South Cove Community Health Center

Clinical Policy Handbook

July 1, 2023

Clinical Policy Handbook

Contents

1.00 General Patient Care Policies

Purpose

General Patient Care Policies are to ensure a continuity of procedures and policies are followed throughout all departments and facilities of South Cove Community Health Center. Certain departments and facilities may follow different or more advanced policies as outlined in their individual department polices.

1.00.1 Patient Rights and Responsibilities

Purpose
The purpose of this policy is to outline the rights and responsibilities of South Cove Community Health Center patients.

Policy
Rights as a Patient
Patients have many rights at South Cove Community Health Center. It is important that patients know and understand these rights. If patients have questions or concerns about them we sternly encourage that they discuss them with their provider or any other South Cove staff members.

Please see the “Patient Rights and Responsibilities at South Cove Community Health Center” notice for complete and detailed rights and responsibilities of all SCCHC patients. This notice is to be posted at each clinical facility.

Note: Under HIPAA Regulations of 1996, SCCHC is required by law to maintain the privacy of health and medical information about a patient as defined under the Protected Health Information (PHI).

1.00.2 Confidentiality of Patient Information

Purpose

In accordance with the Patient Rights Policy and Massachusetts General Law, the South Cove Community Health Center must safeguard the patient's right to privacy. The purpose of this policy is to outline the mechanisms in place for assuring confidentiality of all information concerning patient care service.

Policy

General Statements

a. Confidentiality of all patient information shall be strictly adhered to by all association personnel. Failure to do so will result in disciplinary action, up to and including termination of employment.
b. Upon hire, all staff members are oriented to the issue of confidentiality and will be required to sign a confidentiality statement.
c. All information regarding patient's status, diagnoses, treatment and prognoses shall be considered confidential and may only be shared with authorized persons. Information concerning a patient's financial status and/or insurance is also considered to be confidential in nature and should be treated as such.
d. Discussion of patient information shall be restricted to personnel involved in the patient's care.
e. Information of a sensitive nature shall only be discussed with personnel who require that information to implement patient care.
f. No statement should be made to other than direct health care givers regarding specific causative organisms in patient with infectious disease.
g. Any additional discussion concerning patients other than what is outlined above, or release of information concerning a patient should be with the consent of the patient (refer to policy "Release of Information")
h. All confidential information maintained in paper format should be stored in a secured area, e.g., locked desk, file cabinet, or office that can be locked.
i. Care should be taken to safeguard the confidentiality of patient information in the transporting of patient records between the patient's home and the office.
j. All confidential information shall be disposed of by shredding or tearing the sheets of paper and tied in a plastic bag.

Computer Information

1. Accessing of computer information concerning patients and employees must be directly related to the job responsibilities. (Refer to Information Systems Policy)
2. All personnel assigned a security code to access the Management Information System will sign a security agreement. A copy of this agreement will be kept in the staff member's personnel record.

Management Data

1. All patient-identifying information should be removed from reports, memos, data collection forms, etc. This also includes data and information used when contributing or using external databases, e.g., third party payers, professional organizations.

Medical Records

- Medical records are to be reviewed only by personnel requiring such information for patient care. Medical Records Department staff and staff committee members are authorized to view/review records.
- Patients have the right to review their own medical records during Agency office hours given reasonable notice to the Medical Records Department.

Telephone Requests

- Telephone requests for information shall be referred to the appropriate department.
- Medical Records Department for requests for information contained in the patient's record.
- Nursing Supervisors for general requests on patient status.
- Finance Department for billing and accounting questions.
- Chief Operating Officer/Administrator for requests by news media concerning any agency activities.

- When handling telephone requests for patient information an attempt must be made to verify the identity of the caller. As appropriate, this can be accomplished by returning the call.

Note: Under HIPPA Regulations of 1996, SCCHC is required by law to maintain the privacy of health and medical information about the patients as defined under the Protected Health Information (PHI).

1.00.3 Research Related Use of Patient Data

Purpose

Patient data is the property and responsibility of the South Cove Community Health Center, and its use is confined to patient care. Anyone, including Health Center staff members, seeking to use patient data for non-patient care purposes must request and receive administrative approval first.

Policy

Whenever the South Cove Community Health Center is approached about participation in a research project, study, survey, or any other clinical or academic project which involves the use of Health Center patient data, the research or the proposed project must demonstrate the following:

1. How the project would benefit the patients involved;
2. How the project would promote improving the health care delivery system for Asian populations in general;
3. How the project would ensure patient confidentiality and privacy;
4. How the health center and its service would benefit from this participation;
5. That the data will not be used to create or increase the competition for the Health Center.

The researchers must then submit a written proposal that must be reviewed by the Human Subject Committee of the Health Center (whose membership includes clinicians, administrative leaders, and nursing staff) and approved by the Executive Director.

Incorporating the information above, the proposal must contain the following:

1. A complete explanation of the purpose of the project, especially as it relates to health care delivery to Asians. Any departure from the stated purpose is grounds for immediately voiding any subsequent agreement;
2. A complete description of the way in which the Health Center's patient data is to be used. Any departure from the stated use is ground for immediately voiding any subsequent agreement;
3. An agreement that the use of the patient data will be confined to the original scope of the project and that any subsequent use will be subject to further review and approval by the Health Center;
4. A mechanism for the Health Center to periodically review and provide input into the project;
5. An acknowledgement that the Health Center is the sole owner of the patient data. Only the Executive Director may authorize the dissemination of raw and/or completed patient data outside the research group.
6. Assurance that patient confidentiality will be maintained and a complete description of the methodology that will be used to achieve this;
7. Assurance of proper attribution of credit and/or authorship to the Health Center and to its contributing staff and a description of the manner in which this will be done;
8. Assurance that any proposed publication or dissemination of Health Center patient data is subject to the prior review and approval of the health Center's Executive Director.

The approved proposal becomes part of a contractual agreement signed by South Cove Community Health Center's Executive Director and the project researchers.

These policies also apply to any existing projects approved prior to the enactment of these polices.

1.00.4 Patient Rights – Health Care Proxy

Purpose
The purpose of this policy is to provide guidelines for all clinical and non-clinical staff regarding dissemination of information of Health Care Proxy materials to all patients.

Policy
A Health Care Proxy is a legal document, recognized in Massachusetts, which allows the individual to choose a person to speak for them in cases where that individual becomes unable to do so.

At South Cove Community Health Center, all staff are encouraged to provide information regarding the purpose and establishment of a proxy to all patients. South Cove employees in Member Services/Social Services as well as clinical providers will offer information to patients at the time of their visit. A brief explanation of the proxy information will be given and written materials in appropriate languages will be provided. Patients will be encouraged to review the material and if a decision regarding the proxy is made, they may return this information to their provider at the time of their next visit or the information may be mailed to the provider. **A South Cove employee may witness a proxy, however, it is encouraged that a witness by a family member or friend of the patient not previously named as an agent.**

The provider will review the document and forward it to the Medical Record Department for filing in the record. This information will be maintained according to Massachusetts Law for 30 years. Upon request for the record from hospitals, patients or outside providers, this information will be released after receiving a signed consent from the patient or in the event of emergency treatment.

<u>Requirements for Validity of a Health Care Proxy</u>
Under Massachusetts law, the appointment of a health care agent is accomplished by execution of a proxy. To be effective under the Massachusetts Health Care Proxy Act, the proxy **must**:

a. Be in writing
b. Be signed by or at the direction of the principal, in the presence of two adults who subscribe their names as witness
c. Contain a written affirmation by the witnesses that the principal appeared to be
    a. At least 18 years old
    b. Of sound mind
    c. Under no constraint or undue influence
d. Identify the principal
e. Identify the agent
f. Indicate that the principal intends the agent to have authority for medical decisions on the patients behalf
g. Indicate that the agent's authority becomes effective if it is determined by the principal's attending physician, in writing, that the principal lacks the capacity to make or communicate health care decisions.

The proxy may

1. Include limits on the agent's authority, including specific directions as to types of medical care
2. Designate an alternate agent to serve in the event the agent is not available, willing or competent to serve.

1.01 Patient Registration

Purpose:

To obtain all the proper information to enroll patients at the health center and disclose to the patient all the required information as required by both health center policy and government policy.

Policy:

Patient Registration:

Have patient fill out the following forms:

1 New Patient Information/Patient Information Update Form
2 Patient consent for purposes of Treatment, Payment & Healthcare Operations

Documents needed from patient (as needed):

1. Health Insurance information (e.g. Insurance card, Letter)
2. Proof of current address (e.g. telephone, utility bill etc.)
3. Picture ID: government issued Id (see Photo Identification Policy)

One of the following document will be needed if the patient is a minor (under 18 years old) or patient is incompetent to consent him/herself

4. Child's birth certificate
5. Court issued document (e.g. guardianship)
6. Power of Attorney and the ID of the guarantor/legal representative

Procedure:

1. Have patient to fill out the Registration Form (if not done yet)
2. Collect all the essential documents from the patient
3. Verify the patient if the patient had previously used different names in our EMR system
4. Checking patient's insurance coverage

i. If patient has no coverage and would like to apply financial assistance
ii. Refer patient to Social Services department

5. Enter the data into our EMR system accordingly. Register patient's name by using the same name from patient's insurance card (Patients need to change/update their names with the insurance first, before we can make any changes in our system)
6. Explain to patient/guardian/representative the consent forms and have the forms be signed and dated.
7. Give a copy of the Notice of Privacy Practices to the patient.
8. Have patient to sign the Notice of Privacy Practices Signature of Receipt
9. Print the Front sheet having the patient to review the information and sign the form.
10. Scan the insurance document into eCW and forward the rest signed papers to Medical Records.
11. Perform BIDMC patient registration and add BI MR# to our system
12. Issue patient picture ID

1.02 Patient Information Update

Purpose:
To update all the proper patient registration information and disclose to the patient all the required information as required by both health center policy and government policy.

Policy:
Each Visit:

- Verify the following information with patient
  - . Name/Address
  - . Telephone (s)
  - . Emergency Contact information
  - . Insurance
- Update both Health Center and BI systems if there are any changes accordingly.
- Print the front sheet and confirm the changes with patient and have s/he sign the form
- Fax the signed Front sheet to 617-457-6600.

Annual Update:

- Have patient to fill up the Patient Information Update Form
- Update the information with our system as well as BI system if needed
- Print the Front Sheet (even if there are no changes) for patient to sign and forward the form to Medical Records.

Patient transfers from Pediatric to Adult service:

- Have patient to fill up the Patient Information Update Form
- Update the information with our system as well as BI system
- Go over and have the patient to sign the following two forms:

1. Patent Consent for purposes of Treatment, Payment & Healthcare Operation
2. Notice of Privacy Practices Signature of Receipt (Give a copy of the Notice to patient)

1.03 Photo Identification of Patients

Purpose:
To prevent fraudulent access to health care and to protect the identity of patients at South Cove Community Health Center.

Policy:
Patients who are seen at any medical or dental facility will be asked to produce one form of photo identification issued by a local, state or federal government agency (e.g.: passport/driver license/military ID), or two forms of non-photo identification, one of which must have been issued by a state or federal agency (e.g.: U.S. Social Security card and a utility bill, company or school identification badge).

Note: an employer or school-issued ID is not acceptable on its own.

Scope:
All staff involved in registering patients for treatment at the South Cove Community Health Center.

Procedure:
When a patient checks into any South Cove Community Health Center clinical facility for a first visit:

1. Request that they produce one of the forms of identification listed in the policy statement. Make a photocopy and return the original to the patient.

2. When a patient is under 18 and does not have identification or if a patient is unable due to their condition to produce identification, a responsible parent, guardian or spouse will be asked to produce identification as the person financially responsible.

3. Patients in an emergency situation will have their identification verified by the means outlined above, at an appropriate time in the medical care.

4. If patients are reluctant to produce identification, remind them that this is the same process used to cash a check, make a large credit card purchase or board a plane.

5. No one will be refused care because they do not, at that moment, have acceptable identification with them. Patients will be asked to bring appropriate documents to their next office visit. We will make every reasonable effort to accommodate that rare occasion when a patient cannot produce acceptable documents.

6. Consult with your supervisor when you are unable to obtain an acceptable form of identification.

7. On subsequent visits, access the photocopy or the electronic copy to verify that the patient is indeed legitimate.

8. If you suspect fraudulent activity, you must immediately notify your supervisor.

1.04 Patient Identification during an In-person encounter

Purpose

The following are Practices related to the proper identification of a patient.
These practices are meant to contribute to the efforts of patient safety and reduce the risks of patient errors.

Policy

The use of two patient identifiers improves the reliability of the patient identification process and decreases the chance of performing the wrong procedure on the wrong patient. Additionally, the use of two patient identifiers is necessary in the instances of a name patient alert because two (or more patients) have the same name that can be spelled the same, close to being spelled the same and/or pronounced the same.

Providers, nurses and staff are required to verify a patients identity whenever transitioning care to new person. Identity should be verified by confirming two of the following identifiers:

i. Name
ii. Date of Birth
iii. Assigned identification number/Medical Record number
iv. Telephone number
v. Address
vi. Photograph
vii. Social security number

The patient's room number should not be used as a patient identifier; room numbers are not person-specific identifiers, since patients can be moved from room to room.

Examples of areas where patient verification will be done

i. Check in
ii. Intake
iii. Provider or Nurse handoff
iv. Lab/Phlebotomy

1.05 Patient Identification during Inbound Phone Call

Purpose

The following are Practices related to the proper identification of a patient when calling the health center. These Practices are meant to contribute to the efforts of patient safety and reduce the risks of patient errors.

Policy

The use of two patient identifiers improves the reliability of the patient identification process and decreases the chance of performing the wrong procedure on the wrong patient. Additionally, the use of two patient identifiers is necessary in the instances of a name patient alert because two (or more patients) have the same name that can be spelled the same, close to being spelled the same and/or pronounced the same.

Examples of acceptable patient identifiers include:

i. Name
ii. Date of Birth
iii. Assigned identification number/Medical Record number
iv. Telephone number
v. Address
vi. Social security number

Examples of areas where patient verification will be done

i. Check in
ii. Intake
iii. Provider or Nurse handoff
iv. Lab/Phlebotomy
v. Any inbound phone call when PHI will be discussed.

1.06 Patient Identification during Outbound Phone Call

Purpose
The following are Practices related to the proper identification of a patient when staff are calling a patient. These Practices are meant to contribute to the efforts of patient safety and reduce the risks of patient errors.

Policy
The use of two patient identifiers improves the reliability of the patient identification process and decreases the chance of performing the wrong procedure on the wrong patient. Additionally, the use of two patient identifiers is necessary in the instances of a name patient alert because two (or more patients) have the same name that can be spelled the same, close to being spelled the same and/or pronounced the same.

When an outbound call is made, staff will verify that the person they have called is the patient by asking for the following additional identifiers:

Examples of acceptable patient identifiers include:

i. Name
ii. Date of Birth
iii. Assigned identification number/Medical Record number
iv. Address

Examples of areas where patient verification will be done

i. Any outbound phone call when PHI will be discussed.

1.07 Deaf and Hard of Hearing or Limited English Proficiency (LEP) Patients

Purpose
To provide appropriate services to the deaf and hard-of-hearing or Limited English Proficiency (LEP) patients of South Cove Community Health Center.

Policy
Any deaf or hard of hearing patient that requests or requires the assistance of a sign language interpreter should have the sign language interpreter scheduled at the same time the appointment is scheduled. The Massachusetts Commission for Deaf and Hard of Hearing provides and schedules the ASL interpreters and may be reached at 617-740-1700.

Any Limited English Proficiency (LEP) patient that requires the assistance of an interpreter should be assigned interpreter when appropriate. If an onsite interpreter is unavailable, the provider/staff may utilize a phone interpreter via the health center's Language Line solution. The site manager can provide instructions on accessing the phone interpreter.

1.08 Initial Assessment and Reassessment of Patients

Purpose
The purpose of this policy is to describe the initial and reassessment process at South Cove Community Health Center and to outline the content of assessment in each clinical area.

Policy
Initial Assessment
The scope of the initial assessment is designed to determine the extent of the care needed for the individual and the need for further assessment. All patients at South Cove Community Health Center are evaluated by a licensed provider at the time of initial assessment. This assessment includes at a minimum:

- The reason for the visit
- Chief complaint
- Allergies
- Pain Assessment** (see below)
- Findings of the physical examination
- Plan for treatment
- Review of all medications brought to appointment by patient (all returned to patient)
- The assessment is documented in the patient's record and is signed by the provider to include the appropriate credential.
- By the third visit to South Cove Community Health Center the following information is documented in the patient's record:
- A list of the patient's significant diagnoses and conditions
- Any significant operative/invasive procedures
- Medications the patient is currently taking
- In addition to the above listed minimum requirements, each medical specialty has established the following elements for inclusion in an initial assessment:

Adult Medicine
Refer to Adult Medicine Protocols

Pediatrics
Refer to Pediatric guidelines for maintenance visits and physical exam and visit forms

OB/GYN
Refer to OB/GYN Department Clinical Guidelines.

Dental
Refer to Dental practice protocols.

Behavioral Health
Refer to Behavioral Health guidelines

** Pain management

- The organization assesses and manages the patient's pain.
- When warranted by the patient's condition, the organization either conducts or refers the patient for a comprehensive pain assessment.
- The organization uses methods to assess pain that are consistent with the patient's age, condition, and ability to understand.
- The organization reassesses and responds to the patient's pain, based on its reassessment criteria.
- The organization either treats the patient's pain or refers the patient for treatment.

eCW documentation: the MA or NA can ask the question and document the patient's level of pain on the vital sign sheet. The provider will evaluate or re-evaluate the patient's pain level during the visit and will document it in the Summary of the patient's visit.

Reassessment
Reassessment occurs at the time of each subsequent visit to the Health Center or more often as determined by the patient's conditions, types of procedures being performed or to determine a patient's response to treatment. All information is documented in the patient's record at the time of observation or assessment in order to provide for continuity in care planning.

Given the patient's condition and needs as determined by the assessment or reassessment of the provider, patients may be referred for specialized care such as a nutrition, mental health or social services assessment. Each of these assessments will also be documented in the patient's record and reassessment performed as needed to assure continuity and quality of patient care.

Triage During Regular Hours
Phone Triage

1. Patient will call the main number to the clinic for the department they wish to contact.
2. Information will be taken from the patient based on their question.
3. Front desk staff will forward the call to the nurse and/or appropriate provider in the department for further triage, assessment and plan of action.
4. Clinical staff will advise patient whether to come in to the clinic for an appointment ASAP, or schedule an appointment within the next day or two, or wait for the provider to make a return call for further assessment and action, or advise patient to go to the ER.

Walk-In Triage
Please refer to "Policy 2.10 Assessment of Walk-In Patients"

Off-Hour Coverage
During the hours that the health center is not open, the patients will have access to the "on-call" coverage provided by the clinical departments. The patient can call the individual main telephone number for each site.

The patient will be able to listen to instructions in any of the 4 languages (English, Cantonese, Mandarin and Vietnamese) and select the prompt for the department that they need. The patient will then be connected directly to the person who is on call for the department (see attached grid). Beepers and voicemails are not used to address our off-hour coverage with patients.

Patient Referrals
Providers will refer patients to other facilities for any additional warranted clinical examinations by other providers, radiology films/scan, and others.

Appointment, if required, will be made for the patient by either the clinical department staff or the referral department staff and a referral appointment communicated to the patient.

The patient will also be scheduled for/informed of a mandatory visit (MV) appointment at SCCHC, if appropriate for what has been ordered, with the ordering provider to ensure follow up with the patient of the examination results.

- Note: a MV appointment cannot be cancelled by the patient simply notifying the front desk/clinical staff. The patient must talk to the department nurse/ordering provider to cancel a MV appointment. The provider will make the final decision as to whether the appointment can be cancelled, how soon the patient must make another appointment, etcetera.

Routine scheduling of follow up appointment following referrals:

- Certain procedure /referrals require an automatic MV follow up appointment with the provider.
- The ordering provider will check off the Mandatory Visit section on the referral form if they want the clinical/referral department staff to make a Mandatory Visit follow up appointment at SCCHC with the ordering provider for the patient following the referral appointment.

- The ordering provider may also put the Mandatory Visit (MV) stamp imprint on the referral form and/or the patient's progress notes to remind the nursing staff or other providers that the patient is expected back for a mandatory follow up appointment.
- The referral coordinator will schedule: a 1-week follow up MV for a patient referred to a hospital by their PCP for a radiological exam, and a 2-week follow up MV for a patient referred to a hospital by their PCP for a specialty consultation. The PCP should either use the MV stamp or make a notation on the referral request to alert the referral department to this requirement.

eCW: procedures for making referrals in the eCW are available to providers.

End of life care, treatment, or services:

- The organization through our clinical providers can address a patient's interest, concern, or decision about the care, treatment, or services received at the end of life at any time during the patient's assessment or reassessment visits if requested by the patient and/or family/surrogate decision-maker.
- The organization will honor a patient's end of life decisions.
- The provider will tell the patient and/or patient and family/surrogate decision-maker about how we can help address their end of life questions.
- The provider can offer information for possible sources of help and a description of what are advanced directives, health care proxy, living will, and so forth using the updated information available on the web links for the State of Massachusetts and in particular the: MOLST (Massachusetts Medical Orders for Life-Sustaining Treatment): http://molst-ma.org/
- Note: This website is easily accessible to all staff as it is posted on our internal website under the "Guidelines" section.
- The forms for options of what a patient may want to have access to read/learn about end of life care are available on the website in many languages which include English, Chinese, and Vietnamese most helpful to the majority of the patients cared for by SCCHC.
- In addition, the Massachusetts form for a provider to give to the patient interested in discussing a "Health Care Proxy" is available under the "Patient Education" section link in our eCW in 3 languages: English, Chinese, and Vietnamese.
- Options for a decision to be made about "Advanced Directives" are available for the provider to access on the eCW and this window of information will appear on the main information hub for each patient to be readily visible by authorized users of the eCW medical record.

Note: The majority of the population served by our organization is from the Asian culture. The providers and nursing staff understand the cultural issues present and prevalent amongst the Asian populations regarding talking about end of life issues.

It is not a conversation that a provider would usually initiate and discuss with the patient or family unless it was brought up for discussion by the patient/family or unless the provider had such a relationship with the patient/family to know that is a topic they would be comfortable talking about. The provider will assess what the patient/family want and then provide resources and assistance as needed.

1.09 Assessment of walk-in patients

Purpose
South Cove Community Health Center maintains standards for appropriately directing care when an individual presents to the clinic for care. This policy is to assure that patients are seen in a timely manner, commensurate with their clinical urgency.

Policy/Procedure
When a patient presents to clinic without an appointment the following procedure is followed by the member service representatives, nursing and provider staff.

If the patient describes or has any of the symptoms listed on the emergent guidelines as stated below, the member service staff calls the nurse to assess the patient immediately.

Emergent Guidelines:
- Difficulty breathing
- Throat tightening up or throat swelling, severe itching
- Chest pain or pressure, shortness of breath, sweaty/clammy, arm pain, indigestion, dizziness
- Bleeding (including vomiting or coughing blood, rectal or vaginal bleeding.
- Altered mental status, confusion, seizure, slurred speech, trouble speaking, extremity weakness, severe headache
- Severe neck or abdominal pain
- Severe nausea or any vomiting
- Lacerations, arm or leg deformity
- A red line running up or down an extremity
- Poisoning ingestion, drug overdose
- Suicide threat or attempt

Or if there is any uncertainty as to whether any of the above symptoms or problems are present.
The nurse assesses the patient in a confidential setting in the following situations:
- When a patient comes in to the clinic with signs and symptoms listed on the emergent guidelines.
- When the patient, not experiencing signs and symptoms of an emergent nature, comes into the office without an appointment during office hours and is unable to be placed into the provider's schedule within a reasonable time frame.

When a patient is instructed not to enter the common areas of the building (e.g. measles, chickenpox), the patient will be brought into the clinic through a separate entrance and placed in a patient treatment room that has been identified as the isolation room.

Several factors are considered in addition to the patient's report of symptoms and/or the nurse's physical assessment. They are as follows:
- The nurse attempts to schedule the patient with his/her primary care provider (PCP) in a timely manner related to the patient assessment findings or if possible is scheduled with a provider, depending on urgency.
- If the nurse is uncertain of the urgency of the patient's need to be seen by a provider, or is unable to identify a timely appointment related to the patient's condition, then the nurse will verbally present his/her assessment findings to a provider or the provider on-call. The disposition will be determined by that provider.
- If either the nurse or the provider assesses the individual to be in an emergent situation, rescue is called immediately. All clinical emergencies are overseen by the patient's primary care provider or a provider.

Documentation of the assessment findings and the provider's disposition is recorded as follows:
- when a patient is assessed by the nurse and is scheduled same day, the nurse documents the findings in the patient's chart.

- when a patient is not scheduled for a same day appointment, but is then scheduled for another day, the nurse documents the assessment findings and disposition in the medical record and notifies the patient's primary care provider.
- If the patient does not return for the appointment, the nurse and provider follow up and document the outcome. (See Policy for: No Show Appointments.)

Reference(s)
Policy: No Show Appointments
Policy: Response to Medical Emergency

1.10 No Show Appointments

Purpose
To provide guidelines for consistent follow up for all patients with missed scheduled appointments.

Policy
All patients with missed appointments will have the medical record forwarded to the nursing or medical assistant at the end of every clinic session.

The patients will be contacted by telephone and a new appointment scheduled and noted in the medical record. If the patient does not wish to reschedule, documentation of this information and any reason given will be placed in the record.

If the patient cannot be reached by telephone after 1 attempt, a letter will be sent to the patient requesting they call for an appointment. Notation on the day the letter is sent will be posted in the medical record.

Clinical departments are required to document in the patient's medical record whenever a patient does not show up for a scheduled appointment, a "no-show" appointment.

The department secretary, intake staff, provider, or nurse will document the progress notes of a missed appointment; document the date of missed appointment and type of appointment. The provider must review the chart and recommend the follow up actions to be taken with the patients (call the patient or reschedule the appointment or send the patient a letter of follow up). The appropriate clinical provider must sign the progress notes and return the chart to the department staff for further actions.

1.11 Response to Medical Emergencies

Purpose
To provide guidelines for appropriate response to a medical emergency at SCCHC. This policy will identify medical emergencies for the responsive and non-responsive patient.

Policy
All clinics will keep in a central location in the clinic a first aid kit containing medications to be used in an emergency, tongue blades, airways, oxygen equipment, and AMBU bags of Adult and Pediatric sizes), as well as an oxygen tank, and an Automatic External Defibrillator (AED).

Upon discovery of a medical emergency the following guidelines will be implemented for either a Responsive or Non-responsive patient:
Non-responsive patient:

- Upon discovery of a non-responsive patient, the staff member should immediately call for clinical assistance. Depending on the age of the patient, either an adult or a pediatric provider will be notified to come to the patient. Emergency code of "Code Blue" is identified and secretarial staff is notified. Secretarial staff will immediately telephone "9-911: for 911 Emergency Services to the clinic site.
- If staff member is trained in CPR, an "ABC assessment" is conducted and the staff member will immediately begin CPR if indicated. If staff member is not CPR trained, the staff member will immediately notify a provider or other clinical staff member who will initiate CPR.
- The "AED" will be used only by trained staff in the appropriate situation.
- Physician staff will conduct an assessment of the patient's condition and report this information to the responding EMT's. Physician will take control of the situation and provide instruction for the staff.
- Clinic staff will remain with the patient at all times and complete the medical emergency response form and submit the form to the COO and Director of Clinical Operations.

Responsive Patient:

- Upon discovery of a conscious patient who is experiencing a medical emergency (i.e. shortness of breath, chest pain, dizziness, etc.), the staff member will stay with the patient, make the patient as comfortable as possible, provide for the safety of the patient and immediately call for clinical assistance. Emergency code of "Code Blue" is used to notify the secretarial staff.
- A clinical assessment of the patient's conditions is made by the clinical staff (MD or nurse). The physician will take control of the situation and provide instruction for the staff.
- In the event that the patient will require transport to a hospital, the secretarial staff will dial "9-911" for 911 Emergency Services.

First Aid Kits:

- Each clinical site will have a designated First Aid Kit with appropriate supplies to handle emergencies for both adult and pediatric patients.
- Monthly checks of the First Aid Kits will be done by a designated clinical person at each site. Note; the First Aid Kit check will consist of examining the contents of the kits to ensure that all medications are not expired, and that all supplies are in working order.

Training:

- All staff will be educated regarding their roles in an emergency situation
- Clinical staff will be trained in the use of an automatic external defibrillator (AED)
- Mock training will be conducted on a quarterly basis to assure appropriate response. (The mock training is not necessary if there had been a Code Blue at the site during that quarter).
- Documentation of the training will be maintained by the Director of Clinical Operation

1.12 Response to After Hours Medical Emergencies

Purpose
To provide guidelines for appropriate response to afterhours emergencies at SCCHC.

Policy
After Hours Medical Emergencies
South Cove offers extended hours at specified locations during the week and on Saturdays and Sundays. In the event that a patient experiences a medical emergency after regular and extended hours and has contacted the on-call nurse/provider, the on call provider will triage the patient, and make the clinical decision to send the patient to an Urgent Care/ER, or to see the patient immediately in the morning.
All on-call emergencies are documented in the patients chart.

Patients are notified of regular and extended hours by several methods:
- Hours posted at clinical sites
- Bilingual ads which run in local papers
- Online at www.scchc.org

Hospital Admitting Procedures
South Cove has a formal relationship with Beth Israel Medical Center that upon determination that a patient requires hospital admission or emergency services, a health center staff may arrange to have the patient transported by clinically appropriate means to BIDMC and will send clinically appropriate information whenever possible. All admissions are done through the emergency room at BIDMC. Please refer to MOU with BIDMC for further details.

Clinical staff may also arrange for patients to be transported to other local hospitals or emergency providers when appropriate.

1.13 Emergency Transfers/Obstetrical Transfers

Purpose

To provide guidelines for the emergency transfer of patients who need emergency treatment or obstetric services at another facility/agency/provider.

Policy

Emergency Transfers

- The mode of transportation used for transfers is at the discretion of the treating emergency physician, PA, or NP and based on the individual clinical situation, available options, needed equipment and patient preference. If 911 Emergency Services has responded to an incident then the appropriate emergency vehicle may be used. 911 Emergency Services will transfer the patient to the closest facility.
- If private transfer is being arranged, an agreement to accept the patient in transfer should be obtained from a physician or responsible individual at the receiving hospital in advance of transfer.
- All pertinent records and copies of imaging studies should accompany the patient to the receiving facility or be electronically transferred as soon as is practical (except in the case of involuntary commitment to a psychiatric hospital) to such facility, agency, or provider.

Obstetrical Transfers

- Each clinic providing obstetrical services shall, prior to each patient's expected delivery date, arrange for the patient to be admitted for delivery to a facility licensed to perform deliveries. Unless the patient objects, the clinic shall send a copy of the record of its obstetrical care of the patient to this facility at the beginning of the patient's third trimester of pregnancy, and update it as necessary.
- The health center's electronic medical records is accessible to Beth Israel Lahey Health's Obstetrical department, however, if the patient is admitted to another facility, all pertinent records should be sent as soon as possible.

Hospital Admitting Procedures

South Cove has a formal relationship with Beth Israel Medical Center that upon determination that a patient requires hospital admission or emergency services, a health center staff may arrange to have the patient transported by clinically appropriate means to BIDMC and will send clinically appropriate information whenever possible. All admissions are done through the emergency room at BIDMC. Please refer to MOU with BIDMC for further details.

Clinical staff may also arrange for patients to be transported to other local hospitals or emergency providers when appropriate.

Ambulance Services

In addition to 911 Emergency Services, the health center has an agreement with Fallon Ambulance for emergency/non-emergency ambulance services (1-800-FALLONS).

1.14 Informed Consent

Purpose
To assure that every patient undergoing invasive procedures or specific tests identified within the body of this policy, receives consistent and accurate information to make an informed decision about his/her care. This policy is also intended to outline documentation requirements and communication guidelines for providers.

Policy
The physician providing the treatment or performing the procedure is responsible for obtaining an informed consent from the patient. Specific procedures and treatments for which an informed consent is required include (examples attached):

Vaccination and Immunization
HIV Testing
Hepatitis B Testing
Biopsy
Dental Extractions
Root Canal Treatment

The information provided to a patient must be enough for the patient to make an informed judgment about the proposed treatment. This information should include:

- Nature of the patient's condition and the treatment/procedures to be performed
- Nature and probability of the important risks involved
- Benefits to be reasonably expected of the procedure
- Inability of the physician to predict the results
- Irreversibility of the procedure, if appropriate
- The likely result if no treatment or procedure is carried out
- Available alternatives, including risk and benefits

Documentation Requirements:
All discussions regarding proposed treatment and/or procedures must be documented by the physician in the medical record. Additional written consent forms are required for genetic testing and procedures that involve puncture or incision of the skin or involves the insertion of an instrument or foreign material into the body, and the procedure exposes patients to more than a minimal risk of a significant complication. This definition includes, but is not limited to, biopsies, IUD insertion, or dental extractions.

Consent must be documented with enough detail so as to satisfy the reader that the patient was given and understood the medical information required by this policy.

Documentation should include:

- A statement that all required information was given to the patient; a listing of some major risks, including but not limited to loss of life, loss of limb or function, paralysis, allergic reactions, blood clots, nerve injury;
- The date the patient expressed their consent
- Signature of the MD
- Signature of the patient
- The patient's informed refusal for care or treatment if appropriate.

Who May Consent:

- Any mentally competent individual, 18 years or older or an emancipated minor may consent to procedures, treatment and anesthesia.
- Anyone under the age of 18 years and not an emancipated minor must have the consent from signed by the parent or legal guardian. Exceptions to this are as outlined in 1.03.1 Unemancipated Minor's Consent to Confidential Services.
- Next of kin may consent when a patient is not capable of comprehending and this needs to be documented in the record by an MD. The order for consent would be 1. Spouse, 2. Children of legal age, 3. Parents, 4. Siblings of legal age and 5. Grandparents..

Universal Protocol (time-out)

Note regarding all dental oral surgery patients:

The patient must sign an Oral Surgery Consent from only after the dentist explains the need for a dental extraction to the patient, the x-ray of the tooth/teeth to be extracted are shown to the patient, the tooth/teeth to be extracted are clearly marked in red on the dental chart on the Dental Recall page, the patient has been shown the tooth/teeth to be extracted by the use of a mirror, and a period of 10 minutes “time Out” has been conducted by all on the dental team with the patient.

The verification checklist at the bottom of the Oral Surgery Consent from shall be completed according to the steps taking above and after completion; the checklist shall be initialed by the dental department staff member. The patient’s current blood pressure measurements will be recorded on the consent form by the dental assistant prior to the procedure

Note regarding adult medicine patients:

The patient that will be receiving the procedure “Trigger Point Injection into a Joint” will consent to having the procedure and will participate in a period of “time-out” prior to the start of the procedure. The “time-out” will be witnessed by the provider who administers the injection, any assistant staff in the room and the patient.

Note regarding gynecology patients:

“Time-out” will apply to all colposcopies, all biopsies, IUD and **subdermal implant** insertions, loop electrosurgical procedures (LEEP), and manual vacuum aspirations. All patients receiving the above procedures must sign an informed consent form. Pre-verification checklist will be performed by the provider and clinical assistant, as well as the patient. In all cases, a final “time-out” will be performed" prior to the start of the procedure (either before any speculum is inserted for the procedure or before any anesthesia is administered.) The medical assistant will take the lead, reminding providers "are you ready to do time out." The patient will be asked to identify herself and confirm date of birth followed by the provider stating what procedure is being done. The "time-out" will be witnessed by the designated staff in the room. Pre-verification process and “time-out” will be documented for all procedures.

1.15 Unemancipated Minor's Consent to Confidential Services

Purpose

The policy is to further clarify that SCCHC, in striving to provide services in the patient's best interest, offers confidential services to unemancipated minors in compliance with Massachusetts State Laws.

HIPPA contains a set of privacy standards (The Privacy Rule) that includes a provision for "personal representatives". An unemancipated minor is not given authority to act under the Privacy Rule. However, a personal representative of an unemancipated minor can exercise the minor's rights with respect to their protected health information (PHI). A parent to an unemancipated minor is a personal representative by law (or a guardian or other person acting "in loco parentis" with legal authority.

Despite the authority given to personal representatives over emancipated minors in the Privacy Rule, there are three exceptions that define when the parent (or other legal authority) is NOT considered a personal representative.

The three exceptions are:

i. The minor lawfully consents to a particular service: when State or other applicable law does not require parental consent.

ii. When a court determines or other law authorizes the minor to obtain the service without parental consent.

iii. A parent agrees to a confidential relationship between the minor and the physician.

The regulation states: "These exceptions generally track the ability under State or other applicable laws of certain minors to obtain specified health care without parental consent. The disclosure of health information about a minor child to a parent should be governed by State or applicable law."

Policy

When a patient who is 17 years old or younger presents for any of the following treatment:

i. Birth control/contraceptive care
ii. Pregnancy testing and/or assistance for care during or after a pregnancy
iii. Diagnosis and treatment of sexually transmitted diseases (STDs)
iv. HIV counseling and testing
v. Counseling and health education for any of the above services

the SCCHC provider/RN/FP Counselor must check his/her medical record to determine whether or not SCCHC has the patient's written consent on file by checking for the presence of the signed "Statement of Confidentiality and Consent for Teen Services' form (attached).

a. If there is NOT a form on file, the provider/RN/FP Counselor must describe to the patient the limitation in services to which they can consent and obtain in a confidential manner versus the services that require parental or other consent and which the confidentiality may not be protected against access by a personal representative. After the patient is fully informed, the provider/RN/FP Counselor should give the patient the attached form to sign, and take the necessary steps for the form to be filed in the patient's record.

b. If there IS a form on file, the provider/RN/FP Counselor should check the date it was signed. If the form was signed in the past year, no further action is necessary. If the form was signed over 1 year from the current date, then the provider must have the patient sign a new form.

Provider/RN/FP Counselor should encourage a dialogue between the patient and his or her parent regarding the patient's health status and needs as deemed appropriate by the provider.

"This policy describes South Cove's process of obtaining informed consent from patients 17 years and younger who wish to receive certain confidential medical services according to Massachusetts State Law. The policy also clarifies how a legal guardian is restricted from obtaining information about confidential services provided to a minor according to the HIPPA privacy rules. "

1.16 Elder Protection Policy

Purpose
To provide clear guidelines for patient assessment and intervention in the event of “Possible Victims of Abuse or Neglect.”

Policy
South Cove Community Health Center is committed to responding to patients who may have been abused or neglected through routine screening, assessment, safety planning, and coordination of resources.

Definitions

Massachusetts General Law, Chapter 111, Section 72 F-L: Residents of Nursing Homes

Abuse: “physical contact which harms or is likely to harm the person”

Mistreatment: “the use of medications, isolation or the use of physical or chemical restraints which harms or is likely to harm the person.”

Neglect: “The failure to provide treatment and services necessary to maintain the health and safety of the person provided no person shall be considered neglected for the sole reason that he relies on or is being furnished treatment in accordance with the tenets and teachings of a well organized church.”

Massachusetts General Law, Chapter 19A, Section 14-26: Elders Residing in the Community
Abuse is an act or omission which results in serious physical or emotional injury to an elderly person; provided however, no person shall be considered to be abused or neglected for the sole reason that such a person is being furnished or relies upon treatment in accordance with the tenets and teaching of a church or religious denomination by a duly accredited practitioner thereof.”
Elderly are those person 60 years of age and older (according to the current reporting laws)
Effective July 1, 2004, MGL 19-A Section 14 was amended to expand the statutory definition of elder abuse to include self-neglect. Self-neglecting elders are person age 60 and older who have unmet essential needs for food, clothing, safe and secure shelter, personal care, supervision and medical care that result in serious harm, or in the immediate risk of serious harm, and the inability of the elder to remain safely in the community.

All clinical care providers are mandated reporters of elder abuse and neglect.

Identification: High Risk Signs and Symptoms
Elder abuse should be considered when an individual presents with a constellation of symptoms, which raise a practitioner’s concern. One symptom alone could raise a red flag but should be considered in context.

Physical Abuse/Neglect
- Unexplained bruises, welts, repeated falls
- Lab values inconsistent with history
- Physical impairment inconsistent with history
- Indication of medication overdose or withholding medications
- Gross deterioration of physical status without medical attention
- Evidence of alcoholism or drug abuse in care provider or patient
- Malicious removal of adaptive aids

Emotional/psychological abuse
- Listless, withdrawn
- Evidence of fear of family member or care provider
- Subjective statement regarding mistreatment
- Complaints of pain without evidence of injury or pathology

Sexual Abuse
- Forced sex of any kind
- Inappropriate/unwanted physical touching by care provider

Economic Abuse
- Subjective statement regarding theft of property by care provider
- Violation of patient's (i.e., forced removal from home)
- Depleted bank account with no apparent reason
- Elder unaware of monthly income/finances
- Property transfers against elder's will or without elder's knowledge
- Basic needs of elder not being met by person responsible for finances

Assessment Process
If elderly abuse/neglect is suspected:
Consult your supervisor.

If you and your supervisor determine further investigation is needed:

- Attempt to create a safe environment to conduct a private interview with patient. Additional family members/companion will also be interview, depending on presentation and age of patient.
- Review medical history (or record)
- Perform physical exam
- Discuss observations and concerns with patient, as appropriate
- Discuss concerns and need to report abuse with primary care provider
- It is recommended that the decision to report should be made in consultation with the Patient Safety Committee

Reporting Requirements
If a care provider has reason to suspect abuse or neglect, she/he shall inform the supervisor and implement the following process:

A verbal report must be made immediately by phone or online. A written must be within 48 hours after the verbal report has been made.

If the elder is a NURISNG HOME RESIDENT, call the Massachusetts Department of Public Health Division of Health Care Quality at 617-753-8000. A follow up letter to Department of Public Health Division of Health Care Quality is recommended.

If the elder is a PRIVATE RESIDENCE, call the Massachusetts Department of Elder Affairs at 1-800-922-2275. A written report must also be filed within 48 hours (see form attached). More resources are available at its website: www.mass.gov/elders

For more information about the elder abuse mandated reporting requirements, contact the local Elder Protective services Agency, www.800ageinfo.com or call 1-800-AGE-INFO.

Once a report has been made email it to the CEO.

Safety during Health Care Visit
All providers should do the following:
- Take steps to provide for the patient's safety while in South Cove Community Health Center.
- Assess the patient for potential harm to self or others. Evaluate the need for one-on-one observation and/or referral to a mental health provider.

Referral, Counseling, and Discharge Planning
All providers should do the following:

- Let the patient know that no one deserves to be hurt or threatened. Discuss the violence in an open and non-blaming way, supporting the steps the patient has taken toward safety and considering new options.
- Take steps to develop a safety plan for the patient. Depending upon the situation and setting, the development of this plan MAY include input from consultants, colleagues, the patient and family members.
- Safety planning for the elderly may include:
- Reconsideration of whether the elder should return to residence or nursing home
- Overnight stay in a hospital for further assessment.

Documentation
Following submission of the written report, the mandated reporter and his/her supervisor shall enter a note in the patient's medical record indicating the action(s) taken, the reason(s) the action(s) was (were) taken, and the date the form was completed.

The note MAY include:
- A direct quote of the patient's account of how the incident occurred.
- A brief summary of incident, time and date. Do not name the perpetrator
- Detail the provider's observation of the patient's overall presentation and emotional state.
- Describe treatments/interventions, reports made, disposition, and follow-up care.

1.17 Disabled Persons Protection Policy

Purpose
To provide clear guidelines for patient assessment and intervention in the event of “Possible Victims of Abuse or Neglect.”

Policy
South Cove Community Health Center is committed to responding to patients who may have been abused or neglected through routine screening, assessment, safety planning, and coordination of resources.

Guideline(s) for Implementation:

Definitions

The Disabled Persons Protection Commission (DPPC) was established by Massachusetts General Law, Chapter 19C, to protect disabled adults between the ages of 18 to 59 years from abuse.

Abuse is “an act or omission which results in serious physical or emotional injury to a disabled Massachusetts General Law, Chapter 119A, Section 14-26: Elders Residing in the Community

Disabled Person is “a person between the ages of 18 to 59, inclusive, who is mentally retarded, as defined by Section 1 of Chapter 123, or who is otherwise mentally or physically disabled and as result of such mental or physical disability is wholly or partially dependent on others to meet his daily needs.” (Massachusetts General Law, chapter 19C)

All clinical care providers are mandated reporters of disabled person abuse and neglect.

Identification: High Risk Signs and Symptoms

Abuse or neglect of disabled persons should be considered when an individual presents with a constellation of symptoms, which raise the practitioner’s concern. On symptom alone could raise a red flag but should be considered in context.

Physical Abuse/Neglect
- Unexplained bruises, welts, repeated falls
- Lab values inconsistent with history
- Physical impairment inconsistent with history
- Indication of medication overdose or withholding medications
- Gross deterioration of physical status without medical attention
- Evidence of alcoholism or drug abuse in care provider or patient
- Malicious removal of adaptive aids

Emotional/psychological abuse
- Listless, withdrawn
- Evidence of fear of family member or care provider
- Subjective statement regarding mistreatment

Sexual abuse
- Forced sex of any kind
- Inappropriate/unwanted physical touching by care provider

Economic Abuse
- Subjective statement regarding theft of property by care provider
- Violation of patient’s (i.e., forced removal from home)
- Depleted bank account with no apparent reason
- Elder unaware of monthly income/finances

- Property transfers against elder's will or without elder's knowledge
- Basic needs of elder not being met by person responsible for finances

Assessment Process
If disabled person abuse is suspected:
Consult your supervisor.

If you and your supervisor determine further investigation is needed:

Attempt to create a safe environment to conduct a private interview with patient. Additional family members/companion will also be interviewed, depending on presentation and age of patient.

- Review medical history (or record)
- Perform physical exam
- Discuss observations and concerns with patient, as appropriate
- Discuss concerns and need to report abuse with primary care provider

Reporting Requirements
If a care provider has reason to suspect abuse or neglect, she/he shall: 1) inform the supervisor; 2) request assistance from the Department Head.

A verbal report must be made immediately by phone or online. A written must be within 48 hours after the verbal report has been made.

If the disabled person is a NURSING HOME RESIDENT, call the Massachusetts Department of Public Health at 1-800-462-5540. A follow up letter to Department of Public Health is recommended.

If the disabled person lives in a any setting besides a nursing home, call the Disabled Persons Protection Hot Line at 1-800-426-9009.

After a telephone report is made, the reporter must submit a written summary of the suspected abuse/neglect incident to the Disabled Persons Protection Program, 300 Granite Street, Suite 404, Braintree, MA 02184 within 48 hours. Written report must also be filed within 48 hours of the oral report. (See form attached). More information can be obtained on the website: www.mass.gov/dppc

Once a report has been made email it to the CEO.

Safety during Health Care Visit
All providers should do the following:

- Take steps to provide for the patient's safety while in South Cove Community Health Center.
- Assess the patient for potential harm to self or others. Evaluate the need for one-on-one observation and/or referral to a mental health provider

Referral, Counseling, and Discharge Planning
All providers should do the following:

- Let the patient know that no one deserves to be hurt or threatened. Discuss the violence in an open and non-blaming way, supporting the steps the patient has taken toward safety and considering new options.
- Take steps to develop a safe plan for the patient. Depending upon the situation and setting, the development of this plan MAY include input from consultants, colleagues, the patient and family members.

Safety planning for the elder may include:
- Reconsideration of whether the elder should return to residence or nursing home
- Overnight stay in a hospital for further assessment.

Documentation
Following submission of the written report, the mandated reporter and her/his supervisor shall enter a note in the patient's medical record indicating the action(s) taken, the reason(s) the action(s) was (were) taken, and the date the form was completed. (A copy of the form is NOT placed in the patient's record.)

The note MAY included:

- A direct quote of the patient's account of how the incident occurred.
- A brief summary of incident, time and date. Do not name the perpetrator
- Detail the provider's observation of the patient's overall presentation and emotional state.
- Describe treatments/interventions, reports made, disposition, and follow-up care.

1.18 Possible Victims of Child Abuse and Neglect

Purpose
To provide clear guidelines for patient assessment and intervention in the event of "Possible Victims of Abuse or Neglect."

Policy
South Cove Community Health Center is committed to responding to patients who may have been abused or neglected through routine screening, assessment, safety planning, and coordination of resources.

Definitions (Massachusetts Department of Social Services, Child Abuse and Neglect Information, 1997). *Now renamed as Department of Children and Families*

Child: A person who has not reached his/her eighteenth (18) birthday but does not include unborn children.

Physical Abuse: The non-accidental commission of any act by a caretaker upon a child under age eighteen (18) which causes, or creates a substantial risk of, physical or emotional injury, or constitutes a sexual offense under the laws of the Commonwealth, or any sexual contact behavior between a caretaker and a child under the care of that individual. This definition is not dependent upon location (i.e., abuse can occur while the child is in and out-of-home setting).

Neglect: The failure of a caretaker, whether deliberately or through negligence or inability to take those actions necessary to provide a child with minimally adequate food, clothing, shelter, medical care, supervision, emotional stability and growth or other essential care; provided, however, that such inability is not due solely to inadequate economic resources or solely to the existence of a handicapping condition.

Sexual Abuse: Includes sexual intercourse, sexual exploitation and sexual molestation of a child.

Serious Physical Injury: Includes, but is not limited to a fracture of any bone, severe burn, impairment of any organ or any other serious injury; malnutrition; physical dependence of a child upon an addictive drug at birth and failure to thrive.

Serious Emotional Injury: An impairment to or disorder of the intellectual or psychological capacity of a child as evidenced by observable and substantial reduction in the child's ability to function within a normal range of performance and behavior (i.e. severe anxiety, depression, or withdrawal).

