AFFILIATED PHYSICIANS
ON-SITE VACCINATION AND WELLNESS SERVICES

Policy: P013 – **On-Site Clinic Program**

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I. **Purpose:**

Assess and treat symptomatic employee's on-site [corporate workplace] providing triage and seamless intervention driven by protocols reviewed and signed by Affiliated Physician's Medical Director.

II. Policy:

a. Affiliated Physician and/or agency nurse on-site is to assess corporate employees with specified or unspecified symptoms.

b. Each nurse working an ***On-Site Clinic Program*** event will be trained on all ***Assessment Protocols*** and will be responsible to implement each protocol accordingly.

   i. Acute Chest Pain
   ii. Acute Skin Reaction
   iii. Anaphylaxis
   iv. Asthma Attack
   v. Burn
   vi. Extremity Injury
   vii. Gastrointestinal
   viii. Headache
   ix. Hyper – Hypoglycemia
   x. Hyper - Hypotension
   xi. Nosebleed
   xii. Respiratory
   xiii. Seizure
   xiv. Stroke

c. Each nurse working an ***On-Site Clinic Program*** event will be trained on all ***Medication Protocols*** and will be responsible to implement, along with each correlated ***Assessment Protocol.***

   i. Acetaminophen
   ii. Antacid
   iii. Aspirin
   iv. Benadryl – oral
   v. Benadryl – Intramuscular
   vi. Epinephrine
   vii. Hydrocortisone – on hold
   viii. Ibuprofen
   ix. Imodium – on hold

d. Each nurse working an ***On-Site Clinic Program*** event will be trained on all ***Procedural Protocols*** and will be responsible to implement, along with each correlated ***Assessment Protocol.***
    i. Extremity Ace Bandage/ Triangular Bandage
    ii. Pulse Oximeter
    iii. Splinter
    iv. Glucometer
e. Nurse is to review and confirm understanding of all standing protocols prior to working an event.
f. Nurses are required to have an active BLS certification in order to accept On-Site Clinic Program events.
g. Clinician(s) to follow strict timeliness and adhere to Affiliated Physicians Lateness Policy if running late.
h. Clinician(s) will be responsible to review supplies at start of shift and confirm all supplies are readily available in order to activate all protocols. If any supply stock is running low, email communication is required to Program Support at _DL_Program Support ProgramSupport@affiliatedphysicians.com Logistics will be notified by project management team at logisticsgroup@affiliatedphyscians.com of supply tracking spreadsheet update.
i. All employees seeking on-site assessment by an Affiliated Physician clinician is required to provide written consent and HIPAA disclosure prior to having an assessment completed.
j. Clinician will triage and manage assessments based on urgency, if more than one employee is waiting to be seen. Each Corporation instituting the Affiliated Physicians On-Site Clinic Program shall be made aware of this and shall communicate such to its employees.
k. Vital Signs [blood pressure, heart rate, respirations, temperature, oxygen saturation level, and pain level] must be part of each initial assessment and completed by an Affiliated Physician or contracted agency clinician.
l. Clinician will be required to obtain patient's history, which includes recent activity, medical history, medication list, height, weight, and allergies.
m. Auscultation of breath sounds or bowel sounds may be required dependent on chief complaint.
n. Clinician must exhibit proficient skills to operate company provided equipment: glucometer, stethoscope, blood pressure cuff, pulse ox, IR thermometer, tympanic thermometer, ace bandage, triangular bandage, etc.
o. Clinician required to document all patient encounters, including physical assessment and intervention.
p. WhatsApp application required for documentation transmission. – All clinicians required to disable 'save to phone' to comply with encryption transmission of PHI.

III. <u>Procedure:</u>

a. **Corporation**
    i. Site - suggestions
        1. Designate space for waiting:

a. 2-3 chairs outside immediate assessment area – spaced out by at least 6 feet to comply with social distancing standard.

2. Designate hand sanitizing station in waiting area.
3. Designate space for Triage Nurse.
4. Designate space for Assessments to be completed – adhering to patient privacy standards.
5. Communicate with Affiliated Physicians whether or not there is an AED present on-site prior to beginning an On-Site Clinic program so this information can be shared with the clinical team working these events.
6. Coordinate supply delivery with Affiliated Physicians and confirm safe storage area.

ii. Employees

1. Corporation responsible for communicating with employees regarding Affiliated Physicians On-Site Clinic process
   a. Must have mask on when entering the On-Site Clinic area.
   b. Check in with the on-site clinician when employee first arrives.
   c. Will be taken in if no one is ahead of him/her or will be asked to have a seat in the waiting area if there is another employee ahead of him/her.
   d. When entering the assessment area, employee will be asked a series of questions, will have vital signs taken, and will be symptom managed - according to protocol.

