

The McInnis House Clinical Care Committee Annual Policy Review took place on February 26th, 2008.
All of the policies contained in this manual have been reviewed and approved by the Clinical Care Committee.

These policies have been approved by Monica Bharel, MD; Medical director or designee of the McInnis House Clinic
and
Sarah Ciambone, Director.

Effective Date: February 26th, 2008

Monica Bharel, MD; Medical Director

Date: _____

Sarah Ciambone, Director

Date: _____

DESCRIPTION OF SERVICES AVAILABLE AT MCINNIS HOUSE CLINIC

The following services are available at the McInnis House Clinic

1. Medical
2. Dental services
3. Pharmacy
4. Behavioral Health

POLICY: HOURS OF OPERATION AND OFF- HOURS COVERAGE

The McInnis House Clinic/McInnis House is open for patient assessment and treatment 24 hours a day, seven days a week. There is RN coverage for the McInnis House Clinic/McInnis House 24 hours a day.

Provider coverage (Physician, Nurse Practitioner/Physician Assistant) occurs eight (8) hours a day, seven days a week. Physicians are in the building five days a week. The general business hours for provider staff is 8:30a – 5p

When provider or physician staff is not available for consultation in the McInnis House Clinic/McInnis House, then the nursing staff may call the BHCHP Answering Service (781 221-6565) to speak to the on-call clinician (MD, NP/PA). There is always a provider on-call.

POLICY: CLINIC ACCESS FOR MEDICAL EVALUATION

1st floor

Patients have access to the McInnis House Clinic located on the first floor during the hours of 8a – 5p Monday – Friday on a walk-in or appointment basis.

2nd through 4th floor

Patients at the McInnis House will be evaluated by a nurse at least once/eight hour shift and at least once daily by a nurse practitioner, PA, or physician

Staff will ensure that patients have access to the clinic for nursing assessment 24 hours, 7 days a week.

Patients at the McInnis House are the only patients seen in the McInnis House Clinic on the 3rd and 4th floor exam rooms of the McInnis House clinic.

All patient clinical issues will be assessed by an RN in consultation with Physician or Nurse Practitioner/Physician Assistant as indicated.

POLICY: REFERRAL AND ADMISSION TO the McInnis House Clinic/McInnis House

Rationale: All clinical staff need to understand how patients are accepted for admission.

Procedure:

Referring agencies will complete Referral information paperwork (see attached) and fax the paperwork to the McInnis House Clinic/McInnis House Admissions office for review by the admissions staff between 8:00-4:30 PM Monday through Friday.

For off-shift admissions (after 4:30PM Monday through Friday and weekends and holidays), referrals are accepted and reviewed by the Nurse Manager.

Admissions are accepted depending on bed availability 24 hours/7days a week.

For off shift admissions referred from BHCHP clinic sites, the off shift "Clinic outreach" referral form will be faxed to the RN Manager.

POLICY: OUTSIDE RECORD REVIEW

Rationale:

Our patients are seen by multiple outside providers and specialty services. They are also frequently sent to the emergency department. The majority of our new admissions come from inpatient hospital services. It is imperative that we understand the details of these hospitals, emergency room and office visits in order to provide appropriate care to our patients.

Procedure:

1. For new admissions, all discharge summaries for patients admitted or readmitted must be obtained from the hospital. It is the primary responsibility of the admitting staff to obtain these records. In the unlikely event that the admitting NP/PA/MD does not get this information from the admitting nurse, they must obtain these records within 24 hours. If there is to be a delay in obtaining the records they must speak with the discharging physician before completing the admission.
2. All discharge summaries must be reviewed by both the team NP/PA and the team MD. Each discharge summary must be signed and dated by the team NP/PA and the team MD. This should be done within 48 hours of the patient's admission to MCINNIS HOUSE. (or 72 hours for weekend admissions)
3. When a patient is sent to the ED or admitted to us from the ED the ED report must be obtained when the patient returns to MCINNIS HOUSE. If the ED report is not immediately available, the NP/PA/nurse who is admitting the patient must obtain a verbal report from the ED staff and documents the contents of this in the MCINNIS HOUSE chart. This documentation should include what was done in the emergency room, any abnormal labs and who was spoken to in the ED. A written ED report must be present in the chart within 24 hours of the patient's admission. This written report must be reviewed by the NP/PA and the MD within 24 hours of obtaining the report. Both must sign the ED report.
4. When a patient has an outside office visit while at MCINNIS HOUSE, paperwork documenting the content and recommendations from that visit must be reviewed upon the patient's return. If no documentation is provided then the provider must call the specialty office within 24 hours to review the visit and document a summary of this information in the medical record.
5. When a record is from BMC, it can be reviewed on Logician but then the provider must either print a copy and put this signed copy in the chart or give a summary of the findings in their written notes.
6. For support in obtaining records, the admissions department receives many of these records for new admissions. Also, the medical secretary can be asked to obtain any of the above mentioned records.

POLICY: IV ADMISSIONS

Procedure:

1. In most cases patients with a central line (PICC or Port A Cath) will be admitted. Occasionally, patients with a Hep-Lock, Peripheral Line or Midline Catheter will be admitted.

See policy for short term peripheral line treatment for cellulitis.

2. Patients on IV Antibiotics on the following schedule may be admitted;
 - A. Once/day (daily)
 - B. Every 12 hours (BID)
 - C. Every 8 hours (TID)
 - D. Only 1 IV per nursing team
 - E. If multiple ports, ports must be labeledDo not accept patients on every 6 hours or 4 hourly antibiotics

IV infusion not to exceed 1-2 hours at a time
Do not accept patients on continuous IV pump.
Do not accept on IV Gancyclovir.
Do not accept patients on IV amphotericin

If a patient is on 2 different antibiotics at different times, please check with Director of Nursing or designee before admitting the patient.

3. **All patients with IV's should be admitted with 24 hours notice and before 1pm whenever possible. Weekend IV admissions must be pre-approved by the Director of Nursing or designee.**
4. **On all admissions of patients with an IV, the staff member taking the information should speak with the primary Nurse and make sure the following information is obtained in writing:**
 - a) Type of IV line
 - b) Type of IV medication
 - c) Dosage and time of infusion
 - d) Heparin flush protocol
 - e) Patient to be sent with at least a bag of IV meds, if needed
5. **Nursing supervisor needs to be notified prior to admission.**
6. **Any questionable admissions for IV therapy should be reviewed and approved by the Medical director or designee.**

POLICY: PRE-ADMISSION TUBERCULOSIS SCREENING

Rationale: Tuberculosis is known to be endemic in the homeless population. In an effort to protect patients and staff from exposure to TB, the staff at McInnis House Clinic will adhere to guidelines as outlined.

Procedure:

- I. All patients must be screened by a health care provider (MD, RN, NP-C) prior to acceptance. All homeless patients with new prolonged productive cough (>2 weeks) or a change in chronic pulmonary symptoms must have a Chest X-Ray (CXR), regardless of PPD status.

Patients referred by non-clinicians must be pre-screened in an Emergency Department or the Medical director or designee consulted prior to acceptance.
- II. Patients referred from shelters who have unexplained weight loss, night sweats or fevers, regardless of pulmonary symptoms, must have a CXR to R/O TB. If CXR reveals an infiltrate regardless of lobe(s) involved, 3 negative smears for AFB must be obtained prior to admission to McInnis House Clinic.
- III. If the recent PPD is positive or the patient is anergic with a pulmonary illness or in ANY CASE when the CXR reveals an infiltrate regardless of lobe(s) involved, then the patient must have 3 negative smears for AFB and 3 TB cultures of sputum pending prior to McInnis House Clinic admission unless specifically cleared by the Medical director or designee.
- IV. All HIV positive patients with a productive cough are required to have 3 negative smears for AFB, and 3 TB cultures of sputum pending, regardless of CXR findings, prior to admission, unless specifically cleared by the Medical director or designee.
- V. If you have concerns with regard to acceptance of a patient due to PPD status, anergy, HIV status, etc, please discuss with the Medical Director or designee.

POLICY: TUBERCULOSIS

Rationale: Pulmonary tuberculosis is a communicable disease that presents a serious risk to patients at the McInnis House Clinic, many of whom are immunocompromised by chronic and debilitating illnesses. Therefore, every effort will be made to ensure that individuals with active TB are not admitted to McInnis House Clinic. Patients who have been under adequate treatment for TB and are proven not to be contagious may be admitted to McInnis House Clinic.

Procedure:

Patients with active tuberculosis discovered at McInnis House Clinic will be transferred to an acute care hospital for treatment until such time that the patient is no longer contagious.

All patients will have PPD status documented within the past six months of admission to McInnis House Clinic. If not documented in the past six months then a PPD will be planted at McInnis House Clinic. If a PPD has been positive in the past it will not be repeated. If a person has a past history of positive PPD and has no symptoms suspicious of TB or no change in their chronic symptoms (i.e., chronic smokers cough or COPD), then they do not need a CXR. Any new PPD converter will need a CXR regardless of symptoms. Most new converters should be followed up at BMC TB Clinic.

All new TB cases will be reported to the Department of Public Health using the appropriate forms.

POLICY: CONSENT TO TREATMENT

All patients admitted to the McInnis House Clinic/McInnis House are asked to sign a "Boston Health Care for the Homeless Program/McInnis Health Group Patient's Consent to Treatment" form.

Please see attached form.

POLICY: INFECTION CONTROL

Isolation Precautions

Rationale: Every reasonable attempt will be made to prevent the spread of infection at the McInnis House Clinic. A variety of infection control measures outlined below are used for decreasing the risk of transmission of organisms at the McInnis House Clinic.

All body and blood fluids will be considered infectious regardless of the perceived status of the source individual.

Purpose: To control spread of infection.

Procedure:

A. **Standard Precautions** (formerly referred to as Universal Precautions): used during interaction with **all** patients regardless of their diagnosis or presumed infection status.

Hand-washing: Good hand-washing using soap and water or waterless antiseptic before and after each patient contact, after using the bathroom, after handling soiled material, and after eating is mandatory for all staff. Wash hands after touching blood, body fluids, secretions, excretions, and contaminated items **whether or not gloves are worn**. It may be necessary to wash hands between tasks and procedures on the same patient to avoid cross contamination of different body sites.

Patients are asked to use waterless antiseptic before and after restroom use and before eating meals to avoid infection.

Gloves: As mandated by the OSHA blood borne pathogens final rule:

Gloves should be worn whenever contact with any of the following is expected to occur:

- 1) Blood;
- 2) any body fluids, secretions and excretions *except sweat*, regardless of whether or not they contain visible blood;
- 3) non-intact skin and/or;
- 4) mucous membranes.

In addition gloves should be worn even if not explicitly delineated above whenever:

- 1) a risk of gross contamination of the hands;
- 2) special care to avoid contamination of patients during patient-care procedures, including, but not limited to suctioning, phlebotomy, dressing changes, nail clipping, injections, and wound irrigation or ;
- 3) the possibility of transmission from one patient to another exists;
- 4) handling of contaminated items is required.

Wearing gloves and changing them between patient contacts DOES NOT replace the need for hand-washing. Failure to change gloves between patient contacts is an infection control hazard.

Protective Eyewear and nose/mouth droplet prevention masks:

Protective eyewear and masks should be worn to protect mucous membranes of the mouth, nose and eyes whenever there is a risk of a splash or spray of blood or body fluids. This includes but is not limited to the performance of the following procedures: suctioning, nail clipping, wound irrigation and dental work.

Gown

Non-sterile gowns should be worn when splashes, sprays, or spills of blood or bodily fluids are likely to come into contact with the caregiver's body or clothes. Remove soiled gown as promptly as possible and wash hands.

Patient care equipment

Handle soiled patient care equipment in a manner to prevent, skin and mucous membrane exposure, contamination of clothing, and transfer of microorganisms to other patients and environments. Do not reuse patient care equipment until it has been cleaned and reprocessed appropriately (see 3e). Discard single use items properly.

