

MEETING NOTICE

Governing Board

A regular meeting of the Board of Directors of the Southern Humboldt Community Healthcare District will be held on March 4, 2025, at 2:30 p.m., by teleconference and in-person. Members of the public may participate virtually via Webex or telephone, or appear in person at the Sprowel Creek Campus at 286 Sprowel Creek Road, Garberville, California 95542.

Call-In Information:

<https://shchd.webex.com/shchd/j.php?MTID=mf67b3a22d08784a22d0856ab9904f208>

Join by phone +1-415-655-0001 US Toll

Webex Link:

Written comments may also be sent to boardcomments@shchd.org. Comments received no later than two hours prior to the start of the meeting will be provided to the Board or may be read aloud or summarized during the meeting. Members of the public may also comment in real time during the meeting by attending in person or via Webex or phone.

Agenda

Page

Item

- A. Call to Order
- B. Approval of the Teleconferencing of a Board Member
- C. Approval of the Agendas
- D. Public Comment on Non-Agendized Items
See below for Public Comment Guidelines
- E. Board Member Comments
Board members are invited to address issues not on the agenda and to submit items within the subject jurisdiction of the Board for future consideration. Please limit individual comments to three minutes.
- F. Announcements
- G. Approval of Consent Agenda –

- PG 7 - 12
1. Approval of Previous Minutes
 - a. Governing Board Meeting Minutes, January 30, 2025
- PG 13 - 35
2. SHCHD New and Updated Policies

New Policies and Procedures

RADIOLOGY/MAMMOGRAPHY:

 - a. Disposal of Contrast Media and Components
 - b. Abnormal Mammogram Reports
 - c. Augmented Breast Mammogram
 - d. Diagnostic Mammography
 - e. Image Quality (Phantom)
 - f. Mammography Technique Chart
 - g. OnRAD Teleradiology Mammography Protocol
 - h. Patient History
 - i. Patient Selection Criteria
 - j. Qualified Responsible Personnel
 - k. Quality Control Equipment
 - l. Radiation Dosimeter Badge

COMPLIANCE:

 - m. Complaints and Grievances

LAB:

 - n. General Laboratory Systems
- PG 36 - 162
3. Obsolete Policies for Retirement

Clinic Manual:

 - o. Blood Pressure Monitoring
 - p. Cervical Cancer Screening
 - q. Chaperones
 - r. Clinic Intake Work Aid
 - s. Colposcopy Cervical Biopsy
 - t. Confidentiality of Patient Information
 - u. Endometrial Biopsy
 - v. Guidelines for Preventative Healthcare Services
 - w. Hypertension Diagnosis & Treatment
 - x. Immunization Policy and Procedure
 - y. Mantoux Tuberculin Skin Testing
 - z. Minor Surgical Procedures
 - aa. Oxygen Administration
 - bb. Protime Dosing Guidelines
 - cc. Referrals
 - dd. Specialists
 - ee. Test Results

- ff. Tobacco Cessation Monitoring & Education
- gg. Employee Vaccination & TB Testing
- hh. Animal Bite Treatment
- ii. Code Blue
- jj. Electrical Power Failure
- kk. Key Access
- ll. Abusive and/or Assaultive Patients
- mm. Allergy Injections

Skilled Nursing:

- nn. Care of Diabetic Patient
- oo. Care of Resident with Cardiovascular Disease
- pp. Care of Resident with Genitourinary Tract Disorders
- qq. Care of Resident with Neurological Disorders
- rr. CNA Documentation
- ss. Elastic Bandages
- tt. Notification of a Change in a Resident's Condition or Status
- uu. Oral Hygiene
- vv. Orientation of a Blind Resident

ER Manual:

- ww. Administration of Potassium Chloride Intravenously
- xx. Assessment and Vital Signs Guidelines
- yy. Assisting with Abdominal Paracentesis
- zz. Care of the Patient W Burns
- aaa. Caregiver-Child Separation During a Disaster
- bbb. Central Venous Catheter Care
- ccc. Chest Pain
- ddd. Chest Tube Insertion in the ED
- eee. Controlled Substance and Ambulances
- fff. Crash Carts and Emergency Patient Care Equipment
- ggg. Discharge Instructions
- hhh. ED Triage
- iii. ED Follow Up
- jjj. Envenomation Rattlesnake Bites
- kkk. Initial Management of Amputations
- lll. Observation of Patients
- mmm. Pediatric Medication Safety
- nnn. Pediatric Standards of Care
- ooo. Pelvic Exams in the ED
- ppp. Penetrating Injuries from Missile
- qqq. Postmortem Care
- rrr. Precipitous Delivery

- sss. Procedural Sedation
- ttt. Referrals from the ED
- uuu. Stroke
- vvv. Valuables and Personal Effects

Nursing Manual:

- www. Discharge Instructions for Acute In-Patients and Swing Patients
- xxx. Enteral Tube Feeding
- yyy. Insertion and Maintenance of Peripheral Intravenous Catheters
- zzz. Patient or Resident Fall
- aaaa. Abusive and/or Assaultive Patients

- 3. Quarterly Reports - (Feb, May, Aug, Nov)
 - a. Quality and Risk Management – Kristen Rees, Chief Quality and Compliance Officer and Risk Manager - None
 - b. Human Resources – Season Bradley Koskinen, HR Manager - None
 - c. Foundation – Chelsea Brown, Outreach Manager - None
 - d. Operations – Kent Scown, Chief Operations Officer

PG 163 - 164

H. Last Action Items for Discussion

- 1. 360 Reviews - HR

I. Correspondence, Suggestions, or Written Comments to the Board

J. Administrator's Report – Matt Rees, CEO

- 1. Department Updates
 - a. Milestones
 - b. February Employee Anniversaries – Tommy Graney, Security and Menchie Crosiar, CNA 5 years and Amy Terrones, Community Resources Director 10 years
 - c. Approval of the January Financials – Paul Eves
 - d. CNO Report – Adela Yanez
 - e. Quality and Risk Management – Kristen Rees
 - f. Family Resource Center – Amy Terrones – Mar and Oct

K. Old Business - None

L. New Business

1. Board Orientation Process - Darrin

M. Parking Lot

1. Sprowel Creek Campus parking

N. Meeting Evaluation

O. New Action Items

P. Next Meetings

1. Medical Staff Policy Development Committee – Tuesday, March 11, 2025, 10:00 a.m
2. QAPI Meeting – Wednesday, March 12, 2025, at 10:00 a.m.
3. Medical Staff Committee – Thursday, March 13, 2025, at 12:30 p.m
4. Finance Committee – TBD, 2025
5. Governing Board Meeting – TBD, 2025

Q. Adjourn to Closed Session

1. Closed Session
2. Reports of Quality Assurance Committees **[H&S Code § 32155]**
3. Compliance and Risk - Kristen Rees, CQO
4. Quarterly Reports - Adela Yanez, CNO -
 - a. Patient Safety – Mar., June, Sept., Dec.
 - b. Medication Error – Feb., May, Aug., Dec. – None
5. Approval of Medical Staff Appointments/Reappointments **[H&S Code § 32155]**
 - a. Daniel Lucas,
6. Personnel Matter –Evaluation § 54957
 - a. CEO Matt Rees

R. Adjourn Closed Session; Report on Any Action Taken, If Needed

S. Resume Open Session

T. Adjourn

Abbreviations

<i>ACHD</i>	Association of California Healthcare Districts	<i>ACLS</i>	Advanced Cardiac Life Support Certification
<i>AR</i>	Accounts Receivable	<i>BLS</i>	Basic Life Support Certification
<i>CAIR</i>	California Immunization Registry	<i>CEO</i>	Chief Executive Officer

<i>CFO</i>	Chief Financial Officer	<i>CMS</i>	Centers for Medicare and Medicaid Services
<i>CNO</i>	Chief Nursing Officer	<i>COO</i>	Chief Operating Officer
<i>CPHO</i>	Certified Professional in Healthcare Quality	<i>COO</i>	Chief Quality and Compliance Officer
<i>EMR</i>	Electronic medical record	<i>ER</i>	Emergency Room
<i>FTE</i>	Full Time Equivalent/Full Time Employee	<i>HIM</i>	Health Information Management
<i>HRG</i>	Healthcare Resource Group	<i>HVAC</i>	Heating, Ventilation and Air Conditioning system
<i>IGT</i>	Intergovernmental transfer	<i>IT</i>	Information Technology
<i>JPCH</i>	Jerold Phelps Community Hospital	<i>LCSW</i>	Licensed Clinical Social Worker
<i>LVN</i>	Licensed Vocational Nurse	<i>MPH</i>	Master of Public Health
<i>OBS</i>	Observation	<i>PALS</i>	Pediatric Advanced Life Support Certification
<i>PFS</i>	Patient Financial Services	<i>QAPI</i>	Quality Assurance Performance Improvement
<i>QIP</i>	Quality Improvement Project/Program	<i>RN</i>	Registered Nurse
<i>SHCC</i>	Southern Humboldt Community Clinic	<i>SHCHD</i>	Southern Humboldt Community Healthcare District
<i>SNF</i>	Skilled Nursing Facility	<i>SWG</i>	Swing beds
<i>DO</i>	Doctor of Osteopathic Medicine		

PUBLIC COMMENT ON MATTERS NOT ON THE MEETING AGENDA: Members of the public are welcome to address the Board on items not listed on the agenda and within the jurisdiction of the Board of Directors. The Board is prohibited by law from taking action on matters not on the agenda, but may ask questions to clarify the speaker’s comment and/or briefly answer questions. The Board limits testimony on matters not on the agenda to three minutes per person and not more than ten minutes for a particular subject, at the discretion of the Chair of the Board.

PUBLIC COMMENT ON MATTERS THAT ARE ON THE AGENDA: Individuals wishing to address the Board regarding items on the agenda may do so after the Board has completed their initial discussion of the item and before the matter is voted on, so that the Board may have the benefit of these comments before making their decision. Please remember that it is the Board’s responsibility to discuss matters thoroughly amongst themselves and that, because of Brown Act constraints, the Board meeting is their only opportunity to do so. Comments are limited to three minutes per person per agenda item, at the discretion of the Chair of the Board.

OTHER OPPORTUNITIES FOR PUBLIC COMMENT: Members of the public are encouraged to submit written comments to the Board at any time by writing to SHCHD Board of Directors, 733 Cedar Street, Garberville, CA 95542. Writers who identify themselves may, at their discretion, ask that their comments be shared publicly. All other comments shall be kept confidential to the Board and appropriate staff.

IN COMPLIANCE WITH THE AMERICANS WITH DISABILITIES ACT, if you require special accommodations to participate in a District meeting, please contact the District Clerk at 707-923-3921, ext. 1276 at least 48 hours prior to the meeting.”

**Times are estimated*

COPIES OF OPEN SESSION AGENDA ITEMS: Members of the public are welcome to see and obtain copies of the open session regular meeting documents by contacting SHCHD Administration at (707) 923-3921 ext. 1276 or stopping by 291 Sprowel Creek Rd, Garberville, CA 95542 during regular business hours. Copies may also be obtained on the District’s website, sohumhealth.org.

Posted February 28, 2025

Governing Board

Date: January 30, 2025
Time: 1:30 p.m.
Location: Sprowel Creek Campus and Via Webex Conferencing
Facilitator: Board President, Corinne Stromstad

Minutes

The following people attended at Sprowel Creek Campus and via Webex

Governing Board: Corinne Stromstad, Kevin Church, and Jay Sooter, all in-person.

Not Present: Galen Latsko and Barbara Truitt

Also in person: CFO Paul Eves, Chief of Staff Joseph Rogers, Outreach Manager Chelsea Brown, Grant Writer Nick Vogel, Business Development Director Ryan Staples, Administrative Assistant Darrin Guerra, Accounting Controller Cherie' Hurt, and CQO Kristen Rees

Also via Webex: HIM Manager Remy Quinn, CNO Adela Yanez, COO Kent Scown, and Vice Chief of Staff Dr. Carl Hsu.

A. Call to Order – Board president Corinne Stromstad called the meeting to order.

B. Approval of the Teleconferencing of a Board Member – None

C. Approval of the Agenda

Motion: Kevin Church motioned to approve the agenda.

Second: Jay Sooter

Ayes: Corinne Stromstad, Jay Sooter, and Kevin Church

Noes: None

Not Present: Galen Latsko and Barbara Truitt

Motion Carried

D. Public Comment on Non-Agendized Items - None

E. Board Member Comments – None

F. Announcements

1. Board Resignation
 - a. On 1/17/25 Barbara Truitt presented her resignation to Board President Corinne Stromstad. “Dear SHCHD Board, I hereby resign from the board Effective Immediately, as I can no longer fulfill my duties...Best wishes, Barbara Truitt”

G. Consent Agenda

1. Approval of Previous Minutes
 - a. Governing Board Meeting Minutes, January 6, 2025
2. SHCHD New and Updated Policies
 - Outreach
 - a. Use of Personal Social Media Accounts
 - b. Managing Social Media Presence
 - SLS
 - c. Separation of Psychotherapy Notes for Mental Health Record
 - d. Risk Management
 - e. Requirements for the Telepsychiatry Process
 - ER
 - f. Routine Syphilis, HIV & HCV Testing, Treatment, and Linkage to Care Program (EDSP)
 - Medstaff
 - g. Medical Staff Credentialing and Privileging
 - Mammography
 - h. Corrective Action
 - Lab
 - i. Lab Complaints
 - j. Quality
 - k. Reporting
 - l. Licensure
 - m. Provision
3. Quarterly Reports - (Feb, May, Aug, Nov) - None
 - a. Quality and Risk Management – Kristen Rees, Chief Quality and Compliance Officer and Risk Manager
 - b. Human Resources – Season Bradley Koskinen, HR Manager
 - c. Foundation – Chelsea Brown, Outreach Manager
 - d. Operations – Kent Scown, Chief Operations Officer

Motion: Kevin Church motioned to approve the consent agenda.
Second: Jay Sooter
Ayes: Corinne Stromstad, Jay Sooter, and Kevin Church
Noes: None
Not Present: Galen Latsko
Motion Carried

H. Last Action Items for Discussion

1. Election of Officers

Motion: Corinne Stromstad motioned to approve Kevin church as board President and Corinne Stromstad, Vice President of the SHCHD Governing Board
Second: Kevin Church
Ayes: Corinne Stromstad, Jay Sooter, and Kevin Church
Noes: None
Not Present: Galen Latsko
Motion Carried

2. Governing Board Committees

After a brief discussion, the Board members decided to join the committees as follows

- a. Facilities – Jay Sooter
- b. Outreach – Jay sooter
- c. Bylaws – Kevin Church
- d. Compensation and Retention – Kevin Church

I. Correspondence Suggestions or Written Comments to the Board – None

J. Administrator’s Report – Matt Rees, CEO

Matt Rees presented the administrative report and provided the Board with updates on several current projects, including the success of the Mobile Optometry unit. Since its opening on January 7th, the mobile optometry clinic has served over 100 patients. We are also pleased to welcome Dr. Snehal Raisonni as one of the new providers at our Rural Health Clinic. Lastly, Matt addressed the uncertainty surrounding Federal Funding for the USDA loan. He reassured the Board that, even if this funding were to cease, we have alternative programs available to finance the new facility.

1. Department Updates

- a. Milestones
- b. December Employee Anniversaries - Cherie’ Hurt, Controller 1 Year and Lula Williams Security 10 Years
- c. Approval of July – December 2024 Income Sheets and Balance Statements – CFO Paul Eves
 - i. Paul presented the January – December financials and answered corresponding questions.
- d. Nursing – Adela Yanez, CNO
 - i. Adela Yanez presented her Board report.
- e. Quality and Risk Management – Kristen Rees, CQO
 - i. Kristen presented her verbal Board report
- f. Family Resource Center – Amy Terrones – (Mar and Oct)

Motion: Kevin Church motioned to approve the July – December 2024 Financials.
Second: Jay Sooter
Ayes: Corinne Stromstad, Jay Sooter, and Kevin Church
Noes: None
Not Present: Galen Latsko
Motion Carried

K. Old Business - None

L. New Business

1. February Meeting Schedule
 - a. The Board decided to host the February Finance Committee on February 27th at 10 a.m. and the February Governing Board Meeting on March 4th at 2:30 p.m.
2. Updated Brown Act Teleconferencing Update – Darrin Guerra
 - a. Darrin gave a brief update to the Board, educating them on our new teleconferencing Matrix for 2025. If a district board meets regularly once per month. The directors can attend via AB 2449 two times during the year. There could be two just causes, one just cause and one emergency, or two emergencies.

M. Parking Lot - None

N. Meeting Evaluation – Happy New Year!

O. New Action Items

1. New Brown Act Teleconferencing Matrix
2. Board Committees
3. Election of Officers

P. Next Meetings

1. QAPI Meeting – Wednesday, February 12, 2025, at 10:00 a.m.
2. Medical Staff Committee – Thursday, February 13, 2025, at 12:30 p.m.
3. Medical Staff Policy Development Committee – Tuesday, February 18, 2025, 10:00 a.m.
4. Finance Committee – February 27, 2025, 10:00 a.m.
5. Governing Board Meeting – March 4, 2025, 2:30 p.m.

Q. Corinne Stromstad Adjourn to Closed Session

1. Closed Session Opened
2. Reports of Quality Assurance Committees [**H&S Code § 32155**]
3. Compliance and Risk - Kristen Rees, CQO
4. Quarterly Reports - Adela Yanez, CNO
 - a. Clinic – Jan., Apr., July, Oct.
 - b. Patient Safety – Mar., June, Sept., Dec.

- c. Medication Error – Feb., May, Aug., Nov
- 5. Approval of Medical Staff Appointments/Reappointments [**H&S Code § 32155**]
 - a. Daniel Lucas, MD, Reappointment to Associate for Diagnostic Radiology privileges, 2/01/2025 to 1/31/2027
 - b. Jose Ospina, MD, Reappointment to Associate for Diagnostic Radiology privileges, 2/01/2025 to 1/31/2027
 - c. Scott Baymiller, MD, Appointment to Associate for Telepsychology privileges, 2/01/2025 to 1/31/2028
 - d. Gurkiran Gill, MD, Appointment to Associate for Telepsychology privileges, 2/01/2025 to 1/31/2028
 - e. Amy Frazier, MD, Appointment to Associate for Telepsychology privileges, 2/01/2025 to 1/31/2028
 - f. Heather Grant, NP, Time Limited Appointment as Active for Clinic/Ambulatory privileges, 1/30/2025 to 3/31/2025
 - g. Steven Kushel, MD, Time Limited Appointment as Active for emergency and inpatient privileges, 1/30/2025 to 3/31/2025
- 6. Personnel matter –Evaluation § 54957 - None
 - a. CEO Matt Rees

R. Corinne Stromstad Adjourned Closed Session

S. Corinne Stromstad Resumed Open Session

Motion: Kevin Church motioned to approve Daniel Lucas, MD, Reappointment to Associate for Diagnostic Radiology privileges, 2/01/2025 to 1/31/2027, Jose Ospina, MD, Reappointment to Associate for Diagnostic Radiology privileges, 2/01/2025 to 1/31/2027, Scott Baymiller, MD, Appointment to Associate for Telepsychology privileges, 2/01/2025 to 1/31/2028, Gurkiran Gill, MD, Appointment to Associate for Telepsychology privileges, 2/01/2025 to 1/31/2028, Amy Frazier, MD, Appointment to Associate for Telepsychology privileges, 2/01/2025 to 1/31/2028, Heather Grant, NP, Time Limited Appointment as Active for Clinic/Ambulatory privileges, 1/30/2025 to 3/31/2025, Steven Kushel, MD, Time Limited Appointment as Active for emergency and inpatient privileges, 1/30/2025 to 3/31/2025

Second: Jay Sooter

Ayes: Corinne Stromstad, Jay Sooter, and Kevin Church

Noes: None

Not Present: Galen Latsko

Motion Carried

T. Corinne Stromstad Adjourned Open Session

Submitted by Darrin Guerra

Abbreviations

<i>ACHD</i>	Association of California Healthcare Districts	<i>ACLS</i>	Advanced Cardiac Life Support Certification
<i>AR</i>	Accounts Receivable	<i>BLS</i>	Basic Life Support Certification
<i>CAIR</i>	California Immunization Registry	<i>CEO</i>	Chief Executive Officer
<i>CFO</i>	Chief Financial Officer	<i>CMS</i>	Centers for Medicare and Medicaid Services
<i>CNO</i>	Chief Nursing Officer	<i>COO</i>	Chief Operating Officer
<i>CPHQ</i>	Certified Professional in Healthcare Quality	<i>CQO</i>	Chief Quality Officer
<i>EMR</i>	Electronic medical record	<i>ER</i>	Emergency Room
<i>FTE</i>	Full-Time Equivalent/Full-Time Employee	<i>HIM</i>	Health Information Management
<i>HRG</i>	Healthcare Resource Group	<i>HVAC</i>	Heating, Ventilation and Air Conditioning system
<i>IGT</i>	Intergovernmental transfer	<i>IT</i>	Information Technology
<i>JPCH</i>	Jerold Phelps Community Hospital	<i>LCSW</i>	Licensed Clinical Social Worker
<i>LVN</i>	Licensed Vocational Nurse	<i>MPH</i>	Master of Public Health
<i>OBS</i>	Observation	<i>PALS</i>	Pediatric Advanced Life Support Certification
<i>PFS</i>	Patient Financial Services	<i>QAPI</i>	Quality Assurance Performance Improvement
<i>QIP</i>	Quality Improvement Project/Program	<i>RN</i>	Registered Nurse
<i>SHCC</i>	Southern Humboldt Community Clinic	<i>SHCHD</i>	Southern Humboldt Community Healthcare District
<i>SNF</i>	Skilled Nursing Facility	<i>SWG</i>	Swing beds
<i>DO</i>	Doctor of Osteopathic Medicine		

Subject: Disposal of Contrast Media and Components	Manual: Radiology
---	------------------------------------

POLICY:

It is the policy of Southern Humboldt Community Healthcare District ("SHCHD", "District", "SoHum Health") to properly dispose of CT contrast (oral and iodinated) and the components used for injection.

PURPOSE:

The purpose of this policy and procedure is to ensure that contrast agents and associated components are disposed of properly.

DEFINITIONS:

CT: Computed Tomography

IV: Intravenous

PROCEDURE:

- All oral and IV contrast used in CT is considered medication and will be disposed of as medical waste in properly marked containers.
- All contrast bottles with remaining unused contrast and disposable power injector syringes filled with contrast shall be placed in a pharmaceutical waste bin for incineration after each use.

DEFINITIONS:

None

Subject: Abnormal Mammogram Reports	Manual: Mammogram
--	------------------------------------

POLICY:

It is the policy of Southern Humboldt Community Healthcare District ("SHCHD", "District", "SoHum Health") to that the patient's provider and the patient be notified of findings in an appropriate time-frame ~~timeframe~~ as defined by the California Code of Regulations.

PURPOSE:

To ensure that notification of abnormal findings to the patient and the provider are made within the time frame mandated by state and federal law.

PROCEDURE:

BI-RAD codes 4 or 5 - "suspicious" findings or "suggestive of malignancy"

- The interpreting Radiologist will notify the Radiology department at Jerold Phelps Community Hospital.
- The Radiology department will notify the patient's provider or provider designee by telephone and provide a written report within 3 days of the date of examination.
- Written results will be mailed to the patient within 5 days of the date of examination.
- A CD and reports will be made available for surgical or other consultation.

BI-RAD code 3 - "probably benign" findings

- Written results will be mailed to the patient within 30 days of the date of examination.

BI-RAD code 0 - "additional imaging required"

- The patient and the patient's provider will be notified by telephone and written report with 30 days of the date of examination.
- The patient's provider will be responsible for scheduling recommended additional imaging/procedures
 - Additional mammographic views may be performed at our facility.
 - Ultrasounds, spot compressions or other procedures will be performed at an outside facility.
 - Mammogram [images](#)CD and reports will be provided by the Radiology Department to the outside facility.
- The patient's additional procedures and reports shall be tracked in a separate binder.

DEFINITIONS:

None

Subject: Augmented Breast Mammogram	Manual: Mammography
--	--------------------------------------

POLICY:

It is the policy of Southern Humboldt Community Healthcare District ("SHCHD", "District", "SoHum Health") to provide complete high quality mammographic evaluation of patients with prosthetic implants.

PURPOSE:

Mammography views and techniques shall be modified to provide optimal visualization of all breast tissue.

DEFINITIONS:

AEC: Automatic Exposure Control

PROCEDURE:

- Presence of breast implants will be determined prior to the mammographic exam based on clinical questions at time of scheduling. An Implant Disclosure and Consent Form shall be read and signed by the patient **prior** to the exam.
- A minimum of one (1) hour shall be allotted for the mammogram.
- A complete study should include craniocaudal (**CC**) and mediolateral oblique (**MLO**) views with implants in place **and** with the prosthetic implant manipulated away from the surrounding breast tissue (**ID**).
 - AEC (phototiming) shall not be used with implant in place. AEC cell shall be adjusted to manual when imaging the breast and implant. The AEC shall be adjusted to auto filter appropriate position when implant displaced (**ID**) views are performed.
 - Manual eExposure factors shall be determined from the current mammography technique chart.
- Additional views shall be obtained at the direction of the Radiologist.

DEFINITIONS:

None

Subject: Diagnostic Mammography	Manual: Mammography
--	--------------------------------------

POLICY:

It is the policy of Southern Humboldt Community Healthcare District ("SHCHD", "District", "SoHum Health") that ***effective September 5, 2007, no diagnostic mammography shall be performed at this facility.***

PURPOSE:

To provide appropriate referrals to patients with known or suspected breast abnormalities.

PROCEDURE:

- All patients or providers attempting to schedule diagnostic mammography referral shall be advised to contact a facility that maintains an on-site radiologist.
 - A list of local facilities may be provided as needed.
 - To provide continuum of care, all previous mammograms and/or reports should be requested from Radiology in order to forward needed information to that facility.
- Patients requiring additional films to evaluate a suspicious area seen on the screening mammogram shall be contacted by their provider and advised to schedule an appointment at an appropriate facility.
- Unilateral diagnostic orders will be accepted for mastectomy patients for screening purposes only.

DEFINITIONS:

None

Subject: Image Quality (Phantom)	Manual: Mammography
---	--------------------------------------

POLICY:

It is the policy of Southern Humboldt Community Healthcare District ("SHCHD", "District", "SoHum Health") to provide consistent density, contrast, uniformity, and resolution are maintained within the mammography imaging system.

PURPOSE:

The purpose of this policy and procedure is to assure consistent density, contrast, uniformity, and resolution are maintained within the mammography imaging system.

FREQUENCY:

Weekly (when in use) or as needed for suspected changes in image quality, after service or relocation of equipment.

EQUIPMENT:

- Radiation Measurement, Inc. (RMI) phantom, capable of demonstrating the following:
 - Nylon fibers of 0.40 -1.56 mm.
 - Calcium carbonate, aluminum, or similar calcifications of 0.16 - 0.54 mm.
 - Masses of 0.25 - 2.00 mm.
- Acrylic disc.

PROCEDURE:

- Place phantom as follows:
 - Phantom edge aligned to chest wall edge of image receptor.
 - Nipple marker away from chest wall edge.
 - Acrylic disc placed on marked area of phantom.
 - Compression paddle in contact with phantom.
- Exposure factors:
 - Automatic Exposure Control (AEC) on Auto Filter
 - Acquire image using ACR Phantom Conv. view.
- View image on the monitor to determine the following:
 - Presence of artifacts.
 - Areas of non-uniform density.
 - Number of simulated masses, speck groups and fibers.
- Score phantom:
 - Fibers -1 point if full length or 0.5 if more than half is visible.
 - Speck Groups -1 point if 4 or more specks or 0.5 if 2-3 specks visible.
 - Masses -1 point for generally circular border or 0.5 if density difference seen
 - but circular shape indistinct.
 - Artifacts - Deduct artifactual fiber specks or masses from their appropriate
 - group (-0.5 to -1.0 points)
- Record date, exposure factors, and scoring of phantom and plot results on Phantom Control Chart and

Phantom Control Chart (Tomosynthesis Option).

- Obtain SNR (Signal to Noise Ratio) and CNR (Contrast to Noise Ratio) ~~using Automatic ROI Creation~~. Record results in Technologist's Data Collection Worksheet. Plot results into SNR and CNR Control Chart.
- If criteria are not met, recheck procedure and retest.

CRITERIA:

- Acceptance Score for Tomosynthesis ACR Phantom Image minimum passing score:
 - 4 fibers
 - 3 speck groups
 - 3 masses
- Acceptance Score for Conventional ACR Phantom Image minimum passing score:
 - 5 fibers
 - 4 speck groups
 - 4 masses
- Allowable CNR deviation = $\pm 15\%$. SNR must not fall below 40.

CORRECTIVE ACTION:

- Recheck procedure and retest.
 - Criteria met - resume mammography service and document findings.
 - Criteria not met - discontinue mammography service and:
 - Determine cause, if possible, and correct problem.
 - Contact Hologic, Inc. or physicist as needed.
 - Document action taken and retest.

DEFINITIONS:

None

Subject: Mammography Technique Chart	Manual: Mammography
---	--------------------------------------

POLICY:

It is the policy of Southern Humboldt Community Healthcare District ("SHCHD", "District", "SoHum Health") to provide consistent density for all breast thicknesses.

PURPOSE:

The purpose of this policy and procedure is to provide consistent density for all breast thicknesses, kVp ranges and breast conditions requiring manual techniques.

PROCEDURE:

- Use Automated Exposure Control Filtration (AEC) Moda at density setting "**Auto Filter**," except for the following conditions:
 - Implant views.
 - As requested by the radiologist.
- Refer to technique chart as needed.
- Update with the aid of the medical physicist during annual evaluation

DEFINITIONS:

None

Subject: OnRAD Teleradiology Mammography Protocol	Manual: Mammography
--	--------------------------------------

POLICY:

It is the policy of Southern Humboldt Community Healthcare District (“SHCHD”, “District”, “SoHum Health”) that all mammograms will be sent to OnRad Teleradiology, via PACS (Picture Archive and Communication System), for written interpretation.

PROCEDURE:

Mammography Images and Reports:

- Completed mammograms will be sent to OnRad for interpretation.
- All studies will include:
 - Current and previous films/reports from previous two (2) mammograms.
 - Patient Mammography questionnaire.
- Completed reports will be faxed to Jerold Phelps Community Hospital Radiology.
 - Reports indicating abnormal or questionable findings (BiRads **Code 4 or 5**) will be called and faxed to Jerold Phelps Community Hospital Radiology as soon as possible.
- The Radiology Department will contact the patient’s provider with all abnormal Mammography findings.
 - ~~Distribution of final report copies will be done by the Radiology Department at Jerold Phelps Community Hospital.~~

~~The Radiology Department at Jerold Phelps Community Hospital will be responsible for all patient notification.~~

- Patients requiring additional procedures will be contacted by telephone **and in writing** by outside facility patient’s provider to arrange scheduling.
- All patients will receive written results and personal breast density information in lay terms in accordance with standard policies, state, and federal laws.
- Annual and short-term follow-up reminders will be sent at appropriate intervals.

Quality Assurance:

- The Quality Control (QC) Technologist will perform all required tests and maintain results at Jerold Phelps Community Hospital.
- The QC Technologist will be responsible for scheduling annual procedures (preventive maintenance, physicist’s survey) and maintaining documentation.
- Outcome data will be compiled by the QC Technologist.
- Current data (CEU, licenses, exams interpreted, etc.) for all interpreting physicians will be obtained annually and maintained for inspections.
- A current Policy and Procedure Manual will be maintained by the QC Technologist and reviewed in accordance with hospital policy.
- Qualifications of new or temporary personnel will be evaluated by the Lead Interpreting physician.
 - Questions regarding safety, reliability, clarity and accuracy of mammography services performed at this facility will be directed to the Lead Interpreting Physician or Physicist as appropriate.

Professional Supervision:

- The Lead Interpreting physician will provide professional review and feedback to the Mammography Technologist at least quarterly.

- Review should include:
 - Clinical Image Quality.
 - Quality Assurance procedures.
 - Quality Control documentation.
- All feedback will be documented on the Mammography Quarterly Review Form and signed by the radiologist.
- All “unsatisfactory” findings will be corrected immediately or in accordance with American College of Radiology (ACR) guidelines.

DEFINITIONS:

None

Subject: Patient History	Manual: Mammography
---	--------------------------------------

POLICY:

It is the policy of Southern Humboldt Community Healthcare District (“SHCHD”, “District”, “SoHum Health”) that all mammography patients, with the assistance of the technologist, shall be required to complete a *Mammography Questionnaire* form.

PROCEDURE:

- All mammography patients to *Jerold Phelps Community Hospital* will be requested to complete the questionnaire form with the technologist.
- ~~The technologist shall review, question and complete as necessary.~~
- The technologist shall review previous mammograms and/or inquire if the patient has implants.
- The form shall include the following information:
 - Previous mammogram, location, and date.
 - Childbirth history.
 - Family history of breast cancer with age of onset if available.
 - Use of hormones.
 - All skin changes, including moles, bruises, thickening, dimpling, or nipple inversion.
 - Previous biopsies.
 - Previous radiation or chemotherapy treatments.
 - Prior breast cancer and date.
 - Presence of breast implants or breast reduction surgery.
- The history form shall be sent to OnRad with outside prior reports. Notes shall be documented in electronic medical record.canned into patient’s chart.

DEFINITIONS:

None

Subject: Patient Selection Criteria	Manual: Mammography
--	--------------------------------------

POLICY:

It is the policy of Southern Humboldt Community Healthcare District ("SHCHD", "District", "SoHum Health") to provide patient selection criteria for screening mammography.

PROCEDURE:

- Mammography will not be performed on pregnant or lactating women at this facility.
- Screening mammograms will only be performed once a year unless otherwise recommended by the Radiologist.
- Presence of breast implants will be determined prior to the mammographic exam.
- All patients shall be asked clinical questions at time of scheduling to assist in verification of criteria.

DEFINITIONS:

None



Subject: Qualified Responsible Personnel	Manual: Mammography
---	--------------------------------------

POLICY:

It is the policy of Southern Humboldt Community Healthcare District ("SHCHD", "District", "SoHum Health") to provide a list of responsible qualified personnel.

QUALIFIED PERSONNEL RESPONSIBLE FOR THE FOLLOWING:

- Lead Interpreting Physician** Atul Patel, MD
1770 Iowa Ave Suite 280
Riverside, Ca 92507
951-786-0801
Fax 951-680-1989

- Audit Reviewing Physician** Atul Patel, MD
1770 Iowa Ave Suite 280
Riverside, Ca 92507
951-786-0801
Fax 951-680-1989

- Facility #'s:** EIN #94-2664285
Medicare Outpatient #050482
Medi-Cal #HSP40482G

- Physicist:** Bhujanga Lankipalli
Medical Physics Consulting Service, Inc.
104 Southwind Drive
Pleasant Hill, CA 94523
(925) 674-2769
(925) 372-0673 (FAX)

- QA/QC Technologist:** Lora Simone, Radiology [DirectoManager](#)
(707)923-3921 ext 1242

- Patient Reminders/Results:** Radiology Department
(707) 923-3921 ext. 1242

- Hospital Administrator/Chief Executive Officer:** Matt Rees
(707) 923-3921 ext. 1260

- Chief Financial Officer:** Paul Eves
(707) 923-3921 ext. 1291

- Hologic Service/Repair:** Hologic
(877) 371-4372

- Emergency Repair:** Guy Vitello
Biomed Engineer
(707) 923-3921 ext. 1277

Technical Support:

Hologic
(877) 371-4372

PROCEDURE:

N/A

DEFINITIONS:

None

Subject: Quality Control Equipment	Manual: Mammography
---	--------------------------------------

POLICY:

It is the policy of Southern Humboldt Community Healthcare District ("SHCHD", "District", "SoHum Health") that quality assessment/quality control is performed within the standards and guidelines provided by the FDA, MQSA and mammography equipment manufacturer.

