Board of Trustees

Revised Policy Statements, Retired Policies, Revised Policies, & Unchanged Policy Reviews

Revised Policy Statements (policies listed below) **Action**

- Administration
  - Critical Access Hospital (CAH) Committee
- Medical Imaging Services
  - Interpreting Physician Consultant Requirements
  - Mammography Visual Checklist
  - MRI Safety
  - Obtaining Equipment Service
  - PRN Radiology Technologists
  - Ultrasound Guided Interventional Procedures
- Safety & Security
  - Missing Person

Request to Retire (policies listed below) **Action**

- Physical Therapy
  - Cleaning Procedure for Hydrotherapy Tanks
  - Inpatient Hold Policy
  - Scheduled/Unscheduled Absences/Requests for Time Off
  - Departmental Meetings
  - Documentation of Patient Assessments
  - Inpatient Documentation Guidelines
  - Medical Based Fitness
  - Treatment Programs

Revised Policies (See List Here) **Action**

• Provision of Service	Administration
• Radio and Cell Phone Communications	EMS
• Medical Imaging Services On-Call	Medical Imaging Services
• Mobile Imaging Radioactive Material Safe	Medical Imaging Services
• Pregnant Medical Imaging Workers	Medical Imaging Services
• Ultrasound Definity Standing Orders	Medical Imaging Services
• Medicare Outpatient Observation Notice	Med Surg
• Collections	Patient Financial Services
• Incident Command System Activation	Safety and Security
• Utilization Review and Management Plan	Utilization Review

Unchanged Policy Reviews (See List Here) **Action**

- Emergency Department
- Medical Imaging Services

Board of Trustees

Revised Policy Statements, Retired Policies, Revised Policies, & Unchanged Policy Reviews

- Patient Financial Services
- Risk Management

Revised Policy Statements

Title	Policy Area	Summary of Changes
Critical Access Hospital (CAH) Committee	Administration	Revised policy statement. Revised composition of committee.
Interpreting Physician Consultant Requirements	Medical Imaging Services	changed shall to will
Mammography Visual Checklist	Medical Imaging Services	changed monthly to daily
MRI Safety	Medical Imaging Services	updated 1E verbiage to"It is recommended that all emergency crews"
Obtaining Equipment Service	Medical Imaging Services	changed shall to will
PRN Radiology Technologist	Medical Imaging Services	updated verbiage
Ultrasound Guided Interventional Procedures	Medical Imaging Services	updated physician to provider and HIS to EHR
Missing Person	Safety and Security	Policy rewritten.

Status Pending PolicyStat ID 16220377

Davis County HOSPITAL & CLINICS

An Affiliate of MERCYONE

Origination	03/2024
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Effective	Upon Approval
Last Revised	08/2024
Next Review	2 years after approval

Owner	Amy Marlow: Quality Director
Policy Area	Administration
Applicability	Davis County Hospital

Critical Access Hospital (CAH) Committee

POLICY:

The Critical Access Hospital (CAH) Committee shall be responsible for the review of clinical policies at a minimum of every two years, offering input deemed thoughtful and prudent.

PROCEDURE:

A. Membership:
   1. Advanced Practice Providers (APPs) employed full-time by Davis County Hospital and Clinics (DCHC).
   2. At least one voting member of the Medical Staff.
   3. The Director of Quality, Risk and Safety, who is responsible for the coordination of policies.

B. At minimum, input from two APPs is required to consider policies approved through this committee.

C. APP input on clinical policies shall be obtained through an in-person meeting or via email and records shall be kept serving as minutes of the CAH committee.

D. Minutes of all meetings shall be kept and available for the Medical Staff and Board of Trustees review.

E. The CAH Committee shall be accountable to the Davis County Hospital and Clinics Board of Trustees.

Approval Signatures

Step Description	Approver	Date
CEO	Veronica Fuhs: CEO - DCHC	Pending
	Amy Marlow: Quality Director	08/2024

Applicability

Davis County Hospital

Status Pending PolicyStat ID 16067037

Davis County HOSPITAL & CLINICS

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Next Review	2 years after approval
Owner	Susan Haskell: Medical Imaging Services Manager
Policy Area	Medical Imaging Services
Applicability	Davis County Hospital

Interpreting Physician Consultant Requirements

Policy Number: MIS 01.02.0

POLICY:Interpreting Physician Consultant Requirements

Davis County Hospital and Clinics ~~shall~~will contract a Physician consultant(s) (Radiologists) to provide interpretation of Medical Imaging procedures performed at Davis County Hospital and Clinics(DCHC).

PROCEDURE:

Physician Consultant(s) (Radiologists) will comply with the following:

A. Davis County Hospital and Clinics Medical Staff By Laws.
B. The Credentialing processes of DCHC for Telemedicine privileges.
C. Be currently licensed by the State of Iowa to practice his or her profession and to exercise the privileges held or applied for. May need to be registered by the D.E.A. and the State of Iowa to prescribe drugs if the privileges applied for would require it.
D. Meet any other requirements necessary to maintain DCHC accreditation of regulating and certifying agencies in which they are participants (FDA, MQSA, ACR).
E. Provide transcribed and signed reports to providers who have requested/ordered Imaging procedures for their patients.
F. Maintain continuing education requirements for certifying or credentialing agencies.
G. Participate in peer review and contract review processes.

Approval Signatures

Step Description	Approver	Date
CAH	CAH: DCHC Critical Access Hospital Committee	Pending
Medical Director	Mitchell Erickson: DCHC Radiology Medical Director	06/2024
Senior Leader	Rod Day: Ancillary Services Director	06/2024
	Susan Haskell: Medical Imaging Services Manager	06/2024

Applicability

Davis County Hospital

Status **Pending** PolicyStat ID **16013405**

Davis County HOSPITAL & CLINICS

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Last Approved	N/A
Effective	Upon Approval
Last Revised	06/2024
Next Review	2 years after approval
Owner	Susan Haskell: Medical Imaging Services Manager
Policy Area	Medical Imaging Services
Applicability	Davis County Hospital

Mammography Visual Checklist

Policy Number: Rad.05.30.0

POLICY:

The visual checklist test should be carried out ~~monthly~~daily or after any service or maintenance ~~on~~to the mammographic ~~x-ray~~ system.

PROCEDURE:

1. Review visual checklist and indicate the status.
2. Date and initial the checklist where indicated on QA form.
3. Items listed on the visual checklist should pass or receive a check mark.
    1. Items not passing should be replaced or corrected immediately.
    2. Items missing from the room should be replaced immediately.
4. Corrective action shall be recorded on QA form.

Approval Signatures

Step Description	Approver	Date

CAH	CAH: DCHC Critical Access Hospital Committee	Pending
Medical Director	Mitchell Erickson: DCHC Radiology Medical Director	06/2024
Senior Leader	Rod Day: Ancillary Services Director	06/2024
	Susan Haskell: Medical Imaging Services Manager	06/2024

Applicability

Davis County Hospital

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Davis County HOSPITAL & CLINICS

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Next Review	2 years after approval

Owner	Susan Haskell: Medical Imaging Services Manager
Policy Area	Medical Imaging Services
Applicability	Davis County Hospital

MRI Safety

POLICY:

Davis County Hospitals and Clincs(DCHC) employees will be aware of the safety concerns related to working with an MRI.

PROCEDURE:

1. MRI SAFETY ZONES

A. Zone 1 (areas with unrestricted access)
   1. Freely accessible to the general public
   2. Outside of the MR environment
   3. The area through which all personnel access the MRI environment

B. Zone 2 (interface between public and restricted areas)
   1. Patients and visitors are greeted and supervised in this zone
   2. The area for which patients are gowned and prepped for procedure
   3. Appropriate warning signs about magnetic fields are posted at entry points.

C. Zone 3 (highly restricted area)
   1. MRI control area
   2. All visitors require escort by authorized Level 2 personnel
   3. Appropriate warning signs about magnetic fields are posted at entry points.

D. Zone 4 (potentially hazardous area)

1. MRI scanner "Magnet" room where MRI procedures take place
2. MRI equipment room
3. All Level 1 and non MRI personnel must be accompanied by authorized Level 2 personnel
4. All persons entering Zone 4 must complete MRI Screening Form
5. Magnet room door must display "Magnet is always on" signage
6. All equipment and devices must be MRI compatible (i.e. wheelchairs, carts, anesthesia equipment, etc.)
   II.PERSONNEL CATEGORIES
   A.Visitors/Patients: those with incomplete or no training in MRI safety.
   B.Level 1: those who have been through MRI Safety Training, may enter Zones 2 and 3 unescorted but cannot escort visitors into Zone 4.
   C.Level 2: MRI technologists with Level 1 training plus additional MRI safety training and knowledge of screening and emergency procedures. MRI technologists should be registered technologists under the American Registry of Radiologic Technologists (ARRT) (however this is not required in order to perform MRI procedures as long as the Technologist has received MRI Technologist training and determined to be qualified to perform MRI procedures by ARRT Registered MRI Technologist and/or Medical Imaging Leader.) and maintain current certification in American Heart Association basic life support at the health care provider level.
   D.All non-MRI and Level 1 personnel are subject to the safety screening process performed by Level 2 MRI personnel. This includes families, visitors, office staff, housekeeping, health care professionals, and others who enter the MRI suite.

