34 degrees to 50 degrees Fahrenheit per manufacturer information.
6. Refrigerator and Freezer units will be monitored and daily temperature checks recorded have annual calibration checks and have an alarm system that is continuously monitored and sounds when the temperature is not within the acceptable range. Freezer will be maintained on an emergency power system.
7. In case of a malfunction in the Freezer when the perioperative unit is closed, the nursing supervisor will receive a text message and they will notify the Biomedical Engineer on call and perioperative management personnel or Nurse on call. The integrity of the tissue will be evaluated and if necessary the tissue will be stored on dry ice or in the laboratory blood bank freezer until the problem is resolved.
8. Malfunction of refrigerator or freezer will be documented and tissue monitored to prevent compromise.
9. If malfunction of freezer and Tissue/Bone needs to be relocated to another freezer or stored temporarily:
  - Notify the laboratory for the need to add the frozen tissue/bone to their sub zero freezer.
  - Frozen Tissue/Bone may be transported in an ice chest with enough dry ice to touch the grafts on all four sides.
  - Use appropriate gloves suitable to keep from damaging your hands when handling the frozen tissue.
  - The tissue/bone in the ice chest will be transported to the laboratory for storage until the problem with the surgery tissue/bone freezer has been repaired and has met the appropriate temperature to maintain the integrity of the tissue/bone.
  - The tissue/bone will be transported back in an ice chest with enough dry ice to touch the tissue/bone on all four sides.
  - Tisseel (frozen pre-filled syringes) may also be transported in an ice chest with enough dry ice to maintain their integrity as noted above.
10. If tissue needs to be quarantined, affected tissue will be maintained in a colored plastic bag and segregated from all other tissue.
11. Restricted access to Tissue Banks is required to verify the safety and security of tissues.
12. All tissue will be entered into Tissue Log Book with appropriate information upon arrival (see procedure below).
13. Thawing and graft preparation will be done in accordance with package instructions and physician order.

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14. The Tissue/Bone Bank Log will be reviewed weekly for accuracy by designated personnel.
15. Perioperative staff responsible for receiving, removing, or logging any of the bone/tissue must have completed training and validation for the Bone / Tissue Bank.
16. There will be a tracer audit completed annually to ensure compliance with policy and procedure, noting any changes needed to meet 100% compliance.

**PROCEDURE:**

**Weekly Bone/Tissue Bank Maintenance Check by assigned personnel**

**Tissue/Bone Freezer**

- Freezer is secure and lock is in place
- Temperature is maintained at least -40 degrees Celsius
- Vent Filter is clean and free from lint  
(if needed rinse, pat dry with towel, air dry and replace)
- Daily temperature log is completed and graft is functioning properly

**Freeze Dried Tissue Bank (stainless cart)**

- Bank is secure and doors are closed
- Temperature is maintained at ambient temperature 15 degrees Celsius to 30 degrees Celsius
- Temperature chart is functioning properly and is documenting temperature of cart
- Cart is clean and free from clutter

**Tissue/Bone Bank Log:**

- Review log for accurate and complete documentation

**Log In**

- Date received
- Time received
- Tissue Bank
- Donor ID number
- Appropriate Log for Tissue/Bone type
- Expiration date
- Integrity "Met"
- Temperature
- Initials

**Log Out**

- Storage temperature
- Disposition of tissue/graft
- Date of disposition
- Patient hospital number
- Surgeon
- Implant record returned
- Reconstitution fluids and expiration date

**NORTHERN INYO HOSPITAL  
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- Initials of person who completed the documentation

If documentation is incomplete or not accurate notify Perioperative Nursing Coordinator and person responsible for correction/completion.

**Fresh Frozen Tissue Graft – Receipt and Storage:**

1. At the time of scheduling a case, the Operating Room Clerk, shall notify the Surgical Nurse Coordinator or her designee of the need for a bone allograft. The Operating Room Clerk makes a note in the “notes” or “tasks” section in Operating Room Management Scheduling procedure notes. This information will print out on the surgery schedule alerting personnel of the need for an allograft. The need for an allograft also is printed out in the “notes”/”tasks” section on the physician case card for the procedure which is printed out the day prior to the surgical procedure. The Surgical Nurse Coordinator or her designee will ensure that the appropriate graft is in the inventory and available for use on designated day.
2. The designated freezer will contain a minimal consignment of fresh frozen bone. If desired graft is not stored in this freezer, the tissue bank will be called at least two days prior to the scheduled surgery to confirm proper shipment date and time. The allograft will be scheduled to arrive in time to perform the surgical procedure.
3. The bone graft shall be ordered from and the delivery scheduled with the tissue bank of choice. Fresh Frozen Grafts shall be shipped by Overnight Carrier.
4. Purchasing shall be notified of the expected arrival time and shall be given instructions to immediately deliver the package to Surgery due to the strict temperature requirements.
5. Storage requirements: Refer to Manufacturer requirements.
  - a. Freeze dried ambient temperature 15 degrees Celsius to 30 degrees Celsius.
  - b. Fresh Frozen -40 degrees Celsius to -86 degrees Celsius (laboratory/surgery sub zero freezer)
  - c. Shoulder graft 36 degrees to 50 degrees Fahrenheit (2.2 degrees Celsius to 10 degrees Celsius) to be stored in the designated refrigerator in the perioperative unit.

**Fresh Frozen Tissue Graft – Preparation:**

**Remove desired graft from freezer immediately prior to use as requested by surgeon:**

- **Always refer to graft information included with graft prior to preparation.**

1. Remove the outer clear plastic pouch. This may performed by using scissors and cutting along any border seam of the outer pouch. Use caution to avoid cutting the peel pouch. **Once the outer pouch has been compromised, the allograft shall be transplanted or discarded.**
2. Utilizing sterile technique, open peel pouch and pass sterile inner plastic pouch onto the sterile field.
3. With sterile scissors, open inner sterile plastic pouch and place contents into a sterile basin with thawing solution. **Thaw grafts quickly in warm solution 37 to 40 degrees Celsius (98.6 to 104 degrees Fahrenheit) containing antibiotics if the surgeon’s preference. (DCI’S recommends culturing of the allograft at this time, immediately prior to implantation).**

- **Allow at least 30 minutes for the graft to fully thaw. Once thawed, all frozen allografts must be used immediately or discarded. Thawed allografts may not be returned to DCI or the Tissue/Bone Freezer.**

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- **DCI'S grafts are processed using some or all of the following agents; Bacitracin, Polymyxin B Sulfate, Allowash, Alcohol, or Hydrogen Peroxide. Although the tissue was rinsed with sterile water or sterile saline throughout the processing procedure, traces of the medication and chemicals may remain.**

**FREEZE DRIED TISSUE/BONE ALLOGRAFT:**

Freeze dried bone/tissue graft will be reconstituted if necessary per **bone bank instruction specific for each type of tissue/bone graft. (See literature supplied with each type of tissue/bone graft).**

**DCI'S Bone Bank Rehydration:**

1. Remove the clear plastic, tamper resistant seal or aluminum tear ring. Once seal has been broken the tissue shall be either transplanted or discarded.
2. Utilizing sterile techniques, twist open and remove the screw cap, or remove the protective disk from the bottle.
3. Prepare the top surface of the stopper with alcohol or other germicidal agent and allow to dry.
4. Using a sterile syringe and needle, inject a sufficient quantity of the normal physiologic solution to cover the allograft.
5. Allow the allograft adequate time to fully rehydrate prior to use. **Generally, morsellized allografts and soft tissue allografts require 30 minutes for complete rehydration. Cortical bone and allografts that require further shaping and/or drilling should be rehydrated for a minimum of 4 hours.** Once rehydrated, allografts must be used immediately or discarded. **Rehydrated allografts may not be returned to DCI.**
6. At the time of surgery, aseptically complete vacuum release from bottle and remove sterile stopper.
7. Transfer the contents to a sterile back table. The graft may be rehydrated on the back table in a sterile basin by transferring the graft in the dehydrated state using sterile technique.
8. DCI'S recommends culturing of allograft at this time, immediately prior to transplant.

**ALLO SOURCE Graft Preparation:**

- **Always refer to graft information included with graft prior to preparation.**

1. To reconstitute cancellous products, crushed bone, ground bone, place graft in sterile basin and cover with sterile isotonic solution for a minimum of 30 minutes.
2. To reconstitute tricortical wedges, struts, cortical products, place graft in a sterile basin and cover with sterile isotonic solution for a minimum of 2 hours.
3. **Refer to manufacture literature for further information.**

**MTF (Musculoskeletal Transplant Foundation) Graft Preparation:**

- **Always refer to graft information included with graft prior to preparation.**

The decision to rehydrate MTF freeze-dried bone prior to transplantation should be based upon the surgeon's preference. Bone chips, powders and granules do not need to be rehydrated prior to use. For tissues that are to be cut, shaped, drilled or used for weight bearing purposes, excessive forces should not be applied to the lyophilized bone during manipulation or upon implantation. For ease of handling, it is recommended that freeze-dried soft tissue (tendon and ligaments) be rehydrated prior to use.

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Scope: Surgery, Materials Management	Manual: Invasive Procedures, Preparation and Post Op (OOP), Surgery, Surgery - Operative
Source: DON Perioperative Services	Effective Date: 11/16/2005

1. Allograft tissue should be maintained in an aseptic environment at all times to prevent the possibility of contamination.
2. It is common surgical practice to rehydrate freeze-dried tissue in an acceptable sterile irrigant such as normal saline or lactated ringer's solution. Antibiotics may be used with the irrigant according to the surgeon preference.
3. Patient sensitivity to the antibiotics used to rehydrate allograft tissues should be checked prior to use. Concentration of antibiotic solutions should be less than normally indicated for IV administration.
4. Use new solutions for **each allograft**.
5. Sufficient solution should be prepared to completely cover the tissue.
6. Tissue that is rehydrated for more than two hours should be stored at 4 degrees Celsius to 8 degrees Celsius (39.2 Fahrenheit to 46.4 Fahrenheit).
7. Tissues should be implanted or discarded within 24 hours of opening the final tissue container provided the allograft tissue is maintained in an aseptic environment.

**DOCUMENTATION:**

1. Record the following information in patient's medical records:
  - a. The date and time of thawing.
  - b. Product description including the sticker provided by manufacturer.
  - c. Expiration date of tissue.
  - d. Unique identification number noted on graft packaging.
  - e. Time of implantation.
  - f. Cutting or shaping performed on graft.
  - g. Solution type and lot number for reconstitution of graft.
  - h. Use of antibiotics and their concentration.
  - i. Culture of graft if ordered by surgeon.
  - j. Any other relevant information.
  - k. Signature of the person recording the information.
2. Records must be retained for minimum of 10 years
3. Daily temperature chart must be kept for 10 years

**LOGGING IN TISSUE:**

**Integrity of packaging is "Met" by the following criteria:**

- The package is visually inspected for any signs of damage.
- The package is intact with no signs of damage or tears.
- The package is clean and free from debris.
- The freeze dried package has maintained its temperature during transport.
- The frozen tissue/bone was maintained with enough dry ice to support the desired temperature of -40 degrees Celsius during transport.

All Tissue/Bone Graft material will be logged in upon arrival and monitored for:

1. Make sure the tissue is logged on appropriate form for the tissue type

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Source: DON Perioperative Services	Effective Date: 11/16/2005

2. Date of arrival
3. Time of arrival
4. Tissue Bank Name
5. Identification number (donor ID number)
6. Expiration date
7. Packaging integrity “Met” upon arrival
8. Temperature
9. Initials of person logging in graft

**LOGGING OUT TISSUE/BONE:**

1. Temperature
2. Disposition of graft
  - Implanted
  - Disposed of and how – Tissue bank must be notified of disposition of bone/tissue even if disposed of due to expiration or contamination
  - Returned to Company
3. Date
4. Patient hospital number
5. Surgeon
6. Implant record returned
7. Reconstitution solutions
8. Initial of the person signing out the graft

**REFERENCES:**

1. TJC: TS.03.01.01, TS.03.02.01, TS.03.03.01 CACAH Functional Chapter: Transplant Safety
2. AATB (American Association of Tissue Banks) Standard E3.331 (Storage Conditions for Commonly Transported Human Tissue)

<b>Approval</b>	<b>Date</b>
CCOC	1/28/19
Surgery-Tissue Committee	1/23/19
Medical Executive Committee	2/5/19
Board of Directors	
Last Board of Director review	1/16/19

Revised: 3-07-09, 04-2015BS, 12-2018aw  
 Reviewed 2-14-11  
 Supersedes 02/01  
 Index Listings: Bone Graft Tissue Bank, Tissue Bank

**NORTHERN INYO HOSPITAL  
POLICY AND PROCEDURE**

Title: Preoperative Interview	
Scope: OP/PACU	Manual: Anesthesia, PACU, Surgery
Source: DON Perioperative Services	Effective Date: 10/97

**PURPOSE:**

The preoperative interview, ideally conducted in the week before surgery, facilitates communication between the patient and the perioperative staff. Preoperative teaching helps reduce patient anxiety and increases patient cooperation.

Information from this interview may be used to plan nursing care thus improving and individualizing patient care. Problems that require a physician decision can be addressed beforehand facilitating a smoother perioperative experience.

**POLICY:**

Patients will be interviewed by a perioperative nurse on a weekday prior to surgery, no later than the day before the surgery. Interviews not completed in person should be completed the day before surgery by phone. The information is documented in the patient's medical record.

- I. The perioperative RN will check the OR schedule noting the date / time and type of surgery, the surgeon, type of anesthesia (procedural sedation, MAC, general). Prior to starting the interview the RN should check the patient's chart: the surgeon's orders should be reviewed. The consent should be verified and any other special orders should be noted. The RN should review the chart to ensure lab work and other preoperative testing (EKG, Diagnostic Imaging) has been completed and the values are within normal ranges. If the patient has come to the hospital for preoperative testing or the interview, the perioperative RN will meet with the patient in a private area to conduct the preoperative interview. Most preoperative interviews are conducted over the phone. Unless done before; the perioperative RN will initiate the phone call in the late morning or early afternoon the day prior to the surgery.
- II. The nurse should allow adequate time for the interview (10-20 minutes unless the patient has complex needs) to assess the patient's physical and emotional status. The RN will complete the preoperative sections in the electronic health record. The RN will answer the patient's questions throughout the interview and at the end of the interview the nurse will ask the patient if he/she has any questions. A completed Anesthesia History is helpful for the nurse to review at the time of the interview. These are given to the patient by the staff at the surgeons' office and the patient should have received instructions to complete it, have it ready to use at the time of the preoperative interview, and to bring it in to the hospital the day of surgery where a copy can be scanned into the electronic health record.
  - A. **Assessment:** The preoperative assessment should be completed electronically. This includes screening for allergies, chronic medical conditions, history of infectious diseases, previous surgeries/hospitalizations and current medications and a psycho/social history. If the Anesthesia History is available, it can be used during the interview. If the computerized electronic health record is not available for some reason, a paper version of the preoperative interview /assessment will be used. The first page and 2/3 of the second page of the Preoperative Interview should be completed.
  - B. **Patient Teaching:** This is documented in the Pre-procedure Assessment. The nurse will begin and / or reinforce preoperative teaching and answer other questions as needed.

**Medications to take in the AM:** Following the "Preoperative Medications Guideline" policy / procedure, the nurse will direct the patient in the decision of which medications should be taken the morning of surgery

## NORTHERN INYO HOSPITAL POLICY AND PROCEDURE

Title: Preoperative Interview	
Scope: OP/PACU	Manual: Anesthesia, PACU, Surgery
Source: DON Perioperative Services	Effective Date: 10/97

with a sip of water. If there are any questions about the patient's medications, the anesthesia provider should be contacted for advice.

**Admit time:** Inform the patient of the appropriate arrival time for the day of the surgery. A first case (0730) should be told to arrive at the Admissions Desk at 0600. The patient should be told that the front Admissions Desk does not open until 0600, so arriving earlier than 0600 is not advised. The patients that are scheduled as "To Follow" will be given appropriate arrival times (0700 or later) depending on the length of the case(s) preceding the surgery.

**NPO:** Adults are asked to remain NPO before surgery per the NPO recommendations below. Water, Gatorade, Crystal Light, and/or bowel prep are ok up to 2 hours prior to the surgery start time if so advised by the surgeon.

Children three years and older and under should be instructed per the "NPO Guidelines".

NPO Recommendations:

Patient's Age	Number of hours since solid food / milk / breast milk	Number of hours since clear liquids
< 6 months	4	2
6 – 36 months	6	2
> 36 months – adult	6 – 8	2

The only exception to the NPO guideline is medications specifically ordered by the surgeon or anesthesia provider (or the medication the patient is advised to take following the "Preoperative Medication Guideline" policy/procedure. Patients should be encouraged not to smoke, chew tobacco, or chew gum prior to surgery.

**Preoperative/Surgery Environment:** The nurse will describe the preoperative unit, Surgery, and PACU environments, and describe briefly the steps taken in the preparation for surgery (changing into a gown, height/ weight, vital signs, IV, clipper prep /scrub, etc.).

The nurse should emphasize several points: Clothing-It is best to wear loose comfortable clothing that will be wide enough over the operative area to allow for a dressing. Valuables: It is best to leave all money and jewelry at home including watches. Make-up: It is suggested that no make-up be worn. Nail polish should be removed from the index finger and thumb of both hands, and from the entire hand or foot of any limb involved in the surgery. Equipment: The nurse will review any special equipment the patient might need (braces, crutches, TED hose, etc.) and encourage the patient to bring appropriate equipment he/she may already have to the hospital the morning before surgery. The patient must bring their CPAP machine to the hospital if one is used by the patient at home.

**Discharge RX:** Check with the patient for preferred pharmacy. This allows the PACU nurse to arrange for discharge medications to be dispensed as soon as possible following discharge.

**Transportation:** The patient must be informed that he/she will need to be taken home by a responsible adult if any anesthetic (general, spinal, epidural) or IV sedation has been administered. If the person providing the ride is not at the hospital, the patient must provide the phone number for the person providing transportation home. A responsible adult should be with the patient overnight following any surgery for which the patient has received a general anesthesia.

**NORTHERN INYO HOSPITAL  
POLICY AND PROCEDURE**

Title: Preoperative Interview	
Scope: OP/PACU	Manual: Anesthesia, PACU, Surgery
Source: DON Perioperative Services	Effective Date: 10/97

C. Nursing Care Plan: The interviewing nurse should complete an electronic plan of care for each patient.

**Pediatric patients:** A pediatric assessment form will be used for children age 13 and under. The parents (or legal guardians) usually serve as the source of information for the preoperative interview however if the interview is done in person, the pediatric patient should be included in the interview process. Parents are a source of information for preoperative interviews and should be included.

There are coloring books available to be given to the pediatric patients; these contain illustrations of a same-day-surgery that can be given to the pediatric patients. It may alleviate anxiety to have the parents and child come into the preoperative area to see the area and some of the equipment (such as a gurney, an anesthesia mask, BP cuff, SPO2 probe, the patient monitor, thermometer, etc.), Check with the patient’s parents; a brief tour along with explanations of the equipment use and the procedure for getting a patient ready for surgery may be helpful.

**Adolescent patients:** It may be beneficial to conduct the preoperative interview without having the parents present due to the nature of some of the assessment questions.

Parents/guardians of any pediatric or adolescent patient should be encouraged to stay in the hospital for the duration of the child’s perioperative experience.

**Geriatric patients:** Some information should be written down for these patients if it appears that remembering details is problematic i.e. arrival time, and medications that should be taken with a sip of water at home preoperatively.

**REFERENCES:**

1. TJC Standards PC 02.03.01, PC 03.01.03, CA Code of Regulations, Title 22 Standard 70215 (c), (d)
2. ASPAN 2012-2014 Perianesthesia Nursing Standards, Practice Recommendations, and Interpretive Statements: Standard VI: Nursing Process

**CROSS REFERENCE P&P:**

1. NPO Guidelines
2. Preoperative Preparation and Teaching
3. Preoperative Medication Guidelines
4. Preoperative Instruction Sheet (as an attachment to this policy).

<b>Approval</b>	<b>Date</b>
CCOC	1/28/19
STTA	<u>1/23/19</u>
MEC	2/5/19
Board of Directors	5/16/18
Last Board of Directors Review	1/18/17

Developed:  
Reviewed:

**NORTHERN INYO HOSPITAL  
POLICY AND PROCEDURE**

Title: Preoperative Interview	
Scope: OP/PACU	Manual: Anesthesia, PACU, Surgery
Source: DON Perioperative Services	Effective Date: 10/97

Revised: 9/97, 2/1/01, 9/08, 05/11AW, 7/11 AW, 9/12AW, 1/2018aw, 1/2019aw

Supersedes:

Index Listings: Preoperative Interview; Interview, Preoperative

Draft

**NORTHERN INYO HOSPITAL  
POLICY AND PROCEDURE**

Title: Scheduling of Nursing Personnel	
Scope: Nursing Services	Manual: 3. NAM - Utilization of Nursing Staff and Staffing Budget
Source: Chief Nursing Officer	Effective Date:

**PURPOSE:**

1. The Nursing Services ~~DON's and Staffing Coordinator~~ **Directors, Managers and Assistant Nurse Managers (ANM)** will use long range planning to determine the staffing needs of each department, and to strive to meet those needs through the utilization and allocation of supplemental personnel.
2. Long range planning assures that each department and shift has adequate personnel to meet the patient care requirements.
3. To provide staffing patterns for all staff that address appropriate coverage for the care required to each patient assigned.

**POLICY:**

1. As part of the Master Staffing Plan, a general Master Schedule is developed for each department based on the budgeted mean census (defined as average census over the previous 12 months). **Attention to fluctuations in census on each unit will be taken into consideration in the development of the Master Staffing Plans.**
2. A coverage staffing plan will also be maintained to provide coverage for benefit hour usage and high mode census (defined as the most commonly occurring census above the mean over the previous 12 months.)
3. Staff will be hired for a specific position in a department that correlates with a position control number. The position control is derived from the master Schedule.
4. Full and part time staff is hired with no restrictions for scheduling purposes. Staff may be occasionally asked to rotate shifts based on a department need, **unless precluded by contract**
5. Staff who change positions to another department, status, classification or shift, will automatically assume the weekend obligation of the new position. ~~Refer to Weekend Shift policy and procedure.~~
6. The staffing schedule will cover a six week period and is equivalent to three pay periods, **except in the perioperative department where a 4 week schedule will be utilized.** The staffing week begins on Sunday for days and Saturday for ~~-PM shift.~~ **Three months of posted approved six week schedules will be available for staff direction. Six weeks of non approved schedule will be available for staff to request schedule changes. The schedule will be posted 2 weeks prior to the start of the schedule. Staff will be expected to have requests for time off into the scheduling software 6 weeks prior to the start of the schedule to allow for every opportunity to approve the request.**
7. The department Director, Manager or Assistant Nurse Manager ~~and /or Staffing Coordinator~~ is responsible for developing the ~~six weeks non approved schedule.~~ **of staff for the department at least 12 weeks in advance of the schedule being approved.**
8. Order of time off request received and longevity of employee within the department are considered when granting Paid Time Off (PTO). All staff has an obligation to work their weekend shifts ~~as determined by week end plan hired.~~ **Request for time off may only be approved when the employee has the time accrued in PTO at the time of the request.**
9. Working schedules are maintained in the scheduling software program.
  - a. Approval for requested time off will be done within the scheduling software by the Director, Manager or ANM.
  - b. PTO will be granted based on the NIH PTO Policy.

**PROCEDURE:**

1. Department specific staffing patterns (Master Schedules) will be developed at the department level by the department DON with approval by the CNO based on the hours of nursing care and average daily census.
2. As soon as the staff member is aware of time needed off, a request for time off is completed within the scheduling software.
  - a. Approval or denial of request occurs within the software program by Director, Manager or ANM. **within 15 days of the employee request.**

**NORTHERN INYO HOSPITAL  
POLICY AND PROCEDURE**

Title: Scheduling of Nursing Personnel	
Scope: Nursing Services	Manual: 3. NAM - Utilization of Nursing Staff and Staffing Budget
Source: Chief Nursing Officer	Effective Date:

- b. Set schedules are not guaranteed, however every attempt will be made to provide schedules that benefit the team.
- 4. Once the Schedule becomes approved, minimal schedule changes will be expected. If a staff member needs time off, they will be required to find coverage except for times of illness or emergency.
- 5. The six week Working Schedule is basically set. If any employee needs time off, the employee is expected to find coverage.
  - a. Coverage (trading of shifts) must be approved by the Director, Manager or ANM. In their absence, the House Supervisor may approve the trade.
- 6. Any time an employee has an emergent staffing situation; the employee is to go through the DON of their department.

