Training Handbook for Health Care Professionals
Acknowledgement Form

The Training Handbook outlines important information regarding safety and industry-wide guidelines and standards. Information and training contained in the handbook includes, but is not limited to:

- **Training Quiz, pages 2-4 (complete & return)**
- Safety Guidelines and Practices
  - General/Environmental Safety Rules and Practices
  - Emergency Preparedness
  - Code of Ethics, Patient’s Rights and Patient Care Partnership
  - The 2018 National Patient Safety Goals
  - The Joint Commission “Do Not Use – Abbreviations List”
  - Standard Precautions / Hand Hygiene / Fingernail Policy (CDC Guidelines)
  - Bloodborne Pathogens (Exposure Control Plan / OSHA Standard)
  - Transmission Based Precautions / Fit Testing / Tuberculosis (TB)
  - Hazard Communication and Material Safety Data Sheets (MSDS)
  - Radiation, Fire and Electrical Safety
  - Back Safety / Body Mechanics
  - Physical Restraint Devices and Fall Prevention
  - Medical Device Safety
  - Sentinel Events
  - Process Improvement
  - Harassment Policy
  - Workplace Violence
  - Domestic Violence Reporting (Intimate Partner/Dependent Adult/Child and Elder Justice Act)
- Patient Care Guidelines
  - Medication Administration
  - Pain Assessment and Management
  - Skin Assessment
  - Assessment / Planning
  - Supervision / Leadership / Delegation
  - Documentation
  - Continuity of Care
  - Point of Care Testing and Informed Consent
  - Nutrition
  - Sedation / Resuscitation
  - Cultural Competence and Spirituality
  - Dementia and Alzheimer’s Awareness
- Advance Directives (End of Life Issues and Anatomical Gift Act)
- Emergency Medical Treatment and Active Labor Act (EMTALA)
- Health Insurance Portability and Accountability Act (HIPAA), Health Information Technology for Economic and Clinical Health Act (HITECH Act) and Family Educational Rights and Privacy Act (FERPA)
- Business Courtesies (i.e. Gifts and Entertainment) and Conflict of Interest
- Population (Age) Specific Guidelines

I acknowledge that I have received the Training Handbook and understand that I am required to complete this self-study program and the Training Handbook Quiz prior to beginning work and on an annual basis thereafter. I acknowledge that I have reviewed and understand the Health Information Insurance Portability and Accountability Act of 1996. I will comply with protecting the confidentiality of patient health information, abide by the HIPAA policies and not share information. (Please sign and return this page)

<table>
<thead>
<tr>
<th>Health Care Professional Signature</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Health Care Professional Name &amp; Title</th>
<th>(please print)</th>
<th>Date</th>
</tr>
</thead>
</table>
This Quiz to be Completed Annually

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Passing Score 80%</strong></td>
<td><strong>Score: _____/25 = ____%</strong></td>
</tr>
<tr>
<td>1.</td>
<td>National Patient Safety Goals are primarily based upon aggregate information on sentinel events reported to The Joint Commission:</td>
</tr>
<tr>
<td>a</td>
<td>True</td>
</tr>
<tr>
<td>b</td>
<td>False</td>
</tr>
<tr>
<td>2.</td>
<td>According to The Joint Commission–Do Not Use Abbreviation List, “Q.D.” is an acceptable abbreviation and should be used when ordering/documenting medications:</td>
</tr>
<tr>
<td>a</td>
<td>True</td>
</tr>
<tr>
<td>b</td>
<td>False</td>
</tr>
<tr>
<td>3.</td>
<td>The Standard Precautions Guidelines are designed to:</td>
</tr>
<tr>
<td>a</td>
<td>Require precautions only when the disease or infection status of a patient is known</td>
</tr>
<tr>
<td>b</td>
<td>Be used only when there is a potential of exposure to blood</td>
</tr>
<tr>
<td>c</td>
<td>Reduce the risk of transmitting infectious agents and disease</td>
</tr>
<tr>
<td>d</td>
<td>None of the above</td>
</tr>
<tr>
<td>4.</td>
<td>Personal protective equipment (PPE) consists of which of the following:</td>
</tr>
<tr>
<td>a</td>
<td>Gloves</td>
</tr>
<tr>
<td>b</td>
<td>Gown or apron</td>
</tr>
<tr>
<td>c</td>
<td>Mask and protective eyewear</td>
</tr>
<tr>
<td>d</td>
<td>All of the above</td>
</tr>
<tr>
<td>5.</td>
<td>Bloodborne pathogens that healthcare providers could possibly be exposed to while performing their duties include:</td>
</tr>
<tr>
<td>a</td>
<td>HIV, Hepatitis B, and Hepatitis C</td>
</tr>
<tr>
<td>b</td>
<td>Tuberculosis (TB)</td>
</tr>
<tr>
<td>c</td>
<td>Methicillin Resistant Staphylococcus Aureus (MRSA)</td>
</tr>
<tr>
<td>d</td>
<td>All of the above</td>
</tr>
<tr>
<td>6.</td>
<td>Which of the following is NOT one of the principles to follow to limit exposure to radiation:</td>
</tr>
<tr>
<td>a</td>
<td>Reporting</td>
</tr>
<tr>
<td>b</td>
<td>Time</td>
</tr>
<tr>
<td>c</td>
<td>Distance</td>
</tr>
<tr>
<td>d</td>
<td>Shielding</td>
</tr>
<tr>
<td>7.</td>
<td>Wearing a respirator mask (such as a N95) that has been fitted and tested will maximize protection from Mycobacterium tuberculosis (TB). OSHA requires re-evaluation by a physician and fit testing annually for these types of respirator masks:</td>
</tr>
<tr>
<td>a</td>
<td>True</td>
</tr>
<tr>
<td>b</td>
<td>False</td>
</tr>
<tr>
<td>8.</td>
<td>The “RACE” acronym stands for the following:</td>
</tr>
<tr>
<td>a</td>
<td>Rescue, Alarm, Confine and Extinguish or Evacuate</td>
</tr>
<tr>
<td>b</td>
<td>Run, And, Control, and Evacuate</td>
</tr>
<tr>
<td>c</td>
<td>Rescue, Activate, Control and Elevators</td>
</tr>
<tr>
<td>d</td>
<td>None of the above</td>
</tr>
</tbody>
</table>
9. Which of the following is NOT an example of damaged equipment:
   - a ☐ A cardiac monitor that has been turned off
   - b ☐ Frayed or cut cords or cords where the insulation has pulled away
   - c ☐ Broken cover on light switches and electrical outlets
   - d ☐ Cracked cases or housings

10. Which of the following is the leading cause of injury and sick time for health professionals:
    - a ☐ Head injuries
    - b ☐ Lower back problems
    - c ☐ Colds and viruses
    - d ☐ Assaults

11. Which of the following is NOT an important rule of good body mechanics:
    - a ☐ Have weight evenly balanced on both feet
    - b ☐ It is better to push, pull or roll than to carry something heavy
    - c ☐ It is better to lift something alone than bother another coworker to help you
    - d ☐ Lift by pushing up with your strong leg muscles

12. Misuse of physical restraints can result in injury or death. Which of the following would be considered the misuse of restraints:
    - a ☐ Applying the size of restraint based on the patient’s weight and height
    - b ☐ Applying the type of restraint based on the patient’s condition (i.e. age, disorientation)
    - c ☐ Monitoring the patient less frequently because they are restrained
    - d ☐ Tying knots that can be released quickly

