River Valley
Health & Dental
Your Center for Care

471 Hepburn Street
(Hepburn Plaza)
Williamsport, PA 17701

Policies for Review for November 2022

Clinical Policies

10.0.30 Point of Care Testing: Title change of policy owner
10.0.31 Prescription Medications and Appointment Compliance: Title change of policy owner
10.0.32 Prescription Paper Security and Utilization: Title change of policy owner
10.0.33 Radiation Policy: Title change of policy owner
10.0.34 Referral & Tracking Policy: Title change of policy owner
10.0.35 Open Policy Number
10.0.36 ED Follow Up Ghost Appointment: Title change of policy owner
10.0.37 Hand Hygiene and Handwashing Policy: Title change of policy owner
10.0.38 Medical, Dental, and Behavioral Health Integration: Title change of policy owner
10.0.39 Sterilization Process: Title change of policy owner
10.0.40 Selecting a Primary Care Provider: Title change of policy owner
10.0.41 Stat Lab Orders: Title change of policy owner
10.0.42 Open Policy Number
10.0.43 Open Policy Number
10.0.44 Open Policy Number

New Policy
Dental Waterline Treatment Policy: DRAFT with procedure and attachments

Next Month:
Clinical
10.0.45 – 10.0.54

Quality
15.0.09 QM Plan

SUSQUEHANNA COMMUNITY HEALTH & DENTAL CLINIC, INC.

Point of Care Testing

Policy Category: **10.0.30 Clinical**
Policy Owner: **Director of Clinical Operations~~Clinical Operations Manager~~**
Origination Date: **08/27/2012**
First Date Approved by Board of Directors: **08/27/2012**

Purpose:

- To assure point of care testing meets CLIA (Clinical Laboratories Improvement Amendment) regulatory requirements. Laboratory testing is completed for screening purposes and to provide information for wellness initiatives upon an order from a provider. CLIA guidelines ensure consistency of practice to ensure accurate results through collections of quality laboratory specimens.
- SCH&DC holds a Clinical Laboratory Certificate of Compliance from the Pennsylvania Department of Health.
- The use of "in-house" point of care laboratory testing provides patients with current, safe, accurate and affordable health care.

Policy:

SCH&DC will follow CLIA regulatory requirements as licensed by the PA Department of Health.

Process:

- CLIA license will be prominently displayed in the designated point of care testing area.
- Licensed Nurses and Medical Assistants are required to complete point of care testing competencies on an annual basis.
- All lab test results are documented in the patient's permanent medical record. All quality control logs are retained for two years.
- Infection control practices in the clinical lab are followed and include universal precautions.
- Safety Data Sheets are maintained and available.
- Refrigerator temperatures where reagents are stored are monitored daily.
- Each laboratory test has a procedure document that includes the following compliant with CLIA and the PA State Department of Laboratories. All written test procedures will be supplemented with manufacturer's package inserts, and/or instrument operator's manuals. Procedures do contain direct references to manufacturer's literature:

  a. Test name
  b. Specimen collection requirements
  c. Methodology with step by step directions and material required
  d. Quality control procedure, criteria for and documentation, remedial action procedures for unacceptable controls
  e. Derivation of results and limitation of methodology

f. Normal/Expected ranges
g. Alert Values
h. Directions for preparation, storage of reagents, standards and controls
i. Safety precautions
j. Plan to follow if system inoperable with criteria for referral of specimens
k. Documentation requirements
l. Any special notes or references pertaining to test.

REVIEWED: 01/10/2014, 04/08/2016, 09/01/2018, 10/01/2020, 11/05/2021, 11/09/2022

REVISED: 01/20/2014, 09/24/2018, 11/23/2021

Signatures:

_____ _____ Date:
Kimberly Wetherhold, Board Chair James Yoxtheimer, President & CEO

SUSQUEHANNA COMMUNITY HEALTH & DENTAL CLINIC, INC.

Prescription Medications and Appointment Compliance

Policy Category: **10.0.31 Clinical**
Policy Owner: **Director of Clinical Operations~~Clinical Operations Manager~~**
Origination Date: **08/27/2012**
First Date Approved by Board of Directors: **08/27/2012**

Purpose:
There will be a consistent process in place to monitor the care of patients receiving prescription medications in the Susquehanna Community Health & Dental Clinic, Inc. (SCH&DC)

Process:

Guidelines

1. Narcotic prescriptions require compliance with patient appointments.
2. Schedule II narcotic refills require a patient appointment at the provider's discretion.
3. Patients receiving Schedule II stimulants are seen minimally every three months.

Medication	Requirements
Multi-Vitamins	Seen within 1 year of the date refill is requested.
Iron	Seen within 1 year of the date refill is requested.
Anti-Histamines	Seen within 1 year of the date refill is requested.
H2 Blockers/PPI's	Seen within 1 year of the date refill is requested.
Anti-Inflammatories	Seen within 1 year of the date refill is requested.
Anti-Hypertensives	Seen within 1 year of the date refill is requested.
Statins/Cholesterol Lowering Agent	Seen within 1 year (lipid panel and liver function panel, or AST or ALT—any acceptable) within 6 months.
Thyroids	Seen within 1 year with TSH within that year
Oral Diabetic Agents	Seen within 6 months; BMP during the past 6 months
Inhalers/Singulair	Seen within 6 months of the date refill is requested
Diabetic Testing Supplies	See within 6 months of the date refill is requested
Nasal Steroids	Seen within 1 year of the date refill is requested

REVIEWED: 01/20/2014, 04/08/2016, 10/01/2018, 10/01/2019, 11/01/2020, 11/05/2021, 11/09/2022

REVISED: 01/20/2014, 10/22/2018, 10/28/2019, 11/22/2022

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Kimberly Wetherhold~~John Boll, Jr. D.O.~~, Board Chair James Yoxtheimer, President & CEO

SUSQUEHANNA COMMUNITY HEALTH & DENTAL CLINIC, INC.

Prescription Paper Security and Utilization

Policy Category: **10.0.32 Clinical**
Policy Owner: **Director of Clinical Operations~~Clinical Operations Manager~~**
Origination Date: **08/27/2012**
First Date Approved by Board of Directors: **08/27/2012**

Purpose:
To protect blank prescription paper from loss due to theft for illegal use and to outline proper utilization.

Policy:
1. Prescription paper will be stored in the locked medication room.
2. Printing of prescriptions will be used when electronic prescribing and/or faxing is unavailable.
3. Prescription paper will be removed from the prescription printers each evening and placed in the secure medication room. Paper will be loaded in the prescription printers each morning by the nursing staff.

REVIEWED: 12/04/2013, 01/10/2014, 04/08/2016, 10/01/2018, 11/01/2020, 11/05/2021, 11/05/2022

REVISED: 12/16/2013, 01/20/2014, 10/22/2018, 11/23/2021, 11/22/2022

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Kimberly Wetherhold, Board Chair James Yoxtheimer, President & CEO

SUSQUEHANNA COMMUNITY HEALTH & DENTAL CLINIC, INC.

Radiation Policy

Policy Category: **10.0.33 Clinical**
Policy Owner: **Director of Clinical Operations~~Dental Operations Manager~~**
Origination Date: **06/24/2012**
First Date Approved by Board of Directors: **08/27/2012**

Policy:
All radiation machines are to be registered with the PA Bureau of Radiation Protection to remain in compliance.

Purpose:
To register radiation machines to be in compliance with the PA Department of Environmental Protection, Bureau of Radiation Protection regulations.

Process:
1. Susquehanna Community Health & Dental Clinic, Inc. (SCH&DC) must register radiation machines with the PA Bureau of Radiation Protection within 30 days after acquisition. Registration shall be completed on forms furnished by the bureau and shall contain information required on the form and accompanying instructions, including a registration fee.
2. If there is a change of address, owner, radiation safety officer, or number of machines SCH&DC must notify the bureau in writing within 30 days.
3. A copy of the currently valid certificate of registration should be made available for inspection by the bureau at the facility where the x-ray equipment is used.
4. The registration must be renewed annually. If a renewal form is not received from the bureau within two months of expiration, SCH&DC should contact the bureau.

