Board of Trustees
New policies, Revised Policies, Biennial/Annual Reviews

New Policies (attached in packet)

- Customer Complaints, Grievances, and Service Recovery – Risk Management
- Insight Downtime Policy – Senior Life Solutions

Revised Policy Statements (attached in packet)

- Anesthesia Machine Safety – Anesthesia
- Anesthesia Pediatric Guidelines – Anesthesia
- Anesthesia Workplace – Anesthesia
- Duties and Responsibilities Anesthesia Medical Director – Anesthesia
- Duties & Responsibilities – Certified Registered Nurse Anesthetist (CRNA) - Anesthesia
- Bomb Threat- Safety and Security
- Cleanroom Suite, Segregated Compounding Area and Primary Engineering Control Maintenance – Pharmacy
- Communications Plan – Safety and Security
- Evacuation Levels – Safety and Security
- Incident Command System Activation – Safety and Security
- Maintaining Freezer, Refrigerator, Paraffin, and Hydrocolator Temperatures – PT/OT
- Plain Language Emergency Codes – Safety and Security
- Safety Responsibilities – Safety and Security

Request to Retire

- Patient/Visitor Complaints, Grievances, and/or Suggestions – Administration
- Section 504 Grievance Procedure – Administration
- Grievance Policy – Risk Management
- Grievance Policy – Public Health
- Service Recovery – Risk Management

Revised Policies (changes specified in packet)

- Anesthesia
- EMS
- Med Surg
- Outpatient
- PT/OT
- Safety and Security

Unchanged Policy Reviews (list in packet)

- Anesthesia
- EMS

Board of Trustees
New policies, Revised Policies, Biennial/Annual Reviews

- Medical Imaging Services
- Medical Staff
- Med Surg
- PT/OT
- Quality
- Speech Therapy

New Policies

Title	Policy Area	Summary of Changes
Customer Complaints, Grievances, and Service Recovery	Risk Management	New policy to replace the following policies: 1. Patient/Visitor Complaints, Grievances, and/or Suggestions (admin) 2. Section 504 Grievance Procedure (admin) 3. Grievances (risk management) 4. Grievance Policy (public health) 5. Service Recovery (risk management) There was a change to the federal register outlining that we must respond in writing to grievances that prompted this new/combined policy.
Insight Downtime Policy	Senior Life Solutions DCHC	New. Requested by SLS Program Manager via email 5/13/2024

Status Pending PolicyStat ID 15816394

Davis County HOSPITAL & CLINICS

An Affiliate of MERCYONE

Origination	N/A
Last Approved	N/A
Effective	Upon Approval
Last Revised	N/A
Next Review	2 years after approval
Owner	Amy Marlow: Quality Director
Policy Area	Risk Management
Applicability	Davis County Hospital

Customer Complaints, Grievances, and Service Recovery

Policy:

Davis County Hospital and Clinics will address any patient and/or visitor complaint or grievance for a resolution as promptly and accurately as possible without concerns for future access of care being compromised.

Applicability:

Davis County Hospital and Clinics, Davis County Public Health, Davis County Medical Associates Clinic

Definitions:

Billing Issue:

A verbal or written expression of dissatisfaction regarding a patient's bill or charges that do not involve patient care concerns.

Complaint:

An expression of dissatisfaction or concern by a patient or a patient's representative that can be resolved by staff present at the time or upset with their cost for a service.

Example of complaints:

- Temperature of the room
- Housekeeping concerns
- Customer service/behavior related issues

- Food/beverage related concerns
- Patient's perception of uncontrolled pain
- Post visit communications (including surveys) that would routinely have been handled by staff present, had the communication occurred during that hospital stay or visit.

Grievance:

A grievance is an expression of dissatisfaction, either verbal or written, by a patient or patient's representative regarding the care provided, abuse or neglect, or compliance related concerns.

Examples of grievance include:

- Quality of care concerns that are unable to be resolved immediately.
- Premature discharge concerns.
- All concerns relayed in writing directly to the Hospital.
- Compliance related billing issues provided by 42 CFR 489.
- Concerns related to abuse or neglect.
- Discrimination based on disability as outlined in Section 504 of the Rehabilitation Act of 1973.
    - Grievances pertaining to violation of Section 504 must be submitted in writing within 30 days of the date the person filing the grievance becomes aware of the alleged discriminatory action.
- Compliance with CMS (Centers for Medicare & Medicaid Services) regulations.

Procedure:

- At admission, the patient, or when appropriate, the patient's representative (as allowed under state law), will be informed of their right to discuss any problem or complaint with the department supervisor as stated in the Patient Rights portion of the "Patient's Rights and Responsibilities" as described in the Patient Rights section below.
    - **Billing Concerns**:
        - Should immediately be forwarded to the Patient Financial Services Manager and/or CFO for their review including:
            - A thorough investigation of the situation.
            - Involvement of other leaders as needed.
            - Contacting the pertinent party involved.
            - Documentation of the investigation and resolution.
    - **Complaints**:
        - On-the-spot resolution utilizing conversations, investigations, and follow-up on day of service, or utilizing the Service Recovery tool available when appropriate is encouraged.

        - Concerns relayed through follow-up phone calls are generally considered complaints.
        - Contacting the patient by phone to apologize for their experience is generally recommended.
            - On-the spot resolution does not normally require the reporting/ recording of the patient complaint in the electronic incident reporting program, though may be for review by the department manager and risk manager.

    - **Grievances**:
        - Concerns received either verbally, in writing, or by phone (other than during routine follow-up phone calls), regardless of whom the patient or representative spoke to shall be entered into the electronic incident reporting program.
        - Initial contact by letter or phone with the patient or patient representative should be initiated as soon as possible, preferably within 2 business days.
        - Grievance resolution shall be completed within 7 days when possible. If unable to complete within that time frame, the patient shall be notified that the hospital is still working to resolve the grievance and that the hospital will follow-up with a written response within 30-days.
            - When required, the quality director along with the department manager, and other parties as necessary, will work collaboratively to investigate and respond in writing within 30-days to the patient with the following:
                - The name of the hospital's contact person.
                - The steps taken on behalf of the patient to investigate the grievance.
                - The results of the investigation.
                - The date of completion.
                - Steps taken to correct the situation.
                    - A copy of this communication will be attached to the incident report.
        - If there has been a request for no contact, or no patient contact information is provided, an internal process for follow-up will be completed and documented without follow-up to the patient or representative.

- The quality director is responsible for tracking patient complaints/grievances and involving the appropriate staff in the investigation and resolution.
- If the patient or patient's representative is not satisfied with the resolution of the complaint, they may appeal this decision directly to the CEO.
- Administration retains final responsibility for the resolution of patient/visitor complaints.
- Consider reporting grievances to the Hospital's professional liability insurance carrier.

Patient Rights:

- You may use the hospital's grievance (complaint) resolution process for submitting a written or verbal grievance to your caregivers, patient representative, your healthcare practitioners, or administration.
- You may freely voice complaints and recommend changes without being subject to coercion, discrimination, reprisal, or unreasonable interruption of care, treatment, and services.
    - If you submit a complaint or grievance, it will be investigated.
    - Action will be taken to resolve the concern either verbally or in writing when appropriate.
- You may refer concerns or grievances regarding quality of care, premature discharge, or beneficiary complaints to the Iowa Department of Inspections and Appeals, Lucas State Office Building, 321 E. 12th St., Des Moines, IA 50319, or by phone at 515-281-7102.
- Livanta, the hospitals quality improvement organization, may be reached at 888-755-5580 or online at https://livantaqio.com.

Service Recovery:

Good service recovery can turn angry and frustrated customers into loyal customers. In fact, it can create even more goodwill than if things had gone smoothly in the first place. Nevertheless, not all service recovery efforts will lead to increased satisfaction.

- DCHC empowers all staff to utilize service recovery as needed. Toolkits are available in each patient care area.
- When utilized, report using the hospital's electronic incident reporting system as well as the log within the toolkit so as an investigation can be conducted.
- The quality director is responsible for tracking, monitoring investigations, and assisting with resolution when needed.
- The administrative assistant is responsible for maintaining contents of the service recovery toolkits.

Use the RELATE model to address service recovery.

- **R**ecognize
    - Recognize that you have a "service recovery" opportunity, or a chance to turn a perceived wrong into a right.
- **E**mpathize
    - Put yourself in the customer's shoes. How would you feel? Acknowledge the difficulty whether you agree or not.
- **L**isten
    - Focus on the customer, making eye contact and listening patiently. Listen to the whole story, do not interrupt. Acknowledge what has been said questions for clarity and repeat information provided to ensure accuracy. Don't be defensive or take it personally.

- **A**pologize
    - A simple "I'm sorry" can at times save a negative situation. Don't feel you have to have a justification for the situation, sometimes a broken process is just that until we are aware and figure out why. Do not blame anyone else for what happened. Don't try to excuse the incident with statements like, "we're short-staffed." Or, "He's a new employee."
- **T**hank
    - Thank them for giving us the opportunity to address their immediate concern and to improve the process and/or service for future patients. This step allows you to regain their trust by showing we appreciate their opinion and it does matter to us.
- **E**xplain
    - Explain how you are going to address their concern. What immediate action are you taking – this may be when you provide them with an item from our service recovery kit. However, remember that giving them an item doesn't solve this issue or prevent it from happening again.
    - Write down the patient's information and specifics regarding the concern – this not only shows the patient you are serious, but it will help you document for reporting.
    - If you cannot resolve the issue immediately, or at all, tell the customer what you will do and what they can expect (phone call, letter, someone else contacting them)

Complaint Notification Agencies:

A patient, patient representative, or visitor may contact any of the following agencies, at the contact information below, at any time to register a complaint. This will in no way compromise the care the patient receives.

A. Director of Quality, Safety, and Risk Management
Davis County Hospital and Clinics
641-664-2145 ext. 4572

B. Davis County Hospital and Clinics Compliance Hotline
Phone: 1-866-477-4661

C. U.S. Department of Health and Human Services Office of Civil Rights (must be in writing)
For complaints regarding violations of civil rights, conscience or religious freedom, or privacy or security of health information (HIPAA)
The form can be found at U.S. Department of Health & Human Services - Office for Civil Rights (hhs.gov)

D. Complaint Unit, Iowa Dept of Inspections, Appeal, and Licensure
6200 Park Avenue, Suite 100
Des Moines, Iowa 50321

E. Disability Rights of Iowa
666 Walnut St., Suite 1440
Des Moines, IA 50309

Phone: 515-278-2502

F. Iowa Office of Ombudsman
1112 E. Grand Avenue
Des Moines, Iowa 50319
Phone: 515-281-3592

G. MEDICAID Fraud Control Bureau
321 E. 12th St., Suite 3
Des Moines, IA 50319
Phone: 515-281-5714

H. MEDICARE Anti-Fraud Unit
Phone: 1-800-633-4227

I. Livanta
A Benificiary and Family Centered Care Quality Improvement Organization (BFCC-QIO) that is responsible for supporting the rights of people on Medicare.
Appropriate concerns to relate are Medicare beneficiaries who have concerns about the care received or appealing a discharge from the hospital.
Phone: 1-888-755-5580

Approval Signatures

Step Description	Approver	Date
CAH	CAH: DCHC Critical Access Hospital Committee	Pending
	Amy Marlow: Quality Director	06/2024

Applicability

Davis County Hospital

Status Pending PolicyStat ID 15886067

Davis County HOSPITAL & CLINICS

An Affiliate of MERCYONE

Origination	N/A
Last Approved	N/A
Effective	Upon Approval
Last Revised	N/A
Next Review	2 years after approval
Owner	Rhonda Roberts: SLS Program Director
Policy Area	Senior Life Solutions DCHC
Applicability	Davis County Hospital

Insight Downtime Policy

PURPOSE:

The purpose of this policy is to establish a contingency plan (downtime procedures) to ensure that appropriate steps are followed in the event of a scheduled or unscheduled system outage (or severe degradation) which impedes access to some or all of the INSIGHT application, the electronic documentation software used for SLS services. While occasional unavailability of the application is inevitable due to unplanned software, hardware, and power issues, planned upgrades also result in system unavailability. Effective communication, planning, and training for these events through written processes and staff preparations can mitigate the impact to the organization and our patients, ensuring proper continuity of care.

POLICY:

Senior Life Solutions will ensure that effective downtime procedures are followed in the event that part or all of our INSIGHT documentation application becomes unavailable or degrades significantly enough to revert to downtime procedures.

DEFINITIONS:

PLANNED MAINTENANCE – Planned maintenance is a controlled event, occurring at a known time. The duration is normally predicted. Planned maintenance will be initiated to allow changes/upgrades in hardware or software and is variable in duration, depending on the time needed to take the system offline, make changes, and restore function.

UNSCHEDULED DOWNTIME – Unscheduled downtime is not a planned event and is related to the system going down unexpectedly. This does not allow prior notification. Unscheduled downtime can be attributed to several causes: software problems, program problems, sporadic hardware failure, network

failure, and heavy system use.

