Lehigh Valley Health Network Street Medicine
Policy & Procedure Outline

1. Establishment of Care- see LVHN Street Medicine Policy for Establishment of Care
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11. Site of Care Evacuation Plan- See LVHN Street Medicine Policy for Site of Care Evacuation Plan
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15. Wound Assessment, Measurement, and Documentation- See LVHN Street Medicine Procedure for Wound Assessment, measurement, and documentation
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16. Safe Harbor, Tuesday Night Clinic, Staffing Protocol- See LVHN Street Medicine Protocol for Safe Harbor, Tuesday Night Clinic Staffing Protocol
17. Infection Control- See LVHN Street Medicine Policy for Infection Control
18. Phlebotomy- See LVHN Street Medicine Policy for Phlebotomy
19. General Process- See LVHN Street Medicine Policy for General Process
20. Staff Safety Guidelines- See LVHN Street Medicine Guidelines for Staff Safety Guidelines
21. Scope of Services- See LVHN Street Medicine Policy for Scope of Services
22. Dress Code- See LVHN Street Medicine Dress Code Policy for Dress Code
23. Content and Documentation of Orientation- See LVHN Street Medicine Procedure for Content and Documentation of Orientation
24. Interpreters Line- See LVHN Street Medicine Procedure for Street Medicine Trained Interpreters Line

25. Imaging- See LVHN Street Medicine Guidelines for Street Medicine Imaging

Additional Policies and Procedures from Lehigh Valley Health Network

26. Emergencies- See LVPG Guides Located on LVPG SharePoint at the following website: http://lvhsharepoint4/sites/LVPG/ClinicalServices/CE/LVPG%20Emergency%20Cart/Forms/AllItems.aspx
27. Patient Rights and Responsibilities- See LVHN Policy for Patient Rights and Responsibilities
28. Nurse Visits- see LVPG Policy for Nurse Visits
29. Medical Record- External Agency Record Reviews- see LVH External Review Agency Access to Medical Record
30. Patient Suicidal Ideation- see LVPG Policy for Suicidal thought management, Outpatient
31. Safety Concerns and Disruptive Patients- see LVH Policy for Patient Safety Report- LVHN Administrative Manual

Lehigh Valley Health Network Street Medicine
Establishment of Care

MANUAL: Clinical
ORIGINATION: 1/5/2017 **REVISED:**

KEY WORDS: Triage, Walk-ins, No Show

SUBJECT: Establishment of Care- Street Medicine

SCOPE: Street Medicine Providers and Employees

SKILL LEVEL: RNs, LPNs, MAs

PURPOSE: To provide a standard for order in which patients are seen by clinical staff/provider

POLICY

I. DEFINITIONS:

Provider- PA-C, CRNP, DO, MD

Clinical staff- MA, LPN, RN

Established patient- Any patient who has completed at least one office visit by a clinician in The Street Medicine Clinic Setting within 1year.

II. GUIDELINE/INTERVENTION:

Guidelines:

- No appointments are made in advance. Patients are seen one a "first-come, first-served" basis, unless an urgent issue is brought to the attention of the Clinical Staff or Provider on site.
- Clinical staff reserves the right to see patients out of order of arrival to meet the needs of a patient, based on clinical judgment.
- Fixed Clinic: evening clinic hours- Patients should be signed in on the roster for a visit within 1 hour after clinic start time unless accepted by provider on site.
- A provider is not obligated to see a patient if they are not on the sign-up roster.
- Patients must be present in waiting area to ensure access to care and to be seen in chronological order of patient arrival.

III. DOCUMENTATION:

EMR or Paper Chart:
The following documentation for patient visits should include all documentation needed for a standard LVPG office visit.

- LVPG Street Medicine Encounter Sheet
- LVPG Street Medicine H&P Encounter Sheet
- Communication Form
- HIPPA/Consent to Treat Form

REVISION:

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DISCLAIMER STATEMENT:

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Lehigh Valley Health Network Street Medicine

Clinical Services Rendered

MANUAL: Clinical
ORIGINATION: 1/5/2017 **REVISED:**

KEY WORDS: labs, equipment, specimen handling, gynecological exams

SUBJECT: Clinic Services offered by Street Medicine

SCOPE: Street Medicine Providers and Employees

SKILL LEVEL: RNs, LPNs, MAs

PURPOSE: To provide a standard for all clinical services offered in a Street Medicine clinic setting.

POLICY

IV. DEFINITIONS:

Provider- PA-C, CRNP, DO, MD

Clinical staff- MA, LPN, RN

V. GUIDELINE/INTERVENTION:

Guidelines:

- All lab draws, requisitions, and handling of patient specimens and related equipment will follow LVPG Policy and Procedure
- See LVH Policy and Procedure for specimen Testing: Specimen Testing - Patient Care Services
- See LVPG Quality Control Policy
- See LVPG Specimen Collection and Handling Policy
- See LVPG Laboratory Complaints and Communications Policy
- See LVPG Laboratory Personnel Policy
- See LVPG Patient Lab Test Management Policy
- See LVPG Physician Office Lab QA policy
- See LVPG Proficiency Testing Policy
- See LVPG Annual Laboratory Competency Policy
- See LVPG Lab Safety Policy
- Procedures not offered by LVHN Street Medicine include but no limited to gynecological exams for annual/wellness visits or problem focused exams.

VI. DOCUMENTATION:

EMR or Paper Chart:
The following documentation for patient visits should include all documentation needed for a standard LVPG office visit.

- Clinician order for diagnostic tests in EMR or paper chart

- All specimen collection documentation will follow the LVPG workflow see: Specimen Collection in the Offices (Clinic Collect)
- Resulted diagnostics in EMR or paper chart
- Patient notification of diagnostic result in EMR or paper chart

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Lehigh Valley Health Network Street Medicine
Medical Record Storage

MANUAL: Clinical
ORIGINATION: 1/5/2017 **REVISED:**

KEY WORDS: Medical Records

SUBJECT: Medical Record Storage- Street Medicine

SCOPE: Street Medicine Providers and Employees

SKILL LEVEL: RNs, LPNs, MAs

PURPOSE: Maintain proper storage of Medical Records

POLICY

I. KEY POINTS:

EMR is utilized in the established Street Medicine clinic settings.

Paper Medical Records are stored in Street Medicine clinic site with a double-locked system in a fire proof cabinet.

II. DEFINITIONS:

Provider- PA-C, CRNP, DO, MD

Clinical staff- MA, LPN, RN

III. GUIDELINE/INTERVENTION:

Guidelines:

- All documentation is completed in the EMR unless pre-determined for specific clinic sites. The clinic sites that utilize paper charts for medical record documentation must be stored on clinic site with a double-locked system in a fire proof cabinet.
- All paper charts will be transported to and from the clinic sites via green bag with a tie wrap to be scanned into the EMR.

IV. LVPG Clinical Services Manual

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Lehigh Valley Health Network Street Medicine
Medication Storage

MANUAL: Clinical
ORIGINATION: 1/5/2017 **REVISED: 12/20/2017**

KEY WORDS: Medication Storage, Vaccines

SUBJECT: Medication Storage guidelines- Street Medicine

SCOPE: Street Medicine Providers and Employees

SKILL LEVEL: RNs, LPNs, MAs

PURPOSE: Identifying proper medication storage safe medication storage and handling.

POLICY

I. KEY POINTS: Medication storage requirements must be followed as dictated by LVHN Pharmacy Policy

DEFINITIONS:

Provider- PA-C, CRNP, DO, MD

Clinical staff- MA, LPN, RN

GUIDELINE/INTERVENTION:

Guidelines:

Medications

- Medications at permanent clinic sites are to be stored with a double-locked system in a fire proof cabinet.
- All medications are to be kept at room temperature: 68-77° F per LVHN policy-

  LEHIGH VALLEY HOSPITAL – MUHLENBERG- Pharmacy Department Pharmacy Room Temperature Documentation

  - If medications are noted to be outside this temperature, pharmacy should be consulted for an appropriate expiration date.
- Medications in backpacks for Street rounds are to be stored in a backpack with a lock on it.
  - When backpack is not in use for Street rounds the backpack with medications is to be stored with a double-lock system.
- Medications are maintained in the original packaging.
- If medication is bulk packaged, an original open date should be written on the package upon opening. If the medication is unit dosed, the expiration is as noted on the unit dose packaging.
- Medications are only to be accessed by the prescribing/dispensing providers.

- Medications stored at temporary clinic sites are to be stored with a double-locked system in a fire proof cabinet.

Vaccines

Influenza vaccine is maintained in the refrigerator at 35 – 46 F (2 – 8 C) per: LVPG policy- LEHIGH VALLEY PHYSICIANS GROUP (LVPG) Clinical Services Manual- Medication Storage-Refrigerator & Freezer. **LVPG Clinical Services Manual**

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Lehigh Valley Health Network Street Medicine
Medication Dispensing

MANUAL: Clinical
ORIGINATION: 1/5/2017 **REVISED:**

KEY WORDS: Medication/controlled substance Distribution

SUBJECT: Medication Distribution - Street Medicine

SCOPE: Street Medicine Providers and Employees

SKILL LEVEL: MDs, CRNPs, Pas

PURPOSE: Identify who can prescribe and distribute medications and what medications maybe prescribed and distributed.

POLICY

I. KEY POINTS: Street Medicine Employed Providers may prescribe psychotropic medications. Volunteer providers cannot prescribe benzodiazepines, controlled substances, and other psychotropic medications.

II. DEFINITIONS:

Provider- PA-C, CRNP, DO, MD

Street Medicine Provider- Provider employed by the LVHN Street Medicine Program

Volunteer Provider- Provider who volunteers their time at Street Medicine Clinic Sites without monetary compensation; A Provider not employed by the LVHN Street Medicine Program.

Clinical staff- MA, LPN, RN

III. GUIDELINE/INTERVENTION:

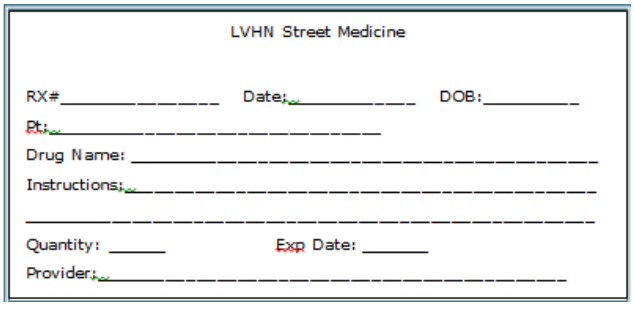
Guidelines:

Medications

- All providers are required to practice within their scope of their license and within compliance of their LVHN credentials.
- Narcotics, benzodiazepines and other controlled substances cannot be prescribed, refilled, or dispensed to patients at any time.
- Street Medicine Volunteer Providers (Physicians & Advanced Practice Clinicians cannot prescribe psychotropic medications unless otherwise approved by a Street Medicine employee Provider. Psychotropic medications include:
    - SSRIs
    - SNRIs
    - Tricyclic Antidepressants
    - MAOIs
    - Antipsychotics

- Buspirone
- Trazadone
- Wellbutrin
- “Mood Stabilizers” (carbamazepime, valproic acid, lithium, lamotrigine)
- Stimulants for ADHD (amphetamines, methylphenidate, etc)

- Street Medicine employee providers are able to prescribe psychotropic medications in accordance with their license.
- Only providers licensed to prescribe medications are able to distribute medications, this includes both counting pills and dispensing to the patients.
- When possible, patients will receive prescribed medications from a Street medicine provider. Medications dispensed to patients from Street Medicine provider must be from the approved Street Medicine medication Formulary List. (Attachment A)
  - Valley Youth House Clinic Medication Formulary is limited to:
    - Azithromycin 250mg tabs, #12
    - TMP/SULFA DS tabs, #20
    - Cephalexin 500mg capsules, #40
    - Naproxen 500mg tabs, #20
    - Loratidine 10mg tabs, # 20
    - Fluticasone nasal spray, #2 inhalers
    - Methylprednisone dose pack, #1
    - No other prescriptions can be provided.
- All medications are to be dispensed in tamper resistant containers/pill bottles unless a waiver is signed by the patient and placed in the medical record chart. (Attachment B)
  - If medications are unit dosed, they may be dispensed in a plastic zip lock bag with a Street Medicine medication label fixed onto the bag.
- All medications should be dispensed with a Street Medicine medication label with all the proper information filled in as indicated on the label sticker. See example below.


LVHN Street Medicine

RX#_____ Date:_____ DOB:_____

Pt:_____

Drug Name: _____

Instructions:_____

_____

Quantity: _____ Exp Date: _____

Provider:_____

- All dispensed medication must be documented on the medication Log located at each established clinic. (Attachment C)
- If a patient requires a prescription item(s) not in stock or not part of the street medicine formulary, then a medication will be chosen from the Spectrum apothecary $4.00 list.
  - Website link: https://www.lvhn.org/sites/default/files/uploads/PDFs/%244%20Generic%20list%20Jan%202016.pdf

- Prescriptions must be written on a Street Medicine prescription and can only be filled at one of the three Health Spectrum pharmacies.
    - 17th and Chew Street, Allentown, PA 18105
    - 1200 South Cedar Crest Blvd, Allentown , PA 18103
    - 2545 Schoenersville Rd, Bethlehem, PA 18017
- If a patient has insurance, Street Medicine may opt to pay the insurance co-pay if the patient is not able to afford the co-pay at the time of service.. If Street Medicine is paying the co-pay, it is indicated on the prescription and taken to a Health Spectrum Pharmacy to be billed to the Street Medicine account.
- If a patient does NOT have insurance, prescriptions taken to Health Spectrum Pharmacy will be billed to the Street Medicine account. The patient will not be responsible for payment or co-payment of the prescription(s).

VACCINES

- Screen patient for any contraindications to the vaccine before administration.
- Upon administration of the above mentioned vaccines, the following information will be documented in the patient record:
    i. vaccine
    ii. dosage
    iii. route
    iv. site
    v. time of administration
    vi. lot number of vaccine
    vii. manufacturer of vaccine
    viii. nurse's signature
- A Vaccine Information Sheet from the Centers for Disease Control (CDC) is provided to the patient prior to the immunization and documented in the medical record.

