

Clinical Placement Online Orientation

MODULE 1: Basics of Student Placements

Student Role and Responsibilities

Students in clinical education settings are obligated with special responsibilities. Students apply their knowledge and skills in the care of patients/residents under the guidance of an instructor and/or preceptor. Students' behavior should reflect the values of the health care organization at all times. Policies and guidelines for clinical placements are designed to facilitate student identity, patient/resident safety and comfort, and infection control.

The student will:

- Understand the objectives and learning outcomes of the course.
- Contribute to the development of objectives for the clinical experience.
- Look for opportunities to learn and recognize the wealth of information available in the clinical area.
- Be prepared for each day, and dress and act in a professional manner.
- Respect the safety and well being of the patient/resident in the clinical learning experience.
- Adhere to the general rules, policies, and regulations of the health care organization.
- Obtain a report from the staff, preceptor or instructor prior to giving care and collaborate with staff members who retain responsibility for the patient/resident.
- Immediately inform the patient/resident care provider of significant changes in a patient's/resident's condition.
- Introduce him/herself appropriately to patients/residents and ask permission to participate in their care.
- Use clear, accurate and effective communication skills in professional interactions.
- Recognize her/his knowledge, skills and abilities, limits of responsibilities, legislative authority and supervision requirements.
- Recognize that she/he is accountable for the quality of care she/he provides within the established objectives.
- Recognize her/his responsibility to notify the educator if learning objectives are not being achieved due to setting and/or the preceptor relationship.
- Communicate situations of conflict in which a student perceives that his or her individual cultural values, ethics, or religious beliefs are in direct conflict with specific aspects of the clinical or observational experience.
- Check with the instructor or preceptor before administering any medications (all medication orders are to be verified per health care organization's policy before they are given).
- Complete the clinical assignments before leaving the facility.
- Document patient/resident assessments or observations, the care provided to the patient/resident, and the patient's/resident's response to that care.
- Give a report to the staff on the condition and care of the assigned patient(s)/resident(s) before leaving the clinical area for any reason.
- Implement measures to promote a safe environment for each patient/resident.
- Delineate, establish, and maintain professional boundaries with each patient/resident.
- Provide privacy during examination or treatment and in the care of personal or bodily needs.
- Provide care to assigned patient(s)/resident(s) without discrimination and treat each patient/resident with courtesy, respect, and with full recognition of dignity and individuality.

- Know the infection control, safety, fire, and emergency procedures of the health care organization.
- Be friendly, courteous and polite.

STUDENTS ARE PERMITTED TO ADHERE TO THE WRITTEN AGREEMENT BETWEEN THE HEALTH PROFESSIONS PROGRAM AND THE HEALTH CARE ORGANIZATION, WHICH INCLUDES SPECIFIC RESPONSIBILITIES OF THE PROGRAM, STUDENT, PRECEPTOR AND FACULTY.

Students are *NOT* permitted to:

- Perform delegated medical acts.
- Act as a witness under any circumstances or for any purpose.
- Provide second signature/check for controlled drugs, blood products, and medications listed as requiring independent double-checking, double signing and documentation.
- Provide telephone advice to discharged patients or their families.
- Perform any skill or procedure for which the student has not attained competency without the clinical instructor, preceptor or staff present.
- Take verbal or telephone orders.
- Carry narcotic keys.
- Be left in sole charge of the department, unit or any patient/resident.
- Transport patients/residents alone when the presence of an RN is required.
- Engage in behavior that causes or may cause physical, verbal, mental, or emotional abuse to a patient/resident.
- Remove a medical record or a printout of the medical record from the unit.
- Falsify any patient/resident record or any other document prepared or used in the health care organization.
- Eat, drink, and chew gum in patient/resident care areas.

PROFESSIONAL IMAGE

- **Clothing/Uniform:**
 - All clothing should be conservative and in keeping with the nature of the health care organization image and appropriate to the nature and scope of the position.
 - Clothing should be neat, clean, pressed, well-fitting and in good repair with no holes or wrinkles.
 - No jeans, sandals or open-toed shoes are allowed.
 - If required, a designated school uniform should be worn as per health professions program's policy.
 - When the task dictates, students are required to wear personal protective equipment (PPE), i.e., gloves, gowns, masks, etc., per Standard Precaution Guidelines and per OSHA requirements.
- **Grooming:**
 - Nails are to be kept short, less than ¼ inch from fingertip.
 - Artificial nails are not allowed.
 - Make-up should be used in moderation.
 - Toiletries with strong odors, such as perfume, aftershave and hair spray should not be detectable.
 - Hairstyles are to be conservative, clean and long hair is to be secured back and away from the face.
 - Beards and mustaches are to be neatly trimmed.
- **Jewelry/Tattoos:**
 - Wear only jewelry that is small in size and that does not create a safety hazard or interfere with one's work. Wear only non-dangling earrings for pierced ears.

- Body piercing and tattoos should be covered and not visible to patients/residents/families at all times.
- **I. D. Badge:**
 - Appropriate school ID badge must be visible at all times.
 - If required, a hospital I. D. badge must be worn and visible at all times.

IF INAPPROPRIATELY DRESSED OR APPEARANCE IS NOT NEAT AND CLEAN, THE STUDENT WILL BE SENT HOME.

- **Smoking:**
 - Many of the health care organizations are smoke free environments; others may permit smoking in a designated area.
- **Telephone:**
 - Telephone etiquette has become a key focus in providing exceptional service. Phones should be answered promptly. Speak clearly and identify yourself as a student. Always use a pleasant and friendly tone. Never interrupt the person while he/she is talking to you.
 - Students are not allowed to take telephone orders or receive critical laboratory results over the phone.
 - DO NOT USE HEALTH CARE ORGANIZATION TELEPHONES FOR PERSONAL CALLS.
- **Pager/Cell Phone:**
 - Use of cellular telephones and pagers in the clinical setting can be disruptive to the learning environment and should not be used during clinical.
 - Absolutely NO texting or personal internet use during clinical.

PROHIBITED CONDUCT

Activities prohibited by health care organizations include, but are not limited to, the following:

- Reporting to clinical experience intoxicated or under the influence of alcohol or drugs.
- Use or consumption of alcohol or other intoxicating substances on health care organization premises.
- Selling or distributing illegal substances while on health care organization premises.
- Stealing from patients/residents, the health care organization, or employees.
- Any form of dishonesty.
- Falsifying any patient/resident record or any other document prepared or used in the course of, or in conjunction with, patient/resident care.
- Disorderly conduct, including fighting; acting in an obscene manner or using obscene, abusive or threatening language; or horseplay.
- Smoking in an area where smoking is prohibited.
- Defacing or damaging the health care organization's property.
- Possession or use of firearms, fireworks, or any other weapon on health care organization's property.
- Use of health care organization's telephones or other equipment for personal matters.
- Insubordination.
- Failure to observe health care organization regulations and/or policies.
- Failure to maintain the confidentiality of health care organization matters, including matters relating to patients/residents.
- Any action that destroys good relations between the health care organization and its employees or between the health care organization and any of its suppliers or patients/residents.

PARKING

If parking is permitted, students must park in the designated parking area. Violators are subject to corrective actions including ticketing, towing, disciplinary corrective action, or revocation of parking privileges. All vehicles are towed at the owner's expense.

Park at your own risk. The health care organization does not assume responsibility for the loss, damage, or destruction of any vehicle or its contents as a result of parking at the health care organization.

ACCIDENT/INCIDENT DURING CLINICAL

If an accident/incident (e.g. puncture wound, splash in the eye, fall or back injury) occurs during a clinical experience, including an exposure to blood and/or other body fluids the instructor, preceptor, or supervisor must be notified immediately. Follow your health professions program's policy and document on the appropriate facility forms.

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Patient Rights

Federal and state laws provide for specific patients' and residents' rights. All patients and residents have rights and are informed of these rights upon health care organization admission. They are known as the **Patient's Bill of Rights**. Many health care organizations have patient advocates who can help patients/residents if they have problems. Many states have an ombudsman office for problems with long term care. The following summarizes **key areas of** federal laws and the MA/ME/NH Patients' and Residents' Rights.

The Right to Information Disclosure.

Patients/Residents have the right to receive accurate, easily understood information to assist them in making informed decisions about their health plans, facilities and professionals.

The patient/resident has the right to:

- The accommodation of special needs, such as language interpreters for communication, special equipment to accommodate physical limitations, or accommodations to meet cultural or religious needs.
- Receive adequate explanation of their health problems, the proposed treatment, the risk and benefits of treatment, and the realistic care alternatives in a manner that they understand so that they may give voluntary and well-informed consent.
- Inspect their medical record, request an amendment, to have such information explained or interpreted as necessary, except when restricted by law, and for a reasonable fee, receive a copy of their record. No fee shall be charged to receive a copy of their medical record if they show that their request is to support a claim or appeal under any provisions of the Social Security Act in any federal or state financial needs-based benefit program.
- Know the identity, specialty of the doctor, and professional status of individuals involved in their care.
- Request and receive an explanation as to the relationship, if any, among the health care facility, educational institutions, other health care providers, or payers that may influence their treatment and case.

Informed Consent

- Informed consent to the extent provided by the law.
- Have their consent obtained prior to any recording or filming of care treatment and services provided to them, which are made for purposes other than the identification, diagnosis or treatment.

Billing and Finance:

- Have their questions answered and long-term financial implications of treatment choices explained, insofar as they are known, except in emergency situations.
- Receive from a person designated by the health care facility, upon request, any available

information that the facility has available relative to financial assistance, payment, and free care.

- Request and receive an itemized explanation of their medical bill reflecting laboratory charges, pharmaceutical charges, and third party credits.

The Right to Choose.

Patients/Residents have the right to choose health care providers who can give them high-quality health care when they need it.

The patient/resident has the right to:

- Freedom of choice in their selection of a facility, or a physician or health service mode, except in emergency medical treatment or as otherwise provided for by contract.
- Request that another physician treat them in the event that they are not satisfied with the medical treatment they are receiving from a particular physician.
- Transfer to another facility when medically appropriate or upon their request. However, the receiving facility must accept the transfer, and the patient or resident must also have the benefit of complete information and explanation concerning the risks, benefits, and alternatives to such transfer.
- Formulate and have advance directives, such as a living will or health care proxy and to have hospital staff and practitioners who provide care in the hospital comply with these directives.
- Participate or have their designated representative participate in the consideration of ethical decisions that may arise in their care.
- Transfer to another room, upon availability, if another patient/resident or visitors in their room are unreasonably disturbing them.

The Right to Access Emergency Services.

Patients/Residents have the right to access emergency health services when and where the need arises.

The patient/resident has the right to:

- Be screened and stabilized using emergency services if they have severe pain, an injury, or sudden illness that makes them believe that their health is in serious danger.
- Use emergency services whenever and wherever they need it, without needing to wait for authorization and without any financial penalty.

- Prompt life-saving treatment without discrimination due to economic status or source of payment.

The Right to Participation in Treatment Decisions.

Patients/Residents have the right to know their treatment options and take part in decisions about their care.

The patient/resident has the right to:

- Make decisions about the plan of care prior to and during the course of treatment and to refuse treatment to the extent permitted by law and health care facility policy, and to be informed of the medical consequences of this action. This includes the withholding of resuscitative services and the foregoing or withdrawing of life-sustaining treatment.
- Have parents, guardians, family members, or others that they select to represent them if they cannot make their own decisions.
- Refuse to be observed, examined or treated by students or any other staff without jeopardizing their access to care.
- Include or exclude any or all family members from participating in their health care decisions.
- Refuse to participate as a research subject, and to refuse any care or examination when the primary purpose is educational or informational rather than therapeutic. A patient or resident who accepts participation has the right to have the proposed studies fully explained prior to consent. A patient or resident who declines participation is nonetheless entitled to the most effective care that the facility can provide.

The Right to Care and Treatment.

Patients/Residents have the right to expect that health care organizations will give the necessary health services to the best of their ability. Treatments, referral, or transfer may be recommended.

The patient or resident has the right to:

- Have a family member or representative of their choice and their family physician notified promptly of their admission to the health care facility.
- A prompt response to all reasonable requests.
- Consult with specialists at their own request and expense.
- Be informed of the health care organization's policies and practices that relate to care,

treatment, and responsibilities.

Pain Management:

- Expect that their pain and symptoms will be assessed and treated with the goal of minimizing their experience of pain and discomfort, to the extent clinically possible.

Special Care Considerations:

- *If a female rape victim of childbearing age:* receive medically and factually accurate written information prepared by the commissioner of public health about emergency contraception; to be promptly offered emergency contraception; and to be provided with emergency contraception upon request. Catholic Hospitals will follow this procedure but first a pregnancy test will be performed and if negative, the patient will be provided with emergency contraception.
- *If suffering from any form of breast cancer:* receive complete information on all alternative treatments that are medically viable.
- *If a maternity patient:* receive information about the hospital's rate of cesarean sections and related statistics.
- *If a dying patient/resident:* receive care that optimizes dignity through the treatment of primary and secondary symptoms (as desired by the patient/resident or the Health Care Proxy), the management of pain, and acknowledgment and support of psychological and spiritual concerns of the patient/resident and family.

The Right to Respect and Non-Discrimination.

Patients/Residents have the right to considerate, respectful care from their doctors, health plan representatives, and other health care providers that does not discriminate against them.

The patient/resident has the right to:

- Safe, equitable, considerate, respectful care at all times and under all circumstances that includes consideration of their psychosocial, spiritual, cultural, and personal values and beliefs.
- Not be discriminated against in the marketing or enrollment or in the provision of health care services, consistent with the benefits covered in their policy and/or as required by law, based on race, ethnicity, national origin, religion, sex, age, current or anticipated mental or physical disability, sexual orientation, genetic information, or source of payment.
- Exercise cultural and spiritual beliefs that do not interfere with treatment and with the well being of others.
- Request pastoral and other spiritual services.
- Obtain a copy of any rules or regulations of the health care facility, which may apply to

their conduct as a patient or resident.

- Exercise all rights, benefits, and privileges as a citizen including the right to vote in primary, special, and general elections and in referenda.
- Promote care for patients/residents in a manner and in an environment that maintains or enhances each patient's/resident's dignity.

The Right to Privacy and Confidentiality.

Patients/Residents have the right to privacy and confidentiality of health information.

The patient/resident has the right to:

- Communicate with health care providers in confidence and to have the confidentiality of their individually-identifiable health care information protected.
- Privacy during medical treatment or other rendering of care within the capacity of the health care facility.
- Be afforded security and confidentiality of information, including all medical records and communications concerning their medical history and treatment to the extent provided by law. Those not directly involved in their care must have the patient's or resident's permission to be present during case discussions, consultation sessions, examination, treatment sessions, and the review of their chart.
- Receive a notice of privacy rights and practices in accordance with the federal law.
- The right to privacy in the patient's/resident's room or the patient's/resident's portion of the room. Staff may not enter a patient's/resident's room without making their presence known, except when the patient/resident is asleep, in an emergency threatening the health or safety of the patient/resident, or as required by the patient's/resident's care plan.

The Right to Speedy Complaint Resolution.

Patients/Residents have the right to a fair, fast, and objective review for resolving differences.

The patient/resident has the right to:

- A fair and efficient process for resolving differences with their health plans, health care providers, and the institutions that serve them, including a rigorous system of internal review and an independent system of external review.
- Be informed of the health care facility policies for resolving disputes, grievances, breaches of privacy, and conflicts, such as Patient Advocate or other methods available at the health care facility and to file a grievance. In addition, the patient or resident has the

right to file a grievance with either the:

- Maine: Maine Department of Human Services, Division of Licensing and Regulatory Services (1-800-791-4080);
- Massachusetts: Massachusetts Department of Public Health (1-800-462-5540), Division of Health Care Quality; the Massachusetts Board in Medicine (1-617-654-9800);
- New Hampshire: The New Hampshire Hospital Patient Rights Investigators (1-603-271-5918); or
- The Joint Commission, Office of Quality Monitoring (1-800-994-6610).

The Right to Safety.

Patients/Residents have the right to expect reasonable safety insofar as the health care facility practices and environments are concerned.

The patient or resident has the right to:

- Be free from any form of physical or chemical restraint(s), which are medically unnecessary or are used as a means of coercion, discipline, convenience, or retaliation by staff.
- In some settings, a restraint can be used if needed to improve the patient/resident well-being or to protect others from harm and only if less restrictive interventions have been determined to be ineffective.
- Access advocacy or protective services and to be free from all forms of abuse and harassment.

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Patient Confidentiality and HIPAA Education

The Health Insurance Portability and Accountability Act (HIPAA), includes important laws and regulations governing health insurance coverage protection and health information security for Americans and their families. Of particular note for students are the sections of HIPAA that guarantee security and privacy of patients'/residents' identifiable information.

All students are required to complete HIPAA training by:

- Reviewing the [HIPAA presentation](#) (PDF) *(the PDF will open in a separate window)*.
- Completing the Module 1 Post-Test
- Signing off on the HIPAA Acknowledgement Form (you will be directed to a page with this form after completing the post-tests for all modules).

Detecting and Reporting Abuse

All health care organizations accept the responsibility to intervene in situations which threaten the general welfare of patients/residents. All cases of suspected abuse and neglect involving children, geriatric patients, and physically and mentally challenged patients/residents are required by law to be reported.

- **Abuse** is defined as physical, emotional or sexual injury and financial exploitation.
- **Neglect** is defined as the refusal or failure to provide a person with the necessities of life including, but not limited to, food, shelter, clothing, and the provision of medical care.

PHYSICAL ABUSE is the use of physical force that may result in bodily injury, physical pain, or impairment. Physical abuse may include but is not limited to such acts of violence as striking (with or without an object), hitting, beating, pushing, shoving, shaking, slapping, kicking, pinching, choking, pulling hair, and burning. In addition, inappropriate use of drugs and physical restraints, force-feeding, reckless driving, and physical punishment of any kind also are examples of physical abuse.

Signs and symptoms of physical abuse:

- Bruises, black eyes, welts, lacerations, and rope burns.
- Bone fractures and skull fractures.
- Open wounds, cuts, punctures, burns, untreated injuries in various stages of healing.
- Sprains, dislocations, and internal injuries/bleeding.
- Broken eyeglasses/frames, physical signs of being subjected to punishment, and signs of being restrained.
- Human bites.
- Hair pulls/bald spots.
- Unusual patterns or shapes which suggest the use of an instrument (belt buckle, electric cord, and cigarette burns).
- Head trauma.
- Laboratory findings of medication overdose or under utilization of prescribed drugs.

Behavioral Indicators:

- Sudden change in behavior or behavioral extremes (withdrawal, aggression, regression, depression).
- Inappropriate or excessive fear of parent or caretaker.
- Antisocial behavior such as substance abuse, truancy, running away, fear of going home.
- Unbelievable or inconsistent explanation for injuries.
- Excessive lies.
- Unusual shyness, wariness of physical contact.
- Report being hit, slapped, kicked, or mistreated.

SEXUAL ABUSE is non-consensual sexual contact of any kind and includes any unwanted touching, forced sexual activity, be it oral, anal or vaginal, forcing the victim to perform sexual acts, painful or degrading acts during intercourse (e.g., urinating on victim), and exploitation through photography or prostitution.

Physical Indicators:

- Torn, stained or bloody underclothes.
- Frequent, unexplained sore throats, yeast or urinary infections.
- Somatic complaints, including pain and irritation of the genitals.
- Sexually transmitted diseases.
- Bruises or bleeding from external genitalia, vagina or anal region.
- Pregnancy.

Behavioral Indicators:

- The victim's disclosure of sexual abuse.
- Regressive behaviors (thumb-sucking, bed wetting, fear of the dark).
- Promiscuity or seductive behaviors.
- Disturbed sleep patterns (recurrent nightmares).
- Unusual and age-inappropriate interest in sexual matters.
- Avoidance of undressing or wearing extra layers of clothes.
- Sudden decline in school performance.
- Difficulty walking or sitting.

EMOTIONAL ABUSE is more subtle and quite often goes unseen. It is the infliction of anguish, pain, or distress through verbal assaults, insults, threats, intimidation, humiliation, harassment, isolating a person from his/her family, friends, or regular activities, and enforced social isolation. Emotional abuse is cruel and is often more seriously damaging to self-esteem.

Physical Indicators:

- Eating disorders, including obesity or anorexia.
- Speech disorders (stuttering, stammering).
- Developmental delays in the acquisition of speech or motor skills.
- Weight or height level substantially below norm.
- Nervous disorders (rashes, hives, facial tics, stomach aches).

Behavioral Indicators:

- Habit disorders (biting, rocking, head-banging).
- Cruel behavior, seeming to get pleasure from hurting children, adults or animals; seeming to get pleasure from being mistreated.
- Age-inappropriate behaviors (bed wetting, wetting, soiling).
- Emotionally upset or agitated.
- Withdrawn and non-communicative or non-responsive.

NEGLECT is defined as the refusal or failure to provide life necessities as food, water, clothing, shelter, personal hygiene, medicine, comfort, personal safety, and other essentials as obligated. Neglect may also include failure of a person who has fiduciary responsibilities to provide care (e.g., pay for necessary home care services) or the failure on the part of an in-home service provider to provide necessary care.

Physical Indicators:

- Poor hygiene, including lice, scabies, severe or untreated diaper rash, bedsores, body odor.
- Squinting.

- Unsuitable clothing; missing key articles of clothing (underwear, socks, shoes); overdressed or underdressed for climate conditions.
- Untreated injury or illness.
- Lack of immunizations, medications.
- Indicators of prolonged exposure to elements (excessive sunburn, insect bites, colds).
- Malnutrition and dehydration.
- Hazardous or unsafe living condition/arrangements (e.g., improper wiring, no heat, or no running water).
- Unsanitary and unclean living conditions (e.g., dirt, fleas, lice on person, soiled bedding, fecal/urine smell).

Behavioral Indicators:

- Age-inappropriate behaviors (bed wetting, wetting, soiling).
- Withdrawn and non communicative or non-responsive.

FINANCIAL ABUSE is the mismanagement of money or stealing property belonging to the victim. Financial abuse may include denying access to funds, to making a person solely responsible for all finances. Examples include, but are not limited to, cashing a physical or mentally challenged person's or elderly person's checks without authorization or permission; forging a person's signature; misusing or stealing a person's money or possessions; coercing or deceiving a person into signing any document (e.g., contracts or will); and the improper use of conservatorship, guardianship, or power of attorney.

Signs:

- Sudden changes in bank account or banking practice, including an unexplained withdrawal of large sums of money by a person accompanying the physical or mentally challenged person or elder.
- The inclusion of additional names on a bank signature card.
- Unauthorized withdrawal of funds using the physical or mentally challenged person's or elder's ATM card.
- Abrupt changes in a will or other financial documents.
- Unexplained disappearance of funds or valuable possessions.
- Sub-standard care being provided or bills unpaid despite the availability of adequate financial resources.
- Discovery of a signature being forged for financial transactions or for the titles of the person's possessions.
- Unexplained sudden transfer of assets to a family member or someone outside the family.
- The provision of services that are not necessary.
- A report of financial exploitation.

Behavior of abuser:

- Controlling.
- Refuses tests/treatments for the patient/resident.
- Blames others for the abuse.
- May attempt to take patient/resident away before treatment is complete.
- Easily angered.
- Overly concerned.
- Refuses to leave patient/resident alone.
- Answers for the patient/resident.

Students Reporting Alleged or Suspected Abuse

- Any student having knowledge or suspicion of elder abuse/neglect, adult/domestic abuse/neglect or abuse/neglect of a child shall report such knowledge or suspicion to their instructor, preceptor, or supervisor.
- Physical signs and symptoms and psychological reactions should be included in the documentation of alleged or suspected abuse.
- Reports should be made immediately to the Nurse Manager/designee to implement the health care organization's policy on abuse which includes referrals to the proper agency.

NURSING HOME ABUSE: Elder abuse has become an increasingly serious problem in America's nursing homes. Nursing home residents are some of the most vulnerable victims due to physical or mental limitations. If there are any signs or indicators that nursing home abuse is present, immediate action should be taken.

Prevention and Prohibition of Abuse

In 1999, the Center for Medicare & Medicaid Services (CMS) added a comprehensive Abuse Prohibition Review to the federal survey protocol which is enforced by Long Term Care Ombudsman Programs in order to assure that facilities have developed and operationalized policies and procedures that prohibit abuse, neglect, involuntary seclusion and misappropriation of property for all residents of nursing homes. These include evaluation of a facility's procedures for the following:

- Screening of potential hires.
- Training of employees on issues related to abuse prohibition practices, i.e., definitions of abuse, neglect, misappropriation of resident property; signs of burnout; reporting of allegations, and appropriate interventions to deal with aggressive residents.
- Prevention information to residents, families and staff on how and to whom they report concerns etc..
- Identification of possible incidents or allegations which need investigation.
- Investigation of incidents and allegations.
- Protection of residents from harm during investigations.
- Reporting of incidents, investigations, and facility response to the results of their investigations.

