SILETZ COMMUNITY HEALTH CLINIC PROCEDURES

NURSING

TABLE OF CONTENTS

Program	Nursing
Procedure	12-Lead Electrocardiogram
Approval	08/13/99
Revised	02/07/06; 03/06/09; 02/09/12; 01/04/19; 10/15/21

12-Lead Electrocardiogram

I. PURPOSE

Cardiac electrical axis and electrical changes associated with ischemia, acute myocardial infarction, bundle branch block and/or hypertrophy. In addition, a baseline ECG is an important part of a patient's medical record so that it can be used later for comparison purposes.

II. EQUIPMENT

A. Schiller AT-2 plus or Burdick ELI280 EKG machine

B. Disposable sensors

C. Alcohol swabs

D. Quiet room

E. Exam table

F. Gown for patient

G. Disposable razors

III. PROCEDURE

A. Explain the procedure to the patient. Assure the patient that there is no pain or danger involved in the procedure.

B. Give the patient a gown and have the patient undress from the waist up, maintaining modesty. Arms and legs must be uncovered as well.

C. The patient should be in a supine position on the exam table. However, the patient may be in a sitting position in a wheelchair if unable to transfer or unable to lie down.

D. Plug in the EKG machine you are using and press the ON key on the front panel. When prompted enter patient data.

E. Cleanse skin at sensor sites with alcohol wipes and allow to dry. This removes skin oil and provides better contact between the sensors and the skin. Chest hair may need to be shaved if it interferes with the connection between the sensor and the skin.

F. Apply limb leads. Choose correct sensors. Each machine uses a different brand of sensors. Use one sensor for the inner aspect of each forearm and for the medial aspect

of each lower leg (ensure sensors are not placed over bone) and attach to electrocardiograph cables with alligator clips. The alligator clips are labeled for correct placement, double check to see that each cable is attached to the proper limb, as an accurate recording is dependent upon proper placement of leads. Leads for lower legs may also be applied to thighs evenly if the patient is in a wheelchair.

G. Apply pericardial (chest) sensors and leads: (See diagram on Schiller AT-102)

H. Double check leads and sensors for proper placement and good contact.

I. Ensure that ECG cables are not too tight or pulling on sensors as this might cause artifact in the tracing.

J. Instruct the patient to lie still and not to talk. Press the RUN TEST button and the ECG recording will begin. Run one or two additional tracings by pushing the manual print button. Push the STOP button when done. Assess quality of tracing and, if necessary, repeat procedure. Show the tracing to the ordering provider, to ensure tracing adequacy, before disconnecting the patient. Remove cables and turn off machine. Assist patient with removing sensors if needed, as they tend to stick tighter with time and should be removed as soon as possible when the ECG is complete.

K. Document procedure in NextGen.

For additional information and sample tracings refer to the Schiller AT-2 plus or Burdick ELI 280 instruction manuals. Operating Instructions for both machines are located on the cart where each machine rests.

Program	Nursing
Procedure	Appointment Check-In
Approval	06/10/02
Revised	02/07/06; 03/06/09; 02/09/12; 01/04/19; 10/15/21

Appointment Check-In

I. PROCEDURE

A. Check-in for appointments are allowed five to fifteen minutes.

B. Pre Check-In

1. Confirm correct patient.

2. Review reason for visit and chart prep so you know what patient needs during the visit. Take I2I report and printed medication list with you to check-in patient.

3. Set up room depending on appointment type or procedure.

4. Ensure room is clean and ready for patient. Ensure paper pillow case cover is on pillow and table paper is pulled down over previously cleaned table.

C. Check-In

1. Greet patient, introduce self.

2. Stop at vital sign station and obtain temperature, weight, and height on all patients. Check height on each visit until age 18, then once a year after age 18 without shoes. Ages 3 and under height is taken in the supine position.

3. Take patient to exam room. Open NextGen and ensure you have the correct patient pulled up by asking patients to verify their date of birth.

4. Open an intake note.

5. Ask patients their reason for visit. Open and use reason for visit template that most closely matches patients' complaint.

6. If reason for visit is injury related verify if injury occurred from MVA or on the job. If it was from MVA or work related patient will need to fill out additional paper work. Direct patient to patient care coordinator after the visit to complete necessary paperwork.

7. Review I2I form and discuss any due now items that were planned on being addressed at this visit.

8. If visit is for annual health physical, women's health exam, or annual check-up review Care Guidelines and address all preventative health items with patient. Place orders as indicated.

9. Collect and document vital signs.

    a. Blood pressures on all patient 3 years and older.

    b. Pulse

    c. Respirations

    d. Oxygen saturation

    e. Document weight, temp, and height (if collected.) If not, click the "carry forward" radio button. HEIGHTS ARE REQUIRED TO BE MEASURED AND DOCUMENTED 1 TIME PER YEAR.

10. Perform medication reconciliation. Use printed med list to review all medications with patient. Make notes if any discrepancies. Open medication module and make any changes. Then go back to intake note and perform medication reconciliation.

11. Review allergies and update as needed. If no changes, click "reviewed no changes". If you added allergies or made changes, click "reviewed, updated".

12. Perform review of systems using the constitutional template and the body part specific template related to reason for visit.

13. Review health history, including past medical, past surgical, family, and social histories. To do this go to histories tab. If patient has been here before and all histories are filled out, click "history review" hyperlink and select appropriate radio button based on what you did. If patient is new or has significant changes to histories, go into corresponding history to update and make necessary changes.

14. Perform diagnostic tests as related to reason for visit, such as RBG, UA, Strep Screen, HGBA1C and document results. All in house labs are documented in the lab module. Open up module and place order of test or tests you performed. Ensure you enter a corresponding ICD-10 code for each test ordered. Then go to results>new results entry. Enter results of test(s) along with time collected.

15. Per standing orders offer, administer, and document any outstanding immunizations. If patient declines vaccines make sure to document they declined.

16. Print Intake Form as required per provider preference.

17. Notify provider patient is ready and give a brief intake report. Each provider has their own preference on what they want for their visit. Some providers like to take the I2I form in, others use the printed intake note. Verify with the provider you are working with what document they would like to take into their visit.

Program	Nursing
Procedure	Orthostatic Blood Pressure
Approval	08/13/99
Revised	02/07/06; 03/06/09; 02/09/12; 10/15/21

Orthostatic Blood Pressure

I. PURPOSE

Assess the compensatory status of the cardiovascular and autonomic nervous systems to changes in body position.

II. EQUIPMENT

A. Sphygmomanometer

B. Stethoscope

C. Watch or clock with second hand

III. PROCEDURE

A. Orthostatic blood pressures are taken by Nurse, Medical Assistant, and providers.

B. Explain procedure to patient that blood pressure and pulse will be taken lying down, sitting, and standing.

C. Position patient supine with head and exam table flat for two minutes

D. Check and record supine blood pressure and pulse rate. Keep blood pressure cuff on patient.

E. Assist patient to sitting position for two minutes and take and record blood pressure and pulse.

F. Assist client to standing for two minutes. Take and record blood pressure and pulse.

G. Safety considerations are important. If blood pressure drops significantly, the patient may become lightheaded and/or dizzy. Get additional help to support patient back to supine position if this occurs. Recheck blood pressure and pulse. Blood pressure systolic drops of greater than 20 mHg are significant. Blood pressure systolic drops to less than 90-100 along with rapid, weak pulse could progress to passing out (syncope). If this occurs, notify provider immediately and monitor with constant blood pressure monitor machine.

Program	Nursing
Procedure	Circumcision
Approval	08/13/99
Revised	02/07/06; 03/06/09; 02/09/12; 01/04/19; 10/15/21

Circumcision

I. PURPOSE

To remove part of the foreskin by a pediatrician, family physician, or other qualified practitioner.

II. GENERAL INFORMATION

Infants under 2 months of age (or older upon Pediatricians consent) may be scheduled for elective circumcision at the Siletz Community Health Clinic.

III. EQUIPMENT NEEDED

A. Mayo Stand

B. Circumcision Tray

C. Plastibells

D. Sterile Drape (Small)

E. Sterile Gloves

F. Procedure Consent Form, signed

G. Betadine Swab (3 each)

H. Needles (Sizes 18G & 30G)

I. Bactroban ointment

J. Syringe 1ml

K. Alcohol Pads

L. EMLA Cream

M. Blue Pads

N. Circ. Board

O. Sterile Saline

P. Small Diaper .

Q. Suction Bulb (small)

R. Exam Lamp

S. Biohazard trash container

T. Receiving Blanket

U. Paper Tape

V. 1% Lidocaine (without epi, blue bottle)

W. Post-op care information sheet

IV. SET UP OF PROCEDURE

A. Mayo Stand: Sterile drape to hold circumcision pack. Open circ pack on stand using sterile technique. Open and drop small sterile drape on to sterile field.

B. On counter have sterile gloves in correct size, along with a back up pair. Lay out syringes, needles, alcohol wipes, lidocaine, and various size of plastibells, and post-op care information sheet.

C. On exam table next to circ board lay out EMLA cream, saline, 1 additional package of sterile 4x4 gauze pads (leave unopened until needed), Bactroban, Saline, extra diaper, Suction bulb, and extra receiving blanket.

V. PROCEDURE

A. Escort patient to pediatric procedure room. Instruct parent to undress baby. Apply Emla cream at base of penis per providers order.

B. Obtain vitals and document in NextGen. At this time baby may have diaper and upper part of body redressed.

C. Fill out "Procedure Consent Form." Parent or guardian and provider sign before procedure is performed.

D. Make sure bottle is made for baby; mother should pump if needed before procedure.

E. Place chux under circ board. Place chux on circ. board after cutting holes for leg straps to go through.

F. Once provider is in room and parents have signed consent for procedure place child on

circ. board with a diaper untaped underneath bottom. Restrain legs only with velcro straps. Wrap receiving blanket around chest with arms crossed over each other and tape blanket to sides of circ. board. Fold a chux for pillow. Position lamp to groin area once doctor is ready to perform procedure.