INFORMATION RESOURCES – Computer systems, applications, and the information they contain, the network, the Internet, as well as telecommunications are collectively known as information resources.

CONTINGENCY PLANNING – Addresses how a practice and/or clinic will continue to function during a temporary disruption or unavailability of information resources. These plans may also be called "downtime procedures."

MISSION CRITICAL COMPUTER SYSTEMS – Are those applications or systems that require the highest level of availability because of their necessity to minimally maintain patient care and operate the clinic and have recovery times of four hours or less.

RECOVERY TIME OBJECTIVE (RTO) – A point in time in which business functions or application systems must be restored to acceptable levels of operational capacity or a disaster is declared.

DISASTER – A natural or manmade event that significantly disrupts the environment of care (treatment of patients) and clinic operations (nonclinical services: scheduling, billing, etc.)

PROCEDURES:

SLS is supported by the following information resources and applications:

Information Resources	Criticality*	Data Maintained or Purpose
Insight	Essential	Staff electronic documentation application
Internet	Essential	Maintain communication, patient's records, documentation
Email	Critical	Communicate for clinical and operational support
Zoom	Critical	Connect with patients to provide services
Telephones	Important	Connect with patients to provide services
Hospital EMR	Basic	Retrieve patient information and store patient's medical record

* Criticality of information systems to the practice's day-to-day operations:

- Essential – Maximum downtime of less than 1 hour
- Critical – Maximum downtime of less than 4 hours
- Important – Maximum downtime of less than 8 hours
- Basic – Maximum downtime of 8 hours or more

DOWNTIME SEVERITY LEVELS:

The severity level (LOS) provides the user with a sense of how long the system is expected to remain unavailable so that appropriate downtime processes can be put into effect, including any directive to

utilize downtime toolkit.

- Downtime Level 1 – not to exceed 2 hours
- Downtime Level 2 – between 2-8 hours
- Downtime Level 3 – between 8-24 hours
- Downtime Level 4 – greater than 24 hours

PROCEDURES:

In the event of INSIGHT downtime (planned or unscheduled), the following procedures will be implemented according to LOS identified.

- **DOWNTIME LEVEL 1** – In the event of planned maintenance, unscheduled downtime, or disaster, not to exceed 2 hours. Program operations will continue as scheduled. Program staff will continue to document in a note format as to be able to recover patient information. Once information resources have been re-established, program staff will enter documented patient information into INSIGHT. Downtime toolkit will not be implemented.
- **DOWNTIME LEVEL 2** – In the event of planned maintenance, unscheduled downtime, or disaster, between 2-8 hours. Program operations will adhere to Level 1 protocol for all documentation that doesn't not require immediate signing and implementation. Physician orders are the exception to this protocol. If physician orders must be obtained during Level 2, downtime toolkit will be implemented. Program staff will obtain physician orders via secure email protocol. Once information resources have been re-established, program staff will enter documented patient information into INSIGHT.
- **DOWNTIME LEVEL 3** – In the event of planned maintenance, unscheduled downtime, or disaster, between 8-24 hours. Program staff will utilize downtime toolkit. If any documentation requires signatures from a staff member not present at program location, program staff will obtain signatures via secure email protocol. Once information resources have been re-established, program staff will upload all patient documentation to INSIGHT according to Policy Reference #8025. Program staff will contact Clinical Team to ensure patient documentation is uploaded correctly and any necessary information is duplicated appropriately to optimize patient chart within INSIGHT.
- **DOWNTIME LEVEL 4** – In the event of planned maintenance, unscheduled downtime, or disaster, greater than 24 hours. Program staff will utilize downtime toolkit. If any documentation requires signatures from a staff member not present at program location, program staff will obtain signatures via secure email protocol. Once information resources have been re-established, program staff will upload all patient documentation to INSIGHT according to Policy Reference #8025. Program staff will contact Clinical Team to ensure patient documentation is uploaded correctly and any necessary information is duplicated appropriately to optimize patient chart within INSIGHT.

SIGNATURES:

In Insight, physician, staff, and patient signatures are received via email. In the event that local internet service is unavailable or email may not be accessed for any reason, signatures will be attained the next business day or when email access is restored, within the time frame allowable for each document if possible. If a Physician Order is needed, it will be obtained by Telephone Order Read Back (TORB) and

signed by the physician within the required time frame if possible.

TEMPORARY EQUIPMENT:

In the event PMC Clinical Team has determined LOS as level 4 effecting individual programs, PMC IT will assess the need for temporary equipment including virtual computer (Cloud PC), laptop, and hotspot. Once need has been assessed and determined, temporary equipment will be provided to individual program staff. Once LOS has expired, PMC IT will collaborate with individual programs to return temporary equipment.

DOWNTIME TOOLKIT:

PMC will maintain a downtime toolkit on the Resource Library. Downtime toolkit will contain forms available for documentation during downtime procedures, according to LOS.

ALL forms available within INSIGHT will be duplicated and stored as a blank PDF on PMC's Resource Library. All forms listed on PMC Chart Format will be stored on PMC's Resource Library. There will be 2 options of the downtime toolkit including PDF forms generated from INSIGHT and word document versions created prior to the implementation of INSIGHT.

COMMUNICATION PLAN:

PLANNED MAINTENANCE – In the event of planned maintenance, PMC IT will notify program staff 48 – 72 hours prior to the event by electronic communication and include:

- Date, time, and length planned maintenance will occur.
- Level of Severity (LOS) and appropriate guidance to follow according to LOS.

UNSCHEDULED DOWNTIME – In the event of:

- **INSIGHT-WIDE DOWNTIME** – In the event of unscheduled downtime effecting all users, electronic communication will be sent by PMC IT once the extent of the problem is determined. Communication will include LOS and appropriate guidance to follow. Once the problem has been resolved, electronic communication will be sent by PMC IT to alert all users of available system use.
- **INDIVIDUAL PROGRAM(S) DOWNTIME** – In the event of unscheduled downtime effecting individual programs, program staff will notify Regional Director of unscheduled downtime. The Regional Director will communicate unscheduled downtime to PMC IT and PMC Clinical Team. PMC Clinical Team will determine LOS and provide appropriate guidance. Program staff will ensure appropriate processes are followed in compliance with our documentation and signature timelines. Program staff will notify Regional Director on any information regarding system availability. Regional Director will communicate information to PMC IT and PMC Clinical Team.

BUSINESS RESUMPTION:

Depending on type of downtime, a restore of the system may result in a loss of data. The data in the applications and systems may only be as current as the most recent backup.

Orders or other transactions and data entered during the day prior to the system downtime may be lost.

Program staff and Clinical Team will determine if an attempt will be made to recreate any lost data.

An essential part of resuming normal business operations will be verifying that the data is current and accurate.

TRAINING AND REVISION:

Employees will be instructed on this contingency plan for downtimes and outages during their initial orientation to the practice. Training would include the location of this plan. A simulated downtime (*walkthrough or tabletop exercise*) should be conducted, and any discrepancies found should be addressed by updating this plan.

PMC's Clinical Team will periodically review this contingency plan especially if there is a change in personnel. This plan will also be updated as soon as there are any significant changes to the information resources. For example, when new information resources are added or deleted.

Related Regulations and Industry Standards

45 CFR Part 164, Health Insurance Portability and Accountability Act of 1996 (HIPAA)

§164.308(a)(7)(i) Contingency plan

§164.308(a)(7)(ii)(D) Testing and revision procedures

§164.308(a)(7)(ii)(E) Applications and data criticality analysis

Approval Signatures

Step Description	Approver	Date
CAH	CAH: DCHC Critical Access Hospital Committee	Pending
Medical Director- Nina Jordania, MD	Carleena Brown: Clinic Director	05/2024
Senior Leader	Carleena Brown: Clinic Director	05/2024

Applicability

Davis County Hospital

Revised Policy Statements

Title	Policy Area	Summary of Changes
Anesthesia Machine Safety	Anesthesia	added "& clinics" to Davis County Hospital to policy statement
Anesthesia Pediatric Guidelines	Anesthesia	added "& Clinics" to Davis County Hospital to policy statement
Anesthesia Work Place	Anesthesia	fixed typo in policy statement
Duties and Responsibilities Anesthesia Medical Director	Anesthesia	In policy statement, corrected typo
Duties & Responsibilities- Certified Registered Nurse Anesthetist (CRNA)	Anesthesia	Changed "C.R.N.A." to "CRNA"
Cleanroom Suite, Segregated Compounding Area and Primary Engineering Control Maintenance	Pharmacy	Multiple changes to policy statement (copy in packet for review)
Maintaining Freezer, Refrigerator, Paraffin, and Hydrocolator Temperatures	PT/OT	Changed checks to weekly in policy statement
Bomb Threat	Safety and Security	added 'from a land line phone' to statement about notifying administration. Added 'and Clinics' to Davis County Hospital in Policy Statement
Communications Plan	Safety and Security	Changes made to contact information. Changed DCH to DCHC throughout.
Evacuation Levels	Safety and Security	Added "and Clinics' to Davis County Hospital in policy statement. Added request to bring laptops in event of evacuation.
Incident Command System Activation	Safety and Security	In policy statement, added 'and Clinics' to Davis County Hospital. Formatting changes in body of policy, and updated incident command position assignments.
Plain Language Emergency Codes	Safety and Security	In policy statement, added 'and Clinics' to Davis County Hospital. Removed NORA. Removed tiered trauma activation level.
Safety Responsibilities	Safety and Security	In policy statement, added 'and Clinics' to Davis County Hospital

Status Pending PolicyStat ID 15584953

Davis County HOSPITAL & CLINICS

An Affiliate of MERCYONE

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Last Revised	04/2024
Next Review	2 years after approval

Owner	Roxanne Leffler: OR/OP Services Manager
Policy Area	Anesthesia
Applicability	Davis County Hospital

Anesthesia Machine Safety

Policy Number: 04.06.0

POLICY:

The anesthesia equipment used at Davis County Hospital & Clinics will contain safety features to protect the patient.

PROCEDURE:

- Safety features include:
- Each anesthesia machine has a safety mechanism which ensures the presence of at least 25% oxygen in oxygen/nitrous oxide and gas mixtures to prevent delivery of hypoxic mixtures.
- Standing bellow – type ventilator.
- Integrated bag – to – ventilator switch valve which removes the automatic pop-off valve from the patient circuit during ventilator operation.
- Diameter index systems are used on all machines.
- Standard color and size coding of gas, scavenging, and breathing systems is to ensure correct connections.
- Oxygen cylinders are attached to the anesthesia machine for use in an emergency.
- An oxygen fail safe protection device to announce failure of oxygen supply is in place.
- An oxygen concentration monitor installed in the breathing circuit displaying inspired oxygen level is in place.
- An in-line respiratory spirometer is present to measure minute ventilation.

- Latching and bayonet – type connections on gas hoses and pressure sensing tubes to help prevent accidental disconnection.
- Carbon dioxide absorber system had an internal gas circuit to minimize the number of exposed gas hoses that could disconnect.

Approval Signatures

Step Description	Approver	Date
CAH	CAH: DCHC Critical Access Hospital Committee	Pending
Medical Director	Robert Floyd: Chief of Staff/ Internal Medicine Physician	04/2024
Senior Leader	Nikki Thordarson: CNO	04/2024
Manager	Roxanne Leffler: OR/OP Services Manager	04/2024
	Jessica Henderson: Anesthesia	04/2024

Applicability

Davis County Hospital

Status Pending PolicyStat ID 15585003

Davis County HOSPITAL & CLINICS

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Effective	Upon Approval
Last Revised	04/2024
Next Review	2 years after approval

Owner	Roxanne Leffler: OR/OP Services Manager
Policy Area	Anesthesia
Applicability	Davis County Hospital

Anesthesia Pediatric Guidelines

Policy Number: 06.39.0

POLICY:

Anesthesia for the pediatric patients at Davis County Hospital & Clinics will be delivered according to the following procedure.

