

Table of Contents

[Administration/Residents](#)

[Appointment Desk](#)

[Nursing/Medical](#)

[Ancillary](#)

[Medical Records](#)

[HIPAA](#)

[Business Office](#)

[Employee Training Programs](#)

[Safety](#)

ADMINISTRATION

[UND CFM Bismarck Welcome](#)

[UND Program Goals/Mission Statement](#)

[UND CFM Staff](#)

[Clinic and University Websites](#)

[Resident Recruitment Criteria](#)

[Clinic Responsibilities](#)

[Clinic Chief Resident Responsibilities](#)

[AMTS Intern Responsibilities](#)

[AMTS Senior Resident Responsibilities](#)

[Conference Attendance Policy](#)

[Goals and Objectives Policy](#)

[Criteria for Advancement to Senior Resident Level](#)

[Well Baby Clinic](#)

[Weekly Time Records for Residents](#)

[Resident Procedure/Experience Database Instructions](#)

[Miscellaneous Hospital Policies](#)

[Hospital Admission Responsibilities](#)

[Protocols for Care for Complex Patients](#)

[Admission Order Signature Policy](#)

[Clinic Patient Scheduling](#)

[Rural Rotations](#)

[Inpatient Pediatrics](#)

[Medical Coverage for Sporting Events](#)

[Moonlighting](#)

[Vacation](#)

[Medical Record Documentation](#)

[Dictation Time Limits](#)

[Diagnostic Reports/ Notification](#)

[Consent for Treatment](#)

[Patient Education](#)

[Patient History](#)

[Geriatric Protocol](#)

[Attending Physician's CFM Clinic Responsibilities](#)

[Graduation Requirements](#)

[Concern Cards](#)

[Complaint Management](#)

[Patient Satisfaction](#)

[Electronic Communication](#)
(Smartphones, tablets ,etc)

[ABBREVIATIONS AND SYMBOLS;](#)
[“COMMON USE” AND “DO NOT USE”](#)

The University of North Dakota Center for Family Medicine, Bismarck, is a fully accredited residency training facility that has graduated over 150 physicians. The Center is administered by the University of North Dakota School of Medicine and Health Sciences. We are a three-year program and accept five first year residents annually through the match system.

Our program is well accepted and respected by both hospitals in the community —Sanford and St. Alexius Medical Center — and enjoys the tremendous support of the local teaching faculty. More than 100 specialists participate in our program.

Bismarck-Mandan combines true progressive technology of a large city with the sincere friendliness of a small town. The basic elements for a happy life, clean living, true friendships, a community of families, fresh air environment-are still found around here.

FACULTY:

DIRECTOR: JEFF HOSTETTER, M.D.

ASSOCIATE DIRECTOR: JACKIE QUISNO, M.D.

ASSISTANT PROGRAM DIRECTORS: GARY BETTING, M.D.
GUY TANGEDAHL, MD
KARIN WILLIS, M.D.
JOSEPH LUGER, MD (Dermatology)
Brynn Luger, MA, LPCC, NCC (Clinical Counselor)

COMMUNITY PART-TIME FACULTY

Peter Woodrow, M.D. (OB/GYN)
George Johnson, M.D. (Pediatrics/Diabetes)

Thomas Jacobsen, M.D.	West River Health Clinic
Joan Connell, M.D.	Center for Family Medicine-UND
Kristin Melby, FNP	Center for Family Medicine-UND

[Home](#)

Overall Program Goals/Mission Statement

- 1) To provide well-trained family medicine physicians to meet the needs of the people of North Dakota.
- 2) To provide continuing, comprehensive quality healthcare in family medicine.
- 3) To provide an integrated and progressive educational program for resident physicians.
- 4) To provide the opportunity for each resident physician to develop and maintain a continuing physician-patient relationship.

[Home](#)

Paramedical/Ancillary Staff

The Center for Family Medicine is fortunate to have a dedicated and enthusiastic ancillary staff. The following is an abbreviated description of the duties for each classification of positions. The staff performs many other duties other than those described below; however, this information is to provide you with the basic function of each job classification.

Business Manager

The Business Manager is responsible for the overall supervision of the ancillary staff and insures the efficient function of most aspects of the clinic. She/he is involved with the budget process (clinic operations and financial management), risk management, personnel administration/human resources (staff procurement), marketing and public relations, and ensures compliance with regulatory agencies. In addition to this, this person is in charge of coordinating the Practice Management/Management of Health Systems module rotation and training for the Residency Program and is involved in the Residency Recruitment process. The Business Managers at the UND-CFMs now have a direct reporting relationship on our Organizational Chart the Associate Dean of Administration & Finance at UND's School of Medicine & Health Sciences. The Business Manager is also a member of the UND-CFM's Oversight Committee.

Administrative Assistant/Residency Coordinator

The Admin Assistant is responsible for the overall scheduling of the Residents. He/ She coordinates Resident schedules with Community Preceptors, Director's schedules, and clinic Preceptor schedules. He/ She is responsible for the monthly calendars (call schedules and rotation schedules) as well as preparing evaluations for dissemination for all of the required residency rotations. The Admin Assistant also is responsible for maintaining Accreditation documents for the Residency Program, and completes the Residency Billings that are invoiced to our sponsoring hospitals for GME reimbursement/reconciliation. This person is responsible for tracking the Resident's clinical and hospital encounters, rural rotations, and elective experiences.

Nursing Staff – Team

This department consists of clinic nursing staff (RNs & LPNs). In addition to this we have a Geriatric Nurse Coordinator and Diabetic Nurse Coordinator. Our nursing staff is efficient and knowledgeable. You will find that you can depend on them to serve you and your patients effectively. They prepare patients to be seen by the physicians, maintain the exam rooms for procedures, schedule appointments for your patients with other physicians and services based on your orders, keep the team pod stocked with supplies and medications, and prioritize patient messages.

Medical Records

Medical Records staff manage all patient charts prior to their visit, file test results, etc. in the patient charts and re-file the charts after the preceptor process is completed. This department is also in charge of HIPAA compliance as well as Release of Information. Presently, our Medical Transcription is outsourced, so the Medical Records Staff are responsible for obtaining signatures and filing of transcription as well.

Front Desk Receptionist/Schedulers

The receptionists are responsible for answering telephone calls that come into the clinic and maintain the core switchboard, routing calls as appropriate. They are responsible for setting up physician schedules and scheduling all patient appointments for physicians, nurses and ancillary support services. The receptionists are also responsible for collecting co-pays and writing receipts for the patients. The receptionists validate patient demographics and insurance information upon the patient's entry to the clinic system. In addition, they follow-up on no-show appointments with a letter to the patient. This department is also in charge of sorting the daily mail and payments. The payments are written on the daily payment log.

Radiology

The department is staffed with a radiologic technologist and a certified Diagnostic Operator. Service is provided during regular clinic hours. Our department performs general diagnostic x-rays and is equipped with a computerized radiology system. Images are read by Sanford's radiologists by means of a PACS system. Radiology is cross-trained to do electrocardiograms, holter monitors, event monitors, pulmonary function tests and hearing screenings.

Laboratory

This department consists of laboratory scientists. Our in-house testing is broad and includes urinalysis, chemistry, hematology, microbiology, serology, and coagulation. What we are unable to do on-site is sent to our reference laboratory, Northern Plains Laboratory. Turn around time for most reference lab results is 12-24 hours. The lab is cross-trained to assist radiology staff with several ancillary testing procedures. The Laboratory Director/Supervisor acts as a lead team member on the UND-CFM's Risk Management Committee and is responsible for tracking/trending of our Incident Reports.

Patient Accounts & Billing (Business Office)

This department consists of certified Professional Coders. The department is in charge of the clinic and hospital billing. They are responsible for maintaining proper billing procedures along with coding the charges with the correct ICD9 diagnosis and CPT Procedures. They make sure all insurance is filed and updated on any major insurance changes. They manage the accounts receivable for charges and collections and reconcile the daily deposit.

Pharmacy

This department consists of a PharmD and a Pharmacy Tech. The department is in charge of assisting the residents/faculty with any medication/prescriptions needs. CFM Pharmacy is open Monday-Friday from 8am-5pm. The pharmacy offers a variety of over-the-counter medications, supplies, and prescriptions to our staff, residents, and patient populations. All pharmaceutical representatives report to the pharmacy for scheduling, displays, and drug samples where the samples are stored, inventoried, and dispensed to the patient (with a valid order from MD's).

[Home](#)

Clinic and University Websites:

Policy and Procedures will be emailed to residents and all clinic departments. A hardcopy of the manual can be found in lab, medical records, nursing and administration.

The URL for the **UND Center for Family Medicine-Bismarck** is as follows:

<http://www.cfm.bismarck.und.edu>

Direct patients and prospective residents to the site as necessary. Biographical sketches/photos are included on the site for all Faculty and Residents.

The **University of North Dakota's School of Medicine & Health Sciences** Home Page is as follows:

<http://www.med.und.edu/>

You can link back to UND Center for Family Medicine - Bismarck by locating the Departments Academic tab.

The University of North Dakota's School of Medicine & Health Sciences **GME Residency Training Program** Home Page is located at

<http://www.med.und.edu/residency>

All UND Researches are required to complete the **UND Institutional Review Board's (IRB) Human Subjects Training Modules:** www.citiprogram.org

[Home](#)

Resident Recruitment Criteria

Purpose: To provide the UND Center for Family Medicine Bismarck with qualified candidates for residency selection.

Policy: The UND Center for Family Medicine Bismarck will use the following guidelines for resident selection:

1. All applicants must hold a doctor of medicine or doctor of osteopathic degree from a medical school approved by the North Dakota Board of Medical Examiners with the date of graduation to be five years or less from start of residency.
2. All applicants must have completed USMLE Step I and Step II, preferably with a score of 80 or above.
3. All applicants must meet the requirements set forth by the North Dakota Board of Medical Examiners to be licensed in the state of North Dakota. In specific, applicants are permitted a maximum of three attempts to pass each step of the licensing examination. The examination requirements must be successfully completed within a seven (7) year period.
4. All applicants must submit two letters of recommendation from a US clinic/hospital or US practicing physician.
5. If an applicant does not meet the above criteria, they can be considered only if they successfully complete an observership at the UND Center for Family Medicine Bismarck.

[Home](#)

CFM Clinic Responsibilities

1. Clinic has priority over rotational responsibilities.
2. Notify the receptionist and/or your nurse at the earliest possible time if you will be late/absent from clinic.
3. Morning clinic schedules ***begin promptly at 9:00 a.m.*** Please call your team nurse directly if you anticipate running late.
4. Afternoon clinic schedules Tuesday through Friday begin promptly at 1:00 p.m.
5. Monday afternoon schedules begin after the residents business meeting (1:30 p.m.)
6. A maximum number of six physicians are scheduled per one-half day. No more than four residents per half day, unless a second preceptor is available.
7. Effective May 1st of each year, third year residents drop to two half days per week until graduation. (During the last five clinic days in June, third year residents are scheduled to work ½ day). This is contingent upon having adequate clinic numbers. Residents are required to see 1650 total patients for the three years.
8. All PGY-1 clinic patient encounters need to be precepted by a CFM faculty member **BEFORE** the patient leaves the clinic.
9. For PGY-2 and PGY-3 residents, a minimum of every third clinic patient encounters needs to be precepted by a CFM faculty member.
10. All Medicare patient encounters need to be precepted by a CFM faculty member. A faculty member must see and examine Medicare patients that are scheduled in clinic for PGY-1 residents during the first 6 months of the PGY-1 training. All Medicare patients provided Level IV or V care must be seen and examined by a precepting faculty. Also a faculty member must be physically present and actively participate for all procedures on Medicare patients. The precepting faculty must write a brief note in the patient chart for all Medicare visits.
11. Resident clinic notes will be audited/reviewed by CFM faculty preceptors.
12. It is mandatory for all OB visits seen by a Resident to be precepted with the Attending Physician **BEFORE** the patient leaves the clinic.

[Home](#)

Clinic Chief Resident Responsibilities

1. Meetings and Conferences:
 - A. Chair the resident weekly business meeting or arrange for the Clinic Chief Resident to do so.
 1. Coordinate questions or problems that need to be discussed at the business meeting.
 2. Inform residents of policies and/or policy changes.
 3. Take and dictate minutes of the meeting.
 4. Place weekend call schedule on board in large conference room.
 - B. Represent Center for Family Medicine at meetings as assigned or required.
 - C. Follow guidelines of Conference Attendance Policy-please see policy for details.
3. Clinical:
 - A. Act as back-up physician in clinic for: medical students, interns, physicians on extended vacations/leave and walk-in patients.
 - B. Arrange medical student orientation and work/call schedule as well as be involved in overseeing their clinical education.
 - C. Act as liaison between the residents and the CFM Clinical Staff.
 - D. Screen telephone calls requested by receptionists and other staff.
 - E. Attend all Center for Family Medicine deliveries as able.
 - F. From 8:00 a.m. to 5:00 p.m., assist in taking telephone questions from Nursing Homes regarding UND's Nursing Home patients when the primary care physician cannot be reached. The Geriatric Nurse, Chris, can be very helpful when these situations arise.
4. Other duties as required or assigned:
 - A. Promote educational activities.
 - B. Receive and handle items referred by the program coordinator, nursing staff, and/or other clinical staff.
 - C. Act as back-up to interns for the AMTS.
 - D. Coordinate orientation of new interns to various departments.
 - E. Escort prospective residents on date of interview.

I acknowledge that I have read and understand the above responsibilities.

Name

Date

[Home](#)

AMTS Intern Responsibilities

1. Interns are expected to, under the direction of the Senior resident, utilize every opportunity to gain experience in the Emergency Room or the Inpatient ward.
2. As directed by the Senior resident, Interns will be responsible for admitting patients to the Adult Medicine Teaching Service (AMTS), performing daily rounds on AMTS patients, and finding patient information among other duties as necessary for patient care.
3. The Senior resident is expected to give the Intern requested guidance and teaching regarding patient care, so ask for help.
4. Follow guidelines of Conference Attendance Policy – please see policy for details.

I acknowledge that I have read and understand the above responsibilities.

Name

Date

[Home](#)

AMTS Senior Resident Responsibilities

1. Senior residents are responsible for admitting all UND Center for Family Medicine (CFM) faculty patients, patients transferred from outlying communities and facilities as well as all “unassigned” patients that are admitted to the Adult Medicine Teaching Service (AMTS) through the hospital Emergency Rooms at either hospital (Sanford and St. Alexius).
 - A. If the Senior resident admits a CFM patient that has been previously admitted and cared for by another CFM resident or another CFM resident is that patient’s primary care physician, the care is transferred to the other resident the following working day at 8:00 a.m. This is contingent upon the patient’s request (priority #1) and mutual understanding between the physicians involved
 - B. All patients on the AMTS must have an Information Sheet (BOHICA Sheet) in order to facilitate communication at sign-out to the other residents. It is the responsibility of the admitting resident to complete the Information Sheet initially. It should be filled out at the time of admission and must be updated before each sign-out.
2. The attending physician must be notified of all acute status changes (i.e. ICU admissions, emergent surgeries, marked clinical deterioration, etc.) on patients on the AMTS.
3. Emergency Room Responsibilities.

The Senior resident may be called for all CFM patients seen at both Emergency Rooms. The Emergency Room physician may call the CFM resident (s) on call at his/her discretion for the care of CFM patients and assistance with the Emergency Room workload. No patient may be discharge from the Emergency Room with out being seen and the chart signed by a licensed physician.
4. The Senior resident is responsible for responding to CFM patient telephone calls after regular clinic hours.
5. Senior residents are responsible for supervising and teaching PGY-1 residents assigned to the AMTS. Specifically,
 - A. The Senior resident is responsible for promptly reviewing (in person) all admissions done by the PGY-1 resident to the AMTS. The Senior resident is required to promptly review (in person) all CFM patients cared for by PGY-1 residents in the Emergency Room.
 - B. The Senior resident is responsible to give the PGY-1 resident requested guidance regarding patient care.
6. Senior residents should confirm conference speakers and conference dates at rounds daily.
7. Senior residents should assign case topics to residents and medical students based on interesting cases from clinic or inpatient experience or as needed.
8. Follow guidelines of Conference Attendance Policy – please see policy for details.

I acknowledge that I have read and understand the above responsibilities.

Name

Date

[Home](#)

Conference Attendance Policy

1. Residents are required to attend 70% of all required conferences.

Expectations:
 - A. Attendance not required if you are on vacation, CME, personal days, or sick leave.
 - B. Residents on rotations other than adult medicine are encouraged to attend morning rounds (when able) but will not be required to do so. They will, however, be required to attend 70% of the other mandatory events.
2. Mandatory Conferences/Events will be marked on the monthly E*Value calendar put out by Residency Coordinator.
3. Attendance reports will be distributed quarterly.
4. Deficient residents must make up their deficiency in the next quarter.
5. Consequences for deficient attendance:
 - A. Residents may not use ANY of their vacation time if they are below the 70% attendance mark. This includes time for family events and elective doctor's appointments. Residency Coordinator keeps track of this on a daily basis.
 - B. If you are out of vacation time, you will be assigned to produce one presentation of 30 minutes in length for each five conferences you are behind in attendance. The topic for each presentation will be chosen by the faculty.
6. Two deficient quarters in a row will result in extension of the resident's training time.

Goals and Objectives Policy

1. Residents are required to review the Goals and Objectives for each rotation with their preceptor no later than the end of the first week of the rotation.
2. Residents are required to have the preceptor sign the Goals and Objectives, and then turn them into the Program Coordinator by the Monday after the end of the first week of the rotation.
3. If the resident fails to turn in the signed Goals and Objectives form, the resident can be placed on vacation until the form is turned in. They can also be taken out of their continuity clinic until the form is turned in.
4. Goals and Objectives are provided to each resident at a minimum of one week prior to any rotation. Goals and Objectives can also be downloaded from the residency website by following the link below.

<http://www.cfm.bismarck.und.edu/?id=54>

[Home](#)

Criteria for Advancement to Senior Resident Level

Purpose:

To ensure that a senior resident is qualified to supervise first year residents.

Policy:

The following criteria must be met in order for a resident to assume Second Call duties:

1. The USMLE Step 3 must be taken by June 30th of the calendar year; i.e. by the end of the PGY-1 year.
2. Faculty must confirm that the resident is qualified to provide PGY-1 supervision in a manner that is safe for patients.
3. If the USMLE Step 3 is failed, whether the resident may continue on Second Call will be determined on an individual basis. Criteria considered by faculty in this situation will include, but not be limited to:
 - A. In-Service Training Exam scores
 - B. Academic standing documented on evaluations
 - C. Number of rotations passed during the PGY-1 year

Well Baby Clinic

This scheduled clinic (first Friday of each calendar month) is the responsibility of the PGY-1 residents on a rotating basis. Similar to PGY-1 call, this scheduled responsibility may be traded between PGY-1 residents.

[Home](#)

Weekly Time Records for Residents

Purpose:

To insure compliance with all duty hour time regulations stipulated by the ACGME.

Policy:

1. All residents will daily log their duty hours using the E*Value website.
2. If the duty hours are not submitted by the end of the third day of the week, the resident will be contacted by the Program Coordinator; then, the Program Director will recall the resident from their assigned duties and place them on vacation time until they submit their duty hours. This will likely have a negative impact on the evaluation for their current rotation.

[Home](#)

Resident Procedure/Experience Data Base Instructions

All residents are required to turn in a listing of their procedures during their time spent at the UND Center for Family Medicine. These records will be used to obtain hospital privileges at the hospital when you have completed residency. You may use one of the following three options to record your procedures:

1. Experience Cards (Yellow Cards) Please fill in as much information as you have on the patient, the diagnoses, and procedures performed. (You may use a hospital sticker for the patient information section, but please be sure to list your preceptor).
2. Procedure Notebook. You may start your own notebook with patient information. Please be sure to include patient's name, age/DOB, site of visit, preceptor, diagnoses, and procedures performed.
3. PDA. Please enter the information you have on your PDA in a database.
4. This information can be turned into the Program Coordinator at any point in time. You **must** have something turned in **before** you leave the program. It is to your advantage as the hospitals do call to validate this information.

[Home](#)

Miscellaneous Hospital Policies

The following is a general overview of Hospital Issues. Please refer to the Medical Staff Policy Manuals for both Sanford Health Systems and St. Alexius Medical Center for details.

1. All Admissions, Discharge Summaries, and Procedures need to be done under the name of an attending physician. It is important to write the name of the attending physician on all orders and to specifically mention the name of the attending physician on all dictations.
2. Family Medicine Residents are not responsible for coverage of any area of either hospital except as outlined in the section titled Residents and as assigned by rotational preceptors. This means that residents are NOT solely responsible for running CODES or coverage of the ER; however, it is expected that residents will participate in these activities.
3. It is expected that ALL documentation will be timely, written or dictated clearly, concisely and with completeness. Use only well recognized and approved abbreviations.
4. Services available to residents at either hospital at no charge include: Lab coats, Meals at St. Alexius, Library services, and Parking.
5. Although there is no specific dress code at the CFM or at either hospital, it is required that physicians dress in a professional and responsible manner. Scrubs are discouraged, and are not allowed to be worn when residents are seeing their clinic patients unless the resident is on an Obstetrics rotation.
6. Family Medicine residents do not have Active Staff clinical privileges at either hospital. Clinical privileges for residents are determined by the clinical privileges of their attending physicians. The level of supervision of residents is determined by level of training of the resident and level of comfort of the attending physician.

[Home](#)

Protocol for Care for Complex Patients

Protocols defining common circumstances requiring faculty involvement: care of complex patients, ICU transfer, DNR decisions, etc.

1) Inpatient AMTS service

When issues arise where there is need for 1) increased supervision of care, 2) expert consultation on the complex patient, 3) overwhelming volume of patient care, or 4) any other situation where the resident does not feel comfortable making decisions, the following protocol should be followed:

- a. Contact the attending physician – explain situation and ask for guidance.
*The attending physician is responsible for determining the course of action.
- b. If unable to contact the attending, contact the Program Director.

Related policies/protocols:

- A. If resident on the AMTS is ill, they should contact the attending physician who will adjust staffing and patient load as they deem necessary to ensure balance between service and educational obligations.
- B. The AMTS has a hard cap of 20 patients.

2) Outpatient continuity clinic

When issues arise where there is need for acute patient care outside the scope of the clinic setting, the following protocol should be followed:

- a. Contact the precepting physician – explain situation and ask for guidance.
*The precepting physician is responsible for determining the course of action.

3) Nursing home or other long-term care facility:

When issues arise where there is need for higher level of care or any questions regarding the most appropriate course of action for patient care, the following protocol should be followed:

- a. During the day, contact the precepting physician at the clinic – explain situation and ask for guidance.
*The precepting physician is responsible for determining the course of action.
- b. During the night, contact the AMTS attending physician – explain situation and ask for guidance.
*The AMTS attending physician is responsible for determining the course of action.
- c. If unable to contact the precepting or attending physicians, contact the Program Director.

4) Patient phone calls

When issues arise where there is any questions regarding the most appropriate course of action for patient care, the following protocol should be followed:

- a. During the day, contact the precepting physician at the clinic – explain situation and ask for guidance.
*The precepting physician is responsible for determining the course of action.
- b. During the night, contact the AMTS attending physician – explain situation and ask for guidance.
*The AMTS attending physician is responsible for determining the course of action.
- c. If unable to contact the precepting or attending physicians, contact the Program Director.

[Home](#)

Hospital Admission Responsibilities

1. Weekdays (7:00 a.m. – 7:00 p.m.)
 - A. All patients are to be admitted by AMTS residents.
 - B. When a clinic patient is admitted to the hospital by other than the primary care resident, the patient is transferred to the primary care resident or AMTS resident as soon as possible. The admitting resident is responsible for the orders and the history and physical.
 - C. Unassigned patients admitted through the ER are admitted by the AMTS residents.
2. Weekday Nights (7:00 p.m. – 7:00 a.m.)
 - A. All patients to be admitted and cared for by the AMTS residents.

Admission Order Signature Policy

Purpose:

1. To ensure admission orders are accurate and that patient safety is maximized.
2. To maximize the amount of learning experienced for PGY-1 residents on the UND AMTS from each hospital admission.

Policy:

1. All admission orders are to be reviewed and co-signed by a PGY-2 or PGY-3 resident BEFORE they are given to the unit secretary to be implemented.
2. This only applies to the initial set of admission orders, not to orders for ongoing care.
3. If a PGY-2 or PGY-3 is the admitting resident, the orders do not need to be co-signed.

[Home](#)

Patient Scheduling

1. First year residents are scheduled 3-6 patients per afternoon; half an hour per patient. Please contact the front desk if more time per patient is needed or if more patients can be scheduled.
2. Schedules can be checked by going to Medicat.
3. Except in emergencies or special arrangements, patients are seen by appointment; however, walk-ins are welcome.
4. If a physician asks an unscheduled patient to come to the clinic, the physician needs to notify the front desk so the patient's chart can be pulled before the patient is seen. If a patient comes in for an exam and is to return for lab work the nurse must be notified.
5. Residents that have morning clinic are expected to arrive at 9:00A.M. Those with afternoon clinic hours are expected to arrive at 1:00 P.M. and remain in the clinic until 5:00 P.M. to cover walk-ins and/or late scheduled patients.
6. If a physician is delayed for a scheduled appointment at the clinic, always notify the appointment desk personnel.

OB Scheduling

1. OB patients will be scheduled with a specific resident if they request so.
2. If the patient does not have a preference or does not request a physician, the patient is scheduled with a resident on a rotating basis.
3. If a resident notifies the receptionist not to schedule any more OB patients, the request is taken into consideration.
4. If a resident notifies the receptionist to schedule more OB patients, the request is taken into consideration.
5. If a patient requests a pregnancy test but does not have a physician, the test is ordered through Chief/Dr. Hostetter. If the test is positive the nurse will instruct the patient to see a physician as soon as possible. If the patient wishes to continue with the Family Practice Center and asks whom they should see, the patient is told to check with the receptionist to see which physicians are available. A patient will occasionally ask the nurse who the physicians are that she works with and will make a choice from the group of physicians

[Home](#)

Rural Rotations

1. Rural rotations will be conducted in a community office outside of the Center for Family Medicine, for a period of not less than two weeks and a maximum of eight weeks, within the second and third years of residency.
2. The Program Director or designee will coordinate, negotiate, and approve all rural rotations.
3. Rural rotations during the last two weeks of June and the first two weeks of July will not be granted.

Inpatient Pediatrics

Purpose:

Provide adequate funding for the required inpatient pediatrics rotation.

Policy:

1. All residents will be required to do a one month rotation with the University of Colorado Pediatrics Department.
2. In addition to the regular monthly salary that the resident will continue to receive while in Denver, the UND Center for Family Medicine will refund the resident mileage to and from Denver at the current state rate.

Medical Coverage for Sporting Events

Purpose:

To delineate the procedures for insuring adequate medical coverage when residents and faculty are providing medical coverage for sporting events.

Policy:

1. Either a faculty member or a PGY-2 or PGY-3 resident will be allowed to provide medical coverage at sporting events in the community.
2. If a resident is providing coverage, a faculty member must be either concurrently present at the event or be available by phone to provide immediate consultation. The resident is responsible for establishing the consulting coverage arrangements BEFORE the start of the sporting event.
3. Medical care will be provided by either the faculty or resident physician based on the policies, procedures and medical releases/permissions of the team.

Moonlighting

1. Moonlighting activities will not interfere with the resident's clinic, hospital, or rotational responsibilities.
2. Moonlighting will **NOT** take priority over the resident's clinic schedule. Clinic or rotation responsibilities will not be shortened for moonlighting purposes.
3. Residents must keep track of moonlighting in their log book.
4. Residents may not moonlight when scheduled on second call or as chief.
5. Residents must log their time spent moonlighting as duty hours in E*Value

[Home](#)

Vacation

1. Vacation time with pay is earned by residents for the purpose of freeing the resident from his/her regular duties to spend time in rest and recreation. Vacation time **cannot** be carried forward from year to year, or accumulated at the end of the residency. **Use it or lose it.**
2. Vacation requests should be presented as far in advance as possible and must be approved by the Vacation Committee. The Vacation Committee is made up of the Program Director, Associate Program Director, and the scheduling faculty member. It will meet every two weeks to review leave requests.

The committee will use the following guidelines for approving leave:

- a) First come, first served.
 - b) No leave allowed if resident is on **NICU, Inpatient Peds, or AMTS** rotations.
 - c) No leave allowed the last week of June and first week of July.
 - d) For a two week rotation, only is two days of leave allowed. For a month rotation, only is five days of leave allowed.
 - *e) For situations involving emergency, health, family problems, or other special circumstances, please attach a written explanation requesting variance from the above policies to the Leave Slip.
3. Procedure residents are to follow in requesting leave:
 - a) Arrange call coverage for the days off requested.
 - b) Submit request at least two weeks in advance by completing a Leave Slip and placing it in the black box on the Program Coordinator's desk.
 - c) Leave slip will be returned to you in your mailbox with either approval or denial written on it. If denied, the reason for denial will be written as well. Special circumstances will be considered, but are not a guarantee that approval will be granted.
 - d) Have front desk supervisor sign off that clinic is covered.
 - e) Return slip to Program Coordinator.
 - *f) **Leave not officially approved until you get front desk approval and return the slip!**
 4. Vacation requests, during the last two weeks of June and the first two weeks of July may be granted with prior approval.
 5. A maximum of one week is granted during any single rotation.
 6. If more than two residents from a given year of training (PGYI, PGY II, PGY III) requests vacation for the same period, approval shall be subject to the Program Director's discretion.
 7. Annual leave with pay is earned on the following basis:
 - First Year Resident** – 15 working days plus 5 CME days
 - Second Year Residents** – 15 working days plus 5 CME days
 - Third Year Residents** – 15 working days plus 5 CME days
 - * Total leave time for conferences **includes** travel time.
 8. Personal leave may be granted for illness, maternity, paternity, funerals, interviews, or family emergencies.
 9. If personal leave days, plus vacation days total more than twenty working days in a calendar year (July - June), those days shall be made up, without pay at the completion of the residency.

[Home](#)

Medical Record Documentation

Medical record documentation is required to record pertinent facts, findings, and observations about the individual's health history including past and present illnesses, examinations, tests, treatments, and outcomes. The medical record chronologically documents the care of the patient and is important element contributing to high quality care.

The principles of documentation listed below are applicable to all types of medical and surgical services in all settings. For Evaluation and Management (E/M) services, the nature and amount of physician work and documentation varies by type of service, place of service and the patient's status. The general principles listed below may be modified to account for these variable circumstances in providing E/M services.

1. The medical record should be complete and legible.
2. The documentation of each patient should include:
 - Reason for the encounter and relevant history, physical examination findings and prior diagnostic results;
 - Assessment, clinical impression or diagnosis;
 - Plan for care;
 - Date and legible identity of the observer.
3. If not documented, the rationale for ordering diagnostic and other ancillary services should be easily inferred.
4. Past and present diagnoses should be accessible to the treating and/or consulting physician
5. Appropriate health risk factors should be identified.
6. The patient's progress, response to and changes in treatment, and revision of diagnosis should be documented.

The CPT and ICD-9CM codes reported on the health insurance claim form or billing statement should be supported by the documentation in the medical record

[Home](#)

Dictation Time Limits

Purpose:

To keep our clinic chart dictations as up to date as possible to ensure the best possible patient care and safety.

Procedure:

1. All faculty and staff providers will have 7 days after the date of visit to have a note for the visit dictated.
2. All dictation must be verified and signed by the Provider within ten days of the clinic visit.
3. If dictation is delinquent, the medical records staff will inform the Program Director.
4. The intervention for being delinquent will be to not allow any patient visits to be scheduled beyond what is already on the Provider’s schedule.
 - a. Patient’s visits will not be cancelled, but no visits will be added until the Provider has completed all delinquent visits and all current visits.
5. Although Providers are strongly encouraged to complete and sign all dictation before going on vacation, the above time limits can be interrupted by vacation time without penalty. For example, if a provider goes on vacation after five days of seeing a patient. They will have an additional two days to complete their dictation upon returning to work.

Notification of Diagnostic Report Results

Notification of diagnostic results to patients is to be monitored to insure that physicians are reviewing patient results and patients are receiving their diagnostic test results in a timely manner.

- a. Routine reports will be communicated with the patient within 2 weeks of receiving the report.
- b. Critical reports will be communicated ASAP from when the report was received.

Internal tracking of diagnostic tests will be done periodically by risk management (lab, xray, EKG, Audiograms, Pap, biopsy). Providers will be reminded monthly if outstanding reports are present in their Medicat tasks.

Notification and reading of results can be documented in Medicat in the Order/Results tab. Mark the read box to document the physician reviewing the result and that the patient has been notified of the result. Fill in the comment field how the patient was notified, by PHONE, VISIT, LETTER or OTHER.

All paper diagnostic reports faxed or mailed to the clinic will also be stamped by the nursing staff for review by the physician. The medical records staff will return reports to the physicians if the stamp is not filled out for them to complete before filing the report in the patients chart.

Date _____ Physician _____
 Patient Notified
 ___ Clinic Visit ___ Phone
 ___ Other _____ ___ Letter _____

Home

Notification of Results

Physicians, lab, x-ray and nurses can **explain** to the patients when a referral or diagnostic test is ordered to contact the clinic if results have not been communicated to them. This information (business card) will be given to the patient along with referral appointment, take home instructions and when lab tests are ordered.

You are having a diagnostic test today or in the near future. If you do not receive your results from your physician within one week of your test, please contact the Center for Family Medicine at 701 751-9500 for your results. If you reschedule this diagnostic test, please notify your physician's nurse. Thank you for choosing UND Center for Family Medicine for your family's healthcare needs.

[Home](#)

Notification of Results

[Home](#)

Education for Physicians, lab, x-ray and nurses **to explain** to the patients when a referral or diagnostic test is ordered. This information (business card) will be given to the patient along with referral appointment, take home instructions and when lab tests are ordered.

You are having a diagnostic test today or in the near future. If you do not receive your results from your physician within one week of your test, please contact the Center for Family Medicine at 701 751-9500 for your results. If you reschedule this diagnostic test, please notify your physician's nurse. Thank you for choosing UND Center for Family Medicine for your family's healthcare needs.

Consent for Treatment

Informed Consent

I. Purpose:

- A. The informed consent process is viewed as being integral to the physician/patient relationship and to the practice of medicine. Informed consent is not simply a signature on a preprinted form; instead, it is a process of information exchange and an opportunity to educate the patient about recommended treatment. Anytime a “material risk” is associated with a procedure, informed consent should be obtained. The attending physician is responsible for obtaining the informed consent from the patient or legal guardian of a minor.
- B. Basic consent entails letting the patient know what you would like to do and asking if it is alright to proceed. Basic consent is important and valid in regard to noninvasive and routine procedures such as x-rays and venipunctures.
- C. The physician, may exercise “therapeutic privilege” and not inform a patient of a particular risk if the physician can document that explanation of such risk would affect the patient’s ability to make a rational decision or cause harm that would exceed the risk itself.
- D. The patient’s consent should only be “presumed” rather than obtained, in emergency life threatening situations, when the patient is unconscious, or incompetent and no surrogate decision maker is available.

1. Procedure:

- A. The informed consent process should be obtained for the following:
 1. Minor surgery which involves entry into the body
 2. Non-surgical procedures involving more than a slight risk or harm to the patient, or involving a risk of change in the patient’s body structure.
 3. Experimental procedures
 4. Patient photographs (involving medical care)
 5. Procedures in which the medical staff determines that a specific explanation to the patient is required.
- B. The consent for diagnostic and/or surgical procedure form should be obtained for the following:
 1. Any minor surgical procedure
 2. Colposcopy
 3. Colonoscopy
 4. Laryngoscopy
 5. Endometrial biopsy
 6. HIV testing
 7. Implanon Insertion
- C. The physician will explain and discuss the proposed procedure with the patient and/or legal guardian.
- D. The diagnostic and/or surgical procedure consent form will be executed, and the physician will obtain informed consent to include the following:
 1. A description of the procedure to be performed in terms understandable to the patient.
 2. A statement of the possible risks, complications and the alternative methods of treatment.
 3. The identity of the physician who will perform or order the procedure.
 4. A statement that indicates that the patient has read and understands the consent form.

5. A statement that indicates that the patient has had an opportunity to ask questions and has had those questions answered in terms understandable to the patient.
6. The patient or legal guardian's signature, the date and time the consent was signed.
7. The signature of a witness, (may be a physician), and the date signed.

E. Special consent forms should be obtained for the following:

1. Against medical advice
2. Sterilization – Tubal ligation and Vasectomy
3. Stress test
4. Influenza vaccines
5. Immunizations
6. Pulse Light Therapy
7. HIV Testing
8. Colonoscopy

F. For Medicaid (female) sterilization procedures:

1. The attending physician is responsible for obtaining the informed consent from the patient, but the physician or the nurse may need to read the contents of the consent form to the patient before instructing the patient to read and sign it.
2. Thirty days must elapse after the date of the patient's signature on the consent form, before the sterilization procedure may be performed.
3. One week in advance of the procedure, the nurse will send the completed form to the physician performing the sterilization procedure, one copy to the hospital, and one copy is retained in the patient's medical record.
4. The physician's statement on the consent form is to be signed by the physician at the time of the hospital admission or shortly before the sterilization procedure.
5. Refer to the Department of Health Information for Women packet.

2. Documentation

In all cases the physician is responsible to document in the progress note or procedure note that the essential elements of informed consent were discussed. At a minimum this should include:

1. Treatment options
2. The risks and complications of the procedure
3. The opportunity for the patient to ask questions

3. Incapacitated persons

Informed consent for health care for a minor patient or a patient who is determined by a physician to be an incapacitated person and unable to consent may be obtained from a person authorized to consent on behalf of the patient. The following is in order of priority that may provide consent to health care on behalf of the patient.

1. The individual to whom the patient has given a durable power of attorney that gives them the authority to make health care decisions for that patient.
2. The appointed guardian of custodian of the patient.
3. The patient's spouse who has maintained significant contacts with the incapacitated person.
4. Children of the patient who are at least eighteen years of age and who have maintained significant contacts with the incapacitated person.
5. Parents of the patient, including a stepparent who has maintained significant contacts with the incapacitated person.
6. Adult brothers and sisters of the patient who have maintained significant contacts with the incapacitated person.

7. Grandparents of the patient who have maintained significant contacts with the incapacitated person.
8. Grandchildren of the patient who are at least eighteen years of age and who have maintained significant contacts with the incapacitated person or
9. A close relative or friend of the patient who is at least eighteen years of age and who has maintained significant contacts with the incapacitated person.

Informed consent for health care for a minor patient or a patient who is an incapacitated person must make reasonable efforts to locate and obtain authorization for the health care from a competent person.

Before any person authorized to provide informed consent, the person must first determine in good faith that the patient, if not incapacitated, would consent to the health care.

No person authorized to provide informed consent pursuant to this section may provide consent for sterilization, abortion, or psychosurgery or for admission to a state mental health facility for a period of more than forty-five days without a mental health evaluation or other court order.

4. Minors

A general rule, a minor cannot consent to their own treatment and the consent of a parent or legal guardian is required to treat the minor for non-urgent matters.

Written consent, **Consent for Minors Medical Care and Information**, is required when someone other than parent/guardian will accompany the minor patient to the appointment if anticipated that the parent/guardian will not be present for the appointment.

Parents/guardian can sign the **Authorization of Release of Information form** for information to go to another person approved by the parent/guardian.

A provider seeking consent for a minor patient must make reasonable efforts to locate and receive authorization for the health care from a parent/guardian.

If written consent cannot be obtained from the parent/guardian, attempt to contact the parent/guardian to discuss the office visit findings and treatment plan, unless the minor patient is permitted by law to obtain treatment without parental consent. State of ND explains a minor to be ≥ 14 years of age for the following exceptions that can be treated without parental consent.

1. Treatment of Minor for sexually transmitted disease
2. Emergency Care
3. Blood donations
4. Prenatal Care and other pregnancy care services

A minor who has been deemed emancipated by a court of law may also consent for their own treatment.

The HIPAA rules provide an exception to protecting a minor patient's PHI when that minor patient seeks treatment without parental consent. If the Provider's professional judgment deems it in the best interest of the minor patient to inform the parent/guardian of the minor patient's visit, the provider may do so. Document the reason for disclosing information in order to support the disclosure was in the minor patient's best interest.

To prevent the unwanted release of information, to include billing charges, to a parent/guardian when a minor seeks treatment the dictation note and that date of service billing charges will need to be flagged to alert all staff to this RESTRICTED note and charges. Follow the **RESTRICTED MINOR VISIT checklist**.

5. Refusal to be Informed

An exception to the informed consent process occurs when a patient refuses to be informed about a treatment or procedure. There could be many reasons for this and it is the responsibility of the physician to attempt to find out why the patient is refusing to be informed before a treatment or procedure is done. Another option is to see if the patient will allow the physician to provide this information to a relative or friend.

Documentation necessary in the event of Refusal to be Informed:

1. Information that was given to the patient before they refused further information, and that the patient refused to be informed.
2. Plan of care.

6. Refusal of Treatment

A mentally competent patient may refuse any medical treatment. In order to satisfy the requirements of the informed consent process, it is important that patients are provided with the risks associated with not undergoing a treatment.

When informing a patient who is refusing a treatment do and document the following:

1. Evaluate the patient's capacity to make decisions.
2. Assess the patient's overall understanding of the information provided.
Re-educate the patient when necessary.
3. Document
 - a) diagnosis and recommended treatment,
 - b) risks and benefits of the recommended treatment,
 - c) alternative treatments if available
 - d) risks and consequences of not having the recommended treatment, and reasons for refusal.

[Home](#)

Patient Education

Patient education is given to a patient to provide help in solving his/her health problem. It should be incorporated in to routine office visits for all patients. Effective patient education ensures that patients have a sufficient level of knowledge and understanding, which allows them to make informed decisions regarding their care.

Patient education is selected to recognize the education level, literacy and language needs of patients. Select education materials that are written at a 5th to 8th grade level. Education materials need to support education provided and not take place of provider education.

Approved Websites to provide patient handouts for education are listed below. Multiple copies of handouts that cover common health problems in the community can be printed. Periodically check website for revisions and update handouts. If education materials are not on this list or part of current handouts the information needs to be approved by a faculty member.

- Family Medicine: <http://familydoctor.org/online/famdocen/home.html>
- Sports Medicine: http://www.summitmedicalgroup.com/library/sports_health/
- Pediatric Medicine: www.cponline.org
- Dermatology: www.aad.org
- Diabetes: <http://www.diabetes.org>
www.internationaldiabetescenter.com
- Health Maintenance <http://epss.ahrq.gov/ePSS/GetResults.do?method=search&new=true>
- American Academy of Pediatrics http://brightfutures.aap.org/tool_and_resource_kit.html

Approved Patient Handouts to provide education to patients are listed below. If new education handouts are to be implemented they need to be approved by a faculty member.

OB: First OB packets
Diabetic Patients

Interpreters:

Pacific Interpreters Service-Nursing will be trained in how to access these services when needed.
Microsoft Office Word Document Language Translation

Documentation Guidelines:

1. Medicat; Choose the correct transaction in the EDUCATION field to find the education handout. It is possible to search by diagnosis also. A Treatment Set can be found in PLAN section of a SOAP note also.
2. Evaluation of the patient’s ability to comprehend the information provided.
3. The content name and source of patient education materials that were provided to the patient. Remember to include all education used-verbal, audio, written. There is NO need to include a copy of the handout in the medical record.
4. Evaluation of the patient’s understanding of the information provided. (e.g., teach back, repeat back)
5. Interpreters-Document use of and service (ex. telephone). Document name of the interpreter services, name of the interpreter, and description of the information provided, patient’s stated level of understanding of the information, signature of nurse of medical provider making the entry.
6. Nursing must have approval of the provider for all education given. List source and handout given per physician.

[Home](#)

Patient Summary (Medicat)

Patient's medical history is summarized in the patient's electronic record on the Patient Summary page. The patient's medical history needs to be reviewed routinely.

MEDICATIONS: Reconciled by nursing for each clinic visit in the Patient Summary. If dosage changes have occurred, nursing will review changes with the physician. Physicians will review and make appropriate changes in Rcopia.

HISTORY: Medical, Family, Surgical and Social history needs to be reviewed and updated by the physician for all established patients on an annual basis. New patients will need to be entered during their initial exam.

For health maintenance and annual medication recheck physicals, all categories in the Patient History Summary need to be reviewed.

For problem focused visits, only the Patient History Summary categories related to chief complaint visit need to be reviewed.

ALLERGIES: Reconciled by nursing every visit in the Patient Summary.

EXCEPTIONS:

OB: Refer to ACOG

PEDS: Forms approved by the American Academy of Pediatrics Bright Futures will be used.

The Child Health Questionnaire needs to be completed on both sides and filed on the left side of the chart. Forms will be scanned and attached to the visit. The clinic Residents using the Pediatric forms are still subject to preceptor review.

Well Child forms are designed for different age brackets. We will as a clinic use these forms for patients up to the age of fourteen. After the age of fourteen the Patient Summary will applicable. An exception would be for patients with disabilities, we can then use the form marked Teen/14-21 years.

The form labeled Ped's Problem List is an optional form that can be used.

[Home](#)

Geriatric Protocol

Nursing Home Rounds

1. Objectives

- a) Identify aspects of the aging process.
- b) Gain an awareness and sensitivity to the medical, emotional, social, economic and physical needs of the elderly.
- c) Enhance perceptions and attitudes toward the elderly.
- d) Develop an insight into the continuity of care of the elderly in a long-term health care center.
- e) Gain knowledge regarding the role of the physician caring for the elderly patient in a long-term health care center.

2. Protocol

- a) There will be an assigned “nursing home week,” where each physician will see their nursing home patient. To meet the Medicare guidelines, this visit will be at least every 30 days on a new admission to the nursing home facility for the first 90 days and at least every 60 days thereafter.
- b) Nursing home teaching rounds will be held one time per month, after the above completed nursing home week. A schedule will be made up for a 1-month rotation.
- c) At the nursing home teaching rounds, all residents will meet during a noon luncheon, along with the geriatric nurse and a preceptor.
- d) One assigned resident will present a short lecture on an assigned geriatric topic.
- e) Each resident physician will present his or her patient to the group. This will give the resident an opportunity to discuss their patient’s care with a preceptor and other residents.
- f) One or two residents will be assigned to go on walking rounds with the preceptor and the geriatric nurse. This is where we will see each patient and sign the appropriate forms.
- g) Resident physicians are required to attend a minimum of one nursing home care conference per year, preferably when the patient’s family members are present, if applicable.
- h) The schedule of the above mentioned care conference dates will be given at the beginning of each month. A reminder of a memo or call will be done closer to the date.

In Summary:

- 1) Residents will become primary care physicians for their nursing home patients by making visits every 60 days and therefore providing continuity of care.

[Home](#)

- 2) Residents will become more family oriented by attending care conferences on their patients. This gives the resident the opportunity to meet the family and to better understand the care that each department of the nursing home provides for their patients.
- 3) Residents will share their geriatric experiences by attending group rounds every month.

Geriatric Home Visits

1. Objectives

- a) Demonstrate the informational value of a home visit.
- b) Develop and maintain observational skills.
- c) Learn about cultural, social and environmental habits of the patient.
- d) Increase understanding of family dynamics.
- e) Aid the resident in developing a more holistic approach to geriatric care, utilizing the information obtained on the home visit.

2. Protocol

- a) The resident is responsible for selecting an appropriate patient for a home visit. The geriatric nurse or preceptor may also suggest patients. When possible the selection of the patient will take place at least 1 week prior to the home visit date.
- b) Geriatric team members that will attend the home visit will include the preceptor, resident physician, geriatric nurse and social worker when possible.
- c) Each resident will participate in a minimum of one geriatric team home visit per year.
- d) The geriatric nurse will schedule home visits. The visits will occur during the day from 0930 to 1200, and from 1330 to 1630, with the approval of the patient and family and in accordance with the other team members' schedules.
- e) The geriatric team visit will be brief (30-60 minutes), and by appointment. The geriatric nurse will have the billing sheet, the patient data base, and chart when available. The nurse will also obtain the patient's vital signs, when appropriate. The geriatric nurse is available to perform venous blood draws, if needed, but this needs to be discussed in advance.
- f) Following the home visit, the resident physician will dictate findings and follow-up plans of treatment.

In Summary:

- 1) The resident will be asked to select a patient for home visit, and make a minimum of one home visit per

year.

[Home](#)

- 2) The resident will be asked to share his or her initial impressions and expectations prior to the visit. This impression will be based on previous contact with the patient either in the office or from the chart.
- 3) The resident will compare the actual findings to the original expectations. This will assist the resident in understanding how stereotypes and preconceived attitudes often affect objectivity about patients.
- 4) The resident physician will observe the following data during the home visit:
 - a) Medication management -including OTC and prescription, as well medication storage.
 - b) Nutritional data - including diet, appetite and weight change.
 - c) Folstein mini-mental status.
 - d) Functional activities of daily living.
 - e) Family issues- including social, financial and emotional.
 - f) Environmental observations - including external and internal.
 - g) Support services - including those utilized or referral if needed.
 - h) A family history and physical exam.

Geriatric Nurse Availability Communication

- 1) The geriatric nurse schedule will be given to the front desk. Because I only work 24 hours/week, I am available for urgent calls at home. Please check with front desk for the number.
- 2) If the issue is not urgent, a note on my desk will be sufficient, and I will get back to you the next time that I am in clinic.
- 3) The calls from the nursing home will come to the geriatric nurse (when available). The question will then be followed up to a physician.
- 4) Please take note to watch for any nursing home orders for you to sign. I will put them on your desk, and after they are signed, they can go into the resident's outgoing mail bin.
- 5) The geriatric nurse is available for questions or concerns.
- 6) **Together we need to communicate patient information, to provide continuity of care.**

Resident Physician Responsibilities

- 1) See nursing home patients during the assigned time, and in a timely manner to meet Medicare regulations.
- 2) Attend nursing home teaching rounds during the scheduled noon luncheon.

[Home](#)

- 3) Present a brief lecture on an assigned topic at the designated time. The resident physician is expected to provide a supplement source of information on the assigned topic, other than that of the article supplied by the geriatric nurse.
- 4) Attend the walking nursing home rounds when assigned.
- 5) Select a patient for a home visit and attend a minimum of one per year.
- 6) Attend a minimum of one nursing home care conference per year, preferably with the family member's present, if applicable.
- 7) Communicate to the geriatric nurse any potential or new nursing home patients.
- 8) Observe for any telephone orders that need to be signed. Then place them into the resident's out going mail bin in a timely manner.
- 9) Communicate to the geriatric nurse when you are not able to attend any of the above-mentioned assignments.

[Home](#)

Graduation Requirements

TO RECEIVE A CERTIFICATE OF COMPLETION YOU MUST:

- **Successfully complete all required rotations including Practice Management and Research.**
- **Make sure all completed rotations have a filled out evaluation form from the preceptor.**
- **Turn in all experience cards and/or documentation.**
 - Must have 30 vaginal deliveries (plus 10 continuity deliveries)**
 - ICU patients (must have 15 patients)**
 - AGB Form-10 documented and card signed**
 - Foley Cath Form-10 documented and card signed**
 - Pap Smear Form-10 documented + 5 Wet Mounts and card signed**
- **Have adequate clinic numbers (1,650 patients) as well as all clinic dictation completed.**
 - Need to have 150 patient encounters at the end of the first year.**
 - **Documentation of patient numbers from any rural rotation.**
- **Updated Procedure Log**
 - **Resident Dues Paid in Full each year**
 - **Duty Hours Up to Date**
 - **Complete GME-TODAY Series**
 - **Complete QA audit**
 - **Complete Residency to Reality Series**
 - **Help Desk Answer Published (FPIN)**
 - **Finish all Medica tasks. Review for missing documentation and/or charges with Medical Records Supervisor and Business Office Supervisor.**

TO BE TURNED IN ON LAST WORKING DAY OF WORK: Book Club Book#:

Key to clinic key
Parking Card (or \$10 if you lost the card)
St. Alexius Access Card
St. Alexius Meal Card
UND Passport Card
Beeper (please let me know of any problems)
Moonlighting Log
Sanford One Access Card
Practice and Home Address

REMINDER:

Apply for your own Medicaid ID#

[Home](#)

Attending Physician's CFM Clinic Responsibilities

1. Attending Physician's need to be available at the clinic during the hours that they are assigned as Preceptor.
2. It is mandatory for all OB visits seen by a Resident be precepted with the Attending Physician.
3. It is mandatory that the precepting Attending observe a significant portion of one patient visit for each Resident during the clinic session. This will apply to all levels of residents.

[Home](#)

Confidentiality and Disclosure of Concern Cards

Purpose: To delineate the procedures for insuring confidentiality of Concern Cards submitted to Program Director (PD).

Policy:

I. Concern Cards submitted to the PD via e*Value or written suggestion will be kept strictly confidential by the PD and the Program Coordinator.

II. If the PD deems that patient safety is in jeopardy from the information on the Concern Card, the PD may choose to intervene immediately in such a way that anonymity of the content of the Concern Card cannot be maintained. However, the actual Concern Card itself will not be shared with the person who is the subject of the report.

III. The PD may use general information from Concern Cards to shape resident or faculty feedback. However, every attempt to maintain the anonymity of the author of the Concern Card will be made.

IV. The Program Coordinator will keep all Concern Cards about a resident in a separate section of their personnel file. These will be not be able to be viewed by anyone other than the PD and Program Coordinator. They will be removed from the personnel file and destroyed when the resident graduates from the program.

[Home](#)

Complaint Management

The Risk Management Team will effectively manage the risk associated with minor and noncritical events. Complaints will be received and responded to within 30 calendar days for both oral and written complaints. All complaints should be resolved at the level the issue occurred.

Complaints will be processed, reviewed and the Risk Management Team & Program Director will be provided with a biannual report.

Purpose:

Complaints or concerns received by clinic staff reflect patient perceptions and expectations. Feedback, solicited or unsolicited, presents an opportunity to identify issues and implement systematic processes to improve care and/or service.

Procedure:

All clinic and administrative staff will be responsible for receiving complaints. Complaints related to a specific department will be forwarded to the department supervisor. Complaints related to physicians will be forwarded either to the Business Manager or the Program Director.

1. The patient complaint is received either verbally or in writing by any staff person.
2. The complaint form (Patient Relations Communication form or State of ND Incident Report) will be initiated by the person receiving the complaint.
3. If the complaint can be resolved at this level, staff member receiving the complaint will:
 - Resolve complaint
 - Complete complaint form including signature and date
 - Completed form will be forwarded onto the Business Manager to be reviewed and original to be filed with the assigned CFM Risk Management Representative & copy to the Risk Management Division of the State of N.D. if warranted.
4. If the complaint cannot be immediately resolved, the complaint form will be forwarded to the Business Manager, Nursing Supervisor, or Provider/Preceptor. An investigation will be initiated and a timely quality review of the event or complaint will be done. Documentation will be made on the complaint form.
5. Changes will be made in policy/process in a timely manner and communicated to all staff as appropriate.
6. The complaint will be filed and tracked for trends during a quarterly review. Any trends found will be reported and discussed with the Program Director. Improvements will be made as needed.

Patient Complaint Records

Improvement activities and training will be identified and monitored by the Risk Management Committee.

