Cogdell

SCURRY COUNTY HOSPITAL DISTRICT
GOVERNING BOARD RECORD OF MEETING
Wednesday, November 4, 2020 | 8:00 am
Hospital Administrative Board Room, 1700 Cogdell Blvd., Snyder, Texas

MISSION	VISION
To provide compassionate, high quality healthcare to the patients we serve and to improve healthcare and healing within our community.	*To be the Regional Healthcare System of choice for patients, physicians and employees.*

The purpose of this meeting is to discuss and, as necessary, act on the agenda items enumerated below.

Conflict of Interest Statement

Board Members Present	Cogdell Staff Present	Others Present	Absent
Jason Cave, OD	Ella Helms, CEO	Kaylee, Snyder Daily News	Russell Riggan
Bennie Marricle	John Everett, COO	Ryan Morris, MD	Andrea Martini
Loretta McCravey	Kristi Hanley, RN, CQO	Patsy Palmer	Judy Moss
Mike Tyrrell	Kathy Goodwin, RN, CNO	Jake Warren, Gov. Capital	
	Rose Ragland, Admin Asst.		

I. Introduction

A. Call to Order — **R. Riggan**

The meeting was called to order at 8:00 am.

B. Invocation

Invocation provided by J. Cave.

C. Announcements/Public Comment — **R. Riggan**

No public comments

II. Meeting Minutes

Minutes from September 30, 2020 Meeting — **R. Riggan**

Meeting minutes from September 30, 2020 were presented. M. Tyrrell motioned to approve the minutes as presented. J. Cave seconded the motion. Motion carried.

III. Old Business

A. Board Self-Evaluation — **E. Helms, CEO** — **Receive Information**

B. Texas Healthcare Trustees Training - December 10, 2020 2:00-4:30pm — **E. Helms, CEO** — **Receive Information**

E. Helms reminded the Board about the Self-Evaluation forms that were sent out. They can do the evaluation on line or paper. She also mentioned the Texas Healthcare Trustee training they could sign up for on line. It is set up for December 10th, 2:00 - 4:30 pm.

IV. New Business

A. Medical Staff Report — **R. Morris, DO** — **Review > Approve**

No Medical Staff report given

B. Credentialing — **R. Morris, DO** — **Review > Approve**

1. New Appointments
   - a. *Michelle Hicks, DO (Envision)*
   - b. *Ammar, Taha MD (Direct Radiology)*
2. Reappointments
   - a. *David Blann, MD (Gynecology - Specialty Clinic)*
   - b. *Brett Gallagher, CRNA (Anesthesiology)*

Dr. Morris presented the new appointments and reappointments for review and approval. M. Tyrrell motioned to approve the appointments and reappointments as presented. L. McCravey seconded the motion. Motion carried.

C. COVID-19 Situation Report — **R. Morris, DO** — **Inform**

Dr. Morris gave the Board an update for Scurry County. COVID numbers are rising. The area hospitals are filling up. Staffing has been a challenge due to employee exposure to COVID. There is about 5% of Scurry County that has tested positive for COVID. CMH has set up an additional 4 negative pressure rooms on Med Surg unit in addition to the rooms in the old OB wing. There have not been any positive flu cases in Scurry County.

D. Mission Moment - Respiratory Therapy — **Patsy Parmer, RRT Inform**

P. Palmer has been at CMH for 40 years. She stated respiratory department currently has 4 ventilators on hand. COVID patients have done well. Respiratory has someone on call 24/7.

E. Documents/Policies/Forms

1. Individual Policies/Documents — *E. Helms, CEO* — *Review > Approve*
   - a. *ORG 1.ORG.SM.1471 Family Leave Expansion & Emergency Paid Sick Leave Policy - FFCRA Coronavirus*

2. Policy Manuals — *K. Hanley, RN* — *Review > Approve*
   - a. *ORG 340B Program Policies and Procedures (Reviewed; no revisions.)*
   - b. *ORG Financial Services (See attached for revision notes.)*
   - c. *ORG Information Services (Reviewed; no revisions.)*
   - d. *ORG Materials Management/Central Supply (Reviewed; no revisions.)*
   - e. *ORG Medical Records Service (Reviewed; no revisions.)*
   - f. *PRS Care Mgmt. (Discharge Planning & Utilization Review) (See attached for revision notes.)*
   - g. *PRS Patient Rights (See attached for revision notes.)*
   - h. *PTC Clinics (Reviewed; no revisions.)*
   - i. *PTC Emergency & Trauma Services, Forensic Nursing (See attached for revision notes.)*
   - j. *PTC Medication Management (See attached for revision notes.)*

E. Helms & K. Hanley presented the P & P for review and approval. J. Cave made the motion to approve the P & P as presented. M. Tyrrell seconded the motion. Motion carried.

F. Resolutions — **E. Helms, CEO** — **Review > Approve**

1. Resolution authorizing the issuance of Scurry County Hospital District revenue bonds, Series 2020; prescribing the terms and provisions thereof; making provisions for the payment of interest thereon and the principal thereof; authorizing the sale thereof; and containing other provisions related to the subject

2. Resolution adopted by Scurry County Hospital District regarding declaration of official intent to Section 1.150-2 of the treasury regulations to reimburse for expenditures

E. Helms introduced Jake Warren to present information regarding loans/bonds. J. Warren informed the board the refinance bonds will be through Government Capital. 15 year fixed rate on 20 year loan with interest rate of 2.5% in the amount of $2.1 million. J. Warren explained the reserve fund and answered questions. M. Tyrrell made the motion to approve the resolution authorizing the issuance of revenue bonds. L. McCravey seconded the motion. Motion carried.

G. Reports (Other Committees/Meetings)

1. Finance Report - Financial Report — J. Everett, CFO — Receive>Approve

J. Everett presented the Finance Report for review. The month of September, admissions are up, deliveries are even with last year, outpatients visits are up, (3400 this month, last year we were at 2800). ED visits are back up with last year numbers, clinic visits are up from last year, and Home Health visits are up. First Bank & Trust loan for $1mil. has been paid off. J. Cave made the motion to approve the finance report. M. Tyrrell seconded the motion. Motion carried.

2. Nursing Report - Monthly Update — K. Goodwin, RN — Inform

K. Goodwin gave the nursing report. COVID count is up. October in patients averaged 24% COVID patients. We are having difficult time transferring patients out to area hospital. Some have had to transfer further out to San Antonio and Austin areas. This has also caused more difficulty transferring non-COVID patients. She also passed out an updated copy of the contingency staffing plan. Kathy also reported that 70 nurses went through boot camp and all are now up to date on competencies. She stated the ED is working on level IV Trauma recertification. This should be in place in the spring of 2021.

3. Quality Management — K. Hanley, RN — Inform
   - a. *Quality, Risk & Regulatory Update*
   - b. *Committee Reports*

K. Hanley gave the QM report. DNV is expected any time after Nov. 1st. Overall volumes decreased this year. There has been an increase in patient satisfaction in spite of the pandemic. CMS has awarded 9 contracts, we have been offered opportunity to participate in 4 year engagement. This will include patient safety, opiod mis-use, quality of care, and other areas of focus.

4. Administration Report — E. Helms, CEO — Inform

No additional report.

H. Announcements

V. Board to convene in executive session pursuant to: — *R. Riggan*

Section 161.032(b) of the Texas Health and Safety Code, Re: Receive and Discuss Quality Assurance Report

Section 551.074 of the Texas Health and Safety Code, RE: Personnel Matters

The board convened in executive session @ 9:07am.

VI. Board to convene in open session and take action if needed on matter discussed in Executive Session	
The board reconvened into open session @ 9:26am. with no action taken from the closed session.	
VII. Meeting Finalization	*R. Riggan*
Next meeting scheduled for December 9, 2020.	
VIII. Adjourn	*R. Riggan*
The board adjourned at 9:27 am	

These minutes have been reviewed and approved by the Board of Directors.

Russell Riggan, President of the Board

Date

Cogdell
MEMORIAL HOSPITAL

New Policy Submission for PATIENT RIGHTS
December 2020

Identifier	TITLE	STATUS	NEED FOR DOCUMENT, REVISION OR REVIEW SUMMARY OF REVISION	REQUESTED ACTION
1.ORG.NS.0800	Suicide and Ligature Risk	NEW	Required with new NIAHO regulations	Approve

I. Title

Suicide and Ligature Risk

II. Purpose

To improve the quality and safety of care for those who are being treated for behavioral health conditions and those identified as high risk for harming themselves or others, including at risk for suicide. To keep all staff, visitors, and patients safe from those who seek to harm others.

III. Policy

Cogdell Memorial Hospital will provide care in as safe a setting as possible by identifying patients who are at risk for intentionally harming themselves or others, identifying and mitigating environmental safety risks and providing environmental safety education and training for employees.

IV. Procedures

1. Identification of 'at risk' patients

a. **Emergency Department**: all patients presenting to the ED with a psychiatric complaint must be screened for suicidal ideation. Under the "General" tab in the *ED Triage and Assessment* form complete the box labeled "Mental Health Concerns". If "YES" is selected, the *Columbia Suicide Severity Rating Scale (C-SSR)* will open up.

b. **Inpatient Units:** All patients admitted to the hospital with a psychiatric complaint must be screened for suicidal ideation. Complete *Admission History Adult; Adult Depression Screening* tab (or pediatric admission and screening, if applicable). If any of the depression screening questions are answered positively, the *Adult Patient Mental Health Questionnaire* will open up for documentation. Any answer other than "None at all" to the question of "Thoughts better off dead or hurting yourself" will activate the *Suicide Risk Assessment* form to open up for completion. If assessment is positive for suicide risk, see step c. below.

c. **Complete the *Columbia Suicide Severity Rating Scale (C-SSR)* for all patients who screen positive.** Ask the patient question #1,"Have you wished you were dead or wished you could go to sleep and not wake up?" If they answer "NO" in their lifetime, the screening is complete. If they answer "YES" pull a paper copy of the SAFE-T Protocol with C-SSR Form. This will help identify the "Risk Level" of the patient. The form will be on the portal, but there will be color copies available in the unit or from the House Supervisor.

d. For all patients who screen at a *moderate* or *high* risk:

- Initiate suicide precautions and notify MD of assessment findings. Obtain an order for suicide precautions, including 1:1 continuous observation
- Obtain an order prior to discontinuing 1:1 continuous monitoring, when appropriate
- Print *Environmental Ligature Risk Assessment* form
- Provide 1:1 continuous observation and at a minimum, every 15 minute documentation.
  ED Patient: Document on paper form *Sitter Observation Log*
  Inpatient: Document in *Individual Observation Record* (ad hoc form under *Behavioral Health* tab.
- Document detailed assessment every 4 hours and PRN
  ED Patient: >Interactive View>ED Adult Systems Assessment>Mental Status/Agitated Behavior Scale

Inpatient: Interactive View>Patient rounding and assessment tab

2. **Identification and mitigation of environmental safety risks**
   a. *Complete Environmental Ligature Risk Assessment* (paper form) upon arrival and at the beginning of **every shift** to identify objects that could be used for self-harm
   b. Remove those objects, when possible, without deterring patient care
   c. Mitigate all risks by providing 1:1 continuous observation
3. **Provision of environmental safety education and training**
   a. All staff providing 1:1 continuous observation and/or caring for an 'at risk' patient will be provided training
   b. Training will include *Guidelines to a Safe Environment, De-Escalation Strategies* and *Keep Yourself Safe and other r*esources as needed
4. Complete all documentation as identified in *Suicide Risk Workflow.* All documents and work instruction are posted in *Workflows* on portal.

V. Definitions

Ligature Risk: anything which could be used to attach a cord, rope, or other material for the purpose of hanging or strangulation

VI. Relevant Federal and State Statutes

NIAHO PE.1.SR1 (Revision 20-1)
CMS §482.13(c)(2)
JCAHO NPSG.15.01.01

VII. Related CMH Documents (all on portal > work instructions>suicide and ligature risk)

Suicidal Ideation Screening and Risk Assessment Workflow for ED Patients
Suicidal Ideation Screening and Risk Assessment Workflow for Inpatients
Environmental Ligature Risk Assessment
SAFE-T Protocol with C-SSRS
Sitter Observation Log
Suicidal Ideation Education

VIII. Dates Approved or Amended

Include origination date, dates of major or minor revisions and dates reviewed without changes.

Originated: Pilot Nov 2020; December 2020	*Effective: December 2020*
	Reviewed without Changes

IX. Contact Information

Quality Management (325) 574-7284

I. Title

Tuition Assistance Plan

II. Statement of Purpose

To establish a procedure for Cogdell Memorial Hospital to assist its employees by providing an opportunity for employees to improve their knowledge, ability and job skills.

III. Policy

CMH will, when appropriate, provide tuition assistance to eligible employees as opportunity and encouragement to gain further knowledge and skills.

IV. Procedure

A. Employee Eligibility Requirements:

1. Employees must be employed at CMH in a full-time or part-time employment status for a minimum of two years immediately preceding the start of the semester. The two year minimum may be waived, with CEO approval, for departments that have forecasted staffing needs of hard-to-fill positions.

2. Must pass each course with at least a B grade in order to be eligible for reimbursement.

3. Employee must not have received a disciplinary action within a year immediately preceding the start of the semester.

B. Course Eligibility Requirements:

1. Non-Degree Programs: The course must be job-related and provide training that will make a direct contribution to the employee's present job performance. The employee's department director/manager and the Human Resource Department will determine if the course meets the job-related criteria.

2. Degree Programs: The degree program must (a) prepare the employee for employment opportunities available at CMH in present or future positions and (b) be determined to be beneficial to CMH.

3. A copy of a degree plan (signed by a school official) from the accredited college or university should be submitted to the CEO for approval.

4. The course must be a college level course for which credit hours are given.

5. The college or university must be accredited.

6. Courses must be successfully completed with a grade of A or B.

C. Application Procedure

1. Employees must submit to their department director/manager a completed Application for Tuition Assistance form with a degree plan prior to the college registration date.

2. The Department Director/Manager will review the application 1) to determine if the course is job-related and will be beneficial to the employee's performance on the job; 2) to verify the employee is not in a disciplinary status.

3. The Director/Manager signs their approval/disapproval and sends the application to the HR Department.

4. Final review and approval/disapproval will be determined by the CEO and noted on the Application form and returned to HR for communication with the employee. The final determination to approve or disapprove on application is completely within the discretion of the CEO. No employee has a vested right or guarantee to receive tuition assistance and the fact that an employee meets the eligibility requirements herein does not automatically mean the employee will receive tuition assistance.

D. Reimbursement

Reimbursement amount to be determined by CEO based on degree obtained.

E. Employee Obligations

1. Employees must submit a completed Application for Tuition Assistance form (with degree plan attached) to department Director/Manager prior to college registration date.

2. Employees must submit within thirty (30) days of each semester end to the HR Department:

   - Original grade report
   - Original tuition fee receipt

3. Employees are obligated to continue to work for CMH for a minimum term dependent upon the total reimbursement amount. The terms set forth in the agreement are subject to approval by the CEO and may be modified at the discretion of the CEO.

4. Employees who voluntarily terminate employment before completing the terms of the Agreement or are dismissed for cause are required to reimburse the hospital the entire amount of the tuition received and the employee will not receive pay out of any accrued Paid Time Off (PTO). Employees must sign an Agreement to receive any reimbursement. If the Agreement is terminated prior to completion of course work, employee will be required to reimburse the hospital the amount of the tuition received. Employee must also agree to allow CMH to deduct any educational assistance owed to CMH from final paycheck.

