The Unit Specific Policy and Procedure Manual has been reviewed and revised March, 2012. The manual will be reviewed on a yearly basis.
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Definition: Responsibility of clinical director.

Policy: The University Internal Medicine Center is under the auspices of a physician clinical director who has the authority and responsibility for carrying out established policies and for providing overall direction in the continuing provision of ambulatory care services.
University Internal Medicine is a full service, state of the art, Internal Medicine practice that strives to provide the best in comprehensive, continuous, coordinated and rapidly accessible care for adults. UIM is located at MUSC’s downtown campus on the 8th floor of Rutledge Tower. UIM includes the Internal Medicine resident continuity/teaching practice and the Internal Medicine Faculty practice as well as the Rapid Access Center.

The twenty two exceptional General Internal Medicine faculty members staffing UIM are a diverse group of clinicians with training and experience in geriatrics, endocrinology, neurology, and health services research, and include nationally recognized clinician educators such as the MUSC Internal Medicine residency program director. Many of these physicians have been recognized with awards such as “Best Doctors in America”, Golden Apple Teaching Awards, General Internal Medicine/Geriatrics has been named Division of the Year for exceptional teaching by the residents for the last three years in a row. It has been recognized as a Patient Centered Medical Home (PCMH) and has NCQA – Level III certification.

135 Rutledge Avenue, 8th Floor
Rutledge Tower
Charleston, SC 29425

New and Return Appointments:
843-876-0888
843-792-4331 or 843-876-0767 (fax)

UIM practice hours are 8 AM to 5 PM, Monday through Friday. A faculty member is on call after hours and on weekends for UIM patients.

Providers:

Sarah Allen, MD   Cara Litvin, M.D.
Elisha Brownfield, M.D.   Mark Lyles, M.D.
Walter J. Brzezinski, M.D.   Cheryl Lynch, M.D.
Courtney Cave, M.D.   Lynn Manfred, M.D.
E. Benjamin Clyburn, M.D.   Lawrence Mohr, M.D.
Kimberly S. Davis, M.D.   William P. Moran, M.D.
Brent Egan, M.D.   Dolores Tetreault, M.D.
Leonard Egede, M.D.   James Thomas, M.D.
Donald L. Fox, M.D.   M. Kathleen Wiley, M.D.
Brad Keith, M.D.   Tamara Wolfman, M.D.
Leonard Lichtenstein, M.D.   Jeffrey Wong, M.D.
A. INTRODUCTION:

1. General description and location
   The University Internal Medicine is located on the 8th floor of Rutledge Tower.

2. Patient population
   UIM serves as a practice site for General Internal Medicine faculty, Department of Medicine residents and medical students. (22 attending and 97 medicine residents) Nurses provide care management for approximately 12,000 patients.

   Types of Patients (Diagnoses)
   - Abdominal pain
   - Headache
   - Asthma
   - Hyperlipidemia
   - Cardiovascular disease
   - Hypertension
   - Cerebrovascular disease
   - Musculoskeletal pain
   - COPD
   - Sickle Cell disease
   - Chronic kidney disease
   - Urinary tract infection
   - Congestive heart failure
   - Degenerative joint disease
   - Depression/Anxiety
   - Diabetes & (complications related to)
   - Fibromyalgia

   Ages of Patients
   - Adult
   - Geriatric

3. Available Procedures or Description of Significant Activities and Processes Performed
   - Aspiration/Injection of joint
   - MSW
   - Blood sugars
   - O2 Administration
   - Coumadin Clinic
   - Pap smears / Wet Prep
   - Diabetes Education
   - Paracentesis
   - Doppler studies
   - Pulmonary function tests
   - Ear Irrigation
   - Rapid Flu / Rapid Strep
   - EKG
   - Urinalysis
   - Incision & Drainage
   - Vaginal Smear – Wet Preps
   - IV Electrolyte Replacement
   - Venipuncture
   - IV Therapy
   - Lumbar Puncture

4. Hours of Operation
   Monday through Friday, 8:00 am to 5:00 p.m. The clinic will follow the MUHA holiday schedule. Non-scheduled, urgent visits will be covered by the physician of the day.
B. CRITERIA FOR ENTRY TO SERVICE AND DISCHARGE:

1. Admission
   Patients can call regional scheduling at 876-0888 Monday - Friday 8:00am - 5:00pm
   Urgent appointments are covered by physician of day/or can be scheduled in Rapid Access
   Clinic (per protocol) or to the unit Resident
   Emergent follow-up are seen in the MUSC Emergency Room/Post Discharge
   Patients can be admitted from the clinic in coordination with the Admissions Office

2. Alternate Units
   None

3. Discharge
   Patients are discharged from the clinic at the conclusion of the physician/nurse visit or
   transferred to the next level of care - either inpatient or the emergency room. Patients can be
   discharged permanently when the episode of treatment or surgery follow up has been
   complete. Patients can be permanently discharged upon violation of the patient physician,
   violation of relationship, violation of policies or pain contract.

C. PLAN OF CARE:

1. Assessment
   Nursing practice in ambulatory care is diverse, covering a multitude of specialty practice
   settings. Every patient seen is ambulatory care may not require professional nursing
   services. Registered nurses practicing in ambulatory care have the expertise, skills, and
   responsibility to systematically assess the need for and ensure the delivery of nursing
   services that meet patient care requirements, whether delivered directly or by other nursing
   staff.

   Care is provided through the nursing process in collaboration with the patient, family,
   physician and other health care providers in order to achieve a maximum level of wellness.
   The patient's health status will be assessed by a RN for the purpose of providing nursing
   care. The collection of data through nursing assessment techniques may include interviews,
   observation, and physical evaluations. Data will be collected by LPNs and certified
caregivers according to the laws of South Carolina governing the practice of nursing.
   Registered nurses may use two levels of assessment in the ambulatory care setting. The
   first is an assessment of patient populations based on risk factors, need for care, and reason
   for visit. For individual patients identified as needing professional nursing care, the
   registered nurse uses a second level of assessment to determine individual patient needs.

   For individual patients identified as requiring professional nursing care:
   1. Identifying patterns of human responses to actual or potential health problems;
   2. Executing a nursing regimen through the selection, performance, management,
      and evaluation of nursing actions
   3. Assessing health status
   4. Ensuring health counseling and health teaching
   5. Administering medications, treatments, and executing regimens prescribed by
      licensed physicians, dentists and podiatrists
   6. Teaching, administering, supervising, delegating, and evaluating nursing
      practice.

