

**SWEET MEDICAL CENTER  
QUALITY IMPROVEMENT PLAN**

Revised and updated: July 1, 2008

Joseph Z. Nemes, M.D. Medical Director  
Karen A. Bradway, Executive Director  
Teresa Stebar: Chief Financial Officer

Effective: August 1, 2008  
Approved: Board of Directors  
Reviewed: July 1, 2008

The Board of Directors of the Sweet Medical Center, Inc. has both a legal and moral obligation to provide an optimal quality of medical and other professional care to its patients remaining faithful to the five major prerequisites for primary care upon which the Quality Improvement Plan clinical program is based:

1. ACCESSIBILITY--hours, location, financial barriers, etc.
2. COMPREHENSIVENESS -- hospitalization, dental, mental health, and social services – available by referral or on-site.
3. COORDINATED AND CONTINUOUS CARE;
4. ACCOUNTABILITY - to the community and users, for providing quality care through the user majority board, and the Internal Quality Improvement Committee.
5. HEALTH PROMOTION AND DISEASE PREVENTION - through all life cycles.

To fulfill these obligations, the Sweet Medical Center, Inc. Board of Directors, Medical staff, and Administration have established the following Quality Improvement Plan reflected in this plan.

The plan sets forth strategies (organizational and functional) to be used in the systematic review and evaluation of patient care.

**OBJECTIVES:**

- a. To establish and implement mechanisms for monitoring various aspects of patient care.
- b. To identify problems, analyze data, and implement remedial action to correct identified problems.
- c. To systematically monitor, through self-evaluation, compliance with county, state and federal guidelines of quality of care.
- d. To document quality assurance findings, conclusions, and recommendations, and to document and track the results of the actions subsequently taken.
- e. To evaluate the Quality Improvement Plan at least yearly, in order to substantiate the overall effectiveness of the Program.
- f. To review ancillary medical services, to ensure their integration and appropriate utilization.

- g. To identify services, practices, professional performance and patient outcomes which vary from professionally recognized standards or are inefficient or unsafe and to effect change so the problems are resolved or improved upon.
- h. To assure that the clinic's environment is safe for patients, employees and visitors.

**ORGANIZATION AND RESPONSIBILITIES:**

The Board of Directors exercises oversight responsibility for the effectiveness and efficiency of patient care services and outcomes at the Sweet Medical Center, Inc. developing policy to assure quality of care. Development of policy is on-going. It is based on identified needs of the community - as determined via local and national Public Health Service data, patient surveys, patient data, and disease information, and as perceived by the staff and board.

The Quality Improvement Plan Committee/Executive Committee, which meets not less than quarterly, consists of the Medical Director, Executive Director, Chief Financial Officer and other appropriate individuals, which may include the Nursing Director and/or a Board Representative.

This committee:

- 1. Reviews and approves, or requires changes in medical or administrative procedures, methods and systems for gathering, analyzing and using information under the Quality Improvement Plan.
- 2. Receives, reviews and acts on appointments, re-appointments, and credentials/privileges issues related to all health professionals reporting to the board as documented in minutes.
- 3. Reviews and amends the annual Quality Improvement Plan Health Care Plan. Minutes of meetings are recorded and distributed to the Chairperson of the Board of Directors or designated Board Committee, Pharmacy Director, Executive Director, Medical Director, and other appropriate individuals.

It also:

- 1. Analyzes data and audits from all departments.
- 2. Requests further investigation of specific topics by various departments.
- 3. Recommends actions for problem resolutions to various departments.
- 4. Reports committee findings and recommendations to the Board of Directors.
- 5. Participates in an annual evaluation of the Quality Improvement Plan Program.

**SCOPE OF SERVICES:**

Sweet Medical Center, Inc. is a primary care clinic offering Comprehensive Primary care health services for individuals and families of all ages. We provide services in:

- 1. Primary health services for all ages.
- 3. Diagnostic Laboratory Tests.
- 4. Diagnostic X-rays.
- 5. Preventive Health Services.
- 6. Dental Services by referral and voucher
- 7. Pharmacy Services by voucher and 340b contract with local pharmacy
- 8. Behavioral/Mental Health Services through referral and voucher.
- 9. Specialty services by referral.
- 10. Transportation by fuel vouchers.

Our professional staff consists of physicians, physician assistants, and support staff. This staff is available to provide primary, episodic and chronic care, health promotion, education, and counseling to patients of varied ethnic backgrounds. Services are provided according to family size, income and ability to pay.

The staff is committed to providing high quality personalized care in an ambulatory setting.

**ASPECTS OF CARE:**

The following aspects of care form the Sweet Medical Center, Inc. framework upon which the Quality Improvement Plan process is based. An annual action plan will be developed addressing these parameters. They are:

1. **Provider Staff Performance:** The ability of the provider staff to use the best available knowledge, skill, and judgment to produce a desired outcome in health.
2. **Support Staff Performance:** The ability of the support staff to contribute toward a positive change in the health status of the patient utilizing thoroughness, efficiency, accuracy, patient rapport, and team interaction.
3. **Continuity of Care:** The concept that the plan of care for a particular patient progresses without interruption.
4. **Medical Record System:** The concept that the medical record can contribute to the health of the patient by providing accurate, complete and timely information to the provider at the time a clinical judgment is made.
5. **Patient Risk Minimization:** The concept that it is important to prevent unwanted change in the health status of the patient as a result of interaction with the health care system.
6. **Patient Satisfaction:** The degree to which health care services and the resulting health status meet the expectations of (pleases) the patient.
7. **Patient Compliance:** The degree to which the patient can and will accept and carry out the health care plan.
8. **Access to Care:** The ease and timeliness with which health care services can be obtained.
9. **Appropriateness of Service:** The concept that a service, whether delivered by the organization or by the individual provider, has a reasonable potential to enhance in a cost effective manner the health status of the patient.
10. **Cost of Services:** The concept that the cost of the service can impact the health status of the patient by compromising either the ability of the organization to deliver the service or the ability of the patient to utilize the service.

**SOURCES OF AUDIT TOPICS:**

Audit and data collection may be directed at problem areas identified by:

- A. Chart and peer reviews;
- B. Needs assessment data;
- C. Utilization reports of ancillary service;
- D. Clinic Logs;
- E. Licensing and funding standards;
- F. Statistical reports;
- G. Prescribing patterns;
- H. Billing data;
- I. Scheduling and Staffing Plans;
- J. Incident reports;
- K. Patient satisfaction surveys/grievance forms.

**CONFIDENTIALITY:**

The activities of the Quality Improvement Plan Program are legally protected to cover those who participate in quality of care of utilization review. Neither the proceedings nor the records of such reviews shall be subject to discovery, nor shall any person in attendance at such reviews be required to testify as to what transpired thereat.