V. Dates Approved or Amended

Originated:	*Effective: 04/2003*
Reviewed with Changes	*Reviewed without Changes*
01/2010, 04/2011, 07/2013, 01/2016	09/2017; 08/2020

VI. Contact Information

Human Resource Director

Cogdell
MEMORIAL HOSPITAL

DOCUMENT SUBMISSION
DECEMBER 2020

IDENTIFIER REASSIGNMENT	*VERSION*	CURRENT IDENTIFIER	TITLE	STATUS	NEED FOR DOCUMENT, REVISION OR REVIEW SUMMARY OF REVISION	REQUESTED ACTION
INFECTION CONTROL (IC)						
1.ORG.IC	V.122020		Admitting Infection Control Plan	revised	adding of COVID-19	approve
1.ORG.IC	V.122020		Anesthesia Infection Control Plan	reviewed	reviewed without changes	
1.ORG.IC	V.122020		Arterial Blood Gases - Respiratory Therapy	reviewed	reviewed without changes	
1.ORG.IC	V.122020		Bed Bugs	reviewed	reviewed without changes	
1.ORG.IC	V.122020		Bioterrorism Plan	reviewed	reviewed without changes	
1.ORG.IC	V.122020		Central-Line Associated Bloodstream Infections - Surveillance	reviewed	reviewed without changes	
1.ORG.IC	V.122020		Central Supply Infection Control Plan	reviewed	reviewed without changes	
1.ORG.IC	V.122020		Clostridium Difficile (C. Difficile)	reviewed	reviewed without changes	
1.ORG.IC	V.122020		Committee - Authority	reviewed	reviewed without changes	
1.ORG.IC	V.122020		Committee - Organization and Function	reviewed	reviewed without changes	
1.ORG.IC	V.122020		Conducting a Root Cause Analysis	reviewed	reviewed without changes	
1.ORG.IC	V.122020		Construction Renovation Guidelines	reviewed	reviewed without changes	
1.ORG.IC	V.122020		Department Specific Guidelines for Infection Control	reviewed	reviewed without changes	
1.ORG.IC	V.122020		Disposal of Sharps	reviewed	reviewed without changes	
1.ORG.IC	V.122020		Emergency Department Communicable Disease	reviewed	reviewed without changes	
1.ORG.IC	V.122020		Emergency Department Infection Control Plan	reviewed	reviewed without changes	
1.ORG.IC	V.122020		Environmental Services Infection Control Plan	reviewed	reviewed without changes	
1.ORG.IC	V.122020		Exposure Control Plan	reviewed	reviewed without changes	
1.ORG.IC	V.122020		Hand Hygiene	reviewed	reviewed without changes	
1.ORG.IC	V.122020		Home Health Infection Control Plan	reviewed	reviewed without changes	
1.ORG.IC	V.122020		Infection Control Plan	new	new	approve
1.ORG.IC	V.122020		Infection Control Program for all Departments	reviewed	reviewed without changes	
1.ORG.IC	V.122020		Infection Prevention and Control Program	reviewed	reviewed without changes	
1.ORG.IC	V.122020		Isolation Precautions	reviewed	reviewed without changes	
1.ORG.IC	V.122020		Job Description and Competency	revised	RN to LVN	approve
1.ORG.IC	V.122020		Laboratory Infection Control and Standard Precautions	reviewed	reviewed without changes	
1.ORG.IC	V.122020		Medical Equipment Management - Education - Orientation Employees	reviewed	reviewed without changes	
1.ORG.IC	V.122020		Methicillin Resistant Staphlycoccus Aureus (MRSA) Management	reviewed	reviewed without changes	
1.ORG.IC	V.122020		Methods of Surveillance	reviewed	reviewed without changes	
1.ORG.IC	V.122020		New Employee Infection Control Orientation	reviewed	reviewed without changes	
1.ORG.IC	V.122020		New Employee Orientation Outline	reviewed	reviewed without changes	
1.ORG.IC	V.122020		Nursing Services Infection Control Plan	reviewed	reviewed without changes	
1.ORG.IC	V.122020		Operating Room Routine Maintenance Equipment	reviewed	reviewed without changes	
1.ORG.IC	V.122020		Patient Owned Medical Equipment Device	reviewed	reviewed without changes	
1.ORG.IC	V.122020		Patient Safety Plan	reviewed	reviewed without changes	
1.ORG.IC	V.122020		Performance Improvement Plan	reviewed	reviewed without changes	
1.ORG.IC	V.122020		Personal Protective Equipment (PPE)	reviewed	reviewed without changes	
1.ORG.IC	V.122020		Pharmacy Infection Control Plan	reviewed	reviewed without changes	
1.ORG.IC	V.122020		Prevention of Catheter - Associated Urinary Tract Infections (CAUTI)	reviewed	reviewed without changes	

Cogdell
MEMORIAL HOSPITAL

DOCUMENT SUBMISSION
DECEMBER 2020

1.ORG.IC	V.122020		Radiology and Nuclear Medicine Infection Control Plan	reviewed	reviewed without changes	
1.ORG.IC	V.122020		Rehabilitation and Wellness Center Infection Control Plan	reviewed	reviewed without changes	
1.ORG.IC	V.122020		Reporting Lab Results to a Receiving Healthcare Facility	reviewed	reviewed without changes	
1.ORG.IC	V.122020		Respiratory Care Services Infection Control Plan	reviewed	reviewed without changes	
1.ORG.IC	V.122020		Response to an Influx of Infectious Patients	reviewed	reviewed without changes	
1.ORG.IC	V.122020		Sanitary Environment	reviewed	reviewed without changes	
1.ORG.IC	V.122020		Sentinel Event	reviewed	reviewed without changes	
1.ORG.IC	V.122020		Sharps Injury Protection	reviewed	reviewed without changes	
1.ORG.IC	V.122020		Storage of Items Under a Sink	reviewed	reviewed without changes	
1.ORG.IC	V.122020		Surgical Services Infection Control Plan	reviewed	reviewed without changes	
1.ORG.IC	V.122020		Surveillance Plan	reviewed	reviewed without changes	
1.ORG.IC	V.122020		Ultrasound Equipment Cleaning	reviewed	reviewed without changes	

I. Title

Admitting Infection Control Plan

II. Policy

The Admitting Department personnel are often the patient's first contact with the hospital. Although seriously ill patients are often admitted directly to the patient care units, many patients are processed through the Admitting Department. Staff members are to be familiar with and practice the principles of the control of infection. In particular, good hand washing/cleansing, being familiar with policies and procedures related to infection control and recognizing the potential for transmission of diseases.

Infection Control Program

1. Standard Precautions and Respirator Hygiene are observed for all patients.
2. All staff members are expected to adhere to recommendations for Standard Precautions.
3. The hospital's general infection control policies and procedures are adhered to.
4. The hospital's employee health and safety policies and procedures are adhered to.
5. Specific policies/procedures relative to the Admitting Department regarding infection control have been developed and are practiced.

III. Procedures

Management and Placement of Patients with known or suspected infections:

1. Patients with known or suspected infections/infectious diseases must be admitted without delay.
2. This would also refer to any patient with draining lesions/wounds, bleeding patients or any condition where blood or body fluids are present.
3. Don a mask, if patient is admitted with a communicable respiratory disease such as pneumonia, or tuberculosis or COVID-19.
4. If an ambulatory patient is exhibiting obvious signs of infection (i.e., coughing, sputum production, fever) transfer patient to assigned room as soon as possible and complete admission process as above.

Exposure Control Plan

1. Although the admitting department personnel are not expected to come in contact with blood and/or body fluids, personnel are expected to remain aware that blood and certain body fluids may contain bloodborne pathogens and present a potential exposure situation. Therefore staff members are expected to be familiar with the hospital's Exposure control plan, found on the portal.
2. If any personnel should come in contact with blood, body fluids or other potentially infectious material, they must immediately inform their immediate supervisor and House Supervisor.

IV. Dates Approved or Amended

Originated: 09/2009	*Effective:*
Reviewed with Changes	*Reviewed without Changes*
	11/2017, 05/2019, 12/2020

V. Contact Information

Infection Control Officer

I. **Title**
COVID-19 Plan

II. **Purpose**: Infection control procedures including administrative rules and engineering controls, environmental hygiene, correct work practices, and appropriate use of personal protective equipment (PPE) are all necessary to prevent infections from spreading during healthcare delivery. Prompt detection and effective triage and isolation of potentially infectious patients are essential to prevent unnecessary exposures among patients, healthcare personnel, and visitors at the facility.

III. A. **Minimize Chance for Exposure**

1. **Before Arrival:**

- When scheduling appointments, instruct patients and persons who accompany them to call ahead or inform healthcare personnel (HCP) upon arrival if they have symptoms of COVID-19 and to take appropriate preventive actions, such as wearing a facemask while in the facility.
- If a suspected of confirmed COVID-19 patient is arriving via transport by emergency medical services (EMS), the service should notify the emergency department (ED) prior to arrival, when possible, and otherwise, immediately upon arrival.

2. **Upon Arrival and During the Visit**

- Take steps to ensure all persons with symptoms of suspected COVID-19 or who have had close, extended contact with a person with COVID-19, adhere to respiratory hygiene and cough etiquette and hand hygiene, which includes wearing a mask.
- Ensure that patients with symptoms of COVID-19 are not allowed to wait in close proximity to others seeking care. Maintain environmental controls whenever possible (separate chairs, provide physical barriers, etc.)
- Ensure rapid triage and isolation of patients with symptoms of COVID-19
- Identify patients at risk for having COVID-19 before or immediately upon their arrival to the healthcare facility
- Screen all staff, patients and visitors for COVID-19 symptoms or recent close, extended contact with someone who is positive, upon arrival to the facility
- Require all who enter the facility to wear a facemask.

B. **Patient Placement**

- When possible, place a patient with known or suspected COVID-19 in a negative pressure room. When a negative pressure room is not available, the door to the patient room should be kept closed at all times.
- If a patient does not require hospitalization they can be discharged home if deemed appropriate. Home instructions are available on the www.dshs.texas.gov/coronavirus website.
- Limit transport and movement around the facility to medically-essential purposes. Ensure the patient is wearing a mask.
- Personnel entering any patient room should use the appropriate PPE as described in *Required PPE for Clinical Staff*

- Only essential personnel should enter the room of a COVID-19 positive patient. Minimize the number of HCP who enter the room. When possible, use dedicated HCP to minimize the risk of transmission and exposure to other patients and HCP.
- Use dedicated or disposable noncritical patient-care equipment when possible (stethoscopes, blood pressure cuffs). If equipment is used for more than one patient, clean and disinfect such equipment before use on another patient, according to manufacturer's instructions.
- When a patient vacates a room, personnel should wait at least 30 minutes (if negative pressure room) or 60 minutes (if not negative-pressure) before they enter the room (for example, to clean the room).
- All rooms will undergo appropriate cleaning prior to being returned to use

C. Hand Hygiene

- HCP should perform hand hygiene using alcohol foam before and after all patient contact, contact with potentially infectious material, and before putting on and upon removal of PPE, including gloves. Hand hygiene can also be performed by washing with soap and water for at least 20 seconds.
- Hand hygiene supplies will be readily available in every patient care area

D. Personal Protective Equipment

- PPE should be used in a manner to prevent self-contamination. All clinical staff and those who have close, extended contact with patients will be taught how to properly don, doff and dispose of PPE.
- Clinical staff will follow the requirements found in *Required PPE for Clinical Staff*
- Any and all staff responding to a Code Blue or a trauma activation situation will don all of the following PPE PRIOR to entering the patient room : Gloves, gown, N95 mask and eye protection
- PPE will be changed as needed and disposed of properly
- When sized N95 masks are not available, all staff must perform a fit check with their N95 mask to ensure a safe fit. All staff are encouraged to wear a face shield over the mask to add an extra layer of protection to the mask.

***E.* Specimen Collection**

Collecting diagnostic respiratory specimens (nasopharyngeal swab) will be done by staff who have a documented skills competency.

F. Discontinuation of Isolation Precautions for suspected or confirmed COVID-19 patients

- Discontinuation of isolation precautions should be based on current CDC guidelines, in conjunction with local, state, and federal guidelines.
- Generally, isolation precautions may be discontinued 10 days after symptom onset or a positive COVID-19 test. Up to 20 days may be required if patient is immunocompromised or was severely ill with COVID-19.

G. Manage Visitor Access and Movement Within the Facility

- Visitors should be restricted from entering the room of known or suspected COVID-19 patients. Alternate mechanisms for patient/visitor interactions will be encouraged. Staff are to help facilitate video visits via the Martti language assistance iPad, when possible. Exceptions may be considered based on end-of-life situations or when a visitor is essential for the patient's well-being and care.
- All visitors are required to wear a face mask while in the facility.
- Visitation for all patients may be limited or restricted, based on local, state, and federal guidelines and current state of transmission within the community or region. Refer to the *COVID-19 Prohibition of Visitors* for the current guidelines.

- Visitors should not be present during aerosol-generating procedures

H. Management of Exposed or Ill Healthcare Personnel

- Decisions regarding work restrictions for any HCP who is ill or who has been exposed to COVID-19 will be made collaboratively between Employee Health staff and public health authorities. Refer *to Interim Guidance for Risk Assessment and Public Health Management of Healthcare Personnel with Potential Exposure in a Healthcare Setting to Patients with Coronavirus Disease 2019 (COVID-19)* for additional information. https://www.cdc.gov/coronavirus/2019-ncov/hcp/return-to-work.html
- If an employee tested positive more than 90 days ago and becomes ill or has close, extended contact with a positive case, they must start over with the current return to work criteria.
- Refer to *Routine, Contingency and Crisis Staffing Plan* when normal staffing patterns are interrupted due to COVID-19.

I. Implement Environmental Infection Control

- All environmental cleaning and disinfection procedures will be followed consistently and correctly
- Routine cleaning and disinfection procedures (i.e. applying an EPA-registered, hospital grade disinfectant to frequently touched surfaces or objects for appropriate contact times as indicated on the product's label) are appropriate for COVID-19 in healthcare settings, including those patient care areas in which aerosol-generating procedures are performed. Products with EPA-approved emerging viral pathogen claims are recommended for use against COVID-19.
- Bleach has demonstrated effectiveness against viruses similar to COVID-19 on hard noon-porous surfaces. Therefore, this product can be used in accordance with the directions for hard, non-porous surfaces. Specific claims for "COVID-19" will not appear on the product or master label.
- Management of laundry, food service utensils, and medical waste should be performed in accordance with routine procedures.

J. Patient Testing

- **Admissions:** All patients who will be admitted to the facility should be tested prior to being sent to the unit using a rapid test, such as the Abbott ID Now. If the test is positive, admission should be to the COVID Unit (CVU). If the test is negative but a presumptive positive, the admission should also be to the CVU. If an admission has tested positive previously, and "recovered" according to the CDC guidelines, the physician may decide to forgo additional testing.
- **Transfers:** All patients who will be transferred to another facility for a higher level of care should be tested prior to transfer. Test results should be communicated to the transport team and to the receiving facility
- **Surgical Patients:** All patients scheduled for surgery should be tested several days prior to surgery. In the case of an emergent case, patient should be tested prior to induction, as possible.
- If a patient has previously tested positive and considered "recovered" by the CDC guidelines within the previous 60 days, and is not experiencing COVID-19 symptoms, the physician may choose not to test the patient. This patient will be treated as negative for COVID-19.
- Testing should be performed utilizing rapid testing, such as the Abbott ID Now, when possible, to ensure quick results turnaround.

K. Establish Reporting within Healthcare Facilities and to Public Health Authorities

A mechanism will be in place that promptly alerts key facility staff of pertinent information including:
Infection Prevention & Control

Kristen Perez, LVN

Dr. Bid Cooper, Medical Director for Employee Health and Infection Control

Chief Nursing Officer
Kathy Goodwin, RN
Facility Leadership, Hospital Administrator on Call
Clinical Laboratory
Bill Dickinson
House Supervisor
Frontline Staff if admitting patient with known or suspected COVID-19
Scurry County Health Unit
Dana Hartman, LVN

L. Postmortem

The following factors should be considered when determining if an autopsy will be performed for a deceased person under investigation (PUI): medico legal jurisdiction, facility environmental controls, availability of recommended PPE and family and cultural wishes.

If it is determined that a postmortem specimen is needed, follow the guidance for specimen collection found here: https://www.cdc.gov/coronavirus/2019-ncov/hcp/guidance-postmortem-specimens.html#autopsy

IV. REFERENCES

https://www.cdc.gov/coronavirus/2019-ncov/hcp/infection-control.html Retrieved 11/10/2020

V. RELATED COGDELL DOCUMENTS

This section includes hyperlinks to any related CMH policies.

VI. DATES AMENDED/APPROVED

Include origination date, dates of major or minor revisions and dates reviewed without changes.

Originated: 12/2020	*Effective: 12/2020*
Reviewed with Changes	*Reviewed without Changes*

VII. CONTACT INFORMATION

Infection Control Nurse
325-574-7141
Chief Nursing Officer
(325) 574-7292

I. Title

Infection Control Job Description and Competency

II. Job Summary

The coordinator of the Infection Prevention and Control, Employee Health and Wellness is a qualified individual who serves as the organization infection control officer with knowledge of CDC guidelines and definitions of healthcare associated infections, NIAHO standards, federal and state regulations. This person is responsible for the development of a system for identifying, reporting, investigating and controlling infections and communicable diseases of patients and personnel. The P&T Committee and IC office shall govern any policies for controlling infections and communicable diseases. This person may institute collection of cultures, employee lab work and initiate appropriate isolation precautions. This person is responsible for assisting with in-service programs and employee education related to infection prevention and control.

III. Essential Functions/Performance Expectations

1. Completes a comprehensive assessment of the program annually and reports to the P&T Committee.
2. Demonstrates effective collaboration with physicians and staff as a facilitator of change, resource person, educator and problem solver in order to successfully meet the Hospital's performance improvement/patient safety goals.
3. Demonstrates support of the organization's Infection Control Program.
4. Performs data analysis using a variety of performance improvements tools to identity when levels of performance indicate a pattern or trend that varies from those expected.
5. Develops root cause analysis and implements corrective action plans for assigned activities so that changes are made that improve performance, improve patient safety and/or reduce risks.
6. Demonstrates critical thinking skills by making decisions that are congruent with the organization's policies, procedures and guidelines.

IV. Education and Experience

1. Must have current licenses as a ~~Registered~~ License Vocational Nurse in the state of Texas or equivalent degree in healthcare.
2. Minimum of 5 years' experience in a hospital setting or Infection Prevention and Control experience.
3. Working knowledge of microbiology, epidemiology, infection disease, aseptic technique and current practices.
4. Able to apply basis principles and tools of performance improvements to a wide range of problems.
5. Language Skills:
    a. Able to read and interpret medical records documents and Hospital policies and procedures.
    b. Able to communicate effectively with patients, families, hospital staff, medical staff and general public.
6. Basic computer knowledge

7. Mathematical Skills:
    a. Able to graph data collected to aid in performance improvements.

V. Physical Requirement

To perform this job successfully, an individual must be able to perform each essential responsibility satisfactorily. Reasonable accommodations may be made to enable individuals with disabilities to perform the essential functions. The individual must be able to; stand, walk, sit, stoop, reach, lift, see, speak and hear. Lifting is limited to 35 lbs. for clinical staff and to 50 lbs. for non-clinical staff. The individual must use an assisted-lift device or get another individual to assist with the lift that is over these maximum limits.

