HEALTH CENTER

Policies and Procedures

The information herein is a compilation of all policies and procedures from electronic format.

Updated 2017

Access to Pharmacy

I. Policy

The pharmacist(s) are the only SHC staff members granted badge swipe access to the pharmacy. Authorized pharmacy staff will access and operate in the pharmacy under direct supervision of the pharmacist(s) on duty that day.

II. Definition

Pharmacist direct supervision-The pharmacist must be present on the same campus where service are being furnished and immediately available to furnish assistance and direction.

III. Procedure

A. The pharmacist(s) SHSU ID card will have swipe access enabled to open the pharmacy door.
    a. In the event that the pharmacist cannot gain access by badge swipe they will contact customer service @ 4-3663 (M-F from 8-5) if after hours, UPD will be contacted @ 294-1000.
B. A Pharmacy Access Log (Attachment A) will be maintained to record all persons entering the pharmacy other than authorized pharmacy staff.
C. The pharmacy physical key is to remain in the pharmacy.
D. The pharmacy physical key will be used to lock/unlock the roll gate and counseling booth doors.
E. If a breach is detected, the following steps will occur:
    1. Notify Health Center Director and UPD
    2. Review camera footage and badge access report
    3. Determine extent of breach
    4. Perform inventory when indicated
    5. Address issues with administration to prevent future occurrences.

IV. Attachments

1. Pharmacy Access Log

V. References

AAAHC Chapter 11, “Pharmaceutical Services”, Standard 11. D.

Date	*Time of Entry*	*Reason for Entry*	*Person*	*Sam ID*	*Signature*

Maintenance of Emergency Equipment Procedure

I. Policy

Emergency equipment will be checked at designated time intervals to ensure that it is in working order and available if needed for an emergency.

II. Procedure

A. Automated External Defibrillator (AED)
   1. The AED should be checked monthly.
   2. Check the AC power supply and all parts for condition and working order per manufacturer specifications.
   3. Ensure that the AED "Rescue Ready" indicator light is green.
   4. AED pads should be checked for expiration date. If the pads are near the expiration date, they should be replaced on or before the expiration date.
   5. The additional equipment pouch should be located in the AED case.
   6. Document on the AED checklist located next to the AED.

B. Emergency Supply Boxes
   1. An emergency supply box is located at each nurse's station and in the allergy injection room.
   2. Each emergency box should be checked monthly for supplies and expiration dates for the supplies and restock as needed.
   3. Each emergency box will have a zip tie lock that will be checked daily and replaced as needed.
   4. Each emergency box will contain the following items:
      a. Ambu bag, a non-rebreather mask, manual blood pressure cuff with regular and large cuff sizes, two oral airways, an oxygen tank, 2 microshield mouth barriers, and the following medications: epinephrine 1:1000, Solu Cortef 250 mg, Benadryl 50 mg, appropriate syringes, needles and alcohol pads
   5. Document on the appropriate checklist

C. Oxygen Tanks
   1. Oxygen tanks will be located in each nurses station, each triage room and the procedure room.
   2. Oxygen tanks will be checked monthly.
   3. Document on the appropriate checklist.

III. Attachments

1. AED checklist
2. Emergency Box Checklist
3. Emergency Box Lock Checklist
4. Oxygen Tank Checklist

IV. References

None

Attachment 1

YEAR:_____

AED CHECKSHEET

Any indication of "NO" MUST be reported immediately to the director or Administrator. The **STAFF IN CHARGE OF ORDERING MEDICAL SUPPLIES** should be notified two months prior to expiration dates of the electro pads **BY THE STAFF PERSON PERFORMING THE MONTHLY CHECK**.

Electro Pad Expiration Date_____

Attachment 2

Emergency Supply Box Checklist

Month	Date	"Rescue Ready" Indicator Green	Electropads in Date	Name
January		YES or NO	YES or NO	
February		YES or NO	YES or NO	
March		YES or NO	YES or NO	
April		YES or NO	YES or NO	
May		YES or NO	YES or NO	
June		YES or NO	YES or NO	
July		YES or NO	YES or NO	
August		YES or NO	YES or NO	
September		YES or NO	YES or NO	
October		YES or NO	YES or NO	
November		YES or NO	YES or NO	
December		YES or NO	YES or NO	

Box Number	1	2	3	4	5	Name and Date
September						
October						
November						
December						
January						
February						

March						
April						
May						
June						
July						
August						

Place a check mark in the box if all items are present and dates are not expired.
Place an "R" and the date in the box if any item was replaced.

Attachment 3

Emergency Supply Box Lock

Month _____

Box Number	1	2	3	4	5	Name and Date
Monday						
Tuesday						
Wednesday						
Thursday						
Friday						
Monday						
Tuesday						
Wednesday						
Thursday						
Friday						

Monday						
Tuesday						
Wednesday						
Thursday						
Friday						
Monday						
Tuesday						
Wednesday						
Thursday						
Friday						
Monday						
Tuesday						
Wednesday						
Thursday						
Friday						

Place a check mark in the box if the lock is intact.
Place an "R" and the date in the box if the lock was replaced.

Attachment 4

Oxygen Tank Checklist

Tank Number	1	2	3	4	5	6	7	8	9	10	11	12	13	Name and Date
September														
October														
November														
December														
January														
February														
March														
April														
May														
June														
July														
August														

Place a check mark in the box if the oxygen tank is full and useable.

Place an “R” and the date in the box if the oxygen tank was replaced

Allergen-specific Immunotherapy Administration Protocol
(Allergy Injection Protocol)

1. **Prior to scheduling a student to start allergy injections at the student health center**:
   a. The front staff will verify the student qualifies for services and is an established SHC patient.
   b. The front staff will notify a nurse of the request for allergy injections.
   c. The nurse will verify the patient has received a physical exam from one of the SHC providers and has been approved to receive allergy injections onsite.
   d. If the patient has not already been assessed by a SHC provider and approved for allergy injections, a pre-Allergy Injection visit should be scheduled with a provider.
   e. If approved for allergy shot injections by a SHC provider, the student should be scheduled for a nurse visit to address the following:
      i. obtain signed “Consent for Administration of Allergy Shots” (Attachment A) and scan into the electronic heath record (EHR),
      ii. review information from allergist provided by the student
      iii. obtain contact information for the student’s allergist, and
      iv. send an “Allergy Injection Initiation Letter” to the student’s allergist.
   f. For any questions regarding administration of allergy injections, the nurse should contact the student’s allergist directly.
2. **Prior to first injection at the student health center**:
   g. Verify the patient has received a physical exam from one of the SHC providers and has been approved to receive allergy injections onsite.

h. Verify a signed "Consent for Administration of Allergy Shots" (Attachment A) has been scanned into the electronic medical record.
i. The nurse will verify that the student health center has received the following documentation from the allergist:
    i. initiation letter signed by the allergist, and
    ii. allergist orders for injections.
j. The nurse will verify the antigen vial(s) is(are) labeled with the patient's name, contents, medication strength, and expiration date.

3. Prior to each injection

a. Authorization: The nurse administering allergy injections will
    i. have demonstrated competency with both of the following SHC protocols within the last 12 months:
        1. Allergen-specific Immunotherapy (Allergy Injection) Administration Protocol and
        2. Anaphylaxis Protocol;
    ii. verify the patient has been approved by a SHC provider to receive allergy injections onsite;
    iii. verify that there is a medical provider in the facility;
b. Patient Assessment: The nurse administering allergy injections will
    i. inquire about the patient's current health status, if the patient is or might be pregnant, has been running fever, feels ill, has difficulty breathing or has asthma that has not been controlled as well as usual;
    ii. inquire about prescribed medications and verify availability of the patient's epinephrine auto-injector, if applicable;
    (If the patient does not have epinephrine auto-injector and it is ordered, the injection cannot be administered. The patient will have to reschedule.)
    iii. assess the patient's temperature and auscultate lungs prior to each injection (and perform peak flow rates, if ordered);
    (If the patient has a temperature greater than 99.9, wheezing, shortness of breath, or the peak flow, if measured, does not attain threshold specified in the allergist's order, the allergist will be notified and the patient will be scheduled for SHC provider assessment within a timely manner.)
    iv. verify the patient does not have a new or recent history of severe asthma, COPD, atrial fibrillation, cardiovascular disease and is not currently prescribed a beta blocker, alpha blocker, or ACE inhibitor;
c. Verification: The nurse administering allergy injections will
    i. remind the patient that a 30 minute observation in the clinic following the injection is required;
    (**If the patient does not have time to wait after the injection, the patient will need to reschedule. Failure to wait the required time or leaving before the nurse is able to assess the injection site will be considered leaving Against Medical Advice).**
    ii. verify the vial has the patient's name, strength of medication, and expiration date, and matches the orders from the allergist.

(**Patient should be notified if the serum will expire before the next injection is due, so that the patient can contact the allergist to obtain a new vial(s) and initial injection(s)).**

iii. verify the patient's identity using <u>two</u> patient identifiers and ask the patient to confirm serum vial;

d. <u>Two-Person Dosage Order Verification:</u> The nurse administering allergy injections will
   i. review the orders from the allergist, the date of the patient's last injection; and
   ii. utilize two person verification of allergist order, vial, and dose drawn according to the SHC protocol.
   (Differences of opinion will be brought to the nurse supervisor's attention for resolution. The administering nurse will consult the patient's allergist directly prior to administration if there are any unresolved questions related to the orders.)
   iii. The second nurse verification of the allergist order, vial, and dose drawn will be documented in EMR and electronically signed but not locked before the dose is administered.

4. Injection administration:

a. Verify the site of the last injection and alternate the site.
b. Draw up the allergy serum as ordered into a 1 ml syringe with a ½-inch 27-gauge needle.
c. Clean the site with alcohol.
d. Administer the allergy serum subcutaneously into the lateral or posterior aspect of the arm.
e. Remove the needle, put pressure over the injection site to prevent leakage.
   (**Avoid rubbing the injection site after injection which may alter absorption and local reaction.)**

5. Post injection:

a. Observe the patient post injection for possible systemic symptoms (see Anaphylaxis Protocol).
b. If the patient has a systemic reaction, the observing staff will
   i. call for assistance without leaving the patient,
   ii. continuously monitor airway, breathing, and pulse,
   iii. initiate the Anaphylaxis Reaction Protocol until a SHC provider arrives, and
   iv. notify the allergist once the patient has been stabilized and transferred.
c. The administering nurse will document in the EHR the allergist order, vial, and dose administered.
d. Once documentation is complete, the patient can be directed to the designated waiting area for further observation if no symptoms or discomfort are evident and the observation time has not yet fully elapsed. Ensure staff are aware and that the patient remains under observation during the required time period.

6. Leaving Against Medical Advice (AMA)

a. If the patient elects to leave prior to the ordered wait time or leaves before the designated nurse is able to assess the injection site, the patient is leaving Against Medical Advice (AMA).
b. The patient will need to sign a waiver which should be scanned into the patient's EHR, and the patient will be informed that future injections will not be administered at SHC.

c. The allergy serum will be returned to the patient or placed in the refrigerator until the patient can return to pick it up.
d. Expired serum will be disposed of per proper protocol and documented.

7. **Allergy site inspection:** The nurse will
    a. assess the injection site for a reaction after the required wait time;
    b. note the extent of localized reaction, and
    c. document the reaction in EMR. The note should then be electronically signed and locked.
8. **Documentation:**
    a. Document the administration of each injection, localized reactions, the presence or absence of systemic symptoms both in the EHR and on the forms provided by the allergist.
    b. All forms provided by the allergist should be scanned into the EHR upon completion, discontinuation of service, or expiration of patient eligibility.
    c. Two person verification of dose should be documented as described above.

Anaphylaxis Protocol

Identify patient demonstrating symptoms of anaphylactic reaction or anaphylaxis
Any of the following may be a sign or symptom of anaphylaxis:

1. **Skin:** flushing (local or generalized), itching of the skin or mucosa (eyes, mouth, lips, tongue, genitals, palms, soles of the feet), angioedema of the skin or mucosa, urticaria, eye itching, redness, tearing and/or swelling, or any lesions arising in multiple locations or in a single location separate from the site bite, sting, or injection.
2. **Respiratory:** nasal itching, congestion, rhinorrhea, sneezing, throat itching or tightness, dysphonia, hoarseness, stridor, coughing, repeated throat clearing, increased respirations, shortness of breath, wheezing, cyanosis, or respiratory arrest.
3. **Gastrointestinal:** abdominal pain (cramping), nausea, vomiting, diarrhea, dysphagia
4. **Cardiovascular:** chest pain, tachycardia, bradycardia, palpitations, arrhythmias, hypotension, feeling faint, incontinence, shock, or cardiac arrest.
5. **CNS:** aura of impending doom, uneasiness, behavior change, dizziness, headache, altered mental state, tunnel vision, confusion, or seizure.
6. **Other:** metallic taste in the mouth, uterine cramping and/or bleeding.

Immediate Interventions

1. Make the patient comfortable and utilize the emergency notification button in the patient room or call for assistance without leaving the patient.
2. Additional staff, once notified, will activate EMS as necessary.
3. Assess airway, breathing, circulation, and orientation.
4. Remove inciting allergen if possible.
5. As soon as possible, administer epinephrine 1:1000 solution dose of 0.5 mg intramuscularly (IM) into the vastus lateralis muscle (thigh).
   Note: Patients prescribed beta blockers should also be given glucagon.
6. Additional staff will bring the emergency bag and AED to the scene.
7. Support the airway and administer oxygen via facemask or provide rescue breathing as necessary.
   Note: Portable oxygen container should be set on maximum flow.
8. Monitor vital signs every 5 minutes and pulse oximetry continuously.
9. Initiate chest compressions if cardiovascular arrest.

Additional Interventions to be considered by Provider

1. Repeat intramuscular epinephrine (0.3-0.5 mg) every 5-15 minutes for up to a total of three (3) injections.
2. Administer albuterol 2.5-5 mg via nebulizer, may repeat as necessary for lower airway obstruction every 15 minutes.
3. Consider administration of diphenhydramine 50 mg IM injection. If oral administration of antihistamine is preferred, consider cetirizine 10 mg.

4. Consider administration of steroid. Hydrocortisone 100 mg to 250 mg IM per injection. **Note:** Dose should be based on patient size and severity of reaction. Remember onset of action for steroids is not immediate.
5. Prednisone can be use orally, 40 to 60 mg orally (PO), for mild reactions.
6. If GI symptoms are present, may consider Ranitidine 50 mg IM.

Transfer to Higher Level of Care

1. Patients receiving an intramuscular dose of epinephrine should be monitored in a setting capable of responding to and treating anaphylaxis for 4 to 6 hours.
2. Provide report of the following information to the emergency responders:
    a. Time of adverse event
    b. Time of call to emergency response
    c. All vital signs collected prior to EMS arrival
    d. Medications administered
        i. Medication
        ii. Dose
        iii. Time of administration
        iv. Patient response
    e. If the event was precipitated by immunotherapy injection (allergy shot), provide the following additional information:
        i. time of administration
        ii. vial label(s)
        iii. dose
        iv. site
        v. Response to allergy shot
3. Assist to transfer patient.
4. Call report to the emergency room providing all of the information in #1 above plus an explanation of events occurring after EMS arrived up to and including the condition of the patient and time of transport enroute to the emergency room.
5. Notify the allergist once the patient has stabilized.
6. Document the above information in the EMR.

Asthma Management Protocol

I. Overview: Patients identified with asthma should undergo pertinent query during their office visits to determine symptom frequency/severity, utilization of rescue/controller medications, exacerbating factors and compliance. Peak flow testing is on site to monitor disease severity. An appropriate treatment regimen and home-monitoring program should be offered to the student. The following stepwise approach is meant to

assist, not replace, the clinical decision-making required to meet individual patient needs.

II. Asthma Management Goals

A. Minimal or no chronic symptoms day or night
B. Minimal or no exacerbations. No limitations on activities; no school or work missed.
C. Maintain (near) normal pulmonary function
D. Minimal use of short-acting inhaled $beta_2$-agonist
E. Minimal or no adverse effects from medication

III. Classify severity

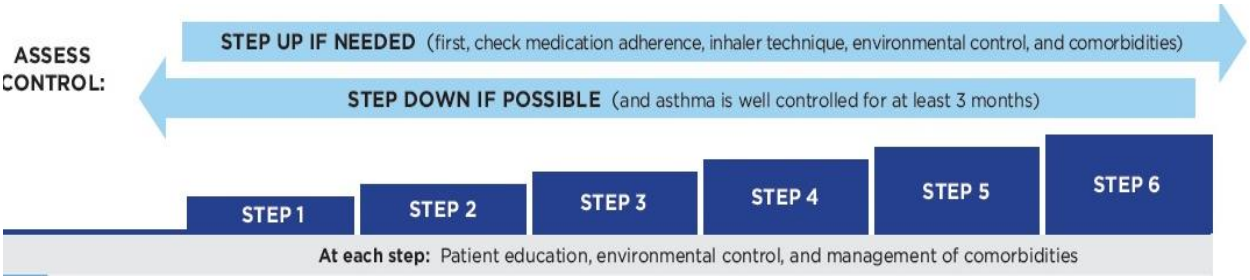
Classification of Adult Asthma Severity for Patients who are NOT Currently Taking Long-term Control Medications*					
Components of Severity		**Intermittent**	**Persistent Mild**	**Persistent Moderate**	**Pesistent Severe**
Impairment Normal FEV_1/FVC: 8-19yr = 85% 20-39 yr = 80% 40-59 yr = 75% 60-80 yr = 70%	**Symptoms**	≤2 days/week	>2 days/week but not daily	Daily	Throught the day
	Nighttime awakenings	≤2 times/month	3-4 times/month	>1 time/week but not nightly	Often 7 times/week
	SABA for symptoms control (not prevention EIB)	≤2 days/week	> 2 days/weel but not > 1 time/day	Daily	Several times per day
	Interference with normal activity	None	Minor limitations	Some limitation	Extremely limited
	Lung function	•Normal FEV_1 between exacerbations •FEV_1 >80% predicted •FEV_1/FVC normal	•$FEV_1 \geq 80\%$predicted •FEV_1/FVC normal	•FEV_1>60% but <80% predicted •FEV_1/FVC reduced 5%	•FEV_1<60% predicted •FEV_1/FVC reduced >5%
Risk	**Exacerbations requiring oral systmemic corticosteriods**	0-1/year	≥ 2/ year		
		Consider severity & interval since last exacerbation. Frequency & severity may fluctuate over time.			
		Relative annual risk of exacerbations may be related to FEV_1			
Step for initiating treatment		**Step 1**	**Step 2**	**Step 3**	**Step 4 or 5 (Consider short course oral corticosteroids to gain control**
		Evaluate level of asthma control and step up or step down therapy as needed			

*Adapted from Expert Panel Report 3: Guidelines for the Diagnosis and Management of Asthma
SABA=short acting $beta_2$agonist, EIB= exercise induced bronchospasm

- Gain control as quickly as possible (consider shorter course of systemic corticosteroids). Then step down to the least medication necessary to maintain control.
- Provide education on self-management and controlling environmental factors that make asthma worse (e.g. allergens and irritants).
- Refer to asthma specialist if there are difficulties controlling asthma or if step 4 care is required. Referral may be considered if step 4 is required.

IV. Treatment

A. Step down: Review treatment during each office visit; a gradual stepwise reduction in treatment may be possible after months of good control.
B. Step up: If control is not maintained, consider step up. First review patient medication technique, adherence, and environmental control.



≥12 years of age	Intermittent Asthma	Persistent Asthma: Daily Medication Consult with asthma specialist if step 4 care or higher is required. Consider consultation at step 3.				
Preferred Treatment†	SABA* as needed	low-dose ICS*	low-dose ICS* + LABA* OR medium-dose ICS*	medium-dose ICS* + LABA*	high-dose ICS* + LABA* AND consider omalizumab for patients who have allergies††	high-dose ICS* + LABA* + oral corticosteroid§§ AND consider omalizumab for patients who have allergies††
Alternative Treatment†,‡		cromolyn, LTRA,* or theophylline§	low-dose ICS* + either LTRA,* theophylline,§ or zileuton‡‡	medium-dose ICS* + either LTRA,* theophylline,§ or zileuton‡‡		
		Consider subcutaneous allergen immunotherapy for patients who have persistent, allergic asthma.**				
Quick-Relief Medication	▪ SABA* as needed for symptoms. The intensity of treatment depends on severity of symptoms: up to 3 treatments every 20 minutes as needed. Short course of oral systemic corticosteroids may be needed. ▪ Caution: Use of SABA >2 days/week for symptom relief (not to prevent EIB*) generally indicates inadequate control and the need to step up treatment.					

C. Minimize use of short-acting inhaled beta$_2$-agonist. Over-reliance on short-acting inhaled beta$_2$-agonist (e.g. use of approximately one canister in 3 months even if not using it every day) indicates inadequate control of asthma and the need to initiate or intensify long-term control therapy.

D. Accurate stratification for a patient may be deferred if he/she presents for treatment only during an acute exacerbation.

E. Pre-emptive treatments for exercise-induced asthma should be counted separately from true breakthrough events.

V. Assessing Asthma Control and Adjusting Therapy

Classification of Adult Asthma Severity for Patients who are NOT Currently Taking Long-Term Medications*				
Components of Severity		**Well Controlled**	**Not Well Controlled**	**Very Poorly Controlled**
Impairment	Symptoms	≤ 2 days/week	>2 days/week	Throughout the day
	Nighttime awakenings	≤ 2 times/month	1-3 times/week	≥ 4 times/week
	SABA for symptoms control (Not prevention EIB)	≤ 2 days/week	> 2 days/week	Several times per day
	Interference with normal activity	None	Some limitations	Extremely limited
	FEV[1] or peak flow	>80% predicted/personal best	60-80% predicted/personal best	< 60% predicted/personal best
Risk	Exacerbations	0-1/year	≥ 2/year	
		Consider severity & interval since last exacerbation		
	Treatment-related adverse effects	Not correlated to level of control but should be consided in assess of therapy.		
Recommended Action		•Maintain current treatment step •Follow up every 6-12 months as needed •Consider step down if well controlled for at least 3 months	•Step up 1 step and •Reevaluate in 2-6 weeks or as clinically indicated.	•Consider short course of oral systemic corticosteroids •Step up 1-2 steps •Reevalute in 2 weeks or as clinically indicated
*Adapted from Expert Panel Report3: Guidelines for the Diagnosis and Management of Asthma SABA=short-acting beta$_2$-agonist, EIB=exercise induced bronchospasm				

VI. Follow Up

A. Patients with a diagnosis of asthma should be seen based on acuity and clinical judgment.
B. Consider the following for frequency of follow-up visits
    1. Follow up at 2-6 week intervals when initiating therapy or if asthma is not well controlled therapy
    2. Follow up at 2 week intervals if asthma is very poorly controlled
    3. Follow up at 3 month intervals when stepping down therapy
C. Assess asthma classification severity and asthma control during each chronic visit
D. Review medication inhaler technique, adherence and assess side effects during each chronic visit
E. Reinforce education
    1. Review asthma action plan and revise as needed
    2. Proper inhaler technique
    3. Importance of adherence with long-term control medications.

Asymptomatic STI Testing

Standing Delegated Order

I. Policy

A. Nurse expedited STI testing provides an option for asymptomatic patients to receive STI testing and education about STI's and prevention. It facilitates screening and identification of patients for whom a provider evaluation is indicated.
B. This standing order applies to patients who are not considered high risk for STI, do not have known exposure to STI, and do not have signs or symptoms of STI or any other acute illness.
C. Under this standing order, nurses should order the STI panel testing for Chlamydia, Gonorrhea, HIV, and Syphilis unless the patient opts out of any particular test.
D. Also, under this standing order, nurses may order the following additional tests if requested: Herpes (IgG and IgM for both Type 1 and Type 2) and the viral hepatitis panel.

II. Procedure

A. Screening
    1. A patient requesting STI testing can schedule an appointment with the nurse clinic.
    2. The nurse will collect and review data for the STI risk assessment tool (located in the electronic health record) with the patient.
    3. If the patient does not have symptoms, known STI exposure, or high risk factors for STI (MSM, rectal intercourse, prostitution), the nurse may proceed with ordering and collecting samples for the STI panel (unless the patient opts out of

any part of the test panel).

4. Additional testing with the herpes panel (#866953) and/or hepatitis panel (#80074) is permissible under this standing delegated order if the patient desires.
5. A patient may, at any time, request an appointment to be evaluated by a provider.

B. Education

The nurse will provide education about STI's including prevention to all patients requesting STI testing. Condoms (male and female condoms) will be offered to all patients.

B. Schedule Provider Visit

If a patient is found to have any symptom(s), has been informed of exposure to a STI, or has high risk factors for an STI (MSM, rectal intercourse, prostitution), the nurse will schedule the patient to see a provider.

C. Test Results

A. The nurse may notify the patient of STI panel results, if the patient is negative for all four organisms tested.
B. The nurse will schedule a provider visit for any patient with one or more positive results on the STI panel.
C. The nurse will forward herpes and hepatitis panel results to a provider for interpretation and further direction.

