Department of Public Health
Office of Nursing

Quality Assurance/Quality Improvement (QA/QI) for Public Health Nursing Practice Manual

February 2015

http://dph.georgia.gov/resourcesformsmanuals

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QUALITY ASSURANCE/ QUALITY IMPROVEMENT (QA/QI) FOR PUBLIC HEALTH NURSING PRACTICE MANUAL

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DEPARTMENT OF PUBLIC HEALTH
QUALITY ASSURANCE/QUALITY IMPROVEMENT FOR PUBLIC HEALTH NURSING
PRACTICE MANUAL
FEBRUARY 2015

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Quality Assurance/Quality Improvement (QA/QI) for Public Health Nursing Practice Manual

Purpose and Background

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PURPOSE

The purpose of the *Quality Assurance/Quality Improvement for Public Health Nursing Practice Manual* is to provide specific standards, measurement tools and processes for improving the quality of public health nursing practice in Georgia. This manual replaces the 2002 manual, *Guidelines for Quality Assurance in Public Health Nursing Practice*. The State Office of Nursing has the responsibility to set training and practice standards in accordance with the most current research and evidence-based practice. The extent to which the standards are implemented is determined by those who govern the day-to-day activities of public health programs and services at the local level.

BACKGROUND

Accountability for nursing practice has significant roots in the history of nursing. Florence Nightingale, the founder of modern nursing, was one of the first to document the need for a systematic approach for reviewing the quality of nursing care. She identified the need to incorporate health data and statistics in quality assurance activities.

HISTORY

Since the 1970's, there have been a wide range of quality assurance and quality improvement models and processes developed by and for the health care system. Quality assurance has been defined as a widely accepted system that compares the care provided to institutionally held standards, evaluates data, identifies problems, plans and implements activities to alleviate the problems and determines whether the activities achieved the desired results (Rowland & Rowland, 1987). Models of quality assurance frequently incorporate three types of standards (outcome, process and structure). Outcome standards define expectations in terms of desirable and achievable benefit, either at the individual client/patient level or at the community level. Process standards reflect expectations in terms of best practices, policies, procedures and interventions, which are evidence-based. Structure standards indicate the operational requirements, staffing characteristics, materials and/or space requirements necessary to provide quality services.

In the 1980's, the concept of total quality management (TQM) or continuous quality improvement (CQI) received considerable attention in the health care arena. TQM/CQI represents an all-encompassing management philosophy that permeates the organization's management infrastructure, policies and practices. TQM principles call for a focus on the customer, an emphasis on systems, the use of data-driven decision-making, the active involvement of leaders and employees and continuously improving performance in all areas (Deming, 1986).

In the 1990's, the emphasis on accountability for public health began an important evolutionary process as part of the health system(s) within the community. This community-based process involves the selection of community indicators that can be used to measure the process and outcomes of intervention strategies for health improvement. Performance improvement should promote health improvement in a context of shared responsibility and accountability for achieving desired outcomes (IOM, 1996).

In 1997, the District Health Directors requested that a more coordinated approach to QA be developed. The Office of Nursing was charged with leading the new approach to QA/QI.

The highlights of the QA/QI initiative follow:

DATE	FOCUS
1997 – 1998	Developed first model of QA that was a mix of process and community indicators, but it was rejected and scratched.
1998	Developed second QA model that was focused on nursing practice under nurse protocol.
1999—2000	Conducted pilot; revised model; produced first site visit manual; completed baseline site visits to one site in each of 19 districts.
2000—2001	Reviewed results of site visits; produced 2nd edition of QA Manual with expanded components.
2002	District teams began making site visits to counties within their respective districts.
2004 – 2005	State office site visits were made to 13/18 districts to assess the QA/QI process and experience. The process of revising the QA/QI Manual began.
2006	Surveyed state office programs regarding QA/TA and Site Visit activities; developed report of findings and recommendations for improved coordination and integration.
2007	New Record Retention Schedules were approved by the Division of Archives and History and distributed. A new CD-ROM on Documentation Standards was produced and distributed. The new standards and training tool were reviewed with District QA/QI Teams via VICS on September 24, 2007. District QA/QI teams continue to make site visits to counties within their districts.

PROGRESS

In 1997, a new model of QA, that focused on outcomes as well as processes was proposed but not implemented. In 1998, the second model, *Quality Assurance for Public Health Nursing Practice under Nurse Protocol,* was developed. In January 1999, a pilot of the new QA/QI initiative was conducted at the Bibb County Health Department. The QA/QI initiative began with the development of standards and tools for measurement of quality and opportunities for improvement. A quality assurance site visit team was formed to include representatives from state offices, districts and counties. The team conducted a two-day site visit to at least one location within each district between January 1999 and December 2000. All site visits were conducted according to schedule, except for Fulton County, which had to be rescheduled to a later date due to Hurricane Floyd, which struck September 15, 1999.

The site visit methodologies included review of written documentation, staff interviews, peer review, direct observations of clinical practice and an exit conference.

In June 2000, a survey was distributed to each state office program to identify the QA/QI activities by program and the extent to which those activities meshed with the Division's QA/QI initiative. The 2000 survey showed that most programs conducted their respective QA/QI activities separately and apart from the Division's QA/QI initiative. The Child Health, STD, SHAPP, TB and Immunizations programs have been coordinating some or most of their QA/QI activities with the Divisions' initiative, while other programs continue their QA/QI activities separate from the statewide effort. The districts have expressed the need to coordinate all QA/QI activities as part of providing an efficient and effective system of accountability. Development of the QA/QI initiative needs to identify the barriers that are keeping programs from merging their QA/QI activities with the Division's statewide initiative and to recommend action steps to eliminate those barriers.

In 2001, the QA/QI team focused on reviewing the results of the site visits by the QA/QI team and refining the standards and measurement tools for future site visits. The QA/QI standards and measurement tools were revised to incorporate the recommendations and feedback from the districts and counties and were expanded to include such components as leadership, customer service, cultural competency and population health.

During 2004-2005, site visits were made by the state office QA/QI Coordinator to 13 of the 18 public health districts to assess the QA/QI process and experience. These site visits assessed such factors as learning how the districts prepared for, conducted, documented and followed up on the findings of the QA/QI processes that they used. A summary of this assessment is on file.

In 2004, the process for updating the 2002 QA/QI Manual began. Although consideration was given to delaying the manual revision until the new direction for public health became clearer, it was decided to proceed with plans to revise the manual in order to support the local public health momentum and ownership of QA/QI and to respond to their demands for the manual to be updated. Revisions to the manual were later postponed due to turnover in the Assistant Chief Nurse position in the Office of Nursing that manages the QA/QI initiative.

In 2005, the Division gained a new Director who began a new strategic direction for public health. According to Dr. Stuart Brown, Director for the Division of Public Health, "The greatest change needed is a shift from serving as the state's safety net health care provider. We must strengthen our role as leaders for prevention and protection of the public's health. We will never have enough resources to fulfill the role of safety net provider. We know that many communities have no alternatives today. People in these communities need preventive health services and the county health department may be their only option. However, county health departments are not resourced to serve in this capacity alone. The responsibilities for ensuring that all Georgians have access to preventive health services must be shared among many partners. Public health must galvanize support for efforts like development of federally qualified health clinics and sliding scale health service providers" (*Just the PHacts,* Volume 17, April/May 2007, page 1).

In 2006, Dr. Janice Carson was appointed as Deputy Director and Liaison to the Districts. Dr. Carson mapped out an integration project in response to the district requests for better integration of state initiatives, including Quality Assurance, technical assistance and site visits. A survey of state office public health branches and offices (Environmental Health, Laboratory, Emergency Preparedness, Family Health Branch, Prevention Branch, and Chronic Disease Branch) showed that all state offices and programs are committed to collaborating on the goal of taking quality to a higher level. All disciplines and all program areas actively participated in the internal assessment process for developing plans for a new and integrated approach to quality. The combined success of each state office program's commitment to quality and the enthusiastic support by local public health for taking quality to a higher level are strong indicators for success in achieving this goal.

In 2007, Meshell McCloud, R.N., A.P.R.N., W.H.N.P.-B.C., was appointed Assistant Chief Nurse and assigned as manager of the QA/QI Initiative. Under her leadership, efforts to complete and approve the QA/QI manual continued. The new Record Retention Schedule was approved by the Division of Archives and History and distributed to the districts and state offices. The new CD-ROM on clinical record documentation was distributed and training for implementing the new standards was conducted on September 24, 2007.

In 2010, Dr. Angela Guidry was appointed Assistant Chief Nurse to serve as the state Office of Nursing leader for QA/QI related to public health nursing practice. In alignment with the strategic goals of the Office of Nursing, Dr. Guidry maintains a vision to advance public health nursing practice to ensure the delivery of quality nursing care to improve the health and safety of all Georgians.

Currently, all districts are conducting their internal QA/QI site visits to each of the counties/sites within the district. Representatives from the state office QA/QI team have participated as members of some of the district internal site visits, but these site visits are primarily managed by the district leadership staff. The county site visit reports are kept within each district and are no longer being submitted to the state office, at the request of the state office. The reason that the state office requested districts to stop sending the QA/QI site visit reports to the state office was that the state office did not establish a process for reviewing the reports, monitoring trends or producing any trend reports based on the reports. This represents a major gap in the QA/QI initiative that needs to be addressed.

Quality Assurance/Quality Improvement (QA/QI) for Public Health Nursing Practice Manual

QA/QI Model

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QUALITY ASSURANCE/QUALITY IMPROVEMENT MODEL FOR PUBLIC HEALTH NURSING PRACTICE

DESCRIPTION

The system wide efforts of the Georgia Department of Public Health, District Public Health Offices and the County Health departments contribute to accountability in public health nursing. These three points of service for public health nursing practice converge to ensure accountability through infrastructure support, health outcomes, and professional development. According to the Office of Nursing Quality Assurance/ Quality Improvement Model for Public Health Nursing Practice, infrastructure support fosters accountability through standardized methods for Data Collection and Analysis, Clinical Record Documentation, and Clinical Operations. The framework further demonstrates the influence of Health Outcomes on accountability through Public Health Priorities, Determinants of Health, and Customer Satisfaction. Finally, the influence of Professional Development on accountability is demonstrated through competencies in population health and emergency preparedness, as well as clinical and leadership competencies.

The Quality Assurance/ Quality Improvement Model is presented to promote understanding of the holistic nature of public health nursing practice accountability. Nursing Protocols, Practice Standards, Rules & Regulations, and Program Standards are rigorous system components that contribute to a robust public health nursing practice in Georgia. The model effectively represents how each system component is integrated and interrelated to assure accountability and quality nursing care.

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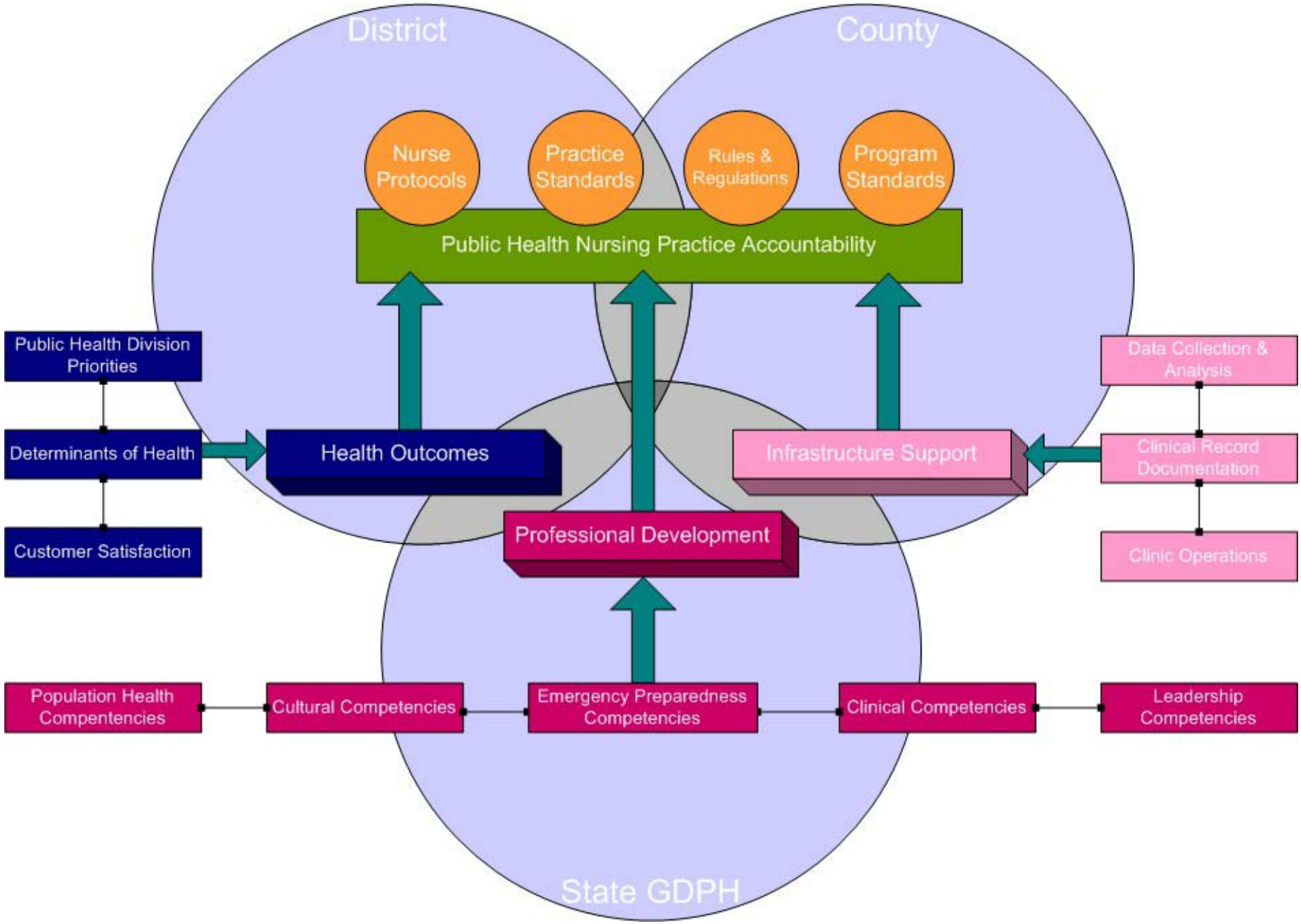
QUALITY ASSURANCE/ QUALITY IMPROVEMENT MODEL FOR PUBLIC HEALTH NURSING PRACTICE

A SYSTEMS FRAMEWORK



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Quality Assurance/Quality (QA/QI) Improvement for Public Health Nursing Practice Manual

Guidelines for Conducting QA/QI Reviews

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GUIDING PRINCIPLES FOR CONDUCTING QUALITY ASSURANCE/ QUALITY IMPROVEMENT REVIEWS

PURPOSE

The following principles will help guide the site visit process and help assure consistency with the concepts of continuous quality improvement.

1. **Expect Excellence.** Use a positive approach and expect to find excellence. The site visit provides an opportunity to identify, acknowledge and/or share models of excellence, which may benefit other public health practice settings.

2. **Apply CQI Concepts.** Quality Assurance/Quality Improvement is a process and a journey. Where there are opportunities for improvement, be constructive when suggesting alternative solutions.

3. **Respect the Environment.** Site visitors do not normally work at the site and need to be mindful of the site's policies and procedures, hours of operation, routines, wearing of proper identification and professional attire, etc.

4. **Focus on Established Standards.** Site visits should be based on established standards.

5. **Build the Partnership.** Site visitors need to work side by side with staff from the site throughout the site visit. This provides an opportunity to discuss and/or clarify all findings in a collaborative manner.

DEPARTMENT OF PUBLIC HEALTH
POLICY

EFFECTIVE DATE: March 1, 2009

TITLE: QUALITY ASSURANCE/QUALITY IMPROVEMENT FOR PUBLIC HEALTH NURSING

INTRODUCTION/BACKGROUND:
For decades, Public Health Nurses have participated in Quality Assurance/Quality Improvement (QA/QI) activities as an integral part of nursing practice. In 1999, a new statewide QA/QI program for Georgia Public Health Nursing was launched. Since the pilot was conducted in January 1999, this QA program has undergone two major revisions (i.e. 1999, 2001), and a third revision is in process. The QA/QI program is currently being used in all 18 Public Health Districts, and the current manual, *Quality Assurance/Quality Improvement for Public Health Nursing Practice,* produced by the Department of Public Health, is posted at http://dph.georgia.gov/resourcesformsmanuals
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AUTHORITY and JUSTIFICATION:
According to the Georgia Nurse Practice Act for Registered Professional Nurses, the practice of nursing requires, among other things, "the substantial specialized knowledge of the humanities, natural sciences, social sciences and nursing theory as a basis for assessment, nursing diagnosis, planning, intervention, and evaluation", O.C.G.A. § 43- 26-3 (6). The act's definition for the practice of nursing also includes "providing for safe and effective nursing care rendered directly or indirectly", as a Registered Professional Nurse O.C.G.A. § 43-26-3 (8) (E).

According to *Public Health Nursing Scope and Standards* (American Nurses Association 2007), one of the professional performance standards covers Quality Practice and calls for the Public Health Nurse to systematically enhance the quality and effectiveness of nursing practice with the following measurement criteria:
The Public Health Nurse:

A. Implements new knowledge and performance improvement activities to initiate changes in public health nursing practice and in the delivery of care to populations.
B. Participates in the development, implementation and evaluation of procedures and guidelines to improve the quality of practice.
C. Participates in the scope of the performance improvement activities as appropriate to the nurse's position, education, and practice environment.
   Such activities may include:
   - Identification of aspects of practice important for quality monitoring.
   - Collection of data to monitor public health nursing practice, including availability, accessibility, acceptability, quality and effectiveness of policies, programs and services.

- Analyzing the data to identify opportunities for improving nursing practice.
- Formulation of recommendations to improve nursing practice or outcomes.

According to the national movement toward voluntary accreditation of public health entities, having a sustainable and effective Quality Assurance/Quality Improvement program in place will facilitate preparation for and transition to accreditation, if and when the Department chooses to seek accreditation.

GENERAL PROVISIONS:

1. A QA/QI site visit shall be conducted in each County by the District QA/QI team at least every 24 months using the standards and guidelines contained in the current edition of the Quality Assurance and Quality Improvement for Public Health Nursing Practice manual, published by the Department of Public Health. Site visits may be conducted more frequently, as deemed necessary by the District or State.
2. Since Quality Assurance/Quality Improvement activities are essential to the provision of safe and effective public health nursing services, Public Health leaders at the state, district and local level shall provide the structure to sustain a system of coordinated, integrated and user-friendly Quality Assurance/Quality Improvement activities at all levels. Compliance with the QNQI standards shall be monitored through an electronic reporting mechanism that is being developed.
3. Public Health leaders at the state, district and local levels shall collaborate and use a partnership approach to assure that a statewide system of QA/QI is ongoing.
4. Quality Assurance/Quality Improvement activities shall be an integral component of and linked to any system of Performance Improvement for Public Health.
5. Quality Assurance/Quality Improvement activities shall respect and be consistent with the following principles:
    - Identify and foster best practices.
    - Identify realistic expectations that are achievable within each county.
    - Set realistic expectations of staff.
    - Use quality indicators as an integral part of QA/QI.

DISTRICT PREPARATION GUIDELINES FOR QA/QI REVIEW

PREPARATION

Six (6) to Eight (8) Months Prior To Review

1) Identify District QA/QI Coordinator.
2) Select Multi-disciplinary Core Team:
3) Role of outside consultants:
   - Fully participate as a team member in the review process, including the preparation, planning, site visit and follow-up.
   - Do not lead the site visit process.
4) Utilize conference calls, e-mail and fax communication as needed.
5) Gather documents/forms that will be used.

Three (3) to Six (6) Months Prior To Review

1) Select sites.
2) Decide timeline.
3) Meet with each site to:
   - Review expectations.
   - Give copies of QA/QI Manual and tools.
   - Answer questions.

Thirty (30) Days Prior To Review

Send Memorandum to confirm site visit to County Nurse Manager or Site Supervisor

Conduct Reviews

Use written guidelines referring to site visit sample agenda.

Follow-Up

1) Preliminary findings are discussed in the exit interview.
2) Written report on findings due back to the site within 30 days. QA/QI tools format will be used.
3) The District QA/QI Coordinator will meet and share site-visit report summary with the site.
4) Plan of action to address opportunities for improvement due back to District QA/QI Coordinator within 30 days (draft during exit conference).
5) Follow up to be done according to priority/urgency.
6) Send copies of report to district staff as appropriate.

COUNTY PREPARATION GUIDELINES FOR QA/QI REVIEW

Six (6) to Eight (8) Months Prior To Review

Review *Quality Assurance/Quality Improvement for Public Health Nursing Practice.*

Three (3) to Six (6) Months Prior To Review

Prepare reports for Review:

a. Evidence of nursing leaders' review, clarification and reinforcement of QA/QI standards and tools for Public Health Nursing Practice.
b. Population Health Competencies.
c. Leadership Competencies.
d. Peer Review.
e. Emergency Preparedness.
f. Address customer satisfaction survey issues.

QA/QI Review

1. Use written guidelines referring to site visit sample agenda.
2. Provide QA/QI Review Team with reports listed above**.**

Follow-Up

1. Preliminary findings are discussed in the exit interview.
2. Written report on findings due back to the site within 30 days. QA/QI Tool format will be used.
3. The District QA/QI Coordinator will meet and share Site Visit Report Summary with the site.
4. Send plan of action to address opportunities for improvement to District QA/QI Coordinator within 30 days (draft during exit conference).
5. Follow up to be done according to priority/urgency.
6. Send copies of report to district.
7. A full report should remain on file at the site.

ROLE AND RESPONSIBILITIES OF THE DISTRICT QA/QI COORDINATOR

- The District QA/QI Coordinator is responsible for the scheduling, planning, preparation, conducting, reporting and the follow up related to the site visit.

- The District QA/QI Coordinator shall serve as the point of contact between the District Management Team, the site and the Department of Public Health QA/QI team.

- The District QA/QI Coordinator will assure that the site staff have the necessary materials and ensure that questions are answered regarding the site visit.

- During the site visit, the District QA/QI Coordinator will oversee the agenda and all aspects of the site visit to ensure that the process is going smoothly. The District QA/QI Coordinator should collaborate with staff to make any necessary changes to the site visit agenda or process.

ROLE AND RESPONSIBILITIES OF THE STATE QA/QI MEMBER

Each district will designate a QA/QI Team to coordinate and conduct the review. The district may invite members from the state QA/QI team to participate as members during each review. State QA/QI representatives will be assigned based upon:

- Schedule availability.
- District request for program representation.

The state QA/QI representatives will serve primarily as QA/QI process consultants. They may also serve to provide consultation as content experts from the programs they represent; however this is not their primary function.

As QA/QI process consultants, the state representatives will assist district teams in promoting a collaborative and positive approach to the QA/QI process. State representatives will also:

- Assist the district team to conduct the review.
- Provide consultation and provide input for the report .
- Participate in the exit conference.
- Serve as the liaison to state programs in identifying any training or resource needs of any particular program areas and will collaborate with the district team to report the need to the appropriate program(s) and to the full state QA/QI team.
- Present and provide a feedback report to the entire state team.
- Collaborate with the state QA/QI team to identify trends, best practices, models of practice and lessons learned in QA/QI to share statewide.

QUALITY ASSURANCE/ QUALITY IMPROVEMENT FOR PUBLIC

HEALTH NURSING PRACTICE SITE VISIT AGENDA

DATE: _____ **SITE:**_____

AGENDA - DAY ONE

8:30a.m. – 9:30a.m. Introductions
Review purpose, agenda and QA/QI Guiding Principles
Review the Community Health Status Profile

9:30a.m. – 12:00p.m. **REVIEW PROCESS:**

1. Credentialing
2. Training/Education
3. Rules/Regulations
4. Immunizations/Vaccines
5. Clinical Record Reviews
6. Drug & Vaccine Storage and Handling
7. Management of Drug Reactions
8. Leadership Competencies
9. Cultural Diversity Competencies
10. Customer Satisfaction
11. Population Health
12. Clinical Operations
13. Emergency Preparedness Competencies

12:00p.m. – 1:00p.m. **LUNCH**

1:00p.m. – 5:00p.m. Observation of Clinical Practice/ Peer Review

AGENDA – DAY TWO

8:30a.m. – 9:30a.m. Assessment of Leadership Competencies

9:30a.m. – 10:30a.m. Complete the Review Process

10:30a.m. – 12:00p.m. Team Preparation (write report, prepare for exit conference)

12:00p.m. – 1:00p.m. **LUNCH**

1:00p.m. – 2:00p.m. Exit Conference

2:00p.m. **Adjourn**

GUIDELINES FOR DOCUMENTING THE QUALITY ASSURANCE/QUALITY IMPROVEMENT SITE VISIT

PURPOSE

These guidelines are to be used in developing the written reports of the Quality Assurance/Quality Improvement site visits conducted in the districts and counties to assess the quality of public health nursing practice.

SELECTION OF CLINICAL RECORDS

The number and type of clinical records to be reviewed should be communicated to the site in written or electronic format. (See sample memo for confirmation of site visit included in this section) The records should be selected in a randomized manner.
NOTE: Entries should be specific and measurable, including positive findings as well as constructive recommendations. Examples include:

Findings:
1. Five of the ten X program records documented drugs ordered which were not covered by the nurse protocol.
2. Mock emergency drills were documented annually for the past 3 years.

Recommendations:
1. Revise the X nurse protocol for X condition and review with staff the importance of following the nurse protocol.
2. Commend staff for the annual mock emergency drills.

Peer Review Tool for the RN/APRN in Public Health

This document should be completed only if direct observations (peer review) of clinical practice are made with a nurse while conducting the visit. The specific instructions for completing this checklist are outlined in the peer review guidelines. All completed forms should be submitted to the County Nurse Manager or site Nursing Supervisor at the end of the site visit.

Peer Review Form

The Peer Review Tool and the Clinician Evaluation Forms will be completed by the nurse being reviewed according to the instructions in the peer review section of the QA/QI for PHN Practice manual. Both completed forms shall be returned to the site and routed to the nurse who conducted the peer review.

QA/QI REVIEW REPORTS

The QA/QI team and site staff will discuss preliminary findings during the exit conference.

The final report is due to the District QA/QI Coordinator within 30 days of the site visit. The District QA/QI Coordinator will meet with site staff and share report results. The final report consists of:

- QA/QI Tool for Public Health Nursing Practice (Tab 4).
- QA/QI Tool for Immunization Practice for Public Health Nurses and Immunization Support Staff (Tab 5).
- Leadership Tool (Tab 11).
- Population Health Competency Measurement Tool (Tab 13).
- Any other evidence/plan to support QA/QI.
- Meeting report of District QA/QI Coordinator and site staff: presentation and discussion of report results.

DOCUMENTATION SOURCES TO BE USED DURING QUALITY ASSURANCE/QUALITY IMPROVEMENT SITE VISITS

PURPOSE

The following documentation sources are essential elements of the QA/QI process and should be reviewed by the QA/QI team during the Quality Assurance/Quality Improvement site visit. Prior to the site visit, this list of documentation sources should be shared with the site staff as well as members of the site visit team.

QA/QI for PHN Practice Section	Documents
SECTION I: Leadership	1. Written reports (e.g., meeting minutes, E-mail, memoranda) 2. On-site QA/QI Leadership Competency: See Tool (Tab 11)
SECTION II: Customer Satisfaction	1. Examples of Site Customer Satisfaction surveys 2. Evidence of Customer Satisfaction survey report to County Board of Health, staff and customers. 3. Plans for addressing negative and positive survey responses
SECTION III: Cultural Competencies	1. Personnel/Supervisory files 2. Peer Review Tool for the Registered Nurse in Public Health
SECTION IV: Credentialing	1. Secretary of State website to verify license 2. Personnel/Supervisory files
SECTION V: Training/Education for Nurse Protocols	Personnel/Supervisory files
SECTION VI: Drug Dispensing and Ordering	1. District Nurse Protocol Manual 2. Nurse Drug Orders within Clinical Records
SECTION VII: Clinical Practice	Peer Review Tool for the Registered Nurse in Public Health
SECTION VIII: Management of Drug Reactions	1. District Nurse Protocol Manual 2. District Policy and Procedure Manual

QA/QI for PHN Practice Section	Documents
SECTION IX: Clinic Operations – Standards & Measures	1. Patient Flow Analysis 2. Evidence of evaluation reported to staff 3. Plans to address positive and negative clinic operations.
SECTION X: Population Health	Written plan for addressing training needs.
Other	District approved list of abbreviations, acronyms and symbols used in clinical documentation.

GUIDELINES FOR THE QA/QI SITE VISIT EXIT CONFERENCE

EXIT CONFERENCE

At the conclusion of each QA/QI review, an exit conference shall be held with staff and the site visit team. The purpose of the exit conference is to share a summary of the findings and to jointly develop continuous improvement plans. Recommendations for conducting the exit conference include:

1. All staff who provide services at the site or have responsibilities for any of the services provided at the site should be encouraged to attend. The District Health Director and the District PHN and Clinical Director should also attend the exit conference.

2. The QA/QI site visit findings should be presented in terms of points of excellence and opportunities for improvement.

3. There should be no surprises when the site visit findings are shared during the exit conference. Throughout the site visit, and prior to the exit conference, all issues of concern are discussed with appropriate staff to clarify the findings and discuss strategies for improvement. All recommendations should be based on identifiable standards or best practices.

4. The exit conference should be focused, positive, constructive, conducive to open dialogue and as succinct as possible. It is recommended that the exit conference be held to 90 minutes or less.

Georgia Department of Public Health

2 Peachtree Street, NW
Suite 15-470
Atlanta, GA 30303-3142

Brenda Fitzgerald, MD, Commissioner Nathan Deal, Governor www.dph.ga.gov

SAMPLE MEMORANDUM

(Date)

TO: County Nurse Manager
or Site Supervisor

THROUGH: (NAME)_____
District Health Director

FROM: (NAME)_____
Quality Assurance/Quality Improvement Coordinator

SUBJECT: Quality Assurance/Quality Improvement Site Visit

This confirms plans for the Quality Assurance/Quality Improvement Site Visit to your county/site on (date)_____ at (time)_____. The site visit team will arrive on (date)_____at (time)_____ at (site location/address)_____.

An agenda and a list of documentation sources are enclosed. The QA/QI manual, which will be used as part of the review process, should be shared with the site staff prior to the visit.

PURPOSE

The purpose of the site visit is to:

1. Recognize and continue to strengthen the quality of public health nursing practice in relation to the standards and expectations outlined in the enclosed quality assurance tools,

2. Recognize and continue to strengthen the quality of immunization practice by public health nurses and support staff, and

3. Measure leadership practices, cultural competencies, clinic operations, and selected health indicators as components of the expanded QA/QI process.

STAFF PARTICIPATION

District and/or county staff are encouraged to join with members of the site visit team and play an active role throughout the site visit process. The enclosed agenda shows the specific times during which district/county participation will be important.

CLINICAL RECORDS
The number and type of records received may vary according to the population served in the respective county/site.

POPULATION	NUMBER OF RECORDS		TOTAL
	OPEN	CLOSED	
HIV/AIDS	8	2	10
Child Health*	8	2	10
Women's Health	8	2	10
STD	5 female/male	5 female/male	10
Tuberculosis**	8	2	10
Perinatal Case Management (if applicable)	8	2	10

BreastTEST and MORE

4 abnormal screenings
1 record in which breast cancer is diagnosed and treated
1 record in which cervical cancer is diagnosed and treated
2 records in which the client refused diagnosis or treatment
2 records in which the client was lost to diagnostic or treatment follow-up
10 **TOTAL**

*__CHILD HEALTH:__ 0-6 months: 2 15 months to 2 years: 2
5 years: 2 9 years: 2
15-21 years: 2

**__TB:__ Cases: 5
Latent Tuberculosis Infection (LTBI): 5

Please also have available the list of district approved abbreviations, acronyms and symbols used in clinical documentation.

QA/QI TEAM MEMBERS:
The members of the site visits team will include the following: (*list specific names and titles of team members).*

PEER REVIEW GUIDELINES:
The site visitors will use the enclosed *Peer Review Guidelines* for conducting the direct observations of clinical nursing practice. These guidelines should be shared with the nurses who will be participating in the review process prior to the site visit.

Again, we appreciate the support of you and your staff with planning this quality assurance/ quality improvement site visit. Please do not hesitate to call if there are questions.

Thank you.

cc: Site Visit Team

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Quality Assurance/Quality Improvement for Public Health Nursing Practice Manual

Standards and Tools

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QUALITY ASSURANCE/QUALITY IMPROVEMENT FOR PUBLIC HEALTH NURSING PRACTICE

INTRODUCTION

Every two years, the Department of Public Health reviews, revises, and updates the standard nurse protocols to be consistent with the most current research and technology, as well as best practices. The standard nurse protocols were written for more than 100 health conditions that require public health nurses to order and dispense drugs, medical treatments, or diagnostic studies. The standard nurse protocols were developed to serve populations in women's health, children's health, as well as populations affected by sexually transmitted disease, HIV/AIDS, tuberculosis, hypertension and infectious disease. Each nurse protocol is reviewed by a clinical team. The team is comprised of, at a minimum, the state office program nurse, state pharmacy director/designee, physician/medical specialist and public health nurses in clinical practice. Representatives from nutrition, immunizations, and laboratory are included as needed. The state office program nurse assures that the clinical team reviews the nurse protocols for their respective program and assists in drafting revisions and/or new nurse protocols at least biannually. The Office of Nursing coordinates the ongoing review process across all programs and manages the development and distribution of new and/or revised nurse protocols.