Any health care provider, including health professions students, who believes a resident in a nursing home has been a victim of abuse must, by law, promptly report the abuse as outlined in the nursing home policy.

Requirement of the Law in Addressing Abuse and Neglect:

- **Child Abuse and Neglect**
"Child" is defined as anyone under the age of 18 or under the age of 21 if they have mental retardation. Required to report to: Local Child Protective Services.
- **Elderly Abuse, Neglect, and Exploitation**
An elder is defined as anyone 60 years of age or older. Required to report to: Local Elder Abuse & Protective Services.
- **Domestic Violence**
Serious injuries (i.e., burns, gunshot wounds, stabbings) attributed to domestic violence are reported to police. An abuse assessment and a safety assessment are made and documented in the record. A safe plan is discussed with the patient and documented.

- **Mentally Retarded Abuse and Neglect**

A person with mental retardation is defined as anyone who qualifies for the services of the Department of Mental Retardation and Development Disability. Required to report to: Local Department of Mental Retardation and Development Disability.

- **Nursing Home Abuse**

Nursing home abuse should be reported to:

- **Massachusetts:** Massachusetts Elder Abuse Hotline: 1-800-922-2275, State Long Term Care Ombudsman: 1-617-727-7750, Office on Aging, Massachusetts Department of Public Health, Board of Registration for Nursing Home Administrators, MassPRO, or Adult Protective Services.
- **Maine:** Elder Abuse Hotline: 1-800-624-8404 or Long Term Care Ombudsman: 1-207-621-1079.
- **New Hampshire:** New Hampshire Elder Abuse Hotline: 1-800-949-0470; Office of the Long-Term Care Ombudsman, or Bureau of Elderly & Adult Services (BEAS).

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- Berlinger, J. S. (2004). Taking an intimate look at domestic violence. *Nursing* 2004, 34(10), 42-46.
- MassResources.org. (2014). What is elder abuse? Retrieved from <http://www.massresources.org/elder-protective/services.html>.
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Workplace Violence

Workplace violence is any physical assault, threatening behavior, or verbal abuse occurring in the work setting (U.S. Department of Labor Safety & Health Administration, n.d.). Workplace violence is a particular concern in health care organizations because a small percentage of patients/residents or visitors may turn violent. Health care staff, health care workers, or their family or friends may also be violent as a result of stress, substance abuse, emotional problems, or troubled relationships. The availability of weapons heightens the danger. As with any hazard or risk, steps must be taken to minimize and prevent incidents of workplace violence.

National Agencies, National Institute for Occupational Safety and Health (NIOSH) and Occupational Safety and Health Administration (OSHA) mandate that health care organizations have a duty to provide a safe environment for their employees. By implementing a **ZERO TOLERANCE** for violence policy, health care organizations can assist in minimizing the frequency of abuse and the potential harm to employees. A comprehensive organizational violence prevention program should include:

- a reporting, documentation and tracking system for acts of violence.
- a workplace violence prevention policy that includes specific strategies that can be instituted system-wide in the event of a violent incident.
- post-event support.
- adequate training of personnel for recognizing danger signs and pre-and post-event incident management.

RECOGNIZING THE DANGER SIGNS

Be alert for signs of trouble, such as a patient/resident, visitor, health care worker or employee who:

- threatens, intimidates, or vows to get even with staff health care workers or others.
- shows or claims to have a weapon.
- states that people are out to get them.
- blames others for the situation.
- holds grudges.
- reacts defensively to criticism and/or is easily frustrated.
- gets angry easily and often and/or expresses undue anger or talks abusively.
- abuses drugs or alcohol.

STEPS TO PROTECT YOURSELF

- Get help if you feel unsafe while dealing with anyone; excuse yourself from the scene, and notify your clinical instructor, preceptor or supervisor immediately.
- Know where alarms are located and how to use them.
- Identify available exits.
- Identify potential weapons.
- Provide respectful customer service.
- Allow person to express concerns.
- Demonstrate empathy.
- Avoid being defensive.
- Use a shared problem solving approach.
- Listen actively; avoid blaming others.
- Report all incidents, (threats, unusual behavior) to your clinical instructor, preceptor or supervisor immediately.

- Report poor lighting.
- Report unauthorized personnel.
- Lock up personal belongings.
- Don't carry (and show) excessive amounts of cash.
- Don't wear excessive amounts of jewelry.
- Wear your ID badge.
- Request a Security escort to your car.
- Use the "buddy system"; never walk alone; and be alert to overly emotional patients, visitors, staff and health care workers who make threats or show extreme anger.

BULLYING

Bullying is a form of abuse and harassment and workplace violence. The bully at work could be your co-workers, managers, supervisors, doctors, patients/residents and/or their families.

Bullying includes:

- Verbal and physical threats.
- Unfair use of discipline.
- Blocking promotions or requests for time off.
- Excessive supervision.
- Undermining responsibility or being set up to fail.
- Spreading malicious rumors.
- Physical Isolation from co-workers.
- Verbal abuse such as: Swearing, racial or sexual slurs, angry intimidating words, verbal humiliation and/or demeaning comments in public or private.

Steps to decrease bullying:

- Tell others you trust and ask for help to develop a plan to address the bullying.
- Keep a diary with dates, incidents, behaviors and comments.
- Ask people you trust for help: co-workers, union representatives, your manager, human resource personnel, the worker ombudsman if available.
- Address the situation by speaking to the bully. Let it be known that the behavior is unacceptable.
- Contact an available Employee Assistance Program through your employer or through your personal health insurance company.

REPORTING

If a student observes signs of trouble, they should report it immediately to their clinical instructor, preceptor, or supervisor.

REFERENCES

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- Wilkinson, C. (2001). Violence Prevention at Work: A Business Perspective. *American Journal of Preventative Medicine*, 20(2), 155-160.

Safe Patient Handling and Movement

Health care providers experience musculoskeletal disorders (MSDs) more often than construction, mining, and manufacturing workers (NIOSH, 2012). Overexertion incidences associated with patient/resident handling activities, such as manual moving and repositioning, are the leading risk factors for MSDs in health care (NIOSH, 2012). There is more than 30 years of evidence that demonstrate that manual patient handling and relying on body mechanic is unsafe (Nelson et al., 2009). The evidence also indicates that safe patient handling (SPH) techniques, where health care providers use assistive equipment during transfers is effective in reducing the incidence of MSDs related to the handing of patient (Water, Nelson, Hughes & Menzel, 2009).

Safe manual handling technique must be used in combination with proper body mechanic (correct body positions or body movements), equipment, technology for safe patient handling and movement. According to the Department of Health and Human Services, there are four primary principles that should be used for manual patient/resident handling in conjunction with SPH techniques when handling and moving patients/residents, which include:

1. Maintain a wide, stable base with feet.
2. Put the bed at the correct height (waist level when providing care; hip level when moving a patient).
3. Try to keep the work directly in front to avoid rotating the spine.
4. Keep the patient/resident as close to your body as possible to minimize reaching.

Student Responsibilities in Using SPH Equipment:

- Student should never move or handle SPH equipment if they have not been oriented to the available equipment at the health care organization; operation of the equipment: assessment criteria for selection of the SPH equipment, and care planning for SPH.
- Students are responsible for knowing the SPH policies at the health care organization where they provide direct patient/resident care.
- Students need to gather the appropriate equipment, clinical instructor/preceptor and other staff as needed, and organize the physical environment and the equipment to ensure safe completion of the task.
- Students need to position themselves using the four primary principles of body mechanics listed above.
- Communicate the SPH procedure to the patient/resident.

SPH - Prevention of Cumulative Trauma Injuries:

Please review this [presentation on the Prevention of Cumulative Trauma Injuries](#) (PDF) (*the PDF will open in a separate window*).

REFERENCES

National Institute of Occupational Safety and Health (NIOSH). (2014). Safe Patient Handling. Center for Disease Control and Prevention. Retrieved from <http://www.cdc.gov/niosh/topics/safepatient/>.

Water, T. R., Nelson, A., Hughes, N., & Menzel, N. (2009). Safe Patient Handling Training for Training for Schools of Nursing. Retrieved from <http://www.cdc.gov/niosh/doc/2009-127/pdfs/2009-127.pdf>.

HIPAA Orientation & Education



Objectives

At the conclusion of this presentation, students will be able to:

- Describe the federal requirements of the HIPAA/HITECH regulations that protect the privacy and security of confidential data.
- Discuss the penalties that can be imposed for violating HIPAA.
- Identify what information must be protected.
- Describe how to protect confidential and sensitive information.
- State their responsibility for good computer practices.
- Discuss application of HIPAA to student's role.

What is HIPAA?

HIPAA is an acronym for the **H**ealth **I**nsurance **P**ortability and **A**ccountability **A**ct, which was enacted by the US Congress in 1996 and stresses three major areas:

- 1. Insurance Portability:** Ensures that individuals moving from one health plan to another will have continuity of coverage and will not be denied coverage.
- 2. Fraud enforcement (accountability):** Significantly increases the federal government's fraud enforcement authority to reduce health care fraud and abuse.
- 3. Administrative simplification:** Ensures system-wide, technical and policy changes in healthcare organizations in order to protect patient and resident privacy and the confidentiality of identifiable/protected health information (PHI).

HIPAA Privacy Act

Effective April 14, 2003, each healthcare organization is required to:

- Give each patient or resident a written Notice of Privacy Practices that describes:
 - How health care organizations may use and share protected health information (PHI)
 - The patient's/resident's privacy rights
- Ask all patients/residents to sign a written acknowledgment that they received the Notice of Privacy Practices, except in emergency situations. If a signature is not obtained, the health care organization must document the reason why it was not role.

HITECH Act

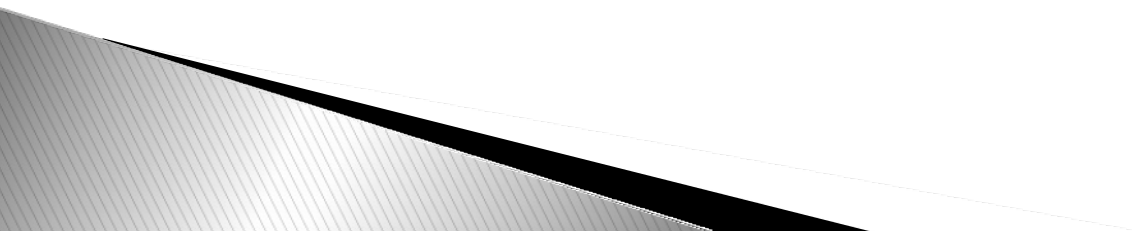
The Health Information Technology for Economic and Clinical Health (HITECH) Act, enacted as part of the American Recovery and Reinvestment Act of 2009, was signed into law on February 17, 2009, updated federal HIPAA privacy and security standards.

- The updates include:
 - Added Business Associates and their contractors/subcontractors to entities that must comply with the HIPAA Act of 1996 and it mandates that these Business Associates are civilly and criminally liable for privacy and security violations.
 - Breach notification requirements for all covered entities.
 - Fine and penalty increases for privacy violations.
 - Right to request copies of the electronic health record in electronic format.

Business Associate

Examples include: :

- Billing
- Claims processing or administration
- Call service management
- Quality assurance
- Data processing or analysis
- Data aggregation
- Transcription services
- Utilization review
- Design or manage an electronic record system
- Accounting
- Accreditation
- Consulting
- Financial services
- Management



Breach

A breach is, generally, an impermissible use or disclosure under the Privacy Rule that compromises the security or privacy of the protected health information such that the use or disclosure poses a significant risk of financial, reputational, or other harm to the affected individual.

Examples of Breaches

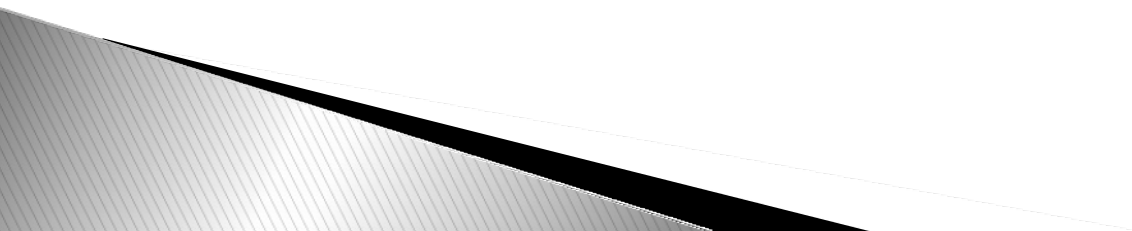
- Reviewing the medical records of family members, neighbors, celebrities, etc. to see how they are doing.
- Leaving papers with a patient's/resident's identifiable information in public areas visible to others.
- Failing to confirm the accuracy of a fax number before faxing patient-identifiable health information.
- Talking in public areas, talking too loudly, talking to the wrong person.
- Email or faxes sent to the wrong address, wrong person, or wrong number.
- User not logging off of computer systems, allowing others to access their computer or system.

Real Examples of Student Breaches

- Used a cell phone to take pictures of a patient/resident.
- Used a cell phone to record a health care provider explaining a surgical procedure.
- Posted a picture of themselves with a patient/resident on Facebook.
- Provided treatment advice to a patient/resident via Twitter.
- Posted a picture of a patient's/resident's open wound on the Internet.
- Posted details about their clinical day without mentioning the patient/resident's name, but giving out details about the injuries to allow others to guess who it was.
- Posted comments to a blog about patients/residents they cared for in the previous year, including the name of the unit.

Unethical Behavior and Possible Breaches

- It is unethical and disrespectful to post negative comments about the health care organizations to which you are assigned for clinical or the staff who work there.
- Instead, share questions and concerns with your clinical instructor rather than posting it on a social media site.
- It's easy to lose perspective and commit a security or privacy breach by mentioning private information in negative comments on social media sites.



Be Ethical, Respectful and Positive

- *Always* maintain a respectful demeanor regarding patient/resident confidentiality.
- Do the right thing.
- When you are in the clinical setting you are representing your nursing program; make them proud.
- When your are in the clinical setting you are allowing the nursing staff and nurse manager to assess your ability to be a part of their patient care team.
- Think of it as a kind of job interview opportunity; make a positive impression!

Breach Notification Requirements

Following a breach of unsecured protected health information covered entities **MUST** provide notification of the breach to:

- **Affected Individual:** Covered entities must notify affected individuals following the discovery of a breach of unsecured protected health information.
- **Media:** Covered entities that experience a breach affecting more than 500 patient/residents of a state or jurisdiction are, in addition to notifying the affected individuals, required to provide notice to prominent media outlets serving the state or jurisdiction.
- **The HHS Secretary:** In addition to notifying affected individuals and the media (where appropriate), covered entities must notify the HHS (US Dept of Health & Human Services) Secretary of breaches of unsecured protected health information.
- **Notification by a Business Associate and their Contractor/ Subcontractor:** If a breach of unsecured protected health information occurs at or by a business associate or their contractor / subcontractor, the business associate must notify the covered entity following the discovery of the breach.

HIPAA Penalties

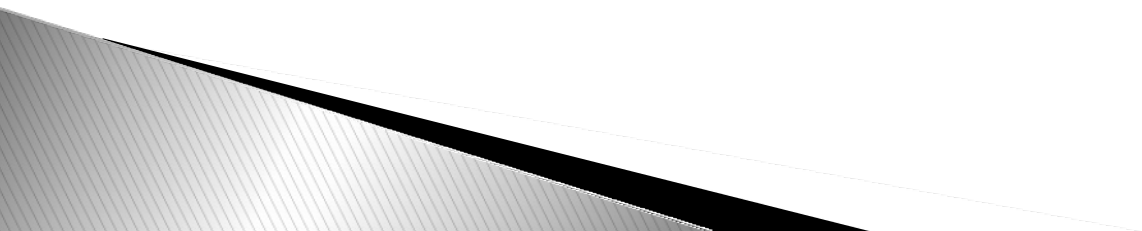
- Verbal or written warnings
- Loss of job or dismissal from nursing program
- HIPAA Criminal Penalties
 - \$50,000 - \$1,500,000 fines
 - Imprisonment up to 10 years
- HIPAA Civil Penalties
 - \$100 - \$50,000 for each violation
 - \$1,500,000 for all such violations of an identical provision in a calendar year.
- State Laws
 - **Fines and penalties apply to individuals as well as health care providers; may impact professional licensure.**



What is Protected Health Information (PHI)

PHI is all personal and health information specific to a patient or resident and must be kept confidential

- Oral
- Written
- Electronic



Examples of PHI

- Name, address, date of birth, social security number, phone number, email address, fax number, URL address, IP address, license number, biometric identifiers (finger and voice prints), vehicle identifiers.
- Medical record, health plan number, diagnosis, photographs, test results, prescriptions and labels on IV bags.
- Billing information, account number, claim data, referral authorization.
- Research records.
- Telephone notes.

Uses and Disclosures of PHI

Healthcare Organizations may Create, Use and Share PHI for: TPO

- **Treatment** that is routinely shared among health care professionals involved in the care to coordinate or manage treatment, both within and outside each healthcare organization, including appointment reminders or laboratory results as part of discharge planning.
- **Payment** of health care bills may be shared with the medical insurer so that the health care organization can be paid for services provided to the patient or resident.
- **Operations** to assess and improve quality of care or re-allocate resources. The details of a patient's surgical procedure may be shared among surgeons to evaluate the patient's surgery based on the outcome.

EXCEPTION: Whenever state law is more stringent, it preempts HIPAA. In Massachusetts and New Hampshire, statutorily protected information including HIV status, behavioral health, psychotherapy notes, and sexually transmitted diseases requires patient authorization prior to use/disclosure.

Examples of TPO

The patient's referring physician calls and asks for a copy of the patient's recent lab report completed at the health care organization (**Treatment**)

A patient's insurance company calls and requests a copy of the patient's medical record for a specific service date (**Payment**)

The Quality Improvement office calls and asks for a copy of an operative report (**Health Care Operations**)

For these TPO purposes, patient information may be provided

Other Uses and Disclosures of PHI

- Facility Directory may include (a) name; (b) location in the health care organization; (c) general condition; and (d) religious affiliation, unless the patient/resident tells the health care organization not to.
- State Law mandates sharing of the PHI to state agencies under certain circumstances, without the patient's or resident's consent, such as abuse reporting to the Department of Social Services and Death Reports to the Office of the Medical Examiner.
- Medical Research may use PHI to further medical research, but only after approval by the Institutional Review Board (IRB), when written permission is not required by Federal or State law.

Other Uses and Disclosure of PHI

Healthcare organizations must get a signed authorization from the patient/resident or their representative to release information:

- To the media.
- To an employer (e.g., a patient's boss calling to verify that the patient had surgery).
- To a researcher without an IRB approval.
- For use in Marketing (Exceptions: A provider may use PHI to communicate to the patient about healthcare organization products or services or to share general health information about disease prevention, wellness classes, etc.).
- For use in Fundraising (Exceptions: Limited PHI – Demographic information such as name, address, and dates of service may be used without a signed authorization).

Minimum Necessary

- HIPAA requires that health care providers use and disclose only the information needed to perform duties.
- Anyone who discloses PHI must be authorized to do so and must understand when specific authorization is required.
- The only exception is that providers do not have to consider the minimum necessary when disclosing PHI to other providers for treatment purposes.

HIPAA Rule

Mandates that all employees, physicians, volunteers, students and other members of the healthcare organization's workforce follow the HIPAA-required procedures and do the **RIGHT THING** when it comes to protecting the privacy and security of their patients or residents.

Receiving Request for PHI in Emergency

- Obtain the requesting provider's name, facility name, location and telephone number.
- Verify the requestor's identity by telephoning the number provided.
- Document the call and identity of the individual who received the call.
- Document the information being sought or requested.
- Document the reason for the request.
- Provide minimum necessary PHI.
- Provide additional information requested as in non-emergency.

The Health Care Organization is Responsible to:

- Educate all employees and students about these rules.
- Monitor work to be sure no one is breaking them.
- Discipline anyone who violates the privacy or security of patient information.

As a Student you may:

- Look at a person's PHI only if you need it to do your assignment.
- Use a person's PHI only if you need it to do your assignment.
- Give a person's PHI to others when it is necessary for them to do their jobs.
- Talk to others about a person's PHI only if it is necessary to do your assignment.

*** REMEMBER:**

If it doesn't pertain to Treatment, Payment or Operations (TPO), don't discuss it.

As a Student you may **NOT**:

Post any information about a patient/resident or the health care organization on any social media site, such as:

- Facebook,
- Twitter,
- Wikis,
- Blogs,
- Podcast,
- Discussion forums,
- Photo Sharing,
- Utube/Video, etc.

Providing for Security of PHI

General awareness

- Use the healthcare organization's policies to know what information is confidential.
- Never discuss patient/resident information outside the workplace.
- Be careful not to discuss patient or resident information in hallways, elevators, cafeterias, or other common areas where you may be overheard.
- Ensure that anyone looking at a patient's/resident's chart or inquiring about information has valid and appropriate identification and a need to know (part of the healthcare team).

Providing for Security of PHI

Computers

- Sign on promptly with individual IDs.
- Do not share your passwords.
- Log-off computers when finished.
- Point computer monitors away from the view of visitors or passers-by.

Note:

- Personal information must be protected and encrypted on laptops or other portable devices.
- Personal information must be encrypted when sent across the internet.

Providing for Security of PHI

Telephone

- Do not leave confidential information on an answering machine.
- Follow established policies about what patient or resident information can be given over the phone.
- Do not listen to your voice mail messages over the telephone speaker.
- Never discuss confidential information on an analog mobile phone (although this is illegal, analog calls can be intercepted and recorded).

Printers/Copiers

- Promptly remove printouts of confidential material.
- Do not leave printouts with a patient's or resident's information unattended.
- Stay at the copier while copying is in process.
- Do not forget to take the original.
- **Do not copy a patient's/resident's medical record.** If patient/resident requests a copy, follow health care organization's policy.

Providing for Security of PHI

Email

- Do not share your password.
- Never forward messages that have confidential patient information unless authorized to do so.
- Do not use sensitive information. Emails can be intercepted.

Fax Machines

- Make sure the fax machine is in a secure location.
- Notify receiver ahead of time that you are faxing information and verify the fax number.
- After you dial the number, double check it on the display before you press send.
- Confirm receipt by calling the recipient or checking the transmission report.
- Retrieve faxed information as soon as it arrives.
- Always use a cover sheet stating that the information being sent is confidential.
- If a fax is sent to the wrong machine, contact the recipient and request the fax be destroyed. NOTIFY PRIVACY OFFICER.

Providing for Security of PHI

Cell Phone Camera

- Do not use a cell phone camera to take a picture of a patient/resident.
- Do not text information about a patient/resident.

Interviewing

- Close patient/resident room doors.
- Close curtains and speak with a softer voice in a semi-private room.

Sensitive Data

- Secure paper records that contain PHI.
- Destroy, shred or put in the designated bins all papers that could contain PHI.
Do NOT put in wastebaskets!
- Understand healthcare organization's policies for handling any patient/resident information.

Security of Electronic Information (ePHI)

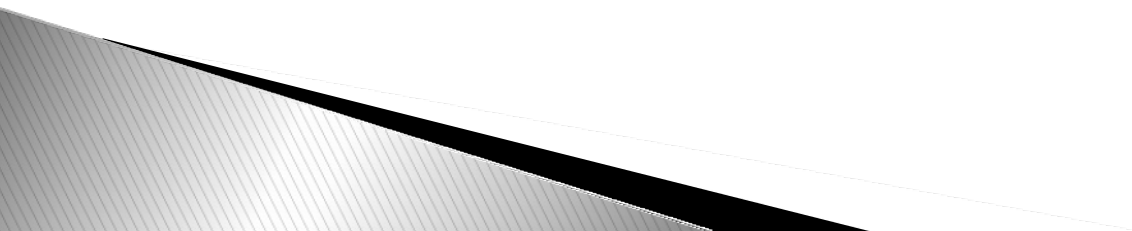
Good security standards follow the “90/10” Rule:

- 10% of security safeguards are technical
- 90% of security safeguards rely on the computer user (**YOU**) to adhere to good computer practices

Why is Protecting Privacy & Security so Important?

- It is the right and ethical thing to do.
- It is the legal thing to do and federal law requires it.