2. Treatment
   Treatments are given upon a physician or health care provider's order or by established
   protocol. Relationship between members of our patient care team.
   Physicians
   Residents
   Home Health Agencies
3. Continuum of Care
Continuums of care needs are based on patient screening and assessments. Intra-hospital and community based agencies including home health and Medicaid services assist in meeting patient continuum of care needs.

D. STAFFING:
1. Staffing Plan
Nursing staff ratios are determined by patients’ needs, based on volumes, activity, visit type, procedures, and patient learning needs.

1.0 NCCC III  9 RNs  4.0 LPNs  4.25 PCTs  Clinical Secretary

2. Staffing Variances
Staffing numbers can be flexed up or down depending on the number of providers and scheduled patients. Information on the number of scheduled patients and providers is reviewed on a weekly basis from information obtained in IDX.

Additional staffing can be obtained by the Ambulatory Care Clinical and Administrative pool or by floating staff to the area of greatest need.

E. QUALIFICATIONS OF STAFF: (Coordination of Care)
A. Qualifications / skill level required of staff
1. Level of Staff
   • RN - graduate NLN approved school of nursing, licensed by South Carolina, BLS certification
   • LPN - Licensed by South Carolina, BLS certification
   • CMA – Graduate of associate degree in applied sciences

Orientation Program
• All new employees attend MUHA Organizational Orientation
• All new employees attend the Outpatient Clinics Department Orientation
• All new clinical employees also attend Point of Care Testing, Fit Testing, Computer training, and HarpNet (RNs) training at MUSC, as well as a morning of Clinical Orientation for the outpatient clinics, which includes: Pain Assessment and Management, Patient Screening/Assessment, MayDay, Patient/Family Education, Cultural Diversity, Patient Safety, Personal Protective Equipment and Safety Devices and other topics
• All new non-clinical employees attend general computer training at MUSC as well as specific training in computer systems they will be using (Centricity, etc.)
• New clinical employees complete modules in Centricity and attend a computer class in EPIC as appropriate for their clinical area
• New clinical employees attend a Facility Ticket Class
• Designated new clinical employees also attend an EKG class. Designated RNs/LPNs complete competencies in Central Venous Lines, Blood Administration, Alaris IV pumps, and Moderate Sedation as appropriate to their clinic setting
• Clinical employees complete unit-specific clinical competencies in their clinics
• All new employees attend MUSC Excellence and Service Recovery during the Outpatient Clinics Department Orientation
• All new employees are assigned a preceptor during the orientation period. The preceptor completes the Unit Specific Orientation checklist with the new employee as well as the Competency Based Orientation (CBO)
• The CBO consists of 4 documents: the Orientation Plan, the Weekly Plan, the Responsibilities and Performance Criteria, and the Self-Assessment and Review

Competency Assessment
• All new RNs and LPNs must complete and pass a test on the Medication Policies (C-21, C-56, C-61, C-78, AC11 and AC32). RNs must also complete and pass a Medication Administration test and LPNs must also complete and pass a Dosage Calculation Test. RNs who will be giving IV push meds must complete a competency on this in their clinic before giving any IV push meds
• The CBO is a mechanism both for assessing competency at the time of orientation and for teaching knowledge and skills needed in the particular setting and then assessing competency. Built into the program are two times (30 days and 60 days) at which the preceptor and orientee review the progress made and set goals or make plans for improvement (Self-assessment and Review). The CBO is completed within the first 90 days of orientation
• Clinical employees complete unit-specific competencies on an annual basis
• All employees complete annual mandatory educational requirements through computerized learning on the CATTS system
• All clinical employees must be certified in BLS and demonstrate competency on an annual basis
• Designated clinical staff are also certified in ACLS or PALS
• Registration staff competency is assessed through monitoring of accuracy rates and quarterly audits
• Registration and scheduling staff attend regularly scheduled UPDATES to learn new information related to insurance plans and other system changes
• The Performance Evaluation Feedback form is used in completing the annual employee evaluation to gather information from the employee’s peer’s and other team members
• Other methods of competency assessment include: observations of staff performance, occurrence reports, and patient satisfaction surveys
• Educational needs assessments are completed on an annual basis. Programs/classes are developed/offered as needs are identified
• Nursing Grand Rounds are held on monthly basis at MUSC
• Staff meetings are used as a forum to identify learning needs and to educate staff
• In-services and classes are offered in Ambulatory Care and in the Medical Center
• Staff are encouraged to attend classes or conferences specific to their practice areas
• Staff are encouraged to complete specialty certification

F. COMMUNICATIONS/RELATIONS WITH OTHER DEPARTMENTS/SERVICES:
1. Methods of Communication.
   Monthly staff meetings – nurse manager & staff meet to discuss immediate area issues.
   Coordinator meetings to communicate needs and changes within network
   Operation meetings – monthly meeting with Nurse Manager, Patient Registration Representative Physician Clinical Director and Scheduler communicate clinic and department issues Staff representatives to Education Resource committee
   Culture of Safety Initiative – Team “huddles”, at least 1 to 2 times a week to communicate operational issues.

   Handoff Communication / SBAR
• **ALL** physician’s orders must be rewritten for patients transferring from a special care unit to a general unit, a general unit to a special care unit or from one service to another within four (4) hours of the transfer
• If the patient is in STABLE CONDITION and does not have an assigned bed, the outpatient clinic will complete and send the outpatient SBAR Transfer form with the patient while the patient awaits bed assignment
• After hours, if the patient has care needs, an RN will stay with the patient until transfer. When a physician remains in the clinic after hours, an LPN may stay with the patient until transfer instead of an RN
• If there is not a physician in the clinic and the patient is NOT STABLE, the patient will be transferred to the Emergency Department to await admission

2. Collaborative/functional relationships with other departments/services
The clinics operating in this area have a direct relationship to the Hospital department or division and Ambulatory Care Services. Pharmacy services provide all medications given in the clinic.

