

QUALITY IMPROVEMENT MANUAL



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TENNESSEE DEPARTMENT OF HEALTH (TDH)

MISSION STATEMENT: To protect, promote and improve the health and prosperity of people in Tennessee.

VISION STATEMENT: A recognized and trusted leader, partnering and engaging to accelerate Tennessee to one of the nation's ten healthiest states.

GOAL: Quality Improvement (QI) is foundational to continuous evaluation and facilitates the process of continuous improvement of Public Health services in all ninety-five Tennessee counties, including the metropolitan areas. Quality Improvement strives to link evaluation, accountability, quality improvement, and the practices of science.

OBJECTIVES: To use best-practices and evidence-based science in all aspects of the public health system. To pursue opportunities for improvement on a continuous basis in order to assure and enhance the quality of the public health system both centrally and locally in Tennessee.

SCOPE: The QI process addresses and evaluates components of clinical and non-clinical care, twice each fiscal year. Guidance and direction for the QI process is based on departmental policies. The Office of Quality Improvement (OQI) does not create the policies or standards for review. The OQI supports the TDH mission and vision statements and the Health Strategic Plan for continuous improvement.

QUALITY IMPROVEMENT OVERSIGHT

Community Health Services Administration (CHS), the Office of Quality Improvement (OQI) and the Regional QI Directors provide oversight of the quality assurance and improvement processes in all regional and county health departments. Regional Quality Teams have been established to facilitate and coordinate Quality Improvement activities at regional and local levels. Quality Units are functional at local levels with team members empowered to resolve problems whenever possible. In addition, the Quality and Performance Improvement Council serves across the Tennessee Department of Health to identify, prioritize, support and track the implementation of department quality improvement and performance management activities.

PERFORMANCE CYCLE

Reviews:	July-Dec Cycle	Due date	Jan-Jun Cycle	Due date
Universal Medical Chart Review	X	January 15	X	July 15
Risk Minimization	X	January 15	X	July 15
Good Catch	Ongoing		Ongoing	
Universal Facility Review (completed by County Directors or their designee and provided to Regional QI Director)	X		X	

REVIEW REPORTING

The reviewer will provide the county/site a summary of the review prior to or during an exit conference. The exit conference should be scheduled as soon as possible after the completion of the review, and participation by the entire reviewed site's supervisory staff is encouraged and welcomed. Every effort will be made by the reviewer to comply with scheduling needs of the reviewed site county director. Regional Quality Improvement Directors/Coordinators are to maintain reports and responses, at a minimum, for the 3 most recent fiscal year data. Data collection includes Universal Medical Chart reviews, Risk Minimization reviews, special requested focus studies, and paper/computer generated reports. Central Office and regional Quality Improvement staff will generate summary Quality Improvement reports.

LAB DEFICIENCIES

Critical Lab standards are: (1) Quality Control testing and (4) Laboratory supplies with valid dates. Upon finding a critical standard deficiency, Quality Improvement Staff should discuss with local staff immediately and notify the appropriate regional office staff.

DENTAL DEFICIENCIES

Critical dental standards are: (20) Dental supplies with valid dates and (22) Compliance with Regional Exposure Control Plan and Infection Control Manual. Upon finding a critical dental standard deficiency, the Quality Improvement Staff should notify the Regional Dental Director.

MEDICATION AND VACCINE DEFICIENCIES

Critical Medication and Vaccine standards are: (6) Vaccine storage, (7) Medications storage. Upon finding the critical standard deficiency, Quality Improvement Staff should make appropriate notifications to personnel that may include but is not limited to: Regional Director of Pharmacy, Regional Immunization Coordinator (if vaccine related), Central Office VFC/Affix Coordinator (if vaccine related), State Director of Pharmacy, the Regional Medical Officer, Regional Director, Regional Nursing Director, State Quality Improvement Director, along with any other regional and state programs (e.g. TB) that were affected.

TOSHA DEFICIENCIES

The critical TOSHA standard deficiency is: (9) Compliance with Regional Exposure Control Plan and Infection Control Manual. Quality Improvement Staff should notify State Clinical Services and Disease Management OSHA/TOSHA Coordinator, the Regional Director, Regional Medical Officer and Regional Nursing Director immediately upon finding the deficiency.

IMPROVEMENT PLAN

If appropriate, an improvement plan (IP) will be developed in collaboration with the county/site supervisory staff or designated personnel and the Regional QI Director. The Improvement Plan process will be initiated at the time of the exit conference unless the concern involves a standard with potential patient impact. In this situation this process will then require an immediate verbal response followed by the appropriate written response.

The Regional QI Director will collaborate with the initiation of the IP and serve local staff as a resource. Every attempt will be made to expedite the initiation of and resolution of the IP. If a concern can be resolved immediately and does not involve potential patient impact, this will be documented and no 30 day IP will be required. The IP will be due to the regional office within 30 days of receipt of review results provided during the exit conference. Follow up for both the 2 Day and 30 Day IP will be done in the following cycle.

Improvement Plan Guidelines: Risk Minimization	2 Day IP	30 Day IP	Other
Critical Standard with Patient Impact	Yes	No	Immediate verbal IP *
Critical Standard with Employee Impact	Yes	No	Immediate verbal IP *
Critical Standard with no Patient Impact	No	Yes	
Non-critical Standard with Patient Impact	No	No	*
Complete Risk Review met at <90%	No	Yes	
Improvement Plan Guidelines: Universal Chart Review			
Standards for all records met at <90%	NA	Yes	

*Incident Report completed per HSA policies 3.4 and 7.5

For the Universal Medical Chart Review, IPs will be developed per standard met at less than 90% for all the records reviewed, not by individual record.

For the Risk Minimization Review, an IP will be developed for a complete review that is met at less than 90%. Critical standards in the Risk Minimization Review that are not met and that involve patient impact will require a 2 Day IP. For the Risk Minimization Review, there will be only one IP written to address all standards found deficient in the review unless a critical standard with patient impact is determined.

- In the case of a critical standard with patient impact, an immediate verbal plan and a 2 Day IP will be required.
- In the case of a critical standard without patient impact, a 30 Day IP will be developed.
- In the case of a non-critical standard with patient impact, an incident report will be developed following HSA policies 3.4 and 7.5.

If clear and obvious patient impact is determined by the QI Director and local management, a 2 Day IP can be initiated immediately. If patient impact is in question, the Medical Officer will make the determination of patient impact and the need for a 2 Day IP.

A 2 Day IP should indicate:

- if any patients or employees were affected and how they were notified,
- what steps were involved in correcting this situation and what will be done to prevent this in the future.
- If patients are called in for additional testing, or if evaluations take more than two days with any steps taken up to that point.
- The timing for the 2 Day IP begins immediately with contact of appropriate personnel after discovery.

The Medical Director or Regional/State QI Director may request a written IP for any finding that warrants improvement actions or continued/repeat deficient findings at their discretion. This required IP must be approved by the Medical Director and Regional and/or State QI Director. The timing for the 30 Day IP will begin at the point of the Exit Conference.

QUALITY IMPROVEMENT RESOURCES

QI studies will assess service provision against practice guidelines specified for each identified standard area of review. The following public health practice guidelines will be utilized in the evaluation process.

- ◆ [Breast and Cervical Cancer Guidelines](#), Current revision 2014
- ◆ [Bright Futures](#)
- ◆ Care Coordination Manual – CSS and Care Coordination Policy Manual 2005 with 2009 and 2011 updates
- ◆ Contraceptive Technology – annually revised
- ◆ Current Procedural Technology (CPT) Manual – Current Year
- ◆ [Standards of Practice for Dental Public Health](#) – 2014
- ◆ [EPSDT and Preventive Services Manual](#)
- ◆ Early Childhood Caries Prevention, A [Fluoride Varnish Program for Public Health Nurses](#), current version on line
- ◆ Ferri's Clinical Advisor (current edition but not older than 2 years)
- ◆ [Community Health Services Policies and Procedures Manual](#)
- ◆ [HSA Policies & Procedures Manual](#)
- ◆ Regional Policies & Procedures Manual – current edition on line
- ◆ [HUGS Program Guidelines](#), current edition on line – Sept. 2011 or later
- ◆ [ICD-10 Coding Manual](#)
- ◆ [Advisory Committee on Immunization Practices \(ACIP\), standards for Adult, Child and Adolescent Immunizations](#)
- ◆ [Infection Control Manual](#), 6th edition 2015 or current edition on line
- ◆ [Laboratory Manual](#) – current edition 2015
- ◆ Tennessee Department of Health [New Employee Handbook January 2015](#)
- ◆ [Public Health Nurse Protocols](#) – current edition on line on HSA Manual Webpage
- ◆ [Public Health Nursing Orientation & Practice Manual](#) –currently under revision
- ◆ [Primary Care Services Guidelines](#) on line – May 2010
- ◆ [Quality Improvement Manual 24th edition](#)
- ◆ [HIV/STD Prevention Program Guidelines](#), current edition on line 5/2012
- ◆ [STD Treatment Guidelines](#), current version on STD Website 2015
- ◆ [Tennessee Code Annotated](#)
- ◆ [Tuberculosis Elimination Program, TB Manual](#) - current edition January 2015
- ◆ [Up to Date](#)
- ◆ [WIC Manual](#) – current edition on line
- ◆ [Family Planning Clinical Guidelines](#), Tennessee Department of Health Family Planning Clinical Guidelines February 2015
- ◆ [PTBMIS Codes Manual](#) – 6/2016 edition on line
- ◆ [Vaccines for Children \(VFC\) Program Homepage](#)
- ◆ [Vaccine Storage and Handling Toolkit](#), current edition June 2016
- ◆ [Record retention and destruction information](#) – statewide 3/28/2011 RDA information
- ◆ [Immunization tables](#) Birth to 18
- ◆ [Immunization tables](#) Adult
- ◆ [Immunization](#) VIS
- ◆ [Immunization](#) Acceptable Version Dates List

UNIVERSAL MEDICAL RECORD REVIEW

Sample Design

Quality Improvement will review medical records for a random sample of patients. Quality Improvement studies will monitor service quality against practice guidelines specified for each identified area of review. It is expected that at least 90 percent of the records will reflect that care provided matches the practice guidelines.

