

**Access to Services**

Policy: Students must be currently enrolled in order to receive services from the SHSU Student Health Center. Their eligibility will be verified by the front office staff each time that a student attempts to access services offered by the Health Center. Verification of enrollment may be accepted from an authorized university representative if the student's enrollment status is not correctly indicated via CHKC01R.

Exceptions may be granted in cases when follow-up treatment from the previous semester is deemed medically necessary. These exceptions are granted only during the summer to students planning to enroll in the fall semester and require the student to pay the Medical Service Fee.

### **Emergency Planning**

- I. General: In the event of an emergency, the Health Center 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. Emergencies are handled in accordance to the university's Emergency Response Plan which can be found at [http://www.shsu.edu/~slo\\_stdss/erp-manual.pdf](http://www.shsu.edu/~slo_stdss/erp-manual.pdf). A written copy of the plan is also maintained in the director's office. In emergencies, the role of the department is dictated by university officials and the nature of the emergency itself.
  
- II. Emergency Drills: The Health Center will conduct emergency drills at least once a quarter. The director will maintain records of the drills.
  
- III. Emergencies within the department shall be dealt with in accordance with the following guidelines:
  - A. Fire (Drill)
    1. Staff will locate and assess fire as appropriate based on (staged) scenario.
    2. Staff will identify primary and secondary evacuation routes based on the (staged) scenario.
    3. Staff will (simulate) notification of the fire department.
    4. Staff will yell "Fire" and all staff will repeat until they evacuate from the building.
    5. Two staff members will attempt to extinguish the fire as appropriate. If the fire is too large, staff should not attempt to extinguish it.
    6. Individual staff members will clear and evacuate the building.
      - a. Evacuation Assignments: Each staff member/workgroup has assigned responsibilities in the case of a fire. These responsibilities are subject to the nature and location of the fire as well as staffing levels on any given day.
        - i. Office Staff: The front office staff will ensure that the waiting room and restrooms are cleared and evacuated.
        - ii. Health Programming Coordinator/Pharmacist: The Health Programming Coordinator/Pharmacist will ensure that the health programming offices, triage room, and pharmacy areas are cleared and evacuated.
        - iii. Medical Providers/Nurses: The medical providers and nurses will ensure that the exam rooms, providers' offices, nursing office, and nurses' station are cleared and evacuated.
        - iv. Medical Technologist: The MT will ensure that the laboratory and restroom are cleared and evacuated.
        - v. Custodian/Director: The custodian and director will ensure that the conference room, laboratory, supply room, and break room are cleared and evacuated.
        - vi. Director: Report headcount to Safety Coordinator/Public Safety Officer.

### **Emergency Planning**

III. Emergencies within the department shall be dealt with in accordance with the following guidelines:

A. Fire (Drill)

7. Evacuation Procedure:

- a. Staff will close the door leading into an area after it has been cleared.
- b. Staff should place a linen in front of a door, an “x” on the door using chalk, or a large piece of masking tape on the door after an area is cleared.
- c. Persons with mobility issues should be evacuated utilizing a wheelchair or rolling chair as appropriate.
- d. Staff should yell “fire” throughout the clearing and evacuation process to ensure that everyone is aware of the fire.
- e. Staff should check to see if all other areas have cleared prior to their evacuation from the building.
- f. Staff will assemble in the predetermined accountability site. The parking lot in front of the building is designated as the primary site while the parking lot behind the building is the secondary site.
- g. Director shall account for all personnel to ensure no one is left in building.
- h. Director will report headcount to the Safety Coordinator/Public Safety Officer.
- i. Staff will not re-enter the building until clearance has been given.
- j. Director will complete the Fire Drill Report and conduct debriefing.

B. Bomb Threat (Drill)

1. Staff member receiving the threat will collect as much information as possible while simultaneously notifying another staff member.
  - a. Repeat threat that is given.
  - b. Ask for the specific location of the bomb and when it will detonate.
  - c. Inform the caller that the building is occupied and the detonation of a bomb could result in death or serious injury to many innocent people.
  - d. Pay attention to details such as noting details about the person’s voice and background noise.
  - e. Staff will (simulate) calling 911.
2. Staff will identify primary and secondary evacuation routes based on the staged scenario.
3. Individual staff members will clear and evacuate the building.
  - a. Evacuation Assignments: Each staff member/workgroup has assigned responsibilities in the case of a bomb threat. These responsibilities are subject to the reported location of the bomb as well as staffing levels on any given day.
    - i. Office Staff: The front office staff will ensure that the waiting room and restrooms are cleared and evacuated.
    - ii. Health Programming Coordinator/Pharmacist: The Health Programming Coordinator/Pharmacist will ensure that the health programming offices, triage room, and pharmacy areas are cleared and evacuated.

**Emergency Planning**

III. Emergencies within the department shall be dealt with in accordance with the following guidelines:

B. Bomb Threat (Drill)

3. Individual staff members will clear and evacuate the building.
  - a. Evacuation Assignments: Each staff member/workgroup has assigned responsibilities in the case of a bomb threat. These responsibilities are subject to the reported location of the bomb as well as staffing levels on any given day (continued).
    - iii. Medical Providers/Nurses: The medical providers and nurses will ensure that the exam rooms, providers' offices, nursing office, and nurses' station are cleared and evacuated.
    - iv. Medical Technologist: The MT will ensure that the laboratory and restroom are cleared and evacuated.
    - v. Custodian/Director: The custodian and director will ensure that the conference room, laboratory, supply room, and break room are cleared and evacuated.
    - vi. Director: Report headcount to Safety Coordinator/Public Safety Officer.
  - b. Evacuation Procedure:
    - i. Staff will close the door leading into an area after it has been cleared.
    - ii. Staff should place a linen in front of a door, an "x" on the door using chalk, or a large piece of masking tape on the door after an area is cleared.
    - iii. Persons with mobility issues should be evacuated utilizing a wheelchair or rolling chair as appropriate.
    - iv. Staff should check to see if all other areas have cleared prior to their evacuation from the building.
    - v. Staff will assemble in the predetermined accountability site. The parking lot in front of the building is designated as the primary site while the parking lot behind the building is the secondary site.
    - vii. Director shall account for all personnel to ensure no one is left in building.
    - viii. Director will report headcount to the Safety Coordinator/Public Safety Officer.
    - ix. Staff will not re-enter the building until clearance has been given.
4. Director will complete the Emergency Drill Report and conduct debriefing.

### **Emergency Planning**

III. Emergencies within the department shall be dealt with in accordance with the following guidelines:

- C. Physical Violence: There are a variety of scenarios in which the threat of physical violence could arise. However, there are some common steps to follow that will reduce the chance and/or degree of physical harm. In the case of the threat of physical violence, staff should:
  - 1. Remain calm. A calm disposition often has a calming effect on others. In the case of a robbery, fully cooperate with the person by giving them what they are asking for.
  - 2. If possible, maintain space between yourself and the person presenting the threat. It is best if you can maintain a barrier (desk, chair, etc.) between yourself and the person presenting the threat.
  - 3. Call 911. As appropriate, staff members not directly involved in the threat should go to an inconspicuous place and call 911.
  - 4. Clear the area in which the threat exists. As appropriate, staff members not involved in the threat should make an effort to reduce/eliminate traffic through the area where the threat exists.
- D. Hurricane/Tornado: In the case of a hurricane or tornado, all occupants of the Health Center will relocate to areas of the building without windows. Such areas include the laboratory, peer educator office, health program coordinator office, lab restroom, staff restroom, lobby restrooms, and treatment room restrooms. Evacuation to these areas will take place in a similar manner to that of a fire. Building occupants will preferably relocate to the south end of the facility.
- E. Medical Emergency: Staff will call 911 in case of a medical emergency. The highest ranking clinical staff member present will determine the appropriate intervention.

IV. Emergency Contacts

- A. Staff Contacts (see staff contact sheet in manual)
- B. Hospital Infection Control (936) 291-4301
- C. TDH (800) 252-8239 or (512) 458-7111
- D. University Safety Office (936) 294-1921
- E. UPD (936) 294-1794 or (936) 294-1000
- F. Residence Life (936) 294-1812

## **Credentialing and Privileging**

### I. Credentialing

The Student Health Center will obtain a completed Credentialing Application from healthcare professionals considered for employment within the department. The credentials listed on the Credentialing Application shall be matched against the minimum credentials listed in A.1-7 based upon the applicant's position. The applicant's credentials shall then be verified by the processes listed in B1-7. Pending the verification of the applicant's credentials, the privileging process may begin. Subsequent verification of healthcare professional's credentials will take place as described in Section C, 1-6.

#### A. Minimum Credentials

1. Physician
  - a. graduation from an accredited School of Medicine
  - b. Texas Board of Medical Examiners licensure or reciprocity licensure from a participating state.
2. Nurse practitioner
  - a. masters degree from an approved nursing school/university in advanced practice nursing
  - b. Texas Board of Nurse Examiners licensure with prescriptive rights
3. Physician Assistant
  - a. completed an educational program for physician assistants accredited by the Commission on Accreditation of Allied Health Education Programs, or by that committee's predecessor or successor entities
  - b. holds a valid and current certificate issued by the National Commission on Certification of Physician Assistants
  - c. TBME licensure
4. Licensed Vocational Nurse
  - a. high school graduation or equivalent
  - b. completion of LVN program of an approved school of nursing
  - c. Texas State Board of Nurse Examiners licensure
5. Registered Nurse
  - a. graduation from approved nursing school
  - b. Texas Board of Nurse Examiners licensure
  - c. Associate's degree or diploma
6. Medical Technologist
  - a. Associate's degree and completion of the prescribed course in Medical Technology or HEW certification equivalency.
  - b. AMT certification
7. Pharmacist
  - a. Bachelor of Science in Pharmacy
  - b. Texas Board of Pharmacy licensure

## **Credentialing and Privileging**

### I. Credentialing (continued)

#### B. Initial Credential Verification

1. Licensure- A copy of the staff member's current license will be made by the director or designee and maintained in the master operations manual upon receipt of the Credentialing Application.
2. License status- The licensee's status with the licensing agency will be verified by the director or designee via internet upon receipt of the Credentialing Application. The report will be printed out and maintained in the master operations manual.
3. DEA Registration- Verification of the physician's registration will be obtained from the DEA database upon the receipt of the Credentialing Application. The copy of the physician's registration and verification will also be retained.
4. National Practitioner Data Bank ([www.npdb-hipdb.com](http://www.npdb-hipdb.com))- A query shall be run for each medical practitioner upon receipt of the Credentialing Application. The subsequent report will be maintained in the master operations manual.
5. Educational/Training Verification- A letter from the program awarding credentials will be maintained in the master operations manual for each healthcare professional. The original letter on the entity's letterhead shall be maintained in the master operations manual by the director or designee.
6. Current liability coverage (if applicable)- Documentation of previous liability coverage for medical practitioners will be obtained to ensure insurability. This document will be maintained in the master operations manual.
7. Certifications- Documentation of current certification will be obtained and maintained in the master operations manual.

#### C. Subsequent Credential Verification

1. current licensure- A current copy of each healthcare professional's license will be maintained in the operations manual. The copy will be made by the director or designee and maintained in the master operations manual.
2. license status- Where applicable, the licensee's status with the licensing agency will be reviewed on-line and printed out each time that a license is renewed. This report shall be maintained in the master operation manual.
3. DEA registration (if applicable)- Verification of the physician's registration will be obtained from the DEA database and printed. The current copy of this document and the DEA registration card will be maintained in the master operations manual.
4. National Practitioner Data Bank- A query shall be run for each medical practitioner at the time of their license renewal. The subsequent report will be maintained in the master operations manual.
5. ability to maintain liability coverage-Self evident through the renewal of medical liability coverage. Documentation of current medical liability coverage will be maintained in the master operations manual.
6. certification (if applicable)- Documentation of current certification will be obtained and maintained in the master operations manual.

**Credentialing and Privileging (continued)**

II. Privileging

- A. Scope of Practice: The medical practitioners may perform the procedures and treatments outlined in the privileges granted by the governing body.
- B. Initial Privileging: Upon the successful verification of credentials, the privileging process may begin. The initial privileging process includes, but is not limited to the governing body's review of the Credentialing Application, the evidence of credential verification, and three complete Practitioner Peer Reference Forms. The governing body will make a decision regarding privileging within 10 business days of receiving the completed documents.
- C. Subsequent Privileging: The reconsideration of granted privileges will take place at least every three years. This process will include the review of subsequent credentialing information as outlined in I.,C.,1-6, relevant development activities, quality assurance activities, and any documented clinical incidents.
- D. Curtailment or Discontinuation of Privileges: Any member of the governing body may make a recommendation for the curtailment or discontinuation of privileges. The governing body will make the final determination regarding any change in a practitioner's privileges. Any such changes will be immediately documented and communicated to the practitioner. In the case that a change in a practitioner's privileges appears to be in order, the governing body will solicit the input of the physician that provides the physician's peer review along with a physician removed from the situation. All privileges will be automatically discontinued upon the formal discontinuation of a practitioner's association with the Health Center whether the association is by employment or contract.



### **Treatment of Minors**

- I. Policy: Minor patients under the age of 18 are treated in accordance with Chapters 31 and 32 of the Texas Family Code. The SHC will attempt to obtain parental consent before providing treatment to a minor. In the event parental consent or consent from other family members is not attainable, the SHC medical provider has the discretion to obtain consent from a minor child as outlined in section D. In the case of non-emergencies, the Secretary II, Secretary III, or director will be informed of new minor patients for whom consent has not been obtained before they receive treatment of any type.
  
- II. Procedure:
  - A. Obtaining consent for treatment of an unemancipated minor.
    1. Telephone parent/legal guardian to obtain verbal consent for treatment and to follow-up with a written consent.
    2. If document from a parent is not available, obtain consent to treat from other family members in the following order:
      - a. Grandparent
      - b. An adult brother or sister
      - c. An adult aunt or uncle
      - d. An educational institution in which the child is enrolled that has received written authorization to consent from a person having the right to consent;
      - e. An adult who has actual care, control and possession of the child and has written authorization to consent from a person having the right to consent.
      - f. A court having jurisdiction over a suit affecting the parent-child relationship of which the child is subject.
      - g. An adult responsible for the actual care, control and possession of a child under the jurisdiction of a juvenile court or committed by a juvenile court to the care of an agency of the state or county; or
      - h. A peace officer who has lawfully taken custody of a minor, if the peace officer has reasonable grounds to believe the minor is in need of immediate medical treatment.
    3. Document on the verbal consent obtained from a non-parent via telephone and witnessed by another SHC employee when possible. Include in documentation the date, time and name of individual providing consent.
    4. Fax or mail the Consent for the Medical Treatment of a Minor form to the parent or legal guardian.
    5. If consent cannot be obtained, treat patient anyway if a medical provider determines that delay would result in harm to patient, and continue diligent effort to obtain consent for treatment from the parent/guardian.
  - B. Obtain consent for treatment of emancipated minors.
    1. Ask the patient to provide proof of emancipated minor status by presenting either an order from a court of law or evidence of the patient's marriage.
    2. File a copy of the order in the patient's medical record.

**Treatment of Minors (continued)**

- III. Procedure:
  - B. Obtain consent for treatment of emancipated minors (continued).
    - 3. If documentation from a court or evidence of the patient's marriage is not presented, consent to treat should be obtained from other family members as directed in A.2. above.
  - C. A child may consent to medical, dental, psychological, and surgical treatment by a licensed physician or dentist if the child:
    - 1. Is on active duty with the armed services of the USA;
    - 2. Is 16 years of age or older and resides separate and apart from the child's parents or guardian and is managing the child's own financial affairs, regardless of the source of the income.
    - 3. Consents to the diagnosis and treatment of an infectious, contagious, or communicable disease that is required by law or a rule to be reported by the licensed physician;
    - 4. Consents to examination and treatment for drug or chemical addiction, drug or chemical dependency, or any other condition directly related to drug or chemical use.
    - 5. Counseling for suicide prevention, chemical addiction or dependency, sexual, physical, or emotional abuse.
      - a. A parent/guardian who has not consented to counseling treatment of a child is not obligated to compensate for services rendered.
  - D. If a medical provider has reason to believe that a minor should be examined to rule out possible abuse or neglect, the medical provider may do so without obtaining prior consent. Reference Section 32.005 Texas Family Code: Examination Without Consent of Abuse or Neglect of Child.
  - E. Persons with an urgent medical problem who are not eligible for services are stabilized, if necessary, prior to being referred elsewhere.

### **Patient Grievances**

- I. Policy: Departmental staff members will attempt to resolve patient concerns and complaints in quick and informal manner. However, patients will be afforded the opportunity to file a written appeal when attempts to resolve the issue otherwise are not successful. Every patient is assured of timely and thorough consideration of any appeal filed. Each student is assured freedom from interference, coercion, discrimination, and reprisal in filing grievances.