**References:**

**Cross Reference P&P:**

- 1. Staffing Management Plan
- 2. Routine Hours of Work
- 3. Weekend Shifts
- 4. Nursing PRN Per Diem Staff

<b>Committee Approval</b>	<b>Date</b>
<b>SIAC</b>	<b>10/14</b>
<b>NEC</b>	<b>12/5/18</b>
<b>MEC</b>	<b>2/5/19</b>
<b>Board of Directors</b>	
<b><u>Board of Directors Last Review</u></b>	

**Developed: 8/14**  
**Reviewed: 6/18ta**  
**Revised:**

## Northern Inyo Healthcare District

# Plan to Eliminate or Substantially Reduce Medication-Related Errors 2018-2019

### Introduction

Northern Inyo Healthcare District (NIHD) operates a Critical Access 25-bed general acute care hospital located in Bishop, California. Northern Inyo Healthcare District serves a rural population of approximately 18,000 residents of Inyo County, 10,000 square miles in area, located between the eastern slopes of the Sierra Nevada and the Nevada/California border.

For purposes of this plan, and in accordance with California Health and Safety Code 1339.63, a "medication-related error" means any preventable medication-related event that adversely affects a patient at Northern Inyo Hospital, and that is related to professional practice, or health care products, procedures, and systems, including, but not limited to, prescribing, prescription order communications, product labeling, packaging and nomenclature, compounding, dispensing, distribution, administration, education, monitoring, and use.

### Multi-disciplinary Process

The Pharmacy and Therapeutics Committee (P&T) is responsible for implementation of the Northern Inyo Healthcare District Medication Error Reduction Plan (MERP). The Pharmacy & Therapeutics Committee is a multi-disciplinary Medical Staff committee.

The Medical Staff Bylaws of 2/15/2017 establish the following:

*The committee is composed of at least two active Medical Staff members, the Pharmacy Director, and the Director of Nursing (Chief Nursing Officer) or other nurse designee. Ex Officio members serving without vote include: Administrator, or the Administrator's designee and the Quality Improvement Coordinator.*

*The committee meets at least once each quarter. The committee is "responsible for development of all drug utilization policies and surveillance of all drug utilization practices within the Hospital, in a reasonable effort to assure optimum clinical results and minimal potential for hazard, subject to such approval by the District Board, the Administrator, and the Executive Committee [of the Medical Staff]."*

*The committee is accountable to the Executive Committee of the Medical Staff.*

The Medication Administration Improvement Committee (MAIC), consisting of members of Nursing Administration, Pharmacy, Medical Staff, and Ancillary services

was established in 2002 and revised in its composition in 2013. MAIC is a subcommittee of the P&T Committee. MAIC reviews all medication errors or near misses to determine cause and develop strategies for future prevention when needed. Policies and Procedures related to medication administration are reviewed in P&T Committee with input from MAIC team. MAIC findings are reported to P&T along with the indicators and any patterns found. MAIC meets monthly to complete concurrent and retrospective evaluations of medication errors and occurrences.

The Pharmacy and Therapeutics Committee with the help of the MAIC will evaluate, assess, and address each of the following:

Prescribing  
Prescription order communications  
Product labeling  
Packaging and nomenclature  
Compounding  
Dispensing  
Distribution  
Administration  
Education  
Monitoring  
Use

External Medication related error alerts will be made accessible to NIHD Staff:

1. ISMP Safety Alert newsletters will be distributed to Nurses and Pharmacists at NIHD via email.
2. Quarterly Action Agenda relative to ISMP alerts are reviewed at P&T committee. Actions are taken at the direction of the committee.

Annual Review of MERP:

The effectiveness of each of the systems within the MERP will be evaluated and reviewed at the P&T committee annually. The plan will be modified as warranted when weaknesses or deficiencies are identified. At NIHD the MERP will be approved annually by the P&T Committee.

Technology used at NIHD in the reduction or elimination of medication errors includes:

Our Electronic Health Record (EHR) provides for automated allergy checking, automated dose checking, automated interaction checking, barcode medication administration and computerized physician order entry. The EHR provides a medication administration record that highlights due and overdue medications. The EHR has medication reconciliation modules for admission, transfer and discharge.

NIHD will be purchasing a new IV pump system in 2019. The decision of which pump to be purchased will be made in an interdisciplinary committee consisting of Nursing, Informatics, Pharmacy, Purchasing, Biomedical engineering, and Information technology services. These pumps will have smart technology, including a drug library that contains safe upper and lower limits, and concentrations of the IV medications on our formulary. This drug library will be owned by pharmacy and reviewed annually in P&T.

The specific planned areas of assessment and improvement for 2018-2019 are:

**Prescribing:**

1. Medication Order sets will be evaluated annually by P&T committee.
2. Antibiotic Stewardship Program (ASP) metrics will be collected and reported to P&T. Pharmacy will actively participate in this process.
3. The Joint commission standards for safe opiate prescribing are being implemented via the Pain project team, an interdisciplinary committee consisting of Nursing, Physicians, Informatics, Social services, Medical staff services, District education, and Pharmacy.

**Prescription Order Communication:**

Verbal order policy is in place with an emphasis on reducing verbal orders except during emergencies or when physician is in a sterile procedure. Optimization and prioritization of provider workflows for CPOE are an ongoing focus. This was done to decrease potential communication errors. NIHD is currently partnering with EHR vendor to make changes necessary for improved prescription order communication.

**Product Labeling:**

Review barcode scanning reports for barcodes that are not scanned and update barcodes. Barcode reports will be reviewed monthly by pharmacy; necessary updates will be done as appropriate. Barcoding statistics from the legacy system are inherently different than the statistics in our current EHR. New system implementation date was 10-1-18. We will compile statistics from our new baseline of 10-1-18 and follow trends for improvement.

We have added Codonics™ printers to the surgery department for the safe labeling of syringes in the operating room. The labels are color coded per the ASA guidelines.

**Packaging and Nomenclature:**

Pre-made medications will be acquired from a 503b compounding facility (Quva) for medications that are unable to be compounded with extended expiration dates. Examples include premixed Oxytocin, Vancomycin 2 gram loading doses, and Narcotic PCA's.

**Compounding:**

We will assess the competency of pharmacy personnel in compounding in accordance with the Board of Pharmacy Sterile Compounding Licensure requirements. Perform ASHP sterile compounding training for each Pharmacy staff member. This will be required before we become USP <797> and <800> compliant by 12-1-19.

**Dispensing:**

Automated dispensing cabinets (ADC) have been added to each surgical suite, the operating corridor, and radiology department near CT and MRI. The Pharmacy department stocks these ADC twice a day. This has removed the requirement for medications to have to be requisitioned from pharmacy (potential source of error).

**Distribution:**

We have added a barcode to pocket prior to refilling the ADC's. This functionality requires

the pharmacy technician to barcode the medication and the barcode on the pocket prior to restocking. This is an additional layer of safety beyond the pharmacist checking the ADC fills prior to distribution.

**Administration:**

Pasero opioid sedation scale (POSS) and Richmond agitation sedation scales (RASS) have been added to routine narcotic/sedative administration monitoring practices. Hold parameters will add a layer of safety to patient medication management.

**Medication Pass Tracers:**

As part of Medication Tracer activity, a medication pass observation will be done across the continuum of care quarterly. The results will be reported to nursing administration and P&T committee. The observations will be used to educate nurses as to best practices. Training and changes in practice will be initiated as needed from the observations. (See Pillars of Excellence for Nursing Quality Department.)

**Education:**

All nursing staff utilizing IV infusion pumps will be educated on drug library and utilization of smart functionality. The drug library will be maintained and reviewed annually in P&T. Updates will be done as needed throughout the year.

The pharmacy will continue to provide an hour of education during nursing orientation to include ADC training, medication security, High Risk-High Alert medications, Look Alike-Sound Alike Medications, multi-dose vials, infection control, drug information, and basic pharmacy information.

**Monitoring:**

Medical records will be reviewed on patients who receive insulin and have a blood glucose lab value of less than 50. This report is followed by pharmacy and reported to CalHIIN.

CalHIIN study of inpatient's who receive opiates is completed by pharmacy to determine if naloxone was required for reversal.

Baseline and routine INR's will be reviewed for all inpatients taking warfarin.

**Use:**

1. Beta Blocker use prior to anesthesia. (See Pillars of Excellence Pre-op/PACU) Monitoring patient compliance, notification of physician when non-compliant to have opportunity to give med prior to surgery. Patient safety-outcome-evidence based best practice.
2. Pneumonia was added as a criteria qualifying for a surveillance MRSA nasal swab. This will reduce the amount (days of therapy) of Vancomycin used empirically for Pneumonia.

Approval	Date
CCOC	

Pharmacy & Therapeutics	1/10/19
Medical Executive Committee	2/5/19
Board of Directors	
Last Board of Director review	4/18/18

Developed:

Reviewed:

Revised:

Supersedes:

Index Listings:

## Emergency Room Service Critical Indicators

2019

1. Physician and Staff Concerns
2. All non-5150 Transfers
3. Formal Patient Complaints
4. AMA
5. Unscheduled Return or Admit Seen Within 72 Hours
6. All Codes, Deaths, and Critical Patients
7. Death Within 24 Hours of Visit
8. All Incoming Transfers
9. Suicide or Attempted Suicide in the ED
10. Concern Regarding Quality of Pre-Hospital Care

### *Approvals:*

Emergency Room Service Committee: 1/9/19

Medical Executive Committee: 2/5/19

Board of Directors:

## **Surgical Critical Indicators**

**2019**

1. Death within 30 days of a surgical or anesthetic procedure.
2. Unanticipated admission to the Intensive Care Unit from a lower level of care.
3. Unanticipated return to the Operating Room.
4. Unanticipated readmission to the hospital within 30 days following a surgical procedure.
5. Unanticipated return to the hospital following surgery.
6. Unanticipated removal or repair of tissue not considered to be a common outcome of the procedure.
7. Unanticipated patient retention of foreign material.
8. Complication consequent to implantation of prosthetic devices or their malfunction or failure.
9. Documented significant postoperative complication within 30 days. These will include ventilator failure, myocardial infarction, stroke, renal failure, pulmonary embolus or deep vein thromboembolic disease, sepsis, or impairment of body function to a level less than that present prior to a surgical or anesthetic procedure, and less than commonly expected as a result of the operative procedure.
10. Airway management for moderate sedation (oral airway or bagging patient).
11. Wrong-site surgery.

*Approvals:*

Surgery/Tissue/Transfusion/Anesthesia: 1/23/19

Medical Executive Committee: 2/5/19

Board of Directors:

# Anesthesia Critical Indicators

2019

*Adopted from 'MACRA Ready' Adverse Events Reporting Form*

## Cardiovascular

1. Dysrhythmia requiring intervention
2. Cardiac arrest (unplanned)
3. Unexpected death
4. Stroke, CVA, or coma
5. Myocardial ischemia
6. Myocardial infarction
7. Vascular access injury  
(arterial/pneumothorax)
8. Uncontrolled HTN

## Respiratory

9. Aspiration
10. Pneumothorax (related to anesthesia)

## Regional

11. Failed Regional Anesthetic
12. Systemic local anesthetic toxicity
13. Post-dural puncture headache
14. Epidural hematoma after spinal/epidural
15. Epidural abscess after spinal/epidural
16. Peripheral nerve injury following regional
17. Infection following peripheral nerve block

## PACU

18. Temperature <95.9° F or <35.5° C
19. Inadequate Reversal
20. Reintubation (planned trial extubation  
documented)
21. Reintubation (no planned trial extubation)

## Medication

22. Medication administration error
23. Adverse transfusion reaction
24. Anaphylaxis

## Process

25. Wrong site surgery
26. Wrong patient
27. Difficult airway
28. Unplanned hospital admission
29. Unplanned ICU admission
30. Wrong surgical procedure

## Miscellaneous

31. Dental trauma
32. Visual loss
33. Malignant Hypothermia
34. Awareness under GA
35. Equipment malfunction
36. Fire in OR
37. Airway fire in OR
38. Corneal abrasion
39. Fall in OR
40. Other

*Approvals:*

Surgery/Tissue/Transfusion/Anesthesia: 1/23/19  
Medical Executive Committee: 2/5/19  
Board of Directors:

## Neonatal Critical Indicators

2019

1. Apgar score 6 or less at 1 or 5 minutes
2. Neonatal resuscitation (PPV or beyond)
3. Infant in Neonatal Peds status
4. Birthweight less than 2000g
5. Infant of a diabetic mother
6. Gestation less than 36 weeks
7. Infant re-admitted within 48 hours of discharge
8. Transfer to NICU
9. Pediatrician attended delivery
10. Any chart brought forward by a RN due to concerns

*Approved:*

*Peri-Peds Committee: 1/25/19*

*Medical Executive Committee: 2/5/19*

*Board of Directors:*

## **Pediatric Critical Indicators**

**2019**

1. Patient transfer to a higher level of care or referral center
2. Readmission to the hospital within 30 days for the same or related diagnosis
3. Respiratory or cardiac arrest (Apnea >15 seconds)
4. Death
5. Abuse
6. Dehydration requiring Intravenous Fluid
7. Neonates < 28 days, admitted to the Acute/Sub Acute Services
8. Length of stay exceeding 48 hours
9. IV/IM antibiotics
10. Nursing concerns

*Approved:*

*Peri-Peds Committee: 1/25/19*

*MEC: 2/5/19*

*BOD:*

## Perinatal Critical Indicators

2019

1. Maternal death or resuscitation
2. Fetal demise beyond 20 weeks gestation
3. Transfer to a higher level of care
4. Apgar score below 7 at 5 minutes
5. Neonatal trauma
6. Maternal seizure
7. Vaginal deliveries coded with shoulder dystocia
8. 3<sup>rd</sup> and 4<sup>th</sup> degree lacerations
9. Postpartum hemorrhage requiring transfusion (~~blood loss greater than 500 ml for vaginal delivery; blood loss greater than 1,000 ml for cesarean section~~)
10. Postpartum readmission
11. Disruption or infection of obstetrical wound
12. Delivery of infant less than 36 weeks gestation
13. Maternal admission to ICU
14. Maternal induction of labor less than 39 weeks without documented indication

*Approvals:*

*Peri-Peds Committee: 1/25/19*

*Medical Executive Committee: 2/5/19*

*Board of Directors:*

## ICU Critical Indicators

2019

1. Unexpected Deaths
2. Ventilator Associated Complications
3. Unexpected Complications After Discharge or Transfer from ICU
4. Staff Concerns

### *Approvals:*

Medicine/ICU Committee: 1/24/19

Medical Executive Committee: 2/5/19

Board of Directors:

## Medical Services Critical Indicators

2019

1. Readmit to hospital w/in 30 days-same or related problem
2. Medical death
3. Hospice inpatient
4. Use of restraints
5. Staff Concerns

### *Approvals:*

Medicine/ICU Committee: 1/24/19

Medical Executive Committee: 2/5/19

Board of Directors:

## Rural Health Clinic Critical Indicators

2019

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: 1/24/19*

*Medical Executive Committee: 2/5/19*

*Board of Directors:*

**NORTHERN INYO HEALTHCARE DISTRICT  
POLICY AND PROCEDURE**

Title: Standardized Procedure – General Policy for the Nurse Practitioner or Certified Nurse Midwife	
Scope: Nurse Practitioner, Certified Nurse Midwife	Manual: Medical Staff
Source: Medical Staff Support Manager	Effective Date: 6/20/18

**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 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.
2. Setting of Practice
  - a. ~~Any of the following outpatient locations, Northern Inyo Healthcare District (NIHD) and affiliated locations,~~ as appropriate for specialty:
    - i. ~~Rural Health Clinic (RHC)~~
    - ii. ~~Rural Health Women’s Health Clinic (RHWC)~~
    - iii. ~~Bishop Pediatrics and Allergy~~

**NORTHERN INYO HEALTHCARE DISTRICT  
POLICY AND PROCEDURE**

Title: Standardized Procedure – General Policy for the Nurse Practitioner or Certified Nurse Midwife	
Scope: Nurse Practitioner, Certified Nurse Midwife	Manual: Medical Staff
Source: Medical Staff Support Manager	Effective Date: 6/20/18

~~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 approved setting of practice. The supervising physician, or his/her relief, will be available 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.
- 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: every 6 months thereafter, in accordance with the Medical Staff Ongoing Professional Practice Evaluation (OPPE) policy.

**NORTHERN INYO HEALTHCARE DISTRICT  
POLICY AND PROCEDURE**

Title: Standardized Procedure – General Policy for the Nurse Practitioner or Certified Nurse Midwife	
Scope: Nurse Practitioner, Certified Nurse Midwife	Manual: Medical Staff
Source: Medical Staff Support Manager	Effective Date: 6/20/18

- 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.

<b>Approval</b>	<b>Date</b>
Interdisciplinary Practice Committee	<del>5/30/18</del> 10/30/18
Medicine/Intensive Care Committee	1/24/19
Medical Executive Committee	2/5/19
Board of Directors	6/20/18
Last Board of Directors Review	6/20/18

Developed:

Reviewed: 5/2018 dp

Revised: 5/2018 dp, 12/2018 dp

Supersedes: *General Policy for the Rural Health Clinic Nurse Practitioner or Certified Nurse Midwife*

Index Listings:

**APPROVALS**

**NORTHERN INYO HOSPITAL  
POLICY AND PROCEDURE**

Title: Certified Nurse Midwife-Standardized Procedures	
Scope: Perinatal, Surgery	Manual: Perinatal - Standards of Practice Independent/Interdependent
Source: OB Nurse Manager	Effective Date: 1/18/17

**I. POLICY**

**A. Definition and Purpose:**

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

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

**B. Experience, training and/or education criteria for Nurse Midwives:**

Criteria: Applicants for membership and privileges as a nurse-midwife shall meet the following criteria:

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

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POLICY AND PROCEDURE**

Title: Certified Nurse Midwife-Standardized Procedures	
Scope: Perinatal, Surgery	Manual: Perinatal - Standards of Practice Independent/Interdependent
Source: OB Nurse Manager	Effective Date: 1/18/17

7. CNM's who request privileges to assist at Cesarean Section Deliveries must meet the following educational and performance criteria:
    - a. Successful completion of a course in CNM First Assisting for Cesarean Sections through an accredited college, or a program approved by the ACNM or Chief of Obstetrical Services, that incorporates didactic and clinical performance sections.
    - b. The CNM will be proctored for minimum of 2 second assists and 3 first assists at Cesarean Sections and/or for a minimum of 3 months, at which time the Chief of Obstetric Services will recommend either an extension of the proctoring period or approval for Cesarean Section First Assistant privileges to the Interdisciplinary Practice Committee.
    - c. Continued competency will be reviewed by the Chief of Obstetrical Services on an annual basis by direct observation of performance and he/she will then make a recommendation for approval or denial of continued privileges through the credentialing process to the Interdisciplinary Practice Committee.
    - d. Refer to appendix B for complete description of CNMFA scope and qualifications.
  8. Application requirements for staff privileges, in addition to the above will include
    - a. The certified nurse-midwife will be required to carry liability insurance
    - b. The certified nurse-midwife will agree not to participate in out of hospital births
  9. Successful completion of CPR and neonatal resuscitation are required; successful completion of ACLS and PALS is preferred.
- C. Probationary/Proctoring Period.
1. The period of observation will be no less than 3 months and will be used for evaluation of midwifery skills. A new graduate will be required to have a total of 10 supervised deliveries by a designated proctor to receive hospital privileges. A midwife with greater than 2 years of documented experience will be required to have 5 supervised deliveries.
  2. Observation will be performed by: supervising physician, other CNMs with current staff privileges, chart review, as well as assessment of obstetrician/gynecologists.
  3. CNM Cesarean Section First Assistant: proctoring period as described under section "B" above
- D. Nurse Midwife Functions:
1. Function as member of the obstetrical team under supervision and guidance of a supervising physician. Arrange for alternate consultation if supervising physician not available
  2. Manage labor, delivery and postpartum course of normal obstetrical patients and deliver care to normal newborn under the auspices of supervising physician and may co-manage exclusions with physician present
  3. Function in the role as First Assistant for Cesarean Sections when requested by an obstetrician-see complete description under appendix B.

**NORTHERN INYO HOSPITAL  
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Scope: Perinatal, Surgery	Manual: Perinatal - Standards of Practice Independent/Interdependent
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**II GUIDELINES:**

**A. Intrapartum Care by Nurse Midwife:**

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

**B. Resuscitation of newborn:**

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

**III RECORDS:**

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

**IV FORMULARY OF APPROVED MEDICATIONS:**

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

**A. Ordering other medications for use in the antepartum, intrapartum and postpartum periods; Caboprost Tromethamine, (Hemabate) 250 mcg. IM or IU to uterine atony/bleeding after delivery**

- Docusate Sodium 250 mg at HS for use as stool softener after delivery.
- Methergine 0.2 mg PO q 8 hours for treatment/prevention of uterine atony after delivery.
- Methergine 0.2 mg IM post delivery for treatment of uterine atony after delivery.
- IV fluids: LR, D5LR, NS, D5W, D5 ½ NS for hydration and for administration of medications.
- Medroxyprogesterone acetate 150 mg IM postpartum method of birth control
- Methergine 0.2 mg IM or IV for treatment of uterine atony after delivery.
- Naloxone 0.4 mg for reversal of respiratory depression.

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

**B. Ordering neonatal medications**

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

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Title: Certified Nurse Midwife-Standardized Procedures	
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<b>Approval</b>	<b>Date</b>
Peri-Peds	1/25/19
Pharmacy and Therapeutics	11/7/16
CCOC	12/15/16
Interdisciplinary Practice Committee	10/30/18
MEC	2/5/19
Board of Directors	1/18/17
Last Board of Director review	3/21/18

Developed: 3/98

Revised: 3/09, 6/09, 9/16SG

Reviewed: 05/2018

Index Listing: Midwife Policy

**NORTHERN INYO HOSPITAL  
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**APPENDIX A: CRITERIA FOR CO-MANAGEMENT, COLLABORATION, EXCLUSIONS AND  
MEDICAL MANAGEMENT.**

Criteria for Certified Nurse Midwife delivery will include:

Gestational age > 36 to < 42 weeks

EFW > 2500 - <4000 grams

Normal prenatal care and low risk factors, gestational diabetes diet-controlled

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

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

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**APPENDIX B: CERTIFIED NURSE MIDWIFE FIRST ASSISTANT (CNMFA)**

**I. POLICY:**

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

**II. PROTOCOL:**

- A. The CNMFA may assist with the positioning and draping of the patient, or perform these actions independently, if so directed by the physician
- B. The CNMFA will provide retraction by:
  - 1) closely observing the operative field at all times
  - 2) managing all instruments in the operative field to prevent obstruction of the surgeon's view
  - 3) anticipating retraction needs with knowledge of the surgeon's preferences and anatomical structures
- C. The CNMFA may provide hemostasis by:
  - 1) sponging and utilizing pressure as necessary
  - 2) utilizing suctioning techniques
  - 3) applying clamps on superficial vessels and tying or electro-coagulation of them as directed by the physician
- D. The CNMFA may perform knot tying by using basic techniques of knot tying to include two-handed tie, one-handed tie and instrument tie
- E. The CNMFA may provide closure of layers by approximating tissue layers under the direct supervision of the physician
- F. The CNMFA will assist the physician at the completion of the surgical procedure by:
  - 1) affixing and stabilizing all drains
  - 2) cleaning the wound and applying the dressing

**III. QUALIFICATIONS:**

- A. A CNM who is approved as a CNMFA at NIH may function as first assistant if all the following conditions exist:
  - 1. currently licensed as a CNM in California

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2. successful completion of a course in CNM First Assisting as noted in the above procedure- refer to section B-5 (a copy of the certificate of completion will be placed in the CNMFA's credentialing file)
3. demonstrated knowledge and skill in applying principles of asepsis and infection control and demonstrated skill in behaviors that are unique to functioning as a CNMFA
4. demonstrated knowledge of surgical anatomy, physiology and operative procedures encountered in a Cesarean delivery
5. demonstrated ability to function effectively and harmoniously as a team member
6. able to perform CPR, completion of ACLS preferred
7. able to perform effectively in stressful and emergency situations

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Title: Certified Nurse Midwife-Standardized Procedures	
Scope: Perinatal, Surgery	Manual: Perinatal - Standards of Practice Independent/Interdependent
Source: OB Nurse Manager	Effective Date: 1/18/17

**APPENDIX C: APPROVALS**

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

Name:	Approval Date:

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

Name:	Approval Date:

C. 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

**NORTHERN INYO HEALTHCARE DISTRICT  
POLICY AND PROCEDURE**

Title: Standardized Procedure – Adult Health Maintenance Policy for the Nurse Practitioner or Certified Nurse Midwife	
Scope: Nurse Practitioner, Certified Nurse Midwife	Manual: Medical Staff
Source: Medical Staff Support Manager	Effective Date: 6/20/18

**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 Nurse Practitioner or Certified Nurse Midwife*.
2. Function: management of adult health maintenance.
3. Circumstances:
  - a. Patient Population: adult patients
  - b. Settings: Northern Inyo Healthcare District (NIHD) and affiliated locations.
    - ~~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.

