

# PROFESSIONAL STAFFING

## ANNUAL UPDATE MANUAL

### #1 HIPAA

Health Insurance Portability and Accountability Act of 1996, called HIPAA, is federal law enacted by Congress. It is healthcare reform and impacts all healthcare industries. Compliance to HIPAA is mandatory. Failure to comply may result in civil and criminal penalties. Health insurance plans, health care clearinghouses, physician offices, hospitals, clinics, and self-insured employers are examples of “covered entities” that must comply with HIPAA regulations.

#### **Intent**

HIPAA touches on many aspects of healthcare. This includes:

- Protecting health insurance coverage and improving access to care
- Reducing the incidence of fraud and abuse
- Improving the quality, efficiency, and effectiveness of healthcare
- Protecting privacy and security of patient health information
- Reducing healthcare administrative costs

#### **How HIPAA Protects Patient Privacy**

- Establishes standards giving patient new rights and protection against the misuse and disclosure of their health information
- Sets boundaries on others for the use and release of medical information
- Provides resources if privacy protections are violated, including civil and criminal penalties to those who knowingly violate HIPAA regulations

#### **Information that HIPAA Protects**

- Protected health Information (PHI) may be individually identifiable if any of the following are present
- Name
- Address including street, city, county, zip and geo-codes
- Names of relatives
- Birth date
- Telephone numbers
- Fax numbers
- Electronic e-mail addresses
- Social security number
- Medical record number
- Health plan beneficiary number
- Medical Records
- Medical history interviews
- Telephone calls
- Faxing
- Account number
- Certificate or license number vehicle or other device serial number
- Web Universal Resource Locator (URL)
- Finger or voice prints
- Photographic images
- Any other unique identifying number, characteristic, code
- Computers
- Patients
- White boards sign in sheets

#### **What does this mean to the healthcare worker?**

- Facilities must identify a process for patient’s family members/friends, designated by the patient to obtain clinical information

- You may still share information without patient authorization as it relates to TPO (Treatment, payment or business operations)
- Required validation of fax numbers and available, appropriate recipients for patient information.

**Examples of Wrongful Disclosure (Reportable to the Ethics and Compliance Officer and Facility Privacy Officer)**

- Appropriate access and disclosure (gossiping)
- Allowing family/friends to assist, observe or visit work area
- Allowing students to observe without workforce training:

Other violations:

- Providing more PHI than necessary
- Nurse/Physician pulling wrong chart
- Disclosure to patient’s employer when the issue is not worker’s compensation
- Providing wrong PHI to a requester (discharge instruction, lab results, bills)
- Accessing personal, friend, family PHI

**#2 Patients Rights**

The patient has the **right** to:

- Exercise his/her rights without regard to sex, cultural, economic, educational or religious background, or their ability to pay
- Effective and safe care, treatment and services without regard to their ability to pay
- Appropriate assessment and management of pain, information about pain, pain relief measures, to participate in pain management decisions, request or reject the use of any or all modalities to relieve pain
- Have a family member (or other representative of your choosing) and your own physician notified promptly of your admission to the hospital
- Have access to spiritual counseling and pastoral visits
- Effective communication and interpretation, including access to translation services and services to address vision, speech, hearing, language and cognitive impairment
- Have access to people outside the hospital through visitors, interpreters, verbal and written communication
- Designate visitors of his/her choosing, if the patient has decision making capacity, whether or not the visitor is related by blood or marriage, unless;
  - No visitors allowed
  - The facility reasonably determines that the presence of the particular visitor would endanger the health/safety of a patient, hospital staff, other visitors, or would significantly disrupt the operations of the hospital;
  - The patient has indicated he/she no longer wants this person to visit
  - The patient lacks decision-making capacity in which case the patient’s wishes are considered in determining who may visit, including any persons living in the household.

However, Hospital’s may establish reasonable restrictions upon visitation, including restrictions upon the hours of visitation and number of visitors.

- Have access to a telephone and space for private conversations as appropriate to the needs of his/her care, treatment and services
- Voice complaints freely and recommend changes regarding the quality of services through the established process, and without being subject to coercion, discrimination, reprisal, or unreasonable interruption of care, treatment and services
- Have access to bioethics committee
- Have access to protective and advocacy services including notifying government agencies of neglect or abuse

The patient has the **right** to:

Respect and Dignity	Privacy and confidentiality	Medical Information and consent
Provisions of information	Medical treatment decisions	Continuity of care
Refusal of treatment	Financial information	Personal safety
Complaints or concerns		

**#3 End of Life Care and Organ Donation**

**The patient, family and significant other have the right to expect:**

- The opportunity to discuss and plan for end-of-life-care
  - Preferences for withholding or withdrawing life sustaining intervention will be honored
  - There will be no abandonment by physicians
  - The burden to family and others will be minimized
  - That care providers will assist the bereaved through early stages of mourning and adjustment
- Attention to the goals of the dying person
  - Pain and other symptoms will be controlled
  - Physical and mental suffering will be carefully attended to and comfort measures intently secured
  - Dignity will be a priority

**Care is provided based on eleven core principles:**

- Respecting the dignity of the patients and caregivers
- Being sensitive to and respectful of the patient’s, family’s, significant other’s wishes
- Using the most appropriate measures that are consistent with patient choices
- Encompassing alleviation of pain and other physical symptoms
- Assessing and managing psychological, social, and spiritual/religious problems
- Offering continuity – the patient should continue to be cared for, if so desired, by his/her primary care and specialist providers
- Providing access to any therapy that may realistically be expected to improve the patient’s quality of life, including alternative or non-traditional treatments
- Providing access to palliative care and hospice care
- Respecting the right to refuse treatment
- Respecting the physician’s professional responsibility to discontinue some treatments when appropriate, with consideration for the patient, family and significant other’s preferences
- Promoting clinical evidence-based research on providing care at the end of life.

**Organ/Tissue Donation**

Hospitals have an organ and tissue policy that each specific facility adheres to. There are federal and state laws that mandate the reporting of all expirations to the OPO (Organ Procurement Organization) hotline, whether or not the patients are suitable for donation. The phone number is (800) 338-6112. Hospitals have clinical triggers which help to identify potential organ donors. Registry and all other outside services do not determine candidates for organ or tissue donation.

**#4 Advance Directives**

*The purpose of an Advance Directive is:*

To recognize the right of all patients to participate actively in decisions regarding his/her medical care. To the extent permitted by law, it is the right of the patient to accept medical care or to refuse treatment and to be informed of the medical consequences of such refusal. It is also the right of the patient to formulate advance directives and appoint ad surrogate to make health care decisions on his/her behalf to the extent permitted by law.

A legally binding advance directive that meets the statutory requirements of 35 states, including California. This document includes a durable power of attorney for health care and the opportunity to express one’s person, emotional and spiritual wishes in addition to medical wishes regarding end-of-life care.

**Advance Directive**

A written instruction that relates to the provision of health care when an individual is incapacitated. In California, these include the Advance Health Care Directive, the Durable Power of Attorney for Health Care, a Declaration to Physicians pursuant to the Natural Death Act, or a Living Will. In an advance directive, a person states choices for medical treatment and/or designates who should make treatment choices if the person creating the advance directive should lose decision-making capacity.

**Durable Power of Attorney for Health Care (DPACH)**

An advance directive established in conformance with California statutory law by which an individual may name someone else (the “agent” or “surrogate”) to make health care decisions in the event the individual becomes unable to make such decisions herself or himself.

**Living Will**

A non-statutory advance directive which is considered advisory to health care providers.

**Health Care Decisions Law**

The new legislation permits an adult with capacity to make oral or written individual health care instructions, designate a primary physician, name a “surrogate” decision maker or appoint an agent for health care decisions.

### **Natural Death Act Declaration**

A declaration by the patient that directs the attending physician to withhold or withdraw life-sustaining treatment in instances of a “terminal condition” as defined below. The Natural Death Act Declaration is valid only if the patient is diagnosed as being terminally ill or being in persistent vegetative state.

### **Patient Self-Determination Act (PSDA)**

A federal statute, enacted as part of the 1990 Omnibus Budget Reconciliation Act (OBRA) (PL 101-508) which requires that health care facilities provide information regarding the right to formulate advance directives concerning health care decisions. Development of hospital policies regarding implementation of the Act and documentation in the medical record are also required. The federal statute applies to a person 18 years and older or a person legally capable of consenting to his or her own medical treatment. The PSDA also applies to hospital in-patient admissions, not out-patient.

### **Proxy Agent/Surrogate**

An individual who participates in health care decision-making on behalf of an incapacitated patient. The surrogate decision-maker may be formally appointed (e.g., by the patient in a DPAHC or by a court in a conservatorship proceeding) or, in the absence of a formal appointment, may be recognized by virtue of a relationship with the patient (e.g., the patient’s next of kin or close friend).

### **Incapacitated**

The condition of an adult whereby the capacity to make informed decisions regarding health care is either temporarily lost (e.g., due to unconsciousness, the influence of mind-altering substances, or treatable mental disability), or is permanently lost (e.g., due to irreversible coma, persistent vegetative state, or untreatable brain injury) or never existed.

### **Health Care Decision-Making**

The process through which a patient or surrogate decision-maker decides among health care options. Options may include withholding or withdrawing life-sustaining treatment.

## **#5 OSHA Safety Precautions/MSDS Hazardous Materials**

### **Employee Rights Under the Law**

#### **Hazard Communication “Right to Know”**

In compliance with the Employee Right to Know Law, employers are required to inform the employees of the hazardous chemicals to which they are exposed in the workplace and to provide training in safe handling practices and emergency procedures. Facilities in which you work are required to communicate location of MSDS, name and location of hazardous materials to which you may be exposed, appropriate protective measures required to lessen or prevent exposures, and an explanation of the labeling system used.

#### **Material Safety Data Sheets**

Material Safety Data Sheets (MSDS) provide information the manufacturer considers necessary for users to know to determine what chemicals are in a product and what steps should be taken to use the product safely. MSDS from various manufacturers look different but they all contain the same type of information.

MSDS are divided into sections usually beginning with the chemical and common name of the product. An important section to look for is usually called “Health Hazards” which tells the type of danger it represents and what happens if you or someone is exposed to this product.

Equally important is the section dealing with “First Aid”. This section gives basic steps to take if you or someone else is affected by the chemicals in this product.

Another section deals with “Protective Equipment”. Here specific recommendations for safety equipment and procedures are listed. This section tells how to protect you from exposure when working with or near this product.

#### **Employees have the right**

- To know the listed hazardous substances in the work area that you may be using or exposed to
- To obtain a copy of the MSDS for each hazardous substance in the area where you work

- To obtain further information on the properties and hazards upon being exposed to the substance(s)
- To refuse to work with a specific substance if not provided a MSDS request within five working days of the written request
- To protection against discharge, discipline, or discrimination for having exercised your rights under this law
- To instructions within 30 days of hire and annually thereafter, on the adverse health effects of each listed toxic substance in your work area, how to handle each substance safely, and what to do in case of emergency

### How Chemicals Enter the Body

In order for a chemical to have any effect on a person, one has to come in contact with the chemical in its solid, liquid, or gas form. There are four “routes of entry” or paths that a chemical can take

- Inhalation (breathing)
- Absorption (through the skin)
- Ingestion (swallowing)
- Injection

### Personal Protective Equipment

Personal protective equipment (PPE) will be specified in the MSDS or in the Infection Control Manual/Exposure Control Plan located in the facility. Required PPE will be available for use. Violation of PPE requirements may result in disciplinary action up to and including termination.

Where occupational exposure remains after institution of engineering and work practice controls, personal protective equipment (PPE) will be utilized. PPE must not allow blood or other potentially infectious materials to pass through to worker’s clothing, skin, or mucous membranes under normal conditions of use and for the duration of time which the PPE will be used.

The facility provides, maintains, launders, disposes, replaces, and assures the proper use of PPE. The facility is responsible for ensuring that workers have access to PPE, at no cost, including proper sizes and types that take allergic conditions into consideration. Appropriate PPE must be used whenever occupational exposure may occur. Facilities and workers ensure the following:

- Removal of PPE immediately following contamination and when leaving the work area and placing the PPE in the appropriately designated container for storing, washing, decontaminating, or disposal.
- Wearing appropriate gloves when in contact with blood, mucous membranes, non-intact skin, or potentially infectious materials is anticipated; when performing vascular access procedures; and when handling or touching contaminated items
- Providing hypo-allergenic gloves, liners, or powderless gloves or alternatives (latex free) to employees who need them
- Replacing disposable, single use gloves as soon as possible when contaminated; or if torn, punctured, or compromised
- NOT reusing disposable gloves
- Decontaminating reusable gloves after each use and discarding the gloves if there are any signs of cracking, peeling, tearing, puncturing, deteriorating, or failing to provide a protective barrier.
- Using full face shields or face masks with eye protection, goggles, or eye glasses with side shields when splashes of blood or other body fluids may occur and when contamination of the eyes, nose, or mouth can be anticipated
- Wearing surgical caps or hoods, including shoe or boot covers, when gross contamination may occur.

### Labeling

All chemicals on site are to be stored in the original or approved containers that have proper labels attached. Facilities rely on manufacturer labels whenever possible. Labels list:

- Contents
- Appropriate hazard warnings
- Name and address of the manufacturer, importer, or supplier

Chemicals may be dispensed from their original container into a second container in small quantities intended for immediate use. The container must be labeled with the contents and first aid requirements for the product. **DO NOT USE ANY CHEMICALS THAT ARE NOT PROPERLY LABELED.**

### General Precautions When Using Chemicals

- When working with any type of chemical, it is important to be alert for signs of accidental spill or release. Other issues to be aware of are: Be suspicious of unusual odors, unusual stains or wet areas, leaking containers, changes in flavors of food or drinks that have been near chemicals. Do not use chemicals that emit vapors in poorly ventilated areas or small spaces. When using chemicals that could splash or splatter, use eye protection or a face shield. Know the location of the Eye Splash Station and its operation. If a chemical is splashed into the eye, rinse with cold water for fifteen minutes.
- Avoid prolonged contact with excess chemical solutions. Wash hands and other exposed skin surfaces after use and be careful not to rub the eyes, nose or mouth while gloves or hands are contaminated with the chemical substance.

- Do not eat or drink in areas where chemicals are used. If accidental ingestion occurs immediately consult the MSDS and call the poison control number or other information listed on MSDS  
Clean spills using appropriate protective equipment as recommended in the MSDS. Mercury spills will require the use of a specialized spill kit.
- Handle all pharmaceutical products in a way that will avoid contact with and inhalation of dust, fumes, mists, or vapors associated with the product
- Keep all chemical tightly closed when not in use. Do not store the containers near heat or other sources of ignition. Small amounts can be discharged into the sewage system unless otherwise specified.

#### **Staff response to exposure incident:**

If you are accidentally exposed to blood or body fluid such as a needle stick, splash to the eye, nose or mouth or if there is contamination of open or abraded skin, do the following immediately:

- Wash the area affected with soap and water or flush mucous membranes with water as soon as possible following contact
- Report the exposure to the facility supervisor
- Complete an Occurrence report in Meditech and a First Report of Injury must be completed for the facility. Include activity being performed at the time of the exposure, route of exposure, suspected or known patient source, cause of exposure, any mitigating circumstances surrounding the incident, and immediate treatment received
- Report the incident as soon as possible.

## **#6 Infection Control**

#### **Transmission of Infectious Diseases**

The goal of the Infection Control program is prevent the spread of infectious diseases between patients, visitors, and workforce members. Infectious diseases can be spread through direct or indirect physical contact or by air, when infectious organisms enter the body or blood stream through open skin (cut, puncture, rash, wound or burn) or mucous membrane (eyes, nose or mouth). It is impossible for you to know who is or is not infected. Therefore, consider ALL blood and body fluids from ALL persons as potentially infectious.

#### **Hand Hygiene – Infection Control and Prevention**

Removing the elements of transmission (by implementing procedures of cleaning, disinfections, sterilization, hand washing, and isolation precautions) can interrupt transmission of infectious diseases. **Hand washing should be performed for a minimum of (15) fifteen seconds.** Practicing good hand hygiene is the most important thing you can do to prevent the spread of infection. Handy hygiene, also referred to as hand antisepsis, reduces the number of healthcare associated infections. You must wash your hands before and after direct patient contact and when visibly soiled or contaminated with blood (or body fluids that may be contaminated with blood).

If hands are not visibly soiled, alcohol hand gel may be used to decontaminate hands:

- 1) Before and after any contact with patients
- 2) Before donning sterile gloves for specific procedures
- 3) Before eating, preparing and serving food
- 4) Before applying make-up and handling contact lens
- 5) After contact with body fluids, mucous membranes, non-intact skin and wound dressings
- 6) After removing gloves
- 7) After using the bathroom, or sneezing, coughing or blowing your nose

Artificial fingernails are **not** permitted for those who have direct contact with patients (who touch the patient as part of their care or service), handle instruments or equipment that will be used by a patient or used directly on a patient, or for those who have contact with food.

- Artificial fingernail is defined as any material applied to the fingernail for the purpose of strengthening or lengthening nails (e.g., tips, acrylic, porcelain, silk, jewelry, overlays, wraps, fillers, superglue, any appliques other than those of nail polish, nail-piercing jewelry of any kind, etc)
- Natural nails must be clean, with tips less than ¼ inch long
- Fingernail polish must be in good condition and free of chips
- Patients are encouraged to remind their healthcare providers to wash/clean their hands prior to providing care

- Staff should encourage patients to perform hand hygiene prior to meals and after using the toilet or commode

### **Standard Precautions**

Standard precautions are used to protect you from exposure to bloodborne pathogens.