PURPOSE

The following document is a tool for conducting QA/QI reviews of public health nursing practice. A review of quality provides an opportunity to identify excellence in practice, as well as opportunities for improvement. QA/QI for public health nursing practice promotes consistency in practice across statewide programs. QA/QI reviews may be conducted by public health staff from the county, district and/or state level. The QA/QI training standards which are delineated in Section VI serve two purposes. This section may be used as part of the overall review of quality in a public health setting. It may also be used to document the training completed by an individual RN as part of the preparation for practicing under nurse protocol.

SECTION I — LEADERSHIP

EXPECTATIONS	Documentation			COMMENTS
	Yes	No	Incomplete	
1. Provide written evidence that Public Health Nurse Leaders define, review, clarify, reinforce, and communicate the leadership competencies and performance measurement criteria to staff (e.g. meeting minutes, memoranda, E-mail).				
2. The Public Health Nurse Leader's performance should be measured in the following areas (See Tab 11). • Organizational Theory • Performance Standards • Shared Vision • Legal and Political Systems • Ethical Standards				
3. As part of the site visit, a dialogue session is conducted with staff regarding the leadership competencies. (See Tab 11 – Leadership Competency Measurement Tool)				

SECTION II — CUSTOMER SATISFACTION

EXPECTATIONS	Documentation			COMMENTS
	Yes	No	Incomplete	
1. Customer satisfaction surveys are conducted at each site at least once annually (See Tab 6 of QA/QI manual for guidelines for developing customer satisfaction surveys).				
2. A written summary of the results of the customer satisfaction surveys, which were conducted during the previous year, has been compiled and made available to the County Board of Health, staff and customers.				
3. Provide written summary of the interventions that are planned and/or being implemented, which reinforce the trends in positive responses to the surveys.				
4. Provide written summary of the interventions that are planned and/or being implemented to improve the trends in negative responses to the surveys.				

Nurse or Site: _____ Date: _____

SECTION III — CULTURAL COMPETENCIES

EXPECTATIONS	Documentation: Yes	No	Incomplete	COMMENTS
1. Each nurse has received training in cultural diversity and/or cultural competency every two years.				
2. There is evidence that staff adequately performs the following: a. Utilizes appropriate methods for interacting sensitively, effectively and professionally with persons from diverse cultural, socioeconomic, educational, racial, ethnic and professional backgrounds, and persons of all ages and lifestyle preferences. b. Identifies the role of cultural, social and behavioral factors in determining the delivery of public health services. c. Develops and adapts approaches to problems that take into account cultural differences. Note: See Tab 12 of manual for complete list of Cultural Competency Skills and Training Resources for Cultural Competence.				

SECTION IV — CREDENTIALING

EXPECTATIONS	Documentation: Yes	No	Incomplete	COMMENTS
1. **Professional Licensure.**				
Each Registered Professional Nurse (RN) and each Advanced Practice Registered Nurse (APRN) practicing under nurse protocol is currently licensed/authorized by the Georgia Board of Nursing. Documentation shall include verification of license(s) through the Internet *(*www.sos.state.ga.us*).* A hard copy of the Internet verification should be documented in the supervisory personnel file prior to employment and at least once annually thereafter.				
2. **Scope of Practice.**				
The nurse protocols are consistent with the Department of Public Health's Scope of Practice Guidelines for Expanded Role RNs and Advanced Practice Registered Nurses.				
3a**. Academic Preparation for RNs without BSN:**				
Written documentation, such as a transcript, which verifies completion of a health assessment/physical assessment course at the baccalaureate level must be on file.				
3b**. Academic Preparation for RNs with BSN:**				
Written documentation, such as a transcript, which verifies completion of a health assessment/physical assessment course at the baccalaureate level must be on file.				
4a. **Clinical Preceptorship for RNs without BSN:**				
Prior to practicing under nurse protocols, written documentation of completion of a health assessment clinical preceptorship and competency demonstration must be on file.				
4b. **Clinical Preceptorship for RNs with BSN:**				
Prior to practicing under nurse protocols, written documentation that a health assessment clinical preceptorship was completed must be on file. This may be part of the baccalaureate education program. If not, the RN must complete a baseline assessment of clinical skills and, if necessary, a clinical preceptorship with competency demonstration to assure clinical competency.				

CREDENTIALING, continued

EXPECTATIONS	Documentation Yes	No	Incomplete	COMMENTS
4c. **Clinical Preceptorship/Peer Review for APRNs:**				
Prior to practicing under nurse protocols, written documentation of a peer review of clinical skills must be on file.				
5. **Statutory Authority to Practice Under Nurse Protocol:**				
a. Initial Practice Requirements: Prior to practicing under nurse protocols, each RN and Advanced Practice Registered Nurse must read and understand each of the following:				
1) Nurse Protocol Statute (O.C.G.A. § 43-34-23).				
2) Rules of Georgia Board of Nursing: Chapter 410-11, Use of Nurse Protocols Authorized by O.C.G.A. § 43-34-23 by Registered Nurses in Specific Settings.				
3) Rules of Georgia State Board of Pharmacy: Chapter 30-480, Dispensing of Drugs under Authority of Job Description or Nurse Protocol.				
4) Department of Public Health Document, *Guidelines for RNs Practicing Under Nurse Protocol* (section 3 of *Standard Nurse Protocols for Registered Professional Nurses in Public Health*).				
5) Achieve at least 80% on the State Public Health "Quiz on Nurse Protocol Statute" (available from the Department of Public Health, Office of Nursing). If unsuccessful on first attempt, may repeat quiz once after a brief review of initial quiz results.				
6) DCH/DPH Quality Assurance Quality Improvement Manual for Public Health Nursing Practice (available from the Department of Public Health, Office of Nursing).				
7) The Drug Dispensing Procedure, the document that establishes the appropriate manner under which drugs may be dispensed pursuant to the Nurse Protocol Statute (O.C.G.A. § 43-34-23).				
8) Introductory pharmacology training on drugs used in practice under Nurse Protocols to include: action, side effects, dosage, contraindications, and teaching.				

CREDENTIALING, continued

EXPECTATIONS	Documentation			COMMENTS
	Yes	No	Incomplete	
b. After the initial practice requirements are completed, each RN and Advanced Practice Registered Nurse practicing under Nurse Protocol is required to document annual reviews of the following:				
1) Nurse Protocol Statute (O.C.G.A. § 43-34-23).				
2) Rules of Georgia Board of Nursing: Chapter 410-11, Use of Nurse Protocols Authorized by O.C.G.A. § 43-34-23 by Registered Nurses in Specific Settings.				
3) Rules of Georgia State Board of Pharmacy: Chapter 30-480, Dispensing of Drugs under Authority of Job Description or Nurse Protocol.				
4) Department of Public Health Document, *Guidelines for RNs Practicing Under Nurse Protocol* (section 3 of *Standard Nurse Protocols for Registered Professional Nurses in Public Health*).				
5) The Drug Dispensing Procedure, the document that establishes the appropriate manner under which drugs may be dispensed pursuant to the nurse protocol Statute (O.C.G.A. § 43-34-23).				
6) Physical assessment peer reviews appropriate for designated or assigned ages, sexes and populations, including history, physical exam, counseling, lab, ordering, dispensing, and administration of medications and treatments.				
7) Pharmacology update for drugs used in practice under nurse protocols.				
6. **Core Requirements: Prior to practicing under nurse protocol and at least annually thereafter, each RN and APRN must read and complete the following:**				
a. Self Study:				
1) Current edition of the Nurse Protocol the nurse is practicing under.				
2) Georgia Immunization Program Manual and Advisory Committee on Immunization Practices (ACIP) Update (Current edition).				

CREDENTIALING, continued

EXPECTATIONS	Documentation: Yes	No	Incomplete	COMMENTS
3) *Guidelines and Legal Principles for Clinical Record Documentation in Public Health Nursing*, Department of Public Health, (DVD), 2006 (every two years).				
b. Didactic/Classroom Training:				
1) Cultural Competency Training (every two years) (https://ccnm.thinkculturalhealth.org).				
2) Adult and Adolescent Immunization Training arranged through District Immunization Coordinator.				

Nurse or Site: _____ Date: _____

SECTION V — TRAINING/EDUCATION FOR THE FOLLOWING NURSE PROTOCOL(S)*:*

CHILD HEALTH

NOTE: This section may be used to review an individual nurse's training and preparation for practicing under nurse protocol. A copy may be placed in the nurse's personnel/supervisory file. It may also be used to review the training and preparation of a group of nurses who are practicing under nurse protocol.

	DOCUMENTATION		
EXPECTATIONS	**Yes**	**No**	**COMMENTS**
INITIAL TRAINING REQUIRED **The nurse must complete the following prior to and ongoing while practicing under nurse protocol :**			
A. SELF-STUDY (Nurse is to review the following):			
1. Georgia Department of Public Health, Maternal and Child Health Programs. *http://health.state.ga.us/programs/family/index.asp*			
2. *Georgia Immunization Program Manual and Advisory Committee on Immunization Practices (ACIP) Recommendations.* www.cdc.gov/vaccines/pubs/ACIP-list.htm			
3. *Preschool Vision Screening for Healthcare Professionals*. American Academy of Pediatrics (current).			
4. Hearing/Screening Section, *Child Health Manual* (current) OR Georgia Department of Public Health (GDPH) Guidelines (current) (when available).			
5. Scoliosis Screening Section, *Child Health Manual (current)* OR *Scoliosis Screening in Georgia Schools, Curriculum for Training Health Workers and Volunteers,* Children's Healthcare of Atlanta (current).			

CHILD HEALTH, continued

EXPECTATIONS	DOCUMENTATION Yes	DOCUMENTATION No	COMMENTS
6. *Screening Young Children for Lead Poisoning*, CDC (current). http://www.cdc.gov/nceh/lead/publications/screening.htm			
7. *Policies and Procedures for Health Check Services, Part II,* Division of Medical Assistance (current).			
8. *Guidelines for Mandatory Reporting of Suspected Child Abuse* (current)			
9. Review pharmacology of drugs used to treat child health conditions listed in Child Health Nurse Protocols.			
10. Georgia Newborn Screening Program. http://health.state.ga.us/programs/nsmscd/			
11. Universal Newborn Hearing Screening and Intervention Program. http://health.state.ga.us/programs/unhs/index.asp			
12. *Bright Futures: Guidelines for Health Supervision of Infants, Children, and Adolescents,* American Academy of Pediatrics (current edition).			
13. Bright Futures Tool and Resource Kit online (when available).			
14. HemoCue Hemoglobin Procedure (Attachment A, B).			
B. **DIDACTIC/CLASSROOM TRAINING COMPLETED:**			
1. Health Assessment Course.			
2. Epidemiology & Prevention of Vaccine Preventable Disease Workshop – CDC.			
3. Ages and Stages Questionnaires (ASQ-3 and ASQ:SE)			

CHILD HEALTH, continued

EXPECTATIONS	DOCUMENTATION Yes	DOCUMENTATION No	COMMENTS
4. Vision Screening of Children provided by State Office, District Coordinator or certified instructor.			
5. Hearing Screening of Children provided by State Office, District Coordinator or certified instructor.			
6. "The Silent Epidemic: Lead Poisoning" - Georgia Childhood Lead Poisoning Prevention Program.			
7. TB Update & Tuberculin Skin Test Certification Workshop provided by State TB Office or District TB Coordinator or certified instructor.			
8. Training for Public Health Personnel on Mandatory Reporting of Child Abuse and Neglect per Georgia Department of Public Health Policy.			
C. PRECEPTORSHIP/CLINICAL:			
1. The extent and duration of the preceptorship/clinical may vary according to the needs of each individual nurse. However, there shall be documentation that the nurse can satisfactorily perform the required clinical skills prior to signing the nurse protocol(s) and practicing under nurse protocol.			
a) A nurse will observe the preceptor performing clinical procedures on infants, toddlers, school-age children and adolescents.			
b) A preceptor will observe the nurse performing clinical procedures on infants, toddlers, school-age children and adolescents.			
D. Child Health Procedures should include, but not be limited to, the following:			
1. Complete History (family, personal, social development and medication).			
2. Physical Assessment.			

CHILD HEALTH, continued

EXPECTATIONS	DOCUMENTATION Yes	DOCUMENTATION No	COMMENTS
3. Hearing & Vision Screening.			
4. Newborn Screening for Metabolic and Sickle Cell Disorders.			
5. Tuberculin Skin Testing.			
6. Lead Screening.			
7. Dental Examination.			
8. Immunization.			
9. Scoliosis Screening.			
10. Ages and Stages Questionnaires. (ASQ3 and ASQ:SE)			
11. Nutrition Screening.			
12. Hemoglobin Screening			
OTHER:			
E. CLINICAL/PEER REVIEW:			
1. Annual peer reviews are required. The District Nursing Director, County Nurse Manager, and/or Nursing Supervisor shall have the discretion to determine which program areas are appropriate for annual peer review based on the following criteria:			
○ Predominate program of practice for each PHN			
○ PHN recently assigned to a different program area			
○ Significant changes in program policies			
2. On an annual basis, the supervisor or peer shall observe and review the nurses' satisfactory performance of one infant, one child and one adolescent health assessment, work-up and client counseling session.			
F. HAVE ACCESS TO REFERENCE MATERIALS:			
1. Ongoing access to current reference materials in initial training.			
2. Nurse Protocols for Child Health, (current).			

CHILD HEALTH, continued

EXPECTATIONS	DOCUMENTATION Yes	DOCUMENTATION No	COMMENTS
3. *Control of Communicable Diseases Manual,* Heymann, D., (current edition).			
4. *Red Book-Report of Committee on Infectious Diseases*, American Academy of Pediatrics (current edition).			
5. Giardino, A.P. & Giardino, E.R. (2002). *Recognition of Child Abuse for the Mandated Reporter,* 3rd Ed., St. Louis, MO: G. W. Medical Publishing, Inc.			
6. Georgia WIC Program Procedures Manual (current edition).			
7. *Pediatrics Dosage Handbook*, Taketomo, C.K., Hodding, J.H., Kraus, D.M. Or other current pharmacology/medication references, such as Lexi-Comp Drug Information, available at www.lexi.com/online (for Districts who have purchased subscriptions).			
8. *The Epidemiology & Prevention of Vaccine Preventable Disease "Pink Book"* CDC (current edition).			
9. Georgia Tuberculosis Program Policy and Procedure Manual, (current edition). www.health.state.ga.us/tb			

RECOMMENDED TRAINING

A. SELF-STUDY:			
1. Annual review of nurse protocols for Child Health, with special attention to any revisions and pharmacology of any new drugs.			
2. Remain current on policies and procedures/manuals regarding Child Health Services, including but not limited to Health Check, developmental screening, immunization and ACIP Recommendations, TB, Nutrition/WIC, child abuse/neglect, vision, hearing, metabolic, sickle cell, and lead screenings.			

CHILD HEALTH, continued

EXPECTATIONS	DOCUMENTATION Yes	DOCUMENTATION No	COMMENTS
3. *Microscopy for Public Health Nurses*, Department of Public Health, Public Health Laboratory, Chapters 1 through 4. (current).			
4. National Institutes of Health, "Pinworm eggs", http://www.nlm.nih.gov/MEDLINEPLUS/ency/imagepages/1004.htm			
5. National Institutes of Health, "Throat Swab Culture", http://www.nlm.nih.gov/medlineplus/ency/article/003746.htm			
6. Review of materials on CDC Public Health Image Library for scabies (and other topics as available and needed) located at http://phil.cdc.gov/phil/home.asp			
B. DIDACTIC/CLASSROOM TRAINING:			
Participation in at least one training per year to remain current on policies and procedures concerning Child Health; such as Health Check, Immunization, TB, Nutrition/WIC, Breast feeding, Child Abuse, Universal Newborn Hearing Screening, Children 1st., Genetics, and Children with Special Health Care Needs.			
C. OTHER:			
Ongoing access to reference materials.			

Attachment A

HemoCue® Hemoglobin Procedure

HemoCue Hemoglobin Procedure
Standard Operating Procedure Template
(Rev 611 8/03)

This document is provided as a convenient tool when developing a standard operating procedure (SOP) for your institution. It follows the NCCLS guidelines on format and content. Simply modify the document to meet your institution's requirements or paste appropriate passages into your current procedures. We hope you will find this a helpful tool in your on-going Quality Assurance efforts.

To remove this message, simply click anywhere in the highlighted box and press "Delete".

PURPOSE

The HemoCue Hemoglobin System is used for the quantitative determination of hemoglobin in blood using a specially designed photometer, HemoCue Hemoglobin Photometer, and specially designed microcuvettes, HemoCue Hemoglobin Microcuvettes.

The quantitative hemoglobin determination is indicated as a general fundamental test in acute as well as elective care. The test is used in assessing the status of a patient in such clinical situations as hemorrhage, hemolysis, dehydration and other shifts in plasma volume - and for verifying the results of transfusion or treatment of other deficiency states such as malnutrition.

PRINCIPLE

The hemoglobin concentration in blood is determined as azidemethemoglobin utilizing a microcuvette with a dry reagent system and a dual wavelength photometer. The erythrocyte membranes are disintegrated by sodium deoxycholate, releasing the hemoglobin. Sodium nitrite converts the hemoglobin iron from the ferrous to the ferric state to form methemoglobin, which then combines with sodium azide to form azidemethemoglobin. Measurements are taken at 570nm and 880nm; the latter to correct for turbidity.

SAMPLE COLLECTION AND PREPARATION

No special patient preparation is required. Capillary, (e.g., fingerstick), venous or arterial blood may be used. Use EDTA, heparin or heparin-fluoride as anticoagulants, preferably in solid form to avoid dilutional effects. Samples collected with the recommended anticoagulants must be used within 24 hours. All specimens must be allowed to come to room temperature before use. Specimens should be mixed by gentle inversion at least ten times prior to use, especially if stored for an extended length of time.

EQUIPMENT, REAGENTS, AND SUPPLIES

HemoCue® Hemoglobin Photometer
HemoCue® Hemoglobin
HemoCue® Hemoglobin
Liquid controls (optional - store according to manufacturer's specifications)
Blood lancets, needles, syringes, blood-collection tubes
Gloves
Disinfecting solution
Gauze or lint-free tissue
Hydrophobic material such as Parafilm®

PROCEDURE

Gloves should be worn at all times during the testing procedure and all appropriate laboratory safety guidelines should be followed.

A. Start Up Procedure

1. Turn the photometer on using the switch in the back. The display screen should read "Hb."
2. Pull the cuvette holder out to the loading position, which will be noted by a distinct stop. After about fifteen seconds the screen will display "READY" with three flashing dashes.
3. The photometer is now ready to perform a measurement.

B. Quality Control

Control Cuvette
The control cuvette must be checked each day of use, prior to patient testing.

1. Place the red control cuvette into the cuvette holder and push the holder into the measuring position.
2. A reading will appear after approximately 10-1 5 seconds. Compare this value to the assigned value on the control cuvette card. This reading should be within _+ 0.3 g/dL of the assigned value. Record this value in an appropriate log.
3. If this value does not fall within the established range, follow local policy for failed quality control, prior to performing any patient testing.

   Note: If using the QC Cuvette Holder, (product # 1301 53), follow the instructions for use in the product package insert.

Liquid Quality Control

1. Commercial liquid quality controls may be used to assure proper hnctioning of the entire system. Follow the manufacturer's procedure for storage and handling.
2. Dispense a drop of control onto a hydrophobic surface and follow steps 8-12 of the capillary testing procedure. Note: Some control products require a "waiting period" prior to inserting the cuvette into the analyzer for measurement. Follow the directions in the package insert for the control product.
3. Record the results in a quality control log.
4. If the results do not fall within the established range, follow local policy for failed quality control prior to performing any patient testing.

C. Patient and Specimen Testing

Capillary Testing – Finger

1. The hand should be warm and relaxed. It is a good idea to heat cold hands in warm water before sampling to increase the blood circulation. The patient's fingers should be straight but not tense, to avoid stasis. For best results, use the middle or ring finger for sampling. Avoid fingers with rings for sampling.
2. Remove a cuvette from the vial and recap the vial immediately.
3. Clean the puncture site with alcohol. Wipe off the alcohol with a clean, dry lint free wipe or allow it to air dry completely.
4. Using your thumb, lightly press the finger from the top of the distal knuckle to the tip. This stimulates the blood flow towards the sampling point.
5. Position the lancet device so that the puncture will be made across the whorls (lines) of the fingerprint. Press the lancet firmly against the finger prior to activating the lancet to aid in obtaining a good sample.
6. While maintaining gentle pressure on the tip of the finger, perform the stick off- center on the fingertip. Discard the lancet in an approved container.
7. Using a dry gauze or other lint free tissue, wipe away the first two or three large drops of blood, applying light pressure as needed again until another drop of blood appears. This stimulates blood flow and lessens the likelihood of a dilutional effect by interstitial fluid. Avoid "milking of the finger."
8. Make sure that the drop of blood is big enough to fill the cuvette completely. Hold the cuvette at the "wing" end and introduce the cuvette tip into the middle of the drop of blood. Fill the cuvette in one continuous process. Do not refill a partially filled cuvette.
9. Wipe off any excess blood from the outside of the cuvette using a clean, lint free tissue, taking care not to touch the opened end of the cuvette.
10. Visually inspect the cuvette for air bubbles in the optical eye. If bubbles are present in the optical eye, discard the cuvette.
11. The filled cuvette should be analyzed immediately and at the latest 10 minutes after it has been filled. Filled cuvettes are to be kept in the horizontal position. Place the filled cuvette into the cuvette holder and gently slide the holder into the measuring position.

12. The result will be displayed within 60 seconds.
13. Pull the cuvette holder out to the loading position. Remove the cuvette and discard it in an appropriate biohazard container.
14. Turn the power switch to "off' at the conclusion of all testing for the day.

Venous or Arterial Specimen from Vacuum Tubes

1. Obtain a specimen according to established procedure. A fresh, well-mixed anticoagulated blood is to be used. Samples stored up to 24 hours at 2-8OC (35-46°F) may be used but must be allowed to come to room temperature prior to testing.
2. Mix the sample by gently inverting ten times.
3. Dispense a drop of blood onto a hydrophobic surface.
4. Proceed as in Steps 8-14 of the capillary sampling instructions.

Venous or Arterial Specimen from Syringes

NOTE: It is very important to test the sample immediately to avoid potentially erroneous results due to coagulation or separation of the specimen.

1. Pull back the plunger slightly and mix the blood by inverting the syringe 8-10 times.
2. While holding gauze over the end of the syringe slowly push the plunger until a few drops of blood have been expelled. This will prime the syringe by removing any air bubbles in the tip.
3. Dispense a drop of blood onto a hydrophobic surface.
4. Proceed as in Steps 8-14 of the capillary sampling instructions.

D. Maintenance

No preventative maintenance is needed for the electronic components of the photometer.

1. **Cuvette Holder**
   - The cuvette holder should be removed at the end of each day of use for cleaning. Alcohol or mild soap solution may be used. It may also be autoclaved. It is important that the holder is completely dry before being replaced in the photometer.

2. **Photometer**
   - The exterior of the photometer may be cleaned as necessary with alcohol or a mild soap solution.

3. **Optronic Unit**
   - Call HemoCue Technical Service for instructions. Have the serial number of the photometer available.

E. Procedural Notes

1. Microcuvettes are stored at room temperature, away from any direct heat source. The vial should be kept tightly capped and cuvettes should be removed as needed for testing just prior to use. Unopened cuvettes have a shelf life of two (2) years from the date of manufacture. The expiration date is printed on each vial. Vials of cuvettes that have been opened are stable for three (3) months if the cap is kept on tightly between use. When opening a new vial, label with the date opened.
2. The HemoCue® Hemoglobin photometer corrects for turbidity in specimens and therefore might produce lower results than those expected for other hemoglobin instruments that do not have this correction feature. Therefore, only controls that are assayed for the HemoCue® Hemoglobin system are recommended.
3. Results above 25.6gm/dl will be displayed as ERROR 999 or ERROR HHH. Refer to the Trouble Shooting Guide in the Operating Manual for interpretations of other error codes.

F. Limitations of the Procedure

Values above 23.5gldL must be confirmed using a suitable laboratory method. Sulfhemoglobin is not measured with this method.

G. Normal Values

Normal values should be established for the patient population being tested. Normal values used by local hospitals, etc. may be acceptable for use.

H. Problem Solving

Refer to the "Troubleshooting" section of the Operating Manual if problems arise. If problems persist, contact your Regional Distributor or HemoCue Inc., Technical Service at 1-800-426-7256 for more detailed instruction.

I. References

HemoCue Blood Hemoglobin Photometer Operating Manual (980922)
HemoCue Blood Hemoglobin Microcuvette Package Insert (990503)
Darcie and Lewis, Practical Hematology, 9th edition, 1-1 -2001

For additional information please contact:
HemoCue, Inc.
Attention: Technical Service
40 Empire Drive
Lake Forest, CA 92630
800-426-7256

HemoCue® Hemoglobin System Maintenance Log

Photometer Serial Number_____

DATE	PROBLEM	CORRECTIVE ACTION	INITIALS

HemoCue® Hemoglobin System Maintenance Log

Begin a new log with each new lot number of microcuvettes

Photometer Serial Number_____Control Cuvette Target_____±0.3g/dL

Microcuvettes	Lot Number	Mfg. Expiration Date	Date Opened

Liquid Controls	Range	Lot Number	Mfg. Exp. Date	Date Opened
Level 1	± g/dL			
Level 2	± g/dL			
Level 3	± g/dL			

Date	Time	Control Cuvette Value	Liquid Control Values			If control values are out of range, note corrective action taken.	Maintenance Dates		Init.
			Level 1	Level 2	Level 3		Cleaned	Battery Change	

Date:_____ Reviewed by:_____

Comments:_____

Attachment B

HemoCue® Hb 201^{+} Procedure Template

PURPOSE

The HemoCue Hb 201^{+} System is used for the quantitative determination of hemoglobin in blood using a specially designed analyzer, HemoCue Hb 201^{+}, and specially designed HemoCue Hb 201 Micro-cuvettes.

The quantitative hemoglobin determination is indicated as a general fundamental test in acute as well as elective care. The test is used in assessing the status of a patient in such clinical situations as hemorrhage, hemolysis, dehydration and other shifts in plasma volume - and for verifying the results of transfusion or treatment of other deficiency states such as malnutrition. The assay of hemoglobin is also used as part of a general health screen e.g., for prospective blood donors and in the assessment of womens' and childrens' health.

PRINCIPLE

The hemoglobin concentration in blood is determined as azidemethemoglobin utilizing a microcuvette with a dry reagent system and a dual wavelength photometer. The erythrocyte membranes are disintegrated by sodium deoxycholate, releasing the hemoglobin. Sodium nitrite converts the hemoglobin iron from the ferrous to the ferric state to form methemoglobin, which then combines with sodium azide to form azidemethemoglobin. Measurements are taken at 570nm and 880nm; the latter to correct for turbidity.

SAMPLE COLLECTION AND PREPARATION

No special patient preparation is required. Capillary (e.g., fingerstick), venous or arterial blood may be used. Appropriate anticoagulants in solid form (e.g., EDTA, heparin or hepardfluoride) may be used. Mix all anticoagulated samples thoroughly on a mechanical mixer for at least two minutes or invert the tube 8-10 times by hand. Alternatively, follow the local recommendations. Hemoglobin remains unchanged for days provided that the blood does not become infected. If the specimen has been stored in the refrigerator, it will be viscid and the blood should be allowed to warm up to room temperature before mixing.

EQUIPMENT, REAGENTS, AND SUPPLIES

HemoCue Hb 201^{+} Analyzer
HemoCue Hb 201 Microcuvettes (store at room temperature)
Liquid controls (optional - store according to manufacturer's specifications)
Blood lancets, needles, syringes, blood-collection tubes
Gloves
Disinfecting solution
Lint-free tissue such as Celltork or gauze
Hydrophobic material such as Parafilm®

PROCEDURE

Gloves should be worn at all times during the testing procedure and all appropriate laboratory safety guidelines should be followed.

A. Start Up Procedure

1. Pull the cuvette holder out to the loading position. Press and hold the left button until the display is activated (all symbols appear on the display).
2. The display shows the version number of the program, after which it will show "⌛" and "Hb". During this time the analyzer will automatically verify the performance of the optronic unit by performing an automatic SELFTEST.
3. After 10 seconds, the display will show 3 flashing dashes and the HemoCue symbol. This indicates that the HemoCue Hb 201$^+$ analyzer has passed the SELFTEST and is ready for use. If the SELFTEST fails, an error code will be displayed.

B. Quality Control

SELFTEST
The HemoCue Hb 201$^+$ analyzer has an internal electronic "SELFTEST". Every time the analyzer is turned on, it will automatically verify the performance of the optronic unit of the analyzer. This test is performed every second hour if the analyzer remains switched on.

Liquid Quality Control
If use of liquid control material is required by local or other regulations, contact HemoCue, Inc. for control information. Follow the manufacturer's procedure for storage and handling of the control material.

1. The analyzer should be in the "ready" mode prior to filling the cuvette.
2. Dispense a drop of control onto a hydrophobic surface and follow Steps 9-16 of the Capillary Testing - Finger section. Note: Some control products require a "waiting period" prior to inserting the cuvette into the analyzer for measurement. Follow the directions in the package insert for the control product.
3. Record the results on a quality control log.
4. If the results do not fall within the established range, follow local policy for failed quality control prior to performing any patient testing.

C. Patient and Specimen Testing

Capillary Testing – Finger
1. To perform a test using capillary blood, the cuvette holder should be in its loading position. The display will show three flashing dashes and the HemoCue symbol.
2. The hand should be warm and relaxed. Heating the hand with warm water, or by some other means, is a good idea to increase the blood circulation. The patient's fingers should be straight but not tense, to avoid stasis. It is best to use the middle or ring finger for sampling, but fingers with rings should be avoided due to the chance of decreased circulation.

3. Remove a cuvette from the vial or the individually wrapped package. Recap the vial immediately.
4. Clean the finger with alcohol or a suitable disinfectant. Then wipe dry with a clean, dry lint-free wipe or allow it to air dry completely.
5. Using gentle pressure, rock your thumb from the top of the patient's distal knuckle to the fingertip. This stimulates the blood flow towards the sampling point.
6. Press the lancet firmly against the finger prior to activating the lancet to aid in obtaining a good sample.
7. While maintaining gentle pressure on the tip of the finger, perform the stick off-center on the fingertip. Discard the lancet in an approved container.
8. Using a dry gauze or other lint-free tissue, wipe away the first two or three large drops of blood, applying light pressure as needed again until another drop of blood appears. This stimulates blood flow and lessens the likelihood of a dilutional effect by interstitial fluid. Avoid "milking of the finger".
9. Make sure that the drop of blood is big enough to fill the cuvette completely. Hold the cuvette opposite the filling end and introduce the cuvette tip into the middle of the drop of blood. Fill the cuvette in one continuous process. Do not refill a partially filled cuvette.
10. Wipe off any excess blood from the outside of the cuvette using a clean, lint-free tissue, taking care not to touch the open end of the cuvette.
11. Visually inspect the cuvette for air bubbles in the optical eye. If bubbles are present in the optical eye, the cuvette should be discarded and a new sample taken for analysis. (Small air bubbles around the edge do not influence the result).
12. The filled cuvette should be analyzed immediately, or at the latest, 10 minutes after it has been filled. Place the filled cuvette into the cuvette holder and gently slide the holder into the measuring position.
13. During the measurement, "⌛" and three fixed dashes will be shown on the display.
14. The result will be displayed within 15 to 60 seconds and will remain on the display as long as the cuvette holder is in the measuring position. When operating on battery power, the analyzer will automatically turn off after approximately five minutes.
15. Pull the cuvette holder out to the loading position. Remove the cuvette and discard it in an appropriate biohazard container, following local procedures for disposal.
16. When the display shows three flashing dashes and the HemoCue symbol, the analyzer is ready for the next measurement.

Venous or Arterial Specimen from Vacuum Tubes

1. Obtain a specimen according to established procedure. A fresh, well-mixed anticoagulated blood sample is to be used. Samples stored at 2-8OC (35-46°F) may be used but must be allowed to come to room temperature prior to testing.
2. Mix the sample on a mechanical mixer for at least 2 minutes or gently invert by hand 8 to 10 times.
3. Dispense a drop of blood onto a hydrophobic surface.
4. Proceed as in Steps 9-16 of the Capillary Testing - Finger section.

Venous or Arterial Specimen from Syringes

NOTE: It is very important to test the sample immediately to avoid potentially erroneous results due to coagulation or separation of the specimen.

1. Obtain a specimen according to established procedure.
2. Mix the syringe according to local procedure.
3. Dispense a drop of blood onto a hydrophobic surface.
4. Proceed as in Steps 9-16 of the Capillary Testing - Finger section.

D. Maintenance

No preventative maintenance is needed for the electronic components of the photometer.

1. **Cuvette Holder**
   - The cuvette holder should be cleaned after each day of use.
     a. Check that the analyzer is turned off (the display should be blank).
     b. Pull the cuvette holder out to the loading position. Using a pointed object or your fingertip, carehlly press the small catch in the upper right hand comer of the cuvette holder.
     c. While pressing the catch, carefblly rotate the cuvette holder to the left as far as possible.
     d. Clean the cuvette holder with alcohol or a mild detergent and allow to dry completely before replacing it in the analyzer.

2. **Photometer**
   - The exterior of the photometer may be cleaned as necessary with alcohol or a mild soap solution.

3. **Optronic Unit**
   - The optronic unit should be cleaned as directed in the Troubleshooting Guide of the HemoCue Hb 201^{+} Operating Manual. See the instructions in the Maintenance section of the Operating Manual or call HemoCue, Inc. Technical Support.