IV. LVPG Clinical Services Manual

V. Attachments:

a. Attachment A – Street Medicine Formulary Medications

b. Attachment B- Tamper Resistant Containers/pill bottles Waiver

c. Attachment C- Medication Dispense Log

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Attachment A

Homeless Outreach Drug Request Sheet

Bill drugs to account # _30-613-6310-300 ___ Date: 6/29/15

Requesting: Jarrod (*Should only be Jarrod Kile RPh. or Brett Feldman PA-C*)

Contact number when medications filled Jarrod

	DRUG	QUANTITY PER PACKAGING	QUANTITY ORDERING
	Acetaminophen 500mg	#700	
	Albuterol inhalter (proventil) (8g)	#1	#20 (Twenty) ← small ones for Hospital use
	Amlodipine 10mg	#1000	
	Amoxicillin 500mg	#100	
	Atenolol 25mg	#1000	
	Azithromycin 250mg	#30	
	Bacitracin ointment tube	#1	
	Bactrim DS tablet	#500	
	Benzonate capsule	#500	
	Bupropion SR 150mg	#500	
	Cephalexin 500mg	#500	
	Ciprofloxacin 500mg	#500	
	Clindamycin 300mg	#100	
	Diclofenac 75mg	#500	
	Diphenhydramine 50mg	#100	
	Famotidine 20mg	#100	
	Fluticasone nasal spray *(flonase)*	#1	
	Furosemide 20mg	#1000	
	Glipizide 5mg	#1000	
	Guaifenesin 600mg	#100	
	Hydrochlorothiazide 12.5mg	#500	
	Ibuprofen 600mg	#500	
	Levaquin 500mg	#100	
	Loperamide 2mg	#100	
	Loratadine 10mg	#500	
	Lisinopril 10mg	#100	
	Metformin 500mg	#1000	
	Metoprolol 25mg	#1000	
	Metoprolol 50mg	#1000	
	Minocycline 100mg	#50	
	Naproxen 500mg	#500	
	Nicotine 21mg patch	#28 (Box)	5 Boxes
	Nortriptyline 10mg	#500	
	Omeprazole 20mg	#1000	
	Paroxetine 20mg	#500	
	Prednisone 10mg	#1000	
	Saline Nasal Spray	#1	
	Sertraline 50mg	#500	
	Simvastatin 20mg	#1000	
	OTHER: Nicotine 14mg patch	1 Box	# 5 Boxes
	OTHER: Nicotine 7mg patch	1 Box	#5 Boxes
	OTHER: Advair 250/50 inhaler		#6 inhalers
	OTHER: Advair 500/50 inhaler		#6 inhalers
	OTHER: Lantus Insulin - 10ml vial	vial	# 10 vials

FILLED BY: _____ DATE: _____

Only ? Call 2389 JF

Attachment B

Request to Dispense Prescription Medication in Nonchild-resistant Container and Release, Hold Harmless and Agreement to Indemnify.

I understand that all prescription medications are required to be dispensed in a child-resistant container unless the patient or the patient's agent authorizes the Pharmacist to dispense the medication in a regular (nonchild-resistant) container. I certify that I am the patient or the patient's authorized representative and agent and that I request that all medications, now and in the future, for the below named patient be dispensed in a nonchild-resistant container.

I understand that prescription medications may be dangerous, especially to children and that a regular (non-resistant) container increases the risk that a child may get hold of the medication in the container. I understand that this may cause serious injury or even death to a child or other person getting hold of this medication.

I hereby release the pharmacist and the pharmacy from all liability, which may be caused by the lack of a child-resistant container for any medications for the below-named patient.

I hereby agree to hold harmless and indemnify the pharmacy and its agents and pharmacists from any loss or damage to any and all third parties including children and their relatives which may result, in whole or in part, from the lack of a child-resistant container for any medications for the below-named patient which have been dispensed in regular (nonchild-resistant) container as authorized and requested in this Release, Hold Harmless and Agreement to Indemnify.

Dated this _____day of _____20_____

_____
Patient

_____
Authorized Agent of Patient

Attachment C

Medication, Practice Stock-Log

Lehigh Valley Health Network

Page ___

Date	Patient Name	Medication and Dose	# Tabs or Amt. of Liquid	Manufacturer	Lot # and Exp. Date	Usage / Instructions	Initials

Lehigh Valley Health Network Street Medicine
Disability Evaluation Guidelines

MANUAL: Clinical
ORIGINATION: 1/5/2017 **REVISED:**

KEY WORDS: Disability Evaluation, SSI, SSD

SUBJECT: SSD/SSI Disability evaluation- Street Medicine

SCOPE: Street Medicine Providers and Employees

SKILL LEVEL: MD, PA, CRNP, DO, Licensed Social Workers, Case managers

PURPOSE: Identify who can complete disability forms for a patient.

POLICY

I. KEY POINTS: Only LVHN Street Medicine providers and associated care managers may complete SSI/SSD forms for Street Medicine Patients

II. DEFINITIONS:

Provider- PA-C, CRNP, DO, MD

Clinical staff- MA, LPN, RN

Care Managers- Social Workers, Case managers

III. GUIDELINE/INTERVENTION:

Guidelines:

- LVHN Street Medicine employed providers and associated care managers may complete SSI/SSD disability evaluations of any kind for Street Medicine patients.
- Copies of all disability forms must be included in the medical records

IV. LVPG Clinical Services Manual

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Lehigh Valley Health Network Street Medicine
Physicals

MANUAL: Clinical
ORIGINATION: 1/5/2017 **REVISED:**

KEY WORDS: Patient Physicals

SUBJECT: Patient Physicals- Street Medicine

SCOPE: Street Medicine Providers and Employees

SKILL LEVEL: MDs, PAs, CRNPs, DOs

PURPOSE: Identify type of physicals conducted by Street Medicine provider (s)

POLICY

I. KEY POINTS: Street Medicine will conduct physicals for Driver's License and Employment related driver's physicals and work physicals at established clinic sites.

II. DEFINITIONS:

Provider- PA-C, CRNP, DO, MD

Clinical staff- MA, LPN, RN

III. GUIDELINE/INTERVENTION:

Guidelines:

- Street Medicine providers may conduct physicals for:
  - Driver's license
  - Pre-employment
- Disability physicals will not be performed unless an exception has been approved by the Director of Street Medicine.
- Records of the physical must be scanned into the EMR

IV. DOCUMENTATION:

EMR or Paper Chart:
Documentation for patient visits includes all documentation needed for a standard LVPG office visit.

V. LVPG Clinical Services Manual

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Lehigh Valley Health Network Street Medicine

Co-signatures

MANUAL: Clinical
ORIGINATION: 1/5/2017 **REVISED:**
KEY WORDS: Co-signatures

SUBJECT: Street Medication Co-signatures needed when preceptor is not a MD or DO.

SCOPE: Street Medicine Providers and Employees

SKILL LEVEL: MDs, Advanced Practice Clinicians, DOs

PURPOSE: Identify those that need co-signatures on patient charts and how they are to be obtained.

POLICY

I. KEY POINTS: If preceptor is not a physician and is a CRNP or PA-C that requires a co-signature the provider will need to obtain a co-signature.

II. DEFINITIONS:

Provider- PA-C, CRNP, DO, MD

Clinical staff- MA, LPN, RN

III. GUIDELINE/INTERVENTION:

Guidelines:

- All charts completed in clinics that utilize the EMR will be co-signed per LVHN and LVPG policy. For the clinic settings in which the medical record is a paper chart, (i.e. Safe Harbor), Street Medicine staff in charge of scanning documents into EMR will send the scanned item(s) to the APC to sign and obtain designated co-signature within 4 days of patient visit.

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Lehigh Valley Health Network Street Medicine
Standards for off-site Street Medicine clinics

MANUAL: Clinical
ORIGINATION: 1/5/2017 **REVISED:**

KEY WORDS: Standard, Clinics

SUBJECT: Standards for off-site Street Medicine Clinic Sites

SCOPE: Street Medicine Providers and Employees

SKILL LEVEL: RNs, LPNs, MAs

PURPOSE: To provide standardization for off-site Street Medicine Clinic Sites.

POLICY

VII. DEFINITIONS:

Provider- PA-C, CRNP, DO, MD

Clinical staff- MA, LPN, RN

Temporary Clinic- Site that does not have a designated area for the Street Medicine Clinic to be held in.

Permanent Clinic- Site that has a designated area for the Street Medicine Clinic to be held in.

VIII. GUIDELINE/INTERVENTION:

Guidelines:

- All document forms required for patient visits will be used at each Street Medicine off-site clinic.
- At all permanent and temporary clinic sites medication storage will follow the LVHN Street Medicine Medication Storage Policy.
- All documentation is completed in the EMR unless pre-determined for specific clinic sites. The clinic sites that utilize paper charts for medical record documentation must be stored on clinic site with a double-locked system in a fire proof cabinet.
- All paper charts will be transported to and from the clinic sites via green bag with a tie wrap to be scanned into the EMR.

IX. DOCUMENTATION:

EMR or Paper Chart:

The following documentation for patient visits should include all documentation needed for a standard LVPG office visit.

- LVPG Street Medicine Encounter Sheet
- LVPG Street Medicine H&P Encounter Sheet
- Communication Form
- HIPPA/Consent to Treat Form

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Lehigh Valley Health Network Street Medicine
Nurse Visits

MANUAL: Clinical
ORIGINATION: 11/22/2017 **REVISED:**

POLICY
To assure that appropriate care is provided to all patients, the following process/practice shall be followed regarding encounters ("nurse visits") provided by clinical staff for medication, treatment, diagnostics, and/or education of established patients:

- Nurse visits shall be performed per specific written practitioner order, approved protocol or standard.
- Clinical staff shall be determined to be competent by the clinical coordinator with written documentation before providing these services.
- Patients receiving nurse visits must be established patients of the office practice.
- A practitioner must be present in the office/practice when nurse visits are provided. The practitioner ordering a particular service need not be the practitioner who is supervising the service (Medicare Benefit Policy–"Incident to" Requirements).

Some nurse visits may require a co-payment which is to be collected at time of service.

SCOPE
LVPG Personnel

DEFINITIONS

Clinical Staff – RN, LPN, PSSR, Medical Social Workers, others as designated by LVPG policy, LVHN policy and/or Medical Staff Rules and Regulations.

"Incident to" – services and supplies furnished as an integral, although incidental, part of the practitioner's personal professional services in the course of diagnosis or treatment of an injury or illness. Services may be performed by auxiliary personnel under the required level of supervision.

Practitioner – a doctor of medicine or osteopathy, dentist, optometrist, podiatrist, chiropractor, certified nurse midwife (CNM), certified registered nurse anesthetist (CRNA), clinical psychologist, physician assistant (PA) and certified registered nurse practitioner (CRNP).

Supervising Practitioner – a practitioner who is available by phone and immediately available to furnish assistance and direction. It does not mean that the practitioner must be present at the site of care when the visit is performed.

Street Medicine Personnel - includes, but is not limited to all employees, medical staff, allied health professional staff, students, volunteers and others engaged in any activities in the network, excluding patients and visitors.

PROCEDURE (Go in a table format)

ACTION	RESPONSIBILITY
1. Scheduling: • Ascertain the reason(s) for the patient's visit. • Document reason in the scheduling system	1. Receptionist

2. Confirm the reason(s) for the visit.	2. Clinical Staff
3. Verify the practitioner's written order or protocol	3. Clinical Staff
4. Follow written order, approved protocol or standard.	4. Clinical Staff
ACTION	**RESPONSIBILITY**
5. Document in the medical record: • reason for visit • ordering practitioner and date of order or protocol • interventions/findings and patient's response(s) ***Documentation Example:*** 9/30/09 4:00 pm Blood pressure check per order of Dr. Smith 9/1/09. BP: 148/84. Patient states she is feeling fine. Taking meds as prescribed. Jane Doe, R.N.	5. Clinical Staff
6. Report findings to the supervising practitioner.	6. Clinical Staff
7. Review findings, make medical decisions as appropriate, and sign completed visit note.	7. Supervising Practitioner
8. Complete an Encounter Form for billable services • Use the supervising practitioner as the billing practitioner. • Refer to Attachment A for clinical staff services visit principles.	8. Clinical Staff

ATTACHMENTS

NURSE VISIT (ATTACHMENT A: Nurse Services Visit Guidelines)

NURSE VISIT (ATTACHEMENT B: Nurse Visit Protocol)

POLICY RESPONSIBILITY IN COORDINATION WITH

Administrator, LVPG Clinical Services Risk Management
LVPG Coding and Compliance

REFERENCES

AMA CPT Manual 2012
Medicare Part B- Chapter 6, Section 20.5.2 – 2012

REVISION

LVPG reserves the right unilaterally to revise, modify, review, rescind or alter the terms and conditions of this policy within the constraints of the law, by giving reasonable notice.

DISCLAIMER STATEMENT

This policy and the implementing procedures are intended to provide a description of recommended courses of action to comply with statutory or regulatory requirements and/or operational standards. It is recognized that there may be specific circumstances, not contemplated by laws or regulatory requirements that make compliance inappropriate. For advice in these circumstances, consult with the department of Risk Management and/or Legal Services.

Lehigh Valley Health Network Street Medicine
NURSE VISIT
(ATTACHEMENT B: Nurse Visit Protocol)

MANUAL: Clinical
ORIGINATION: 11/22/2017 **REVISED:**

I. SCOPE

RN, LPN

II. DEFINITIONS

Established Patient- An individual who has previously been seen by a Street Medicine practitioner.
Practitioner- a doctor of medicine or osteopathy, dentist, optometrist, podiatrist, chiropractor, certified nurse midwife (CNM), certified registered nurse anesthetist (CRNA), clinical psychologist, physician assistant (PA) and certified registered nurse practitioner (CRNP).
Supervising Practitioner – a practitioner who is available by phone and immediately available to furnish assistance and direction. It does not mean that the practitioner must be present at the site of care when the visit is performed.