13. Factors that may place health care facility workers at increased risk for violence include:
    - a ☐ Contact with the public
    - b ☐ Long waits for service and crowded waiting rooms
    - c ☐ Working with unstable or volatile persons
    - d ☐ All of the above

14. The health care worker is obligated to report known or suspected abuse to the appropriate authorities as soon as possible. Which of the following is a form of abuse:
    - a ☐ Sexual abuse
    - b ☐ Physical abuse
    - c ☐ Neglect (failure to provide for another’s basic needs)
    - d ☐ All of the above are forms of abuse

15. Pressure ulcer risk assessment (skin assessment) should be completed how often:
    - a ☐ On admission and then once daily
    - b ☐ Each shift
    - c ☐ Every 4 hours
    - d ☐ Every hour

16. An “Advance Directive” is a document stating health care choices and names someone to make choices for the patient if they become unable to do so:
    - a ☐ True
    - b ☐ False

17. Confidential Information includes all of the following EXCEPT:
    - a ☐ Patient Financial Information
    - b ☐ User ID
    - c ☐ Clinical Information
18. **What is the standard for accessing patient information:**
   - [x] A need to know for the performance of your job
   - [ ] If a physician asks you the diagnosis of the patient
   - [ ] Just because you are curious
   - [ ] You are a relative of the patient

19. **The guidelines in the Emergency Medical Treatment and Active Labor Act (EMTALA) include:**
   - [ ] What is meant by “stabilized”
   - [ ] Provisions for pregnant women in active labor
   - [ ] What to do if a patient requests a transfer
   - [x] All of the above

20. **HIPAA privacy regulations prevent patients from having access to their medical records:**
   - [ ] True
   - [x] False

21. **Population (age) specific awareness is only important for nurses and doctors:**
   - [ ] True
   - [x] False

22. **Assessment of growth and development focuses on three major areas: physical, cognitive/perceptual and psychosocial:**
   - [x] True
   - [ ] False

23. **Safety is only an important issue for neonates and infants:**
   - [ ] True
   - [x] False

24. **When assessing the geriatric client, it is important to perform each of the following EXCEPT:**
   - [ ] Allow plenty of time for them to respond to questions
   - [ ] Assure that the client is kept warm
   - [ ] Ask clear, concise questions using a low tone of voice
   - [ ] Call them “sweetie” and “honey” so they know you care about them

25. **Accidents are the leading cause of death in all the following age groups, EXCEPT:**
   - [ ] Adolescence
   - [x] Preschool
   - [ ] Elder Adulthood
   - [ ] School Age

---

**Return Completed Quiz and Signed Acknowledgment Form**
To your Supplemental Health Care Representative

**Retain Handbook for Future Reference**

---

Health Care Professional Signature

---

Health Care Professional Name & Title **(please print)**

Date
Training Handbook for Health Care Professionals
Table of Contents

General/Environmental Safety Rules and Practices ................................................................. 6
Emergency Preparedness .............................................................................................................. 6
Code of Ethics ............................................................................................................................... 7
Patient’s Rights and The Patient Care Partnership ................................................................. 7
The 2018 National Patient Safety Goals .................................................................................... 8
The Joint Commission “Do Not Use” Abbreviations List ....................................................... 10
Standard Precautions .................................................................................................................. 11
Hand Hygiene Guidelines ......................................................................................................... 11
Bloodborne Pathogens - Exposure Control Plan ..................................................................... 13
Transmission-Based Precautions/Guidelines ........................................................................ 18
  Respirator Fit Testing: ............................................................................................................. 19
  Tuberculosis (TB): .................................................................................................................. 19
Hazard Communication Policy .................................................................................................. 23
Material Safety Data Sheet (MSDS) ....................................................................................... 24
Radiation Safety Review ......................................................................................................... 24
Fire Safety and Prevention ....................................................................................................... 25
Electrical Safety Policy ............................................................................................................ 27
Back Safety Policy / Body Mechanics .................................................................................... 27
Physical Restraint Devices / Fall Prevention ......................................................................... 28
Medical Device Safety ............................................................................................................. 31
Sentinel Event ........................................................................................................................... 31
Process Improvement ................................................................................................................ 32
Harassment Policy ................................................................................................................... 33
Workplace Violence ................................................................................................................ 33
Domestic Violence ................................................................................................................... 35
  Intimate Partner, Dependent Adult, Child and Elder Abuse ................................................ 35
Elder Justice Act ....................................................................................................................... 35
Medication Administration ...................................................................................................... 36
Pain Assessment and Management .......................................................................................... 37
Skin Assessment ....................................................................................................................... 38
Assessment and Planning ......................................................................................................... 39
Supervision/Leadership and Delegation ................................................................................. 39
Documentation ........................................................................................................................ 40
Continuity of Care ................................................................................................................... 40
Point of Care Testing ............................................................................................................... 41
Informed Consent ..................................................................................................................... 41
Nutrition ..................................................................................................................................... 42
Sedation ................................................................................................................................... 42
Resuscitation ........................................................................................................................... 43
Cultural Competence Overview ............................................................................................. 44
Spirituality ................................................................................................................................ 45
Dementia and Alzheimer’s Awareness .................................................................................... 46
Advance Directives and End of Life ......................................................................................... 48
Anatomical Gift Act .................................................................................................................. 50
Emergency Medical Treatment and Active Labor Act (EMTALA) ........................................... 51
Health Insurance Portability and Accountability Act (HIPAA) .............................................. 52
Health Information Technology for Economic and Clinical Health Act (HITECH Act) .......... 52
Family Educational Rights and Privacy Act (FERPA) ............................................................. 55
Business Courtesies (i.e. Gifts and Entertainment) and Conflict of Interest ............................. 55
Population Specific Guidelines for Health Care Providers ................................................... 55
General/Environmental Safety Rules and Practices

Supplemental Health Care (SHC) is committed to providing a safe and productive work environment that poses no immediate risk to health and safety of our health care professionals. These safety rules are patterned after the Federal OSHA requirements. Please review and become familiar with these general safety guidelines on health and wellness. It is the health care professional’s responsibility to familiarize themselves with the specific policies, procedures and emergency plans at the facility/facilities they are assigned.

- Report any injury to your supervisor and Supplemental Health Care representative immediately
- Report any observed unsafe condition to your supervisor immediately
- Horseplay is prohibited at all times
- The drinking of alcoholic beverages is not permitted on the job. Any health care professional discovered under the influence of alcohol or illegal drugs will not be permitted to work and may be subject to disciplinary action up to and including termination
- Give first aid to injured persons only to the level of your training – report injuries to supervisor and appropriate occupational health department
- Appropriate clothing and footwear must be worn on the job at all times
- You should not perform any task unless you are trained to do so and are aware of the hazards associated with that task
- You may be assigned certain personal protective safety equipment. This equipment is available to you, free of charge, for use on the job and should be maintained in good condition and worn when required
- Learn safe work practices. When in doubt about performing a task safely, contact your supervisor for instruction and training
- The riding of equipment not designed for such purposes, is prohibited at all times
- Never remove or by-pass safety devices
- Learn where fire extinguishers are located and become familiar with their operation
- Maintain a general condition of good housekeeping in all work areas at all times
- Obey all traffic regulations when operating vehicles on public highways
- When operating or riding in company vehicles or using your personal vehicle for business purposes, the vehicle's seatbelt must be worn
- Be alert to hazards that could affect you and your coworkers
- Obey safety signs and tags
- Always perform your assigned task in a safe and proper manner; do not take shortcuts. The taking of shortcuts and the ignoring of established safety rules is a leading cause of worker injury

Emergency Preparedness

- Familiarize yourself with policies, procedures and emergency plans at the facility/facilities where you are working
- In the case of an emergency, hazardous materials incident, biological/terrorist incident, natural disaster, or severe weather situation please follow the facility’s emergency and disaster policies and plans
- Contact your Supplemental Health Care Representative for updates and any additional instructions. Supplemental Health Care is equipped with backup systems and procedures for power and telephone failures and should be available to assist you
- Depending on the severity or nature of the emergency you may be contacted by phone or email regarding the emergency situation and plan. Notification or communication, including ongoing communication, may be posted on the Supplemental Health Care website. Other
methods of communication may be used depending on the severity or nature of the emergency.