E. Procedural Notes

1. Microcuvettes are stored at room temperature, away from any direct heat source. The vial should be kept tightly capped and cuvettes should be removed as needed for testing just prior to use. Unopened cuvettes have a shelf life of two (2) years from the date of manufacture. The expiration date is printed on each vial. Vials of cuvettes that have been opened are stable for three (3) months if the cap is kept on tightly between uses and stored correctly. When opening a new vial, label with the date opened. "The individually packed microcuvettes are stable until the expiration date printed on each package".
2. The HemoCue Hb 201$^+$ analyzer corrects for turbidity in specimens, and therefore might produce lower results than those expected for other hemoglobin instruments that do not have this correction feature. Therefore, if required, only controls that are assayed for the HemoCue Hb 201$^+$ system should be used.
3. Results above 25.6gJdL will be displayed as HHH. Refer to the Troubleshooting Guide in the Operating Manual for interpretations of other error codes.

F. Limitations of the Procedure

Values above 23.5gldL must be confirmed using a suitable laboratory method.
Sulfhemoglobin is not measured with this method.
Carboxyhemoglobin levels up to 10% do not interfere with the system.

G. Normal Values

Normal values should be established for the patient population being tested. Normal values used by local hospitals, etc. may be acceptable for use.

H. Problem Solving

Refer to the "Troubleshooting" section of the Operating Manual if problems arise. If problems persist, contact HemoCue Inc., Technical Support at 1-800-426-7256 for more detailed instruction.

I. References

HemoCue Hb 201$^+$ Operating Manual (050523)
HemoCue Hb 201$^+$ Microcuvette Package Insert (050523)

For additional information please contact:
HemoCue, Inc.
Attention: Technical Support
40 Empire Drive
Lake Forest, CA 92630
800-426-7256

HemoCue® Hb 201^{+} System Maintenance Log

Analyzer Serial Number_____

DATE	PROBLEM	CORRECTIVE ACTION	INITIALS

HemoCue® Hb 201+ Quality Control Log

Begin a new log with each new lot number of microcuvettes

Analyzer Serial Number_____

Microcuvettes	Lot Number	Mfg. Expiration Date	Date Opened

Liquid Controls	Range	Lot Number	Mfg. Exp. Date	Date Opened
Level 1	± g/dL			
Level 2	± g/dL			
Level 3	± g/dL			

Date	Time	Control Cuvette Value	Liquid Control Values			If control values are out of range, note corrective action taken.	Maintenance Dates		Init.
			Level 1	Level 2	Level 3		Cleaned	Battery Change	

Date:_____ Reviewed by:_____

Comments:_____

Nurse or Site:	Date:

SECTION V — TRAINING/EDUCATION FOR THE FOLLOWING NURSE PROTOCOL(S):

HIV/AIDS RELATED

NOTE: This section may be used to review an individual nurse's training and preparation for practicing under nurse protocol. A copy may be placed in the nurse's personnel/supervisory file. It may also be used to review the training and preparation of a group of nurses who are practicing under nurse protocol.

	DOCUMENTATION		
EXPECTATIONS	**Yes**	**No**	**COMMENTS**
REQUIRED TRAINING **The nurse must complete the following prior to and at least annually, thereafter, where applicable while practicing under nurse protocol:**			
A. SELF-STUDY (Nurse is to read the following documents and			
1. AIDS Education and Training Centers (AETC), Clinical Manual for Management of the HIV-Infected Adult, current edition. (NOTE: Required for APRNS, recommended for RNs)			
2. Department of Public Health HIV/HBV Policy Manual (current edition).			
3. Georgia DHR, DPH, HIV Unit, Medical Guidelines for the Care of HIV-infected Adults and Adolescents (current edition).			
4. Successful completion of the following HIV Web Study, Case-Based Modules available online at http://depts.washington.edu/hivaids/ (or completion of the one-day didactic training "HIV/AIDS Nurse Protocol Training" by the HIV Unit listed below in Didactic/Classroom Training).			
○ Dermatologic Manifestations – Case 1: Herpes Simplex Virus Infection.			

HIV/AIDS RELATED, continued

EXPECTATIONS	DOCUMENTATION Yes	No	COMMENTS
○ Dermatologic Manifestations – Case 4: Varicella Zoster Virus.			
○ Oral Manifestations – Case 1: Oral Candidiasis.			
○ Opportunistic Infections: Prophylaxis – Case 1: Prophylaxis for *Pneumocystis* Pneumonia.			
○ Opportunistic Infections: Prophylaxis – Case 2: Prophylaxis for *Toxoplasma* Encephalitis.			
○ Opportunistic Infections: Prophylaxis – Case 3: Prophylaxis for *Mycobacterium avium* complex.			
○ Opportunistic Infections: Treatment – Case 6: A 37-Year-Old Migrant Worker with Diarrhea.			
○ Antiretroviral Rx - Case 1: Indications for Initiating Antiretroviral Therapy.			
○ Antiretroviral Rx - Case 2: Antiretroviral Regimens.			
○ Antiretroviral Rx - Case 3: Laboratory Monitoring after Initiating Antiretroviral Therapy.			
B. DIDACTIC/CLASSROOM TRAINING:			
1. Orientation to Adult HIV Care for Health Professionals, a 2-day overview course by the Southeast AIDS Training and Education Center (SEATEC), or an equivalent training.			
Training must include an introduction to the following topics:			
○ *HIV pathogenesis, transmission, and primary infection*			
○ *Elderly and HIV*			
○ *Recognition of HIV at all stages of infection*			
○ *Antiretroviral therapy*			
○ *Symptomatic HIV/AIDS and opportunistic infections*			
○ *Medical complications in HIV management*			
○ *HIV and Oral Health*			
○ *Women, pregnancy, and perinatal prevention*			
○ *Hepatitis and HIV*			

HIV/AIDS RELATED, continued

EXPECTATIONS	DOCUMENTATION Yes	No	COMMENTS
○ *Mental health and substance abuse issues and HIV*			
○ *Methamphetamine use and clinical HIV care*			
2. HIV Counseling and Testing Course provided by the HIV Unit.			
3. HIV/AIDS Nurse Protocol Training, a 1-day course on the 10 GA Public Health HIV/AIDS nurse protocols by the HIV Unit (or successful completion of the HIV Web Study, Case-Based Modules listed above under Self-Study)			
4. TB Update & Tuberculin Skin Test Certification Workshop provided by the State Office TB Program or District TB Coordinator or certified instructor.			
5. STD 101 or equivalent training (when available).			
6. Initial and annual training on work place safety/occupational exposure to bloodborne pathogens.			
7. Annually, receive a minimum of 10 contact hours of HIV/AIDS education through any method (Must include HIV/AIDS-related medication update/ pharmacology).			
C. PRECEPTORSHIP/CLINICAL:			
1. The extent and duration of the preceptorship/clinical may vary according to the needs of each individual nurse. However, there shall be documentation that the nurse could satisfactorily perform the required clinical skills prior to signing the nurse protocol(s) and practicing under nurse protocol.			
a) Complete HIV/AIDS clinic orientation with supervisor, peer and support physician.			
b) Skills Validation component of the Skin Test Certification has been completed after attending the TB Update & Tuberculin Skin Test Certification Workshop (for those who administer PPDs).			
2. Ongoing chart reviews, backup, and consultation by support physician.			

HIV/AIDS RELATED, continued

EXPECTATIONS	DOCUMENTATION Yes	No	COMMENTS
D. CLINICAL/PEER REVIEW:			
1. Annual peer reviews are required. The District Nursing Director, County Nurse Manager, and/or Nursing Supervisor shall have the discretion to determine which program areas are appropriate for annual peer review based on the following criteria:			
○ Predominate program of practice for each PHN			
○ PHN recently assigned to a different program area			
○ Significant changes in program policies			
2. Annual assessment of clinical skills by peer, supervisor or physician			
E. HAVE ACCESS TO REFERENCE MATERIALS:			
1. Bartlett, J.G. and Gallant, J.E., *The Medical Management of HIV Infection*, John Hopkins University, Department of Infectious Diseases (current edition).			
2. The latest versions of the US Department of Health and Human Services (DHHS) HIV-related Guidelines, which are considered "living documents," are available online on the *AIDSinfo* website at http://www.aidsinfo.nih.gov/ including:			
○ *Guidelines for the Use of Antiretroviral Agents in HIV-Infected Adults and Adolescents.*			
○ *Recommendations for the Use of Antiretroviral Drugs in Pregnant Women Infected with HIV-1 for Maternal Health and for Reducing Perinatal HIV-1 Transmission in the United States.*			
○ *Guidelines for the Prevention and Treatment of Opportunistic Infections in HIV-Infected Adults and Adolescents*			

HIV/AIDS RELATED, continued

EXPECTATIONS	DOCUMENTATION Yes	DOCUMENTATION No	COMMENTS
3. Jean R. Anderson (ed.), *A Guide to the Clinical Care of Women with HIV*, HRSA/HAB, Rockville, Maryland (current edition).			
4. Georgia Immunization Program Manual (current edition).			
5. Local agency or health district policies and procedures for standard precautions and bloodborne pathogen occupational exposure control.			
6. An approved, current edition drug reference, including alternative/herbal therapies or online access to drug references may include:			
○ HIV InSite, Antiretroviral Management, http://hivinsite.ucsf.edu/InSite?page=Treatment			
○ Lexi-Comp Drug Information, available at www.lexi.com/online (for Districts who have purchased subscriptions).			
○ Medscape, http://www.medscape.com/			
7. Laboratory reference book or online access to references.			

RECOMMENDED TRAINING

A. SELF-STUDY (Nurse is to read the following documents or complete online tutorials):			
1. AIDS Education and Training Centers (AETC), *Clinical Manual for Management of the HIV-Infected Adult* current edition. (Recommended for RNs, required for APRNs)			
2. HRSA, HAB, *Health Care and HIV, Nutritional Guide for Providers and Clients*, June 2002, http://www.aids-etc.org/pdf/p02-et/et-30-20-01/nutr_guide_0602.pdf			
3. HRSA, University of Miami, Dept. of Family Medicine, *HIV Oral Health Curriculum for Nursing Professionals*, 2005, http://www.aids-etc.org/aidsetc?page=etresdisplay&resource=etres-144			

HIV/AIDS RELATED, continued

EXPECTATIONS	DOCUMENTATION Yes	DOCUMENTATION No	COMMENTS
4. AETC, *Managing Dyslipidemia in HIV: A Comprehensive Toolkit for the Primary Care Clinician,* 2008, online at http://www.aids-etc.org/aidsetc?page=etresdisplay&resource=etres-301 (Recommended for APRNs)			
5. CDC Self-Study Modules on Tuberculosis, available online at http://www.cdc.gov/TB/education/ssmodules/default.htm. or CDC's Interactive Core Curriculum on Tuberculosis: What Clinicians Should Know, current edition – available in print, CD-ROM or web based at http://www.cdc.gov/tb/education/corecurr/			
6. National Quality Center, Quality Academy online tutorials, http://nationalqualitycenter.org/index.cfm/17263			
B. DIDACTIC/CLASSROOM TRAINING:			
1. Viral hepatitis training – May be self paced, see CDC hepatitis training resources at http://www.cdc.gov/hepatitis/Resources/Professionals/TrainingResources.htm			
2. Adult/Adolescent immunization training by the GA immunization Program.			
C. REFERENCE MATERIALS:			
1. Georgia Breast Cancer Policy Manual (current edition).			
2. Georgia Cervical Screening Manual (current edition).			
3. Georgia Family Planning Manual (current edition).			
D. OTHER:			
1. Cross-training to work under STD, TB, and Women's Health Protocols			
2. For APRN's, see the Nurse Protocol Manual section entitled *the Nurse Protocol Agreement Formats for Advanced Practice Registered Nurses*. Ensure that APRN agreements include all the components of the sample agreement including scope of practice, consultation and a drug formulary that excludes controlled substances.			

Nurse or Site:		Date:	

SECTION V — TRAINING/EDUCATION FOR THE FOLLOWING NURSE PROTOCOL(S):

HYPERTENSION, PRIMARY

NOTE: This section may be used to review an individual nurse's training and preparation for practicing under nurse protocol. A copy may be placed in the nurse's personnel/supervisory file. It may also be used to review the training and preparation of a group of nurses who are practicing under nurse protocol.

	DOCUMENTATION		
EXPECTATIONS	**Yes**	**No**	**COMMENTS**
REQUIRED TRAINING			
The nurse must complete the following prior to and at least annually, thereafter, where applicable while practicing under nurse protocol:			
A. SELF-STUDY (Nurse is to read the following documents):			
1. The Seventh Report of the Joint National Committee on			
2. Your Guide to Lowering Your Blood Pressure with DASH. Available at www.nhlbi.nih.gov.			
B. DIDACTIC/CLASSROOM TRAINING:			
Hypertension Workshop, which includes nutrition, pharmacology and all Nurse Protocol components. DPH or other acceptable providers as approved by the State SHAPP Nurse Consultant or Professional Education Nurse Consultant for the Health Promotion and Disease Prevention Program may sponsor the education offering.			

HYPERTENSION, PRIMARY continued

EXPECTATIONS	DOCUMENTATION Yes	DOCUMENTATION No	COMMENTS
A. PRECEPTORSHIP/CLINICAL:			
1. The extent and duration of the preceptorship/clinical may vary according to the needs of each individual nurse. However, there shall be documentation that the nurse satisfactorily performs the required clinical skills prior to signing the nurse protocol(s) and practicing under nurse protocol.			
2. Nurse observes the preceptor in a clinical setting, followed by the preceptor observing the nurse performing skills which include:			
○ Demonstrates correct blood pressure measurement technique and proper documentation.			
○ Utilizes correct blood pressure measurement technique, appropriate cuff size, and properly maintained/calibrated equipment when assessing client's blood pressure.			
○ Counsels client regarding nutrition, medication, exercise/activity, tobacco cessation.			

HYPERTENSION, PRIMARY continued

EXPECTATIONS	DOCUMENTATION Yes	DOCUMENTATION No	COMMENTS
B. CLINICAL/PEER REVIEW:			
1. Annual peer reviews are required. The District Nursing Director, County Nurse Manager, and/or Nursing Supervisor shall have the discretion to determine which program areas are appropriate for annual peer review based on the following criteria:			
○ Predominate program of practice for each PHN			
○ PHN recently assigned to a different program area			
○ Significant changes in program policies			
2. Annually, the supervisor or peer shall observe, review, and document at least one health assessment and client counseling session for hypertension services satisfactorily performed by nurse.			
C. HAVE ACCESS TO REFERENCE MATERIALS:			
1. The Seventh Report of the Joint National Committee on Prevention, Detection, Evaluation, and Treatment of High Blood Pressure, May, 2003 (or most current). Available at www.nhlbi.nih.gov.			
2. "Dietary Approaches to Stop Hypertension (DASH) eating plan." Available at www.nhlbi.nih.gov.			
3. Current approved Drug Reference.			

HYPERTENSION, PRIMARY continued

EXPECTATIONS	DOCUMENTATION Yes	DOCUMENTATION No	COMMENTS
RECOMMENDED TRAINING			
A. SELF-STUDY (Nurse is to read the following documents):			
"Hypertension, Primary", Quality Assurance/Quality Improvement Standards for Public Health Nursing Practice (current edition).			
B. DIDACTIC/CLASSROOM TRAINING			
Programs that do not offer contact hours, such as District Updates and Education Programs may be implemented. The content of the educational activity, including the agenda and objectives should be forwarded by electronic mail to the program Nurse Consultant for brief review prior to the implementing the activity. This brief review will assure that the educational activity is consistent with current guidelines and the goals and objectives of the Health Promotion and Disease Prevention Program. The agenda and objectives should be maintained in the personnel records for all attendees.			
C. OTHER:			
Ongoing Access To Reference Materials			
1. The Seventh Report of the Joint National Committee on Prevention, Detection, Evaluation, and Treatment of High Blood Pressure, May, 2003 (or most current). Available at www.nhlbi.nih.gov.			
2. "Dietary Approaches to Stop Hypertension" eating plan. Available at www.nhlbi.nih.gov.			
3. Current Approved Drug Reference.			
4. "*Nurse Protocols for Registered Professional Nurses in Public Health*" (current edition).			

Nurse or Site:	Date:

SECTION V — TRAINING/EDUCATION FOR THE FOLLOWING NURSE PROTOCOL(S):

SEXUALLY TRANSMITTED DISEASES

NOTE: This section may be used to review an individual nurse's training and preparation for practicing under nurse protocol. A copy may be placed in the nurse's personnel/supervisory file. It may also be used to review the training and preparation of a group of nurses who are practicing under nurse protocol.

	DOCUMENTATION		
EXPECTATIONS	**Yes**	**No**	**COMMENTS**
REQUIRED TRAINING **The nurse must complete the following prior to and at least annually, thereafter, where applicable while practicing under nurse protocol**			
A. SELF-STUDY (Nurse is to read the following documents):			
1. Pharmacology of drugs used to treat STDs.			
2. *A Guide to Physical Examination,* Barbara Bates, M.D. (or similar text) –examination of male and female genitalia, anus/rectum.			
3. Female and male STD exam videos (These were sent to each District).			
4. Current Georgia STD Manual – Clinical Section (current manual).			
5. HIV/HBV Policy Manual, current edition.			
6. HIV Prevention Counseling Pre-course.			
7. Infertility Prevention (Chlamydia) Project Service Protocols, current edition.			

SEXUALLY TRANSMITTED DISEASES, continued

EXPECTATIONS	DOCUMENTATION Yes	No	COMMENTS
B. DIDACTIC/CLASSROOM TRAINING:			.
1. Use and Care of the Microscope, Wet Mounts and Gram Stains and Darkfield. a) In Districts with dark field microscopes, Microscopy course approved by STD Unit (when available).			
2. STD 101 or an STD Intensive course at a CDC STD Prevention/Training Center, or equivalent must be approved by the STD Unit (when available).			
3. HIV Prevention Counseling Course or HIV Counseling & Testing course.			
4. Hepatitis A to E, or equivalent.			
C. PRECEPTORSHIP/CLINICAL:			
1. The extent and duration of the preceptorship/clinical may vary according to the needs of each individual nurse. However, there shall be documentation that the nurse could satisfactorily perform the required clinical skills prior to signing the nurse protocol(s) and practicing under nurse protocol.			
a) The preceptor assures that the nurse observes and performs a physical exam on both male and female clients (e.g., symptomatic and asymptomatic, positive screening tests, STD exposure).			

SEXUALLY TRANSMITTED DISEASES, continued

EXPECTATIONS	DOCUMENTATION Yes	DOCUMENTATION No	COMMENTS
b) The preceptor assures that the nurse observes and performs all laboratory tests for which he/she is responsible; demonstrating knowledge of Clinical Laboratory Improvement Amendments requirements and proper infection control procedures while handling specimens (e.g., wet mount, gram stain, dark field exam, HIV, HSV-I, HSV-II, RPR, Chlamydia and Gonorrhea Specimen Collection).			
c) Preceptor observes the nurse ordering/ dispensing/administering drugs.			
E. CLINICAL/PEER REVIEW:			
1. Annual peer reviews are required. The District Nursing Director, County Nurse Manager, and/or Nursing Supervisor shall have the discretion to determine which program areas are appropriate for annual peer review based on the following criteria:			
○ Predominate program of practice for each PHN			
○ PHN recently assigned to a different program area			
○ Significant changes in program policies			
2. Annually, a supervisor or peer shall review the nurse providing complete STD-related care to at least one client, including history, physical exam, counseling, completing lab work, and ordering/dispensing/ administering drugs.			

SEXUALLY TRANSMITTED DISEASES, continued

EXPECTATIONS	DOCUMENTATION Yes	DOCUMENTATION No	COMMENTS
F. HAVE ACCESS TO REFERENCE MATERIALS:			
1. Websites:			
a) http://www.health.state.ga.us/programs/std/programs.asp . April 20, 2010			
b) http://health.state.ga.us/pdfs/prevention/immunization/requirements.pdf April 20, 2010			
c) http://www.cdc.gov/std/treatment/. April 20, 2010			
2. Manuals:			
a) Microscopy for Public Health Nurses Manual (current edition) http://health.state.ga.us/pdfs/epi/std/Microscope%20Manual%2006pdf.			
b) Darkfield Microscopy Course Supplement (current edition).			
c) Georgia Department of Community Health, Department of Public Health HIV/HBV Policy Manual, (current edition).			
d) Georgia Immunization Program Manual Chapter 7 Hepatitis Section (current edition) http://health.state.ga.us/pdfs/prevention/immunization/Complete%20Immunization%20%20Manual%20with%20Updates%20Rev%20060910.pdf			
e) STD 101 Course Supplement(current edition).			
f) STD Program Operation Manual (current edition).			
g) *Standard Nurse Protocols for Registered Professional Nurses in Public Health* (current edition).			
h) CDC 2006, STD Treatment Guidelines.			
i) Infertility Prevention Project Manual www.cdc.gov/std/infertility/ipp.htm.			

SEXUALLY TRANSMITTED DISEASES, continued

EXPECTATIONS	DOCUMENTATION Yes	DOCUMENTATION No	COMMENTS
RECOMMENDED TRAINING			
A. SELF-STUDY (Nurse is to read the following documents):			
Keep abreast of updates to the STD Manual; the HIV/HBV Policy Manual; and, the Hepatitis, Adolescent & Adult Sections of the Georgia Immunization Program Manual and ACIP.			
B. DIDACTIC/CLASSROOM TRAINING:			
1. Every 1-2 years, attendance at a program with at least some STD-related content. For example: STD Update, Syphilis Case Management course, in-service programs or professional conferences.			
2. Cross-training in related programs (e.g., TB, HIV/AIDS, Substance Abuse, Family Planning).			
3. HIV Prevention Course or HIV Counseling & Testing Course			
C. OTHER:			
Observe/participate in functions of a Communicable Disease Specialist, including field visits.			

Nurse or Site:	Date:

SECTION V — TRAINING/EDUCATION FOR THE FOLLOWING NURSE PROTOCOL(S):

TUBERCULOSIS

NOTE: This section may be used to review an individual nurse's training and preparation for practicing under nurse protocol. A copy may be placed in the nurse's personnel/supervisory file. It may also be used to review the training and preparation of a group of nurses who are practicing under nurse protocol.

	DOCUMENTATION		
EXPECTATIONS	**Yes**	**No**	**COMMENTS**
REQUIRED TRAINING			
The nurse must complete the following prior to and at least annually, thereafter, where applicable while practicing under nurse protocol:			
A. SELF-STUDY (Nurse is to read the following documents):			
1. CDC's Interactive Core Curriculum on Tuberculosis: What Clinicians Should Know,* current edition and/OR CDC's Self Study Modules on Tuberculosis.* current edition (CE credit offered through CDC for both of these). *See Reference Materials (Section E).			
2. Georgia Tuberculosis Program Policy and Procedure Manual, health.state.ga.us/programs/tb/publications.asp (current edition).			
3. Georgia TB Reference Guide, current edition.			
4. Georgia Tuberculosis Infection Control Manual, current edition.			

TUBERCULOSIS, continued

EXPECTATIONS	DOCUMENTATION Yes	DOCUMENTATION No	COMMENTS
B. DIDACTIC/CLASSROOM TRAINING:			
1. The Nurse has completed the following courses:			
a) TB Update & Tuberculin Skin Test Certification Workshop provided by State TB Office or District TB Coordinator or certified instructor.			
b) TB program updates (to include medication updates) provided by State, District or local staff.			
c) Tuberculin Skin Test Certification renewal (every two years).			
C. PRECEPTORSHIP/CLINICAL:			
1. The extent and duration of the preceptorship/clinical may vary according to the needs of each individual nurse. However, there shall be documentation that the nurse could satisfactorily perform the required clinical skills prior to signing the nurse protocol(s) and practicing under nurse protocol.			
a) Skills Validation component of the Skin Test Certification has been completed after attending the TB Update & Tuberculin Skin Test Certification Workshop, documented by supervisor and returned to the State Office.			
2. Ongoing chart reviews and consultation by the District and/or the State Office.			

TUBERCULOSIS, continued

EXPECTATIONS	DOCUMENTATION Yes	DOCUMENTATION No	COMMENTS
D. CLINICAL/PEER REVIEW:			
1. Annually, a supervisor or peer shall observe and review the nurse performing TB services such as initial & ongoing health assessment (to include TB screening), initial or monthly evaluation of LTBI and active TB cases, contact investigation, ordering and dispensing and/or administration of drugs, patient education/counseling and Directly Observed Therapy (DOT).			
2. Nurse observes preceptor in clinical setting followed by the preceptor observing the nurse perform TB services of initial and ongoing health assessment (to include TB screening), initial and monthly evaluation of LTBI and active TB cases, ordering & dispensing and/or administration of drugs, patient education/counseling, DOT & Contact Investigation as available in the county.			
E. CLINICAL/PEER REVIEW:			
1. Annual peer reviews are required. The District Nursing Director, County Nurse Manager, and/or Nursing Supervisor shall have the discretion to determine which program areas are appropriate for annual peer review based on the following criteria:			
○ Predominate program of practice for each PHN			
○ PHN recently assigned to a different program area			
○ Significant changes in program policies			
2. Annually, a supervisor or peer shall review the nurse providing complete STD-related care to at least one client, including history, physical exam, counseling, completing lab work, and ordering/dispensing/ administering drugs.			

TUBERCULOSIS, continued

EXPECTATIONS	DOCUMENTATION Yes	DOCUMENTATION No	COMMENTS
F. HAVE ACCESS TO REFERENCE MATERIALS:			
1. Onsite Access To Reference Materials:			
a) Nurse protocols for Tuberculosis, current edition			
2. CDC's Interactive Core Curriculum on Tuberculosis: What Clinicians Should Know, current edition – available in print, CD-ROM or web based at http://www.cdc.gov/tb/.			
3. CDC's Self Study Modules on Tuberculosis, current edition – web based at http://www.cdc.gov/tb/.			
4. Georgia Tuberculosis Program Policy and Procedure Manual, http://health.state.ga.us/programs/tb (current edition).			
5. Georgia TB Reference Guide, current edition.http://health.state.ga.us/programs/tb.			
6. Georgia Tuberculosis Infection Control Manual, health.state.ga.us/programs/tb/publications.asp (current edition).			
7. The latest versions of the CDC/ATS Guidelines, which are considered "living documents" and are available in print or online at the GDPH website at http://health.state.ga.us/programs/tb/publications.asp or CDC Division of Tuberculosis Elimination website at http://www.cdc.gov/tb/ ○ *Treatment of Tuberculosis.* ○ *Guidelines for the Investigation of Contacts of Persons with Infectious Tuberculosis.* ○ *Guidelines for Preventing the Transmission of Mycobacterium tuberculosis in Healthcare Facilities.* ○ *Prevention and Control of Tuberculosis in Facilities Providing Long-term Care to the Elderly*.			

TUBERCULOSIS, continued

EXPECTATIONS	DOCUMENTATION Yes	DOCUMENTATION No	COMMENTS
G. At District Office:			
CDC Video, *Mantoux Tuberculin Skin Test*, 2003 or current version.			
RECOMMENDED TRAINING			
A. SELF-STUDY (Nurse is to read the following documents):			
Georgia Tuberculosis Program Policy and Procedure Manual, current edition			
B. DIDACTIC/ CLASSROOM TRAINING:			
1. Georgia Regional or Statewide TB Training every two - four years as available.			
2. Participate in at least one Infectious Disease training per year related to HIV, STD, Refugee, Hepatitis, and/or TB.			
3. Participate in other TB education offered by state office or district office as determined by county need (e.g., Basic Contact Investigation, Interviewing Skills, DOT, TB/HIV, Case Management, etc.).			
4. HIV Counseling and Testing Course provided by the HIV Section.			
C. **OTHER:**			
1. Ongoing access to reference materials under Initial Training – E/F.			
2. Purnell, L.D. and Paulanka, B. J. Transcultural Healthcare: A Culturally Competent Approach, F.A. Davis Co., 1988 or current edition			
3. Rom, W.N. and Garay S., *Tuberculosis,* 2nd Ed., Little, Brown and Company (Inc.), 2004 or current edition. (updated)			
4. CDC CD-ROM *TB Information, January 2008* or current edition. (updated)			

Nurse or Site: _____ Date: _____

SECTION V — TRAINING/EDUCATION FOR THE FOLLOWING NURSE PROTOCOL(S):

WOMEN'S HEALTH/FAMILY PLANNING

NOTE: This section may be used to review an individual nurse's training and preparation for practicing under nurse protocol. A copy may be placed in the nurse's personnel/supervisory file. It may also be used to review the training and preparation of a group of nurses who are practicing under nurse protocol.

	DOCUMENTATION		
EXPECTATIONS	**Yes**	**No**	**COMMENTS**
REQUIRED TRAINING **The nurse must complete the following prior to and at least annually, thereafter, where applicable while practicing under nurse protocol:**			
A. SELF-STUDY (Nurse is to read the following documents):			
1. Hatcher, Robert, *Contraceptive Technology* (current edition)- Chapters on essentials of contraception, education/counseling and all methods.			
2. Georgia's Family Planning Services Manual (current edition).			
3. Program Guidelines for Project Grants for Family Planning Services Title X (2001 edition).			

WOMEN'S HEALTH/FAMILY PLANNING, continued

EXPECTATIONS	DOCUMENTATION Yes	DOCUMENTATION No	COMMENTS
4. Georgia laws regarding reporting child abuse and statutory rape and Georgia laws regarding minors and contraception, pregnancy related care, abortion, STD and HIV care, drug and alcohol care and mental health care . Minor's Access to Reproductive Health Care in Georgia - www.gachd.org/Minor's Rights to Confidential.pdf Your Rights as a Minor in Georgia - www.gcapp.org/youth Official Code of Georgia Annotated *O.C.G.A. § 16-6-3 Statutory Rape* *O.C.G.A. § 16-6-22 Incest* *O.C.G.A § 16-12-100 Sexual Exploitation of Children* *O.C.G.A § 19-7-5 Reporting of Child Abuse*			
5. Introduction to Title X for Clinician, Health Educator or Other Staff (free online training program) available from Title X Region IV Training Center for Family Planning @ www.cicatelli.org/titlex/Region4.			
6. Education and Counseling:			
a) Client education and counseling as required by Title X for all clients: Refer to the following pages in Program Guidelines for Project Grants for Family Planning Services: Sections 8.1, 8.2, 8.5-8.7, 9.3-9.6.			
7. Specific Title X Required Education and Counseling for Adolescent Clients:			
a) Family Involvement in decision to seek family planning services. Title X Program Guidelines Section 8.7.			
b) Resisting attempts to being coerced into having sex.			
c) Abstinence.			

WOMEN'S HEALTH/FAMILY PLANNING, continued

EXPECTATIONS	DOCUMENTATION Yes	No	COMMENTS
B. DIDACTIC/CLASSROOM TRAINING: Pre- and post-testing is required for all Didactic Training.			
1. Level I Contraceptive Technology (2 day course).			
2. Level II Contraceptive Technology (1 day course).			
3. Microscope Course (dark field not required for family planning) (when training is available).			
4. CDC Self-Study STD Modules for Clinicians at http://www2a.cdc.gov/stdtraining/self-study/default.asp.			
5. Breast and Pelvic Practicum (includes California method of breast examination) and documentation (1.5 day course).			
C. PRECEPTORSHIP:			
1. Following the completion of the required self-study and didactic components of the training, an additional supervised preceptorship is required. 30 exams must be observed. The extent and duration of the preceptorship will vary according to the competency of each individual nurse.			
2. The preceptor observes the nurse in obtaining a complete history, performing physical assessment, client management, dispensing contraceptive methods, and documentation.			
3. Preceptor observes the nurse performing appropriate laboratory tests, e.g., Pap smear, specimen collection for wet mount and STD tests, hematocrit/hemoglobin, urine dip strip, pregnancy test, gram stain (optional), blood pressure and any other lab tests that the clinic site may perform.			

WOMEN'S HEALTH/FAMILY PLANNING, continued

EXPECTATIONS	DOCUMENTATION Yes	DOCUMENTATION No	COMMENTS
D. CLINICAL/PEER REVIEW:			
1. Annual peer reviews are required. The District Nursing Director, County Nurse Manager, and/or Nursing Supervisor shall have the discretion to determine which program areas are appropriate for annual peer review based on the following criteria:			
○ Predominate program of practice for each PHN.			
○ PHN recently assigned to a different program area.			
○ Significant changes in program policies.			
2. An advanced practice nurse and/or a peer nurse shall observe and review the nurse performing a complete history, physical assessment including laboratory test and contraceptive management on at least one client each year.			
E. ACCESS TO REFERENCE MATERIALS:			
1. Breast and Cervical Cancer Program Manual (current edition).			
2. Georgia Immunization Program Manual and accompanying Advisory Committee on Immunization Practices (ACIP) Recommendations Notebook, Adult and Adolescent Sections.			
3. Pharmacology references.			
4. Physical assessment references.			
5. Resources on herbs and dietary supplements.			
6. Hatcher, Robert, *Managing Contraception* (current edition).			
7. Uphold, Constance R. and Graham, Mary V., *Clinical Guidelines in Family Practice* (current edition).			

WOMEN'S HEALTH/FAMILY PLANNING, continued

EXPECTATIONS	DOCUMENTATION Yes	No	COMMENTS
Recommended Training **It is recommended the nurse complete the following trainings within the first 24 months of practicing under Nurse Protocol for Women's Health.**			
1. Reproductive Health Care Issues for Women over 40.			
2. Women and HIV.			
3. Comfort with Human Sexuality.			
4. Patient-Centered Counseling Skills.			
5. HIV Prevention Course or HIV Counseling & Testing Course.			
6. Natural Family Planning/ Fertility Awareness.			
7. Participation in a least one educational in- service, workshop, training or conference per year to keep updated on current practices in women's health. This training may be provided by the District, State, or a private provider. *			

*State of Georgia – Family Planning Classes to be posted during the fall of each fiscal year at www.cicatelli.org/titlex/region4

Nurse or Site: _____ Date: _____

SECTION VI — TRAINING/EDUCATION FOR DRUG DISPENSING AND ORDERING:

NOTE: This section may be used to review an individual RN's training for practicing under nurse protocol. A copy may be placed in the RN's personnel supervisory file. It may also be used to review the training and preparation of a group of RNs who are practicing under nurse protocol.