III. PROTOCOL

An established patient may be seen for a subsequent nurse visit if they have been diagnosed with any of the following medical issues:

- Diabetes Type 1 & Type 2
    - Start of new diabetic medications
    - Blood Glucose follow up
- Hypertension
    - Start of new hypertensive medications
    - Blood Pressure follow up
- Hypotension
    - Start of new hypotensive medications
    - Blood Pressure follow up
- Wound Care
    - Assessment/evaluation and dressing changes
- Education Gaps related to diagnosis and/or medications
- And any other medical issues deemed appropriate by the Street Medicine practitioner

Lehigh Valley Health Network Street Medicine
NURSE VISIT
(ATTACHMENT A: Nurse Services Visit Guidelines)

MANUAL: Clinical
ORIGINATION: 11/22/2017 **REVISED:**

PRINCIPLES

1. The patient must have been seen by a Street Medicine practitioner before any subsequent nurse visits may take place

   – this can be an established patient only. Billable nurse visits/services must be ordered by a practitioner at a practitioner visit prior to the scheduling the nurse visit/service.

2. The ordering practitioner establishes the medical necessity for a nurse visit. Documentation in the medical record must make reference to the protocol and the date.

3. A supervising practitioner must be available by phone when a nurse visit/service is rendered. The practitioner ordering the nurse visit/service need not be the practitioner who is supervising the service.

4. The documentation must include the reason for the nurse visit/service, as well as the diagnosis. The associated

   ICD 9 (10) must reflect the reason for the service rendered. In summary, the documentation needs to include

   the following.

   - Date of service provided
   - Reference to the original protocol and date
   - Diagnosis based on practitioner's order/protocol
   - Brief note of the services provided by clinical staff and the patient's response
   - Authentication by clinical staff and supervising practitioner.

5. If, during a scheduled nurse visit, the patient needs to be seen by a practitioner, the visit will be coded as a practitioner visit; not a nurse visit/service. However, the documentation must reflect the services that were provided during the nurse visit/service.

Using the CPT Code 99211 for Clinical Staff Services Visit
Examples include: Ordered BP check, diabetic education (excluding when done by a registered dietician), genetic counseling, education related to a negative or positive rapid strep, contraception management, and education related to a PT/INR.
This code could be for any education based on the practitioner order. The diagnosis code used for the clinical staff service visit is to be the same as the diagnosis code used by the ordering practitioner.

99211 Example Guideline Table

Service	LPN-RN	Care Manager	ICD 9- (10)
BP Check	YES	YES	796.2 (elevated BP- no dx of hypertension) or 401.x (hypertension)
Diabetic Education	YES	YES	250.xx
Education related to a Negative/Positive rapid strep	YES	YES	462 (sore throat (+ culture throat)) or 034.0 (positive strep throat)
Contraception Management	YES	YES	V25.xx
Education related to a PT/INR	YES	YES	V58.61 + condition being treated, ex: A-fib, DVT, etc.
36415- Ordered Venipuncture	YES	YES	Reason for test, sign, symptom
87880 – Ordered rapid strep	YES	YES	Reason for test, sign, symptom
81002- Ordered urinalysis	YES	YES	Reason for test, sign, symptom

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Lehigh Valley Health Network Street Medicine
SITE OF CARE EVACUATION PLAN

MANUAL: Clinical
ORIGINATION: 11/22/2017 **REVISED:**

1. Take a head count of all personnel within the site of care.
2. Check that the site of care has been vacated and close the door.*

   *Apply a piece of tape to the outside doorknob when leaving the vacated area. This will allow any others to quickly identify that site of care is empty.

   In the event of a bomb threat:
   - Do not touch or move any suspicious objects or packages
   - Leave doors open
   - Take personal packages, purses, etc.

3. Exit the site of care area and proceed to the nearest fire exit.
4. Assemble in the parking lot outside of the building and await further direction.
5. Repeat the head count to assure all Street Medicine staff are present.

Lehigh Valley Health Network Street Medicine
CLINICAL BAG PROCEDURE

MANUAL: Clinical
ORIGINATION: 11/22/2017 **REVISED: 12/20/2017**

I. PURPOSE

To provide guidance to the clinical staff in the use of a clinical bag in sites of care and on Street Rounds

II. OUTCOME

Clinical staff will have knowledge of the procedure to use when taking the clinical bag into sites of care and on Street Rounds

III. EXPLANATION OF TERMS

Clinical Bag - bag used to carry supplies needed for infection control and patient care.

IV. SKILL LEVEL

RN, LPN, PT, PTA, OT, COTA, SLP, MSW, HHA, Volunteer, Chaplain, CRNP, Medical Director (or designee)

V. POLICY AND GENERAL INSTRUCTIONS

A. The clinical bag contains items used for routine patient assessment and care.
   a. The clinical bag does not contain any medications for dispensing.

B. The bag(s) should not be placed on the floor or ground. It may be placed on a clean, hard surface. If it must be placed on soiled surfaces, a barrier should be placed between the bag and the surface.

C. The inside of the bag is considered clean. Hands must be cleansed before entering the bag. Hand washing supplies and barriers need to be in an accessible area away from the clean supplies.

D. The bag should be transported in an area of the vehicle that is designated as clean. Generally, the bag is transported in the trunk or on the seat of the car.
   1. The transport area must have a lock.
   2. If the clinician is away from the vehicle, the bag should be locked in a clean area not visible from outside of the vehicle to prevent theft.

E. The bag should be constructed of a washable fabric. If the bag becomes soiled or contaminated, the bag should be cleaned with a disinfectant wipe.

1. The clinician will notify the supervisor if the bag must be professionally decontaminated or replaced.

F. If the patient's residence is heavily infested with insects or rodents, the bag should not be brought into the residence.

VI. EQUIPMENT

Contents of the clinical bag may include the following and additional items at the discretion of the clinician:

Liquid soap	Tongue blades
Waterless hand cleaner	Germicidal towelettes
Paper towels	Digital thermometer
Surgical mask	
	Adult BP cuff
	Large adult BP cuff
Gloves – clean	Stethoscope
	Tape measure
Barrier	Wound measurement tool
Alcohol wipes	Few assorted dressings and tape
Applicators	

VII. PROCEDURE

ACTION	RATIONALE
1. Place the bag on a clean surface or barrier and out of reach of children and/or pets.	Prevent contact with contaminated surface. Will also maintain the contents in the inside of the bag as clean supplies.
2. Wash hands before entering the bag using supplies carried in an outside pocket and before donning and removing gloves.	Maintain infection control practices.
3. Remove all items needed for the visit and place them on a clean surface. Use the fold down pocket of bags when available.	Decreases frequency of entering clinical bag and maintaining infection control practices.
4. After patient care, cleanse used equipment with a germicidal/alcohol wipe.	Maintain infection control practices.
5. Return equipment to bag.	
6. If a barrier was used under the bag, dispose of the barrier in the trash or in a trash bag to be disposed of off-site. It may not be reused.	

VIII. DOCUMENTATION

None

IX. ATTACHMENTS

None

X. REFERENCES

Fay Susan, MSN, RN, Infection Control in Home Care and Hospice Second Edition, Home Healthcare Nurse. 24(6); 402-403, June 2006

Rhinehart, E., McGoldrick, M., APIC Infection control in Home Care and Hospice, 2nd Edition

XI. DISTRIBUTION

Lehigh Valley Health Network Street Medicine

XII. DISCLAIMER

This policy and the implementing procedures are intended to provide a description of recommended courses of action to comply with statutory or regulatory requirements and/or operational standards. It is recognized that there may be specific circumstances, not contemplated by laws or regulatory requirements that make compliance inappropriate. For advice in these circumstances, consult with your supervisor and the department of Risk Management/Legal Services.

Lehigh Valley Health Network Street Medicine

APPLICATION OF DRESSINGS TO WOUNDS

I. PURPOSE

To maintain a moist, clean wound bed, to absorb exudate, and to protect wound.

II. DEFINITIONS

Absorptive Specialty Dressing: Dressing comprised of 2 or more layers that is manufactured as a single dressing. These dressings are generally non-adherent but may have an adhesive border.

Collagens: Fibrous insoluble protein found in skin, bones, ligaments and cartilage which stimulates new tissue development and creates an optimal environment for healing.

Composites: Dressings made up of 2 or more physically distinct products that are combined into a single dressing.

Hydrocolloid: Occlusive dressing that is resistant to bacteria or other contaminates. Hydrocolloids are porous to moisture but not water. They are self-adhesive and easy to shape. Facilitates autolytic debridement.

Transparent dressing: Thin, waterproof, see-through non-absorptive dressing. Waterproof and does not allow bacteria to penetrate.

Hydrogel: Transparent water based gel which hydrates body tissues and facilitates autolytic debridement.
Impregnated Gauze: Fibrous dressing which is saturated with some type of ointment, cream, gel or solution.

Alginates: Dressings made of fibers from brown seaweed. Highly absorbent, these fibers can hold up to 20 times their weight.

Silver Antimicrobial Dressings: Antibacterial wound care product, which utilizes silver for its antimicrobial properties

III. SCOPE

RN, LPN

SKILL LEVEL

RN, LPN

IV. INTERVENTIONS/GUIDELINE

A. Dressing choice should be based on the wound characteristics and the patient's health including complicating conditions.

B. A physician's order is required for all wound care. It should include:

1. Anatomical site
2. Cleaning solution and method
3. Primary dressing
4. Secondary dressing if applicable
5. Frequency of dressing change
6. Whether family may be instructed
7. Periwound protection, if needed

C. Wound care in home health is a clean procedure using standard precautions.

1. Cleanse hands before all procedures.
2. Wear clean gloves during wound care.
3. Cleanse hands and change gloves when contaminated by soiled dressings as needed.
4. Wear goggles, mask and gown if splash may occur.

If physician orders aseptic technique, the nurse will call physician to verify the appropriateness of the order in the home environment.

D. Dispose of all contaminated equipment and waste per agency policy.

V. PROCEDURE/EQUIPMENTS

Absorptive Specialty Dressing Procedure

EQUIPMENT:

- Gloves
- Hand Sanitizer or antibacterial soap and paper towels
- Normal saline solution or non-cytotoxic wound cleanser
- Various sized absorptive specialty dressings.
- Other appropriate dressings.
- Tape

PROCEDURE

1. Cleanse hands. Apply clean gloves.
2. Remove old dressing and discard along with soiled gloves.
3. Cleanse hands.
4. Prepare/open dressings.
5. Apply clean gloves.
6. Cleanse wound using appropriate non-cytotoxic wound cleanser.
7. Remove gloves.
8. Cleanse hands.
9. Apply clean gloves.
10. Apply periwound protection, if ordered.
11. Apply absorptive specialty dressing (if using rope, pack wound lightly, if using the square, fluff, cut or fold to wound size.)
12. Cover with secondary dressing.
13. Secure dressing in place.
14. Remove all contaminated materials and discard along with soiled gloves.
15. Cleanse hands.

Collagens

EQUIPMENT:

- Gloves
- Hand Sanitizer or antibacterial soap and paper towels
- Normal saline solution or non-cytotoxic wound cleanser
- Various sized Collagen dressings
- Other appropriate dressings
- Tape

PROCEDURE:

1. Cleanse hands. Apply clean gloves.
2. Remove old dressing and discard along with soiled gloves.
3. Cleanse hands.
4. Prepare/open dressing supplies.
5. Apply clean gloves.
6. Cleanse wound using appropriate non-cytotoxic wound cleanser.
7. Remove gloves.
8. Cleanse hands
9. Apply clean gloves.
10. Apply periwound protection if ordered
11. Apply Collagen dressing (if using rope, pack wound lightly, if using the square, fluff, cut or fold to wound size.)
12. Cover with secondary dressing.
13. Secure dressing in place.
14. Remove all contaminated materials, and discard along with soiled gloves.

15. Cleanse hands.

Composites

EQUIPMENT:

- Gloves
- Hand Sanitizer or antibacterial soap and paper towels
- Normal saline solution or non-cytotoxic wound cleanser
- Composite dressing
- Transparent dressing if needed

PROCEDURE:

1. Cleanse hands. Apply clean gloves.
2. Remove old dressing and discard along with soiled gloves.
3. Cleanse hands.
4. Prepare/open dressing supplies.
5. Apply clean gloves.
6. Cleanse wound using appropriate non-cytotoxic wound cleanser.
7. Remove gloves.
8. Cleanse hands.
9. Apply clean gloves.
10. Apply periwound protection if ordered.
11. Determine appropriate dressing size and shape. Remove backing from the dressing and apply in rolling motion.
12. Windowpane dressing with tape if needed to prevent rolling.
13. Change every 3 to 5 days or as needed.
14. Remove all contaminated materials, and discard along with soiled gloves.
15. Cleanse hands.

Hydrocolloid

EQUIPMENT:

- Gloves
- Hand Sanitizer or antibacterial soap and paper towels
- Normal saline solution or non-cytotoxic wound cleanser
- Hydrocolloid dressing
- Transparent dressing if needed

PROCEDURE:

1. Cleanse hands. Apply clean gloves.
2. Remove old dressing and discard along with soiled gloves.
3. Cleanse hands.
4. Prepare/open dressing supplies.

5. Apply clean gloves.
6. Cleanse wound using appropriate non-cytotoxic wound cleanser.
7. Remove gloves.
8. Cleanse hands.
9. Apply clean gloves.
10. Apply periwound protection if ordered
11. Determine appropriate dressing size and shape. Remove backing from the dressing and apply in rolling motion.
12. Windowpane dressing with tape if needed to prevent rolling.
13. Change every 3 to 5 days or as needed.
14. Remove all contaminated materials, and discard along with soiled gloves.
15. Cleanse hands.