PROCEDURE:

1. **NPO guidelines:**
    a. Meat/Fried foods 8 hours
    b. Solids 6 hours (formula)
    c. Full liquids 4 hours (breast milk)
    d. Clear liquids 2 hours
2. **Sedation if needed:**
    a. versed liquid 0.2 – 0.5 mgs per kilogram to a max of 10 mgs. P.O. Given 30 minutes prior to procedure.
    b. Versed may be mixed with liquid Tylenol if needed at dose per weight 10-15 mgs per kilogram.
3. **IV fluids** LR start only with a 500 ml bag. Maintenance hourly IV rates.
    a. **< 10 kg wt x 4 (i.e. 5kg = 20 ml per hour)**
    b. **10-20 kg (wt x 2) + 20 (i.e. 15 kg = 50 ml per hour)**

c. **> 20 kg wt + 40 (i.e. 30 kg = 70 ml per hour)**

4. **Post operative analgesics:**
    a. Tylenol 10-15 mg/kg PO or rectal every 6 hours (may give single rectal dose of 20-30 mg/kg not to be repeated for 6 hours)
    b. Fentanyl 1-2 mcg/kg IV every 1 hour
    c. Morphine 0.05-0.1 mg/kg IV or IM every 2-4 hours
    d. Codeine 0.5-1 mg/kg PO every 4-6 hours
    e. Meperidine 0.5-1 mg/kg IV or IM every 2-4 hours
5. **Antiemetic's:**
    a. Ondansetron 0.15 mg/kg to max of 4 mg
    b. Phenergan 0.5mg/kg rectally (12.5 - 25 mg)

Reference:

Ezekiel, M. **Current Clinical Strategies. 1995**

Approval Signatures

Step Description	Approver	Date
CAH	CAH: DCHC Critical Access Hospital Committee	Pending
Medical Director	Robert Floyd: Chief of Staff/ Internal Medicine Physician	04/2024
Senior Leader	Nikki Thordarson: CNO	04/2024
Manager	Roxanne Leffler: OR/OP Services Manager	04/2024
	Jessica Henderson: Anesthesia	04/2024

Applicability

Davis County Hospital

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Davis County HOSPITAL & CLINICS

An Affiliate of MERCYONE

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Effective	Upon Approval
Last Revised	04/2024
Next Review	2 years after approval

Owner	Roxanne Leffler: OR/OP Services Manager
Policy Area	Anesthesia
Applicability	Davis County Hospital

Anesthesia Work Place

Policy Number: 06.09.0

POLICY:

Guidelines for the anesthesia work place:

- There shall be in each location sufficient electrical outlets to satisfy anesthesia machine and monitoring equipment requirements, including clearly labeled outlets connected to the emergency power supply.
- No flammable anesthetic agents will be used in the hospital.
- Inhalation anesthetic agents will be added to permanently labeled vaporizers only by a anesthetist.
- At each anesthetizing location there will be suction apparatus.
- The workplace of staff members will be in accordance with the recommendations of the National Institute of Occupation Safety and Health for exhaust of anesthesia waste gases from anesthetizing locations. The hospital will make available the necessary equipment for scavenging of anesthesia waste gases from anesthesia gas machines and from ventilators in anesthetizing locations.
- There shall be in each location a source of piped oxygen, meeting applicable codes, in addition, oxygen shall be available in anesthesia machine cylinders(s) shall be readily available.
- There shall be in each location an anesthesia machine and other anesthesia drugs, supplies and equipment equivalent to that employed in an operating room and maintained to current operating room standards by the hospital.
- The hospital will make available adequate monitoring equipment to allow adherence to guidelines adapted within this document.

- There shall be in each anesthetizing location adequate illumination of the patient, anesthesia machine and monitoring equipment at all times during the administration of the anesthetic. Some form ~~o~~of battery powered illumination must be immediately available.
- There shall be in each anesthetizing location sufficient room to allow continuous access to the patient, anesthesia machine and monitoring equipment.
- There shall be readily available to each anesthetizing location (within two minutes), an emergency cart with a defibrillator, emergency drugs and other resuscitation equipment equivalent to that in the operating rooms
- There shall be an anesthetist readily available to each anesthetizing location at all times during an anesthetic procedure.
- A reliable means of two way communication for summoning of help must be immediately available at each anesthetizing location at all times.

Approval Signatures

Step Description	Approver	Date
CAH	CAH: DCHC Critical Access Hospital Committee	Pending
Medical Director	Robert Floyd: Chief of Staff/ Internal Medicine Physician	04/2024
Senior Leader	Nikki Thordarson: CNO	04/2024
Manager	Roxanne Leffler: OR/OP Services Manager	04/2024
	Jessica Henderson: Anesthesia	04/2024

Applicability

Davis County Hospital

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Effective	Upon Approval
Last Revised	04/2024
Next Review	2 years after approval

Owner	Roxanne Leffler: OR/OP Services Manager
Policy Area	Anesthesia
Applicability	Davis County Hospital

Duties and Responsibilities Anesthesia Medical Director

Policy Number: 01.02.0

POLICY:

The Anesthesia Medical Director will have the following qualifications:

- Member of the active medical staff
- Appointed by the Chief of Staff according to the medical staff bylaws of the hospital.

The duties of the Anesthesia Medical Director will include but not be limited to the following:

- Serve as chairperson of the Anesthesia Department.
- Shall be responsible to the Surgical Services Department and the Chief of Staff for the function of the department.
- Assures that anesthesia services are provided by qualified licensed CRNA'~~S~~s. Recommends privileges for all individuals who have ~~responsibly~~responsibility for the administration of anesthesia. Clinical privileges are then processed through the appropriate medical staff committees.
- Periodically monitors the quality of anesthesia rendered by anesthesia.

RESPONSIBILITIES:

The Anesthesia Medical Director will fulfill the duties and qualifications of the position and work in collaboration with the Chief Nurse Anesthetist to insure safe/accountable 24-hour anesthesia coverage provided by the Bloomfield Anesthetist Group.

Approval Signatures

Step Description	Approver	Date
CAH	CAH: DCHC Critical Access Hospital Committee	Pending
Medical Director	Robert Floyd: Chief of Staff/ Internal Medicine Physician	04/2024
Senior Leader	Nikki Thordarson: CNO	04/2024
Manager	Roxanne Leffler: OR/OP Services Manager	04/2024
	Jessica Henderson: Anesthesia	04/2024

Applicability

Davis County Hospital

Status Pending PolicyStat ID 15649015

Davis County HOSPITAL & CLINICS

An Affiliate of MERCYONE

Origination	09/2004
Last Approved	N/A
Effective	Upon Approval
Last Revised	05/2024
Next Review	2 years after approval
Owner	Roxanne Leffler: OR/OP Services Manager
Policy Area	Anesthesia
Applicability	Davis County Hospital

Duties & Responsibilities- Certified Registered Nurse Anesthetist (CRNA)

Policy Number: 01.04.0

POLICY:

The Certified Registered Nurse Anesthetist (~~C.R.N.A.~~CRNA) administers anesthesia to any patient undergoing a surgical procedure as requested by the attending physician/surgeon. ~~C.R.N.A.~~CRNA's are provided to the Hospital by the Bloomfield Anesthetist Group as per contract.

PROCEDURE:

The ~~C~~CRNA works in collaboration with the operating surgeon.~~R.N.A. works in collaboration with the Operating Physician.~~

The ~~C.R. N.A.~~CRNA must be a registered nurse in the state of hospital licensure, a graduate of an accredited school of anesthesia and member in good standing of the American Association of Nurse Anesthetists. Both license and certification and /or recertification must be current at all times and available for inspection. Current certification in CPR, ACLS, and ~~A.R.N.P.~~ARNP certification of a nurse anesthetist by the state of hospital licensure is an additional requirement.

The ~~C.R.N.A.~~CRNA will make a preoperative and postoperative evaluation of the patient scheduled for surgery and will document his/her findings in the medical record. These findings will be used by the ~~C.R.N.A.~~CRNA in the selection of anesthetic techniques and agents.

In his/her observation, if he/she feels that an anesthetic will put the patient's life in jeopardy, then this condition must be discussed with the operating surgeon or the Medical Director of Anesthesia. The

~~C.R.N.A.~~CRNA can rightfully and legally decline to administer an anesthetic to a patient in this category without repercussion. The choice of anesthetic should be discussed with the operating surgeon.

Prepare patient for anesthesia by evaluation vital signs, checking all laboratory and x-ray findings, all consents and consultations needed for the procedure. Identification of the patient must be verified before the patient is taken into the operation room.

Induce anesthesia and maintain anesthesia at a safe and required level for the procedure.

Continuous monitoring of a patient's vital signs including but not limited to blood pressure, pulse, respiration, and EKG.

Report immediately to the operating surgeon observations of any abnormalities or questionable condition of the patient.

Close observation and resuscitative care must be given to the patient until vital signs and functions are stabilized.

No anesthetized patient will be left in the care of an unlicensed person or anyone who is not familiar in the immediate care of the anesthetized patient.

Check all equipment and agents to be used in the administration of the anesthetic to be sure it is in safe working order. Report all malfunctioning equipment to the Director of Anesthesia, the Chief Nurse Anesthetist, or the Department Head of Surgery.

Demonstrates knowledge of the principles of growth and development over the life span and the skills necessary to provide care appropriate to the age of the patients served. He/She shall be able to interpret data about the patient's status in order to identify each patient's age specific needs and provide the care needed by the patient group including neonate, pediatric, adolescent and geriatric patients. Examples of skills necessary for each specific age group includes:

- Neonates- Pediatrics: Interpreting nonverbal communication, safety practices, and medication dosaging.
- Adolescents: Enlisting patient in treatment, safety, and security practices.
- Geriatric: Physical limitations, psychosocial needs, age related conditions, safety and medication precautions.
- Cultural practices will be addressed and supported as long as such practices do not harm others or interfere with the planned course of medical therapy.

Approval Signatures

Step Description	Approver	Date
CAH	CAH: DCHC Critical Access Hospital Committee	Pending

Medical Director	Robert Floyd: Chief of Staff/ Internal Medicine Physician	05/2024
Senior Leader	Nikki Thordarson: CNO	05/2024
Manager	Roxanne Leffler: OR/OP Services Manager	05/2024
	Jessica Henderson: Anesthesia	05/2024

Applicability

Davis County Hospital

Status Pending PolicyStat ID 15517887

Davis County HOSPITAL & CLINICS

An Affiliate of MERCYONE

Origination	08/1998
Last Approved	N/A
Effective	Upon Approval
Last Revised	04/2024
Next Review	2 years after approval

Owner	Amy Marlow: Quality Director
Policy Area	Safety and Security
Applicability	Davis County Hospital

Bomb Threat

POLICY:

Davis County Hospital and Clinics staff will immediately respond to a bomb threat made against the hospital.

PROCEDURE:

BOMB THREAT received by PHONE, LETTER OR PACKAGE

I. ***PHONE :*** (regardless of who handles the call, everyone should be familiar with the procedure)
   - Keep the caller on the line as long as possible.
   - Using the **Phone Bomb Threat Checklist** for a threat received by a phone caller (attached to this policy and available in each department) and ask as many of the questions as possible. The information obtained (Who, What, When, Where, and Why) will determine the actions that need to be taken and in what order to protect patients, visitors and staff from injury.
     LETTER or PACKAGE: (this could happen in any area of the hospital that receives mail or packages)
   - Using the **Letter or Package Bomb Threat Checklist** (attached to this policy and available in each department), ask as many of the questions as possible.

II. PERSON TAKING THE CALL, OR RECEIVING SUSPICIOUS LETTER OR PACKAGE (AS SOON AS POSSIBLE)
   - Notify Administrator On-Call and dial 911 from a land line phone.
   - Await further instructions from Law Enforcement and Administration.

- If directed by administration page: **ATTENTION Bomb Threat + Location + Action Required** and repeat three times.

III. **SWITCHBOARD PERSONNEL** :

- Confirm that administration and law enforcement were notified.

IV. **IF BOMB THREAT ANNOUNCED**

- If the threat is made by **phone** and it is indicated that a bomb is in the building, staff will immediately conduct a visual inspection of their area and report suspicious findings to the Switchboard. This is done to assist with location & verification of suspicious package/bomb.
- Plant Operations personnel (or their designee) secure entrances and prevent entry into the facility. Please refer External Lock Down policy.
- All nursing staff will report to their assigned patient care area.
- If the threat is due to a suspicious **letter or package,** the area should be secured to prevent entry and staff exposed to the letter or package will remain in the parameter until they can be safely evacuated.
- When paging "bomb threat", include the known or suspected location of the letter or package. (i.e. "ATTENTION - LABORATORY)
- Department leaders ~~**(or their designee**~~(or their designee) and all staff on duty should remain in their service areas until instructed to evacuate or assist in evacuating all patients, visitors and staff.

V. General Safety:

- Under no circumstances is a suspected bomb to be touched.
- Do not use the elevators.
- Do not operate cell-phones or radios.
- Do not turn on any electrical switches.
- During visual search, do not open any drawers, doors or turn on or off switches.

VI. CRITERIA for EVACUATION (any of the following)

- If a definite time is given by the caller.
- Knowledge of a suspicious package.
- If the caller gives any specifics about the hospital that would not be general knowledge.
- Recent adverse employment decision or known hostile domestic disputes.

If Evacuation is need:

- See Evacuation Levels policy.
- Plant ~~opersations~~operations personnel (or their designee) should check the evacuation areas for any suspicious vehicles or packages.
    - If anything suspicious is found, a second evacuation area should be used.

VII. **POST SEARCH PROCEDURE** :

- ~~Law Enforcement will direct Administration when to announce all clear.~~

Law Enforcement will direct Administration when to announce all clear.