**PROCEDURE:**

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

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- 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.

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- 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/manufacturer of vaccine.

<b>Approval</b>	<b>Date</b>
Interdisciplinary Practice Committee	<del>5/30/18</del> 10/30/18
Medicine/Intensive Care Committee	1/24/19
Medical Executive Committee	2/5/19
Board of Directors	6/20/18
Last Board of Directors Review	6/20/18

Developed:  
 Reviewed:  
 Revised: 05/2018 dp, 12/2018 dp  
 Supersedes:  
 Index Listings:

**APPROVALS**

**NORTHERN INYO HOSPITAL  
POLICY AND PROCEDURE**

Title: Standardized Procedure – Emergency Care Policy for the Nurse Practitioner or Certified Nurse Midwife	
Scope: Nurse Practitioner, Certified Nurse Midwife	Manual: Medical Staff
Source: Medical Staff Support Manager	Effective Date: 6/20/18

**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 Nurse Practitioner or Certified Nurse Midwife*.
2. Circumstances:
  - a. Patient population: neonates, pediatrics, adults and geriatrics – as appropriate for specialty.
  - b. Settings: Northern Inyo Healthcare District (NIHD) and affiliated locations.
    - ~~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*).
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 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:

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- 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 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 patient chart.

<b>Approval</b>	<b>Date</b>
Interdisciplinary Practice Committee	<u>5/30/18</u> <u>10/30/18</u>
Medicine/Intensive Care Committee	1/24/19
Medical Executive Committee	2/5/19
Board of Directors	6/20/18
Last Board of Directors Review	6/20/18

Developed:

Reviewed:

Revised: 5/2018 dp, 12/2018 dp

Supersedes:

**NORTHERN INYO HOSPITAL  
POLICY AND PROCEDURE**

Title: Standardized Procedure – Furnishing Medications/Devices Policy for the Nurse Practitioner or Certified Nurse Midwife	
Scope: Nurse Practitioner, Certified Nurse Midwife	Manual: Medical Staff
Source: Medical Staff Support Manager	Effective Date: 07/18/18

**PURPOSE:**

This standardized procedure developed for the use by the Nurse Practitioner (NP) and the Certified Nurse Midwife (CNM) is designed to cover the management of drugs and devices for patients of all ages presenting to the outpatient setting.

**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 Nurse Practitioner or Certified Nurse Midwife*.
2. Circumstances:
  - a. Patient population: neonates, pediatrics, adults and geriatrics – as appropriate for specialty.
  - b. Settings: Northern Inyo Healthcare District (NIHD) and affiliated locations.
    - ~~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.
3. The NP or CNM may initiate, alter, discontinue, and renew medication included on, but not limited to the formulary referenced in Appendix A. Schedule I medications are excluded. NPs and CNMs will be required to have a current “Furnishing Number” which has been obtained from the Board of Registered Nursing. All NP & CNM providers will be required to have a DEA certificate and will prescribe within the constraints of this certification.

**PROCEDURE:**

1. Database – Nursing Practice
  - a. Subjective data information will include but is not limited to: Relevant health history to warrant the use of the drug or device, no allergic history specific to the drug or device, and no personal and/or family history which is an absolute contraindication to use the drug or device.
  - b. Objective data information will include but is not limited to: Physical examination appropriate to warrant the use of the drug or device and laboratory tests or procedures to indicate/contraindicate use of drug or device if necessary.
  - c. Assessment: Subjective and objective information consistent for the use of the drug or device. No absolute contraindications of the use of the drug or device.
2. Treatment – Common Nursing Functions
  - a. Medications/devices furnished by the NP or CNM may be either over-the-counter or medications/devices requiring a prescription.
  - b. Medications/devices may be furnished directly to the patient, or the patient’s direct care giver, by the NP or CNM (section 2725.1 of the NPA).

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- c. Medications may be furnished by transmittal. The NP or CNM may write and sign “transmittal orders” of any prescription personally stated or written by the physician. This is in accordance with the Pharmacy Law, Business and Professions Code, Section 34021
  - d. Office samples may be dispensed per Northern Inyo Healthcare District (NIHD) policy.
  - e. The drug or device will be appropriate to the condition being treated:
    - i. Dosage will be in the effective range per formulary references
    - ii. Not to exceed upper limit dosage per formulary references.
  - f. Medication history has been obtained including other medications being taken, medication allergies, and prior medications used for current condition.
  - g. All Medications/devices furnished shall be documented in the patient’s medical record. The effectiveness of the medication/device shall be documented in the patient’s medical record.
3. Patient Education
- a. Provide the client with information and counseling in regard to the drug or device. Caution the client regarding potential side effects or complications with chosen drug or device. Document education process in the medical record.
4. Consultation and/or referral
- a. Non-responsiveness to appropriate therapy and/or unusual or unexpected side effects and as indicated in general policy statement.
5. Documentation
- a. A current drug list will be maintained in the patient’s record. All medications furnished, changes in medications, and renewals will be documented on this list.
  - b. The name and furnishing number of the NP or CNM is written on the transmittal order.

<b>Approval</b>	<b>Date</b>
Interdisciplinary Practice Committee	<del>6/7/18</del> 10/30/18
Medicine/Intensive Care Committee	<u>1/24/19</u>
Medical Executive Committee	2/5/19
Board of Directors	7/18/18
Last Board of Directors Review	7/18/18

Developed:

Reviewed:

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Index Listing:

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Title: Standardized Procedure – Furnishing Medications/Devices Policy for the Nurse Practitioner or Certified Nurse Midwife	
Scope: Nurse Practitioner, Certified Nurse Midwife	Manual: Medical Staff
Source: Medical Staff Support Manager	Effective Date: 07/18/18

**APPENDIX A:**  
FORMULARY SPECIFICATIONS for  
Furnishing Medications/Devices Policy for the Nurse Practitioner/Physician Assistant  
STANDARDIZED PROCEDURE/PROTOCOL

Formulary: Lexicomp drug database as accessed through UpToDate online reference, current as published and updated online.

Deletions: None.

**NORTHERN INYO HEALTHCARE DISTRICT  
POLICY AND PROCEDURE**

Title: Standardized Procedure – Laboratory and Diagnostic Testing Policy for the Nurse Practitioner or Certified Nurse Midwife	
Scope: Nurse Practitioner, Certified Nurse Midwife	Manual: Medical Staff
Source: Medical Staff Support Manager	Effective Date: 6/20/18

**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 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: Northern Inyo Healthcare District (NIHD) and affiliated locations.
    - ~~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.

**PROCEDURE:**

1. Conditions
  - a. The following diagnostic tests can be initiated by the 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 NP or CNM in consultation with the physician, including:
    - i. When diagnostic test of choice is in doubt.

**NORTHERN INYO HEALTHCARE DISTRICT  
POLICY AND PROCEDURE**

Title: Standardized Procedure – Laboratory and Diagnostic Testing Policy for the Nurse Practitioner or Certified Nurse Midwife	
Scope: Nurse Practitioner, Certified Nurse Midwife	Manual: Medical Staff
Source: Medical Staff Support Manager	Effective Date: 6/20/18

<b>Approval</b>	<b>Date</b>
Interdisciplinary Practice Committee	<u>5/30/18 10/30/18</u>
<u>Medicine/Intensive Care Committee</u>	01/24/19
Medical Executive Committee	2/5/19
Board of Directors	6/20/18
Last Board of Directors Review	6/20/18

Developed:

Reviewed:

Revised: 05/2018 dp, 12/2018 dp

Supersedes:

Index Listings:

**NORTHERN INYO HEALTHCARE DISTRICT  
POLICY AND PROCEDURE**

Title: Standardized Procedure – Management of Acute Illness Policy for the Nurse Practitioner or Certified Nurse Midwife	
Scope: Nurse Practitioner, Certified Nurse Midwife	Manual: Medical Staff
Source: Medical Staff Support Manager	Effective Date: 6/20/18

**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 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 ambulatory care setting.
3. Circumstances:
  - a. Patient population: neonates, pediatrics, adults and geriatrics – as appropriate for specialty.
  - b. Settings: Northern Inyo Healthcare District (NIHD) and affiliated locations.
    - ~~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.

**PROCEDURE:**

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 HEALTHCARE DISTRICT  
POLICY AND PROCEDURE**

Title: Standardized Procedure – Management of Acute Illness Policy for the Nurse Practitioner or Certified Nurse Midwife	
Scope: Nurse Practitioner, Certified Nurse Midwife	Manual: Medical Staff
Source: Medical Staff Support Manager	Effective Date: 6/20/18

- 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.

<b>Approval</b>	<b>Date</b>
Interdisciplinary Practice Committee	<del>5/30/18</del> 10/30/18
Medicine/Intensive Care Committee	1/24/19
Medical Executive Committee	2/5/19
Board of Directors	6/20/18
Last Board of Directors Review	6/20/18

Developed:  
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**NORTHERN INYO HEALTHCARE DISTRICT  
POLICY AND PROCEDURE**

Title: Standardized Procedure – Management of Chronic Illness Policy for the Nurse Practitioner or Certified Nurse Midwife	
Scope: Nurse Practitioner, Certified Nurse Midwife	Manual: Medical Staff
Source: Medical Staff Support Manager	Effective Date: 6/20/18

**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 Nurse Practitioner or Certified Nurse Midwife*.
2. This standardized procedure covers the management of chronic illness in children and adults in the ambulatory setting.
3. Circumstances:
  - a. Patient population: neonates, pediatrics, adults and geriatrics – as appropriate for specialty.
  - b. Settings: Northern Inyo Healthcare District (NIHD) and affiliated locations
    - ~~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.

**PROCEDURE:**

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 HEALTHCARE DISTRICT  
POLICY AND PROCEDURE**

Title: Standardized Procedure – Management of Chronic Illness Policy for the Nurse Practitioner or Certified Nurse Midwife	
Scope: Nurse Practitioner, Certified Nurse Midwife	Manual: Medical Staff
Source: Medical Staff Support Manager	Effective Date: 6/20/18

- 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.

<b>Approval</b>	<b>Date</b>
Interdisciplinary Practice Committee	<del>5/30/18</del> <u>10/30/18</u>
<u>Medicine/Intensive Care Committee</u>	1/24/19
Medical Executive Committee	2/5/19
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Last Board of Directors Review	6/20/18

Developed:

Reviewed:

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Supersedes:

Index Listings:

**NORTHERN INYO HEALTHCARE DISTRICT  
POLICY AND PROCEDURE**

Title: Standardized Procedure – Management of Minor Trauma Policy for the Nurse Practitioner or Certified Nurse Midwife	
Scope: Nurse Practitioner, Certified Nurse Midwife	Manual: Medical Staff
Source: Medical Staff Support Manager	Effective Date: 6/20/18

**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 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: Northern Inyo Healthcare District (NIHD) and affiliated locations
    - ~~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.

**PROCEDURE:**

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.

**NORTHERN INYO HEALTHCARE DISTRICT  
POLICY AND PROCEDURE**

Title: Standardized Procedure – Management of Minor Trauma Policy for the Nurse Practitioner or Certified Nurse Midwife	
Scope: Nurse Practitioner, Certified Nurse Midwife	Manual: Medical Staff
Source: Medical Staff Support Manager	Effective Date: 6/20/18

- 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.

<b>Approval</b>	<b>Date</b>
Interdisciplinary Practice Committee	<del>5/30/18</del> 10/30/18
Medicine/Intensive Care Committee	1/24/19
Medical Executive Committee	2/5/19
Board of Directors	6/20/18
Last Board of Directors Review	

Developed:  
 Reviewed:  
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 Index Listings:

**NORTHERN INYO HEALTHCARE DISTRICT  
POLICY AND PROCEDURE**

Title: Standardized Procedure – Minor Surgical Procedures Policy for the Nurse Practitioner or Certified Nurse Midwife	
Scope: Nurse Practitioner, Certified Nurse Midwife	Manual: Medical Staff
Source: Medical Staff Support Manager	Effective Date: 6/20/18

**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 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: Northern Inyo Healthcare District (NIHD) and affiliated locations
    - ~~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.

**PROCEDURE:**

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 HEALTHCARE DISTRICT  
POLICY AND PROCEDURE**

Title: Standardized Procedure – Minor Surgical Procedures Policy for the Nurse Practitioner or Certified Nurse Midwife	
Scope: Nurse Practitioner, Certified Nurse Midwife	Manual: Medical Staff
Source: Medical Staff Support Manager	Effective Date: 6/20/18

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 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.

<b>Approval</b>	<b>Date</b>
Interdisciplinary Practice Committee	<del>5/30/18</del> 10/30/18
Medicine/Intensive Care Committee	1/24/19
Medical Executive Committee	2/5/19
Board of Directors	6/20/18
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Developed:

Reviewed:

Revised: 05/2018 dp, 12/2018

Supersedes:

Index Listings:

**NORTHERN INYO HEALTHCARE DISTRICT  
POLICY AND PROCEDURE**

Title: Standardized Procedure – Well Child Care Policy for the Nurse Practitioner	
Scope: Nurse Practitioner, Certified Nurse Midwife	Manual: Medical Staff
Source: Medical Staff Support Manager	Effective Date: 6/20/18

**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 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: Northern Inyo Healthcare District (NIHD) and affiliated locations
    - ~~i. Rural Health Clinic (RHC)~~
    - ~~ii. Bishop Pediatrics and Allergy~~
  - c. Supervision: Physicians indicated in the supervisory agreements for the NP

**PROCEDURE:**

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 HEALTHCARE DISTRICT  
POLICY AND PROCEDURE**

Title: Standardized Procedure – Well Child Care Policy for the Nurse Practitioner	
Scope: Nurse Practitioner, Certified Nurse Midwife	Manual: Medical Staff
Source: Medical Staff Support Manager	Effective Date: 6/20/18

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 0.01 ml/kg. Repeat dose 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.

<b>Approval</b>	<b>Date</b>
Interdisciplinary Practice Committee	<del>5/30/18</del> 10/30/18
Perinatal/Pediatrics Committee	1/25/19
Medical Executive Committee	2/5/19
Board of Directors	6/20/18
Last Board of Directors Review	6/20/18

**NORTHERN INYO HEALTHCARE DISTRICT  
POLICY AND PROCEDURE**

Title: Standardized Procedure – Well Child Care Policy for the Nurse Practitioner	
Scope: Nurse Practitioner, Certified Nurse Midwife	Manual: Medical Staff
Source: Medical Staff Support Manager	Effective Date: 6/20/18

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Reviewed:  
Revised: 05/2018 dp, 12/2018 dp  
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Index Listings:

Draft

**NORTHERN INYO HEALTHCARE DISTRICT  
POLICY AND PROCEDURE**

Title: Standardized Protocol – General Policy for the Physician Assistant	
Scope: Physician Assistants	Manual: Medical Staff
Source: Medical Staff Support Manager	Effective Date: 3/21/18

**POLICY:**

1. Definition: Physician Assistant is licensed by the State of California Department of Consumer Affairs and possesses preparation and skills in physical diagnosis, psychosocial assessment, and management of health-illness needs in emergency care, and who has been prepared in a program that conforms to board standards.
2. Development and Review
  - a. All Physician Assistant Protocols are developed collaboratively and approved by the Northern Inyo Healthcare District (NIHD) Interdisciplinary Practice Committee (IDPC) and must conform to Title 16, Chapter 7.7, section 3502.
  - b. All Physician Assistant Protocols will be kept in a manual (either hardcopy or electronic) that includes date and signature of the Physician Assistant who is approved under the protocol and the Physician Supervisor(s).
  - c. All Physician Assistant Protocols are to be reviewed every 3 years at minimum by the PA(s), Chiefs of Service, and by the IDPC. Standardized protocols will be updated as practice changes.
  - d. All changes or additions to the Protocols are to be approved by the IDPC. All Protocols approved by the IDPC will be sent to the Medical Staff Executive Committee and, if so approved, to the NIHD Board of Directors.
3. Setting of Practice: NIHD and affiliated locations.
4. Scope of Practice
  - a. The PA may perform the following functions within his/her specialty area and consistent with their experience and credentialing: assessment, management, and treatment of patients presenting to the emergency department (including but not limited to ordering laboratory procedures, x-rays, EKGs, and referring to or consulting specialty services when indicated).
  - b. Protocol functions, such as prescribing medications, are to be performed at an approved setting of practice. Consulting Supervising Physician(s) will be available to the PA(s) in person, by electronic means or by phone.
  - 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:
    - i. Medical record entries by the PA shall include, for all problems addressed: the patients' statement of symptoms, the physical findings, results of special studies, the PA's

**NORTHERN INYO HEALTHCARE DISTRICT  
POLICY AND PROCEDURE**

Title: Standardized Protocol – General Policy for the Physician Assistant	
Scope: Physician Assistants	Manual: Medical Staff
Source: Medical Staff Support Manager	Effective Date: 3/21/18

assessment and management plan including further studies ordered, medication or procedures, information given patient and the names of any physicians consulted.

- ii. Each time a PA provides care for a patient and enters his or her name, signature, initials or computer code on a patient’s record, chart or written order, the PA shall also enter the name of his or her supervising physician who is responsible for the patient (as specified in CA Code of Regulations 1399.546)

**5. Qualifications and Evaluations**

- a. Each Physician Assistant performing PA Protocol functions must have a current California Physician Assistant license, be a graduate of an approved Physician Assistant program, and have current certification as a Physician Assistant by the California Physician Assistant Committee and the Department of Consumer Affairs.
- b. Evaluation of PA’s competence in performance of Protocol functions will be done in the following manner:
  - i. Initial: Within the initial focused professional practice evaluation (FPPE) period the Supervising Physician(s) will evaluate performance via direct observation, consultations and chart review/co-signature and provide feedback to the interim PA. Input from other physicians and colleagues will be utilized. Recommendations to move from interim status to full status once the FPPE has been satisfactorily completed will be considered. Nurse Manager(s) along with the Medical Director(s) and Supervising Physician(s) will provide feedback utilizing performance evaluation based upon the PA job description.
  - ii. Routine: at least annually after the first year by the Supervising Physician/Medical Director through feedback from the physicians, colleagues and charting review. This will be addressed during the annual performance evaluation. Physician assistants must also participate in ongoing professional practice evaluations (OPPE), the frequency of which is set by the medical staff.
  - iii. Follow-up: areas requiring increased proficiency, as determined by the initial or routine evaluation, will be reevaluated by the supervising physician(s) at appropriate intervals until acceptable skill level is achieved.
- c. The scope of supervision for the performance of the functions referred to in this area shall include chart review as per the Delegation of Services Agreement.
- d. Further requirements shall be regular continuing education in emergency or other relevant medical care, including reading of appropriate journals and new text books, attending conferences sponsored by hospitals, professional societies, and teaching institutions equaling 25 hours a year, minimum.
  - i. A record of continuing education must be submitted to the Medical Staff Office every other year at re-credentialing (50 hours minimum over 2 years).

**NORTHERN INYO HEALTHCARE DISTRICT  
POLICY AND PROCEDURE**

Title: Standardized Protocol – General Policy for the Physician Assistant	
Scope: Physician Assistants	Manual: Medical Staff
Source: Medical Staff Support Manager	Effective Date: 3/21/18

- ii. Continuing education information will remain on file in the PA’s competency notebook. A copy of the competency assurance documents will be submitted to Human Resources at the end of each calendar year to be stored in the PA’s HR file.

6. Protocols

- a. The protocols developed for use by the Physician Assistant are designed to describe the steps of medical care for given patient situations.

**REFERENCES:**

1. UpToDate-evidence-based, Physician-authorized clinical decision support resource
2. Title 16, California Code of Regulations, Sections 1399.540, 1399.544, 1399.546
3. Laws and Regulations Relating to the Practice of Physician Assistants. Issued May 2018.
4. Title 16, California Code of Regulations, Chapter 7.7, Section 3502.

**ATTACHMENTS:**

1. List of Authorized Physician Assistants and Supervising Physicians

<b>Approval</b>	<b>Date</b>
Interdisciplinary Practice Committee	10/30/18
Medicine/Intensive Care Committee	1/24/19
Medical Executive Committee	2/5/19
Board of Directors	3/21/18
Last Board of Directors Review	3/21/18

Developed: 2/2018 sb

Reviewed:

Revised: 2/2018 dp 12/2018 dp

Supersedes: *General Policy for the Emergency Department Physician Assistant – Standardized Protocol; General Policy for the Rural Health Clinic Physician Assistant*

Index Listings:

**NORTHERN INYO HEALTHCARE DISTRICT  
POLICY AND PROCEDURE**

Title: Standardized Protocol – Medical Screening Examination for the Emergency Department Physician Assistant	
Scope: Physician Assistants	Manual: Emergency Dept, Medical Staff
Source: Medical Staff Support Manager	Effective Date: 5/16/18

**PURPOSE:**

To describe the procedure for training a Physician Assistant (PA) to be a Qualified Medical Personnel (QMP) and to be able to perform the Medical Screening Examination (MSE) of patients presenting to the emergency department. The PA is determined qualified by the Hospital’s Medical Staff Bylaws, Rules and Regulations and approved by the Hospital’s Governing Board, in compliance with the provisions of the Emergency Medical Treatment Act (EMTALA) 42 U.S.C., Section 1395.

**DEFINITIONS:**

1. **Medical Screening Examination (MSE)** is the process required to reach with reasonable clinical confidence, the point at which it can be determined whether or not an emergency medical condition exists or a woman is in labor. Such screening must be done within the facility’s capabilities and available personnel, including on-call physicians. The medical screening examination is an ongoing process and the medical records must reflect continued monitoring based on the patient’s needs and continue until the patient is either stabilized or appropriately transferred.
2. **Qualified Medical Personnel (QMP)** is a provider that is qualified to perform the MSE.
3. **Physician Assistant (PA)** is licensed by the State of California Department of Consumer Affairs and possesses preparation and skills in physical diagnosis, psychosocial assessment, and management of health-illness needs in emergency care, and who has been prepared in a program that conforms to board standards.

**POLICY:**

1. Requirements for a PA to perform the MSE:
  - a. Minimal Education/Training
    - i. Be trained and licensed as detailed in the *General Policy for ~~Emergency Department~~ the Physician Assistant*.
    - ii. Successfully complete the hospital didactic module for performing Medical Screening Examination of the Emergency Patient with 100% accuracy.
      1. Upon completion of this module, the PA will be able to:
        - a. List potential consequences of failing to comply with EMTALA
        - b. Recognize key features of the medical screening exam (MSE) under EMTALA
        - c. Identify key feature of stabilizing care under EMTALA
        - d. Cite key features of appropriate patient transfer under EMTALA
  - b. Initial and Ongoing Evaluation
    - i. Evaluation of the PA’s competence in performing the MSE will be done by the supervising physician(s) as detailed in the *General Policy for ~~Emergency Department~~ the Physician Assistant*.