III. Attachments

1. STI Risk Assessment Form

IV. Reference(s)

1. Texas Department of State Health Services Expedited STD Management
https://www.cdc.gov/std/tg2015/chlamydia.htm

S.H. Questionnaire

1. Reason for visit today? (check all that apply)
   ___ Have symptoms ___ Referred by another health clinic
   ___ No symptoms (STI screening only) ___ Possible exposure to a STI
   ___ Other _____

2. Do you have any of the following symptoms?
   ___ Fever ___ Problems with urination (burning, increased frequency, or urgency)
   ___ Nausea/Vomiting ___ Other _____

3. Do you have any of the following symptoms involving genitals, rectum, or anus? (check all that apply)
   ___ Bleeding ___ Pain ___ Discharge of fluid or pus ___ Foul odor
   ___ Rash ___Sores ___Bumps ___ Warts ___ Itching

4. Date of last sexual contact _____.

5. Have you ever experienced domestic violence or sexual assault? ____ Yes ____ No

6. Have you had STI testing in the past? ____ Yes ____ No;
   If yes what testing and dates_____

7. Have you ever had an STI before? ___ Yes ___ No If yes, check all that apply:
   ____ Chlamydia ____ Gonorrhea ____ Herpes ____ Trichomonas
   ____ Genital Warts ____ Syphilis ____ HIV ____ Other

8. How often do you use condoms or other barrier methods:
   ___ Always ___ Sometimes ___ Rarely ___ Never

9. Have you ever had (Check all that apply):
   ___ Oral sex ____ Vaginal sex ____ Anal sex (receptive) ____ Anal sex (insertive)

10. Approximately, how many sex partners have you had? _____

11. Have you ever had sex with (Check all that apply):
    ___ Man ____ Woman ____ Transgender male ____ Transgender female

12. In the past 90 days, have you (Check ***Yes*** or ***No***):
    ___ YES ___ NO Had sex with someone you did not know
    ___ YES ___ NO Had sex with someone you met online or through a phone app

___ YES ___ NO Accepted money or drugs for sex
___ YES ___ NO Payed money or drugs for sex
___ YES ___ NO Exchanged services, drugs, or merchandise for sex
___ YES ___ NO Used drugs like crack, cocaine, crystal meth, or other iv drugs

13. If Female, Last Menstrual Period (LMP): _____
    Might you be pregnant? ___ Yes ___ No

AUTOCLAVE CLEANING AND TESTING

I. Policy

The SHC will maintain and clean the autoclave in accordance with manufacturer's standards and regulations. If at any time, obvious changes in the autoclave performance are noticed then testing will be repeated as necessary.

II. Procedure

A. Daily Cleaning and Care
   1. Clean External Surfaces, wipe with a soft dry cloth
   2. Wash occasionally with a damp cloth and mild soap or detergent

B. Weekly Cleaning and Care
   1. Drain water from the reservoir using drain tube located on front of unit.
   2. Wash inside of unit and tray with mild soap or Speed-Clean and distilled water.
   3. Clean door gasket sealing lip and mating surface with a damp cloth.
   4. Examine gasket for possible damage. Clean Chamber and Trays
   5. Refill reservoir with distilled water.

C. Monthly Cleaning and Care
   1. Drain reservoir and fill with clean, distilled water. Add one ounce of Speed-Clean Sterilizer Cleaner to a cool chamber.
   2. Run one pouch cycle. Instruments should not be sterilized while cleaning the sterilizer.
   3. Drain cleaning solution from the reservoir. Then refill reservoir with clean water and run one unwrapped cycle.
   4. Drain reservoir and allow sterilizer to cool to room temperature.
   5. Remove door and dam gaskets from gasket housing channel. Clean channel and gaskets using a mild soap or Speed- Clean Sterilizer Cleaner and clean, distilled water. A small stiff bristle brush will aid procedure. After cleaning gaskets, inspect for damage, shrinking, or swelling and replace as necessary. Press gasket into the channel and reinstall dam gasket.
   6. Remove trays, tray rack, and tray plate. Pressing downward on top band of tray, pull on end of tray plates and side assembly out of chamber.
   7. Locate chamber filters on bottom and back of chamber. Grasp filter and pull outward while twisting slightly. Filter may be cleaned with mild soap or Speed- Clean Sterilizer Cleaner and clean, distilled water. A small stiff bristle brush or ultrasonic cleaner may be helpful to remove foreign objects from filter surface. Rinse filter with clean, distilled water. Replace filters as necessary. Reinstall filters by pressing inwards and twisting slightly.
   8. Wipe off trays, tray rack, and tray plate. Reinstall assembly by placing back of tray plate in chamber. Pushing downward on top of tray rack, slowly push assembly into chamber.

9. Fill the reservoir with clean, distilled water. Sterilizer is now ready for use.

CAUTION: Do not operate sterilizer without filters in place. Angled end of plate must be toward back of chamber to prevent interference with temperature probe behind chamber.

D. Weekly Testing Procedure

1. Commercially available bacteriologic spore testing will be performed Every week and results noted in the maintenance log. Sterilization indicator strips will be run with each autoclave use when sterilizing instruments to ensure proper machine functioning.
2. If the spore test is returned as "failed", all instruments autoclaved after the spore test will be re-pouched and re-sterilized. If spore testing "fails" twice in a row, the nurse will notify the provider to initiate corrective action.
3. If any thermal indicators fail to change after a standard autoclave cycle, then those instruments will be re-pouched and re-sterilized with attention to manufacturer's instructions. If the thermal indicators fail to change twice, then the nurse will notify the provider to initiate corrective action.
4. It is permissible to delay the weekly spore testing if the autoclave remains unused for the duration of the week. Daily/weekly maintenance will be deferred when the clinic is closed.

III. References

1. AAAHC Standard 7.1.L, 7.1M

IV. Executive Action

Executive Action	Date
Approved	7/17/17

Blood or Other Body Fluid Spills

I. Policy

This policy will provide a guideline for the safe and effective clean-up of body substance spills such as blood and other body fluids.

II. Procedure

A. All members of the healthcare team will manage spills of blood or other body fluids according to facility procedure.

B. Supplies

1. EZ-Cleans Plus Spill Clean-Up Kit:
   a) Vinyl Gloves
   b) 10g. Red-Z Solidifier
   c) Scoop & Scraper
   d) SaniZide Plus Germicidal Wipe
   e) 24” x 24” Red Biohazard Bag
   f) Twist Tie
   g) p.a.w.s. Antimicrobial Hand Wipe
   h) Instructions
2. Face Protection (eye wear and mask, or full face shield)
3. Plastic apron or other similar article
4. Shoe covers

C. Spill Cleaning Procedure

1. Immediately restrict access to the area as much as possible.
2. Notify supervisor
3. Obtain the spill kit from the Clean Linen room.
4. Put on disposable gloves and appropriate protective clothing.
5. Sprinkle Red-Z over spilled area and allow the liquid to congeal for safer handling and transport.
6. Remove gelled material with scoop & scraper. Then carefully place in red biohazard bag.
7. Use SaniZide Plus Germicidal Wipe to clean contaminated surface.
8. Place all contaminated materials (including gloves) in the red biohazard bag.
9. Seal and dispose of bag as required by local, State and Federal regulations for infected soiled waste
10. Remove and dispose of personal protective equipment.
11. Wash hands with soap and running water as soon as possible.

III. Attachments

None

IV. References:

1. To access the CDC's Recommendations for Disinfection and Sterilization in Health-Care Facilities, see the CDC website at: https://www.cdc.gov/infectioncontrol/pdf/guidelines/disinfection-guidelines.pdf
2. To access OSHA's Bloodborne Pathogen Standard, see the OSHA website at: http://www.osha.gov/pls/oshaweb/owadisp.show_document?p_table=STANDARDS&p_id=10051
3. To view a video demonstration on the EZ-Cleans Plus Spill Clean-Up Kit, see the Safetec website at: http://safetec.com/portfolio_item/ez-cleans-plus-kit-17121/

Cervical Cancer Screening DMG

I. Purpose

The purpose of this guideline is to assist in protecting SHC students from cervical cancer by screening and early detection.

II. Cervical Cancer Screening

A. Acceptable Methods of Cervical Specimen Collection for Screening

1. Liquid-based cytology
2. Conventional method (fixed slide)

Note: A small amount of water based soluble lubricant on the speculum may be used, as this does not usually decrease the quality of cervical cytology test results.

B. Screening Criteria

1. Women younger than 21 years should not be screened regardless of behavior related risk factors unless
    a. infected with HIV, or otherwise
    b. immunocompromised.
2. Women aged 21-29 years should be tested with cervical cytology alone every 3 years unless an abnormality on pap is detected.

HPV DNA testing should not be performed in women younger than 30 years old.

3. For women age 30-65, co-testing with liquid-based cytology and HPV DNA testing every 5 years is preferred.

Alternatively, screening with cytology alone every 3 years is also acceptable for this age group.

4. Screening by any modality should be discontinued after 65 years old if
    1. adequate negative prior screening test results,
    2. the most recent test performed since 60 years old, and
    3. no history of CIN 2 or greater in the past.

"Adequate negative prior screening results" within the previous 10 years are defined as either

    a. three consecutive negative cytology results, or
    b. two consecutive negative co-test results.

5. Routine cytology screening and HPV testing should be discontinued in women who have had a hysterectomy with removal of the cervix (total hysterectomy) and have never had CIN 2 or higher on cytological screening or cervical biopsy.

C. The above recommendations <u>do not apply</u> to women with

1. Cervical cancer,
2. History of abnormal pap (see Management of Abnormal Pap Smear DMG),
3. HIV, or
4. Immunocompromised.

III. References

American College of Obstetricians and Gynecologists for cervical cancer screenings (Practice Bulletin #168, October 2016)

*Disease Management Guidelines do not replace sound clinical judgement nor are they intended to strictly apply to all patients.

Chaperone Policy

I. Policy

A chaperone will be utilized at any time a healthcare provider is performing an intimate examination or in the event that a healthcare provider or patient requests to have a chaperone present during the examination. The chaperone can also provide emotional comfort and reassurance to the patient.

II. Definitions

A. Intimate Examination: an examination of the genitals, rectum, and/or breasts.
B. Chaperone: An independent person, appropriately trained, whose role is to independently observe the patient examination and to assist as needed.

III. Procedure

A. Pre-examination
    1. The nurse or medical assistant will explain the chaperone policy to the patient prior to the examination by the health care provider.
    2. The nurse or medical assistant will document if a chaperone will be needed for the examination.
B. During the examination
    1. The chaperone must be in a position to properly observe the examination.
    2. The chaperone should be present during the entire intimate examination.
C. Post examination
    1. The chaperone name should be documented in the patient record.
D. Support
    1. The chaperone can provide emotional support and reassurance to the patient before, during, and after the examination.

IV. Attachments

None

V. References

VI. Executive Actions

Executive Actions	Date
Approved	

Nurse Chart Audit Policy

I. Policy

Chart audits will be completed on nursing documentation on a routine basis to ensure that nursing standards are followed.

II. Procedure

A. Supervisor Review
   1. The nurse coordinator will audit four charts per month for each nurse.
   2. The appropriate monthly chart review form will be used.

B. Peer Review
   1. Each nurse will audit two charts per month on a nurse peer as assigned by the nurse coordinator.
   2. The appropriate monthly chart review form will be used.

C. Discussion
   1. The chart review form will be reviewed and signed monthly with each nurse and the nurse coordinator.
   2. Any changes needed to be improve documentation will be communicated with the nurse and documented on the chart audit form

III. Attachments

1. SHC RN Monthly Chart Review Form
2. SHC LVN Monthly Chart Review Form

IV. References

None

V. Executive Actions

Executive Actions	**Date**
Approved	

Attachment 1

SHC RN Monthly Chart Review																					**Semester:**_____
Nurse:																					
Month																					
Date																					
Criteria for Review/Chart Number																					
Triage, or Nurse visit																					
Vital Signs Identified																					
Allergies Identified																					
Current Medication Identified																					
LMP Identified																					
Chief complaint is noted and in patient's own words																					
HPI is specific to current complaint																					
Clinical decision is appropriate																					
Injections/nurse procedures are clearly marked and documentated per EMR template																					
Plan for the patient is appropriate and documented																					
Documentation on Triage is accurate and complete																					
Patient education is identified and pertinent to current complaint																					
Other:																					

Signature of Reviewer: _____

Acknowledgement: _____ _____

Additional Comments: _____

_____

_____

_____

_____

_____

Attachment 2

SHC LVN Monthly Chart Review **Semester:**_____

Nurse:

Month																				
Date																				
Criteria for Review/Chart Number																				
Nurse or Provider visit																				
All pertinent information is identified including VS, Allergies, current medications, LMP																				
Chief complaint is noted and is in patient's own words																				
Patient summary page is clearly noted and updated each visit																				
needed																				
Injections/nurse procedures are clearly marked and documentated per EMR template																				
Allergies are updated and clearly marked as reviewed each visit																				
Chaparone is indicated if necessary																				
Patient education is identified and pertainent to current complaint and within scope of practice																				
Other:																				

Signature of Reviewer: _____

Acknowledgement: _____ _____

Additional Comments: _____

_____

_____

_____

_____

_____

Cleaning/Sterilization of Instruments after Use

V. Policy

To provide and define responsibility regarding the cleaning, disinfecting, sterilization and storage of patient care instruments and other patient care items after use.

VI. Procedure

A. While utilizing appropriate personal protective equipment (PPE), contaminated instruments should be rinsed with running water immediately after use to remove gross blood and body fluids before removing them from the room .
B. Instruments should be sprayed with approved disinfecting cleaner and rinsed again before being placed in the closed plastic container found in each patient care room.
C. When in the autoclave room, place instruments in the soaking pan that contains disinfecting solution.
D. Instruments should be soaked for at least 30 minutes before being processed for autoclaving.
E. Instruments should be sterilized according to recommended manufacturer's guidelines.
F. Lubricate all instruments which have any "metal to metal" action such as scissors, hemostats, needle holders, etc. with a manufacturer's recommended surgical lubricant. Do **not** use WD40, oil or other industrial lubricant.
G. Unlock all instruments and sterilize them in an open position. Never lock an instrument during autoclaving as the steam cannot reach the metal to metal surfaces and the instrument will not be sterile.
H. Do not overload the autoclave chamber as pockets may form that do not permit effective steam penetration.
I. Package instruments for autoclaving either individually or in sets.
J. Always use the proper sterilization/cleaning technique to render the instrument in required condition for use

VII. Reference

1. Ritter Owner's manual

Concussion DMG

A concussion can result from a direct or indirect blow to the head.

Note: Rotational force or angular acceleration can increase risk for concussion.

Note: Even a relatively minor force can lead to significant symptoms, especially when there is increased susceptibility to concussion or concomitant neurologic or psychologic factors present to exacerbate symptoms.

The Pathophysiology of a Concussion

A wave of energy traveling through the brain triggers neuronal dysfunction via a complex cascade of metabolic, ionic, and physiologic events potentially exacerbated by a secondary insult of decreased cerebral blood flow.

"When In Doubt, Sit It Out"

Most patients recover quickly and fully, but **playing sports with a recent concussion is dangerous.** Besides the cumulative effect of concussions, research has found there is increased risk of having another and more severe concussion within the first 10 days which results in greater potential for long-term disability and even death.

Careful observation is necessary. Signs and symptoms of serious traumatic brain injury may not manifest for 20-30 minutes after injury, and it may take days for signs or symptoms of concussion to manifest. Individuals with a potential concussion should avoid alcohol, recreational/prescription drugs, and not operate a motor vehicle.

Physical and cognitive exertion should be avoided in the acute phase. Cognitive exertion to avoid initially includes attending class, performing coursework, working on a computer, watching television, using a cell phone, reading, playing video games, and text messaging.

Possible Signs and Symptoms

The possible signs and symptoms of concussion are divided into four categories:

1. **Somatic**-headache, dizziness, balance disruption, nausea and vomiting, visual disturbances (blurry vision, double vision, photophobia), phonophobia.
2. **Cognitive**-confusion, amnesia (anterograde or retrograde), loss of consciousness, disorientation, feeling "foggy", vacant stare, excessive drowsiness, delayed response (verbal or motor), slurred or incoherent speech, inability to focus.
3. **Affective**-emotional lability, irritability, fatigue, anxiety, sadness.
4. **Sleep**-difficulty falling asleep, sleeping more than usual, sleeping less than usual.

SHC Post-concussion Evaluations

Clinicians will utilize the Sports Concussion Assessment Tool-5th edition (SCAT 5) for all patients presenting with complaint of blunt head trauma. An individualized concussion treatment plan regarding the resumption of classwork and return to play will be devised in accordance with this DMG. When indicated, patients will be referred to an emergency room or a concussion expert.

Emergency Room Evaluation is necessary when

1. imaging is indicated,
2. hospitalization or surgery may be needed,
3. more careful observation than possible at home may be necessary, or if
4. the patient cannot be adequately observed at home (no responsible adult willing or able to assume responsibility for monitoring).

Findings warranting emergency room evaluation

1. Apparent or suspected neck injury (cervical pain, point tenderness, or loss of range of motion)
2. Focal neurologic deficit including slurred speech and weakness or numbness in any extremity
3. Loss of consciousness greater than 30 seconds
4. Seizure
5. Persistent decreased level of consciousness
6. Increasing or persistent confusion
7. Persistent anterograde amnesia (>30 min)
8. Increasing severity of headache
9. Repeated vomiting
10. Irritability greater than normal or any other unusual behavior
11. Visible trauma to face or head
12. Suspected skull fracture (bruises around or under eyes or behind ear, hemotympanum or evidence of blood draining from ear, clear fluid draining from ear or nose)
13. Worsening symptoms
14. Dangerous mechanism of injury

Referral to a Concussion Specialist is indicated when the

1. Patient has a history of multiple concussions,
2. Patient has risk factors for a prolonged recovery,
3. Symptoms have worsened, or
4. Symptoms have not fully resolved within 10-14 days.

Risk Factors Potentially Complicating Recovery

1. History of previous concussions
    a. Number
    b. Mechanism of injury
    c. Severity
    d. Duration of symptoms
    e. Dates of occurrence

2. Personal and Family History
    a. Migraines
    b. Depression and other mood disorders
    c. Anxiety
    d. Developmental disorders or learning disabilities
    e. Attention Deficit Hyperactivity Disorder (ADHD)

Recovery

Acute Phase-Physical rest and relative cognitive rest are indicated for the first few days after injury before gradually increasing daily activity as long as symptoms do not worsen.

Return to School

Once the patient is able to complete usual daily activities without symptoms, a graduated return to school strategy can be initiated.

Step 1-Start with 5-15 minutes at a time performing typical cognitive activities (reading, texting, screen time) that do not increase symptoms and gradually build up.

Note: A patient who does not have symptoms with mental activity may skip Step 2 and return to school part-time.

Step 2-Start homework, reading, or other cognitive activities outside the classroom.

Step 3-Return to school part-time with partial day (select classes) and/or increased breaks.

Step 4-Gradually increase activities until a full day can be tolerated without symptoms.

Return to Sports

Return to competitive play should take place over days, weeks, or months depending each individual's symptoms and tolerance once the patient has successfully returned to school full-time without symptoms. Recurrence of symptoms should be monitored carefully during progression to each stage of return to play. A patient should not progress more than one stage per 24 hour period and only if there is no exacerbation in symptoms. Should symptoms occur, the patient should rest for 24 hours. Activity can resume 24 hours later at the previous stage at which the patient was symptom-free.

Stage 1-Light aerobic exercise (walking, light stationary biking, light jogging)
Goal: only increase heart rate
Time: 5-10 min
No weight lifting, jumping, or hard running

Stage 2-Moderate aerobic exercise (moderate jogging, brief running, moderate stationary biking, moderate intensity weight lifting)
Goal: limited body or head movement
Time: reduced from typical routine

Stage 3-Non-contact Exercise
Goal: more intense but no contact
Time: close to typical routine

Stage 4-Reintegrate into full contact practice

Stage 5-Return to competition

Attachments

1. SCAT 5 Sport Concussion Assessment Tool-5th Edition
2. SH Rec Sports Athlete's Concussion Packet
3. SHC Return to Play form

References

http://bjsm.bmj.com/content/bjsports/early/2017/04/26/bjsports-2017-097699.full.pdf

https://www.sportphysio.ca/scat-5-consensus-statement-on-concussion-in-sport-the-5th-international-conference-on-concussion-in-sport-held-in-berlin-october-2016/

http://www.sportphysio.ca/wp-content/uploads/SCAT-5.pdf

http://www.sportphysio.ca/wp-content/uploads/The-Concussion-Recognition-Tool-5-CRT5-.pdf

https://www.cdc.gov/concussion/headsup/clinicians/

https://www.cdc.gov/concussion/headsup/clinicians/resource_center/pdfs/Concussion_Symptoms_Checklist.pdf

https://www.cdc.gov/headsup/pdfs/schools/tbi_factsheet_teachers-508-a.pdf

https://www.cdc.gov/headsup/pdfs/schools/tbi_factsheets_parents-508-a.pdf

https://www.cdc.gov/concussion/headsup/clinicians/resource_center/educational_resources.html

https://nfhslearn.com/courses/61064/concussion-in-sports

Controlled Substance

I. Policy

Measure to ensure safekeeping and processing of control substances.

II. Procedure

A. Procurement:
   1. All Schedule II controlled substances will be ordered by a pharmacist who has a signed a limited power of attorney for DEA Forms.
   2. Upon receipt of the schedule II drugs, the DEA Form 222 must be completed by entering the number of packages received, the date, pharmacist's initials and signed by the pharmacist.
   3. A perpetual inventory will be maintained for all schedule II controlled substances stored in the pharmacy. When schedule II controlled substances are received, the quantity received shall be added to the perpetual inventory record of the particular substance.
   4. Records for schedule II control prescriptions will be kept separate from the records from scheduled III to IV control prescriptions.

B. Storage:
   1. All Schedule II controlled substances will be stored in a locked safe inside the pharmacy for security purposes.
   2. All Schedule III – V controlled substances will be dispersed with the general inventory.

C. Dispensing:
   1. The pharmacy will comply with all laws regarding dispensing of controlled substances.
   2. Dispensing records will be sent electronically to prescription monitoring program no later than the 7th day after the prescription is filled.
   3. The patient must appear in person to pick up all schedule II control prescriptions.

D. Disposal
   1. The pharmacy may transfer unwanted controlled substances to a contracted registered reverse distributor. The most current registered reverse distributor list must obtained from a DEA Diversion Investigator.
   2. Contact registered reverse distributor for schedule II Inventory request form to ascertain the proper DEA Form 222. The pharmacy will keep copy 1 (Brown) and mail copy 2 (Green) to local DEA office.
   3. A photocopy of the completed DEA Form 222 will shipped with the unwanted drugs.

III. Attachements

None

IV. References

1. AAAHC Chapter 11 Standards A,B, D, & G
2. 21 Code of Federal Regulations 1304
3. 21 Code of Federal Regulations 1305

4. 21 Code of Federal Regulations 1317
5. Texas Administrative Code Chapter22 Rule §291.34

V. Executive Actions

Executive Action	Date

Custodial Infection Control and Safety Precautions

I. Policy

Each clinic care room and patient area that is used will be cleaned every business day.
Care must be taken to avoid coming in contact with harmful chemicals while ensuring the proper use of equipment.

II. Procedure

A. Cleaning of Exam Rooms

Each room and patient area will be cleaned every business day with the below listed products.
NOTE: Do not use alcohol to disinfect large environmental surfaces.

Product: Sani-Cloth Plus (Germicide)

1. Bed
2. Chair and stool
3. Equipment on wall
4. Light on the bed
5. Counters
6. Door knobs and counter knobs
7. Laptops in the lobby waiting area

Product: Wex-cide 128 (Germicide)
Zep DZ-7
Double D

1. Sink in the exam room
2. Sink in the bathroom
3. Toilet
4. Bathroom: wipe down all the rails, dispensers and paper towel/trash dispenser
5. Mop floors(twice a day-morning and during lunch hour)
6. Lobby floors and wipe down chairs, tables, and counters

B. Cleaning Floors

1. <u>High-Speed Finishers</u>
   NOTE: When stripping a floor, walk on the area that has already been scrubbed, if possible.
2. <u>Vacuums</u>
   a. Know manufacturer's instructions of use and care of machine before use.

C. Cleaning Solutions

1. Know the nature of the chemicals being used. If you have any questions, talk to your supervisor or refer to the **Safety Data Sheets (SDS)** for chemicals. If chemicals should get splashed in your eyes or on your skin, go to eye wash station to flush eyes immediately for 15 minutes, located in the lab and have a fellow employee notify supervisor. If skin becomes irritated, immediately flush with water and refer to SDS sheet for further information.

2. Always utilize appropriate personal protective equipment (PPE) when working with chemicals. Goggles and gloves are the best way to prevent a chemical spill or splash from causing serious bodily harm.
3. Store all chemicals in an approved, clearly labeled, properly sealed container at or below eye level.
4. Do not dispose of a chemical unless you know the procedure required to properly dispose of it and its container. Triple rinse all chemical containers before disposing of them.

D. Trash Removal

1. Do not reach into a trash container to get something out. Empty the whole liner into the trash cart.
2. Always wear gloves when handling biohazardous trash. Biohazardous trash must be checked every morning.

E. Cleaning up Broken Glass or Sharp Object

Wear gloves to pick up the large pieces first. Put them in a puncture-proof container for disposal or box, **not** in a trash liner. Then, vacuum the surface to get the remaining pieces.

F. Moving Furniture

1. To avoid common back injuries, always follow proper lifting procedures.
2. Always consider how heavy the object you're moving is and get help if necessary.

G. Cleaning Stairs

1. Exercise caution when working on stairs.
2. Stand on the stair below or two down from the stair on which work is being performed.
3. Always mark the top and bottom of the stairway with a "wet floor" sign to alert others of danger.

H. Elevators

1. When getting on or off an elevator with a mop bucket or other wheeled equipment, be aware that the wheels could get caught in the crack between the floor and elevator.

I. Custodial Closets

Custodial closets must have the following safety items and meet these safety guidelines:

1. Safety Data Sheets (SDS) for all chemicals stored in the closet, or written instructions or map of the location within the building where the SDS can be found.
2. Safety goggles or glasses.
3. Rubber gloves.
4. "Wet floor" signs or the location within the building where they can be found.
5. All chemicals must be stored at eye level or below and properly labeled.
6. Wet mops must be hung up to dry.
7. Mop buckets must be empty - no standing water or chemicals.
8. Food cannot be stored near chemicals.
9. Equipment cords cannot be frayed or have exposed bare wires.

J. Wet mop and mop bucket with wringer

1. Always place "Wet Area" warning signs before beginning work and leave in place until floor is dry.
2. Leave the mop bucket in a place where it can be visibly seen.
3. Rinse the mop and bucket thoroughly after mopping any type of chemical spill.