[Home](#)

Patient Satisfaction Survey

Policy:

Currently, the UND Center for Family Medicine – Bismarck has two different surveys to measure patient satisfaction.

Purpose:

Patient Satisfaction Surveys reflect patient perceptions and expectations. Feedback, either solicited or unsolicited, presents an opportunity to identify issues and implement systematic processes to improve care and/or service.

Mission:

In making UND Center for Family Medicine the healthcare facility of choice, we are committed to recapture the trust our customers have in UND and our Residency Program, and to insure we exceed our customers' expectations in the event dissatisfaction with service occurs. The patient satisfaction surveys will help us to create individual relationships with our customers and build a service recovery culture within our organization.

Procedure:

Patients are “handed/mailed” the “Physician/Resident” surveys by Nursing Staff at the completion of their clinic visit. This process will occur biannually for Faculty/Resident Evaluations with a random sampling of 5 surveys per Faculty/Resident(Upper level) and 5 per first year Resident. Results of this particular survey will be shared with Residents during their respective evaluation(s). Qualtrics Survey Software is used to record results and view reports per the University of North Dakota policy.

Patient Satisfaction Surveys

General statistical information is gleaned from quarterly reports. Patient Satisfaction Surveys will be reported biannually, or more frequently as determined by Administration, to the Business Manager, Risk Management Committee, Program Directors, Residents, and Ancillary Staff.

Improvement activities will be identified and monitored by the Risk Management Committee.

At a minimum, an annual report will be presented to the Medical Practice Providers including improvement made as a result of patient complaint/concerns. Results of “Patient Satisfaction Surveys” are routinely reviewed and evaluated by the governing board, the medical staff and administration. Complaints identified through patient satisfaction surveys are forwarded to the Risk Management Committee. Risk Management shall collaborate with appropriate staff to investigate and provide follow-up to the patient and/or family.

[Home](#)

Electronic Communications

Purpose

To assure the appropriate use of electronic communication within the UND Center for Family Medicine in addition to the general UND Computing and Network Usage Policy.

Procedure

Password Protection:

All assigned to or created passwords by an employee are private and should not be shared with others. All electronic devices and applications shall be password protected. Passwords need to be changed frequently using a unique password.

Workstation screensavers shall be password protected to prevent a possible breach of PHI.

Only use a program under your personal login information. Do not use a program accessed by another employee. Log employee out and then log in with your information.

E-mail:

When using the University of North Dakota's e-mail system, the individual user must understand that it is an unsecure form of communication. NO patient protected health information (PHI) may be included in the message. Care must be taken at all times to protect against a HIPAA breach.

E-mail is used within the clinic appropriately by staff using the University assigned email address for an employee. By State of North Dakota law, university email content is considered public record, and thus may be open and accessible for inspection.

E-mail communication with patients shall be done with a secure system. Encryption is the only approved mechanism to electronically transmit PHI. The use of the Mediat EMR patient portal will provide a secure means to communicate with patients.

Mobile Applications:

Google Drive is accessed on mobile devices to be used by Providers for patient care. It is administered by a designated UND Center for Family Medicine Faculty member. Each member (Provider's Only) is added by the Administrator to the application. A password is needed to access the application. Information on is updated by Providers and provides a means of communication for each patient.

Personal Device:

All personal devices are not required by staff to fulfill an employee's job requirements. By State of North Dakota law, all electronic communication records are public records, and thus may be open and accessible for inspection. The use of personal devices opens the employee to personal liability for discoverable electronic communication.

Texting:

Intelliweb is available on all computers in the clinic to text providers. Follow this link: <http://206.208.80.22/>

When using texting the individual user must understand that it is an unsecure form of communication. NO patient protected health information (PHI) may be included in the message. Care must be taken at all times to protect confidential information.

Texting should not replace a phone conversation in order to avoid miscommunication between you and the patient or employee. Texting should be avoided during patient care to prevent errors. Texting is not to be used for communication with patients.

Social Media:

Social media is a means of communication using web-based and mobile technologies for the exchange of information. Social Media is not to be used for communication with patients about patients and/or their PHI. No health or medical related information that relates to official activities may be posted on social media.

Lost or Stolen Device:

All lost or stolen devices need to be reported to the department supervisor as soon as possible. The mobile provider will need to be called to deactivate the phone. If a PHI breach is a concern the HIPAA officer will need to be notified of the breach.

Applications are available for devices that can locate the lost device and the phone can be remotely locked or the information can be deleted from the phone. i.e. Find My iPhone. It is recommended that electronic mobile devices have this or a similar application.

Termination or Resignation of Employment:

All employee access to current software applications and devices will be deactivated. This includes but is not limited to Medcat, Orchard Harvest, Round's List, e-mail, e-prescribe etc.

For complete UND policy see the office of Human resources and Payroll Services Annual Notification of Policies.

[Home](#)

ABBREVIATIONS AND SYMBOLS; “COMMON USE” AND “DO NOT USE”

Purpose:

Establish a comprehensive list of abbreviations and symbols to use for notes and charting in a patient’s medical record.

Procedure:

Use the following list of abbreviations and symbols when charting in a patients chart. Use this list as a reference to notes made by nurses or doctors.

A [Home](#)

A ₁ C-----	glycosolated hemoglobin
A.A-----	Alcoholics Anonymous
AAA-----	Abdominal Aortic Aneurysm
AAROM-----	active assistive range of motion
AB-----	abortion
abd.-----	abdomen
ABG-----	arterial blood gases
Abx-----	Antibiotics
AC-----	acromioclavicular, assist control
ac-----	before meals
accel-----	acceleration
ACHES-----	Abdominal pain, chest pain, headaches, eye problems, severe leg cramps
ACL-----	anterior cruciate ligament
ACTH-----	adrenocorticotropic hormone
ad lib.-----	as desired
ADD-----	attention deficit disorder
add-----	adduction
ADH-----	antidiuretic hormone
ADHD-----	attention deficit hyperactive disorder
ADL’s-----	activities of daily living
adm.-----	admission
AE-----	above elbow, adaptive equipment
AFB-----	acid fast bacillus
AFI-----	amniotic fluid index
AFIB-----	auricular fibrillation
AFO-----	ankle/foot orthosis
A/G-----	albumin globulin ration
AI-----	aortic insufficiency
AIDS-----	acquired immunity deficiency syndrome
AK-----	above knee
AKA-----	above knee amputation
alb.-----	albumin
ALG-----	antilymphocyte globulin
Alk. Phos.-----	alkaline phosphatase
ALS-----	ametropic lateral sclerosis

ALT-----	alanine aminotransferase	
A.M. -----	morning	
AMA-----	against medical advice	
AMI-----	acute myocardial infarction	
AML-----	acute myelogenous leukemia	
amp. -----	ampule	
amt -----	amount	
ANA-----	antinuclear antibody	
ant -----	anterior	
AP-----	anterior/posterior or anteroposterior	
A&P Repair-----	Anterior & posterior colporrhapy	
approx. -----	approximately	
appt -----	appointment	
ARC-----	AIDS related complex	
ARDS-----	adult respiratory distress syndrome	
AROM-----	active range of motion	
AROM-----	artificial rupture of membranes	
ASA-----	aspirin	
ASAP-----	as soon as possible	
ASCUS-----	atypical Squamous cells of undetermined	
	significance	
ASCVD-----	arteriosclerotic cardiovascular disease	
ASD-----	atrioseptol defect, atrial septal defect	
ASHD-----	arteriosclerotic heart disease	
ASIS-----	anterior superior iliac spine	
ASO-----	antistreptolysin-o	
AST-----	aspartate aminotransferase	
ATN-----	acute tubular necrosis	
ATNR-----	asymmetrical tonic neck reflex	
ATR-----	Achilles tendon reflex	
A ₂ -----	aortic second sound	
AV-----	arteriovenous	
AV block-----	atrioventricular block	
AVR-----	aortic valve replacement	
AVF, AVL, AVR-----	EKG leads – augmented right arm, left arm, left	leg
A/V/H-----	auditory/visual/hallucinations	

B [Home](#)

Ba-----	barium
baso -----	basophils
BBB-----	bundle branch block
BCM-----	birth control method
BCP-----	birth control pills
b.e. -----	base excess
BE-----	barium enema
BF-----	boyfriend
BG-----	blood glucose
bid -----	twice daily
bilat .-----	bilateral
bili. -----	bilirubin
BK-----	below knee
BKA-----	below knee amputation
BLE-----	both lower extremities

BM-----	bowel movement
BMAT-----	bilateral myringotomy and tube insertion
BMI-----	Body Mass Index
BOS-----	base of support
BOT-----	base of tongue
B.O.W. -----	bag of waters
BP-----	blood pressure
BPH-----	benign prostatic hypertrophy
BPP-----	biophysical profile
BR-----	bathroom
BRP-----	bathroom privileges
b.s. -----	breath sounds
BS -----	bowel sounds
BSE-----	Breast self exam
BSO -----	bilateral salpingo-oophorectomy
BTB-----	Breakthrough bleeding
BTL-----	bilateral tubal ligation
BUE-----	both upper extremities
BUN-----	blood urea nitrogen
BV-----	bacterial vaginosis
Bx, BX-----	biopsy

C [Home](#)

c-----	with
C-----	Centigrade
C1-C7-----	cervical vertebrae 1-7
Ca-----	calcium
CA-----	carcinoma
CABG-----	coronary artery bypass graft
CAD-----	coronary artery disease
cap.-----	capsule
CAPD-----	continuous ambulatory peritoneal dialysis
CARF-----	Commission of Accreditation of Rehabilitation

Facilities

cath.-----	catheter
CBC-----	complete blood count
CBE-----	Clinical breast exam
CBG-----	capillary blood gas
CBI-----	continuous bladder irrigation
CC-----	chief complaint
CCU-----	coronary care unit
CEA-----	carcino-embryonic antigen
CGA-----	contact guard assist
CHF-----	congestive heart failure
CHO-----	carbohydrate
Chol-----	cholesterol
C.I. -----	Cardiac Index
CIN-----	cervical intraepithelial neoplasia
circ -----	circumcision
CIS-----	carcinoma in situ
Cl-----	chloride
CLL-----	chronic lymphatic leukemia

cm.-----	centimeter (2.54cm = 1 in.)
CM-----	case manager/management
CML-----	chronic myelogenous leukemia
CMSS-----	color, motion, sensation, swelling
CMT-----	Cervical mothion tenderness
CMV-----	cytomegalovirus
CNA-----	Certified Nurse Assistant
CNS-----	central nervous system
Coag-----	coagulation
C.O.-----	Cardiac Output
Colpo-----	Colposcopy
c/o-----	complains of
CO-----	carbon monoxide
cont-----	continue
COPD-----	chronic obstructive pulmonary disease
CORF-----	Comprehension Outpatient Rehabilitation Facility
CO ₂ -----	carbon dioxide
COTA-----	Certified Occupational Therapy Assistant
CPAP-----	continuous positive airway pressure
CPD-----	cephalopelvic disproportion
CPK-----	creatinine phosphokinase
CPM-----	continuous passive motion
CPR-----	cardiopulmonary resuscitation
CPT-----	chest physiotherapy
crani.-----	craniotomy
creat-----	creatinine
CRP-----	C-reactive protein
CRTT-----	Certified Respiratory Therapy Technician
Cryo-----	cryoprecipitate
C-Section, C-sect-----	cesarean section
C&S, C/S-----	culture and sensitivity
CSF-----	cerebrospinal fluid
CST-----	contraction stress test
CT-----	computerized tomography
CTRS-----	Certified Therapeutic Recreational Specialist
ctx-----	contractions
cult-----	culture
cu. mm.-----	cubic millimeter
CV-----	cardiovascular
CVA-----	cerebrovascular accident
CVP-----	central venous pressure
CXR-----	chest x-ray
cysto-----	cystoscope/cystoscopy

D [Home](#)

DAT-----	diet as tolerated
DAU-----	daughter
D&C-----	dilation and curettage
decel-----	deceleration
dept-----	department
D/I-----	dry and intact
disch.-----	discharge
DIC-----	disseminated intravascular coagulopathy

DID-----	dissociative identity disorder
DIP-----	distal interphalangeal
DJD-----	degenerative joint disease
DM-----	diabetes mellitus
DME-----	durable medical equipment
DO-----	Doctor of Osteopathy
DOA-----	dead on arrival
DOB-----	date of birth
DP-----	dorsalis pedis
DPT-----	diphtherial toxoid, Pertussis, tetanus toxoid
Dr.-----	doctor
drng-----	drainage
drsg-----	dressng
DSM(edition)-----	Diagnostic&Statistical Manual of Mental Disorder(edition)
DT's-----	delirium tremens
DTR-----	deep tendon reflex
DUB-----	dysfunctional uterine bleeding
DUI-----	driving under the influence
DVT-----	deep vein thrombophlebitis
D/W-----	dextrose and water
Dx-----	diagnosis

E [Home](#)

EAB-----	Elective abortion
EBL-----	estimated blood loss
ECG or EKG-----	electrocardiogram
echo.-----	echocardiogram
E.coli-----	Escherichia coli
ECP-----	Emergency Contraceptive Pill
ECT-----	electoconvulsive therapy
ED-----	Emergency Department
EDC-----	estimated date of confinement
ed-----	Education
EEG-----	electroencephalogram
enc-----	Encourage
EENT-----	eyes, ears, nose and throat
e.g.-----	for example
EGD-----	esophagastroduodenoscopy
EIA-----	exercise induced asthma
ELOS-----	estimated length of stay
EMG-----	electomyogram
ENT-----	ears, nose and throat
EOA-----	esophageal obturator airway
EOB-----	edge of bed
EOM-----	extraocular movements
EOR-----	end of range
eos.-----	eosinophils
ER-----	Emergency Room
ESI-----	epidural steroid injection
ESR-----	erythrocyte sedimentation rate
ESRD-----	end stage renal disease
et-----	and

ET-----	endotracheal
etc. -----	and so forth
ETD-----	Eustachian Tube Dysfunction
ETOH-----	ethyl alcohol
ETT-----	endotracheal tube
eval-----	evaluate, evaluation
expir -----	expiration
ext -----	extension
ext.rot. -----	external rotation

F [Home](#)

F. -----	Fahrenheit
FANA-----	fluorescent antinuclear antibody
FCA-----	functional capacity assessment
FB-----	foreign body
FBS-----	fasting blood sugar
Fe-----	Iron
FECG-----	fetal electrocardiogram

Fetal Position and Presentation:

Vertex Presentations:

LOA-----	left occiput anterior
LOP-----	left occiput posterior
LOT-----	left occiput transverse
ROA-----	right occiput anterior
ROP-----	right occiput posterior
ROT-----	right occiput transverse

Face Presentations:

LMA-----	left mentum anterior
LMP-----	left mentum posterior
LMT-----	left mentum transverse
RMA-----	right mentum anterior
RMP-----	right mentum anterior
RMT-----	right mentum transverse

Breech Presentations:

LSA-----	left sacrum anterior
LSP-----	left sacrum posterior
LST-----	left sacrum transverse
RSA-----	right sacrum anterior
RSP-----	right sacrum posterior
RST-----	right sacrum transverse
FFP-----	fresh frozen plasma
FH-----	family history
FHR-----	fetal heart rate
FHT-----	fetal heart tones
FiO ₂ -----	fractional inspiratory oxygen
fl -----	fluid
FM -----	fetal monitor
FNP-----	Family Nurse Practitioner
FOB-----	Father of Baby
Fr -----	French catheter size

freq. -----	frequent
FSH-----	follicle stimulating hormone
FTA-----	fluorescent treponema antibody
FTA-ABS test -----	fluorescent treponemal antibody absorbed test
FTI -----	free thyroxin index
F/U-----	follow up
FUO -----	fever of unknown origin
FWB-----	full weight bearing
FWW-----	front wheel walker
fx -----	fracture

G [Home](#)

GAF-----	global assessment of functioning
GB-----	gallbladder
GC-----	gonococcus
GCS-----	Glasgow coma scale
GERD-----	Gastro Esophageal Reflux Disease
Gest-----	gestational
GI-----	gastrointestinal
gm -----	gram
G -----	gravida
G6PD-----	glucose-6-phosphodehydrogenase
gtt -----	drops
GTT -----	glucose tolerance test
GU-----	genitourinary
GVHD-----	graft-versus-host disease
Gyn. -----	gynecology
GXT -----	graded exercise test

H [Home](#)

HA-----	headache
HCL-----	hydrochloric acid
HCO ₃ -----	bicarbonate
Hct. -----	hematocrit
HDL-----	high density lipo-protein
HEENT-----	head, eyes, ears, nose & throat
HEP-----	home exercise program
Hg. -----	mercury
Hgb-----	hemoglobin
HGSIL-----	high grade Squamous cell intraepithelial lesion
H/H-----	hemoglobin & hematocrit
HHN-----	hand held nebulizer
HIAA-----	hydroxylindol acetic acid
HLA-----	Human Leukocyte Antigen
HOB-----	head of bed
Hosp. -----	hospital
H&P-----	history & physical
/hpf-----	per high power field
HPI-----	history of present illness
HOH-----	hard of hearing
HR-----	heart rate

hr.-----	hour
HS-----	at bedtime
HSV-----	Herpes simplex virus
ht.-----	height
HTN-----	hypertension
H ₂ O-----	water
hx-----	history
Hz-----	hertz

I [Home](#)

IAB-----	Incomplete abortion
IBC-----	iron binding capacity
ICC-----	Intensive Care Center
ICP-----	intracranial pressure
ICU-----	Intensive Care Unit
I&D-----	incision and drainage
IDDM-----	insulin dependent diabetes mellitus
i.e.-----	that is
IGG-----	immune gamma globulin
IM-----	intramuscular
IMV-----	intermittent mandatory ventilation
incl-----	including
indep-----	independent
INF-----	Infection
INH-----	trademark for preparations of isoniazid
inj-----	Injection
INR-----	International Ratio
insp-----	inspiration
Int. Rot.-----	internal rotation
I&O-----	intake and output
IOL-----	Intraocular lens
I-131-----	radioactive iodine
IPPB-----	intermittent positive pressure breathing
IQ-----	intelligent quotient
IS-----	Insentive Spirometry
ITTP-----	idiopathic thrombotic thrombocytopenic purpura
IUD-----	intrauterine device
IUPC-----	Intrauterine Pressure Catheter
IV-----	intravenous
IVP-----	intravenous pyelogram

J [Home](#)

JP-----	Jackson-Pratt
JVD-----	jugular venous distention
JVP-----	jugular venous pressure or pulsation

K [Home](#)

K-----	potassium
--------	-----------

KAFO-----	knee ankle foot orthosis
KS-----	Kaposi's Sarcoma
K cal. -----	kilocalorie
KCl-----	potassium chloride
K.pad -----	aquamatic pad
kg. -----	kilogram
KUB-----	kidney, ureter, bladder

L [Home](#)

l -----	liter
L1-L5-----	lumbar vertebrae 1-5
L-----	left
lab. -----	laboratory
lac -----	laceration
LAD-----	left axis deviation, left anterior descending
LAH-----	left anterior hemiblock
Lami-----	laminectomy
Lap-----	+name of procedure would indicate laparoscopic, i.e.Lap Chole, Lap Nissen Fundplication, etc.
lap -----	laparotomy
lat -----	lateral
lb. -----	pound
LBQC-----	large based quad cane
LD-----	learning disorder
LDH-----	lactic dehydrogenase
LE-----	lupus erythematosus, lower extremity
LEEP-----	Loop Electrocautery Excision Procedure
LFT-----	liver function test
lg. -----	large
LGA-----	large for gestational age
LGSIL-----	low grade Squamous cell intraepithelial lesion
liq. -----	liquid
LLB-----	long leg brace
LLE-----	left lower extremity
LLL-----	left lower lobe
LLQ-----	left lower quadrant
LMA -----	left mentum anterior
LML-----	left mediolateral (episiotomy)
LMP-----	last menstrual period, left mentum posterior
LMT-----	left mentum transverse
LNMP-----	last normal menstrual period
LOA -----	left occipitoanterior, leave of absence (pass)
LOB-----	loss of balance
LOC-----	level of consciousness
LOP-----	left occipitoposterior
LOS-----	length of stay
LOT -----	left occipitotransverse
LP-----	lumbar puncture
LPH-----	left posterior hemiblock
lpm -----	liters per minute
LPN-----	Licensed Practical Nurse
LR-----	lactated ringers
LS-----	lumbosacral

LSA-----	left sacrum anterior
LSC-----	last sexual contact
LSD-----	lysergic acid diethylamide
LSO-----	left salpingo-oophorectomy
LSP-----	left sacrum posterior
LST-----	left sacrum transverse
LTC-----	long term care
LTG-----	long term goals
LUE-----	left upper extremity
LUL-----	left upper lobe
LUOB-----	left upper outer buttock
LUQ-----	left upper quadrant
LVH-----	left ventricular hypertrophy
lymphs -----	lymphocytes
lytes -----	electrolytes

M [Home](#)

M2-----	meters squared	
MAC-----	monitored anesthesia care	
MAE-----	moves all extremities	
MAESEW-----	moves all extremities spontaneously equally and well	
Mammo-----	Mammogram	
MAP-----	mean arterial pressure	
MAST-----	Medical Anti-Shock Trousers	
mat-----	Maternal(mother)	
max-----	maximum	
max A-----	maximum assist	
MBC-----	minimum bactericidal concentration	
MCA-----	middle cerebral artery	
mc-----	millicurie	
mcg.-----	microgram	
MCH-----	mean corpuscular hemoglobin	
MCHC-----	mean corpuscular hemoglobin concentration	
MCL-----	mid-clavicular line	
MCP-----	metacarpalphalangeal joint	
MCV-----	-mean corpuscular volume	
MD-----	doctor of medicine	
MDD-----	Major Depressive Disorder	
MDI-----	metered dose inhaler	
MDS-----	Minimum Data Set (logging of activities for reimbursement in long-term care)	
med-----	medicine	
mEq. or meq.-----	milliequivalents	
Mg.-----	magnesium	
mg.-----	milligram	
MGF-----	maternal grandfather	
MGGM-----	maternal great grandmother	
mg.%-----	milligrams per 100 milliletes	
MGUS-----	Monoclonal Gammopathy of Undetermined	Significance
MH-----	medical history	
MI-----	myocardial infarction	
M.I.C.-----	minimum inhibitory concentration	
min-----	minimal, minute(s)	

min A -----	minimal assist
misc. -----	miscellaneous
ml. -----	milliliter
mm. -----	millimeter
MMPI-----	Minnesota Multiphasic Personality Inventory
MMT -----	manual muscle test
mo. -----	month
mod. -----	moderate
mod A-----	moderate assist
MOM-----	milk of magnesia
mono -----	monocyte
MPC-----	mucopurulent cervicitis
MPGN-----	membranoproliferative glomerulonephritis
MR-----	mental retardation
MRI-----	magnetic resonance imaging
MS-----	multiple sclerosis
MSW-----	Masters Social Worker
MTP-----	metatarsophalangeal joint
MV-----	minute volume
MVA-----	motor vehicle accident
MVC-----	motor vehicle crash/collision
MVP-----	mitral valve prolapse
MVR-----	mitral valve replacement

N [Home](#)

N/A-----	not applicable
Na -----	sodium
NaCl-----	sodium choloride
NaHCO3-----	sodium bicarbonate
NB -----	newborn
NC -----	nasal cannula
neg. -----	negative
Neuro. -----	neurological
NFP-----	natural family planning
ng. -----	nanogram
NG -----	nasogastric tube
NGU-----	nongonococcal urethritis
NICU-----	Nursery Intensive Care Unit
NIDDM-----	non-insulin dependent diabetes mellitus
NIF-----	negative inspiratory force
NKA-----	no known allergies
NKDA-----	no known drug allergies
noct. or noc-----	nocturnal - at night
NL-----	normal
NOS-----	not otherwise specified
NPO-----	nothing per os (by mouth)
N/S, NS -----	normal saline
NSAID-----	nonsteroidal anti-inflammatory drug
N.S.R. -----	nasoseptal reconstruction
NSR-----	normal sinus rhythm
NST-----	non-stress test
NSU-----	nonspecific urethritis
NSVD-----	normal spontaneous vaginal delivery

NT-----	nasotracheal, not tested
NTG-----	nitroglycerine
N&V, N/V-----	nausea & vomiting
NWB-----	non-weight bearing
NWBCW-----	non-weight bearing crutch walking

O [Home](#)

OB-----	obstetrics
OBS-----	organic brain syndrome, observation
obst.-----	obstruction
occ.-----	occasionally
OCD-----	obsessive compulsive disorder
OCP-----	oral contraceptive pill
OD-----	right eye, overdose
ODD-----	oppositional defiant disorder
OET-----	oral endotracheal tube
OG-----	orogastic
OOB-----	out of bed
oint.-----	ointment
OM-----	oral motor
OP-----	outpatient
Ophth.-----	Ophthalmology, ophthalmic
OR-----	Operating Room
ORIF-----	open reduction internal fixation
Ortho-----	orthopedics
OS-----	left eye
OSA-----	Obstructive Sleep Apnea
O.T.-----	occupational therapy
OTC-----	over the counter
OTR/L-----	occupational therapist registered/licensed
O2-----	oxygen
OU-----	both eyes
ox-----	oximeter
oz.-----	ounce

P [Home](#)

p-----	post, after
P-----	pulse, para
P&A-----	percussion and auscultation (also A & P)
PA-----	Physician Assistant
PAC-----	premature atrial contractions
PA-C-----	Physician Assistant Certified
PACU-----	Post Anesthesia Care Unit
PaCO ₂ -----	arterial carbon dioxide tension
PaO ₂ -----	arterial oxygen tension
Pap-----	Papanicolaou smear
PAP-----	pulmonary artery pressure
PAS-----	periodic acid Schiff
PAT-----	paroxysmal arterial tachycardia
path-----	pathology
PAWP-----	pulmonary artery wedge pressure

pc -----	after meals	
PCA-----	patient controlled analgesia	
PCO ₂ -----	carbon dioxide partial pressure	
PCP-----	Primary Care Physician	
PCWP-----	pulmonary capillary wedge pressure	
PDA-----	patent ductus arteriosus	
PDD-----	Pervasive Development Disorder	
PDR-----	Physician's Desk Reference	
PE -----	physical examination, pulmonary embolus	
PEA-----	pulseless electrical activity	
peds -----	pediatrics	
PEEP-----	positive and expiratory pressure	
Peri-Op-----	Peri-operative	
PERL-----	pupils equal, reactive to light	
PERLA -----	pupils equal, reactive to light and accommodation	
PERRLA-----	pupils equal, round, react to light and accommodation	
PF-----	peak flow	
pg -----	pictogram	
PGF-----	paternal grandfather	
PGGF-----	paternal great grandfather	
PGGM-----	paternal great grandmother	
PGM-----	paternal grandmother	
Preg -----	pregnant	
PH -----	past history	
pH -----	hydrogen ion concentration	
PICU -----	Pediatric Intensive Care Unit	
PID-----	pelvic inflammatory disease	
PIN-----	prostate intraepithelial neoplasia	
PIP-----	proximal interphalangeal joint, positive	inspiratory
pressure		
PKD-----	Polycystic Kidney Disease	
PKU-----	phenylketonuria	
plt -----	platelet	
P.M. -----	afternoon or evening	
PMD-----	primary medical doctor	
PMH-----	past medical history	
PMI -----	point of maximum impulse	
PMN-----	polymorphonuclear	
PMP-----	previous menstrual period	
PMS-----	premenstrual syndrome	
PN-----	progress notes	
PNC-----	Prenatal (care)	
PND-----	paroxysmal nocturnal dyspnea	
PNV-----	prenatal vitamins	
po -----	by mouth	
POA -----	power of attorney	
POC-----	Plan of Care	
POD-----	post-operative day	
pos. -----	positive	
post -----	posterior	
post-op -----	postoperative	
PO ₂ -----	oxygen partial pressure	
PP-----	postpartum	
PPD-----	purified protein derivative	
PPROM-----	pre-term premature rupture of membranes	

PPS-----	Prospective Payment System	
PPTL-----	post-partum tubal ligation	
PRBC-----	packed red blood cells	
PRE-----	progressive resistive exercises	
pre-op-----	preoperative	
prep-----	preparation	
prev-----	previous	
PROM-----	passive range of motion, premature rupture of	membranes
PRN-----	whenever necessary	
PT-----	prothrombin time, physical therapy	
prox-----	proximal	
PSV-----	pressure support ventilation	
psych-----	psychiatry	
pt.-----	patient	
PTB-----	patellar tendon bearing	
PTCA-----	percutaneous transluminal coronary angioplasty	
PTL-----	pre-term labor	
PTSD-----	post traumatic stress disorder	
PTT-----	partial thromboplastin time	
P ₂ -----	pulmonary second heart sound	
PVC-----	premature ventricular contractions	
PVCU-----	post voiding cystourethrogram	
P wave-----	deflection in electrocardiographic tracing	
PWB-----	partial weight bearing	
PWP-----	pulmonary wedge pressure	

Q [Home](#)

q-----	every
Q&R-----	Quain&Ramstad
qid-----	four times a day
QNS-----	quantity not sufficient
QRS complex-----	electrocardiographic tracing
QT interval-----	electrocardiographic tracing
Q wave-----	deflection in electrocardiographic tracing

R [Home](#)

R-----	right
RA-----	room air, rheumatoid arthritis
RAD-----	right axis deviation
RBC-----	red blood cells
RCA-----	right coronary artery
RCM-----	right costal margin
RDS-----	respiratory distress syndrome
reg.-----	regular
rehab.-----	rehabilitation
rep-----	repeat
resp.-----	respiration, respiratory
retic.-----	reticulocyte
retro.-----	retrograde
Rh-----	Rhesus blood factor
RLE-----	right lower extremity

RLL-----	right lower lobe
RLQ-----	right lower quadrant
RMA-----	right mentum anterior
RML-----	right mediolateral (episiotomy)
RMP-----	right mentum posterior
RMT-----	right mentum transverse
RN-----	Registered Nurse
R/O-----	rule out
ROA-----	right occiput transverse
ROI-----	release of information
ROM-----	range of motion, rupture of membranes
ROP-----	right occiput posterior
ROS-----	review of systems
ROT-----	right occiput transverse
RPR-----	rapid plasma reagin
RPT-----	registered physical therapist
RR-----	respiratory rate
RRT-----	Registered Radiology Technician
RSA-----	right sacrum anterior
RSD-----	Reflex Sympathetic Dystrophy
RSO-----	right salpingo-oophorectomy
RSP-----	right sacrum posterior
RST-----	right sacrum transverse
RTS-----	raised toilet seat
r/t-----	related to
RT-----	respiratory therapist, recreational therapist
RTC-----	return to clinic
RUE-----	right upper extremity
RUL-----	right upper lobe
RUQ-----	right upper quadrant
RVH-----	right ventricular hypertrophy
Rx.-----	prescription

S [Home](#)

s or (sine)-----	without
S-----	subjective
S ₁ -----	first heart sound
S ₂ -----	second heart sound
S ₃ -----	third heart sound
S ₄ -----	fourth heart sound
SA-----	sinoatrial
SAB-----	spontaneous abortion
SACH-----	solid ankle cushioned level
SaO ₂ -----	percent arterial saturation
sat-----	saturation
SB-----	stillbirth, stillborn
SBA-----	stand-by assistance
SBE-----	self breast exam
SBQC-----	small based quad cane
sched-----	scheduled
SED-----	seriously emotionally disturbed
sed-----	sedimentation
SGA-----	small for gestational age

SGOT-----	serum glutamic oxaloacetic transaminase (now AST-aspartate aminotransferase)	
SGPT-----	serum glutamic pyruvic transaminase (now ALT-alanine aminotransferase)	
S/H/I-----	Suicidal Homicidal Ideation	
SI-----	sexual intercourse	
SIADH-----	syndrome of inappropriate antidiuretic hormone	
SIDS-----	sudden infant death syndrome	
sig. -----	let it be labeled	
SIMV-----	synchronized intermittent mandatory ventilation	
SL-----	sublingual	
SLB-----	short leg brace	
SLC-----	short leg cast	
SLE-----	systemic lupus erythematosus	
SLR-----	straight leg raising	
SLWC-----	short leg walking cast	
sm. -----	small	
SMO's -----	supramalleolar orthotics	
SN-----	student nurse	
SNF-----	skilled nursing facility	
SO-----	significant other	
SOB-----	shortness of breath	
sol. -----	solution	
S/P-----	status post	
sp.gr. -----	specific gravity	
spec. -----	specimen	
spont -----	spontaneous	
SpO ₂ -----	percent peripheral pulse saturation	
SR-----	sinus rhythm	
SROM-----	spontaneous rupture of membranes	
SS-----	Social Services	
SSE-----	soap suds enema	
staph -----	Staphylococcus	
stat -----	at once	
STD-----	sexually transmitted diseases	
STG-----	short term goal	
STI-----	sexually transmitted infection	
STNR-----	symmetrical tonic neck reflex	
strep -----	streptococcus	
SQ-----	subcutaneous	
suppos. -----	suppository	
surg. -----	surgery	
SVD-----	spontaneous vaginal delivery	
SVE-----	sterile vaginal exam	
SVN-----	small volume nebulizer	
SVO ₂ -----	saturation of venous oxygen	
SVR-----	Systematic Vascular Resistance	
SVT-----	supraventricular tachycardia	
SW-----	Social Worker	
Sx. -----	symptoms	
Sz-----	seizure	

T [Home](#)

T1-T12-----	Thoracic vertebrae 1-12
T&A-----	tonsillectomy and adenoidectomy
T. or temp. -----	temperature
T-3-----	triiodothyronine
T wave-----	deflection in electrocardiogram
T-4-----	thyroxine
tab -----	therapeutic abortion
tach -----	tachycardia
TAH-----	total abdominal hysterectomy
tbsp. -----	tablespoon
TB-----	Tuberculosis
TC,T/C-----	Telephone call
T&C-----	type & cross match
TEDS-----	Thromboembolous Deterrent Stocking
T.E. -----	tracheoesophageal
TENS-----	transcutaneous electrical nerve stimulation
THR-----	total hip relacement
TIA-----	transient ischemic attack
tid -----	three times a day
tinct. -----	tincture
TKO -----	to keep open
TKR-----	total knee replacement
TL-----	tubal ligation
TLC -----	tender loving care
TM -----	tympanic membrane
TMJ -----	temporomandibular joint
TO-----	telephone order
TOC-----	test of cure
TOD-----	thoughts of death
tol. -----	tolerated
TOLAC -----	trial of labor after Cesarean
TP -----	thought process
TPN-----	total parenteral nutrition
TPR-----	temperature, pulse, respiration
TR-----	Therapeutic Recreation
TRACH-----	tracheostomy
Trich-----	Trichomonas (vaginalis)
T&S-----	type and screen
TSH-----	thyroid stimulating hormone
tsp. -----	teaspoon
TSS-----	Toxic Shock Syndrome
TTP-----	thrombotic thrombocytopenic purpura
TUR-----	transurethral resection
TURP-----	transurethral resection of the prostate
TV-----	tidal volume
TVH-----	total vaginal hysterectomy
Tx -----	treatment
TYM-----	trichomonas, yeast, or monilia

U [Home](#)

UA-----	urinalysis
UE-----	upper extremity
UGI-----	upper gastrointestinal

umb -----	umbilicus
UPJ -----	ureteropelvic junction
URI -----	upper respiratory infection
urol. -----	urology
US -----	ultrasound
U.S.P. -----	United States Pharmacopoeia
UTI -----	urinary tract infection
U.V. junction, U.V.J. -----	ureterovesical junction
U wave -----	deflection in electrocardiographic tracing

V [Home](#)

Vag-----	vagina, vaginal
VAIN-----	vaginal intraepithelial lesion
VBAC-----	vaginal birth after c-section
V leads-----	unipolar chest leads
VC-----	vital capacity, verbal cues
VD-----	venereal disease
Vent -----	ventilator
V-Fib-----	ventricular fibrillation
VH-----	vaginal hysterectomy
VIN-----	vulvar intraepithelial lesion
Vit-----	vitamin
VMA-----	vanillylmandelic acid
VO-----	verbal order
VP-shunt-----	ventriculoperitoneal shunt
vs. -----	versus
VS-----	vital signs
VSD-----	ventricular septal defect
VT-----	ventricular tachycardia, tidal volume gas

W [Home](#)

WAIS-----	Wechsler Adult Intelligence Scale
WAIS-R -----	Wechsler Adult Intelligence Scale-Revised
WB-----	weight bearing
WBAT-----	weight bearing as tolerated
WBC-----	white blood count
WBQC-----	wide based quad cane
w/c-----	wheelchair
w/d-----	well developed
WDL-----	within defined limits
WFL-----	within functional limits
WPW-----	Wolf-Parkinson-White
wt. -----	weight

XYZ [Home](#)

x-----	times
-x-----	except
y/o -----	year old

OTHER SYMBOLS: [Home](#)

+-----	plus
♂-----	male
♀-----	female
>-----	greater than
<-----	less than
1 ^o -----	primary
2 ^o -----	secondary
↑-----	increased
↓-----	decreased
▲-----	change
∅-----	no/none, negative
#-----	number, pound
‘-----	feet
“-----	inches

[Home](#)

Abbreviation/ Dose Expression	Intended Meaning	Misinterpretation	Correction
Apothecary Symbols	dram minim	Misunderstood or misread(symbol for dram misread for 3” and minim misread as “ml”).	Use the metric system.
AU	aurio uterque(each ear)	Mistaken for OU (oculo uterque-each eye).	Don’t use this abbreviation.
D/C	discharge discontinue	Premature discontinuation of medications when D/C (intended to mean discharge)has been misinterpreted as “discontinued” when followed by a list of drugs.	Use “discharge” and “discontinue”
µg	microgram	Mistaken for “mg”when hand written.	Use “mcg”.
o.d. or OD	once daily	Misinterpreted as “right eye”(OD-oculus dexter)and administration of oral medications in the eye.	Use “daily”.
TIW or tiw	three times a week	Mistaken as “three times a day”.	Don’t use this abbreviation.
q.o.d. or QOD	every other day	Misinterpreted as “q.d.”(daily) or “q.i.d.”(four times daily) if the “o” is poorly written.	Use “every other day”.
U or u	unit	Read as a zero (0) or a four (4) causing a 10- fold overdose or greater (4U seen as “40” or 4u seen as “44”).	“Unit” has no acceptable abbreviation. Use “unit”.
X3d	for three days	Mistaken for “three doses.”	Use “for three days.”

SS or ss	sliding scale (insulin) or ½ apothecary	Mistaken for 55.	Spell out “sliding scale”. Use “one-half” or use “1/2”.
Zero after decimal point (1.0)	1mg	Misread as 10mg if the decimal point is not seen.	Do not use terminal zeros for doses expressed in whole numbers.
No zero before decimal dose (.5mg)	0.5mg	Misread as 5 mg.	Always use zero before a decimal when the dose is less than a whole unit.
q.d.or QD	every day	Mistaken as q.i.d., especially if the period after the “q” or the tail of the “q” is misunderstood as an “i”	Use “daily” or “every day”.
qhs	nightly at bedtime	Misread as every hour.	Use HS (capital letters)
Sub q	subcutaneous	The “q” has been mistaken for “every” (e.g., one heparin dose ordered “sub q 2 hours before surgery” misunderstood as every 2 hours before surgery).	Use SQ or write “subcutaneous”.
SC	subcutaneous	Mistaken for SL (sublingual).	Use SQ or write “subcutaneous:.”
@	at	Mistaken for “2”.	Spell out “at”.
MS	morphine sulfate	Can mean morphine sulfate or magnesium sulfate	Write Morphine Sulfate
MgSo4 and MSO4	magnesium sulfate	Confused for one another	Write Magnesium Sulfate
Cc	cubic centimeter	Mistaken for u (units) when poorly written	Write “ml” or milliliters

[Home](#)

APPOINTMENT DESK

[Cash Receipts Handling Policy](#)

[Patient Scheduling](#)

[OB Scheduling](#)

[Telephone Procedures](#)

[Missed Appointments](#)

[Credit Card Handling](#)

[Medicat Contigency](#)

[Medical Identity Theft](#)

[**Home**](#)

Cash Receipts Handling Policy

All mail payments received are opened and sorted by the billing department. Cash, checks and credit cards are taken at the reception counter and a receipt is printed out and given to patient.

The checks are then restrictively endorsed with our stamp. The cash checks and credit cards are kept in the cash drawer at reception counter during the day. At the end of the day a payment log is generated and the cash, checks and credit cards are balanced. Payment log, credit cards are placed in a folder to be picked up next morning by administrative assistant. Cash and checks (minus the \$50.00) are placed in deposit bag along with mail payments and log and placed in the safe. Next day the transcriptionist prepares deposit.

The deposit is picked up by the bank courier. A receipt from the bank is returned to the administrative secretary.

Patient Scheduling

7. First year residents are scheduled 3-6 patients per afternoon; half an hour per patient. Please contact the front desk if more time per patient is needed or if more patients can be scheduled.
8. Schedules can be checked by going to medicat.
9. Except in emergencies or special arrangements, patients are seen by appointment; however, walk-ins are welcome.
10. If a physician asks an unscheduled patient to come to the clinic, the physician needs to notify the front desk so the patient's chart can be pulled before the patient is seen. If a patient comes in for an exam and is to return for lab work the nurse must be notified.
11. Residents that have morning clinic are expected to arrive at 9:00A.M. Those with afternoon clinic hours are expected to arrive at 1:00 P.M. and remain in the clinic until 5:00 P.M. to cover walk-ins and/or late scheduled patients.
12. If a physician is delayed for a scheduled appointment at the clinic, always notify the appointment desk personnel.

OB Scheduling

6. OB patients will be scheduled with a specific resident if they request so.
7. If the patient does not have a preference or does not request a physician, the patient is scheduled with a resident on a rotating basis.
8. If a resident notifies the receptionist not to schedule any more OB patients, the request is taken into consideration.
9. If a resident notifies the receptionist to schedule more OB patients, the request is taken into consideration.
10. If a patient requests a pregnancy test but does not have a physician, the patient must schedule with a physician

[Home](#)

Telephone Procedures

The telephone is answered electronically and the patients are given a menu to follow. The daily answering service is activated automatically at 7:30 a. m. through 5:00 p.m.

To change the recording on the answering machine, call Grand Forks at 701 777-4111 and inform them of the changes. The AHC voicemail is as follows:

Thank you for calling the Center for Family Medicine. The Center is closed at this time. If this is an emergency, dial 911. To find out what Doctor is on call, call St. Alexius Medical Center 530-7000 or Sanford at 323-6000. Clinic hours are Monday-Friday 8 a.m. to 5 p.m.

1. Identify the type of call and take action.
 - a. Emergency calls: Put through to the nurse or physician immediately.
 - b. Calls from patients: Transfer to the Phone Nurse.
 - c. Call from other physicians: If the call concerns a patient, pull the medical chart and inform the physician of the call. The physician will decide whether to take the call or to call back.
 - d. Calls from nurses about hospitalized patients: Handled the same way as calls from physicians. Messages are never relayed through someone else other than the physician. Do not breach professional ethics.
 - e. Calls from pharmacists: Transfer to the Phone Nurse.
 - f. Personal/business calls: Route as instructed by physician.

[Home](#)

Missed Appointments

NO SHOW/CANCELLED/RESCHEDULED

Purpose:

Patients may fail to appreciate or comprehend the significance of a particular appointment to their ongoing care and treatment; all missed appointments are to be documented in the patient record and brought to the attention of the physician. A missed appointment is defined as any appointment that has been scheduled that does not occur for any number of reasons.

Policy:

1. Appointment Reminders are sent to all appointments with calls being made one business days before appointment.
2. Receptionist Staff will delete all NO SHOW and CANCELLED patients in Medcat with an appropriate reason code.
3. Receptionist Staff will route patient who miss appointments when a pattern is present to Nursing/Physician. Nursing and Physician will determine follow up for the patient.
4. A record of No Show, Rescheduled, or Canceled Appointments, whether initiated by the patient or the physician are kept within Medcat indefinitely.
5. All Referred Appointments (i.e. Pre-op/Dermatology/Pediatric) to the clinic will be notified that the patient cancelled the referred appointment by calling or sending a letter to the Physician that made the referral.
6. Nursing review of No Show, Cancelled and Rescheduled appointments will be documented on progress notes. Include all copies of Missed Appointment Letter or dictated letter in the patient's chart. Although some patients may be difficult to contact, it is important to document that attempts were made.

Nursing will direct review of chart to Physician as medically necessary. The following are examples of when to review chart with physician. This list is not all inclusive and will require open communication between Physician and Nurse.

Hypertension
Diabetes
Medication Management
Post Hospital Visit
Abnormal Lab Values
Colposcopy
Pregnant Women
Pain Management

OB Patient's that haven't
been seen >1 month

Repeat Pap with history of
Abnormal PAP

7. Physician review of No Show, Cancelled and Rescheduled appointments:
 - a. It is the responsibility of the physician to determine the action to be taken based on a review of the patient record and the clinical needs of the patient at the time. Any contact with the patient, whether by telephone or written communication is to be documented in the patient's chart, any necessary follow-up with the patient should take place and be documented. Non-compliance by the patient will be documented in the chart.
 - b. Although some patients may be difficult to contact, it is important to document that attempts were made.
 - c. Physicians can decide to send the Missed Appointment(form) Letter once. Any other communication by letter will need to be in the form of a dictated letter from the physician explaining the reasons and or risks of not keeping the appointment. This letter is sent as a certified letter. A copy of the letter along with the receipt of delivery (if applicable) should be placed in the patient's medical record.

8. A reminder for follow up appointments for patients can be provided by the physicians.

The INSTRUCTIONS FROM YOUR CLINIC VISIT form will be filled out during a patients visit to remind them of their at home instructions from their recent visit as well as any follow up appointments.

9. Follow up appointments will be monitored for patients, by using the following:
 - a. Use of the Instructions from your clinic visit form.
 - b. Prescription refills from patient or pharmacy phone calls.
 - c. Reviewing all missed appointments.

10. Termination of patient from a physician's practice due to patient's noncompliance will be done following the Clinic's Termination policy.

[Home](#)

July 6, 2015

[Patient Name]
[Address]
[City, State, Zip]

Dear [Patient Name]:

We noticed you were unable to make your recent clinic appointment. The physicians and staff here at the UND Center for Family Medicine are concerned about your health and encourage you to call our office at (701) 751-9500 or Toll-Free at 1-866-870-0464 as soon as possible to reschedule. We understand that life can get busy but also know that regular appointments with your doctor are a vital part of staying healthy.

You can call us any time prior to your appointment to cancel if you cannot make it, still a 24 hour notice is preferred. Your appointment can be rescheduled at that time as well. Please contact me if you have any questions.

Sincerely,

[Physician name, MD or DO]

Take Time for Your Health

[Home](#)

Credit card Handling Policy

Bismarck CFM will follow Section 2, Finance Policy 2.3, Accepting Credit Cards and Electronic set forth by the University of North Dakota's Finance department. This policy can be found at http://und.edu/finance-operations/_files/docs/2-3-accepting-credit-cards-electronic-checks-to-conduct-university-business.pdf.

Only front desk staff, pharmacy staff, and business office staff are allowed to process credit cards. At the current time, no card holder data is to be store unless approved by management.. Once the transaction is processed, the card holder data must be destroyed. Only paid receipts will be kept for deposit reasons. These receipts will hold no card holder data. It is the front desk staff, pharmacy staff, business office staff and the business manager's responsibility to ensure this is being followed. No other employees need access to the credit card machine or the data used in transactions. Batch information does not contain card numbers. These batch reports are used to verify totals. At the end of the day batch reports will be kept in a locked safe.

If credit card information needs to be stored for some reason the following policy is in place: Any security incidents regarding credit cards should be brought to the attention of the business manager. An incident report will be filed if necessary. If necessary, the bank where the transactions are processed will be notified. The University of North Dakota Accounting Services office will also be notified. The reasoning for the storage must be approved by either the Business Manager or the Program Director. Management approval must also be given when determining a storage place or moving a storage place for the data. Cardholder data is to be stored in a restricted, protected area and away from public access. It must also be labeled as classified.

Credit card information cannot and will not be stored in an electronic format.

All transmission of data across an open public network must be encrypted.
Cardholder data is restricted by business need to know basis.

Credit card information must be destroyed when it is no longer needed for business or legal reasons.

This policy will be reviewed twice a year with front desk staff, and annually with the remaining staff.

Procedures for Credit Card Voids/Refunds

1. If an error is discovered immediately, the person performing the transaction must promptly void the transaction and re-run the card.
2. If an error is discovered at the end of the day processing, whoever verifies the charges for the day will process a void before batching out and the card must be re-run with the appropriate amount. Any other parties involved in the error must be informed of the problem.
3. If an error is discovered any time after a batch has been completed and closed, a refund to the credit card will be performed and the credit card will be re-run for the appropriate amount. Two employees must be present to ensure the card is refunded properly.
4. All batches that include voids or refunds must be reviewed and signed off by the Business Manager at the end of batching out.

[Home](#)

Medicat Contingency

Purpose:

To provide a plan for each clinic department to follow when the computers and/or software are not working properly.

ALL DEPARTMENTS:

Retain copies all forms listed in this policy for use. Update forms on a yearly basis if applicable.

Front Reception:

Print Roster of the day's appointments from NOTIFYMD if possible. Retrieve daily appointment schedules on the NotifyMD flash drive. Files will be stored on the flash drive for 30 days. It is locked nightly in the safe.

1. Patient will fill out Registration Form completely.
2. Photo Copy all photo identification and all insurance cards. Verify information on registration form.
 - a. Receptionist will transfer information to template, Patient Registration Labels and print a sheet of labels for each patient to follow the patient throughout their appointment.

Label a travel ticket and clip all information to the ticket.

Record patient room number on patient list. Nursing will provide number to the front desk.

Keep a label for each patient and start a list of patients seen for that day. Update patient information from this list when computer software is operational. File list of patients with medical records supervisor.

Copayments will be kept on receipt books. A label will be placed on all copies of the receipts to include Name and DOB. Staple a copy of the receipt to the travel ticket.

NEED: Patient Registration Forms
Formatted Labels
One additional staff for patient registration and runner (Business Office)
Receipt Books

Nursing/Physicians:

Nurses will copy NOTIFYMD and sort out (highlight) their physicians' appointments for the day.

Notify Nurse by calling the Nurse extension or paging overhead with PAGE 1.

Charge Ticket, Registration Information, Labels can be found in stacker upfront.

Chart requests can be made by phone to the Medical Records department.

Nurse will provide the front desk with the patient's room number and the nurse will record it on the travel ticket.

SOAP/Progress Notes: Progress Notes form will be stamped with Date and Vitals Stamp.

REFERRALS: Record referrals made on the progress notes. Fill out referral form.

DICTION: SOAP NOTE when possible in Medicat with Original DOS noted or Dictation Line.

PRESCRIPTIONS: Hand written on prescription pads. Keep copy with the progress notes for the visit. Rcopia may be operational, if so enter prescriptions appropriately. Note if prescriptions entered electronically so the patient's record can be updated.

HISTORY/MEDICATION: Medication and History forms will be used for documentation. Retain with progress notes for the visit.

COMMUNICATION & NURSES ORDERS: Communication and Encounter Forms. Document and retain with progress notes for the visit.

PATIENT EDUCATION: Refer patient to appropriate websites. Follow-up with patient when possible.

LAB/XRAY ORDERS: Fill out lab and x-ray requisitions completely as possible. Including name, DOB, chart #, ordering physician, dx codes. Place Orders in Lab/X-ray Stacker. Remember to mark WAITING or NOT-WAITING.

Patient Phone numbers can be found on the NOTIFYMD flash drive if unavailable in chart or on lab reports. Nursing will set up a file folder in each hallway and instruct all nurses and physicians to file completed patient information in the files until computers are operational. To include: Travel Ticket, reports and progress notes.

NEED: Progress Notes

Folder for completed patient travel ticket and information

Health History Form

Referral Forms

Bright Futures Forms

Communication and Encounter Forms

Medication Forms

Vitals Stamp

VAR Forms

One additional staff for each hallway chart needs and runner (Business Manager and Office)

LAB/Radiology:

Lab/X-ray will watch stacker for orders.

Insurance information will travel with charge ticket

Waiting Patients will be returned to their exam room by lab/x-ray.

Not-waiting Patients will leave the clinic.

NEED: Lab Requisition

X-ray Requisition

Medical Records

Nursing/Physician Chart Request-Call Ext 26758

Appointment Chart Request- Call Ext 26757

Business Office

Assist other departments as needed

Residents/Faculty

Scheduling can be found on the Amion Schedule and at the front reception desk.

Post Computer Downtime

Master list of patients will be copied and sent to Appointment, Nursing and Business Office Supervisors.

Travel Tickets and attached information will be routed to Appointment Desk to be entered into Mediat.

Appointment Desk can enter appointments by going to the original DOS and entering appointments for each patient.

Travel Tickets will be sent through the clinic in the following order:

Appointment Desk>Nurse>Physician>Business Office>Medical Records

Physicians and Nurses will update history and medication for the patient and visit documentation will be added by attaching dictation or completing a SOAP Note with noting the Original DOS. Referrals will be added to the patient's records as necessary. Rcopia will be synced to the patient's record.

Medical Records will audit chart for completion.

[Home](#)

Identity Theft Prevention Program

The purpose is to outline various measures to prevent, identify and mitigate medical identity theft.

The clinic is committed to protecting patient identification and health insurance information from theft and fraudulent use. All employees and medical staff are responsible for reporting actual and suspected patient medical identity theft and threats.

This clinic policy will follow the policies given by the University and expand to include specific procedures to follow with our patient accounts. University policy can be found at <http://www.und.edu/dept/associatevpfo/html/identitytheft.html>.

Red Flags for health care providers may include:

1. A complaint or question from a patient based on the patient's receipt of:
 - a. a bill for another individual
 - b. a bill returned with incorrect address
 - c. a bill for a product or service that the patient denies receiving
 - d. a bill from a health care provider that the patient never patronized or
 - e. a notice of insurance benefits (or Explanation of Benefits) for health care services never received.
 - f. a collection notice from a bill collector.
2. Records showing medical treatment that is inconsistent with a physical examination or medical history as reported by the patient.
4. A patient or insurance company report that coverage for legitimate hospital stays are being denied because insurance benefits have been depleted, or that a lifetime cap has been reached.
5. A complaint or question from a patient about information added to a credit report by a health care provider or insurer.
6. A dispute of a bill by a patient who claims to be the victim of any type of identity theft.
7. A patient who has an insurance number but never produces an insurance card or other physical documentation of insurance.
8. A notice or inquiry from an insurance fraud investigator for a private insurance company or law enforcement agency.

Prevention of Medical Identity Theft

1. Employee Background Check Procedures:
 - a. Background checks will be conducted on all new employees that fall under the University's Criminal History Background Check policy.
2. Patient Identification Procedures:
 - a. Reasonable efforts will be implemented to verify the patient's identity when new or existing patient account transactions occur.
 - b. New Patient Accounts: Verify patient identification (e.g., name, date of birth, address, driver's license, government issued picture identification, insurance card). Photocopy identification and insurance card(s) given by the patient; scan into Medicat.