E. ~~All~~It is recommended that all emergency crews (fire/rescue, facility services, security, etc.) will review basic MRI safety and procedures on a periodic basis.

III.SCREENING PROCEDURES

A. Level 1 and 2 personnel are to undergo MRI screening as part of their employment interview process. MRI personnel are to immediately report any change in circumstance in which a ferromagnetic or metallic device has been introduced within or on them. Re-screening would then be necessary to determine the safety of allowing that employee into Zones 3 and 4.

B. All non-MRI personnel, patients, and visitors are to be screened by Level 2 MRI personnel prior to entering Zones 3 or 4, and should be accompanied by or under the immediate supervision of MRI-authorized personnel.

C. All MRI patients and accompanying visitors entering Zone 4 are to sign a written screening questionnaire which will then be reviewed and signed by a Level 2 MRI technologist (Form #069007). If the patient is a minor, the questionnaire is to be signed by the accompanying legal guardian. A verbal screening may be done by telephone, with at least one Level 2 technologist and one other DCHC staff witness and sign the screening document.

D. All implanted devices, coils, stents, etc. should be checked for compatibility with the MRI magnet. Screening personnel should refer to the Reference Manual for Magnetic Resonance Safety by Frank G. Shellock, Ph.D. or access the MR safety web site (www.mrissafety.com).

The radiologist will use his/her discretion and will weigh the benefits vs. risks associated with scanning an implanted device. Information on implanted devices must specify at what field strength(s) the device is compatible with. All information regarding implanted devices should be properly documented by the screening personnel.

IV.PREGNANCY AND BREAST FEEDING

A. Patient Pregnancies
    1. MRI contrast agents should not be given to pregnant patients without the approval of a radiologist and primary care provider.
    2. It is the policy of DCHC to permit MRI procedures on pregnant patients only if prior approval has been given by the attending provider and radiologist. The "Informed Consent for Magnetic Resonance Imaging During Pregnancy" form must be completed and signed.

B. MRI Personnel Pregnancies

1. Level 1 and 2 MRI personnel are permitted to work in the MRI suite throughout their pregnancy; however, pregnant MRI personnel are requested to limit their time within Zone 4. Pregnant personnel are not allowed in Zone 4 during actual data acquisition.

C.Breast Feeding

1. Gadolinium-based contrast agents have been determined safe for nursing patients. However, a nursing patient with concerns of potential ill effects of contrast should be referred to the "Administration of Contrast Media to Breast-Feeding Mothers" document so she can make an informed decision to either continue or temporarily abstain from breast feeding.

V.PEDIATRIC PATIENTS

A. Pediatric patients not requiring sedation may be scanned. Personal comfort items such as blankets and stuffed animals should be carefully checked by MRI personnel and a hand-held magnet.

VI.CONTRAST AGENTS AND REACTIONS

A. An FDA-approved gadolinium-based contrast agent is not to be administered without an order by a licensed physician or provider.
B. A Glomerular Filtration Rate (GFR) must be obtained within 14 days on a patient with a history of at least one of the following:
    1. Renal disease (including solitary kidney, renal transplant, or renal tumor).
    2. Age >60
    3. History of Hypertension
    4. History of Diabetes
C. A Glomerular Filtration Rate (GFR) must be obtained within 2 days on patients with a history of:
    1. Severe hepatic disease, liver transplant, or pending liver transplant.
D. If GFR is:

1. >40contrasts may be given without consulting a radiologist
2. <40contrasts may not be given without approval from a radiologist

E. Patients on hemodialysis and/or peritoneal dialysis require approval by the patient's nephrologist and a radiologist for a contrast injection.

F. MRI technologists who have demonstrated and documented proficiency in peripheral IV access are permitted to start and attend to peripheral IV access lines.

G. Contrast may be administered via:

1. peripheral IV
2. central line
3. PICC line (power PICCs may be used for power injections)
4. Pre-accessed Portacaths (must be flushed with saline and heparin post-contrast injection)

H. Contrast may NOT be administered through a dialysis catheter.

I. An MR technologist may give contrast in 3 various forms:

1. bolus
2. slow injection
3. continuous injection

K.In the rare event a patient should experience a contrast reaction, the MRI exam should be stopped immediately.

1. Mild reactions can include nausea, hives, itching, vomiting, and diaphoresis. These reactions should be documented by entering event into risk management system.

a. The technologist will ensure that the patient is well before allowing him/her to leave. The technologist will also notify the referring provider of the mild reaction, and instruct the patient to follow up with his/her provider (or Emergency Dept if provider is unavailable) if experiencing any additional symptoms.

1. Moderate and severe reactions can include convulsions, arrhythmias, respiratory distress, cardiac arrest, unresponsiveness, hypertension, hypotension, and dyspnea. These reactions should be documented by entering event into risk management system.

a. If patient is oriented, the patient will be transported to the E.D. If the patient is unresponsive, pulseless, or breathless, a Code Blue will be activated.

VII.SEDATION

A. IV sedation is not offered at DCHC. Outpatients or inpatients can be pre-medicated as prescribed under the care of their provider.

B. Any outpatient who receives sedation will not be allowed to drive after the MRI procedure. Proper transportation should be arranged by the patient prior to the administration of the sedation.

VIII.EQUIPMENT SAFETY-RELATED ISSUES

A. Coils

1. All coils are to be maintained with safe handling and with regular cleaning and disinfecting of the coils and their associated padding.
2. All coils are to be visually inspected on a regular basis for frayed cables, loose screws, etc. An MRI technologist should report all defects to the magnet manufacturer for prompt repair or replacement.
3. Defective coils should be removed from operation immediately and set aside for repair. MRI staff are to notify all users of the defective coil via signage, e-mail, marker board, or other form of communication.

B. Zone 4

1. The emergency alarm system networked with the manufacturer is not a guaranteed system. MRI staff should report alarms to the appropriate agencies as soon as they are detected. If non-MRI personnel should detect an alarm or a visible magnet hazard (smoke, gasses, fire, or water) and no Level 2 MRI personnel are on site, they should contact the Medical Imaging Services Manager, Director of Ancillary Services or Senior Leadership on-call immediately.
2. MRI staff should contact the scanner manufacturer with malfunctions of the magnet, coldheads, chillers, computers, or coils.
3. MRI staff should contact DCHC Plant Ops with any malfunction of Cooling Equipment

a. The air conditioning system in the "Equipment Room" is maintained by the DCHC Plant Ops Department/staff. They will maintain, clean and service the unit as necessary and according to manufacture guidelines.

b. The MRI Magnet Chiller is serviced and maintained by the MRI Manufacturer. Plant-Ops will also be notified when system is down to maintain the water by-pass system and will ensure it is maintained and properly functioning.

1. All ancillary equipment and supplies to be used in Zone 4 must be checked with a handheld magnet to determine if it is MRI Safe. Any temporary equipment must be inspected for ferrous properties by trained MRI staff.

IX.PATIENT SAFETY-RELATED ISSUES

A. All patients and accompanying visitors in Zone 4 during data acquisition should be appropriately screened.
B. .Thermal insulation (air, pads, linen, etc.) should be placed between the patient and the magnet bore or any electrically conductive material.

A. Patients should avoid crossing legs and/or arms while in the MRI scanner.
B. Wall oxygen or MRI-safe oxygen tanks are available for use in Zone 4; however, oxygen may only be used on patients under the order of a provider.
C. An emergency "squeeze ball" will be made accessible to all patients whose condition allows them to use it.

G.All patients are to wear hospital gowns, scrubs, or clothing checked carefully by MR staff and screened by MRI Level 2 staff prior to entering Zone 4.
H.All patients and accompanying visitors in the magnet room are required to wear hearing protection in the form of ear plugs, sound-attenuating headphones, or both during an examination.

I. Any patient, accompanying visitor or healthcare workers are to be screened and cleared for potential ferromagnetic foreign body of the orbits (eyes) by Radiographic Imaging of the orbits and reviewed by a Radiologist if;

1. Person suspects they may have potential for metallic foreign body of the orbits.
2. They work with metal such as grinding, welding, automotive mechanic or any other occupation or hobby that includes metal fabrication, and have had injury to an eye involving metal.