VIII. ~~Evacuation: See Evacuation Levels Policy.~~

Attachments

Bomb Threat Call Checklist

Approval Signatures

Step Description	Approver	Date
CAH	CAH: DCHC Critical Access Hospital Committee	Pending
	Amy Marlow: Quality Director	04/2024

Applicability

Davis County Hospital

Status Pending PolicyStat ID 15052330

Davis County HOSPITAL & CLINICS

An Affiliate of MERCYONE

Origination	09/2016
Last Approved	N/A
Effective	Upon Approval
Last Revised	02/2024
Next Review	2 years after approval
Owner	Wendy Barker: Pharmacy Manager
Policy Area	Pharmacy
Applicability	Davis County Hospital

Cleanroom Suite, Segregated Compounding Area and Primary Engineering Control Maintenance

Ph 03.23.0

Policy:

The Davis County Hospital Pharmacy Department's USP 797 cleanroom suite, USP 800 containment segregated compounding area and respective laminar flow glove-box isolator (LFGI) hoods in those spaces shall be maintained in good working order according to all applicable rules and regulations. DCHC's pharmacy department shall standardize and define the process by which the controlled compounding environments (ISO Class 5, 7 and 8) and C-SCA are cleaned and maintained in a manner that ensures an environment suitable for compounding sterile preparations.

Definitions:

- ~~Compounded Sterile Preparations (CSPs) – Compounded biologics, diagnostics, drugs, nutrients, and radiopharmaceuticals, including but not limited to the following dosage forms that must be sterile when they are administered to patients: aqueous bronchial and nasal inhalations, baths and soaks for live organs and tissues, injections (e.g., colloidal dispersion, emlusions, solutions, suspensions), irrigations for wounds and body cavities, ophthalmic drops and ointments, and tissue implants. CSPs also include manufactured sterile products that are either prepared strictly according to the instructions appearing in manufacturers' approved labeling or prepared differently than published in such labeling.~~
- ~~Direct Compounding Area (DCA) – A critical area within the ISO Class 5 primary engineering control (PEC) where critical sites are exposed to unidirectional HEPA-filtered air, also known as first air.~~

- ~~Primary Engineering Control (PEC) – A device or room that provides and ISO Class 5 environment for the exposure of critical sites when compounding CSPs.~~
- ~~ISO Class 5 – A classification of air cleanliness set forth by the US Federal Standard according to the number and size of particles permitted per volume of air. ISO Class 5 limits the number of particles of 0.5 micrometers and larger per cubic meter of air to 3,520. This is equivalent to 100 particles per cubic foot.~~

- Anteroom - An ISO Class 8 or cleaner room with fixed walls and doors where personnel hand hygiene, garbing procedures, and other activities that generate high particulate levels may be performed. The anteroom is the transition room between the unclassified area of the facility and the buffer room.
- Buffer room - An ISO Class 7 or cleaner room with fixed walls and doors where PEC(s) that generate and maintain an ISO Class 5 environment are physically located. The buffer room may only be accessed through the anteroom or another buffer room.
- Classified area - An area that maintains an air quality classification based on the ISO standards required in this chapter.
- Cleaning agent - An agent, usually containing a surfactant, used for the removal of substances (e.g., dirt, debris, microbes, and residual drugs or chemicals) from surfaces.
- Compounding area - The area where compounding is occurring (i.e., a cleanroom suite, inside the perimeter of the SCA, or AECA).
- Containment segregated compounding area - A segregated compounding area of negative pressure suitable for the preparation of Category 1 hazardous drug CSPs.
- Compounded Sterile Preparation (CSP) - A preparation intended to be sterile that is created by combining, admixing, diluting, pooling, reconstituting, repackaging, or otherwise altering a drug product or bulk drug substance.
- Direct compounding area (DCA) - A critical area within the ISo Class 5 PEC where critical sites are exposed to unidirectional HEPA-filtered air, also know as first air.
- Garb - Items such as gloves, garments (e.g., gowns), shoe covers, head and facial hair covers, masks, and other items designed to reduce particle-shedding from personnel and minimize the risk of contamination of CSP(s).
- Hazardous Drug (HD) - Any drug identified by at least one of the following six criteria: carcinogenicity, teratogenicity or developmental toxicity, reproductive toxicity in humans, organ toxicity at low dose in humans or animals, genotoxicity, or new drugs that mimic existing HDs in structure or toxicity.
- High-efficiency particulate air (HEPA) filtration - Being, using, or containing a filter designed to remove 99.97% of airborne particles measuring 0.3-micron or greater in diameter passing through it.
- IPA - Isopropyl alcohol; (sIPA = sterile Isopropyl alcohol).
- ISO class - An air-quality classification from the International Organization for Standardization.
- Laminar-flow glovebox isolator (LFGI) - A term used by the manufacturer of our hoods, GERMFREE, to describe the type of PEC they manufacture; It provides a contained ISO Class 5 or better air quality environment with unidirectional HEPA-filtered airflow for sterile compounding without an open front; Rather the unit has a closed front with gauntlet sleeves.

- Line of demarcation - A visible line on the floor that separates the clean and dirty sides of the anteroom.
- One-step disinfectant cleaner - A product with an EPA-registered (or equivalent) claim that it can clean and disinfect a nonporous surface in the presence of light to moderate organic soiling without a separate cleaning step.
- Pass-through chamber - An enclosure with sealed doors on both sides that should be interlocked. The pass-through chamber is positioned between two spaces for the purpose of minimizing particulate transfer while moving materials from one space to another.
- Primary engineering control (PEC) - A device or zone that provides an ISO Class 5 air quality environment for sterile compounding.
- Secondary engineering control (SEC) - The area where the PEC is placed (e.g., cleanroom suite or an SCA). It incorporates specific design and operational parameters required to minimize the risk of contamination within the compounding area.
- Segregated compounding area (SCA) - A designated space, area, or room that is not required to be classified and is defined with a visible perimeter. The SCA must contain a PEC and is suitable for preparation of Category 1 CSPs only.
- Sporicidal disinfectant - A chemical or physical agent that destroys bacterial and fungal spores when used in sufficient concentration for a specified contact time. It is expected to kill all vegetative microorganisms.
- TSA - Trypticase soy agar.
- Unidirectional airflow - Air within a PEC moving in a single direction in a uniform manner and at sufficient velocity to sweep particles away from the DCA.

Procedure:

1. ~~Generalities With Regards to LFGI Maintenance~~
    a. ~~GERMFREE, the manufacturer of our laminar flow glove-box isolators, has provided us with data to indicate that, under dynamic operating conditions, our LFGIs do provide isolation from the room and maintain an ISO Class 5 or better work environment while transferring ingredients, components, and devices into and out of the isolator during preparation of CSPs.~~
        i. ~~Furthermore, they have confirmed that the independent testing done to prove the above was performed without the use of personal protective equipment (PPE). Therefore, PPE such as head covers, beard covers, eye shields, shoe covers, non-shedding gowns with sleeves is not required when working within our LFGIs~~
        ii. ~~Data from GERMFREE indicates a recovery time of one minute or less for our LFGIs to achieve ISO Class 5 air quality after material transfer. Therefore, at least one minute wait shall be observed after placing items in the purge chamber prior to entering the LFGI to begin compounding and opening the purge chamber from the inside.~~
    b. ~~No extraneous material shall be allowed in the LFGI. It shall be kept free of debris and non-essential items.~~

c. Traffic in the IV preparation area shall be kept to a minimum and activities in this area shall be limited to necessary movements.

d. All user manuals, pertinent data and official certification reports for our LFGIs shall be maintained for the life of the device(s).

e. The sleeves in our LFGIs shall be replaced every 6 months. Nonsterile nitrile gloves shall be attached to the sleeves and replaced at least weekly. Gloves may certainly be changed more frequently due to holes, punctures, tears or any other compromise.

2. Viable and Non-Viable Environmental Sampling

a. Environmental sampling for viable and non-viable airborne particles within the LFGIs and surrounding environment is required by USP 797 regulations.

i. Such sampling shall occur as part of a comprehensive quality management program and shall occur minimally under any of the following conditions:

1. As part of the commissioning and certification of new facilities and equipment
2. Following any servicing of facilities and equipment
3. As part of the re-certification of facilities and equipment (i.e., every 6 months)
4. In response to identified problems with end products or staff technique
5. In response to issues with CSPs, observed compounding personnel work practices, or patient-related infections (where the CSP is being considered as a potential source of the infection)

ii. Non-Viable Particle Testing

1. Non-Viable particle testing is intended to directly measure the performance of the engineering controls (e.x., our LFGIs) used to create the various levels of air cleanliness.
2. Such testing shall be performed no less than every 6 months and whenever an LFGI is relocated.
3. Testing shall be performed by qualified operators using current, state-of-the-art electronic equipment with results of not more than 3,250 particles of 0.5 micrometers or larger size per cubic meter of air for the ISO Class 5 environment within our LFGIs.
4. All certification records shall be reviewed by supervising personnel within the pharmacy and maintained for the life of the device.

iii. Viable Air Sampling

1. Evaluation of airborne microorganisms using volumetric collection methods in the controlled air environments (e.x., our

~~LFGIs) shall be performed by properly trained individuals for all compounding risk levels.~~

2. ~~Impaction shall be the preferred method of volumetric air sampling.~~
3. ~~For low- and medium-risk level compounding as is performed at DCH, air sampling shall be performed at locations that are prone to contamination during compounding activities and during other activities such as staging, labeling, garbing and cleaning.~~
    a. ~~Locations shall include zones of air backwash turbulence within the PEC.~~
4. ~~Viable air sampling shall be performed at least every 6 months as part of the re-certification of facilities and equipment.~~
5. ~~A sufficient volume of air shall be sampled and the manufacturer's guidelines for use of the electronic air sampling equipment followed.~~
6. ~~At the end of the designated sampling or exposure period for air sampling activities, the microbial growth media plates are recovered and their covers severe (e.g., taped), and they are inverted and incubated at a temperature and for a time period conducive to multiplication of microorganisms.~~
    a. ~~TSA should be incubated at 30 to 35 degrees for 48 to 72 hours.~~
    b. ~~Malt extract agar or other suitable fungal media should be incubated at 26 to 30 degrees for 5 to 7 days.~~
    c. ~~The number of discrete colonies of microorganisms are counted and reported as cfu and documented. Counts from air sampling need to be transformed into cfu per cubic meter of air and evaluated for adverse trends. The recommended action level for microbial contamination within and ISO Class 5 environment is > 1 cfu per cubic meter of air per plate.~~
7. ~~All certification records shall be reviewed by supervising personnel within the pharmacy and maintained for the life of the device.~~

3. ~~Cleaning and Disinfecting the Compounding Area~~
    a. ~~Environmental contact is a major source of microbial contamination of CSPs. Consequently, scrupulous attention to cleaning and disinfecting the sterile compounding areas is required to minimize this as a source of CSP contamination.~~
    b. ~~Surfaces within our LFGIs, which are intimate to the exposure of critical sites, require disinfecting more frequently than do housekeeping surfaces such as walls and ceilings.~~

i. ~~The ISO Class 5 environment within our LFGIs shall be disinfected with sterile 70% isopropyl alcohol (IPA) at a minimum frequency as follows:~~

   1. ~~At the beginning of each shift~~
   2. ~~Before each batch~~
   3. ~~Not longer than 30 minutes following the previous surface disinfection when ongoing compounding activities are occurring~~
   4. ~~After spills~~
   5. ~~When surface contamination is known or suspected~~

ii. ~~At least weekly and whenever the surface to be disinfected has heavy soiling, loose material and/or residue from spills, a cleaning step shall be completed prior to application of the sterile 70% IPA disinfectant. This cleaning step shall involve either Neutral Quat Disinfectant Cleaner by 3M or Neutral Disinfectant Cleaner by Ecolab, whichever is maintained presently by our Environmental Services department. Sterile water may also be utilized periodically to aid in removal of water-soluble solid residues prior to disinfection with sterile 70% IPA.~~

iii. ~~All cleaning and disinfecting activities shall be logged.~~

iv. ~~Following cleaning and disinfecting, the LFGI shall be turned on and allowed to run for at least 30 minutes prior to commencement of any compounding activities within.~~

   1. ~~Similarly, anytime the LFGI is turned off for any reason, it shall be cleaned/disinfected, turned on and allowed to run for at least 30 minutes prior to compounding.~~

v. ~~Low-shedding wipes shall be utilized for all cleaning/disinfecting activities within the LFGIs.~~

vi. ~~All cleaning activities within our LFGIs shall occur from top to bottom and back to front in long side-to-side sweeping motions.~~

   1. ~~Our positive pressure LFGI shall be opened to allow for optimal cleaning/disinfecting of all surfaces within.~~
   2. ~~However, our negative pressure LFGI shall not be opened for cleaning/disinfecting activities. Instead, a handheld mop shall be kept inside the LFGI and mop-head replaced with each cleaning.~~

      a. ~~Our negative pressure LFGI is rarely utilized and, therefore, may remain inactive without daily cleaning/disinfecting at the discretion of the pharmacy manager.~~

      b. ~~The unit shall be cleaned with Neutral Quat Disinfectant Cleaner/Neutral Disinfectant Cleaner, disinfected with sterile 70% IPA, turned on and allowed to run for at least 30 minutes prior to the performance~~

