Community Outreach Policy

Policy Number: 7.1 Reviewed: 2/2022 Revised: 2/2022 EB Reviewed & Approved: 03/2022 Original Date: 10/1995

PURPOSE

1. Provide guidance for planning, managing, and creating partnerships and programs between the communities and healthcare organizations/agencies that support the mission of the association.
2. Aim to bridge the cultural gap between healthcare providers and the community.

POLICY

A. The community outreach committee is responsible for coordinating any community programs.
B. Develop programs that justifies how and where resources should be allocated to best meet the community needs.

PROCEDURE

The community outreach committee shall:

1. Direct all requests to the president and executive board.
2. Present a project proposal to the executive board for approval (see project proposal form)
3. Establish a schedule and seek volunteers.
4. Provide a written report of project outcomes to include number of volunteers, total number of hours served, total number of community citizens served to the executive board.
5. Provide a written report of any community concern or incident/injury report (incident report form) for any community member receiving first aid treatment.
6. Provide completed health screen release forms of every community member screened for health assessments.
7. Keep client information forms shall be secured. Since programs may be collecting financial, medical, and demographic information, forms should be safeguarded as any other client record and retained for a minimum of four (4) years.
8. Manage all equipment and supplies provided by the association.

Types of Outreach include the following:

A. Health Screening: Provide services that may include blood pressure screening and education to help prevent chronic diseases, such as hypertension and diabetes.
B. First-Aid Responders: Provide on-site basic first-aid, as well as patient stabilization until an ambulance or advanced medical team arrives.
C. Educational Fairs, Community or professional workshops: Deliver interventions that lead to positive health outcomes for populations experiencing health disparities ie Vaccines and vaccine education.
D. Other Supportive Community Outreach: Donation Drives (ie Food and Clothing), Meals on Wheels

First Aid Kits:

A. First aid kits are intended to allow persons to treat for minor medical incidents.
B. Any medical emergency which involves loss of consciousness, profuse bleeding, possible broken bones, head or neck injuries, serious burns, cardiovascular distress, or any serious injury or illness should immediately be referred to Public Safety by dialing 911.
C. First aid kits shall be inspected and replenished at least once a year. All expired items, leaking, or non-sterile items must be removed.
D. Due to possible allergic reactions, the PNAVA shall not fund or maintain any form of medication (oral, inhaled, topical prescription or non-prescription) in first aid kits for use by the general population.
E. The use of a CPR Pocket Mask is best done by those trained specifically in CPR.

REFERENCE (S)

ATTACHMENT(S)
1. Revision History
2. Client Information Form
3. Health Screening Consent Agreement
4. Incident Reporting Form

Attachment 1: Revision History

Original Author: Precy Custodio
President: Venus Tomaneng, 1995
Reviewed: 2017 P&P Committee
President: 2017 Hilo Laxa
Reviewed: 2/2022 P&P Committee
President: 2020-2022 Catherine Paler

Attachment 2: Client Information Form

Community Outreach - Client Information Form

Client Information

Client Name	First	Last
Street Address	City/State	Zip Code
DOB:	Gender: Race:	Marital Status:
Occupation	Employer	Employer Address:

Emergency Contact Information:

Emergency Contact Person	Street Address	City/State
Phone No:	Email:	

Screening Data:

Complaints:
Allergies:
Medications:
Vital Signs: T: B/P: Pulse: Resp: Ht: Wt: Blood Glucose: Cholesterol:
Comments:
Screening Designee: Date:

Attachment 3.
Health Screening Consent Agreement

The undersigned hereby requests that a health screening be performed by the Philippine Nurses Association of Virginia, Inc.'s (hereinafter referred to as "PNAVA, Inc." or "Sponsor") staff present at the Community Health Screening on _____ at _____.

I UNDERSTAND AND ACKNOWLEDGE THE FOLLOWING: The data obtained from the screening is to be considered as preliminary only and in no way conclusive. The screenings are not diagnostic and may occasionally miss abnormalities, which more definitive tests would detect. The professionals involved do not have access to and cannot consider my past medical history or certain characteristics of my overall health. I recognize that physicians, nurses, physical therapists may provide the screenings I receive, or other professionals who are independent contractors not employed by PNAVA, Inc. The Sponsor does not endorse or guarantee the results of such tests and may have no control over individuals providing this service. No physician-patient relationship will be formed by participation in this Community Health Screening and no patient medical record will be created or maintained.

