Board of Trustees March 21, 2022

New Policies / Revised Policy Statements / Biennial Reviews
Action

New Policy

- **Behavior/Mental Health**
  - **Telehealth Emergency**
- **Employee Health**
  - **COVID 19 Vaccination Policy**
- **Health Information**
  - **PRN/Casual Health Information Management Staff**
- **Human Resources**
  - **Weekend Staffing Package VI**
- **Laboratory**
  - **Blood Bank- New Processes & Procedures**
  - **Blood Bank Record Retention**
- **Physicians Clinic**
  - **COVID 19 HERSA Test Kits**
- **Safety & Security**
  - **Severe Weather & Tornado Watch/Warning Plan**

Revised Policy Statements

- **Sleep Lab**
  - **Monthly Staff Education & Training for Somnitech**
  - **MWT Study**
  - **Disasters During a Sleep Study (Somnitech Policy)**
  - **Emergency CPAP Protocol**
  - **Universal Precautions & Bloodborne Pathogens (SomniTech Policy)**

Biennial Reviews

- **Education**
- **Marketing**
- **Medical Staff**
- **Utilization Review/ Plan**

Current Status: *Pending* **PolicyStat ID:** *11240652*

Davis County HOSPITAL & CLINICS

An Affiliate of MERCYONE

Origination:	*N/A*
Effective:	*Upon Approval*
Last Approved:	*N/A*
Last Revised:	*N/A*
Next Review:	*2 years after approval*
Owner:	*Rhonda Roberts: SLS Program Director*
Policy Area:	*Behavioral/Mental Health*
Standards & Regulations:	
References:	
Applicability:	*Davis County Hospital*

Telehealth Emergency

Procedure:

- All Outpatient Hospital Psychiatric Services Programs will follow hospital policy with regard to emergencies within the Senior Life Solutions unit.

Policy:

- Measures will be implemented to ensure the safety and well-being of patients in a group room setting in which the therapist is providing teletherapy from an off-site location.
- When possible, in the case of a therapist providing teletherapy remotely, there will be a Senior Life Solutions (SLS) staff member in close enough proximity to the group room to hear a call for assistance.
- Any therapist who is off-site providing group therapy via telehealth, with patients physically present in a SLS group room, will have the following phone numbers available: The SLS program phone, the Program Director's cell phone, and the Office/Patient Coordinator's cell phone.
- Where possible, there shall be cameras in the group room whereby the on-site staff may be able to perceive an emergency. Similarly, an on-site staff member may join in the virtual meeting, muted and with computer volume down. In either of these scenarios, confidentiality will be respected, and HIPAA regulations shall not be violated.
- In the event the therapist perceives the threatened safety of a patient (including, but not limited to, choking or other medical emergency, aggressive behavior, patients(s) refusing to physically stay within the scope of the teletherapy camera), the therapist will engage in any or all of the following actions as deemed appropriate?

1. Therapist shall immediately call the staff phone numbers listed above, until a staff member is reached and advised of the situation.
2. Therapist will advise a patient to pull the emergency assistance cord or press the call button, depending on safety equipment installed in the group room. He/She may also advise an ambulatory patient to exit the group room and solicit assistance. It should be decided upon and clearly communicated ahead of time which patients will be responsible for providing these interventions in an emergent situation.
3. The SLS staff member reached by phone or summoned by call button will enter the group room and provide assistance or intervention as needed.
4. Therapist or other staff member will call 911 at any point in the process if deemed necessary.
5. Therapist will remain on teletherapy, visible to the patients, and shall provide therapeutic measure in an

attempt to calm other group members in the room or intervene in the situation as he/she is able until help arrives.

Attachments

No Attachments

Approval Signatures

Step Description	Approver	Date
CAH	Nikki Thordarson: CNO	pending
Medical Director- Nina Jordania, MD	Carleena Brown: Clinic Director	02/2022
Senior Leader	Carleena Brown: Clinic Director	02/2022

Applicability

Davis County Hospital

Davis County HOSPITAL & CLINICS

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Last Revised:	*N/A*
Next Review:	*N/A*
Owner:	*Amy Tyson: Education/Infection Prevention/Wellness*
Policy Area:	*Employee Health*
Standards & Regulations:	
References:	
Applicability:	*Davis County Hospital*

COVID-19 Vaccination Policy

COVID-19 Vaccination Policy for Davis County Hospital & Clinics

PURPOSE:

The purpose of this policy is to protect staff, non-employees, patients, and families from acquiring COVID-19 and to help prevent the unnecessary spread of the SARS-COV-2 (COVID-19) virus between employees, non-employees, patients, and families. This is accomplished through the requirement that all health care personnel at Davis Co Hospital & Clinics (DCHC) receive COVID-19 vaccination unless an exemption is granted.

POLICY:

Participation in Davis County Hospital and Clinic's (DCHC) COVID-19 immunization program is mandatory. All contractors, students or other individual serving at DCHC will be required to provide the proof listed below. All providers, staff and volunteers employed by DCHC will be required to do one of the following:

- Receive a COVID-19 vaccination
- Provide proof of immunization. This may be a signed physician's note, immunization record that is dated and signed or a medical record document.
- Submit a medical or religious exemption Form. (see attachment). If submitting medical exemption, take the form to your provider and for religious exemption return the form to human resources.

PROCEDURE:

Individuals may request a Medical or Religious exemption to this requirement based on:

- Medical contraindication to the COVID-19 vaccine, which requires a signed statement from the individual's healthcare provider and identification of the reason
- A sincerely held religious belief that prohibits you from receiving covid-19 vaccine. Religious exemption must be renewed annually.

Medical exemption examples include life threatening allergy. Acute fever, acute respiratory infections or active illness must be resolved prior to receiving covid-19 vaccination.

All reasonable exemption requests must be submitted to Human Resources by the designated date.

The individual requesting the exemption will be notified in writing as to whether his/her request for exemption has been granted. If an exemption request is denied, the individual will be required to be immunized pursuant

to this policy.

Medical or Religious exemption does not exempt the individual from the COVID-19 prevention program, but rather is an alternate method of compliance in place of the COVID-19 vaccine.

All individuals not receiving the COVID-19 vaccine and granted an exemption will be required to adhere to additional safety precautions as indicated by CDC and CMS. Additional safety precautions may include testing for covid-19 and wearing a NIOSH approved N95 or equivalent or higher-level respirator for source control, regardless of whether they are providing direct care to or otherwise interacting with patients. The mask must be worn at all times with exceptions of breaks and mealtimes. Individuals will be required to maintain social distancing during times the mask would be removed such as eating/drinking. The mask should fit snugly and be secured to the face. The mask should be discarded and changed, at a minimum, at the end of the shift and immediately if it becomes soiled or moist.

Documentation

Employee Health will track vaccination status.

All new employees will provide proof of covid-19 vaccination or request an exemption prior to the start of employment.

Employee Health will notify managers of staff that have received an approved exemption. Managers will ensure that staff with approved exemption comply with additional mitigation measures.