(a radiologist's review and assessment of prior CT or MRI contiguous cut images that were obtained since the suspected traumatic event, if available, may also be reviewed as a screening tool).
X.PATIENT-RELATED INCIDENTS AND INJURIES

A. Patient-related incidents can include IV extravasations, skin tears, falls, and RF burns.

1. Consult with the referring physician, ER physician or other available in-house medical provider.
2. Enter event in risk management system.

B. In the event that non-MRI compatible implanted devices are discovered after the patient has entered Zone 4, DO NOT remove the patient immediately.

1. Contact the radiologist prior to removing the patient from Zone 4.
2. If the radiologist advises extraction, proceed to move the patient from Zone 4 slowly and parallel to the bore of the scanner until the patient and table have crossed the 5 Gauss line.
3. Observe patient condition and contact the referring physician. Proceed as instructed by radiologist.
4. Enter event in the risk management program.

XI.EMERGENCIES

A. **Medical Emergencies**

1. Patients who develop respiratory or cardiac arrest will be removed quickly and safely from Zone 4. Emergency medical personnel and their equipment are NOT allowed in Zone 4 at any time.
2. MRI staff will begin CPR after activating the Code Blue call.

B. **Magnet Quench Emergencies**
A magnet quench can result in the release of cryogen vapor into the magnet room if the building vent system fails, leaving a white cloud of vapor in the room. Cryogen vapor released

during a quench can cause asphyxiation, frostbite, or other injuries due to panic. Magnet quenches are indicated by a loud noise, warning message, or the tilting of an image on the imaging console. Should a quench occur, it is critical to have a well-planned method to quickly remove the patient and all personnel from Zone 4.

1. **Controlled Quench**

Should only be initiated by authorized MRI personnel in the event of a potentially life-threatening emergency, such as an individual being pinned to the magnet by a ferrous object and no other method will free them or prevent further injury.

a. Never attempt to pull large metallic objects from the magnetic field. The object may change its magnetic polarity and re-align itself on the magnet and become a projectile which could cause serious injury.
b. Depress the red Emergency Off button.
c. Depress the red Magnet Quench or Rundown button.
d. Turn on the magnet room exhaust fan if available.
e. Carefully prop open the magnet room door with a sandbag. Be aware that if there is excessive pressure in the room from helium, the door may open abruptly and forcefully. If the door cannot be opened, break the window to the magnet room (the MRI fire extinguisher could be used) to relieve the pressure within the magnet room.
f. Open nearby doors to promote air circulation.
g. Enter the magnet room and help the patient exit by staying low to the floor where there is more oxygen. If a gurney or wheelchair is needed, ensure it is non-ferrous, then exit the scan room immediately.
h. Evacuate all ancillary personnel from the area until the air is restored to normal.
i. Contact MRI manufacturer and the Medical Imaging Leader.
j. Emergency Services, Public Safety, and Maintenance personnel are restricted from Zone 4 until confirmation can be made that the static magnetic field is no longer present.

2.Uncontrolled Quench
The MRI system spontaneously quenches by venting off liquid helium.

a. Using the patient intercom system on the imaging console, instruct the patient to remain calm and to stay positioned on the table. Inform the patient you will assist them shortly.
b. Depress the red Emergency Off button.
c. Turn on the magnet room exhaust fan if available.
d. Carefully prop open the magnet room door. Be aware that if there is excessive pressure in the room from helium, the door may open abruptly and forcefully. If the door cannot be opened, break the window to the magnet room to relieve the pressure within the magnet room.

e. Open nearby doors to promote air circulation.

f. Enter the magnet room and help the patient exit by staying low to the floor where there is more oxygen. If a gurney or wheelchair is needed, ensure it is non-ferrous, then exit the scan room immediately.

g. Evacuate all ancillary personnel from the area until the air is restored to normal.

h. Contact MRI manufacturer and the Medical ImagingLeader, Director of Ancillary Services and\or Senior Leadership on-call.

i. Emergency Services, Public Safety, and Maintenance personnel are restricted from Zone 4 until confirmation can be made that the static magnetic field is no longer present.

C. Fire Emergencies

1. The MRI technologist should power off the MRI system by depressing the red Emergency Off button. This will cut electrical power to all components of the MRI system except the static magnetic field. This should only be done if there is an active fire in close vicinity threatening imminent danger of electrocution. DO NOT press the quench button.
2. Evacuate patients and staff.
3. Initiate the Code Red Emergency System
4. Close all doors to contain any fire or smoke.
5. If a fire occurs in Zone 4, the fire should be extinguished using an MRI safe water mist extinguisher located within the MRI suite.
6. If a fire occurs during operational hours, an MRI technologist will evaluate the situation and determine if the magnet needs to be quenched prior to the arrival of Emergency Services.

XII.SCAN ROOM SAFETY

A. The door to the magnet room (Zone 4) is to remain closed at all times.

B. Only MRI Level 2 staff and MRI manufacturer field engineers are to have keys and/or codes for accessing Zone 4.

C. Family members and visitors are prohibited from Zone 4 unless deemed necessary and screened by MR Level 2 staff. Anyone accompanying a patient in Zone 4 must be dressed in MRI safe clothing.

D. Any ancillary staff entering Zone 4 should be screened and all equipment and personal items removed.

E. If a ferrous object enters the room and is immovable from the magnet, MRI staff should contact MRI manufacturer before attempting to remove the object to ensure that extraction will not have an adverse affect on the MR scanner.

XIII.~~DCH MRI~~DCHC SAFETY COMMITTEE

The Safety and Security Committee has established these policies to provide oversight to the operation of the MRI suites. These policies and procedures can be modified at any time when new safety concerns arise.

Attachments

Administration of contrast to women who are breast feeding.pdf

Informed Consent for MRI during pregnancy 060029.pdf

MRI Patient Screening 069007.pdf

Approval Signatures

Step Description	Approver	Date
CAH	CAH: DCHC Critical Access Hospital Committee	Pending
Medical Director	Mitchell Erickson: DCHC Radiology Medical Director	06/2024
Senior Leader	Rod Day: Ancillary Services Director	06/2024
	Susan Haskell: Medical Imaging Services Manager	06/2024

Applicability

Davis County Hospital

Status **Pending** PolicyStat ID **16043924**

Davis County HOSPITAL & CLINICS

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Effective	Upon Approval
Last Revised	06/2024
Next Review	2 years after approval
Owner	Susan Haskell: Medical Imaging Services Manager
Policy Area	Medical Imaging Services
Applicability	Davis County Hospital

Obtaining Equipment Service

Policy Number: Rad.01.17.0

POLICY:

The staff of the Medical Imaging Services department ~~shall~~will utilize the following guidelines when equipment service, facility repair, or preventive maintenance is needed in the department.

PROCEDURE:

The nature of the event should be classified as:

1. Facility
2. Imaging Equipment

Once the classification is established, the staff ~~shall~~will follow the guidelines for that classification for each particular piece of equipment listed below. If it is not listed below, contact the Medical Imaging Services Manager. If the Medical Imaging Service Manager is not available, the staff member who found the problem may make a judgment call on the need of the equipment and follow the guidelines for the classification of the event.

Facility - Repair, install, remodel, replace fixture or equipment that is part of the building or equipment that does not produce images or imaging services and emit irradiation.

A. Determine if the situation calls for immediate action.
B. If immediate action is needed, insure that patient and staff safety are secure. Page Maintenance over the intercom system. Do not use the area or equipment until it is determined to be safe for use.

C. If the situation does not call for immediate action, call 4253, leave a message with detailed information on the problem, time and date called in and the name of the person calling it in with a call back number.

Imaging Equipment - Any equipment, permanent or mobile, that is specific to the operation of the Medical Imaging Services Department.

A. Determine if the problem poses any danger to patients or staff. Insure patient and staff safety are secure.May require the equipment be Locked out/Tagged out per Plant Operations Policy #PO10.10.00.

B. Do not use the equipment if it may cause danger or concerns for the safety of patients, staff or the facility.

C. Contact the service company that is responsible or contracted to repair, replace, or install the equipment that is in need of service. Describe the problem to the contact person.

D. Do not use the equipment until the service is complete or the service technician clears the equipment for use.

E. Issue a Purchase Order (PO#) for the service and give to the repair technician. A PO cannot be issued without prior approval from the Medical Imaging Services Manager and\or Director of Ancillary Services.

