October 2022 New Policies, Revised Policies Annual & Biennial Reviews

New Policies

- **Human Resources -** Weekend Staffing Package VIII
- **Laboratory-** Guide to Laboratory Services
- **Laboratory -** Laboratory Results Turn-Around Time

Revised Policies

- **Lab**
  - Identification of Blood Product Unit
  - COVID-19 Mandatory Reporting
  - Laboratory Call
  - PRN Lab Personnel
  - Microbiology Safety Guidelines
- **Employee Health -** Flu Vaccination Policy

Biennial Reviews

- Laboratory
- Nursing (All shared department nursing procedures OP, Specialty, ER, AC, Surgery)
- Pharmacy
- Plant Ops/ Pool
- Skilled Care
- Medical Associates Clinic
- Utilization Review and Management Plan (Annual Review)

Procedures updated outside of scheduled review

- **Medical Staff**
  - Peer Review (procedure revisions only)

Status Pending PolicyStat ID 12318046

Davis County HOSPITAL & CLINICS

An Affiliate of MERCYONE

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Owner	Pam Young
Policy Area	Human Resources
Applicability	Davis County Hospital

Weekend Staffing Package VIII

Purpose:

The Weekend Staffing Package VIII (WSP VIII) exists to ensure consistent coverage to meet departmental needs.

Procedure:

Listed below are important points pertaining to the WSP VIII.

A. WSP VIII schedule will provide department coverage under the following guidelines.
   1. Coverage will be between the hours of 7am on Fridays through 7pm the following Monday. (ie... Fri, Sat, Sun or Sat, Sun, Mon)
   2. Hours will be a minimum of 3 – 12-hour shifts (36 hours) working in the department as outlined on the WSP VIII Agreement.
      a. Hours subject to change to meet the needs of the department. Department Manager is responsible for scheduling.
      b. "Clocked-In" hours requires employee to be physically in the department performing duties outlined in employees job description or other duties as assigned.
   3. Employee will be scheduled to work 7 of 8 weekends (e.g. work 7 weekends, 8th weekend off, repeat). End of the year total weekends worked must equal 45 of 52 weekend shifts.
      a. Employee will be compensated at the "Premium" rate when working the "Weekend Package".

i. If employee works additional weekend shifts, those shifts will be paid at “premium” pay.

b. The “off weekends” are unpaid. During these weekends, employee can elect to;

i. Not receive pay/wages.

ii. “Cash out” PTO if available. (See Human Resources Policy “Paid Time Off (PTO), refer to PTO Sell Back for further details).

iii. Substitute weekend “Clocked-In” hours during other days of the week, before and after the weekend. These hours will be paid at “base rate”.

c. If employee wants to request a change in the scheduled rotation, the request must be submitted to the department manager for consideration prior to the monthly schedule being available to all department staff. Department manager reserves the right to approve or deny any requested changes to the scheduled rotation.

d. Unscheduled absence or illness will follow DCHC Attendance policy (HR guidelines). Absence can be made up within the 7-8 rotation or working other shift as available. PTO must be used to cover scheduled or unscheduled absence/illness to meet the minimum hours required in the Agreement. This PTO will be paid out at the weekend premium rate.

4. Employee will be considered a “full-time, non-exempt” employee.

a. As full time, the employee is eligible for full time benefits.

5. Holidays worked are on a rotating department wide schedule. In the event that a holiday falls on a weekend that is not part of the weekend technologist’ rotating schedule but if he\she wants to work the holiday, it can be mutually agreed upon between the technologist scheduled for that holiday, the weekend technologist, and the department manager. (Ie. If 4th of July is on a Saturday and another technologist is scheduled to work it based on the department rotating holiday schedule, the weekend technologist can ask to work if they so desire.)

a. Holiday rate, (1.5) x “Premium” pay rate per hour

B. Reimbursement (Pay) Rates

1. Employees have an established “base” rate or starting salary upon hire determined by the HR department. See Compensation Policy HR018.

2. Premium rate is calculated by taking the “base rate” times (x) 1.35% = “Premium Rate”.

3. Holiday pay rate on weekend worked (for paid holidays per Compensation Policy HR018) is calculated by taking “premium rate” x 1.5 per hour.

4. Holiday pay rate worked during a weekday (for paid holidays per Compensation Policy HR018) is calculated by taking “base rate” x 1.5 per hour.

5. If employee works shifts outside of the Weekend Staffing Package VIII, they will be

paid at the “base rate” for hours worked.

6. Employee is eligible for other compensation per HR018 such as Shift Differential, On-Call, Call-In, Overtime, and Holiday pay during WSP VIII or “other” shifts worked.
7. Birthday Holiday (1 day only), see Employee Birthday Vacation Day policy #HR066.
    a. is paid at “premium” rate for 8 hours only regardless of normal hours regularly scheduled during the WSP VIII.
    b. Can be used for one (1) scheduled WSP VIII day when 8 or more hours are normally worked.

C. PTO accrued may be used to cover medical expenses at Davis County Hospital or sold back (See Human Resources Policy “Paid Time Off (PTO) for further details). PTO paid out at the end of employment or cashed out (other than in C. ii. 2.) will be paid out at the employee’s regular base rate of pay.

D. Employee is expected to attend orientation, mandatory in-services, informational meetings, and staff/department meetings and will be paid at the “base” rate of pay.

E. Davis County Hospital & Clinics will not be responsible for provision of off-shift accommodations and this responsibility rests solely on the WSP VIII employee.

F. If at any point Davis County Hospital & Clinics determines to change or discontinue the WSP position, or the WSP VIII employee wishes to resign or transfer to another posted position, a 28-day notice is required by either party to the other.

Approval Signatures

Step Description	Approver	Date
CAH	CAH: DCHC Critical Access Hospital Committee	Pending
CEO	Veronica Fuhs: CEO - DCHC	09/2022
	Pam Young: Human Resources Director	09/2022

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Davis County HOSPITAL & CLINICS

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Owner	Corri Phillips
Policy Area	Laboratory - General
Applicability	Davis County Hospital

Guide To Laboratory Services

Purpose

Accurate results of laboratory tests require optimum collection and handling of the specimen prior to testing, accurate and precise testing, and accurate reporting of the test results.

This Guide to Laboratory Services provides Laboratory Policies and Information to help ensure optimum pre-analytical and accurate post-analytical processing of test specimens.

These policies apply to all testing performed; Waived, Moderate or High Complexity as defined by CLIA '88.

The Laboratory Medical Director reviews and approves:

- All new policies prior to their implementation
- Revisions to policies prior to their implementation
- Validation and correlation studies performed on new instrumentation
- Comparative method studies, when changing test procedures, reagents, or processes
- All policies and procedures on a bi-annual basis

The Laboratory Manager oversees the day-to-day operation of the laboratory.

If you have any questions on testing or the use of this guide, please call the Laboratory at (641) 664-7138 or the Laboratory Manager at (641) 664-2145 ext 2603.

Orders may be faxed to (641) 664-2496.

General Information

Accreditations

Clinical Laboratory Improvement Amendments (CLIA) Certificate of Compliance (CLIA 16D0387155).

Laboratory Oversight

A board-certified pathologist, specializing in both clinical and anatomical pathology, provides medical direction of the laboratory.

Scope of Service

Laboratory services (diagnostic testing of clinical specimens and body fluids to aid in diagnosis and treatment of disease processes) are readily available to meet both Inpatient and Outpatient's needs. Tests, procedures, and services offered are reviewed on an ongoing basis, with input from Physicians (staff and consulting) and patients. Services offered include Hematology, Chemistry, Microbiology, Blood Bank & Transfusion Services, Blood Gases, Coagulation, Urinalysis, Serology, Therapeutic Drug Monitoring, Drug Screen Collection, and Pathology Services.

Patient Population Served

All patient ages from newborn to the elderly are provided laboratory services.

Hours of Operation

The laboratory is open twenty-four (24) hours/day, 7 days a week. Qualified consultants, in the form of Laboratory Manager and/or Pathologists or other lab staff are always available to answer your questions, discuss test results, consult on unusual cases, or arrange for special testing.

Outpatient testing is available from 7:00 am to 5:00 pm Monday through Friday.

Chain of Custody Drug Screen collections are available by appointment, between the hours of 7:00 am and 5:00 pm Monday through Friday.

Staffing

At least one technologist/technician is available on site or on-call twenty-four (24) hours/day, 7 days a week.

In the event that *Overnight* or *Weekend* staff are out, some holidays, or during staff shortages, shifts may be covered on-call.

The laboratory on-call calendar can be found with ER Registrar.

Security

The Laboratory is secured 24 hours a day. Davis County Hospital employee ID badges control access to doors.

Emergency Laboratory Services

All in-house-performed testing is available on an emergency basis. Tests not performed in-house, but needed on an emergency basis, will be referred to the closest CLIA certified laboratory able to perform that testing. The referred tests will be indicated as "STAT" to help expedite the turn-around-time.

Laboratory Orders

Routine Orders

Testing will only be performed upon presentation of a valid order. An order is valid if it is from a licensed healthcare provider, who is allowed under Iowa law to order laboratory testing. The provider must also not be excluded from the Medicare program and provide basic reference information to Davis County Hospital. All orders for laboratory testing must be signed by the requesting healthcare provider. Orders are valid for a period ± 30 days from the estimated collection date listed on the order unless a shorter time is specified on the order. If there is no collection date orders are valid for 30 days from the date the order was written, unless a shorter time is specified on the order. All orders are subject to medical necessity checking. An appropriate ICD 10 code or written diagnosis is required for each test ordered, as required under Federal law.