All copies of minutes, reports, worksheets and other data are to be stored in a manner ensuring strict confidentiality. A written information govern the release of such Confidentiality Policy detailing procedures for maintenance and release of data and other TQI related information. This policy specifies the use identifiers in place of patient names and code numbers in place of physician or other provider names. This policy also provides methods for restricting all quality assurance documents solely to authorized individuals. In addition, all data will be as Medical Staff peer review information and shall be considered protected information.

**ACTION PLANS:**

The attached Action Plans shall become a part of Sweet Medical Center, Inc. Quality Improvement Plan.

Approved:

\_\_\_\_\_  
Chair, Board of Directors

\_\_\_\_\_  
Date

**SWEET MEDICAL CENTER  
QUALITY IMPROVEMENT PLAN  
CREDENTIALING/PROVIDER STAFF SYSTEMS**

Effective: August 1, 2008

Approved: Joseph Z. Nemes, M.D. Medical Director  
Karen A. Bradway, Executive Director

Reviewed: July 1, 2008

**INDICATOR:** Credentialing and Privileging-Provider Staff at Sweet Medical Center, Inc. to meet HRSA requirements governing such Medical providers.

**PERFORMANCE GOALS:**

1. All Practitioners shall have graduated from an accredited school for the preparation/education of Mid-Level Providers (Physician Assistant, Nurse Practitioner) or Physicians.
2. All Practitioners shall be duly licensed in the State of Montana.
3. All Practitioners shall be board eligible/certified in their field of preparation/practice.
4. All Practitioners must have prescribing authority from the State of Montana and DEA certification if applicable/attainable.
5. All practitioners shall maintain BLS and ACLS certification.

All Practitioners must meet criteria for employment as specified by the clinic Provider Contract, including Credentialing and Privileging. These criteria should include, but not be limited to, the following:

- a. Physical and mental health status;
- b. Lack of impairment due to chemical dependency/substance abuse;
- c. History of loss of license and/or felony convictions;
- d. History of loss or limitation of privileges or disciplinary activity and background check.
- e. Performance within the Standard of Practice enabled by licensure. (An affirmative answer to any of the above should not necessarily preclude employment.)

**OUTCOME GOALS:** 100% of Providers' personnel files will contain documentation of above verification(s).

**DATA SOURCE:** Personnel folders at Sweet Medical Center, Inc. Credentialing Information

**FREQUENCY & RESPONSIBILITY:**

1. Concurrent for each new hire.
2. Annual evaluations of Providers are the responsibility Medical Director.
3. Privileging shall be determined by the Medical Director, reviewed by the Executive Director and approved by the Board.

**SWEET MEDICAL CENTER  
QUALITY IMPROVEMENT PLAN  
CURRENT COMPETENCY-PRACTITIONERS**

Effective: August 1, 2008

Approved: Joseph Z. Nemes, M.D., Medical Director  
Karen A. Bradway, Executive Director

Reviewed: July 1, 2008

**INDICATORS:** Current Competency of Practitioners at Sweet Medical Center, Inc. in accordance with State Law governing the practice of such Medical Providers.

**PERFORMANCE GOALS:**

1. Privileging of Practitioners shall be site specific and must be congruent with adequate facilities, equipment, number and types of qualified support personnel and other required support services.
2. The Medical Director is responsible for the initial granting of privileging, renewal and revision of clinical privileging for each Provider.
3. Information shall be reviewed by the Executive Director and approved by the Board of Directors.
4. Competency can be determined by performance activity and outcomes of such performance activity.

**OUTCOME GOAL:** 100% of the Practitioners have 95% competency in performing the task expected within licensure/field of practice.

**DATA SOURCE/RESPONSIBILITY:** Personnel files at Sweet Medical Center, Inc.

**FREQUENCY:**

1. Upon hiring by Sweet Medical Center, Inc.
2. Upon request of the Medical/Executive Director at Sweet Medical Center, Inc. biennially.

**REVIEWERS:**

Medical Director  
Executive Director  
Board of Directors

**SWEET MEDICAL CENTER  
QUALITY IMPROVEMENT PLAN  
PEER REVIEW/MID-LEVEL PROVIDERS**

Effective: August 1, 2008

Approved: Joseph Z. Nemes, M.D., Medical Director  
Karen A. Bradway, Executive Director

Reviewed: July 1, 2008

**INDICATOR:** Peer Review of Physicians & Mid-Level Providers at Sweet Medical Center, Inc.

**PERFORMANCE GOAL:** Positive criticism of Physician's & Mid-Level Provider(s) by their fellow providers. Review shall be confidential.

**OUTCOME GOALS:**

1. Professional growth of the Physician & Mid-Level Provider.
2. Acceptance of positive criticism and to act upon this criticism in a professional manner.
3. Assure timely and accurate charting.

**DATA SOURCE:**

1. Three (3) Charts per provider.
2. Clinical Peer Review Worksheet.

**FREQUENCY:** Every Quarter

**REVIEWERS:**

Mid-Level Providers – Sweet Medical Center, Inc. Medical Director  
Physicians – Dr. Henderson, Northern Montana Medical Group

**SWEET MEDICAL CENTER**  
**QUALITY IMPROVEMENT PLAN**  
**CLINICAL PEER REVIEW WORKSHEET**

Approved: Joseph Z. Nemes, M.D., Medical Director  
Karen A. Bradway, Executive Director

Date Reviewed:  
Clinician Reviewed \_\_\_\_\_

Patient Name: \_\_\_\_\_

Patient DOB: \_\_\_\_\_

Date of Reviewed encounter: \_\_\_\_\_

Areas to evaluate and make comments (Improvements & More importantly Praise)

"SOAP" Format followed: \_\_\_\_\_

Chief complaint clarification: \_\_\_\_\_

Physical exam, appropriate lab/ray: \_\_\_\_\_

Assessment: \_\_\_\_\_

Suggest additional:

Diagnosis \_\_\_\_\_

Plan: \_\_\_\_\_

Does the plan follow our established protocol or standard of care for this diagnosis / assessment? \_\_\_\_\_

Please review entire chart for the following:

Problem list, Medication list, Allergies & History form up to date & used?

\_\_\_\_\_

Health Care Maintenance/Life Cycle Tables:

Up to date? \_\_\_\_\_

Addressed? \_\_\_\_\_

Additional  
Comments: \_\_\_\_\_

\_\_\_\_\_

Reviewer \_\_\_\_\_ Date \_\_\_\_\_

Evaluation

Reviewed \_\_\_\_\_ Date \_\_\_\_\_

**SWEET MEDICAL CENTER  
QUALITY IMPROVEMENT PLAN  
CLINICAL SUPPORT STAFF COMPETENCY**

Effective: August 1, 2008

Approved: Joseph Z. Nemes, M.D., Medical Director  
Karen A. Bradway, Executive Director

Reviewed: July 1, 2008

**INDICATOR:** Clinical Support Staff Competency

**PERFORMANCE GOALS:**

1. The Clinical Support Staff must be capable of the duties required for the position.
2. The Clinical Support Staff can be a mixture of RNs, LPNs and/or MAs.
3. Each Clinical Support Staff employee shall have graduated from an Accredited school or had comprehensive on job training.
4. Each Clinical Support Staff employee shall be licensed or certified in the State of Montana and must maintain a current license or certification.
5. Each Clinical Support Staff employee shall maintain a current BLS certification.
6. Each Clinical Support Staff employee must provide a work history including the following:
  - a. History of loss of license and/or felony convictions;
  - b. Disciplinary action.