All clinical care providers are mandated reporters of child abuse and neglect.

Identification: High Risk Signs and Symptoms

Child abuse should be considered when an individual presents with a constellation of symptoms, which raise a practitioner's concern. One symptom alone could raise a red flag but should be considered in context.

Physical and Behavioral Signs of Physical Abuse

- Unexplained injuries
- Facial bruises, especially on infants
- Bruising on torso, back, buttocks, and thighs
- Unusual patterns that might reflect the patter of an instrument used (i.e., belt, wire hanger)
- Tears in gum tissue (possible force feeding)
- Burns insufficiently explained
- Cigarette
- Immersion burns indicating dunking in hot liquid
- Rope or restraint burns
- Hair loss, bald spots
- Absence of hair and/or hemorrhaging beneath the scalp due to vigorous hair pulling
- Self-destructive Behavior
- Uncomfortable with physical contact or is wary of physical contact with adults

- Demonstrated extremes in behavior – extreme aggressiveness or extreme withdrawal

Physical and Behavioral Signs of Neglect
- Abandonment for long periods of time
- Lack of supervision
- Lack of adequate clothing and hygiene
- Lack of medical and dental care
- Chronic absenteeism from school

Physical and Behavioral Signs of Emotional Abuse
- Speech disorders
- Delayed physical development
- Substance Abuse
- Ulcers, asthma, severe allergies
- Conduct disorders
- Attempted Suicide

Physical and Behavioral Signs of Sexual Abuse
- Pain or injury in genital area
- Difficulty walking or sitting
- Pregnancy
- Withdrawal, depression
- Suicide attempts

Assessment Process
If child abuse/neglect is suspected:
Consult your supervisor.

If you and your supervisor determine further investigation is needed:

- Interview parent/caretaker and child (if age appropriate). The interview can be conducted by the provider who first observed this possible abuse/neglect or by another qualified provider.
- Interview should attempt to determine nature, extent, circumstances surrounding suspected abuse/neglect; the identity of the persons responsible; the name, age of other children in the household; and assessment of the parent/caretaker and the home environment and all other pertinent facts.
- Obtain psychosocial history
- Discuss observation and concerns with parent, if appropriate.
- Discuss concerns and need to report abuse with the primary care provider who many inform/consult other appropriate care provider(s) and determine the need to file a report.

Reporting Requirements
Mandated reporters needs to make an verbal report immediately to DCF, A written report needs to be faxed to DCF within 48 hours.

Whenever possible and when consistent with the safety of the child, the parents/caretakers should be notified of the plan to file a 51-A.

Telephone the 51-A report to the intake unit at the Massachusetts Department of Children and Families (DCF) office serving the child's hometown. To locate the appropriate local DCF office, the information can be found online at: www.mass.gov/dcf or contact Central Office at 617-748-2000 during normal business hours. After hours, weekends, or holidays, contact the Child-At-Risk Hotline at (800) 792-5200.

The reporter should be prepared to describe the situation of suspected abuse or neglect to DCF. Be prepared to give identifying information about the family as well as specific facts about the suspected abuse or neglect. The mandated reporter must also give his/her name, address and telephone number.

Obtain the name of the DCF social worker who takes the verbal report as well as the fax number and time of day you faxed the report. The verbal report must be completed immediately.

Complete the 51-A report within 48 hours of the verbal report. Copies are available in the office of the Site Administrator or online at www.mass.gov/dcf

Submit the written report with a brief cover letter to the appropriate DCF office. The provider preparing the report should retain a copy and email report to the CEO. DO NOT place a copy of the report in the patient's medical record. Once the report is emailed to the CEO, any other physical copy of the report should be shredded.

Safety during Health Care Visit

All providers should do the following:

Take steps to provide for the patient's safety while in South Cove Community Health Center.

Assess the patient for potential harm to self or others. Evaluate the need for one-on-one observation and/or referral to a mental health provider.

Referral, Counseling, and Discharge Planning

All providers should do the following:

- Take steps to develop a safety plan for the patient. Depending upon the situation and setting, the development of this plan MAY include input from consultants, colleagues, the patient and family members.

- Understand that the filing of a 51-A report does not insure the immediate safety of a child. Therefore, if a child is on the premises of South Cove and is deemed to be at risk if released to his/her usual caretaker, the 51A oral report should be made immediately, and the child should be kept at South Cove pending an action plan from DCF. If the child's caretakers resist the efforts to keep the child at South Cove, it is possible to obtain, by telephone, a verbal temporary restraining order. South Cove's Executive Director, or a member of the Executive Team in the absence of the Executive Director, legal counsel and police should be notified in these situations.

Documentation

Following submission of the written report, the mandated reporter and his/her supervisor shall enter a note in the patient's medical record indicating the action(s) taken, the reason(s) the action(s) was (were) taken, and the date the form was completed.

The note MAY include:

- A direct quote of the patient's account of how the incident occurred.
- A brief summary of incident, time and date. Do not name the perpetrator
- Detail the provider's observation of the patient's overall presentation and emotional state.
- Describe treatments/interventions, reports made, disposition, and follow-up care.

1.19 Possible Victims of Domestic Violence

Purpose
To provide clear guidelines for patient assessment and intervention in the event of "Possible Victims of Abuse or Neglect."

Policy
South Cove Community Health Center is committed to responding to patients who may have been abused or neglected through routine screening, assessment, safety planning, and coordination of resources.

Guidelines for Implementation:

Definitions
Abuse: "The occurrence of one or more of the following acts between family or household members: a) attempting to cause or causing physical harm; b) placing another in fear of imminent serious physical harm; c) causing another to engage involuntarily in sexual relations by force, threat or duress." (Massachusetts General Law, Chapter 209A: Abuse Prevention)

Family of household members: "Person who a) are or were married to one another; b) are or were residing together in the same household; c) are or were related by blood or marriage; d) having a child in common regardless of whether they have ever married or lived tougher; or e) are or have been in a substantive dating or engagement relationship." (Massachusetts General Law, Chapter 209A: Abuse Prevention)

Domestic Violence: "A pattern of coercive control that can take four forms: physical, emotional, sexual and economic. Family violence is created by an inequality of power within a relationship that leads to an abuse or power. Each abusive act builds on the others, and each new act of coercion brings to the victim's mind the fear, violence, and coercion of all past acts." (Straus, M.B. (ED) Abuse and Victimization Across the life Span. Baltimore: Johns Hopkins University Press, 1988, P.240-41.)

Family violence can occur in any family, regardless of race, age, socioeconomic status, or sexual orientation.

There is no mandated reporting of domestic violence in Massachusetts, unless the victim is 60 years of age or older, under 18 years of age, or is disable. (Please refer to other appropriate policies in this policy handbook.)

Identification: High Risk Signs and Symptoms

Domestic violence should be considered when an individual presents with a constellation of symptoms, which raise a practitioner's concern. One symptom alone could raise a red flag but should be considered in context.

Physical Abuse/Neglect
- Evidence of injury, esp. to the face, torso, breasts, or genitals
- Signs of choking
- Bilateral or multiple injuries
- Multiple injuries in various states of healing
- Delay between onset of injury and arrival for health care
- Explanation which is inconsistent with injury
- Prior or repeat visits to emergency services

Emotional/psychological abuse
- Complaints of pain without evidence of injury or pathology
- Vague or non-specific complaints
- Fear of companion or others
- Suicidal ideation or attempts
- Accompanied by an overly attentive or aggressive individual

Sexual Abuse

- Evidence of rape or other sexual assault

Economic Abuse

- Misuse of family funds
- Inability to pay for food, clothing, transportation
- Harassment at work
- Keeping patient from getting to work

Assessment Process
If domestic violence is suspected:
Consult your supervisor.

If you and your supervisor determine further investigation is needed:

- Attempt to create a safe environment to conduct a private interview with patient. Additional family members/companion will also be interviewed, depending on presentation and age of patient.
- Review medical history (or record)
- Perform physical exam
- Discuss observations and concerns with patient. Determine whether victim is protected under any mandated reporting statute, i.e., child (17 years or younger), disabled (dependent on another for daily care needs), Elder (age 60 or older).

Safety during Health Care Visit
You and/or your supervisor should do the following:

- Take steps to provide for the patient's safety while in South Cove Community Health Center.
- Assess the patient for potential harm to self or others. Evaluate the need for one-on-one observation and/or referral to a mental health provider.

Referral, Counseling, and Discharge Planning
You and/or your supervisor should do the following:

- Let the patient know that no one deserves to be hurt or threatened. Discuss the violence in an open and non-blaming way, supporting the steps the patient has taken toward safety and considering new options.
- Take steps to develop a safety plan for the patient. Depending upon the situation and setting, the development of this plan MAY include input from consultants, colleagues, the patient and family members.
- Discuss resources with the patient, including police, legal interventions, shelter, and support groups:
- Restraining Order (209A): the decision to secure a restraining order rests solely with the patient. Notify the chairperson of Risk/Safety/Operations Committee or an appropriate person designated by the Chairperson of any patient who has a current restraining order or wishes to obtain one. If a patient has one, request a copy for the chart. Restraining orders are available 24 hours a day for any person who is being physically or sexually abused or threatened by a person (see definition.) Weekdays, patients should go to area District or Probate court to obtain an order, nights and weekends, go to are police department.
- Shelters for battered women are accessible 24 hours/day, via 1-800-992-2600. Patient will need to call to talk with shelter staff directly. Non-English speaking patients may want to call the Asian Task Force Against Domestic Violence (A-TASK) at 617-338-2355. A-TASK will perform on the spot intake, provide advice on whether or not to report domestic violence and will provide shelter placement. In addition to housing battered women, shelters offer support groups, crisis phone lines, and court advocacy.
- Safe Transitions: Domestic Violence Intervention Program offers battered patients services, including support groups, individual counseling, safety planning, and advocacy. Ask the patient for a safe number where follow-up phone call may be made.
- In families with children, their safety must be paramount. Domestic violence does not require the automatic filing of a 51A. Each situation needs to be assessed for abuse or neglect to the children. Assess the patient's judgment and ability to protect the children. IF there are concerns about child abuse or neglect, the filing of a

51A should be considered and discussed with the patient. If filing, be clear with the Department of Social Services that this is domestic violence case. (See Child Protection Policy.)

- The goal in working with the patient is safety, providing options and opportunity to talk. Whether the patient chooses to leave the relationship immediately or not, she/he wishes to be safe. Consider concrete steps toward safety. Discuss the patient's contact with and availability of supportive friends or family (how isolated is the patient?) Explore patient's access to funds and transportation in case of emergency (does she/he have some available money?) Discuss how to contact critical people in an emergency; talk about where the patient might go. (Contact South Cove's Behavioral Health Department, extension 6730, for additional resources and suggestions.)

Documentation
The clinician and/or her/his supervisor shall enter a note in the patient's medical record indicating the action(s) taken, the reason(s) the action(s) was (were) taken.

The note MAY include:

- A direct quote of the patient's account of how the incident occurred.
- A brief summary of incident, time and date. Do not name the perpetrator.
- Detail the provider's observation of the patient's overall presentation and emotional state.
- Describe treatments/interventions, reports made, disposition, and follow-up care.

Evidence Gathering

- If domestic violence is suspected, the clinician shall offer to photograph the patient's injuries. If the victim consents to be photographed.
- The patient shall be requested to sign the standard consent to photograph, which must be witnessed and placed in the patient's medical record.
- Photograph(s) shall be taken by South Cove medical personnel using a camera and observing the following guidelines:
- Each photograph shall include an identifying feature of the patient, e.g., the patient's face, or a document which includes the name of the patient.
- The date along with the signatures of the patient, photographer, and a witness shall be recorded on the back of each photograph.
- Photograph(s) shall be placed in an envelope which is sealed and placed in the medical record along with a written statement to the effect that the photograph(s) are confidential and to be used only by the patient for litigation purposes.

Reporting to Patient Safety Committee
If domestic violence is suspected and an investigation has been performed (history taking, physical examination, contacting A-TASK, etc.), the investigation should be documented in the medical record and a copy sent to the CEO for record keeping, evaluation of the investigation procedures and follow-up with the victim if necessary.

1.20 Play Area and Toy Cleaning

Purpose
The purpose of this policy is to establish guidelines for the proper selection, cleaning and maintenance of play areas and toys used in waiting areas and during examination and treatment. This Policy applies to all general areas of the health center including the Brighton Allston Afterschool and Enrichment Program.

Policy
Toys most suitable for play areas should be easily cleaned and disinfected. Toys such as board books and crayons should be avoided. The health center will not have stuffed toys in play areas or exam rooms.
Toys should be hard plastic only.
Infants and toddlers should not share toys. Toys that have been in children's mouths should be removed and placed in a bin reserved for soiled toys. The assigned staff will disinfect the toys according to the following procedure:

- Scrub the toy in warm soapy water
- Use a brush to scrub crevices
- Rinse the toy in clean water
- Immerse the toy in a mild bleach solution of 1/8 teaspoon bleach and 1 quart warm water and allow to soak in the solution for 10 to 20 minutes
- Remove the toy from the bleach solution and rinse well with cool water
- Air dry

Toys that are appropriately cleaned will be returned to the play area the following clinic day.
Specific cleaning procedures for individual department are attached. The BASE program is licensed by EEC and therefore adheres to all EEC rules and regulations.

Cleaning Policy for WIC playing area and toys
Cleaning policy for the playing area

- Mop area of floor immediately after any accidental soiling of floor using cleaning solution (1 part bleach 10 parts warm water).
- Wash toys three times a week with cleaning solution (1/4 teaspoon of bleach to 2 quarts of water). Clean toy(s) immediately when contaminated with body fluid.
- Wipe the children's table and the two chairs first thing in the morning with cleaning solution (1/4 teaspoon of bleach to 1 quart of water).

Cleaning policy for toys
Toys most suitable for play areas should be easily cleaned and disinfected. Toys such as board books and crayons should be avoided. The health center will not have stuffed toys in the playroom. Toys should be hard plastic only.
Infants and toddlers should not share toys. Toys that have been in children's mouths should be removed and placed in a bin reserved for soiled toys. The WIC staff will disinfect the toys according to the following procedures:

- Use a brush to scrub crevices
- Wash in cleaning solution described in no. 2 above.
- Rinse the toy in clean water
- Air dry

Toys that are appropriately cleaned will be returned to the play area the following clinic day.

Cleaning Policy for Early Intervention playroom and toys
Cleaning policy for the playroom

- Wash floor twice a week using Pine-Sol® with salt and clean water per manufacturer's directions (more often when necessary such as on snow days).
- Mop area of floor immediately after any accidental soiling (vomit, urine, etc) of floor using cleaning solution #4 (1 part bleach to 10 parts warm water).
- Wash toys three times a week with cleaning solution (1/4 teaspoon of bleach to 2 quarts of water) and rinse in clean water afterwards. Clean toy(s) immediately when contaminated with body fluid.

- Wipe tables first thing in the morning and before snack with cleaning solution (1/4 teaspoon of bleach to 1 quart of water).
- Wipe table mats everyday with cleaning solution described in no. 3 above.
- Wash bowls and spoons in kitchen with dish detergent after every use.

Cleaning policy for toys

Toys most suitable for play areas should be easily cleaned and disinfected. Toys such as board books and crayons should be avoided. The health center will not have stuffed toys in the playroom. Toys should be hard plastic only. Infants and toddlers should not share toys. Toys that have been in children's mouths should be removed and placed in a bin reserved for soiled toys. The EI staff will disinfect the toys according to the following procedures:

- Use a brush to scrub crevices
- Wash in cleaning solution described above in no. 3.
- Rinse the toy in clean water
- Air dry

Toys that are appropriately cleaned will be returned to the play area the following clinic day.

Toy Cleaning for Behavioral Health Department

Toys most suitable for play areas should be easily cleaned and disinfected. **The health center will not have stuffed toys in play areas or exam rooms.**

Toys should be hard plastic only.

Toys that have been used or in children's mouths should be removed and placed in a bin reserved for soiled toys. The BH staff will disinfect the toys according to the following procedure:

- Scrub the toy in warm soapy water
- Use a brush to scrub crevices
- Rinse the toy in clean water
- Immerse the toy in a mild bleach solution of 1/8 teaspoon bleach and 1 quart warm water and allow to soak in the solution for 10 to 20 minutes
- Remove the toy from the bleach solution and rinse well with cool water
- Air dry

Toys that are appropriately cleaned will be returned to the play area the following clinic day.

1.21 Patient Inquiries to Clinical Department Staff

Purpose
To clarify the procedure to best address inquiries from patients about their health care.

Policy
All requests by patients for test results or their medical information will be referred to a member of the nursing staff. If the caller is a registered SCCHC patient, the patient chart should be available to the nurse at the time of the call.
If the chart and/or nursing staff is not immediately available, staff should take a message and telephone number from the patient and inform him/her that we will call back with the requested information as soon as possible.
Nursing staff will review the data with the appropriate provider and either the provider or nursing staff (under the direction of the provider) will provide the information to the caller.
Patients who request to speak directly to the provider should be referred initially to the nursing staff if it is a non-urgent call; the provider will call back. If it is an urgent call, the call will be referred directly to a provider.
If a patient's own provider is not available for the inquiry:
Offer to give the inquiry to another provider or provider on call.
Offer to take a message and whether a return call is requested
Tell the patient when the provider will be in the clinic again
Staff are never to just state that the provider is unavailable. Always state when the provider will be available and ask if the caller would like to leave a message and contact number.

1.22 Patient Complaints and Grievances

Purpose
The purpose of this policy is to provide guidelines for all staff handling patient complaints and grievances.

Definitions

Complaint is defined as a verbal expression of dissatisfaction by the patient/ family regarding care or services provided by the health center which can be resolved at the point at which it occurs by the staff present. Most complaints will have simple solutions that can be promptly addressed and are considered resolved when the patient/family is satisfied with the action taken on their behalf.

Grievance is defined as a formal verbal or written expression of dissatisfaction with some aspect of care or service that has not been resolved to the patient/family's satisfaction at the point of service. All verbal or written complaints of abuse, neglect, patient harm or the risk of patient harm, a violation of the Patient Rights and Responsibilities are examples of grievances. A verbal or written complaint sent to the Health Care Quality and Risk Management department or any request from a family to treat a complaint like a grievance will be considered grievance.

Policy
Complaints
All employees at South Cove Community Health Center are responsible for allowing patients to express their complaints in a non-threatening and caring environment. Employees are expected to act as advocates for all patients. All complaints are considered serious and are investigated promptly and followed up in order to resolve the issue appropriately.

Employees discussing an issue with a patient are expected to assist the patient in completing a patient complaint form if needed. If the patient does not wish to complete the form while at the center, a form will be provided to the patient and may be returned to the center at a later date.

Complaint forms are forwarded to the Medical Director and COO for follow up within 24 hours of receipt.

Fact gathering related to the complaint will be conducted and may include interviewing of the complainants as well as other parties with knowledge of the complaint.

A file will be kept which includes the following:
1. The original complaint report
2. Progress reports related to the investigation of the complaint
3. Information of the outcome of the investigation including any actions taken.

Upon completion of the investigation, the complainant will be notified of the outcome by the designated investigator of the complaint.

Greivances
The COO will be responsible for receiving, processing and channeling any grievances that are made by patients or prospective patients of South Cove Community Health Center.

A notice (attached) describing the grievance procedure will be posted at each site. The notice will:
1. Identify the name of the South Cove Community Health Center contact person.
2. Indicate where the office is located.
3. Provide assurance that grievance will be handled confidentially.
4. Indicate how appeals may be lodged.

Documentation of Grievances
1. The South Cove Community Health Center will keep a record of all grievances and resolutions using a grievance form.

2. Grievances that need additional procedures and/or back up will be reviewed by the Quality Assurance/Quality Improvement Committee for recommendation and, as appropriate, with the Board of Directors.
3. Any reports of serious complaints must be submitted by staff to the COO within 24 hours of the complaints. When and if the COO is not available, the Director of Clinical Operations will assume the duties outlined above.
4. During and leading to the resolution of any grievance received, there will be progress reports documented and maintained including interim information from any staff and/or other persons involved. These reports will be documented throughout the investigation. The outcome of the grievance will be duly documented.
5. The complainant will be notified in writing that the complaint has been received and what the expected time frame for processing will be. The complainant will be informed in writing of the grievance resolution.
6. If the complainant is not satisfied with the outcome, an appeal may be lodged with the Board of Directors.

South Cove Community Health Center

Patient Grievance Notice

Any grievance/complaints can be put in writing to the Chief Operations Officer (COO) of the health center whose office is located at:

South Cove Community Health Center
Att: COO
145 South Street
Boston MA 02111

All grievance/complaints will be handled with confidentiality.

1.23 Sentinel Event

Purpose

The purpose of this policy is to assure a consistent and timely analysis and reporting of any Sentinel Event at South Cove Community Health Center.

Policy

A sentinel event is defined as any unexpected occurrence involving death or serious physical or psychological injury or risk thereof. Such events are called sentinel because they signal an intensive and immediate investigation and response. All health center employees are expected to respond in an appropriate manner when such an event is identified. This response would include:

- A thorough root cause.
- Implementation of improvements to reduce the risk
- Monitoring of the effectiveness of any improvements.

All sentinel events should be reported immediately to the Department Head for investigation and resolution. A copy of the event documentation should be forwarded to the Executive Assistant in the office of the Executive Director for follow-up as appropriate and filing.

Based on the scope of care provided at South Cove the following events would signal intensive review:

- An event that has resulted in an unanticipated death or major permanent loss of function not related to the natural course of the patient's illness or underlying condition
- Rape
- Infant/child abduction
- Suicide or attempted suicide in the setting
- Fire
- Pending or actual strike action by employees
- Serious criminal acts such as assault resulting in patient death or major permanent loss of function
- Serious physical injury to a patient resulting from an accident or unknown cause
- Patient fall resulting in death or permanent loss of function related to injuries sustained in the fall.

<u>Process for Investigation:</u>

The following are specific steps to be taken upon notification of a sentinel event.

- Notify the patient's family
- Sequester the medical record and equipment
- Develop a list of providers involved
- Analyze medical record documentation
- Develop a root cause analysis of the event
- Notification of legal department
- Clinical assessment presentation to the Medical Director

Notification of all other events will be made to the Department of Public Health and other agencies as appropriate, within one week, by the Medical Director or Executive Director.

1.24 High Risk Patients

Purpose
To define who “high risk” patients are and develop a list of such, who may require additional care and follow-up.

Policy
South Cove defines high risk patients as those who have a complex condition or catastrophic illness or injury that require extensive medical intervention or long term treatment plan.

A working list of patients that South Cove considers high risk:
Depression relapse and/or any mental illness relapse
Frail elders
HIV/AIDS
Heart attack/heart disease
Stroke
Obesity
Chronic pain
Chronic obstructive pulmonary disease
History of alcohol abuse
Congestive heart failure
Coronary artery disease
Disabled patients (blindness, loss of limb, paralysis)
Co-morbid medical conditions
Hypertension
Renal failure
Diabetes, type 1 and type 2
Tuberculosis
Hepatitis B
Patients receiving ER/LA opiods for pain management
Patients receiving anticoagulant therapy
Any chronic conditions

1.25 Hospitalization Tracking

Purpose
To ensure that patients requiring hospitalization receive timely follow up to review discharge instructions and medications.

Policy
1. Medical Records role:
   a. Hospital admission and discharge paperwork/fax received should be uploaded urgently into eCW and assigned to provider for review and flagged as “high priority.”

2. Clinical Staff role:
   a. Telephone call notification of hospital admission or discharge should be transferred directly to provider or nurse if urgent attention requested,
   OR
   b. Documented in telephone encounter and assigned to provider

3. Provider role:
   a. Review discharge summary
   b. Update past medical history/hospitalizations in eCW with hospitalization dates and discharge diagnosis
   c. Reconcile discharge medication list
   d. Verify if follow up appt scheduled. If no appointment found, should request clinical staff to contact patient to schedule follow up appointment

1.26 Diagnostic Imaging Tracking

Purpose

To ensure that patients requiring diagnostic imaging receive timely action and follow up (for ultrasound, x-ray, CT, MRI. Mammography tracking done separately by Mammography).

Policy

1. Provider role:
    a. Generate diagnostic imaging request via
        i. Electronic referral
        OR
        ii. eCW diagnostic imaging request
    b. Flag all diagnostic imaging referrals or requests as critical, by clicking on priority status: "Urgent"

*** if Diagnostic Imaging is ordered via electronic referral, see Referral Tracking Policy for referral staff and care coordinator roles**

*** For imaging ordered as Diagnostic Imaging request, continue below***

2. Referral Staff role:
1. Create an dummy electronic referral to track all DI imaging requests received
    i. change status of DI imaging order to "received"--for tracking purposes
    ii. **change the DI imaging order "Referred to" field to the "Scheduled, DI"** (otherwise, empty result will be sent back to provider)

2. Follow Referral Tracking Protocol

3. Medical Records role:
1. Scan imaging results into eCW ASAP (within 2 days of receipt of report)

4. Care coordinator role:
    a. Review outstanding imaging orders for **diagnostic imaging orders** (no appt made). (Jelly bean L-->imaging, search by providers, assigned to "all")
    a. check if referral generated for the DI order (other than xray)
        i. if yes, change status to "received" and assign to "Scheduled, DI" (this catches orders missed in step 2.a)
        ii. if no, continue to next step
    b. if imaging report has been received, change status to "reviewed"
    c. if report not received,
        i. check hospital records online
        ii. call patient if no record of exam done
            1. help reschedule appt if necessary
                a. change status to "received"
                b. create dummy referral to radiology: see below
            2. notify provider regarding actions taken via telephone encounter
            3. **If patient refuses imaging order, notify provider via telephone encounter**
                a. **provider will reply whether certified letter needs to be sent**
2. Creating an electronic referral to track Xray orders
    a. Copy name of imaging order to "Reason" for referral

b. Set order date as date of appt
c. Indicate facility if known, otherwise only need to specify “Radiology” as specialty
d. Set priority status as “Urgent”
e. Follow Referral Tracking Protocol
    1. Assist patients in obtaining any xrays ordered not yet obtained

1.27 Referral Tracking

Purpose
To ensure that referrals made for patients receive timey action and follow up.

Policy
1. Provider role:
    i. Generate electronic referrals for **ALL** referral requests
    ii. **Flag critical referrals to track by clicking on priority status: "Urgent"**

2. Referral Staff role:
    i. If provider has submitted paper referral, convert to electronic referral
        i. Submit original paper referral to medical records to scan
    ii. Indicate appointment date when scheduled in eCW
    iii. Change referral status to "Pending" when appointment made
    iv. If specialist office will contact pt to schedule appt, select current day as appt date
    v. Reassign pending referrals assigned to referring provider

3. Medical Records role:
    i. Scan consult reports into eCW ASAP (within 2 days of receipt of report)

4. Care coordinator role:
    i. Daily review list of critical referrals for appointments scheduled for 2 weeks ago
    ii. Check eCW patient docs to see if consult letter back
        i. If report back, change referral status to "Addressed" to close the loop
        ii. If report not back:
            1. obtain, upload (TIF file type), and assign report for provider to review
            2. change referral status to "Addressed"
        iii. If patient no show:
            1. contact pt to schedule follow up
            2. notify provider regarding actions taken via telephone encounter
            3. **If patient refuses referral appointment, notify provider via telephone encounter**
                a. **provider will reply whether certified letter needs to be sent**
        iv. If specialist office was supposed to contact pt to schedule appt:
            1. Contact specialist office to obtain appt date and update referral request with appt date
            2. If no appt date not yet set up, assist specialist office in contacting patient
            3. **If appt date outside range of acceptable if specified by provider**
                a. update referral request with appt date
                b. change referral status to "Open"
                c. note problem and reassign referral back to provider to review

1.28 General Clinical Guidelines/Evidenced Based Guidelines

South Cove Community Health Center follows evidenced based guidelines in all Medical, Dental, and Behavioral Health Clinics. In addition, South Cove clinicians utilize the service “Up-To-Date”, embedded in the EHR, to provide real-time access to evidence based guidelines.

1.29 Palliative Care

Purpose:
The purpose of this policy is to guide the health care team in providing palliative and end of life care.

Definitions:
Appropriate Patient means a patient whose attending health care practitioner has:

I. Diagnosed a terminal illness or condition which can reasonably be expected to cause the patient's death within six months, whether or not treatment is provided, provided that the attending health care practitioner determines that discussion of the palliative care services is not contraindicated; or
II. Determined that discussion of palliative care services is consistent with the patient's clinical and other circumstances and the patient's reasonably known wishes and beliefs.

Attending Health Care Practitioner means a physician or nurse practitioner who has primary responsibility for the care and treatment of the patient within or on behalf of the clinic; provided that if more than one physician or nurse practitioner share that responsibility, each of them shall have a responsibility, unless there is an agreement to assign that responsibility to one such person.

Hospice Care Services means care, including palliative care, provided to terminally ill patients and their family members when the patient is no longer seeking curative or life prolonging treatments. Hospice care services are delivered in the patient's home, long-term care facilities, hospitals or licensed hospice facilities.

Palliative Care means the attempt to prevent or relieve pain and suffering and to enhance the patient's quality of life, and may include, but is not limited to, interdisciplinary end-of-life care and consultation with patients and family members

Policy:
I. Attending Health Care Practitioners at South Cove Community Health Center shall distribute to appropriate patients in its care, directly or through professionally qualified individuals, culturally and linguistically suitable information regarding the availability of palliative care and end-of-life options. This obligation shall be fulfilled by providing the patient with:

A. A Department-issued informational pamphlet; or
B. A culturally and linguistically appropriate pamphlet that includes
i. A definition and explanation of advanced care planning, palliative care services and hospice services; and
ii. All other requirements defined in guidelines of the Department

II. South Cove Community Health Center shall provide it's attending health care practitioners the informational pamphlets for distribution to appropriate patients in a timely manner.

III. South Cove Community Health Center Attending Health Care Practitioners shall identify appropriate patients using clinical judgment, instructional pamphlets and the guidance of professional societies dedicated to palliative care management (see below).

IV. Where the patient lacks capacity to reasonably understand and make informed decisions, all Palliative Care information, and guidance shall be provided to the person with legal authority to make health care decisions for that patient.

V. South Cove Community Health Center shall make available to the Department proof that it is in compliance with 105 CMR 140.1201I. upon request or at the time of inspection.

References:

https://getpalliativecare.org/resources/clinicians/

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Lorenz K, Lynn J, Morton SC, et al. End-of-Life Care and Outcomes: Evidence Report/Technology Assessment No.110. (Prepared by the Southern California Evidence-based Practice Center, under Contract No. 290-02-0003.). AHRQ Publication No. 05-E004-2. Rockville, MD: Agency for Healthcare Research and Quality; December 2004. PMID: 15649108. https://archive.ahrq.gov/clinic/epcsums/eolsum.htm

National Hospice and Palliative Care Organization (NHPCO). NHPCO's Facts and Figures: Hospice Care in America, 2015 Edition. https://www.nhpco.org/sites/default/files/public/Statistics_Research/2015_Facts_Figures.pdf.

2.00 Patient Health Record Policy

Purpose

To establish guidelines for the contents, maintenance, and confidentiality of patient health records that meet the requirements set forth in Federal and State laws and regulations, and to define the portion of an individual's healthcare information, whether in paper or electronic format, that comprises a patient's health record. This policy applies to all SCCHC staff and anyone with access to SCCHC patient records.

2.01 Generating a New Patient Health Record

Purpose
To detail the requirements, process and procedures involved in the opening of a new patient health record.

Policy
1. This policy applies to all South Cove Community Health Center staff.
2. Patients assigned with one health record to be used among all sites.

Generating a Patient Health Record

In order to generate a new health record, the patient must bring in two proofs of address (i.e. telephone bill) and a picture ID (i.e. green card, driver's license, passport etc) to member services. A member services representative will verify with the system if the patient is new to the Health Center. If the patient is a new patient, member services staff will fill out all the necessary registration forms with the patient and enter the data into the Electronic Health Record System, medical records staff will scan all the paper documentation if there are any into EHC system as well. Patient will be assigned with a unique Medical Record number and a patient picture ID will be made for the patient.

1. A paper chart will be created for Dental patient, which only contains any documents related with patient's dental visits.

2. Eventually we will eliminate the creation of new paper charts for new patients when we implement dental EHR.

2.02 Contents of a Patient Health Record

Purpose
To describe the content of a patient health record, and to clarify information that is and should be contained within each section of the patient health record.

Policy
This policy applies to all South Cove Community Health Center staff.

The patient health record is the record that is generated at, or for, South Cove as its business record, is the record that would be disclosed upon request. It contains individually identifiable data, stored on any medium, and collected and directly used in documenting healthcare or health status.

Our patient record is considered to be in a hybrid environment, it consists information in scanned and paper formats and information created in electronic media.

CONTENTS OF PATIENT HEALTH RECORD

Data and documents to Be Considered Part of the Patient Health Record

. Advance directives
. Allergy records
. Alert and reminders
. Analog and digital patient photographs for identification purposes only
. Consent forms for care, treatment and research
. Consultation reports
. Diagnostic images
. E-mail messages containing patient-provider or provider-provider communications regarding care or treatment.
. Graphic records
. History and physical examination records
. Immunization records
. Laboratory reports
. Medication administration records
. Patient education or teaching documents
. Patient identifiers (medical record number/patient account number)
. Photographs (digital and analog)
. Post-it notes and annotations containing patient-provider or provider-provider communications regarding care or treatment.
. Problem Lists
. Progress notes
. Psychology and psychiatric assessment and summaries
. Records received from another healthcare provider if they were relied on to provider healthcare to the patient.
. Referral requests
. Telephone messages containing patient-provider or provider-provider communications regarding care or treatment.
. Telephone note (on-call)

Documents NOT included in the Patient Health Record

The following data and documents should be provided the same level of confidentiality as the legal health record. However, they should not be considered part of the legal health record and would not be produced in response to a subpoena for the medical record.

. Authorization forms for release of information
. Correspondence concerning requests for records
. Financial and insurance forms

. Incident or patient safety reports
. Logs
. Psychotherapy notes

2.03 Authorization to Document in the Patient Health Record "PHR"

Purpose
To identify the individuals who are authorized to document in PHR.

Policy
The following health care staff of SCCHC are authorized to make entries in the PHR:

- Physicians
- Dentists
- Dental Hygienist
- Psychologists
- Mental health clinicians
- Podiatrists
- Optometrists
- Nutritionists
- Nurse practitioners
- Registered and licensed practical nurses
- Behavioral health counselors
- Social workers
- Behavioral health case managers
- Medical assistants
- Dental assistants
- Nursing assistants
- Nutritionist assistants
- Students: medical student/nursing student, with co-signature of either physician or supervising nurse
- Member services staff members responsible for Registration, scheduling appointments/making referrals
- Medical records staff
- Referral staff

Job title abbreviations: the following abbreviations are approved for use for documentation in the EHR:

- MD: Physician
- DMD/DDS: Dentist
- RDH: Dental Hygienist
- LICD: Licensed Psychologist Provider
- MHC: Mental Health Clinician
- POD: Podiatrist
- OD: Optometrist
- NTR: Nutritionist
- CNM: Certified Nurse Midwife
- NP: Nurse Practitioner
- RN: Registered Nurse
- LPN: Licensed Practical Nurse
- BHC: Behavioral Health Counselor
- BHCM: Behavioral Health Case Manager
- LCSW: Licensed Clinical Social Worker
- LICSW: Licensed Independent Clinical Social Worker
- FP: Family Planning staff
- MA: Medical Assistant
- DS: Dental Assistant
- NA: Nurse Assistant
- NS: Nutritionist Assistant
- Mem. Serv.: Member Services staff (front desk/referral/social services)
- Med. Rec.: Medial Records staff

2.04 Unacceptable Abbreviations

Purpose
Standardizing terminology, definitions, vocabulary, and nomenclature facilitates communication of data and information within and among the organization and other organizations. Abbreviations, acronyms and symbols must also be standardized.

The use of a list of approved standardized abbreviations, acronyms, and symbols is to protect patients from the effects of miscommunication.

Policy
Any ambiguous and otherwise dangerous forms of notation should be eliminated from all health care documentation.

These guidelines apply not just to providers' orders but to all handwritten and electronically generated, patient-specific documentation used in the delivery of patient care (all types of orders, progress notes, consultation reports, and operative reports).

All documentation used by SCCHC, including print (pre-printed forms) and electronic (software) used in patient care, must also be in compliance with the National Patient Safety Goals and to Joint Commission standards. SCCHC will check for updates and/or new edition yearly to ensure that the latest guidelines and/or standards are being followed.

2.05 Clinical Documentation – Receiving Critical Test Results

Purpose
To establish the procedures for the use of receiving critical test results in the organization in the administration of patient care. (See also Clinical Laboratory Policy 4.1).

Policy
General Statements:

- Procedures for receiving, transcribing, and authenticating all critical test results, by paper/electronic report, verbally and by phone, are established to protect the quality of patient care, treatment and services.
- The term “critical test results” applies to all diagnostic tests including imaging studies, electrocardiograms, laboratory tests and other diagnostic tests and studies. “Critical test results” include all “stat” and “panic value” reports, and other diagnostic test results that require urgent response.
- Only qualified personnel defined and designated by organization policy, with the approval of the Executive Director and the Medical Director and, as appropriate, in accordance with the Massachusetts state and federal law, are authorized to receive critical test results from authorized individuals.
- Each critical test result received is documented, dated and identifies the names of the individuals who gave and received the result, and the documentation indicates who implemented any action for the patient.

2.06 Clinical Documentation – Use of Telephone or Verbal Orders

Purpose
To establish the procedures for the use of all telephone and verbal orders in the organization in the administration of patient care. (See also Clinical Policy 1.7)

Policy
General Statements:

- Procedures for receiving, transcribing, and authenticating all verbal orders are established to protect the quality of patient care, treatment, and services.
- Only qualified personnel defined and designated by organization policy, with the approval of the Executive Director and the Medical Director and, as appropriate, in accordance with the Massachusetts state and federal law, are authorized to receive and record verbal orders from authorized individuals.
- Each verbal order is dated and identifies the names of the individuals who gave and received it, and the medical record indicates who implemented the order.
- The authorized person receiving the telephone/verbal order from the medical provider should write down the complete order, or enter it into a computer, then “read it back” to receive confirmation from the individual who gave the telephone/verbal order.
- The authorized person receiving the telephone /verbal order will write the words “read back” into the medical record with the documentation of the order received.
- Orders given orally and entered into the patient’s medical record must be signed by the person writing the order in the chart and then signed by the person who gave the telephone/verbal order (for example: prescribed the medication).
- The “read back” requirement applies to all caregivers, including providers and residents and nurses.
- The departmental medical record chart reviews will include a review of the medical orders section to identify the correct use of telephone or verbal orders and to ensure that the procedure is being done consistently.
- In certain situation, such as a Code Blue, it may not be feasible to do a formal “read back” of the verbal order. In such cases, “repeat-back” is acceptable and then when time allows, the order must be written into the medical record by the person who received the order and appropriate signatures applied per standard procedure.

2.07 Timely Completion of Patient Health Record Documentation

Purpose

To assure that entries made in the Patient Health Record are completed in a timely fashion in order to provide continuity of patient care, improve accessibility to the record.

Policy

1. All clinical entries in the PHR should be completed at the time of the patient visit.
2. Providers can either lock the progress notes immediately after completion, in the event that more extensive clinical documentation is needed in the record, such as: follow up to laboratory reports, or completion of referral forms, providers may keep the records open, they must complete and lock the notes within 48 hours of the visit, excluding weekends.

2.08 Storage, Retention, and Recovery of Patient Health Records

Purpose
To describe the process of storing patients' health records, retrieving and reactivating off-site records as well as recovering EHR in case of system disruption.

Policy
No patient records containing original documentation are to be removed from South Cove Community Health Center except for those medical records being transferred to storage areas as specified below.

South Cove Community Health Center shall keep each patient's health record for twenty (20) years after the date for the final treatment of said patient.

Storage Areas
Off-site storage: Iron Mountain Storage Company.

EHR Recovery
Electronic health record recovery is part of IT; for details, please refer to IT HIPAA compliance.

2.09 Clinical Documentation Compliance/Peer Reviews

Purpose
To ensure health records are in compliance with the approved organization's documentation polices.

Policy
EHR documentation reviews will be based on the requirements for documentation as required by specific SCCHC's clinical and administrative polices.

SCCHC Internal Reviews
The number of EHR reviewed at all clinical sites is selected from prior month(s) clinic appointment schedules and the selection must reflect equal representation from all the clinical departments and from all the providers.

The EHR documentation review form (attached) will be provided to all reviewers to collect data from the records. Information will be collated by the department director and reported at individual clinical department meetings and the Patient Care/Medical Records Committee meetings. Specific details of record findings may be provided to the department and/or committee members, Executive Director, Co-Medical Director, Department Directors, or other designated staff as necessary.

Records that are considered to be non-compliant for use of documentation will be referred to the appropriate department director for performance improvement activities.

The re-review of specific department or provider records to evaluate the documentation of performance improvement will be performed based on the guidelines provided by the committee members.

Reviews by Clinical Department Staff

- Frequency = quarterly
- Minimum number of records is specific to each clinical department at each clinical site

Medical Director, with assistance from the clinical department directors, will review the records for these reviews and provide feedback to department directors with information and follow up.

Reports of reviews may be given at the regularly scheduled meetings of Patient Care/Medical Record Committee and suggestions for performance improvement will follow.

Provider Chart Reviews
South Cove Physicians are responsible for peer-reviewing patient charts in their department quarterly. The QA.QI committee assigns the QI Project Leader to generate five charts at random for each provider to review. Each provider reviews five charts from another provider in his or her own department, writes "C" for Compliant, "D" for Deficient, and "N/A" for Not Applicable, and sends the results back to be reported to the QI Project Leader.

Charts are reviewed for completeness and substance, and any deficiencies are reported to the QA.QI committee and heads of respective departments.

The OB/GYN department reviews charts on one of three topics every quarter:

- Annual GYN
- Postpartum Visits
- 36 Week OB Patients

The Pediatrics department reviews charts on one of five topics every quarter:

- 3 year old Immunizations
- 6 year old Immunizations
- Adolescent Immunizations

- Overweight Chart Review
- Pediatric Asthma Chart Review

The Adult Medicine department has one standard chart review it uses quarterly that covers the following topics:

- Medical Record Completeness
- Age appropriate Cancer Screenings
- Tobacco Use and Counseling
- Weight assessment and counseling
- Behavioral Health Counseling and other Lifestyle Issues

The Behavioral Health department has one standard chart review it uses quarterly that covers the following topics:

a. Medical Record Completeness
b. Evaluation of Adherence to Depression Treatment Guidelines

The Dental department conducts chart reviews as follows:

1. Each dentist will complete 5 dental charts and 5 extraction chart reviews every month.
    - Chart review will include 3 prophy, 1 restoration, and 1 extraction procedure.
    - Charts will be selected from different days
    - Type of treatment will be specified: i.e. Dr. Eng – ext, op, pro
    - For chart reviews identified as deficient, provide a copy to the audited provider for follow up
2. Each hygienist will complete 5 Hygiene charts monthly.
    - Charts reviewed should include prophy, sealant, and deep scaling visits.
    - Charts will be selected from different days
    - Type of treatment will be specified: i.e. recall, sealants, deep scaling
    - For chart reviews identified as deficient, provide a copy to the audited provider for follow up

2.10 Third Party (External) Health Record/Documentation Reviews

Purpose
To establish a policy defining the requirements for performing EHR reviews on SCCHC patient health records by external sources and/or organizations.

Policy
EHR documentation reviews will be based on the requirements for documentation as required by specific SCCHC's clinical and administrative polices.

SCCHC regularly receives medical record reviews from external sources and shall comply with all requests deemed appropriate as approved by either the Medical Records supervisor and/or the senior administrative staff.

Agency representative(s) shall show proper credentials and/or identifications upon arriving at the health center. All personnel reviewing SCCHC patient health records are required to sign a Confidentiality Statement and will then be given credentials to log in and view patient health records.

2.11 Obtaining Patient's Medical Record from another Health Care Facility or Provider

Purpose
To identify procedure to be followed when the SCCHC Medical Records department requests a patient's medical information/record from another health care facility or provider.

Policy
The Medical Records department staff will request a copy of a patient's medical record or medical information from another health care facility or provider only after receiving approval from the patient or the patient's legal representative.

The Medical Record department will use the MR form entitled: Authorization to Use or Disclose Health Information.

The patient or patient's legal representative will sign the form and then the MR department staff will send this form to the individual provider or facility that has the requested information.

2.12 Disclosing Patient Health Record

Purpose

In accordance with the South Cove Community Health Center Patients Right Policy and Massachusetts General Law, patients have the right to receive and release medical information from their personal health records. This policy outlines South Cove Community Health Center's mechanism regarding the release of health record as it pertains to administrative operations and patient confidentiality.

Policy

1. This policy applies to all South Cove Community Health Center staff members.
2. All health records are the property of South Cove Community Health Center and shall be maintained to serve the patient, the health care providers, and the institution in accordance with the legal and regulatory agency requirements.
3. All patients have the right to review and access his/her health record information and authorize its release to involved parties. The sole exception being some mental health records, which may be provided to a patient in summary form.
4. The health record may not be released without the written consent from the patient. Information shall be released only upon receipt of a properly signed authorization except in the following cases: patient care (i.e. other health center facilities presently care for the patient, emergency room care); Massachusetts Department of Public Health, Hospital liens (e.g. Mass. Rehab. Representative); Internal Revenue Service, Medicaid/Medicare; Education and Research (as approved by SCCHC); and court order.
5. Only copies, not the originals, shall be released.
6. The responsibility of releasing record lies with the Medical Records supervisor. In absence of the supervisor, a designated person shall be assigned.

Classification of Information

All information contained within a patient's health record is considered confidential. Confidential information consists of clinical data obtained by providers such as diagnosis, types of treatment, response to treatment, or any medical notes, as well as any sensitive information. This information includes concerns of illegitimacy, fetal deaths, congenital defects or birth injuries, venereal disease, mental illness, alcoholism and drug rehabilitation information.

Some data in the health record is/may be considered sensitive information, and may only be released with the patient's specific written permission. This sensitive information includes history of treatment for substance or alcohol abuse; HIV test information, including the fact that the patient was tested, psychiatric history; history of sexually transmitted diseases, records of sexual assault counseling; and confidential communication with a psychotherapist, mental health worker, rape counselor, and or licensed social worker.

Standard for the release of information:

1. A valid authorization must be received from patient or his/her legally qualified representative.
2. The authorization must be sent to Medical Records and the requested information can only be released from Medical Records.
3. South Cove has 30 days to process the request. Stat requests are processed ASAP.
4. All requests for release of behavioral health records are submitted to BH department.
5. All other requests for information will be assessed a reasonable fee based on the guidelines established by the Commonwealth of Massachusetts.
6. All subpoena as require written patient authorization before information can be released.
7. Patient may revoke an authorization in writing. SCCHC will honor this request as long as we have not already taken action on the previous authorization.

The Authorization Form

1. Patients may request a copy of their health information record by completing and signing an Authorization for Use and/or Disclosure of Protected Health Information Form – the "authorization form."
2. Any authorization over six months old will be returned and a new authorization will need to be obtained.

3. The form must be properly signed either by the patient, or in the case of a minor, the patient's parent or legal guardian. In the case of a mentally incompetent person, the next of kin or the legally appointed guardian must sign for the patient. In the case of a deceased patient, the form must be signed by the Executor for the Estate or the next of kin.

4. In general a person under the age of 18 cannot consent to the release of his/her health records without the consent of the parents or legal guardian(s) unless the minor falls under one of the flowing categories:

- ✓ *Emancipated Minors* (MGL c.112, s.12F)

  Except when a minor's life or limb is endangered, records are not released to parents of an "emancipated minor" who is married, widowed or divorced; a parent of a child; a member of the armed forces; pregnant (or believes herself to be); or living apart from parents and managing his/her own financial affairs.

- ✓ *Mature Minors*

  Records are not released to parents of a "mature minor" who is capable of giving informed consent, and would have his/her best interested served by not notifying the parent(s). (Barid v. Attorney General, 371 Mass. 741 (1977))

- ✓ *Abortion Records*

  Records of unmarried minors who have received authorized consent from Superior Court for an abortion (MGL c.112, s.12S) cannot be released without the minor's written consent.

- ✓ *All Minor*

  All Minors regardless of age or legal status who have consented to receive family planning care and services can authorize the release of their family planning records, and that records of their family planning care and services can only be released with the minor's own authorization.

Disclosure of Information

1. Only documents generated by South Cove Community Health Center and/or its staff can be released with the patient's permission. Refer to Policy 5.2 for the contents of the patient health record.
2. **Copies** of records, including x-rays and mammograms, fetal monitoring strips, EEG and ECG tracings shall be released only if they are requested.
3. **Release only what is requested**. Sensitive or privileged information shall not be released as part of the health records unless/until the patient gives specific permission for its release. In the event that a patient refuses consent for the release of sensitive information, that information shall be redacted from the copy of the record being sent, and the record shall be noted as incomplete due to the withholding of sensitive information.
4. With 5 working days' notice, a patient has the right to review his/her health records with proper authorization. Within 30 days after receiving patient's written authorization, the copy of patient's health records will be released.
5. With the patient's consent (and specific consent for sensitive or privileged information), the record may be released to a third party; except if the behavioral health profession deems it is not in patient's best interest, a summary of the record may be made available,
6. Only Physicians or healthcare facilities can receive faxed documents when it is needed for continuum of care. (Verify fax numbers prior to faxing)
7. Records can be picked up in person: the patient or his/her designee will be asked to show a picture ID, which will be documented on the authorization.