All orders must contain the following information:

1. Patient's name
2. Date of Birth-used as unique identifier and to calculate pt. age
3. Test(s) requested must be legible and complete
4. Written diagnosis or ICD 10 diagnosis code that meets medical necessity (*If diagnosis does NOT meet medical necessity, patients may be liable for the costs of the test(s) being performed).*
5. Name of person completing the form if someone other than the doctor
6. Date that the order is written
7. Date labs are to be drawn, if ordered for a future date
8. Any pertinent information such as specimen source for cultures, specific times to draw medication levels, and fasting status, if applicable.
9. Physician signature or e signature, and second identifier

If any of the above items are missing, the physician or the provider on call for the physician, must be contacted to clarify the orders or obtain missing information prior to obtaining the specimen from the patient.

Verbal orders or telephoned orders must be followed immediately by a faxed written order. Processing of a verbal order will not occur until the written order is received. Failure to submit a valid order will delay the testing process. Order will be sent to Health Information Management (HIM) to be scanned into the patient's chart. All physician orders will be kept, in some form i.e., written, electronic, and saved on media for the lifetime of that chart. Telephone or verbal orders should not be routinely used.

An Outpatient requisition form is available from the laboratory. Use of this form will help ensure that all required information is obtained with the order for laboratory test. All outpatient laboratory orders are scanned into the patient's EMR.

Standing Orders

Patients may require frequent monitoring of laboratory tests when on certain medications or with certain medical conditions. In such cases, a Standing Order may be used to help facilitate obtaining laboratory testing. The standing order must include the order start date, stop date (no later than 12 months after the start date) and testing frequency ***in addition to*** the previously listed order requirements.

A Standing Order form is available from the laboratory. Use of this form will help ensure that all required information is obtained with the order for laboratory test.

Test Selection

In-house test selection is done by the use of the hospital electronic medical record. Laboratory tests can be selected by test description. After selecting a test, the order screen information should be checked to ensure that it is the correct patient, correct test, and correct ordering physician. The order screen will also indicate any special instructions such as patient preparation, specimen requirements, special handling, or other information. In some circumstances, manual laboratory requisitions may be necessary, such as during computer down times. If you do not have these requisitions in your area, they may be obtained by calling the laboratory.

Specimen Collection and Handling

Specimen Collection Times

For hospital "Inpatients" the laboratory makes rounds of all patient areas as testing is requested. The early morning rounds generally begin between 5:00 am and 6:00 am, this may vary due to staffing. Inpatient specimens are also collected throughout the day, as orders are received.

Outpatient's specimens are collected at the time the patient presents in the laboratory. Some testing may require special transportation, collection containers or timing to ensure optimal results. In these cases, the patient may be asked to return at a later time.

Drug Screen collections are performed on a scheduled basis.

Patient Identification

Strict adherence to this guideline will maintain high quality patient care and will prevent potentially serious errors. CMS and healthcare regulatory agencies have issued a list of Patient Safety Initiatives to be followed by all hospitals. The first of these concerns the manner in which a patient's identity is verified before lab specimens are taken, before medications are administered, or before blood products are transfused. According to the patient safety guidelines, patient identity verification should be performed using at least two identifiers such as patient name, date of birth, or Medical Record number. **Note that room and bed numbers may NOT be used as identifiers.**

When preparing to obtain laboratory specimens from a patient, the verification process normally involves comparing information from (a) patient responses, (b) patient wristband information, and (c) pre-printed specimen labels or requisitions. Pre-printed specimen labels are generated by the computer system. The information on the label must match the patient's wristband before the labels can be affixed to the specimens. Accurately labeled specimens are the final step in positive patient identification. If pre-printed specimen labels are not available; all specimens must have handwritten information with patient's name, date of birth, date, time of collection and phlebotomist's initials. DO NOT take specimens elsewhere for labeling.

Specimen Labeling

Specimens being sent to Davis County Hospital Laboratory must be properly labeled. Properly labeled tubes enable the testing personnel to positively identify the tube with the request for testing. Without the following information on each tube or specimen coming to the laboratory for testing, there may be identification issues:

1. Patient's full name- do not use initials or nicknames
2. Medical record number and/or DOB
3. Date and time collected
4. Initials of individual collecting specimen
5. Body site or collection method—when indicated

Specimens received without any labeling will be discarded and the collector (if known) will be notified. Specimens received with only partial information may require follow-up investigation and can lead to a delay in testing.

Specimen Transport

Specimens being sent to Davis County Hospital Laboratory need to be properly packaged for specimen transport. Once collected, specimens may have special storage requirements. All specimen containers must be correctly closed to ensure specimen integrity. Stoppers on phlebotomy tubes should remain intact, urine lids properly screwed on, cultures properly placed in collection tubes. Specimens with gross leakage will not be accepted for testing due to possible compromise of specimen integrity and safety concerns for the lab staff.

When the specimen is ready for transport either by patient, nursing personnel or office staff it should be placed in a sealable biohazard bag to prevent specimen leakage. If the specimen is collected in a syringe, the specimen must be transferred to collection tubes and appropriately labeled before transporting the specimen. **Any specimen received in the lab with a needle attached will be rejected due to safety issues** associated with removing the needle and appropriate labeling of the specimen.

Specimen Rejection/Test Cancellation

All specimens must be collected, labeled, transported, and processed according to procedure. Selecting the container type, volume and specimen handling requirements needed before the specimen is collected is essential. If the criteria for these requirements are not met a specimen may be rejected, testing may be delayed or a test may be canceled. The ordering doctor and/or facility will be notified by phone about the specimen rejection and documented on the rejected specimen log sheet. The following represents some reasons for rejection, delay or cancellation:

- Inappropriate specimen type or incorrect patient preparation i.e. fasting etc.
- Inappropriately labeled or unlabeled specimen
- Specimen quality (hemolysis, clotted)
- Insufficient volume
- Inappropriate specimen container
- Specimen leaked in transport
- Specimen in incorrect or expired transport media
- Incomplete or incorrect test request forms

Laboratory Testing

Referred Testing

Those tests currently not performed at Davis County Hospital Laboratory are referred to accredited reference laboratories possessing that specialty or subspecialty under CLIA '88.

Whenever a test is sent to another laboratory the results/report will indicate where the test was performed, along with appropriate normal values for that laboratory.

Reference Laboratories currently approved for use.

MCL, DesMoines, IA 16D0383702

Mayo Clinic Labs, Rochester, MN 24D1040592

LifeServe Blood Center, Des Moines, IA 16D0383665

University of Iowa Hygienic Lab, Ankeny IA, 16D0709302

University of Iowa Hygienic Lab, Iowa City IA, 16D0648109

Test Request Priorities

(See Laboratory Turnaround Time Policy for detailed Turnaround time information on Laboratory Testing)

"Routine" Test results can generally be expected within the same day.

"STAT" Results usually within 60 minutes

"TIMED" Tests that are to be drawn at a specific time will be considered "STAT" for purposes of testing unless the written orders specify otherwise.

Repeat Testing

As part of our concern for quality testing and patient care, we will gladly repeat any testing, at no charge, in which the physician has doubt or other concerns. Please telephone the laboratory as quickly as possible so that we may retrieve specimens and begin re-testing without delay. In some cases, it may be necessary to obtain repeat specimens to rule out errors or other factors.

Lab Results

Reporting of Test Results

Results are sent from instruments via an interface or entered manually into the EMR.

Results are found in the electronic medical record upon completion of the test. Each test report will contain the following:

1. Patients name and identification number or 2 unique identifiers
2. Name and address of the laboratory where the test was performed
3. Test report date
4. Test(s) performed
5. Specimen source, when appropriate
6. Test Results
7. Units of measure, as applicable
8. Reference ranges, as applicable
9. Condition of specimen, as applicable, i.e., hemolysis, icteric, etc.

Additionally, the electronic patient chart will have the following data elements displayed or ability to access the information within the application:

1. Patient Name
2. Medical Record Number
3. Financial number

4. Date and Time of Collection of specimen collection
5. Date and Time specimen was received into the laboratory
6. Date and time the result is released

Outpatient reports for outside providers are faxed to the ordering physician either automatically from our Electronic Health Record system, or manually by lab staff.

Laboratory reports will be faxed (to a secure fax) upon request, either to the requesting physician office or to a consulting physician.

Test results that fall into "critical value" ranges will be telephoned to the physician, office, Charge nurse, or other responsible party. A notation will be made electronically as to the date, time, person making the report and the person who received the report.

Order/Result Audit

At times it is necessary to track or to confirm testing information surrounding a patient's result, such as, which instrument the test was performed, who performed and verified a result, or who corrected a result.

There are tools and applications within Cerner PathNet, available to audit/track a test result. Performing and verification information whether it be manual or automated may be audited.

Cerner provides several auditing programs allowing specific laboratory staff access to this type of testing detail.

 **ORV, Order Results Viewer:** displays the status of the order/result, including verification information, comments associated with an order/result. Corrected results will have a status of Corrected.