K. Custodial Buffer:

1. Before using the buffer, make sure that the drive plate and buffing pad are securely attached. Unplug the buffer before setting the handle, drive plate, or pad. Always return the buffer to an upright position before plugging it in.
2. Store the buffer in an upright position with the drive plate and buffing pad removed.
3. Always control the buffer by using both hands as this will help to avoid damage to walls, furniture, and personnel.
4. Keep the buffing pads clean. This makes the buffer easier to control, and prevents sharp objects from sticking to the pad thus damaging the floor.

II. References

1. https://www.fm.colostate.edu/files/forms/safety/CH-04.Custodial.pdf

Depo Provera Injection Policy and Standing Order

Policy: 1/2014-kc Rev 6/2015-kc

Condition for Standing Order: Student request for Depo Provera Injection for birth control. It will be given either part of a WWE or a nurse visit.

Policy of Protocol: The nurse (RN or LVN) will implement this protocol for Depo Provera administration. This will allow the nurse to order Depo Provera 150 MG IM, once verifying criteria on chart. The nurse will also educate the student regarding their contraceptive management choice and schedule follow-up appointments with the patient.

Criteria for receiving Depo Provera Injections: Student must request injection of Depo Provera. They must have had a WWE with appropriate testing including STI testing for GC and Chlamydia if under 25, within past year either from the SHC or their PCP, and documentation must be on the chart. If they have an outside provider order, then that order will be honored.

Contraindication: If student does not have appropriate documentation to fulfill the request, this must be obtained prior to injection being given.

Precautions: Late injections: If it is more than 7 days from the calculated injection due date and less than 14 days and the patient ***has not*** had unprotected sex after the due date, a urine pregnancy test is done and documented. The nurse will review the results with a clinician for order verification prior to administration. The patient will be advised to use back-up birth control for 2 weeks.

If it is more than 7 days from the calculated injection due date and the patient ***has had unprotected sex after the Depo Provera due date, a clinician is consulted for further orders.***

Procedure: First injection

- A urine test for pregnancy (HCG) is done right before the initial injection.
- Patient reads package insert or Depo Provera pamphlet and signs Contraception Counseling form.
- The first dose of Depo-Provera is given only within the first 5 days of a normal menstrual period unless approved and ordered by a clinician.
- DMPA 150mg/1cc is given in a singular injection deeply in the ventral gluteal or the vastis lateralis or deltoid muscle using a 21 or 22 gauge needle, using standardized nursing practice.
- Nurse instructs patient to use back-up method for two weeks and to schedule follow-up appointment in Nurse Clinic for every 11-13 weeks. The nurse gives the patient written instructions with follow up dates with the patient.

Equipment: Includes the following: Patient handout; Depo-Provera in vial or pre-filled syringes of 150mg DMPA per 1cc; 21g or 22 g safety needle; personal protective equipment is used by nurse; A signed order from a clinician at SHC or from a private physician; Copies of an annual well woman exam, Chlamydia and Gonorrhea testing and pap results as indicated within the last 12 months; Contraception counseling form signed and scanned into EMR.

Follow-up injections:

- Nurse reviews side effects and concerns with patient.
- If the patient returns for follow-up within 11-13 weeks since last injection, the nurse verifies the existing order and the date of the last Well Woman Exam. If the order and exam are current, the nurse may administer the injection. Once the injection is given, the nurse documents the injection on the Depo-Provera Flow sheet in EMR and completes a progress note. The patient is given instructions for their next injection or exam.

Evaluation of Competence:

Initial Competency: Observe 3 times for accurate completion and documentation for Depo injections.

On-going Competency: Chart reviews of this procedure occur as part of the on-going Quality Assurance program of the SHSU Student Health Center. Incident report generates quality assurance audit.

Scope of Supervision: No direct supervision necessary to initiate this procedure.

Criteria for Provider Consultation & Referral: At any time, the LVN or RN may discuss the order with the provider for clarification of order and how to proceed.

Documentation

- The nurse completes the nurse manager template, a progress note and will bill through the system if SHC stock was used for the injection.
- The nurse informs the patient when to make the next appointment and provides a card with the next needed date for injection.

This protocol/standing order shall remain in effect for all patients of the Sam Houston State University Student Health Center until rescinded.

Discarding Expired or Unopened Medications

Policy: 9/2014-kc rev 6/15-kc

Condition for Policy of Protocol: Medications once opened have a limit on how long they can be utilized in the clinic. Once injectables are open, they need to be disposed within 1 month. For oral medications, it is based on the expiration date or if dispensed from the pharmacy then it is for 6 months. Eye drops will need to be disposed of within 1 month of opening. Eye wash will be utilized for 1 patient only. This protects the student from getting tainted or expired medications.

Exceptions: If can be returned for reimbursement.

Contraindication: NONE

Precautions: Check to see the item was dated properly when initialed opened.

Administration of Policy and Procedure:

- Immediately initial and date any medication upon opening.

Injectables

- If the medication is an injectable it must be discarded if not used within 1 month after initially being opened.
- If it is opened it can be discarded in a sharps container so it cannot be retrieved by any one once discarded.
- Complete the "Discarded Medication" record so the clinic can track medication waste. (Appendix 12)
- If the medication has expired and is not opened, return to the pharmacy for disposal.

Oral Medications

- Oral medications do not expire until the expiration date on the label or within 6 months if dispensed from pharmacy
- If expired and opened, mix with sand, coffee grounds or kitty litter prior to dispensing in bio hazard.
- Complete the "Discarded Medication" record so the clinic can track medication waste.

- If the medication has expired and is not opened, return to pharmacy for disposal.

Eye drops

- Proparacaine for the purpose of numbing the eye can be stored in the refrigerator for up to 1 month once seal is broken. Date bottle was open should be written with a sharpie on the bottle
- If expired or discolored, it will be disposed of properly
- Eye wash kept in the rooms, will be charged to the patient and not reused

Initial Competency: Observe experienced nurse implementing this policy, demonstrate successful use of policy at least 3 times under chart audits if possible.

On-Going Competency: Current daily/monthly accurate documentation.

Scope of Supervision: Providers are available at all times to clarify questions

Documentation: Document on Discarded Medication when necessary.

Document Retrieval for Patients/Front office Folder

Policy: 9/2014-kc rev 6/15-kc

Policy of Protocol: It is the policy of the Student Health Center to get needed items to the patient as easily as possible. Occasionally the physical form may not be correct, or a prescription may need to be picked up by the student after the provider has reviewed lab work. Due to different situations a common folder will be in place in the printer room for the nurses to leave the items for the front office to give the patient.

Exceptions: NONE

Contraindication: None

Precautions: None

Equipment: Alphabet folder

PROCEDURE:

- Place the item for the patient to pick up in the folder based on the first initial of their last name
- Call the patient and leave a message they have an item to pick up in the front office.
- Document in a progress note.
- Leave a reminder on the task bar if it is a prescription that needs to be picked up so that if it is not picked up in 3 days, the patient can be contacted again.
- IF a prescription for a reportable STI, leave the STI form in the nurse's station and if the prescription is not picked up within 3 days send the form to TDH as "untreated".
- The front office will document who picks up the forms/prescriptions on the correct clipboard and will give this information to the charge nurse.
- Once a month the folder will be purged by the charge nurse and discard any paper work/prescriptions not picked up after 3 reminders.

Initial Competency: Random audits on charts and papers in folder and see if being completed correctly.

On-Going Competency: Monthly and PRN audits and documented appropriately.

Scope of Supervision: Nurse Coordinator and Charge nurse are available to answer questions.

Documentation: On the form in the communication note book.

Ear Irrigation for the Removal of Impacted Cerumen Protocol

I. Policy

Registered nurses (RNs), licensed vocational nurses (LVNs) and medical assistants (MAs) who have demonstrated competency for ear irrigation for the removal of impacted cerumen can utilize this protocol.

II. Procedure

A. Obtain an order from a provider for an ear lavage.
B. Identify the patient and explain the procedure and answer any questions.
C. Obtain consent from the patient and place in the health record.
D. Assess the patient for contraindications to the procedure: Ear pain, bleeding, vertigo/dizziness, or history of perforation of the tympanic membrane.
E. Consult the provider for any apparent contraindications present or as necessary to address any other concerns or questions.
F. Use the otoscope and examine the external ear canal.
G. The patient may be pre-treated with a solution to soften cerumen.
   Cerumen softening solution should be instilled Place 3-5 drops of a cerumen softening agent or plain water into affected ear15-30 minutes prior to the procedure.
H. Place the patient in a seated position and cover with a towel or drape
I. Place warm water into the irrigation bottle.
J. Verify the comfort of the water temperature with the patient.
K. Have the patient tip their head toward the shoulder and place the basin under the outer ear.
L. Lift the external ear up and back to straighten the ear canal.
M. Irrigate the ear canal with a direct, gentle stream of water applied to the sidewalls of the ear canal.
   1. Right Ear Irrigation
      Point the tip in the 1 o'clock position
   2. Left Ear Irrigation
      Point the tip in the 11 o'clock position
   3. During irrigation, continuously assess the comfort of the patient.
   4. Abort irrigation and notify provider for complaint of or apparent severe discomfort.
N. After flushing 2-3 times, reexamine the ear canal to assess if irrigation is still needed
O. Continue to irrigate the ear canal until the cerumen is cleared if tolerated by the patient.
P. Post- irrigation
   1. Have the patient dry the ear.
   2. Patient may lay down to drain the affected ear as needed.
   3. Reassess the patient's comfort level.
   4. Notify provider to reevaluate the ear canal and tympanic membrane.
Q. Provide patient education
   1. Safe and correct care for the ear
   2. Signs and symptoms of infection
   3. Follow-Up care
R. Document the procedure in the medical record.

III. Attachments

None

IV. References

1. http://emedicine.medscape.com/article/1413546-overview

EBOLA Management protocol for the SHC and SHSU

VIII. Policy

In the case of a government warning or local outbreak of EBOLA, the following is a procedure for the SHSU Student Health Center staff and personnel to follow.

IX. Procedure

A. Screen all students that arrive at the SHC for fevers and recent travel to Western Africa

1. Ginea
2. Sierra Leone
3. Liberia
4. Nigeria
5. Republic of Congo

B. If suspicious for EBOLA exposure

1. Temperature >/= 101.5 AND
2. Epidemiological risk factors within the past 3 weeks such as recent travel to above countries OR contact with the bodily fluids of a suspected or known EBOLA patient
3. Direct handling of bats, rodents or primates from disease endemic areas

C. If patient answers yes to the above screening factors and presents a concern to the staff member, proceed with the process below:

1. Immediately isolate the patient in room, close the door, and place a sign on the door stating “Patient Isolated”.
2. Use contact and droplet precautions and PPEs
    a. Gown, double-gloves, eye protection, shoe covers, surgical cap and mask
    b. Wash and sanitize hands between every patient encounter, even if you wore gloves
3. Gather the following information to report to the SHSU Director of Medical Services, SHSU Student Health Center Director, and Texas Department of State Health Services:
    a. Patient name
    b. DOB/Age
    c. Lives on or off campus and location/room number
    d. Symptoms
    e. Travel History
4. Report information gathered in C.3 to the following:
    a. SHSU Director of Medical Services
    b. SHSU Student Health Center Director
    c. The Director will contact the SHSU Office of Risk
    d. Texas Department of State Health Service: (512) 776-7261
    e. The Centers for Disease Control (CDC)

5. Contact the following and report information as a ‘need to know’ basis (do not provide identifying information):
    a. Call 9-1-1 for ambulance. They will ensure that the patient is in respiratory isolation and transported to the appropriate facility.

X. References

1. https://www.cdc.gov/vhf/ebola/

EKG Procedure

Condition: EKG is ordered by a provider

Policy of Protocol: The patient is brought to the procedure room and placed supine, at a 20 degree angle with arms along sides and ankles uncrossed. Supply a drape for privacy related to the disrobing of the upper body. Note that the chest is dry and remove excess hair with the provided clippers if necessary. Obtain verbal consent from patient for hair removal. Place electrodes according to the diagram provided. Enter all of the patient information into the template on the machine, have the patient be quiet and still with normal breathing. Once an accurate waveform, free of artifact is obtained, print for the provider to review. Once the provider has reviewed the copy, scan it to the chart and place the hard copy in the notebook provided on the EKG machine.

Exceptions: None

Contraindication: None

Precautions: None

Initial Competency: Observe experienced nurse implementing this procedure, demonstrate successful use of procedure at least 3 times under direct supervision, and submit 3 charts to be audited by Charge RN or Nurse Coordinator.

On-Going Competency: Chart review of this procedure in the ongoing audits of charts and Quality Management of the SHSU SHC.

Scope of Supervision: Providers are available at all times to clarify questions.

Documentation: Nurse documents appropriately in EMR according to policy of SHSU SHC.

EMERGENCY EYEWASH STATION

I. Policy

To irrigate the eye and reduce the chance of severe injury caused by contaminates such as acid, alkali, or particulate matter.

II. Procedure

A. Proceed to eyewash station located in the lab that is attached to the sink.
B. Push the button in to activate the flow of **COOL** water.
C. Remove contact lenses if not already done so.
D. Hold eyes open and move eyes over the flow of water and flush for continuous **15** minutes.
E. Eyes should be rotated up and down and side to side to adequately flush the entire surface of the eye.
F. A staff member other than the affected individual should locate the Safety Data Sheet (SDS) if a chemical is involved and give a copy to the treating clinician.
G. The incident should be reported in accordance with SHC Policy 00.0, "Workplace Accidents and Injuries". The report should include the date, time of exposure, length of flushing, chemical or contamination involved, and follow up care.

III. Testing

A. The eye wash station should be tested weekly to ensure the unit is working properly and ready for use.
B. Testing should be documented in the laboratory quality assurance binder.

IV. References

1. OSHA 29 CFR 1910.151
2. ANSI/ISEA Z358.1
3. Opti-Klens eye wash fountain reference sheet

I. General

Effective clinical management of patients with treatable sexually transmitted diseases (STDs) requires treatment of the patients' current sex partner(s) to prevent reinfection. Expedited Partner Therapy (EPT) for heterosexual male partners of female patients has been proven effective in reducing reinfection rates for diagnosed chlamydia and/or gonorrhea infections. On April 4, 2009, the Texas Administrative Code was amended to explicitly allow EPT.

II. Considerations

The clinical assessment of the patient's partner is always preferable. However, EPT can be employed when it appears the patient's partner(s) will not likely seek medical treatment. Consequently, EPT is a viable option for a provider to consider on a case-by-case basis.

III. Implementation

A. Documentation: A note in the patient's medical chart may reference EPT will be offered to the patient's sex partners, the medication and dosage being provided, and whether the partner(s) have any known medication allergies.
Note: The names of partners receiving EPT should not be included in the patient's chart.

B. Written Information for the Partner: The provider should provide the patient with written information for the partner that includes the reason for EPT, risk for drug allergies and adverse reactions, potential for drug-drug interactions, risk for other STDs, and emphasis as to the importance of a clinical evaluation.

C. Treatment Guidelines

1. Chlamydia: Azithromycin 1gm PO x 1 **or** Doxycycline 100 mg BID x 7d.
2. Gonorrhea: If a heterosexual partner of a gonorrhea patient cannot be linked to evaluation and treatment in a timely fashion, EPT with cefixime and azithromycin should still be considered, as not treating partners is significantly more harmful than is practicing EPT for gonorrhea. Cefixime 400mg PO X 1 and Azithromycin 1 gram PO X 1 delivered to the partner by the patient. EPT is not routinely recommended for MSM because of a high risk for coexisting infections, especially undiagnosed HIV infection, in their partners.
3. EPT for Trichomoniasis has not been proven to be beneficial. However, medical providers may elect to provide EPT on a case-by-case basis.
Flagyl 2 gm PO x 1 **or** Flagyl 500 mg BID x 7 d # 14 **or**
Tinidazole 2 gm PO x 1.

D. Prescriptions issued for EPT should include "EPT" in the text of the instructions.

IV. References

1. CDC 2015 Sexually transmitted diseases treatment guidelines. Atlanta: US Department of Health and Human Services; 2015. Accessible at https://www.cdc.gov/std/tg2015/clinical.htm .
2. CDC Expedited partner therapy in the management of sexually transmitted diseases, Atlanta, GA: US Department of Health and Human Services, August 9, 2012. Available at https://www.cdc.gov/std/ept/default.htm .
3. CDC Legal status of EPT in Texas. Available at

https://www.cdc.gov/std/ept/legal/texas.htm .
4. CDC Guidance on the use of Expedited Partner Therapy in the treatment of Gonorrhea. Dec 9, 2016. Available at https://www.cdc.gov/std/ept/gc-guidance.htm .
5. *Trichomonas vaginalis:* a review of epidemiologic, clinical and treatment issues. BioMed Central. BMC Infect Dis. 2015; 15: 307. Available at https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4525749/ .

General Nurse Employee Information

Policy: 7/2014-kc rev 6/15-kc

Policy of Protocol: To assist with the smooth running of the clinic and to ensure the knowledge of the information to be uniform and concise.

Criteria for Policy: Applies to all nursing personnel; excluding APRN.

Exceptions: None

LVN Responsibilities: LVN's are primarily scheduled with providers to provide nursing care needed with seeing patients in the clinic. Anything that is needed by the provider for the care of the patient will be provided by the LVN assigned. It is up to the LVN to be able to time manage the needs and to accomplish them in the most effective manner. These tasks include but are not limited to: rooming patients, collecting intake as needed by the provider, performing orders from the provider including medication administration. Other clerical duties include: informing patients of test results once provider gives direction to them, contacting patients at the request of the provider, answering questions of the patients, updating the referral manager for the provider, obtaining outside records as requested by the provider. Scanning necessary chart documents as they become available to existing charts.

RN Responsibilities: RN's will operate primarily in the nurse clinic. The RN Clinic has many different programs within the parameters of the RN Clinic. These include but are not limited to: Immunizations, Allergy Clinic, Travel Clinic, Triage, Depo Provera, Walk-in clinic, Nurse Education Clinic. The RN clinic will also field all general nurse questions, and handle all prescription refills. As the nurse clinic grows, more opportunities will develop for the students of Sam Houston State University. Also as the SHC grows, more responsibilities will be added to the nurse clinic to include Safety Control, Compliance and other programing as necessary for accreditation.

Dress Code: Nurses will present to work in clean/ironed nursing scrubs that are matching in color and fit appropriately. Appropriate SHSU T-Shirts may be worn with scrub pants. Shoes will be closed toe shoes that can be cleaned if soiled. Hair will be neat with appropriate make-up if applicable. Tattoos will be covered. Piercings will be appropriate and not distracting. On Fridays, SHSU spirit shirts can be worn with blue jeans. The director may also designate other days as casual "jeans" days based on her discretion. Costumes can be worn at the discretion of the director.

Calling In if Ill: If the nurse is unable to attend work a particular day due to illness or family emergency, the nurse must first text the charge nurse by 6:30 AM. If she does not get a response from her within the next 30 min, then she is to text the Nurse Coordinator. If the emergency or illness prolongs past that day, communication is vital to ensure proper staffing. Any days out longer than 3 days will require a doctor's note as per HR requirement.

Leaving Station: If the nurse needs to walk away from their station for a brief moment, than another nurse needs to be made aware to cover the nurse's station and patients. The provider must also be made aware. There will be no going to the counseling center, conference room or upstairs break-room except at lunchtime unless the nurse is on official business.

Lunch Break: Everyone will be given an hour lunch break each day. Typically, if the nurse is scheduled from 8-5 then the lunch break is from 12-1. If the work day is scheduled from 9-6 then the lunch break is from 1-2. The nurse clinic will schedule lunch break to best suit the staffing of the nurse clinic. If the nurse is not able to get away for their entire lunch break at that particular time, the time will be given back with either leaving early a particular day or coming in later. It is up to the discretion of the charge nurse or nurse coordinator. The time will be given back that week and will not roll over unless approved by the nurse coordinator. Rarely will there be mandatory meetings during lunch. If it is not mandatory and the nurse does not want attend a function scheduled during their lunch hour that is at her discretion. If it is mandatory, the time will be given back as stated above.

Nourishment: Water is the only acceptable drink at the nurse's stations or in the triage rooms and will be in a covered cup or closed bottle. Please keep away from electronics and keyboards. Food/snacks/drinks besides water, can be kept and consumed in the nurse break area.

Nurse Break Area: Located in the storage room. The communication notebook that needs to be regularly signed with new information is kept there along with the calendar for days off.

Electronics: Cell phones need to be on silent while at work. Cell phones are not to be used in front of patients or in exam rooms. Games, Facebook, Twitter, and Instagram etc. are only to be used during lunch break.

Scheduled time off during Fall and Spring Semester:

- During the fall and spring semester months, each nurse will have 1 day they can take off for errands, appointments, car maintenance etc. Vacation or sick time will be utilized based on the nature of the request. Only 1 nurse will be allowed off per day and it will be a first ask/first off policy.
- Vacation time- will be granted only at the discretion of the Director, Nurse Coordinator and Charge nurse in agreement.
- There will always be a nurse per provider *scheduled* per each day.

Scheduled time off during Holiday Breaks and Summer: Time off will be granted in addition to University closure based on the following criteria:

- Who requests time off first
- On a rotating basis—the same person will not get the same extra days off each year unless no one else requests it.
- Time off is requested 2 weeks in advance (especially if requesting more than 1 week off at a time)
- There are enough nurses to cover providers working
- There will be a minimum of 2 providers in the building during all class times and 1 when classes are closed. This can change at the discretion of the director.

Staffing when nurses are out: Reassignments will be made at the discretion of the charge nurse or nurse coordinator. If someone is out in the nurse clinic, an LVN might be assigned to work in the nurse clinic or if an LVN is out an RN may cover the LVN working for the provider. The goal is to have the clinic covered with the fewest interruptions to patient /clinic flow.

Initial Competency: Observe nurses following the above policies. If not adhering to policies a verbal

warning will be given.

On-Going Competency: If the above policies fail to be followed, a written unprofessional conduct will be initiated followed by an SPE if needed.

Scope of Supervision: Nurse Coordinator and Charge RN are available for questions.

Documentation: Nurse documents appropriately on appropriated form.

Glucose Monitoring Protocol

V. Policy

A. Glucose monitoring will be conducted to measure quantitative blood glucose level when ordered by a provider.

VI. Procedure

A. Blood glucose testing
   1. Gather supplies for glucose testing. Strips and controls are stored at room temperature. The operator's manual should be kept with the glucometer.
   2. Apply gloves
   3. Insert the test strip into the glucometer
   4. Clean the 3rd or 4th finger with alcohol. Wipe the alcohol off with a clean dry gauze and allow the area to air dry completely.
   5. Lightly press the finger from the top of the distal knuckle to the tip using the thumb to stimulate blood flow towards the sampling point.
   6. Position the lancet device along the side of the finger, so that the tip will be across the lines of the fingertip.
   7. Press the lancet firmly against the finger and activate the lancet. Discard the used lancet in the sharps container.
   8. Wipe away the first drop of blood using clean, dry gauze.
   9. Place one drop of blood that is large enough to fill the strip completely on the test strip.
   10. After 5 seconds record the displayed result.
      a. The glucometer measures glucose levels from 20-600. LO can indicate glucose less than 20 and HI can indicate glucose over 600.
   11. Remove the test strip and dispose of in the biohazard container.
   12. Clean and disinfect the glucometer after each use, using the specified Sani-Cloth Wipes
      a. Clean the area around slots and openings
         i. Do not introduce moisture into the well where the test strip is inserted.
      b. Clean the meter display
      c. Clean the entire meter surface

B. Quality control
   1. Quality control testing should be performed at the following times:
      a. The first time before meter use
      b. At least once a week
      c. When a new box of test strips is opened.
      d. If the test strip box is left open.
      e. If the test strips were incorrectly stored.
      f. If there is a question about a patient's glucose result.
      g. To check the performance of the system.
      h. If the meter was dropped.
   2. Performing a quality control test

a. Make sure the meter display is working properly
b. Check expiration dates on the test strip bottle and control bottle.
   i. When a new bottle of control solution is opened, write the date that it was opened. Discard after 3 months from that date.
c. Insert the test strip into the meter. (The meter will turn on)
d. Check that the code number on the display matches the code number on the test strip container.
e. Select the control solution to be tested. Controls are stored at room temperature.
f. Place the meter on a flat surface.
g. Remove the cap from the control solution bottle and wipe the tip with a lint-free wipe.
h. Squeeze the bottle until a tine drop forms at the tip. Touch the drop to the front edge of the yellow window on the test strip.
i. When the hourglass appears there is sufficient control solution in the test strip.
j. Wipe the tip of the bottle with lint-free gauze and replace the cap.
k. The result will appear on the display along with the control bottle symbol and flashing L.
l. Do not remove test strip. Press right arrow once to mark the result as Level 1. Press right arrow a second time to mark the result as Level 2.
m. Press and release power button to set the control lever in the meter.
n. If the result is in range **OK** and the control result alternate on the display.
i. The range is printed on the test strip container.
j. If the results do not fall within the established range, do not report any patient values until the controls are within the acceptable range.
k. Document the quality controls on the quality control log form. See Attachment A.
l. Problems and with appropriate corrective actions can be found in the operation manual and will be documented on the system maintenance log. See Attachment B

3. No calibration of the Accu-Check Performa Blood Glucose Monitoring System is required.
4. See Operator's Manual for instructions for changing the batter.