VI. Dates Approved or Amended

Originated:	*Effective: 11/2017*
Reviewed with Changes	*Reviewed without Changes*
12/2020	05/2019

VII. Contact Information

Infection Control Officer

Cogdell
MEMORIAL HOSPITAL

DOCUMENT SUBMISSION
DECEMBER 2020

IDENTIFIER REASSIGNMENT	*VERSION*	CURRENT IDENTIFIER	TITLE	STATUS	NEED FOR DOCUMENT, REVISION OR REVIEW SUMMARY OF REVISION	REQUESTED ACTION
EMPLOYEE HEALTH (EH)						
1.ORG.EH	V.122020		Annual TB Testing	reviewed	reviewed without changes	
1.ORG.EH	V.122020		Employee Health Program	reviewed	reviewed without changes	
1.ORG.EH	V.122020		Employee Health Records	reviewed	reviewed without changes	
1.ORG.EH	V.122020		Employee Immunization Program	reviewed	reviewed without changes	
1.ORG.EH	V.122020		Exposure Bloodborne Pathogen (BBP) Lab Work - Reporting	reviewed	reviewed without changes	
1.ORG.EH	V.122020		Influenza Vaccination	reviewed	reviewed without changes	
1.ORG.EH	V.122020		Management of Bloodborne Pathogen Exposure (BBP)	reviewed	reviewed without changes	
1.ORG.EH	V.122020		N95 Fit Test	reviewed	reviewed without changes	
1.ORG.EH	V.122020		N95 Fit Testing During COVID-19 (memo)	new	review	approve
1.ORG.EH	V.122020		Tuberculosis Surveillance Program Utilizing QuantiFERON - TB Gold (TB QFT)	reviewed	reviewed without changes	
1.ORG.EH	V.122020		Work Restriction Guidelines	reviewed	reviewed without changes	

Cogdell

Memo to File

DATE: February 28, 2020
FROM: Kristen Perez, LVN
RE: N95 Fit Testing During COVID-19

Due to the shortage of sized N95 masks, and the inability to purchase them from any vendor, we will not be performing fit checks on newly hired employees. At this time, universal masks will be used by all staff.

Cogdell MEMORIAL HOSPITAL

Nursing Manual Document Submission
December 2020

Identifier	TITLE	STATUS	NEED FOR DOCUMENT, REVISION OR REVIEW SUMMARY OF REVISION	REQUESTED ACTION
1.ORG.NS.1011	Assigning Patient Care	Review w/changes	Minor changes to match DNV guidelines.	Approve
1.ORG.NS.1049	Baby Moses Law	REMOVE	Moved to ORG policies	Approve
1.ORG.NS.1050	Chain of Command for the Professional Nurse	Review w/changes	Minor changes to chain of reporting.	Approve
1.ORG.NS.1015	Chief Nursing Officer Responsibilities and Educational Requirements	Review w/changes	changed to match regulatory language	Approve
1.ORG.NS.1041	Competency Assessment for Nursing Staff	Review	No changes except for contact info and minor clarification on III.C	Approve
1.ORG.NS.1002	Definition of Nursing Care	Review	Small grammatical changes only	Approve
1.ORG.NS.1032	Discharge Instruction Guidelines	Review	Minor changes to wording	Approve
1.ORG.NS.1029	Education of Patient/Family	Review	No changes	Approve
1.ORG.NS.1012	Floating Nursing Staff	Review w/changes	Mnor changes made	Approve
1.ORG.NS.1039	Hospital Admission Policy	Review	Minor change only, for clarification	Approve
1.ORG.NS.1001	Hospital Plan for Nursing	Review w/changes	Added BON language regarding delegation	Approve
1.ORG.NS.1036	House Supervisors Role Accessing Pharmacy After Hours	Review	Minor changes.	Approve
1.ORG.NS.1017	Incident-Based Peer Review	Review	No changes	Approve
1.ORG.NS.1047	Insertion of and Care of IV Sites	Review w/changes	Added section on limiting number of IV starts.	Approve
1.ORG.NS.1005	Lines of Communication in the Department of Nursing	Review w/changes	Minor changes to reflect appropriate personnel/title changes	Approve
1.ORG.NS.1034	Medication Administration	Review with minor change	Minor change to who can administer medications	Approve
1.ORG.NS.1035	Medication Administration; Use of Protocols	NEW	No current policy in place	Approve
1.ORG.NS.1043	Nurse Staffing Committee Charter	Review with minor change	Removed information that does not apply/is incorrect.	Approve
	Nurse Staffing Committee Charter/Policy/Mandatory Overtime-Attachment A	Retire	Not needed; redundant information. See 1.ORG.NS.1043	Approve
	Nurse Staffing Committee Charter/Policy/Mandatory Overtime-Attachment B	Retire	Not needed; redundant information. See 1.ORG.NS.1043	Approve
1.ORG.NS.1025	Nursing Assessment and Plan of Care (Previously Admission Assessment and Reassesment)	Review w/changes	Changes made to match DNV guidelines. Prior name: Admission Assessment and Reassessment Policy.	Approve
1.ORG.NS.1040	Nursing Budget	Review	Minor change to include new contact info	Approve
1.ORG.NS.1014	Nursing Department Credentials	Review w/changes	See policy for changes. Updated to the current process.	Approve
1.ORG.NS.1020	Nursing Orientation	Review w/changes	changed to match regulatory language	Approve
1.ORG.NS.1004	Organizational Description of the Department of Nursing	Review	No changes	Approve
1.ORG.NS.1026	Pain Management	Review w/changes	Added required regulatory elements. Chlanged name from Pain Assessment to Pain Management.	Approve
1.ORG.NS.1060	Peripherally Inserted Central Catheter	Review	No changes except updating Covenant phone number	Approve
1.ORG.NS.1070	Procedure Procotols	NEW	No current policy in place	Approve
1.ORG.NS.1018	Safe Harbor Peer Review	Review w/changes	Updated with current BON language	Approve
1.ORG.NS.1061	Staffing Incentive-Critical Vacancy Bonus	Review	No changes	Approve
1.ORG.NS.1031	Standing Order	Review	No changes except contact info	Approve

Cogdell MEMORIAL HOSPITAL	HOSPITAL DISTRICT DOCUMENTS *ASSIGNING PATIENT CARE* 1.ORG.NS.1011
SECTION: **ORGANIZATION**	SUBJECT: **NURSING ~~STAFF~~ SERVICES**

I. Title

Assigning Patient Care

II. Statement of Purpose

To define the process ~~for nursing staff assignment.~~ for assigning patient care

III. Policy

A. ~~At the beginning of the each shift, the~~ A registered nurse will make patient care assignments.

B. A registered nurse shall make any decisions regarding delegation of nursing care to other nursing staff, based on individual patient needs and staff qualifications

C. Patient care assignments will take into consideration:

- Patient needs, condition and care requirements
- Patient's acuity and stability;
- Complexity of patient assessment;
- Technology utilization and nursing staff skills;
- Degree of supervision required by nursing staff;
- Availability of required supervision;
- Infection control and safety issues;
- Environment in which the nursing care is provided.
- Anticipated admissions, discharges and transfers
- Employee's clinical skills, competence, experience and background
- Any other relevant factors

D. Nursing staff should only accept assignments that are comparable with their education, experience, knowledge and ability.

IV. Relevant Regulatory Guidelines

NIAHO Revision 20-1 NS.1.SR.5

V. Dates Approved or Amended

Originated: 01/1991	*Effective:*
Reviewed with Changes	*Reviewed without Changes*
11/2017, 12/2020	05/2019

VI. Contact Information

~~Director of Nursing~~
Chief Nursing Officer
325-574-7292

Cogdell MEMORIAL HOSPITAL	HOSPITAL DISTRICT DOCUMENTS *CHAIN-OF-COMMAND FOR THE PROFESSIONAL NURSE* 1.ORG.NS.1050
SECTION: **ORGANIZATION**	SUBJECT: **NURSING STAFF**

I. Title

Chain-of-Command for the Professional Nurse

II. Policy

When there is a question or concern related to patient care (Examples: a physician's order, or laboratory, radiology, or other patient service department fails to respond in a timely manner), the professional nurse should initiate the following chain of command until safe, appropriate medical intervention has occurred:

A. Notify the physician of the patient's status or gain clarification of his/her order.

1. From 8:30a.m. through 5:00p.m. Monday through Friday (excluding holidays), contact the patient's attending physician.

2. For days/times when the attending physician is unavailable, the on call physician ~~on-call~~ should be contacted.

3. If the patient is admitted through the ED, the ED physician may be contacted if that physician is a member of the active Medical Staff. (In instances when the ED is staffed by a physician who is not a member of the **active Medical Staff**, the on call physician ~~on-call~~ should be contacted regarding patients who have been admitted or placed in observation.)

B. If the patient situation remains unresolved, the Patient Care Services Director for the unit or the House Supervisor on duty will be notified.

C. The Director or House Supervisor should assess the patient and treatment plan and, if necessary, again contact the physician.

D. If the patient situation remains unresolved, the ~~Nursing Manager~~ Patient Care Services Director or House Supervisor should notify the ~~Nursing~~ Administrator-On-Call (AOC).

E. If ~~Nursing~~ the AOC is unable to resolve the patient situation, he/she will notify the Chief of Staff. ~~and/or Administrator on call the CEO.~~

III. Dates Approved or Amended

Originated: 10/2015	*Effective:*
Reviewed with Changes	*Reviewed without Changes*
11/2017, 12/2020	05/2019

IV. Contact Information

~~Director of Nursing~~
Chief Nursing Officer
325-574-7292

Cogdell MEMORIAL HOSPITAL	HOSPITAL DISTRICT DOCUMENTS *CHIEF NURSING OFFICER RESPONSIBILITIES AND EDUCATIONAL REQUIREMENTS* 1.ORG.NS.1015
SECTION: **ORGANIZATION**	SUBJECT: **NURSING STAFF**

I. Title

Chief Nursing Officer Responsibilities and Educational Requirements

II. Statement of Purpose

~~Organizes and administers areas of Patient Care Services to attain the hospital's objectives established by the governing authority.~~ To ensure that patient needs are met, Cogdell Memorial Hospital will designate a nurse executive, the Chief Nursing Officer (CNO), who is a member of senior leadership and is appropriately qualified, who shall oversee all operations of nursing services.

III. Policy

The Chief Nursing Officer is responsible for the operation of nursing services, including determining the types and numbers of staff necessary to provide nursing care for all patient care areas of the hospital, and standards of nursing practice. The hospital may have only one nursing service and the single nursing service shall be under the direction of one registered nurse (RN).

IV. Qualifications:

The CNO must be a graduate of an accredited school of nursing and current licensure ~~by State~~ as a registered ~~professional~~ nurse in the state of Texas, or another enhanced compact state license. It is preferred that the CNO possess a ~~Bachelor's~~ master's degree in nursing, is actively pursuing a master's degree, or has demonstrated the equivalent nursing experience in comparable positions ~~is desired~~. ~~Experience in the budgeting process and management techniques is essential. Should have a minimum of five years prior experience in Patient Care Services management. Should be able to demonstrate leadership, managerial ability, good interpersonal relationships and the application of sound administrative principles. Membership in professional organizations encouraged.~~

V. ~~General Duties and~~ Primary Responsibilities include:

- **Development and maintenance of nursing policies and procedures;**
- **Supervision of nursing staff, either directly, or indirectly, through other nursing supervisors; and,**
- **Ongoing review and analysis of the quality of nursing care**

~~A.~~

~~B. Knows and practices the prescribed philosophy, purpose, policies and standards of nursing services and the Hospital.~~

~~C. Organizes, directs and administers the nursing services in order to provide the level of care required by current medical and nursing standards.~~

~~D. Plans and coordinates with the Chief Financial Officer, utilizing the respective Service managers for planning the budgeting requirements for personnel, performance of work, supplies and equipment. Responsible for cost controls to insure maximum effectiveness of funds expended from the approved departmental budgets.~~

~~E. Supports and develops the Nurse Managers nursing directors in the coordination of the employee selection process, work assignments, performance evaluations and staff development for these services.~~

~~F. Maintains continuing quality assessment and improvement analysis and evaluation of patient care delivery and communicates with administration on the activities/issues of the nursing services.~~

~~G. Plans and recommends to administration new facilities or equipment, or modification thereto, needed to provide patient care. Serves as a member of P&T Committees in matters pertaining to patient care.~~

~~H. Recommends support and participates with Education Services, programs of education and training, including orientation of new employees. Encourages and facilitates the professional advancement of employees by affording opportunities for further education and experience.~~

~~I. Recommends the modification, addition or deletion of personnel policies to insure reasonable hours and acceptable working conditions to provide patient care coverage.~~

~~J. Provides health services to employees within the scope authorized by the governing authority with the help of the Employee Health Nurse.~~

~~K. Initiates and participates in problem-solving, policy-forming conferences for Patient Care Services. Maintains close coordination with all departments to insure continuity and collaboration of services.~~

~~L. Insures that cordial relationships are maintained with patients, their families and friends, clergy and other interested groups in the community. Interprets the goals of the Patient Care Service areas to the community by maintaining harmonious and effective relationships with the education system, volunteer groups, agencies and the community.~~

~~M. Participates in policy decisions that affect nursing services in the hospital.~~

~~N. Participates in the Executive Finance, Board of Trustee and Medical Staff Department meetings.~~

VI. Relevant Federal and State Statutes

NIAHO Version 20-1 NS.2.SR.1

VII. Dates Approved or Amended

Originated: 05/1991	*Effective:*
Reviewed with Changes	*Reviewed without Changes*
12/2020	11/2017, 05/2019

VIII. Contact Information

~~Director of Nursing~~
Chief Nursing Officer
325-574-7292

I. Title

Chief Nursing Officer Responsibilities and Educational Requirements

II. Statement of Purpose

To ensure that patient needs are met, Cogdell Memorial Hospital will designate a nurse executive, the Chief Nursing Officer (CNO), who is a member of senior leadership and is appropriately qualified, who shall oversee all operations of nursing services.

III. Policy

The Chief Nursing Officer is responsible for the operation of nursing services, including determining the types and numbers of staff necessary to provide nursing care for all patient care areas of the hospital, and standards of nursing practice. The hospital may have only one nursing service and the single nursing service shall be under the direction of one registered nurse (RN).

IV. Qualifications:

The CNO must be a graduate of an accredited school of nursing and current licensure as a registered nurse in the state of Texas, or another enhanced compact state license. It is preferred that the CNO possess a master's degree in nursing, is actively pursuing a master's degree, or has demonstrated the equivalent nursing experience in comparable positions.

V. Primary Responsibilities include:

- Development and maintenance of nursing policies and procedures;
- Supervision of nursing staff, either directly, or indirectly, through other nursing supervisors; and,
- Ongoing review and analysis of the quality of nursing care

VI. Relevant Federal and State Statutes

NIAHO Version 20-1 NS.2.SR.1

VII. Dates Approved or Amended

Originated: 05/1991	*Effective:*
Reviewed with Changes	*Reviewed without Changes*
12/2020	11/2017, 05/2019

VIII. Contact Information

Chief Nursing Officer
325-574-7292

I. Title

Competency Assessment for Nursing Services Staff

II. Statement of Purpose

To define the process to assess initial and ongoing competency of nursing services staff

III. Policy

A. Competency of nursing services staff will be assessed during orientation and at a minimum, annually.

B. Competency determination will be based on written job descriptions.

C. 90-day objectives will be written by the employee's direct supervisor with employee input. At 90 days, or sooner if needed, supervisor will complete an evaluation and review with employee. Any improvements that are needed will be addressed at 90 days, or sooner, if necessary. Any performance Improvement related needs will be addressed as soon as possible, once they are identified.

IV. Dates Approved or Amended

Originated: 04/1991	*Effective:*
Reviewed with Changes	*Reviewed without Changes*
11/2017, 05/2019	12/2020

V. Contact Information

~~Director of Nursing~~
Chief Nursing Officer
325-574-7292

Cogdell MEMORIAL HOSPITAL	HOSPITAL DISTRICT DOCUMENTS *DEFINITION OF NURSING CARE* 1.ORG.NS.1002
SECTION: **ORGANIZATION**	SUBJECT: **NURSING ~~STAFF~~ SERVICES**

I. Title

Definition of Nursing Care

II. Statement of Purpose

To define what constitutes nursing care.

III. Policy

A. Patients receive nursing care at Cogdell Memorial Hospital according to the State Law defining professional nursing.

B. The practice of nursing shall be defined as the performance for compensation of any nursing act (a) in the observation, assessment, intervention, evaluation, rehabilitation, care and counsel, and health teachings of persons who are ill, injured or infirm, or experiencing changes in normal health processes; (b) in the maintenance of health or prevention of illness; (c) in the administration of medications or treatments as ordered by a duly licensed physician.

C. The registered nurse shall:

1. Know and conform to the laws and regulations governing the practice of professional nursing in the state of Texas;

2. Utilize the nursing process to provide individualized goal directed nursing care by:
   a. Completing nursing assessments;
   b. Developing and updatiing a plan of care based on the assessments,
   c. Implementing nursing care and evaluating the patient's response to nursing interventions;

3. Institute nursing interventions to stabilize a patient's condition and/or prevent complications,

4. Know the rationale and effects of proper administration of medications and treatments he/she administers;

5. Accurately report and document patient symptoms, responses and progress;

6. Respect patient rights and responsibilities with regards to confidential information unless obligated or allowed by law to disclose the information;
7. Promote, teach, and counsel health care practices;

8. Collaborate with members of other health disciplines in the interest of the patient's health care.

9. Consult and utilize community resources for continuity of patient care;

10. Consult with appropriate licensed practitioner to clarify any order of treatment that the nurse has reason to believe is inaccurate or contraindicated;

11. Administer, supervise, delegate, and evaluate nursing activities with regard to patient safety and the nursing personnel education, experience and knowledge;

12. Act as an advocate for providing safe delivery of patient care.

D. The practice of nursing by a licensed vocational nurse shall mean assuming the responsibility and performing the acts within the education background and preparation of the vocational nurse, under the direction of a licensed physician, dentist, podiatrist or registered nurse. These Acts Include:

1. Application of nursing techniques and/or procedures in the observation, teaching and caring for the ill, injured and infirmed, and promoting community health.

2. Delegation, under the direction of the registered nurse to those unlicensed persons who have appropriate knowledge and skills to perform nursing tasks in a safe and effective manner including:

3. Collecting, reporting and documentation of data including but not limited to:
   a. Chief complaint and a full set of vital signs
   b. Changes in baseline data established by the RN
   c. Family comments and behaviors related to the plan of care
   d. Ambulation, position, turning and transport of patients within this facility
   e. Personal hygiene
   f. Feeding, socialization, and activities of daily living

E. Nursing practice with Cogdell Memorial Hospital is in accordance with the State Board of Nursing and the Texas Department of Health.