DO NOT ACCESS INFORMATION THAT YOU DO NOT NEED TO KNOW FOR YOUR JOB



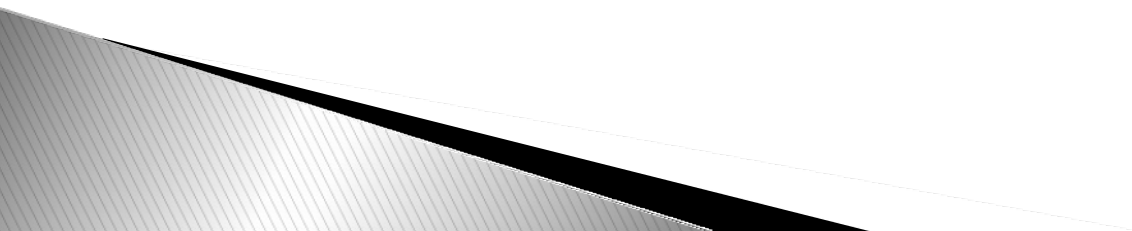
Patient/Resident Rights

Under HIPAA privacy laws, patients/residents have the right to:

- Have their information protected.
- Have their questions answered.
- Receive written notice of how their health information will be used and disclosed.
- Access their own records and request correction of incorrect or incomplete information.
- Receive a list of disclosures of information within the previous six years (beginning 4/14/03).
- Sign an authorization form prior to non-routine uses or disclosures of their health information before the information can be shared with:
 - Employers
 - Insurance Companies
 - Marketing Activities
 - Fundraising Activities

Consequences of Privacy or Security Failure

- Disruption of patient/resident care.
- Increase cost to institution.
- Legal liability and lawsuits.
- Negative publicity.
- Negative patient/resident perception.
- Identify theft.
- Disciplinary action.



Summary

- Patients/residents or their representatives have the right to control who will see their protected health information (PHI).
- HIPAA privacy requirements have been put in place to protect the patient.

NOTE: These HIPAA privacy requirements apply just as much outside the workplace as they do inside. Patient/resident information is never shared outside the workplace, and only as necessary for care within the workplace.

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Module 1 Post-Test

Note: You are logged in as an administrator and administrator accounts can view but not submit tests.

STUDENT ROLE AND RESPONSIBILITIES

1. Which of the following is an example of a situation in which professional behavior has NOT been upheld?
 - a. Administering medication in a manner that is consistent with the policies of the health care organization.
 - b. Conducting an assessment and providing care according to the care plan.
 - c. Providing a report to the assigned nurse before leaving the floor for the day.
 - d. Arranging to meet a patient/resident after he/she is discharged from the hospital.

2. Student responsibilities include which of the following:
 - a. Informing the patient/resident care provider of significant changes in a patient's/resident's condition.
 - b. Checking with the instructor or preceptor before administering medications.
 - c. Obtaining a report from a staff nurse or the instructor prior to providing care.
 - d. Knowing the infection control, safety, fire and emergency procedure of the health care organization.
 - e. All of the above.

PATIENT /RESIDENT RIGHTS

3. Who has an obligation to provide a patient/resident with relevant, current, and understandable information regarding his/her diagnosis and treatment?
 - a. Physician only.
 - b. Nurse and other direct caregivers.
 - c. Physician and family.
 - d. Physician, nurses, and other direct caregivers.

4. Considering the patient's/resident's Bill of Rights, which one of the following statements is FALSE.
 - a. The non-English speaking patient/resident has access to an interpreter.
 - b. The patient's/resident's rights allow for privacy during medical treatment.
 - c. Patients/residents must include family members in his/her health care decisions.
 - d. All patients/residents have the right to have their pain assessed and managed.

PATIENT CONFIDENTIALITY & HIPAA EDUCATION

5. Posting a picture of my patient/resident on Snapchat is a social media HIPAA violation?
 - a. True.
 - b. False.

6. Students who do not adhere to HIPAA policies and procedures can be fined regardless of whether or not they knowingly violated the act.
 - a. True
 - b. False

7. Privacy and confidentiality play a large role in the management of health care information. What information does this include?
 - a. All patient/resident information (including all reports and communication) regardless of the method by which it was received.
 - b. Only what the patient/resident tells you personally.
 - c. Only what is documented in the health record.

- d. Only information divulged for the duration of the hospitalization.
-

8. If a patient/resident decides not to have their name placed in the facility's directory, which of the following applies?

- a. Registration staff cannot give out information about the patient or resident but other staff may do so.
- b. No family members or friends may visit the patient or resident.
- c. No one from the health care organization may give out information about the patient or resident, including the fact that the patient or resident is at the health care organization.
- d. None of the above.
-

9. Your best friend is a patient/resident at the hospital where you are assigned for clinical. You are concerned about her and would like to get more information. What is the best way to find out details about her condition and treatment?

- a. Ask her physician for the information.
- b. Ask her directly.
- c. Access her medical record.
- d. Ask the students in your class, who are on that unit, for more information.
-

10. The purpose of the HIPAA regulations are:

- a. Eliminate the transmission of the patient/resident records.
- b. Protect a patient's/resident's health information.
- c. Reduce the number of health plans who require protected health information.
- d. Increase the availability of all health information.
-

11. Violation of HIPAA includes which of the following?

- a. Posting information about your clinical day on Facebook.
- b. Emailing a friend the name of a local sports figure that you cared for during clinical.
- c. Talking about a patient/resident in the cafeteria during post conference.
- d. Asking a patient/resident on a date after seeing his profile on a dating website.
- e. All of the above.
-

12. As a student, wrongful disclosure of health information or a HIPAA violation via social media could result in a fine of \$50,000 and could lead to dismissal from the nursing program.

- a. True
- b. False
-

DETECTING AND REPORTING ABUSE

13. Healthcare providers are required by law to report suspicions of domestic violence of physical abuse of a 34 year-old woman.

- a. True
- b. False
-

14. Which sign might lead you to suspect sexual abuse?

- a. Lack of medical care and immunizations for a child.
- b. Bruises or bleeding from external genitalia, vagina or anal region.
- c. Malnutrition and dehydration in an elder.
- d. Overdressed or underdressed for climate conditions.
-

WORKFORCE VIOLENCE

15. Some advisable actions to take to protect yourself from workplace violence include:

- a. Wearing your ID badge.
- b. Reporting unauthorized personnel.
- c. Providing respectful customer service
- d. Reporting threats or unusual behavior to your clinical instructor, preceptor or supervisor.

- e. All of the above.
-

16. Which of the following best defines workplace violence?

- a. Intentional battery, rape, and homicide during the course of employment.
b. Violent acts, behavior, or threats occurring in the work setting.
c. Human interaction to threatening situations.
d. None of the above.
-

SAFE PATIENT HANDLING

17. While bending forward, you spend 30 minutes feeding a patient/resident on bed rest. What is (are) the musculoskeletal risk factor(s) in this situation?

- a. Pushing/pulling.
b. Awkward posture.
c. Long duration.
d. Heavy lifting.
e. b and c.
f. All of the above.
-

18. Why are mechanical aides needed for safe patient/resident handling?

- a. Health care providers do not have sufficient training using proper body mechanics.
b. Manual lifting techniques are not sufficient to protect health care providers from injury.
c. Body mechanic algorithms are too complicated and difficult to understand.
d. Staff levels have declined in most institutions in recent years.
-

19. What is the most important factor to consider when deciding the technique to use when transferring a patient/resident from bed to wheelchair?

- a. Number of staff available to help.
b. Whether the bed is height adjustable.
c. Patient/resident ability.
d. Strength of caregiver.
-

20. When changing an occupied bed, the bed should be:

- a. In the lowest position.
b. In the highest position.
c. With the side rails down.
d. In a position of comfort for the health care provider

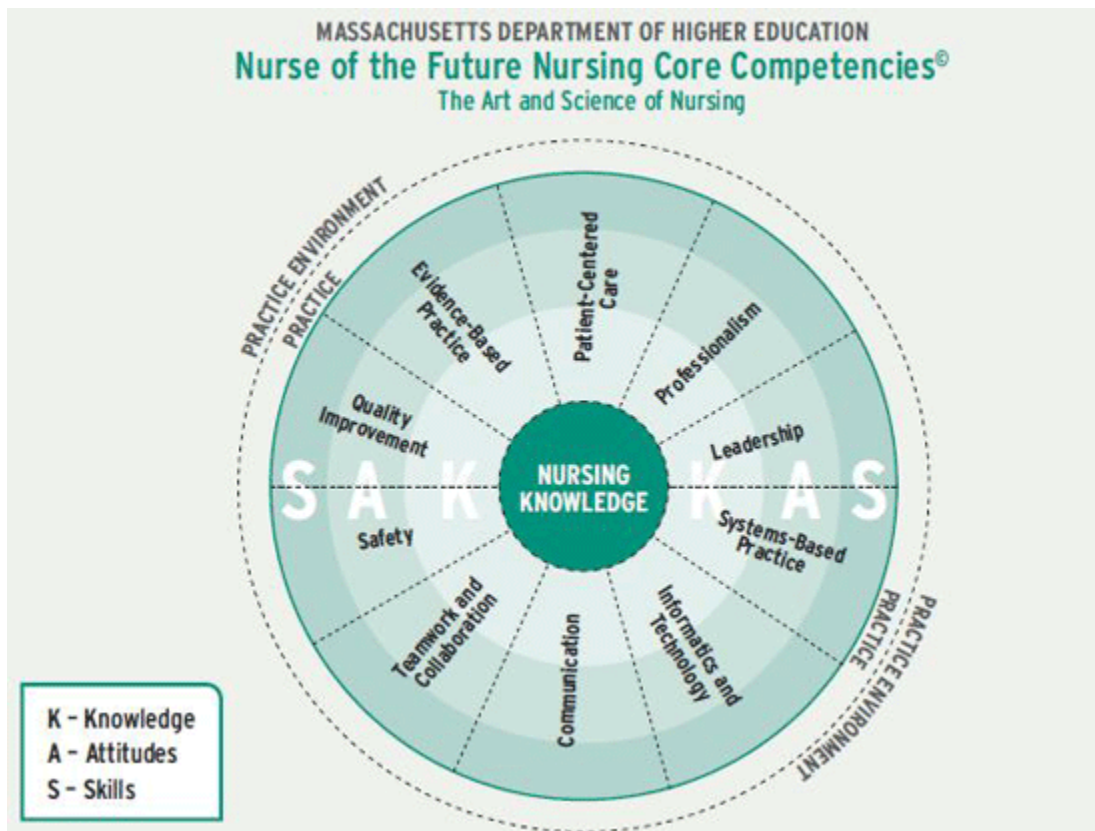
Clinical Placement Online Orientation

MODULE 2: Nurse Core Competencies

Nurse Core Competencies Overview

Competencies are applied skills and knowledge that enable people to perform work. Nurse of the Future (NOF) core competencies represent a set of skills, knowledge and attitudes necessary for the entry-level RN nursing practice.

Massachusetts & New Hampshire



The Nurse of the Future Nursing Core Competency© model is a graphic representation of the NOF Nursing Core Competencies and their relationship to nursing knowledge. Nursing knowledge has been placed at the core to represent how nursing knowledge in its totality reflects the overarching art and science of the nursing profession and discipline. The ten competencies, which guide nursing curricula and practice, derive from this central core and are:

- Patient-centered care.
- Professionalism.
- Leadership.
- Systems-based practice.
- Informatics and technology.
- Communication.

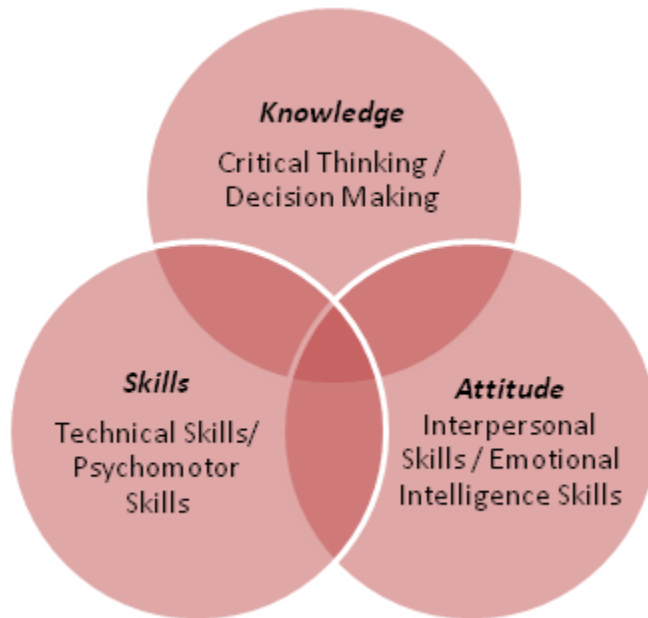
- Teamwork and collaboration.
- Safety.
- Quality improvement.
- Evidence-based practice.

Maine Core Competencies



Maine has added Geriatrics as the eleventh core competency. Massachusetts and New Hampshire have geriatrics included in the patient-centered care competency.

Competency Framework: Knowledge – Skills - Attitudes (KSA)



Fryer, A. The Integration of the Nurse of the Future Nursing Core Competencies into a Practice Setting, PowerPoint.

Essential knowledge, attitudes, and skills (KSA), reflecting the cognitive, affective, and psychomotor domains of learning, are also specified for each competency. The KSAs identify expectations for initial nursing practice following completion of a pre-licensure professional nursing educational program.

The content in Module 2 is organized by Competency:

| Competency | Module 2 Content Title |
|----------------------------|--|
| Patient-centered care | Providing Population Competent Care |
| Leadership | |
| Systems-based practice | |
| Professionalism | |
| Informatics and technology | |
| Communication | Communication and Documentation |
| Teamwork and collaboration | |
| Safety | National Patient Safety Goals Alarm Fatigue |
| Quality Improvement | Quality Improvement |
| Evidence-based practice | |

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Providing Population-Competent Care

The steadily increasing diversity of our patient/resident population and the workforce in the United States has heightened awareness that all health care providers need to be more skilled in understanding and responding to differences. Race, age, gender, disability, religion, personality style, language, sexual orientation, and other cultural and socioeconomic factors influence health promotion and help-seeking behaviors. Health care organizations are committed to creating an environment that is respectful of differences and consistently uses behaviors that communicate respect. All health care providers, including health professions students, must learn to recognize, respect and work with patients/residents across different developmental stages; from different cultures and with different values, beliefs, practices and rituals. This will eliminate barriers to the delivery of health care and generate improved, measurable outcomes.

BARRIERS TO DIVERSITY

People who have negative attitudes towards other people's differences often engage in negative behaviors, including:

- **Prejudice:** a preconceived feeling or bias without ever really getting to know a person.
- **Stereotyping:** applying a certain belief to all members of a particular group.
- **Discrimination:** treating people differently and unequally just because they are a member of a particular group. Discrimination can take many forms -- racism, sexism, ageism are all examples.

CULTURAL COMPETENCE

Cultural competence supports the development of patient/resident-centered care as well as family-centered care by providing individualized care that recognizes the patient's/resident's preferences; values and needs; and respects the patient/resident or designee as a full partner in providing compassionate, coordinated, appropriate, safe and effective care. Cultural competence includes the attitudes, knowledge, and skills necessary for providing quality care to diverse populations and the commitment to minimize the negative behavior of health care providers to cultural differences. Providing culturally competent care includes:

- A willingness to learn about other cultures.
- Knowing and understanding cultural norms, attitudes, and beliefs and culturally influenced health behaviors.
- Listening to patients/residents carefully; asking questions sensitively.
- Valuing diversity.
- Recognizing personal biases, stereotypes, and prejudices. Eliminating stereotypes and generalizations. Avoiding words that suggest all or most members of a particular group are the same.
- Providing an interpreter so that the patient/resident can participate in decisions regarding care.
- Learning verbal and nonverbal cues of other cultures.
- Implementing nursing care to meet the needs of patients/residents based on cultural values and beliefs influencing health care and nursing practice.

AGE-SPECIFIC COMPETENCE

For health care providers to properly and appropriately care for their patients/residents an understanding of the different stages of human development, and tasks to be accomplished at

each stage, are necessary because people generally grow and develop in stages that are related to their age. Health care providers are expected to provide age-specific care which includes:

- Adapting assessment and the delivery of care to the developmental level of the individual.
- Reflecting age-related data in documentation.
- Using appropriate references for tailoring medication administration and/or clinical assessment.
- Using appropriate equipment for size and weight assessment.

This is only a guide and should not be used to interpret what all people are like or should be like. Remember people are individuals.

INFANT: Birth to 12 months

Physical Development

- Normal Vital Signs: Pulse = 150 (+/- 20); Respirations = 35 (+/- 5); Blood Pressure = 80/45 (+/- 20/10).
- Poor temperature regulation during the first few months.
- Period of rapid physical growth:
 - grows approximately one inch during the first month.
 - doubles weight in the first 6 months.
 - triples birth weight by twelfth month.
 - head and chest are equal in circumference at 12 months.
- Born with Strong Reflexes:
 - Automatic Grasp Reflex- Infant's fingers curve around finger placed in infant's palm.
 - Sucking Reflex- Neonate sucks on object placed in mouth.
 - Rooting Reflex- When cheek is brushed, neonate turns head toward stimulus and attempts to grasp with mouth.
 - Moro (Startle) Reflex- Generalized Activity in response to stimulation.
 - Babinski Reflex- When stroking outer sole of foot upward from heel to across ball of foot causes toes to hyperextend.
- Fontanels are soft and flat. Posterior fontanel closes around the second month. Anterior fontanel closes between twelve and eighteen months.
- Rolls over at 2 - 3 months.
- Crawls forward and backward at 6 - 8 months.
- Begins to walk alone at 12 months.
- Gains pleasure from sucking and may use a pacifier.
- Explores items by placing them in mouth.
- Teeth may begin to erupt at 6 - 8 months.

Psychosocial Development

- Responds to environment through visual, auditory, tactile and taste senses.
- Is totally dependent upon caregiver.
- Cries when uncomfortable, sleepy or hungry.
- Develops trust; begins to express love and affection.
- Developing a sense of self; there is evidence of individual personality and temperament.
- Develops fear of strangers at 6 - 7 months.
- May develop a fear of separation at 9 -10 months.
- Starts vocalization.

- Will babble vowels such as "goo" at 5 months.
- Vocalizing/first words "ba", "da", "ma", "mama" at 6 - 8 months.
- Able to form two or three word sentences at 11 - 12 months.
- Tantrums may begin at 11 - 12 months.
- Enjoys simple games.

Nursing Considerations

- Physical assessment includes: vital signs, weight, head and chest circumference, length, assessment of fontanel and reflexes, and immunization status.
- Keep warm.
- Take time to comfort, cuddle the infant.
- Perform most uncomfortable and intrusive procedures last.
- Ensure safety:
 - protect from fall injury.
 - always keep crib side rails up.
 - transport using crib, stretcher, or stroller.
 - assess environment for safety hazards.
 - ensure that small objects are outside of the infant's grasp.
- Encourage participation of the parents.
- Provide instructions to the parents, including information on normal growth and development.
- Check for soiled diapers.
- Maintain feeding schedule. Introduce solid foods at 5 - 6 months. Introduce new foods in this order: cereals, fruits, vegetables, and then meats. Introduce one at a time. Allow a week before introducing the next new food to assess for food allergies. Begin weaning from bottle around 12 months.
- Place infant on back for sleeping.

TODDLER: 1 to 3 Years Old

Physical Development

- Normal Vital signs: Pulse = 110 (+/- 20); Respirations = 25 (+/-5); Blood Pressure = 100/60 (+/- 20/20).
- Continues rapid physical and cognitive growth.
- Can crawl, run, jump, step backward and sideways, and can climb stairs alone.
- Height increases by about four to five inches per year.
- At one and a half years old, develops sphincter control and indicates when diaper needs to be changed.
- Learns to ride tricycle.
- Attempts to spoon-feed self; by age three able to feed self.

Psychosocial Development

- Less fearful of strangers.
- Hugs and kisses parents.
- Developing sense of self as independent person; gaining self-confidence and self-control.
- Shows pride in independence and uses "no" frequently.
- Imitates parents doing household chores.
- By age three, uses three-word sentence and has a vocabulary of over 300 words.
- Knows own name.
- Is mobile and inquisitive and may "get into anything".

- Temper tantrums are less by age three.
- May begin to play with genitals as a process of self-exploration.
- At age two, cannot share possessions. By age three, begins to understand "taking turns" and sharing.
- The toddler may wish to keep a favorite toy or blanket with him or her.

Nursing Considerations

- Appropriate toys include: stuffed animals; musical toys; picture books and stacking blocks.
- Begin toilet training between eighteen and twenty-four months old.
- Teach how to brush teeth and encourage parents to make first visit to the dentist.
- Use repetition to enhance memory and understanding.
- Examine the toddler while in a parent's lap or sitting on the floor.
- Safety considerations include: keeping crib rails up and use of canopy cribs.
- Toddler values honesty. Never tell a child a procedure will not hurt if this is not true.

PRESCHOOL: 3 to 5 years Old

Physical Development

- Normal Vital Signs: Pulse = 92 (+/- 5); Respirations = 25 (+/- 5); Blood Pressure = 100/60 (+/- 10/10).
- Birth length doubles by age four.
- Becomes thinner and taller.
- Nighttime bowel and bladder control should be achieved by age three or four.
- Performs simple self-care skills independently.
- Moves with speed and agility.
- Can lace shoes and jump rope.
- By age five, can use pencil and scissors well.

Psychosocial Development

- Can count to five; knows primary colors.
- Understands concept of time in terms of morning, nights, and later.
- Develops a sense of initiating (being able to explore the world and start projects).
- Enjoys helping with simple chores.
- Thinking is concrete and focuses on concrete details.
- Becomes concerned about even the smallest injury.
- Egocentric in thoughts and behavior.
- Engages in parallel play.
- Enjoys dolls; large puzzles; taking toys apart; finger paints, and hand puppets.
- Child's social interests enlarging to include others outside of immediate family.
- Magical thinking may occur; child may believe that wishing makes things happen.
- May have difficulty separating fantasy from reality and may be fearful.

Nursing Considerations

- Limited ability to judge distances and own strength predisposes child to accidents.
- Preoperative teaching has little meaning, but post-operative review is meaningful and helpful.
- Apply Band-Aids to small scratches and injection sites.

- Intrusive procedures, such as throat swabs, rectal temperatures, blood drawing and IV starts are distressing and should be done in a treatment room.
- Allow to actively participate, such as holding the equipment, examining you as you examine them.
- Provide simple explanations about the procedure.
- Have a parent with the child during examinations and procedures.
- Honesty is important to the child.

SCHOOL AGE: 6 to 12 Years

Physical Development

- Normal Vital Signs: Pulse = 80 (+/- 20); Respirations = 21 (+/- 5); Blood Pressure = 103/60 (+/- 20/20).
- Continues to grow but at a slower rate.
- Gains greater muscle strength and coordination.
- The child works and plays hard but tires easily.
- Able to complete more complex self-care skills.
- Starts to lose temporary teeth; acquires first permanent teeth between six and eight years of age.
- Growth spurt occurs between ten and eleven years with slow increase in height and rapid increase in weight.

Psychosocial Development

- Develops sense of self-worth through accomplishments and interactions with others.
- Enjoys collecting favorite things.
- Learns to get along with peers.
- Chooses best friends, usually of same sex.
- Will accept responsibility for routine household tasks with occasional reminders.
- Likes to participate in family decision-making.
- Likes rough and tumble play.
- Insists on being first in everything.
- Craves attention.
- Begins hero worship.
- Ashamed of failures.
- Interested in schoolwork and begins to read and to think logically.
- May fear looking different.

Nursing Considerations

- Six to Ten Years Old:
 - Enjoys table and board games; jump rope; punching bags; roller skates; musical instruments; puppets; dolls; painting; coloring; magic tricks; dancing; puzzles; listening to music; competition games; crafts; athletic sports and collecting things.
- Ten to Eleven Years Old
 - Enjoys parties; talking on the phone; solitary play; reading mystery and love stories, and going to the movies.
- Often enjoys actively participating in their examination and care.
- Allow them choices within acceptable limits.
- Provide simple explanations, but can accept explanations in greater length.
- May prefer to see health care provider alone rather than with parent in room.

- They are modest and proud. Respect their modesty and keep them covered and screened when possible.
- Do not embarrass them especially in front of other children.
- Well-coordinated and more safety-conscious.
- Demonstrate procedure prior to implementation.

ADOLESCENCE: 13 to 19 years

Physical Development

- Normal Vital Signs: Pulse = 80 (+/- 20); Respirations = 20 (+/- 4); Blood Pressure = 120/78 (+/- 20/10).
- Experiences physical maturation and continued cognitive development.
- Growth spurt takes place between ten and sixteen years old.
- Girls retain more subcutaneous fat than boys.
- Muscle development is greater in boys than in girls.
- Sexual development occurs with girls experiencing menarche and boys experiencing testicular growth.