Standard precautions are a system of safeguards or barriers designed to protect you, including:

- Engineering controls (autoclave, self-sheathing needles and sharps disposal containers)
- Personal protective equipment (gloves, gowns, masks, goggles, etc.)
- Work practice controls (hand washing, proper handling of sharps, good hygiene, etc.)
- Housekeeping (cleaning equipment and work surfaces, properly handling contaminated linen, laundry, proper disposal of trash, etc.)

### **Workplace Transmission**

Hepatitis, HIV and other pathogens may be present in blood, other bodily fluids, tissues, respiratory secretions, etc, and must enter your body to cause infection. These pathogens may be transmitted when infectious organisms enter the body or blood stream through open skin (cut, puncture, rash, wound or burn) mucous membrane (eyes, nose and mouth) or respiratory tract.

Workforce members should

- Maintain personal health and cleanliness to protect self and patients (e.g., hand washing, personal grooming, cleanliness, and long hair contained/pulled back off of face)
- Healthcare workers with exudative lesions or weeping dermatitis should refrain from direct patient care and handling of patient-care equipment until the condition resolves
- Use safe work practices and appropriate personal protective equipment (PPE)
- Report for annual health evaluation and TB surveillance per policy

### **Respiratory Hygiene/Cough Etiquette in Healthcare Settings**

- Individuals with signs and symptoms of a respiratory infection should:
  - Cover the nose/mouth when coughing or sneezing
  - Use tissues to contain respiratory secretions and dispose of them in the nearest trash can after use
  - Wash hands or use alcohol hand gel after having contact with respiratory secretions and contaminated objects/materials
  - Utilize the “Respiratory Hygiene Stations” which have been installed in the lobby areas and in the out-patient clinics, to obtain masks and tissues if needed.
  - Sit at least three feet away, (if possible) from others in common waiting area
- Healthcare Workers: Precautions to minimize exposure to respiratory droplets
  - Healthcare personnel should wear a mask for close contact with coughing patients, such as when examining a patient with symptoms of a respiratory infection, particularly if fever is present
  - The Security Guards, at the hospital entrances, stock masks and tissues to issue to patients who are coughing, sneezing or have visible cold/flu symptoms upon entrance to the facility.

### **Isolation Precautions**

In addition to Standard Precautions, follow Isolation Precautions as for any patient diagnosed with or suspected of having a contagious disease. Know the precautions and work practices to use in your work area or job duties to prevent exposure to blood or body fluids or to airborne infections. Report any exposures or out breaks of communicable diseases to your supervisor. Supervisors are to report these exposures or outbreaks to Infection Control and Employee Health.

There are three (3) categories of isolation. They are Contact, Droplet, and Airborne Precautions.

**Contact Precautions** will be used for patients with known or suspected infections that can be transmitted by direct contact with the patient (hand or skin-to-skin contact that occurs when performing patient-care activities that require touching the patient’s dry skin) or indirect contact (touching) with environmental surfaces or patient care items in the patient’s environment.

**Airborne Precautions** will be used for patients with known or suspected to be infected with microorganisms transmitted person to person by the airborne route. These patients are placed in a negative pressure room.

**Droplet Precautions will be used for patients known or suspected to be infected with pathogens transmitted by respiratory droplets (i.e., large particle droplets) that are generated by a patient who is coughing, sneezing or talking.**

**Special Precautions.** These precautions are to be used for patients who are Neutropenic, which is defined as having an absolute neutrophil count <1,000 cells per milliliter. A good example is a patient diagnosed with Leukemia.

Guidelines for special precautions are listed below, and include:

- A private room with closed door

- Hand washing is required upon entering room
- No gowns or gloves are required
- No fresh fruits, vegetable or flowers may be taken into the room
- No visitors or staff with infectious illnesses may enter the room
- No special precautions must be taken with articles leaving the room

### **Personal Protective Equipment (PPE)**

Gloves: Use gloves before contact with mucous membranes, open skin, blood/body fluids, or the handling of contaminated substances or surfaces. Always change your gloves between patients; DO NOT wear the same pair of gloves when caring for more than one patient. Glove use does not substitute for hand hygiene. DO NOT wear gloves in the hallway when transporting patients or specimens. Carry gloves in your pocket for use if needed.

Other PPE: Use mask, eye and/or face protection, protective gown, caps and shoe covers if splashing is possible.

### **Good Hygiene Practices**

Do not eat, drink, apply cosmetics or lip balm or handle contact lenses in work areas where exposure may occur, per OSHA title 8. Do not keep food or beverages in refrigerators, freezers or cabinets; on countertops or bench tops, or in any other area where they might be exposed to potentially infectious materials.

### **Work Environment**

- All workforce members are responsible to help keep the facility clean and safe
- All solutions used for cleaning/disinfecting equipment/surfaces are to be approved by the Infection Control Committee.
- Staff must wipe off equipment between patients with approved disinfectant wipes/spray.

### **Bloodborne Pathogens**

Hepatitis B virus (HBV), hepatitis C (HCV) and human immunodeficiency virus (HIV) spread most easily through contact with blood. These are the primary bloodborne pathogens that are of concern to healthcare workers. Bloodborne pathogens may be found in blood or other potentially infectious material (OPIM) and the following body fluids:

- Semen
- Vaginal secretions
- Cerebrospinal fluid
- Synovial fluid
- Pleural fluid
- Pericardial fluid
- Amniotic fluid
- Saliva in dental procedures
- Breast milk
- Any other body fluid that is visibly contaminated with blood (e.g., urine)

### **Hepatitis B Virus (HBV) and Hepatitis C Virus (HCV)**

HBV and HCV cause serious liver disease. Some people are infected and have no symptoms. Infection may range from no symptoms at all to flu like symptoms (nausea, vomiting and fever). Transmission of HBV and HCV occurs primarily after exposure to blood or bodily fluids from a person who has had acute or chronic HBV/HCV infections.

HBV and HCV are transmitted in four primary ways:

- Sexual contact (e.g., unprotected intercourse)
- Parenteral exposure (e.g., needle sharing, blood exposure or tattooing)
- Perinatal exposure (may be transmitted from mother to fetus)
- Recipient of blood/blood products (there are blood screening programs)

Most people infected with HBV recover and clear the infection. Most people infected with HCV become chronically infected. HBV is preventable by the Hepatitis B vaccine. Currently, there is no vaccine for Hepatitis C.

### **Human Immunodeficiency Virus (HIV)**

HIV attacks the immune system and causes it to break down. A person infected with HIV may carry the virus without developing symptoms for years.

HIV is transmitted in four primary ways:

- Sexual contact (e.g., unprotected intercourse with an HIV positive individual)
- Parenteral exposure (e.g., needle sharing, blood exposure or tattooing)
- Perinatal exposure (may be transmitted from mother to fetus during pregnancy and in breast milk)



- Transfusion of blood/blood products (there are blood screening programs)

There is no known cure for HIV infection. However, post exposure prophylaxis, if given early enough, may prevent seroconversion.

**Handling and Transporting Specimens of Blood or Other Potentially Infectious Materials**

- Specimens of blood or body fluids are placed in a leak-proof container, placed in a plastic bag and carefully transported to the laboratory
- Specimens to be transported out of the hospital are placed in a leak proof container clearly marked with a “Biohazard” label.

**Handling Blood and Body Fluid Spills**

- Contain area so that others are not exposed
- Call Environmental Services for clean up
- Wear gloves and other protective equipment as necessary during cleaning and decontamination procedure

**Biohazard Waste**

Biohazard waste is defined as waste “dripping with blood”, fluid blood products, and equipment containing blood that is fluid i.e. empty blood page, and laboratory/pathology waste.

**Preventing Sharp Injuries**

<b>DO</b>	<b>DO NOT</b>
Use and activate needle/sharps safety devices	Bend, break or recap needles
Get help with uncooperative patients	Leave needles and sharps at the bedside
Let falling objects fall	Rush or take shortcuts
Dispose of sharps into covered, labeled, and ridged puncture resistant sharps container	Reach into disposal containers
Use tongs or brush & dustpan to pick up broken glass	Touch broken glass
Practice safe handling techniques	Overfill sharps container
	Carry loose sharps in your pockets

**Vaccination**

Hepatitis B, Tetanus, Rubella, MMR and Varicella vaccines are available for employees at risk of exposure to blood and body fluids.

**Exposure to Blood and Body Fluids**

Exposures occur when blood or body fluids come in contact with your open skin (rash, wound or burn) or mucous membrane lining (eyes, nose or mouth)

If you are exposed, **IMMEDIATELY**

- Wash the exposed area
- Report the exposure to your supervisor
- Go the Employee Health/MWI for follow up

**Note:** The most effective treatment is treatment that is started within 1-2 hours of exposure

**Tuberculosis (TB)**

TB spreads through the air in droplets generated when a person with active TB coughs, sneezes or speaks. These droplets are so small that regular air currents within a building can keep them airborne for hours. If you inhale these droplets, you can become infected with TB. When inhaled, the bacteria may become established in your lungs and spread throughout your body. TB is most commonly spread by close, prolonged, intense and unprotected contact indoors to an active TB patient.

TB precautions include the following:

- Annual TB screening for all workforce members
- Early triage and identification of TB suspects
- Isolation of suspect and confirmed TB patients
- Proper engineering and maintenance of negative pressure TB isolation rooms (door is to be kept closed at all times)
- TB patient wears a barrier (yellow surgical) mask when outside of isolation room and in enclosed area
- Any employee providing direct patient care to respiratory isolation patients is to be fit tested and use an N-95 respirator mask:
  - In a TB patient’s isolation room
  - During procedures that generate airborne secretions

- When caring for suspected or confirmed TB patient(s)
- During vehicle transport of suspected or confirmed TB patients
- Patients who have or are suspected of having tuberculosis (TB) should be placed in a negative pressure room where the air is vented to the outside

**TB Disease (active)**

Signs of illness are usually present and may include the following:

- Prolonged cough (2 or more weeks)
- Feel weak
- Have a fever
- Have weight loss
- Loss of appetite
- Night sweats
- Coughing up blood or have chest pain when coughing
- This person can infect others unless he or she is taking the TB medicine as directed

**TB infection (latent)**

This person carries the TB germ but:

- Does not look or feel sick
- Cannot infect others

Preventative treatment is recommended for some people

## **#7 Hospital Acquired Conditions & Serious Preventable Adverse Events**

**Hospital Acquired Conditions**

On February 8, 2006, the President signed the Deficit Reduction Act (DRA) of 2005. Section 5001(c) of DRA requires the Secretary to identify conditions that are: (a) high cost or high volume or both, (b) result in the assignment of a case to a DRG that has a higher payment when present as a secondary diagnosis, and (c) could reasonably have been prevented through the application of evidence-based guidelines. Section 5001(c) provides that CMS can revise the list of conditions from time to time, as long as it contains at least two conditions.

For discharges occurring on or after October 1, 2008, hospitals will not receive additional payment for cases in which one of the selected conditions was not present on admission. That is, the case would be paid as though the secondary diagnosis were not present. A collection of tools have been assembled to assist you in your efforts to eliminate these conditions. We have categorized the selected conditions as follows:

Never Events/Rare Occurrences	Infection Prevention	Patient Safety
Delivery of ABO-incompatible blood products	Surgical Site Infections-Mediastinitis after coronary artery bypass graft (CABG) surgery – Orthopedic surgeries – Bariatric surgery	Falls and fractures, dislocations, intracranial and crushing injury and burns
Object left in during surgery	Vascular catheter-associated infections	Pressure Ulcers
Air embolism	Catheter-associated urinary tract infection	Glycemic Control
		DVT/Pulmonary Embolism

**Serious Preventable Adverse Events (SPAEs)**

In 2002, the National Quality Form (NQF) published a report, *Serious Reportable Events in Healthcare*, which identified 27 adverse events that are serious, largely preventable, and of concern to both the public and healthcare providers. NQF has now formally launched the Consensus Standards Maintenance Committee on Serious Reportable Events to review the list and recommend additions or changes for Members to consider so that the set remains current and appropriate.

*Surgical Events*

- Surgery performed on the wrong body part
- Surgery performed on the wrong patient

- Wrong surgical procedure performed on a patient
- Unintended retention of a foreign object in a patient after surgery or other procedure
- Intraoperative or immediately postoperative death in a ASA Class I patient

#### *Product of Device Events*

- Patient death or serious disability associated with the use of contaminated drugs, devices or biologics provided by the healthcare facility
- Patient death or serious disability associated with the use or function of a device in patient care in which the device is used or functions other than as intended
- Patient death or serious disability associated with intravascular air embolism that occurs while being cared for in a healthcare facility

#### *Patient Protection Events*

- Infant discharged to the wrong person
- Patient death or serious disability associated with patient leaving the facility without permission
- Patient suicide, or attempted suicide, resulting in serious disability while being cared for in a healthcare facility

#### *Care management Events*

- Patient death or serious disability associated with a medication error (e.g., errors involving the wrong drug, wrong dose, wrong patient, wrong time, wrong rate, wrong preparation or wrong route of administration)
- Patient death or serious disability associated with a hemolytic reaction (abnormal breakdown of red blood cells) due to the administration of ABO/HLA – incompatible blood or blood products
- Maternal death or serious disability associated with labor or delivery in a low-risk pregnancy while being cared for in a healthcare facility
- Patient death or serious disability associated with hypoglycemia, the onset of which occurs while the patient is being cared for in a healthcare facility
- Death or serious disability associated with failure to identify and treat hyperbilirubinemia (condition where there is high amount of bilirubin in the blood) in newborns
- Stage 3 or 4 pressure ulcers acquired after admission to a healthcare facility
- Patient death or serious disability due to spinal manipulative therapy
- Artificial insemination with the wrong donor sperm or wrong egg

#### *Environmental Events*

- Patient death or serious disability associated with an electric shock while being cared for in a healthcare facility
- Any incident in which a line designated for oxygen or other gas to be delivered to patient contains the wrong gas or is contaminated by toxic substances. Remember, oxygen is a drug.
- Patient death or serious disability associated with a burn incurred from any source while being cared for in a healthcare facility
- Patient death or serious disability associated with a fall while being cared for in a healthcare facility
- Patient death or serious disability associated with the use of restraints or bedrails while being cared for in a healthcare facility

#### *Criminal Events*

- Any instance of care ordered by or provided by someone impersonating a physician, nurse, pharmacist, or other licensed healthcare provider
- Abduction of a patient of any age
- Sexual assault on a patient within or on the grounds of a healthcare facility
- Death or significant injury of a patient or staff member resulting from a physical assault (i.e., battery) that occurs within or on the grounds of a healthcare facility

### **MRSA – Methicillin Resistant Staphylococcus Auerus**

Overview: An estimated 2 million Americans contract healthcare associated infections (HAIs) each year, affecting 5% of all hospital patients. Approximately 90,000 of these patients will die, more than the number of deaths attributed to breast cancer or automobile accidents. The situation is getting worse. Since 1975, the infection rate has escalated by 36%. *Experts believe that the majority of these infections are preventable.*

MRSA is a potentially deadly strain of common bacteria that frequently inhabits the skin or nostrils of healthy people. Because of its resistance to antibiotics commonly used in treatment, MRSA is among the most common and problematic of HAIs. Approximately 50% of post surgical infections in CABG and orthopedic prosthetic surgeries are now due to MRSA. MRSA & HAI lead to death, complications and avoidable cost. Even when discounting for *per diem* reimbursements, nosocomial MRSA and other HAI result in increased operating costs and malpractice claims.

Proven strategies have reduced or nearly eliminated nosocomial MRSA in selected US hospitals and in countries such as Denmark. Successful strategies to reduce MRSA also reduce rates of other highly resistant HAI's including Vancomycin Resistant Enterococcus

(VRE) and Clostridium difficile (C.diff) colitis. These strategies are simple and cost-effective, but do require behavior change. All patients will benefit from MRSA/HAI reduction

### **Active Surveillance Culture (ASC)**

Should be done upon admission or at a maximum of 12 hours following admission of the designated high risk patients which include:

All ICU admissions and transfers into ICU

All NICU admissions born outside the hospital and transfer into NICU

All patients admitted from a nursing home or other LTC facilities

All Hemodialysis patients

All patients with a history of previous MRSA within the last 12 months

All patients admitted for a hip or knee replacement or spine surgery

All patients admitted for a Coronary Artery bypass or Valve Replacement Surgery.

Obtaining a physician's order to follow ASC protocol will initiate plan of care and documentation requirements for MRSA patients.

Obtaining the nasal swab, documentation of interventions and maintaining the environment of care are key elements in caring for patients with MRSA.

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- All Hemodialysis patients
- All patients with a history of previous MRSA within the last 12 months
- All patients admitted for hip or knee replacement or spine surgery
- All patients admitted for a Coronary Artery bypass or Valve Replacement Surgery
- All patients population and diagnosis deemed necessary by facility IC policy

A copy of the pre-printed order as per facility Infection Control ASC protocol is available at any HCA facility. Nurse will then initiate plan of care and documentation requirements for any patients who meet the ASC criteria. Obtaining the nasal swab, documentation of interventions and maintaining the environment of care are key elements in caring for patients with MRSA.

### **Barrier Precautions Guidance**

#### *Contact Precautions:*

Policy must indicate that Contact Precautions will be used for all patients colonized or infected with MRSA

*Patient Placement:* Patients can be placed alone or cohorted as necessary

*Gowns and gloves:* Gowns and gloves will be worn by physicians/staff for any direct contact (touch with hands/clothing) with the patient or the environment (i.e. bed, bedside tables, linen, and equipment). Disposable gowns will be discarded after each use

*Masks:* Masks should be used according to Standard Precautions when performing splash-generating procedures (i.e. wound irrigation, oral suctioning, intubation) when caring for patients with open tracheostomies and the potential for projectile secretions; and in circumstances where there is evidence of transmission from heavily colonized sources (i.e. burn wounds). Masks are not otherwise recommended for prevention of MDRO transmission from patients to HCW's during routine care, i.e. upon entry into the room.