- c. Existing Patient Accounts: When applicable, verify patient identification (e.g., name, date of birth, address, driver's license, government issued picture identification, insurance card). Verify the validity of requests for change of billing address. Verify patient identification prior to providing personal information.
 - d. Pediatric Patients: Photocopy the parent's Identification for patients <14 years of age. For those patients ≥ 14 years of age, photocopy their school identification card if available.
 - e. Unavailable Identification Card: Politely remind patient that we require identification and to bring it for their next appointment. Provide education to the patient that explains why the clinic wants to protect their medical identity information.
 - f. Documentation: Photocopy identification card and place in chart along with insurance card. Verify photo ID as needed and document "verified, date, initials".
3. Medical Record Security:
 - a. All computers will be password protected and locked when the operator is away from the computer.
4. Portable Electronic and Data Devices that contain patient information:
 - a. Employees and medical staff members are accountable for maintaining the security of patient information that may be contained on laptops, thumb drives, and other portable data devices.
 - b. Any suspected or actual breaches or threats to the security of portable devices must be immediately reported to the Business Manager.
5. Patient Education:
 - a. Patients will be educated on medical identity theft. New patients will receive information when registering for their appointment and have an opportunity at any time to ask questions. Patients receive notification to bring their photo identification on the monthly billing statement.
 - b. Patient education includes, but is not limited to, review of:
 - i. A definition of medical identity theft
 - ii. How to identify medical identity theft
 - iii. How to report actual and/or suspected medical identity theft
 - iv. The patient's right to review and correct their medical record when discrepancies are identified and how to exercise this right.
 - v. The patient's right to an accounting of medical record disclosures and how to exercise this right
 - vi. The importance of guarding insurance card numbers and health insurance records.
6. Risk Management is responsible for developing and training all employee and medical staff upon hire, on an annual basis, and when significant changes have been made to the policy. Documentation will be kept by the trainee signing a training roster at the conclusion of a training session.
 7. Any employee or medical staff member who obtains and/or uses patient financial or medical information fraudulently is subject to disciplinary action, including but not limited to, termination and/or revocation of privileges. Fraudulent activities will be reported to law enforcement and other agencies as necessary.

[Home](#)

D. Identification, Management, and Mitigation of Medical Identity Theft:

1. Reporting Suspected and Actual Identity Theft:
 - a. All employees and medical staff members are expected to immediately report verbal or written notice (e.g., patient-generated reports, receipt of a notice of address discrepancy) of suspected or actual identity theft to their immediate supervisor and to the Business Manager.
2. Patient Generated Reports of Actual or Suspected Medical Identity Theft:
 - a. Patient-generated reports of actual or suspected medical identity theft (e.g., receipt of bills for services not rendered, knowledge of someone else using their information to obtain medical services) will be investigated under the direction of the Business Manager and University.
 - i. A written response, including the results of the investigation and actions taken, will be provided to the patient/guardian/surrogate.
3. Investigation of Actual or Suspected Identity Theft:
 - a. Investigations will be coordinated by the Business Manager.
 - b. Upon completion of the investigation a written report will be completed. Included will be:
 - i. Details outlining the investigation
 - ii. Measures taken to prevent a re-occurrence of a similar event, if applicable.
 - iii. Information regarding reports to law enforcement and/or outside agencies in response to confirmed identity theft.
 - iv. Information regarding all communications made to the patient or guardian.
 - c. Confirmed medical identity theft shall be reported to law enforcement and appropriate agencies, at the direction of the University.
4. Police and/or Agency Requests for Information of actual or suspected identity theft:
 - a. Requests for medical record information and /or billing information shall be granted with the minimum necessary information given in the event of a suspected MIT.
 - b. Any employee receiving a police or agency request for information shall immediately report it to their supervisor or the Business Manager.
5. Medical Record Corrections:
 - a. Refer to the policy under HIPAA regarding patient rights, including the patient's right to request a correction/amendment to their medical records. All corrections to the medical record will be corrected according to HIPAA guidelines. The patient will be notified when corrections are made to their medical record.

[Home](#)



Medical Identity Theft Frequently Asked Questions

What is medical identity theft?

- »It is when a person steals your name to get medical care.
- »It is when a person steals your health insurance data to get medical care.

How do I know if I have been a victim of medical identity theft?

- »You get a bill for care you did not have.
- »You get a bill with the wrong name on it.
- »You see wrong information in your medical record.
- »Your health insurance company tells you that you have used all of your benefits and you have not received health care services related to those benefits.

What should I do if I think I have been a victim of medical identity theft?

- »Please call *Center for Family Medicine-UND* at 701-751-9500.

What can I do to protect myself from medical identity theft?

- »Keep your insurance card in a safe place.
- »Look for wrong information in your medical record.
- »Look for wrong information from your health insurance company.

[Home](#)

Identity Theft

1. New/Established Patient-Verify all personal information. Ask for Photo ID. Photocopy identification and insurance card(s) given by the patient; scan into Mediat.
2. Pediatric Patients: Photocopy the parent's Identification for patients <14 years of age. For those patients ≥ 14 years of age, photocopy their school identification card if available.
3. Unavailable Identification Card: Politely remind patient that we require identification and to bring it for their next appointment. Provide education to the patient that explains why the clinic wants to protect their medical identity information.

[Home](#)

NURSING/MEDICAL

[Team Nursing](#)

[Emergency Call System](#)

[Pagers](#)

[Patient Flow](#)

[Patient Orders](#)

[Patient Charges](#)

[Sending OB Records to Hospital of Delivery](#)

[Diagnostic Reports](#)

[Sample Medications](#)

[Adult Diabetes Care](#)

[Medication Safety Plan](#)

[Vaccine Management Plan](#)

[Injection Orders](#)

[Storage and Warming of IV Fluids](#)

[Perioperative beta-blocker policy](#)

[Acute Chest Pain Protocol](#)

[HIV Testing](#)

[Anaphylactic Reaction](#)

[Telephone Techniques](#)

[Infection Control](#)

[Procedural Sedation and Colonoscopy](#)

[Stress Electrocardiogram \(Welch Allyn\)
Notes for Residents](#)

[Ruth Meirs](#)

[Refusal of Treatment by Provider](#)

[Scheduled II Medications](#)

[Chronic Pain Management](#)

[Circumcision Following Home Birth](#)

[Patient Transportation](#)

[Referral Tracking](#)

[Medicat Alerts](#)

[Home](#)

Team Nursing

1. Provides communication between doctor, nurse and patient.

a. Duties of the team nurse:

1. Take phone calls from patients and relay the messages.
2. Make patient referral appointments as requested.
3. Call for reports.
4. Function as the contact person when the physician has special orders to be carried out.
(Always inform the team nurse or department head of any special procedures.)

b. Residents keep your nurse informed:

1. Regarding patients that may be calling in, i.e. patients you have talked to after hours or have seen in the ER.
2. Of care plans on your patients, i.e. when you are ordering lab work on a patient for a future date put in a Recall, complete the order in the patient's EMR, changing the date to the anticipated future date.
3. When you are taking leave time.
4. Of your expectations.
5. If you change your schedule or if you will be late for clinic hours.
6. Leave orders with your nurse – **do not give them to the receptionist.**

NOTE: First year residents are expected to discuss any questionable case with the preceptor or faculty member prior to dismissing the patient.

Emergency Call System

Each exam and procedure room is equipped with an emergency call button or cord which, when activated, will sound an alarm and light up outside the exam/procedure room door and on a panel in the nurse's hallways. These are to be used primarily for emergency situations. Please push the button for a nurse in an emergency or if assistance is needed while doing a procedure.

Pagers

Each physician is assigned a pager which is also capable of receiving text messages. The clinic staff will send text messages via this pager rather than via personal phones.

[Home](#)

Patient Flow

1. Appointments are reviewed the previous day by the nursing staff. Lab orders are entered into Mediat and post-hospital records are requested.

2. When a patient arrives at the front desk the receptionist checks the patient in on the Mediat system to inform the nurse. If lab work is requested the patient is sent directly to lab.

3. The nurse will prepare for any necessary exam and will get the patient from the waiting room and admit them to an exam room.

a. **Pap smear** – supplies will be set out when there is a Pap scheduled. Thin Prep Pap test containers must be identified with a label on the vial. The pathology department at St. Alexius examines the Pap smear. Cervi-scrapers and cytobrushes or brooms are used to obtain specimens: cytobrushes must not be used on pregnant patients, use cotton tipped applicator in place of cytobrush.

b. **Combined Chlamydia/GC Cultures** – transport media stocked in the rooms.

c. **Wet Mounts** – each room is stocked with test tubes. Collect vaginal secretions with cotton –tipped applicator, put applicator in the tube, add 0.5 cc NaCl, cover, label and take to the lab.

d. **Cultures** – All cultures are done by physicians – culturette tubes are in every room.

e. **KOH** – Skin scrapings are done by physicians – scalpels, slides and cover slips are stocked in lab. Transfer dishes are also provided.

f. **Herpes**, ureaplasma media available upon request from our lab.

g. Arterial blood gases are not done or drawn in our clinic.

h. When using any sharps, please dispose of them in the sharps container after use.

4. The patient’s vitals are taken and recorded in the EMR before the patient is seen by the physician. The nurse will write a brief statement of reason for office visit, the patient’s current medication list and known allergies are reviewed/updated, and “Marked as reviewed” in Mediat by the nurse at each visit. Once the patient is admitted and ready for the doctor, the nurse will change the Mediat screen to indicate that the patient has been admitted and is now ready to see the doctor.

5. When the doctor has concluded the patient visit, he/she will discharge the patient and the nurse will change the patient status in the Mediat.

Orders

- a. Current – When requesting an injection, write an injection order in the EMR. Tell the patient to wait in the room. The nurse will direct the process from that point. If you wish to send the patient to the lab or x-ray, enter the lab/x-ray order into Mediat with the diagnosis code , send the patient to the waiting room and indicate on the computer screen that the patient is “lab &/or x-ray wait or non-wait”.
- b. Future – Preferably, enter a Recall into Mediat listing the diagnostic procedure(s), diagnosis code(s), and your initials or you may comment in the patient’s medical record the orders for any future diagnostic procedures you would like before the patient is seen again. Also note when a recheck appointment is needed.

- c. Referrals for diagnostic tests done outside the clinic and referrals to specialty physicians, PT– You may initiate the referral in Mediat and route it to your nurse to schedule or tell your nurse what type of test or referral is needed, as well as the diagnosis or reason for the test/referral and the facility/hospital the patient prefers. The nurse will take care of the scheduling of diagnostic tests and referral appointments. Many tests require special preparation or diet beforehand. Be sure to clear these things with your nurse.

All patients on Medicaid must have a referral form faxed/sent when referred out of the clinic. Your nurse will take care of this.

Charges

- d. Billing codes are entered into Mediat. Paper charge tickets are currently used to audit fees entered into Mediat to ensure all charges are accounted for. When office visit is complete give the charge ticket to your nurse to enter any charges for medicines, immunizations or supplies given. Once the nurse is finished the ticket is placed in the labeled stacker in the staff hallway.
- e. All diagnoses/codes pertaining to the appointment are to be entered into Mediat under the Assessment tab.
- f. Surgical procedures – The nurse will assist with charges and CPT codes. Procedure codes are filed in a book at the nurse’s station.

[Home](#)

Sending OB Records to Hospital of Delivery

Purpose: To ensure that the clinic records for OB patients are on file with the designated hospital of delivery before the patient's due date and available upon delivery.

Policy:

1. At 28 and 35 weeks gestation, OB records (ACOG form, ultrasound reports and pertinent lab results) are to be faxed by the nurse to Sanford Labor and Delivery.
2. At each subsequent OB visit after 35 weeks gestation updates will be faxed to Sanford Labor and Delivery.

Fax numbers for Sanford: 323-6805

[Home](#)

Diagnostic Reports

1. Physicians will review diagnostic reports in the patient's EMR.
2. The nurse will watch the "Tasks" for any of her doctors that are gone and diagnostic test results will be discussed with the chief resident.
3. If the situation requires a detailed explanation, the patient is called and an appointment with the physician is made.
4. If an appointment is not necessary a letter explaining the patient's diagnostic results may be sent to the patient by the physician.
5. If a voicemail needs to be left for the patient, state your name and UND Center for Family Medicine and ask the patient to call the clinic at their earliest convenience. Do not leave diagnostic results on the patient's voicemail.
4. If the patient has asked for the results to be left on a voicemail, consent will need to be obtained and this will be noted on the Incoming Phone Call template, to include the patients preferred phone number.

Consent to leave diagnostic results on the patient's voicemail will need to be specifically requested to the nurse or physician by the patient and documented in the EMR. Documentation shall include phone number that the patient has consented to for the voicemail message. (i.e. cell and/or home) and the information left on the voicemail.

[Home](#)

SAMPLE MEDICATIONS

Purpose:

Guidelines for sample medications pertaining to management, storage and distribution.

Policy:

1. **Pharmaceutical Representatives:**
 - A. Representatives must schedule an appointment using the schedule binder located in the pharmacy. Appointments can be made Monday thru Friday from 1:30 pm to 3:30 pm. The clinic policies will be posted in the "Pharmaceutical Rep" binder on the Administration side. The policy will also be sent to the Pharmaceutical Rep Secretary.
 - B. Upon arrival the representatives will check in at the pharmacy and the pharmacy staff will notify to medical staff. The doctors will visit with them in the back of the pharmacy. Sample medications can be left at the pharmacy where the staff will log in all samples using lot number, expiration date and strength. A drug sample report will be printed daily to the north and south nursing pods.
 - C. Education of the new policies will come in the form of a letter from administration to the individual Representatives if policy is not adhered to.

2. **Sample Medication:**
 - A. All sample medications with the exception of dermatology will be stored, logged, and dispensed in the pharmacy. Medications stored in the pharmacy will be located on the back shelf apart from pharmacy stock for retail.
 - B. The medications will be checked for expiration dates when given to patients and on a monthly basis.
 - C. Pharmacy will document all recalls according to FDA regulations and removed from stock immediately if necessary. Patients that have been given the recalled medication will be notified by pharmacy immediately if appropriate.
 - D. All sample medications, with the exception dermatology will be dispensed from the pharmacist. The pharmacist will dispense the sample medication with either a verbal or written order from the physician. All 'SAMPLE' orders dispensed from the pharmacy will be entered into the pharmacy system.
 - F. The Medication Room will be unlocked every morning by nursing personnel and locked every evening at the end of the clinic day.

3. **Samples of Insulin, Nuva Ring and Dermatology Products:**
 - A. Samples of Insulins, as well as the Nuva Ring contraceptive, must be refrigerated and are kept in the pharmacy refrigerator.
 - B. Samples of dermatology products will be stored in a locked cupboard in the dermatology procedure room.
 - C. Medication samples will be logged into the pharmacy software with the following information: Name, lot number, expiration date and quantity received.
 - D. Medications will be dispensed by the pharmacist ONLY with a SAMPLE prescription to the patient. The Pharmacist will process the sample prescription under the patients name so that there is record of the lot and expiration number given to the patient.
 - E. Outdates will be done monthly or when necessary.
 - F. When recalls are received the appropriate lot number of the medication will be disposed of immediately. Patients that have been given the recalled medication will be notified immediately if appropriate.

[Home](#)

ADULT DIABETES CARE

Purpose:

To provide the standard of care to all adult diabetic patients using the clinical guidelines from the American Diabetes Association (ADA) Standards of Medical Care in Diabetes – 2006.

Policy: It shall be the policy of the UND Center for Family Medicine to use the ADA Guidelines for Adult Diabetes Care to assist the physicians in managing adult patients with diabetes. The Colorado Clinical Diabetes Care Flowsheet, Version 1 will be placed on every diabetic patient's chart for physician documentation of lab, exams, etc.

Adult Diabetes Visit Procedure:

1. Patient height and weight measurements every visit. Record on the Diabetes Flow Sheet.
2. Calculate BMI each visit.
3. Have patient remove shoes and socks to allow for a foot exam every visit.
4. Ensure that the Colorado Clinical Diabetes Care Flowsheet, Version 1 is in the chart for the physician to complete.
5. Pre-appointment: place a laminated copy of the Guidelines for Adult Diabetes Care in the cover of the chart for the physician to use as a reference during the patient visit.
6. If the patient is due for diabetes labs, then only a two-week refill or samples of meds may be given.
7. Lab standing orders:
 - A. Lipid panel – yearly
 - B. Chem 14 – yearly
 - C. CBC – yearly
 - D. Urine A/C ratio – yearly
 - E. If A1C < 7%, then repeat every 6 months
 - F. If A1C > 7%, then repeat every 3 months
 - G. EKG – yearly

[Home](#)

Medication Safety Plan

Purpose:

UND Center for Family Medicine will promote safe practices in all phases of medication administration thereby reducing the possibility of medication errors.

The medication safety plan includes the following guidelines, as well as guidelines included in the Infection Control Plan.

Procedures:

A. Medication Equipment and Supply Safety:

1. Safety needles, syringes and IV catheters will be stocked and used by all clinic staff. Pre-filled syringes require the use of safety needles.
2. IV drip infusions of medications, as well as IV fluids, shall be done with the use of an IV pump, to control the flow and infusion time.
3. Medications are stored in the Nurses' Medication Room. The Medication Room is locked when clinic is closed.
4. Controlled substance medications ordered for administration on a patient in the clinic will be written on a prescription blank by the doctor and faxed to the CFM Pharmacy. Pharmacy staff will take the medication ordered to the appropriate nurse or the nurse can go to the Pharmacy to obtain the medication.
5. External-use medications will be separated from internal-use medications in the storage area and external-use medications will be labeled "For External Use Only."
6. All medications, reagents, and other products that carry an expiration date are checked on a monthly basis by the Nursing Supervisor, or designee, and discarded once they have expired.
7. Single-dose vials will be stocked and used as much as possible. **Single dose vials are used for one patient only and discarded.**
8. Multiple-dose vials of injectable medications must be labeled with the date opened and are to be discarded 30 days after the date opened. Multiple dose vials are stored in the Medication room and Procedure Rooms.
9. All medications (including samples) dispensed to patients will be properly labeled and documented in the medical record.
10. Vaccines stocked (private and State supplied) are documented in the Medcat Immunization Compliance Manager, as well as logged in the NDIIS Thor website. The name of the vaccine, manufacturer, lot number, and expiration date are recorded in both systems.
11. Hazardous chemicals are not accessible in drug preparation areas. Cytolite and Formalin will be stored in the Procedure Room(s).

B. Safe Injection Practices:

1. Use aseptic technique when preparing and administering medications.
2. Cleanse the access diaphragms ("rubber" stoppers) of medication vials with 70% alcohol before inserting a needle into the vial.
3. Never administer medications from the same syringe to multiple patients, even if the needle is changed or the injection is administered through an intervening length of IV tubing.
4. Do not reuse a syringe to enter a medication vial or solution.
5. Do not administer medications from single-dose or single-use vials, ampoules, or bags of IV solution to more than one patient.

6. Do not use fluid infusion or IV tubing for more than one patient.
7. Dedicate multidose vials to a single patient whenever possible.
8. Dispose of used syringes and needles at the point of use in a sharps container that is closable, puncture-resistant, and leak-proof.

C. Medication Procedures and Protocols:

1. A complete medication history, including over-the-counter medications, vitamins, and herbal products shall be obtained and documented for every patient and will be reviewed and updated at each office visit.
2. A list of allergies and allergic responses shall be obtained and reviewed/updated for every patient during each office visit.
3. A physician's written order is required for all medications to be administered (with the exception of immunizations) to include the name of the medication, dose and preferred route, indicating if consecutive doses are to be administered, e.g. Rocephin 1 Gm. IM x 3 days. All medications that are to be repeated on an ongoing scheduled basis should be written in the medical record in a prominent place.
4. **Verbal orders are to be avoided**; however, any verbal orders given to nursing are to be documented on a Progress Note in the EMR by the nurse and signed by the ordering doctor in a timely manner.
5. Medications will be set up/drawn up in the nurses' workroom to allow for fewer distractions and decreased risk of error.
6. The five rights of medication administration will be checked in all medication administration situations: Right patient (cross referenced by name and DOB), right medication, right dose, right route and right site.
7. Documentation of medication administration in the medical record will include the medication name, dose administered, route, site, patient response and the nurse's electronic signature.
8. A patient who has received a medication via injection for the first time (including vaccinations) must be observed for 20 minutes following the injection for possible symptoms of anaphylactic reaction. If symptoms of anaphylactic reaction occur follow the **Standing Order for Anaphylactic Reaction**. The Anaphylaxis box (with standing order) is located in each Nursing Pod/Hallway.
9. Vaccines administered are documented in the patient's EMR and into the NDIIS (Thor) system.
10. The clinic will follow the Vaccine Management Plan policies and procedures as a Preventive Partnership Provider with the ND Department of Health Division of Disease Control Immunization Program.
11. Vaccine Information Statements (VIS) for foreign-speaking clients are available on the Immunization Action Coalition website at www.immunize.org/vis/.
12. Medication errors will be reported to the patient's provider and to the Nursing Supervisor immediately.
13. Medication refills for patients are to be completed through the e-prescribe system, with the exception of controlled substance medications – these must be written on a secure prescription blank.
14. Controlled substance medication prescriptions are to be mailed to the patient's pharmacy of choice. In cases where controlled prescriptions are needed sooner than they can be delivered to the pharmacy via mail, the prescription must be filled at the Center for Family Pharmacy.

D. High Risk Medications:

The following medications have been identified as "high risk" and additional safeguards are to be followed, as indicated, when administering these medications:

Insulin – The administering nurse should have a second staff nurse check the order and the dose once the insulin is drawn up and prior to administration.

Anti-coagulant medications (Coumadin, Warfarin, Jantoven):

1. Patients on anti-coagulation therapy are to have lab work (Protime/INR) done once a month when their lab values are within the therapeutic range; and more frequently, as determined by their doctor, when they have not achieved a therapeutic range or are in the process of adjusting their medication.
2. PT/INR lab values are reviewed by the doctor the same day as completed if the patient is above or below the therapeutic level, or within 24 hours if the patient is within their therapeutic range. Nurses also shall monitor PT/INR results on a daily basis.
3. All patients on anti-coagulants will have an “Anticoagulation Therapy” template in their medical record. This template is completed with every lab appointment.

Solu-Medrol IV:

1. Often ordered for Multiple Sclerosis patients in a dose of 500 – 1000 mg daily in a sequence of 3 days; however, follow the doctor’s specific order.
2. Mix in 250 ml of 0.9% Normal Saline
3. Administer IV infusion over 4 hours, using an IV infusion pump.
4. Monitor the patients vital signs prior to starting the infusion, every 30 minutes during the infusion, and at the end of infusion.
5. Check for patency of the IV catheter prior to infusion by flushing the IV lock with 1-2 ml of saline. Flush the IV lock again after the Solu-Medrol infusion is complete.
6. If patent, the IV lock may be kept in place for 72 hours. Wrap the site with kling dressing/tube gauze to protect the angiocath between infusions.

E. Storage Requirements:

1. Medications must be stored under the proper temperature requirements per the manufacturer and this information, if not known, can be found in the medication package insert.
2. Vaccines are to be kept refrigerated between 35F and 46F, with the exception of Varicella, Zostavax (Shingles) and Proquad (MMRV) vaccines which must be stored in the freezer at $\leq 5F$ (-1 C).
3. Other medications requiring refrigeration:
 - Insulin
 - Allergy solutions (labeled for specific patients)
 - Ativan (Lorazepam) – injectable form
 - Botox and Dysport
 - Tuberculosis testing solution (PPD Mantoux)
 - Proparacaine ophthalmic (analgesic) solution
 - Rhogam
 - Biologics (Stelera, Enbrel, Humira)
 - Injectable Penicillins (BiCillin C-R, BiCillin L-A)
 - Nuva Ring birth control
 - T.R.U.E. Test allergen patch test

F. Education and Training:

1. The nursing staff resource for medications and administration information is the current edition of Mosby's Nursing Drug Reference, which is kept in the Nurses' Medication Room.
2. Vaccine Information Statements (VIS) for foreign-speaking clients are available on the Immunization Action Coalition website at www.immunize.org/vis/
3. Training and updating current practices for medication safety will be managed by the nurse supervisor. Training will be provided to all new employees and annually to clinic staff.

[Home](#)

Vaccine Management Plan

Purpose: To have standard guidelines for storage and handling of vaccines which correspond to the CDC and NDDoH protocols. It is the responsibility of all nursing staff members to be familiar with and to follow the Vaccine Management Plan.

Routine Vaccine Storage and Handling Plan:

1. Nursing personnel responsible for routine storage and security:
 - Donita Roland, LPN 701-471-3216
 - Nicole Klemisch, RN 701-667-2928(H); 701-400-5817(C)
 - Candace Oswald, LPN 701-400-9521(C)

2. Vaccine ordering is done on the following basis:
 - Private vaccine is ordered as needed by Nicole Klemisch, RN or designee.
 - VFC/State vaccine is ordered every other month by Donita Roland,LPN or designee.

3. Proper temperature for storage of vaccine must be maintained:

Refrigerator	35 ⁰ - 46 ⁰ F	2 ⁰ - 8 ⁰ C
Freezer	+5 ⁰ F to -58 ⁰ F	-15 ⁰ C to -50 ⁰ C

4. Certified, calibrated thermometers are used to monitor and record temperatures twice a day (at the beginning and end of the clinic day) for each unit containing vaccine. Calibration of the thermometers is done annually and the certificates of calibration will be made available to the NDDoH upon request. Thermometers used must be certified according to NIST or ASTM standards.
5. Immediate action must be taken if temperatures are out of range. This may include adjusting the temperature of the storage unit and rechecking the temperature in one hour or relocating the vaccine to another storage unit within the clinic, or in the event of a power failure relocating vaccine to the emergency storage site. These steps are outlined in the following section of this plan.
6. On the temperature log, document what was done to ensure vaccine viability as well as action taken to establish and maintain proper temperatures.
7. Temperature logs are to be kept on file for at least three years.
8. Vaccine shipments are received by the Lab or Pharmacy, who immediately notify the nursing staff of their arrival. Vaccine shipments are immediately unpacked by nursing personnel, enclosed temperature monitors are checked, and the enclosed invoice/shipping information is compared to the actual shipment to verify lot numbers and expiration dates. Vaccine is immediately placed into the proper storage unit.
9. Label VFC/State-supplied vaccines and store them separately from private stock.
10. Store and rotate vaccines according to expiration dates, and use vaccines with the shortest expiration dates first.
11. If vaccines are within 90 days of expiration and will not be used, arrange for provider-to-provider transfers according to NDDoH procedures.
12. If VFC vaccine is expired, wasted or spoiled complete the “Non-Viable Vaccine Return and Wastage” form. Procedures for wasting/returning state-supplied vaccine are detailed on the wastage form.
13. Nonviable opened or used vaccine supplies are to be disposed of in a red biohazard container or sharps container.

Emergency Vaccine Relocation Plan:

1. Personnel responsible for emergency vaccine storage and security:
 - Nicole Klemisch, RN 701-667-2928(H); 701-40-5817(C)
 - Donita Roland, LPN 701-471-3216(C)
 - Tara McGraw, RN 701-400-9521(C)

2. Designated personnel will be notified via Sensiphone alarm in a vaccine storage emergency. Designated personnel have 24-hour access to the clinic and storage units.
3. The following steps are to be followed for proper storage and handling of vaccines to protect them from becoming spoiled:
 - Place in ice-pack-lined coolers and include the thermometer from the storage unit.
 - Transport vaccine-containing coolers immediately to the St. Alexius Inpatient Pharmacy.
 - Follow the same procedure to return vaccines to the clinic.
4. Designated alternate storage units or facilities are:
 - Private vaccine refrigerator in the Medication Room.
 - UND Pharmacy freezer. Contact Billie Krush, Pharmacist: 701-220-9168.
 - St. Alexius Inpatient Pharmacy, 900 E Broadway Ave. Bismarck, ND. Contact Dennis DeLabarre, Asst. Director of Pharmacy: 701-530-6920 or 701-530-6922.
5. The designated refrigerator/freezer repair contact for equipment problems is: Josh at Appliance Solutions, 701-390-3732.
6. Vaccine refrigerator/freezer information for the vaccine storage units is:
 - Crosley Shevlvador (White Unit)
Model #: CB19G6W
Serial #: 11730542GP
 - Summit Commercial (Stainless Steel)
Model #: SCRR230
Serial #/UPC: 761101023290
7. Vaccine storage unit alarm company: Sensaphone Web 600. Contact Information: 610-558-0222 or www.sensaphone.com.
8. See the attached list of Vaccine Manufacturers and contact numbers for vaccine in the clinic inventory.

Refer to <https://www.ndhealth.gov/Immunize/Providers/Manufacturers.pdf> for list of vaccine manufacturers' quality control phone numbers.

[Home](#)

Ordering and Administration of Injectable Medications

Purpose: To promote safe practices in the administration of injectable medications and reduce the possibility of medication errors.

Procedure:

1. Initiate an Injection Order form for the patient in the EMR.
2. The injection must be entered into Rcopia by the ordering doctor or their nurse indicating the frequency of administration, number of doses, and/or **expiration date**. Choose “**sign without sending**”. **The prescription must be signed before the medication can be administered.**
3. The medication order must be renewed annually, with the exception of **Depo-Testosterone (Schedule III) which must be renewed every six months and all other Scheduled medications must be renewed every three months.**
4. Medication administration will be documented via Progress Note, or in the SOAP note if the injection was done with a doctor visit.
5. The nurse giving the last dose before the renewal date is due should initiate the process of renewing the order.
6. The complete medication order (with dose and expiration date) can be found in “Current Meds”, left column under Summary Details, or in the “Orders” section, of the patient EMR.

[Home](#)

Storage and Warming of IV Fluids

PURPOSE:

To provide guidelines for the safe and appropriate warming and storage of IV fluids in the warming cabinet.

POLICY:

1. Whenever it is necessary to warm IV fluids, a medically designed warming cabinet with carefully controlled temperatures must be utilized. The use of a microwave oven and/or water bath must not be used for warming IV solutions.
2. Intravenous solutions placed in the warmer must have the plastic overwrap intact to ensure solution integrity. Write the date the fluid is placed into the warmer on the IV packaging.
3. Intravenous fluids may be stored/warmed in the warming cabinet up to 14 days provided the plastic overwrap is intact, and temperature does not exceed 104⁰ F (40⁰ C).
4. Once removed from the warming cabinet, solutions must be used within 24 hours and/or discarded, and not returned to stock supply or rewarmed.
5. It is acceptable to warm clean blankets in the same warming cabinet – place the blankets on the lower level and IV fluids on the top shelf.

The cabinet temperature will be monitored on a weekly basis and written on a temperature log.

[Home](#)

Perioperative beta-blocker

Purposes:

- 1) Apply evidence-based guidelines for the use of perioperative beta-blockers for patients undergoing non-vascular surgery.
- 2) Apply these guidelines consistently in all cases including clinic pre-operative recommendations and hospital preoperative consultations.

Policy:

- 1) The Revised Cardiac Risk Index (RCRI) will be calculated and documented for all patients.

RCRI

- 1 point for history of each of the following: CHF, Ischemic CAD, CRI, Stroke, DM
- 1 point given if high-risk procedure: AAA repair, Open thoracic operation, PVD grafts, Open cranial operation

- 2) Perioperative beta-blockers will be recommended for all patients whose RCRI is ≥ 2 .
- 3) For all patients on chronic beta-blocker therapy, recommend continuing perioperatively.
- 4) All orders for beta-blockers will include “hold parameters” for bradycardia and hypotension.
- 5) Start beta-blocker therapy 1-4 weeks prior to surgery and titrate dose.
**Stop therapy and do not give preoperatively if bradycardia or other severe side effects.*

Cardiology Comments

- There is probably no benefit to starting BB a few days before surgery. True benefit occurs with >1 week of therapy according to current data.
- For surgical patients on B-Blockers prior to admission: if the B-Blocker is contraindicated perioperatively, the reason must be clearly documented in the H&P or progress notes. *This is in accordance with SCIP measure CARD-2 “Beta Blocker Therapy Pre-Op”*

[Home](#)

Acute Chest Pain Policy

Purpose: To provide a guideline for staff when dealing with patients on the phone or in the clinic with acute chest pain.

Rationale: Patients with acute chest pain should be triaged to the emergency room where they can receive rapid/optimal care to identify a cardiac episode.

Policy:

A. Patients Calling with Acute Chest Pain:

1. Any patient calling the clinic with complaints of acute chest pain (CP) should be instructed to go immediately to the Emergency Room (ER) of their choice.
2. The patient must have someone drive them, take a taxi or call an ambulance. An ambulance should be encouraged if the patient has additional symptoms with the chest pain, such as heartburn, nausea, sweating, shortness of breath (SOB), pain that radiates to the jaw or down left (L) arm.
3. Have the patient take all of their medications or a list of the medications with them to the ER.

B. Patients Presenting with Acute Chest Pain:

Anytime a nurse feels a patient may be presenting with a cardiac event the following protocol should be initiated:

1. Obtain a complete set of vital signs, history of present CP, and family history. Have the patient seen and assessed by a physician as soon as possible (ASAP).
2. Standing orders for acute chest pain:
 - Get an EKG
 - Administer Aspirin 325 mg (81 mg chewable x 4 tablets)
 - Administer Nitroglycerin (NTG) 0.4 mg sublingual every 5 minutes x 3 (or until pain is gone). Continue to monitor VS, especially Blood Pressure (BP).
 - Administer oxygen (O₂) via nasal cannula at 2-4 lpm, or by mask at 5-10 lpm
 - Cardiac monitor
 - Stat lab work to include: Cardiac enzymes and Chem 14
3. If the assigned physician is not available (not at the clinic yet or involved in a procedure), ask the Preceptor or another physician to see the patient initially.

[Home](#)

Standing Order for Anaphylactic Reaction

Purpose: Patients who exhibit signs and symptoms of anaphylaxis should be treated immediately.

Supplies for Anaphylaxis Tray:

Epinephrine 1:1000 1ml vial (2) or EpiPen 0.3mg (2)
Epinephrine 1:1000 1ml vial (2) or EpiPen, Jr. 0.15 mg (2)
Benadryl Oral Liquid
Benadryl Injectable Vial (2)
Syringes, 3 ml (6)
Safety Needles, 25g 5/8in, 25g 1in, 25g 1 1/2 in (6 of each)
Alcohol Wipes
Gauze 2x2s
Bandaids

Procedure:

- A. Mild Reactions – itching, rash, subjective feeling of airway closer without facial swelling.
 1. Administer Benadryl 25 – 50 mg po stat.
 2. Patient to see physician as soon as possible.

- B. Moderate to Severe Reaction – facial or neck swelling, hives, itching, respiratory distress.
 1. Administer epinephrine via syringe or EpiPen subcutaneously (SQ) stat:
 - a. Child: One dose of epinephrine 0.01mg/kg **or** EpiPen, Jr. 0.15mg. May repeat in 15 minutes.
 - b. Adult: – One dose of 0.3 mg of epinephrine **or** EpiPen (Adult) 0.3 mg. Additional doses of 0.15 – 0.3 mg can be administered every 10-15 minutes.
 2. Administer Benadryl 25 – 50 mg po.
 3. Patient to see physician as soon as possible or transfer to ER via ambulance or with a staff (nurse or resident) with an EpiPen available.

[Home](#)

HIV Testing Policy

Purpose: To follow the CDC newly revised recommendations for HIV testing of adults, adolescents and pregnant women in health care settings. Routine HIV screening is recommended for patients aged 13-64 years of age in all health care settings after the patient is notified that testing will be performed, unless the patient declines (opt-out screening).

Procedure:

For patients in all health-care settings:

- Persons at high risk for HIV infection should be screened for HIV at least annually.
- North Dakota requires informed consent to be given to the patient before HIV testing by the physician.
- Separate written consent for HIV testing is required.
- Written consent is not needed for incarcerated patients.

For pregnant women:

- HIV screening will be included in the routine panel of prenatal screening tests for all pregnant women. HIV screening is recommended unless the patient declines (opt-out screening).
- North Dakota requires informed consent to be given to the patient before HIV testing by the physician.
- Separate written consent for HIV testing is required.
- Repeat screening in the third trimester will be performed if high risk of HIV infection is identified by staff or physician.

[Home](#)

TELEPHONE TECHNIQUES

I. Purpose:

- A. To assure and adequate response to patient’s needs and requests.
- B. To instill good communication between physician and patient.
- C. To maintain accessibility of physician to patient.
- D. Guideline – Written protocols are defined for staff handling telephone calls, telephone triage and telephone advice including documentation requirements.

II. Procedure:

- A. The clinic has a nurse phone line which is manned by a nursing staff member during clinic hours and can be accessed by prompts from the main clinic number (701-751-9500). When a telephone call comes into the nurses’ phone line the answering nurse will:
 - 1. Answer the telephone promptly, stating her name and title and saying “May I help you?” speaking clearly and distinctly.
 - 2. Create a written message for the nurse or doctor who the call is for via “Incoming Phone Call” template in Medicat and route it to the doctor’s nurse.
 - 3. A few physicians prefer that their nurse handle all calls directly and those calls may be transferred to the individual nurse’s phone line, unless they are out of the clinic. **Do not transfer any phone calls or messages to a doctor’s direct phone line.**
 - 4. If it is a call regarding a child swallowing household cleansers, medication, etc. have caller call the Poison Control Center at 1-800-222-1222.
 - 5. If the patient wants to know if they need to make an appointment, tell the patient it is hard to assess a problem over the telephone. If they wish to come into the clinic would be happy to see them. If they do not wish to be seen, give common sense information, and if you have any questions, refer to the telephone triage books.
 - 6. Staff should understand that, if they have any doubts about proper instructions or advice, they must check with the physician first. The safest advice that a nurse or physician should provide by phone, when dealing with a medical problem, is to advise the individual to be seen in the office or go to the emergency room. Staff should be instructed never to practice medicine over the phone or give advice beyond their competence. Physicians should be receptive to questions by practice staff. Staff should obtain as much information about the patient’s problem as possible to convey to the physician.
- B. Calls for laboratory results: Create an “Incoming Phone Call” message in Medicat and route it to the nurse, who will handle the call or route it to the appropriate doctor.
- C. Put a patient on “hold” when a need exists to discuss care with another doctor/nurse or if the party wished to speak to someone that is not available immediately. Always tell the patient when they are being placed on “hold”.
- D. Document all telephone calls **in the medical record** where significant medical symptoms are communicated, abnormal test results communicated, medical advice offered, includes telephone calls during office hours and after hour on-call telephone communication. The documentation should be placed in the patient’s medical record to provide a complete picture of the medical care that is being provided to the patients.

Note: While it may be impractical to document every phone call, all telephone contacts in which important patient information is received or advice or prescriptions are given should be documented in the patient record.

- E. The physician must be informed of telephone advice that was given out; this includes having the physician sign the Communication Sheet/Physician’s Order form prior to filing in the medical record.
- F. Instructions or orders should be carefully and thoroughly documented.
- G. Verbal orders given over the phone should be signed as soon as possible.

H. **Licensed nurses** are assigned the responsibility for telephone triage/telephone advice.

I. Documentation on the Communication/Physician's Order form should include:

1. Patient name (and the caller name, if other than the patient)
2. Purpose of the call (in the caller's words).
3. Advice/orders given (including prescription refills).
4. Follow-up instructions and comprehension of instructions.
5. The initials or signature of the staff member responding to the message/call.
6. Date and time.

Documentation should be legible and written as the final copy for the medical record if the original notes are to be used. Avoid partial sentences and abbreviated messages that may be difficult to interpret.

J. After-hours phone calls handled by the on-call physician should be dictated on the clinic dictation line as soon as possible. The clinic dictation line can be accessed from outside the clinic.

K. Annual training will be provided.

Telephone advice is provided following physician consultation/orders or following written protocols that have been approved by the medical staff.

Recommend that telephone advice documentation be reviewed through the quality improvement process.

The manual used as a guideline for the nursing staff in handling telephone triage is **Telephone Triage Protocols for Nurses, Fourth Edition**, by Julie K. Briggs.

Voice mail script for CFM Nurses:

Hello. You have reached (name and title) with the Center for Family Medicine. If this is an emergency please hang up and dial 9-1-1. Please leave your name, date of birth, phone number, your doctor's name and a brief message. I check my phone messages frequently throughout the day and will return your call as soon as possible. If you need a medication refill, please call your pharmacy and have them send us a request. Friday afternoon refill requests may not be processed until Monday. If you are calling after 4:00 p.m., please understand that your call may not be answered until the following business day. Thank you.

[Home](#)

Infection Control Policy

Purpose: To prevent the transmission of infectious diseases (viral and bacterial).

The Infection Control Plan includes the following guidelines and also includes guidelines listed in the Bloodborne Pathogens, Medical Equipment, Pandemic Flu and Medication Safety Policies.

Hand Hygiene:

1. Hand washing/sanitizing will be performed between each patient contact following the CDC guidelines for appropriate hand washing in a healthcare setting.
2. Hand soap is available in every exam room, procedure room, restroom and at every sink.
3. Hand sanitizers are located in each Pod hallway, as well as bottles of hand sanitizer in all waiting areas, nurses' station and throughout the clinic.
4. Training will be provided annually for all front line healthcare staff.

Cleaning of Exam Rooms:

1. Exam table paper is changed after each patient.
2. Pillow cases are changed when soiled or if there has been direct patient contact, and at least weekly when the pillow has remained under the exam paper and there has been no direct patient contact.
3. Exam tables are wiped with approved disinfectant wipes after any wound care, invasive procedure or other situation where contamination with blood or body fluids has occurred.
4. Spills of blood or body fluid on the floor or carpeting will be cleaned up immediately with an approved spill kit.

Cleaning of Equipment:

1. Critical items – objects that enter sterile tissue or the vascular system (i.e. surgical instruments) must be cleaned in an approved disinfectant solution then packaged and sterilized following appropriate sterilization method.
2. Semi-critical – objects that contact mucous membranes or non-intact skin (endoscopes, laryngoscope blades, respiratory therapy equipment) require a high-level disinfection using FDA approved disinfectants and following manufacturer recommendations.
3. Non-critical items – items that contact intact skin (blood pressure cuffs, linens, crutches, bedpans) use an EPA-registered disinfectant following manufacturer's recommendations.

Environmental Cleaning:

1. Clean nonporous surfaces with a healthcare approved disinfectant (chairs, table surfaces, door knobs, handrails). Refer to contract with housekeeping provider.
2. Vacuum carpeted floors, dry mop exam room floors and wet mop as indicated. Wet mop procedure room floors. Refer to contract with housekeeping provider.
3. Clean toys in the children's area weekly with a nontoxic healthcare approved disinfectant.
4. **Pediculosis (lice) or scabies:** Clean the room as you would for any other patient and bag any linen. Upholstered furniture, carpets, rugs, pillows should be vacuumed. Contact precautions (gloves and/or gown, hand hygiene) should be followed for physical contact with the patient.
5. Biohazard garbage cans in the procedure rooms are emptied at least weekly (more often as needed). Refer to the Bloodborne Pathogens Control Plan.

Personal Protective Equipment:

1. Refer to the Bloodborne Pathogens Control Plan

Medication (Injection) Safety:

1. Single dose vials or prefilled syringes should be used as much as possible with safety needles.
2. Multi-dose vials should not enter the patient exam room – dose should be drawn out of the vial in the nurses' medication room or at the nurses' station and the individual syringe taken into the patient room (to prevent contamination of the vial). Multi-dose vials will be clearly labeled with the date that they were opened and will be disposed of 30 days after opening.
3. **A needle and syringe must be used only once.** If more of the medication is needed a new needle and syringe must be used to draw up the med.

Respiratory Hygiene:

1. Signs are posted at entrances and in patient care areas with instructions to patients with symptoms of respiratory infection to cover their mouths/noses when coughing or sneezing, use and dispose of tissue, and to perform hand hygiene.
2. Tissues and no-touch receptacles for disposal of tissues are provided throughout the clinic.
3. Hand-sanitizers are provided in the waiting rooms and public areas of the clinic for patient use.
4. Masks are offered to coughing patients and other symptomatic persons upon entry to the facility. Symptomatic patients will be placed in an exam room as soon as possible.

Reporting of Infectious Disease:

1. The clinic will follow the ND Department of Health's Mandatory reportable conditions at <http://www.ndhealth.gov/disease/Disease%20Reporting/DiseaseCall.htm>
2. Consults for Infectious Disease can be referred to Dr. Kent Martin at Sanford and Dr Supha Arthurs at St. Alexius.

Patient Education :

1. Education will be provided to all patients with infectious diseases to include, but not limited to the need for isolation, cough/sneeze etiquette, vaccinations and the need for protective barriers.

Training:

1. Training and updating current practices for infection control will be managed by the nurse supervisor and safety officer. Training will be provided to all new employees and annually to clinic staff.

[Home](#)

Procedural Sedation and Colonoscopy

Purpose: To provide guidelines for the safe and effective use of procedural sedation at the Center for Family Medicine. To ensure one standard of care for patient management and clinic process before, during and after procedural sedation. To view the colon for diagnostic and screening purposes.

Definitions: **Procedural Sedation** is the administration of sedative, amnestic and analgesic drugs – singly or in combination – with the goal of alleviating or reducing pain and anxiety associated with medical and surgical procedures.

Continuum of Sedation refers to the fact that patients can move from one level of sedation to another without warning. There is not perfect way to ensure an exact level of sedation. Sedation requires frequent assessment and adjustment of sedating medications.

Levels of Sedation are determined according to a pre-defined Sedation Score as shown.

Sedation Score	Level of Sedation	Level of Consciousness	Response-Verbal	Response-Tactile	Airway Patency	Ventilation Oxygenation
0	None	Fully aware of self & surroundings	P	P	P	P
1	“Light”	Mostly aware of self & surroundings, but sedate	P-L	P	P	P
2	“Moderate”	Slightly aware of self & surroundings, usually somnolent, arouses easily with stimuli	L-A	P-L	P-L**	P-L*
3	“Deep”	Not aware of self or surroundings, little arousal with stimuli	A	L (to pain)	L-A	L
4	General Anesthesia	Unconscious, no arousal with painful stimula	A	A (to pain)	L-A	A

P: Present, adequate, or normal	L: Limited, partial, mildly abnormal
A: Absent, inadequate	*: May need supplemental oxygen to keep SaO ₂ ≥ 90%
**: Airway may need limited support	
Note: Deep sedation may be indistinguishable from general anesthesia and carries all the same risks	

General Policies on Procedural Sedation

1. Procedural sedation may be utilized at the CFM Clinic for patients undergoing colonoscopy and other invasive procedures and/or diagnostic tests for the purpose of improving patient comfort and increasing the probability of a successful procedure/test.
2. Only a Certified Registered Nurse Anesthetist (CRNA) may provide procedural sedation.
3. In addition to the CRNA and the physician performing the procedure, an ACLS certified Registered Nurse or Licensed Practical Nurse must be present. The Nurses’ responsibilities may include the continuous monitoring of the patient, assisting in supportive or resuscitative measures if necessary, and continuing to monitor the patient through recovery and discharge from the clinic.

Policy on Qualifications for Provision of Sedation

Because sedation is a continuum, it is not possible to predict how an individual receiving medication will respond. Administration of sedation medications could result in a risk of loss of protective reflexes. Therefore, persons responsible for provision of sedation must meet the following requirements:

1. Physicians must:
 - a) Possess current certification in BLS and ACLS (PALS if performing pediatric sedation).
 - b) Resident physicians must have a preceptor in the room.
2. Nurses must:
 - a) Recovery must be done by an RN.

- b) Possess current certification in BLS and ACLS (PALS if performing pediatric sedation).
- c) Be able to anticipate and recognize complications of sedation in relation to the type of medication being administered.
- d) Review and follow all clinic policies and procedures relating to procedural sedation.

Policy on Pre-Procedural Patient Assessment by the Physician and Anesthesia Team Member

1. The anesthesia team member who is responsible for the overall conduct of the sedation/anesthesia, including the medication orders is required to: (1) assess the patient; (2) assign an ASA status (per table below); and (3) document the sedation plan prior to scheduling any procedure or test (and within 30 days of the procedure).

American Society of Anesthesiologists Patient Classification

ASA 1 - A normal healthy patient. The pathological process for which surgery is to be performed is localized and does not entail a systemic disease.

Example: An otherwise healthy patient scheduled for a cosmetic procedure.

ASA 2 - A patient with systemic disease, caused either by the condition to be treated or other pathophysiological process, but which does not result in limitation of activity.

Example: A patient with asthma or diabetes that is well controlled with medical therapy, and has no systemic sequelae.

ASA 3 - A patient with moderate or severe systemic disease caused either by the condition to be treated surgically or other pathophysiological processes, which does limit activity.

Example: A patient with uncontrolled asthma that limits activity, or diabetes that has systemic sequelae such as retinopathy.

ASA 4 - A patient with severe systemic disease that is a constant potential threat to life.

Example: A patient with heart failure, or a patient with renal failure requiring dialysis.

ASA 5 - A patient who is at substantial risk of death within 24 hours, and is submitted to the procedure in desperation.

Example: A patient with fixed and dilated pupils status post a head injury.

E Emergency status. This is added to the ASA designation only if the patient is undergoing an emergency procedure.

Example: A healthy patient undergoing sedation for reduction of a displaced fracture would be an ASA 1E.

2. If the pre-procedure assessment is not completed immediately prior to the procedure, any interval changes as well as NPO status must be noted when a patient presents for the procedure. This interval assessment must include:
 - a. Any significant changes in health status since the initial evaluation
 - b. Examination of the heart and lungs
3. Pre-procedure history should focus on:
 - a. The **indication** for the procedure/test
 - b. **Cardiopulmonary Disease** may accentuate the cardiovascular and respiratory depression that can be caused by sedatives and analgesics. May require reduction in drug doses. Additional monitoring with an EKG is warranted.
 - c. **Hepatic or Renal Abnormalities** may impair drug metabolism and excretion resulting in increased drug sensitivity and longer duration of drug action.
 - d. **Medications** that the patient is currently taking may interact with the sedatives and analgesics.
 - e. **Allergies**
 - f. **Alcohol or Illicit Substance Abuse** may increase a patient's tolerance to sedatives and analgesics. On the other hand, acute use prior to sedation will be addictive or synergistic to the medication effects.
 - g. **Tobacco Use** increases the risk of bronchospasm, and coughing during sedation.
 - h. **Previous Adverse Reaction** to anesthesia or sedation may increase current risk.
 - i. **Informed Consent** given by physician.
4. Physical exam should focus on:

- a. The **area/system involved** in the procedure/test.
- b. **Cardiac**
- c. **Respiratory/Airway** – including documenting the **Mallampati airway class**.
5. Pre-procedure diagnostic test should include:
 - a. Chem 8
 - b. EKG for individuals ≥ 50 years of age, if not done within the past year.
6. Individuals age 70 and older will be scheduled for an evaluation appointment with Dr. Hostetter prior to scheduling the procedure.
7. Only patients given an ASA Classification of 1 or 2 **AND** having a Mallampati class I – III airway will be qualified to receive clinic-based procedural sedation in the CFM.

Policy on Pre-Procedure Nursing Duties

Patient Instruction and Scheduling:

1. Identify the patient using two patient identifiers (full name and date of birth).
2. Give the Colonoscopy Instruction Packet to the patient, review the Colonoscopy Prep Instructions and schedule the procedure date.
3. Review with the patient the need for a responsible adult to drive the patient home and to be available to the patient for the remainder of the day. Explain to the patient that if a responsible adult is not available the procedure will be cancelled, or if the responsible adult does not return to pick up the patient after the procedure, the patient will be admitted to the hospital for observation, via ambulance from the Center for Family Medicine. The cost for the ambulance transfer and hospitalization may be the patient's responsibility.
4. Send the prescription for the colonoscopy prep to the Pharmacy of the patient's choice via eprescribe or fax.
5. A reminder call will be made to the patient the day before the exam to inform the patient of arrival time and to review prep instructions, NPO after midnight and that a responsible adult is to accompany the patient.
6. General discharge instructions will be reviewed with the patient pre-procedure, before the patient receives sedation. More detailed discharge instructions will be reviewed with the patient and responsible adult driver at the time of discharge and copies will be given to the patient. Educate the patient that these instructions will include what was done during the procedure, follow-up appointments and how to obtain biopsy results, if applicable.

On the day of the procedure, the nurse has the following Responsibilities:

1. Verify the appropriate equipment is available including, but not limited to:
 - a. Crash cart
 - b. Monitoring equipment
 - c. Functioning suction
 - d. Positive pressure breathing device (bag-valve-mask and oxygen tubing)
 - e. Battery backup power source
2. Set up procedure room and check equipment
3. Check to ensure the patient's medical record includes both a pre-procedure physician assessment and a signed informed consent. Verify the patient's NPO status has been a minimum of six hours.
4. Identify the patient using full name and DOB, obtain admission vital signs and Aldrete score (refer to the Aldrete Score Card), and complete pre-procedure paperwork and consents.
5. Have patient change into gown
6. Obtain a blood-glucose on all diabetic patients.
7. Urine pregnancy tests are to be performed on all women of childbearing age (<52), unless they have undergone a sterilization procedure.
8. Ensure the patient has dependable IV access.

9. Connect patient to monitors
10. Position patient on left side
11. CRNA will give IV sedation
12. Circulating nurse will assist physician as needed

Policy on Intra-Procedure Responsibilities

During the procedure, each member of the health care team must carry out the duties assigned to them to ensure maximal efficiency and patient safety. Patient identification, using full name and date of birth, shall be done just prior to the administration of the sedation.

1. The physician performing or precepting the procedure has the final authority and responsibility for all patient care decisions and shall be immediately available from the beginning of sedation until the patient has adequately recovered from their effects.
2. The CRNA should:
 - a. Select medication based on procedure and patient specific indications, and titrate doses to patient response.
 - b. Monitor and document the following vital signs during the procedure:
 - i. Blood pressure
 - ii. Heart rate
 - iii. Oxygen saturation
 - iv. Heart rhythm
 - v. Sedation score
 - c. Provide supplemental oxygen, when appropriate, to maintain pre-procedure saturation.
 - d. Monitor the patient continually for adverse reactions to the medications or procedure.
 - e. Document the procedure on the Procedural Sedation Progress Note.
 - f. CRNA will monitor vital signs and assess patient's comfort level every 5-15 minutes, or more often if required during the procedure.
 - g. Report the status of the patient, including VS, medications used and reversal agents) to the Recovery Nurse.
3. Equipment/Supplies:
 - a. Cart with monitor, processor, light and water source
 - b. Colonoscope
 - c. Suction machine with tubing
 - d. Water bottle with distilled water
 - e. Mayo stand
 - f. Exam gloves
 - g. 4x4's
 - h. Lubricating jelly
 - i. Basin with distilled water
 - j. Small towel
 - k. Chux
 - l. Gowns
 - m. Drape sheet and blanket
 - n. Biopsy forceps and snare
 - o. Specimen trap
 - p. Specimen container and pathology request forms
 - q. 60cc catheter tip syringe
 - r. IV stand

- s. Venipuncture supplies
- t. IV fluid, usually Lactated Ringers or sodium chloride if indicated
- u. EKG/BP/Pulse Oximeter
- v. Sedation medication cart
- w. Syringes/needles
- x. Crash cart
- y. Oxygen tank with nasal cannula or mask

3. The Procedure Nurse should:

- a. Assist the physician during the procedure, which may include assisting with equipment such as biopsy forceps, snare, and cautery, and to assist in obtaining biopsies.
- b. Assist the CRNA should the patient become unstable.
- c. If biopsies are taken, place specimen(s) in labeled pathology container (label with patient's name, DOB, and type of specimen). Complete the pathology form, and take specimen to lab.
- d. At completion of procedure, assist in positioning patient for comfort.
- e. Clean and reprocess colonoscope following proper procedure. Refer to the Pentax Video Lower GI Scopes Manual: Instructions for Use.