**Code of Ethics**

Supplemental Health Care recognizes the importance of providing quality patient care. In our role as a full service provider of health care services, we provide workforce solutions for all specialties in a variety of settings. All Supplemental Health Care services are provided in accordance with the following Code of Ethics and in accordance with the American Hospital Association’s “Patient’s Bill of Rights”, now known as “The Patient Care Partnership”, as adopted by the individual health care facilities.

1. We will consistently strive to provide quality services to our clients and to the community in accordance with the highest professional and ethical standards possible
2. We will abide by all Federal, State, Provincial and local laws, rules, regulations and ordinances
3. We will not discriminate on the basis of race, color, creed, religion, national origin, sexual orientation, age, gender, gender identity, genetics, citizenship, veteran status, disability or any other characteristic protected by law
4. We will carefully match the skills and abilities of our health care professionals to the specific needs of our clients to assure the assignment of a qualified health care professional, and we will make the health care professional as aware as possible of the needs and conditions of our client
5. Each health care professional has the responsibility to report any suspected violations of company principles or laws and regulations
6. We will cooperate with audits by outside agencies and legitimate government investigations
7. We will not knowingly misrepresent our service to our health care professionals
8. We will take all precautions possible to ensure the safety of our health care professionals and clients
9. We will treat each and every person with dignity and respect, in a manner sensitive to their background, age, culture, religion and heritage
10. For the protection of our health care professionals, clients, and ourselves, we require pre-work drug screen and background checks on our health care professionals

**Patient’s Rights and The Patient Care Partnership**

(Adapted from the American Hospital Association brochure)


There is currently no single Patients’ Bill of Rights; the American Hospital Association drafted a Bill of Rights in the early 1970’s to inform patients of what to expect while in the hospital. There are now numerous Bills of Rights including, but not limited to: Mental Health Bill of Rights, Hospice Bill of Rights and individual states Patient’s Bill of Rights.

Topics typically covered in the various Patients’ Bill of Rights include:

- The Right to be Treated with Respect and Non-Discrimination
- The Right to Obtain Medical Records
- The Right to Privacy of Medical Records
- The Right to Make Treatment Choices
- The Right to Informed Consent
- The Right to Refuse Treatment
- The Right to Make Decisions About End-of-Life Care
The American Hospital Association now refers to their Patient’s Bill of Rights as the Patient Care Partnership. The Patient Care Partnership outlines what a patient can expect during a hospital/health care contact. These rights include:

- High quality hospital/health care
- A clean and safe environment
- Involvement in their care
  - Discussing their medical condition and information about appropriate treatment choices
  - Discussing their treatment plan
  - Caregivers getting information from the patient
  - Caregivers understanding the patient’s health care goals and values
  - Understanding who should make decisions when the patient cannot
- Protection of the patient’s privacy
- Help when the patient leaves the hospital or facility
- Help with their billing claims

It is the health care professional’s responsibility to acquaint themselves with the adaptation of Patient’s Rights at the assigned facility and the measures the facility is taking to address the issues. The facility’s Patient’s Rights are typically posted at the front entrance of the facility and/or available upon request.

The American Hospital Association now refers to their Patient’s Bill of Rights as the Patient Care Partnership. The Patient Care Partnership outlines what a patient can expect during a hospital/health care contact. These rights include:

- High quality hospital/health care
- A clean and safe environment
- Involvement in their care
  - Discussing their medical condition and information about appropriate treatment choices
  - Discussing their treatment plan
  - Caregivers getting information from the patient
  - Caregivers understanding the patient’s health care goals and values
  - Understanding who should make decisions when the patient cannot
- Protection of the patient’s privacy
- Help when the patient leaves the hospital or facility
- Help with their billing claims

It is the health care professional’s responsibility to acquaint themselves with the adaptation of Patient’s Rights at the assigned facility and the measures the facility is taking to address the issues. The facility’s Patient’s Rights are typically posted at the front entrance of the facility and/or available upon request.

The 2018 National Patient Safety Goals
http://www.jointcommission.org/standards_information/npsgs.aspx

The Joint Commission’s National Patient Safety Goals (NPSGs) highlight and endorse specific improvements in patient safety. The goals emphasize problems and issues common to health care and describe evidence-based solutions to these concerns. The NPSGs are primarily based on aggregate information from sentinel events reported to the Joint Commission. The Joint Commission releases updated NPSGs annually. Visit the Joint Commission website (see above) or contact your Supplemental Health Care Representative if you would like to review this updated packet prior to your anniversary date. You may also log on to your Supplemental Health Care online profile and view the “Printable Documents”: Training Handbook.

The Joint Commission developed program-specific NPSGs for each of its accreditation and certification programs in an effort to increase the relevance of the goals and requirements. Currently there are no goals specific to Health Care Staffing Services, however many, if not all, of the listed 2018 NPSGs will apply to the area you are working. It is the health care professional’s responsibility to acquaint themselves with the relevant goals at the assigned facility and the measures the facility is taking to address the issues.

*Gaps in numbering indicate that a goal or requirement was “retired,” usually because it was integrated into the standards.

| **Goal 1 - Improve the accuracy of patient/resident identification** | **01.01.01** Use at least two patient/resident identifiers when providing care, treatment or services (Home Care setting, patient identification is less prone to error than in other settings. At the first encounter, the requirement for two identifiers is appropriate; thereafter, and in any situation of continuing one-on-one care in which the clinician "knows" the patient, one of the identifiers can be facial recognition. In the home, the correct address is also confirmed. The patient’s confirmed address is an acceptable identifier when used in conjunction with another individual-specific identifier.) (Nursing Care Center settings, at the first encounter, the requirement for two identifiers is appropriate; thereafter, and in any situation of continuing one-on-one care in which the clinician "knows" the patient or resident, one of the identifiers can be facial recognition.) (Behavioral Health Care settings, treatments covered by this goal include high-risk interventions and certain high risk medications (i.e. methadone). In some settings, use of visual recognition as an identifier is acceptable. Such settings include those that regularly serve an individual (i.e. therapy) or serve only a few individuals (i.e. group home). These... |
are settings in which the individual stays for an extended period of time, staff and populations served are stable, and individuals receiving care are well-known to staff).