Psychosocial Development

- The adolescent must develop his/her own identity.
- May have employment outside the home.
- Becomes independent and self-directed in schedules and homework.
- Begins to explore career options.
- Searches for new beliefs, resolves inconsistencies of old beliefs and begins to form a personal philosophy of life.
- Frequent mood swings.
- Dating may be a major activity.
- Engages in organized, competitive sports.
- Uses slang within and outside peer group.
- Challenges authority and seeks peer acceptance.
- Begins to sever ties with parents.
- Has fewer, but closer friends.
- Enjoys shopping; driving cars; reading, "hanging out" with peers.
- Meal skipping is common. Snacking becomes a part of eating pattern. Fast-food consumption is popular.
- Experimentation with cigarettes, alcohol, drugs and sex may occur.
- Doubts that they can be injured and will take risks.

Nursing Considerations

- Adolescents consider themselves adults.
- Physical assessments are the same as for an adult.
- Adolescents may become extremely self-conscious and embarrassed.
- Provide privacy.
- Drape parts not being examined.
- Adolescents need adequate explanations.
- Allow involvement in decisions about care.
- Teach adolescent girls about self-breast examination.
- The adolescent does not want to appear "stupid" and therefore may not ask questions.
- Parental involvement should be encouraged but with adolescent's agreement.
- Provide discussion time with the adolescent without parents present.

- This is a time of physical maturation; provide learning material as appropriate.
- Recognize risks for drug, alcohol and cigarette use.

YOUNG ADULTHOOD: 20 to 40 Years

Physical Development

- Achieves full physical maturity by age 20; physical changes are minimal.

Psychosocial Development

- The young adult develops close relationships, wants intimacy and may choose a mate.
- Interest expands to include church, community and/or world affairs.
- Continues to develop problem-solving skills.
- Chooses, prepares for and practices a career.
- Moves from a dependent to an independent role in life.
- Childbearing and child rearing are major concerns of those who have children.
- Continually adjusting to stress and satisfaction of work, spouse, parents, and children.
- Establishes a personal set of values; formulates a meaningful philosophy of life.
- Need for ability to cope with change.
- Period of reaching psychosocial maturity.
- Assumes responsibility for health and welfare of self and family.
- Concerned about work limitations and time lost from work due to illness or poor health.

Nursing Considerations

- Hospitalization may pose a serious stress on the family, especially if the ill person provides the major source of income for the family.
- Keep informed of treatment plan along with reason for interventions.
- Provide education and guidance to develop a healthy lifestyle.
- Provide privacy.
- Recognize potential lifestyle stressors.
- Provide information upon request for work related issues such as hazardous materials at the workplace.

MIDDLE ADULTHOOD: 41 to 64 Years

Physical Development

- Begins to experience physical changes such as a decrease in visual acuity, a change in sleeping patterns, and a decrease in muscle tone and bone density.
- Adjustment to menopause.
- More susceptible to anxiety and depression.

Psychosocial Development

- Develops a sense of community and assumes responsibility for others.
- Learns and adjusts to role as grandparents.
- Maintains contact with extended family.
- Reaches and maintains a satisfactory performance in career.
- Develops adult leisure time activities.
- Readies self both financially and psychologically for retirement.

- First awareness that one is becoming "old".

Nursing Considerations

- Provide education regarding osteoporosis risk, hormone therapy, and importance of exercise and nutrition.
- Recognize physical changes and potential psychological changes.
- Recognize potential lifestyle stressors.
- Provide information regarding a healthy lifestyle.

GERIATRIC: 65 years and up

Physical Development

- Vulnerability to disease increases due to general diminution of function.
- Ability to maintain homeostasis decreases.
- The rate of cellular reproduction declines.
- Experiences increased physical and psychosocial changes.
 - Integumentary changes include wrinkling, sagging, growths, and discolorations, loss of hair for men and growth of hair on women's faces, drying and thinning of hair.
 - Musculoskeletal changes include decrease in bone mass, loss of elasticity in joints, degeneration of cartilage and connective tissue and gradual decrease in muscle mass.
 - Pulmonary alterations include decreases in breathing capacity, residual lung volume, and total lung capacity.
 - Metabolic rate declines. Changes in digestive system include slowed peristalsis, periodontal disease (which is preventable!), and decrease in secretion of digestive juices.
 - Cardiovascular changes include narrowing or loss of elasticity of blood vessels.
 - Renal atrophy predisposes to urinary tract infection and diminished renal function. There is decreased hormone secretion.
 - Sexual function declines due to tissue changes that reduce the flexibility of the vagina and the firmness of the penis.
- Ability to perform activities of daily living may be limited by physical changes in vision, hearing and motor skills.
- There is little change in IQ. Skills and abilities tend to become obsolete from disuse rather than from deterioration of mental capacity. May experience some loss of short-term memory.
- At an increased risk for falls and an increased risk for injury, if a fall should occur.

Psychosocial Development

- Life review is an important part in this stage of development.
- Retirement introduces many changes in schedule, reduced income, and leisure time activities.
- There may be a change in living facilities, such as moving from a home to a congregate living facility.
- A warmer climate is often sought.
- Many losses due to death, physical or psychological illness of friends/family members. May reflect on own mortality.
- Often has developed close religious ties.

Nursing Considerations

- Feelings of worth, pride, and usefulness need to be maintained.
- Suggest volunteer work to meet these goals.
- Suggest natural seasoning for foods such as lemon or onion as sense of taste and smell decline.
- Encourage intake of high fiber diet and at least two to three liters of fluid to prevent constipation.
- Acidic fluids will help maintain acid urine, thus reducing the risk of urinary tract infection.
- Recommend yearly dental check-up.
- A regular exercise program is useful, such as walking or bicycling. Protect from hazards as agility and balance decline with aging.
- Medications often require smaller doses due to degenerative changes in body functions. Assess for over-the-counter drug interaction with prescribed medications.
- Respect person's knowledge and experience.
- Recognize normal signs of aging; especially visual and hearing changes.
- Determine patient's/resident's ability to perform activities of daily living.
- Provide adequate time for the adult to process new information.
- Consult with the family when appropriate to obtain historical data and/or to plan for continuity of care.

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National Patient Safety Goals

Introduction

In order to evaluate the safety and the quality of care provided for patients/residents, the Joint Commission establishes National Patient Safety Goals annually. The purpose of this section of Module 2 is to help you understand the National Patient Safety Goals and your role, as a member of the health care team, in promoting patient/resident safety. The exact language of the Goals can be found at www.jointcommission.org.

When a National Patient Safety Goal becomes a standard; the goal number is retired and is not used again. *Therefore, you will find that several numbers are missing.* The goals below have specific requirements for protecting patients/residents and have been revised from the previous year to become more specific in response to concerns from the field about resources needed to comply with National Patient Safety Goals (The Joint Commission, 2012). Compliance with these goals is required for a successful accreditation survey (The Joint Commission, 2013). One new National Patient Safety Goal was added for 2014 on safe clinical alarm management for hospitals and critical access hospitals (Joint Commission, 2014).

Goal 1: Identify Patient Correctly

- Acceptable identifiers include: the individual's name, an assigned identification number, a telephone number, or other person-specific identifiers, such as date of birth and hospital I.D. The patient's/resident's room number or physical location is not used as an identifier. *(Applies to Ambulatory, Behavioral Health Care, Critical Access Hospital, Home Care, Hospital, Laboratory, Nursing Care Center, Office-Based Surgery.)*

Students need to be aware of the identifiers used at their assigned health care organization.

- Make sure that the correct patient gets the correct blood when they get a blood transfusion: Match the blood or blood component to the order; Match the patient to the blood or blood component; and Use a two-person verification process or a one-person verification process accompanied by automated identification technology, such as bar coding. *(Applies to Ambulatory, Critical Access Hospital, Hospital, Office-Based Surgery.)*

Goal 2: Improve Staff Communication

- Get important test results to the right staff person on a timely basis. *(Applies to Critical Access Hospital, Hospital, Laboratory.)*

Goal 3: Improve the Safety of Using Medication

- Label all medications, medication containers, and other solutions on and off the sterile field in perioperative and other procedural settings. Note: Medication containers include syringes, medicine cups, and basins. *(Applies to Ambulatory, Critical Access Hospital, Hospital, Office-Based Surgery.)*
- Reduce the likelihood of patient/resident harm associated with the use of anticoagulant therapy. *(Applies to Ambulatory, Critical Access Hospital, Hospital, Nursing Care Center.)*

Documentation of patient education and detailed discharge instruction are vital to this goal.

- Record and pass along correct information about a patient's/resident's medicines. Find out what medicines the patient/resident is taking. Compare those medicines to new medicines given to the patient/resident. Make sure the patient/resident knows which medications to take when they are at home. Tell the patient/resident it is important to bring their up-to-date list of medications every time they visit a doctor. *(Applies to Ambulatory, Behavioral Health Care, Critical Access Hospital, Home Care, Hospital, Nursing Care Center, Office-Based Surgery.)*

Goal 6: Reduce the Harm Associated with Clinical Alarm Systems

- Make improvement to ensure that alarms on medical equipment are heard and responded to on time. *(Applies to Critical Access Hospital, Hospital.)*

Goal 7: Reduce the Risk of Health Care Associated Infections

- Use the hand hygiene guidelines from the Centers for Disease Control and Prevention (CDC) or the World Health Organization (WHO). Set goals for improving hand cleaning. Use the goals to improve hand cleaning. *(Applies to Ambulatory, Behavioral Health Care, Critical Access Hospital, Home Care, Hospital, Laboratory, Nursing Care Center, Office-Based Surgery.)*
- Implement evidence-based practices to prevent central line-associated bloodstream infections. *(Applies to Critical Access Hospital, Nursing Care Center.)*
- Implement evidence-based practices to prevent health care-associated infections due to multi-drug-resistant organisms in acute care hospitals. *(Applies to Critical Access Hospital, Hospital.)*
- Implement evidence-based practices for preventing surgical site infections. *(Applies to Ambulatory, Critical Access Hospital, Hospital, Office-Based Surgery.)*
- Implement evidence-based practices to prevent indwelling catheter-associated urinary tract infections. *(Applies to Critical Access Hospital, Hospital.)*

Goal 9: Prevent Residents From Falling

- Reduce the risk of falls. *(Applies to Home Care, Nursing Care Center.)*

Goal 14: Prevent health care associated pressure ulcers (decubitus ulcers)

- Assess and periodically reassess each resident's risk for developing a pressure ulcer and take action to address any identified risks. *(Applies to Nursing Care Center.)*

Goal 15: Identify Patient/Resident Safety Risks

- Identify patients/residents at risk for suicide. *(Applies to Behavioral Health Care, Hospital.)*
- Identify risks associated with home oxygen therapy such as home fires. *(Applies to Home Care.)*

Universal Protocol: The organization meets the expectations of the Universal Protocol.

- Prevent Mistakes in Surgery.
 - Conduct a pre-procedure verification process. *(Applies to Critical Access Hospital, Hospital, Office-Based Surgery.)*

- Mark the procedure site. (*Applies to Ambulatory, Critical Access Hospital, Home Care, Hospital, Office-Based Surgery.*)
 - A time out is performed before the procedure. (*Applies to Ambulatory, Critical Access Hospital, Hospital, Office-Based Surgery.*)
-

WHAT DOES A STUDENT NEED TO KNOW FOR A JOINT COMMISSION SURVEY?

- **Occurrence Reporting**

An event, regardless of the degree of seriousness at the time of occurrence should be reported per health care organization's policy. Examples of occurrences for employees, medical staff, patients/residents, students, visitors, and volunteers include: personal injury (falls), medication error, property damage, and theft. If you are involved with or become aware of an occurrence, please notify the nursing staff and your instructor immediately.

Occurrence reporting is not punitive! It is a process of identifying:

- Opportunities for improvement.
- Potential claims.
- Sentinel events.
- Peer case review.

- **Sentinel Events**

A sentinel event is an unexpected patient/resident occurrence that results in, or could result in, death or serious harm to the patient/resident. The purpose of reporting and investigating sentinel events is to improve the quality of patient/resident care by focusing attention on underlying causes and risk reduction and to increase the general knowledge about sentinel events, their causes and prevention. This reporting is not punitive.

Sentinel Event Alerts identify specific sentinel events, describes their common underlying causes, and suggests steps to prevent occurrences in the future. The Joint Commission uses Sentinel Event Alerts to identify potential new Safety Goals and Requirements. Examples of Sentinel Event Alerts include:

- Wrong site surgery.
- Suicide.
- Restraint deaths.
- Transfusion errors.
- Falls with injury.
- Look-alike, sound-alike and high alert medications.

- **What Might Happen if a Student is Caring for a Patient/Resident Picked for a Tracer during a survey?**

If a student is caring for a patient/resident selected for a tracer (patient/resident selected to be tracked and followed) they may be asked to speak with the surveyor. Surveyors are interested in learning how the student fits within the organization and its processes.

The surveyor may also take the student's name and request to see documentation about the hospital-school affiliation agreement, orientation to the facility, and other information showing the student's fitness for duty.

Here are some topics a student should be prepared to discuss with the surveyor:

- Knowledge about the patient/resident and care the patient/resident is receiving.
 - Orientation to the facility – addressing safety, emergency codes, infection control, etc..
 - Oversight of the care given by the student/supervision of the student – who, what, when, how often.
-
- **What else might the surveyor do?**
 - The surveyor may ask to watch the student pass medication. If so, they are looking for infection control, medication safety, patient/resident identification and medication administration process steps.
 - As part of general observation on the unit, the surveyor will also be watching for proper hand hygiene. This will be heavily scrutinized during the survey.

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Alarm Fatigue

Nineteen out of 20 hospitals surveyed rank Alarm Fatigue as a top patient safety concern according to a national survey presented at the annual meeting of the Society for Technology in Anesthesia (2014).

Alarm fatigue occurs when health care providers become desensitized to the constant noise of alarms or are overwhelmed by the sounds and turn alarms down or off. A study done on a 15-bed unit at the Johns Hopkins Hospital found that there are an average of 350 alarms per bed per day (Healthcare Technology Foundation, 2011).

Recognizing alarm fatigue as a serious patient safety issue which can lead to alarm-related deaths and serious alarm-related injuries, the Joint Commission named Alarm Fatigue as a National Patient Safety Goal and requires accredited hospitals and critical access hospitals to improve their systems.

Although the problem of alarm fatigue is well documented in the literature, evidence-based studies that guide health care providers efforts to reduce and/or eliminate false and non-actionable alarms are lacking.

Interventions for Students to Assist in Reducing Alarm Fatigue

- Know and comply with health care organizations' alarm policies.
- Discuss frequency of patient-related alarms during report with the nurse so that they can collaborate with the interdisciplinary team and potentially customize alarm parameters or use different equipment.
- Reduce the potential of false alarms.
 - Use health care organization approved equipment, such as an arm board to support the forearm, wrist and hand during IV therapy to prevent false alarms due to positioning.
 - Provide proper skin preparation for electrocardiogram electrodes to improve conductivity and decrease the number of false alarms.
 - Cvach and colleagues (2011) demonstrated a 46% reduction in the average number of alarms per bed per day when electrodes were changed every day on patients.
- Collaborate with the health care organization in conducting and/or participating in alarm fatigue research, or quality improvement initiatives.

Alarm systems were created to enhance patient safety but have in fact become an urgent patient safety concern (Sendelbach & Funk, 2013). All health care providers, administrators, and medical equipment companies need to work together to eliminate alarm fatigue and provide a safer health care environment.

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Communication and Documentation

Communication

Clear communication is imperative in the health care environment and occurs between various individuals on a daily basis by way of verbal, non-verbal and written communication. Communication is essentially the activity of relaying information, expressing emotions and building relationships (Smallwood, 2011). In order for trust to develop between health care providers and their patients/residents, it is important that effective communication is developed and maintained.

Effective communication between health care providers is extremely important to patient/resident safety. Students lack experience in communicating with physicians and other health care providers. The SBAR (situation, background, assessment, recommendations) communication technique provides an organized logical sequence and improved communication process to ensure patient/resident safety.

The Joint Commission (2012), has added "standardized communication" to the Patient Safety Goals. SBAR is a communication technique and stands for:

- **SITUATION:** What is the situation? Why are you calling the physician? What is happening at the present time? What is the acute change? Explain in the fewest words, exactly what the situation is.
- **BACKGROUND:** What is the background information? What are the vital signs and pertinent history? Explain how the situation came to be? What were the circumstances leading up to this situation?
- **ASSESSMENT:** What is your assessment of the problem? What do you think the problem is?
- **RECOMMENDATION:** What should we do to correct the problem/address the situation? What action/response do you propose?

Example: Call to Physician

| | |
|--|---|
| Situation Dr. Patel this is Mary from Unit 8. I'm calling about your patient, Mr. Robert Smith in room 810 and wanted to let you know his heart rate has increased to the 150's and it is irregular. He does admit to feeling a little dizzy, short of breath and complains of palpitations. | Background Your patient walked for the first time since returning from a percutaneous endoscopic gastrostomy (PEG) placement this morning. His PEG site looks fine. Prior to the walk, his pulse was in the 90's at rest with blood pressure of 110/70. After applying O2 at 2 liters nasal cannula, his O2 sat increased to 96% from 94%." |
| Assessment I think this change in heart rate with exertion is causing him to be symptomatic. After the walk his pulse return to 96 with rest. | Recommendation I would like you to see Mr. Smith as soon as you can. In the meantime, I will have Mr. Smith continue to rest in bed or sitting in the chair with his O2 on. Would you like a 12-lead EKG done at this time? |

SBAR can be applied to almost all forms of communication between health care providers and thus provides a standard framework to transfer important information. SBAR helps students organize their thoughts prior to calling physicians, during handoff to another health care provider, and when transferring patients to other organizations or levels of care.

SBAR communication technique for shift change report:

- SITUATION: Patient's/Resident's name, room number, age, diagnosis, chief complaint, medications and allergies.
- BACKGROUND: Medical history.
- ASSESSMENT: Observations, such as VS, pain assessment, bowel sounds, lung sounds, current IV lines.
- RECOMMENDATION: Patient's/Resident's care plan.

Documentation

Documentation is a vital component of safe, ethical, and effective patient/resident care practice, regardless of whether the documentation is paper-based, electronic, or a combination of the two. Documentation provides a mechanism to describe, record, and communicate data, information, knowledge, and wisdom about a patient/resident; the care provided; the effect of care and the continuity of care. Documentation also provides a legal record of care provided. "Specific principles, standards, policies, procedures, and processes are part of any documentation system and help present the content in meaningful ways (ANA, 2007)". Students need to be familiar with and follow the health care organization's policies, standards and protocols.

Documentation for an individual patient/resident, whether paper-based or electronic, should clearly describe:

- An assessment of the patient's/resident's health status.
- A care plan or health plan reflecting the needs and goals of the patient's/resident's care needs.
- The interventions carried out.
- Patient/resident and family teaching.
- The patient's/resident's response to the intervention.
- Information reported to a physician or other healthcare provider and, when applicable, that provider's response.
- Advocacy taken by the healthcare provider on behalf of the patient/resident.
- Any proposed or needed changes.

DOCUMENTATION STANDARDS

Regardless of the system used to document, the student maintains documentation that is:

- Clear, concise and comprehensive.
- Accurate, true and honest.
- Relevant.
- Reflective of observations, not of unfounded conclusions.
- Timely and completed only during or after giving care.
- Chronological.

- A complete record of care provided, including assessments, identification of health issues, a plan of care, implementation and evaluation.
- Legible and non-erasable.
- Permanent.
- Retrievable.
- Confidential.
- Patient/resident-focused; and completed using forms, methods, systems provided.

GUIDELINES

- Document on the designated health care organization forms.
- Ensure each form clearly identifies the patient/resident.
- Document in permanent black ink.
- Do not leave blank lines between entries.
- Use only approved abbreviations and symbols.
- Do not erase or black out an error and do not squeeze entries between lines.
- Each entry must include the date, time, full legal signature and designation as a student and health professions program of the writer. The full legal signature consists of the first name and last name recorded. The instructor or preceptor must co-sign.
- Never delete, alter or modify anyone else's documentation.
- Document only work done personally; never document for someone else.
- **Incorrect Written Entry**
 - Erasures, whiteout, or alteration of spelling errors are not permitted — draw a line through the incorrect word such that it remains legible. The word "error" is to be marked and initialed.
 - For submission in wrong chart — place a diagonal line and write "wrong chart". Date, time and sign.
- **Late Entry**
 - Document forgotten or late entries at the next available entry space. Write the current date and time and write "Late entry for" date of missed entry.

DOCUMENTATION FORMS

Effective documentation forms provide a framework and guides documentation. Documentation forms include, but are not limited to:

- Assessment.
- Care plans.
- Worksheets and Kardexes.
- Flow sheets and checklists.
- Monitoring strips.

ELECTRONIC HEALTH RECORD

If the health care organization uses an electronic health record, understand that the same documentation principles apply, although there will be different strategies to record data and to ensure privacy, security and confidentiality of the record, as stated in the HIPAA Orientation and Education. Health care organizations may also have a policy for computer downtime situations.

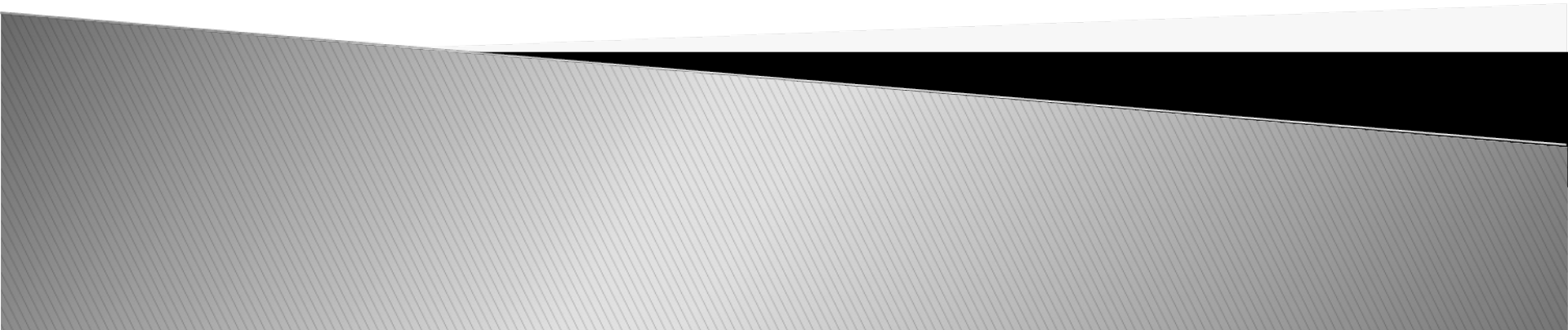
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Quality Improvement

Please review this [presentation on Quality Improvement](#). *(The PDF document will open in a new window.)*

Introduction to Quality Improvement



Objectives

- ▶ To gain an understanding of:
 - Quality
 - Quality improvement
 - The Model for Improvement
 - The PDSA cycle

What is Quality?

- ▶ Institute of Medicine (IOM): “Quality of Care” “is the degree to which health services for individuals and populations increase the likelihood of desired health outcomes and are consistent with current professional knowledge”.
- ▶
- ▶ Institute for Healthcare Improvement (IHI): “Quality is turning into outcomes management, and involves minimizing unnecessary variation so that outcomes become more predictable and certain”.
- ▶ Quality Digest: “Quality is meeting the customer's needs in a way that exceeds the customer's expectations”.

What is Quality Improvement?

- ▶ Patient Safety– Quality Improvement: “A formal approach to the analysis of performance and systematic efforts to improve it.”

- ▶ Definition of quality depends on stakeholders
 - The client/customer (the patient/resident).
 - The provider/employer (health care providers).
 - Management (hospital management).
 - Payer / health care plan.

6 Dimensions of Quality

- ▶ Safe
- ▶ Effective
- ▶ Patient-centered
- ▶ Timely
- ▶ Efficient
- ▶ Equitable

IHI, 2011a

▶ *How can we improve a system to achieve better results in the dimensions of quality?*

To improve a system...

- ▶ You need a good understanding of the system.
 - The procedures, resources and routines needed to carry out a specific activity.
 - **You need to :**
 - **know your customers (patients/residents).**
 - **understand where the system is failing – identify what is wrong.**
 - **make sure it is the step that needs fixing.**
- ▶ Identify processes that can be improved and lead to better quality of care.
- ▶ Then you can implement a change to the “system”

2-Step Model

Step 1: Three questions

+

Step 2: PDSA cycle

=

Model of Improvement

Step 1: The Three Questions

- ▶ The Model for Improvement begins with **three** fundamental questions:
 - 1. The Aim: *What are we trying to accomplish? (How good do we want to get and by when?)*
 - 2. The Measures: *How will we know a change is an improvement?*
 - 3. The Changes: *What change can we make that will result in improvement?*

Step 2: PDSA Cycle

- ▶ **P**lan a change
- ▶ **D**o the change
- ▶ **S**tudy the results
- ▶ **A**ct on the results



- ▶ Walter Shewhart was the first person to propose a version of the PDSA cycle.
W. Edwards Deming modified Shewhart's cycle to PDSA, replacing "check" with "study."