F. Obtain a service report from the repair technician.

Approval Signatures

Step Description	Approver	Date
CAH	CAH: DCHC Critical Access Hospital Committee	Pending
Medical Director	Mitchell Erickson: DCHC Radiology Medical Director	06/2024
Senior Leader	Rod Day: Ancillary Services Director	06/2024
	Susan Haskell: Medical Imaging Services Manager	06/2024

Applicability

Davis County Hospital

Status **Pending** PolicyStat ID **16091110**

Davis County HOSPITAL & CLINICS

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Effective	Upon Approval
Last Revised	06/2024
Next Review	2 years after approval
Owner	Susan Haskell: Medical Imaging Services Manager
Policy Area	Medical Imaging Services
Applicability	Davis County Hospital

PRN Radiology Technologist

Policy Number: Rad.01.19.02

POLICY:

PRN Radiologic ~~technologist~~Technologist work on an as needed basis only and are ~~by definition,~~ not routinely scheduled ~~to have weekly~~on the monthly department schedule. PRN staff may be called in to work ~~hours scheduled on the monthly~~as soon as the Medical Imaging ~~schedule, but are utilized as needed for Imaging staffing needs. PRN staff are called in to work as soon as the Medical Imaging~~ Manager sees the need. PRN staff are not to work in any capacity without prior approval from the Medical Imaging Services Manager, Director of Ancillary Services, and\or Senior Leadership.

PROCEDURE:

A PRN ~~radiologic technologist~~employee must work ~~a~~an in-house shift and/~~ or take~~or a call shift ~~within a 90 day~~once each quarter. The inability of the PRN staff member to work 3 requests in a 6 month period~~. Inability of the PRN staff member to work 3 requests in a 6 month period~~ will be considered, as a voluntary resignation.

PRN staff may be scheduled to work/rotate weekends and holidays, as needed.

PRN staff may volunteer or be assigned to hospital committee's.

PRN staff must attend all mandatory hospital meetings/functions.

~~PRN staff will be required to review monthly department meeting notes and sign-off on them.~~

PRN staff must meet all mandatory education, licensure and certification requirements in Radiology as a condition of continued employment.

PRN staff ~~is~~are responsible for ~~reviewing~~keeping current with various hospital and departmental information, updates, postings and in-services (ie..Reviewing Department meeting notes, Huddle Board updates and Process Change Alerts.)

PRN staff will have a yearly Employee Rounding Review.

Approval Signatures

Step Description	Approver	Date
CAH	CAH: DCHC Critical Access Hospital Committee	Pending
Medical Director	Mitchell Erickson: DCHC Radiology Medical Director	06/2024
Senior Leader	Rod Day: Ancillary Services Director	06/2024
	Susan Haskell: Medical Imaging Services Manager	06/2024

Applicability

Davis County Hospital

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Effective	Upon Approval
Last Revised	06/2024
Next Review	2 years after approval

Owner	Susan Haskell: Medical Imaging Services Manager
Policy Area	Medical Imaging Services
Applicability	Davis County Hospital

Ultrasound Guided Interventional Procedures

Policy Number: Rad.04.20.0

POLICY:

The Ultrasound Department will establish guidelines and procedures that meet or exceed the standards set by the American College of Radiology pertaining to Medical Imaging ~~services and specific~~Services specifically to Ultrasound.

PROCEDURE:

The interventional procedures that can be performed with sonographic guidance include, but are not necessarily limited to, cyst aspiration, fluid aspiration, presurgical needle localization, and fine-needle aspiration biopsy or core needle biopsy.
Prior to the performance of any ultrasound-guided percutaneous, procedure, the area of interest should be evaluated completely with ultrasound which meets the guidelines specific to that body part. Informed consent shall be obtained and signed.
Benefits, limitations, and risks of the procedure as well as alternative procedures should be discussed with the patient. Informed consent should be obtained and documented.
There should be conformity with standards of sterility or cleanliness in the preparation of the area, and the field in which the procedure is to be performed, and the probe housing and transducer face to minimize infection.
The transducer selected for the procedure should operate at the highest clinically appropriate frequency for the structure being examined, realizing that there is a trade-off between resolution and beam penetration. Continuous visualization of the needle path should be conducted when possible.
Documentation of appropriate needle positioning for sampling should be obtained when possible.

Interventional procedures should be documented on a retrievable image storage format.
Laboratory test are conducted according to the ordering ~~physicians~~providers request. Specimens are handed according to the institutions laboratory specifications.
All procedures will be documented and when lab is requested, and the pathology report is available in the ~~HIS.~~EHR

Approval Signatures

Step Description	Approver	Date
CAH	CAH: DCHC Critical Access Hospital Committee	Pending
Medical Director	Mitchell Erickson: DCHC Radiology Medical Director	06/2024
Senior Leader	Rod Day: Ancillary Services Director	06/2024
	Susan Haskell: Medical Imaging Services Manager	06/2024

Applicability

Davis County Hospital

Status **Pending** PolicyStat ID **16192115**

Davis County HOSPITAL & CLINICS

An Affiliate of MERCYONE

Origination	01/2013
Last Approved	N/A
Effective	Upon Approval
Last Revised	07/2024
Next Review	2 years after approval

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

Missing Person

~~**POLICY:**~~

~~When a person is identified as missing from Davis County Hospital, staff will initiate a plan for immediate intervention.~~

- ~~**ALL EXITS WILL BE COVERED TO STOP ALL INCOMING AND OUTGOING TRAFFIC**~~

~~PROCEDURE:~~

1. ~~In the event of a discovery or report of an abducted patient, the following departments will initiate these responsibilities:~~
   ~~**Affected unit:**~~
   1. ~~Recheck entire department to confirm patient is missing.~~
   2. ~~Dial *51; Announce "ATTENTION PLEASE, **Missing Person + Descriptor + Action Required** .~~
   3. ~~Immediately notify law enforcement and patient's physician.~~
   4. ~~Secure the medical record and print a face sheet for law enforcement.~~
   5. ~~In the case of an infant or child abduction, move parents of the child to another private room. Do not move their belongings. Leave the room untouched for processing by law enforcement personnel.~~
   6. ~~Reassure other patients and families in the unit.~~

   ~~**All available hospital staff:**~~
   1. ~~All available staff report to the nearest stairways and exits; attempt to cover all~~

hospital exits. Plant operations staff should cover the perimeter of the campus to observe people leaving and record license plate numbers.

2. Direct all ingress and egress traffic to the main lobby for disposition by law enforcement or administrator on call.
3. Staff is instructed to leave involved area(s) untouched as much as possible and protect the scene for evidence.
4. Staff is instructed to only release information to Administration or Law Enforcement. Patient confidentiality is imperative; staff **WILL NOT** release information to anyone other than administration or law enforcement.
5. All hospital staff will assist/cooperate with law enforcement personnel's investigation.

Switchboard:

1. Notify CEO or Administrator-on-call.
2. Notify minister if requested.

Laboratory:

1. Place any blood samples on hold.

CEO or Administrator on Call (Incident Command):

1. Notify parent(s) if not already aware of incident.
2. Establish communication with the Law Enforcement Liaison – all communication with Law Enforcement should remain with this Liaison.
3. Assist with egress and ingress traffic directives (develop criteria for who can leave or enter and documentation of disposition).
4. Activate the Health Alert Network (HAN) with a full description of the child and the suspected abductor, if known.
5. Collaborate with law enforcement officials to release information to local, state and national news media as appropriate to the case via the Davis County Hospital Public Information Officer.
6. Notify the Department of Inspections and Appeals (DIA) of the incident.
7. Collaborate with Law Enforcement to direct switchboard to announce **Missing Person– All Clear** three times when the incident is resolved.

Additional Resources:

1. National Center for Missing and Exploited Children 1-800-THE-LOST (1-800-843-5678) or www.missingkids.com can provide data and technical assistance in networking with involved agencies, facilitating media coverage, and supporting involved family and caregivers through the trauma of infant or child abduction.

2. ~~HAN (Iowa Hospital Alert Network) www.iowahealthalert.org.~~
3. ~~Division of Inspections and Appeals ph. (515) 281-7102~~

PURPOSE:

To ensure the safety of any missing person at Davis County Hospital and Clinics.

POLICY:

A. When a person is identified as missing from Davis County Hospital and Clinics, staff will initiate a plan for immediate intervention.

B. If such situation occurs, all staff will follow a standard procedure to locate the missing person.

PROCEDURE:

A. If a missing person is not readily seen, page overhead (*51) **Missing Person + Descriptor + Action Required**

1. Each department will begin searching their department for the missing person.
    a. Look in all closets, bathrooms, elevators, and stairwells.
    b. Open and check all exit doors.
    c. If a child is missing, stop any person leaving the facility/grounds with a child and request they not leave until an all clear has been paged.
    d. All available staff report to the nearest stairways and exits; attempt to cover all hospital exits.
    e. Plant operations staff should cover the perimeter of the campus to observe people leaving and record license plate numbers.
    f. Information Technology staff to monitor security cameras.
    g. Direct all ingress and egress traffic to the main lobby for disposition by law enforcement or administrator on call.
    h. Laboratory is to place blood samples on hold.