Attachments

Covid Religious Exemption Request
Medical Exemption or Deferral

Applicability

Davis County Hospital

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Request for a religious exception to the COVID-19 Vaccination Requirement

On November 5, 2021, CMS released the interim final regulations requiring COVID-19 vaccination of eligible staff at healthcare facilities that participate in the Medicare and Medicaid programs. The purpose of this form is to start the accommodation process and help Davis County Hospital & Clinics to determine whether you may be eligible for a religious exception. You do not need to answer every question on the form to be considered for a religious exception, but we encourage you to provide as much information as possible to enable the agency to evaluate your request. Where there is an objective basis to do so, you may be asked for additional information as needed to determine if you are legally entitled to an exception. Objections to COVID-19 vaccinations that are based on non-religious reasons, including personal preferences or non-religious concerns about the vaccine, do not qualify for a religious exception.

Signing this form constitutes a declaration that the information you provide is, to the best of your knowledge and ability, true, and correct. I understand that my director and/or supervisor will be notified of my exemption and that I must wear an isolation mask or other identified PPE while at work. I consent to the release of this request including any supporting documentation to all such representatives of Davis County Hospital & Clinics, for the representatives to carry out their duties and to act on my request for an exemption.

Please return this form to Human Resources

To be completed by employee:

I request an exemption from the COVID-19 immunization based on a sincerely held religious belief that prohibits me from receiving the COVID-19 vaccine. Please provide documentation to the questions stated below:

1. Please describe the nature of your objection to the COVID-19 vaccination requirement.
2. Would complying with the COVID-19 vaccination requirement substantially burden your religious exercise or conflict with your sincerely held religious beliefs, practices, or observances? If so, please explain how.
3. Please provide any additional information that you think may be helpful in reviewing your request. For example:
    - How long have you held the religious belief underlying your objection?
    - Whether your religious objection is to the use of all vaccines, COVID-19 vaccines, a specific type of COVID-19 vaccine, or some other subset of vaccines
    - Whether you have received vaccines as an adult against any other diseases (such as a flu vaccine or a tetanus vaccine

I declare to the best of my knowledge and ability that the foregoing is true and correct.

Signature: _____ Date: _____

RETURN TO HUMAN RESOURCES

Medical Exemption or Deferral from COVID -19 Vaccination

I am requesting an exemption on the basis of a medical contraindication that prohibits vaccination for COVID-19 or a deferral due to a temporary medical condition. I understand that my director and/or supervisor will be notified of my exemption and that I must wear an isolation mask or other identified PPE while at work. I consent to the release of this request including any supporting documentation to all such representation of Davis County Hospital & Clinics, in order for the representatives to carry out their duties and to act on my request for an exemption. All requestion for exemption due to a medical contraindication or deferral due to a temporary medical condition are subject to review and approval by a designated exemption committee. *Return the completed for to Human Resources.*

Employee Name: **Date of Birth:**

Employee Signature_____ Date_____

Healthcare Provider's Statement of Exemption or Temporary Deferral

The above-named individual is a patient of min and should be considered either exempt from receiving the COVID-19 vaccine due to a medical contraindication as identified by the Centers for Disease Control and Prevention (CDC) or deferred from receiving the COVID-10 vaccine due to a temporary medical condition.

Please provide at least the following information, where applicable:

1. The applicable contraindication or precaution for COVID 19 vaccination, and for each contraindication or precaution, indicate: (a) whether is it recognized by the CDC pursuant to its guidance; and (b) whether it is listed in the package insert or Emergency Use Authorization fact sheet for each of the COVID -19 vaccines authorized or approved for use in the United States;
2. A statement that the individual condition and medical circumstances relating to the individual are such that COVID-19 vaccination is not considered safe, indicating the specific nature of the medical condition or circumstances that contraindicate immunization with a COVID -19 vaccine or might increase the risk for serious adverse reaction; and
3. Any other medical condition that would limit the employee from receiving any COVID-19 vaccine.

Description of the medical condition for which the employee listed above should be excepted from complying with the COVID -19 vaccination requirement.

The condition described above is: _____Temporary _____Long Term

If this is a temporary condition or medical circumstance, when is it expected to end or expire (allowing for COVID-19 vaccination to begin after the date you provided):

Medical Provider Name/Title:

Medical Provider Signature: _____ Date: _____

The following are not considered medical contraindications on COVID-19 vaccination: allergic reactions to oral medications (including the oral equivalent of an injectable medication); history of food (including eggs and gelatin), pet, insect, venom, environmental, latex, etc., family history of allergies; delayed onset local reaction after receiving first does of the mRNA COVID19 vaccine, pregnancy, breastfeeding or other infertility treatments. Individuals with a contraindication to one type of the vaccine may be considered for vaccination with the other(s).

References: Centers for Disease Control and Prevention. Interim Clinical Consideration for Use of COVID-19 Vaccines Currently Authorized in the United States. https://www.cdc.gov/vaccines/covid-19/clinical-considerations/covid-19-vaccines-us.html

RETURN TO HUMAN RESOURCES

Current Status: *Pending* **PolicyStat ID:** *11239775*

Davis County HOSPITAL & CLINICS

An Affiliate of MERCYONE

Origination:	*N/A*
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Last Revised:	*N/A*
Next Review:	*2 years after approval*
Owner:	*Lissa Jarr: Health Information Management Manager*
Policy Area:	*Health Information Management*
Standards & Regulations:	
References:	
Applicability:	*Davis County Hospital*

PRN/Casual Health Information Management Staff

PURPOSE

Davis County Hospital and Clinics recognizes that not every person can commit to a full-time or part-time status but still desires employment. The PRN status allows the employee to work as their schedule allows while meeting the needs of DCHC.

PROCEDURE

Casual employees are those who work on occasion, as needed, and may or may not work a regular schedule. These employees may be fully remote, hybrid, or totally in-house if the situation allows.

Casual employees do not receive employee benefits unless otherwise required by law.

PRN employees must work a number of required shifts per year, as agreed upon between the employee and the manager.

PRN employees are not protected by the disciplinary policy.

A PRN relationship can be terminated by either the employee or employer without notice or cause.

Inability of the PRN staff member to work 4 consecutive requests or 4 requests in a 12 month period will be considered a voluntary resignation.

PRN staff may from time to time have mandatory meetings to attend and will complete all required Care Learning education modules set forth by the employee education coordinator. The HIM Manager will make every effort to inform the PRN employee well in advance to allow for their schedule to permit them to successfully meet any required meeting obligations.

Attachments

No Attachments

Approval Signatures

Step Description	Approver	Date
CAH	Nikki Thordarson: CNO	pending
Senior Leader	Kendra Warning: CFO	02/2022
	Lissa Jarr: Health Information Management Manager	02/2022

Applicability

Davis County Hospital

Davis County HOSPITAL & CLINICS

An Affiliate of MERCYONE

Origination:	*N/A*
Effective:	*Upon Approval*
Last Approved:	*N/A*
Last Revised:	*N/A*
Next Review:	*2 years after approval*
Owner:	*Pam Young: Human Resources Director*
Policy Area:	*Human Resources*
Standards & Regulations:	
References:	
Applicability:	*Davis County Hospital*

Weekend Staffing Package VI

PURPOSE:

Listed below are important points we want you to be aware of and agree to pertaining to the Weekend Staffing Package VI (WSP VI). Please read the following statements carefully.