QUALITY ASSESSMENT EQUIPMENT:

- Gammex ACR Phantom with small disk.
- Hologic flat field acrylic phantom.
- Gammex compression scale.
- Specialized Hologic paddle(s).
- Appropriate forms.

PROCEDURE:

N/A

DEFINITIONS:

None

Subject: Radiation Dosimeter Badge	Manual: Mammography
---	--------------------------------------

POLICY:

It is the policy of Southern Humboldt Community Healthcare District ("SHCHD", "District", "SoHum Health") to provide to Radiology personnel the radiation exposure determined by personal dosimetry badges. Results of which shall be monitored by the department manager monthly.

PURPOSE:

The purpose of this policy and procedure is to provide radiation exposure levels and monitor them for compliance with this policy and procedure.

PROCEDURE:

Personal radiation monitors shall be provided and maintained as follows:

- All technologists shall wear a radiation dosimetry badge for monitoring purposes.
- The badge shall be worn at collar level.
- Badges are to remain within Radiology Services when not in use.
- Badges will be exchanged and submitted to dosimeter reading company for interpretation.
- Records for each employee shall be maintained in Radiology and be reviewed by the Radiology Manager upon receipt.
- The California Department of Health Services, Radiological Health Branch shall be notified of any unexplained excess radiation exposure.
- Employees may be subject to disciplinary action if radiation safety policies have not been followed.

DEFINITIONS:

None

Subject:
Complaints and Grievances

Manual:
Compliance

POLICY:

It is the policy of Southern Humboldt Community Healthcare District ("SHCHD", "District", "SoHum Health") to respond to complaints and grievances according to applicable regulations and in a patient-centered, standardized way. SoHum Health strives to provide excellent quality of care and services. Every effort is made to resolve complaints at the time a complaint is received. Grievances are acknowledged, investigated, and an appropriate response provided to the patient/patient representative in a timely manner. "Timely" is defined as within seven (7) days to acknowledge the grievance and within thirty (30) days for the completion of the investigation and a final response back to the patient. For more complicated grievances, an interim response will be sent by thirty (30) days and a final in sixty (60) days. This policy applies to all patients, their families, and all employees, volunteers, contractors, and medical staff at SoHum Health. Billing issues are not usually considered grievances for the purposes of this policy.

All patients/patient representatives have the right to file a complaint, grievance, concern, or suggestion without consequence. Complaints or grievances involving situations that place a patient in immediate danger are resolved immediately in collaboration with the appropriate service director or manager, administrator, and/or medical staff leader. SoHum Health encourages staff members to invite feedback from patients and families and work immediately to resolve the patient/patient representative complaints, at the time the complaint is voiced. Complaints, grievances, or suggestions may include but are not limited to quality-of-care issues, patient safety concerns, staff competency, physician or staff behavior, abuse, neglect, patient harm, or any noncompliance with regulatory requirements.

PROCEDURE

A. Patients and families may file a complaint or grievance using the following methods:

a. Letter or email to the Quality Department

- i. E-mail: QUALITY@SHCHD.ORG
- ii. Letter: Attn: Quality Dept
733 Cedar Street
Garberville, CA 95542

b. Notifying any member of Administration, the Medical Staff, or SoHum Health staff of their concern.

B. The Statement of the Patient Rights is posted in the hospital and outlines the methods for filing a concern, complaint, or grievance. The Statement of Patient Rights includes the phone number and address of the California Department of Public Health Licensing and Certification Program.

C. Regarding care concerns filed by persons other than a patient (e.g., patient's spouse, conservator, or parent/legal guardian of minor child):

- a. SoHum Health supports interested third parties' (e.g., such as patient representatives, family members, or friends), ability to raise concerns regarding patient care. To protect patient privacy, it is our policy to notify the patient/conservator/legal guardian that a concern was raised. We will send our response to the concern to the patient/conservator/legal guardian, not the complainant.

D. Complaints or grievances will be directed as defined below, according to the nature of the issues discussed in the complaint.

- - a. Concerns, complaints, and grievances about billing/charges are directed to Patient Financial Services.
 - b. Concerns, complaints, and grievances concerning privacy violations will be routed to the Compliance Officer for resolution.
 - c. Complaints concerning lost belongings will be directed to the department where the item was lost and that department should:
 - - i. Make efforts to locate the item.
 - ii. Get from the patient or patient representative a description and statement of value for the missing item(s).
 - iii. Investigate the loss and determine an appropriate course.
 - d. Quality of care and all other complaints or concerns will be directed to the appropriate manager, director, or designee for resolution. If it cannot be resolved while the patient is still in the care of SoHum Health, then the complaint will be considered a grievance.
 - e. All grievances will be logged into the event reporting software by the staff member who received the grievance.
 - f. The Quality Department and, for physician complaints, the Medical Staff Coordinator, will coordinate responses and follow-up actions related to the complaint/grievance.
 - g. The Quality Department will send an acknowledgement letter to the patient within seven (7) days of receiving the grievance.
 - h. Grievances will be investigated with the appropriate administrator and or manager and will require an investigation and response within thirty (30) days and a detailed response in writing within sixty (60) days.
 - - i. The response for accredited services must include the following elements and be worded in a manner that is suitable for the patient response letter:
 - - 1. Title of person(s) completing the investigation
 - 2. Steps taken on behalf of the patient to investigate the grievance
 - 3. Results and/or actions taken as a result of the investigation
 - 4. Date investigation was completed
 - ii. For non-accredited services, the minimum expectation would be a phone call to the patient acknowledging their complaint and, if applicable, the outcome of any investigation.
 - i. Grievances regarding physicians are addressed through the Medical Staff Professional Practice Evaluation process.
 - j. The Compliance Officer/Risk Manager and the appropriate administrator will be informed of any grievances which may be potentially compensable or are received as a Notice of Intent. Legal counsel and/or liability insurance carrier(s) may become involved.
 - k. The Compliance Officer and Administrator or the Administrator-On-Call will be immediately notified of any complaints which may involve the media or an imminent safety or security concern.

E. If the grievance was received via E-mail, it is managed via the same process outlined above, but written responses will be sent via US Mail. If there is no mailing address available, the response may be sent via encrypted E-mail.

F. Language Assistance

- - a. For non-English speaking patients, interpreter services are available to assist patients in registering a complaint and to notify them regarding the status of the complaint.

DEFINITIONS:

Complaint: An expression of dissatisfaction by a patient or their family regarding the quality of care or services provided that can be resolved at the point of service by staff present.

Grievance: A formal or written complaint by a patient or their family that cannot be resolved promptly by staff present and requires further investigation.

Subject: General Laboratory Systems	Manual: Laboratory
--	-------------------------------------

POLICY:

It is the policy of Southern Humboldt Community Healthcare District (“SHCHD”, “District”, “SoHum Health”) that the laboratory will have the supplies, materials, and other general laboratory systems it needs to perform the laboratory’s services.

General Systems

The laboratory’s general systems consist of:

- Testing systems capable of producing results within the laboratory’s stated test performance specifications, including:
 - Analytical instruments;
 - One or more suitable microscopes with associated slides and stains;
 - Manual test kits; and
 - Required measuring devices;
- General systems, including:
 - A deionized water system capable of supplying the needs of all the laboratory’s automated and manual test systems; and
 - A laboratory information system¹ with sufficient data storage capacity to allow for current data entry; and
 - Centrifuges capable of separation of blood specimens into platelet-poor plasma and urine specimens into compact sediment;
- Storage devices sufficient to assure optimum integrity of patient specimens, materials, and records, including:
 - Refrigerators;
 - Freezers;
 - Shelving systems; and
 - Paper-records storage space;
- A specimen-identification system² sufficient to assure the positive identification of each specimen through collection, labeling, accessioning, processing, storage, testing, and result reporting;
- Materials, including:
 - Specimen-handling devices such as calibrated and disposable pipettes;
 - Reagents for automated analyzers, immunohematology testing, and manual test procedures; and
 - Materials related to quality activities, such as quality control specimens, calibration sets, linearity/calibration-verification sets, and standard chemical solutions;
- Supplies, including:
 - Venipuncture supplies:
 - Evacuated blood tubes;
 - Phlebotomy needles; and
 - Patient-care items;
 - Arterial blood sampling kits;
 - Skin puncture supplies;
 - Non-blood collection containers for urine, feces, and other body fluids;
 - Labels and related supplies for identification of patient specimens;

¹ See also Policy: Laboratory Use of Epic, Beaker, and Other Information Systems.

² Handled in the Epic EMR / Beaker LIS

- Safety supplies such as personal protective equipment (PPE), spill kits, and hand-hygiene solutions; and
- Office and clerical items needed to provide the laboratory's services.

Quality and Availability of General Systems

Laboratory general systems, supplies, and materials will be:

- Of sufficient quality to perform their intended function;
- Maintained in good working order, as applicable;
- Stored as required by the manufacturer, applicable laboratory standards and regulations, or good laboratory practices; and
- Used on or before their expiration date, if any.

The laboratory director will ensure that the laboratory's general systems are of sufficient quantity and quality to carry out all the laboratory's services, through delegation of this duty as follows:

- The laboratory manager will:
 - Monitor and evaluate the quality and availability of all general laboratory systems;
 - Communicate unmet general systems needs promptly to District personnel responsible for contracting, purchasing, and accounting;
- Technical supervisors / technical consultants will monitor and evaluate the overall quality and availability of general systems applicable to the testing specialties they supervise;
- Laboratory technicians will monitor and evaluate the quality and availability of supplies used in the collection and handling of specimens; and
- All personnel tasked with taking inventory and ordering supplies will place orders of sufficient quantities of materials and supplies far enough in advance for them to arrive before existing stocks run out.

A lack of any needed general systems, materials, or supplies is an incident that must be documented and corrected. See **Policy: Complaints, Incidents, and Nonconformances**.

PROCEDURE:

N/A

DEFINITIONS:

N/A

Subject: Laboratory Use of Epic, Beaker, and Other Information Systems	Manual: Laboratory
---	-------------------------------------

POLICY:

It is the policy of Southern Humboldt Community Healthcare District (“SHCHD”, “District”, “SoHum Health”) that laboratory personnel will use the Epic electronic medical record (EMR), Beaker laboratory information system (LIS), and other electronic record-keeping systems in ways that support the provision of laboratory services and maintain compliance with regulations, standards, and best practices.

General Records Systems

Laboratory personnel will follow the policies and procedures of the District regarding the use of the EMR, LIS, and other record systems. These include but are not limited to:

- Epic EMR;
- Beaker LIS;
- Performance Health, or the current system for reporting nonconformances, incidents, and complaints;
- Communication systems including Webex and Outlook;
- Internal and external trouble-ticketing systems, such as SoHum IT Tickets and the OCHIN JIRA system;
- District-owned computers, including laptops;
- Personal devices, such as cell phones; and
- Manual / analog records systems, including forms, log books, and printed labels.

Laboratory Policies Regarding EMR & LIS

Laboratory personnel will follow these additional policy provisions when using the EMR and LIS.

LIS Scope

For purposes of this policy, the LIS comprises the Beaker module of the Epic EMR and other elements of Epic that relate to the preanalytical, analytical, or postanalytical phases of testing. The LIS excludes:

- Computers, calculators, software applications, and other data processing systems that are not used directly in the phases of testing; and
- Computerized components that are part of an analytic system¹.

LIS Suitability and Validation

The laboratory manager, in consultation with other District managers, laboratory team, and laboratory director, will ensure that the LIS meets the functional, system, and operational requirements of the laboratory and the clients served by the laboratory, across all activities of pre-analytic, analytic, and post-analytic phases of laboratory testing.

The manager is responsible for ensuring appropriate District and contract/external personnel conduct and document:

- Validation of proper performance when the LIS is first installed;
- Validation of changes made to the LIS² once in use;

¹ Unless indicated in the procedure / protocol for a test system, its computerized components are validated by the device’s 510(k) clearance and the manufacturer’s instructions for use.

² In this context, the LIS includes interfaces such as between analyzers and the LIS and between the LIS and external entities, such as Quest and the CalREDIE state-reportable result system.

- Capturing screenshots of each step of any LIS process used for immunohematology and transfusion-medicine activities;
- With all validations approved by the laboratory manager as the laboratory director's designee.

Calculations performed within the LIS will:

- Be verified before being put into use;
- Reverified
 - Annually;
 - Before use for patient results when a system change occurs that could affect a calculation; and
 - Whenever indicated by a particular test system procedure/protocol, such as when changing lots of Prothrombin Time/INR reagent.

LIS Security

The laboratory manager will coordinate with appropriate District and contract/external personnel to develop and enact procedures / protocols that:

- Incorporate adequate security measures to ensure confidentiality of patient data;
- Include defined security mechanisms for data protection, such as firewalls and data encryption;
- Provide network security when using public networks (including cloud storage of data) to exchange or send patient information;
- Define authorized users of the LIS;
- Utilize access codes³ to limit access to only those functions staff are authorized to use, with security mechanisms⁴ to manage access codes.

LIS Operation

Laboratory personnel will have written policies and sufficiently detailed procedures / protocols available to enable them to conduct proper operation of LIS hardware and software, including:

- Startup and shutdown sequences;
- Data entry⁵; and
- Data retrieval.

LIS Maintenance and Troubleshooting

The laboratory manager will coordinate with appropriate District and contract/external personnel to develop and enact procedures / protocols that:

- Direct personnel to perform and document LIS maintenance and back-up activities, including all manufacturer-required maintenance of:
 - LIS computers and peripherals;
 - Networking hardware and systems;
 - Function checks stated by the LIS manufacturer; and
- Ensure notification of LIS users of downtime when required for LIS maintenance; and
- Provide instructions for troubleshooting and reporting hardware/software failures.

³ In the context of the Epic EMR / Beaker LIS, this policy is met by the definition of user roles and the District's application of user roles to personnel only as they apply to each person's duties.

⁴ Surveyors will look for signs of passwords and other access information written on or around workstations with LIS access and may cite the laboratory if they are found.

⁵ Procedures for data entry may be included in specific test procedures.

LIS Downtime

Procedures, protocols, and materials will be prepared and available to continue laboratory services during LIS downtime events. These will include:

- Protocols for performing and documenting all phases of testing when the LIS is not operational, including:
 - Communication of laboratory orders;
 - Documentation of specimen collection and receipt into the laboratory;
 - Operation of LIS-connected test systems during downtime; and
 - Reporting results during downtime.
- Protocols for recovery of the LIS after downtime, including:
 - Verification⁶ of function of the LIS;
 - Retrospective entry of orders and results into the LIS; and
 - Quality assurance activities related to the downtime event, including:
 - Review of a sampling of data files present before the downtime to verify that no alterations have occurred that would affect results for patient care; and
 - Review of a sampling of records created during downtime and transcribed into the LIS after it was restored to rule out systematic or widespread errors of data entry.

LIS Retention

The laboratory manager will coordinate with appropriate District and contract/external personnel to develop and enact procedures / protocols that:

- Ensure retention and ongoing availability of the data in the LIS;
- Enact written procedures / protocols for preserving and restoring data in the event of disruption or disaster, which must describe:
 - Steps to limit the interruption of access to data;
 - Periodic backing up and storing of information;
 - Offsite storage of backup data; and
 - Restoring information from backup media;
- Create a mechanism for retrieving data after the LIS is upgraded or replaced, including:
 - Test results;
 - Reference ranges in effect when the test results were reported;
 - Interpretive information including report comments and footnotes;
- Retain records and accessibility for:
 - Two years after ending use of the LIS; or
 - Ten years from the date of reporting of all records related to immunohematology and transfusion services.

PROCEDURE:

N/A

DEFINITIONS:

N/A

⁶ Verification is intended to be a straightforward demonstration that the LIS is functioning as expected, not a full revalidation. See verification protocol.

Subject: Blood Pressure Monitoring- Blood Pressure Check Visit	Manual: Clinic
---	---------------------------------

POLICY:

It is the policy of Southern Humboldt Community Healthcare District (“SHCHD”, “District”, “SoHum Health”) to promote health maintenance and improve patient care through appropriate practices. The purpose of this policy and procedure is to promote health maintenance and improve patient care through appropriate blood pressure (BP) monitoring.

DEFINITIONS:

Authorized Personnel:

- Provider: Medical Doctor (MD), Physician Assistant (PA), Nurse Practitioner (NP)
- Registered Nurse (RN)
- Licensed Vocational Nurse (LVN)
- Patient Care Coordinator (PCC): Medical Assistant (MA), Certified Nursing Assistant (CNA), Emergency Medical Technician (EMT)

Equipment/Supplies Needed:

- Sphygmomanometer or automated blood pressure machine
- Appropriate-sized blood pressure cuff
- Stethoscope
- Chair with back support
- Table to support arm at heart level

PROCEDURE:

**Refer to Vital Signs Policy & Procedure*

- All patients age 3 and older presenting for a clinic appointment or procedure will have their BP measured and documented in their patient chart.
- Take and document a second BP when indicated.
- Give all patients with onset of chronic hypertension (HTN) a *Patient Blood Pressure Log*.

Adult Patients (scheduled provider visit):

- Using appropriate technique, take the patient’s sitting BP.
- Enter BP in current electronic medical record (EMR) system, Healthland Centriq™.
 - Click on “Clinic Application,” click on “Work Center.” Find patient’s name from the schedule and click on their name OR search for patient’s name and appropriate encounter number on home page by clicking on “Select,” then typing in patient’s name.
 - Click on “Assessment.” Type “Intake” in box. Choose “Clinic Intake” or “Workers Comp Intake” for Workers Comp visits then click “+” icon
 - Fill in each section which includes: Add Vitals
 - Input Vital Signs (VS): Temp, HR, R, **BP**, O2 sat, pain, height, weight
 - **BP: Required at every clinic visit for patients 3 years and older.**
 - Note in VS section if patient refuses, declines, or is unable due to... (i.e. combative)
 - Save and Sign
 - *NOTE: Refer to “Clinic Intake” for further documentation procedures.*
- If HTN is observed, Healthland Centriq™ will highlight the BP in red: greater than 139 systolic and/or greater than 89 diastolic for adults. In this case, staff must repeat BP.
- If the BP is elevated, wait one minute and repeat. If the patient is 70 years of age or older take the second BP in the standing position. Enter the new BP in Healthland Centriq™ under the “Vital Signs” section, click on “Add Vitals,” input data and click “Save and Close.”

- Inform patient of their BP. If BP is high inform their provider.
- At this point the provider will decide what treatment to provide from there.

Walk-in Blood Pressure Checks (provider visit not scheduled):

Note: As with any visit, if the patient expresses any complaints or questions, the LVN or PCC must refer the patient to the RN or provider.

- Using appropriate technique, take the patient’s sitting BP.
- Enter BP in current electronic medical record (EMR) system, Healthland Centriq™.
 - Search for patient’s name and appropriate encounter number on home page by clicking on “Select,” then typing in patient’s name.
 - Click on “Vital Signs,” click on “Add Vitals”
 - Input Vital Signs: Temp, HR, R, **BP**, O2 sat, pain, height, weight
 - Click “Save and Close”
- If HTN is observed, Healthland Centriq™ will highlight the BP in red: greater than 139 systolic and/or greater than 89 diastolic for adults. In this case, staff must repeat BP.
- If the BP is elevated, wait one minute and repeat. If the patient is 70 years of age or older take the second BP in the standing position. Enter the new BP in Healthland Centriq™ under the “Vital Signs” section, click on “Add Vitals,” input data and click “Save and Close.”
- Inform the patient of their BP.
- Follow procedure in Adult Blood Pressure Categories and Actions (Table A) based on the lowest BP reading. (See next page)

Adult Blood Pressure Categories and Actions (Table A)

CATEGORY	Systolic Blood Pressure (SBP)	Diastolic Blood Pressure (DBP)	ACTION
Low	109 or less		LVN/PCC: Recheck BP with patient standing. Standing SBP is 110 or greater, follow action in “Controlled” category in this table. Standing SBP is 109 or less, refer to RN for evaluation. RN: SBP 100-109 without symptoms and previous SBP 110 or greater; instruct patient and scheduler to make follow up BP check appointment in 2 months, release pt. SBP 100 – 109 without symptoms and previous SBP 100 – 109, discuss with provider for possible medication adjustment and timeframe for follow up BP check. SBP 100 – 109 with symptoms or SBP 99 or less without symptoms, discuss with provider for possible medication adjustment and timeframe for follow up BP check. SBP 99 or less with symptoms, instruct patient and scheduler to schedule patient to see provider today or refer patient to Emergency Department (ED).
Controlled	110 - 139	≤89	LVN/PCC: Instruct the patient to follow-up for another blood pressure check in about 6 months. Release the patient.
Stage 1 Hypertension	140 - 159	90 - 99	LVN/PCC: Instruct patient and scheduler to make follow- up BP check appointment in 2 to 4 weeks and release the patient. OR Inform provider patient is waiting for further instructions. OR

			Inform Clinic Nurse Manager or RN that patient is waiting for further instructions.
Stage 2 Hypertension	160 - 179	100 - 109	LVN/PCC Refer patient to RN or provider for evaluation prior to releasing the patient. Release the patient as directed by the RN or provider and instruct patient and scheduler to make a follow up BP check appointment in 1 to 2 weeks and release the patient. RN: No symptoms: Instruct LVN/PCC to release patient with instructions above. Symptoms: Instruct LVN/PCC to schedule patient with provider that day or as recommended after consulting with provider.
Stage 2 Hypertension Urgent	≥180	≥110	Refer to provider for evaluation today and/or refer patient to ED. Do not release the patient.

Smart Phrase List: Suggested RN Documentation Phrases (Table B)

CATEGORY	Systolic Blood Pressure (SBP)	Diastolic Blood Pressure (DBP)	ACTION
Stage 1 HTN	140-159	90-99	BP elevated. Current treatment to be continued. Staff instructed to inform patient of their BP today, to continue current medications, and BP result will be routed to their provider for review. Patient will be notified if their provider orders a change in medication. Patient instructed to return for BP recheck in 2 to 4 weeks.
Stage 2 HTN: RN to discuss case with provider to determine if medication adjustment needed prior to release of patient	160-179	100-109	BP elevated. Current treatment to be continued. Staff instructed to inform patient of their BP today, to continue current medications, and BP result will be routed to their Provider for review. Patient instructed to schedule follow-up appointment with their provider to recheck BP in 1 to 2 weeks.
	≥180	≥110	BP elevated, requiring evaluation today. Staff instructed to schedule patient an appointment to see a provider for BP evaluation today OR refer patient to ED if appointment unavailable.
Low BP	100-109 standing asymptomatic on antihypertension medications		Staff instructed to inform patient of their BP today, to continue current medications, and BP result will be routed to their provider for review. Patient will be notified if their provider orders a change in medication. Patient instructed to schedule follow-up appointment in 3 months.

	<100 standing symptomatic or asymptomatic OR 100-109 standing and symptomatic		Staff instructed to schedule patient to see provider for BP evaluation today and/or refer to ED.
--	---	--	--

Subject: Cervical Cancer Screening (PAP Smears)	Manual: Clinic
--	---------------------------------

POLICY:

It is the policy of Southern Humboldt Community Healthcare District (“SHCHD”, “District”, “SoHum Health”) to encourage healthcare maintenance examinations, such as, Cervical Cancer Screenings, which include, Papanicolaou cytology (PAP) smear test as recommended by current guidelines. The purpose of this policy and procedure is to describe the processes for obtaining a PAP test.

DEFINITIONS:

Cervical Cancer Screening: Cervical cancer screening detects precancerous lesions and early-stage disease, the treatment of which decreases the incidence of cervical cancer and cervical mortality, respectively.

PAP Test: The PAP test consists of cells sampled from the cervix and vagina.

PROCEDURE:

A PAP test should be performed about 1 week after menses. Women should be instructed not to douche, use any vaginal medications, or have sexual intercourse for 24 hours before examination.

All clinic providers are trained to obtain PAP smears.

The Patient Care Coordinator (PCC) will:

- Assemble equipment and set-up tray accordingly. *Refer to, Comprehensive Medical Assisting 4th Ed., Chapter 35 on "Assisting with the pelvic examination and PAP smear".*
 - Tray
 - Gloves (non-sterile)
 - PAP Brush
 - PAP Broom
 - Gown
 - Drape
 - Patient labels
 - Light for speculum
 - Disposable Speculum (provider preference)
 - K-Y Jelly
 - Liquid-based PAP test container
 - Cotton Swab
 - Test Tube of Normal Saline
 - BV Culture Swab
 - GC/Chlamydia Culture Swab
- If patient is of childbearing age, obtain urine sample for urine pregnancy test.
- Document patient’s chief complaint, medication list, any know allergies, family history, and surgical history.
- In addition, obtain the patient’s weight, height, blood pressure (BP), pulse (P), temperature (T), respirations (R), oxygen saturation (O2 Sat), body mass index (BMI), and pain level.
- Give the patient a gown and drape and instruct the patient to undress.
- Notify the provider that patient is ready to be seen.
 - Assist provider with procedure, as needed.
- After procedure has been completed:
 - Label the specimen containers with a patient sticker.
 - Register patient for outpatient lab.
 - Take specimen to the laboratory, placed in designated area and notify lab that specimen is ready for further processing.

The qualified Provider will:

- Verify the urine pregnancy results.
- Review the procedure and answer any questions for the patient.
- Perform procedure.
- Order test through Electronic Medical Records (EMR).

Subject: Chaperones	Manual: Clinic
--------------------------------------	---------------------------------

POLICY:

It is the policy of Southern Humboldt Community Healthcare District (“SHCHD”, “District”, “SoHum Health”) to provide chaperones during medical examinations and procedures as appropriate.

PROCEDURE:

- It is recommended that all practitioners have an appropriate chaperone with them during physical examinations of breasts or genitalia.
- A chaperone will be provided per patient request.
- Patients may waive the presence of a chaperone.
- Chaperones must be employees of SHCHD and at least 18 years of age. It is preferred that chaperones be healthcare professionals.
- Family members are not considered chaperones; however, family members may be present during exams and/or procedures, if so preferred by the patient.

DEFINITIONS:

None

Subject: Clinic Intake Work Aid	Manual: Clinic
--	---------------------------------

POLICY:

It is the policy of Southern Humboldt Community Healthcare District (“SHCHD”, “District”, “SoHum Health”) to try and streamline processes to better ensure quality of care.

The purpose of this policy and procedure is to delineate the steps taken during the clinic intake procedure.

EQUIPMENT/SUPPLIES NEEDED:

- Laptop and/or Computer
- Electronic Health Record (EHR):
- Equipment for vital signs: *See Vital Signs Policy*

PROCEDURE:


PCC or designee will use the Work Center section to view and monitor their patient load/ provider day of scheduled events. This is also the screen in which the PCC can work out of.

- PFS staff will generate a stickered, blank piece of paper and Clinic Fee Ticket for visit the day before the appointment, time permitting.
- Patient arrives at clinic.
- PFS staff checks patient in.
 - Will ask patient during the registration process about their Advance Health Care Directive status and update the patient registration module in the patient’s EHR. If the patient is given an Advance Health Care Directive at that encounter and/or refuses one, this will be documented in the comment section of the patient registration process.
 - Will give all patients an age-appropriate Initial Health Assessment and Behavioral Risk Assessment (IHEBA) questionnaire and then re-administer when the patient has reached the next specific age interval. This will be documented in the comments section of patient registration when this has been completed. If the patient refuses to complete an IHEBA, this will be documented in the comment section of the patient registration process with the date it was refused.
- PFS staff will attach paperwork to clipboard and complete the check-in procedure in the EHR and put paperwork in designated file holder.
- PCC or designee will know patient is ready when the patient’s appointment changes status/color in “Work Center” schedule.
- PCC or designee will greet patient and bring them down for clinic appointment.
- Height and weight will be obtained at every visit (**required** every visit). If patient refuses/declines, document reason. Height and weight can be jotted down on scratch paper or on fee ticket so you don’t forget.
- Write room number on blank paper/Fee Ticket, flip your flag color, and room patient.
- Click on “Clinic Application”
- Click on “Work Center”
- Find patient’s name from the schedule and click on their name.
- Click on “Assessment”
 - Type “Intake” in box
 - Choose “Clinic Intake” or “Workers Comp Intake” for Workers Comp visits and click + icon
 - Fill in each section which includes:
 - Add Vitals

- Input Vital Signs: Temp, HR, R, **BP**, O2 sat, Pain, **Height, Weight**
 - **BP: Required Every Visit for Patient 3 and Older**
 - **Height & Weight: Every Visit Every Patient**
 - Note in VS section if patient refuses, declines, or unable due to (i.e. combative).
 - Save
 - Patient's Chief Complaint/Reason for Visit
 - Sign
 - Type "Social" in box
 - Choose "**Social History**" (**required** every visit) and click + icon
 - Fill in each section
 - If done previously, click SHOW PREVIOUS
 - Ask patient if anything has changed?
 - If NOT, click NO CHANGE
 - If there is a change then document
 - click SIGN
 - Type "TB" in box
 - Choose "**Risk Assessment**" (**required** once a year) and click + icon
 - Fill in each section
 - If done previously, click SHOW PREVIOUS
 - Ask patient if anything has changed?
 - If NOT, click NO CHANGE
 - If there is a change then document
 - click SIGN
 - If the patient answers yes to any question on the screening then document on the blank sheet "Review TB"
 - Any other required assessments:
 - POCT- Urinalysis, Blood Glucose, Occult Blood, Pregnancy- Urine, Strep Rapid
 - Mini Mental, PHQ- Depression Screening
 - See attached list for more assessments available
- Click on "Demographics"
 - Confirm/update reason for visit (HIPPA Compliant reason)
 - Confirm preferred contact method
 - Confirm correct phone number or address depending on preferred method of contact
 - Save
- To obtain Patient Summary, Click on green triangle next to patient's name.
- Click green triangle next to "Allergy History"
 - Allergy
 - Review allergies. Depending on situation choose:
 - No change
 - yes
 - Add Allergy
 - Allergen description
 - Severity
 - Reaction
 - Source
 - Save
 - Home Medications
 - Review medications. Depending on situation choose:
 - "Patient takes no Home Medication" or "Patient Unable to Report Home Medications"
 - Choose SOURCE from drop down then SAVE
 - No change

- Yes
 - Launch ePrescribe- to add medications
 - Confirm PRACTICE INFORMATION Location:
 - Southern Humboldt Community Clinic (Jerold Phelps Community Hospital)
 - Click encounter today
 - Choose Pharmacy
 - Click FAVORITE LIST- FIND
 - Click Keith's Pharmacy or whatever pharmacy they want.
 - Click MANAGE MEDICATIONS
 - Add a Medication and click FIND
 - Choose Medication and enter script
 - Repeat for each medication
 - For Workers Comp
 - In "Comment" section type WC or Workers Comp.
 - Click Log-Out when done
 - Close page by clicking Close this window
 - Click button "F5" on keyboard to update Centriq
 - Click "No Change"
 - Yes
- Surgery
 - Review/Input Past Surgical History. Depending on situation choose:
 - No change
 - Yes
 - Add Surgery
 - Begin typing Surgery/Procedure into box, choose from the drop-down list.
 - For Workers Comp
 - In "Comment" section type WC or Workers Comp.
 - Save or Save and add more
- Immunization
 - Review/Input past Immunizations. Depending on situation choose:
 - No change
 - Yes
 - Add Immunization
 - Fill in required sections and/or all information available.
 - Save or Save and add more
- Family History
 - Review/Input patient's Family History. Depending on situation choose:
 - No change
 - Yes
 - Add Family History
 - Begin typing Problem/Diagnosis into box, choose from the drop down list.
 - Choose type of relationship to patient
 - Save or Save and add more
- Pregnancy - Optional
 - Review/Input Pregnancy History. Depending on situation choose:
 - No change
 - Yes
 - Add Pregnancy
 - Fill in required sections and/or all information available
 - Save or Save and add more

- Alert Provider that patient is ready by changing flag to provider's color and placing paperwork on provider's desk in designated spot.
 - **SNF/Swing Patient Appointments**
- PCC or designee will know it is a SNF/Swing Patient Appointment because it is documented in the "Work Center" schedule.
- PCC or designee will go down to Nursing Floor to do Intake for the appointment. Ask the nursing staff which room the patient is in or where the patient is at currently.
- Click on "Clinic Application"
- Click on "Work Center"
- Find patient's name from the schedule and click on their name.
- Click on "Assessment"
 - Type "Intake" in box
 - Choose "Clinic Intake" and click + icon
 - Fill in each section which includes:
 - Add Vitals
 - Input Vital Signs: Temp, HR, R, **BP**, O2 sat, Pain, **Height, Weight**
 - **BP: Required Every Visit for Patient 3 and Older**
 - **Height & Weight: Every Visit Every Patient**
 - Height and weight should have been obtained by the nursing floor. This can be documented and in comments section write "stated". OR document unable to obtain.
 - Note in VS section if patient refuses, declines, or unable due...
 - Save
 - Patient's Chief Complaint/Reason for Visit (MONTHLY Visit, WEEKLY Visit, etc.)
 - Sign
 - Type "Social" in box
 - Choose "**Social History**" (**required** every visit) and click + icon
 - Fill in each section
 - If done previously, click SHOW PREVIOUS
 - Ask patient if anything has changed?
 - If NOT, click NO CHANGE
 - If there is a change then document
 - click SIGN
 - Type "TB" in box
 - Choose "**Risk Assessment**" (**required** once a year) and click + icon
 - Fill in each section
 - If done previously, click SHOW PREVIOUS
 - Ask patient if anything has changed?
 - If NOT, click NO CHANGE
 - If there is a change then document
 - click SIGN
 - If the patient/nurse answers yes to any question on the screening then document on the blank sheet "Review TB"
- To obtain Patient Summary, Click on green triangle next to patient's name.
- Click green triangle next to "Allergy History"
 - Allergy
 - Review allergies.
 - No change
 - yes
 - Home Medications
 - Review medications.
 - No change
 - Yes
 - Surgery

- Review/Input Past Surgical History. Depending on situation choose:
 - No change
 - Yes
 - Add Surgery
 - Begin typing Surgery/Procedure into box, choose from the drop down list.
 - For Workers Comp
 - In "Comment" section type WC or Workers Comp.
 - Save or Save and add more
 - Family History
 - Review/Input patient's Family History. Depending on situation choose:
 - No change
 - Yes
 - Add Family History
 - Begin typing Problem/Diagnosis into box, choose from the drop down list.
 - Choose type of relationship to patient
 - Save or Save and add more
 - Pregnancy- Optional
 - Review/Input Pregnancy History. Depending on situation choose:
 - No change
 - Yes
 - Add Pregnancy
 - Fill in required sections and/or all information available
 - Save or Save and add more
 - PCC or designee will alert Provider that patient is ready by changing flag to provider's color and placing paperwork (SNF/SWING Fee Ticket) on provider's desk in designated spot.
 - **End of Appointment:**
 - Click on "Clinic Application"
 - Click on "Work Center"
 - Find patient's name from the schedule and click on their name.
 - Choose "Medical Summary" icon
 - Click on "Prepare Document" under Generated Medical Summaries
 - From the drop down box choose "Clinical Summary"
 - Next click on "Generate"
 - Next click  icon
 - From the drop down choose "Patient Portal"
 - Lastly, click "Export"
 - **Clia Tests & Specimens Collected in the Clinic**
 - CLIA Tests completed in the Clinic (i.e., Rapid Strep, UA, Pregnancy-Urine, etc.)
 - Result documented in Assessments under specific test (i.e., Urinalysis CLIA Test, Pregnancy Urine CLIA Test, etc.)
 - Patient Registered by PFS staff for Outpatient Clinic Lab
 - Notify Clinic PFS to do this.
 - Order in CPOE is placed and submitted under Outpatient Clinic Lab encounter.
 - If specimen requires further processing follow steps below.
 - For all Specimens collected in the Clinic (i.e., Wet Mount, PAP, Biopsies, Urine C&S, Wound C&S, Strep, etc.)
 - Patient Registered by PFS staff for Outpatient Lab

- Notify Clinic PFS to do this.
- Order in CPOE is required - Lab requests this prior to receiving the specimen.
- Then bring specimen down to the lab for further processing.
- Notify lab outpatient encounter has been created and order is in the system.