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G. **GOALS OF THE DEPARTMENT:**
The goal of the department in accordance with the philosophy of the MUHA is to provide excellent care to patients. Goals include:
- Maintain safe, efficient, effective patient care
- Increase volume of patients
- Lower patient wait times
- Increase patient education
- Improve patient flow

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H. **IMPROVING QUALITY:**

The Performance Improvement methodology is IMPROVE. Performance Improvement activities include the following projects:
- Monitor patient satisfaction surveys
- POCT proficiency of staff
- Environment of Care
- Procedure reviews
- Monitoring Pap smears and Mammogram results
- Improve Employee Satisfaction

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I. **PATIENT SAFETY INITIATIVES:**
All patients are given a safety booklet at the initial appointment or onset of hospitalization. Ambulatory Care Services in conjunction with MUHA have instituted task forces to improve patient safety in the clinics. The verbal order task force, identification of the site of surgery/treatment and the medication safety task force have been instituted in the past year. Initiatives have been to:
1. Improve the accuracy of patient identification
2. Follow a Verbal order read-back policy
3. Standardize abbreviations, acronyms and symbols
4. Improve the safety of high-alert medications
5. Ensure free-flow protection of infusion pumps
6. Improve medication reconciliation

We encourage an environment of heightened safety awareness through rounding, in-services, inspections, staff assignments, direct observation of care provision, and care team huddles with weekly reporting to Ambulatory Care Manager of Quality to trend data and develop appropriate interventions and support staff to continually improve and maintain a safe environment as well as safe care delivery.

J. ADDITIONAL STANDARDS OF PRACTICE ADOPTED/ADAPTED BY DEPARTMENT/SERVICE:
Ambulatory Care complies with standards established by AAACN, JCAHO and DHEC

REVISED & APPROVED:
Judi Bucknam, RN, BSN
Manager, Medical-Surgical Services
Sherry Gillespie-Miller, RN, MSN
Clinical Director, Ambulatory Care Services

Revised: March 5, 2012
MUHA SCOPE OF SERVICES – CLINICAL
University Internal Medicine

<table>
<thead>
<tr>
<th>CRITERIA FOR SERVICE – INPATIENT AND OUTPATIENT</th>
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<td>Emergent follow-up are seen in 1 West Trauma Center</td>
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### MUHU SCOPE OF SERVICES – CLINICAL  
### UNIVERSITY INTERNAL MEDICINE

#### INTRODUCTION

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- Congestive heart failure  
- Degenerative joint disease  
- Depression/Anxiety  
- Diabetes & (complications related to)  
- Fibromyalgia  
- Headache  
- Hyperlipidemia  
- Hypertension  
- Musculoskeletal pain  
- Sickle cell disease  
- Urinary tract infection  

| Ages of Patients |  
- Adolescent  
- Adult  
- Geriatric  

| Procedures, Activities and Processes Performed | Aspiration/Injection of joint  
Counadin Clinic  
Diabetes Education  
Doppler Studies  
Ear Irrigation  
EKG  
HgA1C  
Incision & Drainage  
IV Electrolyte Replacement  
IV Therapy  
Lumbar Puncture  
MSW  
O2 Administration  
POCT  
Pap Smear/Wet Prep  
Paracentesis  
Pulmonary Treatments  
Port/PICC access for labs  
Fluids, routine flushing  
Pregnancy Testing  
Prep  
Venipuncture  

| Operating Hours | Monday through Friday 8:00 am to 5:00 pm. The clinic will follow the MUHA holiday schedule. Non-scheduled, urgent visits will be covered by the physician of the day. If a patient is in need of admission the RN of the day/week and physician will remain with patient until transfer is complete. |
UNIVERSITY INTERNAL MEDICINE CALL SCHEDULE

Listed attendings may be reached via their beepers or listed telephone numbers. Weekdays 5:00pm – 8:00am Saturday & Sunday (24 hours)
MUSC Paging Operators 792-2123

APRIL 2012

1 Cave
2 Clyburn
3 Egede
4 Schreiner
5 Brzezinski
6 Wiley

7 Moran
8 Schreiner
9 Lynch
10 Cave
11 Fox
12 Schreiner
13 Manfred

14 Lichtenstein
15 Tetreault
16 Wolfman
17 Brownfield
18 Davis
19 Egede
20 Wolfman

21 Brzezinski
22 Lynch
23 Moran
24 Wolfman
25 Brownfield
26 Lichtenstein
27 Davis

28 Wolfman
29 Clyburn
30 Fox

Dr. Allen.........229-9647...4491 Dr. Lichtenstein...884-3366...4187
Dr. Brownfield....795-9233...4055 Dr. Litvin.........276-2865...4693
Dr. Brzezinski.....886-3761...4044 Dr. Lynch..........879-9184...4451
Dr. Cave..........224-0025...4076 Dr. Manfred.......670-8038...4524
Dr. Clyburn.......795-9233...4029 Dr. Moran..........323-8926...4001
Dr. Davis..........762-0620...4408 Dr. Schreiner..513-484-9684...4511
Dr. Egede..........763-2291...4224 Dr. Tetreault.......870-9027...4064
Dr. Fox.............556-7094...4098 Dr. Wiley..........557-0472...4340
Dr. Keith..........766-2757...4008 Dr. Wolfman......795-2551...4004
Dr. Kilb............327-9647...4565 Dr. Wong..........327-6160...4606
University Internal Medicine Medical Center Policy Manual

Rapid Access Center
The Rapid Access Center (RAC) will:

- Provide same day access for adult acute care needs especially for MUSC employees, spouse and adult children.
- Improve acute care services responsiveness of University Internal Medicine practice.
- Strive to provide excellent focused care in a brief appointment (10 minutes).

The RAC provides limited services such as treatment and care for:

- Flu
- Sinus Infection
- Musculoskeletal Pain (excludes chest pain)
- Vaginal Discharge
- Ear Pain
- Joint Pain
- Pink Eye
- Cold
- Cough
- Rash
- UTI
- Skin Infection
- Sore Throat
- Diarrhea

Individuals who can be seen in the RAC:

- Employees-including established UIM patients
- Dependents
- Temp employees*
- Agency*
- Travelers"
  *We recommend you speak with a Financial Counselor to ensure coverage.

Appointments:
To schedule an appointment with the RAC please call 843-876-0888. Please bring your insurance card and copay at the time of the appointment.
(If your condition is related to an Injury at Work you will need to go to Employee Health)

Hours of Operations (Monday-Friday):
8am – Noon
1pm – 5 pm

The RAC discourages “walk-ins” in order to better provide rapid access and turnaround. Please call to schedule an appointment.
Definition: Follow-up for patients requiring close monitoring of their disease processes.

Policy: The University Internal Medicine Clinic shall be available to 1 West Treatment Center at designated appointment times for follow-up of those patients who require close monitoring of their disease processes. The number of appointments available and their times will be based on staffing within the clinic as determined by the Physician Clinical Director.

Procedure:

A. 1 West Treatment Center will maintain an appointment log of available appointments.

B. Physicians in 1 West Treatment Center will be responsible for putting the name, medical record number, and phone number of the patient into the log. The list will be faxed to University Internal Medicine schedulers and it will be entered into the IDX Scheduling System.