G. If instructed by provider assist in cleaning the surgical area by cleaning penis and surrounding skin with three Betadine swabs using sterile technique.

H. Change gloves if needed.

I. Ensure all equipment is ready for provider.

J. Assist provider using sterile technique and observing universal precautions at all times.

K. After procedure is complete, assist in cleaning up infant and applying any wound care dressing as directed by provider.

L. If parents have not stayed in room during procedure, retrieve parents to go over post op instructions and reunite them with baby.

M. Ensure parent's questions have been answered and they leave with post-op care instructions and when to follow up.

N. Clean room per clinic policy. Ensure all sharps are placed in sharps container and contaminated instruments are taken to Sterilization Room for reprocessing.

Program	Nursing
Procedure	Crash Cart and Emergency Defibrillator
Approval	08/13/99
Revised	02/07/06; 03/06/09; 02/09/12; 01/04/19; 10/15/21

Crash Cart and Emergency Defibrillator

I. PURPOSE

A. To ensure monthly that the cart is fully operational and at its assigned location.

B. To ensure monthly that all meds are current and supplies are stocked.

II. MONTHLY INSPECTIONS

The following are checked on a monthly basis by the RNs:

A. Suction, 02, cannulas and masks, ambu bags, CPR board, and AED .

B. Drawers of the crash cart and restocking anything expired. Any supplies, equipment, or medications used will be replaced immediately and the cart will be re-locked.

C. Functioning status of the AED located in 1st floor lobby, 2nd floor lobby, and Behavioral Health Department. The code of the lock needs to be recorded on the Crash Cart list with date and initials of the one locking the cart.

III. PROCEDURE

A. Using the code cart inventory form go through the whole cart to ensure all equipment functions, all supplies are there, and all medications are not expired.

B. If expired items are found, fill out nursing medication pharmacy request form and submit to pharmacy. Leave the expired medication in the cart until replacement arrives. Once unexpired medication arrives, return the expired medication to Clinical Services Director (CSD) for disposal.

C. If equipment is missing or malfunctioning, the CSD or Medical Director will be notified immediately. The equipment will be marked "do not use" until malfunction is corrected.

D. For the controlled medications located in the code cart, additional documentation needs to happen. Find the corresponding form on the clip board. Document the date, medication, quantity remaining, and your initials. Have a staff from pharmacy verify the quantity with you. If any discrepancies are found, notify CSD or Medical Director immediately.

E. Once monthly check is completed, note the code lock number and your initials on the inventory form.

F. Anyone accessing the drawers is responsible for documenting a crash cart check and

replacing code cart lock.

Program	Nursing
Procedure	Dispensing Medical Equipment
Approval	04/02/12
Revised	01/04/19; 10/15/21

Dispensing Medical Equipment

I. POLICY

Durable Medical Equipment (DME) type supplies are to be dispensed to Native patients only. All other patients will be given a prescription for recommended DME to take to an outside DME supplier. All patients who are dispensed medical equipment or devices must receive appropriate education. Competence is evaluated before independent use (ie. crutches, nebulizer, walkers, etc.).

II. PROCEDURE

A. Verify patient is Siletz Tribal Member or other Native.

B. When dispensing Durable Medical Equipment (DME) patients will be provided education on proper use of the item per manufacturer instructions for use.

C. If item is a nebulizer loaner, ensure loan agreement is completed and patient understands when item is due back prior to dispensing.

D. If item is a TENS unit ensure TENS agreement and educational forms are filled out prior to dispensing.

E. If Item is Alpha-Stim ensure agreement and required screening forms are complete prior to dispensing.

F. Staff dispensing item will ensure patient competence in use of item prior to patient's independent use.

G. Dispensed item will be documented in NextGen, including item number, cost, ICD 10 code, patient education, and competence.

Program	Nursing
Procedure	Expiration Monitoring
Approval	04/02/12
Revised	01/04/19; 10/15/21

Expiration Monitoring

I. PURPOSE

To ensure mediations, reagents, solutions, and medical supplies that have a manufacturer's printed expiration date are monitored and disposed, in compliance with manufacturer's guidelines

II. PROCEDURE

A. Medications

1. Each month the appointed RN will check expiration dates for all medications and CLIA waived lab supplies in the medication room and for equipment and medications stored in the code cart in the procedure room.

2. Multi-dose medication vials must be dated and initialed when opened. These are only good for 28 days after date opened. Any open vial undated or past 28 days must be thrown out regardless of manufacturer printed expiration date found during the monthly check.

3. Expired products or MDV undated or past 28 days will be removed from medication room and given to Clinical Services Director (CSD). CSD will dispose of items per manufacturer's instructions if indicated. Medications are returned to pharmacy and disposed of per pharmacy policies.

4. Appointed RN will submit re-order request for expired medications to pharmacy.

5. Appointed RN will document on expiration date log the date items were checked, items were disposed of, and initial. The medication room has a log for items stored in there and the code cart has its own monthly check log.

B. Medical Supplies

1. Staff in each Pod are required to check any reagents, solutions, or medical supplies for currency of items with manufacturer's printed expiration date.

    a. When expired items are identified they are removed from stock and given to CSD for disposal or delegate disposal process. CSD will donate expired medical equipment to Oregon Coast Community College's Allied Health Programs that they are able to accept. NO MEDICATIONS MAY BE DONATED. All other medical supplies will be disposed of per manufacturer's instructions for use

if noted.

2. Staff should restock item in exam room from main supply. If all items in main supply are expired, pull from stock and request reorder.

3. Common areas such as work room, DME room, clean linen room, and both procedure rooms will be checked monthly for expired products. See staff duty board in hallway by medication room for current staff assignments.

4. Each Pod will keep a log of dates their areas are monitored for expired products.

C. Lab

Lab has its own policy and procedure for monitoring and disposal of expired reagents and solutions. See Laboratory policy and procedure.

Program	Nursing
Procedure	Eye Irrigation
Approval	08/13/99
Revised	02/07/06; 03/20/09; 02/09/12; 01/01/19; 10/15/21

Eye Irrigation

I. PURPOSE

A. To cleanse the eye.

B. To relieve inflammation and congestion.

C. To retard growth of bacteria.

D. To remove chemicals.

II. POLICY

Any licensed and trained staff member at the Siletz Community Health Clinic may perform the eye irrigation procedure. The patient should always be seen by a provider after the procedure and before leaving the clinic.

III. EQUIPMENT

A. Bag of normal saline at room temperature and IV tubing.

B. Chux and towel.

C. Emesis basin.

D. Cotton balls

OR

E. Use the emergency eye irrigation located in the lab or either of the procedure rooms.

IV. PROCEDURE (KEY POINTS)

A. Wash hands.

B. Explain procedure to patient.

C. Obtain equipment and assemble in procedure or exam room.

D. Place patient recumbent position with pillow under head.

E. Turn head to side of affected eye.

F. Place chux under patient head and towel under eye.

G. Instruct patient to keep both eyes open and look up; roll eyes when instructed; hold emesis basin to receive return flow.

H. Clean outside of eyelid with dry cotton.

I. Separate lids gently with thumb and forefinger resting them on the cheek and brow.

J. Gently let the solution flow into the eye from the tip of the IV tubing (being careful not to touch to eye with the tubing). Start the flow very slowly and ask the patient to let you know when the flow is getting too forceful. Then reduce flow until it is comfortable for the patient. The flow should be from the inner to the outer canthus.

K. Stop flow and tell patient to roll eye downward.

L. Dry the eyelids gently from the inner to the outer canthus with cotton balls.

M. Make the patient comfortable.

N. Repeat this procedure until the desired effects are obtained.

O. Clean up room. Take used reusable equipment to Sterilization Room for cleaning.

P. Dispose of the disposable items.

Q. To use the eye irrigation station in the lab, turn water on and open coverings. Have patient lean over the sink, hold eyelid open, and let water flush out eye. Support patient as needed. Dry eye as instructed above.

R. Document in EHR. Chart accurately and completely the procedure and how the patient tolerated it. Note time treatment started, length of treatment, solution used, amount used, and the name of the staff member performing procedure.

Program	Nursing
Procedure	Gatekeepers
Approval	08/13/99
Revised	06/10/02; 02/07/06; 03/06/09; 02/09/12; 01/01/19; 10/15/21

Gatekeepers

I. POLICY

Referrals of Purchased/Referred Care (PRC) eligible patients to outside facilities must first be approved by Gatekeepers unless they are deemed a priority 1 by the Medical Director. This includes all specialists and procedures, with some exceptions. The referral specialist and PRC staff keep a list of exceptions. Visits for tubal ligation/vasectomies do not need Gatekeeper approval, but the 30 day consent needs to be signed and on file in the medical record and Business Office. This committee reviews and approves referrals for PRC eligible patients for the purpose of controlling expenditures. PRC has guidelines by which medical necessity is determined, in order to properly and fairly allocate resources.

II. PROCEDURE

A. Following is the procedure for processing a chart to go before the Gatekeeping committee:

1. The patient is seen by a provider, who determines the need for outside referral.

2. The provider enters the referral in the NextGen orders module and tasks it to the referral coordinator.

3. The referral coordinator checks patient's PRC eligibility and determines if the referral needs to be evaluated at the committee meeting. If it does the referral coordinator tasks the referral to PRC staff.

4. If the referral does not need PRC approval the referral will be processed immediately.

III. COMMITTEE MEETINGS

A. The committee meets weekly.

B. The committee reviews the requests, which may be SCHC patients or from another provider; and approves or defers the referral.