Transparent Dressing

EQUIPMENT:

- Gloves
- Hand Sanitizer or antibacterial soap and paper towels
- Normal saline solution or non-cytotoxic wound cleanser
- Transparent dressing

PROCEDURE:

1. Cleanse hands. Apply clean gloves.
2. Remove old dressing and discard along with soiled gloves.
3. Cleanse hands.
4. Prepare/open dressing supplies.
5. Apply clean gloves.
6. Cleanse wound using appropriate non-cytotoxic wound cleanser.
7. Remove gloves.
8. Cleanse hands.
9. Apply clean gloves.
10. Apply periwound protection if ordered
11. Determine appropriate dressing size and shape. Remove backing from the dressing and apply.
12. Windowpane dressing with tape if needed to prevent rolling.
13. Change every 3 to 5 days or as needed.
14. Remove all contaminated materials, and discard along with soiled gloves.
15. Cleanse hands.

Hydrogel

EQUIPMENT:

- Gloves
- Hand Sanitizer or antibacterial soap and paper towels
- Normal saline solution or non-cytotoxic wound cleanser
- Hydrogel
- Appropriate dressing
- Tape
- Sterile Q tips

PROCEDURE:

1. Cleanse hands. Apply clean gloves.
2. Remove old dressing and discard along with soiled gloves.
3. Cleanse hands.
4. Prepare/open dressing supplies.
5. Apply clean gloves.
6. Cleanse wound using appropriate non-cytotoxic wound cleanser.
7. Remove gloves.
8. Cleanse hands.
9. Apply clean gloves.
10. Apply periwound protection if ordered.
11. Apply (approximately 1/8”-1/4” thickness) hydrogel to wound bed.
12. Cover with secondary dressing.
13. Secure dressing in place.
14. Remove all contaminated materials, and discard along with soiled gloves.
15. Cleanse hands.

Impregnated Gauze

EQUIPMENT:

- Gloves
- Hand Sanitizer or antibacterial soap and paper towels
- Normal saline solution or non-cytotoxic wound cleanser
- Impregnated gauze dressing as ordered by physician.
- Other appropriate dressings.
- Tape

PROCEDURE:

1. Cleanse hands. Apply clean gloves.
2. Remove old dressing and discard along with soiled gloves.
3. Cleanse hands.
4. Prepare/open dressing supplies.
5. Apply clean gloves.
6. Cleanse wound using appropriate non-cytotoxic wound cleanser.
7. Remove gloves.
8. Cleanse hands.
9. Apply clean gloves.
10. Apply periwound protection if ordered.
11. Apply impregnated gauze dressing K (cut or fold to wound size.)
12. Cover with secondary dressing.
13. Secure dressing in place.
14. Remove all contaminated materials and discard along with soiled gloves.
15. Cleanses hands.

Alginates

EQUIPMENT:

- Gloves
- Hand Sanitizer or antibacterial soap and paper towels
- Normal saline solution or non-cytotoxic wound cleanser
- Various sized Alginate dressings.
- Other appropriate dressings.
- Tape if needed

PROCEDURE:

1. Cleanse hands. Apply clean gloves.
2. Remove old dressing and discard along with soiled gloves.
3. Cleanse hands.
4. Prepare/open dressing supplies:
5. Apply clean gloves.
6. Cleanse wound using appropriate non-cytotoxic wound cleanser.
7. Remove gloves.
8. Cleanse hands.
9. Apply clean gloves.
10. Apply periwound protection if ordered.
11. Apply alginate dressing (if using rope, pack wound lightly, if using the square, fluff, cut or fold to wound size.)
12. Cover with secondary dressing.
13. Secure dressing in place.
14. Remove all contaminated materials, and discard along with soiled gloves.
15. Cleanse hands.

Silver Antimicrobial Dressings

EQUIPMENT:

- Gloves
- Hand Sanitizer or antibacterial soap and paper towels
- Normal saline solution or non-cytotoxic wound cleanser
- Silver dressing as ordered by physician
- Other appropriate dressings.
- Tape

PROCEDURE:

1. Cleanse hands. Apply clean gloves.
2. Remove old dressing and discard along with soiled gloves.
3. Cleanse hands.
4. Prepare/open dressing supplies.
5. Apply clean gloves.
6. Cleanse wound using appropriate non-cytotoxic wound cleanser.
7. Remove gloves.
8. Cleanse hands.
9. Apply clean gloves.
10. Apply periwound protection if ordered.
11. Apply silver dressing as per manufacturer instructions. Cut or fold dressing to wound size.
12. Cover with secondary dressing.
13. Secure dressing in place.
14. Remove all contaminated materials, and discard along with soiled gloves.
15. Cleanse hands.

DOCUMENTATION

Document assessment findings, interventions, instruction and patient response in medical record.

VI. ATTACHMENTS

None

VII. REFERENCES

Holmes, Nancy H., editor. Nurse's Illustrated Handbook of Home Health Procedures. Springhouse Corporation, Springhouse, PA 1999.

Moreau, David, editor. Wound Care Made Incredibly Easy. Lippincott, Williams, & Wilkins. Philadelphia, PA 2003.

Wound Care Education Institute Inc. www.WCEI.net.

VIII. POLICY RESPONSIBILIY

Sponsor: Lehigh Valley Hospice Clinical Director
Lehigh Valley Hospice Medical Director

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Lehigh Valley Health Network Street Medicine

GUIDELINES FOR WOUND CARE

MANUAL: Clinical
ORIGINATION: 11/22/2017 **REVISED:**

I. PURPOSE

Provide effective wound care in the home setting.

II. OUTCOME

Promote wound healing without complications

III. EXPLANATION OF TERMS

Clean - free from bacterial contamination

Aseptic - condition free of potentially pathogenic organisms; absence of germs

IV. SKILL LEVEL

RN, LPN, PT

V. POLICY AND GENERAL GUIDELINES

A. A physician's order is needed for dressing and/or solution used in wound care.

B. A physician's order is not needed to consult a Certified Wound Specialist. Contact Clinical Services to schedule a visit with a Wound Specialist.
1. Does not progress after two weeks of appropriate treatment consult wound specialist, primary care provider, surgeon, or send patient to the emergency room.

C. Antiseptic solutions - including but not limited to povidone-iodine, sodium hypochlorite, acetic acid, hydrogen peroxide (H_20_2), are cytotoxic and should be avoided unless specifically ordered by the physician. Wounds should be rinsed with NSS if an antiseptic solution is used.

D. Perform wound assessment on each skilled encounter with the patient when a dressing change is required.

E. Document wound assessment findings.

F. Bottled saline solution must be dated when opened, refrigerated and discarded after seven days. Do not use cold saline on wounds. Refrigerate promptly after use to prevent growth of microorganisms. The use of saline wound wash/spray is encouraged.

G. Assess nutrition and hydration status with each skilled nursing encounter with the patient.

H. When wound is full-thickness or in the presence of sinus tracts, undermining, necrotic slough, and/or copious amounts of drainage saline wound wash/spray should be used for wound irrigation.

I. When packing a sinus tract, use <u>one continuous strip</u> of packing ribbon. The end of the strip should extend beyond the wound opening to prevent migration or accidental retention in the wound. If individual gauze squares are used for packing, document the number of squares used to ensure complete removal at the next dressing change. Document length/# of pieces of packing material on outside of dressing.

J. Report to the physician any increased pain, edema, erythema, induration, warmth, fever >100, foul odor, change in characteristics of drainage (i.e., green or purulent).

L. Clean (non-sterile) gloves are used to remove old (soiled) dressings. A clean pair of gloves is used for redressing. An alcohol based waterless handwashing product should be used between glove changes.

M. The skin around the wound is cleansed with saline or soap and water or appropriate non-cytotoxic wound cleanser.

N. A physician's order is obtained for skin barrier protectant sprays, wipes, or a thin layer of barrier cream/ointment which may be used to protect the intact skin surrounding the wound.

O. Sharps such as scissors used in wound care for cutting ribbon, etc., are to be cleaned with alcohol after each use, kept in a clean, dry area such as the original package and discarded after one week in sharps container. Syringes used to irrigate wounds are also disposed of in sharps containers after each use. Other tools such as Q-tips, red rubber catheters, sterile basins etc. are to be put in plastic bag, tied securely and disposed of in a trash container using double bagging technique.

VI. PROCEDURE

A.

ACTION	RATIONALE
1. Cleanse hands.	1. To reduce the risk of infection.
2. Apply non-sterile gloves.	2. Standard Precautions
3. Remove old dressing and discard into plastic bag along with soiled gloves.	3. To prevent contaminating clean area.
4. Cleanse hands.	4. To reduce the risk of infection.
5. Open/prepare all needed supplies.	5. Avoid contaminating supplies.
6. Apply non-sterile gloves. If splashing is a risk, gowns and goggles are to be worn	6. To reduce the risk of infection.
7. Cleanse wound with soap and water.	7. To remove old drainage, tape, etc.
8. Assess area for erythema, edema, pain, induration, or change in drainage. Measure wound at least weekly.	8. Report any abnormal findings to physician.
9. Remove gloves and discard into plastic bag.	9. To prevent contaminating clean supplies.
10. Wash hands or use alcohol based waterless hand washing product.	10. To reduce risk of infection. Alcohol based waterless hand washing product may be used when there is: a. No running water in the house. b. It would be unsafe to leave the patient or walk away from the sterile field/equipment set up for wound care.
11. Apply non-sterile gloves.	11. Standard precautions.
12. Apply new contact dressing, followed by cover dressing. Secure dressing as necessary.	12. As per physician's wound care orders.
13. Remove gloves and discard into plastic bag.	13. To prevent spread of organisms.
14. Tie plastic bag containing waste and dispose into trash.	14. Double bag technique for disposing of soiled dressings in the home.
15. Cleanse hands.	15. To prevent spread of organisms/Standard Precautions.

B. Specific Instructions for Home Hospice Patients

1. Routine, occasionally incontinent patients:
   a. A skin barrier cream should be recommended to physician.
   b. For dermatitis from incontinence of bowel and bladder a skin barrier cream or a petroleum base cream should be recommended to physician.

2. Skin tears:
   a. Recommend foam or silicone dressing and change 2 times per week. If using a silicone dressing as the contact layer, an outer dressing is required to cover and collect drainage. Change the outer dressing as needed for drainage and leave the silicone dressing in place. It is only necessary to

change the silicone dressing twice a week.

3. Pressure Ulcers:
For dry stable eschar, no wound product is required. Paint eschar with skin prep. If there is redness surrounding the eschar edges, or drainage, then apply a calcium alginate powder. Cover wound with a foam dressing.

a. Pressure Ulcer Stage 1: Assess patient for activity status. Apply skin prep to stage 1 pressure wound. If imminent instruct caregiver in proper care of wound and patient repositioning. If patient is bed bound with two to three week prognosis, order gel overlay mattress with supervisor approval. Assess for other factors which may contribute to wound deterioration or the possibility of new wounds occurring. Provide appropriate care to the patient and instruction to the patient and/or caregiver.

b. Pressure Ulcer Stage 2: Cover with a foam dressing. Change border every 2-3 days or prn if dressing is soiled or leaking has occurred.

c. Pressure Ulcer Stage 3 & 4: Consult Wound Care Specialty. For wounds with moderate to heavy drainage place or pack wound with Calcium Alginate and cover with foam dressing.

3. Ostomy
   a. If the ostomy is new, consult the ostomy nurse.
   b. If the ostomy is chronic and stable continue with patient's normal procedure. If the ostomy is chronic and has problems such as; using lots of supplies or fistulas, consult the ostomy nurse For all other ostomies (such as tracheostomy, nephrostomy) that are experiencing drainage or skin irritation surrounding the tube, consult a wound care nurse or ostomy nurse.

4. Call the Clinical Coordinator for all supplies.

VII. DOCUMENTATION

A. Document any changes, physician communication, vital signs, patient response to wound care.

B. Document wound assessment as per Wound Care Documentation Administrative Policy.

VIII. ATTACHMENTS

NONE

IX. REFERENCES

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Care. Aspen Publishers. Gaithersburg, MD.

Schaum, Kathleen, "Documentation of Wound Exudate Amount Leads to dressing Reimbursement After Discharge": Home Health Nurse. June 2002, 20(6): 299.

Sibbald RG, Krasner DL, Lutz JB, et al. The SCALE Expert Panel: Skin Changes At Life's End. Final Consensus Document. October 1, 2009

"Ulcer Doucmentation." Wound Care Information Network., http://www.medicaledu.com/medicare.htm

Wound, Ostomy and Continence Nurses Society. (2001). WOCN Society OASIS Guidance Document http://www.wocn.org.

WCEI.net

X. DISTRIBUTION

Lehigh Valley Health Network Street Medicine

Lehigh Valley Health Network Street Medicine
WOUND ASSESSMENT, MEASUREMENT AND DOCUMENTATION

MANUAL: Clinical
ORIGINATION: 11/22/2017 **REVISED:**

I. PURPOSE

To direct accurate assessment, measurement, and documentation of wounds.

II. OUTCOME

A. All patients will receive accurate assessment and measurement of wounds to demonstrate progress of wound healing.

B. Wounds of any etiology will be documented in a consistent format.

III. EXPLANATION OF TERMS

Contact Dressing: Dressing in contact with wound base.

Covering/Top Dressing: Dressing on top of contact dressing.

Baseline Measurements: Size of wound is measured in centimeters denoting the length, width, and depth.

Undermining: Tissue destruction underlying intact skin along wound margins.

Tunneling/Sinus Tract: Course or path of tissue destruction occurring in any direction from the surface or edge of the wound; results in dead space with the potential for abscess formation.

Wound Bed Color:
Healthy: granulating tissue would be considered red, moist, and beefy in appearance.
Epithelialized tissue – new pink, shiny epidermis.
Necrotic tissue- avascular and is described as either slough or eschar tissue. Slough appears in colors of yellow, gray, green, and brown.

Eschar: Black or brown necrotic, devitalized tissue; tissue can be loose or firmly adherent, hard, soft or soggy.