Environmental control

Please see separate policy on maintenance of clinical areas regarding cleaning and disinfecting, restocking, disposing of outdated materials, equipment maintenance/inspection, separation of clean and dirty items and medical infectious waste disposal.

Linen

All clean linen is to be kept covered. All used linen is to be handled with gloves and deposited in the dirty linen area. Clostridium difficile – all cleaning supplies are dedicated to infected patients and supplies are disposed of in biohazard bags. No sponges are used.

Contaminated Sharps

Never recap needles. All sharps will be discarded in puncture resistant/ leak proof containers located in the clinics. Sharps containers will be inspected daily by the house keeping staff. Full containers will be brought to biohazard room and be replaced by empty containers.

Resuscitation

A one way mask should be used whenever possible if the need for resuscitation arises. These items are located in emergency red carts in the clinic area.

Patient placement

When concerns about patient's infectious status occurs the Medical director or designee will be contacted to determine the need for a private room.

Blood and body fluid exposures/ needle sticks

If a possible exposure due to needle stick, splash, or other accident occurs please refer to policy on "Blood and Body fluid Exposures/Needle Sticks" for course of **immediate action**.

B. Transmission-based Precautions:

Transmission based precautions are designed for patients documented or suspected to be infected with highly transmissible or epidemiologically important pathogens for which additional precautions beyond standard/universal precautions are needed to interrupt transmission. Precautions are determined based on the mode of transmission of the disease/pathogen involved. There are three types of transmission-based precautions: Airborne, Droplet, and Contact.

1. **Airborne Precautions** require special air handling and ventilation specifications that are not possible at the McInnis House Clinic. Therefore anyone with a high suspicion of being an infectious carrier of an airborne pathogen cannot be admitted to McInnis House Clinic program. Airborne pathogens include pathogens that can be transmitted by "droplet nuclei" (residue from evaporated droplets 5um or smaller in size) or dust particles. Diseases that require airborne precautions include: measles, disseminated Varicella zoster (including primary infection), Varicella pneumonia, and pulmonary tuberculosis. Patients with the above diagnoses cannot be admitted to the McInnis House Clinic until they are considered non-infectious and the medical director or his/her designee has reviewed their case.
2. **Droplet Precautions:** Droplet transmission of diseases involves the contact of eyes, or the mucous membranes of the nose or mouth of a susceptible person with "large particle droplets" (larger than 5 um in size) containing microorganisms generated from who is infected by or a carrier of that pathogen. Droplets are generally formed during coughing, sneezing, talking, suctioning and other similar activities. Droplet Transmission requires close contact between source and recipient because droplets generally remain suspended in air for 3 ft or less. Special air handling and ventilation is not required.

In addition to standard precautions patients known or suspected to be infected with microorganisms transmitted by droplets (see attachment) should be treated with the following precautions:

- a) Place patient in private room if available. If no private room is available, place patient in a room with a patient(s) with the same infection, but no other infection that is not shared (cohorting). However roommates should not be immunocompromised.
- b) A mask should be worn within 3ft of the patient. Mask patient when he/she leaves the room. Minimize travel of patient from his/her room.

3. **Contact Precautions:** Transmission of disease can occur through direct and indirect contact. Direct contact

transmission involves direct skin-to-skin contact and physical transfer of microorganisms from a source person to a susceptible host. Indirect-contact transmission involves contact of a susceptible host with a contaminated intermediate object.

In addition to standard precautions patients known to be infected or colonized with an epidemiologically important pathogen that can be transmitted by direct or indirect contact (see attached list) should be treated with the following precautions.

- a) Place patient in a private room if possible. Private room needed for patients with large wound, copious drainage, drainage or body fluids not well contained, patients not able to manage their own hygiene sufficiently. When a private room is not available place patient in a room with a patient(s) who has similar infection and/or colonization. However roommates should not be immunocompromised.
- b) Wear gloves when coming in direct contact with patient. Dispose of gloves **before** leaving the room. Change gloves after contact with material that may have a high microorganism count (fecal material, wound drainage etc.). Wash hands immediately after removing **or waterless antiseptic**.
- c) Wear a gown when entering the room if you anticipate substantial contact with the patient, environmental surfaces or items in the patient's room or if the patient has diarrhea, an ileostomy, a colostomy, or wound drainage not contained by a dressing. Remove gown **before** leaving the patients room. After gown removal ensure that clothing does not contact potentially contaminated surfaces.
- d) Parameters of patient movement will be decided based on the organism in question and the likelihood of environmental contamination by the patient.
- e) When indicated, dedicate the use of patient care equipment (e.g. stethoscope, BP cuff, and thermometer) to the cohort of patients with a single pathogen. Adequately clean and disinfect it between uses with 60% isopropyl alcohol or with disinfectant spray.
- f) A red Biohazard trash bag should be placed in the patient's room for disposal of contaminated material (gloves, masks, etc) A special laundry bag, marked appropriately should be used to bag bed linens and gowns. The room should be completely sanitized with disinfectant detergent surface cleaner followed by germicidal detergent when patient is discharged. Used red biohazard bags are moved to the biohazard waste room.

List of Infections that require precautions in addition to Standard Precautions:

Organism/illness:	Patients should remain on precautions until/for:
<i>Infections that require droplet precautions:</i>	
Pharyngeal Diphtheria	Off antibiotics 2 cultures taken 24 hours apart are negative
Influenza	Duration of illness, avoid room sharing with high risk patients, cohort when possible
Haemophilus influenzae, known or suspected	24 hrs after initiation of effective therapy
Neisseria meningitidis (meningococcal), known or suspected	24 hrs after initiation of effective therapy
Meningococcal pneumonia	24 hrs after initiation of effective therapy
Meningococemia	24 hrs after initiation of effective therapy
Mumps (infectious parotitis)	For 9 days after onset of swelling
Mycoplasma pneumonia	Duration of illness
Pertussis (whooping cough)	5 days after initiation of effective therapy
Pneumonic plague	72 hrs after initiation of effective therapy
Adenovirus pneumonia	Duration of illness
Rubella	7 days after onset of rash
<i>Infections that require comprehensive contact precautions:</i>	
Methicillin/oxacillin resistant <i>Staph aureus</i> (MRSA)	See separate protocol
Vancomycin resistant enterococcus (VRE)	See separate protocol
Cutaneous Diphtheria	Off antibiotic 2 cultures 24 hrs apart are negative
Ebola viral hemorrhagic fever	Call State Health Dept. and CDC for specific advice
Lassa fever	Call State Health Dept. and CDC for specific advice
Marburg Virus disease	Call State Health Dept. and CDC for specific advice
E coli 0157:h7 in a diapered or incontinent patient	Duration of illness
Rotavirus in a diapered or incontinent patient	Duration of illness
Shigella in a diapered or incontinent patient	Duration of illness
Hepatitis A in a diapered or incontinent patient	Duration of illness
Disseminated or severe primary mucocutaneous <i>Herpes simplex</i>	Duration of illness
Impetigo	24 hrs after initiation of effective therapy
Adenovirus pneumonia	Duration of illness
Clostridium difficile in a diapered or incontinent patient	Stool culture negative 1 week after last dose of treatment medication (flagyl or vancomycin)

Conditions that require Modified Contact Precautions (Precaution parameter orders to be written on a case by case basis and approved by medical director or designee):

Lice (pediculosis)	
Scabies	
<i>Clostridium difficile</i>	
Acute viral (acute hemmorrhagic) conjunctivitis	
Body Surface Infections that are not contained by a dressing including: major draining abcess, significant weeping cellulitis, decubitus ulcer with major infection and major wound infections	

NOTE: Precautions that apply to infants and children only, ARE NOT included in this list.

POLICY: BLOOD AND BODY FLUID EXPOSURES/NEEDLESTICKS

Rationale: To protect employees from infection from blood borne pathogens and to assure appropriate follow up care for any employee who has an exposure incident

Procedures:

- Standard precautions are to be used at all times unless specific precautions are ordered (i.e. airborne, contact, etc)
- All patients should be considered potentially infected with bloodborne pathogens.
- All sharps and instruments should be considered potentially infected with bloodborne pathogens.
- Exposure to potentially infectious materials should be minimized.

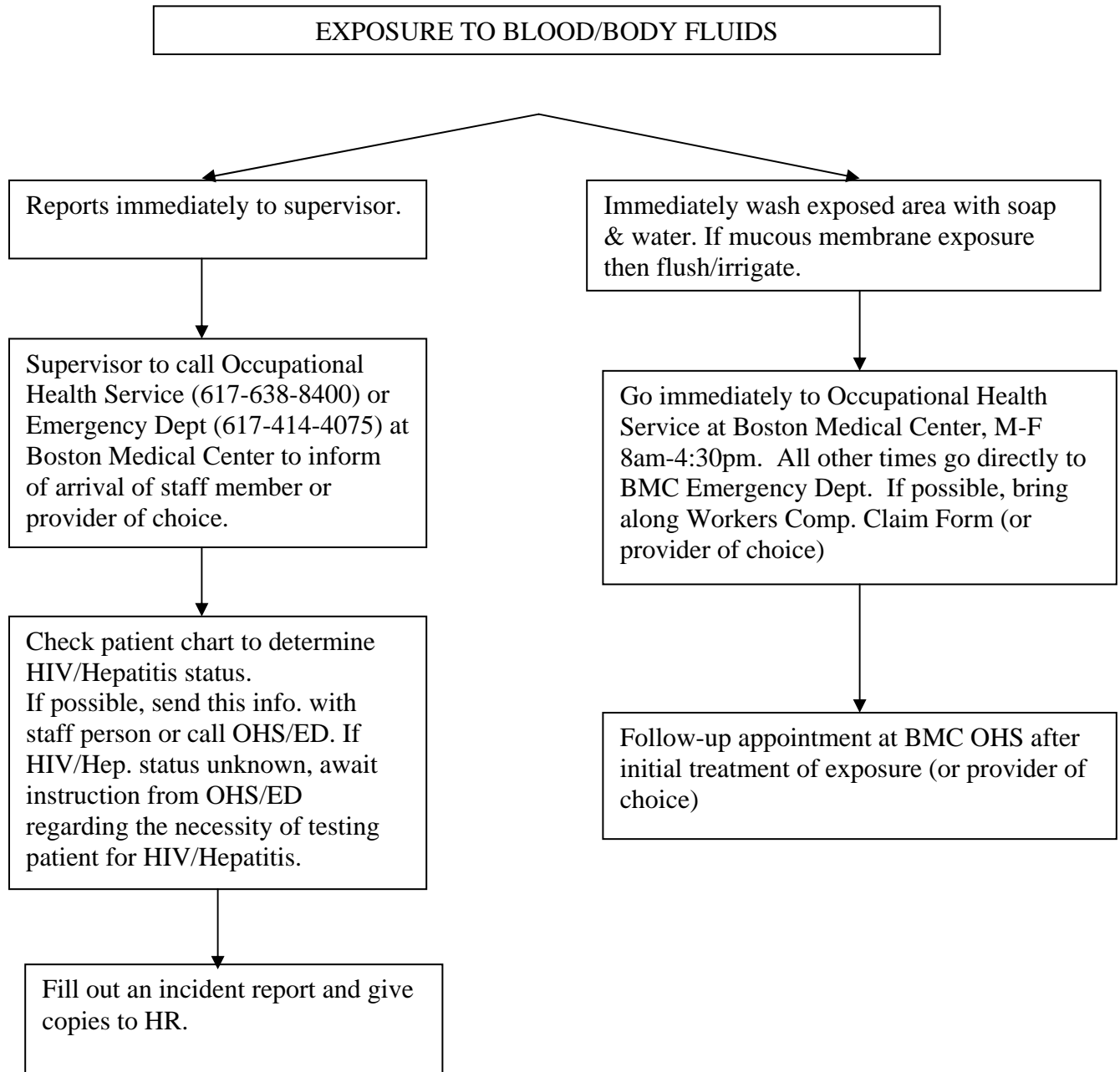
- The Post Exposure Prophylaxis following Occupational Exposure to HIV policy of Boston Medical Center (Addendum) will be adopted with the following changes:
 - Upon exposure, immediately clean the area with antiseptic solution and notify immediate supervisor
 - Supervisor will await instruction from OHS ED regarding the necessity for testing patient for HIV, Hepatitis. Supervisor in consultation with Director of Nursing or designee will confirm that appropriate testing is done
 - Supervisor should check the patient's chart to determine his/her HIV, hepatitis, and RPR status while employee is getting ready to go to BMC Occupational Health Service or their choice of provider.
- If the above status is unknown, obtain the patient's written consent and draw an RPR, HIV, HCV and HbsAG (see attached at Informed Consent Policy). However, this should not delay the employee going to BMC's OHS.