01.03.01 Eliminate transfusion errors related to patient misidentification.

### Goal 2 - Improve the effectiveness of communication among caregivers

02.03.01 Report critical results of tests and diagnostic procedures on a timely basis.

### Goal 3 - Improve the safety of using medications

03.04.01 Label all medications, medication containers (includes syringes, medicine cups, and basins), and other solutions on and off the sterile field in perioperative and other procedural settings.

03.05.01 Reduce the likelihood of patient/resident harm associated with the use of anticoagulation therapy. (This requirement applies only to organizations that provide anticoagulant therapy and/or long-term anticoagulation prophylaxis (for example, atrial fibrillation) where the clinical expectation is that the patient's laboratory values for coagulation will remain outside normal values. This requirement does not apply to routine situations in which short-term prophylactic anticoagulation is used for venous thromboembolism prevention (for example, related to procedures or hospitalization) and the clinical expectation is that the patient's laboratory values for coagulation will remain within, or close to, normal values)

03.06.01 Maintain and communicate accurate patient/resident medication information.

### Goal 6 – Reduce harm associated with clinical alarm systems

06.01.01 Improve the safety of clinical alarm systems.

### Goal 7 - Reduce the risk of health-care associated infections

07.01.01 Comply with either the current Centers for Disease Control and Prevention (CDC) hand hygiene guidelines or the current World Health Organization (WHO) hand hygiene guidelines. (For behavioral health care, this requirement applies only to organizations that provide physical care)

07.03.01 Implement evidence-based practices to prevent health care-associated infections due to multidrug-resistant organisms in acute care and critical access hospitals. (This requirement applies to, but is not limited to, epidemiologically important organisms such as methicillin-resistant staphylococcus aureus (MRSA), clostridium difficile (CDI), vancomycin-resistant enterococci (VRE), carbapenem-resistant Enterobacteriaceae (CRE), and multidrug-resistant gram-negative bacteria).

07.04.01 Implement evidence-based practices to prevent central line-associated bloodstream infections. (This requirement covers short- and long-term central venous catheters and peripherally inserted central catheter (PICC) lines.)

07.05.01 Implement evidence-based practices for preventing surgical site infections.

07.06.01 Implement evidence-based practices to prevent indwelling catheter-associated urinary tract infections (CAUTI). (Refer to [Joint Commission.org](http://JointCommission.org) for evidenced based guidelines).

### Goal 9 - Reduce the risk of patient/resident harm resulting from falls

09.02.01 Reduce the risk of falls.

### Goal 14 – Prevent health-care associated pressure ulcers (decubitus ulcers)

14.01.01 Assess and periodically reasses each patient’s/resident’s risk for developing a pressure ulcer (decubitus ulcer) and take action to address any identified risks.

### Goal 15 - The organization identifies safety risks inherent in its patient population

15.01.01 Identify patients at risk for suicide. (For hospitals, this requirement only applies to psychiatric hospitals and patients being treated for emotional or behavioral disorders in general hospitals)

15.02.02 Identify risks associated with home oxygen therapy such as home fires.

### Universal Protocol – for Preventing Wrong Site, Wrong Procedure, and Wrong Person Surgery

UP 01.01.01 Conduct a pre-procedure verification process.

UP 01.02.01 Mark the procedure site.

UP 01.03.01 A time-out is performed before the procedure.

The Joint Commission standards relate to quality and safety of care issues. Anyone believing that he or she has pertinent and valid information about such matters related to Supplemental Health Care may provide input to The Joint Commission by submitting a complaint to the Office of Quality Monitoring at:
Supplemental Health Care will not initiate disciplinary or retaliatory actions against a health care professional who reports safety or quality of care concerns to The Joint Commission. Supplemental Health Care may also be contacted with any safety or patient concerns, comments and issues. We appreciate your willingness to participate in this process with us.

### The Joint Commission “Do Not Use” Abbreviations List

The Joint Commission originally created the “Do Not Use” list in 2004 as part of the requirements for meeting National Patient Safety Goal (NPSG) #2 – “Improve the effectiveness of communication among caregivers.” The “Do Not Use” List is now part of the Information Management standards. This requirement does not apply to preprogrammed health information technology systems (for example electronic medical records or CPOE systems). However organizations are encouraged when introducing or upgrading their systems to eliminate the use of dangerous abbreviations, acronyms, symbols and dose designations from the software.

<table>
<thead>
<tr>
<th>DO NOT USE</th>
<th>POTENTIAL PROBLEM</th>
<th>USE INSTEAD</th>
</tr>
</thead>
<tbody>
<tr>
<td>U, u (unit)</td>
<td>Mistaken for “0” (zero), the number “4” (four) or “cc”</td>
<td>Write “unit”</td>
</tr>
<tr>
<td>IU (International Unit)</td>
<td>Mistaken for IV (intravenous) or the number “10” (ten)</td>
<td>Write “International Unit”</td>
</tr>
<tr>
<td>Q.D., QD, q.d., qd (daily)</td>
<td>Mistaken for each other</td>
<td>Write “daily”</td>
</tr>
<tr>
<td>Q.O.D.,QOD, q.o.d.,qod (every other day)</td>
<td>Period after the Q mistaken for “I” and the “O” mistaken for “I”</td>
<td>Write “every other day”</td>
</tr>
<tr>
<td>Trailing zero (X.0 mg)*</td>
<td>Lack of leading zero (.X mg)</td>
<td>Write X mg</td>
</tr>
<tr>
<td></td>
<td>Decimal point is missed</td>
<td>Write 0.X mg</td>
</tr>
<tr>
<td>MS</td>
<td>Can mean morphine sulfate or magnesium sulfate</td>
<td>Write “morphine sulfate”</td>
</tr>
<tr>
<td>MSO₄ and MgSO₄</td>
<td>Confused for one another</td>
<td>Write “magnesium sulfate”</td>
</tr>
</tbody>
</table>

*Applies to all orders and all medication-related documentation that is handwritten (including free-text computer entry) or on pre-printed forms.

*Exception: A “trailing zero” may be used only when required to demonstrate the level of precision of the value being reported, such as for laboratory results, imaging studies that report the size of lesions, or catheter/tube sizes. It may not be used in medication orders or other medication-related documentation.
Standard Precautions
Adapted from The Centers for Disease Control and Prevention (CDC) - Guideline for Isolation Precautions: Preventing Transmission of Infectious Agents in Healthcare Settings 2007 (www.cdc.gov)

Standard Precautions guidelines combine the safety principles of Universal Precautions (UP) with the additional safeguards of Body Substance Isolation (BSI) to reduce the risk of transmitting infectious agents and disease. Health care providers working with Supplemental Health Care must comply with Standard Precautions guidelines. According to the CDC, Standard Precautions are based on the principle that all blood, body fluids, secretions, excretions except sweat, non-intact skin, and mucous membranes may contain transmissible infectious agents. Standard precautions include the use of: handwashing, and appropriate use of protective equipment such as gloves, gowns, masks, whenever touching or exposure to patient’s body fluids is anticipated. These practices apply to patients regardless of suspected or confirmed infection status and in any setting in which health care is delivered. The precautions utilized during patient care are determined by the nature of the interaction and the extent of anticipated blood, body fluid or pathogen exposure.

Recent additions to the CDC recommendations include: respiratory hygiene/cough etiquette, safe injection practices, and the use of masks for insertion of catheters or injection of material into spinal or epidural spaces via lumbar puncture procedures. While most elements of Standard Precautions evolved from Universal Precautions that were developed for protection of health care personnel, these new elements of Standard Precautions focus on protection of patients.