Step 1

| |
|--|
| What are we trying to accomplish? |
| How will we know that a change is an improvement? |
| What change can we make that will result in improvement? |

The Aim

The Measure

The Change



Step 2



MODEL FOR IMPROVEMENT

Executing the Model for Improvement

Form a team of people with different perspectives.

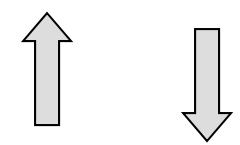
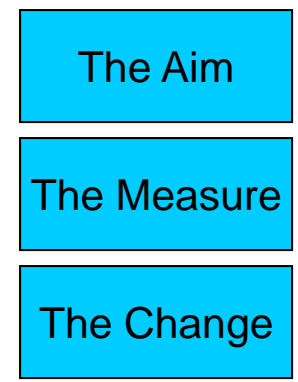
Ask the Three Questions:

- What are we trying to accomplish?
- How will we know the change is an improvement?
- What changes will produce improvement?

Test the changes – PDSA Cycle.

Implement changes that work.

Spread the changes to other areas.



Setting the Aim

- ▶ Time-specific.
- ▶ Measurable.
- ▶ Applicable to a specific population.
- ▶ Applicable to specific systems.

Establishing Measurements

- ▶ Teams use quantitative measures to determine if a specific change actually leads to an improvement.

| | Measurement for Improvement |
|----------|---|
| Purpose | To bring new knowledge into daily practice |
| Tests | Many sequential, observable tests |
| Biases | Stabilize the biases from test to test |
| Data | Gather just enough data to learn and complete another cycle |
| Duration | Short duration |

Selecting Changes

- ▶ The change depends on what you are trying to accomplish.

- ▶ Changes may come from:
 - Insights of people who work in the system,
 - Change concepts or other creative thinking techniques,
 - The experience of others who have successfully improved a system.

- ▶ Developing, testing, and implementing change is essential for those who want to continuously improve.
 - Use **critical thinking** with Flow Chart/Diagram.
 - Benchmark and compare to **best practice**.
 - Use **technology** (Barcodes for medications).
 - Use **creative thinking** (Become a patient for a day).
 - Use **change concepts**.

Change Concepts

- ▶ Eliminate Waste.
- ▶ Improve Work Flow.
- ▶ Optimize Inventory.
- ▶ Change the Work Environment.
- ▶ Producer/Customer Interface.
- ▶ Manage Time.
- ▶ Focus on Variation.
- ▶ Error Proofing.
- ▶ Focus on the Product or Service.

Step 2: Test the Changes – PDSA Cycle

All improvement will require change, but not all change will result in improvement.



PDSA Cycle

- ▶ To test your change use the PDSA cycle –

- ▶ Start with a **PLAN:**
 - Objectives
 - Questions and predictions
 - Plan to carry out the cycle
 - who,
 - what,
 - where,
 - when
 - Plan for data collection



PDSA Cycle

- ▶ **Do:** the action part of the process
 - Document problems and unexpected results.
 - Collect and analyze the data.
 - Meet with the involved parties.



PDSA Cycle

▶ Study

- Analyze process improvement data.
 - Compare data to prediction.
 - Summarize what was learned.
-
- Some focus areas of improvement are:
 - Clinical Outcomes
 - Cost
 - Access to Care
 - Satisfaction
 - Community Service
 - Regular Satisfaction Surveys



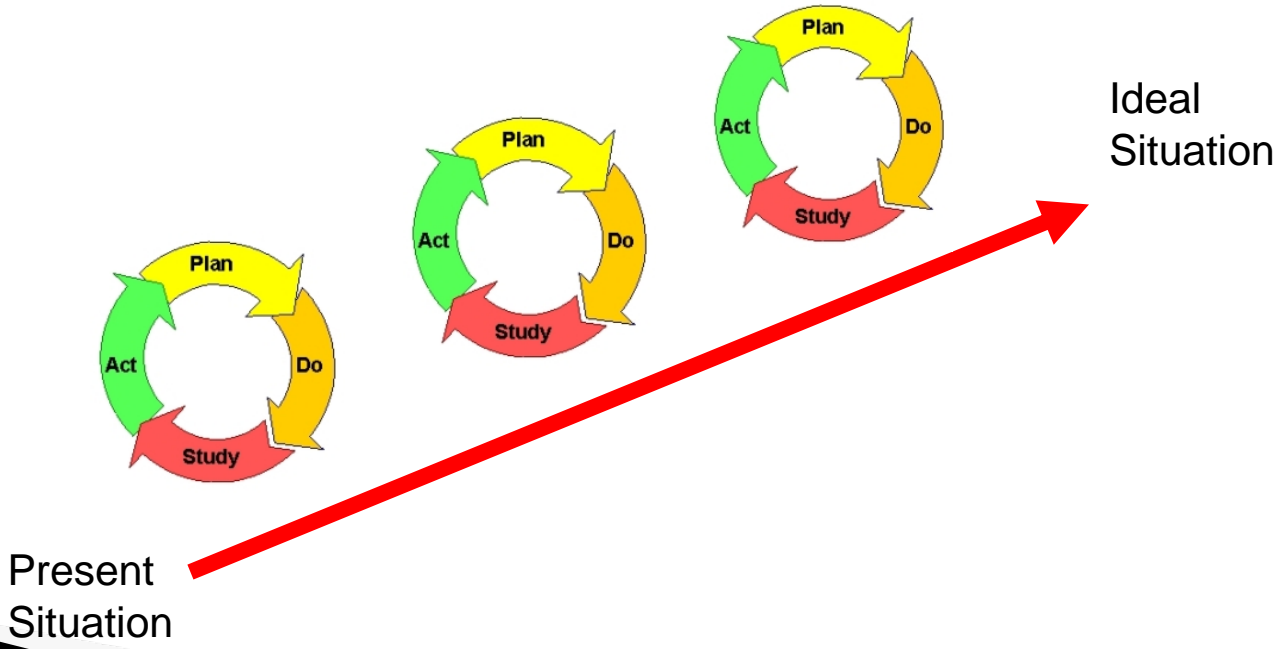
PDSA Cycle

- ▶ **Act**
 - What changes are to be made?
 - Start the next cycle?



Continuous Improvement

- ▶ Start small and think ahead a few steps.
- ▶ Test changes.
- ▶ Continuous improvement often requires a few sequential PDSA cycles.



Next Steps: Implement & Spread the Change

Change usually comes after a series of successful tests.

- ▶ Educate and train everyone involved.
- ▶ Make changes to job descriptions, policies, procedures, forms.
- ▶ Address supply and equipment issues.
- ▶ Assign day-to-day ownership for the maintenance of the new process.

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Module 2 Post-Test

Note: You are logged in as an administrator and administrator accounts can view but not submit tests.

POPULATION-SPECIFIC CARE

1. **Age-specific competency offers the health care provider information and skills that:**

- a. Decrease stress of both patient and caregiver.
 - b. Improve patient outcomes.
 - c. Facilitate individualized care and age appropriate interventions.
 - d. All of the above.
-

2. **For the health care provider, one of the most important parts of the infant's history is:**

- a. Favorite meals.
 - b. Likes and dislikes.
 - c. Favorite toys.
 - d. Immunization record.
-

3. **When caring for patients/residents of different cultural backgrounds, a caregiver's most important action is to:**

- a. Treat every person exactly the same.
 - b. Understand that religion is important to everyone.
 - c. Respect individual person's cultural practices.
 - d. Involve Social Service in every case.
-

GERIATRICS

4. **IV therapy presents the risk of fluid overload for elderly patients because fluid balance is more delicate in elderly persons.**

- a. True
 - b. False
-

5. **Which of the following routine procedures represents greater risks for elderly patients than for younger adults?**

- a. IV starts and blood draws are often more difficult due to small and fragile veins.
 - b. Fragile skin is easily torn during tape removal.
 - c. Fractures may result from very minor trauma due to osteoporosis.
 - d. Medications present special risks because of slowed metabolism.
 - e. b and d.
 - f. All of the above.
-

6. **Adults aged 65 years and older may need to receive information more than once and in segments.**

- a. True.
 - b. False.
-

7. **Elderly patients/residents are at increased risk for falls if they have had a previous fall.**

- a. True
 - b. False
-

NATIONAL PATIENT SAFETY GOALS

8. **Which of the following is NOT a component of the National Patient Safety Goals and Recommendations?**

- a. Improve the accuracy of patient/resident identification.
- b. Improve the safety of using medications.

- c. Reduce the risk of health care-acquired infections.
 - d. Increase compliance with body mechanics guidelines.
-

9. The Joint Commission readiness requires that:

- a. You know the emergency plan for the organization.
 - b. You defer to the nurse to activate the fire emergency.
 - c. You tell the Joint Commission surveyor you are just a student and you will not answer any of their questions.
 - d. You defer to your instructor or preceptor to respond to their questions on transmission-based precautions for your assigned patient/resident.
-

10. When identifying a patient/resident, which two Identifiers may be used when providing care, treatment, and services:

- a. Medical record number and room number.
 - b. Birth date and room number.
 - c. Birth date and name.
 - d. Medical record number and gender.
-

11. A "Time Out" is used before all surgical procedures to double check the identity of the patient and verify the site of the surgery so that an error will be prevented.

- a. True
 - b. False
-

ALARM FATIGUE

12. Which of the following actions is recommended to decrease alarm fatigue?

- a. Having standardized alarm limits on all patients.
 - b. Changing ECG electrodes every 48-72 hours.
 - c. Performing proper skin prep before attaching electrodes.
 - d. ECG monitoring all patients/residents.
-

COMMUNICATION AND DOCUMENTATION

13. In the following situation, indicate which portion of the SBAR model is described: "Dr. Ahmed, this is Sue, the registered nurse, caring for your patient Mrs. Smith. She is complaining of a new onset of severe abdominal pain."

- a. S - Situation
 - b. B - Background
 - c. A - Assessment
 - d. R - Recommendation
-

14. The Joint Commission has a Patient Safety Goal that specifies that a hospital needs to have a standardized approach for hand-off communications. The SBAR communication approach meets this goal because it has enhanced communication and helps reduce avoidable medical errors.

- a. True
 - b. False
-

15. The SBAR model:

- a. is an effective and efficient way to communicate.
 - b. closes the gap between differing communication styles.
 - c. standardizes communication by using four common elements.
 - d. a and c only.
 - e. All of the above.
-

16. In the following situation, indicate which portion of the SBAR model is described: The patient is three days post-op from a colon resection. The patient has been on room air for the past 24 hours and has had no breathing difficulties.

- a. S - Situation

- b. B - Background
 - c. A - Assessment
 - d. R - Recommendation
-

QUALITY IMPROVEMENT

17. Quality is defined as all of the following EXCEPT:

- a. Quality is about meeting the patients/residents needs.
 - b. Quality is only about cutting cost.
 - c. Quality is a degree of excellence.
 - d. Quality is the degree to which health services for individuals and populations increase the likelihood of desired health outcomes.
-

18. After receiving multiple complaints, emergency department staff are implementing a quality improvement plan to reduce the period between arrival and the beginning of treatment for clients. This emergency department is attempting to improve which one of the six improvement aims in their system?

- a. Safety
 - b. Equitable
 - c. Timeliness
 - d. Effectiveness
-

19. Following implementation of the unit's Quality Improvement Committee recommendations, the unit notes a reduction in treatment errors. The health care provider realizes these outcomes are indicative of:

- a. Continuity
 - b. Timeliness
 - c. Effectiveness
 - d. Safety
-

20. Health care organizations are committed to providing quality care. They strive to meet patient/resident needs by using quality improvement models such as the Plan-Do-Study-Act (PDSA) model. Some focus areas of improvement are:

- a. Clinical Outcomes
 - b. Satisfaction
 - c. Access to care
 - d. Cost
 - e. a, b, and c.
 - f. All of the above.
-

Clinical Placement Online Orientation

MODULE 3: Infection Control and Prevention

OSHA Bloodborne Pathogens Standard

The Occupational Safety and Health Administration (OSHA) Bloodborne Pathogens Standard, incorporating the Needlestick Safety and Prevention Act of 2000, is designed to protect at-risk employees from exposure to blood and other potentially infectious materials. Employees and health care workers covered by this standard include those who:

- Have direct patient/resident contact.
- Draw blood.
- Work with blood and other bodily fluid specimens.
- Handle contaminated equipment.

BLOODBORNE PATHOGENS are pathogenic microorganisms such as viruses and bacteria that are present in human blood or other potentially infectious materials that can cause disease in persons who are exposed to blood or other potentially infectious materials containing the pathogens. These pathogenic microorganisms can cause diseases such as Hepatitis B Virus (HBV), Hepatitis C Virus (HCV), Human Immunodeficiency Virus (HIV), and many others.

OSHA STANDARDS for reducing risks of bloodborne pathogens include:

- Implementation of a written Exposure Control Plan (ECP), designed to eliminate or minimize employee exposure, and ensures that employees with occupational exposure to bloodborne pathogens receive appropriate training. The training shall be provided to the employee free of charge and during work hours.
- Use of standard precautions during care of all patients/residents and all tasks that involve a reasonable likelihood for exposure to blood or body fluids.
- Use of personal protective equipment (PPE) whenever there is reasonable anticipation of exposure to blood or other potentially infectious materials.
- Hand washing after the removal of PPE; following contact with blood or other potentially infectious material; and/or prior to, or following, patient/resident care.
- Hand washing prior to or after patient/resident care.
- Use of safer needle devices and needleless devices to decrease needlestick or other sharps exposures.
- Implementation of engineering and work practice controls for proper handling and disposal of needles and other sharps to help prevent exposures.
- Avoid splashing, spraying, spattering, or creating droplets of blood or other fluids.
- Use of containers for transfer or disposal of anything contaminated with blood or infectious materials. The containers should display the biohazard label, be leak-proof and able to close.
- Discarding blood and other potentially infectious body substances in amounts sufficient to cause infection in red bags or containers labeled *Infectious Waste* or marked with the biohazard label.
- Use of health care organization-approved disinfectant on all contaminated items before use on another patient/resident.
- Appropriate use of Personal Protective Equipment, a health-care organization-approved disinfectant, and a blood spill kit for containing and cleaning spills of blood or body substances.

- A plan that ensures a Post-Exposure Evaluation and Follow up is in place to address exposure to blood or body fluids via needlestick, sharps injury, splash to mouth, nose or eyes, or to non-intact skin for all employees.
- A plan that ensures Hepatitis B vaccination has been given or is offered to all employees and health care workers who have the potential for occupational exposure to blood and other potential infectious materials.
- Prohibition of eating, drinking, applying cosmetics or lip balm, and/or handling contact lenses in work areas where there is a likelihood of occupational exposure to blood or other potentially infectious materials.

STANDARD PRECAUTIONS

Standard precautions require that all human blood and other potentially infectious materials be treated as if known to be infectious for HIV, HBV, HCV, or other bloodborne pathogens, regardless of the perceived “low risk” status of a source individual. These precautions are “standard” because they are used for all patients/residents, regardless of whether or not they have a diagnosis of infectious disease. OSHA’s Bloodborne Pathogens Standard recommends that employers and all health care workers, including students implement standard precautions when dealing with blood and other potentially infectious materials, which have the capability of transmitting a bloodborne pathogen. Standard Precautions are used in the health care organizations to:

- Prevent the transmission of infectious agents among patients/residents and healthcare providers.

The OSHA Bloodborne Pathogens Standards apply to blood or **Other Potentially Infectious Material (OPIM)**, which includes:

- Cerebrospinal fluid.
- Synovial fluid.
- Pleural fluid.
- Amniotic fluid.
- Pericardial fluid.
- Peritoneal fluid.
- Unfixed tissue or body organs other than intact skin.
- Semen.
- Vvaginal secretions.
- Any body fluid contaminated with blood.
- Saliva in dental procedures.
- Body fluids in emergency situations that cannot be recognized.
- Blood, organs, and tissue from experimental animals infected with HIV or HBV.

Respiratory Hygiene/Cough Etiquette is a new component of Standard Precautions and is targeted at patients/residents and accompanying family members and friends with undiagnosed transmissible respiratory infections. They apply to any person with signs of illness including cough, congestion, rhinorrhea, or increased production of respiratory secretions when entering a health care facility. The concepts of respiratory hygiene and cough etiquette involve using control measures to prevent patients/residents with respiratory infections from transmitting their infection to others. These measures include asking coughing or sneezing persons to:

1. Cover their mouth and nose with tissues and dispose of used tissues in waste containers.
2. Use a mask if coughing (when a mask can be tolerated).

3. Perform hand hygiene (wash with soap and warm water for 15 seconds or clean hands with alcohol-based hand product if hands are not visibly soiled) after contact with respiratory secretions.
4. To stand or sit at least 3 feet from other persons, if possible.

EXPOSURE

An exposure is contact of bodily organs (the eyes, nose, mouth, non-intact skin or parenteral contact) with blood or other potentially infectious material because of an injury (such as a needlestick, cut or abrasion) that results in a piercing of the skin or mucous membranes.

Steps for Exposure to Blood or Other Potentially Infectious Material

Immediately:

- Wash needlestick and cuts with soap and water.
- Flush splashes to the nose, mouth or skin with water.
- Irrigate eyes with clean water, saline, or sterile irrigates.
- Report exposure to your instructor, preceptor or supervisor.
- Seek medical evaluation because treatments are most likely to be effective if administered as soon as possible after the exposure.

REFERENCES

- Department of Health and Human Services Center for Disease Control and Prevention. (2007). 2007 Guideline for Isolation Precautions: Preventing Transmission of Infectious Agents in Healthcare Settings. Retrieved from www.cdc.gov/hicpac/2007IP/2007isolationPrecautions.html.
- U.S. Department of Labor Occupational Safety & Health Administration. (n.d.). Bloodborne Pathogens and Needlestick Prevention. Retrieved from www.osha.gov/SLTC/bloodbornepathogens/index.html.
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Human Immunodeficiency Virus (HIV)

Human Immunodeficiency Virus (HIV) is a retrovirus that causes Acquired Immunodeficiency Syndrome (AIDS) by infecting and damaging CD4 cells (also called T-helper cells) of the immune system leaving the body defenseless to numerous infections and health problems. Although AIDS, the final stage of this infection, is always the result of an HIV infection, not everyone with HIV has AIDS.

TRANSMISSION

HIV is transmitted through direct contact with the blood or body fluid of someone who is infected with the virus. HIV is transmitted through blood to blood (needle-sharing, needle sticks, blood exposure), sexual contact, and an infected pregnant woman can pass the virus to her baby during pregnancy, birth, or breast-feeding.

HIV is not spread through casual contact (e.g., touching, hugging, shaking hands, sharing eating utensils, eating food prepared by a person with HIV, coughing, sneezing, using restrooms, touching animals or insects (such as mosquitoes or bedbugs), working or attending school with an HIV-infected person).

DIAGNOSIS

A blood test is needed to diagnose HIV by testing for the presence of antibodies (disease-fighting proteins) to HIV. HIV antibodies generally do not reach noticeable levels in the blood for 1 to 3 months after infection. It may take the antibodies as long as 6 months to be produced in quantities large enough to show up in standard blood tests.

CLINICAL MANIFESTATION

HIV is one continuous disease process that ranges from asymptomatic to AIDS. Even during the asymptomatic period, the virus is actively multiplying, infecting, and killing cells of the immune system. Early vague symptoms include fatigue, headache, lymphadenopathy, and night sweats. As the immune system fails, symptoms increase and the illnesses that occur become more and more severe.

TREATMENT

While there is no cure for HIV or AIDS, the U.S. Food and Drug Administration (FDA) has approved a number of drugs that inhibit the virus's growth, prevent or delay the onset of AIDS and allow people living with HIV to remain free of symptoms longer. The most effective treatment strategy is a combination drug therapy which can attack viral replication in several different ways, attack different stages of the HIV life cycle, produce a more sustained antiviral effect in a person with HIV, and decrease the likelihood of drug resistance.

PREVENTION

Despite much research, there is no vaccine that will prevent HIV infection. Only the avoidance of high-risk behaviors can prevent HIV infection. Health care personnel should assume that the blood and other body fluids from all patients/residents are potentially infectious. They should therefore adhere to standard precautions and follow infection control precautions at all times.

HEALTH CARE PROVIDER EXPOSURE

Immediate drug therapy (within two hours of blood exposure) has reduced the transmission of the HIV virus. So, if a needle stick or sharps accident or any other body fluids exposure occurs, immediately:

- Wash needlestick and cuts with soap and water.
- Flush splashes to the nose, mouth, or skin with water.
- Irrigate eyes with clean water, saline or sterile irrigates.
- Report exposure to your instructor, preceptor or supervisor.
- Follow exposure control protocol.

REFERENCES

- Center for Disease Control and Prevention (CDC). (2014). HIV/AIDS. Retrieved from www.cdc.gov/hiv/default.htm.
- U.S. Department of Health and Human Services, National Institute of Allergy and Infectious Diseases. (n.d.). HIV Infection and AIDS: An Overview. Retrieved from www.niaid.nih.gov/topics/hivaids/understanding/Pages/Default.aspx.

ADDITIONAL RESOURCES

- AIDSinfo
<http://aidsinfo.nih.gov/>
1-800-HIV-0440 (1-800-448-0440) or 301-519-2816
1-888-480-3739 (TTY/TDD)
- National Institutes of Health HIV vaccine clinical trials
www.niaid.nih.gov/topics/HIVaids/research/vaccines/Pages/default.aspx
1-866-284-4107

Hepatitis

Hepatitis is an inflammation of the liver usually from a viral infection, but may also be caused by parasites, bacteria, chemicals, alcohol, or toxic agents. The three most common types of viral hepatitis — A, B, and C — affect thousands of people in the U.S. each year and millions worldwide.

| <u>Hepatitis A</u> (HAV) | <u>Hepatitis B</u> (HBV) | <u>Hepatitis C</u> (HCV) |
|--|--|---|
| Etiology | | |
| Caused by the hepatitis A virus (HAV), lasting from a few weeks to several months. It does not lead to chronic infection. | Caused by the hepatitis B virus (HBV). It ranges in severity from a mild illness, lasting a few weeks (acute), to a serious long-term (chronic) illness that can lead to liver disease or liver cancer. | Caused by the hepatitis C virus (HCV). HCV infection sometimes results in an acute illness, but most often becomes a chronic condition that can lead to cirrhosis of the liver and liver cancer. |
| Incubation Period | | |
| 15 to 50 days. | 6 weeks to 6 months. | 2 to 25 weeks. |
| Transmission | | |
| Ingestion of fecal matter, even in microscopic amounts, from close person-to-person contact or ingestion of contaminated food or drinks. | Contact with infectious blood, semen, and other body fluids from having sex with an infected person, sharing contaminated needles to inject drugs, or from an infected mother to her newborn. | Contact with the blood of an infected person, primarily through sharing contaminated needles to inject drugs. |
| Signs and Symptoms | | |
| <p>Some persons, particularly young children, are asymptomatic. When symptoms are present, they usually occur abruptly and can include the following:</p> <ul style="list-style-type: none"> • Fever • Fatigue • Loss of appetite • Nausea • Vomiting • Abdominal pain • Dark Urine • Clay-colored stool • Joint pain | <p>Signs and symptoms varies by age. Most children under age 5 years and newly infected immunosuppressed adults are asymptomatic, whereas 30% to 50% of persons aged ≥ 5 years have initial signs and symptoms. When present, signs and symptoms can include:</p> <ul style="list-style-type: none"> • Fever • Fatigue • Loss of appetite • Nausea • Vomiting • Abdominal pain • Dark urine | <p>Usually are asymptomatic or have mild symptoms that are unlikely to prompt a visit to a healthcare professional. When symptoms occur, they can include:</p> <ul style="list-style-type: none"> • Fever • Fatigue • Dark urine • Clay-colored stool • Abdominal pain • Loss of appetite • Nausea • Vomiting • Joint pain |

| | | |
|---|---|---|
| <ul style="list-style-type: none"> • Jaundice | <ul style="list-style-type: none"> • Clay-colored stool • Joint pain • Jaundice | <ul style="list-style-type: none"> • Jaundice |
| Treatment | | |
| No specific treatment. | Interferon and anti-viral medications. | Interferon (peginterferon) along with antiviral medications. |
| Immunization | | |
| Hepatitis A vaccination is recommended for all children at age 1 year, for travelers to certain countries, for persons who are at increased risk for infection, for persons who are at increased risk for complications from hepatitis. | Hepatitis B vaccination is recommended for all infants, older children and adolescents who were not vaccinated previously, and adults at risk for HBV infection, including healthcare providers. | There is no vaccine for hepatitis C. |
| Prevention | | |
| <ul style="list-style-type: none"> • Hepatitis A vaccine. • Immune globulin within two weeks of exposure. • Good hand hygiene. • Use bleach to clean surfaces contaminated with feces, such as changing tables. • Practice safe sex. | <ul style="list-style-type: none"> • Hepatitis B vaccine. • Immune globulin. within two weeks of exposure. • Practice safe sex. • Clean up infected blood with bleach and wear protective gloves. • Don't share razors, toothbrushes or needles. • Don't inject street drugs. • Don't get a tattoo or body piercing. | <ul style="list-style-type: none"> • Practice safe sex. • Adhere to standard precautions. • Clean up spilled blood with bleach. • Don't share razors or toothbrushes. • Don't inject street drugs. • Don't get a tattoo or body piercing. |
| Prevention for Healthcare Providers | | |
| <ul style="list-style-type: none"> • Adhere to standard precautions. • Use approved health care organization's disinfectant to clean surfaces contaminated with feces. • Use Personal Protective Equipment as needed. • Follow health care organization's policy for contaminated waste disposal. | <ul style="list-style-type: none"> • Hepatitis B vaccine. • Adhere to standard precautions. • Use approved health care organization's disinfectant to clean surfaces. • Use Personal Protective Equipment as needed. • Follow health care organization's policy for contaminated waste disposal. | <ul style="list-style-type: none"> • Adhere to standard precautions. • Use approved health care organization's disinfectant to clean up spilled blood. • Use Personal Protective Equipment as needed. • Follow health care organization's policy for contaminated waste disposal. |

The hepatitis B Vaccine series is offered to all health care workers who have a reasonably anticipated exposure to blood or other potentially infectious materials and is one of the best protective measures against hepatitis B. Since the introduction of the vaccine and adherence to other preventive measures (e.g. Standard Precautions), there has been a significant decline in new cases of hepatitis B among health care workers. The vaccine is given in a series of three injections over a 6-month period and all three injections must be received. Health care workers and health care providers who do not wish to be vaccinated must sign a declination form.