~~of any compounding activities within.~~

c. ~~Surfaces outside of our LFGIs but within the pharmacy department shall be cleaned according to the following frequencies:~~
    i. ~~Counters and easily cleanable work surfaces = Daily (Monday – Friday)~~
    ii. ~~Floors = Daily (Monday – Friday)~~
        1. ~~Floors are to be mopped with cleaning and disinfecting agent once daily at a time when no aseptic operations are in process.~~
    iii. ~~Storage shelving = Monthly~~

d. ~~Cleaning materials utilized within the pharmacy, such as wipers, sponges, and mops, shall be nonshedding whenever possible. Ideally, all cleaning tools are discarded after one use by collection in suitable plastic bags and removed with minimal agitation.~~

4. ~~Surface Sampling~~

a. ~~Surface sampling is useful for evaluating facility and work surface cleaning and disinfecting procedures and employee competency in work practices such as disinfection of component/vial surface cleaning.~~

b. ~~Surface sampling shall be performed in all ISO classified areas every 6 months near the time of PEC recertification. Sampling shall be completed at the end of a compounding shift. In choosing areas to be sampled, consideration shall be given to areas where contamination is likely (e.x., doors, counters, pass-through boxes). In order to monitor for trending, the following specific areas shall be tested every 6 months and results reviewed:~~
    i. ~~Bottom surface of positive pressure LFGI, near door to purge chamber~~
    ii. ~~Bottom surface of negative pressure LFGI, near door to purge chamber~~
    iii. ~~Top shelf of shelving unit located to the left and behind the positive pressure LFGI~~

c. ~~Contact plates of nutrient agar with neutralizing agents such as lecithin and polysorbate 80 shall be used for sampling.~~
    i. ~~To sample, gently touch the sample area with the agar surface and roll the plate approximately 3 – 4 inches across the surface to be samples.~~
    ii. ~~Immediately after sampling, the sampled area shall be thoroughly wiped with a nonshedding wipe soaked in sterile 70% IPA to remove any remaining growth media residue.~~
    iii. ~~Plates shall be closed securely with tape, labeled with date and sample location and delivered to lab for incubation.~~
    iv. ~~Plates shall be incubated at 30 – 35 degrees for 48 to 72 hours.~~

d. ~~Results of surface sampling should be reported as cfu per plate. The action level for surface sampling results obtained in an ISO Class 5 area (positive or negative pressure LFGI) is > 3 cfu per plate. The action level for surface sampling results~~

~~obtained in an ISO Class 8 or worse area (shelving unit) is > 100 cfu per plate.~~

~~i. If results of any sample exceed the corresponding action level, the area involved shall be resampled. If the resampled results are still elevated, the LFGI will be excluded from use and inspected by a commercial agency. If a further sample is unacceptable, a re-evaluation of work practices, cleaning procedures, operational procedures and air filtration efficiency will occur. Sources of contamination could include HVAC systems, damaged HEPA filters, and changes in personnel garbing or working practices. The source of the problem shall be eliminated, the affected area cleaned, and resampling performed prior to any compounding activities being resumed.~~

~~5. Smoke Studies~~

~~a. In situ air pattern analysis via smoke studies shall be conducted to demonstrate unidirectional airflow and sweeping action over and away from the product being compounded under dynamic conditions.~~

~~b. Such smoke studies shall be conducted within the LFGIs upon installation and upon any movement or relocation of the device(s).~~

~~i. Of note, baseline smoke studies were conducted within both the positive pressure LFGI and negative pressure LFGI on June 9, 2016. The studies conducted on this date were observed by the pharmacy manager and 2 pharmacy technicians.~~

~~c. Smoke studies shall be witnessed by as many staff involved in the compounding of sterile preparations within the pharmacy as possible. At a minimum, this shall include the pharmacy manager and any pharmacy technicians present in the pharmacy on the day the study is conducted.~~

~~d. The air pattern observed during smoke studies shall be utilized to help the pharmacy manager and other supervisory personnel determine optimal operating processes based on airflow pattern within the LFGI and to advise additional staff of those optimal processes.~~

1. Generalities With Regards to LFGI Maintenance

A. GERMFREE, the manufacturer of our laminar flow glove-box isolators (LFGIs), indicates a recovery time of one minute or less for our LFGIs to achieve ISO Class 5 air quality after material transfer. There is a red light that appears upon pressing the 'purge' button on the unit and goes off when the purge has ended and recovery time is complete. Operator shall observe the entire recovery time by waiting until the red light goes off before entering the LFGI and beginning cleaning, compounding or any other activity with the unit closed.

B. No extraneous material shall be allowed in either of the LFGIs, the cleanroom suite or the C-SCA. They shall be kept free of debris and non-essential items.

C. Food (including mints, gum, etc.) and drinks must not enter anterooms, buffer rooms, or segregated compounding areas.

D. Traffic in the cleanroom suite and C-SCA shall be kept to a minimum and activities in these areas shall be limited to necessary activities and movements only.

E. All user manuals, pertinent data and official certification reports for our LFGIs shall be maintained for the life of the device(s).

F. The sleeves in our LFGIs shall be replaced every 6 months and the prefilters shall be replaced every 3 months as recommended by the manufacturer. Replacement sleeves and prefilters are obtained directly from GERMFREE. Nonsterile nitrile gloves shall be attached to the sleeves and replaced at least weekly. Gloves may certainly be changed more frequently due to holes, punctures, tears or any other compromise.

2. General Considerations about Cleaning and Disinfecting the Compounding Areas

A. Since the work surface area of the PEC is most intimate to the production of CSPs, this surface requires sanitization most frequently. In addition to daily and monthly cleaning with germicidal/sporicidal detergent agents followed by sanitization with sterile 70% isopropyl alcohol (sIPA) these areas will be sanitized with sIPA on a regular basis, which includes but is not limited to:

i. Immediately before initiating compounding

ii. At least every 30 minutes throughout the compounding process when ongoing compounding activities are occurring

iii. Immediately after compounding if the compounding process takes over 30 minutes

iv. After spills (after decontamination and/or cleaning)

v. When microbial contamination is known to have been or is suspected of having been introduced (after decontamination and/or cleaning)

B. Agents used for cleaning, disinfecting, and sanitizing within the PECs shall be sterile formulations.

C. This policy applied to all non-hazardous and hazardous drug (HD) compounding environments. However, refer to the Chemotherapy Safety and Chemotherapy Spill Procedures policy for additional activities required in environments in which HD compounding/administration occurs related to management of an HD spill.

D. The cleaning agents used in daily and monthly cleaning are EPA registered one-step disinfectant cleaning agents which are used to clean the PECs as well as the buffer room, anteroom and C-SCA.

E. An EPA registered one-step sporicidal disinfectant cleaner (3M C. diff Solution Tablets) will be used monthly in the USP 797 cleanroom suite in place of the germicidal detergent. Only sterile water shall be utilized to dissolve the C. diff tablets in order to prepare the sporicidal solution.

F. Sterile compounding activities occur much less frequently in the USP 800 C-SCA. Therefore, an EPA registered one-step sporicidal disinfectant cleaner with the ability to remove chemotherapy residue (decontaminate) (Peridox RTU) will be used whenever cleaning is indicated. At a minimum cleaning within the USP 800 C-SCA shall occur:

i. Daily on days when compounding occurs and when surface contamination is known or suspected

ii. Monthly (if no compounding has occurred since the last cleaning)

G. Cleaning and disinfecting activities in the controlled environments never take place while compounding is occuring.

H. Monthly cleaning may take place over several days as long as:

i. Daily cleaning activities still take place every day.

ii. Activities are specified to be broken up in a specific way in a general cleanest to dirtiest, top to bottom order (i.e. ceilings and walls day 1, furniture and bins day 2, etc).

I. Cleaning Agents

i. DCHC Pharmacy Department will designate an EPA registered one-step disinfectant cleaner (germicidal detergent) that will be used for all daily cleaning activities in the USP 797 cleanroom suite (PreEmpt RTU).

ii. DCHC Pharmacy Department will designate an EPA registered one-step sporicidal disinfectant cleaner that will be used for all monthly cleaning activities, in place of the regular germicidal detergent, in the USP 797 cleanroom suite (3M C. diff Solution Tablets).

iii. DCHC Pharmacy Department will designate an EPA registered one-step sporicidal disinfectant cleaner with the ability to remove chemotherapy residue (decontaminate) that will be used for all cleaning activities in the USP 800 C-SCA (Peridox RTU).

iv. DCHC Pharmacy Department will utilize sterile isopropyl alcohol 70% (sIPA) in both the USP 797 cleanroom suite and USP 800 C-SCA to disinfect all interior surfaces of the respective PEC after the indicated disinfectant cleaner or sporicidal disinfectant cleaner step has been completed. Surfaces will be allowed to dry completely before beginning any other activity. Sterile IPA shall also used to rinse any other areas within the space that are prone to residue.

v. DCHC Pharmacy Department will utilize sterile isopropyl alcohol 70% (sIPA) during material handling to wipe all items removed from commercial packaging before they enter the buffer room.

vi. DCHC Pharmacy Department will utilize sterile isopropyl alcohol 70% (sIPA) to wipe and thereby disinfect all components before they are transferred into the ISO Class 5 PEC immediately prior to compounding.

vii. If respective sprayer nozzles or squirt caps are not already fully attached to the cleaning agent bottle, outerwrap on the product will be removed and the respective sprayer nozzle or squirt cap will be attached only within an ISO Class 5 PEC to thereby fully activate the product. Once activated, the product bottle will be marked with an expiration date according to manufacturer guidance regarding shelf life for the respective product as follows:

i. PreEmpt RTU - 3 years

ii. Peridox RTU - 2 years

iii. Sterile isopropyl alcohol 70% (sIPA) - 1 year

iv. Our 3M C. diff Solution Tablets, when dissolved with sterile water, will not be kept beyond the shift during which they were dissolved; prepared solution will be discarded

J. Cleaning Equipment and Supplies

i. Materials used (wipers, mop covers, etc.) must be low-linting; made of synthetic microfibers and disposable (single-use only).

ii. Reusable equipment (such as mop handles and heads) must be dedicated for use in particular areas. HD equipment shall be dedicated for use in the USP 800 C-SCA HD compounding area only. In the USP 797 cleanroom suite, floor mops may be used in both the buffer room and the anteroom provided they are used in that order.

iii. A stainless-steel easy reach mop tool shall be used for cleaning and disinfecting the interior of the hazardous drug PEC. The tool is housed inside the PEC and is to be maintained far to the side of the PEC where it will not cause turbulence in the direct compounding area (DCA).

K. Individuals carrying out cleaning activities within the USP 797 cleanroom suite or USP 800 C-SCA shall complete hand hygiene and garbing as indicated in the Compounding Sterile Preparations in the Pharmacy policy.

L. Furthermore, since cleaning solutions may be irritants with potential to damage the skin and eyes, goggles may be worn, if desired, during cleaning of ceiling and walls; during mixing of cleaning agents (if applicable) and on other occasions when there is an increased likelihood of splashing or dripping of solution.

M. Safety Data Sheets must be readily available for reference to all staff in the pharmacy for all cleaning agents (germicidal detergents, sporicidal detergents), isopropyl alcohol and other agents used in the cleaning and disinfecting process.

N. Cleaning must be performed in the direction of cleanest to dirtiest areas and top to bottom. When performing cleaning, wipe from top to bottom in one direction in overlapping strokes so that the surface is thoroughly wetted but not dripped.

O. Dwell Time (Contact Time)

i. Dwell or contact time is the amount of time that an agent must remain wet on a target surface to have its intended effect.

ii. Each cleaning agent (germicidal detergent or sporicidal detergent) must be allowed to dwell on the target surface for the amount of time specified on the manufacturer's instructions for use.

a. PreEmpt RTU - 1 minute dwell time

b. Peridox RTU - 3 minute dwell time

c. 3M C. diff Solution Tablets (dissolved in sterile water) - 4 minute dwell time

d. Sterile isopropyl alcohol 70% (sIPA) - must be allowed to dry

iii. It is imperative that any wiper used to apply the agent is generously wet but not dripping so that the surface may be wet enough to achieve its dwell time.

iv. Surfaces must dry on their own. Do not wipe off or dry the surface since that will reduce the dwell time and render the agent less effective.

v. Agents are to be applied to surfaces with low-linting wipers, mop covers, etc. not by spraying the target surface which often results in inadequate moisture levels. If pre-saturated wipes are not used, then the person performing the cleaning shall take care to ensure that the spray bottle is used only to wet the low-linting wiper generously, not to wet the target surface.

P. If daily or monthly cleaning activities are performed and the room(s) are not entered again beyond the line of demarcation (no personnel, no supplies or any activity) AND the secondary engineering controls remain working (e.g., pressure differentials, air changes per hour and temperature are maintained continuously) AND the PECs are left running and functioning, but the room is not used for a period of time (i.e., over a weekend), there is no rationale that would support needing to clean again. Before beginning compounding, the work surface of the ISO Class 5 PEC shall be sanitized with sterile IPA.