	DOCUMENTATION		
EXPECTATIONS	**Yes**	**No**	**COMMENTS**
STANDARD NURSE PROTOCOLS: Are consistent with the Nurse Protocols for Registered Professional Nurses in Public Health with respect to:			
A. Clinical and laboratory diagnostic criteria.			
B. Drugs and therapeutic criteria.			
NOTE: Any variances in A and B above will be reviewed for acceptable quality by the District QA/QI Team.			
Are available upon request in the setting where the RN/APRN functions under nurse protocols.			
Bear a current review date.			
Are signed by the licensed delegating physician(s).			
Are signed by the RN/APRN practicing under the protocol(s).			
Specify parameters under which delegated medical acts may be performed.			
Include a schedule for quarterly review of patient records by the delegating physician(s).			

DRUG DISPENSING AND ORDERING, continued

EXPECTATIONS	DOCUMENTATION Yes	No	COMMENTS
Are reviewed, revised or updated annually.			
Include a provision for immediate consultation with the delegating physician(s) or designee.			
DRUG ORDERS MUST MEET THE FOLLOWING CRITERIA:			
Based on authority of the Nurse Protocol Statute.			
Fully documented in chart: (Example: Metronidazole 500 mg 1 tablet p.o. bid x 7 days, dispensed 14 tablets) as follows:			
1. Patient name.			
2. Generic name or actual brand name of drug.			
3. Strength of drug.			
4. Dose.			
5. Dosage form.			
6. Route of administration.			
7. Frequency.			
8. Duration of therapy.			
9. Quantity dispensed/provided.			
10. Date Ordered.			
11. Signature of RN/APRN who ordered the drug.			

DRUG DISPENSING AND ORDERING, continued

EXPECTATIONS	DOCUMENTATION Yes	No	COMMENTS
Drugs ordered by an RN/APRN in accordance with a nurse protocol require a client assessment at each visit (i.e., term “refill” not used).			
Drugs ordered and dispensed in accordance with a nurse protocol are documented on a "Drug Dispensing Sign Out Sheet" or equivalent electronic document and signed by the ordering RN/APRN and thus, dispensing under authority of nurse protocol statute. The RN/APRN who is authorized under nurse protocol to order the drug is the same RN/APRN who dispenses the drug.			
A policy and procedure is in place to assure that when drug order(s) are written by an RN/APRN under authority of nurse protocol statute, it is communicated verbally or otherwise communicated to the public health pharmacist (RPh) or the non-public health RPh that the drug order is not a written prescription from the RN/APRN.			
Drug orders written by a physician and dispensed by a physician are documented on a "Drug Dispensing Sign Out Sheet" or equivalent electronic document and signed by the physician ordering and dispensing the drug.			
Drug orders written by a physician and dispensed by a RPh or written by a physician and dispensed by a physician are clearly distinguishable from drugs ordered and dispensed by the RN/APRN under authority of the nurse protocol statute.			

DRUG DISPENSING AND ORDERING, continued

EXPECTATIONS	DOCUMENTATION Yes	No	COMMENTS
INFORMATION ON DRUG LABEL AND COMPONENTS OF PATIENT COUNSELING ARE IN ACCORDANCE WITH DRUG DISPENSING PROCEDURE			
Name, address and phone number of the health district/health department or health center.			
Date and identifying number (at a minimum, 3 digit county code).			
Full name of patient.			
Name of drug (brand, if actual brand name, or generic) and strength.			
Directions for use to patient (Example: Take 1 tablet by mouth twice a day, at 8 am and 8pm).			
Name of RN/APRN or delegating physician or initials “DCH”.			
Expiration date of drug.			
Patient received counseling on drugs in accordance with Drug Dispensing Procedure.			
Counseling on drugs is documented.			
Written drug information was provided as an adjunct to counseling.			
PRESCRIPTION PADS			
Blank prescription pads are stored at the health dept/center for MD use.			
If yes, these prescription pads are secured when not in use by MD.			
DRUG SAMPLES			
If drug samples stored/provided at this site:			
Since there is no legal authority for RN/APRNs working under the nurse protocol statute to possess and distribute drug samples, there should be a policy and procedure for handling drug samples, which is signed by a pharmacist and physician in accordance with the State Drug Dispensing Procedure.			

SECTION VII — CLINICAL PRACTICE:

EXPECTATIONS	Yes	No	Incomplete	COMMENTS
Each RN is informed during orientation that clinical competencies are evaluated and documented at least annually and more frequently as indicated (e.g., competency improvement, change of job assignment). Direct observation of RN clinical competencies are documented on the following forms at least annually or more frequently as indicated (e.g., competency improvement, change of job assignment): ▪ RNs – Clinical Competencies Checklist (see Attachment A). The delegating physician will conduct record reviews for all RNs practicing under the nurse protocol at least quarterly. Each RN is responsible for documenting professional growth and development activities at least annually (e.g., workshops, seminars, community/professional meetings, education, research, and reading).				

SECTION VIII — MANAGEMENT OF ADVERSE DRUG REACTIONS:

EXPECTATIONS	Documentation			COMMENTS
	Yes	No	Incomplete	
A. Clinic site has most current written nurse protocol(s) for managing anaphylactic (allergic) reactions and/or blood-drawing.				
B. Clinic site has appropriate emergency equipment and supplies are readily available as determined in the Guidelines for Emergency Kits/Carts in Public Health Clinic Sites in the Nurse Protocol Manual.				
C. Clinic site has an emergency alert communication system that is known by all staff.				
D. Clinic site has posted local emergency telephone numbers, (i.e., EMS, hospital, etc.) for easy access.				
E. Clinic has posted Georgia Poison Center telephone number for easy access.				
F. Each RN has participated in training updates as needed and in mock emergency drills at least once a year and there must be at least one annual mock emergency drill which includes infants, toddlers, children and adults.				
G. One person (designee) coordinates training and scheduling, implementation and evaluation of the mock emergency drills.				
H. Copies of records on anaphylactic reactions are distributed as follows:				
1. Sent with patient to emergency room, if applicable;				
2. Retained by the clinic for patient record; and				
3. Sent to District Office with incident report.				
I. Review of emergency preparedness for drug reaction is conducted at least once annually.				

SECTION IX — CLINICAL OPERATIONS – STANDARDS & MEASURES:

EXPECTATIONS	Documentation Yes	No	Incomplete	COMMENTS
A. An evaluation of clinic operations, including efficiency, should be completed every two years utilizing one of the following methodologies:				
1. Patient Flow Analysis (PFA) 2. Clinic Operations Review *(see Guidelines and Form in Clinic Operations Section of QA/QI Manual.)* 3. Other: A tool with content similar to either of the above tools.				
B. The results of the review of clinic operations have been shared and discussed with staff.				
C. Interventions are planned and/or implemented to support the positive findings from the evaluation of clinic operations.				
D. Interventions are planned and/or implemented to improve clinic activity.				

SECTION X — POPULATION HEALTH:

EXPECTATIONS	Documentation Yes	No	Incomplete	COMMENTS
A. There is evidence that a population health training needs assessment has been conducted with the nursing staff to identify the knowledge and skills necessary for population health nursing practice for the next three to five years.				
B. A plan has been developed to use the Population Health Competency Measurement Tool (Tab 14) in order to address the identified population health training needs. The plan may be a separate document or a component of a professional staff development plan or a workforce development plan.				

SITE VISIT REPORT SUMMARY

FINDINGS: Strengths

FINDINGS: CHALLENGES

SITE VISIT REPORT SUMMARY

FINDINGS: Opportunities for Improvement

RECOMMENDATIONS:

ATTACHMENT A

PEER REVIEW TOOL FOR THE REGISTERED NURSE IN PUBLIC HEALTH

Clinic Site: _____ Nurse: _____ Date: _____ Time: _____

Reviewer: _____ Program/Type of Client Visit: _____

To assure the quality of client services, this form is used to record the findings from observations of an RN's performance. For each line, mark under the number that most closely fits the consistency of the nurse's performance with programmatic standards and nurse protocols. Comments must be specific and objective.

Rating Code: 1 = Unsatisfactory 2 = Needs some improvement 3 = Satisfactory 4 = Not Applicable

STANDARDS	CLIENT #1				CLIENT #2				
THE NURSE	1	2	3	4	1	2	3	4	COMMENTS
Initial Interaction:									
1. Cordially greets client									
2. Introduces self and observer									
3. Is wearing a clearly visible I.D. badge									
4. Determines reason for visit									
5. Determines reason for chief complaint									
6. Ascertains description of symptoms									
Ascertains Health History:									
1. General Health									
2. Childhood Health									
3. Adult Illnesses									
4. Psychosocial									
5. Injuries									
6. Operations									

Rating Code: 1 = Unsatisfactory 2 = Needs some improvement 3 = Satisfactory 4 = Not Applicable

STANDARDS	CLIENT #1				CLIENT #2				COMMENTS
	1	2	3	4	1	2	3	4	
7. Hospitalizations									
Ascertains Pertinent Family History:									
Determines Current Health Status / Practices:									
1. Allergies									
2. Immunizations									
3. Risky Behaviors									
4. Medications									
5. Diet									
6. Sexual Activity									
7. Review of Systems									
Females: 8. Reproductive history/ contraception/ current									
Performs Physical Examination:									
1. Skin									
2. Head									
3. Eyes									
4. Ears									
5. Nose									
6. Mouth									
7. Neck									
8. Lymph Nodes									
9. Thorax and Lungs									
10. Cardiovascular									
11. Breasts									
12. Abdomen									
13. Genitalia									
14. Rectum									

Rating Code: 1 = Unsatisfactory 2 = Needs some improvement 3 = Satisfactory 4 = Not Applicable

STANDARDS	CLIENT #1				CLIENT #2				
	1	2	3	4	1	2	3	4	COMMENTS
15. Peripheral Vascular									
16. Musculoskeletal									
17. Neurological									
18. Mental Status									
19. Vital Signs									
20. Appropriately drapes / exposes client during									
Performs Laboratory Assessment:									
1. Orders medically necessary tests									
2. Orders appropriate screening tests									
3. Collects/labels specimens correctly									
4. Uses infection control precautions /									
5. Uses microscope correctly									
6. Uses other equipment correctly									
Determines Assessment / Diagnosis and Develops Management Plan									
1. Identifies specific problems									
2. Makes the correct assessment based on history and clinical findings									
3. Develops treatment plan consistent with programmatic standards and nurse protocols									
4. Involves client in developing plan of care									
Implements Management Plan									
1. Orders/administers medication; administers immunization(s), consistent with programmatic standards & nurse protocols									
2. Dispenses medication with correct labeling									

Rating Code: 1 = Unsatisfactory 2 = Needs some improvement 3 = Satisfactory 4 = Not Applicable

STANDARDS	CLIENT #1				CLIENT #2				COMMENTS
	1	2	3	4	1	2	3	4	
3. Consults with physicians/ other health care providers as indicated									
4. Makes appropriate referrals									
5. Schedules follow up visits as indicated									
Provides Appropriate, Client-Centered Counseling and Education									
1. Informs client of assessment/diagnosis									
2. Gives risk-reduction messages									
3. Gives medication and other treatment									
4. Provides other appropriate written materials									
5. Ascertains client's understanding of									
6. Invites questions from client									
7. Uses simple terminology to give appropriate									
Demonstrates appropriate interpersonal skills.									
1. Reviewer should comment on the Clinician's interpersonal skills demonstrated during any part(s) of the interaction with client.									
Produces appropriate documentation:									
1. Medical record is thoroughly completed									
2. Writing is legible									
3. Medical record is signed									
4. Signed consent forms are included with record									
5. Utilizes standard abbreviations, acronyms, symbols and dosage designations as adopted by the Health District and as required by the State Standard Abbreviations Policy.									

Rating Code: 1 = Unsatisfactory 2 = Needs some improvement 3 = Satisfactory 4 = Not Applicable

STANDARDS	CLIENT #1	CLIENT #2	
6. Other: (specify) **See Tab 8 – Clinical Record Standards.**			
Date and Time:	**Date:**	**Time:**	

Feedback/ Strategizing:	
Follow-up Plan:	

Signature of Reviewer: _____ **Signature of Clinician:** _____

Date: _____ **Date:** _____

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Quality Assurance/Quality Improvement (QA/QI) for Public Health Nurses

Immunization

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Review Date: _____

Review Site(s): _____

REVIEW TEAM MEMBERS:

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____

QUALITY ASSURANCE /QUALITY IMPROVEMENT FOR IMMUNIZATION PRACTICE FOR PUBLIC HEALTH NURSES

INTRODUCTION

The Georgia Immunization Program, under the Department of Public Health, produces both an Immunization Program Manual and an Advisory Committee on Immunization Practices (ACIP) Recommendations Notebook that outline the recommended Policies and Procedures for administering vaccines by registered nurses and for providing immunization services. An advisory committee consisting of district immunization coordinators and pediatricians, a state pharmacist and the Immunization Program management team, review and update these manuals on an ongoing basis. Each district is responsible for having written policies and procedures for the administration of vaccines that have been reviewed and signed annually by the health director or their designee. Districts are encouraged to either utilize the Policies and Procedures outlined in the Georgia Immunization Program Manual and the ACIP Recommendations Notebook, or to write their own which should be consistent with those outlined in these two references.

PURPOSE

The purpose of this quality assurance tool is to document the training /education expectations and the parameters of clinical practice immunization services. Use of this tool will help promote consistency in practice across programs on a statewide basis. Quality assurance will provide an opportunity to identify excellence in practice, as well as opportunities for improvement. The components of this tool may be used to conduct QA reviews of training programs, administration of vaccines by registered nurses. These reviews may be done by Public Health staff from either the local and/or state level. The credentialing, training, and education expectations, as well as the parameters of clinical practice for Licensed Practical Nurses in immunization services are located in Chapter 13 of the Georgia Immunization Program Manual. This tool may be used when evaluating immunization services provided by Licensed Practical Nurses.

Nurse or Site: _____ Date: _____

SECTION I - CREDENTIALING

EXPECTATIONS	DOCUMENTATION Yes	DOCUMENTATION No	COMMENTS
1. Professional Licensure for RN's:			
Each Registered Professional Nurse (RN) and each Advanced Practice Registered Nurses (APRN) practicing under the District's Policies and Procedures is currently licensed/authorized by the Georgia Board of Nursing. Documentation shall include verification of license(s) per internet (www.sos.state.ga.us). A hardcopy of the Internet verification should be documented in the supervisory personnel file prior to employment and at least once annually thereafter.			
2. Scope of Practice for RN's:			
The district's written P&P for the administration of vaccines and provision of immunization services are consistent with the Department of Public Health's Scope of Practice Guidelines for Expanded Role of RNs and Advanced Practice Registered Nurse.			
3. Clinical Preceptorship/Peer Review for RN's:			
Prior to practicing under P&P, written documentation of completion of a clinical preceptorship, consistent with the recommended Policies & Procedures outlined in Section II of this document must be on file.			

Nurse or Site: _____ Date: _____

SECTION II — TRAINING/EDUCATION

FOR REGISTERED NURSES (RN's):

NOTE: This section may be used to review an individual nurse's (RN) training and preparation for practicing under Immunization Policies & Procedures (P&P). A copy may be placed in the nurse's personnel file. It may also be used to review the training and preparation of a group of nurses who are practicing under Immunization Policies and Procedures. The self-study and didactic training sections should be completed and documented prior to completing the preceptorship. Each nurse should complete the following:

	DOCUMENTATION		
EXPECTATIONS	**Yes** (Date completed/ Reviewers Initial)	**No**	**COMMENTS**
INITIAL TRAINING – REQUIRED			
The nurse has completed the following:			
A. SELF-STUDY (Nurse is to read the following documents): Familiar with and has access on-site to:			
▪ *Georgia Immunization Program Manual* ∗+ (Also available on line)			
▪ *Advisory Committee on Immunization Practices (ACIP) Recommendations Manual*∗+ (Also available on line)			

II — TRAINING/EDUCATION, continued

EXPECTATIONS	DOCUMENTATION: Yes (Date completed/ Reviewers Initial)	DOCUMENTATION: No	COMMENTS
▪ *Health District Policies & Procedures for Vaccine Administration*∗ ▪ *(Signed annually by the District Health Director or his/her designee)*			
▪ *Health District Policies & Procedures for Administration of Travel* ▪ *Vaccines*∗ *(If district administers travel vaccines)*			
▪ *Health District Emergency Policies & Procedures*∗			
▪ *Georgia Notifiable Disease Fact Sheets*∗+ (District must be able to access on line)			
▪ *Manual for the Surveillance & Reporting of Vaccine Preventable Diseases Manual,* ▪ *CDC*+∗ (District must be able to access on line)			
▪ *Vaccine package inserts.*			
+ See Attachment A for detailed information on these references ∗ Most Current version			

II — TRAINING/EDUCATION, continued

EXPECTATIONS	DOCUMENTATION: Yes (Date Completed/ Reviewers Initial)		DOCUMENTATION: No	COMMENTS
B. DIDACTIC/CLASSROOM TRAINING COMPLETED:				
▪ Basic Epidemiology: Prevention of Vaccine Preventable Diseases: (VPD's) - Attend or view and complete and pass post tests for the CDC Satellite Immunization Training Sessions (webcast, or taped session) on: *Epidemiology & Prevention of Vaccine Preventable VPD's* +* (includes basic vaccine pharmacology).				
▪ Storage and Handling: - View all components of the CDC's Storage and Handling Tool Kit +*(DVD or webcast)and complete and pass post tests for: o *How to Handle Your Vaccine Supply* (See attachments A,B & C) or - Attend Vaccine Storage & Handling training session provided by the GA Immunization Program +*				
▪ Vaccine Administration Techniques - Vaccine Administration Techniques training session +* (Contact GA Immunization Program consultant (IPC) or District Immunization Coordinator) or - View Immunization Techniques Video/DVD +* and pass post test. (see attachments A,D, E, and F)				

II — TRAINING/EDUCATION, continued

EXPECTATIONS	DOCUMENTATION Yes (Date Completed/ Reviewers Initial)		No	COMMENTS
▪ GA Requirements for Day Care and School Attendance: Attend Training Session on GA Requirements for Attending Day Care & School (Provided by District "Certified Trainer" or Georgia IPC- see attachment A)				
▪ Complete CPR Certification Class provided by the district or other entity (must be currently certified).				
▪ Forms, Reports, & Records - Instructed in purpose of and has access to the following forms, reports, and records:				
+ See Attachment A for detailed information on these references * Most Current version				
a. Patient Record (written and computerized) and how to access 1. Immunization status.				
b. Vaccine Information Statements*				
c. Certificates and Statements for School and Day Care Attendance*				
d. Determination of Coverage and Fees (VFC Eligibility, Medicaid, PeachCare, Private Insurance, HMO coverage) and how to apply for Medicaid and PeachCare.				
e. Informed Consent				
f. Vaccine Adverse Event Reporting System (VAERS)				
g. Tracking and Follow up Moved or Gone Elsewhere (MOGE)				

II— TRAINING/EDUCATION, continued

EXPECTATIONS	DOCUMENTATION Yes (Date Completed/ Reviewers Initial)	No	COMMENTS
h. Notifiable Disease Reports			
i. Vaccine Preventable Disease (VPD) worksheets*			
j. Immigration Forms*			
k. Employee Immunization Record			
l. District Immunization documentation forms and charting process*			
m. Precall and Recall process and related forms and letters			
n. Clinical Assessment Software Application (CoCASA) report*			
o. GA Registry of Immunization Transactions & Services (GRITS) (Knows how to access and query for an existing immunization record to determine current immunization status and need for vaccinations)			
p. Current population based immunization study and child care and school audit results			
▪ Tour of Immunization clinic, including information about where vaccine emergency cart trays and immunization forms are stored.			
▪ Informed how to access district immunization coordinator and the GA Immunization Program "On-Call" resource phone line and area IPC .			
▪ Attend at least one (1) training on cultural competencies.			
+ See Attachment A for detailed information on these sessions or videos. * Most current version			

II — TRAINING/EDUCATION, continued

EXPECTATIONS	DOCUMENTATION YES (Dated Completed/ Reviewer's Initial)	NO	COMMENTS
C. PRECEPTORSHIP / CLINICAL:			
The extent and duration of the preceptorship/clinical may vary according to the needs of each individual nurse. However, there shall be documentation that the nurse can satisfactorily perform the required clinical skills on the attached check list (Attachment G) and that the preceptor has observed the required encounters prior to the nurse being allowed to administer vaccines without direct supervision. The minimum number of observed encounters should be two per age group indicated.			
D. HAVE ACCESS ON-SITE TO REFERENCE MATERIALS & RECORDS:			
▪ *Epidemiology & Prevention of Vaccine Preventable Diseases. CDC+**			
▪ *Red Book, AAP,+* (vaccine recommendations section) (at least 1copy at district)*			
▪ *Current Guide to Contraindications to Childhood Vaccinations, CDC+**			
▪ *Control of Communicable Diseases in Man, Heymann, A.S.,+**			
▪ *Current Year Drug Reference (refer to current Nurse Protocol Manual, Drug Dispensing Procedure, for list of acceptable drug references)*			
▪ *GA Registry of Immunization Transactions & Services (GRITS)* (Needs to be able to access and query for an existing immunization record to determine current immunization status and need for vaccinations)			
+ See Attachment A for detailed information on these sessions or videos * Most current version			

II — TRAINING/EDUCATION, continued

EXPECTATIONS	DOCUMENTATION Yes (Date Completed/ Reviewer's Initial)	No	COMMENTS

INITIAL TRAINING – REQUIRED

The nurse has completed the following:

Each Nurse should annually complete the following:				
A. SELF-STUDY (Nurse is to read the following documents)::				
▪ Review of current year's District Policies and Procedures for Administration of Vaccines (if separate from the GA Immunization Program Manual)				
▪ Review of current GA Immunization Program Manual and current updates for the ACIP Recommendations Notebook				
B. DIDACTIC/CLASSROOM TRAINING				
Participation in at least one training per year to keep updated on current policies and procedures concerning administration of vaccines. Recommended training sessions could include but are not limited the following: (Multiple presenter topics available from GA Immunization Program and CDC National Center for Immunization and Respiratory Diseases-Immunization Services +) ▪ CDC Immunization Training Sessions +∗ (live, webcast, or recorded): - Vaccine Safety - Immunization Updates (Childhood or Adult) - Surveillance & Prevention of Vaccine Preventable Diseases - International Travel ▪ Immunization Program training sessions+∗ (Provided by GA Immunization Program staff or District "Certified Trainer") ▪ Cultural Competency Update				
+ See Attachment A for detailed information on these sessions or videos * Most current version				

II — TRAINING/EDUCATION, continued

EXPECTATIONS	DOCUMENTATION: Yes (Date Completed/ Reviewer's Initial)		No	COMMENTS
C. PEER REVIEW/CLINICAL:				
▪ At least once annually, a supervisor or peer shall observe, evaluate, and document on skills checklist (Attachment G) the nurse assess, prepare, administer vaccines, and document information provided to infants and children, adolescents and adults (at least one encounter for each).				
D. OTHER:				
a. Have Access On-Site to: ▪ District Policies and Procedures for Administration of Vaccines.+* (if separate from the GA Immunization Program Manual) ▪ *GA Immunization Program Manual .** ▪ *ACIP Recommendations Notebook.** ▪ *Epidemiology & Prevention of Vaccine Preventable Diseases. CDC+** ▪ *Red Book, AAP+*, (Vaccine Recommendations section) (at least one copy at district)* ▪ *Current Guide to Contraindications to Childhood Vaccinations, CDC+** ▪ *Control of Communicable Diseases in Man, Heymann, A.S., +** ▪ Current year drug reference (refer to current Nurse Protocol Manual, Drug Dispensing Procedure, for list of acceptable drug references) ▪ Health District's P&P for Administrating Travel vaccines* (If applicable) ▪ *GA Notifiable Disease Fact Sheets (available at district and in Chapter 6 of GA Immunization Program Manual)**				

II — TRAINING/EDUCATION, continued

EXPECTATIONS	DOCUMENTATION: Yes (Date Completed/ Reviewer's Initial)		No	COMMENTS
▪ *Manual for Surveillance & Reprinting of VPD Manual CDC+* (available at district)** ▪ Vaccine Package Inserts* *GA Registry of Immunization Transactions & Services (GRITS)* (Needs to be able to access and query for an existing immunization record to determine current immunization status and need for vaccinations)				
+See Attachment A for detailed information on these sessions or videos. * Most current version				

SECTION III — POLICIES & PROCEDURES

EXPECTATIONS	DOCUMENTATION YES (Date Completed/ Reviewer's Initial)	NO	COMMENTS
▪ The district utilizes the Policies & Procedures in the GA Immunization Program Manual and the ACIP Recommendations Manual and both manuals are current.			
▪ The District writes their own Policies and Procedures (P&P) for the Administration of Vaccines and Provision of Immunization Services. The P&P are consistent with the recommendations outlined in the GA Immunization Program Manual and the ACIP Recommendations Manual.			
▪ Are available upon request in the setting where RN practices under the Policies and Procedures.			
▪ Are reviewed, revised or updated annually, or as GA Immunization Program recommends change.			
▪ Are signed by licensed Physician.			
▪ Bear a current review date.			
▪ Include a provision for immediate consultation with a physician or designee.			
▪ Include a provision for the supervision of the LPN by a RN, Physician, Dentist, and/or Podiatrist.			
+ See Attachment A for detailed information on these references * Most Current Version			

SECTION IV — CLINICAL PRACTICE

EXPECTATIONS	DOCUMENTATION YES (Date Completed/ Reviewer's Initial)		NO	COMMENTS
Direct observations of clinical nursing practice will be documented on the Clinical Skills Checklist (see Attachment G) for each nurse administering vaccines.				
+ See Attachment A for detailed information on these references * Most Current Version				

SECTION V — VACCINE STORAGE, HANDLING , ETC.

This section will be documented on a separate report (see Attachment H). This document is updated annually based on CDC requirements. Please check with your Immunization Program Consultant {IPC} for current version)

SECTION VI — MANAGEMENT OF DRUG REACTIONS

	DOCUMENTATION			
EXPECTATIONS	**YES** (Date Completed/ Reviewer's Initial)	**NO**	**Incomplete**	**COMMENTS**
A. Clinic site has most current written, Policies and Procedures for handling anaphylactic (allergic) reactions and/or blood drawing.				
B. Clinic site has appropriate emergency equipment and supplies are readily available.				
C. Clinic site has an emergency alert communication system that is known by all staff.				
D. Clinic site has posted local emergency telephone numbers, (i.e., EMS, Hospital, etc.) for easy access.				
E. Each RN has current CPR certification.				
F. Each RN has received orientation/training updates in emergency procedures within one (1) month of employment.				
G. Each RN has participated in training updates as needed and in mock emergency drills at least once a year.				
H. There must be at least one annual mock emergency drill which includes infants, toddlers, children and adults.				
I. One person (designee) coordinates training and scheduling, implementation and evaluation of the mock emergency drills.				
J. Copies of records on anaphylactic reactions are distributed as follows:				
• Sent with patient to emergency room, if applicable;				
• Retained by the clinic for patient record; and				
• Sent to District Office with incident report.				

SECTION VI — MANAGEMENT OF DRUG REACTIONS (continued)

EXPECTATIONS	DOCUMENTATION			
	YES (Date Completed/ Reviewer's Initial)	NO	Incomplete	COMMENTS
K. Review of emergency preparedness for drug reactions is conducted at least once annually.				
L. Each RN is familiar with the Vaccine Adverse Event Reporting System (VAERS) and the policies and procedures for reporting vaccine adverse events following immunizations.				
+ See Attachment A for detailed information on these references * Most Current Version				

Support Staff or Site: _____ Date: _____

Summary

FINDINGS:

RECOMMENDATIONS:

Georgia Immunization Program Manual
Department of Public Health

Immunization Resources

Name	Ordering Information	Approximate Cost
Georgia Immunization Program Manual	Can be downloaded from program website http://health.state.ga.us/programs/immunization.asp	
Advisory Committee on Immunization Practices (ACIP) Recommendations Manual	No longer available as a complete manual. Single copies of each report may be ordered from the National Immunization Program, CDC; or can be viewed and downloaded at www.cdc.gov/nip/publications/acip-list.htm	
Georgia Notifiable Disease Fact Sheets	Disease-specific fact sheets are available online: http://health.state.ga.us/siteindex/d.asp#diseases and click on specific disease to view fact sheet	
GA VFC Provider Operations Guide	Available for private VFC providers. Contact VFC Program Office or Immunization Program Consultant	Free
Manual for the Surveillance of Vaccine Preventable Diseases, CDC	Available only on CDC website at www.cdc.gov/nip/publications/surv-manual/default.htm	
The Red Book - Report of the Committee on Infectious Diseases 28th Edition, American Academy of Pediatrics, 2009	American Academy of Pediatrics P.O. Box 747 141 Northwest Point Blvd. Elk Grove Village, IL 60009-0927 847-228-5005 Elk Grove, Illinois (Published every 3 years) www.aap.org	$114.95

Georgia Immunization Program Manual
Department of Public Health

Immunization Resources

Publications:

Name	Ordering Information	Approximate Cost
Guide to Vaccine Contraindications and Precautions CDC, 2009	Access from CDC's website at http://www.cdc.gov/vaccines/recs/vac-admin/downloads/contraindications-guide-508.pdf	
The Pink Book – Epidemiology & Prevention of Vaccine Preventable Diseases, CDC, 11th edition, June 2009	One copy provided for each public health facility; or Order from Public Health Foundation 1-877-252-1200 (toll free) Access from CDC's website: http://www.cdc.gov/vaccines/pubs/pinkbook/downloads/table-of-contents-508.pdf	$17.50+ shipping from Public Health Foundation at http://bookstore.phf.org
Control of Communicable Diseases Manual, 19th edition, 2008	Online bookstore: https://majorsbooks.mybooksandmore.com/MBM/screens/index.jsp	
IAC Express – Internet news service of the Immunization Action Coalition	Order from: Immunization Action Coalition Send a message to express@immunize.org and place the word SUBSCRIBE in the subject field	Free
Immunize Georgia, (newsletter) Children's Healthcare of Atlanta and Georgia Immunization Program	Order from: Immunize Georgia Angie Matthiessen 1680 Tullie Circle Atlanta, GA 30329 (404) 785-7225 E-mail: angie.matthiessen@choa.org	Free
Immunize Georgia Your Monthly News and Resource Update (email newsletter)	To register for the electronic subscription, send an email request to: angie.matthiessen@choa.org	Free

Georgia Immunization Program Manual
Department of Public Health

Immunization Resources

Publications:

Name	Ordering Information	Approximate Cost
Morbidity & Mortality Weekly Report (MMWR)	To order electronic subscription go to: http://www.cdc.gov/mmwr/ to submit your email address. To order paper copy, contact: Superintendent of Documents U.S. Government Printing Office Washington, D.C. 20402 Request item #717-016-00000-9.	Free $373.00/year or $4.25 per copy for a single issue of *MMWR* Weekly
NEEDLETIPS - Published biannually	Order from: Immunization Action Coalition Send a message to express@immunize.org and place the word SUBSCRIBE in the subject field	Free

Training Tools

Vaccine Storage and Handling Toolkit	Order from CDC online order form at https://www2.cdc.gov/nchstp_od/PIWeb/niporderform.asp or view online at www2a.cdc.gov/nip/isd/shtoolkit/splash.html	One CD available free
Immunization Administration Techniques, California Department of Health 2001	CA Distance Learning Health Network Phone: (619) 594-5933 Fax: (619) 594-2111 E-mail: info@cdlhn.com Website: www.cdlhn.com	VHS $30.00 DVD $35.00 DVD contains English and Spanish versions, plus Print Material Artwork.
Copies of the CDC Satellite Immunization Training Courses	View webcasts at: http://www.phppo.cdc.gov/phtn/calendar.asp#pastwebcasts2005 or order the DVD using the CDC online order form at: https://www2.cdc.gov/nchstp_od/PIWeb/niporderform.asp	One DVD available free
You Call the Shots web-based training course	Access from the CDC website at http://www.cdc.gov/vaccines/ed/youcalltheshots.htm	Free

Georgia Immunization Program Manual
Department of Public Health

Immunization Resources

Telephone and Fax:

- GA Immunization Program "On Call" Phone Line
  404-657-3158
- GA Vaccines for Children Program
  800-848-3868, 800-372-3627 (Fax)
- CDC Immunization Information Hotline (English & Spanish)
  800-232-4636
- Public Health Foundation
  877-252-1200
- GA Chapter, American Academy of Pediatrics
  404-881-5020
- GA Chapter, American Academy of Family Physicians
  404-321-7445 or (800) 392-3841

Affiliated Computer Services (ACS) Georgia Health Partnership Customer Interation Center
Providers:.....1-800-766-4456
.....404-298-1228
For claim status, eligibility verification, provider enrollment, Electronic Manual Claims (EMC) assistance (GA Better Health and Health Check Services), and to reach your ACS Field Representative Members:
.....1-866-211-0950
.....770-570-3373

TDD/TTY.....1-866-211-0951

Health Check Services 404-657-7882
Health Check and Immunization policy questions 1-800-377-3557

Other Resources
Children Health Care Of Atlanta (Immunize Georgia) 404-785-7225

Vaccine Manufacturers
Bayer Pharmaceutical 800-288-8370
Merck National Service Center 800-672-6372
Merck Vaccine Customer Help Line.....800-982-7482
Sanofi Pasteur.....800-822-2463
GlaxoSmithKline.....800-366-8900
Wyeth-Lederle Laboratories 800-666-7248

Georgia Immunization Program Manual
Department of Public Health

Immunization Resources

Internet Addresses:

- GA Immunization Program
  http://health.state.ga.us/programs/immunization/index.asp
- CDC Home Page Immunization
  www.cdc.gov
- CDC Travel Information
  www.cdc.gov/travel/destinat.htm
- All Kids Count
  www.allkidscount.org
- Immunofacts
  www.immunofacts.com
- GA Chapter, American Academy of Pediatrics
  www.gaaap.org
- National Vaccine Program Office
  www.hhs.gov/nvpo
- Immunization Action Coalition
  www.immunize.org
- Every Child by Two
  www.ecbt.org
- American Academy of Pediatrics
  www.aap.org
- GA Academy of Family Physicians
  www.gafp.org
- Georgia Better Health
  www.ghp.georgia.gov/wps/portal
- Immunize Georgia's Little Guy's (CHOA)
  www.choa.org

Education Presentations:

- Georgia Immunization Program Presentations[1]
- CDC Satellite Training Programs[2]
- Educating Physicians In Your Community (EPIC)[3]

[1]Contact your Immunization Program Consultant to schedule (see page 6 for program offerings)
[2]Contact your Immunization Program Consultant for dates and locations
[3]Contact GA Chapter: Academy Of Pediatrics to schedule

Georgia Immunization Program Manual
Department of Public Health

Immunization Resources

Georgia Department of Community Health is an approved provider of continuing nursing education by the Georgia Nurses Association, an accredited approver by the American Nurses Credentialing Center's Commission on Accreditation.