It is my choice if I wish to obtain any follow-up evaluation or care concerning any and all results detected at this health screening. I am solely responsible for obtaining appropriate medical attention and advice, if any, and may contact any health provider I wish. Neither the Sponsor nor any individual involved in the health screening is responsible for any necessary continuing care. **I understand and acknowledge that there is a minor risk of injury or harm due to the tests I am voluntarily requesting be performed and I agree to assume such risk. Furthermore, at any time during the screening, if I do not wish to continue, I may withdraw from the screening process.**

Privacy Standards:
In the screening environment, because of the space limitations, there can be no guarantee that everything said during the actual screening event will be confidential. Those clients being served in surrounding stations may be able to overhear information about you, i.e., your screening results. If there is information being asked or being discussed about which you do not feel comfortable, you may ask any of our staff to speak with you "one-on-one" in another area. I understand that by signing this form I am agreeing to allow the PNAVA Community Outreach staff to assess me in the screening, and discuss the immediate results, data and healthcare information needed for record keeping, along with answering any questions that I may have. I understand that other participants may overhear what is being

said. I am waiving or giving up my right to privacy of healthcare information, only during the screening event.

I understand that if I have concerns about disclosing information, I may request any staff member to meet and discuss healthcare information in a more private location. I acknowledge that I have had an opportunity to read and review PNAVA's Notice of Privacy and to receive a copy of the same. If you have any questions, contact PNAVA Community Outreach at pnavacomhealth@gmail.com.

I AM EIGHTEEN (18) YEARS OF AGE OR OLDER, COMPETENT, HAVE READ AND UNDERSTAND THE ABOVE STATEMENT AND DESIRE TO HAVE SUCH SCREENING PURSUANT TO THE TERMS CONTAINED HEREIN. I HEREBY RELEASE AND FOREVER DISCHARGE PNAVA, ITS' RESPECTIVE AFFILIATES, OFFICERS, DIRECTORS, EMPLOYEES, VOLUNTEERS, AND AGENTS FROM ANY AND ALL LIABILITY, CAUSES OF ACTIONS, SUITS, CLAIMS AND DEMANDS OF ANY KIND WHATSOEVER ARISING FROM OR IN ANY WAY CONNECTED WITH THE PHYSICAL ACTIVITY, OR OTHER PROCEDURES NECESSARY TO CONDUCT THIS SCREENING. MY SIGNATURE BELOW INDICATES MY CONSENT TO PARTICIPATE IN THIS SCREENING.

Print Name/ DOB	**Sign Name**

Attachment 4. Incident Reporting Form

Incident Report Form

Use this form to report accidents, injuries, medical situations, or student behavior incidents. (Incidents involving a crime or traffic incident should be reported directly to the Police.) If possible, the report should be completed within 24 hours of the event. Submit completed forms to the President for review.

INFORMATION ABOUT PERSON INVOLVED IN THE INCIDENT			
Full Name		Birth Date	
Home Address			
Student	Employee	Visitor	Vendor
Phone Numbers	Home	Cell	Work

INFORMATION ABOUT THE INCIDENT		
Date of Incident	Time	Police Notified ☐ Yes ☐ No
Location of Incident		
Description of Incident (what happened, how it happened, factors leading to the event, etc.) Be as specific as possible (attached additional sheets if necessary)		
Were there any witnesses to the incident? ☐ Yes ☐ No If yes, attach a separate sheet with names, addresses, and phone numbers.		
Was the individual injured? If so, describe the injury (laceration, sprain, etc.), the part of the body injured, and any other information known about the resulting injury(ies).		
Was medical treatment provided? ☐ Yes ☐ No ☐ Refused If yes, where was treatment provided: ☐ on site ☐ Urgent Care ☐ Emergency Room ☐ Other		

REPORTER INFORMATION
Individual Submitting Report (print name)
Signature
Date Report Completed

FOR OFFICE USE ONLY

Report Received by _____ Date _____ **FOR OFFICE USE ONLY**

Document any follow-up action taken after receipt of the incident report.

Date	Action Taken or Follow Up	By Whom