

PIT RIVER HEALTH SERVICE, INC.
MEDICAL POLICY



Approved: May 3, 2022

Health Board Chairperson

Loren Ellery

Chief Executive Officer

Date

6/14/22

Date

PIT RIVER HEALTH
SERVICE, INC.
MEDICAL DEPARTMENT

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Policy Title: Patient Rights and Responsibilities

Section 1: Authorization and Scope

This policy is enacted under the authority of the PRHS Board of Directors, in the governing body of the health clinic. This policy identifies the standard process for identifying a patient's rights and responsibilities

Section 2: Policy and Policy Procedure

Pit River Health Services recognizes the basic human rights of patients and ensures patient understanding in regards to privacy and their rights and responsibilities. PRHS will ensure the rights of patients as set forth and define by the AAAHC Accreditation Manual, Chapter 1.

- (a) Patients are treated with respect, consideration and dignity as outlined in the Patient Rights and Responsibilities document given to every patient upon their initial visit.
- (b) Patients will be provided with privacy throughout their visit. Nurses will use only a first or last name when the patient is called, will not verify any PHI in the hallway, a closed-door will be maintained while in the exam room and privacy will be maintained when patients are being processed throughout the medical department.
- (c) Patient disclosures and records are treated confidentially, as defined by the Notice of Privacy Practices given to every patient upon their initial visit. Patients are also given the opportunity to approve or refuse release of their PHI except when release is required by law. Release of PHI will be the "minimum necessary" needed to satisfy the request, releasing information that is required by law or only releasing information for which we have a valid request on file.
- (d) Information is available to patients and staff concerning:
 - 1. Patient Rights as demonstrated by the Patient Rights and Responsibilities document is given to every patient upon their initial visit, this is also posted in the lobby and available on our website.
 - 2. Patient conduct and responsibilities are defined by the Patient Rights and Responsibilities document given to every patient upon their initial visit, posted in the lobby and available on our website.
 - 3. Services available are demonstrated through brochures which are available in the lobby, website listings and occasional print media.
 - 4. Provisions for after hours and emergency care are listed on the telephone automated message, posted on the front door of the facility and available on the website.

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5. PRHS documents our fees for services through our charge sheet which is available to every staff member and can be reviewed with any patient upon request.
6. Advanced directives as required by state or federal law and regulations as noted in the Patient Rights and Responsibilities document given to every patient upon their initial visit, posted in the lobby and available on our website.
7. The credentials of the health care professionals are documented via their name tags and lab coats, listed in the PRHS brochure, posted in the reception window and available on the website.

Prior to receiving care, patients are informed of their patient responsibilities.

These Responsibilities require the patient to:

1. Provide complete and accurate information to the best of his/her ability about his/her health, any medications, including over-the-counter products and dietary supplements, and any allergies or sensitivities.
 2. Follow the treatment plan prescribed by his/her provider.
 3. Provide a responsible adult to transport him/her from the facility and remain with him/her for 24 hours, if required by his/her provider.
 4. Inform his/her provider about any living will, medical power of attorney or other directive that could affect his/her care.
 5. Accept personal financial responsibility for any charges not covered by his/her insurance.
 6. Be respectful of health care workers and staff, as well as other patients.
- (e) Patients are informed of their right to change their provider if other qualified providers are available.
- (f) Marketing and Advertising for PRHS is done through a variety of means such as flyers, posters, newspaper ads, leaflets, radio and television spots and health fairs, and do not intend to mislead patients in anyway.
- (g) PRHS Service Providers will be covered by Federal Tort malpractice insurance along with wraparound coverage for non-native patients.

Patients are informed about procedures for expressing suggestions, complaints and grievances, including those required by state and federal regulations. This information is provided to our patients via the PRHS brochure and is posted in the lobby

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Section 3: Responsibilities

All Pit River Health Service employees have read and understand a patient's rights and responsibilities and are delegated to carry out this policy

Policy Title: Patient Education

Section 1: Authorization and Scope

This policy is enacted under the authority of the PRHS Board of Directors, in their capacity as the governing body of the health clinic. This policy identifies the stand process for patient education in the medical clinic

Section 2: Policy and Procedure

Patient education is a multidisciplinary process and an integral component of Pit River Health Services. The goal of patient education is to improve health outcomes by promoting healthy behavior and involving patients in their care. Education will be specific to patients' relevant health and education needs, in ways understandable to the patient or his/her representative. A systematic approach to patient education should be used throughout the organization.

PROCEDURE:

1. Patient Education Process

a. Assessment

- i. Patients and/or their legal representatives or families will be assessed for the need for patient education and are involved in the planning of their education. Assessment may be conducted formally through the inclusion of specific questions on the initial patient assessment/history form including highest level of education completed, preferred method of learning (verbal, written, demonstration, etc.), preferred language and ability to read.
- ii. If formal assessment information is not available, informal assessment to determine educational needs should be done by the healthcare provider based out of communication feedback obtained from the patient or his/her representative.

b. Planning-Based RSS needs the patient may be educated about the following:

- i. How to safely and effectively use medications.
- ii. Nutrition intervention, modified diets.
- iii. Oral health.
- iv. Safe and effective use of medical equipment or supplies.
- v. Managing pain.
- vi. Rehabilitation techniques to improve functionality.

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- vii. Resources to obtain further care/follow-up visit.
 - viii. Basic health practices and safety.
 - c. Provision
 - i. Providers provide the initial information regarding diagnosis, prognosis, and medical treatment plan to the patient.
 - ii. Additional education activities with other professional disciplines (PT, OT, dietician) may be coordinated.
 - iii. Patient/family education is augmented and/or reinforced by nursing personnel as appropriate to include additional information about the healthcare system, treatment, procedures, diagnostic tests and other activities pertaining to patients' care; preventive healthcare information and information needed by patients to adequately care for themselves.
 - d. Documentation
 - i. Disciplines are to document education in the medical record/EHR.
 - ii. Patient education materials (e.g. pamphlets, videos) used in the educational process or given to the patient are documented in the chart.
2. Review Criteria for Patient Education Materials. Education materials developed for patients and families should meet review criteria. Review criteria for new or revised patient education material includes reading level, quality of content and technical quality. These criteria are elaborated below to assist staff in evaluating/developing educational materials to be implemented.
- a. Reading level-reading level should be fifth-grade or less to be approved.
 - b. Content and Technical Quality- The content area examines the material accuracy, congruency and relevancy. The information should address issues of concern for most patients with the condition. The technical quality assesses how the material is presented in its total form. The total presentation should be attractive. The material should flow from simple concepts to complex ideas with appropriate headings or spacing as indicated below.
 - i. Title describes content.
 - ii. Purpose is clear.
 - iii. Achieves purpose.
 - iv. Information is accurate and current.
 - v. Information is organized logically.
 - vi. Clearly defines and explains new words and concepts.

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- vii. Avoid jargon/slang.
- viii. Free of stereotypes (racial, ethnic, sexual).
- ix. Steps of procedure are clear, single action, observable.
- x. Provides rationale for content/steps of procedure.
- xi. Covers topic adequately.
- xii. Print is large enough.
- xiii. Lengthy instructions are subdivided with appropriate titles.
- xiv. Key areas are emphasized.
- xv. Spacing of script is attractive, easy-to-read.
- xvi. Illustrations represent a single concept.
- xvii. Illustrations aid learning and retention.
- xviii. Illustrations are clearly labeled and uncluttered

Section 3: Responsibilities

It is the responsibility of the following staff to provide education to patients in the medical clinic.

- a) Providers
- b) Clinical staff
- c) Support staff

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Policy Title: Quality of Care

Section 1: Authorization and Scope

This policy is enacted under the authority of the PRHS Board of Directors, in their capacity as the governing body of the health clinic. This policy identifies the process for providing quality care in the medical clinic to our patients in line with our mission. Through the application of principles of professional practice and ethical conduct, services are provided based on concern for increasing the overall health of the patient population and local community and decreasing costs of care.

Section 2: Policy and Procedure:

PRHS provides quality medical care to its patients as demonstrated by the following:

1. Healthcare provided is consistent with current medical knowledge.
 - a. PRHS providers complete Continuing Medical Education (CME) necessary to maintain their licenses.
 - b. PRHS providers deliver services appropriate to their training, skills and the scope of their privileges.
 - c. PRHS providers use "evidence-based medicine/practice" when participating in Quality Improvement program design and activities.
2. Patients are educated on the diagnosis, treatment options and appropriate preventative measures. Documentation of diagnosis, medication instruction and patient education is recorded in the patient Electronic Health Record (EHR) at each visit.
3. Timely diagnosis is made based on history and physical examination. This is documented in the 'Assessment and Plan'.
4. Review and update of medication history including allergies and medication is done at each visit. Medications include: prescription medication, over the counter (OTC) medications, vitamins and dietary supplements.
5. Treatment is consistent with the clinical impression and working diagnosis in the 'Assessment and Plan'.
6. Consultations/referrals are made in an appropriate and timely manner.
 - a. Consultation/referrals that are urgent are made prior to the patient leaving the office.
 - b. Consultation/referrals that are routine are scheduled in a timely manner. A referral log is maintained by the CHS department for all medical referrals. The log is reviewed on an ongoing basis to ensure completion and follow-up.

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7. Clinically unnecessary diagnostic and therapeutic procedures are avoided.
8. Follow up of physical findings and test results is performed in a timely manner.
9. Patients are expected to cooperate with medical recommendations.
10. Continuity of care and patient follow-up are provided in a timely manner.
11. Patient satisfaction surveyed.
 - a. Patients are randomly requested to complete a satisfaction survey at the end of each visit. Results are used in the Quality Improvement Program.
12. Patients are notified at a scheduled appointment following the testing of all lab and procedure results after the ordering provider reviews them.

The nursing staff that collects blood testing and lab specimens should inform the patient to follow up with a scheduled appointment to review the lab tests results.

Lab tests are tracked in a send out test log. This is done to ensure that the test results are received back and reported in a timely manner to the ordering provider for review with their patients.

If a patient fails to come to their appointment for a lab collection the provider should be notified by the nursing staff and document that the patient failed to come in for their ordered lab test.