Dehisced/Dehiscence: Separation of surgical incision, loss of approximation of wound edges.

Epithelialization: Regeneration of epidermis across a wound surface.

Condition of surrounding tissue: normal, white, bright, dark red/purple or black.

Maceration: The tissue becomes softened by fluid (exudate/drainage).

Exudate/drainage: is defined in terms of amount, type and odor.
Amount:

- None - Wound bed dry; no drainage on contact or outer dressing
- Scant - 1 to 50% of contact dressing moist; no drainage on covering dressing
- Small - Greater than 50% of contact dressing wet; no drainage on top dressing
- Medium - 100% of contact dressing; 1 to 50% of cover dressing wet
- Large - 100% of contact dressing wet; greater than 50% of covering dressing wet

Type: Serous, serosanguinous, or purulent.
Odor: None, foul, fruity, offensive, fecal.

- None – no drainage in wound bed or on contact/outer dressing
- Minimal – wound tissue is wet/ moist (drainage <25% of bandage)
- Moderate – wound tissue is saturated (drainage 25% - 75% of bandage)
- Heavy – exudates flowing freely in wound (drainage >75% of bandage)
- Copious – exudates flowing heavily in wound (drainage 100% + of bandage)

Partial Thickness: Confined to skin layers; damage does not penetrate below the dermis and may be limited to epidermal layers only.

Full Thickness: Tissue damage involving total loss of epidermis and dermis and extending into the subcutaneous tissue and possibly into the muscle or bone.

Pressure Ulcers:
Stage I: An observable pressure-related alteration of intact skin whose indicators as compared to the adjacent or opposite area on the body may include changes in one or more of the following: skin temperature (warmth or coolness), tissue consistency (firm or boggy feel) and/or sensation (pain, itching). The ulcer appears as a defined area of persistent redness in lightly pigmented skin, whereas in darker skin tones, the ulcer may appear with persistent red, blue, or purple hues.

Stage II: Partial-thickness skin loss involving epidermis or dermis, or both. The ulcer is superficial and presents as an abrasion, fluid filled blister, or shallow crater.

Stage III: Full-thickness skin loss involving damage to or necrosis of subcutaneous tissue that may extend down to, but not through, underlying fascia. The ulcer presents clinically as a deep crater with or without undermining of adjacent tissue.

Stage IV: Full-thickness skin loss with extensive destruction, tissue necrosis, or damage to muscle, bone, or supporting structures (e.g., tendon, joint capsule). Undermining and sinus tracts also may be associated with Stage IV pressure ulcers.

Unstageable: Wound is unable to be visualized due to an orthopedic device, dressing, etc. A pressure ulcer cannot be accurately staged until the deepest viable tissue layer is visible: this means that wounds covered with eschar and/or slough cannot be staged, and should be documented as unstageable

Suspected Deep Tissue Injury: Purple or maroon localized area of discolored intact skin or blood-filled blister due to damage of underlying soft tissue from pressure and/or shearing. Tissue may be painful, firm, mushy, boggy, warmer, or cooler as compared to adjacent tissue.

Fully Granulating: Wound bed filled with granulation tissue at the level of the surrounding skin or new epithelium; no dead space, no avascular tissue; no signs of symptoms of infection; wound edges are open.

Early/Partial Granulation: > 25% of wound bed is covered with granulation tissue; there is minimal avascular tissue (i.e., <25% of the wound bed is covered with avascular tissue); may have dead space; no signs or symptoms of infection; wound edges open.

Non-Healing: Wound with ≥ 25% avascular tissue or signs/symptoms of infection or clean but non-granulating wound bed or closed/hyperkeratotic wound edges or persistent failure to improve despite appropriate comprehensive wound management.

Slough- Soft, moist avascular tissue; may be white, yellow, tan, or green. May be loose, stringy or firmly adherent.

IV. SKILL LEVEL

RN, LPN, PT, OT, SLP

V. POLICY AND GENERAL INSTRUCTIONS

A. Wounds will be measured at the time of care and if follow up is ordered. If the patient's wound is being follow by a primary care provider, surgeon, or wound specialist, wound dressing changes and measurements will only be conducted on an as needed basis.

B. If the wound does not progress after two weeks of appropriate treatment consult wound specialist, primary care provider, surgeon, or send patient to the emergency room.

C. Consult the wound care specialist or send patient to the emergency room if:
- The stage of a pressure wound is undetermined or stage III or IV.
- The type of wound is unclear.
- The treatment is ineffective or if the appropriateness of the treatment is in question.

D. Classify wounds using the WOCN standards (see Attachment A).

E. Assess and provide preventative measures as appropriate (i.e. pressure redistribution devices, pressure off-loading footwear for diabetic patients.)

F. Assess nutrition and instruct patient/ family in dietary measures that will promote wound healing.

G. Photographs of wound for medical record purposes may be obtained with patient consent. Photographs maybe taken on any wound patient when a clinician determines photographic wound documentation would benefit the patient's plan of care. (see Attachment B)

VI. EQUIPMENT

Clean gloves
Antiseptic hand cleanser or antibacterial soap
Plastic bags
Wound measuring device
Applicators
Wound care supplies

VII. PROCEDURE

A. Cleanse hands and apply clean gloves.

B. Remove all soiled dressings. Discard along with gloves.

C. Cleanse hands. Apply clean gloves.

D. Determine wound type and site.

E. Assess amount and characteristics of exudate.

F. Cleanse wound as ordered.

G. Remove gloves and cleanse hands.

H. Apply clean gloves.

I. Assess wound appearance including:
   1. Status of periwound skin.
   2. Wound bed including percent of slough, eschar, fibrous tissue, granulation, and epithelial tissue.

J. Measure wound size using appropriate measuring device. Wound measurement is to include length, width, and depth. Length is measured from head and toe and width from side to side. Depth is determined by measuring the deepest part of wound bed.

K. With cotton-tipped applicator, assess for and measure undermining and/or tunneling (if present.).

L. Assess progress of wound healing.

M. Apply new dressings as ordered.

N. Remove gloves.

O. Properly dispose of all waste materials.

P. Cleanse hands.

VIII. DOCUMENTATION PROCEDURE

Street Medicine nursing staff will use the Street Medicine Wound Assessment documentation in the EMR.

A. Document the wound assessment and treatment on the patient medical record.
   1. Be specific in location using anatomical terms.
   2. Pressure Ulcer Stage: describe the extent of the tissue damage and appropriate stage for the pressure ulcers. If it is a pressure ulcer, pressure reduction must be addressed
   3. Stage 1 and 2 pressure ulcers when healed are resolved and do not require additional documentation.
   4. Stage 3 and 4 pressure ulcers when closed continue to be staged as 3 or 4 – they never heal
   5. Pressure Reducing Device: Document type utilized, chair cushion, bed overlay or other – low air loss. Must document DME supplier and equipment utilized.
   6. Other Wounds: Describe the extent of tissue damage in wounds other than pressure ulcers
   7. Document the wound care performed per physician orders on each visit.
   8. Document tissue viability by describing the percentage of healthy and necrotic tissue relative to the entire wound. (Example: an ulcer with 60% granulation tissue and 40% yellow slough tissue.)

B. Treatment changes. Interim orders must be obtained whenever the treatment is changed by the physician. The orders must include:
   1. Wound irrigation/cleansing solution
   2. Contact dressing: specify type of dressing utilized
   3. Cover dressing (if needed)

4. Date order obtained
5. Frequency of wound treatment and duration of order
6. Person responsible for the provision of wound care (nurse, patient, caregiver, etc.)

C. Measure wounds and document measurements at least weekly
1. Length - head to toe
2. Width - right to left side
3. Depth – Measurement to the base of the wound
4. Margins: Check the appropriate description (intact, red, other). If red or other is checked, a description and measurement must be provided. Other descriptive adjectives: Macerated, ecchymotic, pink, re-epithelialized tissue.
5. Undermining: Describe the tissue destruction underlying intact skin along wound margins. The size and location must be documented. (For example: from 12 to 3 o'clock there is 2.5 cm of undermining.)
6. Tunneling: Describe depth/length of the path of tissue destruction. The depth and/or length along with the location must be documented. (For example: at 3 o'clock a 3.5cm tunnel was noted in the sacral decubitus.)
7. Periwound appearance is to be descriptively documented.

IX. ATTACHMENTS

A. Attachment A- WOCN Guidance on wound status.

B. Attachment B- Copy of patient consent for photo.

X. REFERENCES

XI. DISTRIBUTION

Lehigh Valley Health Network Street Medicine

Attachment A:

WOUND OSTOMY CONTINENCE NURSES SOCIETY GUIDANCE ON OASIS-C INTEGUMENTARY ITEMS

OVERVIEW AND BACKGROUND

OASIS-C is a modification to the Outcome and Assessment Information Set (OASIS) that Home Health Agencies must collect in order to participate in the Medicare program. This is the first major update of the OASIS since it was implemented in 2000.

It includes removing items not used for payment or quality, adding items to address clinical domains not covered, modified wording for selected items and adding process items that support measurement of evidence based practices. The system for wound classification uses terms that lack universal definition and clinicians have verbalized concerns that they may be interpreting these terms incorrectly. The WOCN Society has therefore developed the following guidelines for the classification of wounds. These items were developed by consensus among the WOCN Society panel of content experts.

(M1300) Pressure Ulcer Assessment: Was this patient assessed for risk of developing pressure ulcers?

(M1302) Does this patient have a Risk of Developing Pressure Ulcers?

(M1306) Does this patient have at least one Unhealed Pressure Ulcer at Stage II or Higher or designated as "unstageable"?

Definitions:

- **Unhealed:** The absence of the skin's original integrity.
- **Non-epithelialized:** The absence of regenerated epidermis across a wound surface.
- **Pressure Ulcer:** A *pressure ulcer* is localized injury to the skin and/or underlying tissue, usually over a bony prominence, as a result of pressure or pressure in combination with shear and/or friction. *A number of contributing or confounding factors are also associated with pressure ulcers; the significance of these factors is yet to be elucidated.*
- **Pressure Ulcer Stages (NPUAP 2007):**

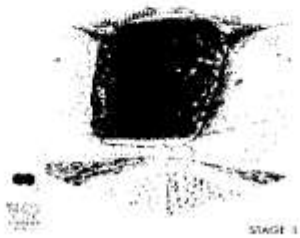
Stage I. A Stage I pressure ulcer presents as intact skin with non-blanchable redness of a localized area, usually over a bony prominence. Darkly pigmented skin may not have visible blanching; its color may differ from the surrounding area.

Further description. The area may be painful, firm, soft, and warmer or cooler as compared to adjacent tissue. Stage I ulcers may be difficult to detect in individuals with dark skin tones and may indicate "at risk" persons (a heralding sign of risk).

Stage II. A Stage II pressure ulcer is characterized by partial-thickness loss of dermis presenting as a shallow open ulcer with a red-pink wound bed without slough. It also may present as an intact or open/ruptured serum-filled blister.

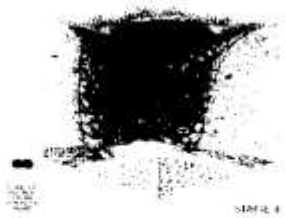
Further description. A Stage II ulcer also may present as a shiny or dry shallow ulcer without slough or bruising. This stage*

*should not be used to describe skin tears, tape burns, perineal dermatitis, maceration, or excoriation. * Bruising indicates suspected deep tissue injury.*



Stage III. A Stage III pressure ulcer is characterized by full-thickness tissue loss. Subcutaneous fat may be visible but bone, tendon, or muscle is not exposed. Slough may be present but does not obscure the depth of tissue loss. Stage III ulcers may include undermining and tunneling.

Further description. The depth of a Stage III pressure ulcer varies by anatomical location. The bridge of the nose, ear, occiput, and malleolus do not have subcutaneous tissue; Stage III ulcers in these locations can be shallow. In contrast, areas of significant adiposity can develop extremely deep Stage III pressure ulcers. Bone/tendon is not visible or directly palpable.

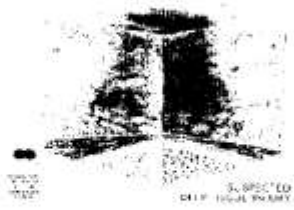


Stage IV. A Stage IV pressure ulcer presents with full-thickness tissue loss with exposed bone, tendon, or muscle. Slough or eschar may be present on some parts of the wound bed. These ulcers often include undermining and tunneling.

Further description. The depth of a Stage IV pressure ulcer varies by anatomical location. The bridge of the nose, ear, occiput, and malleolus do not have subcutaneous tissue; Stage IV ulcers in these locations can be shallow. Stage IV ulcers can extend into muscle and/or supporting structures (eg, fascia, tendon, or joint capsule); osteomyelitis is possible. Exposed bone/tendon is visible or directly palpable.

Unstageable. Full-thickness tissue loss in which the base of the ulcer is covered by slough (yellow, tan, gray, green or brown) and/or eschar (tan, brown or black) in the wound bed may render a wound unstageable.

Further description. Until enough slough and/or eschar is removed to expose the base of the wound, the true depth (and therefore, the stage) cannot be determined. Stable (dry, adherent, intact without erythema or fluctuance) eschar on the heels serves as "the body's natural (biological) cover" and should not be removed.



Suspected Deep Tissue Injury. Deep tissue injury may be characterized by a purple or maroon localized area of discolored intact skin or a blood-filled blister due to damage of underlying soft tissue from pressure and/or shear. Presentation may be preceded by tissue that is painful, firm, mushy, boggy, and warmer or cooler as compared to adjacent tissue.

Further description. Deep tissue injury may be difficult to detect in individuals with dark skin tones. Evolution may include a thin blister over a dark wound

bed. The wound may further evolve and become covered by thin eschar. Evolution may be rapid, exposing additional layers of tissue even with optimal treatment.

