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

New Policies (attached in packet)

- Critical Access Hospital Committee
- Automatic Therapeutic Substitution of Pneumococcal Vaccine When Orders for Prevnar-13
  Auto-Generate Within the HER
- Lidocaine for Use with Intramuscular Ceftriaxone
- Outpatient Hospital Psychiatric Services Program Content
- Outpatient Hospital Psychiatric Services Requirements for the Telepsychiatry Process
- Outpatient Hospital Psychiatric Services Scope of Service
- Outpatient Hospital Psychiatric Services SharePoint Provider Folders
- IINSIGHT Application

Policy Statement Changes (attached in packet)

- CareLearning Assignments for New and Existing Employees
- Competency Assessment Process
- Compounding Sterile Preparations in the Pharmacy

Revised Procedures (changes specified in packet)

- Administration
- Education
- Human Resources
- Infection Prevention
- Medical Staff
- Pharmacy
- Safety and Security
- Utilization Review
- Sleep Lab

Unchanged Policy Reviews (list in packet)

- Education
- Marketing
- Medical Staff
- Senior Life Solutions
- Sleep Lab

New Policies

Title	Policy Area	Revised?
Critical Access Hospital Committee	Administration	New
Automatic Therapeutic Substitution of Pneumococcal Vaccine When Orders for Prevnar-13 (pneumococcal 13-valent conjugate vaccine) Auto-Generate Within the EHR	Pharmacy	New
Lidocaine for Use with Intramuscular Ceftriaxone	Pharmacy	New
Outpatient Hospital Psychiatric Services Program Content	Senior Life Solutions DCHC	New
Outpatient Hospital Psychiatric Services Requirements for the Telepsychiatry Process	Senior Life Solutions DCHC	New
Outpatient Hospital Psychiatric Services Scope of Service	Senior Life Solutions DCHC	New
Outpatient Hospital Psychiatric Services Sharepoint Provider Folders	Senior Life Solutions DCHC	New
INSIGHT Applications	Senior Life Solutions DCHC	New

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Davis County HOSPITAL & CLINICS

An Affiliate of MERCYONE

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

Critical Access Hospital Committee

POLICY:

The Critical Access Hospital Committee (CAH) shall be responsible for the review of clinical policies at a minimum of every two years, offering input deemed thoughtful and prudent. At minimum, two mid-level providers will serve on the committee.

PROCEDURE:

A. In addition to the required mid-level providers, the person responsible for coordination of policies or designee will also serve as a member.

B. Mid-level provider input on clinical policies shall be obtained via email and records shall be kept serving as minutes of the CAH committee.

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

D. The CAH shall be accountable to the DCHC Board of Trustees.

Approval Signatures

Step Description	Approver	Date

CAH	CAH: DCHC Critical Access Hospital Committee	Pending
CEO	Veronica Fuhs: CEO - DCHC	12/2023
	Amy Marlow: Quality Director	12/2023

Applicability

Davis County Hospital

Status **Pending** PolicyStat ID **14687499**

Davis County HOSPITAL & CLINICS

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Owner	Wendy Barker: Pharmacy Manager
Policy Area	Pharmacy
Applicability	Davis County Hospital

Automatic Therapeutic Substitution of Pneumococcal Vaccine When Orders for Prevnar-13 (pneumococcal 13-valent conjugate vaccine) Auto-Generate Within the EHR

POLICY:

Davis County Hospital Pharmacy will no longer stock Prevnar-13 (pneumococcal 13-valent conjugate vaccine) for use with the facility. Unfortunately, however, our EHR does still sometimes auto-generate orders for Prevnar-13 for certain hospitalized patients based on their pneumococcal vaccination assessment completed upon admission. When orders auto-generate for Prevnar-13, automatic therapeutic substitution of the appropriate alternative pneumococcal vaccine may be carried out by pharmacy/nursing according to the procedure below and attached algorithm.

PROCEDURE:

1. Vaccine conversions shall be automatic and shall not require prescriber authorization prior to application to the MAR provided that the patient's vaccination record in IRIS is reviewed and conversions are made according to the attached algorithm.
2. The pharmacist or nurse who discovers an order for Prevnar-13 shall review the patient's IRIS vaccination record and shall use the attached algorithm to determine the appropriate alternative pneumococcal vaccine to be administered. They shall perform the conversion within the EHR by canceling the order for Prevnar-13 and entering a new order for the appropriate alternative vaccine with a frequency of 'On Call' to allow for administration of the indicated vaccine at a time that is most appropriate/convenient for the patient and staff. However, every effort shall be made to ensure that 'On Call' vaccine orders are administered prior to patient dismissal.

3. If an appropriate alternative vaccine is unable to be determined from the algorithm or confusion arises, the attending provider shall be consulted.
4. It is possible that, given a patient's pneumococcal vaccine history, no further vaccination is recommended. In this case, an auto-generated order for Prevnar-13 should be documented as 'Not Given' on the MAR with a comment to indicate that the patient's IRIS record was reviewed and the patient is up-to-date with their pneumococcal vaccination.

Attachments

Pneumococcal Vaccine Algorithm 020323.pdf

Approval Signatures

Step Description	Approver	Date
CAH	CAH: DCHC Critical Access Hospital Committee	Pending
Medical Director	Sarah Brewer: Internal Medicine, DO	02/2024
Senior Leader	Nikki Thordarson: CNO	11/2023
	Wendy Barker: Pharmacy Manager	11/2023

Applicability

Davis County Hospital

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Davis County HOSPITAL & CLINICS
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Owner	Wendy Barker: Pharmacy Manager
Policy Area	Pharmacy
Applicability	Davis County Hospital

Lidocaine for Use with Intramuscular Ceftriaxone

POLICY:

Lidocaine 1% (without epinephrine) may be utilized as the diluent whenever Ceftriaxone is ordered for intramuscular administration (provided that the patient has no allergy or otherwise contraindication to the use of lidocaine).

BACKGROUND:

Intramuscular administration of Ceftriaxone can cause significant pain at the injection site. A study published in Antimicrobial Agents and Chemotherapy showed that doses prepared by using 1% Lidocaine as the diluent were bioequivalent to those prepared with sterile water and no difference in stability was found either. As an advantage, doses prepared with 1% Lidocaine reduced the amount of pain at the injection site by approximately 75%. (Antimicrob Agents Chemother. 1996 February; 40(2):485-487.)

A similar study published in the Archives of Pediatrics and Adolescent Medicine illustrated the safety and efficacy of Lidocaine as a diluent for Ceftriaxone for intramuscular administration in children as well. (Arch Pediatr Adolesc Med. 1994; 148:72-75.)

Furthermore, the prescribing information for Ceftriaxone does list 1% Lidocaine solution (without epinephrine) as an acceptable diluent. (Ceftriaxone for Injection, USP [packag insert]. Apotex Corp., Weston, FL. Rev 02/22.)

PROCEDURE:

1. Lidocaine 1% (without epinephrine) may be utilized as the diluent whenever Ceftriaxone is ordered for intramuscular administration (provided that the patient has no allergy or otherwise contraindication to the use of lidocaine). Consultation with the prescriber who originally ordered intramuscular administration of Ceftriaxone is not required unless questions arise that are not specifically addressed by this policy.

2. If not already specifically indicated on the order, pharmacy or nursing may add an electronic order for the 1% Lidocaine within the EHR citing per 'Protocol' as the communication type to allow for flow of the order to the MAR, retrieval of the Lidocaine from the automated dispensing machine, and proper identification of the Lidocaine via barcode scan, if necessary.

3. The appropriate volume of 1% Lidocaine to be utilized as diluent shall be determined from the chart and 'cheat sheet' below which are adapted from the prescribing information for Ceftriaxone. Depending on the desired dose, it is sometimes best to utilize either the smaller or larger diluent volume so as to result in a specific concentration that allows for achievement of the exact dose in a certain volume (without the need for estimation or rounding). (Ceftriaxone for Injection, USP [package insert]. Apotex Corp., Weston, FL. Rev 02/22.)

VIAL DOSAGE SIZE AND RESULTANT CONCENTRATION CHART:

Ceftriaxone Vial Dosage Size	Amount of 1% Lidocaine to be Added to Achieve a Concentration of 250 mg/mL	Amount of 1% Lidocaine to be Added to Achieve a Concentration of 350 mg/mL
500 mg	1.8 mL	1.0 mL
1 gram	3.6 mL	2.1 mL

2 gram	7.2 mL	4.2 mL

'CHEAT SHEET' FOR SPECIFIC DOSES OF INTRAMUSCULAR CEFTRIAXONE:

- For a 250mg IM Dose of Ceftriaxone
  - Use one 500mg Ceftriaxone vial
  - Reconstitute with 1.8mL Lidocaine 1%
  - Withdraw 1mL
- For a 500mg IM Dose of Ceftriaxone
  - Use one 500mg Ceftriaxone vial
  - Reconstitute with 1mL Lidocaine 1%
  - Withdraw entire contents of the vial
- For a 750mg IM Dose of Ceftriaxone
  - Use one 1 gram Ceftriaxone vial
  - Reconstitute with 3.6mL Lidocaine 1%
  - Withdraw 3mL
- For a 1000mg IM Dose of Ceftriaxone
  - Use one 1 gram Ceftriaxone vial
  - Reconstitute with 2.1mL Lidocaine 1%
  - Withdraw entire contents of the vial

Approval Signatures

Step Description	Approver	Date
CAH	CAH: DCHC Critical Access Hospital Committee	Pending
Medical Director	Sarah Brewer: Internal Medicine, DO	02/2024
Senior Leader	Nikki Thordarson: CNO	11/2023
	Wendy Barker: Pharmacy Manager	11/2023

Applicability

Davis County Hospital

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Davis County HOSPITAL & CLINICS

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Owner	Rhonda Roberts: SLS Program Director
Policy Area	Senior Life Solutions DCHC
Applicability	Davis County Hospital

Outpatient Hospital Psychiatric Services Program Content

POLICY:

Outpatient Hospital Psychiatric Services are tailored for each patient, the goal being to reflect and replicate life in the greater community, emphasizing therapeutic interaction with staff and peers as a means of accompanying change.

PROCEDURE:

Section I. Psychiatric Diagnostic Evaluation

Two CPT codes (90791 and 90792) differentiate between diagnostic services done without medical services (90791) and with medical services (90792). The following information pertains to both (1) CPT code 90791, psychiatric diagnostic evaluation (often referred to as the psychosocial assessment); and (2) CPT code 90792, psychiatric diagnostic evaluation with medical services;

A. Cannot be reported with an E/M code on the same day by the same provider
B. Cannot be reported with a psychotherapy service code on the same day
C. May only be reported once per day
D. May be reported more than once for a patient when separate evaluations are conducted with the patient and other informants (i.e., family members, guardians, significant others) on different days. *However, if 90791 or 90792 are reported more than once per episode of illness, documentation will be required for the establishment of medical necessity.
E. In certain circumstances family members, guardians, or significant others may be seen in lieu of the patient.

90791: A psychiatric diagnostic evaluation (90791) is an integrated assessment that includes history, mental status and recommendations. It may include communicating with the family and ordering further diagnostic studies. Use add-on code 90785 in conjunction with 90791 when the diagnostic evaluation includes interactive complexity services.

90792: A psychiatric diagnostic evaluation with medical services (90792) includes 90791 and a medical assessment. It may require a physical exam, communication with the family, prescription medications and ordering laboratory or other diagnostic studies. Use add-on code 90785 in conjunction with 90792 when the diagnostic evaluation includes Interactive Complexity services

Section II. Psychotherapy Psychiatric Therapeutic Procedures (90832, 90834, 90837-90838, 90845-90853, 90865:

Information in this part of the policy has been subdivided into three (3) sections. These sections address the following CPT/HCPCS procedure codes:

1. Codes 90832, 90834, 90837 represent insight oriented, behavior modifying, supportive, and/or interactive psychotherapy
2. Codes 90846, 90847, 90853 represent family psychotherapy and/or group psychotherapy

Codes 90832, 90834 and 90837 represent insight-oriented, behavior modifying and/or, supportive psychotherapy without medical services provided by licensed mental health professionals.