REVIEWED: 01/10/2014, 04/08/2016, 09/01/2018, 11/04/2020, 11/05/2021, 11/09/2022

REVISED: 01/20/2014, 09/24/2018, 11/22/2022

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SUSQUEHANNA COMMUNITY HEALTH & DENTAL CLINIC, INC.

Referral and Tracking Policy

Policy Category:	**10.0.34 Clinical**
Policy Owner:	**Director of Clinical Operations~~Clinical Operations Manager~~**
Origination Date:	**12/20/2010**
First Date Approved by Board of Directors:	**12/20/2010**

Purpose:

To assure patients requiring referral services receive appropriate and timely referral care, including self-referrals and that Susquehanna Community Health & Dental Clinic, Inc. (SCH&DC) receives follow-up patient information for inclusion into the patient's health record.

Policy:

SCH&DC will track and follow-up all patient referrals, including self-referrals to behavioral health services, obstetrics and gynecology, prenatal and peri-natal services, laboratory, family planning, and other specialty services. Referrals will be tracked until specialist reports is received. Overdue referrals are flagged and followed up by clinical support staff.

Patient Referral Guidelines:

1. All hospital diagnostic and therapeutic inpatient and outpatient services with whom SCH&DC has formal referral and transfer agreements with, including, but not limited to emergency, laboratory, radiology, reproductive health, and social services, are readily available and accessible to SCH&DC patients, dependent on patient needs and the orders of their SCH&DC Primary Care Provider.
2. The SCH&DC Provider, Medical Assistant, Nurse, or Office Assistant will document the referral in the patient's electronic medical record. Pertinent demographic and clinical data are included in the referral. The information documented in the patient's electronic medical record includes type of referral, date of the referral, required timing, tests ordered, ordering provider, reason for the referral, and date of patient notification of the referral. Documentation includes appointment date and time for referral and tests ordered.
3. All routine referrals will be addressed by the Office Assistant within 72 hours, urgent referrals will be addressed within 48 hours, and STAT referrals will be addressed within 24 hours. When the MOA addresses the referral, they will change it to a "pending" status in the EHR.
4. The SCH&DC Office Assistant working with the patient's Primary Care Provider will verify the appropriate consent is documented in the medical record prior to referral.
5. At the time of referral, the SCH&DC Office Assistant will send the pertinent medical and other information regarding the patient necessary to continue the patient's care and treatment along with administrative information, and document this in the patient's electronic medical record.
6. The SCH&DC Office Assistant will advise the patient or the patient's legal guardian that

the patient or their legal guardian will be responsible for arranging payment of hospital or specialty fees and obtaining any applicable sliding fee eligibility or charity care applications. (Hospitals have formally agreed to treat all SCH&DC patients, regardless of ability to pay). The SCH&DC Office Assistant will provide sliding fee scale eligibility information to the patient and set up an appointment with SCH&DC Financial Services, if needed.

7. Patient referral and tracking procedures shall not discriminate against any individual or group based on race, religion, age, sex, sexual orientation, gender, disability, national origin, or any other legally protected status.
8. Referral notes will be received either through electronic faxing or mail. Results are electronically attached to the patient's chart and notification given to Provider. Documentation includes date, name of provider who received the results, recommended follow up, and communication to the patient including successful and unsuccessful attempts.
9. If a patient says that they have seen a specialist (referral provider) but no consult note was returned to the referring provider (health center), clinical support staff will contact the specialist office to receive a copy as soon as possible.
10. SCH&DC does honor patient requests to referral providers to keep health outcomes confidential, such as family planning visits. When there is a patient request, SCH&DC providers discuss referral visits with patients during subsequent primary care visits. .
11. Overdue referrals and tests are reviewed by clinical support staff weekly according to the referral tracking procedure. Once overdue appointments are identified, clinical support staff makes a follow-up call to determine the reason for the missed appointment and the need to reschedule an appointment, and documents this in the patient's electronic medical record. If staff encounters problems with communicating with the patient, the Community Navigator is informed and follows up to identify the reason for the missed appointment and what barriers can be addressed to enable the appointment, then documents in the patient's electronic medical record.

REVIEWED: 07/25/2011, 03/03/2014, 03/10/2014, 05/07/2015, 05/11/2017, 12/14/2017, 10/01/2018, 12/12/2019, 11/01/2020, 11/05/2021, 11/09/2022

REVISED: 03/17/2014, 05/18/2015, 05/22/2017, 12/18/2017, 10/22/2018, 12/23/2019, 11/23/2020, 11/22/2022

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Kimberly Wetherhold., Board Chair James Yoxtheimer, President & CEO

SUSQUEHANNA COMMUNITY HEALTH & DENTAL CLINIC, INC.

ED Follow Up "Ghost Appointment"

Policy Category: **10.0.36 Clinical**
Policy Owner: **Director of Clinical Operations~~Clinical Operations Manager~~**
Origination Date: **08/27/2012**
First Date Approved by Board of Directors: **08/27/2012**

Purpose:
To coordinate urgent follow-up care for patients seen in the emergency department (ED)

Process:
1. Patients evaluated in the ED and requiring follow up care within 24-72 hours for an acute problem will have an appointment scheduled at Susquehanna Community Health & Dental Clinic, Inc. (SCH&DC)
2. Monday through Friday open appointments will be available at SCH&DC to facilitate the scheduling of ED patients in a timely manner.
3. Appointment slots will be noted as "ghost appointment" on the provider schedule.
4. The ED will send referrals for the "ghost appointment" to the Community Navigator.
5. The Community Navigator will coordinate scheduling of the follow-up appointment and complete the referral from the ED.

REVIEWED: 10/18/2012, 01/20/2014, 04/08/2016, 10/01/2018, 11/01/2020, 11/05/2021, 11/09/2022

REVISED: 10/22/2012, 01/20/2014, 10/22/2018, 11/22/2022

Signatures:

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Kimberly Wetherhold~~John Boll, Jr. D.O.~~, Board Chair James Yoxtheimer, President & CEO

SUSQUEHANNA COMMUNITY HEALTH & DENTAL CLINIC, INC.

Hand Hygiene Policy

Policy Category: **10.0.37 Clinical**
Policy Owner: **Director of Clinical Operations~~Dental Operations Manager~~**
Origination Date: **11/25/2019**
First Date Approved by Board of Directors: **11/25/2019**

Purpose

Effective hand hygiene reduces the incidence of healthcare-associated infections.

Policy

All members of the healthcare team will comply with current Centers for Disease Control and Prevention (CDC) hand hygiene guidelines.

Indications for Handwashing and Hand-rubbing

A. Indications for Handwashing

1. When hands are visibly soiled with blood or other body fluids, wash hands with either a non-antimicrobial soap and water or an antimicrobial soap and water.
2. Before eating and after using a restroom, wash hands with a non-antimicrobial soap and water or with an antimicrobial soap and water.
3. Handwashing may also be used for routinely decontaminating hands in the following clinical situations:

- Before having direct contact with patients
- Before inserting indwelling urinary catheters, peripheral vascular catheters, or other invasive devices that do not require a surgical procedure
- After contact with a patient's intact skin (e.g., when taking a pulse or blood pressure, and lifting a patient)
- After contact with body fluids or excretions, mucous membranes, non-intact skin, and wound dressings, even if hands are not visibly soiled
- When moving from a contaminated body site to a clean body site during patient care
- After contact with inanimate objects (including medical equipment) in the immediate vicinity of the patient
- After removing gloves

B. Indications for Hand-rubbing

If hands are ***not visibly soiled***, an alcohol-based hand rub may be used for routinely decontaminating hands in the following clinical situations:

- Before having direct contact with patients
- Before inserting indwelling urinary catheters, peripheral vascular catheters, or other invasive devices that do not require a surgical procedure
- After contact with a patient's intact skin (e.g., when taking a pulse or blood pressure, and lifting a patient)
- After contact with body fluids or excretions, mucous membranes, non-intact skin, and wound dressings, only if hands are not visibly soiled
- When moving from a contaminated body site to a clean body site during patient care
- After contact with inanimate objects (including medical equipment) in the immediate vicinity of the patient
- After removing gloves

References

To access the CDC's hand hygiene guidelines in their entirety, see the CDC website at: http://www.cdc.gov/mmwr/preview/mmwrhtml/rr5116a1.htm;

REVIEWED: 11/01/2020, 11/05/2021, 11/09/2022

REVISED: 11/23/2021, 11/22/2022

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SUSQUEHANNA COMMUNITY HEALTH & DENTAL CLINIC, INC.