 **Daily Reports:** There are three types of reports generated here, Activity, Correction, and Exception Reports. A service resource and date & time are selected, and then a type of report. The reports include patient demographics, accession number, test name and result, tech id, date and time performed and verified.

Please contact the laboratory if you need have any of the above information audited.

Normal Values (Reference Ranges)

The Normal (Expected or Reference) range is reported with each test. This range should be considered the most appropriate values for interpretation of individual results since these results will be specific for the age and or sex of the individual patient if appropriate.

Approval Signatures

Step Description	Approver	Date
Medical Director	Carolyn Pease: Laboratory Medical Director	Pending
Senior Leader	Rod Day: Ancillary Services Director	09/2022
	Corri Phillips: Lab Manager	09/2022

Status Pending PolicyStat ID 12373109

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Policy Area	Laboratory - General
Applicability	Davis County Hospital

Laboratory Results Turn-Around Time

Purpose

Establish guidelines for when laboratory results will be available.

To ensure laboratory results are reported accurately and timely to optimize patient care and patient outcomes.

To ensure that patient care staff are aware of expected Turn-around-times for Laboratory procedures.

Procedure

A. Turn-around-time is defined as ***the interval of time between specimen receipt in the Laboratory and the time that results are reported.*** It does not include the time the order was placed, sample collection or transport time, nor does it include the time required to call, print, or fax results. Turn-around-time may vary due to factors such as staffing, processing requirements, repeat testing, and laboratory instrumentation.

B. Lab tests are prioritized around patient care
    a. Priority is given to trauma patients and emergency room patients

C. If a significant delay in reporting is anticipated, the laboratory will notify the ordering physician or department.

D. Turn-around-time does not apply to wellness testing.

E. Turn-around-times listed below is limited to tests performed at Davis County Hospital Laboratory.

Turn-Around-Times (TAT)

Chemistry

TEST	STAT	TIMED	ROUTINE
Electrolytes	30-45 min.	30-60 min.	1-2 hr
Basic Chemistry Panel	30-45 min.	30-60 min.	1-2 hr
Comprehensive Metabolic Panel	30-60 min.	1-2 hr.	1-2 hr.
Other Profiles/Panels	30-60 min.	1-2 hr.	1-2 hr.
Cardiac Markers: Troponin I, CK, CKMB	30-60 min.	30-60 min.	
Individual chemistry tests: Albumin, ALP, ALT, Amylase, AST, BUN, Calcium, Cholesterol, CK, Creatinine (GFR), Direct Bilirubin, CO_2, Glucose, HDL, K, Chloride, Lipase, Na, Mg, Phosphorus, Total Bilirubin, Total Protein, Triglycerides, Uric Acid, Cystatin-C	30-45 min.	1-2 hr.	1-2 hr.
Ammonia	30-45 min.	30-60 min.	30-60 min.
B-Type Natriuretic Peptide (BNP)	30-60 min.		1-2 hr.
Lactic Acid	30-45 min.	1-2 hr.	1-2 hr.
Procalcitonin	30-60 min.	30-60 min.	1-2 hr.
Arterial Blood Gas	30 min.		30 min.
Venous Blood Gas	30 min.		30-60 min.
Venous pH	30 min.		30-60 min.
Serum Ketones	15-30 min.		1-2 hr.
Lead Level Screen	15-30 min.		1-2 hr.
CRP	30-45 min.		1-2 hr.
Rheumatoid Factor	30-45		1-2 hr.

	min.		
Individual Immunology tests: BATCH T/F C3, C4, IgA, IgG, IgM	30-45 min.		***1-2 hr.*** 24-72 hrs. *** Tues & Friday***
Individual ImmunoAssay tests: Ferritin, TSH, Free T4	60-75 min.		1-3 hr.
Individual ImmunoAssay tests: BATCH T/F Folate, FSH, LH, Prolactin, Testosterone, Free T3, Vitamin B12, Free PSA, Total PSA, Total T3	60-75 min.		***1-3 hr.*** 24-72 hrs. *** Tues & Friday***
Individual Specialty tests: BATCH T/F Vitamin D, TPO, Th-Ab	60-75 min.		***1-3 hr.*** 24-72 hrs. *** Tues & Friday***
Microalbumin	20-45 min.		1-2 hr.
Hgb A1C	20-45 min.		1-3 hr.
HCG, Quantitative	45-60 min.		1-2 hr.
Glucose Tolerance			5-8 hr.

Drug Monitoring

TEST	STAT	TIMED	ROUTINE
Acetaminophen	30-60 min.	1-2 hr.	1-2 hr.
Alcohol, Serum or Plasma	30-60 min.	1-2 hr.	1-2 hr.
Carbamazepine	30-60 min.	1-2 hr.	1-2 hr.
Digoxin	30-60 min.	1-2 hr.	1-2 hr.
Dilantin (Phenytoin)	30-60 min.	1-2 hr.	1-2 hr.
Salicylate	30-60 min.	1-2 hr.	1-2 hr.
Valproic acid	30-60 min.	1-2 hr.	1-2 hr.
Vancomycin	30-60 min.	1-2 hr.	1-2 hr.

Coagulation

TEST	STAT	TIMED	ROUTINE
Protime	30-45 min.	30-45 min.	1-2 hr.
PTT	30-45 min	30-45 min.	1-2 hr.

D-Dimer	30-60 min.	30-60 min.	1-2 hr.

Hematology

TEST	STAT	TIMED	ROUTINE
CBC with auto diff	10-30 min.	10-30 min.	1-2 hr.
CBC no diff	10-30 min.	10-30 min.	1-2 hr.
Manual diff	60-90 min	1-2 hr.	1-3 hr.
Individual hematology tests: WBC H&H Hemoglobin Hematocrit Platelets	10-20 min.	15-60 min.	1-2 hr.
ESR (Sed Rate)	30-60 min.		1-2 hr.

Blood Bank

TEST	STAT	TIMED	ROUTINE
ABO-RH	30-45 min.		1-6 hr.
Antibody Screen	30-60 min.*		1-6 hr.
Crossmatch Without current negative AB screen With current negative AB screen	45-90 min.* 30-60 min.		1-6 hr.
*Positive Antibody Screen will increase Turn-Around-Time			

Urine and Other Body Fluids

TEST	STAT	TIMED	ROUTINE
Urinalysis; no microscopic	10-30 min.		1-3 hr.
Urinalysis; with microscopic	20-40 min.		1-4 hr.
Rapid Urine Drug Test	10-30 min.		1-3 hr.
C.difficile fecal test	30-60 min.		1-3 hr.
Fecal Leukocytes	30-60 min.		1-3 hr.
Stool Occult Blood	10-15 min.		1-2 hr.
Wet Mount/KOH	30-45 min.		1-3 hr.

Serology and Miscellaneous

TEST	STAT	TIMED	ROUTINE
Beta HCG (pregnancy)	15-30 min.		1-2 hr.

Serum Urine			
Monotest	30-45 min.		1-2 hr.
Rapid Strep Test	30-45 min.		1-2 hr.
RSV	30-45 min.		1-2 hr.
Rapid Influenza test	30-45 min.		1-2 hr.
Rapid COVID-19 ID NOW	30-45 min.		1-2 hr.
QIAstat Respiratory Panel	90 min.		1-4 hr.
Rapid HIV (exposure only)	15-30 min.		1-2 hr.
Mycoplasma Ab	30-60 min.		1-2 hr.

Microbiology

TEST	STAT	TIMED	ROUTINE
Routine Cultures: Urine, Wound, Sputum, Eye, Ear, Nasal, Throat	2-3 days		2-3 days
Blood Culture	5-7 days		5-7 days
Gram Stain	1 hr.		24 hrs.
CLO Test	24 hrs.		24 hrs.
MRSA Screen	24 hrs.		24 hrs.

Approval Signatures

Step Description	Approver	Date
Medical Director	Carolyn Pease: Laboratory Medical Director	Pending
Senior Leader	Rod Day: Ancillary Services Director	09/2022
	Corri Phillips: Lab Manager	09/2022

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Policy Area	Laboratory - Blood Bank-DCHC
Applicability	Davis County Hospital

Identification of Blood-Product Unit

~~**POLICY:**~~

~~It is essential that all Blood-product units are sufficiently labeled to ensure the administration of the correct blood-product to the correct patient.~~

Policy

When issuing blood and blood products, it is critical to verify that the correct product is being given to the correct recipient. Proper identification on the unit(s) as well as verification that the unit(s) and recipient information agree will be confirmed prior to the release of the product.

All blood~~-~~ product ~~units~~unit(s) that are to be transfused will be properly labeled ~~using~~with Blood Bank ID (BBID) labels ~~to ensure~~ that ~~the proper patient receives each unit and that proper procedure have and will be followed~~correspond to the patients Blood Bank bracelet.