- Description: Procedures 90832-90837 (psychotherapy) are defined as "the treatment for mental illness and behavioral disturbances in which the physician or other qualified health care professional through definitive therapeutic communication attempts to alleviate the emotional disturbances, reverse or change maladaptive patterns of behavior and encourage personality growth and development." (CPT 2013, *Professional Edition,* p.485)
- Documentation: The medical record must indicate the time spent in the psychotherapy encounter and the therapeutic maneuvers, such as behavior modification, supportive or interpretive interactions that were applied to produce a therapeutic change. Behavior modification is not a separate service but is an adjunctive measure in psychotherapy. Additionally, a periodic summary of goals, progress toward goals, and an updated treatment plan must be included in the medical record. Prolonged periods of psychotherapy must be well-supported in the medical record describing the necessity for ongoing treatment.

Procedure codes 90832-90838 (psychotherapy for 30 to 60 minutes) – report the code closest to the actual time (i.e., 16-37 minutes for 90832, 38-52 minutes for 90834, and 53 or more minutes for 90837. Procedure codes 90833, 90836 and 90838 are add on codes that should be used only in conjunction with evaluation and management (E/M) codes 99201-99239, 99304-99337, 99341-99350).

- Comments: While a variety of psychotherapeutic techniques are recognized for coverage under these codes, the services must be performed by persons authorized by their state to render psychotherapy services. Healthcare providers would include: physicians, clinical psychologists, registered nurses with special training (as described in the "Indications" section), and clinical social workers. Medicare coverage of psychotherapy procedure codes does not include teaching grooming skills, monitoring activities of daily living (ADL), recreational therapy

(dance, art, play) or social interaction. Therefore, procedure codes 90832-90838 should not be used to bill for ADL training and/or teaching social interaction skills.

- Psychotherapy that include an evaluation and management component (90833, 90836, 90838 are payable only to physicians, NPs, CNSs and PAs. The evaluation and management component of the services must be documented in the record. A psychotherapy code should not be billed when the service is not primarily a psychotherapy service, that is, when the service could be more accurately described by an evaluation and management or other code.
- The duration of a course of psychotherapy must be individualized for each patient. Prolonged treatment may be subject to medical necessity review. The provider must document the medical necessity for prolonged treatment.

Codes 90846-90853 represent family psychotherapy, with or without the patient present, and group psychotherapy

Codes 90846, 90847, 90849:

- Description: Procedure codes 90846, 90847, 90849 describe the treatment of the family unit when maladaptive behaviors of family members are exacerbating the beneficiary's mental illness or interfering with the treatment, or to assist the family in addressing the maladaptive behaviors of the patient and to improve treatment compliance. Code 90846 is used when the patient is not present. Code 90847 is used when the patient is present. Code 90849 is intended for group therapy sessions to support multiple families when similar dynamics are occurring due to common issues confronted in the family members under treatment.
- Documentation: The medical record must document the conditions described under the "Description" and "Comments" sections relative to codes 90846, 90847, and 90849.
- Comments: *The Medicare National Coverage Determinations (NCD) Manual,* Chapter 1, Section 70.1, states that family psychotherapy services are covered only where the primary purpose of such psychotherapy is the treatment of the patient's condition. Examples include:
    - When there is a need to observe and correct, through psychotherapeutic techniques, the patient's interaction with family members (90847).
    - Where there is a need to assess the conflicts or impediments within the family, and assist, through psychotherapy, the family members in the management of the patient (90846 or 90847).
- The term "family" may apply to traditional family members, live-in companions, or significant others involved in the care of the patient. Codes 90846 and 90847 are not timed but are typically 45 to 60 minutes in duration.

Codes 90846 and 90847 do not pertain to consultation and interaction with paid staff members at an institution. Facility staff members are not considered "significant others" for the purposes of this service.

Code 90849 represents multiple-family group psychotherapy and is generally non-covered by Medicare. Such group therapy is usually directed to the effects of the patient's condition on the family and its purpose is to support the affected family members. Therefore, code 90849 does not meet Medicare's standards of being a therapy primarily directed toward treating the beneficiary's condition.

Code 90853:

- Description: Code 90853 represents psychotherapy administered in a group setting, involving no more than 10 participants (some states permit a maximum of 12 patients in a group), facilitated by a trained therapist simultaneously providing therapy to these multiple patients. The group therapy session typically lasts 45 to 60 minutes. Personal and group dynamics are discussed and explored in a therapeutic setting allowing emotional catharsis, instruction, insight, and support.

Code G0410:

- Description: Code G0410 represents psychotherapy administered in a IOP group setting, involving no more than 10 participants (some states permit a maximum of 12 patients in a group), facilitated by a trained therapist simultaneously providing therapy to these multiple patients. The group therapy session typically lasts 45 to 50 minutes. Personal and group dynamics are discussed and explored in a therapeutic setting allowing emotional catharsis, instruction, insight, and support.

Code G0176:

- Description: Code G0176 represents activity therapies administered in a IOP group setting, involving no more than 10 participants (some states permit a maximum of 12 patients in a group), facilitated by a competent clinical team member simultaneously providing activity therapy, such as music, dance, art or play therapies not for recreation, related to the care and treatment of patient's disabling mental health problems, to multiple patients. The group therapy session typically lasts a minimum of 45 minutes. Personal and group dynamics are discussed and explored in a therapeutic setting.

Code G0177:

- Description: Code G0177 represents training and educational services administered in a IOP group setting, involving no more than 10 participants (some states permit a maximum of 12 patients in a group), facilitated by a competent clinical team member simultaneously providing training and educational services related to the care and treatment of patient's disabling mental health problems, to multiple patients. The group therapy session lasts a minimum of 45 minutes. Personal and group dynamics are discussed and explored in a therapeutic setting.

Code C7900:

- Description: Code C7900 is used for the diagnosis, evaluation, or treatment of a mental health or substance use disorder, 15-29 minutes, provided remotely by hospital staff who are licensed to provide mental health services under applicable state law(s), when the patient is in their home, and there is no associated professional service.

Code C7901:

- Description: Code C7901 is used for the diagnosis, evaluation, or treatment of a mental health or substance use disorder, 30-60 minutes, provided remotely by hospital staff who are licensed to provide mental health services under applicable state law(s), when the patient is in their home, and there is no associated professional service.

Code C7902:

- Description: Code C7902 is used for the diagnosis, evaluation, or treatment of a mental health or substance use disorder, each additional 15 minutes, provided remotely by hospital staff who are licensed to provide mental health services under applicable state law(s), when the patient is in their home, and there is no associated professional service.

Code C7903:

- Description: Code C7903 is used for group therapy provided remotely by hospital staff who are licensed to provide mental health services under applicable state law(s), when the patient is in their home, and there is no associated professional service.

Documentation: The record must indicate that the guidelines under the "Description" and "Comments" sections were followed.

Comments: Group therapy (codes 90853 and G0410), must be led by a person who is licensed or otherwise authorized by the state in which he or she practices performing this service since it involves psychotherapy. This will usually mean a psychiatrist, psychologist, clinical social worker, clinical nurse specialist, or other person authorized by the state to perform this service. Registered nurses with special training, as described in the "Indications and Limitations of Coverage and/or Medical Necessity" section, may also be considered eligible for coverage. For Medicare coverage, group therapy does not include: socialization, music therapy, recreational activities, art classes, excursions, sensory stimulation or eating together, cognitive stimulation, or motion therapy, etc.

As a reminder, code 90785 is used when the patient or patients in the group setting do not have the ability to interact by ordinary verbal communication and therefore, non-verbal communication skills are employed or an interpreter may be necessary.

Approval Signatures

Step Description	Approver	Date
CAH	CAH: DCHC Critical Access Hospital Committee	Pending
CAH	Rhonda Roberts: SLS Program Director	01/2024
Medical Director- Nina Jordania, MD	Carleena Brown: Clinic Director	11/2023
Senior Leader	Carleena Brown: Clinic Director	11/2023

Applicability

Davis County Hospital

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Policy Area	Senior Life Solutions DCHC
Applicability	Davis County Hospital

Outpatient Hospital Psychiatric Services Requirements for the Telepsychiatry Process

POLICY:

All staff members follow effective patient practice and documentation standards for physician services.

PURPOSE:

To ensure that all Telepsychiatry/Telehealth/Telemedicine sessions are conducted within practice and documentation guidelines for effective care.

PROCEDURE:

A. Staff allowed to facilitate telepsychiatry/telemedicine sessions
   1. Qualified Mental Health Professionals
   2. Registered Nurse or Licensed Practical Nurse
   3. Other staff adequately trained and approved by the Program Director

B. Requirements of staff for Telepsychiatry session
   1. Telepsychiatry sessions are scheduled by program director and psychiatrist. Program director will give psychiatrist advanced notice (at least 3 days) and a list of patients to be seen during the scheduled Telepsychiatry session.
   2. The Program Director will send 1 day prior the last progress note for each patient scheduled for the scheduled telepsychiatry session. The progress note must be sent either by HIPAA-compliant encrypted e-mail or by standard fax-to-fax

transmission. Use of unencrypted e-mail or e-fax by either party is not HIPAA-compliant.

3. The nurse at the program will review patient chart/information with the Psychiatrist prior to the psychiatrist seeing the patient (updating additional patient information since the last psychiatric session; five minutes prior to the patient entering the session).
4. Psychiatrist will see patient alone or with accompanying family member, as patient prefers. When a new patient is scheduled, the nurse will spend more time providing additional information (admission assessment, nursing assessment, psychosocial assessment). The session time will vary per patient need.
5. Once the patient session has ended and the patient has left the session room, the psychiatrist will collaborate with the nurse to complete all required paperwork for that patient before the next patient session begins. No patient will be seen by the psychiatrist until the paperwork from the previous session is completed. The nurse will confirm the session note is completed before presenting the next patient.
6. Nurse will complete each of these steps for each additional patient.
7. Once all the patients are seen, the psychiatrist will then fax/or scan all paperwork to the program nurse immediately following the Telepsychiatry sessions (or collaborate with the Telepsychiatry Supervisor/administrative assistant/staff support person at the physician practice responsible for transmitting the documentation to the outpatient hospital psychiatry services program before the end of the day). The updated note must be sent either by HIPAA-compliant encrypted e-mail or by standard fax-to-fax transmission. Use of unencrypted e-mail or e-fax by either party is not HIPAA-compliant.
8. The program director will confirm receipt with the psychiatrist once received. If the program director does not receive, he or she will be accountable for contacting the psychiatrist to ensure these are submitted to the program as soon as possible. The program must have this documentation within five (5) days of admission or risk compliance issues.
9. The psychiatrist can elect to either keep the documentation originals on-site at the physician practice/university office or mail these originals to the outpatient hospital psychiatry services program. If sending by mail, the program director will ensure the faxed/scanned documents are shredded upon receipt of the originals.

C. Billing

- The Psychiatrist providing the service (from the remote location) will file a claim with the patient's Medicare or other insurance plan using the appropriate CPT code for the service provided with the modifier GT to indicate that the service was provided via telemedicine link. The place of service shown on the claim should be consistent with the location of the patient at the originating facility, usually 22-hospital outpatient department. The address of the originating site should be shown in box 32 of the HCFA 1500 claim form or its electronic counterpart. (When seeing the patient face-to-face at the program, use place of service code 22, the hospital outpatient department, and do not add the modifier GT to the procedure code.)

- This claim should be submitted to Medicare within days or weeks of the service so that it can be computer-matched with the hospital's claim for the originating site facility fee.
- The Program Director will enter a charge of HCPCS code Q3014 representing the telemedicine originating facility fee on the daily/weekly charge sheet and submit to the hospital billing department. The hospital may not submit a separate charge for the use of outpatient department services for the same telemedicine physician's visit.
- Program director should confirm with doctor or doctor's billing office that claim has been submitted using GT modifier.
- Hospital billing department will submit the claim for Q3014 as soon as possible. As Q3014 is not considered a recurring charge, it is not necessary to delay its submission until the end of the calendar month. This should be submitted as a separate Part B claim to Medicare, not on the recurring bill type with other program charges.
- If the hospital's claim as originating site cannot be matched to the physician's claim for service with modifier GT, then neither party will be reimbursed for the service until such time that the claims are corrected, resubmitted and computer-matched.