Hand Hygiene Guidelines
http://www.cdc.gov/handhygiene/Guidelines.html
and

The Centers for Disease Control (CDC) and the World Health Organization (WHO) have developed recommendations to improve hand-hygiene practices of Health Care Workers and to reduce transmission of pathogenic microorganisms to patients and personnel in health-care settings. Each recommendation is categorized on the basis of existing scientific data, theoretical rationale, applicability, and economic impact. The CDC system for categorizing recommendations is:

- **Category IA.** Strongly recommended for implementation and strongly supported by well-designed experimental, clinical, or epidemiologic studies.
- **Category IB.** Strongly recommended for implementation and supported by certain experimental, clinical, or epidemiologic studies and a strong theoretical rationale.
- **Category IC.** Required for implementation, as mandated by federal or state regulation or standard.
- **Category II.** Suggested for implementation and supported by suggestive clinical or epidemiologic studies or a theoretical rationale.
- **No recommendation.** Unresolved issue. Practices for which insufficient evidence or no consensus regarding efficacy exist.

Some of the recommendations from the CDC are listed below. Please refer to either the CDC or WHO resource listed above for the full coverage of this important issue including hand hygiene techniques, selection of hand hygiene agents, skin care and surgical and antisepsis.

**Indications for handwashing and hand antisepsis:**

- When hands are visibly dirty or contaminated with proteinaceous material or are visibly soiled with blood or other body fluids, wash hands with either a non-antimicrobial soap and water or an antimicrobial soap and water (IA)
B. If hands are not visibly soiled, use an alcohol-based hand rub for routinely decontaminating hands in all other clinical situations described in items C--J (IA) Alternatively, wash hands with an antimicrobial soap and water in all clinical situations described in items C--J (IB)
C. Decontaminate hands before having direct contact with patients (IB)
D. Decontaminate hands before donning sterile gloves when inserting a central intravascular catheter (IB)
E. Decontaminate hands before inserting indwelling urinary catheters, peripheral vascular catheters, or other invasive devices that do not require a surgical procedure (IB)
F. Decontaminate hands after contact with a patient’s intact skin (e.g., when taking a pulse or blood pressure, and lifting a patient) (IB)
G. Decontaminate hands after contact with body fluids or excretions, mucous membranes, nonintact skin, and wound dressings if hands are not visibly soiled (IA)
H. Decontaminate hands if moving from a contaminated-body site to a clean-body site during patient care (II).
I. Decontaminate hands after contact with inanimate objects (including medical equipment) in the immediate vicinity of the patient (II)
J. Decontaminate hands after removing gloves (IB)
K. Before eating and after using a restroom, wash hands with a non-antimicrobial soap and water or with an antimicrobial soap and water (IB)
L. Antimicrobial-impregnated wipes (i.e., towelettes) may be considered as an alternative to washing hands with non-antimicrobial soap and water. Because they are not as effective as alcohol-based hand rubs or washing hands with an antimicrobial soap and water for reducing bacterial counts on the hands of HCWs, they are not a substitute for using an alcohol-based hand rub or antimicrobial soap (IB)
M. Wash hands with non-antimicrobial soap and water or with antimicrobial soap and water if exposure to *Bacillus anthracis* is suspected or proven. The physical action of washing and rinsing hands under such circumstances is recommended because alcohols, chlorhexidine, iodophors, and other antiseptic agents have poor activity against spores (II)
N. No recommendation can be made regarding the routine use of nonalcohol-based hand rubs for hand hygiene in health-care settings. Unresolved issue.

**Other Aspects of Hand Hygiene**
A. Do not wear artificial fingernails, extenders, gel or press on nails when having direct contact with patients at high risk (e.g., those in intensive-care units or operating rooms) (IA)
B. Keep natural nails tips less than 1/4-inch long (II)
C. Wear gloves when contact with blood or other potentially infectious materials, mucous membranes, and nonintact skin could occur (IC)
D. Remove gloves after caring for a patient. Do not wear the same pair of gloves for the care of more than one patient, and do not wash gloves between uses with different patients (IB)
E. Change gloves during patient care if moving from a contaminated body site to a clean body site (II)
F. No recommendation can be made regarding wearing rings in health-care settings. Unresolved issue.
G. The hand hygiene products for use in health care facilities vary but should consider the relative efficacy of antiseptic agents against various pathogens and the acceptability of the products to the personnel
H. When using an alcohol-based handrub, the product should be applied to the palm of one hand and the hands rubbed together, covering all surfaces of hands and fingers, until the hands are dry. The volume needed to reduce the number of bacteria on hands varies by products.
I. According to the CDC, allergic contact dermatitis due to alcohol hand-rubs is very uncommon unless used immediately following handwashing with non-antimicrobial soap.

J. Use hand lotions or creams to minimize the occurrence of irritant contact dermatitis

**Bloodborne Pathogens - Exposure Control Plan**

*Policy:*
Supplemental Health Care is committed to providing a safe and productive work environment for our health care professionals. This commitment includes the development and implementation of effective safety programs. In an effort to eliminate or minimize occupational exposure to bloodborne pathogens, we have designed the following Exposure Control Plan (ECP). This plan is in accordance with OSHA standard 29 CFR 1910.1030, “Occupational Exposure to Bloodborne Pathogens.” The Quality Assurance and Clinical Services Department will be responsible for all phases of the ECP. This includes, but is not limited to the implementation, maintenance, review and update of the ECP.

The ECP includes the following topics:
- Determination of health care professional exposure
- Implementation of methods of exposure control, including Universal Precautions, engineering controls, Personal Protective Equipment (PPE) and waste disposal
- Hepatitis B vaccination
- Post-exposure evaluation and follow-up
- Communication of hazards to health care professionals and training
- Record keeping
- Evaluating circumstances surrounding an exposure incident

*Information and Training:*
The most important aspect of the OSHA standard on bloodborne pathogens is its mandate of safety training such as provided in this manual. To insure that you have been trained in the ECP, you must complete this self-study Training Handbook, sign/return the Training Handbook Acknowledgement (page 1), and successfully complete/return the Training Handbook Quiz. This self-study/review must be done prior to working your first shift/assignment and annually thereafter. Additionally, you can request a copy of this program at any time. To provide access to interactive questions and answers on safety issues we offer you the opportunity to call for more information. If you have questions or would like to obtain a copy of the OSHA standard, and an explanation of its contents, please contact, contact our Quality Assurance and Clinical Services Department at 1.800.889.9169 or if your questions are urgent and need attention after-hours please call your Supplemental Health Care Representative on the appropriate 24-hour hotline. Confidentiality is protected.