~~**PROCEDURE**~~

- ~~Blood bank ID **band number** that corresponds to the Blood Bank bracelet will be place on each appropriate blood product to be transfused to such patient.)~~
- ~~The patient's first and last name should be on this label.~~
- ~~ID band number will also be affixed to the Blood Bank record log book next to patient record.~~
- ~~**Compatibility Labels** will be filled out with the appropriate information and attached to the appropriate unit(s) along with signature of Issuer and Issuant.~~
    - ~~Each Unit will be identified by both people by~~
    - ~~Unit Number~~
    - ~~Patient Name~~

        - ~~BB ID NUMBER~~
        - ~~Unit type~~
        - ~~Expiration Date~~
        - ~~DOB~~
        - ~~Patient Type/Rh/Screen~~

Procedure

- Blood bank ID labels that corresponds to the patient's Blood Bank bracelet will be placed on each blood product to be transfused to such patient.
- The patient's first and last name is recorded on this label.
- ID band label will also be affixed to the Blood Bank record log book next to patient record.
- Compatibility Labels are created upon assigning the unit in LIS and will automatically print. These compatibility labels include the following information:
    - Patient Name, DOB and MRN
    - Patient Blood type, Rh and Antibody Screen
    - Blood Product Unit Number
    - Confirmed Unit Blood Type
    - Unit Expiration Date
    - Blood Bank ID number (BBID)
- Compatibility labels are attached to the unit.
- Upon pick up of the unit, both the Lab Technician and Licensed Healthcare Provider will verify the following information on the compatibility tag, the product unit itself, and the blood bank record log.
    - Patients name, MRN and DOB
    - Patients BBID number
    - Patients ABO/Rh and Antibody Screen
    - Blood Product Unit number and Expiration Date
    - Blood Product ABO/Rh
    - Compatibility test results
    - Any special requests, such as irradiation, CMV negative etc.
- The Technician will initial and record the date and time the unit was issued in the Blood Bank record log
- The healthcare provider will initial they have verified the unit information and received the unit.
- The unit is then dispensed in the LIS to the patient and the healthcare provider will enter their information as the courier for the unit.
- The compatibility tag(s) and the unit(s) will be returned to the lab following transfusion.

Approval Signatures

Step Description	Approver	Date
Senior Leader	Rod Day: Ancillary Services Director	Pending
	Corri Phillips: Lab Manager	09/2022

Status Pending PolicyStat ID 12411997

Davis County HOSPITAL & CLINICS

An Affiliate of MERCYONE

Origination	06/2021
Last Approved	N/A
Effective	Upon Approval
Last Revised	09/2022
Next Review	2 years after approval
Owner	Corri Phillips
Policy Area	Laboratory - General
Applicability	Davis County Hospital

COVID-19 Mandatory Reporting

Purpose

~~Iowa Administrative Code 641 requires~~Iowa Administrative Code 641-1.3(139) stipulates that the laboratory must report all ***positive*** ~~and ***negative***~~ results for SARS-CoV-2 testing, including but not limited to molecular detection methods, antigen detection method, and all results for SARS-CoV-2 serological testing detecting antibody, to ~~be reported to~~ the Iowa Department of Public Health within one day of the test being performed.

~~All Iowa health care providers and public, private and hospital laboratories are required to immediately report all positive and negative SARS-CoV-2 testing results to the department. Immediate reporting is defined as reporting within one day of the test being performed.~~

Reporting Procedure

~~All results are reported to the department daily via secure email account set up by the Iowa Department of Public Health.~~

1. ~~***State Reporting – COVID-19 Extract*** Report is scheduled to automatically run each day.~~
2. ~~Report is automatically saved to the Laboratory Department drive.~~
3. ~~Report is attached and sent daily via secure email account to idph.covidreporting@idph.iowa.gov.~~

All results are transmitted to the Iowa Department of Public Health Bureau of Environmental Health Services (IDPH EHS) automatically via Electronic Laboratory Reporting (ELR) from the Davis County Hospital and Clinics Laboratory Information System (LIS).

Approval Signatures

Step Description	Approver	Date
Medical Director	Carolyn Pease: Laboratory Medical Director	Pending
Senior Leader	Rod Day: Ancillary Services Director	09/2022
	Corri Phillips: Lab Manager	09/2022

Status Pending PolicyStat ID 12411804

Davis County HOSPITAL & CLINICS

An Affiliate of MERCYONE

Origination	08/1994
Last Approved	N/A
Effective	Upon Approval
Last Revised	09/2022
Next Review	2 years after approval
Owner	Corri Phillips
Policy Area	Laboratory - General
Applicability	Davis County Hospital

Laboratory Call

Purpose

There is Laboratory coverage twenty-four hours a day, seven days a week. ~~A Laboratory employee will~~In the event that overnight or weekend staff are out, some holidays or during staff shortages, shifts may be ~~ON CALL when the Laboratory is closed for routine testing~~covered on-call.

Procedure

Laboratory on-call schedule will be provided to the ER each month. The schedule will include staff phone numbers, staff name, date and time staff will be on-call. This schedule is kept in the ER on-call book. If there are any changes to the on-call calendar, lab staff will note those changes on the calendar and communicate with ER and House Supervisor.

After Hours On-Call Testing:

- Response time for lab personnel tests ordered in the ER~~/OB~~/ACUTE/SURG is twenty (20) minutes.
- The physician may request more than one Laboratory employee be called in.
- Occasionally there is nonemergency Laboratory Testing ordered after Laboratory hours. It is up to the Laboratory On-Call person to respond appropriately, to such testing, and by communicating with the nursing staff and evaluating each situation individually.
- ~~Occasionally there is nonemergency Laboratory Testing ordered after Laboratory hours. It is up to the Laboratory On-Call person to respond appropriately, to such testing, and by communicating with the nursing staff and evaluating each situation individually. These occasions could include:~~

- ~~New Admissions,~~
- ~~Scheduled Timed tests, or~~
- ~~"Today" orders~~

- ~~The patient care area will be notified of the Laboratory On-Call personnel's estimated time of arrival.~~

Nursing Personnel Responsibilities:

- The Nursing Supervisor, or designee, will contact the Laboratory personnel on call when lab tests are required during on-call hours. This includes, but not limited to, test(s) such as:
  - STAT test(s)
  - "Timed" or "Scheduled" test(s)
  - Add-On testing
  - Additional testing ordered in ACUTE/SURG placed during on-call hours
- The Laboratory Call personnel will be informed of the testing needed and the patient's condition. This will enable the Laboratorian to organize their actions in caring for the patient.

Approval Signatures

Step Description	Approver	Date
Medical Director	Carolyn Pease: Laboratory Medical Director	Pending
Senior Leader	Rod Day: Ancillary Services Director	09/2022
	Corri Phillips: Lab Manager	09/2022

Status Pending PolicyStat ID 12412035

Davis County HOSPITAL & CLINICS

An Affiliate of MERCYONE

Origination	05/2009
Last Approved	N/A
Effective	Upon Approval
Last Revised	09/2022
Next Review	2 years after approval
Owner	Corri Phillips
Policy Area	Laboratory - General
Applicability	Davis County Hospital

PRN Lab Personnel

~~POLICY:~~

POLICY

PRN ~~lab~~Lab staff are by definition, not ~~regularly~~routinely scheduled for work on the monthly Laboratory Work Schedule, but are utilized as needed for lab ~~work schedule, but are utilized as needed for lab~~ staffing needs. PRN staff are called in to work as soon as the lab manager or staff see a need for them. PRN staff are ~~NEVER to clock in~~not to work in any capacity without prior approval of the ~~lab manager~~Laboratory Manager, Director of Ancillary Services, and/or other Senior Leadership.

~~PROCEDURE:~~

PROCEDURE

PRN Lab staff must work at least two (2) shift requests in a 90 day period. Inability of PRN staff to work three (3) consecutive shift requests or three (3) shift requests in a 6 month period will be considered as a voluntary resignation.

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

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

The lab manager or their designee will contact the PRN person as a need is recognized. Once called, and if accepting the offer to work, the PRN person if needed immediately, is expected to report for duty within an hour. If the work requirement is for a future time or date, this will be noted on the lab work schedule and all usual attendance policies will apply. It is understood that PRN staff may not always be available to work on short notice, however the PRN person should recognize the urgent need for them to respond

if possible.

~~If unable to work, such unavailability will be considered a refusal, and will be taken into consideration by the lab manager when future work opportunities arise. Inability of the PRN staff member to work 6 consecutive requests or 6 requests in a 12-month period will be considered a voluntary resignation.~~

~~PRN staff may from time to time have mandatory meetings to attend. The above procedure applies. PRN staff must always have the lab manager's prior approval for any hours worked, including meeting attendance, Health stream module completions or any other work-related situations.~~

Approval Signatures

Step Description	Approver	Date
Medical Director	Carolyn Pease: Laboratory Medical Director	Pending
Senior Leader	Rod Day: Ancillary Services Director	09/2022
	Corri Phillips: Lab Manager	09/2022

Status Pending PolicyStat ID 12413095

Davis County HOSPITAL & CLINICS

An Affiliate of MERCYONE

Origination	04/2012
Last Approved	N/A
Effective	Upon Approval
Last Revised	09/2022
Next Review	2 years after approval

Owner	Corri Phillips
Policy Area	Laboratory - Microbiology
Applicability	Davis County Hospital

Microbiology Safety Guidelines

~~DAVIS COUNTY HOSPITAL~~

~~STANDARD OPERATING PROCEDURES~~

~~Department:~~ Laboratory	~~Policy Number: LAB 08.03.0~~
~~Critical Access Hospital (CAH) Approval date: 04/16/2012~~	~~Page 1 of 1~~
~~Effective: 04/16/2012~~	~~Replaces: NEW~~
~~Board of Trustees (BOT) Approval date~~: 3/16/15	
~~Other Departments Affected:~~	