Policy on Post-Procedure Phase II Responsibilities

1. Identify the patient received from Post-Anesthesia Recovery using full name and DOB.
2. A RN will monitor the patient's Phase II recovery status until discharge criteria are fulfilled.
3. Blood pressure, heart rate and oxygen saturation will continue to be documented every 15 minutes x 4, every 30 minutes x 2 until the patient returns to their baseline.
4. Post-procedure monitoring will continue until the patient returns to their baseline neuro/cardio/respiratory status. The duration of monitoring must be individualized depending on:
 - a. The level of sedation achieved
 - b. The overall condition of the patient
 - c. Any unplanned events occurring during sedation
5. Significant variations in physiologic parameters must be reported to the CRNA or physician immediately including:
 - a. Significant cardiac arrhythmias
 - b. Systolic blood pressure <100 or > 160, or pulse rate <60 or > 100.
 - c. Oxygen saturation <90% and not improving
 - d. Dyspnea, apnea
 - e. Decreasing level of consciousness or need to assist patient to maintain their airway
 - f. Any unexpected patient responses
6. Give patient something to drink (water, juice, Gatorade).
7. Discontinue IV when patient is alert/oriented, vital signs are stable, and patient is tolerating fluids.
8. Review discharge instructions with patient and responsible adult.
9. Discharge patient with responsible adult, escorted to vehicle with nursing staff.
10. Documentation of patient's meeting all discharge criteria including:
 - a. Returning to pre-procedure neuro/cardiac/respiratory status
 - b. Tolerating oral liquids/food (water, juice, tea, crackers).
 - c. Return to pre-procedure ambulatory status
 - d. Aldrete score of 8 to 10, or at the pre-procedure baseline
 - e. Written discharge instruction sheet discussed with the patient and responsible adult and given to patient
 - f. Patient discharged to the care of another responsible adult
 - g. Staff member shall escort patient to vehicle
11. Document the recovery on the Outpatient Phase II Recovery Form

12. Physician will dictate a procedure note
13. The nurse will make a follow-up phone call to the patient on the day following the procedure, or the next business day if the procedure was done on a Friday or the day preceding a holiday.

[Home](#)

Welch Allyn Stress EKG

Purpose: A screening test for the presence of underlying ischemia or coronary artery disease.

Procedure:

1. Patients are reviewed and selected for Stress EKG testing according to the recommended guidelines published by the AAFP in the article “Ordering and Understanding the Exercise Stress Test” January 15, 1999, American Family Physician.
2. Stress tests are scheduled by the Receptionist/Scheduler when a preceptor is available to assist the resident with the procedure. Allow 60 minutes for the test.
3. Upon scheduling the test, the patient will be given (or mailed) a copy of the Stress EKG Pre-Test Instructions.
4. A recent EKG must be available prior to the stress test; therefore, if an EKG has not been done within one month a resting EKG can be done at the time the patient is hooked up before initiating the stress test
5. An ACLS certified staff nurse will get the patient ready for the test and remain in attendance throughout the procedure to monitor and record vital signs and to run the computer-guided program.
6. The patient will be hooked up to the stress EKG machine by the nurse but the test itself must not be started until the resident and the preceptor are in the room.
7. Documentation will be completed by the physician who administers the stress EKG according to the attached guidelines.

Instruct the Patient (may be done in the stress test procedure room):

1. To get onto the treadmill by stepping on the outside edges of the machine.
2. Look forward while walking. People tend to get dizzy if they look down or watch their feet. Stand straight and tall towards the front of the treadmill.
3. Blood pressure (BP) will be taken every 2-3 minutes. Every 3 minutes, or after the blood pressure is taken, the treadmill will incline and speed up for the next exercise level.
4. Tell patient that “AT ANY TIME, if you have CHEST PAIN, SHORTNESS OF BREATH, or are TOO TIRED TO CONTINUE, let the nurse/doctors know and we will STOP the test.”
5. Tell patient that “When the test is completed, there will be a 1-minute cool down and you should continue to walk with it. Once the belt stops, stand completely still to let the machine record a good, clear rhythm strip. This is very important to see how the heart is functioning after strenuous exercise/work level.”

Administering the Test:

1. Move the computer cart to the head of the treadmill.
2. Connect the black cable from the treadmill into the black port on the back of the computer PC. **Tighten the screws** to hold the connector in place so as not to damage the connector. Turn on the treadmill (switch is located at front base of the treadmill just above where the cable attaches to the treadmill).
3. Plug in the grey power strip cord and **turn on the power strip**.
4. Turn on the computer and the monitor. The printer should already be turned on. Check to make sure there is paper in the printer.
5. Enter the password: welchallyn

6. Click on the **Cardio Perfect** icon at the top left of the screen. Username: admin automatically pops in; Password: none needed, just click OK or “enter”
7. Once the order for the stress test has been entered into Mediat, you can search for the patient by entering the Mediat **patient (account) number**. Click on the patient name and the demographic information will automatically fill.
8. If you cannot find the patient, enter patient data:
 - Patient ID number = Mediat **patient (account) number** on the charge ticket.
 - Weight
 - Name
 - Gender
 - Date of birth (m/d/yyyy)
 - You may also enter the indication for the stress test, e.g. chest pain
9. If the patient does not have an EKG on the chart that was done less than 30 days ago, he/she will need an EKG first. This can be done before the stress test.
10. Connect the EKG leads as indicated on the laminated guide (same as the previous stress EKG machine). The lower limb leads can be placed on the back, just above the waist or on the lower abdomen. The sticky lead patches are located in the plastic container with the pink lid (usually on the counter). If we are getting low on packages of sticky patches, let Nicole or Terri know so that more can be ordered. The EKG connecting cords are kept in the wire basket on the cart just below the monitor.

Note: Women should keep their bra on (unless it is an underwire bra) and give them a gown top or have them put their shirt back on after the leads are connected. Men may walk without their shirt, if comfortable, or may wear a shirt or gown top.
11. Once the patient is hooked up, click **EKG** (if needed) or proceed to number **15** below.
12. To record an EKG wait until you see a good rhythm strip on the bottom of the monitor EKG screen then click record. The EKG will automatically print. Take this to the doctor to review before proceeding any further, but leave the patient hooked up.
- 13. Do not start the stress EKG procedure until the Resident and Preceptor are in the room.**
14. To begin the stress EKG have the patient step on the stationary outside edge of the treadmill. Place the QRS box and belt around the handle of the treadmill and fasten the belt. Click on **“Go to Exercise”** at the top of the screen. The program will automatically run.
15. Take the patient’s blood pressure manually when prompted by the BP popup on the computer screen (every 3 minutes). The machine will automatically increase in speed and elevation every three minutes and this occurs soon after the blood pressure is taken. Give the patient forewarning that this will occur.
16. Note: The red button on the front of the treadmill is the emergency stop button; you can also click on a red emergency stop icon at the top of the computer screen.
17. The program will automatically calculate 85% of the patient’s target heart rate and will keep track of this (as well as how close you are to the test goal) at the top of the screen.
18. When the patient has reached the goal and the doctor says the test can be stopped, click **“Go to Recovery”** at the top left of the screen to begin the “cool down” and recovery phase. The treadmill will slow down to a slow walking rate and decrease the incline to level. After a 1-3 minute recovery, click **“Stop the Treadmill.”** Once the machine stops, have the patient stand very still and take the patient’s blood pressure.
19. The patient can then move to the exam table to rest. You will be prompted to take the patient’s blood pressure every 2 minutes. Continue to take blood pressures until the patient returns to their pre-test blood pressure and pulse readings. At this point click **Stop** and confirm that you want to stop the test by clicking **“yes”**. At this time the patient may be unhooked.
20. Offer the patient a towel to dry off with, if necessary and have the patient get dressed.

21. Data will print out automatically, so you do not have to queue the printer. Collect all data printed once complete and give it to the doctor. The patient may be taken to an exam room where the doctor will review the test results with him/her.
22. Close the program and turn off the computer and monitor. Turn off the treadmill. **Disconnect the treadmill cable from the back of the computer** and drape the cable over the treadmill handrail. Turn off and unplug the power strip.
23. Wipe the lead wires with a disinfectant, coil them loosely and put them, along with the QRS box, back into the wire basket on the cart.
24. Move the computer cart back along the wall and plug in the power strip.

[Home](#)

EKG Stress Tests – Notes to Residents

I. FIRST AND FOREMOST, the patient MUST meet criteria for test INCLUDING
Normal (i.e. flat) baseline ST segments on EKG

II. Criteria for a positive test

A. Chest pain or other angina equivalents

B. ST-segment changes:

1. At least 1 mm of depression with flat or down-sloping ST segment 80 milliseconds after the J-point.
2. At least 1.5 -2 mm of depression with up-sloping ST segment 80 milliseconds after the J-point.

C. Loss of normal SBP increase with exercise.

III. Template for dictating an EKG Stress Test report:

Patient Name

Date

Referring/Performing Physician

Preceptor

Indication

Protocol

Test details:

- 1) Protocol
- 2) Heart rate: Resting, Max exercise, % of max predicted
- 3) BP: Resting, Max exercise
- 4) Time of termination
- 5) Reason for termination
- 6) ECG changes: Resting, Max exercise*
- 7) Clinical symptoms: Resting, Max exercise

Impression:*

Recommendations including follow-up:

Signature

* Comments/stock phrases to include in dictation (see attached example):

*6) Resting ECG: “normal sinus rhythm with normal interpretable baselines”

*Impression:

1. Adequacy of stress test; i.e. did they walk at least 6 minutes
2. BP response; i.e. “normal changes with exercise including an increase in SBP with widening of pulse pressure”
3. “(Any or No) clinical criteria for ischemia observed”
4. “(Any or No) ECG criteria for ischemia observed”

[Home](#)

MEDICAL CARE FOR RUTH MEIERS CLIENTS

Purpose:

The UND Center for Family Medicine shall provide charitable health care services to homeless individuals through the Ruth Meier's Hospitality House.

Policy:

The UND Center for Family Medicine will provide health care services free of charge to homeless and indigent persons affiliated with the Ruth Meier's Hospitality House under the following guidelines:

1. The individual has no insurance.
2. The appointments must be scheduled by the nurse from JoAnn's Clinic at Ruth Meier's and the scheduler will enter "Ruth Meier's client" onto the computer screen at the time the appointment is made.
3. The individual must have a signed voucher for services if patient is seen at CFM.
4. If the client needs lab or radiology services these shall be ordered through JoAnn's Clinic, except in a life-threatening situation; or if the client has a suspected urinary tract infection, the CFM nursing staff will perform a simple urine dipstick. Lab order must be sent to Mid Dakota Clinic with "Ruth Meier's Client" noted on the order.
5. When the client needs medication, samples will be given, if at all possible. Prescriptions, if given, will be referred back to the nurse at JoAnn's Clinic.
6. Services provided by CFM staff at Ruth Meier's Clinic will be documented in Medicat.

[Home](#)

REFUSAL OF TREATMENT BY A PROVIDER

Purpose:

The clinic strives to provide quality care to its patients, but occasionally has a situation where we wish to refuse to continue furnishing health care services to a patient. Instances for refusal of care may include:

- Patient or parental behavior is inappropriate and/or abusive and prevents the clinic from providing quality care to the patients;
- Patient falsifies information;
- Patient refuses to accept services and/or wishes to transfer to another clinic;
- Patient is unwilling to comply with plan of care;
- Outstanding/unpaid bills
- Evidence of Medical Identity Theft

Circumstances beyond the clinic's control may at times preclude the clinic from providing quality care to a patient. When these circumstances arise and are not able to be resolved, termination of the patient's care with the clinic may be necessary. The clinic will cooperate in transferring care and medical records to another provider at the patient's request.

Policy:

When a physician or the clinic, either individually or collectively, decides that it is in the best interest of the clinic to refuse/withdraw services:

1. Resolve any acute medical conditions prior to terminating the relationship.
2. The Health Plan must be notified in writing (or by the Health Plan's termination of care form) if the member is a managed care member.
3. The patient is notified in writing via a termination letter (see template), sent by certified mail, which must contain the following information:
 - A. An offer to copy and send medical records to another provider of the patient's choice along with a release of information form included with the letter;
 - B. A statement that care will be provided for a maximum of 30 days to allow transfer to occur. Clearly state date that termination will become effective;
 - C. Provide emergency care until termination date.
 - D. The phone number for member services at the Health Plan;
 - E. Resources and /or recommendations provided to help a patient locate another physician by listing local medical groups and resources, not physicians by name.
4. A copy of the letter and receipts postcard from the certified letter is placed in the medical record. The managed care plan may also require a copy of the letter. All copies of the letter are marked CONFIDENTIAL
5. The medical records are transferred upon receipt of the signed release of information form.
6. Incident report needs to be filed with risk management.

[Home](#)

Letter Templates for Termination of Provider/Patient Relationship:

Certified Mail – Return receipt

Date
Patient's Name
Address
City, State XXXXX

Dear [patient name]:

With this letter, I must let you know that I need to now withdraw as your primary medical provider. Your health plan has been notified in writing of my current decision (if applicable).

Given these circumstances, I suggest that you place yourself under the care of another medical provider/physician without delay.

To assist you, I have provided the phone number for the local medical society [insert phone number]. I have also included the address and phone number of a facility where emergency care can be obtained if needed [insert local hospital names and numbers].

In order to give you reasonable advance notice, our office will be available for your immediate medical needs over the next 30 days, until [date: day, month, year], if you wish. After that date, our office will no longer be available to provide for your medical care.

Our office will be glad to send your medical records to your new physician. For that purpose, I am enclosing a consent form authorizing me to release your medical records to your new physician. Upon receipt of this form, signed by you and designating where to send a copy of the records, I will forward the records promptly.

If you have any questions regarding the content of this letter, you may reach me at my office during normal office hours.

Sincerely,

[Physician name typed]

[Home](#)

[Home](#)

EKG Stress Tests – Notes to Residents

I. FIRST AND FOREMOST, the patient MUST meet criteria for test INCLUDING Normal (i.e. flat) baseline ST segments on EKG

II. Criteria for a positive test

A. Chest pain or other angina equivalents

B. ST-segment changes:

1. At least 1 mm of depression with flat or down-sloping ST segment 80 milliseconds after the J-point.

2. At least 1.5 -2 mm of depression with up-sloping ST segment 80 milliseconds after the J-point.

C. Loss of normal SBP increase with exercise.

III. Template for dictating an EKG Stress Test report

Patient Name Date Referring/Performing Physician Preceptor Indication Protocol Test details: 1) Protocol 2) Heart rate: Resting, Max exercise, % of max predicted 3) BP: Resting, Max exercise 4) Time of termination 5) Reason for termination 6) ECG changes: Resting, Max exercise* 7) Clinical symptoms: Resting, Max exercise Impression: * Recommendations including follow-up: Signature

* Comments/stock phrases to include in dictation (see attached example):

*6) Resting ECG: “normal sinus rhythm with normal interpretable baselines”

*6) Max exercise ECG: +/- arrhythmias, ST segment and T-wave changes

*Impression:

1. Adequacy of stress test; i.e. did they walk at least 6 minutes
2. BP response; i.e. “normal changes with exercise including an increase in SBP with widening of pulse pressure”
3. “(Any or No) clinical criteria for ischemia observed”
4. “(Any or No) ECG criteria for ischemia observed”

[Home](#)

Scheduled II Medications

Policy:

The purpose of this policy is to ensure the patient receives their prescription for Scheduled II Medications.

Procedure:

1. Nurse/Dr. will inform the patient that the prescription will be mailed to their pharmacy of choice. If the prescriptions needs to be filled immediately it will be filled at the UND CFM Pharmacy only.
2. Nursing can hand carry prescriptions to UND CFM Pharmacy when needed immediately.
3. Patients will not be allowed to pick up narcotic prescriptions.

[Home](#)

CHRONIC PAIN MANAGEMENT

Purpose: To assure effective, efficient, consistent care and self-management of the chronic pain patient using the chronic care model.

Procedure:

1. A pain management team will be created and the team will consist of Dr. Jeff Hostetter, CFM Residency Program Director, a Nurse Coordinator, the patient's primary care physician and nurse, pain management consultants, community and support systems or agencies and the patient.
2. All chronic pain patients will be instructed about the Center for Family Medicine's Chronic Pain Management policy and team approach by their primary care physician (PCP) and will sign an informed consent for treatment of pain with opiates, if necessary. The consent will be scanned into Mediat.
3. The chronic pain patient will be required to sign a medication contract and the guidelines for continuing pain treatment with their CFM provider. The original contract will be kept in the patient medical record and a copy will be placed in the nurse coordinator's file and will be scanned into Mediat.
4. Each patient will have an individual treatment plan developed jointly with their provider setting realistic therapeutic goals in four main areas: physical abilities, social and vocational functioning, medication dosages and amounts, and duration of treatment. The treatment plan will also specify patient visit intervals. The treatment plan will be reviewed at each patient visit and updated or revised as needed and scanned into Mediat until the creation of a template.
5. Each patient will receive copies of the informed consent and their medication contract.
6. Prior to each patient visit, the nurse coordinator will obtain a current printout from the North Dakota Board of Pharmacy website (<https://ndpdmpph.hidinc.com> with the logon: JHostett and password: 986324) for the doctor to review.
7. All patient requests for opiate meds will go through the nurse coordinator or her designee.

[Home](#)



Opiate Medication Contract

I, _____, agree to the following rules and conditions regarding refills of opiate pain medications.

I understand that I have the following responsibilities:

1. I will limit my dose of medications to the dose prescribed. I will not change the dose without contacting my doctor.
2. I am responsible for my medications. Lost, misplaced or stolen prescriptions will not be replaced.
3. No early refills will be given.
4. No refills will be given after-hours, on holidays or on weekends.
5. I will obtain all refills for these medications only at one pharmacy: _____.
6. I understand that my doctor may stop prescribing opiates or change the treatment plan if I do not show any improvement in pain from opiates or my level of functioning does not improve.
7. I will not ask for pain medications from other doctors.
8. I will tell any other doctors I see (including Emergency Room doctors) that I am taking opiate pain medications, and that I have a Medication Contract with the doctors at the UND Center for Family Medicine.
9. Prescribed medications are only for my own use, and I will not share them others.
10. I will keep all medications away from children.
11. I agree to participate in any treatments recommended by my doctor that are designed to improve my social, physical, and psychological functioning.
12. I will not use illegal or street drugs or another person's prescription.
13. If my doctor thinks I have an addiction problem with drugs or alcohol and the doctor asks me to enter a program to address this issue, I agree to go to an initial evaluation. I agree to drug or alcohol treatment if the addiction specialist thinks I need to go.
14. If in treatment, I will request that a copy of the program's initial evaluation and treatment recommendations be sent to my doctor. I will also request written monthly updates be sent to verify that I am continuing treatment.
15. I will consent to random drug screening to assure I am only taking prescribed drugs. I understand that a drug screen is a laboratory test in which a sample of my urine or blood is checked to see what drugs I have been taking. I understand that I will be responsible for the cost of these tests.
16. I understand that failure to follow these rules may result in no further prescriptions for opiates.

Patient: _____

Date: _____

Doctor: _____

Date: _____



Patient Informed Consent and Notice of Risks For Treatment of Pain With Opiate Medications

We have discussed potential side effects and risks of opiate substances, including:

- sleepiness, confusion, difficulty thinking
- nausea, vomiting, constipation
- difficulty breathing, shortness of breath, wheezing
- rash, itching
- potential for allergic reaction
- potential for interaction with other medications (increasing effects or side effects of drugs taken together)
- potential for dose escalation/tolerance (need for higher doses for the same effect may occur with long term use)
- potential for dependence (after the body adjusts to these medications, they cannot be stopped abruptly without physical symptoms)
- potential for withdrawal (stopping medications abruptly may cause nausea, vomiting, abdominal pain, sweating, aching, abnormal heartbeat or other symptoms that can be life threatening; medication changes should be under provider supervision)
- potential for addiction (compulsive drug use not related to pain relief)
- potential for impaired judgment and/or motor skills (driving or operating machinery may be hazardous due to effects on the brain and nerves)
- potential for testicular atrophy and impotence in men

Your signature below confirms that I have explained treatment alternatives and the risks of opiate medications to you. You are satisfied with that explanation and desire no further information.

You must sign this document indicating your consent to the use of opiate medications in treating your pain prior to starting treatment.

Patient: _____

Date: _____

Explained by me and signed in my presence:

Doctor: _____

Date: _____



Opiate Pain Medication Partnership Agreement

The greatest success in chronic pain management comes when there is a partnership based on mutual respect between patient and doctor.

The doctor understands that it is important for patients with pain to know that the doctor will:

- Listen and try to understand the patient’s experience living with pain.
- Accept the patient’s reports of pain and response to treatment.
- Thoroughly assess the patient’s pain and explore all appropriate treatment options, including those suggested by the patient.
- Explain what is known and unknown about the causes of the patient’s pain.
- Explain the meaning of test results or specialty visits/consultations, and what can be expected in the future.
- Explain the risks, benefits, side effects and limits of any treatment.
- Respect the patient’s right to participate in making pain management decisions, including the right to refuse some types of treatment.
- Make sure that the patient has access to acute care, even when the provider is not personally available.

The patient understands that it is important for doctors that their patients with pain will:

- Take medication only at the dose and times prescribed.
- Make no changes to the dose or how the medication is taken without first talking to the doctor.
- Not ask for pain medications from other doctors.
- Tell any doctor they see all medications they are taking.
- Arrange for refills only through one doctor’s clinic during regular office hours.
- Not ask for early refills.
- Protect their prescriptions and medications.
This means keep all medicines away from children AND from people (even family members) who might steal them.
- Take medications only for their own use and NOT share them with others.
- Be willing to be involved in programs that can help improve social, physical, or psychological functioning.
- Be willing to learn new ways to manage their pain.

We both agree that the doctor may stop prescribing the medication or the patient may decide to stop taking the medication if there is no improvement in pain or activity, or there are significant side effects from the medication.

We both realize and have discussed that there can be limitations to opiate therapy. It may not be helpful or only partially helpful and that it is only one part of the treatment of chronic pain.

We both agree to work together to find the most effective ways to control pain and improve functioning.

Patient: _____

Date: _____

Doctor: _____

Date: _____ [Home](#)

Circumcision Following Home Birth

1. Circumcision must be done within seven days of birth, unless infant is born premature, then within 10 days.
2. Vitamin K must be administered 24 hours prior to the circumcision.
3. The Vitamin K must be prescription-strength injectable ordered through a pharmacy. CFM Pharmacy does not carry Vitamin K. It may be ordered through the Sanford Outpatient Pharmacy and billed to UND CFM; we will then bill the patient for the cost of the Vitamin K.

[Home](#)

Patient Transportation

Purpose: To provide transportation for clinic patients being admitted to the hospital.

Physicians will use their clinical assessment and judgment to decide on the transportation option for their patient that will include proper medical care and safety for the patient. Transportation options can be discussed with the clinic counselor or preceptor.

Documentation of the transport will be provided in dictation following an informed consent process.

Transportation Options:

1. Releasing the patient to a trusted family member
2. Medical Personnel (Nurse or Physician) walking the patient to the hospital
3. Ambulance
4. Mental Illness and Addiction

Patients who present with mental illness will be transported by dispatch. Call dispatch and let them know we have a Request for Transportation for Emergency Detention.

Proper forms need to be filled out for mental illness transportation:

- a. Request for Transportation for Emergency Detention (SFN 17265 GN-6) for transportation of patient that is willing to be transported to the hospital.
Must be signed by the Physician (preceptor?) or Clinic Counselor.
- b. Request for Transportation for Emergency Detention (SFN 17265 GN-6); Application for Emergency admission (SN 17264 GN-5); Notice of Purpose and Effects of Custody (SFN 17267 GN-8) for transportation of patient that is not willing to be transported to the hospital.

[Home](#)

Referral Tracking

The Nurse is responsible to track referrals for their assigned physicians weekly to provide adequate follow up with the provider and patient. The Nurse will turn over tracking of physician's referrals when on vacation to another nurse as needed.

Use FILTER options to set dates, arrange columns by User, Test, or Provider

Status Changes

Request Made-(Green) Default when referral is initiated

Appointment Made-(Orange) Appointment made by Nurse

Pt Cxd Appt-(Yellow/Gray) Patient Cancelled Appointment-Click NEEDS READING so physician gets a task

Pt Missed Appt-(Yellow/Gray) Patient Missed Appointment-Click NEEDS READING so physician get a task

Appointment Rescheduled-(Orange) Update Comment to reflect new date.

Result/Report Rcd-(Black) Attached by Med Records or Xray and click NEEDS READING

Result Rcd-(Black) Attached by Med Records or Xray and click NEEDS READING

[Home](#)

MEDICAT Alerts

Purpose: Alerts will be used on a limited basis within Mediat to provided needed information to provide care to the patient. The following policy is applicable to all UND CFM-Bismarck employees.

Policy: The following alerts are possible and can be posted to a patient's ticket to initiate the listed PM, EMR or Global alert.

Practice Management (PM) Alerts

1. ALERT Pt Has 3rd Insurance (ALER3RDINS)
2. PM Alert (AlertPM)
3. Alert Memo (MmAlert)

EMR Alerts

1. Pain Contracts
 - a. Pain Management Contract With (facility) PCP: (PAINOUT1)
 - b. UND CFM Pain Management Contract On File PCP: (PAINUND1)
2. EMR Alert- used for various reasons that will be described in the description (AlertEMR)

Global Alerts (seen in EMR & PM)

3. Risk Alert-added by administration only when necessary following a reported incident. Limited information listed in the alert. Contact your supervisor for clarification. (RISKALERT)
4. Privacy For Minor Patient-used when minor patient restricts access to visit (MINOR)
5. Restriction Of {DOS, Notes, Charges} (RESTRICTIO)
 - a. Restricted Notes requested by Patient per HIPAA guidelines
6. Global Alert-used for various reasons that will be described in the description
 - i.e. Lock-In patients (AlertGlobl)

[Home](#)

ANCILLARY

[Laboratory Menu](#)

[Radiology Menu](#)

[Orders](#)

[Results](#)

[Referral Radiology Tests](#)

[Home](#)

LAB MENU:

Hematology: CBC with or without, automated differential, Sed rate (ESR).
Manual Differential, Hgb, Hct, Plt, WBC

Immunology: Monospot, RA

Urinalysis: Routine urinalysis, urine pregnancy test.

Bacteriology: Rapid strep screen, throat cultures
For Group A Strep, Rapid Influenza

Coagulation: Prottime and PTT.

Chemistry: Chem 14 profile, Basic Metabolic Panel, liver profile, lipid profile, cardiac enzymes, Glycosolated Hgb, Microalbumin, Uric Acid, Amylase, TSH, PSA, CRP

Miscellaneous: Wet mounts, KOH, serum pregnancy test.

Reference Labs: Northern Plains Lab & ND PHL

X-RAY MENU:

General Diagnostic X-rays
EKG's
Holter Monitors
Audiogram Screening
Spirometry

To **ORDER** lab and x-rays for your Patient:

Communicate all lab/X-ray orders with your nurse. Change medicat room numbers for proper patient flow through the clinic.

Lab: Electronic orders are generated from EHR. The Laboratory manages the orders from their Laboratory Manager.

X-ray: Electronic orders are generated from EHR. Radiology manages the orders from their Radiology Manager.

Procedure:

1. Enter electronic orders in Medicat.
2. Communicate with the lab/xray that a patient is ready by changing the patient's room placement in Medicat to **Lab Wait, Lab Not wait, Lab/Xray Wait, Lab/Xray Notwait**. Lab/Xray will call the patient from the front waiting room.
3. After completion of the lab procedures the patient is instructed to wait in the waiting room for their radiology tests or for an available exam room.
4. If the patient is not waiting the lab/xray will discharge the patient.
5. If the patient is waiting the lab/xray will tell the patient to wait in the front waiting room and communicate that the patient is ready to be roomed again by changing the room placement to LAB DONE, XRAY DONE, or LAB/XRAY DONE.

[Home](#)

Results

Lab:

1. Completed labs will be interfaced to the EHR, changing the status to Results Received. The physician will receive a task to read the results for the patient.
2. Lab Personnel will not give out test results to patients unless instructed by the physician, or special circumstances.
3. Abnormal labs are reported to the nurse/Physician in the EHR denoted by the color red. Critical values are called to the nurse or physician ASAP. The nurse will notify the patient's physician.
4. Verbal results from reference labs will be given to the nurse or physician. These results are given verbally to the nurse. The technologist will verify the result with the written report when received.

Xray:

1. When the x-ray is completed, the radiology department marks the STATUS as **"Performed"**.
2. Digital images are available for viewing in the preceptor office by an interface to Sanford's PACS (picture archive and communications system). Each authorized user must receive training before being assigned a log-in and password.
3. Images are officially read by a Sanford radiologist. Results are back within 24hrs. For verbal STAT reading a radiologist can be reached by calling 701-323-5210. Once the report is signed by the radiologist it will be scanned and attached to the electronic order by radiology or medical records. The STATUS is then marked **"results received"** and needs **"READING"**. This then sends it to the rendering provider and preceptor for review. **Once the patient has been notified the status is changed to NOTIFICATION and how the patient was notified must be documented in the "comment" section and electronically signed (locked) by marking "read"**.
4. ECGS, PFTS, Audiogram Screenings , and Holter Monitors are attached to the electronic order. The STATUS is marked **"results received"** and needs reading when completed. This will send to the rendering provider and preceptors tasks for review and signature as well. ECGs and PFTs are to be confirmed electronically in Welch Allyn. This is put on the actual tracing as confirmed by... ECG's must be confirmed by a preceptor for all residents.

Referral Radiology Tests

Reports for referral diagnostic testing are managed by Radiology. Any tests that we cannot provide here at UND CFM are included in the Orders/Results of the patient. Ultrasounds, CT scans, MRI's, Nuclear Medicine, contrast studies, and mammograms are included. The patient can choose the facility of choice. The rendering provider will initiate the referral electronically and the appointment will be set up by nursing. Tracking of the referrals are done weekly by each provider/nurse team.

[Home](#)

MEDICAL RECORDS

[Communication of Reports](#)

[Guidelines: Scanned Items](#)

[Release of Medical Information](#) (form)

[Release of Medical Information](#)

[Dictation](#)

[**Medical Charts-DO NOT REMOVE FROM CLINIC**](#)

[Death Certificates](#)

[West Central Human Services](#)

[**Home**](#)

Communication

Mail services to the hospitals

We pick up and drop off mail at St Alexius hospital. Sanford mail is picked up and dropped off daily at the Front Desk.

Interdepartmental mail to the clinics and hospitals

We have a wire basket, located on the counter in the mail center, to place mail which needs to go back to the hospitals and clinics. Place those items in that basket.

Mail which goes to the Post Office needs to be placed in the basket in the mail center. You do not need to worry about postage; we will take care of that for you, except if it is your personal mail. You will need to put postage on that.

Brown interdepartmental envelopes can be found in the drawer by the Interdepartmental Mail basket. Please check both sides of the envelope and cross off last place listed

Mailing envelopes are located in the supply cabinet in Medical Records.

All dictated Clinical Resumes and Hospital History and Physicals will be scanned into EHR then given to billing for hospital charges.

If we have reports on a patient who does not have an established chart, those reports go to the CHIEF Resident and he/she is to present those reports at the weekly resident meeting.

Faxed Reports

All diagnostic reports which come from the fax machine are placed in your hanging folder and will be stamped with the following stamp.

Date _____ Physician _____

Patient Notified
__Clinic Visit __Phone
__Other _____ __Letter

They need to be reviewed and initialed. At that point you can dictate a letter to the patient or call the patient with results.

All faxes coming from Burleigh County Detention Center, the charts are pulled and given to the doctor who saw the patient and if they have never been here before, it goes to the Chief.

If we receive reports on a patient who does not have a chart at our clinic, we have a black file box in medical records, in which we file and hold all reports for 6 months. At the end of 6 months, we check to see if the patient has established a chart at our clinic and if they have we scan the report. If the patient has not been established, those papers are thrown into shredding to be destroyed.

[Home](#)

Guidelines: Scanned

Correspondence In

Any correspondence which is sent in from another clinic-this includes follow up visits
Eye Exams which are sent from another clinic

Correspondence Out

Any letters from our clinic that are sent out
Pap letters from Pathology PC

Dermatology

Dermatology referrals (VA, Tricare, etc.)
iPledge forms

Diabetes

Blood sugar logs

Hospital/ER

All hospital and ER visit notes

Miscellaneous

Patient assistance forms
Prior authorization forms
Great Plains Orders
NPP Acknowledgement Form
HIV consent
Home Health Care correspondence

Nursing Home

All nursing home documents

Ob/Gyn

Paps
Completed ACOGs

Outside Medical Records

Incoming records
Record releases
Ongoing releases

Pain Management

Pain management contracts

Pathology and Laboratory

Incoming labs and path reports that we did not initiate a referral

Prescription Refill Sheets

Refill requests that have been completed and faxed to the pharmacy
Narcotic Scripts

X-ray/Radiology

Incoming x-ray and radiology reports that we did not initiate a referral (ultrasounds, MRI, x-ray, mammograms, etc.)

[Home](#)

Scanned Documents That Are Attached To The Office Visit Note

- Consents
- Instructions
- Well Child Forms
- MChat Form
- Sports Physicals
- DOT Exam Forms
- Orders (if they are for that visit date)
- Title XIX/West Central Papers, authorizations, referrals
- Social Security Disability Paperwork
- Hit, Pride, Enable, Transitional Center, etc. referral forms, doctor's visit notes
- Workers Comp Forms (if they are for that visit date)
- Nursing Home Physician Visits Forms
- Return to work/school notes

[Home](#)

Patient's Right to Amend a MEDICAL RECORD:

The HIPAA privacy rule is federal law and is outlined in the Code of Federal Regulations (CFR §164).

The HIPAA privacy rule, in general, provides the patient with the right to inspect, review and receive a copy of their medical and billing records. The patient must follow your office policy to obtain a copy of their medical records and may be charged a reasonable fee to obtain their medical records.

If the patient thinks the information contained in the medical record is incorrect, HIPAA states they may request that the health care provider amend the information in the medical record. The provider **must** respond to the patient's request and **must** amend the record **if it is incorrect**. If the provider does not agree with the patient's request to amend the record, the **patient** has a right to submit a statement of disagreement and the provider **must** add the disagreement to the medical record. (This means the written statement of disagreement must be filed in the medical record. It does not mean the provider has to agree with it).

Reviewing Patient Requests to Amend Records:

Individuals have the right to request amendment to PHI in the designated record set for as long as the records are maintained in the designated record set.

Writing Requirement: Requests for amendment must be in writing and the individual must provide a reason to support the requested amendment.

Time period for action: The UND Family Practice Centers must act on an individual's request to amend information within 60 days from receipt of the request. The time for action on a request may be extended for an additional 30 days if the UND Family Practice Centers is unable to take action within the original time period for action. To extend the time period for action, provide a written statement of the reasons for the delay to the individual within 60 days from receipt of request. One extension of the time period for action is allowed per request.

Accepting Amendments:

If the UND Family Practice Centers grants the request for amendment in whole or part:

1. Inform the individual in writing that the amendment is accepted.
2. Make the amendment to the PI-II or record by identifying the records in the designated record set that are affected and appending or otherwise providing a link to the location of the amendment.
3. Obtain the individual's identification of persons who have received PHI about the individual and needing the amendment.
4. Obtain the individual's agreement to have the UND Family Practice Center notify the persons they have identified for the purpose of informing the persons of the amendment.
5. Make reasonable efforts to inform and provide the amendment within a reasonable time to the following:
 - i. persons identified by the individual;
 - ii. persons, including business associates, that the health care component knows have the PHI that is the subject of the amendment and that may have relied, or could foreseeably rely, upon the information to the detriment of the individual.
6. Follow the process for denying amendments as to any portion of the amendment that is not accepted.

[Home](#)

Denying Requests for Amendment:

Requests for amendment may be denied if:

- the information is accurate and complete;
- the PHI or record was not created by the Provider Component, unless the individual provides a reasonable basis to believe that the originator of PHI is no longer available to act on the request; or
- the PHI would not be available to the individual under the following unreviewable grounds for denial of access:
 - the PHI is expressly excluded from the right to inspect and copy;
 - the information is not maintained in the designated record set; §research that includes treatment and the research is still in progress, provided the individual agreed to the denial of access when consenting to participate in the research;
 - it would be lawful to deny access to the records under the Federal Privacy Act, 5 U.S.C. § 552a; or
 - the information was obtained from someone other than a health care provider under a promise of confidentiality, and allowing access is likely to reveal the source of the information.
- The PHI would not be available to the individual under the following reviewable grounds for denying access:
 - the PHI refers to another person who is not a health care provider and access is reasonably likely to cause substantial harm to that person; or
 - the access is reasonably likely to endanger the life or physical safety of the individual or another person; or
 - the request for access is made by the individual's personal representative and giving access to the personal representative is reasonably likely to cause substantial harm to the individual or another person.

All denials must be in writing and must include:

1. the basis for denial;
2. statement of the individual's right to submit a written statement disagreeing with the denial and where to file the statement of disagreement;
3. statement that the individual may request that the Provider Component provide the request for amendment and denial with any future disclosures of the PHI that is the subject of the denied amendment; and
4. a description of how the individual may complain to the Provider Component, University or the Secretary, including the name/title, and telephone number of the Privacy Official.

Disputed Amendments: If the amendment is denied, permit the individual to submit a written statement of reasonable length disagreeing with the denial and the basis for disagreement. If the individual prepares a written statement of disagreement, the health care component may prepare a rebuttal statement in response. If a rebuttal statement is prepared, provide a copy to the individual who submitted the statement of disagreement.

Identify the record or PHI in the designated record set that is the subject of the disputed amendment and append or otherwise link the individual's request for amendment, the denial of the request, the individual's statement of disagreement and the rebuttal to the designated record set.

[Home](#)

Future disclosures of PHI related to a request for amendment:

If the amendment is accepted, provide the amendment information with any subsequent disclosures. If the request is denied, and the individual does not submit a written statement of disagreement, provide the request for amendment and denial with future disclosures, if the individuals so requests.

If the individual submits a written statement, provide the appended material related to the disputed amendment or an accurate summary of the appended information with any subsequent disclosure of the information to which the request for amendment relates.

When subsequent disclosures are part of a standard transaction that does not allow provision of the required information as part of the transaction, send the amendment information separately to the recipient of the standard transaction.

If the Provider Component is informed by another covered entity of an amendment to an individual's PHI agreed to by the other covered entity, amend the pm in the designated record set maintained by the University Provider Component.

What does this mean for you and what should you do?

- File the patient's request in the medical record
- Send a written response to the patient (*see below for sample language)
- Schedule an appointment for the physician to examine the patient and determine whether the patient has the particular medical conditions
 - The physician should document the purpose of the appointment (for example, *Patient is being evaluated today according to her request to amend her medical record to include the following conditions...* and list the conditions).
 - The physician should document his/her assessment as usual
 - The physician should document whether he/she agrees or disagrees with the patient's request to amend the medical record
 - If not, the physician's documentation of the assessment should clearly reflect why the physician disagrees
 - If so, the physician should ensure his/her documentation supports their conclusion

The patient may request a copy of the office visit. A copy of the office visit may be provided according to office policy (e.g., the patient signs the authorization for release of medical information).

The point of a medical examination is for the physician to decide whether the medical record should be amended to include this information. If the physician agrees the patient has the medical condition (that the patient requested to add to the medical record) without a medical examination then the record may be amended without a medical examination.

If the physician is unable to determine whether the patient has the medical condition without a medical examination then the patient must be evaluated by the physician. The physician may determine at that time whether the medical record should be amended. If the physician is unable to determine whether the patient has the medical condition without a medical examination and:

- 1) The patient lives out of state and cannot come in for an examination - send a written response to the patient acknowledging receipt of their request and state that the medical record cannot be amended without a medical examination. Invite the patient to contact the office to make an appointment. Inform the patient that their request to amend the record will be filed in their medical record. Provide the name and phone number of someone in the office to contact if they have questions. Keep a copy of any correspondence in the patient's medical record.
- 2) The patient refuses to make an appointment. send a letter to the patient with similar sample language as above (in the first bullet) .

[Home](#)

RELEASE OF PATIENT MEDICAL INFORMATION

Patient Name **Patient's Date of Birth** **Phone Number**

REQUESTED FROM: _____ **TO BE RELEASED TO:** _____

Name of Clinic or Physician **Name of Clinic or Physician**

Address **Address**

City, State **Zip Code** **City, State** **Zip Code**

Phone **Fax** **Phone** **Fax**

PURPOSE OF THIS REQUEST: **DATE NEEDED BY:** _____
 Personal use **Legal**
 Insurance **Military** **Other (Please specify)** _____
 Continued Medical Care **School**

Information to be released:

Last 2 years medical history **Other (Please be specific)** _____

**Records of a sensitive nature will not be released unless specifically authorized below.
 Any patients 14 years or older must authorize the release of their own sensitive information.**

Psychiatric/Mental/Chemical Dependency	_____	Initial	_____	Date	_____
HIV	_____	Initial	_____	Date	_____
Contraception/STD	_____	Initial	_____	Date	_____
Pain Management File	_____	Initial	_____	Date	_____

I understand that if records are released to someone who is not a healthcare provider, health plan, or health care clearinghouse, the health information released as a result of this authorization may no longer be protected by the federal privacy standards and the information may be further disclosed without obtaining my authorization.

I understand that I have a right to inspect or receive a copy of the health information I have authorized to be used or disclosed by this authorization form by contacting Medical Records Department.

I understand that if I sign this authorization, I have a right to receive a copy of this form if requested.

I understand that I am under no obligation to sign this form and the action requested in this release will not be executed without a signature. However, our medical treatment of the patient is not condition on the signing or failure to sign this form. This authorization is effective for one year unless otherwise specified as follows: _____.

I understand I may cancel this authorization at any time by written notification. For information regarding how to withdraw my authorization or to receive a copy of it, I may contact the Medical Records Department.

I have had an opportunity to review and understand the contents of this authorization. By signing this authorization, I am confirming that it accurately reflects my wishes. I release the staff of Center for Family Medicine from all liability pertaining to disclosure of any information in association with this release. A photocopy of this release is as valid as the original.

Signature of Patient or Legal Representative **Date**

If not present, state relationship-proof may be required **Witness**
[Home](#)

Release of Medical Records

WHO NEEDS TO SIGN A RELEASE OF MEDICAL RECORDS?

1. Every patient who is transferring records
2. If we are requesting records from another physician, hospital, or clinic
3. If a patient is requesting their records to be sent to another physician, health care, or any other entity

WHEN DO WE NOT NEED A RECORD RELEASE?

1. If we are referring a patient for further treatment
2. If a patient brings a request for lab work by another physician and it is done at our clinic the reports can be sent without a signed consent
3. If an insurance company is requesting records only for the date of service. (If they are requesting more records a signed release is needed)

WHAT NEEDS TO BE FILLED OUT ON THE RELEASE OF RECORDS?

There are a few things which we need to watch for when filling out a release:

1. If the patient has a guardian, we need to have guardianship papers on file.
2. If another member of the family has Power of Attorney, we need to have a copy.
3. In the event of a death, a combination of the patient's death certificate and a court document establishing estate executorship is needed.

The Privacy Rule permits a covered entity to disclose protected health information about a decedent to a family member, or other person who was involved in the individual's health care or payment for care prior to the individual's death, unless doing so is inconsistent with any prior expressed preference of the deceased individual that is known to the covered entity. This may include disclosures to spouses, parents, children, domestic partners, other relatives, or friends of the decedent, provided the information disclosed is limited to that which is relevant to the person's involvement in the decedent's care or payment for care. For uses or disclosures of a decedent's health information not otherwise permitted by the Privacy Rule, a covered entity must obtain a written HIPAA authorization from a personal representative of the decedent who can authorize the disclosure. A decedent's personal representative is an executor, administrator, or other person who has authority under applicable State or other law to act on behalf of the decedent or the decedent's estate.

The following information needs to be filled in:

1. Patient name
2. Date of birth
3. Requested information from
4. Reports to be released to
5. Purpose of request
6. Information to be released [Home](#)

PLEASE NOTE THE FOLLOWING:

- I. If the records contain anything that is related to Psychiatric/Mental Health the patient needs to initial and date. This includes a history of depression, ADHD, etc. Chemical dependency also includes alcohol abuse.
- II. HIV/AIDS related material also needs to be initialed and dated.
- III. If the patient is 14 years old and older and comes to the clinic for Contraception/STD, the minor needs to initial and date the request before it can be released to the parent. This is protected information.
- IV. Pain management needs to be initialed and dated.
- V. They need to sign and date the request.

RECEIVING RELEASE OF MEDICAL RECORDS

When receiving a release of records:

1. Pull the chart and access the patient's account in EHR.
2. Copy/Print (things to watch for)
 - a. HIV reports.
 - b. Mental health records including depression and anxiety.
 - c. Read what the release is asking for and only send what is requested.
 - d. Watch the ACOG (prenatal form) for HIV reports.
 - e. No blue nurse's sheets (from paper charts) are copied unless they are going to a law office.
 - f. Copy HIV and mental health reports ONLY if they have signed the form for this information to be released.
 - i. If information in a note is not authorized to be released and needs to be blacked out be sure to stamp the record and complete a Records Request Letter.
 - ii. Third party records may be released if requested by the patient.

Social Security Disability Determination Services exam notes cannot be released. If you receive a request for information regarding these notes, contact the patient and explain to them they need to contact Social Security Disability Determination Services to gain access to a copy of these notes.

Requested copies are usually mailed out within two weeks; however, legally we have 30 days to comply with the request.

Requests that will not be process are records that contain information that may be harmful to the patient or another person.

[Home](#)

INCOMING MEDICAL RECORDS

1. Scan the incoming records into EHR under “Outside Medical Records” on the Patient Summary Screen.
2. Send an internal message to the provider so they can review the records.

SENDING OUT MEDICAL RECORDS

1. If records are going to another physician for treatment and care, for information on a current medical charge, or directly to the patient you **do not** need to fill out a HIPAA “Accounting of Disclosures of Protected Health Information” form. All other locations receiving records need a form completed.
2. Mark the original request as sent or stamp it faxed, date it, and initial it.
3. Sending out, you can either fax, send out by mail, or send in interdepartmental mail to the local hospitals or local clinics.
4. Request is scanned into EHR on the Patient Summary Screen under “Outside Medical Records”.

RELEASING INFORMATION TO FAMILY AND/OR FRIENDS

1. Patient must sign an Authorization for Release of Information stating who may receive the information and what information they are allowed to receive.
2. Release is scanned into EHR under “Outside Medical Records” with the title Ongoing Release.

FAXING PHI (Protected Health Information)

When faxing PHI, a coversheet **MUST** be used.

PATIENT ACCESS

A patient has a right to see or copy his/her electronic and/or paper medical record.

1. Check the patient’s ID before allowing access to the medical record.
2. Pull the paper chart if appropriate.
3. Take the patient into a private room.
 - a. Patient can page through their paper chart
 - b. Patient can view their electronic medical record, with some help navigating the computer system.

[Home](#)

Dictation

Document all significant observations as soon as possible after each patient contact. When documentation is complete, sign your note and route to the preceptor if necessary. The preceptor will then review and lock the note, which will prevent future editing. If a note needs to be unlocked, the Medical Records Supervisor, Business Manager, and/or Medical Director can unlock the note.

Chart Corrections/Appending a Note

A correction is a change in the information meant to clarify inaccuracies after the original electronic document was signed or rendered complete.

If a correction is needed or if information is missing, the note will need to be appended.

******DO NOT append a note to include actions that took place after the clinic visit, in this case you would open a new progress note to document what took place.**

Deleting a Chart Note

A chart note can be deleted, however, it is strongly advised to review your note and make an attempt to clean up the note and delete only as a last resort.

Letter to patient-DO NOT INCLUDE THE FOLLOWING

HIV results may not be dictated in a letter to the patient. You may dictate a letter stating “the test which was done at the clinic is negative/positive without saying what the name of the test is. Please come to the clinic to get results.” It is encouraged to have the patient come to the clinic for results. Please do not give results over the phone as the identity of the patient cannot be verified.

At no point is a chart ever to leave the UND Center for Family Medicine. If you need information at the hospital, please call and we will fax that for you. Please see MEMO:

Medical Charts-DO NOT REMOVE FROM CLINIC

Due to patient confidentiality, you are NOT allowed to take charts out of the Family Practice Center. This includes taking charts to the hospitals for admissions or taking them off the premises to catch up on dictations.

[Home](#)

Death Certificates

Can be done on line by registering with Division of Vital Records:

Contact person is: Carmell Barth at 701-328-2303. She will set you up with a user number/password and you can sign them electronically.

cbarth@nd.gov

The website is: <https://secure.apps.state.nd.us/doh/evers/login.htm>

West Central Human Services Forms

When you see a patient who is sent to us for an evaluation from WCHS, you will receive two forms in the chart, one is called “Initial Contact Face Sheet”, and the other is called a “Medical Authorization for Title XIX Clinic Services”. These need to be completed and returned to the nurse on the same day as the patient is seen.

[Home](#)

HIPAA

[Definition](#)

[Release Policy](#)

[Minimum Necessary](#)

[Designated Record Set](#)

[Disclosing Proof of Immunization](#)

[Releasing Information to Family and/or Friends](#)

[Releasing Information to Law Enforcement Officials](#)

[Releasing Information for Judicial and Administrative Proceedings](#)

[Deceased Patient Records](#)

[Employee Access to their Own, Family, Friends, Co-Workers PHI](#)

[Patient Access](#)

[Accounting of Disclosures](#)

[Patient's Right to Amend a Medical Record](#)

[Requests for Restriction](#)

[Patient Privacy-Related Complaints](#)

[HIPAA Breach Notification](#)

[User Auditing](#)

[Sanction](#)

[Electronic Communication](#)

[Media Reuse/Disposal](#)

[Instructions for Destruction of Charts](#)

[Notice of Patient Privacy Practices \(NPP\)](#)

[Medicat Contingency](#)

[**Home**](#)

What is HIPAA?

A Federal law, known as "HIPAA" (the Health Insurance Portability and Accountability Act of 1996) requires health care providers to implement a comprehensive approach to protect the privacy of personal health information (PHI).

HIPAA requires all PHI be kept private and secure by all persons that handle, or have access to, that information. Since many health care program students, faculty, instructors, and staff use PHI as part of the educational process (i.e. students in the clinical setting, use of case studies, etc...), these individuals must be trained on the specifics of HIPAA compliance.

University of North Dakota training available at:

<http://www.med.und.edu/administration/education-faculty-affairs/hippa2.cfm>

[Home](#)



Medical Records Release Policy

No. 1
Effective Date 7/1/15

1.0 Purpose

This policy establishes guidelines by which medical records will be released.

2.0 Persons Affected

All employees of UND Center for Family Medicine

3.0 Policy

When using or disclosing PHI, all appropriate HIPAA guidelines will be followed. A patient's written authorization, or release, is required for any use or disclosure of PHI that is not for treatment, payment or health care operations or otherwise permitted or required by HIPAA's Privacy Rule.

4.0 Definitions

4.1 PHI-Protected Health Information

4.2 CE-Covered Entity

5.0 Responsibility

5.1 All employees are responsible for ensuring compliance of this policy

5.2 The Medical Records department is responsible for ensuring all HIPAA guidelines are met when disclosing PHI

6.0 Procedure

6.1 Examples of when a Release of Patient Medical Information form must be completed include if

6.1.1 A patient is transferring their records

6.1.2 We are requesting records from another physician, hospital, or clinic

6.1.3 A patient is requesting their records be sent to another physician, health care, or any other entity

6.2 Examples of when a release does not need to be completed include if

6.2.1 We are referring a patient for further treatment

6.2.2 A patient brings a request for lab work by another physician and it is done at our clinic

6.2.3 An insurance company is requesting records only for the date of service (if they are requesting more records a release must be signed)

6.3 The following information must be completed on the release form

6.3.1 Patient name

6.3.2 Date of birth

6.3.3 Where the information is being requested from

6.3.4 Where the requested information is to be released to

6.3.5 Purpose of this request

6.3.6 Information to be released

[Home](#)

- 6.3.7 If applicable, sensitive information acknowledgment (initial and date)
- 6.3.8 Sign and date request
 - 6.3.8.1 If signed by patient’s guardian or Power of Attorney, a copy of guardianship or Power of Attorney papers must be on file
 - 6.3.8.2 If patient is deceased, a combination of the patient’s death certificate and a court document establishing estate executorship is needed (for specific policy regarding deceased persons see Privacy of Deceased Person Policy)

6.4 After receiving a completed request

- 6.4.1 Pull the paper chart if necessary and/or access the patient’s account in EHR
- 6.4.2 Review the release to verify that only the requested information is released
- 6.4.3 Copy/Print
 - 6.4.3.1 Watch for sensitive information-only copy if release is initialed and dated
- 6.4.4 If information in a note is not authorized to be released black out information and stamp the copy
 - “Redacted” and complete a Records Request Letter
- 6.4.5 Third party records may be released if requested by the patient
- 6.4.6 SOCIAL SECURITY DISABILITY DETERMINATION SERVICES EXAM

NOTES CANNOT BE RELEASED.

If a patient requests these notes, contact the patient and explain to them they need to contact Social Security Disability Determination Services to gain access to a copy of these notes.

- 6.4.7 Requested copies must be mailed out within 30 days.
- 6.5 If records are going to another physician for treatment and care, for information on a current medical charge, or directly to the patient you do not need to fill out an Accounting of Disclosures of Protected Health Information form. All other locations receiving records need a form completed.
- 6.6 After records are sent, mark the original request as sent or faxed, date, and initial
- 6.7 Scan request into EHR on the Patient Summary Screen under “Outside Medical Records”
- 6.8 If a patient’s family and/or friends are requesting PHI, a signed Authorization for Release of Information must be signed by the patient stating who may receive the information and what information they are allowed to receive.
- 6.9 HIPAA rules permit a CE to disclose PHI to law enforcement officials without the individual’s written authorization, under specific circumstances (see Releasing Information to Law Enforcement Officials Policy)

MINIMUM NECESSARY POLICY

When using or disclosing PHI, or when requesting PHI, reasonable efforts will be made to limit the PHI used, disclosed, or requested to the minimum necessary for the purpose of the applicable activity.

Minimum Necessary standard does not apply in the following circumstances:

1. Disclosures to or requests by a health care provider for treatment purposes
2. Uses or disclosures made to the patient or the patient's authorized representative
3. Uses or disclosures made pursuant to a valid authorization (in which case the disclosure will be limited to the PHI specified on the authorization)
4. Disclosures required for compliance with HIPAA and enforcement purposes (for example, the Secretary of Health and Human Services)
5. Uses and disclosures required by law

Accessibility by Workforce Members:

Employees may use, access, or disclose a patient's PHI only when necessary to carry out their normal job duties.