 - a. If a provider is going to be out of the office for an extended period he/she will make arrangements for a colleague to review incoming labs and procedure reports.
13. Cost of medical care is considered one recommending:
 - a. Laboratory services
 - b. Medication
 - c. Diagnostic procedures
14. Reasonable attempts will be made to communicate to the patient in their language. Information and consultation will be provided in a culturally sensitive manner with consideration for the individual needs of patients.

Section 3: Responsibilities

It is the responsibility of the following staff to provide education to patients in the medical clinic and support staff.

- a) Providers
- b) Clinical staff
- c) Support staff

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Section 4: Review

The Board of Directors and Executive Director shall review this policy to ensure it's Consistency with Federal, state and local regulations, as well as other PRHS policy. This review will also ensure the policy is practical and realistic for the day-to-day operations of PRHS.

Policy Title: Laboratory Handling and Transportation of Specimens

Section 1: Authorization and Scope

Pit River Health Services (PRHS) ensures that the collection and processing of laboratory and pathology specimens, prior to and after arriving in the laboratory, are handled in a way that is professional and confidential, eliminates the potential for exposure to infectious agents and maximize the accuracy of lab processing and reporting.

Section 2: Policy and Procedure

1. Lab specimens obtained by clinical staff:
 - a. Each specimen must be associated with an electronic order initiated by the clinician or his/her designee (such as an RN with a verbal or standing order).
 - b. Blood drawn at the PRHS laboratory will be drawn using proper technique and labeled properly.
 - c. Staff members will wear protective equipment as needed and follow clinic hand hygiene policy.
 - d. Specimens obtained by the clinical staff for processing which contain potentially infectious material (i.e. throat swabs, wound cultures, influenza swabs) will be obtained using the appropriate protective equipment and placed in containers specifically designed for that task as supplied by the manufacturer of the collection device.
 - e. In the lab, the specimen is labeled with patient demographic information, provider and tests ordered.
 - f. Appropriately trained personnel will transport appropriately labeled specimens to the lab if collected in the exam room.
 - g. Specimens obtained on the slide from microscopy will be labeled with a marker pen and placed in a specimen box to be transported by staff.
 - h. The Medical Director is responsible for laboratory service program policies, procedures, standards and oversight of personnel.
2. Lab only specimens:
 - a. Must be accompanied by either a recent, future or standing order in the patient's chart. A written or faxed order from an outside provider is required for labs not ordered by PRHS providers. All outside orders will

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be reviewed by PRHS providers and approved/ordered prior to completion.

- b. Collection is performed by clinic staff as with in-house collections, following all applicable HIPAA and OSHA guidelines.

3. Pathology specimens:

- a. Lesion biopsies, shaves or punches are to be sent to a pathologist for analysis.
- b. Risks and benefits of the procedure are to be explained to the patient and informed consent is received from the patient prior to beginning the procedure.
- c. Sterile technique shall be utilized where appropriate.
- d. Specimens shall be placed in or on the appropriate container or slide with a preservative. Specimens are to be labeled with the patient's name, site of specimen collection and/or other identifying information. The appropriate electronic order or requisition will be associated with the specimen. If there are multiple biopsy sites, each site will be specified on the container.

4. Specimens obtained by the patient:

- a. Laboratory specimens obtained by the patient should be placed in an appropriate collection container provided by the lab or clinical staff.
 - i. When receiving such specimens, staff must handle the container with gloves and check the specimen for accurate labeling.
 - ii. Hand washing is required after handling potentially infectious specimens.
- b. Specimens received by the laboratory are then processed in the same manner as specimens collected by clinic staff.

5. Storing and sending samples:

- a. In-house tests will be performed on the date of service, if possible.
 - i. Urine and other body fluid samples can be discarded after testing, unless other tests have been ordered.
 - ii. EDTA tubes of blood are kept at room temperature for 24 hours before discarding in a biohazard trash.
 - iii. Serum samples not sent to the reference lab are kept in the corresponding days rack row in the lab refrigerator. These samples are held for one week before discarding in the biohazard trash.
- b. Send out tests will be bagged and placed in the courier box to be picked up by the courier at the end of the day.

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- i. Room temperature samples being sent to the reference lab will be placed in the reference lab's two-part transport bag.
 - ii. Refrigerated samples (including viral cultures) will be placed in the lab refrigerator until time to bag it up and placed beside a cold or frozen pack as needed.
 - iii. A frozen sample will be placed in the freezer until bag and inserted in the frozen specimen container for transport.
 - iv. In the event that a pickup is missed or is required after courier has left, arrangements will be made for staff or PRHS transportation to bring the sample to the reference lab with appropriate transportation instructions.
6. All laboratory equipment will be inspected, maintained and calibrated per manufacturer's specifications and guidelines. Calibration logs will be kept up-to-date in the laboratory.
7. Laboratory temperatures for the lab room and lab storage refrigerator are monitored and documented daily to assure that temperature ranges for storage of test media and lab specimens are maintained in recommended temperature ranges. The daily recommended temperature ranges for lab room and refrigerator are listed on the Laboratory Refrigerator and Room Temperature Log for reference. Out of range temperatures should be reported to the Clinic Manager to determine if lab specimens or lab test media have been affected. Adjustments to bring temperatures back to recommended temperatures should be made.
8. Reporting of Lab Results
 - a. Lab specimens that are collected and sent out for testing tracked in a test log. This is to ensure the test results are received back and reported in a timely manner to the ordering provider to review them with their patient.
 - b. Patients are notified at a scheduled appointment following the testing of all lab and procedure results after the ordering provider reviews them. The nursing staff that collects blood testing and lab specimens should inform the patient to follow up with a scheduled appointment to review the lab tests results.

If a patient fails to come to their appointment for a lab collection the provider should be notified by the nursing staff and document that the patient failed to come in for their ordered lab test.

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Responsibilities

The handling of specimens to be transported is the responsibility of

- a) Providers
- b) Clinical staff, medical assistants and nurses

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Policy Title: Laboratory POCT and Quality Control

Section 1: Authorization and Scope

The policy is a guideline of the onsite POC (Point of Care) lab tests performed at the PRHS Medical Clinic and reviewed at the time with the patient at their office visit that day.

Section 2: Policy and Procedure

The policy is a guideline of the onsite POC (Point of Care) lab tests performed at the PRHS Medical Clinic. All POC tests performed are CLIA waived in compliance with the Clinic Lab Improvement Amendment (CLIA). A certificate is maintained current and posted in the designated Clinic lab room.

The over site of the laboratory services performed is under the direction of the PRHS Medical Director and training is reviewed by the Clinic Manager. Point of Care tests are ordered by Providers in the E H R. POC tests are performed by trained Medical Assistants or Licensed Nurses. Results are reported by the staff performing the test into the E H R for review by the ordering Provider and reviewed at the time with the patient at their office visit that day.

The following are a list of onsite POC tests and the frequency quality control (Q.C.) testing should be performed. Reference the Lab Manual for the manufacturers step by step instruction and Quality Control guidelines and logs.

Glucose fingerstick - HemoCue B-Glucose Analyzer

Daily Q.C. is done by using a photometer cassette

Hemoglobin fingerstick - HemoCue 201 +

An internal quality control is performed when the testing device is used for testing a patient sample.

Rapid Strep Screen- by throat swab OSOM Strep A Test

The controls are inside each new test kit. Manufacturer recommends that an external positive and negative controls should be done with each new lot number.

Urine Pregnancy Test by urine sample- McKesson Consult hCG urine test

The manufacturer recommends that an external positive and negative controls should be done with each new lot number.

Urine Dip Test- urine sample Siemens Clinitek Status + Analyzer

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Test Q.C. specimens on the Multistix 10G urine test strips with each new lot and new shipment of reagents. Test reagents monthly that are store for more than 30 days.

Urine Drug Screen- McKesson urine drug test screen cup

Internal controls are run and results indicated on the testing strip for each drug tested for using the urine test cup.

A1C Hemoglobin Siemens DCA Vantage Analyzer

A normal and abnormal control solution for DCA Analyzer is used with the use of a new test kit.

Chemistry - Piccolo Xpress Chemistry Analyzer

An internal Q.C. is performed daily.

External controls are performed at least every 30 days, with each new lot number of rotor panels. External controls are recommended by manufacturer when training new personnel, tests results do not match patient symptoms or clinical findings and if lab conditions have changed significantly.

LeadCare II Blood Lead Test

Level 1 & 2 test controls are run with each newly opened kit lot number and monthly per manufacturer instructions.

Ora Quik oral swab for HIV An internal controls is indicated within the swab test window as confirmation of

Ora Quik oral swab for HCV

Influenza A & B Consult McKesson

The controls are inside each new test kit.manufacturer recommends that an external positive and negative controls should be done with each new lot number.

RSV Quidel QuickVue test kit

The controls are inside each new test kit.manufacturer recommends that an external positive and negative controls should be done with each new lot number.

INR-CoagChekXS-fingerstick bloodtest Internal Control occurs within the Machine when each test strip for an INR test is used.

Section 3: Responsibilities

POC tests are ordered by a medical provider.

POC tests are performed by Medical Assistants and nurses trained to perform POC tests. Results are documented in E H R.

SECTION 4: REVIEW

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The Board of Directors and Executive Director shall review this policy to ensure its consistency with Federal, state, and local regulations, as well as other PRHS policies. This review will also ensure the policy is practical and realistic for the day-to-day operations of PRHS

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Policy Title: Medical Emergency Policy

Section 1: Authorization and Scope

The purpose of this policy is to assure an efficient and prepared process is followed by medical staff when providing medical aid to patients in the event of a life threatening or non-life-threatening medical emergency occurring on PRHS premises.

Section 2: Policy and Procedure

Non-Life-Threatening Emergencies

Non-life-threatening emergencies may include minor injuries, falls, lacerations, weakness, fainting.

- A. Staff that is aware of a medical emergency that occurs outside the medical department should call for assistance by calling the medical receptionist and inform them who is calling, location and that type of patient emergency occurring. The receptionist should find a nurse or M.A. to come to the phone or location of the emergency if the caller must get back to the patient. The caller should stay with the patient until help arrives. Vital signs should be taken if feasible.