IV. Dates Approved or Amended

Originated: 01/1991	*Effective:*
Reviewed with Changes	*Reviewed without Changes*
11/2017	05/2019, 12/2020

V. Contact Information

~~Director of Nursing~~
Chief Nursing Officer
325-574-7292

Cogdell MEMORIAL HOSPITAL	HOSPITAL DISTRICT DOCUMENTS *DISCHARGE INSTRUCTION GUIDELINES* 1.ORG.NS.1032
SECTION: **ORGANIZATION**	SUBJECT: **NURSING ~~STAFF~~ SERVICES**

I. Title

Discharge Instruction Guidelines

II. Statement of Purpose

~~This form~~ Discharge instructions are ~~is~~ used to provide the patient with a written record of instructions to be followed after discharge, as well as permanent record for the patient's chart ~~of instructions given upon discharge.~~

III. Policy

All patients being discharged from the emergency department, surgical services department or from any inpatient stay will be given discharge instructions upon dismissal.

~~IV. Policy~~ Procedure

~~A. Place patient sticker in place provided~~

B. Note date of discharge and signature of nurse giving instructions in the proper place.

C. Discharge instructions should include the following (when applicable):
   1. Date and time of follow-up appointment(s)
   2. ~~Condition of patient at time of discharge~~
   3. Activity level
   4. Diet
   5. Reasons that the patient may need to call physician
   6. Completed the medication reconciliation sheet with dismissal medications, including prior medications that need to be continued or discontinued
   7. Any additional physician orders
   8. Documentation of any personal items which were returned
   9. ~~Method of departure from the department~~
   10. Mode of transportation from the hospital
   11. Actual time the patient leaves the unit

D. ~~Make sure that~~ a copy of the discharge instructions, signed by the patient, are given to the patient, family or caregiver and become part of the medical record.

E. Record the patient, family or caregiver's response to the instructions.

V. Dates Approved or Amended

Originated: 01/1997	*Effective:*
Reviewed with Changes	*Reviewed without Changes*
10/2014, 05/2019	

VI. Contact Information

~~Director of Nursing~~ Chief Nursing Officer
325-574-7292

I. Title

Education of Patient / Family

II. Statement of Purpose

To provide the patient and family with the knowledge and/or skills required to meet the patient's health care needs.

III. Policy

A. The patient and/or, when appropriate, his or her family are provided with appropriate education and training to increase knowledge of the patient's illness and treatment needs and to learn skills and behaviors that promote recovery and improve function.

1. The assessment considers cultural and religion practice, emotional barriers, drive and motivation to learn, physical and cognitive limitations, language barriers and the financial implications of care choices.

2. When called for, by the age of the patient and length of stay, the hospital assesses and provides for patients academic education needs.

3. The safe and effective use of medication in accordance with legal requirements and patient needs, when applicable.

4. The safe and effective use of medical equipment, when applicable.

5. Instruction on potential drug-food interactions and counseling on nutrition intervention and/or modified diets, as appropriate.

6. Instruction in rehabilitation techniques to facilitate adaptation to and/or functional independence in the environment, if needed.

7. Access to available community resources, if needed.

8. When and how to obtain further treatment, if needed.

B. The patient and/or, when appropriate, his or her family are provided with the specific knowledge and/or skills required to meet the patient's ongoing health care needs. Such instruction is presented in ways understandable to the patient and/or his or her family and includes, but is not limited to, the patient's and family's responsibilities in the patient's care.

C. With due regard for privacy, the hospital teaches and helps patients maintain good standards for personal hygiene and grooming, including bathing, brushing teeth, caring for hair and nails and using the toilet.

IV. Procedure

A. Upon admission, the licensed nurse will begin the nursing process for patient education as follows: assess learning needs and learning capabilities of patient, establish teaching plan based on goals and objectives of patient education for the individual implement the teaching plan and evaluate learner's response.

B. Upon admission the staff nurse will orient the patient to the environment-physical, hospital staff, safety issues and other pertinent issues.

C. Teaching will be initiated when the patient's condition permits. Teaching will be modified, as needed, to meet individual needs; ex. language barrier, physical limitations. The family and/or significant others will be included in patient education as frequently as possible, when appropriate.

D. Relevant written materials (approved by patient's physician) including a discharge instruction sheet will be given to the patient by a licensed nurse. The patient will sign the discharge instruction sheet after the patient education has been completed and he/she will retain a copy of his/her discharge instructions for home use.

E. Such patient education includes instruction in the specific knowledge and/or skills needed by the patient and/or where appropriate, his/her significant others, to meet the patient's on-going health care needs including:

1. Safe and effective use of medication.

2. Safe and effective use of medical equipment.

3. Potential drug-food interactions and counseling on medical diets.

4. Instructions about any follow-up care and how to obtain care.

5. Information provided to the patient/family at the time of discharge is provided to the individual or organization providing continuing care of the patient.

V. Dates Approved or Amended

Originated: 04/1997	*Effective:*
Reviewed with Changes	*Reviewed without Changes*
	11/2017, 05/2019, 12/2020

VI. Contact Information

~~Director of Nursing~~ Chief Nursing Officer
325-574-7292

I. Title

Floating Nursing Staff

II. Statement of Purpose

In order to maintain safe staffing ratios, at times, nursing staff must float to another unit to help deliver safe patient care. ~~To~~ This policy establishes guidelines for floating nursing staff ~~floating~~ to areas other than their normally assigned area of practice.

III. Policy

A. Nursing Staff that float to other areas of the hospital will not be solely responsible for the care of patients without direction when the nurse is not trained in a particular area or have not had the opportunity to work with a certain type of patient. Once cross-training orientation has been completed, they may be given a patient assignment that is consistent with their training and competence.

B. When extra staff is needed in an area, the floating personnel will be obligated to administer care that they are familiar with and have been oriented to and/or administer basic nursing care within their realm of education and experience.

C. If the nurse is routinely floated to other nursing care areas, they will complete the unit's orientation skills check list and obtain whatever further education necessary to competently care for those patients.

IV. Relevant Federal and State Statutes

NIAHO (Revision 20-1) NS.1.SR.2, SR.4, SR.5 and SR.6

V. Dates Approved or Amended

Originated: 01/1991	*Effective:*
Reviewed with Changes 12/2020	*Reviewed without Changes*
	11/2017, 05/2019

VI. Contact Information

~~Director of Nursing~~
Chief Nursing Officer
325-57-7292

Cogdell MEMORIAL HOSPITAL	HOSPITAL DISTRICT DOCUMENTS *HOSPITAL ADMISSION* 1.ORG.NS.1039
SECTION: **ORGANIZATION**	SUBJECT: **NURSING ~~STAFF~~ SERVICES**

I. Title

Hospital Admission

II. Statement of Purpose

To outline nurse executive or designee participation in the hospital admission ~~system~~ process for coordination of patient nursing care needs with available nursing care resources.

III. Policy

A. The nurse executive has the authority and responsibility to participate in the hospital's admission system and approve criteria for employment, deployment and assignment of nursing staff. The nurse executive may delegate this responsibility to the Unit Directors or to the House Supervisor on duty.

B. In the event there is a critical lack of nursing personnel, and the patient cannot be adequately cared for, the call back roster fails, or there are disaster circumstances, the House Supervisor notifies the CNO~~/DON~~ who in turn confers with the CEO/CFO and jointly a decision will be made as to the best course of action.

C. The House Supervisor working under the nurse executive authority has the responsibility to discuss with the physician if he/she feels patient nursing care needs cannot be adequately met on the unit assigned.

IV. Dates Approved or Amended

Originated: 01/1991	*Effective:*
Reviewed with Changes	*Reviewed without Changes*
11/2017	05/2019, 12/2020

V. Contact Information

Director of Nursing
Chief Nursing Officer
325-574-7292

Cogdell MEMORIAL HOSPITAL	HOSPITAL DISTRICT DOCUMENTS *HOSPITAL PLAN FOR NURSING* 1.ORG.NS.1001
SECTION: **ORGANIZATION**	SUBJECT: **NURSING ~~STAFF~~ SERVICES**

I. Title

Hospital Plan for Nursing

II. Statement of Purpose

To define the hospital's plan for the provision of nursing care.

III. Policy

A. Nursing services are provided on a continuous basis, 24 hours a day, seven days a week, with at least one registered nurse at all times. The RN on duty ~~will~~ should be immediately available for the bedside care of every patient.

B. A registered nurse will make ~~any~~ decisions regarding delegation of nursing care to other nursing staff, based on individual patient needs and staff qualifications and according the Texas Board of Nursing "Delegation Principles". https://www.bon.texas.gov/pdfs/delegation_pdfs/Delegation-fiverights.pdf

C. Non-employee licensed nurses must adhere to the policies and procedures of Cogdell Memorial Hospital.

D. The CNO~~/DON~~ is responsible for providing adequate supervision and evaluation of clinical activities, including those of non-employee nursing personnel.

IV. Relevant Regulatory Guidelines

NIAHO Revision 20-1 NS.1.SR1, SR.2, SR. 4, SR.4a, SR.5, SR.6

V. Dates Approved or Amended

Originated: 01/1999	*Effective:*
Reviewed with Changes	*Reviewed without Changes*
11/2017, 12/2020	05/2019

VI. Contact Information

~~Director of Nursing~~
Chief Nursing Officer
325-574-7292

I. Title

House Supervisor's Role Accessing the Pharmacy After Hours

II. Statement of Purpose

To outline the House Supervisor's role in obtaining medications from the pharmacy after hours.

III. Policy

A. The House Supervisor may enter the pharmacy after hours to obtain a single dose of medication for a patient if it is not in stock in any of the automated dispensing machines. The House Supervisor may not provide medication to re-stock an automated dispensing machine.

B. The House Supervisor should document the following when removing any medications from the pharmacy:

1. Name/FIN of patient
2. Room Number/Unit of patient
3. Name of the medication
4. Strength of the medication
5. Strength and frequency of the medication order
6. Amount of medication taken from the Pharmacy
7. Signature

IV. Dates Approved or Amended

Originated: 09/1991	*Effective:*
Reviewed with Changes	*Reviewed without Changes*
11/2017, 05/2019	

V. Contact Information

~~Director of Nursing~~
Chief Nursing Officer
325-574-7292

I. Title

Incident-Based Peer Review

II. Statement of Purpose

Incident-based peer review of both RNs and LVNs is governed by the NPR Law, BON Rule 217.19 and selected provisions (§§301.402, .403, .405, & .407) of the NPA relating to mandatory reporting by individual nurses, nursing peer review committees, employers, and state agencies. This organization's philosophy is to utilize nursing peer review to promote a non-punitive, just practice environment for nurses. This includes addressing a nurse's conduct, to the extent consistent with safe patient care, at the facility level and not reporting the nurse to the BON except as required by the NPA and BON rules.

III. Policy

A. The purpose of this plan is to set out the policies and procedures that will govern nursing peer review of licensed vocational nurses (LVNs) and registered nurses (RNs) providing nursing care at Cogdell Memorial Hospital ("Facility/Organization"). These policies and procedures are designed to assure that incident-based nursing peer review is conducted in accordance with The Nursing Peer Review Law (Chapter 303, Occupations Code) ("NPR Law"), Nursing Practice Act (Chapter 301, Occupations Code) ("NPA") and Board of Nursing ("BON") Rule 217.19 (relating to incident-based nursing peer review), and that the nursing peer review committee operates in good faith in carrying out its responsibilities.

B. When Plan Applies:

1. This plan will apply to any nursing peer review conducted for the purpose of evaluating if an RN or LVN has engaged in unacceptable nursing practice that could result in the nursing peer review committee reporting the nurse to the BON.

2. This facility/organization utilizes 10 or more nurses and five or more of those 10 nurses are RNs and is required under NPR Law §303.0015 to establish a nursing peer review committee to perform the following functions:

   a. Peer review nurses who are reported to the committee by individual nurses in lieu of reporting the nurse to the BON;

   b. Peer review nurses who are reported to the committee by state agencies in lieu of reporting the nurse to the BON;

   c. This plan will apply to nursing peer review conducted for these two purposes. It will also apply to:

1. Peer review of nurses reported to the committee for multiple minor incidents to determine if the nurse should be reported to the BON under BON Rule 217.16.

d. It is the policy of this facility/organization not to peer review a nurse that the facility/organization has reported to the BON under the mandatory reporting provisions of the NPA §301.405. In that situation, peer review will be limited to review of the incident to evaluate the role of external factors as required by NPA §301.405 and tins plan will apply only as explicitly provided.

C. Definition and Type of Nursing Peer Review Governed by Policies

1. "Nursing Peer Review" as defined by NPR Law means the evaluation of nursing services, the qualifications of nurses, the quality of patient care rendered by nurses, the merits of complaints concerning nurses and nursing care, and determinations or recommendations regarding complaints.

2. "Incident-Based Peer Review" as defined by Rule 217.19 means peer review that focuses on determining if a nurse's actions, be it a single event or multiple events (such as in reviewing up to five (5) minor incidents by the same nurse within a year's period of time) should be reported to the Board, or if the nurse's conduct does not require reporting because the conduct constitutes a minor incident that can be remediated. The review includes whether external factors beyond the nurse's control may have contributed to any deficiency in care by the nurse, and to report such findings to a patient safety committee as applicable.

3. "Conduct subject to reporting" is defined by NPA §301.401 and Rule 217.19 means conduct by a nurse that:

a. Violates the Nursing Practice Act (NPA) or a Board rule and contributed to the death or serious injury of a patient;

b. Causes a person to suspect that the nurse's practice is impaired by chemical dependency or drug or alcohol abuse;

c. Constitutes abuse, exploitation, fraud, or a violation of professional boundaries; or

d. Indicates that the nurse lacks knowledge, skill, judgment, or conscientiousness to such an extent that the nurse's continued practice of nursing could reasonably be expected to pose a risk of harm to a patient or another person, regardless of whether the conduct consists of a single incident or a pattern of behavior.

4. "Minor incident" as defined by Rule 217.19 means conduct by a nurse that does not indicate that the nurse's continued practice poses a risk of harm to a patient or another person as described in BON Rule 217.16.

5. "Good faith", "bad faith", "malice" are related terms and defined in Rule 217.19 as:

a. "Good faith" means taking action supported by a reasonable factual or legal basis. Good faith precludes misrepresenting the facts surrounding the events under review, acting out of malice or personal animosity, acting from a conflict of interest, or knowingly or recklessly denying a nurse due process.

b. "Bad faith" means knowingly or recklessly taking action not supported by a reasonable factual or legal basis. The term includes misrepresenting the facts surrounding the events under review, acting out of malice or personal animosity towards the nurse, acting from a conflict of interest, or knowingly or recklessly denying a nurse due process.

c. "Malice" means acting with a specific intent to do substantial injury or harm to another.

6. "Patient safety committee" as defined by NPR Law §303.001 means any committee established by this organization with responsibility for reviewing or evaluating quality of patient care or other responsibilities related to addressing patient safety and includes the medical staff committee.

D. Philosophy

Nursing peer review is designed to provide a process for fact finding, analysis and evaluation of events including a nurse in a climate of collegial problem-solving focused on obtaining all relevant information about an event, to assure the nurse due process, to make a determination if the nurse engaged in conduct subject to reporting to the BON, and to make recommendations for corrective actions.

E. Good Faith; Conflict of Interest

All participants in nursing peer review shall act in good faith. If any participant has a conflict of interest or for any reason cannot objectively evaluate the nurse's conduct or present unbiased information about the nurse's conduct, they shall be disqualified from participation. If any person has reason to believe that any participant is not acting in good faith, they should report that concern to the committee chair or the chief nursing officer. A participant who acts in bad faith will be subject to disciplinary action including termination and possible reporting to the BON.

F. Confidentiality

1. The NPR Law and BON Rule 217.19 require that all nursing peer review proceedings be confidential and that the identity of patients be protected. All participants including the nurse being reviewed shall maintain confidentiality of the peer review process and protect patient identity. All participants will be required to sign a statement affirming the confidentiality of the process and agreeing that they will abide by procedures to maintain confidentiality. At each meeting the chair will remind participants of the need to maintain confidentiality. The following guidelines will apply:

a. Only the chair shall disclose any information. All disclosures will comply with the NPR Law and Rule 217.19.

b. A member, agent or employee of the committee, the nurse being reviewed, witnesses or any other participant in any peer review proceedings may not voluntarily disclose any communication to the committee or any record or proceeding of the committee. Nor may they be required to disclose such information.

c. Any person who attends any proceeding of the committee may not voluntarily disclose any information acquired or disclose any opinion, recommendation, or evaluation of the committee or any member of the committee, nor may they be required to disclose this information.

d. Members of the committee and participants may not be questioned about their testimony or about opinions formed as a result of the committee proceedings.

e. Peer review committees are required to protect to the extent possible the identity of patients and procedures will be followed to do so. To the extent feasible, only patient initials and numbers will be used. The nurse being reviewed will be provided the names of patients but patient initials and numbers will be used in all proceedings and documents.

f. The nurse's consulting with her/his attorney does not constitute a breach of confidentiality.

g. Committee members may not report a nurse being reviewed to the BON independently of the committee if the member's sole source of information about the nurse is acquired from being on the committee.