**REFERENCES:**

1. Certification and Compliance for the Emergency Medical Treatment and Labor Act (EMTALA). Retrieved from: <https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/CertificationandCompliance/Downloads/EMTALA.pdf>. 2018 Apr 18.
2. Interpretive Guidelines – Responsibilities of Medicare Participating Hospitals in Emergency Cases. Retrieved from: <http://www.emtala.com/ig.pdf>. 2018 Apr 18.

**NORTHERN INYO HEALTHCARE DISTRICT  
POLICY AND PROCEDURE**

Title: Standardized Protocol – Medical Screening Examination for the Emergency Department Physician Assistant	
Scope: Physician Assistants	Manual: Emergency Dept, Medical Staff
Source: Medical Staff Support Manager	Effective Date: 5/16/18

**CROSS REFERENCE P&P:**

1. *Evaluation and Medical Screening of Patients Presenting to the Emergency Department*

**ATTACHMENTS:**

1. List of Authorized Physician Assistants and Supervising Physicians

<b>Approval</b>	<b>Date</b>
Interdisciplinary Practice Committee	<del>4/30/18</del> 10/30/18
<u>Emergency Services Committee</u>	1/9/19
Medical Executive Committee	2/5/19
Board of Directors	5/16/18
Last Board of Directors Review	5/16/18

Developed: 4/2018 sb

Reviewed:

Revised: 4/2018 dp, 12/2018 dp

Supersedes:

Index Listings:

**NORTHERN INYO HEALTHCARE DISTRICT  
POLICY AND PROCEDURE**

Title: Standardized Protocol – Physician Assistant in the Operating Room	
Scope: Physician Assistant	Manual: Medical Staff, Surgery
Source: Medical Staff Support Manager	Effective Date: 03/21/2018

**PURPOSE:**

To establish guidelines for the adequate supervision and qualifications of the Physician Assistant (PA) who assists the surgeon during a surgical procedure.

**POLICY:**

1. The Physician Assistant (PA) assists the attending surgeon during a surgical procedure by providing aid in exposure, hemostasis, and other technical functions which will help the surgeon carry out a safe operation with optimal results for the patient.
2. Only a PA currently licensed in California, who meets all the criteria specified in Appendix A may perform this procedure. Knowledgeable regarding PA limitations and practices within these.
3. The PA will be evaluated for continued competency ninety (90) days after assuming the position and yearly thereafter. The evaluation will be done by a physician and will contain input from the appropriate attending surgeon(s) based on this protocol, chart review and their observations.
4. The PA may function under this protocol only when the following conditions are met:
  1. The attending surgeon has determined that the PA can provide the type of assistance needed during the specific surgery.
  2. The PA functions under the supervision of the attending surgeon. The attending surgeon does not need to be physically present in the operating room for those portions of the procedure (usually setup and final closure) which in the judgment of the attending surgeon the PA may safely do without direct and in person supervision. The attending surgeon must be able to be present immediately if needed and must have a reliable way to be contacted and summoned, such as a cell phone, if needed. Specifically, the attending surgeon may be in such places as the recovery room, the pre op area, the wards of the hospital, an on campus office, or the ER.

**PROTOCOL:**

The PA will:

1. Assist with the positioning, prepping and draping of the patient, or perform these actions independently, if so directed by the surgeon.
2. Provide retraction by:
  1. Closely observing the operative field at all times.
  2. Demonstrating stamina for sustained retraction.
  3. Retaining manually controlled retractors in the position set by the surgeon with regard to surrounding tissue.
  4. Managing all instruments in the operative field to prevent obstruction of the surgeon's view.
  5. Anticipating retraction needs with knowledge of the surgeon's preferences and anatomical structures.
3. Provide hemostasis by:
  1. Applying the electrocautery tip to clamps or vessels in a safe and knowledgeable manner, as directed by the surgeon.
  2. Sponging and utilizing pressure, as necessary.

**NORTHERN INYO HEALTHCARE DISTRICT  
POLICY AND PROCEDURE**

Title: Standardized Protocol – Physician Assistant in the Operating Room	
Scope: Physician Assistant	Manual: Medical Staff, Surgery
Source: Medical Staff Support Manager	Effective Date: 03/21/2018

3. Utilizing suctioning techniques.
4. Applying clamps on superficial vessels and the tying or electrocoagulation of them, as directed by the surgeon.
5. Placing suture ligatures in the muscle, subcutaneous and skin layer.
6. Placing hemoclips on bleeders, as directed by the surgeon.
4. Perform knot tying by:
  1. Having knowledge of the basic techniques of knot tying to include, two-handed tie; one-handed tie; instrument tie.
  2. Tying knots firmly to avoid slipping.
  3. Avoiding undue friction to prevent fraying of suture.
  4. “Walking” the knot down to the tissue with the tip of the index finger and laying the strands flat.
  5. Approximating tissue rather than pulling tightly to prevent tissue necrosis.
5. Perform dissection as directed by the surgeon by:
  1. Having knowledge of the anatomy.
  2. Demonstrating the ability to use the appropriate instrumentation.
  3. For abdominal surgery: dissection includes all layers to, but not, the peritoneum.
6. Provide closure of layers of tissue as directed by the surgeon; sutures fascia., subcutaneous tissue and skin by:
  1. Correctly approximating the layers, under direction of the surgeon.
  2. Demonstrating knowledge of the different types of closures, to include but not be limited to: interrupted vs. continuous; skin sutures vs. staples; subcuticular closure; horizontal mattress.
  3. Correctly approximating skin edges when utilizing skin staples or suture.
7. Assist the surgeon at the completion of the surgical procedure by:
  1. Affixing and stabilizing all drains.
  2. Cleaning the wound and applying the dressing.
  3. Assisting with applying casts; splints, bulky dressings, abduction devices.

The PA practices within the appropriate limitations and may choose not to perform those functions for which he/she has not been prepared or which he/she does not feel capable of performing.

<b>Approval</b>	<b>Date</b>
Interdisciplinary Practice Committee	10/30/18
Surgery/Tissue/Transfusion/Anesthesia Committee	1/23/19
Medical Executive Committee	2/5/19
Board of Directors	3/21/18
Last Board of Directors Review	3/21/18

Developed:

Reviewed: 3/2018, 12/2018

Revised:

Supersedes:

**NORTHERN INYO HEALTHCARE DISTRICT  
POLICY AND PROCEDURE**

Title: Standardized Protocol – Physician Assistant in the Operating Room	
Scope: Physician Assistant	Manual: Medical Staff, Surgery
Source: Medical Staff Support Manager	Effective Date: 03/21/2018

**APPENDIX A**

1. A Physician Assistant who is approved as a PA at NIH may function as first assistant if all of the following conditions exist.
  - a. Currently licensed as a PA in California.
  - b. Successful completion of an accredited Physician Assistant program. (A copy of the certificate of completion will be placed in the PA’s personnel file and the Medical Staff credentials file.)
  - c. Demonstrated knowledge and skill in applying principles of asepsis and infection control and demonstrated skill in behaviors that are unique to functioning as a PA.
  - d. Demonstrated knowledge of surgical anatomy, physiology and operative procedures for which the PA assists.
  - e. Demonstrated ability to function effectively and harmoniously as a team member.
  - f. Able to perform CPR; ACLS completion preferred.
  - g. Able to perform effectively in stressful and emergency situations.

**NORTHERN INYO HEALTHCARE DISTRICT  
POLICY AND PROCEDURE**

Title: Standardized Protocol – Adult Health Maintenance for the Physician Assistant	
Scope: Physician Assistant	Manual: Medical Staff
Source: Medical Staff Support Manager	Effective Date: 11/2014

**PURPOSE:**

This standardized protocol developed for use by the Physician Assistant is designed to establish guidelines for the management of adult health maintenance.

**POLICY:**

1. ~~Will meet all General Policy—Protocol guidelines. This standardized protocol and those authorized to work through this standardized protocol will meet all guidelines as outlined in the *General Policy for the Physician Assistant*.~~
2. ~~Function: management of adult health maintenance.~~
3. ~~2.~~ Circumstances:
  1. Patient population: Adult patients
  2. Setting: Northern Inyo Healthcare District (NIHD) and affiliated locations
4. ~~3.~~ Supervision: Physicians indicated in Delegation of Services Agreement

**PROTOCOL:**

1. Definition:
  - a. health maintenance, health promotion and prevention activities which promote the physical, psychosocial and developmental well-being of adults. Includes health assessment and disease prevention utilizing:
    - i. physical exam
    - ii. diagnostic testing
    - iii. immunizations
    - iv. developmental screening
    - v. health education.
2. Data Base:
  - a. Subjective: obtain complete histories on all first time patients; interval histories on subsequent visits.
  - b. Objective:
    - i. At each visit obtain vital signs, weight, pain assessment and allergy history.
    - ii. Risk assessment when establishing care and as indicated.
    - iii. Perform complete physical exam.
    - 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 HEALTHCARE DISTRICT  
POLICY AND PROCEDURE**

Title: Standardized Protocol – Adult Health Maintenance for the Physician Assistant	
Scope: Physician Assistant	Manual: Medical Staff
Source: Medical Staff Support Manager	Effective Date: 11/2014

- 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, preventive health behaviors.
  - v. Interventions appropriate to address acute and chronic health problems.
  - vi. Refer to specialist or other community resource indicated.
- 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. Follow-up
  - i. According to adult health maintenance schedule sooner as indicated.
- e. Record keeping
  - i. Appropriate documentation to be maintained 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

**NORTHERN INYO HEALTHCARE DISTRICT  
POLICY AND PROCEDURE**

Title: Standardized Protocol – Adult Health Maintenance for the Physician Assistant	
Scope: Physician Assistant	Manual: Medical Staff
Source: Medical Staff Support Manager	Effective Date: 11/2014

2. Administer 1:1000 (aqueous) Epinephrine. Repeat dose every 15-20 minutes. Usual dose: 0.3 ML Subcutaneously
- 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 physician. Call Code Blue if indicated call for EMS Paramedics
    4. Report adverse reaction to local health department/manufacturer of vaccine.

**REFERENCES:**

1. UpToDate-evidence-based, Physician-authorized clinical decision support resource

**ATTACHMENTS:**

1. List of Authorized Physician Assistants and Supervising Physicians

<b>Approval</b>	<b>Date</b>
Interdisciplinary Practice Committee	11/30/18
Medicine/Intensive Care Service Committee	1/24/19
Medical Executive Committee	2/5/19
Board of Directors	
Last Board of Directors Review	

Developed:

Reviewed:

Revised: 12/2018 dp

Supersedes: *Adult Health Maintenance Policy for Rural Health Clinic Physician Assistants*

Index Listings:

**NORTHERN INYO HEALTHCARE DISTRICT  
POLICY AND PROCEDURE**

Title: Standardized Protocol – Emergency Care Policy for the Physician Assistant	
Scope: Physician Assistants	Manual: Medical Staff
Source: Medical Staff Support Manager	Effective Date: 3/21/18

**PURPOSE:**

1. This standardized protocol developed for use by the Physician Assistant (PA) is designed to establish guidelines for the management of emergency care conditions.

**POLICY:**

- ~~1. Will meet General Policy—Protocol guidelines as described in the General Policy Component. This standardized protocol and those authorized to work through this standardized protocol will meet all guidelines as outlined in the General Policy for the Physician Assistant.~~
- Circumstances:
  - Patient population: pediatric and adult patients
  - Setting: Northern Inyo Healthcare District ~~Emergency Department~~ (NIHD ~~ED~~) and affiliated locations.
  - Supervision: Physicians indicated in Delegation of Services Agreement

**PROTOCOL:**

- Definition: this protocol covers the management of Emergency Care conditions which may present to ~~the NIHD Emergency Department and its affiliated locations.~~
- Database
  - Subjective
    - Obtain pertinent history related to emergency symptoms
    - Collect appropriate information, including past medical history, review of systems, allergies, immunizations, and medications.
  - Objective
    - Perform limited physical examination pertinent to the emergency illness or injury, including any possible involved organ systems.
    - Obtain appropriate evaluative studies, including but not limited to, lab work and imaging studies.
- Assessment
  - Formulate diagnosis consistent with the data base collected.
  - Document diagnosis in the patient chart
- Treatment Plan – medical regimen
  - Patients requiring emergency care will be stabilized to the best of the capabilities of the ~~NIHD ED~~ setting and transferred to or referred to an appropriate provider. The supervising physician will be involved if needed and the care of the patient transferred to the NIHD hospitalist from the emergency department for inpatient care or to an accepting outside physician if transfer to another facility is warranted.
  - The Physician assistant(s) may, whenever necessary, attempt to sustain life. This includes, but is not limited to:
    - Establishing and maintaining an airway

**NORTHERN INYO HEALTHCARE DISTRICT  
POLICY AND PROCEDURE**

Title: Standardized Protocol – Emergency Care Policy for the Physician Assistant	
Scope: Physician Assistants	Manual: Medical Staff
Source: Medical Staff Support Manager	Effective Date: 3/21/18

- 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 or reduce skeletal injuries
  - viii. Incision and drainage of abscesses
  - ix. Irrigate and repair wounds
  - x. Apply heat or cold for exposure
  - xi. Administration of Narcan for suspected narcotic overdose
  - xii. Administration of intravenous glucose for suspected hypoglycemia
  - xiii. Follow Advanced Cardiac Life Support Guidelines
  - c. Physician Consultation: As described in the General Policy Standardized Protocol.
  - d. Consult specialty physician or transfer care of patient.
  - e. Refer to Physician or Specialty Clinic: Diagnosis and/or treatment are beyond the scope of the PA’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 PA, the patient can tolerate transfer by wheelchair, an RN must accompany the patient to the emergency department.
    - ii. Emergent transfers will be managed per NIHD Emergent Transfer Policy. All EMTALA regulations will be followed and appropriate forms, including consent for transfer, will be utilized.
  - f. Medications – see Delegation of Services Agreement and Medication/Device Policy for Emergency Department Physician Assistant
5. Documentation
- a. All emergency care provided will be recorded in the ~~ED~~-patient chart.

**REFERENCES:**

- 1. UpToDate-evidence-based, Physician-authorized clinical decision support resource

**CROSS REFERENCE P&P:**

- 1. EMTALA Policy

**ATTACHMENTS:**

- 1. List of Authorized Physician Assistants and Supervising Physicians

Approval	Date
Interdisciplinary Practice Committee	<u>2/28/18</u> 10/30/18
<u>Medicine/Intensive Care Committee</u>	1/24/19

**NORTHERN INYO HEALTHCARE DISTRICT  
POLICY AND PROCEDURE**

Title: Standardized Protocol – Emergency Care Policy for the Physician Assistant	
Scope: Physician Assistants	Manual: Medical Staff
Source: Medical Staff Support Manager	Effective Date: 3/21/18

Medical Executive Committee	2/5/19
Board of Directors	3/21/18
Last Board of Directors Review	3/21/18

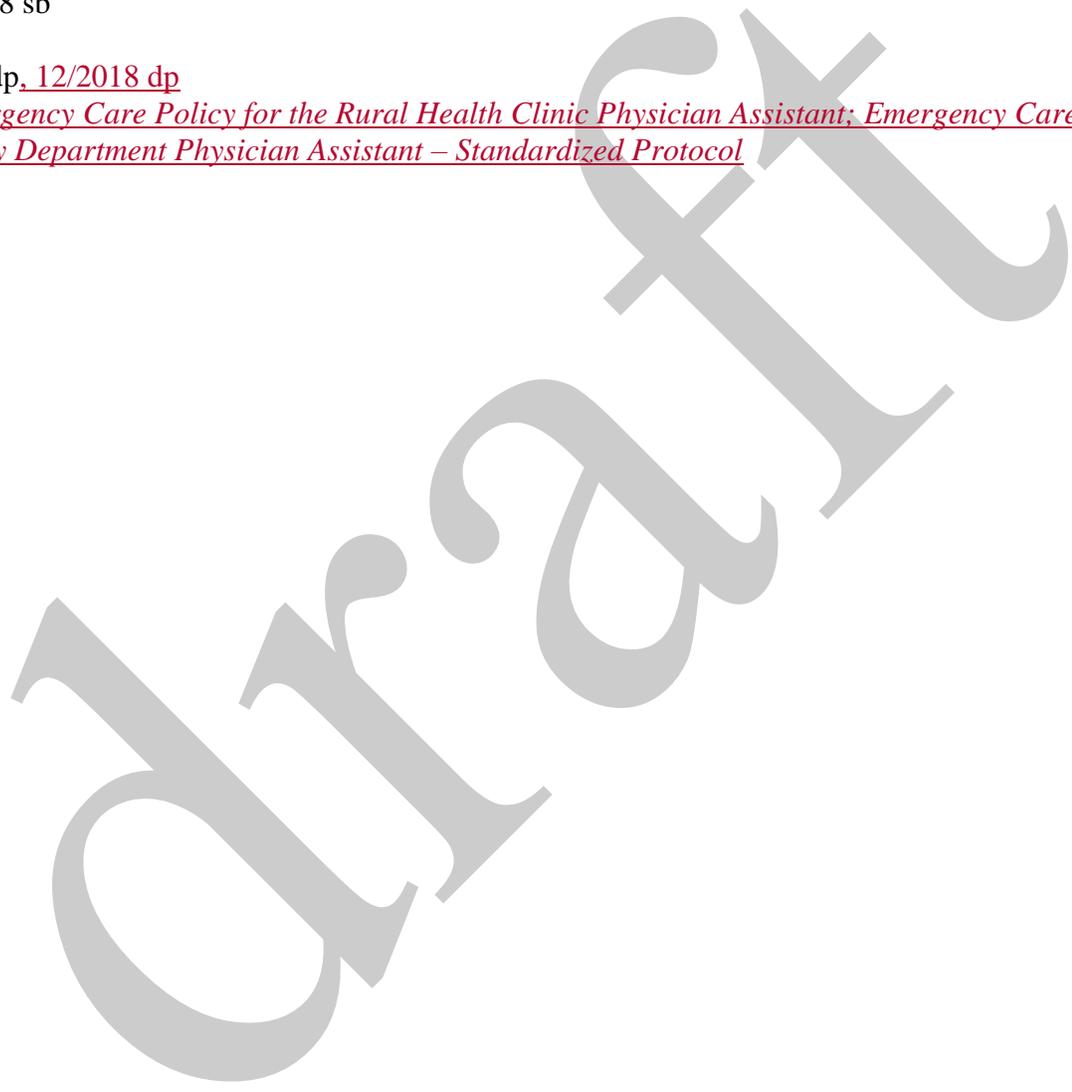
Developed: 2/2018 sb

Reviewed:

Revised: 2/2018 dp, [12/2018 dp](#)

Supersedes: [\*Emergency Care Policy for the Rural Health Clinic Physician Assistant; Emergency Care Policy for the Emergency Department Physician Assistant – Standardized Protocol\*](#)

Index Listings:



**NORTHERN INYO HEALTHCARE DISTRICT  
POLICY AND PROCEDURE**

Title: Standardized Protocol – Laboratory and Diagnostic Testing Policy for the Physician Assistant	
Scope: Physician Assistants	Manual: Medical Staff
Source: Medical Staff Support Manager	Effective Date: 11/2014

**PURPOSE:**

1. This protocol is designed to establish guidelines that will allow the Physician Assistant (PA) to order laboratory and diagnostic tests under the following conditions:
  - a. As an appropriate adjunct to the determination of diagnosis.
  - b. When necessary, to implement, monitor or adjust treatment.

**POLICY:**

1. ~~Will meet all General Policy— Protocol guidelines. This standardized protocol and those authorized to work through this standardized protocol will meet all guidelines as outlined in the General Policy for the Physician Assistant.~~
2. Circumstances:
  - a. Patient population: pediatric and adult patients
  - b. Setting: Northern Inyo Healthcare District (NIHD) and affiliated locations
  - c. Supervision: Physicians as indicated in the Delegation of Services Agreement

**PROTOCOL:**

1. Conditions
  - a. The following diagnostic tests can be initiated by the Physician Assistant Provider without prior consultation with supervising physician:
    - 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 Physician Assistant in consultation with the physician including:
    - i. When diagnostic test of choice is in doubt.

**REFERENCES:**

1. UpToDate-evidence-based, Physician-authorized clinical decision support resource

**ATTACHMENTS:**

1. List of Authorized Physician Assistants and Supervising Physicians

**NORTHERN INYO HEALTHCARE DISTRICT  
POLICY AND PROCEDURE**

Title: Standardized Protocol – Laboratory and Diagnostic Testing Policy for the Physician Assistant	
Scope: Physician Assistants	Manual: Medical Staff
Source: Medical Staff Support Manager	Effective Date: 11/2014

<b>Approval</b>	<b>Date</b>
Interdisciplinary Practice Committee	10/30/18
Medicine/Intensive Care Committee	1/24/19
Medical Executive Committee	2/5/19
Board of Directors	
Last Board of Directors Review	

Developed:

Reviewed:

Revised: 12/2018 dp

Supersedes: *Laboratory and Diagnostic Testing Policy for Rural Health Clinic Physician Assistants*

in approval

**NORTHERN INYO HEALTHCARE DISTRICT  
POLICY AND PROCEDURE**

Title: Standardized Protocol – Management of Acute Illness for the Physician Assistant	
Scope: Physician Assistants	Manual: Medical Staff
Source: Medical Staff Support Manager	Effective Date: 11/2014

**PURPOSE:**

1. This standardized protocol is designed to establish guidelines that will allow the Physician Assistant (PA) to medically manage acute illnesses and conditions.

**POLICY:**

1. ~~Will meet all General Policy—Protocol guidelines.~~ This standardized protocol and those authorized to work through this standardized protocol will meet all guidelines as outlined in the *General Policy for the Physician Assistant*.
2. Circumstances:
  - a. Patient population: pediatric and adult patients
  - b. Setting: Northern Inyo Healthcare District (NIHD) and affiliated locations
  - c. Supervision: Physicians indicated in the Delegation of Services Agreement

**PROTOCOL:**

1. Definition: this protocol covers the medical management of acute illness, allergies, symptomatic complaints and emergencies in children and adults presenting to NIHD and affiliated locations.
2. 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 Delegation of Services Agreement.)
    - 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.

**NORTHERN INYO HEALTHCARE DISTRICT  
POLICY AND PROCEDURE**

Title: Standardized Protocol – Management of Acute Illness for the Physician Assistant	
Scope: Physician Assistants	Manual: Medical Staff
Source: Medical Staff Support Manager	Effective Date: 11/2014

- vi. Refer as indicated to other services/specialties.
- vii. Follow-up as indicated.
- e. 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.

**REFERENCES:**

1. UpToDate-evidence-based, Physician-authorized clinical decision support resource

**ATTACHMENTS:**

1. List of Authorized Physician Assistants and Supervising Physicians

<b>Approval</b>	<b>Date</b>
Interdisciplinary Practice Committee	10/30/18
Medicine/Intensive Care Service Committee	1/24/19
Medical Executive Committee	2/5/19
Board of Directors	
Last Board of Directors Review	

Developed:

Reviewed:

Revised: 12/2018 dp

Supersedes: *Management of Acute Illness for Rural Health Clinic Physician Assistant*

**NORTHERN INYO HEALTHCARE DISTRICT  
POLICY AND PROCEDURE**

Title: Standardized Protocol – Management of Chronic Illness for the Physician Assistant	
Scope: Physician Assistants	Manual: Medical Staff
Source: Medical Staff Support Manager	Effective Date: 02/2015

**PURPOSE:**

1. This standardized protocol is designed to establish guidelines that will allow the Physician Assistant (PA) to manage chronic illnesses.

**POLICY:**

1. ~~Will meet all General Policy—Protocol guidelines.~~ This standardized protocol and those authorized to work through this standardized protocol will meet all guidelines as outlined in the *General Policy for the Physician Assistant.*
2. Circumstances:
  - a. Patient population: pediatric and adult patients
  - b. Setting: Northern Inyo Healthcare District (NIHD) and affiliated locations
  - c. Supervision: Physicians indicated in the Delegation of Services Agreement.