Medical, Dental, and Behavioral Health Integration

Policy Category: **10.0.38 Clinical**
Policy Owner: **Director of Clinical Operations~~Clinical Operations Manager~~**
Origination Date: **08/27/2012**
First Date Approved by Board of Directors: **08/27/2012**

Purpose:
To assure Susquehanna Community Health & Dental Clinic, Inc. (SCH&DC) patients have access to integrated care between Medical/Dental providers and behavioral health services.

Policy:

Referral from Behavioral Health to Medical/Dental:
Behavioral Health staff will use warm hand off model and schedule or consult with medical/dental providers regarding medical concerns of patients seen for behavioral health reasons. Medication management will be at the discretion of the medical provider.

Referral from Medical/Dental to Behavioral Health:

1. Patients experiencing acute psychiatric symptoms will be evaluated by the Behavioral Health Consultant (BHC) if available.
2. If BHC is not available, the patient may be transferred to the ED for evaluation.
3. For routine mental health needs, the medical provider may use the BHC for warm hand off or order a psychiatry referral.
4. Consent to release information will be signed when appropriate, when the patient is referred to outpatient behavioral health services.

REVIEWED: 01/10/2014, 12/14/2017, 10/01/2018, 11/01/2020, 11/05/2021, 11/05/2022

REVISED: 01/20/2014, 12/18/2017, 10/22/2018, 11/23/2021, 11/22/2022

Signatures:

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Kimberly Wetherhold, Board Chair James Yoxtheimer, President & CEO

SUSQUEHANNA COMMUNITY HEALTH & DENTAL CLINIC, INC.

Sterilization Process

Policy Category: **10.0.39 Clinical**
Policy Owner: **Director of Clinical Operations~~Dental Operations Manager~~**
Origination Date: **10/10/2010**
First Date Approved by Board of Directors: **10/10/2010**

Policy:
Cleaning and sterilization of patient care equipment.

Purpose:
To provide consistent cleaning, disinfection, and/or sterilization protocols for Susquehanna Community Health and Dental Clinic, Inc. (SCH&DC) personnel to follow in the management of patient care equipment.

Guidelines:

1. **Guidelines for Sterilization**
    a. The flow of work proceeds from dirty to clean.
    b. Meticulous cleaning should be done before any disinfection or sterilization process is undertaken. Cleaning methods for the office setting is performed manually.
    c. Appropriate personal protective equipment should be worn during decontaminating procedures.
    d. Sterilizers are cleaned and maintained in accordance with the manufacturer's instructions.
    e. Equipment manufacturer's written instruction for cycle parameters are followed for sterilizers.
    f. Personnel who perform cleaning, disinfection, and sterilization functions are trained in these practices.
    g. Only products that have been approved by SCH&DC may be used.

2. **Personnel**
    a. **Personal Protective Equipment**
        i. Gloves must be worn whenever contaminated equipment is handled. ii. If there is a danger of splashing to clothing or extremities with hazardous body fluids, a barrier gown must be worn.
    b. **Training**
        i. Personnel who are responsible for cleaning, disinfection, and sterilization receive orientation and on-the-job training in these practices as well as the following protocols where applicable.
            1. Packaging for the specific items that they will be using for sterilization

2. Sterilization monitoring
3. Loading and unloading of sterilizers

c. **Hand Hygiene:** Please refer to the Hand Hygiene policy and procedure.

3. **Practice**

a. **Instrument Sorting**

i. Handling of soiled items should be kept to a minimum to minimize the potential for personnel exposure.

ii. Begins at point of use whenever possible.

b. **Cleaning/Decontamination**

i. Soiled equipment should be kept separate from clean/sterile equipment.

ii. Work surfaces should be cleaned with an EPA approved surface disinfectant.

iii. Place soiled instruments in in the ultrasonic cleaner. Ultrasonic cleaner should be filled with an enzymatic cleaning solution. An enzymatic cleaning solution is used to prevent bioburden from drying on items and making cleaning more difficult.

1. Container should be labeled with a biohazard symbol
2. Name of the enzymatic solution in the container should be posted near the container.

i.v. Instruments with moving parts should be disassembled to facilitate cleaning

v. Place the instruments in the ultrasonics mesh basket

vi. Set the timer per manufacturer's instructions

vii. Following cleaning, items should be inspected to assure that all visible soil has been removed.

viii. Items that no longer function as intended should be discarded or repaired.

Note: Saline causes deterioration of instrument surfaces and should not be used.

c. **Sterilization**

i. **Sterilizing Time and Temperature**

1. Unwrapped Items—Instruments loose on a tray
   a. Set sterilizer for Unwrapped Cycle (temperature 270 degrees for >3 minutes with a 30-minute drying time).
2. Pouches—Pouched or loosely wrapped instruments
   a. Set sterilizer for Pouch Cycle (temperature 270 degrees for >15 minutes with a 30-minute drying cycle).
3. Packs—Textiles and surgical packs wrapped for sterilization
   a. Set sterilizer for Pack Cycle (temperature 250 degrees for >30 minutes with a 30-minute drying time).

ii. **Methods**

1. **Steam-Gravity Displacement (i.e. table top units)**
   - **a.** Packaging
     - **i.** Items can either be sterilized wrapped/packaged or unwrapped.
   - **b.** Wrapped/Packaged
     - **i.** Packaging materials should be compatible with the sterilization process and may include:
       1. **1.** Peel packs
       2. **2.** Disposable wrappers made of water resistant or impervious material.
     - **ii.** All packing methods and wrapping procedures should allow for the removal of air and direct contact of the steam with the contents of the package. **iii.** Packaging material should provide a barrier to micro-organisms and moisture and be sufficiently strong enough to resist punctures and tears. \
     - **iv.** Each package should have an external indicator placed in each sterilizer load before sterilization which changes color during processing to identify processed from unprocessed items.
       1. **1.** Indicators should be checked for the color change when
          - **a.** Item is removed from the sterilizer
          - **b.** Before use
2. Contents of the sterilizer load which have indicators that have not undergone a color change
   - **a.** Should not be used
   - **b.** Should be repackaged and resterilized
3. Packages should be checked for integrity (i.e. seal intact) or signs of damage (water, visible soil) prior to use.
   - **a.** Items which do not pass visible inspection should be reprocessed

2. Table-Top Sterilizer

- **a.** Protocols for wrapping/packaging items should be followed.
- **b.** Distilled or deionized water should be used to fill the unit to help prevent mineral build up in the system.
- **c.** A biological indicator should be run weekly whenever the sterilizer is used.
- **d.** Daily, when the department is open and before sterilizer use, the gasket should be examined for possible damage that could prevent a good sealing surface.

i. If damage is found the gasket should be changed.
ii. Chamber and trays should be cleaned as recommended by the manufacturer. **iii.** System should be flushed as recommended by the manufacturer.