B. In the case of an infant or child abduction, move parents of the child to another private room. Do not move their belongings. Leave the room untouched for processing by law enforcement personnel.

C. If the missing person can be seen from the hospital or clinic and is within a reasonable distance of the hospital, a member of the staff can go after the missing person and ask them to return to the facility.

D. If the missing person cannot be found, notify the police department with a description of the person and the address they have given us.

E. Staff is instructed to only release information to Administration or Law Enforcement. Patient confidentiality is imperative; staff **WILL NOT** release information to anyone other than administration or law enforcement.

F. Notify the Provider that the missing person is missing.

G. Notify the administrator or designee of the incident.

H. Contact department manager promptly.

I. Documentation in the record must reflect the above mentioned procedures, as well as careful documentation of safety rounds, what the missing person was wearing, and what time the person went missing and/or was last seen. All information regarding a missing person is to be kept confidential.

J. Collaborate with Law Enforcement to direct switchboard to announce **Missing Person– All Clear** three times when the incident is resolved.

Approval Signatures

Step Description	Approver	Date
CAH	CAH: DCHC Critical Access Hospital Committee	Pending
	Amy Marlow: Quality Director	07/2024

Applicability

Davis County Hospital

Requests to Retire

Title	Policy Area	Needed Approver	Revised?
Cleaning Procedure for Hydrotherapy Tanks	PT/OT	CAH	Retire
Departmental Meetings	PT/OT	CAH	Retire
Inpatient Documentation Guidelines	PT/OT	CAH	Retire
Inpatient Hold Policy	PT/OT	CAH	Retire
Medical Based Fitness	PT/OT	CAH	Retire
Scheduled/Unscheduled Absences/Requests for Time off	PT/OT	CAH	Retire
Treatment Programs	PT/OT	CAH	Retire
Documentation of Patient Assessments	PT/OT	CAH	Retire

Status **Pending** PolicyStat ID **16073510**

Davis County HOSPITAL & CLINICS

An Affiliate of MERCYONE

Origination	04/2015
Last Approved	N/A
Effective	Upon Approval
Last Revised	04/2015
Next Review	2 years after approval
Owner	Karen Kincart: Rehab Manager
Policy Area	PT/OT
Applicability	Davis County Hospital

Cleaning Procedure for Hydrotherapy Tanks

Policy Number: PT 00.29.00

POLICY:

To thoroughly clean all whirlpools with proper cleaning supplies and proper protective clothing.

PROCEDURE:

Wear gloves when cleaning

Hubbard/ lowboy whirlpools:

1. If the lift chair was used, lower it into the tank for cleaning.
2. Agitate with turbine for 5 minutes.
3. Drain
4. Spray the lift chair, bottom, sidewalls of tank and turbine shafts with hospital approved one step germicidal detergent. Spray all areas very thoroughly!
5. Using a clean cloth, wipe down chair, tank, and turbine shafts, making sure to clean all crevices.
6. Rise with spray hose.
7. Repeat steps 5-7 with a clean cloth.

Cleaning Procedure for Hydrotherapy Tanks

1. Clean lift chair over tub. **Spray** all parts (top and bottom) of lift chair and mats with red hose. Let sit for 5 minutes. **Wipe** all surfaces of lift chair and mats with clean cloth. **Rinse** all

surfaces of lift chair and mats with blue hose. Repeat entire process – spray, wipe, rinse

2. Clean tub. S**pray** hospital approved one-step germicidal detergent into any openings and flush for 15 seconds. Spray hospital approved one-step germicidal detergent disinfectant on the remainder of the tub. Let set on tub 5 minutes and clean up room. (Laundry, dressings, debridement utensils, etc.)
3. With clean cloth, **wipe** entire tub. (Sides and bottom)
4. Using the blue hose, **rinse** the screen and jet openings for 15 seconds or until the soap has cleared. Then rinse the remaining tub.
5. Repeat cleaning process – spray, wipe, and rinse (#6, 7, 8).
6. Return tub to lowest position. Make sure the hydraulic lift lever is in neutral .

Approval Signatures

Step Description	Approver	Date
CAH	CAH: DCHC Critical Access Hospital Committee	Pending
Medical Director	Donald Wirtanen: ER Physician	06/2024
Senior Leader	Rod Day: Ancillary Services Director	06/2024
PT Manager	Jackie Wells: DPT	06/2024
PT Manager	Karen Kincart: Rehab Manager	06/2024

Applicability

Davis County Hospital

Status **Pending** PolicyStat ID **16073520**

Davis County HOSPITAL & CLINICS

An Affiliate of MERCYONE

Origination	10/2008
Last Approved	N/A
Effective	Upon Approval
Last Revised	10/2008
Next Review	2 years after approval
Owner	Karen Kincart: Rehab Manager
Policy Area	PT/OT
Applicability	Davis County Hospital

Inpatient Hold Policy

Policy Number: PT 00.15.00

POLICY:

OT, PT, & ST services will be put on hold following a transfer of a patient to a special care unit (e.g., intensive care unit, telemetry, surgical intensive care unit) or after a surgical procedure.

PROCEDURE:

1. When notified of a patient's transfer from a nursing floor to a special care unit, the therapist will check the patient's chart for a re-order for therapies.
2. If no new therapy order is present, the therapist will discuss the patient's change in status with the physician and/or nurse to determine whether therapy services are indicated. If indicated, the therapist will request new orders to cover the patient's change in status.
3. The therapist will not routinely check on the patient. The patient will not be seen again until a new order is written.
4. "Hold therapy" orders will be documented in the interdisciplinary progress notes.

Transfer from Swing for Rehabilitative Medicine to acute is considered a discharge and re-admit. Even though a new order for therapy is generated, the patient's medical status may warrant a "hold". The therapist needs to communicate with the physician and/or nurse if further clarification is warranted due to patient status.

Approval Signatures

Step Description	Approver	Date
CAH	CAH: DCHC Critical Access Hospital Committee	Pending
Medical Director	Donald Wirtanen: ER Physician	06/2024
Senior Leader	Rod Day: Ancillary Services Director	06/2024
PT Manager	Jackie Wells: DPT	06/2024
PT Manager	Karen Kincart: Rehab Manager	06/2024

Applicability

Davis County Hospital

Status **Pending** PolicyStat ID **16073497**

Davis County HOSPITAL & CLINICS

An Affiliate of MERCYONE

Origination	05/2011
Last Approved	N/A
Effective	Upon Approval
Last Revised	05/2011
Next Review	2 years after approval
Owner	Karen Kincart: Rehab Manager
Policy Area	PT/OT
Applicability	Davis County Hospital

Scheduled/Unscheduled Absences/Requests for Time off

Policy Number: PT 00.12.00

POLICY:

Allow employees scheduled time off/requests for time off and unexpected absences as needed.

PROCEDURE:

Scheduled versus Unscheduled Absences

Scheduled absences are absences that have been prearranged with the supervisor prior to the day of the absence (greater 30 hours prior to scheduled shift). Jury duty and compassionate leave will be considered scheduled absences. An unscheduled absence is when an employee is not at his/her workstation as scheduled or expected without making previous arrangements in accordance with the guidelines outlined in this department policy. Examples for unscheduled absence include 1) illness of the employee, 2) illness of the employee's immediate family member, 3) leave for emergency situations, whether paid or unpaid. A non-exempt employee will not receive an unscheduled absence if three fourths of the scheduled shift is completed.
explanation of this attendance policy.

Procedure for Calling in for an unscheduled absence

Weekdays: The staff member must call in by 6:30 A.M. prior to start of work shift to Physical Therapist.

Call in Policy for Early Clerical

In the event that the opening clerical staff needs to call in an unscheduled absence, the following procedure needs to be followed:

- If the absence is known the night before, call the Physical Therapist working the next day.
- If something happens during the night, call the Physical Therapist by 6:30 A.M. so arrangements can be made to have someone open the clinic.

PTO

Rehabilitation Services personnel will be granted time off on a first come, first served basis. To ensure a median between adequate patient coverage and requested time off, the minimum number of staff (for each job class) allowed fringe time on a given day has been determined by the clinical supervisor. Deviations from the minimum may occasionally be allowed, and will be considered on an individual basis.

LEAVING DURING A SCHEDULED SHIFT

If an individual must leave the work site during a scheduled shift (not a pre-arranged absence), their supervisor or management on-call must be contacted and verbal approval obtained prior to leaving. Failure to do so may result in review for disciplinary action.