3.00 Infection and Exposure Control Plan

Purpose
The purpose of this plan is to reduce patient risk of nosocomial infection and employee risk of occupational exposure to blood borne pathogens and other infectious diseases through a program of infection and exposure control.

Policy
Surveillance, Prevention and Infection Control.

Definitions:
Blood borne pathogens: Pathogenic microorganisms that may be present in human blood.

Contaminated: The presence or the reasonably anticipated presence of blood or other potentially infections materials on or in an item, substance or surface.

Engineering Controls: Controls (e.g. sharp disposal containers, self sheathing or safety needles) that isolate or remove blood borne pathogens from the work place.

Exposure Incident: means a specific eye, mouth, other mucous membrane, non-intact skin, or parenteral contact with blood or other potentially infectious materials that result from the performance of an employee's duties.

Occupational Exposure: Reasonably anticipated skin, eye, mucous membrane, or parenteral contact with blood or other potentially infectious materials that may result from the performance of an employee's duties.

Personal Protective Equipment(PPE): Specialized clothing or equipment worn by an employee for protection against exposure to blood borne pathogens, or other potentially infectious materials, including but not limited to impervious gowns, aprons, gloves, masks, goggles and face shields that are provided by SCCHC at no cost to the employee.

Cleaning: the physical removal of organic material or soil from objects. It is not designed to kill microorganisms, but to remove them

Sterilization: Sterilization is the complete removal or destruction of all forms of microbial life. Instruments and equipment that enter normally sterile tissue such as the vascular system or any part of the body through which blood flows should be sterile. Steam sterilization is the method in use at SCCHC.

Disinfection: Disinfection is an intermediate measure between physical cleaning and sterilization. (Virtual elimination of all harmful microorganisms except spores.)

Standard Precautions: According to the concept of Standard Precautions, all human blood and certain human body fluids are treated as if known to be infectious for HIV, HBV, and other bloodborne pathogens.

Waste: Hazardous waste and hazardous infectious waste are terms used interchangeably in these Policies & Procedures. Hazardous waste refers to infectious waste.

Responsibility:
The Co-Medical Director and Department Director of the Adult Medicine Department, assisted by the Infectious Disease Specialist physician (if one is on staff) and the Director of Clinical Operations (DCO), is in charge of the infection prevention and control activities at SCCHC. The DCO and nursing staff and dental staff consults with other staff including the infectious disease specialists when necessary. All employees and all departments who are at risk for occupational exposure to bloodborne pathogens or other potentially infectious materials are responsible for adherence to the policies and procedures described in this plan. The DCO is responsible for training and education and record keeping for exposure incidents. The Medical Director and the employee health provider are responsible for ensuring appropriate post exposure evaluation and follow up for any employee experiencing occupational exposure and for providing a safe and healthy work environment for employees at risk

Plan:
The Infection and Exposure Control Program is designed to meet the unique and changing needs of the population we serve. The following high priority risks for the transmission and acquisition of infections agents have been identified:

Spread of resistant organisms, including MRSA infections, within the clinic
Spread of virulent respiratory pathogens
Occupational exposure incidents

The Infection and Exposure Control program goals are developed based on the above prioritized risks. The following goals have been identified:

limiting bloodborne pathogen exposure,
enhancing hand hygiene,
minimizing the risk of transmission of infection associated with procedures, equipment and devices

Reportable Diseases:
SCCHC works closely with the City and State Department of Public Health agencies. We maintain close, cooperative relationships that allow us to respond quickly and in a coordinated manner to health issues that impact our patients. This relationship ensures continuity of care, appropriate follow-up, and prevention of transmission of communicable diseases.
Infections are reported, when appropriate, within the organization and/or to public health agencies.
Case findings and identification of demographically important nosocomial infections provide surveillance data to the organization

Diseases reportable to the Boston Public Health Commission and Department of Public Health may be found in the policy addressing Disease Reporting.

Each clinical department staff will use a log to keep track of the most common infectious diseases reported in South Cove patients. The clinical department directors, providers and nurses will review the logs at least quarterly, or more often (e.g. monthly) as the evidence deems necessary, to detect any trends in infectious diseases. See attached list of the most common infectious diseases tracked.

Investigation of Outbreaks of Infection: In the event a potential or actual communicable disease outbreak is discovered it is reported to the Medical Director or DCO. The nature of the exposure to other patients or staff is evaluated.

If the disease is spread person-to person, contact tracing is begun using patient and work schedules. If necessary, the Department of Public Health is contacted for assistance in contact tracing.

If the disease is spread by fomites or other means, commonalities in the exposure are investigated to identify the source. Persons at risk are contacted and monitored for symptoms or offered prophylaxic medications or vaccination, counseling, and/or referral to outside healthcare providers as the situation dictates.

Patient information will be recorded in the EMR; the nursing staff will ask Medical Records to create a chart for staff if there is not one made already. See policy on Blood or Body Fluid Exposure incident for the correct procedure.

Exposure Determination:

A. Job Classifications
The following job classifications, as a result of performing their job duties, must engage in activities where exposure to blood or other potentially infectious materials is reasonably anticipated:

Physician	Nurse Practitioner
Nurse Assistant	Registered Nurse
Medical Assistant	Licensed Practical Nurse
Phlebotomist	Optometrist

Dentist	Dental Assistant

The following job classifications, employees at this facility, may potentially have contact with blood or other potentially infectious materials:

Maintenance Staff	Site Manager

B. Tasks and Procedures:
In the following procedures performed at SCCHC, occupational exposures can occur:

Patient exam	Aspirations
Inoculations	Phlebotomy
Wound care	Dressing change
Colposcopies	Diaphragm fittings
Induced Sputum	Pap smears
Vaginal exams/OB care	Disposal of Regulated Waste
IV insertion	Cleaning exam rooms
IM/SC/Intra-dermal-medication administration	Dental Procedures

Methods of Implementation and Control
Standard Precautions: In order to protect employees from exposure to infection, SCCHC has adopted Standard Precautions from the "Guideline for Isolation Precautions: Preventing Transmission of Infectious Agents in Healthcare Settings 2007". Standard Precautions assume that every person is potentially infected or colonized with an organism that could be transmitted in the healthcare setting. SCCHC applies the standard precautions, including hand hygiene, use of personal protective equipment, and respiratory hygiene during the delivery of health care. See policy on Standard Precautions.

As any patient's infectivity status cannot reliably be predicted, these blood and body fluid precautions extend to <u>all</u> patients.

Standard precautions apply to blood and to other body fluids containing visible blood.

Standard precautions also apply to the following: Semen, Vaginal secretions, Tissues, Cerebrospinal fluid, Synovial fluid, Pleural fluid, Peritoneal fluid, Pericardial fluid, Amniotic fluid, feces, nasal secretions, tears, urine, vomit and sputum (sweat is not included).

Standard precautions will be followed by all staff. Standard precautions stress that all patients should be assumed to be infectious for HIV and other blood-borne pathogens. Standard precautions do not apply to saliva; except in the dental setting, where saliva is likely to be contaminated with blood.

Protective barriers such as gloves, gowns, masks and protective eyewear are used as needed to reduce the risk of exposure of the health-care worker's skin or mucous membranes to blood or to body fluids containing visible blood and other contaminated fluids to which standard precautions apply.

All laboratory specimens, especially BLOOD specimens, must be considered potentially infectious and must be handled carefully. Whenever possible, laboratory specimens should be placed in clear plastic bags for transport to the lab.

Transmission-Based Precautions: SCCHC also implements transmission based precautions in addition to standard precautions, when indicated. These include: contact precautions, droplet precautions, and airborne precautions. Patients suspected of being infected with an airborne disease should be immediately isolated in a clinic examination room so that staff will take all the steps necessary to ensure standard precautions are followed. If the patient calls into the clinic and the nurse identifies that isolation would be necessary to treat the patient, then the staff will arrange for the patient to enter the clinic using the alternative entrance so that the patient can be masked upon arrival and taken immediately to the examination room. The housekeeping staff will terminally disinfect and clean the entire room upon charge of the patient.

Written Exposure Control Plan: This plan will be available to all affected employees in accordance with 29 CFR 1910.1030(c). It will be reviewed and, if necessary, revised annually, or whenever significant changes in procedure or personnel occur.

Engineering and Work Practice Controls: The following engineering and work-practice controls are implemented as part of Standard Precautions to minimize exposure to human blood borne pathogens.

i. HAND WASHING: SCCHC observes the CDC guidelines for hand hygiene. Hand washing facilities are located in exam rooms, bathrooms, the laboratory, the utility rooms, the kitchen, medication alcoves. All soap dispensers are supplied with antimicrobial soap. Alcohol based hand gel is also provided in all exam rooms and is available to staff and patients. Alcohol based hand gel may be used for routine decontamination when hands are not visibly soiled. Staff are observed for compliance with hand hygiene guidelines.

ii. CONTAMINATED EQUIPMENT: Equipment that may become contaminated with blood or other potentially infectious material will be decontaminated prior to use. If the equipment is a single use item, it will be discarded in the proper receptacle following guidelines for medical waste. Single use items will not be reused.

Non-disposable instruments/equipment is initially put in a metal covered container. A trained staff member removes the covered container. The instruments are cleaned and sterilized. Please refer to the policy for instrument cleaning.

iii. SHARPS AND NEEDLES: Safety needles and safety scalpels are used at all times. Contaminated needles and scalpels will not be bent, recapped, removed, sheared, or purposely broken. If a nurse or provider has the need to draw a medication in the medication room and needs to recap the needle to maintain sterility as he/she walks down the hall to the exam room, a “one-handed scoop technique” (passive recapping) must be use in the medication room. This procedure will only be allowed when handling sterile unused needles and should be avoided if the medication bottle can be carried into the patient’s exam room.
The contaminated needles and scalpels shall be discarded immediately or as soon as feasible in containers that are CLOSABLE, LEAK PROOF, PUNCTURE RESISTANT SHARPS CONTAINERS, with appropriate labels or color-coding. Sharps containers are available at the following sites/locations:

LOCATION:
Exam rooms
Treatment rooms
Procedure Rooms
Laboratory

These containers shall be maintained upright throughout use, replaced routinely, and not be allowed to overfill.

When moving containers of contaminated sharps from the area of use, the containers shall be closed immediately prior to removal or replacement to prevent spillage or protrusion of contents during handling, storage, transport, or shipping.

The container shall be placed in a secondary container if leakage of the primary container is possible. The second container shall be closeable and constructed to contain all contents and prevent leakage during handling, storage, transport, or shipping. The second container shall be labeled or color-coded to identify its contents.

Reusable containers shall not be opened, emptied, or cleaned manually or in any other manner that would expose employees to the risk of percutaneous injury.

Reusable Sharps are not used in this facility. Only safety sharps are used

iv. REGULATED WASTE: Specimens of blood or other potentially infectious materials are kept in leak proof containers (glass blood tubes, plastic screw top containers for sputum, urine or other bodily fluids) during collection, handling and storage. If outside contamination of the primary container occurs, the primary container shall be placed within a secondary container, which prevents leakage during the handling, processing, storage, transport, or shipping of the specimen.

When packages that contain blood or other potentially infectious materials are shipped, a biohazard label is affixed to the outside of the package.

Other regulated waste within this facility, including: blood or body fluid soaked used exam gloves, bandages, gauze and disposable instruments and equipment, shall be placed in containers which are closeable, constructed to contain all contents and prevent leakage of fluids during handling, storage, transportation or shipping.

The waste will be labeled or color-coded and closed prior to removal to prevent spillage or protrusion of contents during handling, storage, transport, or shipping.

Sharps are disposed of in sharps containers. "Full" containers (three quarters full) are closed and removed to a biohazard box in the dirty utility closets. The box is then secured and removed by our hazardous waste vendor. Manifests are generated and kept on file by the COO/Safety Officer.

Other regulated waste is disposed of in a closed container that is lined with a red biohazard bag. Bags are secured and placed in the large biohazard box in the dirty utility room.

v. WORK AREA RESTRICTIONS: In work areas where there is a reasonable likelihood of exposure to blood or other potentially infectious materials, employees are not to eat, drink, apply cosmetics or lip balm, smoke (smoking is not permitted in the building), or handle contact lenses. Food and beverages are not to be kept in refrigerators, freezers, shelves, and cabinets or on counter tops or bench tops where blood or other potentially infectious materials are present. Food and beverages may only be stored in refrigerators designated as "staff only/food only".

All procedures will be conducted in a manner that will minimize splashing, spraying, and generating droplets of blood or other potentially infectious material. Covers will be used on centrifuges and protective clothing will be available to employees to be worn when anticipating exposure to blood or other potentially infectious materials.

Bulb Mechanical Pipettes are available and in use in our facility. Mouth pipetting/suctioning of blood or other potentially infectious materials is prohibited.

vi. TONOMETER TIPS: Tonometer tips will be disinfected according to the manufacturer or CDC guidelines for disinfection of tonometer tips.

Personal Protective Equipment: When there is a chance for exposure to blood or bodily secretions, SCCHC provides PPE, at no cost to its employees. PPE will be considered appropriate only if it does not permit blood or other potentially infectious materials to pass through to or reach the employee's work clothes, street clothes, undergarments, skin, eyes, mouth or other mucous membranes under normal conditions of use and for the duration of time which the protective equipment will be used.

The following PPE is available:

i. DISPOSABLE GLOVES: in appropriate sizes, are available for all workers at risk of exposure, for use at their discretion (i.e. exam rooms, laboratory, utility rooms, acupuncture/massage rooms)

Gloves are required to be used for blood drawing (the tip of one glove may be removed to palpate the vein prior to drawing by lab staff), intravenous cannulation, physical exams (rectal, vaginal. oral, genital procedures, etc.), where there is a potential for exposure. Disposable gloves used in this facility are not to be washed or decontaminated for re-use, and are to be replaced as soon as practical when they become contaminated or as soon as feasible if they are torn, punctured, or when their ability to function as a barrier is compromised.

Hand hygiene will be performed after the removal of gloves.

ii. HYPOALLERGENIC GLOVES are available to workers allergic to regular gloves. Hypoallergenic gloves are supplied in appropriate sizes whenever the need arises. Providers and staff requiring hypoallergenic gloves will have them available in the work areas.

iii. UTILITY GLOVES are available for all housekeeping and other staff. They are checked for cracks at each use and replaced as necessary. Utility gloves are used for the cleaning & decontamination of instruments and equipment, bagging and removal of hazardous waste, or whenever latex gloves are likely to be punctured. Utility gloves may be decontaminated for re-use, provided that the integrity of the glove is not compromised. Utility gloves will be discarded if they are cracked, peeling, torn, punctured, or exhibits other signs of deterioration, or when their ability to function as a barrier is compromised

iv. PROTECTIVE BODY CLOTHING and/or impervious gowns are available for staff when contamination of clothing is likely (cleaning, decontamination procedures, etc.)

v. RESPIRATORY EQUIPMENT: Mouthpieces and resuscitation bags are available for BLS. The resuscitation equipment is on the code carts.

Additionally, CPR masks are available on the crash carts and with each AED.
Masks in combination with eye protection devices, such as goggles or glasses with solid side shield, or chin length face shields, are required to be worn whenever splashes, spray or splatter of droplets of blood or other potentially infectious materials may be generated, and eye, nose, or mouth contamination can reasonably be anticipated.

Additional protective clothing (such as lab coats, gowns, aprons, clinic jackets, or similar outer garments) shall be worn in instances when gross contamination can reasonably be anticipated.

vi. N-95 MASKS - Located in the medical storage cabinets and other rooms as needed. An N95 FFR is a type of respirator which removes particles from the air that are breathed through it. These respirators filter out at least 95% of very small (0.3 micron) particles. N95 FFRs are capable of filtering out all types of particles, including bacteria and viruses.

Housekeeping: Cleaning is the physical removal of organic material or soil from objects. It is not designed to kill microorganisms, but to remove them. Professional cleaning staff maintains general house cleaning on a daily basis. It is the responsibility of the housekeeping staff to daily wash floors, sinks, toilets, and general areas of the clinic. Trash receptacles are not allowed to overflow. All trash receptacles are emptied daily.

Decontamination
Employees are responsible for ensuring that equipment or surfaces are cleaned with an appropriate disinfectant and decontaminated immediately after a spill or leakage occurs, and at the end of the work shift.

i. EXAMINATION ROOMS/TABLES - Examination tables are covered with paper and changed after each patient. If the table becomes contaminated with blood or other body fluids, it is disinfected with a hospital grade disinfectant after the patient leaves the room. The medical assistant/LPN will be responsible for cleaning and will wear gloves. The examination tables and counter surfaces are cleaned daily with a hospital grade disinfectant or commercially prepared germicidal disposable cloth (Sani-cloth).

ii. BROKEN GLASS It is prohibited to pick up by hand any broken glassware that may be contaminated. A brush, dustpan, forceps and/or tongs are available for picking up broken glassware that may be contaminated. The equipment used for these purposes are cleaned, decontaminated or discarded in Biohazard waste if the glass container held any potentially infectious material.

iii. LAUNDRY: Laundry is shipped to the cleaning company vendor for cleaning. Protective gloves are used by all workers who have contact with contaminated laundry; other protective equipment is available as required. Whenever contaminated laundry is wet and presents a reasonable likelihood of soak-through of or leakage from the bag or container, the laundry shall be placed and transported in bags or containers which prevent soak-through and/or leakage of fluids to the exterior.

iv. HAZARDOUS WASTE RECEPTICALS will be emptied on a regular basis as needed to allow for the safe disposal of contaminated materials. The assigned personnel will empty the hazardous waste bags (HWB) on a regular basis to prevent overflow and safe disposable, and place a new bag in the receptacle. The hazardous

waste baskets will be checked daily. The assigned personnel will wear gloves and mask when changing, securing and/or transporting these bags, and will be appropriately trained in these procedures before performing these duties.

The HWB will be placed in the central receptacle located in the soiled utility room and the hazardous waste company will remove the receptacle from this location.

v. CLEAN UP OF BLOOD SPILLS - All spills of blood-contaminated fluids will be promptly cleaned up using and EPA-approved germicide or a 1:10 solution of household bleach in the following manner while wearing gloves. If splashing is anticipated, protective eyewear will be worn along with and impervious gown or apron which provides an effective barrier to splashes. Visible material will first be removed with disposable towels or other appropriate means that ensure against direct contact with blood. The appropriate germicide (bleach solution) is applied. Soiled cleaning equipment is cleaned and decontaminated or disposed of in the Hazardous Infectious Waste receptacles. See *Section 3.07 Blood Spill Procedure* for further information.

Vaccination and Post-exposure Evaluation and Follow up:

SCCHC makes available the Hepatitis B vaccine and vaccination series to all employees who have occupational exposure, and also makes available post exposure follow-up to employees who have had an exposure incident.

The organization will ensure that all medical evaluations and procedures including the Hepatitis B vaccine and vaccination series, and post exposure follow-up, including prophylaxis are:

- Made available at no cost to the employee;
- Made available to the employee at a reasonable time and place;
- Performed by or under the supervision of a licensed physician, or by or under the supervision of another licensed healthcare professional;
- Provided according to the recommendations of the U.S. Public Health Service;
- And that all laboratory tests are conducted by an accredited laboratory at no cost to the employee.

a) **Hepatitis B Vaccination:** Hepatitis B vaccination shall be made available after the employee has been provided information on the hepatitis B vaccine, including information on its efficacy, safety, method of administration, and the benefits of being vaccinated. Hepatitis B vaccination shall be made available within 10 working days of initial assignment to all employees who have occupational exposure unless the employee has previously received the complete hepatitis B vaccination series, antibody testing has revealed that the employee is immune, or the vaccine is contraindicated for medical reasons.

If the employee initially declines Hepatitis B vaccinations, but at a later date decided to accept the vaccination, the vaccination will then be made available.

All employees who decline the Hepatitis B vaccination offered will sign the OSHA required waiver indicating their refusal.

If a routine booster dose of Hepatitis B vaccine is recommended by the U.S. Public Health Service at a future date, such booster will be made available.

b) **Tuberculosis Screening:** In order to minimize risk of transmission of communicable diseases to patients, staff and visitors, each new employee, student, or volunteer with patient contact is required to have a TB-PPD skin test prior to starting employment and annually thereafter.

c) **Flu Immunization:** All employees are offered the flu immunization when supplies are available and are strongly encouraged to have it annually.

Post-Exposure Evaluation and Follow-Up: In the event of an exposure incident, the following procedures are followed in this facility:

- The employee is instructed to first thoroughly wash the site with soap and water. Then notify their supervisor and/or department nursing staff or DCO. SCCHC providers are available on call 24 hours a day for post-exposure management. The Medical Director or designee will perform the evaluation and medical follow-up for the exposed employee at no cost to the employee.

- The exposed employee is offered blood collection and/or testing. The employee has the right to refuse either or both. However, if the exposed employee gives consent for blood collection, but not for HIV testing, the blood is kept for 90 days, during which time the employee can choose to have the sample tested.

- Appropriate post-exposure prophylaxis is offered to the exposed employee. These include immuno-globulin for Hepatitis B & Hepatitis C. The recommendations of an evaluating provider who is familiar with current CDC guidelines on post-exposure prophylaxis treatment for HIV are followed in the event of HIV exposure.

- Counseling and evaluation of any reported illness is provided at no charge to the exposed employee. The results of the provider consultation for post-exposure will be documented in the employee's medical record. Records are maintained in the strictest confidentiality.

Evaluating the Exposure Incident: All exposure incidents will be documented on SCCHC's Incident Report form. The DCO and the department nursing staff will review the circumstances of the incident to determine:

- Engineering controls in use at the time
- Work practices followed
- A description of the device being used
- Protective equipment or clothing that was used at the time of exposure (gloves, eye shields, etc)
- Location of incident
- Procedure being preformed when incident occurred
- Employee's training

Revisions will be made to work practices or this Infection and Exposure Control Plan if determined necessary as a result of the investigation of the incident.

Information Provided to the Evaluating Physician

The following information will be provided to the evaluating physician:

- Related policies and procedures, including the Exposure Control Plan and the Policy and Procedure for Blood and Body Fluid Exposure Incidents.
- A description of the exposed employee's duties as they relate to the exposure incident.
- Description of the exposure incident including the routes of exposure and the circumstances.
- Results of the source individuals blood testing, if available.
- And all medical records relevant to the exposed employee's appropriate treatment including vaccination status.

Communication of Hazards to Employees

a) Labels and Signs: SCCHC uses red color-coding and/or biohazard labels to label all hazardous items. Hazardous items that are so marked include, but are not limited to:

- SHARPS CONTAINERS: Biohazard label and color coding

- CONTAINERS OF OTHER REGULATED WASTE: Biohazard label and color coding

- REFRIGERATORS/FREEZERS THAT HOLD POTENTIALLY HAZARDOUS MATERIAL: Biohazard label.

- CONTAINERS USED TO TRANSPORT HAZARDOUS MATERIAL: Biohazard label

- DIRTY UTILITY CLOSETS: Biohazard Sign

b) Information and Training: Training will be provided at orientation and annually thereafter for employees with risk of occupational exposure.

The training provides employees information on the epidemiology of blood borne pathogens, how to obtain a complete copy of the regulatory text of the OSHA standards, information on SCCHC's policy and procedures related to exposure incidents, methods of prevention of exposure and what to do in the event of an exposure incident.

A post test will be administered to verify understanding of the training and training records will be maintained as described below.

Click here to access the online version of the OSHA Regulatory Text, or go to the following address: http://www.osha.gov/pls/oshaweb/owadisp.show_document?p_table=STANDARDS&p_id=10051

Record Keeping

a) Medical Records: Confidential health records and employee records are kept for all employees who have experience an occupational exposure.
These records include:

- Name, SSN and medical record number
- Hepatitis B vaccination status (including dates of vaccination, records relating to employee's ability to receive the vaccine, and signed declination form, where applicable)
- Provider's consultation note and treatment plan, including for testing and/or treatment.

Employee exposure records are maintained for at least the duration of employment, plus 20 years.

Written permission from the employee is required for non-clinical access to their Health Record. Supervisors have access to the employee file where confidential material is kept.

Employee exposure records are available upon request to the Assistant Secretary and the Director of OSHA if mandated by law.

If this facility ceases to do business, it is understood that the employer must inform the Director of OSHA at least three months before disposing of the records.

b) Training Records: Records for the training of all workers at risk for occupational exposure are kept in this facility. These records include:

Dates of Training Sessions
Material covered
Names, job titles and qualifications of the trainers
Names and job titles of all staff participating in the training

Records are kept for 3 years from the date of training. Employee training records are available upon request to the Assistant Secretary and the Director of OSHA.

3.01 Basic Cleaning Concepts

Defintions

General sanitizing
To make a surface or area clean by removing dirt, germs or unwanted substances.

Bathrooms/restrooms
Restroom cleaning includes the cleaning of toilets and fixtures.

Cleaning
The physical removal of dust, soil, blood and body fluids. Cleaning physically removes germs. It is accomplished with water, detergents and mechanical action. The key to cleaning is the use of friction to remove germs and debris.

Contamination
The presence of germs on hands or on a surface such as clothes, gowns, gloves, bedding, toys, surgical instruments, patient care equipment, dressings or other inanimate objects.

Cross-contamination
Cross-contamination is the transfer of harmful germs from one person, object or place to another.

Disinfectant
A product that is used on surfaces or medical equipment/devices which results in disinfection of the equipment/device. Some products combine a cleaner with a disinfectant (Hospital Grade registered with the EPA).

Disinfection
The killing of germs. Surfaces and equipment must be cleaned first before applying disinfectant in order to kill germs.

Dry mopping
The process of removing dirt and debris from floors using only mop head without water or detergent.

High dusting
High dusting includes all horizontal surfaces and fixtures above shoulder height, including vents. Ideally, the patient/resident should be out of the room during high dusting to reduce the risk of inhaling dust particles.

Wet mopping
Final floor cleaning step using water and detergent or disinfectant.

Purpose
To provide general cleaning concepts and identify staff that are responsible. This policy should be used in conjunction with any specific job responsibilities assigned to staff.

Policy

Cleaning Concepts

Before cleaning:

1. Check whether transmission-based precautions apply
2. Remove clutter where possible
3. Follow manufacturer's instructions for proper dilution and contact time for cleaning and disinfecting solutions
4. Gather materials required for cleaning before entering room
5. Perform hand hygiene upon entering the room
6. Apply required PPE

During cleaning:

1. Progress from the least soiled areas (low-touch) to the most soiled areas (high-touch) and from the high surfaces to the low surfaces
2. Remove gross soils prior to cleaning and disinfection
3. Use a damp mop to clean floors in preference to sweeping
4. Avoid "double dipping" of used cloths into clean solution
5. Change cleaning solutions regularly, and disinfectants should be disposable; the practice of "topping up" is not acceptable since it can result in contamination of the container and solution
6. Be alert for needles and other sharp objects; pick up sharps using a mechanical device e.g. tongs, and place into sharps container and report incident to the supervisor
7. Collect waste, handling plastic bags from the top (do not compress bags with hands)
8. Perform hand hygiene upon leaving the room

After cleaning

1. Tools used for cleaning and disinfecting must be cleaned and dried between uses
2. Disposable mop heads should be used for transmission-based precaution cleans and/or blood/body fluid spills
3. Clean the housekeeping trolley/tray
4. Report any elements that are in poor condition to the supervisor

Responsible Personnel

Housekeeping:

Housekeeping staff maintain general house cleaning on a daily basis. It is the responsibility of the housekeeping staff to daily wash floors, sinks, toilets, and general areas of the clinic.

At a minimum the following schedule is to be maintained:

1. High touch areas will be disinfected twice per day (reception desk counters/areas, door handles, etc...). Some reception areas may be disinfected by non-housekeeping staff such as receptionist).
2. Waiting room chairs will be disinfected at least weekly or as necessary.
3. Bathrooms will be disinfected and cleaned twice per day.
4. Trash receptacles are not allowed to overflow. All trash receptacles are emptied and disinfected daily.
5. Cafeteria areas are to be cleaned twice per day.
6. Floors are cleaned daily.

Medical/Dental/Nurse Assistants

It is the responsibility of the medical/dental/nurse assistants to disinfect patient areas such as exam rooms, intake rooms, dental procedure rooms, or any area that a patient may contaminate an area of the clinic. This includes that proper disposal of biohazardous waste.

At a minimum the following schedule is to be maintained:

1. Exam rooms are to be disinfected between patients and at the end of the day. This includes exam room table, chair, door handles, and any other high touch areas in room.

2. Change exam table paper between patients.
3. Biohazardous waste containers should be emptied when 75% full or at least weekly.
4. Intake rooms are to be disinfected between patients and at the end of the day. This includes intake room table, chair, door handles, scales and any other high touch areas in room.

3.02 Hand Hygiene Policy and Procedure

Purpose
Effective hand hygiene reduces the incidence of healthcare-associated infections.

Policy
All members of the healthcare team will comply with current Centers for Disease Control and Prevention (CDC) hand hygiene guidelines.

Procedure

Indications for Handwashing and Hand rubbing

A. Indications for Handwashing
1. When hands are visibly dirty or contaminated with proteinaceous material or are visibly soiled with blood or other body fluids, wash hands with either a non-antimicrobial soap and water or an antimicrobial soap and water.
2. Before eating and after using a restroom, wash hands with a non-antimicrobial soap and water or with an antimicrobial soap and water.
3. Handwashing may also be used for routinely decontaminating hands in the following clinical situations:

- Before having direct contact with patients
- Before inserting indwelling urinary catheters, peripheral vascular catheters, or other invasive devices that do not require a surgical procedure
- After contact with a patient's intact skin (e.g., when taking a pulse or blood pressure, and lifting a patient)
- After contact with body fluids or excretions, mucous membranes, non-intact skin, and wound dressings, even if hands are not visibly soiled
- When moving from a contaminated body site to a clean body site during patient care
- After contact with inanimate objects (including medical equipment) in the immediate vicinity of the patient
- Before and After removing gloves

B. Indications for Hand rubbing
If hands are ***not visibly soiled***, an alcohol-based hand rub may be used for routinely decontaminating hands in the following clinical situations:

- Before having direct contact with patients
- Before inserting indwelling urinary catheters, peripheral vascular catheters, or other invasive devices that do not require a surgical procedure
- After contact with a patient's intact skin (e.g., when taking a pulse or blood pressure, and lifting a patient)
- After contact with body fluids or excretions, mucous membranes, non-intact skin, and wound dressings, only if hands are not visibly soiled
- When moving from a contaminated body site to a clean body site during patient care
- After contact with inanimate objects (including medical equipment) in the immediate vicinity of the patient
- Before and After removing gloves

Non-Surgical Hand Hygiene Technique

A. Handwashing with soap and water (either non-antimicrobial or antimicrobial)
1. Wet hands with running water
2. Apply hand washing agent to hand
3. Vigorously rub hands together for at least 20 seconds, covering all surfaces of hands and fingers

4. Rinse hands thoroughly with water and with hands angled down in the sink
5. Dry hands thoroughly with a disposable towel(s)
6. Use disposable towel to turn off the water

B. Alcohol-based hand rub

1. Apply product to palm of one hand
2. Rub hands together, covering all surfaces of hands and fingers
3. Continue to rub until hands are dry

Nails

1. Artificial fingernails or extenders may not be worn if duties include direct contact with patients
2. Natural nail tips shall be less than ¼ inch long

Gloves and Hand Hygiene

Gloves reduce hand contamination by 70 – 80 percent, prevent cross-contamination and protect patients and health care personnel from infection. However, the use of gloves does not eliminate the need for hand hygiene.

1. Wear gloves when contact with blood or other potentially infectious materials (other body fluids, secretions and excretions), mucous membranes, non-intact skin and contaminated items will or could occur.
2. Change gloves during patient care if moving from a contaminated body site to a clean body site.
3. Remove gloves promptly after use, before touching non-contaminated items and environmental surfaces, and before caring for another patient.
4. Decontaminate hands after removing gloves.

3.03 Storage of Patient Care Supplies

Purpose
To provide guidelines for the appropriate storage of patient care supplies at South Cove Community Health Center.

Policy
There will be no mixing of soiled/contaminated supplies with clean or sterile supplies. All contaminated items will be maintained in the dirty utility room. All clean supplies are in clean supply closets located throughout the center.

Supplies must be stored in designated areas. Patient care items are not to be stored on the floor or under sinks where they may become contaminated.

Supplies that have become wet, soiled, damaged, have lost package integrity or are outdated are no longer appropriate for patient use and should be disposed of properly.

Stock is maintained and rotated by individuals within each area. This should include medical assistants and clinical staff.

Supplies should not be accumulated in exam rooms.
Outside shipping cartons should not be placed in utility closets designated as clean.

3.04 Cleaning, Disinfection and Sterilization of Equipment

Purpose
To prevent the spread of infection by rendering patient care equipment free from micro-organisms such as bacteria, fungus, spores or virus.

Policy
Clean/sterile equipment must always remain separated from soiled/contaminated equipment. Work spaces should be clearly marked “clean” and “soiled” areas. The processing of patient care equipment should always be performed to keep the functions separate from one another.

Definitions:
Cleaning is the removal of all visible debris and visible soil and impurities. It is not designed to kill organisms only to remove them.

Disinfection is a process that destroys micro-organisms, with the exception of spores. High level disinfection can be expected to destroy all micro-organisms with the exception of high number of bacterial spores. Patient care equipment which comes in contact with mucous membranes or skin that is not intact, must receive high-level disinfection prior to being used on another patient. Dilute solutions of bleach should be used for this function.
Low level disinfection can kill most bacteria, some viruses and some fungi, but cannot be relied on to kill such organisms as TB or bacterial spores. This type of disinfection is used on non-critical patient care items that will not come in contact with mucous membranes or skin that is not intact (e.g. oximeters, stethoscopes and EKG leads)
Sterilization is complete destruction of all organisms. For proper sterilization the following steps should be taken: (refer to separate procedure)

1. Processing of instruments: equipment should be washed and dried prior to undergoing sterilization. Removal of dirt and organic material is required before sterilization.
2. Packaging of instruments: packaging should be done to allow penetration of the sterilant to every object in the wrapper.
3. Monitoring: appropriate chemical indicates should be used on the outside of the package being sterilized.
4. Shelf life is the period of time that sterility is preserved(see manufacturer recommendations).
    a. Labeling and record keeping – labeling should include contents, lot, load control# and initials of the processor.
    b. Contents of sterilization load must be documented to correlate with the lot and load #.
    c. Sterilized items are considered sterile unless outdated or if there has been damage to the package containing the sterilized item.

Maintenance of Sterilizer Performance
Daily or as necessary based on use of the autoclave: (refer to separate procedure)

- Times, temperatures and pressure checks of each load must be checked by the operator.
- Temperature and time readings must be maintained for each sterilizer.
- Outside chemical indicators should be included on each package of equipment being sterilized.

Weekly: (refer to separate policy)

- All steam sterilizers should be tested with a Biological Indicator at least weekly.
- Results of Biological Indicator should be recorded in appropriate log books.
- All ethylene oxide sterilizers must be biologically tested with each load.

Preventive Maintenance: (refer to separate procedure)

- Should be conducted according to manufacturer’s recommendations.
- Verification records and reports of maintenance performed should be kept within each clinical area.

Infection control and sterilization of equipment in health center

Infection Control procedure for sterilization process with positive Biological Indicator (BI) result:

Question: What should I do if a spore test result is positive?

Answer: If the mechanical (e.g., time, temperature, pressure) and chemical (internal or external) indicators suggest that the sterilizer is functioning properly, a single positive spore test result probably does not indicate sterilizer malfunction. Items other than implantable items do not necessarily need to be recalled; however, sterilizer operators should repeat the spore test immediately using the same cycle that produced the positive BI. The sterilizer should be removed from service and sterilization operating procedures reviewed to determine whether operator error could be responsible.

If the result of the repeat spore test is negative and operating procedures were correct, then the sterilizer can be returned to service. If the repeat spore test result is positive, do not use the sterilizer until it has been inspected or repaired and re-challenged with BI tests in three consecutive empty-chamber sterilization cycles. When possible, items from suspect loads dating back to the last negative BI should be recalled, rewrapped, and re-sterilized.

Results of biological monitoring and sterilization monitoring reports should be recorded at all times.

Patient follow up:

The patient records of any patients, who had any procedure performed with the instruments that were used since the sterilizer was last tested and a negative spore result achieved, should be noted/flagged and a review conducted of any return patient visits to the clinic since he/she had the procedure performed with those instruments; review of any progress notes or telephone encounters of complaint or documentation of any possible signs and symptoms of infection; and further follow up with each patient to inquire about possible problems if this is requested by the provider from any department.

Consider these common Factors Influencing the Effectiveness of Sterilization:

Causes:	**Potential problem**
Improper cleaning of instruments	Protein and salt debris may insulate organisms from direct contact with the sterilizing agent and interfere with the efficacy of the sterilization agent.
Improper packaging Wrong packaging material for the method of sterilization Excessive packaging material	Prevents penetration of the sterilizing agent; packaging material may melt. Retards penetration of the sterilizing agent.
Improper loading of the sterilizer Overloading No separation between packages or cassettes even without overloading	Increases heat-up time and will retard penetration of the sterilizing agent to the center of the sterilizer load. May prevent or retard thorough contact of the sterilizing agent with all items in the chamber.
Improper timing and temperature Incorrect operation of the sterilizer	Insufficient time at proper temperature to kill organisms.

3.05 Isolation/Febrile Respiratory Illness Policy

Purpose:
To prevent spread of respiratory and other infections to patients and/or healthcare workers

Procedure

1) Measures to contain respiratory secretions from patients who exhibit signs and symptoms of a febrile respiratory illness from point of entry to clinic:

   a) Signs at entrance informing patients with respiratory illness to :
      i) Cover mouth when coughing
      ii) Wash hands frequently, especially after coughing
      iii) Use tissue paper after when coughing and dispose tissue appropriately

   b) Provide tissue paper and no touch receptacle for disposal.

   c) Resources made available for hand hygiene such as alcohol-based hand wash.

   d) Masks are required for any patient who presents with respiratory illness, especially patients with fever. (Signs are posted at all clinic check-in areas informing patients of the availability of masks).

   e) In patients exhibiting febrile respiratory illness, best effort will be made to place patient in a separate room and examine patient as early as possible. A nurse should be contacted immediately to assess the patient.

   f) Label the room with an appropriate isolation signage to alert anyone entering the room of the isolation reasons and which personal protection equipment (PPE) is appropriate.

   g) Room is to be cleaned and disinfected according to Nurse/Physician instructions. Room should be cleaned after the appropriate time has gone by to remove any airborne contaminant. The table below may be used as a guide. Most rooms within the clinic are set for 6 air changes per hour

Air changes/hour (ACH) and time required for airborne-contaminant removal by efficiency *

The number of air changes per hour and time and efficiency.		
ACH	**Time (mins.) required for removal 99% efficiency**	**Time (mins.) required for removal 99.9% efficiency**
2	138	207
4	69	104
6+	46	69
8	35	52
10+	28	41
12+	23	35

2) In the event of an influx of patients with febrile respiratory illness, please refer to page 3.06 of the Infection and Exposure Control Plan immediately to report the situation.

3.06 Communicable Disease Reporting

Why is communicable disease reporting important?
Communicable disease reporting is the foundation of public health surveillance and disease control. Prompt reporting allows the Boston Public Health Commission (BPHC) time to interrupt disease transmission by locating, identifying and containing outbreaks. Information obtained through disease reporting is crucial to alert the public to potential health concerns, monitor disease trends and identify high-risk groups.

Who is responsible for reporting communicable diseases?
Both the city of Boston and state laws and regulations require the reporting of specified diseases. Diseases are reportable to the jurisdiction where the diagnosis is made, regardless of where the case resides. In Boston, health care providers, health care facility administrators, shelter administrators, school or childcare establishment administrators, or their authorized representatives must report specified diseases to the BPHC. Laboratories are also required to report, but this does not eliminate the requirement for others listed above to report.

When are communicable diseases to be reported to BPHC?
All suspect or confirmed cases must be reported as soon as the diagnosis is suspected or confirmed. Some diseases must be reported to BPHC immediately (within 24 hours) while others must be reported within 1-2 business days. The BPHC website (www.bphc.org/cdc) and the back of the reporting card specify time frames. In addition, any suspect or confirmed cases (or carriers) of enteric disease in food handlers, nursing home caregivers, or childcare workers are reportable within 24 hours of diagnosis. Confirmed or suspected outbreaks of food-borne or waterborne disease must also be reported within 24 hours.

When are communicable diseases to be reported to Massachusetts Department of Public Health rather than BPHC?
HIV/AIDS, sexually transmitted diseases, and suspect or confirmed tuberculosis (latent or active) are to be reported to the Massachusetts Department of Public Health rather than the Boston Public Health Commission. All other diseases and outbreaks are sr to BPHC.

How are communicable diseases to be reported?
A health care provider or representative is required to fill out the enclosed reporting card in full. Reports must contain all essential information and should be faxed to BPHC at 617-534-5905. This is a confidential fax line. Additional reporting forms can be found online at www.bphc.org/cdc. For urgent cases, reports can be submitted by phone by calling 617-534-5611.

A word about communicable disease reporting and HIPAA?
Since the HIPAA regulations were adopted in 1996, some health care providers have expressed concern about providing patient information to other agencies. HIPAA regulations section 164.512 (b) states that reporting of communicable diseases and immunizations to the local/state health department is exempt because it is mandated by the Public Health Department and is used for surveillance and prevention of communicable disease. Information submitted to BPHC is treated as confidential medical information.

For more information, please contact
Boston Public Health Commission
Telephone: (617) 534-5611
Confidential Fax: (617) 534-5905

Reporting forms may be found at: www.bphc.org/cdc

3.07 Blood Spill Procedure

General Information

1. Universal precautions must be observed. Cleaning of blood spills should be limited to those persons who are trained for the task.
2. If an untrained person encounters a spill, he/she should limit access to the area and immediately call the person(s) assigned to this duty.
3. Only disposable towels should be used to avoid the difficulties involved in laundering.
4. If a spill involves broken glassware, the glass should never be picked up directly with the hands. It must be cleaned up using mechanical means, such as a brush and dustpan, tongs, or forceps.
5. Blood Spill Kits are kept in all laboratories if needed.

Personal Protective Equipment

1. Persons who clean blood spills should wear disposable gloves of sufficient strength to not tear during cleaning activities. If the gloves develop holes, tears, or splits, remove them, wash hands immediately, and put on fresh gloves. Disposable gloves must never be washed or reused. Remove gloves one at a time by grasping the wrist opening and pulling toward the fingers so that the gloves come off inside-out. Contaminated gloves and other personal protective equipment should be disposed of as biomedical waste.
2. If enough blood has been spilled to expect splashing during cleaning, utilize a face shield, and protective clothing.

Disinfectants

Read and follow all manufacturer's handling instructions. All spills of blood and blood-contaminated fluids should be properly cleaned using any of these three types of disinfectants:

1. EPA-registered "hospital disinfectant" chemical germicides that have a label claim for tuberculocidal activity,
2. products registered by the EPA as being effective against human immunodeficiency virus (HIV), or
3. a solution of 5.25% sodium hypochlorite (household bleach) diluted approximately 1:10 with water.

Procedures for Cleaning Blood Spills on Hard Surfaces

1. Alert people in immediate area of spill. Isolate the area.
2. Put on appropriate disposable gloves (i.e., nitrile, natural rubbers, latex gloves) and other protective equipment. This may include a lab coat, disposable shoe covers, safety goggles, mask or full face shield.
3. To enhance the effectiveness of any sterilization or disinfection process, surfaces must first be thoroughly cleaned of all visible blood or soil before a germicidal chemical is applied for disinfection.
    a. Cover spill with paper towels or other absorbent materials.
    b. Carefully pour a freshly prepared 1:10 dilution of household bleach (1/2 cup of bleach to 1 quart of water) or other EPA-registered disinfectant around the edges of the spill and then into spill. Avoid splashing.
    c. Use paper towels to wipe the spill, working from the edges into the center.
    d. Collect all paper towels and place in biohazard or opaque bag on which a biohazard label can be placed on the outside.
4. Disinfection
    a. Clean up the spill area again with fresh paper towels soaked in disinfectant or spray.
    b. Follow the manufacturer's recommended contact time or allow 20 minutes of contact time in the absence of manufacturer recommendations.
5. After the spill has been absorbed, collect all disposable personal protective equipment, paper towels, gloves, etc., and place in biohazard or opaque bag on which a biohazard label can be placed on the outside.
6. Place the biohazard bag in a proper storage container for later pick-up by vendor.
7. Notify people in the immediate area of the spill that clean-up has been completed.

Cleaning Blood Spills on Carpeting

1. Isolate the area, if possible.
2. Wear gloves and other appropriate apparel.
3. Use only a registered germicide as discussed in the Section XII.E., "Disinfectants." Read and follow manufacturer's instructions. Do not use chlorine bleach solutions on carpet.
4. Procedures for small spills on carpets (smaller than a quarter) are as follows.
    a. Soak the spill with enough disinfectant to cover the spot.

b. Let dry at least overnight to ensure that the spot is disinfected.
c. Shampoo carpet, if needed, or use 3% hydrogen peroxide to remove discoloration.

• Procedures for larger spills are as follows.
1. Pour disinfectant on the spot and let stand at least 30 minutes to allow some disinfection to take place. Blot up excess liquid with disposable towels.
2. Soak the area with additional disinfectant. Allow to dry overnight. Contact Custodial Services to shampoo carpet, if needed, or use 3% hydrogen peroxide to remove discoloration.

• All contaminated towels and gloves should be disposed of in the Hazardous Infectious Waste receptacles.

3.08 Pre-employment Health Screening

Purpose
To ensure pre-employment screening is accomplished for all employees and volunteers/interns prior to the initiation of employment.

Policy
All employees and volunteers/interns must provide acceptable evidence of adherence to South Cove Community Health Center's Infection Control Policy and Procedures prior to beginning employment or a volunteer/intern position. This will be accomplished as follows:

1. As a part of the offer packet generated and mailed to the individual, details of the position and its corresponding category of Occupational Exposure (COE) will be fully outlined. All positions fall into one of four COEs.

    - COE I – Occupational blood and/or body fluid exposure
    - COE II – Patient interaction without blood and/or body fluid exposure
    - COE III – No patient interaction and no blood and/or body fluid exposure
    - COE IV – Volunteers/interns; may vary by function

2. Prior to the first day of work, employees and volunteers/interns will receive with their appointment letter/orientation packet the COE information. It will be the individual's responsibility to coordinate their doctor's appointment with employee health and for providing the required documentation detailed for their COE.
3. All employee health records are centrally located in the electronic health record (EHR). Human Resources will forward any original documents to Employee Health. Upon completion of the initial infection control requirements, Employee Health will conduct all necessary follow-up.
4. It is important to note that failure to comply with the stated requirements will prohibit the individual from assuming their position with SCCHC.

See policy: HR-5

4.00 Laboratory Policies

4.01 Laboratory Reporting/Tracking of Laboratory Tests Results (Waived/Off Site Tests)

Purpose
The purpose of this policy is to provide consistent and accurate reporting of all laboratory results to the appropriate providers. This policy will describe both waived testing and off-site testing results.

Policy: Waived Testing
South Cove Community Health Center's clinic performs the following 7 waived tests as part of the laboratory daily function:

1. **Hemoglobin (Hgb): blood**
2. **Urine Dip: urine**
3. **hCG Pregnancy Test: urine**
4. **Beta Strep Group A Rapid Screen: tonsils/throat swab**
5. **Glucose testing: blood**
6. **Hemoccult/Stool Guaiac: fecal material**
7. **Influenza A and B rapid screen: nasal/nasopharyngeal swab**

Results of laboratory tests are recorded/reported according to the following guidelines:

1. **Hemoglobin results are:**
    1. Recorded in the laboratory Hgb log book and initialed by lab staff.
    2. Recorded in the eClincalWorks (eCW) electronic medical record.
    3. Any Hgb result less than 10.0 or greater than 17.0 is to be repeated and reported to provider ASAP, and the results entered into eClinicalWorks.

2. **Urine Dip results are:**
    1. Recorded in the urine dip log book and initialed by lab staff.
    2. Recorded in eClinicalWorks.
    3. Any test results with the following criteria are reported immediately to the provider or designated staff by eClinicalWorks:

        1. Glucose < 50 and > 250
        2. Bilirubin > small
        3. Ketone > small
        4. Blood > moderate
        5. Protein > 2+
        6. Urobilinogen +
        7. Leukocytes > moderate

3. **hCG Urine Pregnancy Test results are:**
    1. Recorded in the hCG log book and initialed by lab staff.
    2. Recorded in eClinicalWorks.
    3. Lab staff will notify provider of positive results.

4. **Beta Strep Group A Rapid Screen results are:**
    1. Recorded in the Beta strep log book and initialed by the lab staff.
    2. Recorded in eClinicalWorks.
    3. Lab staff will notify provider of positive results.
    4.
5. **Glucose results are:**
    1. Recorded in the Glucose log book and initialed by the lab staff.
    2. Recorded in eClinicalWorks.
    3. Lab staff will notify provider of glucose ranges less than 60 mg/dL or greater than 300mg/dL.
6. **Hemoccult/Stool Guaiac test results are:**
    1. Recorded in Stool Guaiac log book and initialed by the lab staff.

2. Recorded in eClinicalWorks.
3. Lab staff will notify provider of positive results.

7. **Influenza A and B test results are**
    1. Recorded in the Influenza log book and initialed by lab staff.
    2. Recorded in eClinicalWorks.
    3. Lab staff will notify provider of positive results.

Quality control:
Quality control checks are maintained according to manufacturer's guidelines and are recorded in the respective log books within the lab.

Off-site Laboratory Testing:
Discrepancies in lab results will be handled in the following manner:

- Lab tests performed at BIDMC: lab staff will notify designated clinical department staff and request BIDMC to repeat the test.
- Waived lab tests performed at SCCHC: lab staff will verify testing supplies used are not expired and repeat the test. If there is still a discrepancy, lab staff will notify the clinical provider, request another specimen be collected, and send specimen to BIDMC for testing.
- Offsite testing and results completed by BIDMC will be documented when received daily into daily log book.