b. **Affiliated Physicians – Off-Site**

i. Designate clinical team to work the On-Site Clinic Program; at least one (1) nurse, and more if client requests.
ii. Train nurses prior to scheduled event(s).
iii. Provide resources to best prepare clinical team for On-Site Clinic Program.
iv. Supply delivery to site prior to event date, coordinate with company site contact for safe storage area.
v. Clinician to receive state-licensed physician signed protocols/standing orders by clinical training team prior to working program: https://affiliatedphysicians.com/nursing-protocols/.

c. **On-Site Preparation**

i. Clinician will review supplies; confirm appropriate stock and monitor expirations. This includes having necessary paperwork on hand **[Event Summary, Nursing Assessment/Consent form, Return to Work Slip, Refusal of Care form, Medical Supply Management form]**
ii. All low stock or expiring supplies/medications require immediate communication to the logistics team @ logisticsgroup@affiliatedphysicians.com.
iii. Prepare work area; sanitize counters, tables and chairs located in waiting and assessment areas.

iv. If signage on-site – confirm all signage is in appropriate high-visibility locations near On-Site Clinic.
v. Confirm First Aid cabinet and First Aid Grab-n-Go bag is neat and fully stocked.
vi. Corporate employee voluntarily visits the Affiliated Physicians On-Site Clinic area for symptom assessment and management.
vii. Clinical team must be in full PPE when interacting with any patient [gown, visor/goggle or equivalent eye protection, gloves, N95 mask].
viii. Adhere to proper hand hygiene prior, during and post clinic visit(s).

d. **On-Site Assessment**

i. Clinician will greet employee – provide introduction to self and overview of company sponsored program.
ii. Clinician will obtain and document **employee's name, DOB, gender, time in, and chief complaint.**
iii. Clinician must review **'Consent'** and **'HIPAA'** acknowledgement with patient at start of interaction.
iv. If life-threatening condition immediately identified and is unlikely that consent will be obtained, 911 emergency medical services must be activated and documentation of episode completed on the **'On-Site Program – Assessment Form'**. Clinical team [if applicable] will work cohesively to transfer patient care to EMS emergently and swiftly for any patient experiencing life-threatening symptoms.
v. If non-life-threatening symptoms, clinician obtain patient signature under Consent and HIPAA acknowledgement section located on the back of the ***'On-Site Program – Assessment Form'.***
vi. Consent and HIPAA acknowledgement review and signature must be done prior to vital signs or any other type of physical assessment is conducted.
vii. Once consent and HIPAA release is obtained, clinician proceed with obtaining and documenting **height, weight, Tel#, employer information, vital signs [heart rate, respirations, temperature, blood pressure, pain level and oxygen saturation], medical history, allergies, and recent activity.**
viii. Clinician to proceed with physical assessment, which may include auscultating lung fields, bowel sounds or apical heart rate. Document accordingly.
ix. Based on chief complaint, determine which protocol is being activated
x. Physical assessment will be based on patient's chief complaint – and will help determine which protocol to activate.
xi. If no protocol available for chief complaint and/or physical assessment, clinician to communicate with Affiliated Physicians Hotline @ 646.535.2318 for guidance.
xii. Clinician will adhere to 'medication protocol' if applicable – based on assessment protocol medical orders.
xiii. Maintain privacy throughout patient encounter.

xiv. Document all subjective and objective data – including physical assessment, activated protocol and clinical intervention.
xv. Initial the **'Assessment Form'** with each completed section.
xvi. Print name, sign, initial and date on the bottom of both the front and back of the **'Assessment Form'** once completed. Space for two (2) clinicians, if applicable.
xvii. Follow applicable protocol to refer patient out [i.e. Refer to primary care physician].
xviii. Use clinical judgement regarding return to work or refer to home or otherwise. Any uncertainty should be directed to the Affiliated Physicians Hotline @ 646.535.2318.
xix. Document time out on **'Assessment Form'** when patient encounter concludes.
xx. When patient leaves the assessment area, clean and sanitize according to Affiliated Physicians Infection Control Policy and Procedure.

e. **Return to Work**
   i. **'Return-to-Work'** slip with appropriate referral information to be completed at completion of each patient assessment.
   ii. Follow corporation's policy regarding communication back to company. Be mindful employees are consenting to assessment, treatment and referring out – along with notification of said person participating in company-sponsored program through Affiliated Physicians. **This does not mean we share PHI with said employee's employer – DO NOT SHARE protected health information [PHI].**

f. **Refusal of Care**
   i. If an employee refuses recommended treatment or follow-up care by a primary care physician, Urgent Care, or emergency services when the on-site clinician has made recommendations, patient will be required to sign a **'Refusal-of-Care'** form.
   ii. If an employee refuses to sign the **'Refusal of Care'** form, clinician to document clearly on **'Assessment Form'.**