Medical staff, RN and medical staff who responds to the scene of the emergency should bring the emergency bag located on the wall in the trauma room and oxygen tank on a cart with tubing in the trauma room. The medical responders may assist the patient to the Clinic by wheelchair if appropriate when stable for further medical evaluation and treatment. Medical staff should remain with the patient until dismissed by the licensed person at the scene. If the patient is to be transferred to hospital by ambulance medical staff should remain with patient until dismissed by licensed staff at the scene.

Life Threatening Emergencies

Major medical emergencies are defined as life threatening such as a shortness of breath, possible stroke, anaphylaxis reaction, severe trauma and respiratory arrest.

First person aware of a medical emergency will use the paging system to page "Medical Emergency" and give location. The RN and medical staff will go immediately as first responders to aid the victim. The first person aware should stay with the victim until help arrives.

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Cardiac Arrest and Respiratory Arrest- Code Blue

If the "emergency" is a possible Cardiac Arrest or Respiratory Arrest the page will be given as "Code Blue" and the location and call out for someone to call the medical receptionist to assure medical staff heard the overhead page for " Code Blue" The person who is aware of the emergency will remain with the patient and act as the first responder and initiate CPR if needed.

1. The first responder begins CPR. If second person comes on to the scene they should initiate EMS by calling 911 then assume the role as second rescuer for chest compressions.

When calling 911 for EMS to respond to an emergency the caller should give them the type of emergency, location and nearest cross street.

2. All medical BLS trained staff will respond to the location
3. Upon medical personal arrival EMS should be activated 911 if not already done so.
4. Responsibilities of Medical Staff

Clinic receptionist will inform waiting room of on emergency.

The receptionist or staff designated will direct EMTs to the location of the emergency when they arrive. Their role will include clearing halls/area of patients and onlookers to provide unhindered access.

- a. The Emergency Kit and medications will be brought to site by the R.N.
- b. The physician will order what is needed and begin treatment if necessary. The I.V. fluids and medications will be set up by the R.N.
- c. The F.N.P. will assist the physician, as directed, i.e., IVs, Medications.
- d. The Medical Assistant will bring the oxygen tank on stand with supplies to the location and apply oxygen, if ordered, take vital signs or other delegated duties as well as assist with CPR if required.

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- e. The will RN will obtain and record the emergency treatment on the Code Blue/ Medical Emergency Flow Sheet, keeping track of the medication treatment and time it is administered.
 - f. Upon arrival of the EMS personnel they will be directed to the location of the Code Blue. They will be brought into the Code Blue in process. A M.A. will make a copy of the patient's Face sheet, Code flow sheet and any other pertinent paperwork that should be given to an EMT transporting the patient to the hospital.
 - g. If the emergency does not necessitate Code Blue procedure (use of the Emergency Kit), the physician and the R.N. Clinic Manager will record in the Patient's chart the sequence of events, treatment and disposition of Patient.
5. An incident report of the Code Blue will be documented. Staff involved with the Code Blue will be debriefed regarding the event.

MEDICAL EMERGENCY PREPAREDNESS

Mock Code Blue: The purpose of having an annual "mock code blue" is to familiarize the staff with the emergency equipment, emergency medications and chain of events that take place within a code. It is meant to allow staff to become familiar with what their specific role is in the event of a cardiac arrest patient needing to be stabilized, until the arrival of 911 emergency personnel.

Medical Emergency Equipment

1. Emergency equipment location is on the outside pocket of the blue Emergency bag hanging on the wall in the Trauma and in the log book with the Defibrillator and Emergency Equipment Daily and Monthly Checklist.

The defibrillator is checked daily by running a User test strip and the defibrillator runs an internal daily Self Check strip test strips are mounted in the log book. The defibrillator is checked daily for supplies needed to use the defibrillator and outdates of those supplies checked monthly and documented. The Gomco suction is checked daily by turning it on and checking for function and documented on the checklist.

The oxygen tanks are checked daily for adequate level of oxygen and oxygen supply tubing is attached and ready for use and documented on the checklist.

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Staff will replace any oxygen tubing, adult and pediatric masks, nasal cannulas if used in the course of patient care. This assures oxygen readiness for the next time oxygen equipment is needed.

The emergency supplies and emergency medicines are checked for adequate supply and expiration dates monthly and documented on the checklist.

Staff are to be reviewed on the location and use of emergency equipment annually and as new employees.

SECTION 3: RESPONSIBILITIES

All BLS trained staff of PRHS
Medical Receptionist
Medical Assistants
Licensed staff: RN, F.N.P, P.A., M.D.

SECTION 4: REVIEW

The Board of Directors and Executive Director shall review this policy to ensure its consistency with Federal, state, and local regulations, as well as other PRHS policies. This review will also ensure the policy is practical and realistic for the day-to-day operations of PRHS.

Attachments:

Code Blue/Medical Emergency Flow Sheet
Defibrillator and Emergency Equipment Daily and Monthly Checklist
Emergency Supply List and Location
Emergency Medication Kit Log

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Policy Title: Emergency Transfers

SECTION 1: Authority and Scope

Pit River Health Services (PRHS) recognizes the necessity for the prompt transfer of patients and medical emergency situations. When the patient needs emergency treatment, outside of the scope of practice of PRHS, staff will make immediate arrangements for the appropriate transport of that patient to a facility equipped to receive them.

SECTION 2: Policy and Procedure

1. Patients determined to be in need of immediate emergency medical assistance will be transported via emergency medical services (EMS).
 - a. Any PRHS staff member can initiate a transfer in case of a medical emergency: A patient that appears or states that they are in distress. This will trigger an immediate medical evaluation by a provider.
 - b. The determination of the need for transfer by EMS may also be made by any PRHS medical provider during the course of the patient visit.
2. Once it is determined that patient needs emergency transfer to another facility a PRHS employee will contact EMS via 911 and provide all available information requested during the call.
3. The following information will be sent with the patient:
 - a. A copy of the PRHS Code Blue/Medical Emergency Flow Sheet.
 - b. A copy of the patient demographic page.
 - c. A list of medications and allergies.
 - d. Other medical information as needed.

SECTION 3: Responsibilities

Medical Providers
Medical Assistants
Nurses
Medical Receptionist

SECTION 4: REVIEW

The Board of Directors and Executive Director shall review this policy to ensure its consistency with Federal, state, and local regulations, as well as other PRHS policies. This review will also ensure the policy is practical and realistic for the day-to-operations of PRHS.

May 8, 2018

Policy Title: Informed Consent

SECTION 1: Authority and Scope

Informed consent will be obtained from the patient by the Provider for procedures which require breaking the skin via cutting, or for any procedure involving or potentially involving removal of tissue for debridement or biopsy. This includes but is not limited to procedures such as incision and drainage, punch biopsy, incisional biopsy and suturing.

SECTION 2: Policy and Procedure

1. The procedure will be explained to the patient by the Provider. Information discussed will include why the procedure is necessary, advantages of the procedure, possible complications and possible alternatives to the recommended procedure.
2. Details of the informed consent education will be documented by the provider in the visit notes of the EHR. Documentation will include the type of procedure, benefits/risks, and any potential alternatives that have been discussed with the patient.
3. The patient will be given the opportunity to ask questions.
4. The consent form will be completed by the Provider. The patient (or legal representative/guardian for the patient) will be asked to read and sign the consent form after questions have been answered in the patient agrees to the procedure.
5. The Provider signs the form verifying that they have discussed the procedure with the patient.
6. Prior to the procedure, a witness' signature is obtained by the medical assistant, nurse or provider verifying that the patient signed the form after education and had the opportunity to ask questions prior to the procedure.

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SECTION 2: Responsibilities

- a) Provider
- b) Nurse
- c) Medical Assistant

SECTION 4: Review

The Board of Directors and Executive Director shall review this policy to ensure its consistency with Federal, state, and local regulations, as well as other PRHS policies. This review will also ensure the policy is practical and realistic for the day-to-day operations of PRHS.

Attachments:

Informed Consent General Procedure
Informed Consent for Cyst Removal
Informed Consent for Incision and Drainage
Informed Consent for Joint Injection Steroid
IV Therapy for Medications
Informed Consent for Laceration Repair
Informed Consent for Skin Tag Removal
Informed Consent for Suspicious Skin Lesion
Informed Consent for Toe Nail Avulsion
Informed Consent for Toe Nail Removal

Policy Title: Treatment of Minors

SECTION 1: Authority and Scope

PRHS fully complies with California statutes for the provision of healthcare services to adolescents.

SECTION 2: Policy and Procedure

1. All patients under 18 years of age are considered minors and must be accompanied by a parent or guardian in order to receive medical care. If a parent has arranged for another adult to bring a minor into the clinic, a note must accompany the minor granting the clinic permission to provide medical or dental treatment under supervision of said adult. In the absence of such a note, a phone call from the parent that is witnessed by two PRHS employees may authorize treatment.
2. Exceptions to parental consent:
 - a. When, in the opinion of the Medical Director or medical provider, the minor patient is in need of urgent or emergency care, that care may be provided without first obtaining consent.
 - b. Caregiver's authorization-a grandparent, aunt, uncle or other qualified relative of the patient may consent to medical care for a minor child. A Caregiver's Authorization affidavit must be on file in the patient's medical record.
 - c. A minor of 15 years or older, living away from home, managing his/her own economic welfare whether or not with parental assistance (emancipated minor}, may consent to his/her own medical care.
 - d. A minor of 12 years or older may consent to the following procedures without a parents prior consent and the parents are not usually liable for payment:
 - i. Diagnosis, treatment or counseling for drug or alcohol related problems.
 - ii. Mental health treatment or counseling.
 - iii. A minor of any age may give consent to and authorize treatment for prevention or treatment of pregnancy.
 - iv. disclose to parents a report was made (Cal. Family Code 6928)(Cal.Pena1Code11167 and 11167.5
 - v. Diagnosis and treatment for venereal disease STD services

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- vi. STD prevention strategies but are not limited to:
 - a) Hepatitis B vaccine, HPV vaccine
 - b) Medications to prevent HIV infection, before or after exposure.California law (AB 499) or Chapter 652, Statutes of 2011.
- vii. Treatment for sexual assault or rape. Minors may consent for medical services without a parent's consent. Rape and sexual assault of a minor is considered child abuse under California law and must be reported as such to the appropriate authorities by mandated reporters. See guidelines under attached "California Minor Consent and Confidentiality Laws" (Cal. Family Code 6928) (Cal.Pena1Code11167 and 11167.5

Section 3: Responsibilities

- a) Providers
- b) Nurses
- c) Medical Assistants
- d) Support staff

Attachments:

PRHS Caregiver's Authorization to Treat Minor Affidavit

References:

California Minor Consent and Confidentiality Laws

CHOP Summary of Law (Chapter 652) Prevention of sexually transmitted diseases (STDs)

Consent Requirements for Medical Treatment of Minors by the California Hospital Association

Policy Title: Mandated Reporting of Adult/Elder Abuse

SECTION 1: POLICY AND PROCEDURE

Any physician or mid-level practitioner or medical department staff or ancillary staff who knows or has reasonable cause to believe abuse of a patient who is a dependent adult (18 to 64) or Elder (over 65) has sustained abuse shall immediately report the suspected instance to the local law enforcement agency by telephone and shall prepare and send a written report thereof within 36 hours.