[Home](#)



Designated Record Set Policy

No. 1
Effective Date: 7/1/15

1.0 Purpose

The purpose of this policy is to identify those records that comprise the designated record set.

2.0 Persons Affected

All employees of UND Center for Family Medicine.

3.0 Policy

The HIPAA Privacy Rule Requires that patients be permitted to request access and amendment to their Protected Health Information (PHI) that is maintained in a Designated Record Set. This policy documents the contents of the Designated Record Set.

4.0 Responsibilities

4.1 All UND Center for Family Medicine employees are responsible for following policies and procedures regarding designated record sets.

5.0 Procedure

5.1 Designated Record Set is a group of records maintained by or for UND Center for Family Medicine that consists of the medical records and billing record about a patient and is used, in whole or in part, by or for the facility to make decisions about the patient. The term record means any item, collection, or grouping of information that includes PHI and is maintained, collected, used, or disseminated by or for the facility.

5.2 UND Center for Family Medicine maintains the following as the Designated Record Set:

5.2.1 Patient's clinical record, hard copy and electronic, including but not limited to:

5.2.1.1 Notes or documentation by any health care provider or other individual authorized to make an entry in the patient's clinical record

5.2.1.2 Consultant's reports

5.2.1.3 Diagnostic reports of any type, from within or from outside the clinic

5.2.1.4 Treatment records received from other health care providers and included with the individual's records

5.2.1.5 Health information

5.2.2 Billing records, including, but not limited to

5.2.2.1 Bills, invoices, and statements generated or processed relating to the individual

5.2.2.2 Insurance information regarding the individual

5.2.2.3 Payment records

5.2.2.4 Collection records

5.2.2.5 All other billing, claim, payment, and collection records

5.2.3 Any other record sets used in whole or part to make decisions about the individual.

5.3 Designated Record Set DOES NOT include:

5.3.1 Psychotherapy notes about the patient

5.3.2 Information that is compiled in reasonable anticipation of, or for use in a civil, criminal, or administrative action or proceeding

5.3.3 Risk management records, quality assessment and improvement records, and peer review records that are used for operational analyses and not for making medical decisions about the individual.

5.3.4 Oral communications

5.3.5 Health information generated, collected, or maintained for purposes that do not include decision making about the individual.

[Home](#)



Disclosing Proof of Immunization Policy

No. 1
 Effective Date 7/1/15

1.0 Purpose

This policy/procedure establishes guidelines regarding the disclosure of immunizations

2.0 Persons Affected

All UND Center for Family Medicine employees

3.0 Policy

It is UND Center for Family Medicine’s policy to follow the HIPAA guidelines when disclosing proof of immunizations to a school.

4.0 Responsibilities

- 4.1 The Medical Records department is responsible for obtaining an authorization, either written or verbal, for the disclosure of immunizations.
- 4.2 Nursing is responsible for obtaining an authorization or verifying there is an authorization on file to disclose immunizations.

5.0 Procedure

- 5.1 The Privacy Rule permits disclosure of proof of immunizations to a school that is required by state or other law to have such proof prior to admitting the student, provided the health care provider obtains and documents the authorization to the disclosure from either
 - 5.1.1 A parent, guardian, or other person acting in loco parentis of the student, if the student is an unemancipated minor; or
 - 5.1.2 The student himself/herself, if the student is an adult or emancipated minor
- 5.2 The authorization may be obtained verbally or in writing.
 - 5.2.1 If the agreement is in writing, the release will be scanned into the patient’s account on the Patient Summary screen under the Outside Medical Records heading
 - 5.2.2 If the agreement is verbal, a note documenting the verbal authorization will be documented in the patient’s account.
- 5.3 If applicable, the authorization may be revoked by the parent, guardian, or student.

[Home](#)

RELEASING INFORMATION TO FAMILY AND/OR FRIENDS

1. Patient must sign an Authorization for Release of Information stating who may receive the information and what information they are allowed to receive.
2. Release is scanned into EHR under “Outside Medical Records” with the title Ongoing Release.

[Home](#)

RELEASING INFORMATION TO LAW ENFORCEMENT OFFICIALS

HIPAA Privacy Rule permits covered entities to disclose PHI to law enforcement officials, without the individual's written authorization, under specific circumstances (see below):

A law enforcement official is an officer or employee of any agency or authority of the United States, or a State territory, political subdivision, or Indian tribe who is empowered to (1) investigate or conduct an official inquiry into a potential violation of law; or (2) prosecute or otherwise conduct a criminal, civil, or administrative proceeding arising from an alleged violation of law.

1. To comply with a court order or court-ordered warrant, subpoena, or summons issued by a judicial officer, or a grand jury subpoena. Only that information specifically described in the legal document may be disclosed.
2. To respond to an administrative request, such as an administrative subpoena or investigative demand or other written request from a law enforcement official. This legal document will be issued not by a court of law, but a federal or state agency, or law enforcement official, such as an attorney general. The request for PHI must be specific and limited in scope to the extent possible in light of the law enforcement purpose for which the information is requested; the PHI requested must be relevant and material to a legitimate law enforcement inquire; and de-identified information could not be used.
3. To respond to a request for PHI for purposes of identifying or locating a suspect, fugitive, material witness or missing person; but the covered entity must limit disclosures of PHI to name and address, date and place of birth, social security number, ABO blood type and rh factor, type of injury, date and time of treatment, date and time of death, and a description of distinguishing physical characteristics. Other information related to the individual's DNA, dental records, body fluid or tissue typing, samples, or analysis cannot be disclosed under this provision, but may be disclosed in response to a court order, warrant, or written administrative request.

This same limited information may be reported to law enforcement:

- a. About a suspected perpetrator of a crime when the report is made by the victim who is a member of the covered entity's workforce
 - b. To identify or apprehend an individual who has admitted participation in a violent crime that the covered entity reasonably believes may have caused serious physical harm to a victim, provided that the admission was not made in the course of or based on the individual's request for therapy, counseling, or treatment related to the propensity to commit this type of violent act.
4. To respond to a request for PHI about a victim of a crime and the victim agree.

5. To report PHI to law enforcement when required by law to do so (for example, under state law that requires reporting of gunshot wounds).
6. To alert law enforcement to the death of the individual, when there is a suspicion that death resulted from criminal conduct.
7. To report PHI that the covered entity in good faith believe is evidence of a crime that occurred on the covered entity's premises.
8. When consistent with applicable law and ethical standards:
 - a. To a law enforcement official reasonably able to prevent or lessen a serious and imminent threat to the health or safety of an individual or the public
 - b. To identify or apprehend an individual who appears to have escaped from lawful custody
9. For certain other specialized governmental law enforcement purposes
 - a. To respond to a request for PHI by a correctional institution or a law enforcement officials having lawful custody of an inmate if they represent such PHI is needed to provide health care to the individual or for the health and safety of the individual, other inmates, officers, or employees.
 - b. To federal officials authorized to conduct intelligence, counter-intelligence, and other national security activities under the National Security Act.

When releasing PHI requested by a law enforcement official:

1. Ask for ID (law enforcement badge, for example) and make a copy of the ID for records
 - a. Ask for necessary official paperwork and make copies for records

For accounting of disclosures purposes, record disclosures made under this policy, except 9.b., in the chart of the patient who was the subject of the PHI disclosed.

[Home](#)

Releasing Information For Judicial and Administrative Proceedings

HIPAA's Privacy Rule permits covered entities to disclose PHI in connection with a judicial or administrative proceeding under the following circumstances:

1. In response to a court order or the order of an administrative tribunal, provided that only the PHI requested by the order is disclosed.
2. In response to a subpoena, discovery request, or other lawful process that is not accompanied by an order of a court or administrative tribunal if:
 - a. The covered entity (UND Center for Family Medicine) receives satisfactory assurance from the party seeking the information that reasonable efforts have been made by that party to ensure the individual who is the subject of the PHI has been given notice of the request; or
 - b. UND Center for Family Medicine receives satisfactory assurance from the party seeking the information that reasonable efforts have been made by that party to secure a qualified protective order that meets the following requirements:
 - i. The protective order is an order of a court or administrative tribunal, or a stipulation by the parties to the proceeding that:
 1. Prohibits the parties from using or disclosing the PHI for any purpose other than the litigation or proceeding for which the PHI was requested;
 2. Requires that the PHI (and all copies) be returned to UND Center for Family Medicine or destroyed at the end of the litigation or proceeding.

Satisfactory assurance

The party requesting the information must provide a written statement and accompanying documentation showing:

For a subpoena, discovery request, or other lawful process

1. The party requesting the information has made a good faith attempt to provide written notice to the individual, or the individual's last known address; and
2. The notice included sufficient information about the litigation to permit the individual to raise an objection with the court or tribunal; the time for objections to be filed has passed; and either no objections were filed or, if an objection was filed, the court or tribunal has ruled on it and the ruling permits the disclosure that is being requested; or
3. UND Center for Family Medicine made reasonable efforts to provide notice to the individual that meets the above criteria.

For a qualified protective order

1. The parties to the proceeding have agreed to a qualified protective order and have presented it to the court or administrative tribunal; or

2. The party requesting the PHI has requested a qualified protective order from the court or tribunal.

For accounting of disclosures purposes, record disclosures made under this policy in the chart of the patient who was the subject of the PHI disclosed.

[Home](#)

DECEASED PATIENT RECORDS

Patients retain their right to keep their protected health information private even after death, for a period of 50 years following the death of the patient.

Who is authorized to exercise a deceased patient's rights, including access to a deceased patient's medical records?

- The personal representative of the deceased patient. This will be an executor, administrator or other person authorized under applicable law to act on behalf of the decedent or the decedent's estate. Documents evidence this authority will usually consist of a combination of the patient's death certificate and a court or other legal document showing the representative's authority.
- Protected health information may be disclosed to family members, relatives, and others who were involved in the care or payment for care prior to the patient's death, unless doing so would be inconsistent with any prior expressed preferences by the patient.

For uses or disclosures not permitted, a written authorization must be obtained from the personal representative of the decedent who can authorize the use or disclosure.

Special disclosure provisions:

1. To alert law enforcement of a patient's death, if there is a suspicion that the death resulted from criminal conduct
2. To coroners or medical examiners to identify a deceased patient, determine a cause of death, and perform other functions authorized by law; and to funeral directors as needed
3. For research when the researcher represents that the use or disclosure sought is solely for research on the protected health information of a decedent that the protected health information is necessary for the research, and, if requested, will provide documentation of the death of the individual about whom information is sought.
4. To organ procurement organizations or other entities engaged in the procurement, banking, or transplantation of cadaveric organs, eyes, or tissue for the purpose of facilitating organ, eye or tissue donations and transplantation

[Home](#)

Employee Access to Their Own, Family, Friends, Co-Workers PHI Policy

Employees may not access, through EHR or paper medical charts, information for themselves, family members, friends, co-workers or other individuals for personal or other non-work related purposes, even if written or oral authorization has been given.

In the rare circumstance when an employee's job requires him/her to access and/or copy the medical information of a family member or friend, then he/she should report the situation to his/her supervisor who will assign a different employee to complete the task.

If an employee wishes to access his/her own PHI, he/she must follow the same process for accessing PHI as other patients (a release must be completed).

If an employee wishes to access a family members PHI and a release has been completed, they must follow the same process as other patient's family members.

If an employee violates these guidelines, he/she will be subject to disciplinary action in accordance with UND Center for Family Medicine's Sanction Policy. Routine HIPAA audits, as required by HIPAA law, will be performed.

[Home](#)

Patient Access

Patients, or their personal representatives, have a right to ask to see and get a copy of their protected health information (paper and electronic) that is contained in the designated record set.

The designated record set is the group of records consisting of: the medical and billing records of the patient; and those used to make decisions about the patient.

Procedure

A request for access must be made in writing and must be responded to in a timely manner, but no later than 30 days of receipt of the request. If the request cannot be processed within 30 days, the patient must be provided a written statement containing the reason for the delay and the date on which the information will be provided to the patient (which may be no more than 60 days from the date of the patient's initial request).

Processing Request

Request to inspect in-person

1. Verify the identity of the patient, or if a patient's personal representative, the legal authority of the representative.
2. Document the verification and request to inspect in the patient's chart.
3. Offer the patient or representative a convenient place and time, and private area, if possible, to view the record.

Request for a copy

1. Provide requested copy of the information (paper or electronic) in the form requested if the information is readily producible in such form, or, if not, in a readable hard copy or other form agreed to with the patient.
2. North Dakota state law limits the amount that can be charged for a paper copy of a patient's medical records and medical bills to \$25.00 for the first 25 pages and \$0.75 per page after 25 pages. For an electronic, digital, or other computerized format, the charge is limited to \$30.00 for the first 25 pages and \$0.25 per page after 25 pages. These charges include any administrative fee, retrieval fee, and postage expense.
3. If a copy of the records is requested for purposes of transferring a patient's health care to another health care provider for continuation of treatment, the copy must be provided free of charge.
4. Maintain the written authorization requesting the records in the patient's chart.

Denial of access

The Center for Family Medicine may deny access in the following circumstances.

A. Unreviewable denials:

1. Psychotherapy notes;
2. Information compiled for use in legal proceedings;
3. Certain information held by clinical laboratories;
4. Information requested by an inmate of a correctional institution if granting an inmate copy would jeopardize the health, safety, security, custody, or

rehabilitation of the individual or other inmates, or the safety of any officer, employee, or other person at the correctional institutional or responsible for the transporting of the inmate;

5. Information created or obtained during research that includes treatment, and the patient has previously agreed to the denial of access during the course of the research;
 6. Information contained in records subject to the Privacy Act; and
 7. Information obtained from someone other than a health care provider under a promise of confidentiality, and the copy requested would likely reveal the source.
- B. Reviewable denials, provide the patient is given the right to request a review of the denial, when a licensed health care professional has determined, in the exercise of professional judgment, that:
1. The access requested is reasonably likely to endanger the life or physical safety of the individual or another person;
 2. The information makes reference to another person (other than a health care provider) and the access requested is reasonably likely to cause substantial harm to such other person; or
 3. The request for access is made by the patient's personal representative and the access requested is reasonably likely to cause substantial harm to the individual or another person.

If a patient requests review as allowed under paragraph B above, it must be reviewed by a licensed health care professional designated by the Center for Family Medicine as the reviewer and who did not participate in the original decision to deny. The patient must be informed promptly of the decision.

A patient who has been denied access must be provided a timely written denial, which states in plain language the basis for the denial; and, if applicable, a statement of the patient's review right and how to exercise that right; and a statement of the patient's right to file a complaint with the Center for Family Medicine or the Secretary of HHS and a description of the complaint procedures, along with the name, title and telephone number of the contact person.

A written denial must be maintained in the patient's chart.

[Home](#)

ACCOUNTING OF DISCLOSURES POLICY

Individuals have a right to request an accounting of certain disclosures of their protected health information made by a covered entity in the six years prior to the date of the request.

Procedure:

1. Maintain an accounting of disclosures of protected health information on each patient for at least six years. A disclosure, as defined under 42 C.F.R. § 160.103, is “the release, transfer, provision of access to, or divulging in any other manner of information outside the entity holding the information.”
2. Information that must be tracked and included in an accounting:
 - a. Date of each disclosure
 - b. Brief description of the protected health information disclosed
 - c. Name and, if know, address of the individual/entity who received the information
 - d. Brief statement of the purpose of the disclosure (or a copy of the written request for a disclosure)
 - e. Multiple Disclosures to the same person for the same purpose may have a summary entry. A summary entry includes all information (2 a-de) for the first disclosure, the frequency or number of disclosures made, and the date of the last disclosure.
3. An accounting must include all disclosures except:
 - To carry out treatment, payment, or healthcare operations
 - To the individual of protected health information about that individual
 - Pursuant to a patient’s written authorization
 - Incident to a permissible or required use or disclosure
 - To people involved in the individual’s care
 - For National security or intelligence purpose
 - To correctional institutions or law enforcement officials for certain purposes regarding inmates or individuals in lawful custody
 - Prior to compliance date of April 14, 2003
4. All other disclosures of protected health information must be tracked.
5. Disclosures may be tracked by :
 - a. Manual logs with one log per patient maintained in the patient’s health record
 - b. Authorization forms maintained in the patient’s health record
6. A patient may make a request for an accounting using the Request for Accounting of Disclosures of Protected Health Information form. A copy of both the request and the written accounting that was provided to the patient must be retained, along with documenting the name of individual who received and processed the accounting request.
7. The individual will be provided with an accounting of disclosures within 60 days after receipt of the request.
 - a. If the accounting cannot be provided within 60 days after receipt of the request, the individual will be given a written statement of the reason for the delay and the expected

- b. completion date, which must be no more than 30 days after the initial 60-day processing period.
 - c. Requests can cover a period of up to six years prior to the date of the request.
8. The accounting will be provided to the individual at no charge for a request made during any 12-month period. For any subsequent request within the 12-month period by the same individual, a reasonable fee may be charged provided the individual is informed of the fee in advance and given an opportunity to withdraw or modify the request.

[Home](#)

Patient's Right to Amend a Medical Record

Individuals have the right to request amendment to their PHI in the designated record set for as long as the records are maintained in the designated record set.

Writing Requirement: Requests for amendment must be in writing and the individual must provide a reason to support the requested amendment.

Time period for action: The UND Family Practice Centers must act on an individual's request to amend information within 60 days from receipt of the request. The time may be extended an additional 30 days if the UND Family Practice Centers is unable to act within the original time period for action. To extend the time, provide a written statement of the reasons for the delay to the individual within 60 days from receipt of request. One extension of the time period for action is allowed per request.

Accepting Amendments:

If the UND Family Practice Centers grants the request for amendment in whole or part:

6. Inform the individual in writing that the amendment is accepted.
7. Make the amendment to the PHI or record by identifying the records in the designated record set that are affected and appending or otherwise providing a link to the location of the amendment.
8. Obtain the individual's identification of persons who have received PHI about the individual and need the amendment.
9. Obtain the individual's agreement to have the UND Family Practice Center notify the persons identified in step 3.
10. Make reasonable efforts to inform and provide the amendment within a reasonable time to:
 - i. persons identified by the individual in step 3;
 - ii. persons, including business associates, that UND Center for Family Medicine knows have the PHI that is the subject of the amendment and that may have relied, or could foreseeably rely, upon the information to the detriment of the individual.
11. Follow the process for denying amendments as to any portion of the amendment that is not accepted.

Denying Requests for Amendment:

Requests for amendment may be denied if:

- the information is accurate and complete;
- the PHI or record was not created by UND Center for Family Medicine, unless the individual making the request provides a reasonable basis to believe that the originator of PHI is no longer available to act on the request;
- the PHI is not part of the designated record set; or

- the PHI would not be available to the individual under the following unreviewable grounds for denial of access:
 1. Psychotherapy notes;
 2. Information compiled for use in legal proceedings;
 3. Certain information held by clinical laboratories;
 4. Information requested by an inmate of a correctional institution if granting an inmate copy would jeopardize the health, safety, security, custody, or rehabilitation of the individual or other inmates, or the safety of any officer, employee, or other person at the correctional institutional or responsible for the transporting of the inmate;
 5. Information created or obtained during research that includes treatment, and the patient has previously agreed to the denial of access during the course of the research;
 6. Information contained in records subject to the Privacy Act; and
 7. Information obtained from someone other than a health care provider under a promise of confidentiality, and the copy requested would likely reveal the source.
- The PHI would not be available to the individual under the following reviewable grounds for denying access that must include a determination by a licensed health care professional in the exercise of professional judgement that:
 1. The access requested is reasonably likely to endanger the life or physical safety of the individual or another person;
 2. The information makes reference to another person (other than a health care provider) and the access requested is reasonably likely to cause substantial harm to such other person; or
 3. The request for access is made by the patient's personal representative and the access requested is reasonably likely to cause substantial harm to the individual or another person

All denials must be in writing and must include:

1. the basis for denial;
2. statement of the individual's right to submit a written statement disagreeing with the denial and where to file the statement of disagreement;
3. statement that the individual may request that UND Center for Family Medicine provide the request for amendment and denial with any future disclosures of the PHI that is the subject of the denied amendment; and
4. a description of how the individual may complain to UND Center for Family Medicine or the Secretary of HHS, including the name/title, and telephone number of the Privacy Official.

Disputed Amendments: If the amendment is denied, permit the individual to submit a written statement of reasonable length disagreeing with the denial and the basis for disagreement. If the individual prepares a written statement of disagreement, UND Center for Family Medicine may prepare a rebuttal statement in response. If a rebuttal statement is prepared, provide a copy to the individual who submitted the statement of disagreement.

[Home](#)

Identify the record or PHI in the designated record set that is the subject of the disputed amendment and append or otherwise link the individual's request for amendment, the denial of the request, the individual's statement of disagreement and the rebuttal to the designated record set.

Future disclosures of PHI related to a request for amendment:

If the amendment is accepted, provide the amendment information with any subsequent disclosures. If the request is denied, and the individual does not submit a written statement of disagreement, provide the request for amendment and denial with future disclosures, if the individuals so requests.

If the individual submits a written statement, provide the appended material related to the disputed amendment or an accurate summary of the appended information with any subsequent disclosure of the information to which the request for amendment relates.

When subsequent disclosures are part of a standard transaction that does not allow provision of the required information as part of the transaction, send the amendment information separately to the recipient of the standard transaction.

If UND Center for Family Medicine is informed by another covered entity of an amendment to an individual's PHI agreed to by the other covered entity, amend the PHI in the designated record set maintained by UND Center for Family Medicine.

[Home](#)



Requests for Restriction Policy

No. 1
 Effective 4/1/15
 Date 5/13/15
 Revised

1.0 Purpose

Patient’s right to request restriction on use and/or disclosure of PHI.

2.0 Persons Affected

All employees of UND Center for Family Medicine

3.0 Policy

According to the HIPAA Privacy Rule, patients/personal representatives have the right to request restrictions on the use or disclosure of the individual’s PHI to carry out treatment, payment, or health care operations; or the disclosure of PHI to a family member or friend who is involved with the patient’s care or payment of the patient’s care, but UND Center for Family Medicine is not required to agree to the restriction.

A patient/personal representative also has a right to restrict the disclosure of PHI to a health plan if the PHI pertains to health care services for which the individual or other person has paid for the service in full. UND Center for Family Medicine must agree to the restriction.

4.0 Definitions

4.1 PHI (Protected Health Information)-Individually identifiable health information

4.2 Personal Representative-A person legally authorized to make health care decisions on an individual’s behalf. Documents evidencing this authority includes, a court order appointing them as guardian or durable Power Of Attorney.

5.0 Responsibilities

5.1 All employees shall ensure compliance of this policy.

5.2 The Front Desk staff is responsible for making a copy of the Notice of Privacy Practices available at the time of the individual’s registration and alerting all departments involved in the request for the restriction.

- 5.3 HIPAA Privacy Officer's responsibility to approve/deny all requests for restriction and notify the individual of the decision.
- 5.4 The Billing Department is responsible for excluding the charge from insurance if the patient chooses to restrict visit from their insurance.
- 5.5 The Medical Records Department is responsible for ensuring restricted notes are not released to restricted individuals/organizations.

6.0 Procedure

- 6.1 Individuals will be informed of their rights to request restrictions on how their PHI is used and/or disclosed for treatment, payment, and healthcare operations in the Notice of Privacy Practices, which is offered and available at the front desk upon registration.
- 6.2 Except a restriction on disclosure to a health plan for services paid in full by the patient, UND Center for Family Medicine is not required to approve restrictions but will accommodate reasonable restriction requests when possible.
- 6.3 If an individual requests a restriction, a "Request for Restrictions" form must be completed by the patient/personal representative.
 - 6.3.1 The patient will pay in full on the same day of service if he/she wishes to restrict their insurance company from receiving a claim for services. The front desk will inform the billing department and the nurse.
 - 6.3.2 The front desk will generate an alert stating there is a restriction in the patient's account.
 - 6.3.2.1 Under the Ticket heading, select Transaction Code Restricted and Post the item (Post the item to the correct date of service).
 - 6.3.2.2 Enter what is being restricted i.e. date of service, address/phone, etc. (Make entry very descriptive).
 - 6.3.3 The address, phone number, etc. that the patient does not want to be used will be deleted out of the account.
 - 6.3.3.1 The front desk will explain to the patient when/if they want the old address, phone number, etc. reactivated they will

need to let the Front Desk know since our system is unable to have more than one address in the account.

- 6.3.4** The EMR note will be restricted by the physician/nurse by selecting the Restricted icon in the SOAP note. This will also alert the medical records department that the note is restricted and cannot be sent to the specified organization.
- 6.3.5** All “Request for Restriction” Forms will be given to the HIPAA Privacy and Security Office who will scan the form into the patient’s account and alert all supervisors of the restriction.
- 6.4** If a restriction is accepted, no use or disclosure of the patient’s health information will be made in violation of the specified restriction unless:
 - 6.4.1** Emergency treatment is needed and the restricted information is needed to provide care to the patient. If the information is disclosed to another health care provider for the emergency care, request that the provider not further use or disclose the information.
 - 6.4.2** The Secretary of the U. S. Department of Health and Human Services request the information for compliance and/or investigation purposes
 - 6.4.3** The restricted information is required by the law to be disclosed
- 6.5** An agreed-to restriction may be terminated by the patient or, except a restriction on disclosure to a health plan for services paid in full by the patient, by UND Center for Family Medicine.
 - 6.5.1** The patient may terminate the restriction by one of three ways, which the HIPAA Privacy and Security Officer will be made aware
 - 6.5.1.1** The patient may sign the “Request for Restriction” form on the Request Revoked line
 - 6.5.1.2** The patient may verbally inform the staff of UND Center for Family Medicine that he/she wishes to terminate the restriction
 - 6.5.1.3** The patient may provide a written request to terminate the restriction
- 6.6** If a restriction is terminated the following steps must be completed:
 - 6.6.1** Under the Ticket heading, select Transaction Code Termination and Post the item
 - 6.6.2** Enter what restriction is being terminated (Date of services, Address, Phone, etc.)

6.6.3 Remove the checkmark from the alert in the Alert box.

[Home](#)



Patient Privacy-Related Complaints Policy

No. 1
Effective Date: 7/1/15

1.0 Purpose

Provide a process for patients to file a complaint if the patient feels his or her privacy rights have been violated.

2.0 Persons Affected

All employees of UND Center for Family Medicine

3.0 Policy

UND Center for Family Medicine will follow a process for the patient to file a complaint if he or she feels their privacy has been violated.

- 3.1 The HIPAA Privacy Officer will receive and investigate the complaints.
- 3.2 Any intimidation of or retaliation against patients, families, friends, or other participants in the complaint process is prohibited.
- 3.3 If the patient’s rights have been violated, employees who violates those rights are subject to disciplinary action (see sanction policy).

4.0 Responsibilities

- 4.1 All employees of UND Center for Family Medicine are responsible for following all HIPAA policies and procedures.
- 4.2 The HIPAA Privacy Officer is responsible for investigating and responding to the complaint.

5.0 Procedure

- 5.1 Patients may make a complaint by calling, writing, or presenting in person to the HIPAA Privacy Officer.
- 5.2 The HIPAA Privacy Officer will summarize the complaint on the Patient Complaint Report Form.
- 5.3 The complaint will then be investigated by the Privacy Officer
- 5.4 A written response will be provided to the patient within 30 days from the date the complaint was filed.

A written summary of the complaint and actions taken will be filed with the Privacy Officer.

- 5.5 Patients or others can also file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue S.W., Washington, DC 20201, calling 1-877-696-6775, or visiting www.hhs.gov/ocr/privacy/hipaa/complaints/
- 5.6 All documentation will be retained for six years. [Home](#)

HIPAA BREACH NOTIFICATION POLICY

HIPAA requires a covered entity notify individuals whose unsecured protected health information (PHI) has been impermissibly acquired, accessed, used, or disclosed, compromising the security or privacy of the PHI. Notification only applies to a breach of unsecured PHI.

A. Definitions

1. **Breach** means the acquisition, access, use, or disclosure of PHI in a manner not permitted under HIPAA, which compromises the security or privacy of the PHI.

Breach excludes:

- I. Any unintentional acquisition, access, or use of PHI by a workforce member or person acting under the authority of a covered entity or a business associate, if such acquisition, access, or use was made in good faith and within the scope of authority and does not result in further use or disclosure in a manner not permitted under HIPAA.
 - II. Any inadvertent disclosure by a person who is authorized to access PHI at a covered entity or business associate to another person authorized to access PHI at the same covered entity or business associate, or organized health care arrangement in which the covered entity participates, and the information received as a result of such disclosure is not further used or disclosed in a manner not permitted under HIPAA.
 - III. A disclosure of PHI where a covered entity or business associate has a good faith belief that an authorized person to whom the disclosure was made would not reasonably have been able to retain such information.
2. **PHI** means individually identifiable health information that is transmitted by electronic media, maintained in electronic media, or transmitted or maintained in any other form or medium.
 3. **Unsecured PHI** means PHI that is not rendered unusable, unreadable, or indecipherable to unauthorized persons through the use of technology or methodology, such as encryption or destruction, as specified by the Secretary of Health and Human Services.
 4. **Workforce** means employees, volunteers, trainees, and other persons whose conduct, in the performance of work for a covered entity or business, is under the direct control of such covered entity or business associate, whether or not they are paid by the covered entity or business associate.

B. Discovery of Breach

A breach shall be treated as discovered by a covered entity as of the first day on which such breach is known to the covered entity, or, by exercising reasonable diligence, would have

been known to the covered entity to the covered entity or any person, other than the person committing the breach, who is a workforce member, or agent of the covered entity.

Upon discovery of a potential breach, it shall be reported to the HIPAA Privacy & Security Officer, who shall initiate and document an investigation, including a risk assessment, and, based on the results of the investigation, determine whether notification is required.

A breach is presumed to have occurred unless the covered entity can demonstrate there is a low probability that the PHI has been compromised based on the investigation and risk assessment.

C. Determine if there was a breach

1. Is the data “PHI”?

If the data is not PHI, stop here. No further action is needed.

2. Is the data “unsecured PHI”?

If review determines PHI is secured, stop here. Document your review that came to this conclusion. Document any actions to reduce the likelihood of another breach from reoccurring.

If not, proceed to next step.

3. Determine and document whether the incident falls under one of the exceptions of the breach definition:

- a. Good faith, unintentional acquisition, access, or use of PHI in the course of performing one’s job and such access does not result in further impermissible use or disclosure. (EX: went into the wrong John Smith’s account)
- b. Inadvertent disclosure of PHI by one workforce member to another and no further impermissible use or disclosure of PHI (EX: PHI on employee’s desk and another employee sees)
- c. When PHI is improperly disclosed but the covered entity believes in good faith that the recipient of the unauthorized information would not be able to retain the information.

If the disclosure falls into one of these exceptions, notification is not necessary. You can stop at this point.

If the disclosure does not fall into one of these exceptions, proceed to next step.

4. Complete a **risk assessment** to determine probability of a compromise to the PHI and whether breach notification is required, the HIPAA Breach Notification Rule requires consideration of **at least the following four factors:**

- a. **Nature and extent of the PHI involved, including the types of identifiers and the likelihood of re-identification.**

- I. Identifying financial and demographic data: SS#, credit card info, financial data

- II. Clinical data: Diagnosis, treatment, medications
 - III. Behavioral health, substance abuse, sexually transmitted diseases
 - b. The unauthorized person who used the PHI or to whom the PHI was disclosed**
 - I. Does the person have obligations to protect privacy and security?
 - II. Does the person have the ability to re-identify the PHI?
 - c. Whether the PHI was actually viewed or accessed.**
 - I. Rarely an answer here. Hard to prove.
 - d. The extent to which the risk to the PHI has been mitigated.**
 - I. Can the person who received the PHI provide satisfactory assurances that the PHI will not be further used or disclosed or that it will be destroyed?
 - i. PHI faxed to wrong doctor’s office. They state they will destroy the PHI.
 - ii. Lost flash drive with PHI
 - II. What level of effort has been expended to prevent future related issues and/or to lessen the harm of the actual breach?
5. Can it be concluded that there is a low probability that the PHI has been compromised?
*If so, notification is not necessary. Complete documentation and retain for future reference or investigations (documentation must be saved for 6 years).
 For a medium or high finding that data has been compromised, complete the appropriate notification steps for each individual affected.
 Individuals must be notified within 60 days or without unreasonable delay. If patients are notified HHS must be notified. If over 500 individuals affected HHS notified immediately.*
6. A breach assessment must also be conducted under North Dakota State breach notification law (N.D. Cent. Code Ch. 51-30). (NOTE: **North Dakota breach notification law only applies to computerized data.**)
- a. Was the electronic information “personal information?”

Personal information means an individual’s first name or first initial and last name in combination with any of the following data elements: 1) the individual’s social security number; 2) the operator’s license number; 3) a non-driver color photo identification card number; 4) the individual’s financial institution account number, credit card number, or debit card number in combination with any required security code, access code, or password that would permit access to the individual’s financial accounts; 5) the individual’s date of birth; 6) the maiden name of the individual’s mother; 7) medical information; 8) health insurance information; 9) an identification number assigned to the individual by the individual’s employer; or 10) the individual’s digitized or other electronic signature. Personal information does not include publicly available information that is lawfully made available to the general public from federal, state, or local government records.

If yes, proceed to next question. If no, stop here.

- b. Was the electronic personal information encrypted or otherwise rendered unreadable or unusable?

If yes, stop here. If no, proceed to next question.

- c. Was electronic personal information impermissibly acquired?

Factors to consider in determining whether information has been acquired, or is reasonably believed to have been acquired: 1) Indications that the information is in the physical possession and control of an unauthorized person, such as a lost or stolen computer or other device containing information; 2) Indications that the information has been downloaded or copied; or 3) Indications that the information was used by an unauthorized person, such as fraudulent accounts opened or instances of identity theft reports.

If yes, proceed to next question. If no, stop here.

- d. Does the exception apply:

A good faith acquisition of person information by an employee or agent of the covered entity is not a breach, if the personal information is not used or subject to further unauthorized disclosure.

If yes, stop here. Breach notification is not required. If no, breach notification is required. Complete the steps for notifying affected patients. Unlike HIPAA, North Dakota law does not require notification to the media or the government.

Notification Steps

Notify a patient of a breach:

1. Notification to affected patients must be provided without unreasonable delay and in no case later than within 60 calendar days of when you first discovered the breach.
2. A written notice of the breach by first class mail is required. The notification to the affected patients will include:
 - a. A brief description of what happened
 - b. The date of the breach and the date the breach was discovered
 - c. A description of the type of unsecured PHI involved in the breach
 - d. Steps the patient should take to protect themselves from potential harm as a result of the breach
 - e. A brief description of what the practice is doing to investigate, mitigate, and protect against further breaches

- f. Contact procedures for patients to ask questions or learn more information, which must include a toll-free number, email address, and website or postal address
3. If there is insufficient or out-of-date contact information for 10 or fewer patients, substitute notice may be provided by an alternative form of written notice, telephone, or other methods of contact.
4. If there are 10 or more patients with insufficient contact information, substitute notice may be provided by either a conspicuous posting on the home page of the clinic's website for 90 days or conspicuous notice in major print or broadcast media in geographic areas where the affected patients by the breach likely reside. Both methods must include a toll-free phone number that remains active for 90 days where a patient can learn whether the patient's unsecured PHI may be included in the breach.

Reporting the breach to the Government and the media:

1. Contact UND School of Medicine's Associate Direct of Administration and Finance.
2. If the breach involves 500 or more patients, OCR must be notified without unreasonable delay and in no case later than 60 calendar days after discovery of the breach. Notification to the OCR should be made at the same time notification is made to the affected patients. Notification to the local prominent media is also required without unreasonable delay and in no case later than 60 calendar days after discovery of a breach. The same information must be included for notification to the media as is required for individual notice described above.
3. If the breach involves 499 or less patients, a breach log must be maintained and provided to the OCR on an annual basis (by February 28 of the next calendar year).
4. Breach notification instructions and forms are available at <http://www.hhs.gov/ocr/privacy/hipaa/administrative/breachnotificationrule>

Delay of notification for law enforcement purposes

- A. If a law enforcement official states to the practice that a breach notification, notice, or posting required under HIPAA would impeded a criminal investigation or cause damages to national security the practice shall:
 - a. If the statement is in writing and specifies the time for which a delay is required, delay such notification, notice, or posting for the time period specified by the official;
or

- b. If the statement is made orally, document the statement, including the identity of the official making the statement, and delay the notification, notice, or posting temporarily and no longer than 30 days from the date of the oral statement, unless a written statement as described above is submitted during that time.

Business associate responsibilities

As required under the practice's business associate agreements, a business associate shall, without unreasonable delay and in no case later than 60 calendar days after discovery of a breach of unsecured PHI, notify the practice of a breach. Such notice shall include identification of each individual whose unsecured PHI has been, or is reasonably believed by the business associate to have been, access, acquire^{3d}, used, or disclosed during the breach. The business associate shall provide the practice with any other available information that the practice is required to include in notification to the patient at the time of the notification or promptly thereafter as information becomes available. Upon notification by the business associate of discovery of breach, the practice will be responsible for notifying affected patients, unless otherwise agreed upon by the business associate agreement.

[Home](#)



User Auditing Policy

No. 1
Effective Date: 7/1/15

1.0 Purpose

To ensure that appropriate safeguards are in place to protect the confidentiality, integrity, and availability of patient ePHI. To ensure these safeguards are in place and effective, user access and activity will be audited.

2.0 Persons Affected

All UND Center for Family Medicine employees.

3.0 Policy

All Mediat users’ access and activity of ePHI will be audited biannually, unless suspicious activity or a patient complaint warrants an investigation.

4.0 Definitions

4.1 Audit-Internal process of reviewing system access and activity.

4.2 ePHI-Electronic protected health information

4.3 Audit Log-Record of activity maintained by the system

4.4 Audit Trail-Means to monitor system operations by providing a chronological series of events.

An audit trail identifies who (login) did what (create, read, modify, delete, add, etc.) to what (data) and when (date, time)

5.0 Responsibilities

5.1 HIPAA Privacy and Security Officer and Risk Management Director to audit all users.

6.0 Procedure

6.1 The HIPAA Officer and Risk Management Director will audit all users by running security audit log reports

6.1.1 Select Administration

6.1.2 Select Security Audit Logs

6.1.3 Select the user and date range. Refresh to populate the audit log, which will show the audit trail of the user.

6.2 The auditing process will address

6.2.1 Login/logoff attempts-appropriate times/dates, denials, “timeout sessions”

6.2.2 User activity-accounts accessed, activity performed

6.3 An Audit Form will be completed for each user, indicating the user, who reviewed the audit, the date range the audit was completed for and what activity was found.

6.4 If unauthorized activity is found

6.4.1 Further investigation will be completed

6.4.2 The supervisor will be notified

- 6.4.3** If unauthorized activity is performed by a supervisor, the HIPAA Officer will address the activity
- 6.4.4** Appropriate corrective action will be taken and documented on the Audit Form
- 6.5** Audit summaries will be retained for six years.

[Home](#)

SANCTION POLICY

All employees must comply with all security and privacy policies and procedures or disciplinary action will be taken. It is every employee's responsibility to report a suspected breach.

Examples of some possible breaches are listed below; however, these are just some examples and not a complete list:

- Employee faxes the wrong PHI to another practice
- Employee emails PHI
- Employee views patient records out of curiosity, not necessity
- Employee shares PHI because the information is interesting or gossip-worthy, but not for treatment
- Employee shares computer passwords
- Employee discusses confidential patient information in an unsecure area
- Employee uses PHI for personal gain
- Employee uses PHI to cause harm, such as exposing information to unauthorized individuals out of spite or dislike of the owner of the PHI
- Employee gives access to PHI to an unauthorized individual

Failure to comply with all security and privacy policies and procedures could result in a verbal and/or written warning, re-education, suspension, or termination. The appropriate sanction for a violation will depend on the severity of the violation; for example, whether it was intentional or unintentional and whether it was part of or indicates a pattern or practice of improper use and disclosure of PHI.

Employees could also face civil or criminal penalties. Each breach will be handled on a case-by-case basis.

[Home](#)

Electronic Communications

Purpose

To assure the appropriate use of electronic communication within the UND Center for Family Medicine in addition to the general UND Computing and Network Usage Policy.

Procedure

Password Protection:

All assigned to or created passwords by an employee are private and should not be shared with others. All electronic devices and applications shall be password protected. Passwords need to be changed frequently using a unique password.

Workstation screensavers shall be password protected to prevent a possible breach of PHI.

Only use a program under your personal login information. Do not use a program accessed by another employee. Log employee out and then log in with your information.

E-mail:

When using the University of North Dakota's e-mail system, the individual user must understand that it is an unsecure form of communication. NO patient protected health information (PHI) may be included in the message. Care must be taken at all times to protect against a HIPAA breach.

E-mail is used within the clinic appropriately by staff using the University assigned email address for an employee. By State of North Dakota law, university email content is considered public record, and thus may be open and accessible for inspection.

E-mail communication with patients shall be done with a secure system. Encryption is the only approved mechanism to electronically transmit PHI. The use of the Mediat EMR patient portal will provide a secure means to communicate with patients.

Mobile Applications:

Google Drive is accessed on mobile devices to be used by Providers for patient care. It is administered by a designated UND Center for Family Medicine Faculty member. Each member (Provider's Only) is added by the Administrator to the application. A password is needed to access the application. Information on is updated by Providers and provides a means of communication for each patient.

Personal Device:

All personal devices are not required by staff to fulfill an employee's job requirements. By State of North Dakota law, all electronic communication records are public records, and thus may be open and

accessible for inspection. The use of personal devices opens the employee to personal liability for discoverable electronic communication.

Texting:

Intelliweb is available on all computers in the clinic to text providers. Follow this link:

<http://206.208.80.22/>

When using texting the individual user must understand that it is an secure form of communication. NO patient protected health information (PHI) may be included in the message. Care must be taken at all times to protect confidential information.

Texting should not replace a phone conversation in order to avoid miscommunication between you and the patient or employee. Texting should be avoided during patient care to prevent errors.

Texting is not to be used for communication with patients.

Social Media:

Social media is a means of communication using web-based and mobile technologies for the exchange of information. Social Media is not to be used for communication with patients about patients and/or their PHI. No health or medical related information that relates to official activities may be posted on social media.

Lost or Stolen Device:

All lost or stolen devices need to be reported to the department supervisor as soon as possible. The mobile provider will need to be called to deactivate the phone. If a PHI breach is a concern the HIPAA officer will need to notified of the breach.

Applications are available for devices that can locate the lost device and the phone can be remotely locked or the information can be deleted from the phone. i.e. Find My iPhone. It is recommended that electronic mobile devices have this or a similar application.

Termination or Resignation of Employment:

All employee access to current software applications and devices will be deactivated. This includes but is not limited to Medicat, Orchard Harvest, Round's List, e-mail, e-prescribe etc.

For complete UND policy see the office of Human resources and Payroll Services Annual Notification of Policies.

[Home](#)



Media Reuse/Disposal Policy

No. 1
 Effective 4/1/15
 Date:

1.0 Purpose

This policy/procedure establishes guidelines by which media containing PHI will be reused and/or disposed of.

2.0 Persons Affected

All employees in the Medical Records, Laboratory, and Radiology Departments at UND Center for Family Medicine that process ePHI requests.

3.0 Policy

It is UND Center for Family Medicine’s policy to ensure the privacy and security of PHI in the maintenance, retention, and eventual destruction of media. Media containing PHI may be reused when appropriate steps are taken to ensure that all stored PHI has been effectively rendered inaccessible.

3.1 If a request that PHI be received in electronic form, however the media is not picked up by the patient after 30 days, the media will be wiped and reused.

4.0 Definitions

4.1 ePHI (Electronic Protected Health Information)-Any individually identifiable health information protected by HIPAA that is transmitted by or stored in electronic media.

4.2 Media- Any device which will be used to store ePHI. (CD, USB drives, etc.)

5.0 Responsibilities

Anyone who processes a request for ePHI will ensure media is wiped before using.

6.0 Procedure

6.1 Any media device not picked up by the patient after 30 days will be wiped clean by deleting all records.

6.1.1 Insert CD

6.1.2 Select Computer on your menu

6.1.3 Select the CD you are working with

6.1.4 Right click and select Format. Remove the “label” and start the format, which will erase everything on the CD

6.2 If a media device must be destroyed, the media will be placed in the locked shred bin where it will be disposed of properly.

[Home](#)

INSTRUCTIONS FOR DESTRUCTION OF CHARTS

Retention schedule is:

1. Decreased for more than 10 years
2. Date of last visit plus 10 years or until age 19, whichever is longer

Example:

1. Patient was 2 years old on last visit date-can be destroyed
2. Patient was 17 years old on last visit date-must add another 10 years before being destroyed.

**ALL CHARTS FOR DESTRUCTION MUST BE RECORDED
IF USING THE LAPTOP COMPUTER, INSERT THE USB FLASH DRIVE**

Record in Microsoft Office Excel

Go to Microsoft office Excel
Open folder
Select patient chart for destruction
Click on open

[Home](#)

University of North Dakota

Bismarck Center for Family Medicine

701 E. Rosser Ave
Bismarck, North Dakota 58501
701.751.9500 Fax: 701.751.9508

NOTICE OF PATIENT PRIVACY PRACTICES

Effective Date June 1, 2015

Your Information. Your Rights. Our Responsibilities.

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. **Please review it carefully.**

Your Rights

You have the right to:

- Get a copy of your paper or electronic medical record
- Ask us to correct your paper or electronic medical record
- Request confidential communication
- Ask us to limit the information we use or share
- Get a list of those with whom we've shared your information
- Get a copy of this privacy notice
- Choose someone to act for you
- File a complaint if you believe your privacy rights have been violated

Your Choices

You have some choices in the way that we use and share information as we:

- Tell family and friends about your condition
- Provide disaster relief
- Provide mental health care

Our Uses and Disclosures

We may use and share your information as we:

- Treat you
- Run our organization
- Bill for your services
- Help with public health and safety issues
- Do research
- Comply with the law
- Respond to organ and tissue donation requests
- Work with a medical examiner or funeral director
- Address workers' compensation, law enforcement, and other government requests
- Respond to lawsuits and legal actions

Your Rights

When it comes to your health information, you have certain rights. This section explains your rights and some of our responsibilities to help you.

Get an electronic or paper copy of your medical record

- You can ask to see or get an electronic or paper copy of your medical record and other health information we have about you. Ask us how to do this.

- We will provide a copy or a summary of your health information, usually within 30 days of your request. We may charge a reasonable, cost-based fee.

Ask us to correct your medical record

- You can ask us to correct health information about you that you think is incorrect or incomplete. Ask us how to do this.
- We may say “no” to your request, but we’ll tell you why in writing within 60 days.

Request confidential communications

- You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address.
- We will say “yes” to all reasonable requests.

Ask us to limit what we use or share

- You can ask us not to use or share certain health information for treatment, payment, or our operations. We are not required to agree to your request, and we may say “no” if it would affect your care.
- If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer. We will say “yes” unless a law requires us to share that information.

Get a list of those with whom we’ve shared information

- You can ask for a list (accounting) of the times we’ve shared your health information for six years prior to the date you ask, who we shared it with, and why.
- We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We’ll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

Get a copy of this privacy notice

You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.

Choose someone to act for you

- If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information.
- We will make sure the person has this authority and can act for you before we take any action.

File a complaint if you feel your rights are violated

- You can complain if you feel we have violated your rights by contacting us at our address or phone number listed at the beginning of this notice.
- You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting www.hhs.gov/ocr/privacy/hipaa/complaints/.
- We will not retaliate against you for filing a complaint.

Your Choices

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

In these cases, you have both the right and choice to tell us to:

- Share information with your family, close friends, or others involved in your care
- Share information in a disaster relief situation

If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.

Our Uses and Disclosures

How do we typically use or share your health information?

We typically use or share your health information in the following ways.

Treat you

We can use your health information and share it with other professionals who are treating you.

Example: A doctor treating you for an injury asks another doctor about your overall health condition.

Run our organization

We can use and share your health information to run our practice, improve your care, and contact you when necessary.

Example: We use health information about you to manage your treatment and services.

Bill for your services

We can use and share your health information to bill and get payment from health plans or other entities.

Example: We give information about you to your health insurance plan so it will pay for your services.

How else can we use or share your health information?

We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html.

Help with public health and safety issues

We can share health information about you for certain situations such as:

- Preventing disease
- Helping with product recalls
- Reporting adverse reactions to medications
- Reporting suspected abuse, neglect, or domestic violence
- Preventing or reducing a serious threat to anyone's health or safety

Comply with the law

We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.

Respond to organ and tissue donation requests

We can share health information about you with organ procurement organizations.

Work with a medical examiner or funeral director

We can share health information with a coroner, medical examiner, or funeral director when an individual dies.

Address workers' compensation, law enforcement, and other government requests

We can use or share health information about you:

- For workers' compensation claims
- For law enforcement purposes or with a law enforcement official
- With health oversight agencies for activities authorized by law
- For special government functions such as military, national security, and presidential protective services

Respond to lawsuits and legal actions

We can share health information about you in response to a court or administrative order, or in response to a subpoena.

Our Responsibilities

- We are required by law to maintain the privacy and security of your protected health information.

- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

Records Retention

Your medical records will be maintained for as long as you are a patient at the UND Center for Family Medicine at Bismarck. Your medical records are kept for 10 years after the date of your last visit or until age 19, whichever is longer. When your medical records have met their retention time they will be destroyed following appropriate procedure.

For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html.

Changes to the Terms of this Notice

We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, in our office, and on our web site.

[Home](#)

Medicat Contingency

Purpose:

To provide a plan for each clinic department to follow when the computers and/or software are not working properly.

ALL DEPARTMENTS:

Retain copies all forms listed in this policy for use. Update forms on a yearly basis if applicable.

Front Reception:

**All patient charts will be gathered for the day's appointments and placed at the front reception desk. Print Roster of the day's appointments from NOTIFYMD if possible. Retrieve daily appointment schedules on the NotifyMD flashdrive. Files will be stored on the flashdrive for 30 days. It is locked nightly in the safe.

New Patient

3. New Patient will fill out Registration Form completely.
4. Photo Copy all photo identification and all insurance cards. Verify information on registration form.
 - a. Receptionist will transfer information to template, Patient Registration Labels and print a sheet of labels for each patient to follow the patient throughout their appointment.

Established Patient

1. Receptionist will verify information in patient's chart and make photocopies of any updated insurance or photo identification cards.
2. Receptionist will transfer information to template, Patient Registration Labels and print a sheet of labels for each patient to follow the patient throughout their appointment.

Label a travel ticket and clip all information to the ticket or place in the chart.

Record patient room number on patient list. Nursing will provide number to the front desk.

Keep a label for each patient and start a list of patients seen for that day. Update patient information from this list when computer software is operational. File list of patients with medical records supervisor.

Copayments will be kept on receipt books. A label will be placed on all copies of the receipts to include Name and DOB. Staple a copy of the receipt to the travel ticket.

NEED: Patient Registration Forms
Formatted Label Template
One additional staff for patient registration and runner (Business Office)
Receipt Books

Nursing/Physicians:

Nurses will copy NOTIFYMD and sort out (highlight) their physicians appointments for the day.

Notify Nurse by calling the Nurse extension or paging overhead with PAGE 1.

Chart, Charge Ticket, Registration Information, Labels can be found in stacker upfront.

Chart requests can be made by phone to the Medical Records department.

[Home](#)

Nurse will provide the front desk with the patient's room number and the nurse will record it on the travel ticket.

SOAP/Progress Notes: Progress Notes form will be stamped with Date and Vitals Stamp.

REFERRALS: Handwritten and faxed appropriately. Retain with progress notes for the visit.

DICTATION: SOAP NOTE when possible in Mediat with Original DOS noted or Dictation Line.

PRESCRIPTIONS: Hand written on prescription pads. Keep copy with the progress notes for the visit.

HISTORY/MEDICATION: Medication and History forms will be used for documentation. Retain with progress notes for the visit.

IMMUNIZATIONS: VAR forms. Retain with progress notes for the visit. Update THOR.

COMMUNICATION & NURSES ORDERS: Communication and Encounter Forms. Document phone calls, orders and other communication and retain copy for updating Mediat.

PATIENT EDUCATION: Refer patient to appropriate websites. Followup with patient when possible.

Lab/X-ray Orders: Fill out lab and x-ray requisitions completely as possible. Including name, DOB, chart #, ordering physician, dx codes. Place Orders in Lab/X-ray Stacker. Remember to mark WAITING or NOT-WAITING.

Patient Phone numbers can be found on the NOTIFYMD flash drive if unavailable in chart or on lab reports.
Nursing will set up a file folder in each hallway and instruct all nurses and physicians to file completed patient information in the files until computers are operational. To include: Travel Ticket, reports and progress notes.

NEED: Progress Notes
Folder for completed patient travel ticket and information
Health History Form
Bright Futures Forms
Communication and Encounter Forms
Medication Forms
Vitals Stamp
Referral Form
VAR Forms (Immunizations)
Diagnosis Code-Cheat sheets
One additional staff for each hallway chart needs and runner (Business Manager and Office)

LAB/Radiology:

Lab/X-ray will watch stacker for orders.

Insurance information will travel with charge ticket

Waiting Patients will be returned to their exam room by lab/xray.

Not-waiting Patients will leave the clinic.

NEED: Lab Requisition
Xray Requisition

[Home](#)

Medical Records

Nursing/Physician Chart Request-Call Ext 26758

Appointment Chart Request- Call Ext 26757

Business Office

Assist other departments as needed

Residents/Faculty

Scheduling can be found on the Amion Schedule and at the front reception desk.

POST COMPUTER DOWNTIME

Master list of patients will be copied and sent to Appointment, Nursing and Business Office Supervisors.

Travel Tickets and attached information will be routed to Appointment Desk to be entered into Mediat.

Appointment Desk can enter appointments by going to the original DOS and entering appointments for each patient.

Travel Tickets will be sent through the clinic in the following order:

Appointment Desk>Nurse>Physician>Business Office>Medical Records

Physicians and Nurses will update history and medication for the patient and visit documentation will be added by attaching dictation or completing a SOAP Note with noting the Original DOS. Referrals will be added to the patients records as necessary.

Manage Rcopia as needed for patient.

Medical Records will audit chart for completion.

[Home](#)

BUSINESS OFFICE

[Clinic Fee Ticket](#)

[Guidelines for Determining Fees](#)

[New Patient Fees](#)

[Diagnosis](#)

[Hospital Fee Ticket](#)

[Professional Courtesy](#)

[Financial Assistance](#)

[Financial Assistance Adjustments](#)

[Collections](#)

[Home](#)

CLINIC FEE TICKETS

The level of service needs to be checked by the physician and given to the receptionist for payment, or submitted to insurance.

1. Patient billing information.

- a. Patient name, date of birth, sex
- b. Responsible party
- c. Patient record number
- d. Date of the patient's visit
- e. Doctor's name
- f. Name of insurance company, copy of the insurance card is scanned , policy holder, and policy holder's DOB
- g. Social Security Number
- h. Home, Cell and work telephone number
- i. Account billing address

2. Miscellaneous information

- a. Prenatal charge slips should have "OB" written on the diagnosis line.
- b. Medicare is to be stamped in blue with attending physician initials or written, near label and then to be written on the schedule by appropriate names. New patient is stamped in green. Include Medicare stamp for medicare patients for PQRI measures.
- c. Date of accident
- d. Type of surgery
- e. Diagnosis – Indicate on the fee ticket the diagnosis. The diagnosis should be the condition, probable, or the reason for the encounter of the visit. No rule out diagnosis is acceptable. If encounter is for yearly routine visit, please note the primary diagnosis as yearly exam and use preventive medicine E/M codes and secondary diagnosis as problem symptom complaints. All lab work needs to have a diagnosis.
- f. **Elective/Non-Covered Tests and Procedures** – Medicare patients having lab work done for routine, patients request and a non-covered diagnosis not warranting the service must have a wavier completed. The wavier states that you, the physician, discussed with the patient that their Medicare may not pay for the designated lab work. Please check wavier signed on charge ticket.