A. WSP VI staffing schedules will consist of 3 (12) twelve-hour shifts worked between Friday, Saturday, Sunday and Monday - 4 out of 5 weekends to be eligible. Positions must have administrative approval prior to implementation. Scheduling exceptions may be based on departmental needs (i.e., Monday versus Friday). Administrative approval must be sought for exceptions.

B. Covered hours for the WPS VI include from 07:00 a.m. Friday to 7:00 a.m. Tuesday.

C. Weekend staffing employees will be expected to work holidays that occur on weekends. Requests will not be accepted for weekends off in which holidays occur.

D. WSP VI employees are eligible for every 5th weekend off. The 5th weekend is unpaid unless an employee "cashes out" PTO. PTO cashed out to cover these weekends will be paid out at weekend premium rate. With Manager approval, the employee would also have the option of working alternate days through the week on the 5th week.

E. All time off/ PTO request must be approved by manager prior to schedule finalization. PTO accrued will be used to cover any unscheduled absences.

F. PTO accrued may also be used to cover medical expenses at Davis County Hospital or sold back. See policy HR025 for further details. PTO paid out at end of employment or cashed out (other than for the shifts noted above in D) will be paid out at the employee's regular base rate of pay.

G. If the employee works on the 5th weekend, they will receive the weekend package rate.

H. WSP VI employees may be subject to low census staffing and mandatory staff reductions. Low census shifts will be counted towards the required 4 out of 5 weekends. Employee will be paid only for weekend hours worked, compensated at weekend premium rate of pay. Low census hours will be paid utilizing PTO at premium rate of pay, if the employee chooses PTO.

I. Unscheduled absence/illness: 2 unscheduled absences (shifts) due to illness will be allowed to be made up each calendar year. These shifts must be made up within the next 30 days on a shift that has a need. If made up they will not count towards the allotted weekends off, but still count towards the hospital's outlined attendance policy. If not made up, it will be applied to your allotment of time off. PTO accrued will be used to cover any unscheduled absences not made up (paid at premium rate of pay)

J. WSP VI employees will be expected to attend general orientation, designated in-services and staff meetings. Attendance at meetings will be paid at base rate of pay for that department. Also, additional shifts worked (weekday shifts) will be paid at regular base rate of pay.

K. Those employees agreeing to work 4 out of 5 weekends per year will be classified as full time employees and are eligible for benefits as specified on the HR non-exempt benefit chart.

L. WSP VI employees who request to transfer to a different shift or unit are required to follow the job posting policy.

M. If at any point Davis County Hospital wishes to change or discontinue the WPS VI or the employee wishes to terminate participation or transfer into the program, a minimum of 28 calendar days written advanced notice is required.

N. Davis County Hospital will not be responsible for the provision of overnight accommodations. WSP VI employees will be responsible for arranging, securing, and paying for overnight accommodations.

O. **Reimbursement: Premium pay is granted to those individuals who qualify and agree to work the Weekend Staffing program. Premium pay is calculated as follows:**

P. **Weekend Rate:** Regular base pay rate plus 25% per hour (weekend premium) and applicable shift differential.

Q. **Weekday Rate:** Regular base pay rate per hour and applicable shift differential.

- We are required by the FLSA to blend all compensation earned in the pay period into the hourly rate, this includes all rates of pay earned, all differentials during hours worked, premium pay, etc.

Attachments

No Attachments

Approval Signatures

Step Description	Approver	Date
CAH	Nikki Thordarson: CNO	pending
CEO	Veronica Fuhs: CEO - DCHC	01/2022
	Pam Young: Human Resources Director	12/2021

Applicability

Davis County Hospital

Davis County HOSPITAL & CLINICS

An Affiliate of MERCYONE

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Effective:	*Upon Approval*
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Last Revised:	*N/A*
Next Review:	*2 years after approval*
Owner:	*Corri Phillips: Lab Manager*
Policy Area:	*Laboratory*
Standards & Regulations:	
References:	
Applicability:	*Davis County Hospital*

Blood Bank - New Processes and Procedures

Purpose

The 28th Edition of AABB Standards for Blood Banks and Transfusion Services states that "The blood bank or transfusion service shall have a process to develop new processes and procedures or change existing ones. This process shall include identification of specifications and verification that specifications have been met. Before implementation, the new or changed processes and procedures shall be validated."

In order to meet these requirements and ensure the quality of the blood components and services remains high, the Davis County Hospital Laboratory will ensure any changes in our blood bank policies, procedures and processes are carried out under controlled conditions.

Procedure

Policies and Procedures

- All new policies and procedures shall be reviewed by the Laboratory Manager, Ancillary Director and Laboratory Medical Director.
- Any changes in policies and procedures shall include necessary verification that manufacturer specifications have been met (new reagents, kits, equipment, etc.). Policies shall follow the manufacturer's instructions.
- All Blood Bank staff shall be made aware of any new policies and procedures and receive any necessary training concerning the changes.
- All laboratory staff will read and review new policies or policy changes in order to remain proficient.
- Any deviates from established laboratory procedures must be approved by the Lab Manager and Laboratory Medical Director.

Equipment

- All new Blood Bank equipment shall be approved by the Laboratory Manager, Ancillary Director (and Laboratory Medical Director for major equipment) prior to purchase and use.
- Necessary calibrations and verifications will be performed on all new equipment prior to use and routinely thereafter as needed.

Testing Method

- If there is a process change that involves testing or a change in the testing method, parallel testing should be completed, if possible, to ensure that patients will not be negatively affected by any changes.
- Validation study will be completed with 10 samples, and can be run from proficiency testing samples or samples from LifeServe. The results from the old and new methods should correlate. Validation study should also confirm that both positive and negative results could be obtained through the old and new method.

References

AABB Technical Manual, 17th edition. 2011. AABB. Bethesda, MD 20814.

AABB Standards for Blood Banks & Transfusion Services, 28th Edition. 2012. AABB. Bethesda, MD 20814.

Attachments

No Attachments

Approval Signatures

Step Description	Approver	Date
CAH	Nikki Thordarson: CNO	pending
Medical Director	Carolyn Pease: Laboratory Medical Director	01/2022
Senior Leader	Rod Day: Ancillary Services Director	01/2022
	Corri Phillips: Lab Manager	01/2022

Applicability

Davis County Hospital

Davis County HOSPITAL & CLINICS

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Next Review:	*2 years after approval*
Owner:	*Corri Phillips: Lab Manager*
Policy Area:	*Laboratory*
Standards & Regulations:	
References:	
Applicability:	*Davis County Hospital*

Blood Bank Record Retention

Purpose

To define laboratory record retention requirements to meet regulatory and legal standards.

Policy

Laboratory Blood Bank records will be maintained in accordance with CLIA and Blood Bank Requirements in addition to state or Federal requirements that are applicable.

Procedure

Records shall be maintained for each significant step and be as detailed as necessary.

All records shall be legible, identify the person performing the work, specific dates, results and interpretation of results, expiration dates.

All Blood Bank records shall be retained for no less than 10 years.