G. Nursing Peer Review Committee

1. Membership, Terms, Orientation, Voting Rights, Compensation, Etc. [Rule 217.19 requires that policies address issue.]

a. Since the committee will review the practice of both RNs and LVNs, it will consist of at least three-fourth nurses (RNs and LVNs) and two- thirds RNs. It shall consist of 5 permanent members (3 RNs, 2 LVNs, 0 non-nurse members) and rotating members as needed. Permanent members will serve staggered two-year terms and may be re- appointed. At least a majority of the permanent members shall be nurses who spend a majority of their time in direct patient care. If feasible, LVNs will be on the committee when an LVN is being reviewed.

b. If feasible, at least one member should have a working familiarity with the area of practice of the nurse being reviewed. A pool of rotating members from specialty areas of practice will be appointed and will be used to have a nurse on the committee with a working familiarity with the area of practice of the nurse being reviewed. A member from this pool may not necessarily be appointed to serve for every meeting of the committee.

c. Any individual with administrative authority for personnel decisions directly relating to a nurse being reviewed will be automatically disqualified from being appointed and if already appointed will be disqualified from serving as provided in Section G.1.b.

d. A quorum shall consist of 50% of the permanent members (at least a majority of which must be involved in direct patient care) plus any rotating members appointed for that meeting.

e. When an RN is being reviewed, only RNs will vote. When an LVN is being reviewed both RNs and LVNs will vote. The committee may use the alternates as needed.

f. A chairperson will be elected by the peer review committee and will serve a two-year term with possible re-election. The chairperson may be a member of administration or a direct patient care registered nurse with knowledge of the peer review process.

g. All committee members must participate in an orientation before serving on the committee.

h. Committee members will receive their regular wages for time served on the committee.

2. Disqualification and Removal of Members

a. Any committee member that has a conflict of interest or is otherwise unable, for whatever reason, to participate in the process in an unbiased way will be disqualified from participating in that matter.
b. Any committee member with administrative authority for personnel decisions directly relating to the nurse being reviewed will be automatically disqualified from serving.

H. Timelines

1. The committee will comply with the following timelines unless waived in writing by both parties after peer review is initiated. They may NOT be waived in advance.

Notice to Nurse	Not less than 21 or more than 45 calendar days from meeting of committee and promptly (within 5 calendar days) after decision is made to conduct peer review of nurse
Nurse Provided Opportunity to Review Documents	At least 15 calendar days before meeting of committee, Nurse or attorney may review files
Nurse provided Witness List and Copies of Written Testimony	At least 48 hours before committee meeting
Meeting of Committee	Not less than 21 days or more than 45 calendar days from when nurse was notified that being peer reviewed Timeline can be extended up to an additional 45 days if committee determines needed to consult with a patient safety committee on external factors.
Decision of Committee	Not more than 14 calendar days from conclusion of committee meeting
Notice to Nurse of Decision	Not more than 10 calendar days of committee decision
Filing of Rebuttal Statement	Not more than 10 calendar days after receipt of Notice of Decision
Report to BON If Required	Timely

I. Methods for Giving Notice

J. Initial Procedures

1. Initiation of Peer Review

a. Peer review proceeding shall be initiated by the committee chair in the following situations:

1. a nurse or state agency reports a nurse to nursing peer review in lieu of reporting the nurse the BON

2. a nurse is reported to nursing peer review to determine if nurse should be reported to BON because of multiple minor incidents

3. The request [or a review may be initiated by any nursing staff member, other health care provider or member of the Peer Review Committee. This request must be made by a written statement describing the known situation.

K. Preliminary Screening

1. If a nurse is reported to nursing peer review by a nurse or state agency in lieu of reporting the nurse to the BON, the chair shall consult with the person reporting to determine if the person believes or suspects the nurse's practice is impaired by chemical dependency or mental illness and whether a suspected practice violation is involved. If both impaired practice and a practice violation are suspected, the chair shall advise the person to report the nurse to the BON. If impaired practice but no practice violation is suspected, the chair will counsel the nurse whether it is more appropriate to report the nurse to TPAPN or BON.

2. In situations in which convening of the nursing peer review committee is not required by law, the chair will make a preliminary decision as to whether incident-based nursing peer review should be initiated.

L. Notification of Nurse

Once the decision is made that a nurse should undergo incident-based nursing peer review to determine if the nurse should be reported to BON, the nurse shall be promptly notified (within no more than 5 calendar days after the decision is made to conduct peer review) in writing that she/he will be subject to peer review. The notice shall comply with BON Rule 217.19 and include a description of the event(s) to be evaluated in sufficient detail to inform the nurse of the incident, circumstances and conduct (error-or or omission), including date(s), time(s), locations(s), and individual(s) involved. Initials or number shall identify the patient/client; and the name, address, telephone number of a contact person to receive the nurse's response will be included. The notice shall be sent by certified mail, return receipt requested to address on file with organization, or personally delivered to the nurse and receipt acknowledged in writing. If sent by certified mail, a duplicate notice shall be sent by first class mail.

M. Investigation

The committee chair or the chair's designee shall conduct an investigation including reviewing relevant documents and interviewing of witnesses. The nurse being reviewed hall be interviewed and given an opportunity to submit a written statement.

N. Informal Workgroup

As permitted by Rule 217.19, this organization will utilize an informal workgroup as appropriate and if consented to by the nurse. If the informal workgroup results in a mutually satisfactory resolution, nursing peer review shall be concluded and the findings of the workgroup shall be the findings of the nursing peer review committee. If a mutually satisfactory resolution is not reached by the workgroup, evaluation of the nurses by the full committee shall continue in accordance with the timelines set out in this plan or as otherwise agreed to by the nurse.

O. Pre-Meeting Discovery by Nurse

1. Review of Documents by Nurse

   At least 15 calendar days before the date of the committee meeting or as otherwise agreed to in writing by the nurse, opportunity shall be provided to the nurse's attorney or the nurse and the attorney together to review documents relating to the incident(s) involved. The documents will include any incident reports, medical records of the patients, etc. The review will occur in the committee chair's office or other location designated by the chair. The nurse or the nurse's attorney shall not be permitted to remove any records from the office or to make copies of any records without the written authorization of the chair.

2. Providing Nurse with Witness List and Written Testimony or Evidence

   a. At least 15 calendar days before the date of the committee meeting or as otherwise agreed to in writing by the nurse, opportunity shall be provided to the nurse's attorney or the nurse and the attorney together to review documents relating to the incident(s) involved. The documents will include any incident reports, medical records of the patients, etc. The review will occur in the committee chair's office or other location designated by the chair. The nurse or the nurse's attorney shall not be permitted to remove any records from the office or to make copies of any records without the written authorization of the chair.

   b. Witnesses included on the list will be notified in writing that they have been identified to the nurse as a witness and 1) if the nurses requests to talk to them, it is each witness's choice whether or not she/he wishes to talk to the nurse, and 2) if the witness is called to testify at the committee meeting by either the nurse or the committee, the nurse will have the opportunity to question the witness when the witness testifies.

   c. If information packets are prepared for committee members, a similar packet shall be provided to the nurse at the time provided to committee members.

P. Meeting of Committee

1. Agenda

   a. The meeting of the committee will follow the agenda below:

      1. Opening statement by chair on purpose, process, confidentiality, etc.

      2. Opening statement by supervisor/investigator

         a. Summarize the alleged incident and

b. What the investigation has shown

3. Opening statement by nurse

4. Presentation of evidence by facility

   a. Documentary evidence

   b. Witnesses

      i. Live or written statements/summaries only (define which)

      ii. Nurse has right to question witness

   c. Response by nurse

      i. Asking questions of and responding to questions of committee members.

      ii. Putting on own witnesses (required)

   d. Closing statement by supervisor/investigator

   e. Closing statement by nurse

   f. Statement by chair on what committee will decide, when decision will be made, continuing obligation to maintain confidentiality, etc.

2. Evidence
   Peer review is not a legal proceeding and the rules of evidence used in court proceedings will not apply. Evidence and facts normally relied on by reasonable persons including hearsay evidence will be accepted with consideration being given to its source, its credibility and the nature of the evidence. Witnesses will be subject to questioning by members of the committee and the nurse.

3. Nurse's Participation in Meeting
   The nurse may be present throughout the meeting and will be given an opportunity to make an opening statement, call witnesses, question witnesses, and be present when testimony or evidence is being presented, ask questions and respond to questions of the committee, and make a closing statement after all evidence is presented. (Required)

4. Nurse's Representative (Attorney or Nurse Peer) at Meeting
   The nurse's attorney or a nurse peer may accompany the nurse to the meeting; and consult with the nurse during the meeting. This facility chooses to limit the participation to conferring with client only.

5. Role of Committee Chair

The committee chair shall have the authority to take any action necessary to ensure that the meeting is conducted in an orderly manner that respects the rights of all participants including the nurse, witnesses, and committee members. If necessary, unless the participant is entitled to specific rights by law or BON rule, the chair may limit the rights of participants otherwise granted by these policies. The chair may suspend the meeting whenever she/he determines it is necessary to maintain the integrity of the process.

Q. Involvement of Nurse's Representatives in Process

1. Involvement of Attorneys
   Both the nurse and facility have the right to consult with an attorney. The nurse's attorney shall have the right to review documents relating to the incident under review as provided above. The nurse's attorney may be present at the meeting and consult with the nurse. If either the nurse or the facility intends to have their attorney at the meeting, they must notify the other in writing at least 7 calendar days in advance. Failure to do so will waive the right to have an attorney present. The other party need not give notice to have their attorney present. Any modification of this paragraph must be in writing and signed by the nurse and the committee chair or the chair's designee.

2. Involvement of Nurse Peer [Rule 217.19 requires that policies address issue]
   The nurse shall have a right to have a nurse peer at the nursing peer review committee meeting even if the nurse also has an attorney present. The nurse peer shall have the right to make an opening and closing statement to the committee. This facility limits the participation of the nurse peer to that of conferring only.

R. Evaluation of External Factors

1. Evaluation. In evaluating a nurse's conduct, the nursing peer review committee will evaluate the extent to which system problems or other factors beyond the nurse's control may have contributed to any deficiency in nursing care. The nurse will be held accountable only to the extent the conduct being reviewed is attributable to the nurse's own deficiencies in judgment, knowledge, training or skill.

2. Sharing of Information with Patient Safety Committee. If external factors are identified, that information will be shared with the appropriate patient safety committee which will evaluate the external factors and report its findings back to the nursing peer review committee. In evaluating the potential role of external factors, the nursing peer review committee may seek information from a patient safety committee. All communications shall be between the nursing peer review committee chair and the chair(s) of the patient safety committee(s) and governed by the confidentiality).

3. Extension of Peer Review Timeline. If necessary, to fully evaluate the role of external factors the chair may extend the time period (up to a maximum of 45 additional days) for the committee to conclude its meeting.

S. Post-Meeting Procedures

1. Decision of Committee, Summary of Findings, Notification of Nurse
   The committee shall make its decision no later than 14 calendar days after the committee meeting, and a Summary of Findings shall be promptly prepared. The decision shall include whether the nurse engaged in conduct subject to reporting, what corrective action is recommended and whether the committee recommends the BON take formal disciplinary action against the nurse. The nurse will be notified in writing of the committee's decision no later than 10 calendar days after the decision has been made. The notice shall include the Summary of Findings and explain the nurse's right to submit a rebuttal statement.

2. Rebuttal Statement
   The nurse shall have the right to submit a rebuttal statement responding to the committee's findings and shall be given at least 10 calendar days after notification of committee's determination to submit the statement. The statement shall not include any patient identifying information. The committee chair or designee shall review the statement and delete any patient identifying information. The nurse's rebuttal statement will be made a permanent part of the committee's findings and included whenever the committee's findings are disclosed.

3. Reporting of Nurse to BON

   a. Nurses found to have engaged in conduct subject to reporting will be reported to the BON unless the conduct is found to constitute a minor incident that is not required to be reported under BON Rule 217.16. If it is a minor incident, then the incident will be documented as required by that rule. The report to the BON will include the Summary of the Committee's Findings and the nurse's Rebuttal Statement. The committee's report will include:

      1. the identity of the nurse;

      2. a description of any corrective action taken against the nurse;

      3. a recommendation whether the BON should take formal disciplinary action against the nurse and the basis for the recommendation;

      4. a description of the conduct subject to reporting;

      5. the extent to which any deficiency in care provided by the reported nurse was the result of a factor beyond the nurse's control; and

      6. any additional information the BON requires.

   b. To assist the licensing board to the greatest extent possible in deciding if further disciplinary action against the nurse is in the public interest, the committee's report will set out in detail what corrective action was taken, why that particular corrective action was appropriate and whether it was successfully completed. If the committee report recommends that the licensing board not take further disciplinary action, the report will set out in detail why the committee believes that further disciplinary action would not be productive. The report will identify the extent to which the nurse's conduct was attributable to factors other than deficiencies in the nurse's judgment, knowledge, training or skill.

4. Reporting of Findings to Organization

The committee's findings shall be reported together with nurses rebuttal statement on the form labeled as, Detailed Summary of Peer Review Committee Findings. These findings will be shared with the nurse, the facility and the Board of Nursing.

T. Nurses Whose Practice May Be Impaired by Chemical Dependency of Mental Illness

1. If at any point in the nursing peer review process there is reason to believe that the practice of the nurse being reviewed is impaired by chemical dependency or mental illness, as required by Rule 217.19, review of the nurse shall be suspended and the nurse reported to the BON or the Texas Peer Assistance Program for Nurses (TPAPN) as follows:

   a. If there is no reasonable factual basis for determining that a practice violation is involved, the nurse shall be reported to TPAPN:

      1. If there is a reasonable factual basis for a determination that a practice violation is involved, the nurse shall be reported to the BON.

      2. Following suspension of peer review of the nurse, the committee shall proceed to evaluate external factors to determine if any factors beyond the nurse's control contributed to a practice violation; and any deficiency in external factors enabled the nurse to engage in unprofessional or illegal conduct. If the committee determines that external factors do exist, the committee shall report its findings to a patient safety committee or to the CNO or nurse administrator if there is no patient safety committee.

U. Nurse's Right Not to Participate

The nurse has the right not to participate in the nursing peer review process. When required by law, nursing peer review will be conducted even if the nurse elects not to participate. The peer review records will reflect that the nurse elected not to participate. As long as the nurse's election not to participate is not in writing, the nurse will be notified of all proceeding as if the nurse were participating. The committee findings will reflect that the nurse elected not to participate.

V. Waiver of Rights by Nurse

The nurse may waive any right or timetable provided the nurse under this plan. Any waiver shall be made only after the nurse has been notified that peer review has been initiated with respect to the nurse's conduct, be in writing and signed by the nurse and committee chair or the chair's designee.

W. Responsibilities of Chief Nursing Officer

The chief nursing officer is administratively responsible for the proper conducting of nursing peer review. If any nurse believes that nursing peer review is not being conducted properly or has any concerns about nursing peer review, the nurse should address those concerns with the chair of the nursing peer review committee. If for mw reason, the nurse does not feel comfortable addressing those concerns with the chair, the nurse should address them with the chief nursing officer.

X. Non-Employed Nurses (Temporary Agency Nurses, Nursing School Faculty)

Any nurse providing care in this facility shall be subject to peer review under this plan. If the nurse is employed by another organization, that organization may name a nurse to serve on the peer review committee. That nurse may not have administrative responsibility for making personnel decisions about

the nurse. The committee's findings together with the nurse's rebuttal statement shall be provided by the nurse's employer.

Y. Role in Administrative/Personnel Decisions
The administrative/personnel decision other than that of the nursing peer review committee's report must be submitted to the BON when a nurse is reported because of termination or other substantial disciplinary action taken against the nurse because of a practice-related incident.

Z. Peer Review When Nurse Reported to BON as Part of Facility/Organization Mandated Reporting
If the organization reports a nurse to the BON under the mandatory reporting requirements of NPA §301.405, the nurse will not be peer reviewed to determine if the nurse shall be reported to the BON by the nursing peer review committee. As authorized by NPA §303.405, nursing peer review shall be limited to an evaluation of the role of external factors in the deficiency in nursing care. The nurse shall not be entitled to due process as required by BON Rule 217.19 or this plan. If it is determined that external factors contributed to the deficiency in nursing care that information shall be provided to the BON.

AA. When Due Process Requirements Will Not Apply

1. In accordance with BON Rule 217.19, the procedural due process provided by BON Rule 217.19 and this plan will not apply in the following situations:

   a. Peer review conducted solely in compliance with NPA §301.405 (relating to mandatory report by employer, facility or agency) to review of external factors, after a mandatory report of a nurse by the organization to the BON has already occurred; or

   b. Suspension of peer review because the nurse's practice is suspected of being impaired due to chemical dependency, drug or alcohol abuse, substance abuse/misuse, "intemperate use," mental illness, or diminished mental capacity;

   c. When a nurse is reported to nursing peer review but peer review is not initiated because a) the person reporting believes or suspects the nurse's practice is impaired and 2) a practice violation is involved that requires a direct report of the nurse to the BON.

   d. Nurse elects not to participate in peer review process.

BB. Status of Nursing Peer Review Determination To Report Nurse to BON; Failure to Comply with Requirements
An incident-based peer review committee has a separate responsibility to protect the public by reporting a nurse to the BON as set forth in NPA §301.403 and BON Rule 217.19 and a determination by ail incident-based peer review committee to report a nurse to the BON cannot be overruled, dismissed, changed, or reversed. However, if the CNO or nurse administrator designated by the CNO has reasonable cause to believe the nursing peer review process did not comply with the requirements of BON Rule 217.19 or this plan, it may request that peer review be redone in compliance with Rule 217.19 and this plan.

CC. Amendments to These Policies
The policies may be amended by Nursing Administration or as outlined in legislative changes. Unless otherwise stated at time of adoption, amendments shall become effective immediately upon adoption. No amendments shall apply to any pending nursing peer review matter unless the nurse agrees in writing to having such amendment apply.