REFERENCES

- About.com. (2014). Hepatitis. Retrieved from <http://hepatitis.about.com>.
- Center for Disease Control and Prevention (CDC). (2008). Hepatitis B and the healthcare worker. Retrieved from www.immunize.org/catg.d/p2109.pdf.
- Center for Disease Control and Prevention (CDC). (2014). Viral Hepatitis. Retrieved from www.cdc.gov/hepatitis.

Tuberculosis

Please review this [presentation on tuberculosis](#). *(The PDF document will open in a new window.)*

Healthcare-Associated Infections

Medical advances have brought lifesaving care to patients/residents in need, yet many of those advances come with a risk of healthcare-associated infections (HAI). HAI are infections caused by a wide variety of common and unusual bacteria, fungi, and viruses during the course of receiving medical care. HAIs are among the leading causes of preventable deaths in the United States, accounting for an estimated 1.7 million infections and 99,000 associated deaths in 2002 (CDC, 2012). The financial burden attributable to these infections is estimated at \$28 to \$33 billion in excess health care costs each year (CDC, 2012).

Many bacterial agents are responsible for HAIs, the most common of which is methicillin-resistant *Staphylococcus aureus* (MRSA). The number of MRSA-associated hospital stays more than tripled after 2000, reaching 368,600 in 2005. Patients hospitalized for MRSA have longer hospital stays and are more likely to die than patients who do not have MRSA.

Health care employs many types of invasive devices and procedures to treat patients and to help them recover. Infections can be associated with the devices used in medical procedures, such as catheters or ventilators. Nearly 3 out of every 4 HAIs in the acute care hospital setting are a result of 1 of the following 4 categories of infection, listed in order of prevalence:

1. Catheter-associated urinary tract infections.
2. Surgical site infections.
3. Central-line associated bloodstream infections.
4. Ventilator associated pneumonia.

| Specific Measures for Prevention of Healthcare–Associated Infections Recommended by the Centers for Disease Control and Prevention | | |
|---|---------------------------------------|---|
| Healthcare–Associated Infection | Preventive Measure | Definition |
| All healthcare–associated infections. | Hand hygiene. | Washing hands before and after each patient contact. |
| Central venous catheter–related bloodstream infections (CRBSI). | Maximal sterile barrier precautions. | Use aseptic technique including the use of a cap, mask, sterile gown, sterile gloves, and a large sterile sheet for the insertion of all central venous catheters (CVCs). |
| | Chlorhexidine skin antisepsis. | Use 2% chlorhexidine gluconate solution for skin sterilization at the CVC insertion site. |
| | Appropriate insertion site selection. | Avoid femoral site for nonemergency CVC insertion. |

| | | |
|--|---|--|
| | Prompt removal of unnecessary catheters. | Removal of CVC that is no longer essential for care. |
| Surgical site infection (SSI). | Appropriate use of perioperative antibiotics. | Administration of appropriate prophylactic antibiotic, generally begun within 1 hour before skin incision and discontinued within 24 hours. |
| | Avoidance of shaving of the operative site. | Use clippers or other methods for hair removal in the area of skin incision(s). |
| | Perioperative glucose control. | Maintenance of blood glucose less than 150 mg/dL during postoperative period (tighter control may be more beneficial in specific patient populations). |
| Ventilator-associated pneumonia (VAP). | Semirecumbent positioning. | Elevation of the head of the bed to more than 30 degrees for all mechanically ventilated patients. |
| | Daily assessment of readiness for weaning. | Minimize duration of mechanical ventilation by minimizing sedative administration (including daily "sedation holidays") and/or using protocolized weaning. |
| | Oral care protocols. | These protocols decrease dental plaque and oral flora which have been associated with increased risk of VAP. |
| Catheter-associated urinary tract infection (CAUTI). | Aseptic insertion and catheter care. | Use of skin antisepsis at insertion and proper aseptic technique for maintenance of catheter and drainage bag; use of closed urinary drainage system. |
| | Prompt removal of unnecessary catheters. | Removal of urinary catheter when no longer essential for care. |

(Adapted from: AHRQ <http://psnet.ahrq.gov/primer.aspx?primerID=7> - Ranji SR, Shetty K, Posley KA, et al. Prevention of healthcare-associated infections. In: Shojania K.G., McDonald K.M., Wachter R.M., Owens, D.K., (2007). Closing the Quality Gap: A Critical Analysis of Quality Improvement Strategies. Technical Review 9. AHRQ Publication No. 04-0051-6. Rockville, MD: AHRQ.

Multi-drug Resistant Organisms (MDROs)

Preventing infections will reduce the burden of MDROs in health care settings (CDC, 2006). MDRO is a bacteria that is resistant to many antibiotics, which means that certain drug treatments will not work. Examples of MDROs are:

- Methicillin Resistant Staphylococcus Aureus (MRSA)
- Vancomycin Resistant Enterococcus (VRE)
- Extended Spectrum Beta Lactamase (ESBL)
- Klebsiella Pneumoniae Carbapenemase Producer (KPC)

According to the CDC (2006), prevention practices to reduce antimicrobial resistance in health care settings include:

- Infection prevention.
- Accurate and prompt diagnosis and treatment.
- Prudent use of antimicrobials
- Prevention of transmission.

REFERENCES

Agency for Healthcare Research and Quality (AHRQ). (2009, September). AHRQ's efforts to prevent and reduce health care-associated infections [fact sheet]. AHRQ Publication No. 09-P013, Rockville, MD: AHRQ. Available from: www.ahrq.gov/qual/haiflyer.htm.

Center for Disease Control and Prevention (CDC). (2013). Healthcare-associated Infection (HAI). Retrieved from www.cdc.gov/HAI/index.html.

Center for Disease Control and Prevention (CDC). (2006). Management of Multi-drug Resistant Organisms in Healthcare Settings. Retrieved from http://www.cdc.gov/hicpac/mdro/mdro_4.html.

Transmission-Based Precautions

Transmission-Based Precautions are designed to supplement standard precautions in patients/residents with documented or suspected infection/colonization of highly transmissible or epidemiologically important pathogens. The three categories of Transmission-Based Precautions include:

- Contact Precautions
- Droplet Precautions
- Airborne Precautions

For diseases that have multiple routes of transmission (e.g., Severe Acute Respiratory Syndrome (SARS)), more than one Transmission-Based Precautions category may be used. When used either singularly or in combination, they are always used **in addition to** Standard Precautions.

TRANSMISSION-BASED PRECAUTIONS CATEGORIES

Contact Precautions are designed to reduce the risk of transmission of microorganisms by direct or indirect contact. Direct contact transmission involves the physical transfer of microorganisms to a susceptible host from an infected or colonized person. Indirect contact transmission involves contact of a susceptible host with a contaminated intermediate object. Examples of Diseases: gastrointestinal infections (including diarrhea of unknown origin), wound and skin infections (e.g. impetigo) and colonization with multidrug-resistant bacteria (e.g. methicillin-resistant *Staphylococcus aureus* (MRSA)).

- **Special Factors:**
 - Private room or rooms with a patient/resident who has a similar diagnosis.
 - Patient/resident should stay in room except for medically necessary procedures or therapies.
 - Gloves for any contact with patient/resident or touching anything in the room.
 - Gown if it is likely that clothing will be in contact with any patient/resident or any surfaces in the patient/resident care environment.
 - Mask and eye protection if splashing or splattering of any contaminated substance is likely.
 - Patient/resident care items such as blood pressure cuff, stethoscopes or thermometer should be “dedicated” (used only for that patient/resident and disinfected or discarded after the patient/resident is discharged).

Enteric Precautions are being used in many health care organizations for patients/residents who have active infection with *C. difficile*, rotavirus or norovirus. They are a type of contact precautions. Many health care organizations separate them out to remind health care providers that soap and water hand washing must be performed instead of using an alcohol-based hand rub because the alcohol is not effective in removing the pathogens from the hands.

Droplet Precautions are designed to reduce the risk of droplet transmission of infectious agents. Infectious droplets are released when the infected person sneezes or coughs and the large droplet spray may spread as far as three feet. Examples of Diseases: Influenza, meningococcal meningitis, mumps, rubella, diphtheria, pneumonic plague, pertussis and infections caused by multi-drug resistant *Streptococcus pneumoniae*.

- **Special Factors:**
 - Private room or rooms with a patient/resident who has a similar diagnosis.

- Patient/resident should stay in their room except for medically necessary procedures; a mask should be worn when out of the room.
- A regular/surgical mask should be used for any potential exposure within three feet of the patient/resident.
- Gloves and gowns are required when delivering patient/resident care in droplet precautions.
- Patient/resident care items such as blood pressure cuff, etc. should be dedicated to that patient/resident.
- Patient/resident should be taught to cover their nose and mouth with tissues when coughing or sneezing and to discard tissues into a bag.

Airborne Precautions are designed to reduce the risk or eliminate the airborne transmission of infectious agents. The infectious particles are so small that they can remain suspended in the air for long periods of time and are carried on air currents. Examples of Diseases: varicella (chickenpox), tuberculosis, measles.

- **Special Factors:**

- Private room with special ventilation; door must be kept closed.
- The patient/resident should stay in his or her room except for essential reasons; a special mask should be worn when out of the room.
- Respirators are worn by personnel if the patient/resident has or is suspected of having an airborne illness. In general, students are not usually fitted for respirators.
- Respirators are worn for chickenpox or measles only if the employee entering has not had the disease or has not been immunized.
- Gloves: Worn when in contact with respiratory secretions.
- Patient/resident care items such as blood pressure cuffs, etc. should be dedicated and disinfected or discarded after the patient/resident is discharged.
- Patient/resident should be taught to cover their nose and mouth with tissues when coughing or sneezing and to discard tissues in a bag.

REFERENCES

- Center for Disease Control and Prevention (CDC). (2014). Healthcare-associated Infections. Retrieved from <http://www.cdc.gov/hai>.
- Siegel, J.D., Rhinehart, E., Jackson, M., Chiarello, L., & the Healthcare Infection Control Practices Advisory Committee. (2007). 2007 Guideline for Isolation Precautions: Preventing Transmission of Infectious Agents in Healthcare Settings. Retrieved from www.cdc.gov/hicpac/pdf/isolation/isolation2007.pdf.
- U.S. Department of Labor Occupational Safety & Health Administration. (n.d.). Regulations (Standards - 29 CFR) Bloodborne pathogens. - 1910.1030. Retrieved from www.osha.gov/pls/oshaweb/owadisp.show_document?p_table=STANDARDS&p_id=1005
[1](#)

Blood and/or Body Fluid Exposure Accident

An exposure incident is contact with blood or other potentially infectious material with eyes, nose, mouth, non-intact skin, or parenteral contact, which is an injury that results in a piercing of the skin or mucous membranes, such as needlestick, bite, cut, or abrasion.

TASKS AND ACTIVITIES THAT MAY INVOLVE EXPOSURE TO BLOOD & BODY FLUIDS INCLUDE:

- Phlebotomy procedures (drawing blood).
- Starting an IV.
- Sputum collection or suctioning.
- Performing dressing changes.
- Surgical procedures.
- Clean up of contaminated instruments or items.
- Clean up of environmental surfaces.
- Handling stool or urine.
- Performing CPR.

STEPS FOR EXPOSURE TO BLOOD OR OTHER POTENTIALLY INFECTIOUS MATERIAL:

Immediately

- Wash the wound or skin site with soap and water.
- In case of eye injury, remove contacts (if worn) and irrigate the eye immediately with sterile water or normal saline or irrigate with a gentle stream of aerated water from eye station for at least fifteen minutes.
- Report exposure to your instructor, preceptor or supervisor.
- Seek medical evaluation because treatments are most likely to be effective if administered as soon as possible after the exposure.

REFERENCES

U.S. Department of Labor Occupational Safety & Health Administration. (n.d.). Regulations (Standards - 29 CFR) Bloodborne pathogens. - 1910.1030. Retrieved from www.osha.gov/pls/oshaweb/owadisp.show_documents?p_table=STANDARD&p_id=10051

Personal Protective Equipment

Personal Protective Equipment (PPE) is specialized clothing and equipment worn by employees and health care providers for protection against a hazard, such as blood or other potentially infectious materials. This equipment should be readily available in an assortment of sizes and types. Health care providers should never put themselves at risk by not using appropriate PPE and the equipment should be removed after use.

TYPES OF PERSONAL PROTECTIVE EQUIPMENT

Gloves: Latex, vinyl, or synthetic gloves are to be worn to provide a barrier and to prevent contamination of hands when touching blood and other potentially infectious material. Gloves must be worn at all times when drawing blood, starting IV's, and when contact with blood and body fluid is likely. Gloves must be changed between patient/resident contacts and hand hygiene should be performed as per health care organization policy, after glove removal, between patients/residents, and after touching potentially contaminated equipment or surfaces.

Remove and discard gloves carefully, either at the doorway or immediately outside patient's/resident's room. As a rule, health care workers should not wear gloves or isolation attire to transport a patient/resident outside of their room. If necessary, follow health care organization's policy.

Gowns: Gowns should be worn when there is a likelihood of clothing or skin being splashed or soiled with blood and body fluids. Gloves and gowns should be put on when entering the room and removed prior to leaving the room.

Face and Eye Protection: The mucous membranes of the eyes, nose and mouth must be covered during procedures that are likely to generate splashes or sprays of blood or body fluids.

Mask: Masks or respirators should be used to reduce risk of respiratory exposure. Respirators are designed and engineered for distinctly different functions than surgical masks and the amount of exposure reduction offered by respirators and surgical masks differs. The National Institute for Occupational Safety (NIOSH) and the Center for Disease Control and Prevention (CDC) recommends the use of a NIOSH-certified N95 or better respirator for airborne precautions (NIOSH, 2009).

Surgical caps and/or shoe covers: Surgical caps or hoods and/or shoe covers or boots shall be worn in instances when gross contamination can reasonably be anticipated.

OTHER SAFETY DEVICES

Mouthpieces, resuscitation bags, and ventilation devices will be available for resuscitation purposes.

Eye wash stations in patient/resident care areas are available to immediately cleanse eye if contamination with blood, body fluid or hazardous chemicals should occur. Immediately rinse eye(s) and inner surface of eyelid(s) with water continuously for fifteen minutes.

Needle safety devices and sharps containers are available for use when performing tasks with a potential for needlestick injury.

A label called a "biohazard label" is used as a warning sign to indicate that the contents of a container may include blood, body fluids, or other potentially infectious fluids.

REFERENCES

- U.S. Department of Labor Occupational Safety & Health Administration. (n.d.). Personal Protective Equipment (PPE). Retrieved from www.osha.gov/SLTC/personalprotectiveequipment/index.html.
- U.S. Department of Labor Occupational Safety & Health Administration. (n.d.). Regulations (Standards - 29 CFR) Bloodborne pathogens. - 1910.1030. Retrieved from www.osha.gov/pls/oshaweb/owadisp.show_document?p_table=STANDARDS&p_id=10051.
- National Institute for Occupational Safety and Health (NIOSH). (2009). N95 Respirator and Surgical Mask. Retrieved from <http://blogs.cdc.gov/niosh-science-blog/2009/10/14/n95/>

Hand Hygiene

The single most important infection control measure to prevent the transmission of bloodborne pathogens is hand hygiene.

New guidelines developed by the Center for Disease Control and Prevention (CDC) and infection-control organizations recommend that health workers use an alcohol-based hand rub (a gel, rinse or foam) to routinely clean their hands between patient/resident contacts, as long as hands are not visibly dirty. Alcohol-based hand sanitizers — which don't require water — are an excellent alternative to hand washing, particularly when soap and water aren't available. According to CDC, alcohol-based hand rub is actually more effective than soap and water in killing bacteria and viruses that cause disease.

RECOMMENDATIONS

- **Alcohol-based hand rub:** Use alcohol-based hand rub if hands are not visibly soiled for routinely decontaminating hands.
- **Soap and water handwashing:** Wash with non-antimicrobial or antimicrobial soap and water if hands are visibly dirty, contaminated, or are visibly soiled with blood or other body fluids, before eating or after using the restroom.
- **YOU MUST USE SOAP AND WATER:**
 - IF A PATIENT/RESIDENT HAS CLOSTRIDIUM DIFFICILE.
 - WHEN ANTHRAX IS SUSPECTED OR CONFIRMED.
 - IF YOU ARE PERFORMING ANY PROCEDURE WITH POSSIBLE STOOL CONTAMINATION.

INDICATIONS FOR HAND HYGIENE

- Before and after treating each patient/resident.
- Before glove placement and after glove removal.
- After barehanded touching of inanimate objects in the immediate vicinity of the patient/resident or likely to be contaminated by blood, saliva, or respiratory secretions.
- When hands are visibly soiled.

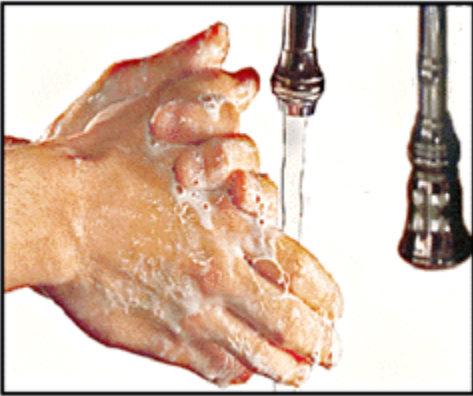
HAND HYGIENE TECHNIQUES

Hand-rub with alcohol-based hand sanitizer:

- Apply volume: based on manufacturer's recommendation, usually about 1.5 to 3 ml (about the size of quarter), of an alcohol gel or rinse to the palm of one hand, and rub hands together.
- Cover all surfaces of your hands and fingers, including areas around/under fingernails.
- Continue rubbing hands together until alcohol dries (about 15-25 seconds).



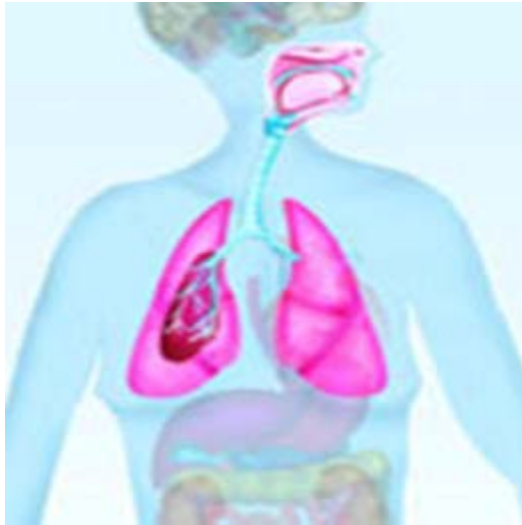
Handwashing with soap and water:



- Turn on the faucet.
- Wet hands and apply 3 to 5 ml of soap.
- Lather well using vigorous rotary motion and friction for at least 15 seconds.
- Be sure to wash all part of your hands, including palms, between fingers, backs of hands and around your wrists and thumbs.
- Rinse under running water, letting water run toward your fingertips.
- Dry your hands thoroughly with paper towels.
- Use the paper towel to turn off faucet.

REFERENCES

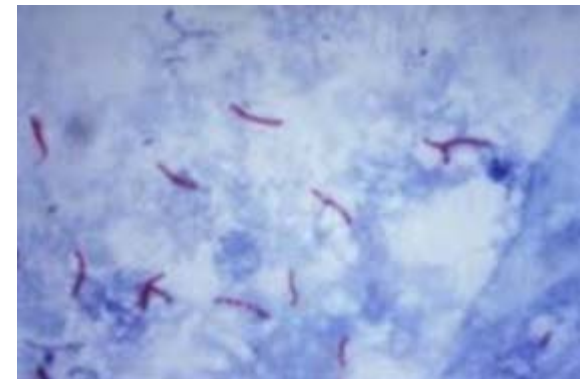
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Tuberculosis

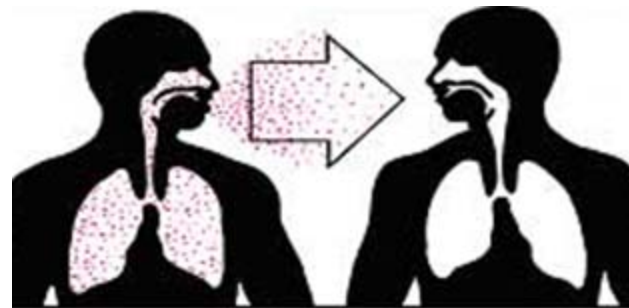
Overview

- ▶ Tuberculosis (TB) is an ancient infectious disease caused by the bacterium *Mycobacterium tuberculosis* (Mtb), which most commonly affects the lungs but can also affect the central nervous system, lymphatic system, circulatory system, genitourinary system, bones and joints.
- ▶ Suspected and confirmed TB cases must be report within 24 hours to the state’s designated department or health official.
- ▶ If not treated properly, TB disease can be fatal.



Transmission

- ▶ TB is spread through the air via airborne droplet nuclei from one person to another. People with the active disease expel bacilli into the air by:
 - coughing,
 - sneezing,
 - shouting,
 - talking,
 - laughing,
 - or any other way that will expel bacilli into the air.



Pathogenesis

TB Infection

- ▶ Susceptible person inhales droplet nuclei containing Mtb bacilli that then become established in the body. This causes the Mtb infection.
- ▶ Within 2–10 weeks after initial infection the immune response limits further spread of tubercle bacilli; however, some of the bacilli remain viable but are dormant as long as the immune system remains active and functions normally. This is known as latent TB infection.
- ▶ People who have latent TB infection do not get sick and do not spread the bacteria to others. But some people with latent TB infection eventually do get TB disease
- ▶ Progression to active disease is more likely in: people with medical conditions that result in immune deficiencies; the elderly; and those less than 4 years of age.

TB Disease

- ▶ For someone to develop active TB disease, the following two events must take place:
- ▶ The entrance of TB bacteria into the body to cause the Mtb infection.
- ▶ The inability of the immune system to stop the TB bacteria from growing and spreading after the initial infection.
- ▶ In most cases the bacteria affects the lungs, but can be found in all parts of the body.