DEFINITIONS:

None

Subject: Colposcopy Cervical Biopsy	Manual: Clinic
--	---------------------------------

POLICY:

It is the policy of Southern Humboldt Community Healthcare District (“SHCHD”, “District”, “SoHum Health”) to optimize patient care by providing colposcopy services, as necessary.

DEFINITIONS:

Colposcopy: A colposcopy is used to identify or rule out the existence of any precancerous conditions in the cervical tissue. A biopsy of suspicious tissue can be taken using a colposcope.

Colposcope: A colposcope is a bright illuminated optical instrument which can magnify an area, enabling the practitioner to visualize stained and unstained cervical epithelium.

PROCEDURE:

The Patient Care Coordinator (PCC) will:

- Assemble Equipment and set-up accordingly. Take care to maintain sterility before and during a sterile procedure. Refer to, *Comprehensive Medical Assisting 4th Ed., Chapter 22 on "Preparing and Maintaining a Sterile Field"*.
 - Tray 1
 - • Lugol's Solution
 - • Monsel's Solution
 - Vinegar
 - • 2- biopsy pots
 - • 2- patient labels
 - • 5 toothpicks
 - • 5 Cotton-tipped applicators
 - • 5 Scopettes
 - 5 pieces of torn paper towel
 - Tray 2: Sterile Set-up
 - Colposcopy Instrument Set:
 - Ring forceps
 - Baby Tischler Punch biopsy
 - Endocervical Curette (ECC)
 - Endocervical speculum
 - Other
 - Urine Pregnancy test
 - Biopsy lab requisition
 - Patient label
 - Colposcope (plug in)
 - Gloves (non-sterile)
 - Sterile gloves
 - PAP Set-Up (provider preference):
 - Collection Brush
 - Collection Broom
 - K-Y Jelly
 - non-sterile speculum
 - PAP Collection Vial
 - Sterile speculum
 - Sterile Drape (2)
 - Drape
 - Naproxen 500mg tablet
 - Cup of water
 - Sanitary pad
- Obtain Colposcopy Cervical Biopsy form packet, which includes, *Colposcopy Cervical Biopsy Informed Consent, Colposcopy Cervical Biopsy Patient Handout, and Colposcopy Cervical Biopsy Worksheet.*
- If patient is of childbearing age, obtain a urine sample and perform a urine pregnancy test prior to rooming the patient.
- Give the labeled *Colposcopy Cervical Biopsy Informed Consent* form to the patient to review and sign. If the patient has any questions regarding the procedure the provider will answer them.
- Give the *Colposcopy Cervical Biopsy Patient Handout*, which discusses follow-care, to the patient. The

provider will review this with the patient.

- Ask the patient if they are allergic to or have taken any non-steroidal anti-inflammatories (NSAIDs) (i.e., ibuprofen, Advil, Motrin, aspirin, Aleve) the day of the procedure.
 - If they are not allergic to or have not taken any, dispense Naproxen 500mg tablet and instruct the patient to take it because it decreases discomfort from the procedure. The patient can choose not to take the medication, too. Notify the provider either way.
 - If patient is allergic to or has taken any NSAIDs notify provider and ask how to proceed.
- Document the following on the labeled *Colposcopy Cervical Biopsy Worksheet* with the patient's help: Name, Date, Blood Pressure (BP), Pulse (P), Last Menstrual Period (LMP), number of pregnancies (Gravida), number of live births (Para), Birth Control Method (BCM), PAPS with dates and results, Smoker, Family history of cervical cancer, History of condyloma (HPV), Prior colposcopy exam, Known exposure to condyloma and any prior treatment for condyloma.
- Once the top portion of the worksheet is completed give the patient a drape and instruct the patient to undress from the waist down.
- Notify the provider that patient is ready to be seen.
- After procedure has been completed
 - Label the specimen containers with a patient sticker.
 - Register patient for outpatient lab.
 - Take specimen to the laboratory, placed in designated area and notify lab that specimen is ready for further processing.
 - If a PAP is performed, in addition, follow the "PAP SMEARS" policy.

The qualified Provider will:

- Verify the urine pregnancy results.
- Review the *Colposcopy Cervical Biopsy Informed Consent* form with the patient and answer any questions.
- Review *Colposcopy Cervical Biopsy Patient Handout* with the patient.
- Perform procedure.
- Order test through Electronic Health Records (EHR).

Once the clinic receives the pathology results the provider will review them, and the patient will be notified to schedule an appointment to review the results.

Subject: Confidentiality of Patient Information	Manual: Clinic
--	---------------------------------

POLICY:

It is the policy of Southern Humboldt Community Healthcare District (“SHCHD”, “District”, “SoHum Health”) to treat information known or contained in the patient’s medical record as confidential and be released only within the guidelines provided for by HIPAA.

The purpose of this policy and procedure is to establish proper protocol of confidentiality of patient information.

PROCEDURE:

- A. All persons employed at Southern Humboldt Community Healthcare District and Southern Humboldt Community Clinic having access to information concerning patients, such as volunteers, staff members, and physicians, must complete HIPAA training and hold all information in strict confidence.
- B. No information concerning patients, physicians, staff members or volunteers is to be relayed to others. Information which may be ordinary facts and necessary for planning of specific care and services will be handled with professional discretion and on a “need to know” basis.
- C. Requests for patient information will be directed to the Health Information Management Department. In the event that no Health Information Management Department personnel is available to fulfill an emergency request for release of information, appropriately trained personnel will release the information. The fulfillment of such requests will be in accordance with the district’s established policy and procedures for release of information.
- D. At no time shall staff members, volunteers, or others associated with Southern Humboldt Healthcare District and Southern Humboldt Community Clinic, who have access to confidential patient or hospital information, speak with the news media, or others outside the hospital, without the prior approval from the district administration. All encounters with the news media should be directed to administration.

See SHCHD’s *Health Information Management policies and procedures* for further information.

DEFINITIONS:

None

Subject: Endometrial Biopsy	Manual: Clinic
--	---------------------------------

POLICY:

It is the policy of Southern Humboldt Community Healthcare District (“SHCHD”, “District”, “SoHum Health”) to optimize patient care by providing endometrial biopsy services, as necessary.

DEFINITIONS:

Endometrial Sampling: Endometrial sampling is a minimally invasive option for diagnosis of endometrial cancer, hyperplasia, and other endometrial pathology and is used to identify or rule out the existence of any precancerous conditions in the endometrial tissue.

Biopsy: A biopsy of suspicious tissue can be taken using a pipelle.

PROCEDURE:

The Patient Care Coordinator (PCC) will:

- Assemble Equipment and set-up accordingly. Take care to maintain sterility before and during a sterile procedure. Refer to, *Comprehensive Medical Assisting 4th Ed., Chapter 22 on "Preparing and Maintaining a Sterile Field"*.
 - Tray 1
 - • Betadine
 - • 2- biopsy pots
 - • 2- patient labels
 - Tray 2: Sterile Set-up
 - Endometrial Instrument Set
 - • Ring forceps
 - • Sound
 - Tenaculum
 - Sterile Cotton Balls or Large Cotton Swabs
 - Sterile speculum (variety of sizes available)
 - Sterile Drape (2)
 - Pipelle (have at least 3 extra available)
 - Other
 - • Urine Pregnancy test
 - • Biopsy lab requisition
 - • Patient label
 - Gloves (non-sterile)
 - K-Y Jelly
 - Sterile gloves
- Obtain Endometrial Biopsy form packet, which includes, *Endometrial Biopsy Informed Consent* and *Endometrial Patient Handout*.
- If patient is of child bearing age, obtain a urine sample and perform a urine pregnancy test prior to rooming the patient.
- Give the labeled *Endometrial Biopsy Informed Consent* form to the patient to review and sign. If the patient has any questions regarding the procedure the provider will answer them.
- Give the *Endometrial Patient Handout*, which discusses follow-care, to the patient. The provider will review this with the patient.
- Ask the patient if they are allergic to or have taken any non-steroidal anti-inflammatories (NSAIDs) (i.e., ibuprofen, Advil, Motrin, aspirin, Aleve) the day of the procedure.

- If they are not allergic to or have not taken any, dispense Naproxen 500mg tablet and instruct the patient to take it because it decreases discomfort from the procedure. The patient can choose not to take the medication, too. Notify the provider either way.
- If patient is allergic to or has taken any NSAIDs notify provider and ask how to proceed.
- Document patient's chief complaint, medication list, any known allergies, family history, and surgical history.
- In addition, obtain the patient's weight, height, blood pressure (BP), pulse (P), temperature (T), respirations (R), oxygen saturation (O2 Sat), body mass index (BMI), and pain level.
- Ask if the patient is allergic to iodine.
- Give the patient a drape and instruct the patient to undress from the waist down.
- Notify the provider that patient is ready to be seen.
- Assist provider with procedure, as needed.
- After procedure has been completed:
 - Label the specimen containers with a patient sticker.
 - Register patient for outpatient lab.
 - Take specimen to the laboratory, placed in designated area and notify lab that specimen is ready for further processing.
 - If a PAP is performed, in addition, follow the "PAP SMEARS" policy.

The qualified Provider will:

- Verify the urine pregnancy results.
- Review the *Endometrial Biopsy Informed Consent* form with the patient and answer any questions.
- Review *Endometrial Patient Handout* with the patient.
- Perform procedure.
- Order test through EHR.
- Once the clinic receives the pathology results the provider will review them and the patient will be notified to schedule an appointment to review the results.

Subject: Guidelines for Preventive Healthcare Services -Adults	Manual: Clinic
---	---------------------------------

POLICY:

It is the policy of Southern Humboldt Community Healthcare District (“SHCHD”, “District”, “SoHum Health”) to make accurate, up-to-date, and relevant recommendations about preventive services that are offered to our patients.

PURPOSE:

The purpose of this policy is to provide guidelines for preventive health care services.

PROCEDURE:

Summary of Recommendations for Screenings:

Breast Cancer Screening:

- Recommends biennial screening mammography for women aged 50 to 74 years.
- Decision to start regular, biennial screening mammography before the age of 50 years should be an individual one and take patient context into account, including the patient’s values regarding specific benefits and harms.

Cervical Cancer Screening:

Recommendation applies to women who have a cervix, regardless of sexual history. Does not apply to women who have received a diagnosis of a high-grade precancerous cervical lesion or cervical cancer, women with in utero exposure to diethylstilbestrol, or women who are immunocompromised (such as HIV positive).

- Age 21 to 65 years with cytology (Pap smear) every 3 years or, for women age 30 to 65 years who want to lengthen the screening interval, screening with a combination of cytology and human papillomavirus (HPV) testing every 5 years.

Chlamydia Infection Screening:

- Recommends screening for all sexually active, non-pregnant young women ages 24 and younger and non-pregnant women 25 years and older who are at increased risk.
- Recommends screening in all pregnant women ages 24 and younger and in older pregnant women who are at increased risk.

Colorectal Cancer Screening:

- Beginning at age 50 years and continuing until age 75 years.
 - Recommends screening using fecal occult blood testing (FOBT) annually OR sigmoidoscopy every 5 years with FOBT every 3 years OR colonoscopy every 10 years.

Diabetes Mellitus:

- Asymptomatic adults with sustained blood pressure greater than 135/80 mm Hg.
 - Recommends screening using fasting plasma glucose (FPG) OR 2-hour postload plasma OR Hemoglobin A1c.
 - The American Diabetes Association (ADA) recommends screening with FPG, defines

diabetes as FPG greater than or equal to 126 mg/dL, and recommends confirmation with a repeated screening test on a separate day.

Hepatitis C Screening:

- One time screening for everyone born during 1945 through 1965, also known as baby boomers.
- Persons at high risk for infection should be screened periodically.

HIV:

- Adolescents and adults aged 15 to 65 years, younger adolescents and older adults at increased risk of infection, and pregnant women should be screened.

Lipid Disorder Screening:

- MEN
 - Strongly recommends screening aged 35 and older.
 - Recommends screening aged 20 to 35 who are at increased risk for coronary heart disease CHD.
- WOMEN
 - Strongly recommends screening aged 45 and older who are at increased risk for CHD.
 - Recommends screening aged 20 to 45 who are at increased risk for CHD.

Lung Cancer Screening:

- Asymptomatic adults aged 55 to 80 years who have a 30 pack year smoking history and currently smoke OR have quit smoking within the past 15 years.
 - Yearly screening with low-dose computed tomography (CT scan) of chest. Discontinue screening when the patient has not smoked for 15 years.

Obesity Screening:

- Adults aged 18 years or older
 - Obtain a body mass index (BMI) on patients. BMI of 30 kg/m² or higher should be offered or referred to intensive, multicomponent behavioral interventions.

Osteoporosis:

- Women age greater than or equal to 65 years without previous known fractures or secondary causes of osteoporosis AND Women less than 65 years old whose 10-year fracture risk is equal to or greater than that of a 65-year-old white women without additional risk factors
 - Obtain dual-energy x-ray absorptiometry (DEXA) of the hip and lumbar spine.
 - Use FRAX fracture risk assessment tool, <https://www.sheffield.ac.uk/FRAX/>, the 10-year fracture risk in a 65-year-old white women without additional risk factors is 9.3%.

Tuberculosis Screening:

- Recommendation varies. Refer to Centers for Disease Control and Prevention (CDC) and/or UpToDate for current recommendation.

Additional Screening Recommendations available at U.S. Preventive Services Task Force, Agency for Healthcare Research and Quality, CDC and/or UpToDate.

DEFINITIONS:

None

Subject: Hypertension Diagnosis & Treatment Recommendations	Manual: Clinic
--	---------------------------------

POLICY:

It is the policy of Southern Humboldt Community Healthcare District (“SHCHD”, “District”, “SoHum Health”) to provide optimum patient care through evidence-based practices.

The purpose of this policy and procedure is to promote evidence-based practices by providing current hypertension diagnosis and treatment recommendations.

DEFINITIONS:

Hypertension:

Hypertension (HTN) is considered a systolic blood pressure (SBP) of 140mmHg or more, OR a diastolic blood pressure (DBP) or 90 mmHg or more or taking antihypertensive medications and is based upon the average of two or more properly measured readings at each of two or more office visits after an initial screening.

Joint National Committee (JNC) VII Classification of BP in Adults 18 years or Older

BP Classification	Systolic BP (mmHg)	Diastolic BP (mmHg)
Normal	<120	and <80
PreHTN	120 – 139	Or 80 - 89
Stage 1 HTN	140 – 159	Or 90 – 99
Stage 2 HTN	≥ 160	Or ≥ 100

Monitoring Ambulatory BP Monitoring (ABPM) and Home BP Monitoring Reading:

- Meeting one or more of these criteria using ABPM qualifies as HTN:
 - A 24-hour average of 130/80 mmHg or above
 - Daytime (awake) average of 135/85 mmHg or above
 - Nighttime (asleep) average of 120/70 mmHg or above

White coat HTN:

- BP that is consistently elevated by office readings but does not meet diagnostic criteria for HTN based on out-of-office readings.
- Although generally considered benign, may be associated with an increased risk of stroke, possibly related to later development of sustained hypertension.

Masked HTN:

- BP that is consistently elevated by out-of-office readings but does not meet the criteria for HTN based upon office readings.
- The risk of cardiovascular complications associated with masked hypertension is similar to that seen with persistent hypertension.

Resistant HTN:

- BP that is not at target despite a three-drug regimen, including an angiotensin-converting enzyme inhibitor (ACEI) or an angiotensin receptor blocker (ARB) + a calcium channel blocker (CCB) + a diuretic appropriate for the patient's glomerular filtration rate (GFR). OR
- Controlled BP while taking four or more medications.

Standing and Supine BPs:

Standing and Supine BPs should be measured before the initiation of combination antihypertensive therapy. Orthostatic (postural) hypotension is diagnosed when, within 2 to 5 minutes of quiet standing, one or more of the following is present:

- At least a 20mmHg fall in systolic pressure
- At least 10mmHg fall in diastolic pressure

PROCEDURE:

DIAGNOSIS:

- *See Health Care Guideline: Hypertension Diagnosis and Treatment Diagnosis Algorithm.*
- *Use United States Preventive Services Task Force (USPSTF) guidelines for screening for elevated BP.*
- Blood Pressure Monitoring
 - Includes: Ambulatory blood pressure monitoring (ABPM), Home BP monitoring, Office-based BP
 - measurements
 - To establish diagnosis and confirmation of hypertension, ABPM is first recommended. If this is not feasible then home BP monitoring and, if neither are feasible then BP must be measured in the office. However, if office BP is used to confirm the diagnosis of hypertension, multiple measurements on different days are required.
 - ABPM can be used in the following situations:
 - Suspected white coat hypertension
 - Suspected episodic hypertension
 - Hypertension resistant to increasing medication
 - Hypotensive symptoms while taking antihypertensive medications
 - Autonomic dysfunction
 - All home monitors should be checked for accuracy, initially and then at least annually, in the clinician's office, and patients or caregivers should be able to demonstrate the correct technique of BP measurement. When using home monitoring in obese patients, appropriately sized arm cuffs may be unavailable; in these situations, wrist cuffs may be used.
 - In general, measurements obtained by ABPM and home BP monitoring are lower than those obtained by routine office measurement by approximately 5 to 10 mmHg. Thus, the following definitions are used to define hypertension according to the measurement strategy that is employed; notably, the thresholds for hypertension are identical with daytime ambulatory BP, home BP, and automated oscillometric BP (AOBP):
 - If ABPM is used, a daytime average systolic pressure ≥ 135 mmHg or a daytime average diastolic pressure ≥ 85 mmHg; alternatively, a 24-hour average systolic pressure ≥ 130 mmHg or a 24-hour average diastolic pressure ≥ 80 mmHg
 - If home BP measurements are used, a systolic pressure ≥ 135 mmHg or a diastolic pressure ≥ 85 mmHg
 - If routine office BP measurements are used, a systolic pressure ≥ 140 mmHg or a diastolic pressure ≥ 90 mmHg
 - If AOBP is used, a systolic pressure ≥ 135 mmHg or a diastolic pressure ≥ 85 mmHg
 - If manual office readings are used to diagnose and monitor BP, proper measurement requires attention to all of the following: Time of measurement, Type of measurement device, Cuff size, Patient position, Cuff placement, Technique of measurement, Number of measurements

INDICATIONS:

Plan:

- **General interventions:**

- Advise weight loss for overweight or obese patients. As little as a loss of 10 pounds reduces BP.
- Advise to limit or discontinue alcohol intake. Women who consume two or more alcoholic beverages per a day and men who have three or more drinks per day have significantly increased incidence of HTN.
- Encourage smoking cessation.
- Encourage increased physical activity. Current recommendations advise adults to engage in 40 minutes of aerobic physical activity three to four times a week. Aerobic exercise should involve moderate-to-vigorous intensity.
- Encourage some form of relaxation technique.

- **Patient teaching:**

- Stress asymptomatic nature of disease.
- Stress importance of ongoing monitoring and treatment under the direction of a health care provider.
- Review Risk factors for cardiac, renal and cerebrovascular disease and possible preventive measures.
- Review Modifiable and Non-modifiable Risk for Control of HTN

Modifiable and Non-modifiable Risk for Control of HTN

Modifiable		Non-modifiable	
Sedentary lifestyle Diet Sodium intake Obesity	Smoking Lipid control Alcohol intake	Age Gender Ethnicity	Diabetes Postmenopausal

- 5) Patients with diagnosis with hypertension should monitor their BP at home, if possible. If home BP cannot be monitored, management of the patient BP can be done through office measurements.
 - 6) Use BP education and management tools.
- Patient Care Instructions through Healthland Centriq
 - *Hypertension, Easy-to-read*
 - *Managing Your High Blood Pressure*
 - *How to Take Your Blood Pressure*
- Handout
 - *High Blood Pressure Action Plan*
 - *How You Can Control Your Blood Pressure*
 - *Blood Pressure Log*
- Resources
 - *American Heart Association (AHA)*
 - *Center for Disease Control (CDC)*
- Dietary management
 - Handout dietary recommendation sheets,
- *Guidelines for Low Cholesterol, Low-Triglyceride Diets*
- *DASH Eating Plan* (Patient Care Instructions through Healthland Centriq)
 - Diet alone will only make the lowest incremental change in BP; therefore, it should be combined with
 - lifestyle modifications.

- A low-salt diet is recommended as a component of non-pharmacologic therapy.
- It is essential for the patient/family to read labels for sodium, fat content, and serving sizes.
- Other dietary changes include low-fat/low-cholesterol diets and limiting fats

- D) Pharmaceutical therapy

- If lifestyle changes alone are not adequate to control HTN, consider drug therapy.
- Medication doses are dependent on age, ethnicity, and comorbid conditions.
- Consider starting antihypertensive and/or diuretics.
- See JNC 8 Hypertension Guideline Algorithm
- See JNC 8 Hypertension Management Algorithm
- Review table below

- **American Heart Association (AHA), American College of Cardiology (ACC), and Center for Disease Control (CDC) 2013 Suggested Hypertensive Medications by Medical Condition**

• Medical Condition	• BB	• ACEI or ARB	• ALDO ANTAG	• Thiazide	• CCB
• Coronary artery disease/ post MI	• X	• X	•	•	•
• Systolic heart failure	• X	• X	• X	• X	•
• Diastolic heart failure	• X	• X	•	• X	• X
• Diabetes	• X	• X	•	• X	•
• Kidney Disease	•	• X	•	•	•
• Stroke or TIA	•	• ACEI	•	• X	•

- *Beta-blocker (BB), angiotensin-converting enzyme inhibitor (ACEI), angiotensin receptor blocker (ARB),*

- *aldosterone antagonist (ALDO ANTAG), calcium channel blocker (CCB)*

- Most patients require two or more medications to control BP. Combination therapy with drugs from different classes has a substantially greater blood pressure-lowering effect than doubling the dose of a single agent. ACE inhibitors and ARBs should **not** be used together.
- Fixed-dose, single-pill combination medications should be used whenever feasible to reduce the burden on patients and improve medication adherence
- Antihypertensive/diuretics should be started low and increased if there is inadequate response to initial therapy and nonadherence is ruled out.

- **Consider the following:**

- Increase drug dose
 - (ii)Substituting another drug
- Adding a second drug from another class; a diuretic is recommended if one is not already being used.
- Beta blockers are no longer first-line antihypertensive agents. Atenolol may increase central aortic pressure.
- ACEIs and ARBs are critical medications to prescribe and titrate to maximum dose as a first-line medication in people with renal disease, diabetes, and proteinuria.
- If response is still inadequate, add second or third drug or diuretic if one has not already been tried.
- Evaluate the patient for secondary cause if severe HTN is resistant to therapy.

- Resistant HTN; rule out all inadequate response to the three-drug therapy (ACEI or ARB or CCB
 - + diuretic):
- “White Coat” HTN: Have the patient begin to take and record his or her BP at home and report the values.
- Use of size-appropriate BP cuffs on obese patients.
- Nonadherence to therapy, including side effects, medication regimen, too complex, and/or cost/affordability.
- Volume overload due to excessive salt intake, progressive renal damage, fluid retention from BP reduction, inadequate diuretic therapy.
- Drug problems: Dose too low, wrong type of diuretic, inappropriate combinations, rapid inactivation, drug actions, and interactions.
- Associated conditions: smoking, obesity, sleep apnea, insulin resistance, ethanol intake greater than 30mL (1oz) per day, panic attacks, chronic pain, and organic brain syndrome.
- Adding spironolactone can decrease SBP by 25 mmHg average and DBP an average of 12 mmHg in resistant hypertensives.
 - Treat with decongestants very cautiously. Pseudoephedrine HCl has the least cardiovascular effect
 - Diuretics may worsen gout and diabetes.
 - Beta blockers are contraindicated in asthma, HF, and heart block.
 - Use diltiazem HCl and verapamil HCl cautiously in HF or block.
 - Ace inhibitors may cause coughing.
 - Abrupt cessation of therapy with a short-acting beta blocker, such as propranolol, or the short acting alpha-2-agonist clonidine can lead to a potentially fatal withdrawal syndrome. Gradual
 - discontinuation of these agents over a period of weeks should prevent this syndrome.
 - For individuals over age 65 years with isolated systolic hypertension (eg, an office diastolic
 - Blood pressure below 90 mmHg), caution is needed not to reduce the diastolic blood pressure
 - Too aggressively (<55 to 60 mmHg), since low achieved diastolic pressures have been
 - Associate with an increased risk of myocardial infarction and stroke.
- **Follow-Up:**
 - If drug therapy is initiated, see the patient again in 2 to 4 weeks for follow-up.
 - Once the patient is stable, they need to be seen by a provider every 3 to 6 months for to
 - ensure maintenance control.
 - Evaluate the patient yearly, including uric acid, creatine, and potassium.
 - Review and discuss drug therapy compliance, effectiveness, and adverse reactions (including
 - effect on sexual activity) at each visit.
 - Home and ambulatory BP monitoring (ABPM) is an adjunctive tool for the management of HTN.
- **BP tracking apps, websites, or by paper:**
 - Consider sleep study for diagnosis of OSA.
 - Patients with preHTN without diabetes, chronic kidney disease, or CV disease should be treated by nonpharmacological therapy should be evaluated annually.
- **Consultation/Referral:**
 - Many antihypertensive drugs are harmful to fetus. Consider consultation with specialist for patients who are pregnant.
 - Consider triage patient to ED for DBP greater than 130 mmHg, acute hypertensive emergency.
 - Consider consultation with other provider/specialist if patient needs more than three drugs for therapy.
- **Note:**

- Pregnancy
- May be chronic or pregnancy-induced hypertension (PIH).
- Considered chronic if present before pregnancy or diagnosed prior to the 20th week of gestation.
- PIH is diagnosed if SBP increases 30 mmHg or more, or if DBP increases 15mmHg or more, compared with BP readings before the 20th week of gestation. When BP readings are not known, a reading of 140/90 or higher is considered abnormal.
- Maternal as well as fetal mortality and morbidity improve with treatment.
 - Pediatrics
 - Begin BP evaluation at every visit starting at 3 years of age.
 - HTN can occur with acute illnesses OR may be a chronic problem.
 - Determine high BP by correlating height indexes with BP readings.
 - Geriatrics
- The optimal BP treatment goal in the elderly has not been determined. HTN in elderly
 - has not been determined. HTN in the elderly places the patient at risk for coronary
 - events, stroke, HF, and PAD.
- Elderly persons with HTN are more likely to develop orthostatic and postprandial
 - hypotension, which may result in falls or syncope.
 - Evaluate side effects, such as, dizziness, sedation, depression or confusion.
- General approach to drug therapy is to start low and go slow.
- Check the *Beers List* for harmful drugs in this population.
- To avoid hyperkalemia, potassium-sparing diuretics should not be given with ACEI or
 - ARBS.
 - Symptoms of cerebra hypoperfusion, such as dizziness.

Non-Dipping: Failure of the BP to fall by at least 10%[^] during sleep is called "non-dipping" as is a strong predictor of adverse cardiovascular outcomes than daytime BP.

Isolated systolic HTN (ISH): is defined when the SBP is greater than or equal to 140 with the DBP normal or below normal (<90mmHg).

Isolated diastolic HTN (IDH): is defined as DBP greater than or equal to 90mmHg with systolic pressure less than 140mmHg.

Malignant HTN: is marked HTN with retinal hemorrhages, exudates, or papilledema. Usually associated with diastolic pressures above 120mmHg.

Subject: Immunizations	Manual: Clinic
---	---------------------------------

POLICY:

It is the policy of Southern Humboldt Community Healthcare District (“SHCHD”, “District”, “SoHum Health”) to offer immunizations according to the guidelines of the Center for Disease Control and Prevention (CDC) and the Advisory Committee on Immunization Practices (ACIP) as appropriate for patients in order to provide optimum quality care.

PURPOSE:

The purpose of this policy is to make recommendations for the use of immunizations in the clinic while delineating the procedures for administration, documentation, and patient teaching.

It is also the purpose to reduce morbidity and mortality from vaccine-preventable diseases.

PROCEDURE:

Recommendations:

SHCHD will utilize the most current recommendations provided by the CDC for infant, child, teen, and adult immunizations when evaluating the need for vaccination.

See attached documents for current recommendations: "Recommended Immunization Schedules for Persons Aged 0 through 18 Years" and "Recommended Adult Immunization Schedule".

PROCEDURE:

- Identify a patient’s need for vaccination using the provided recommendation schedules.
- Screen all patients for contraindications and precautions to the specific vaccine(s) they will be receiving.
 - *See attached document: "Guide to Contraindications and Precautions to Commonly Used Vaccines"*
 - *See attached document: "Guide to Contraindications and Precautions to Commonly Used Vaccines in Adults"*.
- Perform Hand Hygiene.
- Administer the vaccine(s) per directions.
 - *See attached document: "Administering Vaccines: Dose, Route, Site, and Needle Size"*.
- Document each patient’s vaccine administration information and follow up in the following places:
 - **Medical chart:** Record the date the vaccine was administered, the manufacturer and lot number, the vaccination site and route, and the name and title of the person administering the vaccine. If vaccine was not given, record the reasons(s) for non-receipt of the vaccine (e.g., medical contraindication, patient refusal).
 - **Personal immunization record card:** Record the date of vaccination and the name/location of the administering clinic.
- Patient (parent/legal representative) teaching:
 - Review the common side effects for the vaccine(s) administered. Common side effects are printed on the VIS forms.

- Review signs of a serious allergic reaction and when to seek medical help. This includes:
 - High fever, difficulty breathing, weakness, hoarseness or wheezing, a fast heartbeat, hives, dizziness, paleness, or swelling of the throat.
- Inform the patient verbally and written, when the next vaccination is due according to the recommended guidelines.
- Provide all patients (parent/legal representative) with a copy of the most recent federal Vaccine Information Statement (VIS). These are available through *Patient Education - Exit Care* in and/or online at the CDC.
- Document in *Patient Education (Facility Based)* section the education that was given.
- Be prepared for management of a medical emergency related to the administration of vaccine.
- For all patients with a suspected adverse reaction to an immunization:
 - A Quality Review Report (QRR) indicating a possible adverse reaction must be completed by the clinic staff member involved.
 - The Risk Manager or Infection Prevention Nurse or Clinic Nurse Manager will report to the federal Vaccine Adverse Event Reporting System (VAERS) at www.vaers.hhs.gov or by calling (800) 822-7967.

DEFINITIONS:

None

Subject: Mantoux Tuberculin Skin Testing	Manual: Clinic
---	---------------------------------

POLICY:

It is the policy of Southern Humboldt Community Healthcare District (“SHCHD”, “District”, “SoHum Health”) to use the Mantoux tuberculin skin test (TST) whenever possible to determine exposure to Tuberculosis (TB). Only appropriately licensed, trained health care providers (HCP) are permitted to administer and read Mantoux TST in this facility.

BACKGROUND:

Tuberculosis (TB) is a disease caused by a bacterium called *Mycobacterium tuberculosis* (*M. tuberculosis*). TB is spread through the air from person to person. Tiny water particles containing *M. tuberculosis* may be expelled into the air when a person with infectious TB of the lungs, airway, or larynx: coughs, sneezes, speaks, and sings. These particles, called droplet nuclei, can remain in the air for several hours, depending on the environment. If another person inhales air that contains droplet nuclei, they may become infected. However, not every person that is exposed to TB becomes infected. Additionally, not everyone infected with *M. tuberculosis* becomes sick. People who are infected but not sick have latent TB infection (LTBI). A person with LTBI does not spread the disease but can go on to develop TB disease. Only persons with TB disease spread the bacterium.

Persons with TB disease usually have one or more symptoms. Because different parts of the body can be affected by TB, symptoms can vary. General symptoms of TB disease include fever, chills, night sweats, weight loss, appetite loss, fatigue, malaise. Other symptoms relating to pulmonary TB disease include a cough lasting 3 or more weeks, chest pain, and coughing up blood or sputum (phlegm).

Diagnostic tests that can be used to detect TB infection include: The Mantoux tuberculin skin test (TST) or Interferon-gamma release assays (IGRAs). A positive TST or IGRA result only indicates if someone has been infected with *M. tuberculosis*. These tests cannot identify if a person has TB disease.

PROCEDURE:

- **Staff Certification:**
 - Only appropriately trained licensed staff are permitted to administer and read TST at this facility.
 - The Infection Preventionist, Employee Health Nurse or designee is responsible for training and certification of staff.
 - Training and certification consists of:
 - Reviewing the appropriate DVD (i.e. from the Centers for Disease Control and Prevention (CDC)).
 - Passing a written test.
 - Performing three TST on a manikin, volunteer, or patient (under supervision)
 - Reading and documenting three TST.

Administration Procedure:

- Administration
 - Patient education
 - Discuss why the skin test is given, what is involved in the procedure, and when they should return for the test to be read.
 - Explain that 48 to 72 hours after the test is administered, they must return to have the induration measured and evaluated.

- If they cannot return with that time period, do not administer the test.
- Prepare, locate and clean injection site
 - Wash your hands, using an appropriate hand-washing technique before administering the test or any procedure involving patient contact.
 - On a firm, well-lit surface, expose the patient's left arm and slightly flex it at the elbow.
 - If left arm is unavailable or inappropriate for placement of TST the right arm may be used.
 - Injection should be placed on the palm-side-up surface of the forearm 2 to 4 inches below elbow joint.
 - Select an area free of barriers (e.g., scars, sores, veins, heavy hair) to placing and reading
 - Clean the area with an alcohol swab by circling from the center of the site outward.
 - Allow the site to dry completely before the injection.
- Prepare syringe
 - Check expiration date on vial and ensure vial contains tuberculin (5 TU per 0.1mL).
 - If the vial has been open more than 30 days or the expiration date has passed, the vial should be disposed of and a new vial used.
 - When you open a new vial, write the date and your initials on the label to indicate when the vial was opened and who opened it.
 - Use a single-dose tuberculin syringe with a ¼- to ½- inch, 27-gauge needle with a short bevel.
 - Wipe the top of the vial with a new alcohol swab before drawing up the tuberculin solution.
 - Draw out slightly more than the one tenth of a milliliter (0.1mL) needed for the test. Expel all air and excess fluid from syringe and needle, leaving exactly 0.1mL of tuberculin solution in the syringe.
 - The skin test should be given as soon as possible after the syringe is filled.
- Inject tuberculin
 - Don gloves.
 - Stretch taut the selected area of skin between the thumb and forefinger.
 - With the needle bevel facing up and the syringe flange parallel to the forearm, hold the syringe between your thumb and forefinger.
 - With the needle bevel against their skin, insert it slowly at a 5- to 15- degree angle.
 - Needle bevel can be seen just below skin surface and should be advanced approximately 3 mm so that the entire bevel is covered and lies just under the skin.
 - Slowly inject the tuberculin solution. A tense, pale wheal should appear over the needle bevel.
 - Remove the needle without pressing or massaging the area.
 - Discard the used syringe immediately in the designated puncture-resistant container. Follow safe injection practices.
- Check skin test
 - To determine if the skin test was administered properly, measure the wheal. The wheal should be 6 to 10 mm in diameter.
 - If not, repeat test at a site at least 2 inches, or 50 mm, from the original site.
 - If a drop of blood appears at the injection site, lightly blot the blood away with a 2x2 gauze or cotton ball. This is perfectly normal.
 - Do not cover the site with adhesive bandage due to potential irritation and interference with the test results.
 - Repeat hand hygiene after injection is completed.
- Post-injection education
 - Reinforce to them the dates and times for their return for a TST result reading.
 - Explain that mild itching, swelling, or irritation may occur and these are normal reactions that do not require treatment and usually go away within a week.

- Explain care of site to patient: avoid scratching, wiping or scrubbing, keep the site clean and dry, avoid putting creams/lotions, or adhesive bandages on it, and getting the site wet with water is not harmful.
- Return the tuberculin vial to the refrigerator.
- Record information
 - Record all the information required for documentation: date and time of test administration, the name and manufacturer of the injected solution, lot number, and tuberculin dose administered, the expiration date, location of injection site, and name of person who administered the test.