#### *Patients Outside Their Rooms:*

Patients may ambulate outside their room if they:

- Have on a clean gown
- Have performed hand hygiene
- Are not coughing (if they are and really need to ambulate more than in the room-then place a surgical mask on them)
- Are continent of bowel and bladder
- Have wounds with drainage contained by dressings

*Food Service:* Food service does not deliver food trays to isolation rooms

*Visitors:* The use of gowns and gloves by visitors is not required but strongly encouraged. Family members or visitors who are providing direct care or having very close contact (i.e. feeding or holding), should also wear gowns & gloves. The act of just sitting in the room may be evaluated on a case-by-case basis

#### *Patient Transport:*

Limit the movement and transport of the patient from the room for essential purposes only. If the patient is transported out of the room, ensure that precautions are maintained to minimize the risk of transmission of organisms to other patients or the environment.

- Place a sheet or other physical barrier over gurney or wheelchair before transporting the patient

- If possible, have the patient put on a clean patient gown prior to transport
- Transporter should wear gloves (and possibly gown) to assist the patient into and out of the wheelchair/gurney. The PPE should then be removed prior to leaving the patient's room and hands decontaminated.
- When transportation is complete, thoroughly clean all surfaces of the wheelchair or gurney with a hospital approved disinfectant

The transferring unit will ensure that the Contact Precautions status of the patient and the organism of concerns (MRSA, VRE, C.difficile, etc.) are communicated to the receiving unit as part of the hand-off.

### **Vancomycin-Resistant Enterococci (VRE)**

Enterococci are bacteria that are normally present in the human intestines and in the female genital tract and are often found in the environment. These bacteria can sometimes cause infections. Vancomycin is an antibiotic that is often used to treat infections caused by enterococci. In some cases, enterococci have become resistant to vancomycin and are called vancomycin-resistant enterococci.

The following persons are at an increased risk of becoming infected with VRE:

People who have been previously treated with the antibiotic vancomycin or other antibiotics for long periods of time

People who are hospitalized, particularly when they receive antibiotic treatment for long periods of time.

People with weakened immune systems such as patients in Intensive Care Units or in cancer or transplant wards

People who have undergone surgical procedures such as abdominal or chest surgery

People with medical devices that stay in for some time such as urinary catheters or central intravenous (IV) catheters

People who are colonized with VRE

Information collected by the Centers for Disease Control and Prevention during 2006 and 2007 showed that enterococci caused about 1 of every 8 infections in hospitals and only about 30% of these are VRE. VRE can be more common in certain groups of people such as those with weakened immune systems. People who are colonized (bacteria are present, but have no symptoms of an infection) with VRE do not usually need treatment. Most VRE infections can be treated with antibiotics other than vancomycin.

*What should I do to prevent the spread of VRE infection to others?*

VRE is often passed from person to person by the hands of caregivers. VRE can get onto a caregiver's hands after they have contact with other people with VRE or after contact with contaminated surfaces. VRE can also be spread directly to people after they touch surfaces that are contaminated with VRE. VRE is not usually spread through the air by coughing or sneezing.

### **Acinetobacter**

*Acinetobacter* is a group of bacteria commonly found in soil and water. It can also be found on the skin of healthy people, especially healthcare personnel. While there are many types or "species" of *Acinetobacter* and all can cause human disease, *Acinetobacter baumannii* accounts for about 80% of reported infections. Outbreaks of *Acinetobacter* infections typically occur in intensive care units and healthcare settings housing very ill patients. *Acinetobacter* infections rarely occur outside of healthcare settings.

*Acinetobacter* causes a variety of diseases, ranging from pneumonia to serious blood or wound infections and the symptoms vary depending on the disease. Typical symptoms of pneumonia could include fever, chills, or cough. *Acinetobacter* may also "colonize" or live in a patient without causing infection or symptoms, especially in tracheostomy sites or open wounds. *Acinetobacter* poses very little risk to healthy people. However, people who have weakened immune systems, chronic lung disease or diabetes may be more susceptible to infections with *Acinetobacter*.

Hospitalized patients, especially very ill patients on a ventilator, those with prolonged hospital stay or those who have open wounds, are also at a greater risk for *Acinetobacter* infection. *Acinetobacter* can spread to susceptible persons by person-to-person contact, contact with contaminated surfaces or exposure in the environment. *Acinetobacter* is often resistant to many commonly prescribed antibiotics. Decisions on treatment of infections with *Acinetobacter* should be made on a case-by-case basis by a healthcare provider. *Acinetobacter* infection typically occurs in very ill patients and can either cause or contribute to death in these patients.

*What should I do to prevent the spread of Acinetobacter infection to others?*

*Acinetobacter* can live on the skin and may survive in the environment for several days. Careful attention to infection control procedures such as hand hygiene and environmental cleaning can reduce the risk of transmission.

### **Clostridium difficile (c-diff)**

*Clostridium difficile* (c-diff) is a bacterium that causes diarrhea and more serious intestinal conditions such as colitis, sepsis, and rarely death.

Symptoms include:

- Watery diarrhea (at least three bowel movements per day for two or more days)
- Fever and loss of appetite, nausea and abdominal pain/tenderness

C.difficile is generally treated for 10 days with antibiotics prescribed by physicians. The drugs are effective and appear to have few side-effects. People who have other illnesses or conditions requiring prolonged use of antibiotics and the elderly are at greater risk of

acquiring this disease. The bacteria are found in the feces. People can become infected if they touch items or surfaces that are contaminated with feces and then touch their mouth or mucous membranes. Healthcare workers can spread the bacteria to other patients or contaminate surfaces through hand contact.

*What should I do to prevent the spread of C.difficile?*

- Wash hands with soap and water, especially after using the restroom and before eating
- Clean surfaces in bathrooms, kitchens and other areas on a regular basis with household detergent/disinfectants.

## **#8 Acquired Conditions Serious Preventable Adverse Events**

### **Back Safety/Body Mechanics**

Healthcare workers are the riskiest occupation for back injury, more so than truck drivers, construction workers, stock handlers, and baggers. The two main risk factors for healthcare-related back injuries are transferring and lifting patients and bed making.

**Good lifting and transferring techniques** may help decrease the potential for back injury.

These include:

- Always ask for help if the patient is too heavy
- Identify the patient
- Tell patient of intention for lifting or transferring
- Let the patient see the destination during the transfer or lift
- Lock all wheels to prevent slipping
- Patient should be wearing appropriate shoes that resist slipping
- Stand close to the patient facing him or her
- Have the patient roll onto one side, swing legs over the side of the bed and use his or her elbow and hand to push up. The key points on control are patient's hips and shoulders or reach under the patient's arms and grasp his or her back
- Bend your knees, not your back
- Grip the patient firmly
- Bring the patient close to your body when lifting
- Keep your trunk square with the patient, back straight
- Lift head and shoulders first with your back straight, then use the strength of your legs to slowly and smoothly push up
- Do NOT twist your body! A torquing action can be especially dangerous
- Move your feet first to change direction
- Bend your knees to lower the patient
- Lower the patient slowly and smoothly
- Check all tubes, cords, etc to assure they are untangled and unknicked
- Place call bell, phone, TV control, etc within reach of the patient
- 

### **Emergency Preparedness**

#### **Disaster Plan**

Healthcare facilities where you work have developed and maintain emergency preparedness plans for events that may occur internal or external to the facility. Critical components of the plan include:

- Communication plan
- Direction of key personnel to specific areas or tasks
- Evacuation procedures
- Restricted access to the facility (make sure you have your ID badge!!)

#### **Emergency Response Team**

In the event of a catastrophic event impacting a facility, locally or nationally, the facility will activate the disaster plan and contact clinical employees for availability to assist their colleagues. Each employee will be asked for their availability to work before, during, or after the emergency, length of time available and ability to travel

#### **Pandemic Preparedness and Response Act**

Pandemic Preparedness and Response Act is a bill introduced on October 5, 2005 in response to the growing threat of an outbreak of the avian virus. The bill calls for:

- Preparing for pandemic by finalizing, implementing and funding pandemic preparedness and response plans
- Improving surveillance and international partnerships to monitor the spread of avian flu and detect the emergence of a flu strain with pandemic potential immediately
- Protecting Americans through the development, production and distribution of an effective vaccine
- Planning ahead for a pandemic by stockpiling antivirals, vaccines and other essential medications and supplies
- Strengthening the public health infrastructure
- Increasing awareness and education about pandemic flu
- Devoting adequate resources to pandemic preparedness

#### **Preparing for a Pandemic:**

- Strict hand washing regimens with soap and water and alcohol based hand wash
- Vaccinate the children first and then the elderly
- Don't stress out. Chronic stress undermines the effectiveness of the vaccine
- Cook all poultry and poultry products to a temperature of 180 F.
- Stock up on Advil or Tylenol
- Stay home if you have flu symptoms. (The contagious period is the first few days of the flu)
- Use Standard Precautions and Droplet precautions at all times during the outbreak,
- Have a family disaster plan (stocking up on food and water) in the event of a quarantine

All hospitals have plans for education, supplies, contingency staffing, communication, lab testing, vaccinations, surge capacities and many other facets of disaster preparedness.

#### **Avian Flu**

##### **History:**

In January 2004, a highly pathogenic avian influenza (HPAI) virus of the H6N1 subtype was first confirmed in poultry and humans in Thailand. The disease in birds has two forms. The first causes mild illness, sometimes expressed only as ruffled feather or reduced egg production. Of greater concern is the second form, HPAI, which can be transmitted from birds to humans.

There are many types of Type A flu viruses. These viruses are constantly changing and may adapt over time to infect and spread among humans.

##### **Basic Control Measures:**

Avoid contact with birds and poultry, (chickens, ducks and turkeys). The most important control measure is rapid destruction of entire flocks of infected poultry and birds followed by quarantining and disinfecting of farms. Disinfection can occur with heat (132 F for 3 hours or 140 for 30 minutes) and common disinfectants such as formalin and iodine. The virus can survive for up to four days at 71.6F and for more than 30 days at 32F. Currently, available vaccines will not protect against disease caused by H5N1 strain in humans.

**Annual vaccines are produced for routine use in protecting humans during seasonal epidemics of influenza. They offer no protection against infection with the H5N1 avian virus, but may potentially reduce the risk of death.**

##### **Symptoms**

In addition to typical influenza symptoms of fever, cough, sore throat, muscle aches and pneumonia. You may have:

- General malaise
- Upper respiratory infection
- Severe Respiratory complications
- Life threatening complications

#### **Swine Flu (H1N1 – Novel Influenza)**

##### **Definition**

Swine flu refers to a respiratory infection caused by influenza. A viruses that ordinarily cause illness in pigs. Humans can catch swine flu from infected pigs, but pig-to-human transmission of true swine flu is also possible but infrequent. The recent outbreak in April 2009 of what is being called swine flu involves a new H1N1 type A influenza strain that's a genetic combination of swine, avian and human influenza viruses. It's capable of spreading from human to human.

This new swine flu is being called by a number of names, including: swine-origin influenza A, swine influenza A (H1N1), influenza A/California/H1N1, swine origin influenza virus, North American flu and influenza A (H1N1).

Symptoms

The symptoms of swine flu in humans are similar to those of infection with other flu strains.

- Fever
- Cough
- Sore throat
- Body aches
- Headache
- Chills
- Fatigue
- Diarrhea
- Vomiting

Symptoms develop three to five days after you're exposed to the virus and continue for about another week. You can pass the virus to other people for about eight days, starting one day before you get sick and continuing until you've recovered. Severe complications of human swine flu H1N1 seem to develop and progress rapidly.

Influenza viruses infect the cells lining your nose, throat and lungs. You can be exposed to swine flu virus if you have contact with infected pigs. The virus enters your body when you inhale contaminated droplets or transfer live virus from a contaminated surface to your eyes, nose or mouth on your hand.

Human swine flu H1N1 is sensitive to oseltamivir (Tamiflu) and zanamivir (Relenza), both of which are neuraminidase inhibitors. It's important to start treatments as soon as possible after you become ill. These antiviral medications are most effective if treatment begins within 48 hours of developing symptoms.

CDC anticipates that there will be more cases, more hospitalizations and more deaths associated with this new virus in the coming days and weeks because the population has little to no immunity against it.

## **Environment of Care**

### **Safety Codes**

Facility communication codes related to events that impact safety may vary from facility to facility. Knowing these codes is important in assuring safety for you and others. Learning these codes is part of your initial orientation process to the facility where you are assigned to work. It is recommended that frequently confirm use of the same codes with a facility manager or supervisor. Some general safety concerns that are referenced by a code name may include:

- Cardiopulmonary arrest
- Pediatric cardiopulmonary arrest
- Neonatal arrest
- Fire
- Hazardous waste spill
- Inclement weather
- Bomb threat
- Order to evacuate building
- Missing infant
- External emergency
- Threatening person
- Missing patient

### **Fire Safety**

Fire alarms are never to be taken lightly. All fire alarms are to be treated as REAL fires as fires are a constant threat to everyone and can strike at any time. Hospitals are susceptible to fires because of the presence of flammable chemicals and materials as well as the large amount of electrical equipment used.

### **Basic fire prevention rules include**

- Responsibility for fire prevention belongs to everyone
- Watch for fire hazards and report them
- Keep work areas clean and free of excess storage
- Store flammables in isolated, approved areas
- Know the location of the closest alarm and fire fighting equipment
- Inspect the electrical equipment for loose wiring
- Do not overload outlets
- Do not use unapproved extension cords



- Do not store anything within 18 inches of ceiling sprinkler heads as this could block the effectiveness of the sprinkler system in the event of a fire

If patients, visitors, or staff is in immediate danger from fire, move them from the area. Send ambulatory patients to their own room and have them keep their doors closed or move them beyond the nearest smoke door out of hallway traffic.

Patients confined to bed should be moved by hospital personnel as necessary to a safe location outside of the fire zone.

In case of fire **close all doors** and:

**R-Rescue** patient if in immediate danger

**A-Alarm** pull the fire alarm

**C-Confine** the fire, close doors and windows

**E-Extinguish** use of the appropriate extinguisher

When using the fire extinguisher:

**P-Pull** the pin

**A-Aim** at the base of the fire

**S-Squeeze** the handle

**S-Sweep** from side to side

### **Electrical Safety**

To get an electrical shock, the body must, in some manner become a part of an electrical circuit. Potential means that an electrical force exists that will cause current to flow if a path is provided. Electricity always tries to reach the ground. Excellent conductors include people, water, damp floors, or metal

Human errors are the major cause in most electrical accidents. Lack of familiarity with the item, improper usage, lack of caution, and inattention to good safety practices are contributing factors in most occurrences.

### **Electrical Safety Guidelines**

- Do not use any appliance or machinery while touching metal or anything wet
- “Cheaters”-3 prong to 2 prong adapter and extension cords should not be used
- Do NOT take anything for granted. Perform a visual inspection of electrical equipment before using it. If anything is loose, cracked, broken, bent, or exposed, do not use the item. Contact the facility supervisor for repair and utilize appropriate facility repair tags and remove from patient care areas.
- Always use care in moving line powered equipment. Leads, cords, switches, and knobs need to be fastened firmly. Caution should be used during transit, especially through doorways
- Keep fluids, chemicals, and heat away from equipment cables at all times. Most liquids are good conductors and cause shock paths that can affect the accuracy of the data obtained or delivered by the equipment.
- Always plug portable equipment into the wall outlet with the power switch off and especially before connecting it to the patient.
- Connect and disconnect line powered equipment by holding the plug firmly and straight when inserting or retracting it from the wall outlet. “Whipping” or jerking the plug from the outlet will damage both the outlet and the plug.
- Understand the function of each control before turning on the equipment or before adjusting the controls.

### **Rules for Working Around Electricity**

- Keep electrical cords out of traffic areas where someone could trip over them
- Water and electricity do not mix! Keep hands dry and keep areas surrounding electrical equipment dry.
- Protect cord, plugs and appliances from damage
- Inspect electrical equipment for damage before each use. If a problem exists, do not use the equipment. Take it out of service and notify the supervisor promptly.
- Use the 3-prong plug as it protects electricity from leaking through wire. Never remove the third prong
- Report any electrical problems immediately. A small shock, sparking, overheating, or burning electrical smells are urgent warnings
- Disconnect power and follow established lockout procedures before repairing or cleaning machinery

### **Emergencies and Medical Emergency Care**

Appropriate response to medical emergencies requires rapid assessment and prompt intervention to avoid further deterioration of the patient. Hospital medical emergencies are usually announced through pre-designed codes in use of the facility.

### **Rapid Response Teams – (RRT)**

As a participant in the Institute for Healthcare Improvement’s “100,000 Lives” campaign and in compliance with The Joint Commission’s National Patient Safety Goal #16, *“Improve recognition and response to changes in a patient’s condition, Rapid*

Response Teams have been implemented throughout the hospital systems. These teams, the make-up of which varies, may consist of a critical care nurse, an intensivist/hospitalist, and a respiratory therapist. The teams may be in addition to the Cardiac Arrest Team or the same team. The concept is to give the bedside caregiver additional assistance when a patient begins to deteriorate and before cardiac arrest. Criteria and guidelines for activating the RRT may vary from hospital to hospital but the basis is the deterioration of the patient. The nurse does not waste precious moments trying to locate the attending physician and the team works with and communicates with the attending when the patient is stabilized. The Rapid Response Teams have helped decrease the number of cardiac arrests in hospitals and decreased morbidity and mortality statistics.