C. The patient shall be given a yellow appointment card at the time the appointment is made.
Definition: Adequate staffing is determined by acuity and volume of patients.

Policy: It is the policy of the University Internal Medicine Center to provide staffing determined by acuity and volume of patients, number of providers, and type of visit. Each clinic will be staffed with RN Case Managers, LPNs, and patient care techs. Pool staff may be used when staffing variances arise. Staff may be adjusted from one clinic to another to meet patient care needs. Staff hours are adjusted to accommodate volume of patients and types of visits.
Definition: Responsibilities of Attending Physicians.

Policy: As elsewhere in the Medical University of South Carolina system, residents, interns, and students must have attending supervision at all times. This includes being available for discussion and guidance over patient care issues, signing of billing sheets, and signing the patient’s note with the indication that the attending has discussed and examined the patient, as indicated, and agrees with the plans as set forth in the note.
**University Internal Medicine Medical Center Policy Manual**

**Number & Title:** Ashley Team (Attending) RN of the Week  
**Owner:** Dr. Kim Davis  
**Location / File name**  
**Clinical Policies**  
Reviewed: 3/12  
Revised: 3/12  
New: 12/09

**Definition:** Responsibilities of Ashley side RN of the Week. Nurse's beeper # is 18185.

**Policy:**

**Procedure:**

A. Each week an assigned RN will cover the Ashley Pods and RAC calls during clinic hours of 8am – 5pm.

B. Manager of the scheduling office will have a copy of the schedule in advance for the schedulers.

C. Schedulers will page the RN of the Week using pager number 18185 if they are unable to reach the POD nurse or RAC nurse for **immediate patient needs only**.

D. RN of the Week will respond to scheduler calls/pages within 10 minutes of the page.

E. If the RN of the Week needs to leave early, come in late or will be absent during their scheduled week, coverage will be responsibility of the assigned RN.

F. All pages/calls from schedulers will be documented.

G. Clinical Care Manager for UIM, Judi Bucknam, will handle all after hours calls.
Definition: Responsibilities of Cooper side RN of the Day. Nurse's beeper # is 18184.

Policy:

Procedure:
A. Each day the RN who is working on the floor will cover the Cooper unit from 8am – 5pm.
B. The Scheduling Coordinator will receive the monthly schedule of coverage in advance for the schedulers.
C. The schedulers will page the designated RN using pager 18184 for immediate patient needs only.
D. The designated RN will respond to the scheduler’s page within 10 minutes of the page.
E. It is the designated RN’s responsibility to secure beeper coverage if he/she needs to leave early, come in late or will be absent during their scheduled day.
F. All pages from the schedulers will be documented in the beeper folder.
G. The Clinical Care Manager for UIM, Judi Bucknam, will handle all after-hour calls.
Definition: Role of case manager to ensure continuity of patient care.

Policy: All physicians and their patients at University Internal Medicine Clinic will be assigned to an RN Case Manager (CM). The Case Managers are responsible for ensuring the continuity of care for their patient population. They serve as a communication link for the physician and their patients.

Procedure:
A. CMs facilitate patient flow by scheduling urgent patients throughout the clinic day.
B. Patients will be assessed by their CM during clinic and nurse visits for teaching needs related to their diagnoses and medications. Patients may also require reinforcement about scheduled tests and the importance of follow up.
C. Lab reports from the previous day are given to the Physician Assistant or in the absence of the Physician Assistant the reports are given to the Attending Physician of the Day for review.
D. After review of abnormal lab reports, the physician enters a progress note that outlines follow-up required by the CM. This may include scheduling an earlier return appointment, calling in a prescription, scheduling additional labs, etc. If the patient is not available by phone, a letter will be sent to the patient. All actions will be noted in the patient record. Pap smear and Mammography follow up is outlined in additional policies.
E. Facility charges will be completed by the patient’s CM.
Definition: Patients who have called scheduling requesting to speak to the Nurse Case Manager.

Policy:

Procedure:

A. ROUTINE PHONE MESSAGES
   1) **Non urgent calls** received from patients should be taken by the scheduling office within
      the electronic medical record stating the patient’s name, date of birth, medical record
      number, return phone number and a short message stating why the patient is calling. It
      will then be printed to the appropriate clinic or POD.

   2) **Urgent calls** received from patients should be forwarded immediately to the nursing case
      manager of the provider caring for the patient.

Case Managers phone numbers are:

**Cooper Clinic:**
- Sherry Doniphan-Davies  792-8050
- Michael Howard       876-0787
- Tim West            792-4601
- Chris Wheeler       876-0762

**Ashley Clinic:**
- Beverly Barrineau  876-0833
- Beth Fleming       876-0979
- Carol Martin     792-4862
- Kathy Salter      792-9543

***Note, if the scheduler is unable to reach the nurse, the patient will be put on hold and the
Nurse of the Day (Cooper) or the Nurse of the Week (Ashley) will be contacted.

B. MEDICATION REFILL REQUESTS
   Patient requests for medication refills will be transcribed by the schedulers within the electronic
   medical record and printed in the appropriate clinic/POD.

C. NURSE OF THE DAY / WEEK
   A registered nurse is available between the hours of 8am – 5pm. If the scheduler is unable to
   reach the nurse, the patient will be put on hold and the Nurse of the Day (Cooper) or the Nurse of
   the Week (Ashley) will be contacted.
Definition: Patients who request refills on medications.

Policy: Licensed nursing staff may call in, fax or eprescribe medication refills if the following conditions are met:

Procedure:
A. The requested medication must have been prescribed by a UIM physician and on the medication list.
B. The requested medicine must not be a Schedule II controlled substance.
C. Medications that require pre-authorization may be renewed for a year.
D. If the patient has been seen at UIM within the last 6 months, 6 refills may be called in, faxed, or eprescribed for chronic medications.
E. If the patient has not been seen within the last year, a 30 day refill may be called in or faxed. The patient will be instructed there will be no additional refills until seen by their physician.
F. Medication refills will be documented in Epic.
G. LPNs may call in and document medication refills at the discretion of the RN.
H. CMA’s may call in and document medication refills at the discretion of the MD except for the following medication categories: (No benzodiazepines, opioids, Coumadin, Pradaxa, ACE/ARBS, anti-arrhythmics, Steroids, immunodulators, Growth Hormone, HIV meds, antibiotics).
Definition: Reporting of abnormal lab values after hours.

Policy:

Procedure:
   A. After hours laboratory personnel will immediately notify the ordering physician.
   B. If ordering physician is not available, the physician on call for UIM will be contacted.
Definition: Defining timelines to be followed when patients are late for their scheduled appointment and process developed according to timeline.