REFERENCES:

- https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/TelehealthSrvcsfctsht.pdf
- http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/MM7631.pdf

Approval Signatures

Step Description	Approver	Date
CAH	CAH: DCHC Critical Access Hospital Committee	Pending
CAH	Rhonda Roberts: SLS Program Director	01/2024
Medical Director- Nina Jordania, MD	Carleena Brown: Clinic Director	11/2023
Senior Leader	Carleena Brown: Clinic Director	11/2023

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Owner	Rhonda Roberts: SLS Program Director
Policy Area	Senior Life Solutions DCHC
Applicability	Davis County Hospital

Outpatient Hospital Psychiatric Services Scope of Service

POLICY:

Overview – Senior Life Solutions is an outpatient geropsychiatric service provided by the hospital.

The Outpatient program is grounded in clinical geropsychiatry, interdisciplinary patient care standards, and administrative policies, all of which have been used to design an Outpatient Psychiatric Hospital Program for patients primarily 65 and older. The program does not discriminate on the basis race, color, religion, national origin, age (except within the scope of the programs geriatric focus), sex, disability, or any other prohibited basis in admission, treatment, or participation in its services. The primary service area is defined by patient's ability to attend the program at the frequency determined by the psychiatrist that would best meet their care needs.

In order to meet the needs of the community, Senior Life Solutions has developed a treatment program focused on psychotherapy including process groups, psycho-educational groups, coping skills groups, individual therapy, and family therapy, as warranted. Such goals as distinguishing between normal and pathological aging, maximizing patient functioning and enhancing quality of life are inherent to the program. Appropriate treatment for older patients must be interdisciplinary in nature, based on comprehensive and detailed patient assessment and be developed jointly by the patient and treatment team. It is imperative that the needs of the patient's family and caregiver are addressed for the patient to optimize treatment goals and return to the community at the highest level of independent functioning. Senior Life Solutions requires dedicated, knowledgeable professional staff who have chosen to work in the field of geriatric psychiatry.

The outpatient program provides scheduled psychotherapy Monday through Friday, excluding holidays recognized by the hospital. The outpatient program is designed to be multidisciplinary in

its approach to treatment, maximizing the strengths of all disciplines in order to return each patient to his/her highest level of functioning.

Senior Life Solutions is focused on providing the following services:

- A clinical program that is superior ethically and clinically.
- A clinical program that meets the expectations of the Centers for Medicare and Medicaid Services (CMS).
- An environment that allows personal and professional growth for all staff.
- Individualized treatment services based on the needs of each client/patient.
- Any additional services along the continuum of care which allow treatment of the client/ patient in the least restrictive environment as needed.

Program Values Statement – Our goal is to provide the highest level of quality care to all of the clients, patients and families (as applicable) we serve. We will be caring and compassionate and treat each individual with dignity and respect. Specifically,

- We value treating the elderly with compassion, dignity and respect.
- We value the interdisciplinary approach to caring for the elderly We value our professional code(s) of ethics.
- We value the services we provide in the continuum of care.
- We value client relationships.
- We value all of our staff.
- We value trust in each member of the team.
- We value communication.

Program Vision Statement – Our vision is to redefine the treatment available to the elderly by developing a program that is focused on patient outcomes. We believe that a sound clinical program will result in patients not only living longer but enjoying the quality of life that comes with aging.

IV. **Staffing –** The multidisciplinary team in the Senior Life Solutions program consists of a

Medical Director, a Nurse Program Director, a Therapist, and a Patient and Office Coordinator. All clinicians are certified and/or licensed by the governing board of each independent profession. Clinicians providing individual, group and/or family therapy must be certified, licensed and/or authorized by the State to perform psychiatric services, specifically the provision of clinical psychotherapy for the treatment of mental illness including Licensed Clinical Social Workers (LCSW), Licensed Practical Counselors (LPC) and others, as applicable. In addition to education and prior experience, Senior Life Solutions provides the Program Director, Therapist, Nurse, and Patient Coordinator with additional job specific training. Training includes specific geropsychiatric training, crisis prevention, and community education. The Medical Director is responsible for overall direction of the program's psychiatric care, monitoring and evaluating the appropriateness of medical diagnosis, and treatment of all patients enrolled in the outpatient program.

V. **Referral** – Patients are referred to the Senior Life Solutions Program from a potential patient, potential patient's family, an outside agency, physician or mental health professional. A referral call could include inquiries about community psychiatric services, the program's services or procedures for admission to the program.

- During program hours, referral calls are handled by qualified personnel on the Senior Life Solutions unit.
- After hour calls are handled the next business morning.
- Emergencies are referred to surrounding Emergency Rooms 24 hours a day. If after hours, patients are requested to hang up the phone and call the nearest emergency room or dial 911.
- The Referral Assessment is completed by a competent, licensed staff member such as a Registered Nurse (RN), Licensed Practical Nurse (LPN), Licensed Practical Counselor (LPC), Licensed Clinical Social Worker (LCSW), or other staff trained to perform mental health assessments. Documentation is completed on all inquiries into the program using the Referral Screening Log. A disposition is made on the basis of information provided by referral source or caller. One of the following dispositions is made:
    - Information given
    - Referral to another level of care and/or treatment source
    - Referral Assessment scheduled with a qualified staff member. In circumstances where there is a waitlist for treatment the potential patient should be screened for severity of symptoms, offered referral to alternative treatment sources or placed on the program's wait list.
    - The Wait List Sheet should be utilized to help ensure continuity of care with other providers.

In arriving at a disposition, the Program Director will consult with the attending psychiatrist or the other professional staff as necessary.

When the caller is requesting only information about the Program or other treatment programs in the area, this information is provided in an accurate and professional manner. When appropriate, a brochure describing the program is sent to the caller.

If the disposition of a direct referral call is referred to an alternative treatment source, this is made in a cooperative manner. If clinically indicated, the alternative treatment source is contacted to review the patient's case consistent with the rules and regulations on confidentiality. A list of alternative treatment resources is available on site.

A. **Admission Assessment –** The Program Director schedules the potential admission in coordination with the attending physician.
    1. A face-to-face assessment is completed by a qualified staff member on every potential admission to Senior Life Solutions unless the referral was made by an attending physician who has evaluated the potential admission face-to-face within the previous 24 hours.
    2. Standardized assessment tools should be utilized to facilitate clinical data

gathering.

3. If the referral is made from an outside source, and the patient meets criteria for admission, an appointment is made for the patient to see the Medical Director during his/her next scheduled visit to the program.
4. A completed Referral Intake form is placed in the medical record. Prior to the Referral Intake staff should request verbal consent to conduct the Referral Intake and obtain written consent by signature of patient at time assessment is performed.
5. If indicated, the attending Physician is consulted, and assessment information reviewed with him/her before disposition is made. If the patient does not meet admission criteria, the patient is referred to an appropriate agency or service.

B. **Admission to the Program**

1. If admission to the program is indicated after completing the pre-admission assessment, the Program Director or his/her designee will review the clinical information with the Medical Director. The physician then makes a determination as to whether or not the patient is appropriate for admission based on a psychiatric evaluation and the willingness of the patient to be admitted. If the patient is to be admitted to the program, the physician orders the admission and treatment pursuant to an individualized treatment plan. The plan must state the type, amount, frequency, and duration of the services to be furnished and indicate the diagnoses and anticipated goals. (A plan is not required if only a few brief services are furnished.)
2. Upon the patient's arrival to the program, the assigned staff member or therapist coordinates:
    a. Orientation to the program;
    b. The review of patient rights and confidentiality
    c. Review of the patients' handbook
    d. Signing of all legal forms for admission to the program
3. Upon admission, when appropriate and feasible, the therapist meets with the patient's family so that they can gather additional information regarding the patient's psychosocial history and also receive information about the program.
4. The patient will attain "patient" status only after all of the admission forms are properly signed and reviewed by the personnel designated to complete the admission packet.

C. **Admission Criteria –** The Senior Life Solutions program will primarily admit persons aged 65 and older who meet the requirements for eligibility for outpatient hospital psychiatric services. Persons under the age of 65 may also be admitted with approval from the Program Director and Medical Director of the program if they will benefit from the therapeutic milieu of the program. The impairment leading to treatment should be acute and inconsistent with the patient's usual behavior. Outpatient hospital psychiatric services represent a level of care less intensive than partial hospitalization. It is not appropriate for patients whose psychiatric illness is so severe that they require 24-hour care thus resulting in an inpatient admission. All referrals will be assessed, by qualified staff, for appropriateness of admission to the outpatient program.

1. a. Inclusion Criteria
    a. Patients will be 65 years of age and older. (All referrals less than 65 years of age will be assessed on an individual basis, i.e., appropriateness.)
        i. The patient exhibits psychiatric symptoms that significantly impair their social, occupational, or other important areas of functioning.
        ii. The patient would otherwise require admission or continued admission to an inpatient or partial hospitalization facility.
        iii. The Outpatient program is appropriate for individuals who:
            a. Are likely to benefit from a coordinated program of services and require more than isolated sessions of outpatient treatment.
            b. Do not require 24-hour care and have an adequate support system outside the hospital setting while not actively engaged in the program.
            c. Are not judged to be dangerous to themselves or others.
            d. Have a diagnosable condition that, in general can be referenced in the most current edition of the Diagnostic and Statistical Manual of Mental Disorders. However, the diagnosis in itself is not the sole determining factor for treatment. A specific list of accepted diagnosis codes is usually included in the Local Coverage Determination (LCD) provided by the Medicare Administrative Contractor (MAC).
            e. Services must be reasonable and necessary for the diagnosis and active treatment of the individual's condition; reasonable expectation to improve or maintain the individual's condition and functional level to prevent exacerbation, deterioration, and /or relapse must be expected.
            f. Individual has one or more psychiatric disorders and is expected to participate in a structured interdisciplinary program that provides intensive services within an individualized treatment plan.
            g. Program is designed to treat patients who exhibit severe to moderate or substantially disabling conditions related to psychiatric/psychological condition or a mild to moderated exacerbation of a severe and persistent mental disorder.
2. Exclusion Criteria
    a. i. Patients who refuse or who cannot participate (due to their

behavioral, cognitive, or emotional status) with the active treatment process or who cannot tolerate the intensity of the outpatient program.

ii. Patients who are gravely suicidal, homicidal, or severely demented, who require 24-hour supervision and present a significant security risk.

iii. Patients who demonstrate inadequate impulse control manifested by self-mutilating or self-destructive behavior, requiring 24-hour supervision.

iv. Patients who require primarily social, custodial, recreational, or respite care (i.e., moderately to severely demented patients with no evidence that active treatment would modify the clinical course)

v. A patient with multiple unexcused absences is not receiving "active treatment" and, therefore, it is not appropriate for him/her to participate in the outpatient program.

vi. Patients who have achieved sufficient stabilization of the presenting symptoms and sufficient intervention in skills or coping ability and mobilization of family and/or community support no longer require involvement of an outpatient program.

vii. Patients who have achieved sufficient stability that they now require limited intervention (medication management) on an intermittent basis which may be performed in the outpatient or office setting.

viii. Patients who require a higher level of care, such as inpatient or partial hospitalization.

D. **Psychiatrist Supervision and Evaluation –** Services must be supervised and periodically evaluated by a psychiatrist to determine the extent to which treatment goals are being realized. The evaluation must be based on periodic consultation and conference with therapists and staff, review of medical records, and patient interviews. Psychiatrist entries in medical records must support this involvement. The psychiatrist must also provide supervision and direction to any therapist involved in the patient's treatment and see the patient periodically to evaluate the course of treatment and to determine the extent to which treatment goals are being realized and whether changes in direction or emphasis are needed.

E. **Reasonable Expectation of Improvement –** Services must be for the purpose of diagnostic study or reasonably be expected to improve the patient's condition. The treatment must, at a minimum, be designed to reduce or control the patient's psychiatric symptoms so as to prevent relapse or hospitalization and improve or maintain the patient's level of functioning.

1. It is not necessary that a course of therapy have as its goal restoration of the patient to the level of functioning exhibited prior to the onset of the illness, although this may be appropriate for some patients. For many other psychiatric patients, particularly those with long-term, chronic conditions, control of symptoms and maintenance of a functional level to avoid further deterioration or hospitalization is

an acceptable expectation of improvement. "Improvement" in this context is measured by comparing the effect of continuing treatment versus discontinuing it. Where there is a reasonable expectation that if treatment services were withdrawn the patient's condition would deteriorate, relapse further, or require hospitalization, this criterion is met.