3. Specific Considerations about Cleaning and Disinfecting the Compounding Areas

A. Material Handling

i. All products must be removed from their master shipping cartons (non-laminated, brown, coarse or corrugated cardboard) or non-plastic over wrap prior to leaving the general pharmacy area. Master cartons, secondary packaging and non-plastic over wrap generate considerable particular matter and harbor mold and microorganisms, which may also contaminate CSPs and the controlled environments.

ii. Surfaces of supplies and components will be wiped with sterile IPA before entry to the clean side of the anteroom either for storage or for immediate compounding.

iii. By wiping off all materials going into the anteroom and buffer room, particulates and microbial bioburden on the outer container are removed thereby lessening their introduction into the controlled environments.

iv. Prior to introduction into the PEC all supplies and components shall be wiped with sIPA to further enhance the sanitization of items.

v. Once inside the PEC, critical sites will be disinfected by wiping vigorously and in a single direction several times with a sIPA wipe. Vigorous mechanical action is important to sweep colony forming units (CFUs) and particular matter away and assists in the disinfectant action of the sIPA wipe.

vi. Wipe all critical sites first so they have enough time to dry completely before they are entered.

vii. Supplies that are are required frequently or are otherwise needed close at hand, but not necessarily needed for the scheduled operations of the shift can be wiped and stored on shelving in the anteroom.

viii. If supplies have been stored on the shelving, they must once again be wiped down with sIPA before they are introduced into the ISO Class 5 PEC.

ix. High particle shedding materials may not enter the buffer room. This includes paper documents (i.e., compounding worksheets and order forms). Absolutely no paper documents may enter the ISO Class 5 environment at any time.

x. Cleaning activities should be documented on the appropriate paper document log within the main pharmacy AFTER compounding is complete.

B. Prior to Beginning Daily Cleaning Activities

i. Staff shall gather supplies needed prior to enter cleanroom suite or C-SCA and perform appropriate hand hygiene and garbing.

ii. Garbage receptacles are to be emptied prior to any cleaning activities.

iii. Cleaning will occur in the direction of cleanest to dirtiest area. Therefore, the PEC is cleaned first followed by the ISO Class 7 butter room, followed by the ISO Class 8 anteroom

C. General Considerations for Cleaning the PECs

i. Always clean irregular surfaces first since they must be cleaned manually followed by flat surfaces that a mop or cleaning tool can cover.

ii. The positive pressure PEC in the USP 797 cleanroom suite may be turned off and opened during cleaning. Use of the easy reach mop tool may be employed, but it is not required. However, if the mop tool is not used, care must be taken never to inadvertently put one's head inside the PEC when reaching inside to clean in the corners.

iii. The negative pressure PEC in the USP 800 C-SCA shall not be opened for cleaning. A stainless-steel easy reach mop tool shall be used for cleaning and disinfecting the interior of the hazardous drug PEC. The tool is housed inside the PEC and is to be maintained far to the side of the PEC where it will not cause turbulence in the direct compounding area (DCA).

D. General Considerations for Cleaning Floors

i. Clean floors last (after PECs and high touch and horizontal room surfaces).

ii. Begin at the location farthest from the door the space being cleaned, working toward the exit to avoid walking over cleaned areas.

iii. Move all furniture, garbage receptacles, carts, shelving as cleaning is performed to ensure cleaning of the floor underneath such items.

E. Specific Considerations for Cleaning the PECs

i. Perform hand hygiene and garbing as indicated in the Compounding Sterile Preparations in the Pharmacy policy.

ii. Inspect the inside of the PEC for any spills or puddles of crystallized residue. Use sterile water to dissolve the dried spill before proceeding with the routine cleaning procedure.

iii. Begin with sterile germicidal/sporicidal detergent agent (as indicated) inside the PEC by moving in a general cleanest to dirtiest, top to bottom manner such as:

a. Hard to reach irregular surfaces including IV bar, bar support channels, and hooks.

b. Ceiling of PEC that contains the HEPA filter grill. Never spray cleaning agent toward the grill; always clean the grill with a flat cleaning device or sterile gloved hand with low-lint wiper.

c. Back of the PEC followed by either side (in a top to bottom, back to front manner).

d. Remaining side (top to bottom, back to front manner).

e. PEC work surface (back to front).

iv. The process in section iii shall be followed for use of germicidal and sporicidal cleaning agents as well as for use of sIPA.

F. Frequency of Cleaning, Disinfection, and Application of Sporicidal Disinfectant - The following chart shall be used to determine the frequency of cleaning activities. As stated previously, sterile compounding activities occur much less frequently in the USP 800 C-SCA. Therefore, cleaning within the USP 800 C-SCA may occur as infrequently as once monthly but shall depend upon when compounding activites occur within that space and will be done 3M C. diff Solution tablets dissolved in sterile water.

	Frequency of Cleaning and Disinfecting	**Frequency of Applying Sporicidal Disinfectant**
Inside PECs - including all surfaces, direct compounding area and work tray, and equipment used inside the PEC	Daily on days when compounding occurs and when surface contamination is known or suspected	Monthly
Surfaces Underneath Removable PEC Work Tray (if applicable)	Monthly - surfaces under the tray	Monthly
Pass Through(s) - all interior surfaces and external handles	Daily on days when compounding occurs	Monthly
Work Surfaces Outside of PEC	Daily on days when compounding occurs - all	Monthly - all surfaces

	"high touch" surfaces	including high touch surfaces
Floors	Daily on days when compouding occurs	Monthly
Sinks	Daily on days when compounding occurs	Monthly
Walls, Doors, and Door Frames	Monthly	Monthly
Ceilings	Monthly	Monthly
Storage Shelves and Bins	Monthly	Monthly
Equipment Outside of the PEC(s)	Monthly	Monthly

G. Cleaning Shall be Performed in this Order (unless it is a monthly clean and activites are to be split up):
    i. Inside surfaces of ISO Class 5 PEC by authorized pharmacy personnel.
    ii. Work surfaces and high touch surfaces in the buffer room.
    iii. Counters, sinks and easily cleanable and high touch work surfaces in the anteroom if those areas are on the 'clean side' of the line of demarcation.
    iv. Floors in the buffer room from farthest point away from the door progressing toward the door to the anteroom while moving easily movable carts and shelving.
    v. Floors of the anteroom from farthest point away from the door progressing toward the door to the anteroom while moving easily movable carts and shelving.

H. Monthly Cleaning of Controlled Environments
    i. Monthly cleaning within the USP 800 C-SCA shall be conducted by properly trained pharmacy staff. Monthly cleaning within the USP 797 cleanroom suite shall be conducted by either pharmacy staff or environmental services (EVS) staff so long as they are properly trained.
    ii. Clean in a general top to bottom manner. In the case of monthly cleaning, it may not always be possible to move cleanest to dirtiest and top to bottom simultaneously.
        a. It is permissible to clean the ISO Class 5 PEC first followed by a top down approach to the remainder of the space in question.
        b. It is also permissible to clean the ceilings, walls and furniture first and then clean the ISO Class 5 PEC.
    iii. Monthly cleaning includes all the elements of the daily cleaning plus the following:
        a. Surfaces underneath the removable PEC work tray
        b. Walls, doors and door frames

c. Ceilings

d. Storage shelves and bins

e. Equipment outside of the PEC(s)

I. Remedial Cleaning for Out-of-Specification Conditions

i. As directed by the designated person providing oversight for all sterile compounding activities, a remedial cleaning may be performed and documented on an as needed basis. Remedial cleaning ranges from cleaning and disinfection to application of a sporicidal disinfectant to triple cleaning affected compounding areas, depending on the reason of need for the remedial cleaning.

a. A triple clean consists of two separate and distinct applications of an approved one-step disinfectant cleaner (allowing for full wet contact time between applications) followed by a separate application of an approved sporicidal disinfectant and removal of residue (as needed) with sIPA.

J. Checklists for Guiding/Documenting Cleaning Activities

i. Checklists detailing procedural steps for daily and monthly cleaning activities may assist personnel with cleaning and disinfection activities. At a minimum, a checklist will be used to guide and document monthly cleaning activities in both the USP 797 cleanroom suite and the USP 800 C-SCA. A checklist is not required (but may be used, if desired) for daily cleaning activities. Daily cleaning shall be documented on the Laminar Airflow Hood Cleaning Record chart.

4. Certification and Recertification of Compounding Areas

A. Certification and recertification of the compounding areas shall be conducted in accordance with USP 797 and USP 800 regulations as well as any related rules from the Iowa Board of Pharmacy.

B. Certification of the classified areas including the PEC must be performed initially, and recertification must be performed at least every 6 months and must include:

i. Airflow testing

ii. HEPA filter integrity testing

iii. Total airborne particle count testing

iv. Dynamic airflow smoke pattern test

C. DCHC will contract with a reputable provider of cleanroom testing/certification services to conduct the required recertification processes. DCHC utilizes Technical Safety Services (TSS). They provide a written report via email to the pharmacy manager after each biannual (every 6 month) recertification is complete and the results have been compiled. The pharmacy manager will be responsible for reviewing the results of all above testing and implementing/documenting a corrective action plan for any results that fall outside of the parameters allowed within USP <797> or USP <800> depending upon the PEC/room that is implicated.

Specifically, for airborne particle sampling, if the levels measured during the total air sampling program exceed those in the following chart, the cause must be investigated and corrective action taken and documented.

ISO Class	Particle Count per Cubic Meter
5	3520
7	352,000
8	3,520,000

D. Dynamic airflow smoke pattern testing is performed to demonstrate unidirectional airflow within the PEC(s) and shall be observed by the pharmacy manager whenever possible and utilized to determine optimal operating processes based upon airflow patterns within each respective PEC.

E. In addition to airborne sampling, DCHC shall conduct monthly surface sampling as required by USP 797 and USP 800. DCHC utilizes Technical Safety Services (TSS) for assistance with such sampling. Kits containing sterile contact TSA (tryptic soy agar) plates, a cold pack, parafilm, sample labels, chain of custody form and return shipping label/container are sent from TSS to DCHC on a monthly basis. The pharmacy manager will undergo 'Viable Sampling Training' via TSS's online learning platform. The pharmacy manager will be the responsible for conducting the monthly surface sampling, once appropriately trained. Specific locations within each PEC, classified area and pass-through to be sampled will be determined from previous smoke studies and will be indicated on a Viable Sample Diagram depicting the USP 797 cleanroom suite and the USP 800 C-SCA space. Specific locations will remain constant for sampling from month to month so that trends can be identified. Once complete, surface samples are packaged according to instructions in the 'Viable Sampling Training' platform and are shipped to TSS for appropriate incubation and review. Results are emailed to the pharmacy manager. If levels measured during surface sampling exceed the levels in the following chart, the cause must be investigated and correction action must be taken. The corrective action plan must be dependent on the cfu count and the microorganism recovered.

ISO Class	Surface Sampling Action Level (cfu/media device)
5	>3
7	>5
8	>50

Attachments

Checklist - Cleaning (Daily) of Positive Pressure Cleanroom.xlsx

Checklist - Cleaning (Monthly) of Negative Pressure C-SCA.xlsx

Checklist - Cleaning (Monthly) of Positive Pressure Cleanroom.xlsx

Laminar Airflow Hood Cleaning Record.pdf

Approval Signatures

Step Description	Approver	Date
CAH	CAH: DCHC Critical Access Hospital Committee	Pending
Medical Director	Sarah Brewer: Internal Medicine, DO	05/2024
Senior Leader	Nikki Thordarson: CNO	02/2024
	Wendy Barker: Pharmacy Manager	02/2024

Applicability

Davis County Hospital

Status Pending PolicyStat ID 15676246

Davis County HOSPITAL & CLINICS

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Owner	Amy Marlow: Quality Director
Policy Area	Safety and Security
Applicability	Davis County Hospital

Communications Plan

Policy:

~~DCH~~Davis County Hospital and Clinics (DCHC) will develop and maintain an emergency preparedness communication plan that complies with both federal and state laws. Patient care must be well-coordinated within the facility, across health care providers, and with state and local public health departments and emergency management agencies and systems to protect patient health and safety in the event of a disaster. This plan will be reviewed and updated at least annually.