(M1307) The Oldest Non-epithelialized Stage II Pressure Ulcer that is present at discharge

(M1308) Current Number of Unhealed (non-epithelialized) Pressure Ulcers at Each Stage

(M1310) Pressure Ulcer Length: Longest length "head-to-toe"

(M1312) Pressure Ulcer Width: Width of the same pressure ulcer; greatest width perpendicular to the length

(M1314) Pressure Ulcer Depth: Depth of the same pressure ulcer; from visible surface to the deepest area

(M1320) Status of Most Problematic (Observable) Pressure Ulcer

0 - Newly epithelialized
1 - Fully granulating
2 - Early/partial granulation
3 - Not healing
NA - No observable pressure ulcer

Definitions:

- **Newly epithelialized**
  - wound bed completely covered with new epithelium
  - no exudate
  - no avascular tissue (eschar and/or slough)
  - no signs or symptoms of infection

- **Fully granulating**
  - wound bed filled with granulation tissue to the level of the surrounding skin
  - no dead space
  - no avascular tissue (eschar and/or slough)
  - no signs or symptoms of infection
  - wound edges are open

- **Early/partial granulation**
  - ≥25% of the wound bed is covered with granulation tissue
  - < 25% of the wound bed is covered with avascular tissue (eschar and/or slough)
  - no signs or symptoms of infection
  - wound edges open

- **3 - Not healing**
  - wound with ≥25% avascular tissue (eschar and/or slough) OR
  - signs/symptoms of infection OR
  - clean but non-granulating wound bed OR
  - closed/hyperkeratotic wound edges OR
  - persistent failure to improve despite appropriate comprehensive wound management

WOUND OSTOMY CONTINENCE NURSES SOCIETY
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(M1322) Current Number of Stage I Pressure Ulcers

(M1324) Stage of Most Problematic Unhealed (Observable) Pressure Ulcer

(M1330) Does this patient have a Stasis Ulcer?

(M1332) Current Number of (Observable) Stasis Ulcer(s)

(M1334) Status of Most Problematic (Observable) Stasis Ulcer

0 - Newly epithelialized
1 - Fully granulating
2 - Early/partial granulation
3 - Not healing
NA - No observable stasis ulcer

Definitions:

- **Newly epithelialized**
  - wound bed completely covered with new epithelium
  - no exudate
  - no avascular tissue (eschar and/or slough)
  - no signs or symptoms of infection

- **Fully granulating**
  - wound bed filled with granulation tissue to the level of the surrounding skin
  - no dead space
  - no avascular tissue (eschar and/or slough)
  - no signs or symptoms of infection
  - wound edges are open

- **Early/partial granulation**
  - ≥25% of the wound bed is covered with granulation tissue
  - < 25% of the wound bed is covered with avascular tissue (eschar and/or slough)
  - no signs or symptoms of infection
  - wound edges open

- **3 - Not healing**
  - wound with ≥25% avascular tissue (eschar and/or slough) OR
  - signs/symptoms of infection OR
  - clean but non-granulating wound bed OR
  - closed/hyperkeratotic wound edges OR
  - persistent failure to improve despite appropriate comprehensive wound management

(M1340) Does this patient have a Surgical Wound?

WOUND OSTOMY CONTINENCE NURSES SOCIETY
GUIDANCE ON OASIS-C INTEGUMENTARY ITEMS

(M1342) Status of Most Problematic (Observable) Surgical Wound:

0 - Newly epithelialized
1 - Fully granulating
2 - Early/partial granulation
3 - Not healing
NA - No observable surgical wound

Definitions:

- **Newly epithelialized**
  - wound bed completely covered with new epithelium
  - no exudate
  - no avascular tissue (eschar and/or slough)
  - no signs or symptoms of infection

- **Fully granulating**
  - wound bed filled with granulation tissue to the level of the surrounding skin
  - no dead space
  - no avascular tissue (eschar and/or slough)
  - no signs or symptoms of infection
  - wound edges are open

- **Early/partial granulation**
  - ≥25% of the wound bed is covered with granulation tissue
  - < 25% of the wound bed is covered with avascular tissue (eschar and/or slough)
  - no signs or symptoms of infection
  - wound edges open

- **3 - Not healing**
  - wound with ≥25% avascular tissue (eschar and/or slough) OR
  - signs/symptoms of infection OR
  - clean but non-granulating wound bed OR
  - closed/hyperkeratotic wound edges OR
  - persistent failure to improve despite appropriate comprehensive wound management

This guidance applies to surgical wounds closed by either primary intention (i.e. approximated incisions) or secondary intention (i.e. open surgical wounds).

(M1350) Does this patient have a Skin Lesion or Open Wound, excluding bowel ostomy, other than those described above that is receiving intervention by the home health agency?

Attachment B

LEHIGH VALLEY
HEALTH NETWORK

Consent to Photograph/Interview

I consent to be interviewed and/or to the taking of any photographic, audiovisual, or other media recordings or representations of _____ _____ by a person selected by Lehigh Valley Health Network or my own representative.

I understand any of these materials prepared by a person selected by Lehigh Valley Health Network may be used publicly through media outlets (newspapers, television/radio broadcast); in Lehigh Valley Health Network publications (internal or external, including electronic [on-line]); in scientific journal articles by its employees, agents, representatives, physicians; and for research/educational purposes.

I hereby waive any right that I may have to copyright, inspect, or approve the finished product that may be used hereunder, or the specific use or context to which it may be applied.

I hereby release Lehigh Valley Health Network, its components, employees, agents and physicians from any liability connected with the taking or use of these interviews.

_____ Witness

_____ Subject / Person Authorized to Consent on Behalf of Subject

_____ Date

_____ Name of Person Taking Photograph, etc.

Location: _____ Time: _____

Subject: _____

_____

_____

Use: _____

Requested By: _____ Date: _____

PHGY-01 Rev. 2/00

Lehigh Valley Health Network Street Medicine
Safe Harbor Tuesday Night Clinic, Staffing Protocol

MANUAL: Clinical
ORIGINATION: 11/22/2017 **REVISED:**

Provider Shortage upon entering the first of the month:

- Street Medicine paid Providers to attempt to fill the void
    - If Street Medicine paid Providers are unable to fill the void
        - The scheduled provider must be contacted & confirm their willingness to proceed as a sole provider but with a patient cap of 6 unless the provider is willing to see additional patients
    - If there are no Volunteer Providers scheduled for the day of Clinic
        - Street Medicine paid Providers to attempt to fill the void
        - If only one Street Medicine paid Provider can pick up the clinic shift, then the patient cap of 6 unless the provider is willing to see additional patients
        - If not provider is on site:
            - The Safe Harbor Clinic will continue to be conducted as Nurse Visits ONLY. Only ESTABLISHED patients can be seen at this time. All other patients need to be referred to the next clinic date and/or directed to the ER.
- If Clinic is canceled due to Provider shortage, a Safe Harbor Clinic will be scheduled for that week if already not in scheduled to ensure patient care is addressed.
    - All Clinic Cancelations must be done no later than 1500 for nurse staffing cancelation as per LVHN policy.
- If Clinic is a Nurse Visit ONLY clinic, an additional clinic will be scheduled for that week if already not scheduled to ensure patient care is addressed.

Nursing Shortage upon entering the first of the month:

- If there is a nursing shortage/call off, the shift will be offered to Per Diem Nurse Staff. If Per Diem Staff is unable to cover the shortage the full time Street Medicine Nursing Staff will cover the void.

Lehigh Valley Health Network Street Medicine
Infection Control

MANUAL: Clinical
ORIGINATION: 11/22/2017 **REVISED:**

I. POLICY

The goal of the Infection Control and Prevention Program is to prevent the transmission of infectious diseases between the environment, patients, personnel, and visitors.

II. SCOPE

LVHN Employees, Medical Staff, Allied Health Practitioners practicing within Lehigh Valley Health Network including Lehigh Valley Hospital, Lehigh Valley Hospital-Muhlenberg and Fairgrounds Surgical Center as well as the Transitional Skilled Unit, Home care, Hospice, Health Network Laboratories, LVH-Tilghman and LVHN Surgery Center - Tilghman as applicable.

III. DEFINITIONS

None

IV. PROCEDURE

A. Personnel Practices

1. Fulfill pre-employment immunization, other diagnostic studies and other health measures as required by Employee Health Services policies.

2. Report illness, disease exposures and other work-related incidents to Employee Health Services for management as per their policies.

3. Follow dress code established within the department.

4. Shower and change clothing as soon as possible if it becomes contaminated with blood/body fluids. Clean footwear as soon as possible if it becomes contaminated with blood/body fluid.
   a. Refer to IC Policy, Contaminated Clothing, for specifics on laundering contaminated personal clothing.

5. All Street Medicine Employees are to follow IC Policy, Requirements for Hand Hygiene. Always use soap and water if hands are visibly soiled or the patient has *C. difficile* or Norovirus.

6. Leave hand cleansing supplies in outer pocket of clinical bag. Cleanse hands before entering the main part of the clinical bag.

7. All staff will be provided with information about department specific Infection Control and Prevention practices.

8. Complete required Network employee education programs annually. Maintain record of attendance at all educational programs.

9. Contact the Infection Control and Prevention Department for any infection control problems or deficiencies.

IV. PROCEDURE

B. Environmental Practices

1. Limit amount of reusable equipment taken into the sites of care.
   a. When possible leave reusable equipment in the site of care.
   b. When non-critical equipment is removed from the site of care, clean and disinfect items before removing them by using a low level disinfectant. Place clean reusable items in a plastic bag for transport to appropriate site for subsequent cleaning and disinfection before use with another patient.

2. For transport of sterile/clean supplies to the sites of care, use a clean plastic/brown paper bags.

3. Examine package integrity of sterilized items prior to opening and anticipated use, recognizing the principle of event-related sterility. Items found in non-intact packages shall not be utilized but discarded or returned for reprocessing.

4. Ensure extra supplies left in sites of care are stored in clean areas in a location where it will not be disturbed.

5. Discard all non-sharp disposable single patient use items after use in plastic bags tied securely and place in site of care trash.

6. Digital thermometers are the standard. Use a clean thermometer sheath for each patient. Wipe thermometer after each use with an alcohol swab and allow to dry 30 seconds.

7. Disinfect reusable items according to specific manufacturer's instructions.

8. Provide patient with instructions regarding various aspects of care, Standard Precautions, and reprocessing of reusable items. Supplement instruction with return demonstration and written material when available.

9. To clean spills of blood or body fluid, wear gloves (and other personal protective attire as appropriate). While wearing gloves, blot the spill with paper towels. Use germicide wipe to clean surfaces. Discard soiled items in plastic bag, tie securely, and discard in site of care trash.

12. All staff should contact the Network Infection Control and Prevention department when assistance in the practice of asepsis is required. Other available resources include: Patient Care Services Manual, Infection Control and Prevention Manual.

13. Follow procedure for nursing bag technique according to the Street Medicine Manual to ensure the bag is used as a clean piece of equipment and to protect the contents from contamination.

C. Patient Care Practices

1. Handle sharp items (needles, scalpel blades, etc.) with caution to prevent accidental injuries.

2. Immediately after use, discard used sharp items into puncture resistant containers, located as close as is practical to the area of use.

3. Do not recap, bend, break or remove needles from syringes or manipulate sharps by hand.

IV. PROCEDURE

4. Maintain and carry personal protective equipment/attire and cleaning materials including:
    i. Disposable gloves
    ii. Fluid-resistant mask
    iii. Paper towels
    iv. Germicidal towelettes
    v. Plastic bags

5. Use personal protective attire in accordance with Standard Precautions.

6. Use gowns, face shields/goggles, or a combination of eyewear and face masks when splash exposure is anticipated or when performing procedures that have more extensive contact with blood/body fluids as intubation attempts, suctioning, and cleaning contaminated supplies.

7. Put patient specimens in plastic bag, tightly seal, and place in a protective container (i.e. ice cooler) marked biohazard for transport to lab. Refer to the HNL Handbook for specific instructions relating to the transportation of patient specimens.

8. Carefully discard body fluids, secretions, or excretions into toilet.
    i. If indoor plumbing is not available, instruct patient/caregiver to place liquid inside container, add an ounce of bleach solution to the liquid and, tightly cover, and place inside a plastic bag for trash removal.

9. Discard trash and other non-sharp waste into a plastic garbage bag. Seal before discarding with household trash. Double bag if of questionable strength or the bag becomes contaminated.

10. Tightly seal sharps containers for final disposal.

V. ATTACHMENTS

None

VI. DISTRIBUTION

Infection Control and Prevention Manual

VII. POLICY RESPONSIBILITY IN COORDINATION WITH:

Infection Control and Prevention Lehigh Valley Home Care and Hospice Department

VIII. REFERENCES

Centers for Disease Control and Prevention; HICPAC/SHEA/APIC/ISDA Hand Hygiene Task Force. Guideline for Hand Hygiene in Health-Care Settings. October, 2002.
Federal register/Vol.56,No.235/Friday. December 6, 1991 /Rules and regulations. OSHA 29 CFR Part 1910.1030 Occupational exposure to Blood borne Pathogens; Final Rule.
Siegel JD, Rhinehart E, Jackson M, Chiarello L, and the Healthcare Infection Control Practices Advisory Committee, 2007 Guideline for Isolation Precautions: Preventing Transmission of Infectious Agents in Healthcare Settings, **June 2007**
Rhinehart, Emily, RN, MPH, et all and McGoldrick, Mary, MS, RN, CRNI. Infection Control in Home Care and Hospice, 2nd edition, 2006.
APIC Home Care Membership Section 2000, Embry, F, and Chinnes, L. ACIP – HICPAC Surveillance Definitions for Home Health Care and Hospice Infections. February 2008.

IX. DISCLAIMER STATEMENT

This policy and the implementing procedures are intended to provide a description of recommended courses of action to comply with statutory or regulatory requirements and/or operational standards. It is recognized that there may be specific circumstances, not contemplated by laws or regulatory requirements that make compliance inappropriate. For advice in these circumstances; consult with the department of Risk Management and/or Legal Services.