Title of Presentation	Length of Presentation	Certification Credits Awarded if given by GA Immunization Program Staff Contact Hours= CH
Adolescent and Adult Immunizations	1 Hour	CH 1.2 Hours
Childhood Immunization Update (Combination review of the immunization schedule and GA requirements for daycare & school attendance)	1 Hour	CH 1.2 Hours
Childhood Immunization Requirements (for WIC and Clerical Personnel)	1 Hour	
Epidemiology & Prevention of Viral Hepatitis From A-E (Contact Hepatitis Program Director at (404) 657-3171)*	3 Hours	CH 3.6 Hours
GA Requirements for School and Day Care Attendance (presentation for health care Providers, day care, and school personnel)	1 Hour	CH 1.0 Hours Day Care certification ECE-2
GRITS (GA Registry of Immunization Transactions and Services) Overview	1 Hour	
GRITS Train-The-Trainer Training	5 Hours	
Perinatal Hepatitis B Prevention (Inservice for Birthing Hospitals) (Contact Hepatitis Program Director at (404) 657-3171)*	1 Hour	
Review Of The Recommended Immunization Schedule	1 Hour	CH 1.2 Hours
Vaccine Administration Techniques (Contact Nurse Consultant (404)-657-3157)*	1 Hour	CH 1.0 Hours
Vaccine Storage & Handling	1 Hour	CH 1.0 Hours

To schedule a training session:

Contact your Georgia Immunization Program Consultant at 404-657-3158

- **Contact the appropriate Coordinator or Consultant**

Georgia Immunization Program Manual
Department of Public Health

Immunization Resources

Training Resources for Cultural Competencies

Monica L. Vargas, Statistical Analyst II
Georgia Refugee Health Program
Tel: 404-679-4919
mlvargas@dhr.state.ga.us

Policy Planning and Compliance Group Limited English Proficient/Sensory Impaired Program
Georgia Department of Human Resources
lepsi@dhr.state.ga.us

Kitty Kelly, Anthropologist
678-839-6455
kittykellyphd@yahoo.com
University of West Georgia

Kathryn A. Kozaitis, Chair
Department of Anthropology
College of Arts and Sciences
Georgia State University
Atlanta, Georgia 30302-3998
Tel.: 404-651-1760
Fax: 404-651-3235
antkxk@langate.gsu.edu

Department of Health and Human Services
Office of Minority Health
Culturally Competent Nursing Care: A Cornerstone of Caring
An online educational program designed specifically for nurses and is accredited by the American Nurses Credentialing Center (AACN)
https://ccnm.thinkculturalhealth.org/default.asp

POST TEST

"How to Protect Your Vaccine Supply"

Please mark one correct answer for each question. Each question counts 10 points.
A passing score is 80%.

1. The type of refrigerator/freezer utilized to store vaccine should be:

   A. Standard refrigerator with separate freezer door and seal
   B. Dormitory type refrigerator with small hanging freezer inside
   C. Dormitory type refrigerator and separate dormitory type freezer

2. Which vaccines go in the freezer?

   A. IPV & DTaP
   B. Td, Hib
   C. Varicella
   D. DT and Pneumococcal

3. The temperature in the refrigerator and freezer should be checked:

   A. Once a day
   B. Twice a day
   C. Once a week
   D. Once a month

4. To stabilize temperature in the refrigerator it is helpful to keep the following in there:

   A. All vaccine diluents
   B. Large plastic containers filled with water
   C. Lunch

5. Vaccine should never be stored in which part of the refrigerator?

   A. Floor
   B. Door
   C. Lower right-hand corner

6. You can tell if the temperature in your freezer does not go above freezing if:
   A. A penny on top of a cup of ice does not become covered with ice.
   B. The cola you put in there at 7:00AM explodes by lunch time.
   C. The freezer needs to be defrosted.

7. When handling varicella vaccine, which of the following are very important?

   A. Keep at 5°F or below and protect it from light.
   B. Dry ice must be present when the vaccine is delivered.
   C. Discard reconstituted vaccine if not used within 30 minutes.
   D. All of the above

8. The expiration date on the vial of vaccine you are holding is today's date. This vaccine is ok to use.

   A. True
   B. False

9. When rotating the vaccine stock,

   A. Use short dated vaccine first.
   B. Use the longest date vaccine first as this is the "freshest."
   C. Rotating stock is not that important as long as you don't use anything outdated.
   D. Always over-order to make sure nothing out dates.

10. You should have a sign on your refrigerator/freezer plug to prevent accidental unplugging.

    A. True
    B. False

POST TEST

Answers

"How to Protect Your Vaccine Supply"

Please mark one correct answer for each question. Each question counts 10 points.
A passing score is 80%.

11. The type of refrigerator/freezer utilized to store vaccine should be:

    A. Standard refrigerator with separate freezer door and seal
    B. Dormitory type refrigerator with small hanging freezer inside
    C. Dormitory type refrigerator and separate dormitory type freezer

12. Which vaccines go in the freezer?

    A. IPV & DTaP
    B. Td, Hib
    C. Varicella
    D. DT and Pneumococcal

13. The temperature in the refrigerator and freezer should be checked:

    A. Once a day
    B. Twice a day
    C. Once a week
    D. Once a month

14. To stabilize temperature in the refrigerator it is helpful to keep the following in there:

    A. All vaccine diluents
    B. Large plastic containers filled with water
    C. Lunch

15. Vaccine should never be stored in which part of the refrigerator?

    A. Floor
    B. Door
    C. Lower right-hand corner

16. You can tell if the temperature in your freezer does not go above freezing if :

    A. A penny on top of a cup of ice does not become covered with ice.
    B. The cola you put in there at 7:00AM explodes by lunch time.
    C. The freezer needs to be defrosted.

17. When handling varicella vaccine, which of the following are very important?

    A. Keep at 5°F or below and protect it from light.
    B. Dry ice must be present when the vaccine is delivered.
    C. Discard reconstituted vaccine if not used within 30 minutes.
    D. All of the above

18. The expiration date on the vial of vaccine you are holding is today's date. This vaccine is ok to use.

    A. True
    B. False

19. When rotating the vaccine stock,

    A. Use short dated vaccine first.
    B. Use the longest date vaccine first as this is the "freshest."
    C. Rotating stock is not that important as long as you don't use anything outdated.
    D. Always over-order to make sure nothing out dates.

20. You should have a sign on your refrigerator/freezer plug to prevent accidental unplugging.

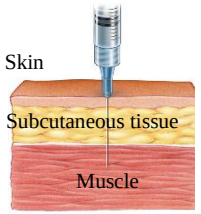
    A. True
    B. False

Administer these vaccines via I.M. (intramuscular) route: DTaP, DT, Td, Tdap, Hib, Hepatitis A, Hepatitis B, Influenza, Pneumococcal Conjugate (PCV), Meningococcal Conjugate (MCV4), and Human Papillomavirus Vaccine (HPV). Administer IPV & Pneumococcal Polysaccharide (PPV) either IM or subQ.

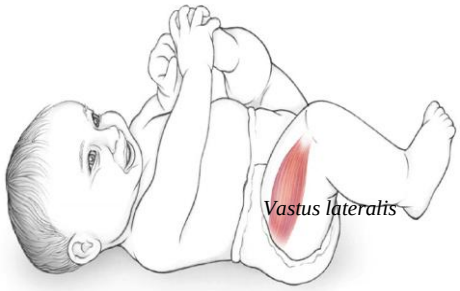
When you administer these vaccines, follow the age recommendations indicated in the current Advisory Committee on Immunization Practices (ACIP) schedules.

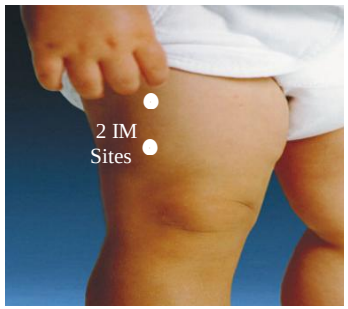
Patient's Age	Site (see illustrations below) **	Needle Size*	Needle Insertion
Infants (birth to 12 months of age)	Vastus lateralis muscle in anterolateral aspect of middle or upper thigh	5/8" (0-28 days of age) 1" needle (1-12 months of age) 22-25 gauge	Use a needle long enough to reach deep into the muscle. Insert needle at an 80° to 90° angle to the skin with a quick thrust. Retain pressure on skin around injection site with thumb and index finger while needle is inserted. The 2006 Red Book (p.21) states the following regarding the need to aspirate. "Aspiration before injection of vaccines or toxoids (i.e., pulling back on the syringe plunger after needle insertion, before injection) is not required because there are no large blood vessels at the preferred injection sites." Multiple injections given in the same extremity should be separated as far as possible (preferably 1" to 1½" with minimum of 1" apart). Multiple vaccines should not be mixed in a single syringe unless specifically licensed and labeled for administering in one syringe.
Toddlers (12 to 36 months of age)	Vastus lateralis muscle preferred until deltoid muscle has developed adequate mass (approximately age 36 months)	5/8" for deltoid 1" needle for vastus lateralis 22-25 gauge	
Toddlers (>36 months of age) **Children and Adults**	Densest portion of deltoid muscle – above armpit and below acromion **For the above vaccines, the gluteus maximus (buttocks) is not a recommended site for any age.	1" to 2" needle 22-25 gauge	

80°-90° angle



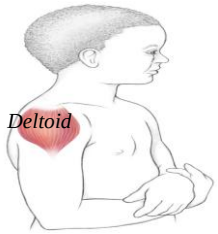
IM Site For Infants and Toddlers (birth to 36 months of age)

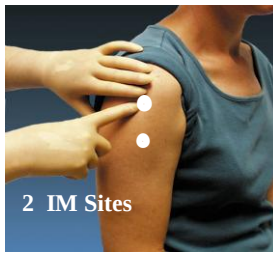




Insert needle at 80°-90° angle into vastus lateralis muscle in anterolateral aspect of middle or upper thigh.

IM Site For Older Toddlers, Children and Adults.





Needle size and site: Decide on the needle size and site of injection based upon each patient's:

- age
- volume of material to be administered
- the size of the muscle
- and the depth below the muscle surface into which the material is to be injected.

Needle size and site: The needle length should depend on the patient's weight:

- 1 1/2'' for Males ≥ 118 kg (260 lbs)
- 1" for Males 60-118 kg (130-260 lbs)
- 1 1/2" for women ≥ 90 kg (200 lbs)
- 1'' for women 60-90 kg (132-198 lbs)

(The Red Book, 2006, American Academy of Pediatrics)

Insert needle at 80°-90° angle into densest portion of deltoid muscle above armpit and below acromion.

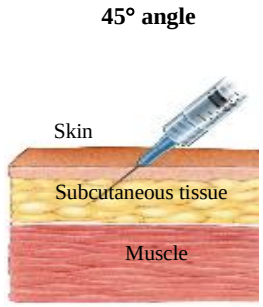
* References: 2006 Red Book, American Academy of Pediatrics, 27th edition; Morbidity and Mortality Weekly Report (MMWR), "General Recommendations on Immunization", December 1, 2006, Vol. 55/No. RR-15

Adapted from the MN and CA Departments of Health Vaccine Administration charts, June 2001. (This information is intended for the education of licensed medical personnel.)

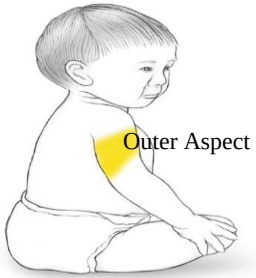
Administer these vaccines via subQ (subcutaneous) route: MMR, Varicella, MMRV, Meningococcal Polysaccharide (MPSV4), and zoster vaccine. Administer IPV & Pneumococcal Polysaccharide (PPV) either subQ or IM.

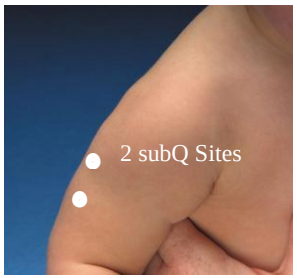
When you administer these vaccines, follow the age recommendations indicated in the current Advisory Committee on Immunization Practices (ACIP) schedules.

Patient's Age	Site (see illustrations below)	Needle Size	Needle Insertion
Infants (birth to 12 months of age) **and** **Toddlers** (12 to 36 months of age)	Fatty area of the thigh or outer aspect of upper arm	5/8" to 3/4" needle 23-25 gauge	Insert needle at 45° angle to the skin. Pinch up on subQ tissue to prevent injection into muscle. The 2006 Red Book (p.21) states the following regarding the need to aspirate: "Aspiration before injection of vaccines or toxoids (i.e., pulling back on the syringe plunger after needle insertion, before injection) is not required because there are no large blood vessels at the preferred injection sites." Multiple injections given in the same extremity should be separated as far as possible (preferably 1" to 1½ " with minimum of 1" apart). Multiple vaccines should not be mixed in a single syringe unless specifically licensed and labeled for administering in one syringe.
Children and Adults	Outer aspect of upper arm	5/8" to 3/4" needle 23-25 gauge	



SubQ Site for Infants and Toddlers (birth to 36 months)





Insert needle at 45° angle into fatty area of anterolateral thigh or outer aspect of upper arm. Make sure you pinch up on subQ tissue to prevent injection into muscle.

SubQ Site for Children and Adults

Insert needle at 45° angle into outer aspect of upper arm or fatty area of the thigh. Make sure you pinch up on subQ tissue to prevent injection into muscle.

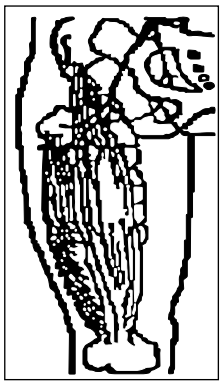
∗ References: 2006 Red Book, American Academy of Pediatrics, 27th edition; Morbidity and Mortality Weekly Report (MMWR), "General Recommendations on Immunization", December 1, 2006, Vol. 55/No. RR-15

Adapted from the MN and CA Departments of Health Vaccine Administration charts, June 2001. (This information is intended for the education of licensed medical personnel.)

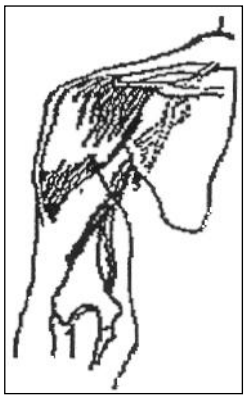
Vaccine Administration Techniques

POST-TEST

1. Indicate the site for (a) an intramuscular, and (b) a subcutaneous immunization on an adult.



2. Please mark the site for an infant or toddler's DTaP immunization.



3. Please indicate above with arrows the angle of the needle used for (a) an intramuscular and (b) a subcutaneous immunization.

4. If the following three vaccines were to be administered simultaneously to an adult, which site and method of immunization would be used for each:

Type of Vaccine	Route of Injection	Site
Influenza	_____	_____
Pneumococcal	_____	_____
Td	_____	_____

5. What factors should be considered when determining the needle size and site for an intramuscular injection?
   a. Patient's age
   b. Volume of material to be administered
   c. Size of the muscle
   d. Depth below muscle surface into which the material is to be injected
   e. All of the above

6. Circle the site which is never recommended for immunizations
   Deltoid Vastus Lateralis
   Anterolateral Thigh Gluteus Maximus

7. Check the pediatric vaccines which may be given to a child on the same visit as a TB skin test:
   __Varicella __DTaP
   __Hib __MMR

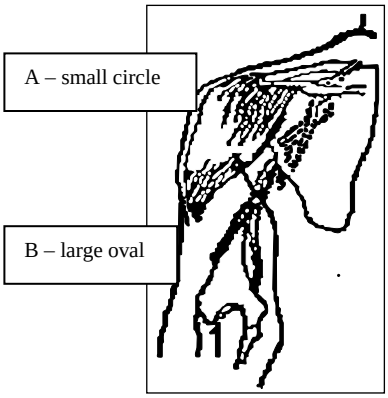
8. Vaccines can be mixed in a single syringe when:
   a. Vaccines are licensed and labeled to be mixed
   b. There is need to decrease the number of injections to be given
   c. Giving all live or all inactivated vaccines.

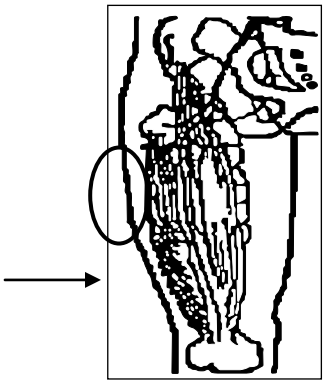
NAME:_____ DATE:_____ SCORE:_____

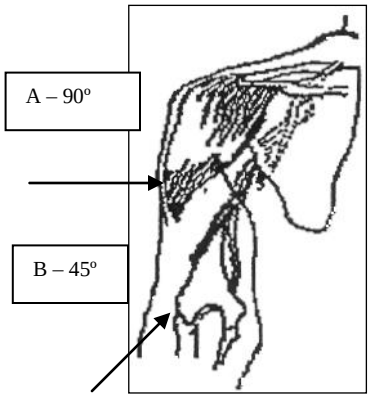
8 Vaccine Administration Techniques

POST-TEST ANSWER KEY

Score 10 points for correct answers to 1a, 1b, 2, 3a and 3b. Score 10 points for completely correct answers to questions 4 through 8. Passing score = 80%







1. Indicate the site for (a) an intramuscular, and (b) a subcutaneous immunization on an adult.
2. Please mark the site for an infant or toddler's DTaP immunization.
3. Please indicate above with arrows the angle of the needle used for (a) an intramuscular and (b) a subcutaneous immunization.

4. If the following three vaccines were to be administered simultaneously to an adult, which site and method of immunization would be used for each:

Type of Vaccine	Route of Injection	Site
Influenza	*Intramuscular*	*Either deltoid**
Pneumococcal	*Either SC or IM*	*SC upper arm; IM deltoid**
Td	*Intramuscular*	*Either deltoid**

****Note: Different arms preferred. Separate sites required***.

5. What factors should be considered when determining the needle size and site for an intramuscular injection?
   a. Patient's age
   b. Volume of material to be administered
   c. Size of the muscle
   d. Depth below muscle surface into which the material is to be injected
   e. All of the above

6. Circle the site which is never recommended for immunizations
   Deltoid Vastus Lateralis
   Anterolateral Thigh Gluteus Maximus

7. Check the pediatric vaccines which may be given to a child on the same visit as a TB skin test:
   _✓_Varicella _✓_DTaP
   _✓_Hib _✓_MMR

8. Vaccines can be mixed in a single syringe when:
   a. Vaccines are licensed and labeled to be mixed
   b. There is need to decrease the number of injections to be given
   c. Giving all live or all inactivated vaccines.

NAME:_____ DATE:_____ SCORE:_____

CLINICAL SKILLS CHECKLIST
Nursing

Clinic site_____ Name and title of person being reviewed_____
Program/type of client visit_____Date_____Time_____Reviewer_____

To assure the quality of client services, this form is used to record the findings from observation of RN's performance. For each line, mark under the number that most closely fits the consistency of the RN's performance with programmatic standards and policies and procedures. Comments must be specific and objective. This form may be used for one observation per age group indicated. A minimum of two observations per age group are required for completion of ***preceptorship****. A minimum of one observation per age group is required annually for peer review.*

RATING CODE: (1) = Unsatisfactory (2)= Needs improvement (3)= Satisfactory (4) = Not applicable

STANDARDS	Infant				Child				Adolescent				Adult			
	1	2	3	4	1	2	3	4	1	2	3	4	1	2	3	4
Nursing																
Interview Process																
1. Cordial with client displaying excellent customer service																
2. Uses simple, explicit immunization terminology																
3. Introduces self and observer																
4. Is wearing a clearly visible ID badge																
5. Listens attentively																
6. Conducts session in language participant speaks/understands																
7. Reviews appropriate immunization-screening questions prior to administration according to district and state policies and procedures (allergies, fever, immunocompetence, previous reactions, blood products, etc.) and counsels client appropriately																
8. Demonstrates appropriate knowledge of true contraindications and precautions when assessing and administering vaccines																
9. Evaluates immunizations from computer and or personal immunization record and accurately determines immunizations needed. Process includes accessing, querying, and reviewing records in GRITS.																
10. Explains to client/parent/caregiver appropriate immunizations needed in a accurate and professional manner																
11. Has client/caregiver review current, appropriately translated, Vaccine Information Statement (VIS) for each vaccine to be administered and answers questions or concerns prior to administering vaccine																

STANDARDS	Infant				Child				Adolescent				Adult			
	1	2	3	4	1	2	3	4	1	2	3	4	1	2	3	4
Administration Techniques																
1. Uses immunization resources appropriately (Georgia Immunization Program Manual, ACIP Manual, District Policies and Procedures (P&P), CDC's Recommendations for Travel, CDC's Epidemiology and Prevention of Vaccine Preventable Diseases, The Red Book , etc.) to assess and administer vaccine indicated for age																
2. Utilizes current recommended schedule and recommendations and district policies and procedures to assess and administer adult and childhood vaccines																
3. Uses accelerated vaccination schedule when appropriate																
4. Verifies that appropriate vaccine for client is being administered.																
5. Checks expiration date and lot number of each vaccine before administering																
6. Follows universal precautions and appropriate hand washing techniques during immunization administration																
7. Appropriately prepares site for administration																
8. Uses appropriate needle length and gauge for type of injection																
9. Uses appropriate route of administration for each vaccine (IM, SQ, PO, ID, intranasal)																
10. Administers vaccine in appropriate site																
11. Uses correct technique for administering injectable vaccines																
12. Uses correct technique for administering oral vaccines																
13. Utilizes appropriate positioning techniques to administer vaccine																
Documentation:																
1. Documents according to P&P, the type of vaccine administered, date of administration, manufacturer, lot number, site, route, nurses' initials, and VIS publication date																
2. Demonstrates knowledge of informed request policy. Reviews current VIS for each vaccine, answers questions, and has client sign appropriate consent																
3. Demonstrates use of VAERS (Vaccine Adverse Event Reporting System) reporting system according to Georgia Immunization Program regulations																
4. Appropriately accounts for vaccine wasted																
5. Accurately documents immunizations administered and next due date on clinic record																
6. Accurately documents next vaccine due and "date next immunization due" on client's personal immunization record																
7. Documents certificates issued in accordance with district P&P																
8. Documents MOGE (Moved or Gone Elsewhere) criteria according to Georgia Immunization Program standards																
9. Follows hepatitis B guidelines according to Georgia Immunization Program recommendations (also correctly determines High Risk or VFC eligibility)																

STANDARDS	Infant				Child				Adolescent				Adult			
	1	2	3	4	1	2	3	4	1	2	3	4	1	2	3	4
Counseling/Education																
1. Informs client/parent of any immunization problem (delinquent immunization status, screening for private provider use/MOGE status)																
2. Schedules follow-up as indicated (return visit coordinated with other clinics, labs, voucher pick-ups, etc.)																
3. Provides appropriate referrals as needed (to private providers, Children First, CMS, etc.)																
4. Provides "After the Vaccines" document (in most appropriate translation) explaining side effects for any vaccine administered																
5. Provides client with appropriate immunization certificate(s) according to the GA laws and rules and regulations for school and day care attendance, and an updated immunization history, including next immunization “due date”																
Computer/Automation																
1. Computer security procedure followed per district policy																
2. Data and/or billing correctly entered																
3. Correct immunization procedure codes, lot numbers, etc. entered correctly according to Georgia Immunization Program standards																
4. Demonstrates knowledge of Clinic Assessment Software Application (CoCASA) criteria and Immunization Programmatic Progress Report (IPPR) contract deliverables																
5. Demonstrates knowledge of completing monthly IPPR report to District Immunization Coordinator per Georgia Immunization Program standards																
Storage and Handling																
1. Demonstrates appropriate Vaccine Storage and Handling techniques according to Georgia Immunization Program standards																
Other (specify)																

SUMMARY

FEEDBACK/STRATEGIZING_____

_____

_____

FOLLOW-UP PLAN_____

_____

Signature of Reviewer:_____ Signature of Clinician:_____
Date:_____ Date:_____

2008 GIP Provider Site Visit Questionnaire
(for Public Health Department Sites)

Please fill out and return to (IPC) at @dhr.state.ga.us
Please save as a Microsoft Word Document using your County name
If you have questions, please contact (IPC) at:

Date:

Facility Name: GIP ID Number: GRITS Org ID:
Address:
City: State: Zip: Telephone: Fax Number:

District: County: Reviewer's (IPC) Name:

Contact Person for Immunization:
Email:

Hours of Operation:	Open	Closed	Open During Lunch Hours (Select One)
Monday	-	-	☐ Yes ☐ No
Tuesday	-	-	☐ Yes ☐ No
Wednesday	-	-	☐ Yes ☐ No
Thursday	-	-	☐ Yes ☐ No
Friday	-	-	☐ Yes ☐ No
Saturday	-	-	☐ Yes ☐ No

Type of Practice:
☒ Public Health Dept Clinic

Specialty Type for Practice:
☒ Multi-specialty ☐ Family Planning or STD/HIV Only ☐ Teens Only

SECTION I. VFC COMPLIANCE

Questions (1-7) should be answered by interviewing the provider.

1. a. What is the vaccine administration fee charged to non-Medicaid VFC eligible children (uninsured, American Indian/Alaska Native, underinsured)?_____
   b. What is the vaccine administration fee charged to adults who receive state-supplied vaccine? _____(Cap for both adults and children = $14.81 per injection)

2. Under what circumstances would a client be referred to another facility for immunization services?
   - ☐ Not applicable, clients are never referred
   - ☐ Vaccine is unavailable
   - ☐ Client is under-insured
   - ☐ Client/parent is unable to pay administration fee
   - ☐ Client/parent is unable to pay office visit fee
   - ☐ Other (specify)

3. Which of the following vaccines are **NOT** routinely recommended for clients in this facility (including adults)?
   - ☐ DTaP
   - ☐ Influenza (during flu season)
   - ☐ Pneumococcal Polysaccharide*
   - ☐ Hepatitis A
   - ☐ Meningococcal Conjugate
   - ☐ Polio
   - ☐ Hepatitis B
   - ☐ MMR
   - ☐ Rotavirus
   - ☐ HIB
   - ☐ MMR-V
   - ☐ Td
   - ☐ Human Papillomavirus
   - ☐ Pneumococcal Conjugate
   - ☐ Tdap
   - ☐ Other:_____
   - ☐ Varicella

   **High-risk adults, adults over age 65 years, and high risk children ≥ 2 years of age.*

4. When does this clinic provide patients with copies of the Vaccine Information Statements (VIS) to keep?
   - ☐ Every time the patient receives a vaccination
   - ☐ When the client receives the first dose of vaccine within a particular series (e.g. 1st dose of DTaP)
   - ☐ Does not provide
   - ☐ Other (specify)_____

5. In order to complete the annual provider profile, how does this clinic determine the number of VFC-eligible patients in this clinic? *Note: "Provider profile" is the number of children (not doses) by age category that the provider expects to immunize within a 12-month period. The VFC Program requires annual updates of this information.*
   - ☐ Use doses administered data
   - ☐ Use benchmarking data
   - ☐ Use Medicaid and billing data
   - ☐ Immunization Information System (GRITS)
   - ☐ Other (please describe):_____

6. When does the clinic/practice screen children for VFC eligibility?
   - ☐ First immunization visit to the office only
   - ☐ Every immunization visit
   - ☐ Does not screen for VFC eligibility
   - ☐ Not applicable, clinic serves 100% VFC eligible children and has appropriate Comprehensive Certification form with up-to-date signature on file.
   - ☐ Other (specify) _____

7. (A) Does this clinic/practice always notify the Immunization Program when publicly purchased vaccine has been involved in a cold chain failure, has expired or been wasted?
   ☐ Yes ☐ No

   (B) Does this clinic/practice always notify the Immunization/VFC Program of short-dated vaccine at least three months prior to the date of expiration so that vaccine may be transferred to another provider?
   ☐ Yes ☐ No

8. When does this clinic prepare vaccine for administration to patient?
☐ Immediately before administration ☐ Other: specify process_____

Questions 9-10 should be answered based on a physical review of clinic's written plan and VISs.

9. Does the clinic have a **written plan** for vaccine management include the following (review for accuracy):

	Yes	No
Designation of primary vaccine coordinator and at least one back-up staff		
Proper vaccine storage and handling		
Vaccine shipping (includes receiving & transport)		
Procedures for vaccine relocation in the event of a power failure or mechanical difficulty or emergency situation (emergency plan)		
Has the emergency plan been reviewed or updated annually or since change in responsible staff?		
Vaccine ordering and reporting (i.e., should be **monthly**)		
Inventory control (e.g., stock rotation)		
Vaccine wastage		

10. Please identify the publication date for each of the VIS currently being used in this clinic/practice and then check the appropriate status for each VIS. *(If not using VISs or using outdated VISs, leave current VISs.*

VACCINE*	VIS VERSION BEING USED IN THIS FACILITY			
	Current	Outdated	None Used	Does Not Administer
DTaP (5/17/07) E & S	☐	☐	☐	☐
Polio (1/1/2000) E & S	☐	☐	☐	☐
MMR (1/15/03) E & S	☐	☐	☐	☐
Hepatitis B (7/18/07) E & S	☐	☐	☐	☐
Varicella (1/10/07) E & S	☐	☐	☐	☐
Hepatitis A (3/21/06) E & S	☐	☐	☐	☐
Hib (12/16/98) E & S	☐	☐	☐	☐
Pneumococcal Conjugate (9/30/02) E & S	☐	☐	☐	☐
Inactivated Influenza (7/16/07) E & S	☐	☐	☐	☐
Live, Intranasal Influenza (10/04/07) E & S	☐	☐	☐	☐
Td (6/10/94) E & S	☐	☐	☐	☐
Adult Pneumococcal Polysaccharide (PPV23) (7/29/97) E & S	☐	☐	☐	☐
Meningococcal Conjugate (MCV) (8/16/07) E & S	☐	☐	☐	☐
Tdap (07/12/06) E & S	☐	☐	☐	☐
Rotavirus (4/12/06) E & S	☐	☐	☐	☐
Human Papillomavirus (2/2/07) E & S	☐	☐	☐	☐
Shingles (9/11/06) E & S	☐	☐	☐	☐
Other _____	☐	☐	☐	☐

VIS website: http://www.cdc.gov/vaccines/pubs/vis/default.htm Current VIS publication dates as of 11/13/07

Questions (11-13) should be answered based on a review of patient charts, electronic medical records, patient log (electronic or manual) which records VFC eligibility status, or GRITS.