**OUTCOME GOALS:**

1. Clinical Support staff personnel files will reflect 100% compliance of licensure/credentials.
2. Clinical Support staff must be at least 95% competent in performance of tasks required within 90 days of employment.
3. Clinical Support staff personnel files will reflect CPR compliance.

**DATA SOURCE:**

1. Personnel Files at Sweet Medical Center, Inc.
2. Job Description
3. Performance Check List

**FREQUENCY:**

1. Upon hiring.
2. When indicated by performance.
4. Yearly evaluation

**REVIEWERS:**

Medical Director  
Executive Director

**SWEET MEDICAL CENTER  
QUALITY IMPROVEMENT PLAN  
LABORATORY STAFF COMPETENCY**

Employee Name: \_\_\_\_\_

Scoring Guide: S = Satisfactory      NI = Needs Improvement  
                     U = Unsatisfactory      NA = Not Applicable

Can explain, understand and/or demonstrate the following: Test or Procedure	Performed Correctly	Scoring	Date	Evaluator Initials
1. Venipuncture	Y / N			
a. Was performed successfully within guidelines of no more than two tries?	Y / N			
b. Inverts tubes properly and immediately?	Y / N			
c. Pressure held long enough on venipuncture site.	Y / N			
2. Fingerstick & Heelstick	Y / N			
3. Blood Culture Collection	Y / N			
4. Collection and Transport of Sample	Y / N			
a. Identifies patient	Y / N			
b. Collects specimen according to collection and handling policy.	Y / N			
c. Proper order and sequence of collection	Y / N			
d. Labels specimens and document collection date, time and tech initials.	Y / N			
e. Fills out laboratory requisitions.	Y / N			
f. Utilizes computer to obtain information needed.	Y / N			
g. Uses appropriate personal protective equipment.	Y / N			
h. Specimen rejection criteria.	Y / N			
5. Review Procedure Manual	Y / N			
6. Review Policy Manual	Y / N			

7. Review Safety Manual	Y / N				
8. Centrifuge Operation	Y / N				
9. Microscope Operation	Y / N				
10. Temperature Charts	Y / N				
12. Quality Control	Y / N				
a. Performs QC as required by procedure	Y / N				
b. Documents QC as required by policy	Y / N				
c. Performs corrective action when control values fall outside acceptable limits.	Y / N				
d. Does not report patient values when controls are outside range.	Y / N				
e. Documents all corrective action performed.	Y / N				
f. Monitors reagents and supplies for optimal inventory control.	Y / N				
g. Discards all expired reagents.	Y / N				
h. Initials all documentation.	Y / N				
i. Notifies appropriate personnel when problems occur.	Y / N				
13. Proficiency Testing	Y / N				
a. Documents each step of handling for proficiency testing performed.	Y / N				
b. Retains all printouts and worksheets.	Y / N				
c. Submits proficiency testing samples within the allowed amount of time.	Y / N				
d. Achieves acceptable results for all proficiency testing performed.	Y / N				
e. Performs corrective action due to failure of proficiency testing challenge.	Y / N				
14. Patient Test Management	Y / N				

a. Performs testing only when requested by an authorized person.	Y / N				
b. Documents the time of specimen receipt in the laboratory.	Y / N				
c. Documents all required information on the department worksheet.	Y / N				
d. Notifies and documents the notification of authorized person of all critical values.	Y / N				
e. Repeats tests according to the test repeat policy.	Y / N				
f. Reports all test results within the expected turn around time.	Y / N				
g. Retains instrument printouts, worksheets and all documentation of testing.	Y / N				
h. Initials all work.	Y / N				
	Y / N				
15. Urinalysis	Y / N				
a. Start Up Clinitek 50	Y / N				
b. Shut Down Clinitek 50	Y / N				
c. Urinalysis QC	Y / N				
d. Set up Urine Cultures	Y / N				
e. Collection of adequate specimen	Y / N				
f. Preparation of urine for microscopic	Y / N				
g. Dipstick Urinalysis	Y / N				
16. Hematology Analyzer	Y / N				
a. Start Up	Y / N				
b. Shut Down	Y / N				
c. Calibration	Y / N				
17. Hematology QC/Review QC	Y / N				
18. Hematology PM's	Y / N				

19. Blood Smear Preparation	Y / N				
a. Differential	Y / N				
b. Platelet Estimate	Y / N				
c. WBC Estimate	Y / N				
d. RBC Morphology	Y / N				
20. ESR	Y / N				
21. Mono Test	Y / N				
22. Prottime/ INR	Y / N				
23. Influenza A & B	Y / N				
24. Pregnancy Test Urine	Y / N				
25. Occult Blood	Y / N				
26. Whole Blood Glucose	Y / N				
27. Hemoglobin A1C	Y / N				
28. Pinworm Prep	Y / N				
29. Rapid A Strep Test	Y / N				
a. Throat Culture Collection	Y / N				
30. H. Pylori	Y / N				
31. Filling out Reference Laboratory Forms	Y / N				
32. Report Laboratory Results	Y / N				
33. Complete Incident Reports as needed.	Y / N				

Corrective Action:

Evaluator:

Reviewed By:

Date:

**SWEET MEDICAL CENTER  
QUALITY IMPROVEMENT PLAN  
NURSING STAFF COMPETENCY**

Procedure	Date trained	Date Observed	Comments	Initial
<b>INJECTIONS/ MEDICATIONS:</b>				
Intramuscular/SQ				
Intravenous(RNs)				
Intradermal/skin Test				
IV Start(RN,LPN)				
<b>IMMUNIZATIONS:</b>				
Tracking				
<b>WZARD</b>				
<b>VITAL SIGNS:</b>				
Ht. Adult				
Ht. Child				
Wt. Adult				
Wt. Child/Infant				
BP Adult				
BP Child				
Temp/Oral				
Temp/Rectal				
Temp/Tympanis				
Pulse, radial				
Pulse, apical				