Plan:

1. The emergency preparedness communications plan will provide guidelines, contact information and procedures for how information should be shared during all phases of an unexpected occurrence that requires immediate action. This plan contains contact information for neighboring hospitals, including critical access hospitals.
   Internal communication methods during a disaster may include office phones, overhead paging, ~~Skype messages~~messaging platforms, email, cell phones, and/or radios. External communication methods will include office phones, cell phones, email, and radios when possible.
   In the event of staff and patient relocation, the evacuation policies will be followed. Tracking of all patients and staff relocated will be documented.
2. **External Contact Information**

External Contacts				
Agency	**Purpose for Contact**	**Contact Name/Title**	**Contact Info**	

Local Emergency Management Staff	Resources	Mike Lamb, EMA	(641) 724-3223 (641) 895-0407		
Local Public Health Department	Vaccines, alternate care site	~~Lynn Fellinger, RN~~	~~(641) 208-0240~~	Megan Hull, RN	(641) 208-5660
Iowa Department of Homeland Security and Emergency Management	Resources	John Benson, Director	(515) 725-3260		
Iowa Department of Health and Human Services	Resources, guidance	Bureau of Emergency and Trauma Services (BETS)	(515) 281-0620		
Iowa Department of Health and Human Services	Communicable disease assistance	Center for Acute Disease Epidemiology (CADE)	(800) 362-2736 After hours, call state patrol (515) 323-4360		
~~CMS~~CMS Regional Office	Regulatory issues		~~(877) 267-2323~~ ~~(410)~~ ~~786-3000~~(816)426-5233		
US Dept of Health & Human Services Office of the Assistant Secretary for Preparedness & Response (ASPR)	Response	Medical Reserve Corporation	(202) 692-4724		
FEMA	Resources	General Region 7 Contact Info	(816) 283-7061		
State Licensing and Certification	Regulatory issues	Iowa Department of Inspections,	~~(515) 281-7102~~(515) 281-3425		

Agency		Appeals & Licensing (DIAL)		
Fire	Fire related issues	Jeff McClure, Fire Chief	911 (641) 644-1147	
EMS	Transport	Teri Hanna	Rig phones 26-7 (641) 208-6267 26-8 (641) 208-6268 26-9 (641) 208-6269	
Police	Security assistance	Chief of Police Zack Dunlavy	911 (641) 664-2700	
Sheriff	Security assistance	Dave Davis, Sheriff	911 (641) 664-2385	
Bloomfield Care Center			(641) 664-2699	
Davis Center			(641) 664-3202	
Bloomfield Senior Center			(641) 664-1167	
Bloomfield Christian Church	Shelter		(641) 664-2181	
Bloomfield United Methodist Church	Shelter, resources		(641) 664-3206	
Mutchler Community Center	Shelter		(641) 664-3939	
MercyOne Centerville	Neighboring county CAH		(641) 437-4111	
Ottumwa Regional Health Center	Neighboring county hospital		(641) 684-2300	
Van Buren County Hospital	Neighboring county hospital		(319) 293-3171	
Kincart Physical Therapy	Contract PT provider	Karen Kincart	home (641)664-3369 cell (641)208-0319 Brian cell (641)208-6990	

Bloomfield Anesthesia Group	Anesthesia group		(641) 664-3602	
Docs Who Care	ED provider group		(913) 397-7800 (877) 397-7800	

3. **Staff Contact Information**
   HR utilizes an automated system which is used to contact ~~DCH~~DCHC staff. The system is capable of making calls or sending texts. It will be updated regularly and tested at least yearly. Internal extensions and some staff cell phones can be found on the intranet.

4. **Provider Contact Information**
   The most up to date phone directory is available on Sharepoint which includes providers phone numbers. The phone directory paper form is also available in each conference room with a phone and most department offices. Email Addresses are available in the Email Directory using Outlook from a DCHC email account.

5. ~~**Volunteer Contact Information**~~
   ~~DCH uses volunteers only for gift shop staffing and they would not be contacted in the event of an emergency.~~

6. ~~**Primary and Alternate Means of Communication**~~

~~**Means of Communication**~~		
~~**Contact**~~	~~**Primary Method**~~	~~**Alternate Method**~~
~~Staff~~	~~HR automated system~~	~~Calldown trees/Facebook~~
~~Local Emergency Management Staff~~	~~Cell phone~~	
~~Local Public Health Department~~	~~Office phone~~	~~Cell phone~~
~~State Public Health Department (Emergency Preparedness)~~	~~Cell phone~~	~~HAN message~~
~~CMS~~	~~Phone number~~	~~Through Iowa Department of Inspections and Appeals~~
~~ASPR~~	~~Phone number~~	~~Through IDPH Bureau of Emergency and Trauma Services~~
~~FEMA~~	~~Through Emergency Management Coordinator~~	~~Phone number~~

Volunteer Contact Information
Volunteers would not be contacted in the event of an emergency.

1. **Primary and Alternate Means of Communication**

Means of Communication		
Contact	**Primary Method**	**Alternate Method**

Staff	HR automated system - contact HR director or administrative assistants	Calldown trees/ Facebook
Local Emergency Management Staff	Cell phone	
Local Public Health Department	Office phone	Cell phone
State Public Health Department (Emergency Preparedness)	Cell phone	HAN message
Centers for Medicare and Medicaid Services (CMS)	Phone number	Through Iowa Department of Inspections, Appeals and Licensure
Administration for Strategic Preparedness and Response (ASPR)	Phone number	Through IDPH Bureau of Emergency and Trauma Services
Federal Emergency Management Agency (FEMA)	Through Emergency Management Coordinator	Phone number

7. **EMResource**
   EMResource is a tool that hospitals can use to alert and communicate with each other and with emergency response partners. It can be used during emergencies, but can also be used on a day-to-day basis to communicate hospital resources. EMResource allows hospitals to communicate their occupancy status (such as beds available) and send alerts to relevant partners. EMResource is intended primarily for hospitals, but is also available to EMS, first responders, public health, physician offices, law enforcement, fire departments, dispatch centers, and emergency management directors.
   ~~Teri Hanna and Lynn Fellinger~~EMS manager and Chief Nursing Officer have log in information for EMResource.

8. **HIPAA Decision Flowchart**
   HIPAA is not waived in emergency events and staff should be aware of the need to protect patient information at all times. However, certain information can be shared during emergency events if the protected health information is disclosed for public health emergency preparedness purposes. The At-A-Glance Disclosure Decision Flowchart (linked below) can help staff make choices about disclosing protected health information. If there is uncertainty about the appropriateness of disclosing information, staff should err on the side of caution or contact their HIPAA Privacy Officer for guidance. https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/SurveyCertEmergPrep/Downloads/OCR-Emergency-Prep-HIPPA-Disclose.pdf.

Attachments

OCR_EmergencyPrepHIPPADisclose.pdf

Approval Signatures

Step Description	Approver	Date
CAH	CAH: DCHC Critical Access Hospital Committee	Pending
	Amy Marlow: Quality Director	04/2024

Applicability

Davis County Hospital

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Policy Area	Safety and Security
Applicability	Davis County Hospital

Evacuation Levels

POLICY:

Davis County Hospital and Clinics (DCHC) will establish levels of evacuation necessary to control an unfavorable incident that may compromise safety. The levels will address the severity and action to be taken.

PROCEDURE:

1. **Initiation of Evacuation:**
   At the time a decision is made by the CEO or Administrator on Call to evacuate ~~Davis County Hospital~~DCHC, the incident command center will instruct the switchboard to page the evacuation level and any other specific instructions. This may include activation of call list.
   a. **Evacuation Level I (horizontal) –**
      - Patients, visitors and staff are to immediately leave the location of the hazard/incident.
      - The overhead page will include the area to be evacuated and the relocation site. The information paged will be **Evacuation + Location (to be evacuated) + Action Required + Relocation Site (internal)** .
      - Staff will assist with patient relocation.

   b. **Evacuation Level II (vertical) –**
      - Patients, visitors and staff are to move from one floor to another within the hospital.
      - ~~The page will~~Page: **Evacuation + Location (to be evacuated) + Action Required + Relocation Site (internal)** .

- Staff will assist with patient relocation.

c. **Evacuation Level III (off-site) –**

- Patients, visitors, and staff are to exit and travel, at a minimum, one block away from the building.
- ~~The page will include the incident command center location. Information to be paged will be~~Page: **Evacuation + Location (to be evacuated) + Action Required + Relocation Site (external) + Incident Command Center Location.**
- The command center will be responsible for contacting sites and transportation services or instructing the switchboard personnel to do so by cell phone or radio, unless evacuation is due to bomb threat, then alternate communication methods shall be used.
- Staff will assist with patient evacuation.

2. **Evacuated area posting:**
    - A pillow needs to be put in the doorway of patient rooms that have been completely evacuated.
    - In the non-clinical areas of the hospital, the last person to leave a department should put painter's tape across the doorway of their area to show it has been evacuated. Painter's tape is available in every fire extinguisher cabinet throughout the hospital.
3. **Evacuation Sites and Documentation (directed by incident command):**
    - **Non – Critical patients:**
        - Christian Church
        - Bloomfield Care Center
        - Davis County Elementary School
            - Hospital issued laptops are to be taken by staff to access the patient's electronic health record.
    - Critical patients and residents:
        - Ottumwa Regional Hospital
        - Van Buren County Hospital
        - ~~MercyOne Centerville~~MercyOne Centerville
            - Hospital issued laptops are to be taken by staff to access the patient's electronic health record.
    - ~~Charts are to go with the patient~~
4. **Evacuation and Transportation:**
    - The transportation officer, designated by Administrator or Administrative person on-call, will act as dispatcher.
    - Transportation vehicles will include:

        - Local ambulances,
        - School buses, and
        - Community transportation buses.
        - Employee personal vehicles will be expected to be used as alternative patient transportation to evacuation sites.

5. In the event of a hazardous material incident:
    - Haz-mat trained personnel, wearing appropriate personal protective equipment, are responsible for total evacuation.

Approval Signatures

Step Description	Approver	Date
CAH	CAH: DCHC Critical Access Hospital Committee	Pending
	Amy Marlow: Quality Director	04/2024

Applicability

Davis County Hospital

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Applicability	Davis County Hospital

Incident Command System Activation

POLICY:

Davis County Hospital and Clinics (DCHC) will use the Incident Command System (ICS) when responding to incidents.

PROCEDURE:

1. In the event of a disaster, every off duty employee should exert maximal effort to report to the hospital **after** seeing to the safety of their own family.
2. Each department will maintain a current call list with a method to ensure all staff can be contacted efficiently. These lists will be ~~keep in HR~~kept in Human Resources for the mass call system.
3. ~~Incident command activation:~~

Incident command activation:

- ~~Switchboard~~ **Switchboard**
    - When an incident with multiple victims is reported to the hospital, try to relay the call to the House Supervisor, if unable; obtain the following information:
        - What type of disaster and the general location?
        - How many persons involved?
        - Name of person calling or agency reporting?
        - Have police been notified?
- **Incident Commander**– CEO or Administrator on call will serve as the immediate Incident

~~Commander= CEO or Administrator on call will serve as the immediate Incident~~ Commander; the house supervisor is the Incident Commander in the absence of Administration. The position must be handed off from the house supervisor to the CEO or the Administrator on call.

- Coordinate the disaster from Emergency Operations Center (EOC) (for example, the CEO's ~~Office~~office, a conference room, etc…)
  - Attempt to confirm the disaster
  - Assign Hospital Emergency Incident Command System (HEICS) positions as needed – obtain ICS file folder box from disaster room for assignment sheets and vests.
  - Assign personnel to begin the Master Call List activation according to need
  - Notify community facility if evacuation is considered~~. (Christian Church)~~ (See Evacuation policy).
  - See other duties as listed on Incident Commander assignment sheet
  - Instruct opening of disaster supply area in Environmental Services Department

~~Position~~ **Position**	~~Primary~~ **Primary**	~~Backup~~ **Backup**	~~Secondary Backup~~ **Secondary Backup**		
~~Incident Commander~~ **Incident Commander**	CEO	CNO	~~Ancillary Services Director~~ CFO		
~~Liaison Officer~~ **Liaison Officer**	~~Ancillary Services Director~~ CNO	CFO	Quality Director		
~~Safety Officer~~ **Safety Officer**	~~Maintenance Lead~~	~~Ancillary Services~~Quality Director	~~Infection Prevention~~	Ancillary Services Director	Clinic Director
~~Public Information Officer~~ **Public Information Officer**	~~Marketing Coordinator~~ Compliance Officer	Quality Director	CNO		
~~Operations Chief~~	~~Infection Prevention~~	~~Surgery/ Outpatient Leader~~	~~Quality Director~~		
Operations Chief	Clinic Director	HR Director	IT Director		

~~Logistics Chief~~ **Logistics Chief**	IT Director	Plant Ops Manager	Patient Services Manager	~~Surgery/ Outpatient Leader~~		
~~Planning Chief~~ **Planning Chief**	~~CNO~~	~~Infection Prevention~~	~~Patient Services Manager~~	Ancillary Services Director	IT Director	Plant Ops Manager
~~Finance Chief~~ **Finance Chief**	CFO	Accounting Lead	~~Accounting Assistant~~ Ancillary Services Director			

- PROVIDERS:
  - Report to personnel pool (in cafeteria unless otherwise communicated).
- ALL HOSPITAL STAFF (except as noted below):
  - Perform emergency work/duties only; all available staff report to the Personnel Pool located in the Cafeteria. The Personnel Pool Leader will track personnel pool members (register on clip board and track assigned personnel to and from duties).
- MATERIALS MANAGEMENT:
  - Report to own department and prepare for dispensing of supplies
- PHARMACY:
  - Report to own department and prepare for dispensing of supplies and medications
- MINISTERS:
  - Report to Incident Command Center
- PUBLIC RELATIONS: (ALL HOSPITAL EMPLOYEES)
  - If approached by members of the media, be courteous and kind.
  - Direct them to the Public Information Officer (PIO)
- MORGUE:
  - Area for morgue should be secured with limited access (example, Cardiac Rehab, Computer Lab, etc…)
- TRIAGE: See ER Mass Casualty Incident (MCI) and Disaster Surge Planning Policy and Procedure
  - The Triage Officer will set up/ maintain the triage area (follow job action sheet)
  - The Triage Officer will inform assistants on how to tag and at what level to tag patients.
  - Only trained personnel are to conduct the Triage procedure.
  - Assistant may fill tag if instructed on procedure.

a. Fill in the name of casualty on tag (if known). If unknown, use the number on the tag.

b. Attach tag to wrist or ankle. (If able) Do not attach to clothes.