DD. Record Keeping
All forms, communications, reports, etc. will be maintained separately and not as part of personnel records to avoid waiver of confidentiality. The following documents will be kept in secured files, committee minutes, case activity chart (if used), due process checklist (if used), copy of report to BON and copy of report to facility

EE. Nurse Advocate/Ombudsman
The organization will make a nurse advocate/ombudsman available to the nurse at the facility's cost. The nurse advocate will be required to have special training in the incident-based nursing peer review process with a special interest on the rights of the nurse being reviewed. "The role of the nurse advocate will be to assist the nurse with the process of incident-based nursing peer review, advising as to compliance with procedures, and supporting the nurse including accompanying her or him to the committee meeting. The nurse advocate/ombudsman will be afforded all of the rights that the nurse has including attending the meetings and questioning witnesses. With the nurse's written consent, the nurse advocate will automatically be provided any materials provided the nurse.

NOTE: This item involves a policy decision about how the facility wishes to implement nursing peer review and whether to use it to help promote a supportive work environment.

IV. Dates Approved or Amended

Originated: 11/1999	*Effective:*
Reviewed with Changes	*Reviewed without Changes*
11/2017	05/2019, 12/2020

V. Contact Information

~~Director of Nursing~~
Chief Nursing Officer
325-574-7292

I. Title

Insertion of and Care of IV Sites

II. Statement of Purpose

To describe specific guidelines to be followed for insertion and care of intravascular needles and catheters to minimize the risk of infection.

III. Policy

A. IV therapy should be used only for definitive therapeutic or diagnostic indications.

B. IV therapy should be initiated only by licensed personnel trained in IV therapy. Students will be placed under the direct supervision of the nursing instructors.

C. As a general guideline, after two unsuccessful attempts to obtain IV access, a nurse should request that another nurse attempt to obtain access. If two nurses are unable to obtain IV access, consider requesting a CRNA at the bedside to obtain access.

D. Hand Washing:

1. Hospital personnel will wash their hands with soap and water or use a hospital-approved hand sanitizer before inserting an IV cannula.

2. Glove will be worn when starting IV's.

E. The appropriate IV needle/catheter should be selected based on the site and type of infusion.

F. In adults, the upper extremity (or if necessary, subclavian and jugular sites) should be used in preference to lower extremity sites for IV cannulation. All cannulas inserted into a lower extremity should be changed as soon as satisfactory site can be established elsewhere.

G. Site should be cleaned with an antiseptic prior to venipuncture.

H. Insertion techniques:

1. Reference should be made to *Lippincott Procedures,* on the CMH portal, for the appropriate venipuncture technique.

2. The cannula should be secured to stabilize it at the insertion site.

3. A dressing or op-site should be applied to cover the insertion site. The dressing and tape should cover the wound.

4. The date and time of insertion should be documented on the dressing. The procedure should be documented in the medical record.

I. Maintenance of IV site.

1. Patients with IV devices should be evaluated at least every shift for evidence of cannula related complications. This evaluation should include gentle palpations for the insertion site through the intact dressing. If they patient has an unexplained fever or there is pain or tenderness at the insertion site, the dressing should be removed and the IV site inspected.

2. For peripheral cannulas that must remain in place for prolonged periods, the IV site should be inspected and dressed with a new dressing at 72 hours and PRN.

J. If prolonged IV therapy with a peripheral cannula is indicated; the cannula should be changed when signs and/or symptoms of infection or infiltration are observed. Cannulas inserted without proper asepsis, for example, those inserted in an emergency, should be replaced at the earliest opportunity.

K. Special procedures of central cannula.

1. Central cannulas should be inserted with aseptic technique and sterile equipment.

2. Central cannulas that are inserted through a subclavian or jugular approach need not be changed routinely. Central cannulas inserted through a peripheral vein should be treated as peripheral cannulas.

3. For central cannulas that must remain in place for prolonged periods, the insertion site should be inspected each shift and a new sterile dressing placed every 72 hours.

L. Maintenance of administration sets

1. IV administration tubing should be routinely changed every 72 hours.

2. Secondary tubing should be changed every 24 hours.

3. Tubing used for hyper alimentation should be routinely changed every 24 hours.

4. Tubing should also be changed after the administration of blood, blood products, or lipid emulsions.

5. Between changes of components, the IV system should be maintained as a closed system as much as possible. All entries into the tubing, as for administration for medications, should be made through injections ports that are disinfected just before entry.

6. Peripheral lines can be gently aspirated with a syringe of normal saline.

7. Central IV lines which cannot regain potency by aspiration should be evaluated by a doctor.

8. A completely blocked IV should ~~always~~ be restarted.

Remove the following section. This is not related to IV insertion and site care.

~~M. Quality control during and after admixture administration:~~

~~1. Parental and hyper alimentation fluids should be admixed in the pharmacy, unless clinical urgency require admixture in patient care area.~~

~~2. Personnel should wash their hands before mixing parenterals.~~

~~3. In the pharmacy, a laminar flow hood should be used for admixing parental fluids.~~

~~4. All containers of parenteral fluid should be checked for visible turbidity, leaks, breaks, and particulate matter and for manufacturer's expiration date before admixing and before use.~~

~~5. Single-use/single dose container vials should be used for admixture whenever possible. Multiple dose containers are good until expiration date, unless visible contamination is seen or suspected. The product label or package insert should be consulted to determine if refrigeration of the container is necessary.~~

~~6. All admixed fluid should be refrigerated or started within 6 hours of admixing. Admixed parenterals may be stored in the refrigerator for up to one week before use.~~

~~7. Once started, all parenterals should be completely used or discarded within 24 hours.~~

~~8. Infusion of lipid emulsions should be completed within 12 hours of starting.~~

IV. Dates Approved or Amended

Originated: 03/1989	*Effective: 03/1989*
Reviewed with Changes	*Reviewed without Changes*
10/2014, 12/2020	05/2019

V. Contact Information

~~Director of Nursing~~
Chief Nursing Officer
325-574-7292

Cogdell MEMORIAL HOSPITAL	HOSPITAL DISTRICT DOCUMENTS *NURSING LINES OF COMMUNICATION ~~IN THE DEPARTMENT OF NURSING~~* 1.ORG.NS.1005
SECTION: **ORGANIZATION**	SUBJECT: **NURSING ~~STAFF~~ SERVICES**

I. Title

Lines of Communication in the Department of Nursing

II. Statement of Purpose

To ensure the proper lines of communication in the nursing department.

III. Policy

A. The CNO is directly responsible to the CEO. The Patient Care Services Directors may assume the responsibilities for the CNO in his/her absence. In the absence of the CNO and/or the ~~Nurse Managers~~ Patient Care Services Director, the House Supervisor has the CNO authority.

B. ~~The Nursing Director of Home Health and Hospice have the direct responsibility to their areas 24 hours per day. The Home Health Nursing Director is directly responsible to the CEO. The CNO acts as a consultant to the Nursing Director of Home Health and the Nursing Director of the Price Daniel Medical Unit.~~The Nursing Director of Home Health and Hospice and the Rural Health Clinic have responsibility for their areas 24 hours per day. Both report to the CEO. The CNO acts as a consultant to these Directors.

C. The Patient Care Services Directors are ~~directly~~ responsible to the CNO and have direct responsibility for their departments 24 hours per day. Charge nurses, ~~on each unit and each shift,~~ staff nurses, CNAs, ~~Ward Clerks~~ and ER Techs ~~on each unit~~ are responsible to their Director, or the House Supervisor, in the absence of the Director.

D. The House Supervisor has the responsibility for direct supervision of the shift they are working.

E. The CNO, Patient Care Services Directors and House Supervisors work in cooperation with one another to assure safe and effective patient care management on each shift.

IV. Dates Approved or Amended

Originated: 1988	*Effective: 1988*
Reviewed with Changes	*Reviewed without Changes*
10/2014; 12/2020	05/2019

V. Contact Information

~~Director of Nursing~~
Chief Nursing Officer
325-574-7292

I. Title

Medication Administration

II. Statement of Purpose

To designate who may administer medications at Cogdell Memorial Hospital.

III. Policy

A. Medication Administration requires a basic knowledge of pharmacology

1. A medication skills competency assessment is performed during unit orientation.
2. A medication calculation exam must be passed prior to giving medications.

B. Nursing personnel ~~designated to~~ allowed to independently administer medications (PO, IM, IV, SQ) are:

1. RN
2. GN
3. LVN
4. GVN

C. Student nurses may administer medications under the direct supervision and in the presence of their instructor or a staff nurse.

IV. Dates Approved or Amended

Originated: 01/1991	*Effective:*
Reviewed with Changes	*Reviewed without Changes*
11/2017	05/2019, 12/2020

V. Contact Information

~~Director of Nursing~~
Chief Nursing Officer
325-574-7292

I. Title

Medication Administration; Use of Protocols

II. Purpose

To improve the quality and safety of care for those administering and receiving medications.

III. Policy

All medications must be administered according to an order by a physician, physician's assistant or APRN.

IV. Procedures

Any medication administered by the nurse shall be completed according to a practitioner's written order. In the absence of a previously established medication administration protocol, the nurse should follow the instructions in the ***Emergency Critical Care Pocket Guide 8th Ed*** *(Jones & Bartlett Learning, Burlington, MA, 2014).* This resource can be found on the **CMH portal** under the **Clinical Resources** tab. The rovider should write an order to administer according to the protocol and provide appropriate parameters for the nurse to follow. For example, an appropriate parameter for a blood pressure drip might be "titrate Levophed drip to maintain a systolic blood pressure between 110 and 140 mm Hg". Should the nurse have any questions regarding the order or the parameters, they should seek assistance from the ordering provider.

V. Relevant Federal and State Statutes

NIAHO Revision 20-1 MM.1.SR.3, SR.10

VI. Related CMH Documents

VII. Dates Approved or Amended

Include origination date, dates of major or minor revisions and dates reviewed without changes.

Originated: 12/2020	*Effective: 12/2020*
	Reviewed without Changes

VIII. Contact Information

Chief Nursing Officer
325-574-7292

I. Title

Nurse Staffing Committee Charter / Policy

II. Statement of Purpose

To designate to the Nurse Staffing Committee to be responsible for soliciting and receiving input from nurses on development, ongoing monitoring, and evaluation of the staffing plan.

III. Policy

Cogdell Memorial Hospital will establish and maintain a Nurse Staffing Committee and a Nurse Staffing Plan according to State Law. https://statutes.capitol.texas.gov/Docs/HS/pdf/HS.257.pdf

~~Policy/Procedure Title~~	~~Nurse Staffing Committee Charter~~		
~~Policy/Procedure #~~	~~NS 3.13 1.~~	~~Effective~~	~~8/31/09 Page 1 of 17~~
~~Department Generating Policy~~	~~QRM~~		
~~Affected Departments~~	~~All Nursing Departments~~		
~~Prepared By~~	~~Teresa Ragland;~~	~~Dept./Title~~	~~Nursing/CNO~~
~~Dept. I Committee Approval (If Applicable)~~		~~Date/Title~~	
~~Dept. I Committee Approval (If Applicable)~~		~~Date/Title~~	
~~Dept. I Committee Approval (If Applicable)~~		~~Date/Title~~	
~~Medical Staff Approval (If Applicable)~~		~~Date/Title~~	
~~Board Approval (If Applicable)~~		~~Date/Title~~	

IV. Nurse Staffing Committee Charter

A. The Hospital Safe Staffing Law requires Cogdell Memorial Hospital to adopt a nurse staffing policy that includes the establishment of a nurse staffing committee as a hospital standing committee. The committee is responsible for developing and recommending a nurse staffing plan to the hospital's governing board. The committee's plan also is presented to hospital leadership, which will adopt the hospital's official nurse services staffing plan.

B. The hospital shall designate an advisory committee established in accordance with Health and Safety Code (HSC) §§161.031-161.033, to be responsible for soliciting and receiving input form nurses on the development, ongoing monitoring, and evaluation of the staffing plan.

C. On a semi-annual basis, the committee must report to the governing board on its evaluation of the effectiveness of the official nurse staffing plan. The committee charter establishes a collaborative process for hospital leadership and direct care nurses together to create a staffing plan that will achieve positive patient outcomes. (See Attachment A – Appendix A)

D. Purpose and Objectives

1. The purpose of the committee is to recommend a nurse staffing plan that protects patients, supports greater retention of registered nurses and promotes adequate nurse staffing. In furtherance of these goals, the committee will:

   a. Develop and recommend a unit-and-shift-based staffing plan to guide the hospital-wide assignment of nurses;

   b. Solicit feedback and review, assess and respond to staffing concerns expressed to the committee; and,

   c. Evaluate the effectiveness of the hospital's nurse staffing plan based on nurse-sensitive outcome indicators and variations between the plan and the actual staffing.

E. Composition and Roles:

1. The committee shall consist of the following members:

   a. The chief nursing officer as a permanent member of the committee and will provide the semi-annual report to the governing board;

   b. A registered nurse or representative from infection control, risk management or quality/performance improvement;

   c. Direct care nurses comprising of a least sixty percent (60%) of committee membership must be "selected" by their direct care nurse peers [While direct election is not required, the nurses ultimately selected must be direct care nurses who are selected by direct care nurses. For example, from each nursing unit, the direct care nurses could elect a direct care nurse from their unit to serve on the committee. Ideally, each such direct care nurse would have at least four (4) years of unit-based experience.];

d. Committee membership representing multiple areas of nursing practice within the facility, direct care nurses serve in liaison roles to their respective practice areas;

e. The committee members shall vote a chairperson and co- chairperson who will be responsible for setting agendas, scheduling meetings, and ensuring minutes are documented and forwarded to the organization leadership and the quality/performance improvement council;

f. Each committee member shall have an equal vote; and,

g. A financial analyst as an ad hoc, non-voting member of the committee to provide budgetary/financial information as needed.

F. Operations:

1. The committee shall meet quarterly and more often as indicated. (Quarterly meetings are required).

G. Ground rules: Ground rules represent a behavioral agreement among committee members regarding how they will act:

1. Ground rules: ground rules shall establish a code of conduct for behavior of committee members represented and include items such as expected levels of participation (e.g., attendance at meetings, verbal contributions, active listening) and how members will communicate and treat each other (respectfully).

2. Since the committee has legal protections, there is an expectation of confidentiality surrounding the information to be disclosed. Information will be disclosed by the committee as a whole, not by individual members.

H. Decisions:

1. One of the most important processes for the committee to determine is how decisions will be made. Consensus decision-making fits well with a collaborative model. It is:

a. Inclusive: stakeholders are represented (e.g., all practice areas);

b. Participatory: actively solicits involvement of all members in the process;

c. Cooperative: members strive to reach the best possible decision for the group as a whole; and,

d. Egalitarian: All members have equal input into the process (e.g., CNO cannot veto an individual member's proposal).

2. Reaching consensus requires a commitment to hearing and considering different opinions and perspectives and working to design a solution that all members can ultimately support. The risk of "group think" - a failure to critically evaluate decision-making and alternatives - can be avoided by making sure someone plays a "devil's advocate" role and poses critical questions about the decision for the group to consider.

3. However, despite good-faith efforts by all parties, the committee may not be able to reach consensus on a decision. In this situation, the committee may need to conduct a formal vote.

I. Developing the Staffing Plan:

1. Other processes to be defined include how the committee will go about developing a staffing plan. The committee will require data and information regarding:

   a. Staff: characteristics such as skill mix, experience and expertise, position control, vacancy rates, projected changes such as new graduate hires, leaves-of-absence, retirements, and satisfaction results;

   b. Staffing: staffing patterns, scheduling practices, variances, use of agency staff, use of mandatory overtime and current national standards; (See Attachment C – Mandatory Overtime)

   c. Patients: census, acuity (trends, projections and variability) and outcome measures; and,

   d. Budget: historically budgeted hours per patient day, budgeted productive/non- productive hours, and direct/indirect, fixed/variable staff and anticipated changes in budget. Although the budget is not to drive the staffing plan, budgetary information will assist the committee in understanding relationships between staff resources and staffing/scheduling.

2. Committee members may need an orientation to the data and how the information can be used to develop a staffing plan from which other tools are derived (position control, hppd, productivity tools, etc.). The also may need assistance in interpreting relationships among data elements (e.g., scheduling and staffing, staffing, and hppd, position control and vacancies, and most importantly, staffing and patient outcomes). A beginning knowledge base of the various tools common to managing personnel needs of a hospital department will assist the committee in its work.

3. If managers previously have developed staffing plans for their units, the hospital will need to consider how they will manage the transition to the staffing committee and how the manager's role will be affected. Additionally, how can the expertise of department managers' facilitate the work of the committee?

4. The hospital will need to define how department or unit managers interface with the committee in the development and evaluation of the staffing plan for their respective areas.

5. The committee's plan must set minimal staffing levels for patient care units and address the following areas:

   a. Critical factors including patient characteristics, patient intensity, scope of services, context of care and nursing characteristics;

   b. Current standards established by professional organizations (see Appendix B);

   c. Method for adjusting the plan to meet patient needs;

d. A contingency plan when patient care needs unexpectedly exceed direct patient care resources; and,

e. Use of mandatory overtime.

6. Mandatory overtime means a requirement that a nurse work hours or days that are in addition to the hours or days scheduled, regardless of the length of a scheduled shift or the number of scheduled shifts each week. In determining whether work is mandatory overtime, prescheduled on call time or time immediately before or after a scheduled shift necessary to document or communicate patient status to ensure patient safety is not included.

   a. The hospital may not require a nurse to work mandatory overtime, and a nurse may refuse to work mandatory overtime.

   b. A nurse may volunteer to work overtime.

   c. The hospital may not use on call as a substitute for mandatory overtime.

7. Exceptions: The prohibition against a hospital requiring a nurse to work mandatory overtime does not apply if:

   a. the need for health care personnel, unexpectedly affects the country in which the nurse is employed or affects a contiguous county;

   b. A federal, state, or county declaration of emergency is in effect in the county in which the nurse is employed or is in effect in a contiguous county;

   c. There is an emergency or unforeseen event of a kind that:

      1) Does not regularly occur;

      2) Increases the need for health care personnel at the hospital to provide safe patient care; and,

      3) Could not prudently be anticipated by the hospital; or

      4) The nurse is actively engaged in an ongoing medical or surgical procedure and the continued presence of the nurse through the completion of the procedure is necessary to ensure the health and safety of the patient.

   d. If the hospital determines that an exception exists, the hospital shall, to the extent possible, make a good faith effort to meet the staffing agency nurses, assigning floats, or requesting an additional day of work from off duty employees.