~~SUBJECT: Microbiology Safety Guidelines~~

~~POLICY:~~ ~~To protect the staff from possible pathogen exposure certain guidelines have been established for safety along with PPE when needed. The following guidelines should be used at all times and PPE worn when appropriate.~~

~~PROCEDURE:~~

1. ~~All culture specimens will be treated as infectious. So appropriate PPE should be used.~~
2. ~~Gloves should be worn when handlings specimens and setting up cultures.~~
3. ~~All cultures will be setup under hood.~~
4. ~~Protective equipment includes but not limited to:~~

a. ~~Disposable gloves~~

b. ~~Fire extinguisher~~

c. ~~Drench Hose/shower~~
d. ~~Disinfectants~~
e. ~~Splash guards for eyes~~
f. ~~Goggles~~
g. ~~Disposable lab coats~~
h. ~~Vent Hood~~

1. ~~Clean all workstation counters with bleach wipes.~~
2. ~~Counters are to be cleaned daily after Microbiology has been completed for shift.~~
3. ~~Log will be kept tech will initial and time when counters have been cleaned.~~
4. ~~Daily dispose of Biohazard Container containing 10% bleach and prompt fluids down the drain followed by large quantities of water.~~

Purpose

Continued exposure to actual and potential hazards involving the health and safety of personnel is inherent in a laboratory. Exposure in the laboratory to pathogenic organisms can occur in a number of ways. Most pathogenic organisms have a usual route of infection, which produces characteristic disease. However, when agents are introduced by another route (occupational exposure), the disease produced may be atypical and difficult to diagnose. When working with and around pathogenic organisms care must be taken. All cultures must be treated as containing pathogenic organisms. Following these guidelines can reduce exposure to pathogenic organisms and provide a safer work environment.

Exposure

Exposure to pathogenic organisms may occur in the following ways:

- Airborne: through opening of culture swabs, unscrewing specimen containers or opening lids especially if gas pressure has built up during transport or storage of the material to be cultured. Spills may also produce airborne pathogens.
- Contact: through skin or mucous membranes and/or penetration of skin. May occur if surfaces have not been properly disinfected after use. If skin contains scratches, cuts or open areas the risk of contracting a pathogenic organism is increased. Penetration may occur through needles or other sharps. Care must be taken when using needles or other sharps and their safety mechanism must be employed.
- Ingestion by mouth: usually occurs when hand washing is not performed or not performed properly. Could involve airborne and contact methods of exposure.

Equipment

Availability and proper use of equipment can limit exposure to pathogenic organisms. The following equipment is available in the department.

- Personal Protective Equipment: gloves, gowns, masks, pipetting devices
- Disinfectants: Approved hand cleansers, 10% bleach solution, Sani clothes
- Spill kits: Blood/Body fluid
- Cover waste receptacles: color coded Red
- Biological Safety Cabinet

Precautions

- All specimens submitted for culture must be treated as infectious.
- All specimens must be handled under the Biological Safety Cabinet.
- Wear gloves and other PPE as needed when handling specimens.
- Change any PPE that is visibly contaminated.
- Wash hands with approved hand cleansers as needed and when leaving the area.
- Eating, drinking, inserting or removing contact lenses and application of cosmetics and lip products are prohibited in testing area.
- Pipetting by mouth is prohibited
- Clean and disinfect work area as needed during procedures and when completed with work in that area.
- Clean and disinfect any equipment that is exposed to contamination
- Clean up any spilled specimens immediately using approved cleaners/disinfectants.

Disposal

Disposal, single use equipment will be used whenever possible. All disposable items, items used to clean spills or contaminated items must be placed in Red biohazard bags with in the designated waste receptacles.

Approval Signatures

Step Description	Approver	Date
Medical Director	Carolyn Pease: Laboratory Medical Director	Pending

Senior Leader	Rod Day: Ancillary Services Director	09/2022
	Corri Phillips: Lab Manager	09/2022

Status Pending PolicyStat ID 12382694

Davis County HOSPITAL & CLINICS

An Affiliate of MERCYONE

Origination	01/2022
Last Approved	N/A
Effective	Upon Approval
Last Revised	09/2022
Next Review	1 year after approval

Owner	Amy Tyson
Policy Area	Employee Health
Applicability	Davis County Hospital

Flu Vaccination Policy

Flu Vaccination Policy for Davis County Hospital & Clinics

PURPOSE:

The purpose of this policy is to protect staff, non-employees, patients, and families from acquiring seasonal influenza and to help prevent the unnecessary spread of the influenza 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 annual influenza vaccination unless an exemption is granted.

POLICY:

Participation in Davis County Hospital and Clinic's (DCHC) influenza immunization program is **mandatory**. All contractors, students or other individual serving at DCHC will be required to provide the proof listed below prior to October 31st, or date determined by DCHC administration team each year. All providers, staff and volunteers employed by DCHC will be required to do one of the following:

- Receive a flu vaccination offered by DCHC free of charge
- Provide proof of immunization if received outside of our program. 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) and return to Human Resources. ~~Take the form to your provider or your religious leader (Paster, Minister, Rabbi, Clergy, Priest, etc.) to complete and return to Employee Health.~~

PROCEDURE:

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

- Medical contraindication to the flu vaccine, which requires a signed statement from the individual's healthcare provider and identification of the reason
- ~~Religious practice or creed that prohibits immunization, which requires a signed statement from the individual's minister/religious leader and must be renewed annually.~~A sincerely held religious belief that prohibits you from receiving influenza vaccine. Religious exemption must be renewed annually.

Medical exemption examples include life threatening allergy, sensitivity to thimerosal, history of Guillain-Barre' Syndrome, and pregnancy (until the point of pregnancy when the provider gives documented approval to safely vaccinate). Acute fever, acute respiratory infections or active illness must be resolved prior to receiving influenza vaccination.

All reasonable submitted exemption requests must be submitted to ~~Employee Health~~Human Resources by October 15th ~~and are reviewed and processed by Employee Health, Infection Control, and HR~~.

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 annual influenza prevention program, but rather is an alternate method of compliance in place of the influenza vaccine.

All individuals not receiving the flu vaccine and granted an exemption will be required to wear respiratory protection in the form of a hospital provided surgical mask which must be always worn with exceptions of breaks and mealtimes. Individuals will be required to wear the mask for the duration of the influenza season which ends March 31st. 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 oversee receiving completed flu consent forms and completed exemption forms. All department leaders are responsible for making sure their staff are allowed adequate time to get their flu vaccinations. Employee Health will track all vaccinations and exemption documents.

All new employees will receive the flu vaccine or provide documentation of their immunization or exemption prior to the start of employment.

Employee Health will notify managers of staff that will not receive the flu vaccine due to medical or religious exemption. Managers will ensure that staff not receiving vaccine will comply with always wearing masks during flu season.

All flu vaccine will require employee written consent, consent forms are kept in the employee's Employee Health file, vaccinations are recorded electronically in IRIS (Iowa Registry of Immunization Services)

Vaccine Shortages

In the event of an influenza vaccine shortage, the situation will be evaluated by DCHC administration, relying of the expertise of Employee Health, Infection Prevention, Human Resources, Pharmacy, and

medical leadership. Influenza vaccinations will be offered to personnel based on job function and risk of exposure to influenza. Priority will be established in accordance with recommendations by the Iowa Department of Public Health.

Attachments

Certificate of Immunization Exemption - Medical 12-21-16 Final (1).pdf

DCH Influenza Vaccination Relgious Exemption Request-updated 9-16-2021 (002) (2) (1).docx

Approval Signatures

Step Description	Approver	Date
Medical Director	Dr. Ron Graeff: Provider	Pending
Senior Leader	Nikki Thordarson: CNO	09/2022
	Amy Tyson: Education/IP/ Employee Health/Wellness	09/2022

Laboratory Services Biennial Review
2022

Title	New	No Changes	Revised Statement	Revised Procedure	Retired	Comments
Blood Bank-New Processes & Procedures	x	x				Went to CAH March 2022, Reviewed Oct 2022
Blood Bank Record Retention	x	x				Went to CAH March 2022, Reviewed Oct 2022
Comparison of Past Blood Bank Records		x				
Critical Hematology Results				x		Formating changes, updated procedure
Error File - Blood Banking		x				
Laboratory Call			x	x		Revised Purpose and procedure
Look Back and Patient Notification				x		Minor typo fixed, updated reference PS ID
Massive Blood Transfusions				x		Formatting and updated procedure
Microbiology Safety Guidelines			x	x		Updated entire policy for current guidelines
Notifying FDA of Fatalities Related to Blood Collection or Transfusion		x		X		Updated Procedure March 2022, Reviewed Oct. 2022
PRN Personnel			x	x		Updated to follow current Lab PRN Policy
Proficiency Testing				x		Minor edit in procedure.
Quality Control Daily Decision				x		Minor typo fix, added heme/coag
Quality Control Requirements				x		Updated formatting and QC requirements
Release of Blood in Emergency Situations				x		Minor correction in procedure.
Releasing of Crossmatched Units Back to Blood Bank Inventory				x		Added clearer language
Selection of Donor ABO/RH		x				No changes on Policy, just removed label on policy with incorrect number. Crossover from previous system.
Ordering Tests Using Order Management					x	Requested to be retired in 2020 - Still in Policy Stat
Storage of Blood Components in the Event of the Loss of Monitored Refrigeration or Refrigerator Malfunction					x	This is duplicate information. Please Retire this Policy.
Quality Assurance Plan				x		edited to fit current Lab Quality Assurance Program.
Blood Lead Test Mandatory Reporting				X		Updated reporting process
COVID-19 Mandatory Reporting			X	X		Updated Purpose to no longer report negatives, updated reporting procedure.
Emergency Transfer of Blood Components with a Patient to Another Institution				x		Formatting changes, updated procedure.
Identification of Blood Product Unit			x	x		Updated Policy statement and procedure
Laboratory Quality Assessment: Phlebotomy Adverse Reactions		x				
Guide to Laboratory Services	x					
Laboratory Results Turn-Around-Time	x					