Policy: University Internal Medicine Center patients who arrive late for their appointments will be processed in a manner that supports optimal care for all patients as well as preserves the educational mission of the clinic.

Procedure:
A. Patients who arrive 15 minutes after their scheduled appointments will be seen.

B. Patients who arrive more than 15 minutes and up to 30 minutes after their scheduled appointments, Registration Desk will follow the process below:
   a. Registration Desk advises the Doctor of the Day in the resident’s clinic or patient’s physician in the attending clinic that the patient has arrived.
   b. The Physician will assess the patient’s condition and determine the cause of the late arrival.
   c. The physician decides whether the patient will be seen.
   d. If the patient is not seen, the Registration Desk will advise the patient and the patient will be rescheduled.
   e. If the patient is to be seen, the Registration Desk will advise the patient that they will be seen after the patients who arrived on time have been seen.

C. If patient arrives 1 hour late for their appointment, Registration Desk will advise the patient that they will have to reschedule their appointment.
Definition: Patients who arrive at the clinic without an appointment.

Policy: Walk-ins to University Internal Medicine are strongly discouraged. However if a patient arrives on the floor without a scheduled appointment, the registration staff will take the patient’s name, MRN # and reason for needing to be seen and notify nurse of the day or case manager. The patient's disposition will be determined by nursing and physician of the day.
Definition:

**Policy:** All patients will be screened at each visit on the following topics on the nurse intake note: Allergies, Abuse/Neglect, Smoking/Tobacco, and Flu (during flu season). In addition, other topics will be screened as needed based on the patient population or individual patient. These topics are: Pain, Nutrition, Psychosocial, Cultural/Spiritual, Functional/Mobility, TB, Continuing Care Needs, and Immunization.

Topics with positive screens will be referred to the appropriate health care professional for assessment (Social Worker, RN, MD or other provider). Referrals to other health care professionals will be made as needed (e.g., primary care provider, specialty care provider, PT/OT etc.).

Reassessment will be done as needed based on the patient’s plan of care or changes in his/her condition.
Number & Title: Tracking Protocol for Mammogram Reports  
Owner: Dr. Kim Davis  
Location / File name: Reviewed: 11/09, 3/12  
Clinical Policies: Revised: 12/99, 10/00, 10/03, 3/12  
New: 12/98

**Definition:** Patients receiving mammograms and follow-up.

**Policy:** All mammograms that are ordered by the University Internal Medicine Clinic will be processed in a manner that supports optimal patient care. Normal and abnormal mammograms will be tracked from the time they are ordered in the clinic through the time that the report is received, reviewed by the physician, and dispositioned appropriately, according to standards.

**Procedure:**

A. Mammogram, ordered by the provider, will be processed according to standard clinic policy.

B. Case manager will enter the patient’s name and MRN into the mammogram report.

C. The case manager will identify the patient's name in the log once a report has been received or retrieved from OACIS.

D. If the mammogram is normal, this is noted in the electronic medical record.

E. If the mammogram is abnormal, further evaluation as per Radiology is ordered and scheduled. The patient is notified by their case manager and a note is put into the electronic medical record. The date of the additional testing is placed in the log of mammograms for further review.

F. If the patient did not keep his or her appointment, the case manager may note this in the electronic medical record. The mammogram department sends out letters if the patient does not keep their appointment.
Mammogram Follow-Up Protocol

Mammogram ordered

Patient name and MRN is entered into mammogram log by case manager.

Mammogram report reviewed by case manager through OACIS.

Normal mammogram- noted in nurses note tab.

Abnormality reported-patient advised, evaluation arranged, and note is placed in progress notes in practice partner. Evaluation date is placed into log.

Patient did not keep appointment – Case manager notes in practice partner but letters are sent by the mammogram
Definition: Patients receiving hemoccult testing.

Policy: All hemoccult cards that are ordered by the University Internal Medicine Clinic will be processed in a manner that supports optimal patient care. Normal and abnormal hemoccult cards will be tracked from the time they are ordered in the clinic through the time that the cards are developed, reviewed by the physician, and dispositioned appropriately, according to standards.

Procedure:

A. Hemoccult cards, once ordered by the provider, will be processed according to standard clinic policy.

B. If the hemoccult cards are normal, the case manager of her designee will enter the result in the electronic medical record in the point of care lab section as well as enter a note into the progress note section using the normal hemoccult template.

C. If the hemoccult cards are abnormal, the case manager or her designee will complete the abnormal hemoccult report and distribute it to the patient’s attending physician or the attending physician of the day for the residents’ patients.

D. The attending physician will determine what further evaluation is required. Any consults for further evaluation will be given to the case manager or her designee for scheduling. The physician will document the plans for evaluation and management in the record via the abnormal hemoccult template.

E. The attending physician or the case manager or her designee will notify the patient of the planned evaluation and will document that correspondence in the record. Patients who cannot be reached by phone will be sent a certified letter advising of the need for further evaluation and requesting they contact the clinic for further explanation. This, too, shall be entered into the record.
**ABNORMAL HEMOCOCCULT RESULTS**

- Stool cards found to be positive.

- Abnormal stool card report distributed to MD.

- Endoscopy referral is filled out by attending in Practice Partner if indicated.

- Endoscopy referral is given to the appropriate case manager who contacts patient and documents in progress note section of PP. Note updates health maintenance section.

**NORMAL HEMOCOCCULT RESULTS**

- Stool cards found to be negative.

- Report entered into the point of care section and progress note section by Case Manager or her designee. The note will update the health maintenance section of PP.
Definition: Patients receiving pap smears and follow-up.

Policy: All PAP smears that are performed at the University Internal Medicine Clinic will be processed in a manner that supports optimal patient care. Normal and abnormal PAP smear will be tracked from the time they are performed in the clinic through the time that the report is received, reviewed by the physician, and dispositioned appropriately, according to standards.

Procedure:
A. PAP smear, once done by the provider, will be processed according to standard clinic policy.

B. PCT, LPN, or case manager will enter the patient’s name and MRN into the PAP report log after the PAP smear is done.

C. The case manager will identify the patient’s name in the log once a report has been received or retrieved from OACIS.

D. The PAP smear report, will be placed in the physician review box in the physician room with a result card attached.

E. The attending physician will fill out the attached result card.

F. The attending physician will place the signed reports in the appropriate case manager’s office.

G. The case manager will send the result cards for the normal PAP smears to the patient.

H. For abnormal PAP smears, the case manager will arrange for evaluation as indicated on the report by the attending physician and notify the patient.
PAP Smear Follow-Up Protocol

PAP smear is done by provider.