2. Some patients may undergo a course of treatment that increases their level of functioning, but then reach a point where further significant increase is not expected. Such claims are not automatically considered non-covered because conditions have stabilized, or because treatment is now primarily for the purpose of maintaining present level of functioning. Rather, coverage depends on whether the criteria discussed above are met. Services are non-covered only where the evidence clearly establishes that the criteria are not met; for example, that stability can be maintained without further treatment or with less intensive treatment.

F. **Individualized Treatment Plan –** An Individualized Treatment Plan is initiated on the first day of treatment and is completed within 3 treatment days of admission to the program. Each member of the treatment team is required to submit information on the treatment plan, review, and sign it. The Individualized Treatment Plan is also reviewed and signed by the patient. Treatment planning is an ongoing, collaborative effort. Such effort should be documented on the Treatment Team Update which includes a patient status update, individualized treatment plan update, and a recertification of medical necessity. Each patient is reassessed to determine current clinical problems, needs and responses to treatment. Reviews occur approximately every 2 weeks in the Senior Life Solutions program and are documented on the Treatment Team Update.

G. **Patient Discharge –** The Attending Psychiatrist orders the patient's discharge. The treatment team is responsible for developing and coordinating the continuing care and discharge plan. All disciplines complete the Continuing Care/Discharge Instructions and then the plan is reviewed with the patient (and the family, as allowed). A copy of the discharge and continuing care plan is given to the patient and/or family upon discharge. The patient is informed of any follow-up appointments, medication community resources, etc. upon discharge. All patients will be referred back to their Primary Care Provider and/or a less intensive level of treatment, if indicated. The attending physician may determine that he/she will provide the follow-up therapy with the patient. In addition, patients may be referred to a local community mental health program. Other providers involved in the patient's care will be notified of discharge to promote continuity of care. As a part of the discharge and continuing care plan, all patients will be asked to sign consent for follow-up form, giving the Program consent to contact the patient and/or the continuing care provider for the provision of aftercare. Continuing care follow-up is attempted with every patient who completes the program on a routine basis. Such continuing care (aftercare) is documented, accordingly. The Senior Life Solutions Program will develop an approach to aftercare that ensures continued care and interest. The Program Director (or designee) is responsible for making sure an adequate amount of aftercare is provided.

1. Contacts with the patient may be made by telephone, in person, or by mail.
2. Documentation of such contact may be documented on the Aftercare Log, or another document approved by an executive member of PMC.
3. A confidential aftercare file is maintained in the program director's office.

H. **Medical Records –** Medical records are maintained in a secure double locked area. Only authorized personnel have access to the medical records. Once the records are no longer being utilized by a staff member who is present in the room, the medical records must be stored in a locked area.

I. **Supplies –** The Program does not maintain any clinical supplies. Staff will make sure that supplies are maintained, replaced, and disposed of when outdated.

J. **Quality Assurance –** The Senior Life Solutions Program staff members participate in the development of quality improvement activities specific to the program and in collaboration with the Quality Assurance Department.

Approval Signatures

Step Description	Approver	Date
CAH	CAH: DCHC Critical Access Hospital Committee	Pending
CAH	Rhonda Roberts: SLS Program Director	01/2024
Medical Director- Nina Jordania, MD	Carleena Brown: Clinic Director	11/2023
Senior Leader	Carleena Brown: Clinic Director	11/2023

Applicability

Davis County Hospital

Status Pending PolicyStat ID 14717965

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

Outpatient Hospital Psychiatric Services Sharepoint Provider Folders

POLICY:

Outpatient hospital psychiatric services healthcare professionals will utilize SharePoint to facilitate the storage and sharing of protected health information (PHI) and/or medical records. Outpatient hospital psychiatric services staff and physicians will use SharePoint to collaborate internally and externally in a HIPAA compliant manner.

PROCEDURE:

- Psychiatric Medical Care (PMC) IT will generate a SharePoint folder for each outpatient hospital psychiatric services clinic on the PMC SharePoint site.
- Access to SharePoint program folders will follow HIPAA guidelines and be managed by PMC IT.
- Regional Directors will submit an IT ticket to request access for staff to a program's SharePoint folder.
- Program staff will create a SharePoint folder with files, as illustrated in Addendum A, for each of their patients.
- To meet best practice standards around efficacy, timeliness, and organization program staff will utilize each of the following folders: an 'MD Signature Needed' folder, a 'Doctor Day' folder, and a 'Charges' folder.
- It is the expectation for program staff to process documents through folders in compliance with our documentation timelines.

- Program staff will ensure the contents of their SharePoint folder remain current.
- Files within SharePoint folders will be labeled by date of completion and document name, e.g. 2-2-22 Progress Note.
- Program staff will delete patient folders from SharePoint at the time of discharge from outpatient hospital psychiatric services. No archived patient data will remain in program folders.

Addendum A

ASSESSMENTS

- Psychosocial Assessment (23)
- Psychosocial Update, if applicable (23A)
- ACE Questionnaire (3D)
- Nursing Assessment (20A)
- AIMS Assessment (20D)

CONSENTS

- Release of Information (7)

FACESHEET

HISTORY, PHYSICAL & CONSULTS

- Annual History & Physical from PCP

INPATIENT STAY DOCUMENTATION

- Psychiatric and/or general medical discharge summaries

INTAKE ASSESSMENT

- Referral Intake Form (3)

LABS & OTHER MEDICAL TESTING

- Labs, X-ray, EKG, etc.

MED LOGS

- Medication Log and Updates (22)

MISC PSYCH HX DOCUMENTATION

- Documents from previous psychiatric care, if applicable and when available

MULTIDISCIPLINARY NOTES

- Multidisciplinary Notes (29)

OUTCOME TESTING

- Mini Mental Status Index
- Geriatric Depression Scale
- CORE-10
- ZUNG Anxiety Scale
- SBQ-R Suicide Assessment
- C-SSRS Suicide Risk Assessment, if applicable

PSYCHIATRIST'S NOTES

- Physician Progress Notes (26)
- Psychiatric Evaluation (15)

PSYCHIATRIST'S ORDERS

- Physician Orders (18)
- Physician Admission Orders (17)
- BP Parameters Order (18.3)

TREATMENT PLAN

- Treatment Plan Update (28)

Approval Signatures

Step Description	Approver	Date
CAH	CAH: DCHC Critical Access Hospital Committee	Pending
CAH	Rhonda Roberts: SLS Program Director	01/2024
Medical Director- Nina Jordania, MD	Carleena Brown: Clinic Director	11/2023
Senior Leader	Carleena Brown: Clinic Director	11/2023

Applicability

Davis County Hospital

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Next Review	2 years after approval
Owner	Rhonda Roberts: SLS Program Director
Policy Area	Senior Life Solutions DCHC
Applicability	Davis County Hospital

INSIGHT Application

PURPOSE:

Senior Life Solutions plans for the management and storage of information to ensure that the flow of information within the organization as well as to and from external organization is supported to achieve efficient data collection and distribution.

POLICY:

To deliver, analyze, and improve care, treatment or services, Senior Life Solutions has access to accurate information that is able to be retrieved, disseminated or transmitted into formats that meet patient or consumer needs.

Senior Life Solutions retains data and information for time frames consistent with state and federal law and regulation.

Outpatient hospital psychiatric services healthcare professionals will utilize a computer application named INSIGHT to facilitate the storage and sharing of protected health information (PHI) and/or medical records. INSIGHT is the documentation system utilized by PMC; it is not the patient's permanent medical record. Outpatient hospital psychiatric services staff and physicians will use INSIGHT to collaborate internally and externally in a HIPAA compliant manner.

PROCEDURE:

- Psychiatric Medical Care (PMC) provides the INSIGHT computer application for each outpatient hospital psychiatric services clinic, giving that clinic access to their patients at that program only.

- Access to INSIGHT program PHI will follow HIPAA guidelines and be managed by PMC IT.
- Users may submit an IT ticket to request assistance with technological issues in the application.
- It is the expectation for program staff to process documents through the application in compliance with our documentation and signature timelines.
- Program staff will ensure the contents of their patient's folders remain current.

Approval Signatures

Step Description	Approver	Date
Senior Leader	Carleena Brown: Clinic Director	Pending

Applicability

Davis County Hospital

Revised Policy Statements

Title	Policy Area	Summary of Changes	Revised?
CareLearning Assignments for new and existing employees	Education	Removed class list from policy and added class list as an attachment to prevent having to update policy each time assignments change. Minor policy statement change.	Revised
Competency Assessment Process	Education	Removed redundant sentence. Grammatical error corrected in policy statement	Revised
Compounding Sterile Preparations in the Pharmacy	Pharmacy	Completely revised to adhere to new USP 797 and USP 800 regulations which became effective November 2023. Policy statement changes.	Revised

Status **Pending** PolicyStat ID **15284890**

Davis County HOSPITAL & CLINICS

An Affiliate of MERCYONE

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Effective	Upon Approval
Last Revised	02/2024
Next Review	2 years after approval
Owner	Amy Tyson: Education/IP/ Employee Health/Wellness
Policy Area	Education
Applicability	Davis County Hospital

CareLearning Assignments for new and existing employees

POLICY:

All staff will complete mandatory competencies yearly via CareLearning ~~as listed below~~.

PROCEDURE:

~~1. Mandatory competencies for all staff~~

- ~~ADA~~
- ~~FMLA~~
- ~~Worker's Compensation~~
- ~~IT Security Awareness training~~
- ~~Bloodborne Pathogens~~
- ~~Emergency Preparedness~~
- ~~Electrical Safety~~
- ~~Fire Safety~~
- ~~Hazard Communication~~
- ~~infection Prevention and Control for Non-Clinical staff~~
- ~~Moving, Lifting and Repetitive Motion~~
- ~~Patients' Rights~~
- ~~Slips, Trips and Falls~~
- ~~Tuberculosis Prevention~~

- ~~Abuse and Neglect~~
- ~~Hand Hygiene~~
- ~~Influenza~~
- ~~EMTALA~~
- ~~Sexual Harassment~~
- ~~HIPAA~~
- ~~Workplace Diversity~~
- ~~FACTA Red Flags~~
- ~~Workplace Violence Prevention~~
- ~~Compliance~~
- ~~COVID-19: Coronavirus Disease~~
- ~~Cultural Competence in the Workplace~~
- ~~Customer Service~~

~~2. Clinical staff will also complete mandatory clinical competencies yearly via CareLearning as below:~~

- ~~Isolation and Standard Precautions~~
- ~~Medical Radiation Safety~~
- ~~Pain Management~~
- ~~Population Specific Care - The Adult Patient~~
- ~~Population Specific Care - The Pediatric Patient~~
- ~~Restraint and Seclusion~~

~~3~~1. CareLearning assignments will be made to staff upon hire~~, and yearly~~ and annually thereafter.

~~4. Due date for completion of all assignments is December 15th at midnight.~~

~~5~~2. Course completion reports will be sent to department managers periodically throughout the year prior to the due date.

~~6~~3. New employees will complete ~~Carelearning courses~~CareLearning assignments per the ~~following~~attached table as part of orientation ~~and first 90 days~~with due dates as indicated.

~~**Orientation ~ Carelearning Plan**~~

~~**Orientation**~~	~~**Within first 30 days**~~	~~**Within first 90 days**~~
~~ADA~~	~~FACTA~~	~~Customer Service~~
~~Worker's Compensation~~	~~EMTALA~~	~~Population Specific – Adult - clinical~~
~~Sexual Harassment~~	~~IT Security Awareness training~~	~~Population Specific – Pediatric - clinical~~
~~Workplace Diversity~~	~~Patient Rights~~	~~Abuse and Neglect~~

~~HIPAA~~	~~Moving, Lifting, and Repetitive Motion~~	~~Cultural Competence~~
~~Bloodborne Pathogens~~	~~FMLA~~	
~~Hand Hygiene~~	~~Influenza~~	
~~Fire Safety~~	~~Slips, Trips and Falls~~	
~~Electrical Safety~~	~~Tuberculosis Prevention~~	
~~Hazard Communication~~		
~~Emergency Preparedness~~	~~Medical Radiation Safety - clinical staff~~	
~~Workplace Violence~~	~~Pain Management - clinical staff~~	
~~Infection Prevention and Control for Non-clinical~~	~~Restraint - clinical staff~~	
~~Isolation and Standard Precautions - clinical staff~~		

4. Completion of annual competencies is due by September 1 each year.

~~7~~5. The employee's manager and senior team leader will deal with non-completion by deadline.