VII. **Attachments**

Attachment A: Quality Control Log
Attachment B: System Maintenance Log

IV. Reference(s)

1. Accu-Chek Performa Operator's Manual

V. Executive Actions

Executive Actions	**Date**
Approved	

Attachment A

ACCU-CHEK Performa Blood Glucose Monitoring System

Quality Control Log

Begin a new log with each new lot number of strips

Analyzer Serial Number _____

Strips	Lot #	Mfg. Exp. Date	Date Opened

ACCU-CHEK Controls	Range	Lot Number	Mfg. Exp. Date	Date Opened
Level 1	mg/dL			
Level 2	mg/dL			

Date	Control ---------- --- Level 1	Values ---------- -- Level 2	If Control values are out of range, note corrective action taken	<u>Maintenance</u> Date Cleaned & Disinfected	Initial

Attachment B

ACCU-CHEK Performa SYSTEM MAINTENANCE LOG

Analyzer Serial Number _____

DATE	PROBLEM	CORRECTIVE ACTION	INITIALS

HAND HYGIENE

XI. Policy

The SHU staff will take necessary steps to minimize the transmission of germs in the clinic by practicing proper hand hygiene practices

XII. Procedure

A. Utilize soap and water in the following situations
   1. Before, during and after patient care
   2. Before and after treating a cut or wound
   3. After using the restroom
   4. After blowing your nose, coughing or sneezing
   5. After touching an animal
   6. After touching a contaminated object or garbage
   7. If your hands are visibly dirty

B. You may use Alcohol-Based Hand Sanitizer (must contain at least 60% alcohol)
   1. Before, during and after patient care if hands are not visibly soiled
   2. If soap and water is not available
   3. When removing gloves

C. Proper Handwashing Technique
   1. Soap and Water
      a. Wet your hands with clean running water (warm or cold) and apply soap
      b. Lather your hands by rubbing them together
      c. Scrub all surfaces of your hands, including the palms, backs, fingers, between your fingers, and under your nails. Keep rubbing for **20 seconds**
      d. Rinse your hands under clean, running water
      e. Dry your hands using a clean cloth or towel then **turn off faucet with paper towel**

   2. Alcohol-Based Hand Sanitizer
      a. Apply enough product on hands to cover all surfaces
      b. Rub hands together, until hands feel dry (about 20 seconds)

XIII. References

1. https://www.cdc.gov/handwashing
2. AAAHC Standard 7.1.O

XIV. Executive Actions

Executive Actions	Date
Approved	06/24/17

Independent Double Check for High Alert Medication Administration

VIII. Policy

Independent double check prior to the administration of identified high-alert medication is a widely promoted strategy to detect and minimize errors before the medication reaches the patient. High alert medications requiring double check prior to administration will be identified by the Student Health Center Nurse Workgroup.

IX. Procedure

Prior to administration of high-alert medications, two licensed healthcare professionals will independently complete the required or expected steps preparatory for administration of the medication and compare their conclusions before the medication is drawn and administered.

A. Each licensed healthcare professional will independently review the order for the medication.
B. If both healthcare professionals agree with the order, the medication will be drawn and the dose will be verified by both healthcare professionals.
C. After verification of the dose, the medication may be administered.
D. Once the medication, dose, and amount prepared has been verified by two healthcare professionals, the independent double check process is complete, and the administering healthcare provider may proceed independently.
E. Any differences of judgement or opinion, or if any questions arise regarding the administration of a high alert medication, the issue will be brought before the nurse coordinator or a provider.
F. The independent dose verification will be documented in the health record by both parties involved in the process.

X. Attachments

None

XI. Reference(s)

2. Institute for Safe Medication Practices www.ismp.org

UPPER RESPIRATORY TRACT ILLNESS CONTAINMENT MEASURES

XV. Policy

The SHC staff will take steps to reduce the spread of upper respiratory tract illness.

XVI. Procedure

A. Front Office

If an individual presents to the SHC exhibiting or complaining of high fever and/or cough, the front office staff will

1. ask the individual
   a) to place a blue mask over face and
   b) sit in an area of the lobby that is somewhat secluded.
2. notify clinical staff of the individual's condition.

B. Clinic Staff

Once notified of an individual presenting with high fever and/or cough, the staff member will expedite seclusion of the patient into an exam room, gather vital signs, collect any other clinically pertinent data, and notify a provider.

C. Provider

1. The provider will evaluate the patient's condition and query regarding known exposures.
2. For signs of influenza (high fever, repetitive cough, body aches, vomiting), the provider will
   a) Consider ordering a flu test on a case-by-case basis,
   b) Advise the patient to self-quarantine for 7 days,
   c) Offer influenza prophylaxis to exposed companions,
   d) Complete the influenza reporting packet for confirmed or probable cases of flu, and
   e) Deliver completed reports to the clinic director by the end of the same day which will be forwarded to the Vice President of Student Services (VPSS) and Residence Life.
3. For other potentially infectious conditions, the provider will provide treatment and recommendations as clinically indicated.

XVII. Reference

www.cdc.gov/flu

Condition for Receiving Information via fax: Additional outside information is sometimes required for continuity of care.

Policy of Protocol: When information intended for the student's medical record is received over the fax machine it will be logged in by the person that is responsible for that fax machine. The log will be in the "T" drive under "Patient Information Received over Fax Machine". Include the patient name, Sam ID ", and where the information is coming from. It will then be given to the nurse assigned to the patient's provider. The nurse will scan the new information into the patient record. If it is information that was requested by an order it should be attached to the order. If it is not associated with an order place it under "scanned documents" on the patient summary page. The nurse should then open a progress note with documentation of what information was received and forward it to the provider. The paper copy can then be shredded.

Exceptions: None

Contraindication: None

Precautions: None

Initial Competency: Observe experienced nurse implementing this procedure, demonstrate successful use of procedure at least 3 times under direct supervision, and submit 3 charts to be audited by Charge RN or Nurse Coordinator.

On-Going Competency: Chart review of this procedure in the ongoing audits of charts and Quality Management of the SHSU SHC.

Scope of Supervision: Providers are available at all times to clarify questions.

Documentation: Nurse documents appropriately in EMR according to policy of SHSU SHC.

This protocol shall remain in effect for all patients of the Sam Houston State University Student Health Center until rescinded.

Pharmacy Inventory

I. Policy

The pharmacy staff along with supporting student health center staff will conduct a full inventory of the medications stocked in the pharmacy at the end of each long semester (Fall/Spring).

II. Procedure

A. The pharmacist will contact the director to initiate inventory.
B. The director will assign staff members to verify counts.
C. The inventory may be taken either as of the opening of business or as of the close of business on the inventory date. The inventory record shall indicate the time of day.
D. The pharmacist will generate the computerized inventory and a designated scribe will match it against the physical counts done by the appointed counting staff.
E. The inventory shall include all stocked medications and devices located in the pharmacy.
F. The inventory of Schedule I or II controlled substances shall be listed separately from the inventory of Schedule III, IV, and V controlled substances.
G. The inventory report along with a summary will be submitted to the director upon completion of the inventory. The summary report will include a list of any discrepancies and causes along with any expired medications discovered.
H. The inventory shall be maintained in a written, typewritten, or printed form; and shall be kept in the pharmacy available for inspection for 2 years. The inventory shall be filed separately from all other records.

III. Attachments

None

IV. References

1. Texas Administrative Code Title 22 Part 15 Chapter 291 Subchapter A Rule §291.17
2. AAAHC Chapter 11 Pharmaceutical Services, standards A and C

Laboratory Ordering Protocol and Standing Order

Policy: 1/2014-kc rev 6/15-kc

Condition for Standing Order: Student request for certain laboratory testing, based either on concern from the student, for outside agency or medical provider.

Policy of Protocol: The nurse (RN or LVN) will implement this protocol for specific laboratory testing. This list will be limited to ordering the following. This will allow the nurse to order the following laboratory testing, educate the student, and facilitate additional follow-up with a provider with students with positive results.

- urine pregnancy testing
- HIV testing
- immunization titers
- drug screening for employment
- outside orders from another agency
- Repeat blood work with order in chart
- STI panel testing (see policy for additional guidelines.)

Criteria for testing: Student must request testing for urine pregnancy and HIV and must have a written order for the others either from employment agency, school enrollment protocol, or from medical provider.

Contraindication: If student does not have appropriate documentation to fulfill the request, this must be obtained prior to test being order. The only exception is pregnancy testing and HIV testing.

Precautions: None

Administration of standing order:

The nurse will order the appropriate labs after confirming the ordering source. The labs will then be routed through to the provider for evaluation of the results. The only exception is with urine pregnancy test, the nurse may give the results to the patient at the time of the visit.

- If pregnancy testing is for the initiation of OCP or DPMA, then the order needs to be stated previously on the chart by the initial provider with the orders routed back through the same provider DPMA initiation standing order.
- If the patient is requesting an HIV test or urine pregnancy test, the nurse will utilize the nursing process and determine if testing is needed based on information of patient history and symptoms. The nurse will order these tests if indicated and then will notify patients of the results if urine pregnancy. The HIV results will be routed through the designated provider.
- If a patient makes a unique request for laboratory order, the nurse will collaborate with a provider to see if the testing is necessary. The nurse will order the tests as indicated by the designated provider.
- If the patient is requesting titers for pre-employment or student entering a health field program for clearance. The nurse orders titers for communicable disease, including hepatitis B, measles, mumps, rubella, and varicella as indicated. The labs will be then routed to the designated provider for evaluation. The nurse will contact the patient with the results once reviewed by the provider.

Initial Competency: Observe experienced nurse implementing this procedure, demonstrate successful use of procedure at least 3 times under direct supervision, and submit 3 charts to be audited by Charge RN or Nurse Coordinator.

On-Going Competency: Chart review of this procedure in the ongoing audits of charts and Quality Management of the SHSU SHC.

Scope of Supervision: Providers are available at all times to clarify questions around ordering labs under this standardized procedure.

Documentation: Nurse documents appropriately in EMR according to policy of SHSU SHC.

This protocol shall remain in effect for all patients of the Sam Houston State University Student Health Center until rescinded

Maintenance of Pharmacy Records

I. Policy

Pharmacy records are maintained to ensure the control and safe dispensing of drugs in compliance with federal and state laws as well as university policy.

II. Procedure

A. Prescription hard copy files will be maintained for 10 years after date of graduation as required by university policy.
B. Invoices, annual inventories, drug return records, temperature log and clinic requisitions are to be maintained 2 years.
C. Log book & log book addendum of pharmacy staff signature will be maintained for 7 years.
D. Medication samples will not be stored in the pharmacy. Clinical staff are responsible for records required for medication sample.

III. References

1. AAAHC Chapter 11 Pharmaceutical Services, Standard 11.D.
2. Texas Administrative Code Title 22 Part 15 Chapter 291 Subchapter B Rule 291.34
3. Texas Administrative Code Title 22 Part 15 Chapter 291 Subchapter B Rule 303.3
4. University Records Retention

IV. Executive Actions

Executive Action	Date
Approved	July 6, 2017

Medication Administration Procedure

I. Policy

Registered nurses (RN's) licensed vocational nurses (LVN's) and medical assistants (MA's) are able to administer medications, utilizing the six rights of medication administration, at the student health center via the following administration routes: Oral, intramuscular, subcutaneous, intradermal, inhaled, and topical.

II. Procedure

A. Oral medication administration
   1. Verify the order for the medication.
   2. Assess the patient for allergies to the ordered medication.
   3. Obtain the medication from the medication room and verify the medication and dose with the order, place medication in a medication cup.
   4. Identify the patient using their name and Sam ID.
   5. Administer the medication as ordered.
   6. Document the medication administration in the order manager in the electronic health record.

B. Parenteral medication administration (intramuscular, subcutaneous, intradermal injections)
   1. Verity the order for the medication.
   2. Assess the patient for allergies to the ordered medication.
   3. Obtain the medication from the medication room and verify the medication and dose with the order.
   4. Select the appropriate syringe and needle size.
   5. Wipe the surface of the vial with alcohol if drawing from a vial, attach appropriate needed to pre-filled syringe and expel any air from the pre-filled syringe.
   6. Draw up the ordered medication into the syringe, expelling any air in the syringe.
   7. Utilize safety device to protect the needle or re-cap the needle using a one hand scoop method.
   8. Identify the appropriate site for injection based on the type of injection administered.
      a. Intramuscular injection sites and landmarks
         (1) Deltoid: Find the acromion process then four fingers down, but above the axillae
         (2) Vastus Lateralis: The location is halfway between the area just above the knee and the greater trochanter on the lateral aspect of the leg.
         (3) Ventrogluteal: Place the palm of the hand at the greater trochanter, point the thumb toward the groin and index finger to the anteriorsuperior iliac spine and extend the middle finger back along the iliac creast, creating a "V"
      b. Subcutaneous Injection sites
         (4) Posterior upper arms
         (5) Abdomen-avoid one inch from the umbilicus and 1 inch from existing scars
      c. Intradermal Injection sites

(6) Inner forearm

(7) Upper back

9. Gloves are encouraged for injections but not required unless there is contact with body fluids or open lesions on the hands.
10. Clean the area with alcohol and allow to dry
11. Using a 90 degree angle inject the medication into the muscle for intramuscular injections, using a 45 degree angle inject the medication into the subcutaneous tissue and using a 5-15 degree angle inject the medication intradermally.
12. When administering intradermal medications notice that a bleb appears on the skin surface.
13. Document the medication in the order manager in the electronic health record.
14. Monitor patient after injections for 15 minutes after intramuscular injections of medications and 30 minutes after subcutaneous injections for allergy injections.

C. Topical medication administration
1. Verify the order for the medication.
2. Assess the patient for allergies to the ordered medication.
3. Obtain the medication from the medication room
4. Apply gloves
5. Administer the medication as ordered.
6. Document the medication administration in the order manager in the electronic health record.

D. Inhaled medication administration
1. Verify the order for the medication.
2. Assess the patient for allergies to the ordered medication.
3. Obtain the medication from the medication room.
4. Administer the medication.
5. Have the provider re-assess the patient as needed
6. Document the medication administration in the order manager in the electronic health record.

(8)

(9)

I. Attachments

None

II. References

Potter and Perry Fundamentals of Nursing 8th edition

Nebulizer Machine Maintenance Procedure

III. Policy

The nurse or medical assistant (MA) will ensure proper cleaning and maintenance of the nebulizer machine.

IV. Procedure

A. Each nebulizer machine should be wiped down after each use and weekly.
B. The nebulizer filter should be replaced every 6 months or sooner if the filter turns gray.
    1. Remove the filter cap by grasping it firmly and pulling it out of the unit.
    2. Remove dirty filter with fingers and discard.
    3. Replace with a new filter.
    4. Document the filter change on the Nebulizer Filter Change Checklist.

V. Attachments

1. Nebulizer Filter Change Checklist

VI. References

None

Attachment 1

Nebulizer Filter Change Checklist

Document filter change every 6 months

	1	2	3	4	5	6	7	8
Date & Initials:								
Date & Initials:								

Signature_____

Nebulizer Treatment Protocol

VII. Policy

The nurse or medical assistant (MA) will provide medication via the nebulizer when ordered by a provider.

VIII. Procedure

A. Verify the order from the provider for a nebulizer treatment.
B. Prior to administering the treatment, obtain peak flow rates, oxygen saturation, and document both in the medical record.
C. Explain the procedure to the patient including possible side effects of the medication.
D. Administration
    1. Plug the nebulizer machine into a grounded power outlet.
    2. Assemble the nebulizer parts.
    3. Connect the tubing to the air-outlet connector on the machine.
    4. Place the medication into the nebulizer cup and connect the device.
    5. Have the patient
        a. hold the device upright in his/her hand,
        b. place the mouthpiece between teeth and close mouth.
    6. Turn on the machine to start the treatment.
    Note: The nurse or MA will supervise the patient if severely compromised with wheezing or coughing. Also, monitor closely if the heart rate is greater than 100.
    7. Direct the patient to inhale deeply and slowly through the mouth as the aerosol begins to flow then exhale. Patient should inhale and exhale through the mouthpiece.
    8. If the treatment must be interrupted, turn the power switch off.
    9. Once all of the medication has been inhaled, turn off the machine and offer the patient fluids to drink.
    10. Obtain post-treatment peak flow rates, oxygen saturation, and respiratory rate. Document measurements in the medical record.
    11. Notify the provider to re-assess the patient.
    12. Discard the tubing and mouthpiece. If repeat breathing treatment is anticipated in the near future, can save personal equipment in clean ziplock.
    13. Unplug the nebulizer machine and wipe down with germicidal wipes after each use and as per Nebulizer Machine Maintenance Protocol SHC 00.0.

IX. Attachments

None

X. References

None

Needle Stick or Other Sharps Injury

I. Policy

Any employee who receives a needle stick or other sharps injury must immediately comply with the procedures listed below to facilitate prompt treatment and documentation.

II. Definitions

A. **Employee**-Any person employed, contracted, or volunteering services at the SHC.
B. **OSHA**-Occupational Safety and Health Administration
C. **Student**-Any person enrolled as a student at SHSU and qualifying for services at SHC who is not also employed by SHC.

III. Procedure

A. The injury should be immediately treated as clinically appropriate. For instance, the injury and surrounding area should be washed with soap and water. Hemostasis should be attained as quickly as possible.
B. After receiving necessary first aid, the recipient will immediately report the needle stick to supervisor.
C. A provider will examine the recipient, determine any possible ill effects, and take all necessary precautions immediately. If the employee refuses examination, the employee should sign the Informed Refusal of Post-exposure Medical Evaluation form provided by the Infection Control Officer or Nurse Coordinator.
D. If the needle or sharp was contaminated and/or came in contact with a patient prior to the injury, the Infection Control Officer or Nurse Coordinator will complete both the OSHA Bloodborne Exposure Incident Report and the OSHA Sharps Injury Report.
E. The clinic may provide the following testing of the source patient and employee at no charge:
    1. Source Patient-Baseline testing of HIV, RPR, HCV and Hepatitis B antibodies or antigen. Testing the source patient requires written consent. The OSHA Consent to Draw Blood and Test Blood (Source Patient) form will be provided by the Infection Control Officer or Nurse Coordinator.
    2. Employee-Testing of HIV, RPR, HCV and Hepatitis B antibodies or antigen on the day of the initial incident, followed by 3 months, 6 months and 1 year.
F. If the employee wants to start prophylactic anti-virals, the employee should contact the Department of State Health Services (DSHS) or private medical provider.
G. The Clinic Director and Director of Medical Services will be notified on the same day the needle stick incident occurred.
H. All needle stick or other sharps injury incidents will be entered on the Sharps Injury Log by the Infection Control Officer.
I. The Infection Control Officer will complete the SHC Sharps Injury Follow Up form (Attachment A) to document completion of recommended testing and any treatment rendered to active employees for up to twelve (12) months following the injury.
J. If a student gets a needle stick or other sharp injury while performing an internship or clinical rotation in a setting other than the SHC, the SHC will perform a courtesy draw

for baseline testing. The student will then be referred to DSHS or private medical provider for future testing and consideration of possible anti-virals.

IV. Attachments

A. SHC Follow Up to Blood and Body Fluid Exposure

XVIII. IV. References

1. OSHA Compliance Manual 2017.

SHC Follow Up to Blood and Body Fluid Exposure

Describe the circumstances under which the exposure occurred:

XIX. Student/Employee

1. What body fluid was involved?
2. Route of exposure:
   ( ) needle stick
   ( ) intact skin ( ) non intact skin
   ( ) eyes ( ) mouth ( ) nose
   ( ) other
3. What device caused the injury?

XX. Source Patient

1. Is the source patient known? ( ) yes ( ) no
2. Is Hepatitis B Surface Ag status known? ( ) yes ( ) no
3. Is Hepatitis C Ab status known on the patient? ( ) yes ( ) no
4. Is HIV status known? ( ) yes ( ) no
5. Liver function available prior to exposure? ( ) yes ( ) no
   Results_____ Date collected _____

XXI. Student/Employee

1. Hepatitis screen done on student/employee? ( ) yes ( ) no
   Results: Hepatitis B Ag: _____ Hepatitis B Ab: _____ Hep C Ab_____
2. Liver Function tests done? ( ) yes ( ) no
   Results: _____Date collected_____
3. HIV test done? ( ) yes ( ) no
   Results: _____Date collected_____
4. RPR testing done? ( ) yes ( ) no
   Results: _____Date collected_____
5. Hepatitis B Vaccine series completed? ( ) yes ( ) no
   If not, declination form signed? ( ) yes ( ) no
6. Referral made to PCP or ER for prophylactic HIV medications? ( ) yes ( ) no
7. Referral made to PCP or er for future testing and guidelines? ( ) yes ( ) no

Follow Up

1. Did student/employee start prophylactic HIV medications? ( ) yes ( ) no
   If yes, what _____

2. Baseline results:
   HIV_____ RPR _____ HCV_____

   HBV_____ LFT_____

3. 3 months
   HIV_____ RPR _____ HCV_____

   HBV*_____ LFT_____

4. 6 months
   HIV_____ RPR _____ HCV_____

   HBV*_____ LFT_____

5. 12 months

   HIV_____ RPR _____ HCV_____

   HBV*_____ LFT_____

*Note: If immune to HBV no need to retest

Electronic Health Records (EHR)

I. Policy

Electronic Health Records and all health care documentation should be treated confidentially in a manner complying with state and federal regulations (e.g., HIPAA). Student Health Center (SHC) staff will maintain primary responsibility for the care, distribution, protection, and utilization of the health records.

II. Procedure

A. Paper Records
   1. Personal Health Information (PHI) recorded on paper should be filed and stored in a locked area that is protected from unauthorized individuals.
   2. Paper records should be scanned into the patient's electronic medical record as soon as possible.
   3. Once scanned into the EHR, the paper copy may be destroyed in a manner appropriate for confidential records as long as the paper copy does not have additional anticipated purpose.

B. Electronic Records
   1. Electronic devices used to access the EHR should be locked each time the staff member steps away from his or her work area.
   2. Patient records should **never** be left unattended or in view of unauthorized individuals.

III. Electronic Medical Record Content

A. Patient Demographics
   1. Contact information
   2. Insurance
   3. Patient student Identification number
   4. Billing Method
   5. Communication Preference
   6. Consent to treat/Financial policy
   7. Nursing Consent (for nursing student)

B. Patient Summary
   1. Allergies
   2. Current Medication
   3. Social History
   4. Medical History
   5. Family History
   6. Surgery History

C. Intake
   1. Vital Basic
   2. Female Exam Intake

3. Intake
4. Orthostatic Vitals
5. Peak Flow
6. Vision Screen Intake

D. SOAP Note

1. Subjective
2. Objective
3. Assessment
4. Plan

E. Progress Note

IV. Attachments

None

V. References

1. AAAHC Chapter 6 “Clinical Records and Health Information” , Standards A, C, E, and P
2. Health Information Portability and Accountability Act
3. https://www.hhs.gov/hipaa/for-professionals/privacy/index.html
4. https://www.cdc.gov/mmwr/preview/mmwrhtml/m2e411a1.htm

VI. Executive Actions

Executive Action	Date
Approved	07/11/17

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SORE THROAT/PHARYNGITIS/TONSILLITIS DMG

Policy: This DMG will provide a general guideline for evaluation and management of patients with sore throats.

Procedure:

A. Bedside Assessment:
   1) Subjective: Query the patient to describe symptom severity, duration, and progression of symptoms along with pertinent complaints of fever, cough, earache, headache, or sinus pressure.
      a. Include contact with others who have or may have had similar symptoms.
      b. Inquire regarding recent medication use or other self-treatments.
      c. Inquire regarding relevant conditions particularly asthma or tobacco use.
      d. Inquire regarding also impact of symptoms on sleep, work, and class attendance.
   2) Objective: Review vital signs for fever, tachycardia, tachypnea, or hypoxemia.
      a. Perform HEENT/Chest/Cardiac exams with particular attention to oropharynx and cervical nodes.
      b. Note any atypical features such as ulcers, vesicles, suppuration, or enlargement of tonsils if present.
      c. Particularly note if stridor, trismus, dysphonia, or drooling are present.

***Pattern Caveats: Tonsillar abscess, Mononucleosis, HSV, Epiglottitis, HFM, Herpangina.

B. Evaluation:
   1) Consider submitting a throat culture if fever >100.5, pharyngeal erythema, and tender cervical adenopathy are concurrently present.
   2) Consider obtaining a monospot+CBC if fever >101.5, excessive fatigue, or unusually enlarged cervical nodes are present.
   3) Request urgent physician evaluation or prompt ER referral if any of the following findings are present:
      a. Dysphonia,
      b. Trismus,
      c. Stridor,
      d. Asymmetric tonsillar enlargement, or
      e. palatal edema.

C. Management:
   1) Document and treat as a presumptive viral illness if none of the above thresholds are met.
   2) Self care may include warm gargles
   3) Analgesics can be offered as needed.
   4) Consider emperically treating for strep while awaiting culture results if patient has worsening symptoms, +exposure history, or fever+pharyngeal erythema+cervical adenopathy.
      The presence or absence of tonsils won't generally alter care.
   5) Preferred Medication choices:
      a. Amoxil 500mg TID or 875mg BID x10 days (or Augmentin).

   b. PenVK 500mg QID x10 days.
   c. Duricef 250-500mgBID x 10 days.
6) Medication choices if limited by drug allergies:
   a. Zithromax Z-Pack or 250 mg qd x6-7 days.
   a. Biaxin 250-500mg BID x7-10 days.
   b. Levaquin 500mg qd x7 days.
   c. Clindamycin 300mg TID x 5-7 days.
7) Follow up throat culture results and medication response in 2-3 days.
8) Review Monospot/CBC results with patient, if performed and manage accordingly if positive. Consider retesting in 1 week if negative but clearly symptomatic. Persons with suspected or confirmed mononucleosis typically need leave from class, work, and especially contact sports. Offer supportive care measures and follow-up.
9) Written and or verbal advisories for self-care are appropriate particularly regarding persistent or worsening symptoms.

Nurse Orders Procedures Policies Protocol and StandingOrder

Policy: 1/2014-kc rev 6/15-kc

Condition for Standing Order: Student needing nurse treatment prior to leaving the clinic. These may include; elastic wrapping, splint applying, crutch sizing, suture or staple removing, wound care and bandaging.

Policy of Protocol: It is the policy of the SHC to provide the following treatments as ordered by the provider. Registered Nurses working in triage are able to perform these procedures under the triage standing order protocol. All nurses who have demonstrated competency are able to complete these tasks. As the SHC services many students from diverse areas and complaints these tasks are necessary to offer as many do not have transportation, nor know how to do these tasks. In turn, this affords many different education experiences for the student regarding their health and well-being.