Only one subject will be covered in any one grievance. If a written grievance is submitted, it must contain a clear and concise statement of the grievance and the relief the grievant is seeking. Filing a Grievance Statement Form is the final appeal of a determination made through the informal process. All written grievances will be forwarded to the director upon receipt.

The director or designee will notify the grievant of the outcome within five business days of receiving the grievance. The director's determination is final.

- II. Procedure:
  - A. Staff members will inform patients about the patient grievance procedures.
  - B. Staff members will make and document informal efforts to resolve patient complaints. If the patient's complaint is resolved, the related documentation will be retained by the Administrative Secretary.
  - C. If the patient's complaint is not resolved through the informal process, the patient will be instructed to complete the Grievance Statement Form in order to appeal the determination made during the informal grievance process. The staff member will then forward the Grievance Statement Form along with the documentation related to the informal processes to the director immediately upon receipt.
  - D. The director will review the Grievance Statement Form and notify the grievant of the final determination within five business days.

### **Patient Rights and Responsibilities**

- I. Policy: Patients of the SHSU Student Health Center are afforded certain rights. The patient's rights and responsibilities will be presented in the new patient packet. Effective January 5, 2005, a signed copy of patients' rights and responsibilities will be maintained in all new patient files. The patient's rights and responsibilities are as follows:
  - A. Patient Rights
    1. The patient is treated with respect, consideration, and dignity.
    2. The patient is provided appropriate privacy.
    3. The patient's medical information is confidential and is released as indicated on the forms pertaining to the release of medical information.
    4. The patient is provided, to the degree known, complete information concerning their diagnosis, evaluation, treatment, and prognosis. When it is medically inadvisable to give such information to a patient, the information is provided to a person designated by the patient or to a legally authorized person.
    5. The patient is given the opportunity to participate in decisions involving their healthcare except when such participation is contraindicated for medical reasons. These decisions include the right to change health care providers if available and the right to refuse treatment.
    6. The patient has the opportunity to provide input on ways to improve the services and programs offered by the Student Health Center. Such input may be provided either verbally or by utilizing the suggestion box located in the lobby.
    7. The patient may file a formal grievance by submitting a completed grievance form to the director or other staff member.
  - B. Patient Responsibilities
    1. The patient is to provide complete and accurate information to the best of their ability about his/her health, any medications, including over-the-counter products and dietary supplements and any allergies or sensitivities.
    2. The patient is to adhere to the prescribed treatment plan.
    3. The patient is to provide a responsible adult to transport them from the facility and remain with them for 24 hours if required by the provider.
    4. The patient is to inform the provider about any legal directive that could affect his/her care.
    5. The patient is to accept financial responsibility for incurred charges.
    6. The patient is to treat the staff and other patients with respect, consideration, and dignity.
    7. The patient is to arrive on time for their appointment and cancel their appointment if they are unable to make it. Patients failing to show up for their appointments will be subject to a "no-show fee".
    8. The patient is to inform the clinician of any changes in his/her health status that could affect treatment.
    9. The patient is to ask questions to clarify areas of concern.
    10. The patient is to report any adverse side effects of treatment and/or worsening of their condition to the clinician.

**Professional Development**

Policy: The Student Health Center encourages its staff to take advantage of opportunities for professional development. Employees may, with prior approval from the director, receive paid leave when attending relevant professional development activities. Additionally, the department may pay for all or a portion of the cost associated with relevant development activities. Such is subject to budget status and the discretion of the director.

In addition to encouraging its staff to take advantage of opportunities for professional development, the department will provide opportunities for professional development through in-house training.

### **Sexual Assault Protocol**

- I. Policy: The staff members of the Sam Houston State University Health Center shall address reports of sexual assaults in a manner that empowers the student to make informed decisions. Disclosure of information related to sexual assaults will take place in accordance with applicable laws. These policies and procedures serve as a general guide for Health Center staff and allow for prudent professionals to act in accordance with established professional standards while ensuring that applicable laws, policies, and procedures are followed.
  
- II. Procedures: The following procedures will be followed when receiving a report of a sexual assault:
  - A. The staff member will educate the student of their options by offering:
    1. medical care as appropriate
      - a.) a referral to HMMH-ER for evidence collection (rape kit)
      - b.) pregnancy screening and emergency contraception as appropriate
      - c.) STD screening and treatment as appropriate
    2. the Sexual Assault Response Team and related counseling services.
    3. to contact UPD for assaults occurring on campus and HPD for off-campus
    4. assistance in contacting friends or family
  - B. The staff member will act in accordance with the student's wishes only contacting others with the student's consent
  - C. The staff member will make a generic notification to the director indicating whether the incident occurred on or off campus and whether the alleged perpetrator poses an immediate threat on campus or in the local community.\* The staff member will make a notification of same to the Vice President for Student Services if the director is not available.
  - D. The director will make a generic notification to the Vice President for Student Services indicating whether the event occurred on or off campus and classifying the alleged perpetrator as either a threat or non-threat to campus safety.
  
- III. Checklist
  - Offer referral to HMMH-ER for evidence collection.
  - Offer pregnancy screening and emergency contraception as appropriate.
  - Offer STD screening and treatment as appropriate.
  - Offer SART notification and counseling services.
  - Offer notification of UPD / HPD as appropriate.
  - Offer assistance contacting friends and family.
  - Notify director or VPSS in absence of director.

*\*This classification shall be made based on the information given by the student. This classification is by no means an indication of the seriousness of the incident, but rather an indication of whether the alleged perpetrator poses an immediate threat on campus or in the local community.*

## **Adverse Incidents**

- I. Definition of adverse incident:
  - A. An unexpected occurrence during a healthcare encounter involving patient death or serious physical or psychological injury or illness, including loss of limb or function, not related to the natural course of the patient's illness or underlying condition.
  - B. Any process variation for which a recurrence carries a significant chance of a serious adverse outcome.
  - C. Events such as breeches in medical care, administrative procedures or other events resulting in a negative impact on a patient, even where death or loss of limb does not occur.
  
- II. Identification of adverse incidents- Identification of adverse incidents is the responsibility of each Health Center staff member. An adverse incident may be identified by:
  - A. Observation
  - B. Patient/staff complaint or concern
  - C. Review of documentation
  - D. Adverse Incident Form
  - E. Any indication of an undesirable outcome
  
- III. Reporting of adverse incidents- The reporting of adverse incidents is to take place in a manner that facilitates the most expeditious minimization or repair of the harm or potential harm arising as a result of the incident.
  - A. *If the adverse incident caused or could have caused harm, the observing staff member will:*
    1. take immediate actions to minimize the harm or potential harm arising as a result of the incident (i.e. post wet floor sign, address unexpected medical outcome, verbally notify appropriate staff member(s), etc.)
    2. verbally notify the most appropriate staff person(s) to repair or remove the harm or threat of harm resulting from the incident (i.e. treating practitioner for clinical incidents, custodian for spills, etc.)
    3. initiate an Adverse Incident Report and forward it to their supervisor immediately after the completion of step two. Adverse Incident reports are not necessary for incidents that meet ALL of the following criteria:
      - a. the incident is not medical in nature
      - b. the incident caused no actual harm
      - c. the causal factors have been identified and corrected
  - B. If the adverse incident does not pose an immediate threat, the observing staff member will:
    1. verbally notify the most appropriate staff person(s) to address the incident (i.e. treating practitioner for clinical incidents, custodian for spills, etc.)
    2. initiate an Adverse Incident Report and forward it to their supervisor within one hour of the completion of step one if the causal factor persists.

**Adverse Incidents**

III. Reporting of adverse incidents (continued)

- C. Adverse Incident Forms- Staff members are to complete this form according to the instructions listed forwarding it to the director after its completion. Adverse Incident reports are not necessary for incidents that meet the criteria listed in under item III, A, 3.

IV. Analysis of Adverse Incidents- Upon receipt of the Adverse Incident Form, the director will ensure that the incident is investigated to determine the causal factors. Once the causal factors are identified, the director will work with the appropriate staff members to determine and implement the appropriate action to prevent reoccurrence of the incident. Copies of all documentation related to adverse incidents will be retained by the director.

V. Prevention of Adverse Incidents- Many of the department's policies and procedures are designed to prevent adverse incidents. Departmental staff members can prevent adverse incidents by:

- A. Adhering to policies, procedures, and industry standards
- B. Offering input regarding the prevention of adverse incidents
- C. Exercising vigilance



**Governing Body**

Policy: The governing body will consist of the director and the medical practitioners. Given the size and structure of the department, the members of the governing body regularly work together on issues under the governing body's purview. Nonetheless, the governing body will formally meet at least twice a year to review activities in the following areas:

- A. Adverse Incidents
- B. Patient Grievances
- C. Quality of Care
- D. Quality Improvement Program
- E. Policies, Procedures, and Clinical Protocols
- F. Peer Review
- G. Professional Liability Insurance
- H. Cost of Care Issues
- I. Patients Recommended for Dismissal From Care
- J. Prevention of Unauthorized Prescribing
- K. Policies, Procedures, and Protocols
- L. Cost of Care
- M. Other

**Interns and Student Workers**

Policy: The University Health Center regularly employs student workers to assist in front office operations and health promotion activities. Additionally, the Health Center periodically hosts students needing to complete their internship requirements. These students' responsibilities are limited to those delineated by their supervisor and will not, in any case, involve the provision of medical care.

**Visitors at the Student Health Center**

- I. Policy: Only authorized personnel, escorted visitors, and patients are allowed beyond the lobby area of the Sam Houston State University Health Center. In order to protect patient confidentiality and to help maintain a professional atmosphere, staff members' friends and family are not allowed in the office or clinic areas unless authorized by the director or designee.
  
- II. Procedures:
  - A. Visitors will enter through the front door of the Health Center and ask for the person that they came to visit.
  - B. The receptionist will inform the staff member that they have a visitor.
  - C. Visitors will conduct themselves in manner that preserves a professional atmosphere. Any visitors conducting themselves in a contrary manner will be asked to leave.
  - D. Any personal visits with staff members must not affect the operations of the Health Center.

**University Human Resource Policies**

SHSU Human Resource Policies may be found at  
[http://www.shsu.edu/~acc\\_www/policies/policy3a.html#human](http://www.shsu.edu/~acc_www/policies/policy3a.html#human).

**Work Stations**

- I. Policy: In order to facilitate proper operation of the Health Center, each employee is expected to remain at his / her workstation during working hours. It is reasonable to expect that designated breaks and that some job duties will foster instances where employees will be away from their designated workstations. However, these instances should not interfere with the operation of the Health Center and must coincide with policies and procedures.
  
- II. Procedure:
  - A. Each employee will remain at his or her workstation throughout the workday.
  - B. If possible, the employee that left their workstation should keep their workstation in direct line of sight. This is particularly important if there is no other employee manning the workstation.
  - C. If it is not possible for the employee to keep their workstation in line of sight, they must notify a co-worker of their departure from the workstation.
  - D. The employee's supervisor must approve any prolonged absence from an employee's workstation lasting longer than a few minutes.

**Staff-Patient Interaction**

I. Policy: The staff of the Health Center will treat patients with respect, consideration, and dignity. Staff will maintain such treatment regardless of the patient's behavior. Staff will ensure that their interaction with patients over the telephone meet these same standards.

II. Procedure

- A. Staff will knock on the exam room door before entering.
- B. Staff will utilize the student's name and make eye contact when interacting in person with patients.

**Staff Attendance**

I. Policy: The nature of the services offered by the Health Center mandate good attendance by its employees. Employee absenteeism and tardiness can result in patients not receiving needed services and / or unnecessarily increasing the workload of co-workers. When it is necessary for a staff member to be absent or late, they must notify their supervisor as far in advance as possible. A staff member with an attendance pattern that routinely interferes with the operation of the Student Health Center will be deemed problematic and addressed accordingly.

II. Procedure:

- A. Staff will notify their supervisor of the need to be absent in advance when possible. When it is not possible to notify the supervisor in advance, the staff will directly notify their supervisor at the beginning of the day on which they will be absent.
- B. Staff should not use sick time as vacation time. Sick time is intended for days on which the employee or someone in their care is sick or in need of health care services.
- C. If sick leave is requested in advance because of an appointment, the staff member will provide documentation of their attendance to the appointment upon their return to work.
- D. Staff should make every effort to avoid being absent or late.

**Appointment Policy**

- I. Appointment Scheduling: The Health Center will schedule appointments for its patients in a manner that facilitates the timely delivery of needed healthcare services. The Student Health Center will schedule appointments as posted Monday – Friday. Exceptions must be authorized by the director. Appointments may be scheduled in person or over the telephone no more than one day in advance. Exceptions may be made in the case of follow-up appointments or other extenuating circumstances. Patients describing symptoms or in obvious distress will be referred to a nurse.
  
- II. Fee for Missed Appointments: Students failing to show up for their appointments without providing a cancellation notice at least one hour prior to their appointment time may be charged a “no-show” fee. Exceptions may be granted if the student presents reasonable circumstances that prevented them from providing advance notice of their inability to keep their appointment. Such appeals must be presented no more than two business days after the missed appointment unless the circumstances themselves prevented them from doing so. The front office staff will inform patients of the “no-show” fee when they schedule their appointments.



**Staff Conduct**

- I. Policy: Due to the nature of the services provided by the Health Center, it is extremely important that the conduct of the staff foster a professional environment. Staff conduct will convey professionalism and competency. Employees should remember that their conduct affects the patient's level of confidence in the services the Health Center provides.
  
- II. Procedure:
  - A. Conversations between staff will be held in a quiet manner and will only be business related in the presence of patients.
  - B. Staff will refrain from horseplay, cursing, loud talking, and loud laughing.
  - C. Staff members' conversations and comments will contribute to the betterment of the Health Center. Gossip and inappropriate comments will not be tolerated.
  - D. Staff should not give the impression that they are loitering in or around the Health Center.

**Release of Information / Records**

- I. General Policy: The Health Center will maintain the confidentiality of patient-related information. Access to patient information will be restricted. Information will not be released without written consent unless allowed by law. Breaching confidentiality of patient information is grounds for corrective action up to and including termination.
- II. Release of Information
  - A. Purpose: Patient information will be routinely released for the purpose of facilitating treatment, payment, and healthcare operations only. A specific consent is required to release medical information for non-routine purposes.
  - B. Consent: A written consent is required prior to the release of any patient information that is not specifically allowed by law. The consent, unless otherwise stated, allows for the release of information as stated in A. *Purpose*.
  - C. Documentation of Release: Each release of medical records will be recorded in a log located in the copy room.
  - D. Release of Information Via Facsimile:
    1. All faxes are to be sent using the Health Center's fax coversheet.
    2. Staff members will not fax any medical information without written consent to release the information.
    3. Staff members will double check the fax number before sending the records.
  - E. Release of Information to Patient: Staff will verify the patient's identity by photo identification prior to releasing written copies of their record.
  - F. Restrictions: The patient may place restrictions on the consent to release information.
  - G. Non - Routine: Any release of information that is not related to treatment, payment, and health care operations is categorized as non-routine. A specific consent for the release of information is required in such situations.
  - H. Required or Allowed By Law: A consent is not required in order to release information mandated or permitted under law. Examples include: pertinent patient information during a medical emergency, subpoenaed records, and non-identifiable patient information such as age, gender, diagnosis, and treatment for statistical purposes.
  - I. Staff members will not release patient information unless written consent is given by the patient.
- III. Staff Access to Records- Staff will have varying access to patient records depending on their job duties. Access to patient information is granted on a need to know basis. All of the staff, except the custodian and health programming coordinator, are either involved in patient care or have administrative duties that require varying access to medical records.
- IV. Patient Access to Records: Patients may review their records and request amendments.

**Release of Information / Records (continued)**

- V. Computerized Medical Records: Computerized health information is not transmitted outside the local network of the Health Center. Access to the computer programs are protected by permit, username, and password.

**Disposal of Patient Information**

Policy: All documents containing patient information must be shredded prior to disposal.

**Health Center Purchases**

Policy: Purchases will be made in accordance with the university purchasing policies and procedures. The university policies and procedures governing purchasing can be found at <http://www.shsu.edu/administrative/policies/purch.html> . These policies and procedures include information pertaining to the limitations on the authority and types of purchases that can be made with express purchase orders. In the event of that the on-line guidelines do not represent the most current policies and procedures, the department will adhere to those in effect at the time of the purchase.