The sample size will be calculated such that there is a five percent chance of drawing a non-representative sample (or a 95 percent chance that the sample is representative of the true population of medical records). The true percentage of records that match the guidelines should lie within 10 percent of the sample percentage. For example, if 90 percent of the records in the sample of records match the practice guidelines, the percentage in the entire population that match should lie within the range (90 – 10) and (90 + 10) or between 80 – 100 percent.

The size of the sample based on these assumptions is calculated as:

$$n = \frac{(1.96)^2 \times (90) \times (10)}{(10)^2} = 35$$

Where 1.96 is the abscissa of the normal curve that cuts off .05 in each tail, 90 is the estimated proportion of the records that match the guidelines, 10 is the estimated proportion of records that do not match the practice guidelines and 10 percent is the margin of error in the estimate that has been agreed will be acceptable.

Therefore, the sample should include 35 records to match the guidelines on sample design.

Because we will be sampling from finite populations of various sizes, the finite population correction factor should be applied to the initial calculations of the sample sizes.

If n_0 = the original calculation of the sample size, the corrected sample size is calculated as:

$$n = \frac{n_0}{1 + \frac{n_0 - 1}{N}}$$

For example if the population or records for a given county is 150 for the selected group, the sample for that county will be calculated as:

$$n = \frac{35}{1 + \frac{35 - 1}{150}}$$

which equals 28 records.

Alpha Numeric list method for obtaining Sample size Population:

After the sample size is calculated, the actual sample will be drawn from a computer list of the medical records in the county. The records for each of the selected sites should be listed separately. A systematic sample will be drawn from each group.

First, the number of records to be included in the sample is divided by the total number of records in the list for the selected sites to be sampled. For example, if the list includes 150 records and the sample should include 29 records, 150 is divided by 29 and the result (5.17) is rounded to the nearest whole number, 5. Therefore, we will randomly select a beginning number and then take every 5th number. The beginning number will be selected as a number between 1 and 5.

Query method to obtain Sample size population:

A query is to be generated that will provide a list that is populated with all patients seen in the site of review for a given period of time, generally one full standard clinic week. Weeks that include holidays and or mass clinics are discouraged as this will artificially increase or decrease the query population results. The query is to be generated from encounters that include the medical programs serviced by the site with the exception of the Dental program, (DN, DNV, 63, 64, DA, DC, DNF, DH, 49, DNH, DL, 47, or DP), Administration (AM), AIDS testing and counseling (80), Alcohol and drug (AA or 73), Birth certificate (BC or BR), Central referral (CRS), Chest clinic (39), Child health referrals (04), Civil service (CV), Community health agency (HA), Community outreach (ZCO), Community service (CM), CSS special project (18 or 19), Current year CSS certification (CY) Educational materials (ZED), Exposure (EX), Families first (FF), Family resource center (FRC), Food and general sanitation (FG), Frail and elderly (FE), Gatekeeper (GA, GB, GH, GP, GR, GT, GS, GU, or GV), Head start (13), Health promotion (HP), Healthy start (HSP), Healthy start federal (HSF), HIV program (40), HIV/STD homeless outreach (36), Home visit (ZHV), Homeless employment service (75), Homeless mental health (72), Homeless primary care (70), Homeless respite services (76), Homeless service center-other (77), Homeless social work service (74), Homeless TB (78), Homemaker (HM), Hypertension (HY), Indigent health (IH), Infant mortality PRG-HAM.CO. (IMP), Infusion program (42), Insurance (IN), Jury duty (JD), Laboratory - Knox (LB), Local appropriation (LA), Local supplemental (LS), Mass media, All (ZMA), Medicaid labs (ML), Medicaid transportation (MT), Meetings (ZMT), Men's health housed (MH1), Men's health housed homeless (MHI), Men's health Hispanic (MHS), Midas (68), Migrant health (MIG), MISC Family planning (98), Mobile outreach (71), O V with immunizations (VI), Off-site monitoring (OM), Outreach, Other (OR), Pediatric specialty unit (10), TennCare Outreach phone call contacts, (ZPH), PPI (PPI), Prior year CSS certification (PY), Project teach (PT), Rape prevention (RP), Refugee program (84), Renal disease (RD, 34, or RDE), Rural health (RH), SARS monitoring (SAR), School based dental screening (DS), School health home visits (HSH), Sick child (SC), SIDS (SD), Social service-Knox county (SS), Special payment (PS), Supplemental pay (SP), TEIS program (21), TennCare overages (TN), TennCare reverification (TRV), Traveler's assistance (79), Undetermined payment (UP), Veteran's capitated program (VA), WIC farmers market nutrition (FMW), WIC overcharges (WO), Wise moves (WM), Women's health homeless (WHH), Women's health housed (WH1), Women's health Hispanic (WHS), Women's HLTH housed homeless (WHI), Women's health (Age21+) free (WHF), Written outreach (ZWO), VAOP – voluntary acknowledgment of paternity, Environmental encounters (EN, ENR, ENA, ENF, ENS, or ENT) vital record encounters (VA), and mass files, where an individual patient medical record is not generated, are not to be included in the population sample size. When the query is presented to the reviewer in a randomized list, the records of the selected groups can be chosen for review as they fall numerically on the list.

**Office of Quality Improvement
Random Sample Size**

<u>Total Number of Records</u>	<u>Number of Records to be Reviewed</u>
1 - 13	All
14 - 20	13
21 - 24	14
25 - 27	15
28 - 30	16
31 - 33	17
34 - 38	18
39 - 42	19
43 - 48	20
49 - 54	21
55 - 61	22
62 - 69	23
70 - 79	24
80 - 91	25
92 - 105	26
106 - 124	27
125 - 149	28
150 - 182	29
183 - 230	30
231 - 305	31
306 - 441	32
442 - 759	33
760 - 1000	34
1001 or more	35

QUALITY IMPROVEMENT GLOSSARY OF TERMS

CYCLE: Period of review. For the TDH OQI, the review cycles are 6 months in length: January-June and July to December.

DATA: A set of collected facts. There are two basic kinds of numerical data: measured or variable data, and counted or attribute data.

DATA SOURCE: Source(s) from which data are obtained for measurement.

DENOMINATOR: The lower part of the fraction used to calculate a rate or ratio. In a rate, the denominator is usually the population at risk. The total number of parts created from the whole.

EXCLUSIONS: A brief text description of exclusions from the target population.

LOCAL QUALITY UNITS (Meet as needed): County Director, Nursing Supervisor, Public Health Office Supervisor, etc.

MEASURE: An indicator of change. Key measures should be focused and be reportable. A measure is used to track the delivery of proven interventions to patients and to monitor progress over time. Outcome measures assess results of healthcare experienced by patients.

NUMERATOR: An expression to be divided by another. In a fraction, the number that is above the line and represents how many parts of the whole will be considered.

PLAN-DO-STUDY-ACT: Commonly referred to as PDSA (or PDCA, for Plan-Do-Check-Act), refers to the cycle of activities advocated for achieving process or system improvement. The PDSA cycle represents one of the cornerstones of continuous quality improvement (CQI).

QUALITY IMPROVEMENT: Encompasses all of the work people are doing to improve healthcare and the health of individuals and populations. QI is both systematic and ongoing. Healthcare professionals and providers, consumers, researchers, employers, health plans, suppliers and other stakeholders all contribute to effective quality improvement.

QUALITY IMPROVEMENT TEAM: (Meet quarterly or minimally face to face twice yearly, once during each review cycle). Central Office Support Staff for Regions and Programs as indicated, Regional QI Directors/Coordinators and team members, State QI Director.

RANDOM SAMPLING: A commonly used sampling technique in which sample units are selected so all combinations of n units under consideration have an equal chance of being selected as the sample.

REGIONAL QUALITY TEAMS: Appointed by Regional Director (meet quarterly as needed): Regional Director, Regional Health Officer, Regional Nursing Director, Administrative Support Director, Regional QI staff, and Representation from Medical, Nursing, Administrative, Dental, Programs, etc.

RELIABILITY: The probability of a product's performing its intended function under stated conditions without failure for a given period of time.

SAMPLING METHODS: The selection of units for study. Different sampling methods include judgment sampling, simple random sampling, proportionate random sampling, systematic sampling, and stratified sampling.

VALIDITY: The ability of a feedback instrument to measure what it was intended to measure; also, the degree to which inferences derived from measurements are meaningful.

