PRECISION VASCULAR ACCESS

San Diego's Mobile PICC Nurse

HOME HEALTH NURSE VISITS: ADMISSION AND STANDARDIZED WORKFLOW

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I. PURPOSE

The purpose of this policy is to describe and define guidelines for the Home Health Nurse Visit admission process and standardized workflow.

II. POLICY

A. Precision Vascular Access (PVA) reserves the right to defer clients to Emergency Medical Services (EMS) at the discretion of the nursing staff at any time.

B. A physician order is required to perform home health services including but not limited to: nursing assessments, patient education, infusion therapy, central line dressing changes, midline dressing changes, lab draws and follow-up care as needed.

C. Perform hand hygiene before and after handling vascular access devices (VAD)s and any attached lines, dressing changes, catheter manipulation or lab draws.

D. PICC lines and midlines should be secured and immobilized as appropriate. Venipuncture and blood pressure should be avoided in the ipsilateral arm as the VAD.

E. Aseptic technique shall be maintained when accessing any VAD, such as a PICC line, midline or peripheral IV and any attached lines.

1. Prior to accessing any VAD, the entire access must be scrubbed with a Chloraprep pad (3.15% Chlorhexidine Gluconate and 70% Isopropyl Alcohol) for 15 seconds and allow adequate time to dry per manufacturer's instructions.
   a) If the client has a chlorhexidine allergy/sensitivity or chloraprep is unavailable, an alcohol pad may be used.

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b) The patient, family and/or caregivers should also be instructed to maintain aseptic technique when accessing any VAD, such as a PICC line, midline or peripheral IV and any attached lines.

F. Nursing staff shall always practice universal precautions and wear gloves when conducting nursing care.

G. The patient, family and/or caregivers participating in the patient's care in the home setting shall meet satisfactory return demonstration and verbalize full understanding of the setup and administration process by the conclusion of the first visit.

1. If the patient is elderly or requires additional educational reinforcement and instruction, nursing staff may arrange for a next day follow-up visit at the visiting nurse's discretion. The visiting nurse shall notify the Nurse Supervisor and document rationale for next day follow-up visit in the Electronic Health Record (EHR).

a) If the patient, family and/or caregivers are unable to provide satisfactory return demonstration to the visiting nurse after the next day follow-up visit, notify the Nurse Supervisor that the patient is not suitable for home health services and document evaluation in EHR.

2. If the patient's home environment is not safe or suitable for home health, the visiting nurse shall notify the Nurse Supervisor and document assessment in EHR.

a) The Nurse Supervisor shall notify the proper authorities and coordinate care as appropriate.

H. In the event of a medical emergency such as anaphylactic shock, chest pain, shortness of breath or loss of consciousness, the visiting nurse shall contact EMS immediately and begin CPR, if appropriate, until EMS arrives.

I. All documentation shall be kept secure and in compliance with HIPAA regulations.

1. Paperwork that is not submitted within 48 hours of visit shall incur a penalty fee per day.

III. DEFINITIONS

A. Peripherally Inserted Central Catheter (PICC): Catheter inserted approximately two inches or higher above the antecubital space and inserted into the basilic, brachial or cephalic vein. The tip lies in the distal one third of the superior vena cava (SVC). These catheters provide long-term venous access, generally longer than one month and up to one year. A POWER PICC is made of material that can tolerate high pressures used during injection of CT contrast materials either by hand or with power injector.

B. **Midline:** Catheter inserted approximately two inches or higher above the antecubital space and inserted into the basilic, brachial or cephalic vein. The tip lies near the axillary level.

These catheters provide venous access up to 29 days. This is NOT considered a central catheter, but is cared for the same way as a PICC line.