Attachments

Care Learning on hire.docx

Approval Signatures

Step Description	Approver	Date
CAH	CAH: DCHC Critical Access Hospital Committee	Pending
Senior Leader	Nikki Thordarson: CNO	02/2024
	Amy Tyson: Education/IP/ Employee Health/Wellness	02/2024

Applicability

Davis County Hospital

CareLearning Assignments on Hire

Orientation	Within first 30 days	Within first 90 days
ADA	EMTALA	Abuse, Neglect & Exploitation
Bloodborne Pathogens	FACTA Red Flags-Identity Theft Prevention	Cultural Competence in the Workplace
Code of Conduct Annual Training	Influenza	Customer Service
Criminal Record History	IT Security Awareness Training	Donation 101: The Hospital's Role
Electrical Safety	Moving, Lifting & Repetitive Motion	FMLA
Emergency Preparedness	Patient Rights	Mandatory Reporter: Child Abuse
Fire Safety	Slips, Trips & Falls	Mandatory Reporter: Dependent Adult Abuse
Hand Hygiene	Tuberculosis Prevention	Run, Hide, Fight
Hazard Communication		
HIPAA	Isolation & Standard Precautions-clinical staff only	Knife Safety—dietary staff
Sexual Harassment	Medical Radiation Safety-clinical staff only	Food Safety—dietary staff only
Worker's Compensation	Pain Management-clinical staff only	Population Specific-Adult—clinical staff only
Workplace Diversity	Restraint & Seclusion-clinical staff only	Population Specific-Pediatric-clinical staff only
Workplace Violence Prevention	Medication Administration-nursing only	

Student ID:

Password:

Status **Pending** PolicyStat ID **15266961**

Davis County HOSPITAL & CLINICS

An Affiliate of MERCYONE

Origination	09/2000
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Effective	Upon Approval
Last Revised	03/2024
Next Review	2 years after approval
Owner	Amy Tyson: Education/IP/ Employee Health/Wellness
Policy Area	Education
Applicability	Davis County Hospital

Competency Assessment Process

Policy Number: HR074

POLICY:

Davis County Hospital is committed to ensure that the competence of all staff, employed by ~~DCH, are~~DCHC is assessed, verified, and maintained. These assessment processes are mandatory.

PROCEDURE:

Each department manager is responsible to develop an orientation competency program for their department based on departmental needs and regulations.

1. Department Manager is responsible for documentation of training. Documentation should be submitted to Education Department .
2. Mechanisms for verifying competency/orientation include, but are not limited to: demonstration of skills, verbal and written tests, self-study modules, surveillance, supervision, and general data collection.

A. **INITIAL COMPETENCY ASSESSMENT/VERIFICATION**

1. **House-wide Competency Assessment**
   Initial house-wide competencies are assessed and verified for each employee upon initial hire. These competencies are as follows:
   - Infection Prevention
   - Safety Management (includes General Safety, Risk Management and Hazardous Materials)
   - Emergency Preparedness

- Employee Health and Well Being (includes Workers' Comp., Body Mechanics)
- Organizational Performance Improvement
- Interpersonal Relationships
- Compliance Responsibility Plan (Standards of Conduct)
- HIPAA
- This document is filed in the personnel file

2. ~~**Department Specific Competencies**~~
   ~~Each department manager is responsible to develop an orientation competency program for their department based on departmental needs and regulations. Documentation should be submitted to Education.~~

B. **ONGOING COMPETENCY**

1. **House-wide Competencies**
   Completion of assigned CareLearning online courses will demonstrate competency in mandatory education areas yearly. Clinical staff will complete yearly clinical CareLearning online courses. Education will maintain the CareLearning online system and communicate progress and completion reports to department managers.
2. **Department Specific Competencies**
   a. Each department manager is responsible to develop an ongoing competency program for their department based on departmental needs and regulations.
   b. Individual action plans designed to improve competency are developed by the department manager with each employee who does not meet defined competency requirements. Each employee who fails to complete the action plan will undergo the disciplinary process. This process can be initiated at any step depending on the severity of the issues.
   c. Documentation should be submitted to Education.

Attachments

Department Specific Competencies

Approval Signatures

Step Description	Approver	Date

CAH	CAH: DCHC Critical Access Hospital Committee	Pending
Senior Leader	Nikki Thordarson: CNO	03/2024
	Amy Tyson: Education/IP/ Employee Health/Wellness	03/2024

Applicability

Davis County Hospital

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Davis County HOSPITAL & CLINICS

An Affiliate of MERCYONE

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Last Approved	N/A
Effective	Upon Approval
Last Revised	01/2024
Next Review	2 years after approval
Owner	Wendy Barker: Pharmacy Manager
Policy Area	Pharmacy
Applicability	Davis County Hospital

Compounding Sterile Preparations in the Pharmacy

Ph 01.09.0

Policy:

~~All compounded sterile preparations (CSPs), except those for immediate use, will be compounded in the pharmacy under controlled conditions. Davis County Hospital Pharmacy has been determined to be a low and medium risk compounding area.~~

All compounded sterile preparations (CSPs) at Davis County Hospital, except those for immediate use, will be compounded within the pharmacy under controlled conditions and in accordance with USP 797 and USP 800 regulations. The ultimately goal of DCHC's sterile compounding program is to minimize harm to human patients that could result from microbial contamination, variability from the intended strength of correct ingredients, physical and chemical incompatibilities, chemical and physical contaminates, and/or use of ingredients of inappropriate quality.

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.
- Aseptic technique - A set of methods used to keep objects and areas free of microorganisms and thereby minimize infection risk to the patient. It is accomplished through practices that maintain the microbe count at an irreducible minimum.
- Beyond-use date (BUD) - The date, or hour and the date, after which a CSP must not be used, stored, or transported. The date is determined from the date and time the preparation is compounded.
- Buffer room - An ISO Class 7 or cleaner room with fixed walls and doors where PEC(s) that generate and maintain an ISO Clas 5 environment are physically located. The buffer room may only be accessed through the anteroom or another buffer room.
- Category 1 CSP - A CSP that is compounded under the least controlled environmental conditions and is, therefore, assigned a BUD of 12 hours or less at controlled room temperature or 24 hours or less refrigerated that is compounded in accordance with all applicable requirements for Category 1 CSPs in the USP 797 regulation. (At DCHC, a Category 1 CSP designation shall be applied to CSPs prepared within our USP 800 C-SCA).
- Category 2 CSP - A CSP that is compounded under more stringent environmental controls and may, therefore, be assigned a BUD of greater than 12 hours at controlled room temperature or greater than 24 hours refrigerated that is compounded in accordance with all applicable requirements for Category 2 CSPs in the USP 797 regulation. (At DCHC, a Category 2 CSP designation shall be applied to CSPs prepared within our USP 797 cleanroom suite).
- Category 3 CSP - A CSP that may be assigned a BUD exceeding the limits for Category 2 CSPs and is compounded in accordance with all applicable requirements for Category 3 CSPs in the USP 797 regulation. (At DCHC, we do not engage in compounding of any Category 3 CSPs as we do not prepare any CSPs with non-sterile starting ingredients and we do not perform any sterility testing on prepared products).
- 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.
- Compouding area - The area where compounding is occuring (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.
- Critical site - A location that includes any component or fluid pathway e.g., vial septa, injections ports, and beakers) or openings (e.g., opened ampules and needle hubs) that are exposed and at risk of direct contact with air (e.g., ambient room or HEPA filtered), moisture (e.g., oral and mucosal secretions), or touch contamination.
- Designated person(s) - One or more individuals assigned to be responsible and accountable for the performance and operation of the facility and personnel as related to the preparation of CSPs.
- 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.
- First air - The air exiting the HEPA filter in a unidirectional air stream.
- 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 measuing 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 decsribe 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.
- Media-fill test - A simulation used to qualify processes and personnel engaged in sterile compounding to ensure that the processes and personnel are able to prepare CSPs without contamination.
- 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 classifed 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:

A. Generalities Regarding Preparation of CSPs

1. All preparation of CSPs not for immediate use will be performed in the pharmacy within a properly maintained and certified laminator flow glove-box isolator. Only proprietary products (ex. ADD-vantage®, Mini-Bag Plus® and addEASE® preparations) and admixtures for immediate use may be prepared in nursing stations or in patient care areas.
2. Compounding is divided into the following risk categories:
    i. No Additional Risk – Proprietary products such as the ADD-vantage®, Mini-Bag Plus® and addEASE® preparations are neither low nor medium risk and can be mated/prepared outside of a controlled environment including in nursing stations and patient care areas. They do require proper handwashing technique prior to manipulation and adherence to their respective manufacturer's instructions for use.
    ii. Immediate-Use – The immediate-use provision is intended for situations where there is a need for emergency or immediate patient administration of a CSP including situations where the preparation of the CSP under controlled conditions (ISO Class 5) subjects the patient to additional risk due to delays in therapy. The immediate-use provision allows for preparation of certain CSPs outside of ISO Class 5 environment at nursing stations or in patient care areas. Immediate-use CSPs are not intended for storage for anticipated needs or batch compounding. Preparations that are medium-risk level and high-risk level shall not be prepared as immediate-use CSPs. Criteria for immediate-use are as follows:
        1. Simple transfer of not more than three commercially manufactured packages
        2. Not more than two entries into any one container or package
        3. Continuous process not to exceed one hour
        4. Aseptic technique is followed and the product is under constant supervision to minimize contact with nonsterile surfaces

5. ~~Administration begins not later than one hour after compounding is completed or the product is discarded~~
6. ~~Unless immediately and completely administered by the preparer, the CSP shall be thoroughly labeled~~

iii. ~~Low Risk = Low-risk conditions are defined as:~~

1. ~~The CSPs are compounded with aseptic manipulations entirely within ISO Class 5 or better air quality using only sterile ingredients, products, components, and devices.~~
2. ~~The compounding involves only transfer, measuring, and mixing manipulations using not more than three commercially manufactured packages of sterile products and not more than two entries into any one sterile container or package (e.g., bag, vial) of sterile product or administration container/device to prepare the CSP.~~
3. ~~Manipulations are limited to aseptically opening ampuls, penetrating disinfected stoppers on vials with sterile needles and syringes, and transferring sterile liquids in sterile syringes to sterile administration devices, package containers of other sterile products, and containers for storage and dispensing.~~

iv. ~~Medium Risk = Medium-risk conditions are defined as:~~

1. ~~Multiple individual or small doses of sterile products are combined or pooled to prepare a CSP that will be administered either to multiple patients or to one patient on multiple occasions.~~
2. ~~The compounding process includes complex aseptic manipulations other than the single-volume transfer.~~
3. ~~The compounding process requires unusually long duration, such as that required to complete dissolution or homogeneous mixing.~~

v. ~~High Risk = High-risk conditions are defined as:~~

1. ~~Nonsterile ingredients, including manufactured products not intended for sterile routes of administration (e.g., oral), are incorporated or a nonsterile device is employed before terminal sterilization.~~
2. ~~Any of the following are exposed to air quality worse than ISO Class 5 for more than 1 hour...~~
    a. ~~Sterile contents of commercially manufactured products~~
    b. ~~CSPs that lack effective antimicrobial preservatives~~
    c. ~~Sterile surfaces of devices and containers for the preparation, transfer, sterilization, and packaging of~~

CSPs

3. Compounding personnel are improperly garbed and gloved.
4. Nonsterile water-containing preparations are stored for more than 6 hours before being sterilized.
5. It is assumed, and not verified by examination of labeling and documentation from suppliers or by direct determiniation, that the chemical purity and content strength of ingredients meet their original or conpendial specifications in unopened or in opened packages of bulk ingredients.

3. All preparation of CSPs will be done according to the manufacturer's labeled instructions and final products will be assigned a beyond-use date according to the policy 'Assigning Beyond-Use Dates, Ph 05.20.0.'
4. Prior to any manipulation within, the LFGI shall be thoroughly cleaned according to the 'Laminar Flow Glove-Box Isolator Hood Maintenance' policy.
5. No extraneous materials shall be allowed in the LFGI. It shall be kept free of debris and non-essential items.
6. Traffic in the IV preparation area shall be kept to a minimum and activities in this area shall be limited to necessary movements.