Criteria for protocol: All students in need of nursing procedure at the discretion of the provider or the need of a triage patient.

Exceptions: None

Contraindication: None

Precautions: None

Administration of standing order: Any Nurse or medical assistant who is trained and shows competency except for suture/staple removal. This will be performed by licensed personnel only.

Procedure:

Elastic Wrapping: This procedure is performed following an injury to stabilize the joint or muscle area.

- Start at most distal part of the injury
- Wrap around once to anchor
- Begin wrapping with slight tension overlapping previous wrap and just above injury then begin to wrap back down over the injury.
- Make sure to check for circulation by evaluating, color of skin, distal pulses and capillary refill.
- Instructions given on when to remove, watching for circulation problems and how to rewrap.
- Document in EMR

Splint applying: Similar to elastic wrapping. This is performed to stabilize an injured joint. More ridged then elastic wrapping.

- Splints applied at SHC include: finger, wrist, ankle

- Use best size and shape to stabilize the joint as intended.
- If unable to attach the splint, use either tape or elastic wrap in proper manner

- Check circulation by evaluating, color of skin, distal pulses and capillary refill.
- Instructions given on when to remove, watching for circulation problems and how to reapply splint.
- Document in EMR

Suture/ Staple Removal: This is performed by licensed nurse personnel only after evaluation from a provider prior to removal of sutures or staples.

- Verbal or written order given by a provider on day of removal of sutures or staples.
- Start with instructing patient on the task at hand.
- Use aseptic technique utilizing a sterile suture or staple removal kit.
- Start with taking out every other suture or staple. If unsure about the wound, notify provider.
- Apply steri-strips with benzocaine if needed.
- After use of sterile instruments, place in cleaning receptacle for autoclaving or dispose of properly if disposable.
- If at any time wound begins separating, then cover with moist gauze and notify provider immediately.
- Instruct patient on keeping area clean and about removing steri-strips if they were applied.
- Document in EMR.

Crutch sizing: SHC provides crutches for students unable to bear weight on extremity. These can be issued following protocol if patient presents to the SHC requesting crutches with obvious injury. If nurse is unsure, she/he can always collaborate with provider.

- Start with measuring the height of the patient. If unable to get height, verbal height is ok or can measure from fingertip to fingertip.
- Collect the right size crutches for their height and adjust accordingly.
- Make sure there are no loose pieces or rubber ends that need replacing.
- Have the patient stand with the correct height crutches and adjust if needed. Should be about 2 inches below the axillary area.
- Instruct patient on proper crutch walking technique and evaluate stableness of use.
- Document in EMR.

Wound cleaning and bandage applying- If the wound is superficial it can be evaluated, cleaned and dressed by competent trained nurse. If the wound is from a procedure from an outside clinic or provider, need to have orders from the initial place and be evaluated by a provider first.

- Determine what kind of wound it is. Superficial, more in-depth, or from an outside agency or surgery
- If it is superficial, may clean with warm soap and water, saline cleaning spray and/or betadine. Pat dry, and may apply bactroban if needed. Dress with sterile gauze, no stick gauze, band aids as appropriate. Have them follow-up with provider if needed.
- If a deeper injury or laceration, have it evaluated by a provider prior to dressing.
  The provider will instruct on which type of bandage is necessary. The wound can be cleaned initially as stated above.

- If from an outside clinic, surgery or procedure, the clinic needs descriptive orders for treatment of the wound and release from the initial clinic. Also a provider needs to evaluate and document the wound prior to initial bandage treatment and wound cleaning.
- Instructions given to patient of how to keep wound clean, what is needed from the store and signs to watch for infection
- If at any time wound is becoming worse, having drainage or foul odor, the provider is to be notified.
- Documentation in EMR of precise wound description with measurements, color, drainage and any other pertinent information.

Initial Competency: Observe experienced nurse implementing this procedure, demonstrate successful use of procedure at least 3 times under direct supervision, and submit 3 charts to be audited by Charge RN or Nurse Coordinator.

On-Going Competency: Chart review of this procedure in the ongoing audits of charts and Quality Management of the SHSU SHC.

Scope of Supervision: Providers are available at all times to clarify questions around the above procedures and protocols.

Documentation: Nurse documents appropriately in EMR according to policy of SHSU SHC.

This protocol shall remain in effect for all patients of the Sam Houston State University Student Health Center until rescinded.

Nurse Order Manager Policy

XI. Policy

The nurse order manager will be used to receive a provider order, document completion of the order, and charge patient account.

II. Procedure

E. Orders will be entered into the patient's chart within the electronic health record (EHR) in one of the following manners:
   a. The provider enters the order directly into the EHR,
   b. A nurse enters a verbal order from the provider into the EHR, or
   c. In the event the EHR is not operational, the provider will make written documentation of the order and the nurse will enter the order into the EHR once it is again operational.

F. The nurse or medical assistant (MA) will locate active orders in the nurse order manager.

G. Upon completion of an order, the nurse or MA will document completion in the nurse order manager as follows:
   a. Update the order status to *Order Completed*,
   b. Complete the order template if applicable, and then
   c. Enter charge.

III. Attachments

None

IV. References

Education for Medicat Users-Order Management-Introduction to Orders Management
https://client.medicat.com/details

Nurse's Station and Exam Room Inventory

Policy: 9/2014 rev 6/15-kc

Policy of Protocol: It is the policy of the SHC clinic to have exam rooms and nurse's stations essentially the same. This is to ensure that any personnel can find supplies needed no matter where they are assigned to work. This is also to assist with supplies and to ensure items are used prior to expiration if possible and that rooms are not overstocked to prevent irresponsible use of SHC monies.

Exceptions: If a provider has a specific item or document it can be added but others cannot be taken away.

Contraindication: None

Precautions: None

Equipment: Inventory list that is added for exam rooms and nurse's Station

PROCEDURE:

Exam Rooms

- Each exam room will have essentially the same items and the same number of items needed for proper flow of the room. (appendix 6)
- Each week the rooms will be examined by the nurse assigned and the appropriate paper work will be initialed to indicate the room is stocked appropriately. The paper will be kept in the communication book. Restock the room with the appropriate supplies keeping in mind the typical use for the room and plan accordingly. i.e. more speculums in a women's health room and more ace wraps in a walk in room. (appendix 6)
- One room will be randomly chosen per month and PRN to be audited. First offense will be a verbal reprimand. Second will be an unprofessional write up with the third being an SPE. (appendix 5)

Nurse's Station

- Each nurse will have their "personal" area to maintain appropriately. Tasteful decorations are allowable with family photos if not a distraction to the rest of the nurse's station.
- A hanging folder box will be in each nurse's station with needed documentation. This will include: OTC suggestion form (on blue paper); OTC order form; SOAP notes (if computer is not available), nurses' notes (if computer is not available for progress notes), record release, excuse notes, outside doctor list. Other items may be added but the above must be available to all staff

and providers.

- Other items will be stocked as listed on *Inventory for Nurse's Station Supply List.* (appendix 3)
- Weekly the nurse's station will be examined by the nurse typically assigned to that station. The appropriate paper work will be initialed to indicate the station is stocked appropriately. This paper will be kept in the communication book.
- Restock the station as needed.
- One nurse's station will be chosen randomly per month and PRN to be audited. First offense will be a verbal reprimand. Second will be an unprofessional write up and the third will be an SPE.

Initial Competency: Exam Rooms and Nurse's station will be audited and examined as stated above.

On-Going Competency: Monthly and PRN audits and documented appropriately.

Scope of Supervision: Nurse Coordinator and Charge nurse is available to answer questions.

Documentation: On the inventory form as indicated above in appendices 3-6

This protocol shall remain in effect for all patients of the Sam Houston State University Student Health Center until rescinded

EHR Summary Page

I. Policy

The Patient Summary section of the Electronic Health Record (EHR) should be reviewed and updated with the patient at each clinic visit. After doing so, medical personnel should document in the EHR that the information has been reviewed.

II. Procedure

Medical personnel should review the following information in the patient summary with the patient at each visit:

1. Allergies
    1. Medication allergies,
    2. Food allergies, or
    3. If no allergies, mark NKA.
2. Current Medication
   Medications the patient is prescribed and over-the-counter medications the patient is taking should be noted with the correct dose and frequency.
3. Medical History
   Document any chronic illness or current conditions the patient has.
4. Surgical History
   Document any surgeries the patient has had.
5. Family History
   Document chronic illnesses with which the patient's family (parents, siblings, and grandparents) has been diagnosed.
6. Social History:
    1. Alcohol use,
    2. Tobacco use,
    3. Recreational drug use, and
    4. Screen for potentially abusive relationships.
7. Additionally, document any educational information offered.

III. Attachments

1. None

IV. References

1. AAAHC Chapter 6, standard O.1.

V. Executive Actions

Executive Action	Date
Approved	July 7, 2017

Peak Flow Testing Protocol

I. Policy

Registered nurses (RNs), licensed vocational nurses (LVNs) and medical assistants (MAs) who have demonstrated competency may administer peak flow testing to patients with respiratory symptoms or disease.

II. Procedure

A. Contraindications and Cautions
   1. Peak flow is contraindicated for patients with severely compromised respiratory function or oxygen saturations below 96%.
   2. Use caution with patients with coughing or wheezing.

B. First, explain the procedure to the patient.

C. Before each use, verify the sliding pointer on the Peak Flow Meter (PFM) is on the zero mark.

D. Remind the patient that if he/she coughs during a measurement, it will need to be repeated.

E. Ensure the patient's mouth is free from food, gum or other foreign bodies.

F. Have the patient stand up straight and hold the PFM by the handle.

G. Instruct the patient to seal their lips and teeth tightly around the mouthpiece.
   1. Tell the patient to take a deep breath and then blow out hard and fast through the mouthpiece.
   2. Document the patient's measurement from the PFM in the health record.
   3. Reset the pointer to zero.
   4. Repeat this procedure for three readings.
   5. Ensure all measurements are recorded in the patient's medical record.

H. Notify the provider if results are less than 80% expected according to age and sex or the patient is complaining of symptoms.

I. Discard the disposable mouthpiece; clean the peak flow meter with germicidal wipes.

II. Attachments

1. Peak Flow Chart

III. References

1. http://www.lung.org/lung-health-and-diseases/lung-diseaselookup/asthma/living-with-asthma/managing-asthma/measuring-your-peak-flow-rate.html
2. http://www.sh.lsuhsc.edu/fammed/outpatientmanual/peakflowtables.htm

Attachment 1

Peak Expiratory Flow Rates

child and adolescent female: 6 - 20 years of age

Height (in)	42	46	50	54	57	60	64	68	72
Age: 6	134	164	193	223	245	268	297	327	357
8	153	182	212	242	264	287	316	346	376
10	171	201	231	261	283	305	335	365	395
12	190	220	250	280	302	324	354	384	414
14	209	239	269	298	321	343	373	403	432
16	228	258	288	318	340	362	392	421	451
18	247	277	306	336	358	381	411	440	470
20	266	295	325	355	377	400	429	459	489

child and adolescent male: 6 - 25 years of age

Height (in)	44	48	52	56	60	64	68	72	76
Age: 6	99	146	194	241	289	336	384	431	479
8	119	166	214	261	309	356	404	451	499
10	139	186	234	281	329	376	424	471	519
12	159	206	254	301	349	396	444	491	539
14	178	226	274	321	369	416	464	511	559
16	198	246	293	341	389	436	484	531	579
18	218	266	313	361	408	456	503	551	599
20	238	286	333	381	428	476	523	571	618
22	258	306	353	401	448	496	543	591	638
24	278	326	373	421	468	516	563	611	658

25	288	336	383	431	478	526	573	621	668

adult female: 20 - 80 years of age

Height (in)	**58**	**60**	**62**	**64**	**66**	**68**	**70**
Age: 20	357	372	387	402	417	432	446
25	350	365	379	394	409	424	439
30	342	357	372	387	402	417	431
35	335	350	364	379	394	409	424
40	327	342	357	372	387	402	416
45	320	335	349	364	379	394	409
50	312	327	342	357	372	387	401
55	308	320	334	349	364	379	394
60	297	312	327	342	357	372	386
65	290	305	319	334	349	364	379
70	282	297	312	327	342	357	371
75	275	290	304	319	334	349	364
80	267	282	297	312	327	342	356

adult male: 25 - 80 years of age

Height (in)	**63**	**65**	**67**	**69**	**71**	**73**	**75**	**77**
Age: 24	492	520	549	578	606	635	664	692
30	481	510	538	567	596	624	653	682
35	471	499	528	557	585	614	643	671
40	460	489	517	546	575	603	632	661
45	450	478	507	536	564	593	622	650

50	439	468	496	525	554	582	611	640
55	429	457	486	515	543	572	601	629
60	418	447	475	504	533	561	590	619
65	408	436	465	494	522	551	580	608
70	397	426	454	483	512	540	569	598
75	387	405	444	473	501	530	559	587
80	376	405	433	462	491	519	548	577

Reference: http://www.sh.lsuhsc.edu/fammed/outpatientmanual/peakflowtables.htm

GREEN ZONE	YELLOW ZONE	RED ZONE
80 to 100 percent of your usual or "normal" peak flow rate signals all clear.	50 to 80 percent of your usual or "normal" peak flow rate signals caution. It is time for decisions. Your airways are narrowing and may require extra treatment. Your symptoms can get better or worse depending on what you do, or how and when you use your prescribed medication. You and your healthcare provider should have a plan for yellow zone readings.	Less than 50 percent of your usual or "normal" peak flow rate signals a Medical Alert. Immediate decisions and actions need to be taken. Severe airway narrowing may be occurring. Take your rescue medications right away. Contact your healthcare provider now and follow the plan they have given you for red zone readings.

Reference: http://www.lung.org/lung-health-and-diseases/lung-disease-lookup/asthma/living-with-asthma/managing-asthma/measuring-your-peak-flow-rate.html

Prescription counseling

V. Policy

The pharmacist counsels on all new prescriptions. Patients can request counseling on refills and over the counter medications.

VI. Definition

Counsel - the discussing of medication by a pharmacist to a patient to optimize drug therapy.

VII. Procedure

A. The counseling area will maintain the confidentiality and privacy of the pharmacist /patient communication.
B. Counseling information can include but is not limited to the following:
    i. How and when to take the medication.
    ii. What the medication is intended to do.
    iii. What side effects may occur and what to do about them.
    iv. Any special storage need of the medications.
    v. What other medications that can or cannot be taken with the new medication.
    vi. What foods and drinks to avoid.
    vii. Answer any questions that may arise.
C. Actions such as gathering patient's information, quoting drug prices, telling a patient that his or her medication is ready, or indicating to a patient that we do not have a particular drug does not constitute counseling a patient.
D. Pharmacy technicians are not allowed to counsel or advise patients.

VIII. Attachments

None

IX. References

Texas Administrative Code Tile 22 Part 15 Chapter 291 Subchapter B Rule §291.33

X. Executive Actions

Executive Action	Date

Pharmacy Environment

XI. Policy

The pharmacy shall be arranged in an orderly fashion and kept clean. All required references shall be current and organized.

XII. Procedure

A. The custodial staff will provide routine cleaning such as trash removal, floors swept and mopped and light dusting only when pharmacy staff is present.
B. Each employee will be responsible for keeping their area clean and organized as well as share in the responsibility for common areas. The following are some examples of what is expected at all times:
    1. A clean, unobstructed pharmacy drop off area (window).
    2. Counters are cleaned with alcohol throughout the day.
    3. Counting trays are cleaned with alcohol to remove residue left from tablets to prevent cross contamination as needed throughout the day.
    4. Workstations, shelves and files are neat and orderly making for easy retrieval of necessary items.
C. Medications shall be stored under proper condition with regard to light, moisture, and temperature.
D. The reference library will include but is not limited to the following:
    1. Texas Pharmacy Acts & Rules
    2. Texas Dangerous Drug Acts
    3. Texas Controlled Substance Acts and Rule
    4. Federal Controlled Substance Acts and Rule
    5. Reference Text: Facts & Comparison
    6. Basic antidote chart (Poison Control 1-800-222-1222)
    7. Pharmacy technician training manual

XIII. Attachments

None

XIV. References

1. AAAHC Chapter 11 Pharmaceutical Services Standard A
2. Texas Administrative Code Title 22 Part 15 Chapter 291 Subchapter B Rule §291.33
3. Texas Administrative Code Title 22 Part 15 Chapter 291 Subchapter B Rule §297.6

XV. Executive Actions

Executive Action	Date
Approved	July 17, 2017

Pharmacy Security

Measures are in place to ensure the control of drugs.

I. Procedure

A. Keys
   1. Electronic cards and overhead doors aid to secure the pharmacy.
   2. The pharmacist is the only person granted electronic access to the pharmacy entrance doors.
   3. The pharmacist maintains a key to the pharmacy unless otherwise deemed necessary and approved in writing by the director.
   4. The prescription area is locked at all times.

B. Alarm System
   1. Arming of alarm will occur at the end of each business day.
   2. University police monitors the alarm at the pharmacy.
   3. Documentation of alarm testing will be stored on the T-Drive.

C. Security Camera
   1. The pharmacy area is monitored via security cameras.
   2. University police reviews camera footage upon request from the Health Center director.
   3. The security cameras will run continuously without interruption.

II. Attachments

None

III. References

1. Texas Administrative Code Title 22 Part 15 Chapter 291 Subchapter B Rule291.33

IV. Executive Action

Executive Action	Date
Approved	July 6, 2017

Phone Call Protocol and Documentation to Patients

Policy: 1/2014-as rev 6/15-kc

Protocol: The nurse (RN or LVN) will always identify herself when calling. She should also ask the patient to identify themselves with their name and student ID before giving any information. Any conversations between nurses and patients will be documented in the EMR. If the patient has a question for the provider it should be put into the EMR progress note and routed to the provider. They can then reply, and route it back to the nurse.

Criteria for phone conversations with students: All communication between students and SHC will be confidential, and documented in the EMR.

Exceptions: None

Contraindication: None

Precautions: None

Initial Competency: Observe experienced nurse implementing this procedure, demonstrate successful use of procedure at least 3 times under direct supervision, and submit 3 charts to be audited by Charge RN or Nurse Coordinator.

On-Going Competency: Chart review of this procedure in the ongoing audits of charts and Quality Management of the SHSU SHC.

Scope of Supervision: Providers are available at all times to clarify questions around ordering labs under this standardized procedure, results, and/or recommendations pertaining to lab results.

Documentation: Nurse documents appropriately in EMR according to policy of SHSU SHC.

This protocol shall remain in effect for all patients of the Sam Houston State University Student Health Center until rescinded.

Pregnant Patient Triage Protocol

XII. Policy

Registered nurses will triage pregnant patients who call or come into the clinic with identified non-pregnancy related medical complaints.

XIII. Procedure

A. In the event that patient calls the SHC for an appointment and discloses that she is pregnant, the phone call will be transferred to an RN.
   1. The RN can schedule an appointment with a provider for a routine, non-pregnancy related health issue.
   2. If the patient has any of the following conditions, the RN will instruct the patient to go directly to the emergency room and notify the OB/GYN:
      a. Vaginal bleeding,
      b. abdominal or pelvic pain,
      c. menstrual like cramps or contractions,
      d. severe nausea and vomiting,
      e. shortness of breath,
      f. severe headache or blurred vision,
      g. chest pain,
      h. swelling of the face or lower extremities,
      i. high fever (temperature >101),
      j. urinary symptoms,
      k. falls or injury.

B. In the event a pregnant patient walks into the SHC with the following health complaints, the RN will triage the patient and consult with a provider.
   1. The RN will obtain the following information from the patient:
      a. LMP,
      b. date of the positive pregnancy test,
      c. weeks gestation and estimated delivery date,
      d. name and phone number of patient's obstetrician,
      e. date of the last visit to obstetrician, and
      f. a signed release of information authorizing SHC to disclose all records and information to the obstetrician.
   2. The RN will immediately notify a provider of emergent or urgent complaints including but not limited to the following:
      a. vaginal bleeding,
      b. abdominal or pelvic pain,
      c. menstrual like cramps or contractions,
      d. severe nausea and vomiting,
      e. shortness of breath,
      f. severe headache or blurred vision,
      g. chest pain,
      h. fever,
      i. urinary symptoms,

j. falls or injury

XIV. Attachments

None

XV. Reference(s)

None

Prescription Process

I. Policy

Pharmaceutical services are provided in a safe and effective manner, in accordance with ethical and professional practice and applicable to federal and state laws under the direction of a licensed pharmacists who is qualified to assume professional, organizational, and administrative responsibilities for the quality of services rendered within the SHC.

II. Definitions

NDC- National Drug Code is a unique product identifier used in the United States for drugs intended for human use.

III. Procedure

A. Prescriptions Received

Student's prescriptions written by a licensed practitioner will be filled in accordance with all applicable rules, regulations, and laws. Students have the right to fill prescriptions at the pharmacy of their choice.

B. Prescription Safety

To ensure that the drug is dispensed and delivered accurately as prescribed the dispensing process shall include drug regimen review and verification of accurate prescription data entry, packaging, preparation, and labeling.

C. Best Practice Guideline/ Filling Process

1. Station 1 (receive Rx and data entry)
   Obtain patient phone number, date of birth, allergies, health conditions, and current medications.
2. Station 2 (assembly)
   a. Prescriptions will be dispensed with correct drug, vial, and closure.
      i. first check- pull prescribed drug from stock by name/strength and NDC#
      ii. second check- check NDC# on stock bottle against NDC# on original RX. Scan barcode on prescription label against barcode of stock bottle in pharmacy software.
   b. All prescriptions will be accurately labeled and contain appropriate warnings as needed.
3. Station 3 (drug regimen review, counseling, and delivery)
   a. Review the patient's medication record to identify clinically significant
      i. known allergies
      ii. rational therapy contraindications
      iii. reasonable dose and route of administration
      iv. duplication of therapy
      v. drug/drug interactions
      vi. drug/food interactions
      vii. drug/disease interactions
      viii. adverse drug reactions

ix. proper utilization (including over utilization or underutilization)

b. Upon identifying any clinical significant conditions, the Pharmacist shall address any issues with a medical provider and document such occurrences.

c. Counseling will be conducted to improve patient compliance and understanding of their drug therapy. Verbal counseling shall be conducted in a manner that maintains the patients' confidentiality.

i. Significant information about the prescription drug will be communicated to the patient.

ii. Communications shall be reinforced with written information.

D. Prescription Pickup

1. Prescription Pickup by Owner
   a. Patient presents to pharmacy to pick up a filled prescription must identify themselves with their name and SAM ID number.
   b. The pharmacy staff confirms information.
   c. The patient will sign a prescription filled signature log.
2. Prescription Pickup by Designee
   a. The patient must verbally notify the pharmacist that he or she is unable to pick up the prescription and must designate someone to pick up the prescription.
   b. The patient will also notify the pharmacy in writing (email) who will be picking up the prescription. The email will contain the patient's Sam ID as well as the Sam ID or driver's license number of the person picking up the prescription.
   c. When the patient verbally notifies the pharmacy, the patient will be counseled on all new prescriptions and answering any questions on any refilled prescriptions.
   d. The person picking up will sign the pharmacy software system for the prescription pickup.
3. Schedule II Pickup
   a. The patient must appear in person to pick-up all schedule II controlled prescriptions.
   b. See prescription pickup by owner for details.

IV. References

1. Texas Pharmacy Law and Regulations TAC 22 291.33
2. Texas Pharmacy Law and Regulations TAC 22 291.34
3. Texas Pharmacy Law and Regulations TAC 22 291.9
4. AAAHC Standards A,B,E,J,N,P

V. Executive Actions

Executive Action	Date
Approved	July 17, 2017

Prescription Refill Policy

XVI. Policy

A. Refill requests can be received via fax or phone call from a pharmacy
B. A patient can call requesting refill for a medication previously prescribed.

XVII. Procedure

A. The nurse receiving a fax or phone call request from a pharmacy will send the information to the ordering provider for review.
B. Patient phone call refill requests will be sent to the nurse who will open a progress note that will be sent to the ordering provider for review.
C. Refill requests will be fulfilled at the discretion of the ordering provider as clinically indicated and appropriate.

XVIII. Attachments

None

XIX. Reference(s)

None

PRESCRIPTON PAD AND PAPER SECURITY

I. Policy

To protect against misuse of prescription paper and controlled substance prescription pads.

II. Procedure

A. Prescription paper is designed to prevent unauthorized copying of a completed prescription and to prevent the erasure or modification of information written on the prescription by the prescribing practitioner.
B. The bulk supply of electronic and controlled substance prescription pads should be stored in a locked area.
C. Prescription paper should not be left unattended.
D. Pre-signed and postdates prescriptions are prohibited.

III. Attachments

None

IV. Reference

1. Texas Administrative Code Title 22 Part 15 Chapter 291 Subchapter B Rule §291.34

Quality Management Plan

I. Policy

The Student Health Center (SHC) will strive to improve the quality of care and promote efficient utilization of resources via an active, data-driven and peer-based program of quality assurance and quality improvement. Quality Improvement studies will be completed through the various SHC committees and reported to the Governing Body on an annual basis (at least 2 studies per year).

II. Definitions

Quality Assurance-Systematic monitoring and evaluation of the various aspects of a project, service, or facility to maximize the probability that minimum standards of quality are being attained.

Quality Improvement (QI)-Ongoing, measurable, and sustained improvements to the care and safety of patients.

Quality Monitoring-The ongoing collection of data about a specific aspect of performance over a defined interval of time that can be compared to past or future intervals in order to identify desirable and undesirable changes.

III. Procedure

A. Scope of Plan-The quality management program should address patient outcomes as well as other clinical, administrative, and cost-of-care performance issues.

B. Oversight-The endeavor of quality assurance and quality improvement is a primary responsibility of each staff member, the Governing Body (GB), as well as each GB subcommittee and workgroup. These efforts will be overseen and coordinated through the Quality Assurance Committee.

