County of Los Angeles Public Health

Lead Poisoning

Pertinent Healthy People 2010 Leading Health Indicators:

- Environmental Quality
- Access to Health Care

Assess

Nursing Practice

1. Review Lead Poisoning Case Management Reporting (CMR) form and Childhood Lead Poisoning Prevention Program (CLPPP) progress notes when received from Public Health Nursing Supervisor (PHNS) and on the Nursing Practice Management System (NPMS). Document Date/Time/Signature on referral when received from PHNS.
2. Analyze report for:
   a. Laboratory results, Lead Poisoning Case Management Reporting (CMR) form and CLPPP Progress Notes
3. Assess case/family/caregiver and complete the forms related to:
   a. Lead exposure and management per guidelines in the:
      - Lead Poisoning Follow-up form or Instructions/Appendix C (LPFF)
      - Management Guidelines for Childhood Lead Exposure by Blood Lead Levels (BLL Matrix)
      - MOU between Maternal Child & Adolescent Health Program, CLPPP, Environmental Health Services & Community Health Services
      - Medi-Cal Outreach Questionnaire
      - 'Reminder' cover letter
   b. Educational and resource needs related to lead exposure
4. Assess client and household per PHN Assessment criteria.
5. Assess nutrition status of client with the client's caregiver using the CLPPP nutritional screening form "What does your child eat?"
6. Assess client and household members for lead exposure per the CLPPP Progress Notes and the LPFF.

Diagnose

1. Verify the medical diagnosis & determine priority of action:
   a. Review Section/page D3 of the Public Health Nursing Practice Manual for priority per CLPPP Matrix or determine the priority of action in consultation with the PHNS as needed. Document priority selected.
2. Consider client's/household members' need for nursing interventions based on possible or potential lead exposure and/or lead hazards.
3. Consider client's/household members' need for nursing intervention to promote health, facilitate well being, foster healing, alleviate suffering, and improve quality of life.

Identify Outcomes

Outcome Objective:

1. Prevent and/or minimize risk factors associated with lead exposure by:
   a. Identifying the lead exposure source
   b. Interrupting pathway of the lead exposure
   c. Ensuring a reduction in the elevated BLL
   d. Reducing/eliminating the consequences

Nursing Practice:

1. Determine & document specific health needs/goals for client's/household members' situation.
   a. Determine appropriate timelines for attainment of lead related outcomes according to the assessment and diagnoses (see Matrix & MOU).

Other References

- Health Education Materials
- Public Health Nursing Practice Manual
- Childhood Lead Poisoning Prevention Program

Plan

Plan for the following Public Health Nursing Interventions:

1. **Health Teaching/Counseling:**
   a. Educate client/household members/caregiver using lead awareness & health education materials included in the DPHN packet received w/referral.
   b. Provide nutrition counseling based on assessment from nutritional screening form "What Does Your Child Eat?" and "My Pyramid Steps to a Healthier You" at www.mypyramid.gov.
2. **Case Management:**
   a. Provide nursing care per guidelines in Matrix & the MOU.
   b. Maintain desk card until closure.
   c. Coordinate re-testing of client every 4-6 weeks with the primary care provider (PCP).
   d. Select growth chart by age and gender and plot height and weight.
   e. Monitor medical management with primary care provider until case meets criteria for closure (see literature provided with case by CLPPP).
   f. Obtain caregiver/client signatures for the DHS General Consent Form (H521) and the DHS Release of Confidential Information Consent Form (H196).
   g. Follow at-risk household members with elevated BLL per the same guidelines in the Matrix as for the client.
   h. Open a medical record.
3. **Surveillance:**
   a. Monitor adherence to recommended medical treatment.
   b. Monitor client & at-risk household members until they meet closure definition.
   c. Review BLL results of client & at-risk household members every 4-6 weeks.
   d. Review with Registered Environmental Health Services Specialist (REHS) the progress of remediation, abatement or removal of lead source.
4. **Case Finding:**
   a. Ensure that at-risk household members receive a BLL per guidelines in the Matrix.
5. **Consultation:**
   a. Provide advice to PCP based on Matrix guidelines.
6. **Collaboration:**
   a. Provide update (including BLLs) to CLPPP PHN every 3 months.
7. **Referral and Follow-up**:
   a. Make referrals as needed based on assessment.
   b. Follow-up with PCP on PHN & REHS recommendations in Appendix C.
   c. Follow-up with PCP every 4-6 weeks to ensure client and at-risk household members are retested for BLL.
   d. Consult with CLPPP-PHN for household members who have no PCP and no health care coverage.
   e. Refer client and household members for health care coverage based on results on Medi-Cal Outreach questionnaire.
8. **Disease and Health Event Investigation:**
   a. Provide disease and health event investigation per guidelines in LPFF & Appendix C, Matrix, MOU, & CLPPP Progress notes.
9. **Other:**
   a. Plan interventions needed to assist client/household members with concerns identified in PHN Assessment.

Implement

1. PHN interventions are implemented as stated in the plan.
2. Document all consultations, collaborations, interventions, and encounters with caretaker on the investigation forms, and/or in the medical record/NPMS.

Evaluate

1. Evaluate effectiveness of interventions on the health of the client/household members; e.g. document client understands lead poisoning.
2. Determine action for non-adherent client/household member:
   a. Consult with PHNS and CLPPP PHN.
3. Complete and submit investigation forms:
   a. Submit initial documentation on LPFF (p.1-10), Appendix C, nutritional assessment "What Does Your Child Eat", growth chart and Medi-Cal Outreach Questionnaire to PHNS for review within 14 days of initial home visit or within the timeframe agreed upon with PHNS.
   b. Fax initial documentation on the LPFF (p.1-10), Appendix C (p.1) to assigned REHS within 30 calendar days of initial DPHN home visit.
   c. Submit original LPFF and Appendix C, nutritional assessment "What Does Your Child Eat", growth chart, client consent form, client release of information form, Medi-Cal Outreach Questionnaire, and PHN Assessment to assigned CLPPP PHN within 30 days of case closure.
   d. Retain a copy of all forms for district medical record.
4. Document in NPMS:
   a. File a copy of the PHN Assessment per PHN Assessment Form instructions.
5. Evaluate caregiver satisfaction:
   a. Give client satisfaction form to caregiver for completion and submission in a pre-addressed, stamped envelope.