**SWEET MEDICAL CENTER  
QUALITY IMPROVEMENT PLAN  
NURSING STAFF COMPETENCY**

Procedure	Date observed	Date Proficient	Comments	Initial
Respirations				
Head Circumference				
<b>CLEANING:</b>				
1. Triage Room				
2. Exam rooms				
3. EKG/Sick Room				
4. Nurse Station				
<b>STOCKING/ORDERING</b>				
1. Ordering/Receiving Supplies				
2. Stocking Rooms				
3. Ordering/Receiving Equipment				
<b>EKG</b>				
1. Use of equipment				
2. Maintenance of equipment				
<b>SURGITRON</b>				
1. Use of equipment				
2. Maintenance of equipment				
<b>SPIROMETRY</b>				
1. Use/Maint of Pulmonary Function Equipment				
2. Use/Maint of Equipment Nebulizer				

<b>AUDIOMETRY:</b>				
Use/Maint of Equipment				
<b>CENTRIFUGE:</b>				
Use/Maint of Equipment				
<b>AUTOCLAVING:</b>				
1. Instrument cleaning				
2. Instrument wrapping				
3. Use/cleaning of equipment				
4. Biological Testing				
<b>FILING/TRACKING:</b>				
1. Computer Competency				

**SWEET MEDICAL CENTER  
QUALITY IMPROVEMENT PLAN  
OFFICE SUPPORT STAFF COMPETENCY**

Effective: August 1, 2008

Approved: Joseph Z. Nemes, M.D., Medical Director  
Karen A. Bradway, Executive Director

Reviewed: July 1, 2008

INDICATOR: Office Support Staff Competency

**PERFORMANCE GOAL:**

1. The Office Support Staff at Sweet Medical Center, Inc. must be capable of the duties required for the position.
2. Each Office Support Staff shall maintain a current CPR certification. The clinic will provide training biennially.
3. Each Office Support Staff must provide a work history which will include the following:
  - a. Physical and mental health status;
  - b. Lack of impairment due to chemical dependence/substance abuse;
  - c. History of any felony convictions.
  - d. Any Disciplinary action. (An affirmative answer to any of the above should not necessarily preclude employment.)
4. Any certificates of graduation or special training.

**OUTCOME GOALS:**

1. Office Support Staff must be at least 95% competent in the performance of tasks required within 90 days of employment.
2. Office Support Staff personnel files will reflect CPR compliance.

**DATA SOURCE:**

1. Personnel Files
2. Job Description
3. Performance Check List

**FREQUENCY:**

1. Upon hiring.
2. Yearly review of personnel files.
3. Yearly evaluation

**RESPONSIBLE REVIEWERS:**

Finance Director  
Executive Director

**SWEET MEDICAL CENTER  
 QUALITY IMPROVEMENT PLAN  
 CHIEF EXECUTIVE OFFICER COMPETENCY**

Procedure	Date trained	Date Observed	Comments	Initial
Coordination with external agencies				
EMR Administration				
Safety Program Management				
Public Relations				
Financial Management Oversight				
Marketing Program				
Emergency Management Planning				
Policy Update & Implementation				
Board Coordination & Communication				
Patient satisfaction program				
Grant writing & management				
Confidentiality				
Facility Management				
Utilization of MIS				
Universal Precautions				
Planning				
Staff Coordination & Communication				

**SWEET MEDICAL CENTER  
QUALITY IMPROVEMENT PLAN  
CHIEF FINANCIAL OFFICER COMPETENCY**

Procedure	Date trained	Date Observed	Comments	Initial
Development of Grant Budgets				
Development/presentation of Board reports				
HAP expertise				
Oversight/supervision of billing function/personnel				
Supply system management				
Utilization of MIS				
Communication with patients/vendors/staff				
Accurate/timely grant financial reports				
Banking accuracy				
Currency/Accuracy of A/P				
Handling of patients				
Confidentiality				
Accurate Supply and Equipment management				
Accurate annual financial audit				
Management of petty cash				
Mgmt of collections				
Timely and accurate data analysis				
Universal Precautions				

**SWEET MEDICAL CENTER**  
**QUALITY IMPROVEMENT PLAN**  
**MEDICAL RECORDS SUPERVISOR COMPETENCY**

Procedure	Date trained	Date Observed	Comments	Initial
Maintenance of Pt EMR				
CPT/ICD9 understanding - Correct coding of pt visits – also ensuring lab procedures have appropriate supporting diagnosis				
Scanning in pt information				
Train/assist staff with EMR use				
Medical Record/ Completion-Forms				
Universal Precautions				
Telephone skills				
Work with MIS staff on EMR/MIS upgrades and software changes				
Collection of money - co-payments- Sliding Fee				
Oversight and knowledge of Front Desk Operations				
Chart audits				
Confidentiality				

**SWEET MEDICAL CENTER  
QUALITY IMPROVEMENT PLAN  
FRONT DESK MANAGER COMPETENCY**

Procedure	Date trained	Date Observed	Comments	Initial
Telephone Skills				
Maintain appointment schedule				
Check in patients/notify lab or nurse of pt arrival				
Insurance verification				
HAP Verification				
Referral of patients to billing office				
Collection of money - co-payments				
Universal Precautions				
Copy records for patients, insurance, etc.				
Data entry				
Confidentiality				
Provide clinic information to patients and inquiries				
Charts pulled for appointments				
Computer skills				
Daily Production Reports				
Maintenance of Patient Files				
New charts made				

**SWEET MEDICAL CENTER**  
**QUALITY IMPROVEMENT PLAN**  
**PATIENT ACCOUNTS MANAGER COMPETENCY**

Procedure	Date trained	Date Observed	Comments	Initial
Telephone Skills/ Handling of patient				
HAP Application to patient bill & sign up patient				
Insurance verification				
Collection of money - co-payments				
Balance deposits with CFO				
Confidentiality				
Billing Accuracy				
Mailing of statements				
2nd Insurance Billings				
CPT/ICD9 understanding				
Computer skills				
Universal Precautions				
Understanding Reimbursements/EOB's				
Daily Production Reports				
Delinquent Accts./ Collection Policy				
Front Desk Operations				
Maintenance of Patient Files				

**SWEET MEDICAL CENTER  
QUALITY IMPROVEMENT PLAN  
CASE MANAGER COMPETENCY**

Procedure	Date trained	Date Observed	Comments	Initial
Coordinate nurse work schedules				
Coordinate nurse training				
Supervise clinic nursing staff				
Liaison between nurses and Medical Director				
Track referrals				
Health Assistance Program				
Administration of in-house patient assistance and voucher programs				
Administration of pharmaceutical patient assistance programs				
Collaborate with area agencies/resources to develop client care plans				
Social Service – medical service resource for patients				
Perform QI audits and data collection				
Maintain patient charts				
Handling of patient				
Confidentiality				
Provide medical care to patients as instructed by Medical Director				

**SWEET MEDICAL CENTER  
QUALITY IMPROVEMENT PLAN  
HOUSEKEEPER COMPETENCY**

Procedure	Date trained	Date Observed	Comments	Initial
Cleans common areas in building				
Cleans all clinical areas				
Fill soap and towel containers				
Cleans restrooms				
Empties trash throughout medical clinic and common areas				
Cleans windows as required				
Periodically deep cleans floors and carpets				
Ensure all cleaning products and supplies are OSHA approved				
Arranges back up during absences				
Reports safety/facility problems to management				
Completes all required safety and patient privacy training.				