C. Quality Assurance (QA/QI) Committee

1. Consistent with the QA/QI Committee's charter, at least one physician, nurse, pharmacy representative, and front office staff will serve on the QA committee at a time.
2. The QA/QI Committee will conduct quality assurance and quality improvement studies as the committee or the GB determine.
3. The QA/QI Committee will also coordinate quality management activities with each GB subcommittee by soliciting quality management ideas and by staying abreast of individual subcommittee quality improvement studies.

D. Objectives

Objectives of the quality management plan are to optimize the quality of care rendered at SHC with special emphasis on patient safety, staff safety, and efficient utilization of state resources.

E. QI Studies

1. Study Design

   Care should be taken in the study design phase to ensure data required to accomplish the project is attainable with available resources and will accurately measure the desired outcome.
2. Data collection

a. Data may be collected from the EHR retrospectively or prospectively as long as patient confidentiality is maintained.
b. Data may also be collected via other available electronic information sources such as financial (e.g. billing, invoices), prescriptions, etc.
c. Information resulting from analysis of peer review conducted by the provider workgroup and/or the nurse workgroup.
d. Patient Satisfaction results
e. Data should be qualitative (use numeric values)

3. Study Analysis
   a. Benchmarks- compare your current performance measure to a specific metric
      i. External benchmarks from valid local, state, or national sources will be utilized.
      ii. Internal benchmarks comparing the same measure from a previous month, year, or result.
   b. A *SMART* (Specific, Measureable, Achievable, Relevant, Time Bound) goal will be set to evaluate results requiring improvement.
4. QI Study Reports

   QI Study reports should include the following minimum elements:
   a. Purpose of the study that includes a description of the problem and an explanation of why it is significant to the SHC.
   b. A *SMART* performance goal
   c. A description of the data that will be collected.
   d. Evidence of data collection included with the report
   e. Data analysis that describes findings about the frequency, severity, and source(s) of the problem(s).
   f. A comparison of the SHC's current performance against a previously identified performance goal.
   g. Identify corrective action needed
   h. Re-measurement if indicated (a second round of data collection and analysis)

F. QA/QI Reporting
   1. The results of quality improvement studies conducted by the QA/QI Committee or any GB subcommittees will be reported to the involved staff, appropriate subcommittee chairs, and to the GB.
   2. Each chair of the QA/QI Committee, Risk Management Committee, Provider Workgroup, and Nursing workgroup presents a report of the chair's respective committee or workgroup's activities and recommendations to the GB quarterly.

G. Annual Review

   The Quality Management Plan will be evaluated at least annually by the QA/QI Committee. The QA/QI Committee should submit an annual report regarding the quality management plan that includes recommendations for updating the plan which are subject to the GB approval.

IV. References

1. AAAHC Standards 5.I.A., 5.I.B., and 5.I.C.

Referral Manger Tracking Procedure

I. Policy

The referral manager tracking system will be utilized to follow up with patients requiring transfer of care, referrals to specialists, and outside orders.

II. Procedure

D. Review of Referral manager

Designated staff will review the referral manager at a minimum of one time per week to identify patients requiring follow-up phone calls as determined by the specific referral reason.

E. Referral Tracking

1. Emergency Room Referral

   Staff will call the patient the next business day after referral to the emergency room. If unable to reach the patient, two more attempts should be made over the next two business days. If unable to contact the patient, the staff member will notify the SHC director to utilize university resources to assist in contacting the patient. The staff member will document communication or inability to communicate with the patient in the medical record.

2. General Referral

   Staff will call the patient in one month after the referral was ordered. The staff member will request that the patient have the outside provider/specialist records sent to the SHC. If the patient is not planning to proceed with the referral, document accordingly and remove the entry from referral manager.

3. Outside Diagnostic Tests

   Staff will call the patient in one month after the test was ordered. The staff will obtain the results from the facility and scan in to the medical record for provider review. If the patient is not planning to proceed with the test, document accordingly and remove the entry from referral manager.

4. Pending In-house Laboratory Orders

   When a SHC provider has ordered lab testing for a patient to be done on a different day, the patient will be reminded by phone, text, or email within 7 days of date the test is due. Staff will call the patient to reschedule the test within 7 days after the test was ordered, if still not completed. If the patient is not planning to proceed with the test, document accordingly and remove the entry from referral manager.

5. Inability to Contact the Patient

   Three attempts will be made to contact patients regarding general referrals, outside diagnostics, and pending lab orders. If the patient is unable to be contacted after three attempts, notify the provider for recommendations. The provider may advise to notify SHC director to utilize university resources to assist in notifying patient. Certified letters may be used as a last resort. All attempts should be documented in the medical record.

F. Other tracking

1. Abnormal Pap Smear

Abnormal Pap smear tracking can be placed on the referral manager or as a recall function to serve as a reminder to notify patients to return in one year for repeat pap smear. The nurse will notify the patient to schedule an appointment prior to due date. If the staff member is unable to contact the patient, notify the provider for further instructions.

2. Test of Re-Infection for Sexually Transmitted Infections
   Test of re-infection reminders can be placed on the referral manager or as a recall function to serve as a reminder to notify patients to return for re-testing of their infection. The nurse will notify the patient to schedule an appointment prior to the due date.

III. Attachments

None

IV. References

AAAHC Chapter 4, Standard E-6, E-8

Requesting Records for Patients

Policy 8/2014-as rev 6/15-kc

Condition for Receiving Information via fax: Additional outside information is sometimes required for continuity of care.

Policy/Protocol: When information is requested from another health care facility by your provider the nurse will assist the student in completing the form, fax the form on the patient's behalf, and then scan to the patient chart. The nurse will then open a progress note stating that the records were requested, and from whom. They should leave the note open on their own task bar so that they can follow up if records are not received. When the records are received, it should be documented in the same note and forward the note to the provider for their review. The note can be locked at this time by the provider. If After 3 attempts to obtain the information on the patient's behalf, notify the provider for further instructions. This also may include notifying the patient to obtain the medical records for us to continue their care.

Exceptions: None

Contraindication: None

Precautions: None

Initial Competency: Observe experienced nurse implementing this procedure, demonstrate successful use of procedure at least 3 times under direct supervision, and submit 3 charts to be audited by Charge RN or Nurse Coordinator.

On-Going Competency: Chart review of this procedure in the ongoing audits of charts and Quality Management of the SHSU SHC.

Scope of Supervision: Providers are available at all times to clarify questions.

Documentation: Nurse documents appropriately in EMR according to policy of SHSU SHC.

This protocol shall remain in effect for all patients of the Sam Houston State University Student Health Center until rescinded.

Scanning Documents to the Patient EMR

Policy: 1/2014-kc rev 6/15-kc

Condition for Scanning Information to the Patient EMR: Complete and accurate records are necessary for continuity of care.

Policy of Protocol: Any information received that is considered pertinent to the patient medical history should be scanned and added to the patient EMR. This includes previous records from a paper chart, physical forms (Concorde, Athletic, etc.) brought in by the patient and completed in the treatment room, results from outside labs, radiology, etc. The nurse (RN or LVN) will implement this protocol by scanning documents and attaching them to the appropriate section of the EMR. A paper chart should be attached under "Old Paper Chart" with each page labeled by what it is. Any form that pertains to a visit should be attached to that days note at the bottom of the SOAP note and also under scanned documents and properly labeled to be found quickly. Information received should be placed on the patient summary page under "Scanned Documents". Examples are records from other providers, RX refill requests, and record release authorization forms. Use an accurate description on these entries so that the needed information is easily located. If it is something the provider needs to review, the nurse should initiate a progress note to the provider notifying them that the attachment has been received and is on the EMR.

Exceptions: Duplicate Information

Contraindication: None

Precautions: None

Initial Competency: Observe experienced nurse implementing this procedure, demonstrate successful use of procedure at least 3 times under direct supervision, and submit 3 charts to be audited by Charge RN or Nurse Coordinator.

On-Going Competency: Chart review of this procedure in the ongoing audits of charts and Quality Management of the SHSU SHC.

Scope of Supervision: Providers are available at all times to clarify questions around ordering labs under this standardized procedure.

Documentation: Nurse documents appropriately in EMR according to policy of SHSU SHC.

This protocol shall remain in effect for all patients of the Sam Houston State University Student Health Center until rescinded.

Seizure (Active) Protocol

I. PURPOSE

The purpose of this policy is to establish guidelines for addressing and monitoring acute seizures.

II. PROCEDURE:

When a seizure is witnessed or suspected, follow the seizure plan and protocol.

1. If a seizure occurs, remain with individual and call for help.
2. Remove any surrounding objects that could cause injury.
3. Assist the individual into the recovery position and stabilize the head until a pillow or towel roll can be placed under the head.
   Do not restrain individual or place any objects in mouth.
4. Stabilize individual (airway, breathing, circulation, disability, neurological exam.
5. Loosen any tight neckwear.
6. Administer oxygen if indicated by nasal cannula or facemask.
7. Time seizure from its onset to completion and monitor vital signs.
8. Document the individual's level of responsiveness, vital signs and behavior during and following the seizure.
9. Call 911 for seizures lasting longer than 5 minutes, prolonged post-ictal confusion, new onset seizure, or as directed by provider.

III. References

1. American Academy of Neurology. (2015). Evidence-based guideline:Management of an unprovoked first seizure in adults. http://www.neurology.org/content/84/16/1705.full.pdf+html
2. American Epilepsy Society. 2016. https://www.aesnet.org/clinical_resources/guidelines

Emergency Planning and Procedures

I. Policy

Outlines the responsibilities and procedures in relation to emergency response for Health Center staff.

II. Procedure

In the event of an emergency, the SHC will endeavor to function as directed by SHSU administration. The department will cooperate with local, state, and federal health authorities, law enforcement, and other campus and community entities to provide medical services and information. In emergencies, the role of the department is directed by University officials and the nature of the emergency itself. The SHC Director will be responsible for deploying the SHC staff in regards to roles and responsibilities in an emergency response situation.

A. Emergency Response

1. **Fire-** Designated evacuation location is across Avenue J, in front of the Student Services annex building (along the sidewalk)
    a. Staff will identify primary evacuation route based on the location of the fire
    b. During the exit of the building staff will have designated areas to verify that it is clear of any patients that are currently in the Student Health Center. Once that room/location is deemed "clear" the door will be left open to indicate this. Assigned areas are as follows:
        - Pharmacy staff- pharmacy waiting area, consultation rooms, staff restroom in pharmacy hallway
        - Front office staff- main lobby, lobby bathrooms, notify Dental office of evacuation
        - Nursing staff- nurse triage rooms, procedure rooms, clinic area bathrooms
        - Provider staff- each treatment room designated to the provider that day
        - Laboratory staff- lab, lab restroom, main supply room
    c. Persons with mobility issues should be evacuated utilizing a wheelchair or rolling chair as appropriate. In the event of a difficult evacuation due to limited mobility the patient/staff/visitor should be evacuated at a minimum to the fire rated stair well location at the first floor loading dock exit; if this exit is not obstructed by the location of the fire.
2. **Tornado-** In the case of a Tornado or other severe weather event staff procedure will be:
    a. Relocate to internal areas of the building without windows
    b. Relocate any patients/visitors to the same area
    c. Close doors to rooms with windows
3. **Campus Lock Down**- If the Director is notified by a campus authority of a lock down situation staff procedure will be:

a. The building will be locked remotely by UPD
b. All staff, patients/visitors will relocate to a central area of the clinic (supply room)
c. Staff will begin calling patients to notify them not to present for their appointments and they will be rescheduled once the lock down is cleared

4. **Medical Emergency Response**- Various medical emergencies could present and each will be handled with the appropriate medical intervention under the direction of an MD, ANP or PA present in the facility at the time.

B. Emergency Drills- The SHC will conduct emergency drills at least once a quarter and 2 of these drills annually will be related to an emergency medical response.

1. The Health Center Director and/or Medical Director will initiate all drills and give the "all clear" to the Health Center staff at the conclusion of a drill.
2. Drills will be documented in a standardized form and there will be a short review and debrief following each drill with all participating staff.

III. Attachments

None (see Drill Reports folder)

IV. References

1. AAAHC Standards: 7.II.E 8.B.7, 8.D, 8.E.3, 8.N, 8.O

GUIDELINES FOR STUDENT HEALTH CENTER POLICIES

I. Policy

These guidelines establish the format for Student Health Center (SHC) policies and the process for developing and reviewing policies. All SHC policies must be developed and approved according to these guidelines. A policy generally affects more than one department and is a statement that guides decision-making required for organizational operation. All policies will be written and reviewed by designated Governing Body subcommittees or discipline specific workgroups and must be approved by the SHC Director of Medical Services and the Health Center Director. Approved SHC policies will be made available to all SHC staff.

II. Procedure

A. Format

1. All policies will be formatted using the SHC Policy Template (Attachment 1).
    a. Policies should be typed in New Roman font size 12.
    b. Subdivisions with in the policy should be as follows:
2. Subdivisions and numbering system within policy Procedures section.

I. Policy Section (capital Roman numeral)

A. Procedure Subheading (capital letter)

1. Subdivision level one (Arabic number)

a. Subdivision level two (little letter)

i. Subdivision level three

(little Roman numeral)

B. Sections

1. All policies will have four major sections, which will be titled: Policy, Procedure, References, and Executive Actions.
    a. Policy – clearly state the policy and its intent.
    b. Definitions – only include if the policy has specific terms that should be described for clarity
    c. Procedure – state the procedures necessary to implement the policy. Describe the procedures without going into unnecessary detail. Detailed procedure statements may be developed separately for use by departments.
    d. Attachments – Policies should include relevant attachments, which are forms or documents to which the policy specifically refers that have been created or adopted by the SHC. The attachments should be identified in parentheses when the form or document is referenced in the policy.
    e. References – American Ambulatory Association of Health Care (AAAHC) standards, state and/or federal statutes, or established sources of health care standards upon which a policy is based should be referenced in this section.
    f. Executive Actions – document actions taken with regard to the policy beginning with the date first approved as official SHC policy. Subsequent dates will reflect when the policy is superseded by revision (formal) or administrative revision, reviewed (without revision), or deleted.

C. Access to Policies

1. SHC polices will be made available to all SHC staff via the SHC Document Management System. The SHC Document Management System will contain current, active policies maintained by Administration.
2. Previous and archived policies will also be maintained and designated as such in the SHC Document Management System.

D. Approval of New Policies
1. The assigned subcommittee or workgroup will write new policy and submit to the Director of Medical Services.
2. A draft of the policy will be distributed to all applicable subcommittees and workgroups for their review and comment.
3. The original subcommittee will incorporate suggestions/changes and send the final draft to the Director of Medical Services and the Health Center Director for final review and approval.
4. Upon final approval, the policy will be ratified by the Governing Body.
5. The final policy will be posted on the SHC Document Management System and distributed to all employees.

E. Review of Policies
1. All policies will be reviewed at least every year by the assigned subcommittee or workgroup.
2. **If no changes are needed**, the chair of the assigned subcommittee or workgroup will inform the Director of Medical Services and Health Center Director of the new review date and accordingly revise the policy's review date in SHC Document Management System.
3. **If minor changes or corrections are needed**, the assigned chair will make the changes and forward the policy to the Director of Medical Services and the Health Center Director. Once approved, the minor changes or corrections will be finalized in SHC Document Management System. The final policy will be posted on the SHC Document Management System and distributed to all employees.
4. **If significant changes are needed**, the chair will submit a draft to the Director of Medical Services.
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F. Termination of Old Policies
1. When a current policy is no longer needed, the assigned chair will inform the Director of Medical Services.
2. The proposal will be distributed to all other applicable subcommittees and workgroups for feedback.
3. Based on feedback, the Director of Medical Services and the Health Center Director will approve or disapprove the deletion.
4. **If deletion is approved**, the old policy will be removed from the active policy files in SHC Document Management System, but will not be deleted from the archive. Documentation within SHC Document Management System will reflect the date the policy was deleted.

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6. **If deletion is not approved**, the version of the policy most recently approved remains in effect.

G. New policy numbering system
1. Policies should be numbered in a manner that indicates policy category and organization that is most sensible.
2. Policy numbers will be alpha-numeric following the directions provided in the SHC Policy Manual Numbering System (Attachment 2).

III. Attachments

1. SHC Policy Template
2. SHC Policy Manual Numbering System

IV. References

1. None

V. Executive Actions

The chart below will reflect the executive actions taken with regard to the policy beginning with the date first approved as official Student Health Center policy. Subsequent dates will reflect when the policy is superseded (formal revision or administrative revision), reviewed, or deleted.

Action	Date
Approved	

ATTACHMENT 1

SAMPLE POLICY

V. Policy

Brief paragraph that succinctly describes the purpose and intent of the policy.

VI. Procedure

Policy procedures should be presented in local sequence and organization to facilitate comprehension and compliance.

A. Procedure Subheading

1. Subdivision level one
    a. Subdivision level two
        a. Subdivision level three

VII. Attachments

1. Attachments should be listed numerically in this section.

The heading of each attachment should include the policy title (all caps and non-bolded), the attachment number (bolded), and the attachment title (bolded).

VIII. References

1. Pertinent references should be listed in this section.

IX. Executive Actions

This section should demonstrate when the policy was first approved, revised, reviewed (with no changes), or deleted.

Executive Action	Date

X. Signing Authority

_____ _____

Director of Medical Services Date

_____ _____

Health Center Director Date

GUIDELINES FOR STUDENT HEALTH CENTER POLICIES
ATTACHMENT 2

POLICY MANUAL NUMBERING SYSTEM

Alpha Abbreviations:

1. Administration-**AD**
    a. Governance
    b. Administration
    c. Personnel
2. Risk Management-**RM**
    a. Patient Rights
    b. Risk Management
    c. Facilities and Environment
    d. Quality Improvement
3. Infection Control-**IC**
4. Patient Care-**PC**
    a. Patient Care
    b. Medical Staff (Providers)
    c. Nursing Services
    d. Medical Procedures
5. Behavioral Health-**BH**
6. Laboratory Services-**LS**
7. Pharmacy Services-**PS**
8. Medical Records-**MR**
9. Education and Development-**ED**
    a. Health Education
    b. Staff Development

Numeric Component:

Use the category 2 letter code followed by a hyphen, two digits, period, and one more digit.

Example: XX-01.0

Subcategories should be separated by an order of at least 10 from the last policy in the preceding section. For example, if the last policy in the Governance subcategory is AD-06.7, then the first policy in the

Administration subcategory could be AD-16.0. However, it would be preferable to start with the next full set of 10, which would be AD-20.0.

GUIDELINES FOR STUDENT HEALTH CENTER POLICIES

VI. Policy

These guidelines establish the format for Student Health Center (SHC) policies and the process for developing and reviewing policies. All SHC policies must be developed and approved according to these guidelines. A policy generally affects more than one department and is a statement that guides decision-making required for organizational operation. All policies will be written and reviewed by designated Governing Body subcommittees or discipline specific workgroups and must be approved by the SHC Director of Medical Services and the Health Center Director. Approved SHC policies will be made available to all SHC staff.

VII. Procedure

A. Format

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VIII. Attachments

1. SHC Policy Template
2. SHC Policy Manual Numbering System

IX. References

1. None

X. Executive Actions

The chart below will reflect the executive actions taken with regard to the policy beginning with the date first approved as official Student Health Center policy. Subsequent dates will reflect when the policy is superseded (formal revision or administrative revision), reviewed, or deleted.

Action	Date
Approved	

ATTACHMENT 1

SAMPLE POLICY

XI. Policy

Brief paragraph that succinctly describes the purpose and intent of the policy.

XII. Procedure

Policy procedures should be presented in local sequence and organization to facilitate comprehension and compliance.

A. Procedure Subheading

1. Subdivision level one
    a. Subdivision level two
        a. Subdivision level three

XIII. Attachments

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XIV. References

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XV. Executive Actions

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Executive Action	Date

GUIDELINES FOR STUDENT HEALTH CENTER POLICIES
ATTACHMENT 2

POLICY MANUAL NUMBERING SYSTEM

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    b. Administration
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    a. Patient Rights
    b. Risk Management
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    d. Quality Improvement
12. Infection Control-**IC**
13. Patient Care-**PC**
    a. Patient Care
    b. Medical Staff (Providers)
    c. Nursing Services
    d. Medical Procedures
14. Behavioral Health-**BH**
15. Laboratory Services-**LS**
16. Pharmacy Services-**PS**
17. Medical Records-**MR**
18. Education and Development-**ED**
    a. Health Education
    b. Staff Development

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Risk Management Program

I. Policy

The Risk Management Program is designed to be a proactive program that supports the mission and vision of the SHSU Student Health Center (SHC) in a non-punitive culture promoting awareness and empowering staff to identify and address risk-related issues to protect the health and safety of patients, employees, visitors, third party vendors, and volunteers as well as to maintain compliance with federal, state, and local statutes, regulations, and the accrediting body standards.

II. Definitions

Adverse Incident- An event that results in unintended harm to the patient by an act of commission or omission rather than by the underlying disease or condition of the patient.
Near Miss- An event of a situation that did not produce patient harm, but only because of timely intervention.
Incident- Any occurrence that is not consistent with the routine care or operations of the organization.
Medication Error- Any variation from a prescription or drug order not corrected prior to furnishing the drop to the patient. (Note: This does not include generic drug and dosage form substitutions. A medication error is a type of incident and can also be an adverse incident or a near miss when applicable.)

III. Procedure

The risk management program contains the following elements:

A. Education of stakeholders regarding emerging and known risk exposures to reduce potential for adverse events.

B. Utilization of risk management strategies to identify and minimize the frequency and severity of near misses, incidents, and claims. A risk assessment of the SHC will be completed annually.

C. Enhancement of patient safety through participation in National Patient Safety Goals (applicable to ambulatory care), organizational safety strategies, and other patient safety initiatives.

D. Promotion of quality of patient care via quality assurance and performance improvement activities.

E. Enhancement of environmental safety for patients, visitors, and staff through participation in environment of care-related assessment.

F. Inclusion of event reporting to identify and track patterns with the potential for causing a near miss, adverse incident, or medication error. The reporting, investigation and review process will be as follows:

1. In the event of the discovery of an adverse incident or medication error, the supervisor should be immediately notified.
2. The person who identified the event, along with their supervisor support, will complete an *Incident Report Form* (Attachment 1).
3. The incident will be assigned a tracking number based on the year, month, day and number of occurrences that same day. Ex: May 9 2017 = tracking number 170509-1.
4. The health center director or director of medical services will appoint an ad hoc committee to review the incident. The review will ensure that proper steps have

been taken to address the specific incident including notification of all those involved in the incident and notification of any required external entities. These finding as actions will be documented in the *Incident Review Form* (Attachment 2).

G. Protection of confidentiality and release of information will be maintained in a manner consistent with federal, state, and local statutes, regulations, and standards including but not limited to the:

1. Texas Medical Privacy Act
2. Health Information Portability and Accountability Act (HIPAA) and
3. Family Education Rights and Privacy Act (FERPA).

H. Direction may be provided through policy and procedure regarding the management of unexpected situations related to patient care, including but not limited to:

1. Dismissal or refusal of patient care,
2. Incapacitation of a health care professional during a medical or surgical procedure,
3. Management of impaired health care professionals, and
4. Prevention of unauthorized prescribing.

I. Assessment and enhancement of patient satisfaction through patient surveys and regular feedback to staff regarding results of such surveys.

J. Collaboration with SHSU Risk Management Department
The risk management committee chair will collaborate with the SHSU risk management department to ensure compliance with university guidelines and to maintain an effective program.

K. Reports to the Governing Body (GB)

1. The Risk Management Committee Chair will provide an annual risk assessment and periodic reports to the governing body as indicated. The *Annual Risk Assessment* (Attachment 3) will summarize activities, achievements, and on-going risk management issues that occurred since the prior report.
2. In the event of an incident, a summary of that incident along with the corrective actions will be presented to the GB. Any additional recommendations by the GB will be documented and completed.

IV. Attachments

1. Incident Report Form
2. Incident Review Form
3. SHC Annual Risk Assessment

V. References

1. Texas Medical Privacy Act
   www.law.uh.edu/healthlaw/perspectives/Privacy/010830Texas.html
2. HIPPA:
   https://www.hhs.gov/hipaa/index.html/
3. FERPA:
   https://www2.ed.gov/policy/gen/guid/fpco/ferpa/index.html
4. AAAHC STANDARDS:
   5.II.A.1-7, 5.II.E, 7.II.A, 7.II.E, 8.D, 8.E.3, 8.N, 8.O

Scanning Medical Information to EMR

XVI. Policy

Information that is pertinent to patient care should either be entered or scanned into the patient's electronic health records (EHR).

XVII. Procedure

A. Medical Records from an outside source

1. Medical records received from an outside source by fax, mail, or presented by the patient should be scanned in the patient's EHR in the appropriate section. For instance, immunizations records should be scanned into the immunization section of the patient's EHR.
2. Medical records obtained during a visit that is pertinent to the patient should be attached to the clinical note for that day's visit.
3. Faxed records and reports should be
    a. logged by front desk,
    b. distributed to appropriate medical staff,
    c. attached in the appropriate section of the patient EHR, and the
    d. provider should be notified that records have been received.

XVIII. Attachments

None

XIX. References:

1. AAAHC standard O.1.

XX. Executive Actions

Executive Action	Date
Approved	

Service Limits

I. Policy

Lack of equipment and clinical expertise may necessitate referral for services or evaluations of an enrolled SHSU student outside the Student Health Center (SHC). Specific situations for which patients should not be scheduled appointments at SHC are described in this policy. Otherwise, determination of the need to refer patients for external services should be made on a case-by-case basis by a medical provider after obtaining clinically pertinent information (e.g. history and physical).

II. Procedure

If a student contacts the SHC to make an appointment for any of the following visit reasons, the student will be referred to an appropriate location to initiate care.