Intervention protocols and the responsibilities of health care professionals responding to the emergency are specified by the facilities where you work. You must be aware of hospital specific policies and protocols that outline responsibilities of the patient care team during a cardiac or respiratory arrest. If you are credentialed or certified follow the American Heart Association or Associated Organizations guidelines, i.e. BLS, ACLS, PALS, ENPC, AWOHNN, STABLE, TNCCE.

### Quality Indicators/Risk Management CORE Measures and Quality Indicators

When talking about CORE Measures it is critical to understand how these are actually integrated into direct patient care. Based on a national assessment of trends and occurrences the Hospital Quality Alliance, CMS and the Joint Commission have established a set of CORE Measures to impact quality patient care. Clinical Staff involvement should be in: **Prioritization, timeliness, follow-through, documentation and critical thinking** with protocols and orders for the CORE Measurements. Interventions for CORE Measures should be considered critical junctures for your patient outcomes. A critical juncture is a point in the patients care that interventions or lack of an intervention will directly impact the patients experience and outcomes. It is your responsibility to utilize the appropriate resources including individual hospital order sets, processes and chain of command to assure your patients' outcomes are timely and positive.

CORE Performance Measure sets have been identified for hospitals. These include **acute myocardial infarction, heart failure, pneumonia, pregnancy and related conditions, surgical care infection prophylaxis, outpatient measures and children's asthma.** DVT/PE prevention and hospital-based inpatient-psychiatric services measures are among the next measure sets scheduled to follow. All Joint Commission measures are submitted to the National Quality Forum (NQF) for review and have all been endorsed by the NQF.

<b>PN (Pneumonia)</b>	<b>Explanation of Treatment</b>
Patients Given Adult Smoking Cessation Advice/Counseling	Smoking is linked to pneumonia. Quitting may prevent reoccurrence of getting pneumonia again
Patients having Blood Cultures Performed prior to First Antibiotic Received	Blood cultures indicate the kind of antibiotic to treat the pneumonia. Antibiotics given prior to blood cultures can cause inaccurate lab reports
Patients Given Initial Antibiotic Timing Within Timeframe (4-24 Hours) of Arrival as per facility policy	Antibiotics treat pneumonia caused by bacteria and timeliness impacts outcomes
Patients Given Oxygenation Assessment	Having enough oxygen in the blood promotes lung function and decreases the workload of the heart
Influenza screening/vaccination	Flu vaccines can decrease cases of pneumonia
Pneumococcal Vaccination	A pneumonia (pneumococcal) shot can help prevent pneumonia.

### #9 Unapproved Abbreviations

#### OUR GOAL IS TO ELIMINATE THE FOLLOWING ABBREVIATIONS

<b>DO NOT USE THESE ABBREVIATIONS OR DOSE DESIGNATIONS</b>			
<b>Do Not Use</b>	<b>Intended Meaning</b>	<b>Misinterpretation</b>	<b>Correction</b>
U or u	Unit	Mistaken for a zero or four	Write "Unit" No acceptable Abbreviation
IU	International Unit	Mistaken for IV or 10	Write "international unit"
QD and QOD	Every Day and Every Other Day	Mistaken for each other or for QID	Write daily or every other day
MS-MS04- MgS04	Morphine sulfate Magnesium sulfate	Confused with each other	Write Morphine or Magnesium sulfate
"Trailing Zero" Use of Zero after Decimal Point (1.0)	1 mg	Misread as 10mg if the decimal point not seen	Do not use terminal/trailing zeros for doses expressed in whole numbers
Lack of	0.5 mg	Misread as 5mg if	Always use zero

"Leading Zero" before decimal dose (.5)		the decimal is not seen	before decimal when dose is less than whole unit
T.I.W	Three times per week	Three times per day or twice weekly	Write "three times per week" or "3 times per week"
A.S A.D A.U	Left ear Right ear Both ears	Left eye Right eye Both eyes	Write Left ear, Right ear, or both ears
ug	Microgram	Mg-milligram	Write meg

## #10 Restraints

### Restraints

Effective January 10, 2010, new policies, guidelines and training mandates were adopted in accordance with the new requirements from The Joint Commission (TJC) and the Center for Medicare/Medicaid Services (CMS). This self-study guide will assist all Healthcare Personnel in providing a safe environment for patients requiring restrictive resources for violent or non-violent reasons. The new policies will provide the caregiver with skills to appropriately assess the need for activity restriction or an alternative intervention for patients displaying behaviors that may pose a threat to themselves or others.

### Previous Verbiage:

Medical Restraints  
Behavior Restraints

### Current Verbiage:

Non-Violent or Non-Self Destructive Behavior  
Violent or Self Destructive Behavior

### RN's Role:

- Initiate **alternative interventions** promptly for patient at risk for restraint
- Make **determination** that alternatives have failed
- Obtain **2<sup>nd</sup> tier** approval on initial application. (Renewals of restraint orders do not require 2<sup>nd</sup> tier approval). The review must include: alternatives attempted, reason for restraint, least restrictive restraint, staff's knowledge of cause of patient behavior, staff availability for monitoring. (**In an emergency application, the review will occur immediately after application of restraint**).
- Order for Restraint:
  - Obtain order for restraint from physician or LIP (where allowed by state law or facility policy). If telephone order is required, RN must write down the order while the physician is on the phone, and read-back the order to verify accuracy. When a physician/LIP is not available, the RN, with demonstrated competency may initiate restraint use based upon face-to-face assessment. In these situations, the order must be obtained during the emergency application or within minutes after application of the device. The order must include:
    - Clinical justification for restraint
    - Date and time ordered
    - Duration of use
    - Type of restraint
    - Criteria for release of restraint
  - Order for restraint with Non-Violent or Non-Self Destructive Behavior
    - Must not exceed 24 hours for the initial order. If reassessment by the LIP/physician determines continued use of restraints, a new order must be written each calendar day by the LIP/physician
  - Order for restraint with Violent or Self-Destructive Behavior
    - Must be time limited
    - 4 hours for adults aged 18 or older

- 2 hours for children and adolescents aged 9-17
  - 1 hour for children under 9 years
  - **Renewal orders may not exceed these time requirements**
- **Application** of restraints
  - Are only applied by staff with demonstrated competence
  - Patient is informed of reason for restraint and criteria for removal of restraint
  - Family is informed of reason for restraint and criteria for removal of restraint
- **Monitoring** of Patient in Restraints
  - Assess by RN immediately after application of restraint
  - An RN will assess patient every 2 hours. Assessment will include:
    - Signs of injury, including CMS of extremities
    - Respiratory and cardiac status
    - Psychological status, including level of distress or agitation, mental and cognitive status
    - Need for range of motion, exercise of limbs and need for systematic release of limbs are met
    - Hydration and nutritional needs are met
    - Hygiene and toileting needs are met
    - Patients rights, dignity and safety are met

#### **Patient Safety:**

- CMS (Circulation, Movement & Sensation)
  - Fingers should be pink, warm, and non-swollen
  - Able to move finger freely and feel touch
  - Skin under restraint is free from pressure
- 
- **Security**
  - Check restraint & knot for security
  - Assure quick release knot
  - Be rails are up if necessary
  - Bed is in low position
  - Bed alarms are audible
  -

#### **Patient Dignity**

- Privacy
  - Patient is appropriately clothed
  - Not viewable from hallways and other patients
- Refer to patient by name
  - “Mr. Or Mrs. Or preferred name
- Maintenance of quiet environment
  - Reduce stimuli: noise, bright lights, soft music, etc.

#### **Patient Rights**

- Remind patient of behaviors exhibited for restraint use and behaviors expected for release
  - Patient must meet expectations for release of restraints
- Positional, nutritional, elimination, warmth or cold needs
  - All needs must be met to reduce agitation and increase comfort
    - Patients understanding of criteria for release of restraints
    - Considerations of less restrictive restraint
  - More frequent monitoring, and notification of physician will occur if:
    - Patient’s medical and emotional needs and health status change
    - The restraint device poses increased risk
    - Escalation of behavior because of restraint
    - Evidence of injury related to restraint
  - A trained staff member monitors patient in restraint at least 4 times an hour to assure safety, dignity and patient rights are maintained. The check will be documented in either electronic record or on paper and may be recorded at the end of the shift
  - For patients under continuous audio, video or in-person observation, care is entered in real time but documentation that safety, rights and dignity were maintained may be entered at end of the shift
- Simultaneous use of Restraint and Seclusion requires higher level of monitoring

- Continuous, uninterrupted monitoring, face-to-face by trained, competent staff in close proximity to the patient for at least the first hour.
- After the first hour, continuous uninterrupted monitoring done in close proximity to the patient so as to allow emergency intervention if a problem arises
- Face-to-Face assessment by a Physician/LIP:
  - A face-to-face assessment by a physician or LIP, RN or physician assistant (in accordance with facility policy), must be done within one hour of restraint/seclusion initiation or administration of medication to manage the behavior. The assessment will:
    - Work with staff and patient to identify ways to help patient regain control
    - Evaluate the patient's immediate situation, reaction to the intervention, medical and behavioral condition and the need to continue or terminate the restraint/seclusion
    - Revise the plan of care, treatment and services as needed
  - When the 1 hour face-to-face is performed by an RN or physician assistant with demonstrated competence, the following must occur:
    - The RN or physician assistant must notify the physician who is responsible for the care of the patient as soon as possible after the assessment ("As soon as possible" is to be as soon as the attending physician is able to be reached by phone or in person).
    - The consultation should include, a discussion of the findings at the 1 hour evaluation, the need for other treatments, and the need to continue or discontinue the restraint or seclusion
- Plan of Care
  - The plan of care will clearly reflect assessment, intervention, and evaluation requirements for restraint, seclusion and medications
- Discontinuation of Restraint/Seclusion
  - When RN determines that the patient meets the criteria for release in the restraint order, the restraints are discontinued by competent staff
  - Once restrains are discontinued, a new order for restraint is required
  - A temporary release during toileting, feeding or range of motion, is not considered a discontinuation of restraint/seclusion
- Documentation Requirements:
  - Assessment for risk restraint
  - Restraint alternative employed
  - Determination of effectiveness/ineffectiveness of restraint
  - Restraint application
  - Assessment of the patient
  - Medical and behavioral evaluation for restraint management
  - Physician notification of changes in patient condition
  - Patient and family education
  - Second tier review
  - Order for restraint and any renewal order for restraint
  - Family notification of restraint use
  - Monitoring of patient
  - Modifications in plan of care
  - Restraint removal

**Interventions: To be Attempted Prior to Restraint Utilization**

- **Psychosocial Alternatives**
  - Diversion                      Family interaction                      Orientation                      Pastoral visit                      Reading
  - Relaxation Techniques                      Interpreter Services                      Personal Possessions Available                      Quiet Area
  - One-on-One discussion
  - Decreased Stimulation                      Change in environment                      Re-establishing communication                      Setting Limits
- **Environmental Alternatives**
  - Commode at bedside                      Decreased noise                      Music/TV                      Specialty low bed
  - Night Light within                      Room close to nursing station                      Call light                      Orientation
  - Bed alarm in use                      Decreased stimulation                      Sensory aides available (glasses, hearing aide)
  - Providing a quiet area                      Physical activity
- **Physiological Alternatives**
  - Toileting                      Fluids/nutrition/snack                      Positional devices

- Pain intervention                      Assisted ambulation                      Re-positioning
- Rest/sleep                                  Providing assistance                      Additional warmth
- Decreased temperature                  Check lab values                          Pharmacy consult

• **Sitters**

Sitters may be used for those patients whose behavior is out of control (i.e., increased motor activity, impulsive with lack of judgment, inability to tolerate environmental stimuli, faulty sense of reality, all other alternatives have proven ineffective and the next step would be to restrain the patient).

**Definitions:**

**Physical Restraint:** Any manual method or device, material or equipment attached or adjacent to the patient’s body that they cannot easily remove that restricts freedom of movement or normal access to one’s body. Includes: tucking in sheets very tightly, use of side rails to prevent a patient from voluntarily getting out of bed, holding a patient to prevent movement, pinning of mitts on infants, arm restraints, arm restraints or wrapping that prevent patients from removing invasive lines or opening surgical sites.

**Seclusion:** Seclusion may only be used for the management of violent or self destructive behavior. Seclusion is not limited to confining him/her alone in a room or area where he/she is physically prevented from leaving. This definition does not apply to “timeout” which is an intervention in which the patient consents to being alone in a designated area for an agreed upon timeframe from which the patient is not physically prevented from leaving.

**Drugs as Restraints:** A drug or medication when it is used as a restriction to manage the patient’s behavior or restrict the patient’s freedom of movement and is not a standard treatment or dosage for the patient’s condition is considered a restraint.

**Physical Escort:** A physical escort would include a “light” grasp to escort the patient to a desired location. If the patient cannot easily remove or escape the grasp, this would be considered a restraint.

**Physical Holds:** The regulation permits the physical holding of a patient for the purpose of conduction routine physical examination or tests. The patient has the right to refuse treatment. Holding a patient in a manner that restricts the patient’s movement against the patient’s will is considered restraint.

**Physical Holds for Forced Medications:** The patient has a right to be free of restraint and also has a right to refuse medications, unless a court has ordered medication treatment. The use of force in order to medicate a patient must have a physician’s order prior to application of restraint.

**Weapons:** CMS regulations specifically state that the use of weapons (pepper spray, mace, Tazers, stun guns, etc.) is not considered safe appropriate health care intervention.

**LIP:** For purpose of restraint ordering, is any practitioner **permitted by State law and by facility policy**, with the authority to independently order restraints or seclusion. This authority must be **within the scope of the individual’s license**.

**Restraints with Heightened Risk:** Vest restraints which tie crisscross have proven to contribute to patient injury and **should not be used within most facilities**.

**Exceptions to Definition of Restraints:**

- Stretcher Side Rails
- Handcuffs
- Use of voluntary mechanical support devices (Orthopedic appliances and braces)
- Voluntary mechanical position or securing device: (Backboards, IV boards, surgical positioning)
- Age or developmentally appropriate protective safety interventions: (stroller safety belts, crib rails)
- Recovery from anesthesia: when patient is in ICU or recovery room. If the intervention is maintained when the patient is transferred to another unit, a restraint order would be necessary.

**Fall Risk Assessment**

Falls and their subsequent outcomes are serious health threats for older adults. An estimated one third of all persons age 65 years and over who live at home fall each year; over one half to two thirds of nursing home residents fall; and around one half of hospitalized older patients fall. Both in the community and institutional settings, the rate of falls increases proportionately with the increased number of cognitive and functional impairments and risk factors.

Falls do not have to happen; most falls are preventable. A falls prevention program is essential to the provision of holistic care for older adults. Since normal and pathological changes, which are common in aging, contribute to falls, assessment of the risk factors for falls is necessary.

Recommendations for fall prevention are abundant throughout the literature, and many tools exist to identify individuals at highest risk for injurious falls.

A sample Fall Assessment Tool (provided below) includes client and environmental factors that contribute to falls. Additional environmental risks may be present depending on the physical setting. To administer the tool, simply circle the score that corresponds with the risk factor listed on the left hand side of the instrument.

The tool should be administered on admission to the facility or agency and again at specified intervals and when warranted by changes in health status. Scores of 15 and higher indicate high risk, and preventive fall measures should be implemented.

**Strengths and Limitations of the Fall Assessment Tool**

The strength of this tool lies in its efficient ability to detect those individuals at highest risk for falls

**Documentation on Risk to Fall**

Meditech screens on Risk to fall include

- History of decreased functional ability and falls
- Current mobility around ADL’s
- Ambulatory assistive devices used
- Assessment of the current status: Mental, sensory, mobility and elimination; when used repeatedly on the same individual, the instrument is able to detect minor changes in cognitive and functional ability, as well as environmental alterations that put individuals at risk for falls. However, the use of such a tool may limit the establishment of preventive measures for all older adults as a high-risk population for falls.
- Implementing strategies for elderly fall prevention is good practice for all facilities and agencies.

**Sample Fall Assessment Tool**

Circle the score that corresponds with the risk factor listed on the left hand side of the instrument. The tool should be administered on admission to the facility or agency and again at specified intervals and when warranted by changes in health status.=

<b>Client Factors</b>	<b>Date</b>	<b>Initial Score</b>	<b>Date</b>	<b>Reassessed Score</b>
History of falls		15		15
Confusion		5		5
Age (over 65)		5		5
Impaired judgment		5		5
Sensory deficit		5		5
Unable to ambulate independently		5		5
Decreased level of cooperation		5		5
Increased anxiety/emotional liability		5		5
Incontinence/urgency		5		5
Cardiovascular/respiratory disease affecting perfusion and oxygenation		5		5
Medications affecting blood pressure or level of consciousness		5		5
Postural hypotension with dizziness		5		5
<b>Environmental factors</b>				
First week on unit (facility, services, etc.)		5		5
Attached equipment (e.g. IV pole, chest tubes, appliances, oxygen, tubing, etc.)				