B. Prior to Preparation of CSPs

1. When individuals are experiencing rashes, sunburn, weeping sores, conjunctivitis, active respiratory infections, as well as when they wear cosmetics, they shed skin particles at an even higher rate than normal. Therefore, compounding personnel with such conditions shall be excluded from working in our laminar flow glove-box isolators until their conditions are remedied.
    i. Cosmetics may be worn within the pharmacy but must be removed by compounding personnel prior to entering the laminar flow glove-box isolator and commencing any manipulations.
2. Prior to entering the laminar flow glove-box isolator, compounding personnel shall remove personal outer garments (e.g., bandannas, coats, hats, jackets, scarves, sweaters, vests); all cosmetics; and all hand, wrist, and other visible jewelry or piercings that can interfere with the effectiveness of personal protective equipment (PPE).
3. The wearing of artificial nails or extenders is prohibited while working in the sterile compounding environment. Natural nails shall be kept neat and trimmed.
4. Prior to entering the laminar flow glove-box isolator, a hand cleansing procedure shall be performed by removing debris from underneath fingernails using a nail cleaner under running warm water followed by vigorous hand washing.
    i. Hands and forearms shall be washed to the elbows for at least 30 seconds with soap (either nonantimicrobial or antimicrobial) and water.
    ii. Hands and forearms to the elbows will be completely dried using lint-free disposable towels.

5. ~~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. ~~Furtherfore, 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.~~
6. ~~Following an appropriate hand cleansing procedure as detailed above, compounding personnel may choose to don cotton glove liners. These liners are to be worn on the outside of the isolator but within the glove ports. They do not have to be sterile and may be washed periodically and reused.~~
7. ~~Compounding personnel shall disinfect components/vials with a sterile 70% IPA prior to placing them into the ISO Class 5 work area. Personnel shall introduce only essential materials in a proper arrangement in the ISO Class 5 work area.~~
8. ~~After placing hands/arms inside the glove port sleeves of the LFGI, compounding personnel shall don appropriate sized sterile gloves over the gloves attached to the glove port sleeves ensuring that there is a tight fit with no excess glove material at the fingertips.~~
    i. ~~Personnel shall examine gloves to ensure that there are no defects, holes or tears. If any breaches are identified, hand cleansing shall be repeated and gloves replaced.~~
    ii. ~~While engaging in sterile compounding activities, personnel shall routinely disinfect gloves with sterile 70% IPA prior to work in the direct compounding area (DCA) and after touching items or surfaces that may contaminate gloves.~~

C. ~~Preparation of CSPs~~

1. ~~During preparation of all CSPs, compounding personnel shall adhere to the following:~~
    i. ~~Does not interrupt, impeded, or divert flow of first-air to critical sites~~
    ii. ~~Ensures syringes, needles, and tubing remain in their individual packaging and are only opened in the ISO Class 5 work area.~~
    iii. ~~Performs manipulations only in the appropriate DCA of the ISO Class 5 device.~~
    iv. ~~Does not expose critical sites to contact contamination or worse than ISO Class 5 air.~~
    v. ~~Disinfects stoppers, injection ports, and ampul necks by wiping with sterile 70% IPA and allows sufficient time to dry (at least 10 seconds).~~
    vi. ~~Affixes needles to syringes without contact contamination.~~

vii. ~~Punctures vial stoppers and spikes infusion ports without contact contamination.~~

viii. ~~Labels preparation(s) correctly with the following:~~

1. ~~Names and amounts/concentrations of ingredients~~
2. ~~Total volume~~
3. ~~Beyond-use-date (BUD)~~
4. ~~Route of administration~~
5. ~~Storage conditions~~
6. ~~Date prepared~~
7. ~~Any other information for safe use~~

ix. ~~Disinfects sterile gloves routinely by wiping with sterile 70% IPA during prolonged compounding manipulations.~~

x. ~~Disposes of sharps and waste according to institutional policy or recognized guidelines.~~

D. ~~After Preparation of CSPs~~

1. ~~When compounding is completed, personnel shall remove the sterile gloves within the isolator and discard. They shall remove their hands/arms from the glove port sleeves and perform hand hygiene prior to retrieving finished product(s) from the purge chamber.~~
2. ~~All final products shall be visually inspected for particulate matter.~~
3. ~~If an admixture is prepared by a pharmacy technician, the finished product along with the empty containers of the drug products added will be left for final checking by the pharmacist prior to dispense.~~
4. ~~For technician prepared admixtures, the pharmacist checking the finished product shall initial the label.~~
5. ~~A production record shall be maintained for all compounded sterile admixtures prepared in the pharmacy. Such record shall include;~~

i. ~~Date/time of preparation~~

ii. ~~Rx#~~

iii. ~~RPh initials~~

iv. ~~Date/time of dose~~

v. ~~Expiration date~~

vi. ~~List of each ingredient with:~~

1. ~~Name/strength~~
2. ~~NDC~~
3. ~~Lot#~~
4. ~~Expiration date~~

5. Quantity utilized

6. For technician prepared admixture, the log shall also include a detailed listing of each step taken in the compounding process and each step shall be initialed by the preparer and the checking pharmacist.

E. Competency in Preparing CSPs

1. New employees that will be involved in compounding sterile preparations within the pharmacy will be required to receive didactic training in the theoretical principles and practical skills of aseptic manipulations, pass a written test on proper aseptic technique, and perform a media-fill test of aseptic manipulative skills and glove fingertip sampling as a means of attaining competency for the independent compounding of sterile preparations.

2. Personnel who prepare CSPs within the pharmacy will be provided with appropriate didactic training from at least one of the following sources:

    i. Video instruction

    ii. Expert personnel

        1. Davis County Hospital staff may be allowed to attend hands-on training with expert sterile compounding pharmacists and pharmacy technicians at Mercy Des Moines or Mercy WestLakes.

    iii. Professional publications

        1. Davis County Hospital maintains the following reference book: Johnston, M. *Sterile Products and Aseptic Techniques for the Pharmacy Technician*. 2nd ed. Upper Saddle River, NJ: Pearson Education, Inc.; 2011. This book shall be provided to all staff being trained to prepare CSPs within the pharmacy.

3. Personnel will also be trained in the practical procedures involved with compounding sterile preparations including:

    i. The donning of appropriate gloves

    ii. Maintaining a sterile environment free from contamination

    iii. Proper use of the Laminar Flow Glovebox Isolator

4. Annual Review for Low/Medium Risk CSPs at DCH – All personnel who prepare CSPs within the LFGIs in the pharmacy shall perform didactic review and pass a written exam, hand hygiene assessment, media-fill test of aseptic manipulative skills and gloved fingertip sampling test at least annually. Compounding personnel who fail written tests or whose hand hygiene, media-fill or gloved fingertip sampling vials/plates result in microbial growth beyond acceptable action levels must be immediately re-instructed and re-evaluated by expert compounding personnel to assure correction of all aseptic practice deficiencies.

    i. Hand Hygiene Assessment

        1. The aforementioned hand cleansing procedure shall be

followed. Personnel shall then place hands/arms inside the glove port sleeves of the LFGI and don appropriately sized sterile gloves prior to beginning their media fill procedure.

2. Personnel shall be assessed using the attached 'Form for Assessing Hand Hygiene and Garbing'.

ii. Media-Fill Procedure

1. Commercially available sterile fluid culture media, such as Soybean-Casein Digest Medium that is able to promote exponential colonization of bacteria shall be utilized for media-fill tests.
2. See attached 'Low/Medium Risk Media Fill Procedure' for the exact steps to be followed during a media-fill test.
3. Personnel shall be assessed using the attached 'Form for Assessing Aseptic Technique.'
4. Following the test, media-filled vials and bags are to be incubated at 20 to 25 degrees for a minimum of 14 days.
5. Failure is indicated by visible turbidity in the medium on or before 14 days.

iii. Gloved Fingertip Sampling Procedure

1. Sampling shall be done after compounding has been completed.
2. Immediately prior to sampling, gloves shall not be disinfected with sterile 70% IPA.
3. Plates filled with nutrient agar with neutralizing agents such as lecithin and polysorbate 80 added shall be used.
4. Personnel shall "touch" the agar with the fingertips and thumb of both hands in separate plates in a manner to create a slight impression in the agar.
5. The sampled gloves shall be immediately discarded and proper hand hygiene performed after sampling.
6. The nutrient agar plates shall be securely covered and inverted and shall be incubated at 30 to 35 degrees for 48 to 72 hours.
7. The action level for microbial contamination following Gloved Fingertip Sampling in an ISO Class 5 environment is >3 cfu per person. The cfu action level for gloved hands will be based on the total number of cfu on both gloves, not per hand.

F. Preparation of CSPs for Immediate Use

1. During those times when the Davis County Hospital pharmacy is closed and personnel trained to prepare CSPs within our laminar flow glove-box isolators are unavailable, certain IV admixtures may be prepared by nursing staff, following established nursing policies.

2. ~~General considerations to be followed by nursing when preparing IV admixtures are as follows:~~
    i. ~~Admixtures are to be prepared in clean, low-traffic areas.~~
    ii. ~~Strict aseptic technique is to be observed at all times.~~
    iii. ~~Only admixtures involving proprietary products (ADD-vantage®, Mini-Bag Plus® and addEASE®) or those intended for immediate-use may be prepared outside of a laminar flow glove-box isolator (see above for criteria for immediate-use).~~
    iv. ~~Completed admixtures, if not immediately and completely administered (or witnessed) by the person who compounded the preparation, shall be properly labeled including:~~
        1. ~~Patient identification information~~
        2. ~~Names and amounts of all ingredients~~
        3. ~~Name of initials of the person who compounded the preparation~~
        4. ~~Exact one-hour beyond-use date and time~~

A. Generalities Regarding Preparation of CSPs
    1. Sterile compounding is defined as combining, admixing, diluting, pooling, reconstituting, repackaging, or otherwise altering a drug product or bulk drug substance to create a sterile preparation. While not an exhaustive list, the following CSPs are considered sterile preparations that may be compounded at DCHC:
        a. Injections
        b. Infusions
        c. Irrigations for internal body cavities
        d. Ophthalmic dosage forms
        e. Aqueous preparations for pulmonary inhalation
    2. The USP 797 regulation distinguishes three categories of CSPs: Category 1, Category 2, and Category 3, primarily based on the state of environmental control under which they are compounded, the probability of microbial growth during the time they will be stored, and the time period within which they must be used.
        a. Category 1 CSP - A CSP that is compounded under the least controlled environmental conditions and is, therefore, assigned a BUD of 12 hours or less at controlled room temperature or 24 hours or less refrigerated that is compounded in accordance with all applicable requirements for Category 1 CSPs in the USP 797 regulation. (At DCHC, a Category 1 CSP designation shall be applied to CSPs prepared within the ISO Class 5 PEC in our USP 800 C-SCA).
        b. Category 2 CSP - A CSP that is compounded under more stringent environmental controls and may, therefore, be assigned a BUD of greater than 12 hours at controlled room temperature or greater than 24 hours refrigerated that is compounded in accordance with all applicable

requirements for Category 2 CSPs in the USP 797 regulation. (At DCHC, a Category 2 CSP designation shall be applied to CSPs prepared within the ISO Class 5 PEC in our USP 797 cleanroom suite).

c. Category 3 CSP - A CSP that may be assigned a BUD exceeding the limits for Category 2 CSPs and is compounded in accordance with all applicable requirements for Category 3 CSPs in the USP 797 regulation. (At DCHC, we do not engage in compounding of any Category 3 CSPs as we do not prepare any CSPs with non-sterile starting ingredients and we do not perform any sterility testing on prepared products).