8. In addition, the plan must consider operational outcomes (e.g., nurse turnover and work- related injuries), nurse-sensitive patient outcomes (e.g., pressure ulcers, hospital-acquired infections and falls) and patient complaints related to staffing.

J. Soliciting Input and Responding to Concerns:

1. Under current hospital licensing rules, the hospital must orient nurses to the process for reporting concerns. The nurse staffing committee is tasked with soliciting input for nursing staff on the development, ongoing monitoring and evaluation of the staffing plan. The committee should explore possible options, including surveys, staff meetings, open forums, rounds or online mechanisms. The intent of the Hospital Safe Staffing Law is to expand the nurse staffing committee's responsibility in responding to nurses' concerns. The committee must review, assess and respond to staffing concerns and will need to have a process to accomplish this.

K. Collecting Data for Evaluating the Staffing Plan:

1. The hospital will need to provide the committee with data, such as performance on nurse- sensitive outcome indicators and staffing variances for evaluating the staffing plan. For and organized. The committee will analyze and compare the data over time, evaluating the relationship between and looking for patterns and trends between staffing and outcome indicators. Committee members should be aware of the following in their considerations:

   a. Understand the concept of significance and trends. Two data points do not constitute a trend, and every trend may not be significant.

   b. Co-occurrence does not constitute a relationship. Data must be related and evaluated over time.

   c. When it looks like a relationship, drill down and ask why. Look at other variables, such as patient characteristics, staff experience/expertise, availability of support staffing, use of agency nurses, etc.

   d. Consider external benchmarks. If outcome measures are below benchmark and hppd are low, the two may be related and staffing may need to be adjusted to achieve better outcome measures.

L. Considering Variance between Planned and Actual Staffing:

1. The committee will consider hospital reports of staffing variances, that is, when actual staffing did not match the staffing plan. A variance does not indicate a problem automatically. There will be instances when the staffing plan does not reflect actual patient needs as determined by the nursing assessment, which is why the staffing plan requires a provision for adjustment according to patient needs.

2. When looking at staffing variances, the committee should pay attention to:

   a. Both number and skill mix of staff;

   b. Possible patterns in variances (certain units, shifts or type of staff);

c. Reason for the variance (acuity called for less staff, staff not available, unexpected increase in census or change in patient condition) and whether the situation was preventable (too many nurses on or change in patient condition) and whether the situation was preventable (too many nurses on vacation at the same time) or unforeseeable (rapid increase in census related to flu epidemic); and,

d. Certain unit characteristics, such as:

1) Units that have great fluctuations in census,

2) Units with complex patient care needs, and

3) Units with high variability in the patient characteristics.

3. The committee may identify opportunities for improvement in staffing and include recommendation in its evaluation of the staffing plan.

M. Evaluating the Staffing Plan:

1. After careful review of all the data - nurse-sensitive outcome measures, relationships between staffing levels and outcomes, staffing variances, the committee will need to produce an evaluation of the staffing plan.

2. This is perhaps the most important step in the process as it comprises a feedback loop. This measurement will be used to direct continued refinement of the staffing plan, based upon evidence of what most effectively and efficiently meets patient needs and supports nurse satisfaction. Questions for the committee to consider include:

a. Is the plan effective? Does it make the best use of the nurse resources available to the hospital?

b. Is the hospital achieving its goals for patient and nurse satisfaction, as well as for clinical and operational (including financial) outcome measures?

c. Is there a general sense that staffing is adequate or not? Does it vary between units?

d. What concerns have been expressed to the committee? What is the nature of these concerns? Are they related to the staffing plan (e.g., unable to meet staffing?

e. Plan requirements because of vacancy rates, decisions made not to staff according to the plan, new treatments or procedures being done requiring increased nursing time, etc.)? Are these concerns specific to individual units or shifts? Are these concerns related to other issues?

f. Did the plan fail to take into account a certain characteristic?

g. If the evaluation were a report card, how would the plan score?

h. What recommendations does the committee have to improve the plan?

N. Reporting to the Hospital Board:

1. The hospital will need to determine the structure (format) and process for presenting the committee's report to the hospital board. Minimally, a written report of the committee's findings - including an analysis of the data considered by the committee, strengths and shortcomings of the staffing plan, and recommendations for improving staffing adequacy should be submitted for the hospital governing board's consideration. A verbal report by the CNO and/or committee chair may be included on the board's agenda, offering an opportunity for board members to ask questions and to obtain any necessary clarification about the committee's report.

O. Deliverables:

1. The committee will:

a. Develop and recommend a hospital-wide, unit- and shift-based staffing plan that:

1) Considers critical factors, including patient characteristics, patient intensity, scope of services, and context of care and nursing characteristics;

2) Sets minimal staffing levels for patient care units;

3) Reflects current standards established by professional organizations; includes a method for adjusting the plan to meet patient needs; and, includes a contingency plan for when patient care needs unexpectedly exceed direct patient care resources.

2. Select nurse-sensitive outcome measures for evaluating the effectiveness of the final nurse staffing plan;

3. Solicit input from direct care nurses regarding staffing concerns and respond to such feedback;

4. Evaluate effectiveness of the nurse staffing plan semiannually; and,

5. Report the evaluation and aggregate variations in staffing to the hospital's governing board semi-annually.

P. Relationship with other organizational entities:

1. The committee will be established as a standing committee of the hospital and will provide a written report to the hospital's quality/performance improvement committee on the results of the variations of nursing staffing plan and the relationship of the nurse sensitive outcome indicators on a quarterly basis.

2. The report of the evaluation and aggregate variations in staffing will be forwarded to the hospital's governing board by the Chief Nursing Officer on a semi-annual basis.

Q. Outcome Indicators:

1. Consistent with the movement toward evidence-based decision-making in healthcare, existing hospital licensing rules require hospitals to collect data, correlate it to nurse staffing and use this information in evaluating the adequacy of staffing. Current rules also specify that hospitals must select at least one indicator from three types of outcomes: patient, operational, and patient complaints related to staffing. Several nursing organizations - the American Nurses Association, the American Association of Critical Care Nurses and the American Organization of Nurse Executives - as well as the National Quality Forum ("NQF") and the Joint Commission have identified outcomes related to nursing care.

2. The staffing committee is responsible for deciding on the nurse-sensitive outcome indicators (data) that will be used to evaluate the staffing plan and may find it helpful to select indicators from this list (see below). Other considerations that may assist the committee include:

   a. Use data one already has, such as data collected for reporting to other agencies, survey data, patient complaints etc.;

   b. Select indicators that the facility believes are related to staffing or can be affected by staffing and use such as an opportunity to really make a difference in patient care; and,

   c. Drill down to the unit level, which is where staffing decisions are made.

R. Identifying Relationships among Indicators and Staffing:

1. Once the indicators are selected, a process will need to be developed for collecting the data (if they are not available currently) and presenting the information in a usable format. Important considerations:

   a. Establish standard a definitions for the indicators, for example, "falls include all witnessed/un-witnessed or assisted falls with injury," or adopt the definition by the NQF;

   b. Identify numerator and denominators (for example, the numerator might be the number of hospital-acquired pressure ulcers Stage II or greater identified during

      1) a prevalence survey on the second Tuesday of the month, and the denominator would be the total number of patients examined); and,

   c. Determine acceptable ranges or trigger levels, which may be reflective of past performance, expert opinion, literature or national benchmarks.

V. Relevant Federal and State Statutes

https://statutes.capitol.texas.gov/Docs/HS/pdf/HS.257.pdf

VI. Dates Approved or Amended

Originated: 09/2009	*Effective:*
Reviewed with Changes	*Reviewed without Changes*
12/2020	10/2014, 11/2017, 05/2019

VII. Contact Information

~~Director of Nursing~~
Chief Nursing Officer
325-574-7292

Cogdell MEMORIAL HOSPITAL	HOSPITAL DISTRICT DOCUMENTS ~~ADMISSION~~ NURSING ASSESSMENT, AND ~~REASSESSMENT~~ PLAN OF CARE 1.ORG.NS.1025
SECTION: **ORGANIZATION**	SUBJECT: **NURSING ~~STAFF~~ SERVICES**

I. Title

~~*Admission*~~ *Nursing Assessment and* ~~*Reassessment*~~ *Plan of Care*

II. Statement of Purpose

~~To collect data for the coordination of Patient Care.~~ Nursing assessments should collect the necessary data for the nurse to be able to develop a plan of care to keep the patient safe while addressing the presenting and concomitant conditions.

III. Policy

A. ASSESSMENT and REASSESSMENT

1. Each patient will be assessed by a registered nurse, within 12 hours of admission to a patient care unit.
2. The admission assessment will include, but is not limited to, the following;
    - Allergies
    - Admitting problem
    - History of pain and current pain assessment
    - Pre-existing or other conditions
    - Current medications
    - ADL needs
    - Dietary requirements
    - A head-to-toe examination
3. Patients will have a head-to-toe assessment completed and documented by an RN each shift, and if the patient's condition changes. The assessment/reassessment of care and/or treatment needs of the patient is continuous throughout the patient's hospitalization and should be documented as such.

B. PLAN OF CARE

Nursing staff shall develop and begin a customized plan of care for each patient as soon as possible, and within 12 hours of admission, that reflects the findings of a completed nursing assessment and input of other disciplines as appropriate.

1. The plan of care will be based on assessment of patient's nursing care needs, and will include developing appropriate goals, implementing nursing interventions in response to those needs, and evaluating the patient's progress towards those goals. Both physiological and psychosocial factors will be taken into consideration.
2. The patient's plan of care will be reviewed daily and revised as necessary, based upon ongoing assessments of the patient's needs and the patient's response to interventions, in response to assessments.
3. The plan of care includes planning the patient's care from admission through discharge, with discharge planning initiated upon admission.
4. The plan of care will be consistent with the attending practitioner's plan for medical care
5. The plan of care is included as part of the patient's medical record.

IV. Relevant Federal and State Statutes

NIAHO Version 20-1 NS.3.SR.1., SR2 and SR.3

V. Dates Approved or Amended

Originated: 01/2011	*Effective:*
Reviewed with Changes	*Reviewed without Changes*
11/2017, 12/2020	05/2019

VI. Contact Information

~~Director of Nursing~~
Chief Nursing Officer
325-574-7292

I. Title

Nursing Budget

II. Statement of Purpose

Define development of the nursing budget.

III. Policy

A. The CNO/DON in conjunction with the Patient Care Services Directors will prepare a budget for each nursing unit annually. The following will be included:

1. Assumptions on which to build the nursing budget.
2. Preparation of a budget calendar.
3. Use of applicable data from ~~QA,~~ QM, including classification and acuity of patients, staffing plans and risk management.
4. Use of applicable information from the hospital strategic planning process.
5. Identification of processes used to monitor unit performance in regard to ~~all~~ approved budget, including methods for acting on variances.

B. The nursing service budget will be presented to the CEO and CFO for approval at a time identified by hospital administration.

IV. Dates Approved or Amended

Originated: 01/1988	*Effective:*
Reviewed with Changes	*Reviewed without Changes*
11/2017	05/2019, 12/2020

V. Contact Information

Director of Nursing
Chief Nursing Officer
325-574-7292

I. Title

Nursing Department Credentials

II. Statement of Purpose

To define credentialing required for nursing staff ~~employment~~ employed by Cogdell Memorial Hospital.

III. Policy

A. Current Licensure must be ~~evident~~ verified and maintained for employment as an RN or LVN. Nurse aide certification is required unless currently enrolled in at least the second semester of a nursing program.

B. Upon application for employment and prior to employment interview, licenses must be ~~presented to~~ verified with the appropriate Board of Nursing by Human Resources ~~and the Nurse Manager~~

~~C. The Human Resource department will verify the Licensure with the appropriate Board of Nursing.~~

D. Maintenance of licensure is the responsibility of the licensed employee.

E. Steps will be taken by CMH to ensure continuity of licensure.

F. If licensure should expire, the nurse will not be allowed to practice in ~~her~~ the capacity of a nurse until ~~notification of~~ license reinstatement is ~~received from~~ reported on the Board of Nursing website.

G. A GN or GVN failing boards cannot administer medications or give nursing care that requires licensure. They may continue to work as a nurse's aide or a nurse tech, if HR and the CNO agree. ~~or permit to~~.

H. LVN's who have taken and successfully completed the RN program will be employed as a GN until ~~boards are~~ the NCLEX is completed and passed. Should the LVN fail to pass the NCLEX, they may no longer work as a GN, but may work as an LVN, as long as that license is active and in good standing.

IV. Dates Approved or Amended

Originated: 05/1981	*Effective:*
Reviewed with Changes	*Reviewed without Changes*
11/2017, 12/2020	05/2019

V. Contact Information

~~Director of Nursing~~ Chief Nursing Officer
325-574-7292

Cogdell MEMORIAL HOSPITAL	HOSPITAL DISTRICT DOCUMENTS *NURSING ORIENTATION* 1.ORG.NS.1020
SECTION: **ORGANIZATION**	SUBJECT: **NURSING ~~STAFF~~ SERVICES**

I. Title

Nursing Orientation

II. Statement of Purpose

To provide nursing orientation for newly employed licensed nursing personnel.

III. Policy

A. All ~~hospital employed~~ nursing services staff, including contract staff, students and volunteers, must ~~complete both hospital and nursing~~ receive an orientation prior to working independently in their respective role.

B. Orientation will address, at a minimum, the following topics:

1. Organizational structure
2. Patient confidentiality and ethics
3. ~~Policies, procedures and work instructions~~ Document control, retrival land verification (specific to policies, procedures, and work instructions/protocols)
4. Internal reporting requirements for adverse patient events
5. Patient safety
6. General safety (work environment)
7. Emergency procedures
8. Infection control and universal precautions
9. ~~Age specific considerations~~
10. Role specific competencies

IV. Relevant Regulatory Guidelines

NIAHO Revision 20-1 SM.4

V. Dates Approved or Amended

Originated: 01/1991	*Effective:*
Reviewed with Changes	*Reviewed without Changes*
11/2017, 12/2020	05/2019

VI. Contact Information

~~Director of Nursing~~

Chief Nursing Officer

325-574-7292

I. Title

Organizational Description of the Department of Nursing

II. Policy

A. The Department of Nursing at Cogdell Memorial Hospital is an organized department managed by a qualified registered nurse who has the clinical and managerial experience necessary to work with other registered nurses in developing hospital wide patient care programs, policies, and procedures that direct the nursing department in meeting the nursing care needs of patients, and that the patient populations are assessed, evaluated, and those needs are met.

B. The Department of Nursing of Cogdell Memorial Hospital organizational structure flows both horizontally and vertically to demonstrate participative management within the department of nursing.

III. Scope of Service

A. Cogdell Memorial Hospital nursing care is delivered to patients in the following departments, services, and areas:

1. Medical Surgical Unit
2. Emergency Department
3. Ambulatory Services
4. ~~Operating/Recovery~~ Surgical Services
5. Perinatal Services
6. ~~Home Health and Hospice~~

IV. Dates Approved or Amended

Originated: 01/1991	*Effective:*
Reviewed with Changes	*Reviewed without Changes*
11/2017	05/2019, 12/2020

V. Contact Information

~~Director of Nursing~~ Chief Nursing Officer
325-574-7292

Cogdell MEMORIAL HOSPITAL	HOSPITAL DISTRICT DOCUMENTS *PAIN ~~ASSESSMENT~~ MANAGEMENT* 1.ORG.NS.1026
SECTION: **ORGANIZATION**	SUBJECT: **NURSING ~~STAFF~~ SERVICES**

I. Title

~~Assessment of~~ Pain ~~on Admission~~ Management

II. Statement of Purpose

Patients have a right to pain management as part of their care. Nursing assessment, interventions, and reassessment of pain following an intervention, is an integral part of pain management. ~~baseline pain assessments and interventions assessment to all patients~~.

III. Policy

All patients will be ~~screened on admission about the presence of pain~~ assessed for pain upon admission, with each assessment, when vital signs are obtained, and <60 minutes of when pain medication is administered.

~~IV. Guidelines~~ Procedure

- All patients at admission are asked the following questions about the presence of pain;
    1. "Do you have pain now?"
    2. "Have you had pain in the last several weeks or months?"
- If "yes" to either question, obtain the additional assessment data about the following elements:
    1. Pain intensity
        a. Use ~~the hospital-approved~~ a pain intensity rating scale appropriate for the patient population.
        b. Pain intensity is obtained for pain now, at worst and at least.
    2. Location of pain (ask the patient to mark on a diagram or point to the site).
    3. Quality, patterns or radiation, if any, and character (document in the patient's own words when possible).
    4. Onset, duration, variation and patterns.
    5. Alleviating and aggravating factors.
    6. Present pain management regimen and effectiveness.

7. Pain management history (including a medication history, presence of common barriers to reporting pain and using analgesics, past interventions and response and manner of expressing pain).

8. Effects of pain (impact on daily life, function, sleep, appetite, relationships with others, emotions and concentration).

9. The patient's pain goal (include pain intensity and goals related to function activities and quality of life and acceptable level of pain).

10. Physical exam/observation of the pain site.

- Each area of pain is assessed and documented.
- Any time a patients rates pain above a '4' on the 0-10 scale, or any time the patient reports an unacceptable level of pain, an intervention should be offered. Documentation should include pain rating, intervention offered and patient response.
    1. Consider pharmacologic and non-pharmacologic interventions.
    2. Assess and document pain rating prior to and within 60 minutes following an intervention
- Each patient should be educated on the pain scale upon admission. This education is to be documented in the EMR.
- Each patient who is reporting pain should have a corresponding plan of care documented.