**Total Points: 15 or Greater**

**Implement fall precautions for a total score of**

**Significant fall risk scores may result in the need for restraint orders (see above criteria for restraints)**

**Abuse or Neglect Identification**

	<b>Children <u>Less than 18</u></b>	<b>Young and Middle <u>Adults 18-59</u></b>	<b>Older Adults <u>60 or Older</u></b>
Presentation or Manifestation	Behavioral issues (truancy, acting out) Nightmares Insomnia Inappropriate family reactions Sexual acting out Withdrawal Bruises, cuts, cigarette burns Frequent UTIs	Fatigue Anxiety Depression Possible suicide attempt Extent or type of injury inconsistent with patient’s explanation Frequent ED visits	Bruises, especially on upper arms from where shaken Laceration to the face; injuries at various stages of healing Flinching, especially if sees abuser



	STDs No proper parental care (young child left alone)	Problem pregnancies Feeling trapped	Depression Poor eye contact Delay in treatment (caretaker not giving meds, not being taken to appointments) Over-sedated Unclean appearance
Who do I Call?	<b>Children Less than 18</b> Per facility procedure, may Be hospital social worker or nursing supervisor	<b>Young and Middle Adults 18-59</b> Per facility procedure, may be hospital social worker or nursing supervisor	<b>Older Adults 60 or Older</b> Per facility procedure, may be hospital social worker or nursing supervisor
Does the law require Social Services to be Notified?	Know the laws in the state you work	Know the laws in the state you work	Know the laws in the state you work
What do I do if suspect a criminal act has occurred? (e.g. use of firearm, knife or sharp instrument, sexual assault)	Notify the appropriate party per facility procedure. May be hospital social worker or nursing supervisor. Requires reporting to the police by either the physician or hospital designated representative	Notify the appropriate party per facility procedure. May be hospital social worker or nursing supervisor. Requires reporting to the policy by either the physician or hospital designated representative	Notify the appropriate party per facility procedure. May be hospital social worker or nursing supervisor Requires reporting to the police by either the physician or hospital designated representative.
Since my job requires documenting in the patient record, what do I have to document?	All pertinent documentation including patient quotes regarding circumstances; specific location and size of injuries or bruises; conversations related to injury. Refer to facility procedure for specifics.	All pertinent documentation including patient quotes regarding circumstances; specific location and size of Injuries or bruises; referrals provided; that Patient encouraged to report domestic violence; conversation related to injury. Refer to facility procedure for specifics.	All pertinent documentation including patient quotes regarding circumstances; specific location and size of injuries or bruises; conversations related to injury. Refer to facility procedure for specifics.

## #11 Age Specific Competencies

### Age Specific Review

#### Infant 0 (Birth) to 1 Year

##### Physical

Period of rapid growth  
Anterior fontanel: Diamond shaped, 1.5-2.0 cm, sunken if infant dehydrated closes at 12-18 months  
Toward end of 1<sup>st</sup> year: primitive reflexes diminish  
Teething starts. Has 8 teeth at year 1  
Regular bowel and bladder pattern develops  
Unable to control body warmth due to immature health regulation ability  
Normal temperature 97-99 F.

##### Motor/

Responds to light and sound

##### Sensory

Towards middle of year progresses to raising head, turning over, and moving to sitting position

Primitive reflexes; startle, step, random movements

Towards end of year progresses to crawling, standing alone, walking with assistance

##### Cognitive

Manipulates objects in the environment

Recognizes bright objects and progresses to recognizing familiar objects and persons

Towards end of year, speaks 2 words, and mimics sounds  
Obeys single commands and understands meaning of several words  
Seeks experiences

Learns by imitation

Psychosocial

Significant persons are the parents or primary caregivers  
Develops a sense of trust and security if needs are met consistently and with a degree of emotion  
Fears unfamiliar situations

Smiles, repeats actions that elicit response from others (wave good-bye, plays pat-a-cake)

Pain

Infants experience pain

Degree of pain perception is unknown

Death

Infants do not understand the meaning of death

Developing sense of separation serves as a basis for an initial understanding of death

Interventions

Involve patients in procedures and daily care  
Keep parent in infant's line of vision  
Limit the number of strangers caring for infant  
Provide nutrition as appropriate  
Ensure infant warmth  
Keep familiar objects near  
Cuddle often  
Use distraction: bottle, pacifier, etc.  
Ask parents about immunization history  
If teaching:  
Provide opportunities for parent/caregiver to give a return demonstration  
Allow time for parent or caregiver to ask questions  
Safety Interventions  
Use equipment specific to size and age of child  
Keep crib side rails up at all times  
Make sure toys do not have removable parts and check for safety approval  
Keep bulb syringe available for suctioning as needed

**School Age Years 1-12**

**Toddler 1-3 Years**

Physical

Learning bowel and bladder control  
Abdomen protrudes  
Decreased appetite and growth  
First teeth erupt: all deciduous teeth by 2 ½ -3 years  
Body systems mature  
Grows 2-2 ½ inches and gains 4-6 pounds yearly  
Bowel and bladder control develops at 18 months – 3 years

Motor/

Responds better to visual cues rather than spoken

Sensory

Walks independently, progressing to running, jumping and climbing

Feeds self

Goal directed behavior

Cognitive

Develops concepts by use of language  
Sees things only from own point of view  
Able to group similar items  
Constructs 3 to 4 word sentences  
Short attention span  
Beginning memory  
Ties words to actions  
Understands simple directions and requests

Psychosocial

Significant persons are parents  
Discovers ability to explore and manipulate environment  
Asserts independence (autonomy) and develops a sense of will, has temper tantrums  
Understands ownership, "mine"  
Attached to security objects and toys  
Knows own gender and differences of gender

	Able to put toys away <u>Plays simple games, enjoys being read to, plays alone</u>
<u>Pain</u>	No formal concept of pain Reacts as intensely to painless procedures as to ones that hurt especially when restrained Intrusive procedures, such as temperatures, are very distressing Reacts to pain with physical resistance, aggression, negativism, and regression Rare for toddlers to fake pain <u>Verbal responses concerning pain are unreliable</u>
<u>Death</u>	Understanding of death still very limited Belief that death is temporary reinforced by: Developing sense of object permanence Repeated experiences of separations and reunions Magical thinking <u>TV shows and cartoons</u>
<u>Interventions</u>	Always explain what you do before you start Use play in explanation Involve parents in procedures and education of procedures Use firm, direct approach Use distraction techniques Give one direction at a time. Prepare child shortly before procedure Allow choice when possible Safety Interventions: Use equipment specific to size and age of child as defined in department standards <u>Provide safe environment; use side rails, make sure toys do not have removable parts and check for safety approval</u>

## School Age Years 1-12

### Pre-school 3-5 Years

<u>Physical</u>	Gains weight and grows 2-2 ½ inches per year <u>Becomes thinner and taller</u>
<u>Motor/</u>	Skips and hops
<u>Sensory</u>	Roller skates, jumps rope Dresses and undresses self Prints first name Draws person with six major parts <u>Throws and catches ball at around 5 years</u>
<u>Cognitive</u>	Able to classify objects, enjoys doing puzzles Understands numbers, can count Constructs sentences, asks “why” questions Knows phone number and address Attention span is short Ritualistic, likes routines <u>Likes to play “make believe”</u>
<u>Psychosocial</u>	Significant persons are parents, siblings and peers Increasing independence starts to assert self, likes to boast and tattle Behavior is modified by rewards and punishment Plays cooperatively, able to live by rules, capable of sharing May be physically aggressive Learns appropriate social skills <u>At 5 year, uses sentences, knows colors, numbers and alphabet</u>
<u>Pain</u>	Pain perceives as punishment for bad thoughts or behavior Difficulty understanding that painful procedures help them get well Cannot differentiate between “good” pain as a result of treatment and “bad pain”, resulting from injury or illness <u>Reacts to painful procedures with aggression and verbal reprimands, “I hate you”, “You’re mean”</u>
<u>Death</u>	Incomplete understanding of death fosters anxiety due to fear of death Death seems an altered state of consciousness in which person cannot perform normal activities such as eating or walking

Perceive immobility, sleep, and other alterations in consciousness as death-like states and phrases, “put to sleep”, with death

Death seen as reversible, reinforced by TV, cartoons

Unable to perceive inevitability of death due to limited time concept

Views death as punishment

Interventions

Explain procedures to child, using correct terms, include parents

Explain the equipment

Plan for a longer teaching session than with the toddler

Child will enjoy games, rewards, and praise

Allow child to have some control, explain unfamiliar objects

Consider elimination needs

Provide nutrition, as appropriate. May be picky eater

Safety Interventions

Provide safe environment, do not leave unattended

Use equipment specific to size and age, as defined in department standards

**School Age Years 1-12**

**Child 6-12**

Physical

Permanent teeth erupt

Growth is slow and regular

May experience “growing pains” with bone growth and stretching of muscles

May experience fatigue

May experience pubescent changes

Motor/

Uses Knife, common utensils, and tools

Sensory

Cares for pets

Draws, paints

Makes useful articles

Assists in household chores

Likes quiet as well as active games

Cognitive

Comprehends and can tell time

Starts to think abstractly and to reason

Proud of school accomplishments

Enjoys reading

Starts to view things from different perspectives

Increased attention span and cognitive skills

Functions in the present

Needs limits and rules defined

Psychosocial

Significant persons are peers, family, and teachers

Prefers friends to family

Works hard to be successful in what he or she does

Belonging and gaining approval of peer group is important

Explores neighborhood

Uses phone

Plays games with rules

Pain

Reaction to pain affected by past experiences, parental/caregiver response, and the meaning attached to it

Better able to localize and describe pain

Pain can be exaggerated because of heightened fears of bodily injury, pain and death

Death

Concept of death more logically based

Understands death as the irreversible cessation of life

View death as tragedy that happens to others and not themselves

When death is actual threat, may feel responsible for death and experience guilt

Interventions

Explain procedures to child using correct terms, include parents

Explain the equipment, plan for a longer teaching session

Child will enjoy reward and praise

Allow child to have some control

Plan in advance for procedures to decrease child’s waiting time. Involve child whenever possible

Provide nutrition as appropriate

Provide for privacy. Allow for emotional needs in planning care or procedures  
Safety Interventions  
Plan for mobility and functional needs, as identified in assessment goals, that are appropriate to age and motor skills  
Provide equipment appropriate for size and age

### **Adolescent Years 13-18**

<u>Physical</u>	Rapid growth of skeletal size, muscles masses, adipose tissue, and skin Maturation of the reproductive system; development of primary and secondary sexual characteristics Onset of menarche in girls and nocturnal emissions in boys <u>Vital signs approximate those of the adult</u>
<u>Motor/ Sensory</u>	Awkward in gross motor activity in early adolescence Easily fatigued Fine motor skills are improving <u>Early adolescence may need more rest and sleep</u>
<u>Cognitive</u>	Increases ability to use abstract thought and logic Able to use introspection Develops more internal growth and self-esteem <u>Beginning development of occupational identity, what I want to be</u>
<u>Psychosocial</u>	Interested and confused by own development Often critical of own features and concerned with physical appearance “Friend” and belonging to peer group are important and valued; may criticize parents Interested in the opposite sex; achieving female/male role Accepts criticism or advice reluctantly Longs for independence but also desires dependence Achieves new and more mature relations Develops physical activities that are socially determined <u>Identity is threatened by hospitalization, as adolescents are concerned about bodily changes</u>
<u>Pain</u>	Can locate and quantify pain accurately Often hyper-responsive to pain; reacts to fear of changes in appearance or function <u>In general, highly controlled in responding to pain and painful procedures</u>
<u>Death</u>	Understanding of death similar to adult Intellectually believe that death can happen to them, but avoid realistic thoughts of death <u>May adolescents defy possibility of death through reckless behavior, substance abuse, or daring sports activities</u>
<u>Interventions</u>	Explain procedure to adolescent and parents using correct terminology Supplement explanations with reasons for “Why?” Encourage questions regarding “fears” Provide for privacy Involve in decision-making and planning Provide nutrition, as appropriate Include patient in discussion of care Provide for communication needs Plan for mobility and functional needs, as identified in assessment goals, that are appropriate to age and motor skill <u>Provide equipment appropriate for size and age</u>

### **Adult Years 19-65**

<u>Physical</u>	Growth of skeletal systems continues until age 30; bone mass begins to decrease Skin begins to lose moisture and elasticity Calcium loss especially after menopause Muscular efficiency is at its peak between 20-30 years Decreased muscle strength and mass if not used: endurance declines in later years (45+) GI system decreases secretions after age 40 In later years (45+), may be more prone to infection <u>In later years (45+), receding hairline in males, more facial hair in females</u>
<u>Motor/ Sensory</u>	Visual changes in accommodation and convergence Some loss in hearing, especially high tones In later years (45+), slowing of reflexes

Muscle activity may increase or decrease  
Visual changes, especially farsightedness  
Noticeable loss of hearing and taste  
Muscles and joints respond more slowly  
Decreased balance and coordination  
More prolonged response to stress

Cognitive

Mental abilities reach a peak during the twenties (reasoning, creative imagination in skills)  
In later years (45+), mood swings  
Decreased short-term memory or recall  
Re-evaluation of current life style and value system  
Synthesis of new information is decreased  
Decrease in mental performance speed

Psychosocial

Searching and finding a place in society  
Initiating a career, finding a mate, developing loving relationships, marriage  
Begins to express concerns for health  
Achievement oriented, working up the career ladder  
Moves from dependency to responsibility  
In later years (45+), responsible for children and aging parents  
Future oriented or self-absorbed  
May experience empty nest syndrome expressed positively or negatively  
Adjustment to changes in body image  
Mid-life crisis  
Recognition of limitations  
Adjustment to possibility of retirement  
Measures accomplishment against goals

Pain

Assess and manage pain based on needs and responses

Death

Leading causes of death, ages 19-45: MVA, homicide, suicide, heart disease, sexually transmitted diseases  
Leading causes of death, ages 46-59: heart attack, stroke, lung cancer, breast cancer, cirrhosis, COPD, hypertension

Intervention

Provide education to patient and/or significant others based on learning needs  
Goals are defined following assessment of function  
Provide for special communication needs  
Provide plan to meet discharge needs as identified per discharge assessment  
Provide for information on community services  
Allow for cultural and religious beliefs in providing services  
Involve patient in decision-making and development plan for treatment and care  
Provide for privacy and confidentiality of patient information  
Provide nutrition, appropriate  
Encourage questions regarding “fears”  
Safety Interventions  
Explain equipment used  
Provide for mobility  
Discharge planning needs may include having functional needs met for patient to return to work environment

**Late Adulthood Years Older than 65**

Physical

Decreased tolerance to heat and cold  
Decreased peripheral circulation  
Declining cardiac and renal function  
Decreased response to stress and sensory stimuli  
Atrophy of reproductive organs  
Loss of teeth leading to changes in food intake  
Loss of skin elasticity and ability to store fluids; dehydration  
More skeletal changes

Motor/

Sensory

Decreased visual acuity  
Hearing loss  
Decreased sensitivity to taste buds and smell  
Decreased tolerance to pain

<u>Cognitive</u>	Hesitant to respond; skills declining Decline depends upon earlier cognitive abilities, general health, and involvement in society Sharing wisdom with others
<u>Psychosocial</u>	<u>Decrease in memory, slowing of mental functions</u> Retirement Death of spouse and friends, acceptance of death Adapting to change of social role Developing supportive relationships Pursuing second career, interest, hobbies, community activities, leisure activities Coming to terms with accomplishments Children leave home; re-establishes as a couple; grand parenthood Concern for health increases
<u>Pain</u>	Assess and manage pain based on needs and response Decreased tolerance to pain <u>Narcotics with a long half-life may present side effects, which are increased in the elderly</u>
<u>Death</u>	Chronic conditions Cardiovascular disease Cancer Diabetes Acute and chronic respiratory disease Gastrointestinal problems <u>Remain alert for depressive symptoms, suicide, risk for falls, changes in cognitive functions</u>
<u>Interventions</u>	Provide education as identified on patient assessment of learning ability Speak distinctly due to loss of ability to discriminate sounds Focus light directly on any objects due to decrease visual acuity. Slow paced presentation Change positions slowly due to decreased circulation Allow for frequent bathroom breaks Ensure patient warmth Involve patient in decision-making and control of plan for care Discharge needs may include functional needs in returning to work Assess skin integrity Involve family with care Provide privacy Provide nutrition, may desire or need snacks Safety interventions Keep environment safe May become disoriented at night Be aware of the risk of multiple medications Teach medication side effects/toxicity <u>Take frequent breaks if fatigued</u>

## #12 Pain Management

### Types of Pain

#### Acute

- Serves as a warning signal to the body
- Duration <6 months
- Usually a single, fixable cause
- Subsides as healing occurs
- Input from nociceptors which are peripheral pain receptors
- May be associated with autonomic nervous system responses
- Treatment focused on cause of pain

#### Chronic

- Duration >6 months
- Pain persist beyond “usual course of an acute disease”

- Difficulty to identify cause
- No known nociceptive input
- Pain may continue for remainder of life
- Treatment focused on pain reduction

**Nociceptive versus Neuropathic pain**

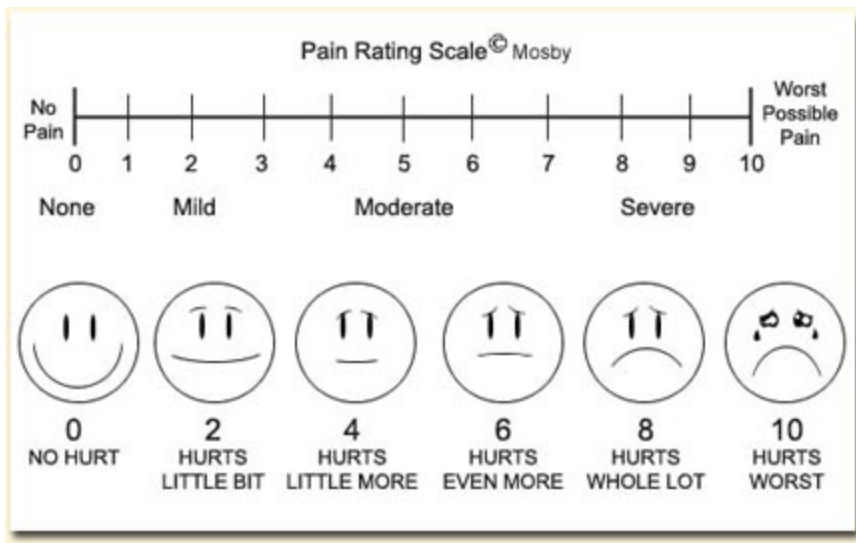
*Nociceptive pain* is the normal processing of stimuli that damage normal tissue or has the potential to do so if prolonged. Can be somatic or visceral. Somatic pain arises from bone, joint, muscle, skin or connective tissue, is usually described as aching or throbbing, and is well-localized. Visceral pain arises from visceral organs such as the GI tract and pancreas. It is described as aching, cramping and is poorly localized.