Reading the Mantoux Tuberculin Skin Test

- Timing
 - TST should be read between 48 and 72 hours after the skin test has been administered.
 - If they do not return within 72 hours another skin test is required.
- Supplies
 - A small, plastic, flexible ruler marked in millimeters to measure the test, a pen to mark the edges of the induration, and an alcohol pad to clean off the pen marks.
- Inspection
 - Locate the skin-test site, inspect the arm in good light and on a firm surface, turn the arm palm up, and slightly flexed at the elbow.
 - Basis of reading the skin test is the presence or absence of induration, which is a hard, dense, raised formation.
 - ONLY the part of the reaction that can be felt, induration, is measured, even if there is soft swelling or erythema at the site.
 - Reactions to the TST at the injection site can range from no induration to a large, well-defined induration.
 - To feel the induration properly, you must rely on palpation with your fingertips to discover if there's induration at the site.
 - With your fingers together, touch the area lightly with the pads of your fingertips. Using a light, gentle motion, sweep the fingertips over the surface of the forearm in a 2-inch diameter in all four directions to locate the margins or edges of induration.
 - If induration is present, use a zigzag, feather-like touch over the area of induration to outline the margins of induration. Determining margins all around the induration helps to find the edges, which will be measured later.
 - When palpating for margins, be careful not to confuse a margin of induration with a margin of muscle on the forearm. To check this, raise the patient's arm to a 45-degree angle and palpate again. You should still be able to palpate the margins of induration. The diameter of the induration is measured across the forearm, from the thumb side of the arm to the little finger side of the arm or vice versa.
 - To mark the edges of the induration, hold your palm over the injection site with your fingertips at the outer edge of the patient's forearm. Without lifting, move the fingertips from the outer edge of the forearm towards the induration. Rest one fingertip firmly against the induration margin border on one side before marking the margin. The fingertip should remain in contact with the skin at all times. Mark lightly with a fine dot at the widest edge of the induration, using the fingertip as a guide.
 - Repeat the procedure from the other side of the patient's forearm and place the second mark on the margin of induration. Palpate again to double check that the induration was marked correctly. If the margin is not equally clear all the way around the induration, it's still necessary to mark the margins on each side of the induration. Palpate around the induration from the easily felt margin to the not-so-easily-felt margin. If the margins of induration are irregular, mark and measure the longest diameter across the forearm.
- Measurement
 - To measure the diameter of the induration, use the millimeter ruler.
 - Place the zero ruler line inside the left dot edge and read the ruler line inside the right dot edge. If the measurement falls between two divisions on the millimeter scale, record the lower mark.

- Reactions to the skin test will vary. For example, with a very large reaction with blistering, swelling, and redness. Make sure to record blistering, even if no induration is present. Palpate this induration gently, as it may be painful. Measure only the induration.
- Immediately after the test is measured, write the exact measurement in millimeters of induration on the patient's record. Do not simply record the interpretation of the results as "negative" or "positive," and do not record the results in centimeters.
- For example, an induration that measures 3 mm should be recorded as "3 mm" and not as "negative." Additional information should include the date and time the test was read, the name and signature of the person who read the skin test, and the presence or absence of adverse effects.
- Interpretation should be performed by a trained health care provider in accordance with CDC guidelines.

Interpretation of TST:

- Skin test interpretation depends on two factors:
 - Measurement in millimeters (mm) of the induration.
 - Person's risk of being infected with TB and progression to disease if infected.
- The three cut points below should be used to determine whether the skin test reaction is *positive*. A measurement of 0 mm or a measurement below the defined cut point for each category is considered *negative*.
 - Induration of **5 or more mm** is considered positive in:
 - Human immunodeficiency virus (HIV)-infected persons.
 - Recent contacts of TB case patients.
 - Persons with fibrotic changes on chest radiograph consistent with prior TB.
 - Patients with organ transplants and other immunosuppressed patients (e.g., receiving the equivalent of 15 mg/d of prednisone for 1 month or more)
 - Induration of **10 or more mm** is considered positive in:
 - Recent immigrants (i.e., within the last 5 years) from countries with a high prevalence of TB.
 - Injection drug users.
 - Residents and employees* of the following high-risk congregate settings:
 - prisons and jails, nursing homes and other long-term facilities for the elderly, hospitals and other health care facilities, residential facilities for patients with acquired immunodeficiency syndrome (AIDS) homeless shelters
 - Mycobacteriology laboratory personnel
 - Persons with the following clinical conditions that place them at high risk:
 - Silicosis, diabetes mellitus, chronic renal failure, some hematologic disorders (e.g., leukemia and lymphomas), other specific malignancies (e.g., carcinoma of the head, neck, or lung), weight loss of 10% of ideal body weight, gastrectomy, jejunioileal bypass
 - Children 5 years of age
 - Infants, children, and adolescents exposed to adults at high risk for developing active TB
 - Person with no known risk factors for TB (per California Public Health Department).
 - *For employees who are otherwise at low risk for TB and who are tested as part of an infection prevention screening program at the start of employment, a reaction of 10 mm is considered positive.
 - Some health care workers participating in an infection control screening program may have had an induration 0 mm that was considered negative at baseline. If these health care workers have an increase in induration size upon subsequent testing, they should be referred for further evaluation.

Result Notification:

- All tests whose reading is greater than 5 mm as read by two readers, must be forwarded to the Infection Preventionist or designee.
- A person with a positive reaction will be referred to see their healthcare provider for evaluation and treatment recommendations.

- Their healthcare provider will determine the persons TB status (latent TB infection or TB disease) through the use of symptom review, chest x-ray, IGRAs and/or sputum cultures and arrange treatment and follow-up if necessary.
- Public Health Department will be notified per state requirements.

SEE EMPLOYEE IMMUNIZATION AND TUBERCULOSIS SCREENING PROCEDURES FOR INFORMATION

DEFINITIONS:

None

Subject: Minor Surgical Procedures	Manual: Clinic
---	---------------------------------

POLICY:

It is the policy of Southern Humboldt Community Healthcare District (“SHCHD”, “District”, “SoHum Health”) to optimize patient care by providing minor surgical procedures, as necessary, using aseptic technique and appropriate monitoring of the patient during the procedure.

PROCEDURE:

Minor surgical procedures that are performed in the clinic, include, but are not limited to:

- Colposcopy Biopsy (*see Colposcopy Cervical Policy*)
- Endometrial Biopsy (*see Endometrial Biopsy Policy*)
- Incision and Drainage of Abscess or Cyst
- Laceration Repair
- Lesion Biopsy/Removal
- Toenail Removal

Pre-Procedure:

When necessary, written instructions are given to the patient regarding:

- Applicable restrictions on food and drugs before the procedure.
- Any special preparations to be made by the patient.
- Any post-procedure requirements.
- An understanding that admission to the hospital may be required in the event of an unforeseen circumstance.

PROCEDURE:

The Patient Care Coordinator (PCC) will:

- Assemble Equipment and set-up accordingly. Take care to maintain sterility before and during a sterile procedure. *Refer to, Comprehensive Medical Assisting 4th Ed., Chapter 22 on "Preparing and Maintaining a Sterile Field".*
 - Incision and Drainage of Abscess or Cyst/Laceration Repair/Lesion Biopsy/Removal
 - Tray 1
 - • Anesthetic (provider preference)
 - • 4x4 gauze
 - • Syringe (provider preference)
 - • Alcohol wipes
 - Needles:
 - 18g 1"
 - Provider Preference (usually 30g ½" or 27g 1 ¼")
 - • Gloves (non-sterile)
 - • Sterile gloves
 - • Razor
 - • Iodine swabs
- Tray 2: Sterile Set-up
- Suture Instrument Set
 - • Kelly Forceps
 - • Iris Scissor
 - Scissor
 - Forceps
 - Pick-ups
- Sterile Drape (2)
 - Scalpel (provider preference)
 - Suture (provider preference)

- Gauze Sponge
 - Other
 - • Chlorhexidine scrub
 - • Normal Saline
 - • Lamp
 - • Patient labels
 - • Biopsy lab requisition
 - • 2- biopsy pots (for lesion biopsies)
 - • Sterile Fenestration Drape
 - • Drape
 - • Gown
 - • Hyfercator and tip
 - • Cryotherapy machine (for lesion removals)
 - • Disposable Punch Biopsy (provider preference)
- **Toenail Removal:**
 - • Anesthetic (provider preference)
 - • 4x4 gauze
 - • Syringe (provider preference)
 - • Alcohol wipes
 - • Curved Kelly Forceps
 - • Mosquito Forceps
 - Scissors, Large
 - Needles:
 - 18g 1"
 - Provider Preference (usually 30g ½" or 27g ¼")
 - • Gloves (non-sterile)
 - • Sterile gloves
 - • Rubber band
 - • Iodine swabs
 - • Phenol (if available)
 - • Cotton Swabs (if using Phenol)
- Document patient's chief complaint, medication list, any known allergies, family history, and any surgical history available.
- In addition, obtain the patient's weight, height, blood pressure (BP), pulse (P), temperature (T), respirations (R), oxygen saturation (O2 Sat), body mass index (BMI), and pain level.
- Ask if the patient is allergic to iodine.
- For Lesion Biopsy/Removal and Toe Nail Removal, give the labeled *Procedure Consent* form to the patient to review and sign. If the patient has any questions regarding the procedure the provider will answer them.
- Depending on the procedure location the patient may need to undress and be provided with a drape or gown or both.
- Notify the provider that patient is ready to be seen.
- Sedation is not used in the clinic, only a local or regional anesthetic is used.
- Assist provider with procedure, as needed.
- After procedure has been completed
 - Assist the provider with patient clean-up and dressing of any wounds, which can include the application of an antibiotic ointment and bandage(s).
 - For Biopsy:
 - Label the specimen containers with a patient sticker.
 - Register patient for outpatient lab.
 - Take specimen to the laboratory, placed in designated area and notify lab that specimen is ready for further processing.
 - Prepare the room for the next patient, which includes properly disposing of disposable items, sharps, and contaminated or unused supplies. Patient gurneys, mayo stands and other equipment will be wiped down with District approved germicide. Instruments will be placed in transport container after use. *See Infection Prevention-Clinic Policy for further information.*

The qualified Provider will:

- Review the *Procedure Consent* form with the patient and answer any questions.
- Review any discharge/follow-up instructions with the patient which is obtained through *Patient Education* and *Patient Education-Facility Based*.
- Perform procedure.
- The patient is examined by the physician prior to discharge from the clinic.
- Order test through EHR, as needed.
- Document accordingly
 - Any anesthetic and the amount used.
 - Biopsy: site, size, what type of biopsy (i.e., punch, shave), if know, what type of structure

- that is being biopsied.
- Incision & Drainage: site, size, and closure method (i.e., derma bond, drain).
- Laceration: length, location, simple/intermediate/complex, any underlying conditions (tendon involvement).

Once the clinic receives the pathology results the provider will review them, and the patient will be notified to schedule an appointment to review the results with the provider.

DEFINITIONS:

None

Subject: Oxygen Administration	Manual: Clinic
---	---------------------------------

POLICY:

It is the policy of Southern Humboldt Community Healthcare District ("SHCHD", "District", "SoHum Health") to provide best quality of care and comfort to ensure quality of life.

PROCEDURE:

AUTHORIZED PERSONNEL:

- Provider: Medical Doctor (MD), Physician Assistant (PA), Nurse Practitioner (NP)
- Registered Nurse (RN)
- Licensed Vocational Nurse (LVN)
- Patient Care Coordinator (PCC): Medical Assistant (MA), Certified Nursing Assistant (CNA), Emergency Medical Technician (EMT)

EQUIPMENT/SUPPLIES NEEDED:

- Oxygen via portable tank or wall hook-up (not available in clinic).
- Low Flow devices
 - Nasal cannulas
 - Simple face masks
 - Non rebreather masks
- High Flow devices
 - CPAP mask device (not available in clinic)
 - Bag valve mask device
- Pulse oximeter – keep in place during entire interaction, while O₂ is being administered.

INDICATIONS:

- The lowest flow oxygen should be given to patients to return and stabilize them to normal oxygen levels.
- The use of a pulse oximeter can indicate the need for supplemental oxygen and the amount. Patient observation, respiratory rate and comfort can further indicate the need for supplemental oxygen.
- It is appropriate to administer high concentration oxygen to patients during the initial assessment to avoid any unnecessary delay for those patients who are truly hypoxic.
- Once the initial assessment has been completed, oxygen administration can then be titrated to the patient's needs.
- Those with evidence and visible hypoxia (agitation, discomfort, or cyanosis) should always receive high concentration oxygen.
- Severe trauma patients, GI bleed or potential hypovolemic patients or patients who are in need of care unavailable by the clinic should receive high concentration oxygen and should be delivered immediately to the Emergency Department.

PROCEDURE:

- Assemble supplies and equipment, e.g. oxygen tank, nasal cannula/face mask.
- Obtain baseline pulse oximetry level when available.
- Ensure oxygen is available in quantity needed – check the PSI on the oxygen tank.
- Determine patient's oxygen need and provide oxygen via appropriate device.

- Connect device to oxygen source and adjust liter flow to desired rate. Be sure oxygen is flowing before patient application.
- Apply delivery device to patient.
- Recheck and observe patient frequently for signs of improvement or deterioration.
- Evaluate pulse oximetry reading frequently.
- Titrate oxygen delivery to maintain Pulse Oximetry of 94% or as instructed by provider.

DOSAGE:

Mild Distress	<ul style="list-style-type: none"> • No Signs of hypoxia or hemodynamic compromise. • Patients with Pulse Oximetry of 94% to 100% 	Low flow/ low concentration	2 to 6 liters via Nasal Cannula or blow by (utilizing a nonrebreather mask at 15 lpm, held close to the patient s face but not fastened).
Medium Distress	<ul style="list-style-type: none"> • Signs of hemodynamic compromise and a normal mentation with adequate respiratory rate and effort. • During initial evaluation of potentially critical patients (complicated chest pain patients or stroke patients) 	Low flow/ medium to high concentration	12-15 lpm via simple face mask or non-rebreather Mask

*If patient requires more than the above supplemental oxygen the patient needs to be taken to the emergency department immediately with the indication from the provider.

*Remember COPD patients react differently to the administration of oxygen, while observing a COPD patient for a recovering O₂ saturation, the observer may find depletion.

DEFINITIONS:

Low Flow: adds oxygen to patients' inspiratory supply.

High flow: provides inspiratory supply.

High vs. low concentration:

- Low concentration (21% - 50%)
- High concentration (51% - 100%)

Subject: Protime Dosing Guidelines	Manual: Clinic
---	---------------------------------

POLICY:

It is the policy of Southern Humboldt Community Healthcare District (“SHCHD”, “District”, “SoHum Health”) to ensure all patients on warfarin/Coumadin therapy being followed by the clinic will have proper dosing of medication based on their current International Normalized Ratio (INR) result in order to provide optimum quality care.

To outline the steps the provider will take when prescribing warfarin/Coumadin therapy. To also define the scope and clinical criteria nurses will follow when processing Protime (PT)/International Normalized Ratio (INR) laboratory results and to clarify their role within the patient care team.

Registered Nurses (RNs) and Licensed Vocational Nurses (LVNs) are authorized to ensure all patients on warfarin/Coumadin therapy will have proper dosing of medication based on their current INR result according to policy and procedure. RNs/LVNs will refer to the prescribing provider or their care team when required by policy and whenever they have any concern about a laboratory result.

PROCEDURE:

Provider:

- Warfarin/Coumadin will be prescribed in 5 mg doses.
- Standing Order for PT/INR with frequency of As Needed (PRN) will be generated in SHCHD’s electronic health record (EHR). If patient wishes to have lab work done at another facility a paper order will be generated and given to the patient and/OR sent directly to the lab of their choice.
- Patient Education will include:
 - Patient Care Instructions through Healthland Centriq
 - ◆ What You Need to Know About Warfarin
 - Warfarin (Coumadin) Dose Reminder Chart
- Will notify RN/LVN of PT/INR laboratory results as they are received.
- Will notify RN/LVN will patients begin warfarin/Coumadin therapy.

RNs/LVNs:

- Will review PT/INR laboratory results for each patient that is monitored by the clinic as they are received by the clinic provider(s).
- Patient is to be instructed to phone if they have not heard from clinic in one day after having blood drawn for PT/INR laboratory test.
- Patient laboratory results and dosing will be tracked electronically using the assessment form *Warfarin Flowsheet – INR 2.0 – 3.0* or *Warfarin Flowsheet – INR 2.5 – 3.5* depending on patient’s target INR range.
- The Anticoagulation Decision Support table will be used to determine the appropriate therapeutic ranges unless otherwise specified by the provider.
- The Dose Adjustment Algorithms below will be used to adjust warfarin/Coumadin levels according to patients INR laboratory value.

ANTICOAGULATION DECISION SUPPORT		
Indication	Target INR	Duration of therapy
<i>Deep vein thrombosis (DVT) or Pulmonary embolism (PE)</i> <ul style="list-style-type: none"> ○ 1st episode, transient risk factor ○ 1st episode, idiopathic DVT 	<ul style="list-style-type: none"> ▪ 2.0 - 3.0 ▪ 2.0 - 3.0 	<ul style="list-style-type: none"> ▪ 3 months ▪ 6 to 12 months*

<ul style="list-style-type: none"> ○ 1st episode, patient with cancer ○ 1st episode and single risk factor[^] 	<ul style="list-style-type: none"> ▪ 2.0 - 3.0 ▪ 2.0 - 3.0 	<ul style="list-style-type: none"> ▪ LMWH for 3 to 6 months, then warfarin; treat until cancer is resolved* ▪ 6 to 12 months*
ANTICOAGULATION DECISION SUPPORT		
Indication	Target INR	Duration of therapy
<ul style="list-style-type: none"> ○ 1st episode, antiphospholipid antibodies or at least two risk[^] ○ Recurrent DVT <p>Atrial fibrillation</p> <p>Valvular disease</p> <ul style="list-style-type: none"> ○ Rheumatic mitral valve and atrial fibrillation or previous emboli ○ Rheumatic mitral valve disease, normal sinus rhythm, and left atrial diameter >5.5 cm ○ Aortic St. Jude Medical bileaflet valve ○ Mitral tilting disk valves and bileaflet mechanical valves ○ Aortic CarboMedics bileaflet or Medtronic Hall tilting disk valves, normal sinus rhythm, and no LAE ○ Mechanical valves with risk factors (atrial fibrillation, myocardial infarction, LAE, endocardial damage, low ejection fraction) ○ Caged ball or disk valve ○ Mechanical valve with breakthrough embolism despite INR 2.0 to 3.0 ○ Bioprosthetic valve (mitral) ○ Bioprosthetic valve (aortic) 	<ul style="list-style-type: none"> ▪ 2.0 - 3.0 ▪ 2.0 - 3.0 ▪ 2.0 - 3.0 ▪ 2.0 - 3.0 ▪ 2.0 - 3.0 ▪ 2.5 - 3.5 ▪ 2.0 - 3.0 ▪ 2.5 - 3.5 ▪ 2.5 - 3.5 ▪ 2.0 - 3.0 ▪ 2.0 - 3.0 	<ul style="list-style-type: none"> ▪ 12months* ▪ Indefinitely ▪ Indefinitely[¥] ▪ Indefinitely ▪ Indefinitely ▪ Indefinitely ▪ Indefinitely ▪ Indefinitely ▪ Indefinitely,* low-dose aspirin (ASA) ▪ Indefinitely,* low-dose ASA ▪ Indefinitely,* low-dose ASA ▪ 3 months after placement 3 months of warfarin or ASA

* - Consider indefinite therapy for selected patients

[^] - Deficiency of antithrombin III, protein C, or protein S; prothrombotic gene mutation such as V Leiden or prothrombin 20210; homocystinemia, or factor VIII levels above the 90th percentile of normal; or persistent residual thrombosis on repeated testing with compression ultrasonography.

[¥] - Not indicated in patients younger than 65 years who do not have risk factors (i.e., heart failure, hypertension, previous ischemic stroke or transient ischemic attack, or diabetes mellitus).

DOSAGE ADJUSTMENT ALGORITHMS

For target INR of 2.0 to 3.0, no bleeding:*

INR	< 1.5	1.5 to 1.9	2.0 to 3.0	3.1 to 3.9	4.0 to 4.9	≥ 5.0
Adjustment	Increase dose 10 to 20%; consider extra dose	Increase dose 5 to 10% [^]	No change	Decrease dose 5 to 10% [^]	Hold for 0 to 1 day then decrease dose 10%	See below.
Next INR	4 to 8 days	7 to 14 days	No. of consecutive in-range INRs x 1 wk (max: 4wks) [¥]	7 to 14 days	4 to 8 days	See below.

For target INR of 2.5 to 3.5, no bleeding:*

INR	< 1.5	1.5 to 2.4	2.50 to 3.5	3.6 to 4.5	4.5 to 6.0	> 6.0
Adjustment	Increase dose 10 to 20%; consider extra dose	Increase dose 5 to 10% [§]	No change	Decrease dose 5 to 10%; consider holding one dose [§]	Hold for 1 to 2 days then decrease dose 5 to 15%	See below.
Next INR	4 to 8 days	7 to 14 days	No. of consecutive in-range INRs x 1 wk (max: 4wks) [¥]	7 to 14 days	2 to 8 days	See below.

[^] - If INR is 1.8 to 1.9 or 3.1 to 3.2, consider no change with repeat INR in 7 to 14 days.

[¥] - For example, if a patient has had three consecutive in-range INR values, recheck in 3 weeks.

[§] - If INR is 2.3 to 2.4 or 3.6 to 3.7, consider no change with repeat INR in 7 to 14 days.

MANAGEMENT OF SIGNIFICANTLY ELEVATED INR WITH OR WITHOUT BLEEDING

- INR 5.0 to 8.9, no significant bleeding: Omit 1 to 2 doses; reduce 10 to 20 percent; monitor frequently. Alternately consider vitamin K1 to 2.5 mg orally.
- INR ≥ 9.0, no significant bleeding: Hold warfarin therapy; give vitamin K1 5 to 10 mg orally; monitor frequently. Resume at lower dose when INR is therapeutic.
- Serious bleeding, any INR: Hold warfarin; give vitamin K1 10 mg slow intravenous (IV) plus fresh plasma or prothrombin complex concentrate, depending on urgency; repeat vitamin K1 every 12 hours as needed.
- Life-threatening bleeding, any INR: Hold warfarin; give prothrombin complex concentrate (or recombinant factor VIIa as an alternate) supplemented with vitamin K1 (10mg slow IV); repeat as needed.

NOTE:

- Never hold for more than 2 days before next PT/INR.

DEFINITIONS:

None

Subject: Referrals	Manual: Clinic
-------------------------------------	---------------------------------

POLICY:

It is the policy of Southern Humboldt Community Healthcare District (“SHCHD”, “District”, “SoHum Health”) to provide patients with appropriate referrals for additional testing and/or consultations with specialists as deemed necessary by the Provider.

PROCEDURE:

- Patients require an appointment to be evaluated for referral(s).
- Provider will:
 - Determine the patient’s need for referral.
 - Explain to the patient the reasons, benefits, and potential complications for referral.
 - Complete the appropriate referral form:
 - Referral Request
 - Diagnostic Imaging Referral Request
 - Physical Therapy Referral
 - Etc.
- Patient Care Coordinator (PCC) will:
 - Give/place referral form in the designated area
- Referral Coordinator will:
 - Correlate the Referral Request form along with supporting documentation (fax cover sheet, demographics, copy of insurance cards, chart note, medication list, etc.) and fax to the appropriate facility and/or specialist office.
 - Generate and mail a Referral Follow-Up Letter to the patient. This letter includes the name of the specialist/diagnostic center, phone number, and any other pertinent information. *See Referral Follow-Up Letter for example.*
 - Scan the Referral documentation into the patients in the patient’s electronic medical record (EMR) in the designated section.
 - Obtain pre-authorization as necessary if required by the insurance company.
 - Resubmit referral to different specialist’s office as a result of a declined referral or due to patient’s request. The Declined Referral Follow-Up Letter will be used to communicate these changes. *See Declined Referral Follow-Up Letter for example.*
 - Follow-up on Urgent referrals to see if patient has been scheduled, seen, or refused referral.
 - Document prior authorization, who the patient was referred to and for what and any other pertinent information done in the Patient Communication section of the patient’s EMR.
- A Referrals Brochure on the referral process is available for patients. *See attached Referral brochure.*
- Any communication on patient’s scheduled appointment(s) from various specialists will be scanned into the patient’s EMR in the designated section.
- Follow-up
 - Bi-monthly, the Referrals Coordinator will review referrals sent for receipt of referred provider’s chart notes or imaging report or if chart note or appointment time is not present, then calls the referred provider to obtain chart notes, via fax.
 - Once notes are scanned into the EMR, the referral is considered completed.
 - The Referral Coordinator follows up if a patient call is received, stating they have not heard from the referred provider.
 - The Referral Coordinator monitors compliance/attendance when instructed by the PCP for some patients that may need additional assistance in the referral process.

DEFINITIONS:

None

Subject: Specialists Most Commonly Used	Manual: Clinic
--	---------------------------------

POLICY:

It is the policy of Southern Humboldt Community Healthcare District (“SHCHD”, “District”, “SoHum Health”) to provide quality patient care, which includes the referral to additional medical professionals, services, and care.

The purpose of this policy and procedure is to outline the most used specialist. The primary care provider (PCP) will determine the type of provider and specialty based on the individual patient needs such as diagnosis.

PROCEDURE:

1. When possible, a referral will be made to a specialist who visits the Southern Humboldt Community Clinic to save the patient from long distance travel. However, should the need for the referral be sooner than the next specialist visit, a referral to the specialist in their city may be needed. In addition, the patient may wish to travel to see the specialist and the PCP shall take that into consideration when placing the referral.
2. The list of specialists below are the most commonly used, however there may be others that a referral may be made to depending on the patients’ needs.
3. Whenever possible, a referral will be made to a provider/organization that is participating with the patient’s insurance plan, however this cannot always be guaranteed and ultimately, it is the patient’s responsibility to determine if the specialist is in network or out of network.

See Attachment *List of Most Commonly Used Specialties*

DEFINITIONS:

None

Subject: Test Results	Manual: Clinic
--	---------------------------------

POLICY:

It is the policy of Southern Humboldt Community Healthcare District (“SHCHD”, “District”, “SoHum Health”) to review and notify clinic patients of their laboratory, radiology, and/or other diagnostic test results in a routine manner to ensure accurate diagnoses, effective attention and treatment, and optimal patient care.

PROCEDURE:

Results Received Electronically

- Laboratory, radiology, and diagnostic results from departments within the District are uploaded into the patient’s electronic health record (EHR) and are flagged for the ordering provider to review on their scheduled work days.
- During vacations, the clinic nurse manager will review the vacationed provider’s results and triage them to other clinic providers accordingly.
- Notification of Results:
 - The provider will send a *Patient Communication* through EHR to the Patient Care Coordinator (PCC) with directions of how to proceed with the result. The Provider will include the test in reference to and any pertinent information.
 - NORMAL-
 - The PCC will phone the patient and speak with the patient or patient’s designated representative.
 - The PCC will notify them of their results per the Providers directions in *Patient Communication*.
 - If the patient has further questions regarding the results, the PCC will direct the patient to make an appointment for further discussion.
 - Once the call is completed the PCC will check *Resolved* in *Patient Communication* and type “Spoke with Patient RE: Results”.
 - If unable to reach the patient after 3 attempts a letter will be generated.
 - “Test Results” letter (see attachment).
 - The letter will include the “within acceptable limits” and the test(s) performed. In addition, for Hemoglobin A1C, include the laboratory value in the letter.
 - i.e., This is to inform you that the following test(s) you had recently was/were: within acceptable limits: Complete Blood Count and Complete Metabolic Panel.
 - i.e., This is to inform you that the following test(s) you had recently was/were: within acceptable limits: A1C- 7.1.
 - For sexually transmitted infection (STI) results (Chlamydia, Gonorrhea, HIV, RPR/Syphilis) the PCC will write “On (date of test) were negative.”
 - i.e., This is to inform you that the following test(s) you had recently was/were: on 7/25/2014 were negative.
 - For tests that results are given as negative the PCC will write “Negative” and the test(s) performed. An example of these tests might be: Lyme, Fecal Occult Blood, H. Pylori, Hepatitis B or C, Mono, etc.
 - i.e., This is to inform you that the following test(s) you had recently was/were: Negative: Hepatitis C.
- The letter is then mailed to the patient.
- Once the letter is completed the PCC will check *Resolved* in *Patient Communication* and type “Letter Sent.”
- APPOINTMENT REQUEST

- The PCC will send an email to the group scheduling requesting an appointment to be scheduled.
- The PCC will include name of Patient/DOB/Reason for Appointment Request (i.e. Test Results) and any other pertinent information (i.e., Urgent) in the Message.
- The PCC will update the *Patient Communication* as *In Progress* and type "Appointment Request sent to Scheduling staff".
- The scheduler will call the patient to schedule an appointment.
 - If the scheduler cannot reach the patient after three attempts have been made, the scheduler will send the patient the "Follow-up Appointment Needed Letter".
 - The Scheduler will document the actions taken and/or patient's scheduled appointment date and time by sending a return *email* to the PCC.
- The PCC
 - Will update *Resolved* in *Patient Communication* with either appointment date OR what action was taken by scheduler.

Results Received via Electronic Fax

- Urgent results will be triaged to the clinic nurse manager for review if the ordering Provider is unavailable that day to review them.
- Results will be placed in the ordering and/or c.c. clinic Provider's electronic folder and will be reviewed on their scheduled workdays.
- During vacations, the clinic nurse manager will review the vacationed Provider's results and triage them to other clinic Providers accordingly.
- Provider's will review results/records in electronical fax and notify their PCC of any action needed via *Patient Communication*.

Note:

- A "Test Results" letter will ONLY be generated for tests ordered by clinic Providers.
- A letter will NOT be sent for Mammograms. Patients are notified of their Mammogram results by the Radiology Department.

DEFINITIONS:

None

Subject: Tobacco Cessation Monitoring & Education	Manual: Clinic
--	---------------------------------

POLICY:

It is the policy of Southern Humboldt Community Healthcare District (“SHCHD”, “District”, “SoHum Health”) to provide education on smoking cessation.

The purpose of this policy and procedure is to delineate the steps taken to ensure tobacco cessation education.

PROCEDURE:

- Patient Care Coordinator (PCC) or designee will document patient’s tobacco use under “Social History.” Refer to *Clinic Intake Policy and Procedure* for documentation procedure.
- PCC or designee will offer/have information on smoking cessation available for patients who are tobacco dependent.
 - Use smoking cessation education and management tools.
 - Patient care instructions through Healthland Centriq
 - *Smoking Cessation, Easy-to-read*
 - Resources
 - *1-800-QUIT-NOW*
 - *1-800-NO-BUTTS*
 - *SmokeFree.gov*
- PCC or designee will document cessation education in “Social History.”
 - If patient declines information “Patient Refused” option should be chosen. If patient accepts information “Tobacco Cessation Counseling Performed” or “Given” should be chosen.
 - Comments section is utilized to document what education information was given to patient (e.g., smoking cessation through Centriq, phone number to 1-800-NO-BUTTS).
- Provider should follow the *Tobacco Use Patients Assessment, Educate, and Managing Flowchart* when addressing tobacco cessation.
 - The use of the 5 R’s of Motivation: Relevance, Risks, Rewards, Roadblocks, and Repetition can be a beneficial tool to use for patients not willing to make an attempt at quitting.
 - Document discussions with patient regarding tobacco cessation.
 - Use *Pharmacologic Product Guide: FDA-Approved Medications for Smoking Cessation* as an aid when prescribing nicotine replacement therapy.

DEFINITIONS:

None

Subject: Employee Vaccination & TB Testing	Manual: Clinic
---	---------------------------------

POLICY:

It is the policy of Southern Humboldt Community Healthcare District (“SHCHD”, “District”, “SoHum Health”) to provide a safe, healthful work environment for its employees. In order to achieve this goal, the District may require employees to undergo TB testing and receive certain other vaccinations as a condition of employment. Establish a program to ensure the health and safety of employees at Your County Health District, doing business as Clinic Name Here (the District), by requiring TB testing of all employees and certain vaccinations be given to employees based upon their position/occupational exposure risk.

PROCEDURE:

- All employees will undergo TB testing at hire and as necessary when a potential exposure is suspected.
- Dietary personnel will be offered the hepatitis “A” vaccine at the time of hire.
- Employees will be offered the flu vaccine as long as there are sufficient supplies of the vaccine.
- If the District believes an employee will have a reasonably anticipated occupational exposure to hepatitis “B”, the employee will receive appropriate training and will be offered the hepatitis “B” vaccination series and any boosters as recommended. Taking the hepatitis “B” series is not mandatory, nor is it a bona fide occupational qualification. Employees may decline the hepatitis “B” series initially and later change their mind and receive the series. All costs associated with this policy will be borne by the District.

DEFINITIONS:

None

Subject: Animal Bite Treatment	Manual: Clinic
---	---------------------------------

POLICY:

It is the policy of Southern Humboldt Community Healthcare District (“SHCHD”, “District”, “SoHum Health”) to provide optimal patient care and the following procedures for the staff to follow when caring for the patient with an animal bite.

Procedure:

The purpose of this policy and procedure is to provide guidelines for the treatment of animal bites. Direct pressure should be applied to actively bleeding wounds and a neurovascular assessment should be performed in areas distal to the wound. Deep wounds to vital structures should be treated as major penetrating trauma and triaged to the Emergency Room.

Meticulous wound care constitutes one of the most important steps in treating a laceration due to an animal or human bite.

The wound should be carefully explored to identify injury to underlying structures and the possible presence of a foreign body. Wounds over or near the metacarpophalangeal joints should be explored carefully in the anatomical AND the clenched-fist position to assess for damage to the underlying tendon sheath, fascia, joint capsule, and metacarpal head. If a potentially deep bite occurs near a bone or if a foreign body might be present, appropriate imaging should be obtained (e.g. plain radiograph or ultrasound).

- Be sure the HPI includes date, time, location and species of animal, circumstance of attack, i.e. breaking up a dog fight vs. unprovoked attack or other abnormal behavior of animal.
- Consider rabies prophylaxis. Rule of thumb: cats, dogs, humans - no; bats, foxes, skunks, raccoons – yes.
- It is advised to capture and hold the animal or carcass. For testing of an animal, contact Environmental Health weekdays (445-6215), and Sheriff Dispatch (445-7251) after hours.
- If you have questions regarding the need to begin prophylaxis, contact the County Office of Environmental Health for assistance. Humboldt County Department of Public Health may also be consulted (445-6200).
- California Department of Public Health online can also be used as a reference.
- For dog and cat bites, complete the Animal Bite Report Form. Can be obtained electronically through Humboldt Government website. Fax form as soon as possible to (707) 840-9185, and then mail form as directed.
- For bites from other animals, call Environmental Health at (707) 445-6215. They do not need the form completed. They will want to know the patient’s name, phone number, bite information, and whether or not the rabies protocol has been initiated.

Rabies Postexposure Treatment and Vaccination

All postexposure treatment should begin with immediate cleansing of the wound with soap and water (for approximately 15 minutes).

Rabies Immune Globulin (RIG)

- Persons **not** previously immunized:
 - Local wound infiltration/IM: 20 units/kg in a single dose, RIG should always be administered as part of rabies vaccine regimen. If anatomically feasible, the full rabies immune globulin dose should be infiltrated around and into the wound(s); remaining volume should be administered IM at a site distant from the vaccine administration site. If rabies vaccine was initiated without rabies immune globulin, rabies immune globulin may be administered through the seventh day after the administration of the first dose of the vaccine (day 0). Administration of RIG is not recommended after the seventh day post vaccine since an antibody response to the vaccine is expected during this time period.
- Persons previously immunized:
 - Do not administer rabies immune globulin.

Rabies Vaccine

- Persons **not** previously immunized:
 - Immunocompetent: IM: 4 doses (1mL each) on days 0, 3, 7, 14
 - Immunocompromised: IM: 5 doses (1mL each) on 0, 3, 7, 14, 28
- Persons who have previously received postexposure prophylaxis with rabies vaccine, received a recommended IM pre-exposure series of rabies vaccine or have previously documented rabies antibody titer considered adequate:
 - IM: Two doses (1mL each) on days 0 and 3; do not administer rabies immune globulin.