**PROTOCOL:**

1. Definition: this protocol covers the management of chronic illness in children and adults at NIHD and affiliated locations.
2. Data Base:
  - a. Subjective:
    - i. Pertinent history including symptoms related to the chronic illness.
    - ii. Present state of chronic illness (patient’s perception).
    - 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 Well Child Care (WCC) or adult Health Maintenance Exam (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 Delegation of Services Agreement.)
    - ii. Laboratory/diagnostic testing as indicated.
    - iii. Patient education appropriate to chronic illness and any procedures, diagnostic testing, or medications ordered.

**NORTHERN INYO HEALTHCARE DISTRICT  
POLICY AND PROCEDURE**

Title: Standardized Protocol – Management of Chronic Illness for the Physician Assistant	
Scope: Physician Assistants	Manual: Medical Staff
Source: Medical Staff Support Manager	Effective Date: 02/2015

- iv. Order/perform therapeutic procedures as appropriate.
- v. Order medical supplies and necessary equipment for treatment.
- vi. Refer as indicated to other specialists/services/school programs.
- vii. Follow-up as indicated.
- e. 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.

**REFERENCES:**

1. UpToDate-evidence-based, Physician-authorized clinical decision support resource

**ATTACHMENTS:**

1. List of Authorized Physician Assistants and Supervising Physicians

<b>Approval</b>	<b>Date</b>
Interdisciplinary Practice Committee	10/30/18
Medicine/Intensive Care Committee	1/24/19
Medical Executive Committee	2/5/19
Board of Directors	
Last Board of Directors Review	

Developed:

Reviewed:

Revised: 12/2018

Supersedes: *Management of Chronic Illness for Rural Health Clinic Physician Assistants*

**NORTHERN INYO HEALTHCARE DISTRICT  
POLICY AND PROCEDURE**

Title: Standardized Protocol – Management of Minor Trauma for the Physician Assistant	
Scope: Physician Assistants	Manual: Medical Staff
Source: Medical Staff Support Manager	Effective Date: 11/2014

**PURPOSE:**

1. This standardized protocol is designed to establish guidelines that will allow the Physician Assistant (PA) to manage patients presenting with minor traumatic injuries.

**POLICY:**

1. ~~Will meet all General Policy – Protocol guidelines. This standardized protocol and those authorized to work through this standardized protocol will meet all guidelines as outlined in the *General Policy for the Physician Assistant*.~~
2. Circumstances:
  - a. Patient population: pediatric and adult patients
  - b. Setting: Northern Inyo Healthcare District (NIHD) and affiliated locations
  - c. Supervision: Physicians indicated in the Delegation of Services Agreement

**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 protocol).
2. Assessment:
  - a. Formulate a working diagnosis consistent with data base collected.
3. Plan:
  - a. If indicated, develop or initiate a therapeutic regimen including, but not limited to, the following:
    - i. Physician consultation prior to management as per policy statement or in the following cases:
      1. Any injury threatening to life or limb.
      2. Any laceration requiring complicated suture closure (see minor surgical protocol).
      3. Any fracture or injury requiring immobilization by full casting.
      4. Complicated or extensive burns.
      5. Injury that may involve litigation or compensation.
      6. Any case where surgical intervention may be needed.
    - ii. Further diagnostic tests.
    - iii. Skin/wound care appropriate to injury.
    - iv. Apply or furnish appropriate medications and/or immunizations.

**NORTHERN INYO HEALTHCARE DISTRICT  
POLICY AND PROCEDURE**

Title: Standardized Protocol – Management of Minor Trauma for the Physician Assistant	
Scope: Physician Assistants	Manual: Medical Staff
Source: Medical Staff Support Manager	Effective Date: 11/2014

- v. Refer to appropriate support services including Physical Therapy, and “in-house” support services.
- vi. Develop appropriate follow-up care plan to maximize healing and rehabilitation.
  - 1. 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.
  - 2. Schedule follow-up appointments as appropriate.
- vii. Update problem list.

**REFERENCES:**

- 1. UpToDate-evidence-based, Physician-authorized clinical decision support resource

**ATTACHMENTS:**

- 1. List of Authorized Physician Assistants and Supervising Physicians

<b>Approval</b>	<b>Date</b>
Interdisciplinary Practice Committee	10/30/18
Medicine/Intensive Care Committee	1/24/19
Medical Executive Committee	2/5/19
Board of Directors	
Last Board of Directors Review	

Developed:

Reviewed:

Revised: 12/2018 dp

Supersedes: *Management of Minor Trauma for Rural Health Clinic Physician Assistants*

**NORTHERN INYO HEALTHCARE DISTRICT  
POLICY AND PROCEDURE**

Title: Standardized Protocol – Medication/Device Policy for the Physician Assistant	
Scope: Physician Assistants	Manual: Medical Staff
Source: Medical Staff Support Manager	Effective Date: 3/21/18

**PURPOSE:**

1. This standardized protocol developed for use by the Physician Assistant (PA) is designed to cover the management of drugs and devices for patients of all ages.

**POLICY:**

- ~~Will meet all General Policy Protocol guidelines. This standardized protocol and those authorized to work through this standardized protocol will meet all guidelines as outlined in the *General Policy for the Physician Assistant*.~~
- Function: use of specific drug or device
- Circumstances:
  - Patient population: Adult/Pediatric patients
  - Setting: Northern Inyo Healthcare District Emergency Department (NIHD ~~ED~~) and affiliated locations.
  - Supervision: Physicians indicated in Delegation of Services Agreement

**PROTOCOL:**

- Definition:
  - Management of drugs and devices for patients of all ages ~~presenting to the Emergency Department~~. The Physician Assistant may initiate, alter, discontinue, and renew medication included on the formulary referenced in Appendix A. The adoption of this written, practice-specific formulary is governed under Business and Professions Code, Title 16, §3502.1(a)(2). Schedule I medications are excluded.
- Data Base:
  - Subjective data information will include but is not limited to: Relevant health history to warrant the use of the drug or device, no allergic history specific to the drug or device, and no personal and/or family history which is an absolute contraindication to use the drug or device.
  - Objective data information will include but is not limited to: Physical examination appropriate to warrant the use of the drug or device and laboratory tests or procedures to indicate/contraindicate use of drug or device if necessary.
  - Assessment: Subjective and objective information consistent for the use of the drug or device.
- Treatment
  - Physician assistants may administer or provide medication to a patient, or transmit orally, or in writing on a patient's record or in a drug order, an order to a person who may lawfully furnish the medication or medical device per Business and Professions Code, Title 16, §3502.1.(a)
  - Medications/devices prescribed by the PA may be either over-the-counter or medications/devices requiring a prescription.
  - Medications/devices may be furnished directly to the patient, or the patient's direct care giver, by the PA.

**NORTHERN INYO HEALTHCARE DISTRICT  
POLICY AND PROCEDURE**

Title: Standardized Protocol – Medication/Device Policy for the Physician Assistant	
Scope: Physician Assistants	Manual: Medical Staff
Source: Medical Staff Support Manager	Effective Date: 3/21/18

d. Physician assistants may only prescribe medication/devices appropriate for use in the type of practice engaged in by the current supervising physician(s) defined in the Delegation of Services Agreement.(Business and Professions Code, Title 16, §3502.1(a)(2))

d.e. Office samples, when applicable, may be dispensed per NIHD policy.

e.f. The drug or device will be appropriate to the condition being treated:

- i. Dosage will be in the effective range per formulary references
- ii. Not to exceed upper limit dosage per formulary references.
- iii. Indications or uses as specified by the formulary references.
- iv. No absolute contraindications of the use of the drug or device.

f.g. Medication history has been obtained including other medications being taken, medication allergies, and prior medications used for current condition.

g.h. All medications/devices furnished shall be documented in the patient’s medical record. The effectiveness of the medication/device shall also be documented in the patient’s medical record.

4. Patient Education:

- a. Provide the patient with information and counseling in regard to the medication/device. Caution the patient regarding potential side effects or complications with chosen medication/device. Document the education process in the medical record.

5. Physician consultation is to be obtained under the following circumstances:

- a. Emergent conditions requiring prompt medical intervention after the initial stabilizing care has been started.
- b. Acute decompensation of patient situation.
- c. Problem which is not resolving as anticipated.
- d. History, physical, or lab finding inconsistent with the clinical picture.
- e. Upon request of patient, nurse, or supervising physician.

**REFERENCES:**

- 1. UpToDate-evidence-based, Physician-authorized clinical decision support resource

**ATTACHMENTS:**

- 1. List of Authorized Physician Assistants and Supervising Physicians

<b>Approval</b>	<b>Date</b>
Interdisciplinary Practice Committee	<del>2/28/18</del> 10/30/18
<u>Medicine/Intensive Care Committee</u>	1/24/19
Medical Executive Committee	2/5/19
Board of Directors	3/21/18
Last Board of Directors Review	3/21/18

Developed: 2/2018 sb

Reviewed:

**NORTHERN INYO HEALTHCARE DISTRICT  
POLICY AND PROCEDURE**

Title: Standardized Protocol – Medication/Device Policy for the Physician Assistant	
Scope: Physician Assistants	Manual: Medical Staff
Source: Medical Staff Support Manager	Effective Date: 3/21/18

Revised: 2/2018 dp, [12/2018 dp](#)

Supersedes: *[Medication/Device Policy for the Emergency Department Physician Assistant](#)*; *[Medication/Device Policy for the Rural Health Clinic Physician Assistant](#)*

Index Listings:

Draft

**NORTHERN INYO HEALTHCARE DISTRICT  
POLICY AND PROCEDURE**

Title: Standardized Protocol – Medication/Device Policy for the Physician Assistant	
Scope: Physician Assistants	Manual: Medical Staff
Source: Medical Staff Support Manager	Effective Date: 3/21/18

**APPENDIX A:  
FORMULARY SPECIFICATIONS for  
Furnishing Medications/Devices Policy for the Nurse Practitioner/Physician Assistant  
STANDARDIZED PROCEDURE/PROTOCOL**

Formulary: Lexicomp drug database as accessed through UpToDate online reference, current as published and updated online.

Deletions: None.

Draft

**NORTHERN INYO HEALTHCARE DISTRICT  
POLICY AND PROCEDURE**

Title: Standardized Protocol – Minor Surgical Policy for the Physician Assistant	
Scope: Physician Assistants	Manual: Medical Staff
Source: Medical Staff Support Manager	Effective Date: 8/17/2016

**PURPOSE:**

1. This standardized protocol is designed to establish guidelines that will allow the Physician Assistant (PA) to perform minor surgical procedures incidental to the provision of routine primary care to ambulatory patients of Northern Inyo Healthcare District and affiliated locations.

**POLICY:**

1. Will meet all General Policy—Protocol guidelines. This standardized protocol and those authorized to work through this standardized protocol will meet all guidelines as outlined in the General Policy for the Physician Assistant.
2. Circumstances:
  - a. Patient population: pediatric and adult patients
  - b. Setting: Medical Clinics Northern Inyo Healthcare District (NIHD) and affiliated locations.
  - c. Supervision: Physicians as indicated in the Delegation of Services Agreement

**PROTOCOL:**

1. Conditions: after appropriate training and experience minor procedures that can be performed by the PA without direct physician supervision include:
  - a. Pessary placement
  - b. Electrocautery of external, non-malignant, e.g. warts
  - c. Epidermal cyst removal
  - d. Incision and drainage of abscess (excluding peri-rectal abscesses)
  - e. Suture laceration without nerve or tendon involvement
  - f. Mole removal
  - g. Punch or shave biopsy
  - h. Toe nail removal
  - i. Cryotherapy
  - j. IUD insertion and removal
  - k. Excision of simple lesions
  - l. Simple foreign body removal
  - m. Endometrial biopsy
  - n. Arthrocentesis/Steroid joint injection
  - o. Excision of hemorrhoid thrombus
  - p. Nexplanon insertion/removal
  - q. Circumcision of newborn
2. Data Base:
  - a. Subjective:
    - i. Obtain pertinent history including involved organ system, injury, trauma, dermatology problems, etc.

**NORTHERN INYO HEALTHCARE DISTRICT  
POLICY AND PROCEDURE**

Title: Standardized Protocol – Minor Surgical Policy for the Physician Assistant	
Scope: Physician Assistants	Manual: Medical Staff
Source: Medical Staff Support Manager	Effective Date: 8/17/2016

- 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.
- 3. Assessment:
  - a. Formulate diagnosis consistent with the above data base.
  - b. Document
- 4. Plan:
  - a. Develop therapeutic regimen
    - i. Perform appropriate procedure utilizing standard aseptic technique.
    - ii. Obtain additional diagnostic studies as indicated.
    - iii. Physician consultation/assistance in performing the procedure as per policy statement or above conditions.
    - iv. Patient education and self-care techniques.
    - v. Development of appropriate follow-up care plan.
    - vi. Update problem list.
  - b. Provide written discharge instructions to the patient.

**REFERENCES:**

- 1. UpToDate-evidence-based, Physician-authorized clinical decision support resource

**ATTACHMENTS:**

- 1. List of Authorized Physician Assistants and Supervising Physicians

<b>Approval</b>	<b>Date</b>
Interdisciplinary Practice Committee	10/30/18
Medicine/Intensive Care Service Committee	1/24/19
Medical Executive Committee	2/5/19
Board of Directors	8/17/16
Last Board of Directors Review	

Developed:

Reviewed:

Revised: 12/2018 dp

Supersedes: *Minor Surgical Policy for the Rural Health Clinic Physician Assistant*

**NORTHERN INYO HEALTHCARE DISTRICT  
POLICY AND PROCEDURE**

Title: Standardized Protocol – Well Child Care Policy for the Physician Assistant	
Scope: Physician Assistants	Manual: Medical Staff
Source: Medical Staff Support Manager	Effective Date: 12/2012

**PURPOSE:**

1. This standardized protocol is designed to establish guidelines that will allow the Physician Assistant (PA) to manage well child care.

**POLICY:**

1. ~~Will meet all General Policy—Protocol guidelines.~~ This standardized protocol and those authorized to work through this standardized protocol will meet all guidelines as outlined in the *General Policy for the Physician Assistant*.
2. Circumstances:
  - a. Patient populations: pediatric patients
  - b. Setting: Northern Inyo Healthcare District (NIHD) and affiliated locations
  - c. Supervision: Physicians indicated in the Delegation of Services Agreement

**PROTOCOL:**

1. Definition: health maintenance, health promotion and disease prevention activities which promote the physical, psychosocial and developmental well-being of children. Includes health assessments, appropriate laboratory tests, and disease prevention through immunizations, developmental screening, and health education.
2. 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.
      1. At each visit obtain vital signs, height, weight, HC, (under 1 years) plot on growth graph, hearing and vision tests (after 3 years).
      2. Perform complete physical exam.
      3. Perform appropriate development assessment.
      4. Assess parent-child interaction; social assessment.
      5. Laboratory testing as needed.
3. 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

**NORTHERN INYO HEALTHCARE DISTRICT  
POLICY AND PROCEDURE**

Title: Standardized Protocol – Well Child Care Policy for the Physician Assistant	
Scope: Physician Assistants	Manual: Medical Staff
Source: Medical Staff Support Manager	Effective Date: 12/2012

- 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 Acute Illness Protocol).
  - 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, family, nurse, or supervising physician.
  - 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
- 4. 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
- 5. 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.
      - 3.4. Usual dose: infants 0.05-0.10 ml, children 0.10-0.30 ml
      - 4.5. 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.

**NORTHERN INYO HEALTHCARE DISTRICT  
POLICY AND PROCEDURE**

Title: Standardized Protocol – Well Child Care Policy for the Physician Assistant	
Scope: Physician Assistants	Manual: Medical Staff
Source: Medical Staff Support Manager	Effective Date: 12/2012

2. Administer Epinephrine as outlined above.
3. Refer to M.D. Call 911
4. Report adverse reaction to local health department/manufacturer of vaccine.

**REFERENCES:**

1. UpToDate-evidence-based, Physician-authorized clinical decision support resource

**ATTACHMENTS:**

1. List of Authorized Physician Assistants and Supervising Physicians

<b>Approval</b>	<b>Date</b>
Interdisciplinary Practice Committee	10/30/18
Perinatal/Pediatrics Committee	1/25/19
Medical Executive Committee	2/5/19
Board of Directors	
Last Board of Directors Review	

Developed:

Reviewed:

Revised: 12/2018 dp

Supersedes: *Well Child Care Policy for the Rural Health Clinic Physician Assistant*

## Chief of Staff (COS)

### Job Description

#### Summary:

Elected by the voting members of the Medical Staff in accordance with Medical Staff Bylaws. Serves as Chair of the Medical Executive Committee and participates with other Medical Staff committees and departments. Reports Medical Staff information to the Board relating to credentialing, peer review, disciplinary investigations and actions and Medical Staff interests as specified in the bylaws. Also, communicates Board information and needs to Medical Staff departments and committees. Functions as advisor to facility's senior executive leadership by attending Chief-level meetings. Provides clinical leadership to implement goals and objectives that support the District's values. Is responsive to the concerns and needs of Medical Staff members and is expected to foster and contribute to a close and mutually beneficial relationship between the Medical Staff leaders and hospital management.

#### Medical Administrative Duties:

Helps direct and advise medical processes and systems within the hospital system in collaboration with the COO. Functions as the physician liaison for all aspects of the health system EMR and optimization in collaboration with the CIO. Helps to ensure safe patient care, treatment and services in collaboration with CNO.

Is an active member of the medical staff as well as an advisor to Administration and participates in Administrative and Medical Staff meetings, committees, and is an invited participant to the District Board meetings.

Is responsible for physician recruitment and retention along with HR and the Medical Staff Office. Integrates with the hospital on a community-wide assessment in determining a 5-year plan for physician succession.

Provides physician oversight, expertise and leadership, including:

- Medical Staff Office – coordinates with the administrative Director of Medical Staff Services in relation to credentialing and privileging, peer review, responding to unusual occurrence reports and enforcement of Medical Staff bylaws and rules including behavioral standards. Directs physician recruitment and retention. Demonstrates a commitment to quality by using data analytics in decision-making, ensuring that outcomes are continually monitored and measured (e.g. FPPE and OPPE). Serves as a physician advisor who promotes the development and satisfaction of healthcare professionals through counseling, mentoring, teaching and self-assessment.
- Directs development of and adherence to policies and procedures, bylaws and rules and regulations.
- Quality Management – Physician advisor for Utilization Review; promotes patient safety; provides recommendations on patient access and satisfaction; clinical outcomes and process improvement and guideline development and regulatory compliance; ensures best practice guidelines to decrease overall LOS, decrease variation in practice, promote coordination of patient care throughout the hospital experience and post-discharge phase, in coordination with the Hospitalist Director, aligning and coordinating ambulatory and inpatient care.
- Performance Improvement – Actively involved in the organizational performance improvement, environment of care and strategic planning, including quality and safety of patient care, treatment and services.

**Clinical Duties:** Ongoing practice (0.25 FTE to 0.5 FTE) of clinical medicine as defined by their board certification.

#### Job Relationships:

- Chair of Medical Executive Committee and Medical Staff.
- Member of the following committees, at a minimum:
  - Bylaws
  - Utilization Review
  - Credentials
  - Infection Control
- Provides supervision of Department Chairs.
- Medical Staff Office reports to the COS, with oversight from CEO.

**Requirements:** Unrestricted CA medical license; Board Certified in applicable specialty; valid DEA; active member of the Medical Staff in good standing. Administrative and clinical experience, exceptional interpersonal and communication skills, demonstrates initiative, ability to work independently; capacity for conceptual thinking, peer motivation and problem solving; experience in physician recruitment and retention. MBA, MMM, MPH, or MHA preferred, but not required.

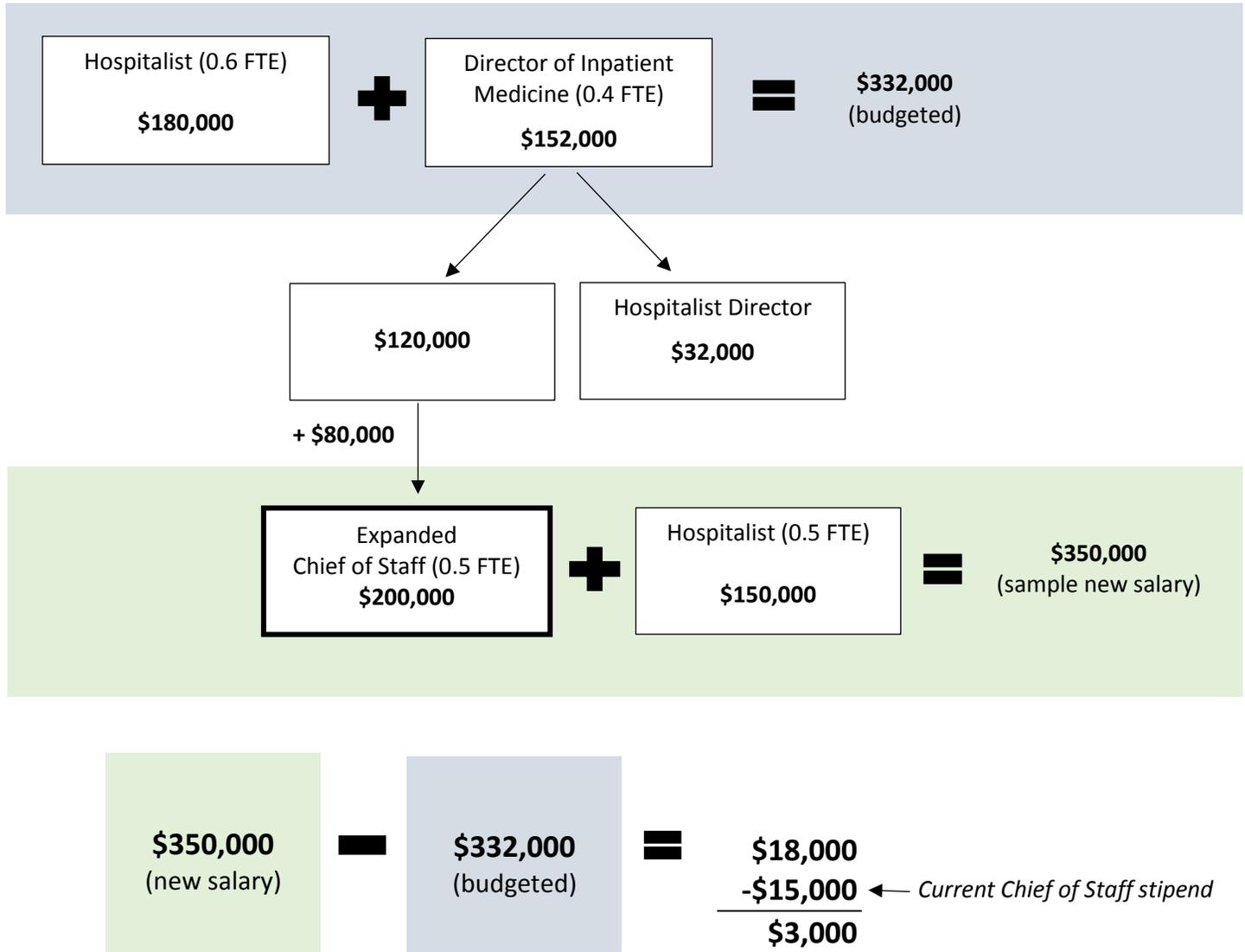
**Compensation:** \$200,000 annually via independent contract with the Medical Staff.

## FUNDING FOR EXPANDED CHIEF OF STAFF

### Background

- Typical full-time Hospitalist salary: \$300,000
- Director's salary: \$32,000

### Analysis



**TOTAL ADDITIONAL FUNDING NEEDED: \$3,000**

## Compliance Report February 2019

1. Comprehensive Compliance Program review
  - a. As of February 8<sup>th</sup>, 2019, 98.1% District's employee (including temporary, traveler, and contract workers) workforce) of the District's employee workforce have reviewed the Compliance Program within 90 days of their first day of employment. This is a vast improvement from the 80% reported in October 2018.
  - b. The Compliance Department has been following up individually with employee workforce members who have not read the assigned Compliance Program, since it is mandatory.
2. Breaches
  - a. Calendar Year (CY) 2018 – (attachment A)
    - i. 71 alleged breaches of PHI (Personal Health Information) potentially affecting more than 190 patients have been investigated by the Compliance Office
    - ii. 20 of the alleged breaches of PHI have been reported to California Department of Public Health (CDPH) and/or the Office of Civil Rights (OCR)
      1. CDPH has completed investigation of 15 cases. Fifteen (15) breaches were substantiated, but assigned no deficiency.
      2. Five (5) cases are still pending CDPH investigation or letter of findings, indicating that at least several are likely to incur some deficiency and potential penalty.
3. Issues and Inquiries
  - a. CY 2018 – More than 275 requests for research and input on a wide variety of topics have been made to the Compliance Department.
    - i. Compliance and regulation research tops the list.
    - ii. Policy advice and research
    - iii. Potential compliance concerns that do not reach the level of a full investigation. (Usually require training and education)
  - b. Compliance currently reviews all new referring physicians to verify they are not on a Federal or State exclusions list. To date in 2018, Compliance has verified several thousand providers. Conducting business with anyone on an exclusions list places

NIHD at risk. It is considered fraud to bill any government payer for diagnostic or treatment claims, if ordered by an excluded provider.