As a health care professional you have risk of occupational exposure to bloodborne pathogens and must receive training, this self-study section will serve as that training. All health care professionals will receive training on the epidemiology, symptoms, and transmission of bloodborne pathogens. In addition, the training program covers, at a minimum the following elements:
- A copy (kept on file at the SHC office) and explanation of the standard
- An explanation of our ECP and how to obtain a copy
- An explanation of methods to recognize tasks and other activities that may involve exposure to blood or Other Potentially Infectious Material (OPIM), including what constitutes an exposure incident
- An explanation of the use and limitations of engineering controls, work practices and PPE
• An explanation of the types, uses, location, removal, handling, decontamination and disposal of PPE
• An explanation of the basis for PPE selection
• Information on the Hepatitis B vaccine, including information on its efficacy, safety, method of administration and benefits of being vaccinated, and that the vaccine will be offered free of charge
• Information on the appropriate actions to take and persons to contact in an emergency involving blood or OPIM
• An explanation of the procedure to follow if an exposure incident occurs, including the method of reporting the incident and the medical follow-up that will be made available
• Information on the post-exposure evaluation and follow-up that the employer is required to provide for the health care professional following an exposure incident
• An explanation of the signs and labels and/or color-coding required by the standard and used at most facilities
• An opportunity for interactive questions and answers with a member of SHC

Record Keeping:
OSHA specifies the content and duration of Supplemental Health Care’s maintenance of records on training related to bloodborne pathogens and any incidents of exposure. The training records of this Training Handbook include the date of the self-study and a summary of the training in the packet. As our health care professional, Supplemental Health Care’s records are available to you, to anyone to whom you give written consent, to OSHA and to the National Institute of Occupational Safety and Health (NIOSH). These documents will be kept for at least three years and will be made available within 15 working days of request.

OSHA Standard:
As OSHA mandates, Supplemental Health Care maintains a copy of the complete OSHA Standard for Occupational Exposure to Bloodborne Pathogens and will make it available for your review upon request or you may find it on the web at www.osha.gov.

Risk of Exposure:
As a healthcare professional you are at risk for exposure to bloodborne pathogens while performing your duties. The hospital, clinic or other clinical setting you are assigned to should provide all necessary PPE, engineering controls (such as sharp containers) and the appropriate waste disposal items that will minimize your risk of exposure. Please locate these items at your clinical assignment and seek out appropriate training. If you have concerns related to these items please notify the Supplemental Health Care Quality Assurance and Clinical Services Department or your appropriate Supplemental Health Care Representative.

Bloodborne pathogens that you could possibly be exposed to include: HIV, Hepatitis B, Hepatitis C and Ebola. Bloodborne pathogens must enter your body to cause infection. These pathogens may enter the body in a number of ways including a pierce, puncture or cut by a sharp object that is contaminated with an infectious material. These bloodborne pathogens may also gain entry through open cuts, skin abrasions and mucous membranes. Indirect transmission of bloodborne pathogens can occur by touching contaminated surfaces and then transferring the infectious materials to open skin or mucous membranes.

| Hepatitis B | • May have no symptoms at all or you may suffer flu-like symptoms, fatigue and jaundice
  | • Hepatitis B vaccination available, free of charge |
|---|---|
| Hepatitis C | • Causes inflammation of the liver which can damage the liver and lead to cirrhosis of the liver and death |
Symptoms similar to Hepatitis B
Less common than Hepatitis B, currently no vaccine available

Human Immunodeficiency Virus (HIV)
- Attacks the body’s immune system leading to the disease known as AIDS (Acquired Immunodeficiency Syndrome)
- May be asymptomatic for years
- May develop flu-like symptoms including fever and fatigue
- Transmitted primarily through sexual contact
- Currently no vaccine available

Ebola Virus
- Ebola Virus Disease can only be spread to others after symptoms begin
- Symptoms can appear 2-21 days after exposure; once patient recovers they are no longer infectious
- Signs and symptoms include: Fever ≥ 100.4°F or 38.0°C, severe headache, muscle pain, weakness, diarrhea, vomiting, abdominal pain, unexplained hemorrhage.
- Meticulous use of PPE is essential to prevent the spread of the Ebola Virus
- Currently no vaccine available

Ways that workers can minimize exposure to bloodborne diseases:
- Training and education programs
- Use of personal protective equipment such as gloves, gowns, facemasks and eye protection
- Work practices such as thorough hand washing after each patient
- Proper handling of sharps
- Engineering controls such as biological safety cabinets and puncture-resistant sharps containers
- Immunization programs
- Proper disposal of contaminated waste
- Use of disinfectants
- Labeling and signs

Engineering Controls and Work Practices:
Engineering controls and work practice controls will be used to prevent or minimize exposure to bloodborne pathogens. These engineering controls and practices involve, but are not limited to, safe use of needles and the prevention of needle and sharp related injuries and exposures. Needlestick injuries can expose workers to a number of bloodborne pathogens that can cause serious or fatal infections. Any worker who may come in contact with needles is at risk, including health care professionals, lab workers, doctors and housekeepers.

Past studies have shown that needlestick injuries are often associated with these activities:
- Recapping needles
- Transferring body fluids between containers
- Failing to dispose of used needles properly in puncture-resistant sharps containers

The best way to protect yourself from needlestick injuries is to:
- Avoid the use of needles where safe and effective alternatives are available
- Help your facility/supervisor select and evaluate devices with safety features that reduce the risk of needlestick injuries
- Use devices with safety features provided by your facility/supervisor
- Avoid recapping, bending or removing contaminated needles and other sharps unless such an act is required by a specific procedure or has no feasible alternative
- Do not shear or break contaminated needles
- Have a plan for safe disposal and handling of needles before beginning the procedure
- Promptly dispose of used needles in appropriate sharps containers
- Notify appropriate facility personnel when an unsafe situation exists including sharps containers that are overfilled or require maintenance
• Report all needlestick and sharps-related injuries promptly to ensure that you receive appropriate follow-up care
• Tell your facility/supervisor about any needlestick hazards you observe
• Participate in training related to infection prevention
• Participate in facility evaluation of changing engineering control, work practices and new procedures or products
• Notify the Quality Assurance and Clinical Services Department if you need further assistance or have questions that you need answered. 1.800.889.9169

**Personal Protective Equipment (PPE) and Safety Equipment:**
Personal Protective Equipment (PPE) is provided by the facility and shall be worn when the nature of the anticipated patient interaction indicates that contact with blood or body fluids may occur – all PPE must be removed and discarded before leaving the patient’s room or patient care area.
• Facility must provide PPE, at no cost (see discussion below on latex sensitivity)
• Receive on-site training for use of appropriate PPE for the tasks and procedures you will perform
• Health care professionals must use PPE
• PPE use must be chosen based on the risk of the task NOT the perceived risk of the patient
• PPE includes:
  - Gloves must be worn when delivering patient care, handling specimens, doing domestic cleaning, and handling items that may be soiled with blood or body fluids
  - Gloves are to be worn when handling all specimens to prevent contamination from body specimen fluids or blood
  - Gowns (potential for contact with clothing or skin – should cover both arms, upper torso and go down to the knees)
  - Gowns or aprons must be worn during procedures or while managing a patient situation when there will be exposure to body fluids, blood, draining wounds or mucous membranes
  - Wear appropriate face and eye protection when splashes, sprays, splatter, or droplets of blood, or other potentially infectious material, pose a hazard to the eye nose or mouth
  - Safety glasses (most common type of eye protective equipment)
  - Goggles (use when potential for splashes – fits closer to eyes than glasses)
  - Face shields or masks (use when there is great potential for splashes, use along with safety glasses or goggles)
  - Eye Protection
  - Mouthpieces, resuscitation bags, pocket masks, or other ventilation devices
  - Other fluid resistant barriers which do not permit blood or other potentially infectious materials to pass through or reach worker’s clothing
• Know how to find, use and properly dispose of PPE and safety equipment
• Remove PPE in the proper order (i.e. gown first then gloves) before leaving the work area and place it in the proper waste receptacle
• Consistent use of PPE and safety equipment is an excellent way to reduce risk of exposure

*All health care professionals using PPE must observe the following precautions:*
• Wash hands immediately, or as soon as feasible after removal of gloves or other PPE
• Remove PPE after it becomes contaminated and before leaving the work area
• Used PPE must be disposed in appropriate waste containers
• Wear appropriate gloves when it can be reasonably anticipated that there may be hand contact with blood or other secretions, and when handling or touching contaminated items or surfaces; replace gloves if torn, punctured, contaminated, or if their ability to function as a barrier is compromised
Utility gloves may be decontaminated for reuse if their integrity is not compromised; discard utility gloves if they show signs of cracking, peeling, tearing, puncturing, or deterioration.