1. **Full Time Therapists**
    a. Time off for weekend days worked is arranged in conjunction with the supervisor, and is scheduled for the week before/after the weekend worked. Speech therapists time off for weekend days worked is taken on Tuesday/Thursday, unless arranged in advance with the CC.
    b. An alternate therapist may have to work a portion of one or both days, or the entire weekend dependent on patient load and staffing. Upon the completion of the weekend, the therapist will contact their immediate supervisor & try to arrange time off for the weekend days worked.
    c. Home Health – Physical Therapists that are scheduled to as primary will be scheduled off Thursday of the preceding week and Tuesday of the following week unless other arrangements are made with the supervisor. The alternate therapists may have to work a portion of one or both days, or the entire weekend dependent on patient load and staffing. Time off is Thursday following the weekend worked unless other arrangements are made with the supervisor.
2. **Support Staff (Rehab Techs & Aides)**
    a. Once the weekend schedule has been completed it is the responsibility of the support staff member wishing to have a weekend day off to switch weekends or find another support staff member to work for them.
    b. A support staff employee can request a weekend day(s) on a PTO request & submit it to the scheduler prior to the completion of the weekend schedule. If the PTO request is granted & the support staff employee should then be scheduled for that weekend, it will be the responsibility of the management staff to find an available staff member to work.

Requests

For licensed and non-licensed staff who are regularly scheduled to work Monday through Friday:

1. Days off for working the weekend must be requested on PTO slips.
2. Requests are placed in the Calendar in Physical Therapy Office.
3. Employees may request a consistent day(s) to be off for working their regularly scheduled weekends (e.g. Wednesday before and Tuesday after). This would allow ease in scheduling, and the employee would not have to fill out a PTO slip for each weekend worked **unless** requesting a variation from their usual day(s) off.

Time Frames

1. Requests are submitted by the Wednesday two (2) full weeks prior to the weekend to be worked.
2. Time off requests will be considered by the end of Wednesday.

Exempt staff

- Full time employees in an exempt job class must work and take time off in full day increments.
- Alternate therapists may work a portion of one or both days, or all weekend. Upon completion of the weekend, the therapist will contact their immediate supervisor and try to arrange time off.
- Time off for the weekend is taken during the week before and/or the week after the weekend worked.
- Part-time exempt staff are not scheduled for additional days off when working a scheduled weekend.

Hourly staff

Must follow their work agreement when requesting time off for the weekend. A day off will be schedule for the week before and the week after the weekend worked.

Approval Signatures

Step Description	Approver	Date
CAH	CAH: DCHC Critical Access Hospital Committee	Pending
Medical Director	Donald Wirtanen: ER Physician	06/2024
Senior Leader	Rod Day: Ancillary Services Director	06/2024
PT Manager	Jackie Wells: DPT	06/2024
PT Manager	Karen Kincart: Rehab Manager	06/2024

Applicability

Davis County Hospital

Status **Pending** PolicyStat ID **16073503**

Davis County HOSPITAL & CLINICS

An Affiliate of MERCYONE

Origination	10/2008
Last Approved	N/A
Effective	Upon Approval
Last Revised	10/2008
Next Review	2 years after approval
Owner	Karen Kincart: Rehab Manager
Policy Area	PT/OT
Applicability	Davis County Hospital

Departmental Meetings

Policy Number: PT 00.11.00

POLICY:

To have Department meetings at least once a month to keep all lines of communication open and review all patients charts.

PROCEDURE:

Participation in department and clinic meetings is expected; certain meetings may be mandatory. If any employee cannot attend due to illness, scheduling conflict or vacation, the absence is to be approved by the employee's clinical coordinator. Unexcused absences greater than 50 percent will result in review for disciplinary action.

Employees are responsible for all information shared in meetings and documented in meeting minutes. It will be the employee's responsibility to read the minutes of the meeting and to become familiar with topics discussed through communication with the clinical coordinator and/or manager.

The management team will be responsible for overseeing and implementing the following meetings, as well as monitoring their effectiveness and the need for modification or addition. The regular meetings will be:

1. **Unit meetings**
   Held a minimum of every other week; these meetings are be attended by the staff involved in delivering patient care in the specific clinic. Agenda items will cover:
   - Mission and values integration

- General department/facility information pertaining to employees, including information discussed during management team meetings (designated as clinic agenda items)
- Performance improvement activities, including Six Sigma project status reports
- Guest relations information e.g. customer satisfaction survey result
- Department status report to include staffing, pertinent financial data, status of equipment requests
- Introductions of new employees, students and guests

2. **Department meetings**
   Held at least quarterly, day and time to be determined based on topic.
   - Educational programs or mandatory training identified by the management team as appropriate for the entire department
   - Team building/social functions

3. **In-service education meetings**
   Topics identified through various means, including educational needs survey; new equipment; new procedures or processes, requests from rehab or medical staff, etc.
   - These meetings shall include, but not be limited to, a combination of videotapes, lectures, meetings with sales representatives, and assigned readings. The employee's signature will signify completion of the program. Management team members, and/or designee, will schedule in-services, determine the effectiveness and appropriateness of all topics and training, and coordinate with the organization-wide education committee.
   - Employees attending continuing education courses on physical therapy time and/or paid for by DCH will present an in-service in the month following the course. Notice of all inservices will be posted on the monthly calendar and in the department newsletter. The employee is responsible for scheduling to ensure attendance by target audience.

4. **Department management team meetings**
   Held every other week; these meetings will be attended by the director, clinical supervisors and administrative secretary. Topics discussed will include:
   - Operations
   - Management development
   - Patient care
   - Performance improvement/Six Sigma
   - Policies and procedures
   - Marketing and promotion of departmental services
   - Department budget
   - Department staffing
   - New equipment assessment

- Space assessment and utilization
- Guest relations
- Continuing educatio

5. **Clerical Meetings**
   Held once a month or as needed; agenda items include but are not limited to:
   - Revisions to policies and procedures
   - Guest relations information
   - Process improvement
   - Audit results
   - Team building

Approval Signatures

Step Description	Approver	Date
CAH	CAH: DCHC Critical Access Hospital Committee	Pending
Medical Director	Donald Wirtanen: ER Physician	06/2024
Senior Leader	Rod Day: Ancillary Services Director	06/2024
PT Manager	Jackie Wells: DPT	06/2024
PT Manager	Karen Kincart: Rehab Manager	06/2024

Applicability

Davis County Hospital

Status **Active** PolicyStat ID **15643828**

Davis County HOSPITAL & CLINICS

An Affiliate of MERCYONE

Origination	05/2013
Last Approved	06/2024
Effective	06/2024
Last Revised	10/2021
Next Review	06/2025
Owner	Karen Kincart: Rehab Manager
Policy Area	PT/OT
Applicability	Davis County Hospital

Documentation of Patient Assessments

Policy Number: 00.35.00

POLICY:

Rehabilitative services will document all patient assessments, also known as initial evaluations, which will include Subjective, Objective, Assessment, and Plan.

PROCEDURE:

Initial Evaluation/Questionnaire:

Comprehensive evaluation, completed during initial therapy session. May include, but is not limited to:

Subjective/objective examination

- Patient history; chief complaint (CC) including date of onset (if gradual, date of physician visit);
- Review of social and family history and previous functional level;
- Complications/safety issues related to CC;
- Occupational history;
- Review of current functional/ADL/communication-cognitive limitations;
- Review of past history, previous testing and treatment results;
- Indicated vital signs and inspection of body;
- Deep tendon reflexes or special tests as indicated;
- Palpation of soft tissues and joints;
- Determination of the range of motion & strength of the involved joints;
- Specific or comprehensive physical, orthopedic, and neurological testing.

- Pain assessment
- Domestic violence screen
- Food allergies (swallowing evaluation)

Assessment

- Identifies the nature and severity of the problem(s); specific deficits to be treated
- Indicates prognosis for improvement: why it is important to treat now; functional limitations
- Determines candidacy for skilled treatment: skilled services to be provided
- Establishes goals (expected outcome):
    A. Related to a functional activity that can be measured
    B. Qualified (when will goal be reached)
    C. Related to patient (not caregiver or therapist)

Plan

- Specific treatment modalities and/or procedures to be provided
- Specific frequency and duration of treatment
    A. Based on the severity of the impairment and the patient's response to treatment
    B. Based on treatment week, not calendar week

Time Frame for completion:

Must be completed within four working days of initial session. If full evaluation or A & P dictated, indicate dictation on progress note sheet; give brief plan of treatment for next scheduled visit. A&P to include information as indicated on dictation format. (Attachment)

Treatment Attendance/Charge Record:

Indication of when the patient was treated & what was charged to the patient. If patient is seen by more than one discipline, then all disciplines will document on this form. Documentation will include:

- Year
- Date & Day of the week, starting with first day of treatment (follow Medicare week)
- Treatment frequency
- Treatment charges
- Functional status, balance and safety level of the patient shall be documented on the medical record.
    - Functional Status:
        - Complete all portions of the form, assessing the patient's level of functioning accordingly. Include any further descriptions of the patient's functional status that are indicated (i.e., wheelchair distance, time limit for sitting/standing) in the comment section. Also, comment on whatever limits the activity.