Pending lab results:
Pending results more than two weeks old must be investigated and an explanation recorded on the print out status lab report by the lab staff receiving the report.

Critical Values (CV) (per BIDMC's Laboratory manual):
Critical Values are described as "laboratory results which indicate a condition likely to require prompt clinical intervention." The laboratory must communicate these results immediately to a health care provider (clinical provider's name is noted on the lab requisition) in accordance with policy. In case of a report needing to be communicated from BIDMC lab to a SCCHC provider/staff after closing hours, the BIDMC lab staff will call the SC main clinic number 617-482-7555, listen for the prompt to connect to the appropriate clinical provider/department and listen for the name of the on-call staff member and telephone number to call to deliver lab results.

1) Critical values are posted in the lab, in each clinical department and in the central providers' room within the health center.
2) Date and time received will be recorded in the daily log book.
3) Results will be hand delivered to the clinical provider/designated department clinical staff immediately.
4) The provider will then make the decision for the next action to be taken for the patient. The provider's orders may include having the patient return to the clinic or to closest hospital to have another blood sample taken to determine current lab test result, to potentially rule out error in prior lab results, and to use in data base to make further clinical decision on patient's care.

NOTE:

1. The SCCHC providers have set the standard of an acceptable time frame within which they should receive the critical value test report and receipt by the responsible licensed caregiver of the critical test results and values performed by an offsite laboratory facility. This time frame shall be no longer than one (1) hour after the off-site laboratory has stated by their policy that the result will be available to the ordering provider following their completion of running and viewing the test results.
2. The SCCHC clinical departments will keep a log of all critical value test results reported and conduct a

monthly audit to determine if the time the critical value test result that was called to the SCCHC provider/nurse meets the criteria of the reporting laboratory and the documentation that is on the reporting result laboratory form from the offsite laboratory of when the lab specimen was tested.

4.02 Hemoglobin using HemoCue Hb 801 System

Purpose

Hemoglobin is the protein inside red blood cells that carry oxygen. HemoCue HB 801 will measure hemoglobin levels as a screening tool to monitor general health and to rule out a variety of disorders such as anemia and other medical diagnosis.

Principles of Method

The HemoCue Hb 801 System consists of an analyzer together with microcuvettes. The microcuvette serves both as a pipette and as a sample carrier. Blood is drawn into the microcuvette cavity by capillary action. The measurement takes place in the analyzer, which measures the absorbance of whole blood at an Hb/HbO2 isosbestic point (506 nm), and at a wavelength (880 nm) to compensate for possible interfering background (e.g. turbidity).

The HemoCue Hb 801 System is intended for the quantitative determination of hemoglobin in capillary or venous whole blood (K2 EDTA and Li-Heparin) in point-of-care settings. The HemoCue Hb 801 System is intended to be used to determine the hemoglobin concentration for adults, adolescents, children, and infants above 1 month old. The HemoCue Hb 801 System is for professional in vitro diagnostic use only.

Policy

Specimen Collection and Test Procedure

Glove must be worn when performing testing procedure.

For venous sample, anticoagulant EDTA vacutainer is used. Venous sample can be stored and transported for up to 24 hours at room temperature or in refrigerator before measuring. Follow the procedure below to perform a measurement on venous sample or control material.

1. If refrigerated, allow the sample to reach operating conditions. Mix thoroughly on mixer for at least 2 minutes, or invert manually 8–10 times. When mixing controls, follow instructions for the control material used.
2. Place a drop of blood or control material onto a hydrophobic surface, using a suitable transfer device.
3. Fill the microcuvette completely—in one single step. Do not refill. Do not let more than 40 seconds pass between step 3 (filling) and step 6 (inserting the microcuvette into the microcuvette holder).
4. Wipe off excess blood from the outside of the microcuvette. Make sure that no blood is drawn out from the microcuvette.
5. Make a visual inspection. If the microcuvette is not completely filled with blood, or if there are air bubbles, discard and fill a new microcuvette.
6. Make sure the analyzer is in Ready State. Insert the filled microcuvette into the microcuvette holder and press down. The result will be displayed within a second.
7. When a result is displayed, remove and discard the microcuvette. The result is displayed for 10 seconds after measurement.

For Capillary blood, follow the procedure below to collect a capillary sample and perform a measurement.

1. Make sure the patient’s hand is warm and relaxed. Use the middle or ring finger for sampling. Avoid fingers with rings on. Sample at the side of the fingertip for best blood flow and comfort.
2. Clean the fingertip and allow to dry.
3. Using your thumb, lightly press the finger from the top of the knuckle towards the fingertip to stimulate blood flow.
4. Press lightly towards the fingertip, and puncture using a high-flow lancet.
5. Wipe away the first 2 or 3 drops of blood. Press lightly towards the fingertip until another drop of blood appears.
6. Fill the microcuvette. Make sure the blood drop is large enough to fill the microcuvette completely in one single step. Do not refill. Do not let more than 40 seconds pass between step 6 (filling) and step 9 (inserting the microcuvette into the microcuvette holder).
7. Wipe off excess blood from the outside of the microcuvette. Make sure that no blood is drawn out from the microcuvette.

8. Visually inspect the microcuvette. Precaution: If the microcuvette is not completely filled with blood, or if there are air bubbles, discard and fill a new microcuvette.
9. Make sure the analyzer is in Ready State. Insert the filled microcuvette into the microcuvette holder and press down. The result will be displayed within a second.
10. When a result is displayed, remove and discard the microcuvette. The result is displayed for 10 seconds after measurement.

Storage and Handling
Store unopened HemoCue Hb 801 Microcuvettes in 10–40 °C (50–104 ° F) Microcuvettes in the vial (opened or unopened) are stable until expiration date, printed on package. Use the microcuvettes prior to expiration date. Microcuvettes in the vial (opened or unopened) can be stored for a shorter period of time (6 weeks) between -18–50 °C (0–122° F). Keep all unused microcuvettes in the original package.

Maintenance
Clean analyzer each day after use. Follow this procedure to first clean and then disinfect the analyzer. Cleaning is an important step to prepare for an efficient disinfection.

- Cleaning agents: water, alcohol (20–70 %), mild detergent, or recommended disinfectant.
- Disinfectant: Super Sani-Cloth Germicidal Disposable Wipe, EPA Reg. No. 9480-4. Only use disinfectant recommended by HemoCue. Read and follow instructions for the disinfectant used.

1. Turn off the analyzer, and remove the microcuvette holder.
2. Lightly dampen a cotton swab with cleaning agent. Clean all surfaces in the cavity; make sure to clean all the way down.
3. Clean the microcuvette holder with cleaning agent. Let the microcuvette holder dry outside of the analyzer, while moving on to step 4.
4. Lightly dampen a wipe with cleaning agent, and clean all outer surfaces. Now the analyzer is ready for disinfection. Follow steps 5-8 to disinfect. If no disinfection is needed, make sure all parts are completely dry before reattaching the microcuvette holder. Disinfection Before disinfection, the analyzer must be cleaned (steps 1-4 above).
5. Wipe the microcuvette holder repeatedly with a new Super Sani-Cloth Germicidal Disposable Wipe. Make sure that all surfaces stay wet for 2 minutes.
6. Wipe all outer surfaces repeatedly with a Super Sani-Cloth Germicidal Disposable Wipe. Make sure that all surfaces stay wet for 2 minutes.
7. Make sure that the surfaces in step 5 and 6 have been wiped repeatedly in order to stay wet for the whole 2 minutes (wet-time/contact time).
8. Remove any excess disinfectant, or allow to air dry. Make sure all parts are completely dry before reattaching the microcuvette holder, and turning on the analyzer.

Quality Control
The HemoCue Hb 801 Analyzer has an internal quality control, a self-test. It automatically verifies the performance of the analyzer every time the analyzer is turned on, when the microcuvette holder is put back into place after removal, and every hour when in use.

The HemoCue Hb 801 System is calibrated against the hemiglobincyanide (HiCN) method, the international reference method recommended by ICSH (International Council for Standardization in Haematology), for the determination of the hemoglobin concentration in blood. The system is factory calibrated and needs no further calibration.

As of November 9th, 2020, letter from HemoCue advised regarding HemoCue Hb 801 Analyzer that machine does not require recalibration of the analyzer or testing of external controls.

Documentation
Any hemoglobin result less than 10 or greater than 17 gram/dl, repeat the test, report results to provider as soon as possible.

Document patient's name, South Cove MR#, results and initial of staff performing lab test on Hgb log book. Result will be documented into eClinicalWorks**.**

All records will be kept for 4 years in accordance to regulation requirements.

Disposal
Discard blood specimen, microcuvettes, lancets and all material in contact into biohazard trash or sharps container once results are obtained and documented. Patient specimens and all material that comes in contact should be handled as potentially infectious and disposed with proper precaution.

References
HemoCue Hb 801 Operating Manual

4.03 Urine Dip using Siemens Multistix 10 SG Reagent Strip Test

Purpose

Multistix 10 SG Reagent Strip Test Urinalysis include test pads for protein, blood, leukocytes, nitrite, glucose, ketone (acetoacetic acid), pH, specific gravity, bilirubin and urobilinogen. The strips are intended for use in at-risk patient groups to assist diagnosis in the following areas: kidney function, urinary tract infections, carbohydrate metabolism (e.g., diabetes mellitus), and liver function. The strips also measure physical characteristics, including acid-base balance and urine concentration. Test results can be used along with other diagnostic information to rule out certain disease states and to determine if microscopic analysis is needed. This test is used for screening and is not intended for diagnostic use. Any positive results from urine sample may be sent to BIDMC for further testing.

Principle of Method

Siemens Multistix 10 SG reagent strips are ready to use upon removal from the bottle and the entire reagent strip is disposable. The strips are read visually. The directions must be followed exactly. Accurate timing is essential to provide optimal results. The reagent strips must be kept in the bottle with the cap tightly closed to maintain reagent reactivity. For the chemical principles of each test area, please refer to the product insert found in the box with each bottle of Multistix 10 SG.

Policy

Specimen Collection and Test Procedure

Collect freshly-voided urine in a clean container and test it as soon as possible. The container should allow for complete dipping of all reagent strip areas. A first-morning specimen is preferred but random collections are acceptable. Test the urine within two hours after voiding. If unable to test within the recommended time, refrigerate the specimen immediately and let it return to room temperature, between 15–30 °C (59–86 °F), before testing.

1. Upon opening a new box of Siemens Multistix Reagent strips, label the date of opening on bottle.
2. The lab staff receives the urine sample with patient name, date and South Cove MR # from the patient.
3. Visually examine and record in log sheet color and appearance of urine.
4. Mix urine well just before testing, but do not centrifuge.
5. Remove a strip from the bottle and replace the cap. Note, do not touch the test pad on the strip.
6. Completely immerse all the test pads of the strip into urine and immediately remove the strip to avoid dissolving out reagents.
7. While removing run the edge of the strip against rim of container to remove excess urine. Start Timer.
8. Hold stripe in horizontal position to prevent possible mixing of chemicals from adjacent reagent area and/or contaminating the hands with urine.
9. Visually read and compare reagent areas to corresponding color chart on the bottle labeling the times observed on the label to obtain result for each test area.
10. Hold strip carefully, avoid applying strip directly on the color chart as this will result in the urine soiling the chart.
11. Proper reading is critical for optimal results:
    - 30 seconds – glucose and bilirubin
    - 40 seconds – ketone
    - 45 seconds – specific gravity
    - 60 seconds – pH, protein, urobilinogen, blood, and nitrate
    - 120 seconds – leukocytes

Storage and handling

All unused strips must remain in the original bottle. Transfer to any other container may cause reagent strips to deteriorate and become unreactive. Store at temperatures between 15–30°C (59–86°F). Do not use the strips after their expiration date. Do not store the bottle in direct sunlight and do not remove the desiccant from the bottle.

Quality Control

Siemens Multistix 10 SG reagent strips are recommended to be tested with negative and positive control when you first open a new bottle.

South Cove will perform two levels of controls upon opening a new bottle of Siemens Multistix 10 SG reagent strips. Bottle lot number and expiration dates will be documented into Urine Dip log book. Positive and negative control lot number, expiration dates and result of control testing will also be documented into Urine Dip log book.

South Cove uses Bio-Rad qUAntify Advance Control Levels 1 and 2
Level 1: Negative
Level 2: Positive
Control product should be treated as patient sample and instructions for use should be followed as noted in above section (Specimen Collection and Testing Procedure) and documented into Urine dip log book. Please refer to Bio-Rad product insert for level 1 and 2 control ranges.

If control is not within expected ranges follow the corrective action below.

1. Check expiration dates on control bottle and urine reagent strips. If supplies are expired obtains new supplies. If supply are not expired repeat test.
2. If control is still out of range inform provider and send urine samples to BIDMC for testing.

This control product will be stable until the expiration date when stored unopen at 2 to 8 ^{o}C (36–46 ^{o}F). Once opened controls will be stable for 31 days when stored tightly capped at 2–25 ^{o}C (36–77 ^{o}F).

Documentation
Any test result with the following criteria are reported immediately to the provider or designated staff in eClinicalWorks.

1. Glucose < 50 and > 250
2. Bilirubin > small
3. Ketone > small
4. Blood > moderate
5. Protein > 2+
6. Urobilinogen +
7. Leukocytes > moderate

Document patient's name, South Cove MR#, results and initial of staff performing lab test on Urine Dip log book. Result will be documented into eClinicalWorks**.**

All records will be kept for 4 years in accordance to regulation requirements.

Disposal

Discard all specimen into the flush rim sink in the soil utility room and all material in contact into biohazard trash once results are obtained and documented. Patient specimens and all material that comes in contact should be handled as potentially infectious and disposed with proper precaution.

References
Siemens: Multistix 10SG product insert
Bio-Rad qUAntify Advance Control Levels 1 and 2 product insert

4.04 Urine hCG using ICON 20 hCG Urine Test

Purpose
ICON 20 hCG Urine Test is a simple immunoassay for the qualitative detection of human Chorionic Gonadotropin (hCG) in Urine for the early detect of pregnancy.

Principle of Method
The ICON 20 hCG Urine Test is a rapid test for detecting hCG qualitatively. The test employs a solid-phase chromatographic immunoassay technology to selectively detect elevated levels of hCG in serum or urine with a high degree of sensitivity. A fixed volume of sample is applied to the sample well. If hCG is present in the sample above or at the detection level, pinkish purple lines will appear at Test position (T) and Control position (C). If hCG is present below the detection level or not present in the sample, only one line at the Control position (C) will appear. Therefore, the presence of two colored lines, one at the Test position and the other at the Control position indicates a positive result, while the absence of the line at the Test position indicates a negative result.

Policy
Specimen Collection and Test Procedure
First morning urine specimen is preferred since it generally contains the highest concentration of hCG. However, randomly collected urine specimens may be used. Collect the urine specimen in a clean glass or plastic cup. Urine containing excessive bacterial contamination should not be used since spurious results may occur with such specimens. If testing will not be performed immediately, the specimens may be refrigerated 2 to 8 °C (36–46 °F) for up to 48 hours prior to testing.

1. The lab staff receives the urine sample with patient name, date and South Cove MR # from the patient.
2. Open one ICON 20 hCG Urine Test pouch, and label ICON 20 hCG with patient ID.
3. Using provided disposable dropper, allow the dropper to fill with urine sample without air bubbles.
4. Holding the dropper in vertical position add 3 drops of sample into the sample well. Start timer.
5. Read results at 3-5minute.

Interpretation of Test Results
- **Positive**: Two pinkish-purple lines, one each at the Test position (T) and at the Control position (C). One of the following indicates a positive test result:
    a. Two strong pinkish-purple lines, one each in the Test (T) and Control (C) positions.
    b. One strong pinkish-purple line at the Test position (T) and one light pinkish-purple line at the Control position (C).
    c. One light pinkish-purple line at the Test position (T) and one strong pinkish-purple colored line at the Control position (C).
- **Negative**: In the absence of hCG, or if the hCG concentration is below the detection limit of the test, there will be no apparent line at the Test position (T). The line at the Control position (C) should be clearly readable.

Storage and handling
ICON 20 hCG Serum/Urine Test kit is to be stored at 2–30 °C (36–86 °F) in the sealed pouch.

Quality Control
Internal Control: Each ICON 20 hCG Serum/Urine Test device has a built-in control. The Control line is an internal positive procedural control. A distinct pinkish-purple Control line should appear at the C position indicating an adequate sample volume was used, the sample and reagent are wicking on the membrane, and the test reagents at the Control line and the conjugate-color indicator are reactive. In addition, the clearing background in the Result window is considered as an additional procedural control by providing a distinct readable result. This may be considered an internal negative procedural control. If background color appears in the Result window, interfering with your ability to read the test result and obscuring the formation of the Control band, your result may be invalid.

External controls: ICON 20 hCG recommends that a control be used for testing before using a new lot or a new shipment of kits to assure that the test devices are working properly and that the assay procedure was followed correctly.

South Cove will perform two levels of controls upon opening a new box of ICON 20 hCG testing kits. Kit lot number and expiration dates for will be documented into hCG log book. Positive and negative control lot number, expiration dates, and results of control testing will also be documented into hCG log book.

South Cove uses Bio-Rad qUAntify Advance Control Levels 1 and 2

Level 1: Negative

Level 2: Positive

Control product should be treated as patient sample and instructions for use should be followed as noted in above section (Specimen Collection and Testing Procedure) and documented into log sheet daily.

If control band does not appear on test kit follow the corrective action below.

1. Check expiration dates on control bottle and hCG test kits. If supplies are expired obtains new supplies. If supply are not expired repeat test.
2. If control band still does not appear contact provider and send urine samples to BIDMC for testing.

This control product will be stable until the expiration date when stored unopen at 2 to 8 ºC (36–46 ºF). Once opened controls will be stable for 31 days when stored tightly capped at 2–25 ºC (36–77 ºF).

Documentation

Document patient's name, South Cove MR#, results and initial of staff performing lab test on hCG log book. Result will be documented into eClinicalWorks**.** Lab staff will notify provider of positive results.

All records will be kept for 4 years in accordance to regulation requirements.

Disposal

Discard all material in contact into biohazard trash once results are obtained and documented. Patient specimens and all material that comes in contact should be handled as potentially infectious and disposed with proper precaution.

References

ICON 20 hCG Product Instruction insert

4.05 Rapid B Strep (Group A) using OSOM Ultra Strep A Test

Purpose

The OSOM Ultra Strep A Test is a color immunochromatographic assay intended for the qualitative detection of Group A Streptococcal antigen directly from throat swab specimens. For laboratory and professional in vitro diagnostic use only. It is intended for screening, and can be confirmed by throat culture sent to BIDMC reference lab.

Principle of Method

The OSOM Ultra Strep A Test is a color immunochromatographic assay using Dual Label Technology (DLT). DLT uses antibody labeled color particles coated at two separate locations in the test device. DLT allows greater sensitivity than the conventional single label technology without sacrificing specificity. In the test procedure, a throat swab is subjected to a chemical extraction of a carbohydrate antigen unique to Group A Streptococcus. The Test Stick is then placed in the extraction mixture and the mixture migrates along the membrane. If Group A Streptococcus is present in the sample, it will form complexes with the anti-Group A Streptococcus antibody conjugated color particles located at two separate locations on the Test Stick. The complex will then be bound by the anti-Group A Streptococcus capture antibody and a visible blue Test Line will appear to indicate a positive result. A red Control Line will also appear to indicate the test is valid.

Policy

Specimen Collection and Testing Procedure

Glove must be worn when performing testing procedure.

1. Receive order for throat swab from clinical department provider with patient name South Cove MR # and date. Enter information into daily log sheet and Rapid B Strep logbook.
2. Collect specimens with a sterile swab from the tonsils and/or the back of the throat taking care to avoid the teeth, gums, tongue or cheek surfaces.
    - Do not use swabs with cotton tips, wooden shafts or calcium alginate swabs.
    - Do not use a collection system that contains charcoal or semisolid transport media.
    - Process the swab as soon as possible after collecting the specimen. If you do not perform the OSOM Ultra Strep A test immediately, store the swabs either at room temperature or refrigerated for up to 48 hours. The swabs and the test kit must be at room temperature prior to running the test.
3. Just before testing, squeeze the Extraction Reagent Bottle to crush the ampule inside. Note: The ampule must be crushed before proceeding to the next step.
4. Vigorously shake the Extraction Reagent Bottle 3–5 times to mix the contents. The liquid in the Extraction Reagent Bottle should turn from pink to light yellow. Add only 6 drops of the Extraction Reagent to the Test Tube. Note: Adding more than 6 drops during this step may provide erroneous results
5. Immediately put the swab into the Test Tube. Vigorously mix the solution by rotating the swab forcefully against the side of the Test Tube at least ten (10) times. Best results are obtained when the specimen is vigorously extracted in the solution. Start timer. Let stand for 2 minutes.
6. Express as much liquid as possible from the swab by squeezing the sides of the tube as the swab is withdrawn. Discard the swab.
7. Remove the Test Stick(s) from the container; re-cap the container immediately. Place the Absorbent End of the Test Stick into the extracted sample. Start timer.
8. Read results at 5 minutes. Positive results may be read as soon as the red Control Line appears. Negative results must be confirmed at 5 minutes. Results are invalid after the read time.

Interpretation of Test Results

- **Positive:** A blue Test Line and a red Control Line is a positive result. A positive result means that the assay detected Group A Streptococcus antigen in the specimen. Note that the blue line can be any shade of blue and can be lighter or darker than the line.
- **Negative:** A red Control Line but no blue Test Line is a negative result. A negative result means that no Group A Streptococcus antigen was detected, or the levels of antigen in the specimen were below the detection level of the assay.
- **Invalid:** If after 5 minutes, no red Control Line appears or background color makes reading the red Control Line impossible, the result is invalid. If this occurs, repeat the test using a new sample.
- **Note:** A blue or red line that appears uneven in color density is still considered a valid line. In some cases,

a trail of color may remain in the background; as long as the Test Line and Control Line are visible, the results are valid.

Storage and Handling
Store lab strips and reagents tightly capped at 15-30C (59-86F). Do not use test strip, reagent, or control after the expiration date. Store Extraction Reagent Bottles inside the box. Avoid exposure to light. Avoid dropping Extraction Reagent Bottles as this may cause ampule breakage.

Quality Control
Each kit contains Positive and Negative Control material. The controls are for external quality control testing. Use the Controls to test that the extraction reagents and the Test Sticks are working properly. Also use the Controls to test that you are able to correctly perform the test procedure, including the antigen extraction portion of the test procedure. Use Group A and non Group A Streptococcus ATCC reference strains as external controls. Sekisui Diagnostics recommends that positive and negative external controls be run with each new lot.

If control is not within expected ranges follow the corrective action below.

1. Check expiration dates of the testing kit. If testing kit is expired obtain new kits. If kits are not expired repeat test.
2. If control is still out of range inform provider and send urine samples to BIDMC for testing.

Documentation
Document patient's name, South Cove MR#, results and initial of staff performing lab test on Strep log book. Result will be documented into eClinicalWorks**.** Lab staff will notify provider of positive results.

All records will be kept for 4 years in accordance to regulation requirements.

Disposal
Discard all material in contact into biohazard trash once results are obtained and documented. Patient specimens and all material that comes in contact should be handled as potentially infectious and disposed with proper precaution.

References
OSOM Ultra Strep A Test Product Insert

4.06 Blood Glucose using HemoCue Glucose 201 System

Purpose

Blood glucose is the sugar found in blood and is the body's main sources of energy. The HemoCue Glucose 201 will test capillary whole blood to determine blood glucose levels and to determine if glucose level are within normal ranges.

Principles of Method

The HemoCue Glucose 201 technique is based on an optical measuring microcuvette of a small but precise volume and short light path. The microcuvette cavity contains reagents deposited on its inner walls. The blood sample is drawn into the cavity by capillary action and is mixed spontaneously with the reagents. The microcuvette is then placed in a HemoCue Glucose 201 Analyzer in which the transmittance is measured and the absorbance and plasma equivalent glucose level is calculated. Thus the technique makes it possible to sample the blood, mix and chemically react it with the reagents in the same microcuvette as is used for measurement.

The microcuvette is made of polystyrene plastic and contains a cavity that holds approximately 5 µL of specimen. The distance between the walls of the optical window is about 0.16 mm, which permits photometric determination of glucose in undiluted whole blood or control material.

The chemical reaction in the cavity has two phases; hemolysis, and the glucose reaction. Hemolysis, the disintegration of erythrocyte membranes, is caused by saponin. The glucose reaction is a modified glucose dehydrogenase method in which a tetrazolium salt is used to obtain a quantification of glucose in visible light. α-D-glucose is transformed to β-D-glucose using mutarotase. Glucose dehydrogenase acts as a catalyst for the oxidation of β-D-glucose, to form NADH, which in the presence of diaphorase produces a colored formazan with MTT, a tetrazolium salt. The formazan is quantified photometrically using a two wavelength photometric method at 667 nm and 840 nm.

Policy

Specimen Collection and Testing Procedure

Glove must be worn when performing testing procedure.

For venous sample, anticoagulant EDTA vacutainer is used. Venous sample can be stored and transported for up to 24 hours at room temperature or in refrigerator before measuring. Follow the procedure below to perform a measurement on venous sample or control material.

1. If refrigerated, allow the sample to reach operating conditions. Invert manually 8–10 times. When mixing controls, follow instructions for the control material used.
2. Place a drop of blood or control material onto a hydrophobic surface, using a suitable transfer device.
3. Fill the microcuvette completely—in one single step. Do not refill. Do not let more than 40 seconds pass between step 3 (filling) and step 6 (inserting the microcuvette into the microcuvette holder).
4. Wipe off excess blood from the outside of the microcuvette. Make sure that no blood is drawn out from the microcuvette.
5. Make a visual inspection. If the microcuvette is not completely filled with blood, or if there are air bubbles, discard and fill a new microcuvette.
6. Make sure the analyzer is in Ready State. Place the microcuvette into the cuvette holder and start measurement as soon as possible but no later than 40 seconds after filling the microcuvette by gently pushing the cuvette holder to its measuring position.
7. After 40 –240 seconds, the glucose value of the sample is displayed. The result will remain on the display as long as the cuvette holder is in the measuring position. DO NOT remeasure the microcuvette.

   For Capillary blood, follow the procedure below to collect a capillary sample and perform a measurement.

   1. Make sure the patient's hand is warm and relaxed. Use the middle or ring finger for sampling. Avoid fingers with rings on. Sample at the side of the fingertip for best blood flow and comfort.
   2. Clean the fingertip and allow to dry.
   3. Using your thumb, lightly press the finger from the top of the knuckle towards the fingertip to stimulate blood flow.
   4. Press lightly towards the fingertip, and puncture using a high-flow lancet.

5. Wipe away the first 2 or 3 drops of blood. Press lightly towards the fingertip until another drop of blood appears.
6. Fill the microcuvette. Make sure the blood drop is large enough to fill the microcuvette completely in one single step. Do not refill. Do not let more than 40 seconds pass between step 6 (filling) and step 9 (inserting the microcuvette into the microcuvette holder).
7. Wipe off excess blood from the outside of the microcuvette. Make sure that no blood is drawn out from the microcuvette.
8. Visually inspect the microcuvette. If the microcuvette is not completely filled with blood, or if there are air bubbles, discard and fill a new microcuvette.
9. Make sure the analyzer is in ready state. Place the microcuvette into the cuvette holder and start measurement as soon as possible but no later than 40 seconds after filling the microcuvette by gently pushing the cuvette holder to its measuring position.
10. After 40 –240 seconds, the glucose value of the sample is displayed. The result will remain on the display as long as the cuvette holder is in the measuring position. DO NOT remeasure the microcuvette.

Storage and Handling
Store unopened HemoCue Glucose 201 Microcuvettes below 46 °F (8° C) (incl. storage in a freezer). Note, microcuvettes stored in a freezer must be allowed to reach room temperature 15–30 °C (59-86 °F) (approx. 30 minutes) before analysis. Microcuvettes kept in an opened vial are stable for 30 days when stored in a refrigerator at 2–8 °C (35–46 °F). After breaking the seal, the vial can be stored at room temperature 15–30 °C (59–86 °F) for up to 3 days. Close the lid immediately after microcuvettes are removed from the vial.

Maintenance
The cuvette holder should be cleaned after each day of use.

1. Pull the cuvette holder out to the loading position.
2. While pressing the catch, carefully rotate the cuvette holder sideways in open position as far as possible to the left.
3. Remove the cuvette holder from the analyzer, it will come off the stainless steel pin it rotates on.
4. Clean the cuvette holder with alcohol (20–70 %) or mild detergent. Wait 15 minutes before replacing the cuvette holder and using the analyzer. Make sure the cuvette holder is dry before inserting. The optical parts should be cleaned when directed to do so in the Troubleshooting Guide.

Dirty optical parts may cause an error code. Follow step 1–3 under Daily maintenance and then clean optical parts as follows. Make sure that the HemoCue Cleaner reaches both upper and lower cover glasses.

1. With the cuvette holder removed from the analyzer push the Cleaner into the opening of the optic unit, as far in as possible. Move from side to side 5–10 times, see picture 5b and thereafter push in and pull out the Cleaner 5–10 times, cleaning the cover glasses, placed to the left, see picture 5c. If the Cleaner is stained, repeat with a new Cleaner.
2. Wait 15 minutes before replacing the cuvette holder and using the analyzer. Make sure the cuvette holder is dry before inserting. The cover may be cleaned with alcohol (20–70 %) or mild detergent.

As an alternative to the HemoCue Cleaner, a lint free cotton swab, non-pretreated, moistened with alcohol (20–70 % without additive) or water may also be used. If a cotton swab is used make sure it is not too wet and not too dry. Use a dry swab to wipe away excess liquid in the optic house after cleaning with a moistened swab. To avoid scratches on the cover glasses, only the cotton part of the swab should come in contact with the cover glasses.

Quality Control
The HemoCue Glucose 201 Analyzer has an internal electronic self-test. Every time the analyzer is turned on, it will automatically verify the performance of the optronic unit of the analyzer. This test is performed at regular intervals if the analyzer is left turned on. The HemoCue Glucose 201 system must be verified on the days of testing using at least one level of commercially available controls.

Recommended control solution currently in use at South Cove is Glucotrol-AQ manufactured by Eurotrol. GlucoTrol-AQ is a quality control material containing a known glucose concentration in clinically relevant ranges. When measured like a patient sample, the regular use of the quality control material can provide proof for proper functioning of the HemoCue Glucose 201 system. The control product should be treated as a patient sample and instructions for use should be followed as noted in above section (Specimen Collection and Testing Procedure) and documented into Glucose log daily.

Eurotrol GlucoTrol-AQ must be stored in refrigerator at 2–8 °C (35–46 °F). Stored at this temperature it is guaranteed stabled as indicated until he expiration date on the outer box and vial. After opening the vial, GlucoTrol-AQ is stable for 1 month when properly closed and stored at 2-30 °C (35-86 °F).

Documentation
The measuring range is 0–444 mg/dL (24.6 mmol/L). Results above 444 mg/dL (24.6 mmol/L) will be displayed as HHH and should be confirmed with another laboratory method.

When result is less than 60 mg/dl or greater than 300 mg/dl, repeat the test, report results to provider as soon as possible.

Document patient's name, South Cove MR#, results and initial of staff performing lab test Glucose log book. Result will be documented into eClinicalWorks**.**

All records will be kept for 4 years in accordance to regulation requirements.

Disposal
Discard blood specimen, microcuvettes, lancets and all material in contact into biohazard trash or sharps container once results are obtained and documented. Patient specimens and all material that comes in contact should be handled as potentially infectious and disposed with proper precaution.

References
HemoCue Glucose 201 Operating Manual
Eurotrol GlucoTrol-AQ product insert

4.07 Hemoccult/Stool Guaiac using McKesson Fecal Occult Blood Test Enhanced Readability

Purpose
The Fecal Occult Blood Test is a rapid, convenient and qualitative method for detecting occult blood in the stool. This is only a screening test, do not use this test as a diagnostic test.

Policy
Specimen Collection and Preparation
Nurse assistants will educate and instruct patient on preparation as recommended by McKesson noted below. All supplies and information are given to patient by provider or nursing assistants. Label on specimen card will include names of patient, South Cove MR#, and provider information. The tests may be prepared and developed immediately, or prepared and stored at room temperature, protected from heat and light for up to twenty-one (21) days before developing. Keep testing area, hands, etc. clean and free from blood to avoid false positive results.

A red-meat-free, high residue diet is recommended, starting two days before testing and continuing through the test period. Raw fruits and vegetables which contain peroxidase-like substances (turnips, broccoli, horseradish, cauliflower, cantaloupe, parsnips, red radish etc.) should be avoided during the test period.

SUGGESTED DIET DURING TEST PERIOD
Vegetables. . . . . Raw and cooked, especially lettuce, spinach and corn
Fruits. . . . . .Prunes, grapes, bran cereals, apples and plums
Peanuts . . . . . Moderate amounts
Popcorn. . . . . .Moderate amounts
Well-Cooked Chicken. . . . . Moderate amounts
Canned Tuna. . . . . .Moderate amounts

A diet such as this helps reduce the number of false positive test results and at the same time provides roughage to help uncover silent lesions which may bleed only intermittently. If any of the above foods are contraindicated or known to cause patient discomfort, patient should be instructed not to eat them or to make appropriate substitutions. Any concerns by patient should be consulted with provider prior to testing.

Interfering Substances
There are some oral medications such as aspirin, corticosteroids, reserpine phenylbutazone, indomethacin, etc. that can cause gastrointestinal irritation and occult bleeding in some patients. Ascorbic acid (Vitamin C) taken in units greater than 250 mg per day may cause false negative results. Iron or preparations containing Iron may cause false positive results. Two (2) days prior to and during the test period such medications should be avoided. Patients with bleeding from other conditions such as hemorrhoids, dental work, constipation or menstrual bleeding should not be tested while such conditions are present. Do not collect a specimen if patient is using rectal preparations. The provider ordering test should be consulted when discontinuing prescription medications.

Test Instructions
McKesson Consult Fecal Occult Blood Test Slides:

1. **Slide Identification**: Identify each slide with patient's name, South Cove MR#, name of provider and date.
2. **Slide Preparation**: 1. With an applicator, apply a thin smear of stool inside Area indicated with Roman numeral I. Using the same applicator repeat from a different portion of the stool for Area II. Discard the applicator in the biohazard trash after use.
3. **Slide Development**: 1. On the back of slide, open perforated section, marked 1 and 2. 2. Apply two (2) or more drops of McKesson Consult Fecal Occult Blood Test Developing Solution to exposed test paper. 3. Read results between thirty (30) seconds and sixty (60) seconds. a) Any trace of blue is positive for occult blood. b) No indication of blue is negative.

Quality Control and Performance Standards Development:
Performance standards on the slides allow for testing the function and stability of the slides and developer. A positive (+) performance standard and a negative (-) performance standard are located under the perforated flap on the back of the

slide. It is important that the Performance Standards be developed after specimens to avoid interference or prejudice of test interpretation.

1. Add one (1) drop of developer directly onto control area (between positive (+) and negative (-) performance standards.)
2. Read results within thirty (30) seconds. The positive standard contains a hemoglobin derived catalyst. After addition of the developer, a blue color should appear within thirty (30) seconds. The negative standard should not show a blue color. If the standards do not react as expected, the test results should be regarded as invalid. Invalid results should be reported to provider and repeat of test may be necessary.

A light blue discoloration may be noticed on the guaiac test paper, which does not affect the accuracy or test performance when interpreted according to the recommended procedure. When developer is added directly over the fecal smear on a discolored slide, the blue color migrates outward and forms a blue ring at the edge of the wetted area, this blue ring would be considered a negative result. The guaiac paper around the fecal smear will remain off white in color. Any blue on the edge of or within the fecal smear would be considered a positive result. Proper storage will prevent discoloration.

Do not use any of the test components after the expiration dates. Lot number and expiration date of slides and developer are recorded on log sheet on the date when Fecal Occult Blood Tested is performed.

Special note: Test results should not be interpreted by individuals with blue color blindness. All lab staff are required to take and pass the Ishihara's Design Chart Test for color vision.

Documentation
Document patient's name, South Cove MR#, card lot number, reagent lot number, expiration dates, results and initials of staff performing test on stool guaiac log. Record results in eClinicalWorks. Lab staff will notify provider of positive results.

All records will be kept for 4 years in accordance to regulation requirements.

Disposal
Discard specimen, slides, applicators and all material in contact into biohazard trash once results are obtained and documented. Patient specimens and all material that comes in contact should be handled as potentially infectious and disposed with proper precaution.

References
McKesson Consult FOBT product insert

4.08 Influenza A and B Using QuickVue Influenza A+B Test

Purpose

The QuickVue Influenza A+B test allows for the rapid, qualitative detection of influenza type A and type B antigens directly from nasal swab, nasopharyngeal swab, nasal aspirate, and nasal wash specimens. The test is intended for use as an aid in the rapid differential diagnosis of acute influenza type A and type B viral infections. The test is not intended to detect influenza C antigens. Negative results should be confirmed by cell culture; they do not preclude influenza virus infection and should not be used as the sole basis for treatment or other management decisions. The test is intended for professional and laboratory use.

Principle of Method

The QuickVue Influenza A+B test involves the extraction of influenza A and B viral antigens. The patient specimen is placed in the Reagent Tube, during which time the virus particles in the specimen are disrupted, exposing internal viral nucleoproteins. After extraction, the Test Strip is placed in the Reagent Tube where nucleoproteins in the specimen will react with the reagents in the Test Strip. If the extracted specimen contains influenza A or B antigens, a pink-to-red Test Line along with a blue procedural Control Line will appear on the Test Strip indicating a positive result. The Test Line for influenza A or B will develop at separate specified locations on the same Test Strip. If influenza A or B antigens are not present, or are present at very low levels, only the blue procedural Control Line will appear.

Policy

Specimen Collection and Test Procedure

Nasal Swab Sample: For optimal test performance with a nasal swab specimen, use the swabs supplied in the kit. It is important to obtain as much secretion as possible. Therefore, to collect a nasal swab sample, insert the sterile swab into the nostril that presents the most secretion under visual inspection. Using gentle rotation, push the swab until resistance is met at the level of the turbinate (less than one inch into the nostril). Rotate the swab a few times against the nasal wall.

Nasopharyngeal Swab Sample: It is important to obtain as much secretion as possible. Therefore, to collect a nasopharyngeal swab sample, carefully insert the sterile swab into the nostril that presents the most secretions under visual inspection. Keep the swab near the septum floor of the nose while gently pushing the swab into the posterior nasopharynx. Rotate the swab several times.

All clinical specimens must be at room temperature before beginning the assay. Expiration date: Check expiration on each individual test package or outer box before using. Do not use any test past the expiration date on the label.

1. Patient name, date and South Cove MR #, provider order confirm with patient. The lab staff collects specimen per instruction noted above using nasal swab.
2. Dispense all of the reagent solution into reagent tube. Gently swirl the tube to dissolve its contents.
3. Place the patient swab with sample into the reagent tube. Roll the swab at least three (3) times while pressing the head against the bottom and side of the reagent tube. Start timer. Leave the swab in reagent tube for one (1) minute.
4. Roll the swab head against the inside of the reagent tube as you remove it. Dispose of the used swab into biohazard waste container.
5. Place the test strip into the reagent tube with the arrows on the test strip pointing down. Do not handle or move the test strip until the test is complete and ready for reading.
6. Start timer and read results at ten (10) minutes. Some positive results may appear sooner. DO not read result after ten (10) minutes.

Interpretation of Test Results

- **Positive Result:**
  At ten minutes, the appearance of ANY shade of a pink-to-red Test Line, either above or below the blue Control Line, AND the appearance of a blue procedural Control Line indicates a positive result for the presence of influenza A and/or B viral antigen. Hold the test strip with the arrows pointed down.
  1. If the red line is above the Control Line, the test results are positive for type A.
  2. If the red line is below the Control Line, the test results are positive for type B.
- **Negative Result:**

At ten minutes, the appearance of ONLY the blue procedural Control Line indicates influenza A and B viral antigen were not detected. A negative result should be reported as a presumptive negative for the presence of influenza antigen. A negative result does not exclude influenza viral infection. Negative results should be confirmed by cell culture.

- **Invalid Result:**
  If at ten minutes, the blue procedural Control Line does not appear, even if any shade of a pink-to-red Test Line appears, the result is considered invalid. If at ten minutes, the background color does not clear and it interferes with the reading of the test, the result is considered invalid. If the test is invalid, a new test should be performed with a new patient sample and a new Test Strip.

Storage and Handling
Store the kit at room temperature, 59–86°F (15–30°C), out of direct sunlight. Kit contents are stable until the expiration date printed on the outer box. Do not freeze

Quality Control

Built-in Control Features

The QuickVue Influenza A+B test contains built-in procedural control features. The manufacturer's recommendation for daily control is to document these built-in procedural controls for the first sample tested each day.

The two-color result format provides a simple interpretation for positive and negative results. The appearance of a blue procedural Control Line provides forms of positive control by demonstrating sufficient flow has occurred and the functional integrity of the Test Strip was maintained. If the blue procedural Control Line does not develop at 10 minutes, the test result is considered invalid.

A built-in negative control is provided by the clearing of red background color, verifying that the test has been performed correctly. Within 10 minutes, the result area should be white to light pink and allow the clear interpretation of the test result. If background color appears and interferes with interpretation of the test result, the result is considered invalid. Should this occur, review the procedure and repeat the test with a new Test Strip.

External Quality Control

External controls may also be used to demonstrate that the reagents and assay procedure perform properly. Quidel recommends that positive and negative controls be run once for each new shipment of kits. External Positive and Negative Control Swabs are supplied in the kit. Control product should be treated as patient sample and instructions for use should be followed as noted in above section (Specimen Collection and Testing Procedure) and documented into Influenza log book.

South Cove will perform positive and negative control for opening of each new box QuickVue Influenza A+B Test kit. Kit lot number and expiration dates for will be documented into Influenza log book. Positive and negative control lot number, expiration dates, and results of control testing will also be documented into Influenza log book.

Documentation
Document patient's name, South Cove MR#, results and initial of staff performing lab test on Influenza log book. Result will be documented into eClinicalWorks**.** Lab staff will notify provider of positive results.

All records will be kept for 4 years in accordance to regulation requirements.

Disposal
Discard all material in contact into biohazard trash once results are obtained and documented. Patient specimens and all material that comes in contact should be handled as potentially infectious and disposed with proper precaution.

References
QuickVue Influenza A+B Test Product insert

4.09 Temperature Controls for Laboratory Rooms and Refrigerator

Purpose
Provide specific guidelines and instructions to maintain quality controlled standards of temperatures for both the laboratory rooms and for the refrigerator located in the laboratory. This is necessary to maintain equipment, chemicals, medicines, and laboratory specimens within acceptable temperature ranges.

Policy
Laboratory room temperature
The laboratory room temperature, in the main laboratory room and phlebotomy work space, will be maintained between 10º-40°C (50º-104°F) at all times. The relative humidity is usually maintained below 85 % (percent). If requirements for the temperature range change then the laboratory supervisor will revise the acceptable ranges.

Monitoring temperature
Laboratory staff will check the temperature noted on the digital thermometers posted in each laboratory room twice daily (once in the morning no later than 10 AM and once in the afternoon no later than 3 PM) and document this information on the temperature log sheets (see blank attached) posted in each room. The log is posted for the current month, removed at the end of the month, and placed in the monthly log book in the main laboratory at the clinic sites.
The acceptable range for the room temperature is set by the laboratory supervisor on the Fisher Scientific digital meter according to manufacturer's guidelines for the items that need to be placed in temperature control environments.

Refrigerator temperature:
The temperature of the refrigerator in the laboratory will be monitored using both a digital thermometer and a manual thermometer as a secondary check system. The temperature will be maintained between 2° and 8° C (36° - 46° F) at all times. If requirements for the temperature range change based on the items stored in the refrigerator than the laboratory supervisor will revise the standard ranges.

Monitoring temperature
Laboratory staff will check the temperature noted on the digital thermometer posted on the notice board (once in the morning no later than 10 AM and once in the afternoon no later than 3 PM) and document this information on the temperature log sheets (see blank attached) posted on the refrigerator door. The log is posted for the current month, removed at the end of the month, and placed in the central temperature log book in the main laboratory at the clinic sites.

The acceptable range for the refrigerator temperature is set by the laboratory supervisor on the digital thermometer according to the Public Health Department guidelines. An alarm mechanism on the thermometer will alert laboratory staff to any variances in the temperature above or beyond the set ranges.

Action for alarm activation
Lab personnel will note alarm and check first to see if it may have been caused by low battery. If the temperature has changed due to problems with the power source for the refrigerator then the laboratory supervisor, appropriate clinical department personnel that utilize the refrigerator, clinic site director and/or administrative personnel must be notified to alert them of problem.

Power Failure
Refrigerator located in the laboratory: The refrigerator located in the laboratory at WS site has a backup generator available in case electrical power is lost to that particular outlet.
In the event that power to this outlet or that this medication refrigerator is non-functioning, supplies will be transferred immediately to another refrigerator(s)/freezer within the site.

Use of Digital Thermometer
A copy of operations manual is available in the laboratory temperature control log book and posted in the room near thermometer. Temperature control range is set in Centigrade values. System alarm will sound when battery is low or the temperature falls above or below the set ranges.

4.10 Processing “STAT” Ordered Laboratory Specimens

Purpose
To identify the process to be followed for a laboratory specimen ordered for “STAT”/immediate processing by BIDMC laboratory

Policy:
Lab staff will do the following:

- Prepare the specimen (phlebotomy or other means of collection) in the standard manner and prepare specimen for transport to BIDMC.
- Place a STAT label on the red STAT biohazardous pick up bag.
- Call the BIDMC customer service desk at 1-617-667-5227. Document time of call, name of responsible person.
- Inform BI that the specific SC clinic has a lab specimen for STAT processing that needs to be picked up at the clinic. Other information regarding specimen must also be communicated (for example: the specimen needs to be placed on ice or frozen). BI customer service will inquire BI # and what test to be performed STAT.
- Place specimen in pickup area and check at least every 30 minutes to see that specimen has been picked up. If delay occurs, call BI again and request another pick up.

4.11 Developing Labels for Laboratory Specimens

Purpose
Identification of laboratory specimens being processed by SCCHC laboratories with patient identification labels.

Policy
Laboratory staff will do the following to create a label for each specimen collected/brought to the laboratory for processing:

1. Using BIDMC computer monitor, enter user name and password, proceed to main CCC (Center for Clinical Computing).
2. Click clinical pathology
3. Enter L for login option
4. Enter R for registration option
5. Enter patient ID number
6. Click yes if all information is correct
7. Click number of labels required

4.12 Handling Confidential Patient Laboratory Tests

Purpose
Identify procedure to be followed to maintain patient confidentiality when required by specific laboratory tests.

Policy
Confidential laboratory results are handled separately from the routine laboratory tests requested by the provider (as outlined in Lab policy 4.1).

"Confidential" will be written on the laboratory requisition form by the provider. Lab staff will put confidential on the log sheet as indicated by the provider. After specimen collected; the report of test results will be hand delivered to a staff member in the Medical Records department; and then the MR staff member writes pertinent information in the MR log book and then hand delivers the lab report to the appropriate provider/designated department staff for review/action.

Results of specific laboratory tests (for example: pregnancy test for teenagers, sexually transmitted diseases test) require that confidentiality of the patient's identification and their test results only be reported by the laboratory staff to the clinical provider and/or other specifically designated department staff.

Following standard laboratory procedures, the lab staff will log the request for the test in the lab daily log book and prepare the specimen for transport to BIDMC lab with the BIDMC regular lab specimen collection pick up.

After the lab receives the test results, the lab staff will sign the final report, document on the daily log sheet, and hand deliver the test results to the Medical Records Department.

HIV Testing according to BIDMC no longer requires confidential procedure.

4.13 Transportation of Laboratory Specimens to BIDMC from Clinics

Purpose
Provide information and schedule developed for SCCHC by BIDMC to fulfill agreement developed by both organizations to provide pick up/collection of laboratory specimens from two clinic sites.

Policy:
BIDMC has established an agreement with SCCHC to provide courier pick up/collection of laboratory specimens from the two SCCHC laboratories (Washington Street, Boston and Quincy clinic sites) to BIDMC using NOW Courier Service.

NOW Courier Service will provide:

1) Three scheduled collections of lab specimens to the Boston Washington Street site and three scheduled collections to the Quincy site Mondays through Fridays
2) Two scheduled collection on Monday through Friday to South Street and Commercial St.
3) One scheduled collection on Saturday on Washington Street, Quincy South Street and Commercial St.
4) One schedule collection on Sunday on Washington Street and Quincy site.
5) The courier is expected to arrive at the clinic locations within 15 minutes of the scheduled pick up and go into the laboratory to pick up the specimens
6) Any deviation from scheduled pick up times will be documented by the lab staff and the SCCHC Medical Director and the Executive Director will be notified ASAP.