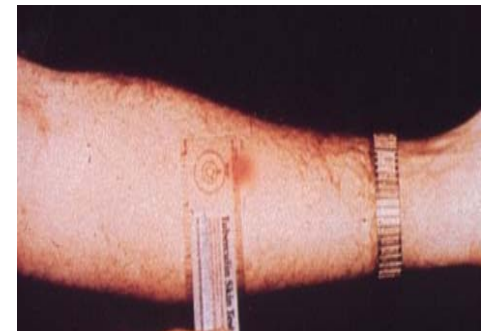
Sign and Symptoms

- ▶ Productive cough 3 weeks or longer
- ▶ Shortness of breath
- ▶ Chest pain
- ▶ Hemoptysis
- ▶ Night sweats/fever/chills
- ▶ Loss of appetite/unexplained weight loss
- ▶ Weakness/fatigue/lethargy

Diagnosis

TB Infection:

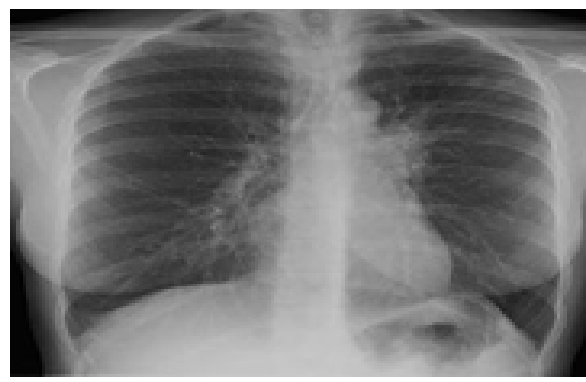
- Mantoux Tuberculin Skin test (TST): uses TB antigens called purified protein derivative to detect TB infection. It cannot tell if the infection is active or inactive (latent).
 - Redness alone at the skin test site is a negative reaction.
 - A firm red bump is a positive reaction. The size of the bump determines whether the test results are significant, based on risk factors for TB.
 - A false-positive test most likely occurs if a person has been infected with a different type of mycobacterium other than the one that causes TB, or if vaccinated with the bacillus Calmette-Guerin (BCG) vaccine, a vaccine used in other countries with high TB infection rates.
- Blood tests (interferon-gamma release assays [IGRAs]): measure how the immune system reacts to the bacteria that cause TB.



Diagnosis

TB Disease

- Medical history and physical examination
- Chest radiograph (X-ray)
- Bacteriologic or histologic examinations: tests to see if TB bacteria are in the sputum



Treatment

- ▶ TB Infection
 - Isoniazid (INH) for 9 to 12 months is the preferred regimen to kill the TB bacteria that are in the body and to prevent the person from developing TB disease.

- ▶ TB Disease
 - TB disease can be treated by taking several drugs for 6 to 12 months.

 - Of the approved drugs, the first-line anti-TB agents that form the core of treatment regimens include:
 - isoniazid (INH)
 - rifampin (RIF)
 - ethambutol (EMB)
 - pyrazinamide (PZA)

Treatment

- ▶ The length of therapy and combination of antibiotics is decided based upon the organism's sensitivity to the antibiotics, signs of improvement, and patient's compliance with medication regimen.
- ▶ It is especially important that the prescribed drug therapy regimen be completed in order to kill all bacilli.
- ▶ Drug resistance may develop when medications are taken incorrectly by either skipping doses or not taking the medication for the prescribed amount of time.

Who is at Risk of Tuberculosis Disease?

- ▶ People infected with HIV.
- ▶ People with close contact to an individual with active infectious tuberculosis.
- ▶ People with conditions that increase the risk of active tuberculosis after infection (diabetes mellitus, chronic renal failure, malignancies, etc.).
- ▶ People born in countries or geographic regions with a high prevalence of tuberculosis.
- ▶ Substance abusers, such as alcoholics, IV drug users, and cocaine or crack users.
- ▶ Residents of long-term care facilities, nursing homes, prisons, mental institutions, homeless shelters, and other congregate housing settings.
- ▶ Medically underserved low-income populations.
- ▶ Healthcare workers and others who provide service to any high-risk group.

Infection Control and Prevention

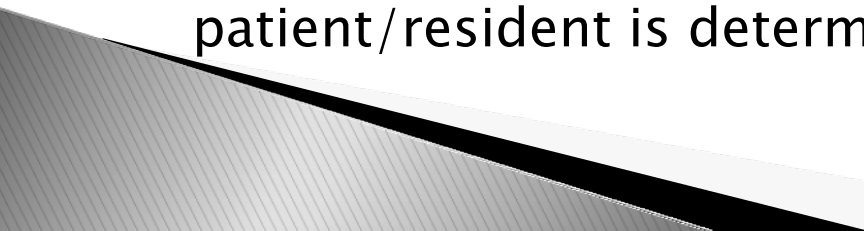
- ▶ Early detection and prompt treatment of patients/residents who have TB.
- ▶ Placement of any patient/resident with active symptoms and a suspected diagnosis of active TB, a positive chest x-ray, positive sputum smears, or positive sputum cultures in an airborne infection isolation room (AIIR).
- ▶ Enforcement of the requirement for health care providers to wear specially designed and fitted **NIOSH-Approved Particulate Respirator Masks**, at least an N-95, in:
 - Airborne infection isolation room (AIIR);
 - Rooms where cough inducing procedures are performed;
 - Vehicles transporting infectious TB patients/residents.

Infection Control and Prevention

According to current federal guidelines, unless a facility can provide airborne infection isolation, the patient/resident must be transferred to a health care facility that has appropriate airborne infection isolation room (AIIR).

Minimizing Exposure

- ▶ Provide as many services in the isolation room as possible (e.g. portable x-ray);
- ▶ Place a surgical mask on the patient/resident for transport or relocation;
- ▶ Take the individual directly to the location;
- ▶ Immediately perform the procedure upon arrival;
- ▶ Return the patient/resident to the isolation room as soon as practical;
- ▶ If possible choose a time when the procedure area is not being used by others;
- ▶ Delay elective procedures and surgeries until the patient/resident is determined to be non-infectious.



References

- ▶ Center for Disease Control and Prevention. (2014). Tuberculosis. Retrieved from www.cdc.gov/tb/.
- ▶ Mayo Clinic. (2013). Tuberculosis. Retrieved from www.mayoclinic.com/health/tuberculosis/DS00372.

Module 3 Post-Test

Note: You are logged in as an administrator and administrator accounts can view but not submit tests.

OSHA BLOODBORNE PATHOGENS STANDARD

1. **OSHA Standards for reducing risks of bloodborne pathogens include all EXCEPT:**
 - a. Use of personal protective equipment (PPE) whenever there is reasonable anticipation of exposure to blood or other potentially infectious materials.
 - b. Disposal of used or contaminated sharps in sharp containers.
 - c. Replace sharps containers when contents reach the top.
 - d. Hand washing after the removal of PPE, following contact with blood or other potentially infectious material, and/or prior to or following patient/resident care.

2. **Standard precautions should be used:**
 - a. Only with patients/residents known to have an infectious disease.
 - b. With all patients/residents.
 - c. Only when contact with infected blood is likely.
 - d. Only with patients/residents suspected of having a bloodborne disease.

3. **Standard precautions are the action taken with patient/resident, all of the time, to prevent transmission of germ from patient to health care worker, patient to patient, and health care worker to patient.**
 - a. True.
 - b. False.

4. **According to Standard Precautions, how does a health care provider determine when to wear gloves?**
 - a. Check the patient's/resident's diagnosis for possible communicable disease.
 - b. Identify whether the patient/resident falls into any of the risk categories for AIDS or other blood-borne pathogens.
 - c. Use gloves for every patient/resident when contact with any blood/body substance, mucous membrane, and non-intact skin is possible.
 - d. Review the policy and procedure manual for which patients/residents need isolation precautions.

5. **When used in caring for a patient/resident in contact isolation, patient care items such as blood pressure cuffs, stethoscopes or thermometers should be:**
 - a. Disposable.
 - b. Discarded after each use.
 - c. Dedicated and used only for that patient/resident.
 - d. Disinfected every morning.

HUMAN IMMUNODEFICIENCY VIRUS (HIV)

6. **Human Immunodeficiency Virus (HIV) is NOT transmitted by:**
 - a. Casual contact such as hugging.
 - b. Needle-sharing.
 - c. Sexual contact.
 - d. Giving birth.

HEPATITIS

7. **Hepatitis B:**
 - a. Can be transmitted via a needlestick.
 - b. Can be found in wound drainage.
 - c. Is the greatest bloodborne risk to health care workers.

- d. All of the above.
-

8. Which statement is NOT true about Hepatitis?

- a. Infected persons may display no symptoms.
b. All forms of Hepatitis can be prevented by vaccination.
c. A symptom may be darkened urine.
d. Hepatitis causes inflammation of the liver.
-

TRANSMISSION-BASED PRECAUTION

9. Methicillin-resistant staphylococcus aureus (MRSA) in the urine requires which type of precaution?

- a. Contact Precautions.
b. Droplet Precautions.
c. Airborne Precautions.
d. None of the above.
-

10. Contact isolation requires:

- a. Having the health care provider wear a mask if working within three feet of a patient/resident.
b. Having the patient/resident wear a mask if leaving the room.
c. Use of a certified respirator.
d. Use of gloves for any contact with the patient/resident and gown if it is likely that clothing will be in contact with the patient/resident.
-

11. Tuberculosis is transmitted by:

- a. Needlesticks.
b. Airborne particles.
c. Touching respiratory secretions.
d. None of the above.
-

BLOOD AND/OR BODY FLUID EXPOSURE ACCIDENT

12. Droplet precautions do NOT require:

- a. A mask to be worn by the health care provider for any potential exposure within three feet of the patient/resident.
b. A private room with special ventilation.
c. A mask worn by the patient/resident when out of the room.
d. The patient/resident to cover their nose and mouth with a tissue when coughing or sneezing and to discard tissues into a bag.
-

13. If you have been exposed to blood or body fluid you should:

- a. Immediately wash the exposed area with an alcohol-based cleanser.
b. Immediately wash the exposed area with soap and water and report to your clinical instructor, preceptor or supervisor.
c. Immediately cover the area and report to the emergency department.
d. Immediately check to see what co-morbidities the patient/resident may have.
-

HEALTHCARE-ASSOCIATED INFECTIONS

14. Healthcare-associated infections (HAI) are infections caused by a wide variety of common and unusual bacteria, fungi, and viruses during the course of receiving medical care.

- a. True
b. False
-

15. Prevention of catheter-associated urinary tract infection (CAUTI) includes which of the following:

- a. Use of skin antiseptics at insertion and proper aseptic technique for maintenance of catheter and drainage bag.

- b. Use of closed urinary drainage system.
 - c. Removal of the urinary catheter when no longer essential for care.
 - d. All of the above.
 - e. Only a and c.
-

PERSONAL PROTECTIVE EQUIPMENT

16. Which of the following are examples of Personal Protective Equipment (PPE)?

- a. Gloves, mask, safety syringe, and goggles.
 - b. Gloves, gown, goggles, shoe covers, and alcohol gel.
 - c. Gloves, mask, gown, and goggles.
 - d. Mask, goggles, soap, and alcohol gel.
-

HAND HYGIENE

17. What is the most important factor in preventing the spread of disease?

- a. Performing proper hand hygiene.
 - b. Wearing a gown.
 - c. Wearing a mask.
 - d. Maintaining short fingernails.
-

18. Hands should be washed for a minimum of:

- a. 8 seconds.
 - b. 10 seconds.
 - c. 15 seconds.
 - d. 20 seconds.
-

19. An alcohol based hand sanitizer may be used when caring for a patient with *Clostridium difficile* or performing any procedure with possible stool contamination.

- a. True
 - b. False
-

20. When should hands be washed?

- a. On arrival to work and before going home.
 - b. Between patients.
 - c. Before and after invasive procedures.
 - d. After using the restroom
 - e. Before and after eating.
 - f. All of the above.
-

Clinical Placement Online Orientation

MODULE 4: Environment of Care

Fire Safety

Please review this [presentation on Fire Safety](#). *(The PDF document will open in a new window.)*

Electrical Safety

Electrical safety requires the cooperation of ALL personnel in each department.

ELECTRIC SHOCK

Electric shocks are caused by electricity flowing through the body after contact with a damaged electrical device or an electrical object. The results of electric shock may include:

- muscle spasms.
- burns.
- cardiac arrest.
- respiratory arrest.

ACCIDENT PREVENTION AND GENERAL SAFETY TIPS

Follow these simple steps to prevent electrical accidents from happening:

- **Electrical Equipment:** learn proper operation BEFORE using; visually inspect before use; check to make sure inspection sticker or tag is on; do not stack anything on or behind equipment; turn OFF before plugging/unplugging.
- **Do Not Use Equipment if:** it is wet; a liquid has been spilled into it; an object has been dropped onto or into it; it has been dropped or has fallen; your hands are wet; you feel a tingling sensation upon touching.
- **Plugs/Cords/Outlets:** make sure wall outlets are in good condition; make sure plugs fit snugly and securely into wall outlets; pull on the plug, NOT on the cord to remove from an outlet or equipment.
- **Do Not** rest equipment on electrical cords; use extension cords on patient/resident care equipment or overload any electrical outlets.
- **Always Remember To:**
 - Turn equipment "OFF" when plugging in/disconnecting from wall outlets.
 - Turn off all equipment when not in use.
 - IMMEDIATELY clean up spills on and around equipment.
 - Check with your clinical instructor, preceptor, or supervisor if you are unsure whether use of an electronic personal item is permitted.

REPORTING ELECTRICAL HAZARDS

ALL health care workers are responsible for identifying and reporting hazards involving electricity and electrical equipment. Report any hazards to your clinical instructor, preceptor or supervisor.

REFERENCES

- U.S. Department of Labor Occupational Safety & Health Administration. (n.d.). Electrical. Retrieved from www.osha.gov/SLTC/electrical/index.html

Medical Waste

Health care organizations generate a complex array and quantity of waste that may pose significant environmental challenges. Improper handling of medical waste may negatively impact the health of the local and/or global community.

Each health care organization has a Waste Management Plan that is designed to comply with all applicable federal, state, and local laws, regulations, and standards relevant to the health care environment. The Waste Management Plan defines the responsibilities and procedures for the safe handling, storing, use and disposal of hazardous materials and waste. All health care providers must handle and dispose of hazardous materials and waste according to this plan and in a way that ensures patient/resident and worker safety and minimizes potential risks. Students must dispose of biohazardous and medical waste according to the health care organization's waste management program.

REGULATED MEDICAL WASTE includes:

- blood and items dripping or saturated with blood,
- bulk body fluids,
- needles, syringes, and medical sharps, and
- any pathological or microbiological wastes.

DISPOSAL OF REGULATED WASTE

- Sharps (needles, broken glass, scalpels, or other items that could cause a cut or puncture wound) – use designated sharps disposal containers (puncture-resistant, leak proof, color-coded or labeled containers).
- Soiled or blood-soaked bandages, culture dishes, cultures, swabs used to inoculate cultures, specimen containers, and tissue/body organs – use regulated waste container (closable, leak proof, red or biohazard-labeled bags).

REFERENCES

- U.S. Department of Labor Occupational Safety & Health Administration. (n.d.). Bloodborne Pathogens Regulations (Standards - 29 CFR) - 1910.1030. Retrieved from www.osha.gov/pls/oshaweb/owadisp.show_document?p_table=STANDARDS&p_id=10051.

Emergency Codes

Health care organizations use codes to indicate an emergency. Each facility has specific codes for each emergency which will be shared with you as part of the facility orientation.

General Code Information

- **Fires:** Most fires start small and if not managed, get progressively out of control. The facility is designed to contain fires within fire compartments, which have special fire doors. The intent of the fire door is to prevent the spread of fire from one fire compartment to another. Most hospitals use "Code Red" to alert staff to a fire.
- **Cardiac Arrest:** If you witness the collapse of a patient/resident, visitor or employee, shout for help. Determine that the collapsed person is unresponsive and has not completed a DNR (DO NOT RESUSCITATE) form or does not have a current DNR physician's order. If you are certified, begin CPR. Once the emergency response team arrives, please provide them with any specific information you have about the patient/resident and the events immediately preceding the collapse.
- **Bomb Threat:** If you hear the Code for a bomb threat, report to your assigned area and follow the directions of your instructor, preceptor or supervisor. Report any suspicious findings, such as an unattended bag or box to your instructor, preceptor, or supervisor, but do not touch the item.
- **Disaster:** In the event of an internal or external disaster code, report to your unit immediately and follow the directions of your instructor, preceptor, or supervisor.
- **Infant/Child Abduction:** If you need to report a missing infant or child, dial the in-house emergency access number and provide all necessary information. Assist staff in sealing off the building (including exits, elevators, fire doors and stairwells) so that no one is allowed to leave the building until the code is cancelled. Follow policy and procedure as outlined by the supervisor.
- **Elopement:** An elopement occurs when a patient/resident who lacks safety awareness leaves a safe area within or outside the facility without the knowledge of the facility's staff and without proper supervision. A patient/resident who elopes is at risk of many dangers, including heat or cold exposure, dehydration, drowning, falling, being struck by a motor vehicle, etc. In the case of an elopement, assist the staff with locating the patient/resident and follow the policy and procedure as outlined by the supervisor.
- **Communication Failure:** If the telephone system is not working, a communication failure exists. When this happens, the supervisor will provide you with information on other available modes of communication.
- **Other:** Facilities assigned may have additional emergency codes. These will be provided/explained during your facility-specific orientation.

Specific Emergency Code Information

Please click on [this link](#) to see the set of **standardized** New Hampshire emergency codes (the link will open as a PDF file in a new window).

In Maine and Massachusetts, each health care organization has its own set of emergency code names and system. Please familiarize yourself with the emergency codes of the specific health care organization to which you have been assigned.

Emergency Preparedness

As part of America's vital health care infrastructure, hospitals play a key role in disaster readiness throughout our country. Emergencies or disasters can happen any time, and they usually occur without warning. When an emergency (such as a fire, hazardous materials release or power outage) strikes, the safety of patients/residents and prompt recovery from the disaster depends on existing levels of preparedness. Students have a responsibility for knowing what to do during and after an emergency to protect their own safety and the safety of patients/residents.

TYPES OF DISASTERS

An **Internal Disaster** is an incident within the institution that may compromise its structural integrity, result in injuries to health care staff and/or patients/residents, or otherwise threatens the institution's ability to care for patients/residents. Such events could include the following:

- telephone interruption.
- steam interruption.
- water interruption.
- electricity interruption.
- major compressed gas interruption or leak.
- fire, smoke or explosion.
- major chemical spills.
- radiation accidents/events.
- biological accidents/events.
- bomb.

An **External Disaster** is an event within the community or region that causes multiple casualties such as fire, explosion, hurricane, transportation accident, terrorist event or civil disorder.

A **Potential Disaster** includes the threat of an event that could cause either an internal or external disaster. Examples of potential disasters include a major storm or flood.

STUDENTS' RESPONSIBILITIES

- Be familiar with the emergency codes of the health care organization.
- Be prepared to act quickly, correctly and calmly.
- Know the health care organization's emergency numbers.
- Know how to recognize and initiate emergency alarms.
- Be prepared to assist in an emergency, including assisting with evacuation.
- Know the evacuation routes, where fire extinguishers, fire hoses and fire pull stations are located.
- Report to your instructor, preceptor, or supervisor for any specific assignment.

Hazard Communication

To keep health care providers informed about the hazards they may face at work, OSHA created standards including the *Hazard Communication Standard*, also known as the **Right to Know Law**. These standards, enacted in 1983, give you the right to know about chemical hazards in your workplace and require training of individuals who may work with hazardous substances.

Recent changes in OSHA's Hazard Communication Standard have brought the regulation more in line with international standards with the implementation of the Global Harmonizing System (GHS). The GHS includes criteria for the classification of health, physical and environmental hazards, as well as specifying what information should be included on labels of hazardous chemicals as well as safety data sheets (OSHA Hazard Communication, n.d.).

Implementing the GHS helps ensure improved quality and consistency in the classification and labeling of all chemicals, which in turn, improves an employee's ability to quickly understand critical safety information - **Right to Understand**.

TYPES OF HAZARDS

- **Physical hazards:** usually result from improper use or storage of dangerous chemicals. These are chemicals that are:
 - flammable (catches fire easily);
 - explosive (causes a sudden release of pressure, gas and heat); and
 - reactive (burns; explodes; or releases toxic vapor if exposed to other chemicals, heat, air, or water).
- **Health hazards:** bodily organs or systems (e.g., lungs, eyes, kidneys, skin, mucous membranes, blood-producing system, and the reproductive system) may be affected by exposure to hazardous chemicals. Existing medical conditions may also be aggravated by exposure to hazardous chemicals.
- **Environmental hazards:** usually the result of effects to the marine, land and ozone layers.

TYPES OF EXPOSURE

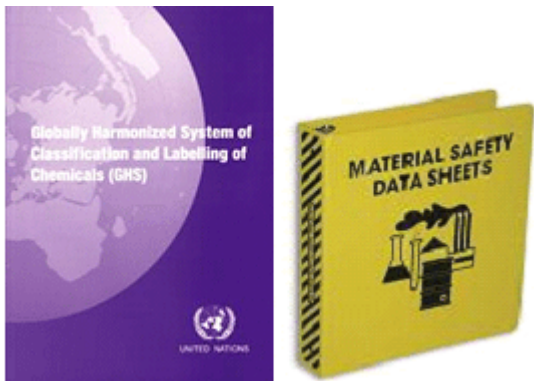
- **Inhalation:** Inhaling hazardous chemicals causes dizziness, headaches, nausea, and throat or lung damage.
- **Absorption:** Skin and eye contact with hazardous chemicals may cause burns, allergies, vision problems, or blindness. Cuts and other skin injuries allow chemicals to pass into the bloodstream.
- **Ingestion:** Swallowing hazardous chemicals when eating, drinking, or smoking in areas where chemicals are located may damage internal organs.
- **Injection:** Accidental percutaneous injury (needle puncture, scalpel, or any sharps injury) allows toxins to enter the bloodstream directly and circulate throughout the body.

LABELING

All containers of hazardous chemicals must be labeled with at least these items:

- **Responsible Party:** Name, address and telephone number of the manufacturer, importer, or other responsible party.
- **Product Identifier:** Indicates how the hazardous chemical is identified.

- **Signal Words:** Indicates the relative level of severity of the hazard and alerts the reader to potential hazard by the label. There are only two words used as Signal Words: "**Danger**" and "**Warning**".
- **Hazard Statement:** Describes the nature of the hazard(s) of the chemical, including, where appropriate, the degree of hazard.
- **Precautionary Statement:** Recommended measures that should be taken to minimize or prevent adverse effects resulting from exposure to hazardous chemicals or improper storage or handling.
- **Supplementary Information:** the label producer may provide additional instructions or information it deems helpful.
- **Pictogram:** Graphic symbols used to communicate specific information about the hazards of a chemical.



SAFETY DATA SHEETS (SDS)

The (Material) Safety Data Sheet (SDS) provides comprehensive information for use in workplace chemical management (OSHA GHS, n.d.). Health care providers use the SDS as sources of information about hazards and to obtain advice on safety precautions. The GHS Document (referred to as "The Purple Book", as shown above) establishes agreed hazard classification and communication provisions with explanatory information on how to apply the system. The GHS Purple Book provides the minimum information that is required in each section of the SDS.

All health care organizations should have an SDS or access to an SDS (online) for each chemical and medication that has hazardous chemical properties. Check with your clinical instructor, preceptor, or supervisor for the location of or access to the facility's SDS.

DEALING WITH HAZARDOUS SPILLS

All health care organizations will have specific clean-up policies for hazardous spills. Please consult with your clinical instructor, preceptor or supervisor in the event you encounter a hazardous spill in your work area. In general, you should respond to a hazardous spill by:

- protecting your safety and the safety of others.
- isolating the scene and denying entry to it.
- notifying the individual or department who is responsible for hazardous spill cleanup.

HAZARDOUS ENERGY (Lockout/Tagout)

Workers performing service or maintenance on machinery and equipment may be exposed to injuries from the unexpected energization, startup of the machinery or equipment, or release of stored energy in the equipment. The Lockout/Tagout standard requires the adoption and implementation of practices and procedures to shut down equipment, isolate it from its energy source(s), and prevent the release of potentially hazardous energy while maintenance and servicing activities are being performed.



Lockout: The practice of using keyed or combination security devices ("locks") to prevent the unwanted activation of mechanical or electrical equipment.



Tagout: The practice of using tags in conjunction with locks to increase the visibility and awareness that equipment is not to be energized or activated until such devices are removed. Tags are non-reusable, attachable by hand, self-locking, and not easily removed.

If health care worker's duties include performing work covered by the Lockout/Tagout program, they must be trained.

REFERENCES

- U.S. Department of Labor Occupational Safety & Health Administration (29 CFR 1910.1200). (n.d.). Hazard Communication OSHA Standards. Retrieved from www.osha.gov/pls/oshaweb/owadisp.show_document?p_table=STANDARDS&p_id=10099.
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- U.S. Department of Labor Occupational Safety & Health Administration. (n.d.). GHS: A Guide to the Globally Harmonized System of Classification and Labeling of Chemicals. Retrieved from <http://www.osha.gov/dsg/hazcom/ghs.html>.

