Sexually Transmitted Infection Screening
Standing Orders

Definition
Non-Patient Specific Standing Orders are written instructions, orders, rules, regulations, or procedures prepared by a physician and designed for a patient population with specific preventative care or screening needs. Standing Orders are distinct from specific orders written for a particular patient.

Purpose
The purpose of these Standing Orders is to provide authority for specific acts of STD clinical services under authority of New York State. Reference: Education Law §6909, §6801 and 8 NYCRR §64.7, §64.5.

Authorized Delegated Acts
This Standing Order gives the authorized registered nurse authority to perform the acts described in this Standing Order in consultation with Dr. Jonathan Swartz, Chief Medical Officer or the site Medical Director as needed.

It is the intent of all parties involved that all procedures conform to the New York State Laws regarding Non-Patient Specific Orders and Protocols and the 2015 CDC STD Treatment Guidelines, published June 2015.

Level of Experience, Training, Competence and Education Required
To carry out acts under this SDO, an authorized licensed nurse must:

1. Be an employee of ****
2. Be a registered nurse
3. Hold a current nursing license from the New York State Board of Nursing
4. Be currently certified in Basic Life Support;
5. Have completed Chief Medical Officer approved training in accordance with appropriate STD clinical procedures and standards;

Procedures and Requirements to be followed by Authorized Registered Nurses

1. Adhere to all infection control precautions when participating in clinical services.

2. Utilize interpreter services to facilitate patient and provider communication as it relates to limited English proficient (LEP) patients.

3. Ensure, to the extent possible, that the patient seen for STD clinical services is, in fact, who the person claims to be, using two patient identifiers name and date of birth,

4. Document the history and the physical findings in the patient's medical record, including:
    a. A personal and medical (including sexual) history;
    b. Nursing care delivered on each patient visit, including an appropriate physical examination,
    c. Actions carried out under the Standing Order
    d. Drugs or medications administered, provided, or observed to be taken by the patient (directly observed therapy);

e. Patient teaching and counseling, including precautions and preventive measures; and

Limitations on Setting
Authorized registered nurses can provide services under these standing orders in the Health Center setting or other field settings when the authorizing physician can be contacted by phone.

1. Nurses (RNs) who provide services using these orders should contact the authorizing physician (or the authorized health care provider on call) directly when medical direction or consultation is needed, if patient assessment data deviates from normal limits, or as specified in any individual standing order. In an emergency, the Registered Nurse is to call 911, provide first aid services, and contact the supervising physician.

PROTOCOL: When an established patient presents or calls and there is little or no providers availability the patient will be offered the option of Registered Nurse STI screening visit. **The patient may opt for comprehensive services visit with a provider on a later date**.

If the assessment reveals no high-risk criteria and the patient has no symptoms, the registered nurse may collect a urine specimen and as appropriate pharyngeal, rectal and vaginal self-swabs from the patient for Gonorrhea and Chlamydia testing and have the patient's blood drawn for HCV, HIV and Syphilis. Self-collected vaginal swabs are recommended as they are more likely to detect infection in women than the urine test.

If the history and/or assessment reveals the patient has symptoms and or recent exposure. The patient may be referred to a provider for a comprehensive exam or visit converted to a co-visit to allow for same day treatment.

PATIENT EDUCATION: Counseling should include – 1) how to obtain results, 2) symptoms of complications (e.g., pelvic pain in women, testicular pain in men, or fever in men or women), 3) referral to prenatal care or family planning if pregnancy is confirmed or possible, 4) how to take the medication (if provided), 5) abstaining from sex for at least seven days after completing treatment, 6) ensuring all partners have been treated, and 7) the need to be re-screened three months after treatment 8) STI prevention strategies and condom use should be reviewed and documented.

SEXUALLY TRANMITTED INFECTION (STI) NURSE VISIT PROCEDURE

Initial Patient Interaction

1. Cordially greet patient.

2. Verify name and address.
3. Determine the chief complaint – get to the patient's agenda first.
4. Stress the importance of confidentiality.
5. Verify best contact number to reach patient for lab results follow up.

Obtain and Document Sexual History and Family Planning Screening

1. Use open-ended questions when eliciting the medical/sexual history outlined in the patient's medical record. (Begin questions with "Who," "What," "When," "Where," "How," "Tell me about," etc.)
2. The history should cover the "Five Ps"
    - **P**artners – gender and number, new partners, most recent sexual exposure
    - Sexual **P**ractices – oral (give/receive), anal(give/receive), vaginal sex
    - **P**revious STDs – when and how treated, last HIV test
    - **P**rotection from STDs – condom use, risk reduction
    - **P**regnancy Prevention – contraceptive use
    - Transgender patients - Clinicians should assess STD and HIV-related risks for their transgender patients based on current anatomy and sexual behaviors. There is a broad range of physical and gender expression (i.e., surgical affirming procedures, hormone use, etc.) among transgender patients. The most important principle to apply in general prevention and screening is to provide care based on the patient's anatomy, history (i.e., partners, practices, past STDs, protection and pregnancy prevention), and symptoms, regardless of the patient's self-description or identification, or presenting gender. STD/sexual health care should always be provided in a sensitive, respectful, and affirming manner that recognizes and honors the patient's self-description or self-identification.