Laboratory schedule for courier pick up of specimens (per BIDMC)

MONDAY TO FRIDAY:

Site	Pickup Time	Days of the Week
Washington Street	10:45am 4:00pm 6:00pm 7:00pm 3:00pm 1:45pm	Monday – Friday Monday – Friday Tuesday – Friday Monday Saturday Sunday
Quincy Site	12:00pm 3:30pm 5:30pm 6:30pm 3:00pm 2:00pm	Monday – Friday Monday – Friday Wednesday – Friday Monday – Tuesday Saturday Sunday
South Street	11:00am 6:00pm 1:00pm	Monday – Friday Monday – Friday Saturday
Commercial Street	11:00am 6:00pm 1:00pm	Monday – Friday Monday – Friday Saturday

Procedure for a DELAYED or NO Show by courier for lab collection/pick up

DELAYED:
If a courier does not arrive by the scheduled collection time, BIDMC has directed that:

- SC lab staff, at the specific clinic laboratory, will call NOW Courier Customer Service office at: 1-800-543-9669 and inform them that the courier has not arrived for collection within the scheduled collection times.
- Find out information from NOW Courier CS desk as to whether the courier has been only temporarily delayed on route to the clinic by traffic/other collections, etc., and is still planning to arrive at the clinic for the pickup prior to the final closing of the clinic
- The lab staff will then inform the courier of the name of the either the designated lab staff or clinic staff that will be in the clinic to give them the lab specimen collection bags.

NO SHOW:

- If the lab staff finds out from the NOW Courier CS desk that the courier will not show up at the clinic for the scheduled collection prior to the clinic closing by calling 800-543-9669:
- The lab staff will inform the NOW Courier CS desk that the clinic will be closing and the courier will not be able to get into the lab to pick up the specimens for transport to BIDMC so they need to cancel the courier collection.
- The lab staff will inform NOW Courier CS that South Cove will find alternative to delivery to BIDMC.
- The lab staff at Washington Street and South Street will call Independent Taxi 617-426- 8276-7 for pick up, let them know it will be a voucher pick up to BIDMC.
- The lab staff will give the taxi driver a print out for BIDMC address and drop off instruction for BIDMC lab. Lab staff will also fill the taxi voucher log book.

4.14 Processing Laboratory Specimen for Test

Purpose
Outline the protocol used by SCCHC laboratories when presented with a request to collect/process a specimen collected for testing (whether Waived or performed offsite)

Policy:
Laboratory staff will follow this procedure after receive a request to collect/process a specimen for testing:

1. Patient will present a laboratory request form.
2. Laboratory requisition form should include: provider's name, patient's name, patient's medical record number, and appropriate ICD 10 code provided by clinical providers.
3. Labels will be made following procedure as outlined in Lab policy 4.10 (see attached sample). One label will be placed on the laboratory daily log sheet.
4. Enter the lab number, time, ICD 10 code, provider's name, and what tests have been requested.
5. Lab staff will call patient from patient waiting area and escort patient to phlebotomy room/area and ask patient to further identify self by telling their name and date of birth.
6. Specimens will be collected (patient will be informed of the number of test tubes that will be collected prior to the blood being collected) and labels placed on collection tubes.
7. Collect any/all the same patient's specimens collected (blood/urine/throat swab) and place in a biohazard lab guard specimen bag.
8. Place patient's lab requisition in the outside compartment of the bag and double check that all the specimens in the bag belong to the patient identified on the requisition.
9. Collection bag will be placed with other lab bags awaiting pick up by BIDMC courier.

4.15 Sending a Laboratory Specimen After Final Daily Scheduled Courier Collection

Purpose

Explain procedure to be followed to send a laboratory specimen to the BIDMC laboratory collected from a patient after the BIDMC courier has picked up the final/last regularly scheduled collection of laboratory specimens from the clinic for that day.

Policy:

If a provider orders a lab test on a patient that must be sent to the BIDMC laboratory and it is collected from the patient after the last routine courier collection of lab specimens for the day from that particular clinic, the following procedure will be followed:

- lab staff will collect and prepare specimen for transportation to BIDMC following standard laboratory policies and procedures
- Washington Street & South Street: place a telephone call to the Independent Taxi Service, 617- 426-8276, explain what is needed, provide them with a taxi voucher and address of the BIDMC laboratory, and prepare biohazard bag for pick up. (The folder containing the taxi vouchers and information is located on the left of the refrigerator.
- Quincy site: place a telephone call to Yellow Cab, 617-773-6262, and request a pick-up for delivery to the lab at BIDMC. Lab staff will give the lab specimen to the taxi driver upon arrival with taxi voucher and printed address of BIDMC lab.

4.16 Patient flow and instruction process for collection of specimens

Purpose
To provide the procedures to the patients and staff that will provide an order to the flow of the appointment process from the patient's visit with the Provider or Nurse to the Laboratory department.

Policy
Patients will obtain the specimen containers and instructions for collection from the staff in the clinical department in which they had their appointment.

Order of flow:

1) Patient will have their appointment with the provider or nurse.
2) Patient will check in with the nurse assistant (NA)/medical assistant (MA) after seeing the provider/nurse.
3) He/she will show the lab requisition form to NA/MA for evaluation of what needs to be done next.
4) To simplify the laboratory process, the patient will have the EKG and any necessary injections or other procedures done by the NA/MA before proceeding to the laboratory. This will prevent the patient from having to return to the department after the laboratory.
5) The NA/MA will also review the lab requisition. NA/MA will provide a urine cup or stool specimen container, or other specimen collection container to the patient before the patient comes to the lab. The NA/MA will place two patient forms of identification on the specimen cups.

Laboratory requisition:
The laboratory will only accept SCCHC laboratory requisitions for patient specimen collection.
The lab requisition should include the following information:

1) Two forms of patient identification
2) ICD-10 Code
3) Provider's information

4.17 Communication with clinical departments regarding laboratory requisition, specimen, or result

Purpose
The purpose of this policy is to help establish a protocol that laboratory staff will follow when there is a question about a laboratory requisition, specimen, specimen collection, and result from a patient from any of the clinical departments.

Policy
If there is any question at any time by the laboratory staff about a laboratory requisition, specimen, specimen collection, and result for a patient that was ordered by one of the SCCHC providers, the laboratory staff member will notify that patient's provider as soon as possible.

It will be the responsibility of the provider to evaluate the situation and provide direction to the laboratory staff for what will be the next step in the process of obtaining the laboratory results or further collection and analysis.

The laboratory supervisor will be informed by the laboratory staff of any occurrences or incidents regarding these situations. It will be the responsibility of the laboratory supervisor to ensure that proper and adequate follow up by the laboratory is provided so that the patient receives the appropriate care and that the care is not compromised.

5.00 Medication Administration Program

Purpose

The goal of the medication management program within the SCCHC organization is to provide medications for patients, as prescribed by their providers, from the medication closet supplies in a safe and consistent manner.

The sources of the medication supplies are from the clinic pharmacy, sample medications received from the pharmaceutical companies, the medications purchased by the organization as stock medications, and the medications and vaccines received from the Department of Public Health or Boston Medical Center for administration to the qualified patients.

The policies that govern the receipt and distribution of the medications were developed to provide the guidelines and procedures for the administration and storage of the medications and vaccines.

The medication management system presents possibilities for both risks and safety issues.
The program must be evaluated by the clinical and administrative staff on an annual basis and will include the nursing staff responsible for the maintenance of the medication closets and the department directors from the appropriate departments.
The mechanism in the organization that is most appropriate to evaluate this program is the Patient Safety Committee and will review this program at their routinely scheduled meeting in August every year.

The medication administration system should be reviewed for possible risks in the areas of:

1) the list of approved medications;
2) the order, purchase, receipt, storage, placement of medications in designated secured closets, refrigerators, or freezers;
3) the available Look-Alike/Sound-Alike (LASA) medications and posted lists;
4) the list of most prescribed medicines for each department;
5) the administration, distribution, and documentation of administered medications;
6) the medication logs maintained by the Adult Medicine, Behavioral Health, and Pediatric Departments at all health center sites;
7) any episodes of FDA recall;
8) disposition of outdated, compromised, or recalled medications;
9) episodes of untoward side effects, adverse or allergic reactions reported by patients;
10) any other area of medication administration warranting safety concerns.

The clinical department representatives will routinely evaluate the literature for new technologies or successful practices that have been demonstrated to enhance safety in other organizations to determine if SCCHC can improve its own medication management system.

5.01 Sample Drugs Management and Distribution

Purpose
The purpose of this policy is to provide a consistent and safe process for the dispensing and management of sample drugs, according to Massachusetts State Law, Department of Public Health 105 CMR 700.000: Implementation of M.G.L. c. 94C, at South Cove Community Health Center.

Policy
The definition of "sample medication for the purpose of 105 CMR 700.000 shall mean a unit of prescription drug distributed by the manufacturer or distributor to practitioners in the original package from the manufacturer, not repackaged and given free of charge to patients. Such medications shall include but not be limited to those medications dispensed as part of an indigent patient drug program."

Procurement
All sample medications are obtained from pharmaceutical representatives who have properly identified themselves at the registration area, signed the visitor log sheet, and have been given a visitor badge. The representatives will then speak to a nurse regarding the purpose of the visit and to help identify the needs of the department. The nurse will then refer the representative to a provider. A provider must sign for the receipt of or the placement of an order for any sample medications.
An order for samples is placed with the representative in person.
A nurse or a provider is authorized to accept medications from pharmaceutical representatives, medical suppliers and DPH.
Upon receipt of the medication, the medication is immediately placed in the locked medication room and the appropriate log sheet must be completed.

Identification and Logging of Sample Drugs
All sample medications are logged in the medication log located in the medication room.
Access to the locked medication closet/cabinet is for designated staff.
The logging of sample medications will be done by a nurse or provider within each department. This log is maintained in a chronological method to maintain an accurate inventory of each sample, lot number and dispensing information. Each medication will have a log sheet that will be identified by the dose and name of each medication and a separate sheet kept according to the different dosages of the medication. (**See attached log sheet**)

Monitoring for Outdates
Monitoring for outdated medication and inventory will occur on a monthly basis. A nurse will inventory each logged medication checking for quantity and outdates monthly. Each outdated medication will be discarded appropriately, in biohazard boxes and witnessed by another provider. Both signatures will be documented on the medication log. Discrepancies in the inventory will be filed as an incident report by the nurse or physician conducting the inventory.

Dispensing, Logging and Labeling of Samples
A licensed provider is the only one authorized to dispense medications. The provider must label the sample medication with a South Cove medication label (available in English and Chinese) or provide patients with written instructions on how to take the medications.
Nurse practitioners and certified nurse midwives may dispense and prescribe medications according to Massachusetts Law and the State Board requirements for physician supervision.
In accordance to 105 CMR 700.010: Dispensing and Labeling of Sample Medications by Practitioners: "A schedule VI sample medication is a single dose or in such quantity as is in the opinion of the practitioner appropriate for the treatment of the patient but not exceeding a 30 day supply per dispensing; provided, however, that this quantity may be increased to a 90 day supply if dispensed as part of an indigent patient drug program and deemed appropriate in the professional judgment of the practitioner."

All South Cove dispensed sample medications shall have a label (in Chinese or English) affixed to the outside of the package and it includes the following information as required under 105 CMR 700.010:

- Practitioner's name and clinic site address and telephone number
- Date of dispensing
- Name of the patient
- Name, dosage form and strength
- Clear, simple directions for use
- Cautionary statements
- Expiration date of the medication

The information will be presented in a manner that can be easily understood by the patient in a language (either Chinese or English) appropriate for the patient. A combination of written information, labeling and counseling maybe used to meet this requirement, based upon the individual needs of each patient.

If multiple packages of the same sample medications are dispensed at the same time to the same patient, under 105 CMR 700.010, practitioners are allowed to place the samples in a larger brown or plastic bag to which one label containing applicable information will be affixed.

Medications stored in the medication rooms must be categorized according to Look-Alike/Sound-Alike and/or Drug Alert and the appropriate labels placed on the shelf in front of the medication. (See policy 1.8)

Recall System

In the event of a medication recall and upon notification of the staff from the manufacturer, all patients will be identified from the sample medication log and notified to discontinue the drug. Follow-up appointments will be made for each individual to evaluate for potential side effects as needed.
The drug manufacturer and state and local officials will be notified as indicated by law.

Re-packaging of Samples

Re-packaging of sample medications **should not occur**. Medication will be maintained in their original packaging and labeled according to the above stated guidelines.

5.02 Medication Administration and Storage

Purpose
This policy is written to provide guidelines for the professional staff in the proper and safe administration of medications at South Cove Community Health Center.

Policy
General Statements:

- Each nurse and provider is responsible for understanding the pharmacological aspects of each drug being administered.
- Drugs noted to have abnormal characteristics or that have expired should not be given. This should be reported to the Medical Director immediately.
- All medications to be administered must be ordered by a physician or nurse practitioner and include name of the drug, dose and route of administration.
- Medications will be administered to patients by a licensed provider or nurse or medical assistant.
- Staff must always inquire and document in the medical record any known allergies to medications and verify these allergies prior to administering the medication to patients.
- Tablets and capsules may not be split or opened in order to alter dosage prescribed.
- Staff may not change the route of administration without a written order.
- Label all medicines that are not already labeled. For example: medicine in syringes, cups and basins.
- Medications may not be administered in the same syringe unless specifically written in the medication order. The exception is insulin.
- Medications that are given to the patient by injection must be drawn up by the nurse or medical assistant and label placed on the syringe identifying the specific medicine being given. If multiple injections are to be given to patient such as in the Pediatrics department during the same patient appointment, then the nurse/medical assistant can draw up the medication for preparation but must be sure that a label is placed on each of the syringes placed on the tray prior to administering the injections to the patient.
- Medication errors should be reported immediately to the provider both verbally and in writing using an “Incident Reporting Form.” Incident forms will be forwarded to the Medical Director.
- Adverse Drug Reactions shall be immediately reported to the provider and documented in the progress notes and on the ADR check sheet (see attached). If needed, the “**Emergency Policy**” for South Cove should be initiated. An Incident Report shall also be completed and forwarded to the Medical Director within 24 hours of the occurrence.
- South Cove uses both computer printout and paper prescription pads. Prescription pads will be kept in the possession of the provider or locked in the medication room. Only providers shall have access to such prescription pads. Pads are ordered centrally at each site and kept track through a log sheet by the designated staff.

Storage and Security:

- The clinic pharmacy inventory is only available for SCCHC patients and pharmacists are in control of the inventory.
- Medication syringe labels will be kept in either the medication room or nursing stations.
- Medications and syringes needles will be maintained in the designated medication rooms or nursing stations and kept secured at all times.
- Refrigerators containing medications, including vaccines, will be kept in either the medication room or nursing stations or laboratory refrigerator. Only authorized licensed providers and/or only designated clinical department staff will have access to these refrigerators.
- All medication rooms must be locked at all times and the doors closed. The code to the door lock will only be given to those authorized access to the medication rooms. The key to the medication room in Behavioral Health will be available to those authorized access to the medication room.

- Any controlled substances, Schedule 2-5, will be kept at the SCCHC clinic pharmacy ONLY, and in double-lock cabinets.
- Access to medications in the clinic pharmacy is only accessible when the clinic is open.

Monitoring for Outdates:

Monitoring for outdated medication and inventory will occur on a monthly basis. A nurse or pharmacist will inventory each logged medication checking for quantity and outdates monthly. Each outdated medication will be discarded appropriately, in biohazard boxes and witnessed by another provider. Both signatures will be documented on the medication log. Discrepancies in the inventory will be filed as an incident report by the nurse or physician or pharmacist conducting the inventory.

Recall System:
In the event of a medication recall and upon notification of the staff from the manufacturer, all patients will be identified from the sample medication log and notified to discontinue the drug. Follow-up appointments will be made for each individual to evaluate for potential side effects as needed.
The drug manufacturer and state and local officials will be notified as indicated by law.

Poison Prevention and Control:
The regional center for poison control and prevention serving Massachusetts can be reached at 1-800-222-1222.
See attached guidelines and alerts from HHS.

Patient Medication Lists and Medication Reconciliation:

- It is the responsibility of the provider to give a list to the patient.
- A patient's medication list should initially be given to the patient from their provider/PCP during an appointment to provide the patient with a list to keep for their own information and to have available use in case of visit to an emergency room, another provider outside of SCCHC, etcetera.
- A provider can give the patient their medication list by different options as long as the patient receives the list and the provider documents in the progress notes that the patient was given their list of medications (documentation can be handwritten or by use of the pre-printed stamp available to providers: "Medication list given to patients, or be noted in the patient's progress sheet in eCW.)
- Different options available to the providers include: writing the list on a piece of paper or in a notebook, printing it out from the eCW, or using the form developed for SCCHC providers to use. (Sample of form attached to this policy.)
- The medication list form may be copied by the staff and placed on the inside front cover of the patient's hard copy medical record on top of the chart's Problem/Medication List for future reference to the providers in case the patient does not bring their copy of the list with them to the appointments. If this list is revised at the appointment then a new copy will be given to the patient and a new copy placed in the chart or in patients' eCW chart.
- The medication list should be reviewed by the patient's provider with each appointment and revised whenever the list of medications is changed.
- The complete list of the patient's medications will be communicated to the next provider of service when a patient is referred or transferred to another setting, service, practitioner or level of care within our outside the organization.
- The complete list of medications is also provided to the patient on discharge from the facility.
- The patient and/or family members should be encouraged to read the list and asked to keep this list in their wallet and to bring this list with them to every SCCHC appointment and whenever they see a provider outside of SCCHC.

The Joint Commission Requirement for Multi-dose Vials:

- The Joint Commission requires organizations to re-label multi-dose vials with a revised expiration date (beyond-use date) once a multi-dose vial is opened or punctured because the expiration date is no longer valid.
- The Joint Commission defines “expiration date” as the last date that the product is to be used. (The manufacturer bases the expiration date on the fact that the product has not been opened.)
- The Joint Commission requires a 28-day expiration date for multi-dose vials from the date of opening or puncture, unless the manufacturer specifies otherwise. The Joint Commission bases this 28-day time frame on the fact that manufacturers are required by law to test the effectiveness of the bacteriostatic agent used in the multi-dose for a period of 28 days.
- The FDA allows manufacturers to provide extended dating in the package insert if they have conducted testing beyond the minimum 28 days. However, if the manufacturer identifies an original expiration date earlier than the revised expiration date, then the earliest date must be used.
- If sterility is questioned or compromised, the multi-dose vial should be immediately discarded.
- This dating expectation does not apply to vaccines in the Center for Disease Control and Prevention and state immunization programs which have separate requirements for when multi-dose vials must be discarded.

Administration of Medication

Subcutaneous:

Procedure	Points
Prepare injection using aseptic technique and a 25 gauge needle	Medication may be prepackaged in its own syringe.
Select injection site and position patient accordingly.	1. Anterior and lateral thigh 2. Middle third of upper arm
Cleanse site with alcohol wipe	
Compress and lift subcutaneous tissue	To avoid injecting into muscle.
Insert needle at an angle a) 45 to 60 degree b) 90 degrees for heparin and insulin injections and other medications as indicated	Angle should depend on amount of subcutaneous tissue.
Release pinched skin.	Prevents leakage from needle track.
Aspirate	To avoid giving medication intravenously.
Inject medication into tissue.	
Remove needle in the same direction as inserted.	
Massage area with alcohol wipe	Except when contraindicated.

IM Injections:

Procedure	Points
Prepare injection using aseptic technique using 21 to 23 needle	Medication may be prepackaged.
Select injection site and position patient accordingly.	Sites may include: a. Ventrogluteal b. Deltoid c. Dorso gluteal d. Vastuslateralis
Cleanse site with alcohol wipe	

Make skin taut by stretching skin between forefinger and thumb.	To avoid injecting into muscle.
Insert needle at 90 degrees	
Release pinched skin.	Prevents leakage from needle track.
Aspirate	To avoid giving medication intravenously.
Inject medication slowly	
Remove needle in the same direction as inserted.	
Apply pressure to site. If bleeding occurs, maintain pressure for one to two minutes.	Except when contraindicated.

Oral:

Procedure	Points
Ensure that patient can swallow medication	Swallowing should be assessed as some patients may have difficulty. This is especially true for children, elderly or the dehydrated individual.
Identify the patient by name and administer the medication. Stay with the patient until medication is taken.	

Recording Medications Given:

Procedure	Points
Any medication administered to the patient must be charted in the progress notes to include: a. Date b. Type of medication c. Dosage d. Route e. Site f. Signature of the provider	Signature must include provider's full name and credential.
Immunizations should be recorded on the immunization record in the patient's chart and also on the bubble sheet located in the medication room. The immunization documentation should include all the above information and the lot number.	

5.03 Adverse Drug Reaction Reporting and Documentation

Purpose
The purpose of this policy is to provide guidelines for reporting and monitoring of Adverse Drug Reaction at South Cove Community Health Center.

Policy
Definition:
An Adverse Drug Reaction (ADR) is defined as an undesirable or unexpected event that requires discontinuation of a drug, modifying the dose or providing supportive treatment in response to the reaction.

The following steps should be initiated after report of an ADR:

- Upon report from the patient of a reaction to a medication, the patient's primary care provider should be notified immediately.
- An assessment of the symptoms the patient is experiencing is conducted and action taken as indicated based on the findings.
- Appointment for follow-up is made for the patient if indicated.
- "Allergy" label is placed on the outside of the patient's medical record and information noted on the problem list and record.
- Any sentinel events identified are evaluated and reported to the appropriate agencies according to federal and state regulations (FDA, Board of Registration in Medicine, etc.)

5.04 Medication Administration – Vaccine

Purpose
The purpose of this policy is to provide information to all licensed nurses and providers responsible for the handling, administration, documentation and reporting in order to be in compliance with established state and federal programs.

Policy
The attached guidelines describe in detail all requirements for participation in the vaccine program. All providers will be aware of such requirements and be responsible for all documentation in the patient record as well as to the individual as required by statute.

All vaccine records will be maintained as part of the permanent patient record for 20 years as required by law.

All vaccine will be stored appropriately according to the federal requirements and temperature recorded twice daily within each clinical department in which vaccine is stored.

The MDPHIP (Massachusetts Department Public Health Immunization Program) has established Patient Eligibility Criteria and schedules for pediatric and adult immunization programs and all providers should assess and administer vaccine according to the guidelines.

The current guidelines are kept in the appropriate clinical departments

All providers are responsible for reporting of all vaccine related injury events according to the November 10, 2008 National Vaccine Injury Table (see attached resource). Adverse events should be reported to the Vaccine Adverse Events Reporting System (VAERS) and forward this information to:

VAERS
c/o ERC BioServices Corporation
A Division of Ogden Biomedical Service Group
First Street
Rockville, MD 20850

VAERS forms and instructions are available on the VAERS website at http://vaers.hhs.gov/index or by calling 1-800-822-7967.

5.05 Temperature controls for medicine storage rooms/refrigerators/freezers

Purpose
Provide specific guidelines and instructions to maintain quality controlled standards of temperatures for both the medicine storage rooms and the refrigerators and freezers used to store medicines and vaccines in the clinics. This is necessary to maintain equipment and shelf life of medicines and vaccines.

Policy
Medicine room temperature
The medicine room temperature will be maintained between 68 and 77 degrees Fahrenheit (68º-77ºF) or 20 and 25 degrees Centigrade (20º-25ºC) at all times. If requirements for the temperature range change then the clinical department's designated representative will revise the acceptable ranges.

Monitoring temperature:
Department staff will check the temperature noted on the digital thermometers or thermometers posted in each medicine room twice daily (once in the morning no later than 10AM and once in the afternoon no later than 3PM) and document this information on the temperature log sheets (see blank attached) posted in each room. The log is posted for the current month, removed at the end of the month, and placed in the central temperature log book in the department at the clinic sites.

The acceptable range for the room temperature is set on the digital thermometer according to manufacturer's guidelines for the items that need to be placed in temperature control environments. An alarm mechanism on the thermometer will alert staff to any variances in the temperature above or beyond the set ranges.

Action for alarm activation:
The appropriate department staff will note alarm and check to see if caused by malfunction of thermometer due to low battery or from environmental changes. If the environmental temperature has changed due to variances in the building heating/air conditioning systems then staff must notify the appropriate clinical department nurse that utilizes the refrigerator, clinic/site manager and /or administrative personnel to alert them of problem.

Use of Digital Thermometer:
A copy of operations manual (see attached) is available in the department's temperature control log book and posted in the room near thermometer.
The temperature control range is set in either Centigrade or Fahrenheit values.
The power source is provided by one AAA (triple A) battery.
System alarm: an alarm will sound when battery is low or the temperature falls above or below the set ranges.

Refrigerator temperature:
The temperature of the refrigerator in the medicine room will be monitored using a digital thermometer and/or a manual thermometer. The temperature will be maintained between 35-46 degrees F (or 2-8 degrees C) at all times. If requirements for the temperature range change based on the items stored in the refrigerator then the department representative will revise the acceptable standard ranges.

Monitoring temperature:
Designated department staff will check the temperature noted on the thermometer posted at or in the refrigerator twice daily (once in the morning no later than 10AM and once in the afternoon no later than 3PM) and document this information on the temperature log sheets (see blank attached) posted near/on the refrigerator. The log is posted for the current month, removed at the end of the month, and placed in the central temperature log book in the department.

The acceptable range for the refrigerator temperature is set on the digital thermometer according to manufacturer's guidelines for the medicines/medical supplies that need to be placed in the refrigerator in

a temperature control environment. An alarm mechanism on the digital thermo meter, if used, will alert staff to any variances in the temperature above or beyond the set ranges.

Action for alarm activation:
The appropriate department staff will note alarm and check first to see if it may have been caused by low battery. If the temperature is out of range for any reason then the department nurse, clinic/site manager and/or administrative personnel must be notified to alert them of problem.

If the temperature is unable to be maintained to protect the stored items at the manufacturer's guidelines then the items will be moved to another refrigerator/freezer in the clinic or discarded based on acceptable manufacturer guidelines.

Use of Digital Thermometer:
A copy of operations manual for digital thermometer is available in the temperature control log book and posted in the room near thermometer. Temperature control range is set in either F or C values. Power source is provided by battery. System alarm will sound when battery is low or the temperature goes above or falls below the set ranges.

Freezer temperature:
The temperature of the freezer in the laboratory will be monitored using both a digital thermometer and a manual thermometer as a secondary check system. The temperature will be maintained at -15°C to -50°C. If requirements for the temperature range change based on the items stored in the freezer than the laboratory supervisor will revise the standard ranges.

Monitoring temperature:
The appropriate department staff will check the temperature noted on the digital thermometer posted on the side of the freezer twice daily (once in the morning no later than 10 AM and once in the afternoon no later than 3 PM) and document this information on the temperature log sheets (see blank attached) posted on the freezer door. The log is posted for the current month, removed at the end of the month, and placed in the monthly log book in the main laboratory at the clinic sites.

The acceptable range for the freezer temperature is set by the laboratory supervisor on the digital thermometer according to manufacturer's guidelines for the items that need to be placed in the freezer in a temperature control environment. An alarm mechanism on the thermometer will alert laboratory staff to any variances in the temperature above or beyond the set ranges.

Action for alarm activation:
The appropriate department staff will note alarm and check first to see if it may have been caused by low battery. If the temperature is out of range for any reason then the department nurse, clinic/site manager and/or administrative personnel must be notified to alert them of problem.

If the temperature is unable to be maintained to protect the stored items at the manufacturer's guidelines then the items will be moved to another refrigerator/freezer in the clinic or discarded based on acceptable manufacturer guidelines.

Use of Digital Thermometer:
A copy of operations manual for thermometer is available in the laboratory temperature control log book and posted on the side of the refrigerator/freezer. Temperature control range is set in Centigrade values. Power source is provided by battery. System alarm will sound when battery is low or the temperature falls above or below the set ranges.

5.06 Medication Administration Documentation – Unacceptable Abbreviations

Purpose
Standardizing terminology, definitions, vocabulary, and nomenclature facilitates communication of data and information within and among the organization and other organizations. Abbreviations, acronyms and symbols must also be standardized.

The use of a list of approved standardized abbreviations, acronyms, and symbols is to protect patients from the effects of miscommunication.

Policy
This policy provides a list of abbreviations that **are not to be used** by any of the professional staff that participates in any clinical documentation at SCCHC.

The National Patient Safety Goals by the Joint Commission and the Institute for Safe Medication Practices contain a list of the **unacceptable abbreviations, acronyms and symbols** that are prohibited from use in any phase of medication administration and clinical documentation due to their being identified as dangerous to patient care.

An abbreviation on the “do not use” list should not be used in any of its forms – upper or lower case; with or without periods.

In addition to the **abbreviations listed on the attached page**, any ambiguous and otherwise dangerous forms of notation should be eliminated from all health care documentation.

5.07 Medication Administration – Use of Telephone or Verbal Orders

Purpose
The purpose of this policy is to clarify the procedures for the use of all telephone and verbal orders in the organization in the administration of patient care.

Policy
General Statements:

- Procedures for receiving, transcribing, and authenticating all verbal orders are established to protect the quality of patient care, treatment, and services.
- Only qualified personnel defined and designated by organization policy, with the approval of the Executive Director and the Medical Director, and, as appropriate, in accordance with the Massachusetts state and federal law, are authorized to receive and record verbal orders from authorized individuals.
- Each verbal order is dated and identified the names of the individuals who gave and received it, and the medical record indicates who implemented the order.
- The authorized person receiving the order from the authorized person should write down the complete order, or enter into a computer, then read it back to receive confirmation from the individual who gave the order.
- The authorized person receiving the telephone/verbal order will write the words “read back” into the medical record with the documentation of the order received.
- Orders given orally and entered into the patients’ medical record must be signed by the person writing the order in the chart and then signed by the person who gave the verbal order (for example: prescribed the medication).
- The “read back” requirement applies to all caregivers, including physicians and residents and nurses.
- The departmental medical record chart reviews will include a review of the medical orders section to identify the correct use of telephone or verbal orders and to ensure that the procedure is being done consistently.
- In certain situation, such as a Code Blue, it may not be feasible to do a formal “read back” of the verbal order. In such cases, “repeat-back” is acceptable and then when time allows, the order must be written into the medical record by the person who received the order and appropriate signatures applied per standard procedure.

5.08 Medication Administration – Patients' Own Medications (POM)

Purpose

Patients requiring periodic injectable medications such as Immunotherapy and hormone injections may need to bring their own medication to the clinic for assistance from clinical staff to administer their medications.

Policy

1. The nurse will check a patient's own mediation (POM) brought to the office to ensure it is prescribed by a health care provider and labeled with the patient's name, medication name/strength/expiration date and directions for use.
2. The nurse or licensed provider will administer the medication as per the treating physician's order and document the administration in the medical record.
3. After administration of the medication, the patient's own medication will be returned to the patient or stored in the medication closet or medication refrigerator as appropriate.
4. The nurse will notify patient when medication is running low or close to expiration so that the patient can obtain more medication. For immunotherapy, the nurse may contact the allergist office to obtain allergen refills and directions for use.
5. Nurse will dispose of the POM properly when it becomes expired and inform patient. For pediatric allergy shots, nurse will dispose of the POM and contact Allergy Department at Children's Hospital for re-fill.
6. The allergy shots order come on a flow sheet on which we notate dates and dosage of medications. Once the vial is completed, a copy is faxed to the allergist and the flow sheet scanned into the chart.
7. The other injectables (hormones) have the order in the consult note which is scanned into the eCW.
8. Renew order every 3 month.

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5.09 Look-Alike/Sound-Alike, Drug Alert and Most Prescribed Medications

Purpose
The policy provides guidelines on handling medications in order to improve the safety of using medications.

Policy
Look-Alike/Sound-Alike
Identify a list of look-alike/sound-alike (LASA) drugs used by each clinical department and take action to prevent errors involving the interchange of these drugs.

Implementation Expectations:
1. Review the list of look-alike/sound-alike drugs used by each clinical department at least annually.
2. Each clinical department takes action to prevent errors involving the interchange of these drugs.
3. Whenever possible, determine the purpose for the medication before dispensing or drug administration. Most products with look or sound-alike names are used for different purposes.
4. Change the appearance of look-alike/sound-alike product names on med closet, shelf labels and bins by highlighting through bold face, color, and/or tall man letters, the parts of the names that are different.
5. Affix “drug alert” stickers to areas where look or sound-alike products are stored.
6. When applicable, use a LASA sticker to help identify potential look-alike/sound-alike medications.
7. Report errors and potentially hazardous conditions with look and sound-alike product names and use the information to establish priorities for error reduction.
8. The following resource websites are recommended for additional information: ISMP (www.ismp.org), FDA (www.fda.gov) and USP (www.usp.org) and the Joint Commission (www.jointcommission.org).

“Drug Alert”
For medications that would cause a safety concern. A label “drug alert” would be placed on the shelf. This label is to alert providers of potential patient safety issues.

Most Prescribed Medications
Each clinical department must develop and review at least annually a list of the “most prescribed” medications that are ordered by all the providers in that clinical department. This list is available in hardcopies and via the South Cove internal website to all providers.

5.10 Anticoagulant Therapy Protocol

Purpose

This policy establishes all protocols and guidelines concerning the anticoagulant (Coumadin) therapy for SCCHC patients.

Policy

Coumadin initiation therapy for SCCHC patients

1. Only SCCHC patients who have a primary care provider (PCP) at SCCHC are treated and maintained for Coumadin therapy by SCCHC providers.
2. SCCHC patients with multiple providers from various healthcare facilities will not be followed for Coumadin therapy at SCCHC unless the SCCHC PCP is in charge of the Coumadin therapy.
3. Provider orders the Coumadin therapy dose for the patient.
4. Provider informs the Adult Medicine Department nurse (LPN or RN) of the order.
5. The patient's paper chart is labeled with a Coumadin alert label as a safety alert.
6. The nurse initiates the patient's individual "Coumadin Therapy Record" in the Coumadin therapy binder for the patient (see sample of log attached) and maintains a record for each following month/day that the patient is supposed to return for the scheduled appointment to return to clinic for follow up INR.
7. The logs are maintained for at least 2 years.
8. The nurse provides counseling to the patient and education materials (see attached samples of documents) regarding the medication and instructions on: when to call the nurse/provider to report any problems, when to return for follow up laboratory tests (next INR) and appointments with the provider, how to take the medicine, teach patient how pills are color coded by doses, and the dietary precautions and drug interactions.
9. The patient is instructed to return per provider's orders for nurse visit for the INR pending the INR result. (The INR is not scheduled for a day before a Holiday when the clinic would be closed.)
10. The nurse will tell the patient the result of the INR and the provider's orders to continue the same/change the dose by telephone the day after the lab test is completed. A telephone encounter is documented in the EMR and/or the chart to document the current/changes therapy.
11. If a patient is a "No Show" for a scheduled lab test then the nursing staff will call the patient per protocol for No Show patients and remind them of the need for the lab test and inquire as to why patient missed the appointment.
12. If a patient is going to be on vacation (whether in USA or outside USA) the nurse will keep this list on file with the patient data in the record and follow up with the patient upon return from vacation.
13. The nurse will contact the patient's provider or provider 'on call' for any results or problems encountered with the patient's lab test results, therapy, urgent patient problems.
14. The medical Director of Adult Medicine or a designated provider is responsible to conduct a quarterly review with one of the department's nurses of each clinic's entire Coumadin therapy records of all patients and assess the records for at least the following 2 items: that the anticoagulation therapy of all patients is within a reasonable range and that the Coumadin doses of all patients have been adjusted appropriately to the INR results. The physician and nurse will sign the review form upon completion of the record review.
15. Additional information regarding the initiation of anticoagulation, management of INRs for patients with different illnesses, and drug-drug interactions is attached to this policy for further guidance.

6.00 Behavioral Health Policies

6.01 Intake

Purpose
This policy provides guidelines for proper intake protocol. Guidelines apply to referrals, triage/ general procedures, intake forms, case assignment, and registration.

Policy
Referral
Front desk staff will direct intake calls to the BH case manager.

General Procedures

1. Procedure for Office Manager / Front Desk Staff
    a. Direct the intake call to the BH case manager.
    b. For emergency intake calls or walk-ins, contact an available clinician or Clinical Supervisor.

2. Triage (Procedure for Case Managers)
    a. Record pertinent information on the Outgoing Referral intake box of the electronic medical record. In case of an emergency, inform the referral source specific action(s) being taken. Then report the case to the Clinical Supervisor or a senior clinician.

    b. External Referral: Talk to the referral source regarding reasons for referral and record pertinent information on the Outgoing Referral intake box of the electronic medical record. The case manager and referral source should discuss strategy to engage patient, whether referral source has informed patient of the referral and obtained consent for services (referral agencies usually are in a better position to inform patient of our services before an initial contact), and reach a clear understanding as to who will make the initial contact.

    c. Self-Referral: Record pertinent information and inform caller that the Clinical Supervisor will make a decision if referral is accepted. The case manager will be the contact person until case is assigned.

    d. Walk-Ins: Case manager meets with the individual to gather pertinent information and inform individual that a clinician will contact them for an appointment. Case manager is the contact person until case is assigned.

    e. Internal Referrals: Internal Referrals are checked on a daily basis, twice a day, through eclinical by the Clinical Supervisor. If the Clinical Supervisor is unavailable, another BH clinician will be assigned to triage referrals. The referrals will be assigned for medication management and/or therapy.

3. Intake Procedure:
    a. To refer through Eclinical:
        i. Open Referral Box under Outgoing
        ii. Refer to: Behavior, South Cove
        iii. Specialty- Psychiatry
        iv. Assigned to Referral, BH
        v. Please Do Not assign to a BH Clinician

    b. BH staff/clinician will document in the “Notes” section in the Referral Screen under “General Note” any communication with the patient such as messages left, appointments offered, patient declines treatment, etc. Once the patient is evaluated, the BH clinician will document the disposition under the “Notes” section and click “Addressed” to close the

loop. A Telephone Encounter will be sent to the Referring Provider when the evaluation is completed, a patient misses the diagnostic evaluation, or the patient declines treatment.

4. Emergency/Urgent referrals to BH:
   If a patient requires immediate help due to high risk of suicidal or homicidal behavior, the provider should call 911 and have patient transported to the nearest Emergency Room.
   a. If it is not an emergency situation, please send a referral to B.H. and describe your concerns.

   b. If unsure whether this is an emergency, providers are encouraged to call the Behavioral Health Director or Clinical Supervisor for consultation.

5. Other Emergencies
   a. If an emergency arises during clinic hours involving someone not known to our clinic, the case manager and/or clinical supervisor should be notified and will make an assessment of the situation. In the event that someone creates a disturbance or becomes assaultive, refer to the "Emergency Procedure" section.

Outgoing Referral Intake Box
The case manager should fill out the Outgoing Referral intake box of the electronic medical record as completely as possible. The following information should be obtained:

1. Biographic Data
   a. name, age, gender, language, ethnicity, address, phone number, and SSN
2. Insurance Information
   a. name of the insurance company, policy number, and contact number
3. Presenting Problem(s)
4. Medical Concerns
5. Risk Assessment
   a. include S/I, H/I, AVH

Most patients have access to medical insurance. If a patient needs to sign up for insurance, refer them to the Social Services Department. Inform them that it will take 4+ weeks to process the application. Once application is approved, an appointment will be given. Patients also have the option to pay out of pocket. This may occur if they do not want to use the health insurance coverage or clinicians are "out-of-network". Rates will be negotiated beforehand.

Case Assignment
The Clinical Supervisor will assign the referral based on the following:

1. Clinician's expertise and credentials
2. Compatibility of language/culture/age/gender
3. Clinician's workload
4. Schedule

Registration
Clinicians should ask patients to arrive at least 60 minutes prior to the first appointment to register and check-in.

6.02 Diagnostic Evaluation

Purpose
This policy provides guidelines for proper diagnostic evaluation protocol. Guidelines on conducting a diagnostic evaluation, the diagnostic process, reporting of the diagnostic evaluation, re-opening of old cases, and treatment plans are provided.

Policy
Conducting Diagnostic Evaluation
A diagnostic evaluation session usually takes 50 to 90 minutes. The diagnostic evaluation needs to be completed by the end of the workday. In the first session, clinicians should conduct the following:

1. Review the Limits of Confidentiality
    a. Individuals who are seeking Behavioral Health services must be explained of their rights in a language they fully understand. Clinicians should explain the legal limitations of confidentiality.

2. Obtain informed consent
    a. Clinicians should make an effort to give a clear and concise explanation of diagnostic and treatment procedures and scope of involvement of the interventions, including the likelihood of success, possible adverse effects and potential risks. The law indicates if any one item is not given, informed consent has not been obtained. When presenting the above information, clinicians should also consider the patients' cognitive, cultural, linguistic, and current mental status, and deliver the information accordingly. Clinicians should clearly spell out their role and responsibilities in the proposed treatment procedures. At the end of the diagnostic session, the clinician discusses the disposition plan and obtains the patient's agreement. For patients under 18, a parent or guardian needs to sign the Parental Consent Form and filed into the medical record.

3. If a clinician determines that the patients' needs cannot be met by services at SCCHC, the clinician may refer to outside resources. The clinician should assist in coordinating other services, which means providing adequate information to facilitate the referral.

Diagnostic Process
The following information should be obtained:

1. Chief Complaint
    a. The clinician will clarify presenting problem(s) and obtain a description of the major complaints. In child cases, the parent or primary caretaker, or other relevant adults may give information. However, it is also useful to elicit the child's understanding of the referral.

2. Presenting Problems
    a. The information obtained in this section assists in a DSM / ICD diagnosis and diagnostic formulation based on the current presenting problem. Clinical measurement instruments are strongly encouraged to establish a baseline for treatment. The department adopted the PHQ-9 Depression screening tool for new all new adult patients (18 and above). As of November 30, 2008, Masshealth Managed Care Entities (MCE's) requires clinicians to use the CANS tool to assess any child under the age of 21. Other screening tools include: The Beck Depression Inventory, Harvard Trauma Questionnaire, and Hopkins Symptom Checklist is available to help determine diagnoses. It may be helpful at this point to discover the patient's defense mechanism, coping strategies, strengths, weaknesses, and resources.

3. Past Psychiatric/Counseling History
    a. Information will help to further assist in case formulation and understand the current presentation. Clinicians need to record when and from whom the patient had received services, length of time, diagnosis, if known, and to what extent the patient responded to different modes of treatment. Notate previous medications. Ask for family history of psychiatric illnesses.

4. Current Medications and Allergies
    a. Record the names of current medications. Clinicians should rule out medication induced or related psychological conditions.

5. Medical History
    a. Record any medical problems. Clinicians should consider the causal relationship between medical symptoms and behavioral symptoms. Ask for family history of medical illnesses.

6. Substance Use History
    a. Include history and current use of all recreational substance and alcohol. Assess for nicotine and caffeine intake. If the information obtained indicates a substance use history or current usage, clinicians should use the Substance Abuse Assessment as a screening procedure. It is mandated by state law for clinicians to make sure the patients who have substance abuse problems receive adequate information about HIV/AIDS, which are included in the Substance Abuse Assessment.

7. Pain History
    a. Obtain patient's level of pain from a scale of 1 to 10.

8. Education, Work, and Legal History
    a. Clinicians should obtain educational, employment, legal status, and immigration history.

9. Family and Developmental History
    a. Obtain a developmental history for children. A genogram may be drawn as part of the assessment. Obtain information about the family and social relationships, environmental, and cultural factors.

10. Strengths and Social Supports
    a. Clinicians pay attention to the patients' strengths and resources and their social and emotional support system and incorporate these into the treatment plan.

11. Identified Risk Factors
    a. Record the identified risk factors. Managing risk factors always take priority in treatment planning and intervention. Patient should be asked to sign the Contract for Safety form when the clinician determines that personal safety may be the central focus.

12. Mental Status
    a. The clinician conducts a mental status examination in the first evaluation session.
    b. Clinicians should assess for appearance, attitude, and behavior; characteristic of speech; mood and affect; content of thought (e.g., capacity to test reality); risk of harm to self and others; future orientation (e.g., pessimistic, hopeful, etc.); orientation (time, place, and person), memory, and intellect (e.g., abstract thinking, reasoning and judgment, and insight).

13. Disposition Plan
    a. The disposition plan should address, but not limited to, addressing risk factors, psychotherapy, family or group therapy, psychiatric consultation, psychological testing.

14. Interagency Coordination
    a. List all agencies and resources, which the clinician plans to contact (e.g., Pediatrician, PCC, schools, DCF, courts, and other resources).

Reporting of the Diagnostic Evaluation
The diagnostic evaluation needs to be completed by the end of the workday. If other information is provided, such as reports or consultation notes, clinicians should briefly summarize relevant aspects of other reports as they pertain to the diagnostic impression. Unlicensed clinicians need to discuss and obtain a supervisor's approval before the note is locked and sent to the supervisor for a signature.

If the referral is internal, send a telephone encounter informing the disposition to the referral source and/or PCP. If the referral is external, obtain patient's consent forward the diagnostic evaluation to the referral source. Inform the front desk staff the name of the agency and address of where the report should be sent.

Re-opening of old cases
If a former patient requests for services, they should go through the former intake process. The Clinical Supervisor may approach the former therapist to re-open the case or assign to a new clinician depending on staff availability.

Treatment Plan
The Treatment plan is due at the same time of the Diagnostic Evaluation. The Behavioral Health Department currently adopts the PIC Treatment format.

1. Identify the primary issues and formulate a tentative explanation of how the problems occurred. Take into consideration cultural factors and immigration factors. Case formulation should also take into consideration DSM diagnostic guidelines.

2. Record a formal diagnosis.

3. Create a goal plan. Identify types of intervention, modality (e.g., individual, group, family, couples, psychopharmacology, vocational, etc.), frequency, and duration.

The treatment plan should be created in collaboration with the patient. It is important that the patient fully understands the treatment procedures and consents to the plan. Unlicensed clinicians need to submit the treatment plan to his/her supervisor for review.

6.03 Documentation and Case Management

Purpose
This policy provides guidelines for the proper documentation and case management protocol. The protocol for documentation of progress notes, quarterly treatment summary, transfer summary, termination, supervision, record keeping, multidisciplinary team review, quarterly treatment plans, and quality management training are discussed.

Policy
Progress Notes
Clinicians are responsible to maintain adequate, accurate, and current progress notes in medical charts. Progress notes must reflect the treatment plan. At times, new problems may arise that are not included in the treatment plan and should be adjusted accordingly through the progress notes. Also notate changes in diagnosis. Clinicians need to bear in mind the following:

1. Goals and objectives of treatment plan
2. Rationale for goals or intervention
3. Risks involved and justification for intervention
4. If alternative treatments were considered and why alternatives were rejected or delayed
5. Any steps to improve or increase effectiveness of chosen treatments
6. Documentation of informed consent

Progress notes need to follow the "SOAP" format.

S- Subjective data: patient's report of symptoms, efforts made to change their circumstances, other problems, and difficulties.

O- objective data: your observation and the observation of others; measurable signs, results of psychological testing

A- assessment: your conclusions, interpretations, impressions, and analyses of the data

P- Plan: next steps, next appointment date

Also document any homework or tasks assigned, if any.

Treatment Plans
Treatment Plans should be reviewed every 3 months (for ages 17 and under) and 6 months (for ages 18 and older) after the diagnostic evaluation. Clinicians may review treatment plans in group or individual supervision. Clinicians also need to re-administer the PHQ-9 or CANS for those with certain health insurance coverage.

Transfer
The primary clinician is responsible to write the Transfer Summary providing reasons for the transfer and consent from the patient. Primary clinician should facilitate the transfer to the new clinician.

Termination
Document reasons for termination, course of treatment and recommendations. The case can be terminated after three missed appointments. Clinicians should make an effort to contact patient either by mail or phone to assess patient is interested in services. The clinician places the patient on the inactive list after the third consecutive no-show with no adequate explanation. At the time of termination, the clinician should inform the patient that s/he may return to the clinic for services in the future.

Supervision
Unlicensed clinicians are assigned a supervisor for individual meetings to discuss the patient list in detail. Depending on the discipline of the clinician, individual supervision may be scheduled weekly, biweekly, or monthly. Group supervision is also provided through the MD Rounds. Clinicians will present a case on a

rotating basis. Clinicians should follow the Case Presentation Outline when preparing to present. MD Rounds are held bimonthly. Participants are generally limited to the clinical team. Caseworkers from DDS and/or DMH may be invited. Clinicians need the approval from the primary supervisor or clinical supervisor if a guest is invited to a meeting.

Trainees are required to inform patients and primary caretakers that they are in training and cases are supervised. Patient identification will be disguised.

Record Keeping
Clinicians are responsible to keep and update medical charts. A completed medical chart should contain the following information:

1. Problem / Medication List
2. Registration Packet (i.e., address, insurance information, emergency contact information, consent forms, HIPPAA, Patient's Rights, etc.)
3. Diagnostic Evaluation
4. Treatment Plan and Quarterly Treatment Summary
5. Transfer or Termination, if appropriate
6. Medical records
7. Consultation notes or reports
8. BH Progress Notes

Multidisciplinary Team (MDT) Review
To ensure quality clinical care, each Diagnostic Evaluation, Treatment Plan, Transfer and Termination Summary shall be signed by the treating clinician and at least one other clinician. The MDT comprises of a psychiatrist, psychologist, psychiatric nurse practitioner and licensed independent clinical social worker. For unlicensed clinicians, the supervisor will also need to sign before it can be approved. In the rare case that one of the signatures of the three disciplines cannot be obtained, the Behavioral Health Director (M.D.) will sign.

Effective July 1, 2009, MBHP changed the requirement to the MDT review (105 CMR 140.530 B and C) process. MBHP adopted the regulations set forth by DPH in which clinical review of treatment plans may be completed by two clinicians of any discipline. However, unlicensed clinicians will still need a supervisor's signature in addition to the licensed reviewer.

Effective October 2009, Beacon Health Strategies also adopted these new standards from DPH.

Quarterly Treatment Plans
All clinicians use templates created in the EMR for Diagnostic Evaluations, Treatment Plans, Progress Notes, Individual Action Plans, Termination and Transfer Notes

Effective September 2010, The **Frequency** of the Treatment Plan was adopted to be **quarterly** for child cases and **semiannually** for adult cases as recommended by MBHP.

Quality Management Training
South Cove will access quality management training for its mental health Quality Management Council members and other program/Clinical Supervisor / Directors through organizations such as the Massachusetts League of Community Health Centers. It will also arrange for in-house training to be provided by consultants with established expertise in this area during its monthly in-service training time slots.