Medical Chart Review – Universal

Interpretive Guidelines

For use with:	Universal Medical Chart Checklist		
Review Date/ Version Date:	2015-06-05	Implementation Date:	

General Tips:

- Run or have query run to pull sample of medical charts for review
- Determine number of medical charts to be reviewed
- Determine Date of Service (DOS) criteria to be used
- Randomize list of medical charts
- Universal portion of review will apply to all medical charts

GUIDELINES/STANDARDS	GUIDANCE TO REVIEWER
Section 1. Universal Medical Chart Review	
<p>1. Program Eligibility Available score: 10 points – all or none</p>	<p>The patient should meet the criteria for their reason to come to the health department. The following Health Department programs have eligibility guidelines.</p> <ol style="list-style-type: none"> 1. AP – AIDS Prevention – patients of any age seeking testing, screening, education or counseling regarding AIDS prevention. 2. AR – Ryan White program – only to be used for patients that have a confirmed HIV; a Tennessee resident; and meet financial guidelines 3. BF – Breastfeeding – Patient is seeking education, counseling, equipment supply, or support in consideration of or to actively breastfeed. 4. BCS - Breast and Cervical Screening Program: Female at or below 250 percent of poverty – See current program manual for program eligibility criteria. Tennessee Breast and Cervical Screening Program Manual 5. CHAD. CHAD services are for those families at risk of abuse and/or neglect residing in one of the counties specified as a CHAD county. Recipient of AFDC or SSI – Children who are abused or neglected or are at risk of abuse or neglect are eligible without regard to income if they need the service – persons whose gross income is within the income standards, as defined in the poverty level income standard. Children- The need for service is established when a child under six years of age has a verified handicap, a manifested developmental delay or is considered to be at risk of developmental delay, either because of biological factors or because of environmental

factors. **Expectant Mothers** – Women under the age of 18 who are pregnant can be enrolled in CHAD with CSA approval. Women age 18 and over cannot be enrolled in CHAD due to technical interpretation of DCS guidelines. The need for service is established when an expectant minor mother is at risk of delivering a developmentally delayed child because of biological factors. The need for service is also established when the unborn child is at risk of becoming developmentally delayed because of environmental factors.

6. **CH** – Under age 21
7. **CSS** – Medical Services are available to individuals who meet diagnostic and financial criteria as outlined in program policy. – Financial eligibility for the CSS Program requires the family income be equal to or less than 200% of the Federal Poverty Level. Children must meet diagnostic criteria based on program policy. – CSS application for re-certification completed annually (may be up to 4 to 8 weeks early). – Must document reason for delay of re-certification.
8. **Dental Varnish** – Target population 0-5 yrs. Will accept up to age 21. This is a voluntary program. Resource: [Public Health Protocol](#).
9. **EPSD&T – Well Child** – Birth to 21 years of age and a TennCare patient. Reference: EPSDT manual.
10. **Family Planning** – Of reproductive age and desires FP Program services. Resource: Tennessee Department of Health Family Practice Clinical Guidelines February 2015.
11. **HUGS** – Enrollment in the program has minimal eligibility requirements. There are no financial eligibility criteria. Prenatal and postpartum women with an identified need for care coordination including postpartum women who have lost a child by miscarriage, stillbirth, prematurity, SIDS, etc. Children birth through 5 years of age with an identified need for care coordination/home visiting services. Reference: HUGS Program Guidelines July 2011
12. **MH** – Men 21 years and older
13. **Primary Care** – Age 19 through 64 years of age patients that are uninsured or underinsured. Currently TDH is contracting for some insured patients. Underinsured: Their current insurance does not cover the condition for which they are being seen in the health department. For PCP sites, primary care patients may be any age and on TennCare. Patients with Medicare are allowed if they have Part A only. Reference: 2010 Primary Care Program Guidelines.
14. **STD** – Patients of any age requesting treatment, screening or evaluation for sexually transmitted diseases. Patients presenting or sent to the health departments as a contact or case investigation by Disease Intervention Specialists.
15. **TB** – Patients at risk of Tuberculosis that are being screened, treated, investigated according to program guidelines.
16. **Vaccine VFC** – Follow current Immunization Program guidelines for vaccine eligibilities for VFC/Adult, insured and uninsured. Contact Regional Immunization Director for current guidelines
17. **WH** – Women 21 years and older

	<p>18. WIC (women, infants , children) Categorical eligibility pregnant, breastfeeding, postpartum, infants, children 1 –5 years old, income eligible (see program guidelines) – nutritional risk eligibility- physical presence- identity- residency eligibility Reference: WIC Manual</p>
<p>2. Consent for Services Available score: 10 points – all or none</p>	<p>The Informed Consent Signature Sheet is to be updated and signed each WIC Certification for WIC participants (WIC Manual) and every 6 months for all other patients presenting for services. HSA Policy 7.9 (Policy is in process of revision) Not required documentation for HUGS program.</p>
<p>3. Appropriate medical history - Initial history (assumed Family History); Interval history Available score: 10 points – all or none</p>	<p>This standard will never be NA. The extent of the history is dependent upon clinical judgment and on the nature of the reason for the visit or chief complaint. An interval visit can be the subjective statement of the reason for the visit or determining that there is no contraindication to the needed immunizations. The levels of Evaluation and Management (E/M) services recognize four types of history: problem focused, expanded problem focused, detailed, and comprehensive. See current CPT Manual - Evaluation and Management section for descriptions of the components of each history level. History may be documented on a history form, in narrative documentation or on the physical form.</p>
<p>4. Allergies Available score: 10 points – all or none</p>	<p>This standard will never be NA. Documentation of allergies is required on the Immunization Clinic Record and is to be and can be documented by any Health Care Provider. The Medical Leadership Team (MLT) passed that allergy documentation is only "required" to be on the Immunization Clinic Record (1/1/09). If no allergies are identified, documentation in the medical alert box of the Immunization Clinic Record must include NKA or NKDA and is not to be left blank. If no changes have occurred, no annual update documentation is required. If there is a change in allergy status, document change, date and initial the change in documentation. It is not a deficiency if allergy documentation is not present on any of the other forms with areas for allergy documentation Not required documentation for HUGS program</p>
<p>5. Immunizations Total available score - 15 points</p> <p>a. 5 R's Available score - 10 points</p> <p>b. Document assessment Available score - 5 points</p>	<p>All patients presenting for any clinical services (where the medical chart is pulled for the visit) are to be evaluated for their immunization status. TBST is not to be considered for this standard.</p> <p>a. All the appropriate 5 R's of medication documentation are to be present to receive any of the 10 points.</p> <ol style="list-style-type: none"> 1. Right vaccine 2. Right patient 3. Right dose - 4. Right route 5. Right time – interval <p>b. Documentation is to show that each patient is provided any needed/available immunizations, immunizations were offered and declined, or reappointed. The documentation of a statement such as “immunizations assessed or immunizations addressed” is to signify any needed and available immunizations were offered. If documentation present in the computer and/or medical chart forms show that the patient is up to date on all needed vaccines, no additional documentation is expected.</p>

<p>6. Medication Available score – 15 points – all or none</p> <p>a. 5 R's</p> <p>b. Primary Care</p> <p>c. All Other Programs</p>	<p>Medication documentation is to follow current documentation guidelines for all prescribing providers. Mark this standard NA if the visit does not and should not contain documentation of medications being given or prescribed for the date of service being reviewed.</p> <p>a. All the appropriate 5 R's of medication documentation are to be present.</p> <ol style="list-style-type: none"> 1. Right medication 2. Right patient 3. Right dose 4. Right route 5. Right time <p>b. Primary Care: The Problem List and Medication Summary form is current according to Primary Care Guidelines.</p> <p>c. Documentation in record is on all appropriate program forms, Progress/SOAP note. Program Protocols should be followed for visit being reviewed.</p> <p>The number of refills should be clearly stated in the original medication order. In subsequent visits for medication refill, it is not required for the provider to document that this is refill number X of X in the visit documentation.</p>
<p>7. Plan of Care Total available score – 10 points</p> <p>a. Findings from the documented assessment are addressed - 5 points</p> <p>b. Follow-up required - 5 points</p>	<p>Plan of care should be appropriate for assessment and follow the APN/PHN Protocols and program guidelines.</p> <p>a. Plan should summarize the findings from the assessment and document the treatment, tests ordered, lifestyle changes, referrals, etc.</p> <p>b. Return to clinic follow-up needs, such as lab work, appointments, call back for test results, or instructions to subsequent providers of future needs should be documented.</p>
<p>8. Coding Total available score 10 points</p> <p>a. Correct code – diagnosis, procedure, office visit, etc. 5 points</p> <p>b. Diagnosis and procedure codes are appropriately linked 5 points</p>	<p>The codes in PTBMIS follow current coding standards and regulations.</p> <p>a. Documentation in medical chart supports codes in PTBMIS and codes in PTBMIS match documentation of visit.</p> <p>b. Procedure codes should be linked to the appropriate diagnosis code that supports rationale for the procedure. 4 diagnosis codes can currently be linked to a single procedure.</p>

<p>9. Medical Record Documentation Total available score – 10 points</p> <ul style="list-style-type: none"> a. Name – 2 points b. Date of service – 2 points c. Provider ID – 2 points d. Legibility – 2 points e. Errors are corrected according to standard – 2 points 	<p>Documentation should follow appropriate guidelines</p> <ul style="list-style-type: none"> a. Name – patient’s name, medical chart number or patient label should be on each document in the chart. b. Date of service – each provider is to date their signature or visit according to the form or visit guidelines. c. Provider ID – Provider’s signature is to be first initial, last name and title. Example: J. Doe, MD d. Reviewer is to be able to read all visit documentation. e. There are no documentation errors or errors are corrected according to state/regional standards.
<p>Total possible score</p>	<p>100 points</p>