The following records are an exception to this and are saved indefinitely:

- Difficulty in blood typing
- Clinically significant antibodies
- Adverse reactions to transfusion

References

1. Standards for blood banks and transfusion services, 17th Edition, AABB, 1996.

Attachments

No Attachments

Approval Signatures

Step Description	Approver	Date
CAH	Nikki Thordarson: CNO	pending
Medical Director	Carolyn Pease: Laboratory Medical Director	01/2022
Senior Leader	Rod Day: Ancillary Services Director	01/2022
	Corri Phillips: Lab Manager	01/2022

Applicability

Davis County Hospital

Davis County HOSPITAL & CLINICS

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Last Revised:	*N/A*
Next Review:	*2 years after approval*
Owner:	*Carleena Brown: Clinic Director*
Policy Area:	*Physicians Clinic*
Standards & Regulations:	
References:	
Applicability:	*Davis County Hospital*

COVID 19 HRSA test kits

Policy: HRSA COVID-19 Testing Supply Program Conditions of Participation

Purpose: To follow the guidelines of the HRSA COVID-19 Testing Supply Program that is designed to give testing supplies to our clinic to be given to our patients and community at no cost.

Procedure:

Conditions of Participation

1. The COVID-19 testing supplies will be used in confirmation of the Food and Drug Administration's (FDA) Emergency Use Authorization (EUA) for the COVID-19 test kits provided, the EUA Fact Sheet for Health Care Providers, and all other FDA authorized accompanying materials (and as the FDA may revise the EUA and accompanying materials), and consistent with all requirements recommendations and other guidance of HHS.
2. The clinic will not sell or seek reimbursement for the testing supplies provided by the federal government.
3. The testing supplies will be provided regardless of the recipient's ability to pay administration or related fees or coverage status.
4. We will not seek reimbursement, including through balance billing, from the test recipient.
5. The clinic will comply with FDA EUA requirements for use of testing supplies, including ensuring that appropriate storage, inventory management and administration methods are in place.
6. The supplies will be ordered under the HRSA COVID-19 Testing Supply Program through the HHS-designated systems.
7. The testing supplies will be reported by number in stock, expired, or wasted using the HHS designated diagnostic ordering system.
8. We will comply with all federal, state, local, or territorial laws that impact the distribution of self-tests or COVID-19 test administration to patients and within the community.
9. We will comply with applicable patient consent laws for administration of COVID-19 tests.
10. We have processes in place to ensure timely and proper acceptance of testing supplies. Those processes must include, but are not limited to, procedures for accepting delivery through commercial delivery services.
11. We will report any testing supplies that are damaged upon delivery pursuant to the process provided by the delivery service and to HHA within 24 hours. HHS will provide procedures for reporting.

Process for Accepting Supplies:

- Delivery will be accepted by the DCHC Materials Management Department from the commercial delivery system.
- Upon delivery into the DCHC building, the supplies will be brought to the clinic managers office.
- Clinic staff will visually inspect the delivery. Any defects will be immediately reported to the Clinic Manager or Clinical Lead Nurse in the Manager's absence. HRSA will be notified of any defects within 24 hours of delivery.

Process for Distribution of Supplies:

- Any request for free testing supplies will be honored so long as HRSA testing supplies are available.
- Patient/Community Members will receive an instruction sheet with the kits. The sheet will include information on using directions in the box and what to do if the test is Negative or Positive, including the latest CDC guidelines for quarantine, along with notes on when to be evaluated by their PCP.
- At no time will the kits be used to recruit new patients to the clinic.

Process for tracking supplies:

- A spreadsheet will be used to log out supplies disbursed to a community member or patient, supplies destroyed due to expiration dates, or wasted for any other reason.

Attachments

No Attachments

Approval Signatures

Step Description	Approver	Date
CAH	Nikki Thordarson: CNO	pending
RHC advisory board	Carleena Brown: Clinic Director	02/2022
Nurse Practitioners	Haleigh Skaggs: MA Provider	02/2022
Nurse Practitioners	Beverly J. Oliver: MA ARNP	02/2022
Medical Director	Robert Floyd: Chief of Staff/Internal Medicine Physician	02/2022
	Carleena Brown: Clinic Director	02/2022

Applicability

Davis County Hospital

Davis County HOSPITAL & CLINICS

An Affiliate of MERCYONE

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Last Revised:	*N/A*
Next Review:	*N/A*
Owner:	*Nikki Thordarson: CNO*
Policy Area:	*Safety and Security*
Standards & Regulations:	
References:	
Applicability:	*Davis County Hospital*

Severe Weather and Tornado Watch/Warning Plan

POLICY:

All employees will follow the instructions of the Severe Weather or Tornado Watch /Warning plan.

PROCEDURE:

DEFINITIONS:

A **Severe Thunderstorm WATCH** is issued by the NOAA Storm Prediction Center meteorologists who are watching the weather 24/7 across the entire U.S. for weather conditions that are favorable for severe thunderstorms. A watch can cover parts of a state or several states. **Watch** and **prepare** for severe weather and stay tuned to NOAA Weather Radio to know when warnings are issued.

A **Severe Thunderstorm WARNING** is issued by your local NOAA National Weather Service Forecast Office meteorologists who watch a designated area 24/7 for severe weather that has been reported by spotters or indicated by radar. Warnings mean there is a serious threat to life and property to those in the path of the storm. **ACT** now to find safe shelter! A warning can cover parts of counties or several counties in the path of danger.

A **Tornado WATCH** is issued by the NOAA Storm Prediction Center meteorologists who watch the weather 24/7 across the entire U.S. for weather conditions that are favorable for tornadoes and severe weather. A watch can cover parts of a state or several states. Watch and prepare for severe weather and stay tuned to NOAA Weather Radio to know when warnings are issued.

- Issued to alert public of the possibility of a tornado.
- Covers a specific area (usually 140 miles by 200 miles long) for a specific period of time (usually 2-6 hours).
- Normal activity need not be interrupted unless conditions change.

A **Tornado WARNING** is issued by your local NOAA National Weather Service Forecast Office meteorologists who watch the weather 24/7 over a designated area. This means a tornado has been reported by spotters or indicated by radar and there is a serious threat to life and property to those in the path of the tornado. **A tornado warning indicates that you should ACT NOW** to find safe shelter! A warning can cover parts of counties or several counties in the path of danger.

- Issued when a tornado has been seen or indicated by radar.
- Covers specific area (a county or two) and lasts an hour or less.
  ALERT

Weather radios are located at OP Registration/Centralized Scheduling, ER Registration, Acute Care Nurse Station and Senior Life Solutions. These Weather Radios should alert staff of Severe Weather and/or Tornado Watches or Warnings. **ANY DCHC Staff member** who hears a Weather Alert from these radios shall immediately contact the following personnel of an **ALERT**;

1. House Supervisor
2. Senior Team Member on call
3. Person operating the Switchboard. **DIAL "0"**
    - Switchboard Operator from 6:30am to 6:00pm
    - ER Registration Clerk from 6:00pm to 10:30pm
    - Acute Care Nurse station from 10:30pm to 6:30am.

Many DCHC staff may have weather alert capabilities on their personal devices. It should be common practice that should any employee receive such an alert, they contact their Manager or Director who will then follow the ALERT process described above.

Weather Radio's will be checked for functionality on a monthly basis by Plant Operations staff and log results on a Weather Radio Form. Plant Operations Manager will maintain forms in his/her office.