C. For SCHC patients the referral coordinator will make note whether the referral request was approved or denied in patient's medical record.

D. For PRC eligible patients who are not SCHC patients PRC staff will document approval or deferral of request and let requesting provider know.

E. PRC will document decision in its electronic health record system.

Program	Nursing
Procedure	Gatekeepers
Approval	08/13/99
Revised	06/10/02; 02/07/06; 03/06/09; 02/09/12; 01/01/19; 10/15/21

IV. FOLLOW UP

A. PRC notifies each patient of the decision by letter.

B. If approved the referral coordinator will begin the referral process. See referral procedure for detailed information on this process.

C. Once the patient has a scheduled appointment he or she needs to contact PRC for an authorization number.

V. KEY POINTS

A. Gatekeeper's approvals are only good for a period of 90 days. If the patient has not scheduled an appointment within that time, it must be sent back to the committee for approval.

B. All tests and appointments require an authorization number even if it is a priority 1 or does not require Gatekeeper approval.

C. It is important to determine whether the patient is PRC eligible before routing the referral to Gatekeepers. This information is found in Practice Management portion of NextGen and under eligibility in the EHR side of NextGen.

Program	Nursing
Procedure	Hearing Tests
Approval	02/07/06
Revised	03/06/09; 02/09/12; 01/04/19; 10/15/21

Hearing Tests

I. DEFINITION

The audiometer is used to measure the threshold of hearing for pure-tone frequencies and loudness. Tympanometry is an examination used to test the condition of the middle ear and mobility of the eardrum (tympanic membrane) and the conduction bones by creating variations of air pressure in the ear canal. Tympanometry is an objective test of middle-ear function.

II. EQUIPMENT NEEDED

A. GSI 39 Auto Tymp Machine

B. Quiet Room

III. PREPARATION

A. Refer to GSI 39 instructions manual for questions.

B. Orient yourself with the controls and switches you will need to access for testing.

C. Plug in the machine and turn it on, the switch is in the back left as you look at the front of the machine.

D. Clear the memory (M- - button) so you only have your tests on the machine when you finish.

IV. TYMPANOGRAM

A. Select the tympanogram (TYMP) button on the front panel.

B. If testing an infant (6 months and under) you will need to switch the machine to the 1khz setting. The machine defaults to the 226Hz for adults and children over 6 months of age.

C. Select the ear to be tested, (R) for right ear or (L) for left.

D. The probe will need to have a clean probe ear tip for each patient.

E. Grasp the patient's ear you may need to gently pull the ear up and back to keep the canal open during the testing.

F. Gently but firmly insert the ear tip in the opening of the ear canal, select the right size to get a good seal.

G. On the box the probe connects to there are two lights.

1. Yellow indicates the probe is occluded.

2. Blinking yellow, check the probe seal.

3. Green flashing indicates ready to test.

4. Solid green, test successful.

5. When you have a successful test select the other ear.

6. Repeat steps C-G above.

7. If you have concerns about the validity of testing, there is a test cavity provided to verify between calibrations of the machine. This is only a test and will not affect the machine function in any way. We have an outside vendor who comes in yearly to check the tools calibration, typically between June and September so we are prepared for Head Start physical exams that occur at that time of year.

V. AUDIOGRAMS

A. Find the quietest room you can, with as little outside noise as possible. We do not have a "sound proof" room. The small procedure room has no Musac and tends to be the quietest.

B. Explain the procedure to the patient and ensure you have answered all their questions.

C. Instruct the patient to raise a hand or arm corresponding to the side they hear the sound, as soon as they hear the sound.

D. Place the patient facing away from you, so they cannot see what you are doing with the controls. Sit behind them, for children you may need to make it a game.

1. Choose from solid tone(—), dashed tone(- - -) or frequency modulation (FM) for the test.

E. Place the headset so the right ear has the red lead, the left is blue.

F. When you turn on the machine you will need to select the audio setting, (AUD) on the front panel.

G. Select the ear to be tested L or R on the front panel.

H. Select (R) for the right ear.

Program	Nursing
Procedure	Hearing Tests
Approval	02/07/06
Revised	03/06/09; 02/09/12; 01/04/19; 10/15/21

I. Turn the volume to 40db for the first test.

J. Push down on the "present bar" to play selected tone. You will turn the volume knob to adjust the machine. The knob adjusts in 5db increments up if they do not hear the test, adjust down 10db if the patient is able to hear it right away. A patient may hear tones to -5 or -10, 0db is not truly 0 but an average.

K. Press the save key (M+) to mark the setting.

L. Use the arrow key (< or >) to change the frequency to the next lower (<) or higher (>) tone. Typically 1k, 2k, 4k, 6k, and 8k, you may repeat 1k to ensure the patient understood your instruction. If there is greater than 20db difference between frequencies you will want to test the middle frequencies. For instance, if there is greater than 20db between 2k and 4k, you will choose to test 2.5k, 3k, 3.5k in addition to the other "standard" frequencies.

M. Repeat steps A-L for each frequency.

N. Switch to the other ear, press (L) for left.

O. Repeat steps A-L for the ear.

VI. PRINT TEST RESULTS.

On the front panel above the volume (db) knob are three buttons. The left one prints only the page shown on the display. The center one prints all tests from the last time the machine memory was cleared. The right one advances the paper, used when changing the paper or to provide space between tests.

NOTE: Do not unplug the machine until it is done printing your results.

Program	Nursing
Procedure	Immunization Administration
Approval	08/13/99
Revised	10/16/01; 09/23/05; 03/06/09; 02/09/12; 01/01/19; 10/15/21

Immunization Administration

I. PURPOSE

To provide immunity from communicable diseases; thereby decreasing the impact of such diseases on our patients as well as the general population.

II. POLICY

A. It shall be the policy for licensed nursing staff to give immunizations in accordance with current standing orders and recommendation set forth by the "Oregon Health Department Handbook/Advisory Committee on Immunizations Practices (ACIP)," the "US Recommended Childhood Immunization Schedule" and the "Center for Disease Control (CDC), Epidemiology and Prevention of Vaccine-Preventable Diseases," 5th ed. All of these reference materials are kept in the Clinical Services Director's (CSD) office. Current Vaccine Information Sheets (VIS) are located in the medication room and are printable from NextGen. VIS statements must be offered with each immunization for families to read. This information is also found in the "Literature Inserts" found in each packaged immunization vial or prefilled syringe.

B. Immunizations are given with a provider's order—current or standing. Immunization status and adverse reactions to prior injections will be reviewed before drawing up immunizations.

C. Vaccine Information Sheets are given prior to immunizations per Federal and State law.

III. PROCEDURE

A. Review immunization record using NextGen and Oregon Immunization Alert. If it is an immunization visit for school exclusions, the patient will have a letter with them stating what immunizations are required before they can return to school.

B. Patient must be accompanied by a parent or guardian if less than 15 years old.

C. Once it has been determined that vaccinations are needed Vaccine Information Sheets are given and parent is advised to read prior to vaccinations being administered.

1. All pediatric patients have to have a completed Screening Questionnaire for Child and Teen Immunization form prior to immunizations. If the patient is under 15 years of age, the form must be completed by a legal guardian. Over 15 years of age, the patient can complete the form for themselves.

D. Administer specific immunizing agent according to standing orders.

Program	Nursing
Procedure	Immunization Administration
Approval	08/13/99
Revised	10/16/01; 09/23/05; 03/06/09; 02/09/12; 01/01/19; 10/15/21

IV. SUPPLIES

A. Immunizations are found in a small refrigerator in the medication room. Back up stock of immunizations are found in the refrigerator in the Sterilization room. VFC vaccines have pink stickers that state "VFC". Locally owned "Private" stock vaccine have orange stickers with the letter "P" on them.

B. Ensure you have checked patient' eligibility and choose the vaccine from the correct stock.

C. Zostivax, Varicella, MMR, and Proquad are stored in the sterilization room freezer.

D. Immunization supplies are kept in the medication room.

E. VIS are available in the medication room, in NextGen, and at www.cdc.gov/vis

V. DOCUMENTATION

A. For SCHC patients

1. If the patient is seen by a provider, document the immunizations given in the immunization module in NextGen. Hit "saved" to ensure immunizations are sent to Oregon Immunization Alert.

2. If it is a RN visit for immunizations, document immunizations in immunization module as above. Hit "save" to send immunizations to ALERT.

3. An influenza screening form must be completed by all patients receiving influenza vaccine and reviewed by staff administering the immunization prior to administration.

B. For non-SCHC patients, document the immunizations received, being sure to include: immunization, amount, location, route, lot number, and expiration date, on the immunization screening form (adult, adolescent, or influenza) and enter in Oregon Immunization ALERT. The form then goes in a file in the Health Information Service's office.

VI. FOLLOW UP PROCEDURE

A. Before discharge from the clinical area; advise the patient and/or family regarding possible reactions and their treatment. Advise the patient or parent to call with any additional questions.

B. Ensure patient or parent has been provided with printed Vaccine Information Sheets for

home reference.

C. After injection patient will wait 15 minutes before leaving the clinic.

VII. ORDERING IMMUNIZATIONS

A. Child and adolescent vaccines are ordered from The Vaccines for Children (VFC) Program, and include; Dtap, IPV, Prevnar, Hib, Varicella, MMR, Hep A and B, Tdap, Pentacel, Kinrix, Pediarix, Menactra, HPV, Proquad, Bexsero and Influenza. Immunizations are ordered bi-monthly by the CSD or RN Supervisor.

B. Adult immunizations include, Hep A, Hep B, Tdap, Td, Pneumococcal PPSV23, Prevnar, Influenza, HPV, Bexsero,and Shingrix. Immunizations are ordered as needed from pharmacy by the CSD or designee.