- c. Compliance is assisting ITS in ensuring provider databases in the 4 systems (Athena, 7Medical, Orchard Harvest, and Redoc) are entered correctly and remain the same. In doing this process, Compliance is reviewing the address, phone, and fax numbers of all providers entered to reduce the probability of breaches from our electronic systems. Compliance has reviewed several hundred since 10/1/18.
4. The Compliance Department has conducted over 46 investigations related to compliance concerns that are not breaches.
5. Audits
  - a. Employee Access Audits (attachment B) - The Compliance Office manually completes audits for access of patient information systems to ensure that employees access records only on a work-related, “need to know,” and “minimum necessary” basis.
    - i. The HIPAA and HITECH Acts imply that organizations must perform due diligence by actively auditing and monitoring for appropriate use of PHI. These audits are also required by the Joint Commission and are a component of the “Meaningful Use” requirements.
    - ii. Access audits monitor who is accessing records by audit trails created in the systems. These audits allow us to detect unusual or unauthorized access of patient medical records.
    - iii. Compliance performs between 300-500 audits monthly.
      1. Each audit ranges from hundreds of lines of data to hundreds of thousands of lines of data.
    - iv. Protenus has been selected to provide semi-automated auditing software services to NIHD beginning as soon as IT resources are able to be allocated for the project.
  - b. Business Associates Agreements (BAA) audit
    - i. Contracts are currently under review to ensure all vendors, individuals, and entities providing services that access, disclose, retain, or transmit PHI for NIHD have an up-to-date Business Associates Agreement.
    - ii. We currently have around 130 Business Associates Agreements.
    - iii. Currently reviewing NIHD partnerships to assess for Organized Health Care Arrangements and Affiliated Covered Entity arrangements. These are

arrangements that would be put into place between NIHD and other local healthcare partners in place of a BAA

- c. PACS User Access Agreements – Compliance is now processing access agreements for external entities/providers to gain access to the NIHD PACS Portal (electronic Imaging system). Requests from 6 external entities/providers have been processed since 1/1/2019.
  - d. HIPAA Security Risk Assessment – Completed December 2019
    - i. Annual requirement to assess security and privacy risk areas as defined in 45 CFR 164.3. Review of 157 privacy and security elements performed in conjunction with Information Technology Services.
6. Conflicts of Interest questionnaires
- a. Compliance has not yet sent the Conflict of Interest questionnaire form to the District workforce this year. We are awaiting full resolution of conflicts identified in 2018 prior to requesting this information.
  - b. The Management Plan form has been re-designed to simplify the process for our leadership team. We have management plans in place for 98% of the workforce for whom they are needed. We are working with leadership teams to develop and review the plans for the remaining conflict.
7. CPRA (California Public Records Act) Requests
- a. The Compliance office has responded to 10 CPRA request in CY 2018.
    - i. 8 requests throughout the year for companies that harvest data from healthcare organizations to aid their marketing products.
    - ii. 2 in December from District resident, Ms. Freeman
  - b. The Compliance office has responded to 3 CPRA requests from District resident, Ms. Freeman in 2019. She has informed us to expect requests.
8. Compliance Workplan (attachment C)
- a. The Department of Health and Human Services Office of Inspector General's (OIG) creates an annual workplan for auditing, based on areas of high concern for fraud, waste, and abuse. The Centers for Medicare/Medicaid Services Medicare Administrative contractors (MACs) also create an annual audit workplan.
  - b. OIG recommends that annual Compliance Department workplans are created, based on the facility Compliance Program, and the OIG and MAC workplans, along with areas of risk for the organization.

- c. The attached work plan updated in January 2019 for progress and approved by the Compliance and Business Ethics Committee.

9. Unusual Occurrence Reports (UOR)

- a. Transition to Unusual Occurrence reports (UOR) – next two quarters
- b. Compliance has processed greater than 700 UORs since 1/1/2018.
- c. Trending
- d. ComplyTrac- tracking software – software build and implementation is currently in progress

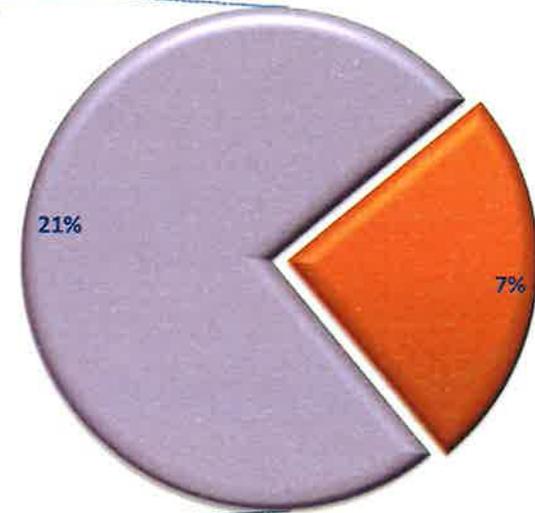
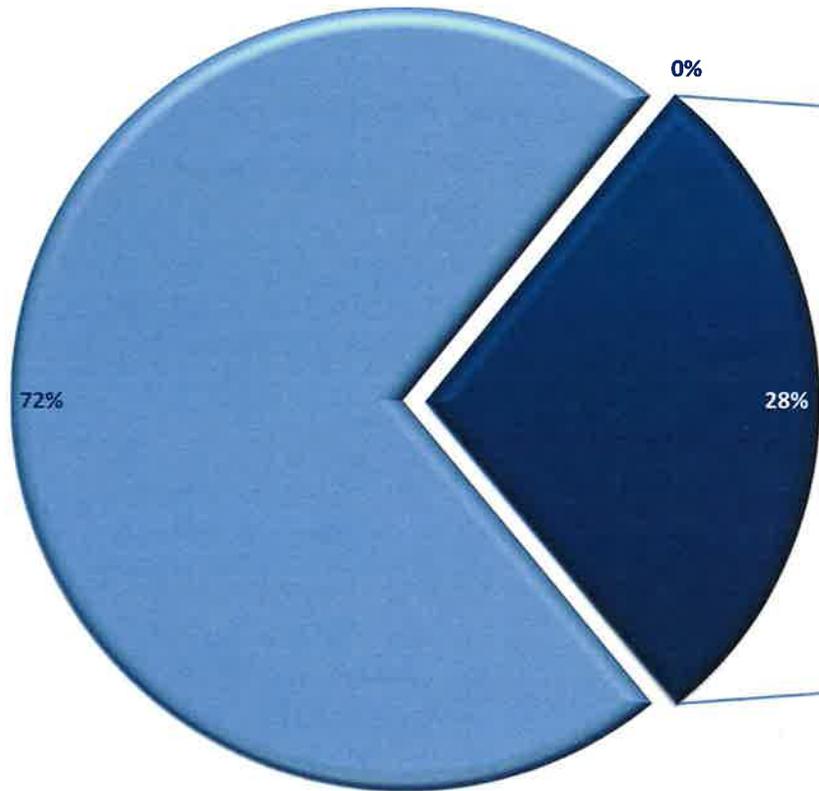
10. CDPH Licensing Survey Response Monitoring

- a. Compliance will be working with Department leadership teams to follow corrective actions and monitor for sustained compliance. Those metrics will be reported here, no less than annually.
  - i. Referral arrangements from non-staff ordering providers.
  - ii. Pediatric Consultations
  - iii. Code Amber drills
  - iv. RN Competency Validations
  - v. Sterile compounding area ceiling, and refrigerator temperature monitoring
  - vi. Staff knowledge of location of Malignant Hyperthermia cart
  - vii. Add crash cart medication list to Crash Cart Policy – completed. No additional monitoring required.
  - viii. Titratable sedatives and sedation scale use
  - ix. Proper storage of clove oil in ED dental box – Clove oil removed from supplies and supply list. Monthly monitoring has determined this has been effective. No additional monitoring required as of 1/1/2019.
  - x. Beyond-use-date labeling of medications
  - xi. Expired supply in crash cart
  - xii. TB Surveillance program – letter of compliance sent to CDPH. No additional monitoring is required.
  - xiii. Infection Prevention Program monitoring
  - xiv. Workforce N95 mask fit testing
  - xv. Equipment preventative maintenance stickers – in progress.

## 2018 Breach Outcomes

71 Breach investigations potentially affecting 190 patients

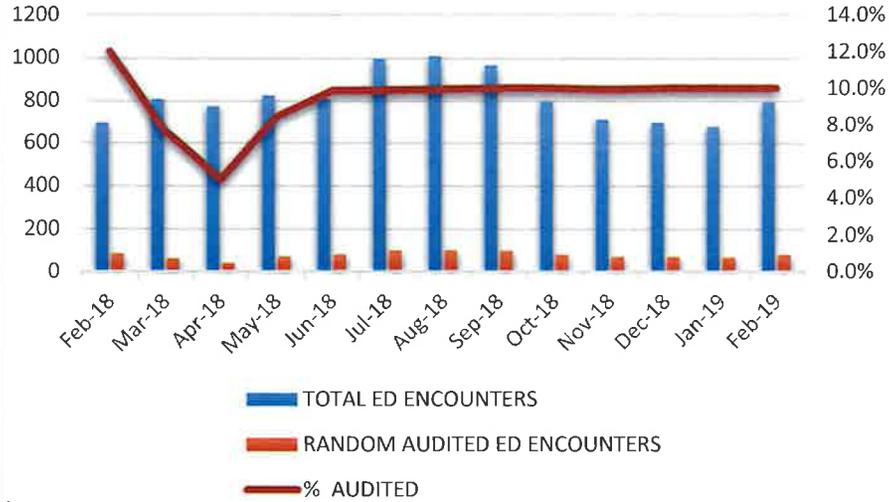
- Near-miss breach (no CDPH reporting)
- Reported to CDPH
- Unsubstantiated
- Substantiated, No Deficiency
- Deficiency, possible penalties
- Ongoing CDPH Investigation



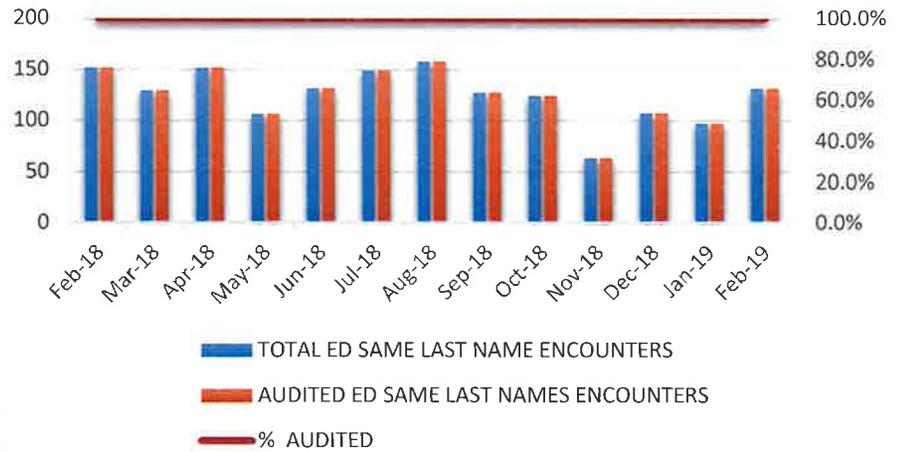
# Employee EHR Access Audits

## Emergency Room Encounters

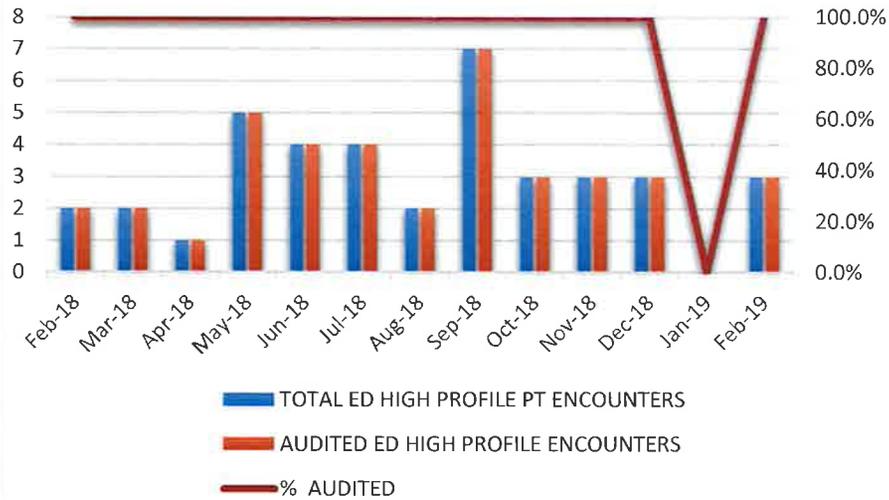
### Random ED Encounter Audits



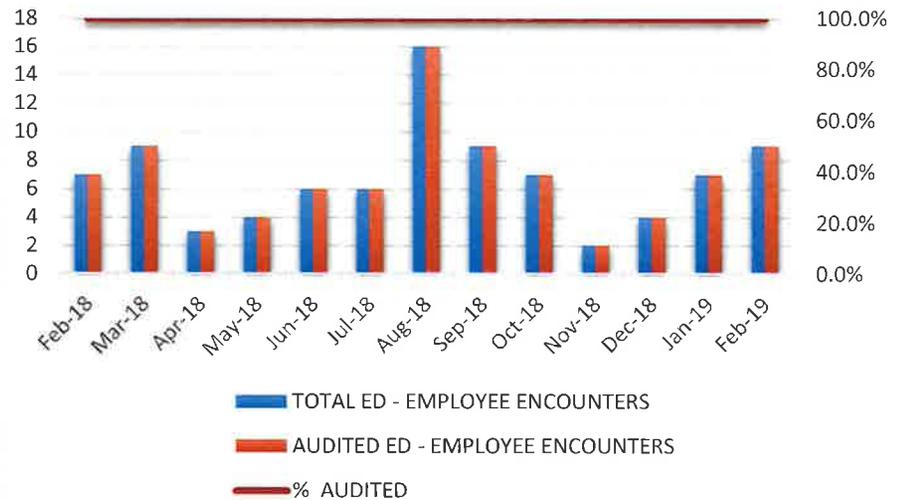
### ED Patient with the same last name as an employee



### HPP ED Encounters



### Employee ED Encounters

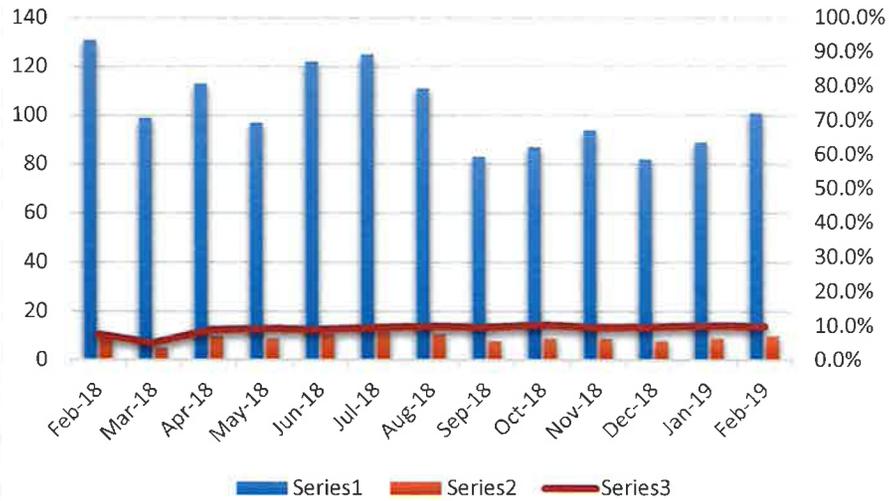


105

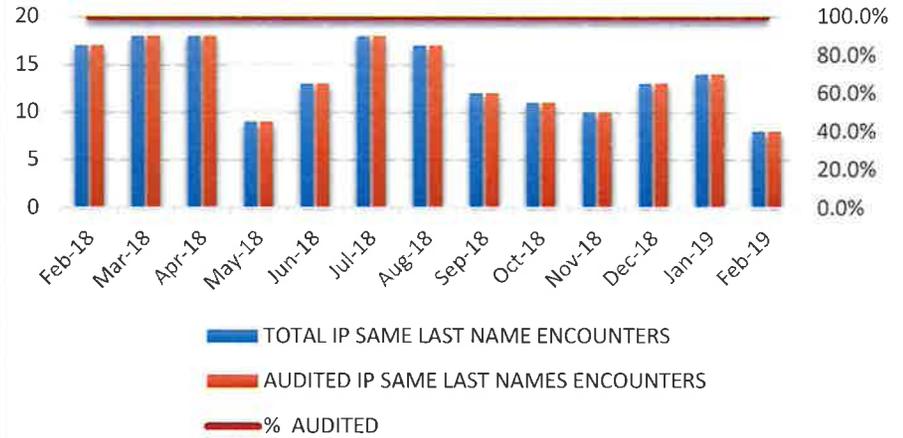
"B"

# Employee EHR Access Audits Inpatient Encounters

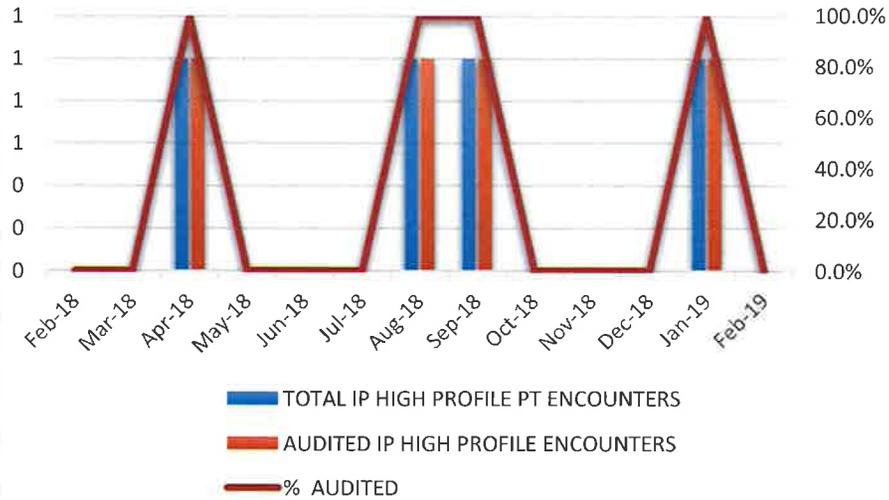
## Random IP encounter Audits



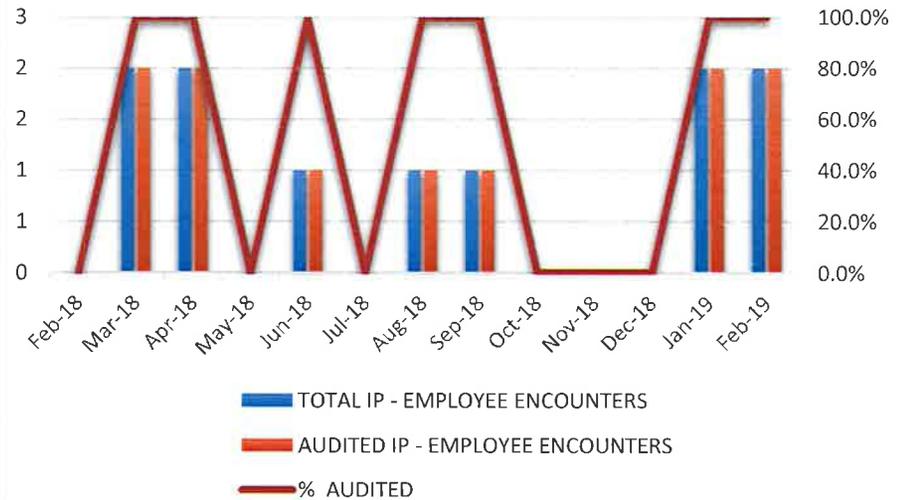
## Inpatient with the same last name as an employee



## HPP IP Encounters

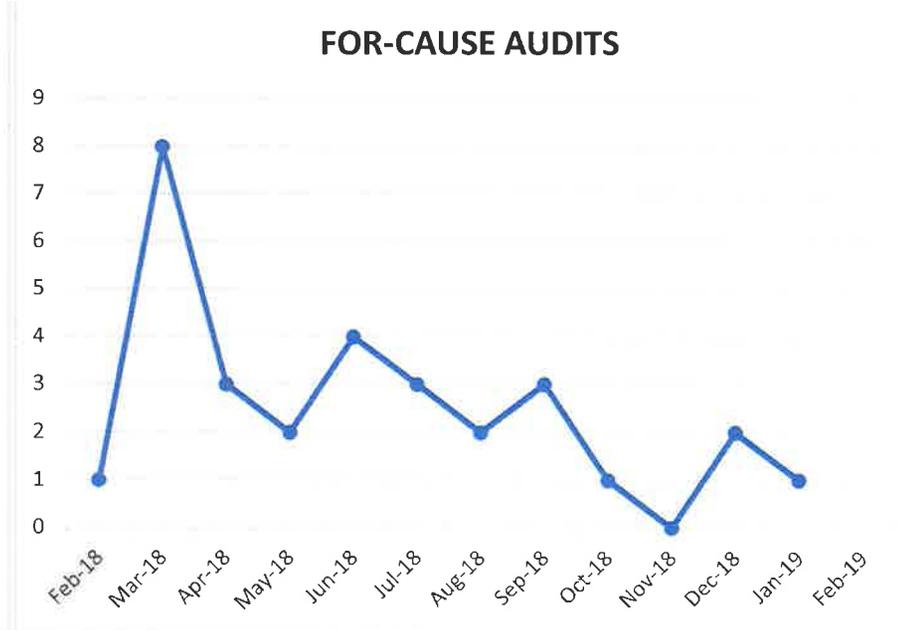


## Employee IP Encounters

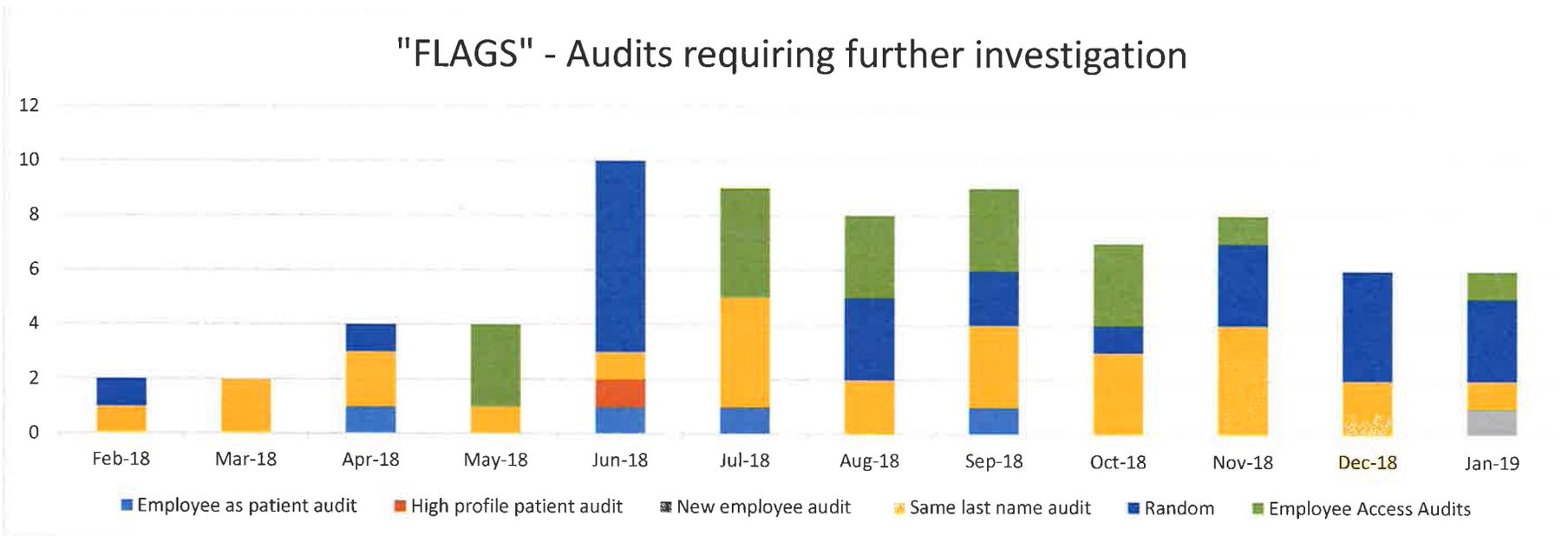


"B"