Notify pharmacy to order follow-up vaccine to complete series.

DEFINITIONS:

None

Subject: Code Blue	Manual: Clinic
-------------------------------------	---------------------------------

POLICY:

It is the policy of Southern Humboldt Community Healthcare District (“SHCHD”, “District”, “SoHum Health”) to alert staff throughout the facility when the clinic encounters a cardiac or respiratory emergency situation or any life-threatening situation when a patient's condition is deteriorating rapidly.

The purpose of this policy is to describe the emergency code blue procedure in the Clinic.

PROCEDURE:

The Clinic is a Basic Life Support (BLS) provider.

When an individual encounters an emergency situation, he/she should:

- Assess the situation
 - Check the patient for unresponsiveness or life threatening emergencies.
 - Communicate the emergency by calling out "Help."
 - **Page a code blue and identify the area.**
 - Begin BLS according to American Heart Association or American Red Cross guidelines.
- All individuals who hear the emergency code should respond appropriately according to the "Emergency Codes" policy.
- You may be asked to do **any of the following**:
 - Help with CPR, as needed.
 - Bring the backboard to the scene (located in Exam Room 3).
 - Help place patient onto backboard and then gurney.
 - Remove bystanders and extra furniture from the scene.
 - Help transport the patient to the emergency room.
- The patient will be transferred to Jerold Phelps Community Hospital Emergency Department as soon as stable enough to move them and headed off to the physician covering the emergency room.
- At the conclusion of the emergency situation it is essential that someone take the responsibility to call an "All Clear". See policy "Emergency Codes" for procedure.
- A staff person from Southern Humboldt Community Clinic will stay with the patient's family if available to answer questions and provide support.
- Efforts shall be made to contact the family at the first available opportunity. The attending provider shall inform the family of the patient's status.
- The patient's provider will complete appropriate documentation.

THE EMERGENCY KIT:

The emergency kit kept in the Clinic includes the following and is located at the nursing station:

- Airways
 - Nasal
 - Oral
- Bag-valve-mask ventilator
- Oxygen Mask

- Oxygen
- Anaphylaxis kit (epinephrine, diphenhydramine, and Solu-Medrol)

Anaphylaxis Treatment

Only licensed medical professionals can administer medications.

- Medications Available
 - Oxygen via face mask 100% high flow
 - Epinephrine: 1:1000 (1mg/mL)
 - ◆ Adult: 0.3-0.5mg (0.3-0.5mL) IM
 - ◆ Pediatric: 0.01mg/kg IM
 - ◆ May repeat in 5 to 15 minutes
 - Diphenhydramine (Benadryl):
 - ◆ Adult: 25-50mg IM/IV
 - ◆ Pediatric: 1mg/kg IM/IV, max 40mg
 - Methylprednisolone (Solu-medrol):
 - ◆ Adult: 125mg IM/IV
 - ◆ Pediatric: 1mg/kg IM/IV, max 30mg

DEFINITIONS:

None

Subject: Electrical Power Failure	Manual: Clinic
--	---------------------------------

POLICY:

It is the policy of Southern Humboldt Community Healthcare District (“SHCHD”, “District”, “SoHum Health”) to provide a plan for clinic operations during power system failures.

The purpose of this policy and procedure is to delineate the process in which the clinic will respond in the event that the electrical power is interrupted or has failed.

PROCEDURE:

The clinic is not supported by the hospital’s emergency power system. The clinic has a separate gasoline powered generator that is maintained by Engineering. In the event of a power outage, the Clinic Reception Area, Patient Exam Rooms 2, 5, 6, 7 and 8 can be powered using the generator and extension cords.

Pre-event:

1. An adequate supply of flashlights and extra batteries shall be maintained in the clinic at all times.
2. Flashlights shall be stored in appropriate and accessible locations in the building.
3. All clinic patient staff shall be trained in the location of emergency flashlights and the department procedure for electrical power failure.

During:

1. Each staff member on duty will immediately obtain an emergency flashlight if necessary.
2. Staff members will contact each patient or visitor inside the clinic building to inform them of the power failure. Patients and visitors will be reassured and instructed to remain calm. Exit routes will be identified for patients and visitors.
3. The Engineering Manager or designee will keep in close contact with the electric company so that schedulers may optimize the rescheduling of appointments.
4. If the duration of the power failure is greater than 90 minutes, patients may be discharged, and appointments rescheduled.
5. Schedulers will contact scheduled patients, confirming that their appointments will be kept.
6. One nursing staff member and one practitioner will remain on duty in the clinic to accommodate walk-ins and patients who were unable to be contacted, *if closure or rescheduling of patients is determined to be appropriate.*

After:

1. An evaluation of department policy and procedures, as well as, staff performance will be made. Written documentation of the evaluation will be maintained.
2. Department policies and procedures will be modified as indicated by the post-evaluation event.
3. All department staff will receive training of any policy or procedure, which is modified as a result of the evaluation.

DEFINITIONS:

None

Subject: Key Access	Manual: Clinic
--------------------------------------	---------------------------------

POLICY:

It is the policy of Southern Humboldt Community Healthcare District (“SHCHD”, “District”, “SoHum Health”) to maintain a secure environment in the clinic.

PURPOSE:

The purpose of this policy and procedure is to describe clinic key access procedures.

PROCEDURE:

Security:

Clinic staff is expected to acknowledge the importance of protecting District assets. We achieve this by providing access to employees, patients, and others only as necessary. Employees are instructed not to lend their keys to anyone. Employees are only assigned keys required for the performance of their job duties.

KEYS:

- Distribution and maintenance of keys to file, supply, and medication cabinets along with clinic desks and the clinic nursing station are the responsibility of the Clinic Nurse Manager. The Director of Patient Care Services assumes this responsibility in the absence of the Clinic Nurse Manager.
- Patient Care Coordinators (PCC) will have key access to the clinic supply cabinets, clinic nursing station, clinic medication cabinets, clinic rooms, and clinic medical records. The clinic medical records employee will have a key to clinic medical records. The Director of Patient Care Services and Practitioners will have key access to their office. In addition, the Emergency Room nurse will have key access to the clinic providers’ offices and clinic rooms.
- It is the responsibility of the Clinic Nurse Manager to determine appropriate access to any other locked area in the clinic.
- Employees whose job duties include unlocking/locking the waiting area public access doors may be issued a key to outside doors by the Engineering Supervisor.
- Non-staff members providing contract services must make special arrangements for access to the Clinic with the director or supervisor responsible for oversight of their engagement.

Clinic Lock-up Steps:

At the end of the business day the Clinic Nurse Manager or designee will:

- Close and lock all windows and doors;
- Check that the medication cabinets are locked;
- Check that the treatment room cabinets are locked;
- Check that all the supply cabinets are locked and/or nursing station is locked;
- Turn off all lights;
- Notify anyone remaining in the building of steps not completed.

DEFINITIONS:

None

Subject: Abusive and/or Assaultive Patients	Manual: Clinic
--	---------------------------------

POLICY:

It is the policy of Southern Humboldt Community Healthcare District (“SHCHD”, “District”, “SoHum Health”) to ~~not condone~~ to not tolerate abusive and/or assaultive behavior from patients and/or their families. The purpose of this policy and procedure is to delineate the procedures for dealing with abusive and/or assaultive patients and/or their families.

DEFINITIONS:

Abusive behavior: loud, argumentative voice; shouting, yelling, profanity.

Assaultive behavior: physically striking-out

PROCEDURE:

- Individuals who exhibit either abusive or assaultive behavior toward any member of District staff will be clearly told to cease this activity immediately. If staff feels threatened, they may call a “Code Gray” to obtain assistance. If necessary, staff should call 911 for assistance and notify Humboldt County Sheriff’s Department.
- A report in RLDatrix needs to be completed.
- After this event, the patient and/or family will receive a written notice from the district that abusive and/or assaultive behavior will not be tolerated, and any further episodes will result in dismissal from the medical practice.
- If there is a second occurrence of same or similar behavior, the patient and/or family will receive a letter of dismissal from the practice. This letter will be sent by certified mail. The letter will clearly state that true emergency services will continue to be available through the Emergency Department and that any prescription medications will be supported for thirty (30) days.
- In the event that the behavior of an individual is so extreme that there is concern for immediate safety, the patient can be discharged from the practice immediately; however, a certified letter is still required.
- A copy of the dismissal letter will be kept in the patient’s medical record.

Subject: Allergy Injections	Manual: Clinic
--	---------------------------------

POLICY:

It is the policy of Southern Humboldt Community Healthcare District (“SHCHD”, “District”, “SoHum Health”) to provide the service of allergy injections to our clinic patients.

PROCEDURE:

1. A written order received from the patient’s allergy provider is reviewed and approved by the clinic physician and/or midlevel provider.
2. The patient’s allergy medication is labeled with the patient's name, concentration of extract, and expiration dose. The medication is stored in the refrigerator between 1.67°C (36°F) and 7.7°C (46°F).
3. A form provided by the patient’s allergy provider will be used to document the patient’s immunotherapy injections.
4. The patient is required to return to their allergy provider when there are no doses remaining of their allergy medication.

Administration of Injections:

1. Allergy injections must be given in a medical facility with a physician on site.
2. Allergy injection vials must be refrigerated.
3. Ask the patient if there were any problems with the previous injection, then select dose accordingly.
4. Use a 1mL disposable allergy or tuberculin syringe with a 26-gauge or 27-gauge needle.
5. Check vial for correct patient identification and dilution; shake vial before dose is withdrawn.
6. Observe sterile technique: follow appropriate OSHA guidelines.
7. Give injection subcutaneously in the back portion of the upper arm, four to six inches above the elbow. Pinch the skin and insert the needle straight in. After inserting the needle, gently aspirate for three seconds. If no blood appears, proceed with the injection. If blood appears, withdraw the needle, and select a new site.
8. 30-minute wait time: Each patient is required to wait 30 minutes in a medical facility after his/her allergy injection so that he/she can be checked for local and systemic reactions.
9. Because of liability, patients will be notified that if they refuse to wait the 30 minutes in the facility, they will no longer be able to get allergy injections at SoHum clinic.
10. Either arm may be used, or the arms may be alternated.

Precautions:

1. NEVER give an allergy injection unless Epinephrine and extra syringe are readily available, along with other medications and equipment for treating systemic anaphylaxis. A PHYSICIAN/MIDLEVEL PROVIDER MUST BE IMMEDIATELY AVAILABLE AT ALL TIMES WHEN INJECTIONS ARE GIVEN.
2. Do not give the injection if the patient is having acute wheezing, acute or severe allergy symptoms, or fever greater than 99.5 degrees.
3. Do not administer allergy injections to a patient who is on a beta blocker medication unless a special exception has been made by the allergist/immunologist prescribing the allergy extract.
4. The patient should not engage in vigorous exercise for one hour before and two hours after an allergy injection.
5. Notify specialist office if the patient becomes pregnant.

Immunotherapy Build-up Schedule:

See specific Allergy and Asthma Specialist Policies and Procedures for procedure.

Humboldt Medical Specialists Allergy and Immunology

- Immunotherapy: General Instructions for Giving Allergy Injections
- Allergy Injection Dose Escalation after Re-Mixed Vials
- Immunotherapy: Adjustment to Giving Allergy Injections During the Grass Pollen Season. Allergy and Asthma Adult and Pediatric Medical Group of the Redwoods, Inc.
- Immunotherapy Build-up Process
- Introduction to Immunotherapy
- Red Vial Maintenance
- Required Knowledge for Outpatient Clinics.

Reactions to Allergy Injections

Local Reactions

Treatment:

Applying an ice pack to the injection site will usually relieve discomfort. An oral antihistamine also is indicated. An analgesic such as acetaminophen may be used.

Systemic Reaction:

Systemic reactions are evidenced by throat tightness, tongue swelling, wheezing, chest tightness, cough, nasal symptoms, and generalized hives. Rarely, hypotension and cardio-respiratory arrest may occur.

In Case of Systemic Reaction:

- **NOTIFY PHYSICIAN IMMEDIATELY**
- Give Epinephrine 1:1000 (1mg/mL) IM STAT
 - >60 lbs.: 0.3mL
 - <60 lbs.: 0.1mL
- Dose may be repeated in 5 to 10 minutes if no response.
- Give Benadryl (Diphenhydramine) IM
 - >12 years old: 50mg
 - <12 years old: 25mg
- Monitor blood pressure and pulse every 10 minutes
- Further emergency procedures should be at the discretion of the attending physician.
- Transport the patient to the emergency room.

Note: If the patient experiences a systemic reaction following an allergy injection, they will need to return to the specialist office for further instructions prior to the administration of further allergy injection.

DEFINITIONS:

None

Subject: Care of the Diabetic Patient and/or Resident	Manual: Skilled Nursing Facility
--	---

POLICY:

It is the policy of the Southern Humboldt Community Healthcare District ("SHCHD" or "District") to provide appropriate care of the patient and/or resident ("patient") with diabetes.

PURPOSE:

The purpose of this policy and procedure is to outline specific nursing assessment and documentation for patients with diabetes.

PROCEDURE:

The initial assessment by a licensed nurse should include, but is not limited to the following:

- The patient's vital signs.
- The presence or absence of diaphoresis.
- The results of the last fasting blood sugar.
- The patient's level of urine sugar and acetone.
- The patient's level of consciousness.
- The patient's skin condition and turgor, particularly in the lower extremities.
- The presence or absence of wounds, infections, or gangrenous sites.
- The patient's medications.

The licensed nurse is to observe and document on a daily basis any or all of the following:

- Changes in the patient's level of consciousness.
- Patient complaints of sudden thirst, weakness or diaphoresis.
- Signs of systemic infection such as temperature elevation.
- The patient's dietary intake.
- The status of wounds, infections, or gangrenous sites.
- The patient's fasting blood sugars.
- The patient's insulin dosage.
- Second nurse verification for all medications.

Any Blood Glucoses obtained are to be documented in the Blood Glucose Clinical Laboratory Improvement Amendment (CLIA) test assessment and in the vitals section of the Electronic Medical Record (EMR).

Always document units given and second nurse verification in the comments section.

Report any blood glucose of 60 or less or 400 or higher to the provider and chart in EMR Blood Glucose Monitoring Flowsheet Assessment as well as vitals. Follow the INSULIN ADMINISTRATION Policy and Procedure in nursing folder.

DEFINITIONS:

None

Subject: Care of the Resident with Cardiovascular Diseases	Manual: Skilled Nursing Facility
---	---

POLICY:

It is the policy of the Southern Humboldt Community Healthcare District ("SHCHD" or "District") to provide residents with comprehensive cardiovascular nursing care.

PURPOSE:

The purpose of this policy and procedure is to outline specific nursing assessment and documentation for patients with diabetes.

PROCEDURE:

The initial and daily assessment by a licensed nurse should include, but is not limited to, observing and recording:

- The resident's vital signs.
- The resident's color.
- Any edema in the lower extremities.
- Any dyspnea, particularly upon exertion.
- Resident's complaints of chest pain or palpitations.
- The presence of neck vein distention.
- The mobility or functional endurance of the resident.
- The resident's response to his drug regimen; for example, evidence of, bruising or bleeding when receiving anticoagulants, or bradycardia on digoxin.
- The resident's intake and output, or weight changes when receiving diuretics.
- Apical radial differential, particularly on residents with an arrhythmia or pacemaker.
- The resident's response to transfer and increased ambulatory levels.

The licensed nurse is to observe and document on a daily basis any or all of the following:

- The resident's vital signs.
- The presence or absence of cyanosis or dyspnea, particularly with activity or orthopnea.
- The presence or absence of edema in the lower extremities.
- The presence or absence of cough or pulmonary congestion.
- Resident's complaints of chest pain or palpitations.
- The presence of diaphoresis.
- Evidence of peripheral vascular impairment, such as a cold or mottled lower extremity.

DEFINITIONS:

None

Subject: Care of the Resident with Genitourinary Tract Disorders	Manual: Skilled Nursing Facility
---	---

POLICY:

It is the policy of the Southern Humboldt Community Healthcare District ("SHCHD" or "District") to provide appropriate nursing care for residents with genitourinary tract disorders.

PURPOSE:

The purpose of this policy and procedure is to delineate the process for nursing care and documentation for the resident with a genitourinary tract disorder.

PROCEDURE:

The initial assessment by a licensed nurse should include, but is not limited to, observing and recording:

- The quality of the resident's vital signs.
- The color, consistency, and amount of the resident's urine. (The number of wet briefs per shift.)
- The patency of the catheter if present.
- Any abdominal distention or discomfort.
- The resident's color (for evidence of temperature elevation and hydration status.)

The licensed nurse is to observe and document on a daily basis all of the following:

- The resident's temperature.
- The resident's voiding patterns, such as frequency or incontinency.
- Any complaints of burning or pain with voiding.
- Any changes in urine, such as color, odor or consistency.
- Any abdominal pain or distention.
- The presence of a catheter and, if one, its patency, and the resident's intake and output.
- Any evidence of blood in the resident's urine.

The licensed nurse is to document treatments as ordered by the physician and is to observe and document the resident's response. For example:

- Note and report results of urinalysis or culture and sensitivity reports.
- Note whether or not specific symptoms of infection are alleviated in response to antibiotic use, and any complaints of rash or itching.
- Document the resident's progress in a formal bladder training program.
- Note and record the color and consistency of urine upon irrigating a Foley catheter.

DEFINITIONS:

None

Subject: Care of the Resident with Neurological Disorders	Manual: Skilled Nursing Facility
--	---

POLICY:

It is the policy of the Southern Humboldt Community Healthcare District ("SHCHD" or "District") to provide appropriate nursing care for residents with neurological disorders.

PURPOSE:

The purpose of this policy and procedure is to delineate the process for nursing care and documentation for the resident with a neurological disorder.

PROCEDURE:

The initial assessment by a licensed nurse should include, but is not limited to, observing and recording:

- The quality of the resident's vital signs.
- The resident's level of consciousness or response to verbal stimuli.
- The resident's neurological signs and reflexes.
- The resident's speech ability or dysphagia.
- The resident's bladder and bowel function.
- The resident's functional ability in sitting, transferring, eating, dressing, etc.
- Any evidence of contractures.

The licensed nurse is to observe and document daily all of the following:

- Changes in quality of the resident's vital signs.
- Changes in level of consciousness, or occurrence of seizures.
- The degree of impairment in the resident's extremities, i.e., loss of sensation, reflex, dependent edema, or early evidence of contractures.
- The resident's response to verbal stimuli.

The licensed nurse is to observe and record the resident's functional level in activities of daily living, for example:

Level of Awareness:

"Resident is nonresponsive to verbal stimuli but opens eyes and follows movement after position change."

Transfer Ability:

"Transfers to bedside chair with the assistance of one person."

Activities of Daily Living:

"Resident self-feeding with assistance in cutting of food; self-dresses upper extremities; requires assistance with footwear only."

DEFINITIONS:

None

Subject:
Certified Nursing Assistant (CNA) Documentation

Manual:
Skilled Nursing Facility

POLICY:

It is the policy of the Southern Humboldt Community Healthcare District ("SHCHD" or "District") to provide up-to-date resident conditions and documentation for the care team.

PURPOSE:

The purpose of this policy and procedure is to outline the documentation requirements of the Certified Nursing Assistants (CNAs).

PROCEDURE:

Each shift the CNA will complete the CNA Daily Record located in the Electronic Medical Record (EMR) system. Once a day, the day shift CNA will complete the Activity Flow Sheet also located in the EMR. When there is not a CNA, the nurse caring for the resident is responsible for completing these forms.

The CNA Daily Care Record includes the following information:

- Care Team
- Whether they were able to care for the resident (if they were out of the facility.)
- Bathing/Showering
- Bed Linen Services
- Oral Care
- Peri-care
- Foley Care
- Bladder Elimination & Bowel Movements
- Dressing Patient
- Mobility & Transfer
- Therapy (Speech or Physical)
- Safety
- Meals
- Sleeping Pattern
- Skin Observation
- Mood/Behavior/Emotional State

Any changes in the resident must be reported to the nurse caring for the resident immediately.

The Activity Flow Sheet includes the following information:

- Inside Activities
- Do Hair
- Nails
- Cards
- Arts & Crafts
- Games
- Indoor Walks
- Arm Exercises
- Leg Exercises
- Propels wheelchair
- Family Visit
- Grooming

- Decorates
- Party

- Exercise Program
- Writes Letter
- Reads
- Listens to Radio
- Television
- Movies
- Visits others
- One on One
- Dining Room
- Computer
- Church
- Bible Study
- Outside Activities
- Physical Therapy
- Speech Therapy
- Outing
- Gardening
- Telephone calls
- Puzzles

DEFINITIONS:

None

Subject: Elastic bandages (ACE) and Pressure Stockings	Manual: Skilled Nursing Facility
---	---

POLICY:

It is the policy of the Southern Humboldt Community Healthcare District ("SHCHD" or "District") to provide appropriate application of elastic bandages/Ace wraps and pressure stockings.

PURPOSE:

The purpose of this policy and procedure is to be a reference for the nursing staff to ensure correct application of elastic bandage or pressure stockings. Elastic bandages or stockings are applied to the body or extremities for the following reasons:

- To give support or protection
- To hold dressings or splints in place
- To immobilize part of the body or a limb
- To prevent or reduce edema by applying pressure for support of weak blood vessels or control of bleeding

PROCEDURE:

Application of elastic bandage:

A physician's order is required for application of an elastic (Ace) bandage or pressure stocking.

An elastic bandage or stocking is applied from the distal part of the extremity toward the trunk. Position resident comfortably and support the part to be bandaged.

Begin wrapping area by making two circular turns of bandage to secure the end. Stretch only slightly to give a secure, but not tight, fit. Leave tips of fingers or toes exposed for checking circulation. When bandage is stretched tightly, circulation will be impaired.

Continue circular wrap toward trunk, overlapping $\frac{1}{2}$ to $\frac{2}{3}$ of previous layer of bandage. Make a figure eight at ankle or elbow to ensure a snug, smooth fit. Wrinkles in the bandage will cause pressure ridges. It should follow its natural course and not be stretched to make it fit.

Continue spiral up extremity with even overlapping of each turn. Do not overwrap any section. Uneven overlapping doubles the pressure in some areas giving an uneven pressure.

When bandage runs out, lap end completely over last lap and secure end with the Velcro edge of the bandage. Be sure it is comfortable and do not fasten over an area of inflammation.

Pressure Stockings and/or ace wraps must be removed once a shift for at least 30 minutes to assess skin and accomplish skin care.

Observe skin and extremities for appropriate and intact circulation and pulses; document findings in the EHR.

DEFINITIONS:

None

Subject: Notification of a Change in a Resident’s Condition or Status	Manual: Skilled Nursing Facility
--	---

POLICY:

It is the policy of the Southern Humboldt Community Healthcare District (“SHCHD” or “District”) to promptly notify the resident, his or her attending physician, and representative of changes in the resident's condition and/or status.

PURPOSE:

The purpose of this policy and procedure is to delineate when to notify the attending physician, and resident’s representative of changes in the resident's condition and/or status.

TEAM MEMBERS MAY INCLUDE:

1. Chief Nursing Officer/Director of Patient Care Services
2. Director of Nursing for Skilled Nursing Facility
3. Charge Nurse (LVN)
4. Activities Director
5. Dietician or Certified Dietary Manager
6. MDS Coordinator
7. Medical Director
8. Physical Therapist
9. Quality/Risk Coordinator
10. Utilization Coordinator
11. Pharmacy Representative
12. Resident, family member or POA

PROCEDURE:

The Nurse will notify the resident's attending Provider when:

- The resident is involved in any accident or incident that results in an injury including injuries of an unknown source.
- There is a significant deterioration in the resident's physical, mental or psychosocial status.
- There is a need to alter the resident's treatment significantly.
- The resident repeatedly refuses treatment or medications (i.e. two (2) or more consecutive times).
- The resident is discharged without proper medical authority.
- Deemed necessary or appropriate in the best interest of the resident.

Unless otherwise instructed by the resident, the Nurse will notify the resident's next of kin or representative when:

- The resident is involved in any accident or incident that results in an injury including injuries of an unknown source.
- There is a significant deterioration in the resident's physical, mental, or psychosocial status.
- There is a need to alter the resident's room assignment.
- A decision has been made to discharge the resident from the facility.
- It is necessary to transfer the resident to a higher level of care.

Except in medical emergencies, notifications will be made within eight hours (8 hours) of a change occurring in the resident's condition or status.

Regardless of the resident's mental or physical condition, nursing services will inform residents of any changes in their medical care or nursing treatments.

The Nurse will record in the resident's medical record any changes in the resident's medical condition or status.

If a significant change in the resident's physical or mental condition occurs, a comprehensive assessment of the resident's condition will be conducted by the Skilled Nursing Director/DON.

A representative of administration will notify the resident, his/her next of kin, or representative when:

- There is a change in the resident's billing.
- There is a change in resident rights under federal or state law or regulations.

There is a change in the rules of the facility that affects the rights or responsibilities of the resident

DEFINITIONS:

None

Subject: Oral Hygiene Policy for Skilled Nursing Residents and Swing Bed Patients	Manual: Skilled Nursing Facility
--	---

POLICY:

It is the policy of the Southern Humboldt Community Healthcare District (“SHCHD” or “District”) to provide a comprehensive, evidence-based oral hygiene program for residents of the Skilled Nursing Facility and Swing Bed patients.

PURPOSE:

The purpose of this policy and procedure is to assure high quality oral hygiene for Skilled Nursing Facility residents and Swing Bed patients.

PROCEDURE:

- An oral health history will be completed as part of the resident admission assessment and will include oral hygiene beliefs, practices and current state of oral health.
- All residents will have assessment of oral health documented:
 1. Within 24 hours of admission
 2. At least quarterly and annually
 3. As oral health status changes
- Residents’ oral health status will be assessed using the Oral Health Assessment Tool (OHAT) for Long-Term Care (see Appendix A). The OHAT will be reviewed and updated after each assessment.
- An individualized Oral Hygiene Care Plan will be developed and implemented based on the completed oral assessment (OHAT), resident’s preferences, functional ability, cognition and ability to cooperate and follow instructions.
- At the time of admission and throughout their stay, residents will have access to oral health professionals including dentist and dental hygienist.
 1. Based on the nursing assessment and in consultation with the resident, referrals to an oral health professional (dentist or dental hygienist) will be made.
- ORAL CARE PROCEDURE
 1. General considerations:
 - i. Prior to initiating oral care, staff should review the oral hygiene care plan and be aware of the resident’s cognitive status, their responsive behaviors, communication, sensory and functional impairments, and dysphagia.
 - ii. Staff will provide or remind residents of oral care at least twice daily. If possible, oral care should be completed in the resident’s bathroom (i.e., due to the physical cues available).
 - iii. Encourage residents to be independent with oral care. Staff will complete any oral care that the resident is not able to complete. Staff will provide or supervise the provision of oral care for those residents at risk of aspiration.
 - iv. Communicate with the resident at all times during oral care ensuring that the resident is aware of the steps of the procedure and independent tasks required.
 - v. Never use toothpaste or mouth rinses with residents who have swallowing difficulties. Only use water.
 - vi. Never use lemon glycerin swabs with oral care. They increase dryness of the mouth.
 - vii. The resident should be properly positioned (upright) to prevent aspiration before receiving oral care.
 2. Residents with Dentures

- i. Brush dentures (as you would natural teeth) at least twice daily.
 - 1. Plaque & tartar form on dentures just the same as they form on natural teeth.
 - ii. Dentures will be removed daily for at least 3 hours for gums to rest (overnight is easiest)
 - iii. Denture cups and toothbrushes will be labelled and replaced every 3 months and as required.
 - iv. Use a separate brush for any natural teeth.
 - v. Ask the resident to remove their dentures. Assist if they can't.
 - 1. For upper dentures slide your index finger along the denture's side, then push gently against the back of the denture to break the seal. Grasp it and remove by rotating it.
 - 2. Grasp lower dentures at the front and rotate.
 - 3. For partial dentures: place thumbnails over or under the clasps and apply pressure, being careful not to bend the clasps or catch them on lips or gums.
 - vi. Denture cleaning procedure:
 - 1. Wear gloves
 - 2. Line the sink with a towel
 - 3. Fill it with some cool water just in case the dentures slip and fall. Hot water can warp dentures.
 - 4. Rinse with cold water to remove food.
 - 5. Scrub dentures using a denture brush and denture paste. Never use abrasive cleaners or scouring powders
 - 6. Thoroughly brush all surfaces especially those that touch the gums. Rinse well.
 - 7. Brush the mouth tissues and tongue with soft bristle brush prior to returning dentures to the mouth.
 - 8. At bedtime, place dentures in denture cup with cool water and vinegar (½ water and ½ vinegar)
 - a. Use an alternative to vinegar on dentures with any metal on them as vinegar will cause the metal to turn black.
 - 9. NEVER use denture tablets for soaking dentures of residents with dementia
 - a. ingestion of tablets/solution is serious.
3. Natural teeth cleaning
- i. Toothpaste
 - 1. Use pea-sized amounts of toothpaste. Squeezing out a long strip of toothpaste is too much.
 - 2. Most toothpastes have a strong taste. Many residents don't like this.
 - 3. DO NOT use toothpaste for residents who have dysphagia, who cannot swallow or spit/rinse properly, or have high level of dementia.
 - 4. The foaming action of toothpaste increases saliva flow and will result in the resident wanting to spit > > choke, gag. There are oral cleansing gels available.
 - ii. Toothbrushes
 - 1. The best type of toothbrush to use for residents is one with a small head, soft bristles, larger handle with rubberized grip.
 - 2.2-Toothbrush Technique:
 - a. For residents who bite down during care or have trouble keeping their mouth open, consider using 2 toothbrushes – one to prop the mouth open and one for cleansing.
 - 3. Replace toothbrush every 3 months or after an oral infection

EDUCATION:

- Orientation: New patient care staff will receive oral hygiene care education and information during their orientation. This will include training in the use of the Oral Health Assessment Tool for Long-Term Care (OHAT).

- Continuing Education: Staff education sessions regarding oral care hygiene will be provided annually and more frequently, as necessary.
- Families of residents will be informed about the purpose of the oral care program.

MONITORING

An annual evaluation by the Nurse Manager will be performed. Additional or alternate interventions will be added as necessary. The evaluation will assess:

- Residents' satisfaction with oral hygiene care received.
- Family satisfaction with oral hygiene care provided.

DEFINITIONS:

None

Subject: Orientation of a Blind Resident	Manual: Skilled Nursing Facility
---	---

POLICY:

It is the policy of the Southern Humboldt Community Healthcare District ("SHCHD" or "District") to provide a resident, centered orientation upon being newly admitted to our Skilled Nursing Facility (SNF).

PURPOSE:

The purpose of this policy and procedure is to outline the steps for orienting a blind resident to the SNF. The blind resident is given additional orientation to the facility in order to assist in adjusting to the facility. This information will help reduce anxiety and promote resident safety.

PROCEDURE:

All hazardous areas should be marked for the blind resident so they can easily be identified (i.e. with sandpaper strips). These hazardous areas include:

- Outside exit doors
- Housekeeping area
- Utility rooms
- Kitchen

The blind resident's handrail directly outside his room should be marked with a tactile substance that is perceptible to touch to assist the resident to find their own room.

Patient Orientation includes but is not limited to the following:

- Instruct the resident in use of the call bell. Allow resident to turn the bell on several times to be sure they understand its functioning.
- Take the resident around their room explaining the position of furniture and its usage.
- If not contraindicated, take the resident out of their room (either in a wheelchair or walking) and allow the resident to become acquainted with different areas in the facility.
- Explain the facility's system of marking hazardous areas. Point out the potential danger of entering these areas.
- Explain the facility's system for identification of their room.
- Stay with resident and walk with them until they feel oriented and comfortable.

DEFINITIONS:

None

Subject: Administration of Potassium Chloride Intravenously	Manual: Emergency Department
--	---

POLICY:

It is the policy of the Southern Humboldt Community Healthcare District ("SHCHD" or "District") to treat all patients with hypokalemia effectively and safely.

PURPOSE:

The purpose of this policy and procedure is to ensure that intravenous Potassium Chloride will be safely prepared and administered.

PROCEDURE:

IV Access:

Peripheral vein, large
20-gauge intravenous catheter or larger

Diluents:

- NS, D5W or LR
- MEDICATION / DILUTIONS / INFUSION RATES
 - a) 10 mEq / 100 ml / 1 hr
 - b) 20 mEq / 250 ml / 2 hr
 - c) 40 mEq / 500 ml / 4 hr
- Maximum Concentration of Potassium Chloride is 1 mEq / 10 ml
- Maximum Infusion Rate is 10 mEq / hr

Administration Procedures:

Intravenous Potassium Chloride is delivered via a dedicated line, no other solutions or connections to the line. Potassium Chloride is **never** delivered as a bolus.

All IV Infusions of Potassium Must be Delivered by an Infusion Pump

Intravenous Potassium Chloride solutions should be prepared immediately prior to administration and the bag should be adequately mixed by inverting the bag at least 10 times. The infusion must be properly labeled with the medication, dose, and patient sticker. Potassium Chloride must be documented in full; abbreviations are not acceptable. Disconnect the infusion line as soon as infusion is completed.

Monitoring:

Cardiac Monitor, continuously, as may cause arrhythmias and EKG changes.
Assess infusion site frequently for pain and extravasation.
Immediately stop infusion if there are any signs and symptoms of infiltration and report to the ordering provider.

DEFINITIONS:

None

Subject: Assessment and Vital Signs Guidelines	Manual: Emergency Department
---	---

POLICY:

It is the policy of the Southern Humboldt Community Healthcare District ("SHCHD" or "District") to provide emergent assessment and vital signs guidelines to the Emergency Department (ED) nursing staff.

PROCEDURE:

A. Triage

All patients will have vital signs assessed at Triage, including an initial pain assessment. Pediatrics are defined as less than 14 years old and/or up to 21 years old at physician's discretion. Not obtaining a Pediatrics blood pressure (BP) is acceptable unless the chief complaint warrants initial vital signs such as:

- Altered level of consciousness (ALOC)
- Trauma
- Hemorrhage
- Severe Headache
- Sepsis
- Cardiogenic Shock

Pediatric Vital Sign Guidelines:

	<u>Resp. Rate</u>	<u>Heart Rate</u>	<u>Systolic BP</u>
Preterm (<37wks):	50-70	120-180	40-60
Newborn (37-42wks):	40-60	100-170	50-70
Neonate (1-28 days):	30-50	90-160	60-80
Infant (1-12 months):	25-40	80-160	70-100
Toddler (1-3 yrs.):	20-30	80-130	70-110
Preschooler (3-5 yrs.):	20-30	80-110	80-110
School Age (6-12 yrs.):	20-24	75-100	80-120
Adolescent (>13 yrs.):	12-20	60-90	94-130

Vital signs in the ED should be taken at least once an hour or more depending on condition

B. Discharge

Discharge vital signs will be obtained within 30 minutes of discharge on the following patients:

1. Any patient with an initial triage level of 1, 2, 3.
2. Any patient who has received an intravenous (IV), intramuscular (IM), subcutaneous (SQ) or nebulized medication.
3. Any patient who has had abnormal vital signs during their course in the ED.
4. Any patient who complains of light-headedness, has had a syncopal episode or who is "abnormally" unstable when ambulating.
5. Anytime the nurse is concerned about the patient's readiness for discharge.

C. Triage Priority Level 1-Emergency/Unstable

Patients with life or limb threatening illnesses or injuries requiring immediate emergency medical care. Sudden onset of a medical/traumatic condition manifesting itself by acute symptoms of sufficient severity (including severe pain, psychiatric disturbances, symptoms of substance abuse or any woman

presenting with a chief complaint of pregnancy and/or labor at a time when delivery is imminent) such that the absence of immediate medical attention could reasonably be expected to result in:

1. Placing the individual's health in severe jeopardy.
2. Serious impairment to bodily functions.
3. Serious dysfunction of any bodily organ or part.
4. Placing others at risk.