Phone numbers:

Redding - (530) 225-5798 (Adult Abuse Hotline)

Redding Enterprise - (530) 224-4200

Burney - (530) 335-4523

SECTION 3: RESPONSIBILITIES

All PRHS health care providers, physicians, mid-level practitioner, nursing staff are identified as mandated reporters of adult or elder abuse and are responsible to contact the local Shasta County Health and Human Services Agency department of Adult Protective Services. Attached resources for phone numbers with the reporting forms are attached.

Attachments:

State of California DHHS form 341 Report of Suspected Dependent Adult/Elder Abuse

Adult Protective Services Brochure DHHS Shasta County. Phone numbers for towns in Shasta County listed.

Policy Title: Mandated Reporting Child Abuse

SECTION 1: POLICY AND PROCEDURE:

For these purposes, child abuse is defined by California Penal Code, section 11165. This section also outlines conditions which must be reported. Section 11166 notes that reports are required when the person, within the scope of his or her professional capacity, gains knowledge of, observes or reasonably suspects child abuse. Mandated reporters are also required to report certain instances of sexual activity by minors.

1. It is the responsibility of the healthcare provider who may receive such knowledge to make a telephone report as soon as practically possible, and to supply a written report within 36 hours.
2. The report is required to be submitted to only one child protective agency. The law defines both law enforcement and child welfare services as "Child Protective Agencies". For purposes of telephone reports, reports may be made to the law enforcement agency with jurisdiction in the area or local Shasta County of Health and Human Services department of Child Protective Services by calling the Child Abuse Hotline, (530)225-5144.

SECTION 2: RESPONSIBILITIES

It is the responsibility of all PRHS health care providers, physicians, mid-level providers and nursing staff to report identified cases of child abuse.

Attachments:

California Mandated Reporting Easy Steps Brochure

DHSS Mandated Child Abuse Reporters Suspected Child Abuse Report form SS 8572

Policy Title: Mandated Reporting Domestic/Intimate Partner Violence

POLICY: For these purposes, "Domestic Violence" means abuse committed against an adult or a fully emancipated minor who is a spouse, former spouse, cohabitant, former cohabitant or person with whom the suspect has had a child or is having or has had a dating or engagement relationship. California Penal Code Sections 11160.

PROCEDURE:

1. All PRHS to staff will complete training in recognizing victims of abuse upon initial orientation and annually thereafter.
2. Patients will be screened for evidence of abuse upon initial medical clinic visit and at least annually thereafter.
3. PRHS staff will complete reporting requirements for domestic violence per AB 1652, "Injuries Resulting from Criminal Conduct-Reports by Healthcare Practitioners" and Penal Code 11160 "Report of Injuries by a Deadly Weapon or Assaultive or Abusive Behavior". Reporting requirements of the law take precedence over any patient/provider confidentiality rights.
 - a. A written report ("Report on Injury or Suspected Abuse" form) will be filed if staff observes or learns of the patient who is suffering from a wound or other physical injury inflicted as a result of assaultive or abusive conduct. Reporting is also mandated for all injuries caused by knives, firearms or other deadly weapons, whether or not a crime is suspected. This specifically includes self-inflicted injuries.
 - b. A telephone report will be made to the law enforcement agency with jurisdiction over the place where the crime occurred. The telephone report will be followed by a written report. The written report will include: the name of the injured person, if known; the injured person's whereabouts; the character and extent of the injured person's injuries; and the identity of any person the injured person alleges inflicted the wound, other injury or assaultive or abusive conduct upon the injured person.
 - c. A health practitioner is required to make a telephone report immediately and send a written

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report to the local law enforcement agency within
two working days.

Attachment:

State of California Suspicious Injury Report CES- 920

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Policy Title: Mandated Reporting Communicable Diseases

POLICY: For these purposes, communicable diseases are those diseases determined by the Public Health Service and are described under General section 2500 of California code of regulations.

PROCEDURE:

1. It is the responsibility of the attending medical-provider who diagnoses any reportable communicable disease to report this finding. A Confidential Morbidity Report (CMR) is to be completed and submitted to the local Health Department in the county wherein the subject patient resides. These reports will be submitted within the appropriate time limits as described in the "List of Reportable Diseases and Conditions". Forms for reporting as follows: Form CDHP 110a for reporting all conditions except tuberculosis, and conditions reportable to OMV. Form CDHP 110b for reporting tuberculosis. Form CDHP 110c for conditions reportable to OMV. Completed Confidential Morbidity Reports are faxed to Shasta County Public Health fax number (530)225-507. Phone number (530)245-6853. A copy of all forms are saved in Vista Imaging.
2. If a specific disease entity requires a preliminary phone call or earlier than usual reporting by mail, it will be the responsibility of the diagnosing medical provider to conform to those regulations.

Attachment:

State of California DHHS: Confidentiality Morbidity Report

Policy Title: Mandated Reporting of Pesticide Related Illness

POLICY: Pesticide related illnesses or incidents are reported to the county Public Health Department. California Administrative Code, Title 17, Health Title 22, Chapter 7, Article 3.6.

PROCEDURE:

1. Any medical provider who knows, or has reasonable cause to believe that a patient has a pesticide related illness, must report the incident to the local health officer by telephone within 24 hours.
2. The reporting requirement includes fill types of pesticide cases: skin and eye injuries, as well as systemic poisonings. It includes suicides and homicides; home cases as well as occupational cases.
3. If the pesticide related illness is due to an occupational exposure, a copy of "Doctor's First Report of Occupational Injury or Illness" must be submitted with the "Pesticide Illness Report" to the local health officer.

Attachment:

State of California Cal/EPA Pesticide Illness Report

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Policy Title: Mandated Reporting of Animal Bites and Injuries

Policy: All animal bites/injuries that result in more than superficial broken skin will be treated at PRHS or referred to the emergency room for appropriate care and/or follow up of potential rabies vaccine treatment if needed.

Procedure:

Animal bites and injuries that are seen at PRHS will be reported to the Shasta County Animal Control.

A report of the information related to the animal bite or injury will be documented in the Rabies Control Investigation Record. This completed form should be faxed to Shasta County Animal Regulations at fax number (530)245-6069. They may be reached by phone at (530)245-6065.

Attachments:

Shasta County Animal Regulations
Rabies Control Investigation Record
Animal Regulations list of phone and fax numbers

Policy Title: Medication Dispensing

POLICY:

Drugs dispensed from Clinic supply will be stored, handled and distributed in a safe and effective manner.

PROCEDURE:

1. All drugs stored in the clinic are the property of the Medical Director.
2. A formulary list of stock medication is maintained in an accurate and timely manner, reviewed and updated at least annually.
3. Except under special circumstances, prescriptions for patients use of off-site medications will be filled at the patient's personal pharmacy or at a pharmacy contracting with Pit River health Services.
4. Medication samples will be dispensed from the Clinic as starter or trial supplies, but are intended to be supplemented by a prescription filled at a pharmacy for continued treatment.
5. No drugs shall be administered except on the written order of a person lawfully authorized prescribed medication, i.e., physician, nurse practitioner. A telephone/verbal order for administration may only be given to a physician or licensed nurse and shall be signed by the person giving the order within ten (10) days.
6. Orders for drug administration shall be entered into the patient's health record and be signed by the prescriber and shall include drug name, dosage, route time of frequency of administration.
7. Drugs shall be administered as prescribed and shall be recorded in patient's health record of given on-site or dispensed from the Clinic. If a prescription is given for off-site administration, all of the drug information, or a copy of the prescription, will be included in the health record.
8. All drugs will be kept in the lockable storage cabinet or medication room with the following exceptions:
 - a) Preparations requiring cold storage will be kept in the refrigerator in the treatment room. Daily temperature logs will be maintained of freezer and refrigerator.
 - b) Emergency medications, which will be kept locked, will be monitored and inventoried monthly and PRN.
9. Prescription pads currently in use will remain in the possession of the provider at all times. After hours they shall be stored in a locked office. New pads are

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locked in storage and dispensed/inventoried by the Clinic manager as needed.

DISPENSING:

1. Only the Clinic Physician is lawfully authorized to dispense medications.
2. All dispensing shall be done in compliance with all applicable laws and regulations. Pills will be controlled and dispensed by a licensed provider.
3. A record of drugs dispensed will be entered into the Medication Dispensing Log for each medication name and lot number and included in the patient's health record.
4. Medication Dispensing Logs will be given to the Clinic Manager to be stored in files for reference as needed for 3 years.
5. All medications for off-site use, filled by the clinic, will be packaged in an appropriate container which will be moisture resistant, light restrictive and childproof, if applicable, and will be labeled with all of the following:
 - a. Name, address and phone number of the clinic
 - b. Patient's name
 - c. Prescriber
 - d. Date and time of issue
 - e. Drug name
 - f. Drug strength
 - g. Quantity dispensed
 - h. Expiration date
 - i. Any precautions to be taken during usage (i.e., no call, do not drive while taking, etc.)
6. There will be no routine delivery or pickup of controlled substances unless specifically instructed by the Medical Director under emergency or special circumstances.

Multidose vials will be dated on the label with permanent marker to indicate the expiration date 28 days from when it was opened. They will be disposed of within 28 days of first use.