**SWEET MEDICAL CENTER  
QUALITY IMPROVEMENT PLAN  
MEDICAL RECORDS REVIEW SUMMARY**

MEDICAL RECORD CONTENT	YES	NO	N/A
1. Do All scanned pages contain patient ID?			
2. Is there demographic data?			
3. Is the provider identified on each entry?			
4. Are all entries dated?			
5. Are scanned pages legible?			
6. Is there a completed problem list?			
7. Are allergies & adverse reactions to medications prominently displayed?			
8. Is there an appropriate past medical history in the record?			
9. Is there documentation of smoking habits and history of alcohol use or substance abuse?			
10. Is there pertinent history and physical exam?			
11. Are lab & other studies ordered as appropriate?			
12. Are working diagnoses consistent with findings?			
13. Are plans or action/treatment consistent with diagnosis(es)?			
14. Is there a date for return visit or other follow-up plan for each encounter?			
15. Are problems from previous visits addressed?			
16. Is there evidence of appropriate use of consultants?			
17. Is there evidence of continuity & coordination of care between primary & specialty physicians?			
18. Does the care appear to be medically appropriate?			
19. Do consultant summaries, lab and imaging study result reflect primary care physician review?			
20. Is there a completed immunization record?			
21. Are preventative services appropriately used?			

Comments (please list appropriate item number for each specific comment)

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Reviewer \_\_\_\_\_ Date \_\_\_\_\_

Reviewer \_\_\_\_\_ Date \_\_\_\_\_

**SWEET MEDICAL CENTER  
QUALITY IMPROVEMENT PLAN  
CONTINUITY OF CARE**

Effective: August 1, 2008

Approved: Joseph Z. Nemes, M.D., Medical Director  
Karen A. Bradway, Executive Director

Reviewed: July 1, 2008

**INDICATOR:** Progression of patient care carried on without interruption

**PERFORMANCE GOALS:**

1. 3 – 6 month collaborative and referral reviews
2. Scheduled medical record audits

**OUTCOME GOALS:**

Zero tolerance on negative outcomes as a result of break in continuity or support

**DATA SOURCE:**

1. Incident reports
2. Chart audits/medical record reviews
3. Collaborative data review

**FREQUENCY:**

3-6 month scheduled reviews of collaborative data, referrals, medical record audits

**REVIEWERS:**

Medical Director  
QI Committee  
Case Manager  
Support Staff

**SWEET MEDICAL CENTER  
QUALITY IMPROVEMENT PLAN  
RISK MINIMIZATION**

Effective: August 1, 2008

Approved: Joseph Z. Nemes, M.D., Medical Director  
Karen A. Bradway, Executive Director

Reviewed: July 1, 2008

**INDICATOR:** Training to minimize risk

**PERFORMANCE GOAL:**

1. Safety training is to be conducted annually. Content will include: Back Safety, Drug Free Work Place, Fire/Disaster, Bloodborne Pathogens, chemical hazards (including MSDS), electrical safety, prevention, infection control, handwashing, PPE, sharps, cleaning, exposure control, ionizing radiation, workplace violence, sexual harassment and incident reporting. CPR training will be conducted biennially. Emergency Code training and any other relevant training will be conducted on a period basis.
2. HIPAA training is to be conducted annually. Content will include: privacy and patient consent, patient rights, use of patient information, authorized disclosures, business associates, parents and minors, billing and payments, patients who do not sign consent forms, passwords, and consequences of noncompliance.
3. Corporate Compliance training is to be conducted annually. Content will include a review of Sweet Medical Center, Inc. policies concerning: affirmative action, confidentiality, grievances, procurement procedures, property and equipment use and security, treatment of minors, credentialing, billing and collections, contract review and approval, financial policies and procedures, MIS (including email and internet usage), employment policies, grievance policies, conflict of interest, political activities, human resources, and hazardous waste.

**OUTCOME GOAL:**

100% of employees will participate in training annually.

**DATA SOURCE:**

Review sheets will be gathered and placed in personnel files.

**FREQUENCY:**

When hired

Yearly (safety) or biennially (CPR, corporate compliance, HIPAA)

**REVIEWERS:**

Medical Director

Executive Director

Chief Financial Officer

**SWEET MEDICAL CENTER  
QUALITY IMPROVEMENT PLAN  
PATIENT SATISFACTION/PATIENT COMPLAINTS**

Effective: August 1, 2008

Approved: Joseph Z. Nemes, M.D., Medical Director  
Karen A. Bradway, Executive Director

Reviewed: July 1, 2008

**INDICATOR:**

1. Patient Satisfaction Survey
2. Patient Complaints
3. Incident Reports

**PERFORMANCE GOAL:**

1. Patient Satisfaction Survey will be done twice yearly.
2. Review of Incident Reports will be done twice yearly.

**OUTCOME GOAL:**

1. 80% of all patients fall in the agree category.
2. 95% of corrective action has been taken regarding incidents and patient complaints.

**DATA SOURCE:**

1. Patient Surveys
2. Incident Reports
3. Patient complaint files

**FREQUENCY:** Semi-Annual report to Board of Directors

**REVIEWERS:**

Executive Director  
Medical Director  
Board of Directors

**SWEET MEDICAL CENTER  
QUALITY IMPROVEMENT PLAN  
PATIENT COMPLIANCE**

Effective: August 1, 2008

Approved: Joseph Z. Nemes, M.D., Medical Director  
Karen A. Bradway, Executive Director

Reviewed: July 1, 2008

**INDICATOR:** The degree to which the patient can and will accept and carry out the health care plan

**PERFORMANCE GOALS:**

1. 6-month referral audit
2. Collaborative data reviews
3. Medical record reviews
4. No show/reminders

**OUTCOME GOALS:**

Key Measure Goals as established for health disparity collaboratives

**DATA SOURCE:**

1. Medical record audits
2. Collaborative data

**FREQUENCY:**

1. Semiannual referral audits
2. Quarterly collaborative audits

**REVIEWERS:**

Medical Director  
QI Committee  
Case Manager  
Support Staff

**SWEET MEDICAL CENTER  
QUALITY IMPROVEMENT PLAN  
ACCESS TO CARE**

Effective: August 1, 2008

Approved: Joseph Z. Nemes, M.D., Medical Director  
Karen A. Bradway, Executive Director

Reviewed: July 1, 2008

**INDICATOR:** Ease and timeliness with which health care services can be obtained

**PERFORMANCE GOALS:**

1. Quarterly review of appointment/no show report
2. Semiannual review of patient surveys and incident reports

**OUTCOME GOALS:**

1. All possible open appointment slots filled
2. 80% of patient surveys indicate satisfaction with access to care
3. No incident reports relating to access to care