Nursing Biennial Review

(All Nursing Department's shared procedures - Outpatient, Specialty, ER, Med/Surg, Surgery)

2022

Title	New	No Changes	Revised Statement	Revised Procedure	Retired	Comment
Administration of Medication		x				**Revised Policy statement through CAH august 2022**
Authorization for Decisions in the Absence of the CNO		x				
Basic Life Support/CPR Education		x				
Chain of Command for Patient Care Concerns		x				
Changes in Patient Status		x				
Emergency Medication Drug Reference		x				
General Information: Rabies		x				
Informed Consent		x				
IV Potassium Administration		x				
Mandatory Reporting of Naloxone Administration					x	No longer required
Notification of Medical Examiner/Police		x				
Patient Identification		x				
Patient Self-Determination Act/Do Not Resuscitate		x				
Patient Transfer within Hospital		x				
PRN Nursing Pool		x				
Public Inquiries of Patient's Physical Condition		x				
Refrigerators that Contain Medicaitons		x				
Restraints		x				
Safe Haven for Newborns		x				
Special Drug Precautions		x				
Time Out- Universal Protocol for Prevention Wrong Site, Wrong Procedure and Wrong Person Surgery		x				

SOPs

SOP Acute Alcohol Intoxication		x				
SOP Administering Medications to Children 16 Years and Younger		x				
SOP Adrenal Insufficiency Screening with Cosyntropin		x				
SOP Autopsies		x				
SOP Blood Transfusion, Administration of Blood		x				
SOP Blood Warmer		x				
SOP Crash Cart		x				
SOP Decontamination Procedure		x				
SOP Defibrillator		x				
SOP Discharge Against Medical Advice		x				
SOP Discharge Criteria After Sedation/Anesthesia		x				
SOP EKGs		x				
SOP Emergency Drugs and Supplies for the Pediatric Patient		x				
SOP Emergency Request for Uncrossed-Matched Blood		x				
SOP Epidural Analgesic, Continuous Infusion or Bolus		x				
SOP Feeding Tube Maintenance		x				
SOP Fungal Cultures		x				
SOP Heparin Drip		x				
SOP Infusions, Transfusions, and IV Medications		x				
SOP Initial Dosing Guidelines		x				
SOP Insertion of PICC		x				
SOP Instructions for Patients Who Have Been Transfused		x				
SOP Insulin Pens		x				
SOP Intrathecal Narcotic Post-Operative Pain Management		x				
SOP Intravenous Immune Globulin Infusion		x				

SOP Intravenous Medication Administraiton During a Code Blue		x				
SOP IPOST		x				
SOP IV Conscious Sedation		x				
SOP IV Push Dilantin Adminstration		x				
SOP IV Remicade Infusion		x				
SOP Keo Feeding Tube Insertion		x				
SOP Lumbar Puncture		x				
SOP Lumbar Puncture for Pediatric Patient		x				
SOP Management of Occluded PICC Line		x				
SOP Medical Emergency Procedure/Cardiopulmonary Resuscitation		x				
SOP Nasogastric Tube		x				
SOP Nursing Performance Improvement Plan		x				
SOP Obtaining Blood from the Lab		x				
SOP Obtaining Eyes for Donation		x				
SOP Ostomy Care		x				
SOP Pain Management		x				
SOP Pediatric IV Therapy, Soluset Guidelines		x				
SOP Pediatric Safety/Security		x				
SOP Safeguarding the Patient with Allergies		x				
SOP Seizure Precautions		x				
SOP Severe Sepsis/Septic Shock		x				
SOP Telephone Advice		x				
SOP Tetanus - Diptheria		x				
SOP Thermometers		x				
SOP Treatment for Pain- Chronic vs. Acute Conditions		x				
SOP Urethral Specimens (Male and Female)		x				
SOP Use of Blanket Warming Cabinet		x				
SOP Use of LMX Cream Prior to IV Needle Insertion		x				

SOP Valuables		x				
SOP Viral Studies Procedure		x				
SOP Weighing the Patient		x				
SOP Wound Photography				x		Updated instructions. Can now be done on IPAd and uploaded to Cerner.

Pharmacy Biennial Review

Oct-22

Title	New	No Changes	Revised Statement	Revised Procedure	Retired	Comments
Admitting, discharging, and transferring of patients in the automated dispensing machines.		X				
Adverse Drug Reactions		X				
After Hours Drug Procurement		X				
After Hours Pharmacy Coverage		X				
Ambulance Service		X				
Antimicrobial Stewardship		X				
Assigning Beyond-Use Dates to Compounded Preparations		X				
Automatic Stop Orders		X				
Automatic Therapeutic Substitution for Hydrocodone/Acetaminophen (APAP) Tablets		X				
Automatic Therapeutic Substitution for Proton Pump Inhibitors		X				
Bedside Medications		X				
Bulk Medication Dispensing Upon Discharge		X				
Chemotherapy safety and chemotherapy spill procedures.		X				
Compounding of Non-Sterile Preparations in the Pharmacy		X				
Compounding Sterile Preparations in the Pharmacy		X				
Controlled Substance Medication Removal from Omnicell		X				
Controlled Substance Restock		X				
Controlled Substances		X				
Daily Pharmacy Routine		X				
Drug Allergies		X				
Drug Product Recall		X				
Drug Substitution		X				
Drug Utilization Review/Antibiotic Utilization.		X				
Drug/Drug Interactions		X				
Drugs and Services in a Disaster		X				
Emergency Boxes and Carts		X				
End of Shift Count of Narcotics and Controlled Substances		X				

Title	New	No Changes	Revised Statement	Revised Procedure	Retired	Comments
Financial Tracking		X				
Formulary		X				
General Nursing Access Options		X				
General Safety		X				
General Support		X				
High Alert Medications		X				
Infiltration and Extravasation Management		X				
Intranasal Drug Delivery Via Atomizer		X				
Investigational Drugs		X				
Laminar Flow Glove-Box Isolator Hood Maintenance		X				
Licensure of Pharmacy Personnel		X				
Medication Acquisition, Inventory Control and Floorstock Inspections.		X				
Medication Administration with a Patient on Leave of Absence		X				
Medication HCPCS J-Codes and Software Behavior With Regard to Quantity		X				
Medication Removal		X				
Medication Restock		X				
Medication Shortages		X				
New employee orientation.		X				
New Medication Orders		X				
Obtaining Non-Formulary Drugs from Outside Pharmacies		X				
Omnicell Drawer will Not Open		X				
Operator Access		X				
Patient Education		X				
Patients Home Medications		X				
Pharmaceutical Sales Representatives		X				
Pharmacist Responsibilities for Automated Medication Distribution Systems (AMDS)		X				
Pharmacist Review of Medication Orders		X				
Pharmacy Access when Pharmacist is Absent		X				
Pharmacy and Therapeutics Committee		X				
Pharmacy Department Hours of Operation		X				
Pharmacy Record Keeping		X				
Pharmacy Requirements		X				

Title	New	No Changes	Revised Statement	Revised Procedure	Retired	Comments
Report Request		X				
Reporting of Medication Errors, Adverse Drug Events and Drug Incompatibilties		X				
Returning Unused Medications to Omnicell		X				
Safe Handling of Hazardous Drugs		X				
Safe Injection Practices		X				
Sample Drugs		X				
Security of the Pharmacy Department		X				
Sound Alike / Look Alike Drugs (SALAD)		X				
Stat Orders		X				
Telepharmacy		X				
Unit Dose Packaging		X				
Unresolved Controlled Substance Discrepancy		X				
Vancomycin Laboratory Monitoring Guidelines				X		Revised procedure to allow pharmacist discretion to manage trough levels and make dosage adjustments.
Wasting Controlled Substance Medications		X				