V. Relevant Federal and State Statutes

NIAHO Revision 20-1 PR.2.SR.11

VI. Dates Approved or Amended

Originated: 01/1991	*Effective:*
Reviewed with Changes	*Reviewed without Changes*
11/2017; 12/2020	05/2019

VII. Contact Information

Chief Nursing Officer
325-574-7292

I. Title

Peripherally Inserted Central Catheter (PICC) Line Policy and Procedure

II. Policy

A Registered Nurse with demonstrated proficiency and documented competency in PICC placement may:

1. Insert device with physician order
2. Verify tip placement utilizing chest x-ray or tip location device
3. Write an order to use the PICC line during the same admission as placement

A Registered Nurse or a Licensed Vocational Nurse with demonstrated proficiency and documented competency in PICC care may:

1. Access the device for medication or fluid administration, draw blood or measure central venous pressure
2. Flush device as appropriate
3. Attempt to restore the patency of the device
4. Perform dressing changes
5. Remove the device with physician order

III. Procedures

Insertion:
https://procedures.lww.com/lnp/view.do?pId=4450068&hits=insertion,picc,inserted,piccs,insert,inserting&a=false&ad=false

Medication Administration:
https://procedures.lww.com/lnp/view.do?pId=4450964&hits=lines,administration,medications,medication,picc,line&a=false&ad=false

Flushing:
https://procedures.lww.com/lnp/view.do?pId=4449664&hits=central,catheter,catheters,venous,declotting&a=false&ad=false

Declotting:
https://procedures.lww.com/lnp/view.do?pId=4451155&hits=declot,declotting,venous,declotted,central,catheters,catheter&a=false&ad=false

Dressing Changes: https://procedures.lww.com/lnp/view.do?pId=4450397&hits=piccs&a=false&ad=false

Removal: https://procedures.lww.com/lnp/view.do?pId=4450962&hits=picc&a=false&ad=false

IV. Definitions

Peripherally Inserted Central Catheter (PICC): Long catheter placed through a peripheral vein and advanced to the subclavian vein into the superior vena cava or right atrium, and used to administer parenteral fluids or medications, draw blood or measure central venous pressure.

V. Dates Approved or Amended

Originated: 08/2018	*Effective: 08/2018*
Reviewed with Changes	*Reviewed without Changes*
10/2018	05/2019, 12/2020

VI. Contact Information

PICC Placement Team (Covenant Health)
~~806-721-6933~~ 806-831-5026

Cogdell MEMORIAL HOSPITAL	HOSPITAL DISCTICT DOCUMENTS *PROCEDURE PROTOCOLS* 1.ORG.NS.1070
SECTION: ORGANIZATION	SUBJECT: NURSING SERVICES

I. Title

Procedure Protocols

II. Purpose

To improve the quality and safety of nursing interventions and procedures.

III. Policy

- Cogdell Memorial Hospital will provide care in as safe a setting as possible. The hospital uses "Lippincott Procedures", a web-based program that provides evidence-based guidelines of patient care as the official nursing procedure manual.
- Nurses are responsible for following the guidelines put forth by the Texas Board of Nursing Scope of Practice guidelines when determining whether the performance of a procedure is within their scope of practice for which the nurse is licensed.

IV. Procedure

Any procedure performed by the nurse shall be completed according to a written, established protocol. In the absence of a previously established and approved protocol, the nurse should follow the guidance found in "**Lippincott Procedures**". This resource can be found on the **CMH portal** under the **Clinical Resources** tab.

V. Dates Approved or Amended

Include origination date, dates of major or minor revisions and dates reviewed without changes.

Originated: 12/2020	*Effective: December 2020*
	Reviewed without Changes

VI. Contact Information

Chief Nursing Officer
325-574-7292

Cogdell MEMORIAL HOSPITAL	HOSPITAL DISTRICT DOCUMENTS *SAFE HARBOR PEER REVIEW* 1.ORG.NS.1018
SECTION: **ORGANIZATION**	SUBJECT: **NURSING ~~STAFF~~ SERVICES**

I. Title

Safe Harbor Peer Review

II. Statement of Purpose

~~Policy on informing~~ To inform nurses of the right to request Safe Harbor Peer Review and procedures for making request.

III. Policy

A. Cogdell Memorial Hospital regularly utilizes 10 or more nurses and safe harbor nursing peer review is available to the nurses it utilizes. Cogdell Memorial Hospital will implement Safe Harbor Nursing Peer Review in accordance with Sec. 303.005 and Texas Board of Nursing (BON) Rule 217.20. The Chief Nursing Officer is responsible for taking the steps reasonably necessary to ensure Safe Harbor Nursing Peer Review is appropriately implemented.

B. Section 303.005(i) of the Safe Harbor Nursing Peer Review Law requires adoption and implementation of "a policy to inform nurses of the right to request a nursing peer review committee determination and the procedure for making a request." The following outlines:

1. How Safe Harbor Nursing Peer Review will be implemented by this hospital and,

2. How nurses will be informed of their rights under Safe Harbor Nursing Peer Review and how they can make a request.

3. Nurses will be informed of their right to request safe harbor nursing peer review and of the procedures for making the request on the internal Portal; Policies and Procedures; Nursing Services; Safe Harbor Peer Review. ~~the hospital distributing to each nurse a pamphlet developed by the Texas Nurses Association titled "Nurse's Rights Under Safe Harbor Nursing Peer Review".~~

4. BON Rule 217.20(d)(3) and (4) requires a request for Safe Harbor Nursing Peer Review be in writing and include either:

   a. The information required for the Quick Request Form under 217.(d)(3); or

   b. The information required for the Comprehensive Written Request Form under 217.(d)(4)

   c. If a nurse is unable to complete a Safe Harbor Quick Request or other written form meeting the requirements for a Safe Harbor Quick Request due to immediate patient care needs, the nurse may orally invoke safe harbor by notifying the nurse's supervisor of the request. After receiving oral notification of a request, the nurse's supervisor must record in writing the requirements of a Safe Harbor Quick Request, described in Board Rule 217.20(d)(3), which must be signed and attested to

by the requesting nurse and the nurse's supervisor who prepared the written record. The BON Safe Harbor Quick Request Form can be used to meet these requirements as well, however, use of the BON's form is not required but is provided to make invoking safe harbor an easier process.

5. If a nurse uses the Quick Request Form to make the initial request, the nurse must submit a Comprehensive Written Request Form before she/he leaves the work setting at the end of the work period. If the Comprehensive Written Request Form is used to make the initial request, no additional forms need be submitted.

   a. Link to Texas BON Quick Request Form https://www.bon.texas.gov/pdfs/safe_harbor_forms_pdfs/BONSafeHarborQuickRequestForm.pdf

   b. The Quick Request Form Contain must contain the following information:

      1) the nurse(s) name making the safe harbor request and his/her signature(s);

      2) the date and time of the request;

      3) the location of where the conduct or assignment is to be completed;

      4) the name of the person requesting the conduct or making the assignment; and

      5) a brief explanation of why safe harbor is being requested.

   c. Link to Texas BON Comprehensive Written Request Form https://www.bon.texas.gov/pdfs/safe_harbor_forms_pdfs/BONComprehensiveWrittenRequestforSafeHarborNursingPeerReview.pdf

   d. The Comprehensive Written Request Form must contain the following information:

      1) The conduct assigned or requested, including the name and title of the person making the assignment or request;

      2) A description of the practice setting, e.g., the nurse's responsibilities, resources available, extenuating or contributing circumstances impacting the situation;

      3) A detailed description of how the requested conduct or assignment would have violated the nurse's duty to a patient or any other provision of the NPA and Board Rules. If possible, reference the specific standard (217.11 of this title) or other section of the NPA and/or Board rules the nurse believes would have been violated. If a nurse refuses to engage in the requested conduct or assignment, the nurse must document the existence of a rationale listed under subsection (g) of this section.

      4) If applicable, the rationale for the nurse's not engaging in the requested conduct or assignment awaiting the nursing peer review committee's determination as to the nurse's duty. The rationale should refer to one of the justifications described in subsection (g) (2)

of this section for not engaging in the conduct or assignment awaiting a peer review determination.

5) Any other copies of pertinent documentation available at the time. Additional documents may be submitted to the committee when available at a later time; and

6) The nurse's name, title, and relationship to the supervisor making the assignment or request.

6. The on duty House Supervisor will provide the nurse the forms at the time the nurse indicates she/he wants to request safe harbor nursing peer review.

7. The forms should be submitted to the nurse requesting the conduct or making the assignment.

C. The process followed for safe harbor nursing peer review will be the process outlined in BON Rule 217.20.

D. It is the policy of this hospital to try to resolve any request for Safe Harbor Nursing Peer Review in a mutually acceptable manner that is consistent with the nurse's duty to the patient. The Nurse Manager and/or House Supervisor is challenged with the task of trying to find a resolution that is mutually acceptable. If this occurs after hours the House Supervisor must notify both the Unit Nurse Manager and the Chief Nursing Officer that a nurse has requested safe harbor peer review.

E. It is the policy of this hospital not to ask a nurse to continue to engage in the same conduct if the nursing peer review committee has determined that the conduct violates the nurse's duty to the patient.

F. Any nurse, who has a question about Safe Harbor Nursing Peer Review, may contact the following person(s): Kathy Goodwin, RN, CNO or Kristi Hanley, RN, CQO.

IV. Relevant Federal and State Statutes

https://www.bon.texas.gov/pdfs/safe_harbor_forms_pdfs/GeneralInformationAboutSafeHarbor.pdf
https://www.bon.texas.gov/forms_safe_harbor.asp

V. Dates Approved or Amended

Originated: 04/2008	*Effective:*
Reviewed with Changes 12/2020	*Reviewed without Changes*
	11/2017, 05/2019

VI. Contact Information

~~Director of Nursing~~
Chief Nursing Officer
325-574-7292

Cogdell MEMORIAL HOSPITAL	HOSPITAL DISTRICT DOCUMENTS ***HOSPITAL STAFFING INCENTIVE - CRITICAL VACANCY BONUS*** **1.ORG.NS.1061**
SECTION: **ORGANIZATION**	SUBJECT: **NURSING STAFF**

I. Title

Hospital Staffing Incentive-Critical Vacancy Bonus

II. Policy

- All qualified hospital staff nurses and nurse techs/CNAs will be eligible to participate in the **Critical Vacancy Bonus** (CVB) program during times of critical shortages in the Medical-Surgical Unit, Perinatal Unit, CVU and Emergency Department
- Each Unit Director will communicate staffing opportunities and shifts designated as bonus shifts for the 4-week schedule prior to posting the schedule. The Unit Director or House Supervisor may offer the CVB bonus for unscheduled needs that arise
- A **Critical Vacancy Bonus** (CVB) will be paid when a staff member works more than fourteen 12-hour hospital shifts during the 4-week schedule. In order to earn the bonus, **all scheduled** shifts must be worked during the 4-week schedule
- If a regularly scheduled shift is not worked (due to a call-in) during the same week as an extra shift is picked up, the employee is not eligible for the bonus
- If an employee is cancelled for an extra shift, no bonus will be paid for that shift
- The amount of the CVB is as follows:

RN/LVN	$125	each extra shift over 14 shifts during a 4-week schedule **or**
	$475	for 3 extra shifts (17 total) during a 4-week schedule
Ancillary (NT, CNA)	$40	each extra shift over 14 shifts during 4-week schedule **or**
	$150	for 3 extra shifts (17 total) during 4-week schedule

- The CVB amount is the same for all shifts: days, nights, weekdays, weekends or holidays.
- A **Critical Vacancy Bonus Shift Log** must be completed by the employee prior to the end of the 4-week schedule and turned in to the Unit Director or CNO prior to the Monday of a payroll week. The Unit Director or CNO will submit it for payment through the payroll system. Paperwork that is turned in late may delay the payment of the bonus
- The CVB will be offered during time of staffing shortages, but is not automatically in effect every schedule. The bonus may be revoked at any time. All shifts must be worked in one of the following units: Medical-Surgical, CVU, OB or ER.
- Any variation from this policy has to have a verbal/written approval from the CNO. If the CNO is unavailable, verbal/written approval must be obtained from the CEO or CFO

III. Related CMH Documents: Critical Vacancy Shift Log

http://portal/index.php?option=com_content&view=article&id=123&Itemid=546#

IV. Dates Approved or Amended

Originated:	*Effective: 09/2016*
Reviewed with Changes	*Reviewed without Changes*
6/2020	11/2017, 05/2019, 12/2020

V. Contact Information

Chief Nursing Officer, Human Resources

I. Title

Standing Orders

II. Statement of Purpose

Define use of standing orders.

III. Policy

Standing orders may be implemented by nursing service on order of the physician. These standing orders will be reviewed and revised as often as necessary, but not less than yearly.

IV. Dates Approved or Amended

Originated: 05/1988	*Effective:*
Reviewed with Changes	*Reviewed without Changes*
	11/2017, 05/2019, 12/2020

V. Contact Information

~~Director of Nursing~~
Chief Nursing Officer
325-574-7292

Second Amendment to Tax Abatement Agreement
between
Scurry County Hospital District and Canyon Wind Farm, LLC

State of Texas	**§**
	§
County of Scurry	**§**

This Second Amendment to the Tax Abatement Agreement (this "*Amendment*") is made and entered into by and between Scurry County Hospital District ("*Hospital*"), acting by and through its duly elected officers, and Canyon Wind Farm, LLC, a Delaware limited liability company ("*Owner*") to amend the Tax Abatement Agreement entered into between Hospital and Owner dated on or about January 8, 2019 ("*Agreement*"). Undefined capitalized terms herein shall have the meaning ascribed to them in the Agreement.

I. Authorization

This Amendment is authorized by Chapter 312 of the Texas Tax Code as it exists on the effective date of this Amendment and by the Scurry County Guidelines for Granting Tax Abatements as they exist on the effective date of this Amendment.

II. Amendment

For good and valuable consideration, the receipt of which is hereby acknowledged, the Hospital and Owner hereby agree that the Agreement is hereby amended as follows:

1. Section III C. of the Agreement is hereby deleted in its entirety and replaced with the following:

   "Owner contemplates that construction of the Improvements is expected to begin by May 31, 2021, or earlier, and is expected to be completed by May 31, 2022. Hospital recognizes that the above dates are "best estimates" at the time of this Agreement. Hospital also recognizes that Improvement may be constructed in phases."

2. Section IV A. of the Agreement is hereby deleted in its entirety and replaced with the following:

   "Unless terminated earlier as provided elsewhere herein, this Agreement shall be effective January 1, 2023, following execution of this Agreement, and shall continue in effect until December 31, 2032."

3. The first sentence of Section IV C.1. of the Agreement is hereby deleted in its entirety and replaced with the following:

"Beginning January 1, 2023, and ending upon the conclusion of ten (10) full calendar years, Abatement is granted as follows:"

4. Section IV E. of the Agreement is hereby deleted in its entirety and replaced with the following:

"As additional consideration for this Abatement, Owner agrees to pay to the Hospital the following:

1. Annually for years one (1) through ten (10) of the Abatement, Eight-Hundred Dollars ($800.00) per installed megawatt capacity within the Reinvestment Zone; the first such payment shall be due on October 31, 2023, with the remaining nine (9) payments due annually thereafter.

5. The portion pertaining to Owner in Section X. of the Agreement is hereby deleted and replaced with the following:

"If to Owner:

Canyon Wind Farm, LLC
c/o Silverpeak Renewables Investment Partners, LP
40 W 57th Street, 29th Floor
New York, NY 10019
Attn: Antonio Giustino"

III. Miscellaneous

The Agreement is hereby amended in accordance with the foregoing provisions of this Amendment. Except for the amendment of the Agreement as provided for herein, all other terms and provisions of the Agreement shall remain in full force and effect as if this Amendment had been incorporated in the Agreement as originally executed and delivered. In the event of any inconsistency between the provisions of the Agreement and this Amendment, the provision of this Amendment shall control.

This Amendment may be executed in any number of counterparts or with counterpart signature pages, each of which counterparts shall be deemed to be an original and all of which shall constitute one and the same agreement and shall be binding upon the undersigned.

IN TESTIMONY OF WHICH, THIS AMENDMENT has been executed by the County as authorized by Scurry County Hospital District on _____ ___, 2020, and by the Owner on _____ ___, 2020, and is effective upon the execution of both parties hereto.

ATTEST/SEAL:

HOSPITAL

SCURRY COUNTY HOSPITAL DISTRICT

By:_____
Ella Helms
Chief Executive Officer

Attest:

Executed by Chief Executive Officer, Ella Helms, on _____ ___, 2020.

_____
John Everett, Board Secretary

OWNER

CANYON WIND FARM, LLC

By:_____
Thomas M. Carbone
Authorized Signor

Ella R. Helms

From: Ella R. Helms
Sent: Monday, November 2, 2020 4:29 PM
To: 'Teague Dill'
Cc: Lily Reagan; Rose Ragland; John Everett
Subject: Request to post public notice - deadline to post is No[illegible] Please let me know if you have questions!

Dec. 9th

Notice of Public Hearing - Wednesday, December 9, 2020

The Scurry County Hospital District will hold a public hear[illegible] the tax abatement agreement between the hospital and:

Canyon Wind Farm, LLC
Silverpeak Renewables Investment Partners, LP
40 W 57th St., 29th floor
New York, NY 10019

This project is located in the Canyon Wind Reinvestment Zo[illegible] turbines, foundations, collection systems, transmission lines a[illegible] onal meteorological towers, roads, operations and maintenances fa[illegible] sary for commercial generation of electricity.

The estimated capacity of the project is for the construction of 240[illegible] t to change. The estimated project cost is $240 million.

The meeting will be held at 8:00 a.m. in the administration foyer on Wednesday, December 9, 2020.

Ella

Ella R. Helms
Chief Executive Officer
Cogdell Memorial Hospital
1700 Cogdell Boulevard
Snyder, Texas 79549
325-574-7437