*Neuropathic pain* is the abnormal processing of sensory input by the peripheral or central nervous system.

**Consequences of Pain**

- Breakdown of body tissue
- Water retention
- Increased blood glucose and prevention of glucose utilization
- Increased heart rate and myocardial oxygen needs
- Depressed immune system
- Decreased cough leading to atelectasis, retention of secretions, pneumonia
- Increased blood pressure
- Decreased gastric motility
- Muscle tension
- Increased thromboembolic risk
- Increased post-op morbidity
- Increased length of stay
- Increased risk for chronic pain syndromes
- Decreased quality of life

**Pain Scale**



**FLACC Pain Scale:**



The FLACC Pain Scale can be used with infant and pediatric patient's age 0-3 years, cognitively impaired patients, and those patients unable to use other scales.

- Access the patient in each area, total the score, and evaluate the total using the 0-10 pain scale parameters.

<b>Categories</b>	<b>Score</b>	<b>Description</b>
FACE	0	No particular expression or smile, eye contact and interest in surroundings
	1	Occasional grimace or frown, withdrawn, disinterested, worried look face, eyebrows lowered, eyes partially closed, cheeks raised, mouth pursed
	2	Frequent to constant frown, clenched jaw, quivering chin, deep furrows on forehead, eyes closed mouth opened, deep lines around nose/lips
LEGS	0	Normal position or relaxed
	1	Uneasy, restless, tense, increased tone, rigidity, intermittent flexion/extension of limbs
	2	Kicking or legs drawn up, hypertonicity, exaggerated flexion/extension of limbs, tremors
ACTIVITY	0	Lying quietly, normal position, moves easily and freely
	1	Squirming shifting back and forth, tense, hesitant to move, guarding, pressure on body part
	2	Arched, rigid, or jerking, fixed position, rocking, side to side head movement, rubbing of body part
CRY	0	No cry/moan (awake or asleep)
	1	Moans or whimpers, occasional cries, sighs, occasional complaint
	2	Crying steadily, screams, sobs, moans, grunts, frequent complaints
CONSOLABILITY	0	Calm, content, relaxed, does not require consoling
	1	Reassured by occasional touching, hugging, or 'talking to'. Distractible
	2	Difficult to console or comfort

Each of the five categories (F) Face; (L) Legs; (A) Activity; (C) Cry; (C) Consolability is scored from 0-2, which results in a total score between zero and ten

### Nurses Role in Pain Management

The number one reason for poor pain management is poor assessment. Pain assessment should follow the WILDA acronym and include the following:

- Words to describe pain
- Intensity of pain using scale above
- Location of pain
- Duration of pain
- Aggravating and alleviating factors

Other causes of poor pain management include:

- Physician's under-prescribing pain medications
- Nurses under medicating
- Patient under-reporting pain

<b>Pain Management Principles</b>	<b>Birth - 12 Mths</b>	<b>Toddler 12-36 Mths</b>	<b>Preschool 3-6 Years</b>	<b>School Age 6-12 Years</b>
Pain Management	Infant's reflex to pain is greater and more prolonged than that of adults and because the sensory nerve cells are linked to larger areas of skin, they feel pain over a greater area of their bodies. pain in newborns is often unrecognized and untreated.	Infants can metabolize opioids similarly to older children. A child's tolerance for pain increases with age	3 year olds can use pain scales and 4 year old's can point to pain source Children often demonstrate increased behavioral signs of discomfort with repeated painful procedures.  Educate child about pain before procedure  Guided imagery – have child talk/write about a pleasurable experience.	
Emotional Needs	Giving medication on	Medication is not candy	Medication is not candy	Medication is not

	an empty stomach may avoid spitting up give after medication administration	or punishment. Do not injection in child's safe zone, i.e., bed, parents lap	or punishment. Carefully restrain Give medication promptly after telling child about treatment	candy or punishment. Give medication promptly after telling child about treatment
Medication Administration	Assessing pain in neonates is available through different pain management tools See Neonatal or Infant Pain Scale Up to 1.5ml given in rectus femoris site (anterior thigh) Non pharmacological interventions may include: swaddling holding, facilitated tucking, pacifier, decrease in stimuli, repositioning, increased rest periods.	Up to 1.5ml given in recutus femoris site (anterior thigh)	Up to 0.5ml can be given indeltoid. Up to 1.5ml given in rectus femoris site (anterior thigh) Up to 2.0ml given in vastus lateralis (lateral thigh) Check tubing frequently for kinking or disconnection	All injection sites can be used check tubing frequently for kinking or disconnection
	<b>Adolescent 13-18 Years</b>	<b>Adult 19-69 Years</b>	<b>Geriatric 70 Years</b>	
Pain Management	Pain may not be possible to identify and therefore early use of analgesics is now advocated for patients with acute abdominal pain		Elderly patients often underreport pain  Drugs are absorbed more slowly in the elderly due to increased gastric pH, decreased intestinal blood flow and increased gastric emptying time Drugs remain and act longer due to decrease in lean body mass and decreased total body water Metabolism is decreased due to decreased liver mass, enzyme activity and hepatic blood flow Decreased excretion and elimination of medications due to decreased renal blood flow, creatinine clearance and golmerular filtration rate <i>"Start low and go slow"</i> with opioids Avoid IM injections Avoid Aspirin use Avoid Demerol and Darvon due to toxic metabolite Build up Use NSAID's with caution Educate patient about pain	
	<b>Adolescent 13-18 Years</b>	<b>Adult 19-69 Years</b>	<b>Geriatric 70 Years</b>	
Emotional Needs	Major concern is compliance with medication schedules Teaching about prescription drugs, illegal drugs and alcohol	Education on the medication and interaction with other foods/meds is imperative	Visual deficits may hinder reading medication labels  Older people may share medications  Drug misuse can occur when medications are saved for "later" Fixed income adults may stress which medication to fill	
Medication Administration	All IM/Sub q sites may used	All IM/Sub q sites may used Obese adults may require longer needle to avoid the IM	All IM/Sub q sites may be used  Risk for toxicity is increased because of altered renal and hepatic functioning	

medication being  
sub q

Decreased salivation and elasticity of oral mucosal  
areas may result in dry mouth and delayed  
esophageal clearance, which may impair swallowing

The dorso gluteal site  
is the least desired as the  
thick layer of fat may  
deposit the medication  
in the sub q space.

Thin adults may require  
pinching skin and injecting  
needle below to insure  
sub-q delivery

### Neonatal or Infant Pain Scale (NIPS)

After a procedure is performed, and the infant returned to the pre-procedure state, assess the pain in 30 seconds after the procedure and use a pain scoring scale

- 0-4 Minimal to no pain with no interventions required
- 5-6 Minimal to moderate pain requiring non-pharmacological intervention with a reassessment within 30 minutes
- 7 Moderate to severe pain requiring non-pharmacological intervention and notification of the MD for further intervention.  
Reassess within 30 minutes

It is assumed that the procedure hurts and you are assessing for continued pain or relief of pain. Baseline pain assessment should also be done with the NIPS. NIPS can be utilized for infants up to 18-24 months of age.

### Neonatal or Infant Pain Scale (NIPS)

Behavior Indicator	0	1	2
Facial Expression	Relaxed muscles Natural expression	Tight facial muscles, furrowed brow, chin, jaw	
Cry	Quiet-not crying	Mild moaning, intermittent cry	Loud scream, rising shrill continuous
Breathing Pattern	Relaxed	Changes in breathing: irregular faster than usual, gagging, breath holding	
Arms	Relaxed, no muscular rigidity, occasional random movement of arms	Flexed/extended tense, straight arms, rigid and/or rapid extension/flexion	
Legs	Relaxed, no muscular rigidity, occasional random movement of legs	Flexed/extended, tense, straight legs, rigid and/or rapid extension/flexion	
State of Arousal	Sleeping/awake, quiet Peaceful, sleeping, alert and settled	Fussy, alert and restless, thrashing	

### General Pain Management Principles

- It's easier to treat pain before it becomes severe
- Pain that is present > 12 hours should be treated with around the clock (ATC) dosing, not PRN dosing
- Oral pain medication should be administered whenever possible
- IV pain medications should be used initially for post-op if the patient cannot tolerate oral meds.
- IM pain medications are not recommended – they are painful, may cause tissue damage and have a variable rate of absorption
- Combination medications (e.g. Percocet or Vicodin) are useful since they work on the peripheral and central nervous system
- Attempt to determine the type of pain the patient is experiencing.
- NSAIDS are appropriate for somatic pain

## # 13 Critical Thinking/Chain of Command

Critical thinking is the responsibility of the healthcare team.

- Entails purposeful, outcome-directed thinking
- Is driven by patient, family and community needs

- Is based on principles of nursing process and scientific method
- Requires knowledge, skills and experience
- Is guided by professional standards and ethics codes
- Requires strategies that maximize utilize individual strengths and compensates for problems created by human nature
- Is constantly reevaluating, self correcting, and striving to improve.

Critical thinking is the responsibility of all individuals comprising the healthcare teams. Critical thinking is a continuous and sometimes revolving process.

#### **CRITICAL THINKING/CHAIN OF COMMAND**

- Identify a Problem
- Look at the Signs & Symptoms of the Problem
- Immediate Interventions Initiated
- What Potential Causes Lead to the Problem?
- Additional Interventions Initiated
- Assessment of Interventions Effectiveness
- Notification of Physician/Additional Orders?
- Additional Orders/Interventions Initiated
- Assessment of Interventions Effectiveness
- Documentation of Event, Interventions, Patient Response
- Does this outcome require the involvement of:
- Charge RN? Director? Risk Manager? CNO?
- Sentinel Event?
- Root Cause Analysis
- Reflection on Previous events
  - What lead to this problem?
  - Were interventions prioritized appropriately?
  - Were the interventions effective?
  - What could have been done differently?
  - Was something missed that might have helped choosing a more effective action?
- **Ask Why with Every Step and Every Process**
- **Known Outcome**
- **Unknown Broken Processes**

### **#14 2024 NATIONAL PATIENT SAFETY GOALS**

The National Patient Safety Goals are derived primarily from informal recommendations made in the Joint Commission's safety newsletter, Sentinel Event Alert. The Sentinel Event database, which contains de-identified aggregate information on sentinel events reported to the Joint Commission, is the primary, but not the sole, source of information from which the Alerts, as well as the National Patient Safety Goals, are derived.

NPSG.01.01.01 Use at least two ways to identify patients. For example, use the patient's name and date of birth. This is done to make sure each patient gets the correct medicine and treatment.

#### **Improve staff communication**

NPSG.02.03.01 Get important test results to the right staff person on time.

NPSG.03.04.01 Before a procedure, label medicines that are not labeled. For example, medicines in syringes, cups and basins. Do this in the area where medicines and supplies are set up.

NPSG.03.05.01 Take extra care with patients who take medicines to thin their blood

NPSG.03.06.01 Record and pass along correct information about a patient's medicines. Find out what medicines the patient is taking. Compare those medicines to new medicines give to the patient. Give the patient written information about the medicines they need to take. Tell the patient it is important to bring their up-to-date list of medicines every time they visit a doctor.

#### **Use alarms safely**

NPSG.06.01.01 Make improvements to ensure that alarms on medical equipment are heard and responded to on time

**Prevent infection**

NPSG.07.01.01 Use the hand cleaning guidelines from the Centers of Disease Control and Prevention or the World Health Organization. Set goals for improving hand cleaning.

**Identify patient safety risks**

NPSG.15.01.01 Reduce the risk for suicide

**Improve health care equity**

NPSG.16.01.01 Improving health care equity is a quality and patient safety priority. For example, health care disparities in the patient population are identified and a written plan describes ways to improve health care equity.

**Prevent mistakes in surgery**

UP.01.01.01 Make sure that the correct surgery is done on the correct patient and at the correct place on the patient's body

UP.01.02.01 Mark the correct place on the patient's body where the surgery is to be done

UP.01.03.01 Pause before the surgery to make sure that a mistake is not being made

## #15 STANDARDS OF CONDUCT

It is the responsibility of every member of Professional Staffing's clinical field staff to exercise appropriate judgment, and conduct themselves in a manner that reflects the highest standards of professional and personal ethics and behavior

**Professional Staffing Employee Responsibilities**

Professional Staffing Employee is and shall be duly licensed to practice his/her profession in any State where Professional Staffing Field Employee is assigned and shall maintain current professional standing at all times. Evidence of such licensing shall be

submitted to Professional Staffing prior to commencing the Assignment. Professional Staffing Field Employee agrees to give immediate notice to Professional Staffing in the case of suspension or revocation of his/her license, initiation of any proceeding that could result in suspension or revocation of such licensing, or upon the receipt of any notice or any other matter which may challenge or threaten such licensing.

Professional Staffing Field Employee agrees to submit to Professional Staffing, before commencing any Assignment, all requested documentation that is necessary to comply with Joint Commission, Client and Professional Staffing expectations 10 days prior to Assignment start date in Assignment Detail.

Professional Staffing Field Employee agrees to and shall observe and comply with the applicable policies, procedures, rules and regulations established by Client.

Professional Staffing Field Employee agrees to work all scheduled shifts as directed by Client (including weekends and holidays).

Professional Staffing Field Employee agrees to adhere fully with all quality assurance, peer review, risk management program or other programs that may be established by Client to promote appropriate professional standards of medical care. Professional Staffing Field Employee agrees to accept both clinical and operational supervision from his/her immediate supervisor.

Professional Staffing Field Employee agrees that patient records and charts shall at all times remain the property of the Client. Professional Staffing Field Employee agrees to maintain the confidentiality of all information related to patient records, charges, expenses, quality assurance, risk management or other programs derived from, through, or provided by clients and all information related to this Agreement.

Professional Staffing Field Employee agrees to immediately provide written notice to Professional Staffing as to any legal proceeding instituted or threatened, or any claim or demand, made against Professional Staffing Field Employee or Professional Staffing with respect to Professional Staffing Field Employee's rendering of services under this Agreement.

Professional Staffing Field Employee agrees to notify Client of any unscheduled absence at least two (2) hours prior to beginning a shift and to notify Professional Staffing within twenty-four (24) hours to report the unscheduled absence.

Any injury or illnesses suffered by Professional Staffing Field Employee must be reported to a Professional Staffing representative within 24 hours of the incident. If injury occurs while working, notify your supervisor immediately, and if applicable, seek appropriate medical attention and follow the Client's specific injury procedures.

Employee agrees not to disclose any Professional Staffing trade secrets or any confidential or proprietary information of Professional Staffing, Professional Staffing employees, Clients, or patients of Clients. Professional Staffing Field Employee further agrees not to compete either as a direct competitor or with a competing company at the Client assignment where Professional Staffing Field Employee has been placed by Professional Staffing for a term of six (6) months after Professional Staffing Field Employee's final day of work at Client.

## **#16 CUSTOMER SERVICE**

It is important for all Professional Staffing nurses to promote our culture of service excellent while on assignment at a client facility. Every time you interact with a customer and patient, you are representing Professional Staffing.

### Behaviors of Exceptional Customer Service

1. Take pride and joy in creating a positive experience
2. Smile and be friendly.
  - a. Make eye contact
  - b. Give a genuine warm greeting, using patient/customer name when possible
  - c. Be positive, talk positively
  - d. Respect patients and co-workers
  - e. Take ownership: you are responsible for safety, cleanliness and confidentiality
  - f.

### Standards of Service Excellence

1. Use L.E.A.P: if you receive a patient complaint, OWN IT!
  - a. L- Listen
  - b. E- Empathize
  - c. A- Ask questions
  - d. P- Produce a solution
  - e.
2. Customer perceptions are reality: Deliver service the customer wants (not what you think they want)
3. Provide SMART feedback to team members. Everyone wants feedback. Build positive relationships with coworkers by recognizing their strengths, successes and weaknesses. Be:
  - a. S- Sensitive
  - b. M- Meaningful
  - c. A- Accurate
  - d. R- Reinforcing
  - e. T- Timely

## **#17 SUSPECTED ABUSE: IDENTIFICATION, TREATMENT AND REPORTING**

### ELDER/ADULT ABUSE

With an elderly person (65 years of age or older) or disabled adult (18 years of age or older), abuse means the willful infliction of injury, unreasonable confinement, intimidation, or cruel punishment with resulting physical harm or pain or mental anguish or the willful deprivation by a caretaker or one's self of goods or services which are necessary to avoid physical harm, mental anguish, or mental illness.