11. What is the VFC eligibility screening coverage in this clinic/practice? *(Screening of children for eligibility for VFC or state-supplied vaccine, not immunization coverage rates.)*
    ☐ VFC screening coverage of 100%
    ☐ VFC screening coverage of at least 95%
    ☐ VFC screening coverage of at least 90%
    ☐ VFC screening coverage below 90%

12. What methodology was used to determine VFC eligibility screening coverage during this site visit?
    ☐ CDC Lot Quality Assurance (LQA) Protocol
    (*Review of at least 30 randomly selected records, or ALL records if 30 not available. Records may be client charts or in clinic's information system.*)
    ☐ CoCASA

13. Do all immunization records contain the following documentation required by statute 42 US Code 300aa-25?
    (✓one box per item)

Required Documentation	Yes	No
Name of vaccine given	☐	☐
Date vaccine was given	☐	☐
Date VIS was given	☐	☐
Name of vaccine manufacturer	☐	☐
Lot number	☐	☐
Name and title of person who gave the vaccine	☐	☐
Address of clinic where vaccine was given	☐	☐
Publication date of VIS	☐	☐

SECTION II. Standards for Pediatric & Adolescent Immunization Practices

Vaccine Administrative Policy

1. How does the clinic/practice offer immunization services to patients? (Check all that apply)
   ☐ During well-child visits
   ☐ Immunization-only appointments
   ☐ Walk-in immunizations
   ☐ Dedicated days/times for immunizations
   ☐ Off-site immunizations
   ☐ During other visits such, as STD, FP, WIC or SHAPP
   (*check all that apply*)
   ☐ Other (specify)_____

2. Is an office visit fee charged in addition to any vaccine administration fees for an imm-only visit?
   ☐ Yes ☐ No
   If yes, what is the amount of the office visit fee if immunization is the only service? _____

3. Is a physical exam required before immunizations are given?
   ☐ Yes ☐ No

Assessment of Vaccination Delivery*(Share information re: True Contraindications to Immunization.)*

4. Does the clinic routinely immunize when the client has:

	Yes	No	Situational
A "cold"	☐	☐	☐
Low grade fever (e.g. 100.4°F [38°C] or lower)	☐	☐	☐
Recently been exposed to infectious illness	☐	☐	☐
Mild diarrhea	☐	☐	☐
Convalescing from an acute illness	☐	☐	☐

Effective Communication about Vaccine Benefits and Risks

5. Does the clinic staff know how to obtain foreign-language Vaccine Information Statements (VIS) for patients/families whose first language is not English?
   ☐ Yes ☐ No

Proper Storage and Administration of Vaccines and Documentation of Vaccinations

6. Does the clinic/practice have a copy or have access to a copy of the most recent version of the following documents? (*If no, leave current copy.)*

	Yes	No
Recommended Childhood Immunization Schedule	☐	☐
Revised Standards for Child and Adolescent Immunization Practices	☐	☐
Current Guide to Contraindications to Childhood Vaccines, CDC	☐	☐
Vaccine Management: Recommendations for Handling & Storage of Selected Biologicals	☐	☐
2006 Red Book, AAP **(District)**	☐	☐
Standards for Adult Immunization Practices	☐	☐
Georgia Immunization Program Manual	☐	☐
Epidemiology & Prevention of VPD's (Pink Book) 10th edition, January,2007, CDC	☐	☐
Current ACIP (Advisory Committee of Immunization Practices) Manual	☐	☐
Health District's P&P for Administration of Vaccines	☐	☐
Health District's Policies and Procedures for Administration of Travel Vaccines	☐	☐
Health District's Management of Adverse Drug Reactions	☐	☐
Vaccine Package Inserts	☐	☐
Communicable Diseases in Man; 18th edition, Heymann **(District)**	☐	☐
Surveillance and Reporting of Vaccine Preventable Diseases Manual, CDC (only available online) http://www.cdc.gov/nip/publications/surv-manual/default.htm	☐	☐

7. Are up-to-date, written vaccination protocols accessible at all locations where vaccines are administered?
   ☐ Yes ☐ No (Ask to see a copy.)

8. Who gives immunization injections? (Check all that apply)
   ☐ MD ☐ NP ☐ PA ☐ RN ☐ LPN ☐ MA

9. How do persons who administer vaccines and staff who manage or support vaccine administration receive ongoing education regarding immunization? (Check all that apply.)
   ☐ No ongoing training
   ☐ In-house training by staff at least once a year
   ☐ Distribution of written materials
   ☐ Other (specify) _____
   ☐ In-house training by health dept./professional organization at least once a year
   ☐ Off-site conferences or workshops at least once a year
   ☐ Web-based training or satellite broadcasts

10. Does the clinic document ongoing education regarding immunization for persons who administer vaccines and staff who manage or support vaccine administration?
    ☐ Yes ☐ No

11. Does the clinic simultaneously administer all vaccines for which the client is eligible?
    ☐ Yes ☐ No

12. What size needles are generally used for intramuscular injections? (Check **ONE** only)
    ☐ 5/8 " (inch) ☐ 1 " (inch) ☐ 7/8 " (inch)
    ☐ Depends on age/size ☐ Other (specify)_____

13. Does the clinic pre-fill syringes? (*This does not refer to manufacturer-prefilled syringes*.)
    ☐ Yes ☐ No

14. Does the clinic have VAERS forms and know how to report to VAERS? *(If not, leave copy.)*
    □ Yes □ No

15. Does the clinic require staff who have contact with patients to be immunized or show proof of immunity against the following vaccine-preventable diseases? (Check all that apply)
    □ None required □ Measles/Mumps/Rubella □ Hepatitis B
    □ Hepatitis A □ Varicella □ Influenza
    □ Td/Tdap □ Other (specify)_____

Implementation of Strategies to Improve Vaccination Coverage

16. How does the clinic remind patients of their next appointment? (Check all that apply)
    □ Mail □ Written appointment slip given at last visit
    □ Telephone □ Does not remind patients of next appointment
    □ Verbally at last visit □ Other (specify)_____

17. How does the clinic contact patients who miss their appointments? (Check all that apply)
    □ Mail □ Telephone
    □ Does not contact patients who miss their appointments
    □ Other (specify)_____

18. How does the clinic identify patients if no appointment is made and immunizations are due/overdue? (Check all that apply)
    □ Cannot identify patients due/overdue for immunizations □ Immunization registry
    □ Computer (office-based, not connected to a registry) □ Paper-based "tickler" system or
    □ Other (specify)_____ chart review

19. How frequently does the practice generate reminder/recall notices (or phone calls) to patients who are due/overdue for a vaccination? (Check all that apply)
    □ Quarterly □ Monthly □ No regular schedule
    □ Weekly □ Clinic/practice does not distribute recall notices to patients

20. Is a district- or clinic-based patient record review and vaccination coverage assessment performed at least once a year (check all that apply)?
    □ No □ Yes
    If Yes, □ By clinic/district staff
    □ By immunization/VFC program
    □ By other external reviewer
    When was the most recent district- or clinic-based patient record review and vaccination coverage assessment?
    Date:_____(month/day/year)

21. Does the clinic participate in GRITS?
    □ Yes □ No If yes, what date were shots last entered/uploaded?

22. What community-based approaches does the clinic use to increase immunization coverage?
    (Check all that apply)
    □ No community-based approaches used □ Participates in health fairs
    □ Provides off-site immunization services □ Conducts community-based outreach/education
    □ Partners schools/school nurses □ Other (specify)_____

23. Is the provider using Form 3231 with a Revision Date of 3/2007?
    □ Yes □ No

24. What is the source of the Form 3231 that the provider uses routinely?
    - ☐ Printed from GRITS
    - ☐ Form ordered from GIP and completed manually
    - ☐ Form printed from provider's clinical information system
      If printed from provider's system: Has the form been approved by GIP? ☐ Yes ☐ No
      Does the form display all required components in the correct format? ☐ Yes ☐ No
    - ☐ Other
      Describe_____

SECTION III. Delivery and Services

1. Are immunizations available at this site during **all** regular business hours?
   ☐ YES ☐ NO

2. Are the regular business hours offered as a rigid 8am to 5pm schedule?
   ☐ YES ☐ NO

3. Are immunization services routinely provided after hours?
   ☐ YES ☐ NO

4. Are immunization services routinely provided on weekends?
   ☐ YES ☐ NO ☐ N/A

5. Do you periodically monitor wait time for your walk-in clients?
   ☐ YES ☐ NO ☐ N/A

6. Do you provide counseling, education and materials on how to apply for Medicaid or Peach Care for Kids?
   ☐ YES ☐ NO

7. Are WIC services provided in the same building as Immunization services?
   ☐ YES ☐ NO

8. Are clients receiving Immunization services being referred to WIC services, if needed?
   ☐ YES ☐ NO

9. Are you sharing Immunization past due list with WIC for referral back to Immunization services?
   ☐ YES ☐ NO

10. How are you compensated for vaccine administration? (Check all that apply)
    ☐ Medicare Reimbursement/Medicaid ☐ State Funding
    ☐ Private Pay ☐ Other, please explain

11. Do you charge a vaccine administration fee in addition to the visit fee if seen in other programs (HIV, STD, FP, SHAPP, etc.)?
    ☐ YES ☐ NO

SECTION IV - Initial Training or Orientation – Nursing Staff

1. Does the District provide and document the completion of an orientation training for all RN's and LPN's consistent with required self-study and didactic training listed in the QA tool:

   a. Review all the required references listed under Self-Study ☐ YES ☐ NO

   b. Attend or view and complete and pass post tests of the following CDC Satellite Immunization Training Sessions live or video taped:
   Epidemiology & Prevention of Vaccine Preventable Diseases ☐ YES ☐ NO
   c. View video and complete and pass the post tests for: (must answer YES to one of these)
      i. The Storage and Handling Tool Kit produced by CDC ☐ YES ☐ NO
      http://www2a.cdc.gov/nip/isd/shtoolkit/splash.html
      or
      ii.Attend Vaccine Storage & Handling presentation given by a GA Immunization Program Consultant
      ☐ YES ☐ NO
   d. Vaccine Administration Techniques (must answer YES to one of these)
      i. Attend Vaccine Administration Techniques training session provided by the GA Immunization Program
      ☐ YES ☐ NO
      or
      ii. View the video and pass post-test for Vaccine Administration Techniques developed by CA Department of Health, 2001. ☐ YES ☐ NO
   e. GA Requirements for Attending Day Care & School presentation provided by the GA. Immunization Program Consultant ☐ YES ☐ NO
   f. Tour of immunization clinic, including information about where vaccines emergency cart trays and immunization forms are stored, and proper vaccine storage and handling techniques
      ☐ YES ☐ NO
   g. Informed how to access district immunization coordinator or designated immunization resource person and GA Immunization Program "on call" resource phone line for immunization inquiries
      ☐ YES ☐ NO

2. Does the District provide and document the completion of an immunization preceptorship for all RN's and LPN's consistent with the recommendations outlined in the Georgia Immunization Manual and the Quality Assurance review?
   ☐ YES ☐ NO

3. Does the District provide and document the completion of at least (1) annual immunization training program for all RN's and LPN's consistent with the recommendations outlined in the Georgia Immunization Manual and the Quality Assurance review? ☐ YES ☐ NO

4. Does the district document the self-study of the current year's P&P for the Administration of Vaccines by each nurse?
   ☐ YES ☐ NO

5. Does the District annually review the clinical practice skills of all RN's and LPN's as outlined in the QA review?
   ☐ YES ☐ NO

Training and Education – Support Staff

6. Does the District provide and document the completion of orientation training for ALL staff that supports the provision of Immunization services (i.e., clerical, epidemiological, outreach and other), which is consistent withthe recommendations outlined in the Georgia Immunization Manual and the Quality Assurance review?
   ☐ YES ☐ NO

7. Does the District provide and document the completion of a preceptorship for ALL staff that supports the provision of Immunization services (i.e., clerical, epidemiological, outreach and other), which is consistent with the recommendations outlined in the Georgia Immunization Manual and the Quality Assurance review?
☐ YES ☐ NO

8. Does the District provide and document the completion of annual training programs for ALL staff that support the provision of Immunization services (i.e., clerical, epidemiological, outreach and other), which is consistent with the recommendations outlined in the Georgia Immunization Manual and the Quality Assurance review?
☐ YES ☐ NO

9. Does the District annually review the clinical practice skills of all support staff as outlined in the QA review?
☐ YES ☐ NO

Temperature Dependent Vaccines

10. What type of storage units does this clinic use to store vaccines, including varicella? Check all that apply.
(Dual thermomstats/temperature controls are preferred if using household unit.)

Varicella Vaccine	All Other Vaccines
☐ Stand alone freezer	☐ Stand alone freezer
☐ Stand alone refrigerator	☐ Stand alone refrigerator
☐ Dormitory style refrigerator/freezer	☐ Dormitory style refrigerator/freezer
☐ Combined refrigerator/freezer with separate refrigerator and freezer doors (e.g. household style appliance)	☐ Combined refrigerator/freezer with separate refrigerator and freezer doors (e.g. household style appliance)
☐ Combined refrigerator/freezer with a single door	☐ Combined refrigerator/freezer with a single door
☐ Does not administer vaccines requiring freezer storage	

Questions (11-27) should be answered based on a physical review of clinics' refrigerator(s) and freezer(s).

11. Are working thermometers placed in a central area of each refrigerator and freezer?

	Refrigerator					Freezer				
	#1.	#2.	#3.	#4.	#5.	#1.	#2.	#3.	#4.	#5.
Yes										
Have thermometer but not placed properly										
No thermometer										

12. (A) What type of thermometer is used by the clinic (check all that apply)?

	Refrigerator					Freezer				
	#1.	#2.	#3.	#4.	#5.	#1.	#2.	#3.	#4.	#5.
Standard Fluid Filled										
Continuous Recording										
Min-Max										
Dial										
Digital										
Other (specify)										

12. (B) For each type of thermometer used by the facility, indicate if thermometer is **certified** (check all that apply).

	Refrigerator					**Freezer**				
	#1.	#2.	#3.	#4.	#5.	#1.	#2.	#3	#4	#5
Standard Fluid Filled	**YES___ NO ___**	**YES___ NO ___**	**YES___ NO ___**	**YES___ NO ___**	**YES___ NO ___**	**YES___ NO ___**	**YES___ NO ___**	**YES___ NO ___**	**YES___ NO ___**	**YES___ NO ___**
Continuous Recording	**YES___ NO ___**	**YES___ NO ___**	**YES___ NO ___**	**YES___ NO ___**	**YES___ NO ___**	**YES___ NO ___**	**YES___ NO ___**	**YES___ NO ___**	**YES___ NO ___**	**YES___ NO ___**
Min-Max	**YES___ NO ___**	**YES___ NO ___**	**YES___ NO ___**	**YES___ NO ___**	**YES___ NO ___**	**YES___ NO ___**	**YES___ NO ___**	**YES___ NO ___**	**YES___ NO ___**	**YES___ NO ___**
Dial	**YES___ NO ___**	**YES___ NO ___**	**YES___ NO ___**	**YES___ NO ___**	**YES___ NO ___**	**YES___ NO ___**	**YES___ NO ___**	**YES___ NO ___**	**YES___ NO ___**	**YES___ NO ___**
Digital	**YES___ NO ___**	**YES___ NO ___**	**YES___ NO ___**	**YES___ NO ___**	**YES___ NO ___**	**YES___ NO ___**	**YES___ NO ___**	**YES___ NO ___**	**YES___ NO ___**	**YES___ NO ___**
Other (specify)	**YES___ NO ___**	**YES___ NO ___**	**YES___ NO ___**	**YES___ NO ___**	**YES___ NO ___**	**YES___ NO ___**	**YES___ NO ___**	**YES___ NO ___**	**YES___ NO ___**	**YES___ NO ___**

13. How often are refrigerator and freezer temperatures recorded (check all that apply)?

	Refrigerator					**Freezer**				
	#1.	#2.	#3.	#4.	#5.	#1.	#2.	#3.	#4.	#5.
Once a day										
Less than once a day										
Twice a day										
More than twice a day										

14. Record the highest and lowest temperatures logged in the last 3 months. Please indicate if recordings are Celsius (°C) or Fahrenheit (°F). *(If no log is available for the past 3 months, record the highest and lowest temperatures from available logs.)*

	Refrigerator (2-8°C / 35-46°F)					**Freezer**(-15°C / 5°F or lower)				
	#1.	#2.	#3.	#4.	#5.	#1.	#2.	#3.	#4.	#5.
Lowest	**____'C ____'F**	**____'C ____'F**	**____'C ____'F**	**____'C ____'F**	**____'C ____'F**	**____'C ____'F**	**____'C ____'F**	**____'C ____'F**	**____'C ____'F**	**____'C ____'F**
Highest	**____'C ____'F**	**____'C ____'F**	**____'C ____'F**	**____'C ____'F**	**____'C ____'F**	**____'C ____'F**	**____'C ____'F**	**____'C ____'F**	**____'C ____'F**	**____'C ____'F**
Log available for last 3 months?	**YES NO**	**YES NO**	**YES NO**	**YES NO**	**YES NO**	**YES NO**	**YES NO**	**YES NO**	**YES NO**	**YES NO**

If any of the lowest and/or highest temperatures are out of the recommended range, then **GO TO** question 16. If the temperatures are within the recommended guidelines, **SKIP** to question 19.

15. During past 3 months, how many times were the temperatures outside the recommended range?

	Refrigerator (2-8°C / 35-46°F)					Freezer (-15°C / 5°F or lower)				
	#1.	#2.	#3.	#4.	#5.	#1.	#2.	#3.	#4.	#5.
Below Guidelines										
Above Guidelines										

16. When the temperatures were outside the recommended range, what action did the provider take? *(✓all that apply)*

- ☐ **Adjusted thermostat in refrigerator/freezer**
- ☐ **Measured temperature with different thermometer to check accuracy of original reading**
- ☐ **Moved vaccine to a different refrigerator/freezer maintained at proper temperature**
- ☐ **Called the vaccine manufacturer to determine the potency of the vaccine**
- ☐ **Called the local/state immunization program for assistance**
- ☐ Did not do anything

17. Does the clinic have written documentation of the action taken when the temperatures were outside the recommended range?
☐ Yes ☐ No

18. Record the current temperatures. **(THIS IS NOT OPTIONAL.)**

	Refrigerator (2-8°C / 35-46°F)					Freezer (-15°C / 5°F or lower)				
	#1.	#2.	#3.	#4.	#5.	#1.	#2.	#3.	#4.	#5.
Practice Thermometer	____'C ____'F	____'C ____'F	____'C ____'F	____'C ____'F	____'C ____'F	____'C ____'F	____'C ____'F	____'C ____'F	____'C ____'F	____'C ____'F
Reviewer's Thermometer	____'C ____'F	____'C ____'F	____'C ____'F	____'C ____'F	____'C ____'F	____'C ____'F	____'C ____'F	____'C ____'F	____'C ____'F	____'C ____'F

19. Are current temperatures within the guidelines according to the **reviewer's** thermometer?
(Refrigerator: 2-8°C / 35-46°F, Freezer: -15°C / 5°F or lower)

Refrigerator					Freezer				
#1.	#2.	#3.	#4.	#5.	#1.	#2.	#3.	#4.	#5.
YES	**YES**	**YES**	**YES**	**YES**	**YES**	**YES**	**YES**	**YES**	**YES**
NO	NO	NO	NO	NO	NO	NO	NO	NO	NO

20. Is food stored with vaccines in the refrigerator and freezer?

Refrigerator					Freezer				
#1.	#2.	#3.	#4.	#5.	#1.	#2.	#3.	#4.	#5.
YES	YES	YES	YES	YES	YES	YES	YES	YES	YES
NO	**NO**	**NO**	**NO**	**NO**	**NO**	**NO**	**NO**	**NO**	**NO**

21. Are vaccines stored in the doors of the refrigerator and freezer or in the vegetable bins?

Refrigerator					Freezer				
#1.	#2.	#3.	#4.	#5.	#1.	#2.	#3.	#4.	#5.
YES	YES	YES	YES	YES	YES	YES	YES	YES	YES
NO	**NO**	**NO**	**NO**	**NO**	**NO**	**NO**	**NO**	**NO**	**NO**

22. Is vaccine stored in the middle of the storage unit and stacked with air space between the stacks and side/back of the unit to allow cold air to circulate around the vaccine?
(Discuss placing MMR nearest freezer and HepB nearer bottom of unit.)

Refrigerator					Freezer				
#1.	#2.	#3.	#4.	#5.	#1.	#2.	#3.	#4.	#5.
YES	**YES**	**YES**	**YES**	**YES**	**YES**	**YES**	**YES**	**YES**	**YES**
NO	NO	NO	NO	NO	NO	NO	NO	NO	NO

23. Is there a "DO NOT DISCONNECT" sign on the refrigerator/freezer electrical outlet?

Refrigerator					Freezer				
#1.	#2.	#3.	#4.	#5.	#1.	#2.	#3.	#4.	#5.
YES	**YES**	**YES**	**YES**	**YES**	**YES**	**YES**	**YES**	**YES**	**YES**
NO	NO	NO	NO	NO	NO	NO	NO	NO	NO

24. Is there a "DO NOT DISCONNECT" sign on the circuit breaker?
☐ **Yes** ☐ No ☐ Don't Know

25. Are short-dated vaccines stored in front and used first, rotating stock effectively?

Refrigerator					Freezer				
#1.	#2.	#3.	#4.	#5.	#1.	#2.	#3.	#4.	#5.
YES	**YES**	**YES**	**YES**	**YES**	**YES**	**YES**	**YES**	**YES**	**YES**
NO	NO	NO	NO	NO	NO	NO	NO	NO	NO

26. Can the clinic physically differentiate privately purchased vaccine from publicly purchased vaccine? To answer yes, clinic must be able to demonstrate how this is done.
☐ **Yes, clinic can physically differentiate public vaccine from private vaccine.**
☐ **No, clinic cannot physically differentiate public vaccine from private vaccine.**
☐ Not applicable, clinic has no private stock.
☐ Other method (please specify)_____

*(*Should investigate if this clinic vaccinates fully insured children or provides adult immunizations for employment purposes, such as Hepatitis B for public safety workers. If so, private stock is required.)*

27. Upon checking the provider's vaccine supply, did you find any unreported wasted or expired vaccine?
☐ Yes ☐ **No**

Section V – Non-Refrigerated Vaccine Diluent

1. Are there designated storage areas for non-refrigerated vaccine diluent?
   ☐ **YES** ☐ NO ☐ N/A – stores diluent in refrigerator

2. Are the storage areas for **non-refrigerated** vaccine diluent sufficient to insure proper sanitation, temperature, light, ventilation, moisture control, segregation and **security**?
   ☐ **YES** ☐ NO ☐ N/A – stores diluent in refrigerator

3. Are vaccine diluent stored or separated by **physical barriers** from drug items for external use and/or cleaning supplies?
   ☐ **YES** ☐ NO ☐ N/A – stores diluent in refrigerator

SECTION VI – Record Keeping/Policies and Procedures

1. Is there a backup for the person responsible for vaccine storage and handling?
   ☐ **YES** ☐ NO

2. When state-supplied vaccine arrives
   a. Is it counted? ☐ **YES** ☐ NO
   b. Are the contents of shipment compared with packing slip? ☐ **YES** ☐ NO
   c. Are the contents refrigerated and/or frozen immediately? ☐ **YES** ☐ NO

3. When vaccines are received in the clinic, are the vaccine name, lot number, expiration date, manufacturer and quantity and the name of the person receiving the drugs/vaccines documented in GRITS?
   ☐ **YES** ☐ NO

4. When vaccines are shipped or moved from the clinic, are the details of these vaccine transfers recorded in GRITS and also reported to the State Office?
   ☐ **YES** ☐ NO

5. Are all vaccine records (including eligibility, storage and handling, etc.) kept on file for a minimum of 3 years?
   ☐ **YES** ☐ NO

6. Which of the following is applicable in this district? (check one)
   ☐ **The district utilizes the Georgia Immunization Program manual and the ACIP recommendations manual as the district's official Policies and Procedures for administering vaccines.**
   ☐ The district writes its own Immunization Policies and Procedures?

7. Do the district's Policies and Procedures bear a current review date and physician signature?
   ☐ **YES** ☐ NO

8. If the district writes its own Policies and Procedures for the administration of vaccines, are the **Policies and Procedures** consistent with the Policies and Procedures outlined in the current Georgia Immunization Program manual and ACIP manuals?
   ☐ **YES** ☐ NO ☐ N/A

Questions (9-10) should be answered based on results of the Site Visit.

9. Are corrective actions recommended for this site?

☐ Yes ☐ No (STOP here)

If "yes," complete the Corrective Action Summary. Be sure all "!" issues are addressed.

10. Please indicate your plan for following-up with the site to ensure recommendations were implemented.

☐ Provide technical assistance at time of site visit, no further follow-up is needed
☐ Telephone call
☐ Site Visit
☐ Suspended delivery of vaccine until storage/handling problems resolved
☐ Other:

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Quality Assurance/Quality Improvement (QA/QI) for Public Health Nursing Practice

Guidelines for Customer Satisfaction

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GUIDELINES AND STANDARDS FOR CUSTOMER SATISFACTION SURVEYS

PURPOSE

The purpose of these guidelines is to assist the agency/program in the development of customer satisfaction surveys. A customer satisfaction survey should be conducted at least once annually.

Customer satisfaction surveys inform the customer/client that the agency/program is interested in knowing the customer/client viewpoints on quality and are looking for ways to improve. The three (3) most asked about issues are (1) quality of health care; (2) care accessibility; (3) and respectful and courteous treatment. Customer satisfaction surveys include some of the following client's concerns/issues:

1. Access (telephone calls, appointments, waiting times, etc.)
2. Communication (quality of health information, ability to receive follow-up or returned calls, receiving test results, etc.)
3. Staff (courteous, caring, helpful, etc.)
4. Interaction with provider (exhibit good listening skills, takes the time to answer questions asked, time spent with client, etc.)
5. Privacy/confidentiality
6. Facility safety and cleanliness

SECTION I: MEASURING CUSTOMER SATISFACTION

The focus for using customer satisfaction surveys in performance evaluations and reports is to document how well agencies are progressing toward the goal of service improvement.

Customer satisfaction surveys are a form of feedback from those who have received services. By asking clients about their level of satisfaction on a regular schedule, using the same questions and similar procedures, agencies can produce a set of careful, consistent, quantitative measurements or ratings of their performance at various points in time.

Customer satisfaction surveys properly conducted can economically produce appropriate, valid, reliable measures of performance that would otherwise not be available.

SECTION II: GUIDELINES FOR CUSTOMER SATISFACTION

FIGURE 1:
25 GUIDELINES FOR STATE AGENCY CUSTOMER SATISFACTION SURVEYS

Plan

1. Conduct customer satisfaction surveys for purposes that are clearly stated and designed to improve services to the public.
2. Assign and supervise trained staff to be responsible for the survey.
3. Follow standards, which are scientifically valid methods to reduce errors and potential problems.

Identify Customers

4. Develop a list of those who received services that are the subject of the survey.
5. Select all customers from the list or select a random sample of customers large enough to provide accurate estimates of satisfaction.
6. Try to obtain responses from the greatest possible percentage of those selected and check to ensure that those who respond are representative of customers receiving the services being studied.

Construct and Ask Questions

7. Write clear questions and response options at the appropriate literacy level and language.
8. Allow for various degrees of satisfaction or dissatisfaction.
9. Be neutral throughout.
10. Ask about several aspects of customer satisfaction during a specific time period.
11. Expect only moderate knowledge and recall of specific services.
12. Use efficient, well-established data collection methods.
13. Treat respondents respectfully.
14. Encourage voluntary participation.
15. Confirm that respondents are customers.

Edit and Archive Data

16. Make every attempt to ensure that data are technically error-free.
17. Document any changes to original data.
18. Make it possible for others to independently confirm the results later.

Analyze Data and Results

19. Objectively analyze all relevant, usable customer satisfaction data.
20. Attempt to explain unexpected or unusual results.
21. Interpret results with the appropriate level of precision and express the proper degree of caution about conclusions that can be drawn from results.
22. Ensure that published data are consistent with survey results.
23. Make note of possibly significant problems and limitations.
24. Provide basic descriptive information about how the survey was done.
25. Follow-up with making and/or implementing any recommendations or changes.

SOURCE: American Association for Public Opinion Research. *Code of Professional Ethics and Practices* **(May 2010)**.

PLAN

1. **Conduct customer satisfaction surveys for purposes that are clearly stated and designed to improve services to the public.**

    a Surveys should provide sound direction about how to improve services to clients, possibly by modifying ineffective services or upgrading a method of service delivery.
    b Agency managers must actively support the development of any credible survey and ensure that results are wisely used to improve customer service.
    c Planners must also anticipate the following basic procedures in assigning staff to the survey:
        1) Develop a specific list or "sampling frame" from which to identify and/or sample from the population of customers;
        2) Identify a method to collect;
        3) Develop and pretest a set of standard questions;
        4) Specify how customers will be selected from the customer list;
        5) Devise methods to maximize the percentage of participants who complete the questionnaire;
        6) Ensure that appropriate techniques are used to obtain high quality data from respondents;
        7) Process the data accurately;
        8) Statistically analyze and summarize data;
        9) Explain the results of the analysis; and
        10) Document procedures followed in the course of the survey, data processing, analysis and presentation of results.

NOTE: Some of these steps are best conducted by staff with statistical or survey research training; others amount to administrative duties that clerical staff can complete under routine supervision.

2. **Assign and supervise trained staff to be responsible for the survey.**
    a. Initial planning efforts should include the advice of a consultant or staff member with experience in survey research methods;
    b. Focus of survey and general content of questions should best come from programmatic staff involved with the routine service delivery;
    c. Establish a survey team that is responsible for most of the planning work. The team is responsible for every step in the survey process, including contracting with an outside consultant, if necessary.

3. **Follow standards, which are scientifically valid methods to reduce errors and potential problems**

IDENTIFY CUSTOMERS/CLIENTS

4. Develop a list of those who received services that are the subject of the survey.
    a. Those who received services are known as "customers" or "clients";
    b. Decide which particular groups will be surveyed and propose a study period.

5. Select all customers from the list or select a random sample of customers large enough to provide accurate estimates of satisfaction.
   a. (See Figure 2. Sample Sizes Needed for Populations of Various Sizes)

6. Try to obtain responses from the greatest possible percentage of those selected and check to ensure that those who respond are representative of customers receiving services being studied.
   a. Results are questionable when few respond.
   b. The agency should demonstrate that those who responded are reasonably similar to the customer population as a whole or that data have been adjusted to correct for known differences.
   c. Agencies need to calculate the percentage of respondents and the customer population in various, relevant categories i.e., geographic location, gender, ethnicity and age.

CONSTRUCT AND ASK QUESTIONS

7. Write clear questions and response options in the appropriate literacy level and language.
   a. Avoid emotional or loaded questions;
   b. Avoid boring, dense, clinical, unfriendly or unnecessary questions;
   c. Respondents must understand precisely what is being asked and feel welcome to answer;
   d. Technical assistance from an outside reviewer may help to avoid jargon, stay focused on the topic and phrase questions simply;
   e. Ideally, respondents should be able to complete questionnaires in 25 minutes or less.

8. Allow for various degrees of satisfaction or dissatisfaction.
   a. Important to allow respondents to express a range of opinions from one extreme to the other and also allow the possibility that the respondent may have no opinion or uncertainties of how to respond to certain questions;
   b. Examples of responses that have been shown to be most useful in studies of customer satisfaction are the following: “very satisfied” (5), “satisfied” (4), “no opinion” (3), dissatisfied” (2), “very dissatisfied” (1), and “does not apply” (0)

9. Be neutral throughout.
   a. Customer satisfaction surveys should be designed with care;
   b. Surveys should include a cover letter or other introduction that establishes the need for the questionnaire and its legitimacy by briefly describing the survey’s purpose and stating the purpose to the intended respondent.
   c. Surveys should provide contact person, address and telephone number;
   d. Questionnaire’s title should use clear, neutral, non-specialized language that is likely to interest the respondent in the project;
   e. Graphic images or logos should not suggest a specific opinion or position, and instructions should be carefully worded;

f. Avoid suggestions that the program or agency is already doing a good job, cannot do better without added resources, or have done things already to make customers happy.

10. Ask about several aspects of customer satisfaction during a specific time period.
    a. Not recommended practice to ask customers about their overall satisfaction because the results are not likely to yield much information that agencies can use to improve services.
    b. Questions should be designed to indirectly identify what they must do to increase customers' level of satisfaction;
    c. Questionnaires should include time periods for which the customers are to rate services or products i.e., "within last year", or "last visit"; and time periods should be clear.

11. Expect only moderate knowledge and recall of specific services.
    a. Avoid asking for exact responses, such as how satisfied customers were with a service on a given date;
    b. Surveys should ask customers to assess services soon after use, when memories are fresh;
    c. Surveys may be distributed continually throughout the year or quarterly, yearly or at other intervals;
    d. Avoid asking customers to recall a service from the distant past, this increases the likelihood not remembering the service, confusion with something else or knowledge is insufficient to reliably rate satisfaction.

12. Use efficient, well-established data collection methods.
    a. Phone interviews or mail questionnaires are typically used to collect customer satisfaction information;
    b. Onsite interviews is another collection method;
    c. Survey boxes or Suggestion boxes are another collection method;
    d. Pretest of questionnaire with a small group of customers should be conducted before finalization of the survey;

13. Treat respondents respectfully.
    a. All interviewers must respect respondents' wishes and rights to privacy;
    b. Agencies and/or programs should "never" coerce responses or returns of questionnaires;
    c. Interviewers must "never" discuss who has or has not responded or any other personal information obtained from the survey, especially income or any other sensitive information, except if necessary among the project team (Survey team).
    d. Strive for anonymity. Clients are more likely to answer honestly if they believe their identity is protected.
    e. Inform clients of confidentiality and anonymity;
    f. Give the client the option of providing his/her name for follow-up.
    g. Inform the respondents of what the survey is asking, who will see the results and how the agency/program will use the results.
    h. After the survey, "thank" respondents for their participation.

14. Encourage voluntary participation.
    a. Provide incentives for returning questionnaires;
    b. Incentives help improve response rates;
    c. Voluntary responses can be obtained by designing questionnaires easy to complete, interesting to fill out and worthy of trust;
    d. Personal appeal to customers is helpful. Notification that a questionnaire is forthcoming and that their participation is valuable and important but not officially required.

15. Confirm that respondents are customers.
    a. When asking about multiple services, questionnaires should include as a response option “do not use this service”, or similar wording to avoid influencing nonusers to give satisfaction ratings.

EDIT AND ARCHIVE DATA

16. Make every attempt to ensure that data are technically error-free.
    a. Computers and databases or statistical software are not always necessary in processing customer satisfaction data, but the use of these tools is highly recommended;
    b. Time should be spent editing or cleaning-up survey data before analysis.

17. Document any changes to original data.

18. Make it possible for others to independently confirm the results later.
    a. The following are items needed by others as they later attempt to confirm results:
    b. Completed questionnaires or the equivalent in electronic form;
    c. Cover letter, introductory letter and/or instructions to the respondents;
    d. Tabulations and/or computer output showing results;
    e. Documentation of customer lists, respondent and population characteristics, survey administration, data processing and analysis; and
    f. Reports or memos explaining results.

ANALYZE DATA AND RESULTS

19. Objectively analyze all relevant, usable customer satisfaction data.
    a. After data have been collected, recorded and corrected, it is incumbent on the district and county programs to make full use of the information;
    b. Statistical analysis is not necessary but may be useful and efficient if the number of completed questionnaires is large, or the agency and/or program wishes to know how responses vary among subsets of the sample or customer population.