3. Immediate-Use CSPs - When all of the following conditions are met, compounding of CSPs for direct and immediate administration is not subject to the requirements of an above category in USP regulations and may be done outside of an ISO Class 5 PEC and respective controlled environment. (At DCHC, preparation of immediate-use CSPs is generally limited to times when the DCHC Pharmacy is closed and a pharmacist is thereby unavailable to prepare product within our controlled environments).

    a. Aseptic technique is strictly followed; the CSP is prepared in a clean, low-traffic area such as the med room; and the CSP is under continuous supervision to minimize potential contact of critical sites with non-sterile surfaces

    b. The preparation is performed in accordance with evidence-based information for physical and chemical compatibility of the drugs (e.g., approved labeling, stability and compatibility studies); DCHC has compatibility wall charts available in the Acute Care and ER med rooms; DCHC has Intravenous Medication reference books available in several departments, including Acute Care and ER for review as needed

    c. The preparation involves not more than 3 different sterile products

    d. Any unused starting component from a single-dose container must be discarded after preparation is completed

    e. Administration of the CSP must begin within 4 hours following the start of preparation or the CSP must be discarded

    f. Unless directly administered (or witnessed) by the person who prepared it, the CSP must be labeled with names and amounts of all active ingredients, initials of person who prepared it, and the 4 hour time period within which administration must begin

4. Docking and activation of proprietary bag and vial systems (e.g., Vial-Mate®, ADD-Vantage®, Mini-Bag Plus® and addEASE®) in accordance with the manufacturer's labeling for immediate administration to an individual patient is not considered compounding and may be performed outside of an ISO Class 5 environment. This activity should be conducted in a clean, low-traffic area such as the med room.

B. Roles and Responsibilities for Preparation of CSPs

1. DCHC must designate one or more individuals (i.e., the designated peron(s)) to be

responsible and accountable for the performance and operation of the facility and personnel in the preparation of CSPs.

a. DCHC's designated person shall be the pharmacy manager.

2. The designated person shall be specifically responsible for:

a. Maintaining compliance with USP 797 and USP 800 regulations, all applicable federal and state laws and accreditation standards

b. Creating and implementing a training program for personnel

i. Personnel who perform compounding of CSPs **PLUS** restocking/cleaning/disinfecting duties (e.g., pharmacists, certain pharmacy technicians) shall be initially trained and shall demonstrate knowledge and competency in compounding as well as maintaining the quality of the sterile compounding environment before being allowed to perform their respective job duties independently. Training shall be specific to each individual's role and the duties they perform. Training of the pharmacy manager (designated person) shall be conducted by staff from Goss Service Associates according to their established process and with supplies they provide. Training of additional DCHC staff members to perform sterile compounding shall be conducted by either the designated person (pharmacy manager) or staff from Goss Service Associates. When training is done by Goss Services Associates, documentation of training/competency is completed by their staff and a copy is provided to the pharmacy manager for file at DCHC. When training is done by the pharmacy manager, supplies will be provided by DCHC and the forms attached to this policy will serve to guide and document the training.

ii. Personnel who perform restocking/cleaning/disinfection duties **ONLY** (e.g., certain pharmacy technicians, environmental services technicians, etc.) shall be initially trained and shall demonstrate knowledge and competency in maintaining the quality of the sterile compounding environment before being allowed to perform their respective job duties independently. Training shall be specific to each individual's role and the duties they perform.

a. On January 21st, 2021, both the pharmacy manager (designated person) and the environmental services manager were trained and competency tested by Brian Kershner of Healthcare Solutions (now Goss Service Associates) in the proper garbing and cleaning within the USP 797 cleanroom suite and USP 800 C-SCA.

b. Either that pharmacy manager or that environmental services manager may train and assess competency of additional staff as needed to ensure that the above

named areas are cleaned according to our 'Cleanroom Suite, Segregated Compounding Area and Primary Engineering Control Maintenance' policy.

iii. Visitors (e.g., certifiers, inspectors, vendors, students, etc.) shall be escorted and overseen by the designated person or designee while in the pharmacy department and any controlled environment; They will be expected to comply with all aspects of the sterile compounding program at DCHC (e.g., hand hygiene, garbing, conduct, etc.) They will be assisted through the complete hand hygiene and garbing process by either the designated person or a trained and qualified staff member (designee).

c. Ensuring standard operating procedures (SOPs) and/or policies are fully implemented, and that action is taken if problems, deviations, or errors are identified.

C. Training Program for Personnel Competency

1. Personnel who perform compounding of CSPs **PLUS** restocking/cleaning/ disinfecting duties (e.g., pharmacists, certain pharmacy technicians) shall be trained and evaluated according to the following chart:

Topic of Training	**Description of Required Training**	**Process for Evaluating Knowledge/ Competency**	**Frequency of Training/ Assessment**
Appropriate Knowledge/ Understanding of USP 797 (and USP 800, if applicable to the employee's assigned duties)	Didactic discussion and demonstration regarding the principles involved in sterile compounding; Reading/Review of USP 797 (and USP 800, if applicable to the employee's assigned duties)	Didactic Test of Knowledge and Competency in Sterile Compounding (see attached) Must answer ≥ 80% correctly to pass	every 6 months
Proper Garbing	Before beginning to compound Category 1 or Category 2 CSPs or have direct oversight of compounding personnel, the	Form for Assessing Hand Hygiene and Garbing of Compounding Personnel + Form for Assessing Gloved Fingertip	every 6 months

	employee must successfully complete an initial garbing competency evalution no fewer than 3 separate times, in succession. The garbing competency evaluation consists of a visual observation and gloved fingertip and thumb sampling (GFT) of both hands. GFT sampling after garbing, but before applying sterile 70% IPA to gloves, must be performed on donned sterile gloves on both hands in a classified area or SCA. After the initial successful GFT x 3, subsequent GFT evaluations must be performed after a media-fill test on both hands inside of an ISO Class 5 PEC. If conducting gloved fingertip and thumb sampling in a CAI, CACI, or a	Sampling of Compounding Personnel (see attached) Must result in 0 cfu total to pass initial garbing competency 3 times; Must result in 3 or fewer cfu total to pass subsequent GFT assessments	

	pharmaceutical isolator, samples must be taken from the sterile gloves placed over the gloves attached to the isolator sleeves.		
Proper Aseptic Technique	Before beginning to compound Category 1 or Category 2 CSPs independently or have direct oversight of compounding personnel, the employee must successfully complete an aseptic manipulation competency evaluation. The aseptic manipulation competency evaluation consists of a visual observation, media-fill testing, followed by a gloved fingertip and thumb sampling on both hands, and surface sample of the direct compounding area to assess aseptic technique and related practices.	Form for Assessing Aseptic Technique of Compounding Personnel (see attached) Failure of media-fill testing is indicated by visible turbidity or other visual manifestations of growth in the media in one or more container closure unit(s) on or before the end of the incubation period. Microbial identification of the cfu is not required for media-fill testing.	every 6 months

Proper Cleaning	The cleaning competency consists of discussion of USP 797 and USP 800 regulations and the resultant need for proper deactivation, decontamination, cleaning and disinfection as well as demonstration by the trainer of appropriate cleaning techniques and movements followed by visual observation of the employee in proper hand hygiene, garbing and cleaning practices within the USP 797 cleanroom suite. If the employee will be cleaning in the USP 800 C-SCA, additionally they will talk through with the trainer the additional activities that would be required in that space.	Form for Assessing Cleaning Competency (see attached)	whenever changes are made to the 'Cleanroom Suite, Segregated Compounding Area and Primary Engineering Control Maintenance' policy or if the employee goes > 1 year without performing USP 797 or USP 800 related cleaning duties

2. Personnel who perform restocking/cleaning/disinfection duties **ONLY** (e.g., certain pharmacy technicians, environmental services technicians, etc.) shall be trained and evaluated according to the following chart:

Topic of Training	Description of Required Training	Process for Evaluating Knowledge/ Competency	Frequency of Training/ Assessment
	The cleaning competency consists of discussion of USP 797 and USP 800 regulations and the resultant need for proper deactivation, decontamination, cleaning and disinfection as well as demonstration by the trainer of appropriate cleaning techniques and movements followed by visual observation of the employee in proper hand hygiene, garbing and cleaning practices within the USP 797 cleanroom suite. If the employee will be cleaning in the USP 800 C-SCA, additionally they will talk through with the trainer the additional activities that would be required in that space.	Form for Assessing Cleaning Competency (see attached)	whenever changes are made to the 'Cleanroom Suite, Segregated Compounding Area and Primary Engineering Control Maintenance' policy or if the employee goes > 1 year without performing USP 797 or USP 800 related cleaning duties

D. Prior to Preparation of CSPs (including Hand Hygiene and Garbing)

1. Individuals entering a compounding area must be properly garbed and must maintain proper personal hygiene to minimize the risk of contamination to the environment and/or CSPs.
2. Individuals that may have a higher risk of contaminating the CSP and the environment (e.g., personnel with rashes, recent tattoos, oozing sores, conjunctivitis, or active respiratory infections) must report these conditions to the designated person. The designated person is responsible for evaluating whether these individuals should be excluded from working in compounding areas before their conditions have resolved because of the risk of contaminating the CSPs and the environment.
3. Before entering a compounding area, individuals must remove any items that are not easily cleanable or are not necessary for compounding. At a minimum, individuals

must:

a. Remove personal outer garments (e.g., bandanas, coats, hats, jackets, sweaters, vests)

b. Remove all cosmetics because they shed flakes and particles

i. Cosmetics may be worn within the main pharmacy area but must be removed by personnel prior to entering the USP 797 cleanroom suite or the USP 800 C-SCA

c. Remove all hand, wrist, and other exposed jewelry, including piercings that could interfere with the effectiveness of garbing (e.g., the fit of gloves, cuffs of sleeves, and eye protection) or otherwise increase the risk of contamination of the CSP. Cover any jewelry that cannot be removed.

d. Not wear earbuds or headphones

e. Not bring electronic devices that are not necessary for compounding or other required tasks into the compounding area

f. Keep nails clean and neatly trimmed to minimize particle shedding and avoid glove punctures. Nail products (e.g., polish, artificial nails, and extenders) must not be worn.

g. Wipe eyeglasses, if worn

h. Tie back long hair so that it can be fully covered by a head cover

4. The designated person may permit accommodations to personnel preparation as long as the quality of the CSP and environment will not be affected. Accommodations must be documented.

5. The order of garbing to enter our USP 797 cleanroom suite is as follows:

a. Mask

b. Beard cover, if applicable

i. Even individuals with goatee-type beards must done a standard beard cover over the facemask.

c. Head cover

d. First shoe cover (step first foot over line of demarcation)

e. Second shoe cover (step fully over line of demarcation)

f. Wash hands

i. Any person entering a compounding area where Category 1, Category 2, or Category 3 CSPs are prepared must wash hands and forearms up to the elbows with soap and water before initiating compounding activities. Brushes must not be used for hand hygiene. Hand dryers must not be used.

ii. The proper hand washing procedure is as follows...

a. Clean underneath fingernails under warm running water using a disposable nail cleaner

b. Wash hands and forearms up to the elbows with soap and water for at least 30 seconds

c. Dry hands and forearms up to the elbows completely with low-lint disposable towels or wipers

g. Gown

h. Non-sterile gloves

i. Enter cleanroom

j. Hand sanitizer (over non-sterile gloves)

i. The proper hand sanitizing procedure is as follows...

a. Apply an alcohol-based hand rub

b. Apply product to one hand and rub hands together, covering all surfaces or hands and fingers, until hands are dry

c. Allow hands to dry thoroughly before proceeding

k. Just before any item is introduced into the PEC, it must be wiped with sterile 70% IPA using a low-lint wiper and allowed to dry before use. When sterile items are received in sealed containers designed to keep them sterile until opening, the sterile items may be removed from the covering as long as the supplies are introduced into the ISO Class 5 PEC without the need to wipe the individual sterile supply items with sterile 70% IPA. The wiping procedure must not render the product label unreadable.

l. Cotton glove liners, if desired

i. Following an appropriate garbing, hand washing and hand sanitizing procedure as detailed above, compounding personnel may choose to don cotton glove liners. These liners are to be worn on the outside of the LFGI but within the glove ports. They do not have to be sterile and may be reused. They shall be replaced periodically whenever needed.

m. Sterile gloves (placed over the gauntlet gloves of the LFGI, prior to compounding)

i. After placing hands/arms inside the glove port sleeves of the LFGi, compounding personnel shall don appropriately sized sterile gloves over the gloves attached to the glove port sleeves ensuring that there is a tight fit with no excess glove material at the fingertips.

a. Personnel shall examine all gloves to ensure that there are no defects, holes, or tears. If any breaches are identified, hand cleansing shall be repeated and gloves replaced.

b. While engaging in sterile compounding activities, personnel shall routinely disinfect gloves with sterile

70% IPA prior to work in the direct compounding area (DCA) and after touching items or work surfaces that may contaminate gloves.