Lehigh Valley Health Network Street Medicine
PHLEBOTOMY

MANUAL: Clinical
ORIGINATION: 11/22/2017 **REVISED:**

I. PURPOSE

To obtain a venous specimen for testing and treatment using proper technique and equipment to prevent infection, sustain viability of the vein and produce the highest quality specimen.

II. OUTCOME

To obtain the highest quality specimen using a safe and correct phlebotomy procedure.

III. EXPLANATION OF TERMS

Aerobic - Contains oxygen.

Anaerobic - Does not contain oxygen.

IV. SKILL LEVEL

RN, LPN

V. POLICY AND GENERAL INSTRUCTIONS

A. Utilize safety products when drawing blood.

B. The nurse is responsible for correct collection procedure including:

1. Patient identification will be verified by using 2 patient identifiers prior drawing blood.
2. Correct tubes.
3. Correct specimen handling.
4. Proper labeling in the presence of the patient.

C. The order for drawing blood specimens is:

1. Blood cultures
2. Non-additive tubes
3. Coagulation tubes
4. Other additive tubes

D. When utilizing a butterfly needle, place a red top tube onto the collection device to eliminate the air in the tubing. After butterfly tubing is filled with blood, the next

tube in the blood draw order can be placed onto the collection device. If this procedure is not followed, the air in the butterfly tubing will not allow the blue top tube to fill completely.

E. When drawing all additive specimens, coagulation and CBC specimens are always drawn first.

G. After two unsuccessful attempts at venipuncture by a nurse, another resource needs to be utilized. If still unsuccessful, notify the physician to obtain orders regarding specimen collection.

H. Documentation on each tube must include:

1. Collection time/date
2. Identification of collector (initials)
3. Patient name, DOB
4. Completion of the lab slip at the location that the blood was drawn

I. Documentation in note:
1. Number of attempts
2. Patient's tolerance
3. Receiving lab
4. Lab test(s) obtained
5. Venipuncture site
6. If the specimen is for lab courier pick up, the confirmation number must be recorded

J. Gloves are mandatory for all phlebotomy procedures.

K. All vacutainer needles and holders are single-use items and must be discarded in a biohazard sharps container. DO NOT disconnect needles from holder.

L. Tourniquet is to be disposed of after use.

M. Refer to the *Laboratory Handbook* for vacutainer tube definitions, as to color, volume and collection guidelines.

VI. EQUIPMENT

See specific section for equipment needs.

VII. PROCEDURE

See specific section for procedure.

A. PREPARATION

Equipment:

Tape or Band-Aid
Appropriate size needle
Dry gauze pad
Gloves

Isopropyl alcohol pads
Disposable tourniquet
Tubes for tests ordered
Disposable vacutainer adapter
Sharps container and Biohazard container/tote

ACTION	RATIONALE/PRECAUTIONS
1. Check for allergies to alcohol, tape and latex.	
2. Check for restrictions on available venipuncture sites.	
3. Assemble necessary equipment.	4. Choose needle size and type related to the vein size and amount of blood needed.
4. Wash hands and don gloves.	5. Washing hands and wearing gloves supports the premise upon which standard precautions were formulated. Infection Control Standard
5. Select an arm, wrist or hand site for venipuncture; consider both upper extremities and preferably, arm without IV patent or potential hemodialysis access; affected extremity especially mastectomy.	6. Venipuncture of the legs or feet predisposes the patient to phlebitis. Use of a lower extremity requires a physician order and can be done by RN only.
6. If arm with IV must be used, always collect your specimen below the intravenous site.	7. IV additives and the concentration of IV fluid can contribute to unreliable laboratory values.
7. If absolutely no other site is available, ordered labs may be drawn above IV site: a.. Turn off the IV (RN only). b. Flush line with 3 ml of normal saline solution (RN only). c. Wait 5 minutes. d. Draw the specimen. e. Turn IV back on (RN only).	8. IV additives and the concentration of IV fluid can contribute to unreliable laboratory values.
8. Always collect the specimen above a hematoma, if present.	9. To avoid hemoconcentration of the blood sample.
9. Apply the disposable tourniquet and lower the arm.	10. These measures allow the vein to fill and should be left in place for no longer than two minutes.
10. Palpate and trace the path of the vein for successful venipuncture.	
11. Cleanse skin with antiseptic.	
12. Perform venipuncture using the techniques described in this procedure.	
13. After phlebotomy, discard needle/vacutainer adapter and any discard lab tubes in the sharps container.	

14. Discard gloves, gauze, alcohol pads and tourniquet in double bagged waste system.	

B. LABELING

ACTION	RATIONALE/PRECAUTIONS
1. Label tubes after collection in the presence of the patient.	
2. Blood cultures must be labeled with: a. patient name and date of birth b. date, time of sample collection c. initials of the person collecting the sample d. Site identification	
3. Place all filled vacutainers in the lab specimen bag. The completed lab copy of the lab requisition slip should be placed in the outside pouch of the lab bag. Return the other copy to medical records for placement in the patient's chart.	
4. Place specimen in the biohazard container and deliver to designated laboratory. Call lab for specific transport instructions if needed.	
5. When blood draws occur at a contracted site of care, call HNL with client ID number and request a courier specimen pick up. After call is made to HNL, place the confirmation number on the lab slip and in the patient chart. Place specimen in the HNL designated pick up box and place the box in the designated location at the site of care for HNL courier pick up.	

C. VACUTAINER

Equipment:

Adhesive tape
Appropriate size blood collection needle

Collection label
Dry gauze pad
Gloves
Two isopropyl alcohol pads for all blood cultures
Alcohol prep applicator
Disposable tourniquet
Tubes for tests ordered
Disposable vacutainer adapter

ACTION	RATIONALE/PRECAUTIONS
1. Follow preparation procedure.	
2. Thread needle into the vacutainer adapter.	
3. Place your first tube clear side up into the vacutainer adapter.	3. To allow visualization of blood return.
ACTION	**RATIONALE/PRECAUTIONS**
4. Remove cover from needle, turn needle so that the bevel is in the upward position. The needle should be at a 15° angle to the patient's arm and in a direct line with the vein.	4. Utilize safety device, blood collection needle or Safety Lok.
5. Pull the skin taut using the thumb and/or forefinger of your non dominant hand.	5. Keeping the skin taut will stabilize the vein and puncture site.
6. Puncture the skin and vein in one quick motion. Grasp the flange of the vacutainer adapter and push tube forward as far as it will go, allowing tube to fill completely.	6. The penetration should only be deep enough for the orifice of the needle to enter the vein wall.
7. Keep the needle and adapter steady.	7. Movement of the needle can dislodge it from the vein.
8. If multiple tubes need to be drawn, remove the tube as soon as the blood flow stops and insert the next tube into the holder.	
9. After drawing tubes with <u>additives</u>, invert the tube gently ten times.	9. <u>Do not vigorously</u> shake <u>any</u> lab specimens, additives or no additives. this causes hemolysis. Gently inverting tubes evenly distributes additives.
10. The tourniquet may be released as soon as blood enters the tube or you may leave the tourniquet on during the entire procedure. Remove tourniquet before withdrawing needle.	10. If there is no blood flow, reposition the needle in the vein, insert a new tube into the vacutainer adapter. Do not remove the needle from the skin. If another venipuncture is necessary use a clean needle.
11. Remove last tube from the vacutainer.	

12. Lightly place gauze pad above the venipuncture site when removing the needle, maintaining a 15° angle. Cover site with gauze pad and have patient apply light pressure and hold gauze in place until bleeding subsides. If patient unable to assist, hold site for patient. Activate protective needle device. a. Engage Eclipse safety device, b. Engage Push Button Blood Collection Set (butterfly).	
ACTION	**RATIONALE/PRECAUTIONS**
14. With the arm still extended, apply a gauze bandage or band aid.	14. Bending the arm at the puncture site may cause a hematoma to occur.
15. After phlebotomy, discard needle/vacutainer adapter and any discarded lab tubes in the sharps container.	15. DO NOT REMOVE NEEDLES FROM VACUTAINERS. DO NOT place needle and vacutainer in patient wastebaskets.
16. Discard gloves, gauze, alcohol pads, tourniquet in double bagged waste system.	

D. BUTTERFLY BLOOD COLLECTION TECHNIQUE:

Equipment:

Adhesive tape
Alcohol prep applicator
Collection label
Dry gauze
Gloves
Disposable tourniquet
Disposable vacutainer holder
21-23 Butterfly Collection Set

ACTION	**RATIONALE/PRECAUTIONS**
1. Follow preparation procedure.	
2. Peel off the paper backing and remove the push button collection set. Avoid contact with the black button during the removal of the device.	
3. Thread the luer end of the butterfly into the vacutainer holder.	
4. Place the first tube, clear side up, into the vacutainer adapter.	4. To allow visualization of blood return.

5. Remove cap from needle, turn needle so that the bevel is in the upward position. The needle should be at a 15° angle to the patient's arm and in a direct line with the vein.	
6. Pull the skin taut using the thumb and/or forefinger of your non-dominant hand.	6. Keeping the skin taut will stabilize the vein and puncture site.
7. Cleanse skin with antiseptic	
ACTION	**RATIONALE/PRECAUTIONS**
8. Puncture the skin and vein in one quick motion.	8. A flash back of blood will be seen in the butterfly tubing.
9. Keep the butterfly needle steady.	9. Movement of the needle can dislodge it from the vein.
10. The tourniquet may be released as soon as blood enters the tube or you may leave the tourniquet on during the entire procedure. Remove before withdrawing needle.	10. If there is no blood flow, reposition the butterfly in the vein, observe for flash back; insert a new tube into the vacutainer adapter and repeat the procedure for venipuncture.
11. When utilizing a butterfly needle, place a discarded tube onto the collection device to eliminate the air in the tubing. After tubing filled with blood, the specimen tube can be placed onto the collection device.	11. If this procedure is not followed, the air in the butterfly will not allow the blue top tube to fill completely.
12. Remove last tube.	
13. Lightly place gauze pad above the venipuncture site. Engage safety device as follows: a. Push the engage the safety feature on the device while the needle is still in the vein. b. Apply pressure to the venipuncture site with gauze pad to stop bleeding. c. Confirm needle is in shielded position prior to disposal.	13. The device is designed to be activated while the needle is still in the patient's vein.
14. With the arm still extended, apply a gauze bandage/bandaid.	14. Bending the arm at the puncture site may cause a hematoma to occur.
15. Dispose of needle in shielded position.	15. DO NOT REMOVE NEEDLES FROM VACUTAINER HOLDERS. DO NOT place needles, tubes or vacutainer in patient wastebaskets.
16. After phlebotomy, discard needle/vacutainer adapter and any discarded lab tubes in the sharps container.	
17. Discard gloves, gauze, alcohol pads, tourniquet in double bagged waste system.	

VIII. DOCUMENTATION

A. Identification of the patient

B. Number of attempts

C. Site of venipuncture

D. Time laboratory studies drawn

E. Collector's initials or signature

F. Physician collection of specimen

G. Patient toleration of procedure

H. HNL Lab courier pick up confirmation number, if applicable.

IX. ATTACHMENTS

None

X. REFERENCES

Lehigh Valley Health Network Policy

Buffington S., Brabson C. Specimen collection and testing. *Nursing Procedures.* 3rd Ed. Springhouse Corporation: Springhouse, Pennsylvania; 2000; 132-140.

McCall, R., Tankersley, C. *Phlebotomy essentials.* 2nd Ed. Philadelphia: Lippincott; 1998:114-225.

Dunne WM, Nolte FS, Wilson ML. Blood Cultures III. *CumitechlB.* April 1997.

Weinstein SM. *Plumer's Principles and Practice of Intravenous Therapy.* 6th Edition. Philadelphia: Lippincott; 116-7.

XI DISTRIBUTION

Lehigh Valley Health Network Street Medicine

Lehigh Valley Health Network Street Medicine
General Process

DEFINITION: Street Medicine urgent/emergent care guidelines

RESPONSIBLE PERSON-WHO IS PERFORMING FUNCTION:

Various Staff Members

HOW, WHEN (FREQUENCY):

As Needed

PROCESS-WHAT NEEDS TO BE DONE:

Hours of Operation – 8:30am- 4:30pm Monday- Friday.

1. Qualified personnel are present during hours of operation. No patient care may take place without a provider available by phone.
2. All staff who work in patient care must maintain BLS.
3. Any staff member should dial 555 in the event of an emergency when on Network property. Any staff member should dial 911 in the event of an emergency when at a site of care.
4. Any emergency responses must be reported via completion of a safety report.
5. Any patient transferred to the hospital must have an order and vitals written in the chart, a copy should be sent along with the patient. The provider and/or nurse should call the receiving unit with a report using the "SBAR" tool. (Situation, Background, Assessment, Recommendations).
6. A licensed professional on call schedule is implemented for after hour patient access. One Street Medicine licensed professional is designated as the on call provider daily for the calendar year. A copy of the Street Medicine on call schedule is provided to the LVH paging operator and the contracted answering service.

Originated: July 2017
Revised:

Lehigh Valley Health Network Street Medicine

Street Medicine Staff Safety Guidelines

ORIGINATION: 11/22/2017 **REVISION:**

PURPOSE:

To ensure the safety of all individuals partaking in Street Rounds.

DEFINITIONS:

Street Medicine Staff- Paid Street Medicine Employee

Street Rounds- A patient visit outside of a building with inclusion of medical personnel

GUIDELINES:

1. At least 2 Staff Members will be present during Street Rounds at any time.

2. When going on Street Rounds or patient visits the designated team member should be notified of meeting location, patient (if possible), and time.

3. Interns must be accompanied by a Street Medicine Staff Member during Street Rounds.

4. Appropriate footwear must be worn during Street Rounds
    a. Hiking Boots/Shoes
    b. Cowboy Boots
    c. Sneakers

Lehigh Valley Health Network Street Medicine
SCOPE OF SERVICES

ORIGINATION: 11/22/2017
REVISED:

I. POLICY To describe Street Medicine operations and care delivery

II. SCOPE

Street Medicine Staff

III. DEFINITIONS

None

IV. PROCEDURE

Lehigh Valley Hospital Street Medicine will operate at designated sites of care that will provide a safe and adequate space. Clinical services will be rendered at the sites of care at the designated days of the week and times.