20. Attempt to explain unexpected or unusual results.
    a. Results that are difficult to explain or unanticipated should be addressed;

b. Questions should be asked (i.e. what might have been done to influence customers' level of satisfaction). External factors that may influence customer satisfaction should also be considered.

21. Interpret results with the appropriate level of precision and express the proper degree of caution about conclusions that can be drawn from results.
    a. Survey results should be interpreted cautiously;
    b. Avoid false impressions about the precision of measurement;
    c. Caution readers about the margin of error, if applicable and other sources of error;
    d. Rounding to the nearest percentage point is better than reporting percentages to several significant digits, which convey a false sense of precision e.g., 88.35% should be rounded to 88%.

22. Ensure that published data are consistent with survey results.
    a. Public trust is essential, therefore agencies and/or programs must avoid any attempt to disguise unfavorable results or draw misleading conclusions from surveys;
    b. It is essential that public reports contain the same data as shown by surveys and the text of reports matches the interpretation of data analysts who typically summarize results in internal memos and technical documents.

23. Make note of possibly significant problems and limitations.

24. Provide basic descriptive information about how the survey was done.
    a. The American Association for Public Opinion Research code of professional ethics and practices include a set of standards for minimal disclosure of essential information about surveys (see Figure 3).

25. Follow-up
    a. Share the results with all staff. Remember the goal is quality, not placing blame;
    b. Act on key items that are causing dissatisfaction. Prioritize and develop an action plan.
    c. Celebrate areas of SUCCESS.

FIGURE 2
SAMPLE SIZES NEEDED FOR POPULATIONS OF VARIOUS SIZES

FOR SAMPLING ERROR OF:			
Population Size	**± 3 % Points**	**± 5% Points**	**± 10 % Points**
100	92	80	49
250	203	152	70
500	341	217	81
750	441	254	85
1,000	516	278	88
2,500	748	333	93
5,000	880	357	94
10,000	964	370	95
25,000	1,023	378	96
50,000	1,045	381	96
100,000	1,056	383	96
1,000,000	1,066	384	96
100,000,000	1,067	384	96

Note: Sample sizes are shown for the 95% confidence level, referring to the likelihood that a sample this size, drawn repeatedly from a population, contains the true population value within the sampling error specified.

Sample sizes are based on the number of completed, usable questionnaires, not the starting sample size. Figures assume maximum variation in responses and should be used if other information is not available.

How to read this table
For a population of 250 whose responses are expected to be evenly split (for example, 50% YES, 50% NO), a sample of 152 is needed for results which carry a sampling error of ± 5% points in 95 of 100 cases.

Reference: Priscilla Salant and Donald Dillman*, How to Conduct Your Own Survey* (New York: John Wiley and Sons, 1994), p**. 55.**

FIGURE 3
American Association for Public Opinion Research Minimal Disclosure Standards

1. Who sponsored the survey, and who conducted it.
2. The exact wording of questions asked, including the text of any preceding instruction or explanation to the interviewer or respondent that might reasonably be expected to affect the response.
3. A definition of the population under study and a description of the sampling frame used to identify this population.
4. A description of the sample selection procedure, giving a clear indication of the method by which the respondents were selected by the researcher, or whether the respondents were entirely self-selected.
5. Size of sample and, if applicable, completion rates and information on eligibility criteria and screening procedures.
6. A discussion of the precision of the findings, including, if appropriate estimates of sampling error, and a description of any weighting or estimating procedure used.
7. Which results are based on parts of the sample, rather than on the total sample.
8. Method, location and dates of data collection.

SOURCE: American Association for Public Opinion Research (2005). *Code of Professional Ethics and Practices*, Retrieved April 22, 2010 from: http://www.aapor.org/AM/Template.cfm?Section=AAPOR_Code&Template=/CM/ContentDisplay.cfm&ContentID=1806.

REFERENCES

1. Guidelines for State Agency Customer Satisfaction Surveys, October 1995, Program Evaluation Division Office of the Legislative Auditor State of Minnesota, St. Paul, MN
2. American Association for Public Opinion Research. *Code of Professional Ethics and Practices*, August 2005
3. White, B., (1999) Measuring Patient Satisfaction: How to do it and why to bother. Available online: http://www.aafp.com/fpm/990100fm/40.html
4. Walpert, B. (2000) Patient Satisfaction Surveys: How to do them right. Available online: http://www.acponline.org/journals/news/apr00/surveys.html
5. Collecting Useful Survey Data. Available online: www.CustomInsight.com or http://customer-satisfaction-surveys.custominsight.com/collecting-data.html (Current).
6. Maximizing Survey Responses. Available online: www.CustomInsight.com or http://customer-satisfaction-surveys.custominsight.com/maximize.html (Current).

:

Customer Satisfaction Survey

Thank you for coming today. We want to give the best service we can. Please take a few moments to fill out this survey. Your comments will help us to improve the services we provide.

Age _____ Male ____ Female ____

Check (✓) the box that best describes how you feel about each of the following:

	Very Satisfied (5) ☺☺☺	**Satisfied (4)** ☺☺	**No Opinion (3)** 😐	**Dissatisfied (2)** ☹☹	**Very Dissatisfied (1)** ☹☹☹	**Does not apply** (0)
Making an appointment was quick and easy.						
My wait time in the office was reasonable.						
The staff members were nice and professional.						
The office hours were convenient for me.						
I understood the information I was given.						
I am happy with the care I received.						
I was given privacy when I received care.						
I was given privacy when financial information was discussed.						
I was given privacy for my entire visit.						
The facility was neat and clean.						

What did you come for today?

How can we serve you better?

Comments:

Encuesta de Satisfacción del Cliente

Gracias por venir el día de hoy. Queremos darle el mejor servicio que podamos. Por favor tome unos cuantos momentos para llenar esta encuesta. Sus comentarios nos ayudarán a mejorar los servicios que nosotros proporcionamos.

Edad _____ Masculino ____ Femenino ____

Marque con (✓) el recuadro que describa mejor cómo se siente acerca de cada uno de los siguientes:

	Muy Satisfecho(a) (5) ☺☺☺	**Satisfecho(a) (4)** ☺☺	**Sin Opinion (3)** 😐	**Insatisfecho(a) (2)** ☹☹	**Muy Insatisfecho(a) (1)** ☹☹☹	**No Aplica** (0)
El hacer una cita fue rápido y fácil.						
Mi tiempo de espera en la oficina fue razonable.						
Los miembros del personal fueron agradables y profesionales.						
Las horas de oficina fueron convenientes para mí.						
Entendí la información que se me dio.						
Estoy feliz con el cuidado que recibí.						
Se me dio privacidad cuando recibí cuidados.						
Se me dio privacidad cuando se discutió información financiera.						
Se me dio privacidad durante toda mi visita.						
El establecimiento estaba aseado y limpio.						

¿A qué vino el día de hoy?

¿Cómo le podemos servir mejor?

Comentarios:

EXAMPLE FOR DISTRICT PROCEDURE ON HOW TO IMPLEMENT STANDARDS FOR CUSTOMER SATISFACTION SURVEYS

Purpose Statement

Each County Health Department will conduct an annual customer satisfaction survey to obtain information about the level of satisfaction of individuals who access services. Surveys will be anonymous and will provide valuable information regarding client satisfaction with health care delivery and the quality of services provided. County Health Departments and the District's Quality Assurance Team will use the information to document progress toward service improvement goals.

Guidelines

It is recommended that the surveys be printed on colored paper in order to help differentiate them from other pieces of information.

Number of Surveys

Number of surveys to be completed by each county annually:

County (or site) 1	100
County (or site) 2	50
County (or site) 3	50
County (or site) 4	50
County (or site) 5	150

Timeline

September

1. County Health Department staff will administer surveys annually in September.

November

2. (Responsible person/title) will submit summary information to the County Nurse Manager and to the Nursing and Clinical Director by November 1.
3. The District Nursing Office will forward a copy of the summaries to the District QA/QI Team by November 15.
4. The QA/QI Team will evaluate the survey summaries using quantitative and qualitative analysis. The QA/QI Team will report recommendations to the Nursing and Clinical Director and each county health department by December 31.
5. Each County Nurse Manager will evaluate their County Health Department's survey using quantitative and qualitative analysis, report results to health department staff and use in developing an action plan to address opportunities for improvement.

Sampling

1. Pre-assigned County Health Department staff will request that all clients receiving services on a specific date(s) in September complete the survey (or other program-required survey). Parent/guardian should complete the survey for clients under the age of 15.
2. The survey process will be complete when the assigned numbers of completed surveys have been collected. (See Number of Surveys above.) If needed, the pre-assigned staff will offer to assist clients by reading the instructions and questions, word for word. They may assist the client in marking the survey per the client's request.

Procedure

1. County Nurse Manager and/or (responsible person/title) will be responsible for assigning staff to:
   a. issue survey,
   b. provide client instruction on survey completion,
   c. gather completed surveys following client visit, and
   d. enter data into the computer database.
2. Before giving the survey to a client, the assigned staff will add any required information to top or surveys (e.g., date, survey number or program). Surveys are to be numbered sequentially; if program information is added, it should indicate the primary service received by client at that visit.
3. Clients will return completed survey to (assigned staff or place).
4. When required number of surveys have been collected, assigned staff will forward them to (responsible person/title) who will assure the data is entered into the computer database.
5. The (responsible person/title) will create and forward a summary report to the District Nursing and Clinical Director and County Nurse Manager by November 1 (see timeline). If any average score is less than 3.0, a narrative plan of corrective action should be attached.

Interpretation of Results

Survey results are based on a Likert scale of 1-5, with "1" being very dissatisfied and "5" being very satisfied. A data entry of "0" denotes client omission on a particular line item. This "0" does not impact survey results. The data detail report will give averages of itemized categories based on level of satisfaction. Items averaging below 3.0 should be addressed and an action plan to address opportunities for improvement should be developed.

Follow-Up

Customer satisfaction survey results are to be shared with County Health Department staff. Questions should be asked (i.e., what may have contributed to or influenced customers' level of satisfaction); external factors that may influence customer satisfaction should also be considered.

Quality Assurance/Quality Improvement (QA/QI) for Public Health Nursing Practice

Peer Review Standards and Measures

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PEER REVIEW STANDARDS AND MEASURES

DEFINITION

Peer review is a process by which clinicians of the same rank, profession or setting critically appraise each other's work against established standards. It includes direct observation of clinical practice, analysis of documentation, clinical chart audits followed by a feedback/strategy planning.

RATIONALE

1. Promotes accountability and improves quality of patient care.
2. Provides information to assess knowledge and skills of protocols/standards for evaluation.
3. Shapes planning for training and development.
4. Stimulates personal and professional development.
5. Challenges clinicians to think critically about their own and their colleagues' practices.
6. Empowers clinical staff.

FREQUENCY

Peer review must be done annually, at a minimum. If areas for improvement have been identified, implement a suitable action plan and reevaluate when completed. There should be a follow-up peer review, based on the individual plan, before the next annual review.

PEER REVIEWER SELECTION

Peer reviewers should be selected based on their experience, willingness to participate, skillfulness and knowledge of standards. Peer reviewers should be trained and supported in the process of peer review. There should be more than one designated peer reviewer for each clinic.

CHARACTERISTICS OF A PEER REVIEWER

1. Objective and fair
2. Resourceful/knowledgeable
3. Effective communicator
4. Supportive
5. Respectful
6. Possesses good listening skills
7. Patient

COMPONENTS OF PEER REVIEW

There are three major components of peer review; observation, feedback and strategizing. Observing the work of the clinician gives the peer reviewer genuine and detailed information needed to direct and support the clinician's skills. Feedback and strategizing creates an interactive environment in which skill enhancement develops out of the clinician's hearing the peer reviewer's reactions and perspective. These methods aid the clinician in creating his/her own solutions for improving performance with the support of the peer reviewer. The peer reviewer should make sure that the clinician receives additional instructions and training in clinical areas where competency was lacking. This should be done in a timely manner.

OBSERVATION

1. Definition:
   Observation is witnessing an activity/interaction to gather direct information about what transpired. Expectations must be developed for technical skills as well as professional behavior during observation.

2. Steps to setting up initial expectations:
   a. Negotiate the specifics of the observation (schedule, which clients, etc.).
   b. Give the clinician as much control as possible over the experience.
   c. Clarify the purpose of observation (may be used for assessment of competency, part of annual performance evaluation, professional development and as contribution to a learning environment).
   d. Ensure that clinician knows standards and tools to be used.
   e. Specify arrangements for feedback/strategizing, minimizing the time lapse between observation and feedback/strategizing sessions.
   f. Provide opportunity for clinician to express anxieties, expectations and needs.
   g. Establish with and by whom information will be shared.

3. Observation Logistics:
   a. Strategize with clinician on how client's permission and cooperation can be obtained.
   b. Strategize with clinician on how client's anxieties can be addressed.
   c. Plan with the clinician the physical arrangement for seating, introduction, etc.

4. Peer Reviewer's Behavior during Observation:
   a. Preplan roles and communication.
   b. Plan ways to minimize impact of peer reviewer's presence, and to withdraw if necessary.
   c. Consider mechanisms for intervention (reviewer is to actively intervene during harmful/potentially unsafe practice).
   d. Minimize note-taking; focus on the positive.

FEEDBACK

1. Definition:
   Feedback is the review/discussion between the clinician and peer reviewer for the purpose of reinforcing strengths and identifying areas of weakness. Effective communication is the key to feedback.

2. When Giving Feedback:
   a. Provide feedback in a confidential setting.
   b. Respond objectively, not personally.
   c. Ask for the clinician's self-assessment first (e.g.," How do you feel it went?").
   d. Focus on the positive.
   e. When giving critical feedback:

1) If feedback is overwhelmingly negative, chose to focus on one or two priorities.
2) Use “I” in place of “you” when giving constructive criticism.
3) Do not link positive feedback with “but” or “however”.
4) Be aware of the other person’s limits.
5) Describe the behavior specifically, without judgment.
6) Describe your own reactions; do not blame or excuse the clinician.
7) Talk about things the clinician can do something about, not about things he/she has no control over.

f. Check to ensure understanding.
g. Invite feedback from the clinician.
h. Never express anger in a peer review session.

3. When Receiving Feedback:
   a. Be inquisitive, not defensive.
   b. React objectively, not personally.
   c. Check to ensure understanding.
   d. Never express anger in a peer review session.

STRATEGIZING

1. Definition:
   Strategizing is the cooperative development of approaches for addressing needs and solving problems

2. When Strategizing:
   a. Mutually decide which areas to work on.
   b. Discuss the rationale for alternative approaches.
   c. Ask strategic questions to stimulate clinician to think of ways to support or increase his/her skills or foster change.
   d. Discuss the benefits of changing behavior.
   e. Provide additional instruction/training/counseling to a clinician who has not shown competency in a clinical area.
   f. Invite clinician to talk about session
   g. Offer support by monitoring on a regular basis.
   h. Reinforce positive changes. Look for observable, measurable changes.
   i. Always end on positive note. Peer should leave feeling empowered and supported.

PEER REVIEW TOOL FOR THE ADVANCED PRACTICE REGISTERED NURSE IN PUBLIC HEALTH

Medical Record # _____ **APRN** _____

Reviewer _____ **Date** _____

STANDARDS	Yes	No	Partial	N/A
Clinical Records Documentation				
1. Record is legible.				
2. Entries are dated, signed and indicate title.				
3. Signature must include APRN who ordered the drug.				
Assessment				
4. History is relevant.				
5. Physical exam based on history and age.				
Diagnosis				
6. Assessment/diagnosis is appropriate and based on history, physical exam and clinical findings.				
7. Health risks and needs are identified.				
Plan				
8. Plan is prioritized according to chief complaint, history and physical examination.				
9. Appropriate diagnostic tests are ordered.				
10. Diagnostic tests results are addressed.				
11. Appropriate pharmacological treatments are ordered.				
12. Non-pharmacologic treatments are identified.				
13. Formulates/documents patient education.				
14. Consultations/referrals are made when appropriate.				
15. Follow-up interval is appropriate.				
16. Health care goals and outcomes are documented.				

STANDARDS	Yes	No	Partial	N/A
Legal Requirements of Nurse Protocol Agreements				
17. Nurse Protocol Agreement defines the scope of practice for the APRNs and the specific county and district location.				
18. Nurse Protocol Agreement specifies parameters under which delegated acts may be performed. Therefore, the written agreement must specify the medications that may be ordered to treat and manage acute and chronic health conditions. These medications may be included in specified classes of drugs (e.g., Beta blocker) NOTE: A statement which excludes controlled substances should be included in the APRNs' Agreement.				
19. Nurse Protocol Agreement specifies the text(s), written guidelines, and or other reference documents, which will be used by the APRN relative to his/her scope of practice.				
20. Nurse Protocol Agreement specifies conditions that warrant physician consultation or referral.				
21. Nurse Protocol Agreement specifies how services will be documented, including what forms will be used and how follow-up to referrals will be documented.				
22. Nurse Protocol Agreement is signed and dated by each APRN using these protocols and each delegating physician.				
23. Nurse Protocol Agreement is reviewed at least annually and re-dated appropriately.				
24. Nurse Protocol Agreement includes a schedule for quarterly review of patient records by the delegating physician.				

EVALUATION OF THE PEER REVIEW PROCESS BY THE APRN

Date: _____ Name of Peer Reviewer: _____

Name of APRN Reviewed: _____

Instructions: This is an optional form to be completed by the APRN who is reviewed by a peer. Please rate the characteristics of your peer reviewer using the Likert Scale below and then answer the following questions. We appreciate your time in completing the evaluation.
This completed form should be given to your District Quality Assurance/Quality Improvement Coordinator.

	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
1. Objective and Fair	1	2	3	4	5
2. Resourceful/knowledgeable	1	2	3	4	5
3. Communicated effectively	1	2	3	4	5
4. Supportive	1	2	3	4	5
5. Respectful	1	2	3	4	5
6. Listened to my comments/concerns	1	2	3	4	5
7. Patient	1	2	3	4	5
8. Demonstrated understanding of the clinician role	1	2	3	4	5

Did you receive information from the peer review about your performance that you found helpful? ___ Yes ___ No

Did the peer reviewer suggest resources to you that will aid in improving your job performance? ___ Yes ___ No

What aspects of the peer review do you feel will benefit your job performance?

_____

_____

What were the strengths of the peer reviewer?

Please make any suggestions for improvement in the evaluation approach of the peer reviewer.

REFERENCES

1. Andrews, Jeanette, et. al., “Attaining Role Confirmation in Nurse Practitioner Practice,” *Clinical Excellence for Nurse Practitioners*, Vol. 3, No. 5, 1999, pp. 302-310.
2. Smith, Maureen A., et. al., “Peer Review of the Quality of Care: Reliability and Sources of Variability for Outcome and Process Assessments,” *JAMA*, Vol. 278, No. 19, November 19, 1997, pp. 1573-1578.
3. Briggs, Linda A., et. al., “Peer Review for Advanced Practice Nurses: What Does It Really Mean?” *AACN Clinical Issues*, Vol. 16, No. 1, January-March 2005, pp. 3-15.
4. John-Mazza, Lorinda, “Pearls for Practice - Advanced Practice Peer Review: Setting New Standards,” *Journal of the American Academy of Nurse Practitioners*, Vol. 9, No. 12, December 1997, pp. 569-573.
5. Nurse Protocols for Registered Professional Nurses in Public Health for 2010, Department of Public Health, Office of Nursing Section, November 2009.

PEER REVIEW STANDARDS AND MEASURES FOR INTERPRETERS

DEFINITION

Peer review is a process by which interpreters of the same rank appraise each other's work against established standards. It includes direct observation of medical interpretation in clinical practice followed by a feedback/strategizing session.

RATIONALE

1. Promotes accountability and improves quality of client care.
2. Provides information to assess knowledge and skills of standards for evaluation.
3. Shapes planning for training and development.
4. Stimulates personal and professional development.
5. Challenges interpreters to think critically about their own and their colleague's practices.
6. Empower interpreters.

FREQUENCY

Peer review must be done annually, at a minimum. If areas for improvement have been identified, implement a suitable action plan and reevaluate when completed. There should be a follow-up peer review, based on the individual plan, before the next annual review.

CHARACTERISTICS OF A PEER REVIEWER

1. Objective and fair
2. Knowledgeable
3. Effective communicator
4. Supportive
5. Respectful
6. Possesses good listening skills
7. Patient

COMPONENTS OF PEER REVIEW

There are three major components of peer review: observation, feedback and strategizing. Observing the work of the interpreter gives the peer reviewer genuine and detailed information needed to direct and support the interpreter's skills. Feedback and strategizing creates an interactive environment in which skill enhancement develops out of the interpreter hearing the peer reviewer's reactions and perspective. These methods aid in the interpreter creating his/her own solutions for improving performance with the support of the peer reviewer. The peer reviewer should make sure that the interpreter receives additional instructions and training in the area or areas of which competency was lacking and should be done in a timely manner.

OBSERVATION

1. Definition:
   Observation is witnessing an activity/interaction to gather direct information about what transpired. Expectation are based on the Bridging the Gap technical skills as well as professional behavior during observation.

2. Steps to setting up initial expectations:
   a. Negotiate the specifics of the observation (schedule, which clients etc.).
   b. Give the interpreter as much control as possible over the experience.
   c. Clarify the purpose of observation (may be used for assessment of competency, part of annual performance evaluation, professional development as contribution to a learning environment).
   d. Ensure that interpreter knows standards to be used.
   e. Specify arrangements for feedback/strategizing, minimizing the time lapse between observation and feedback/strategizing sessions.
   f. Provide opportunity for interpreter to express anxieties, expectations and needs.
   g. Establish with and by whom information will be shared. E.g. Interpreters supervisor.

3. Observation Logistics:
   a. Arrange with interpreter on how client's permission and cooperation can be obtained.
   b. Strategize with interpreter on how client's anxieties can be addressed.
   c. Plan with the interpreter the physical arrangement for seating, introduction, etc.

4. Peer Reviewer's Behavior during Observation:
   a. Plan ways to minimize impact of peer reviewer's presence, and to withdraw if necessary.
   b. Consider mechanisms for intervention (reviewer is to actively intervene during potentially unsafe interpretation).
   c. Minimize note-taking; focus on the positive.

FEEDBACK

1. Definition:
   Feedback is the review/discussion between the interpreter and the peer reviewer for the purpose of reinforcing strength and identifying areas of weakness.
   Effective communication is the key to feedback.

2. When Giving Feedback:
   a. Provide feedback in a confidential setting.
   b. Respond objectively, not personally

c. Ask for the interpreter's self-assessment first (e.g., "How do you feel it went?").
d. Focus on the positive.
e. When giving critical feedback:
    1) If feedback is overwhelmingly negative, chose to focus on one or two priorities.
    2) Use "I" in place of "you" when giving constructive criticism.
    3) Do not link positive feedback with "but" or "however".
    4) Describe the behavior specifically, without judgment.
    5) Describe your own reactions; do not blame or excuse the interpreter.
    6) Talk about things the interpreter can do something about, not about things he/she has no control over.
f. Check to ensure understanding.
g. Invite feedback from the interpreter.
h. Never express anger in a peer review session.

3. When Receiving Feedback:
    a. Be inquisitive, not defensive.
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    c. Ask questions to stimulate interpreter to think of ways to support or increase his/her skills or foster change.
    d. Discuss the benefits of changing behavior.
    e. Provide additional instruction/counseling to an interpreter who has not shown competency.
    f. Invite interpreter to talk about session.
    g. Offer support by monitoring on a regular basis
    h. Reinforce positive changes. Look for observable measurable changes.
    i. Always end on a positive note. Peer should leave feeling empowered and supported.

DISTRICT:	**Date:**				**Time:**
Peer Review for Interpreters					
Interpreter Name:	**Peer review by:**				
# 1 Satisfactory # 2 Needs some Improvement #3 Unsatisfactory #4 Not Applicable					
	1	**2**	**3**	**4**	**Comments**
Clean, neat, and appropriate (hair, dress, nails & shoes).					
Wearing a clearly visible state I.D. badge.					
Cordially greets clients.					
Pre-session with client (Defines role of interpreter to client at the beginning of the encounter).					
Positions self in back of or to the side of the client.					
Pre-session with provider.					
Interprets everything spoken by the provider and client exactly as it is said nothing added, nothing omitted and nothing changed.					
Accuracy of interpretation.					
Completeness of interpretation.					
Conveying cultural context.					
Non-judgmental attitude.					
Intervenes appropriately (transparent/third person).					
Identifies and helps the provider understand any cultural issues or needs that may facilitate proper care and instruction.					
Identifies and helps the client understand any area of need that may facilitate proper understanding.					
Clarifies the information (verified the translation).					
Asks provider or client to repeat or restate to clarify any misunderstandings.					
Asks client to repeat instruction at the end of the visit.					
Assists client with check out and follow-up as necessary.					
Uses Written Language aids as needed.					
Demonstrates appropriate interpersonal skills.					

DISTRICT:	**Date:**				**Time:**
Peer Review for Interpreters					
Interpreter Name:	**Peer review by:**				
# 1 Satisfactory # 2 Needs some Improvement #3 Unsatisfactory #4 Not Applicable					
	1	**2**	**3**	**4**	**Comments**
Reviewer should comment on the interpreter's interpersonal skills demonstrated during any part(s) of the interaction with the client. (e.g. instilled trust, caring, attentive).					
Professional (punctual, prepared, respectful and courteous).					
Other: (Specify)					
Feedback:					
Signature of Reviewer: _____ Signature of Interpreter:_____					

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Quality Assurance/Quality Improvement (QA/QI) for Public Health Nursing Practice

Clinical Record Documentation Standards

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CLINICAL RECORD DOCUMENTATION STANDARDS

1. Contents of a clinical record must meet all regulatory, accrediting and professional organization standards. Common requirements specific to nursing documentation include, but are not limited to:
   a. The nursing assessment and care provided;
   b. Informed consent for any/all procedures;
   c. Teaching provided either to the client directly or to his/her family; and
   d. Response and reaction to teaching.

2. Determine and assure adequate security measures for the entire documentation system, electronic and/or paper.

3. Record the client's name on every page.

4. Record the date and time on all entries.

5. Sign every entry with full name and initials of professional and educational titles (e.g., RN, APRN, FNP).

6. Entries by students, interns, and residents should indicate title (e.g., SN: Student Nurse) and be countersigned by the licensed professional supervising their training.

7. Make sequential entries, only on approved forms and in approved locations on the client's record.

8. Make all entries permanent. For handwritten entries, use only blue or black non-erasable ink. Do not alter the character of a record with “white-out”, highlights, scratchings or other markings. Any change in character or altered look in any of the documentation should never occur in a client’s medical record.

9. Do not attempt to erase, obliterate or “white-out” a handwritten error. If errors are made, write "error" and initial/date the line.

10. Assure that entries are legible, with no blank spaces left on a line or in any area of documentation. Draw a line through blank spaces to the end of a line, or use diagonal lines to mark through an area. (In a lawsuit, an effective case may be made for a sloppy record to suggest sloppy care).

11. Use only standard, approved or accepted list of abbreviations, acronyms, symbols and dose designations as outlined in the current policy on standard abbreviations (See copies of policy and standardized list in the current Public Health Nursing Policies and Practice Guidelines Manual).

12. Write entries specifically and completely, using objective data from one's own observation, assessment and treatment of the client. Avoid language that is ambiguous, vague or speculative.

13. Make all entries promptly and within appropriate time periods, given the client's condition and diagnosis.

14. Late entries or entries made at a day/time other than when care was provided should be clearly indicated.

15. Write objectively and with extreme care when making entries that describe an adverse episode and subsequent interventions.

16. Specify the client's approval when family members or non-healthcare professionals serve as translators or when documenting informed consent (including signed consent forms).

17. Document all counseling and education given to the client. Be specific, including client's reactions and responses.

18. Specify when a client fails to comply with recommended self-care regimen or refuses to accept recommended diagnostics and/or treatment.

19. Record the date, time and content of all telephone communications. If messages are left for a client, document the name/relationship of the person taking the message.

20. Assure that entries of verbal orders are signed by the order-giver within the time frame established by organizational policy.

21. To assure continuity of care for clients, all clinical health information pertaining to an individual client should be stored in one clinical record, which includes clinical data from any single service, encounter, and/or program.

22. Use appropriate Current Procedural Terminology (CPT) codes for maximum reimbursement.

SPECIFIC TO ELECTRONIC RECORDS

1. Only one service provider with his/her own (individual) password should close an entry in a client’s record on the computer (electronic record). Once the documentation is locked, the primary record can not be changed or altered. Any additions should be entered as a supplemental entry or as an addendum in the electronic “Progress Notes”.

2. All entries in the electronic record should document the full name and initials of the professional title of the person making the entry (e.g., RN, LPN). If the electronic record and/or “Progress Note” is printed out, the person making the entry must sign his/her complete signature and title on the printed hard copy.

3. For the purpose of periodic chart review, the electronic record may be printed. Since this record must be destroyed after the review process is completed, the record does not

have to be signed by the provider. Document in the "Progress Note" following completion of this chart review that the copies of e-charting records have been destroyed.

4. If a client requests a Release of Information (ROI), the district must provide the client with an electronic copy of the requested information and a copy of the printed, signed copy from the client's medical record. There should not be any documentation discrepancies between the two systems.

REFERENCES

1. Joseph, Eric D. and Webster, Nancy E, *The Record that Serves and Protects*, 1st ed., Care Education Group, Inc., 1999.
2. Missouri State Health Department, "Documentation, General Documentation Guidelines", <www.health.state.mo.us/Publications/300-25.html>.
3. Barry Herrin, J.D., telephone conversation, recorded by Argartha Russell, RN, MSA, CPHQ, September 13, 2000.
4. “Guidelines and Legal Principles for Clinical Record Documentation in Public Health Nursing”, Georgia Department of Public Health, Office of Nursing, (DVD), 2008.
5. “Principles for Documentation,” American Nursing Association, Silver Spring, 2005.
6. Georgia Department of Public Health, Division of Medical Assistance, October 1, 2007.
7. Medicaid Policy on Documentation – Policies and Procedures for Physician Services.

Quality Assurance/Quality Improvement (QA/QI) for Public Health Nursing Practice

Record Review Principles

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CLINICAL RECORD REVIEW PRINCIPLES

1. Clinical record reviews can serve the following purposes:
   a. To determine if services were provided in accordance with quality program standards, policies, procedures, best practices and nurse protocols;
   b. To determine the appropriateness of diagnoses, problem identification, treatment, and plan of care;
   c. To assess completeness of documentation;
   d. To assess outcomes; and
   e. To determine adherences to documentation standards.

2. Record reviews are multi-level and may be performed by an individual or a committee:
   a. Routine reviews should be a continuous process at each clinic site, at least every six months.
   b. Periodic reviews may be part of a district-wide quality assurance process.
   c. Programmatic reviews are done for all of the above purposes and to meet funding-source requirements. These are done by state or district staff.

3. Reviewed records should be representative of clients seen (e.g., age, race, sex, reason for visit). Appropriate samples may be selected using daily clinic logs, computer-generated lists or a Random Digit Table.

4. The use of tools for conducting record reviews is optional. The attached Generic Record Review tool is one option. A district/county may use a local tool.

5. Post-review feedback (i.e., exit interview) should be conducted with appropriate staff as soon as possible. This should include discussion of areas of excellence, opportunities for improvement and a plan of action. A written summary should follow in a timely manner.

6. Record reviews of nursing practice under nurse protocol (of RNs and APRNs) by the delegating physician are to be conducted at least quarterly, beginning April 2007.

CLINICAL RECORD REVIEW PRINCIPLES

Health Dept _____ **Date Reviewed**_____ **Provider** _____

Type of Record: _____ **Chart/ID Number:**_____ **DOB:**_____

	Y	N	INC.	N/A	COMMENTS:
SUBJECTIVE					
A. Reason for visit					
B. History of present illness					
C. History					
1. Family					
2. Social					
a. Sexual					
b. Smoking					
c. Street Drugs/ Alcohol					
d. Dietary and Exercise					
e. Occupation					
3. Past Medical					
a. Chronic illnesses					
b. Childhood diseases					
c. Immunizations					
d. Gynecologic Reproductive					
D. Allergies					
E. Medications					
F. Review of Systems					
OBJECTIVE					
A. Vital signs					
B. Height & weight					
C. Physical/exam complete, as indicated					
D. Findings clearly described					
E. Results of laboratory & diagnostic tests					
F. Developmental assessment done					
ASSESSMENT					
A. Diagnosis(es) correlates with history, exams, lab & diagnostics findings					
B. Identified problems recorded on problem list					
PLAN					
A. Education/Counseling documented					
B. Treatment correlates with diagnostic studies result					
C. Appropriate referrals made					
D. Follow-up plans included					

EVALUATION	Y	N	INC.	N/A	COMMENTS:
A. Progress notes/flow sheets reflect action taken for each active problem					
B. Documented referral and/or follow-up as indicated with closure of resolved problems					
C. Appropriate consent/ release forms obtained					
D. Appropriate signatures/ titles recorded.					
E. Desired clinical outcomes achieved, or plan of care was revised.					
F. Utilizes standard abbreviations, acronyms, symbols and dosage designations as adopted by the Health District and as required by the State Standard Abbreviations Policy.					
G. Produces appropriate documentation: 1. Medical records are thoroughly completed. 2. Writing is legible. 3. Medical record is signed. 4. Signed consent forms are included with record. 5. Other: (specify) See Tab 8 – Clinical Record Documentation Standards.					

Signature of Reviewer _____

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Quality Assurance/Quality Improvement (QA/QI) for Public Health Nursing Practice

Clinical Operations Standards and Measures

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CLINIC OPERATIONS STANDARDS AND MEASURES

Assuring quality of all public health clinic operations should be a dynamic and ongoing process with the following components:

1. Written quality assurance standards for all aspects of clinic operations.

2. Criteria and tools to measure standards.

3. Yearly review of all clinic operations to evaluate progress towards meeting standards and to identify areas needing improvement.