C. Upon delivery all vaccines are labeled according to inventory stock, entered in NextGen and ALERT and stored in proper location, either refrigerator or freezer.

D. Storage and Handling of Vaccines. Refer to the Vaccine Management Guide located in CSD's office for detailed information and plan on the ordering, storage, handling, and management of vaccines.

E. Refrigerator and freezer temperature are checked 1 time per day (preferably first thing in the morning), along with daily minimum and maximum temperatures and documented on temp logs. Temperature logs for current month are located in the medication room. Additional supplies of temperature monitoring logs can be found in CSD's office. Each refrigerator and freezer has a temperature data logger that is WiFi cloud based. Temperature logs are reviewed periodically and when there is an alert of a temperature excursion by the CSD and/or designee.

VIII. REMINDERS

Nursing staff review immunizations at every visit and as part of chart prep. Patients are offered immunizations at each visit until they are up to date.

Program	Nursing
Procedure	Insulin Administration
Approval	08/13/99
Revised	02/07/06; 03/06/09; 02/09/12; 01/01/19; 10/15/21

Insulin Administration

I. ADMINISTERED BY

RN, FNP, PAC, MD, or DO ONLY.

II. EQUIPMENT

A. Insulin syringe with needle –or-

B. Insulin pen

III. INSULIN

Brand and type as specified by prescription for each individual.

IV. INSULIN ADMINISTRATION

A. Insulin pens are for individual use only. They are to never be used for more than one person. If you receive an order to administer or train insulin administration from a provider, the patient's prescribed pen must be picked up from pharmacy and used for administration and/or training.

B. Multiple-dose vials of insulin should be dedicated to a single person whenever possible.

C. If the vial must be used for more than one person, it should be stored and prepared in a dedicated medication preparation area outside of the patient care environment and away from potentially contaminated equipment.

D. Medication vials must be dated and initialed when opened. Unused portions must be disposed of 28 days after date vial opened.

E. Medication vials should always be entered with a new needle and new syringe each time.

F. Dispose of used injection equipment at point of use in approved sharps container. Never reuse needles or syringes.

V. PROCEDURE

A. Verify the type of insulin and dose ordered with the ordering provider.

B. Roll all vials of cloudy insulin gently in palms of hand to insure the insulin is completely mixed.

C. Cleanse rubber top of vial with an alcohol sponge.

D. Inject air into the vial equal to the amount of insulin prescribed and withdraw the prescribed amount of insulin into syringe.

E. If using insulin pen, attach needle, dial up 2 units and press inject button to prime the needle. Then dial up the ordered dose.

F. Have a 2nd RN or provider verify the order received and the type and amount of insulin you've drawn up.

G. Inject the insulin subcutaneously.

H. Dispose of insulin syringe and needle in sharps container

I. Document in NG under 'Standing Orders'. Complete the medication template and submit to superbill.

Program	Nursing
Procedure	Lead Screening
Approval	01/04/09
Revised	10/15/21

Lead Screening

I. PURPOSE

Lead is a naturally occurring soft metal found in rocks and soil. At high levels it is a potent neurotoxin that can lead to severe medical conditions such as encephalopathy and even death. At small amount it can cause irreversible brain damage and contribute to developmental delays and behavioral disturbances. Federal standards mandate blood lead level (BLL) screening for all children eligible for Medicaid and Head Start.

II. POLICY

All Medicaid eligible children must receive a screening blood test at ages 1 and 2 years of age. If a child between the ages 3-5 years has not had a BLL they should receive 1 screening test. All test results whether normal or abnormal must be faxed to Oregon Health Authority (OHA). All normal results must be faxed within 7 days. Abnormal results must be faxed within 1 day. The CDC adopted reference value of a lead result ≥ 5ug/dl as a lead poisoning that requires further investigation through the local health department and State health department.

III. PROCEDURE

A. During chart prep the MA will determine if a child that is 1 or 2 years old is due for a blood lead level test. Head Start physicals require a lead level done within the past year.

B. If the BLL test is due the MA or RN rooming the patient will collect the sample during the rooming process.

C. SCHC uses Lead Care II Blood Lead Testing System to perform capillary lead level screening.

1. All MA's and RN's must watch the CDC video on collecting a capillary lead sample and go through competency training with Nursing Supervisor prior to collection of any sample.

2. After initial training competency will be performed annually.

3. Thorough hand washing must be completed by staff member collecting sample and the hand of the patient must be thoroughly washed with soap and water. Hands should be dried with a lead free towel. All materials used during collection process must be lead free.

4. Set out all required supplies on a lead free surface. Example would be a chuxs or scale cover.

5. Supplies include: lancet, alcohol wipes, cotton balls, band-aids, Lead Care II capillary collection tubes, and infant heel warmer.

6. Perform capillary skin puncture and collection per guidelines found in SCHS Capillary Skin Puncture Procedure.

D. Place order for in-house lead level in NextGen orders module.

E. Ensure patient identification label is on specimen container. Then take specimen to lab for processing.

F. Lab staff will enter results into NextGen. Lab staff is responsible for reporting all test results to Oregon Health Authority as stated in policy above.

G. The Lead Care II Blood Lead Testing System will read as "low" for any result < 3.3 ug/dl.

H. For BLL greater than 5ug/dl and up to 9ug/dl send patient lab of choice for confirmatory venous draw ASAP or within 7-14 days.

I. For BLL 10-44ug/dl send for confirmatory venous testing ASAP or within 7 days.

J. For BLL 45-59ug/dl send for confirmatory venous testing ASAP or within 2 days.

K. For BLL 60-69ug/dl send for confirmatory venous testing ASAP or within 1 day.

L. The Lead Care II Blood Testing System will read any lead level >65ug/dl as "high".

M. Our reference laboratory Lab Corp automatically sends any venous draw blood lead level results to the Local County Health department and The Oregon Health Authority.

N. Elevated Lead levels that are confirmed with venous blood draw will have an investigation done by Lincoln County Public and Environmental Health. The SCHC will work closely with them to facilitate records release and help with their investigation any way we can.

O. If LCHD performs an investigation follow up lead testing is performed at their recommended intervals.

Program	Nursing
Procedure	Nebulizer Treatment
Approval	02/07/06
Revised	03/06/09; 02/09/12; 01/04/19; 10/15/21

Nebulizer Treatment

I. PURPOSE

To provide guidelines for appropriate use and care of nebulizer equipment for aerosol therapy at Siletz Community Health Clinic. The nebulizer provides a safe and simple means of delivering medication in aerosol form by converting liquid medication into a "mist" that is inhaled into the bronchial tree.

II. USES

A. The nebulizer shall only be used for aerosol therapy once a valid order has been received from provider. Order must include medication to be delivered, dose, and frequency. The order and medication administration will be documented in NextGen.

B. The nebulizer is intended for use in urgent respiratory crisis at the discretion and order of provider.

C. The nebulizer equipment will be provided to the patient in exam room upon provider request. The equipment shall be returned to storage, after appropriate cleaning.

D. Each individual using the nebulizer must have his/her own tubing and mouthpiece. This tubing and mouthpiece will be disposed of when treatment is finished, or sent home with the patient if they have a home unit, or one will be prescribed.

E. The nursing supervisor shall ensure that appropriate cleaning/maintenance is performed by staff per manufacturer's guidelines. This includes the filter changing. The date of the last filter change and the due date of next filter change will be tagged on unit.

III. PROCEDURE

A. General Precautions

1. Always unplug equipment immediately after using.

2. Do not use near water. Do not place in or store equipment where it could fall or be pulled into a sink.

3. Do not leave unattended when plugged in.

4. Never operate equipment if it has been dropped, damaged, or submerged in water.

5. Plug equipment into a properly grounded outlet only. Keep the cord away from

heated surfaces.

6. Never block the air openings of nebulizer or place it on a "soft" surface, such as a bed, where the air openings may be blocked. Keep the air openings free of lint, hair, or debris.

Nursing Action	Key Points
Assemble equipment and appropriate medications	Compare to provider's order
Take equipment and medication to exam room. Wash your hands and use appropriate PPE	Ensure there is an appropriate place to put the equipment and a grounded outlet to plug into
Take patients HR, RR, BP, and SPO2. Document results in NextGen	To have pre-treatment results to compare vital signs to, in order to assess response to treatment
Provide appropriate teaching to patient regarding procedure	Make sure the patient or parent understand and can/will cooperate.
Place the nebulizer on a flat, firm surface and near the grounded outlet	Ensure air vents are not blocked
Attach the clear connecting tubing to the nebulizer	Ensure tubing is clean and intact
Unscrew the nebulizer cup and place on a clean, flat surface. Check provider order for a type and amount of medication prescribed, and pour medication into nebulizer cup.	This may be done in medication room. Follow the "six rights" of medication administration.
Screw the nebulizer cup back onto the nebulizer assembly.	Make sure that the liquid does not spill out
Have patient hold the nebulizer assembly and plug the compressor into the grounded wall outlet	Make sure patient holds cup level and liquid does not spill
Switch nebulizer on	When the nebulizer is on, the mouthpiece emits aerosolized medication
Instruct the patient to place the mouthpiece between his/her teeth and breathe through it normally.	Ensure they are breathing in/out through mouth and not nose.
If patient is infant or young child, have them sit on parents lap. Parent may hold mouthpiece in front of child, or a nebulizer mask may be used.	Show parents how to hold in front of child's face and "blow-by" the aerosolized medication.
Keep nebulizer cup upright at all times to ensure adequate nebulization of the medication.	Adequate nebulization of the medication is necessary to ensure that all medication is given as ordered.

B. Care For and Cleaning of Nebulizer Equipment

Refer to manufacturer's instructions/guidelines. At a minimum the tubing and mouthpiece is to be disposed of or sent home with patient for their use. The nebulizer machine is to be wiped down with approved disinfectant wipes after each patient use. Check and ensure the filter change is compliant.