On **the same day as the exposure**, if it occurs during daytime hours, the Boston Medical Center Occupational Health Service (OHS) will be contacted, Mon-Fri 8:00am-4:00pm, 414-4632 or 638-8400 (or provider of choice).

- The staff member will be instructed to proceed directly to OHS. If possible, the Worker's Comp. Claim form must accompany the employee to OHS.
- On **the same day as the exposure**, if it occurs after 4pm, the employee should go to the BMC Emergency Department (or provider of choice). The BMC ED knows the procedures followed by BMC OHS and can arrange for follow-up there as soon as possible. **Employee should be seen at OHS or ED within an hour of exposure.**
- Report to Medical Director or, if s/he is not available, page the on-call physician.
- **ALL INSTANCES OF EXPOSURE MUST BE REPORTED TO OHS.**
- An incident report should be filled out. Copies need to go to HR, Director of Nursing or designee and appropriate supervisor.
- Clinical care committee will review all exposure incidents and monitor for trends, equipment evaluation and make recommendation for staff education.
- Follow-up after the initial exposure evaluation is mandatory in all cases, and particularly important for exposures from HIV-positive patients or for persons starting prophylaxis. Follow-up should be done at BMC OHS (or provider of choice) as soon as is possible.

Blood and Body Fluid Exposure Flow Chart

(Exposures include; cuts with dirty needle or other sharp objects, human bites, blood on open cuts or other breaks in the skin, splashes to the eyes or mucous membranes)



PATIENT LAB DRAW CONSENT FORM AFTER CRITICAL EXPOSURE

I _____ CONSENT / DO NOT CONSENT to have blood drawn for the purpose of determining:

HIV status _____

Hepatitis status _____

RPR status _____

And for staff, as appropriate, to know the results and provide results to the Occupational Health Service of Boston Medical Center if necessary.

Signature

Witness

Date

Date

POLICY: INFECTIONS THAT REQUIRE AIRBORNE TRANSMISSION PRECAUTIONS

Varicella Zoster

Primary (Chicken Pox): Patients with known or suspected chicken pox cannot be admitted to McInnis House Clinic until they are not infectious. Similarly employees, visitors, and volunteers are not allowed on the premises until they are not infectious. A person can be considered not infectious when all lesions are crusted.

Disseminated Herpes zoster or Herpes zoster affecting more than one dermatome should be treated as above.

Localized Herpes zoster (one dermatome) should be treated with Standard Precautions only. If it is possible for a non-susceptible caregiver to give care to the affected patient that is preferable, but not required.

Rubeola (measles)

Patients with know or suspected measles (Rubeola) cannot be admitted to McInnis House Clinic until the resolution of their illness or the diagnosis of measles is disproved.

Tuberculosis (TB)

See separate TB policy.

POLICY: COMMUNICABLE DISEASE REPORTING

Rationale: Certain communicable diseases are reportable to the Massachusetts Department of Public Health under state law.

Procedure:

The provider, who receives the result is responsible for completing the Communicable Disease Reporting Card. This card identifies all of the reportable communicable diseases and the process for reporting. (see attached)

POLICY: BIOMEDICAL WASTE SPILL

Purpose: To appropriately clean after any biomedical waste spill

Procedure: Biomedical Spill Kits should be used to clean and disinfect large amounts of potentially infectious liquid spills, i.e. blood and body fluids.

The purpose of the kit is to solidify a liquid spill so that it can be disposed of by staff in a safe manner.

The kits are accessible from housekeeping. The kits are located in each clean utility room and transportation Vans.

Contents of the kits include:

- solidifying powder
- shovel
- germicidal/chlorine solution
- disposal materials
- directions for use of kit

POLICY: MULTI-DRUG RESISTANT ORGANISM

Vancomycin Resistant Enterococcus (VRE)

In addition to Standard Precautions and Contact Precautions the following procedures will be followed for any patients with VRE infection or colonization:

Obtain cultures of stool or rectal swabs of roommates of patients newly diagnosed with VRE to determine their colonization status and apply isolation precautions as necessary.

Patients should remain on VRE precautions until VRE-negative results are found on three consecutive occasions at least 3 days apart from multiple body sites including: stool or rectal swab, perineal area, axilla or umbilicus, wound, Foley catheter and/or ostomy sites if applicable.

All patients colonized or infected with VRE will have access to a private bathroom or a bathroom shared with patients with the same organism when appropriate. Patients are expected use only that bathroom while at Barbara M. McInnis House Clinic.

Charts of VRE colonized patients will be recorded in the BHCHP electronic medical record.

Methicillin/oxacillin Resistant Staph Aureus (MRSA)

In addition to following Standard and Contact Precautions for all patients known to be MRSA infected or colonized, MRSA status will be recorded in the BHCHP electronic medical record.

After mattresses are wiped with cleanser they are air dried before linens are placed for MRSA precautions.

POLICY: HIV COUNSELING AND TESTING POLICY AND GUIDELINES

Policy: HIV counseling and testing should be considered in all patients in BHCHP's primary care practice. The primary care clinicians and nursing staff will assess risk factors and discuss options for testing and counseling as deemed appropriate. BHCHP staff offers confidential counseling and testing.

In addition, BHCHP will offer HIV testing and counseling at shelter clinics and Barbara McInnis House to guests requesting the test

Guidelines:

- I. Who may perform HIV counseling and testing
 - A. HIV Counselor - The HIV Counselor, having completed the Boston Public Health Commission's or equivalent course in HIV counseling, will be available on a walk-in basis and by appointment to see patients referred by BHCHP clinical staff, including RN's, NP's, PA's, MD's and mental health clinicians. The Counselor may also see patients of BHCHP who self-refer.
 - B. BHCHP Clinicians (MD, NP, PA, RN) – It is recommended that any staff member who orders HIV testing be familiar with the CDC Guidelines for HIV Counseling and Testing. Any clinician can order HIV testing for his or her patient but must adhere to DPH guidelines, review with and have the patient sign the consent form.

- II. Place of Counseling

HIV Counseling may take place in a designated BHCHP clinic, at the Barbara McInnis House or at a shelter at which BHCHP provides services and which has approved the performance of HIV counseling at its site, such approval having been expressed to the Medical Director.

- III. Type of testing/site of test performance

The Counselor or clinician may perform an oral swab or may have a medical provider order a blood test for HIV testing. Blood tests performed in a shelter site or at BMC will be sent to the BMC lab and/or the State Lab. Blood tests performed at MGH shall be sent to the lab at that site. Oral Mucosal Testing (OMT) will be sent to the Massachusetts State Lab.

Rapid HIV testing by fingerstick blood specimen may be provided at the Respite facility or any clinic site as determined by the Director of HIV Services which has been added to the CLIA Waiver. Staff who perform this test must be trained according to program policies and procedures. They will follow all program policies and procedures as well as those of the State of Massachusetts in regard to testing and quality control measures

IV. Record Keeping

The HIV Counselor will keep track of patients' demographics, dates of counseling, test, return and result in the electronic medical record. If someone other than the HIV counselor does the counseling and testing, he or she must give the data to the HIV Counselor. Whoever performs the counseling and testing must also put all the appropriate information in the EMR. Each client will read and sign consent either for OMT or blood test. The HIV counselor and tester will keep a copy of the consent in a locked file cabinet with other records. Reporting on each patient tested must be sent to DPH. The HIV counselors are responsible for gathering this information.

Record keeping for rapid HIV testing will adhere to specific procedures delineated in "Policies and Procedures for Rapid HIV Testing".

The HIV counselor is responsible for reporting all test results to the Massachusetts State Department of Public Health via the official reporting form.

V. Patient Follow-up

All patients tested with OMT or serum will be scheduled at the pre-test counseling visit for a return appointment to receive the results. If the testing is performed in a shelter, the patient should be told which day the counselor will be there to give the results. The person who performed the pre-test counseling will inform the patients of the results.

In unusual circumstances, the HIV counselor may give a result to another counselor's client, or the patient's primary care giver may give the result to the patient in the absence of the Counselor. Every effort should be made to find a patient to give him or her a test result but at no time compromising confidentiality

For rapid HIV testing, the results will be available in 20 minutes. Separate policy and procedure is available for this type of testing. As with positive tests above, since the result will be known in 20 minutes, the counselor must assure that appropriate support is available before initiating the test.

VII Positive Test Result

See Guidelines for Giving Positive HIV Test Results in BHCHP Guidelines

VI. Primary Care Follow-up

If a patient tests positive and wants to get primary care through BHCHP, he or she will be referred to the HIV Team for an initial nursing and case management intake and appointment for medical evaluation. Should the patient wish to have care at another site, the counselor will assist the client in scheduling the appointment. At Massachusetts General, the patient could be followed for primary care by a BHCHP clinician with referral to Infectious Disease Clinics for HIV care.

POLICY: POLICY FOR GIVING POSITIVE TEST RESULTS TO PATIENTS

Policy:

HIV counselors/testers will make every effort to have adequate support at any site before giving a positive result.

Procedure:

Barbara McInnis House: Before giving a positive test result, the HIV counselor will inform the medical provider and/or behavioral health staff that s/he will be giving a result and ascertain whether there may be any psychiatric or other issues that may impact the person's reception of the results. The counselor will also notify his or her supervisor if a positive test result will be given. Positive test results should be given on Monday, Tuesday, Wednesday or Thursdays to ensure that adequate behavioral health staff are available for any potential crisis. Before the counselor gives a positive test result at Barbara McInnis House, a behavioral health clinician should be on site.

After giving the test result, the counselor will ask the patient for permission to have a behavioral health clinician check in with him or her. The counselor will inform the patient about options for medical evaluation and care.

Hospital Based Clinics: If the patient has a primary care and/or a behavioral health clinician, the counselor will tell him or her that their patient will be getting a result from HIV testing and ascertain if there are any known issues that may cause problems. The counselor will also notify his or her supervisor. The counselor should give the result at a time when behavioral health staff are on site. After giving the test result, the counselor will ask the patient for permission to have a behavioral health clinician check in with him or her. The counselor will inform the patient about options for medical evaluation and care.

St. Francis House or other shelter clinic: If the patient has a primary care and/or a behavioral health clinician, the counselor will tell him or her that their patient will be getting a result from HIV testing and ascertain if there are any known issues that may cause problems. The counselor will also notify his or her supervisor. Positive test results should be given at a time when behavioral health staff or medical staff who feel comfortable with crisis management are on site. After giving the test result, the counselor will ask the patient for permission to have a behavioral health clinician check in with him or her. The counselor will inform the patient about options for medical evaluation and care.

If, for any reason, the HIV counselor needs crisis management and none is available, he or she should call the BEST Team for assistance.

For rapid HIV testing, all above procedures are to be followed before initiating the test since the result will be available in 20 minutes.

POLICY: EMERGENCY CARE

Rational:

All staff will be familiar with emergency procedures in the event of a patient emergency to ensure quality care and a safe outcome. Patients requiring an emergency level of care will be transported to the nearest medical facility.

Procedures:

1. In the event of medical/psych emergencies at the McInnis House Clinic, Code Blue and Code Green will be followed (*see separate policies.*)
2. See "Emergency Equipment Policy" for a listing of emergency equipment supplies and locations
3. Patients requiring emergency level care will be transported to the most appropriate emergency department.
4. A formal agreement exists between the McInnis House Clinic and Boston Medical Center's Emergency Department.
5. BHCHP has a written agreement with Boston Medical Center to provide emergency services for the transfer of patients.
6. In the event of an emergency transport, a copy of pertinent patient medical information will be sent with them.
7. All clinical staff will be certified in CPR. This includes CNAs, RNs, NPs, PAs, MDs, DMDs, Dental Assistants, Hygienists, Social Services and Behavioral Health staff.