- **I = Independent** - Patient is able to perform the activity without verbal, physical or cognitive assist in all situations and environments, within a reasonable time frame. (Time frame is judged according to patient's age and condition.)
- **S = Supervised** - Patient is able to plan, organize, implement and direct management of activity without physical assist or prompting in routine situations. The patient may require physical or verbal prompting in a new environment or the patient may require occasional prompts for safety.
- **CG/SBA = Contact Guard/Stand By Assist** - Patient may require occasional physical assist or occasional verbal prompting to initiate, perform or complete the directed activity.
- **Min A = Minimal Assistance** - The person assisting the patient performs (up to) 25% of the activity; the patient requires light physical contact and the patient expends 75% or more of the effort; or, the patient needs continual verbal prompting to sequence/perform the activity.
- **Mod A = Moderate Assistance** - The person assisting the patient performs (up to) 50% of the activity, with the patient expending 50% or more of the effort.
- **Max A = Maximal Assistance** - The person assisting performs (up to) 75% of the activity, such that the patient only expends 25% of the effort. The patient attempts to assist with various phases of the activities, but needs continual assist throughout the activity.
- **Dep = Dependent** - The person assisting performs 100% of the activity; the activity is impractical for the patient to perform, or the patient needs total assist by one or more persons to perform the activity.

- Balance:
    - Assess balance in sitting and standing as applicable and note if patient is using upper extremity for support. Terms used should be: poor, fair, good. Grade balance as follows:
        - Static:
            - **Unable** - Activity impractical for patient to perform; may not be clinically feasible.
            - **Poor** - Patient needs continual assist to maintain balance and/or upright position.
            - **Fair** - Patient is able to maintain position independently without physical assist of therapist for three minutes.
            - **Good** - Patient is able to maintain position indefinitely without assist and with adequate posture.

- **Normal** - Patient is able to maintain position against resistive challenges. Correct posture is maintained.

- Dynamic:
  - **Unable** - Activity impractical for patient to perform; may not be clinically feasible.
  - **Poor** - Patient needs continual assist to maintain balance during weight shifting or change in center of gravity.
  - **Fair** - Patient is able to weight shift slightly away from center of gravity, but needs intermittent physical assist with larger weight shifting due to decreased balance reactions.
  - **Good** - Patient is able to weight shift during functional activities without loss of balance or the need for physical assist. Balance reactions are adequate during all situations. Verbal prompting may be necessary.
  - **Normal** - Patient able to perform high-level balance activities without assistance and with intact balance reactions.

- Safety:
  - Document the patient's level of safety according to the following key. If further qualification of the patient's status is needed, a narrative note should be added.
    - **Good** - The patient is safe to be alone in a home environment. No external cues are required for safety, including weight bearing status and surgical and joint precautions. This category includes safe use of equipment.
    - **Fair/Good** - The patient is safe to be alone in a home environment for a limited period of time. Generally, the patient knows precautions and equipment use, but may forget when fatigued, feeling ill or in a new and/or stressful environment.
    - **Fair** - The patient is not safe to be alone in a home environment. The patient has some knowledge of weight bearing status, equipment use and other precautions; however, patient needs frequent prompting for full safety. The patient can usually recognize precautions when they are presented, but cannot fully recall or apply these to functions.
    - **Poor/Fair** - The patient is not safe to be alone in a home environment. The patient has no knowledge of weight bearing, equipment use and other precautions. The patient needs constant external prompting for safety. Patient is beginning to recognize precautions when presented but cannot recall them. Application of precautions is only immediate.

- **Poor** - The patient is not safe to be alone in a home environment. Patient has no recognition or recall of precautions and requires external prompting at all times for safety.

Ref. #8012

https://www.apta.org/apta-and-you/leadership-and-governance/policies/documentation-authority-for-physical-therapist

Approval Signatures

Step Description	Approver	Date
Board of Trustees	BOT: DCHC Board of Trustees	06/2024
Medical Staff	Medical Staff: DCHC Medical Staff	06/2024
CAH	CAH: DCHC Critical Access Hospital Committee	06/2024
Medical Director	Donald Wirtanen: ER Physician	04/2024
Senior Leader	Rod Day: Ancillary Services Director	04/2024
PT Manager	Jackie Wells: DPT	04/2024
PT Manager	Karen Kincart: Rehab Manager	04/2024

Applicability

Davis County Hospital

Status **Pending** PolicyStat ID **16073500**

Davis County HOSPITAL & CLINICS

An Affiliate of MERCYONE

Origination	10/2008
Last Approved	N/A
Effective	Upon Approval
Last Revised	10/2008
Next Review	2 years after approval
Owner	Karen Kincart: Rehab Manager
Policy Area	PT/OT
Applicability	Davis County Hospital

Inpatient Documentation Guidelines

Policy Number: PT 00.14.00

POLICY

Documentation of therapy must be completed at time of service. Hand written notes are legible.

Abbreviations used only if defined on each page of medical record. Use of National Patient Safety prohibited abbreviations (QD, QOD, D/C, TIW, CC) is not allowed.

PROCEDURE:

Sections of Inpatient Charts and Rehab documentation

1. **Patient Education / Plan**
    - Signature Log
        a. Full name and professional abbreviation (clearly identifiable to a license).
        b. Co-signed when necessary (support staff and students).
        c. Intervening treatment by PT for PTA **after** 3 visits or 2 consecutive calendar days.
    - Education Flow Sheet
        a. Pts. are educated about any of the following : exercises, posture, body mechanics, adaptive equipment (crutches, walker, toilet riser etc.), compensatory strategies, work simplification, energy conservation, safe transfers, swallow precautions, pain management, community resources,
        b. Education regarding patient's discharge is documented– i.e. destination,

time frame, further therapy services recommended.

2. **Interdisciplinary Progress Notes**
    - Evaluation note
        a. Assessment (rehab diagnosis)
        b. Rehab potential (prognosis
        c. Plan for treatment is individualized and appropriate to patient's needs (what therapy interventions/modalities will be utilized to improve patient deficits)
        d. Services require a skilled therapist
        e. Specific frequency & duration - no ranges
        f. DC plan – indication that DC was addressed, i.e where the patient will be discharged (SAC, home with home care) or "unknown at this time"
    - Treatment note
        a. Documentation of pain level every treatment session
        b. Treatment given appropriate for patient's needs (i.e no progression)
        c. Treatment reflects the plan of care and current goals
        d. all notes dated (day-month-year) with time & initials
        e. Minutes per timed CPT code charged are listed
        f. Weekly, specific documentation of progress towards goals – Unacceptable= "goals progressing", "goals cont."., "goals appropriate"
3. **Interdisciplinary Treatment Notes**
    - Therapy Treatment Record
        a. If frequency is not met, are attempts/cancels documented
        b. follows the rule of 8's guideline – charges cannot exceed time frame.
    - Evaluation form(s):
        a. Complete current medical condition – short summary for why admission to hospital
        b. Social status – home environment (stairs, assistance at home…)
        c. Functional status – pre-admit function
        d. Objective physical data - (measurable data or observed behaviors)
        e. Re-evaluation if changes in patient's condition or every 28 days *** "N/A" if treatment is < 28 days.
        f. Pain assessment – completion of a pain scale or indication of why score not given (if no pain – this must be stated.)
    - Goal Form(s):
        a. Goals are measurable and functional.

b. Goals specific to the individual patient and their discharge needs.
c. Goals set with specific time frame ––no ranges (i.e.2-3 weeks) and no longer than 1 month
d. Goals revised when needed – i.e. time frame elapsed, change in patient status, or goal attainment. Goal sheets allow for 1 revision.

Approval Signatures

Step Description	Approver	Date
CAH	CAH: DCHC Critical Access Hospital Committee	Pending
Medical Director	Donald Wirtanen: ER Physician	06/2024
Senior Leader	Rod Day: Ancillary Services Director	06/2024
PT Manager	Jackie Wells: DPT	06/2024
PT Manager	Karen Kincart: Rehab Manager	06/2024

Applicability

Davis County Hospital

Status **Pending** PolicyStat ID **16073516**

Davis County HOSPITAL & CLINICS

An Affiliate of MERCYONE

Origination	04/2015
Last Approved	N/A
Effective	Upon Approval
Last Revised	04/2015
Next Review	2 years after approval

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

Medical Based Fitness

Policy Number: PT 00.52

POLICY:

To evaluate and provide continuing rehabilitation care for patients who have completed their physical therapy plan.

PROCEDURE:

Criteria

1. Patient does not require services by skilled therapist. i.e. range of motion, endurance, simple exercises (bed-rest) ambulation
2. Adjunct to increase activity.