Latex Allergy

Please review this [presentation on Latex Allergy](#). *(The PDF document will open in a new window.)*

Needlesticks or Sharps Injuries

Health care workers use many types of needles and other sharps in the performance of their duties. Although there have been engineering advances to make these products safer, needlestick or sharps injuries remain a very real occupational hazard. Needlesticks or sharps injuries pose a significant risk of occupational transmission of bloodborne pathogens such as human immunodeficiency virus (HIV), hepatitis B virus (HBV), and hepatitis C virus (HCV) to health care workers.

In 2001, to protect all health care workers from unnecessary needlesticks, the Federal Needlestick Safety and Prevention Act was created. This law requires employers to provide safer medical devices such as retractable needles, which may eliminate accidental needlesticks. The U.S. Department of Labor Occupational Safety & Health Administration (OSHA) requires all facilities to:

- Maintain a sharps injury log accessible to all employees.
- Evaluate safety-engineered devices annually.
- Involve clinicians in evaluating products (including syringes).

PREVENTION OF SHARPS INJURIES

- Learn and follow health care organization's policies on working with bloodborne pathogens.
- Avoid the use of needles when safe and effective alternatives are available.
- Use devices with safety features, such as needle-less system/sharps safety equipment.
- Do not recap, break, bend or remove contaminated needles.
- Identify sharp disposal containers and plan for safe handling and disposal of needles before using them. Bring a sharps disposal container in the room if one is not available in the room.
- Promptly dispose of used needles in appropriate sharps disposal containers.
- Do not place fingers inside a sharps disposal container.
- Do not overfill disposal containers. Once a container is 3/4 full, start a new container.
- Report all needlestick and sharps related injuries promptly to your instructor, preceptor, charge nurse or supervisor to ensure you receive appropriate follow-up care and complete the health care organization's required forms.

REFERENCES

- Eck, E. K., DeBaun, B., & Pugliese, G. (2001). OSHA Compliance: Needlestick Prevention Requires Planning, Products, and People. *Infection Control Today Magazine*. Retrieved from <http://www.infectioncontroltoday.com/articles/2001/08/osha-compliance.aspx>.
- U.S. Department of Labor Occupational Safety & Health Administration. (n.d.). Bloodborne Pathogens and Needlestick Prevention. Retrieved from www.osha.gov/SLTC/bloodbornepathogens/index.html.

Fire Safety

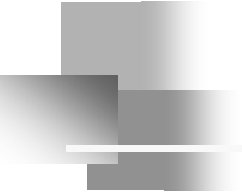
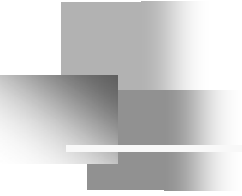




Fire Safety

- ▶ Fires are a constant threat to any health care organization and all fires are potentially disastrous situations.
- ▶ Besides threatening the safety of patients/residents, visitors, and personnel, a fire may reduce the health care organization's ability to provide services.

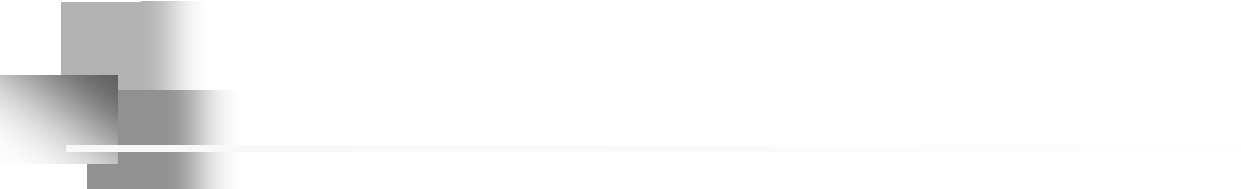
For these reasons, it is essential that students know the proper method to prevent fires and be able to respond quickly and appropriately in the case of a fire.



Fire Safety

- ▶ Everyone has a role and responsibility in the event of a fire emergency. Roles may involve:
 - Rescuing patients/residents and others,
 - Assisting with moving them to safety,
 - Sounding the alarm, or
 - Just staying out of the way of firefighters and other designated emergency response personnel.



- 
- ▶ **ALL HEALTHCARE PROVIDERS** must know the:
 - Health care organization's Fire Emergency Plan
 - Location of fire pull/call boxes
 - Location and proper use of a fire extinguisher
 - Places of safe refuge
 - Evacuation procedures

Simple guidelines to reduce the possibility of a fire.

- Remind patients/residents and visitors of the necessity of observing the smoking policy.
- Observe safety guidelines when using electrical equipment.
- Keep all chemicals, flammables and gases stored in their proper containers and use them appropriately.
- Be alert and aware of potential fire hazards and eliminate these hazards in the work area.
- If a fire is discovered, it is essential that you react quickly to avoid panic among patients/residents, visitors and personnel. This can only be accomplished through adequate training and familiarity with procedures.

Always Supervised When In Use



Not Allowed

- Space heaters (unless approved and tagged by electrical maintenance department)
- Extension cords
- Candles



In the Event you hear a **Fire Code** or **Fire Drill**

- Listen for the building location of the fire emergency. If the fire emergency is in your building, listen for further announcements.
- Follow the fire procedures for your area.

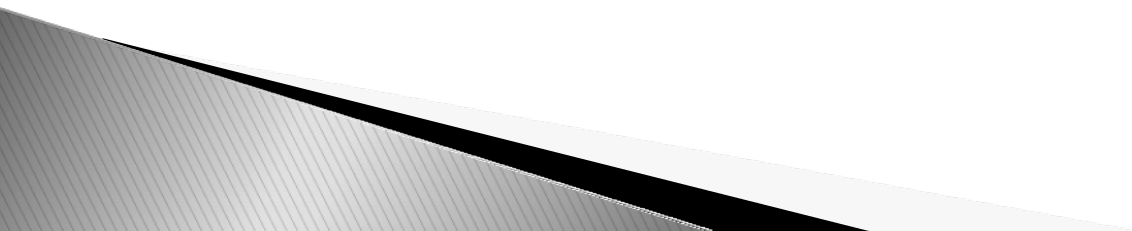
IMPORTANT:

- NEVER attempt to enter a room where a fire is contained without **FIRST** checking to see if the door is warm or hot to the touch.
- NEVER open a door if it is hot to the touch.
- Do not use elevators. Only use the stairs.
- Keep all marked Fire Doors *closed* except when passing through.
- Clear corridors of all obstructions.
- Listen for the all-clear code. You may then resume your normal activity.



If you see & hear an alarm

DO NOT
assume it is a **FALSE ALARM,**
your life may depend on it!



What to do if you discover a FIRE

If you see Smoke or Fire, remember the acronym

R.A.C.E

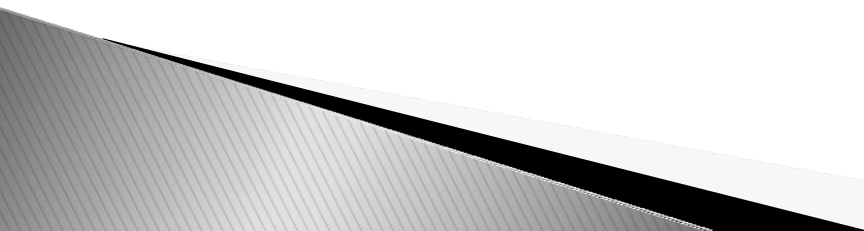




R.A.C.E. stands for:

- ▶ **R: Rescue/Remove**
- ▶ **A: Alarm**
- ▶ **C: Confine/Contain**
- ▶ **E: Extinguish/Evacuate**

Each of these actions must be accomplished while responding to a fire emergency at any location throughout the Institution.



The R.A.C.E. protocol

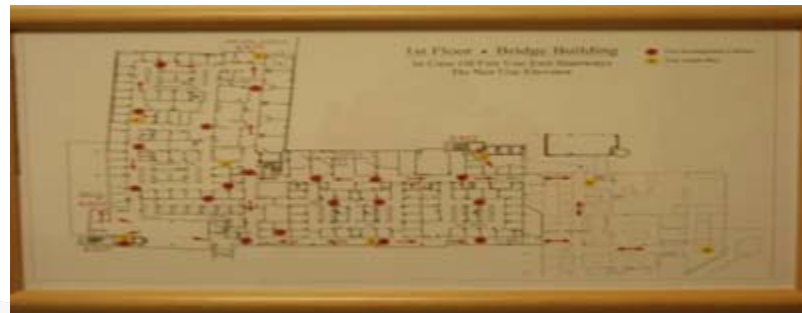
- **“R”- RESCUE/REMOVE:** Individuals not capable of self-preservation (i.e. patients/residents, injured healthcare workers, employees or visitors) must be rescued from the immediate area of fire origin.
- **“A”- ALARM:** Activate the emergency call box or pull station. Dial the health care organization’s emergency number and give the page operator your name, the phone number you are calling from, the exact location (building, floor and room or office number), and state what you are reporting (sight or smell of smoke, or sight of fire and location).



The R.A.C.E. protocol

- **“C”- CONFINE/CONTAIN:** Fire, smoke and toxic combustion products must be confined to the area where the fire started as much as possible. Close doors, windows, turn off fans.
- **“E”- EXTINGUISH/EVACUATE:** Handheld fire extinguishers are located throughout the health care organization. Extinguish the fire with the appropriate extinguisher if it is small.

Evacuate from the fire zone to a safe zone beyond the fire doors, or to next lower level or outside.



Why do we close doors?

*To compartmentalize and contain fire and smoke,
and
To limit the spread of smoke and fire*



Fire Extinguishers

- ▶ The most commonly used fire extinguisher is the ABC type and it can be used for most types of fires. If a specialty extinguisher is required in a particular area, you will be oriented to its use.

- ▶ **REMEMBER:**
 - Never use water on grease or electrical fires.
 - If you are not familiar with fire extinguishers and have not been trained in their use, DO NOT attempt to use them!

FIRE EXTINGUISHER OPERATION

▶ P.A.S.S. Method

- **Pull the pin:** This will allow you to squeeze the handle in order to discharge the extinguisher
- **Aim at the base of the fire**
- **Squeeze the handle:** This will release the pressurized extinguishing agent
- **Sweep side to side:** Cover the entire area that is on fire. Continue until fire is extinguished. Keep an eye on the area for re-ignition.

P



A



S



S





Types of Evacuations

- ▶ Horizontal evacuation: is used first and consists of moving patients/residents down the corridor, through at least one set of fire doors to safe area.
- ▶ Vertical evacuation: consists of moving patients/residents down the stairs to a lower level of safety and ultimately out of the building.
 - **NEVER** use elevators to evacuate a fire area
 - Evacuate ambulatory patients/residents before non-ambulatory patients/residents
 - Move patient/resident charts with patients/residents
- ▶ Entire Building Evacuation: consist of moving patients/residents out of the building to a designated location.

Latex Allergy



What is latex?

- The term “latex” refers to natural rubber latex, the product manufactured from a milky fluid derived from the rubber tree, *Hevea brasiliensis*.
- Several types of synthetic rubber are also referred to as "latex," but these do not cause allergic reactions.



What products contain natural rubber latex?

- Disposable gloves
- Surgical masks
- Airway & IV tubing
- Syringes
- Stethoscopes
- Catheters
- Dressings & bandages
- 40,000 consumer products (e.g. balloons, condoms, athletic shoe soles, rubber toys, nipples and pacifiers, etc.)
- Components of Human Patient Simulators (such as IV tubing, etc.)





Latex Allergy

- Latex allergy is a reaction to certain proteins in latex rubber.
- Health care workers are at risk of latex allergies.
- For some individuals, exposure to latex products, such as powdered latex exam gloves, can cause a mild to severe allergic reaction.
- Airborne powder from gloves can cause reactions in some sensitive individuals.

Persons at increased risk for latex allergies

- Healthcare workers
- Individuals with occupational exposure (e.g., from frequent use of latex gloves)
- Individuals requiring frequent bladder catheterization
- Individuals with neural tube defects (e.g., spina bifida, myelomeningocele)
- Individuals who have had multiple surgeries
- Individuals with multiple allergies (especially to balloons or other latex products)
- Individuals with a history of anaphylactic reactions during surgery
- Individuals with allergies to foods such as banana, avocado, chestnut, kiwi, potato, tomato and related foods



Exposure to Latex

- Frequent exposure to latex causes one to become sensitized.
- Sensitization then puts one at risk for allergic reaction.
- Sensitization occurs through:
 - Direct skin contact;
 - Latex particles dispersed into the air when powered gloves are taken off.



Latex Allergy Reactions

- Skin rash and inflammation
- Hives
- Flushing
- Itching
- Nasal, eye, or sinus symptoms
- Respiratory irritation
- Asthma
- Shock (rare)



Other Types of Latex Reactions

- Irritant contact dermatitis: Dry, itchy, irritated areas on skin.
 - Caused by irritation from wearing gloves and by exposure to the powders added to them.
- Chemical sensitivity dermatitis: Skin rash similar to poison ivy.
 - Results from chemicals added to latex during harvesting, processing, or manufacturing.

Protection from Latex Exposure and Allergy

- Use non-latex gloves for activities that will not involve direct contact with infectious material.
- If you must use latex gloves, use powder-free latex gloves.
- Do not use oil-based hand creams or lotions with latex gloves. The lotion can deteriorate the gloves.
- Wash and dry hands thoroughly after removing latex gloves.
- Clean any areas contaminated with latex dust.
- Become familiar with protocols for preventing latex allergy.
- Learn to recognize symptoms of latex allergy.

What should you do if you think you have a Latex Allergy?

- If you develop symptoms of latex allergy, avoid direct contact with latex and other latex-containing products until you can see a physician experienced in treating latex allergy.
- If you have latex allergy, consult your physician regarding the following precautions:
 - Avoiding contact with latex gloves and products.
 - Avoiding areas where you might inhale the powder from latex products used by other workers.
 - Informing your health profession program that you are allergic to latex.

Avoidance of Latex

- Is the only means to assure prevention of a latex allergy, and
- Is the only protection from allergic symptoms for a person who has already developed a latex allergy.





How is Latex Allergy Treated?

- Detecting symptoms early, reducing exposure to latex, and obtaining medical advice are important to prevent long-term health effects.
- Certain medications may reduce allergy symptoms but complete latex avoidance is the most effective approach.



REMEMBER

- Immediately report signs and symptoms of a latex allergy or sensitivity to your clinical instructor, preceptor, or supervisor.
- If you have a known allergy it is important to remember that “Latex Contained” and “Latex Reduced” areas do NOT indicate latex free and it is your responsibility to protect yourself.



Patient/Resident Care Guidelines

- On admission, ask patients/residents if they have a sensitivity or allergy to latex.
- Remove all latex containing products from the patient's/resident's room.
- Follow the health care organization's policy for Latex Allergy.



References

- Reddy, S. (1998). Latex Allergy. American Family Physician. Retrieved from <http://www.aafp.org/afp/1998/0101/p93.html> .
- National Institute for Occupational Safety and Health. (2010). Occupational Latex Allergies. Retrieved from www.cdc.gov/niosh/topics/latex .
- U.S. Department of Labor Occupational Health & Safety Administration. (2008). Latex Allergy. Retrieved from www.osha.gov/SLTC/latexallergy/index.html.

Additional Resources:

- American Latex Allergy Association: www.latexallergyresources.org.
- OSHA: www.osha.gov.

Module 4 Post-Test

Note: You are logged in as an administrator and administrator accounts can view but not submit tests.

FIRE & SAFETY

1. If you notice a smoke or fire situation, the first thing you should do is:

- a. Close the doors in the immediate area.
 - b. Pull the nearest fire alarm box.
 - c. Rescue the people in immediate danger.
 - d. Grab the nearest fire extinguisher and attempt to put the fire out.
-

2. If you discover a fire in your department, you should:

- a. Make sure all doors are open to avoid smoke inhalation.
 - b. Follow the RACE and the PASS protocols.
 - c. Put as many people as possible on the elevators to quickly evacuate the area.
 - d. All of the above.
-

3. "PASS" is the acronym used to remember the directions for use of Fire Extinguishers. Which one is INCORRECT?

- a. P is for pull the pin.
 - b. A is to aim at the top of the fire.
 - c. S is to squeeze the lever.
 - d. S is to sweep from side to side.
-

4. You find a small fire in the wastebasket of a patient's/resident's room. What should you do?

- a. Remove patient/resident from danger, pull the fire alarm, and call the health care organization's emergency number.
 - b. Pull the fire alarm, and call the health care organization's emergency number.
 - c. Call the switchboard and have Security paged.
 - d. Call 9-1-1 to report the fire.
-

5. Which of the following statements can help minimize the occurrence of and damage caused by fires in health care facilities?

- a. Enforce Smoking/Non-Smoking Policy rules.
 - b. Know the location and operation of alarm boxes.
 - c. Never use faulty electrical equipment.
 - d. All of the above.
-

ELECTRICAL SAFETY

6. Frayed or damaged electrical cords or extensions cords:

- a. Pose no safety hazard.
 - b. Should be removed and repaired or replaced.
 - c. May continue to be used.
 - d. Require no special attention.
-

7. The use of an extension cord is an electrical safety risk.

- a. True.
 - b. False.
-

MEDICAL WASTE

8. A dressing saturated with blood may be disposed of in the bedside garbage can.

- a. True
- b. False

9. All health care providers must handle and dispose of hazardous (regulated) materials and waste according to policy and in a way that ensures patient/resident and worker safety and minimizes potential risks. Regulated medical waste includes:

- a. Needles, syringes, and medical sharps.
 - b. Any pathological or microbiological wastes.
 - c. All the above.
 - d. None of the above.
-

EMERGENCY CODES

10. If you hear a Code for a bomb threat, you should:

- a. Report to your assigned area and follow the directions of your instructor, preceptor or supervisor.
 - b. Report any suspicious findings, such as an unattended box, to your instructor, preceptor or supervisor.
 - c. Both a and b.
 - d. None of the above.
-

11. An Elopement is an emergency situation in which a patient/resident who lacks safety awareness leaves a safe area within or outside the facility without the knowledge of the facility's staff and without proper supervision.

- a. True
 - b. False
-

EMERGENCY PREPAREDNESS

12. A student's role in the event of a disaster is:

- a. Stay with assigned patient/resident.
 - b. Immediately leave the health care organization to return home.
 - c. Report to your instructor, preceptor, or supervisor for any specific assignment.
 - d. Leave the health care organization and meet at your school.
-

13. An example of an internal disaster is:

- a. Radiation accident/event.
 - b. Hurricane.
 - c. Transportation accident on the highway.
 - d. Terrorist event at the airport.
-

HAZARD COMMUNICATION

14. What information is on a Safety Data Sheet (SDS)?

- a. Product Information: product name, manufacturer and suppliers names, addresses, and emergency phone numbers.
 - b. Hazardous Ingredients.
 - c. Fire or Explosion Hazard Data.
 - d. Toxicological Properties: health effects.
 - e. First aide measures.
 - f. All of the above.
-

15. The use of labels, signs or color-coding to make health care providers aware of the presence of blood or other potentially infectious material refers to:

- a. Hazard communication.
 - b. Price control communication.
 - c. Infection control communication.
 - d. Medical record-keeping communication.
-

16. Safety Data Sheets (SDS) should be consulted:

- a. In the event of an explosion.

- b. Before working with a chemical.
 - c. In the event of a chemical spill.
 - d. All of the above.
 - e. Only b and c.
-

LATEX ALLERGY

17. Which statement is NOT true regarding latex allergy?

- a. There is only one type of reaction to latex.
 - b. Health care workers are at risk of developing latex allergy because they use latex gloves frequently.
 - c. Detecting symptoms early and reducing exposure to latex are ways to treat latex allergy.
 - d. Latex exposure can occur through skin contact and through inhalation while workers are changing gloves.
-

18. Symptoms of latex allergy include skin rash, hives, flushing, itching, nasal or eye drainage, sinus symptoms, asthma, and shock.

- a. True
 - b. False.
-

NEEDLESTICK OR SHARP INJURIES

19. What types of needles may cause needlestick injuries?

- a. Blood collection needles.
 - b. Suture needles.
 - c. Needles used in IV delivery systems.
 - d. All of the above.
-

20. What must occur if you are stuck by a needle during a clinical rotation?

- a. Immediately tell another student.
 - b. Drink 24 ounces of fluid.
 - c. Put a Band-Aid on the site.
 - d. Immediately report the injury to your instructor or preceptor so that you receive appropriate follow-up care.
-

MODULE 1

| Question | Answer |
|----------|--------|
| 1 | d |
| 2 | e |
| 3 | d |
| 4 | c |
| 5 | a |
| 6 | a |
| 7 | a |
| 8 | c |
| 9 | b |
| 10 | b |
| 11 | e |
| 12 | a |
| 13 | b |
| 14 | b |
| 15 | e |
| 16 | b |
| 17 | e |
| 18 | b |
| 19 | c |
| 20 | d |

MODULE 2

| Question | Answer |
|----------|--------|
| 1 | d |
| 2 | d |
| 3 | c |
| 4 | a |
| 5 | f |
| 6 | a |
| 7 | a |
| 8 | d |
| 9 | a |
| 10 | c |
| 11 | a |
| 12 | c |
| 13 | a |
| 14 | a |
| 15 | e |
| 16 | b |
| 17 | b |
| 18 | c |
| 19 | d |
| 20 | f |

MODULE 3

| Question | Answer |
|----------|--------|
| 1 | c |
| 2 | b |
| 3 | a |
| 4 | c |
| 5 | c |
| 6 | a |
| 7 | d |
| 8 | b |
| 9 | a |
| 10 | d |
| 11 | b |
| 12 | b |
| 13 | b |
| 14 | a |
| 15 | d |
| 16 | c |
| 17 | a |
| 18 | c |
| 19 | b |
| 20 | f |

MODULE 4

| Question | Answer |
|----------|--------|
| 1 | c |
| 2 | b |
| 3 | b |
| 4 | a |
| 5 | d |
| 6 | b |
| 7 | a |
| 8 | b |
| 9 | c |
| 10 | c |
| 11 | a |
| 12 | c |
| 13 | a |
| 14 | f |
| 15 | a |
| 16 | d |
| 17 | a |
| 18 | a |
| 19 | d |
| 20 | d |

Online Orientation Acknowledgement Statement Form

You have passed your orientation tests for all modules.

Before receiving your certification, you must submit the acknowledgement form below. Please read each section carefully. Place a check mark in the appropriate check box within each section to acknowledge, confirm and certify that you understand and will comply with the standards described within this Online Orientation Program. Then click **Submit** at the bottom of this page.

Students will be unable to participate in clinical until this Acknowledgement Statement Form has been submitted.

Electronic Acknowledgement Form for:

Name:

Program:

Student ID:

Date:

Individual HIPAA Education Acknowledgement Statement

Standards:

- All students must maintain security of Personal Health Information (PHI). In addition to being a moral obligation, under HIPAA this is a legal obligation
- All students must understand and recognize the harm that can occur when proper security measures are not followed. These include harm to the patient/resident, harm to healthcare organization, and harm to the student.
- All students must take steps to avoid security risks. These include password security, access controls, duty to report breaches of security, physical safeguards, email risks, fax risks, and copier risks.
- All students must cooperate with efforts to maintain security of PHI information.

By checking this box, I acknowledge and confirm that I have read the information presented in the HIPAA Orientation & Education Module and understand what is required of me as a student. I agree to adhere to by the above standards at all times, and if I have any questions regarding my responsibilities, I will seek further clarification from the health care organization.

Confidentiality Statement

I, , understand that in the performance of my duties as a student at a health care organization, I am required to have access to and am involved in the processing of patient/resident data. I understand that I am obliged to maintain the confidentiality of these data at all times, both at work and off duty. I understand that a violation of these confidentiality considerations may result in disciplinary action. I further understand that I could be subject to legal action.

By checking this box, I certify that I have been given an explanation concerning the privacy and confidentiality considerations of patient/resident information.

Online Orientation Acknowledgement Statement

- Module 1: Basics of Student Placements - Student Role and Responsibilities, Patient Rights, Patient Confidentiality and HIPAA Education, Detecting and Reporting Abuse, Workplace Violence, Safe Patient Handling;
- Module 2: Nurse Core Competencies - Competency Overview, Providing Population Competent Care, National Patient Safety Goals, Alarm Fatigue, Communication and Documentation, Quality Improvement;

- Module 3: Infection Control and Prevention - OSHA Bloodborne Pathogens Standard, Human Immunodeficiency Virus (HIV), Hepatitis, Tuberculosis, Healthcare-Associated Infections, Transmission-Based Precautions, Blood and/or Body Fluid Exposure Accidents, Personal Protective Equipment, Hand Hygiene;
- Module 4: Environment of Care - Fire Safety, Electrical Safety, Medical Waste, Emergency Codes, Emergency Preparedness, Hazard Communication, Latex Allergy, Needlesticks or Sharps Injuries.

By checking this box, I acknowledge and confirm that I have completed the Online Orientation modules listed above and I confirm that I have completed the online post-test for each module.

Submit