**Patient Charges**

- I. Policy: The Health Center will provide medically necessary health care services to patients regardless of their ability to pay. Prior to receiving services that will result in charges, the patient will be advised of the fee charged for the proposed service. Patients are expected to pay for any charges incurred at the time of their visit. If the patient is unable to pay for medically necessary services, they may charge the fees to their account. However, this is not encouraged and should be considered the last resort. Patients receiving laboratory work that must be sent out, must pay for the tests the same day. Regardless of the circumstances, only the director or designee maintains the authority to dismiss patient charges for services rendered.
- II. Procedure:
  - A. The practitioners and nurses will alert the patient to any possible charges they will incur before they receive chargeable services (see *Patient and Chart Flow*).
  - B. If the patient cannot pay for the services rendered, they may charge it to their account as the last resort with the exception of lab work that must be sent out.
  - C. Front desk personnel will inform the student of the terms and conditions of the charge.

**Vacation**

- I. Policy: Staff members of the Health Center will be allotted vacation in accordance with the policies and procedures of the university. The director and/or designees maintain the authority to grant or deny vacation request in the interest of the operation of the department. Staff members should be mindful of the impact that their absence will have on the operation of the Student Health Center in making their vacation request. When conflicting request are made, the director and/or designees will, using his / her discretion, grant or deny vacation request.
  
- II. Procedure:
  - A. Staff members will submit their request for time off to their supervisor at least two weeks in advance using a *Time Off Request* sheet.
  - B. The director or designee will review the request and either grant or deny the request.
  - C. If approved, the director will sign and date the approval and submit the request to the Secretary III.
  - D. The supervisor will notify the employee of the decision made regarding the request.
  - E. The Secretary III will submit the Time Off Request sheet with the timesheets for the corresponding pay period.

**Dress Code**

- I. Policy: Employees of the Health Center are expected to dress in a manner suitable for their position and the type of work they perform. Employee dress will comply with all applicable industry and safety guidelines. All clothing should be neat, clean, and intact. The practitioners and non-clinical staff will dress, at minimum, in business casual attire. The nurses and medical technologist will dress in scrubs. Employees violating the dress code may be asked to leave the Health Center without pay until the violation is corrected.
- II. Guidelines
  - A. Headwear/hats: Headwear and hats are prohibited unless required during prolonged outdoor activities or they are a component of an approved promotional activity.
  - B. Shirts: no t-shirts or sweat shirts
  - C. Pants: slacks, skirts, dresses; denim is prohibited unless it is a component of an approved promotional activity. No shorts.
  - D. Footwear: socks or hose are required; shoes must be closed-toe and secured to the back of the foot.



**Consumption of Food and Beverages in the Clinic**

Policy: Eating and drinking by employees will be done in a manner as to not interfere with the operation of the Health Center. Such activity should take place out of the view of patients and away from areas in which work-related materials and equipment could be damaged by a mishap. Eating and drinking is disallowed in the examination rooms and laboratory due to the possible presence of blood borne pathogens.

**Patient / Chart Flow**

- I. Policy: The Sam Houston State University Health Center will ensure the timely delivery of quality health care services by facilitating efficient patient / chart flow. This will be accomplished by establishing a pattern and method by which the patient and their chart will be directed while the patient is obtaining the needed health care services.
  
- II. Procedure:
  - A. Front Office Staff
    1. The patient will enter the Health Center and approach the receptionist's window. At that time, the receptionist will greet the patient and inquire / document the needed information (see Front Office Manual).
    2. If the patient has been in the clinic before, the receptionist will retrieve the patient's chart.
    3. If the patient has not visited the clinic before, a new chart will be made for the patient.
    4. The patient will be asked to sit in the lobby until the nurse calls the patient's name.
    5. The receptionist will place the patient's chart in the appropriate practitioner's slot for the nurse to pick up.
  - B. Nurse
    1. Upon the availability of an examination room, the nurse will go into the lobby and call out the patient's first name.
    2. The nurse will escort the patient from the lobby into the examination room.
    3. The nurse will confirm the patient's identity by asking their middle and last names and SHSU ID/social security number.
    4. The nurse will document the patient's vital signs, chief complaint, history of chronic disease, current medications, and allergies on the assessment sheet in the chart.
    5. The nurse will take the chart to the practitioner. If the practitioner is unavailable, the nurse will place the chart in the holder outside the examination room in which the patient is waiting.
  - C. Practitioner
    1. The practitioner will review the patient's chart and enter the examination room.
    2. The practitioner will examine the patient and ask questions, as appropriate, in order to determine proper diagnosis and orders.
    3. The practitioner will document the diagnosis, orders, and any related notes in the patient's chart on the assessment sheet.
    4. The practitioner will brief the patient on the diagnosis and treatment / order and ask the patient if they have any questions. At this time, the practitioner will advise the patient of any related charges.
    5. The practitioner will escort the patient to the nurses' station and present both the chart and patient to the nurse.

**Patient / Chart Flow (continued)**

II. Procedure:

D. Nurse

1. The nurse will review the orders with the patient and ask if they have any questions.
2. The nurse will outline any related charges with the patient.
3. The nurse will indicate any incurred charges on the billing sheet.
4. The nurse will enter the appropriate codes on the computer using RCPT43M.
5. If the practitioner orders a laboratory test, the nurse will direct the patient to the laboratory. If the test must be send out, the patient should be advised that the lab test charge must be paid that day.

E. Medical Technologist

1. The MT will collect the laboratory requisition from the printer to determine which tests have been ordered.
2. The MT will escort the patient into the lab and educate the patient on the corresponding specimen collection procedure.
3. The MT will collect the specimen.
4. If the test can be completed in-house, the MT will direct the patient to wait in the front lobby while the test is completed.
5. If the test has to be sent out, the MT will advise the patient when they should expect the results (*see Results Notification*).
6. Upon the completion of in-house tests, the MT will take the white copy of the laboratory requisition and the test results and place them face down on the pending labs holder.

F. Nurse

1. The nurse will take the laboratory requisition and test results and paper clip the white copy of the laboratory requisition / results face up on the chart.
2. The nurse will escort the patient back to the examination room and deliver the chart to the practitioner. If the practitioner is unavailable, the nurse will place the chart in the holder outside.

G. Practitioner

1. The practitioner will review the laboratory results.
2. The practitioner will enter the examination room and discuss the results of the laboratory test and any corresponding orders with the patient.
3. The practitioner will document any new orders on the assessment sheet.
4. The practitioner will escort the patient to the nurses' station and present both the chart and patient to the nurse.

H. Nurse

1. The nurse will outline any related charges to the patient.
2. If the practitioner orders a prescription, the nurse will direct the patient to the pharmacy if the patient wishes to fill the prescription at the Health Center.

**Patient / Chart Flow (continued)**

II. Procedure:

I. Pharmacist

1. The patient will present the prescription to the pharmacist.
2. The pharmacist will enter the patient information and prescription in the computer.
3. The pharmacist will take the printed prescription labels and place one on the actual prescription, one on the medication container, and one on the bag.
4. The pharmacist will record the number of prescriptions filled for that particular patient on the prescription label that is placed on the bag.
5. The pharmacist will give the medication and corresponding patient information sheet to the patient.
6. The pharmacist will inform the patient of any special instructions.

J. Nurse

1. If the patient does not receive services that result in charges, the nurse will place the patient's chart in the *No Charges / Finished Charts* slot at the front desk.
2. If the patient receives services that result in charges, the nurse will place the patient's chart in the *Check Out* slot at the front desk.
3. The patient will be directed to the front office to pay any charges due for the services rendered.

K. Front Office Staff

After collecting payment (see Front Office Manual), the receptionist will file any laboratory requisition or test results attached to the chart and return the patient's chart to the chart room and file it in alphabetical order.

## **Universal Precautions**

- I. Policy: All Health Center employees will use universal precautions when coming in contact with potentially infectious materials. *Potentially infectious materials* will be defined as any fluid or item likely containing or coming in contact with a blood borne pathogen. All potentially infectious materials will be considered infectious and treated as such. Such precautionary actions are the essence and definition of universal precautions. Universal precautions will be applied specifically as outlined in *Blood Borne Pathogen Exposure Plan* and generally as outlined in these policies and procedures.
  
- II. Procedures
  - A. Hygiene practices
    1. employees will wash their hands with soap and water after removing their gloves.
    2. any equipment that has come in contact with potentially infectious materials will be sterilized after use if subsequent use of that equipment is planned.
    3. any disposable equipment that has come in contact with potentially infectious material will be disposed of as biohazardous waste (see *Handling and Disposing of Biohazardous Waste*).
    4. clothing that has come in contact with potentially infectious material will be immediately removed and placed in a contaminated laundry bag for proper handling. Saturated clothing will be disposed of as biohazardous waste.
    5. laboratory personnel will remove their lab coat before leaving the laboratory
    6. employees will not eat, drink, or apply cosmetics in the lab or treatment rooms
  - B. Disposal practices

All items coming in contact with potentially infectious materials will be sterilized or disposed of as biohazardous waste (see *Sterilization of Clinic Instruments and Handling and Disposing of Biohazardous Waste*).
  - C. Personal Protective Equipment

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 Health Center will provide and require use of certain protective equipment by its employees (see *Blood Borne Pathogen Exposure Plan*). If there is potential for splashes, protective eye wear, shields, or masks will be utilized. Gloves and lab coats will be used during potential exposures to infectious materials.
  - D. Training and Education

Employees will annually review the policies and procedures related to universal precautions and blood borne pathogens.

**Blood Borne Pathogen Exposure Control Plan**

- I. Reference: OSHA Blood Borne Pathogens Standard, 29 CFR 1910.1030.
- II. Exposure Determination: Occupational exposure is defined as reasonably anticipated skin, eye, mucous membrane, or parenteral contact with blood or other potentially infectious materials that may result from the performance of job duties.
  - A. Custodian
    1. disinfecting and cleaning of treatment and exam rooms
    2. handling and disposing of regular and biohazardous waste
    3. cleaning spills of an unknown nature
    4. cleaning of blood
  - B. Physicians, Physician Assistants, and Nurse Practitioners
    1. examination and/or treatment of genital and anal areas where blood, semen, or vaginal secretions could be present
    2. treatment of open wounds
    3. examination/treatment of open lesions
    4. examination/treatment of lacerations
    5. taking or handling cultures
    6. administration of CPR
    7. handling urine and stool samples with evidence of blood
    8. treatment of any trauma
    9. drawing blood
    10. inoculations
    11. handling of sharps, needles, slides, tubes, and scalpels
    12. wart treatment
    13. handling of biohazardous waste
  - C. Medical Technologist
    1. hematology, serology, HIV, and other sexually transmitted disease testing where exposure to blood, semen, or secretions is present during the test procedure.
    2. spinning of blood
    3. slide preparation and reading
    4. culture handling
    5. preparing samples
    6. capping and uncapping tubes
    7. disposal of blood products, glass, and sharps
    8. phlebotomy
  - D. RN/LVN
    1. examination or treatment of genital/ anal areas where blood, semen, or vaginal secretions could be present
    2. assisting physicians with suturing or other types of wound treatment
    3. dressing changes
    4. treating lacerations
    5. taking or handling cultures
    6. administration of CPR

**Blood Borne Pathogen Exposure Control Plan (continued)**

II. Exposure Determination:

D. RN/LVN

7. handling urine / stool samples with evidence of blood
8. treatment of trauma patients
9. drawing blood
10. administration of inoculation
11. clean up of treatment area after exam or treatment
12. handling of blood samples
13. handling of sharps such as needles, glass, scalpels, scissors, and slides
14. treatment of warts
15. handling of biohazardous waste

E. Office Personnel/Pharmacist

No anticipated potential for exposure in the discharge of duties.

III. Implementation Schedule and Methodology:

A. Compliance Methods: Universal precautions will be observed at this facility. All blood or other potentially infectious material will be considered infectious regardless of the perceived status of the source. Engineering and work practice controls will be implemented to eliminate or minimize exposure to blood borne pathogens. Where occupational exposure remains after the institution of these controls, personal protective clothing and equipment shall be worn. All will be inspected and maintained on a regular basis (see *Universal Precautions*).

1. Engineering and Work Practice Controls

- a.) self-sheathing needles will be used by employing the one-handed technique in this facility and will be inspected before use by the user.
- 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 microscope will be inspected daily and maintenance will be performed as needed, but at least annually.

**Blood Borne Pathogen Exposure Control Plan (continued)**

III. Implementation Schedule and Methodology:

A. Compliance Methods:

1. Engineering and Work Practice Controls

f.) hand washing facilities will be available to employees who incur exposure to blood or other potentially infectious materials. These facilities are available in:

- i. all examination and treatment rooms
- ii. laboratory
- iii. all restrooms
- iv. nursing station

g.) employees will, after removing their gloves, immediately wash their hands and any other potentially contaminated skin area with soap and water. If an employee incurs skin or mucous membrane exposure, these areas shall be washed or flushed with water immediately after contact.

2. Needles: 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. All needles will be equipped with a needle stick protection device. These devices must be engaged after the needle is used.

B. Work Area Restrictions:

1. Employees will not eat, drink, apply cosmetics or lip balm, smoke, or handle contact lenses in areas where there is a reasonable likelihood of exposure to blood or other potentially infectious materials (see Consumption of Food and Beverage *in the Clinic*).
2. Food and beverages are not to be kept in refrigerators, freezers, shelves, cabinets, or on counter tops where blood or other potentially infectious materials are present.
3. Employees are prohibited from mouth pipetting or orally suctioning blood or other infectious materials.
4. Methods Employed to Control Splashing, etc.: All procedures will be conducted in a manner that will minimize splashing, spraying, splattering, and generating droplets of blood or other infectious materials by:
  - a.) using a covered centrifuge
  - b.) inserting a tube cap or parafilm before vortexing



**Blood Borne Pathogen Exposure Control Plan (continued)**

III. Implementation Schedule and Methodology

- C. Personal Protective Equipment: Employees will wear personal protective equipment when performing any job duty where blood or other possibly contaminated fluids are present in order to minimize exposure. Any outer garment saturated with potentially infectious material will be disposed of as biohazardous waste. Durable equipment such as goggles will be disinfected in a 10% bleach solution after each use.
1. Laboratory
    - a.) gloves will be worn for all phlebotomy
    - b.) gloves and eyewear will be worn when uncapping tubes
    - c.) lab coat will be worn at all times in the lab
    - d.) lab coat and gloves will be worn when performing test
    - e.) eyewear will be worn when splashes are likely
  2. Examination / Treatment Rooms
    - a.) gloves, lab coats, and eyewear will be used when performing any job duties where blood is present
    - b.) gloves and lab coats will be worn when examining patients
    - c.) masks will be worn when performing procedures where excessive blood is present.
- D. Specimens:
1. Specimens of potentially infectious materials will be placed in containers that prevent leakage during the collection, handling, processing, storage, and transport. The container used for this purpose will be labeled or color-coded in accordance with the requirements of OSHA Standards. Specimens that remain in the facility will be handled using universal precautions and will be recognizable as specimens.
  2. Any specimens that could puncture a primary container will be placed within a secondary puncture resistant container. If outside contamination of any primary container occurs, the primary container will be placed within a secondary container that prevents leakage during the handling, processing, storage, transport, or shipping of the specimen.
- E. Contaminated Equipment:  
Equipment that has become contaminated with potentially infectious materials will be examined prior to servicing or shipping and shall be decontaminated as necessary unless the decontamination of the equipment is not feasible.
- F. Possible Exposure: In cases of possible exposure, see *Workplace Injuries and Accidents*.

**Employee Vaccinations**

Policy: Certain vaccinations along with TB tests will be made available to employees in accordance with their potential for exposure as a result of the discharge of their job duties. The Hepatitis B and Tdap vaccines along with PPD tests will be made available free of charge to employees with a reasonable opportunity for exposure (see Blood Borne Pathogen Control Plan, page 38 – 39, II, A - E ). Eligible employees that decline the Hepatitis B vaccine must sign the Hepatitis B Declination Form. The flu vaccine is available free of charge for all departmental employees. The MMR vaccine is routinely available at the employee's expense.

## **Handling and Disposing of Biohazardous Waste**

### I. Definitions:

- A. *Biohazardous waste* will, for Health Center purposes, be defined as any body tissue or fluid or item that has come in contact with body tissue or fluid that otherwise cannot be sterilized to remove the threat of cross contamination.
- B. *Non-sharps* will be defined as biohazardous waste that does not have the potential to puncture the skin.
- C. *Sharps* will be defined as biohazardous waste that does have the potential to puncture the skin.

- ### II. Policy:
- All biohazardous waste will be disposed of in accordance with industry and University policies and procedures. Only designated personnel will handle and dispose of biohazardous waste. All persons handling biohazards must wear protective equipment to include, at minimum, gloves. Needles, broken glass products, or any other object that has the potential to puncture the skin must be disposed of in a sharps container. All other biohazardous waste must be disposed of in a red biohazard trash bag housed by a biohazardous container. Captured biohazardous liquids will be disposed of in a sealed vial and placed in a biohazard trash bag.