These patients (adult/pediatrics) are unstable, may not be referred elsewhere for care and are to be taken immediately to the treatment area of the Emergency Department for further evaluation. **Nurses will reassess all patients in this category every 30 minutes or more frequently as the patient's condition dictates.** If afebrile (temp. <100.5/38 °C), repeat the temperature every 2 hours.

D. Triage Priority Level 2-Emergent

An Emergency Medical Condition is present or cannot be ruled out, requiring treatment/evaluation ranging from prompt to within several hours to prevent loss of life or limb. **Nurses will reassess patients in this category every hour or more frequently if the condition requires.** If afebrile (temp. <100.5° F or 38° C), repeat temperature every four hours.

E. Triage Priority Level 3-Urgent

This patient does not exhibit signs or symptoms consistent with an Emergency Medical Condition. Patients in this category have illnesses or injuries that require follow-up, but where time is not a critical factor. If these patients remain within the Emergency Department (waiting room or treatment areas), **nurses will reassess this patient every two hours or more frequently if the conditions require.**

F. Triage Priority 4-Urgent/Stable

The patient does not exhibit signs and symptoms consistent with an Emergency Medical Condition. Conditions that place a patient in Level 4 have usually developed slowly and have been tolerated by the patient for some time. **If these patients are kept within the Emergency Department, they will be reassessed typically at triage and then discharge or more often if needed.**

G. Triage Priority Level 5-Non-Urgent

Definitions:

None

Subject:
Assisting With Abdominal Paracentesis

Manual:
Emergency Department

POLICY:

It is the policy of the Southern Humboldt Community Healthcare District ("SHCHD" or "District") to provide optimal patient care and the following procedures for the staff to follow when caring for the patient with abdominal paracentesis.

PURPOSE:

The purpose of this policy and procedure is to provide guidelines for the nursing staff to assist with abdominal paracentesis.

Equipment:

- Sterile paracentesis tray and gloves
- Local anesthetic
- Drape or cotton blankets
- Collection bottle (vacuum bottle)
- Skin preparation (antiseptic)
- Specimen bottles and laboratory forms

PROCEDURE:

Preparatory Phase:

1. Explain procedure to the patient.
2. Ensure procedural consent form was signed by the patient and the provider.
3. Document pre-procedural vital signs.
4. The patient should be placed on the bedside monitor, monitor heart rate, saturations and blood pressure.
5. Have the patient void before the procedure.
6. Position patient in Fowler's position with the back, arms, and feet supported.
7. Drape the patient with a sheet keeping the abdomen exposed.

Performance Phase:

1. Assist in preparing skin with antiseptic solution.
2. Open and set up the sterile tray and sterile gloves, have the antiseptic for the skin ready to apply.
3. Have the collection bottles and tubing available.
4. Access pulse and respiratory status frequently during the procedure; watch for pallor, cyanosis, or syncope. These signs indicate shock. Keep emergency medications available.
5. The provider will administer local anesthesia and introduce the needle trocar.
6. The needle trocar is connected to tubing and a vacuum bottle or syringe; fluid is slowly drained from the peritoneal cavity. Drainage is usually limited to 1-2 liters to relieve acute symptoms and minimize risk of hypovolemia and shock.
7. Apply dressing when the needle is withdrawn. Usually a dressing is sufficient: however, if the trocar wound is large, the provider may close the incision with sutures.

Follow-up Phase:

1. When the procedure is finished, assist the patient to a comfortable position.

2. Record the amount and characteristics of the fluid removed, number the specimens sent to the laboratory and the patient's condition during the treatment.
3. Check blood pressure and vital signs every ½ hour for 2 hours, every hour for 4 hours and every 4 hours for 24 hours. Close observation will detect poor circulatory adjustment and possible development of shock.
4. Watch for leakage or scrotal edema after paracentesis. If seen, report at once.

DEFINITIONS:

NONE

Subject:**Care of the Patient with Burns****Manual:****Emergency Department****POLICY:**

It is the policy of the Southern Humboldt Community Healthcare District ("SHCHD" or "District") to provide optimal patient care and the following procedures for the staff to follow when caring for the patient with burns.

PURPOSE:

The purpose of this policy and procedure is to minimize extent of injury, to provide pain relief and to preserve organ function for a patient with burns.

DEFINITIONS:

- First Degree (Superficial) – epidermis - damage to the skin is limited to the outer layer (epidermis.) The skin is intact and typically appears to be pink/red in color, very warm or hot to the touch and painful. Swelling and small blisters may be present. Common cause: sunburn.
- Second Degree (Partial Thickness) - epidermis and dermis - damage to the skin includes the outer layer and penetrates to the middle layer of tissue (dermis). The wound is typically moist/wet and red. Swelling is usually present, there may be blisters or sloughing (loss) of skin; it is very painful.
- Third Degree (Full Thickness) - all three layers of the skin (epidermis, dermis and hypodermis/subcutaneous tissue) are damaged; the injury can include deep penetration into muscles, organs and bones. The affected area is dry, leathery and may present in many colors (i.e., whitish, charred or tan-colored). Due to nerve destruction, full thickness areas are non-sensate (loss of feeling/sensation)

PROCEDURE:**Initial Steps:**

- Assemble your team.
- Prepare your room and assign roles: early IVF access and airway assessment are critical in this patient population.
- Evaluate goals of care. Consider early conversations with patient and family, if possible, in the clinical context. Patients with a Baux Score (Age + TBSA) >160 have nearly a 100% mortality rate.
- Calculate the total body surface area (TBSA) that has been burned. Diagram listed in policy if needed.
- Administer 100% oxygen by simple mask or non-rebreather

Assessment:

- Airway, Breathing, Circulation:
Maintain open airway, provide humidification, evaluate for inhalation injury (i.e., singed nasal hairs, face or neck burns, carbonaceous sputum, soot in the upper airways, voice changes or wheezing). Anticipate possible need for intubation, cricothyrotomy or tracheostomy. (Stridor, respiratory distress, hypoventilation, or decreased mental status).
- Examine and treat for external and internal bleeding, fractures, head trauma, abdominal injuries, etc.

Stop Burning Process:

- Cut away all clothing - do not pull adhered clothing from wound.
- Cool the burn by applying cool, sterile water as ordered.
- Wrap patient in a sterile sheet after removing clothing.

Estimate Severity:

- Size and depth of burn - use "Rule of Nines."
- Age of patient.
- Past medical history including allergies, current medicines, and last tetanus prophylaxis.
- Concurrent injuries.

Consider Major Burn If:

- The injury is 3rd degree over 10% of body surface, or 2nd degree over 20% of body surface.
- The patient is under 4 years of age, or over 60 years of age.
- There are concurrent injuries.
- There is chronic or severe medical illness.
- The burn involves the hands, face, feet, or perineum.
- It is an electrical injury.
- There is an inhalation injury.

Respiratory and Fluid Guidelines:

- Start oxygen via nasal cannula @ 4L per minute. If pulmonary injury or carbon monoxide poisoning is suspected, rate can be increased to 8L per minute or use non-rebreather mask (15L).
- If carbon monoxide poisoning or inhalation injury suspected by respiratory distress or by history (trapped in a closed space), draw carboxyhemoglobin level and arterial blood gases. Do not wait for results; go forward with transfer arrangements if indicated.
- Endotracheal intubation via nose or mouth if indicated for airway obstruction or Pa O₂ less than 60 mm Hg.
- Anticipate need for 2 large bore peripheral IVs. Ideally, a central line should be inserted in an unburned area.
- Amount of Ringer's Lactate for initial 24-hour load:
 - $4 \times \% \text{BSA burned (average)} \times \text{Wt (Kg)} = 24\text{-hour fluid requirement}$
 - rate of administration:
 - 1/2 during 1st 8 hours
 - 1/4 in each following 8-hour period
- Time is calculated from onset of burn.
- It is important that each Ringer's Lactate bottle is labeled in order of administration (1, 2, 3, etc.)
- Goal of urine output via Foley catheter is 0.5ml/kg/hr

Medication:

- Tetanus prophylaxis, if indicated.
- Narcotic analgesic: IV only when indicated. Avoid IM or subcutaneous routes due to poor circulation and fluid shift process.
- Silvadene cream should be applied as directed by physician.

Wound Care:

- Everyone involved in care is in sterile gown, gloves, mask, and shoe covers. Aseptic technique is maintained during initial burn dressings.
- Cleanse gently with mild soap and water.
- Remove debris.
- Leave blisters intact.
- Cover patient for warmth.

- If wound dressings are required, apply a non-adherent bandage such as telfa with cling wrap. Do not use tape on skin.

Additional Care:

- Keep patient NPO.
- Urethral catheterization to measure hourly output. (Should be 0.5 cc/kg/hour.)
- Anticipate possible need for nasogastric tube in patients who are unconscious or with burns 30% or greater to relieve gastric dilatation which occurs in burns of this magnitude.
- Transfer - see area wide transfer protocol. Use transfer patient checklist along with usual transfer forms.

Electrical Burns:

An electrical burn causes injury as a result of heat generated by an electrical current passing through tissue. One of the major concerns with electrical injuries is the development of cardiac dysrhythmia. In cases of electrical burns check urine for myoglobin and pH.

Emotional Support:

Reassure patient and allow them to express feelings about disfigurement.

Documentation:

- Chart all pertinent findings.
- Monitor vital signs, including urinary output every 15 minutes, or as ordered by attending physician.
- Vital signs, including cardiac monitoring, may need to be noted more frequently as indicated/ordered.

Discharge Planning:

- Consult transfer agreements for anticipated out-of-area transfers. Transfer per area-wide transfer protocol.
- Telephone physician in charge of the burn unit for further instructions or aid in transfer.

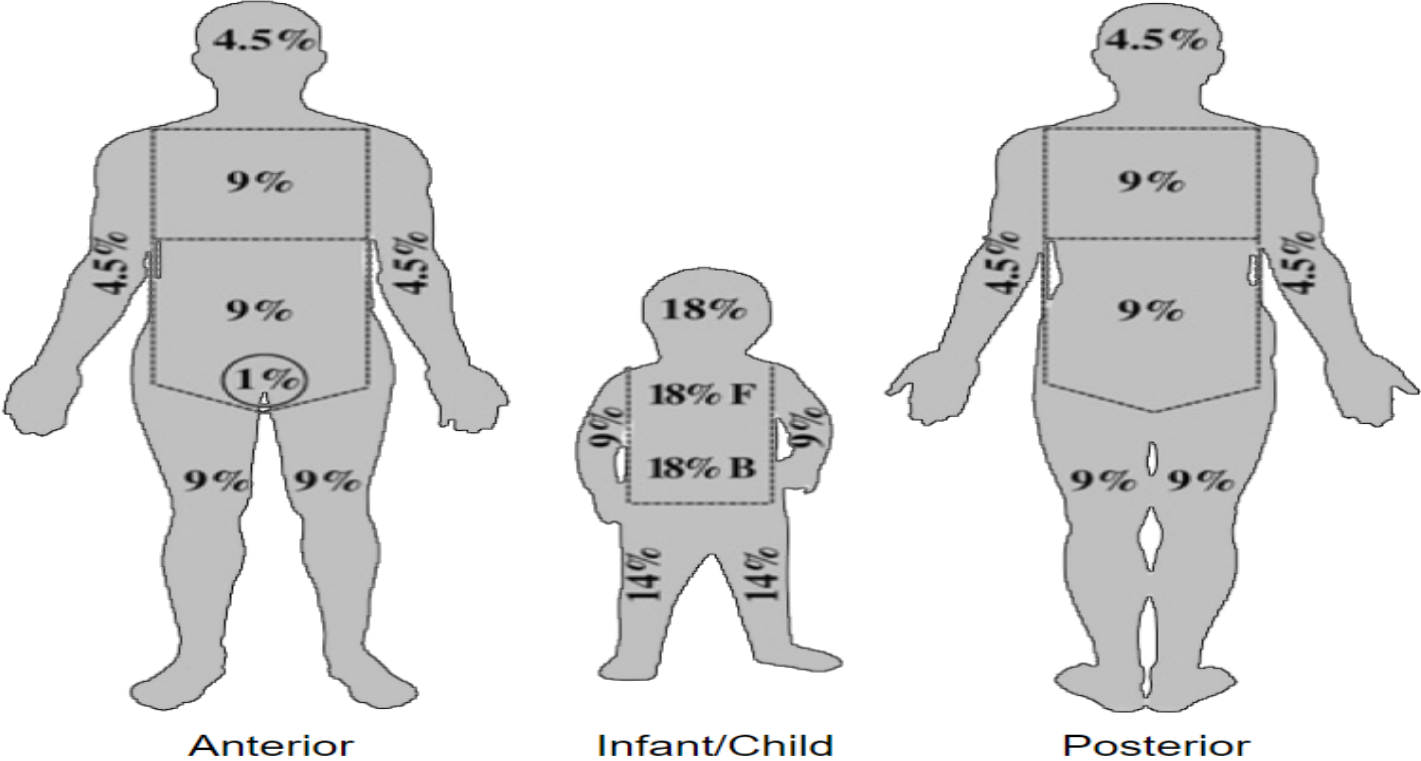
Who Typically Requires Admission to a Burn Center:

- Partial Thickness burns >10% of TBSA (age <10 or >50) or >20% of TBSA (age 10-50)
- Third Degree Burns
- Electrical Burns (including lightning injury)
- Chemical Burns
- Inhalation Injury
- Circumferential burns
- Burns to hands, face, genitalia, perineum, major joints
- Burns in patients with other medical comorbidities that may prolong recovery

Remember:

- Follow your ABCs. Remember, these patients can present with rapidly evolving, critical airways.
- Obtain a directed history from patient or EMS regarding burning agent (don't forget about chemical burns!), whether injury was sustained in an open or enclosed space, risk of blast injury.
- Treat CO and cyanide if history, exam, or labs are suggestive.
- Begin resuscitation with IV fluids (LR) based on specific burn formula (ISR, Brooke, Parkland).
- Don't forget that burn patients can be MORE than just a burn: think about trauma, toxicologic etiologies, and blast injuries.
- Pain management is paramount in this critically ill population. Reassess early and often.

body region.



Remember Palmer Hands: Each hand is 1%

- Patients who leave AMA whose blood alcohol level is above the legal limit for the operation of a motor vehicle will be reported to the police. If the physician deems it necessary, the Garberville Sheriff's Substation or CHP may be contacted for assistance in controlling a patient who becomes a public nuisance for disturbing the peace.

Subject: Caregiver-Child Separation During a Disaster	Manual: Emergency Department
--	---

POLICY:

It is the policy of the Southern Humboldt Community Healthcare District ("SHCHD" or "District") to protect our vulnerable pediatric patients during the event of a disaster.

PURPOSE:

To minimize parent-child separation and provide methods for reuniting separated children with their families.

DEFINITIONS:

Child:

Any persons under the age of 18.

Unaccompanied children:

(Also called unaccompanied minors)- are children who have been separated from both parents and other relatives and are not being cared for by an adult who, by law or custom, is responsible for doing so.

Tracing:

In the case of children, the process of searching for family members or primary legal or customary caregivers. The term also refers to the search for children whose parents are looking for them. The objective of tracing is reunification with parents or close caregivers.

Identification:

The process of establishing which children have been separated from their families or other caregivers.

Verification:

The process of establishing the validity of relationships and confirming the willingness of the child and the family member to be reunited.

Reunification:

The process of bringing together the child and family or previous care-provider for the purpose of establishing or re-establishing long-term care.

Pediatric patients separated from parents have rights:

- The right to physical and legal protection
- The right to not be separated from their parents.
- The right to provisions for their basic sustenance.
- The right to care and assistance appropriate to their age and developmental needs.
- The right to participate in decisions about their future.

PROCEDURE:

- During the event of a natural disaster all patients will be triaged using the S.T.A.R.T method as discussed in safety manual policies and procedures located in the red binder at the nurse's station.

- If there are pediatric patients who are found to be separated from family, then it will become the Emergency Department Doctor/Nurse's responsibility to provide services that reunite families as quickly as possible.
- If a child's identity is not known, the relevant authorities should take appropriate measures to ascertain it. A new identity should be established only as a last resort. Proper documentation by medical staff that describes the child's approximate age, the child's appearance and characteristics may help family identify the unidentifiable pediatric patient at a later time. Taking a photograph of the child during registration and prior to imminent transfer will help families to identify their children accordingly. Any clothing that may be removed from the child for medical treatment should be saved for family members to help identify the pediatric patient.
- Precautions must be taken when sharing and publishing information on unaccompanied and separated children, including photographs of children for tracing. It is important to know who will have access to the information collected.
- If large numbers of children are separated from their parents or other relatives in an emergency, priority should be given to the most vulnerable, whether accompanied or unaccompanied.
- A child's opinion should be listened to and given due weight in relation to the child's age and maturity. Children must be kept informed about plans being made for them including placement of care, tracing, and reunification.
- Cooperation among all organizations concerned are critical for the care and protection of separated children. It is important that action be coordinated with local agencies such as Humboldt County, Red Cross, Redwoods Rural, local schools, and other relevant authorities. Dialogue and coordination mechanisms need to start in the early phases of the emergency and be maintained throughout the process. A communication strategy through the local media would be warranted in the case of child/caregiver separation.
- Roles such as "sitter" for the stable children will be implemented appropriately to those who are qualified based on credentials and availability.
- The pediatric patient who was separated from family members and is in need of being transported to a facility with needed higher level of care will be traced accordingly so when the patient's family is able to make contact, they are well informed of where their child is. It will be this facility's responsibility to try to locate the closest most appropriate higher level of care for the pediatric patient.

Subject: Chest Pain Protocols	Manual: Emergency Department
--	---

POLICY:

It is the policy of Southern Humboldt Healthcare District ("SHCHD" or "District") to follow American Heart Association Advanced Cardiac Life Support (ACLS) OR PALS (Pediatric Advanced Life Support) guidelines for the management of patients presenting to the facility with chest pain, as appropriate based on the availability of resources.

PURPOSE:

To provide interventions and stabilization of patients with potential or recognized cardiac problems.

DEFINITIONS:

PEARLS:

- Females, diabetics and geriatric patients often have atypical signs/symptoms, or only generalized complaints
- Remember Erectile Dysfunction drugs are now being used to treat pulmonary hypertension
- Do not administer Nitroglycerin in any patient who has used Viagra (sildenafil) or Levitra (vardenafil) in the past 24 hours or Cialis (tadalafil) in the past 36 hours due to potential severe hypotension
- If possible, establish a second IV on STEMI patients.

<p>ACS Signs & Symptoms Chest pain- any non-traumatic pain between the jaw & umbilicus Chest pressure, discomfort or tightness Complaints of "heart racing" or palpitations Bradycardia Syncope Weakness in patients > 45 years old New onset stroke symptoms Difficulty breathing (without obvious cause i.e. asthma or CHF)</p>	<p>STEMI Criteria ST segment elevation of ≥ 1 mm in 2 contiguous leads with or without signs & symptoms of ACS</p>	<p>12 Lead EMS ECG Criteria Patients > 20 years old experiencing any ACS signs & symptoms OR Any age patient with ACS signs & symptoms AND a history of: HTN Cardiac disease Smoking Diabetes mellitus Severe Obesity High Cholesterol Recent recreational drug use</p> <p>When in Doubt, Obtain an ECG</p>
---	---	---

PROCEDURE:

- Patients presenting to the facility with chest pains are triaged into the Emergency Department immediately. The ED physician will be contacted as soon as possible.
- A Registered Nurse will do the following:

First Steps:

- Place patient on gurney in gown preferably in Bed 1 with at least one handrail up at all times.
- Apply cardiac monitor leads and enter patient into the cardiac monitor system.
- Minimize patient exertion
- Assess Airway, Breathing, and Circulation
- Obtain a Full set of Vital Signs, Continuous Pulse Oximeter and ECG within 10 minutes of patient

- contact.
- If STEMI, alert physician for immediate transport to appropriate PCI capable hospital (St. Joseph's Hospital in Eureka).
 - Place Oxygen on patient via nasal cannula starting at 2 LPM as needed, if a mask is appropriate use a simple mask at 6 LPM
 - Place IV Lab draw preferably an 18G – CBC, basic metabolic panel, cardiac enzymes, PT, PTT
 - Aspirin total 325 mg once on arrival (chew and swallow 4 non-enteric baby aspirin 81 mg each) Contraindicated (aspirin allergy)
 - Screen for Viagra, Levitra and Cialis in the past 48 hours

If SBP > 110 mmHg

<p>0.4 mg nitroglycerin SL tablet or SL spray q 5 minutes until pain is gone or max 3 doses. Maintain SBP > 110 mmHg</p>
<p>Pain unrelieved by Nitro: Morphine 2-4mg slow IVP max 20mg</p> <p style="text-align: center;">OR</p> <p>Fentanyl 1mcg/kg q 15 minutes max 200 mcg</p>

If SBP falls < 110 mmHg in response to treatment: Discontinue Nitro and Analgesic Treatments and place patient supine

- Document effectiveness of all medication. Obtain vitals prior to giving all doses.
 - MD may prefer Nitroglycerin paste- apply ½ to 1 inch topically to chest wall once at arrival per MD.
 - Obtain portable chest X-Ray.
- Obtain a detailed history and document patient's chest pain, including:
 - Onset of pain (e.g., abrupt or gradual)
 - Provocation/Palliation (which activities provoke pain, which alleviate pain)
 - Quality of pain (e.g., sharp, squeezing, pleuritic)
 - Radiation (e.g., shoulder, jaw, back)
 - Site of pain (e.g., substernal, chest wall, diffuse, localized)
 - Timing (e.g., constant, or episodic, duration of episodes, when pain began and at what time)
 - Prepare patient for possible stat transfer. If patient is positive for a STEMI, follow the St. Joseph's STEMI fast track protocol.

Please Note:

It is optimal if items listed be performed in the order presented. However, many tasks are done simultaneously and/or the order may be varied to accommodate the patient's condition and other factors.

Subject:
Chest Tube Insertion in the Emergency Department

Manual:
Emergency Department

POLICY:

It is the policy of the Southern Humboldt Community Healthcare District ("SHCHD" or "District") to provide optimal patient care and the following procedures for the staff to follow when caring for the patient with chest tubes.

PURPOSE:

The purpose of this policy and procedure is to provide guidelines for caring for a patient with chest tubes.

PROCEDURE:

Supplies:

- Thoracotomy tray
- Local anesthetic (typically 1% or 2% lidocaine with epinephrine) with syringe and needles
- MobiVac-II suction with canister
- Chest tube drainage system (Pleur-evac)
- Sterile suction tubing for suction machine
- 500 ml sterile water
- PPE including Sterile gloves, sterile gown, shoe covers, and mask with face shield
- If conscious sedation, obtain sedatives per physician preference.
- 2 bedside tables (mayo stands)
- Vaseline gauze
- Sterile 4x4's

During the preparatory phase:

- Assess the patient for pneumothorax, hemothorax, presence of respiratory distress
- Document a full lung assessment
- Obtain a chest X-ray and/or CT
- Obtain Informed Consent
- Pre-medicate if indicated
- Assemble the drainage system
- Position the patient on the opposite side or per physician preference

Positioning:

- Whether the patient is awake, sedated, or intubated, positioning is vital to the proper placement of a chest tube both in terms of the appropriate anatomical location as well as the directionality and position of the tube within the pleural cavity. The patient should be lying supine with the ipsilateral arm flexed and abducted above or behind the patient's head.
- The anatomical site should then be chosen and marked with a marking pen.
- The physician and nurse should check and recheck with the diagnostic imaging modality that has provided the diagnosis to assure the procedure is being performed on the correct side.

Set up drainage system (Pleur-evac)

- Remove the Pleur-evac from its sterile packaging and check to ensure that all the parts and the unit are intact. (Refer to package insert).
- Using the funnel provided, add sterile water through the short suction tube in the "water seal chamber" to the "fill to here" line. This is the 2 cm line seen on the front of the water seal chamber.

- Add sterile water to the "Suction Control Chamber" by first removing the "Atmospheric Vent" cover and using the funnel. Pour sterile water through the "Atmospheric Vent" filling to the 20 cm level line or to the level ordered by the physician. Remove the funnel and replace the cover. In the event either chamber is over filled, remove excess water by using a 20-cc syringe with 18-gauge needle and aspirating through the ports provided on the front of the Pleur-evac.
- Connect the long tube from the "Collection Chamber" to the patient's thoracic catheter. (Some catheters have a blue cap on the distal end, which must be cut off to attach the chest tube to the Pleur-evac tubing). Connect the "Suction Chamber" tubing (short tube in the water seal chamber) to the suction source using sterile suction extension tubing. Suction is provided by using the MobilVac-II. Select continuous suction and adjust to the lowest setting then increase until gentle bubbling is seen in the water seal chamber.

Assisting with Insertion (Thoracotomy)

- Set up the Mayo stand with sterile gloves, Betadine with 4x4's for prep, sterile field, chest tube insertion tray, and chest tube of the size ordered by the MD.
- Set up sterile field: items from kit, syringe/needles, trocar (if requested), sterile gloves, and minor suture tray (if requested).
- Position the patient on the opposite side.
- Assist with insertion and securing tube. Connect to suction as outlined above. Tape all connections.
- After insertion, dress site with Vaseline gauze, 4x4s and 2" tape with a pressure dressing. Apply a dry, occlusive dressing with or without petroleum gauze.
 - Take 3 layers of 4x4 gauze, cut a line through them to the midpoint, and insert them over the chest tube so that the tube lies within the middle of the gauze. You may choose to apply petroleum gauze directly to where the tube rests on the skin prior to 4x4 occlusive dressing.
 - Using 3-4-inch adhesive tape or tegaderm adhesive dressings, seal each corner of the gauze.
 - Once the occlusive dressing is applied, you may further utilize either adhesive tape or tegaderm to secure the more distal tubing to the anterolateral chest wall and flank. The adhesive tape or tegaderm should be applied horizontally across the tubing as it runs down the chest wall.

Post procedure:

- Re- assess the patient for presence of respiratory distress
- Document a full lung assessment
- Observe drainage system for blood/air
- Observe that there is free fluctuation of water in the tube on respiration
- Obtain a follow-up chest x-ray
- Assess for bleeding, infection, leakage of air and fluid around the tube
- Keep the drainage system below the patient's chest level
- Check the connections periodically. The tube should be as straight as possible
- Mark the original fluid level with tape outside of the drainage system (mark hourly)
- Report immediately to the physician signs of rapid, shallow breathing, cyanosis, chest pressure, subcutaneous emphysema, or signs of hemorrhage
- Make sure there is fluctuation tidaling of the fluid level in the drainage system. This is an indication of patency and intrapleural pressure.
- With patient sitting upright, encourage deep breathing and coughing every 2 hours
- Do not clamp the tube; this is only done briefly with drainage system replacement, and chest tube removal to assure lungs are re-expanded

DEFINITIONS:

None

Subject: Controlled Substances and Ambulance Procedures	Manual: Emergency Department
--	---

POLICY:

It is the policy of Southern Humboldt Community Healthcare District (“SHCHD” or “District”) to supply the local ambulance company with certain controlled substances as allowed by state and local EMS policies. Ultimate responsibility for controlled substances on board the ambulance lies with the district pharmacist.

PURPOSE:

Ambulance services are not permitted by law to purchase controlled substances but may administer both Morphine and Valium per EMS protocols. This policy and procedure delineate how the district will supply, account for, and bill for controlled substances.

PROCEDURE:

- City Ambulance is the ambulance company mainly responsible for prehospital care in this area. However, other services are utilized as backup when necessary.
- City Ambulance carries both Morphine Sulfate and Valium injectables for use per EMS protocols.
- In the ambulance, these medications are stored and counted per ambulance policy and applicable law.
- Controlled substances are administered to prehospital patients by qualified ambulance personnel via radio order and/or protocols from their medical provider.
- Controlled substances used by the ambulance service on transported patients will be restocked from the Emergency Department.
 - The ED RN will verify with the ambulance personnel, which medications were used by reviewing the prehospital radio run report. All medications requested by the ambulance personnel **must** have been authorized or reported to the nurse or physician before they will be replaced.
 - The ED RN will replace the medication from the ED locked narcotic drawer. Both the ED RN and the ambulance personnel will sign the Narcotics Log including date, time, patient name and “EMS” in the “room” column.
- The ED Nurse Manager, CNO and Pharmacist routinely review all completed narcotic logs. During this review, any medications given to the ambulance company will be listed on the “Ambulance Medication Stock Requisition.” This form will be forwarded to Materials Management quarterly for the purposes of billing the ambulance service.

DEFINITIONS:

None

Subject:**Crash Carts and Emergency Patient Care Equipment****Manual:****Emergency Department****POLICY:**

It is the policy of the Southern Humboldt Community Healthcare District ("SHCHD" or "District") to maintain the equipment necessary to provide basic and advanced cardiac life support, as appropriate for each patient.

PURPOSE:

The purpose of this policy and procedure is to describe the emergency equipment, its location, and its use during a medical emergency.

PROCEDURE:

- **Crash Carts – Two (2) Advanced Life Support crash carts and one (1) Pediatric Life Support crash cart**
- There are three (3) crash carts located in the facility — Two (2) Adult Advanced Life Support crash carts; one is in the Emergency Room between beds 1 and 2 and the other in Room 109 on the Acute unit. The Pediatric Life Support crash cart is in the Emergency Room next to bed 4.
- The carts include:
 - Defibrillator/pacer/oxygen saturation monitor/blood pressure monitor
 - Oral suction machine, catheters, Yankauer suction
 - Oral airways, bag-valve-mask, face masks
 - Cart with drawers for emergency airway management and pharmacological management
 - Backboard
 - Clipboard with checklists and code records
 - 3. The Emergency Department cart **MUST** always remain in the Emergency Room area when there is a patient present.
 - 4. The Crash Carts are kept sealed when not in use. The equipment not sealed in the cart is checked each shift by the ER nurse. Documentation of checks is made on the "Crash Cart Checklist." See example ED-Crash Cart Checklist attached. Documentation also includes noting that the drawers are locked with a red band. The number on the band is documented.
 - 5. In the event that a cart is opened and used, the nurse who used the cart is responsible to review the "Crash Cart Contents" list, the nurse may give the list to either the Pharmacy Technician or the Pharmacist. If the cart needs to be restocked prior to the start of the business day the nurse may gather and restock needed supplies and medication, so the cart is always at the ready. The **EARLIEST** outdated drug or supply is noted on a piece of tape and placed on the front of the cart. The cart is then sealed with a yellow tag, and a note is left with the pharmacist to replace this with a red tag. The pharmacist will take this opportunity to review the medications in the cart. Additionally,
 - at the end of each month the Pharmacy Tech and/or the Pharmacist will check the contents for refreshing supplies, removing outdated and/or expired supplies and place a new red tag on the cart.
 - **Note:** The cart contents checklist is available on the clipboard attached to the cart. This list is to state exactly how many of each item is in the cart. Additional items should not be added to the cart. This list **MUST** be an accurate reflection of the contents and expiration date of the items in the cart. Nurses checking the cart should use this list to assure the cart is stocked adequately.

- If an arrest occurs on the Acute or Skilled Nursing unit, the cart in Room 109 is taken to the arresting patient's room and resuscitation is started according to American Heart Association guidelines.

- **Emergency Equipment for Clinic – Basic Life Support**

- The Clinic is a Basic Life Support provider. In the event of a cardiac or respiratory emergency, the Clinic staff will begin basic life support and call "911" to dispatch the ambulance to take the patient to the Emergency Department.
- The Clinic is equipped with airways, bag-valve-mask ventilator, oxygen, and masks.

- **Emergency Equipment for the remainder of the facility – Basic Life Support**

- For cardiac arrests that occur in any other part of the Acute facility, Basic Life Support (CPR) should be started by the first responder, usually the staff person in that department. A staff person should page "Code Blue and the location" three times. ED staff will respond, if available. The cart from the acute unit will be taken to the department. When the patient is stable, he/she will be transported to the ED.

- **DEFINITIONS:**

None

Subject: Discharge Instructions	Manual: Emergency Department
--	---

POLICY:

It is the policy of the Southern Humboldt Community Healthcare District ("SHCHD" or "District") to give clear and appropriate Discharge Instructions from our Emergency Department that include verbal and written instructions.

Purpose:

The purpose of this policy is to ensure every patient receives written and verbal discharge instructions, specific to their condition, upon being discharged from the emergency Department.

DEFINITIONS:

None

PROCEDURE:

1. The Emergency Department provider will write and give clear Discharge Instructions specific to the patient's condition. The District supplies **wound care, head injury, bruise, fracture or sprain, and general discharge instruction sheets** along with exit care, which will have a variety of options.
2. The nurse will explain the Discharge Instructions and have the patient sign stating they read and understand the instructions. If the nurse deems necessary to add additional information, they may use exit care or Up-To-Date to provide additional instructions.
3. Patients and family members will be encouraged to engage and participate in the process of discharge as equal partners. The needs, wishes and rights of the patient will be paramount throughout the process.
4. Discharge must be timely. Discharge shall occur within 30 minutes of the discharge order unless the patient is not medically fit or safe to be discharged and then the discharge will be cancelled.
5. Assessment and vitals related to the discharge will commence at the earliest opportunity. The last set of vitals should be collected within 30 minutes of discharge. If abnormal, vitals should be repeated, and doctor informed prior to discharge.

DISCHARGE INSTRUCTIONS

1. The physician will provide written discharge instructions providing a clear management of care for the patient's condition. The doctor will ensure the patient is medically fit and any outstanding assessments or interventions are communicated to the nurse.
2. All patients rendered emergency care will be referred to their private physician or referred to a specialist, or having no private physician, will be referred to the health department or the Clinic for any procedure or follow-up care deemed necessary by the emergency department physician.
3. The emergency department physician may also want the patient to follow up in the ED and an out-patient follow-up order will be created for the patient to come back to receive services.
4. Nursing Responsibility:
 - a. The nurse will ensure that all orders have been completed prior to discharge and any abnormal vitals or assessments are communicated to the physician.

- b. All patients must be told to seek further medical assistance if they get worse or fail to get better.
- c. Nurses are to inform patients of what to expect (common symptoms that may persist, any activity or dietary restrictions, and when to come back to the ED).
- d. Document patient's understanding of discharge instructions. Give a copy of the instructions to the patient or those responsible for the patient, verbally and in writing.

Common Example of Symptoms that require a return to the emergency department or private physician:

1. Wounds: If the wound becomes red or swollen, develops pus, red streaks or feels sorer rather than less sore as days go by.
2. Head injury: Patients with head injuries and persons caring for them must understand the necessity to return if the patient has:
 - a. Persistent vomiting, stiff neck, fever, or headache.
 - b. Unequal sized pupils (one large pupil, one small).
 - c. Confusion, unusual drowsiness, or dizziness.
 - d. Inappropriate or slurred speech.
 - e. Convulsions or unconsciousness.
 - f. Stumbling or other problems with the normal use of arms or legs; areas of numbness of the skin.
 - g. Persistent nosebleed or fluid draining from nose or ear.
3. Eye injuries: Patient must return if they have increasing pain one (1) hour after anesthetic wears off.
4. Splinted patients should return and have checked immediately if the injury:
 - a. Gets cold
 - b. Feels numb
 - c. Becomes very painful
 - d. Swells markedly
 - e. Turns blue or dark
 - f. Cap refill greater than 3 seconds.
5. As directed by the emergency department provider.

Subject: ED Triage	Manual: Emergency Department
-------------------------------------	---

POLICY:

It is the policy of the Southern Humboldt Community Healthcare District (SHCHD) to ensure that individuals coming to the hospital for emergency services be evaluated by a triage-qualified Registered Nurse (RN) utilizing the Emergency Severity Index (ESI) Five-Level Triage System.

PURPOSE:

The purpose of this policy and procedure is to provide necessary safety and health care to patients for whom a reasonable possibility of suicide or danger to others exist.