[Home](#)

Guidelines for Determining Fees

1. The doctor is responsible for checking the appropriate level of service.
2. Established Patients

A. LEVEL ONE – 99211 Office or other outpatient visit for the evaluation and management of an established patient, this may not require the presence of a physician or other qualified health care professionals.

Usually, the presenting problem (s) are minimal.

Typically, 5 minutes are spent performing or supervising these services

B. LEVEL TWO – 99212 Office or other outpatient visit for the evaluation and management of an established patient, which requires at least two of these three key components:

- a problem focused history
- a problem focused examination
- straightforward medical decision making

Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem (s) and the patient's and/or family's needs.

Usually, the presenting problem (s) are self-limited or minor. Physicians typically spend 10 minutes face-to-face with the patient and/or family.

C. LEVEL THREE – 99213 Office or other out patient visits for the evaluation and management of an established patient, which requires at least two of these three key components.

- an expanded problem focused history
- an expanded problem focused examination
- medical decision making of low complexity

Counseling and coordination of care with other physicians, other qualified health care professionals, or agencies, are provided consistent with the nature of the problem (s) and the patient's and/or family's needs.

Usually, the presenting problem(s) are of low to moderate severity. Physicians typically spend 15 minutes face-to-face with the patient and/or family.

D. LEVEL FOUR – 99214 Office or other outpatient visit for the evaluation and management of an established patient, which requires at least two of these three key components.

- A detailed history
- A detailed examination
- Medical decision making of moderate complexity

Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs.

Usually, the presenting problem(s) are of moderate to high severity. Physicians typically spend 25 minutes face-to face with the patient and/or family.

[Home](#)

5. **LEVEL FIVE - 99215** Office or other outpatient visit for the evaluation and management of an established patient, which requires at least two or these key components.

- A comprehensive history
- A comprehensive examination
- Medical decision making of high complexity

Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and /or family's needs.

Usually, the presenting problem(s) are of moderate to high severity. Physicians typically spend 40 minutes face-to-face with the patient and/or family.

6. Accident/Emergency Care – The “Date of Injury” is required on the fee ticket (D.O.I.). The diagnosis must be specific as to how the injury occurred. If laceration repair the length of laceration and place of laceration is required.
7. Counseling Limited – The amount of time spent needs to be documented on the fee ticket, if visit exceeds 50% of time of exam.
8. Level of office visit should be used when a patient has an exam prior to a surgery. The type of surgery and the name of the surgeon is also required on the fee ticket. The person responsible for performing a service is also responsible for recording the fee on the fee ticket.

Physicians should check level of office visit, last person to perform a cosmetic service(s) gives the patient the fee ticket with instructions to take it to the cashier/front reception. The patient is instructed to pay at the cashier. Payment at the time of service is requested.

C. **NEW PATIENT**

1. **LEVEL ONE – 99201** Office or other outpatient visit for the evaluation and management of a new patient which requires these three key components:

- A problem focused history
- A problem focused examination
- Straightforward medical decision making

Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs.

Usually, the presenting problems are self limited or minor. Physicians typically spend 10 minutes face-to-face with the patient and/or family.

2. **LEVEL TWO – 99202** Office or other outpatient visit for the evaluation and management of a new patient, which requires these three key components:

- An expanded problem focused history
- An expanded problem focused examination
- Straightforward medical decision making

Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs.

Usually, the presenting problem(s) are of low to moderated severity. Physicians typically spend 30 minutes face-to-face with the patient and/or family.

3. **LEVEL THREE – 99203** Office or other out patient visit for the evaluation and management of a new patient, which requires these three key components:

- A detailed history
- A detailed examination
- Medical decision making of low complexity

Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs.

Usually, the presenting problem(s) are of moderate severity. Physicians typically spend 30 minutes face-to-face with the patient and/or family.

4. **LEVEL FOUR – 99204** Office or other outpatient visit for the evaluation and Management of a new patient, which requires these three key components:

- A comprehensive history
- A comprehensive examination
- Medical decision making of moderate complexity

Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs.

Usually, the presenting problem(s) are of moderate to high severity. Physicians typically spend 45 minutes face-to-face with the patient and/or family.

5. **LEVEL FIVE – 99305** Office or other outpatient visit for the evaluation and management of a new patient, which requires these three key components:

- A comprehensive history
- A comprehensive examination
- Medical decision making of high complexity

Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs.

Usually, the presenting problem(s) are of moderate to high severity. Physicians typically spend 60 minutes face-to-face with the patient and/or family.

Diagnosis

Diagnosis must be recorded on EVERY charge ticket. The physician is responsible for writing the diagnosis on the bottom of the charge ticket.

[Home](#)

Hospital Ticket Fee

A hospital fee ticket (purple sheet) is completed, by the physician, on all Center for Family Medicine patients, for admissions, consultations, and ER services. Patients are billed directly from the hospital fee ticket. All information concerning the patient's care must be recorded daily.

It is the Chief's responsibility to make sure all hospital fee tickets (purple sheets) from both hospitals are accounted for, filled out/completed, and given to the billing office.

1. The hospital fee ticket must include:
 - a. Date of admission
 - b. Date of discharge
 - c. Total number of days the patient was hospitalized
 - d. Physician's signature/attending physician's initials
 - e. Diagnosis and all procedures performed by the CFM physician
 - f. Name of physician requesting consultation
 - g. ER visit and level
 - h. EKGs are to be recorded
 - i. Any procedure done
 - j. For critical patients, the physician has to document time spent with patient

The fee tickets are available at both hospitals and are usually placed in the patient's chart by hospital personnel when the patient is admitted. If not available on the chart, please ask the nursing staff for one.

Hospital personnel will forward the hospital fee ticket to the CFM when the patient is discharged.

Fee sheets are purple with our logo. Make sure the patient's name is stamped on or is on the hospital sheet.

It is the chief residents duty to make sure all charge tickets are completed and handed in to the billing department.

Professional Courtesy

1. 100% Courtesy: (excluding any cosmetic services. i.e. hair removal, botox)
 - a. Center for Family Medicine physicians, and their dependents.
Please Note: Eligible dependents are defined as those that reside within the same household.
 - b. Employees, their spouse and dependent children
2. Physician's Professional Fee (excluding lab tests, x-rays, shots, supplies, etc.)
 - a. Medical students and their dependents
3. Miscellaneous

- a. Individual consideration for a discount for any patient may be available with approval of the Business Manager. Please notify Linda in the Business Office if you have an inquiry.
- b. In all cases of professional courtesy, where health insurance benefits are payable, the Center for Family Medicine will file a claim for the full insurance benefit, and adjustments are made after receiving Insurance Explanation of Benefits.

[Home](#)

Financial Assistance

Purpose:

UND Center for Family Medicine – Bismarck (UND CFM) is committed to providing quality health care to individuals and families in the Bismarck –Mandan community regardless of their ability to pay. This charity care policy is in effect for uninsured patients seeking medical services. It is also in effect to serve as a consistent, objective process for determining eligibility.

Policy:

In recognizing its responsibility to provide healthcare to members of the community, the UND CFM offers reduced or free care to eligible patients. Eligibility for this program is based on verified annual household income and family size. Each applicant will be required to complete an application form and provide the requested supporting documentation for verification. The income standards used are in accordance with the Federal Poverty Guidelines established by the Health and Human Services Department.

Responsibilities of UNDCFM

- Will allow all patients the opportunity to apply for charity care.
- Will respond within 14 days of receipt of application with either a denial or approval letter.
- Will allow the applicant 14 days to appeal a denial or correct any errors in documentation
- Will work with any denied applicant in determining a payment plan
- Documentation of successful and unsuccessful requests for charity care will be kept on file.

Responsibility of Applicant:

- Will actively participate in the screening process
- Will complete the application, Financial Assistance Application, in full and return it to UND CFM within 14 days
- Will annually re-apply for charity care eligibility

If responsibilities are not followed, the application will be denied and the applicant will be responsible for all outstanding balance.

Other Conditions:

- Only one denial request for review will be offered per year
- Conditions of the policy are subject to change
- Persons who are found eligible for charity care, that have not been extended 100% charity care, are still required to make monthly payments on their accounts. If the account becomes delinquent, the charity care will be reversed and the remaining outstanding amount will be sent to collections.

[Home](#)

{BlankPage}

[Home](#)

Charity Care Adjustments										
Based on 2014 Federal Poverty Guidelines										
Family Size	100% Discount		80% Discount		60% Discount		40% Discount		20% Discount	
	Above	Below	Above	Below	Above	Below	Above	Below	Above	Below
1	\$0	\$ 11,670	\$ 11,671	\$ 14,588	\$ 14,589	\$ 17,505	\$ 17,506	\$ 20,423	\$ 20,424	\$ 23,340
2	\$0	\$ 15,730	\$ 15,731	\$ 19,663	\$ 19,664	\$ 23,595	\$ 23,596	\$ 27,528	\$ 27,529	\$ 31,460
3	\$0	\$ 19,790	\$ 19,791	\$ 24,738	\$ 24,739	\$ 29,685	\$ 29,686	\$ 34,633	\$ 34,634	\$ 39,580
4	\$0	\$ 23,850	\$ 23,851	\$ 29,813	\$ 29,814	\$ 35,775	\$ 35,776	\$ 41,738	\$ 41,739	\$ 47,700
5	\$0	\$ 27,910	\$ 27,911	\$ 34,888	\$ 34,889	\$ 41,865	\$ 41,866	\$ 48,843	\$ 48,844	\$ 55,820
6	\$0	\$ 31,970	\$ 31,971	\$ 39,963	\$ 39,964	\$ 47,955	\$ 47,956	\$ 55,948	\$ 55,949	\$ 63,940
7	\$0	\$ 36,030	\$ 36,031	\$ 45,038	\$ 45,039	\$ 54,045	\$ 54,046	\$ 63,053	\$ 63,054	\$ 72,060
8	\$0	\$ 40,090	\$ 40,091	\$ 50,113	\$ 50,114	\$ 60,135	\$ 60,136	\$ 70,158	\$ 70,159	\$ 80,180
% of Pove	100%		125%		150%		175%		200%	

{Blank Page}

[Home](#)

COLLECTION POLICIES

1. Payment is expected at the time of service unless arrangements are made with the patient accounts representative, or insurance coverage is available.
2. The front desk will collect **co-pays** at the time of service. This is to be done in every case where we know the deductible and co-pay amounts. A routine collection of \$25 should be collected when co-pay amounts cannot be determined.
3. The insurance office will bill all insurance carriers. The patient is responsible to provide proper insurance information to the front desk.
4. If no insurance, a minimum of \$25 is requested up front. After visit, patient is to set up payment arrangements in the Business Office.
5. All collection activities are subject to some flexibility depending on known history of the patient and availability of staff.
6. All account balances older than 120 days are subject to collections. Collection letter #1 will be sent and if no response is generated within 30 days, letter #2 will be sent. If there is still no response from the account holder within 20 days of letter #2 then the account will be turned over to the collection agency and written off. All accounts ready to be sent to collections must be approved by the Business Manager, Associate Dean of Administration and Finance, and Accounting Services Director.

DOCUMENTATION GUIDELINE FOR EVALUATION AND MANAGEMENT SERVICES

Medical record documentation is required to record pertinent facts, findings, and observations about the individual's health history including past and present illnesses, examinations, tests, treatments, and outcomes. The medical record chronologically documents the care of the patient and is important element contributing to high quality care.

GENERAL PRINCIPLES OF MEDICAL RECORD DOCUMENTATION

The principles of documentation listed below are applicable to all types of medical and surgical services in all settings. For Evaluation and Management (E/M) services, the nature and amount of physician work and documentation varies by type of service, place of service and the patient's status. The general principles listed below may be modified to account for these variable circumstances in providing E/M services.

7. The medical record should be complete and legible.
8. The documentation of each patient should include:
 - Reason for the encounter and relevant history, physical examination findings and prior diagnostic results;
 - Assessment, clinical impression or diagnosis;
 - Plan for care;
 - Date and legible identity of the observer.
9. If not documented, the rationale for ordering diagnostic and other ancillary services should be easily inferred.
10. Past and present diagnoses should be accessible to the treating and/or consulting physician

11. Appropriate health risk factors should be identified.

12. The patient's progress, response to and changes in treatment, and revision of diagnosis should be documented.

The CPT and ICD-9CM codes reported on the health insurance claim form or billing statement should be supported by the documentation in the medical record

[Home](#)

EMPLOYEE ONLINE TRAINING

[Harrasment](#)

[LMS Module](#)

[HIPAA](#)

[Home](#)

Harassment/Discrimination

The University of North Dakota does **NOT TOLERATE** harassment or discrimination **OF ANY KIND!**

Refer to all policies: <http://und.edu/affirmative-action/harassment.cfm>

Use this website page for the following links for training and information: <http://und.edu/affirmative-action/harassmenttraining.cfm>

Equal Employment Opportunity/Affirmative Action Office
Tel: 701.777.4171
Fax: 701.777.2077

[Home](#)

Learned Management System-LMS Safety Training –REQUIRED

Online Training-WSI <https://gm1.geolearning.com/geonext/ndwsi/login.geo>

Login CFMBfirstname.lastname

Password safety1!

Above is the information you will need to log into our new online training for the clinic. This training is provided to us free of charge from the ND WSI department. It has 300+ training classes available to us and provides better reporting to department supervisors to show employee participation.

The LMS is similar to UND Blackboard and includes a tutorial for all of you to view. I am going to list a few dos and don'ts for the system.

ALWAYS LOGOUT of the system-Do not close internet window to close out. The system needs to record your activity and logging out helps this happen.

The training is **INTERACTIVE**. You will be asked questions periodically as you view the course and you will be **required** to finish the post test. You will need to pass with an 70%. You can retake the test until you pass.

TROUBLESHOOTING-If you have trouble viewing the course please let me know and I will help you troubleshoot your computer. You will need an updated JAVA and FLASHPLAYER on your computer. Also, you may need to turn off your POP-UP BLOCKERS.

DEADLINE to finish course will be one month from your notification email unless stated otherwise. Notification email will be sent to you that you have a course(s) to take from Monica or Jodi. I will follow up at the end of the month with a report to supervisors of employees who have not completed training.

TUTORIAL should be watched by everyone. Log into the above address and complete the tutorial. Attached to this email are directions to complete your training, view your transcript and create shortcuts. I will help anyone get started, just ask.

[Home](#)

[SAFETY](#)

[General](#)

[Substance Abuse/Drug-Free Workplace](#)

[Safety Training](#)

[UND Emergency Codes](#)

[Emergency Evacuation \(All Personnel Alert\)](#)

[Severe Weather \(Gray Alert\) /Community Action
\(Code Lockdown\)](#)

[Power Outage](#)

[Fire \(Dr. Red \)](#)

[Emergency Eyewash Station/Shower](#)

[Preventative Maintenance](#)

[Medical Emergency](#)

[Code Blue](#)

[Emergency Management-Pandemic Flu](#)

[Emergency Management-Ebola](#)

[Infection Control](#)

[Code Amber](#)

[Communicable Diseases](#)

[Tuberculosis Guidelines](#)

[Bloodborne Pathogens](#)

[Bloodborne Pathogens Exposure Plan](#)

[Hazard Communication Standard](#)

[Radiation](#)

[Workplace Violence \(Manpower Alert\)](#)

[Palomar Medilux System](#)

[Emergency Telephone Contacts](#)

[Notifind](#)

[Emergency Management-Disaster](#)

[UNDCFM/BSC Risk Management](#)

[Medicat Contingency](#)

[Home](#)

*Refer to UND Environmental and Safety information at <http://und.edu/finance-operations/environmental-health-and-safety/policies-and-procedures/index.cfm>

General Safety Policies

The Center for Family Medicine strives to provide a safe and healthy environment for its students, facility, staff and visitors. Teamwork is necessary for all involved to provide a safe environment and operations under their control.

Office Safety

A large percentage of workplace accidents and injuries occur in offices. The office requires preventive measures to ensure a safe and healthful environment. Common causes of office accidents include the following:

- Slipping, tripping, and falling hazards
- Burning, cutting and pinching hazards
- Improper lifting and handling techniques
- Dangerous electrical wiring
- Exposure to toxic substances
- Horseplay

Many office accidents are caused by insufficient housekeeping practices. By keeping the office floor both neat and clean, you can eliminate most slipping, tripping, and falling hazards. Other good housekeeping practices include the following:

- Ensure the office lighting is adequate. Replace burned out light bulbs and have additional lighting installed, as necessary.
- Ensure that electrical cords and phone cords do not cross walkways or otherwise pose a tripping hazard. If you cannot move a cord, have a new outlet installed or secure the cord to the floor with cord covering strips. Do not run cords underneath carpet, and avoid using tape whenever possible.
- Report or repair tripping hazard such as defective tiles, boards, or carpet immediately.
- Clean up spills and pick up fallen debris immediately. Even simple items such as a loose pencil could cause a serious falling injury.
- Keep office equipment, facilities, and machines in good condition.
- Store items in an approved storage space. Take care not to stack boxes too high or too tight. Clearly label boxes with their contents.
- Keep all drawers and cupboard doors closed when unattended.

Housekeeping

Poor housekeeping is a major contributor to occupational injuries and illness. Housekeeping encompasses all activities related to the cleanliness of facilities, materials, and equipment, as well as the elimination of nonessential materials and hazardous conditions. All employees must work towards maintaining their respective workplace in a clean and orderly manner.

Good housekeeping guidelines include keeping aisles and stairways free from clutter, cleaning spills, minimizing combustibles in workplace and storage areas, and keeping all exits free from obstructions.

[Home](#)

Access to emergency equipment, such as fire extinguishers, pull stations, eye wash units, etc., must be maintained free and clear of obstructions.

Space Heaters

The use of portable electric space heaters should always be a last resort. If your workspace is too cold, your first action should always be to report the problem to Management.

When necessary, the use of portable electric space heaters is allowed in University buildings. When used improperly though, space heaters are an accident waiting to happen. They can cause fires, electric shocks, and can reduce oxygen levels. Fuel fired space heaters (e.g., natural gas, kerosene, propane, fuel oil, etc.) are prohibited in office settings. The following apply when using portable electric space heaters:

- Use only for the purpose for which they are designed (refer to manufacturer's labeling and recommendations)
- The heater must be Underwriters Laboratory or Factory Mutual approved.
- The space heater must have devices that automatically turn it off if tipped over and when the room is warmed.
- Keep the heater in a stable, upright position with at least 30 inches of space between the front of the unit and any other surface.
- Never operate the heater in a closed area, such as beneath furniture, in cabinets, beneath/behind curtains, drapes, or other combustibles (i.e., paper, cardboard, etc.). Never hang a portable heater from a wall or ceiling unless it has been specifically designed for that type of installation.
- Check the cord to make sure it is not frayed or worn.
- If an extension cord is needed, use only one that is rated to handle the heater's electrical load.
- Always unplug heaters when they are not in use.
- Do not overload electrical circuits.
- Never touch an electric heater if your hands are wet or if you are in contact with water.

For any further questions regarding the use of portable electric space heaters, contact Safety and Environmental Health at 777-3341 or the safety officer.

Indoor Air Quality

The following practices will help ensure optimum indoor air quality:

Fix leaks and drips

Clean mold and mildew growths with a bleach/water mixture to prevent growth

Ensure that indoor ventilation filters are changed regularly.

Minimize usage of fragrances.

[Home](#)

Minimize chemical and aerosol usage. Ventilate your area when chemical or aerosol usage is required.

Do not attempt to control temperatures by blocking air ducts.

Avoid cooking in enclosed areas.

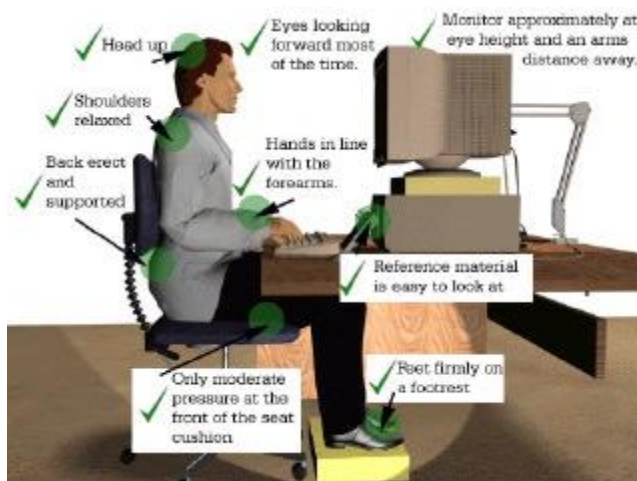
Smoking is prohibited within clinic property.

Ergonomics and Work Station Arrangements

Ergonomics involves adjusting work processes or stations to fit a particular employee. Improper ergonomic design can cause debilitating long-term musculoskeletal effects.

Suggestions for maintaining an ergonomic work atmosphere:

- Stay in good physical condition.
- Take "mini" breaks and stretch intermittently in both sitting and standing positions.
- Change tasks frequently
- Adjust your computer screen to limit glare and take frequent vision breaks away from your computer to allow your eyes to fully relax. Periodically gazing across the room or out a window will help the eye muscles rest and receive oxygenated blood.
- Keep items frequently used in close proximity to you.
- Maintain good posture and use a chair with adequate support to adjust your upper extremities to a neutral position.
- Be aware of cumulative trauma disorder warning signs such as tingling, numbness or burning pain in fingers, hands, arms, wrists and shoulders.



Report any symptoms to your supervisor.

To reduce stress and prevent fatigue, it is important to take mini-breaks throughout the day. If possible, change tasks at least once every two hours. Stretch your arms, neck, and legs often if you do the same type of work for long periods of time. Rest your eyes often by closing them or looking at something other than the work at hand. For a quick pick-me –up, breathe deeply several times by inhaling through your mouth. In addition, try eating your lunch somewhere other than your desk.

Other examples of stress-relieving exercises that can be done at your desk including the following:

Head and Neck Stretch:

Slowly turn your head to the left, and hold it for three seconds. Slowly turn your head to the right, and hold it for three seconds. Drop your chin gently toward your chest, and tilt it back as far as you can. Repeat these steps five to ten times.

Shoulder Roll:

Roll your shoulders forward and then backward using a circular motion.

Upper Back Stretch: Grasp one arm below the elbow and pull gently towards the other shoulder. Hold this position for five seconds and then repeat with other arm.

Wrist Wave:

With your arms extended in front of you, raise and lower your hands several times.

Finger Stretch:

Make fists with your hands and hold tight for one second, then spread your fingers wide for five seconds.

Lifting

Using good judgment is the key to safely lifting objects. If the object is too heavy to lift, seek assistance or use mechanical equipment to move the object.

When lifting heavy objects, follow these guidelines to ensure your safety:

- Face and stand as close as possible to the object with feet wide apart and with good footing.
- Bend at the knees, keeping the back as straight as possible.
- Keeping your back as straight as possible, make the lift smoothly and under control as you begin straightening your legs.
- When moving the object, keep the load evenly balanced and proceed with caution through the doors and around corners.
- Avoid twisting your body while lifting, moving, or setting down an object.
- When setting the load down, squat down, bending at the hips and knees, keeping your back straight as possible.

Removing objects from overhead storage also requires special attention. Before bringing an object down from above, test its weight by pushing up on it. If the only way you can reach an object is by standing on the tips of your toes and reaching way over your head, do not move the object. If the object is too high, use a ladder or other appropriate means to safely reach it.

Ladders and Step stools

Always use an approved ladder or step stool to reach any item above your extended arm height. Never use a makeshift device, such as a desktop, file cabinet, bookshelf, chair or box, as a substitute for a ladder or step stool.

[Home](#)

Substance Abuse/Drug-Free Workplace

Employees are required to report to work in a condition to perform their jobs in a safe, efficient, and satisfactory manner. The presence of alcohol and other drugs on the job and the influences of those substances on employees during working hours are inconsistent with the objectives of a drug and alcohol free workplace and will not be tolerated.

The clinic prohibits the use, possession, and manufacturing, distribution, selling or being under the influence of alcohol or illegal drugs or use legal drugs illegally. In addition, the legal use of prescribed drugs is permitted on the job only if it does not impair an employee's ability to meet standards and perform the essential functions of the job in a safe manner that does not endanger other individuals, equipment, or property in the workplace.

Staff or employees who violate this policy shall be subject to disciplinary action such as reprimand, suspension, or dismissal.

Any employee who is convicted of unlawful manufacture, distribution, possession, or use of controlled substance or other criminal drug statute is required to notify his/her supervisor no later than five working days after such conviction shall be grounds for disciplinary action up to and including dismissal and/or participation in a substance abuse rehabilitation or treatment program. Violations may also have legal consequences.

A manager may require an employee to leave the workplace if the manager determines the employee has reported to work in an inappropriate condition and cannot perform the essential functions of the job effectively in a safe manner that does not endanger themselves or others. The employee should not operate a motor vehicle; the manager should arrange transportation for the employee. If the employee refuses to accept transportation and insists on operating a motor vehicle, they will be informed by the manager that law enforcement officials will be notified that the employee appears unfit to operate a motor vehicle. Law enforcement officials should be appropriately notified. The use of alcohol and illegal use of drugs while operating a state vehicle is prohibited. Individuals operating a state vehicle under the influence of alcohol or illegal drugs will be subject to disciplinary action up to and including termination of employment.

Employees with questions and concerns about substance dependency or abuse are encouraged to use the resources of the Employee Assistance Program. Employees may also wish to discuss these matters of this policy with their supervisor to receive assistance or referrals to appropriate resources in the community.

Tobacco-free Building

The University of North Dakota tobacco-free campus policy provides a healthy working and learning environment. Refer to policy at: <http://und.edu/health-wellness/healthy-und/tobacco-free-und/undtobaccofreepolicy.cfm>

[Home](#)

Safety Training

Employees of the clinic are provided training necessary to perform their duties in a safe, competent, and responsible manner. Training will be documented by employees signing in on a clinic employee roster. The roster will be filed with the business manager.

Reporting of Injuries, Accidents or Hazards

Emergency assistance should be requested by dialing 911 whenever a situation poses a threat to person or property.

A person receiving any injury must report this without delay to their supervisor. When notified of the injury/accident, the supervisor shall immediately set any accident preventive measures in motion and shall be responsible for seeing that a report is filled out by the injured and given to business manager to file with the State Risk Management Office within 24 hours.

The Incident Report and Incident Investigation forms must be completed and sent to Safety and Environmental Health within 24 hours of the incident. Forms can be faxed to 777-4132 and original copies mailed to Safety and Environmental Health, Box 9031

If the injured person is a UND employee, medical treatment must be obtained from the University's Designated Medical Provider (DMP) or the employee's own physician of choice if the employee has designated one on their DMP form. Staff at Safety and Environmental Health will file the Workforce Safety and Insurance (formerly ND Workers Compensation) claim for injured employees.

Accident/Workers Compensation Claims Investigations - All accidents must be investigated to determine the cause so as to avoid any future accidents. Accidents involving minor damage or injuries requiring only first aid must be investigated by the person in charge. After the investigation, the Incident Investigation form must be completed and submitted to Safety and Environmental Health. In the case of more serious property damage or injury requiring medical attention, Safety and Environmental Health will conduct an investigation in addition to that done by the person in charge. Please notify Safety and Environmental Health immediately if there is a serious injury or incident at 777-3341.

Claims Management – When a claimant comes to Safety and Environmental Health to sign the Workforce Safety application for benefits, they will be informed of their assigned claim number from Workforce Safety & Insurance. The injured employee is responsible for calling this claim number to his or her care provider. If restrictions are put into effect by the care provider, the injured worker will adhere to these. Transitional (modified) duty may be assigned. There will be communication between the supervisor, injured worker, and claims manager in Safety and Environmental Health. These communications will continue until the injury is resolved. All changes in restrictions must be sent to Safety and Environmental Health to be reviewed by the claims manager. Call 777-3341 if there are any questions regarding this process.

INCIDENT REPORTING FORM – (EMPLOYEES, STUDENTS, VISITORS OR ACCIDENTS WITH STATE FLEET VEHICLES OR RENTAL VEHICLES)

INCIDENT INVESTIGATION FORM – (SUPERVISORS OF EMPLOYEES OR SOMEONE WHO MAY HAVE ADDITIONAL KNOWLEDGE REGARDING THE DAMAGES OR INJURY).

ONLINE REPORTING USING RISK MANAGEMENT WEB SITE CAN BE DONE ONLY WHEN THERE HAS BEEN A MEDICAL INCIDENT THAT INVOLVED A THIRD PARTY (PARTICULARLY PATIENTS) THEY SHOULD BE FILED ONLINE AND WITHIN 24 HOURS. MUST USE THE MEDICAL SERVICES INCIDENT REPORT AND IT GOES DIRECTLY TO RISK MANAGEMENT.

GIVE COPY OF THE INCIDENT REPORTING PROCEDURES TO BOTH ENTITIES
ALL OTHER INCIDENTS WHETHER EMPLOYEES, STUDENTS OR VISITORS MUST BE **FILED ONLINE BY THE SAFETY OFFICE** .

THE INCIDENT REPORTS AND THE INCIDENT INVESTIGATION FORMS CAN BE FOUND ON THE FOLLOWING WEB SITE:

<http://und.edu/finance-operations/environmental-health-and-safety/policies-and-procedures/generalsafety/incident-reporting.cfm>

Reporting and eliminating Unsafe Practices and Hazardous Conditions

Near accidents, hazardous conditions and practices must be promptly reported to the supervisor. The Safety and Environmental Health office at UND can be contacted for advice.

Safety evaluation

Safety meetings, corrective actions, and training programs for employees will be documented. Safety policies and procedures will be reevaluated annually.

[Home](#)

UND Emergency Codes

Dr. RED=FIRE

GRAY ALERT=TORNADO

CODE SILVER=PERSON WITH WEAPON*

MANPOWER ALERT=VIOLENCE*

CODE BLUE =MEDICAL

CODE LOCKDOWN=LOCKDOWN*

ALL PERSONNEL ALERT=DISASTER

CODE ADAM=Missing Child*

***Notify Sanford @ 214-9269 or 1111**

Paging on Phones

Dial 4646

WAIT for 1 sec delay

Announce CODE

plus Location 3 times.

Speak slow and clearly.

Ex. CODE BLUE SOUTH PATIENT HALLWAY

Pre-Emergency Preparation

*Be Familiar with buildings and their exits.

*Review Fire Evacuation Route Map.

*Be familiar with the emergency alarm system in the building.

*Review the Emergency Evacuation Procedures regularly.

[Home](#)

EMERGENCY EVACUATION (All Personnel Alert)

Severe Weather (Gray Alert) /Community Action (Code Lockdown)

In the event of an emergency/severe weather the Business Manager/Director will determine if the clinic operations will be continued or discontinued. If the clinic will be closed the employees will follow an emergency evacuation plan. If the weather emergency happens before the start of the clinic day the employees will be notified by NOTIFIND of the emergency and directions. Patients will be directed to contact the local hospital if they need care. The community of Bismarck has an Emergency Alert System that all persons need to understand in order to know what to do in the event of an emergency. There are many different reasons that this alert system may be activated. Some examples include Tornadoes, Floods, Wind Storms, Terrorist/War Threat, Violence or Chemical Spill. These emergencies often come with little or no warning.

Typically, notification of emergencies having an immediate potential for injury or death will be initiated by the sounding of the civil defense sirens. When you hear these sirens, immediately turn on either a radio or television. The designated Emergency Alert Stations are KFYP 550 AM, KFYP-TV and KXMB-TV. Do not contact 911 or your local emergency provider for information. Local television and radio stations will provide the appropriate instructions relative to the emergency. These instructions may be to evacuate the area/neighborhood or seek shelter indoors. For specific hazards, special instructions will also be provided (wet towels under doors, turn off furnace, etc.) Be familiar with the sirens, the system is tested monthly on the last Friday at 9 a.m.

Tornado (Gray Alert)

Emergency conditions such as tornadoes can develop very quickly and without warning. In the event of the weather conditions that set up the possibility of a tornado, the weather should be monitored using a weather radio.

Tornado Watch: Means weather conditions are right or favorable for a tornado to develop. In the event of a tornado watch the employees will be notified by the safety officer or the business manager to be on alert in case the weather worsens. Continue alert until an “all clear” is announced.

Tornado Warning: Is declared when a funnel cloud has been sighted or indicated by radar. If notice is received to seek shelter and move to safer locations the business manager or safety officer will page overhead a “**Gray Alert and location**” three times.

1. Evacuation of patients will be handled by the employees. Have everyone evacuate to the hallways. Person(s) should then proceed to the nearest protected inside area away from windows and cluttered areas. Assume a crouched position with arms over your head. Remain there until the “ALL CLEAR” is announced by the weather service.
2. Person(s) located on second floor need to evacuate to the lowest level using the stairs.

Evacuation:

1. It is the responsibility of the staff to remove all patients to safety. Refer to the Emergency Evacuation route maps to be familiar with evacuation routes.
2. Daily patient schedules can be accessed by calling UND School of Medicine at 777-4168 to run daily reports that can be emailed to the Business Manager.
3. Evacuation of People with Disabilities:

*Refer to the clinic’s Building Emergency Action Plan(BEAP)

The clinic staff and faculty will provide assistance to people with disabilities.

Areas of Rescue are located on second floor at the East and West corridors. Disabled Persons will be rescued by rescue personnel from these areas. Person(s) can wait here if they are unable to use the stairwell. A rescue call button is located at each Area of Rescue. Push to alarm that someone is at the Area of Rescue and to speak to rescue personnel.

4. Staff will exit after all patients are removed from danger. All staff and patients should be instructed to meet in the south reception area if safe or in the southeast corner of the clinic parking lot. The Business

Manager and Department Supervisors will account for all patients and staff. All staff and patients may return after rescue personnel have given the "All Clear".

5. Evacuation Responsibilities to clear patients and visitors from the clinic during an emergency evacuation

Receptionist-Clear Front waiting room Bathrooms, Waiting Rooms, Monitor Elevator to be sure no one uses the elevator and monitor stairs so no one goes to the second floor.

Business Manager or their designee-Direct Traffic and assist emergency personnel. Inform the fire department that the building is all clear or the areas in which patients or staff may need additional assistance in evacuating.

Nursing-Clear all exam rooms and Procedure Rooms 2, 3, 4. Keep the nursing side hallway door open when the room is cleared after all rooms are cleared, staff members from each hallway quickly close all nursing hallway exam doors to stop the spread of fire. Clear employee bathrooms.

Lab/X-ray-Clear lab bathrooms, phlebotomy rooms, x-ray changing rooms. Assist to clear Procedure room 1. Clear Residency Offices.

Medical Records/Business Office-Clear employee bathrooms, employee exercise room, locker rooms.

Residency/Physician Offices-Clear conference room, kitchenette, conference room

Pharmacy-Clear pharmacy and assist with Procedure rooms 2, 3, 4

School of Medicine-Clear all classrooms, office space, conference room and student lounge.

6. Shelter-In-Place will be decided to fit the emergency. A Shelter-In-Place is where we will evacuate to if the emergency alert system is requesting us to stay inside to wait for further instructions. Possibilities are the Conference Room and Employee Health Center
7. Training will be provided annually. Evacuation drill will be included with the fire drill annually.

Fire Prevention

The following rules are critical to the prevention of most fire emergencies:

*Never block or obstruct fire lanes, they must remain clear at all times to provide access for emergency vehicles.

*Do not obstruct any of the required exits or exit pathways from buildings.

*Never store flammable or combustible liquids in areas used for exits, stairways, or normally used for the safe passage of people.

*Store flammable or combustible liquids only in approved closed containers.

*Never tamper with or attempt to alter any fire protection equipment.

*Never overload existing power circuits.

*Carryout good housekeeping practices.

*Candles, incense, or similar devices with open flames are prohibited in the clinic.

* Holiday Decorations must not disguise, cover or interfere with any fire safety device.

The clinic complies with the fire codes and standards for the State of North Dakota. Combustibles are objects that are capable of catching fire and burning, including but not limited to: paper, cardboard, wood, and fabric.

[Home](#)

FIRE PROCEDURE (Dr. RED)

1. The person who discovers the fire will notify the rest of the clinic by pulling the nearest fire pull located on the wall.
2. The staff member nearest the location of the fire will bring the nearest fire extinguisher to the fire and attempt to put out the flames if it can be done safely.
3. When a room or area of the clinic is cleared, close doors to stop the spread of fire.
4. Follow the Evacuation policy to remove everyone from the building.
5. Staff will exit after all patients are removed from danger. All staff and patients should be instructed to meet in the southeast corner of the clinic parking lot. The Business Manager and Department Supervisors will account for all patients and staff. All staff and patients may return after the fire department has given the "All Clear".

Fire Extinguishers

Location of extinguishers can be found on all fire evacuation maps on each floor.

Fire Extinguishers will be maintained and inspected yearly. Monthly visual checks for proper location, accessibility and visibility, intact tamper seal, allowable pressure range, corrosion or damage to the tank, clogging of the discharge nozzle.

Only consider using a fire extinguisher if you are trained to do so, and if you can safely do so without risk to yourself or other persons. Consideration should be given to the type of extinguisher needed to combat a particular class of fire. The type of extinguishers available in the clinic is dry chemical.

Fire Classifications are as follows:

Class A: Fire in ordinary combustible materials such as wood, cloth and paper, where the quenching and cooling effect of large quantities of water or solutions containing a large percentage of water is of first importance. Use water or the dry chemical extinguishers for this type of fire.

Class B: Fires in flammable liquids such as gasoline, fuel oil, alcohol or grease, where a blanketing effect is essential. Use the dry chemical fire extinguisher for this type of fire. **DO NOT USE WATER.**

Class C: Fires in electrical equipment where the use of an electrically nonconductive extinguisher agent is of first importance. Use the dry chemical fire extinguisher only for this type of fire. **DO NOT USE WATER.**

The inspection of the Fire Extinguishers is done yearly by Dakota Fire Station Inc.

Sprinklers

Maintain 18 inches directly underneath sprinklers in all areas of the clinic.

Fire Exit Drill

Fire Drills are coordinately yearly with the Sanford Safety Department, Watchmen and Fire Station.

The purpose of a drill is to insure familiarity and safe use of all available exits and fire extinguishers. Proper drills insure orderly evacuation without undue panic. Speed in vacating the building, while desirable, is not in itself the objective and should be secondary to the maintenance of proper order and discipline. All fire drills must be coordinated with Sanford Safety, ElectroWatchman, Fire Dept, School of Medicine and CFM Administration. Record results on Fire Evacuation Drill Form, listing any changes or problem areas.

False Alarm

Report by calling 221-6801

[Home](#)

Electrical Safety/Power Outage

Safe work practices must be used to prevent electric shock or other injuries that may result from contact with an energized circuit. Electrical equipment needs to be free from recognized hazards that are likely to cause death or serious physical harm. Employees should report any dangerous hazards.

Keep work areas clean and dry. Cluttered work areas invite accidents and injuries.

Preventive maintenance plays a key role in electrical safety and prevention of electrical accidents

Some common conditions to be aware of are:

- Flickering lights
- Warm switches or receptacles
- Burning Odors
- Loose connections
- Frayed, cracked or broken wires
- Tripped circuit breakers
- Wet or damp locations

Emergency Lights located throughout the clinic will be inspected monthly and maintenance performed as needed. These lights will automatically turn on during a power outage.

If you are involved in a procedure in the treatment room during the power outage, there is a backup battery located in the room to plug the instruments and lights into at all times. This backup battery will power the instruments for up to 1 hour. This battery is monitored by the nursing department and checked monthly.

Care of Refrigerated Medicine and Reagents during a Power Outage

Purpose: To outline the action to be taken to protect vaccine and other refrigerated or frozen medications in the nursing department, as well as the chemical reagents used in the laboratory from spoilage in the event of an extended power outage.

Procedure:

1. Refrigerator temperature min and max for the last 24-48 hours will be checked and documented each morning Monday through Friday on the temperature log sheet. This will alert the nursing staff if the temperature has been out of the acceptable range for viability of the medications. If the temperature has been out of range, a nursing staff member will contact the vaccine manufacturers to determine if the vaccine remains viable and can be used.
2. In the event of a power outage, Web 600 Sensaphone will monitor and alert appropriate staff to the change in temperature for laboratory and nursing refrigerators. The Web 600 will start notifying when the temperature is out of range set up in the Web 600 program.
- 3.

Procedure for Vaccines and Medications by Nursing Personnel:

1. In the event of a power outage and the Sensaphone on the refrigerator alarms, Nicole or Donita will go to the clinic and remove refrigerated vaccines and medications, placing them into ice-pack-lined coolers and transport to St. Alexius Medical Center Inpatient Pharmacy for temporary storage until the power is restored at the Center for Family Medicine.

Note: Dennis Delabarre, Assistant Director of Inpatient Pharmacy at St. Alexius Medical Center has agreed that their pharmacy will be able to provide temporary storage of our refrigerated vaccines and medications.

2. Frozen vaccines are to be placed into an ice-packed-lined cooler and transported to St. Alexius Medical Center Inpatient Pharmacy for temporary storage.

Procedure for Chemical Reagents by Laboratory Personnel:

1. All Laboratory staff will be notified and will call Northern Plains Laboratory, 530-5700, to determine if the CFM chemical reagents can be temporarily stored at their facility until power is restored at the CFM.
2. Lab personnel will transport the chemical reagents to the Northern Plains Lab in coolers.

3. If Northern Plains Lab is unable to store the chemical reagents from CFM lab, another alternative is Sanford Lab.

[Home](#)

Emergency Eyewash Station/Shower

Emergency drenching/flushing equipment must be available when reasonable potential for exposure to injurious corrosive materials exists. The clinic's eyewash station is located in the laboratory, north hallway and soiled utility.

To activate North Hallway Eyewash:

1. Pull off the green caps.
2. Turn on the cold water.
3. Pull the silver knob on the front of the eyewash faucet.
4. Position eyes/skin continuously over the stream of water for at least 15 minutes. Hold eyelids open with fingers so flushing fluid can fully irrigate the eyes. Never use homemade neutralizing solutions.
5. People may not always be able to flush their eyes on their own because of intense pain. Persons nearby should be prepared to assist.
6. Turn water off and replace caps when finished.

To activate Eyewash in Laboratory

1. Pull down eyewash.
2. Position eyes/skin continuously over the stream of water for at least 15 minutes. Hold eyelids open with fingers so flushing fluid can fully irrigate the eyes. Never use homemade neutralizing solutions.
3. People may not always be able to flush their eyes on their own because of intense pain. Persons nearby should be prepared to assist.

To activate Shower/Eyewash in Soiled Utility Room

1. Shower-Pull handle straight down and stand under water for ≥ 15 minutes for corrosive materials.
2. Eyewash-Push handle located on the right side of eyewash. Position eyes/skin continuously over the stream of water for at least 15 minutes. Hold eyelids open with fingers so flushing fluid can fully irrigate the eyes. Never use homemade neutralizing solutions. People may not always be able to flush their eyes on their own because of intense pain. Persons nearby should be prepared to assist.

Notify supervisory personnel and seek medical attention after use of emergency shower/eyewash station.

Maintenance:

Eyewash/Shower stations will be tested weekly. Temperature of the Eyewash/Showers will be monitored periodically.

[Home](#)

Preventive Maintenance of Medical Equipment

Purpose:

To safely inspect, manage and maintain all equipment in use at the clinic routinely. Report all malfunctioning equipment to your supervisor. Do not use equipment that is malfunctioning or compromises the safety of the patient or staff.

Policy:

1. All equipment is regularly inspected on a PM schedule provided by each department supervisor. Supervisors will maintain all PM records. An equipment list will be kept for each department.
2. Business Manager/Department Supervisors will maintain and update equipment contracts.
3. Department Supervisors will supervise all equipment repairs and return equipment to use in the clinic.
4. Proper training of employees will be documented when new equipment is implemented. Supervisors will complete a yearly competency evaluation of existing equipment.
5. Defective Equipment Guidelines

Steps to take if an Incident occurs:

- a. Do not use equipment that is malfunctioning or compromises the safety of the patient or staff. Remove equipment from use immediately.
 - b. Staff will remove equipment from use and tag as "DO NOT USE-NEEDS REPAIR". Tag equipment visibly when equipment is cumbersome to move.
 - c. Report all malfunctioning equipment to your supervisor.
 - d. Supervisor will investigate equipment failure and decide when and if the piece of equipment can be used again for patient care.
 - e. Repair equipment as soon as possible. Decontaminate item to be serviced by cleaning all visible residue whenever possible. Where infectious materials were used, disinfect all surfaces with an effective disinfectant. Place into a red biohazard bag before shipping equipment to be repaired. Label with a biohazard label if bagging is not possible.
 - f. Document all equipment investigation and repair. Person(s) involved in incident will properly fill out incident report and forward it to their Supervisor.
 6. Documentation of all medical device recalls will be kept by department.
- Training: Training will be provided during orientation and annually.

[Home](#)

MEDICAL EMERGENCY

First Aid

Unless providing first aid is within a person's job description, anyone performing first aid will typically be acting outside of the scope of their employment. North Dakota law does provide protection to individuals who render aid or assistance to persons who have been injured or are ill (chapter 32-03.1 of the North Dakota Century Code which is commonly referred to as the "Good Samaritan Act"). Much of the material included in these guidelines is aimed at persons who have been trained in providing first aid services, particularly in the area of CPR. If you have not had training in these areas, you should not attempt to perform these maneuvers unless absolutely necessary (i.e., there is nobody else available to provide these services and no way of contacting help); The American Red Cross and American Heart Association are two local organizations that offer CPR/first aid training.

First aid training is necessary to prevent and treat sudden illness or accidental injury. The primary objective of first aid is to save lives. This objective is achieved with the following:

- Preventing heavy blood loss
- Maintaining breathing
- Preventing further injury
- Preventing shock
- Getting the victim to a physician or Emergency Medical Service (EMS)

People who provide first aid must remember the following:

- Avoid panic
- Inspire confidence
- Do only what is necessary until professional help is obtained.

If you are the first one on the scene of a medical emergency, your first priority is to remain calm. Your action will vary depending upon the nature of the situation, but the following rules apply to any medical emergency.

1. Assess the Situation:

Can you safely approach the victim? If not, what can you do to help without threatening your own safety? Determine what is wrong with the victim.

2. Set Priorities:

Is the victim conscious? How serious is the emergency? Can someone else call 911/EMS, if necessary? If no one else is available, decide if it is more important to administer first aid immediately or to call 911/EMS and leave the victim unattended. If the victim is in a life-threatening situation, never leave them without first trying to remove them from immediate danger.

3. Check the ABCs (unconscious victims only)

- A. **Airway:** Place the victim on their back. Place one hand on the forehead and one hand under the chin and tilt the head back. NOTE-Never move a victim if you suspect back or neck injury. Open the victim's mouth and check for obstructions. If the victim is unconscious and an obstruction is visible, remove it with your fingers.
- B. **Breathing:** Place your ear above the victim's mouth and look at the chest. Listen for breathing and look for the rise and fall of the chest. If the victim is not breathing, someone formally trained in mouth-to-mouth breathing should begin resuscitation.

- C. **Circulation:** Using two fingers, gently feel for the carotid artery in the neck and check the pulse. To find the artery, place your fingers on the victim's Adams's apple and then slide them down the side of the neck until you feel the groove between the windpipe and neck muscles. IF there is no pulse, someone formally trained in CPR should begin cardiopulmonary resuscitation.

Administer first aid and/or call 911/EMS, as appropriate.

Bleeding (External)

Most bleeding injuries are minor; however, heavy external bleeding can cause death in three to five minutes.

In addition to the procedures for initial first aid, follow these steps for external bleeding:

- Using a sterile dressing, clean cloth, or other material, apply pressure directly over the wound.

IMPORTANT: Direct contact with a victim's blood may expose you to various communicable diseases. Always wear plastic gloves when assisting a bleeding victim.

- If possible, elevate the bleeding area. Otherwise, lay the victim flat, and elevate the legs.
- Keep the victim lying down and treat the victim for shock, if necessary.
- Do not release pressure or lift the bandage until you are sure the bleeding has stopped. For severe bleeding, initial bandages should not be removed unless done by EMS or medical personnel.
- Have someone call 911/EMS, if necessary.
- IMPORTANT: Do not use a tourniquet unless an arm or leg has been amputated. Tourniquets present unique hazards and should only be used by trained personnel.

Burns

Thermal and chemical burns require immediate attention. In addition to the procedures for initial first aid, follow these steps for thermal burns.

For first and second degree burns:

- Immerse the burned area in cold water or apply ice packs to the affected area.
- Cover the burned area with a clean cloth.
- Treat the victim for shock, if necessary.
- Do not apply butter, oil, or cream to a burn.

For serious burns (e.g., large area burns and charred skin):

- Remove clothing from the injured area. Cut around clothing that adheres to the skin.
- Place an approved burn blanket or the cleanest available cloth over the entire burn area.
- Treat the victim for shock, if necessary.
- If the victim is conscious, provide nonalcoholic fluids.
- Call 911/EMS as soon as possible.

Cardio-Pulmonary Resuscitation (CPR)

When a person stops breathing, immediate assistance is necessary. If the person stops breathing due to choking, follow the first aid instructions for choking victims. If the person stops breathing due to a hazardous atmosphere, move the victim to fresh air immediately. Always wear personal protective

[Home](#)

equipment when entering hazardous atmospheres. Do not attempt a rescue without adequate protection or proper training.

Someone formally trained in CPR should provide assistance to victims who are not breathing and victims who do not have a pulse.

- Assess the victim for a response and look for abnormal breathing.
- Activate the EMS and get an AED.
- Position the patient on their back. Check the victim's carotid pulse.
- Perform 5 cycles of compressions and breaths (30:2 ratio), starting with compressions (at a rate of at least 100/min.).
- Open the victim's airway by placing one hand on the forehead and one hand under the chin and tilting the head back. Check for any obstructions in the mouth or throat.
- If the victim is not breathing, pinch the victim's nose closed and use a mouth-to-mouth breathing barrier to give two slow, deep breaths.
- Check a pulse. If a pulse is present but the victim does not start breathing continue rescue breathing as follows:
 - ✓ Adult: one breath every 5-6 seconds (10-12 breaths per minute).
 - ✓ Infant and Child: one breath every 3-5 seconds (12-20 breaths per minute).
- Continue this procedure until the victim starts breathing or EMS arrives.
- If a pulse is not present, have someone formally trained in CPR begin mouth-to-mouth breathing and chest compressions. **The compression/breath rates for one person CPR are 30 compressions/2 breaths for all ages.**
- The compression/breath rates for 2-person CPR are:
 - ✓ Adult: 30 compressions using heel of hand/2 breaths
 - ✓ Child: 15 compressions using heel of hand/2 breaths
 - ✓ Infant: 15 compressions using two fingers/2 breaths
- Continue this procedure until the victim has a pulse and starts breathing or EMS arrives.

Code Blue

1. The first person to discover a medical emergency shall use the telephone intercom. Press "**Page**" and announce "**Code Blue**" and location three times.
2. If the medical emergency is a cardiopulmonary arrest, resuscitation (CPR) should be initiated as quickly as possible.

Clinic Personnel will respond to a CODE BLUE as Follows:

<i>Code Leader:</i>	Physician in charge (first to arrive) or, in the absence of a physician, an ACLS certified nurse.
<i>Nursing:</i>	Bring AED (automatic external defibrillator) and crash cart. Provide nursing services. Call the ambulance (Dial 911). Keep crash cart medications up-to-date and keep crash cart adequately stocked.
<i>Lab/X-ray:</i>	Bring the lab drawing tray and EKG machine. Assist as needed with crash cart, open IV bag and tubing/medication boxes and assist with CPR as needed.
<i>Front Desk:</i>	Remain at the reception desk and direct the ambulance to the code site.

Recorder: Designated by the code leader. Keep records-time of day, condition of patient, medications administered, procedures administered, time of ambulance arrival and departure, condition of patient at the time of departure. [Home](#)

Med. Records: Do not need to respond to the code, unless more help is needed, you will be notified if help is needed.

Business Office: Do not need to respond to the code, unless more help is needed.

Bus. Manager: Goes to the waiting room to direct traffic.

CPR Certification

All clinic employees are required to maintain Basic Life Support (BSL) certification. This is accomplished by passing the required written test and practical test given by qualified instructors in Basic Life Support, in accordance with the standards of the American Heart Association.

New employees who are not BLS certified have the opportunity to take the initial basic learning session, which will qualify them for BSL certification.

BLS renewal certification is made available to all employees every two years. The nurse supervisor will set up recertification.

Chemical Splashes

Chemical splashes on the skin require immediate attention. Follow these steps:

1. Go to emergency shower located in the soiled utility room.
2. Remove contaminated clothing.
3. Wash area with water thoroughly for 15 minutes.
4. Seek medical attention.

Choking

Choking victims cannot speak, breathe, or cough forcefully. Follow these steps for conscious choking victims:

1. Ask the victim if they are choking. IF the victim indicates yes, begin the Heimlich Maneuver.
2. Get behind the victim and make a fist with one hand. Circle around the victim from behind them. Grasp your fist with the other hand and place your hands slightly above the victim's navel. Give quick, upward thrusts backwards until the object is expelled or the victim loses consciousness.

Note: For pregnant or obese victims, use a chest thrust. Place your fist on the sternum, and thrust backwards repeatedly.

3. If the victim becomes unconscious while choking:
 - Call 911/EMS.
 - Place the victim on their back.
 - Open the victim's airway by placing one hand on the forehead and one hand under the chin and tilting the head back.
 - Check for any obstructions in the mouth or throat. Attempt mouth-to-mouth rescue breathing. If the airway remains blocked, place the heel of your hand slightly below the victim's ribs. Give six to ten abdominal thrusts.

Note: For pregnant or obese victims, use a chest thrust. Place your fist on the sternum, and thrust backwards repeatedly.

[Home](#)

- Sweep the mouth to remove any dislodged objects and attempt mouth-to-mouth rescue breathing again. Continue this procedure until the object is dislodged or the victim starts breathing.

Eye Injury

If hazardous liquid, particles, or gas irritate a person's eye, have the victim flush the eye with water for at least 15 minutes. Use an eye wash station located in each nursing hallway and in the lab. Seek assistance from a physician, as necessary.

If a foreign object (e.g., glass, pencil lead, etc.) is embedded in the eye, place a plastic cup or gauze over the affected eye. This will keep the eye from moving and inflicting further damage. Seek assistance from a physician immediately.

Insect Bites

Call 911/EMS or a physician whenever someone suffers multiple stings (or suffers adverse effects from a single sting) from wasps, bees, fire ants, or other stinging insects.

For a single insect sting, remove the stinger by scraping the skin. Do not use tweezers or your fingers to remove a stinger. Removing a stinger in this manner may release more venom.

People who are extremely allergic to certain insect bites should carry appropriate medication and inform others of their allergy.