County Cosite Number	
Medical Chart Number	
Date of Service Reviewed	
Date of Review	
Reviewer Signature	

Universal Medical Chart Review

Review Item	Notes	Review Comments	Possible Points	SCORE
HIGH	See Interpretive Guidelines for examples			
1. Program Eligibility	Program Eligibility – eligible for the program visit that is part of the chief complaint (for today’s visit) a. BCS, FP, WIC, HUGS, CSS, TB, PC, AP, AR, etc.		10	
2. Consent	Consent Form a. Universal Consent for Treatment (Informed Consent Signature Sheet – with Income Verification Labels on the chart)		10	
3. Appropriate medical history Initial history (assumed Family History); Interval history	Forms – Health Questionnaire; Immunization Form; Progress Note (SOAP) Review appropriate medical history → i.e. an initial visit would have an Initial History (and includes Family History)		10	
4. Allergies	Documented on the IMM Clinic Record Form Every chart must have at least one IMM Clinic Record Form		10	
5. Immunizations			15	
a. 5Rs b. Document assessment	a. All 5Rs must be present → miss one, do not get any points b. “Immunizations assessed” acceptable documentation. If assessed and no vaccinations given (patient is up to date), then no documentation of assessment is required.		10 5	

6. Medications			15	
<ul style="list-style-type: none"> a. 5Rs - documented and updated on correct form b. Primary Care c. All other Programs 	<ul style="list-style-type: none"> a. All 5Rs must be present → miss one, do not get any points b. Primary Care - documented on Primary Care Problems List and Medication Summary Form c. Any other program – Medications documented on Progress/SOAP note or on a program form (i.e. FP Summary Form) <p>For refills → go to the original 5Rs on the Primary Care Problems List and Medications Summary Form or original order.</p>		15 All or nothing	
7. Plan of Care			10	
<ul style="list-style-type: none"> a. Findings from assessment are addressed (assumes assessment is documented as well) b. Follow-up required 	<ul style="list-style-type: none"> a. Summarize the findings from the assessment and document the plan (i.e. medications or lifestyle change) b. Return follow-up documented 		5 5	
8. Coding			10	
<ul style="list-style-type: none"> a. Correct diagnosis; procedure code; (visit type and other procedures) b. Diagnosis and procedure codes are appropriately linked 	<ul style="list-style-type: none"> a. Documentation supports codes and PTBMIS codes match the paper record documentation b. 3 diagnosis codes can link to one procedure code. 		5 5	
9. Medical Record Documentation			10	
<ul style="list-style-type: none"> a. Name b. Date of Service c. Provider ID d. Legibility e. Errors corrected according to standard 	Chart format no longer reviewed Partial Credit – each one of equal value		2 each	
		TOTAL SCORE	100	

Risk Minimization Standards and Interpretive Guidelines

 = Standards that **may** require 2 day written improvement plans

County/site:

Date:

GUIDELINES/STANDARDS	GUIDANCE TO REVIEWER	REVIEW COMMENTS	POSSIBLE POINTS	SCORE
<u>LABORATORY SECTION</u>	Mark standards 1-4 NA if the site does not have a laboratory.			
<p>1. </p> <p>A. Quality control tests are performed and documented according to the Laboratory Policies and Procedures Manual for Local Health Departments.</p> <p>B. QC logs are maintained for at least 2 years.</p> <p>C. Controls must be applicable to the brand of product being used.</p> <p>D. Product package inserts will be retained with the applicable control test documentation.</p>	<p>Reference: Lab Manual</p> <p>1. Observe Specimen/ Quality Control (QC) Log for acceptable, non-acceptable findings and corrective action taken for control tests completed since last review.</p> <p>2. Observe that Specimen/ Quality Control Log form is completed correctly for the test.</p> <p>3. Observe that controls are applicable to the brand of product being used.</p> <p>4. Observe that controls used were in date and were run by specified frequency as outlined in the current Lab Manual and/or package insert.</p> <p>5. Observe that QC logs are maintained for 2 years beyond date of last use.</p> <p>6. An immediate verbal plan of action and 2 day written IP is required for any deficiencies noted for this standard when it is determined to have patient impact. The Regional Medical Director, or physician designee, may be consulted to make the final determination as to patient impact.</p>		<p>Total possible: 10</p> <p>Breakdown of points:</p> <p>A. 4</p> <p>B. 2</p> <p>C. 2</p> <p>D. 2</p>	
<p>2. Competency Evaluation and Proficiency testing or Comparison testing are performed appropriately for the clinic laboratory with a CLIA</p>	<p>Reference: Lab Manual – Section Comparison testing or CLIA approved proficiency testing for moderate complex / PPM tests (urine microscopy and</p>		<p>3</p>	

<p>Provider Performed Microscopy (PPM) Certificate.</p>	<p>vaginal wet mount tests) is performed for clinics with a CLIA Provider Performed Microscopy (PPM) Certificate. Competency and comparison testing can be done at the same time. Documentation of these activities is required.</p> <p><u>Competency evaluation of personnel:</u> is done every 6 months during the first year of employment and annually thereafter.</p> <p><u>CLIA approved Proficiency Testing:</u> Proficiency Testing is used to monitor the performance and quality of laboratory testing. Results of tabulation and grading must be reviewed by the laboratory director, supervisor and individuals performing the tests. If one or more challenges are missed, corrective action must be taken. Check documentation of test results on the proficiency testing control log.</p> <ol style="list-style-type: none"> 1. Determine that tests were conducted and returned in a timely manner to the Proficiency Testing Program. 2. Were all sites represented according to testing schedule? 3. Were results satisfactory? Ask to see results from provider. 4. If indicated, was corrective action performed? 5. If indicated, were QC tests performed to demonstrate that problems have been corrected? 6. Maintain proficiency testing 			
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	<p>results and corrective action documentation for 2 years.</p> <p>Comparison testing: when a proficiency testing program is not available, comparison testing is to be done twice annually.</p>													
<p>3. Lab supplies and specimens are stored under proper conditions of sanitation, temperature, light, moisture, ventilation and refrigeration. Temperature logs for lab supplies/specimen storage are retained for at least 2 years.</p>	<p>Reference: Lab Manual</p> <ol style="list-style-type: none"> 1. Check current temperature process and ask for log with recorded temperatures listed. 2. Check temperature log for any variances in temperature and corrective action taken. Logs are retained at least 2 years. 3. Incubator temperature and Lab refrigerator temperatures are to be read and documented on a Temperature Log daily. Data logger reports are acceptable if lab supplies are stored in a vaccine storage refrigerator. 		3											
 <p>4. Only laboratory supplies with valid dates are available for use.</p>	<p>Reference: Lab Manual, Section 1</p> <ol style="list-style-type: none"> 1. Examine all areas of the laboratory, work-up areas, clinic rooms, and storage areas for expiration dates of all lab supplies or any supplies used to obtain, run tests or store lab specimens. (examples –see below) <table border="0"> <tr> <td>culture plates</td> <td>normal saline</td> </tr> <tr> <td>control solutions</td> <td>viral cultures</td> </tr> <tr> <td>blood tubes</td> <td>KOH</td> </tr> <tr> <td>HemoCue cuvettes</td> <td>Dipsticks</td> </tr> <tr> <td>vacutainer needles</td> <td>distilled water</td> </tr> </table> <ol style="list-style-type: none"> 2. An immediate verbal IP is required for any lab supply related deficiency, when it 	culture plates	normal saline	control solutions	viral cultures	blood tubes	KOH	HemoCue cuvettes	Dipsticks	vacutainer needles	distilled water		10	
culture plates	normal saline													
control solutions	viral cultures													
blood tubes	KOH													
HemoCue cuvettes	Dipsticks													
vacutainer needles	distilled water													

	is determined to have patient impact. The Regional Medical Director, or physician designee, may be consulted to make the final determination as to patient impact.			
<u>MEDICATION /VACCINE SECTION</u>	Mark standards 5-8 NA if the site does not have a drug room or pharmacy.	REVIEW COMMENTS	POSSIBLE POINTS	SCORE
5. All medications and vaccines are kept under lock except when authorized personnel are in attendance.	Observe the drug room/regional pharmacy casually at many different times while at the site to see if the door remains locked. Note the location of the key to determine if the key is in a secure location. This applies to all medications and vaccines, including vitamins, inhalants, and injectables.		5	
 <p>6. A. Vaccines are stored under proper conditions of sanitation, temperature, light, moisture, ventilation and refrigeration.</p> <p>B. Only vaccines with valid dates are available for administration.</p> <p><u>References:</u> CDC -Vaccine Storage and Management Toolkit June 2016; Tennessee Department of Health Vaccine Temperature Monitoring Guidance for All Federal, State, or Local Vaccines Stored in Public Health Clinics.</p>	1. Review the Data Logger logs. 2. Check to see that vaccines are stored according to the Vaccine Storage and Management Toolkit and the Tennessee Department of Health Vaccine Temperature Monitoring Guidance for All Federal, State or Local Vaccines Stored in Public Health Clinics. 3. Any temperature excursions are reviewed and documented according to the above guidance. 4. Examine vaccine inventory for expired stock. 5. An immediate verbal IP is required for any deficiencies noted for this standard when it is determined to have patient impact. The Regional Medical Director, or physician designee and/or Regional Pharmacist may be consulted to make the final determination as to patient impact. If		Total possible: 10 A. 5 B. 5	

	one is required, the written two-day plan of action, should note if patients need to be identified and any action steps taken. A follow-up report may detail the outcome of the patient contact. All two-day plans should be completed in consultation with the Regional Director, Regional Medical Officer, Regional Nursing Director, the Regional Pharmacist and Regional Immunization Program Director.			
 <p>7. A. Medications are stored under proper conditions of sanitation, temperature, light, moisture, ventilation and refrigeration.</p> <p>B. Only medications with valid dates are available.</p> <p>CHS Policy 3.03.b</p>	<ol style="list-style-type: none"> 1. Examine pharmacy inventory for expired stock. 2. An immediate verbal improvement plan is required for any deficiencies noted for this standard when it is determined to have patient impact. The Regional Medical Director and/or Regional Pharmacist will be consulted to make the final determination as to patient impact. If one is required, the written two-day improvement plan, should note if patients need to be identified and any action steps taken. A follow-up report may detail the outcome of the patient contact. All two-day plans should be completed in consultation with the Regional Director, Regional Medical Officer, Regional Nursing Director, and Regional Pharmacist. 		<p>Total possible: 10</p> <p>A. 5</p> <p>B. 5</p>	
<p>8. Drug labeling and packaging are performed appropriately.</p> <p>CHS Policy 3.03.b</p>	<ol style="list-style-type: none"> 1. Examine the drug room for any evidence of repackaging of medications, as repackaging is not allowed in the clinics. 2. Inspect drug room stock labels to assure labels are intact and legible. 		2	