# Employee EHR Access Audits



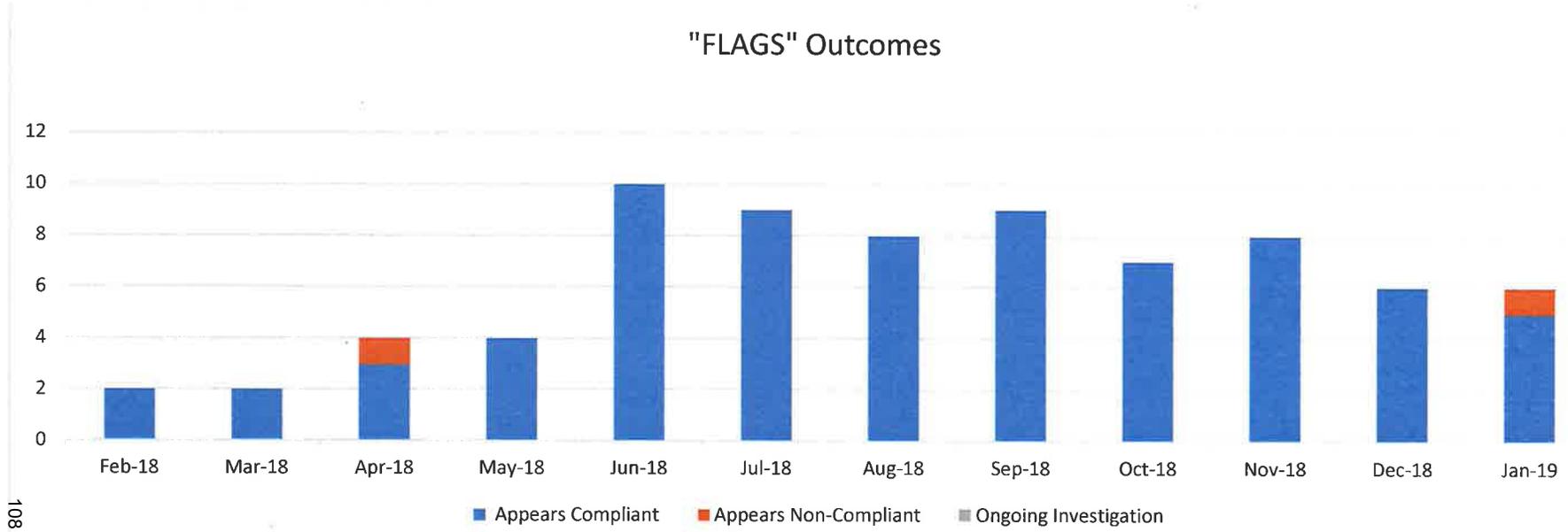
107



"B"

# Employee EHR Access Audits

## "FLAGS" Outcomes



No.	Item	Reference	Comments
<b>Compliance Oversight and Management</b>			
1.	Review and update charters and policies related to the duties and responsibilities of the Compliance Committees.	NIHD Compliance Program (p.17)	Completed Jan 2019
2.	Develop and deliver the annual briefing and training for the Board on changes in the regulatory and legal environment, along with their duties and responsibilities in oversight of the Compliance Program.	NIHD Compliance Program (p.17)	Colin Coffey, Jan 2019. Also CO briefing and updates in August 2018. "Takeaways" from monthly HCCA magazine
3.	Develop a Compliance Department budget to ensure sufficient staff and other resources to fully meet obligations and responsibilities.		Completed June 1, 2018
<b>Written Compliance Guidance</b>			
4.	Audit of required Compliance related policies.		Annual review conducted on regular monthly schedule Throughout the year
5.	Annual review of Code of Conduct to ensure that it currently meets the needs of the organization and is consistent with current policies. (Note: Less than 12 pages, 10 grade reading level or below)		7/30/2018 - Completed
6.	Verify that the Code of Conduct has been disseminated to all new employees and workforce.		Completed 7/2018
<b>Compliance Education and Training</b>			
7.	Verify all workforce receive compliance training and that documentation exists to support results. Report results to Compliance Committee.		January 2019
8.	Ensure all claims processing staff receive specialized training programs on proper documentation and coding.	In progress following Athena go-live	
9.	Review and assess role-based access for EHR and partner programs. Implement/evaluate standardized process to assign role-based access.	R-BAT created 7/2018. Currently working with Athena to update RBA controls.	In progress
10.	Compliance training programs: fraud and abuse laws, coding requirements, claim development and submission processes, general prohibitions on paying or receiving remuneration to induce referrals and other current legal standards.	Completed at Orientation. Need to send to Med Staff. PPM and Relias for current workforce.	

"C"

<b>Compliance Communication</b>			
11.	Review investigation log. Prepare summary report for Compliance Committee on types of issues reported and resolution		Quarterly 2019
12.	Develop a report that evidences prompt documenting, processing, and resolution of complaints and allegations received by the Compliance Department.	Case Log, Investigation Reports, A	Completed Dec 2018
13.	Document test and review of Compliance Hotline.		Completed 7/2018
14.	Physically verify Compliance hotline posters appear prominently on employee boards in work areas.		Verified 7/2018
<b>Compliance Enforcement and Sanction Screening</b>			
15.	Verify that sanction screening of all employees/workforce and others engaged by NIHD against OIG List of Excluded Individuals and Entities has been performed in a timely manner, and is documented by a responsible party.	Ongoing - HR performs employees/travelers/temps monthly. Compliance verifies new providers. MSO verifies all medical staff. Accounting verifies all vendors.	Current through 1/2019
16.	Develop a review and prepare a report regarding whether all actions relating to the enforcement of disciplinary standards are properly documented.		Unable to complete due to restructure of Compliance Team and addition of UOR/Patient complaints/CDPH/CMS monitoring
17.	<b>Audits</b>		
	a. Arrangements with physician (database)		Unable to complete due to restructure
	b. EMTALA		
	c. Cost reports	Wipfli	Completed at BOD 1/2019
	d. Payment patterns		Unable to complete due to restructure
	e. Bad debt/ credit balances	Will work with J. Tremble.	Unable to complete due to restructure
	f. OPS - Home health and DME	HHS OIG target	Initial meet with P West 1/2019
	Lab services	MAC target	Unable to complete due to restructure
	Imaging services (high cost/high usage)	MAC target	Unable to complete due to restructure
	Rehab services	HHS OIG workplan	Unable to complete due to restructure

18.	Ensure that high risks associated with HIPAA and HITECH Privacy and Security requirements for protecting health information undergo a compliance review.		November 2018
	a. Annual Security Risk Assessment		Security Risk Assessment due in Feb 2019 - completed Dec 2018
	b. Periodic update to SRA		
	c. Monthly employee access audits		Current through 12/2018
19.	Audit required signage		Proper signage is posted in all areas except the DI waiting area. It is in progress. 1/2019
20.	Audit HIMS scanned document accuracy		Delayed due to restructure and EHR change
21.	Develop metrics to assess the effectiveness and progress of the Compliance Program		Delayed due to restructure
22.	Implement automated access monitoring/auditing software (Protenus)		Starts January 2019 when we have allocation of IT resources.
23.	<del>Review CMS CoPs (CAH)</del>		Delayed due to restructure
<b>Response to Detected Problems and Corrective Action</b>			
24.	Verify that all identified issues related to potential fraud are promptly investigated and documented	In progress. Documented in Case log	1/2019
25.	Review all corrective action measures taken related to compliance to verify they have been completed and validated as being effective. Prepare a summary report for the CBEC		Delayed due to restructure and addition of PHHC
26.	Conduct a review that ensures all identified overpayments are promptly reported and repaid.	Working with WJ, MET, HIMS dept to review all audits, recoupments	In progress October 2018
27.	UOR tracking and trending - UOR/Unusual occurrence reporting is now a function on the Compliance Department.	Implementing ComplyTrac incident management system.	Fast track due to restructure. ongoing
	a. Provide trend feedback to leadership to allow for data driven decision-making		On-going

" C "

	I. Overall QRR process		August 2018
	II. Workplace Violence		September 2018
	III. Sharps		October 2018
	IV. Overweight laundry		October 2018
28.	Pioneer Home Health and Hospice of the Owens Valley Compliance Review, ACE agreement	In Progress	1/2019
29.	Patient complaints	In Progress	Restructure adds these to Compliance Workplan
30.	Breach Investigations	On-going	On-going – see Compliance report

2018 Compliance Work Plan – updated 1/2019

**NORTHERN INYO HOSPITAL  
POLICY AND PROCEDURE**

Title: Authorization of Hours Worked Beyond Regularly Scheduled Shift (Including Overtime Request)	
Scope: Nursing Services	Manual: 3. NAM - Utilization of Nursing Staff and Staffing Budget
Source: Chief Nursing Officer	Effective Date: 12/1/13

**PURPOSE:**

It is the policy of Northern Inyo Hospital to monitor Nursing Services hours worked beyond hired status (regularly worked hours) to identify patient care situations, meetings, etc., that alter workload completion, efficiency, and delivery of patient care.

**POLICY:**

1. Any hours worked beyond the regularly scheduled shift hours hired or in addition to the scheduled shift, are considered overtime and must be recorded in the **scheduling software for monitoring, where it will be approved by the nursing department Director, Manager, Assistant Nurse Manager or House Supervisor.**
2. Overtime pay will be issued in accordance to the HR payroll policy.
3. Any Nursing hours worked beyond the scheduled shift or in addition to the scheduled shift, including not taking the 30-minute lunch break must be approved by the House Supervisor **on duty.**
4. Indirect work hours (meetings, Learning Management System completion) are to be completed during the assigned (direct care) shift **unless otherwise approved by nursing management.**

**PROCEDURE:**

1. When an employee becomes aware that he/she is unable to complete their workload by the end of the assigned shift, he/she will notify the house supervisor (HS). This may be related to meeting attendance, change in patient condition, etc.
2. The House Supervisor will evaluate the existing situation and provide action as indicated (additional help, assistance with organization and priority setting, approval of meeting attendance, etc.).
3. Employees who,
  - a. are on call or called in,
  - b. attend meetings, in- service, etc., outside their regular work ours,
  - c. do not take a 30-minute lunch break,
  - d. cannot complete the workload within the assigned shift,
  - e. called in early to work or asked to stay over,
  - f. works extra shifts beyond those hours hired,will have the work hours documented by the House Supervisor in the department Staffing Management **software with attached reason for the overtime.**
  - g. Scheduled to complete Learning Management System without a patient assignment, **hours will be moved under education within the scheduling software to allow for tracking of hours.**
4. If staff are unable to complete indirect work hours such as meeting attendance, Learning Management System, etc. during the assigned shift, staff are to clock into KRONOS using the correct code.
  - a. Staff usage of indirect hours for workshops, meetings, etc., are to be monitored by the employee manager
5. The manager and/or designee will utilize the Staffing Management **Software** to verify the KRONOS sheets, monitor OT trends, adjust scheduling, and forecast budgeting.

**REFERENCES:**

1. Fair Labor Standards Act

**CROSS REFERENCE P&P:**

2. Scheduling of Nursing Personnel
3. Payroll Policies and Procedures
4. Staff work expectations beyond scheduled shift in department that closes
5. Fixed Staff Floating

**NORTHERN INYO HOSPITAL  
POLICY AND PROCEDURE**

Title: Authorization of Hours Worked Beyond Regularly Scheduled Shift (Including Overtime Request)	
Scope: Nursing Services	Manual: 3. NAM - Utilization of Nursing Staff and Staffing Budget
Source: Chief Nursing Officer	Effective Date: 12/1/13

- 6. Deployment of Nursing Staff at Department Level and Patient Care Areas
- 7. Routine Hours of Work
- 8. Hours, Rest and Meal Periods

<b>Approval</b>	<b>Date</b>
NEC	6/20/18
Board of Directors	
Last Board of Director Review	4/18/18

Developed: 11/1/13  
 Reviewed:  
 Revised: 6/18ta  
 Supersedes:  
 Index Listings:

**NORTHERN INYO HOSPITAL  
POLICY AND PROCEDURE**

Title: Guidelines for Licensed Nurses Nursing Students Giving Medications	
Scope: District Wide	Manual: Nursing Administration
Source: Director of Nursing	Effective Date:

**GUIDELINES FOR LICENSED NURSES  
NURSING STUDENTS GIVING MEDICATIONS**

The licensed nurse remains responsible for the nursing care received by the patient from the nursing student.

The instructor is ultimately responsible for the training and education provided for the nursing student. The instructor is employed by the university/college and has ultimate responsibility for the students under this circumstance. Therefore, there needs to be good communication and coordination between the NIHD licensed nurse and the instructor.

NIHD provides preceptorship under special agreement which includes the student, preceptee, who works directly under the supervision of a specifically assigned NIHD licensed Registered Nurse, preceptor. In this case all documentation by the preceptee must be co-signed by the preceptor.

1. Students shall work with the nursing instructor or preceptor RN in administering medications to one team of patients.
2. Students must be supervised by the NIHD licensed nurse preceptor or licensed nurse instructor and should not be given total responsibility or left on the unit to give medications alone. The NIHD licensed nurse preceptor, or the licensed nurse instructor, will cosign the medications given by the nursing student. In the case where the nursing student is not provided with access to document within the chart, the licensed nursing instructor will be responsible to supervise and document the medication administration.
3. Students are responsible to give and chart only those medications they have prepared and give themselves. If the student is not provided access to electronic documentation, the nursing instructor must be present during medication administration and must document the medication administration.
4. Policy requires double check on high risk medications which must be checked by the NIHD licensed nurse instructor or licensed nurse preceptor.
5. When student preceptees are assigned to work with the licensed nurse, they should be given an overview of responsibilities. They should make rounds to assess patients with the licensed nurse and with the physician, verify and carry through on doctors' orders, chart on several patients, identify important assessments and observations, and include pertinent information in report.
6. When students under the direction of a licensed nursing instructor are assigned to work with a patient, they must collaborate with the RN who has responsibility for the patient's care. They should be given an overview of the care required and the responsibilities associated. They may participate in provision of care under direct observation of the RN or the licensed nursing instructor. They are required to provide a hand-off utilizing the SBAR-QC tool after any important change in the patient's condition and at the end of their clinical shift to the responsible RN.

**NORTHERN INYO HOSPITAL  
POLICY AND PROCEDURE**

Title: Guidelines for Licensed Nurses Nursing Students Giving Medications	
Scope: District Wide	Manual: Nursing Administration
Source: Director of Nursing	Effective Date:

**REFERENCE:**

1. TJC (CAMCAH 2019) NR.02.01.01 and NR.02.02.01

<b>Approval</b>	<b>Date</b>
Nurse Executive Committee	1/16/19
Board of Directors	
Last Board of Director review	4/18/18

Developed:

Revised: 8/11, 1/19ta

Reviewed:

Index Listing: Medications, Student Guidelines; Students, Guidelines for Medications

**NORTHERN INYO HOSPITAL  
POLICY AND PROCEDURE**

<b>Title: Thrombolytic Therapy for Acute Myocardial Infarction</b>	
Scope:	Department: <b>Emergency Dept, ICU/CCU</b>
Source: Manager - Emergency Department	Effective Date: 6/16/04

**PURPOSE:**

Ensure the timely, safe and appropriate administration of thrombolytic therapy for the treatment of acute myocardial infarction (AMI)

**POLICY:**

1. Emergency Department (ED) physicians, Internal Medicine Physicians, Family Practice physicians trained in the management of AMI, may initiate thrombolytic therapy.
2. Tenectapase (TNK) will be used exclusively for thrombolysis in AMI.
3. A Tenectapase supply shall be available in the Emergency Department at all times. A back-up supply shall be available in the pharmacy.
4. A thrombolytic administration packet consisting of
  - a. Acute MI Thrombolytic Therapy – Tenectapase Order Sheet
  - b. Patient Selection Worksheet For Thrombolytic Therapy
  - c. Consent For Use Of Thrombolytic Therapy
  - d. Frequent Vital Signs Sheet
  - e. Drug Use Evaluation – Tenectapase
  - f. Nursing Focus Review

➤ Packet contents are on the intranet: Forms>Departmental Forms>ED>MI TNK Packet  
<http://intranet/Forms/Downtime/ED/Thrombolytic%20use%20Guidelines%20for%20Acute%20Myocardial%20Infarction.pdf>
5. Nursing personnel shall provide the thrombolytic administration paperwork/packet ( in the intranet) to the physician.
6. The Acute MI Thrombolytic Therapy – Tenectapase order sheet shall be used to order TNK. TNK may also be ordered separately in CPOE.
7. The Emergency Department Physician may contact a cardiologist for consultation while giving thrombolytics and should also discuss coordination of further care of patient who has received thrombolytic therapy with transfer center physician.
8. The Emergency Department triage nurse will initiate the chest pain triage protocol upon determining that a patient has presented with chest pain:
  - g. Oxygen therapy at an initial rate of 2 liters/min.
  - h. Continuous cardiac monitoring, pulse oximetry and blood pressure monitoring,
  - i. Chest X-Ray
  - j. CBC, PT, PTT, Troponin, Chem-14, Type and Screen, UA
  - k. EKG

**NORTHERN INYO HOSPITAL  
POLICY AND PROCEDURE**

<b>Title: Thrombolytic Therapy for Acute Myocardial Infarction</b>	
Scope:	Department: <b>Emergency Dept, ICU/CCU</b>
Source: Manager - Emergency Department	Effective Date: 6/16/04

1. Aspirin 325mg if the patient has not taken aspirin or been given aspirin prior to arrival, and if the patient is not allergic to aspirin or related NSAIDs (e.g.: Ibuprofen, Naproxen).
  - m. Start an IV with Normal Saline 1000ml at 20ml/hr.
9. Start a 2<sup>nd</sup> IV if AMI is determined and TNK is to be administered. Verify with physician before breaking TNK seal.
  10. Have patient sign consent prior to administration of TNK.
    - o 11. House supervisor shall be notified regarding patient transfer.
  12. Nursing Focus Review and Drug Use Evaluation sheet shall be turned in to ED Manager after form is completed.

**REFERENCE:**

1. Genentech. TNkase (Tenectaplast). Retrieved from:  
[https://www.gene.com/download/pdf/tnkase\\_prescribing](https://www.gene.com/download/pdf/tnkase_prescribing).

**CROSS REFERENCE:**

1. Emergency Department Triage Protocols
2. Thrombolytic Therapy Consent

<b>Committee Approval</b>	<b>Date</b>
Clinical Consistency Oversight Committee	3/26/18
Emergency Services Committee	5/16/18
Med/ICU Committee	4/27/18
Medical Executive Committee	7/9/18
Board of Directors	
Last Board of Director review	6/21/17

Revised 03/18 gr  
 Reviewed 6/11as; 2/15as, ; 1/17 LA  
 Supersedes

# NORTHERN INYO HOSPITAL

## POLICY AND PROCEDURE

Title: Charge Capture Policy and Procedure	
Scope: All revenue generating service departments of Northern Inyo Hospital	Manual: Revenue generating service departments, Billing, Credit and Billing
Source: Charge Capture Manager	Effective Date:

**PURPOSE:** To ensure that each service department accurately, completely and in a timely manner, records patient service revenue.

### **POLICY:**

Charges for services provided to patients will be recorded in the appropriate patient visit upon the delivery of care for all system generated charges. Manual charges will be placed within seventy-two (72) hours of the provision of care.

Each service department providing patients with chargeable services and supplies is solely responsible for the timely and accurate posting of their charges to the appropriate patient visit. Each service department is also responsible for the daily reconciliation of all charges to ensure accurate and complete posting of charges into the organization's financial system.

### **DEFINITIONS:**

1. Charge Description Master (CDM): A list detailing the official rate charged by a hospital for individual procedures, services and supplies.
2. Current Procedural Terminology (CPT): These are medical code sets that are used to report medical, surgical and diagnostic procedures and services to entities such as physicians, health insurance companies and accreditation organizations.
3. Modifier(s): A modifier indicates that a service or procedure has been altered by some specific circumstance, but not changed in its definition or code. Modifiers are used to add information or to change the description of a service in order to improve specificity.
4. Service department: Any department within the hospital that provides a service for which a charge can be generated.

### **PROCEDURE:**

#### **1. Charge Identification and Recording**

- a. The development of procedures to address the charge capture processes shall be service area specific. The procedures need not be the same for different services within a single department (i.e., X-ray, MRI, CT).
- b. Each service department will have designated staff positions assigned the responsibility to provide system inherent charge capture entry and review. Assignments will be developed to provide coverage of this responsibility on a daily basis. There will be a minimum of two staff members trained in the charge capture activities so that back-up can be provided at all times.
- c. Utilizing the appropriate charge description master (CDM) codes, the caregiver shall accurately document all chargeable services and supplies at the time of service in an appropriate manner and format as designated by each service department's policies and procedures.
- d. If charges are generated and entered via documentation of those services, the service department will record all documented charges the appropriate patient visit within twenty-four (24) hours of the provision of the service.
- e. All manual charges will be placed on the patient's visit within seventy-two (72) hours of the date the service(s) was rendered by the department providing the service.

# NORTHERN INYO HOSPITAL

## POLICY AND PROCEDURE

Title: Charge Capture Policy and Procedure	
Scope: All revenue generating service departments of Northern Inyo Hospital	Manual: Revenue generating service departments, Billing, Credit and Billing
Source: Charge Capture Manager	Effective Date:

### 2. Charge Audit and Control

- a. Each service department will be responsible for the daily reconciliation of charge capture, charge entry, charge interface processes, system inherent charge review and for the appropriate resolution of identified errors and omissions by midnight of the following day.
- b. Each service department is responsible for documenting and implementing an audit process to ensure all chargeable services are accurately documented at the time of service.
- c. The documented services and supplies will be compared to the daily department census (revenue and usage report), schedules and/or interface service reports within twenty-four (24) hours of the original posting date.
- d. All errors or omissions will be corrected on the patient's visit in the system on the day the error or omission is discovered.

### 3. Interface

- a. Each service department is responsible for implementing an audit process to ensure accurate transmittal of system-recorded charges from each subsystem to the financial system.
- b. Each service department is responsible for having or developing an interface related error report listing all transmittal failures.
- c. Each service department is responsible for reviewing the error report and correcting the error within twenty-four (24) hours of the report.
- d. If issues with the report or the correction of the errors occur, the service department should contact the Charge Capture Department for assistance.

### 4. Documentation

- a. Each service department shall prepare individual detailed service area specific charge procedures including the following sections:
  - i. Charge capture process
  - ii. Charge capture reconciliation process
  - iii. Charge capture auditing procedure
  - iv. Charge entry auditing procedures
  - v. Charge interface procedures
  - vi. Audit documentation procedures
- b. Copies of these procedures will be provided to members of the Executive Team and the Charge Capture Manager.
- c. The Charge Capture Manager will ensure internal audit review of these procedures on a random basis.