POLICY: EMERGENCY EQUIPMENT

Emergency Equipment will be maintained on each floor of the building for Code Blue response. AEDs will be easily accessible in emergency situations.

Procedure:

A. Cart Locations:

1. Basement
2. Lobby
3. First Floor
4. Second Floor
5. Third Floor
6. Fourth Floor

B. Cart Security:

1. All carts will be sealed with a breakable numbered seal.
2. Each cart will be checked daily for integrity of the seal by the 11 pm – 7 am shift. A checklist which identifies each cart's contents will be attached to the **outside** of each emergency cart. 11 pm – 7 am RN Manager (or his/her designee) will be assigned to check the contents of each cart on a monthly basis. Glucometers and flashlights must be checked at this time. Extra batteries should be made available for the carts.
3. Whenever the cart is opened, the shift nurse manager will assure that the cart is restocked as applicable and a new breakable numbered seal applied.
4. The staff member who does the daily and/or monthly checks must sign the applicable check list.

C. Cart Contents:

1. The following equipment and/or supplies will be available on or in the carts. Drawers will be labeled with the contents.

Suction machine with tubing/yankauer
Oropharyngeal airways
Goggles
Masks
CPR micromasks Tongue depressors
Defibrillator pads
Disposable gowns
Small bottles normal saline
Yankauer suction with tubing
Suction catheters
Connection tubing
Lubricating jelly
Wire cutters
Biohazard bags
Blood pressure cuffs
Stethoscope
4x4's
Kerlix wrap
Tape
EMT scissors
Notebook/pen
Emergency Recording Sheet/clipboard
Ambu bag with masks
Nonrebreather masks
Rebreather masks
Blood sugar test kit/glucometer
Emergency drug kit
Glucose
Penlight/batteries
Sterile gloves
Exam gloves
Oxygen tank

D. Emergency Drug Kit:

- 1) The cart contains a sealed box with emergency drugs with an expiration date for the most recent drug to expire.
- 2) Whenever the box is opened or the box needs to be exchanged due to expiration date, the pharmacy will be notified and the box exchanged.
- 3) Kit contents:

2 IM syringes	1 bottle chewable 81 mg Aspirin
1 narcan ampule	100 Nitroglycerin 0.4 mg tabs
1 glucagon kit	2 Benadryl 50 mg ampules
1 epipen	3 alcohol wipes

Date	RN Signature	Cart sealed daily changed 1st of month	Two O2 tanks ready to go and wrench	Suction machine & back board	Eye wash station exp. Date	Lobby first aid kit and O2 tank present	lock number on cart	Automated external defibrillator "status" indicator green?
1								
2								
3								
4								
5								
6								
7								
8								
9								
10								
11								
12								
13								
14								
15								
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31								

It is the night charge nurse or designee's responsibility to check the emergency equipment on a daily basis. If an item is missing, please make a notation in the appropriate box and order supplies immediately to replace the defective or missing item. Monthly the seal on the cart should be broken to check integrity of equipment and expiration dates before being resealed by charge nurse or designee.

POLICY: CODE BLUE - EMERGENCY RESPONSE FOR PATIENTS IN ACUTE DISTRESS

Purpose: To establish guidelines for response for a person found in acute distress

Procedure:

- 1) An employee who discovers a patient unresponsive or in acute distress will IMMEDIATELY:
Call for clinical assistance and remain with patient. Activate the IGEACOM system where available.
 - a) Request or activate a code on the overhead system by announcing:
" Attention All Staff: CODE BLUE exact location), CODE BLUE (exact location),
CODE BLUE (exact location)
 - c) The Unit Secretary will repeat this announcement by pressing the emergency call button on the phones.

- 2) All Clinical staff in the location of the code are expected to respond. Staff access emergency equipment (AED, code cart, oxygen tank, patient chart) while en route.
 - a) The first responding clinical staff member will assess patient's status and will initiate emergency measures to include, if indicated, CPR and 911 activation.
 - b) The most senior clinical responder will assume leadership of the code response and will delegate code response activities as follows:
 - (1) State " I am in charge"
 - (2) Confirm EMS activation (911 Response)
 - (3) The senior clinical responder (person in charge) will determine need to call for additional medical staff
 - (4) Acquisition of additional EQUIPMENT as needed
 - (5) Designate person responsible as RECORDER of code to complete "Emergency Response Record".

NOTE: The Emergency Response Record will be forwarded to the Director of Nursing (or designee)

 - (6) Designation of person responsible for TRAFFIC CONTROL to ensure elevator control, direction of EMT to location and removal of other patients from area
 - (7) Document note in patient's medical record after the Code Blue.

- 3) The MCINNIS HOUSE supervising RN responds to all code calls on all shifts. She assumes the role of code leader unless an NP/PA is present; who then assumes the role of code leader unless an MD is present who then assumes the role of code leader. The code leader then assigns the following roles as appropriate:

Roles: Recorder, AED carrier, Call 911 (code leader determines whether a 911 call is necessary), Equipment manager
CPR performers, Runners, Data manager

POLICY: CODE GREEN

Rationale: To clarify the management of all behavioral emergencies

Definition: A Code Green applies to any situation in which the safety of staff and patients is immediately jeopardized by the behavior of a person who is acting out verbally or physically and/or where a person threatens harm to self or others in an acting out manner.

Procedures:

- 1) Activate the panic button
- 2) Overhead page Code Green three times and state where this is occurring.
- 3) Safety comes first and all are to remember that no-one should approach a person who is being violent or threatening.
- 4) All assigned staff and security should respond by going towards the location immediately. This includes all management team staff, food services and housekeeping staff, security staff and all available behavioral health staff. Between the hours of 4pm-9a and weekend, all staff respond to code green.
- 5) The appropriate senior staff member should determine what steps to take: options include calling 911, requesting a psychiatric evaluation if available, isolating the situation.
- 6) Patients and visitors are to be asked to clear the area
- 7) Peripheral staff who are at the scene should be present but non-confrontational and act in a way to de-escalate the situation, consistent with training.

After the event:

- 1) Reassure staff and patients
- 2) For code green on the basement or first floor the code leader pages the director of clinical operations (or his designee) and for code green on floors 2-4 page the MCINNIS HOUSE director.
- 3) Write an incident report
- 4) For the floors 2-4, inform Admissions, if the incident resulted in a patient being administratively discharged, of readmission criteria.
- 5) For the basement and first floor, the director of clinical operations and the medical director will review the incidents.

POLICY: PSYCHIATRIC EMERGENCY POLICY FOR MCINNIS HOUSE/MCINNIS HOUSE CLINIC

Rationale: To clarify the management of all psychiatric emergencies at the McInnis House Clinic/McInnis House.

1. Please immediately page the McInnis House Clinic/McInnis House Director.
 2. Please also immediately notify the Nurse Manager at the McInnis House. It is essential that he/she be aware of any emergency in progress.
 3. **Monday-Friday 8 am to 5 pm**
- Please page the Associate Medical Director for Psychiatry and/or Medical director or designee regarding all emergencies. Please do so prior to calling the BEST team.
 - Please utilize the Behavioral Health Team to also assist with behavioral problems. The Associate Medical Director for Psychiatry can be paged to meet with patients and their treatment team if needed. If a patient is known to the Clinical Nurse Specialist, or the Street Team/Pilot Team psychiatrists, they may also be paged Monday to Friday during regular work hours to assist.

After hours and weekends

- Please call the Psychiatrist on call through the Answering Service before calling the BEST team.
- Please leave a message for Director and Medical director or designee or contact directly as appropriate.
 1. Please follow the BEST team protocols (see attached 2 pages)
 2. If there are any problems with disposition, e.g. the BEST team is refusing to transfer a patient, please call the on call Psychiatrist to help with negotiating a safe plan.
 3. Once the patient is transferred, or even if the patient is to remain at Barbara M. McInnis House Clinic, please notify the following staff:
 - A. McInnis House Clinic Director by voicemail (857-654-1701)
 - B. McInnis House Clinic Medical director or designee, by voicemail (857-6540-
 - C. Nurse Manager at McInnis House Clinic
 - D. On call Psychiatrist

It is important that these staff are both aware of the existence of an emergency, but also the disposition plan.

The Admissions staff at McInnis House Clinic should also be notified that the patient was discharged for psychiatric reasons, so that future referrals will be screened by the Associate Medical Director for Psychiatry. If there have been behavioral issues as well, a copy of the treatment agreement used during the current admission should be sent to Admissions for future use.

POLICY: GUIDELINES FOR CONTACTING THE BEST TEAM^[A2]

Please have the following information available when contacting the BEST team:

- 1) General Demographic information, e.g. Name, DOB, SSN, health insurance etc.
- 2) Medical history and current medical issues including whether patient is medically stable or not.
- 3) Relevant psychiatric and substance abuse history.
- 4) Current medications.
- 5) Reason for contacting them:
 - a) Suicidal ideation
 - b) Homicidal ideation or aggressive or threatening behavior
 - c) Psychotic symptoms e.g. hearing voices, paranoia etc. that are leading to patient being at risk of harm to self or others.
 - d) Any change in behavioral status that makes them at risk of harm to self or others e.g. delirium (this is a medical diagnosis, but if the patient refuses to go to the Emergency Room or is combative, a Section 12 will be issued for transfer).
- 6) The BEST team will likely ask if we can accept the patient back; only do so if the patient is clearly assessed as not presenting a risk of harm to self or others, and that staff are comfortable with managing him/her. Do not accept the patient if he/she needs to be on 1:1.

PLEASE REMEMBER TO CALL THE PSYCHIATRIST ON CALL PRIOR TO CONTACTING THE BEST TEAM.

POLICY: MOCK CODES

Rationale: To prepare for potential codes

Procedure:

The Medical director or designee in consultation with the Director of Nursing or designee (DON) will determine when a mock code is to be performed.

Scenarios will be designed to simulate real-life emergency medical situations.

The staff will follow code response protocols for CODE BLUE and CODE GREEN and will simulate 911 call as necessary.

The Director of Nursing or designee and Medical Director (or their designee) will oversee and assess the responses of the clinicians and staff to the mock code.

Mock codes analysis is reviewed in Clinical Care Committee to determine need for further training.

POLICY: DNR/DNI Policy

1. All patients admitted to McInnis House Clinic/McInnis House with existing DNR/DNI orders must have a signed DNR/DNI order in their chart.
2. If the DNR/DNI order is from a physician not affiliated with the McInnis House Clinic/McInnis House, then a staff physician at McInnis House Clinic/McInnis House must verify with the patient upon admission his or her wishes regarding life-saving measures and must reflect this information in the patient's chart. The staff physician must subsequently complete a DNR/DNI form reflecting the patient's wishes.
3. Documentation by the MD in the patient chart must clearly state that a discussion took place between the MD and the patient with regards to the patient's wishes concerning life sustaining treatment. The types of interventions must be clearly outlined in the orders.
4. Admitting staff will discuss the admission timing with the medical director or designee or MD on call to ensure that either an existing DNR/DNI order will be verified and signed within 24 hours or that the MD will be present at the time of the patient's admission to discuss the issue with the patient and sign the DNR/DNI order.
5. Patients who are DNR/DNI will have an alert sticker on the front of their chart and will wear a Massachusetts Comfort Care/DNR bracelet.
6. A DNR/DNI order must be renewed with each admission.
7. If a DNR order exists and a patient is found in cardiac or respiratory arrest, then the following steps must be taken:
 1. Remove all other patients from the patient's room.
 2. Immediately notify the administrator and physician on call.
 3. The MD on site or on call must pronounce the patient.
 4. The medical examiner's office must be notified (617-267-6767) and, if arrangements have been made, then the funeral home should be notified.
8. If there is a doubt about how to proceed, whether to resuscitate or not, then staff should initiate life support measures.
9. Telephone orders for a DNR/DNI order will not be accepted.
10. Patients can change their mind at any time and terminate their DNR/DNI order. Above procedures for documentation will be followed.