### III. Procedures:

#### A. Disposal of Biohazardous Waste

- 1. non-sharps
  - a.) the staff will, while wearing gloves, place solid biohazardous waste in a biohazard trash bag housed by a biohazard trash can
  - b.) the staff member will remove their gloves placing them in the biohazardous trash bag.
- 2. sharps
  - a.) the staff will, while wearing gloves, grasp the biohazardous waste in a manner that eliminates the probability of a skin puncture and place it in the sharps container
  - b.) the staff member will remove their gloves placing them in the biohazardous trash bag.

#### B. Clean up of biohazardous spills

- 1. the staff will obtain a spill kit
- 2. the staff will follow the instructions included with the spill kit
- 3. the staff member will remove their gloves placing them in the biohazardous trash bag
- 4. the area will then be disinfected with a 10% bleach solution
- 5. any mop water used in the disinfection of the spill area must be disposed of after the clean up is complete.

**Service Exclusions**

Policy: Due to the limited nature of the medical services provided at the SHSU Student Health Center, the department does not provide:

- A. Initial treatment or evaluation of injuries sustained in a motor vehicle accident (other than stabilization for EMS transport).
- B. Treatment for Worker's Compensation cases
- C. Treatment of pregnant women
- D. Conditions requiring urgent care or any condition that the practitioner deems appropriate for outside treatment.

### **Quality Improvement Program**

- I. Policy: The Student Health Center's commitment to continually improve its services and programs is demonstrated through both formal and informal activities that comprise its quality improvement program. Opportunities for improvement are revealed through adverse incidents, peer review, quality assurance activities, patient grievances, patient satisfaction surveys, comparison with established benchmarks, and patient and staff input. Quality improvement activities are presented to and reviewed by the governing body. Due to the size and structure of the department, the members of the governing body, the director and physician, are often involved in the quality improvement activity itself. The director maintains responsibility for the program although all of the staff members are involved. The quality improvement program itself will be reviewed annually by the governing body.
- II. Quality Improvement Processes/Mechanisms
  - A. Adverse Incidents- Adverse incidents indicate possible areas of needed improvement. Completion of the Adverse Incident Form facilitates the quality improvement process.
  - B. Peer Review- The medical record review process is a quality assurance process that measures medical records against established criteria. If the process identifies an area of needed improvement, it is addressed through the quality improvement process.
  - C. Patient Grievances- Patient grievances have the potential to identify areas of potential improvement.
  - D. Satisfaction/Evaluation Surveys- Surveys have the potential to identify areas of potential improvement.
  - E. Quality Assessment- The department's quality assessment studies will be designed to measure performance and to identify areas of potential improvement when they exist. These type studies are simply a discovery process and may or may not identify areas of potential improvement. Quality improvement studies are conducted when an area of potential improvement and intervention has been identified.
  - F. Quality Assurance- The department's quality assurance activities will measure actual performance against predetermined standards and determine areas of potential improvement if any.
- II. Goals and Objectives FY 2009
  - Goal: Complete two quality improvement studies.
  - Objective 1: Complete a study that established internal benchmarks and measure patient outcomes.
  - Objective 2: Complete a study in a non-clinical area.

**Risk Management Program**

Policy: The Student Health Center maintains a risk management program comprised of a variety of measures. The governing body is responsible for reviewing and developing the risk management program. The risk management program as a whole will be reviewed annually while risk management issues will be reviewed by the governing body as needed. The risk management program includes, but is not limited to the review of issues related to:

- A. Adverse Incidents
- B. Quality of Care Issues
- C. Malpractice Claims
- D. Patient Complaints
- E. Patients Recommended for Dismissal From Care
- F. Professional Liability Insurance
- G. Peer Review
- H. Prevention of Unauthorized Prescribing
- I. Policies and Procedures

Policy: In the event of an emergency, the Health Center 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.

**Follow-up for Missed Appointments**

- I. Policy: Front office staff will provide and document follow-up for patients that miss their appointment. The follow-up will take place by the end of the business day after their missed appointment.
  
- II. Procedure:
  - A. The front office staff will place a large “x” across the Patient Assessment Sheet when a patient misses their appointment.
  - B. The patient’s chart will be placed in the “Missed Appointment” tray.
  - C. The front office staff will gather the charts in the “Missed Appointment” tray and attempt to contact the patient by phone.
  - D. The front office staff will document the contact on the Patient Assessment Sheet.
  - E. The front office staff will then place the chart in the “To Be Filed” bin.



**Interactions With Patients**

- I. Policy: The front office staff has a significant impact on a patient's perception of the Health Center. Therefore, their interaction with the patient is very important and must be treated as such. All staff members are expected to present themselves in a professional and courteous manner at all times regardless of circumstances. A smile and a good attitude are mandatory.
  
- II. Procedure:
  - A. Common courtesy is to be used when interacting with patients. This includes smiling, saying "please" and "thank you", and presenting a courteous demeanor.
  - B. It is very important to immediately acknowledge patients when they come to the window even when you can not help them right away. While smiling, make eye contact, and tell the patient, "I will be with you in one moment". After returning to them say, "I am sorry to keep you waiting, how can I help you?"
  - C. Always present options to a patient when you are unable to meet their needs to show them that you are really interested in helping them.

## **Patient Charts**

### I. Definitions:

- A. *Active Chart*, for Health Center purposes, will be defined as the records of a patient who has visited the Health Center within seven years.
- B. *Inactive Chart*, for Health Center purposes, will be defined as the records of a patient who has not visited the Health Center within seven or more years.

### II. Policy:

- A. **General:** The Health Center will construct, maintain, and store patient charts in a manner that will facilitate the timely delivery of quality medical services. Patient charts and the documents thereof shall be treated as confidential documents (see *Confidentiality of Information / Records* ). The Administrative Secretary maintains primary responsibility for the care, distribution, protection, and utilization of the medical records.
- B. **Labeling:** Patient chart labels will include the patients' last name, first name, middle initial, and SHSU ID along with a sticker noting the year of their last visit.
- C. **Filing and Storage:** All patient charts will be filed in the chart room alphabetically by the patient's last name.
- D. **Retention of Records:** The Health Center shall maintain patients' medical records for seven years from the anniversary date of the date of last treatment.
- E. **Destruction of Inactive Records:** Prior to destroying any record, an entry documenting the patient name, date of last activity, general content of record, and date of destruction must be made in the Medical Record Destruction Log. During the winter and summer break of each year, inactive records will be purged and destroyed via shredding.

### III. Basic Content of Record

- A. Patient Information Sheet containing demographic, contact, insurance, and payment information.
- B. Health History Summary
- C. Patient Privacy Act
- D. Patient Rights & Responsibilities
- E. Patient Health History
- F. Patient Rights & Responsibilities Form
- G. Blank Patient Assessment containing sections for documentation of the patient's chief complaint, vital signs, diagnosis, treatment, charges / payment, name, SHSU ID, receipt number, the date of visit, and the practitioner's signature
- H. Previous Assessment Sheets containing the completed documentation of the information outlined in item G.
- I. Related nursing or practitioner notes documenting pertinent information related to the patient's visit
- J. Reports relevant to the patient's visit such as test results
- K. Miscellaneous documents related to the patient's medical care

**Answering the Telephone**

I. Policy: Health Center staff will answer the phone in a professional and courteous manner. Staff will direct phone calls to the appropriate extension in order to meet the caller's needs. Unless licensed, staff answering the phone will not answer medical questions or give medical advice. Front office staff will give an incoming call priority as the person calling in cannot "see" why the phone is not being answered during normal business hours.

II. Procedure:

- A. Staff will answer the phone by stating, "Health Center, how may I help you?"
- B. If the staff answering the phone is unable to meet the caller's need, the call will be transferred to the appropriate extension. If the phone is not answered, it will automatically transfer to the voice mail system. Inform the caller of this before they are transferred by stating, "I am going to transfer you, if they are not available to take your call please leave a message and they will return your call as soon as possible."
- C. If it is necessary to place the person on hold please inform them that you will place them on hold while you attempt to help them. Do not leave a person on hold for more that two minutes without checking back with them.
- D. Staff will consult with their supervisor if they are unsure of how to handle a particular phone call.

**Checking in Patients**

- I. Policy: All patients must check in prior to going beyond the lobby. This allows the front office staff to, at minimum check the student's enrollment. Front office staff will register patients in such a manner as to facilitate professional, courteous, and efficient service. To ensure confidentiality, staff will not inquire about specific details of their medical needs.
  
- II. Procedure:
  - A. Staff will greet patients by asking, "Good Morning/Afternoon, how may I help you?"
  - B. If the patient indicates that they have an appointment, staff will check the appointment roster for the patients name and place a mark to the left of their name.
  - C. Staff will ask the patient for their ID card to verify enrollment by entering the patient's SHSU ID.
  - D. Staff will ask new patients to fill out a Patient Information Form. Staff will make and date necessary corrections on the form only one time before requesting that the patient fill out a new form.
  - E. Staff will print a chart label for new patients containing the patient's last name followed by their first name middle initial, and SHSU ID.
  - F. Staff will record the patient's name, SHSU ID, on the bottom of the Patient Assessment Form.

## **Transactions**

- I. Policy: Only the assigned staff member for a given day may conduct transactions. Exceptions may be granted by the director or designee; however, the drawer must be reconciled prior to the second staff member conducting a transaction.
- II. Computer Procedures
  - A. Entering Transactions
    1. staff will access NELL
    2. staff will access the TCPT01M program
    3. staff will enter the patient's social security/SHSU ID
    4. staff will indicate if the patient is returning an item
    5. if yes, staff will choose the item that they are returning
    6. staff will indicate if the patient filled a prescription at the pharmacy
    7. if yes, staff will enter the amount
    8. staff will enter the amount paid on total clinic charges
    9. staff will enter the amount paid on total pharmacy charges
    10. staff will enter the total amount paid next to the correct method of payment (cash, credit card, check)
    11. staff will press enter to print out a receipt
    12. staff will keep the short receipt to send to Administrative Accounting, give one of the long receipts to the patient, and keep the other for clinic records
  - B. Investigating Total Amounts Due- The total amount listed on the screen is most likely correct. However, when the total amount due deviates from the total clinic charges, staff must investigate the total by doing the following:
    1. access the RCPT10R, STUDENT BALANCE REPORT
    2. note whether any outstanding debits/credits have been applied to their account
    3. inform the student of what you have noted and the amount that is owed
  - C. Correcting Incorrect Entries
    1. access RCPT44M, CHANGE AMT/DATE DUE FOR CLINIC
    2. enter the patient's social security/ID number
    3. enter the correct amount where the cursor appears
    4. press the tab button
    5. repeat steps 3 and 4 until all charges/payment amounts are correct
    6. press enter
    7. when prompted press the "s" key
  - D. End of the Day Report
    1. access TCPT02R, CLINIC END OF DAY PAYMENT SUMMARY
    2. enter "c" for clinic
    3. press <Enter> for the report representing the current day or enter the date for the desired report

**Transactions (continued)**

III. Credit card transactions

- A. The staff will take the patient's Visa or Master Card and swipe it through the machine.
- B. The staff will enter the last four digits of the credit card number and press the *Enter* key.
- C. The staff will enter the transaction amount and press the *Enter* key.
- D. The staff will wait for the transaction to be approved and receipt to be printed.
- E. The staff will remove the receipt from the credit card machine.
- F. The staff will present the credit card and receipt to the patient.
- G. The staff will ask the patient to sign the receipt and list a phone number at which they can be reached.
- H. The staff will give the patient the pink copy of the receipt and place the white and yellow copies in the cash register after entering the transaction.

IV. Closing the Credit Card Machine for the Day

- A. Staff will press "M/Report" key
- B. Staff will press the "2/Detail" key
- C. Staff will press the "4/Log" key
- D. Staff will wait for the "Swipe Customer" message
- D. Staff will press the "E/Transmit" key
- E. Staff will press the "Enter" key twice at the appearance of the "yes or no" prompt.
- F. Staff will wait for a report of the credit card transactions for the day to print.
- G. Staff will remove the report and place the white copy with the deposit and the yellow copy with the credit card receipts from the day.

**Payment for Services**

- I. Policy: Payment for services is required at the time services are rendered. Students experiencing health conditions requiring services and/or medications may defer payment of their charges. Students have 14 days to pay the amount due before a \$10 late fee is assessed. Students may not charge discretionary services or medications such as STD testing, send out laboratory tests, pregnancy tests, and contraception.
- II. Procedure:
  - A. The front office staff will direct patient's attention to the payment policy on the bottom of the patient information sheet.
  - B. Front office staff will explain the policy to any student attempting to charge discretionary services and medications. If the student insists that they do not have any money the staff will suggest that they come back later that day with the money. The charges have already been entered so the student will still have to pay even if they do not return.
  - C. Inform students who want to charge services or medications of our payment policy. If they insist that they cannot pay, inform them that you will place the balance on their account and it must be paid within 14 days or a \$10 late fee will be assessed.

### **Appointment Scheduling**

- I. Policy: The Health Center will schedule appointments for its patients in a manner that facilitates the efficient delivery of healthcare services. Appointments may be scheduled in person or over the telephone one day in advance. Patients describing symptoms or in obvious distress will be referred to a nurse.
- II. Procedure:
  - A. Appointments will be available every fifteen minutes during the designated hours of operation. Exceptions must be authorized by the director. The person scheduling the appointment will:
    1. ask the person if they are enrolled in the current semester
    2. if the student is not enrolled, the staff will inform the student that they must be enrolled to receive services
    3. if the student is enrolled, the staff member will determine the appointment time and ask the student their first name, last name, middle initial, phone number, and SHSU ID and record it on the Patient Roster. The staff will also determine if the student is a new patient. The staff will inform the patient of the date and time of the appointment, the name and position of the practitioner, and the “no-show” fee for failing to keep their appointment without providing at least a one hour notice.
  - B. Patients arriving early for their appointment may be seen before their appointment time.



### **Diabetes Screening Protocol**

Effective June 2006, the SHSU Student Health Center adopted a slightly modified version of the American Diabetes Association's recommendations for screening patients for diabetes. As a result of the high number of patients with obesity, we will offer a 2 hour oral glucose tolerance test for those with a BMI  $\geq 30$  and one or more of the high risk factors. The 2 hour oral glucose tolerance test is utilized based upon the fact that the first apparent glucose abnormality is the post prandial glucose level.

Although diabetic screening is clearly valuable not all office visits allow enough time for preventive care discussions. If diabetic screening cannot be complete during the intake process then it can be deferred to a follow-up visit.

#### High Risk Factors

- 1.) Sedentary lifestyle
- 2.) Prior history of glucose intolerance
- 3.) Race / ethnicity (Hispanic, African-American, Native American, Asian, Pacific Islander)
- 4.) Family history of diabetes in one or more first-degree relatives
- 5.) History of HTN  $> 140/90$
- 6.) History of vascular disease
- 7.) History of dyslipidemia: HDL  $< 35$  mg/dl and/or Triglycerides  $\geq 250$  mg/dl
- 8.) Markers of insulin resistance (Acanthosis nigricans and/or waist circumference  $> 40$  inches in men and  $> 35$  inches in women.)
- 9.) History of polycystic ovarian syndrome (PCOS)
- 10.) History of Gestational diabetes or delivery of a baby weighing  $> 9$  pounds at birth.

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Physician Signature Date

**Cervical Cancer Screening**

- I. Overview: Effective June 12, 2006, the SHSU Student Health Center adopted the following cervical screening guidelines established by the American College of Gynecology in order to manage patients under the age of 30 whose Pap tests are abnormal, particularly those indicating atypical squamous cells of undetermined significance (ASC-US).
  
- II. Screening Protocol
  - A. Conventional Cytology
    1. Negative → routine annual screening
    2. ASC-US → obtain thin prep w/ HPV DNA in 6 months
  3. > ASCUS → refer to GYN
  - B. Thin prep
    1. Negative with HPV (-)\* → routine annual screening
    2. ASC-US:
      - a. HPV (-) → Repeat thin prep and HPV DNA in 1 year
      - b. HPV (+)
        - i. (+) High Risk HPV → Refer for colposcopy
        - ii. (-) High Risk HPV → Repeat thin prep and HPV DNA in 6 months
    3. > ASC-US with any HPV → refer for colposcopy
  - C. Last Pap Abnormal → thin prep and collect HPV DNA

\* HPV (-) and Low Risk HPV are equivalent.