Patient name and MRN is entered into PAP log

PAP report comes to case manager by hard copy or on PAP log review, and patient is identified in log.

Report is placed in the physician review box in conference room with return card attached.

Attending reviews the report and signs as normal or orders further evaluation if abnormal and enters note in Practice Partner. The card is signed by the attending and the chart copy is initialed.

Reports signed by attendings are placed in the appropriate case manager’s office.

Normal PAP – Card sent to patient

Abnormal PAP- Evaluation as ordered by attending arranged, patient notified.
Definition: Follow-up for patients with trichomonas on Pap Smears

Policy: All UIM PAP smear reports which return with the notation of trichomonas being present will be processed in a manner that supports optimal patient care.

Procedure:
A. PAP smear report is received in the clinic.
B. The attending physician reviews report.
C. The attending physician will order Flagyl by documenting in the progress note if felt clinically indicated.
D. The case manager will call in the Flagyl and contact the patient regarding the prescription as well as the need for her partner(s) to receive treatment at his (their) provider(s) of the health department. She will also advise the patient regarding need to abstain from alcohol. The case manager will call in prescription. Patient should be advised that Trichomonas found on PAP smear may have been dormant for many years. Further questions should be addressed by the attending.
TRICHOMONAS ON PAP

PAP smear with trichomonas received.

Report reviewed by attending physician.

Flagyl ordered by physician if felt indicated.

Patient notified by case manager of Trichomonas, Flagyl, need to abstain from alcohol for at least 3 days after treatment, and need for partner(s) to be evaluated by his (their) health care provider or health department. Trichomonas on PAP smear may have been dormant for many years. Further patient questions should be addressed by the attending.
Definition: Patients who require digital retinal imaging.

Policy: After written order from physician, trained personnel to perform retinal imaging.

Procedure:

A. Preparation
   1. Turn on the computer and start control software.
   2. Turn on the power of the main unit.
   3. Unlock the stage unit.
   4. Adjust the height of the main unit.
   5. Darken the room.
   6. Input the study information into the computer.
   7. Disinfect the forehead rest and replace chin paper.

B. Adjusting the Position and Focusing
   1. Explain procedure to the patient.
   2. Patient is to be seated with the main unit aligned to the patient’s eyes.
   3. Display patient’s eye to be photographed on monitor and align to pupil.
   4. Display the retina observation screen, adjust the brightness, decide on area to be photographed, photograph range, bring eye into focus, adjust position of retinal image.

C. Photography
   1. Take a photograph.
   2. Review the image.
   3. Take a photograph of the other eye.
   4. End the study, lock the stage unit and turn off the power of the main unit.

D. Download
   Click on: VIEW STORED IMAGES
   Highlight both images you want to export
   Click on: EXPORT
   Click on: BROWSE
   Click on: MY COMPUTER
   Click on: OS (c drive)
   Click on: SCANS
   Click on: Medium under Resolution
   Click on: OK
   Click on: YES
   Click on: OK
Definition: Giving UIM PA and NP Rights to Access Attendings’ Inbox during Faculty Absences

Policy: All attendings must give rights for the UIM PA and/or NP to be able to access their inbox during their absence (vacation, extended sick leave, conferences, etc) for the purpose of reviewing patients’ results and other tests. You will only need to give rights once. The covering midlevel will notify the patient of their results.
Definition: Outpatient Clinic Huddle Guidelines

Policy:

Procedure:

A. Huddle Guidelines
   1. Implement “huddles” in outpatient clinics as part of our Daily Continuous Improvement to facilitate a culture centered on safety and excellence.
   2. Include two key questions in every huddle discussion:
      a. What do we need to know that will adversely impact or delay patient care today?
      b. Did any unsafe conditions occur yesterday that should be reported?
   3. Participants will practice effective, open and honest communication with each other.
   4. Huddles will be conducted at least 1-2 times a week, preferably before clinic starts.
   5. Integrate huddles into daily work flow similar to shift report out.
   6. Huddle should eventually include a member from each discipline, including physicians and Department Staff.
   7. Huddles may involve the following key roles: Registration, Lab, PCT, RN, Financial Counselor, Scheduling, Technician, Departmental Administrative Assistant, Pharm D, PA, Physician, etc.

B. Designate a Huddle Champion who will be responsible for the following:
   1. Choose time/place for huddle and communicate to all team members
   2. Complete and submit the Communication Form
   3. Lead Huddles according to the following guidelines:

C. Huddle Guidelines
   1. Limit huddles to 7 minutes or less and start/stop on time-stress timeliness of attendance to all members.
   2. Choose a consistent day, time and place for the huddle. Hold the huddle in a central location and stand rather than sit.
   3. All members are equal – leave rank outside of huddle. Set a positive tone – suggest opening with request for wins.
   4. Reporting is respectful of others, open and honest, fair and just. Ask ‘what happened’ instead of ‘who made the mistake.’
   5. Designated team members should be prepared to review pertinent pieces related to their area of responsibility.
   6. Maintain ‘huddle folder or binder’ on site with blank forms. At week-end, staple completed Communication Forms to Summary form and retain in folder/binder.
   7. Ask recommended “safety” questions during every huddle (See Communication Form)

D. Managers / Supervisor Responsibilities:

See Performance Criteria on HR Website
**Definition:** Established patients who do not keep scheduled appointments with their physician provider.

**Policy:** UIM patient appointments, which are not kept by the patient, will be processed in a manner that supports optimal patient care. The fact that a patient did not keep his or her appointment is information that is directly related to their care.

**Procedure:** Nursing personnel will note on the daily schedule when a patient does not keep his or her appointment.
Definition: New patients who do not keep scheduled appointments with their physician provider.

Policy: All new UIM patients who have scheduled appointments with physician/providers are expected to come to the visit. Two “no-shows” by a new patient may result in the patient being discharged from the practice.

Procedure:
A. It is the responsibility of the physician/provider to send a certified letter to the patient notifying them that they will not be rescheduled with the practice for future appointments due to the number of previously “no-showed” (missed) appointments.

B. The physician or designee is responsible for notifying the schedulers when a new patient has been discharged from University Internal medicine in order that a notation can be placed in IDX (scheduling system) so that the patient does not receive future appointments.

C. The physician/provider is responsible for documenting a progress note within Practice Partner indicating the rationale for patient discharge from the practice.
Definition:

Policy:

Procedure:
{To be printed on official letterhead}

Patient Name
Address
MRN
Date

Dear {Patient Name}:

You have missed three or more scheduled appointments with your physician at University Internal medicine within the past year without calling to reschedule these visits prior to missing the appointments.