POLICY: BIOCHEMICAL MARKERS FOR ACUTE CHEST PAIN

Biochemical markers for acute chest pain should **NEVER** be ordered at McInnis House Clinic.

Rationale: Acute myocardial infarction can be complicated by hemodynamic instability and life threatening arrhythmia. According to the GUSTO-1 study, as many as 10% of patients with acute myocardial (MI) infarction can have ventricular tachycardia or ventricular fibrillation. Most cases occur in the first 48 hours. Additionally, many patients with acute MI are candidates for percutaneous coronary intervention. Prompt restoration of myocardial blood flow can salvage myocardium and decrease mortality. Therefore, if you have enough suspicion to order a troponin or creatine kinase then the patient must be transferred to an acute hospital setting to allow for a higher level of monitoring and treatment. Delay in transfer can result in missed opportunity for reperfusion and complications such as hemodynamic instability and life threatening arrhythmia.

Procedure:

1. Never order serum biochemical markers (creatine kinase, troponin) at McInnis House Clinic.
2. If the differential diagnosis includes myocardial infarction or ischemia then the patient should be transferred to an acute care facility to allow for enhanced monitoring and treatment.
3. If you have a special circumstance then this needs to be discussed with the medical director or designee (i.e. a patient with chest pain who is competent and refusing to go to the ED)

POLICY: DISPOSITION ROUNDS at McInnis House Clinic/McInnis House

Purpose: To establish a format in which members of the health care team are able to discuss medical and psycho-social issues pertaining to each patient's discharge plan.

Rationale:

To establish improved communication between members of the health care team and facilitate the transition for each patient from the McInnis House Clinic/McInnis House.

Procedure:

- Disposition rounds will be held for each of the teams once each week.
- Present for disposition rounds will be: RN case manager, team case manager, team provider, supervising MD, psychiatrist, team nurse (as available).
- Discussion must include: medical diagnosis, treatment plan, progress, proposed discharge date, patient's own plans, barriers to discharge, i.e. psychiatric issues, benefits issues, previous behavioral issues.
- Discussion will be documented on the form designated "Team Treatment Plan" following the outline of this form.
- All treatment and discharge plans will be formulated in conjunction with the patient's primary care physician and other health care providers as warranted.
- The treatment plan will be discussed with the patient during new patient rounds and at regular intervals thereafter.

POLICY: REFUSAL OF CARE at McInnis House Clinic//McInnis House

Rationale: Our clinical staff follow appropriate guidelines and determine the medical and nursing needs of each patient based on their presenting symptoms and medical history and assessment. From time to time, a patient will refuse the care that we prescribe. It is a patient's right to refuse care but it is our responsibility to educate the patient, assess the patient's clinical competence and appropriately document this process.

Procedure:

1. If a patient refuses care (this includes, but is not limited to, emergency room transfer, taking medications, having labs drawn, etc) then the provider should inform their supervising MD, the medical director or designee and the director of nursing (or their designees).
 - a. Off hours, the nurses should inform the nursing supervisor and leave a message for the nursing director. The nursing supervisor will then use her discretion to determine if the on call provider needs to be notified.
2. The chart must reflect appropriate documentation with the patient, including discussion of consequences of refusing treatment and a clinical evaluation that the patient comprehends the consequences of his/her actions.

POLICY: MEDICATION BORROWING

Borrowing medications between patients is strictly prohibited. In the event of extenuating circumstances related to a patient's medical condition, staff must consult the medical director or designee.

POLICY: PRESCRIPTION PADS

Prescription pads are kept double locked in the Medical Director's office. The director or his/her designee is the only one who has access to these prescriptions. A record is kept of prescription distribution to providers

Prescriptions for daily use are given to the providers by the medical director or designee and kept under a double locked security cabinet in the third and fourth floor medication rooms. (Please see policy)

Prescription pads contain:

- a. A signature line for the practitioner's signature
- b. A line for the practitioner to print or type his/her name
- c. Below the signature line there is a space where the following words shall be printed, "Interchange is mandated unless the practitioner writes the words 'no substitution' in this space."
- d. The name and address of the clinic is printed on the prescription pad
- e. The prescription pad has space for the practitioner to write in their registration number, the date of issuance of the prescription, name/dosage/strength and quantity of medication, name and address of the patient, directions for use and a statement indicating the number of times to be refilled and space for the provider to enter clearly the name of the supervising physician
- f. Each prescription is sequentially numbered.

POLICY: INVESTIGATIONAL DRUG USE

Rationale: At times, patients are offered investigational drugs through their outside clinicians. Many times, these are experimental medications that may be the only option for alleviation of symptoms, treatment or cure.

Procedure:

1. A patient accepts the use of an investigational drug offered by an outside clinician
2. The patient's provider obtains details of the investigational drug and presents to the medical director or designee
3. The medical director or designee reviews the details and of the investigational drug and the ability to follow the set protocol at the McInnis House Clinic.
4. The medical director or designee approves or disapproves the use of this drug and notifies the provider, Director of Nursing or designee and program director.
5. Investigational drugs are stored as per clinic policy on medication storage
6. All investigational drug cases are reviewed at the P+T committee

POLICY: IN-HOUSE LABORATORY TESTS

The following tests are performed at the McInnis House Clinic and are covered under the CLIA waiver:

- Finger stick for glucose
- Urine ketones
- Urine dipstick
- Urine pregnancy test
- Urine toxicology test
- Stool guiacs
- Wet prep / KOH
- HIV testing (see separate policy)
- HAIC

POLICY: MEDICAL INFECTIOUS WASTE

Rationale: There is a color-coding system for waste and linen. Medical/Infectious waste is disposed of in red bags inside barrels.

Medical/Infectious waste includes:

1. Any disposable item visibly saturated with blood or body fluids;
2. Disposable barrier protection devices (gloves, masks, gowns, aprons) which are saturated with blood or body fluids;
3. Disposable suction containers;
4. Sharps (medical devices that may cause cut or puncture injuries) - to include disposable needles, syringes, broken glassware, scalpel blades, suture needles, and glass tubes with blood serum or other body fluids.

Procedure:

Sharps **must** be placed in leak proof, rigid puncture resistant containers. These containers (needle box) are mounted in all clinical areas.

An outside contractor is employed to collect and dispose of this waste per Department of Public Health regulations. Records are maintained by the Director of facilities or designee.

POLICY: MEDICATION ROOMS

Stock medications stored in the medication rooms will be checked on a monthly basis for date of expiration. Any expired medications will be disposed of and reordered as necessary. The nurse who checks will sign and date the Stock Medication Expiration Date Check List Form.

POLICY: REFRIGERATORS

All refrigerators for patient care

- Medication Room
- Laboratory specimen refrigerator
- Patients medically necessary nourishments

Will be cleaned on a monthly basis by nursing staff or designee. The staff member cleaning will sign and date the Refrigerator Cleaning sign off sheet for each refrigerator.

All refrigerators for staff use will be cleaned by maintenance and housekeeping staff.

(See attached form)

POLICY: MEDICAL SUPPLIES FOR MCINNIS HOUSE CLINIC

Policy: Clinics on each floor are stocked from the main medical supply room. The main medical supply room will be checked for the appropriate quantity of medical supplies on a weekly basis.

Procedure:

- Supplies will be reordered as needed.
- The manager or designee will then sign the medical supplies inspection and inventory signing sheet on a monthly basis.
- Individual clinics will be stocked as needed.
- The main medical supply room will be checked for expired, soiled, or damaged items on a monthly basis. This will be done by the day shift manager or his/her designee.
- All expired, soiled or damaged items will be discarded and reordered as necessary.
- Individual clinics will be checked monthly for expired, soiled or damaged items. The clinic area inspection signing sheet will be completed.

There will be one clipboard containing inspection signing sheets on each floor.

In General

If a staff member at any time notes that a medical supply is expired or that the integrity of the packaging is damaged, s/he should discard the item and notify the manager to reorder such supplies.

**MEDICAL SUPPLIES INSPECTION
AND
INVENTORY SIGNING SHEET**

DATE	TIME	SIGNATURE	INVENTORY DONE Y/N	INSPECTION DONE Y/N

POLICY: LINEN AND LAUNDRY

Purpose: To allow for the proper handling of soiled linen and laundry. To assure the proper storage of clean linen and laundry.

All soiled linen and laundry will be handled according to universal precautions.

Procedures:

Clean linen will be brought to the floors on a daily basis by the nursing staff or designees. Clean linen will be stored in a non-patient area and will be kept covered at all times.

POLICY: HEALTH AND SAFETY - PREVENTIVE MAINTENANCE PROCEDURES

1. Once a month, the maintenance staff will evaluate all non-electrical equipment used in the clinic areas for safety of use.
2. Outside vendor reviews all electrical equipment annually. The Manager of Clinical Support Services or designee ensures that this inspection takes place and that all of the electrical equipment is operational and is safe.
3. All scales, which are used in the clinics, will be inspected annually by the City of Boston Division of Weights and Measures (also checks all electric scales) to ensure their accuracy. The Manager of Clinical Support Services ensures that this inspection occurs.
4. If an item is believed to be unsafe and cannot be repaired immediately, the maintenance staff person will:
 - a. Notify the Nurse Manager immediately;
 - b. If possible, remove the item from the clinic area and label appropriately.
 - c. Notify the Manager of Housekeeping and Maintenance to arrange for repair or replacement.
5. After completion of the inventory, the maintenance staff member will sign and date the Preventive Maintenance Log (*Attachment PREVENTIVE MAINTENANCE LOG*)
6. The log will remain in the possession of the Director of facilities.

PREVENTIVE MAINTENANCE LOG

DATE	TIME	SIGNATURE	COMMENTS

POLICY: CLINIC CLEANING

Policy: The McInnis House Clinic will be maintained in an appropriate manner to provide quality patient care.

Procedures:

A. Daily Schedule

1. The clinic will be cleaned thoroughly on a daily basis and as needed throughout the day by the housekeeping staff.

Duties include: emptying waste containers; dusting work surfaces and equipment; sweeping and damp mopping the floor; washing all examination tables, work areas and sinks with a bacteriocidal cleanser, and attending to noticeably soiled areas.

2. Clinical staff will wash the examination tables and any contaminated surface with a bacteriocidal cleanser after each use.
The cleanser will be stored under the sink in every exam room.
3. If housekeeping staff is not available and a spill occurs in the clinic, nursing staff will be responsible for cleaning the spill according to appropriate infection control protocols.

B. Weekly Schedule

The clinic will be deep cleaned on a weekly basis by the housekeeping staff. Duties include: All of the daily cleaning tasks; vacuuming; washing the walls, light fixtures, equipment, and floor.

POLICY: POLICY REVIEW

Rationale: McInnis House Clinic policies need to reflect the actual clinical and non-clinical practices of the McInnis House Clinic.

Procedure:

To ensure that policies are up-to date and accurate, policies will be reviewed annually at a minimum by members of the Clinical Care Committee.

Policies will be reviewed and the review will be ongoing as policies are developed.

It will be the responsibility of the Clinical Care Committee to oversee the policy review process and approve all policies.

Policies will be made available at anytime to staff and representatives of the Department of Public Health.
Retired policies will be kept in director's office or designee.

Policies will be brought to the Board of Director for approval on an annual basis.

POLICY: MCINNIS HOUSE CLINIC TOTAL QUALITY MANAGEMENT PLAN

Purpose: The staff, administrators, and Board of Directors of the Boston Health Care for the Homeless Program embrace the concepts of Total Quality Management (TQM). We recognize that this is an ongoing process (continual quality improvement) rather than a static approach to evaluating or insuring quality care and services.