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Physician Signature Date

### **Asthma Management Protocol**

- I. Overview: The Sam Houston State University Student Health Center follows the diagnostic and therapeutic guidelines set forth by the 2002 National Asthma Education and Prevention Program\* as condensed on the following page. Students 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 and/or spirometry testing are available on site to corroborate disease severity. Once stratified, an appropriate treatment regimen and home-monitoring program should be offered to the student. Short-term follow up within one week is strongly recommended after an acute exacerbation. Patients requesting refills of their rescue inhalers more often than every 90 days will be encouraged to follow up with their clinician.
- 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<sub>2</sub>-agonist
  - E. Minimal or no adverse effects from medications
- III. Treatment intensity
  - A. Step down: Review treatment every 1 to 6 months; a gradual stepwise reduction in treatment may be possible.
  - B. Step up: If control is not maintained, consider step up. First review patient medication technique, adherence, and environmental control.
- IV. Miscellaneous Notes
  - A. The stepwise approach is meant to assist, not replace, the clinical decision making required to meet individual patient needs.
  - B. Classify severity: assign patient to most severe step in which any feature occurs (PEF is % of personal best FEV<sub>1</sub> is % predicted).
  - C. Gain control as quickly as possible (consider shorter course of systemic corticosteroids), then step down to the least medication necessary to maintain control.
  - D. Minimize use of short-acting inhaled beta<sub>2</sub>-agonist. Over-reliance on short-acting inhaled beta<sub>2</sub>-agonist (e.g. use of approximately one canister a month even if not using it every day) indicates inadequate control of asthma and the need to initiate or intensify long-term control therapy.
  - E. Provide education on self-management and controlling environmental factors that make asthma worse (e.g. allergens and irritants).
  - F. 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.
  - G. Accurate stratification for a patient may be deferred if he/she presents for treatment only during an acute exacerbation.

**Staphylococcal Abscess Protocol**

In order to minimize cost, potential side effects, and overuse of systemic antibiotics yet retain therapeutic efficacy, the following regimen is recommended for management of most staphylococcal boils.

NOTE: The 2005 antibiogram at Huntsville Memorial Hospital showed a 71% methicillin resistance rate from over 900 staphylococcal aureus cultures.

- I. Abscess with cavity and erythema  $\leq$  5cm diameter.
  - A. Treat with drainage<sup>1</sup>, topical antibiotics, and local heat.
  - B. Follow-up office visit should be scheduled in 1-3 days<sup>2</sup>.
  
- II. Abscess with cavity and erythema  $>$  5cm diameter OR presence of comorbidities<sup>3</sup>
  - A. In most cases, should be treated both by systemic antibiotics and adequate drainage, topical antibiotics, and local heat.
  - B. Wound culture is strongly recommended.
  - C. Follow-up office visit should be scheduled in 1-3 days.

Footnotes

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<sup>1</sup> Not all abscesses will be drained due to variables including but not limited to size, severity, and fluctuance.

<sup>2</sup> Recommendations for follow-up are dependent upon the patient's condition and may include orders to return if their condition does not improve.

<sup>3</sup> Comorbidities: Systemic illness, structure involved other than skin, immunosuppression of any sort, multiple sites or disseminated pattern, relapse/recurrence or failed initial incision and drainage, heart murmur, or the presence of any indwelling line or implanted device.

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Physician Signature Date

Protocol revised-09/07/07

**Licensing Board and NPDB Reporting**

- I. Policy: The Health Center will report all professional review action based on issues related to professional competence or conduct that adversely affects clinical privileges for a period longer than 30 days. Additionally, the department will report any voluntary surrender or restriction of clinical privileges while under, or to avoid, investigation. Such information will be reported to the appropriate licensing board within 15 days of the action in accordance with the governing regulations.
  
- II. Procedure:
  - A. The governing body shall formulate and review the report.
  - B. The governing body will submit the report to the appropriate agency in accordance with reporting requirements.
  - C. The director will formulate and review the form with the physician providing peer review if the report is concerning the staff physician.
  - D. The director will submit the report.
  - E. The governing body will ensure that any subsequent changes such as reinstatement of privileges are reported in accordance with requirements.

**Medical Abbreviations**

I. Policy: In order to ensure consistency in written communications regarding medical matters, the Student Health Center’s staff will use the abbreviations listed below.

A. Pharmaceutical Abbreviations

<b>BID</b>	Twice daily	<b>MWF</b>	Monday, Wednesday, Friday	<b>qd</b>	Once daily
<b>BIW</b>	Twice weekly	<b>OD</b>	Right eye	<b>qhs</b>	At bedtime
<b>cc</b>	cubic centimeters	<b>OS</b>	Left eye	<b>QID</b>	Four times daily
<b>gm</b>	gram	<b>OU</b>	Both eyes	<b>qod</b>	Every other day
<b>IM</b>	Intramuscularly	<b>PO</b>	By mouth	<b>qpm</b>	Each evening
<b>IU</b>	International Units	<b>PR</b>	By rectum	<b>SQ</b>	Subcutaneously
<b>kg</b>	kilogram	<b>PRN</b>	As needed	<b>TID</b>	Three times daily
<b>mcg</b>	Microgram	<b>qac</b>	Before meals	<b>TIW</b>	Three times weekly
<b>mg</b>	Milligram	<b>qam</b>	Each morning	<b>units</b>	Units
<b>ml</b>	milliliters				

B. Progress Note/Assessment Abbreviations

<b>(B)</b>	Bilateral	<b>CTA&amp;P</b>	Clear to auscultation & percussion	<b>PERRI &amp; EOMI</b>	Pupils equal round & reactive to light with extraocular movement intact.
<b>B ♂</b>	Black Male				
<b>♀</b>	Female	<b>CX</b>	Cervix		
<b>(L)</b>	Left	<b>CXR</b>	Chest Xray	<b>PIP/DIP</b>	Proximal Interphalangeal
<b>♂</b>	Male	<b>D/C</b>	Discharge Discontinue	<b>PMHx</b>	Past Medical History
<b>(R)</b>	Right			<b>PND</b>	Post Nasal Drip Paroxysmal Nocturnal Dyspnea
<b>Abnl</b>	Abnormal	<b>EAC’s</b>	External Auditory Canals	<b>PSHx</b>	Past Surgical History
<b>ASAP</b>	As Soon As Possible	<b>EG</b>	External Genitalia	<b>PPD</b>	Purified Protein Derivative
<b>BF</b>	Black Female	<b>Extr</b>	Extremities	<b>RICE</b>	Rest, Ice, Compression, Elevation
<b>Bilat</b>	Bilateral	<b>GU</b>	Genitourinary		
		<b>FHx</b>	Family History		
<b>BM</b>	Black Male	<b>HA</b>	Headache	<b>RRR</b>	Regular Rate & Rhythm
<b>BME</b>	Bimanual Exam	<b>I&amp;D</b>	Incision & Drainage	<b>s</b>	Without
<b>BMI</b>	Body Mass Index	<b>LA</b>	Lymphadenopathy	<b>SBE</b>	Subacute Bacterial Endocarditis
<b>BRAT(T)</b>	Bananas, Rice, Apples Tea (Toast)	<b>LAF</b>	Latin American Female		
		<b>LAM</b>	Latin American Male		
<b>BRBPR</b>	Bright Red Blood Per Rectum	<b>MCP</b>	Metacarpophalangeal	<b>SHx</b>	Social History
<b>BSE</b>	Breast Self Exam	<b>MMG</b>	Mammogram	<b>STAT</b>	Immediately (Due to life threatening condition)
<b>BS’s</b>	Bowel Sounds	<b>MRI</b>	Magnetic Resonance Imaging		
<b>BUS</b>	Bartholin’s/Urethra/Skenes	<b>MTP</b>	Metatarsophalangeal	<b>USG</b>	Ultrasound
<b>c</b>	With	<b>N/V/D</b>	Nausea/Vomiting/Diarrhea	<b>WF</b>	White Female
<b>c/o</b>	Complains of	<b>NAD</b>	No Apparent Distress	<b>WM</b>	White Male
<b>c/w</b>	Consistent with	<b>NT/ND</b>	Nontender/Nondistended	<b>WME</b>	Well Man Exam
<b>Cor:</b>	Cardiac (Coronary)	<b>o/p</b>	Oropharynx	<b>WNL</b>	Within Normal Limits
<b>CP</b>	Chest Pain	<b>o/w</b>	Otherwise	<b>WWE</b>	Well Woman Exam
<b>CT</b>	Computed Tomography	<b>p</b>	After	<b>x</b>	Except

**Medical Abbreviations**

C. Diagnostic Abbreviations

<b>ADD</b>	Attention Deficit Disorder	<b>LUL</b>	Left Upper Lobe
<b>ADHD</b>	Attention Deficit Hyperactivity Disorder	<b>LUQ</b>	Left Upper Quadrant
<b>AK's</b>	Actinic Keratoses	<b>MONO</b>	Mononucleosis
<b>(B) OM</b>	Bilateral Otitis Media	<b>MRSA</b>	Methicillin-Resistant Staph Aureus
<b>(B) SOM</b>	Bilateral Serous Otitis Media	<b>MVA</b>	Motor Vehicle Accident
<b>BV</b>	Bacterial Vaginitis	<b>MVC</b>	Motor Vehicle Collision
<b>CAD</b>	Coronary Artery Disease	<b>OA</b>	Osteoarthritis
<b>CHF</b>	Congestive Heart Failure	<b>OCA's</b>	Oral Contraceptive Agents
<b>CHLAM</b>	Chlamydia	<b>OCD</b>	Obsessive Compulsive Disorder
<b>CMV</b>	Cytomegalovirus	<b>PID</b>	Pelvic Inflammatory Disease
<b>COPD</b>	Chronic Obstructive Pulmonary Disease	<b>PMS</b>	Pre-Menstrual Syndrome
<b>CTS</b>	Carpal Tunnel Syndrome	<b>PPD</b>	Purified Protein Derivative
<b>ED</b>	Erectile Dysfunction	<b>PTSD</b>	Post Traumatic Stress Disorder
<b>ETD</b>	Eustachian Tube Dysfunction	<b>RA</b>	Rheumatoid Arthritis
<b>FX</b>	Fracture	<b>RAD</b>	Reactive Airway Disease
<b>GC</b>	Gonorrhea (Gonococcus)	<b>RLL</b>	Right Lower Lobe
<b>GERD</b>	Gastroesophageal Reflux Disease	<b>RLQ</b>	Right Lower Quadrant
<b>HEP A</b>	Hepatitis A	<b>RML</b>	Right Middle Lobe
<b>HEP B</b>	Hepatitis B	<b>(R) OM</b>	Right Otitis Media
<b>HEP C</b>	Hepatitis C	<b>(R) SOM</b>	Right Serous Otitis Media
<b>HIV</b>	Human Immunodeficiency Virus	<b>RUL</b>	Right Upper Lobe
<b>HPV</b>	Human Papilloma Virus	<b>RUQ</b>	Right Upper Quadrant
<b>HSV</b>	Herpes Simplex Virus	<b>SEB DERM</b>	Seborrheic Dermatitis
<b>HTN</b>	Hypertension	<b>SLE</b>	Systemic Lupus Erythematosus
<b>IBD</b>	Inflammatory Bowel Disease	<b>STD</b>	Sexually Transmitted Disease
<b>IBS</b>	Irritable Bowel Syndrome	<b>STI</b>	Sexually Transmitted Infection
<b>ITP</b>	Idiopathic Thrombocytopenic Purpura	<b>TB</b>	Tuberculosis
<b>JRA</b>	Juvenile Rheumatoid Arthritis	<b>TMJ</b>	Temporomandibular Joint
<b>L/S</b>	Lumbar Strain	<b>TYPE I DM</b>	Type I Diabetes Mellitus
<b>LBP</b>	Low Back Pain	<b>TYPE II DM</b>	Type II Diabetes Mellitus
<b>LLL</b>	Left Lower Lobe	<b>URI</b>	Upper Respiratory Infection
<b>LLQ</b>	Left Lower Quadrant	<b>UTI</b>	Urinary Tract Infection
<b>(L) OM</b>	Left Otitis Media	<b>WT</b>	Weight
<b>(L) SOM</b>	Left Serous Otitis Media		

**Medication Samples**

Policy: The prescription drug samples will be maintained by the physician. The medications will be stored in a secure location. An inventory of sample prescription medications will be maintained and a full inventory count will take place at the end of each semester. Expired medications will be separated from stock and disposed of through the pharmacy.



**Security of Prescription Pads**

Policy: In order to protect against misuse of prescription pads due to unauthorized patient access, the following measures have been implemented:

- A. The bulk supply of prescription pads is stored in a locked cabinet.
- B. Prescription pads are not otherwise left unattended in areas where patients have unrestricted access.
- C. Pre-signed and postdated prescription pads are prohibited.

**Patient Record Summaries**

Policy: Effective May 25, 2006, the SHSU Student Health Center will utilize Patient Record Summaries on all medical records.

**Chaperone Policy**

Policy: A chaperone will be present in the exam room during all female pelvic, breast, and rectal exams. During male genital and rectal exams, a chaperone will also be present for female practitioners. A male practitioner may examine a male patient without a chaperone.

**Permanent Discharge of Patients**

Policy: Any practitioner wishing to permanently discharge a patient from their care must submit a written request to the governing body. The request must specify the reason for wanting to discharge the patient along with documentation that other alternatives have been exhausted. The governing body shall review such a request and render a decision within three business days. If a decision to discharge a patient is made, the decision must be communicated to the patient in writing and presented to the patient in a meeting with the treating practitioner and the director present. All decisions to discharge patients shall be made in concert with the VPSS.

**Review and Filing of Patient Information**

- I.** Policy: Reports, histories, and physicals, progress notes, and other patient information such as laboratory reports, x-ray readings, operative reports, anesthesia records, and consultations will be reviewed and incorporated into the patient record within two business days of receipt.
- II.** Procedure:
- A. Send-out Lab Results**
1. Upon receipt of the results, the medical technologist will put the lab results into the “Labs” tray located in the front office.
  2. Front office staff will pull the chart, paperclip the lab results to the front of the chart and hand it to one of the nurses.
  3. The nurse will give the chart to the treating practitioner for review and signature.
  4. After signing, the practitioner will put the chart into the tray at the Nurses’ Station and one of the nurses will contact the patient with the results.
  5. After contacting the patient, the nurse will put the chart in the “No Charge” slot.
  6. The front office staff will then check that the lab has been signed by the practitioner before filing it in the chart.
- B. In-house Lab Results**
1. Upon the completion of the test, the medical technologist will put the lab results on the “Pending Labs” clip across from the nursing station.
  2. A nurse will paperclip the lab results to the patient’s chart and take the patient to an exam room for the treating practitioner to discuss the results.
  3. The nurse will enter the diagnosis into the computer.
  4. The chart is put into the “Check Out” slot.
  5. The front office staff will then check that the lab has been signed by the practitioner before filing it in the chart.
- C. Faxed Lab/Test Results**
1. Front office staff will check regularly for incoming faxes.
  2. All lab results will be given to the medical technologist upon receipt. All other faxed test results will be handled as outlined in A, 2 – 6.
  3. After making a copy and initialing, the medical technologist will put the lab results into the “Labs” tray located in the front office.
  4. Follow steps 2 – 6 under Section II, A.
- D. Faxed Medical Records**
1. Front office staff will check regularly for incoming faxes.
  2. Follow steps 2-6 under Section II, A.
- E. Mailed Medical Records**
1. Upon receipt, the secretary will put the medical records into the “Labs” tray located in the front office.
  2. Follow steps 2-6 under Send-Out Lab Results.

**Crisis Intervention**

- I. Policy: Staff will activate the Crisis Team in the case of a patient that poses an imminent threat to themselves or others. If a patient chooses to leave the facility against medical advice, the staff will not hinder the person from doing so. The director and physician are to be notified regarding any student who has been deemed to be an immediate threat to themselves or others. Thorough documentation of the department's intervention must be made in the medical record in such instances.
- II. Procedure: If a patient has been deemed an imminent threat to themselves or others, the treating practitioner will:
  - A. Notify the physician as appropriate
  - B. As appropriate, discuss the need for an immediate consultation with a counselor from the Counseling Center.
  - C. Contact the Counseling Center and, as appropriate, UPD to inform them of the crisis.
  - D. Ensure thorough documentation in the patient's medical record regarding the intervention and outcome.
  - E. Notify the director of the incident. Staff will notify the dean of students if the director is not available.
  - F. The director will notify the dean of students.

### **Sexual Assault Protocol**

- I. Policy: The staff members of the Sam Houston State University Health Center shall address reports of sexual assaults in a manner that empowers the student to make informed decisions. Disclosure of information related to sexual assaults will take place in accordance with applicable laws. These policies and procedures serve as a general guide for Health Center staff and allow for prudent professionals to act in accordance with established professional standards while ensuring that applicable laws, policies, and procedures are followed.
  