4. Applications of principles of continuous improvement.

The Standards for Clinic Operations on the following pages provide guidelines for the quality assurance review process. They were adapted from the Sexually Transmitted Disease Clinical Practice Guidelines published by the Centers for Disease Control and Prevention. They are appropriate for either an integrated service or specialty clinic setting.

The *Clinic Operations Review Tool* (on page 5) provides an outline for gathering pertinent information for each review category. This information should be used to rate each aspect of the review categories using the following terms:

Acceptable	Meets Standards
Needs Improvement/ Conditional	Does not meet some standards. This assessment is accompanied by an explanation of the observed deficiency(s) and recommendation for improvement.
Not Acceptable	Does not meet standards. This assessment is accompanied by an explanation of the observed deficiency(s) and recommendation for improvement.
Not Evaluated	The reviewers either could not review this aspect or were unable to make sufficient in-depth observations to justify a rating or recommendations.

STANDARDS FOR CLINIC OPERATIONS

ACCESSIBILITY OF SITE AND SERVICES

1. Clinic hours are flexible to meet the needs of the working community, such as extended hours, weekends, evenings, etc.
2. Clinic hours of operation are adequate for the number of requests for services.
3. Clinic is accessible to available public transportation.
4. Clinic telephone number and address is easy to locate in the telephone directory.
5. Clinic service fees are on a sliding fee scale and prominently displayed.
6. Clinic policy does not deny service because of inability to pay.
7. Clinic displays poster regarding non-discrimination policy.
8. Clinic meets the American Disabilities Act (ADA) requirements.
9. Clinic has plans for oral and/or written interpretation for clients who do not speak English as their primary language.
10. Clinic displays and complies with Health Insurance Portability and Accountability Act (HIPAA) policies.

CLINIC ENVIRONMENT

1. Waiting areas should be clean with adequate seating.
2. Education pamphlets and information regarding services should be readily available, including translated versions as appropriate for setting.
3. Examination rooms should be clean, private and adequately equipped.

CLIENT REGISTRATION

1. Registration personnel should gather only demographic and financial information from clients in order to verify financial eligibility.
2. Clients should be registered in an efficient manner with minimal time (less than 30 minutes) between registration and face-to-face contact with a health care provider.
3. Confidentiality and privacy should be assured.
4. Clinic staff should be trained in cultural diversity.

CLINIC FLOW

1. Clinician coverage should be available to allow for a combined appointment and walk-in system.

2. Clinic flow is designed so that client assessment points/stops are kept to a minimum (3 or less).

3. A fast-track system should be used to handle acute care problems.

CLINICAL RECORDS

1. Clinical records will contain sufficient clinical information to allow for prompt evaluation and interpretation of assessment and clinical findings.
2. Clinical records will be stored in files that are secure and inaccessible to unauthorized persons.
3. Electronic clinical records will have rigorous access protection procedures and a back-up filing process.
4. Clinic will have a written procedure for purging medical records.

CLINIC MANAGEMENT

1. Job qualifications for clinic staff should include specific clinical and/or personnel management skills.

2. Job duties of clinic management staff include personnel and clinical services supervision, staff training and implementation of QA/QI process.

3. Current policy and personnel manuals, medical/nurse protocols and current reference books should be available at the clinic site.

4. A current *Official Notice Bill of Rights for the Injured Worker, Worker's Compensation Fraud Notice* and *Workers Compensation Reporting Instructions* must be posted in prominent places at each work location. Information can be obtained from the Office of Human Resources Management (OHRM) at 404-656-4588.

LABORATORY MANAGEMENT

1. Clinic staff standard should follow precautions for all specimen collection and handling.

2. Disposable syringes and needles are placed in puncture-resistant containers for disposal.

3. Laboratory must meet CLIA and/or state licensure requirements.

4. Clinic will comply with Georgia Department of Public Health, HIV/HBV Policy, Chapter I. Bloodborne Pathogens, Infection Control Guidelines and Exposure Control Plan (current edition).

EMERGENCY PROCEDURES

1. Clinic site has a written emergency management protocol.

2. Clinic site has equipment, supplies and medications needed to manage acute drug reactions.

3. Clinic staff has current certification in cardio-pulmonary resuscitation.

4. After hours emergency care provider's phone number and address is prominently displayed on the front door, and appropriate after hours information is provided on the Clinic's voicemail or answering machine.

QUALITY ASSURANCE PROCEDURES

1. Clinical records audits should be conducted according to the district's QA/QI recommendations.

2. Clinicians should receive a performance/clinical evaluation according to the district's QA/QI recommendation.

3. A clinical operations review should be conducted annually.

4. A customer satisfaction survey should be ongoing, but at least conducted annually.

5. Clinic has a procedure for resolving clients' complaints/grievances.

EPIDEMIOLOGY SURVEILLANCE AND REPORTING

1. Clinic has a procedure for tracking and reporting infectious diseases, contact investigation and disease intervention.

2. Clinic has a procedure for reporting child maltreatment and adult sexual, emotional and physical abuse to the county Department of Family and Children's Services.

CLINIC OPERATIONS REVIEW FORM

DATE: _____ **REVIEWER:** _____ **SITE:** _____

RATINGS: **1=** Acceptable **2 =** Needs Improvement **3 =** Not Evaluated

STANDARDS:	**1**	**2**	**3**
ACCESSIBILITY			
1. Hours/Appointments			
2. Public Transportation			
3. Advertising/Publicity			
4. Fees and Services			
5. Language/Physical Impairment			
CLINIC ENVIRONMENT			
1. Waiting Area			
2. Educational Materials			
3. Exam Rooms			
4. Client Complaints			
CLIENT REGISTRATION			
1. Information Gathering			
2. Registration Efficiency			
3. Confidentiality			
CLINIC FLOW			
1. Client Scheduling			
2. Client Care Stops			
3. Triage System			
MEDICAL RECORDS			
1. Medical Records Composition			
2. Medical Records Storage			
3. Medical Records Purging			
4. Medical Records are HIPAA compliant			
CLINIC MANAGEMENT			
1. Staff Job Qualifications January 2006			
2. Staff Job Duties			
3. Manuals, Protocols, References			
4. Injury/Accident Surveillance			
LABORATORY MANAGEMENT			
1. Management of Specimens			
2. Disposal of Syringes/Needles			
3. CLIA Compliance			
EMERGENCY MANAGEMENT			
1. Emergency Protocol			
2. Equipment, Supplies, Medications			
3. Staff Training			
QUALITY ASSURANCE			
1. Clinical Record Review			
2. Clinician Performance Evaluation			
3. Clinical Operations Review			
4. Customer Survey			
EPIDEMIOLOGIC SURVEILLANCE AND REPORTING			
1. Tracking, Reporting and Intervention			
2. Child Maltreatment Reporting Procedure			

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Quality Assurance/Quality Improvement (QA/QI) for Public Health Nursing Practice

Leadership Competency Measurement Tool

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LEADERSHIP COMPETENCY MEASUREMENT TOOL

The Leadership Competency Measurement Tool provides the Public Health Nurse Leader (PHNL) the opportunity to document his/her accomplishments in the area of leadership. The form provides clearly defined leadership competencies and criteria by which to measure performance. The definition of a Public Health Nurse Leader may include nursing leaders at the district, county, or programmatic level. This tool may also be used for documenting leadership competencies among staff that may or may not have supervisory, management, or leadership responsibilities.

Instructions:

1. Prior to the date of the evaluation, the PHNL should be instructed to make a copy of the Leadership Competency Tool and complete the column with the heading "Provide examples (Quantitative and/or Qualitative) of how the leadership competency is met."
2. The above mentioned column affords the nurse leader the opportunity to give specific events, plans, data, collaborations, responses from staff, input from outside organizations, etc. that show how the competency was met.
3. It is recommended that Public Health Nursing Leaders meet three of the four criteria for measuring leadership competency.
4. If three of the four criteria are not met, a follow-up plan for meeting the criteria should be established.
5. Completion of the tool may require use of additional sheets. The PHNL may hand in the completed tool prior to the actual evaluation/assessment so that the nurse evaluator has time to review it, or it may be collected on-site and reviewed at the start of the evaluation. The information provided on the tool should give the nurse evaluator specific information with which to discuss leadership within the context of that particular organization.

Example:

Leadership Competency	Criteria for Measurement	Criteria Met? YES/NO	Examples of How Criteria are Met	Follow-Up Plan
1. Uses organizational theory to model the way and challenge the process.	1. Contributes to system change that supports the delivery of public health services		Our no-show rates in WIC were approaching 60%. Patients frequently complained that they did not have transportation. After discussions with staff, we assigned one nurse to home-visiting new mothers to start them on WIC, and arranged with a local non-emergency medical transport company to pick clients up 2 days a week at a central location. Our WIC no-show rate has decreased to 15%.	

LEADERSHIP COMPETENCY MEASUREMENT TOOL

Leadership Competency	Criteria for Measurement	Criteria Met? YES/NO	Examples of How Criteria are Met	Follow-Up Plan
1. Uses organizational theory to model the way and challenge the process.	1. Contributes to system change that supports the delivery of public health services. 2. Advocates for the infrastructure needs of public health through local government and the legislature. 3. Identifies and communicates advocacy outcomes **to** staff. 4. Has a vision for the organization and its position in the community. Shares that vision with staff, and encourages feedback and active participation in its implementation.			

Leadership Competency	Criteria for Measurement	Criteria Met? YES/NO	Examples of How Criteria are Met	Follow-Up Plan
2. Contributes to the development, implementation and monitoring of performance standards.	1. Reviews and gives feedback on proposed performance standards, and assures that staff is kept informed. 2. Identifies key concepts for assessment, monitoring and evaluation of populations in order to identify opportunities for improving services.			

Leadership Competency	Criteria for Measurement	Criteria Met? YES/NO	Examples of How Criteria are Met	Follow-Up Plan
3. Inspires a shared vision through use of principles and core values.	1. Promote policies that are consistent with public health core values*, 2. **E**xplains the meaning of those values to staff. 3. Participates in the development, implementation and evaluation of strategic plans. 4. Assures that mechanisms are in place for internal and external issues to be identified and addressed. *Public Health Core Values: • Basis in social justices philosophy • Inherently political nature • Dynamic, ever-expanding agenda • Link with government • Grounded in the sciences • Uncommon culture and bond • Use of prevention as a prime strategy			

Leadership Competency	Criteria for Measurement	Criteria Met? YES/NO	Examples of How Criteria are Met	Follow-Up Plan
4. Uses the legal and political systems to effect change.	1. Participates in policy development. 2. Reviews policies periodically for currency and initiates policy changes. 3. Utilizes community health indicators for policy development. 4. Participates in educating legislators about issues critical to public health and public health nursing.			

Leadership Competency	Criteria for Measurement	Criteria Met? YES/NO	Examples of How Criteria are Met	Follow-Up Plan
5. Creates a culture of ethical standards within the organization that displays integrity and earns public trust.	1. Advocates on behalf of recipients of services and personnel. 2. Maintains privacy, confidentiality and security of patient, client, staff and organization data. 3. Fosters a climate that values diversity and creates opportunities for staff and clients to flourish. 4. Assures that a system of addressing ethical issues within the organization is present, used, and periodically evaluated.			

REFERENCES

1. Train National (2010). *Competencies list- with skill levels.* Retrieved April 27, 2010 from https://www.train.org/Competencies/compskill.aspx?tabID=94
2. Turnock, B. J. (2009). *Public health: What it is and how it works* (4th ed.). Gaithersburg, MD: Aspen Publishers, Inc.

Quality Assurance/Quality Improvement (QA/QI) for Public Health Nursing Practice

Cultural Competency Skills

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CORE COMPETENCIES FOR PUBLIC HEALTH PROFESSIONALS

Cultural Competency Skills

PURPOSE

The following lists of cultural competency skills serve as a reference document to the Quality Assurance/Quality Improvement review process. These cultural competency skills may be used to evaluate the content of training programs in cultural competency. They may also be used to communicate expectations to staff and to assess the staff's level in regards to cultural competencies.

Specific Competencies	Front Line Staff	Senior Level Staff	Supervisory and Management Staff
1. Utilizes appropriate methods for interacting sensitively, effectively and professionally with persons from diverse cultural, socioeconomic, educational, racial, ethnic and professional backgrounds, and persons of all ages and lifestyle preferences**.**	Proficient	Proficient	Proficient
2. Identifies the role of cultural, social and behavioral factors in determining the delivery of public health services**.**	Knowledgeable	Proficient	Proficient
3. Develops and adapts approaches to problems that take into account cultural differences**.**	Proficient	Proficient	Proficient

ATTITUDES

1. Understands the dynamic forces contributing to cultural diversity**.**	Knowledgeable	Knowledgeable to proficient	Proficient
2. Understands the importance of a diverse public health workforce**.**	Knowledgeable	Proficient	Proficient

TRAINING RESOURCES FOR CULTURAL COMPETENCIES

Monica L. Vargas, Statistical Analyst II
Georgia Refugee Health Program
Tel: 404-679-4919
mlvargas@dhr.state.ga.us

Policy Planning and Compliance Group Limited English Proficient/Sensory Impaired Program
Georgia Department of Human Resources
lepsi@dhr.state.ga.us

Kitty Kelly, Anthropologist
678-839-6455
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University of West Georgia

Kathryn A. Kozaitis, Chair
Department of Anthropology
College of Arts and Sciences
Georgia State University
Atlanta, Georgia 30302-3998
Tel.: 404-651-1760
Fax: 404-651-3235
antkxk@langate.gsu.edu

Department of Health and Human Services
Office of Minority Health
Culturally Competent Nursing Care: A Cornerstone of Caring
An online educational program designed specifically for nurses and is accredited by the American Nurses Credentialing Center (ANCC)
https://ccnm.thinkculturalhealth.org/default.asp

REFERENCES

1. Train National (2010). *Competencies list- with skill levels.* Retrieved April 27, 2010 from https://www.train.org/Competencies/compskill.aspx?tabID=94
2. Cross Cultural Health Care Program (n.d.). *Cultural competency programs.* Retrieved April 27, 2010 from http://www.xculture.org/cultcompprograms.php
3. National Center for Cultural Competence (n.d.). *Resources and tools.* Retrieved April 27, 2010, from the Georgetown University Center for Child and Human Development Web site: http://nccc.georgetown.edu/resources/index.html

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Quality Assurance/Quality Improvement (QA/QI) for Public Health Nursing Practice

Population Health Competency Measurement Tool

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POPULATION HEALTH COMPETENCY MEASUREMENT TOOL

The Population Health Competency Tool provides the Public Health Nurse (PHN) the opportunity to document their accomplishments in the area of population health. The form provides clearly defined population health competencies and criteria by which to measure performance.

Instructions:

- Prior to the date of the evaluation, the PHN should be instructed to make a copy of the Population Health Competency Tool and complete the column with the heading "Provide examples (Quantitative and/or Qualitative) of how the population health competency is met."
- The above mentioned column affords the PHN the opportunity to give specific events, plans, data, collaborations, responses from staff, input from outside organizations, etc. that show how the competency was met.

Example:

Population Health Competency	Criteria for Measurement	Criteria Met? YES/NO	Examples of How Criteria are Met	Follow-Up Plan
1. Community Health Assessment and Diagnosis.	1. Uses multiple data sources to assess the health of the community			

- Completion of the tool may require use of additional sheets.

The PHN may hand in the completed tool prior to the actual evaluation so that the nurse evaluator has time to review it, or it may be collected on-site and review it at the start of the evaluation. The information provided on the tool should provide the nurse evaluator with specific information with which to discuss population health competency within the context of that particular organization.

POPULATION HEALTH COMPETENCY MEASUREMENT TOOL

Population Health Competency	Criteria for Measurement	Criteria Met? YES/NO	Examples of How Criteria are Met	Follow-Up Plan
1. Community health assessment and diagnosis.	**<u>Assessment</u>:** 1. Uses multiple relevant and appropriate data sources to assess the health of the communities. 2. Uses qualitative and quantitative data appropriately. 3. Collaborate with community partners to validate the meaning of data. 4. Collaborate with community partners to identify health priorities and eliminate duplication of services 5. Clusters assessment data relevant to public health. **<u>Diagnosis:</u>** 6. Recognizes how assessment data impacts ethical, political, scientific, economic, and overall public health issues.			

Population Health Competency	Criteria for Measurement	Criteria Met? YES/NO	Examples of How Criteria are Met	Follow-Up Plan
	7. Identify and monitor disease trends. 8. Defines problems in the community			
2. Interpreting and presenting health information to local leaders, policy makers and partners.	1. Collects, summarizes, and interprets information relevant to a public health issue. 2. Identifies policy options and writes clear and concise policy statements. 3. Identifies, interprets, and implements public health laws, regulations, and policies related to specific programs. 4. Communicates effectively orally and in writing 5. Communicate accurate demographic, statistical, programmatic, and scientific information to professional and lay audiences. 6. Interpret and apply health information to			

Population Health Competency	Criteria for Measurement	Criteria Met? YES/NO	Examples of How Criteria are Met	Follow-Up Plan
	develop, adapt or eliminate community programs**.** 7. Advocate for health policy to benefit unserved and underserved populations and to address program needs**.**			
3. Using computer technology in the health planning and policy development processes.	1. Identify and use appropriate and relevant electronic health databases (e.g., OASIS, United Health, CDC)**.** 2. Proficient in basic computer skills. 3. Demonstrate advanced computer skills in research, and health policy analysis. 4. Applies advanced computer skills to data collection processes, information technology applications, and computer systems storage / retrieval strategies**.**			

Population Health Competency	Criteria for Measurement	Criteria Met? YES/NO	Examples of How Criteria are Met	Follow-Up Plan
4. Building and sustaining community coalitions.	1. Establishes and maintains collaborative relationships with key stakeholders to promote the health of the population. 2. Utilizes leadership, team building, negotiation, and conflict resolution skills to build community partnerships. 3. Understand how public and private organizations operate within the community**.** 4. Accomplishes effective community engagements**.** 5. Identifies community assets and available resources**.** 6. Describes the role of Public Health in the delivery of health services**.** *Public Health Core Values: 1. Basis in social justices			

Population Health Competency	Criteria for Measurement	Criteria Met? YES/NO	Examples of How Criteria are Met	Follow-Up Plan
	philosophy 2. Inherently political nature 3. Dynamic, ever-expanding agenda 4. Link with government 5. Grounded in the sciences 6. Uncommon culture and bond 7. Use of prevention as a prime strategy			

REFERENCES

1. Jakeway, C.C., Cantrell, E.E., Cason, J.B., & Talley, B.S. (2006). Developing population health competencies among public health nurses in Georgia. *Public Health Nursing* 23(2), 161-167.
2. Public Health Foundation (2001). *Core Competencies for Public Health Professionals, Council on Linkages between Academia and Public Health Practice.* p.1-6.

Quality Assurance/Quality Improvement (QA/QI) for Public Health Nursing Practice

Workplace Safety

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WORKPLACE SAFETY CHECKLIST

PURPOSE

To provide an overview of workplace safety areas that are centered on current state or Department policies. The intent is not that Nurse Managers be responsible for these areas but an individual or committee be designated to review workplace safety. This checklist is not all-inclusive. Each district may have additional policies whereby quality assurance indicators may be utilized.

Site: _____ **Date:** _____

Reviewer: _____

Part I: Review of Written Programs, Training, and Record Keeping				
Item No.	**Yes**	**No**	**N/A**	**Management and Employee Training Program**
1				**New-hires trained on DPH policies regarding Violence in the Workplace, Bloodborne Pathogens, reporting accidents in the workplace and any other local workplace safety policies**
2				**Regular follow-up training conducted as required**
3				**Training records maintained for 10 years**
				Written Emergency Evacuation Plan/Emergency Procedures
4				**Evacuation procedures posted and accessible to all employees (Severe Weather and Fire)**
5				**Annual evacuation drills conducted and recorded**
6				**All individuals responsible for evacuation plan identified, trained, and their duties outlined in writing**
7				**Anaphylaxis protocol reviewed annually with drills as required by the Immunization Program Guidelines**
				Preventing Workplace Violence
8				**Review DPH Policy 413 yearly**
9				**All employees informed to report all threats or acts of violence, restraining orders by or against them**
10				**If work location has 50 or more employees, a committee is in place to oversee the implementation and management of the prevention of workplace violence plan**
				Written Bloodborne Pathogens Policy
11				**Review the State Guidelines for Standard Precautions and Bloodborne Pathogen Occupational Exposure Control Policy yearly**
12				**District has a bloodborne pathogen exposure control plan and the plan is based upon the above State policy. It is to be updated annually. The policy addresses the following:**
13				• **HANDWASHING**
14				• **PERSONAL PROTECTIVE EQUIPMENT**
15				• **BIOHAZARDOUS WASTE MANAGEMENT**
16				• **ENVIRONMENTAL CONTROLS**
17				• **SHARPS INJURY PROTECTION**
18				**Employees covered by the standard are identified**
19				**Employees trained in protective procedures**

Part I: Review of Written Programs, Training, and Record Keeping (cont'd)				
Item No.	**Yes**	**No**	**N/A**	**Written Tuberculosis Infection Control Policy**
20				**Appropriate post-exposure management as outlined in State guidelines**
21				**Adopt and implement State TB Infection Control Plan**
22				**Health department Risk Assessment completed yearly**
23				**Areas and job tasks which place the employee at risk for exposure to tuberculosis are identified at the time of hire or job transfer**
24				**Document TB education, TB screening, and respirator fit testing (if needed) for employees**
25				**Implement TB screening program for employees, physicians, and volunteers. Notify employee when screening is due and assure screen completed within 30 days**
26				**Designate an individual to monitor and maintain controls**
27				**Implement and enforce the Respiratory Protection Policy**
28				**Implement engineering controls based on the level of risk of the facility**
				Employee Health
29				**Is there an Employee Health Policy in place?**
30				**Review plans with employee for Occupational Exposure on hire and yearly**
31				**Is there a plan in place to ensure that all employees are informed of required and recommended vaccines and that appropriate employee immunization records are kept?**
				Risk Management
32				**If there is no policy in place, is there one in development?**
33				**If yes, does this policy include identifying ways to prevent future accidents, incidents?**
				Home Visit Safety
34				**District has written safety guidelines and procedures in place to ensure safety of personnel during home visits**
35				**Employees who conduct home visits receive safety training**
36				**District provides picture IDs to personnel who make home visits and require that the ID be worn at all times when in the field.**
37				**Districts maintain an employee file for personnel who make home visits, so it can be shared with authorities in case of emergency.**

Item No.	**Comments on Deficiencies in Part I**

Part II: Inspection of Equipment With Review of Safety Repair				
Inspect the following yearly or more frequent as indicated. Document results. Problems discovered should be noted and defective equipment taken out of service until repairs are complete.				
Item No.	**Yes**	**No**	**N/A**	**Equipment**
38				**Compressed Gas Cylinders (Oxygen)**
39				**Personal Protective Equipment**
40				**Laboratory Equipment**
Item No.	**Comments on Deficiencies in Part II**			

Part III: Inspection of Facility and Grounds				
The third and final part of the program is an actual inspection tour of your facility.				
Item No.	**Yes**	**No**	**N/A**	**General**
41				**Emergency telephone numbers are posted where they can be readily found**
42				**All work areas are adequately illuminated**
43				**There are separate clean and dirty work areas and a "dirty-to-clean" workflow is used**
44				**Non-employees are excluded access to dirty areas**
				Housekeeping
45				**All aisle ways clear of slip and trip hazards**
46				**Areas around equipment clean and free of materials that could cause slips or falls**
47				**Trash removed on a regular basis**
48				**Facility, both public areas and private offices, including bathrooms, are kept clean and cleared of trash, and furniture is in good repair.**
				Electrical
49				**Electrical power cords in good condition and properly grounded if necessary**
50				**Electrical cabinets kept closed and properly labeled as to purpose and voltage**
51				**Electrical panels easily accessible, the front of each panel clear of obstruction**
52				**Appropriate signage in place to indicate circuits to refrigeration units, so vaccines and medications can be properly handled in case of interruptions of power**
				Exits
53				**All exits and aisle ways clearly marked and clear of encumbrances**
54				**All exits, and routes to all exits, clearly marked**
55				**All exit doors clear of obstruction and functioning properly**

Part III: Inspection of Facility and Grounds (cont'd)				
56				All exits adequately illuminated and all exit signs lighted
				Stairs, Walkways, and Overhead Storage
57				All stairs supplied with required handrails
58				All floor and stairwell openings properly guarded and identified
				Fire Extinguishers
59				Fire extinguishers checked regularly for proper charge and cylinder test date
60				Clear, easy access to each fire extinguisher
61				Fire extinguishers hung at proper intervals and heights
				Flammable Liquid and Compressed Gas Cylinder Handling and Storage
62				All flammable liquids identified and their use strictly controlled
63				Oxygen cylinders separated from flammable gas cylinders by at least 25 feet or a fire wall
64				All cylinders chained in upright position when full
65				Cap guards on all cylinders when not in use
66				All containers clearly labeled per requirements
				First Aid Supplies
67				Location of emergency cart clearly labeled and clear of encumbrances which would prohibit access
68				Maintain supplies as defined in the emergency anaphylaxis protocol
				Heating/Air Conditioning Units
69				Units are operational and filters clean
				Water Supply and Plumbing
70				Handwashing facilities and products are readily accessible to employees
71				Toilets and sinks are operational without leaks or other evidence of malfunction
				Biohazard Waste
72				Sharps containers are clearly marked and located convenient to the workstation
73				Sharps containers are replaced routinely and not allowed to overfill
74				Full biohazard containers are properly stored until removed by licensed disposal company
				Personal Protective Equipment (PPE)
75				PPE is readily accessible in a variety of sizes
76				PPE is cleaned, laundered, repaired, or disposed of appropriately
				Parking Lot
77				Parking lot is highly visible and well-lit
78				Parking is available close to building or work site
79				Parking is available near the main entrance
80				Emergency phones or panic button are available
81				There is video surveillance of the parking lot
82				Security patrols the parking lot and/or escorts employees to parking lot after hours
Item No.	**Comments on Deficiencies in Part III**			

Item No.	**Comments on Deficiencies in Part III (cont'd)**

Follow-up of Findings			
Item No. & Deficiency Noted Above	**Person assigned**	**Activities to Address Deficiency**	**Completion Date**

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Quality Assurance/Quality Improvement (QA/QI) for Public Health Nursing Practice

Emergency Preparedness

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Emergency Preparedness for Public Health Nurses

INTRODUCTION

An appropriately trained and competent workforce is one of the components of a strong public health infrastructure. To assure public health nurses are able to perform during emergencies, they must demonstrate proficiency in public health emergency preparedness competencies, and acquire the necessary training and professional development to respond to public health emergencies. Emergency Preparedness Competencies for Public Health Nurses in Georgia are listed in the following chart:

Figure 1:

1. Identify and locate the emergency response plan and describe his/her role in emergency response. Demonstrates role effectively during drills. a. Demonstrate basic therapeutic interventions, including: • Basic 1st aid skills. • Initial wound care. • Knowledge of protocols (e.g., American Red Cross Disaster Protocols, Bio-Chemical Protocols, etc). • Safe administration of vaccines. b. Demonstrate knowledge and skill related to personal protection and safety including the use of PPE.
2. Describe the role of public health in a range of responses to possible emergencies. a. Identify, interpret, and implement public health laws, regulations, and policies related to public health emergency response (legal authority, isolation and quarantine, related to documentation). O.C.G.A § 16-13-72; 31-2-1; 31-3-2.1; 31-3-3-4; 31-12-3 & 4; 38-3-51; 43-34-23; and 43-34-26. These laws may be retrieved from http://www.lexis-nexis.com/hottopics/gacode/.
3. Describe the chain of command and management system of emergency response and the emergency chain of command in his/her agency. a. Demonstrate the correct use of all emergency communication equipment.
4. Utilize community information to identify community resources, assets, and vulnerabilities; demonstrate the ability to access other relevant information sources to aid in appropriate and effective decision-making during an emergency.
5. Develop and maintain partnerships with emergency response partners. Include regular communication, maintaining a current directory of partners and their emergency contact numbers, and team building.

PURPOSE

The purpose of these tools is to document the required training and education that is needed in the area of emergency preparedness.

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EMERGENCY PREPAREDNESS

Note: This section may be used to review an individual nurse's training and preparation in Emergency Preparedness. A copy may be placed in the individual nurse's personnel or training file. It may also be used to review the training and preparation of a group of nurses related to competencies in Emergency Preparedness.

	DOCUMENTATION		
EXPECTATIONS	**Yes**	**No**	**COMMENTS**
TRAINING—REQUIRED **The nurse has completed the following:**			
A. Didactic/Classroom Training:			
1. Current CPR certification.			
2. Completion of Georgia NIMS training (specify required courses).			
3. Completion of Adult and Adolescent Immunizations course.			
B. Self-study:			
Annual review of: (Written documentation of individual/group review)			
1. American Red Cross Health Services Protocols.			
2. County Emergency Response Plan.			
3. District Emergency Response Plan.			
4. SNS Emergency Response Plan.			
6. Biochemical Protocols.			
C. Participates in Emergency Preparedness Drills (specify quarterly, annually, etc).			
1. Locates appropriate emergency plan.			
2. Identifies individual role in emergency plan.			
3. Identifies/contacts appropriate personnel for the identified emergency.			

SECTION — EMERGENCY PREPAREDNESS, continued

EXPECTATIONS	DOCUMENTATION Yes	No	Incomplete	COMMENTS
a) Health Department (HD) has a county plan for mass dispensing and/or vaccination.				
b) The county plan was developed using a multi-disciplinary approach including local hospital, EMA, public safety and other as appropriate.				
c) The county plan has identified an adequate number of sites to carry out mass dispensing and/or vaccination based on population & geography.				
d) The HD Nurse Manager is involved in and supports Pandemic Influenza Planning in the county.				
e) All HD staff has participated in at least one emergency drill or exercise in the past 24 months.				
f) All HD staff has a Family Readiness Plan that has been updated in the last 12 months and is maintained on site.				
g) The county team members are known and are aware of their team responsibilities				
h) A call down roster is maintained that includes HD, EMA, Public Safety, and other staff as appropriate:				
1) A call down of staff has been performed in the last 6 months.				
2) Call downs to be performed bi-annually or every 6 months.				

SECTION — EMERGENCY PREPAREDNESS, continued

EXPECTATIONS	DOCUMENTATION Yes	No	Incomplete	COMMENTS
i) The county SNS plan includes:				
1) Contact information for all persons involved in emergency preparedness and SNS Planning.				
2) A flow diagram of the dispensing/vaccinating site.				
3) MOUs with dispensing/vaccinating site, and other stakeholders as appropriate.				
j) Review of the county SNS plan is conducted at least once annually.				
k) The county has participated in or plans to participate in one emergency drill or exercise each year.				
l) All HD staff is familiar with the National Incident Management System and is up-to-date on training requirements (i.e. IS100, IS200, IS700, etc).				

Georgia NIMS Training Guidelines

Baseline for Training

Front Line Employees

ICS-100: Introduction to ICS or equivalent

FEMA IS-700: NIMS, An Introduction

Entry level first responders and Disaster workers including: EMS personnel, firefighters, hospital staff, police officers, public health workers, public works/utility personnel, skilled support personnel, and other emergency management response personnel at the federal, state, and local level

Front Line Supervisors

ICS-200: Basic ICS or equivalent

ICS-100: Introduction to ICS or equivalent

FEMA IS-700: NIMS, An Introduction

First line supervisors, single resource leaders, field supervisors, and other emergency management/response personnel that require a higher level of ICS/NIMS training.

Middle Management

ICS 300: Intermediate ICS or equivalent

ICS-200: Basic ICS or equivalent

ICS-100: Introduction to ICS or equivalent

FEMA-800: National Response Plan (NRP), An Introduction

FEMA IS-700: NIMS, An Introduction

Middle management including strike team leaders, unit leaders, division/group supervisors, branch directors, and multi-agency coordination system/ emergency operations center.

Command Staff

ICS 400: Advanced ICS or equivalent

ICS 300: Intermediate ICS or equivalent

ICS-200: Basic ICS or equivalent

ICS-100: Introduction to ICS or equivalent

FEMA-800: National Response Plan (NRP), An Introduction

FEMA IS-700A: NIMS, An Introduction

Command and general staff, select department heads with multi-agency coordination system responsibilities, area commanders, emergency managers, and multi-agency coordination system/ emergency operations center managers.

www.fema.training.gov

EMERGENCY PREPAREDNESS CHECKLIST

NAME:_____

HEALTH DEPT._____

	Date
Demonstrates appropriate use of in-house communications equipment, i.e. paging system, Southern Link, and/or walkie-talkies	
Has completed a personal or family emergency plan which has been placed in the personnel record.	
Has read and been given the opportunity to ask questions about • The facility's emergency preparedness plan • The District's emergency preparedness plan • Emergency Support Function 6 and 8	
Has been oriented to the agency chain of command and has received instruction as to who to call in case of an emergency.	
Provided with up-to-date agency phone tree and demonstrates correct use of same.	
Has been oriented as to the location and use of emergency phone numbers • EMA, EMS, Sheriff, Marshals, Poison Control, Fire, etc.	
Circle all that apply according to instructions on Georgia NIMS Training Guidelines Baseline for Training	
Completed ICS – 100	
Completed ICS – 200	
Completed ICS – 300	
Completed ICS – 400	
Completed ICS – 700	
Completed ICS – 800	

For Nurses Only

Current CPR/AED certification	
Review and sign-off: • SNS/Dispensing plan	
• Bio-Chemical Protocols	
• American Red Cross Health Services Protocols	
• Disaster Health Nursing	