C. Key Points for Filters

1. Check for dust build-up, weekly or as needed.

2. Absorb excess water from filter with dry towel and replace to original location.

3. Change filter every 6 months or sooner if it appears grey or dirty.

4. Failure to change the filter will make the compressor unit work harder than it should and will eventually cause the unit to fail.

D. Post Treatment Evaluation and Documentation.

Document the following treatment in the patients encounter note:

1. Date and time of treatment

2. Vital signs, including SP02, pre and post treatment

3. Medication used

4. Tolerance to treatment

5. Other relative information

Program	Nursing
Procedure	Nitrous Tank
Approval	08/13/99
Revised	07/18/05; 03/06/09; 02/09/12; 01/04/19; 10/15/21

Nitrous Tank

I. INTRODUCTION

A. Liquid nitrogen is nitrogen in a liquid state at a very low temperature. It is a cryogenic fluid that causes rapid freezing on contact with living tissue. Since the liquid to gas expansion ratio of nitrogen is 1:694 at 20 degrees Celsius, a tremendous amount of force can be generated if liquid nitrogen is rapidly vaporized. In addition, because of its extremely low temperature, careless handling of liquid nitrogen may result in cold burns. As liquid nitrogen evaporates, it reduces the oxygen concentration in the air and can act like an asphyxiant. Since nitrogen is odorless, colorless and tasteless, it can produce asphyxia without any sensation or prior warning.

B. Due to its multiple hazards and the lack of good warning properties, the following procedure must be followed when handling liquid nitrogen in the clinic.

II. PURPOSE

The purpose of this procedure is to provide information for the safe handling of liquid nitrogen. The Siletz Community Health Clinic Medical Clinic uses liquid nitrogen for freezing various lesions.

III. POTENTIAL HAZARDS

A. Fire

The use of liquid nitrogen will condense oxygen from the atmosphere. Exposure of combustible materials to oxygen-enriched liquid nitrogen enhances the combustibility of the material.

B. Explosion

A cryogenic liquid such as nitrogen expands by orders of magnitude upon vaporization. One liter of liquid nitrogen becomes 24.6 cubic feet of nitrogen gas. This can cause an explosion of a sealed container.

C. Asphyxiation

A poorly or non-ventilated room will be quickly enveloped by the expanding gas of a cryogenic liquid. This will lead to displacement of oxygen and asphyxiation of the user.

IV. EXPOSURE HAZARDS

A. Contact/Absorption

Cryogenic liquids such as nitrogen are extremely cold at atmosphere pressure. Direct contact with the skin may lead to burns and/or severe frost bite.

B. Inhalation

Inhalation of liquid nitrogen may cause respiratory tract discomfort or irritability. Prolonged exposure may lead to asphyxiation/suffocation.

V. PERSONAL PROTECTIVE EQUIPMENT

A. Eye Protection

Safety glasses/goggles and face shields should be worn during operations where liquid nitrogen is being poured from a large container to a Dewar or another smaller container.

B. Hand Protection

Loose fitting thermal insulated (cryogloves) are recommended. There are 2 pair provided in 2 different sizes. Must be used when transferring liquid nitrogen from large container to Dewar.

C. Body Protection

Long sleeve shirt, lab coat, pants without cuffs and closed toed shoes.

VI. ENGINEERING CONTROLS

Adequate ventilation is essential when working with liquid nitrogen because a small amount of liquid can rapidly convert to a large volume of gas. Do not use in confined spaces because of the threat of asphyxiation.

VII. SPECIAL HANDLING PROCEDURES

A. Never allow any unprotected part of the body to touch exposed pipes/vessels containing cryogenic liquids; skin coming in contact with cold metal may adhere to it and tear when attempting to withdraw.

B. Only use containers or equipment specified for cryogenic use.

C. Never plug containers holding cryogenic liquid; cover them when not in use to prevent an accumulation of moisture and ice.

D. Inspect pressure relief valves on equipment (e.g., 150 Liter Dewar flask) for ice build-up.

VIII. STORAGE REQUIREMENTS

A. Store liquid nitrogen containers in a dry ventilated area.

B. Do not store in a confined space area.

C. Never place liquid nitrogen in a sealed container or object that could cause entrapment of the gas.

IX. LABELING REQUIREMENTS

Identify containers with the name of the cryogenic liquid (e.g., liquid nitrogen). Label storage areas appropriately as well.

X. FIRST AID

A. Recovery from frostbite may be complete if only the skin and underlying tissues are damaged. If blood vessels are damaged, gangrene may ensue which may require amputation of the affected area. If medical assistance is not immediately available, re-warming first aid may be given:

1. Immerse the affected area (s) in warm (never HOT) water, or apply warm cloths repeatedly for 20 to 30 minutes. The recommended water temperature is 104 to 108 degrees Fahrenheit. Keep circulating the water to aid the warming process. Severe burning pain, swelling and color change may occur during the warming process. Warming is complete when the skin is soft and sensation returns.

2. Apply dry, sterile dressing to frostbitten areas. Put dressings between frostbitten fingers or toes to keep them separated.

3. Move thawed areas as little as possible.

XI. TRANSPORT OF LIQUID NITROGEN

The following procedure will be followed for the delivery and storage of the liquid nitrogen:

A. The vendor will go to the designated storage/use area.

B. The vendor will transport the empty tank to the nearest elevator.

C. The empty tank will then be transported to the loading dock area where it will be exchanged for a full one.

D. The full tank will be transported to the elevator and back to the designated storage/use area.

XII. SPILL AND ACCIDENT PROCEDURE

A. During the transport of the tank, if there is an emergency spill or leak, which would generate a potential oxygen deficient atmosphere, the tank will be immediately taken to the outside loading area. It will be the vendor's responsibility to eliminate the emergency situation.

B. For a small spill in a well ventilated area the spill can be cleaned up using universal absorbent pads. Use appropriate personal protective equipment when cleaning up.

C. For a large spill in an enclosed area:

1. Do not touch spilled material

2. Notify others in the immediate and surrounding area.

3. Evaluate the spill area and prevent others from entering area.

4. Use water spray to reduce vapors or divert vapor cloud drift.

5. If possible, turn leaking containers so that gas escapes rather than liquid.

6. Ventilate area well prior to allowing entry to area

Program	Nursing
Procedure	Oxygen or Compressed Gases
Approval	08/13/99
Revised	02/07/05; 03/06/09; 02/09/12; 01/04/19; 10/15/21

Oxygen or Compressed Gases

I. PURPOSE

A. To provide adequate oxygenation for patients and ensure proper assessment of a patient's oxygenation status prior to and during oxygen use. This also serves to outline the safe use and storage of oxygen cylinders.

B. Compressed gas, including oxygen, constitutes several safety hazards. Any gas cylinder with a broken valve head becomes a missile capable of penetrating walls. Specific gases may be toxic or flammable. Finally, heating of cylinders may result in explosion. The following precautions shall observed:

1. Cylinders must be secured at all times so they cannot fall over.

2. Valve safety covers shall be left in place until pressure regulators are attached.

3. Containers or cylinders must be clearly marked with the name of the contents. Tanks with wired on tags or color code only should not be accepted. Color code must be glued on to ensure correct gas, a wired on tag indicates tank is not full.

4. Hand trucks or dollies must be used in moving the cylinders. Do not roll or drag cylinders.

5. The use of oil, grease, or other lubricant on valves, regulators, or fittings is prohibited.
6. Do not attempt to force a stuck cylinder valve.

II. OXYGEN USAGE

Whenever oxygen is administered, certain precautions must be taken to prevent fire and/or explosion. They include the following:

A. All matches, lighters, and other sources of flame or spark must be removed from the area.

B. Smoking is to be positively prohibited in or near the area where the oxygen is administered.

C. All electrical outlets and devices must be grounded.

D. Electrical medical devices and equipment must be kept at least 5 feet from oxygen equipment.

Program	Nursing
Procedure	Oxygen or Compressed Gases
Approval	08/13/99
Revised	02/07/05; 03/06/09; 02/09/12; 01/04/19; 10/15/21

III. OXYGEN ADMINISTRATION PROTOCOL

The following guidelines will be followed in determining the indications for oxygen therapy and for the appropriate selection of oxygen delivery device.

A. Indications for oxygen therapy include:

1. Documented hypoxemia of Sp02 less than 90% in all patients

2. In acute care situations associated with suspected tissue hypoxia such as pulmonary edema, drug overdose, or carbon monoxide poisoning.

3. Clinical signs or symptoms of tissue hypoxia such as tachycardia, tachypnea, dyspnea, cyanosis, diaphoresis, confusion, or chest pain.

4. Acute myocardial infarction with continuing pain, arrhythmias, congestive heart failure.

5. Other medical emergency situations including but not limited to:

   a. Adult respiratory distress syndrome, pulmonary embolism, pneumonia, near drowning, asthma, COPD exacerbation, or bronchiolitis.

   b. Respiratory distress in infants and children

   c. Other medical emergencies such as: congestive heart failure, drug overdose, trauma, shock, or post seizure.

B. Guidelines for selection of appropriate oxygen delivery device:

1. High flow versus low flow oxygen therapy

   a. High flow systems will provide adequate flow of oxygen to meet/exceed patients inspired flow rate needs.

   b. Low flow systems will only provide flow of oxygen to supplement the patient's inspired flow rate needs.