As a result, University Internal Medicine will no longer be able to provide medical care to you. Consequently, you should place yourself under the care of another physician. If you have not received a referral to another physician, or if you wish to contact a physician who has not previously cared for you, you may call the Charleston County Medical Society, 198 Rutledge Avenue, Charleston, South Carolina 29403 at (843) 577-3613.

To make it easier for you to transfer your care to another physician, I will remain available to treat you for a short time which should be no more than 30 days following the date of this letter. Please try to make the transfer to a new physician as quickly as possible within that period. In the event you have an emergency prior to transfer of your care to another physician, you may call the office.

When you have selected another physician, please send me a signed authorization so that I can provide a copy of your medical chart and/or a summary of its content to your new physician.

Sincerely,

{Enter Physician’s Name Here}
Certified Letter
Definition:

Policy:

Procedure:
{To be printed on official letterhead}

Patient Name
Address
MRN

Date

Dear {Patient Name}:

You missed your first two scheduled appointments as a new patient in our office at University Internal Medicine. You did not call or reschedule these visits prior to missing the appointments.

Our policy is to not reschedule you for future appointments with our practice.

Please make other arrangements for your future health care.

Sincerely,

{Enter Physician’s Name Here}

Certified Letter
Chest Pain Protocol

Staff will follow the following guidelines for Patients who present to UIM with acute check pain:

1) Registration will notify the nursing staff for assessment and the patient will be placed in an available room immediately
2) Patient will be placed on O2 sat monitor and vital signs obtained including pain level
3) Patient will be placed on O2 @ 2L via NC
4) Provider will be notified of patient status
5) An EKG will be obtained by nursing staff, and copy of report presented to provider for review
6) If patient is to be admitted, they will be kept under close observation by the nursing staff, with vital signs to be taken every 15 minutes and documented appropriately. Further orders per provider/physician

If being admitted, nursing staff will initiate an INT (18 or 20 gauge INT)
Shortness of Breath Protocol:

Staff will follow the following guidelines for Patients who present to UIM with acute shortness of breath:

1. Registration will notify the nursing staff for assessment and the patient will be placed in an available room immediately
2. Patient will be placed on O2 sat monitor and vital signs obtained
3. If O2 sat is <90% then the patient will be placed on 2L O2 via NC
4. Provider will be notified of patient status
Urine to Evaluate for Infection

A clean catch urine sample will be collected from the patient if the patient has the following symptomatology:

1. Pain with urination +/- fever
2. Urinary frequency
3. Tell the staff they are concerned they have a urinary tract infection

The staff will perform a POCT-U/A on the patient urine specimen and record the results in the patient’s EMR as well as report it to the physician/provider that will be seeing the patient immediately.

Hold the urine specimen until the end of the half day or until the physician makes determination regarding whether the specimen should be sent for urine culture, whichever comes first.

A standing order indicating this was completed will be sent by the performing staff to the provider for signature.
**Urine Pregnancy Test**

A clean catch urine sample will be collected from the patient if the patient has the following:

1. Patient is of reproductive age and is going to have an x-ray putting a potential fetus at risk
2. When a patient presents in clinic for a Depo-Provera injection off schedule obtain a urine sample and perform a POC urine pregnancy test.

Results will be documented in the EMR and (+) results reported immediately to the provider seeing the patient.

A standing order indicating this was completed will be sent by the performing staff to the provider for signature.
Visual Acuity Test

A visual acuity test will be performed on the patient and documented in the electronic medical record if the patient presents with any of the following symptomatology:

1. Blurred vision
2. Eye drainage, crusting or concern for eye infection
3. Eye pain

Results will be reported to the provider seeing the patient immediately.

A standing order indicating this was completed will be sent by the performing staff to the provider for signature.
Strept A-Pharyngitis

A sample from the throat using a sterile culture collection swab may be obtained if the following are present for screening of Strep A:

1) Complains of a sore throat and fever
2) Does **NOT** have "cold symptoms" including running nose, cough, conjunctivitis
3) May have a headache, pain with swallowing, potato voice, abdominal pain/nausea/vomiting

If 1, 2, 3 apply, then collect a throat specimen using the sterile culture collection swab and perform a POCT rapid Group A strep antigen test.

If the Rapid Group A Strep antigen is negative, then a second specimen will need to be collected and sent to the lab for a back up throat culture.

Document results in the electronic medical record and report the outcome immediately to the physician.

A standing order indicating this was completed will be sent by the performing staff to the provider for signature.
Checking Point of Care HgbA1C

Procedure:

A. At the time of triage, the last Point of Care HgbA1C or lab HgbA1C will populate in the Nurse Intake Note.

B. Nursing Personnel will note if the diabetic patient's date of the last HgbA1C is three months or longer and will inform the patient of the rationale for the retaking of the test and perform a Point of Care Test of HgbA1C.

C. The results will be clipped to the paperwork outside the patient's door if the faculty/resident have not seen the patient. If the faculty/resident is with the patient, the staff will knock on the door and take the results into the room and give to the physician.

The results will be entered into the EMR as a POCT Test and the charge marked on the University Internal Medicine Facility Ticket.
COMPETENCY ASSESSMENT

CRITICAL BEHAVIORS FOR PATIENT SAFETY

1. Performs hand hygiene and dons gloves, a mask, protective eyewear, and (optionally) a gown.
2. Verifies correct patient using two identifiers.
3. Takes an accurate history to identify signs of infection or past problems with the ears that might indicate perforation of the tympanic membrane.
4. Ensures that the nurse or practitioner performed an otoscopic examination before cerumen removal. *Gently pulled the pinna up and back in adults (down and back in children younger than 3 years) before inserting the otoscope. Identified the cerumen plug and assessed the integrity of the tympanic membrane. If the tympanic membrane visible, do not perform cerumen removal.*
5. Drapes the patient with towels or absorbent padding.
6. Advises the patient that sensations of dizziness are commonly experienced during irrigation and to alert the person performing the procedure if this occurs.
7. Ask the patient to lie on his/her side so that the affected ear is facing up.
8. If the tympanic membrane is intact, uses a commercial ceruminolytic agent, sodium bicarbonate ear drops, docusate sodium, or sterile water to penetrate the accumulation of cerumen and loosen the plug. Have patient lie in this position for 15 minutes.
9. For irrigation, tilts the head 15 degrees toward the affected ear and positioned a basin to collect the fluid as it drained. Uses lukewarm water to prevent dizziness, nystagmus, and nausea. Directs the flow of water to the edge of the cerumen, not directly onto the tympanic membrane. If using a high-pressure irrigation device, aims the stream toward the side of the ear canal away from the tympanic membrane.
10. Assists the practitioner as necessary during the removal of cerumen with suction or a cerumen loop or curette.
11. If irrigation is used during the cerumen removal, gently dries the canal with a cotton-tipped applicator.
12. Ensures that the nurse or practitioner performs an otoscopic examination after cerumen removal to assess the integrity of the tympanic membrane and confirms the removal of the cerumen plug.
13. Asks the patient about pain according to institution standard.
15. Monitors for tinnitus and/or vertigo.
16. Discards supplies, removes personal protective equipment, and performs hand hygiene.
17. Documents the procedure in the patient’s record.