Procedure:

The Clinic Administrator/Director of the McInnis House Clinic and/or Medical director or designee is responsible for insuring that we implement the concepts of TQM. The primary mechanism to develop and monitor TQM will be through the Clinical Care Committee (CCC).

The CCC is multidisciplinary in nature and has been in existence since the inception of the McInnis House Clinic Program (McInnis House Clinic). At a minimum the Committee will consist of the Director, Medical Director (M.D.), Director of Nursing or designee, RN case manager, Manager of Clinical Support Services. A staff RN and a staff NURSE PRACTITIONER OR PHYSICIAN ASSISTANT are encouraged to attend. The Committee will be open to other staff members of BHCHP.

The CCC will meet at least 8 times annually and will have a core agenda along with a variable agenda to meet the identified needs. Members of the Committee may review areas including but not limited to: utilization data, discharge disposition, all staff and patient incident reports (non-medication related), programming changes, patient complaints, issues related to OSHA compliance, and relevant infectious disease issues.

The responsibility for continually evaluating the effectiveness of medication prescribing and administration will be the Pharmacy and Therapeutics Committee that the Medical director or designee of the McInnis House Clinic chairs. The Committee will consist of at least the Medical director or designee, Director of Nursing or designee, consulting Pharmacist, and a staff RN, and a Physician Assistant or Nurse Practitioner.

The P & T Committee members will review all incident reports and audits as related to medications and will classify all medication errors. Nursing and Medicine will be responsible for reporting on interventions, which had been made to investigate and resolve the errors. All Schedules II - V discrepancies will be reviewed with their corresponding reports to the Massachusetts Department of Public Health and the Drug Enforcement Administration.

Recommendations that come from the CCC or the P & T Committee will be brought to the department staff meetings at the McInnis House Clinic for discussion. Also, problems, ideas, and issues from the monthly staff meetings are brought back to either P & T or the CCC.

Each Department Director is also responsible for bringing issues and ideas back to their respective discipline for discussion. The Nursing Department will meet at least 10 times annually and the Providers (MD, PA, NP) will meet at least bi-monthly as a group.

The Director will be responsible for assembling Task Forces to address continual quality improvement issues. Examples of these Task Forces are the Patient Outcomes and the Expansion Task Force. Each Task Force has been and will continue to be multidisciplinary in make-up and will incorporate key personnel. The minutes of these meetings will be made available to all staff and will be discussed at the staff meetings.

Nurse Practitioners and Physician Assistants will receive supervision as described in the: Boston Health Care for the Homeless Program, The McInnis House Clinic, Guidelines For Physician Assistant Practice: Physician/Physician Assistant Collaboration Agreement and Guidelines For Nurse Practitioner Practice: Physician/Nurse Practitioner Collaboration Agreement.

POLICY: SERIOUS INCIDENTS

Serious incidents are defined as any occurrence which will seriously affect the health and safety of patients. This includes, but is not limited to: fire, suicide, serious criminal acts, patient fall with serious injury or pending strikes by employees.

In the event of a serious incident it is mandatory that the Nurse Manager notify the McInnis House Director of Clinical Operations or designee immediately via beeper. At her discretion, the Director will notify the Medical director or designee and the Director of Nursing or designee.

The Department of Public Health will be notified via telephone immediately and will follow with a written report within one week at the discretion of the Administrator.

The Director will follow the Department of Public Health reporting guidelines.

POLICY: PATIENT COMPLAINT PROCESS at McInnis House Clinic/McInnis House

Rationale: All patients have the right to make a complaint about the care they receive and to have this complaint addressed in a timely, compassionate and comprehensive way. The complaint process is an important tool for administration and clinical staff to learn about the patients' perceptions and experiences and much can be learned from patients in the ongoing attempt to improve the overall quality of patient care.

Procedures:

Notice of Patient Rights is posted in all patient areas. Patients are encouraged to bring serious complaints to the attention of the staff and/or to the attention of the Program Director or designee. This information will be received by the Program Director or designee within one day from clinic staff, in writing. The Program Director or designee completes the Patient Complaint Form(see following page). The Program Director or designee will proceed with a fact-gathering investigation and create a complaint file that includes the original report of complaint, progress reports as investigation is carried out, and outcome by investigation including action taken. The complainant is notified of the outcome of the investigation. The patient complaints are to be brought to the Quality and Efficiency Committee for review. They are also available for inspection by Department of Public Health agents.

PATIENT COMPLAINT REPORT FORM

PATIENT NAME:

DATE & TIME OF COMPLAINT:

NATURE OF COMPLAINT:

WHAT ACTIONS/PROCESS WERE TAKEN:

RESULTS/OUTCOMES & NEXT STEPS:

SIGNATURE:

DATE & TIME OF FINAL REPORT:

POLICY: WAIVERS FOR HAND RUBS AND MASSAGE

Rationale: At times, volunteers trained in hand rubs and/or massage services offer these services at MCINNIS HOUSE. These services are not part of the standard medical care at MCINNIS HOUSE so a waiver form is requested for this voluntary service.

Procedure:

If a patient would like to participate in this service, they are asked to:

- a. Review the contraindications of the service as explained by the volunteer
- b. Sign a waiver form for the service (see attached)
- c. The therapist will consult the clinical staff prior to seeing each patient.
- d. A copy of the waiver form is kept in a separate binder (separate from medical record) by the volunteer.

BOSTON HEALTH CARE FOR THE HOMELESS PROGRAM, INC.

Hand Rub Client Waiver

CONFIDENTIAL

Please review each statement and sign and date below.

1. I understand that the hand rub is for the purposes of stress reduction and general relaxation.
2. I understand that the hand rub volunteer does not diagnose illness, disease, or any other physical or behavioral disorder. The volunteer does not prescribe medical treatment of pharmaceuticals. It has been made clear that hand rubs are not substitutes for medical examination or diagnosis and that it is recommended that I see a medical practitioner for any physical ailment that I may have.
3. I understand that services offered today, and in the future are not a substitute for medical care and that any information provided by the volunteer is for educational purposes only, and is not diagnostically prescriptive in nature.
4. I have reviewed the list of hand rub contraindications and have notified the volunteer of any that I may have. I have consulted a medical doctor or licensed medical health care practitioner regarding these and any other medical conditions I may suffer from.

By signing this release, I hereby waive and release the Boston Health Care for the Homeless Program, Inc. and its staff, and hand rub volunteers from any and all liability, past, present, and future relating to hand rubs.

I hereby affirm that I have read and fully understand the above and agree to be legally bound by it. I also affirm that I am over 18 years of age.

PATIENT'S NAME: _____

PATIENT'S SIGNATURE: _____

DATE: _____

Volunteer SIGNATURE: _____

BOSTON HEALTH CARE FOR THE HOMELESS PROGRAM, INC.

Massage Therapy Client Waiver

CONFIDENTIAL

Please review each statement and sign and date below.

5. I understand that massage therapy and body work are for the purposes of stress reduction, relief from muscular tension and spasm, general relaxation, and improvement of circulation and energy flow.
6. I understand that the massage therapy provider does not diagnose illness, disease, or any other physical or behavioral disorder. The practitioner does not prescribe medical treatment of pharmaceuticals, nor does he/she perform any spinal manipulations. It has been made clear that massage therapy and bodywork are not substitutes for medical examination or diagnosis and that it is recommended that I see a medical practitioner for any physical ailment that I may have.
7. I understand that services offered today, and in the future are not a substitute for medical care and that any information provided by the therapist is for educational purposes only, and is not diagnostically prescriptive in nature.
8. I have consulted a medical doctor or licensed medical health care practitioner regarding any described conditions. And I have reviewed the list of contraindications for massage.

By signing this release, I hereby waive and release the Boston Health Care for the Homeless Program, Inc. and its staff, and massage therapy providers from any and all liability, past, present, and future relating to massage therapy and bodywork.

I hereby affirm that I have read and fully understand the above and agree to be legally bound by it. I also affirm that I am over 18 years of age.

PATIENT'S NAME: _____

PATIENT'S SIGNATURE: _____

DATE: _____

THERAPIST SIGNATURE: _____

POLICY: SMOKING

In order to maintain consistency with our mission to promote good health, the McInnis House Clinic has been designated as a non-smoking facility.

Smoking is prohibited within all areas of the McInnis House Clinic, and is allowed only in the designated outdoor area. Employees are to smoke in the designated area.

POLICY: FIRE DRILLS AT JEAN YAWKEY PLACE

1. Fire drills will be conducted twice per year on each of the three shifts.
2. The Director of Facilities will be responsible for scheduling the dates and times of these drills.
3. All staff on each shift will participate in each drill as outlined in the facility's fire drill plan (Attachment 1).
4. A written report of each fire drill will be completed and maintained on file at the facility (Attachment 2). All reports will be reviewed by the Facility's Operations Committee and, if indicated, the BHCHP Quality and Efficiency Committee/Emergency Preparedness Task Force.
5. The Facility's Operations Committee will formally review the fire drill and fire evacuation plans at least annually, and will revise them as necessary.

Effective date: _____

Approved by: _____

Medical Director

Director of Clinical Operations

Operations Committee Members

Director of Facilities

Nurse Manager

Director of Dental

Director of Respite

FIRE DRILL PLAN AND PROCEDURES (Attachment 1)

Goals of fire drills:

1. Fire drills will be conducted at the Jean Yawkey Place twice per year on each shift. The goal of the fire drills is to ensure that all staff knows what to do in the event of a real fire. The fire drill provides the opportunity to assess where staff is not familiar with the procedures and what trainings must occur to ensure that all staff knows how to respond quickly and efficiently in the event of an actual fire and in ensuring patient and staff and building safety.

Overall Fire Drill Roles and Responsibilities

Fire drill command staff:

Incident Commander: Nurse Manager/Respite
Nurse Manager/Clinic

Organizes and directs operations of staff during the fire drill
Overall responsibility for the safety of the building and its occupants
Ensures all staff complies with fire drill responsibilities

Operations Officer: Director of Facilities or Designee

Advises incident commander
Provides administrative authority and information to the incident commander
Decides when fire drills will be conducted and scheduled for all shifts

Specific roles and responsibilities

2. The **Operations Officer (Director of Facilities)** in coordination with the Operations Team will be responsible for:
 - (a) Scheduling the dates and times of each fire drill with J. & M. Brown Alarm Company, who will notify the Boston Fire Department that the facility's master alarm box will be off-line during the fire drill;
 - (b) Directing the Incident Commander (Nurse Manager) of the given shift to activate a fire alarm detection device to initiate the fire drill.
 - (c) Designate an observer for each area who will assess and evaluate the responses of the staff to the fire drill and identify where staff need training on fire drills so as to ensure safety during a potential real fire.
 - (d) Observing and noting where problems which need maintenance and repair might occur such as fire doors not closing automatically.
 - (e) Maintains Facility's Fire Drill Reports

3. The Nurse Manager will act as the **Incident Commander**
 - (a) Activating the fire alarm detection device as directed by the Director of Facilities
 - (b) The Nurse Manager will identify the location of the fire on the panel located at the 1st Floor Lobby Security desk and the 2nd Floor Security Desk.
 - (c) Sending another runner/designee to each of the other two floors to instruct staff on those floors to review floor specific census and informing the staff on the other floors of the location of the fire; After the census is checked it is to be immediately returned to Incident Commander when it is completed so that all patients are accounted for
 - (d) Directing the actions of other unit staff;
 - (e) Completing the Fire Drill Report and having each staff member sign the attendance sheet as having participated in the drill;
 - (f) Announcing the "All Clear" after the Fire Drill has been completed and the fire alarm detection system has been reset.

4. **All other staff** on each floor will remain calm and will be responsible for:
 - (a) Taking a census on that floor to make sure all patients/staff are accounted for on that floor and giving this report to the Incident Commander;
 - (b) Quickly clearing the corridors of all patients and equipment;
 - (b) Reassuring patients that this is a fire drill and not a real fire and ensuring that all patients are secure in their rooms with the door closed;
 - (b) Closing all doors to patient rooms and clinics and team rooms
 - (b) Ensuring no patients are remaining unaccounted for in the Interview room or clinics or hallway bathrooms
 - (c) Closing the fire doors in the area of the fire alarm if they do not close automatically;
 - (d) Reporting to the nurses' station for further instructions from the Incident Commander;
 - (e) Remaining on stand-by until the "all clear" has been given.