Poisoning

Since there are many poisons that react differently to various treatments, this section only covers the most basic aid. If you suspect a victim has been poisoned through ingestion, inhalation, or skin exposure, try to determine what the poisoning agent is. Contact 911/EMS or the Poison Control Center (1-800-222-1222) for specific first aid instructions.

Seizures

Do not try to restrain seizure victims. Remove any objects that could harm the victim, and wait for the seizure to end. Call for a physician immediately. Contact 911/EMS if this is the victim's first seizure, the seizure is exceedingly violent, or lasts for a long time.

Do not place anything in a seizure victim's mouth.

Shock

Shock commonly accompanies severe injury or emotional upset. Symptoms of shock include the following: Cold, clammy skin, pale skin tone, shallow breathing, chills.

Follow these steps to assist shock victims:

1. Call for a physician
2. Keep the victim lying down.
3. Maintain an open airway. IF the victim vomits, turn the head sideways and the chin downward.
4. Elevate the victim's legs.
5. Keep the victim warm.
6. Reassure the victim.
7. Call 911/EMS if necessary.

[Home](#)

Emergency Management

Pandemic Flu

Response Team:

Business Manager Representative	Response Coordinator
Nursing Supervisor Representative	Infection Control
Risk Management/Lab Representative	Education
Administration Representative	Communication
Nursing Representatives	Infection Control Community Outreach
Radiology Representative	Surveillance Coordinator
Reception Representative	Surveillance

Surveillance/Communication:

1. Monitor State, County and City Public Health advisories. The clinic will monitor all facsimiles, emails and telephone calls. Updates will be made to the Response team and communicated to all clinic employees by posting updates on the Pandemic Bulletin Board and staff meetings. Refer to contact list (Appendix 1).
2. Inform members of the Response team when pandemic influenza is in the U.S. and when it is nearing the geographic area.
 - o ND Health Alert Network(HAN)
 - Categories of Health Alert messages:
 - Health Alert conveys the highest level of importance; warrants immediate action or attention.
 - Health Advisory provides important information for a specific incident or situation; may not require immediate action.
 - Health Update provides updated information regarding an incident or situation; no immediate action necessary.
 - Health Information provides general information that is not necessarily considered to be of an emergent nature.
3. Monitor and review influenza activity in patients cared for by clinical staff.
 - o The clinic is a sentinel provider involved in the ND Influenza Surveillance Network. Influenza data is reported to the state Influenza Coordinator on a weekly basis during the normal influenza season. The network will notify the clinic if there is a need to increase reporting requirements. We will monitor any changes and increase reporting requirements accordingly.
4. Report unusual cases of influenza-like illness and influenza to the local and state health department.
 - o The health department will provide recommendations to health care providers using the HAN. We will be responsible for reporting potential cases. Clinicians should immediately contact the health department when they suspect a human case of infection with an avian or animal strain of influenza

or any other novel human influenza strain. Nursing will call public health for current information when a patient is suspected to have contact with a pandemic strain of influenza.

- Clinical Criteria-Fever plus one of the following, sore throat, cough and dyspnea. Different flu strains may present differently. For more current information refer to www.cdc.gov/flu or www.pandemicflu.gov
5. Periodically, updates to the local regional pandemic plans will be monitored at <http://www.flu.gov/planning-preparedness/hospital/index.html#>
 6. Communication with other community hospitals and clinic will be accomplished by attending the bimonthly SW Hospital Region Emergency Response and Preparedness Planning meetings.

[Home](#)

Phases of a Pandemic: (WHO)

In the 2009 revision of the phase descriptions, WHO has retained the use of a six-phased approach for easy incorporation of new recommendations and approaches into existing national preparedness and response plans. Phases 1–3 correlate with preparedness, including capacity development and response planning activities, while Phases 4–6 clearly signal the need for response and mitigation efforts. Furthermore, periods after the first pandemic wave are elaborated to facilitate post pandemic recovery activities.

Clinic Response:**PHASE 1-4**

1. Prepare for Pandemic.
2. Stockpile PPE for clinic staff.
3. Continue Surveillance.

PHASE 5:

1. Post Signage: Cough Etiquette, Notice to Patients.
2. Stock isolation masks to be given to patients with flu like symptoms in proper areas. (receptionist desk, nursing pods)
3. Limit the patients movement within the clinic.
4. Employees should stock N 95 masks for use with patient care.
5. Provide facial tissues and hand sanitizers for patient and employee use.
6. Provide Patient Education.
7. Continue Surveillance and employee updates.
8. Inform staff to use proper infection control measures and to follow HAN directives.

PHASE 6: PANDEMIC

1. Continue PHASE 5 response.
2. Response team will meet to discuss changes in patient care and clinic response. (Cancel/Rescheduling of Non-essential Appointments, Designating separate times for non-pandemic and pandemic patients, Hospilization) (Appendix 5)
3. Triage patients to determine who requires medical evaluation. Follow the TRIAGE PROTOCOL (Appendix 2)
4. Follow HAN directives.

POST-PANDEMIC

1. Response team will evaluate clinic's response to the pandemic and discuss changes that are needed.

Continue Surveillance and prepare for the second “wave” of the pandemic flu.

[Home](#)

Infection Control

Summary of Infection Control Practices can be found in Appendix 4

1. Personal protective equipment

a. PPE for standard and droplet precautions

PPE is used to prevent direct contact with the pandemic influenza virus. PPE that may be used to provide care includes surgical or procedure masks, as recommended for droplet precautions, and gloves and gowns, as recommended for standard precautions (Box 1). Additional precautions may be indicated during the performance of aerosol-generating procedures (see below). Information on the selection and use of PPE is provided at www.cdc.gov/ncidod/dhqp/gl_isolation.html.

▪ Masks (surgical or procedure)

- Wear a mask when entering a patient’s room. A mask should be worn once and then discarded. If pandemic influenza patients are cohorted in a common area or in several rooms on a nursing unit, and multiple patients must be visited over a short time, it may be practical to wear one mask for the duration of the activity; however, other PPE (e.g., gloves, gown) must be removed between patients and hand hygiene performed.
- Change masks when they become moist.
- Do not leave masks dangling around the neck.
- Upon touching or discarding a used mask, perform hand hygiene.

▪ Gloves

- A single pair of patient care gloves should be worn for contact with blood and body fluids, including during hand contact with respiratory secretions (e.g., providing oral care, handling soiled tissues). Gloves made of latex, vinyl, nitrile, or other synthetic materials are appropriate for this purpose; if possible, latex-free gloves should be available for healthcare workers who have latex allergy.
- Gloves should fit comfortably on the wearer’s hands.
- Remove and dispose of gloves after use on a patient; do not wash gloves for subsequent reuse.
- Perform hand hygiene after glove removal.
- If gloves are in short supply (i.e., the demand during a pandemic could exceed the supply), priorities for glove use might need to be established. In this circumstance, reserve gloves for situations where there is a likelihood of extensive patient or environmental contact with blood or body fluids, including during suctioning.
- Use other barriers (e.g., disposable paper towels, paper napkins) when there is only limited contact with a patient’s respiratory secretions (e.g., to handle used tissues). Hand hygiene should be strongly reinforced in this situation.

▪ Gowns

- Wear an isolation gown, if soiling of personal clothes or uniform with a patient’s blood or body fluids, including respiratory secretions, is anticipated. Most patient interactions do not necessitate the use of gowns. However, procedures such as intubation and activities that involve holding the patient close (e.g., in pediatric settings) are

examples of when a gown may be needed when caring for pandemic influenza patients.

- A disposable gown made of synthetic fiber or a washable cloth gown may be used.
- Ensure that gowns are of the appropriate size to fully cover the area to be protected.
- Gowns should be worn only once and then placed in a waste or laundry receptacle, as appropriate, and hand hygiene performed.
- If gowns are in short supply (i.e., the demand during a pandemic could exceed the supply) priorities for their use may need to be established. In this circumstance, reinforcing the situations in which they are needed can reduce the volume used. Alternatively, other coverings (e.g., patient gowns) could be used. It is doubtful that disposable aprons would provide the desired protection in the circumstances where gowns are needed to prevent contact with influenza virus, and therefore should be avoided. There are no data upon which to base a recommendation for reusing an isolation gown on the same patient. To avoid possible contamination, it is prudent to limit this practice.

- **Goggles or face shield**

In general, wearing goggles or a face shield for routine contact with patients with pandemic influenza is not necessary. If sprays or splatter of infectious material is likely, goggles or a face shield should be worn.

b. **PPE for special circumstances**

- **PPE for aerosol-generating procedures**

During procedures that may generate increased small-particle aerosols of respiratory secretions (e.g., endotracheal intubation, nebulizer treatment, bronchoscopy, suctioning), healthcare personnel should wear gloves, gown, face/eye protection, and a N95 respirator or other appropriate particulate respirator. Respirators should be used within the context of a respiratory protection program that includes fit-testing, medical clearance, and training. If possible, and when practical, use of an airborne isolation room may be considered when conducting aerosol-generating procedures.

- **PPE for managing pandemic influenza with increased transmissibility**

The addition of airborne precautions, including respiratory protection (an N95 filtering face piece respirator or other appropriate particulate respirator), may be considered for strains of influenza exhibiting increased transmissibility, during initial stages of an outbreak of an emerging or novel strain of influenza, and as determined by other factors such as vaccination/immune status of personnel and availability of antivirals. As the epidemiologic characteristics of the pandemic virus are more clearly defined, CDC will provide updated infection control guidance, as needed.

- **Precautions for early stages of a pandemic**

Early in a pandemic, it may not be clear that a patient with severe respiratory illness has pandemic influenza. Therefore precautions consistent with all possible etiologies, including a newly emerging infectious agent, should be implemented. This may involve the combined use of airborne and contact precautions, in addition to standard precautions, until a diagnosis is established.

c. **Caring for patients with pandemic influenza**

Healthcare personnel should be particularly vigilant to avoid:

- Touching their eyes, nose or mouth with contaminated hands (gloved or ungloved). Careful placement of PPE before patient contact will help avoid the need to make PPE adjustments and risk self-contamination during use. Careful removal of PPE is also important.
- Contaminating environmental surfaces that are not directly related to patient care (e.g., door knobs, light switches)

Essential Staff

The number of staff necessary for patient care during a severe pandemic on a given day will include physicians, nurses, x-ray, lab and receptionists. If necessary, nonessential staff will be moved to administration based on patient care needs and infection control for staff and patients.

Vaccine and Anti-virals

Vaccine and Anti-virals will follow CDC recommendations for use. Updated information can be found at

www.cdc.gov/h1n1flu/recommendations.htm

Seasonal Influenza Vaccine

- a) All employees who are directly involved in patient care are required to receive the seasonal influenza vaccine.
- b) Employees with egg allergies are to receive the recombinant seasonal influenza vaccine.
- c) Exceptions for seasonal influenza vaccine:
 - i) A history of severe medical complications from seasonal influenza vaccine. A note from a physician will be required.
 - ii) Religious conflicts; the exact nature of this must be reported. Reporting “It is against my religion” is not acceptable.
- d) Staff who cannot receive the seasonal influenza vaccine will be
 - i) Reassigned to non-patient care duties or
 - ii) Required to wear a mask when seasonal influenza is present in the community at the discretion of the employee’s direct supervisor.

The Response Team will monitor employees who are at increased risk of flu complications and symptomatic employees. Employees that are exposed can discuss the need for and use of antivirals with a physician.

Antiviral medication will be given to employees by prescription to a pharmacy.

[Home](#)

Appendix 1

CONTACTS LIST FOR AN INFLUENZA PANDEMIC

LOCAL HEALTH CONTACTS: BURLEIGH COUNTY HEALTH
ALERT NETWORK

ADDRESS: 500 E. FRONT AVE., BISMARCK,
ND 58504
PHONE: 701-222-6525

CHERYL UNDERHILL: "Regional Emergency Response Coordinator"

Phone: 701-355-1546
Fax: 701-226-6524
E-MAIL: cunderhill@nd.gov

GLORIA DAVID: "Public Information Officer"

Phone: 701-355-1306
Fax: 701-222-6407
E-MAIL: gdavid@nd.gov

STATE HEALTH DEPT: "NORTH DAKOTA DEPARTMENT OF
HEALTH EMERGENCY

PREPAREDNESS & RESPONSE"
ADDRESS: 918 E. DIVIDE AVE. BISMARCK, ND 58505
PHONE: 701-328-2270
FAX: 701-328-0357

TIM WIEDRICH: "Director of Emergency Preparedness and
Response"

Phone: 701-328-2270
E-MAIL: twiedrich@nd.gov

BARB WINKING: "IT/Health Alert Network(HAN) Coordinator"

Phone: 701-328-2297
E-MAIL: bwinking@nd.gov

HAN WEBSITE: www.ndflu.com

GEORGE GERHARDT: "STRATEGIC NATIONAL STOCKPILE
COORDINATOR"

Phone: 701-328-1308 E-MAIL:
gyantzer@nd.gov

SUPPLIES WEBSITE: <http://hanassets.nd.gov/>

Supplies are stockpiled and can be requested
from this site. Ph: 328-1326

HEALTHCARE ENTITIES CONTACT:

ST. ALEXIUS MEDICAL CENTER PRIME CARE

DEREK HANSON: EMERGENCY PREPAREDNESS & SAFETY
OFFICER

PHONE: 701-530-8620 OR 530-7000
E-MAIL: dhanson@primecare.org

SANFORD

BRAD ERICKSON: SAFETY OFFICER
PHONE: 701-323-6319 OR 323-6000
E-MAIL: berickson@mohs.org

LAB RESOURCES

ND PUBLIC HEALTH LABORATORY

MYRA KOSSE: DIRECTOR
PHONE: 701-328-6272
FAX: 701-328-6280
E-MAIL: mkosse@nd.gov

[Home](#)

Appendix 2

TRIAGE PROTOCOL FOR PATIENTS WITH SUSPECTED INFLUENZA INFECTION (ANTIVIRAL MEDICATIONS)

Use for established CFM patients only – Non-established patients should be told to come into the clinic to see a doctor and medications will be prescribed if indicated.

1. Has Pandemic influenza been documented in the community?

If no, do not use this protocol.

2. Is there a documented fever of 100°F (37.8°C) or higher?

If no, go to item 12.

3. Does the patient have symptoms of runny nose/nasal congestion, cough, or a sore throat?

If no, go to item 12.

4. Did the illness start abruptly (e.g., going from feeling well to quite ill in a few hours)?

If no, go to item 12.

5. Is there any rash?

If yes, go to item 11.

***There is an 80 percent likelihood of influenza infection (when influenza is present in the community).**

6. Is the patient between the ages of 5 and 49 years?

If no, go to item 11.

7. Has the illness been present for less than 36 hours?

If no, go to item 11.

8. Does the patient or patient's parent or caregiver feel that the patient should be seen by a physician?

If yes, go to item 11.

9. Does the patient have an ongoing chronic illness, or is there any coexisting psychiatric illness or any indication of renal failure?

If yes, go to item 11.

10. This patient is a candidate for over-the-phone prescribing of antiviral therapy. Advise follow-up if condition worsens and routine follow-up two to three days after initiating therapy.

***A. Does the patient have any allergies?**

***B. What pharmacy does the patient use?**

11. This patient should be evaluated (interviewed and/or examined) by a physician.

12. The illness may be influenza or another respiratory virus. If significant concerns exist on the part of the patient, parent, or other person, consider scheduling a visit with a health care professional. Otherwise, advise hydration, rest, acetaminophen or ibuprofen for fever and aches, and follow-up as needed.

[Home](#)

Appendix 3
**Home Care Guidance:
Physician Directions to Patient/Parent**

You will probably be sick for several days with fever and respiratory symptoms.

Take Medications as Prescribed:

- Take all of the antiviral medication as directed.
- Continue to cover your cough and wash your hands often, even when taking antiviral medications, to prevent spreading influenza to others.
- Call the office if you (or your child) experience any side effects; i.e. nausea, vomiting, rash, or unusual behavior.
- Take medications for symptom relief as needed for fever and pain such as acetaminophen (Tylenol®) and ibuprofen (Advil®, Motrin®, Nuprin®), and cough medicine. These medicines do not need to be taken regularly if your symptoms improve.
- Do **not** give aspirin (acetylsalicylic acid) or products that contain aspirin (e.g. bismuth subsalicylate – Pepto Bismol) to children or teenagers 18 years old or younger.
- Children younger than 4 years of age should not be given over-the-counter cold medications without first speaking with a health care provider.

Seek Emergency Care

If your child experiences any of the following:

- Fast breathing or trouble breathing
- Bluish or gray skin color
- Not drinking enough fluids
- Severe or persistent vomiting
- Not waking up or not interacting
- Being so irritable that the child does not want to be held
- Flu-like symptoms improve but then return with fever and worse cough

In adults, emergency warning signs that need urgent medical attention include:

- Difficulty breathing or shortness of breath
- Pain or pressure in the chest or abdomen
- Sudden dizziness
- Confusion
- Severe or persistent vomiting
- Flu-like symptoms improve but then return with fever and worse cough

Follow These Home Care Recommendations:

- Stay home for at least 24 hours after you are free of fever(100°F), or signs of a fever without the use of fever-reducing medications.
- Drink clear fluids (such as water, broth, sports drinks, electrolyte beverages for infants) to keep from being dehydrated.
- Dishes can be done in dishwasher or with hot soapy water.
- Throw away tissues and other disposable items used by the sick person in the trash. Wash your hands after touching used tissues and similar waste.
- Have everyone in the household wash hands often with soap and water, especially after coughing or sneezing. Alcohol-based hand cleaners are also effective.
- Avoid touching your eyes, nose and mouth. Germs spread this way.

- Laundry can be washed with warm or cold water. Avoid “hugging” laundry to avoid contamination.

For more detailed information about novel H1N1 home care, visit www.cdc.gov/h1n1flu or call 1-800-CDC-INFO

[Home](#)

Appendix 4

Summary of Infection Control Recommendations for Care of Patients with Pandemic Influenza

Component	Recommendations
Standard Precautions	
Hand hygiene	Perform hand hygiene after touching blood, body fluids, secretions, excretions, and contaminated items; after removing gloves; and between patient contacts. Hand hygiene includes both handwashing with either plain or antimicrobial soap and water or use of alcohol-based products (gels, rinses, foams) that contain an emollient and do not require the use of water. If hands are visibly soiled or contaminated with respiratory secretions, they should be washed with soap (either non-antimicrobial or antimicrobial) and water. In the absence of visible soiling of hands, approved alcohol-based products for hand disinfection are preferred over antimicrobial or plain soap and water because of their superior microbicidal activity, reduced drying of the skin, and convenience.
Personal protective equipment (PPE) <ul style="list-style-type: none"> • Gloves • Gown • Face/eye protection (e.g., surgical or procedure mask and goggles or a face shield) 	<ul style="list-style-type: none"> • For touching blood, body fluids, secretions, excretions, and contaminated items; for touching mucous membranes and nonintact skin • During procedures and patient-care activities when contact of clothing/exposed skin with blood/body fluids, secretions, and excretions is anticipated • During procedures and patient care activities likely to generate splash or spray of blood, body fluids, secretions, excretions
Safe work practices	Avoid touching eyes, nose, mouth, or exposed skin with contaminated hands (gloved or ungloved); avoid touching surfaces with contaminated gloves and other PPE that are not directly related to patient care (e.g., door knobs, keys, light switches).
Patient resuscitation	Avoid unnecessary mouth-to-mouth contact; use mouthpiece, resuscitation bag, or other ventilation devices to prevent contact with mouth and oral secretions.
Soiled patient care equipment	Handle in a manner that prevents transfer of microorganisms to oneself, others, and environmental surfaces; wear gloves if visibly contaminated; perform hand hygiene after handling equipment.
Soiled linen and laundry	Handle in a manner that prevents transfer of microorganisms to oneself, others, and to environmental surfaces; wear gloves (gown if necessary) when handling and transporting soiled linen and laundry; and perform hand hygiene.
Needles and other sharps	Use devices with safety features when available; do not recap, bend, break or hand-manipulate used needles; if recapping is necessary, use a one-handed scoop technique; place used sharps in a puncture-resistant container.
Environmental cleaning and disinfection	Follow standard facility procedures for cleaning and disinfection of environmental surfaces; emphasize cleaning/disinfection of frequently touched surfaces (e.g., bed rails, phones, lavatory surfaces).
Disposal of solid waste	Contain and dispose of solid waste; wear gloves when handling waste; wear gloves when handling waste containers; perform hand hygiene.

Respiratory hygiene/cough etiquette	Cover the mouth/nose when sneezing/coughing; use tissues and dispose in no-touch receptacles; perform hand hygiene after contact with respiratory secretions; wear a mask (procedure or surgical) if tolerated; sit or stand as far away as possible (more than 3 feet) from persons who are not ill.
Droplet Precautions	
Patient placement	Place patients with influenza in a private room or cohort with other patients with influenza.* Keep door closed or slightly ajar; maintain room assignments of patients in nursing homes and other residential settings; and apply droplet precautions to all persons in the room. *During the early stages of a pandemic, infection with influenza should be laboratory-confirmed, if possible. Personal protective equipment Wear a surgical or procedure mask for entry into patient room; wear other PPE as recommended for standard precautions.
Patient transport	Limit patient movement outside of room to medically necessary purposes; have patient wear a procedure or surgical mask when outside the room.
Aerosol-Generating Procedures	During procedures that may generate small particles of respiratory secretions (e.g., nebulizer treatment, suctioning), healthcare personnel should wear gloves, gown, face/eye protection, and a fit-tested N95 respirator.

[Home](#)

Appendix 5

Cancelling an Appointment for Pandemic Flu Reasons

1. While in Pass, go into PassI 1
2. Choose option 2 to Find an appointment – Cancel/Reschedule/No-Show
3. Search for the patient by Last Name, First Name or Medical Record #
4. Select the appointment to be cancelled
5. In the cancel box, put a “Y”
6. In the reschedule box put a “Y”, “H”, or “K” depending on what you want to do
7. In the reason box put “PF” then press enter.
8. You may need to hit F13 to confirm the cancellation – depending on your choice in #6.

Create Pandemic Flu Cancellation Listing

1. While in Pass, go into PassB1
2. Choose option 2 - To Be Rescheduled List
3. Put a “Y” in the “Cancelled Appointments List?” box
4. Enter the date range you wish to run the report for in the “Beginning/End Dates” fields.
5. Hit F10 to bring up the special limits pop-up screen
6. In the Reason Codes section put an “I” in the first box, and put “PF” in the first of the ten boxes. The screen should look like the following. The bold font information is already on the screen:
Reason Code: I (A/I/E) PF _ _ _ _ _
7. Hit F3 to exit the pop-up screen.
8. Hit Enter to run the report.
9. When the report is complete it will be posted in your work spool.

[Home](#)

Emergency Management-Ebola

Clinic Protocol

- Daily review areas of interest for EBOLA.
 - <http://www.cdc.gov/vhf/ebola/outbreaks/2014-west-africa/distribution-map.html#areas>
- Front Desk-Triage Patients
 - Daily review areas of interest for EBOLA
 - <http://www.cdc.gov/vhf/ebola/outbreaks/2014-west-africa/distribution-map.html#areas>
 - Phone:
 - Do you have a fever? If yes,
 - Have you traveled from or been in contact with someone from an area of interest for Ebola?
 - Symptoms:
 - Headache
 - Weakness
 - Muscle pain
 - Vomiting
 - Diarrhea
 - Abdominal pain
 - Bruising or Bleeding
 - **Patient has a fever and travel history to an area of interest instruct patient to go to the emergency room.
 - Walk-In/Illness Visit
 - Fill out a Triage sheet for each patient that is here for an illness visit. DO NOT give the patient the form, staff will ask questions and fill out for them.
 - Patient presents with a fever and has a travel history: Immediately mask patient and send to Procedure Room 1. Notify nursing.
 - Give the form and travel ticket to the Nurse.
- Medical Staff
 - Post precautions signage-Isolation
 - DO NOT bring computers, paper or travel ticket into the room.
 - All staff entering the room must sign in using the room entry sign-in sheet.
 - Access Medcat after entering the isolation room on the provided tablet located in Procedure Room 1. Medcat messaging will be used for communication with clinic staff.
 - Use appropriate Blood and Body Fluid precautions and PPE.
 - Complete intake and evaluation of patient. Assess the patient's symptoms, temperature and pulse.
 - Discuss symptoms and vitals with the Physician. Physician will decide on plan and transportation of a possibly infected EVD patient to the emergency room. Keep patient in isolation until ambulance arrives.

- Disinfect room using 10 % Bleach solution.
- Remove PPE appropriately
- Exit Room.
- Document in Medicat

Infection Control:

- <http://www.cdc.gov/vhf/ebola/hcp/procedures-for-ppe.html>
 - The following procedures provide detailed guidance on the types of personal protective equipment (PPE) to be used and on the processes for donning and doffing (i.e., putting on and removing) PPE for all healthcare workers entering the room of a patient with Ebola virus disease. And emphasizing the importance of **training, practice, competence, and observation** of healthcare workers in correct donning and doffing of PPE selected by the facility.
- This guidance contains the following key principles:
- Prior to working with Ebola patients, all healthcare workers involved in the care of Ebola patients must have received repeated training and have demonstrated competency in performing all Ebola-related infection control practices and procedures, and specifically in donning/doffing proper PPE.
- While working in PPE, healthcare workers caring for Ebola patients should have no skin exposed.
- The overall safe care of Ebola patients in a facility must be overseen by an onsite manager at all times, and each step of every PPE donning/doffing procedure must be supervised by a trained observer to ensure proper completion of established PPE protocols.
- In healthcare settings, Ebola is [spread through direct contact](http://www.cdc.gov/vhf/ebola/transmission/human-transmission.html) (<http://www.cdc.gov/vhf/ebola/transmission/human-transmission.html>) (e.g., through broken skin or through mucous membranes of the eyes, nose, or mouth) with blood or body fluids of a person who is sick with Ebola or with objects (e.g., needles, syringes) that have been contaminated with the virus. For all healthcare workers caring for Ebola patients, PPE with full body coverage is recommended to further reduce the risk of self-contamination.
- To protect healthcare workers during care of an Ebola patient, healthcare facilities must provide onsite management and oversight on the safe use of PPE and implement administrative and environmental controls with continuous safety checks through direct observation of healthcare workers during the PPE donning and doffing processes.

PERSONAL PROTECTIVE EQUIPMENT – PPE:

- Gown
- Gloves – 2 pair
- N95 Respirator mask
- Safety Glasses (optional)
- Hair Bonnet or Hood

- Boot Covers

DONNING PPE:

PPE must be put on in the order listed below and you will need a properly trained partner to observe and help you make sure the PPE is properly worn. **PERFORM HAND HYGIENE BEFORE BEGINNING.**

1. **Engage Trained Observer:**
2. **Remove Personal Clothing, Jewelry and Items:**
3. **Inspect PPE Prior to Donning**
4. **Perform Hand Hygiene.**
5. **Put on Inner Gloves:** Put on first pair of gloves.
6. **Put on Boot or Shoe Covers.**
7. **Put on Gown or Coverall:** Put on gown or coverall. Ensure gown or coverall is large enough to allow unrestricted freedom of movement. Ensure cuffs of inner gloves are tucked under the sleeve of the gown or coverall.
8. **Put on N95 Respirator:** Put on N95 respirator. Complete a user seal check.
9. **Put on Surgical Hood:** Over the N95 respirator, place a surgical hood that covers all of the hair and the ears, and ensure that it extends past the neck to the shoulders. Be certain that hood completely covers the ears and neck.
10. **Put on Outer Gloves:** Put on second pair of gloves (with extended cuffs). Ensure the cuffs are pulled over the sleeves of the gown. Tape if necessary
11. **Put on Face Shield:** Put on full face shield over the N95 respirator and surgical hood to provide additional protection to the front and sides of the face, including skin and eyes.
12. **Observer Verify:** After completing the donning process, the integrity of the ensemble is verified by the trained observer. The healthcare worker should be comfortable and able to extend the arms, bend at the waist and go through a range of motions to ensure there is sufficient range of movement while all areas of the body remain covered.
13. **Disinfect Outer Gloves:** Disinfect outer-gloved hands with ABHR. Allow to dry prior to patient contact.
14. **SIGN THE EBOLA ISOLATION SIGN IN SHEET** before entering the room.

REMOVING PPE:

PPE must be removed in the order listed below and assisted/observed by a trained partner (who is also attired in the PPE).

1. **Inspect:** Inspect the PPE to assess for visible contamination, cuts, or tears before starting to remove. If any PPE is visibly contaminated, then disinfect using 10% Bleach or Sani-Cloth.
2. **Disinfect Outer Gloves (DO THIS BETWEEN ALL STEPS)**
3. **Remove Boot or Shoe Covers:** While sitting down, remove and discard boot or shoe covers.
4. **Disinfect and Remove Outer Gloves:** Remove and discard outer gloves taking care not to contaminate inner gloves during removal process.
5. **Inspect and Disinfect Inner Gloves:** Inspect the inner gloves' outer surfaces for visible contamination, cuts, or tears. If an inner glove is visibly soiled, cut, or torn, then disinfect the glove. Then remove the inner gloves, perform hand hygiene and don a clean pair of gloves. If no visible contamination, cuts, or tears are identified on the inner gloves, then disinfect the inner-gloved hands.
6. **Remove Face Shield:** Remove the full face shield by tilting the head slightly forward, grabbing the rear strap and pulling it over the head, gently allowing the face shield to fall forward and discard. Avoid touching the front surface of the face shield.
7. **Disinfect Inner Gloves**
8. **Remove Surgical Hood:** Unfasten (if applicable) surgical hood, gently remove, and discard. The trained observer may assist with unfastening hood.
9. **Disinfect Inner Gloves**
10. **Remove Gown or Coverall:** Remove and discard. Depending on gown design and location of fasteners, the healthcare worker can either untie fasteners, receive assistance by the trained observer to unfasten to gown, or gently break fasteners. Avoid contact of scrubs or disposable garments with outer surface of gown during removal. Pull gown away from body, rolling inside out and touching only the inside of the gown.
11. **Disinfect and Change Inner Gloves:** Don a new pair of inner gloves.
12. **Remove N95 Respirator:** Remove the N95 respirator by tilting the head slightly forward, grasping first the bottom tie or elastic strap, then the top tie or elastic strap, and remove without touching the front of the N95 respirator. Discard N95 respirator.
13. **Disinfect Inner Gloves**
14. **Disinfect Washable Shoes:** Sitting on a new clean surface (e.g., second clean chair, clean side of a bench) wipe down every external surface of the washable shoes.
15. **Disinfect and Remove Inner Gloves:** Remove and discard gloves taking care not to contaminate bare hands during removal process.
16. **Perform Hand Hygiene**
17. **Inspect:** Perform a final inspection of healthcare worker for any indication of contamination of the surgical scrubs or disposable garments. If contamination is identified, immediately inform supervisor before exiting the room.

Hand Hygiene

Perform hand hygiene frequently, including before and after all patient contact, contact with potentially infectious material, and before putting on and upon removal of PPE, including gloves.

Response Team:

Medical Director	Response Coordinator
Nursing Supervisor	Infection Control
Risk Management/Lab	Education
Administration Representative	Communication
Nursing Representatives	Infection Control
	Community Outreach
Radiology Representative	Surveillance Coordinator
Reception Representative	Triage/Surveillance

Surveillance/Communication:

- Monitor State, County and City Public Health advisories for changes in information. The clinic will monitor all facsimiles, emails and telephone calls. Updates will be made to the Response team and communicated to all clinic employees by posting updates and staff meetings.
- Inform members of the Response team when U.S. and when it is nearing the geographic area.
 - ND Health Alert Network(HAN) <http://www.ndhan.gov/health/>
 - Categories of Health Alert messages:
 - Health Alert conveys the highest level of importance; warrants immediate action or attention.
 - Health Advisory provides important information for a specific incident or situation; may not require immediate action.
 - Health Update provides updated information regarding an incident or situation; no immediate action necessary.
 - Health Information provides general information that is not necessarily considered to be of an emergent nature.
- Monitor and review Ebola in patients cared for by clinic staff.
- Report any cases of Ebola to the local and state health department.
 - The health department will provide recommendations to health care providers using the HAN. We will be responsible for reporting potential cases. Clinicians should immediately contact the health department when they suspect a human case of infection with an avian or animal strain of influenza or any other novel human influenza strain. Nursing will call public health for current information when a patient is suspected to have contact with Ebola
 - Clinical Criteria-Fever plus travel to area of interest. For more current information refer to www.cdc.gov/flu
- Periodically, updates to the local regional pandemic plans will be monitored at
 - CDC: <http://www.cdc.gov/vhf/ebola/hcp/index.html>

- OSHA: <https://www.osha.gov/SLTC/ebola/>
- NDDOH: <http://ndhealth.gov/disease/ebola/CDC.aspx>
- CDC and NDDOH website includes a **Checklist for Patients Being Evaluated for Ebola Virus Disease (EVD) in the United States checklist.**

Essential Staff

The number of staff necessary for patient care during a severe pandemic on a given day will include physicians, nurses, x-ray, lab and receptionists. If necessary, nonessential staff will be moved to administration based on patient care needs and infection control for staff and patients.

Employee Exposures

An exposure is defined as persons with percutaneous or mucous membrane exposures to blood, body fluids, secretions or excretions from a patient with suspected Ebola VD or breach of the PPE.

When exposure to a patient with known or suspected EVD occurs, employees should:

- Stop working and immediately wash the affected skin surfaces with soap and water. Mucous membranes (eyes) should be irrigated with copious amounts of water or eyewash solution.
- Immediately contact your supervisor and NDDOH.
- Staff who develop sudden onset of fever, intense weakness or muscle pains, vomiting, diarrhea, or any signs of hemorrhage after an exposure through direct contact to blood or body fluids of a patient with Ebola VD should:
 - Not report to work or should immediately stop working and notify their supervisor and NDDOH. Seek medical evaluation and testing.
 - Comply with work exclusion until they are deemed no longer infectious to others by primary care provider and NDDOH.

****Staffing concerns and exposure will be assessed on a case by case basis by the NDDOH, Kirby Krueger.**

For asymptomatic staff who had an unprotected exposure (not wearing recommended PPE at the time of patient contact or through direct contact to blood or body fluids) to a patient with Ebola VD:

- Should receive medical evaluation. Follow-up care will include fever monitoring twice daily for 21 days after the last known exposure
- Maintain temperature log .
- May continue to work if asymptomatic while receiving twice daily fever checks.
- IF employee develops symptoms, employee must stop work immediately and contact supervisor and NDDOH.

Contact List for Ebola

- Sanford Health – Jodi Barnum, Infection Control 323-6168
One Call 323-1225
- St. Alexius – Sue Zieman, Infection Control 530-7648
- Metro Ambulance – Dan Schafer 255-0812
- NDDoH:
 - Tim Wiedrich, Emergency Preparedness & Response 328-2270 (monitored 24/7)
 - Kirby Kruger, Medical Services Director (staff concerns) 328-2378
 - Tracy Miller, State Epidemiologist 328-2378
 - Michelle Feist, Epidemiology & Surveillance 328-2378
- NDPHL:
 - Tim Brosz, ND Specimen Collection and Testing 328-6272
 - State Radio, AHC NDPHL 1-800-472-2121
- CDC Laboratory Testing:
 - Consult all testing with CDC 1-770-488-7100

Transportation

- Sanford Health: One Call 323-1225
 - **Before transferring the patient** call the One Call to give them the patient information re: temp, travel hx to area of interest for Ebola, and other symptoms and that it is a suspected Ebola case
 - Call Metro Ambulance service and give them patient information and that it is a possible Ebola case.
- Metro Area Ambulance: Dan Schafer, Admin. 255-0812
 - Transporting patients to emergency rooms

Disinfection

https://www.osha.gov/Publications/OSHA_FS-3756.pdf

10 % Bleach solution (9 C. Water and 1C.Bleach).

PDI Sani-Cloth Bleach Wipes

- **To reduce exposure among staff to potentially contaminated textiles (cloth products) while laundering, discard all linens, non-fluid-impermeable pillows or mattresses, and textile privacy curtains into the waste stream and disposed of appropriately.**
- Cleaning and disinfection of hard, non-porous surfaces (e.g., high-touch surfaces such as bed rails and over bed tables, housekeeping surfaces such as floors and counters) should be done.⁴ Before disinfecting a surface, cleaning should be performed. Use cleaning and disinfecting products according to label instructions. Check the disinfectant's label for specific instructions for inactivation of any of the non-enveloped viruses (e.g., norovirus, rotavirus, adenovirus, poliovirus) follow label instructions for use of the product that are specific for inactivation of that virus. Use disposable cleaning cloths, mop cloths, and wipes and dispose of these in leak-proof bags. Use a rigid waste receptacle designed to support the bag to help minimize contamination of the bag's exterior.

Waste Management**ALL BIOHAZARD TRASH RECEPTICLES WILL BE TRIPLE LINED WITH RED BIOHAZARD BAGS**

- The Ebola virus is classified as a Category A infectious substance by and regulated by the U.S. Department of Transportation's (DOT) Hazardous Materials Regulations (HMR, 49 C.F.R., Parts 171-180). Any item transported offsite for disposal that is contaminated or suspected of being contaminated with a Category A infectious substance must be packaged and transported in accordance with the HMR. This includes medical equipment, sharps, linens, and used health care products (such as soiled absorbent pads or dressings, kidney-shaped emesis pans, portable toilets, used Personal Protection Equipment (gowns, masks, gloves, goggles, face shields, respirators, booties, etc.) or byproducts of cleaning) contaminated or suspected of being contaminated with a Category A infectious substance.

- **Stericycle** works closely with the U.S. Department of Transportation (DOT) and Centers for Disease Control (CDC), Stericycle has been advised to address each situation on a case-by-case basis until such time that they have an all-encompassing protocol.
 - A Special Permit will be obtained by Stericycle for Category A Waste removal. Once granted, Stericycle will provide a current copy of the special permit to be maintained at the Generator's site as per DOT regulations.
 - All waste generated from a suspected/confirmed patient should be treated as special Category A waste and packaged and handled according to the attached guidance.
 - Additional guidance for contingency planning will be provided as more information becomes available.

Category A Waste Handling & Packaging Procedures

Guidelines for a Suspected or Confirmed Case of Ebola

- With a suspected or confirmed Ebola case immediately contact the local/state health department and CDC.
- All waste generated from a suspected/confirmed patient should be treated as special Category A DOT waste as follows:

1. Make sure you are utilizing all PPE and following all applicable guidelines as directed by the following link from the CDC:

<http://www.cdc.gov/vhf/ebola/hcp/environmental-infection-control-in-hospitals.html?mobile=nocontent>

2. Place soft waste or sealed sharps containers into a primary medical waste bag (min 1.25 or 1.5ml – ASTM tested; can be provided by Stericycle).
3. Apply bleach or other virocidal disinfectant into the primary bag to sufficiently cover the surface of materials contained within the bag; securely tie the bag.
4. Treat the exterior surface of the primary container with bleach or other virocidal disinfectant.
5. Place the primary bag into a secondary bag and securely tie the outer bag.
6. Treat the exterior surface of the secondary bag with bleach or other virocidal disinfectant.

If you HAVE Stericycle 55 gallon special Category A DOT Waste “GREEN DRUMS” on site go to Step 10 below

If you do NOT have special Stericycle 55 gallon special Category A DOT Waste “GREEN DRUMS” on site continue to Step 7 below

7. The double bagged waste should then be placed on a hard non-porous surface in a secure room close to the point of use. Make sure the collection area is clearly labeled special Category A DOT Waste.
8. Contact your Stericycle representative who will arrange delivery of the special Category A DOT Waste containers (containers can be shipped for overnight delivery).
- 9. As soon as your special Category A DOT Waste Containers arrive follow step 10 below.**
10. The double bagged waste should then be placed into special Category A DOT Waste packaging/drums provided by Stericycle with the liner tied securely and container closed per the packaging instructions provided. Label the special Category A DOT Waste with provided labels.
11. Store the special Category A DOT Waste containers separate from other regulated medical waste in a secure area preferably isolated and with limited access.

- Stericycle recommends using disposable sharps containers for suspected/confirmed Ebola cases. The disposable container should be sealed and disposed of as special Category A waste following the instructions above. If a reusable sharps container is inadvertently used that container should also be sealed and disposed of inside the bags with the Category A waste.
- Contact your Stericycle representative who will begin the process with the DOT to acquire a “Special Permit” as required.

- *Stericycle has been advised by the DOT and CDC that we must address each situation on a case by case basis until such time that they have an all-encompassing protocol.*
- *Once the Special Permit has been granted, Stericycle will provide a current copy of the special permit to be maintained at the Generator's site as per DOT regulations.*
- *Contact your Stericycle representative should you need additional supplies to properly package Category A waste.*

TRIAGE PROTOCOL FOR PATIENTS WITH SUSPECTED EBOLA

UND CFM
701 E. Rosser Ave
Bismarck, ND 58503

Fever Questionnaire

Patient Name: _____

Date of Birth: _____

Do you have a fever? Yes /No

Have you traveled from or been in contact with someone from an area of interest for Ebola?

Do you have any of these symptoms?

- a. Headache
- b. Weakness
- c. Muscle pain
- d. Vomiting
- e. Diarrhea
- f. Abdominal pain
- g. Bruising or Bleeding

[Home](#)

Code Amber

If a Parent/Guardian approaches a staff member and reports a child missing, Follow these steps:

1. Notify the Business Manager (Code Leader) to a possible missing child. The Business Manager will interview the parent promptly. If the Business Manager is unavailable lab or x-ray personnel will be available.
2. Ask the following:
 - a. What is the child's name? _____
 - b. How long ago did you see the child? _____
 - c. Where was the last place you saw the child? _____
 - d. Did you check the area where the child was last seen?
 - e. Get a detailed description of the child.
 - i. Name _____ Age _____
 - ii. Hair Color _____ Eye Color _____
 - iii. Approximate Weight _____ and Height _____
 - iv. What is child wearing (remember to ask shoe color and style)
3. Announce CODE AMBER ALERT over the PA system ASAP. Repeat CODE AMBER X3. Give complete description of child. *Script below**
4. Notify Sanford Security ASAP using Sanford house phone or dialing 214-9269.
5. Explain to the parent what is happening and ask them to remain calm. Keep the parent with you in an open exam room.
6. Designated staff move to designated exit door and other staff begin sweep of all clinic areas.**Report to the Code Leader when you are finished with your area.
7. Place a call to local police by calling 911 following the initial sweep of all clinic areas if child is still reported missing.
8. When child is found notify Code Leader and 911 ASAP.
9. If the child is found and appears to have been just lost and unharmed, the child is reunited with parent/guardian.
10. If the child is found accompanied by someone other than the parent/guardian, use reasonable efforts to delay their departure without putting the child, staff, or visitors at risk. Notify police and give details about the person, vehicle, direction of travel etc...
11. The Code Amber is canceled after child is found. Over PA system repeat CODE AMBER CANCELED X3.
12. Complete incident report and file with risk management.

*Script: Attention, Code Amber, Code Amber, Code Amber; we have a lost child named _____, age _____, with _____ hair and _____ eyes, weighs approximately _____ pounds and _____ feet tall, last seen wearing _____.

**Exit Doors: (Fire Evacuation Route Map) Listed is the entrance or exit that needs to be monitored followed by the assigned department.

1. Front Doors and Elevator First Floor-*Reception*
2. Elevator/East Stairwell Second Floor-*Business Office*
3. South Stairwell First Floor-*Pharmacy*
4. West Stairwell First Floor-*Nursing/Residents*
5. South and West Stairwells Second Floor-*Medical Records/Administrative Asst.*

**Clinic Areas: Listed is the clinic area that needs to be checked for the missing child followed by the assigned department.

1. Toy Room/Bathrooms/coat closet/Elevator: *Front Desk*

2. South Stairwell/Equipment Rooms/Clean and Soiled Utility: *Pharmacy*
3. Second Floor Bathrooms/Elevator/ East Stairwell: *Business Office*
4. Second Floor Offices/Conf. Room/Employee Health Ctr/Employee Lounge: *Medical Record/Administration/Admin Asst.*
5. Procedure Rooms 2-4/exam rooms/nursing hallways/offices/resident offices: *Nurse/Resident*
6. Lab Bathrooms/Proc Rm 1/Xray rooms: *Lab/X-ray*
7. Administration Entrance: *Administrative Asst*
8. Administration Exit: *Administrative Asst*

[Home](#)

COMMUNICABLE DISEASES

TUBERCULOSIS EXPOSURE

Purpose:

All health-care settings need an infection-control program designed to ensure prompt detection, airborne precautions, and treatment of persons who have suspected or confirmed tuberculosis.

Procedure:

1. Patients who have suspected or confirmed TB disease should be considered infectious if they are coughing, undergoing cough-inducing procedures, or have positive sputum smear results for acid-fast bacilli (AFB); and they are not receiving adequate therapy or have just started therapy.
2. Particulate filter respirators certified by the CDC and NIOSH such as properly fitted N95 (disposable) masks are to be worn by staff in direct contact with a suspected or confirmed TB patient. Stock masks appropriately in your work area.
3. The patient is to wear an N-95 disposable mask to stop the spread of the disease as well. Stock masks appropriately in patient areas. Limit the movement of the patient within the clinic and in the waiting room. All rooms with TB patient contact should be disinfected.
4. *If an employee is exposed to someone with TB disease:*

The employee will be seen by a physician and a mantoux tuberculin skin test (TST) will be performed if there are no contraindications. A TST result of >10mm of induration within 48 hours is positive. If the tuberculin skin test is positive then a chest x-ray will be performed.

The employee should watch for the following symptoms; unexplained weight loss, loss of appetite, night sweats, fever, fatigue, chills, coughing for > 3 weeks, and chest pain. The employee will report any of these symptoms to their supervisor.

N95 Respiratory Mask Fit Testing:

Respirator Fit testing will be announced in advance and is done for essential staff. The masks will be properly fitted for employees annually and when major facial changes occur. Mask fitting will be done at the Center for Family Medicine and takes approximately 20 minutes. Your report will be provided to you so that you know what size is for you and a copy will be kept in the Business Manager's office for reference.

N95 Masks are stored in the pandemic flu closet and general nursing supplies. They come in 3 sizes. The best size for you will be determined during Fit testing. Be sure to stock your appropriate size in the area you work so they are easily accessible.

[Home](#)

BLOODBORNE PATHOGENS CONTROL PLAN

HISTORY

Then Bloodborne Pathogen Standard was passed by the U.S. Congress to protect health care workers from occupational exposure to blood or other potentially infectious materials that may cause the transmission of HIV, HEPATITIS B (HBV), HEPATITIS C (HCV), or other bloodborne pathogens.

UNIVERSAL PRECAUTIONS

The employees at Center for Family Medicine-Bismarck treat all blood and body fluid specimens as being potentially biohazardous.

INFECTIOUS MATERIALS AND TRANSMISSION

OSHA defines the following as being potentially infectious materials: blood or Other Potentially Infectious Materials (OPIM) such as semen, vaginal secretions, cerebrospinal fluid, synovial fluid, pleural fluid, pericardial fluid, peritoneal fluid, amniotic fluid, and saliva, any body fluid visibly contaminated with blood or all body fluids where it is difficult or impossible to differentiate between body fluids. They also include any unfixed tissue or organ other than intact skin from a human (living or dead), and any cell, tissue or organ cultures that contain HIV or HBV.

Transmission can occur when a task is performed and results in a skin puncture from a sharp object, non-intact skin from an existing wound or skin condition being exposed to blood or OPIM, or mucous membranes splashed, sprayed, or touched with blood or OPIM.

EMPLOYEES POTENTIAL FOR RISK

The following job classifications in this facility have occupational exposure to blood or other potentially infectious materials:

PHYSICIANS, NURSES, LABORATORY TECHNICIANS.

The following job classifications in this facility may occasionally have contact with blood or other potentially infectious materials. Their exposure is limited to emergency situations, entering the laboratory to ask questions, and carrying specimens to the laboratory (this is to be limited by requesting the patient to deliver the sample).

RECEPTIONIST, MEDICAL RECORDS, BILLING PERSONNEL

PROCEDURES WITH RISK FOR EXPOSURE

Patient examinations
 Aspirations
 Inoculations
 Lesion excisions
 Wound care
 Colposcopies
 IUD insertions
 Vasectomies
 Vaginal examinations/OB Care
 Biopsies
 Venipuncture
 Capillary blood draw
 Lacerations
 I&D
 Sigmoidoscopy
 Catheterization

Circumcisions
 Processing of blood samples
 Ear and eye irrigation
 Spinal taps
 Cryotherapy
 Collection for Cultures
 Nasal Laryngoscopy

[Home](#)

ENGINEERING/WORK PRACTICE CONTROLS

Engineering and work practices designed to eliminate or minimize employee exposure shall be used when performing exposure potential tasks. All procedures involving blood and OPIM will be performed in a way that prevents or minimizes splashing, spraying, spattering, and generation of droplets. Where occupational exposure remains, personal protective equipment shall also be used. Engineering and work practice controls will be evaluated, maintained, and/or replaced on a regular basis to ensure their continued effectiveness. This facility identifies the need for changes in engineering controls and work practices through review of incident records, use of checklists, evaluation forms, and employee concerns. Should an exposure incident occur while using these controls, the controls will be evaluated as to the reason for the failure, corrected, and changes will be made to the policy. Ongoing training of employees will occur to reflect new changes in procedures. Engineering and workplace controls will need to be monitored continuously by all employees involved in using them.

WORK PRACTICE CONTROLS

- Hand washing is required in this facility. Employees have been instructed in this procedure and know where facilities are located. Hands are to be washed immediately or as soon as feasible after removal of gloves, between patients, and after handling potentially contaminated items. They are to be washed using a bactericidal soap or one with a nonrynl-9 base. (See engineering controls for further information).
- Recapping of sharps, and bending or breaking of needles is prohibited in this facility. Employees have been trained in these procedures (See housecleaning schedule). If needles must be recapped for safety reasons, the one-handed scoop (passive recapping) is approved. The laboratory uses a safety needle (BD Safety Lok/Protex Needle Pro) and sharps container when performing venipuncture. Safety-Lok Blood Collection devices are used for butterfly draws. New safety devices will be evaluated as needed. (See Sharps Handling)
- Disposal of sharps (Ex. syringes, scalpel blades, pipettes) immediately after use, all sharps are placed in the red hard sided receptacles and cream colored with appropriate labels and warning placed on the outside of the container for disposal. The containers meet the requirements as outlined in OSHA regulations for engineering controls. Employees have been trained in these procedures, and have been instructed not to overfill (>80% full) containers to help prevent accidental exposure. Sharps are to be disposed by the person using the sharp and are not to be left for others to dispose (See engineering controls for further details). Red bags are used for contaminated waste and garbage; the waste is double bagged to prevent leakage.
- Mechanical pipettes are required in this facility where appropriate. Mouth pipetting is not allowed for any reason. Blood and other potentially infectious materials are handled with care in this facility. Employees have been trained in these procedures.
- Eating, drinking, smoking, applying cosmetics and handling contact lenses is prohibited in this facility in work areas where there is any risk of occupational exposure. Employees have been informed of this rule.
- Storage of food and drink is prohibited in places where other potentially infectious materials are kept. This applies to refrigerators, freezers, shelves, cabinets; counter tops, and bench tops. Employees have been informed of this rule.
- Equipment that may become contaminated is inspected for blood or other potentially infectious materials on a regular basis and decontaminated if necessary (See cleaning schedule). Stericycle is responsible for all red-bagged garbage and will use their protocol in handling this waste. The waste is stored in the soiled utility room in the marked gray containers until it is picked up weekly. Proof of regulated waste destruction shall be filed and maintained for a minimum of 3 years.
- The nurses will disinfect and decontaminate surgical instruments and miscellaneous instruments and supplies with the appropriate method either cold disinfection or by autoclaving (See cleaning schedule).
- Equipment is inspected routinely. It is repaired or shipped and decontaminated if necessary. If it cannot be decontaminated before repair or shipment, the staff has been instructed to label the site(s) of contamination clearly with a biohazard label.
- Laundry service is supplied by Central Dakota Laundry and AmeriPride Linen and Apparel Services. Place soiled garments in the appropriate bins in the Utility Room. Red bag items that are grossly contaminated with blood or body fluids.

- Bader Maids provides daily cleaning and waste disposal for the clinic.

ENGINEERING CONTROLS

- Hand washing facilities are available for staff use at the following locations: patient examination rooms, nurse's station, laboratory, and restrooms.
- Leak-proof, puncture-resistant sharps containers are located in each of the patient examination rooms, the nurse's station, and the laboratory. The containers are red hard sided containers or cream colored with appropriate labels and warning placed on the outside of the container. When the container reaches the manufacturers fill limit, the revolving lid is to be closed, sealed and placed in the cast room closet in the labeled gray containers for pickup by Environmental Transport Services Inc. These containers are not to be emptied by anyone. The containers in the examination rooms are to be used to dispose of used syringe needles and their holders, also any sharp objects that may puncture through a red bag. The container in the lab will be used to dispose of syringe needles and their holders, butterflies, sharps, blood tubes, and any broken glass.
- OSHA Needlestick and Prevention Act require the identification, evaluation, and selection of engineering and workplace controls by non-managerial personnel. Use of needleless systems should be used where appropriate. Refer to the Sharps Handling section of this policy.
- Blood specimens or other potentially infectious materials are kept in leak-proof containers during collection, handling, and storage. Double-bagged, red garbage bags are used to reduce accidental leakage. These bags may contain used gloves, blood soaked gauze, bandages, and other forms of contaminated material such as soiled clothing. The garbage bags are to be removed by nursing and laboratory employees.
- Mechanical pipettes are available in the laboratory when needed. Mouth pipetting is unnecessary and is not allowed.
- Contaminated instruments will be placed in a biohazard bag or container to be transferred to cleaning areas. This will help prevent incidental contamination of areas.
- Eyewash equipment is located in the laboratory.
- Engineering controls outlined above are inspected and maintained annually.

[Home](#)

PERSONAL PROTECTIVE EQUIPMENT

The following personal protective equipment is available in this facility free of charge. It is to be used whenever there is potential risk of exposure to blood or OPIM. PPE shall be evaluated as to appropriateness, size and effectiveness as needed and on an annual basis. Notify your supervisor if you need or would like to try a different product than what is available in the facility. There is a list for personal protective equipment required for different procedures. Additional equipment may be used if desired by the employees.

- Antiseptic hand cleaner is used when employees wash their hands. Hand Sanitizer by Dial is also available in nursing and lab areas.
- Gloves should be worn any time contact with blood or body substances is possible. Disposable gloves, in appropriate sizes, are available for all workers at risk of exposure, at the following locations in this facility: each of the patient examination rooms, the nurse's station, and the laboratory. Hypoallergenic gloves or glove liners will be available upon request. Latex free gloves are available for use if required or requested. Gloves are to be checked for physical defects and discarded if unacceptable. Gloves must be changed between patient contacts. Gloves are to be replaced as soon as possible when contaminated, torn, or punctured. Gloves should also be removed before handling non-contaminated items or when leaving the laboratory or other contaminated areas. Remove gloves so that the gloves outer surface never touches the skin. Disposable gloves cannot be washed or decontaminated and reused. Utility gloves will be provided for housekeeping personnel by ServiceMaster.
- At this time face protection, footwear, headwear, and respiratory equipment is not required but is available if requested. A mask, face and eye protection should be used when splashes or sprays of blood, other body fluids, secretions or excretions are possible. Masks are stored in the procedure room if requested.
- Protective body clothing is required at this facility. Lab coats or disposable gowns are to be worn (and buttoned shut) in the lab at all times. Before leaving the laboratory, the following procedure is to be followed in the order given: gloves are to be removed, and then jackets, and finally, the hands are to be thoroughly washed. A clean lab coat may be worn to other areas of the clinic.
- Protective gowns are to be utilized by physicians and nurses in some procedures (See the procedure list for examples). They must be removed immediately upon contamination in a manner which will avoid contamination of clothing underneath.
- Employees have the right to use PPE to protect them. It is the responsibility of each employee to follow the policies. Time must be allowed for the employee to put on the equipment before handling anything that may be contaminated with body fluids. The *only* time this rule is not effective is in a life threatening situation.