Clinical Alerts/Rationale

**Step 4:** Irrigation is contraindicated in the presence of tympanic membrane perforation, tympanostomy tubes, or an intact tympanic membrane that has an atrophic region after perforation and suboptimal spontaneous healing.
**Clinical Alerts/Rational (cont):**

Otitis externa is a relative contraindication to the removal of cerumen because irrigation may aggravate the condition. Otitis externa should be treated with antibiotic eardrops, and cerumen removal should be accomplished after the condition is resolved. Other contraindications to irrigation include a history of ear surgery, middle ear disease, known inner ear disease, vertigo, and history of radiation to the ear.³

Additional training required:

<table>
<thead>
<tr>
<th>Resources</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mosby’s Nursing Skills:</td>
</tr>
<tr>
<td>• Cerumen Removal</td>
</tr>
</tbody>
</table>

I acknowledge that the above employee has met the critical behaviors for this competency.

Evaluator Signature: ________________________________  Date: __________
Accessing Central Port Policy (Sherry Doniphan-Davies to get policy)
Tuberculosis Skin Test (TST/PD)

PPD may be placed on active patients for job screening, college entry and exposure to someone who has active tuberculosis. Results to be read in 48-72 hours. If no indurations, record as 0 mm. Do not record as “positive” or “negative”. Only record measurement in millimeter (mm). Document any indurations or redness. If results are not read within time allotment, then PPD must be redone in one week from initial placement. Document in electronic medical record.
Orthostatic Vital Signs

Orthostatics should be done on a patient if they report any of the following symptoms:

1. Dizzy/light headed
2. Hx of GI symptomatology-nausea/vomiting, diarrhea
3. Hx concerning blood loss
4. Systolic bp <100 and appears acutely ill

If the orthostatics are positive (+) then the physician/provider will be notified by staff immediately.

These vital signs will be documented in the electronic medical record.
Definition: List of standing order medications with dosage, route, and location to be given.

Policy: Fluvax, Pneumovax, DT, TDAP and PPD with or without controls may be given according to this protocol by University Internal Medicine Clinic licensed nursing personnel.

Procedure:

- Fluvax 0.5 cc IM
- Pneumovax 0.5 cc IM
- DT 0.5 cc IM
- PPD 0.1 cc ID L forearm
- Monila 0.1 cc ID R forearm
- Mumps 0.1 cc ID R forearm
- TDAP 0.5 cc IM
- Zostavax 0.65 sc
- HPV 1.0 cc IM
- Hepatitis A 1.0 cc IM
- Hepatitis B 1.0 cc IM
- H1N1 0.5 cc IM
- Twinrix 1.0 cc IM
Definition: Patients requesting and/or qualifying for the flu vaccine.

Policy: It is the policy of the University Internal Medicine Clinic to administer the flu vaccine yearly from October 15 to January 30 to patients who are in any of the following high-risk categories:

- Age>65
- Diabetic
- Heart Disease
- Chronic Lung Disease
- Sickle Cell Disease
- Chronic use of steroids or other immunosuppressive drugs
- Chronic Immunosuppressive Disease
- Health Care Provider
- Household members or caregivers of high risk patients
- Anyone who wishes to decrease the risk of influenza
Definition: Patients who request MMR Vaccine

Policy: It is the policy of the University Internal Medicine Clinic to administer MMR vaccine 0.5 cc IM in response to requests for the immunization against measles, mumps, and/or rubella. If a second dosage is required, it should be given as MMR 0.5 cc IM no less than one month from the previous injection (MMWR 19891 38 (5-9) L 1-18). MMR shall not be given to women of childbearing age without knowledge of their pregnancy status.
Definition: Responsibilities of clinician or nurse preparing a wet mount (saline & KOH)

Policy:

Procedure:

A. Assist clinician with obtaining vaginal or cervical specimen using a sterile, cotton-tipped swab with a non-lubricated dry speculum. The patient should not douche for 3-4 days before the specimen is collected.

B. Roll swab in saline on a glass slide.

C. Gently cover with a clean cover slip.

D. Clinician / Physician will record results in the patient's electronic medical record.
1. Patients, who have been seen by their provider in the past year and are currently taking Depo-Provera, may sign in as a nurse only visit for administration of their next dose. Depo-Provera is administered once every 12 weeks.

2. Nursing staff will review the patient’s PAP smear status:
   - Patients under 30 years of age should have a PAP smear completed every 2 years.
   - Patients over 30 years of age should have a PAP smear every 3 years.
   - Patients that are not current for PAP smears may receive their Depo-Provera, and then be advised to follow up with their primary providers prior to any subsequent Depo-Provera shots.

3. Nursing staff will review the patient’s last given medication history for Depo-Provera. Patients should return every 12 weeks for administration with flexibility of dosing between 11 and 13 weeks.

4. If a patient presents for administration of Depo-Provera beyond the 13 weeks, a Urine10C HCG will be obtained prior to any administration of medication.
   - If the Urine HCG is negative, the nursing staff may administer the medication. If positive, the patient will not be given any medication, and an appointment will be set up for follow up care with their primary provider.
MUHA SCOPE OF SERVICES – CLINICAL
UNIVERSITY INTERNAL MEDICINE

ADDITIONAL STANDARDS OF PRACTICE ADOPTED/ADAPTED

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<tr>
<th>Description</th>
<th>Ambulatory Care complies with standards established by AAACN, JCAHO and DHEC</th>
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APPROVED:

__________________________
Judi Bucknam, RN, BSN
Manager, Medical-Surgical Services

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Sherry Gillespie-Miller, RN, MSN
Clinical Director, Ambulatory Care Services

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David C. Neff, MHA, FACHE
Administrator, Ambulatory Care Services

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