**DATA SOURCE:**

1. Patient satisfaction scores
2. Appointment/no show reports
3. Incident reports

**FREQUENCY:**

1. Quarterly review of appointment/no show reports
2. Semiannual review of patient satisfaction surveys and incident reports

**REVIEWERS:**

Medical Director  
Executive Director  
Front Desk Manager  
Case Manager

**SWEET MEDICAL CENTER  
QUALITY IMPROVEMENT PLAN  
APPROPRIATENESS OF SERVICE**

Effective: August 1, 2008

Approved: Joseph Z. Nemes, M.D., Medical Director  
Karen A. Bradway, Executive Director

Reviewed: July 1, 2008

**INDICATOR:** Improved health status of patients accomplished in a cost-effective/efficient manner

**PERFORMANCE GOALS:**

1. Cost of care reviews.
2. Scope of service reviews
3. Ongoing chart reviews/Peer reviews

**OUTCOME GOALS:**

1. Dialog changes as documented in medical staff minutes
2. Follow-up evaluations on changes documented.

**DATA SOURCE:**

1. Clinical surveys
2. Financial reports

**FREQUENCY:**

1. Semiannually review clinical and financial indicators, including review of productivity

**REVIEWERS:**

Medical Director  
Executive Director  
Chief Financial Officer  
Board of Directors Representative

**SWEET MEDICAL CENTER  
QUALITY IMPROVEMENT PLAN  
COST OF SERVICES**

Effective: August 1, 2008

Approved: Joseph Z. Nemes, M.D., Medical Director  
Karen A. Bradway, Executive Director

Reviewed: July 1, 2008

INDICATOR: Utilization data

**PERFORMANCE GOAL:**

Develop methodologies to collect utilization data paying particular attention to common requirements for managed care systems and the new reporting Uniform Data System requirements of Section 330 funded clinics.

**OUTCOME GOALS:**

Collection and reporting provider specific utilization.

**DATA SOURCE:**

1. Encounter forms
2. Appointment books
3. Tracking systems
4. Computer software.

**FREQUENCY:**

Monthly and in accordance with external reporting requirements

**SWEET MEDICAL CENTER  
CLINICAL REVIEW INDICATORS**

Frequency	Indicator	J	F	M	A	M	J	J	A	S	O	N	D
Monthly													
	Cost of Services	x	x	x	x	x	x	x	x	x	x	x	x
Quarterly													
	Physician Peer Review	x			x			x			x		
	Mid-level Peer Review	x			x			x			x		
	DM Collaborative Review		x			x			x			x	
	HTN Collaborative Review		x			x			x			x	
	Medical Records Audits			x			x			x			x
	Access to Care			x			x			x			x
Semi-Annual													
	Review of Incident Reports	x						x					
	Appropriateness of Service		x						x				
	Continuity of Care			x						x			
	Patient Compliance				x						x		
	Patient Satisfaction												
Annually													
	Clinical/Administrative Support Staff Proficiency Rev		x										
	QA Plan/Policy Review											x	
	Laboratory QI Plan/Policy Rev/CLIA Certification											x	
	State Immunizations Program Review					x							
	Risk Minimization	x											
	Clinical Staff Credentialing						x						

**SWEET MEDICAL CENTER  
QUALIFY IMPROVEMENT PLAN  
LABORATORY QUALITY ASSURANCE**

**QUALITY ASSESSMENT POLICY & STATEMENT**

The terms Quality Control and Quality Assurance are often interchanged. The fact is that these terms actually represent two different aspects of an overall Quality Program. The first phase of such a program is Quality Control. This is the survey aspect of the program and is designed to acquire the data necessary to accomplish the second phase, that of Quality Assessment. Quality Assessment is the review process by which decisions are made as to the changes, if any, are needed in the laboratory to maintain the level of reliability and accuracy to monitor the overall quality of testing process from beginning to end.

In order to accomplish these tasks, five guarantees must be made:

- The staff is competent for their assigned tasks.
- The equipment and reagents are reliable, safe and properly maintained.
- The methods are modern, accurate, precise and validated.
- Laboratory performance is subject to impartial audit.
- Reports are checked for errors, are convenient to interpret and are delivered to the right place at the right time.

The following statements and protocols represent the intent of the laboratory.

**PERSONNEL**

The laboratory will staff with those people who have by education, experience, or both, the training necessary to perform the tasks assigned to them.

- Staffing Patterns-The laboratory will provide staff and supervision at adequate levels for the tasks employed.
- Supervisors-The supervisor will oversee the technical and quality control aspects of the laboratory. It will be his/her responsibility to see that the clinical data is accurate, precise and delivered in a timely manner.
- Records & Rosters-Personnel records will be maintained by the CEO and contain authentication of education and/or experience, continuing education documentation, periodic performance evaluations and job descriptions.
- Personnel Safety-A Laboratory Safety Manual has been prepared with detailed protocols concerning the health and safety of employees and patients. Pertinent health records (such as TB testing) are maintained as a part of the employee personnel record.

**SPECIMENS-COLLECTION AND STORAGE**

The first step in quality laboratory work is proper specimen collection, processing and storage. To this end, the laboratory will maintain a procedure manual that clearly details the processes

necessary to obtain the proper specimen for the procedure requested. The following is an outline of the protocols used in this laboratory regarding specimen collection, processing and storage.

1. Specimen Collection: The laboratory procedure manual will contain information concerning the following specimen collection information:
  - A. Patient preparation
    1. Fasting Status
    2. Preparative diet
    3. Collection times
  - B. Collection procedures
  - C. Specimen preservatives
  - D. Review of phlebotomy procedures
  - E. Time sampling
  - F. Accessioning and labeling criteria
  - G. Transportation requirements
  - H. Mislabeled specimen policy
  - I. Labeling of hazardous specimens
  - J. Referred specimen procedures
2. Specimen Rejection Criteria: The individual procedure found in the procedure manual contains information regarding the acceptance or rejection of specimens for that procedure. Information should also be included as to interferences caused by specimens deemed adequate but not ideal. (i.e. turbid, lipemic, or slightly hemolyzed) Those specimens that have been accepted but are not ideal should have comments explaining those problems on the final charted report.
3. Specimen Storage: Policies regarding the storage of specimens prior to analysis are detailed in the procedure manual and the individual tests procedure.

## EQUIPMENT

The laboratory will maintain records of validation, maintenance, and repair on all instrumentation in the laboratory.