Policy Title: Medication Disposition

POLICY: Drug containers which are cracked, soiled or without secure closures, expired drugs, contaminated or deteriorated drugs shall not be used and will be disposed of in a safe and legal manner.

PROCEDURE:

1. Drug containers which are cracked, soiled, or without secure closure:
 - a. If the drug arrives this way, did not place in storage area.
 - b. Replace drug and packing container.
 - c. Notify drug distributor.
 - d. Mark outside of container with the date and write **DO NOT USE** on the container.
 - e. All outdated medications will be deposited in a pharmacy disposal hazard waste RCRA black and white container stored in the supply room and transferred to a proper disposal facility.
 - f. Any containers found that are cracked, soiled, or without secure closures are placed in the sharps container and disposed of per the biohazard waste procedure.
 - g. List all medications on Record of Disposed Drugs and fill in all columns.
2. Drugs that are outdated or contaminated:
 - a. All medication storage areas in the supply shelves for stock medications, medication cabinets and medication refrigerators and freezer will be checked for medications expiring one month ahead of the current date. A monthly checklist documenting areas checked and number of expired medications removed due expirations is keep in the nurse's station. Monthly Checklist notebook.
 - b. All outdated medications will be deposited in a pharmacy disposal hazard waste RCRA black and white container stored in the supply room and transferred to a proper disposal facility.
 - c. Medication Dispensing Log sheets will be documented when medications are expired or completely used on the log for that lot number. The log sheets will be stored for 3 years in files designated by the Clinic Manager for reference as needed.

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Policy Title: Medication Recall

POLICY: All medications dispensed through our clinic should be tracked in a manner that allows for patient identification in case of a recall.

PROCEDURE:

1. When informed of a notice of a recalled medication from a supplier, manufacturer or pharmacy. The RN will be notified of the received notice . The nursing staff will verify the medication, manufacturer, strength and lot numbers of the recalled medication to confirm if we currently have the recalled medication in stock.
2. The nursing staff will review our medication tracking logs to identify if we have dispensed the medication that has been recalled.
3. If we do not have the medication that has been recalled, we will follow the FDA or manufacturer's instructions concerning the destruction of the medication. If there are no instructions concerning its destruction, the medication will be discarded with other discarded medications will be disposed per hazardous pharmaceutical waste protocols. The record of the recall notice and copy of the medication log of the indicated recalled medication will be kept in a Medication Recall folder in the RNs office.
4. If we have dispensed the medication that has been recalled, we will extract the patient information from the medication tracking program from the stored Medication Dispensing Log for each medication name and lot number stored in designated files by the Clinic Manager and inform the ordering provider. The patient who was dispensed recalled medication will be contacted with follow up instructions from the patient's provider. The nursing staff will inform the patient to discontinue the use of the recalled medication and any other instructions directed by the provider.
5. If discontinued medication requires a weaning or medication substitution, this will be performed under the direction of a medical provider.
6. If the medication was not dispensed by our clinic we can assist a pharmacy by querying RPMS about those with active orders for certain medications. In concert with local pharmacies we will contact the patient and inform them of the recall and the plan regarding discontinuation and/or replacement of the medication.

Policy Title: Sample Medications

POLICY: Medication samples will be logged in the tracking system. Medication Dispensing logs are used to track samples dispensed for each patient.

PROCEDURE:

1. Upon receipt of any sample medication, name, strength, lot number and number of units received will be entered in the tracking system on individual Medication Dispensing Logs are placed the Sample Medication Log book for each medication name and lot number. The expiration date and NDC number will be included on the dispensing log sheet.
2. Each time a sample medication is dispensed to the patient, the person dispensing the medication will create the patient entry on the medication sheet. The date dispensed, the patients name and date of birth should be included in order of dispensing on the log sheet. Sample medications will be dispensed by physicians order only. Entry will also be made into the patient's Electronic Health Record.
3. When a sample expires or the stock is completely used the log sheet will be removed from the Sample Dispensing Log Book and given to the Clinic Manager to be stored in a designated file for 3 years.

Policy Title: Nursing Protocol/Triage

POLICY:

Prior to being seen by a medical provider, the appropriate vital signs will be taken and recorded for each patient. All unscheduled patients seeking a doctor's visit at PRHS will be triaged by the Nurse Administrator and seen by medical provider based on severity of illness and availability.

PROCEDURE:

1. Vital signs will be taken for all patients which will include:
 - a. Temperature-taken and recorded for all patients.
 - b. Weight-obtained and recorded for all visits.
 - c. Height-obtained and recorded on all initial visits, all well child visits or yearly to age 18. All adult health-maintenance visits or yearly.
 - d. Head circumference on initial visit and well child visits for all children up until their third birthday.
 - e. Pulse-obtained and recorded for all visits.
 - f. Blood pressure-obtained and recorded on the first visit for all patients over age 3 and then at interval exams for all adults over 18 and acutely ill patients.
 - g. Respiratory rate-obtained and recorded for all visits.
 - h. Allergies will be documented and reviewed at each patient visit.
2. Patients will be triaged according to their clinical presentation and severity of medical problem according to the following:
 - a. Patients who present with life-threatening signs and symptoms should have a RN assess them **immediately**. A medical provider should be summoned to treat the patient for all life-threatening emergencies including the following:
 - i. Chest pain
 - ii. Cyanosis
 - iii. Allergic reaction
 - iv. Respiratory distress
 - v. Severe abdominal pain
 - vi. G.I. bleeding
 - vii. Altered mental status
 - viii. Syncope or loss of consciousness
 - ix. Hemorrhage/bleeding or shock

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- b. All other patients will be screened by an RN and scheduled at the next available appointment, as indicated. If an RN is a LVN or Medical Assistant may gather and report information immediately to the clinic medical provider for determination to be made.

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Policy Title: Language Line

Policy:

PRHS provides Language Line services at designated phone lines that may be accessed for the purpose of providing interpretation of languages other than English to the patient and the clinic staff.

The Language Line for the patients needing interpretation of their language is available in exam room 4 in the Medical Clinic. The language line phone number is posted on the phone. This room and phone may be used by the business office staff and receptionist that may need an interpreter for a patient for their discussion with them.

Once the provider or staff member is ready to see the patient with the language line requirement the staff member will call the number, provide the necessary information and begin use of the service. A brief E H R note is created indicating "Language line used".

The Medicare Partnership provides a language line service for their members as our primary resource for interpretation services. Their services are outlined on the attachment. Medical Partnership requests that the patients be scheduled three days for their language service three days prior to the patient's appointment.

All insurances may be contacted at the customer service department phone number on the back of the patient's insurance card to inquire of the language line services that the patient's insurance plan may be available to provide for the patient's medical appointment.

Attachment:

Medical Partnership Language Line Service
US Department of Health & Human Services – Medicare
Blue Shield of California

Policy Title: Blood Borne Pathogen Exposure Control

POLICY

The Pit River Health Service is committed to providing a safe and healthful work environment for our entire staff. In pursuit of this goal, the following exposure control plan (ECP) is provided to eliminate or minimize occupational exposure to blood borne pathogens in accordance with OSHA standard 29 *CFR* 1910.1030, "Occupational Exposure to Blood Borne Pathogens."

The ECP is a key document to assist our organization in implementing and ensuring compliance with the standard, thereby protecting our employees. This ECP includes:

- Determination of employee exposure
- Implementation of various methods of exposure control, including:
 - Universal precautions
 - Engineering and work practice controls
 - Personal protective equipment
 - Housekeeping
- Hepatitis B vaccination
- Post-exposure evaluation and follow-up
- Communication of hazards to employees and training
- Recordkeeping
- Procedures for evaluating circumstances surrounding exposure incidents

Implementation methods for these elements of the standard are discussed in the subsequent pages of this ECP.

PROGRAM ADMINISTRATION

- The Safety Committee at PRHS headed by the Medical Director are responsible for implementation of the ECP will review will maintain, review, and update the ECP at least annually, and whenever necessary to include new or modified tasks and procedures.
- Those employees who are determined to have occupational exposure to blood or other potentially infectious materials (OPIM) must comply with the procedures and work practices outlined in this ECP.
- The RN Clinic Manager will provide and maintain all necessary personal protective equipment (PPE), engineering controls (e.g., sharps containers), labels, and red bags as required by the standard. The Clinic Manager will ensure that adequate supplies of the aforementioned equipment are available in the appropriate sizes.

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- The Human Resources Manager will be responsible for ensuring that all medical actions required by the standard are performed and that appropriate employee health and OSHA records are maintained.
- The Human Resources Manager will be responsible for training, documentation of training, and making the written ECP available to employees, OSHA, and NIOSH representatives.

EMPLOYEE EXPOSURE DETERMINATION

The following is a list of all job classifications at our establishment in which all employees have occupational exposure:

<i>Job Title</i>	<i>Department/Location</i>
Medical Doctor	Medical -Medical Clinic
Family Nurse Practitioner	Medical- Medical Clinic
Nurses	Medical -Medical Clinic and Outreach
Medical Assistants	Medical Clinic- Medical Clinic
Dentist	Dental Clinic- Medical Clinic
Dental Hygienist	Dental Clinic- Dental Clinic
Dental Assistants	Dental Clinic-Dental Clinic
Sterile Technician	Dental Clinic- Dental Clinic
Contracted Health Representatives	Outreach -Administration
Behavioral Health Counselors	Behavioral Health -Administration Building
Transportation Coordinator and Drivers	Transportation- Administration Building
Housekeepers	Housekeeping- Medical and Dental Clinics

METHODS OF IMPLEMENTATION AND CONTROL

Universal Precautions

All employees will utilize universal precautions. Precautions are taken and use of personal protective equipment is used by employees to treat all human blood and OPIM (other Potentially infectious materials) as if known to be infectious with blood borne pathogens.

Exposure Control Plan Employees covered by the blood borne pathogens standard receive an explanation of this ECP during their initial training session. It will also be reviewed in their annual refresher training.
The Safety Committee is responsible for reviewing and updating the ECP annually or more frequently if necessary to reflect any new or modified tasks and procedures that

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affect occupational exposure and to reflect new or revised employee positions with occupational exposure.