PROCEDURE:

- Upon entering the Emergency Department (ED), a patient will receive an initial triage screening to identify life-threatening conditions and prioritize patients according to acuity.
- The following steps should occur when making a triage decision:
 - Determine chief complaint.
 - Patients requiring immediate life-saving interventions or high-risk patients do not require a detailed physical assessment or a full set of vital signs, in most cases.
 - Physical examination relative to the patient’s chief complaint.
- Following the initial triage in the ED, the ED nurse will determine the disposition of the triage level based on the following algorithm:
- Only the assessment necessary to accurately assign a triage level based on the ESI system should be performed in triage and the patient properly assigned to a location.
- Interventions as defined in the SHCHD ED protocols are to be initiated based on the RN patient assessment.
- The ESI five-level triage system is based as follows:

<p>ESI Triage Level 1</p> <p>Is The Patient Dying?</p> <p><u>Requires Immediate Live-saving Intervention:</u> Airway, emergency medications, or other hemodynamic interventions</p>	<p><u>The ESI level-1 patient always presents to the emergency department with an unstable condition. These patients will be taken immediately to the treatment area, the physician is at the bedside and nursing is providing intensive care.</u></p> <p><u>Examples:</u></p> <ul style="list-style-type: none"> • Intubated pre-hospital • Cardiac Arrest • Respiratory Arrest • Sever Respiratory Distress • SpO₂ <90 • Critically injured trauma patient who presents unresponsive • Overdose with respiratory rate of 6 or less • Severe respiratory distress with agonal or gasping-type respirations • Severe bradycardia or tachycardia with signs of hypoperfusion
--	--

	<ul style="list-style-type: none"> • Hypotension with signs of hypoperfusion • Trauma patient who requires immediate crystalloid and colloid resuscitation • Chest pain, pale, diaphoretic, blood pressure 70/palp • Weak and dizzy, heart rate=30 • Anaphylactic reaction • Baby that is flaccid • Hypoglycemia with a change in mental status • Unresponsive with a strong odor of ETOH <p><u>Unresponsiveness is defined as a patient that is either:</u></p> <ol style="list-style-type: none"> 1. nonverbal and not following commands (acutely); or 2. Requires noxious stimulus (P or U on AVPU scale). <p>Psychiatric complaint:</p> <ol style="list-style-type: none"> 1. All suicidal patients 2. Actively hallucinating/hearing voices 3. Delusional and agitated 4. Potential danger to self or others 5. Paranoid
--	---

<p>ESI Triage Level 2</p> <p>Should the Patient Wait?</p> <p>Is this a high-risk situation?</p> <p style="text-align: center;">Or</p> <p>Is the patient confused, lethargic or disoriented?</p> <p style="text-align: center;">Or</p> <p>Is the patient in severe pain or distress?</p>	<p><u>The ESI level-2 patient is one whose condition could easily deteriorate or who presents with symptoms suggestive of a condition requiring time-sensitive treatment. This is a patient who has a potential major life or organ threat.</u></p> <p><u>Examples:</u></p> <ul style="list-style-type: none"> • Active chest pain, suspicious for coronary syndrome, stable • History of angioplasty with chest pain, stable vital signs • Severe asthma • Acute epiglottitis • Signs of a stroke, but does not meet Level-1 criteria • Headache, fever, lethargy, rash. Rule out meningitis. • Sudden onset of a headache, no history of headaches • An immunocompromised patient, with a fever. On chemotherapy or post organ transplant or on waiting list • A needle stick in a health care worker • Abdominal pain in the elderly • Gastrointestinal bleeding • Acute arterial occlusion • Signs and symptoms of compartment syndrome • Extremity injury with neurovascular compromise • Testicular torsion, sudden onset of pain • Acute renal failure, unable to be dialyzed • A rule-out ectopic pregnancy, hemodynamically stable
--	--

	<ul style="list-style-type: none"> • Spontaneous abortion, bleeding and tachycardia with stable blood pressure • Pediatric with vomiting, diarrhea, unable to eat. Exhibiting sunken fontanel, poor skin turgor, lethargy • Pediatric asthma attack with nasal flaring or use of intercostals • Infant less than 28 days with a fever of 100.4°F or 38°C, or greater • Motor vehicle crash with transient loss of consciousness • Stab wound to groin, bleeding controlled, stable vital signs • Sexual assault • Acute urinary retention, in severe distress • Trauma to the eye, sudden partial or full loss of vision, or chemical splash to the eye <p>Psychiatric complaint</p> <ol style="list-style-type: none"> 1. Panic attack 2. Depressed-no suicidal ideation 3. Intoxicated-cooperative, ambulatory 4. Drug withdrawal
--	--

ESI Triage Levels 3,4 and 5 will be based on the number of resources needed to reach a disposition

Labs (blood, urine)	History & physical (including pelvic)
ECG, X-rays CT-MRI-Ultrasound	Point-of-care testing
IV fluid (hydration)	Saline or heplock
IV, IM, or nebulized Medications	PO medications Tetanus immunization Prescription refills
Specialty consultation	Phone call to PCP
Simple procedure=1 (lac repair, Foley cath)	Simple wound care (dressings, recheck)
Complex procedure=2 (conscious sedation)	Crutches, splints, slings

ESI Triage Level 3	<p><u>The ESI level-3 patient presents in stable condition. These patients will require 2 or more resources for the clinician to arrive at a disposition.</u></p> <p><u>Examples:</u></p> <ul style="list-style-type: none"> • Abdominal pain • Chronic migraine headache <p>Procedures requiring conscious sedation</p> <ol style="list-style-type: none"> 1. Vermilion border laceration 2. Displaced fracture requiring closed reduction prior to splinting <p>Psychiatric complaint</p> <ol style="list-style-type: none"> 1. Anxious-no acute distress 2. Request for medication refill
---------------------------	--

<p>ESI Triage Level 4</p>	<p><u>The ESI level-4 patient presents in stable condition. These patients will require only 1 resource for the clinician to arrive at a disposition.</u></p> <p><u>Examples:</u></p> <ul style="list-style-type: none"> • Wound requiring incision and drainage • Simple laceration • Urinary tract infection symptoms • Simple extremity injury requiring x-ray
----------------------------------	---

<p>ESI Triage Level 5</p>	<p><u>The ESI level-5 patient presents in stable condition. These patients will require no resources for the clinician to arrive at a disposition</u></p> <p><u>Example:</u></p> <ul style="list-style-type: none"> • Prescription refills • Poison ivy • Dental pain • Ear infection • Routine physical exam
----------------------------------	--

If a Patient Refuses to Consent to Examination or Stabilizing Treatment:

- The Nurse will encourage the patient to receive further medical examination and stabilizing treatment.
- The Nurse will inform the patient of the risks and benefits of refusal to receive examination and treatment.
- The Nurse shall take all reasonable steps to secure the written informed refusal of the individual.
- Should the patient request a transfer to another hospital or care provider.

DEFINITIONS:

None

Subject: Emergency Department Follow Up	Manual: Emergency Department
--	---

POLICY:

It is the policy of the Southern Humboldt Community Healthcare District, ("district" or SHCHD), to assure appropriate follow-up care is provided for patients in the Emergency Room.

Purpose:

The purpose of this policy and procedure is to assure that patients' x-rays and laboratory results are evaluated when the final results come back after the patient has been discharged from our care.

DEFINITIONS:

None

PROCEDURE:

1. Lab or x-ray results requiring follow-up will be placed in a folder in the MD office for review by MD on call.
2. After review by the MD, the follow ups are placed in the appropriate nursing supervisor's mailbox or office.
3. The follow-up will be analyzed by the MD for Emergency Department RN involvement, as necessary.
4. If new orders or follow-up information is added, this will be noted in the patient medical record.
5. There is a clipboard in the ED that will show the patients needing a call back the following day by RN on duty.

It is the expectation that this process will be implemented within 24 hours of receipt of the x-ray or laboratory results, or other need for follow up.

Subject:
Envenomation Rattlesnake Bites

Manual:
Emergency Department

POLICY:

It is the policy of the Southern Humboldt Community Healthcare District to assure appropriate care is provided for patients who present to the Emergency Room due to rattlesnake bite.

Purpose:

The purpose of this policy and procedure is to provide guidance in the case of rattlesnake bites and prevent complications from envenomation such as local tissue necrosis and to ensure early antivenin administration.

DEFINITIONS:

None

PROCEDURE:

Assessment

1. Immediately bring patient into the ED and notify the physician if snake bite occurred.
2. Obtain Vital Signs every 15 minutes.
3. Obtain history of incident including description of reptile and approximate time of envenomation.
4. Attach cardiac monitor to patient.
5. Immobilize affected area at heart level and in physiologic position.
6. Cleanse the puncture wounds with Hibiclens and Sterile water.
7. Use a skin marker to outline the area that has been affected. Mark the leading edge of swelling and measure the circumference at 10 cm and 20 cm proximal to the bite every 15 minutes.
8. Remove jewelry.
9. Ask about any allergies to medications, latex, or food,
10. **AVOID** nasogastric tubes, arterial punctures, aspirin containing products, ice or heat application, tourniquets.

Emotional Support

Keep patient at rest and provide reassurance to patient and family.

Anticipate:

1. Mild sedation is often indicated.
2. Lab studies
3. Diagnostic Studies: EKG
4. Strict Bed rest
5. Treatment: Antivenin, antibiotics, tetanus prophylaxis, pain control, steroids, and antihistamines may be given per MD order.
6. NPO for 24 hours
7. Foley Catheter with I & O's
8. Notify **1-87-SERP-DRUG (1-877-377-3784)** or Poison Control
9. Start the **transfer** as soon as possible to a receiving facility.

OBSERVE and DOCUMENT EVERY 15 MINUTES FOR:

1. Signs of shock
2. Pain (0-10 scale; may be 0 in envenomated diabetics)
3. Swelling (mark the leading edge and measure the circumference at 10 cm and 20 cm proximal to the

- bite; may be none in a severely envenomated patient)
4. Weakness or faintness
 5. Numbness or tingling (face, scalp, tongue, lips, fingers, toes, site of the bite)
 6. Change in taste (metallic, rubbery, or minty taste in the mouth = rattlesnake envenomation)
 7. Fasciculations (most noticeable on the face and over the muscle of the back and neck, as well as the bitten extremity)
 8. Nausea/vomiting/diarrhea
 9. Diaphoresis
 10. Difficulty swallowing
 11. Erythema
 12. Ecchymosis (appears where skin rubs against skin or where slight injury occurs)
 13. Bleeding

Report to the physician any changing signs or symptoms of envenomation or any abnormal lab values.

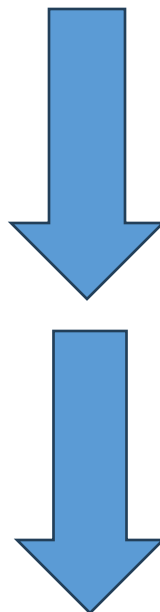
Antivenin Administration

The importance of early antivenin administration preferably intravenously (IV) cannot be overemphasized. The amount to be used depends upon the species and size of the snake, the site envenomation, the size of the patient and other factors. Increased efficacy if given within 4 hours of a bite. It is recommended to administer the antivenin up to 24 hours.

The medication is stored in the ED Pyxis refrigerator and in the main Pyxis refrigerator. It is a white box with green letters and states Crotalidae Polyvalent Immune Fab (Ovine) CroFab®

Dosages

- The starting dose of CroFab® may vary from a minimum of 4 vials to a maximum of 12 vials based on clinical judgement and severity of envenomation.
- Infuse over 60 minutes, proceeding slowly over the first 10 minutes at 25 to 50 mL/hour with careful observation for any allergic reaction.
- If no allergic reaction occurs, increase infusion to the full 250 mL/hour until completion • If necessary, administer an additional 4-6 vials of CroFab® ~1 hour after end of first infusion.



Reconstitution

CROFab[®]
crotalidae polyvalent immune fab (ovine)



1

Select and fill syringe with 18 mL of 0.9% sodium chloride



2

Inject diluent slowly into CroFab[®] vial



3

Rotate vial 180 degrees and manually invert up to twice per second until no solid material remains in the vial. Do not shake. The entire dose should then be further diluted in normal saline to a final total volume of 250 mL for infusion

Step-by-Step Instructions:

1. Select appropriate sized syringe
2. Fill syringe with 18 mL 0.9% sodium chloride
3. Insert syringe into CroFab[®] vial
4. Inject sterile saline slowly into the vial
5. If necessary, vent the vial
6. Remove needle and hold the vial between thumb and forefinger
7. Rotate the vial 180 degrees and reverse the motion for one manual inversion. Do not shake.
8. Continue to manually invert up to twice per second until no solid materials remain in the vial
9. Some bubbles may form at the top of the vial during reconstitution
10. Reconstituted product should be used within 4 hours

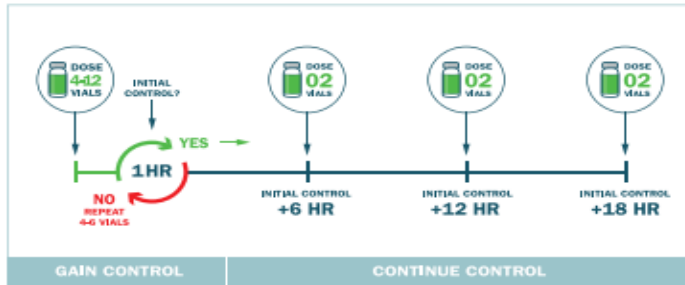
Indication

CroFab[®] Crotalidae Polyvalent Immune Fab (Ovine) is a sheep-derived antivenin indicated for the management of adult and pediatric patients with North American crotalid envenomation. The term crotalid is used to describe the Crotalinae subfamily (formerly known as Crotalidae) of venomous snakes which includes rattlesnakes, copperheads and cottonmouths/water moccasins.



The above picture is a correctly reconstituted CroFab[®] vial. The reconstituted product will appear colorless to pale yellow, and opalescent (not clear).

Administer CroFab® appropriately to gain and continue control of envenomation^{1,2}



Gaining initial control¹:

- The starting dose of CroFab® may vary from a minimum of 4 vials to a maximum of 12 vials based on clinical judgement and severity of envenomation
- infuse over 60 minutes, proceeding slowly over the first 10 minutes at 25 to 50 mL/hour with careful observation for any allergic reaction
- If no allergic reaction occurs, increase infusion to the full 250 mL/hour until completion
- If necessary, administer an additional 4-6 vials of CroFab® ~1 hour after end of first infusion

Discharge/ Transfer/ Obtaining Additional Doses of Antivenin

A safe discharge would include a fibrin degradation Product (FDP) of 10-40 or greater than 40 can be predictive of a worsening condition. **This is a test in which our facility must send out and therefore the patient will need to be transferred before discharge.**

If we are unable to transfer before the 1st dose is completed, we need to obtain additional CroFab from Redwood Memorial or St. Joseph's in Eureka.

Resources

Rocky Mountain Poison and Drug Center CroFab Line
1-87-SERP-DRUG (1-877-377-3784)

OR

Contact your local or state Poison Information Center 1-800-222-1222

Subject: Initial Management of Amputations (Severed Extremities)	Manual: Emergency Department
---	---

POLICY:

It is the policy of the Southern Humboldt Community Healthcare District (“SHCHD” or “District”) to provide optimal patient care and the following procedures for the staff to follow when initial management of amputations (severed extremities) are presented in the Emergency Department.

Purpose:

The purpose of this policy and procedure is to stabilization and limb preservation. Stump and amputated part vessels remain viable preoperatively.

Definitions (1,2)

- **Partial Amputation:** bone, muscle, or tissue keeps the amputated segment connected to the body.
 - Ideal treatment = revascularization
- **Complete Amputation:** no connecting tissue
 - Ideal treatment = re-implantation
- **Sharp/Guillotine Amputation:** Well-defined edges, minimal damage to associated anatomy.
 - Best prognosis for re-implantation
- **Crush Amputation:** extensive soft tissue & arterial damage
 - Re-implantation less likely to be successful.
- **Avulsion Amputation:** forceful overstretching & tearing of nerves & vascular tissue at many different levels from the site of separation.
 - Re-implantation unlikely

ED management is the same for ALL types of traumatic amputation => ALL patients are candidates for re-implantation until a surgeon says otherwise!

DEFINITIONS:

None

PROCEDURE:

The viability of the amputated limb depends on multiple factors, including the care delivered by all providers who come in contact with the patient. Knowing what not to do is as important as knowing what care to give. At any point, re-implantation may be made impossible with the wrong intervention.

STEPS:

1. Airway and ventilation problems recognized and controlled.
2. Major bleeding controlled by pressure and elevation of the affected extremity. Splint injured extremity.
3. Cardiac function evaluation.
4. Anticipate need for large bore IV for volume replacement. Obtain physician's order for same.
5. Anticipate antibiotic order. Check for allergies and sensitivities to same.
6. Inquire about current status of tetanus prophylaxis.
7. Keep patient NPO.
8. See standard for shock management.

SPIRITUAL/EMOTIONAL SUPPORT:

Give emotional support to patient and family and opportunity to express feelings of loss and disfigurement.

Care of the amputated segment (1,2,3)

- Irrigate with saline or sterile water & remove gross contamination.
- Remove all jewelry.
- Control any bleeding with a pressure dressing.
- Wrap in moistened sterile gauze & seal in water-tight container.
- Place container on ice, in ice water bath, or in refrigerator.
- Do NOT allow limb to freeze!

Care of the stump (2,4)

- Elevate the limb.
- Irrigate with saline & cover with damp gauze.
- Splint obvious/unstable fractures, keep as near anatomic position as possible.
- Control hemorrhage!

Tourniquet Use

- Indications for tourniquet use (5,6)
 - Uncontrollable bleeding from a site amenable to proximal placement of a tourniquet.
 - Limb amputation or mangled extremity.
 - Exsanguinating wound associated with shock.
 - Life-threatening hemorrhage inadequately controlled with direct pressure, elevation and other hemostatic methods.
- Tourniquet application (5)
 - Place the tourniquet as distal as possible, at least 5 cm proximal to the injury.
 - Spare joints as much as possible.
 - Apply directly onto exposed skin.
 - Time of application should be recorded.
 - Any amputated limb should be transported with the patient to the hospital.

Remember Life over limb!

Other Considerations

- Tetanus prophylaxis
- Prophylactic antibiotics (2,7)
 - Strep & staph coverage
 - Should be given within 6 hours of trauma.
 - Cefuroxime 1.5g IV q8h or Cefazolin 0.5-1.5g IV or IM q6-8h
 - Peds: 25-100mg/kg/d divided q8hr (max 6g/d)
 - MRSA coverage: Vancomycin 15-20mg/kg IV q12h
 - Clostridia coverage: Piperacillin/Tazobactam 80mg/kg IV q8h
 - Immediate surgical consultation – orthopedics, plastics, vascular, trauma! Time is limb!

Traumatic amputation is a surgical emergency! Get the patient to a surgeon ASAP!

PHYSICIAN CONTACT:

California Pacific Medical Center- Davies Campus; Emergency Department, San Francisco, CA. Phone number; 415-600-0600

DOCUMENTATION:

1. Documentation of assessments, treatments, procedure(s).
2. Copy all pertinent medical data for transport protocol.
3. Transfer per Hospital Wide Transfer Protocol.

Subject: Observation of Patients	Manual: Emergency Department
---	---

POLICY:

It is the policy of the Southern Humboldt Community Healthcare District, (“district” or “SHCHD”) to provide a period of time for the patient in the Emergency Room (ER) that can be used for definitive observation and care. Observation patients are either not sick enough for full admission or are still in process of being diagnosed.

Purpose:

The purpose of this policy is to ensure patients receive adequate care and treatment for the illness/injury they presented to the Emergency Department for which requires them to stay longer than 24 hours.

PROCEDURE:

- The ER provider fills out pre-printed order sheet.
- The ER provider and nursing staff determine if the patient will remain in the ER or go the Acute floor. If the patient moves to the Acute floor, the Acute care nurse will assume care for the patient.
- Observation status requires a goal and reassessment throughout the patient’s stay. There must be hourly charting done for patient in observation status.
- The ER provider and nursing staff will ensure that patient has received the Medicare Outpatient Observation Notice (MOON form) for Medicare patients. Or the Outpatient Observation Notice (OON form) for non-Medicare patients, and that it has been signed and dated appropriately.

Observation Patients need to be admitted as Inpatients, transfer to a higher level of care, or discharge home after 48 hours of admission.

DEFINITIONS:

None

Subject:
Pediatric Medication Safety

Manual:
Emergency Department

POLICY:

It is the policy of the Southern Humboldt Community Healthcare District ("SHCHD" or "District") to provide safe administration of medications to the pediatric patient. For the purposes of this section pediatric patients are defined as less than fourteen (14) years old and below fifty (50) kg in weight.

Purpose:

To safely administer medication to the pediatric patient.

PROCEDURE:

- Weight-based pediatric medication orders:
 - All neonatal orders will be written as weight-based in kilograms. The order will contain the weight-based dosing parameter.
 - All pediatric medication orders with the exception of the following will be written as weight based. The order will contain the weight-based dosing parameter and the MD will calculate the specific dosage.
 - Vitamins and iron preparations
 - Topical preparations
 - Vaccines
 - Nebulized medication(s)
- All pediatric medications, require an independent double check* by a second nurse, after the initial review process by the nurse administering the medication has been completed. The second nurse practicing in their scope will review the order for accuracy, dosage calculation and medication appropriateness. If another nurse is not available, the provider or pharmacist will be contacted to complete the second check.
- The nurse will review the current order and the eMAR at the patient's bedside:
 - Identify patient using the two-patient identifier process; name and date of birth
 - Check for allergies.
 - Compare medication to eMAR for right patient, right medication, right dose, right route and right time/frequency.
 - Document the actual administration time at "point of care."
- The nurse will remain with the patient until the medication is taken. Medications are not left at the bedside. For pediatric patients, parents may give oral medications in the RN or LVN's presence.
- If the patient or patient's guardian refuses the medication, the nurse will return the unopened/unused medication to the appropriate medication drawer and document on the eMAR as "not given."

DEFINITIONS:

None

Subject: Pediatric Standards of Care	Manual: Emergency Department
---	---

POLICY:

It is the policy of the Southern Humboldt Community Healthcare District (SHCHD) to make sure that nursing staff will follow approved protocol in caring for pediatric cases.

Purpose:

The purpose of this policy is to ensure quality care is given for the pediatric patient.

PROCEDURE:

- Blood pressure is required on all pediatric patients over 10 years old or on any pediatric patient whose chief complaint warrants initial vital signs.
- Weights are to be taken and recorded in kg on all children.
- Temperatures are to be obtained on all pediatric patients, either, rectally, tympanic, orally. Axillary temps are not to be taken. Rectal temps will be assessed on all patients less than 5 years of age.
- Special supplies needed to treat the pediatric patient are to be kept in the Emergency Department at all times. This includes but is not limited to the following:
 - Pediatric paddles for the defibrillator
 - Pediatric laryngoscope blades
 - Pediatric airways, suction tubing and equipment
 - Pediatric O₂ masks and ambu bag
 - Pediatric splints
 - Pediatric lumbar puncture tray
 - Pediatric chest tubes
 - Broslow tape is kept on the pediatric crash cart listing dosages for emergency drugs for the pediatric patient based on length and weight.
 - Pediatric patients requiring specialized intensive care services will be transferred to an appropriate pediatric hospital

DEFINITIONS:

None

Subject: Pelvic Exams in the Emergency Department	Manual: Emergency Department
--	---

POLICY:

It is the policy of the Southern Humboldt Community Healthcare District ("SHCHD" or "District") to provide optimal patient care and the following procedures for the staff to follow when assisting with pelvic exams.

Purpose:

The purpose of this policy and procedure is to outline guidelines to assist the emergency room provider with a pelvic exam. All providers need a chaperone.

PROCEDURE:

Set up equipment for a Standard Vaginal Exam Tray:

- Lubrication (use warm water for evidentiary collections)
- Speculum
- Light
- Culture
- Large cotton swab
- Wet mount prep (Tube with sterile NS)
- G/C & Chlamydia Swab
- Provider Gloves

Provide the patient with a drape or blanket for comfort.

- Explain procedure to patient, provide screening, drape sheet and remind patient to empty bladder prior to exam if possible and collect urine sample for any possible testing.
- Assist patient to dorsal recumbent or lithotomy position as required by physician, assist patient with foot stirrups if lithotomy position is used.
- Encourage patient to use deep breathing for relaxation of pelvic muscles during exam. Offer comfort to patient during any painful or uncomfortable procedures.
- Assist physician when needed, with culture, swabbing, or lab tests.
- After exam, assist patient to sitting position, provide warm water and cloth for cleansing perineum.

DEFINITIONS:

None

Subject: Penetrating Injuries from Missile	Manual: Emergency Department
---	---

POLICY:

It is the policy of the Southern Humboldt Community Healthcare District that all gunshot and stab wounds are reportable incidents to law enforcement, following California Penal Code #11160. Forensic considerations include careful documentation of patient's condition with accurate description of injury, careful removal of clothing, evidence handling and disposition of bullets, weapons.

Purpose:

To ensure the following in a patient with trauma resulting from stab wounds and gunshot wounds: local bleeding controlled (hypovolemic shock avoided by adequate fluid volume), wound cleansed and prepared, reduction or elimination of pain, appropriate reporting to law enforcement agencies and appropriate handling of evidence.

PROCEDURE:

ASSESSMENTS/OBSERVATIONS:

Stab Wounds:

- With penetrating chest and abdominal injuries, watch for respiratory insufficiency.
- Obtain data on length/size of weapon.
- Check neurovascular status of affected limbs.
- Check for arterial injury with continued bleeding and hypovolemic shock.
- Document time elapsed since injury.

Gunshot Wounds:

- Look for entrance and exit wounds.
- Find out type of gun and bullet caliber, if possible, distance from victim and time elapsed.
- Assess for bleeding/hypovolemic shock.
- Check for pulses and neurovascular status.

Interventions:

- Notify physician immediately of patient condition upon arrival.
- Control active bleeding by direct pressure, maintain circulation, airway, and breathing status.
- Establish (2) large bore IV's.
- Monitor neurovascular status upon arrival and every two hours.
- Don't attempt to remove if there is an impaled object, instead stabilize and secure the object.
- Administer analgesia as order by physician.
- Assist with debriding, irrigating, removal of missile and closing procedures as needed, or prepare patient for surgery.
- Notify appropriate law enforcement agency and complete a Suspicious Injury Form.
- Do not give patient's name or circumstances to anyone except immediate family; consider registering as a confidential patient.
- Anticipate administration of IV antibiotics and tetanus immunization.
- Bag clothing removed in paper bags and preserve for evidence collection.
- Bag patient hands in cases of gunshot wound when circumstances are unknown.

Documentation:

Initial assessment, as described, and all interventions performed with outcomes. Document notification of law enforcement and disposition of all evidence in the nurse's notes and indicate there is supplemental documentation in the Secondary Assessment. Document the officer's name and the case or CAD number on the Suspicious Injury Report.

DEFINITIONS:

None

Subject: Postmortem Care – Coroner Cases	Manual: Emergency Department
---	---

POLICY:

It is the policy of Southern Humboldt Community Healthcare District (“SHCHD” or “District”) to provide optimal patient care and the following procedures for the staff to follow when there is a death in the facility.

Purpose:

The purpose of this policy is to provide procedures to Emergency Department staff to follow in postmortem cases.

PROCEDURE:

- Contact the attending physician or the physician on-call to make the pronouncement of death.
- Contact the patient’s family or designated person(s).
- Contact the County Coroner for all Coroner cases:
 - All DOAs.
 - Death without medical attendance.
 - Death during continued absence of physician (7 days).
 - Where attending physician is unable to state cause of death.
 - In suspected cases of Sudden Infant Death.
 - Where patient has been in hospital less than 24 hours.
 - Where the deceased patient was killed or committed suicide.
 - Where the deceased patient dies as a result of an accident.
 - Under circumstances affording reasonable grounds to suspect death was caused by the criminal act of another.
 - When in doubt, report the case.
- Leave identification band on the body.
- Collect patient’s possessions and valuables and give to the family member or designated person(s), including all medications except controlled substances. Controlled substances should be placed in the drug room in pharmacist’s locked box with controlled drug record.
- If not a Coroner’s case, contact the mortuary of the family’s preference.
- Make body presentable. Remove all IVs and tubes, except in Coroner cases – leave everything as is.
- Notify mortuary of any contagious or infectious disease they would need to take precautions for when caring for the body. A body bag may be placed on the body as a precaution as needed.
- Complete the **Consent to Release of Body** form. The person entitled to control the disposition of the remains must sign this form. If unable to have form signed by the next of kin who are present in the hospital, consent by telephone with a witness is adequate.
- The mortuary director, or his designated representative, receiving the body must complete the **Consent to Release of Body** form.
- Have physician who pronounced the death sign the death certificate prior to release of the body, if possible. If it is a Coroner case, the physician does not sign the death certificate, nor does he solicit autopsy permit or order an autopsy without permission of the Coroner.
- Contact the organ/tissue donation center to report all deaths, regardless of age or morbidity: 1-800-55-DONOR.
- Send **Dismissal Slip** to admitting, **Dietary Communication** slip to dietary, and document death and time on the census sheet.

DEFINITIONS:

None

Subject:
Precipitous Delivery Procedure

Manual:
Emergency Department

POLICY:

It is the policy of the Southern Humboldt Community Healthcare District ("SHCHD" or "District") to transfer patients to the nearest most appropriate Childbirth Center when indicated, or to provide successful delivery of infant in the Emergency Department when delivery is imminent. If the patient is crowning, and there is insufficient time to transport the patient to the Childbirth Center, the delivery is controlled by the ED physician following the standard delivery process. Both mother and infant are cared for in a safe manner while taking measures to prevent any complications.

Purpose:

The purpose of this policy is to provide a procedure for a safe delivery in the case of imminent childbirth in the Emergency Department setting.

PROCEDURE:

• **EQUIPMENT AND LOCATION:**

- The OB packs are secured in the Emergency Department on the bottom shelf of the metal rack in room two. The infant warming unit is obtained from the changing room across the hall from the Emergency Department.

- Notify the receiving Childbirth Center of imminent delivery.

- Obtain history on patient including prenatal care, EDC, gravidity and parity, drug/alcohol use and HIV status/GBS.

- Prepare for imminent delivery if the fetal head is visible at the introitus, or if the woman is multigravida, is completely dilated with sudden rupture of the membranes, and complains of rectal pressure.

• **Care of the mother:**

- Maintain CAB, start large bore IV.
- Assist physician with delivery process as necessary.
- Provide breathing instructions, avoiding expulsive pushing. Panting may be encouraged.
- Note time of delivery.
- Collect 10cc of cord blood (two tall, 6cc, red top tubes located in the lab) to be sent with mother and infant to the Childbirth Center.
- Monitor for postpartum hemorrhage (blood loss >500cc).
- Anticipate administration of IM Oxytocin (10 units IM).
- Perform fundal massage as ordered by physician.
- Include family/significant others in process, providing emotional support.

• **Care of the infant (as directed by the attending):**

- Check for cord around neck and gently remove, if present.
- Suction infant's nose and airway immediately upon presentation with a bulb syringe.
- Assist with clamping and cutting the cord after it has stopped pulsating.
- Dry infant and place on top of mother, allowing for breastfeeding and bonding
- Perform **A**ppearance, **P**ulse, **G**rimace, **A**ctivity, and **R**espiration or **APGAR Score** at 1 minute and 5 minute intervals. See table on next page.

Sign	SCORE		
	0	1	2
Colour	Blue or pale grey	Pink body, blue extremities	Pink all over
Heartbeat	Absent	Less than 100 beats/minute	More than 100 beats/minute
Respiration	Absent	Slow, irregular, gasping	Normal
Grimace (response to stimuli)	None	Grimace (slight)	Cry
Activity (muscle tone)	Limp	Some flexion of extremities	Active motion

- Keep infant warm with blankets and infant warmer.
 - Baby is banded immediately after delivery to match bracelet of mother.
 - Treat newborn eyes with Erythromycin ointment within 2 hours after birth, after eye contact between mother and baby has been established.
 - Weigh and measure infant.
 - Check cord for bleeding every 15 minutes x 3, then every 2 hours.
 - Notify the physician of any of the following:
 - Grunting, flaring, retractions or abnormal cyanosis.
 - APGAR less than 7 at one minute or less than 8 at ten minutes.
 - Birth weight of less than 5 pounds or greater than 9 pounds.
 - Initiate breast feeding at mother's request as soon as possible after birth.
 - Support parents in touching and holding infant.
 - Assist as necessary with infant feeding technique.
- After the delivery, and when the mother and newborn are stable, notify the Childbirth Center of transfer of mother and infant to their location.

DEFINITIONS:

None

Subject: Procedural Sedation	Manual: Emergency Department
---	---

POLICY:

It is the policy of the Southern Humboldt Community Healthcare District ("SHCHD" or "District") to provide guidelines for procedural sedation. This policy is to provide all patients receiving in any setting, for any purpose, by any route, procedural sedation as defined in this policy. The organization currently defines two (2) levels of procedural sedation:

- **Minimal sedation (anxiolysis)** – a drug induced state during which patients respond normally to verbal commands. Although cognitive function and coordination may be impaired, ventilatory and cardiovascular functions are unaffected.
- **Moderate sedation/analgesia ("conscious sedation")** – a drug induced depression of consciousness during which patients respond purposefully to verbal commands (Note: Reflex withdrawal from a painful stimulus is not considered a purposeful response), either alone or accompanied by light tactile stimulation. No interventions are required to maintain a patent airway, and spontaneous ventilation is adequate. Cardiovascular function is usually maintained.

Purpose:

The purpose of this policy and procedure is to provide guidelines for appropriate monitoring of patients receiving procedural sedation before and after the procedure.

DEFINITIONS:

Pediatrics:

A pediatric patient is defined as anyone under the age of 14 and/or up to the age of 21 at the Physician's discretion.

This policy does not apply to medications used for the management of pain control, seizures, pre-operative medications, or medication given to an intubated patient on a ventilator.

PROCEDURE:

Before Sedation:

- Obtain Informed Consent.
- Bring up conscious sedation flow sheet in the EMR (electronic medical record).
- Document allergies and weight.
- **NPO Status:**
 - (Nothing by mouth) Evaluate recent food/fluid intake. (The use of sedation must be preceded by an evaluation of food and fluid intake. Since protective airway reflexes can be lost, gastric contents may be regurgitated into the airway. Therefore, patients with a history of recent oral intake or with known risk factors, such as trauma, decreased level of consciousness, extreme obesity, pregnancy, or bowel motility dysfunction, require careful evaluation before administration of sedatives. If possible, such patients may benefit from delaying the procedure and administering appropriate pharmacologic treatment to reduce gastric volume and increase gastric PH. When proper fasting has not been assured, the

increased risks of sedation must be carefully weighed against its benefits, and the lightest effective sedation should be used. An emergency patient may require protection of the airway before sedation (intubation).

- The following NPO guidelines apply for otherwise healthy patients:
 - Patients less than 2 years old - may take solids and formula up to 6 hours prior to the procedure, may take human milk up to 4 hours prior to surgery, and may take clear liquids up to 2 hours before procedure.
 - Patients greater than 2 years old - may take clear liquids up to 4 hours before procedure and may have a light meal up to 6 hours before procedure.
- Documentation of the time of the last oral intake. Variations in these guidelines may be indicated because of the patient's clinical presentation.
 - **Equipment needed before sedation:**
 - Have appropriate sized Ambu bag and mask ready to go.
 - Oxygen (2L NC on patient) and suction at bedside/
 - Have all emergency equipment, including reversal drugs and defibrillator available.
 - Obtain baseline vital signs (continuous pulse oximeter and blood pressure monitor) and pre-procedure cardiac monitoring strip.
 - IV or saline lock in place when indicated.

During Sedation/Treatment:

- Use **Procedural Sedation Flow Sheet**
- Continuous monitoring of O₂ saturation by oximetry, heart rate, blood pressure and respiration rate every 15 minutes.
- Document all treatments and medications as they are done.

Significant changes to be reported immediately by the registered nurse to the attending practitioner:

- Heart rate changes:
 - Adult: +/- 20% change from baseline; < 60 or > 100 beats per minute
 - Pediatric: +/- 20% change from baseline
- Oxygen saturation changes:
 - Adult: - 10% drop and/or saturation < 92%
 - Pediatric: -5% drop and/or saturation < 92%
- Level of consciousness changes or if the patient cannot be aroused
- Tissue perfusion changes with cyanosis, mottled skin or clamminess.
- Infants with a history of apnea, those born prematurely (less than 37 weeks gestation) who are less than 60 weeks post conceptual age, or full-term newborns less than 44 weeks post-conceptual age are monitored for 12 hours following moderate sedation. The degree of monitoring post-procedure is determined by measures of appropriate discharge criteria from the department in which the procedure occurred.