1. Preventative Maintenance & Service: Schedules, charts and other documents pertaining to the maintenance of laboratory equipment is to be kept in the laboratory. Those instruments that are to be serviced under contract by the manufacturer or other designate will have records kept indicating the time, date, and nature of any work performed on them. Copies of work orders will be maintained and kept in maintenance manual.
2. Instrument Function Checks: Those instruments that require periodic checks of temperature, voltage, etc., will have records of those checks in the laboratory. The documentation of those checks will include the results, limits of acceptable performance, the technologist performing the check and corrective action taken should those checks not be within limits. Instrumentation that cannot pass its respective function tests must be removed from service until such time as it can pass those checks.
3. Instrument Safety: Safe operation of all instrumentation will be addressed in the procedure manuals or in the laboratory safety manual for general laboratory apparatus.

## METHODOLOGY

All methods used in the laboratory can be referenced by five areas. These areas are procedure manuals, panic lists, consultation guides, validation procedures and control limits. An explanation of these areas and where they can be found is listed below.

1. Procedure Manuals- The laboratory will have procedure manuals that conform to a set format compatible with NCCLS recommendations. Each manual will have an index listing its contents and will contain all procedures performed the laboratory. Each procedure will contain information regarding the following:
  - A. References
  - B. Principle
  - C. Specimen requirements
  - D. Reagent preparation & storage
  - E. Step-by-step procedure
  - F. Calculations (when necessary)
  - G. Q.C. to be run and evaluated
  - H. Limitations of the procedure
  - I. Reference ranges
  - J. Additional notes or comments
  - K. Action to be taken when test system becomes inoperable
  - L. Include life threatening values
  - M. Criteria for specimen referral

These procedure manuals will be reviewed on an annual basis by the laboratory director and show their initials or signature on any revisions of the original procedure.

2. Panic Lists- A critical or panic list will contain those lab results that are so abnormal that they indicate that the patient may require immediate medical attention. When results are generated on a patient that falls into the panic list criteria, the results must be personally transmitted by phone or in person, directly to the caregiver who can evaluate the test results without delay and take appropriate action.
3. Consultation Guidelines-In each procedure manual, there shall be a section which gives guidelines to the technologists as to when tests should be repeated or give to a pathologist or attending physician for further evaluation. Attention should be given to the proper reporting of results that lie out of the calibration range (both low & high) and when it is appropriate to comment on abnormal specimen condition.
4. Validation Procedures-There shall be instructions in the procedure manual of each department as to the proper way to validate new procedures or to validate procedures found to be out of control. This should include such items as the number of parallel studies to be run and the acceptable difference from one method and another. Use of controls and standards should be mentioned and documentation of such evaluations should be kept on file.
5. Control Limits-Since different lots or types of control material can be used within the framework of a given procedure, the defined limits for controls need not be given in the procedure manual. Control limits will, however be posted in clear view, stating the type, lot number, outdate of that particular material.

## REAGENTS

The quality, specifications, and disposal of materials in this laboratory shall be monitored to assure that those materials perform as expected and offer no health hazard to employees or patients.

1. Sterilization and Decontamination-Procedures for the decontamination and sterilization of contaminated materials in the laboratory can be found in the Laboratory Safety Manual.
2. Water Quality-The specific needs for water are addressed in those procedures requiring specific grades of water. Grade Two water is used for the reconstitution and make of laboratory reagents.
3. Labeling & Index-All reagents used in the laboratory will be labeled as to date of receipt or manufacture in the laboratory, date on which the reagent was first opened, its shelf life or outdate, and the initials of the person making a reagent in-house.
4. Parallel Testing-Laboratory policies regarding the parallel testing of new reagents against old shall be instituted. Mention of controls to be run or standards to be used will be included. Not all reagents need to be parallel tested, but whenever reagents are changed, sufficient controls must be run to ascertain the potency and accuracy of the new reagent.

## CONTROLS & STANDARDS

The most important aspect of quality assurance is the appropriate selection of controls and standards and the interpretation of the data obtained by those controls and standards. This laboratory will establish control limits for all procedures run. It will run at least two levels of controls and will keep records of these results on file for at least two years. The selection of controls used in a given procedure should take into account as many parameters of that test as possible. Standards will be appropriate to the test and where available will have pedigreed to nationally established standards. The following list is a minimum level of information that will be included in procedure manuals for each procedure performed in the laboratory.

1. A description of what controls are to be run. Are these controls in-house, commercial, high, low, etc. On control charts, the lot number, out-dating and manufacturer must be noted.
2. The frequency in which these controls are to be used. If more than one level or one type of control is used, a policy explaining when and how the various controls are to be used.
3. Control charts will list the tolerance limits of the respective control materials. A notation of when these values were put in place or last evaluated.
4. The procedure manual will explain how control data is to be recorded and what methods are used to evaluate the data (i.e.  $\pm 2$  S.D. Weston rules, Westgard.)
5. The laboratory will have a protocol explaining the procedure to follow when out of control results are obtained. These procedures should explain what avenues are to be taken to return the test to a controlled status and what should be done with patient data that may have been run before the out-of-control state was discovered.
6. Reference values for tests performed should be generated from either in-house studies or referenced to nationally accepted values to which the laboratory has found no conflicts. Periodically the appropriateness of these reference values should be checked.

7. A monthly review of all quality control data will be performed by the laboratory director. Questions and concerns regarding this information will be addressed at this time.

#### PROFICIENCY TESTING

- The laboratories quality assessment program will include an independent evaluation of its methods by submitting to regular proficiency testing.
- It is strongly encouraged that all members of the technical staff be given an opportunity to participate in these surveys. Specimen material not necessary of analysis should be saved as best as possible for further evaluation when survey results return. (It is recognized that the fragile nature of some survey materials makes this impossible.)
- Survey Specimens should be handled as a patient sample as much as possible. These materials are to be handled with as much due caution in regard to the infectious nature and potential for contamination as a patient sample.

#### RECORDING OF RESULTS

- Results of proficiency testing are to be completed within the time frame allowed by the surveying agency. Proper documentation such as controls and reruns should be kept together. The laboratory technician is responsible for seeing that the survey results are completed and the results are sent in on time.
- The laboratory technician will keep a file of all survey results and their original reports. These records will be kept for at least two years from date of completion and will be made available to state and federal inspectors

#### EVALUATION OF SURVEY RESULTS

- Deficiencies must be evaluated and decisions made as to how to correct those deficiencies. A written report or comments regarding the survey should be made and saved along with the survey results. This report will contain documentation of the changes made to correct deficiencies.

#### REPORTS

The final report represents the culmination of a considerable effort on the part of everyone in the laboratory. This document should be clear and precise. The report will be delivered to the physician in a timely manner and have sufficient patient information so that physician is not confused about when or where the test results were performed.