RESPONSE TO ALERTS

WATCH

ACTION

The following actions should be performed in preparation that a Severe Weather Warning could become dangerous/threatening and could escalate to a Severe Weather Warning or a Tornado Watch or Warning.

Upon notification of a **Severe Weather or Tornado WATCH,** the staff operating the phones will notify, **BY PHONE,** the;

1. House Supervisor
    i. House Supervisor will assign staff to monitor radio, tv, or other media outlets for updates and/or cancelations who will notify House Supervisor, Admin On-Call and phone operator of any weather changes.
2. Administrator on Call
3. Public Health staff by calling cell phone **641-208-0240,** M - F**,** 8a – 5p. This person will then notify other PH staff.
4. Additional personnel as instructed by the CEO, Administrator on Call, or Supervisor.

In the event of a **WATCH**, All DCHC staff are to;

1. Immediately review department role in preparation and response if storms escalate into a **WARNING.** Determine evacuation route to safe place and be prepared to move (see AREAS OF SAFETY listed below).
2. Check flashlights, close all windows, drapes, curtains and blinds in their work area & prepare equipment for necessary "shutdown".
3. Notify visitors in their area of the **WATCH**.
4. Turn on TV's to local channel in lobby, waiting rooms, nearby patient rooms to monitor weather patterns

and listen for updates. Volume should be turned up so everyone can be kept aware of situation.

5. Place personal cell phone in pocket or area that can be retrieved quickly. Use only to monitor storm (professional use) following HR Policy SOP #HR014, "Use of Telephones and Cellular Telephones".
6. Assist other areas as needed.
7. **Nursing staff in patient care areas** shall observe the following general guidelines:
    a. Check flashlights, close all windows, drapes, curtains and blinds in their work area and patient rooms & prepare equipment for necessary "shutdown".
    b. Prepare/assemble supplies and equipment for potential to move patients as necessary.
    c. Prepare/assemble supplies, equipment and staff for those determined to need to remain in patient rooms.
    d. Assign duties and patients for evacuation and monitoring, including any outpatients. Inform visitors in their area of the Severe Weather or Tornado **WATCH**.
    e. Place patients shoes near the beds.
    f. Call other departments if additional staff needed to prepare or monitor patients.

WARNING

SEVERE WEATHER WARNING

Upon notification that a **Severe Weather WARNING** has been issued, the staff operating the phones shall page:

"Weather Alert - Severe Weather Warning". This will be stated **3** times.

Phone Operating Staff shall then notify, **BY PHONE,** the;

1. House Supervisor (secure hand-held radio).
2. Administrator on Call (secure hand-held radio).
3. Public Health staff by calling cell phone **641-664-0240,** M - F, 8a – 5p.
4. Additional personnel as instructed by the CEO, Administrator on Call, or Supervisor.

ACTION

The following actions should be performed in preparation that a Severe Weather Warning could become dangerous/threatening and could escalate to a Tornado Watch/Warning.

A. Close all doors, drapes, curtains, or blinds where time permits.
B. Inform patients/visitors with patients in waiting rooms or those observed entering or leaving the building of the Severe Weather **WARNING**.
C. Turn on TV's to local channel in lobby, waiting rooms, nearby patient rooms to monitor weather patterns and listen for updates. Volume should be turned up so everyone can be kept aware of situation.
D. Place personal cell phone in pocket or area that can be retrieved quickly. Use only to monitor storm (professional use) following HR Policy SOP #HR014, "Use of Telephones and Cellular Telephones".
E. Determine evacuation route to safe place and be prepared to move (see AREAS OF SAFETY listed below).
F. Prepare/assemble supplies and equipment for potential to move patients as necessary.

G. Call other departments if additional staff needed to prepare or monitor patients.

H. Place ambulatory patients in wheelchair, wheeled recliner, or carts/cots for possible transport to safe areas.

I. Move beds, wheelchairs, recliners, carts/cots away from windows.

J. For patients who cannot be removed from the beds (only if absolutely necessary):

   a. Gather pillows and blankets to cover patients if need arises.

   b. Prepare/assemble supplies and equipment.

   c. Determine a staff member who is **volunteering** to stay in area with patient. Staff to seek shelter in restroom or another nearby safe place if necessary.

      i. If no staff volunteers to remain in area, patients must be moved to an AREA OF SAFETY. PT-2 would work for these patient types.

TORNADO WARNING

Upon notification that a **Tornado WARNING** has been issued, the staff operating the phones shall page:

"Weather Alert + Tornado Warning + Seek Shelter". This will be stated **3** times.

ACTION

After paging "Tornado WARNING", the person operating the phones (shall immediately relocate to the Lower Level Copy Room and operate the phones from that AREA OF SAFETY and begin to quickly notify the following:

1. House Supervisor (HS to secure hand-held radio).
2. Administrator on Call if in building (secure hand-held radio).
   a. Immediately report to **Lower-Level Copy Room** to assume Incident Command (see further instructions below).
   b. Assist Operator to notify staff listed in this paragraph.
   c. If Admin on call not in building, Chain of command to
      I. Other Senior Team (secure hand-held radio).
      II. House Supervisor
      III. Plant Ops Manager (secure hand-held radio).
      IV. Plant Ops staff (secure hand-held radio).
      V. Department Manager/Leader/Lead
3. Operating Room (OR) at extension **#2800**.
4. Public Health staff cell phones **641-208-0240,** M- F, 8a – 5p.
   a. This person will then notify other PH staff.
5. EMS Manager or other EMS personnel in house to relocate ambulance (see ambulance relocation guidelines below).
6. Staff located in the "On-Call" rooms (use room number list).

STAFF GUIDELINES

In the event of a **Tornado WARNING,** staff shall observe the following general guidelines:

1. Remain calm, avoid panic, and offer reassurance to patients and other staff.
2. Place or retrieve (if time allows) personal cell phone in pocket. Use only to monitor storm (professional use) following HR Policy SOP #HR014, "Use of Telephones and Cellular Telephones".
3. Take available flashlights and laptop computers to AREAS OF SAFETY.
4. Close doors, including corridor/hallway fire doors, so that they latch, and relocate to AREAS OF SAFETY after securing work areas (see AREAS OF SAFETY listed below).
5. **Do not** attempt to **use elevators** due to the possibility of power failure.
6. Inform visitors with patients in exam or treatment rooms, in waiting rooms, or those observed entering or leaving the building of the Tornado **WARNING** and direct or assist them to AREAS OF SAFETY. Discourage leaving the building.
7. Transfer all Acute Care area patients and outpatients to AREAS OF SAFETY. Use wheelchair, wheeled recliner, or carts/cots or beds for transport. Efforts should be made to separate patients from community members in the AREAS OF SAFETY. Acute/Swing patients should be placed in PT-2 area.
8. For patients who cannot be removed from rooms/beds (only if absolutely necessary):
    a. Determine personnel who is **volunteering** to stay in area with patient. Staff to seek shelter in restroom or another nearby safe place if necessary. Crouch near the floor or under heavy, well-supported objects and cover your head.
        i. If no personnel volunteers to remain in area, patients must be moved to an AREA OF SAFETY. Acute/Swing patients should be placed in PT-2.
    b. Move beds, recliners, carts/cots away from windows.
    c. Gather pillows and blankets and cover patients.
    d. Prepare/assemble supplies and equipment.
9. Crouch near the floor or under heavy, well-supported objects and cover your head.
10. Stay clear of all windows, corridors with windows, or large freestanding expanses.
11. Be alert for fire. In the event of FIRE, the hospital FIRE PLAN will be activated.