Engineering Controls and Work Practices Engineering controls and work practice controls will be used to prevent or minimize exposure to blood borne pathogens. All safety engineered sharps systems are disposed of immediately after use. Needles are never recapped. A one-handed technique is used to activate the sharp safe needle using the hand holding the syringe in order to avoid exposure to the free hand that is not exposed to the uncapped needle.

The following are specific engineering controls used in the medical and dental departments:

Safety engineered needle systems used are:

Venipuncture needles

Venipuncture safety butterfly needles

Injection needles

IV catheters

Scalpels

Sharps disposal containers are inspected and maintained or replaced by the medical assistants or nurses in the Medical Department and by the dental assistants in the Dental Department before reaching 2/3 full capacity to prevent overfilling.

This facility identifies the need for changes in engineering controls and work practices through reviewing CDC and OSHA guidelines to assure the need for new products regularly.

The Safety Committee is responsible for ensuring that these recommendations are implemented.

Personal Protective Equipment (PPE) PPE is provided to our employees at no cost to them. Training in the use of the appropriate PPE for specific tasks or procedures is provided by the employee's immediate supervisor and reviewed in annual and updated training for ECP and Blood Borne Pathogens. The types of PPE available to employees are as follows:

Nitrile gloves

Goggles

Face shields

Splash resistant disposable gowns and jackets

Disposable head coverings

NIOSH N95 masks

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PPE is located in the medical department lab and procedure exam room 4. PPE is available in the drawer of each Dental Lavatory. Replacement of all PPE for the departments is available from the department supervisor or manager where PPE is used.

All employees using PPE must observe the following precautions:

- Wash hands immediately or as soon as feasible after removing gloves or other PPE.
- Remove PPE after it becomes contaminated and before leaving the work area.
- Used disposable PPE may be disposed of in biohazard waste containers if soiled with blood or body fluid. If not soiled with blood or body fluid the disposable PPE may be disposed in regular waste containers in the room used.
- Reusable PPE may be decontaminated using TB/QT spray on the PPE item. Let dry for 3 minutes before wiping off residue of the disinfectant, rinse and dry. Reusable PPE includes: safety glasses, goggles, face shields, CPR Laedral masks,
- Wear appropriate gloves when it is reasonably anticipated that there may be hand contact with blood or OPIM, and when handling or touching contaminated items or surfaces; replace gloves if torn, punctured or contaminated, or if their ability to function as a barrier is compromised.
- Utility gloves may be decontaminated for reuse if their integrity is not compromised; discard utility gloves if they show signs of cracking, peeling, tearing, puncturing, or deterioration.
- Never wash or decontaminate disposable gloves for reuse.
- Wear appropriate face and eye protection when splashes, sprays, spatters, or droplets of blood or OPIM pose a hazard to the eye, nose, or mouth.
- Remove immediately or as soon as feasible any garment contaminated by blood or OPIM, in such a way as to avoid contact with the outer surface.

MEDICAL WASTE

Regulated waste is placed in containers which are closable, constructed to contain all contents and prevent leakage, appropriately labeled with a BIOHAZARD label and closed prior to removal to prevent spillage or protrusion of contents during handling. Regulated waste when taken from the patient care areas is disposed as described in a

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final locked container that is locked from the outside and labeled BIOHAZARD. The contracted Biohazard waste disposal company will pick up the waste as regulated by

Contaminated Disposable Supplies

Red waste containers with a flip up lid with a foot control to open it. The container is lined with a plastic disposable red trash liner that fits the container. Red waste containers are labeled with a red BIOHAZARD label and are used in each patient care area room in the medical and dental departments for disposing of supplies and waste that are contaminated with blood or body fluids.

The red waste containers are checked and replaced daily when used. The inner red biohazard waste liner is removed wearing gloves and placed into a second larger red waste liner so the contaminated wastes are double bagged for transport into the final locked waste container for pick up by the contracted waste disposal company.

Contaminated Sharps

Sharps disposal containers are easily accessible in the immediate area where sharps are used in each patient care room. Designated plastic puncture-resistant, leak proof sharps containers are housed in a locked hard plastic enclosure and appropriately labeled with a red BIOHAZARD label. The disposable sharps container in the locked enclosure is replaced before or when the container is 2/3 full. It must be replaced to prevent overfill which will create difficulty adding sharps into the container past the 2/3 mark.

Broken glassware, glass slides that may be contaminated are only picked up using mechanical means, such as a brush and dustpan that may be disinfected or by using a instrument such as tongs or forceps that may be autoclaved to sterilize

Decontamination of Equipment and Work Surfaces

All work surfaces and equipment are to be decontaminated after completion of each room after patient visits and procedures and immediately after any spill or OPIM and at the end of each work day.

Medical and Dental staff have QT-TB surface spray germicide and POI Sani-Cloth wipes are available to decontaminate any surface, furniture and equipment as needed.

Housekeeping staff daily cleans all surfaces including counters, equipment and furniture, door knobs, light switches in exam areas and waiting areas with the QT-TB and/or POI Sani wipes.

Laundry

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Dirty laundry including towels and linen are placed in a yellow biohazard bagged container in the medical and dental departments for pick up and transported in the yellow laundry bags to the laundry area by the housekeeping staff twice weekly for laundering. The housekeeping staff will wear gloves when handling dirty laundry.

Labels and Signs

Biohazard signs should be affixed to containers of regulated waste. The label should include the Universal Biohazard Symbol and legend. "BIOHAZARD" In the case of regulated waste the words "Biohazard Waste" may be substituted for the "BIOHAZARD" legend. The label should be fluorescent orange or orange-red.

Red BIOHAZARD labels are used to identify waste containers containing contaminated wastes and sharps containers containing contaminated sharps.

Yellow bags and laundry hampers have labeling identifying the contents have contaminated laundry.

Employees are to notify their supervisor if they discover regulated waste containers OPIM (other potentially infectious materials), contaminated equipment, etc., without proper labels.

Hepatitis B Vaccine

The will provide training to employees on hepatitis B vaccinations, addressing safety, benefits, efficacy, methods of administration, and availability

The hepatitis B vaccination series is available at no cost after initial employee training and within 10 days of initial assignment to all employees identified in the exposure determination section of this plan. Vaccination is encouraged unless: 1) documentation exists that the employee has previously received the series; 2) antibody testing reveals that the employee is immune; or 3) medical evaluation shows that vaccination is contraindicated.

However, if an employee declines the vaccination, the employee must sign a declination form. Employees who decline may request and obtain the vaccination at a later date at no cost. Documentation of refusal of the vaccination is kept in the employee's patient record and in Human Resources employee personnel file.

Hepatitis B Vaccination will be provided by PRHS Medical Clinic. Following the medical evaluation, a copy of the health care professional's written opinion will be obtained and

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provided to the employee within 15 days of the completion of the evaluation. It will be limited to whether the employee requires the hepatitis vaccine and whether the vaccine was administered. A Hepatitis B Vaccine Declination Form (attached) is to be completed by any employee who wishes to decline the opportunity to receive the Hepatitis B vaccine at no charge.

POST-EXPOSURE EVALUATION AND FOLLOW-UP

Should an exposure incident, needle stick or sharps injury occur the employee should contact their immediate supervisor who notifies the Human Resources Manager and the PRHS Medical Clinic RN

An immediately available confidential medical evaluation and follow-up will be conducted by a PRHS medical provider. Following initial first aid (clean the wound, flush eyes or other mucous membrane, etc.), the following activities will be performed:

- Document the routes of exposure and how the exposure occurred.
- Identify and document the source individual (unless the employer can establish that identification is infeasible or prohibited by state or local law).
- Obtain consent and make arrangements to have the source individual tested as soon as possible to determine HIV, HCV, and HBV infectivity; document that the source individual's test results were conveyed to the employee's health care provider.
- If the source individual is already known to be HIV, HCV and/or HBV positive, new testing need not be performed.
- Assure that the exposed employee is provided with the source individual's test results and with information about applicable disclosure laws and regulations concerning the identity and infectious status of the source individual (e.g., laws protecting confidentiality).
- After obtaining consent, collect exposed employee's blood as soon as feasible after exposure incident, and test blood for HBV and HIV serological status

If the employee does not give consent for HIV serological testing during collection of blood for baseline testing, preserve the baseline blood sample for at least 90 days; if the exposed employee elects to have the baseline sample tested during this waiting period, perform testing as soon as feasible.

ADMINISTRATION OF POST-EXPOSURE EVALUATION AND FOLLOW-UP

The Human Resources Manager ensures that health care professionals responsible for employee's hepatitis B vaccination and post-exposure evaluation and follow-up are

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given a copy of OSHA's blood borne pathogens standard.

The Medical Clinic RN ensures that the health care professional evaluating an employee after an exposure incident receives the following:

- a description of the employee's job duties relevant to the exposure incident
- route(s) of exposure
- circumstances of exposure
- if possible, results of the source individual's blood test
- relevant employee medical records, including vaccination status

The medical provider provides the employee with a copy of the evaluating health care professional's written opinion within 15 days after completion of the evaluation.

**PROCEDURES FOR EVALUATING THE CIRCUMSTANCES
SURROUNDING AN EXPOSURE INCIDENT**

The Medical Clinic RN will review the circumstances of all exposure incidents to determine:

- engineering controls in use at the time
- work practices followed
- a description of the device being used (including type and brand)
- protective equipment or clothing that was used at the time of the exposure incident (gloves, eye shields, etc.)
- location of the incident (O.R., E.R., patient room, etc.)
- procedure being performed when the incident occurred
- employee's training

Human Resources Manager will record all percutaneous injuries from contaminated sharps in a Sharps Injury Log.

If revisions to this ECP are necessary the Human Resources Manager will ensure that appropriate changes are made. (Changes may include an evaluation of safer devices, adding employees to the exposure determination list, etc.)

EMPLOYEE TRAINING

All employees who have occupational exposure to blood borne pathogens receive initial and annual training conducted by the Safety Officer.