3. **Record Keeping**
    a. **Rationale:** Record keeping control documents the medical devices that have been processed and their monitoring control evidence. This documentation provides evidence that the sterilization cycles have been checked and it is within acceptable limits. Documentation also provides information that allows the comparison of actual sterilizer performance to the predetermined standards for sterilization. This comparison highlights discrepancies, which may indicate unacceptable cycle parameters or the need for sterilizer maintenance and assists in diagnosing sterilization process failures.
    b. **Procedure:** For each sterilizer, the following are kept:
        i. The results of the biological indicator
        ii. Record of repair and preventative maintenance
        iii. These records must be kept for seven years
4. **Shelf Life of Sterilized Items**
    a. Sterility assurance is event related.
    b. Items should not be used if sterility is questionable.
    c. At the time of use, each sterilized item should be inspected for package integrity and evidence of water exposure or soilage.
    d. If package fails visible inspection, the item should not be used and should be reprocessed.
5. **Storage of Clean and Sterile Items:**
    a. Should be stored in a clean area that provides protection against dust, moisture, insects, temperature/humidity and a place that has limited traffic.
    b. Sterile items should be stored so that the packaging is not compromised.
    c. Items should be stored off the floor on shelves.
    d. Packages should be evaluated before the use for loss of integrity (i.e. torn, wet, and punctured).
6. **Recall**
    a. **Follow Up**
        i. In the event of a positive biological culture, steps are initiated to retrieve potentially nonsterile supplies.
        ii. Appropriate personnel in the Center will:

1. Retrieve the appropriate sterilization load record listing items sterilized in that load (for sites that keep such records).
2. Attempt to immediately locate and retrieve such supplies. Retrieved supplies will be reprocessed according to established protocols outlined above.
3. The effected sterilizer will be removed from service until repaired.
    a. A record of repairs will be retained.
    b. Retrieve non-sterilized instruments and reprocess in another sterilizer.
    c. Documentation of three negative (Biological Indicators) cultures will be in place prior to resumption of service of the involved sterilizer.

b. Repair (Minor and Major) Relocation or Installation of Sterilizers

i. When repair, relocation, or installation of sterilizers are performed, the steam gravity displacement sterilizer will be challenged by:

1. Performing biological indicator testing on three consecutive cycles for each cycle (unwrapped, wrapped, etc.) that is available on the sterilizer.
2. All biological indicators test results must be final (48 hours) and all results must be negative before the sterilizer can be release for use.

c. Sterilizer Preventative Maintenance

i. Sterilizers should be cleaned and maintained in accordance with the manufacturer's instructions. **ii.** If sterilizer does not meet performance expectations, appropriate outside vendor is to be notified to check the unit.

1. Unit is not to be used for sterilization until cleared for use by personnel that perform maintenance.
2. If unit undergoes corrective maintenance or major repair, biological monitoring will be followed.

iii. Chambers should be allowed to cool before performing any cleaning or maintenance procedure.

iv. Documentation of when preventative maintenance was performed needs to be kept by the Center for at least seven years.

Sterilization Process

APPENDIX A

DEFINITIONS

Bioburden: The number and type of contaminating organisms in or on an object before decontamination.

Biological Indicator: A preparation of spores resistant to a sterilization process, which are used to determine if sterilizing conditions were achieved.

Cleaning: The removal of all visible dust, soil, and foreign material. Since soilage can inactivate cleaning agents and protect micro-organisms from contact with disinfectants/sterilants. It is the single most important step in making a medical device ready for reuse since it removes a large number of micro-organisms from a device. The steps in the cleaning process begin at sorting and include soaking, washing, rinsing, and drying or draining.

Critical Item: Instruments or objects that are introduced directly into the bloodstream or other normally sterile areas of the body. Examples: surgical instruments, catheters, implantable devices, arthroscopes. Critical items require sterilization before they can be reused.

Decontamination: The physical or chemical process that renders an inanimate object contaminated with harmful microbial life safe for further handling.

Flash Sterilization: A steam sterilization process in a gravity displacement sterilizer and prevacuum sterilizers that uses the unwrapped method for 30 to 10 minutes at 130 degrees Centigrade (270 degrees Fahrenheit) for metal objects. The shorter cycle time is due to the absence of porous material such as pouches and wrappers.

Gravity Displacement Sterilizer: It is a type of sterilizer where steam enters the chamber at the top and displaces the air in the chamber through a drain port at the bottom of the chamber. Air displacement and removal continues until most of the air is removed and the thermal sensor probe located in the chamber drain line registers the pre-selected temperature. Typical operating temperature range from 121 degrees to 123 degrees Centigrade (250 degrees to 254 degrees Fahrenheit) and 132 degrees to 135 degrees Centigrade (270 degrees to 275 degrees Fahrenheit). Exposure time is determined by the materials being processed and rages from 15-30 minutes.

Monitoring: Process to assure that the requirements for sterilization have been met. The monitoring parameters include mechanical, chemical, and biological parameters.

Sterilization: A process by which all forms of microbial life including bacteria, viruses, fungi, and all spores are killed. Methods of sterilization can include steam, ethylene oxide, peracetic acid, and plasma.

Shelf Life: The time period a sterilized item is safe for use. Sterility maintenance is event related which depends on the package integrity and storage conditions and handling. An event (i.e. package is torn or becomes wet) can compromise or destroy the barrier effectiveness of the package material.

Steam Sterilization: Sterilization process, which employs a chamber that can withstand high pressures needed to bring saturated steam up to temperatures that will accomplish sterilization. The size of the chamber may range from small table-top units of less than 1 cubic foot to several hundred cubic feet in large industrial units. Steam sterilization can be used for almost all metal items, rubber goods, surgical trays, fabric packs, glassware, and some hard-plastic items.

Table-Top Steam Sterilizer: A compact gravity displaced steam sterilizer that has a chamber

volume of not more than 2 cubic feet and generates its own steam when distilled or deionized water is added by the user. Since it generates its own steam, the come-up time is longer than the large chamber sterilizers, which makes the total cycle time longer.

APPENDIX B

LOAD CONTROL FOR THE TABLE TOP GRAVITY STEAM STERILIZATION PROCESS USING 3M ATTEST BIOLOGICAL INDICATORS

Policy:
Evidence of an effective steam sterilization processes will be documented.

Rationale: Load control is the process by which a load is monitored and released based on the results of a biological indicator. Biological indicators are designed to equal or exceed the resistance of highly resistant, naturally occurring micro-organisms on clean medical devices. Biological indicators play a key role in sterilization process monitoring because they respond to sterilization conditions much like "natural" micro-organisms. A biological indicator that has tested negative in combination with equipment control, (i.e. mechanic readings) that confirm a specific time/temperature profile and end pack control (i.e. chemical indicators) with acceptable end point responses proved an assurance that the sterilization process was effective. They do not, however, guarantee the sterility of each individual product within the load.

Procedure:

1. Routine Biological Indicator (BI) monitoring is performed in a fully loaded sterilizer.
2. A BI is used to monitor each of the steam sterilizers.
3. The BI is identified with the appropriate sterilizer load information.
4. The BI is placed in the center of the sterilizer load. The load being monitored:
    a. Open perforated tray for the 270-degree Fahrenheit/132 degree Centigrade >3 or>10-minute cycles in loads which contain unwrapped perforated trays.
    b. Wrapped perforated tray or peel pouch (include porous items, if appropriate) for a 270-degree Fahrenheit/132 degree Centigrade >15-minute cycle in loads which contain wrapped trays or peel pouches.
    c. Wrapped pack for 250 degrees Fahrenheit/121 degrees Centigrade >30-minute cycle in loads containing wrapped packs.
5. The test pack is placed in the center of the load.
6. The cycle specified by the sterilizer manufacturer is selected and initiated.
7. The test package is retrieved and the Attest 1262 BI incubated and read according to instructions of the manufacturer of the BI.
8. The results of the BI are recorded (i.e. record keeping control)
9. All positive test results must be reported to the Dental Operations Manager immediately for further investigation and/or action.

Biological Indicator, Incubation, and Interpretation of Results for Table Top Steam Sterilizers

Rationale: Load control is the process by which a load is monitored and released based on the Results of a biological indicator. If all the spores are killed on the biological indicator, then you have assurance that the sterilization process was effective. Positive biological indicator results indicate that the sterilization process was not effective at killing spores. The problem may be the malfunctioning of the sterilizer, poor quality or quantity of sterilant, incorrect packaging, loading, choosing the incorrect cycle parameters for the load, or choosing the incorrect biological test pack for the load. All biological indicator results, including biological indicator controls, must be included in the sterilization records, (i.e. record keeping control). All personnel performing sterilization activities will follow the procedure for incubation and reading of all biological indicators.

