PRECISION VASCULAR ACCESS

San Diego's Mobile PICC Nurse

HOME HEALTH NURSE VISITS: FOLLOW-UP VISITS AND STANDARDIZED WORKFLOW

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I. PURPOSE

The purpose of this policy is to describe and define guidelines for the Home Health Follow-up Nurse Visit 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. If the patient develops changes in mentation and is unable to safely deliver medications through the VAD or if the patient's home environment changes and becomes unsafe or unsuitable for home health, the visiting nurse shall notify the Nurse Supervisor and document assessment in the Electronic Health Record (EHR).

1. 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. Follow-up Nurse Visit

1. The patient's identity must be confirmed prior to the initiation of care.

a) Perform a visual comparison of the photo in the patient's file in the EHR and ask the patient to verify their identity by confirming their name and birthday according to our records.
   i. If the patient is unable to verbally confirm their identity, perform a visual comparison of the photo in the patient's file with the patient. For further verification, confirm with their guardian, caregiver or conservator that the patient has been properly identified as the correct person.

b) Ensure that the patient's name and birthday correlate with the physician order.

2.. Perform nursing assessment according to paperwork to include:

a) Nurse 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.

3. Complete all required paperwork prior to initiating nursing care.

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.

4. Perform follow-up nursing care:

a) Collect lab work according to physician order.
   i. Have patient verify correct name and birthday on both the lab slip and each specimen tube according to physician order.
   ii. Deliver specimen to the appropriate facility after each visit, within two hours of collection time.

b) Perform VAD care and maintenance.
   i. Change VAD dressing, biopatch, securement device, claves and extension tubing, if applicable.
   ii. Assess VAD for blood return and flush per protocol.
   iii. Measure and annotate external catheter length, in centimeters, for PICC lines.
   iv. Measure and annotate arm circumference three inches above the insertion site, in centimeters, for PICC lines.
   v. NEVER use scissors around VAD.

c) Assess for any issues or concerns:
   i. Perform general head to toe nursing assessment, including vital signs, while assessing for signs and symptoms of adverse drug reactions.
   ii. Assess for any issues with medication administration and provide additional instruction/reinforcement as needed.

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iii. Assess inventory of supplies and medications. Direct patient to call their dedicated Coram Supply Manager, or call Coram Supply Manager on behalf of the patient, if necessary.

5. Review important contact numbers and signs and symptoms to report:
   a) Call PVA- Issues with infusions, VAD or home visit appointments.
   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.
6. Documentation for the follow-up 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. Lab Specimen Collection and Dropoff
1. The patient's identity must be confirmed prior to the initiation of care.
   a) Perform a visual comparison of the photo in the patient's file in the EHR and ask the patient to verify their identity by confirming their name and birthday according to our records.
      i. If the patient is unable to verbally confirm their identity, perform a visual comparison of the photo in the patient's file with the patient. For further verification, confirm with their guardian, caregiver or conservator that the patient has been properly identified as the correct person.
   b) Ensure that the patient's name and birthday correlate with the physician order.
2. Label each specimen tube appropriately and fill out appropriate lab slip.
   a) See Lab Test Guide for assistance in determining appropriate tube tops for each test according to lab facility.
   b) Label each tube with the tube top to the left of the label.
      i. Label each tube with the patient's name and birthday.
      ii. Always include date, time, initial and source of collection (venipuncture or catheter) on the label.
      iii. Scripps will not process labs without the Scripps Medical Record Number (MRN).
      iv. VA will not process labs without last four of SSN.
      v. LabCorp will not process labs without patient insurance information.

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c) Scripps patients lab specimens shall only be dropped off at a Scripps Clinic lab location.
   i. Use a Scripps lab requisition slip.
   ii. Must include ICD9 diagnosis code on the lab requisition slip for processing.
   iii. Scripps will not process labs without the Scripps MRN on the lab requisition slip and on each specimen tube.
   iv. Each specimen tube must have patient's name, Scripps MRN and patient birthday clearly labeled on each tube.
   v. Always include date, time, initial and source of collection (venipuncture or catheter) on the label.