g. **Tracking Medical Supplies**
   i. Upon initiation of an On-Site Clinic Program, clinician is responsible for completing the **'Medical Supply – Expiration Tracking Form'** [see section IV, f.].
   ii. Columns 1 and 2 ONLY need to be completed upon program initiation
      1. Column 1 = expiration date
      2. Column 2 = clinician initial
   iii. Column 3 is to be completed IF a replacement item is needed
      1. Column 3 = Replacement Needed - Y
   iv. Columns 4, 5, 6 to be completed when a replacement item is received
      1. Column 4 = Replacement Date
      2. Column 5 = New Exp. Date
      3. Column 6 = Initial

v. Direct all questions to Hotline -
vi. Reminder – If running low on supplies, it is the responsibility of the clinic program nurse to communicate with the project management team via _DL_Program Support ProgramSupport@affiliatedphysicians.com

h. **Nursing Documentation – reporting, paperwork submission and review**
   i. All RNs working OSC programs required to provide an end-of-shift report via email to _DL_Program Support ProgramSupport@affiliatedphysicians.com
   ii. End-of-Shift reports should follow this format:

Example:

AY (patient initials)

Chief Complaint: (chronic) low back pain

Protocol: Injury/Ibuprofen

Outcome: VSS, denied recent trauma. No swelling or bruising. States physical job involves a lot of bending, twisting & lifting. Ibuprofen given. Use good body mechanics. F/U with PCP

   iii. At the completion of each shift, RN to compile paperwork and submit via prepaid FedEx envelope.
   iv. Upon paperwork receipt, logistics team will scan into system for medical record maintenance.
   v. Project Management team is responsible for reviewing clinical documentation for accuracy.
      1. Training Team to be made aware if noted deficiency(s) and need for more detailed training to incoming new nurses
      2. Project Management Team to communicate any/all deficiency with regards to documentation to existing program nurses

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Nursing Assessment - Front Page

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On-Site Clinic Program - Nursing Assessment Form

Date of Visit:	Time of Visit:	
Patient Name:	DOB:	Gender: M F T
Tel:	Height:	Weight:

Employer Name:	Employer Tel:
Employer Address:	

Chief complaint(s): 'x' body part effected in diagram below **Allergies: ______________________________**

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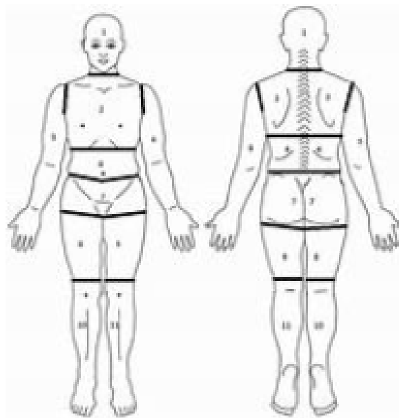

- ☐ **Abdominal Cramping**
- ☐ **Arthritic pain**
- ☐ **Body aches**
- ☐ **Burn**
- ☐ **Cough**
- ☐ **Chest pain**
- ☐ **Chills**
- ☐ **Confusion**
- ☐ **Fever**
- ☐ **Headache**
- ☐ **Injury**
- ☐ **Insect bite**
- ☐ **Nausea**
- ☐ **Neck pain**
- ☐ **Neck stiffness**
- ☐ **Radiating pain**
- ☐ **Shortness of breath**
- ☐ **Skin rash**
- ☐ **Sore throat**
- ☐ **Sweating**
- ☐ **Other**

____

Clinician Initial: ______ [Chief Complaint, VS, Hx]

Vital Signs:	**R**	**HR**	**BP**	**T**	**O2 Sat. Level _______ %**	**Pain Level (0-10) _________**
Patient Medical History, Chief Complaint, and Current Medications:						

- ☐ Patient with NO life threatening symptoms and advised to seek follow up care with primary care physician
- ☐ Patient with NO life threatening symptoms, however requires URGENT follow up with PCP or Urgent Care Center
- ☐ Patient with life threatening symptoms and 911 emergency service activated

Clinician Name:		Clinician Name:	
Clinician Signature:	Initial:	Clinician Signature:	Initial:
Date:		Date:	

****Affiliated Physicians onsite clinic is intended for assessment of minor workplace injuries and/or sudden symptom onset. All suspected life threatening injuries, illness, and/or symptoms require immediate medical attention via activation of 911 Emergency Medical Service.**

last revised 09.22.20

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Nursing Assessment – Back Page

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Patient Name:	DOB:
Tel:	

Clinician Initial: __________

Assessment:
Intervention – Treatment Protocol:
Recommendation:

Additional Notes:

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HIPAA Privacy Authorization Form - Authorization for Use of Disclosure of Protected Health Information

(Required by the Health Insurance Portability and Accountability Act –45 CFR Parts 160 and 164) **Clinician Initial:** __________

I, ____________________________, hereby authorize and request Affiliated Physicians to release my health information pertaining to this on-site screening to the following person(s). I acknowledge that I have the right to authorize access and disclosure of my Protected Health Information (PHI) to anyone of my choosing for billing, condition, treatment and prognosis to the following individual(s).