Carefully remove gloves following acceptable practice guidelines so as not to allow any substances from the soiled gloves to come in contact with your hands.

Never wash or decontaminate disposable gloves for reuse.

Remove immediately, or as soon as feasible, any garment contaminated by blood or other potentially infectious material, in such a way as to avoid contaminating your skin, clothing or mucous membranes.

Remove gown and perform hand hygiene before leaving the patient’s environment – do not reuse gowns even for repeated contacts with the same patient.

Food and drinks must not be in patient care areas.

Utilize isolation signs and carts whenever possible.

Notify the Supplemental Health Care Quality Assurance and Clinical Services Department if you need further assistance or have questions that you need answered.

Additional Guidelines Related to PPE Use with Ebola Virus Disease Patients:

- The procedures are extensive and should be reviewed in entirety at: http://www.cdc.gov/vhf/ebola/hcp/procedures-for-ppe.html
- Prior to working with Ebola patients, all healthcare workers must have received rigorous and repeated training and have demonstrated competency in performing all Ebola-related infection control practices and procedures; specifically training in the donning and doffing of PPE.
- While working in PPE, healthcare workers caring for Ebola patients should have no skin exposed.
- The overall safe care of Ebola patients in a facility must be overseen by an onsite manager at all times, and each step of every PPE donning/doffing procedure must be supervised by a trained observer/monitor to ensure proper completion of established PPE protocols.

Latex Sensitivity – Identification and Minimizing the Risk:

Since the introduction of Universal Precautions the use of latex gloves has become commonplace. This increased use of latex gloves has been accompanied with the increasing reports of allergic reactions to natural rubber latex among health care personnel. Reactions to latex may be localized or systemic. Symptoms may present as dermatitis, conjunctivitis, rhinitis, urticaria, angioedema, asthma and even anaphylaxis. Avoiding latex products is the key in preventing sensitization and reactions to natural rubber latex products.

If you believe you have such a sensitivity or allergy:

- See an allergist, immunologist or your physician to discuss the symptoms and determine whether additional diagnostic tests for latex allergy are needed, and if so what kind of precautions are necessary for your condition.
- Please have your physician document the latex sensitivity or allergy and any suggested precautions on your physician physical form.
- Communicate the information from your physician with your Supplemental Health Care Representative.
- Supplemental Health Care must have this information before we can confirm your assignment.
- Subsequent action and accommodation is determined based on the severity of the allergy as documented by your physician.
- The accommodations may include, but are not limited to:
  - Contact allergy to latex: If you have a contact allergy to latex the health care facility that you are assigned should provide you with latex-free or powder-free gloves for use. We will provide you with these items if they are not offered in the facility where you are assigned.
- **Inhalant allergy to latex:** If you have a documented allergy to latex once you have interviewed for an assignment and accepted an offer the recruiter or clinical liaison will notify the facility's human resources department about your allergy to determine the availability of latex risk management procedures at the institution. Depending on your individual triggers for your allergy the facility will determine if the:
  - Facility is latex-free
  - Facility can assign you to a latex-free unit and/or
  - Facility can provide you a powder-free and/or latex-free unit to protect you from aerosolized latex

- Only when accommodations can be arranged will the assignment be confirmed
- The 1990 Americans with Disabilities Act (ADA) covers people with severe allergies to substances such as latex. If you are otherwise qualified but can no longer work with latex in a job setting because of your allergy you may have to work with your Supplemental Health Care Representative to determine other options where reasonable accommodations can be made

### Transmission-Based Precautions/Guidelines

<table>
<thead>
<tr>
<th>Transmission mode</th>
<th>Disease examples</th>
<th>PPE and precautions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Percutaneous injury</td>
<td>Type B viral hepatitis</td>
<td>Gloves</td>
</tr>
</tbody>
</table>
| Mucous membrane | Non-A, non-B viral Hepatitis C | - For all vascular access
| Non-intact skin | Human Immunodeficiency Virus (HIV) | - With non-intact skin
| Sexual transmission | Ebola Virus Disease (EVD) | - With non-intact mucous membranes
| | | - When handling specimens
| | | - When handling laundry
| | | Fluid resistant gowns (if splash likely)
| | | Goggles / face masks / shields (if splash likely)
| | | Resuscitators for arrests / codes
| | | Avoid unprotected mouth to mouth resuscitation
| | | Surgical caps, hoods, shoe covers, gowns (if contamination likely)
| | | Handwashing
| | | All healthcare workers involved in the care of Ebola patients must have received rigorous and repeated training and have demonstrated competency
| Airborne | Tuberculosis | Private room |
| | Meningitis | Closed door |
| | H. influenza | Negative pressure |
| | Meningococci | Mask / gown / gloves |
| | Pertussis | Resuscitators for arrests / codes |
| | Chickenpox | Avoid unprotected mouth to mouth resuscitation |
| | Disseminated herpes zoster | Handwashing |
| | H1N1 influenza | TB – wear a fit-tested respirator (see below)
| | | Caregiver must be immune to chickenpox
| Fecal / Oral | Difficile | Gown (if soiling likely)
| | Suspected infectious acute diarrhea | Gloves |
| | Type A viral hepatitis | Handwashing |
| | Rotavirus | |
| Contact | Respiratory syncytial virus (RSV) | Gown (if soiling likely)
| | Conjunctivitis | Gloves |
| | Group A Strep | Handwashing |
| | Herpes simplex | |
| | Major skin wound and infection | |
| | Antibiotic resistant organisms | |
| | H1N1 influenza | |
Respirator Fit Testing:
Please check with your Supplemental Health Care Representative for instructions on completing fit testing. The field healthcare professional may be directed to an independent health care professional or facility to be properly fit tested. Supplemental Health Care is committed to providing a safe and healthful work environment for our health care professionals. The following guidelines are designed to give you a brief overview of safety measures that the health care professional should be aware of regarding respirator fit testing. As with any safety preparation, YOU MUST become familiar with the plan at the site where you are working.

These guidelines are adopted based on the following understanding with regards to OSHA Standard 1910.134:
- The plan for respirator use must be site specific. A generic overall program is not acceptable and the respiratory protection program must be revised and changed as worksite situations and conditions change.
- The healthcare professional must become familiar with the respiratory protection program with the required worksite-specific procedures and elements for required respirator use at the facility where they are working.
- The OSHA Respirator Medical Evaluation Questionnaire (1910.134 App C) is to be filled out confidentially, the employer/facility and supervisor must not look at the answers, and the questionnaire is to be reviewed by a health care professional.
- The employer/facility may only maintain the written recommendation on a health care professionals’ eligibility to wear a respirator (not the medical questionnaire or medical evaluation).
- The respirator fit test process and medical evaluation of health care professionals required to use respirators must be completed by a "licensed health care professional".
- Requires employers/facility to determine through the services of a physician the state of health a health care professional must possess in order to be physically able to perform the assigned work and wear a respirator.
- Outpatient facilities such as Occupational Healthcare Centers, Ambulatory Care Settings or your client contact may be able to assist you with the locations where you may complete the initial and annual mask fitting and evaluation. If you need further assistance please contact the Quality Assurance and Clinical Services Department.
- OSHA requires annual re-evaluation by a physician and annual mask re-training.
- Maintenance and monitoring of the use of respirators must be evaluated periodically.
- In addition to the protection of the health care professional from hazardous material and disease processes there are also health risks to the health care professional involved with the wearing of positive pressure as well as negative pressure respirators.