Plant Ops / Pool Biennial Review

2022

Title	New	No Changes	Revised Statement	Revised Procedure	Retired	Comments
Air Handling Eguipment		x				
Alarm System Test and Drill		x				
Back-Up Energy Source for Boilers		x				
Boiler/Boiler Room		x				
Definitions of Utility Failure		x				
Electrical Distribution System Annual Inspection		x				
Elevator Failure		x				
Emergency Generator Failure		x				
Failure of Fire System		x				
Failure of Gas or Vacuum Systems		x				
Failure of Natural Gas Supply		x				
Failure of Sprinkler System						under review
Failure of Water Distribution-System		x				
Fire Door Inspections		x				
Fire Extinguisher Inspection		x				
Kitchen Hood Fire Extinguishing System		x				
Management of Electrical System Failure		x				
Personal Electrical Equipment		x				
Preventative Maintenance of Emergency Generator		x				
Preventive Maintenance of Air Filters		x				
Record Retention		x				
Records on Contracted Equipment and Services		x				
Refrigeration Equipment		x				
Rules and Regulations		x				
Test of Emergency Diesel Generators		x				
Therapy Pool Sanitation Policy		x				
Types of Fires Fire Extinguishers		x				
Underground Storage Tank		x				
Use of Electric Equipment in Oxygen Enriched Environments		x				
Utilities and Equipment, Continuing Education		x				
Utilities Management Emergency Power		x				
Utilities Management Emergency Shutoff Labels		x				
Utilities Management Program		x				
Water Management plan		x				
Sprinkler System Impairement		x				
Water temperatures in patient/exam rooms		x				

SOPs

Buildings & Grounds Safety		x				
Company Vehicles		x				
Compressed Gas & Oxygen Use		x				
Confined Space Entry		x				
Control of Air Flow in Facility		x				
Cutting Welding & Hot Work Operations		x				
Departmental Safety		x				
Electrical Systems		x				
Emergency Phone Numbers						
Eq. Operation, Condition, and Malfunction report		x				
Extension Cords		x				
Failure of Essential Equipment		x				
Failure of HVAC System		x				
Failure of Plumbing System or Flooding		x				
Failure of-Steam Delivery System		x				
Fire Alarm components testing & inspecting		x				
Hazard Communication Program		x				
Holiday/Seasonal Decorations		x				
Infection Control for Maint. personnel		x				
Inventory and Inspection of New Equipment		x				
List of Chemicals Not To Be Mixed		x				
Lock out/Tag-out Program during equipment repair		x				
Logbook and Significant Occurrences		x				
Maintenance Department On-Call Policy		x				
Maintenance Work Request System		x				
Maintenance Work Schedule		x				
Vacuum Systems Preventive Maintenance		x				
Outside Contractors		x				
Painting Procedure All Areas		x				
Plant Operations and Maintenance Program		x				
Preventative Maint of Water Dist & Plumbing System		x				
Preventative Maintenance		x				
Preventative Maintenance of Boiler and Steam System		x				
Preventative Maintenance of HVAC System		x				
Scheduled or Requested Plant Improvements		x				
Snow Removal		x				
Emergency Phone Numbers		x				

Skilled Care Services Biennial Review
2022

Title	New	No Changes	Revised Statement	Revised Procedure	Retired	Comments
Admission to Skilled (Swing Bed) Level of Care		x				
Dental Services		x				
Referrals from Outside Facilities		x				
Skilled Rehab Services		x				
Skilled Resident Assessments		x				
Skilled Resident Nutrition		x				
Skilled Social Services		x				
Skilled/Swing Bed Resident Activities		x				
Skilled/Swing Bed Resident Rights		x				
Specialized Rehabilitative Services		x				
Swing Bed/Skilled Comprehensive Care Plans & Service Provided		x				
Transfer or Discharge of Skilled/Swing Bed Resident		x				

Title	Policy Area	Summary of Changes	Revised?
Clinic Office Schedule	Physicians Clinic	update providers and hours	Revised procedure
Clinic Staffing	Physicians Clinic	Added Paramedic to provider's nurse	Revised procedure
Compliance with Federal, State and Local Laws	Physicians Clinic	spelling error	Revised procedure
Confidentiality of the Clinical Record	Physicians Clinic	added "and clinics"	Revised procedure
Emergency Drugs	Physicians Clinic	changed clean utility to South Nurse work area	Revised procedure
Infection Prevention	Physicians Clinic	added "or on the wall outside the exam room	Revised procedure
Management of Pain Prescriptions	Physicians Clinic	changed contract to agreement # 5& 6 and added the agreement orginates from chart with a copy given to patient in # 5	Revised procedure
Patient Medical History	Physicians Clinic	under #2 changed "past medical history to current medication and histories	Revised procedure
Program Evaluation	Physicians Clinic	Annual changed to Biannual (every two years)	Revised procedure
Administrative Structure	Physicians Clinic		Unchanged
Bladder Scanner	Physicians Clinic		Unchanged
Chaperone Policy	Physicians Clinic		Unchanged
Cleaning and Sterilization of Instruments	Physicians Clinic		Unchanged
Cleaning of the Clinic	Physicians Clinic		Unchanged
Clinic Charges and Billing	Physicians Clinic		Unchanged
Clinic Operating Hours	Physicians Clinic		Unchanged
Concurrent Review of Patient Care	Physicians Clinic		Unchanged
Consent to Treatment/Informed Consent	Physicians Clinic		Unchanged
Disclosure of Ownership	Physicians Clinic		Unchanged
Documentation	Physicians Clinic		Unchanged
Dress Code	Physicians Clinic		Unchanged
Drugs and Biologicals	Physicians Clinic		Unchanged
Emergency Care During Clinic Hours	Physicians Clinic		Unchanged
Governing Body	Physicians Clinic		Unchanged
In-service Training/Continuing Education	Physicians Clinic		Unchanged
Medical Director	Physicians Clinic		Unchanged
Medical Record Audit	Physicians Clinic		Unchanged
No Show Appointments	Physicians Clinic		Unchanged
Non-Medical Emergencies	Physicians Clinic		Unchanged
Normal Daily Routine of the Clinic	Physicians Clinic		Unchanged

Organizational Chart	Physicians Clinic		Unchanged
Patient Assistance Plan	Physicians Clinic		Unchanged
Patient Dismissal	Physicians Clinic		Unchanged
Performance Improvement	Physicians Clinic		Unchanged
Performing an Electrocardiogram	Physicians Clinic		Unchanged
Pharmacy Review	Physicians Clinic		Unchanged
Physical Plant Safety	Physicians Clinic		Unchanged
Physician Responsibilities	Physicians Clinic		Unchanged
Policies and Procedures	Physicians Clinic		Unchanged
Preventive Maintenance	Physicians Clinic		Unchanged
Protection of Health Information	Physicians Clinic		Unchanged
Provider Treating Self and Family Members	Physicians Clinic		Unchanged
Provision of Rural Health Clinic Services	Physicians Clinic		Unchanged
Refrigerators at the Clinic	Physicians Clinic		Unchanged
Release of Information	Physicians Clinic		Unchanged
Retention and Storage of Medical Records	Physicians Clinic		Unchanged
Review of Clinic Operations	Physicians Clinic		Unchanged
Review of Health Care Policies	Physicians Clinic		Unchanged
Scope of Care by Midlevel Practitioner	Physicians Clinic		Unchanged
Security and Confidentiality of the Health Record	Physicians Clinic		Unchanged
Snow and Ice	Physicians Clinic		Unchanged
Storage of Medications	Physicians Clinic		Unchanged
Tornado Alert Plan/Severe Thunderstorm	Physicians Clinic		Unchanged
Vaccine and Medication Storage and Handling	Physicians Clinic		Unchanged
Vaccines for Children	Physicians Clinic		Unchanged
Clinic Management	Physicians Clinic	update renewal date to 2 years	unchanged

Status Pending PolicyStat ID 12446682

Davis County HOSPITAL & CLINICS

An Affiliate of MERCYONE

Origination	09/2018
Last Approved	N/A
Effective	Upon Approval
Last Revised	10/2021
Next Review	1 year after approval

Owner	Tara Porter
Policy Area	Utilization Review
Applicability	Davis County Hospital

Utilization Review and Management Plan

Effective for:

Medical and Hospital staff

Statement of Purpose:

- The purpose of this plan is to assure the delivery of medically necessary, timely, quality patient care through cost effective utilization of resources.
- Provides review of the medical necessity of admissions, continued stays and services rendered. The Utilization Plan (U.R.) Plan addresses over-utilization, under-utilization, inefficient scheduling of resources and denial of services from external agencies.
- The U.R. Plan applies to all patients regardless of payment source. The Plan does not address or include utilization review conducted by members of the medical staff under contract with, or via other means of delegation by, a third payer.

Utilization Review Committee Structure:

The U.R. Committee is a standing committee of the medical staff and is responsible to the Medical Staff Executive Committee. Membership shall consist of a least two physician members with active staff privileges. Other members of the medical staff may be asked to review cases when their expertise is required. Nonmedical staff members include the Director of Quality and Utilization Review Coordinator.

Meetings:

The U.R. Committee meets monthly if needed, at minimum quarterly. Additional meetings may be held when needed. A simple majority of committee members shall constitute a quorum.

Conflict of Interest:

A physician may not participate in the review of any cases in which he/she has been or anticipates being professionally involved. Physicians having a direct or indirect financial interest in the case(s) being reviewed may not participate in the utilization management activities pertaining thereto. Individuals having a direct financial interest in the hospital may not participate in utilization management activities.

Confidentiality:

The proceedings of the U.R. Committee, its subcommittees and its derivative documents are confidential. Members of the committee have a duty to preserve this confidentiality. To assure confidentiality, patient references are identified by visit ID # and physician identification is by an assigned code number.

Definitions:

Physician Reviewer: A physician member of the medical staff and U.R. Committee or appointee of the committee who is assigned responsibility for performing peer review functions in accordance with the Medical Staff Peer Review Process and this U.R. and Management Plan.