Name: ____**Relationship:** ________________________ **Tel #:** ________________________

Consent and release for Affiliated Physician's on-site clinic staff to complete assessment, treat per established protocol, and refer as necessary for additional care and oversight.

I am participating in this company sponsored screening and education program voluntarily. I consent to vital sign monitoring [blood pressure, heart rate, oxygen saturation, respirations, pain level, temperature] and clinician assessment of primary complaint or symptom(s). I release Affiliated Physicians, and any other organizations associated with this screening, and all affiliates participating in this screening, from any liability arising from or in any way connected with this screening. I understand my participation in the program will be shared with my employer, and *my individual assessment and PHI will not be shared, unless otherwise directed*. I understand that:

1. My Vital Signs are for screening purposes only and does not necessarily determine my overall health status.
2. Any or all of my symptoms should be followed up by my primary care physician or equivalent.
3. I will contact my physician for follow up. The responsibility for follow up is mine alone and not those associated with this screening.

____ ________________________

Patient Signature Date

Clinician Name:		Clinician Name:	
Clinician Signature:	Initial:	Clinician Signature:	Initial:
Date:		Date:	

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Return-to-Work Slip

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On-Site Clinic Program Visit Date__________

Time in_________ Time out__________

[name]____ was assessed and treated at Affiliated Physician's on-site program.

Chief Complaint____

☐ Return to Work ☐ Recommend Home ☐ Refer follow-up w/ PCP

☐ Referred Urgent Care ☐ 911 EMS Activation

Clinician Name_______________________________________

Clinician Signature____________________________________

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i. Refusal of Care

Refusal of Immediate Care Against Medical Advice

Employer Name: ______________________________ Event Location: ______________________________________

Screening Type: ______________________________(describe: Flu immunization, Glucose, Blood Pressure, Etc.)

Criteria for refusing care:
The patient meets all of the following:

- ☐ Is over the age of 18 years
- ☐ Exhibits no evidence of:
  - Altered level of consciousness
  - Alcohol or drug ingestion that would impair judgment
- ☐ Understands the nature of the medical condition, as well as the risks and consequences of refusing care.

Care Recommendation: ____

____

____

______________________________ ______________________________ _______________
Clinician Signature Clinician Name Date

1. Acknowledgement of Information (Initial on line)
_____I acknowledge that I have been informed of a biometric screening result which indicates I may require immediate medical attention. I elect not to seek the medical care recommended above, and/or to refuse further evaluation, treatment and/or transport.

2. Release of Liability (Initial on line)
_____ By signing this form, I am releasing Affiliated Physicians of any liability or medical claims resulting from my decision to refuse care against medical advice.

I understand that if I change my mind at a later time, I should call 911, go to the nearest emergency room, or call my private doctor for guidance.

Name Printed: _______________________________________

Signature____ Date________________

Witness Information

Signature: _______________________________ Name Printed: _________________________________

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Medical Supply Tracking

Medical Supply - Expiration Tracking Log Site Location____________________________

COLUMN →	1	2	3	4	5	6
Medication and Supplies	Exp. Date	Initial	Replacement Needed - Y	Replacement Date	New Exp. Date	Initial
Epinephrine/Adrenalin						
Benadryl - IM						
Acetaminophen						
Benadryl - Oral						
Ibuprofen						
Imodium						
Antacid						
Hydrocortisone Cream						
Decongestant						
Aspirin						
Glucose Chewable						
Burn Cream						
Antibiotic Ointment						
Sting Relief						
Glucometer Strips						
Antiseptic BSK wipes						
Alcohol Wipes						
Non-stick Bandage						
Conforming Gauze						
Gauze 2x2						
Gauze 4x4						
Cold Compress						
Triangular Bandage						
Band-Aids’						
Cotton Tip Applicators						
Ace Bandage						

**Columns 1 and 2 - complete upon Program Initiation and with each New Form [new form ONLY when new supply received]

**Column 3 - complete when supply is running low and replacement is needed

**Columns 4, 5 and 6 to be completed when a replacement item has been received

Clinician Name:	Initial:
Clinician Signature:	Date:
Clinician Name:	Initial:
Clinician Signature:	Date:

IV. **Resources:**

a. https://affiliatedphysicians.com/nursing-protocols/

b. **Assessment Form – Front Page**

[i] Created Date – 09.19.20
[ii] Last revised – 10.01.20, 04.12.21
[iii] Approved Date – 10.01.20