OCCUPATIONAL HEALTH/ INFECTION CONTROL SECTION	GUIDANCE TO REVIEWER	REVIEW COMMENTS	POSSIBLE POINTS	SCORE
<p>Reference: Basic Guidelines of Infection Control for Regional and Local Health Departments 2015</p>				
<p> 9. A. The site complies with the Regional Exposure Control Plan and Infection Control Manual.</p> <p>CHS Policy 3.02.a</p> <p>B. Post Exposure incidents are handled according to Regional Exposure Control Policy.</p> <p>CHS Policy 3.02.a</p>	<ol style="list-style-type: none"> 1. Ask to see Exposure Control Plan and the Infection Control Manual to ensure they are available. Online accessibility is acceptable. 2. Observe that appropriate PPE (personal protective equipment) are available in the clinics and used for hazardous tasks. 3. No food or drinks should be in the clinical or lab areas. 4. Cleaning and disinfecting are done according to a written schedule. 5. Question the clinic supervisor or random employees about the procedure to be followed if a hazardous exposure incident occurs (if you get a needle stick what happens?). 6. Employees involved in an exposure or employees who have a TB skin test that converts to positive are handled according to the Exposure Control Manual. 7. In any incident/accident that involves bloodborne exposure, OSHA mandates that strict limitations be placed on the circulation of medical information. In these instances, both the Incident/Accident Investigation Report and the Accident Report (Worker's Comp) should contain only 		<p>Total possible: 10</p> <p>A. 5 B. 5</p>	

	<p>information specified in OSHA regulations. The health professional evaluating and managing the exposed employee should place all confidential medical information in a sealed envelope in a locked file.</p> <p>8. Copies of all Incident/Accident Investigation Reports are to be retained locally for a period of two (2) years, except for those occurrences involving exposure to hazardous or infectious substances. In these cases, the form must be kept 30 years from the date of from employment.</p> <p>9. An immediate improvement plan is required for any deficiency for this standard.</p>			
<p>10. A. Autoclave is used appropriately according to manufacturer's instructions.</p> <p>B. Autoclave is cleaned regularly per manufacturer's instructions.</p> <p>C. The required biological indicator testing is done each week the autoclave is used.</p>	<p>Mark this standard NA if the review site does not have or use an autoclave. CHS Infection Control Guidelines</p> <p>1. Check autoclave logs to confirm if cleaning cycles are run per manufacturer's instructions and correctly documented.</p> <p>2. Check autoclave logs for record that spore testing is done according to manufacturer's instructions and Infection Control Guidelines.</p> <p>3. Biological indicator logs must be kept for 2 years.</p>		<p>Total possible: 6</p> <p>A. 2</p> <p>B. 2</p> <p>C. 2</p>	
<p>11. Sterilized items are appropriately wrapped, labeled, dated & stored to maintain sterility and are within date.</p>	<p>Mark this standard NA if the review site does not have any sterilized items to be reviewed. (Items autoclaved) Infection Control Guidelines</p>		<p>3</p>	

	<ol style="list-style-type: none"> 1. Examine sterilized packages for integrity and evidence of appropriate sterilization procedure (i.e. appropriate color change for steam autoclave tape). 2. Muslin and paper wrapped sterilized supplies expire after 30 days, if kept dry and the package integrity is maintained. 3. Heat-sealed supplies are considered sterile for one year from the date sterilized. 4. Commercially prepared sterile supplies may have an expiration date for more than one year or no expiration date. This would include all commercially sterile items such as sutures, needles, syringes, and prepackaged instrument sets. 5. Metal speculums after use are cleaned and autoclaved per Infection Control Guidelines “should be stored in clean dry cabinet ...” Do not mark deficient for sterilization dates over one year for metal speculums. They are not required to be kept sterile and do not need expiration date. 			
<p>12. Hepatitis B Vaccine is made available at no cost to all employees who have occupational exposure to blood or other potentially infectious materials within 10 working days of assignment. (Federal Register 29 CFR 1910.1030)</p> <p>“At risk” employees must sign an OSHA approved Declination Form if</p>	<ol style="list-style-type: none"> 1. Ask for list of employees whose job classification is at risk for occupational exposure. 2. Confirm that all at risk employees were offered the Hepatitis B vaccine series. 3. Confirm that all employees, whose job classification puts them at risk for occupational bio hazardous exposure, have either received (or 		2	

<p>their choice is not to receive Hepatitis B vaccine. HSA Policies Manual 3.9 and CHS Policy 3.02.b</p>	<p>are receiving) the 3-dose hepatitis B vaccine series, or have signed a declination form.</p> <p>4. See Federal Register 29 CFR 1910.1030 1910.1030(f)(1)(i) through 1910.1030(f)(2)(iv)</p>			
<p>13. All employees, including part-time, contractual, and volunteers who have patient contact and are at risk of effective exposure, shall be screened for tuberculosis. The Regional Medical Director shall determine the risk of effective exposure.</p> <p>CHS Policy 3.02.c</p>	<p>Have site provide you with skin test date documentation for each employee. Confirm that all at risk employees have had the annual screening. If treatment of disease or preventive therapy is indicated for the employee, see guidance from the Regional Medical Director and/or the Regional TB Control Physician</p>		<p>2</p>	
<p>14. Vaccine Preventable Disease Coverage for Employees</p> <p>CHS Policy 3.02.b</p> <p>A. “Employees in direct contact with individuals seeking health department services, including part-time, contractual and volunteers, <i>will provide proof of immunity to measles, mumps, rubella, and varicella.</i> Documentation and/or history of disease must be reviewed by nursing or medical management staff”. CHS 3.02 revision date April 25, 2016.</p> <p>B. Employees will provide proof of immunity to varicella or be offered varicella immunization. This includes part-time, contractual, and volunteers.</p>	<p>1. Review documentation to confirm that all applicable employees have shown proof of immunity to measles, mumps and rubella, and varicella. If no proof of immunity is provided, confirm that a refusal statement has been signed.</p> <p>2. Review documentation to confirm that employees have received Tdap vaccine or a refusal statement has been signed.</p>		<p>Total points: 6</p> <p>A. 2</p> <p>B. 2</p> <p>C. 2</p>	

C. All employees shall be offered Tdap Vaccine, if not previously obtained.				
15. All appropriate public health staff are to be trained in Blood-borne Pathogens (OSHA) on an annual basis. The employer shall provide a training program to all employees in handling human pathogens. All training must be documented and retained for 3 years from the date on which the training occurred. (Federal Register 29 CFR 1910.1030)	<ol style="list-style-type: none"> 1. Review OSHA policy regarding all appropriate staff receiving yearly training Blood-borne Pathogens. 2. Training must be documented and records retained for 3 years from the date of training. 3. See: Federal Register 29 CFR 1910.1030 - scroll down to 1910.1030(g)(2)(ix)(C) 		4	

<u>MEDICAL RISK CONTROL SECTION</u>	GUIDANCE TO REVIEWER	REVIEW COMMENTS	POSSIBLE POINTS	SCORE
16. Standards of practice and protocols are developed, reviewed annually, updated when appropriate, approved by appropriate professional and administrative staff, and signed by individuals practicing under the standard for each discipline providing clinical patient services.	<ol style="list-style-type: none"> 1. Ask Nursing Supervisor for copy of current Public Health Nursing Protocol to ensure it is available. Online accessibility is acceptable. 2. Ask Nursing Supervisor for copy of current providers who are employed at the site and would be using Protocol Manual. 3. Check copy of Nursing Protocol Manual for current year, revision dates, copy of provider signatures, and current signature of Health Officer who approved Protocol 4. Ask employee to show you location of Protocol Manual, or how they access the protocol. 5. For Nurse Practitioners, yearly evaluation of protocol reference book "Ferri's Clinical Advisor" is to be no older than 2 years. 		3	