Personnel Requirements:

- All procedural sedation must be administered under the direct supervision of a licensed physician practitioner who holds clinical privileges for the level of procedural sedation that is being administered.
- A qualified registered nurse or qualified physician must have the primary responsibility for medication administration and monitoring the patient's vital signs and level of consciousness during the administration of procedural sedation.
- The registered nurse administering medication, monitoring, or recovering the patient receiving procedural sedation must demonstrate current competence, as evidenced by completion current ACLS & PALS certification and demonstrated competency in the following areas:

- Airway Management
- Cardiac Monitoring and arrhythmia recognition
- Use of sedation and reversal agents
- Oxygen therapy
- The ability to intervene in the event of complications
- Procedural Sedation hospital-wide policy

If administering sedation to a pediatric patient, PALS or NRP certification is required.

Vital signs pre-procedure; then q15 minutes during procedure; then q30 minutes post-procedure until discharge criteria is met

After Treatment:

- Continuous monitoring and vital signs every 30 minutes until patient meets discharge criteria as stated on **Procedural Sedation Flow Sheet**.
 - **Discharge Criteria** (all must be present before discharge)
 - Cardiovascular function within normal limits (vital signs stable, SaO2 WNL).
 - Patient's protective reflexes are present and patient is alert and oriented x 3.
 - Patient can ambulate unaided without difficulty.
 - A Discharge & Procedural Sedation Instructions given and patient verbalizes understanding of them.
- Obtain physician order for discharge.
 - Discharge with appropriate instruction form.

Subject: Referrals from the Emergency Department	Manual: Emergency Department
---	---

POLICY:

It is the policy of the Southern Humboldt Community Healthcare District ("SHCHD" or "District") to provide appropriate referrals to patients who have been seen in the Emergency Department (ED).

PURPOSE:

The purpose of this policy and procedure is to delineate the procedures for obtaining referrals through the ED.

PROCEDURE:

- *Non-urgent referrals* can be done through the ED. If the ED physician feels that a referral is needed, he/she will instruct the patient, via the Discharge Instructions, on how the referral process works.
- *Urgent referrals*, those that should be done within 72 hours should be done as needed in the ED.
- The following steps should be taken for all referrals out of the ED:
 - The ED physician will document that there is no Emergency Medical Condition (EMC) present indicating that the patient is "stable" (per EMTALA) and a *referral*, rather than a *transfer*, is appropriate.
 - The physician will enter the referral within Epic.
 - The Referrals Coordinator will retrieve the referral from within Epic to process.
 - The nurse will document that a referral was made in the Emergency Department in the nurses' notes section of the patient's Electronic Medical Record.

DEFINITIONS:

None

Subject: Stroke Policy and Procedure	Manual: Emergency Department
--	--

POLICY:

It is the policy of the Southern Humboldt Community Healthcare District (“SHCHD” or “District”) to provide optimal patient care and the following procedures for the staff to follow using an evidence-based approach to treat and care for patients who present with signs and symptoms consistent with acute stroke. Although these guidelines assist in guiding the care of the patient, responsibility to determine appropriate care for each individual remains with the provider themselves.

PURPOSE:

The purpose of this policy and procedure is to provide guidelines for the care of patients with signs and symptoms of acute stroke.

PROCEDURE:

OUTCOMES/GOALS	<ol style="list-style-type: none"> 1. Rapid Identification of Stoke 2. Manage patient appropriately and efficiently 3. Evaluate in a cost-effective manner
TRIAGE/REGISTRATION	<ul style="list-style-type: none"> • Document Chief Complaint such as sudden onset of weakness, numbness, difficulty speaking, vision changes, severe headache, and dizziness. • Screen for suspected stroke using the NIHSS stroke screen and swallow study. If one positive finding and onset was less than 12 hours prior, then level for ESI Level 1 or 2 per patient condition. • If onset is greater than 12 hours or symptoms have resolved, and patient’s ABCs are stable then the triage level ESI Level 3 is applied. May upgrade as needed. • Registration should be done at bedside.
RN	<p>Notify doctor, CT, and lab to anticipate STROKE orders. Anticipate Orders for:</p> <p>CT without contrast Labs for CBC, CMP, PT/INR, aPTT, serum HCG female less than 50</p> <p>Obtain capillary blood glucose 12 lead EKG CXR (chest X-ray) if indicated</p>
ED PHYSICIAN	<p>If symptom onset was less than 12 hours prior to visit, evaluate for suspected stroke within 10 minutes of patient arrival.</p> <ul style="list-style-type: none"> • ORDER STAT HEAD-CT without contrast. • LABS: CBC with diff, INR, PTT, POC troponin, POC Chem 8. • Order STAT tele-neuro consult if NIHSS > 6. If NIHSS is greater than 6 then order a STAT CTA. CTA for patients who could be candidates to bridge from IV tPA to intra-arterial intervention- DO NOT DELAY tPA TO COMPLETE THE CTA] If the patient has a significant neurological deficit (i.e. NIHSS > 6) and/or CTA demonstrates proximal vessel occlusion, the patient

	<p>needs neurointerventional and needs to be transferred STAT.</p> <ul style="list-style-type: none"> • Obtain and read 12 lead EKG within 45 minutes of patient arrival. Obtain CXR as needed. • Obtain patient History including age, time of onset (when last seen normal), duration, type of symptoms, medications (antiplatelets and anti-coagulants), past medical HX, previous strokes/TIA, illicit drug use • Exam: NIH Stroke Scale to document visual fields, extraocular muscles, speech impairment, weakness or sensory deficits, incoordination, ataxia
<p>ED NURSE</p>	<ul style="list-style-type: none"> a. Establish 2 IV sites, including stat 20 or 18 gauge antecubital IV for CTA (ideally on right), start 0.9% NS 250-500 cc bolus followed by NS @ 80 cc/hour b. Cardiac monitor, pulse oximeter, continuous vital signs c. 12 lead EKG and CXR after CT – unless experiencing chest pain d. Clinical evaluation for active illicit drug use (toxicology screen) or ETOH intoxication e. Obtain patient weight early f. Notify manager early regarding potential tPA preparation.
<p>ACUTE/SWING INPATIENT</p>	<p>For those patients with a suspected stroke while hospitalized:</p> <ol style="list-style-type: none"> 1. Alert the ED physician and nurse. 2. Stat bedside glucose 3. Stat Head CT, CTA if NIHSS > 6 4. Place order for IV tPA- notify Manager 5. Order stat stroke labs 6. tPA approved by ED physician. tPA can be given by the ED nurse or a nurse with critical care licensing. 7. Transfer patient to ED for tele-neuro and better observation 8. Establish 2 IV sites, including stat 18 or 20 gauge antecubital for CTA, start 0.9% NS 250 cc bolus followed by NS @ at 80 ml/hour 9. Cardiac monitor, pulse oximeter, monitor vital signs 10. Initiate transfer <p style="text-align: center;">Once tPA has been started –</p> <p>Do not perform for 24 hours post tPA unless procedure is life-saving:</p> <ul style="list-style-type: none"> • Arterial or central venous punctures/lines, IM injections, nasogastric tubes, Foley catheters • Place the patient on anticoagulation precautions until 24 hours after the infusion • Do not give any antithrombotic drugs (including heparin, warfarin, aspirin, clopidogrel, dipyridamole, ticlopidine, or NSAIDS) x 24hrs
<p>ADMINISTRATION OF ACTIVASE (TPA), ED NURSE AND MD RESPONSIBILITIES</p>	<p>Administration</p> <ul style="list-style-type: none"> • After speaking with tele-neuro or neurologist at accepting hospital, administer IV tPA with ED physician order and manager being aware. • Administer tPA in monitored setting (emergency room) Bolus may be given on floor for in-house strokes as long as critical care or ED nurse is present • Mix a 100 mg tPA vial with 100 cc NS- 1ml=1mg • Weight should be on file for all patients being admitted. Use weight to calculate dose. Should be done once by physician and then by nurse.

- Calculate TOTAL tPA DOSE: 0.9 mg per kg (not to exceed 90 mg total dose)
 - Give 10% as IV bolus over 1 minute
 - Give other 90% as IV infusion over 60 minutes – infuse 50 ml NS after dose to flush medication
- Vital signs and neuro-checks at least every 15 min for first 2 hours, including NIHSS scores, which must be documented and a swallow screening.
- Treat systolic BP if it rises to >180 mm Hg or diastolic BP >105 mm Hg for more than 15 minutes Pause infusion while BP is being controlled.
- Avoid BP decrease <160/ 85 mm Hg
- Notify physician immediately if SBP/DBP greater than 175/100
- Do not insert Foley catheter or nasogastric tube unless ordered
- Document hourly neurologic reassessment (more frequently if changes occur)
- ED physician: Calculate IV tPA dose based on weight estimate and tPA dosing table: Document estimated weight; Review with nursing staff to ensure accuracy Confirm BP within safe limits Write order for tPA total dose as a bolus plus infusion Administer the 10% bolus over 1 minute and document time on ED medication order sheet.
- Repeat NIHSS evaluation if patient exam has changed significantly Strict control of blood pressure for 24 hours.
- The patient remains under the care of the ED until officially transferred to accepting facility.

tPA Dosing (estimated weight)

Estimated Weight (lbs)	Conversion to Kilograms (Kg)	Total iv t-PA Dose (mg) at 0.9 mg/kg	t-PA Bolus (mg) *10% of total*	t-PA Bolus (ml)	Discard Dose t-PA (Not for infusion)	Infusion Dose (mg)	Infusion Rate (ml/hr)
220+	100.0	90.0	9.0	9.0	10.0	81.0	81.0
210	95.5	85.9	8.6	8.6	14.1	77.3	77.3
200	90.9	81.8	8.2	8.2	18.2	73.6	73.6
190	86.4	77.7	7.8	7.8	22.3	70.0	70.0
180	81.8	73.6	7.4	7.4	26.4	66.3	66.3
170	77.3	69.5	7.0	7.0	30.5	62.6	62.6
160	72.7	65.5	6.5	6.5	34.5	58.9	58.9
150	68.2	61.4	6.1	6.1	38.6	55.2	55.2
140	63.6	57.3	5.7	5.7	42.7	51.5	51.5
130	59.1	53.2	5.3	5.3	46.8	47.9	47.9
120	54.5	49.1	4.9	4.9	50.9	44.2	44.2
110	50.0	45.0	4.5	4.5	55.0	40.5	40.5
100	45.5	40.9	4.1	4.1	59.1	36.8	36.8

Monitoring:

1. Blood pressure monitoring:
 - a. During the first 24 hours after tPA, monitor BP:
 - Every 15 minutes for 2 hours after starting the infusion, then
 - Every 30 minutes for 6 hours, then
 - Every 60 minutes until 24 hours after starting treatment

- b. If systolic blood pressure is >180 mmHg or if diastolic blood pressure is >105 mmHg for 2 or more readings 5 to 10 minutes apart, the following is recommended:
 - **First tier intervention:** Give IV labetalol 10 mg over 1 to 2 minutes. Labetalol may be repeated up to 3 doses every 10 to 20 minutes (doubling doses if needed depending on effect of preceding dose; eg. 1st dose-10mg, 2nd dose- 20mg, 3rd dose-40mg, then consider drip)
 - For heart rate <60/minute, use hydralazine 5-20mg intravenous over 1-2 minutes every 20-30 minutes. After second bolus, consider second line intervention
 - Monitor blood pressure and neurologic exam every 15 minutes during treatment and observe for development of hypotension for all 3 tiers of BP interventions
 - **Second tier intervention:** If 3 doses of labetalol or hydralazine bolus or 30 minutes pass without sufficient BP control, the next step should be a nicardipine drip
 - **Third tier intervention:** If nicardipine drip fails, then the next step should be a labetalol drip

****To avoid worsening of cerebral ischemia, target BP of 155-175/85-100.**

- Use 0.9% NS **only**, as needed (avoid hypotonic solutions). Initiate fluid hydration in the ED with 250-500 cc bolus followed by 80 cc per hour, except in those patients who have a contraindication (pulmonary edema, renal failure, known CHF)

5. Further management as directed by tele-neuro or accepting neurologist

Intravenous tPA in Acute Ischemic Stroke

Approved FDA use for LESS than 3.0 hours from initial symptoms

Off-label use for 3 to 4.5 hours (see additional warnings below – requires consent)

A. Indications

- For patients with NEW symptomatic ischemic stroke with clearly defined *Last Known Well* < 3 hours
- Age 18 or more
- Patient evaluated by tele-neurology and physician, and tPA approved by ED attending (via phone or in person)

B. Contraindications

- CT scan findings of intracranial hemorrhage or major acute infarct (> 1/3 cerebral hemisphere)
- Suspicion of subarachnoid hemorrhage (even if head CT is negative for hemorrhage)
- Significant head trauma or prior stroke in the past 3 months
- Intracranial or intra-spinal surgery within the past 3 months
- History of previous intracranial hemorrhage or large (>10mm) brain aneurysm, vascular malformation or intraparenchymal brain tumor
- Arterial puncture at non-compressible site in previous 7 days
- Known bleeding diathesis **OR**
 1. Current use of oral anticoagulants with INR > 1.7 or PT > 15 seconds
 2. Use of heparin within 48 hours preceding onset of stroke AND prolonged aPTT at time of presentation. Low molecular weight heparin use (i.e.- Lovenox) in the past 24 hours.
 3. If suspected abnormal platelet counts and platelets <100,000

- 4. Active internal hemorrhage
- 5. Novel oral anticoagulant use in the past 48 hours. If last dose >48 hours, confirm normal renal function [creatinine clearance >50 mL/min] and normal coagulation [aPTT, INR, platelet count, thrombin time or appropriate factor Xa activity assays] before tPA administration.
- Persistent systolic BP >185 mm Hg or diastolic BP >110 mm Hg despite treatment.
- **Patients treated within 3-4.5 hour window warnings**
 - **Age > 80**
 - **Any anticoagulant use (even if INR < 1.7)**
 - **NIHSS > 25**
 - **History of stroke AND diabetes**

C. Warnings (risks must be weighed against anticipated benefits)

- MI within last 3 months (with normal TTE)
- Current use of oral anticoagulants with INR > 1.5 or PT > 15 seconds
- Major surgery or serious trauma within previous 2 weeks, consider surgical site hemorrhage risk
- Non-disabling, or rapidly improving symptoms
- High likelihood of left heart thrombus
- Aortic dissection
- Small or moderate-sized intracranial aneurysm (<10 mm) or vascular malformation. Consider for severe neurologic deficits and disabling symptoms.
- Severe neurological deficit (NIH stroke scale score >22)
- Seizure at symptom onset, particularly with head trauma
- History of IVDU and/or suspicion for endocarditis
- Tox-screen positive for ETOH, cocaine, opiates, or amphetamines (if available, but should not delay tPA protocol)
- Subacute bacterial endocarditis
- Acute pericarditis
- History of hemorrhagic diabetic retinopathy
- Significant hepatic dysfunction with abnormal INR
- Pregnancy
- Sickle cell disease
- Internal hemorrhage (e.g., GI or urinary tract) < 3 weeks
- Blood glucose < 50 mg/dL

D. Not a contraindication

- Current aspirin, NSAID or antiplatelet drugs (dipyridamole, ticlopidine, clopidogrel)
- History of PUD (not currently active [>3 months])

Treatment of patients who sustain a hemorrhage soon after IV t-PA administration

- STAT call to physician and order for standard labs, check fibrinogen
- Cryoprecipitate 10 units
- Consider aminocaproic acid or tranexamic acid
- Consider platelet transfusion (6-8 units) if available
- Consider FFP transfusion

Last Known Norm	Blood Glucose: _____(PTA)_____ (on-site) <small>(result) (result)</small>		
Arrival to ED	Weight in Kg by Scale:	✓ <i>Check</i> or Time	Notes
Compliance Targets	Code Stroke Protocol Initiated		
≤5 min	<ul style="list-style-type: none"> • Physician, lab and CT called • Code Stroke Panel ordered • Tele-Neuro called or consult 		

≤10 min	<ul style="list-style-type: none"> MD rapid assessment and NIHSS Assessment 				
≤15 min	<ul style="list-style-type: none"> Tele-Neurologist or consult responded/case discussed 				
In CT Room					
≤15-25 min	<ul style="list-style-type: none"> IV access <i>(do not delay CT for IV access)</i> 				
	<ul style="list-style-type: none"> Labs drawn <i>(before scan)</i> <i>(notify MD if greater than 5 min delay)</i> 				
≤30 min	<ul style="list-style-type: none"> CT and CTA scans completed 				
Return to Unit					
	<ul style="list-style-type: none"> RN enters wt, ht, and allergies into EMR 				
	<ul style="list-style-type: none"> Full NIH Stroke Scale (physician/RN) 				
	<ul style="list-style-type: none"> Confirm O2 Saturation greater than 92%. Oxygen at 2-4L by nasal cannula if SpO2 less than 92% 				
≤45 min	<ul style="list-style-type: none"> NPO until RN Swallow Screen Result: _____ <i>(do NOT delay alteplase for Swallow Screen)</i> 				
	<ul style="list-style-type: none"> 2nd IV access <i>(do NOT delay alteplase for access)</i> 		Time	RN Init	Medication/Tx
	<ul style="list-style-type: none"> ECG, 12-lead <i>(do NOT delay alteplase for ECG)</i> 				Oxygen 4L/min, titrate to maintain SpO2 greater than 92%
	<ul style="list-style-type: none"> CXR <i>(do NOT delay alteplase for CXR)</i> 				IV Normal Saline at 80mL/hr
Thrombolytic Decision Support					2 nd IV Normal Saline Lock
≤55 min	<ul style="list-style-type: none"> CT Scan formal reading resulted 				ASA 300 PR if patient NPO
	<ul style="list-style-type: none"> PT/INR and platelets resulted 				
If Thrombolytic (alteplase) to be Given:					
≤55 min	<ul style="list-style-type: none"> alteplase order either 1) entered electronically by MD OR 2) written order delivered. Confirm dose done by MD and nurse. 0.9mg/kg dosing. 1st 10% bolus 				Code Stroke called at _____ or alteplase bolus given at _____
	<ul style="list-style-type: none"> Manager or Physician called for 2nd witness 				
	<ul style="list-style-type: none"> Confirm SBP less than or equal to 185mm Hg, DBP less than or equal to 110 mm Hg 				
	<ul style="list-style-type: none"> <i>Only if indicated in next 24 hours, foley placed (do NOT delay alteplase for foley cath)</i> 				
	<ul style="list-style-type: none"> Confirm verbal informed consent for alteplase. Get signed consent if possible. 				
	<ul style="list-style-type: none"> NIHSS by RNs @ care transfer with vitals 				
60 min Target:	<ul style="list-style-type: none"> alteplase bolus administered → 				
RN Signature: _____ RN Initials _____					
Date _____ Time _____ MD _____					
Patient Label					

DEFINITIONS:
None

Subject: Valuables and Personal Effects	Manual: Emergency Department
--	---

POLICY:

It is the policy of the Southern Humboldt Community Healthcare District (SHCHD) that it does not assume responsibility for valuables kept by the patient, nor for the loss or damage of personal belongings not deposited in a hospital valuables envelope. Personal effects will be placed in a “belongings” bag and labeled with the patient’s identification. Valuables will be bagged, labeled with the patient’s identification, and locked at the Nurses’ station if patient is unconscious, no relatives are present, or if the patient expires.

PROCEDURE:

- For the alert, conscious, non-critical patient, personal belongings are placed in a labeled bag or envelope and kept with the patient and are the patient's responsibility. If the patient is sent to x-ray, property is kept with the patient on the cart, wheelchair, or hand carried.
- If the patient is unconscious and no relatives are present, valuables should be inventoried by two nursing staff members, bagged, labeled and locked in the double lock drawer in the Emergency Room. This should be noted on the patient's chart.
- Medications brought from home that are not approved for patient use shall be sent home with the patient’s family member or designee. If the medications cannot be removed from the Emergency Department by the patient’s family or designee, the medications should be treated and stored as valuables.
- If the patient is admitted to the hospital:
 - All effects are placed in a labeled bag and returned to the patient.
- All valuables should be returned to the family or locked at the Nurses' Station and so noted on the patient's chart.
- If the patient is transferred to another facility:
 - All effects are placed in a labeled bag and given to the family or the ambulance attendants.
 - All valuables should be returned to the family or locked at the Nurses' Station and so noted on the patient's chart.
- If the patient is dead on arrival (DOA) or expires, the personal effects and valuables are given to the family except in a coroner's case. In a coroner's case the personal effects are labeled and given to the coroner. In each instance the disposal of the personal effects is noted on the patient's chart.
- If the patient is in custody of the Humboldt County Sheriff or California Highway Patrol:
 - All belongings shall be placed in a “belongings” bag and labeled.
 - The personal belongings shall be released to the Humboldt County Sheriff Deputy or the California Highway Patrol Officer and so noted on the Emergency Room record.

DEFINITIONS:

None

Subject: Discharge Instructions for Acute In-Patients and Swing Patients	Manual: Nursing
---	----------------------------------

POLICY:

It is the policy of Southern Humboldt Community Healthcare District ("SHCHD" or "District") to assess and reassess a patient's need for services following discharge using a coordinated interdisciplinary approach during the patient's hospital stay as well as to provide each patient with a functional set of discharge instructions and education relevant to their diagnosis and patient stay.

PURPOSE:

The purpose of this policy is to ensure Acute, and Swing Patients are discharged according to their needs and to outline the process for discharging a patient to home with or without follow-up care.

DEFINITIONS:

None

PROCEDURE:

Verbal communications concerning discharge, or the discharge planning process shall be conducted in layman's terms using the patient's preferred language. Written discharge instructions shall also be provided, using materials that have been translated into the patient's preferred language whenever possible.

1. Assist in contacting the patient's family/caregiver(s) to inform them of the discharge date and confirm transportation arrangements.
2. The nurse caring for the patient must complete the discharge instructions.
3. Provide patient and family/caregiver(s) with a written discharge instruction sheet

The written discharge instruction sheet given to the patient/caregiver will detail:

1. Any scheduled follow-up appointments or specialty referrals
2. Medications and prescribed treatments to continue at home
3. Medications discontinued upon discharge
3. Provider contact information
4. Diet and activity level
5. RN and patient signature for returned patient medications and personal belongings
6. Information about any community resources identified during the discharge process
7. Any wound care, CVC/PICC care, urinary catheter care, proper brace care, or any other care specific to devices or procedures to be continued at home after discharge.
8. Availability of assistance from community resources, including referrals to other health care agencies, as

appropriate.

Ask the patient and family/caregiver(s) to verbalize their understanding of the discharge instructions *and* to give a return demonstration of any care procedures.

The following information **must be documented** in the patient's discharge note or on appropriate approved forms in the medical record:

1. Description of all discharge-related patient/family/caregiver education and teaching related to care of specific to patient diagnosis, Central Venous Catheter lines/ports, indwelling urinary catheters, wound care, or proper medication administration.
2. Discharge vital signs.
3. Availability of transportation.
4. Assessment of availability and readiness of family or other caregivers (s) to assist with the care of the patient at home **and** description of proper return demonstration of any care procedures.
5. Availability of medical equipment, supplies, and medication as indicated.
6. Follow-up plan.

Subject: Enteral Tube Feeding	Manual: Nursing
--	----------------------------------

POLICY:

It is the policy of the Southern Humboldt Community Healthcare District ("SHCHD" or "District") to provide only bolus tube feeding to patients if there is a Physician's order. SHCHD does not provide continuous tube feeding for any patient.

PURPOSE:

The purpose of this policy and procedure is to outline the policy surrounding enteral tube feeding at SHCHD.

DEFINITIONS:

None

PROCEDURE:

Enteral tube feeds will be administered to patients who are in need but are only to be administered through bolus feeding with a Physician's order for bolus feeding, specifying the type of tube feeding, the amount of tube feed per bolus administration and the amount of free water boluses to be given for hydration of the patient.

For all enteral tube feed boluses administered the enteral tube shall be flushed with 30ml of tap water before and after the bolus is administered.

1. The nurse shall follow the written order of a provider regarding the enteral tube feeding bolus using the six rights of administration, per the Medication Administration policy.
2. The equipment needed for the administration is a non-sterile 60ml catheter tip syringe and 2 non-sterile graduated cylinders. One graduated cylinder shall be labeled "water" while the other shall be labeled "tube feed" and they both shall be labeled with the date and time they were first used. The nurse shall measure the needed amounts into the correctly labeled cylinders.
3. The nurse shall begin with testing the residual of the tube ONLY if the tube is placed in the stomach. If the residual is greater than 500ml then the tube feed shall be held, and the contents shall be returned to the stomach via the tube and rechecked in 2 hours. If there is less than 500ml the nurse shall continue with the tube feed as ordered.
4. The nurse shall flush the tube with 30ml of tap water by placing the 60ml syringe into the graduated cylinder with water and drawing up the 30ml and then uncapping the tube that is attached to the patient's abdomen and attaching the tip of the syringe to the tube and slowly pushing the water out of the syringe and into the tube.
5. The nurse shall administer the tube feed in the amount per the provider's order in the same fashion.
6. The nurse shall again flush the tube with tap water in the same fashion.
7. In the event that a patient has tube feeding from home that is not in cans/bottles but prepared in a bag that is to be spiked with tubing and administered through a tube that may be confused with IV tubing, that tube shall be labeled with a purple sticker with "tube feed- NOT IV" written on the label.
8. The supplies used for tube feeding boluses shall be discarded every 24 hours and new supplies used for the next tube feeding bolus.

Subject: Insertion and Maintenance of Peripheral Intravenous Catheters	Manual: Nursing
---	----------------------------------

POLICY:

It is the policy of the Southern Humboldt Community Healthcare District ("SHCHD" or "District") to establish and maintain peripheral intravenous access on patients as needed for the intermittent or continuous administration of medications and fluids.

PURPOSE:

The purpose of this policy and procedure describe the process of obtaining and maintaining peripheral intravenous access on a patient on whom it is deemed necessary.

DEFINITIONS:

None

PROCEDURE:

Once a physician or practitioner has deemed it necessary for a patient to have a Peripheral Intravenous catheter (IV) inserted, a qualified person will gather the supplies necessary to insert the IV.

Qualified personnel consists of a Medical Doctor (MD), Registered Nurse (RN), Nurse Practitioner (NP), or an IV- certified Licensed Vocational Nurse (LVN).

Supplies:

- Tourniquet
- 2% chloraprep swabs
- gloves
- Angiocath (size determined based on the situation)
- 3-10ml syringe prefilled with 0.9% normal saline
- Extension set with removable ULTRASITE injection site and a luer-loc connector
- Transparent Dressing
- Tape

1. After examining the patients' upper peripheral extremities (lower peripheral extremities, if multiple failed attempts on the upper extremities) and deciding the site where the venipuncture will take place, the extension set will be primed with the 0.9% NS by connecting the syringe to the luer-loc connector on the end of the Ultrasite valve.
2. The tourniquet will be placed above the site and the site will be cleaned with chloraprep and allowed to air dry.
3. Perform hand hygiene and don gloves. The Angiocath will be inserted, and the catheter threaded into the vein with positive blood flow signifying correct placement. The safety button will be pressed so that the needle retracts and the safety mechanism is activated.
4. The extension set will be connected to the Angiocath and then flushed for patency. Checking for swelling, pain, and redness. Pull back slightly on the Angiocath and watch for blood return to indicate good placement.
5. The Angiocath and the tubing will be secured with tape and a transparent dressing. The dressing will be labeled with the date, time, and initials of the person who inserted the IV. Replace the tubing every 72 hours and label it with the date to be changed.

6. The IV site will be checked for patency by flushing with at least 3ml 0.9% NS and watching for swelling, pain, redness, and blood return with the flush before each IV medication is administered or once a shift if the patient is not currently receiving any IV medications. IV assessment will be charted in the Electronic Health Record (EHR) at least once per shift. This shall be charted through the IV Site icon.
7. If a patient has multiple IV/central line sites and multiple medications/fluids that are being administered to the different lines, the qualified personnel that are responsible for monitoring the lines will label all lines with a date and time sticker and all medication bags with an orange medication label that clearly states the medication or fluid that is being administered through that IV line and then chart in the EHR chart notes that the lines were labeled to prevent medication and/or fluid errors.
8. Clean the injection port with an alcohol pad before accessing the system to flush or administer medication. Scrub vigorously for several seconds.
9. Inspect the catheter insertion site daily for signs of phlebitis and infection (warmth, erythema, tenderness, swelling, or discharge). Remove the catheter if signs of phlebitis, infection, or extravasation are present.
10. For inpatients, the IV can be in place for up to 96 hours as long as it remains patent and without signs of phlebitis or infection. After the four days have passed the IV must be discontinued and restarted in another location unless the Provider order instructs otherwise.
11. All inpatients must have a patent IV while admitted to the hospital to allow for emergency medication administration unless otherwise ordered by the provider.

Subject: Patient or Resident Fall	Manual: Nursing
--	----------------------------------

POLICY:

All patients will have an appropriate assessment and definitive care as needed following any fall, accident, or unusual occurrence.

PURPOSE:

To provide patients/residents with consistent and appropriate care following a fall.

DEFINITIONS:

None

PROCEDURE:

1. Staff who are with the patient/resident during the fall, should stay with the patient, call out for help or turn the call light on.
2. Patient/resident should not be moved until he/she has been assessed for fractures and/or other injuries.
3. Determine if the patient/resident lost consciousness. Determine the current level of consciousness.
4. Have the patient explain if he/she can, where he/she was going or what happened.
Ask the patient questions which cannot be answered with a "yes" or "no."
(i.e., "Where were you going when you fell?" NOT "Were you going to the bathroom when you fell?")
5. Inspect for any cuts, bruises, or bone deformities.
6. Provide emotional support to the patient and/or family as appropriate.
7. Assist back to bed as condition indicates or take to the ED if necessary, after clinic hours.
8. Obtain a "Fall Sheet" and begin taking vital signs according to form. All patients/residents will have one hour of vital signs taken.
9. If the fall was unwitnessed, the patient must be treated as though he/she has a head injury. Enter vital signs and the neuro assessment in the EHR. Checks are to be done every 15 minutes x 4, then q 2 hours x 24 hours.
10. Notify the physician of a fall based on assessment and nursing judgment.
11. Physician may discontinue vital signs if appropriate. This must be done by a written order into the Computerized Physician Order Entry system (CPOE).
12. Notify the patient's family as soon as possible, if appropriate. If it is at night and the patient appears uninjured, you may wait until morning.
13. Document carefully in the nurses' progress notes.
14. Submit a report to RL Solutions and notify the appropriate nurse manager and or chief nursing officer as appropriate.

Document the following:

1. Complete assessment of the resident including the description of any wound or injury
2. Neuro assessment if applicable
3. Complete vital signs: initial and ongoing
4. Time MD was notified
5. Time family notified
6. Update the fall risk assessment
7. Update the resident's plan of care

Subject: Abusive and/or Assaultive Patients	Manual: Clinic
--	---------------------------------

POLICY:

It is the policy of Southern Humboldt Community Healthcare District (“SHCHD”, “District”, “SoHum Health”) to ~~not condone~~ to not tolerate abusive and/or assaultive behavior from patients and/or their families. The purpose of this policy and procedure is to delineate the procedures for dealing with abusive and/or assaultive patients and/or their families.

DEFINITIONS:

Abusive behavior: loud, argumentative voice; shouting, yelling, profanity.

Assaultive behavior: physically striking-out

PROCEDURE:

- Individuals who exhibit either abusive or assaultive behavior toward any member of District staff will be clearly told to cease this activity immediately. If staff feels threatened, they may call a “Code Gray” to obtain assistance. If necessary, staff should call 911 for assistance and notify Humboldt County Sheriff’s Department.
- A report in RLDatrix needs to be completed.
- After this event, the patient and/or family will receive a written notice from the district that abusive and/or assaultive behavior will not be tolerated, and any further episodes will result in dismissal from the medical practice.
- If there is a second occurrence of same or similar behavior, the patient and/or family will receive a letter of dismissal from the practice. This letter will be sent by certified mail. The letter will clearly state that true emergency services will continue to be available through the Emergency Department and that any prescription medications will be supported for thirty (30) days.
- In the event that the behavior of an individual is so extreme that there is concern for immediate safety, the patient can be discharged from the practice immediately; however, a certified letter is still required.
- A copy of the dismissal letter will be kept in the patient’s medical record.

Operations Report as of 02/28/2025

Project status

Utility Infrastructure Upgrades project: Work at the hospital and skilled nursing unit is nearing completion. Paperwork and the final issue punch list are being worked on.

- BBI needs to refer to the IOR's most recent log, which has all the open items that need to be addressed. Subs and BBI addressed them. The IOR needs to back-check it.
- 2-28-25 is the tentative date for the final punch list walk. Still on schedule on 2-28-28
- The architect confirmed with HCAI that the plumbing sub is permitted to conduct testing on the backflow preventer in lieu of a third-party testing company.
- HCAI is scheduled to complete their final walk before 3-4-25.
- The Fire Alarm amendments need to be completed as soon as possible. Schedule for completion on 2-25-25.
- The contractor needs to submit the following for approval. All will be submitted by 3-7-25:
 - Labor Warranties
 - Material Warranties
 - As-Builts

New hospital design process: We are in the Construction Design phase of the project. Meetings with department heads continue. Other work includes interior wayfinding, landscape and exterior design consideration, Caltrans consultation (preparing for traffic studies to be completed), Caltrans and FAA information work around the helistop location, low voltage systems design, radiation protection design, fire sprinkler and alarm scope, elevator design, nurse call and paging design, additional civil engineering work regarding property line verification, etc. The architects are also sorting through CDPH and HCAI preliminary review comments. Currently, the project timeline remains on track as follows:

CD's

- March 28, 2025 – 50% CD Pricing Set to Cost Estimator
- May 23, 2025 – 95% Pricing Set to Cost Estimator
- June 27, 2025 – 100% CD's to HCAI (Hospital) and County (Clinic Building)

AGENCY REVIEW/BIDDING – 11 months

- June 30, 2025 – May 29, 2026 – HCAI Review (11 months)
- March 1, 2026 – May 29, 2026 – Bidding (overlaps the last 3 months of HCAI review)

- We assume Agency Review/Bidding for the Clinic Building and for the small Playhouse package would occur within this time, too
- CONSTRUCTION ADMINISTRATION – 24 months
 - June 1, 2026 – June 2, 2028 – CA for both the Hospital and Clinic Building – assuming 1 GC for both
- CLOSEOUT – 2 months – June 5, 2028 – July 28, 2028
- OWNER MOVE-IN (EARLY) – 5-month buffer max. – July 31, 2028, at the earliest
- OWNER MOVE-IN (LATE) – January 1, 2029, at the latest

Meetings with department heads continued this week, gathering equipment space, electrical, plumbing, and data needs.

Employee Rental Housing

Three of the five houses have been remodeled and are occupied by providers as temporary residences. A fourth is well underway in its remodel, preparing for sheetrock and finishes. The fifth is scheduled for renovation after the relocation of HR and Quality has been completed, likely by the end of 2025-spring 2026.

Maple Lane and Redwood Drive Properties

Design Development is being finalized in preparation for submitting permit applications in March. These are local jurisdiction projects. Department leaders have approved the layout for OP therapies. Pharmacy and business function areas are planned to primarily be free-standing furnishings. Layouts will be designed once the required elements and proposed elevations are completed. The projected start to work is May/June of this year.

Parking Lots

The Elm Street and Garberville Pharmacy parking lot designs are complete and permitted. We are currently working on obtaining bids for construction.

Dishwasher Replacement

The project is complete and ready for HCAI sign-off.

X-Ray Remodel

Door re-hang and cabinet work remain. It should be wrapped up soon.

As always, please feel free to stop in if you have questions or comments.

-Kent