AREAS OF SAFETY

The main AREA OF SAFETY is the Lower Level Tunnel area, area by EVS and Plant Ops Manager offices, Lower Copy Room, PT-2, Billing hallway.

Other AREAS OF SAFETY could be rooms and corridors without windows, especially rooms and corridors that do not border on an outside wall (i.e. lower level hallways, and etc.).

SHOW BUILDING AREAS OF SAFETY MAPS

Incident Command (IC)

Administrator on Call / Incident Commander will:

1. Maintain leadership of AREA OF SAFETY.
2. Assign duties to staff as necessary.
3. Assign staff or assist "Operator" with call list.

4. Administrator on Call / Incident Commander will determine when "Tornado Warning, All Clear" is to be announced. All Clear will be determined by:
    a. Expiration of the watch.
    b. Announcement over the weather radio.
5. If "ALL CLEAR" to be announced, IC will assign someone from the AREAS OF SAFETY to
    a. Open fire door toward Materials Hallway to get visualization and listen for on-going storm sounds, perform damage assessment and report findings.
    b. Open fire door toward Plant Operation to get visualization and listen for on-going storm sounds, perform damage assessment and report findings.
    c. Open fire door toward IT/EVS to get visualization and listen for on-going storm sounds, perform damage assessment and report findings.
    d. To check Fire Alarm Panel in Acute, ER, or Central Scheduling area (secure hand-held radio before leaving AREA OF SAFETY.
        i. Will also a perform damage assessment to and from IC.
        ii. Report finding by radio, phone (x5555) or return to IC.
    e. Assign staff to contact relocated Ambulance/personnel to check their status and give instruction for actions.

IF NO DAMAGE

After notification and assessment, IC will instruct the staff operating the phones to page "ALL CLEAR":

"ATTENTION PLEASE, TORNADO WARNING ALL CLEAR". This will be stated **3** times.

IF DAMAGE

1. Staff should be aware of electrical hazards, escaping gases. broken glass, and hazardous debris. Do not touch any loose or dangling wires.
2. In the event the hospital sustains extensive damage building or any outlying buildings, initiate Incident Command System Activation and/or Emergency Operations Plan as necessary.
    a. If possible, page or assign staff to page activation of plan(s).
3. Initiate and assign staff to perform Damage Assessment.
    a. Damage Assessment:
    The individual in charge of all units/departments which have received damage from the storm are to report the areas involved, type and extent of damage and the priority for repair.
4. In the event of FIRE, the hospital FIRE PLAN will be activated.
5. Contact Davis County Law Center with instruction (may need mutual aid).

AMBULANCE RELOCATION GUIDELINES

1. One ambulance and two crew members will be moved out of the garage and travel to random areas away from projected storm path to provide the best access to victims in the community for emergent needs.
2. If EMS staff appear to be in imminent danger or getting in harm's way, they shall:
    a. remain at DCHC and follow Staff Guidelines listed above.

b. Seek shelter in a safe location near the relocation area.

c. Contact IC of current location.

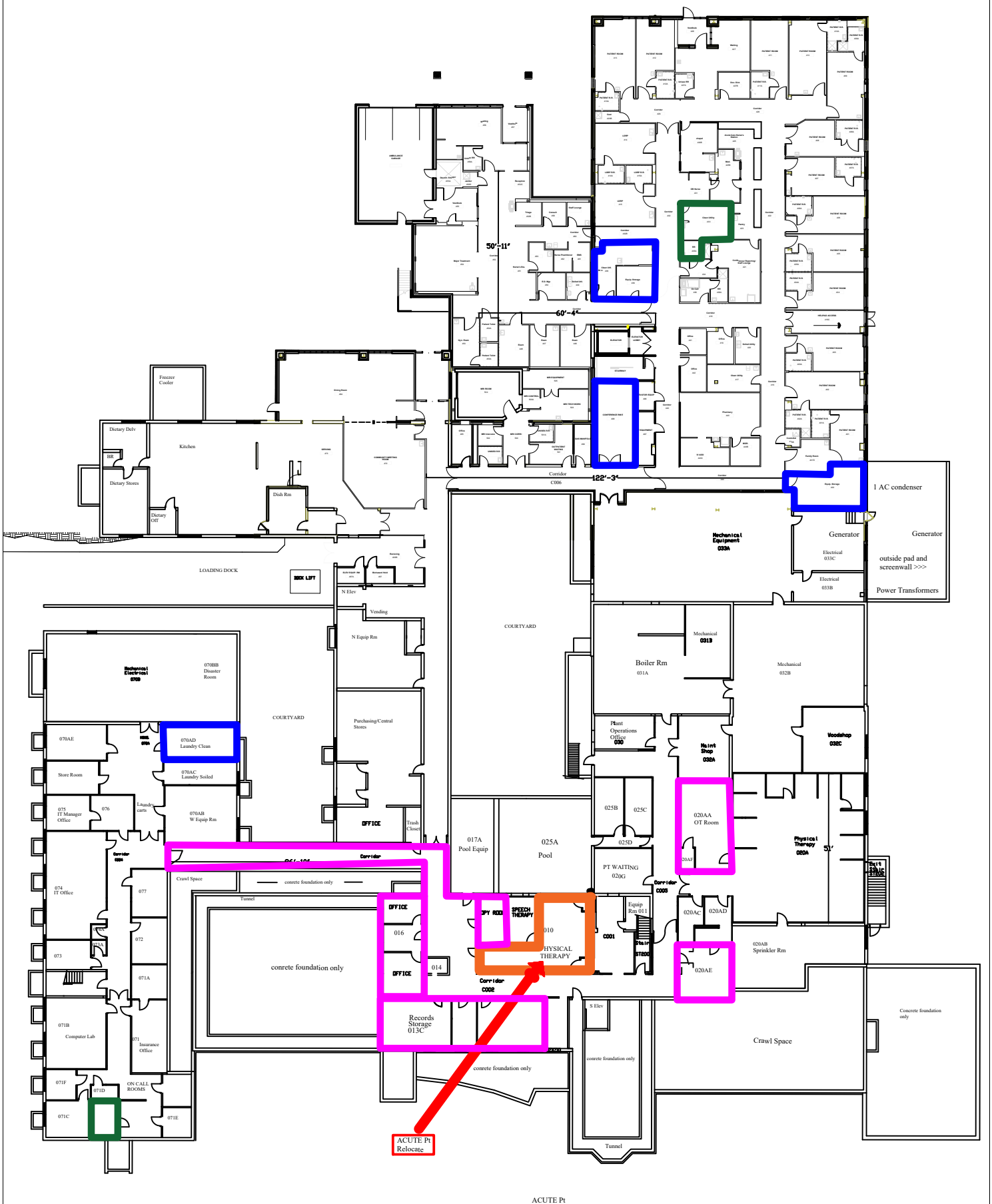
3. Follow instructions of IC and/or Law Center Dispatch if able and when safe to do so.