<p>17. Emergency equipment/supplies are fully stocked and inspections are documented monthly. All supplies are within date.</p> <p>Public Health Nursing Protocol Appendices</p>	<ol style="list-style-type: none"> 1. Review Public Health Nursing Protocol for current list of required equipment for emergency kit. 2. Ask Nursing Supervisor at site to show you location of emergency kit and oxygen tank. 3. Inspect all medications and supplies in emergency kit for expiration dates. 4. Check monthly log sheet for dates and signatures of person responsible for checking emergency kit. 		4	
<p>18. All licensed staff will maintain current certification in an approved cardiopulmonary resuscitation (CPR) course.</p> <p>CHS Policy 3.04</p>	<p>All licensed staff (including dental staff) will maintain current certification in an approved cardiopulmonary resuscitation course (CPR) to include Automated External Defibrillator (AED) training. Other health department staff will receive instruction in CPR as determined by each Regional Medical Director.</p>		4	
<p>19. Provisions are made to conduct annual fit testing of respirators and any additional fit tests in the event of physical changes in the employee that may affect respirator fit or in the event of damage to respirators in use. Masks are stored appropriately.</p> <p>Division of Community Health Services Respiratory Protection Program Manual</p>	<p>Annual fit testing of respirators will be conducted on employees who have been identified as being at risk in the TB program and BT program and any other employees identified by the Regional Medical Director.</p> <p>Fit testing and training is conducted for all employees required to wear tight-fitting face piece respirators as follows: Prior to initial use; whenever an employee switches to a different tight-fitting face piece respirator (for example, a different size, make, model or type); at least annually. The employer shall conduct an additional fit test whenever</p>		3	

	<p>the employee reports, or the employer, Physician or other health care provider (PLHCP), supervisor, or program administrator makes visual observations of, changes in the employee's physical condition that could affect respirator fit. Such conditions include, but are not limited to facial scarring, dental changes, cosmetic surgery, or an obvious change in body weight. Check with the Nursing Supervisor to get a list of all employees who received annual fit testing, training and dates. Ask Nursing Supervisor to relate procedure for determining when additional fit testing is indicated for employees in the event of physical changes or damage to respirators currently in use.</p>			
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<u>DENTAL CLINIC RISK SECTION</u>	GUIDANCE TO REVIEWER <i>Mark standards 20-24 NA if the site does not have a dental clinic.</i>	REVIEW COMMENTS	POSSIBLE POINTS	SCORE
 <p>20. Only dental supplies with valid dates are available for use.</p>	<p>Reference: Standards of Practice for Dental Public Health .</p> <p>NOTE: Distilled water is for single use only and should be discarded after use.</p> <p>1. Examine all areas of the dental clinic and dental storage areas for expiration dates of all dental supplies and appropriate stock rotation. (examples – see below)</p> <p>Anesthetic Dycal Cleaning materials Distilled Water Dental filling materials</p>		10	

	Temp bond Sealant materials Fluoride Varnish 2. An immediate verbal improvement plan is required for any dental supply related deficiency, when it is determined to have patient impact. The Regional Dental Director will be consulted to make the final determination as to patient impact.			
21. A. Water line treatment procedures should follow manufacturer's instructions. B. Waterline testing should be completed every six months by dental personnel.	1. Ask to see the documentation of the waterline treatment procedures and the six months waterline testing.		Total points: 20 A. 10 B. 10	
 22. A. The site complies with the Regional Exposure Control Plan And Infection Control Manual. CHS Policy 3.02.a B. Post Exposure incidents are handled according to Regional Exposure Control Policy. CHS Policy 3.02.a	1. Ask to see Exposure Control Plan and the Infection Control Manual to ensure they are available. Online accessibility is acceptable. 2. Observe that appropriate PPE (personal protective equipment) are available in the clinics and used for hazardous tasks. 3. No food or drinks should be in the dental area. 4. Cleaning and disinfecting of all clinical surfaces are done prior to the start of the day and after each patient. 5. Question the clinic supervisor or random employees about the procedure to be followed if a hazardous exposure incident occurs (if you get a needle stick what happens?). 6. Employees involved in an exposure or		Total points: 20 A. 10 B. 10	

	<p>employees who have a TB skin test that converts to positive are handled according to the Exposure Control Manual.</p> <p>7. In any incident/accident that involves bloodborne exposure, OSHA mandates that strict limitations be placed on the circulation of medical information. In these instances, both the Incident/Accident Investigation Report and the Accident Report (Worker's Comp) should contain only information specified in OSHA regulations. The health professional evaluating and managing the exposed employee should place all confidential medical information in a sealed envelope in a locked file.</p> <p>8. Copies of all Incident/Accident Investigation Reports are to be retained locally for a period of two (2) years, except for those occurrences involving exposure to hazardous or infectious substances. In these cases, the form must be kept 30 years from the date of termination from employment.</p> <p>9. An immediate improvement plan is required for any deficiency for this standard.</p>			
<p>23. A. Autoclave is used appropriately according to manufacturer's instructions.</p> <p>B. Autoclave is cleaned regularly per manufacturer's instructions.</p>	<p>CHS Infection Control Guidelines</p> <p>1. Check autoclave logs to confirm if cleaning cycles are run per manufacturer's instructions and correctly documented.</p> <p>2. Check autoclave logs for record that</p>		<p>Total points: 20</p> <p>A. 5</p> <p>B. 5</p> <p>C. 10</p>	

<p>C. The required biological indicator testing is done each week the autoclave is used.</p>	<p>spore testing is done according to manufacturer's instructions and Infection Control Guidelines.</p> <p>3. Biological indicator logs must be kept for 2 years.</p>			
<p>24. A. Sterilized items are appropriately wrapped to maintain sterility.</p> <p>B. Sterilized items are appropriately dated and stored to maintain sterility and are within date.</p>	<p><u>Infection Control Guidelines</u></p> <ol style="list-style-type: none"> 1. Examine sterilized packages for integrity and evidence of appropriate sterilization procedure (i.e. appropriate color change for steam autoclave tape). 2. Muslin and paper wrapped sterilized supplies expire after 30 days, if kept dry and the package integrity is maintained. 3. Heat-sealed supplies are considered sterile for one year from the date sterilized. 4. Commercially prepared sterile supplies may have an expiration date for more than one year or no expiration date. This would include all commercially sterile items such as sutures, needles, syringes, and prepackaged instrument sets. 		<p>Total points: 20</p> <p>A. 10</p> <p>B. 10</p>	

UNIVERSAL FACILITIES

Starting **May 1, 2014**, the Universal Facility Review will be implemented as the sole facility review to ensure a safe and effective place to conduct the work of the Tennessee Department of Health.

Implementation:

- The review will be completed two times per year (Jan. 1st to June 30th and July 1st to Dec. 31st).
- The County Director is responsible for the Universal Facility Review. The County Director may designate an assistant or a team to conduct the review. The Regional leadership will assure that all facilities have gone through at least one review per six-month cycle.
- County Directors may utilize the review tool more frequently. The tool is designed to foster continued compliance with facility standards.
- The Regional QI Directors will only check that the review has been completed on time. The details of the review are the responsibility of the regional and local health leadership.
- The Universal Facility Review FORM is available in MS Word/paper. (As well as the Interpretive Guidelines.)
- The Universal Facility Review FORM is to be kept by each facility for review by Regional Leadership and Regional QI Directors for a period of three (3) years. This document will serve as the verification that reviews are being done in a timely manner and that issues found at reviews are being addressed in a timely manner.

Required state and federal posters would need to be posted in the appropriate language according to the Title VI guidelines for translation of vital documents. Those posters designated by ♦ and ◇ are required by the state and federal government to be posted in the public area. If the LEP % for that site met the criteria to require that vital documents be translated into a given language, for example Spanish, then the state and federal posters that are required to be posted in the public areas of the clinic, would also have to be posted in Spanish.



Office of Quality Improvement

Title:	Universal Facilities Review Checklist and Interpretive Guidance		
Implementation Date:	04-15-2014	Revision Date:	8-10-2016
Distribution:	Regional and County Directors	Frequency Cycle of Review: Due Date of Review:	Every 6 months Due by June 30 and December 31 each year
References:	TDH Quality Improvement Manual	Reviewer Assigned:	County Director/team

Date of Review: [Click here to enter text.](#)

Completed by: [Click here to enter text.](#)

Region: [Click here to enter text.](#)

County: [Click here to enter text.](#)

Facility Name: [Click here to enter text.](#)

General Tips:

- Review all standards prior to beginning walk through to reduce backtracking.
Many standards can be reviewed simultaneously as the reviewer walks through the building.
- Take a writing pad along to note findings that need to be addressed.
- Review is to be completed by the County Director or by a designated team that includes the County Director.