IV. LOW FLOW SYSTEM

A. Criteria for use of a Low Flow System:

1. Respiratory rate less than 25 bpm

2. Regular ventilator pattern

3. FIO2 less than 45%

4. Sp02 less than 90%

B. Types of Low Flow Devices:

1. Nasal cannula- Delivers FIO2 approximately 24-45%. Most appropriate initial device for COPD patients

2. Simple oxygen Mask-Delivers FIO2 of 40-60%

3. Partial Rebreather mask-Delivers FIO2 of 50-80%

V. HIGH FLOW SYSTEM

A. Criteria for use of a High Flow System:

1. FIO@ greater than 45%

2. Respiratory rate greater than 25 bpm.

3. Evidence of alveolar hypoventilation with CO2 retention.

B. Types of High Flow Devices:

1. Non-rebreather mask-delivers FIO2 of 85-95%+

VI. PROCEDURE

A. Oxygen is stored in various locations at Siletz Community Health Clinic

1. Crash Cart

2. Medical work room

3. DME Supply room. There are 2 areas marked for oxygen tank storage. One area is for full cylinders and the other area is for empty cylinders.

B. To administer Oxygen:

1. Attach oxygen cannula, mask or oxygen supply tubing (based on guidelines above and order from provider) to plastic nipple

2. Turn metal handle counter clock wise until gauge registers oxygen contents.

3. Turn large green or black knob to desired liter number.

4. Secure mask or cannula on patients face.

5. Monitor patient's condition and vital signs as directed by provider.

C. When oxygen is discontinued turn oxygen tank off securely and vent gage, dispose of used tubing and replace with new oxygen administration set up on tank handle.

D. Oxygen cylinders will be checked monthly for safety and to ensure adequate oxygen supply available for use. Cylinders will be changed out if oxygen level is less than 500 on gauge. Return empty cylinder to DME room. Notify Clinical Services Director (CSD) when there is 2 or less full oxygen tanks remaining in storage room. CSD will place order for replacement cylinders or delegate task to medical staff

Program	Nursing
Procedure	Peak Flow
Approval	02/07/06
Revised	03/06/09; 02/09/12; 01/04/19; 10/15/21

Peak Flow

I. INTRODUCTION

Peak flow tests are performed by RNs and MA per provider order to assess and monitor lung function and how well air is moving out of a patient's lungs. This test is used to monitor chronic health conditions such as asthma, COPD, and other chronic pulmonary diseases.

II. PURPOSE

To provide a standard for use of the Peak Flow Meter for multiple patients and guidelines for daily cleaning and quality control.

III. EQUIPMENT

A. SCALE and height

B. PEAK FLOW METER chooses appropriate size. Different sizes for adults and children

C. DISPOSABLE MOUTHPIECE, choose appropriate size

IV. PROCEDURE

A. Obtain and document patient's height and weight in NextGen

B. Choose correct peak flow meter and mouth piece based on patient's size.

C. Attach a disposable mouthpiece to peak flow meter.

D. Ensure the pointer on the meter is set to zero

E. Have patient stand

F. Remove chewing gum or food from mouth

G. Hold PFM by handle, ensuring pointer is unobstructed and resting at zero.

H. Instruct patient to take a deep breath prior to sealing lips around mouthpiece. Then have them blow out as hard and fast as possible.

I. Record the number where the pointer stops on the scale.

J. Reset the pointer to zero.

K. Have patient repeat two more times, resting in between as needed.

L. Record the best of the three samples in NextGen and notify provider of results

M. Dispose of disposable mouthpiece in trash. Clean PFM with Sani-Cloth after patient use.

V. DAILY CLEANING AND QUALITY CONTROL

A. If used by multiple patients in 1 day the PFM must be terminally cleaned.

1. At end of the day take PFM to Sterilization room and wash with warm soapy water. Do not soak or try to clean inside of the meter with a brush.

2. Rinse thoroughly with running water, shake out excess water, and allow to air dry.

3. Observe the meter for damage, cracks, or chips.

4. Ensure that the indicator moves with blowing air.

5. Replace meter with a new one from stock if it does not read accurately or function properly.

Program	Nursing
Procedure	Recalls of Medications, Vaccines, Medical Equipment, or Devices
Approval	04/02/12
Revised	01/04/19; 10/15/21

Recalls of Medications, Vaccines, Medical Equipment, or Devices

I. PURPOSE

To ensure recalled items are identified and appropriate measures are taken for continued patient and staff safety.

II. PROCEDURE

A. When notification of a recall of medications, vaccines, medical equipment or devices is received, the Clinical Services Director will be notified and shall remove the item from any areas of storage in the Clinic. The CSD will work with Pharmacy Director if the recall is a nursing medication stocked in the med room.

B. Recall notices are received from various sources including, but not limited to, FDA, CDC, manufacturers or other supply companies. Recall notices are received via email or postal mail. The Clinical Services Director (CSD) or delagee will be given recall notices relating to medications, medical supplies and durable medical equipment dispensed to patients by medical staff. The CSD may delegate tasks related to recall to member of medical staff.

C. The CSD or designee will determine whether notices apply to our facility.

D. The CSD will notify staff and providers of recalled items and any alternative that are available.

E. If applicable, CSD will notify Admin/QI who will generate a list of patients who may have received the item in question and those patients affected will be contacted by phone or mail to recover any recalled item and monitor for related adverse effects.

F. SCHC will follow manufactures recommendation in disposition or return of recalled items.

G. The CSD will keep a copy of all recall notices for items in our facility affected by recall. A note will be made if our lot number, manufacture number, or other id number that match the recalled item and a list of patients affected by recall if applicable.

H. The CSD will provide a report of any such action to the Health Director and Admin/QI.

Program	Nursing
Procedure	Referrals to Other Health Care Providers
Approval	06/11/02
Revised	06/26/06; 03/06/09; 04/02/12; 10/15/21; 01/21/22

Referrals to Other Health Care Providers

I. PURPOSE

Referrals to outside medical providers and specialties require close supervision and follow up. The clinic utilizes a Referral Specialist to manage its referrals. This staff person must possess knowledge of the referral process, an understanding of what medical records, labs, and diagnostic studies should be provided to the Specialist, insurance prior authorizations and approvals from various payers, frequent communication with the patient and the ability to accurately document the referral process in I2I, our referral tracking software.

II. PROCEDURE

A. Referral to specialist:

1. The provider will initiate the referral by sending a referral order via NextGen order management template. The provider will include: specialty type, location if known, diagnosis, time frame if pertinent, and any other details critical to specialist. This order will be tasked to the Referral Specialist.

2. The Referral Specialist will start the referral process. If patient is Purchase Referred Care (PRC) eligible the referral must go through the gate keeping process first. The Referral Specialist will send referral to the Purchased/Referred Care Technician via task in NextGen to submit for gate keeping. Gate Keepers meet every Wednesday.

   a. If patient has alternate resource other than PRC, Referral Specialist will verify eligibility and submit prior authorization if needed. Referral Specialist will document the date the referral was sent for authorization.

   b. After approval from either PRC or alternate resource, the Referral Specialist will generate referral document from NextGen and will attach all necessary chart notes, labs, and diagnostics and fax to specialist. If referrals are ordered to providers in healthcare systems we have access to EMR, orders will be placed directly in that health system EMR. Supporting documents will be uploaded if needed.

   c. A letter is generated in NextGen to patient letting them know where they are being referred along with specialist phone number.

   d. In most cases, the specialist will call the patient to schedule the appointment. In the event a patient needs help scheduling the

appointment the Referral Specialist will work with the patient to schedule.

e. Orders for diagnostic imaging will be entered into EMR of imaging provider if we have that availability. If not, order will be faxed along with patient demographic sheet. For STAT or urgent diagnostic referrals, the Referral Specialist will schedule the appointment and notify patient. For routine imaging, a letter will be sent to patient informing them where imaging order was sent.

f. All documentation related to referrals will be completed in I2I referral package.

g. The Referral Specialist will also assist patients who need help with transportation to/from appointments. Several community resources are available to assist with transportation.

3. Referral Follow up

a. After order is placed and letter sent to patient, the Referral Specialist will set a follow-up date for 30 days out. Exception is urgent or STAT imaging orders, those will be followed-up on in 3 days.

b. When date of the patient's appointment is known a follow up is set for 7 days after to verify we have received chart notes and notes have been sent to ordering provider's PAQ in NextGen.

c. The date referral is due to have follow-up, the Referral Specialist or assigned staff will check NextGen to see if records have been received. If no notes are found Referral Specialist will access the specialist EMR and pull necessary records. If no access to EMR Referral Specialist will call for records.

d. Once notes are received, the Referral Specialist will mark status of referral as "complete" in I2I and NextGen.

e. If no records are found, Referral Specialist will reach out to either patient or specialist to see if they have appointment scheduled. If no appointment scheduled, Referral Specialist will contact patient via letter or phone reminding them of referral/order. A new follow-up date will be set for 30 days.

f. On the date of 2nd referral follow-up, staff will check NextGen to see if records have been received. If no records found referral will be marked as 'cancelled' and order closed.

g. If a PRC approved referral takes longer than 90 days to be seen, the referral must go back through the Gate Keeping process to get reapproved.

4. Quality Improvement

a. The Clinical Services Director (CSD) or designee will perform quarterly quality improvement audits to ensure referrals are being processed in a timely manner, referral documentation is concise and accurate, and results are being received. Issues found during audits will be sent to Referral Specialist for review and process improvement if necessary.

b. The Referral Specialist is required to submit referral data to the CSD to be included in each quarterly report. That data is to include:

i. Total number of referrals ordered that quarter

ii. Number of referrals completed

iii. Number of referrals pending reports

iv. Number of referrals pending appointments

v. Number of referrals pending authorization

vi. Number of referrals declined by patient

vii. Number of referrals canceled

Program	Nursing
Procedure	Medical Orientation
Approval	01/04/19
Revised	10/15/21

Medical Orientation

I. PURPOSE

All new registered nurses, medical assistants, and providers receive orientation to introduce them to the Indian Health Services and the Siletz Community Health Clinic.