- II. Procedures: The following procedures will be followed when receiving a report of a sexual assault:
  - A. The staff member will educate the student of their options by offering:
    1. medical care as appropriate
      - a.) a referral to HMH-ER for evidence collection (rape kit).
      - b.) pregnancy screening and emergency contraception
      - c.) STD screening and treatment
    2. the Sexual Assault Response Team and related counseling services.
    3. to contact UPD for assaults occurring on campus and HPD for off-campus
    4. assistance in contacting friends or family
  - B. The staff member will act in accordance with the student's wishes only contacting others with the student's consent.
  - C. The staff member will make a generic notification to the director indicating whether the incident occurred on or off campus and whether the alleged perpetrator poses an immediate threat on campus or in the local community.\* The staff member will make a notification of same to the Vice President for Student Services if the director is not available.
  - D. The director will make a generic notification to the Vice President for Student Services indicating whether the event occurred on or off campus and classifying the alleged perpetrator as either a threat or non-threat to campus safety.
  
- III. Checklist
  - Offer referral to HMH-ER for evidence collection.
  - Offer pregnancy screening and emergency contraception as appropriate.
  - Offer STD screening and treatment as appropriate.
  - Offer SART notification and counseling services.
  - Offer notification of UPD / HPD as appropriate.
  - Offer assistance contacting friends and family.
  - Notify director or VPSS in the director's absence.

*\*This classification shall be made based on the information given by the student. This classification is by no means an indication of the seriousness of the incident, but rather an indication of whether the alleged perpetrator poses an immediate threat on campus or in the local community.*

### **Clinical Research**

Policy: The Student Health Center's participation in clinical research is limited due to its mission. In cases that the department does participate in clinical research, the study must receive the Institutional Research Board's approval prior to the initiation of the study. This allows for the independent review of the study to ensure the protection of the participants' rights including informed consent.

Any notation in a patient's clinical record indicating diagnostic or therapeutic intervention as part of clinical research is clearly contrasted with entries regarding the provision of non-research related care.



**Medical Record Review**

- I. Record Review - At least 3% charts for each medical provider shall be reviewed at least once a month using the Medical Record Review. In order to facilitate maximum efficiency and consistency, the Medical Record Review will be completed on a weekly basis unless circumstances prevent doing so. In such cases, the Medical Record Review will be completed as soon as possible, but no later than one month after the completion of the last Medical Record Review. Any items denoted as inadequate will be addressed on the back of the form. This documentation should indicate an explanation of the inadequacy and any related corrective action. The Medical Record Review forms will be reviewed by the governing body at least once a year.
- II. Review Procedure
  - A. On a daily basis, the front office staff will record 3% of both the physician's and APN's/PA's charts on the Medical Record Review.
  - B. On a weekly basis, the front office staff will present the Medical Record Review and the corresponding charts to the physician.
- III. Assignment of Reviewing Party- The physician shall review the APN/PA records and an outside physician shall review the physician's records.

**Consultations/ Referrals**

- I. Policy: A referral form will be used when a student is being sent to an off-campus specialist. Use of this form will expedite communication with the specialist and clarify the purpose and timing of the appointment for the student.
  
- II. Procedures:
  - A. When a student is referred to an off-campus specialist, the referral form is to be completed by the provider or delegated clinic staff.
  - B. If possible, the appointment to the specialist will be made while the student is present.
  - C. Pertinent clinical records as determined by the practitioner will be flagged, copied, and attached to the consult form.
  - D. Alternatively, the records may be mailed or faxed to the receiving party if the records are bulky or contain sensitive information.
  - E. The discharge nurse is responsible for reviewing the consult form and preparing the records for release.
  - F. One copy is to be given to the student at that time, a second copy will be filed in the patient's chart, and a third copy will be filed in a month to month file.
  - G. Each month the Consultative/Referral Forms from the preceding 2 – 3 months will be pulled by the nursing staff. If the Consultative Reply Form(or other consult note) has been received from the respective specialist then the consult request is simply filed in the appropriate chart. If no reply letter is found then the patient is to be contacted to determine if they have been to see the requested specialist. Any refusal to see the recommended specialist or delay greater than 60 days is to be noted on the Consultative/Referral Form and then filed into the respective charts.

**Autoclave Proficiency Testing**

- I. Policy: In order to insure adequate sterilization of surgical instruments, periodic testing of the autoclave is required. If at any time obvious changes in the autoclave performance are noticed then testing may be repeated as necessary.
- II. Procedures:
  - A. All instruments will be steam autoclaved in commercially available sterilization pouches with 250 degree thermal indicators. If any of the 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(s) to initiate corrective action.
  - B. If for whatever reason loose (un-pouched) instruments need to be sterilized then a loose 250 degree thermal indicator will be included in that autoclave cycle and monitored as above.
  - C. Commercially available bacteriologic spore testing will be performed every week and results noted in the maintenance log. Any spore test failures will be immediately reported to the provider(s). 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 if the clinic is closed for holidays.

**Sterilization of Clinic Instruments**

- I. Policy: The Health Center will sterilize used instruments in accordance with industry standards and regulations. The nurses at the Health Center will be responsible for carrying out the sterilization procedures.
  
- II. Procedures:
  - A. The nurse will, while wearing gloves, rinse and scrub the soiled instruments with soap and water.
  - B. The nurse will place the instruments in Cetylcide solution that is changed monthly or as needed.
  - C. The nurse will, while wearing gloves, remove the instruments from the solution.
  - D. The nurse will rinse the instrument with water and dry them off.
  - E. The nurse will place the instruments in an appropriately sized sterilization pouch.
  - F. The nurse will date the pouch two years from the current date using a permanent marker.
  - G. The nurse will place the pouches in the autoclave machine and close the door.
  - H. The nurse will operate the autoclave machine following the directions on the door of the machine.

**Autoclave Care/Cleaning For Ritter M9 UltraClave**

- I. Policy: The Health Center will maintain and clean the autoclave in accordance with manufacturer's standards and regulations. The nurses at the Health Center will be responsible for carrying out the cleaning and care procedures as outlined in the procedure. Daily and weekly maintenance will be deferred if the clinic is closed for holidays. The responsible nurse should reference the autoclave installation and operation guide manual for diagrams and further warnings and information.
- II. Procedures
  - A. Daily
    1. Clean External Surfaces
      - a.) Wipe with a soft dry cloth.
      - b.) Wash occasionally with a damp cloth and mild soap or detergent.
    2. Examine gasket for possible damage.
  - B. Weekly - Clean Chamber and Trays
    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. Refill reservoir with distilled water.
    4. Clean door gasket sealing lip and mating surface with a damp cloth.
  - C. Monthly
    1. Cleaning Chamber and Plumbing - *Do not process instruments while cleaning sterilizer.*
      - a.) Drain reservoir and fill with clean, distilled water then add one ounce of Speed-Clean Sterilizer Cleaner to a cool chamber.
      - b.) Clean by running one **POUCHES** cycle.
      - c.) Press **STOP** button when **Drying** portion of cycle begins.
      - d.) Drain reservoir and refill with clean, distilled water.
      - e.) Rinse by running one **UNWRAPPED** cycle.
      - f.) After cycle has completed, drain reservoir and allow sterilizer to cool. *Press STOP button to cancel chamber preheat.*
      - g.) Remove trays and tray rack and wipe off with a damp cloth.
      - h.) Remove and clean filters.
      - i.) Wipe out the inside of the chamber using care not to damage the heating element, steam temperature probe or level sensor probe.
    - j.) Re-install filters and tray rack.
      - k.) After filling the reservoir with clean distilled water, sterilizer is ready for use.
    2. perform pressure relief valve check
      - a.) Press **UNWRAPPED CYCLE**
      - b.) Press **START**
      - c.) Wait until pressure in chamber reaches between 25 PSI (172 kPa) and 26 PSI (179 kPa).

**Autoclave Care/Cleaning For Ritter M9 UltraClave**

II. Procedures

C. Monthly

2. perform pressure relief valve check (continued)
  - d.) Pull upward on the pressure relief lever for approximately 3 seconds. Steam should discharge freely from beneath rear of unit. If pressure relief valve does not close completely when lever is released, pull upward on lever again and release it quickly so valve snaps back into position. Do this until valve seats properly.
  - e.) Release lever (B). Valve should close, stopping release of steam.
  - f.) Press **STOP** button to abort the cycle, preventing unit from overheating.
  - g.) If excessive force is required to open pressure relief valve or pressure relief valve will not seat properly, the pressure relief valve must be replaced.

## **Ordering and Administering Local Anesthesia**

### I. Provider Requirements

#### A. Responsibilities of supervising physician

1. Supervision required for Mid-Level Provider services rendered must be a MD licensed in the state of Texas and who has been granted clinical privileges by SHSU to function as the Medical Director or designated alternate physician.
2. The MD will maintain availability either on site or by phone to assist in patient selection, wound management and selection of appropriate interventions when needed.
3. If a complication or an adverse event occurs, the MD would need to be accessible in a similar manner to assist in patient management.
4. Provide long-term review of anesthetic capabilities, techniques and adverse events. When or if new anesthetic procedures are utilized, the MD will directly supervise the Mid-Level Provider to insure adequate performance.

#### B. Responsibilities of Mid-Level Provider rendering local anesthesia:

1. The APN must have completed the appropriate level of educational training as required by the Texas Board of Nurse Examiners
  - a. Master's degree
  - b. Advanced training as APN accredited by the state BNE and AANP
  - c. Advanced Nursing continuing education or clinical training for administration of local anesthesia
  - d. Privileged by the governing body to administer local anesthesia
2. Maintain accessibility to supervising physician

### II. Responsibilities of Provider Rendering Anesthesia

- A. The provider will examine the patient immediately prior to administering the anesthetic and evaluate the risks involved.
- B. After appropriate selection of a patient with a wound and prior to an elective procedure, informed consent for the procedure explaining and documenting all potential risks that the procedure involves as well as documenting the plan to administer local anesthesia will be obtained (for consent form, see appendix A).
- C. In providing anesthesia- related services, the practitioner shall select, obtain and administer drugs which fall within categories of drugs generally utilized for local and/or topical anesthesia which are:
  1. 1% and 2% Xylocaine
  2. 1% and 2% Xylocaine with Epinephrine 1:100,000
  3. 2% Lidocaine topical solution-viscous
- D. Local and topical anesthetics are not inherently weight-based therapies. However, we will not exceed 10cc of local anesthetic in an attempt to perform a procedure at SHSU Student Health services.

**Ordering and Administering Local Anesthesia (continued)**

III. Technique for the administration of local anesthetic

- A. Local anesthetic agents are injected into the plane between the dermis and subcutaneous layer at the site where anesthesia is desired. Local anesthesia is used for any procedure that may result in localized pain.
  - 1. Select the appropriate anesthetic agent (the nurse will draw up the appropriate amount of anesthetic using aseptic technique)
  - 2. Choose the smallest needle possible for subcutaneous injection of the anesthetic
  - 3. After cleaning the field with an appropriate antimicrobial, the provider will inject the needle into the subcutaneous tissue and aspirate the syringe immediately prior to infiltration. If there is a blood return, the needle will be repositioned before infiltration.
  - 4. Repeat the above procedure until an adequate area is anesthetized for the procedure to be done
  - 5. The anesthetized site will be tested for pain sensation prior to proceeding to ensure optimal pain control
  - 6. Aseptic technique using sterile instruments will be maintained throughout the procedure
- B. Digital nerve blocks involve infiltrating a local anesthetizing solution at the base of the two nerves to each finger or toe. Digital nerve blocks are used in areas where local anesthesia is difficult to apply, or effectiveness is lessened by infection or edema.
  - 1. Perform a neurological exam of the area to be anesthetized.
  - 2. Select the appropriate anesthetic agent and appropriate size needle (the nurse will wipe the top of vial with alcohol and draw up appropriate amount of anesthetic using aseptic technique)
  - 3. Clean and prepare the skin over the injection site in a sterile manner
  - 4. Using sterile technique, insert the needle in dorsal-lateral aspect of finger or toe, just distal to metacarpalphalangeal or metatarsalphalangeal joint, aspirate and then inject about 0.5ml of anesthetic agent at this point. Advance the needle adjacent to the bone and, after aspiration inject about 1ml around the appropriate nerve.
  - 5. Repeat this procedure on the opposite side of the digit
  - 6. Allow 5-15 minutes for anesthesia to take full effect. Test for sensation before performing procedure.

IV. General requirements

- A. The patient's condition will be monitored at all times during and immediately after administration of local anesthesia.
  - 1. Adverse reactions such as pre-syncopal and vagal responses as well as potential allergic reactions are not uncommon while undergoing local anesthesia. Frequent assessment of the patient's physical condition will be done in order to maintain the patient in a sound physiologic status throughout the duration of procedure.



**Ordering and Administering Local Anesthesia (continued)**

IV. General requirements

- B. The following equipment will be available at all times in the rare occurrence of an adverse reaction to the anesthesia:
1. Oxygen
  2. Self-inflating hand resuscitator bag capable of administering 90% oxygen
  3. Pulse oximeter
  4. Necessary instruments required to monitor blood pressure
  5. Oral airway
  6. Epinephrine injectable
  7. Ammonia inhalant
  8. Suction source

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Physician Signature Date

**Discharge Privacy Protocol**

Specific discussions related to a patient's care will take place in the exam room or other designated discharge area of the clinic. Patient confidentiality will be maintained at all times by using appropriate voice level such that these instructions cannot be overheard in adjoining rooms or other physical proximity. The patient will be removed from bystanders in order to maintain privacy.

**Procedural Consent Form**

The General Consent Form will be used prior to performing any procedure that requires parenteral anesthesia or is likely to result in significant pain, bleeding or disfigurement. The Ear Lavage Consent will be used prior to all ear lavages. The content of the consent form will be verbalized by the practitioner performing the procedure and may be reiterated by the treating nurse as necessary.

**Fee for Service Notification**

The treating nurse is responsible for informing patients of any fees that they will incur as a result of the clinical services that they will receive. Fee-related services typically are incurred with procedures, labs, injections and medical supplies. The practitioner may also delineate these fees to the patient.

**Standing Orders on Lab Tests**

I. Policy: The nurses may order HCG's (urine and serum), HIV's, as well as honor orders from other providers for lab tests if a staff practitioner is not immediately available.

II. Procedure:

- A. The nurse will have the laboratory test completed.
- B. The nurse will have a staff practitioner sign off on the orders prior to the patient's chart being filed.

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Physician Signature Date

**Patient Notification of Lab Results**

- I. Policy: The Health Center staff will promptly notify any patient for whom the Health Center receives abnormal test results. The practitioner and/or their designee will be responsible for attempting to notify the patient in a timely manner upon receipt of the abnormal results. The patient will be considered notified upon the occurrence of an actual conversation between the Health Center Staff and the patient during which the results were discussed or a return receipt of a notification letter signed by the patient. Critical lab values or emergent x-ray findings may be called to the practitioner after hours or on weekends. When this occurs, the practitioner is responsible for attempting to notify the patient immediately. Any action based upon these findings is to be recorded in the patient's chart by the end of the next business day.
  
- II. Procedure:
  - A. The Medical Technologist will verbally notify the practitioner immediately upon the receipt of an abnormal Pap smear.
  - B. All test results including x-rays and labs will be attached to their corresponding charts and reviewed by the practitioner within two business days.
  - C. The practitioner or nurse delegated by the practitioner will attempt to notify the patient by telephone of all abnormal test results.
  - D. If the patient does not answer the phone, the Health Center staff may leave a message asking the patient to contact the Health Center practitioner.
  - E. If contact for abnormal test results is not established after three consecutive days, the practitioner will send a notification letter with return receipt requested.
  - F. A copy of the letter as well as the signed return receipt should be kept in the practitioner's files.
  - G. If the Return Receipt does not return signed, the practitioner will notify the Medical Director.