6. The order of garbing to enter our USP 800 C-SCA is as follows:
    a. Mask
    b. Beard cover, if applicable
    c. Head cover
    d. Wash hands
    e. Chemo gown
    f. First pair of shoe covers
    g. Second pair of shoe covers
    h. Chemo gloves (ASTM standard D6978 certified, non-sterile)
    i. Goggles for eye protection (when cleaning a spill)
    j. Enter C-SCA room
    k. Sterile chemo gloves (placed over the gauntlet gloves of the LFGI, if compounding)
    l. Second pair of non-sterile chemo gloves (if cleaning only)
7. Doffing of Garb
    a. Removal of compounding garb shall occur in a similar reverse order to original donning.
    b. After exiting the buffer room, the gown may be removed and hung on the edge of the shelving rack in the anteroom. The gown may be reused within the same shift by the same person if the gown is maintained in the anteroom and is store in a manner that prevents contamination.
    c. All other garb cannot be reused and must be discarded by personnel on the 'dirty' side of the anteroom.
8. Generalities Regarding Garbing
    a. Gowns and garb must be stored in a manner that minimizes contamination (E.g., away from sinks to avoid splashing).
    b. Garb must be replaced immediately if it becomes visibly soiled or if its integrity is compromised.

E. During Preparation of CSPs
1. Prior to entry into the USP 797 cleanroom suite or USP 800 C-SCA, all materials necessary to prepare the ordered CSP should be gathered to minimize the need to exit and reenter the space.
2. Components and supplies should be checked for the following:
    a. Expiration date

b. Inappropriate changes in color or appearance
c. Particulate matter
d. Cloudiness, if abnormal
e. Leakage or packaging defects that could impact the integrity of the CSP
i. Components should not be used for compounding if any of the above are found

3. Prior to moving components into the direct compounding area of the PEC, personnel should spray gloved hands with sterile IPA and allow them to dry and spray the direct compounding area with sterile IPA, wipe with a low-lint wipe and allow to dry.
a. The spray of sterile IPA (or any other agent) should never be directed towards the HEPA filter.

4. Components necessary for compounding may then be moved into the direct compounding area.
a. Items should be arranged inside the PEC so that they are all receiving first air.

5. Once all materials have been transferred to the PEC, personnel should spray their gloved hands again and allow to dry.
a. Sterile gloves may be donned (as discussed above) when the gauntlet gloves have dried.

6. Critical sites (e.g., vial stoppers, ampule necks, and intravenous bag septums) must be wiped with sterile 70% IPA in the PEC to provide both chemical and mechanical actions to remove contaminants. The sterile 70% IPA must be allowed to dry before personnel enter or puncture stoppers and septums or break the necks of ampules.

7. During preparation of all CSPs, compounding personnel shall adhere to the following principles of aseptic technique:
a. Do not interrupt, impede, or divert flow of first-air to critical sites
b. Ensure syringes, needles, and tubing remain in their individual packaging and are only opened in the ISO Class 5 work area
c. Perform manipulations only within the direct compounding area of the ISO Class 5 device
d. Do not expose critical sites to contact contamination or worse than ISO Class 5 air
e. Disinfect vial stoppers, ampule necks, and intravenous bag septums by wiping with sterile 70% IPA as described above
f. Affix needles to syringes without contact contamination
g. Puncture vials stoppers and spike infusion ports without contact contamination
h. Disinfect sterile gloves routinely by wiping with sterile 70% IPA during prolonged compounding manipulations

i. Dispose of sharps and waste according to institutional policies and recognized guidelines

F. After Preparation of CSPs

1. When compounding is complete, personnel shall remove the sterile gloves within the isolator and discard with other items to be disposed. They shall remove their hands/ arms from the glove port, remove cotton glove liners, if used, and apply hand sanitizer prior to retrieving the finished CSP product(s) from the purge chamber.
    a. They may exit the buffer room and doff garb (as described above) and exit the anteroom to return to the main pharmacy for final inspection of the product.
2. Before release and dispensing, the CSP must be visually inspected to determine whether the physical appearance of the CSP is as expected (e.g., free of inappropriate visible particulates or other foreign matter, discoloration, or other defects).
    a. When a CSP has been prepared by a pharmacy technician, the finished product along with the empty containers of any ingredients used to prepare the product will be left for final check by the pharmacist prior to dispense
3. The CSP label must be visually inspected to confirm that the CSP and its labeling match the prescription or medication order and a BUD must be assigned according to our 'Assigning Beyond-Use Dates to Compounded Preparations' policy.
    a. Category 1, Category 2, and Category 3 CSPs must be labeled with appropriate, legible, identifying information to prevent errors during storage, dispensing and use.
    b. For technician prepared CSPs, the pharmacist checking the finished product shall initial the label and assign an appropriate BUD.
4. The inspection also must include a visual inspection of container closure integrity (e.g., checking for leakage, cracks in the container, or improper seals).
5. Any CSP found to be of unacceptable quality (e.g., observed defects) must be promptly rejected, clearly labeled as rejected, segregated from active stock to prevent use, and ultimately discarded according to facility policies.
6. A compounding record documents the compounding of each CSP. A compounding record must be created for all Category 1, Category 2 and Category 3 CSPs and for immediate use CSPs prepared for more than one patient.
    a. DCHC Pharmacy does not engage in compounding of Category 3 CSPs or immediate use CSPs for more than one patient. Therefore, our compounding record shall be used to document Category 1 and Category 2 CSPs only.
    b. The compounding record shall include the following:
        i. Date/time of preparation
        ii. Rx#

iii. Pharmacist initials

iv. Date/time of dose

v. BUD assigned to the CSP

vi. List of each ingredient with:

a. Name/strength

b. NDC

c. Manufacturer lot#

d. Manufacturer expiration date

e. Quantity utilized

vii. An indication of whether or not a refrigerate sticker was affixed to the product to indicate that it should be stored in the refrigerator

viii. Notation of any additional special handling labels affixed

a. For technician prepared CSPs, the compounding record shall also include a detailed listing of each step taken during the compounding process and each step shall be initialed by the preparer and the checking pharmacist

7. A master formulation record (MFR) is a detailed record of procedures that describe how the CSP is to be prepared. An MFR must be created for all CSPs prepared from nonsterile ingredient(s) or CSPs prepared for more than one patient.

a. DCHC Pharmacy does not engage in preparation of CSPs from nonsterile ingredients nor in the preparation of CSPs for more than one patient. Therefore, an MFR is not required.

Attachments

Didactic Test of Knowledge and Competency in Sterile Compounding.docx

Form for Assessing Aseptic Technique 030123.docx

Form for Assessing Cleaning Competency.docx

Form for Assessing Gloved Fingertip Sampling 030123.docx

Form for Assessing Hand Hygiene and Garbing 042123.docx

Media Fill Procedure 022823.docx

Approval Signatures

Step Description	Approver	Date
CAH	CAH: DCHC Critical Access Hospital Committee	Pending
Medical Director	Sarah Brewer: Internal Medicine, DO	02/2024
Senior Leader	Nikki Thordarson: CNO	02/2024
	Wendy Barker: Pharmacy Manager	01/2024

Applicability

Davis County Hospital

Revised Policies

Title	Policy Area	Summary of Changes	Revised?
Policy Development and Approval Process	Administration	Updated to current process used. Deleted requirement for filling out a separate spreadsheet outside of policy management system. Non-clinical approval workflow updated to reflect current build (Manager, Senior Leader, CAH and BOT). No policy statement changes.	Revised
Provision of Service	Administration	Changed biomed company to GE. Revised current service lines offered (removed derm, added pain, general surgery). No policy statement changes.	Revised
Break Time for Nursing Mothers	Human Resources	updated step #2.	Revised
Leaves of Absences Other Than Family/Medical Leaves	Human Resources	clarified when IA Pregnancy & PTO will run concurrently under the Pregnancy Leave section of policy	Revised
Termination of Employment	Human Resources	added language to clarify that entire monthly premium for benefits will be deducted from employee's check. Depending on when the employee terminates- this might mean that the entire amount will be deducted from one paycheck.	Revised
Travel and Training Compensation	Human Resources	updated procedure for hospital requested	Revised
Bloodborne Pathogens Exposure Control Plan	Infection Prevention	Omitted sentence stating list of specific safe sharps in use, dates of implementation & approved exemptions available from IP coordinator.	Revised
Initiation of Isolation and Precautions	Infection Prevention	Reference to Kardex updated to EHR Updated link to CDC Guidelines for Isolation Precautions Removed table with information on Type & Duration of Precautions for Selected Infections and Conditions and replaced with link to CDC page with this information.	Revised

Respirator Protection Plan	Infection Prevention	Information about reuse of N95s updated to refer to following CDC guidelines of reuse in times of critical shortages.	Revised
Standard Precautions	Infection Prevention	Information about HIV/HBV testing omitted. Content of CareLearning bloodborne pathogen class updated Reference to annual written evaluations of compliance with standard precautions omitted	Revised
Tuberculosis Exposure Control Plan	Infection Prevention	*omitted paragraph ranking importance of control measures--it did not seem to provide any useful information *added room number (1) to negative pressure room in ER	Revised
SOP-Pet Visitation	Infection Prevention	added specification that animal waste must be placed in an outdoor trash can	Revised
Surveillance Program Cultures	Infection Prevention	Omitted step #2 and added instructions that drains should not be cultured to step 1.	Revised
Suspected IV Associated Infection	Infection Prevention	Added removal of IV and send catheter tip for culture with suspected IV infections.	Revised
File Maintenance of Health Care Professionals Certificates	Medical Staff	No changes.	Revised
Assigning Beyond-Use Dates to Compounded Preparations	Pharmacy	Revised to adhere to USP 797 and USP 800 regulations	Revised
Severe Weather and Tornado Watch/Warning Plan	Safety and Security	Body of procedure re-written to condense and make more user friendly. Policy statement did not change.	Revised
Emergent Dental Care	Utilization Review	Updated dentist that DCHC has agreement with due to local dentist office closing.	Revised
Definitions	Sleep Lab	definitions added.	Revised
Disasters during a Sleep Study (SomniTech policy)	Sleep Lab	Typo's fixed.	Revised

Unchanged Policies

Title	Policy Area	Revised?
CEU (continuing education unit) credit programs	Education	Unchanged
Continuing Education Attendance	Education	Unchanged
Employee Reaction to Latex	Employee Health	Unchanged
Protocol for Managers of Employees with Latex Allergy	Employee Health	Unchanged
Antibiotic Resistant Bacteria	Infection Prevention	Unchanged
Positive Results of Blood Borne Pathogen Testing	Infection Prevention	Unchanged
Speaking to the Media	Marketing	Unchanged
Sponsorship	Marketing	Unchanged
Consent for Treatment	Medical Staff	Unchanged
Consultations	Medical Staff	Unchanged
Credential Process	Medical Staff	Unchanged
Expedited Credential and Privileging Process	Medical Staff	Unchanged
Hospital Admissions, Discharges, and Transfers	Medical Staff	Unchanged
Order for Treatment	Medical Staff	Unchanged
Patient Death	Medical Staff	Unchanged

Persons Employed By a Privileged Practitioner (PEPPs) Who are Authorized to Perform Duties at Davis County Hospital	Medical Staff	Unchanged
Primary Coverage for Emergency Care	Medical Staff	Unchanged
Renewal of Healthcare Professional's Licenses and Certifications	Medical Staff	Unchanged
Review of Credential Application	Medical Staff	Unchanged
Telehealth Emergency	Senior Life Solutions DCHC	Unchanged
Emergency CPAP Protocol	Sleep Lab	Unchanged
Monthly Staff Education and Training for SomniTech	Sleep Lab	Unchanged
MWT Study	Sleep Lab	Unchanged
PM (Portable Monitoring)/ HST (Home Sleep Testing)	Sleep Lab	Unchanged
SomniTech Equipment Inspection	Sleep Lab	Unchanged
SomniTech Monthly Meetings	Sleep Lab	Unchanged
SomniTech Records	Sleep Lab	Unchanged
Staffing (SomniTech Policy)	Sleep Lab	Unchanged
Universal Precautions and Bloodborne Pathogens (SomniTech Policy)	Sleep Lab	Unchanged