South Cove Behavioral Health also adopts and implement MBHP's proposed utilization management program.

The FB&H Director is responsible for the following:

1. Oversees all aspects of the utilization management program

2. Provides regular reports and analyses on trends in utilization
3. Coordinates utilization management across sites
4. Reviews appropriateness of all cases regarding authorization
5. Ensures that cases are reviewed by treatment team or appropriate supervisors at designated intervals
6. Ensure that periodical reviews are properly documented
7. Coordinate the collection and analysis of utilization statistics and retrospective chart review data
8. Ensures that clinical staff receive regular training on Partnership authorization policies and procedures, strategies to identify and target appropriate treatment modalities, admission and discharge criteria, writing behaviorally oriented, goal focused treatment plans

The Clinical Supervisor

1. Review all treatment plans
2. Recommend observable, measurable behaviorally oriented goals for treatment outcome
3. Review treatment plans for extensions of care beyond the estimated time in treatment or amount of service utilization

Many of the preceding elements of the Quality Management plan have been operating at South Cove. However, mechanisms need to be developed to facilitate easy access to such utilization statistics and chart review data. In particular these mechanisms must be implemented with little to no negative impact on the clinicians' capacity in their clinical delivery.

6.04 Prescribing Psychiatric Medication

Purpose
This policy provides guidelines for proper protocol for prescribing psychiatric medication.

Policy
Medication
Staff psychiatrists and psychiatric nurse practitioners, in the BH department, are allowed to prescribe psychotropic medication to our behavioral health patients.

Staff psychiatrists and psychiatric nurse practitioners may jointly see patients with the patient's caseworker (if appropriate) to review patient's medication record. The visit, with detailed information about medication dosage and amount to be given, is recorded each time in the progress notes.

6.05 Risk Management Protocol

Purpose
This policy provides guidelines for proper risk management protocol for assessing for suicidal potential, assessing patient's danger to others, and guidelines for working with dangerous patients.

Policy
Assessing for Suicidal Potential
Clinicians conduct a suicidal assessment as indicated. Clinicians ask all patients about suicidal ideation during the initial intake session and document in the record how the patient responded to the questioning. Clinicians may begin by saying that she/he has some standardized questions like "Have you ever been so down or discouraged that you've thought about killing yourself?" If the patient responds "yes," clinicians should inquire more about the patient's current thoughts of suicide, a plan or means of suicide, previous episodes of suicidal thoughts, previous suicidal gestures or attempts, and alternative means of coping.

During the course of therapy, clinicians maintain an effort to be cognizant of some cues about their patient's potential for carrying out a suicidal ideation. The following should be considered:

- Patients who report any moderate or severe depression needs to be assessed for suicidal ideation. Tools to use: Beck Depression Inventory (BDI), Hamilton Depression Rating Scale, and Chinese Depression Scale.

- Patients who recently engaged in a dangerous activity that is potentially life threatening.

- Patients who make vague or philosophical comments about death may be a warning sign for suicidal ideation (e.g., she doesn't have to worry about me anymore because I won't be around.")

- Patients may be exhibiting behavioral cues such as giving away all their possessions.

In addition, clinicians pay attention to demographic (age, gender, and ethnicity), social, and psychological predisposing factors in evaluating a patient's potential for suicide:

1. Direct (e.g., "I'm going to jump off the bridge.") or Indirect (e.g., "My children would be better off if I weren't around.") verbal warning.
2. Present with a plan, especially one that is specific, involves a lethal method, and readily available to the patient.
3. History of previous suicidal attempts
    a. Family history of suicide
4. Frequency of suicidal ideation
5. Nature of suicidal ideation
6. Diagnosis of depression, substance abuse, schizophrenia, and post traumatic stress disorder
7. Demographic factors:
    a. Age- risk increases with adolescents and individuals aged 45 and older
    b. Gender- the suicide rate for men is about three times that for women, although women make three times as many attempts
    c. Race- Caucasians (in U.S.) have the highest suicide rate
    d. Religion- Protestants have a higher rate than Catholics or Jews
    e. Marital Status- separated, divorced, or widowed individuals are more susceptible
    f. Social Support- living alone, lack of social support
    g. Employment Status- unemployed or retired
8. Behavioral patterns
    a. Impulsivity, self-injurious, rigid thinking, isolation, suddenly getting life in order, giving away of possessions, failing grades, indifferent or poor work performance, risk-taking behaviors, frequent accidents (may be disguised suicide attempts)
9. Antecedent events

    a. Recent improvement in depressive symptoms, recent significant loss (i.e., job, friend, spouse, family member, physical abilities) or anniversary of a loss, major life changes without adequate coping strategies, history of psychiatric hospitalization, release from hospitalization in past six to twelve months (suicide risk is greater during weekend leave or discharge).
10. Physical conditions
    a. Persistent insomnia, recent surgery or childbirth, intractable pain, presence of hopelessness, helplessness, or exhaustion; significant appetite changes (either increase or decrease), or dramatic change in physical appearance
11. Abandonment
    a. Clinicians clearly document how they respond to patient emergencies, and arrangements they've made for coverage on days not available. Clinicians need to make sure that patients who may be suicidal have access to emergency covering clinician or to call 911.

Assessing Danger to Others
The professional literature acknowledges the imperfection of therapists in predicting violence. Nevertheless, clinicians are expected to exercise clinical judgment in assessing the potential for violence. An ongoing process of systematic self- and peer monitoring and evaluation is recommended. This may be in the form of a structured consultation group, use of patient satisfaction forms, or a psychological testing evaluation. Whenever clinicians have a patient who has a propensity to harm others, consultation with other professionals and documentation of the consultation is essential.

Duty to Warn
If a patient has a history of physical violence, which is known to the clinician, and he/she has a reasonable basis to believe that there is a clear and present danger that the patient will attempt to harm a reasonably identifiable victim, there is a duty to warn mandate.

Whenever circumstances give rise to a duty to warn, clinicians should carefully document in the patient's record their course of action, including the exact times of telephone contacts and phone numbers to the police and the potential victim(s), document names of persons you spoke to if it is not the potential victim, and the exact information verbalized to the police of potential victim(s). The potential victim(s) must be reasonably identifiable to justify a duty to warn the individual. However, when someone else other than the patient is the dangerous party, the clinician does not have the legal mandate to report.

Guidelines for Working with Dangerous Patients
1. Carefully document in the patient's record all actions taken, including your assessment of patient's dangerousness to others and all treatment interventions
2. Keep the patient in therapy with a treatment goal to deal with the aggression
3. Assess the patient's history for violence before breaching confidentiality
4. Consider having the patient get rid of all lethal weapons
5. Increase the frequency of sessions on an outpatient basis (least restrictive environment) or consider inpatient treatment (preferably voluntary status)
6. Encourage the patient to telephone certain identified persons whenever feelings emerge to harm others
7. Enlist the support of patient's family or friends
8. Have patient sign a contract to not harm others, keep a copy on the chart and give a copy to patient
9. Consider a psychiatric consultation for medication
10. Warn third parties only if other actions and measures have been ineffective
11. If warning a third party is unavoidable, only disclose information that is necessary to ensure the safety of the victim, including the name of the therapist, name of patient, name of victim, and the content of the threat
12. Do not give the police or intended victim any information about the patient's diagnosis or family background

13. Use an informed consent approach by receiving the patient's permission for disclosure and contacting the third party in the presence of the patient
14. Consult with colleagues and attorney who have expertise and experience in dealing with patients who are dangerous

Restraint and Seclusion:
Because South Cove is an outpatient community health center, we do not condone or use restraints or seclusion methods. If a patient or individual is causing a disturbance and appear out of control, we will contact emergency services.

6.06 Medical Records Policy

Purpose
This policy provides guidelines for paper and electronic medical record usage and documentation.

Policy
Paper Medical Records
Starting March 2009, the Behavioral Health Department switched over to Electronic Medical Record (EMR). A shadow chart is no longer necessary. Starting in April 1, 2009, some of the paper medical record was scanned into EMR. The following documents include:

1. Registration information
2. All Diagnostic Evaluations prior to 03/09
3. The last two quarterly treatment plans
4. Miscellaneous forms- IEP's Psychological reports, correspondence

Electronic Medical Records

1. Medication and Problem List:
   Medication List and Problem list will be documented and revised using ECW.
   a. MD's will document "Med list reconciled" and "Med list given" under Treatment section (Hit "browse" button) or free text this information.
   b. For non medical SCCHC patients, clinicians will document medications under "Current Medication" if patients know their medication or document that patient did not bring in list of medications under the "Medication History" section. This should be documented in the Diagnostic Evaluation.

2. **Clinical Medical Record Review Form:**
   Starting January 2010, a new clinical record review form will be used. The new form combines the old BH record review form with the Clinical Medical Record Review form of March 31, 2008. The following items were deleted because these items are automatically included in the EMR system. These items are as follows:
   a. Each page contains the patient's name and chart #
   b. Demographic information, including emergency contacts and guardianship information
   c. Appropriate consent forms
   d. All entries include the following: clinician name and degree
   e. All entries are dated
   f. The record is legible
   g. Has patient had 3 or more visits in the Behavioral Health Dept? If not, defer the record review
   h. Unacceptable abbreviations used when writing prescriptions in progress notes?

   The BH Record Review includes the Clinical Medical Record Review Form (01/2010) and The Checklist for Evaluation of Adherence to Treatment Guideline for Depression.

   Peer reviews are to be completed quarterly. Each clinician must evaluate 5 of his or her peers' clinical medical records. If possible, clinicians should evaluate an assortment of different types of appointments (ex. Evaluations vs. Follow-ups vs. Cancellations vs. IAP treatments vs. BH terminations).

3. **Laboratory Reporting of Laboratory Tests Results:**
   a. Certain psychiatric medications require regular lab tests (i.e., Depakote, Lithium, and Clozapine).
   b. Sensitive lab tests are used to measure for LFT's, Lithium, CBC, and WBC.

c. Providers will give a copy of the lab slip to the patient. The lab order will be documented in the progress note or telephone encounter. If the lab result shows abnormal or critical value, the designated provider will be contacted immediately for review/action. If the provider cannot be reached, the provider on site or the medical director will be contacted for consultation.
d. For non-critical labs, the provider will be notified through ECW. The provider will review results and address the report.

4. No Show Policy

- If patient fails to show for the appointment, the provider will send a telephone encounter to the front desk staff or BH case manager to reschedule by the end of the work day.
- The patients will be contacted by telephone and a new appointment scheduled and noted in the medical record via Telephone Encounter in ECW. If the patient does not wish to reschedule, documentation of this information and any reason given will be placed in the record.
- If the patient cannot be reached by telephone after 3 attempts, a letter will be sent to the patient requesting they call for an appointment. Notation on the day the letter is sent will be posted in the medical record.
- Clinician's are required to document in the patient's medical record whenever a patient does not show up for a scheduled appointment, a "no-show" appointment under Telephone Encounter in ECW.
- Clinicians are responsible to document and reschedule patient's appointments in ECW under telephone encounter.

Paper Mail Correspondence to Providers

As of June 16, 2010, all paper mail correspondence received in the Behavioral Health Department for part time providers will be opened by the Site Manager and/or Clinical Supervisor to ensure a timely response.

6.07 Supervision Protocol

Purpose
This policy provides guidelines for proper supervision protocol, and describes the role of the Clinical Supervisor and/ or other designated supervisors.

Policy
Clinical supervision for clinicians is scheduled on a regular basis according to the caseload and the need of the clinician. Trainees (i.e., psychology or social work interns, psychology and social work practicum students, psychiatry interns/residents), are required to have weekly supervision with a designated licensed supervisor. Trainees will also attend group supervision that include MD Rounds, Multidisciplinary Team rounds, and trainee group supervision (if available).

Clinical supervisors of the department or other designated supervisors who provide individual supervision are responsible for implementing the following procedures:

1. Standard Treatment Issues Review:
   Supervisee brings the current case-list to the supervision session for review. This review shall include the following content when appropriate:
   a. Intake
   b. Diagnostic Evaluation
   c. Treatment Plan
   d. Individualized Action Plan (IAP)
   e. Updates on progress of cases
   f. Other relevant issues

2. Risk Management
   a. Supervisee identifies patients who are at risk, seeks suggestions for immediate and appropriate actions. Supervisor discusses the situation and makes suggestions and recommendations. If the problem area is beyond the expertise of the supervisor, consultation should be sought elsewhere.
   b. Supervisor looks for signs and indications of symptoms suggesting potential risks concerning the patient and discusses such issues with the supervisee.

3. Supervisor reviews with supervisee other issues affecting directly or indirectly patient services. Examples of such issues include ethical dilemmas, protecting patient privacy, fee arrangements, and transference/counter-transference.

4. Signing of Clinical Documentation
   a. All clinical documentation must be co-signed by the supervisor.

5. Conflict Resolution
   a. Supervisor attempts to resolve disagreement with supervisees in the supervision process. When unable to resolve the differences, supervisor should consult with the clinical director, if deemed necessary.

6. Clinical Supervisors will keep a log of each supervision encounter with a trainee or non-licensed clinician.

6.08 Policy Title: Toy Cleaning and Purchasing Guide

Purpose
This policy provides guidelines for proper toy cleaning and purchasing.

Policy
Cleaning Toys
Toys most suitable for play areas should be easily cleaned and disinfected. The health center will not have stuffed toys in the playroom. Toys should be hard plastic only. Toys should be cleaned at least on a daily basis. Toys that have been in children's mouths should be removed and placed in a bin reserved for soiled toys.

At the end of each day, the BH staff will disinfect the toys according to the following procedures:

- Scrub the toy in warm soapy water
- Use a brush to scrub crevices
- Rinse the toy in clean water
- Immerse the toy in a mild bleach solution of 1/8 teaspoon bleach and 1 quart warm water and allow to soak in the solution for 10 to 20 minutes
- Remove the toy from the bleach solution and rinse well with cool water
- Air dry

Toys that are appropriately cleaned will be returned to the play area the following clinic day.

Board games and cards will be wiped down using mild soap and water. Games should be wiped down after each use.

Purchasing Toys
All toys purchased for the use of therapy will first be checked on the US Consumer Product Safety Commission website for lists of recalled products. This policy took effect on March 9, 2009 after it was discovered there was a large recall of toys produced in 2007 from China. All toys were checked and inspected against the recall list. Any new toys purchased will need the approval of the Clinical Supervisor.

6.09 General Safety and Emergency Procedures during Working Hours

Purpose
This policy provides guidelines for general safety protocol and emergency procedures during working hours.

Policy
General Safety Procedures:
For **all** incoming individuals:

1. Ask individual:
   "Can I help you?"
   "Are you a patient of South Cove?"
   "Who are you here to see?"

2. Check medical record to see if individual has an appointment.

3. If individual does not have an appointment and they want to see a provider, take name and phone number down and tell individual you will message the provider.

4. Please contact the provider via eclinicial through the "message" system. Please do not call the provider because providers may not pick up right away. Do not allow individual to enter the provider hallway or office. Then, tell individual that they need to leave**.**

   If the individual refuses to leave, see emergency safety procedures below.

Emergency Safety Procedures:
If feeling unsafe at any time, call 911 **and/or** use the paging system and say, "Mr. Smith, please come to (specify floor)".

Please follow this script to call 911:
I am calling from South Cove Community Health Center located at (i.e., 145 South St., 88 Holmes Street, 435 Hancock St. or 885 Washington St). My callback number is _____. There is a patient/individual here on the __ (specify floor and department) who appears unstable and is making the health center staff feel unsafe. The patient/individual has been asked to leave and refuses to do so. Can you please send a police officer right away?

When a BH patient is in a crisis or causing a disturbance at the clinic, the primary mental health provider of the patient should be notified. This primary provider is responsible for handling the situation. The provider should also notify the Clinical Supervisor and/or Director, and PCP (if appropriate) for consultation.

If the crisis involves a non-BH patient, the procedure for Triage (see Intake, Policy 1.1) should be followed. A behavioral health clinician should be notified to evaluate the situation and to follow through with disposition. Clinical Supervisor/ Director can also be paged at any time for consultation. If the patient is taken to the emergency room, provide the EMT a copy of patient's cover sheet, problem list and medication list. Inform the PCP, if appropriate.

If this person is unknown to the above places and continues to create a disturbance, request police assistance by dialing 911. Upon police arrival, the following options should be considered depending on the situation:

1. Request the police to take the person off the premise immediately
2. The person may be escorted to the police station for evaluation

3. The person may be escorted to the nearest emergency room

Clinicians should take the following action if they do not feel safe with a patient or potential patient:

1. Alert the front desk and request for someone to walk by the counseling room in case assistance is needed.
1. Keep the door open. Inform the patient the reason you are keeping the door open.
2. Request for another clinician to sit in on the evaluation for assistance.
3. Do not sit between the patient and the office door. Sit to the side of both patient and the office door for easy access to exit.

Specific sites should modify safety procedure as needed**.**

6.10 Emergency Procedures after Working Hours and on Weekends

Purpose
This policy provides guidelines for proper protocol for emergency procedures after working hours and on weekends

Policy
If a BH patient is in a crisis after work hours or on weekends, patients can call 617-482-7555 or 617-521-6730 and be directed to reach BH on call clinician.

Patients should also be instructed to go to the nearest emergency services of a general hospital, if in crisis. This information should be related to the patient's BH provider who will make the necessary contacts and follow-up the following workday. This information is also provided on every appointment card.

6.11 Patient Hospitalization- Holmes Street

Purpose
This policy provides guidelines for proper protocol for patient hospitalizations at the Holmes Street location.

Policy
Patients in need of hospitalization should be sent to the nearest emergency room. The emergency room will be notified and arrangements should be made to transport the patient to that location. In the event of an emergency, call 911 for assistance. Do not make any announcements on the intercom system.

BH Provider

1. Assess patient to determine if patient needs to be further evaluated at the emergency room.

2. Involuntary Hospitalization
    a. Fill-out paperwork (Section 12Aform: "Application for an Authorization of Temporary Involuntary Hospitalization", provide the EMT a copy of patient's cover sheet, problem list and medication list, notify authorities and notify front desk staff.
    b. Identify yourself by name to front desk staff as they are not familiar with who is in on a given day, vacation coverage, etc.

3. Voluntary Hospitalization
    a. Assess patient's competency to apply for voluntary admission to hospital as well as desire to receive treatment.
    b. For patients under the age of 16, ensure and confirm the representative applying for admission is indeed patient's parent/guardian.
    c. Refer to Department of Mental Health Regulations (104 CMR 27.06)

> **§ 2.2 VOLUNTARY ADMISSION**
>
> A person may be admitted voluntarily to a Department of Mental Health–operated or -licensed facility for the care and treatment of mentally ill persons (*see* G.L. c. 123, § 1; 104 C.M.R. § 27.03(2)) on either of two statuses:
>
> - voluntary, or
> - conditional voluntary.
>
> G.L. c. 123, § 10.
>
> In either case, the person must be in need of inpatient care and treatment, and the facility must be suitable to provide such care and treatment. G.L. c. 123, § 10; 104 C.M.R. § 27.06(1)(a). Any mental disorder of whatever degree of severity, including alcoholism, is sufficient for voluntary or conditional voluntary admission, if necessary and appropriate. 104 C.M.R. § 27.05(2). In contrast, involuntary commitment requires that the person suffer from mental illness, which is defined as
>
> > [a] substantial disorder of thought, mood, perception, orientation or memory which grossly impairs judgment, behavior, capacity to recognize reality or ability to meet the ordinary demands of life, but shall not include alcoholism or substance abuse as defined in G.L. c. 123, § 35.

Applications for admission may be made by

- the person, if sixteen or older (104 C.M.R. §§ 27.06(7), 27.09(6));
- the parent or legal guardian of a minor (104 C.M.R. §§ 27.06(7), 27.09(6)); or
- a health care agent, pursuant to a validly executed health care proxy.

G.L. c. 123, § 10; 104 C.M.R. § 27.06(1)(c). With respect to a health care proxy, see *Cohen v. Bolduc*, 435 Mass. 608 (2002). General Laws c. 190B, § 5-309(f) prohibits a guardian of an incapacitated adult from admitting that person into a psychiatric facility.

An individual applying for admission may be admitted only if he or she is competent and wants to receive treatment. 104 C.M.R. § 27.06(1)(b)–(d). Before being admitted, the applicant must be afforded the opportunity to consult with an attorney, or a person working under the supervision of an attorney, regarding the legal effect of such an admission. G.L. c. 123, § 10; 104 C.M.R. § 27.06(2). Failure to inform the person of his or her right to consult with counsel before signing a conditional voluntary admission form brings into question the legal validity of the conditional voluntary admission. Counsel should always inquire into the circumstances by which the conditional voluntary form is signed. Upon admission, the person must be informed of his or her legal and human rights within the facility. 104 C.M.R. § 27.06(3). A complete psychiatric and physical examination must be conducted within twenty-four hours of admission. G.L. c. 123, § 5; 104 C.M.R. § 27.05(3).

https://www.publiccounsel.net/mh/wp-content/uploads/sites/3/2016/03/Ch.-2-Admission-to-a-Psychiatric-Facility.pdf

Front Desk Staff

1. Notify other front desk staff members, Margaret, and the 2nd floor BH Unit Secretary that the ambulance is on its way.
2. BH Unity Secretary will inform other 2nd floor front desk staff about what is happening.
3. The police may also arrive if warranted by the BH provider.

Next Steps

1. Once ambulance has arrived, the front desk staff will inform the BH provider
2. Margaret or a front desk staff member will escort the authorities to the BH office
3. If a stretcher is necessary, exit the building using the staff hallway on the 2nd floor along the Medical Records room.

Telephone Extensions

Front Desk	x3201
Margaret Cheung	x3245
Shirley Zhen	x3233
Catherine Vuky/Owan Chow	x3234
Eva Wu	x3235
Pauline Chan	x3236

6.12 Patient Hospitalization- South Street

Purpose
This policy provides guidelines for proper protocol for patient hospitalizations at the South Street location.

Policy
Patients in need of hospitalization should be sent to the nearest emergency room. The emergency room will be notified and arrangements should be made to transport the patient to that location. In the event of an emergency, call 911 for assistance. Do not make any announcements on the intercom system.

BH Provider

1. Assess patient to determine if patient needs to be further evaluated at the emergency room.

2. Involuntary Hospitalization
    a. Fill-out paperwork (Section 12Aform: "Application for an Authorization of Temporary Involuntary Hospitalization", provide the EMT a copy of patient's cover sheet, problem list and medication list, notify authorities and notify front desk staff.
    b. Identify yourself by name to front desk staff as they are not familiar with who is in on a given day, vacation coverage, etc.

3. Voluntary Hospitalization
    a. Assess patient's competency to apply for voluntary admission to hospital as well as desire to receive treatment.
    b. For patients under the age of 16, ensure and confirm the representative applying for admission is indeed patient's parent/guardian.
    c. Refer to Department of Mental Health Regulations (104 CMR 27.06)

§ 2.2 VOLUNTARY ADMISSION

A person may be admitted voluntarily to a Department of Mental Health–operated or -licensed facility for the care and treatment of mentally ill persons (*see* G.L. c. 123, § 1; 104 C.M.R. § 27.03(2)) on either of two statuses:

- voluntary, or
- conditional voluntary.

G.L. c. 123, § 10.

In either case, the person must be in need of inpatient care and treatment, and the facility must be suitable to provide such care and treatment. G.L. c. 123, § 10; 104 C.M.R. § 27.06(1)(a). Any mental disorder of whatever degree of severity, including alcoholism, is sufficient for voluntary or conditional voluntary admission, if necessary and appropriate. 104 C.M.R. § 27.05(2). In contrast, involuntary commitment requires that the person suffer from mental illness, which is defined as

> [a] substantial disorder of thought, mood, perception, orientation or memory which grossly impairs judgment, behavior, capacity to recognize reality or ability to meet the ordinary demands of life, but shall not include alcoholism or substance abuse as defined in G.L. c. 123, § 35.

Applications for admission may be made by

- the person, if sixteen or older (104 C.M.R. §§ 27.06(7), 27.09(6));
- the parent or legal guardian of a minor (104 C.M.R. §§ 27.06(7), 27.09(6)); or
- a health care agent, pursuant to a validly executed health care proxy.

G.L. c. 123, § 10; 104 C.M.R. § 27.06(1)(c). With respect to a health care proxy, see *Cohen v. Bolduc*, 435 Mass. 608 (2002). General Laws c. 190B, § 5-309(f) prohibits a guardian of an incapacitated adult from admitting that person into a psychiatric facility.

An individual applying for admission may be admitted only if he or she is competent and wants to receive treatment. 104 C.M.R. § 27.06(1)(b)–(d). Before being admitted, the applicant must be afforded the opportunity to consult with an attorney, or a person working under the supervision of an attorney, regarding the legal effect of such an admission. G.L. c. 123, § 10; 104 C.M.R. § 27.06(2). Failure to inform the person of his or her right to consult with counsel before signing a conditional voluntary admission form brings into question the legal validity of the conditional voluntary admission. Counsel should always inquire into the circumstances by which the conditional voluntary form is signed. Upon admission, the person must be informed of his or her legal and human rights within the facility. 104 C.M.R. § 27.06(3). A complete psychiatric and physical examination must be conducted within twenty-four hours of admission. G.L. c. 123, § 5; 104 C.M.R. § 27.05(3).

https://www.publiccounsel.net/mh/wp-content/uploads/sites/3/2016/03/Ch.-2-Admission-to-a-Psychiatric-Facility.pdf

Front Desk Staff

1. Notify Christine and/or other Front desk staff that the ambulance is on the way.
2. The police may also arrive if warranted by the BH provider.

Next Steps

- Once ambulance has arrived, the front desk staff will inform the BH provider.
- Christine or a front desk staff member will lead the authorities to the BH office.

If a stretcher is necessary, exit the building using the elevator in the waiting room area.

Telephone Extensions

Front Desk	x6730
Christine Keung	x6782
Catherine Vuky	x3234
Yun (San) Wang	x6738, x3233
Dr. Paul Yin	x6737
Owan Chow	x6734
Dr. Albert Yeung	x6736
Senki Liu	x6733
Pauline Chan	x3236
Danielle Joyce	x6731

Dr. Alison Tam	x3235

6.13 Medical Records Release Policy

Purpose
This policy provides guidelines for proper protocol for the release of patients' medical records, particularly psychotherapy notes.

Policy
Definitions

1. **Psychotherapy Notes**:
   Psychotherapy notes are notes that are recorded (in any medium) by a mental health professional and that document, analyze, or interpret the contents of a conversation during a private individual, joint, group, or family counseling session.

2. **Mental Health Professional** includes:
   a. Psychiatrist,
   b. licensed Psychologist,
   c. licensed Social Worker,
   d. interns
   e. practicum student
   f. any Psychiatry Resident, Psychiatry or Psychology Fellow or graduate student of the foregoing categories who is providing services under supervision; licensed Psychiatric Nurse Practitionert; AND "allied mental health and human services professional" to the extent that any work for South Cove. This includes:
      - licensed Mental Health Counselor
      - licensed Marriage and Family Therapist
      - licensed Rehabilitation Counselor
      - licensed Educational Psychologist
      -

3. **Legal Health Record** is:
   a. generated at or for SC as its business record.
   b. the record that will be disclosed upon request
   c. the documentation of healthcare services provided to an individual during any aspect of healthcare delivery in any type of healthcare organization.
   d. individually identifiable data, stored on any medium, and collected and directly used in documenting healthcare or health status.

Maintenance of Psychotherapy Notes

1. Psychotherapy notes contain highly sensitive information. Consequently, they require an extraordinary level of confidentiality (Reference: Individuals' Right under HIPAA to Access their Health Information 45 CFR § 164.524).
2. Psychotherapy notes may be accessed by all South Cove providers overseeing a patient's care. Under certain circumstances, providers other than behavioral health providers may be denied access to a patient's psychotherapy notes.

Use and Disclosure of Psychotherapy Notes

1. A patient's psychotherapy notes may not be used or disclosed without a patient's prior authorization, unless the use or disclosure is to carry out the following purposes:
   a. Use by the originator of the psychotherapy notes for treatment;
   b. Use or disclosure by the covered entity for its own training programs in which students, trainees, or practitioners in mental health learn under supervision to practice or improve their skills in group, joint, family, or individual counseling;
   c. Use or disclosure by the covered entity to defend itself in a legal action or other proceeding brought by the individual;

d. A disclosure required by the Office of Civil Rights (OCR) to investigate or determine South Cove's compliance with the HIPAA Privacy Standards;
e. Use or disclosure required by law and the use or disclosure complies with and is limited to the relevant requirements of such law;
f. To a health oversight agency for oversight activities authorized by law with respect to the oversight of the originator of the psychotherapy notes;
g. To a coroner or medical examiner for the purpose of identifying a deceased person, determining a cause of death, or other duties as authorized by law; or
h. If necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public, and is to a person or persons reasonably able to prevent or lessen the threat, including the target of the threat.
i.

Patient Access to Psychotherapy Notes

1. The patient does NOT have a right to inspect or obtain a copy of their psychotherapy notes. The originating provider may deny patient access to their psychotherapy notes. The reason for refusal must be clearly documented. However, the patient may be provided access to a summary of their behavioral health treatment.

Notes from Psychotherapy Visits

1. Documentation beyond "Psychotherapy Notes" needs to be present and generally available to other clinicians in order to identify scope and treatment. Elements that do not require special protection include:
    a. medical prescription and monitoring,
    b. allergies,
    c. counseling session start and stop times,
    d. the modalities and frequencies of treatment furbished,
    e. results of clinical tests, and
    f. any summary of the following items:
        - diagnosis
        - functional status
        - treatment plan
        - symptoms
        - prognosis
        - progress to date.

Release of Medical Records

1. Procedures
    a. Patients requesting access to their medical records will be provided an "Authorization to Disclose Health Information" form. Patients must accurately complete this form in its entirety.
    b. Upon receipt of this completed authorization form, the request will be submitted for approval. The process for managing these requests is as follows:
        - If the request is granted, the patient or their designee (person or entity) will be provided with the information requested within the receipt of the request.
        - If the request is denied in whole or in part, the patient or their designee (person or entity) will be provided with a written notice of the denial within one week. This notice includes the following:
            - the basis for the denial,
            - if applicable, a statement of the individual's review rights, including a description of how they may exercise such rights, and
            - a description of how the individual may file a complaint with the Site or to the Office of Civil Rights. The description must include the name or title, and telephone number of the contact person or office.

c. Patients may request the right to review their medical records in person and/or with their provider. In these situations, a time within business hours will be scheduled when appropriate site staff or the patient's provider will be available while the patient reviews the record in a confidential setting.
d. A patient of less than 18 years of age cannot consent to disclosure of his/her health record without the authorization of a parent or legal guardian. The parent or legal guardian also retains the right to inspect the minor's medical record. However, there are exceptions where a minor patient has the right to consent to the disclosure of his/her health record. The exceptions are as follows:
    - Emancipated minor, except when a minor's life or limb is endangered, medical records are not to be released to parents of a minor who is: a) married, widowed or divorced; b) a parent; c) a member of the armed forces; d) pregnant (or believes to be); e) living apart from parents and managing his/her own financial affairs; f) reasonably believes him/herself to be suffering from sexually transmitted or other disease dangerous to the public health and the health record relates to diagnosis or treatment of such disease; or g) at least 12 years old, has been found to be drug dependent by 2 or more physicians and the health record relates to the diagnosis or treatment of such drug dependency.
    - Mature minor, a minor who a physician deems to be "mature" may be treated as an adult for purposes of consent to medical treatment and access to health records. The physician will consider a) whether the minor is capable of giving informed consent, and b) whether or not it would be in the minor's best interest to notify his or her parents. If the treating physician has treated the minor as a mature minor for treatment and consent decisions, it is appropriate to treat the minor consistently with regard to access to health records and confidentiality.
    - *Whenever a parent or legal guardian requests access to a health record (or copies of a record) for a patient age 12 years to 18 years, a thorough review of the health record must occur to determine if it contains statutorily protected or sensitive information. If the health record contains such information and if the minor does not fall under the "emancipated minor" definition, then the physician that has provided and/or documented the information must be contacted directly prior to its release. The provider will be asked if the patient has been treated as a "mature minor". If the provider indicates the patient is being treated as a "mature minor" then he/she must document that the patient is being treated as a mature minor. Any notes that the provider determines should not be released to the parents should be labeled as such.*
    - Records of minors who have received authorized consent from Superior Court for a termination of pregnancy cannot be released without the minor's or court's authorization.

2. Contents of Legal Health Record: Data and documents to Be Considered Part Legal Health Record
    a. Allergy records
    b. Consent forms for care, treatment and research
    c. Consultation reports
    d. Diagnostic images
    e. Discharge summaries
    f. E-mail messages containing patient-provider or provider-provider communications regarding care or treatment.
    g. Emergency department records
    h. Laboratory reports
    i. Medication administration records
    j. Patient education or teaching documents
    k. Patient identifiers (medical record number)
    l. Problem Lists

m. Progress notes
n. Psychology and psychiatric assessment and summaries
o. Records received from another healthcare provider if they were relied on to provide healthcare to the patient.
p. Referral requests
q. Telephone messages containing patient-provider or provider-provider Communications regarding care or treatment.
r. Telephone note (on-call)

3. Documents Not Included in the Legal Health Record
The following data and documents should be provided the same level of confidentiality as the legal health record. However, they should not be considered part of the legal health record and would not be produced in response to a subpoena for the medical record.

a. Authorization forms for release of information

b. Correspondence concerning requests for records

c. Databases containing patient information

d. Financial and insurance forms

e. Incident or patient safety reports

f. Logs

g. Psychotherapy notes

6.14 Psychiatric Medication Administration – Patients' Own Medications (POM)

Purpose

Patients requiring periodic long-acting antipsychotic injections need to bring their own medication to the clinic for assistance from clinical staff to administer their medications.

Policy

1. The psychiatric nurse practitioner or licensed provider will check a patient's own mediation (POM) brought to the office to ensure it is prescribed by a health care provider and labeled with the patient's name, medication name/strength/expiration date and directions for use.
2. The psychiatric nurse practitioner or licensed provider will administer the medication as per the treating physician's order and document the administration in the medical record. Injections will be given only if there has been a documented order by the psychiatrist within the last three months.
3. Injections will be administered in a lab or exam room on the 1st floor (Ob/Gyn dept.).
4. After administration of the medication, the patient's own medication will be returned to the patient or discarded as appropriate.
5. The psychiatric nurse practitioner or licensed provider will notify patient when medication is running low or close to expiration so that the patient can obtain more medication.
6. Psychiatric nurse practitioner or licensed provider will dispose of the POM properly when it becomes expired and inform patient.
7. In the absence of an authorized BH provider, a nurse in the Adult Medicine department will administer the medication. The person giving the injection will document administration of medication. Additionally, if a prescription change is needed, the back-up psychiatrist or psychiatric nurse practitioner should be contacted. Other physicians in SCCHC should not be used in this situation.

7.00 Dental Policies

Department mission:
South Cove's Dental Department Mission is to provide high quality, accessible and affordable dental care for all patients and families registered at the health center and to make a positive impact on the dental health of the Asian American communities in the greater Boston area.

Types and/or ages of patients served:
South Cove's Dental Department is a general dentistry practice and serves all ages of patients within the scope of services defined for a general dentistry license. Our service usually begins with children at ages 1-3 years through the elderly. All our services are ambulatory and primary care.

Scope and complexity of patient Needs:
South Cove's Dental Department provides all mandatory Level I (Emergency Dental Services) and Level II (Primary Prevention) services. High priority for dental care is given to those families registered as South Cove members. Emphasis will be given to preventive dental services such as fluoride education and dental prophylaxis. All the dentist practicing at the department are general dentists. If complicated situations arise, the patients will be given a referral to the appropriate specialist for care.

Patients are seen by appointments primarily. Appointments will vary depending on the needs of the patients. Emergency patients will be triaged and seen within twenty-four hours of the call, according to the dental department emergency protocol.

The appropriateness, necessity and timeliness of support services:
South Cove dental services are an internal part of the primary care services of the health center. The department shares the same medical record with the rest of the organization. Consultations referred by other departments are handled on the same day unless the referring provider deems the condition non-emergent. South Cove dentists refer all patients with significant medical conditions such as uncontrolled hypertension and heart murmurs to the appropriate physicians for review and consultation. All dental records are stored in the general medical records department and release of records follows standard procedures.

Availability of necessary staff:
South Cove's Dental Services is designed to be staffed by at least one licensed dentist during the normal working hours of the health center. In most weekdays, there are two dentists working with two dental assistants except for new start-up locations where there may be only one team.

Emergency telephone triage is available through the Adult Medicine or Pediatric emergency call service. The Dental Director or designate will be contacted by the Internist or Pediatrician as needed.

Recognized standards of practice guidelines:
The Dental Department subscribes to the guidelines for Dental programs listed in the Massachusetts Department of Public Health.

Scheduled Office Hours

The dental clinic will operate under an appointment system for all regularly scheduled office hours.

The hours are:

<u>Dental Hours – South Street</u>

Monday – Friday: 9:00 AM – 5:30 PM

Saturday: 9:00 AM – 3:00 PM

Dental Hours – Quincy Site

Monday – Friday: 9:00 AM – 5:30 PM
Saturday: 9:00 AM – 3:00 PM

The dental clinic will observe all holidays in accordance to the holiday schedule of the health center.

Staff Courtesy

Staff courtesies will be maintained in accordance with the health center's established polices.

Appointment Reminders

All schedule patients will be reminded, by a telephone call from a South Cove staff, 24 – 72 hours in advance of their appointment.

Recall Policy

When the dental treatment plan for each patient is completed, the dentist will advise the patient on a recall schedule that is determined by the individual needs of the patient, based on sound clinical judgment. The dentist will communicate this recall schedule to the patient in the dental operatory. He/she will also communicate this recall schedule, by writing on the encounter form, to the scheduling receptionist, who will make an appointment for the patient in South Cove's computerized appointment system. The patients will be reminded of their scheduled recall appointment based upon the above reminder policy.

7.01 Protocol for dental patients with an appointment

1. New patients will be requested to arrive 15 minutes prior to their dental appointment for South Cove registration.

2. During the initial visit:
    a. Medical and histories are taken
    b. Charting of the oral cavity and documentation of the head and neck examination will be performed.
    c. Dental radiographs are taken where indicated.
    d. Dental treatment planning occurs.

3. During subsequent visits:
    a. The agreed upon treatment plan and sequence is followed
    b. Referrals when indicated
    c. Routine recall & reassessment plan is established.

7.02 Protocol for walk-in emergency patients

1. The walk-in patient, if new, will be registered at central registration
2. Medical and dental histories are taken
3. Oral examination of the acute area. Dental radiographs will be taken when indicated.
4. Discussion of the diagnosis and recommended dental treatment with the patient. If agreed upon, the treatment is rendered, or appropriate referrals given.
5. Follow-up treatment and appointment will be given, where indicated.

7.03 No Show Appointments

Purpose
The purpose of this policy is to provide guidelines for the consistent follow up of patients who have missed a scheduled appointment.

Policy
For any patient who missed their appointment:

1. A note will be placed in the progress notes of the chart by the dentist.

2. If a follow-up evaluation is indicated by the dentist in the previous progress notes, the receptionist will call and reschedule the patient.

3. Any uncertainty in the progress note should be brought to the attention of the dentist.

4. After three no-show appointments, SCCHC has the right to deny the patient further dental appointment EXCEPT in cases of emergencies.

7.04 Obtaining Medical Information for a SCCHC Dental Patient from another Provider in SCCHC

Purpose
The policy describes the procedure to follow to obtain medical information for SCCHC dental patients from another provider in SCCHC.

Policy
The Dental Department maintains a separate dental health record for every patient that is treated in the dental department at both clinical sites that provide dental care to patients. The dental patients that are being seen by providers other than the dental providers will maintain the same medical record number as on their primary health record.

The Dental Department providers will always be able to have access to the medical record information of the dental patients being treated by any other providers at SCCHC.

The dental providers will be able to obtain the patient's most current Problem List and Medication List and any other pertinent information from either the Washington Street clinic or the Hancock Street clinic by contacting the Medical Records Department staff at either clinic and requesting the documents of the particular patient, or by viewing the patient's data in the eClinicalWorks electronic medical record on the computer.

The Medical Records Staff will then either fax the documents or send a copy of the documents via the interoffice mail, depending on the time of the scheduled dental appointment, to the requesting Dental Department for review by the dental provider and insertion into the Dental medical records.

7.05 Obtaining Medical Information for a Patient from another Provider/Healthcare Facility/Dental Office

Purpose
Procedure to follow to obtain medical information for dental patients from another provider or healthcare facility or dental office.

Policy
The dental staff will use the SCCHC Clinical Policy 5.8 to obtain the necessary information: “Obtaining Patient’s Medical Record from another Healthcare Facility or Provider”.

7.06 Dental Extractions

Purpose
The purpose of this policy is to provide guidelines for dental extraction procedures.

Policy
1. The dentist should first explain to the patient the need for a dental extraction in conjunction with the following steps:
   a) The x-ray of the tooth/teeth to be extracted shall be shown to the patient to indicate non-restorable status.
   b) The tooth/teeth to be extracted should be clearly marked by a red pencil in the dental chart on the Dental Recall page.
   c) The patient shall be shown the tooth/teeth to be extracted by the use of a mirror.
   d) Time-Out – a period of 10 minutes shall be given to the patient to make an informed decision for the extraction.

2. Once the patient agrees to the extraction, he/she must sign an Oral Surgery Consent form. The contents of the form shall be fully explained to the patient (by an interpreter, if needed). After the patient has acknowledged that he/she fully understood the terms, both the patient and dentist will sign and date the consent form.

3. The verification checklist at the bottom of the Consent form shall be completed according to the steps taken above. After completion, the checklist shall be initialed by the staff member.

4. Once the patient has agreed to the extraction, the dental assistant will take the blood pressure and record the reading on the Oral Surgery Consent form.

5. When all the above steps have been completed, the dentist can proceed with the extraction.

7.07 Management of an Emergency in Dental Department

Purpose
Procedure to follow in an emergency in the dental department.

Policy
Procedure to follow in an emergency:

1. The dentist will stay with the non-responsive patient.

2. For Quincy: the dental assistant will immediately page “Code Blue, Dental Department” by dialing x3303 and also ask someone to dial 911 and report the emergency.

3. For South Street: the dental assistant will immediately page “Code Blue, Dental Department” by dialing x3301 and also ask someone to dial 911 and report the emergency.

4. Staff will follow the Emergency protocol for the health center.
(See Policy 1.04 in the SCCHC Clinic Policy Manual).

7.08 After Clinic Hours Telephone Coverage

Purpose
Emergency coverage for after-clinic hours.

Policy
During clinic hours (see below for the two sites), all dental emergencies will be directed to the dental department. The dental staff will assess the emergency and will treat the patient appropriately. After the clinic hours, all emergencies will be covered via the emergency answering service of the health center. The phone calls will be covered by Adult Medicine on-call staff.

If the situation is acute and the on-call staff determines that a dentist's involvement is needed, then the on-call staff will determine from the patient who is his/her regular dentist at south Cove. The on-call staff will then call that dentist for consultation. If that dentist is not available, then the Dental Director should be contacted.

Dental Hours – South Street

Monday – Friday: 9:00 AM – 5:30 PM
Saturday: 9:00 AM – 3:00 PM

Dental Hours – Quincy Site

Monday – Friday: 9:00 AM – 5:30 PM
Saturday: 9:00 AM – 3:00 PM

7.09 Emergency triage of patients in the Dental Department

Purpose
Protocol for emergency triage of patients in the dental department.

Policy
Procedure to follow to provide emergency triage services to dental patients is as follows:

1. The patient will be referred to a dental provider for emergency triage of care by either the dental department receptionist during normal working hours or by the Adult Medicine/Dental department representative who is on “off hours call”.

2. The patient’s complaint will be screened and triaged by the dental provider.

3. Patients complaining of, or presenting with any kind of oral swelling must be evaluated on the same day be a dental provider.

4. All emergency patients should be seen within three days (72 hours) if all possible.

5. Each dental provider may be given up to two (2) emergency patients per day of their schedule.

6. The preferred hours within which to schedule the patient with an emergency are recommended as between 9:00-11:00 AM and 1:00-4:00 PM.

7. The patient may be referred to another dental care facility for care if the provider deems this necessary and in the best interest of the patient.

7.10 Dental Department Storage of Local Anesthetic Medicine

Purpose
Provides a consistent and safe process for the management and dispensing of local anesthetic medicines used in the administration of dental care to patients.

Policy
The central supply of all local anesthetic medicines used in the dental department will be secured and stored in a locked cabinet inside each exam room.

The department director must authorize and approve the list of persons having access to the medicine supply cabinet as well as the location and accessibility by designated dental department staff of the key to the cabinet.

Allocation of the medicines to the dentists working in the department will be done on a “one box/container at a time” method of distribution for usage. Each dental operatory room will have one container of each of the two medicines securely stored in a locked drawer of a cabinet in the dental room.

A log of the use of each of the local anesthetics will be the responsibility of the dentist.

The log will contain the name of the patient, dental record number, date/time of usage, number of doses administered and provider’s signature.

A log book will be used for each box of medicine and it is maintained in each exam room.

7.11 Surgical Instrument Cleaning Protocol

Purpose

The purpose of this policy is to list the steps to follow when cleaning surgical instruments.

Policy

The Dental Department's dental assistant is instructed to do the following:

1. Wearing rubber gloves, place all the surgical instruments into the basket of the Hydrim instrument washer.
2. Close the door and select the appropriate cycle
    - Regular cycle for lightly soiled instruments
    - Heavy-duty cycle for heavily soiled instruments
3. Once the cycle is completed, unload the instrument and place in the dated sterilization pouch.
4. Place pouches into the autoclave in the recommended manner.
5. Close and latch the door.
6. Select "Pouch" cycle.
7. Press "Start" button.
8. Run cycle.
9. Remove instruments from autoclave when cycle is completed.
10. Date pouch with current date.

7.12 Protocols for using the Ultrasonic Unit

Purpose

The purpose of this policy is to list the steps to follow when cleaning dental burs and other instruments.

Policy

The dental assistant is instructed to do the following:

1. Make the solution to be used for soaking/cleaning the instrument
   - Select one of the clean empty distilled water gallon containers.
   - Measure 2 ounces of “multi-enzymatic cleanser” and pour into the bottle. Fill the bottle with water.
   - Shake the bottle to mix the cleanser with the water
   - Pour the solution into the stainless steel pan.

2. Place the dental burs/instruments into the ultrasonic unit.
3. Soak the bur/instrument for at least 10 minutes before taking out of solution.
4. Preparation of cleaned instrument for the packing pouches for autoclave:
   - Remove the cleaned instruments from pan
   - Rinse with clean tap water
   - Pat dry with clean paper towels
   - Place instruments into dated sterilizer packing pouch
   - Place pouches into autoclave in the recommended manner
   - Close and latch the door
   - Select “pouch” cycle
   - Press “start” button
   - Run cycle
5. Remove the pouch from the autoclave when the cycle is complete.
6. Date the pouch with current date.
7. At the end of the day, empty the ultrasonic unit.

7.13 Dental Instruments Cleaning Protocol

Purpose
The purpose of this policy is to list the steps to follow when cleaning dental cassettes and headpieces.

Policy
The Dental Department's dental assistant is instructed to do the following:

Dental Instruments
1. Wearing protective gloves, place all dirty instrument cassettes into the Hydrim instrument washer and follow its manual of operation
2. Pack the dried cassettes into appropriate dated sterilization pouch.
3. Place into the Statim or autoclave.

Dental Headpieces
1. Wearing utility gloves, scrub dirty headpieces under the flowing water to remove all visible contaminants.
2. Pat dry the headpieces
3. Place the headpieces into the statmatic handpiece maintenance unit and run the cycle.
4. Once completed the cycle in the statmatic unit, remove and place into dated sterilization pouch.
5. Place into the statim or autoclave.
6. Place lubricant into the slow handpiece motor before usage.

Procedure for Hydrim Instrument Washer
1. Load dirty cassettes into the washer
2. Set the power button to ON.
3. Select the appropriate program (P0-P4):
    - The display will show the selected program
    - The program then starts automatically
    - During the program, the display alternated between the cycle selected and the approximate time remaining in the cycle. The indicated light for the selected program is lit.
4. The program has ended when "00" appears in the display and the buzzer sounds for 10 sounds.
5. After the program has ended:
    - Set the power button to OFF and open the door
    - Remove the instruments from the washer to be packaged.

**For a complete list of step-by-step instruction, please review the Operation Instruction section of the Hydrim L110w Operator's Manual.

Procedure for Statim Autoclave
1. Load instrument in usual manner. DO NOT OVERLOAD!!
2. Insert the cassette into the statim unit
3. Push the "WRAPPED CYCLE" button.
4. Push the "START" button
5. After the sterilization cycle is finished, and before removing the cassette for the autoclave, the assistant must call the dentist to verify the cycle.
6. Record the cycle into the logbook.

**For a complete list of step-by-step instruction, please review the Operation Instruction section of the Statim Operator's Manual.

7.14 Protocols for Spore Test

Dental Department conducts weekly spore test for all of the Dental heat sterilizers using the Confirm 10 Biological Indicator for Steam Sterilization.

Protocol for Using Crosstex Confirm 10 Biological Indicator system

1. Record the sterilizer number, load number and processing date on the Biological Indicator label.
2. Place one or more Biological Indicator's inside an instrument tray, rigid container, peel pouch or process challenge device.
3. Test the most challenge area in the sterilizer as indicated in the sterilizer manual.(i.e. the bottom shelf near the door, over the drain of the large sterilizer or in the middle shelf of a small sterilizer)
4. Process the load according to the manufacturer's instructions.
5. Remove the Biological Indicator and confirm the process indicator printed on the label has turned Brown/Black. Causation: After processing, the Biological Indicator is hot and under pressure. Always allow to cool for 10 minutes before crushing. Failure to do so will cause the glass ampule inside the Biological Indicator vial to burst which may result in injury. For this reason, wear safety when handling and crushing the Biological Indicator.
6. Positive Control: Place a non-sterilized Confirm 10 biological indicator in the incubator each day you put in an activated sterilized biological indicator (Must be from same lot# as the Biological Indicator).