Procedure:

1. The Attest BI is removed from the sterilizer and the test pack.
2. The BI are incubated for the appropriate time at temperature according to the instructions of the manufacturer of the BI. A positive control (i.e. non-sterilized) BI from the same manufacturing date and lot number as the test/sterilized BI's are incubated.
    a. Steam—Bacillus stearothermophilus
        i. 3M Attest Steam Incubator 56 + 2 degrees Centigrade (133 + 3 degrees Fahrenheit)
        ii. BI—48 hours
3. All BI's are checked at 48-hour time intervals as described in the manufacturer's instructions for the earliest detect on a sterilization process failure.
    a. If results at 24 hours show color change that suggest (visual color change) a positive result, the sterilizer will be taken out of service and checked by Biomed and all items that were sterilized in the sterilizer from the last negative BI will be recalled.
4. After the last reading, the results of the tests and control are recorded and the BI's are removed from the incubator and discarded.
    a. **Negative results,** spores killed:
        i. **BI**—no visual color change (i.e. purple) after 48 hours.
    b. **Positive results,** spores not killed:
        i. **BI**—visual color change (i.e. purple to yellow) in 48 hours.
    c. **Positive control results**—spores viable and capable of growing
        i. **BI**—visual color change (i.e. purple to yellow in 48 hours.

SUSQUEHANNA COMMUNITY HEALTH & DENTAL CLINIC, INC.

APPENDIX C

PACK CONTROL 3M INTERNAL CHEMICAL INTEGRATORS FOR TABLE TOP STEAM STERILIZERS

Policy:
Evidence of an effective sterilization process will be documented.

Rationale: Pack control monitoring is the use of chemical indicators for internal monitoring of packs, trays, containers, and peel pouches. Internal pack monitoring validates that the sterilants has penetrated to the point of placement in the pack and confirms that sufficient exposure conditions have been met. Chemical integrator test packs under specific condition, approximate the result of biological indicators and provide information on how well the sterilizer is performing before the load has been released. Chemical integrators should be used inside each package to detect local problems that sometimes occur due to human errors such as incorrect packaging and loading or mechanical malfunctions. Even with a negative biological indicator result, the sterilants may not penetrate individual packs adequately and exposure conditions may be inadequate. Do not use a pack that has an internal chemical indicator that has not reached its acceptable end point response.

Procedure:

1. Place the appropriate Chemical Integrator in the most difficult area to sterilize in each load to be processed.
2. The person opening the pack should read the results of the internal chemical integrator.
    a. An acceptable end point response of the internal chemical integrator (window says accept) indicates that the sterilants penetrated to the inside of the load and sufficient exposure to conditions have been met.
    b. An unacceptable end point response of the internal chemical integrator (window says reject) indicates that the sterilants did not penetrate to the inside of the load. Should not be used but returned for reprocessing.
3. The Dental Operations Manager should be immediately notified if a package has an internal chemic integrator with an unacceptable end point response so further investigation and/or action can occur.
    a. Check the recorded cycle profile to assure that the selected parameters were attained.
    b. Notify Biomed and request they check the sterilizer.

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REVIEWED: 08/27/2012, 01/10/2014, 04/08/2016, 10/01/2018, 11/01/2019, 11/04/2020, 11/05/2021, 11/09/2022

REVISED: 08/27/2012, 01/20/2014, 10/22/2018, 11/25/2019, 11/23/2021, 11/22/2022

Signatures:

_____ _____ Date:

Kimberly Wetherhold, Board Chair James Yoxtheimer, President & CEO

SUSQUEHANNA COMMUNITY HEALTH & DENTAL CLINIC, INC.

Selecting a Primary Care Provider

Policy Category: **10.0.40 Clinical**
Policy Owner: **Director of Clinical Operations~~Clinical Operations Manager~~**
Origination Date: **12/04/2013**
First Date Approved by Board of Directors: **12/16/2013**

Purpose:
Susquehanna Community Health & Dental Clinic, Inc. (SCH&DC) has established this policy to identify the process for choosing a primary care provider (PCP) when a new patient requests an appointment.

Process:
1. Medical Office Assistant (MOA) will identify a new patient by searching for an existing account in the medical record.
2. Once established as a new patient, MOA informs the patient of primary care providers that are accepting new patients.
3. The patient is assigned to a PCP unless the patient requests a specific provider. Efforts are made to accommodate patient requests based on provider availability and existing panel size.
4. MOA schedules the new patient an appointment and marks the chosen provider in the demographics section of the medical record.

REVIEWED: 01/10/2014, 04/08/2016, 10/01/2018, 11/01/2020, 11/09/2022

REVISED: 01/20/2014, 10/22/2018, 11/22/2022

Signatures:

_____ _____ Date:
Kimberly Wetherhold~~John Boll, Jr. D.O.~~, Board Chair James Yoxtheimer, President & CEO

SUSQUEHANNA COMMUNITY HEALTH & DENTAL CLINIC, INC.

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Policy Category:	**10.0.40 Clinical**
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REVIEWED: 01/10/2014, 04/08/2016, 10/01/2018, 11/01/2020, 11/09/2022

REVISED: 01/20/2014, 10/22/2018

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Kimberly Wetherhold~~John Boll, Jr. D.O.~~, Board Chair James Yoxtheimer, President & CEO

SUSQUEHANNA COMMUNITY HEALTH & DENTAL CLINIC, INC.

Stat Lab Orders

Policy Category:	**10.0.41 Clinical**
Policy Owner:	**Director of Clinical Operations~~Clinical Operations Manager~~**
Origination Date:	**08/27/2012**
First Date Approved by Board of Directors:	**08/27/2012**

Policy:
All stat lab results ordered by Susquehanna Community Health & Dental Clinic, Inc. (SCH&DC) providers will be reviewed within 30 minutes of receiving results.

Purpose:
To assure patients requiring stat lab tests receive appropriate and timely follow up care by the ordering provider.

REVIEWED: 01/10/2014, 04/08/2016, 10/01/2018, 11/01/2020, 11/05/2021, 11/09/2022

REVISED: 01/20/2014, 10/22/2018, 11/23/2021, 11/22/2022

Signatures:

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Kimberly Wetherhold, Board Chair James Yoxtheimer, President & CEO

SUSQUEHANNA COMMUNITY HEALTH & DENTAL CLINIC, INC.

Dental Waterline Maintenance Policy

Procedure Category:	**9.0.05 Dental**
Procedure Owner:	**Director of Clinical Operations**
Origination Date:	**11/3/2022**
First Approved by Board:	**11/22/2022**

Purpose: The water supply of the dental operative unit is sourced from municipal water or a closed bottled water system. Municipal water contains microorganisms that may be considered safe for drinking water, but could potentially cause patient infections when used during dental procedures. Dental unit waterlines, including those connected to municipal water sources or closed-bottle systems, typically cannot be sterilized; however, they should be routinely cleaned and disinfected. Without proper cleaning and disinfection, waterborne microorganisms can collect in the dental unit waterline and form a biofilm, a layer of microorganisms or bacteria adhered to the surface of the dental unit waterline, that can become dislodged and enter the water stream. Contaminated dental unit waterlines pose a risk of infection to the patient, particularly during surgical procedures by direct exposure of waterborne pathogens and to dental professionals due to inhalation of aerosols. The *Centers for Disease Control and Prevention (CDC) Guidance Document Guidelines for Infection Control in Dental Health-Care Settings — 2003* recommends treating the water used in dental units with commercial products such as chemical germicides to meet drinking water standards. The American Dental Association (ADA) recommends routine monitoring of the water to demonstrate bacteria count of less than or equal to 500 Colony Forming Units (CFU) per milliliter of heterotrophic bacteria.

Policy:

1. At the beginning of each workday, dental unit lines and devices should be purged with air or flushed with water for at least two minutes prior to attaching handpieces, scalers, air water syringe tips or other devices.
2. The dental unit lines and devices should be flushed between each patient for a minimum of 20 seconds.
3. Waterline shock treatment will be performed quarterly.
4. Individual waterline units will be tested quarterly.
5. Refer to *Dental Waterline Maintenance Procedure* for specific guidance on manufacturer's recommendations for monitoring and treatment.
6. Waterline testing logs shall be kept for 3 years or per manufacturer's recommendations

REVIEWED:

REVISED:

Signatures:

_____	_____ Date:
Kimberly Wetherhold, Board Chair	James Yoxtheimer, President & CEO

SUSQUEHANNA COMMUNITY HEALTH & DENTAL CLINIC, INC.