A. Injuries sustained as a result of serious trauma requiring imaging, such as a Motor Vehicle Accident **(**MVA).

1. SHC does not have radiology services or equipment. Therefore, patients injured in a MVA cannot have an **initial evaluation** at SHC.
2. Following an initial evaluation that includes a qualified assessment and appropriate imaging, a student injured in a MVA may obtain follow up care at SHC, if approved by a SHC medical provider. To approve follow up care, the medical provider should review the student's medical records to verify necessary equipment and expertise required for follow up care are available at SHC.
3. If a patient presents to the SHC immediately following an MVA and ambulance transport is indicated, the SHC medical team will attend to the patient to the extent feasible while waiting for ambulance transport.

B. Workers Compensation

The SHC is not a participating entity with the Texas Department of Insurance (TDI) Division of Workers Compensation. Students needing evaluation and/or treatment of a work-related injury should be directed to 800-252-7031 or http://www.tdi.texas.gov/wc/employee/index.html.

C. Obstetrics and Prenatal Care

Depending on the expertise and diagnostic services required, medical services unrelated to pregnancy may be addressed by SHC. However, students requiring obstetrics and prenatal care should be immediately referred to an obstetrician.

III. Attachments

None

IV. References

None

Standing Delegated Order for Administering Hepatitis B Vaccine to Adults

XX. Policy

E. Under this standing order, registered nurses (RNs), licensed vocational nurses (LVNs), and medical assistants (MAs) who have demonstrated competency may vaccinate patients against the hepatitis B virus (HBV) who meet the identified criteria established by the Centers for Disease Control (CDC) and Prevention's Advisory Committee on Immunization Practices.

F. Under this standing order, the supervising physician delegates the authority to the MA to administer hepatitis B vaccines in a manner consistent with the standing order with the following additional requirements:
   a. At least one provider is present on the premises of the student health center, and
   b. Prior to administration of vaccination, the MA must present the vaccine to a RN, physician, nurse practitioner (APRN), or physician assistant (PA) to verify correct medication and dosage if drawn from vial rather than using a manufacturer prefilled syringe.

XXI. Procedure

A. Assess Adults for Need of Vaccination against HBV infection according to the following criteria:
   1. Any person who wants to be protected from HBV infection
   2. Patients with diabetes mellitus
      Note: for patients age 60 years or older with diabetes, at the discretion of the treating clinician.
   3. Patient with end-stage renal disease (ESRD), including patient receiving hemodialysis
   4. HIV infection
   5. Chronic liver disease
   6. Sexually active and not in a long-term, mutually monogamous relationship (e.g., more than 1 sex partner during the previous 6 months)
   7. Seeking evaluation or receiving treatment for a sexually transmitted infection (STI)
   8. A male who has sex with males (MSM)
   9. A current or recent injection-drug user
   10. At occupational risk of infection through exposure to blood or blood-contained body fluids (e.g., health care worker, public safety worker, trainee in a health professional or allied health school)
   11. Residents or staff of an institution for persons with developmental disabilities
   12. Sex partner who is chronically infected with HBV (HBsAG-positive).
   13. Household member (including adopted child) of a person who is chronically infected with HBV (HBsAG-positive)
   14. Planned travel to a country with high or intermediate prevalence or endemic HBV infection (for hepatitis B travel information from CDC, go to www.nc.cdc.gov/travel/diseases/hepatitis-b)
   15. People who live in correctional facilities
   16. All teenagers ages 18 and younger who are not fully vaccinated

B. Screen for Contraindications and Precautions
   1. Contraindications

A person who has experienced a serious systemic or anaphylactic reaction (e.g. angioedema, respiratory distress, lightheadedness, or recurrent emesis) to a prior dose of the vaccine or any of its components.
For a list of components, refer to the manufacturer's package insert
   a. www.immunize.org/packageinserts) or
   b. www.cdc.gov/vaccines/pubs/pinkbook/dowloads/appendiced/B/excipient-table-2.pdf.

2. Precautions
   a. Moderate or severe acute illness with or without fever
3. Note regarding patients with eggs allergy
   a. People with egg allergy of any severity can receive any licensed and recommended influenza vaccine that is otherwise appropriate for the patient's age and health status
   b. For people with severe allergic reaction to egg involving any symptom other than hives (e.g. angioedema, respiratory distress, lightheadedness, or recurrent emesis), or who required epinephrine or another emergency medical intervention, the selected vaccine should be administered in a medical setting (e.g. health department or physician office). Vaccine administration to such patients should be supervised by a healthcare provider who is able to recognize and manage severe allergic conditions.

C. Provide Vaccine Information Statements
Provide all patients with a copy of the most current federal Vaccine Information Statement (VIS). Provide non-English speaking patients with a copy of the VIS in their native language, if one is available and desired; these can be found at www.immunize.org/vis.

D. Prepare the Administer the Vaccine
For a vaccine that is to be administered intramuscularly (IM), choose the needle gauge, needle length, and injection site according to the following chart:

Gender and Weight of Patient	**Needle Gauge**	**Needle Length**	**Injection Site**
Female or male less than 130 lbs	22-25	1 inch	Deltoid muscle of the arm
Female or male 130-152 lbs	22-25	1 inch	Deltoid muscle of the arm
Female 153-200 lbs	22-25	1 -1.5 inch	Deltoid muscle of the arm
Male 153-260 lbs	22-25	1-1.5 inch	Deltoid muscle of the arm
Female 200+	22-25	1.5 inch	Deltoid muscle of the arm
Male 260+	22-25	1.5 inch	Deltoid muscle of the arm

E. Administer hepatitis B vaccine
Administer 0.5 ml or 1 ml (see dosage guideline below), via the IM route, according to the following dosing information and schedule:

1. For people 19 years and younger, administer 0.5 mL hepatitis B vaccine, pediatric formulation IM
2. For people 20 years and older, administer 1 mL hepatitis B vaccine, adult formulation IM

History of Previous Vaccination	Schedule for Administration of the Hepatitis B Vaccine
None or unknown	Give a 3-dose series at 0, 1, and 6 months
1 dose	Give dose #2 at least 4 weeks after #1; then, give dose #3 at least 8 weeks after dose #2 and at least 16 weeks after dose #1
2 dose	Give dose #3 at least 8 weeks after dose #2 and at least 16 weeks after dose #1

3. Information on certain risk groups
    a. For persons born in Asia, the Pacific Islands, Africa, or other countries identified as having high rates of HBV infection (see MMWR 2005; 54[RR-16]:25), ensure that they have also been tested for hepatitis B surface antigen (HBsAg) to find out if they are chronically infected. If test is performed on same visit, administer hepatitis B vaccine after the blood draw. Do not delay initiating hepatitis B vaccination while waiting for results. If patient is found to HBsAG-positive, appropriate medial follow-up should be provided; no further doses of the hepatitis B vaccine are indicated
    b. Certain people need testing for immunity (anti-HBs) 1-2 months following vaccination. Check ACIP recommendations for details (www.cdc.gov/mmwr/PDF/rr/rr5516.pdf).

F. Document Vaccination
    1. Document each patient's vaccine administration information and follow up in the following places:
        a. Medical record:
        b. Document the date the vaccine was administered, the manufacturer and lot number, the vaccination site and route, and the name and title of the person administering the vaccine. You must also document the publication date of the VIS and the date it was given to the patient. If the vaccine was not administered, record the reason(s) for non-receipt of the vaccine.
        c. Personal immunization record card
        Record the date of the vaccination and the name/location of the administering clinic.
        d. Immunization Information System (IIS) or "registry"
        Report the vaccination to the appropriate state local IIS, if available.

G. Be Prepared to Manage Medical Emergencies

1. Utilize emergency medical protocols (e.g. Anaphylaxis Protocol) and have emergency equipment and medications available. For IAC's "Medical Management of Vaccine Reactions in Adult Patients," go to www.immunize.org/catg.d/p3082.pdf.
2. To prevent syncope, vaccinate patients while they are seated or lying down and consider observing them for 15 minutes after receipt of the vaccine.

H. Report All Adverse Events to VAERS

Report all adverse events following administration of the influenza vaccine to the federal Vaccine Adverse Event Reporting System (VAERS) at www.vaer.hhs.gov. Forms are available on the website or by calling (800) 822-7967.

XXII. Attachments

None

XXIII. Reference(s)

1. Immunization Action Coalition: www.immunize.org/catg.d/p3076.pdf

XXIV. Executive Actions

Executive Actions	Date
Approved	

Standing Delegated Order for Administering Influenza Vaccine to Adults

XXV. Policy

G. Under this standing order, registered nurses (RNs), licensed vocational nurses (LVNs), and medical assistants (MAs) who have demonstrated competency may vaccinate patients against influenza who meet the identified criteria established by the Centers for Disease Control (CDC) and Prevention's Advisory Committee on Immunization Practices.

H. Under this standing order, the supervising physician delegates the authority to the MA to administer influenza vaccines in a manner consistent with the standing order with the following additional requirements:
   1. At least one provider is present on the premises of the student health center, and
   2. Prior to administration of vaccination, the MA must present the vaccine to a RN, physician, nurse practitioner (APRN), or physician assistant (PA) to verify correct medication and dosage if drawn from vial rather a manufacturer prefilled syringe.

XXVI. Procedure

I. Assess Adults for Need of Vaccination against influenza
   17. All adults are recommended to receive influenza vaccination each year.
   18. Pregnant women should only receive inactivated influenza vaccine. The inactivated vaccine can be administered during any trimester.
   19. People who do not recall whether they received influenza vaccine this year and do not have any reasonably retrievable documentation, should be vaccinated.

J. Screen for Contraindications and Precautions
   4. Contraindications for use of all influenza vaccines
      A person who has experienced a <u>serious systemic or anaphylactic reaction</u> (e.g. angioedema, respiratory distress, lightheadedness, or recurrent emesis) to a prior dose of the vaccine or any of its components.
      For a list of components, refer to the manufacturer's package insert
      c. www.immunize.org/packageinserts) or
      d. www.cdc.gov/vaccines/pubs/pinkbook/dowloads/appendiced/B/excipient-table-2.pdf.
   5. Precautions for use of all influenza vaccines
      b. Moderate or severe acute illness with or without fever
      c. History of Guillain-Barre syndrome within 6 weeks of a previous influenza vaccination
   6. Note regarding patients with eggs allergy
      c. People with egg allergy of any severity can receive any licensed and recommended influenza vaccine that is otherwise appropriate for the patient's age and health status.
      d. For people with severe allergic reaction to egg involving any symptom other than hives (e.g. angioedema, respiratory distress, lightheadedness, or recurrent emesis), or who required epinephrine or another emergency

medical intervention, the selected vaccine should be administered in a medical setting (e.g. health department or physician office). Vaccine administration to such patients should be supervised by a healthcare provider who is able to recognize and manage severe allergic conditions.

1. Note regarding patients on oral anticoagulation
    a. People receiving oral anticoagulation with a therapeutic INR can receive any licensed and recommended influenza vaccine that is otherwise appropriate for the patient's age and health status.
    b. The vaccine should be administered in a clinical setting under provider supervision after verifying the patient's level of anticoagulation.

K. Provide Vaccine Information Statements

Provide all patients with a copy of the most current federal Vaccine Information Statement (VIS). Provide non-English speaking patients with a copy of the VIS in their native language, if one is available and desired; these can be found at www.immunize.org/vis.

L. Prepare the Administer the Vaccine

For a vaccine that is to be administered intramuscularly (IM), choose the needle gauge, needle length, and injection site according to the following chart:

Gender and Weight of Patient	Needle Gauge	Needle Length	Injection Site
Female or male less than 130 lbs	22-25	1 inch	Deltoid muscle of the arm
Female or male 130-152 lbs	22-25	1 inch	Deltoid muscle of the arm
Female 153-200 lbs	22-25	1 -1.5 inch	Deltoid muscle of the arm
Male 153-260 lbs	22-25	1-1.5 inch	Deltoid muscle of the arm
Female 200+	22-25	1.5 inch	Deltoid muscle of the arm
Male 260+	22-25	1.5 inch	Deltoid muscle of the arm

M. Administer the Influenza Vaccine

Administer 0.5 ml IM in the deltoid muscle.

N. Document Vaccination

1. Document the date the vaccine was administered, the manufacturer and lot number, the vaccination site and route, and the name and title of the person administering the vaccine. You must also document the publication date of the VIS and the date it was given to the patient.
2. If the vaccine was not administered, record the reason(s) for non-receipt of the vaccine. Reoffer the vaccine to the patient at the next visit.

O. Be Prepared to Manage Medical Emergencies
    1. Utilize emergency medical protocols (e.g. Anaphylaxis Protocol) and have emergency equipment and medications available.
    2. To prevent syncope, vaccinate patients while they are seated or lying down and consider observing them for 15 minutes after receipt of the vaccine.

P. Report All Adverse Events to VAERS

Report all adverse events following administration of the influenza vaccine to the federal Vaccine Adverse Event Reporting System (VAERS) at www.vaer.hhs.gov. Forms are available on the website or by calling (800) 822-7967.

XXVII. Attachments

None

XXVIII. Reference(s)

2. Immunization Action Coalition: http://www.immunize.org/catg.d/p3074.pdf

XXIX. Executive Actions

Executive Actions	Date
Approved	

Standing Delegated Order for Administering Meningococcal ACWY Vaccine

XXX. Policy

I. Under this standing order, registered nurses (RNs), licensed vocational nurses (LVNs), and medical assistants (MAs) who have demonstrated competency may vaccinate patients against meningococcal disease caused by serotypes A, C, W, or Y who meet the identified criteria established by the Centers for Disease Control (CDC) and Prevention's Advisory Committee on Immunization Practices.

J. Under this standing order, the supervising physician delegates the authority to the MA to administer meningococcal ACWY vaccine in a manner consistent with the standing order with the following additional requirements:

3. At least one provider is present on the premises of the student health center, and
4. Prior to administration of vaccine, the MA must present the vaccine to a RN, physician, nurse practitioner (APRN), or physician assistant (PA) to verify correct medication and dosage if drawn from a vial rather than a manufacturer pre-filled syringe.

XXXI. Procedure

Q. Screen for Contraindications and Precautions

7. Contraindications
   A person who has experienced a serious systemic or anaphylactic reaction (e.g. angioedema, respiratory distress, lightheadedness, or recurrent emesis) to a prior dose of the vaccine or any of its components.
   For a list of components, refer to the manufacturer's package insert
   e. www.immunize.org/packageinserts) or
   f. www.cdc.gov/vaccines/pubs/pinkbook/dowloads/appendiced/B/excipient-table-2.pdf.
8. Precautions
   Moderate or severe acute illness with or without fever

R. Provide Vaccine Information Statements
Provide all patients with a copy of the most current federal Vaccine Information Statement (VIS). Provide non-English speaking patients with a copy of the VIS in their native language, if one is available and desired; these can be found at www.immunize.org/vis.

S. Vaccine Schedule Depending on Indication

1. **Immunocompetent** adults with an indication for meningococcal vaccine will require a single dose.
2. Adults with **asplenia** (functional or anatomic), **HIV** infection, or **persistent complement deficiency** will require two doses given 8 weeks apart.

T. Administer the Vaccine

1. **MPSV** (Menomune) is to be administered subcutaneously in the fatty tissue over lying the triceps muscle. Use a 23-25 gauge, 5/8 inch needle for the injection. Draw 0.5 ml of MPSV vaccine into syringe for injection.
2. **MenACWY** is to be administered intramuscularly (IM). Draw 0.5 ml of MenACWY vaccine into syringe for injection.

For a vaccine that is to be administered intramuscularly (IM), choose the needle gauge, needle length, and injection site according to the following chart:

Gender and Weight of Patient	Needle Gauge	Needle Length	Injection Site
Female or male less than 152 lbs	22-25	1 inch	Deltoid muscle of the arm
Female 153-200 lbs	22-25	1 -1.5 inch	Deltoid muscle of the arm
Male 153-260 lbs	22-25	1-1.5 inch	Deltoid muscle of the arm
Female 200+	22-25	1.5 inch	Deltoid muscle of the arm
Male 260+	22-25	1.5 inch	Deltoid muscle of the arm

U. Document Vaccination
   1. Document each patient's vaccine administration information and follow up in the following places:
      a. Medical record:
      b. Document the date the vaccine was administered, the manufacturer and lot number, the vaccination site and route, and the name and title of the person administering the vaccine. You must also document the publication date of the VIS and the date it was given to the patient. If the vaccine was not administered, record the reason(s) for non-receipt of the vaccine.
   2. Personal immunization record card
      Record the date of the vaccination and the name/location of the administering clinic.
   3. Immunization Information System (IIS) or "registry"
      Report the vaccination to the appropriate state local IIS, if available.

V. Be Prepared to Manage Medical Emergencies
   1. Utilize emergency medical protocols (e.g. Anaphylaxis Protocol) and have emergency equipment and medications available. For IAC's "Medical Management of Vaccine Reactions in Adult Patients," go to www.immunize.org/catg.d/p3082.pdf.
   2. To prevent syncope, vaccinate patients while they are seated or lying down and consider observing them for 15 minutes after receipt of the vaccine.

W. Report All Adverse Events to VAERS
   Report all adverse events following administration of the influenza vaccine to the federal Vaccine Adverse Event Reporting System (VAERS) at www.vaer.hhs.gov. Forms are available on the website or by calling (800) 822-7967.

XXXII. Attachments

None

XXXIII. Reference(s)

3. Immunization Action Coalition:
    a. http://www.immunize.org
    b. http://www.vaccineinformation.org

XXXIV. Executive Actions

Executive Actions	Date
Approved	

Standing Delegated Order for Administering Tdap/Td to Adults

XXXV. Policy

K. Under this standing order, registered nurses (RNs), licensed vocational nurses (LVNs), and medical assistants (MAs) who have demonstrated competency may vaccinate patients against tetanus, diphtheria, and pertussis infection who meet the identified criteria established by the Centers for Disease Control (CDC) and Prevention's Advisory Committee on Immunization Practices.

L. Under this standing order, the supervising physician delegates the authority to the MA to administer hepatitis B vaccines in a manner consistent with the standing order with the following additional requirements:

5. At least one provider is present on the premises of the student health center, and
6. Prior to administration of vaccine, the MA must present the vaccine to a RN, physician, nurse practitioner (APRN), or physician assistant (PA) to verify correct medication and dosage if drawn from a vial rather than a manufacturer pre-filled syringe.

XXXVI. Procedure

X. Assess Adults for Need of Vaccination against tetanus, diphtheria, and pertussis according to the following criteria:

20. Lack of documentation of ever receiving a dose of tetanus and diphtheria toxoids and acellular pertussis vaccine (Tdap) as an adolescent or adult
21. Currently pregnant and no documentation of Tdap given during current pregnancy
22. Lack of documentation of receiving at least 3 doses of tetanus-and diphtheria-containing toxoids (Tdap/Td)
23. Completion of a 3 dose primary series of tetanus-and diphtheria-containing toxoids with no documentation of receiving a booster dose in the previous 10 years
24. Recent deep or dirty wound (e.g., contaminated with dirt, feces, saliva) and lack of evidence of having received tetanus toxoid-containing vaccine in the previous 5 years

Y. Screen for Contraindications and Precautions

9. Contraindications
    a. A person who has experienced a <u>serious systemic or anaphylactic reaction</u> (e.g. angioedema, respiratory distress, lightheadedness, or recurrent emesis) to a prior dose of the vaccine or any of its components.
    For a list of components, refer to the manufacturer's package insert
        g. www.immunize.org/packageinserts) or
        h. www.cdc.gov/vaccines/pubs/pinkbook/dowloads/appendiced/B/excipient-table-2.pdf.
    b. Do not give Tdap to a person who has experienced encephalopathy within 7 days following DTP/DTaP/Tdap not attributable to another identifiable cause.
2. Precautions

d. Moderate or severe acute illness with or without fever
e. History of Gillain-Barre syndrome within 6 weeks of a previous dose of tetanus toxoid-containing vaccine
f. History of an Arthus-type hypersensitivity reaction after a previous dose of tetanus toxoid-containing vaccine; in such cases, defer vaccination until at least 10 years.
g. For Tdap only, progressive or unstable neurologic disorder, uncontrolled seizures or progressive encephalopathy until the patient's treatment regimen has been established and the condition has stabilized

Z. Provide Vaccine Information Statements

Provide all patients with a copy of the most current federal Vaccine Information Statement (VIS). Provide non-English speaking patients with a copy of the VIS in their native language, if one is available and desired; these can be found at www.immunize.org/vis.

AA. Prepare the Administer the Vaccine

For a vaccine that is to be administered intramuscularly (IM), choose the needle gauge, needle length, and injection site according to the following chart:

Gender and Weight of Patient	**Needle Gauge**	**Needle Length**	**Injection Site**
Female or male less than 152 lbs	22-25	1 inch	Deltoid muscle of the arm
Female 153-200 lbs	22-25	1 -1.5 inch	Deltoid muscle of the arm
Male 153-260 lbs	22-25	1-1.5 inch	Deltoid muscle of the arm
Female 200+	22-25	1.5 inch	Deltoid muscle of the arm
Male 260+	22-25	1.5 inch	Deltoid muscle of the arm

BB. Tdap or Td vaccine Schedule (except pregnant women)

Administer 0.5 ml, via the IM route, according to the following criteria and schedule:

The routine schedule for Tdap/Td vaccination is to administer a 3-dose series at 0, 1, and 6-12 month intervals, including one dose of Tdap, preferably as the first dose, followed by a Td booster every 10 years.

History of Previous Vaccination	Schedule for Administration of Tdap and Td
None or unknown	Give 0.5 ml Tdap as dose #1. Give #2 (Td) at least 4 weeks later, and dose #3 (Td) 6-12 months after dose #2.
1 previous dose Td	Give 0.5 ml Tdap as dose #2 at least 4 weeks after dose #1. Give dose #3 (Td) 6-12 months after dose #2.
1 previous dose Tdap	Give 0.5 ml Td, as dose #2 at least 4 weeks after dose #1. Give dose #3 (Td) 6-12 months after dose #2
2 previous doses, both Td	Give 0.5 ml Tdap as dose #3 at least 6 months after dose #2

2 previous doses, 1 Td and 1 Tdap	Give 0.5 ml Td at least 6 months after dose #2
3 or more previous doses, Td only	Give 0.5 ml Td booster every 10 years unless patient needs prophylaxis for wound management sooner.

If Td is indicated but not available, Tdap may be substituted.

CC. Tdap Vaccination for Pregnant Women

Pregnant women should receive Tdap during each pregnancy, preferable during the window of 27 through 36 weeks gestation, regardless of number of years since prior Td or Tdap vaccination.

DD. Document Vaccination

1. Document each patient's vaccine administration information and follow up in the following places:
    a. Medical record:
    b. Document the date the vaccine was administered, the manufacturer and lot number, the vaccination site and route, and the name and title of the person administering the vaccine. You must also document the publication date of the VIS and the date it was given to the patient. If the vaccine was not administered, record the reason(s) for non-receipt of the vaccine.
2. Personal immunization record card
    Record the date of the vaccination and the name/location of the administering clinic.
3. Immunization Information System (IIS) or "registry"
    Report the vaccination to the appropriate state local IIS, if available.

EE. Be Prepared to Manage Medical Emergencies

1. Utilize emergency medical protocols (e.g. Anaphylaxis Protocol) and have emergency equipment and medications available. For IAC's "Medical Management of Vaccine Reactions in Adult Patients," go to www.immunize.org/catg.d/p3082.pdf.
2. To prevent syncope, vaccinate patients while they are seated or lying down and consider observing them for 15 minutes after receipt of the vaccine.

FF. Report All Adverse Events to VAERS

Report all adverse events following administration of the influenza vaccine to the federal Vaccine Adverse Event Reporting System (VAERS) at www.vaer.hhs.gov. Forms are available on the website or by calling (800) 822-7967.

XXXVII. Attachments

None

XXXVIII. Reference(s)

4. Immunization Action Coalition: www.immunize.org/catg.d/p3078.pdf

XXXIX. Executive Actions

Executive Actions	Date
Approved	

Expedited UTI Evaluation for Females, Standing Delegated Order

I. Policy

This standing order provides for registered nurses (RN) to obtain a urine sample and order a urinalysis for female patients presenting to the nurse clinic with UTI symptoms (dysuria, urinary frequency, and/or urinary urgency).

II. Procedure

D. The nurse will instruct the patient about how to obtain a clean catch urine sample and order a urinalysis.
E. If the results are positive, the patient will be scheduled to see a provider for UTI evaluation.
F. If the results are negative or equivocal, the patient will be schedule to see a provider for a female health examination.
G. The nurse will consult with a provider at any time for any questions.

III. Attachments

None

IV. References

None

SYNCOPE

Fainting is a partial or complete loss of consciousness (Syncope). Simple fainting spells can be due to a low blood pressure, low blood sugar, anxiety, fear, pain, overheating, emotional stress, dehydration, heavy sweating, or exhaustion. Simple fainting resolves in 1 to 2 minutes.

I. ASSOCIATED SIGNS AND SYMPTOMS

A. Extreme paleness
B. Sweating
C. Coldness of the skin
D. Slurred speech
E. Confusion
F. Nausea
G. Disturbance of vision
H. Dizziness or lightheadedness

II. FIRST AID

A. If a person is feeling faint, recline the person in the laboratory-drawing chair, on exam table, or on the floor if necessary.
B. Call for assistance and notify a provider.
C. Loosen any restrictive clothing or belt.
D. If the person vomits, roll him onto his side or turn his head to the side.
E. Maintain an open airway.
F. Do not give any liquid unless the person has revived.
G. The person should be carefully observed after fainting to ensure resolution of symptoms.
H. Provider assessment should rule out potential underlying serious illness.

III. REFERENCE

1. The American National Red Cross, Standard First Aid & Personal Safety, First Edition, 1973, Doubleday & Do. Inc., Garden City, New York.
2. Grubb BP. The fainting phenomenon: understanding why people faint and what to do about it, Second Edition, Blackwell Publishing Inc., Malden 2007.

Orthostatic Vital Signs

XII. Policy

The nurse or medical assistant (MA) will perform orthostatic vital signs when ordered by a provider. This may include patients presenting with dizziness, nausea, vomiting, or diarrhea. The nurse or MA must monitor the patient during the procedure for potential syncopal episodes.