All employees who have occupational exposure to blood borne pathogens receive training on the epidemiology, symptoms, and transmission of blood borne pathogen

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diseases. In addition, the training program covers, at a minimum, the following elements:

- a copy and explanation of the OSHA blood borne pathogen standard
- an explanation of our ECP and how to obtain a copy
- an explanation of methods to recognize tasks and other activities that may involve exposure to blood and OPIM, including what constitutes an exposure incident
- an explanation of the use and limitations of engineering controls, work practices, and PPE
- an explanation of the types, uses, location, removal, handling, decontamination, and disposal of PPE
- an explanation of the basis for PPE selection
- information on the hepatitis B vaccine, including information on its efficacy, safety, method of administration, the benefits of being vaccinated, and that the vaccine will be offered free of charge
- information on the appropriate actions to take and persons to contact in an emergency involving blood or OPIM
- an explanation of the procedure to follow if an exposure incident occurs, including the method of reporting the incident and the medical follow-up that will be made available
- information on the post-exposure evaluation and follow-up that the employer is required to provide for the employee following an exposure incident
- an explanation of the signs and labels and/or color coding required by the standard and used at this facility
- an opportunity for interactive questions and answers with the person conducting the training session.
-

Training materials for this facility are available at the Human Resources Department.

Record Keeping

Training Records Training records are completed for each employee upon completion of training. These documents will be kept for at least three years in Human Resources personnel files.

The training records include:

- the dates of the training sessions
- the contents or a summary of the training sessions
- the names and qualifications of persons conducting the training
- the names and job titles of all persons attending the training sessions

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Employee training records are provided upon request to the employee or the employee's authorized representative within 15 working days. Such requests should be addressed to the Human Resources Manager.

Medical Records

Medical records are maintained for each employee with occupational exposure in accordance with 29 *CFR* 1910.1020, "Access to Employee Exposure and Medical Records."

The PRHS Medical Records Clerk is responsible for maintenance of the required medical records. These confidential records are kept in the Medical Records Department for at least the duration of employment plus 30 years.

Employee medical records are provided upon request of the employee or to anyone having written consent of the employee within 15 working days. Such requests should be sent to PRHS Medical Records Department.

OSHA Recordkeeping

An exposure incident is evaluated to determine if the case meets OSHA's Recordkeeping Requirements (29 *CFR* 1904). This determination and the recording activities are done by

Sharps Injury Log

In addition to the 1904 Recordkeeping Requirements, all percutaneous injuries from contaminated sharps are also recorded in a Sharps Injury Log. All incidences must include at least:

- date of the injury
- type and brand of the device involved (syringe, suture needle)
- department or work area where the incident occurred
- Explanation of how the incident occurred.

This log is reviewed as part of the annual program evaluation and maintained for at least five years following the end of the calendar year covered. If a copy is requested by anyone, it must have any personal identifiers removed from the report.

Attachments:

Hepatitis B Vaccine Declination Form
Sharps Injury Log

Policy Title: Infection Prevention and Control Plan

Policy:

The Infection Prevention and Control Plan at PRHS is implemented with the goal of minimizing the risk of exposure to infections to our patients and healthcare workers. Infection prevention and control guidelines are followed as referenced in the CDC "Guide to Infection Prevention for Outpatient Settings: Minimum Expectations for Safe Care", Version 2.3- September 2016.

Procedure:

Infection prevention at PRHS is provided by the application of standard precautions, guidance and surveillance of exposure to infections.

Measures to prevent transmission of potentially infectious illnesses between patient and staff include:

- Hand hygiene guidelines based on the CDC and WHO recommendations. Visible public hands-free hand sanitizers dispensers for patients and staff. Hands free antibacterial soap dispensers in all restrooms, exam rooms, breakrooms. Hand hygiene reminders in restrooms.
- Cleaning and disinfection guidelines for housekeeping and staff per Housekeeping disinfection guidelines and Exposure Control Plan for Blood Borne Pathogens. Use of germicidal wipes POI saniwipes.
- Disinfection of medical equipment and instruments.
- PPE (Personal Protective Equipment) including gloves, goggles, eye shields, fluid resistant gowns and jackets, hair bonnets, shoe covers, masks NIOSH N95.
- Disinfection of medical equipment and instruments.
- Respiratory Infection Control
- TB Prevention Protocol
- Contagious Communicable Illnesses Prevention and Evaluation.

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Hand Hygiene

Hand Hygiene is a primary standard precaution in preventing transmission of pathogens. The following are key recommendations for hand hygiene recommended by CDC and WHO.

Healthcare personnel are educated regarding appropriate indications for hand hygiene upon hire, prior to provision of care and annually.

Situations that hand hygiene are recommended are:

- a) Before and after touching a patient, even if gloves are worn.
- b) Before performing a septic task (e.g. insertion of IV, preparing an injection).
- c) After contact with blood, body fluids, excretions or wound dressings or contaminated surfaces.
- d) Prior to performing a aseptic task.
- e) If hand will be moving from a contaminated body site to a clean body site during patient care.
- f) After removal of personal protective equipment (PPE).
- g) After glove removal.

Hand washing with soap and water should be used:

Hands are visibly soiled

Before eating

After using the restroom

After caring for a patient with infectious diarrhea

After caring for patient with C.difficile

Hand sanitizers

Use of alcohol-based hand sanitizers is the most commonly and preferred method in clinical settings used for hand hygiene. Hand rub s sanitizers are easier and require less time to use since water is not needed and less irritating to hands. Hands free hand

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sanitizer dispensers are available by the reception windows and lobbies and on the back-office walls next to exam rooms. Hand sanitizers should be used by rubbing the hand sanitizer over the hands completely and between fingers for 20-30 seconds to effectively sanitize hands.

Hand washing

Hand washing with soap and water should be used:

When hands are visibly soiled

Before eating

After using the restroom

After caring for a patient with infectious diarrhea

After caring for patient with C.difficile

Hands free antiseptic soap dispensers are available by all sinks in all exam rooms, restrooms and break rooms. Hand washing should be performed using soap and water over the entire hands for at least 20 seconds before rinsing to be effectively sanitize hands.

Nail Hygiene

Natural nails should be kept trimmed to $\frac{1}{4}$ inch length. Artificial nails and extenders should not be worn by healthcare workers.

Personal Protective Equipment

Key recommendations for use of PPE

The medical clinic healthcare staff are provided with PPE and oriented to the location, types and appropriate use of PPE recommended for use. Hand hygiene should be performed after removal of PPE. Healthcare staff are trained on the use upon hire and prior to performing patient care and annually.

Types of PPE available and use are:

Gloves

Nitrile powderfree gloves. Gloves should be worn when there is potential for contact with blood, body fluids, mucous membranes, non-intact skin and contaminated

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equipment. Gloves should be worn for all specimen collection including venipuncture procedures to collect blood test and processing of blood and specimens.

Do not wear the same pair of gloves for more than one patient. Do not wash gloves for purpose of reuse.

Gowns

Fluid resistant universal precaution gowns and jackets are available in the Lab storage cabinet above the counter and in the cabinet above the counter in the procedure room and supply room shelves.

Wear a gown to protect skin and clothing during procedures or activities where contact with blood or body fluids is anticipated. Do not wear the same gown for the care of more than one patient.

Disposable Hats and Shoe Covers

Disposable hats and shoe covers that are fluid resistant are stored in the supply room shelf

Eye Protection

Plastic goggles and disposable eye shields with and without masks are available in the lab cabinets and procedure rooms and supply room shelf.

Wear mouth, nose and eye protection during procedures that are likely to generate splashes or sprays of blood or other body fluids.

Masks

Disposable routine respiratory protection masks and NIOSH N95 mask recommended for potential exposure to TB available in each work station and the supply room. All masks are for one-time patient contact use.

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Decontamination of Equipment and Work Surfaces

All work surfaces and equipment are *to* be decontaminated after completion of procedures and immediately after any spill or OPIM (Other Potentially Infectious Materials) and at the end of each work day.

Medical and Dental staff have QT-TB surface spray germicide and POI Sani-Cloth wipes are available to decontaminate any surface, furniture and equipment as needed between patients using the same exam room.

Housekeeping staff daily cleans all surfaces including counters, equipment and furniture, door knobs, light switches in exam areas and waiting areas with the QT-TB and/or POI Sani wipes.

INSTRUMENT STERILIZATION POLICY

The following procedures are performed by the Sterilization Technician or the dental employees covering these tasks in the absence of this employee. Appropriate PPE should be worn at all times while working with the sterilization of instruments.

Sterilization Equipment

The Dental Department has two Midmark M-11 autoclaves (one located at the XL clinic), and one Midmark M3 Ultrafast Statum autoclave. One ultrasonic machine is provided at the Burney and XL clinic. The Medical Department uses the Dental Department autoclaves for their instruments with their sterilization steps are listed below. Sterilization envelopes are used to store instruments with a stamped date of the date of sterilization along with the autoclave used. The policy is to re-sterilize the instruments 6 months after the sterilization date on the envelopes.

Spore Testing Procedure

Spore testing is documented by the results sent back from the Spore Check System which is done weekly scheduled for Monday mornings. If the spores are destroyed during the sterilization process it is acknowledged that any other microorganisms are also destroyed and that the autoclave load is sterile. A report is sent back to us documenting the results and is kept in a binder.

When the spore test comes back with a positive result, all autoclave procedures are halted and a repairman is scheduled to arrive for repair immediately. Regular sterilization procedures are resumed after repairs are made. The procedures of reporting the problem, repair the autoclave, retrieve all instruments sterilized since the previous negative spore test, retest the autoclave, and re-sterilize the instruments involved are followed as per recommendation by the manufacturer.

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Sterile Packaging

The Medical Department uses an enzyme soak for 30 minutes and then follows up with scrubbing the instruments and allowing them to dry. Instruments are then put in separate sterilization envelopes with an indicator strip inside. The instruments are delivered to the Dental Department sterilization room for completion of the sterilization process. The Dental Department Sterilization Technician then delivers the instruments back to the Medical Department.

The Dental Department uses several sizes of sterilization envelopes which have an installed internal and external process indicator present. Each envelope is marked with the date of sterilization, the load identification, and the general information written or identified by the color coding on the cassettes.

The process indicators will change color when processed with steam and ethylene oxide. The sterilizers both use steam in the sterilizing process. First thing to observe when opening the door and prior to instrument envelope removal from a completed sterilization cycle is the color of the indicators located on the corner of the envelope. The indicators will turn dark grey to black after the sterilization process is complete.