IV. PERSONNEL

A. Registered Nurse (RN)

v. PROCEDURES

A. Intake/Admission Process

1. The patient's identity must be confirmed prior to the initiation of care.
    a) Upload the digital copy of the patient's identification card, front and back if applicable, into the EHR.
    b) Instruct the patient to verbally confirm the name and birthday on the identification card for further verification.
        i. If the patient is unable to verbally confirm their identity, perform a visual comparison of the photo ID and the patient. For further verification, confirm with their guardian, caregiver or conservator that the patient has been properly identified as the correct person.
    c) Ensure that the patient's name and birthday correlate with the physician order.
2. Obtain a digital copy of the patient's insurance card, front and back if applicable, and upload into the EHR.
3. Perform baseline nursing assessment according to admission paperwork to include:
    a) Nurse Admission Visit Record
        i. Ensure "Visit Time Start" and "Visit Time End" is documented.
        ii. Document "Next Nursing Visit" and "Next MD Visit".
        iii. Obtain patient signature.
    b) Patient Medication Profile
        i. Ensure prescribed medication for home health correlates with discharge medication from hospital and/or physician order for home health.
    c) Plan of Treatment
        i. Initial Certification Period shall be 60 days from the Start of Care (SOC)
4. Complete all required admission paperwork prior to initiating patient education.
    a) Every page of each form must include the patient's name, Coram ID number and visit date at the top.
    b) Forms must have patient signature to validate home health nurse visit.

5. Documentation for the admission visit and corresponding paperwork shall be completed by the end of the visit.
    a) Paperwork shall be submitted within 24 to 48 hours of the visit for processing.
        i. Paperwork that is not submitted within 48 hours of visit shall incur a penalty fee per day.

B. Education for Home Health Infusions

1. Provide adequate and thorough patient education regarding self-administration of intravenous medications to the patient, family and/or caregivers who may participate in the patient's care. Key points to highlight include the following:
    a) Emphasis on hand hygiene prior to initiating infusion therapy.
    b) Emphasis on "scrubbing the hub" for a minimum of 15 seconds each time the port is accessed.
        i. Have the patient return demonstrate "scrubbing the hub".
        ii. Maintain aseptic technique when accessing ports.
    c) Avoid injecting air bubbles into VAD.
        i. Have the patient return demonstrate ejecting air bubbles out of saline and/or heparin syringe.
        ii. Teach patient how to prime the IV infusion tubing for infusions, if applicable.
        iii. Tiny "champagne bubbles" can safely be reabsorbed by the body.
    d) Emphasis to maintain correct frequency of medication dose.
        i. Patients have a one-hour window to in which to give the medication "on time", which is 30 minutes before and 30 minutes after the scheduled dose time.
    e) Identify important key parts of the infusion setup for ease of troubleshooting over the phone, if necessary:
        i. Drip chamber
        ii. Pincher clamp(s)
        iii. Slider clamps(s)
        iv. IV infusion tubing regulator
        v. Extension tubing
    f) Troubleshooting:
        i. Check for kinked tubing
        ii. Check for unopened clamps
        iii. Check the flow rate on the regulator
2. Provide instruction for self-administration using the SASH Method:
    a) S- Saline, flush the line
    b) A- Administer, Administer medication

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c) S- Saline, flush the line
d) H- Heparin, Heparinize the line to avoid clotting

3. VAD dressing changes and extension tubing shall be performed by the visiting nurse only.
   a) Reinforce teaching to keep VAD clean and dry at all times.
   b) NEVER use scissors around VAD.
   c) Best time to take a good shower is on a visiting day when dressing change is due to be changed.
4. IV Infusion tubing and/or batteries for pumps shall be changed every 24 hours.
5. Review Sharps Disposal Process:
   a) Instruct the patient to sign the form on the side of the box the Sharps Container was packaged in on the "Generator Signature" line. Return the signed form to the outside of the box.
   b) The box is prepaid for by Coram and should not be thrown away.
   c) Upon completion of therapy, the patient will package the Sharps Container into the clear bag provided inside of the box and seal with the provided wire. The entire Sharps Container and sealed bag will then be placed back into the box and sealed with the provided tape.
   d) Upon completion of prescribed therapy, the patient can take the entire Sharps Container Box to the Post Office for disposal.
6. Ensure satisfactory return demonstration of infusion setup, administration and takedown with the patient and all participating family members and/or caregivers.
   a) Review educational laminated handouts for infusion setup, administration and takedown provided by Coram with the patient after satisfactory return demonstration to reinforce teaching.
7. Review important contact numbers and signs and symptoms to report:
   a) Call PVA- Issues with infusions, VAD or home visit appointments.
      i. Provide patient with PVA postcard with contact number.
   b) Call Coram- Issues with supplies or medications.
   c) Call Primary Care Doctor (PCP)- Any new signs or symptoms that may develop, perceived symptoms of an adverse reaction to the infusion medication, or worsening symptoms.

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