5. **Facilities staff** will be responsible for:
 - (a) Remaining on alert and responding and helping as directed by the Incident Commander (Nurse Manager).
 - (b) Remaining on stand-by until the "all clear" has been given.

6. **Security staff** on the first floor will be responsible for:
- (a) The elevator will dump to the 1st floor and doors will remain open.
 - (b) Preventing unauthorized entry to or exit from the building during the drill;
 - (c) Evacuating any staffs and patients from the 1st floor and direct to the parking lot in the rear of the building
 - (d) Checking census with the names of the people in the back of the building who have been evacuated from the 1st floor
 - (e) Assisting clinical or facilities staff as directed.

FIRE DRILL REPORT

DATE: ____/____/____

START TIME: ____AM / PM

END TIME: ____AM / PM

SCHEDULED DRILL: YES NO

OTHER (explain): _____

Location of review: 1st floor 2nd floor 3rd floor 4th floor Basement (Please circle one)

INSPECTION CONDUCTED BY: _____

OBSERVATIONS

- | | | |
|---------------------------------------|---------|---------|
| 1. Staff responded promptly | Y _____ | N _____ |
| 2. All employees participated | Y _____ | N _____ |
| 3. Alarm System worked | Y _____ | N _____ |
| 4. All room doors closed | Y _____ | N _____ |
| 5. Corridor fire doors closed | Y _____ | N _____ |
| 6. Corridors unobstructed | Y _____ | N _____ |
| 7. Elevator secured from use in lobby | Y _____ | N _____ |
| 8. All patients accounted for | Y _____ | N _____ |
| 9. All staff accounted for | Y _____ | N _____ |
| 10. Sprinklers Inspected | Y _____ | N _____ |
| 11. Exit Signs Inspected | Y _____ | N _____ |
| 12. Stairwells unobstructed | Y _____ | N _____ |

Problems Identified	Actions Taken
1.	1.
2.	2.
3.	3.
4.	4.
5.	5.
6.	6.
7.	7.
8.	8.
9.	9.
10.	10.

Fire Drill Report

Drill Evaluation: Excellent Very Good Good Fair Poor

Comments:

Attendance of all Employees Present

Employee Name	Signature	Department	<u>Observer's Use Only</u> (Please indicate if employee was responsive or not on fire drill responsibilities)	
			YES	NO
1.				
2.				
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				
11.				
12.				
13.				
14.				
15.				
16.				
17.				

POLICY: FIRE EVACUATION

Rationale: According to the US Fire Administration, the United States has one of the highest fire death rates in the industrialized world. All staff must know the Jean Yawkey Place Fire Drill and Fire Evacuation policies and procedures in the event of a real fire and know how to evacuate the building quickly and efficiently in the event of a real fire in order to save lives and prevent injury to everyone.

Procedures:

1. **In the event of an actual fire, the primary responsibilities of all personnel are to:**
 - (a) Save the lives of all persons in immediate danger from smoke or fire;
 - (b) Contain the fire area until the Fire Department arrives;
 - (c) Assist in the evacuation of patients to a safe location, if such action is warranted;
 - (d) Provide assistance to the Fire Department as directed.

2. Any employee who discovers a fire must **IMMEDIATELY:**
REPORT THE FIRE
 - (a) Activate the nearest fire pull station;
 - (b) Notify the Nurse Manager/Director of Facilities who is now the Incident Commander until the Fire Department arrives

3. The **Incident Commander** (Nurse Manager/Director of Facilities) will calmly:
 - (a) Incident Commander will go to fire panel at security desk at 1st floor security desk or 2nd floor security desk to determine location of fire
 - (b) Send a runner/designee to each floor to announce location of fire and check the census;
 - (c) Implement the facility's fire response/evacuation plan;
 - (d) Assume direction of ALL personnel until the arrival of the Fire Department
 - (e) Notify Management Team as soon as possible

4. All Jean Yawkey Place staff that is present will assist as outlined in the facility's fire response/evacuation plan (Attachment 1).

5. A written report of the fire will be completed and maintained on file at the facility (Attachment 2). All reports will be reviewed by the Facility's Operations Committee and, if indicated, the BHCHP Quality and Efficiency Committee/Emergency Preparedness Taskforce

6. The facility's Operations Committee will formally review the fire drill and fire evacuation plans at least annually, and will revise these as necessary.

JEAN YAWKEY PLACE
FIRE RESPONSE/EVACUATION PLAN
AND
PROCEDURES

A. In General

1. Any employee who discovers a fire must **IMMEDIATELY**:

- (a) Activate the nearest fire pull station;
- (b) Notify the Director of Facilities.

NEVER assume that someone else will do this. Prompt action is critical.

2. The Nurse Manager as the Incident Commander will:

- (a) Incident Commander will go to fire panel at security desk at 1st floor security desk or 2nd floor security desk to determine location of fire
- (b) Send a runner/designee to each floor to announce location of fire;
- (c) Notify the Director of Facilities immediately;
- (d) Implement the facility's fire response/evacuation plan;
- (e) Assume direction of ALL personnel until the arrival of the Fire Department, Director of Facilities,
- (f) Determine whether and to what extent evacuation of patients is necessary.

B. Fire Response

- 1. Regardless of the location of the fire, all persons who are in the area of the fire must be removed first to the nearest safe location. This location will depend upon the severity of the fire and will be determined by the individual in charge. Refer to the **Evacuation** section below for more detailed procedures regarding the movement of persons at risk.
- 2. Close off the fire area, if possible, to prevent the spread of smoke, gas, or fire. Close all doors in the immediate area.
- 3. The deployment of personnel to the fire area will be determined by the individual in charge.
- 4. All personnel responding to the fire area will contain the fire with the equipment on hand.

C. **Evacuation**

1. The individual in charge will determine whether evacuation is necessary, and to what extent. Under certain conditions, it may be safer to close off the affected area and keep patients in their rooms or staff in offices or in a designated safe location than to evacuate them.
2. **In the event that evacuation of patients is necessary, the following procedures should be followed:**
 - (a) Turn off any oxygen equipment in use and move oxygen tanks away from the fire area.
 - (b) Personnel designated by the Incident Commander (individual in charge) will lead all ambulatory patients to the nearest exit stairwell, and they will go downstairs and around the building and to the rear parking lot.
 - (c) Personnel designated by the individual in charge will move **non-ambulatory patients by wheelchair** to the nearest fire stairwell. These patients **SHOULD NOT** be brought down the stairwell unless an imminent danger exists. **The Fire Department will assist in the evacuation of patients from the stairwells, and staff must remain with these patients until evacuation is completed.**
 - (d) As patients are moved to the stairwells to be evacuated, the doors to their rooms should be closed.
4. During the evacuation process, the automatic fire doors should never be blocked by persons or equipment.
5. **The Nurse Manager is responsible for accounting for the presence of all patients by using the daily census sheet on Respite floors. On Administrative Floors ALL Department Managers and members of the Management Team in those areas will be responsible for accounting for each member of their staff and for instructing their staff to walk quietly and calmly down the stairwells thru exit doors and meet in the rear parking lot of the building. Staff are to remain in this area until further instructions are given.**
6. Once evacuation is completed, no one may reenter the building without the authorization of the Fire Department

SUMMARY OF RESPONSIBILITIES (in moving/evacuating patients)

I. Facility and Administrative Staff should remain calm and

- A. Elevators will automatically dump to the 1st floor and doors will remain open. If the fire is on the 1st floor the elevators will dump to the basement and doors will remain open.
- B. Assist in closing off the area of the fire.
- C. Assist in containing the fire.
- D. Assist in evacuating patients and other persons in danger, and in moving equipment as directed.
- E. Terminate all utilities within the building at the direction of the Fire Department.
- F. Remain on alert and respond as directed by the individual in charge.

II. Security staff should remain calm and

- A. Assist with the evacuation of persons in immediate danger and move all patients on the ground floor out the doors to the rear parking lot
- B. Confirm that elevators are secure.
- C. Prevent unauthorized entry to or exit from the building or specific fire areas.
- D. Direct the Fire Department upon its arrival to the location of the fire and the individual in charge.
- E. Remain on alert and respond as directed by the individual in charge.

III. Clinical Staff should remain calm and

- A. Assist with the evacuation of persons in immediate danger.
- B. Assemble and remain with patients in the safe area, after evacuation this is in the rear parking lot. Before evacuation remain with wheelchair patients who are waiting to be evacuated at the top of the stairwells or accompany ambulatory patients down the stairs and walk them to the safe area in the rear of the building.
- C. Account for the presence of all patients in the facility.
- D. Assist in containing the fire, as directed.

Remain on alert and respond as directed by the individual in charge.

General Principals: The following are general precautions to follow during a real fire. These principles can be applied wherever you are in a real fire.

The following precautions should be taken during a fire related evacuation: (Source: Jane's Workplace Security Handbook Copyright 2002). There is a sprinkler system in the building which will activate in the event of a fire and smoke.

Remain calm

Stay **low to the ground and cover your mouth** if there is smoke present

If clothes catch fire, **stop, drop to the ground and roll**

If there is smoke or fire in the nearest escape route, use your alternate escape route. If you must exit through smoke, crawl low under the smoke and cover your mouth.

If escaping through a closed door, feel the door and the door handle/knob before opening it. If they are warm, use an alternative escape route.

If smoke, heat or flames block exit routes, stay in the room with the door closed and signal for help using a bright colored item at the window.

NEVER use elevators during a fire

DO NOT risk life by attempting to **extinguish the fire**

DO NOT WASTE TIME by **collecting personal items**

ALWAYS follow Fire Department instructions

Please make sure you are aware of where the locations of the fire extinguishers in the building. **It is everyone's responsibility!**

1st Floor: See diagram attached

2nd Floor: See diagram attached

3rd Floor: See diagram attached

4th Floor: See diagram attached

Basement: See diagram attached

POLICY: SUPERVISION OF PHYSICIAN ASSISTANTS AND NURSE PRACTITIONERS

1. Physician supervision of all Nurse Practitioners and Physician Assistants will conform with all applicable state regulations, the requirements of each practitioner's regulatory board, and the policies and procedures of the McInnis House Clinic.
2. Written approval for physician supervision of physician assistants will be obtained from the Board of Registration in Medicine as required per 243 CMR 2.08. Any given physician will not supervise more than 4 physician assistants at any one time.
3. Physician Assistants will practice according to written guidelines which will be mutually developed between the physician assistant and supervising physician in conformance with 263 CMR 5.00 et. seq.
4. Nurse Practitioners will practice according to written guidelines which will be mutually developed between the nurse practitioner and supervising physician in conformance with 244 CMR 4.00 et. seq.
5. All nurse practitioners will apply for prescriptive privileges in accordance with 105 CMR 700.003 et. seq.
6. If the PA or NP does not have prescriptive privileges, all medication orders written must be cosigned immediately by a physician or NP/PA who has prescriptive privileges. For prescribing privileges, see Med. Policy.
7. All NP/PAs have malpractice insurance under FTCA through Boston Health Care for the Homeless Program, Inc.

See "BHCHP guidelines for practice" for details

POLICY: PRACTICE PROTOCOLS FOR NURSE PRACTITIONERS AND PHYSICIAN ASSISTANTS

UpToDate online and RxDx online have been adopted as the practice guidelines for Nurse Practitioners, Physician Assistants and MD's.

All clinical staff have access to UpToDate online and RxDx online.

POLICY: LICENSE RENEWALS FOR REGISTERED NURSES AND LICENSED PRACTICAL NURSES

1. It is mandatory to verify license status and licensee standing with the Board of Registration of Nursing prior to offering employment
2. Proof of licensure renewal is required to be presented to the Human Resources every second year on employee's birth date. The original license must be presented for verification. A front and back photocopy of the signed license will be maintained in Human Resources.
3. License renewal for Registered Nurses is every two (2) years and is granted on the even years. License renewal for LPN's is every two years on the odd numbered years.
4. It is the individual responsibility of the nurse to maintain authenticated records of continuing education offerings completed.