### 5. Late Charges

- a. Any charges processed more than four (4) days from the date of service delivery to a patient, will be considered a "Late Charge". Exceptions to this are charges for services requiring:
  - i. Creation of a charge for a new service
  - ii. Tests requiring a result before the service is charged

# NORTHERN INYO HOSPITAL

## POLICY AND PROCEDURE

Title: Charge Capture Policy and Procedure	
Scope: All revenue generating service departments of Northern Inyo Hospital	Manual: Revenue generating service departments, Billing, Credit and Billing
Source: Charge Capture Manager	Effective Date:

- iii. Tests requiring a signed medical report before the service is charged
- b. Late charges are followed as an "Exception" event in the Charge Capture process and are audited for circumstances or processes necessitating corrective action.
- c. It will be necessary to submit late charges to the Charge Capture Department for processing. The Charge Edit Form is attached to this policy.
- d. Extraordinary circumstances resulting in a late charge(s) must be submitted to the Business Office Manager with an explanation of the circumstances on a case-by-case basis so resources and affected areas can be informed as necessary.
- e. Charges for send out services (outside labs) are to be charged at the time of the specimen send out, not as of the result.

### 6. Charging for Opened and Unopened Supplies

- a. Service departments are responsible for patient chargeable supplies issued/used by the department, even when the revenue for the supply is credited to a common revenue department (Supplies Charged to Patients).
- b. Patients should not be charged for supplies ordered by the physician or surgeons that were not used during the procedure. These items are to be included in administrative costs of the service department.
- c. If the procedure is discontinued due to a medical complication and after the patient is given anesthesia, the provider may be reimbursed by Medicare and the payors for the collective cost of the initially planned procedure; however, a separate bill of unused items for the initial procedure will not be accepted. In this instance the modifier seventy-four (74) applies and will be attached at the claim level. (Reference #7, vi. Below detailing the use of modifier seventy-four (74)).
- d. When unused, supplies determined to be inappropriate in size and do not end up fitting, are not reusable (i.e., screws or implants). They can be billed to CMS and commercial payers in the following instances:
  - i. The items have come into contact with the patient and are subsequently removed, or if they are unsuccessfully inserted.
  - ii. Staff must thoroughly document all opened and unused items during each procedure, including the reason for nonuse, and attach documentation to the claims.
  - iii. Such supplies and implants are to be offered to the patient.

### 7. Charging for Discontinued Service or Patient Left Without Being Treated

- a. If a patient arrives and is registered into the system, documentation must be recorded as to the reason why the patient did not receive the service, or the reason the service was not completed if it began.
  - i. If the diagnostic service is discontinued because the patient could not tolerate the procedure, charge for the service and a modifier fifty-two (52) will be attached at the claim level.
  - ii. If the service is discontinued due to equipment failure, **do not charge**. Place the applicable department "zero charge" indicative of the reason for the zero charge.

# NORTHERN INYO HOSPITAL

## POLICY AND PROCEDURE

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Scope: All revenue generating service departments of Northern Inyo Hospital	Manual: Revenue generating service departments, Billing, Credit and Billing
Source: Charge Capture Manager	Effective Date:

- iii. If the service is discontinued because the physician or provider could not proceed for reasons related to patient well-being, charge for the service and a modifier fifty-three (53) will be attached at the claim level.
  - iv. If the patient was welcomed and placed in an exam room, vitals were taken and the patient left without seeing the provider, **do not charge**. Place the applicable department “zero charge”, indicative of the reason for the zero charge.
  - v. If a surgery or diagnostic procedure is cancelled after the patient has been made ready and taken to the room where the procedure is to be performed but has not received anesthesia, the provider can cancel or discontinue the procedure. If none of the planned procedure(s) is completed, the first/only procedure is charged with the usual CPT code and a modifier seventy-three (73) will be attached at the claim level. The other procedures are not charged.
  - vi. If a surgery or diagnostic procedure is cancelled due to extenuating circumstances or those that threaten the well-being of a patient, and after the administration of anesthesia or after the procedure has started, the procedure is charged using the usual CPT code and a modifier seventy-four (74) will be attached at the claim level.
- b. For any circumstances surrounding a question of to charge or not, contact the Charge Capture Manager or the Business Office Manager.

### REFERENCES:

1. Healthcare Business Insights
2. Healthcare Financial Management Association
3. CMS Coding and Billing Manuals

<b>Committee Approval</b>	<b>Date</b>
<b>Executive Team</b>	<b>1/29/2019</b>

**Developed: 1/29/2019**

**Reviewed:**

**Revised:**

**Supercedes:**



- CALL TO ORDER                      The meeting was called to order at 5:30 pm by Mary Mae Kilpatrick, President.
- PRESENT                                Mary Mae Kilpatrick, President  
Jean Turner, Vice President  
Peter Tracy, Treasurer  
M.C. Hubbard, Member at Large  
Allison Robinson MD, Chief of Staff  
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
- ABSENT                                 Robert Sharp, Secretary  
Evelyn Campos Diaz, Chief Human Resources Officer (*exited meeting at 5:45 pm*)
- OPPORTUNITY FOR PUBLIC COMMENT                      Ms. Kilpatrick announced at this time person in the audience may speak on any items not on the agenda for this meeting on any matter within the jurisdiction of the District Board and speakers will be limited to a maximum of three minutes each. Comments were heard by Robbin Cromer-Tyler, MD.
- WIPFLI LLP ANNUAL AUDIT REPORT FYE JUNE 20, 2018                      Jeff Johnson with Wipfli LLP presented Northern Inyo Healthcare District's (NIHD's) audit results for the July 1 2017 through June 30 2018 fiscal year. Mr. Johnson's report reviewed the following:
  - Schedule of Sources and Uses of District Revenues
  - Required Communications/Overview of 2018 Audit results
  - Review of Audited Financial Statements
  - Net Pension Liability – Changes of Assumptions
  - Financial Analysis
  - Accounting and Auditing Update
  - Industry Update
  - Key Financial IndicatorsResults of the Wipfli annual audit reflected a bottom line increase in net position of \$1,711,000 for the year. It was moved by Jean Turner, seconded by M.C. Hubbard, and unanimously passed to approve the 2017/2018 NIHD fiscal year financial audit as presented.
- STRATEGIC PLAN UPDATE, PATIENT EXPERIENCE COMMITTEE REPORT                      NIHD Human Resources Assistant Michelle Garcia and NIHD Rehabilitation Services Director Raychel Hosch provided an update on work accomplished by the District's Patient Experience Committee established for the purpose of addressing the patient experience-related goals of the District's Strategic Plan. The Committee's report included information on the following:

- Action planning based on results of an in-house Patient Experience survey
- Input from District leadership regarding improving the patient experience in all departments of the District
- Additions of manager and physician members to the Patient Experience Committee
- Updates on training and education efforts for District staff, including the expansion of AIDET training

It was noted that the Committee will re-survey patients in the next several months in order to measure any improvement in patient experience scores. The Committee also continues to analyze patient satisfaction data collected by Press Ganey.

#### BREAST HEALTH SERVICES TEAM REPORT

NIHD Patient Navigator Rosie Graves provided a Breast Services Team report which included an overview of the history and development of the District's breast health and oncology patient navigation program. Ms. Graves' report included the following:

- NIHD's Cancer Patient Navigation program began in 2016, and addressed Breast Cancer services only. Breast program services continue to be provided by Stuart Souders MD and Jay K. Harness MD.
- Cancer patients are navigated from diagnosis through treatment, survivorship, post treatment, and long-term follow-up
- Summary statistics on patients treated were provided for 2016, 2017, and 2018, as well as surgery and clinic visit totals
- Community outreach programs for 2019 include Moonlight Mammograms; a Colorectal Walk/Run/Bike Ride; Employer Health Talks; and Colorectal Evening Screenings
- An overview of resources available to patients both locally and nationally was provided

#### LIFETIME ACHIEVEMENT AWARDS AND DISTRICT BOARD RESOLUTIONS 19-01 AND 19-02

Chief Executive Officer (CEO) Kevin S. Flanigan, MD, MBA called attention to a proposal to establish two Lifetime Achievement Awards to be presented by the District on an annual basis. The proposed awards are as follows:

- The *John A. Ungersma MD Lifetime Achievement Award* for achievement in healthcare leadership, intended to honor individuals whose lifetime achievements in healthcare have significantly benefited the citizens of this community
- The *Peter Watercott Lifetime Achievement Award* for service to the community in healthcare, intended to honor individuals whose lifetime achievements in service to the communities of the District have fulfilled a need of the citizens and resulted in the enhanced health status of the community

The proposed awards will be presented on an annual basis at the NIHD Foundation's *Avenue of Excellence* awards dinner. It was moved by Peter Tracy, seconded by Ms. Turner, and unanimously passed to approve the

establishment of both Lifetime Achievement awards, as well as District Board Resolutions 19-01 and 19-02 corresponding to those awards.

COMPLIANCE  
PROGRAM UPDATE  
APPROVAL

Compliance Officer Patty Dickson called attention to an update to the *Compliance Program for Northern Inyo Healthcare District*, with the main update being the addition of clinical and nursing membership to the Compliance and Business Ethics Committee. It was moved by Ms. Hubbard, seconded by Ms. Turner, and unanimously passed to approve the updated *Compliance Program for Northern Inyo Healthcare District* as presented. The Board noted its appreciation of the contributions of the Compliance program to the quality of work provided by the District.

POLICY AND  
PROCEDURE  
APPROVAL,  
COMMUNICATING PHI  
VIA ELECTRONIC MAIL

Ms. Dickson also called attention to approval of a proposed Policy and Procedure titled *Communicating Protected Health Information Via Electronic Mail (Email)*, being established to delineate the procedures governing NIHD workforce member use of electronic mail. It was moved by Ms. Hubbard, seconded by Ms. Turner, and unanimously passed to approve the proposed Policy and Procedure titled *Communicating Protected Health Information Via Electronic Mail (Email)* as presented, including spelling out all of the acronyms included in the policy.

MEDICAL STAFF  
SERVICES PILLARS OF  
EXCELLENCE REPORT

Medical Staff Support Manager Dianne Picken called attention to the *Medical Staff Services Pillars of Excellence* quarterly report. The report for the 4<sup>th</sup> quarter of the 2018 calendar year reflects a high level of performance with efforts meeting or exceeding expectations in most areas.

CHIEF OPERATING  
OFFICER REPORT

Chief Operating Officer Kelli Davis provided a bi-monthly report which included updates on operations in the following District departments:

- Cardiopulmonary
- Diagnostic Services
- Lab
- Pharmacy
- Rehab Services
- Environmental Services and Laundry
- Dietary
- Health Information Management

Ms. Davis additionally reported on improvements implemented as a result of the NIHD Safety program, and on the development of Safety Coaches at NIHD.

CHIEF FINANCIAL  
OFFICER REPORT

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

- The Finance department was greatly affected by Athena implementation, and it is facing a greater number challenges than expected. As a result, many of the District's bills were paid late in the months following implementation.
- Finance will return to using the Paragon system in order to process

Accounts Payable in a more timely fashion

- Accounting is still determining how to integrate information into the Intaact general ledger in order to produce monthly financial reports as well as departmental financial reports
- Billed charges were good for the month of October, near plan in November, and 7% behind plan in December
- Now that the audit for the fiscal year ending 6/30/18 has been completed, Accounting will proceed with filing the Medi-Cal cost report

CHIEF NURSING  
OFFICER REPORT

Chief Nursing Officer Tracy Aspel RN, provided a bi-monthly update on Nursing Department activities including the following:

- The OB department is involved in a Beta project on patient safety
- Standardized procedures in the Emergency Department are being improved upon
- The District's first ICU RN trainee is currently training at Glendale Adventist
- The District has more permanent employees and fewer travelers in both the ICU and OB departments
- An OR nurse manager has been hired, and the District continues to grow its own OR RN's

Ms. Aspel also recognized the recent retirement of Lynn Lippincott RN, who worked for the District for 35 years. She additionally reported that Chief Operating Officer Kelli Davis recently earned her Master's degree in Business Administration, specializing in Healthcare Management.

ICU ACUITIES POLICY  
AND PROCEDURE  
APPROVAL

Ms. Aspel then called attention to proposed Policy and Procedure titled *ICU Acuties*. It was moved by Mr. Tracy, seconded by Ms. Hubbard, and unanimously passed to approve the *ICU Acuties* Policy and Procedure as presented.

CHIEF EXECUTIVE  
OFFICER REPORT

Doctor Flanigan provided a bi-monthly CEO report which included the following:

- The District is preparing the (newly acquired) Joseph House to house incoming and part-time physicians
- District Leadership is working on streamlining a management plan that may reduce the number of Directors and increase the number of Managers in the NIHD workforce

FISCAL ISSUES AND  
REDUCTION IN  
WORKFORCE

Doctor Flanigan additionally presented a report on fiscal issues, noting the following as of the end of the first half of the current fiscal year:

- Surgery cases are running 10 cases short of budget per month
- The daily inpatient census average is 8 patients, budgeted for 10
- ACA funding is now uncertain
- The District will realize a \$1.2M deficit vs budget if current trends hold

Doctor Flanigan stated District leadership will attempt to address the projected budget shortfall by implementing a reduction in workforce

(RIF) consisting of three phases: Phase I - reorganization/realignment of District Departments; Phase II - Consolidation and reduction of workforce responsibilities; and Phase III - develop an early retirement package for interested and eligible employees. He additionally noted that Phase I is expected to begin in the next 3 to 10 days.

CONSENT AGENDA

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

- *Approval of minutes of the December 7 2018 special meeting*
- *Approval of minutes of the December 19 2018 regular meeting*
- *Policy and Procedure annual approvals*

It was moved by Ms. Hubbard, seconded by Ms. Turner, and unanimously passed to approve all three Consent Agenda items as presented.

CHIEF OF STAFF  
REPORT

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 District-Wide Policy and Procedure:

- *Discharge Planning for Homeless Patients*

POLICY AND  
PROCEDURE  
APPROVAL

It was moved by Ms. Hubbard, seconded by Ms. Turner, and unanimously passed to approve the *Discharge Planning for Homeless Patients* Policy and Procedure as presented.

MEDICAL STAFF  
APPOINTMENTS AND  
PRIVILEGES

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

1. Jon Bowersox, MD (*general surgery*) - appointment to locum tenens/temporary staff
2. Paul Schneider, MD (*internal medicine*) - appointment to locum tenens/temporary staff
3. Michael Rhodes, MD (*internal medicine*) - appointment to locum tenens/temporary staff
4. Stefan Schunk, MD (*internal medicine*) - appointment to locum tenens/temporary staff

It was moved by Mr. Tracy, seconded by Ms. Turner, and unanimously passed to approve all four Medical Staff appointments and privileging as requested.

REAPPOINTMENT TO  
NEW STAFF  
CATEGORY

Doctor Robinson also stated following careful review and consideration the Medical Executive Committee recommends the following reappointment to a new Medical Staff category:

- *Atashi Mandal, MD (internal medicine)* - appointment from Temporary Staff to Provisional Active Staff for a term not to exceed two years (through December 31, 2020)

It was moved by Ms. Hubbard, seconded by Mr. Tracy, and unanimously passed to approve the reappointment of Doctor Mandal as requested.

TEMPORARY  
PRIVILEGES

Doctor Robinson additionally reported the Medical Executive Committee recommends the extension of temporary privileges for:

- Akash Rusia, MD (*internal medicine*) - extension of temporary/locum tenens privileges for the provision of hospitalist services through June 30, 2019 to fill an important patient care need

It was moved by Ms. Hubbard, seconded by Ms. Turner, and unanimously passed to approve the temporary privileges of Akash Rusia, MD as requested.

MEDICAL STAFF  
ADVANCEMENTS

Doctor Robinson also stated following careful review and consideration the Medical Executive Committee recommends the following Medical Staff advancements from Provisional Staff, following satisfactory completion of introductory focused professional practice evaluations:

1. Kristen Irmiter, MD (*pediatrics*) - advancement from Provisional Active Staff to Active Staff
2. Daniel Firer, MD (*family medicine/emergency medicine*) - advancement from Provisional Active Staff to Active Staff

It was moved by Ms. Hubbard, seconded by Ms. Turner, and unanimously passed to approve both Medical Staff advancements as requested.

MEDICAL STAFF  
RESIGNATIONS

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

1. Leon Kujmanian, MD (*endocrinology*) - effective 12/3/18
2. Zarmen Israelian, MD (*endocrinology*) - effective 12/3/18
3. Amikjit Reen, MD (*internal medicine*) - effective 12/6/18

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

PROPOSAL FOR  
EXPANDED CHIEF OF  
STAFF ROLE

Doctor Robinson also provided an update on the Medical Staff proposal to expand the Chief of Staff role, stating the membership prefers establishing a permanent Chief of Staff rather than designating a Chief Medical Officer (CMO), and that they will draw up a proposed job description for the Chief of Staff and present it at the next regular Board meeting. She additionally noted that the Chief of Staff will be elected by the Medical Staff, and that an analysis of the impact on the District's budget will be provided when approval of the new Chief of Staff model is requested.

BOARD MEMBER  
REPORTS

Ms. Kilpatrick asked if any members of the Board of Directors wished to report on any items of interest. She then stated that she recently attended the NIHD Rehab Department's Healthy Lifestyles talk, which she felt was outstanding. She additionally noted the passing of former Board member Mr. Phil Hartz, expressing the Board's condolences. Ms. Kilpatrick additionally stated that Mr. Hartz at one time requested that a new sound system be installed in the NIHD Board Room, and that it is also her wish that a new sound system be installed in order to improve the acoustics in the room. No other reports were heard.

ADJOURNEMTN TO  
CLOSED SESSION

At 8:28 pm Ms. Kilpatrick announced the meeting would adjourn to Closed Session to allow the Board of Directors to:

- A. Confer with Legal Counsel regarding threatened litigation, 1 matter pending (*pursuant to Government Code Section 54956.9(d)(2)*).
- B. For discussion of a personnel matter (*pursuant to Government Code Section 54957*).

RETURN TO OPEN  
SESSION AND REPORT  
OF ACTION TAKEN

At 9:02 pm the meeting returned to Open Session. Ms. Kilpatrick reported the Board took no reportable action.

ADJOURNMENT

The meeting adjourned at 9:02pm.

\_\_\_\_\_  
Mary Mae Kilpatrick, President

Attest:

\_\_\_\_\_  
Jean Turner, Vice President

## Diagnostic Imaging Policies

*For BOD Review February, 2019*

1. Diagnostic Imaging – C-Arm (fluoroscope) Radiation Safety
2. Diagnostic Imaging – Handling of Radioactive Packages, Non-nuclear Medicine Personnel
3. Diagnostic Imaging – Radioactive Material Delivery After-hours Policy/Procedure
4. Diagnostic Imaging – Radioactive Waste, Storage and Disposal
5. Diagnostic Imaging – Radioactive Material Hot Lab Security
6. DI – CT Radiation Safety
7. ALARA Program

# Language Services Policies

For BOD Review February, 2019

Special Transportation Options

Language Access Services Program

Language Access Services Policy

Investigation and Reporting of Unlawful Access, Use or Disclosure of Protected Health Information

Intimate Partner Abuse Guidelines for Victims of

Home Health Care

Handling of Soiled Linen

Environmental Disinfectant - Cleaning Solution

Electronic Communication (Email) Acceptable Use Policy

EASTERN SIERRA CANCER ALLIANCE

De-escalation Team

Competency Plan

Cleaning Procedures: Contact and Enteric Isolation Rooms at Discharge

# Perinatal and NEST Policies

For BOD Review February, 2019

Warfarin Monitoring Protocol
Vaginal Delivery in the OR
Tuberculosis Exposure Control Plan
Telephone Triage*
SUBMISSION OF BIOPSY (TISSUE) SPECIMENS (NOT FLUID)
Standards of Patient Care in the Perinatal Unit
Standards of Care- The NEST
Standardized Procedure - Medical Screening Exam for the Obstetrical Patient
Staffing Guidelines Perinatal Unit Including High Risk
Special Transportation Options
Self Help Utensils
Scope of Service Perinatal
Saline Lock For Blood Draw
Safety Surrendered Baby Policy and Procedure
Responding to Ventilator, BiPAP, Vapotherm, EtCO2 and SpO2 Alarms
Recommendation for Prophylaxis After Occupational Exposure to HIV
Pre-Eclamptic and/or Eclamptic Patient Care of
Potassium Intravenous Administration
Postpartum Patient Care in the PACU
Poison and Drug Overdose Information
Placenta Disposal
Patient Nutritional Care
Patient Locator
Ordering Dietary Supplements
OmniCell Automated Dispensing Unit (ADU)
Observation in the Operating Room
Nursing Care of Outpatient Interventional Radiology Patient
Newborn Screening Test
Newborn Pulse Oximetry Screen
Newborn Hearing Screening Program
Newborn Blood Glucose Monitoring*
Neonatal Death, Fetal Demise & Spontaneous Abortion Procedure
Lidocaine Anesthetic For Local Infiltration Prior To Peripheral Catheter Placement
Leaving Hospital Against Medical Advice Refusal of Treatment or Transfer
Latex Precautions
Isolette Policy and Procedure
Investigation and Reporting of Unlawful Access, Use or Disclosure of Protected Health Information
Intimate Partner Abuse Guidelines for Victims of
Interfacility Transfer Guidelines
Infant Oxygen Protocol

# Perinatal and NEST Policies

For BOD Review February, 2019

Home Health Care
HIV Prevention Program Perinatal
Hearing Screening Program Newborn
Handling of Soiled Linen
Handling of Infants/Fetus/Stillborns and Genetic Workup
Evaluation of Pregnant Patients in the Emergency Department
Environmental Disinfectant - Cleaning Solution
Emergency Medication Boxes in Perinatal Unit
Emergency Medication and Code Blue Crash Cart Policy
eMAR Downtime Procedure
Electronic Communication (Email) Acceptable Use Policy
EASTERN SIERRA CANCER ALLIANCE
Drugs of Abuse Maternal and Infant
Documentation of Nursing Care Flow Sheet
De-escalation Team
Cylinder Safety and Handling
Coroner's Cases
Cord Blood Cryopreservation - Maternal Blood Draw
Competency Plan
Cleaning Procedures: Contact and Enteric Isolation Rooms at Discharge
Chart Check Guidelines
Breastfeeding the Term Infant
BiliChek Transcutaneous Bilirubin Testing
Adoption Policy and Procedure
Admission, Transfer, and Discharge care of the Obstetrical Patient
Admission, Care, Discharge and Transfer of the Newborn
Admission / Classification and Charges

# Pharmacy Policies

*For BOD Review February, 2019*

Protecting Public from Impaired or Dishonest Pharmacy Employee<sup>1</sup>

Recalls: Drugs<sup>1</sup>

Repackaging and Compounding of Medications

Safe Handling and Disposal of Occupationally Hazardous Drugs and Environmentally Hazardous Drugs<sup>1</sup>

Single-dose vs Multi-dose Vial Policy<sup>1</sup>

Sterile Products: Compounding Quality Assurance Program<sup>1</sup>

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CALL TO ORDER                    The meeting was called to order at 10:00 am by Mary Mae Kilpatrick, President, in the Northern Inyo Healthcare District (NIHD) Board Room at 2957 Birch Street, Bishop, California.

PRESENT                            Mary Mae Kilpatrick, President  
Jean Turner, Vice President  
Robert Sharp, Secretary  
M.C. Hubbard, Member at Large  
Kevin S. Flanigan, MD, MBA, Chief Executive Officer  
John Tremble, Chief Financial Officer

ABSENT                             Peter Tracy, Treasurer

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

ADJOURNMENT TO  
CLOSED SESSION                At 10:01 am Ms. Kilpatrick announced the meeting would adjourn to Closed Session to:  
    A. Discussion pending litigation (*Pursuant to Government Code Section 54956.9(d)(2)*), one matter.

RETURN TO OPEN  
SESSION AND REPORT  
OF ACTION TAKEN                At 10:07 am the meeting returned to Open Session. Ms. Kilpatrick reported the Board took unanimous action to approve negotiated terms of a settlement, Superior Court of California County of Inyo Case Number CV1760919, and to authorize Kevin S. Flanigan, MD, MBA to sign settlement documents.

ADJOURNMENT                    The meeting was adjourned at 10:08 am.

\_\_\_\_\_  
Mary Mae Kilpatrick, President

Attest:

\_\_\_\_\_  
Robert Sharp, Secretary