Attachments

life safety lower level - Tornado.pdf

Applicability

Davis County Hospital



ACUTE Pt
Relocate

DAVIS COUNTY HOSPITAL

LIFE SAFETY DRAWINGS

LOWER LEVEL

BEST

BETTER

GOOD

TORNADO
PLAN

Davis County HOSPITAL & CLINICS

An Affiliate of MERCYONE

Origination:	*01/2018*
Effective:	*Upon Approval*
Last Approved:	*N/A*
Last Revised:	*11/2021*
Next Review:	*2 years after approval*
Owner:	*Tammy Smoot: Cardiopulmonary Manager*
Policy Area:	*Sleep Lab*
Standards & Regulations:	
References:	
Applicability:	*Davis County Hospital*

Monthly Staff Education and Training for SomniTech

POLICY:

~~Employees~~SomnniTech employees are required to attend monthly staff/education trainings.

PROCEDURE:

Trainings will encompass education relevant to the sleep techs duties. Trainings will also include in-service training on any new equipment prior to it being placed in- service. Training will be a minimum of 2 hours in length not to exceed 4 hours unless previously communicated to employees of an extended training.

All meetings/training sessions are mandatory and attendance is tracked through a sign in sheet. Any tech that will be absent from meeting/training is required to notify the Regional Administrator of the absence prior to the start of the meeting/training. Any absence will be recorded as an unexcused absence.

Attachments

No Attachments

Approval Signatures

Step Description	Approver	Date
CAH	Nikki Thordarson: CNO	pending
Medical Director	Dr. Ron Graeff: Provider	11/2021
Senior Team Member	Rod Day: Ancillary Services Director	11/2021
	Tammy Smoot: Cardiopulmonary Manager	11/2021

Applicability

Davis County Hospital

Davis County HOSPITAL & CLINICS

An Affiliate of MERCYONE

Origination:	*01/2018*
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Last Approved:	*N/A*
Last Revised:	*05/2021*
Next Review:	*2 years after approval*
Owner:	*Tammy Smoot: Cardiopulmonary Manager*
Policy Area:	*Sleep Lab*
Standards & Regulations:	
References:	
Applicability:	*Davis County Hospital*

MWT Study

POLICY:

The Sleep staff will perform Maintenance of Wakefulness tests (MWT's) in accordance with the Clinical Practice Parameters for MWT's established by the ACHC.

PROCEDURE:

- The 4-trial MWT 40 minute protocol is recommended. The MWT consists of four trials performed at two hour intervals, with the first trial beginning about 1.5 to 3 hours after the patient's usual wake up time. This usually equates to a first trial starting at 0900 or 1000 hours.
- Performance of a PSG prior to MWT should be decided by the sleep clinician based on clinical circumstances
- Based on the Rand/UCLA Appropriateness Method, no consensus was reached regarding the use of sleep logs prior to MWT. There are instances, based on clinical judgment, when they may be indicated.
- The room should be maximally insulated from external light. The light source should be positioned slightly behind the subjects head such that it is just out of his/her field of vision, and should deliver an illuminance of 0.10-0.13 lux at the corneal level (a 7.5 W night light can be used, placed 1 foot off the floor and 3 feet laterally removed from the subject's head). Room temperature should be set based on the patient's comfort level. The subject should be seated in bed, with the back and head supported by a bed rest (bolster pillow) such that the neck is not uncomfortably flexed or extended.
- The use of tobacco, caffeine, and other medications by the patient before and during MWT should be addressed and decided upon by the sleep clinician before MWT. Drug screening may be indicated to insure that sleepiness/wakefulness on the MWT is not influenced by substances other than medically prescribed drugs. Drug screening is usually performed on the morning of the MWT, but its timing and the circumstances of the testing may be modified by the clinician. A light breakfast is recommended at least 1 hour prior to the first trial, and a light lunch is recommended immediately after determination of the second noon trial.
- Sleep technologists who perform the MWT should be experienced in conducting the test.
- The conventional recording montage for the MWT the include central EEG (C3- M2, C4-M1), frontal EEG (F3-M2 and F4-M1) and occipital (O1-M2, O2-M1) derivations, left and right eye electrooculograms (EOG's), mental/submental electromyogram (EMG), and electrocardiogram (EKG).
- Computer set-up will be performed and the appropriate montage will be selected. *(refer to Montage*

Protocol)

- Once the hook up and computer set-up is completed, an impedence check is performed to verify that all electrodes are at or below 10Kohms. Any electrode over 10Kohms will be reprepped or replaced. When the subject is ready,

  have them lie in the bed. Check the signals in the recorded channels to insure they are of a high quality, (no artifact).

- Prior to each trial, the patient should be asked if they need to go to the bathroom or need other adjustments for comfort. Standard instructions for bio-calibrations prior to each trial include: 1. sit/lie quietly with your eyes open for 30 seconds, 2. Close both eyes for 30 seconds, 3. Without moving your head, look to the right, then left, then right, then left, right and then left, 4. Blink eyes slowly for 5 times, and 5. Clench or grit your teeth tightly together.
- Instructions to the patient consists of the following: "please sit still and remain awake for as long as possible. Look directly ahead of you, and do not look directly at the light." Patients are not allowed to use extraordinary measures to stay awake such as slapping the face or singing.
- Sleep onset is defined as the first epoch of > 15 seconds of cumulative sleep in a 30 second epoch.
- Trials are ended after 40 minutes if no sleep occurs, or if after unequivocal sleep, defined as three consecutive epochs of stage 1 sleep, or one epoch of any other stage of sleep.
- The following data should be recorded: start and stop times for each trial, sleep latency, total sleep time, stages of sleep achieved for each trial, and the mean sleep latency (the arithmetic mean of the four trials).
- Events that represent deviation from standard protocol or conditions should be documented by the sleep technologist for review by the sleep specialist.
- If there is a CPAP titration study immediately prior to the MWT, and there is a change of pressure by 2 cwp or less, the MWT will be performed. Any CPAP pressure increase of 3 cwp or greater, the physician will be notifed prior to MWT start.

Attachments

No Attachments

Approval Signatures

Step Description	Approver	Date
CAH	Nikki Thordarson: CNO	pending
Medical Director	Dr. Ron Graeff: Provider	11/2021
Senior Team Member	Rod Day: Ancillary Services Director	11/2021
	Tammy Smoot: Cardiopulmonary Manager	05/2021

Applicability

Davis County Hospital

Davis County HOSPITAL & CLINICS

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Last Revised:	*05/2021*
Next Review:	*2 years after approval*
Owner:	*Tammy Smoot: Cardiopulmonary Manager*
Policy Area:	*Sleep Lab*
Standards & Regulations:	
References:	
Applicability:	*Davis County Hospital*

Disasters during a Sleep Study (SomniTech policy)

POLICY:

All SomniTech sleep staff personnel will follow approved procedures for ~~the facility that the studies are being performed in,~~Davis County Hospital in the event of ~~external (environmental)~~ emergencies.