Laboratory Specimens

1. Serological specimens for syphilis and HIV can be collected by nursing or laboratory personnel.
2. Urine specimens for male patients NAAT testing are collected.
3. Vaginal Self Swabs (preferred method) or urine specimens collected for female patients
4. Urine specimens from women are collected before the physical exam. Urine specimens may be needed for pregnancy testing or evaluation for urinary tract infection.
5. Vaginal and rectal NAAT tests may be collected by patients or clinicians. If collected by clinician chaperone required.
6. Perform a urine pregnancy test if a female reports abdominal pain or undiagnosed pregnancy is suspected [i.e., the patient is not using a reliable method of contraception and she is ≥4 weeks past her last menstrual period (LMP).]
7. An antibody test for Hepatitis C is recommended when the following risks are present in the patient's history:
    a. HIV infection
    b. A recognized exposure
    c. Past or current injection drug use
    d. A blood transfusion before 1992
    e. Long-term hemodialysis
    f. Born to a mother with HCV infection
    g. Intranasal drug use
    h. An unregulated tattoo and other percutaneous exposures
    i. Born between 1945-1965
8. See next section, Specimen Collection, for descriptions of proper collection techniques for each test.

Specimen Collection

NAAT urine test:

1. Ensure that the patient has not voided within the last hour prior to collection.
2. Instruct patient to collect the first part of the urine stream, obtaining 15-20 cc. of urine in a paper or disposable cup -- allow the remainder of stream to go into the toilet.
3. Obtain urine specimen from patient and use kit pipette to transfer 2 cc. to the urine tube provided in the kit. (This is different than urine collection for culture which requires clean-catch midstream in a sterile container.)
4. Close the tube securely and label with patient's name, clinic name, and date of collection. Place in biohazard bag with requisition form (when required) and refrigerate immediately if transport is delayed.

NAAT vaginal swab (preferred method):

1. Peel open the swab package and remove the swab. Be extremely careful not to touch the soft tip or to lay the swab down. If the soft tip becomes contaminated, a new vaginal swab collection kit must be opened and used.
2. Hold the swab, placing your thumb and forefinger in the middle of the swab shaft covering the score line. Do not hold the swab shaft below the score line.
3. Carefully insert the swab into the vagina about 2 inches (5 cm.) past the introitus and gently rotate swab for 10 to 30 seconds. Make sure the swab touches the walls of the vagina so that moisture is absorbed by the swab and then withdraw swab without touching the skin.
4. While holding the swab in the same hand, unscrew the cap from the tube. Do not spill the contents of the tube. If the contents of the tube are spilled, use a new vaginal swab specimen collection kit.
5. Immediately place the swab into the transport tube so the score line is at the top of the tube.
6. Carefully break the swab shaft at the score line against the side of the tube.
7. Immediately discard the top portion of the swab shaft.
8. Tightly screw the cap onto the tube.
9. Place in biohazard bag with requisition form when required.

Rectal NAAT (if available for applicable):

1. Stand patient at the end of the examination table facing the length of table. Ask patient to bend forward until his elbows are resting on the examination table.
2. Insert the swab 3 - 5 cm into the rectum and rotate against the rectal wall several times. Move swab from side-to-side in the anal canal to sample crypts. If it is difficult to adequately visualize the anus, request that the patient assist by grasping a buttock in each hand and gently spreading the opening for specimen collection.
3. Allow swab to remain 10-30 seconds for absorption of organisms onto the swab.
4. Repeat the process if the swab is grossly contaminated with feces.
5. Immediately place the swab in to the specimen transport tube.
6. Break the swab at the score line. Recap the tube tightly.

Pharyngeal NAAT

a. Swab back of throat and tonsillar area with a sterile applicator in the test kit.
b. Carefully remove the swab, not touching any area of the mouth. Immediately place

the swab into the specimen transport tube and break swab at the score line.

c. Recap the tube tightly.
d. Recap the swab specimen tube tightly. Label with patient's name, date, and clinic name.
e. Place in biohazard bag with requisition form when required.

Date and Signature of the Authorizing Physician

This Standing Order shall become effective on the date that it is signed by the authorizing physician, below, and will remain in effect until it is either rescinded, upon a change in the authorizing physician.

Authorizing Physician's Signature:

_____

Authorizing Physician's Title: _____

Printed Name:

_____

Effective Date:

_____

Emergency Contact Information: _____