d) VA patients lab specimens shall only be dropped off at a VA Clinic lab location.
   i. No lab requisition slip necessary.
   ii. VA will not process labs without the last four of the SSN clearly labeled on each specimen tube.
   iii. Each specimen tube must have the patient's name (last name, first name) and the last four of the patient's SSN clearly labeled on each tube.
   iv. Always include date, time, initial and source of collection (venipuncture or catheter) on the label.

e) All other Hospital/Clinic patients lab specimens shall only be dropped off at a LabCorp location.
   i. Use a LabCorp lab requisition slip.
   ii. Must include ICD9 diagnosis code on the lab requisition slip for processing.
   iii. LabCorp will not process labs without patient insurance information. Provide insurance company name, insurance policy number and insurance group number on the lab requisition slip.
   iv. Each specimen tube must have patient's name and patient's birthday clearly labeled on each tube.
   v. Label the lab requisition sticker(s) on the lab requisition slip with the date, time, initial and source of collection (venipuncture or catheter). Apply the corresponding lab requisition sticker(s) from the lab requisition slip to each tube for further verification.

3. Ensure that the identifying information on the lab specimen tubes and lab requisition slip correlate with the physician order.
   a) Have the patient verify their name and birthday on the lab specimen tubes and lab requisition slip prior to collection.
4. Collect blood specimen(s).

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a) Assess line patency by flushing with 10 ml normal saline.
b) Using the same flush syringe, check for blood return. Waste a minimum of 5 ml of blood prior to specimen collection. Dispose of wasted blood in Sharps Container receptacle provided by Coram.
c) Connect vacutainer to access port. Collect blood specimen(s) according to physician order. Dispose of vacutainer in Sharps Container receptacle provided by Coram.
d) Flush with 20 ml normal saline, followed by heparin 100 units/5 ml.
e) Clamp the line and replace the alcohol cap for the access port.
f) If unable to draw from line, attempt venipuncture to collect labs.
    i. If venipuncture unsuccessful, contact Coram pharmacist on behalf of patient and ask for guidance.
    ii. Notify Nurse Supervisor of inability to collect blood from line. Document assessment, diagnosis, plan and intervention in the patient's chart under "Notes" tab in Patient Management (PM) chart.

5. Drop off specimens to the appropriate facility within two hours of collection time.
    a) Do not leave specimens unattended.
    b) A lab personnel must perform a visual inspection of the specimen(s) and the lab requisition slip.
        i. You may be asked to leave your contact number in case of any questions related to the lab draw.

C. Discharge Nurse Visit
1. The patient's identity must be confirmed prior to the initiation of care.
    a) Perform a visual comparison of the photo in the patient's file in the EHR and ask the patient to verify their identity by confirming their name and birthday according to our records.
        i. If the patient is unable to verbally confirm their identity, perform a visual comparison of the photo in the patient's file with the patient. For further verification, confirm with their guardian, caregiver or conservator that the patient has been properly identified as the correct person.
    b) Ensure that the patient's name and birthday correlate with the physician order.
2.. Perform nursing assessment according to paperwork to include:
    a) Nurse Visit Record
        i. Ensure "Visit Time Start" and "Visit Time End" is documented.
        ii. Document "Next Nursing Visit" and "Next MD Visit".

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v. Obtain patient signature.

b) Discharge Summary

3. Complete all required paperwork prior to initiating nursing care.
   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.
4. Perform nursing assessment to include general head to toe nursing assessment and vital signs.
5. Provide discharge instructions:
   a) Patient is to notify physician of fever greater than 100 degrees Fahrenheit within 24 hours of discharge.
   b) Patient is to notify physician if complications develop at VAD site within 48 hours of removal.
   c) Patient is to notify physician if symptoms return after medication has been discontinued.
   d) Leave occlusive dressing on for 24 hours.
6. Discontinue VAD per physician order.
   a) For PICC lines, instruct patient to inhale slowly to take a deep breath. Hold for one second, then slowly exhale. Pull PICC line out slowly while patient is exhaling.
      i. If patient is unable to follow instructions, pull the PICC line on patient exhale.
   b) Hold pressure until bleeding has subsided. Apply an occlusive dressing and instruct patient to leave occlusive dressing in place for 24 hours.
7. Documentation for the discharge nurse 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.
      ii. Paperwork that is not submitted within 48 hours of visit shall incur a penalty fee per day.

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