Street Medicine administrative hours of operation will be 8:30am to 4:30pm Monday through Friday, except for designated holidays or other days as directed by the Medical Director, Program Director or designee. Designated organization personnel will be available to patients on an on-call basis during non-office hours. Services will be available twenty four (24) hours a day, seven (7) days a week.

Services rendered during Street Rounds will be conducted in areas that the Street Medicine staff deem to be safe and adequate.

Scope of Services at Sites of care and Street Rounds

A. Medical Services – provided in accordance with network, accrediting body and current clinical guidelines

B. Nursing services- provided in accordance with network, accrediting body and PA DOH standards. Only licensed nursing personnel may administer medications.

V. ATTACHMENTS

None

VII. DISCLAIMER STATEMENT

This policy and the implementing procedures are intended to provide a description of recommended courses of action to comply with statutory or regulatory requirements and/or operational standards. It is recognized that there may be specific circumstances not contemplated by law or regulatory requirements that make compliance inappropriate. For advice in these circumstances, consult with the department of Risk Management and/or Legal Services.

VIII. REVISION DATES

ADMINISTRATIVE POLICY MANUAL
LVHN STREET MEDICINE
DRESS CODE

I. **POLICY**

Lehigh Valley Health Network (LVHN) requires all personnel while on duty and/or while representing or performing network business to maintain standards of dress and grooming that are appropriate for a professional health care environment and adhere to safety and infection control requirements.

All employees and contracted staff are expected to maintain an image of professionalism through appearance, grooming, and conservative dress. Lehigh Valley Health Network reserves the right to make dress code regulations in regard to patient and/or public contact, safety, modesty, professionalism and business judgment.

II. SCOPE

LVHN Employees, Medical Staff, Allied Health Practitioners practicing within Lehigh Valley Health Network including Lehigh Valley Hospital, Lehigh Valley Hospital-Muhlenberg and Fairgrounds Surgical Center as well as the Transitional Skilled Unit, Home care, Hospice, Health Network Laboratories, LVH-Tilghman and LVHN Surgery Center - Tilghman, LVHN-Mack Boulevard and LVHN – One City Center as applicable.

III. **DEFINITIONS**

Direct Patient Care - applies to all personnel who as part of their routine daily activities do any of the following:

- Direct hands-on patient care/treatment.
- Perform treatment or procedures on patients.
- Handle equipment/items that are used directly in the care/treatment of patients.

Artificial Nails- are any materials which is attached to the natural nail, included but not limited to plastic press-on nails, acrylic nails, acrylic nail tips, fiberglass, gels, silk wraps, nail extenders, or any additional items applied to the nail surface.

IV. PROCEDURE

1. **Clothing** worn by personnel shall be neat, clean, in good repair, appropriate size and may not expose midriffs or undergarments. Spandex, leather, sheer or clinging fabrics are not acceptable. The following are not acceptable: sweatshirts (except for those provided by LVHN), sweat pants, leggings, miniskirts, jeans, tank tops, tube tops, shorts, walking shorts, Bermuda shorts and Capri pants, baseball caps (unless issued as part of a uniform), recreational attire, or T-shirts.

Direct Patient Care Attire for Street Medicine Staff:

a. Business casual attire includes khakis, pants (mid-calf to ankle length is an appropriate length, knee- length pants are not acceptable).
b. Business casual includes open/collared shirt (polo style) that is neat in appearance. Reasonable fashion logos of clothing designers are

permissible (sports logos are not acceptable). LVHN name and logo on clothing and other items are permissible.

c. Shoes must be clean, neat and in good repair and safe for the environment. Beach sandals, flip flops and thong sandals are not acceptable in any department or at any time.
d. Business casual does not include shorts (Bermuda, walking, city short or Capri), backless or halter tops, midriff tops, low cut/revealing tops, sweatshirts, sweatpants, leggings, stirrup pants, mini-skirts, tank tops, tube tops, baseball caps, evening attire (tight fitting, sheer or revealing fabrics), leather pants, recreational attire (fleece or separates), any sports clothing (spandex) or T-shirts (novelty clothing with writing or graphic messages). Clothing shall not contain offensive visual images or language, advertisements, or political statements.

Outreach Worker Attire for Street Medicine Staff:

a. Denim/jeans are acceptable provided the clothing is neat, clean, appropriate size, good condition (not torn, ripped, faded, frayed, bleached or stone washed) and free of any studs, embroidery, jewelry, etc.
b. Shoes must be clean, neat and in good repair and safe for the environment. Beach sandals, flip flops and thong sandals are not acceptable in any department or at any time.
c. Business casual does not include shorts (Bermuda, walking, city short or Capri), backless or halter tops, midriff tops, low cut/revealing tops, sweatshirts, sweatpants, leggings, stirrup pants, mini-skirts, tank tops, tube tops, baseball caps, evening attire (tight fitting, sheer or revealing fabrics), leather pants, recreational attire (fleece or separates), any sports clothing (spandex) or T-shirts (novelty clothing with writing or graphic messages).
d. Clothing shall not contain offensive visual images or language, advertisements, or political statements.

Office Attire for Street Medicine Staff:

Appropriate semi-formal business attire when there is no Direct Patient Care taking place or when staff will be interacting with the public or conducting business outside of the office.

2. A neat, hairstyle is required as part of an overall well groomed appearance. Extremes in hair styles, hair color, make-up or manicure are not acceptable for any position. Hairstyles should not impede vision and/or present any other safety concerns while performing job duties. Some work areas preclude employees from having any obvious facial hair. Removal of facial hair may be required if facial hair impedes effectiveness of the type of respirator mandated under OSHA standards for specified duties. Hair and beards must be groomed, neat and clean at all times.

3. All personnel are required to wear LVHN issued photo identification while on duty. The identification badge shall be worn above the waist with picture visible. The badge must be free from all non-approved LVHN insignia symbol or information. (See Administrative Policy Photo Identification Card).

4. Management reserves the right to request an employee to cover tattoos or any other "body art" offensive to customers. If the employee cannot or will not cover the area in question, disciplinary action will be taken per Human Resources Policy, HR2000.40 (Counseling, and Discipline).

5. An insignia, button, or label worn will be limited to identifying staff working

responsibilities in LVHN or, which distinguishes their profession by licensure, regulation or established LVHN practice.

6. Jewelry will be kept simple and appropriate for the position. Earrings are limited to two per ear and may not pose a safety hazard. Visible face or body jewelry (i.e. nose, lip, eyebrow, or tongue jewelry) are not permitted while on duty.

7. Healthcare workers that provide direct patient care are not permitted to wear artificial nails or nail jewelry. Natural nails shall be kept short, clean and healthy and not impede job performance and/or create a safety hazard.

8. **Footwear** should be closed to shoes at all times. Footwear must be clean, in good repair, appropriate and safe for the position.

9. **Sun glasses** are not to be worn within the LVHN facilities during working hours, unless medically required and must be cleared through Employee Health.

10. All staff is expected to maintain good **personal hygiene.** Due to close contact with others, deodorant or antiperspirant shall be worn. A light cologne or perfume is acceptable unless it is offensive to others.

11. In keeping with our **Smoke Free Environment,** healthcare workers that provide direct patient care may not provide care to patients if the staff member has a noticeable smell of tobacco or smoking odor.

21. The Department Director will address non-compliance with the dress code by discussion, sending the employee home (without pay) to change, or other disciplinary action in accordance with the Employee Counseling & Discipline HR Policy 2000.40. Exceptions to the provisions of this dress code may be granted due to a medical condition provided Employee Health Department clearance is obtained. This exception will be applied at the discretion of the Department Director and Division Vice President. Consultation with Human Resources should take place, as appropriate.

22. During department orientation, staff will be advised of any additional specific departmental dress requirements.

23. Individual departments may establish additional requirements to this dress code however; they may not deviate from the minimum requirements as stated in this policy. Guidance should be obtained from Human Resources to ensure compliance.

24. Staff dressed inappropriately or violating other provisions of this policy shall be handled in accordance with Human Resource Policy HR 2000.40 (Counseling and Discipline)

V. DISTRIBUTION

Administrative Manual

VI. POLICY RESPONSIBILITY

Human Resources

VII. REFERENCES

CDC Guidelines for Hand Hygiene in Health Care Settings MMWR; October 25, 2002Nol. 51 No. RR-16. The Joint Commission 2010 Comprehensive Accreditation Manual for Hospitals.

VIII. DISCLAIMER STATEMENT

This policy and the implementing procedures are intended to provide a description of recommended courses of action to comply with statutory or regulatory requirements and/or operational standards. It is recognized that there may be specific circumstances, not contemplated by laws or regulatory requirements that make compliance inappropriate. For advice in these circumstances, consult with the departments of Legal Services and/or Risk Management

IX. REVISION DATES

Approved by:

Approval Date:

Original Creation Date: **Next Review Date:**

Lehigh Valley Health Network Street Medicine
Community Health Department
ORIGINATION: 11/22/2017 REVISED: 12/20/2017

Contents and Documentation of Orientation
Employee: _____ Position: _____Starting Date: _____

Instructors are to date and initial each segment. Do not initial and arrow or bracket. Sign full name on last page.

DATE	INSTRUCTOR	INITIALS	N/A	TOPIC
	Program Director			Community Health Department- introduction to the Department
	Program Director			LVHN Street Medicine- introduction to the Program
	Program Director			Practice Administration
	Clinical Coordinator			Corporate Compliance
	Clinical Coordinator			Performance Improvement / Quality Management
	Clinical Coordinator			Patient Rights and Responsibilities
	Program Director			Advanced Directives
	Program Director			Ethics
	Program Director			Communication Confidentiality Cultural Diversity – includes language, religion, approach to health, traditions Barriers to communication including age, physical status, mental status
	Program Director			Funding Sources a. Dorothy Rider Pool Grant b. Operational c. Other funding sources
	Clinical Coordinator			Infection Control
	Office Coordinator			Navigations
	Clinical Coordinator			Patient Safety Child, elder or domestic abuse Code Orange / trauma informed care Patient Safety Report and Quality Assurance Review Form
	Office Coordinator			Employee Safety

				Employee Safety Policy Workplace Violence Sexual Harassment LVHN Security Employee Incident Forms
	Clinical Coordinator			Personnel/HR Items • I/S Access Form • CPR card, Job Description • Work Hours/expectations • Performance Appraisal • Pager • API time entry • PTO coordination • Sick call out procedure • Occurrence policy
	Clinical Coordinator			PRIDE / AIDET
	Program Director			Role of: Job description
	Clinical Coordinator			Forms/documentation
				Departmental Overview
	Clinical Coordinator and clinic staff			Clinic • Visit process • Community Worker Role • Nursing role • Physician role
	Community Health Worker			Role and Responsibility: • Program Overview
	Office Coordinator			I/S and Technology Training / walkthrough • SharePoint • Other IS needs • Email training
	Office Coordinator			IS software requirements
	Office Coordinator			Voice mail / phone systems
	Office Coordinator			Procurement
	Program Director			Marketing, Development, Events
	Clinical Coordinator			Medication competency

				Observations: • Community Health Worker_____ • Clinic _____ • Street Rounds _____ • Other _____ • Other _____

Employee Signature _____Initials _____

Instructor(s)

Name _____Initials _____

Name _____Initials _____

Name _____Initials _____

Name _____Initials _____

Street Medicine Trained Medical Interpreters Line

Contact Information: Trained Medical Interpreters

Number: 1-800-481-3293

Street Medicine Account Number: 501015662

Street Medicine PIN: 5224

When Calling Be Sure To Provide: YOUR Name, Street Medicine, 1627 W. Chew Street Allentown, Pa, Phone Number, Account Number, & PIN

Medicine Clinical Coordinator Laura LaCroix, RN

Date: 3/4/2016

Street Medicine Imaging

For Free imaging the following items must be completed:

1. All orders for testing must be written on a Street Medicine Prescription
2. Patient MUST go to Lehigh Valley Hospital on 17th and Chew for imaging. If the patient does not have insurance, the bill is forwarded to Street Medicine.
3. Any additional imaging (i.e. CT scans, MRI or Ultrasound) should be discussed with Street Medicine Director prior to ordering.
4. All prescriptions for imaging purposes need to include "CC to Brett Feldman PA-C"

Please be prudent in ordering imaging studies due to budget restrictions. Consider the Emergency Department if clinical judgment indicates a patient requires an urgent work up.

Street Medicine Clinical Coordinator: Laura LaCroix, RN

Date: 3/4/2016

Street Medicine Reportable Clinic Metrics:

1. Influenza Vaccination– Number administered/Refused
2. Controlled Blood pressures (Street Medicine Definition systolic <140 and Diastolic <90)
    a. Protocol POCT Blood Glucose conducted for systolic >140 and diastolic >90
3. Controlled Diabetes (Street Medicine Definition A1C <8.0)
    a. Protocol POCT Blood Glucose conducted for those with history of pre-diabetes or diabetes
    b. Protocol POCT A1C conducted every 6 months for those with history of pre-diabetes or diabetes
4. Smoking Counseling Provided

Please note, that the reportable Clinic Metrics have been chosen specifically to reflect metrics that are currently in place and looked at by both LVH and LVPG. These metrics are able to be pulled in EPIC as they are "point and click" items or "clinician orders."

Continued Monitoring and Report out of Inpatient Metrics:

1. Number of monthly Consults
    a. Medical/Behavioral
2. Number of Re-admission
    a. Medical/Behavioral
3. Length of Stay
4. Age
5. Diagnosis
6. All numbers can be quarterly once Roya and Sam can reliably pull from EPIC.

Continued Monitoring and Reporting of Outpatient Numbers:

1. Number of monthly Patient Encounters
2. Number of individuals that month who are insured
3. All numbers can be quarterly once Roya and Sam can reliably pull from EPIC.