- EVACUATION: See Evacuation Levels policy and procedure
- DECONTAMINATION AND SET UP OF NEGATIVE AIRFLOW ROOMS: See Decontamination Procedure for ER Treatment and Mass Casualty Incident Policy

Approval Signatures

Step Description	Approver	Date
CAH	CAH: DCHC Critical Access Hospital Committee	Pending
	Amy Marlow: Quality Director	04/2024

Applicability

Davis County Hospital

Status **Pending** PolicyStat ID **15643850**

Davis County HOSPITAL & CLINICS

An Affiliate of MERCYONE

Origination	10/2008
Last Approved	N/A
Effective	Upon Approval
Last Revised	05/2024
Next Review	2 years after approval

Owner	Karen Kincart: Rehab Manager
Policy Area	PT/OT
Applicability	Davis County Hospital

Maintaining Freezer, Refrigerator, Paraffin, and Hydrocolator Temperatures

Policy Number: PT 00.28.00

POLICY:

Freezer, refrigerator and hydrocolator will be checked on a ~~monthly~~weekly basis to ensure required temperatures.

PROCEDURE:

Temperature is checked and logged on a ~~monthly~~weekly basis. If temperature remains out of required range for more than 1 days, Biomed should be called.

- Freezer temperature should be maintained between 0 - 10° F (-17.8 to -12.2 C).
- Hydrocolator temperature should be maintained between 160°-170°F (71.1 to 76.7 C).
- Refrigerator temperature should be maintained between 36° - 41°F (2.2 to 5.0 C).
- Paraffin temperature should be maintained between 120° – 130°F (48.9 to 54.4 C).

Approval Signatures

Step Description	Approver	Date

CAH	CAH: DCHC Critical Access Hospital Committee	Pending
Medical Director	Donald Wirtanen: ER Physician	05/2024
Senior Leader	Rod Day: Ancillary Services Director	05/2024
PT Manager	Jackie Wells: DPT	05/2024
PT Manager	Karen Kincart: Rehab Manager	05/2024

Applicability

Davis County Hospital

Status Pending PolicyStat ID 15676143

Davis County HOSPITAL & CLINICS

An Affiliate of MERCYONE

Origination	10/2014
Last Approved	N/A
Effective	Upon Approval
Last Revised	04/2024
Next Review	2 years after approval
Owner	Amy Marlow: Quality Director
Policy Area	Safety and Security
Applicability	Davis County Hospital

Plain Language Emergency Codes

POLICY:

Davis County Hospital and Clinics uses plain language for emergency codes.

PROCEDURE:

1. When the need for ~~a~~an emergency code is identified, staff will call the code using overhead paging, using the scripting below as a guide.

2. The general form is (Type of Alert) + (Location and/or Descriptor) + (Action Required).

Emergency Alert	Plain Language
Facility Alerts	
Fire	Fire Alarm + Location +Action Required
Evacuation	Evacuation +Location +Action Required + Relocation Site
Hazardous Material Spill	Hazardous spill + Location (Internal or External) + Action Required
Weather Alerts	
Severe Weather	Weather Alert + Descriptor + Action Required
Security Alerts	
Missing Person	Missing Person + Descriptor +Action Required
~~NORA (Need officer right away)~~	~~Do not page- ask staff to call NORA for you~~
Aggressive Intruder	Security Assistance Requested + Location + Description+ Action

	Required
Bomb Threat	Bomb Threat + Location + Action Required
Disaster (internal or external)	(Internal or External) Emergency + Descriptor + Activate Incident Command System
Medical Alerts	
Medical Emergency	Medical Emergency + Location
Patient Assistance (crash cart not needed)	Patient Assistance + Location
Mass Casualty	Mass Casualty + Location
STEMI	STEMI alert + Location
Stroke	Stroke alert + Location
Trauma Team Activation	Trauma ~~(Red or Yellow)~~alert + Location

Approval Signatures

Step Description	Approver	Date
CAH	CAH: DCHC Critical Access Hospital Committee	Pending
	Amy Marlow: Quality Director	04/2024

Applicability

Davis County Hospital

Status Pending PolicyStat ID 15676131

Davis County HOSPITAL & CLINICS

An Affiliate of MERCYONE

Origination	04/1999
Last Approved	N/A
Effective	Upon Approval
Last Revised	04/2024
Next Review	2 years after approval

Owner	Amy Marlow: Quality Director
Policy Area	Safety and Security
Applicability	Davis County Hospital

Safety Responsibilities

POLICY:

It is the policy of Davis County Hospital and Clinics (DCHC) to promote "Safety First" in all areas of the hospital. Employees must follow all ~~DCH~~DCHC policies and laws with due diligence and care to minimize hazardous materials exposures.

PROCEDURE:

Managers' responsibilities include the following:

1. Provide personal leadership to safety in their department.
2. Conduct safety and housekeeping inspections and document findings, corrective action, & follow-up.
3. Complete and appropriately report accidents.
4. Discipline employees who disobey safety rules.
5. Orient new workers.
6. Review and update all staff on a periodic basis.
7. Monitor the appropriate use of personal protective equipment for employee safety, document variances, and investigate findings.

Employees Responsibilities:

1. Conduct their work in a safe manner.
2. Follow all safety rules.

3. Report immediately any existing or potential conditions hazardous to human health or the environment or a known violation to ~~DCH~~DCHC policies to the compliance officer/designee.

Administration:

1. Committed to safety of each employee, patient, and visitor.
2. Monetary support for the safety program.

Approval Signatures

Step Description	Approver	Date
CAH	CAH: DCHC Critical Access Hospital Committee	Pending
	Amy Marlow: Quality Director	04/2024

Applicability

Davis County Hospital

Revised Policies

Title	Policy Area	Summary of Changes
Anesthesia Apparatus	Anesthesia	Changed "O.R." to OR, changed "primary physician" to "primary provider", corrected "switched" to "switches"
Blood Utilization	Anesthesia	changed on-set to onset
Duties and Responsibilities Chief Nurse Anesthetist	Anesthesia	switched "insuring" to "ensuring"
Infection Control Procedures During Anesthesia	Anesthesia	changed "pt" to "patient"
Management of Local Anesthetic Systemic Toxicity (LAST)	Anesthesia	Changed owner to Roxanne
Neuraxial Anesthesia and Anticoagulation	Anesthesia	Updated ASRA recommendations to reflect most current practices from 2018
Ambulance Response to Dispatches and Emergency Driving of Ambulances	EMS	change lead to manager in last paragraph.
Patient Ambulance Transfers	EMS	Added Crew should not leave county without EMS coverage, cleaned up language in paragraph about destination other than DCHC.
Patient Refusals for Ambulance Transport	EMS	minor name changes
Procurement and Restock of EMS Drugs from Pharmacy	EMS	change EMS Lead to manager, outdates completed by pharmacy.
Storage of Drugs in the EMS Department and Ambulances	EMS	change leader to manager
Bed Usage at Davis County Hospital	Med-Surg	Removed east wing from outpatient
Diet Interventions	Med-Surg	Removed attachments
Visiting Hours	Med-Surg	fixed a typo
Vital Signs Per Protocol	Med-Surg	Increasing the frequency of monitoring abnormal vital signs
Management of Pain Prescriptions	Outpatient	typo fixed
Establishing Patient Treatment Frequency	PT/OT	deleted final sentence
Process for Medical Service During Therapy Treatment	PT/OT	change 211 to 51 and medical personnel verbage
Treatment Errors	PT/OT	updated to incident reporting software

Revised Policies

Title	Policy Area	Summary of Changes
Emergency Operations Plan	Safety and Security	Clarified abbreviations throughout. Changed Iowa Department of Public Health to Iowa Department of Health and Human Services throughout.
Fire Plan	Safety and Security	changed new employee competencies to orientation as relates to training on extinguisher locations.
Hazardous Materials Incident	Safety and Security	added Safety Data Sheet (SDS)
Incident Command System Activation	Safety and Security	In policy statement, added 'and Clinics' to Davis County Hospital. Formatting changes in body of policy, and updated incident command position assignments.
Severe Weather and Tornado Watch/Warning Plan	Safety and Security	Change made to announcement language. Changed incident command center to lower-level former billing office. Updated Public Health contact information.
Violent Intruder/Active Shooter (Run, Hide, Fight)	Safety and Security	Formatting changes

Unchanged - Annual Reviews

Title	Policy Area
Anesthesia Administration Outside the OR	Anesthesia
Anesthesia Gas and Nitrogen Storage	Anesthesia
Anesthesia Guidelines for Anesthesia Management	Anesthesia
Anesthesia Latex Allergy Policy and Procedure	Anesthesia
Anesthesia Safety Regulations	Anesthesia
Anesthesia Selection Guidelines	Anesthesia
Completion of Anesthesia Record Sheet	Anesthesia
Continuing Education Requirements	Anesthesia
Criteria for Notifying Surgeon, Physician, or Anesthesia	Anesthesia
Management of Patient with Malignant Hyperthermia	Anesthesia
Organization of the Anesthesia Department	Anesthesia
Oxygen Enriched Atmosphere – Safety in Surgical Suites	Anesthesia
Quality Improvement of Anesthesia Department	Anesthesia
Administration of Pre-hospital Medications by EMS Personnel	EMS
Ambulance Response Procedures	EMS
Documentation and Use of Controlled Substances Pre-hospital by EMS Staff	EMS
Medical Screening Exams and Transfers	EMS
Relationship between DCH EMS and the Davis County Hospital Pharmacy	EMS
Medical Imaging Protocols	Medical Imaging Services
Medical Student/Resident Credential and Privileging Process	Medical Staff
Administration of Special IV Medications in Acute Care	Med-Surg
Levels of Care for the Hospice Patient	Med-Surg
Nursing Assignments	Med-Surg
Nursing Performance Improvement/Peer Review in Med/Surg Area	Med-Surg
Patient Care Plan	Med-Surg
Patient Rights and Responsibilities	Med-Surg
Patient/Family Access to Medical Records	Med-Surg
Spiritual-Pastoral Care	Med-Surg

Unchanged - Annual Reviews

Title	Policy Area
Adaptive Equipment	PT/OT
Adverse Reaction to Treatment	PT/OT
Aquatic Therapy	PT/OT
Care of the Patient	PT/OT
Cleaning Hydrocollators	PT/OT
Cleaning Procedure for Hydrotherapy Tanks	PT/OT
Departmental Meetings	PT/OT
Direction, Utilization and Supervision	PT/OT
Discharge Criteria	PT/OT
Discharge Planning - Rehabilitation Services	PT/OT
Discharge Planning for Rehab Services Patients	PT/OT
Documentation of Patient Assessments	PT/OT
Draping of Patients to Maintain Privacy	PT/OT
Electrical Muscle Stimulation (E-Stim)	PT/OT
Electrical Safety / Equipment Use	PT/OT
Employee Orientation / Equipment Training	PT/OT
Evaluation	PT/OT
Hydrocollator Packs	PT/OT
Infection Prevention Procedures for Physical Therapy Department	PT/OT
Initiation of Therapy for Patients on Bedrest	PT/OT
Inpatient Documentation Guidelines	PT/OT
Inpatient Hold Policy	PT/OT
Logrolling	PT/OT
Management of Outpatients No Show/No Cancellation/Late/Multiple Cancellations	PT/OT
Medical Based Fitness	PT/OT
Occupational Therapy for Orthopedic Patients	PT/OT
Occupational Therapy Scope of Practice	PT/OT
Patient and Family Education – Physical Therapy	PT/OT
Patient Treatment Plan	PT/OT
Phonophoresis	PT/OT
Physical Therapy Care, Treatment and Services	PT/OT
Physical Therapy Scope of Practice	PT/OT

Unchanged - Annual Reviews

Title	Policy Area
Physician Approval for Inpatient Plans of Care	PT/OT
PT Guidelines for Contraindications of Exercise/Physical Activity	PT/OT
Re-Evaluation	PT/OT
Registration of a Minor for Outpatient Rehabilitation	PT/OT
Scheduled/Unscheduled Absences/Requests for Time off	PT/OT
Scope of Practice	PT/OT
Taking / Returning Inpatients	PT/OT
Transcutaneous Electrical Nerve Stimulation (TENS)	PT/OT
Transfer of Primary Care	PT/OT
Treatment Prioritization	PT/OT
Treatment Programs	PT/OT
Ultrasound Modality	PT/OT
Wound Care - Burns	PT/OT
Wound Care - Debridement	PT/OT
Quality Assessment and Performance Improvement Program	Quality
Choking Precautions	Speech Therapy
Dysphagia Precautions	Speech Therapy
Speech Therapy Scope of Practice	Speech Therapy