- The Physician Reviewer is responsible to review the cases referred by the Review Coordinator or appointee and make appropriate determination of medical necessity regarding the patient's level of care. The Physician Reviewer will also contact the attending physician if a negative determination is made. In addition, Physician Reviewers shall serve as liaison between the U.R. Committee and the medical staff. In the event a Physician Reviewer is unable to review a case referred by the Review Coordinator due to a conflict of interest (see "Conflict of Interest" section above) or for other reasons, the Chairperson must assign an alternate Physician Reviewer.

Review Coordinator: The non-physician committee member designated by the Utilization Management Committee to have oversight responsibility for the following activities.

- Admission and continued stay review
- Referral to Physician Reviewers of all patients who do not meet criteria for the ordered level of care on admission or continued stay review.
- Communication of denials by eternal review organizations to the appropriate parties
- Performance of other duties as delegated by the U.R. Committee.

Discharge Planning: A collaborative process by nursing, additional members of the healthcare team, the patient and his/her family or significant others, and the attending physician to facilitate timely and successful transition to another level of care or to home with appropriate services. Discharge planning occurs on all patients and is initiated at the time of admission. Discharge planning conferences and activities shall be documented in the medical record.

Review Criteria: Standards established by the U.R. Committee and approved by the Medical Staff

Executive Committee for use by the non-physician personnel in screening for appropriate utilization. The review criteria will be reviewed for relevance on a regular basis and revised as necessary.

Working Day: a day when U.R. personnel are available to perform review, and shall be, at a minimum, Monday through Thursday of every calendar week, excluding observed holidays.

Review Procedures:

- Concurrent Review: Concurrent review focuses on the medical necessity for admission and continued stay for all patients. The number and type of cases to be reviewed will be determined by the U. R. Committee based on identified problems and specific practitioners with known or suspected patterns of inappropriate utilization. The source of payment must not be the sole determinant in identifying patients for concurrent review.
- Admission Review: Within one working day of admission, the Review Coordinator must screen the medical record of patients identified for review to determine the medical necessity and appropriateness of admission and to ensure that the physician has certified that the patient requires a 2-midnight stay for all inpatients. The Reviewer Coordinator will utilize Milliman Care Guidelines and the screening criteria established by the U.R. Committee to perform these reviews. If the admission meet criteria and is considered appropriate, the Review Coordinator will certify the admission and assign a continued stay review date based upon the principal diagnosis, severity of illness, intensity of service, required length of stay norms and acute treatment plan.
- If the admission does not meet the screening criteria f or medical necessity, the Reviewer Coordinator will refer the case to the Physician Reviewer who performs review based on clinical judgement, not screening criteria. If the Physician Reviewer finds the admission to be inappropriate, the Physician Reviewer then notifies the patient's attending physician and affords him/her an opportunity to present his/her views before a final determination is made.
- In cases of dispute between the attending physician and the Physician Reviewer, a second Physician Reviewer must be consulted. Concurrence form the two Physician Reviewers will be required in all adverse decisions that the attending physician protests.
- If a determination is made that the admission was not medically necessary, written notice which includes specified procedures for appealing the denial will be given to the patient (or his/her representative), and the attending physician no later than two (2) working days following admission. When the patient is a Medicare beneficiary, the CMS specified denial letters are used to notify the patient and the QIO of the denial.
- If the physician reviewer determines that an admission is justified, the attending physician shall be notified and an appropriate date for subsequent extended stay review will be selected.
- Medicare Patients Inpatient Admission Changed to Outpatient (Condition 44): In cases where screening criteria lacks medical necessity for inpatient admission, the U.R. Coordinator will contact the attending physician to re-evaluate admission status and/or possible change to outpatient/observation status. If the patient status remains unchanged, without additional

medical necessity identified, a U.R. Committee Physician will be contacted for review. If the attending physician does not concur with the Committee Physician Reviewer the case will be referred to a second U.R. Committee Physician Reviewer. If the attending physician concurs, the admission order will be changed to outpatient status provided the following criteria are met:

A. The change from inpatient to outpatient status is made during hospitalization, prior to discharge or release.

B. A claim for the inpatient admission has not been submitted to Medicare.

C. The attending physician concurs with the U.R. Committee decision

D. The physician's concurrence with the U.R. Committee decision is documented in the medical record.

In cases of dispute between the attending physician and the Physician Reviewer, a second Physician Reviewer must be consulted. Concurrence from the two Physician Reviewers will be required in all adverse decisions that the attending physician protests.

Continued Stay Review:

The continued stay review date is assigned by the Review Coordinator (see admission review), based on the patient's principle diagnosis, severity of illness, intensity of service and/or other criteria established by the U.R. Committee. Justification for continued stay is based on the attending physician's documentation in the medical record. If a case meets criteria for continued stay, the Review Coordinator will certify continued stay and assign the next review date.

- Cases which do not meet the criteria for continued stay will be referred to a Physician Reviewer for review. The Physician Reviewer uses clinical judgement, not screening criteria, as a basis for decision. IF an adverse decision is considered, the attending physician will be given opportunity to present his/her views before the determination is made.
- In case of dispute between attending physician and the Physician Reviewer, a second Physician Reviewer must be consulted. Concurrence form the two Physician Reviewers will be required in all adverse decisions that the attending physician protests.
- If a decision is made that further inpatient stay is not medically necessary, written notice which includes specified procedures for appealing the denial will be given to the patient (or his/her representative), and the attending physician no later than one (1) working day after the final determination is made. When the patient is a Medicare beneficiary, the CMS specified denial letters are used to notify the patient and the QIO of the denial.
- If the physician reviewer determines that an extended stay is justified, the attending physician shall be notified and an appropriate date for subsequent extended stay review will be selected.

Retrospective Review:

Retrospective review will be performed in the following circumstances:

- Problem cases not identified by concurrent review;
- Random sampling of cases to pick up situations that are new or to verify that the system is working properly;
- Address case of underutilization;
- Review cases post discharge for which third party payers question or deny care;
- Required by a third party;
- Focused review.

Focused review is a review of known or suspected specific problems. The U.R. Committee initiates the review and sampling methods without regard to pay source.

- The U.R. Committee identifies cases associated with unusually high costs or excessive services and classes of admissions wherein patterns of care are found to be questionable. If analysis indicates inappropriate use of hospital resources, corrective action should be specific to the problem and may include concurrent review, education or training programs, amended staff patterns, provision of new equipment or facilities, or improved scheduling of resources or adjustments in staff privileges. Questions that deal with appropriateness and quality of the professional services rendered will be referred to the medical staff director/ committee responsible for that service. That department/ committee will in turn study, analyze and act upon its findings and will also report back the results of such studies to the U.R. Committee. To demonstrate that corrective action has been effective, follow up must be implemented until it is shown that the problem has been corrected.

The quality Improvement Steering Team may, as appropriate, refer problems to the U.R. Committee to conduct reviews of appropriateness and medical necessity of admission, continued stays, supportive services and provision of discharge planning.

Appeals Process:

If the attending physician disagrees with the adverse findings of the two Physician Reviewers, he/she may at any time within sixty days request reconsideration by the Medical Staff Executive Committee. These reconsiderations will be conducted at a regular scheduled meeting of the Medical Staff Executive Committee. In no instance shall a Physician Reviewer involved in an initial determination be involved in making a reconsidered determination. Reconsideration is not a formal adversary process. The Medical Staff Executive Committee shall make a reconsidered determination affirming, modifying, or reversing the initial adverse determination. In all cases, the findings of the Medical Staff Executive Committee shall be binding.

Discipline:

The U.R. Committee is not a disciplinary committee. Any perceived problems with medical staff members will be forwarded to the Medical Staff Executive Committee for consideration. Medical staff members who frequently experience utilization management denials may be subjected to preadmission monitoring, focused review or other restrictions which the Medical Staff Executive deems necessary to

correct the utilization related problems(s).

Approval/Evaluation of the Utilization Review Program:

The U.R. Plan is reviewed, evaluated and approved on an annual basis by the U.R. Committee, CAH Advisory Committee, Medical Staff and the Governing Body, and constitutes the official plan. Policy and procedure for conduct of utilization management services. The plan may be additionally updated or revised based upon the ongoing evaluation of the utilization management activities and their relationship to the quality of patient care. U.R. reports are provided to Administration, Medical Staff Executive Committee and the Board of Trustees on a quarterly basis.

Iowa Medicaid Enterprises (IME) conducts a desk review on all Critical Access Hospital Utilization Review Programs every 3 years to assure policies and procedures are in place to meet the requirements. Program scores are received and will include deficiencies if identified. If corrective action is indicated a formal corrective action plan must be submitted within 30 days.

Extended Stay Review:

An "Extended Stay" is defined as an acute length of stay > 9 days.

All Extended stays are reviewed by the U.R. Coordinator and the Physician Reviewer. Case review findings will be presented at the U.R. Committee Meetings.

Approval Signatures

Step Description	Approver	Date
CAH	CAH: DCHC Critical Access Hospital Committee	Pending
Medical Director	Robert Floyd: Chief of Staff/ Internal Medicine Physician	10/2022
Senior Leader	Nikki Thordarson: CNO	09/2022
	Tara Porter: Patient Services Manager	09/2022