Rapid Response to Medical Emergencies Protocol

Policy Category: **15.0.10 Quality Management**
Policy Owner: **Director of Clinical Operations**
Origination Date: **08/27/2012**
First Date Approved by Board of Directors: **08/27/2012**

Policy: The Rapid Response Team is committed to providing critical life-saving measures during a medical crisis or acute life-threatening condition.
A physician order is not required for a Rapid Response Activation, but all treatments and interventions require a physician's order.
Any staff member may activate the Rapid Response Team. No healthcare provider or staff member should discourage or prohibit the use of the Rapid Response Team.

Criteria for initiating the Rapid Response Team

- Heart rate over 140/min or less than 40/min
- Respiratory rate over 28/min or less than 8/min
- Systolic blood pressure > 180mmHg or < 90 mmHg and if patient is symptomatic
- Oxygen saturation less than 90% despite supplementation
- Acute change in mental status (acute confusion, difficulty arousing)
- Chest pain
- Breathing problems
- Choking
- Bleeding that will not stop
- Fainting or loss of consciousness
- Seizure
- Any other reason a staff member has significant concern about a patient's condition

Activation of the Rapid Response Team

1. When an adverse patient condition is identified, the staff member shall activate the RRT by using the overhead paging system by dialing *460.
2. The staff member will announce "rapid response team" and the exact location (i.e., exam room #5, dental operatory #3, waiting room, etc.). The announcement will be repeated twice.

~~The announcement will be repeated twice.~~

3. The RRT will respond immediately to all RRT announcements and assess patient rapidly and provide interventions using evidence-based treatment algorithms and protocols.
4. The dental office at 259 Allegheny Street will call 911 for any medical emergencies. An AED and O_2 (Oxygen) equipment are on site.

Roles and Responsibilities of the RRT Team

1. **RRT Team Leader (Medical Provider)**
   - Promptly responds to RRT announcement
   - Directs team members
   - Assesses and stabilizes patient condition
   - Gives orders for medical interventions
   - Releases RRT following an event
   - Conducts debriefing of RRT events

2. **RRT Nurse (RN or LPN) X 2**
   - Promptly responds to RRT announcement
   - Serves as Team Leader until medical provider arrives
   - Provides SBAR to Team Leader
   - Performs nursing interventions
   - Remains with patient until RRT is released
   - Documentation of RRT event
   - Provides report to EMS

3. **RRT Medical Assistant**
   - Responds promptly to RRT announcement
   - Brings emergency cart/AED to patient location
   - Obtains vital signs
   - Applies oxygen if indicated
   - Performs CPR
   - Obtains supplies
   - Assists with nursing interventions

4. **RRT Medical Office Assistant (MOA)**
   - Calls 911 if directed by clinical staff
   - Notifies patient's family member if indicated
   - Directs EMS to patient location
   - Informs patients in waiting room of possible delays

BLS Certification

All licensed professionals as well as some direct clinical care personnel are required to be certified in Basic Life Support (BLS) including:

- Physician
- Nurse Practitioner
- Physician Assistant
- Registered Nurse
- Licensed Practical Nurse
- Medical Assistant
- Dentist
- Dental Hygienist
- Dental Assistant
- Expanded Function Dental Assistant

BLS certification for other clinical and non-clinical personnel is optional.

Treatment Algorithms

Treatment algorithms offer guidelines to care for basic emergencies.

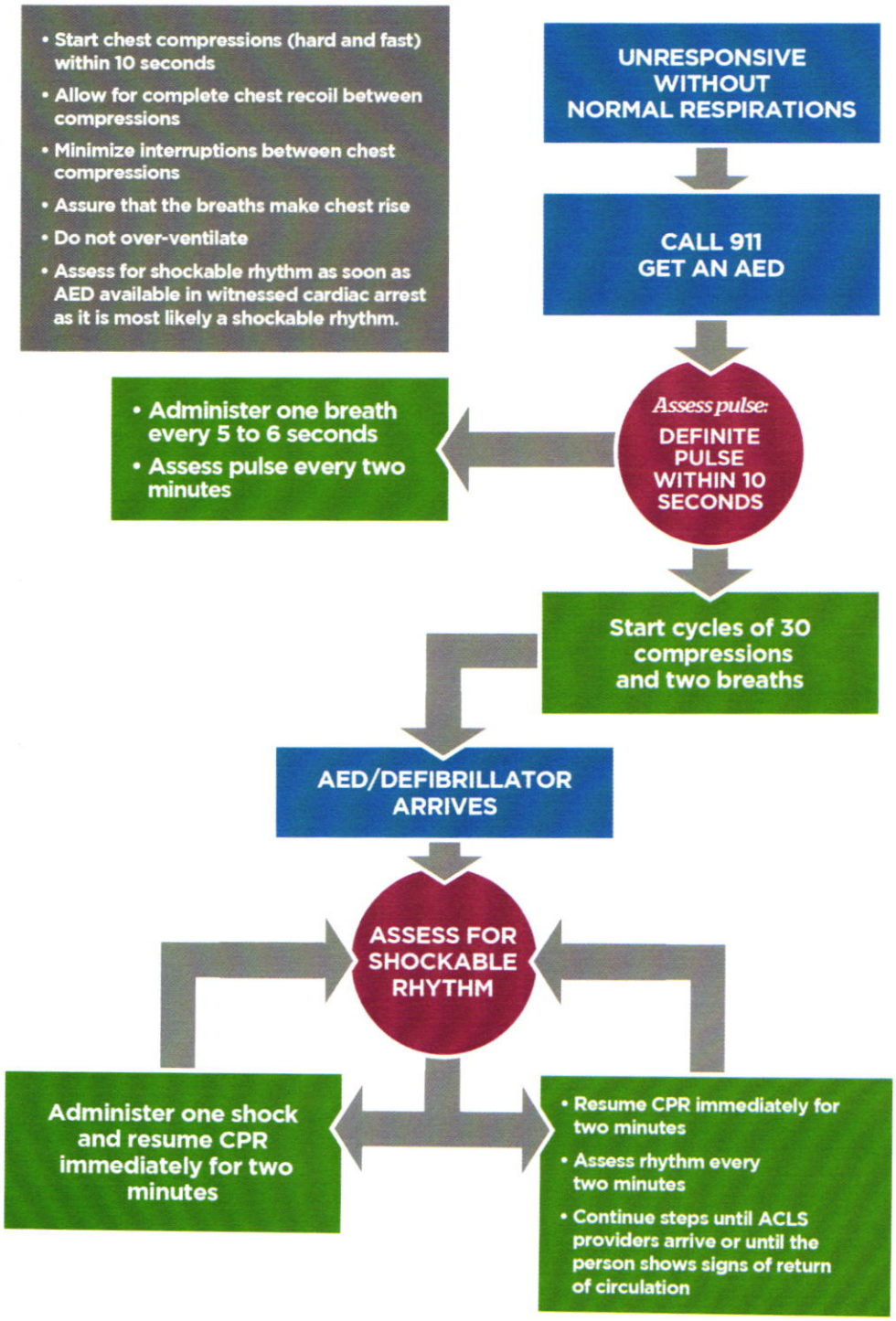
All emergency response should include CAB's:

- Circulation
- Airway
- Breathing

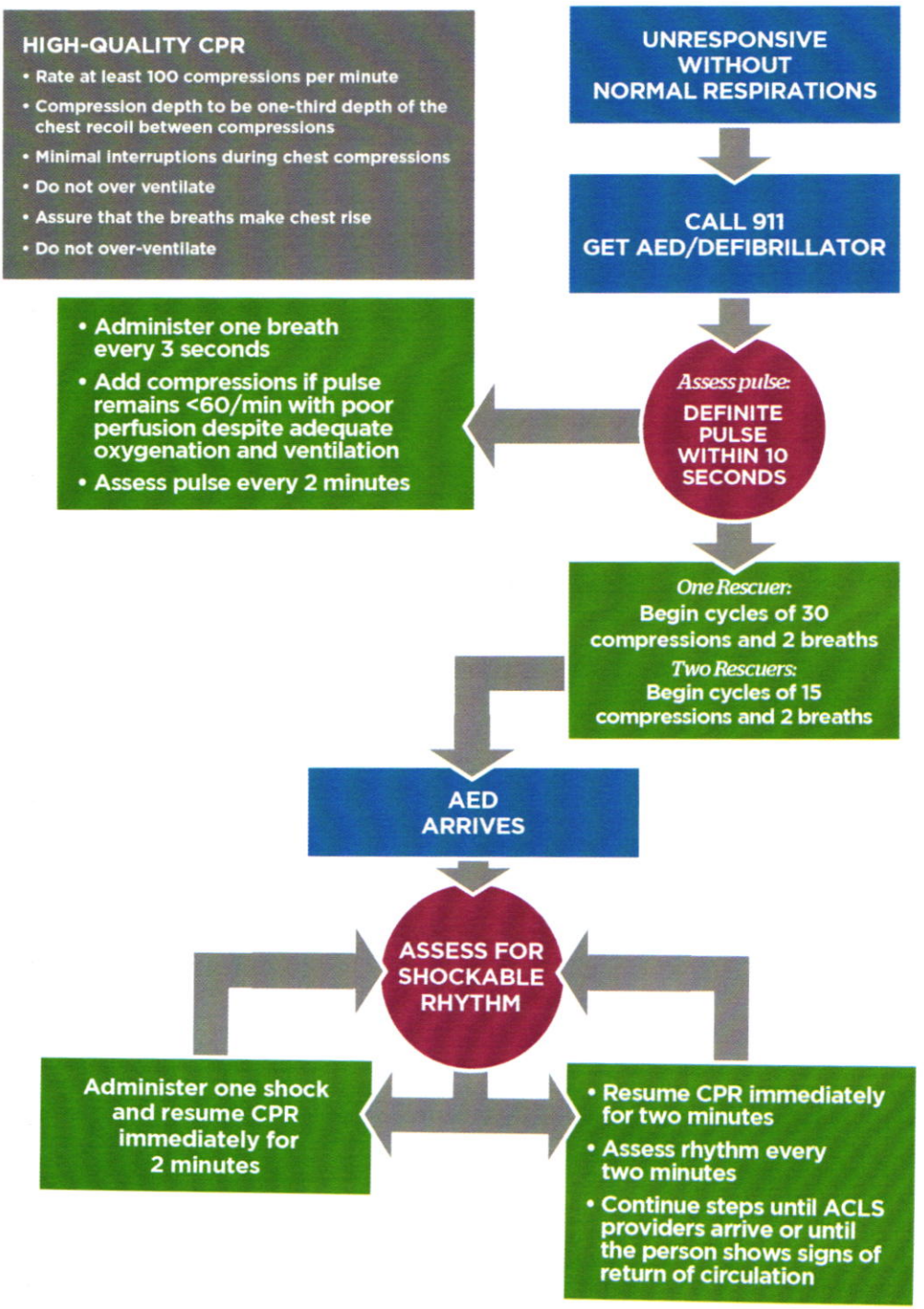
This plan contains the following algorithms:

- Adult BLS
- Pediatric BLS
- Adult Coronary Syndrome
- Suspected Opioid Overdose