Activation and Incubation

1. Activate the processed Biological Indicator within 24 hours after processing by gently crushing the inner glass media tube using a vial crusher.
2. Incubate at 50-60°C for 10 hours checking the spore growth (visual color change from purple to yellow) at regular intervals (i.e. 3,5 and 8 hours). Growth of surviving spores has been observed in as little as 2.5 hours.

Final Interpretation and recording of Test Results

1. After 10 hours of incubation of the Confirm 10 Test and Control vials.
2. Verify and record the results of the Biological Indicator (Purple = Pass, Yellow = Negative). A Pass means spores did not grow in the processed vial.
3. Verify and record the results of the control (Yellow = Pass, Purple = Fail). A Pass means that spores grew in the un-processed test vial.
4. Report any failure in the Biological Indicator or Control immediately to a supervisor and take the sterilizer out of service until resolved.
5. Dispose of used indicators in accordance with facility policy. You may wish to sterilize any positive indicators (ask your supervisor for proper procedure).

Protocol for a failed spore test

1. Any instrument that was sterilized since the last negative spore test result will need to be re-sterilized.
2. Any patient seen within the period of a failed spore test will have their medical record flagged in the eCW system for any possible dental/medical emergency.
3. The sterilizer will need to be re-tested again and pass the spore test before it can be used for sterilization.
4. After re-testing the sterilizer, if still getting failed test results, Stat-Biomedical should be contacted immediately.

7.15 Dental Department Statmatic Handpiece Maintenance Unit

Procedure

Statmatic Handpiece Maintenance Unit cleans dental headpieces. Operating and maintenance procedures are summarized below.

Instructions for Use

1. Turn on power switch. LED (Stand by) will illuminate green.
2. Open front door, place instruments inside. Close front door.
3. Press “Start” button. Program runs automatically.
4. Open front door, remove instruments.
5. LED will turn off upon removal of instruments.

See attached for complete instructions.

Maintenance

Routine maintenance involves performing the following:

1. Insert spray can
2. Remove spray can
3. Disposal of spray can
4. Exchange absorption pad
5. Set maintenance time

See attached for complete instructions.

Troubleshooting

1. Absorption pad should be changed when the spray can is empty
2. If LED illuminates orange, check to see if it is time to change:
    c. The spray scan
    d. The air compressor.

7.16 Dental Digital Radiograph Procedure

Procedure

1. Seat the patient in x-ray position.*
2. Open the Dexis application in the computer.
3. Connect the Dexis senor to the computer.
4. Place the lead apron onto the patient; make sure the neck area is covered to protect the thyroids.
5. Adjust x-ray machine to the proper exposure time.
6. Exit the room and push the x-ray button outside the room.**
7. After completion of x-ray taken, wipe down the sensor and the lead apron with caviwipe. Return the sensor into the storage box and hang up the apron.

*Per Massachusetts Department of Public Health Radiation Control Program Regulation, doors can remain open during the x-ray procedure.

** For handicap or non-compliance patient, a family member can maintain in the room to assist with the radiograph process with proper protection.

7.17 Dental Panoramic Film

South Cove Community Health Center does not have the panoramic machine in the facility. Therefore, any patient who is required to have a panoramic film will be referred to Dr. Doreen Chong's office. A referral letter needs to be given to the patient. Dr. Chong's office will charge $125 for the service and will send film to the Dental department once it is processed.

7.18 Dental Department Unit water lines Cleaning Procedure

Procedure

All dental unit water lines are cleaned with Dentapure water purification system and Maxizyme tabs as described below.

Daily water line maintenance procedure

1. Each morning, prior to daily use, wash the inside and outside of the water bottle and rinse thoroughly.
2. Wipe down the cartridge and make sure the intake port is not obstructed.
3. Fill the water bottle with fresh water and complete a 2 minute morning flush before daily usage.
4. At the end of the day, empty the water bottle and replace the bottle back on the manifold.

Weekly water line maintenance procedure for the high and low evacuation suction unit

Maxizyme Tabs are used weekly in addition to the Dentapure cartridge to further ensure proper cleaning and maintenance of the evacuation unit.

1. At the end of the workday, add 2 tabs of the Maxizyme tablets into a gallon of warm water container.
2. Be sure all the tablets are dissolved, and mixture must be used within 24 hours. Pour appropriate amount of the liquid into an empty external dental unit water bottle.
3. Run the solution through the system.
4. Allow to sit in the unit overnight.
5. At the beginning of the next workday, fill bottle with hot water. Flush each line until the bottle is empty

Quarterly Iodine Testing

Perform an Iodine test with the appropriate test strips quarterly. If the level of iodine output falls to less than 0.5 ppm replace the DentaPure cartridge.

Annual Filter Change

The DentaPure cartridge is to be changed after 365 days or earlier in cases as noted above described above.

7.19 Dental Patient Treatment Protocol starting 5/18/20

Procedure

1. Before start of the workday, all dentists and staff members will need to have their temperature taken in the clinic and to complete the daily screening log questionnaire to determine whether he/she is safe to work. If you have a fever, please notify the Dental Director immediately.
    - Dentists and staff members should also check their temperature at home before leaving for work. This is to avoid someone having to travel to work if he or she has a fever.
2. South Cove Front desk staff will contact the patient 48 hours before the patient's appointment to remind him or her of the date and to complete the pre-appointment section of the Patient Screening Form with the patient. If there are any symptoms of covid-19, the patient needs to make a new appointment after the symptoms have dissipated for at least 14 days.
3. All patients will be required to put on a mask once he or she enters the health center. Mask will be provided by South Cove if they do not have one.
4. The front desk staff will complete the in-office section of the Patient Screening form with the patient during registration. An assistant will then take the patient's temperature in the waiting area. The treating dentist should be informed whenever a patient has a temperature >100.4˚F or 38˚C. If there are any symptoms of covid-19, the patient will need to make a new appointment after the symptoms have dissipated for at least 14 days. If the patient has a fever or other symptoms of covid-19, the front desk staff will tell the patient he/she can follow up with his/her Health care provider.
5. The assistant/hygienist will bring the patient into the designated dental room when ready to be seen.
    - No one besides the patient is permitted into the dental clinic except for a parent/guardian of a patient under 5 years of age or a needed translator.
    - All dental set up in the operatory must be completed (i.e., cassettes, hand pieces, lab case, local anesthesia, etc.) before the patient enters the room.
    - All paper documents for the patient (including patient chart, encounter form, Patient Screening Form) should be placed in the container on the outside of the operatory door. The personal information on the documents must face the door to preserve the privacy rights of the patient as per HIPPA regulation.
6. The assistant/hygienist will instruct the Patient to clean his or her hands with hand sanitizer for at least 20 seconds before entering the dental operatory.
7. Before starting any treatment,
    - The assistant/hygienist will give the patient a pre-treatment rinse with either a 1.5% Hydrogen peroxide (50% water+ 50 % Hydrogen peroxide) or Listerine mouth rinse for 30 seconds.
    - The assistant/hygienist will stay with the patient in the operatory until treatment is completed. At no time will the patient be left alone in the operatory by himself/herself.
8. The dental treatment will be performed with proper PPE protocol. All dentists, hygienists and assistants are required to watch the PPE video in the Training section of South Cove internal website. An instruction on the proper sequence and manner of putting on/off PPE is posted in the Lab room to be followed by all. (see A-Dental PPE Protocol)
    - To reduce the amount of the aerosol created during treatment, it is recommended that a rubber dam together with a high evacuation suction be used.
    - Operatory door needs to be closed at all time. A second assistant (the floater, if available) will assist in bringing in patients to the dental operatory and to assist the chairside assistant/dentist/hygienist from the outside of the dental room, such as providing any needed materials/equipment. The floater should not enter the operatory to minimize traffic and spread of contaminants.

- The dentist should assess the need for dental x-rays before start of treatment. This is to avoid the dentist and the assistant having to leave the operatory with contaminated PPE after the start of treatment. If x-rays are needed, the chairside assistant will prepare for and take the x-ray. The dentist will wait in a clean operatory.
- All returned lab case needs to be thoroughly washed with soap and water before try-in/insertion. The dentures must be disinfected before it can be polished in the lab room.
- Hygienist, when you are ready to conduct a dental exam, please ask the floater or call the dental operatories to check which dentist is available to complete the examination.
- Whenever a patient is required to sign a form (such as a consent form), it will be done with the patient wearing a glove and the pen will be subsequently sanitized. Place the consent form into a plastic bag which will be wiped down with Caviwipe. The bag is then placed into a designated envelope with a date and send to the record room for filing.
- The dentist and the assistant should not leave the operatory until treatment is completed, and the patient has left.
- Treatment of a patient should be completed within the scheduled allotted time to avoid patient congestion in the waiting area.

9. Post-treatment instructions:
    - The assistant/hygienist will remind patient that he/she will get a follow-up phone call from South Cove within 48 hours for a post-treatment patient screening call. The patient is directed to call the dental department of any signs or symptoms of Covid-19 within 14 days after the dental visit.
10. After the patient leaves the operatory, the assistant/hygienist should immediately spray the surface area of the room with Cavicide spray and wait a minimum of 15 minutes before returning to complete the cleaning process.
    - For detailed Dental Room Clean up protocol, see B-Dental Room Clean Up Protocol.
11. After the dental operatory is used to treat a patient, it is contaminated and should not be used such as a place for writing charts until the room is disinfected.

<u>Care of Personal Attires</u>

- The disposable gown:
    - When the treatment involves aerosol generated procedures, (including drilling, use of ultrasonic tip, surgical extraction) the gown must be discarded in the operatory bin after the treatment. The soiled gown should be turned inside-out and roll up before discarding. If the gown is used in a non-aerosol generated procedures such as a denture adjustment, it can be re-use for the next patient.
    - The gown must be removed when exiting the dental operatory unless the dentist needs to immediately do a hygiene exam or see another patient in the next room. This applies to the assistant as well.
- The Masks:
    - The outer contaminated surgical mask must be removed and discarded in the operatory bin after each patient or when leaving the operatory.
    - The inner N95 mask can be used throughout the workday.
        - N95 can be reused for a maximum of 5 times when working on multiple patients or be discarded after a single high aerosol generated procedure.
        - The mask needs to be checked for proper seal before each patient.
        - Mask seal check should be done with a pair of gloves and then discard it.
    - A dental mask must always be worn inside the dental clinic.
- Head and Foot coverings: Discard them if soiled or discard them at the end of the day.

- Dental Gloves should be removed and discarded in the operatory bin after each patient or when leaving the operatory.
- During break/lunch: hair caps, gowns, shoe coverings, face shields, dental loupes, and white lab coats must be removed and placed in a cleaned operatory.
- All dental staff should wear scrubs to work. At the end of the workday, everyone needs to change out of scrubs into streetwear to avoid any transmission of contaminants to the household.

** As a reminder, do not touch your face because the virus enters the body through your nose, eyes, and mouth.

7.20 Dental Room Clean Up Protocol

Procedure

1. After the patient leaves the dental operatory, the chairside assistant/hygienist will place all dirty instruments on the tray.
2. Remove the soiled gloves and perform hand hygiene (20 seconds).
3. Spray all surface area within a radius of 6 ft from the dental chair with Cavicide. If the shoe coverings are not heavily soiled and do not need to be disposed of, spray them with Cavicide.
4. After spraying all surface area, remove and dispose the outer disposable gown, cap, shoe covering if they are heavily soiled. (see A-Dental PPE protocol). If not, they can be left on to be reused.
5. Remove the face shield, spray outside of shield with Cavicide. (see A-Dental PPE protocol). Remove the surgical mask and discard it in the trash bin inside the room.
6. Perform hand hygiene (20 seconds).
7. Exit room and close the door.
8. The operatory should be left untouched for a minimum of 15 minutes, before assistant/hygienist goes in to disinfect, clean and set up the room. The dental chair and all surface area within a radius of 6 feet from the dental chair need to be wiped down with Caviwipe. The Caviwipe needs to stay wet on the surface area for at least 3 minutes to achieve proper disinfecting level.
9. The table and the computer together with the covered keyboard need to be wiped with Caviwipe.
10. The tray with the used instruments needs to be covered during transport to the dirty room.
11. The chairside assistant, floater and hygienist are responsible to clean the operatory when it is done.
12. All assistants and hygienists are responsible for sterilizing the used instruments.
13. Each night the cleaning crew will disinfect the operatory floor and common areas.

7.21 Dental PPE Protocol- Effective 5/18/2020

Procedure

1. Identify and gather all the proper PPE to be used.
2. Perform Hand hygiene with hand sanitizer for 20 seconds.
3. Place on the foot covering.
4. Put on isolation gown.
5. Put on N95 Mask, conduct a positive seal check.
    - See poster on “How to wear a N95 surgical mask” in the Training section of South Cove internal website.
6. Place on the Bouffant cap.
7. Put on the outer surgical mask.
8. Place on dental loupes/protective eyewear, then put on the face shield.
9. Perform hand hygiene (20 seconds) before putting on gloves.
10. Put on gloves and you are ready for patient care.

8.00 Pediatrics Policies

8.01 List of Abbreviations Used

AFOF	anterior fontanelle open and flat
AT	atraumatic
BIL	bilateral
BS	breath sounds, bowel sounds
CN	cranial nerves
C/O	complaint of
CTA	clear to auscultation
DTR	deep tendon reflexes
EOMI	extra ocular movements intact
FROM	full range of motion
HR	heart rate
HSM	hepatosplenomegaly
H/O	history of
LAD	lymphadenopathy
MMM	mucous membranes moist
MAEW	moves all extremities well
NAD	no apparent distress
NC	normocephalic
NL	normal
NT	nontender
PERRLA	pupils equally round & reactive to light and accommodation
RHCM	rountine health care maintenance
RRR	regular rate and rhythm
TMs	tympanic membranes
W/	with
W/O	without
WD	well developed
WN	well nourished

8.02 Access and Communication Policies

Appointment scheduling:

- Whenever possible, appointments will be made with the primary care physician for continuity of care.
- Urgency/immediacy of appt. will be determined by initial triage (nursing staff with physician consultation) and by patient/guardian request/concern.
- Sick visits/urgent (acute illness): will be offered the same day, whenever possible based on triage of patients condition and parent request.
- Sick visits/non-urgent (follow up, chronic): will be offered within 2 days, or as determined to be appropriate by physician.
- Well visits: will be offered within 4 weeks with the patient's primary care physician.
- When possible, follow up visits, and routine infant visits will be scheduled when the patient is in the office for an appointment.
- Patients/guardians will be called prior to the appointment with a reminder.
- Patients who miss appointments will be called to reschedule.

Outside appointment scheduling:

- Whenever possible, visits with multiple clinicians and/or diagnostic tests will be coordinated in one trip
- Telephone procedures:
- Phones will be answered live between office hours to allow for immediate response.
- Emergent calls will be directed to the physician by phone for immediate response (within 15 minutes).
- Non-urgent advice calls should be handled by the staff within one hour, or may be directed by message on ECW to the physician to be returned as soon as possible within the same day, whenever possible, if the physician is in the office, or the next business day the physician is working.

After hours:

1. Physician on call will be available after hours to answer patient calls. Call backs when possible will be made within 15 minutes of the page.

Insurance information:

a) Patients who do not have insurance, will be provided with urgent sick care as needed, and will be provided with health insurance resources.

8.03 Pediatric Immunization and Lab Guidelines

(Revised Oct 2012)

	birth	2 wks	1 mos	2 mos	4 mos	6 mos	9 mos	12 mos	15 mos	18 mos	2 yo	3 yo	4 yo	5 yo	6-10 yo	11-18 yo
Well Child Care		x	x	x	x	x	x	x	x	x	x	x	x	x	x	x
Ht/Wt/BMI	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x
HC	x	x	x	x	x	x	x	x	x	x	x					
BP												x	x	x	x	x
Vision												x	x	x	x	x
Hearing													x	x	x	x
Hepatitis B	x			x		x										
Hib				x[1]	x[1]	x[1]				x[1]						
DTaP				x[1]	x[1]	x[1]				x[1]			x			
IPV				x[1]	x[1]	x[1]							x			
PCV 13				x	x	x		x								
Rotavirus				x	x	x										
MMR									x				x			
Varivax									x				x			
Hep A								x		x						
TdaP																x
Menactra																x + booster >16yrs
HPV																x (mos 0,2,6)
PPD								x			x (screen annually for risk)					
Hct/CBC							x				x	x	x			x (yearly if menses)
Lead							x				x	x	x			
HBsAg/HBsAb							x (if indicated)									
Cholesterol																x (if risk factors)
UA													x			x (yearly if sex)[2]

[1] or Pentacel (DTaP, IPV,Hib) or Pediarix (DTaP,IPV,Hep B)

[2] Sexually active- RPR, urine GC/Chlamydia, Hep B titers if not previously done

*see catch up schedule for any patient not up to date on vaccines

Massachusetts Health Quality Partners (MHQP)
Pediatric Preventive Care Recommendations

http://www.mhqp.org/guidelines/preventivePDF/MHQP_Pedi_DeskGuides07-08.pdf

8.04 Protocol for Hepatitis B Screening

The following management guidelines for pediatric hepatitis B infection has the goal of preventing hepatitis B transmission and improving chronic hepatitis B management at South Cove Community Health Center.

Definitions

- *chronic hepatitis B infection*:
  - HBsAg positive>6months, serum HBV DNA>10^5 copies/mL, and persistent or intermittent elevation in ALT/AST levels
- *inactive HBsAg carrier state*:
  - HBsAg positive>6months, HBeAg negative, anti-HBe positive, serum HBV DNA<10^5 copies/mL, and persistently normal ALT/AST levels
- *resolved hepatitis B*:
  - Previous known history of acute or chronic hepatitis B or the presence of anti-HBc ± anti-HBs, HBsAg negative, undectable serum HBV DNA, and normal ALT levels

Infants Born to HBsAg positive mother:

a) HBIG within 12 hours of birth and HBV#1 at different sites
b) HBV#2 via Pediarix at 2 months of age
c) HBV#3 via Pediarix at 6 months of age
d) Test for immunity at 9 months or 1 yr of age: HBsAg/Ab
e) If Ab titer < 10mIU/mL, administer 2nd series of HBV (at 0,1,4 months) & retest HBsAg/Ab in 1 month: if Ab titer still <10, will label patient as "nonresponder"

New Immigrants from High-Risk Country:

- Obtain obtain HBsAg/Ab on all new immigrants
- If HBsAg/Ab are negative, will administer complete Hep B series regardless of previous vaccination status

Children who are HBsAg positive:

Definitive recommendations on the frequency and indications for specific tests are not yet available because of a lack of data on reliability in predicting sequelae. Rationale for testing at our center is as follows:

Baseline tests:

LFT's	If abnl, monitor every 3-6 months; refer to GI if >2x normal,
AFP	Screen for hepatocellular cancer; refer to GI if positive
HBeAg/Ab	Tests for HBV replication.
HBV DNA	Not routine. Tests for HBV replication.
Abdominal Ultrasound if pt >10 yrs old*	Refer to GI if abnl. *Age of 10yrs based on Schwarz's recommendation to start US screening at age 10
Repeat HBsAg/Ab in 6-12 months	To verify diagnosis of "chronic" Hep B carrier

Periodic testing:

Exam	Interval	Rationale
LFT's	annual	If abnl, monitor every 3-6 months; refer to GI if >2x normal,
AFP	annual	Screen for hepatocellular cancer; refer to GI if positive
HBeAg/Ab	annual*	* only if initial HBeAg positive, then assess for continued presence of active viral replication
HBsAg/Ab	Every 3-5 years	To assess if viral clearance has occurred

Indications to refer to GI:

- LFT's >2x normal
- AFP positive
- abnormal ultrasound findings

Effective Date: 03/01/04, revised 10/10/05, 1/16/07, reviewed 12/09, 10/12, 8/13

References:
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Red Book 2003, p318-336.
Follow-Up Tests on Children with Chronic Hepatits B. PKIDs' PHR
Smith, CI. Does your patient have chronic hepatitis B? www.immunize.org #P2162 (1/03)
Schwarzenberg, SJ. What the Physician Can Do to Help the Child with Chronic Hepatitis B Virus Infection. www.immunize.org #P2170 (1/03)

8.05 Protocol for Evaluating the "Sick Child"

Usually, children with upper respiratory infections and other childhood illnesses with low grade fevers can wait their turn to see the providers. The following guideline is to assist the Nursing Assistant in evaluating the degree of distress or need for urgent care of a child.

The following situations are considered urgent, requiring immediate consultation with RN or Provider:

1. child 2 months old and younger with fever (temperature >100.3 rectally)

2. child with visual distress, i.e., breathing difficulties (wheezing, flaring, increased respiratory rate, retracting), signs of dehydration (lethargy, dryness, pallor)

3. child with physical trauma, i.e., lacerations, fractures, or in obvious pain

4. child suspected of having highly contagious disease. i.e., chickenpox

5. child with fever >102F or >39C – consult with Provider—only RN or Provider may dispense medications.

REMINDER: Rectal temperatures are required for children age 2 yrs and under and whenever a tympanic measurement is suspected of being inaccurate.

Secretaries are reminded to be alert and aware of a child requiring immediate attention. It is also their responsibility to assist in recognizing the child in need of urgent care.

8.06 Protocol for Referrals to TB Clinic

Tuberculin Testing Guidelines:

- for patients with routine contact with foreign born adults, check PPD at age 1, between 4-6, 11-16
- for immigrants, incubation period 8-10 wks, check PPD 8-10 wks after arrival.
- for travelers, check PPD if they've traveled outside of US >1 month in endemic area.
- people who were born in the US but live in Chinatown Boston and live among immigrants are NOT considered high risk (only for those new immigrants, or recent travelers, or have household contacts of active TB)
- if PPD is less than 10mm, and pt is asymptomatic, do not repeat the PPD (provided the testing is done 8-10 wks after their first arrival), to avoid false positive from the booster phenomenon which lasts from 1 wk to 1 year after the initial testing

Diagnosing and Referral Procedures:

- Positive PPD needs provider verification.
- Provider makes referral to BMC TB clinics.
- Medical assistant faxes TB referral from to BMC.
- After appointment date received, medical assistant will contact family with appointment date and time.

Follow-up:

- After the patients have been evaluated at the TB clinic, the report will be assigned to the referring provider for review.
- Medical assistant will contact patient to return to clinic once TB medication has arrived from BMC.

Family Screening:

- Providers and staff to encourage family members of positive PPD patients to get screened.
- Important to get history of any possible contact/exposure and stress need for compliance to drug treatment as indicated.

8.07 Protocol for Cholesterol Screening

Whom to Screen:

Children and adolescents starting at age 2 with any of the following risk factors:

1. Positive family history of hypercholesterolemia (>240 mg/dL) or other dyslipidemias
2. Positive family history of early atherosclerotic vascular disease (i.e., men<55 yrs, women<60 years) or sudden cardiac death.
3. Children or adolescents with disorders predisposing to hyperlipidemias, such as diabestes, hypertension, Kawasaki disease
4. Adolescents who are smokers or who are on oral contraceptive
5. Children or adolescents on medications predisposing to hyperlipidemia (i.e. isotretinoin (Acctane) or steroids)
6. Children or adolescents who are obese (BMI > 95%)

What to Screen:

Non-fasting total cholesterol for initial screen

Classification of Total and LDL-Cholesterol Levels in Children and Adolescents From Families With Hypercholesterolemia or Premature Cardiovascular Disease

Category	Total Cholesterol (mg/dL)	LDL-Cholesterol (mg/dL)
Acceptable	<170	<110
Borderline	170-199	110-129
High	≥200	≥130

What to do for abnormal test results:

Consider secondary causes of hypercholesterolemia and test accordingly
For borderline cholesterol level: offer nutritional counseling and repeat test in 1 yr
For high cholesterol:
Dietary therapy in consultation with nutritionist (table 32)
Lab tests following 2-3 months of diet:
Lipoprotein analysis after 12-hr fast, including total cholesterol, HDL, and triglycerides.

When to refer for possible drug therapy:

After adequate trial of dietary therapy (6 months-1yr), LDL still >190 mg/dL, or LDL>160 mg/dL with presence of risk factors.

References:

AMERICAN ACADEMY OF PEDIATRICS: Cholesterol in Childhood ,Committee on Nutrition, Pediatrics Vol. 101 No. 1 January 1998, pp. 141-147

8.08 Protocol for Lead Screening

1. **Routine lead testing (capillary or venous):**
   - All children at age 9-12 months & annually 2-4yrs old
   - Once before starting Kindergarten if none previously done

2. **Capillary lead ≥ 10 mcg/dL:**
   - Repeat with venous sample

3. **Capillary or venous lead level 10-14 mcg/dL:**
   - Environmental history: counseling
   - Rescreen in 3 months (venous)

4. **Venous lead levels 15-19 mcg/dL:**
   - Environmental history, counseling
   - +/- Iron supplements
   - Rescreen in 2 months

5. **Venous lead level 20-24 mcg/dL:**
   - Environmental history, counseling
   - Iron supplements
   - Rescreen in 1 month
   - +/- Referral (depending on age and risk factors, of if repeated test between 20-25)

6. **Venous lead level ≥ 25 mcg/dL:**
   - Environmental history, counseling
   - Iron supplements (2-6 mg/kg/day)
   - Refer to Boston City Hospital Lead Clinic (617-534-4841): evaluation for chelation
   - Verify Dept of Public Health intervention (617-727-7909): environmental investigation, home inspection, abatement procedures, etc.
   - Continue to follow lead levels until < 15 mcg/dL

8.09 Pediatric Pain Screening

Protocol:

- Pain screening tool to be assessed on all patients ≥5 yrs old, as "5th vital sign" for visits generating an intake form
- Medical/nurse assistant will screen for pain with Y,N,N/A pain question, and document on progress note
- Provider will then further assess pain, including rating with Faces Pain Rating Scale (FPRS) and documenting pain score from 0-10; and manage pain as appropriate

Measures for quarterly peer review:
Documentation should include: whether pain screening done, plan for pain management, appropriate follow-up, and any referrals made.

Effective Date: July 1, 2004

Addendum 10/31/05:
Periodic chart reviews from July 2004 to Oct 2005 show consistent pain screening in all visits. Pediatric department will discontinue quarterly peer review in pain screening and investigate other methods to reduce pain in children.

References:

Barlow SE, et al. Obesity Evaluation and Treatment: Expert Committee Recommendations. Pediatrics. 1998;102(3):e29

Barlow SE, et al. Medical Evaluation of Overweight Children and Adolescents: Reports From Pediatricians, Pediatric Nurse Practitioners, and Registered Dietitians. Pediatrics. 2002;110:222-228.

8.10 Pediatric Overweight Project

Pediatric Overweight Guidelines were reviewed and adopted from the references below.

Definitions:
Pediatric at risk for overweight is defined as BMI ≥ 85% for age.
Pediatric overweight is defined as BMI ≥ 95% for age.

The problem:
Childhood obesity is an epidemic in our community. Many children have a high calorie, high fat diet, and are not physically active. Many parents are unconcerned about their children become overweight and are unaware of the health risks of obesity. A chart review of 150 pediatric patients showed that 24% of our patients are overweight or obese, and 70%were not identified so on their chart.

Goal:
To identify children at South Cove who are overweight or obese, and assist families to adopt healthier nutritional and exercise habits to prevent and monitor for medical complications of obesity.

Protocol:
Identification: All children aged 2-18 will have BMI assessed and documented during annual physical exams. Consider separate medical assessment for evaluation of risks of obesity. Children classified at at risk for overweight or at risk for overweight will be entered into a registry and contacted by overweight case manager to encourage follow-up.

Education:
Children classified as overweight or obese will receive educational packet with language appropriate information.

Referral:
Children ages 2-5 will be referred to WIC nutritionist.
In-House Nutritionist >5yrs old
Boston Medical Center Nutrition For Life Program
Children's Hospital OWL program
YMCA Fit Kids/Teens

Followup:
To be determined by provider, but at least quarterly to assess dietary and activity habits, monitor growth and for complications from obesity.

Measures for Quality Improvement Monitoring:
BMI classification, overweight plan documentation, follow up visit scheduled.

References:
Barlow SE, et al. Obesity Evaluation and Treatment: Expert Committee Recommendations. Pediatrics. 1998;102(3):e29
Barlow SE, et al. Medical Evaluation of Overweight Children and Adolescents: Reports From Pediatricians, Pediatric Nurse Practitioners, and Registered Dietitians. Pediatrics. 2002;110:222-228.

8/04, revised 10/05, 01/07, reviewed 12/09, 10/12, 8/13

8.11 Asthma Management

See: http://www.nhlbi.nih.gov/guidelines/asthma/index.htm

- Starting 01/2010, all patients with persistent asthma should have at an annual Asthma Action Plan completed in eCW.
- Chart reviews starting in 2nd quarter of 2010 will monitor for compliance with this measure.

8.12 Pediatric Behavioral Health Screening Protocol

Well child visits 0-3 yrs old:
MA duties:
- Give bilingual PEDS form to family to complete*
- Return PEDS form to provider before visit
- Document in EMR if parent declined to complete screening

Provider duties:
- Score PEDS: and refer/counsel as appropriate
- Code for PEDS administration in EMR

Well child visits 4-13 yrs old:
MA duties:
- Give bilingual PSC to family to complete*
- Score PSC
- Return PSC form to provider before visit

Provider duties:
- Review PSC and refer/counsel as appropriate.
    - Age 4-5yrs old: Score ≥24 = positive screen
    - Age 6-13yrs old: Score ≥28 = positive screen
- Code for PSC administration in EMR

Well adolescent visit: 14-20 yrs old:
MA duties:
- Give NEW adolescent questionnaire to patient
- Return questionnaire to provider before visit

Provider duties:
- Score CRAFFT section of questionnaire.
    - ≥2 yes answers suggests a problem
    - refer/counsel as appropriate
- Code for CRAFFT administration in EMR

** MA should tell parents: "This is an **optional** questionnaire to complete so your doctor can know more about your child's development and behavior. Would you like to fill out the form on your own or have someone go through it with you?"*

CODING INSTRUCTIONS:
- If NO behavioral need identified, code CPT code 96110.U1
- If behavioral need identified, code CPT code 96110.U2

8.13 VFC Program Description, Eligibility, and Billing Requirements

VFC Program Description:
The Vaccines for Children (VFC) Program helps provide vaccines to children whose parents or guardians may not be able to afford them. This helps ensure that all children have a better chance of getting their recommended vaccinations on schedule. Vaccines available through the VFC Program are those recommended by the Advisory Committee on Immunization Practices (ACIP). These vaccines protect babies, young children, and adolescents from 16 diseases.

Funding for the VFC program is approved by the Office of Management and Budget (OMB) and allocated through the Centers for Medicare & Medicaid Services (CMS) to the Centers for Disease Control and Prevention (CDC). CDC buys vaccines at a discount and distributes them to grantees—i.e., state health departments and certain local and territorial public health agencies—which in turn distribute them at no charge to those private physicians' offices and public health clinics registered as VFC providers. More information can be found on the program's website:

https://www.cdc.gov/vaccines/programs/vfc/about/index.html

SCCHC will refer to Massachusetts Department of Public Health (MDPH) for all guidance for compliance with Federal and State Vaccine Administration Requirements. Please refer to guideline for further instructions regarding requirements including:

a. Appropriate Use of State-Supplied Vaccine (Including Restitution Policy)
b. Vaccine Management
c. Billing and Charging for State-Supplied Vaccine
d. Vaccine Information Statements (VIS) and Consent
e. Documentation of Vaccine Administration
f. Vaccine Safety
g. Responsibility of the Medical Director.
h. Site Visits
i. Additional Guidance Including Injection Safety

MDPH 2023 Guidelines for Compliance with Federal and State Vaccine Administration Requirement can be found on program's website:

https://www.mass.gov/doc/guidelines-for-compliance-with-federal-vaccine-administration-requirements/download

VFC Eligibility
Screening to determine a child's eligibility to receive vaccines through the VFC Program and documentation of the screening results must take place with each immunization visit. SCCHC utilizes eClinical Works (eCW) to create internal drop-down menus offering options for VFC eligibility for providers to screen at each immunization visit and provides a means for recording parent responses to VFC eligibility questions. The parent, guardian or provider may complete the eligibility information. Verification of parent/guardian responses is not required. Patient eligibility screening should be maintained on file for a minimum of 3 years after service to the patient has been completed unless state law/policy establishes a longer archival period.

Children <19 years of age in the following categories are eligible for VFC vaccine. eCW VFC screening internal drop-down menu option available for selection includes:

- VFC Eligible – Medicaid: a child eligible for MassHealth or Medicaid, including Medicaid HMOs. This category may be selected even if the child has MassHealth or Medicaid as their secondary insurance.

- VFC Eligible – Uninsured: a child with no insurance.
- VFC Eligible – American Indian/Alaskan Native: a child who (or whose parent/guardian) self identifies as American Indian (Native American) or Alaskan Native. Please note that no documentation/verification is required.
- Not VFC Eligible: Any child with private health insurance.
- VFC Eligible – Underinsured: a child with private health insurance that does not cover vaccines.

Underinsured children are eligible to receive VFC vaccine only through a Federally Qualified Health Center (FQHC), or Rural Health Clinic (RHC) or under an approved deputation agreement.

Children whose health insurance covers the cost of vaccinations are not eligible for VFC vaccines, even when a claim for the cost of the vaccine and its administration would be denied for payment by the insurance carrier because the plan's deductible had not been met.

The Children's Health Insurance Program (CHIP), known as Title XXI, enables states to expand health insurance coverage for uninsured children. Title XXI children enrolled in a separate Children Health Insurance Program are not VFC-eligible because these children are considered insured. Title XXI children enrolled in a Medicaid-expansion CHIP program are Medicaid eligible and entitled to VFC program benefits. Some states have implemented their CHIP programs as a combination plan with some children becoming Medicaid eligible through an expansion plan and some children enrolled in a separate CHIP. The Medicaid-eligible children are entitled to VFC program benefits, and the children enrolled in the separate CHIP program are considered insured and are not entitled to VFC program benefits.

VFC Billing Requirements
South Cove Community Health Center may not impose a charge for the cost of a state-supplied vaccine to a patient or a third party (e.g., an insurance company or Medicaid).

For Medicaid VFC- eligible children, providers must accept the reimbursement for vaccine administration set by the Massachusetts Medicaid agency or the contracted Medicaid health plans.

For Non-Medicaid (uninsured, under-insured, or who are American Indian or Alaskan Native) VFC-eligible patients: South Cove may charge an administration fee of up to $23.29 per dose.

For Third Party Payers: South Cove may bill administration fees in accordance with the terms of their contracts. South Cove may not deny state-supplied vaccines to an established patient due to the inability of the child's parent/guardian/individual of record to pay the administration fee. "Established patient" applies only to private providers.

As an FQHC, South Cove must administer state-supplied vaccines to any VFC-eligible child who presents for immunization services.

Effective January 1, 2020, South Cove may bill for the vaccine administration fee of a non-Medicaid, VFC-eligible child after the date of service, but may issue only a single bill to the patient within 90 days of vaccine administration. This policy does not apply to vaccine administration fees billed to Medicaid for children who meet the Medicaid eligibility criteria for the VFC program. **Unpaid administration fees may not be sent to collections, and the provider may not refuse to vaccinate an eligible child whose parents have unpaid vaccine administration fees.**

No patient will be denied for immunization services due to inability to pay.

8.14 VFC Vaccine Ordering, Storage, and Handling

Purpose:
To ensure the safe storage and handling of vaccines in order to maintain optimum potency.

Responsibilities:

Vaccine Manager (VM):
The Vaccine Manager is responsible for oversight of all vaccine storage and handling.

Backup Vaccine Manager:
The Backup Vaccine Manager will perform the duties of the Vaccine Manager during vacations or other vacancies.

Site Manager:
The Site Manager is responsible for all administrative activities within the clinic.

Medical Director:
The Medical Director is responsible for all clinical activities at all sites of the health center.

Chief Operating Officer:
The Chief Operating Officer is responsible for all daily activities at all sites of the health center.

Site Contacts:

Role	885 Washington St Boston, MA 02111	88 Holmes St Quincy, MA 02171	277 Commercial St Malden, MA 02148
Vaccine Manager	Chia Mei Lu, RN 617-521-6803	Maddie Hao, MD 617-318-3220	Chanel Lee, RN 781-912-2526
Backup Vaccine Manager	Pauline Wong, RN 617-521-6830	Annie Lam, RN 617-318-3212	Kathy Mei, RN 781-912-2500
Site Manager	Kali Cen 617-521-6812	Margaret Cheung 617-318-3245	Frances Ma 781-912-2500
Medical Director	Rong Guan, MD 617-482-7555	Rong Guan, MD 617-482-7555	Rong Guan, MD 617-482-7555
Chief Executive/Operating Officer	Eric Tiberi 617-521-6708	Eric Tiberi 617-521-6708	Eric Tiberi 617-521-6708

Health Center VFC Sites/Equipment Locations:

Site Address	Refrigerator Locations	Freezer Locations	Backup Site Location/ Site Contact
885 Washington St Boston, MA 02111	(1) Pedi Med Room (1) Adult Med Room (1)Laboratory	(1) Pedi Med Room	435 Hancock St Quincy, MA 02171 Adult/Pedi Nurse
88 Holmes St Quincy, MA 02171	(1) Pedi Med Room (1) OB/GYN Med Room	(1) Pedi Med Room	435 Hancock St Quincy, MA 02171 Adult Nurse
277 Commercial St Malden, MA 02148	(1) Med Room	(1) Med Room	885 Washington st Boston, MA 02111

- **This table does not include any non-VFC sites/refrigerator/freezers**

Procedures:
Each clinic site will utilize MDPH recommended written standard operating procedures (SOP) for proper vaccine management. The SOP for Vaccine Management must be completed, reviewed and updated annually by the clinic's VM, or whenever there is a change in responsible staff. The recommended SOP template provided by MDPH can be found on the program's website:

https://www.mass.gov/doc/sample-standard-operating-procedure-sop-0/download

In addition each clinic site will utilize MDPH recommended Vaccine Transport SOP for proper transportation of vaccines. The Vaccine Transport SOP must be completed, reviewed and updated annually by the clinic's VM, or whenever there is a change in responsible staff. The recommended Vaccine Transport SOP template provided by MDPH can be found on the program's website:

https://www.mass.gov/doc/vaccine-transport-sop-2023/download

Vaccine Ordering:

- VM will place vaccine orders through the MIIS Vaccine Management Module and upload the most recent temperature logs for all vaccine storage units within one day of submitting order.
- VM will complete a physical inventory of all vaccines in the refrigerators and freezer, checking expiration dates at least monthly and before placing an order.
- VM will order when vaccine inventories reach about a 4 weeks supply.
- VM will establish a routine to order no more than once per month.
- VM will contact the Vaccine Unit to update any changes in shipping address, Changes to Shipping hours or shipping contact can be updated directly into the MIIS. Vaccines will be delivered directly to this provider's office based on shipping information in the MIIS.
- VM will transfer short dated vaccines to another pediatric provider 2-3 months prior to expiration. Document all vaccine transfer in the MIIS Transfer Vaccine Module.

Vaccine Receiving:

- Upon arrival at South Cove, vaccine will immediately be counted and compared with packing list and original order form making sure the order and delivery is correct, with all expiration dates and lot numbers matching.
- Ensure that all containers noted on the packing list have been delivered.
- Check the temperature monitor to make sure the temperature stayed within appropriate range during transport.
- VM will contact the MDPH Vaccine Management Unit (617) 983-6828 immediately for guidance should there be any concerns and inaccuracies with the order or temperature.
- Then, the vaccine will be immediately place in the refrigerator/freezer designated for vaccine storage only.

Vaccine storage:
Do not store any vaccine in a dorm style unit with an internal freezer compartment

- Set all refrigerators/freezers designated for vaccine storage to maintain the proper temperature using a calibrated glycol-encased probe Digital Data Logger thermometer, certified by an appropriate agency (National Institute of Standards and Technology). Please contact the Vaccine Unit to replace broken MDPH-supplied thermometers.
- Calibrated product temperature thermometers will be used to monitor temperatures.
- All refrigerated vaccines will be stored within the temperature range of 2˚C to 8˚C or 36˚F to 46˚F. Varicella, MMRV, and MMR vaccines will be stored in a stand-alone freezer in the Nurse Room and the temperature will be maintained at -50˚C to -15˚C or - 58˚F to 5˚.
- Department designated RN will be responsible for oversight of all vaccine storage and handling within department.

- Department designated RN will make sure short-dated vaccines are stored in front and used first, rotating stock effectively.
- Mark or identify inventory to differentiate state-supplied and privately purchased vaccine.
- Place the digital data logger probe in a central area of the refrigerator and freezer unit, adjacent to the vaccine.
- Do not store food or beverages in vaccine storage units.
- Store vaccines centrally in the refrigerator or freezer, and away from walls to allow for proper air circulation. There should be sufficient space between rows of vaccine boxes or bins and shelving units to allow proper air circulation.
- Do not store vaccine on the top shelf, the door, or in front of the cold air duct of a household refrigerator.
- Stabilize refrigerator temperatures by placing cold gel packs/water bottles where vaccine should not be stored (on the door and bottom of the unit and on the top shelf of a household unit), unless the manufacturer's instructions.
- Store cold gel packs in the refrigerator as part of your emergency preparedness, in case the need arises to transport vaccine during an emergency.
- Stabilize freezer temperatures by placing conditioned water bottles anywhere there is empty space.
- Post a "DO NOT UNPLUG" sign next to the electrical outlet for all vaccine storage units and a "DO NOT DISCONNECT" sign must be posted next to the circuit for any vaccine storage units on the circuit breaker.
- Plug all vaccine storage units directly into a wall outlet. Never plug into a power strip, surge protector or extension cord. Never plug into Ground Fault Circuit Interrupter outlets (GFC).

Vaccine Returns:

- Document all vaccines that cannot be used due to expiration, exposure to unsafe temperatures or wasted/damaged in the New Order Module or the Storage/Handling Problem Module. Refer to the Quick Reference Guide for instructions.
- Pack vaccine to return in a box with the return form and a return label will either be e-mailed or UPS will provide a label at time of pick up.
- Do not return broken vials or syringes, opened multi dose vials or vaccine drawn up into a syringe. Do still document these vaccines in the MIIS.
- **Only the Vaccine Management Unit can determine loss of efficacy due to exposure to out of range temperatures.**

Temperature Monitoring:

- Monitor refrigerator/freezer daily minimum and maximum temperatures and acknowledge at least twice daily by pressing the read button on the state issued data logger 4x in AM and 2x in PM. Other monitoring systems must have this capability and will need prior authorization to be used by the MDPH Vaccine Unit. A Certificate of calibration must be kept on file. All vaccine storage units holding state-supplied vaccines must be monitored by a digital data logger.
- Review temperature logs or digital data logger digital read outs at least once a day for any deviations from recommended temperature ranges. If your state-supplied data logger is broken, call the Vaccine Unit for immediate replacement.

VFC Data loggers:

The Vaccine for Children (VFC) program provides data loggers that monitor and record refrigerator and freezer temperatures for VFC stored vaccines. The data recorded on the data loggers will be uploaded monthly by the Vaccine Manager per VFC Guidelines.

Temperature Out of Range:

- Immediately contact the Vaccine Unit for guidance about any out of range temperatures (refrigerator or freezer). Upon discovery of an out of range temperature, the exposed vaccine is maintained at proper temperature and marked 'Do Not Use'. Vaccine Unit staff will determine if

the vaccine is still viable for use. Upload temperature logs into the MIIS and select 'Urgent Temperature Log Issue' and immediately call the Vaccine Unit.
- Mark any vaccine left out of refrigeration 'Do Not Use,' put the vaccine back into refrigeration, and call the Vaccine Unit for guidance.
- Document, for all out of range temperature, contact with the Vaccine Unit and all actions and results of these actions documented on a trouble-shooting log.

Alarms:
Each vaccine refrigerator and freezer is equipped with an alarm (either audible or visible).
If the alarm is triggered the VM or Site Manager should be notified immediately.

Power Failure:
- In the event of one of the medication refrigerators/freezer is non-functioning, vaccines will be transferred immediately to other vaccine refrigerators within the site.
- In the event of an extended building power failure or all the refrigerators/freezers are non-functioning, vaccines will be packed in insulated containers with conditioned water bottles and a certified, calibrated product thermometer and transport to secure refrigerators located at the prearranged site.
- The above temperature ranges and monitoring procedures will be followed at the back up site. The MDPH Vaccine Management Unit will be notified immediately at 617-983-6828
- Notify the Vaccine Unit before transporting Varicella and MMRV vaccine, if possible.
- Review and update the practice emergency plan on an annual basis.

Vaccine Transportation Procedures:

Guidance regarding packing and transport of vaccine can be found on Vaccine Transport SOP and CDC's program website:

https://www.cdc.gov/vaccines/recs/storage/downloads/emergency-transport.pdf

- Obtain and store an adequate number/amount of appropriate packing containers and materials (conditioned water bottles, cardboard, bubble wrap, Styrofoam container) needed to pack vaccines for safe transport.
- Use separate packing containers for vaccines required to be refrigerated and vaccines required to be frozen.
    - Refrigerated conditioned water bottles should be placed in the container used to transport refrigerated vaccines.
    - Frozen conditioned water bottles should be placed in the container to transport frozen vaccines. **(Dry ice, coolant and gel packs, are not recommended for the transport of frozen vaccines as it increases risk of freezing vaccines.)**
- Place a calibrated thermometer in each packing container near the vaccine to monitor the temperatures.
- Record the time and temperature when vaccine was removed from the storage units and placed in the containers at the beginning and end of the transport.
- Transport of vaccines is considered a temperature excursion
    - Contact the Vaccine Unit with the hours out of refrigerator or freezer and the warmest temperature recorded
- Do not discard vaccine without contacting the Vaccine Unit for guidance.
- Contact the Vaccine Unit whenever you are considering transporting state-supplied vaccines outside of your facility to ensure you have the most relevant guidance and advice for your specific situation.

8.15 VFC Staff Training/Provider education requirements

Purpose:
To ensure that staff are appropriately trained on VFC policies and procedures.

Policy:

- The Primary Vaccine Coordinator and the Backup Vaccine Coordinator will participate in one of the following activities each year. Certificates of completion must be kept on file.
    - VFC compliance site visit (conducted every other year, must be present at site visit to receive certificate).
    - In-person classroom style presentation (VFC breakout session at MIAP, MDPH Immunization Update Conference, or on-site training by MDPH staff). Certificates will be given after each activity.
    - MDPH on-line webinar trainings.

9.00 Internal Medicine Policies

9.01 Cancer Screening Guidelines

The Department of Adult Medicine uses the American Cancer Society Guidelines for breast cancer, cervical cancer, colon cancer and prostate cancer screening:

https://www.cancer.org/healthy/find-cancer-early/cancer-screening-guidelines/american-cancer-society-guidelines-for-the-early-detection-of-cancer.html

Please use the link for the most updated guidelines. The interval of screening and appropriate follow up are addressed and documented in annually physical examination.

10.00 Optometry Policies

10.01 Optometry Equipment Cleaning Policy

Purpose
The purpose of this policy is to list the steps to follow when cleaning the Visual Acuity and Retinal Scanner Machines

Policy
After use of either Visual Acuity Machine or the Retinal Scanner Machines, the Optometry Department's optometry assistant is instructed to enter the room, wipe the machines with drying alcohol wipes, then wait the necessary time for drying (the time for drying should be indicated on the back of the alcohol wipe packet). This procedure should be repeated after each use on both machines

11.00 OB/GYN Policies

11.01 South Cove OBGYN Department Clinical Guidelines

The South Cove OBGYN department provides comprehensive women's health services. We are a team of OBGYN physicians, family medicine physician, nurse practitioners, registered nurses, and clinical assistants. Our OBGYN physicians are all board-certified or board-eligible with the American Board of Obstetrics and Gynecology (ABOG). All providers practice according to the clinical guidelines set forth by the following organizations:

American Congress of Obstetricians and Gynecologists (ACOG)- www.acog.org

ASCCCP (American Society of Colposcopy and Cervical Pathology) – www.asccp.org

Center for Disease Control and Prevention (CDC) – www.cdc.gov

Massachusetts Department of Public Health -- http://www.mass.gov/eohhs/gov/departments/dph

12.00 Mammography Policies

12.01 Mammography Screening Protocol

Purpose:
To Provide culturally and linguistically appropriate screening mammography to all eligible patients receiving care at South Cove Community Health Center.

Policy:
The Mammography Department uses the American Cancer Society Guidelines for breast cancer screening.

https://www.cancer.org/healthy/find-cancer-early/cancer-screening-guidelines/american-cancer-society-guidelines-for-the-early-detection-of-cancer.html

Please use the link for the most updated guidelines.

Procedure
A patient will have their mammogram status assessed during a clinical visit with either their South Cove PCP and/or OB/GYN provider.

If a patient is due for a screening mammogram and is eligible according to screening guideline criteria, a mammography order is entered into the EHR.

Patients are then directed to the appointment desk to schedule the appointment.

South Cove's Imaging department is responsible for obtaining prior mammogram films from the appropriate sources (should include at a minimum the patient's two previous mammograms if available).

Prior to mammogram patient is interviewed using Mammography screening questionnaire.

12.02 Mammogram - Confirming, Cancelling, No Show Appointments

Purpose:
To ensure that every effort to provide efficient access to mammography appointments is taken and that no show appointments receive appropriate follow up.