	Yes	No	N/A	Corrective Action Needed/Comment	Guidance to Reviewer
1. EXITS					
a. Exit pathway corridors/hallways have a minimum	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> N/A	Click here to enter text.	Americans with Disabilities Act 403.5.1 – All exit paths should be a minimum of 36 inches of clear space –

of 36 inches clear of obstruction.					assure that no boxes, furniture or other obstruction decreases walking area to less than the required space.
b. Stairwells/stairways are clear of all obstructions.	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> N/A	Click here to enter text.	National Fire Protection Association (NFPA) 101 Life Safety Code 7.2.12.2.3. Mark NA if no stairs present at entrance or within the building.
c. Electrically illuminated exit signs are working (lighting) and pass inspection/test (if applicable).	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> N/A	Click here to enter text.	National Fire Protection Association 101 Life Safety Code Test all lighted exit signs to assure battery backup is working. How often do your batteries need to be changed, what type of batteries, what is life expectancy? Do you have spare batteries
d. Exit stairwell doors (fire doors) are kept closed.	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> N/A	Click here to enter text.	NFPA – 7.2.1.8.1 Mark NA if no stairwells within building. Fire doors that automatically close when smoke detectors/fire alarms activate can remain open. Assure that no fire door is blocked open.
e. Fire exit doors can be opened in one motion to allow egress, without use of a key or special knowledge or effort.	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> N/A	Click here to enter text.	ADA Access 404.2.9 NFPA 7.2.1.5.2 Assure that no fire exit doors are blocked, locked or malfunctioning. These doors should be easy to open and always clear of obstructions
2. DISABILITY ACCESS					State and local governments give people with disabilities an equal opportunity to benefit from all of their programs, services and activities. American Disabilities Act . “State and local governments are required to follow specific architectural standards in the new construction and alteration of their buildings. They also must relocate programs or otherwise provide access in inaccessible older buildings, and communicate effectively with people who have hearing, vision, or speech disabilities. Public entities are not required to take actions that would result in undue financial and administrative burdens. They are required to make reasonable modifications to policies, practices, and procedures where necessary to avoid discrimination, unless they can demonstrate that

					doing so would fundamentally alter the nature of the service, program, or activity being provided.” ADA Title II: State and Local Government Activities.
a. The clinic has handicapped access or has alternate service site.	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> N/A	Click here to enter text.	If site does not have handicapped access, there is an alternate service site available
b. Designated handicapped parking.	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> N/A	Click here to enter text.	Observe that there is designated parking and space for a handicapped person to park with appropriate signage.
c. Designated handicapped toilet facilities.	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> N/A	Click here to enter text.	Observe that there are designated toilet facilities that are appropriately equipped with proper door widths, handrails, sinks and lighting etc. as specified by the American Disabilities Act.
3. FIRE AND LIFE SAFETY DEVICES/EQUIPMENT					
a. Fire alarm system pull stations are visible (no obstructions placed in front of a pull station).	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> N/A	Click here to enter text.	All fire alarm pull stations should have unobstructed access with no furniture, plants, signage, etc. placed in close proximity.
b. Emergency lights have passed inspection or have been tested.	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> N/A	Click here to enter text.	Testing will depend on type of equipment, may be tested by Fire Marshall during inspection, or may be contracted to outside vendor to confirm operational status.
c. All fire extinguishers have current service tags and have been inspected monthly.	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> N/A	Click here to enter text.	OSHA requirement 1910.157(e)(2) Check all fire extinguishers to confirm that pull pin is in place, gauge is showing full charge, and there is no damage evident to the device.
4. FIRE HAZARDS					
a. Flammable and combustible materials are safely stored.	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> N/A	Click here to enter text.	Tennessee incorporates by reference the federal regulations for flammable and combustible liquids; therefore, the state requirements are identical to the federal requirements. Click on the following links to view the state and federal regulations regarding flammable and combustible liquids: Tennessee: Rules and Regulations of the State of

					<p><u>Tennessee, Rules of the Tennessee Department of Labor, Chapter 0800-1 Occupational Safety and Health, Chapter 0800-1-1 Occupational Safety and Health Standards for General Industry, 0800-1-1-.06 Citation and Adoption of Federal Standards</u> http://www.state.tn.us/sos/rules/0800/0800-01/0800-01.htm Federal: 29 CFR 1910.106, .107, .122, .123, .124, .125, and .126</p>
b. Annual Fire Inspection	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> N/A	Click here to enter text.	<p>HSA Policy 8.4b Each site will be inspected annually for compliancy with fire safety regulations. Deficiencies requiring major financial expenditures will be reported to the appropriate county and/or State authority.</p>
c. Electrical Hazards					<p>There should be a 3 foot clearance in front of and to the sides of the electrical service panel. National Electrical Code, Article 110.26</p>
5. BIOHAZARDS and HAZARDOUS CHEMICALS					
a. Sharps containers are appropriate, readily accessible, and are not over filled.	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> N/A	Click here to enter text.	<p>HSA 2015 Infection Control Manual Section IV page 33 OSHA - 1910.1030</p>
b. The spill kit is fully stocked and readily accessible to staff.	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> N/A	Click here to enter text.	<p>HSA 2015 Infection Control Manual Section II, page 12 #9</p>
c. All regulated wastes are contained in closable, leak proof puncture resistant, and biohazard labeled or color-coded containers, stored in limited access areas and removed from the facility by an appropriately licensed contractor.	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> N/A	Click here to enter text.	<p>HSA 2015 Infection Control Manual Appendix H OSHA - 1910.1030</p>
d. Biohazard labels are used appropriately.	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> N/A	Click here to enter text.	<p>HSA 2015 Infection Control Manual Section I page 8 Section D: Communication of Hazards. 1. Warning labels and biohazard sticks or signs must be affixed to all regulated wastes, refrigerators and freezers containing blood or infectious or hazardous</p>

					waste materials. Containers used to store, transport or ship blood or other potentially infectious materials must also be labeled. OSHA - 1910.1030
e. All inspections and calibrations have been performed according to the maintenance schedule on applicable medical equipment (i.e. autoclaves, microscopes) according to manufacturer’s recommendation.	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> N/A	Click here to enter text.	Laboratory Policy and Procedure Manual for Local Health Departments 2015
f. All public health staff has been trained regarding SDS forms and can locate the forms.	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> N/A	Click here to enter text.	OSHA 1910.1200 Annual training regarding SDS sheets is required – review site’s documentation to assure all staff members have received appropriate training annually. Ask a random staff member to locate SDS Manual.
g. SDS forms are available to all employees and forms are to be kept for as long as the chemical is in use or stored; the chemical list must be maintained for 30 years.	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> N/A	Click here to enter text.	OSHA 1910.1200 The site’s SDS Manual is to be available to all staff at all times. List of chemicals should be current and reviewed annually for completeness. TCA 50-3-2001
6. EMERGENCY PLANS					
a. Emergency action plans are reviewed, drilled, and exercised per CHS Policy.	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> N/A	Click here to enter text.	HSA Policy 8.4 Patient Centered Emergency Drill – annual (actual patient emergency cannot be substituted for a drill) with checklist documentation; Fire Drill – annual; Weather Related Emergency Drill – every 2 years; Violence in the Workplace – annual. Documentation should show employees that participated.
b. The facility evacuation plans are posted.	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> N/A	Click here to enter text.	HSA Policy 8.4 Floor plan type of evacuation plans should be posted in both public and employee area. The plan should have indicators that designate fire extinguishers, exits, and “You are here”

7. RECORDS					
a. Employee Records – Any employee records on site are maintained in an assigned, secure location with restricted access.	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> N/A	Click here to enter text.	All employee records should be in secure, protected areas that do not allow general staff access.
b. Patient Records – All patient records are maintained in the central filing system, that provides secure and limited access, except during clinic visit or for use during a review/audit. A method of designation for location is to be used for any patient record removed from central filing for any reason other than a current clinic visit.	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> N/A	Click here to enter text.	Current HSA Policy 3.9 (Records and Forms Management 5.0, 5.2) Assess several records from recent clinical visit dates to determine if the record is filed in Central Filing correctly. During walk through of building, observe for patient records located in non-secure areas. Records out of Central Filing for audit/review processes should be designated by list or out-guide placed in the Central Filing area.
8. GENERAL					
a. Posters - Required posters are present and readable*.	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> N/A	Click here to enter text.	All required posters/memorandums of information are posted as directed in the Central Office, Regional Offices, and at all local Health Departments. The multiple in one poster may be used and can be purchased from Labor Law Center, at www.GovDocs.com or each individual poster may be posted. These required federal posters can be obtained free at the following link: http://www.dol.gov/oasam/programs/osdbu/sbrefa/poster/matrix.htm or from the Workforce Development representative in your area. For office locations go to (updated 2/14/11): http://www.tennessee.gov/labor-wfd/et_dw_map.pdf Required state posters can be obtained free at the following link: http://www.tn.gov/labor-wfd/poster.htm
List of required posters: P=Display in Public Area E=Display in Employee Area ◊=Required State Poster ◆ = Required Federal Poster					

1) "Equal Employment Opportunity is the Law" 11/2009	◆ P	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> N/A	Click here to enter text.	This information is to be posted in a public area.
2) "Employee Rights under the Family and Medical Leave Act" revised 4/2016	◆ P	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> N/A	Click here to enter text.	This information is to be posted in a public area.
3) "Employee Rights Under the Fair Labor Standards Act" July 2016	◆ P	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> N/A	Click here to enter text.	This information is to be posted in a public area. This poster was revised 7/2016
4) "It's The Law! You Have a Right to a Safe and Healthful Workplace" 7/2015 TOSHA version	◇ E	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> N/A	Click here to enter text.	Post the Tennessee TOSHA poster instead of the OSHA poster which may be included on the commercially obtained multi-poster. This information is to be posted in an employee area.
5) "Tennessee Law Prohibits Discrimination in Employment" July 2014	◇ P	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> N/A	Click here to enter text.	TN Human Rights Commission, (615) 741-5825 Department of Labor & Workforce Development. This information is to be posted in a public area.
6) State of Tennessee Executive Order by the Governor #3 1/15/2011	P	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> N/A	Click here to enter text.	This information is to be posted in a public area. Poster is dated January 15, 2011 and is by Governor Haslam. (615) 741-3245 TN Dept. of Human Resources, Equal Employment Opportunity.
7) (a) "Having problems getting health care from TennCare" 12/9/13	P	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> N/A	Click here to enter text.	Poster should be posted in public area. Please note that (b) hyperlink contains two posters.
(b) "Can't get your medication from TennCare?" 12/9/13	P	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> N/A		
(c) "Can't get your medicine until TennCare OK's it?" 12/2/13	P	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> N/A		
9) Fair Hearing Procedure/WIC Regional WIC Director 1995	P	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> N/A	Click here to enter text.	This information is to be posted in a public area. Contact Regional WIC Director
10) "And Justice for All!" USDA Form AD-475-A 2015	P	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> N/A	Click here to enter text.	This information is to be posted in a public area. "And Justice for All" posters are to be displayed in a specific size: 11" width x 17" height. Contact Regional WIC