Guidelines

1. Initial evaluation by primary therapist (determine appropriateness) to establish maintenance program.
2. Complete the Medical based fitness Plan– and place in the patient's chart.
3. Physical therapy aide completes treatment, documents in the medical based fitness chart. Physical therapy aide contacts the primary therapist with any questions/concerns (i.e. change of status) or if patient is unable to complete the medical based fitness plan.
4. Primary therapist follows up to review program, and adjust as needed.

In such situations the initial evaluation of the patient's needs, the designing by the qualified physical therapist of a maintenance program which is appropriate to the capacity and tolerance of the patient and

the treatment objectives of the physician, the instruction of the patient or supportive personnel, e.g., aides or nursing personnel (or family members where physical therapy is being furnished on an outpatient basis) in carrying out the program and such infrequent reevaluations as may be required would constitute physical therapy.

Approval Signatures

Step Description	Approver	Date
CAH	CAH: DCHC Critical Access Hospital Committee	Pending
Medical Director	Donald Wirtanen: ER Physician	06/2024
Senior Leader	Rod Day: Ancillary Services Director	06/2024
PT Manager	Jackie Wells: DPT	06/2024
PT Manager	Karen Kincart: Rehab Manager	06/2024

Applicability

Davis County Hospital

Status **Pending** PolicyStat ID **16073512**

Davis County HOSPITAL & CLINICS

An Affiliate of MERCYONE

Origination	05/2013
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Effective	Upon Approval
Last Revised	04/2015
Next Review	2 years after approval
Owner	Karen Kincart: Rehab Manager
Policy Area	PT/OT
Applicability	Davis County Hospital

Treatment Programs

Policy Number: PT 00.39.00

POLICY:

- Treatment programs are offered in the service of rehabilitation medicine in acute stage and subsequent stages of illness to minimize or prevent dysfunction for the following types of patients:
    - Fractured hip
    - Cerebral Vascular Accident (CVA)
    - Hip replacement
    - Knee replacement
    - Head injury
    - Arthritis
    - Amputee
    - Spinal cord injury
    - Back fracture
    - Spinal fusion
    - Peripheral nerve injury
    - Upper extremity fracture
    - Chronic obstructive lung disease
- Fractured Hip:
    - Post-fracture characteristics will include prior history of self-care, pain and impaired

range of motion at the hip which limits independence in lower extremity self-care and increases the patient's risk for falls.

- Treatment will include education in safety precautions, strengthening of hip and lower extremity musculature, self-care adaptive equipment and promotion of independence in self-care and ADLs to facilitate return to previous level of independence.

- Cerebral Vascular Accident (CVA):
  - Patients who are favorable candidates for (occupational) rehabilitation therapy following CVA exhibit characteristics, such as decreased range of motion, decreased muscle strength, spasticity or sensation deficits, decreased independence in ADL, decreased or impaired functional mobility, or decreased functional use of involved extremity. Patients with impaired sensorimotor function, body image or cognition are eligible.
  - The treatment program will be oriented toward facilitation of increased independence and function. Individual therapy will be oriented toward the specific limiting factors of each patient. Education of family will be included to help facilitate rehabilitation.

- Hip or Knee Replacement:
  - Patients with history of independence in self-care and post-op characteristics including lower extremity pain or weakness, impaired gait, decreased range of motion resulting in decreased self-care and/or ADL independence and who have motivation toward rehabilitation and return to independent living.
  - Treatment will include safety precautions, instruction in use of adaptive equipment; the program will be oriented toward improved functional mobility, and independent self-care and ADL for return to independent living.

- Head Injury:
  - Post injury features will include prior medical history conducive toward rehabilitation, physical deficits such as spasticity, decreased range of motion, loss of motor control, memory loss, attention span deficits, disorientation and sensorimotor deficits.
  - Treatment program will be oriented toward facilitation of patient's maximum functional potential, emphasizing specific limiting factors of the patient. Education of the family shall also be included.

- Arthritis:
  - Patients should have a prior history of independent self-care which has decreased due to diagnosis.
  - Treatment shall include use of adaptive equipment, strengthening exercises and compensatory techniques with emphasis on patient's capabilities rather than deformity of disability.

- Amputee:
  - Patients with history of independent self-care prior to upper extremity amputation

with or without prosthesis; lower extremity amputation with prosthesis.

- Treatment includes instruction in application and removal of prosthesis, instruction regarding maintenance of residual limb, instruction in operation of terminal device of upper extremity prosthesis or one-handed techniques if prosthesis is not indicated. Emphasis will be on independent ADL for return to previous lifestyle.

- Spinal Cord Injury:
  - For patients with physical deficits, including decreased range of motion and motor control, contractures and impaired sensation, functional ability and self-care.
  - Individual treatment programs will be aimed at minimizing deformity and maximizing functional potential in order to attain the highest level of self-care possible.

- Back Fracture:
  - Patients with history of independent self-care prior to decreased independence due to back pain or limitations on range of motion.
  - General treatment shall include instruction in safety precautions, body mechanics and use of adaptive equipment as indicated. Emphasis placed on independent functions.

- Spinal Fusion:
  - Patients with a history of independent self-care prior to decreased independence due to back surgery.
  - General treatment shall include instruction in spinal precautions, body mechanics and use of adaptive equipment as indicated. Emphasis placed on independent functions.

- Peripheral Nerve Injury:
  - Patients with characteristics of weakness or paralysis and sensory loss that prevents independent functions.
  - Treatment approach includes prevention of joint injury, instruction in techniques to compensate for disability and facilitation of return of motor function.

- Upper Extremity Fracture:
  - Patients should have multiple fractures that prevent independent self-care or decreased strength and functional potential.
  - Treatment approach shall emphasize return to independent self-care and ADLs.

- Chronic Obstructive Lung Disease:
  - For patients with impaired independence in self-care and ADLs due to decreased pulmonary function.

Treatment approach includes emphasis on residual abilities, not on disabilities, and instruction in energy conservation and breathing control during activity

Ref. #8114

Approval Signatures

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Applicability

Davis County Hospital

Revised Policies

Title	Policy Area	Summary of Changes
Provision of Service	Administration	Removed urology service line. Revised review schedule to every six months.
SOP - Radio and Cell Phone Ambulance Communications	EMS	change OPS to Dig OPS
Medical Imaging Services On-Call Policy	Medical Imaging Services	deleted contacting the operator
Mobile Imaging Radioactive Material Safe Handling/Contamination	Medical Imaging Services	attached policy
Pregnant Medical Imaging Workers	Medical Imaging Services	updated employee file to reflect Employee Health File
Ultrasound Definity Standing Orders	Medical Imaging Services	changed physician to provider
Medicare Outpatient Observation Notice (MOON)	Med-Surg	Removed handwritten portion and added via IPAD. Included in person to number 6
Collections	Patient Financial Services	Updating from service use to Apex and Cerner system. Updating days from 30 to 28 day statement cycle due to Cerner system.
Incident Command System Activation	Safety and Security	Updated incident command positions to match our NIMSCAST updates.
Utilization Review and Management Plan	Utilization Review	Changed from monthly meetings to quarterly

Unchanged Annual Reviews

Title	Policy Area	Needed Approver
Medical Provider Coverage of Emergency Department	Emergency Department	CAH
Infectious Waste	Medical Imaging Services	CAH
Mammography Consumer Complaint Mechanism	Medical Imaging Services	CAH
Mammography Federal, State & Local Laws & Regulations	Medical Imaging Services	CAH
Mammography Infection Control	Medical Imaging Services	CAH
Mammography Orientation Program	Medical Imaging Services	CAH
Mammography Personnel Licensure and/or Registration	Medical Imaging Services	CAH
Mammography Quality Assurance/Quality Control Testing Guidelines	Medical Imaging Services	CAH
Medical Imaging Week-End Technologist Staffing	Medical Imaging Services	CAH
Occupational Radiation Exposure and Records	Medical Imaging Services	CAH
Patient's Right to Refuse Medical Imaging Procedure	Medical Imaging Services	CAH
Retention of Radiographs and Reports	Medical Imaging Services	CAH
Ultrasound Scheduling Procedures	Medical Imaging Services	CAH
Administration of Medication	Nursing Policies	CAH
Departmental Record Retention Standard	Patient Financial Services	CAH
Discount for Uninsured (Self Pay) Patients With Ability to Pay	Patient Financial Services	CAH
Financial Assistance Program	Patient Financial Services	CAH
Financial Inducement/Waiver of Co-payments or Deductibles	Patient Financial Services	CAH
PATIENT ACCESS PRN	Patient Financial Services	CAH
Prompt Pay Discount for Insured Patients	Patient Financial Services	CAH
Record Retention	Patient Financial Services	CAH
Risk Management Plan	Risk Management	CAH