II. PROCEDURE

The new employee attends orientation with human resources and clinic administration prior to orientation to the medical department. The topics of discussion during medical orientation include:

A. Clinic Services Director or Designee

1. Introduction to staff
2. Clinic philosophies, expectations, and hierarchy
3. Overall clinic schedule
4. Dress code
5. Meetings overview
6. Location of policies and procedures
7. Lab Proficiencies
8. Needle stick protocol
9. Assigned provider and provider preferences
10. Lunch and break schedule
11. Daily staffing sheet
12. Assigned duties board
13. How to request time off
14. How to get access to Immunization ALERT
15. Onboarding schedule and team assignment for training

B. Knowledge of Other Departments Relating to Medical

1. Medical Reception-patient registration and check in.

2. Pharmacy-who can receive services, med room supplies, Erx.

3. Patient Accounts-billing, money collection.

4. Administration-QI projects, purchase orders, check requests, training requests.

5. Purchased/Referred Care (PRC)-gate keeping procedure, same day number request, stat number request.

6. Dental-being called up to see patients, who is eligible for services.

7. Behavioral health-referrals, A&D physicals, resources.

8. Community Health/Diabetes-referrals and services.

9. Medical Records-scanning, ROIs.

C. Safety

1. Location and use of:

   a. AEDs

   b. Red Cross blackout flashlights

   c. Fire Alarms (4 total in medical. 1 by each stairwell entrance, 1 by lab, and 1 on wall by med room.)

   d. Fire extinguisher (4 total in medical. 1 on wall by Peds pod, 1 on wall by lab, 1 on wall by procedure room A, and 1 on wall by door to lobby in Pod A.)

   e. Fire drill plan and evacuation routes

   f. Eye wash stations

   g. Spill kits

   h. SDS book-how to use

2. Emergency Protocols-Review only, this is covered in Clinic Orientation.

   a. The clinics ER code system and phone protocol

b. Verify employee has emergency announcement code sheet

c. Verify they understand each color and code

d. How to call 911

3. Universal Precautions-Review only, this is covered in Infection Control Training.

a. Locations of PPE

b. Types of PPE

c. When and where to use PPE

d. How to handle and dispose of biohazards-sharps containers, needle safety, BBP, used instruments and how to transport, body fluids.

e. Infection Control Training date, time, and location.

D. Tour of Medical Floor

1. Exam Rooms

a. Layout

b. Supplies and stocking of rooms

c. Sharps containers

2. Pods

a. Layout

b. Vital sign stations

c. BGL kits

d. Spot vital sign machine-plug in every night

e. Temporal scanner or infrared scanner

f. Phones and voicemail policies

g. Computers

h. Scanners

i. Staff duty board and extra duties to be completed each month

3. Workroom

a. Copy/fax machine

b. Patient education file cabinet

c. EKG machines

d. Liquid Nitrogen-how to get ready for provider and PPE, SDS.

e. Oxygen tanks-how to check level, how to change out empty tank, nasal cannulas, face masks, NRB, SDS.

f. Medical supplies

g. How/who orders medical supplies

h. Confidential shred bin

i. Dremel

4. Medication Room

a. HGB A1C machines and influenza reader

b. OTC meds

c. Rx meds

d. Immunizations and refrigerator

e. Waived lab tests

f. Hemocue machine

g. Supplies

h. SDS book

5. Sterilization Room

a. Layout–flow of clean to dirty

b. Refrigerator/Freezer-vaccine storage

c. Overview of equipment in room-ultrasonic cleaner, sterilizer, biologic attest, water distiller.

d. Where to put dirty instruments

e. No performing sterilization until training is received

6. Dirty Utility Room

a. Sharps container

b. Laundry baskets-how to separate, who does what laundry

7. Mail Room

a. Mail boxes

b. Copy/fax machine

c. Desk supplies and copy paper

8. MAT Offices

a. What is MAT and who is eligible

b. Review location of MAT staff

9. Referral Specialist

a. How referrals are ordered and processed

b. Referral follow up

c. Updating Care Guidelines

10. Lab

a. Where to put specimens

b. Where to get supplies for our med room

c. Competencies that must be completed

d. Eye wash station

11. Medical Records Room/Reception Desk

    a. Incoming mail-who gets mail, process and flow for incoming mail.

    b. Scanning

    c. Reception desk extensions

12. Medical Supply Room (DME Room)

    a. Who is eligible for supplies in this room

    b. Layout and supplies kept in there

    c. Full O2 cylinders and empty cylinders

    d. Batteries

    e. Wrist BP cuffs to give out to patients

    f. TENS units–TENS agreement

    g. Loan nebulizers-Nebulizer agreement and return policy

13. Clean Linen Room

    a. Layout and supplies kept in there

    b. Laundry service

14. Pharmacy

    a. RNs ONLY-how to order med room supplies and where to pick up, how to get controlled inject able medications, where to take outdated medications.

    b. Where to drop off written RXs if needed

    c. Who can utilize pharmacy services

15. Procedure Rooms

    a. Use and difference between the two

    b. Layout and location of supplies

c. Negative air flow use and signage, location of switch and when to turn on, and ball in the wall.

d. PPE cabinet

e. Procedure Room 150

i. Code cart

ii. AED

iii. O2

iv. IV supplies

v. Instruments

vi. Catheter supplies

f. Procedure Room 124

i. Electronic table use

ii. Circumcision supplies and equipment

iii. Audiometer/Tympanometer

16. Break Room

a. Locker-if one is wanted contact the Administrative Assistant.

b. Refrigerator/freezer use-label your stuff if you do not want others using it.

c. Coffee-if drink it contribute to fund, watch for email requesting donations.

d. Clean up your own dishes each day.

17. X-Ray Room

a. 2 doors-look for lights being on before entering

b. Overview of X-ray ordering

c. How to help your provider obtain an x-ray

E. Various Equipment Introductions

1. Welch Allyn Spot Vital Sign Machines

    a. How to use-BP, HR, SPO2, Temp.

    b. Various cuff sizes and how to determine which to use

    c. How to take a BP-sitting for several minutes first, feet flat on floor, proper cuff size, remove bulky clothing, proper cuff position.

    d. Cleaning-Cavicide wipes

    e. Plug in every night

2. EKG Machines

    a. Burdick Eli 280-newest machine

    b. Schiller AT-2 Plus-also has spirometry on it

    c. How to use each machine-lead placement, proper body positioning, shaving, patient instructions during exam, running machine, printing reports.

    d. Care of electrodes

    e. Cleaning-Cavicide wipes

    f. Initial that EKG Procedure reviewed

3. Nebulizers

    a. How to use-set up, review medication options and location of meds.

    b. Neb kits-different types

    c. Cleaning-Cavicide wipes

    d. Loaner nebs-check out board, checking back in and cleaning.

    e. Loaner neb agreement

    f. How to order home nebulizer

    g. Initial that Nebulizer Procedure reviewed

4. Audiometer/Tympanometer

a. How to use

b. Testing done in procedure room 124 only-no music in that room

c. Cleaning-Cavicide wipes

d. Initial that Audiometer Procedure reviewed

5. Pulse Oximeter

a. Location of equipment

b. How to use and interpret readings

c. Barriers to accurate readings-finger nail polish remover

d. Peds has own pulse oximeter with different sensor sizes

e. Cleaning-Cavicide wipes

6. Exergen Temporal Scanner and Infrared Scanner

a. Locations

b. Watch training DVD

c. Take competency evaluation exam

d. Return demonstration with Nursing Supervisor

e. Cleaning-alcohol wipe only after each use

7. Blood Glucose Monitor

a. Locations

b. How to use-watch videos included in lab proficiency training. Review PowerPoint training.

c. Weekly controls-who does them, where to document, and what to do if out of range.

d. Where to get more test strips

e. Documenting of results in NextGen

f. BGL done on every diabetic at every visit

g. Cleaning-Cavicide wipe after each use

h. Initial that Insulin Administration Procedure reviewed (RN ONLY)

F. Various Procedures

1. Rooming a Patient

a. Vital signs-Ht, Wt, BP, HR, RR, Temp, Orthostatic BPs, SPO2.

b. NextGen-purpose of visit, med rec, allergies, histories tab, GPRA data.

c. BGL at every visit for DM patients

d. HGB A1C every 3 months for DM patients

e. Immunizations

f. Pediatric patients- length, weight, head circumference, BP, HR, RR. Know difference VS values adults vs. peds. Vision, hearing, lead, hgb.

g. Initial that Appointment Check-In Procedure reviewed

2. Ear Irrigation

a. 3 different ways to perform task-Elephant Ear, syringe, and Welch Allyn ear wash system

b. Watch video on Elephant Ear

c. Warm water

d. Initial that Ear Irrigation Procedure reviewed.

3. Immunizations

a. Adult vs. pediatric-who does what

b. VFC and local stock-who is eligible for what

c. Watch Oregon Immunization ALERT videos-then get OR ALERT login in and password

d. Take immunization self assessment quiz

e. How to document

f. Where standing orders are kept

g. RN visit for immunizations only

h. Initial that Immunization Procedure reviewed

4. On the Floor Labs

a. Do proficiency videos/tests first, then skills check off.

b. HGB A1C-machines in med room

c. Rapid Strep and Throat Culture-when and how to collect

d. Urine HCG

e. Urine specimen collection- adults and peds

f. HGB- machine in med room and peds pod

g. Lead-peds only

h. Influenza Reader

i. How to order and document in NextGen

5. Setting up and Assisting with Various Procedures

a. WHE

b. Circumcision-Pediatrician Only-Initial that Circumcision Procedure reviewed

c. Toenail removal

d. Minor surgical procedures

e. Suture/staple removal-RN can do

f. IUD insertion/removal

g. Consent forms, location of forms, and post op instructions.