The final reports issued to the physician will contain the following information:

1. Patient name, Age, Date of Birth, Sex
2. Date & time specimen was obtained, collection date & time is time requisition was created.
3. Test requested
4. Ordering Provider
5. Reporting units (where applicable)
6. Reference intervals (if applicable)
7. Date & time finalized
8. Lab where tests were performed

- These reports must be legible and contain any other pertinent information deemed necessary for the report to be properly evaluated by the physician.
- Prior to the charting of any laboratory results, a review of those results must be accomplished. This review will include a check for clerical errors, incompatible results.
- Copies of all laboratory reports will be kept on file for at least two years. These reports will be kept in a manner such that their timely retrieval can be accomplished should the need arise. Work logs are acceptable with reporting tech's initials.
- It is very important that a two-way communication between the physician and the laboratory staff be maintained. Questions and comments from both the laboratory and the physician and staff are strongly encouraged. Confidentiality of all patient information must be maintained at all times.

#### PATIENT INFORMATION RELEASE POLICY

Medical records will be available to each patient or in the case of a minor, to his/her legal guardian at any time on the patient's request. Copies of the patient's medical record will only be released to specified parties upon receipt of a signed release for medical information, designating what records may be released and to whom the records may be released.

Approved: \_\_\_\_\_  
(Date)

\_\_\_\_\_  
Chair, Board of Directors

**SWEET MEDICAL CENTER  
QUALITY IMPROVEMENT PLAN  
COMPETENCY/EKG INTERPRETATION**

Effective: August 1, 2008

Approved: Joseph Z. Nemes, M.D., Medical Director  
Karen A. Bradway, Executive Director

Reviewed: July 1, 2008

**POLICY:** Provider EKG Interpretation

**PROCEDURE:**

1. Each EKG done at Sweet Medical Center, Inc. will be interpreted by the provider ordering it.
2. The medical director/supervising physician will review all EKG's ordered by mid level providers at time of service. He will discuss any interpretive discrepancies with the individual provider.
3. When the medical director/supervising physician is not available, the EKG will be reviewed by the medical director /supervising physician with in one week and any discrepancies will be discussed with the to the ordering midlevel. If the midlevel provider needs an immediate consult, he may fax the EKG to an appropriate physician.
4. The EKG shall be kept as part of the patients' permanent record in the patients chart.
5. The Mid-Level Provider is responsible for informing the patient of the interpretation of the EKG and shall be responsible for documenting the interpretation in the patient's chart. I i interpretation of EKGs at Sweet Medical Center, Inc.

**INDICATOR:** Competency of Mid-Level Providers in reading EKGs.

**PERFORMANCE GOAL:** All Mid-Level Providers shall possess some degree of competency in the interpretation of EKGs ordered by that provider.

**OUTCOME GOAL:** 95% accuracy in the Mid-Level Interpretation of EKGs.

**FREQUENCY:** As completed the accuracy of the interpretation of EKGs shall be reviewed by the medical director/supervising physician.

**REVIEWERS:**

Medical Director

## **SWEET MEDICAL CENTER EMERGENCY POLICY**

Effective: August 1, 2008

Approved: Joseph Z. Nemes, M.D., Medical Director

Reviewed: July 1, 2008

Board Reviewed:

### **PURPOSE:**

To establish a policy for the triage, management and care for the patient presenting to Sweet Medical Center with a medical emergency.

### **POLICY:**

1. The patient that presents with what appears to be a medical emergency is immediately escorted to the Procedure Room by the most appropriate mode of transportation available at the time.

a. Triage may be done by the first contact person. This may be the receptionist the medical tech., the nurse, the provider or anyone else who may come in contact with the patient.

b. The triage person immediately contacts the next most appropriate medical person available.

Initial efforts should be directed toward airway, breathing and circulation.

2. If the patient is bleeding, pressure is provided and the medical provider is notified. Emergency care is then directed by the provider. Every effort is made to protect one's self against contact with the patient's blood, per OSHA guidelines.

3. If the patient is having chest pain, O<sub>2</sub> is started at 2 liters per minute via nasal cannula, the patient is placed on a stretcher in the Fowler's position (45 degree elevation) and the medical provider is notified. The patient is placed on a monitor, a vein is accessed, and EKG is obtained and the emergency care is directed by the provider. Transport may be necessary with the provider in attendance.

4. If the patient is S.O.B., the patient is placed on a stretcher in the Fowler's position. A pulse oximetry is obtained. If the percent saturation is less than 90%, the patient is placed on 2 liters of O<sub>2</sub> via nasal cannula and the provider is notified. It may be necessary to acquire vein access and/or give an SVN treatment and preparations to do so should be made. Epinephrine administration may also be necessary. The provider will direct emergency care. Transport may be necessary with the provider in attendance.

Page 2-Emergency Policy

5. If the patient is having a seizure, the patient should be rolled to the side, collar should be loosened, and the patient should be protected from harm/injury. (Do not restrain the patient.) Observers should be asked to move to another location.

The provider should be notified. Emergency care will then be directed by the provider. Oxygen may be useful if the seizure is prolonged and should be readily available. A vein may need to be accessed and preparation to do so should be made. Anticonvulsant medication may be given and should be readily available as well as an oral airway. Transport may be necessary with the provider in attendance.

6. If the patient is overdosed and is not breathing, an airway should be opened and maintained. It may be necessary to perform cardiac massage, in other words, the ABC's of emergency care may be the first care delivered. (A-Check Airway, B-Check Breathe, and C- Begin Chest Compressions.) The provider should be notified and emergency care should be directed by the provider. Preparations should be made to access a vein. If the patient is breathing and can maintain an airway, preparations to give oral activated charcoal should be made. Transport may be necessary with the provider in attendance.

7. If the patient is a known diabetic, a blood sugar should be obtained and the provider should be notified immediately. Emergency care will be directed by the provider. Vein access is most likely needed and preparations to do so should be made. Transport may be necessary with the provider in attendance.

8. If the patient has been burned, clothing and articles that conduct heat should be removed immediately using sterile gloves and preserving the intact skin as much as possible. The provider should be notified immediately. Preparations for ABC's(See above) and shock should be made. Vein access is vital and should be made immediately if the burns are extensive. The patient should be covered with a sterile drape after saline dressings are applied. Transport may be necessary with the provider in attendance.

9. If the patient gives a history of a chemical burn of the eye(s) irrigation of the eye(s) should begin immediately. The provider should be notified. The eye tray should be at hand. The provider may need to refer the patient to the hospital or to an ophthalmologist.

10. O.B. emergencies should be handled as they present. If delivery is eminent, the precipitation tray should be available. If the patient is bleeding, convulsing, or an abruption is suspected, emergency care appropriate to the situation should be delivered, including oxygen, and immediate transport should be given with the provider in attendance.

Realizing the above situations will not cover all emergencies that may present to the Sweet Medical Center, emergency care will be given in the most appropriate manner, by the most qualified person available, at the time, according to the presenting emergency.

Medical staff members will undergo proficiency testing yearly to ensure proper use of emergency equipment, defibrillators, suction devices and location of supplies. Mock codes will be conducted biannually.