						Director
11) Services are available on a sliding fee scale basis.	P	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> N/A	Click here to enter text.	Posted in reception area. HSA Policies 7.9 and 7.22
12) Clinic Hours and Names of Direct Care Staff on Duty	P	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> N/A	Click here to enter text.	Clinic hours are posted on the front door or in front window of each Local or Regional Health Department site to be visible from the outside of the building. Each health department facility is required to have in public view for each clinic session, an up-to-date roster of direct health providers who staff the clinic.
13) Name and telephone number of nearest Poison Control Center Tennessee Poison Center – 1-800-222-1222	P	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> N/A	Click here to enter text.	This information is to be posted in a public area.
14) Equal Opportunity is The Law, Title VI Section 601, of the Civil Rights (P) Act of 1964, Dept. of Health, Office of Title VI/Non-Discriminatory Compliance and Diversity Business	P	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> N/A	Click here to enter text.	This information is to be posted in a public area. Office of Title VI/Non-Discriminatory Compliance and Diversity Business, Luvenia H. Butler, MS, Director, (615) 741-9421
15) Abuse Notice Regarding Chapter Number 804 of the Public Acts of 2006 (P) and Chapter Number 446 of the Public Acts of 2007. Effective 7/1/2007	P	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> N/A	Click here to enter text.	This information is to be posted in a public area. Poster was generated by CHSA Central Office and distributed through Regional Directors in 2007.
16) Complaint process forms for Civil Rights Act of 1964 Tennessee Department of Health Title VI Compliance Director (615) 741-9421	P	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> N/A	Click here to enter text.	Does not have to be posted on the wall but must be visible and available to the public without asking. This information is to be present in a public area.
17) “No Smoking” signs are posted in patient waiting rooms and other appropriate areas.	P E	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> N/A	Click here to enter text.	“Smoking of cigarettes, cigars, and pipes is not permitted in any portion of any Local Health Department or Regional Office used routinely for the delivery of services to children if the services are funded directly or indirectly with federal dollars. If clinical services are not provided at the facility, a “designated smoking area” indoors must be provided.” This information is to be posted in an employee and a public area. “No Smoking” signs must be posted at each entrance specifying that smoking is not permitted

						within 50 feet of any entrance.
18) Copy of the Department's Non-Discrimination Affirmative Action Policy	P E	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> N/A	Click here to enter text.	This information is to be posted in an employee and a public area. Check to see if the Commissioner's memorandum regarding Affirmative Action is posted. This memorandum is updated as needed by each Commissioner of Health in the State of Tennessee Department of Health Affirmative Action Plan (March 1, 2012 most recent memo).
19) Workplace Harassment Policy Revised December 4, 2012	P E	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> N/A	Click here to enter text.	This information is to be posted in an employee and a public area. Tennessee Department of Human Resources (615) 741-6350
20) TN Unemployment Insurance Poster 6/2013	◇ E	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> N/A	Click here to enter text.	This information is to be posted in an employee area.
21) Workers' Compensation Posting Notice – Revised 7/2015	◇ E	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> N/A	Click here to enter text.	This information is to be posted in an employee area. Department of Labor & Workforce Development
22) OSHA 300A Summary Form to be posted each February, March and April.	E	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> N/A	Click here to enter text.	Log is to be posted on employee bulletin board in each section in central office, and in each health department, or regional office. Respective information regarding incidents occurring on site should be reflected on form. Dept of Labor & Workforce Development
23) Your Rights Under USERRA, the Uniformed Services Employment and Reemployment Rights Act . U.S. Dept. of Labor, VETS October 2008	◆ E	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> N/A	Click here to enter text.	This information is to be posted in an employee area. U.S. Department of Labor, VETS
24) State Regulations for Protection Against Radiation (" Notice to Employees "), s posted as required by law. Revised 6/2012	E	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> N/A	Click here to enter text.	This document should be posted as required by law in the x-ray employee area. https://www.posterguard.com/posterimages/EHTN02.pdf
25) Know Your Rights Under the Recovery Act! - Federal Whistleblower	◆ E	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> N/A	Click here to enter text.	This July 2009 poster (poster is not dated) is to be posted in the employee area. Link to the Recovery and Reinvestment Act of 2009 document: http://www.oig.dol.gov/recovery/Section1553Whistle

						blowerProvisions.pdf This poster is not available in Spanish (as of 5/13/13)
b. Employee Identification – All employees, volunteers and interns have their work-issued employee identification visible at all work times.	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> N/A	Click here to enter text.		HSA Policy 3.10 All employees should wear identification badge in clear line of sight all times while in the work environment for security and identification. Lost or damaged tags should be reported to supervisor and replaced immediately.
c. Laboratory - Clinic laboratory maintains a current CLIA certificate.	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> N/A	Click here to enter text.		The local health department clinic laboratory maintains a current Clinical Laboratory Improvement Amendments (CLIA) certificate. The certificate does not need to be posted but needs to be available to upon request. http://www.cms.gov/Regulations-and-Guidance/Legislation/CLIA/index.html

*Required state and federal posters would need to be posted in the appropriate language according to the Title VI guidelines for translation of vital documents. Those posters designated by ♦ and ◇ are required by the state and federal government to be posted in the public area. If the LEP % for that site met the criteria to require that vital documents be translated into a given language, for example Spanish, then the state and federal posters that are required to be posted in the public areas of the clinic, would also have to be posted in Spanish.

All identified findings have been addressed (Yes/No) <input type="checkbox"/> Yes <input type="checkbox"/> No If No, Explain: Click here to enter text.
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NOTE: If the finding can be corrected immediately, then the component is marked “Yes.” The Facility Review will reflect the correction. (Not a deficiency).

[Click here to enter text.](#)

GOOD CATCH

The Good Catch Initiative will be implemented **July 1, 2014**, as staff has the opportunity to be trained on the process.

The Good Catch Initiative is a quality improvement technique that encourages the identification of potential system errors or problems before they reach the patient and/or cause harm. In some organizations these are known as “near misses”. The initiative recognizes staff for identifying “good catches” and is designed to share key findings across the organization.

The Good Catch Initiative will be ongoing on a daily basis and the process will be owned and directed by local staff and managers, not the responsibility of the QI Coordinator. The methods and procedures should be widely practiced and the process should be transparent. Positive and thorough feedback should be communicated by managers in such a way that clinic staff is aware of the difference their reporting makes.

This model will produce an environment that continues to build staff confidence in the quality improvement process through a non-punitive approach. Staff will be able to see where their efforts to report “Good Catches” result in action being taken to address the issues and concerns they identify. It also allows staff to be recognized for their contributions and further strengthen a culture of quality and safety.

Regional Core Management staff will monitor Good Catches to identify regional trends. The State Office of QI will compile reports to identify state-wide trends.

<https://www.youtube.com/watch?v=pug2jPX-uel&feature=youtu.be>

TDHTennessee Department of Health
Community Health Services**Good Catch Report**Questions about this form?
Please call (423) 979-4626

Good Catch : An unplanned event or situation that could have resulted in an accident, injury, illness, exposure or damage, but did not, either by chance or timely intervention (e.g. no slip, trip, fall, expired drug, incorrect label, or wrong medication occurred). Good Catches are opportunities for learning and afford the chance to develop preventive strategies and actions. Good Catches receive the same level of scrutiny as adverse events that result in actual injury.

Instructions

1. The witness or person with knowledge of the near potential hazard must complete section 1
2. The person who completed Section 1, must give the report to their supervisor
3. The supervisor must conduct an investigation, review with frontline staff, make recommendations and complete section 2
4. The entire report must be faxed to the Regional Staff

Section 1-To be completed by witness or person with knowledge of near miss/potential hazard

Date: _____ Time: _____ AM/PM Department: _____ Location: _____

Check all that apply: Expired Drugs Incorrect patient data/medication labeling Facility Unsafe equipment/equipment failure Other Description: _____

Print Name (Optional): _____ Date: _____

Section 2-To be completed by supervisor after investigation of potential hazard

After the investigation, explain in detail what caused the potential hazard to occur. Please print.

Supervisor Signature: _____ Date Reviewed: _____

Date faxed to Regional Staff: _____

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TDH

Tennessee Department of Health
Community Health Services



Good Catch Report

Questions about this form?
Please call (XXX) XXX-XXXX

Section 3-Regional Management Comments:

County or Staff specific Trend Identified County Action Plan Designed Regional Trend Identified Regional Action Plan Designed
Region: _____ Date Reviewed: _____
Date faxed to State QI: _____ Thank you note sent: _____

05/10/2014

TDH

Tennessee Department of Health
Community Health Services



Good Catch Report

Questions about this form?
Please call (XXX) XXX-XXXX

Section 3-Regional Management Comments:

County or Staff specific Trend Identified County Action Plan Designed Regional Trend Identified Regional Action Plan Designed
Region: _____ Date Reviewed: _____
Date faxed to State QI: _____ Thank you note sent: _____

05/10/2014