XIII. Procedure

E. Explain the procedure to the patient.
F. Place the patient in the supine position for a minimum of 3 minutes and preferably 5 minutes.
G. Obtain the patient's blood pressure and pulse while in the supine position.
H. Assist the patient to a seated position and wait for one minute.
   Ask the patient about dizziness, weakness, visual changes, observe for diaphoresis or pallor
I. Obtain the patient's blood pressure and pulse while sitting.
   Note: If the patient has orthostatic changes while sitting DO NOT continue to standing. Have patient return to the supine position, document the changes, and consult with the ordering provider.
   Orthostatic vital signs are considered positive if one or more of the following occur:
   1. The patient's heart rate increases by 20 beats per minute (BPM),
   2. Systolic blood pressure decreases by 20 mmHG, or
   3. Diastolic blood pressure decreases by 10 mmHG.
J. Assist the patient to a standing position, and have patient stand for one minute.
   Ask the patient about dizziness, weakness, visual changes, observe for diaphoresis or pallor.
K. Obtain the patient's blood pressure and pulse while standing.
L. Document the time, position and vital signs in the medical record. Allow the patient to assume the position most comfortable to the patient.

XIV. Attachments

None

XV. References

Orthostatic Vital Sign Measurement from the Agency for Healthcare Research & Quality https://www.ahrq.gov/

Transporting Specimens from the Exam Rooms to Lab

Policy: 9/2014-kc rev 6/15-kc

Condition for Policy of Protocol: There are many specimens that are collected in the exam rooms which need to be transported to the lab for evaluation. In order to not cause contamination to the specimen or to the clinic, it is imperative items are transferred in similar fashion to limit the risk to other patients as well as other staff and nurses.

Exceptions: NONE

Contraindication: NONE

Precautions: Change into clean gloves prior to walking in the hallway with the specimen to prevent contamination on surfaces within the clinic.

Administration of Policy and Procedure:

Transporting specimens collected in the room

- Properly identify the item with name, student ID number, date and any other identifying info need per lab specifications.
- After proper collection by the provider or nurse place the item in a biohazard bag provided by the lab (specifically LabCorp). This includes: pap smears, thin preps, cultures, urine specimens, biopsies, etc.
- Wet preps will be capped first then placed in biohazard bag prior to transporting.
- **Considering getting urine specimen in lab prior to exam. Limits the transportation as well as a better sample if prior to vaginal exam.**
- Change into clean gloves if needed prior to transporting item.
- Document how item was transported to lab in chart.

Initial Competency: Observe experienced nurse implementing this policy, demonstrate successful use of policy at least 3 times under chart audits.

On-Going Competency: Current daily/monthly accurate documentation.

Scope of Supervision: Providers are available at all times to clarify questions

Documentation: Document on a procedure note the necessary information.

This protocol shall remain in effect for all patients of the Sam Houston State University Student Health Center until rescinded.

Triage Documentation Procedure

Policy: 9/2014-kc rev 6/15-kc

Condition for Policy of Protocol: When triage patients present to the clinic it is imperative documentation is concise, thorough and consistent. The following steps will ensure this. Experienced RN's will be able to utilize this. RN's do not give medical diagnosis but NANDA approved nursing diagnosis. This will also give boundaries for the RN's within the "Triage Clinic".

Exceptions: NONE

Contraindication: NONE

Precautions: The provider may give orders outside of the "treatment set" for triage clinic. If this occurs documentation needs to reflect where the order is coming from. All suture removal/staple removal needs to be evaluated by provider prior to removal.

Administration of Policy and Procedure:

Patient presents to the "***Triage Nurse Clinic"***

- Start with Soap Note in Medicat- Get basic vital signs including pulse oximetry. May also obtain a tilt test, peak flows and vision screening based on complaint from patient.
- **Subjective-use** "*Triage Form*".
    - Fill out triage form completely
    - This is the information the person tells you or states.
    - Based on information the "plan" is decided accordingly: i.e. see a provider immediately, go to ER, Schedule for first available appointment, etc.
    - If seeing a provider immediately, the triage visit is complete as the provider will take over the documentation and will give a medical diagnosis. A nursing diagnosis may be included but is not necessary if being seen by a provider. (See Triage P&P)
    - Save the document to give the RN's signature with the proper information.
- **Objective**-problem focused. Include assessment findings. This is the information the nurse examines on the patient. Can use narrative or templates. Utilize if not being seen by a provider.
    - Save the document to give the RN's signature with the proper information.
- **Assessment**-This is the diagnoses area. If seeing a provider immediately it is not necessary to include a nursing diagnoses as the provider will include a medical diagnoses. RN's do not provide medical diagnoses and only allowed to include NANDA approved nursing diagnoses. The list can be found under "*Nursing Diagnoses*" in Dx group.
- **Treatment set**-If not seeing a provider, the RN may utilize the "*nurse visit treatment set*". This is the parameter ordering may occur as there are standing orders for these items. If an order is needed outside this set, a provider must be consulted prior to the order and documented that

the provider was consulted. The following need to be included on each patient:

- **Nurse Clinic Visit**- This tally's how many visits to the nurse clinic for statistical purposes.
- **Nurse Visit Follow Up**- This provides an order on the referral manager to follow up with the patient or to check Medicat to ensure the patient kept their appointment. After a patient is seen in the triage clinic, they either need a provider visit or a nurse phone call to see how they are doing. If the patient is "*scheduled for next available appointment"*, the date and time needs to be included in the chart for following purposes.
- **Nurse Intervention**: Assess, Encourage, Promote- These items can be chosen as pertain to the patient and further documentation. One at least needs to be included with all patients to document the nursing care or teaching given to the patient.

Initial Competency: Observe experienced nurse implementing this policy, demonstrate successful use of policy at least 3 times under chart audits.

On-Going Competency: Current daily/monthly accurate documentation; monthly chart audits.

Scope of Supervision: Nurse Coordinator and/or Charge Nurse are available at all times to clarify questions

Documentation: As reported through this procedure.

This protocol shall remain in effect for all patients of the Sam Houston State University Student Health Center until rescinded.

Triage Protocol and Standing Order

Policy: 1/2014-kc rev 6/15-kc

Condition for Standing Order: Student presents to Student Health Center to be seen and evaluated for the following criteria and there is not an appointment time available.

Policy of Protocol: It is the policy of the SHC to see any patient who presents and requests an evaluation. If the provider's schedules are full, the student will be evaluated by a competent RN who has gone through training and documentation at the SHC for assessment and nurse education specifically. If there is not an RN available, the LVN assigned will be able to start the triage process but the student's case will need to be reviewed and possibly examined by the provider prior to the student leaving the clinic. The SHC is not equipped to address potentially life threatening or otherwise serious health conditions. Therefore, SHC medical staff will stabilize as appropriate and then refer patients with such conditions to the emergency room or community medical provider.

Criteria for evaluation: All students who present to the SHC with a physical complaint that would like to be evaluated by a nurse if the providers are full

Exceptions: None

Contraindication: None

Precautions: None

Administration of standing order:

Procedure:

At any time the front personnel can request a patient brought immediately to the clinical area if they are unsure of the severity of their health status.

If a patient presents to a nurse with a medical condition requiring immediate attention the nurse will:

- Escort the patient to the treatment room as appropriate
- Take vital signs and stabilize the patient while delegating a staff member to summons the medical provider to the clinic treatment room
- Call 911 as appropriate
- Document intervention in patient's EMR using the triage template.

If a patient presents with a non-emergent medical condition that is not potentially life threatening, the nurse will:

- Escort the patient to the clinic treatment room,
- Check vital signs as indicated based on presenting complaint

- If a patient is bleeding, clean the wound, assess, and perform hemostatic measures as needed
- Complete the triage template asking appropriate questions for chief complaint and doing a problem focused assessment if necessary. The triage form will utilize the nursing process in all documentation of the visit. RN's do not give medical diagnoses but NANDA approved nursing diagnoses.
- If the patient's illness or injury does not meet the criteria for seeing a provider immediately, the RN may give over the counter medication suggestions and administer over the counter medications in the clinic. They may also offer compression and/or crutches and advice on the RICE procedure. Outside clinic lists can also be given to the patient. The Triage form will be sent to a provider for final review. If an RN is not available to triage the patient, the LVN will review with the provider before the patient is discharged from the clinic.

The following list is not all exhaustive, however, if the patient presents with any of the following criteria, the nurse will discuss the assessment with the provider along with the completed triage template.

Upper and lower respiratory: severe throat pain with difficulty swallowing

- temp>101 w/ systemic symptoms
- SOB and or wheezing
- persistent and/or profuse nose bleed

Abdomen and genital-urinary

- multiple occurrences of vomiting and/or diarrhea > 5 episodes in 24 hours
- abdominal pain or flank pain with or without temp >101
- visible hematuria or pelvic pain

Injuries

- any eye injury or possible foreign body
- severely swollen injury site
- inability to move or bear weight on injured body part
- bony deformity or any indication of vascular compromise
- **all head injuries**

Skin

- lacerations that are not easily treated with basic first aid
- severe rash if taking medications
- painful rash
- swollen eyes, lips, tongue
- draining or non-draining lesion that are warm hot and greater than 1 CM or at RN's discretion

- erythema and warmth to skin
- second or third degree burn or covering a large portion of the body
- foreign body

Neuro/CV:

- altered mental status
- syncope
- chest pain with or without SOB
- severe, new onset headache

Psychiatric:

- suicidal ideation or psychotic behavior

The provider will review the chart and will determine if the patient needs to be seen or referred to the ER or an outside clinic. The provider will continue documentation on the Triage form started by the nurse.

Initial Competency: Observe experienced nurse implementing this procedure, demonstrate successful use of procedure at least 3 times under direct supervision, and submit 3 charts to be audited by Charge RN or Nurse Coordinator.

On-Going Competency: Chart review of this procedure in the ongoing audits of charts and Quality Management of the SHSU SHC.

Scope of Supervision: Providers are available at all times to clarify questions around ordering labs under this standardized procedure.

Documentation: Nurse documents appropriately in EMR according to policy of SHSU SHC.

This protocol shall remain in effect for all patients of the Sam Houston State University Student Health Center until rescinded.

Standing Delegated Order for Administering a Tuberculin Skin Test (TST)

I. Policy

M. Under this standing order, registered nurses (RNs), licensed vocational nurses (LVNs), and medical assistants (MAs) who have demonstrated competency may place tuberculin skin tests (TST) for patients who meet the identified criteria.

N. Under this standing order, the supervising physician delegates the authority to the MA to administer TST in a manner consistent with the standing order with the additional requirement that at least one provider is present on the premises of the student health center.

II. Procedure

GG. Assess for the need to receive a TST according to the following criteria:

1. Health care workers
2. Pre-service requirement
    a. Employment
    b. Volunteer
    c. Student

HH. Screen for Contraindications and Special Considerations

10. Contraindications

    Persons who have had a sever reaction (necrosis, blistering, anaphylactic shock, or ulcerations) to a previous TST.

11. Special Considerations

    h. MMR or Varicella vaccines

    May receive TST on the same day as vaccination with a live virus, otherwise must wait 4-6 weeks after the administration of the live-virus.

    i. Small pox vaccine

    May receive TST at least one month after the administration of a small pox vaccine.

II. Administration of the TST

1. Assess the surface of the forearm for placement of the TST. (Avoid skin with veins, rashes, or excess hair)
2. Draw up 0.1 ml of Purified Protein Derivative (PPD) solution into a tuberculin syringe using a 27-gauge ½-inch needle.
3. Clean the area for administration with alcohol and allow to dry.
4. Inject all of the antigen intradermally forming a 6-10 mm wheal
5. If the wheal disappears immediately, is less than 6 mm, or no wheal forms, repeat the test immediately approximately 2 inches away from the original site or on the other arm.
6. Dab the area with cotton ball if bleeding occurs.
7. Do not cover the area with a bandage or apply pressure to the injection site.
8. Instruct patient not to rub or manipulate the site.

JJ. Documentation of Administration

Record the date, time, and location of the TST in the medical record.

KK. Reading the results of the TST

1. The TST results should be conducted 48-72 hours after the administration of the TST. If the patient does not return within 72 hours, a new TST will have to be administered.
2. Reaction is measured in mm of induration (palpable, raised, hardened area or swelling). The reader should not measure erythema (redness). Induration should be measured across the forearm perpendicular to the long axis

LL. Skin Test Interpretation

1. Induration of 5 mm or more is considered positive in the following:
    a. HIV infected persons,
    b. Recent contact of persons with TB disease,
    c. Persons with fibrotic changes on chest radiograph consistent with prior TB,
    d. Persons with a history of organ transplantation, or
    e. Persons immunocompromised for other reasons (> 15 mg/day of prednisone for 1 month or longer, TNF alpha antagonists).
2. Induration of 10 mm or more is considered positive in the following:
    a. Recent immigrants from high prevalent countries (< 5 years),
    b. Injection drug users,
    c. Residents and employees of high risk congregate settings,
    d. Mycobacteriology lab personnel,
    e. Persons with clinical conditions that place them at high risk.,
    f. Children < 4 years of age, or
    g. Infants, children, adolescents exposed to adults in high-risk categories.
3. Induration of 15 mm or more is considered positive in any person, including persons with no known risk factor for TB
4. If the patient has a negative skin test reading, document the results in the medical record and provide the patient with necessary documentation.
5. If the person has a positive skin test reading, document the results in the medical record and consult with a provider for further instructions.

III. Attachments

None

IV. Reference(s)

5. https://www.cdc.gov/tb/publications/factsheets/testing/skintesting.htm
6. https://www.cdc.gov/tb/topic/testing/whobetested.htm

UNIVERSAL PRECAUTIONS

I. Policy

SHSU employees will use universal precautions when coming in contact with potentially infectious materials.

II. Definitions.

Universal Precautions-All blood and other potentially infectious materials OPIM) will be handled as if infectious.

Other potentially infectious materials (OPIM)-includes the following human bodily fluids: semen, vaginal secretions, cerebrospinal fluid, synovial fluid, pleural fluid, pericardial fluid, peritoneal fluid, amniotic fluid, saliva, any body fluid visibly contaminated with blood, and all body fluids where it is difficult or impossible to differentiate between body fluids. Also includes unfixed human tissue.
Note: Feces, nasal discharge, saliva, sputum, sweat, tears, urine and vomitus meet the definition of OPIM, medical waste, biohazard waste, regulated waste, and hazardous waste only when grossly contaminated with blood.

III. Procedures

A. Hygiene practices
   1. Employees will wash their hands with soap and water after removing their gloves or alcohol based (at least 60%) hand sanitizer. (see *Hand Hygiene* policy).
   2. Clothing that has come in contact with potentially infectious material will be immediately removed and placed in a contaminated laundry receptacle for proper handling. Saturated clothing will be disposed of as biohazardous waste.
   3. Employees will not eat, drink, or apply cosmetics in the lab or treatment rooms.
   4. All tasks involving blood or OPIM must be performed in a manner that minimizes splashing, spraying, spattering, and/or generation of droplets of these substances.

B. Disposal practices
   1. All items coming in contact with potentially infectious materials will be sterilized or disposed of as biohazardous waste (see *Sterilization of Clinic Instruments* and *Managing Regulated Waste*).
   2. Sharps Injury Prevention
      a. Self-sheathing needles and/or syringes will be used by employing the one-handed technique in this facility and will be inspected before use.
      b. Specimens gathered in the treatment rooms will be capped or covered before they are transported to the lab.
      c. Sharps containers will be used and will be inspected for integrity and capacity daily by the custodian and staff using the container.
      d. In the laboratory, a centrifuge cover will be used. The cover will be inspected at each use and maintenance will be scheduled as needed, but at least semi-annually.
      e. In the laboratory, the microscopy will be inspected daily and maintenance will be performed as needed, but at least annually.

3. Needles and Other Sharps
    a. Contaminated needles and other sharps will not be bent, recapped, removed, sheared, or purposely broken unless the action is required by the medical procedure. If such action is required, the recapping or removal of the needle must be accomplished by the use of a mechanical device or one handed technique.
    b. All needles will be equipped with a needle stick protection device. These devices must be engaged after the needle is used.
    c. In the case of a needle stick, the provider will assess the injury and refer to the OSHA Documentation Manual and Needle Stick Injury protocol.
    d. Employees will, after removing their gloves, immediately wash their hands and other any potentially contaminated skin area with soap and water.

C. Personal Protective Equipment (PPE)
    1. Based upon the potentially infectious material, the likelihood of exposure, the potential volume of the material, the probable route of exposure, and the overall working conditions, the SHC will provide and require use of certain protective equipment by its employees
    2. If there is potential for splashes, protective eye wear, shields, or masks will be utilized. Care will be taken to minimize splashing, spraying, splattering, and generating droplets of blood or other infectious materials.
    3. Gloves and impervious gowns will be used during potential exposures to infectious materials.

D. Contaminated Equipment

    If equipment becomes contaminated during a procedure, if will be decontaminated according to manufacturer's guidelines.

IV. References

1. AAAHC Standard 7.1.G, 7.II.M
2. OSHA Blood Borne Pathogen Standard, 29 CFR 1910.1030

Urine Pregnancy Test Standing Delegated Order

V. Policy

Under this standing order, registered nurses (RNs) and licensed vocational nurses (LVNs) may order urine pregnancy testing in the event that a patient comes in requesting to be tested.

VI. Procedure

A. The nurse will order the appropriate test based on the patient request.
B. The lab specimen will be collected.
C. When a urine pregnancy test is collected, the nurse can notify the patient if the result is negative. If the result is positive, a provider will notify the patient.
D. The nurse will ask for the most recent date of sexual contact and schedule a follow-up testing date if less than 10 days have elapsed.
E. Documentation will take place in the medical record.

VII. Attachments

None

VIII. References

None

Vaccine Safety and Storage

Policy 6/2015/kc

Condition for Policy and Procedure: Vaccine efficacy depends on maintaining the vaccine 'cold chain' at every stage from the manufacturer to the recipient.

Vaccines are biological substances, that may lose their effectiveness quickly if they become too hot or too cold at any time, especially during transport and storage. Vaccines naturally biodegrade over time, and storage outside of the recommended temperature range – including during transport and storage – may speed up this loss of potency, which cannot be reversed. This may result in the vaccine failing to protect, as well as resulting in vaccine wastage.

Inactivation of vaccines may only come to light when immunized individuals acquire the disease in question. It may then be difficult to demonstrate a clear link between this and previous inadequate storage, distribution and handling practices

Each stage in the cold chain should be the subject of careful quality control, not least in the general practice setting.

High standards are necessary and are encouraged in primary care by appropriate training of staff involved with immunization, clear designation of responsibilities to named individuals, the development and implementation of written protocols, and continuing regular audit.

Policy of Protocol: All staff will implement this policy, from the person who gets the vaccines from shipping, to the nurses who regulates the refrigerator.

Contraindication: none

Precautions: monitoring the vaccines during power outages especially and to ensure the proper use of generator.

Policy and Procedure for:

Safe Vaccine storage

- A storage refrigerator must be dedicated to vaccines and medicines only. It is recommended that an additional vaccine storage refrigerator is available to cover periods of particularly high usage, (e.g. the influenza immunization period).
- Vaccine storage, and the associated record keeping, should be delegated to a named individual currently the Charge Nurse with delegation to LVN of choice.
- Vaccines should be placed, as appropriate, in their original packaging, in the storage refrigerator **immediately** on receipt. Vaccine stocks should be placed within the refrigerator so that those with shorter expiry dates are used first. **Vaccines must never be used when past their expiration date.**
- Sufficient space should be allowed in the refrigerator to allow circulation of cool air.
- A log book of all vaccine batch numbers and expiration dates should be kept
- Vaccines must be kept within the temperature range recommended by the manufacturer (usually 2-8 degrees Centigrade for injectable vaccines.) Vaccines must **never** be frozen.
- Refrigerator temperatures should be monitored/recorded twice daily using a maximum/minimum thermometer, appropriate actions must be taken if the temperature

recording is out of range.

- A record book for deliveries, recording date and time received, batch numbers and expiration dates should be kept for each vaccine received to the SHC. Form can be found in theSHC T-drive under *Nursing/Vaccine delivery/Refrigeration Record.*

Defrosting and Cleaning Refrigerators

- When cleaning the refrigerator, vaccines must be transferred to the second refrigerator. This temporary storage refrigerator must also be monitored to ensure the correct temperature (2°C to 8°C) is maintained. Alternatively, store the vaccines in a pre-cooled insulated containerwith icepacks. Continue to monitor the temperature inside the container until the usual vaccine refrigerator is ready for use again. This should occur every 6 months or asneeded.

Transportation of vaccines to outlying practices

- Validated cool boxes and ice packs must be used and must be appropriate for the purpose required. Individual manufacturers' instructions should be strictly adhered to.
- Vaccines must be kept in the original packaging, wrapped in bubble wrap (or similarinsulation material) and placed into a cool box with cool packs as recommended by the manufacturers' instructions. This will prevent direct contact between the vaccine and the cool packs andwill protect the vaccine from any damage, such as being frozen.

Refrigerator failure or disruption of the cold chain

- The refrigerator is located in the medication room of the SHC. The temperature is taken 2xper day and recorded. In case of power failure, there is a backup generator that will automatically initiate in the event of a power failure. If the refrigerator itself begins to not keep accurate temperatures, the vaccines will be placed in the spare refrigerator at the same location.

- **Vaccine Storage Troubleshooting Record along with the Emergency Response Worksheet** will be initialized.

- In general, any vaccine that has been exposed to temperatures outside the recommended storage range should not be administered.
- The vaccine manufacturer or SHC pharmacist should be contacted and the following information provided.
    - Vaccine Storage Troubleshooting Record will be used.
    - Length of time the refrigerator has been off/malfunctioning
    - Current internal temperature of the refrigerator
    - Minimum and maximum temperature during last 24 hours (temperature records should be made twice daily)
    - Previous minimum and maximum temperatures
    - Type of vaccine product, date of expiration and batch numbers

- Discard any stock as advised by manufacturer/pharmacist

Return salvageable products to cold chain immediately and:

- Mark each product with date of break in cold chain and USE FIRST (and within the time scale suggested by manufacturer or SHC pharmacist)
- Mark each product with the new expiration date as advised by manufacturer or SHC Pharmacist

- Inform the SHC director who should:
  - Complete critical incident procedure to allow risk analysis
  - Check insurance policy covers for loss of stock

If an individual has inadvertently received a vaccine that is subsequently found to have been exposed to temperatures outside the recommended storage range, or if the vaccine is found to have passed its expiry date, advice should be sought on an individual basis from the vaccine manufacturer the CDC.

Initial Competency: Observe RN implementing this policy, demonstrate successful use of record keeping at least 3 times per chart audits. .

On-Going Competency: Chart review of this procedure in the ongoing audits of charts.

Scope of Supervision: Nurse Coordinator and Charge nurse are available to answer questions.

Documentation: Nurse documents appropriately on forms for vaccine safety protocol.

Vital Sign Protocol and StandingOrder

Policy: 1/2014-kc rev 6/15-kc

Condition for Standing Order: Student presents to Student Health Center to be seen and evaluated.

Policy of Protocol: The nurse (RN or LVN) will implement this protocol on arrival of the student. It is the standard operating procedure at Sam Houston State University Health Center to obtain routine vital signs, (blood pressure, temperature, pulse, respiratory rate and pulse oximetry), plus LMP, on all patients being evaluated for illness or injury. Orthostatic vital signs may be obtained under the discretion of the clinician for patients who present with dizziness or nausea, and vomiting or diarrhea or other conditions that may evoke a hypovolemic status in the patient. The exception is if the patient presents to triage, the RN may decide to collect orthostatic vital signs based on presentation of the patient with the above mentioned symptoms.

Peak flow monitoring may be done by the discretion of the clinician on patients who presents with URI complaint and/or a history of asthma, as well as all patients with a complaint of shortness of breath or wheezing. Again, the exception is if the patient presents to triage, the RN may decide to collect orthostatic vital signs based on presentations of the patient the above mentioned symptoms.

Criteria for testing: All students who present to the SHC.

Exceptions:

- Vital signs are not required for Tb testing, allergy injections or routine immunizations. Exception is temperature is collected on all patients. The nurse may decide to collect vital signs based on the acuity of the patient or if ordered by the allergist.
- Nurse visits for non-illness reasons do not require vital signs, unless vital signs are part of the purpose of the visit (e.g. blood pressure checks)

Contraindication: None

Precautions: None

Administration of standing order: Vital signs will be obtained in usual manner in accordance with nursing standards. Nurses may use electronic monitoring for BP, pulse and temperature, but if BP and pulse are not within normal range, they will be taken manually. A radial pulse is appropriate, but if the pulse is irregular an apical pulse will be obtained for a full minute. Temperatures will wait to be obtained if it is within 15 minutes of drinking liquids or smoking tobacco. **Equipment will be cleaned between each patient.**

Vital signs outside of the below parameters should be retaken right away, documented in the Electronic Medical Record and immediately reported to a clinician for a determination of a plan of care:

BP systolic	**<85**	**>166**
BP diastolic	**<55**	**>100**
Pulse	**<55/min**	**>110/min**
Orthostatic (changes between lying to standing)	**BP sys drops >20 points or diastolic drop of >10 points**	**Pulse increase of >20 bpm**
Respirations	**<12/min**	**>26/min**
Temp	**<96 F**	**>102 F**
O2 Sat	**<95%**	**n/a**
Peak Flow	**<280**	**n/a**

Initial Competency: Observe experienced nurse implementing this procedure, demonstrate successful use of procedure at least 3 times under direct supervision, and submit 3 charts to be audited by Charge RN or Nurse Coordinator.

On-Going Competency: Chart review of this procedure in the ongoing audits of charts and Quality Management of the SHSU SHC.

Scope of Supervision: Providers are available at all times to clarify questions around ordering labs under this standardized procedure.

Documentation: Nurse documents appropriately in EMR according to policy of SHSU SHC.