POLICY: NURSING CLINICAL POLICY

BOOK: Galias, Delores RN, A.R.T. Resident Care Policies and Procedures for Nursing Facilities.
3rd edition: Briggs, Stock No. 7384

This is the official Nursing Procedure Book for all current nursing practice at the Barbara M. McInnis House Clinic/McInnis House.

RxDx and UpToDate are available on line to all nursing staff.

POLICY: NURSING INTERSHIFT REPORTS

Rationale: Shift reports provide an informational bridge from one shift to another. The report should be informative enough so that no gaps are left in the continuity of care for each patient; it should convey all pertinent facts about care given during the shift.

1. Intershift may be verbal or written and should include:
 - A. Date, shift, patient census, special diet orders, discharges, transfers, admissions, patients out at appointments.
 - B. Brief account of patient's chief complaints or reason for admission.
 - C. Significant past Medical History.
 - D. Other significant issues

POLICY: INSERVICE TRAINING

Rationale: In-service trainings will be offered at the McInnis House Clinic no less than eight times per year and will include at least two CPR courses.

Staff members will be strongly encouraged to attend the in-services at the Boston Health Care for the Homeless Program, including Grand Rounds.

Staff will also be encouraged to attend trainings at Boston Medical Center where a formal agreement exists between the two institutions.

The following in-services are mandatory annually:

- Occupational, Safety and Health Administration - All staff
- CPR - Refer to CPR policy (every two years)
- Patient Rights, HIPAA, Sexual Harassment, Safety - All staff
- Monthly new staff Orientation - All staff

POLICY: HOLIDAY COVERAGE POLICY

Rationale: On official BHCHP holidays the medical staff at MCINNIS HOUSE is consists of four providers who are responsible for the 104 patient in house. Given that this is a 24 hour facility we need to have clear guidelines for the responsibility for this holiday coverage.

Procedure:

1. Four providers will be assigned to cover MCINNIS HOUSE during a holiday.
2. Two providers are primarily on the third floor and two providers are primarily on the fourth floor.
3. A daily progress note should be written on each patient.
4. Each patient is discussed with the team nurse to determine which patients to see first.
5. All admissions on holidays will be cleared with the medical director or designee.
6. Any patients that are sick or need further attention or immediate actions on the day after the holiday should be signed out to the provider on call and a note should be left for the team provider.

POLICY: SCHEDULE II PRESCRIPTION WRITING POLICY AT BARBARA MCINNIS HOUSE

Rationale: To maintain compliance with federal and state regulations as well as Massachusetts Board of Registration in Medicine and the Massachusetts Board of Registration in Nursing prescribing policies and guidelines and to adhere to the Boston Health Care for the Homeless Program policies and procedures surrounding the ordering and prescribing of Schedule II controlled substances.

General Information:

1. Schedule II controlled substances can only be ordered by properly licensed NP/PA/MD in accordance with federal and state laws.
2. Prescriptions must be issued in the usual course of professional practice and for a legitimate medical purpose. In order to establish a proper diagnosis and regimen of treatment, at a minimum, on first encounter a provider must:
 - a. Take and record an appropriate medical history.
 - b. Perform an appropriate physical exam and/or behavioral status exam and record results.
3. Follow the U.S. Drug Enforcement Administration Prescription Guidelines, as well as the Commonwealth of Massachusetts Board of Registration in Medicine and Board of Registration in Nursing Prescribing Practices Policy and Guidelines.
4. Upon admission to Barbara McInnis House (MCINNIS HOUSE), an initial supply of the Schedule II controlled substance will be prescribed for the patient. Once a patient has been admitted, medically deemed necessary Schedule II controlled substances are ordered on Mondays (4 day supply) and Fridays (3 day supply).
5. As per MCINNIS HOUSE policy, all provider orders are reviewed and re-written every 30 days.

Procedure for writing Schedule II Prescriptions:

1. The metal double-lockboxes containing the required prescriptions and marble notebook are located in the 3rd and 4th floor locked medication rooms.
2. Hand -write a legible hard-copy prescription on BHCHP carbon-copy prescription pad found in the metal lockbox.
 - a. Note **patient name**
 - b. Note **drug name**, dose, strength, concentration, frequency of doses and quantity dispensed
 - c. DEA number should be clearly hand-written or stamped
 - d. Clearly print or stamp name under signature
 - e. Indicate 'no refill'
3. Record script in marble notebook in metal lockbox
 - a. Note date, prescription number, patient name, medication name, dose, strength, frequency of doses and quantity dispensed.

4. Leave carbon copy of prescription in metal lock-box
5. Package original prescription in 5x7 manila envelope with orange sticker on it. (Supply found on top of metal lockbox).
 - a. Leave envelope in clear folder attached to wall by metal lockbox for pharmacy to pick up.
 - b. Pharmacy technician will obtain manila envelope from nursing staff three (3) times a day on **Monday** and **Friday**: 10 A.M., 12 noon and 4 P.M.
 - c. On **Tuesday, Wednesday** and **Thursday**, the pharmacy technician will pick up the prescriptions at 12 noon and if a clinician calls to notify them that a prescription has been written before or after that time.
 - d. On **week-ends**, no pharmacy technician is available. A pharmacist is available from 9 A.M. to 3 P.M. If a Schedule II controlled substance needs to be ordered during that time, the provider will call the pharmacist and notify him/her that a Schedule II has been written. The provider will either take the script to the pharmacy or they will arrange a pick-up time.
 - e. On **holidays**, there usually is a pharmacy technician available. If a Schedule II controlled substance needs to be ordered, the provider will call the pharmacy and notify them that a Schedule II has been written. The technician will make rounds at 1:30 P.M. and deliver medications. Schedule II's cannot be ordered or delivered after that time.

References:

Commonwealth of Massachusetts Board of Registration in Medicine Prescribing Practices Policy and Guidelines. 12.12.01, pp. 16-25

Commonwealth of Massachusetts Board of Registration in Nursing Practice and Prescriptive Guidelines; regulations 244 CMR

POLICY: ESCORTING PATIENTS TO APPOINTMENTS

Rationale: To ensure that patients are able to safely go to their appointments that are located outside McInnis House Clinic.

General Information:

1. Due to the close proximity to McInnis House Clinic, patients who have appointments at BMC, in the Yawkey Ambulatory Care Center, the Menino Pavilion and the Moakley Building are not be transported by the van.
2. Patients often require assistance getting to appointments due to underlining medical and psychiatric conditions, and also due to behavioral issues.
3. It is the providers' responsibility to determine which patients need this assistance based on a clinical assessment.
4. The two types of assistance are, (a) an escort and (b) a buddy.
 - a. An escort is a staff member assigned to accompany the patient to and from the building where the appointment is located. This includes transportation by van. They do not accompany the patient into the building.
 - b. A buddy is a staff member assigned to accompany the patient to and from the appointment, AND remains with the patient during the entire appointment.

Procedure:

1. When a patient has an outside appointment, based on a clinical assessment, the provider will document in the Appointment & Transportation Sheet if a patient needs (a) an escort, (b) a buddy, or (c) can go to appointment without assistance.
2. The unit secretaries will make arrangements for all escort requests. The providers will arrange all buddy requests with the scheduler in the Nursing Department.

POLICY: PATIENTS BELONGINGS

Rationale: To establish a process of handling patient's belongings upon admission and discharge.

Procedure upon admission:

Upon admission, the admission nurse will notify the referring source of our **2 bag policy** to avoid patients bringing more belongings than they are allowed to. If patient presents with more than 2 bags, they will be asked to size down. All patient belongings upon admission as well as discharge will be searched.

After a patient is admitted, a respite aide will provide the patient with a MCINNIS HOUSE admission kit which includes, toiletries, socks, 2 towels and 2 wash cloths. Admission kit will also include an informative cheat sheet referring to patient services provided at the MCINNIS HOUSE.

If any clothing is needed, the case manager will assess the clothing need and will leave a request with the clothing volunteer.

The Benefits Coordinator will review Patient Conditions and guidelines including use of the TV, meal times, visiting hours, laundry hours, food policies, smoking, vitals signs, and TV rules.

In the event that the Manager of Clinical Support Services is not available, patients are encouraged to ask the RN Supervisor to lock the valuables temporarily in the lock box. The next business morning **all valuables** stored in the lock box will be checked by the manager of clinical support services and will be locked up in her office and logged into the patient valuables logbook. The patient is given a receipt of these items, including any money that needs to be secured.

Procedure upon discharge:

When a patient leaves the McInnis House Clinic AMA/ AWOL and abandons his or her belongings, the belongings will be placed in a bag labeled and dated.

All labeled bags will be entered in the Patient Storage Log. These belongings will be stored for up to 72 hours in the event that the patient might return to claim them. All patient belongings will be stored in the closet in the Dave Walker Lobby on the second floor. The Manager of Clinical support services will take care of any additional valuables that might need to be secured.

If the belongings have not been claimed after 72 hours, all clothing items will be recycled into the clothing collection and may be distributed to other patients. Other non valuable items will be discarded. Valuables will be stored for six months.

For patients who are admitted to the hospital, belongings will be bagged and labeled and dated. Bags will be stored in the closet in the Dave Walker Lobby of the second floor until the patient returns or the items delivered to him or her in the hospital. All bags must be logged in the Patients Storage log.

POLICY: SEARCH OF PATIENT'S ROOM AND/OR BELONGINGS

Purpose: To balance the patient's right to privacy with the safety and security of patients, staff and visitors.

Rationale: The search of a patient, visitor, patient's room, or other areas may be carried out when there is reasonable cause for a search (as described below), and when it is the least invasive and most effective means available to meet the safety, security and medical needs of the patients and staff.

Procedures:

The McInnis House Clinic/Barbara McInnis House reserves the right to search the belongings brought to the McInnis House by new patients, parcels sent through the mail to patients, gifts brought to patients by visitors and items brought back on return from appointments. In addition, patients may also be asked to show the security guard food and beverages brought into the building.

- A)** Reasonable cause for search is defined as a situation in which the patient possesses or is reasonably believed to possess or to be given:
1. Prohibited medications
 2. Illegal substances.
 3. Weapons, firearms, ammunition or other dangerous items.
 4. Intoxicating substances.
 5. Food
 6. Other items which present a danger to the life, health, wellbeing and/or safety of the patient and others.
 7. Property belonging to the McInnis House Clinic or to others.
 8. Any other item prohibited by the McInnis House Clinic.
- B)** All searches of the patient's room or belongings are conducted in a reasonable manner with due regard for the safety, health, wellbeing and privacy of the patient and his/her belongings. The search is carried out in a calm, quiet, and efficient manner.
- C)** Prior to searching a patient's room, the need to search is brought to the attention of the McInnis House Clinic/ McInnis House Director.
1. Advise the patient that he/she and his/her belongings are subject to a search.
 2. Conduct the search by at least two (2) persons, one of whom is a manager (or designee) and one of whom is a security guard or other available staff member.
 3. If the patient objects to the search, staff will notify the McInnis House Clinic/McInnis House Director to evaluate the situation and determine a course of action.
- D)** Situation may arise where the administrator may determine the need to search an entire floor or the entire building. Procedures will be defined as above.

- E) If a patient or visitor has a prohibited item, they should be advised that it must be given to the McInnis House Clinic staff for custody and may be destroyed (in the case of narcotics, weapons or perishable prohibited items). Other property which needs to be locked in the valuables safe by the Manager of Clinical Support Services; or sent home with family/legal guardians, or responsible adult/significant other.

Schedule II-IV medications given to the McInnis House Clinic/McInnis House staff may be destroyed per our destruction policy. Determination to store and return or destroy an item will be on a case by case basis as determined by the Barbara McInnis House Medical director or designee or Barbara McInnis House Director. Prohibited items such as weapons will not be stored.