**HIV Testing Protocol**

- I. Policy: The Sam Houston State University Health Center provides anonymous HIV testing as an available service to students. The Health Center provides both pre-test and post-test patient education. The patient is encouraged to pay for the test in cash to ensure anonymity. The patient must pay for HIV testing when the service is rendered. The patient will be notified of their option to have the HIV test completed separately when the test is conducted in conjunction with other services. The patient will be informed that choosing not to pay for the test in cash separately from other services rendered compromises the patient's anonymity.
- II. Procedure:
  - A. The patient approaches the front window and asks to see a nurse. The patient does not give their name.
  - B. The patient is escorted to a private room for consultation.
  - C. After determining that a HIV test is requested, the nurse counsels the patient regarding the test procedure, high-risk behavior, confidentiality, window on test, and possible test results.
  - D. The nurse obtains a numbered receipt and assigns a test number that is located in the nurses' station.
  - E. The nurse records the charge for the HIV test under the *Miscellaneous* category (111-86-0055) to ensure anonymity.
  - F. The patient's gender, the date, and test number are entered on the list in the folder.
  - G. The nurse gives the patient their assigned test number and escorts the patient to the lab where a duplicate number is given to the medical technologist.
  - H. Before the test is administered, the nurse notifies the patient that they should return in 1 – 2 days to obtain the results.
  - I. HIV test results are entered into the folder with the corresponding test number.
  - J. Upon the patient's return to obtain test results, the patient presents their test number to the nurse.
  - K. The patient is directed to a private room while the nurse obtains the results from the folder by matching the patient's test number to the test number in the folder along with the corresponding results.
  - L. Upon the receipt of negative test results, the nurse will return to the room and notify the patient of the results. The copy of the result is given to the patient. The nurse will advise the patient to return again in six months and how to reduce risks of infection.
  - M. Upon positive test results, the nurse will notify a practitioner whom will notify the patient of lab results and resources for treatment. Referrals will be made as appropriate.
  - N. Any student who receives a positive HIV screen will be strongly encouraged to get prompt Western Blot confirmation. Non-anonymous confirmatory testing is preferable for accurate reporting to TDH and referrals. However, a student can get anonymous conformation if they wish.

## **Triage**

I. Policy: The Health Center is not equipped to address potentially life threatening or otherwise serious health conditions. Additionally, the Health Center does not render initial evaluation or treatment of injuries sustained in motor vehicle accidents, pregnant women, or injuries or illnesses related to worker's compensation cases. Therefore, Health Center medical staff will stabilize as appropriate and then refer patients with such conditions to the emergency room or community medical provider. Medical staff will document significant medical advice, as defined in Section C, given either in person or on the telephone. Anytime an ER evaluation is recommended, documentation of these instructions will be noted on the chart.

### II. Procedure:

#### A. Medical Emergencies:

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

1. Escort the patient to the treatment room as appropriate
2. Take vital signs and stabilize the patient while delegating a staff member to summons the medical provider to the clinic treatment room
3. Call 911 as appropriate
4. Document intervention in patient's chart

#### B. Medical Non-Emergencies Receiving Nurse Intervention

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

1. Escort the patient to the clinic treatment room,
2. Check vital signs as indicated based on presenting complaint
3. If a patient is bleeding, clean the wound, assess, and perform hemostatic measures as needed.
4. Present the patient's medical record and a Triage Form to the provider for review if the patient presents with symptoms including, but not limited to those listed under items a – f below. A provider will review the triage form and advise the nurse regarding the recommendations as indicated by the provider on the Triage Form. The patient will then be advised of the provider's recommendation. After the Triage Form is completed, it will be left on the chart as part of the progress note. Outside of the circumstances listed, the nurse will use prudent clinical judgment and will notify the provider with any uncertain circumstances that may occur.
  - a. Upper and lower respiratory:
    - i. severe throat pain with difficulty swallowing
    - ii. temp >101 w/ systemic symptoms
    - iii. SOB and or wheezing
    - iv. persistent and/or profuse nose bleed
  - b. abdomen and genital-urinary:
    - i. multiple occurrences of vomiting and/or diarrhea > 10 episodes in 24 hours
    - ii. abdominal pain or flank pain with or without temp >101
    - iii. visible hematuria or pelvic pain



**Triage (continued)**

II. Procedure:

B. Medical Non-Emergencies Receiving Nurse Intervention

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

5. Present the patient's medical record to the provider for review if the patient presents with symptoms including, but not limited to those listed under items a – f below. Outside of the circumstances listed, the nurse will use prudent clinical judgment and will notify the provider with any uncertain circumstances that may occur.
  - c. Injuries: Injuries which do not meet criteria will be treated by the nurses with compression and/or crutches when applicable in conjunction with appropriate medical advice until follow-up appointment
    - i. any eye injury or possible foreign body
    - ii. severely swollen injury site
    - iii. inability to move or bear weight on injured body part
    - iv. bony deformity or any indication of vascular compromise
    - v. head injury
  - d. Skin:
    - i. lacerations
    - ii. severe rash if taking medications
    - iii. painful rash
    - iv. swollen eyes, lips, tongue
    - v. draining or non-draining lesion
    - vi. erythema and warmth to skin
    - vii. burns
    - viii. foreign body
  - e. neuro/CV:
    - i. altered mental status
    - ii. syncope
    - iii. chest pain with or without SOB
    - iv. severe headache
  - f. psychiatric:  
suicidal ideation or psychotic behavior
6. If the patient's condition does not meet the above criteria, the nurse may refer patient to the appropriate medical facility for care which can include treatment at SHSU SHC if appropriate and available in a timely manner. The nurse will advise the patient to follow-up immediately with a medical provider if symptoms worsen.
7. Document findings and medical advice given in patient's chart.

**Triage**

II. Procedure:

C. Telephone Inquiries

If a patient contacts a nurse in order to seek medical advice related to the recommendation of over-the-counter medications, general medical questions, or sprain/strain management, the nurse will advise the patient in accordance with their training and departmental policies, procedures, and protocols without rendering a diagnosis. Such information may be documented in the patient's record at the nurse's discretion.

In the case of any other inquiries, the nurse will:

1. Verbalize to the patient that nurses cannot diagnose conditions,
2. Advise the patient to make an appointment at the Health Center or other facility, come in for a nurse visit, go to the ER, or call 911 as appropriate.
3. If the patient has a skin injury, ask the patient to come in for triage (see II, A & B).
4. If a patient has questions regarding a recent visit, medical advice within the scope of the nurse's practice may be given and then documented in the patient's chart.

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Physician Signature Date

### **Allergy Injections**

- I. Policy: As a service to its patients, the Student Health Center administers allergy antigens provided by the patient's allergist. Regular hours for allergy injections are Monday – Friday, 8:00a.m.-11:00a.m. and 1:00p.m. – 4:00p.m. In order to facilitate accuracy and efficiency when providing this service, the following criteria apply.
  - A. The allergist must submit an initiation letter that outlines administration instructions including the injection schedule and frequency and what action to take if the patient misses an injection or has an allergic reaction.
  - B. The antigen vial(s) must be clearly labeled with the patient's name, contents, medication strength, and expiration date unless prior arrangements have been approved by the Health Center's staff physician.
  - C. The Student Health Center will not administer the first dose of an antigen nor do we not conduct the test wheal in our facility.
  - D. There must be a practitioner in the facility in order for an allergy injection to be administered.
  - E. Although patients are allowed to store their allergy medications at the Student Health Center, the patient maintains responsibility for their own medication including the ordering of refills.
  
- II. Protocol
  - A. The nurse will remove the patient's chart from the allergy rack and check the orders and the date of the patient's last injection.
  - B. The nurse will ask the patient if they had any reaction to their last injection.
  - C. The nurse will check the medication vial for the patient's name, strength of medication, expiration date, and compare with the practitioner's order.
  - D. If any questions arise regarding time between injections, the amount to be given, or any other relevant information, the nurse will consult the patient's allergist or their appropriate health care provider.
  - E. The nurse will check the patient's chart for the site of the last injection.
  - F. The nurse will use a disposable syringe and draw up the medication as ordered.
  - G. The nurse will inject the medication subcutaneously in the lateral aspect of the patient's arm using a 1cc TB syringe.
  - H. The nurse will pull back the plunger of the syringe to make certain that the antigen is not injected into a blood vessel.
  - I. The nurse will then administer the medication by pushing in the plunger.
  - J. As the needle is removed, the nurse will press on the injection site to prevent leakage through the needle tract.
  - K. The nurse will then place the medication back in the refrigerator.
  - L. The nurse will instruct the patient to wait in the lobby for at least 15 minutes so that the injection site can be checked for possible reaction to the medication. If the patient leaves without having the injection site checked, it is considered AMA and it is not the Health Center's responsibility.
  - M. The nurse will chart information in the nurses' notes and on any form provided by the allergist.

**Allergy Injections**

II. Protocol (continued)

- N. The nurse will treat any reaction per the practitioner's orders. The standard treatment for a general reaction consisting of shortness of breath, tightening of the throat, or swelling of the lips is 1/3cc Adrenaline subcutaneously.

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Physician Signature Date

**Anaphylactic Reaction Protocol**

I. Less Severe Reaction

- A. Epinephrine .3 - .5 mg. of a 1:1000 solution SQ q 20 – 30 minutes as needed up to 3 doses.
- B. Check vital signs and pulse oximetry. Check vital signs q 5 minutes x 3, then q 15 minutes x 4, then q 30 minutes x 2.
- C. Diphenhydramine 50 mg po immediately, then instruct patient to take it q 6 hours up to 72 hours OR Cimetidine 400mg BID x 10 days.
- D. 250mg Solucortef IM
- E. Brochdilator, if persistent brochspasm-.083% Albuterol/NS premixed solution in HHN.
- F. 20 mg Prednisone taper for at home use
  1. 20 mg po tid x 3 days
  2. 20 mg po bid x 3 days
  3. 20 mg po q days 3 days
  4. ½ tab q day x 3 days
  5. Prescribe epi-pen

II. Severe Reaction- with laryngeal edema and hypotension

- A. Epinephrine .5 mg of a 1:1000 solution SQ
- B. Call 911

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Physician Signature Date

**Syncope Prevention**

1. Patients will be asked to wait inside the clinic for 15 minutes for 15 minutes after all injections except PPD testing.
2. Patients may request to have phlebotomy in the supine position if they are concerned or fearful. (hx of fainting)
3. Staff will use good clinical judgment regarding patients who may be dehydrated, light-headed, or orthostatic by taking steps to ensure patient safety.

**Syncope Management**

1. Have patient put head between their knees
2. Evaluate the patient and assist in placing patient in a supine position.
3. Contact a provider and obtain vital signs if a patient loses consciousness or fails to resolve pre-syncopal symptoms.

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Physician Signature Date

**Ear Irrigation**

1. If the practitioner has given orders for ear irrigation, the nurse will execute the Ear Lavage Consent and carry out the orders.
2. The nurse will look into the patient's ears with an otoscope in order to establish a baseline for later comparison.
3. If necessary, the nurse will fill the patient's ear with Cerumenex and wait 10 minutes.
4. The nurse will lavage the patient's ear canal with the ear lavage device chosen by the practitioner.
5. The nurse will stop the irrigation and notify the practitioner upon any complaint of pain or ear discharge such as blood or pus.
6. After the irrigation is complete, the nurse will re-examine the ear to see if they are clean and the eardrum is visible.
7. The nurse will ask the practitioner to re-examine the patient's ears if necessary.
8. The nurse will instruct the patient to schedule a follow-up visit if the ear irrigation is unsuccessful.

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Physician Signature Date

**Administration of Depo-Provera Injection**

1. The nurse will obtain written proof of Pap smear within the past 12 months.
2. Obtain verbal or written verification that the previous injection, if any, was given within 11-13 weeks of current date.
3. If the previous injection was given less than 11 weeks prior to the current date, the nurse will advise the patient when she can have the injection administered.
4. If the previous injection was given more than 13 weeks prior to the current date or if the date of the previous injection cannot be determined, a pregnancy test will be ordered prior to the administration of the injection.
5. Prior to administering the injection, the nurse will obtain a written order from the practitioner.
6. After the injection is administered, the nurse will chart the name of the medication, the dosage, route, injection site, time, and any specific instructions given to the patient.

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Physician Signature Date



**Contraceptive Counseling**

During the course of each well-woman examination, the nurse will discuss the various types of contraceptives, appropriate use, and effectiveness. The nurse will discuss any health hazards that might pertain to the chosen method of contraception. After the discussion with the patient takes place, the nurse will sign and date the Contraception Counseling Form and also have the patient sign. The nurse will place the signed consent form in the patient's chart as part of their permanent record. A copy of potential health risks will be given to the patient at the time of visit.

**Medical Supply Closets**

When checking in supplies, the supplies are to be unpacked and placed on the shelves together with like items. Supply orders should be unpacked and organized during the same week they are received.

All empty containers are to be removed and placed in the waste containers.

**Treatment Room Supply and Maintenance**

1. All supplies are to be kept in stock and up to date.
2. The packs for sutures and suture removal will be cleaned, autoclaved, and placed in triage room and exam rooms.
3. Clean and replace the instrument soaking solution each month and as needed.
4. The treatment room is to be checked periodically during the day and cleaned PRN.
5. The treatment room is to be cleaned after each procedure:
  - a.) the table paper will be replaced
  - b.) dispose of waste
  - c.) clean used instruments and place in soaking solution until autoclaved
  - d.) biohazardous waste will be emptied every week or PRN (see *Handling and Disposing of Biohazardous Waste*)

**Crutch Room Repair and Maintenance**

1. Upon the return of crutches, the nurse will return them to the crutch room placing them on the right wall until they are cleaned and inspected.
2. The nurse will inspect the crutches for missing parts such as screws, bolts, nuts, etc.
3. The nurse will replace worn crutch tips and shoulder tops as needed.
4. The nurse will clean the crutches.
5. The nurse will fasten the crutches together using material strips.
6. The nurse will place the crutches on the left side of the closet.
7. The crutch room should be clean and in order by Friday afternoon.
8. Standard contact isolation and body fluid precautions apply to loan arrangements for all DME. Specifically, patients who have diagnosed with MRSA or other similar conditions cannot return DME devices unless the device can be autoclaved. Items heavily soiled or exposed to body fluids should not be accepted for return.

**Mandatory Treatment Room Supplies**

**Exam rooms**

1. Epinephrine ampule 1:000 and/or epi-pen
2. TB syringe
3. Airway

**Treatment room**

1. Epinephrine ampule 1:1000 and/or epi-pen
2. TB syringe
3. Ambu bag
4. Oxygen tank(s) w/tubing
5. Airway
6. Suction device

**Sterilization of Clinic Instruments**

- I. Policy: The Health Center will sterilize used instruments in accordance with industry standards and regulations. The nurses at the Health Center will be responsible for carrying out the sterilization procedures.
  
- II. Procedures:
  - I. The nurse will, while wearing gloves, rinse and scrub the soiled instruments with soap and water.
  - J. The nurse will place the instruments in Cetylcide solution.
  - K. The nurse will, while wearing gloves, remove the instruments from the solution.
  - L. The nurse will rinse the instrument with water and dry them off.
  - M. The nurse will place the instruments in an appropriately sized sterilization pouch.
  - N. The nurse will date the pouch two years from the current date using a permanent marker.
  - O. The nurse will place the pouches in the autoclave machine and close the door.
  - P. The nurse will operate the autoclave machine following the directions on the door of the machine.

**Needle Sticks**

- I. Policy: Any employee receiving a needle stick must immediately comply with the procedures listed below to facilitate prompt treatment and proper documentation.
- II. Procedure:
- A. The recipient of the needle stick will note any witnesses and record their names and social security numbers.
  - B. The recipient will treat the site as appropriate (promote bleeding to flush out contaminants).
  - C. The recipient will report the needle stick to their supervisor.
  - D. The practitioner will examine the recipient, determine any possible ill effects, and take necessary precautions immediately.
  - E. If the needle was contaminated and / or came in contact with a patient prior to the needle stick, the practitioner will obtain the patient's name and SHSU ID and complete the Contaminated Sharps Injury Reporting Form.
  - F. The recipient will fill out a Needle Stick Form and deliver it to the director on the same day on which the stick occurred.
  - G. The director will notify the Safety Office of any needle stick that breaks the skin.
  - H. The director or designee will complete the Supervisor Investigation of Injury form [http://www.shsu.edu/safety/forms/sup\\_invest.html](http://www.shsu.edu/safety/forms/sup_invest.html) as well as the appropriate worker's compensation forms.

**Prescribing Psychoactive Medications**

Policy: The Health Center will facilitate services spanning the continuum of care when treating a patient with psychiatric issues. As an alternative to, or together with medication, counseling services will be strongly recommended for patients with psychiatric issues. When medication is prescribed for psychiatric issues, the practitioner will prescribe up to a 30-day supply of the medication and then require a follow-up appointment to determine its efficacy and note any possible side effects. After the 30-day follow up, the practitioner may, at their discretion, renew the prescription for up to six months at a time before requiring the patient to come in for a follow-up visit.

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Physician Signature Date



**Tissue Biopsy Assessment**

- I. Policy: In order to insure adequate diagnostic evaluation of potentially malignant lesions, all skin biopsy specimens will be sent for dermatopathology except for the exempted tissues listed below.

If a student refuses or is unable to pay for the cost of specimen processing, then the practitioner has the option to refuse removal of any suspicious lesions.