6. Telephones

a. Keep VM updated

b. Check VM every few hours at minimum

c. Do not leave for day with VM left on phone

d. Document messages and deal with appropriately

e. RNs triage all request for appointments

f. Initial review of Nursing Triage Procedure

7. RN Visits

a. Immunizations

b. RX injections

c. Wound care

d. Head lice check

e. Suture/staple removal

f. Sore throat

g. UTIs

h. Pregnancy test

i. Catheter change

j. Review standing orders for nurse visits. Location of order.

G. Opening and Closing

1. Opening

a. Turn on computers

b. Turn on lights in exam rooms

c. Make sure exam rooms clean

d. Turn on A1C machines in med room

e. Ensure daily refrigerator/freezer temps taken and daily min/max documented

f. Review patients with provider/make plan for day

2. Closing

a. Terminal room cleaning-must be done in every room before anyone leaves. Terminal cleaning is the following: Exam table, patient chairs, provider stool, handles of otoscope and ohpthalmascope, counters, handles to every cupboard and drawer are ALL wiped down with EPA approved cleaner. Directions and contact time on approved cleaner must be followed.

b. Check and deal with VM. Do not leave messages on machine.

c. Re-start computers. DO NOT TURN OFF as updates are scheduled to be performed after hours.

d. Turn off A1C machines in med room. Clean med room. Wipe down counters, clean handles to cupboards and drawers. Set garbage outside of door for cleaning crew to remove. Once a week set out red biohazard trash for disposal.

e. Ensure all refrigerators and freezer doors shut.

f. Make sure in baskets are empty and all paperwork has been routed to provider.

Program	Nursing
Procedure	Sputum Sample Collection
Approval	08/13/98
Revised	06/11/02; 07/18/05; 03/06/09; 02/09/12; 01/04/19; 10/15/21

Sputum Sample Collection

I. PURPOSE

To obtain specimens of sputum from coughing patients to aid in the diagnosis and determination of disease and to obtain mucous that is coughed up from the lungs, not the saliva in the mouth.

II. EQUIPMENT

A. Sterile covered container or other appropriate collection container based on laboratory test ordered

B. Proper PPE, at a minimum gloves and mask for staff assisting patient.

C. Tissues

III. PROCEDURE

A. Explain procedure to patient. Explain that sputum is the mucous coughed up from the lungs and not the saliva in the mouth. Saliva is thin, clear and watery. Mucous is often described as viscous or thick. It can be various colors.

B. Wash your hands and apply appropriate PPE.

C. Have patient rinse mouth out with water prior to collecting sample.

D. Stand to the side of patient. Offer them a tissue to loosely cover mouth while coughing.

E. Instruct patient to take three deep breaths and hold last breath for 5 seconds.

F. Have patient cough forcefully twice before taking another breath.

G. If sputum is produced, have patient spit into sterile collection container. Close the lid, then wash and dry outside of container.

H. Remove PPE and perform hand hygiene. Instruct patient to perform hand hygiene as well.

I. Take specimen to lab for processing following SCHC infection control policies for transporting lab specimens through clinic.

J. Ensure order has been placed for laboratory analysis of sputum.

K. If sputum is not produced have patient repeat breathing coughing process until sample is obtained or patient cannot tolerate process any longer.

L. If patient is unable to produce a sample in the clinic instruct patient on home collection. Including to try first thing in the morning, or after a shower. Have patient follow same process as above. If sputum is collected at home, it needs to be brought into lab as soon as possible. Send patient home with lab specimen bag and ensure lab specimen collection container has proper patient identification on it.

Note: Saliva will not be useful. Do not send saliva to lab for processing. Send patient home with supplies and instructions to collect sputum.

Program	Nursing
Procedure	Tracking Usage of Scheduled II Medications
Approval	08/13/99
Revised	02/07/06; 03/06/09; 0 2/09/12; 01/04/19; 10/15/21

Tracking Usage of Scheduled II Medications

I. PURPOSE

All paranteral narcotic medications administered by RNs will be tracked. The medications that are tracked in this manner are: Morphine, Valium, Depo-Testosterone, Suboxone, and Sublocade.

II. PROCEDURE

A. Provider enters order into Med module in NextGen. Rx is either sent electronically to pharmacy or hard copy is printed. If RX is for Morphine or Valium and wet signature is required on printed RX.

B. RN takes hard copy to the pharmacy if RX was printed.

C. Pharmacist gets medication and log book. Verifies order.

D. RN draws up ordered medication and amount, making sure to document lot number and expiration date.

E. Pharmacist and RN verify amount in syringe.

F. Both individuals sign for the medication.

G. If medication was not administered or there was a dose change, the RN takes the medication back to pharmacy and wastes medication in presence of pharmacist. Both RN and pharmacist initial the waste amount.

NOTE

If a patient brings back scheduled 2 medications for disposal, the medication must be counted and disposal witnessed by 2 staff members. A note must be made in NextGen documenting the date, RX, amount wasted, and staff members who witnessed waste.

Program	Nursing
Procedure	Ear Irrigation
Approval	10/15/21
Revised	

Ear Irrigation

I. INTRODUCTION

Ear irrigation is used to remove cerumen (wax) or foreign bodies that occlude the ear canal and prevent sound from reaching the tympanic membrane (ear drum). It is a process of flushing the external ear canal with water or normal saline.

II. PURPOSE

When performing an ear irrigation, staff will use proper technique and standard precautions during the procedure.

III. CONTRAINDICATIONS/PRECAUTIONS

Do not offer ear irrigation if the patient has suspected or known perforation of the eardrum. An acute perforation can cause bloody drainage. Consult with the medical provider if the patient's ear is tender, red and/or there is fever or foul smelling discharge from the ear.

Ear irrigation can cause temporary dizziness. Wrong water temperature can cause patient to experience dizziness and/or nausea.

IV. PROCEDURE

A. Supplies needed:

1. Otoscope
2. Blue pad or chux
3. Appropriate PPE
4. Container for water
5. Collection container for under ear
6. Disposable ear curette
7. Elephant Ear washer system OR 60 cc syringe with irrigation tip

B. Gather supplies as listed above.

C. Perform hand hygiene and explain procedure to patient or parent.

D. Instruct patient to sit on exam table and drape chux over patients shoulder on side to be irrigated, taking care to tuck into clothing to prevent clothes becoming wet. Ask patient to hold container under ear for water to drain in.

E. Fill either container or bottle of Elephant Ear wash system with LUKE WARM water. Luke warm is neither hot nor cold.

F. Fill syringe (if using) or attach irrigation tubing to Elephant Ear wash system and expel air.

G. Grasp auricle and pull upward and backward (for adults) or downward and backward (for children).

H. Introduce the tip of the syringe approximately ¼ inch into the UPPER EAR CANAL.

I. Slowly and gently, begin irrigating the ear canal. Flow should be steady.

J. Stop irrigation immediately, if the patient complains of pain, nausea, or vertigo.

K. If patient is tolerating irrigation, continue to irrigate until water returns clear. Occasionally stopping to check ear canal with otoscope. May use an ear curette to assist in removing loose debris in ear canal.

L. Once irrigation is complete check ears with otoscope or notify provider irrigation is complete so they may continue with exam.

M. Remove supplies, perform hand hygiene, and document procedure in EMR.

N. If irrigation is unsuccessful, notify provider. If patient is instructed to return for irrigation, advise patient to use a wax-softening agent for 2-3 days prior to next office visit.

Program	Nursing
Procedure	Nursing Triage
Approval	Approved as a Policy: 08/13/99
Revised	Revised as a Policy: 04/29/02; 08/05/06; 05/02/09; 04/20/12; 11/20/15; 12/21/18 Revised as a Procedure: 10/15/21

Nursing Triage

I. PURPOSE

A. To screen patients who call or walk into the clinic to ascertain whether they should be fit into the schedule that same day, offered to be evaluated in the walk in clinic, referred elsewhere or advised on home care until the next available appointment is scheduled. A registered nurse (RN) or medical provider performs the assessment.

B. To ensure that any patient who sincerely feels he or she must see a medical provider immediately is seen that same day. Whether the patient is seen in the clinic or referred elsewhere is the decision of the RN or provider triaging the particular patient.

II. SAME DAY APPOINTMENT REQUEST (BY PHONE)

Patients are transferred to the RN for the patient's primary care provider or a triage RN. If a RN is not immediately available the patient can leave a voicemail for the RN or a message with the Patient Care Coordinator (PCC) that is routed to the appropriate RN. The RN returns the patient's call within two-hours of the call.

III. SAME DAY APPOINTMENT REQUEST (PATIENT AT CLINIC)

PCC calls the appropriate RN and makes the request known. PCC places patient on the nursing schedule but does not check him or her in. A RN discusses the concerns with the patient and determines if the patient needs to be seen immediately, can be seen in the walk in clinic provided every afternoon, or scheduled for an appointment through the normal scheduling process. Once a decision is made by the RN, the PCC is instructed to check in the patient as a nursing visit or schedule an appointment with a provider.

IV. POSSIBLE URGENT CARE REQUIRED

If a PCC receives a call from a patient who feels he or she needs urgent care and all nursing phone lines are in use, the PCC pages the triage RN.

V. CLINIC CLOSED

Callers are advised of the clinic closure by the PCC or telephone voice message. Patients are advised to call the answering service and ask for the on-call provider.

VII. REQUIRED DOCUMENTATION

All assessment data, instructions to the patient and the follow-up plan are documented in the patient's medical record. Phone call triage is documented in NextGen using the telephone communication template. Office triage RN visits are documented in NextGen using the SOAP template. If a patient is instructed to come back for the walk in clinic or scheduled to see a provider, a chart note is entered in NextGen stating the instructions given to the patient.