### SIGNS AND SYMPTOMS OF ELDER/ADULT ABUSE

- Patient or family member states that abuse is happening in the home
- Explanation for injuries is inconsistent with the injury
- Family or caregiver attempts to conceal injury
- Indications that someone is exploiting patient's finances or property

- Delay in seeking treatment
- Multiple bruises or injuries in various stages of healing
- Human bite marks
- Burns especially on back or buttocks
- Bruises in the shape of a hand or fingers
- Patient's behavior changes in the presence of the family or caregiver

### CHILD ABUSE

With a child (under 18 years of age), abuse includes:

1. Mental or emotional injury that results in an observable and material impairment in the child's growth, development, or psychological functioning;
2. Causing or permitting the child to be in a situation in which the child sustains a mental or emotional injury that results in an observable and material impairment.
3. Physical injury that results in substantial harm to the child or the genuine threat of substantial harm from physical injury to the child
4. Failure to make a reasonable effort to prevent an action by another person that results in substantial harm to the child;
5. Sexual contact, sexual intercourse, or sexual conduct;
6. Failure to make a reasonable effort to prevent sexual contact, sexual intercourse, or sexual conduct.

### SIGNS AND SYMPTOMS OF CHILD ABUSE

- Burns on the soles of the feet (from forced standing in hot places)
- Burns on buttocks, thighs, hands or feet (from submersion in hot water)
- Explanation for injury does not match developmental stage (for example, caregiver explains a broken leg by saying the patient fell down, but the patient is too young to stand up)
- Evidence of sexually transmitted disease
- Bruising or tearing around the genital area

### NEGLECT

With an adult, neglect means failure to provide...the goods or services, which are necessary to avoid physical harm, mental anguish, or mental illness.

With a child, neglect includes leaving the child in a situation where the child would be exposed to a substantial risk of harm, i.e., and failure to seek or follow through with medical care, failure to provide food, clothing, or shelter.

### SIGNS AND SYMPTOMS OF ELDER/ADULT NEGLECT, INCLUDING SELF-NEGLECT

- Malnutrition
- Dirty, unkempt
- Unattended medical conditions
- Alcohol or substance abuse by caretakers

### SIGNS AND SYMPTOMS OF CHILD NEGLECT

- Chronic truancy (caregivers do not send child to school)
- Failure to thrive (unexplained weight loss)
- Unexplained delay in development
- Accidental injuries that suggest poor supervision.

### SPOUSAL PARTNER/VIOLENCE

Spousal/partner violence involves the situation where a victim has been involved in an intimate, romantic or spousal relationship with the perpetrator. It encompasses violence against both men and women and includes violence in same-sex relationships. It consists of a pattern of behaviors that establish power over another adult

### SIGNS AND SYMPTOMS OF SPOUSAL PARTNER/VIOLENCE

Signs and symptoms of spousal/partner violence can include the usual signs and symptoms of abuse and neglect. Violence in a relation may not result in physical evidence. For example, the abuser may deny the victim the ability to communicate with friends or relatives. The abuser may abandon the victim in a dangerous place, refuse help when sick or injured or prohibit access to money or other basic necessities.

### EXPLOITATION

The illegal or improper act or process or a caretaker using the resources of an elderly or disabled person for monetary or personal benefit, profit, or gain.

- The treatment team may identify possible history of abuse, neglect, or exploitation
- Any staff member suspecting child and or adult abuse and/or neglect is required to report suspicions according to local law and the rules and regulations of the state's Department of Human Services (DHS) or appropriate agency. If clarification is necessary concerning the criteria for reporting in Adult Protective Supervisor will occur without disclosing the identity of the patient and/or family.
- The report to DHS may be made orally or in writing. It shall include:
  - a) The name, age, and address of the person
  - b) The name address of the person responsible for care
  - c) The nature and extent of the person's condition
  - d) The basis of the reporter's knowledge
  - e) Any other relevant information
  - f) Documentation shall occur in the appropriate section of the patient record.
- If circumstances allow, the reporting procedure will be discussed with the patient and/or family involved, prior to the report being made. Consent will be obtained if deemed appropriately by the treatment team.
- Outside agency personnel requesting information about the family should be referred to the patient's physician or other appropriate staff.
- Any act of omission is reportable. A reportable suspicion includes a child victims or abuse shall be documented in the appropriate section of the medical record.
- Symptoms resulting from abuse will be addressed by the patient's treatment team.
- Documentation of physical marking should include photographic documentation (with appropriate patient identification) and included in the appropriate portion of the patient's medical record.
- Any other evidentiary material of abuse released by the patient will be included in the appropriate portion of the patient's medical record.
- Adult patients shall be given information regarding legal counsel
- Physical injuries requiring medical attention will be treated as deemed necessary by the patient's physician.

#### ABUSE REPORTING

All healthcare practitioners are mandated reporters. Social workers are not on site 24 hours/day, so practitioners need to know appropriate procedures to take when abuse is suspected. Failure to report child, spousal or elder abuse or neglect is a misdemeanor punishable by up to six months in jail and a \$1000 fine. The law requires that the suspected abuse be reported immediately by telephone and followed up with a written report within 26 hours. In order to recognize these situations, it is important to know signs and symptoms of abuse.

Suspected abuse, neglect and/or exploitation should be reported directly to the Nurse Manager/Nurse Director/Charge Nurse and should include:

- a. A description of the incident
- b. To whom the incident happened
- c. When the incident occurred
- d. Where the incident occurred
- e. Who was responsible for the neglect/abuse

### **#18 UNDERSTANDING CULTURAL DIVERSITY**

Ineffective culturally diverse relations can lead to prejudice, discrimination and racism. All three are due to a combination of factors.

- Lack of understanding of culturally diverse groups other than one's own.
- Stereotyping of members of culturally diverse groups without consideration of individuals within the group.
- Judgment of culturally diverse groups according to standards /values of one's own group.
- Assigning of negative attributes to the members of other culturally diverse groups.
- View of the quality and experience of other groups as inferior to those of one's own group.

#### ETHNOCENTRISM



Because culture influences people so strongly including the way they feel, think, act, and judge the world is not typical for people to subconsciously restrict their view of the world to the point of inability to accept other cultures. This is called ethnocentrism.

Ethnocentrism can prevent one from accepting others and can lead to clash of values, shaky interpersonal relationships and poor communication.

#### APPROACHES TO MINIMIZE CULTURAL CONFLICTS IN THE MEDICAL SETTING

- Deliver patient care that emphasizes the interrelationships among persons, cultures, health and medicine.
- Facilitate the medical employees/clients relationship through the development of special resources such as translators and multicultural workforce.
- Establish norms allowing family involvement in the healing process.
- Identify and increase knowledge about non-traditional community resources such as local herbalist or specialty stores.
- Explain community health practices to clients and assess their level of acceptance.
- Include cultural diversity concept in the education of medical personnel and the orientation of hospital employees.

#### CROSS CULTURAL COMMUNICATION FOR HEALTHCARE EMPLOYERS

In the business of healthcare, 90% of activities involve communication. Achieving effective communication is a challenge to managers even when the workforce is culturally homogenous. Communication is the exchange of meaning. Communication includes any behavior that another human being perceives and interprets. The meaning interpreted by the receiver may be different from the information being conveyed by the communicator. Translating meanings and behaviors, that is into meaning is based on a person's cultural background and is not the same for each person. The greater the differences in backgrounds between the sender and the receiver the greater the difference in meaning attached to particular words and behaviors. Cross-cultural communication occurs when a person from one culture sends a message to a person from another culture.

There are ways to increase the chances to accurately understanding people who speak a different language.

#### VERBAL BEHAVIOR

- Speak clearly and slowly.
- Repeat each important idea.
- Use simple sentences
- Use active verbs.

#### NON-VERBAL BEHAVIOR

- Visual restatements (use pictures, graphs, etc.)
- Gestures (use facial and hand gestures).
- Demonstration: Act out the themes
- Pause, more frequently

#### ATTRIBUTION

- SILENCE: when there is silence, wait. Do not jump to fill in the silence. The other person is probably thinking.
- INTELLIGENCE: Do not equate poor grammar and mispronunciation with lack of intelligence. It is a sign of second language use.
- DIFFERENCES: If unsure, assume differences rather than similarities.

#### COMPREHENSION

- UNDERSTANDING: Do not assume that they understand. Assume that they do not
- CHECK: Have the people repeat their understanding
- BREAKS: Take more breaks, second language comprehension is exhausting.

#### MOTIVATION

- ENCOURAGEMENT: Verbally and non-verbally encourage and reinforce.
- REINFORCEMENT: Do not embarrass speakers.

### STRATEGIES TO COMMUNICATE EFFECTIVELY

Strategies to overcome our natural parochial tendencies do exist. With care, the default option can be avoided. We can learn to understand and control our own cultural conditioning. In facing foreign cultures, we can emphasize description rather than interpretation or evaluation and thus minimize self-fulfilling stereotypes and premature closure. We can recognize and use our stereotypes as guides rather than rejecting them as simplification. Effective cross-cultural communication pre-supposes the interplay or alternative realities. It rejects the actual or potential domination of one reality over another.

Miscommunication is a frequent problem in healthcare organizations. The most obvious case is when the patient and the hospital personnel do not speak the same language. Also patients and staff's may operate on different beliefs, values, clocks, causing confusion and resentment for all parties.

### TIME

When is the right time? People of different cultural background may give different answers to this question. Some people count time by a watch. They see time as money saved, spent, squandered. Others see only the rhythm or cycles of growth of people or things.

- Make allowances for the fact that differences about time can be legitimate cultural differences. Do not jump to conclusions that others are irresponsible. Do not assume that you are stupid or insensitive because you don't manage time the way they do.
- If you cannot adapt to the other person's sense of time, negotiate something that will work for both of you.
- Remember that culture runs deep. It is one thing to make an agreement and another to create a habit. Changes here will take patience, persistence with others and yourself.

### SPACE

How large space is depends on your background and culture. Getting too close may make another think you are intrusive, aggressive, or pushy. Staying too far may give them the impression that you are cold, impersonal, afraid or disinterested.

- Learn to be flexible
- Know that others may feel differently about space. Stay put and let the other people adjust to where they feel comfortable with you.

### TOUCHING

When people touch physically it means different things.

- I have power
- Hello/Goodbye
- I want you to understand
- I like you
- I want to congratulate

### COMMUNICATE

When you communicate, be aware of:

- Tone of voice
- Body posture
- Breathing rate
- Distance
- Timing and pacing of speech patterns

The purpose of performance management is to enhance the knowledge, skills and behaviors of all employees. This is accomplished by providing a means of measuring employee's effectiveness on the job; identifying areas of development where employees are in need of training, growth, improvement and/or additional resources; maintaining a high level of motivation through feedback with management and establishing individual performance goals.

### INITIAL ASSESSMENT

Upon hire, Professional Staffing's director of nursing must meet with all new hires to inform them of the competencies that must be met. For the initial assessment, the competency self-assessments will serve as the baseline assessment. Review and education for errors on any competency exams, pharmacology exams and additional examinations will also serve as areas of improvement.

### ON-THE-JOB ASSESSMENTS

Professional Staffing has implemented a continuous, systematic and coordinated approach to measure and assess hospital's feedback on all agency personnel being utilized. The following assessments are utilized to ensure employee performance and customer satisfaction:

- Initial Shift: Nurses are assessed by the charge nurse, nurse manager or hospital designee at the completion of the first shift. Assessment focuses on professionalism, safety, patient care, compliance, assessment, planning and documentation.
- Random: Nurses are assessed by the charge nurse, nurse manager or hospital designee at random. Assessment focuses on professionalism, safety, patient care, compliance, assessment, planning and documentation.

Any unsatisfactory scores will be reviewed and discussed with each nurse and methods for improvement recommended by Professional Staffing's Clinical Liaison. For more information on Professional Staffing's Progressive Discipline Program, please see Progressive Discipline Program.

### PERIODIC ASSESSMENTS

Professional Staffing's Clinical Liaison conducts annual assessments of all staff. Quarterly performance evaluations are solicited via phone calls from to review clinical performance based on client feedback. The Clinical Liaison and clients evaluate employee job performance based on the functions and standards as outlines in the job descriptions. Together, the Clinical Liaison and employee will identify strengths, accomplishments and areas for improvement and development. All hospital reviews, including initial and random assessments are also incorporated into the ninety-day and annual performance review. Employees will also update their competency self-assessments at this time.

If a Performance Plan is required, a plan identifying the performance expected will be created and will be used to gain the employee's commitment to perform to those expectations. The Clinical Liaison will provide coaching, resources and suggestions to assist the employee in working toward the performance expectations established in this phase. In the event that a Performance Plan is created, it is expected that the Clinical Liaison conduct Progress Checks, or informal reviews of performance to determine if the agreed-upon goals and objectives are being achieved, to recognize achievements, to discuss developmental needs, and/or to provide assistance in the accomplishment of performance goals.

### EMPLOYEE PERFORMANCE REVIEW

- Every healthcare professional employed by Professional Staffing, who has worked in the last year, will have an annual performance evaluation carried out by the Professional Staffing, on or around your anniversary date.
- Professional Staffing will attempt to obtain feedback from client representatives regarding clinical staff competence and ongoing performance of professional employee. Unfortunately, some clients will not cooperate with Professional Staffing in this regard, so Professional Staffing follows a competence by exception philosophy. In the absence of client feedback, unless there is evidence of a performance issue, we assume that our employees are meeting performance expectations.
- Feedback from our clients regarding clinical and/or professional performance is addressed with our employees immediately. Follow-up with our clients is completed within an appropriate time frame.
- Annual skills checklists which apply to specialty area of work will be completed by every health professional employed by Professional Staffing.
- When training needs are identified, an opportunity to complete the training will be provided at the earliest possible occasion.
- The company assesses aspects of employee's competence at hire, at performance evaluation and as needed or required by state licensing agencies, to ensure that employees have the skills or can develop the skills to perform and continue to perform their duties.
- Clinical Liaison is responsible to ensure that any areas of development are identified and addressed.

## EDUCATION

Ongoing continuing education is the responsibility of Professional Staffing employees to ensure that all clinical staff has a current knowledge and practice base. Professional Staffing maintains information on available resources for BLS, ACLS, PALS, etc. The following online education programs are also available for continuing education; however this is not an inclusive list of available resources: [www.nursetesting.com](http://www.nursetesting.com), [www.nursingspectrum.com](http://www.nursingspectrum.com), and [www.lww.com](http://www.lww.com). Evidence of continuing education and annual required in-service education are part of the ongoing competency assessment program and will be maintained in your personnel file. Please provide Professional Staffing with copies of your continuing education certificates.

## **#20 EBOLA VIRUS DISEASE (EVD)**

### **Frequently Asked Questions**

The recent EVD outbreak in West Africa has increased the possibility of patients traveling from the impacted countries to the United States. Additionally, two American citizens with EVD were medically evacuated to the United States to receive care at Emory University in Atlanta. The following are answers to frequently asked questions about the safety of this medical evacuation and the necessary infection control procedures to protect patients and healthcare providers in U.S. hospitals.

#### **Are the U.S. hospitals ready to care for patients with EVD?**

Yes – any U.S. hospital that is following CDC's infection control recommendations and can isolate a patient in a private room is capable of safely managing a patient with EVD. CDC recommends that U.S. hospitals isolate the patient in a private room and implement standard, contact, and droplet precautions.

#### **What should U.S. hospitals do if they have a patient with suspect EVD?**

Early recognition is critical for infection control. Healthcare providers should be alert for and evaluate any patients suspected of having EVD who have:

1. A fever of 38.0 degrees Celsius or 100.4 degrees Fahrenheit or greater, and additional symptoms such as severe headache, muscle pain, vomiting, diarrhea, abdominal pain, or unexplained hemorrhage

AND

2. Risk factors within the past 3 weeks before the onset of symptoms, such as contact with blood or other body fluids of a patient known to have or suspected to have EVD; residence in – or travel to – an area where EVD transmission is active; or direct handling of bats or nonhuman primates from disease-endemic areas. Malaria diagnostics should also be a part of initial testing because it is the most common cause of febrile illness in persons with a travel history to the affected countries.

#### **When should patients with suspected EVD in U.S. hospitals be tested?**

CDC recommends testing for all persons with onset of fever within 21 days of having a high-risk exposure such as:

- percutaneous or mucous membrane exposure or direct skin contact with body fluids of a person with a confirmed or suspected case of EVD without appropriate personal protective equipment (PPE)
- laboratory processing of body fluids of suspected or confirmed EVD cases without appropriate PPE or standard biosafety precautions, or
- participation in funeral rites or other direct exposure to human remains in the geographic area where the outbreak is occurring without appropriate PPE.

For persons with a high-risk exposure but without a fever, testing is recommended only if there are other compatible clinical symptoms present and blood work findings are abnormal (i.e., thrombocytopenia <150,000 cells/uL and/or elevated transaminases).

#### **If a patient in a U.S. hospital is identified to have suspected or confirmed EVD, what infection control precautions should be put into place?**

If a patient in a U.S. hospital is suspected or known to have EVD, healthcare teams should follow standard, contact, and droplet precautions, including the following recommendations:

- **Isolate the patient:** Patients should be isolated in a single patient room (containing a private bathroom) with the door closed
- **Wear appropriate PPE:** Healthcare providers entering the patient's room should wear: gloves, gown (fluid resistant or impermeable), eye protection (goggles or face shield), and a facemask. Additional protective equipment might be required in certain situations (e.g., copious amounts of blood, other body fluids, vomit, or feces present in the environment), including but not limited to double gloving, disposable shoe covers, and leg coverings

- **Restrict visitors:** Avoid entry of visitors into the patient’s room. Exceptions may be considered on a case by case basis for those who are essential for the patient’s wellbeing. A logbook should be kept to document all persons entering the patient’s room. See CDC’s infection control guidance on procedures for monitoring, managing, and training of visitors.
- **Avoid aerosol-generating procedures:** Avoid aerosol-generating procedures. If performing these procedures, PPE should include respiratory protection (N95 or higher filtering facepiece respirator) and the procedure should be performed in an airborne infection isolation room.
- **Implement environmental infection control measures:** Diligent environmental cleaning and disinfection and safe handling of potentially contaminated materials is of paramount importance, as blood, sweat, vomit, feces, urine and other body secretions represent potentially infectious materials should be done following hospital protocols.