Procedure for a Failed Envelope Sterilization Indicator

When a batch of sterilization envelopes does not show the indicator black, the color will show a lighter orange or brown color. In this case, the instruments are sent through another sterilization cycle with an additional spore test. The next load is checked to see if the temperature and pressure comes up to the optimum as recommended by the manufacturer. If the sterilizer continues to cycle incorrectly, all autoclave procedures are halted and a repairman is scheduled to arrive for repair as soon as immediately possible. Regular sterilization procedures are resumed after repairs are made.

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Respiratory Infection Control

Infection prevention measures in preventing transmission of respiratory illness include:

Posted signs in the waiting room for anyone with a cough or sneeze to cover their mouth. Disposable tissues are available in the front and back office areas. Masks are available upon request at the reception desk and patient exam areas.

Patients with febrile respiratory symptoms will be moved to exam rooms separate from common waiting areas as soon as possible.

TB Prevention Protocol

Measures to prevent the transmission of TB to patients and staff are as follows:

Employee screening for TB by PPD Mantoux skin test is performed for each employee at their Pre-Employment physical. A history questionnaire is given to the employee to screen for possible previous exposure or positive PPD skin test prior to the application of the PPD skin test.

All PPD skin test patients or employees return in 48-74 hours for reading of the PPD TB skin test are reported to the ordering Provider. Positive skin tests are reported to a provider once read by the RN immediately for further evaluation of possible active disease.

PPD clearance is reported to the HR Manager and record kept in the employee patient chart.

Patients that present with clinical symptoms including possible active TB, cough, sudden weight loss and night sweats or who are known to have active TB should be treated to reduce risk of exposure to other patients and employees. Patients who are identified once in the Clinic will notify a Provider and RN Manager. Respiratory control NIOSH N95 masks should be worn by the staff when entering into an exam room that is potentially or is known to have active TB. NIOSH N95 masks are available in labeled RESPIRATORY PRECAUTION MASKS plastic bags in the nurses' station and lab and at the front reception desk for quick access. Once the patient is ready to leave the Clinic a patient mask is given to them to wear when leaving the Clinic. The patient will be directed to exit using the building using the closest exit to the exam room. The exam room that the potentially contagious patient was in will be closed for two hours. A HEPA filter will be placed in the room to run for two hours before the room may be reopened and used for other patients that day.

Facilities such as lab or radiology receiving a patient with potentially active TB should be advised of Respiratory Precautions.

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If a patient with possible active TB symptoms is scheduled to be seen, the RN should be informed. The patient will be instructed to meet the nurse or M.A. at the back entry to the clinic where they will be met by a nursing staff member who will wear a NIOSH N95 mask and give the patient a mask to wear before entering the clinic. The patient will exit the Clinic wearing the mask after the exam through the same back door closest to the exam room. A HEPA filter will be placed in the room to run for two hours before the room may be reopened and used for other patients that day. The patient will follow this routine for Clinic visits until cleared by their Physician that is no longer necessary to use the respiratory precautions

FIT mask fitting of the NIOSH masks are to be available at the time of hire for employees with direct patient contact.

Contagious Communicable Illness Evaluation

All potentially contagious communicable illnesses that may be spread by contact with the patient may include febrile respiratory illness, measles, rubella, mumps should be treated with precaution to protect patients and staff.

When there is a concern that a patient may have a communicable illness that has contacted the Clinic by phone will speak to a nurse or M.A. who will instruct the patient to go to the back entry to be taken to an exam room.

If the patient presents to the waiting room nursing staff will be informed and the patient taken immediately from the waiting room to an exam room for medical treatment.

If the patient is found to have a communicable disease after medical evaluation, the patient should exit the clinic.

In all cases of exams following a contagious communicable disease infection control measures should be followed.

Training and review of all infectious disease measures are review with staff routinely. Supplies and protective equipment is available for all employees who may have a risk for infectious disease exposure.

Policy Title: Hazard Communication Standards

Policy:

Pit River Health Service Hazard Communication Program is based on the requirements of the OSHA Hazard Communications Standard, 29 CFR 1910.1200.

Procedure:

To ensure that information about the dangers of all hazardous chemicals used by PRHS is known by all affected employees, the following hazardous information program has been established. Under this program, employees are of the contents of the OSHA Hazard Communications standard, the hazardous properties of chemicals with which you work, safe handling procedures and measures to take to protect yourself from these chemicals.

This program applies to all departments in our company where you may be exposed to hazardous chemicals under normal working conditions or during an emergency situation. All departments will participate in the Hazard Communication Program. The Safety Committee coordinates the program, with overall responsibility for the program, including reviewing and updating this plan as necessary.

Safety Data Sheets (SDSs)

SOS (Material Safety Data Sheet) is provided by manufacturers to inform users of the products level of safety or hazard of the product and proper use. The SOS provides the proper disposal, and treatment in the event of a spill or physical exposure to the employee.

The SOS information is useful to determine the levels of Health Hazard, level of health risk if exposed to the product, Fire or flammability, Reactivity level of reactivity if mixed with any other element. PPE (personal protective equipment) indicates the type of protective equipment if any the user should wear when using the product. See the attached legend to show how the various levels are determined.

The Safety Committee is responsible for establishing and monitoring the company SOS program. The department managers will ensure that procedures are developed to obtain the necessary SDSs and will review incoming SDSs for new or significant health and safety information. He/she will see that any new information is communicated to affected employees. The procedure below will be followed when an SOS is not received at the time of initial shipment:

Each department will maintain a SOS manual containing an alphabetized list of all chemicals used in the department. A SOS from the manufacturer or supplier should be maintained in the manual in alphabetical order. A new SOS should be added as new products are introduced into the department and the list updated. This applies to when a

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current product is removed. The old SOS should be removed and the list updated. The department staff should receive notice of the new product and SOS information that is added to the manual. A digital file will be maintained of uploaded copies of the SOS information identified by each department.

Copies of SDSs for all hazardous chemicals to which employees are exposed or are potentially exposed will be kept in the main office of each Department and available to all employees during their work hours.

Each Department Manager will verify that all containers received for use will be clearly labeled as to the contents, note the appropriate hazard warning, and list the manufacturer's name and address. It is best that all chemicals are kept in the original container which lists the categories of hazards and contact information for the manufacturer.

The use of secondary containers should be minimized. The department manager in each section will ensure that all secondary containers are labeled with either an extra copy of the original manufacturer's label or with labels marked with the identity and the appropriate hazard warning. Commercial labels specifically for secondary container hazard labeling will be used. For help with labeling see the Safety Officer. Attached is an example of the labeling to be used on secondary containers if the product is transferred from the original manufacturer's container.

Eye Wash Station

The eye wash station is available for instances of eye exposure to a substance or chemical for irrigation of the eyes. The Eye Wash Station is located at the Medical Clinic nurses' station sinks. The door to the lab has signage indicating the location of the eye wash station.

Employee Training and Information

The Safety Committee is responsible for the Hazard Communication Program and will ensure that all program elements are carried out.

Everyone who works with or is potentially exposed to hazardous chemicals will receive initial training on the hazard communication standard and this plan before starting work. Each new employee will attend a health and safety orientation that includes the following information and training:

- An overview of the OSHA hazard communication standard
- The hazardous chemicals present at his/her work area
- The physical and health risks of the hazardous chemicals

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- Symptoms of overexposure
- How to determine the presence or release of hazardous chemicals in the work area
- How to reduce or prevent exposure to hazardous chemicals through use of control procedures, work practices and personal protective equipment
- Steps the company has taken to reduce or prevent exposure to hazardous chemicals
- Procedures to follow if employees are overexposed to hazardous chemicals
- How to read labels and SDSs to obtain hazard information
- Location of the SOS file and written Hazard Communication program

Prior to introducing a new chemical hazard into any section of this company, each employee in that section will be given information and training as outlined above for the new chemical hazard.

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Policy Title: Prevention of Medication Errors and Reporting Adverse Vaccine Reactions

Policy: The following are guidelines that the providers and nursing staff are to follow to prevent any incident of medication errors.

Procedure:

Before all medications are given a written order or an electronic documented order in the E H R is provided to the nursing staff. The nursing staff is to follow the six rights of medication administration to assure the correctness and safety of the medication being administered. The six rights are:

Six Rights of Medication Administration

1. Right Patient. Two patient identifiers are used. The patient is asked their name and date of birth.
2. Right Medication. The medication label is checked against the written order.
3. Right Dose. Check the order Confirm the appropriate dose. Medical Assistants are to always have their prepared medication checked for correctness in dose by a licensed nurse or provider. Licensed nursing staff may whenever necessary have the correctness of the medication to be administered verified by another licensed staff member.
4. Right Route. Check the order for the correct route. Confirm the patient can receive the medication by the prescribed route.
5. Right Time. Check the order for the correctness of the time the medication is to be given.
6. Right Documentation. Document the medication administration after giving the ordered medication. This includes the medication name, dose, route and time.

According to regulations of the California Medical Board all Medical Assistants must have the medications to be administered be verified by a physician, podiatrist or other licensed staff.

To further insure prevention of medication errors. Look alike and sound alike medications are placed in storage separated from one another.

Most injectable medications are provided in single dose vials. In cases when a medication is provided in multi-dose only vial, the vial will be marked with a 28-day expiration date when opened. The vial will be discarded in the pharmaceutical hazardous waste RCRA black and white disposal container if not empty on the date of expiration. This container will be transferred to a proper disposal facility.

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If a medication error should occur the administering staff member should report the incident to their supervisor and ordering provider immediately for the course of action to take for the care of the patient. An Incident Report form will be completed and forwarded to Administration.

Adverse Reactions to Vaccines

In the event of adverse reaction to a vaccine health care provider are required by the National Childhood Vaccine Injury Act a report to the VAERS (Vaccine Adverse Event Reporting System). A VAERS report may be made on line at <http://www.vaers.hhs.gov/>. The form requires:

- The type of vaccine
- The timing of the vaccine
- The onset of the adverse event
- Current illnesses or medication
- Past history of adverse events following vaccination.
- Demographic information about the recipient

The VAERS program sends a confirmation letter and a VAERS ID number for follow up as needed