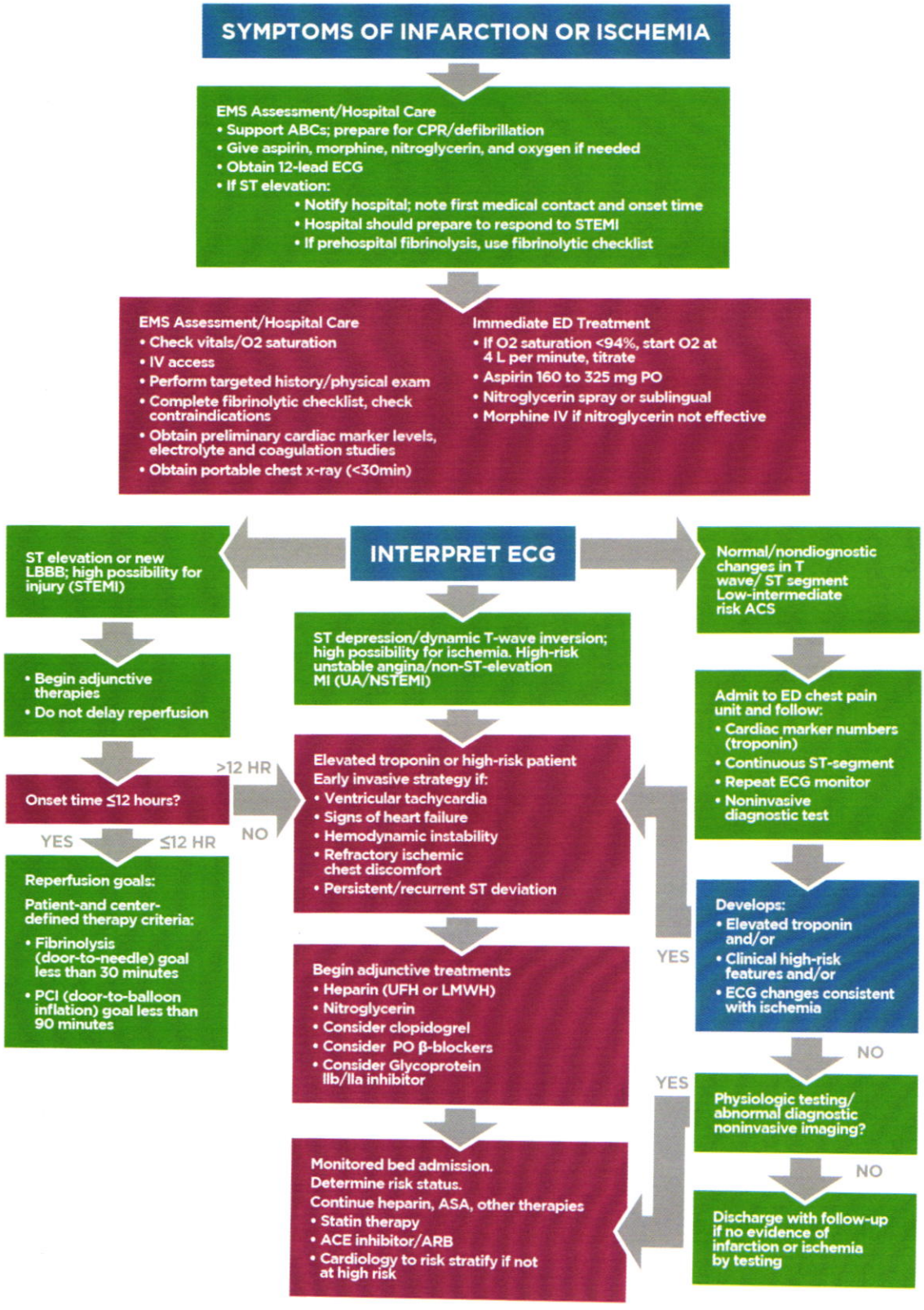
Adult BLS



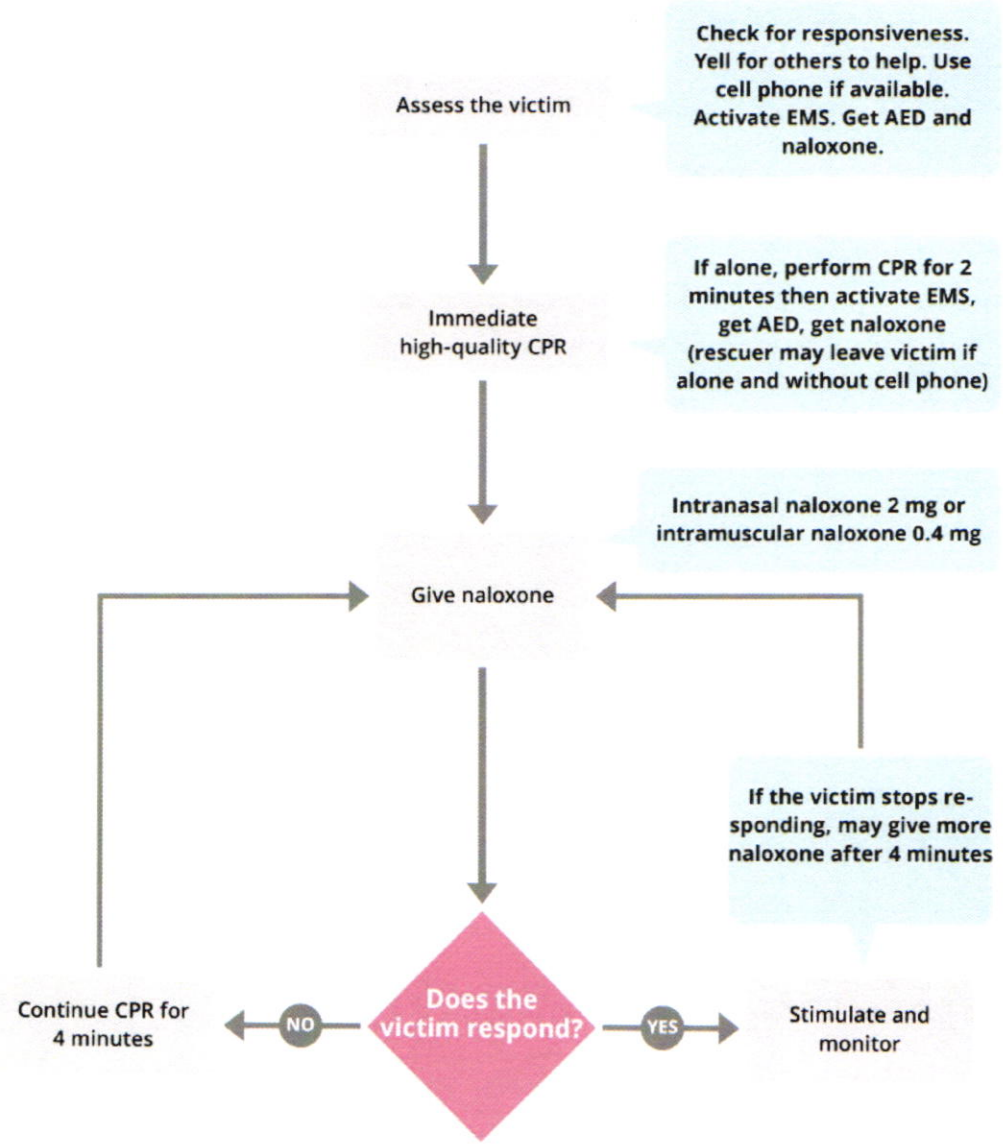
Pediatric BLS



Adult Coronary Syndrome


SYMPTOMS OF INFARCTION OR ISCHEMIA
EMS Assessment/Hospital Care
• Support ABCs; prepare for CPR/defibrillation
• Give aspirin, morphine, nitroglycerin, and oxygen if needed
• Obtain 12-lead ECG
• If ST elevation:
• Notify hospital; note first medical contact and onset time
• Hospital should prepare to respond to STEMI
• If prehospital fibrinolysis, use fibrinolytic checklist
EMS Assessment/Hospital Care
• Check vitals/O2 saturation
• IV access
• Perform targeted history/physical exam
• Complete fibrinolytic checklist, check contraindications
• Obtain preliminary cardiac marker levels, electrolyte and coagulation studies
• Obtain portable chest x-ray (<30min)
Immediate ED Treatment
• If O2 saturation <94%, start O2 at 4 L per minute, titrate
• Aspirin 160 to 325 mg PO
• Nitroglycerin spray or sublingual
• Morphine IV if nitroglycerin not effective
INTERPRET ECG
ST elevation or new LBBB; high possibility for injury (STEMI)
• Begin adjunctive therapies
• Do not delay reperfusion
Onset time ≤12 hours?
>12 HR
NO
YES
≤12 HR
Reperfusion goals:
Patient-and center-defined therapy criteria:
• Fibrinolysis (door-to-needle) goal less than 30 minutes
• PCI (door-to-balloon inflation) goal less than 90 minutes
ST depression/dynamic T-wave inversion; high possibility for ischemia. High-risk unstable angina/non-ST-elevation MI (UA/NSTEMI)
Elevated troponin or high-risk patient
Early invasive strategy if:
• Ventricular tachycardia
• Signs of heart failure
• Hemodynamic instability
• Refractory ischemic chest discomfort
• Persistent/recurrent ST deviation
Begin adjunctive treatments
• Heparin (UFH or LMWH)
• Nitroglycerin
• Consider clopidogrel
• Consider PO β-blockers
• Consider Glycoprotein IIb/IIa inhibitor
Monitored bed admission.
Determine risk status.
Continue heparin, ASA, other therapies
• Statin therapy
• ACE inhibitor/ARB
• Cardiology to risk stratify if not at high risk
Normal/nondiognostic changes in T wave/ ST segment Low-intermediate risk ACS
Admit to ED chest pain unit and follow:
• Cardiac marker numbers (troponin)
• Continuous ST-segment
• Repeat ECG monitor
• Noninvasive diagnostic test
Develops:
• Elevated troponin and/or
• Clinical high-risk features and/or
• ECG changes consistent with ischemia
YES
NO
Physiologic testing/ abnormal diagnostic noninvasive imaging?
YES
NO
Discharge with follow-up if no evidence of infarction or ischemia by testing

Suspected Opioid Overdose



REVIEWED: 04/08/2016, 12/14/2017, 08/01/2018, 07/23/2019, 08/03/2020, 05/10/2021, 08/17/2022, 11/14/2022

REVISED: 12/18/2017, 08/27/2018, 08/26/2019, 05/24/2021, 08/23/2022

Signatures:

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Kimberly Wetherhold, Board Chair James Yoxtheimer, President & CEO

SUSQUEHANNA COMMUNITY HEALTH & DENTAL CLINIC, INC.

Nurse Triage

Policy Category: **10.0.23 Clinical**
Policy Owner: **Director of Clinical Operations~~Clinical Operations Manager~~**
Origination Date: **11/20/2012**
First Date Approved by Board of Directors: **11/26/2012**

Purpose:
To ensure patients have 24/7 access to care.

Policy:
1. SCH&DC contracts with UPMC Nurse Triage which ~~which~~ is available to answer~~s~~ our patient calls Monday- Friday 5pm-8am the following day and Saturday from 8am through 8am Monday as needed by the Center. All calls transfer to Nurse Triage 15 minutes prior to Center closure. This contract also covers inclement weather, unexpected closures, and holidays as needed. ~~to 8am the following day and 8am Saturday through 8am Monday. Holidays are also covered form 8am to 8am the following day. until midnight. After midnight, Nurse Triage transfers telephone calls to the UPMC Emergency Department.~~
2. Nurse Triage/Emergency Department staff triage patient calls and documents via SCH&DC EHR access. Documentation of any after-hours calls is sent directly to the team nurse of the patient's primary care provider (PCP) for review and coordination of care where appropriate in instances where SCH&DC EHR access is unavailable follow up information will be faxed to SCH&DC the following morning.
3. SCH&DC provider staff follows an On-Call schedule. The On-Call provider is accessible by beeper and/or cell phone.
4. The On-Call Provider is trained to access medical records remotely according to the "Acceptable Use of IT" policy and "Remote Access Authorization".

REVIEWED: 03/12/2014, 04/08/2016, 03/30/2017,09/01/2018, 10/01/2019, 10/01/2020, 04/19/2022, 11/14/2022

REVISED: 03/17/2014, 09/24/2018, 10/28/2019, 10/26/2020, 10/26/2021, 04/26/2022

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_____ _____ Date:
Kimberly Wetherhold, Board Chair James Yoxtheimer, President & CEO