PROCEDURE:

~~1. Type of Disaster:~~

~~A. Tornado:~~

- ~~Help in moving sleep patients to areas free of windows~~
- ~~Help in returning sleep patients to area after threat is over.~~

~~B. Flood:~~

- ~~Not applicable~~

~~C. Hurricane:~~

- ~~Not applicable~~

~~D. Earthquake:~~

- ~~Move patients and staff to secure areas such as between door openings.~~

~~E. Fire:~~

- ~~If a small fire, obtain extinguisher, pull pin, press handle and sweep fire from side to side at the base of the fire.~~
- ~~Pull fire alarm.~~
- ~~Remove patient(s), go to designated or directed location outside of building.~~

A. Somnitech personnel will follow guidelines outlined in Davis County Hospital policies.

B. Copies of Tornado and Fire Policies as well as other Plan Language Codes will be made available and accessible to SomniTech staff.

C. Type of Disaster:

1. A. Tornado:
    a. Follow DCHC "Severe Weather/Tornado Watch & Warning" Policy
    b. Assist moving sleep patients to "Areas of Safety".
    c. Assist returning sleep patients to area after threat is over.Flood:
2. Fire
    a. Follow DCHC "Fire Plan" Policy
    b. Remove patient(s), go to designated or directed location outside of buildin
3. Earthquake
    a. Move patients and staff to secure areas such as between door openings
4. Flood
    a. Not applicable
5. Hurricane:
    a. Not applicable

Attachments

No Attachments

Approval Signatures

Step Description	Approver	Date
CAH	Nikki Thordarson: CNO	pending
Medical Director	Dr. Ron Graeff: Provider	11/2021
Senior Team Member	Rod Day: Ancillary Services Director	11/2021
	Tammy Smoot: Cardiopulmonary Manager	05/2021

Applicability

Davis County Hospital

Davis County HOSPITAL & CLINICS

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Last Revised:	*03/2022*
Next Review:	*2 years after approval*
Owner:	*Tammy Smoot: Cardiopulmonary Manager*
Policy Area:	*Sleep Lab*
Standards & Regulations:	
References:	
Applicability:	*Davis County Hospital*

Emergency CPAP Protocol

POLICY:

~~Staff~~SomniTech staff will follow appropriate procedures for cardiac and oximetry issues.

PROCEDURE:

Cardiac Criteria:

If any of the following arrhythmias occur, awaken the patient, assess, and notify the on- call ~~physician~~provider for instructions:

- Ventricular tachycardia (greater than 5 beats in a row)
- Sinus pauses (greater than 3 seconds)

It is important to document that these arrhythmias are occurring in the presence of sleep disordered breathing and appear to be directly related to an obstructive event. If this is the case, then CPAP may be instituted prior to meeting the split night criteria as defined as an apnea/hypopnea index of 15 or more with a minimum of 2 hours documented sleep.

Oximetry Criteria:

If a patient develops desaturation below 70% during sleep disordered breathing without any arrhythmias, then begin CPAP ONLY AFTER the patient has met split night criteria. If the desaturations are occurring without obvious apneas or hypopneas, then begin nasal oxygen supplementation per the oxygen protocol. Any questions regarding the use of oxygen should be referred to the ~~physician~~provider on call.

The on call supervisor should always be notified whenever the technician believes that emergency CPAP protocol has been met.

Attachments

No Attachments

Approval Signatures

Step Description	Approver	Date
	Tammy Smoot: Cardiopulmonary Manager	pending

Applicability

Davis County Hospital

Davis County HOSPITAL & CLINICS

An Affiliate of MERCYONE

Origination:	*01/2018*
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Last Revised:	*05/2021*
Next Review:	*2 years after approval*
Owner:	*Tammy Smoot: Cardiopulmonary Manager*
Policy Area:	*Sleep Lab*
Standards & Regulations:	
References:	
Applicability:	*Davis County Hospital*

Universal Precautions and Bloodborne Pathogens (SomniTech Policy)

POLICY:

All SomniTech sleep staff will follow Universal Precautions and Bloodborne Pathogen standards for contact with all patients. Sleep staff will attend a mandatory infection control and OSHA blood borne pathogens in-service annually and at the time of new employee orientation.

PROCEDURE:

- Technicians are required to wash their hands before and after each and every contact with patients.
- Gloves will be used for hook-up and disconnect of patient electrodes
- Gloves will be used if there is a potential of blood-body fluid contact
- Masks will be worn if potential for TB exposure.
- Personnel Protective Equipment, (gloves, gowns, masks) are available from the facility.
- Common infectious conditions that would result in the technician or patient being rescheduled. (cold, flu, other acute respiratory illnesses , etc.)
- Mandatory infection control and blood borne pathogen in-services are performed annually.

Attachments

No Attachments

Approval Signatures

Step Description	Approver	Date
CAH	Nikki Thordarson: CNO	pending

Step Description	Approver	Date
Medical Director	Dr. Ron Graeff: Provider	08/2021
Senior Team Member	Rod Day: Ancillary Services Director	05/2021
	Tammy Smoot: Cardiopulmonary Manager	05/2021

Applicability

Davis County Hospital

Education Biennial Review

2022

Title	New	No Changes	Revised Statement	Revised Procedure	Retired	Comments
CareLearning Assignments				X		Updated coursework to meet regulatory requirements and updated course names of carelearning
CEU credit programs		x				
Competency Assessment Process		x				
Continuing Education Attendance		x				

Marketing Biennial Policy Review

2022

Title	New	No Changes	Revised Statement	Revised Procedure	Retired	Comments
Speaking to the Media		x				No changes
Sponsorships & Donations		x				No changes

Medical Staff Biennial Review

2022

Title	New	No Changes	Revised Statement	Revised Procedure	Retired	Comments
Consent for Treatment		X				still in review process
Consultations		X				
Credential Process				X		Removed statement concerning Peer Review results.
Expedited Credential and Privileging Process				X		Added reference to distant site Telemedicine entities. Corrected hospital name
File Maintenance of Health Care Professionals Certificates				X		Added reference to distant site Telemedicine entities and electronic credentialing files. Corrected hospital name.
Hospital Admissions, Discharges, and Transfers		X				
Order for Treatment		X				
Patient Death				X		Removed statement stating that it is the duty of all staff to offer autopsies whenever appropriate.
Peer Review		X				still in review process
Persons Employed By a Privileged Practitioner (PEPPs)			X			Removed (as defined in Section I.D. because it did not apply. Added exclusion. Revised Statement was approved in March 2021. Removed reference to rules & regulations. Updated TB testing and competencies requirements.
Primary Coverage for Emergency Care		X				
Renewal of Healthcare Professional's Licenses and Certifications		X				
Review of Credential Application				X		Added reference to distant site Telemedicine entities. Added reference to NPDB form. Clarified CEU requirement period. Clarified recommendation statement. Added reference to distant site Telemedicine entities.
Student/Resident Credential and Privileging Process				X		Minor grammar corrections, added the word 'Medical' in front of student for clarification

Utilization Review Biennial Review

2022

Title	New	No Changes	Revised Statement	Revised Procedure	Retired	Comments
Admission Medical Necessity		x				
Discharge Follow-Up Phone Contacts				x		Revised to reflect current process under #1
Discharge Planning		x				
Emergent Dental Care		x				
Iowa Care Act		x				
Request for Post-Hospital Care		x				
Retention of Records ad Reports		x				
Utilization Review and Management Plan		x				
Swing Bed Information Sheet		x				

SOPs

SOP Guidelines for Hospital Issued Notice of Non-Coverage		x				