[Home](#)

TASK ASSESSMENT

TASK	PROTECTIVE EQUIPMENT	ENGINEERING CONTROLS
Phlebotomy	Gloves, gown	Sharps container, safety sharps
Processing blood samples	Gloves, gown	
Plating cultures	Gloves, gown	
Aspirations	Gloves, gown	Sharps container
Inoculations	Gloves	Sharps container
Lesion excisions	Gloves, gown (as indicated)	Sharps container
Wound care	Gloves, gown (as indicated)	
Colonoscopy	Gloves, gown	Sharps Container
Colposcopies	Nurse-gloves, Doctor-glove, gown	
IUD insertion	Nurses-gloves, Doctor-gloves	
Vasectomies	Gloves, gown	Sharps container
Vaginal Exam	Gloves	
OB care	Gloves	
Biopsies	Gloves, gown (as indicated)	
Lacerations	Gloves, gown (as indicated)	Sharps container
I&D	Gloves, gown, face shield	
Sigmoidoscopy	Gloves, gown	
Circumcision	Gloves	Sharps container
Catheterization	Gloves	
Nasal Laryngoscopy	Gloves	
Cryotherapy	Gloves	
Eye and ear irrigation	Gloves	
Spinal tap	Gloves, gown	Sharps container
Toenail Removal	Gloves	

As *indicated* in such cases that clothing contamination is possible. For example: Any large or bloody wound, any wound irrigation, or any wound irrigation or any situations where possible aerosols may be generated. These situations would require a gown to be worn. There are face shields available if desired for protection.

LABELS

* Labels are to be attached to regulated waste. They should also be placed on refrigerators and freezers containing blood or other potentially infectious waste, as well as on containers used to store, transport, or ship blood or other potentially infectious material. Labels must contain the biohazard symbol and must be fluorescent orange or orange-red with lettering of symbols in contrasting color. Red bags or containers may be substituted for labels.

HOUSEKEEPING

Cleaning Spills and Decontaminating Surfaces:

- Gloves are required for all cleaning procedures; a gown should be worn when a large spill is cleaned up.
- If blood or body fluid spill is small and a hard surface, wipe up with Metrix Caviwipes. If spill is large and on a hard surface flood with 10% bleach solution and allow to sit 10 minutes. Then mop up spill and bleach with disposable toweling and throw into the biohazardous waste. Assure no leakage is possible (double bag if necessary) and place in the Soiled Utility room in the gray containers.

Cleaning up Broken Glass or Dropped Sharps:

- Do not use your HANDS!
- Put on glove; use a brush and dustpan to sweep up glass. You may also use forceps or tongs. Place the glass or sharp into a sharps container. If the glass or sharp was contaminated, you must decontaminate the utensils used by soaking them in 10% bleach for 10 min, rinsing, and wiping them dry.

Sharps Containers:

- Insure that sharps containers do not become overfilled. Change container when it becomes 80% full.
- Sharps containers must be closed before removal.
- On wall-mounted sharps containers, you must use a key to unlock the containers from the mount.
- Once removed, place used sharps container in the cast room closet in the gray containers for disposal by Stericycle

[Home](#)

Schedule for Decontamination of Work Areas

WORK PRACTICE	PERSON RESPONSIBLE	DUTY
Sharp Containers	Nurse/Lab	Replace as needed when 75-80% full
Exam Tables	Nurse	Wipe down at the end of the day and as needed with Cavi-wipes
Laundry	Nurse/Lab	Place in Utility Room as needed
Analyzers	Lab	Clean appropriately as needed
Protective Coverings	Nurse/Lab	Replace if visibly contaminated
Surgical/Misc Instruments	Nurse	Autoclave M 11 Ultraclave daily/as needed

NEEDLESTICK SAFETY

Non-managerial employees responsible for patient care will be involved in selecting and testing of new safety devices. New devices will be evaluated and the findings will be documented on an evaluation form. All staff will be trained in the use of new devices prior to implementation into daily use. Documentation of evaluations and updates will be kept by department supervisors. New technology will be reviewed on a yearly basis.

TRAINING

Training is required at the time of employment, within 90 days of standard and yearly, or if tasks or procedures change that affects the employee's occupational exposure. Training will be provided to all full time, part time, temporary, contract or per diem employees.

Training must be provided by employers at no cost to employees during work hours and must include the following:

1. A copy of the regulatory text of the standard and explanation of its contents.
2. A general explanation of epidemiology and symptom of bloodborne pathogens.
3. Explanation of modes of transmission of bloodborne pathogens.
4. Explanation of the exposure plan and how to get a copy.
5. Explanation of methods for recognizing tasks and other activities that may involve exposure to blood or other potentially infectious materials.
6. Explanation of use and limitations of methods that will prevent or reduce exposure(ex: engineering controls, personal protective equipment, work practices)
7. Explanation of use, disposal, decontamination, removal or handling personal protective equipment.
8. Information on Hepatitis B vaccine-efficacy, safety, administration, and that it is offered free of charge.
9. Information on appropriate actions to take and persons to contact in an emergency involving blood or other potentially in factious materials.
10. Procedures to follow if an exposure incident occurs: method of reporting, medical follows up.
11. Post exposure evaluation and follow up; that it is required by the employer
12. Explanation of signs and labels and color coding that is required.
13. Interactive questions and answers with person conducting training session; person performing the training must be knowledgeable.

TRAINING RECORDS

The training records must include the following information:

1. Dates of session
2. Contents and summary of training sessions
3. Names and qualifications of persons conducting training.
4. Names and job titles of persons attending.
5. Keep roster for 3 years from training session

The training form will be the clinic meeting roster with the above information listed.

QUALITY ASSURANCE

This policy will be reviewed on a yearly basis by the Risk Management Committee. The policies will also be reviewed with major changes that may occur in daily practice within the clinic. Training and record keeping will be provided by the risk management committee and department supervisors.

All employees, residents, and faculty are required to participate in a yearly review of this policy.

HEPATITIS B VACCINE

Hepatitis B is the most common bloodborne pathogen contracted due to an exposure. Of those infected with hepatitis B, one third will have no symptoms at all, one third will have mild flu symptoms, one third of may suffer from flu-like symptoms so severe that they may require hospitalization. These symptoms are jaundice, dark urine, fatigue, anorexia, abdominal pain, nausea, skin rash, and fever. The incubation period for HBV is 160-180 days. About five percent of those infected with HBV will become chronically infected. The good news is there is a vaccine for hepatitis B.

Hepatitis B vaccine is to be made available to all current employees and to all new employees within 10 days of employment. The vaccine is given in a series of 3 shots over 6 months. Vaccination is unnecessary if the employee has previously received the completed Hepatitis B vaccination (employee needs to provide documentation or signed statement as part of the employee's medical record), antibody testing has revealed the employee is immune, or the vaccinations are medically contraindicated (to be evaluated by a physician). Contraindication may include allergy to yeast or other ingredients, auto immune disease and fever. The employer cannot make participation in a pre-screening program a prerequisite for receiving the vaccine. If the employee chooses not to receive the vaccination they must sign a waiver declining the vaccination. (See the enclosed waiver) The employee will be informed that the vaccination will be available to them at any time, should they reverse their decision not to accept it initially. If routine booster doses are recommended by United States Public Health Service, they will be available at no cost to the employee or use of employees insurance.

If the schedule of HBV vaccinations has been interrupted, the entire course does not need to be restarted. If the vaccination series is interrupted after the first dose, the second and third doses should be given separated by an interval of 3-5 months. Persons who are late for the third dose should be given this dose when convenient.

Post-vaccination screening for antibody to HBsAg (Anti-HBs) is advised for personnel at ongoing risk of blood exposure. To determine if response to vaccination has occurred and to aid in determining the appropriate post-exposure prophylaxis or need for revaccination. The CDC requires that a titer be measured on each employee 1-2 months following the last injection of the 3-injection series. If the antibody level is too low or not detectable, the series will be repeated.

Revaccinated persons should be tested for Anti-HBs at the completion of the second vaccine series. If they do not respond, no further vaccination series should be given and they should be evaluated for the presence of HBsAg and follow the recommendations of a physician. Document all measures taken for the employee as a non-responder to the vaccine?

Up to 60% of those who initially respond to vaccination would lose detectable Anti-HBs over 12 years. Booster doses are not recommended because persons who respond to the initial vaccine series remain protected against Hepatitis B.

Note: Hepatitis B vaccines have been found to be safe when administered to infants, children, and adults. Common side effects include pain at injection site, mild to moderate fever. Vaccine can be given during pregnancy or lactation.

HEPATITIS C

HCV infection occurs among persons of all ages. Hepatitis C virus accounts for 70% of chronic hepatitis and 30% of end-stage liver disease. The incubation period of the acute infection is 7-8 weeks. Less than 15% of patients with HCV infection have a spontaneous cure. HCV infection causes chronic hepatitis in 85% of patients. 85% of those infected with HCV have no symptoms at all. They can be asymptomatic for up to 20 years. 15% suffer symptoms including jaundice, dark urine, fatigue, abdominal pain, loss of appetite. There is no vaccine that can prevent infection from HCV.

HIV

The virus that causes AIDS, attacks the body's immune system. A person infected with HIV may suffer from flu-like symptoms; fever, diarrhea and fatigue, eventually develop AIDS, may carry the virus without developing symptoms for several years, and may develop AIDS-related illnesses. There is no vaccine to prevent infection.

DISCIPLINARY ACTION

The following format will be followed by department supervisors when addressing employees who do not comply with OSHA regulations concerning bloodborne pathogens. It is the responsibility of each employee to follow the policies established within this Bloodborne Pathogens Control Plan. Failure to do so could subject the employee to disciplinary action.

1. **FIRST OFFENSE:** The employee will be informally reminded to comply with the regulations as mandated in the Bloodborne Pathogens Control Plan Procedure.
2. **SECOND OFFENSE:** The employee will be formally reminded to comply and will participate in a retraining session.
3. **THIRD OFFENSE:** The employee will be formally directed to comply. Documentation of the incident will be placed in the employees file.

[Home](#)

BLOODBORNE EXPOSURE CONTROL PLAN

PURPOSE

In the unfortunate event that an employee sustains a needlestick or mucous membrane exposure to blood or body fluids, a Risk Management Medical Services incidence report will be filled out. All follow-up is covered at no charge to the worker. Follow the procedure listed below:

STEP 1 Provide immediate care to the exposure site

If the employee experiences a cut or needle stick, the area is to be washed with medicated soap and water. If the mucosal or conjunctiva are contaminated, the area is to be flushed with large quantities of water. It is the employee's responsibility to notify the supervisor at the time of the incident that she/he has been exposed to a patient's blood or body fluids.

STEP 2 Determine risk associated with exposure by:

Type of fluid: blood, bloody fluid, other potentially infectious fluid or tissue, and concentrated virus.

Type of exposure: percutaneous injury, mucous membrane or non-intact skin exposure, and bites resulting in blood exposure.

STEP 3 Obtain the name of source patient. Evaluate the source patient to assess the risk of HBV, HCV, and HIV infection (patient history, IV drug use, multiple sex partners etc).

- For known sources whose infection status is unknown (e.g., patient refuses testing), consider medical diagnoses, clinical symptoms, and history of risky behaviors. An informed consent must be signed before blood can be drawn for testing. (see source patient consent form) Explain to source that an employee was accidentally exposed to their blood or body fluid and by law we need their consent to run further tests. They do have the right to refuse testing. If the source refuses testing, explain to her/him that this incident may place the employee at risk for not only hepatitis, but also HIV infection.
- Test known sources for HBV, HCV, and HIV. The HIV forms are kept at the nursing station. Have the physician go over the consent to testing form with the patient. When the form is filled out, the form is given to the laboratory; the blood will then be drawn and sent to the appropriate labs. Results of the sources tests will be given to the employee who will be informed of confidentiality laws to protect the source. If the source patient is NOT infected with a bloodborne pathogen, further follow up of the exposed worker is NOT necessary.
- If the source person is HIV seronegative and has no clinical evidence of AIDS or symptoms of HIV infection, no further testing of the exposed employee for HIV infection is indicated. The likelihood of the source person being in the "window period" of HIV infection in the absence of the symptoms of acute retroviral syndrome extremely small.
- For unknown sources, assess risk of exposure to HBV, HCV, or HIV infection by considering the likelihood of bloodborne pathogens infection among patients in the exposure setting. Do not test discarded needles or syringes for virus contamination. Consult with a physician. Call PEP Hotline for assistance 1-888-448-4911.

STEP 4 Evaluate the exposed employee.

- Assess HBV immune status (Hep B vaccination and vaccine response).
- Provide medical care within two hours of exposure.
- Provide counseling to the employee about what happened and how to prevent secondary infections.
- Test employee for HBV, HCV, and HIV. HIV testing should be sent to Northern Plains Lab with test code: HIVR for a rapid result.
- If employee refuses HIV testing at this time, a blood sample needs to be kept for 90 days in case the employee changes his/her mind or symptoms develop that might relate to HIV infection.

STEP 5 Give Post Exposure Prophylaxis (PEP) for exposures posing risk of infection transmission of HBV (see Table 1) and HIV (see Tables 2 and 3).

- Initiate PEP ASAP, preferably within hours of exposure.
- Offer pregnancy testing to all women of childbearing age not known to be pregnant.
- Seek expert consultation if viral resistance is suspected.
- Administer HIV PEP for 4 weeks if tolerated.
- PEP for HCV is not recommended.

STEP 6 Forms

- * *Fill out UND Incident Form and UND Investigation Form* to be sent to the UND Safety and Environmental Health Office, Box 9031, 3851 Campus Road, Fax 701-777-4132
- **Workmans'Comp Form** and send it to Workforce Safety Office. To facilitate the injured employee needs to fill out this form. We are required to send notification to the ND Worker's Compensation Bureau within 24 hours of the injury.
- **Written Opinion from Physician**
- **Source patient and Employee consent forms**

STEP 7 Perform follow-up testing and provide counseling.

The employer must make immediately available to employee a confidential medical evaluation and follow up. Advise exposed persons to seek medical evaluation for any acute illness occurring during follow-up. The physician in charge of follow-up with the exposed employee determines necessity for additional testing or treatment.

HBV Exposures

- Provide HBV vaccine for any unvaccinated person, plus potential post exposure prophylaxis of hepatitis B immunoglobulin (HBIG) and /or hepatitis B vaccine series.
- Perform follow-up anti-HBs testing in persons who receive hepatitis B vaccine. Refer to Hepatitis B vaccination policy

HCV Exposures

- Immune globulin and anti-viral agents are not recommended for PEP after exposure to HCV-positive blood. When HCV infection is identified early, refer the infected employee to a specialist knowledgeable in this area for medical management.
- Perform baseline and follow-up testing for anti-HCV and alanine aminotransferase (ALT) at 4 to 6 months after exposure.
- Perform HCV RNA test at 4 to 6 weeks if earlier diagnosis of HCV infection is desired.
- Confirm repeatedly reactive anti-HCV enzyme immunoassays with supplemental tests.
- No recommendations exist regarding restricting the professional activities of health care workers with HCV infections.

HIV Exposures

- Perform HIV-Ab testing for at least 6 months post exposure (e.g., at baseline, 6 weeks, 3 months, and 6 months).
- Perform HIV-Ab testing if illness compatible with an acute retroviral syndrome occurs.
- Advise exposed persons to use precautions to prevent secondary transmission during the follow-up period.
- Extended HIV follow-up is recommended for the employee who became infected with HCV following exposure to a source co infected with HIV and HCV.
- Provide a 4 week regimen of a 2-drug combination, plus a third drug for exposures that pose an increased risk for transmission (see Tables 2 and 3). Avoid the drug nevirapine during PEP because of the risk for liver damage.
- Evaluate exposed persons taking PEP within 72 hours after exposure and monitor for drug toxicity for at least 2 weeks.

Step 8 Written Opinion from Physician and Confidentiality of Employee

The physician will provide a written opinion to the employer stating whether hepatitis B vaccination was recommended for the exposed employee and whether or not the employee received the vaccination. The physician will also note if the employee has been informed of the results of the evaluation and told of any medical conditions resulting from exposure to blood which require further evaluation or treatment.

Documentation

The employer shall establish and maintain an accurate record for each employee with a risk to an occupational exposure. These will be kept in the business manager's office separate from their personnel file. They include:

1. Name and social security number
2. Copy of Hepatitis B vaccination
3. Copy of all examinations, medical testing and follow-up procedures (if exposed)
4. Employer's copy of healthcare professional's written opinion (if exposed)
5. Copy of information provided to healthcare professional/Risk Management Incident Report. (If exposed)
6. Results of source patient's blood testing from exposure (if exposed).

A copy of all records will be given to the employee following an exposure while maintaining confidentiality for the source patient.

These records are confidential; a written consent from employee is needed prior to their release. They must be kept for the term of employment +30 years

Step 9 Safety Meeting with all employees who perform the same task in which the incident occurred. Document the meeting was held by filling out an employee roster. Make changes to any engineering devices by removing or ordering new replacements. Make any necessary changes to the Exposure Control plan

UND SAFETY AND ENVIRONMENTAL HEALTH OFFICE

This office in Grand Forks will initiate a Work Force Safety claim for you on-line once your UND incident report is received. All injured employees must contact this office to arrange to sign their claim. Call 777-3341. Provide the claim number given to you by UND to the clinic.

[Home](#)

Center for Family Medicine-Bismarck
 701 E. Rosser Ave
 Bismarck, ND 58501

EMPLOYEE EXPOSURE FLOWCHART

Employee Protocol

Employee Responsibility	Supervisor Responsibility
1. Cleanse area with soap/water	1. Review incident report. Complete supervisory section
2. Report to Supervisor	2. Send incident forms to Risk Management and UND.
3. Complete Incident report for UND and risk management-(2 separate forms)	3. Send Source patient and consent forms to lab.
4. Know name of source patient	4. Complete Workman's Comp. form
5. Follow Exposure Procedure	5. Follow Exposure Procedure
	6. Employee Post Exposure Consent Form
	7. Fill out UND Investigation Form

Known Source/Exposure Risk

1. Refer Employee to Physician for initial evaluation
2. Determine risk factors of source. Call PEP Hotline for assistance 1-888-488-4911.
3. Order labs on employee: HIV, Anti-HBS, HCV AB, Hep B core AB if indicated.
4. If source is know HCV Pos order ALT on employee. Do a Qualitative HCV-RNA on source and employee.
5. Determine Hepatitis Vaccine Status (see exposure policy)
6. Determine if PEP is needed-(Refer to exposure policy)
7. Start PEP per physician orders. (Consent and Pregnancy test required)
8. Determine follow up evaluation, testing, (6 weeks, 3 months, 6 months, 12 months if indicated) and counseling for employee.

Unknown Source/Unknown Risk

1. Refer employee to physician for initial evaluation.
2. Determine risk factors of source. Call PEP Hotline for assistance 1-888-488-4911.
3. Order following labs on Employee-Anti -HBS, HIV, HCV AB, Hep B core if indicated
4. Determine Hepatitis Vaccine Status of Employee (see exposure policy).
5. Determine follow up evaluation, testing (6 weeks, 3 months, 6 months, 12 months if indicated), and counseling for employee.

Send all paperwork to Business Manager's Office and to UND
Refer to complete policy for detailed steps for an employee exposure

[Home](#)

Hazard Communication Standard

In 1983 OSHA created the original Hazard Communication Standard and based it upon a simple concept: employees have both the need and the right to know the hazards of chemicals to which they are exposed at work. They also need to know what protective measures they can use to safeguard themselves from exposure to those hazardous chemicals.

In March of 2012, Federal OSHA adopted elements of the United Nations’ Globally Harmonized System of Classification and Labeling of Chemicals and is now in force on a national basis.

Globally Harmonized System’s requirements now adds the “right to understand” by requiring pictograms and other simplified communication elements that will make hazard communication easier.

Manufacturers, importers, and their distributors are required to transmit the required information to downstream employers who purchase and use the products.

OSHA defines a hazardous chemical as one that is a physical hazard or a health hazard, a simple asphyxiant, combustible dust, pyrophoric gas, or a hazard not otherwise classified. A simple asphyxiant is a substance or mixture that displaces oxygen in the ambient atmosphere, and can thus cause oxygen deprivation in those who are exposed, leading to unconsciousness and death. Combustible dust refers to fine particles that present an explosion hazard when suspended in air in certain conditions. A pyrophoric gas means a chemical in a gaseous state that will ignite spontaneously in air at a temperature of 130 degrees Fahrenheit or below.

Health Hazards

“Health hazards” refer to any of the following hazardous effects that a chemical might exhibit:

- | | |
|---|---|
| Acute toxicity, through any route of exposure | Carcinogenicity |
| Skin corrosion or irritation | Reproductive toxicity |
| Serious eye damage or irritation | Specific target organ toxicity through either single or repeated exposure |
| Respiratory or skin sensitization | Aspiration |
| Germ cell mutagenicity | |

Physical Hazards

“Physical hazards” refer to any of the following:

- | | |
|---|--|
| Explosives | Self-reactives |
| Flammables (gases, aerosols, liquids, or solids) | Pyrophorics (liquid, solid, or gas) |
| Oxidizers (liquid, solid, or gas) | Self-heating chemicals |
| Gases under pressure Compressed, liquefied, refrigerated liquefied, dissolved | Organic peroxides |
| | Corrosive to metal |
| | Chemicals which, when in contact with water, emit a flammable gas. |

Physical hazard criteria are presented in detail in Appendix B of the Standard.

Labeling

Manufacturer Product Labels

Chemical manufacturers and importers are required to provide labels on the chemicals they sell that include the following elements:

- A product identifier or name;

- A signal word such as “danger” or “warning” used to emphasize hazards;

- A hazard statement using standard phrases for particular hazard classes and categories;










- Pictograms, or symbols, that convey health and physical information assigned to a Globally Harmonized System hazard class and category;

- Precautionary statements that provide measures to minimize or prevent adverse effects; and

- Supplier information including the name, address, and telephone number of the manufacturer or supplier.

Pictograms

In addition to the other label requirements, OSHA has adopted 8 of the 9 Globally Harmonized System pictograms shown below. Pictograms are simple graphics used on labels and Safety Data Sheets to communicate specific hazards.

<p>Health Hazard</p>  <ul style="list-style-type: none"> • Carcinogen • Mutagenicity • Reproductive Toxicity • Respiratory Sensitizer • Target Organ Toxicity • Aspiration Toxicity 	<p>Flame</p>  <ul style="list-style-type: none"> • Flammables • Pyrophorics • Self-Heating • Emits Flammable Gas • Self-Reactives • Organic Peroxides 	<p>Exclamation Mark</p>  <ul style="list-style-type: none"> • Irritant (skin and eye) • Skin Sensitizer • Acute Toxicity (harmful) • Narcotic Effects • Respiratory Tract Irritant • Hazardous to Ozone Layer (Non-Mandatory)
<p>Gas Cylinder</p>  <ul style="list-style-type: none"> • Gases Under Pressure 	<p>Corrosion</p>  <ul style="list-style-type: none"> • Skin Corrosion/ Burns • Eye Damage • Corrosive to Metals 	<p>Exploding Bomb</p>  <ul style="list-style-type: none"> • Explosives • Self-Reactives • Organic Peroxides
<p>Flame Over Circle</p>  <ul style="list-style-type: none"> • Oxidizers 	<p>Environment (Non-Mandatory)</p>  <ul style="list-style-type: none"> • Aquatic Toxicity 	<p>Skull and Crossbones</p>  <ul style="list-style-type: none"> • Acute Toxicity (fatal or toxic)

Each of the pictograms is discussed individually below.

Health Hazard Pictogram

The health hazard pictogram shows a black silhouette of a human form with a white area in the chest region. This pictogram is used to indicate hazardous chemicals that are:

- Carcinogens;
- Respiratory sensitizers;
- Toxic to the reproductive system;
- Toxic to a target organ;
- Cause mutations in sperm or egg cells, or that;
- Present a hazard of being aspirated through the oral or nasal cavities.

Chemicals that are toxic to specific organ systems might be toxic as the result of a single exposure or through repeated or prolonged exposure.

Flame Pictogram

The flame pictogram might be used with flammable gases or aerosols, flammable liquids, and/or flammable solids. Flammable, of course, refers to things that can burn, but OSHA has very technical definitions for such terms. Appendix B2 of the Standard provides the following precise definitions.

A flammable gas is one having a flammable range in air at 68°F and a standard pressure of 14.7 psi;

An aerosol is a gas that is compressed, liquefied, or dissolved under pressure in a container with a release valve that ejects it in the form of gas, foam, paste, powder, or liquid particles;

Aerosols are considered flammable if they have any component that is a flammable gas, a flammable liquid, or a flammable solid.

We've already seen OSHA's definition for what a flammable gas is, but what about a flammable liquid or a flammable solid?

A flammable liquid is basically one that has a flash point under 200°F;

There are 4 categories of flammable liquids. Liquids with a flash point below 73.4°F and an initial boiling point equal to or less than 95°F are Category 1, or most flammable and, therefore, most hazardous;

Liquids with a flash point below 73.4°F and an initial boiling point above 95°F are Category 2;

Liquids with a flash point equal to or greater than 73.4°F and equal to or less than 140°F are Category 3;

Liquids with a flash point greater than 140°F and less than or equal to 199.4°F are Category 4.

A flammable solid means a solid that is a readily combustible solid, or a solid that can cause or contribute to fire through friction;

Readily combustible solids are powdered, granular, or pasty chemicals that are dangerous if they can be easily ignited by brief contact with an ignition source such as a burning match and if the flame spreads rapidly.

In addition to flammables, the Flame pictogram can be used with:

- Pyrophorics;
- Self-heating substances;
- Substances that emit flammable gas;
- Self-reactives; and
- Organic peroxides.

Exclamation Mark or Sensitizer Pictogram

The exclamation mark pictogram covers a wide variety of health hazards as discussed in detail in an Appendix to the Hazard Communication Standard:

Corrosive reactions that might be ulcers, bleeding, running scabs, or discoloration due to blanching of the skin, and which include: Skin corrosion that is the product of irreversible damage to the skin for up to four hours following the application of a chemical

Skin irritation that is the production of reversible damage to the skin for up to four hours following the application of a chemical

Dermal chemicals that cause a substantial proportion of exposed people or animals to develop an allergic reaction in normal dermal tissue after contact;

Acute toxicity refers to those adverse effects that occur following oral administration of a single dose of a substance, or multiple doses given within 24 hours, or an inhalation exposure of four hours. Acute toxicity, depending on severity, can also be communicated by the skull and crossbones pictogram that will be discussed further below;

Narcotic effects have to do with chemicals that cause dulling of the senses, alteration of mood or behavior, or that cause drowsiness or sleep;

A respiratory tract sensitizer or irritant means a chemical that will lead to hypersensitivity of the airways following inhalation;

An exclamation mark pictogram can be used for any chemical that causes any of the above health hazards. It can also be used with chemicals that are hazardous to the ozone layer, although that particular hazard is actually regulated by the Environmental Protection Agency rather than OSHA.

Gas Cylinder or Gases Under Pressure Pictogram

The gas cylinder pictogram is used for gases under pressure. Gases under pressure refer to gases that are contained in a receptacle having pressure equal to or greater than 29 pounds per square inch, or gases that are liquefied, or liquefied and refrigerated. A gas under pressure can be a compressed gas, a liquefied gas, a refrigerated liquefied gas, or a dissolved gas. Gases under pressure can explode if heated, or if they are refrigerated gases, they can cause cryogenic burns or injuries.

Corrosion Pictogram

The corrosion pictogram is used for chemicals that can cause severe skin burns and eye damage or for chemicals that can be corrosive to metals.

Exploding Bomb Pictogram

The exploding bomb pictogram is used with chemicals that can cause an explosion or fire, with self-reactives, or with organic peroxides.

An explosive chemical refers to a solid or liquid chemical that is, in itself, capable, by chemical reaction, of producing gas at such a temperature and pressure and at such a speed as to cause damage to the surroundings;

A pyrotechnic chemical is a chemical designed to produce an effect by heat, light, sound, gas, or smoke, or by a combination of these, as a result of non-detonative, self-sustaining, exothermic, chemical reactions;

Pyrotechnic chemicals are included in this classification even when they do not evolve gases;

An unstable explosive is an explosive that is thermally unstable and/or too sensitive for normal handling, transport, or use;

An intentional explosive is a chemical or item that is manufactured with the intent to produce a practical explosive or pyrotechnic effect;

Organic peroxide means a liquid or solid organic chemical that is considered a derivative of hydrogen peroxide.

Organic peroxides are liable to: Explosive decomposition;

Burn rapidly;

Be sensitive to impact or friction;

React dangerously with other substances.

Flame over Circle or Oxidizer Pictogram

The flame over circle pictogram is used for oxidizers. Oxidizing liquids, solids, or gases can cause fire or explosion or can intensify fires caused by other means.

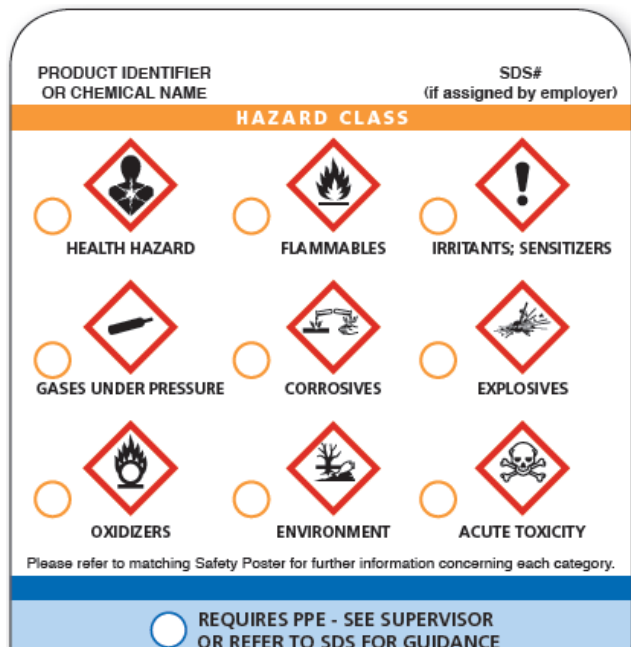
Environment Pictogram

In the United Nations Globally Harmonized System, the Environment pictogram is used to refer to chemicals that are hazardous to the aquatic environment. In the United States, however, it is the Environmental Protection Agency, rather than OSHA that regulates environmental concerns. For that reason, OSHA has not itself adopted the Environment pictogram. You might, however, still see it on labels.

Skull and Crossbones or Acute Toxicity Pictogram

The skull and crossbones pictogram refers to acute toxicity, meaning those adverse effects that might occur following oral or general administration of a single dose of a substance, or multiple doses given within 24 hours, or from an inhalation exposure of four hours. Acute toxicity might occur through swallowing, contact with the skin, or through inhalation of gases, vapors, dusts, or mists.

Workplace Labels



When a hazardous chemical is purchased, the manufacturer’s information will, of course, be present on the original product label. If some of the chemical from the original container is transferred to a secondary container, however, then a workplace label must be attached to that secondary container. Secondary containers must be labeled with workplace labels in English. Workplace labels are required to contain either much of the same information that a manufacturer’s original product label contains (product identifier, signal word, hazard statement, pictogram, and precautionary statement), or, alternatively, they are considered acceptable to OSHA if they contain at least the following 2 items of information:

Product identifier; and

Words, pictures, symbols, or combination thereof that provide at least general information about the hazards of the chemical.

Employers are also permitted to use workplace labels in languages other than English, as long as an English workplace label is also provided.

Workplace Labeling Poster

To go along with the new workplace labels discussed above, posters explain the meaning for the various pictograms used on those labels. These posters will be posted in Lab and the Medication Room.

Exceptions to Workplace Labeling

There are some exceptions to when workplace labeling is required, even upon a worker pouring a hazardous chemical from its original container into an unmarked workplace or secondary container. For example, an employee is not required to label secondary containers into which a hazardous chemical has been transferred (from its labeled container), if the chemical is intended only for the immediate use of the employee who performed the transfer.

Another exception permits drugs that are dispensed by a pharmacy to a healthcare provider, for direct administration to a patient, to be exempted from labeling required by the Hazard Communication Standard.

Safety Data Sheets

The clinic needs to obtain and maintain the classification information developed by the producers/importers and then to communicate that information to their workers via a comprehensive, written Hazard Communication Program. This includes proper container labeling, employee training, Safety Data Sheets, and other forms of warnings as discussed below.

Safety Data Sheets (abbreviated as SDS) are the documents that OSHA requires manufacturers, producers, or importers of hazardous chemicals to prepare for the purpose of transmitting information about hazardous chemicals downstream to employers and users. Safety Data Sheets are similar to what were formerly referred to as Material Safety Data Sheets, but there have been significant revisions to what they must now contain and how that information must now be presented.

Safety Data Sheets are required to be written in English. Additional languages are permitted, but they do not take the place of an English version. A completely different OSHA Standard, the Access to Medical Records Standard, 1910.1020, requires that “some record” of hazardous chemicals be maintained in the workplace for a period of 30 years, and keeping SDSs for that period of time, therefore, is one means of compliance with that requirement.

The Safety Data Sheet is the document that answers such questions as:

What is the material?

What do I need to know?

What do I need to do if a hazardous situation occurs?

How can I prevent hazardous situations?

Any other useful information.

Safety Data Sheets must now contain the 16 sections that are discussed below.

Format for Safety Data Sheets

As of June 1, 2015, the Hazard Communication Standard will require new Safety Data Sheets to follow a uniform format and to include the section numbers, the headings, and the associated information presented below:

Section 1, Identification includes product identifier, manufacturer or distributor name, address, phone number, emergency phone number, recommended use, restrictions on use.

Section 2, Hazard(s) identification includes all hazards regarding the chemical and required label elements.

Section 3, Composition/information on ingredients includes information on chemical ingredients and any trade secret claims.

Section 4, First-aid measures includes important symptoms/effects, whether acute or delayed, and any required treatment.

Section 5, Fire-fighting measures lists suitable extinguishing techniques, equipment, and any chemical hazards from fire.

Section 6, Accidental release measures lists emergency procedures, protective equipment, and proper methods of containment and cleanup.

Section 7, Handling and storage lists precautions for safe handling and storage, including any incompatibilities.

Section 8, Exposure controls/personal protection lists OSHA’s Permissible Exposure Limits (PELs), Threshold Limit Values (TLVs), appropriate engineering controls, and Personal Protective Equipment (PPE).

Section 9, Physical and chemical properties lists, as the section name indicates, the chemical’s physical and chemical characteristics.

Section 10, Stability and reactivity lists chemical stability and possibility of hazardous reactions. OSHA’s

Section 11, Toxicological information includes routes of exposure, related symptoms, acute and chronic effects; and any numerical measures of toxicity.

Section 12, Ecological information*

Section 13, Disposal considerations*

Section 14, Transport information*

Section 15, Regulatory information*

Section 16, Other information, includes the date of preparation or last revision.

*** Special Note:**

Since other Agencies regulate the information for the sections above marked with asterisks, OSHA will not itself be enforcing the requirements of Sections 12 through 15 and will leave enforcement to the appropriate Agencies.

Consumer Products Exemption

There are some exemptions to the requirements of the Hazard Communication Standard for certain types of products. One such exemption is for “consumer products,” provided such consumer products are used for the:

- Same purpose;
- Same duration of time; and
- Same frequency of use as that of general consumers.

Consumer products are products that can be purchased in a retail store for general consumers.

Other Items Not Covered by the Hazard Communication Standard

In addition to consumer products, other types of products, which are exempt from the requirement to have Safety Data Sheets, include:

- Pesticides regulated by FIFRA, the Federal Insecticide, Fungicide, and Rodenticide Act;
- Toxic substances regulated by the Environmental Protection Agency through the Toxic Substances Control Act.
- Tobacco;
- Natural wood products for retail sale;
- Articles that do not result in employee exposure via inhalation, ingestion, or skin absorption;
- Food or alcoholic beverages;
- Ionizing and non-ionizing radiation;
- Biological hazards; and
- Food, drugs,* and cosmetics.

*See next section for discussion of the drugs.

Hazardous Drugs

An asterisk has been placed beside the word drugs in the last line above, because although most drugs are exempt from the Hazard Communication Standard, hazardous drugs are not exempted from the requirement to have Safety Data Sheets and other requirements of the Standard. OSHA treats hazardous drugs exactly like any other hazardous chemicals. While there is not a precise definition for drugs that OSHA considers hazardous, there are at least some helpful guidelines. OSHA uses the American Society of Hospital Pharmacists guidelines and considers any drug to be hazardous if the drug is in liquid or aerosol form at the time it is taken by the patient and if the drug can:

- Affect a cell’s genetic material;

Cause cancer;

Cause developmental malformations to an embryo or fetus; or

Target specific organ systems (such as kidneys, nervous system, blood forming system, etc.).

Training Requirements

OSHA requires Hazard Communication training whenever a worker is initially assigned to a position where there is a potential for exposure to hazardous chemicals. Retraining is required whenever a new chemical hazard, for which employees have not previously been trained, is introduced into the work area. Some states also have Workers Compensation or Right to Know regulations that require similar annual training on hazardous chemicals. It is, therefore, recommended that annual Hazard Communication training be provided in all states just to ensure that an employer has covered all the bases.

Hazard Communication training is required to cover the following areas of information:

Hazards of chemicals in the work area, including: Physical hazards

Health hazards

Simple asphyxiation

Combustible dust

Pyrophoric gas

Hazards not otherwise classified;

Methods and specific procedures workers can use to protect themselves, including: Work practices

Emergency procedures

PPE to be used;

Operations where hazardous chemicals are present;

- Details, location, and availability of: The employer's written Hazard Communication Program

Master list of hazardous chemicals

Explanation of labels received on containers

Workplace labeling system used by the employer

Safety Data Sheets, including Order of information

How employees can obtain and use correct hazard information, and the

Methods used to detect the presence or release of hazardous chemicals.

Incorporation of the Globally Harmonized System has also created some specific training requirements about changes to the Standard. OSHA requires training to be completed by December 1, 2013 on the following elements of the Globally Harmonized System:

Revised label elements, including pictograms; and

Revised Safety Data Sheets.

[Home](#)

RADIATION SAFETY

EMPLOYEES-TECHNOLOGISTS

Our technologists are certified by the American Registry of Radiologic Technologists (ARRT) or are Limited Diagnostic X-Ray Operators. They must have completed the educational requirements of the ND Radiologic Health Rules 33-10-06-03 for limited x-ray operators.

All radiology technologists wear whole body dosimetry badges. These badges are monitored by “Landauer , Inc.”. Badges are measured bi-monthly. Reports are sent to us with replacement badges and reviewed upon receipt. These reports are placed in the radiology department manual for future reference.

EQUIPMENT

Our equipment is registered with the ND Department of Health by their Air Quality/Radiation Control Program. A “Radiation Protection Survey Report” is provided to us. The registration/survey is done bi-annually or when implementing new equipment.

A quality control program is in place within our facility also.

PATIENT PROTECTION

A variety of lead shields are available for the patients (and staff) protection.

Female patients are screened for possible pregnancy before the exam by their ordering physician . Signs are posted in the dressing room and exam room alerting female patients to warn the technologist before having and x-ray if she may be pregnant. The physician will then order a pregnancy test and make the final decision whether or not to proceed with the exam.

ALARA (as low as reasonably achievable) is the radiation safety principal by which we provide quality exams along with radiation safety for the patient.

[Home](#)

Workplace Violence (Manpower Alert)

Workplace violence is any physical assault, threatening behavior or verbal abuse occurring in the work setting. It includes, but is not limited to, beatings, stabbings, suicides, attempted suicides, shootings, rapes, psychological traumas such as threats, obscene phone calls, and intimidating presence and harassment of any nature.

Purpose:

To provide guidelines for the prevention or intervention related to violent or threatening behavior involving employees, patients, visitors, volunteers, students, and temporary personnel. Violence can be expected but can be avoided or minimized through training and understanding of what you should do in a violent situation with a fellow employee or patient.

Definitions:

Threats and Acts of Violence: Behavior consisting of, but not limited to, any expressed intention, directly or indirectly to:

1. Harm another individual or oneself.
2. Endanger a group of employees or others in the clinic.
3. Destroy personal or clinic property.

Threats may be verbal, written, contained in a letter/package, electronic mail, telephone/voice, or overheard in conversations.

Non-Imminent Threat: Behavior consisting of, but not limited to, actions or statements that are not considered an immediate potential for violence against persons or property. This includes:

- threats
- harassment
- intimidation
- history of physical abuse
- verbal abuse, and /or
- Coercion from employees, patients, customers, visitors, or others.

Imminent or Direct Threat: Behavior consisting of, but not limited to: a potential physical assault or use of a weapon, actions or statements that have the immediate potential for violence against persons or property (e.g. breaking or throwing objects, gesturing with a fist, etc.)

Policy:

*Refer to the clinic's Building Emergency Action Plan (BEAP)

It is the policy of Center for Family Medicine to make every effort to maintain a safe work place environment and protect employees, patients, medical staff, visitors, volunteers, temporary personnel and students from harm caused by violent acts of others. Any act of verbal, physical, or emotional assault or threat, which may result in physical or psychological harm, is considered a serious offense and is not tolerated.

Employees are responsible for helping to maintain a safe work place. No employee may commit an act of violence or threat of violence while on clinic property, in state vehicles, or during working hours (including lunch and breaks) or during non-working hours when such acts may impact and employee's work performance and /or safety of others.

Employees who threaten or engage in harassment, intimidation, physical abuse, verbal abuse, stalking or coercion are subject to disciplinary action up to and including termination. This policy does not exempt an employee or non-employee from any legal or civil action. Appropriate legal action may also be taken against non-employees for violation of this policy.

[Home](#)

All employees are required to immediately report any threat or potential violence related to the work place, directed against himself/herself, to their supervisor or nearest coworker, unless disclosure could result in personal harm.

Procedure:

If the victim or witness to any of the above situations, or others not mentioned, you will do the following:

1. Notify your supervisor or the physician immediately if anyone has reason to believe that a patient, visitor, employee appears at risk for self harm or potential harm to others.
2. Supervisor, employee and physician will work together to obtain and maintain a safe environment for the patients, and staff. It will be explained that any behavior, which is threatening or violent in nature, is not acceptable, and if the behavior continues, the involved person(s) will be asked to leave the clinic.
3. Call a MANPOWER ALERT. Notify the Front desk and they will announce CODE YELLOW and location of the clinic over the PA system 3 times. Ex. CODE YELLOW Red Pod.
4. Available Staff, Residents, and Faculty will respond to the Code.
5. Dial 9-911 when the danger of physical harm appears to be imminent. Give your name, location, name and description of suspects. Trust your instincts. If you feel uncomfortable in a place or situation, call a 9-911.
6. If evacuation of clinic is warranted, follow the fire evacuation plan.
7. Try to remember details so you can describe the offender(s), including sex, age, race, hair, clothing and distinguishable features. Also attempt to obtain a description and license number of any vehicles involved. Note the direction taken by the offender(s) or vehicles and report these to police.
8. Where possible, preserve the crime scene. Do not touch any items involved in the incident. Close off the area of the incident and do not allow anyone in the crime area until police arrive.
9. Documentation: An employee will report a situation/incident within 24 hours. *Patient*-medical record and incident report. *Visitor*-Incident Report, *Employee*-Incident Report. Incident reports are forwarded to the Business Manager. When the danger of physical harm does not appear to be imminent, the endangered employee or observing employee must still provide an incident report.

If an employee is harmed during the incident a Workman’s Comp form, UND investigation report and UND incident report will be completed.

Dealing with Potentially Violent or Disruptive Persons

If you find yourself in a situation were a person is disruptive or potentially violent use the following suggestions to deal with the person. If you are able, try to notify your supervisor or a coworker for help. The police will be called if the situation escalates.

10. Assess the situation.
11. Project calmness.
12. Be patient and empathetic, and encourage the person to talk.
13. Ask questions. Find out specifically what the problem may be.
14. Focus your attention on the other person to show you are interested I what he/she has to say.
15. Maintain a relaxed, yet attentive, posture and position yourself at a right angel rather than directly in front of the other person.
16. Acknowledge the person’s feelings.
17. Ask for small, specific favors such as asking them to move to a quieter area.
18. Establish ground rules if unreasonable behavior persists, but accept criticism positively.
19. Use delay tactics that will give the person time to calm down.
20. Be reassuring and point out choices.
21. Ask for recommendations and repeat what you feel is being requested.
22. Arrange yourself so that your exit is not blocked
23. Have a neutral manager or third party in the room with you.
24. Don’t use styles of communication that generate hostility.
25. Don’t reject all of their demands from the start.

26. Don't pose in challenging stances.
27. Avoid any physical contact, finger pointing or long periods of eye contact.
28. Don't make sudden moves that may seem threatening.
29. Don't challenge, threaten or dare the individual.
30. Never belittle or make the person feel foolish.
31. Don't criticize or act impatient, especially if the person is agitated.
32. Don't attempt to bargain with a threatening individual.
33. Don't make false statements or promises you cannot keep.
34. Don't explain technical or complicated information when emotions are high.
35. Don't take sides or disagree with fabrication.
36. Don't take remarks personally.
37. Don't show your anger.
38. Don't patronize, show respect.
39. Don't invade the individual's personal space.

Sexual Assault

If you have been sexually assaulted, you are encouraged to seek medical treatment immediately. It is recommended you do not bathe, douche, use the toilet or change clothing. Report the crime as soon as possible.

Telephone Harassment

Notify your supervisor immediately. Note the time, date and telephone number at which the treat was received. If the threat involves an imminent act of violence, such as a bomb threat, report it immediately to the staff by announcing a CODE YELLOW and calling 9-911. Other harassing phone calls should be reported if they persist. If you receive such a call, remain calm and hang up. Inform your supervisor. Complete an Incident Report within 24 hours of the incident.

Bomb Threat

***Refer to the clinic's Building Emergency Response Plan (BEAP)**

***Refer to UND policy for more information <http://und.edu/emergency-management/tov-bomb-threat.cfm>**

Written Threats

Notify your supervisor immediately. Handle the written material and any envelopes as little as possible, and then only by the corners. Place both the written material and any envelope in a large envelope. Note the names of any one who handled the material after its arrival. If the threat involves an imminent act of violence, such as a bomb threat, follow the bomb threat protocol.

If the treat is not imminent, report it to your supervisor. Complete an Incident Report within 24 hours of the incident.

Minimize employee risk

- State clearly to patients, clients and employees that violence is not permitted.
- Employees will report all assaults or threats to a supervisor.
- Respond promptly to all complaints.
- Prohibit employees from working alone in remote areas of the clinic. Another employee will be available for assistance if needed before 8:00 a.m. or after 5 p.m.
- Follow the fire evacuation policy if immediate evacuation is necessary.
- Treat and interview aggressive or agitated patients in relatively open areas that still maintain privacy and confidentiality. Nurses will assess patients before rooming them into the exam room.

- Survey the facility periodically to remove tools or possessions left by visitors or staff that could be used inappropriately by patients.
- Patients should not be allowed into the residence offices, locker rooms or workout room.
- Departments are to discuss how to alert a fellow coworker if a violent situation occurs and what they would do to escape a dangerous situation. Think of rooms that have doors that lock if you are unable to escape out of the building.

Response to Incidents of Violence/Counseling of Employee

Violence against employees, patients or visitors will be managed by staff and supervisor during the emergency and prompt response to complaints will be investigated by the supervisor and risk management and appropriate action will be taken to protect employees, patients, visitors, and property. Employees are expected to cooperate in any investigation in the clinic's efforts to maintain a safe work place.

Employees are encouraged to report incidents and will not be discriminated against for initiating a report. It is the responsibility of all clinic staff and faculty to reduce and eliminate risks of workplace violence. Report any unsafe or questionable situations to your supervisor. Employees making malicious or bad faith reports are subject to disciplinary action.

Employees will be given comprehensive treatment if victimized, prompt treatment of staff and psychological evaluation whenever an assault takes place, regardless of its severity. Victims of workplace violence suffer a variety of consequences in addition to their actual physical injuries including, short and long term psychological trauma, fear of returning to work, changes in relationships with coworkers and family, feelings of incompetence, guilt, and powerlessness, fear of criticism by supervisors, managers or coworkers. Counseling is available to employees through the Employee Assistance Program. 1-800-327-7195

UND Weapons Policy

In accordance with NDCC 12.1-01-04(6)(10), and 62.1-01 the possession, storage or use of weapons i.e.: shotguns, rifles, pistols, paint ball guns, explosives, switchblade knives, or fixed blade knives with a blade length of five inches or greater, or any other such offensive weapons, are prohibited on the property of the University of North Dakota. This policy shall apply to all faculty, staff and students of UND and to all visitors and/or residents of the campus, on property of the University. Thus, the possession of weapons, or the unreported knowledge of such items, on the University's premises or during University programs, on or off campus, is considered a serious offense subject to disciplinary actions.

The University policy does not apply to authorized law enforcement officials in the lawful discharge of their duties. Temporary exemption may be granted with advance written permission, by the University's Chief of Police or authorized designee for job related, educational or demonstration purposes. Concealed weapons permits are not valid on the property of the University of North Dakota or at sanctioned events.

Adult Protective Services

Intervention for clients/families: Adult Protective Services Carla Backman 328-8868

Training/Evaluation:

Training will be provided to employees upon hire and annually. This policy will be evaluated and updated on an ongoing basis due to an incident occurring within the clinic and/or annually. Training updates will be provided to employees at staff/resident meetings.

[Home](#)

Palomar Medilux System

The Palomar MediLux System is designed to deliver light pulses of broadband incoherent light to a predetermined target site. Output wavelengths range from 400nm to 1400nm. It is specially developed for hair removal, pigmented and vascular lesion treatment and other cosmetic applications.

The system is housed in a protective cabinet. Delivery of the energy to the treatment site is through a handpiece that has a sapphire window for direct light delivery to the treatment site.

All persons operating the Palomar MediLux System and persons in the treatment room during its operation must be aware of the safety requirements for this Class II Intense Pulsed Light (IPL) medical device.

1. During treatments, all persons must wear protective eyewear to protect against possible eye damage. Never look directly at the light coming from the distal end of the handpiece as this may cause eye injury.
2. Treatment door must be closed during the use of the Palomar MediLux System.
3. No one other than Palomar Medical authorized personnel may service inside the protective covers of the MediLux System. Dangerous voltages are present inside the system.
4. Operators will be familiar with the system controls and know how to shut down the system instantly using the Key Switch and Emergency Stop built into the device.
5. Potential for fire hazard exists, however unlikely, because of the nature of light treatment. A fire extinguisher is located in the treatment room under the sink.

Training will be provided by Shelly Botsford, FNP, who is IPL certified, for faculty, residents, and employees before using the device for medical treatment.

[Home](#)

Emergency Telephone Numbers

Fire/Ambulance/Police		911
Bismarck Police		1-701-223-1212
UND Safety Officer	Terry Wynne	1-701-777-3759
Environmental Safety Officer	David Glatt	1-701-328-5150
CDC National Aids Hotline		1-800-342-2437
National Clinicians' Postexposure Prophylaxis Hotline (PEP)		1-888-448-4911
ND Department of Health		1-701-328-2372

NOTIFIND

The North Dakota Notifind System is used to contact all clinic and SW campus employees during an emergency. The system is maintained by the safety officer and the ND OMB Risk Management Division.

Emergency Management-Disaster

The UND CFM clinic will respond to emergencies following the University's Emergency Management plan located at <http://und.edu/emergency-management/>. Follow the link to all campus emergencies.

The Office of Emergency Management is responsible for coordinating the University's preparation for (the before), response to (the during), and recovery from (the after) any major emergency, no matter the cause. This includes all off campus departments.

The Business Manager and Medical Director will work closely with the Office of Emergency Management, City, County and State entities to respond to all needs of the clinic.

The UND CFM clinic and the Office of Emergency will prepare a new location and equipment for patient care if the need arises. Hospitals in the city of Bismarck will be contacted for temporary supplies and physical location possibilities. The School of Medicine IT will be contacted to help implement VPN access and to assist with connection to new computers until IP addresses are open to the servers.

BUILDING EMERGENCY ACTION PLAN (BEAP)

The UND Center for Family Medicine and the UND Southwest Medical School have a joint plan filed with the UND Office of Emergency Management. A copy of the plan is filed with the UND CFM Business Manager and the Southwest Campus Administration.

[Home](#)

UNDCFM/BSC Risk Management

Purpose:

Risk management procedures for the shared clinic between UND Center for Family Medicine and the Bismarck State College to provide non-emergent care to BSC students and employees on a part-time basis. The physical location of the BSC Student Health Center will be on the BSC campus at the Armory.

Policies

Policies written will be a combination of BSC and UNDCFM policies that will adhere to the University of North Dakota, Bismarck State College and the State of North Dakota policies and procedures.

Close communications between UND CFM and BSC will be imperative for all incidents and policies implemented.

UND CFM Policies: <http://www.cfm.bismarck.und.edu/?id=71>

BSC Policies:

BSC General and Employee policies

<http://www.bismarckstate.edu/staff/humanresources/policiesprocedures/generalpolicies/>

Staff Handbook

<http://www.bismarckstate.edu/uploads/resources/499/staffbook.pdf>

The Faculty Handbook

<http://www.bismarckstate.edu/uploads/resources/501/fachand.pdf>

The Emergency Procedure Manual

<http://www.bismarckstate.edu/uploads/resources/399/emergency-procedure-manual-final-2013.pdf>

And the Campus Security website – there is a section on specific security related policies

<http://www.bismarckstate.edu/security/>

Emergency Procedures

BSC and UND CFM employees will follow the emergency procedures implemented by the Bismarck State College Security/Risk Management department.

UND CFM employees are trained in the proper safety policies within the UND CFM clinic. BSC will train UND CFM employees on any facility specific policies that pertain to BSC.

Incident Reporting

- An incident related to the clinic operations/services should be reported by and through UND CFM; ensure that the location is clearly identified as the clinic at BSC.
- BSC employees can report any injuries through the BSC procedures.
- Nursing students will be covered by BSC 's workers compensation coverage.
- UND CFM employees will follow the UND CFM procedures for reporting incidents and complaints.
- Incidents involving the grounds/facilities can be reported directly to the BSC RM Contact, John Lemieux (john.lemieux@bismarckstate.edu; 224-5789) who will submit the report and take corrective actions as necessary.
- An employee/student/patient incident report will be reported to the employee's employer. UND CFM will provide BSC risk management department with a copy of the report.

[Home](#)