**Why do responders in Africa wear so much personal protective equipment (that can include full body suits) for this EDV outbreak when CDC says hospitals here could safely manage the care of an EDV patient without a full body suit?**

There are important differences between providing care or performing public health tasks in Africa versus in a U.S. hospital. In field medial settings, additional PPE may be necessary to protect healthcare workers. If some places in Africa, workers may not have the ability to prepare for potential exposures. For example, in some places, care may be provided in clinics with limited resources (e.g., no running water, no climate control, no floors, inadequate medical supplies), and workers could be in those areas for several hours with a number of EDV infected patients. Additionally, certain job responsibilities and tasks, such as attending to dead bodies, may also require different PPE than what is used when providing care for infected patients in a hospital.

**How do I protect myself against EDV?**

If you must travel to an area affected by the 2014 EDV outbreak, protect yourself by doing the following:

- Wash hands frequently or use an alcohol-based hand sanitizer
- Avoid contact with blood and body fluids of any person, particularly someone who is sick
- Do not handle items that may have come in contact with an infected person’s blood or body fluids
- Do not touch the body of someone who has died from EDV
- Do not touch bats and nonhuman primates or their blood and fluids and do not touch or eat raw meat prepared from these animals.
- Avoid hospitals in West Africa where EDV patients are being treated. The U.S. Embassy or consulate is often able to provide advice on medical facilities.
- Seek medical care immediately if you develop fever (temperature of 100.4°F/38.0°C or higher) and any of the other following symptoms: headache, muscle pain, diarrhea, vomiting, stomach pain, or unexplained bruising or bleeding
- Limit your contact with other people until and when you go to the doctor. Do not travel anywhere else besides a healthcare facility

**Has the first patient to become sick in this outbreak, known as “patient zero” been identified?**

Reports in the medical literature and elsewhere have attempted to identify the patient who might have been the initial person infected in the West Africa EDV outbreak. It’s important for CDC to learn as much as it can about the source and initial spread of any outbreak.

With regard to the West Africa EDV outbreak, tracing the lineage of how EDV has spread thus far can help CDC apply that knowledge toward better prevention and care techniques. The knowledge gained in this work might entail details about specific patients. CDC generally refrains, however from identifying particular patients in any aspect of an outbreak.

**What is the protocol for the arrival of ill travelers?**

If an ill traveler arrives in the U.S., CDC has protocols in place to protect against further spread of disease. These protocols include having airline crew notify CDC of ill travelers on a plane before arrival, evaluation of ill travelers, and isolation and transport to a medical facility if needed. CDC, along with Customs & Border Patrol, has also provided guidance to airlines for managing ill passengers and crew and for disinfecting aircraft. CDC has issued a Health Alert Notice reminding U.S. healthcare workers about the importance of taking steps to prevent the spread of this virus, how to test and isolate patients with suspected cases, and how to protect themselves from infection.

**INFECTION CONTROL**

**Can hospitals in the United States care for an EDV patient?**

Any U.S. hospital that is following CDC infection control recommendations and can isolate a patient in their own room with a private bathroom is capable of safely managing a patient with EDV.

**TRAVELERS**

## **What is being done to prevent ill travelers in West Africa from getting on a plane?**

### **In West Africa**

CDC's Division of Global Migration and Quarantine (DGMQ) is working with airlines, airports, and ministries of health to provide technical assistance for the development of exit screening and travel restrictions in the affected areas. This includes:

- Assessing the ability of EDV affected countries and airports to conduct exit screening,
- Assisting with development of exit screening protocols,
- Training staff on exit screening protocols and appropriate PPE use, and
- Training in-country staff to provide future trainings.

### **During Travel**

CDC works with international public health organizations, other federal agencies, and the travel industry to identify sick travelers arriving in the United States and take public health actions to prevent the spread of communicable diseases. Airlines are required to report any deaths onboard or ill travelers meeting certain criteria to CDC before arriving into the United States, and CDC and its partners determine whether any public health action is needed. If a traveler is infectious or exhibiting symptoms during or after a flight, CDC will conduct an investigation of exposed travelers and work with airline, federal partners, and state and local health departments to traveler on a cruise or cargo ship, CDC officials work with the shipping line to make an assessment of public health risk and to coordinate any necessary response.

### **In the United States**

CDC has staff working 24/7 at 20 Border Health field offices located in international airports and land borders, CDC staff are ready 24/7 to investigate cases of ill travelers on planes and ships entering the United States.

CDC works with partners at all ports of entry into the United States to help prevent infectious diseases from being introduced and spread in the United States. CDC works with Customs and Border Protections, U.S. Department of Agriculture, U.S. Coast Guard, U.S. Fish and Wildlife Services, state and local health departments, and local Emergency Medical Services staff.

Relatively few of the approximately 350 million travelers who enter the United States each year come from these countries. Secondly, most people who become infected with EDV are those who live with or care for people who have already caught the disease and are showing symptoms. CDC and healthcare providers in the United States are prepared for the remote possibility that a traveler could get EDV and return to the U.S. while sick.

## **What do I do if I'm returning to the U.S. from the area where the outbreak is occurring?**

After you return, pay attention to your health

- Monitor your health for 21 days if you were in an area with an EDV outbreak, especially if you were in contact with blood or body fluids, items that have come in contact with blood or body fluids, animals or raw meat, or hospitals where EDV patients are being treated or participated in burial rituals.
- Seek medical care immediately if you develop fever (temperature 100.4°F/38.0°C) and any of the other following symptoms; headache, muscle pain, diarrhea, vomiting, stomach pain, or unexplained bruising or bleeding.
- Limit your contact with other people until and when you go to the doctor. Do not travel anywhere else besides a healthcare facility.

## **Are there any cases of people contracting EDV in the U.S.?**

CDC confirmed on September 30, 2014, the first travel-associated case EDV to be diagnosed in the United States. The person traveled from West Africa to Dallas, Texas and later sought medical care at Texas Health Presbyterian Hospital of Dallas after developing symptoms consistent of EDV. The medical facility has isolated the patient. Based on the person's travel history and symptoms, CDC recommended testing for EDV.

CDC recognizes that even a single case of EDV diagnosed in the United States raises concerns. Knowing the possibility exists, medical and public health professionals across the country have been preparing to respond. CDC and public health officials in Texas are taking precautions to identify people who have had close personal contact with the ill person and healthcare professionals have been reminded to use meticulous infection control at all times.

## **Is there a danger of EDV spreading in the United States?**

EDV is not spread through casual contact; therefore, the risk of an outbreak in the U.S. is very low. We know how to stop EDV's further spread; through case finding, isolation of ill people, contacting people exposed to the ill person, and further isolation on contacts if they develop symptoms. The U.S. public health and medical systems have had prior experience with sporadic cases and diseases such as EDV. In the past decade, the United States had 5 imported cases of Viral Hemorrhagic Fever (VHF) disease similar to EDV (1 Marburg, 4 Lassa). None resulted in any transmission in the United States.

## **Treatment**

No FDA-approved vaccine or medicine (e.g., antiviral drug) is available for EDV. Symptoms of EDV are treated as they appear. The following basic interventions, when used early, can significantly improve the chances of survival:

- Providing intravenous fluids (IV) and balancing electrolytes (body salts)
- Maintaining oxygen status and blood pressure
- Treating other infections if they occur

Experimental vaccines and treatments for EDV are under development, but they have not yet been fully tested for safety or effectiveness.

Recovery from EDV depends on good supportive care and patient’s immune response. People who recover from EDV infection develop antibodies that last at least 10 years, possibly longer. It isn’t known if people who recover are immune for life or if they can become infected with a different species of EDV. Some people who have recovered EDV have developed long-term complications, such as joint and vision problems.

**Diagnosis**

Diagnosing EDV in a person who has been infected for only a few days is difficult, because the early symptoms, such as fever, are nonspecific to EDV infection and are seen often in patients with more commonly occurring diseases, such as malaria and typhoid fever.

However, if a person has the early symptoms of EDV and has had contact with the blood or body fluids of a person sick with EDV, contact with objects that have been contaminated with the blood or body fluids of a person sick with EDV, or contact with infected animals, they should be isolated and public health professionals notified. Samples from the patient can then be collected and tested to confirm infection.

Laboratory tests used in diagnosis include:

<b>Timeline of Infection</b>	<b>Diagnostic tests available</b>
Within a few days after Symptoms begin	Antigen-capture enzyme-linked immunosorbent assay (ELISA) testing IgM ELISA Polymerase chain reaction (PCR) Virus isolation
Later in disease course or after recovery	I’m and Gig antibodies
Retrospectively in deceased patients	Immunohistochemistry testing PCR Virus isolation

**Prevention**

There is not FDA-approved vaccine available for EDV.

If you travel to or are in an affected by an EDV outbreak, make sure to do the following:

- Practice careful hygiene. For example, wash your hands with soap and water or an alcohol-based hand sanitizer and avoid contact with blood or body fluids.
- Do not handle items that may have come in contact with an infected person’s blood or body fluids (such as clothes, bedding, needles, and medical equipment)
- Avoid funeral or burial rituals that require handling the body of someone who has died from EDV.
- Avoid contact with bats and nonhuman primates or blood, fluids, and raw meat prepared from these animals.
- Avoid hospitals in West Africa where EDV patients are being treated. The U.S. Embassy or consulate is often able to provide advice on facilities.
- After your return, monitor your health for 21 days and seek medical care immediately if you develop symptoms of EDV.

Healthcare workers who may be exposed to people with Ebola should follow these steps:

- Wear protective clothing, including masks, gloves, gowns and eye protection.
- Practice proper infection control and sterilization measures
- Isolate patients with EDV from other patients
- Avoid direct contact with bodies of people who have died from EDV
- Notify health officials if you have direct contact with blood or body fluids, such as but not limited to feces, saliva, urine, vomit, and semen of a person who is sick with EDV. The virus can enter the body through broken skin or unprotected mucous membranes in, for example, the eyes, the nose or mouth.

### **Here in the United States, are our dogs and cats at risk of becoming sick with EDV?**

The risk of an EDV outbreak affecting multiple people in the United States is very low. Therefore, the risk to pets is also very low, as they would have to come into contact with blood and body fluids of a person with EDV. Even in areas in Africa where EDV is present, there have been no reports of dogs and cats becoming sick with EDV.

### **Can I get EDV from my dog or cat?**

At this time, there have been no reports of dogs or cats becoming sick with EDV or of being able to spread EDV to people to animals. The chances of a dog or cat being exposed to EDV virus in the United States is very low as they would have to come into contact with blood and body fluids of a symptomatic person sick with EDV.

### **Can my pet's body, fur, or paws spread Ebola to a person?**

We do not know whether or not a pet's body, paws, or fur can pick up and spread EDV to people or other animals. It is important keep people and animals away from blood or body fluids of a person with symptoms of EDV infection.

### **What if there is a pet in the home of an EDV person?**

CDC recommends that public health officials in collaboration with a veterinarian evaluate the pet's risk of exposure to the virus (close contact or exposure to blood or body fluids of an EDV patient). Based on this evaluation as well as the specific situation, local and state human and animal health officials will determine how the pet should be handled.

### **Can I get my dog or cat tested for EDV?**

There would not be any reason to test a dog or cat for EDV if there was no exposure to a person infected with EDV. Currently, routine testing for EDV is not available for pets.

### **What are the requirements for bringing pets or other animals into the United States from West Africa?**

CDC regulations require that dogs and cats imported into the United States be healthy. Dogs must be vaccinated against rabies before arrival into the United States. Monkeys and African rodents are not allowed to be imported as pets under any circumstances. Each state and U.S. Territory has its own rules for pet ownership and importation, and these rules may be different from federal regulations. Airlines may have additional requirements

### **Questions and answers about EDV and Pets**

The ongoing epidemic of EDV in West Africa has raised several questions about how the disease affects the animal population, and in particular, the risk to household pets. While the information available suggests that the virus may be found in several kinds of animals, CDC, the US Department of Agriculture, and the American Veterinary Medical Association do not believe that pets are at significant risk of EDV in the United States.

### **How are animals involved in EDV outbreaks?**

Because the natural reservoir host of EDV has not yet been confirmed, the way in which the virus first appears in a human at the start of an outbreak is unknown. However, scientists believe that the first patient becomes infected through contact with an infected animal, such as a fruit bat or primate (apes and monkeys), which is called a spillover event. Person-to-person transmission follows and can lead to large numbers of affected persons. In some past EDV outbreaks, primates were also affected by EDV, and multiple spillover events occurred when people touched or ate infected primates. In the current West African epidemic, animals have not been found to be a factor in ongoing EDV transmission.

### **How does EDV spread?**

When infection occurs in humans, the virus can be spread in several ways to others. EDV is spread through direct contact (through broken skin or mucous membranes in, for example, the eyes, nose, or mouth) with

- Blood or body fluids (including but not limited to urine, saliva, sweat, feces, vomit, breast milk, and semen) of a person who is sick with EDV



- Objects (like needles and syringes) that have been contaminated with the virus
- EDV is not spread through the air or by water, or in general, by food. However, in Africa, EDV may be spread as a result of handling bushmeat (wild animals hunted for food) and contact with infected bats
- Only a few species of mammals (for example, humans, monkeys and apes) have shown the ability to become infected with and spread EDV. There is no evidence that mosquitoes or other insects can transmit EDV.

### **Can dogs get infected or sick with EDV?**

At this time, there have been no reports of dogs or cats becoming sick with EDV or of being able to spread EDV to people or other animals. Even in areas in Africa where EDV is present, there have been no reports of dogs and cats becoming sick with EDV. There is limited evidence that dogs become infected with EDV, but there is no evidence they develop the disease.

### **Can monkeys spread EDV?**

Yes, monkeys are at risk for EDV. Symptoms of EDV infection in monkeys include fever, decreased appetite, and sudden death. Monkeys should not be allowed to have contact with anyone who may have EDV. Healthy monkeys already living in the United States and without exposure to a person infected with EDV are not at risk for spreading EDV.

### **Can bats spread EDV?**

Fruit bats in Africa are considered to be a natural reservoir for EDV. Bats in North America are not known to carry EDV and so CDC considers the risk of an EDV outbreak from bats occurring in the United States to be very low. However, bats are known to carry rabies and other diseases in the United States. To reduce the risk of disease transmission, never attempt to touch a bat, living or dead.

### **Where can I find more information about EDV and pet dogs and cats?**

CDC is currently working with the U.S. Department of Agriculture, the American Veterinary Medical Association, and many other partners to develop additional guidance for the U.S. pet population. Additional information and guidance will be posted on this website as well as partner websites as soon as it becomes available.

### **What are body fluids?**

EDV has been detected in blood and many body fluids. Body fluids include saliva, mucus, vomit, feces, sweat, tears, breast milk, urine and semen.

### **Can EDV spread by coughing? By sneezing?**

Unlike respiratory illnesses like measles or chickenpox, which can be transmitted by virus particles that remain suspended in the air after an infected person coughs or sneezes, EDV is transmitted by direct contact with body fluids of a person who has symptoms of EDV disease. Although coughing and sneezing are not common symptoms of EDV, if a symptomatic patient with EDV coughs or sneezes on someone, and saliva or mucus come into contact with that person's eyes, nose or mouth, these fluids may transmit the disease.

### **What does "direct contact" mean?**

Direct contact means that body fluid (blood, saliva, mucus, vomit, urine and feces) from an infected person (alive or dead) have touched someone's eyes, nose or mouth or an open cut, wound or abrasion.

### **How long does EDV live outside the body?**

EDV is killed with hospital-grade disinfectants (such as household bleach). EDV on dried on surfaces such as doorknobs and countertops can survive for several hours; however, virus in body fluids (such as blood) can survive up to several days at room temperature.

### **Are patients who recover from EDV immune for life? Can they get it again – the same or a different strain?**

Recovery from EDV depends on good supportive clinical care and a patient's immune response. Available evidence shows that people who recover from EDV infection develop antibodies that last at least 10 years, possibly longer.

**If someone survives EDV, can he or she still spread the virus?**

Once someone recovers from EDV, they can no longer spread the virus. However, EDV has been found in semen up to 3 months. People who recover from EDV are advised to abstain from sex or use condoms for 3 months.

**Can EDV be spread through Mosquitoes?**

There is no evidence that mosquitoes or other insects can transmit EDV. Only mammals (for example, humans, bats, monkeys and apes) have shown the ability to spread and become infected with EDV.

## **#21 EMPLOYEE CONFLICTS OF INTEREST**

A conflict of interest in healthcare can range from the most simple and obvious to extraordinarily complex.

Conflict of interest in the healthcare industry occurs when the primary goal of protection and increasing the health of patients comes into conflict with any other secondary goal, especially personal gain to healthcare professionals.

Each employee will perform his/her duties honestly, in good faith and for the benefit of the patients. Decisions must never be influenced by personal considerations or interests.

A conflict of interest arises when your outside activities influence the performance of your responsibilities in a manner contrary, or giving the appearance of being contrary.

You must be alert to any situation that may suggest even the appearance of a conflict of interest. You are expected to disclose such situations to your supervisor or Professional Staffing.

You must not accept gifts or entertainment which would give the appearance of being given to obtain favoritism.