- II. Exempted Tissues
- A. Blood clots
  - B. Cerumen
  - C. Foreign bodies
  - D. Hair
  - E. Nails with or without adjoining cuticle
  - F. Sebaceous cysts
  - G. Skin tags
  - H. Warts

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Physician Signature

Date

**Abnormal Occurrences While Performing Nursing Duties**

- I. Definition of abnormal occurrence: Any event, circumstance, symptom, etc. that could possibly affect the treatment plan or compromise the quality of care rendered.
  
- II. Policy:
  - A. Nursing Staff: The nursing staff will document the incident on the chart and immediately notify the treating practitioner of same.
  - B. Medical Practitioners: The treating practitioner will document their response in the chart as appropriate.

### **Recommendations for Follow-up**

Policy: Patient compliance with the treating practitioner's plan of care, including recommendations for follow-up, is the patient's responsibility. Contacting every patient that does not comply with recommendations for follow-up has proved labor intensive and unproductive <sup>1</sup>. However, the providers may, at their discretion, indicate on the Patient Assessment that a patient is to be contacted in case of non-compliance with a recommendation for a follow-up.

Procedure: When a practitioner determines that a patient is to be contacted in case of non-compliance with a recommendation for a follow-up:

- A. The practitioner will check the "TRACK" box located in the "Follow-up" section of the Patient Assessment.
- B. The nurse will write the description and code that corresponds with the follow-up category (e.g. 0-7 days) on the Patient Assessment.
- C. The nurse will enter the corresponding code into the computer.
- D. No later than 10 business days after the expiration of the corresponding follow-up category:
  4. a designated staff member will:
    - a. assist in determining if the patient complied with the recommendation.
    - b. notify nurse that the patient was non-compliant.
  2. the nurse will contact the patient and document contact in the nursing notes.

### **FootNotes**

<sup>1</sup> Follow-up Compliance Study (February 2007)

**Positive Chlamydia Results**

The CDC recommends a test of cure exam in three months for confirmed cases of Chlamydia. Upon notifying patients of positive test results for Chlamydia, the practitioner will:

- A. Explain to the patient the purpose of follow-up testing in three months.
- B. Expedite partner treatment as appropriate.
- C. Follow-up with the patient to provide a reminder of the needed follow-up testing in three months (effective 9/15/07).

## **Nurse Practitioner and Physician Assistant Protocol**

### I. Purpose

The purpose of this document is to describe the scope of practice for the Advanced Practice Nurse (APN) and Physician Assistant (PA) at the Health Center and to serve as written authorization for the APN and PA to initiate medical aspects of patient care and to sign prescription drug orders for dangerous drugs.

### II. General

- A. The following information shall be maintained on file regarding the APN and PA initiating medical aspects of care under this protocol:
  - 1. Current approval as an APN/PA from the Board of Nursing Examiners (BNE)/Board of Physician Assistant Examiners (BPAE)
  - 2. Current prescription authorization number from the BNE (Nurse Practitioner)
  - 3. Copy of the form sent to the BNE/BPAE designating the APN/PA as a person authorized to sign prescriptions
  - 4. Current specialty certification
- B. The physician shall maintain the APN's/PA's current license number on file.

### III. Setting for which protocols will be used

These protocols were developed for use in providing care for patients at the Sam Houston State University Health Center.

### IV. APN/PA Functions *tie in with privileging and scope of practice*

- A. The scope of the APN's/PA's practice will be that of primary care services provided to students. The APN/PA is authorized to perform the following functions:
  - 1. Render preventative healthcare services to include, but not limited to immunizations, examinations, and screenings.
  - 2. Establish medical diagnosis and determine a plan of care for short-term health problems, stable chronic health problems and / or exacerbation of chronic health problems. Examples include, but are not limited to: Anemia, Conjunctivitis, Constipation, and Otitis Media.
  - 3. Order and interpret routine diagnostic studies to include but not limited to CBC, UA, culture and sensitivities, FBS, chemistries, and serum pregnancy test.
  - 4. Perform therapeutic, corrective, and cosmetic measures including but not limited to the treatment of superficial wounds, Pap smears, STD work-ups, incision and drainage of abscesses, condyloma, nevi, and skin tag management, administration of topical and local anesthesia, foreign body removal, ingrown toenail removal, and puncture aspirations.
  - 5. Prescribe medications as outlined in *V. Carrying out or Signing Prescription Drug Orders*.

**Nurse Practitioner and Physician Assistant Protocol**

IV. APN/PA Functions *tie in with privileging and scope of practice*

- B. The scope of the APN's/PA's practice will be that of primary care services provided to students. The APN/PA is authorized to perform the following functions (continued):
  - 6. Refer patients to appropriate licensed physicians, clinics, or other health care providers for the purpose of chronic management or treatment of acute or complex medical conditions.
- C. Emergency Care  
Patients with potentially life threatening conditions will be transferred via EMS to Huntsville Memorial Hospital Emergency Department.

V. Carrying out or Signing Prescription Drug Orders

- A. Authority to prescribe
  - 1. This practice qualifies one in which an APN/PA can prescribe medications by virtue of being a primary practice site under 157.053, *Prescribing at Physician Primary Practice Sites*, of the Medical Practice Act.
  - 2. The APN/PA can prescribe medication consistent with the practice and functions described in IV. The APN/PA can write prescriptions for all categories of dangerous drugs and medical devices including, but not limited to antibiotics, analgesics, antipyretics, immunizations, and decongestants.
  - 3. The APN/PA will write prescriptions using single signature prescriptions.
  - 4. The APN/PA will use duplicate prescriptions one of which will be retained in the patient charts in order to account for and monitor the issuance of prescriptions by the APN.
  - 5. The APN/PA cannot prescribe controlled substances.
- B. Generic substitutions  
The APN/PA may authorize generic substitutions by the pharmacist routinely unless the APN's/PA's experience warrants specific name brands.
- C. Patient instruction  
All patients will receive written instruction from the pharmacy regarding filled prescriptions. Specific medication instructions may be given by the APN/PA or delegated to nursing staff.
- D. Requesting drug samples  
The APN/PA may request and sign for samples of any category of dangerous drug for which the APN/PA may write a prescription.

**Nurse Practitioner and Physician Assistant Protocol**

VII. Supervising Physician Responsibilities

- A. Supervisory: Physician supervision of APN/PA's duties must conform to what a reasonable, prudent physician would find consistent with sound medical judgment, but may vary with the education and experience of the particular advanced practice nurse or physician assistant. A physician shall provide continuous supervision, but the constant physical presence of the physician is not required.
  - 1. The physician will maintain the SHSU Health Center as their primary practice site as defined by Section 157.053(a)(1) of the Medical Practice Act.
  - 2. The physician will maintain a review of at least 3% of the APN/PA charts.
  - 3. The physician will annually review the APN/PA standing orders and clinical protocols. Any recommendations for updating the APN/PA practice will be addressed as needed.
- B. Referral / Consulting Source: The physician will serve as a consultant and referral resource for the APN/PA. Note that the APN/PA will document consultations with the physician in the patient record.

VIII. Quality Assurance and Quality Improvement

- A. Policy: The supervising physician will provide physician oversight of the APN/PA as required by the TBME and BNE/BPAE in accordance with the Medical Practice Act.
- B. Procedure: The quality of care rendered under this protocol will be monitored and evaluated as follows:
  - 1. The physician will collaborate with the APN/PA to maintain the standard of patient care by means of a 3% review of the APN/PA patient records. Any issues arising from the review of the medical records will be presented to the APN/PA and documented by the physician. Records of such reviews shall be documented and kept in the Medical Record Review Log.
  - 2. The physician will annually review the APN's/PA's standing orders, medical guidelines, and medical diagnoses. Recommendations for updating the APN's/PA's practice will be addressed at these times or anytime the need for change arises.
  - 3. Physician supervision of the medical aspects of care provided by the APN/PA under this protocol should be documented by the APN/PA making the notation in the patient file when the physician is consulted.
  - 4. The system for accounting and monitoring the issuance of prescriptions by the APN/PA will be by the use of duplicate prescriptions. One copy of the prescription will be retained in the patient's chart.

**Protocol for the Delegation of Limited Prescriptive Authority and Initiation of Medical Aspects of Care to APN/PA**

The undersigned Advance Practitioner Nurse (APN) / Physician Assistant (PA) and Physician agree that the attached protocol will govern the APN/PA practice effectively on the date indicated and will be reviewed at least annually and revised as appropriate.

\_\_\_\_\_  
APN/PA Signature            Date  
Printed Name: \_\_\_\_\_  
License Number: \_\_\_\_\_  
Prescription Authorization #: \_\_\_\_\_

\_\_\_\_\_  
APN/PA Signature            Date  
Printed Name: \_\_\_\_\_  
License Number: \_\_\_\_\_  
Prescription Authorization #: \_\_\_\_\_

\_\_\_\_\_  
Physician Signature            Date  
Printed Name: \_\_\_\_\_  
License Number: \_\_\_\_\_  
Prescription Authorization #: \_\_\_\_\_

I have read and understand the protocols contained in this manual as they pertain to my position. I agree to perform my job duties in accordance with the aforementioned clinical protocols.

\_\_\_\_\_  
APN/PA Signature            Date

\_\_\_\_\_  
APN/PA Signature            Date

\_\_\_\_\_  
Medical Technologist Signature            Date

\_\_\_\_\_  
Nurse Signature            Date

\_\_\_\_\_  
Nurse Signature            Date

\_\_\_\_\_  
Nurse Signature            Date



**Pharmacy Services**

- I. Policy: Pharmaceutical services are provided within the Health Center at Sam Houston State University.
  
- II. Procedure: Student's prescriptions written by a licensed practitioner will be filled in accordance with the regulations set forth by the Texas State Board of Pharmacy. Patients have the right to fill their prescription at the pharmacy of their choice.

**Pharmacy Privacy Rules**

I. Policy: The Pharmacy will maintain the confidentiality of patient related information.

II. Procedure:

- A. The patient signature on the Health Center privacy practices form will be captured at the reception desk if seen by a Health Center practitioner or at the Pharmacy if seen by an outside practitioner.
- B. Patient documents to be disposed will be shredded.
- C. Violation of privacy standards is grounds for corrective action up to and including termination.
- D. Pharmacy employees will be trained in privacy awareness.

**Pharmacy Security Rules**

I. Policy: The Pharmacy will protect the patient's health information from unauthorized access, destruction, or alteration.

II. Procedure:

A. Administrative safeguards

1. The pharmacist-in-charge will be the security officer.
2. Once yearly risk analysis will be made to evaluate current pharmacy systems.
3. Violation of security standards is grounds for corrective action up to and including termination.
4. If a Health Center Pharmacy employee moves to another department or is terminated, the pharmacy keypad combination will be changed and the employee username will be deleted from the software system.
5. Electronic patient health information will be protected using a once weekly hard drive backup kept in a fire safe in the pharmacy with the chief pharmacist and director having the only keys.
6. In the event of an emergency situation or other occurrence, the Health Center Pharmacy will relay information to Director of the Health Center to assist in retrieval of electronic patient health information as needed
7. Pharmacy software will be used to track all user access to electronic patient health information.
8. Pharmacy employees will be trained in security awareness.
9. A business associate agreement will be on file with the pharmacy software support provider.

B. Physical safeguards

1. Physical access to the pharmacy electronic system is limited to pharmacy employees only.
2. The pharmacy door keypad combination is known only by pharmacy employees.
3. When the pharmacy is unattended, the window opening is protected by a roll down metal front with two side locks and the door is locked.
4. The receipt and removal of hardware and electronic media that contain electronic patient health information will be coordinated with the University's Department of Computer Services.

C. Technical Safeguards

1. Access to the pharmacy software program will be controlled by a unique username and password that expires every thirty days.
2. Maximum logon attempts will be five.
3. Sessions will automatically terminate after ten minutes of inactivity.

**Pharmacy Workstation**

- I. Policy: The pharmacy shall be arranged in an orderly fashion and kept clean.
- II. Procedure: Required equipment shall be clean and in good operating condition. Daily disinfecting of the pharmacy counter tops and dispensing area will be recorded. The Pharmacist will ensure that the medications are not mixed through the powdery residues left on the counting tray by wiping down the pill counter between prescriptions.

**Pharmacy Dispensing Errors**

- I. Policy: Documentation of an adverse quality related event will be made as soon as possible after discovery.
  
- II. Procedure: Initial pharmacy dispensing error report will contain: patient information, prescription number, drugs involved, description of error, drug regimen review and counseling activities, prescriber instructions, action taken and persons involved in error.

**Pharmacy Dispensing**

- I. Policy: 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.
  
- II. Procedure: Best practice guidelines.
  - A. Station 1 (receive Rx, data entry, drug regimen review)
    1. Attain patient address, phone number, date of birth, allergies, health conditions, and current medications
    2. Review the patient's medication record to identify clinically significant
      - a. known allergies
      - b. rational therapy contraindications
      - c. reasonable dose and route of administration
      - d. duplication of therapy
      - e. drug/drug interactions
      - f. drug/food interactions
      - g. drug/disease interactions
      - h. adverse drug reactions
      - i. proper utilization (including over utilization or underutilization)
    3. Upon identifying any clinically significant conditions, the Pharmacist shall address any issues and document such occurrences.
  - B. Station 2 (assembly)
    1. Prescriptions will be dispensed with correct drug, vial, and closure.
      - a. first check - pull prescribed drug from stock by name/strength and ndc#
      - b. second check - check ndc # on stock bottle against ndc # on original Rx then circle and initial
      - c. third check - check name/strength on stock bottle against original Rx then underline and initial
    2. All prescriptions will be accurately labeled and contain appropriate warnings as needed.
    3. The Pharmacist will ensure that the medications are not mixed through the Powdery residues left on the counting tray by wiping down the pill counter between prescriptions.
  - C. Station 3 (delivery and counseling) Verbal counseling shall be conducted in a manner that maintains the patient's confidentiality.
    1. Prescription to be given to correct patient patient to verify address
    2. Counseling will be conducted to improve patient compliance and understanding of their drug therapy.
      - a. Significant information about the prescription drug will be communicated to the patient.
      - b. Communication shall be enforced with written information.

**Pharmacy Inventory**

- I. Policy: The pharmacist will conduct a full inventory of the medications stocked in the pharmacy at the end of each long semester and at the end of the fiscal year. Such inventory will match the physical inventory against the computerized inventory. A full inventory will be conducted at the end of each fiscal year and each long semester. 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.
  
- II. Procedure  
At the end of the fiscal year and each long semester:
  - A. The pharmacist will contact the director to initiate the inventory.
  - B. The director will assign a staff member to verify the count.
  - C. The pharmacist will generate the computerized inventory and match it against the physical count.
  - D. The Pharmacist will remove expired drugs monthly from dispensing stock and quarantine together until such drugs are submitted on the inventory report and then disposed of properly.

**Pharmacy Data Management Software**

- I. Inventory
  - A. Routine Inventory
    - 1. Enter “4. File Maintenance” from the main menu
    - 2. Enter “4. Inventory”
    - 3. Enter “2. Physical Count”
    - 4. Enter “C” for create and change “Anda” to ALL
  - B. Change Inventory for purposes of adding new stock, correcting counts, and removing expired medications
    - 1. Enter “4. File Maintenance”



2. Enter "3. Drug"
  3. Enter "1. Add/Edit"
  4. Enter "A" to add new drug
  5. Enter drug name
  6. Enter the item number to change
  7. Enter the updated information
- II. Filling a Prescription
- A. Existing patient
    1. Dispense
    2. Dispense
    3. Enter Patient Name
  - B. New Patient/Change Patient Information
    1. Enter "4. File Maintenance"
    2. Enter "1. Patient"
    3. Enter "1. Add/Edit"
    4. Enter patient info
- III. Updating Software
- A. Enter "7. System Options"
  - B. Enter "2. Install Software"
  - C. Follow onscreen instructions
- IV. Sorting Function: After adding new patient, drug, or prescriber, the sort function must be enacted.
- A. Enter "7. System Options"
  - B. Enter "5. Maintenance Functions"
  - C. Enter sort function appropriate for change made
- V. End of the Day Report
- A. Enter "6. End of the Day"
    1. Enter "1. Generate End of the Day Report"

Notes:

Desktop Icons: CRX (3)- Instructions  
CRX (Read-me)- QS-1 Company Information  
QS-1 Autorun- Automatic start up  
CRX Client- Data Management Program

Forms: Change of Pharmacist form needed for Jessie and in-coming pharmacist

Location of important items

End of the day report log book below printer  
Vendor catalog in desk drawer  
Prescription files above desk

Gray filing cabinet

Bottom drawer- invoices (drug recalls, expired medications in blue book)

4<sup>th</sup> drawer- meeting agendas, QS-1 information

3<sup>rd</sup> drawer- controlled invoices & inventory