Policy:
South Cove will make every effort to remind our patients of upcoming appointments, reschedule appointments as necessary, and follow up on all no show appointments.

Procedure
The appointment desk or designated staff will make reminder calls to all patients of upcoming appointments within two days prior to the appointments.

If a patient calls to cancel a scheduled appointment, the appointment desk should reschedule them at that time if possible.

Patients who are “No Show” for their scheduled appointment are sent a reminder letter of their missed appointment.

Documentation of a patient cancelled and/or “no show” appointment is noted in the EHR and the referring provider or PCP is to be notified.

12.03 Mammogram Film Permanent Transfer Consent

Purpose:
To provide the interpreting radiologists with the proper information to make the best interpretation of mammogram images.

Policy:
Consent for the release of prior mammogram films may be necessary from individual patients referred for a screening mammogram at South Cove. This is required in order to allow for a comparative mammogram reading by the interpreting radiologists.

Procedure
To facilitate the process for obtaining prior films, patients are asked to sign the disclosure release form at the time of their visit:

1. In the Mammography Clinic
   or
2. During a clinic visit in OBGYN or Adult Medicine, then forwarded to the Imaging dept.

The mammography staff is responsible for retrieving patient prior films. Upon receipt of the patient films, storage will be made available in a patient film folder.

12.04 Mammography Image Requests

Purpose
To establish and maintain a system for requests for Mammography Images from outside facilities.

Policy
Requests for South Cove patient mammogram images from an outside facility and received by either phone or fax will be accommodated. Either mammogram films or images can be sent electronically via secure communication or via mail or courier service for films or other hard media.

Patients will need to sign a consent for the release of their mammogram images. Patient permission by phone is acceptable in unforeseeable urgent situations.

12.05 Mammogram Images/Films and Documentation Storage

Purpose
To establish and maintain a system for storage of images/films, reports, and medical records pertaining to patient mammograms.

Policy
All mammogram images and films, reports, and other related patient medical records are confidential and shall not be disclosed without written authorization of the patient or their representative.

All images/films must be retained in a patient's record (film or pacs system) for a period of 120 calendar months (10 years) following the date of service or until time as the patient should request that the patient's images/films be forwarded to a medical institution or a physician designated by the patient. All reports are to be filed in the patient's electronic health record and subject to South Cove's medical record retention policy (which at a minimum must meet the minimum retention period stated in this policy).

If the facility should cease to operate before the end of the 120 month period, the images/films must be retained in a manner which provides security and which permits former patients or their physician's access to them for the remainder of the 120 month period.

12.06 Mammography Clinical Follow-up for Abnormal Findings

Purpose:
To ensure that the appropriate follow-up for abnormal mammography findings are performed.

Policy:
South Cove staff will follow the appropriate clinical follow-up procedures to ensure that patients and providers receive the appropriate information and the appropriate actions are taken to ensure proper medical care.

Procedure
Referring/Primary Care Providers will be informed of any abnormal mammogram result by the mammography clinic staff.

- Mammography staff will contact referring provider and/or designated clinical department nurse via electronic health record (EHR) when a patient has an abnormal mammogram result and which it recommends the following: breast biopsy, surgical consut, MRI, diagnostic imaging, or ultrasound.

- A copy of signed abnormal mammogram report will be faxed/scanned into EHR and assigned to the appropriate referring South Cove provider or designated clinical department nurse.

Patients will be informed of any abnormal mammogram result by the mammography staff according to the following table. All documentation shall be maintained within the EHR (telephone encounter for phone calls, scanned in copy of certified letter if sent).

Mammography Clinical Follow-up Procedures

Category	Definition	Procedure
0	Additional imaging evaluation and/or comparison to prior mammograms is needed.	• Result is sent to the patient using the Patient Plain Language Letter. • Patient is contacted by phone to schedule recommended follow-up. If patient can not be contacted by phone then a certified letter will be sent. • Any additional screening films recommended by an interpreting radiologist can be performed in South Cove's Mammography clinic. Films are sent back to interpreting physician. • A South Cove provider can opt to send a patient for additional views to an external facility for diagnostic imaging (such as BIDMC or Tufts). In this case, the patient mammogram images will be sent to the designated facility. • Additional imaging requiring a breast ultrasound, breast surgery, consult and/or biopsy recommended by an interpreting radiologist are obtained at an external facility (such as BIDMC or Tufts) as referred by the appropriate provider. • Monitoring for any of the above patients requiring further evaluation at an outside facility will be tracked by the mammography clinic staff until the case is closed or when recommended follow-up is complete.
1	Negative	• Result is sent to the patient using the Patient Plain Language Letter. • No further follow up required.
2	Benign (non-cancerous) finding	• Result is sent to the patient using the Patient Plain Language Letter. • No further follow up required.
3	Probably benign finding – Follow-up in a short time frame is suggested	• Result is sent to the patient using the Patient Plain Language Letter. • Patient is contacted by phone to schedule recommended follow-up. If patient can not be contacted by phone then a certified letter will be sent.
4	Suspicious abnormality – Biopsy should be considered	• Result is sent to the patient using the Patient Plain Language Letter. • Patient is contacted by phone to schedule recommended follow-up. If patient can not be contacted by phone then a certified letter will be sent. • Breast ultrasound, breast surgery, consult and/or biopsy recommended by an interpreting radiologist are obtained at an external facility (such as BIDMC or Tufts) as referred by the appropriate provider. • Monitoring for any of the above patients requiring further evaluation at an outside facility will be tracked by the mammography clinic staff until the case is closed or when recommended follow-up is complete.
5	Highly suggestive of malignancy – Appropriate action should be taken	• Result is sent to the patient using the Patient Plain Language Letter. • Patient is contacted by phone to schedule recommended follow-up. If patient can not be contacted by phone then a certified letter will be sent. • Breast ultrasound, breast surgery, consult and/or biopsy recommended by an interpreting radiologist are obtained at an external facility (such as BIDMC or Tufts) as referred by the appropriate provider. • Monitoring for any of the above patients requiring further evaluation at an outside facility will be tracked by the mammography clinic staff until the case is closed or when recommended follow-up is complete.

12.07 Mammography Medical Reporting and Audit Guidelines

Purpose
To establish and maintain a system for collection and review of outcome data and correlation of pathology results with initial mammography results. The active collections and follow-up data is to focus on positive mammograms with correlation between pathology results and interpreting radiologist's initial mammography interpretation.

Policy
The practice will collect and review patient outcome data. All Bread Imaging Report and Data System (BI_RADS) B0, B3, B4, B5 mammogram reports will be collected.

Patient with BI-RADS B0, B3, B4, B5 outcomes results will be reviewed and recorded along with their corresponding initial BI-RADS Category Assessment.

Protocol
Reports are received electronically from the Interpreting Radiologist and printed in the Imaging Department.

The Mammography technologist records the BI-RADS result and breast density in the daily log book.

Reports are given to the Mammography Coordinator who then records all BI-RADS B0, B3, B4, and B5 into a spreadsheet.

Patients with a BI-RADS B0 or B3 are called by telephone and scheduled for additional imaging or referred out for ultrasound as appropriate (see Mammography clinical follow-up guidelines)..

Patients with a BI-RADS B4 or B5: Referring provider is contacted by telephone and patient is then referred out for the appropriate service (see Mammography clinical follow-up guidelines).

All reports are then date stamped and sent to medical records to be scanned into patient's electronic health record.

BI-RADS® Category Assessment

Category	Definition	What it means
0	Additional imaging evaluation and/or comparison to prior mammograms is needed.	This means the radiologist may have seen a possible abnormality, but it was not clear and you will need more tests, such as another mammogram with the use of spot compression (applying compression to a smaller area when doing the mammogram), magnified views, special mammogram views, or ultrasound. This may also suggest that the radiologist wants to compare your new mammogram with older ones to see if there have been changes in the area over time.
1	Negative	There's no significant abnormality to report. Your breasts look the same (they are symmetrical) with no masses (lumps), distorted structures, or suspicious calcifications. In this case, **negative** means nothing bad was found.
2	Benign (non-cancerous) finding	This is also a negative mammogram result (there's no sign of cancer), but the radiologist chooses to describe a finding known to be benign, such as benign calcifications, lymph nodes in the breast, or calcified fibroadenomas. This ensures that others who look at the mammogram will not misinterpret the benign finding as suspicious. This finding is recorded in your mammogram report to help when comparing to future mammograms.
3	Probably benign finding – Follow-up in a short time frame is suggested	The findings in this category have a very high chance (greater than 98%) of being benign (not cancer). The findings are not expected to change over time. But since it's not proven to be benign, it's helpful to see if the area in question does change over time. You will likely need follow-up with repeat imaging in 6 months and regularly after that until the finding is known to be stable (usually at least 2 years). This approach helps avoid unnecessary biopsies, but if the area does change over time, it still allows for early diagnosis.
4	Suspicious abnormality – Biopsy should be considered	Findings do not definitely look like cancer but could be cancer. The radiologist is concerned enough to recommend a biopsy. The findings in this category can have a wide range of suspicion levels. For this reason, some, but not all, doctors divide this category further: **4A:** Finding with a low suspicion of being cancer **4B:** Finding with an intermediate suspicion of being cancer **4C:** Finding of moderate concern of being cancer, but not as high as Category 5
5	Highly suggestive of malignancy – Appropriate action should be taken	The findings look like cancer and have a high chance (at least 95%) of being cancer. Biopsy is very strongly recommended.
6	Known biopsy-proven malignancy – Appropriate action should be taken	This category is only used for findings on a mammogram that have already been shown to be cancer by a previous biopsy. Mammograms may be used in this way to see how well the cancer is responding to treatment.

13.00 Pharmacy Policies

13.01 Preface

Purpose

This manual shall state SCCHC Pharmacy policies and set forth operational procedures. All pharmacy employees must become familiar with SCCHC Pharmacy Policies and may refer to this manual as needed. Additionally, this manual is a teaching tool to acquaint employees with the SCCHC Pharmacy operation. Compliance with these policies and procedures is a condition of employment and noncompliance may lead to termination. When unaddressed issues arise, remember to prioritize the patients' needs first, and to uphold the respect of the Community Pharmacy, Health & Wellness Center, Shingle Springs Band of Miwok Indians, and all applicable laws.

Mission Statement

SCCHC Pharmacy and its staff strive to offer SCCHC's patients, customers and patient's comprehensive pharmacy services in a professional and friendly setting. All individuals are treated with respect and dignity without regard to race, religion, economic status, gender, age or sexual orientation. The Pharmacy and staff puts the patients' needs and concerns as its top priority.

Scope of Practice

SCCHC Pharmacy is a full service clinic pharmacy. This pharmacy's purpose is to provide comprehensive pharmacy service to patients of the *South Cove Community Health Center*. South Cove Community Health Center staff must prescribe all prescriptions filled by the pharmacy. The pharmacy does not fill any outside prescriptions (non-South Cove patient prescriptions). This also includes South Cove contracted pharmacies.

Policy Review

No less than annually shall this manual be reviewed for the timeliness and appropriateness of content. A notation shall be made on the appropriate page by the reviewing pharmacist as to the date the policy was reviewed and any changes made to the policy. Occasionally a complete revision may occur, and a new manual with a new version number (i.e. v *X*.2) will be created. Additions shall be dated as they are added to the manual. The Pharmacy Director is responsible for reviewing this manual. Any changes must be approved by the Executive Director, Medical Director, and the Board of Directors. All SCCHC policies apply to any employee working in the SCCHC pharmacy. If at any point the two policies conflict, the SCCHC policies will supersede.

Policy Notification by Memo

New or changed policies may be issued by memo, posted in a common place for staff to read. After reading, each employee shall initial and date where indicated. Dated, acknowledged memos will be retained in the appendix of this manual for incorporation in future revisions.

Pharmacy Details

South Cove Community Health Center Pharmacy
435 Hancock Street
Quincy, MA 02171

617-318-3310
617-318-3390 fax

Pharmacy License: DPH 4140
DEA number: AS7512189
NCPDP: 2244147
NPI number: 1740527175
MCSR: MA0061743
Pharmacist in Charge:
Sandy Chan, PhD

Pharmacy Staff & Contact List

	Name	Phone	License
Pharmacist in Charge	Sandy Chan	617-318-3310	PH233183
Pharmacist	Raymond Yu	617-318-3310	PH233323
Pharmacist	Jaclyn Mei	617-318-3310	PH237730

Pharmacist in Charge

The pharmacy must have a 'Pharmacist in Charge'. The PIC is responsible for the daily operation of the pharmacy, and has full authority to assure the pharmacy's compliance with all laws governing Pharmacy operation.

13.02 Administrative Policies

Impairment and Diversion Policy

The pharmacy must take action to protect the public when a licensed individual employed by or with the pharmacy is discovered or known to be chemically, mentally, or physically impaired to the extent it affects his or her ability to practice the profession or occupation authorized by his or her license, or is discovered or known to have engaged in the theft, diversion, or self-use of dangerous drugs. In such an event, the individual must be immediately dismissed pending investigation.

The pharmacy must report to the pharmacy board within 14 days of the receipt or development of information with regard to any licensed individual employed by or with the pharmacy: Any admission by a licensed individual of chemical, mental, or physical impairment affecting his or her ability to practice

i. Any admission by a licensed individual of theft, diversion, or self-use of dangerous drugs
ii. Any video or documentary evidence demonstrating chemical, mental, or physical impairment of a licensed individual to the extent it affects his or her ability to practice
iii. Any video or documentary evidence demonstrating theft, diversion, or self-use of dangerous drugs by a licensed individual
iv. Any termination based on chemical, mental, or physical impairment of a licensed individual to the extent it affects his or her ability to practice
v. Any termination of a licensed individual based on theft, diversion, or self-use of dangerous drugs

The pharmacist in charge will immediately report any of the above to the Clinic Manager.

Absence of Pharmacist

During the temporary absence of the pharmacist for breaks or meal periods, including authorized duties of personnel, the pharmacist is responsible for checking all work performed by ancillary staff during the absence.

Orders for controlled drugs or those that require consultation must not be dispensed without a pharmacist immediately available.

Regardless, it remains the Pharmacist's responsibility for maintaining the security of the pharmacy thus if the Pharmacist on duty must be out of the pharmacy for any reason the Pharmacy Director will take his/her place until they return.

Inventory

The on-site pharmacy maintains both 340b purchased and non-340b purchased drugs. These drugs are to be physically separated and treated separately within the dispensing software. The on-site

pharmacy will perform physical inventory verification and updates twice per year in June and December. Any discrepancies shall be reported to the PIC.

The contracted pharmacy located at Tai Tung Pharmacy maintains a separate 340B drug inventory purchased by South Cove Community Health Center. The contract pharmacies will perform physical inventory verification and updates twice per year in June and December. Any discrepancies shall be reported to the Controller.

The contracted 340b pharmacy arrangement with Walgreens is a virtual inventory that is maintained by Walgreens. The inventory is reconciled twice per year and any discrepancies are reported to the Controller.

Quality Assurance Program

The pharmacy Quality Assurance binder shall be readily retrievable, and contain associated documents. The quality assurance program documents medication errors attributable, in whole or in part, to the pharmacy or its personnel. Pharmacy quality assurance policies and procedures are maintained in the QA binder and are immediately retrievable and maintained in the pharmacy for at least one year from the date it was created.
The pharmacist will notify the patient or patient's agent that a medication error has occurred and the steps required to avoid injury or mitigate the error. When a medication error has occurred and the drug was administered to or by the patient, or resulted in a clinically significant delay in therapy the pharmacist must notify the prescriber of the error has occurred. Investigation of pharmacy medication errors must be initiated within two business days from the date discovered.

An Incident Report (See Form 'Incident Report: Quality Assurance Binder' in Appendix) for a medication error contains:
Date, location, and participants; pertinent data and other information related to the error reviewed; findings and determinations; and recommended changes to pharmacy policy, procedure, systems or processes, if any.

Identification Tags

Pharmacists, interns, pharmacy technicians, and pharmacy technician trainees wear nametags that contain their name and credentials.

Records

Completed pharmacy self –assessments must remain on file for three years in the Staff Training Binders.
All drug acquisition and disposition records are maintained for at least three years, SCCHC Pharmacy will maintain these records for 10 years (electronic prescriptions may be kept electronically).

These records include:

i. Prescription records

ii. Purchase Invoices for all prescription drugs
iii. Biennial controlled substances inventory iv. U.S. Official Order Forms (DEA Form 222)
iv. Power of Attorney for completion of DEA 222 forms
v. Theft and Loss Reports (DEA Form 106)
vi. Record documenting return of drugs to wholesaler or manufacturer
vii. Record documenting transfers or sales to other pharmacies, licensees and prescribers

Shipment & Delivery Policy

Controlled Substances and devices that are delivered to the pharmacy, and must be signed by a pharmacist.

Refusing to Fill

A pharmacist must prevent the dispensing of:

i. A prescription order that is contrary to the law.
ii. A prescription order the pharmacist has determined would cause harm or otherwise adversely affect the patient's medical condition.
iii. Any prescription deemed not for legitimate medical need

No prescription that contains significant error, omission, irregularity, uncertainty, ambiguity or alteration shall be dispensed without clarification and confirmation from the prescriber.

Pharmacists should note their corresponding responsibility to determine that a prescription written for a controlled substance was issued for legitimate medical purposes. Even after conferring with the prescriber, the pharmacist does not dispense a controlled substance prescription if he or she knows or has objective reason to know that the prescription was not issued for a legitimate medical purpose. Any refusal to fill should be documented in the QA Binder, with an explanation, supporting paperwork, and a copy of the original if possible. The pharmacist may be called upon to justify the refusal.

If a pharmacist refuses to fill particular medications due to personal beliefs, that objection must be submitted in writing in advance and kept on file.

13.03 Customer Service

Philosophy

South Cove Community Health Center is the primary governing body, and the Pharmacy's intended objective is to provide exceptional health service to the Community. In addition, the Pharmacy must provide the same professional, ethical, and customer-service oriented services to any and all patients presenting.

Acknowledging / Greeting Patients

Patients must be quickly acknowledged or greeted upon arrival to the counter or by phone, even if employees are occupied. The employee shall greet the patient, and convey that they will be helped momentarily. Failure to promptly acknowledge a patient who has been waiting at the counter is unacceptable.

Returns

Prescription medications that have been dispensed and left the pharmacy are forbidden by law to be 'returned' and put back into inventory. In general, 'returns' are not acceptable. If accountable to Pharmacy Error, the transaction may be refunded and the medication put with waste/outdates – the Pharmacist on Duty must approve the acceptance of the return.

Verbal or Physical Abuse or Intimidation

Customer service in a pharmacy can be difficult; there may be occasions when a patient becomes upset or emotional. These occurrences must be handled professionally, and with tact. The employee shall maintain a helpful, professional demeanor while not being subjected to verbal or physical abuse.

In the event of physical or verbal abuse, the employee should notify the Pharmacist on duty and the Pharmacy Director immediately. The Clinic Manager will be notified immediately and if needed Police should be notified. An Incident Report documenting the interaction, whether in person or via phone, will be made and given to the Clinic Manager.

13.04 Standards of Practice

Assure Appropriateness of Therapy

The pharmacy shall assure that drug therapy is safe, efficacious, and cost effective. Concerns or questions about the drug therapy shall be resolved with the prescriber prior to dispensing. Pharmacists shall screen for the appropriateness of therapy with attention to the following

i. correct patient
ii. legality of drug orders
iii. completeness of medication orders
iv. drug-induced or drug-related problems
v. appropriateness of drug therapy
vi. interactions: drug-drug, drug-diet, and drug-lab test
vii. conditions that require order change or modification
viii. appropriateness of the dose form
ix. appropriateness of the dose

Patient Education

Patients who present to the pharmacy shall receive medication counseling in a secluded consultation area. The pharmacist shall educate patients regarding the purpose, proper use and expected outcomes of the drug therapy, and will determine patient understanding through patient or caretaker feedback. Supplemental written information shall be provided as necessary.

Counseling shall include the following:
The indication for which the patient is taking the medication; the name and strength of the medication; how the medication is to be used; dosage and administration schedule; technique; duration of therapy; preparation for use; medication storage; ancillary instructions; desired therapeutic outcome; potential unwanted effects and minimization; other treatment plan elements.

Assure Availability of Medications

The pharmacy will assure drug availability; distribution and control are safe and appropriate and meet patient need. Drug and dosage form selection, purchasing, preparation and dispensing shall meet contemporary, national standards. Controlled substances shall be distributed and controlled according to current Federal and State law and regulations. The pharmacy service shall maintain an appropriate inventory of drugs. Provision shall be made for determining the need for medications not routinely available at the facility and for obtaining needed medications that are not routinely available. The pharmacy service shall assure that quality medications are available at reasonable cost according to the current market supply.

Drug Information and Consultation

The pharmacy shall provide drug information and education by a variety of methods, including:

a. Pharmacist-initiated, patient-specific interventions
b. Drug therapy consultation on request from other professional staff
c. In-service education to other professionals and health workers such as community health representatives and health aides.

Other methods of providing drug information and education may include publishing drug therapy bulletins and/or drug information handouts for patients or providers.

The patient has the right to refuse patient counseling; however, they may be specific situations where the pharmacist may not dispense a medication without counseling when it is deemed medically necessary. Patient education and counseling does not only apply to prescription medications but also to Over-the-Counter medications as well. In certain circumstances, it may be necessary to provide this education over the phone.

Compliance with this standard shall be assessed by review of records of interventions and consultations and documentation of in-service education and preceptor activities.

13.05 Pharmacy Personnel

Job Descriptions

i. Pharmacist

Pharmacist duties are often dynamic, and rely on professional judgement. Some basic duties include, but in no way limited to:

Patient consultation;	Prescriber consultation;
Reading and interpreting written Rx's;	Transcribing Rx's from telephone;
Typing, Filling and dispensing Rx's;	Receiving drug orders;
Submitting drug orders;	Supervision of Techs and Staff;
Answering telephones;	Interprets clinical data in EMR;

Performs any other duty which federal or state law or regulation authorizes only a registered pharmacist to perform;

Performs all functions which require *professional judgment*

ii. Intern Pharmacist

The intern pharmacist may perform all the functions of a pharmacist, but *only* under the direct supervision of a pharmacist. A pharmacist may supervise two interns at any one time.

All prescriptions filled or refilled by an intern are, prior to dispensing, checked for accuracy by a licensed pharmacist and the prescription label initialed by the checking pharmacist.

During a temporary absence of a pharmacist or duty free breaks or meal periods, an intern pharmacist may not perform any discretionary duties nor act as a pharmacist.

iii. Technician

All pharmacy technicians must maintain active licensing. Registered pharmacy technicians will perform packaging, manipulative, repetitive, or other nondiscretionary tasks, while assisting and under the direct supervision and control of the pharmacist on duty. Along with clerks, pharmacy technicians will assume primary responsibility for phone calls and customer service at the windows.

Technicians will not count or handle open bottles of controlled drugs or narcotics until their technique has been observed and approved by the managing pharmacist.

Each pharmacy technician or trainee wears identification that identifies them as a technician or technician trainee. A pharmacy technician trainee participating in an externship may perform packaging, manipulative, repetitive or other nondiscretionary tasks only under the direct supervision and control of a pharmacist; a pharmacist may only supervise one technician trainee and only for a period of no more than 120 hours.

iv. Clerk

A non-licensed person (clerk/typist) is permitted to type a prescription label or otherwise enter prescription information into the computer system, and at the direction of a pharmacist *may request and receive refill authorization*. The number of non-licensed personnel supervised by each pharmacist does not interfere with the pharmacist's responsibilities or performance.

13.06 Pharmacy Operations

PDMP

The PDMPs are considered to be a tool for prescribers and pharmacists to monitor and deter prescription medication misuse, abuse, addiction and diversion and ensure appropriate clinical care.

i. The pharmacist shall access PDMP data during the following activities and discuss any potential abuse or diversion with prescribers:
   a. Prior to filling or refilling for a controlled substance prescription for Schedules CII-CV medications.

Drug Stock Maintenance

The pharmacy shall maintain that drug stock is clean, orderly, properly stored, properly labeled and in date. As with the entire pharmacy, drug inventory should remain dust-free and appropriately organized.

Refrigerator

As per requirements, refrigerators and freezers for medication storage must have minimum twice daily temperature logs. Current plans include the use of automated, wireless systems to continually document temperatures and notify personnel with alarms, text, or email.

Reconstituted Medications

Any medicinal product for oral use manufactured in the powdered state which is reconstituted by SCCHC Pharmacy personnel shall receive an expiration date consistent with the recommendations of the manufacturer. Any such medication shall be labeled with the expiration date and stored under the conditions recommended by the manufacturer.

Powdered drugs are not mixed until the patient has arrived to pick the order up.

· All technicians and clerks must be able to identify reconstitutable drugs, and prevent dispensing unmixed product.

Multi-Dose Vials

Not Applicable

Special Orders: OTC

At the discretion of the pharmacy staff with considerations such as cost, availability of return, history of past orders, etc. a non-stocked item may be ordered for a specific patient request. Upon receiving the item, the pharmacy will call the customer who requested it. The items will be kept for 14 days. If they have not been purchased, they may be sent back to the wholesaler for credit and return. The pharmacy will not order special order items from sources other than the primary wholesaler

Special Orders: Rx Items

In general, requests for specific generic brands due to patient preference cannot be accommodated. The wide variation in wholesale cost and low reimbursement rates prohibit the purchase of specific generic manufacturers; often times 2-3 times the cost of a preferred generic. The pharmacist may make exceptions under certain circumstances but is encouraged to find alternative measures.

Drug Samples

Drug samples are not allowed to be intermixed with in-date pharmacy inventory. Samples should be stored in a separate, locked cabinet/closet within the Health Center. Receiving, distribution, and appropriate documentation are performed by the prescriber or the prescriber's agent according to policy. Unwanted or expired drug samples may be placed in the pharmacy 'Outdates and Recalls' container for destruction.

Recalled Medications

Notification of drug recall may be made through several sources, including but not limited to, local and national media, wholesaler, FDA website, or the manufacturer. For any level of product recall or withdrawal by the FDA, the Pharmacy will act immediately: stock is examined in the Pharmacy and Health Center for recalled products or lot numbers. If a recalled product is found, it is removed from stock and returned to the appropriate agency per the recall letter instructions. If found, copies of recall documentation are initialed, dated and filed for at least two years. If the product is recalled at the consumer level, every effort will be made to track down and notify patients who may be affected of the recall.

Expired Drugs

Expired drugs or supplies are all returned to the pharmacy for disposition by the pharmacy. This may include return to the manufacturer or wholesaler or for credit or destruction by a return processing company on a regular basis.

Outdated and Recalled Inventory

A segregated container shall be used to isolate drugs that must not be in the dispensing inventory. CII medications shall be counted and marked on the bottle, and kept in a similar, locked container.

13.07 Prescription Dispensing Procedure

Scope

The pharmacy furnishes dangerous drugs only to a patient pursuant to a prescription, a wholesaler from whom the drugs were purchased, a manufacturer from whom the drugs were purchased, a licensed wholesaler acting as a reverse distributor, or another pharmacy in emergency situations.

Receipt of Prescription from Patient or E-Script

Patient information should be documented, including spelling of name, DOB, phone, address, and allergy details. This information should be kept up to date and re-verified with the patient on a regular basis.

Rx Transfers

Only pharmacists transfer prescriptions from pharmacy to pharmacy, and records of prescription transfers are kept as required.
Schedule III, IV and V prescriptions can be transferred only once. When receiving a transfer, the prescription is reduced to writing by the pharmacist and “transfer” is written on the face of the transferred prescription and all other information is recorded as required.

Verbal Prescription Orders

Orally transmitted prescriptions are received and reduced to writing only by a pharmacist or intern pharmacist working under the direct supervision of a pharmacist. If orally transmitted, the pharmacist who received the prescription initials and dates the prescription.

Facsimile prescriptions are received only from a prescriber’s office, and must contain a ‘wet signature’ for controlled (CIII-CIV) drugs, as required by law.

Rx Day Supply

Not Applicable

Filling of Prescription

Prescriptions are dispensed in a new and child-resistant container, or senior-adult ease-of-opening tested container, or in a non-complying package only pursuant to the prescriber or when requested by the purchaser.

Prescription Labels

All State and Federal Regulations are to be strictly followed for the labeling of prescriptions.

Controlled Substances

All State and Federal Regulations are to be strictly followed. Several statutes follow, however this is in no way a comprehensive list of requirements.

Schedule II prescriptions, invoices, US official order forms, and inventory records are separate from Schedule III, IV and V and indicates on the inventory record whether that inventory was taken at the "open of business" or at the "close of business." (21 CFR 1304.11[a])

Schedule III-V prescriptions are maintained by the pharmacy software system - easily identifying controlled substances by prescription number, and the original prescription documents can be retrieved promptly. (21 CFR 1304.04[h][2])

Inventories and records for Schedule III-V controlled substances are filed separately or are designated in some manner that makes the required information readily retrievable from ordinary business records. (21 CFR 1304.04)

Official Order Form (DEA Form222) or electronic equivalent (CSOS) is utilized when ordering all schedule II controlled substances. When schedule II controlled substance orders are received by the pharmacy, for each item received, the date and quantity received is indicated on the form, which is then signed by the pharmacist and retained for 5 years.

Pharmacist will hand initial prescription records or prescription labels, or record their identity as the reviewing pharmacist in a secure computer system.

A faxed prescription for a Schedule II controlled substance is not fillable.

If unable to supply the full quantity, the pharmacist partially fills a Schedule II prescription and is aware that if the remaining portion of the prescription is to be filled, it must be filled within 72 hours. (21 CFR 1306.13[a])

Electronic image transmissions and faxed prescriptions are printed as a hard copy and filed.

A computer generated prescription that is not an e-script, and is printed out or faxed by the practitioner's office must be manually signed by the prescriber. (Applies to CIII-CV Only).

Final Verification of Prescription

Before dispensing, a prescription is checked for accuracy by a licensed pharmacist and that pharmacist initials the prescription label, or logs similar data in the pharmacy software.

Patient Counseling

Consultations shall be in a manner that protects the patient's information, in an area suitable for confidential patient consultation. The pharmacist will review a patient's drug therapy and medication record prior to or during consultation. Appropriate drug warnings must be provided orally or in writing.

The pharmacist shall provide patient-specific drug information about drugs and drug therapy to health professionals, patients, and patients' caregivers as appropriate. Responses to general and patient-specific drug information requests shall be provided in an accurate and timely manner by a pharmacist.

Pharmacists shall be available to participate in patient education and to ensure that all patients are given adequate information about the medications they receive in to help patients with their own health care decisions. Patient education activities shall be coordinated with the nursing, medical, and other clinical staff as determined by Administration.

If necessary, interpretative language services (written or oral) will be made available to patients.

Language Barriers

To the best of their ability, pharmacy staff will assist patients with limited or no English proficiency to understand the information on the prescription label, or supplemental paperwork in the patient's language. In such a situation the pharmacy may use documentation in the patient's language, or employ the use of an interpreter.

Refills

Authorization is obtained from the prescriber and documented before refilling a prescription.

Refills for Schedule II controlled substances are prohibited.

Pharmacy Technicians and Clerks my both request and receive refill authorizations by phone for *Non-Controlled Medications Only.*

Written documentation of refill authorizations must include the Date, Name of Patient, Name of Prescriber, name of staff person calling, drug name, strength, quantity and additional number of refills. The person recording such authorization must clearly indicate their identity on the new hard copy.

Early Refills

Early refills for high-risk medications will not be acceptable without a legitimate reason and prescriber approval. If the patient is under our Controlled Substance Agreement, the patient must obtain prescriber approval for early fills ahead of time.

Medication Loan Policy

Prescriptions may be filled without the prescriber's authorization if the prescriber is unavailable if, in the pharmacist's professional judgment, failure to refill the prescription may interrupt the patient's ongoing care or have significant adverse effect on the patient. The quantity dispensed should be the minimum sufficient until the anticipated return of the prescriber. Controlled medications are up to the judgment of the Pharmacist on duty.

Schedule II Emergency Dispensing

In the event of lost/stolen medication the pharmacy does not accept Police Reports. Prescriptions will not be refilled without the provider writing a new prescription for the lost or stolen medications.

Note: Nearly any 'Emergency' scenario presenting inside the pharmacy can be referred to a nearby Emergency Room, Urgent Care or 911 Services if Clinic Providers are inaccessible.

Errors and Discipline

Whenever the pharmacist or Pharmacy Director sees an error being made by a technician or pharmacist, an informal discussion memo will be generated and discussed with the employee. This should be done as soon as possible after the error is discovered, but no later than 7 days. If more immediate action is necessary, the pharmacist or Pharmacy Director will fill out a corrective action plan according to SCCHC policy.

13.08 Staff Training

Performance Reviews

There shall be regularly scheduled evaluation of the performance of pharmacy personnel. The evaluation format should be consistent with that used by the Clinic. The competencies of the position shall be well defined in the position description, short- and long-term goals should be established for each employee, and the employee's competency shall be assessed regularly. The pharmacy director shall ensure that an ongoing competency assessment program is in place for all staff, and each staff member should have a continuous professional development plan.

Education & Training

All personnel shall possess the education and training required to fulfill their responsibilities and shall participate in relevant continuing-education programs and activities to maintain or enhance their competence. Licensed employees must remain current, up-to-date licensure.

Documentation of Competencies

Employee training and compliance documentation will be maintained in an individual binder within the pharmacy. Employee performance reviews will be maintained separately by administration.

HIPAA Training

HIPAA training will be renewed annually, and the completed forms held in the employees training binder.

Patient information must be maintained to safeguard confidentiality, and all HIPAA regulations must be strictly followed. All prescriptions are kept confidential and only disclosed as authorized by law. The pharmacy ensures electronically transmitted prescriptions are received, maintained and transmitted in a secure and confidential manner. Staff must maintain private pass codes, and lock unattended terminals within reach or sight of the general public.
Remember: Patient identifiable items must be disposed in a HIPAA compliant manner.

Medicare FWA

Pharmacy staff must certify and record annual Medicare Fraud, Waste and Abuse training.

Key FWA points are:

Participating pharmacies will comply with all applicable laws, rules, and regulations, including, without limitation, the Social Security Act, Medicare Part D implementing regulations, 42 CFR Parts 400-423, CMS instructions and the federal anti-kickback statute, 42 USC §1320a-7b(b), as any of which may be amended from time to time.

The participating pharmacy represents that neither it nor any of its owners, directors, officers, employees, or contractors are subject to sanction under the Medicare/Medicaid program or debarment, suspension, or exclusion under any other federal or state agency or program, or otherwise are prohibited from providing services to Medicare or Medicaid beneficiaries.

Medicare Part D

As required under 42 CFR 423.505(I)(2), for a period of *ten (10) years* following the final year of the Term in which Pharmacy provides Services under any Medicare Part D Program, Pharmacy will maintain, preserve and make available for inspection and review all books, contracts, documents, papers, and other records of Pharmacy, its related entities, contractors, subcontractors, or transferees, that pertain to Medicare Enrollees, the services provided under this Agreement or other matters relevant to Part D Plans (collectively, the "Records"), in accordance with security and privacy protections described.

Notwithstanding the foregoing, the ten-year retention period may be extended if:

i. CMS determines there is a special need to retain a particular Record or a group of Records for a longer period and notifies the Pharmacy at least 15 days before the normal disposition date
ii. There is a termination, dispute, or allegation of fraud or similar fault by any Part D Plan Sponsor, in which case the retention may be extended to six (6) years from the date of any resulting final resolution of the termination, dispute or fraud or similar fault;
iii. Records that relate to an ongoing investigation, litigation, or negotiation by CMS, DHS, Department of Health and Human Services Office of Inspector General, Department of Justice, or a State, or the Records otherwise relate to suspicions of fraud and abuse or violations of Federal or State law.

Licensure

All licensed personnel must maintain active licensing in good standing with their respective boards. In the event of license expiration or other sanctions, the licensee must notify the Pharmacist in Charge and HR Manager immediately and discontinue all activities subject to said license.

13.09 Security

Access by Non–Pharmacy Personnel

Only registered pharmacists may possess keys to the actual pharmacy. Non-Pharmacy personnel may only enter the pharmacy with consent of the Pharmacist on duty.

Security Precautions

i. Management and staff should not discuss pharmacy procedures, cash handling, pharmacy layouts, security systems, etc., with *any* outsider, even family.
ii. Pharmacy personnel should not discuss inventory controls with other employees. iii. Co-workers or other pharmacy personnel do not need to know the measures taken to hide targeted drugs.
iv. Staff should be alert and observant. They should quickly acknowledge and regularly offer assistance to clients

Robberies

In the face of crisis, stay calm and comply with the demands of the intruder.
Advice from the DEA:

What to do during a robbery:

· Do not resist; cooperate fully with the robber.
· Remain calm and avoid sudden movements.
· Do exactly what you are told to do, nothing more and nothing less.
· Make mental notes on a physical description (e.g., clothing, hair, size, build, tattoos, scars, and other body features).
· Do not attempt to apprehend the criminal yourself.

What to do After a Robbery:

· Immediately get treatment for anyone who may be injured.
· Sound the alarm as soon as possible.
· Call local police first, then your supervisor who will then notify the Clinic Manager.
· Lock doors immediately to prevent re-entry and keep closed until police arrive.
· Request customers to remain in the store to give a statement to police.
· Protect the crime scene. Stop others from touching anything touched by the suspect(s).
· Do not trust your memory. The quicker you write down what you observed the better.

Burglaries

What to do after a burglary:

· Notify police department.
· Avoid touching or disturbing anything.
· After the police arrive, prepare a detailed list of what was stolen.
· Take the appropriate steps to improve security.

Reporting Theft or Loss of Controlled Medications

If controlled drugs were taken, report it to your local DEA Field Office in writing within one business day, and submit a completed DEA Form 106, *Report of Theft or Loss of Controlled Substances*, as soon as possible.

13.10 340B Program

The 340B Program is a discounted Drug Pricing program that allows eligible facilities to purchase medications at VA Pharmacy Prime Vendor prices. Participation in this program requires strict adherence to the program guidelines. In general, the use of and proceeds from 340B Medications is intended for SCCHC Patients.

Definition of Eligible 340B Patient

To be eligible to receive 340B-purchased drugs, patients must receive health care services other than drugs from South Cove Community Health Center. An individual is a patient of South Cove Community Health Center only if:

- South Cove Community Health Center has established a relationship with the individual, such that the covered entity maintains records of the individual's health care; ***and***
- the individual receives health care services from a health care professional who is either employed by South Cove Community Health Center or provides health care under contractual or other arrangements (e.g. referral for consultation) such that responsibility for the care provided remains with South Cove Community Health Center; ***and***
- the individual receives a health care service or range of services from South Cove Community Health Center which is consistent with the service or range of services for which grant funding has been provided to South Cove Community Health Center.

An individual will not be considered a patient of South Cove Community Health Center if the only health care service received by the individual from South Cove Community Health Center is the dispensing of a drug or drugs for subsequent self-administration or administration in the home setting.

Definition of Eligible 340B Prescription

To be eligible to receive 340B-purchased drugs, a prescription must meet the following criteria:

- must be dispensed to an eligible South Cove Community Health Center 340B Patient (as defined above).
- the prescription must originate within the Clinic, by Clinic Prescribers. Prescriptions written by a Clinic Provider but originating from a non-SCCHC location are not eligible, nor are orders from outside providers.

Avoiding Duplicate Rebates

Section 340B(a)(5)(A) of the Public Health Service Act prohibits duplicate discounts; that is, manufacturers are not required to provide a discounted 340B price and a Medicaid drug rebate for

the same drug. The health center must ensure that duplicate discounts are not taken by utilizing the proper inventory and billing procedures as follow:

For certain plans, Massachusetts has made arrangements to receive rebates directly from the manufacturer. The following Masshealth plans are not eligible for 340B Inventory usage:

- Masshealth ACO programs including but not limited to:
  - Tufts with BIDCO
  - Tufts Masshealth
  - BMC HealthNet Masshealth
  - NHP Masshealth

For the plans listed above, the pharmacy must utilize the non-340B inventory to fill prescriptions. The health center will bill these prescriptions per the instructions given by Masshealth.

Auditing/Drug Diversion

Drug diversion in the program is defined as a 340B drug being provided to an individual who is not an eligible outpatient of the entity and/or dispensed in an area of a larger facility that is not eligible (eg, an inpatient service or a non-covered clinic).

Examples of drug diversion include:

- Dispensing 340B drugs at ineligible sites.
- Not monitoring and correcting inventories
- Dispensing 340B drugs written by ineligible providers
- Dispensing 340B drugs to non-eligible patients at a contract or onsite pharmacy

Drug diversion may also result in duplicate discounts being taken through the Medicaid rebate program. Examples of duplicate discounts include:

- Billing Medicaid contrary to HRSA Medicaid Exclusion file listing
- 340B drugs used for Medicaid patients at contract pharmacy with no arrangement to prevent duplicate discounts
- Medicaid claims incorrectly coded when provided to the state
- Incorrect Medicaid or NPI number in HRSA Medicaid exclusion file
- Outpatient sites incorrectly listed on HRSA Medicaid exclusion file

Monthly audits of each pharmacy program (On site Pharmacy, Contract Pharmacy) provided by the health center is to be completed to ensure that drug diversion is not occurring. A minimum of five prescriptions dispensed through each 340b program will be reviewed for accuracy and integrity. Findings will be filed and kept for no less than 10 years. Monitoring and correcting of inventory is to be completed according to inventory policy.

13.11 DAW

DAW (dispensed as written) – Standard NCPDP Codes are:

0 = No product selection indicated
1 = Substitution not allowed by prescriber
2 = Substitution allowed - patient requested product dispensed
3 = Substitution allowed - pharmacist selected product dispensed
4 = Substitution allowed - generic drug not in stock
5 = Substitution allowed - brand drug dispensed as a generic
6 = Override
7 = Substitution not allowed - brand drug mandated by law
8 = Substitution allowed - generic drug not available in marketplace
9 = Other

13.12 340B Auditing Tool

Month/Year_____ Date:_____

Name:_____

	Pharmacy Site	Script#	Date Filled	Prescribing Provider	Drug Name/NDC	Insurance	340B Eligible Prescriber?	340B Eligible Patient?	340B Eligible Ins./ Self Pay?	340 Drug?	Pass/ Fail
1											
2											
3											
4											
5											
6											
7											
8											
9											
10											
11											
12											
13											
14											
15											
16											
17											
18											
19											
20											

Script Passes Testing when either:

1. Eligible Provider, Eligible Patient, Eligible Insurance, 340B Drug are all Yes.
2. Eligible Provider, Eligible Patient or Eligible Insurance are No, and 340B Drug is No

Forward to Eric Tiberi, COO

APPENDIX

MASSACHUSETTS DEPARTMENT OF Children & Families
Supporting Children • Strengthening Families

Report of Child(ren) Alleged to be Suffering from Abuse or Neglect

Massachusetts law requires mandated reporters to immediately make a report to the Department of Children and Families (DCF) when they have reasonable cause to believe that a child under the age of 18 years is suffering from abuse and/or neglect by:

STEP 1: Immediately reporting by oral communication to the local DCF Area Office (see contact information at end of form); and

STEP 2: Completing and sending this written report to the local DCF Area Office within 48 hours of making the oral report.

For more information about requirements for mandated reporters and filing a report of alleged abuse and/or neglect please see **A Guide for Mandated Reporters** available on the DCF website at **www.mass.gov/dcf.**

Please complete all sections of this form. If some data is uncertain or unknown, please signify by placing a question mark ("?") after the entry.

CHILDREN REPORTED

Name	Current Location/Address	Language Spoken	Birth Sex		Age or Date of Birth	ICWA/Tribal Affiliation
			Male	Female		

EMERGENCY CONTACT(S) FOR CHILDREN REPORTED: Please list the emergency contact information for all of the reported children, including contact name, relationship, and contact number information.

OTHER CHILDREN: Please include information about other children in the home/family, including name and age/date or birth (if known).

PARENT, GUARDIAN OR CAREGIVER 1

Name: _____
First Last Middle

Address: _____
Street & Number City / Town State Zip Code

Phone #: Age/Date of Birth:

Language Spoken: Relationship to Child(ren):

PARENT, GUARDIAN OR CARGIVER 2

Name: _____
First Last Middle

Address: _____
Street & Number City / Town State Zip Code

Phone #: Age/Date of Birth:

Language Spoken: Relationship to Child(ren):

REPORTER / REPORT

Report Date: Mandatory Report Non Mandatory Report

Reporter's Name: _____
First Last Middle
(If the reporter represents an institution, school or facility, please indicate)

Reporter's Address: _____
Street & Number City / Town State Zip Code

Phone #:

Has reporter informed caregiver of report ? Yes No

What is the reporter's relationship to the child(ren)?

What is the nature and extent of injury, abuse, maltreatment or neglect? Please list any prior evidence of same and/or other worries regarding danger to the child(ren). (Please cite the source of this information if not observed firsthand.)

RELATED CONCERNS: Please check all that apply.

☐ Substance Use/Misuse ☐ Acute/Chronic Medical Condition ☐ Runaway

☐ Substance Exposed Newborn ☐ Housing Instability/Homelessness ☐ Gang Involvement

☐ Neonatal Abstinence Syndrome ☐ Human Trafficking ☐ None Applies

☐ Domestic Violence ☐ Sexual Exploitation ☐ Unknown

☐ Mental/Behavioral Health Challenges ☐ Teen Parenting ☐ Other

DESCRIPTION OF RELATED CONCERNS: Please include additional information that will help DCF further understand the concerns checked above. This includes any specific concerns about alcohol/drug use by the parent/guardian/caregiver. If there are concerns related to domestic violence, please also list any information that will help DCF make safe contact with the family (e.g., work schedule, place of employment, daily routines for the adult victim, etc.).

If known, please provide the name(s) and address, phone #, DOB/age, relationship to child, and language spoken of the person(s) responsible for the injury, abuse, maltreatment or neglect and/or any other information that you think might be helpful in establishing the cause of the injury, abuse, maltreatment or neglect.

What are the circumstances under which the reporter became aware of the injury, abuse, maltreatment or neglect? Please include information on dates and timeframes for when the injury, abuse, maltreatment or neglect occurred.

Pedikit# (if applicable): Incident Date (if known):

What action has been taken thus far to treat, shelter or otherwise assist the child(ren) to deal with the situation?

Are there any concerns for social worker safety?

Please provide any information about the family's strengths and capacities that you think will be helpful to DCF in ensuring the child's safety and supporting the family to address the abuse and/or neglect concerns.

Signature of Reporter:

To report child abuse and/or neglect: Weekdays from 9:00 am to 5:00 pm call the local DCF Area Office.
Weekdays after 5:00 pm and 24 hours on weekends and holidays call the
Child-At-Risk-Hotline 1-800-792-5200

DCF AREA OFFICES

Boston Region		**Central Region**		**Northern Region**	
Dimock Street, Roxbury	617-989-2800	North Central, Leominster	978-353-3600	Cambridge/Somerville	617-520-8700
Harbor, Chelsea	617-660-3400	South Central, Whitinsville	508-929-1000	Cape Ann, Salem	978-825-3800
Hyde Park	617-363-5000	Worcester East	508-793-8000	Framingham	508-424-0100
Park Street, Dorchester	617-822-4700	Worcester West	508-929-2000	Haverhill	978-469-8800
				Lawrence	978-557-2500
				Lowell	978-275-6800
				Lynn	781-477-1600
				Malden	781-388-7100

Southern Region		**Western Region**	
Arlington	781-641-8500	Greenfield	413-775-5000
Brockton	508-894-3700	Holyoke	413-493-2600
Cape Cod & Islands	508-760-0200	Pittsfield	413-236-1800
Coastal, Braintree	781-794-4400	Robert Van Wart Center, East Springfield	413-205-0500
Fall River	508-235-9800		
Plymouth	508-732-6200	Springfield	413-452-3200
New Bedford	508-910-1000		
Taunton/Attleboro	508-821-7000		

South Cove Community Health Center

Statement of Confidentiality & Consent for Teen Services

I understand that Massachusetts law allows minors (person age 17 and younger) to consent to and obtain limited health care services without parental or guardian consent or knowledge.
I understand that I can receive examination, diagnosis and treatment for those limited services in a confidential manner and that my parent or legal guardian does not have a right to know.
These services include:

vi. Birth control/contraceptive care
vii. Pregnancy testing and/or assistance for care during or after a pregnancy
viii. Diagnosis and treatment of sexually transmitted diseases (STDs)
ix. HIV counseling and testing
x. Counseling and health education for any of the above services

I also understand that other services I may want to receive at SCCHC do not fall under my right to consent as a minor, and that my SCCHC provider will need to make an attempt to obtain legal consent from my parent or legal guardian.

These services include:

- Routine preventive health physicals
- School physicals
- Routine illness treatment (such as for the flu, asthma or ear aches)

I further understand that in rare situations my SCCHC provider cannot protect my confidentiality.
Examples of this include:

1. If am at risk for hurting myself or other people
2. If I am being abused

I understand the above information and I am signing this document to consent to confidential services.
Because I do not want my parent or legal guardian to become aware of my receiving such services,
I will provide SCCHC with alternative means for contacting me (cell phone, school phone).
I agree to review this form at least once a year.

Patient name (print): _____ SCCHC Medical Record #:_____

Patient signature: _____ Date signed: _____

Provider/RN/Family Planning Counselor name: _____

Provider/RN/Family Planning Counselor signature: _____ Date signed: _____

I am not a Confidential Teen.

I understand the above agreement and do not desire confidential care as a minor.

I agree to review this form at least once a year:

Patient name (print): _____ SCCHC Medical Record #:_____

Patient signature: _____ Date signed: _____

Provider/RN/Family Planning Counselor name: _____

Provider/RN/Family Planning Counselor signature: _____ Date signed: _____