Tuberculosis (TB):
Mycobacterium tuberculosis is spread through the air by droplets from a person with active TB when they cough, yell, sing, sneeze or spit. You can become infected with TB when you inhale the droplet nuclei. Unfortunately, these droplet nuclei are so small that air currents inside a building keep them circulating in the air for hours. The simplest way to control the spread of droplets is for patients and workers to always cover all coughs and sneezes with a tissue. As a health care provider you need extra protection when you share breathing space with a patient with TB. Wearing a respirator mask, such as N95, that has been fitted and tested will maximize your protection. Check with your facility to determine if they offer or require fit-tested respirators on the unit or area where you will be working. Contact your Supplemental Health Care Representative if you need assistance with fit-testing.
**Waste Disposal and Housekeeping:**
- Regulated waste is placed in containers which are closable, constructed to contain all contents and prevent leakage, appropriately labeled or color-coded and closed prior to removal to prevent spillage or protrusion of contents during handling.
- Contaminated sharps are discarded immediately or as soon as possible in containers that are closable, puncture-resistant, leak-proof on sides and bottoms and labeled or color-coded appropriately.
- Bins and pails are cleaned and decontaminated as soon as feasible after visible contamination.
- Broken glassware, which may be contaminated, is picked up using mechanical means, such as a brush and dustpan.
- Place wet contaminated laundry in leak-proof, labeled or color-coded containers before transport (red bags or biohazard marked bags).
- Wear appropriate PPE, minimum gloves, when handling and or sorting contaminated laundry, and handle as little as possible.
- Biohazard labels and signs shall be fluorescent orange or orange-red or predominantly so, with lettering and symbols in a contrasting color.
- Biohazard signs shall also indicate the name of the infectious agent, special requirements for entering the area and the name and phone number of the responsible person.
- Ensure that warning labels are affixed or red bags are used as required for regulated waste or contaminated equipment.
- Notify your supervisor if you discover regulated waste containers without proper labels.

<table>
<thead>
<tr>
<th>PIMW (Sharps)</th>
<th>PIMW (Red Bag)</th>
<th>General (Clear Bag)</th>
</tr>
</thead>
<tbody>
<tr>
<td>- Needles</td>
<td>- Blood and blood products</td>
<td>- Urine / feces</td>
</tr>
<tr>
<td>- Sutures</td>
<td>- Cultures and stocks</td>
<td>- Bedpans</td>
</tr>
<tr>
<td>- Syringes</td>
<td>- Animal wastes</td>
<td>- Urinals</td>
</tr>
<tr>
<td>- Needle-less systems</td>
<td>- Human pathological wastes</td>
<td>- Chux pads</td>
</tr>
<tr>
<td>- Scalpels</td>
<td>- Any item or body fluid visibly contaminated with blood</td>
<td>- Coffee cup</td>
</tr>
<tr>
<td>- Blades</td>
<td>- Saliva in dental products</td>
<td>- PPE</td>
</tr>
<tr>
<td>- Unused sharps</td>
<td>- Pleural fluid</td>
<td>- Item wrappers</td>
</tr>
<tr>
<td></td>
<td>- Pericardial fluid</td>
<td>- IV bags / tubing</td>
</tr>
<tr>
<td></td>
<td>- Amniotic Fluid</td>
<td>- Glove boxes</td>
</tr>
<tr>
<td></td>
<td>- Synovial Fluid</td>
<td>- Respiratory care items</td>
</tr>
<tr>
<td></td>
<td>- All body fluids when one fluid cannot be differentiated from another</td>
<td></td>
</tr>
<tr>
<td></td>
<td>- Vaginal secretions</td>
<td></td>
</tr>
<tr>
<td></td>
<td>- Cerebrospinal fluid</td>
<td></td>
</tr>
<tr>
<td></td>
<td>- HIV and HBV cells</td>
<td></td>
</tr>
<tr>
<td></td>
<td>- Semen</td>
<td></td>
</tr>
<tr>
<td></td>
<td>- Tissues, organs, and cultures; human or experimental animals</td>
<td></td>
</tr>
</tbody>
</table>

*If any item of general waste contains any PIMW, or has dried, caked, liquid, or semi-liquid PIMW, it must be disposed of as PIMW.

*Most health care facilities’ managers work hard to assure that non-infectious trash is not placed in Potentially Infectious Medical Waste (PIMW) containers for disposal because treatment of infectious medical waste is costly.

**Post Exposure Evaluation and Follow-up:**
Compliance with the OSHA Bloodborne Pathogens standard has significantly reduced the risk that workers will contract a bloodborne disease in the course of their work. An exposure incident means a specific eye, mouth, other mucous membrane, non-intact skin or parenteral contact with blood or other potentially infectious materials that results from the performance of a health care professional’s duties. In the event you sustain an exposure incident please follow the hospital or clinic body fluid exposure plan. The plan should include, but not be limited to, the following:
Immediately wash the area involved with soap and water (for eyes flush with water only)
Notify immediate supervisor
Fill out Incident Report, have signed by your supervisor, and complete the Exposure Information Sheet
Report to Employee Health/Occupational Health or where directed from hospital or work site Representative
Notify your Supplemental Health Care Representative or after-hours emergency number as soon as possible. They will follow-up with the Supplemental Health Care Quality Assurance and Clinical Services Department
Keep follow-up appointments

Follow-up Should Include:

- Incident report/medical documentation of the circumstances of exposure and how it occurred
- Identify and document the source individual (unless the employer/facility can establish that identification is infeasible or prohibited by state or local law)
- Obtain consent and make arrangements to have the source individual tested as soon as possible to determine HIV, HCV and HBV infectivity; document that the source individual’s test results were conveyed to the health care professional’s health care provider
- If the source individual is already known to be HIV, HCV and/or HBV positive new testing need not be performed
- Assure that the exposed health care professional is provided with the source individual’s test results and with information about applicable disclosure laws and regulations concerning the identity and infectious status of the source individual
- After obtaining consent, collect exposed Supplemental Health Care health care professional’s blood as soon as feasible after exposure incident, and test blood for HBV and HIV status
- If the health care professional does not give consent for HIV testing during collection of blood for baseline testing, preserve the baseline blood sample for at least 90 days; if the exposed health care professional elects to have the baseline sample tested during this waiting period, perform testing as soon as feasible
- Post-exposure evaluation, counseling and prophylaxis will be offered
- Expenses accrued will be covered under worker’s compensation
- Confidentiality of the injured health care professional is protected
- The Supplemental Health Care Quality Assurance and Clinical Services Department is available to assist you with all phases of evaluation and follow-up

Administration of Post-Exposure Evaluation and Follow-up:
The SHC Quality Assurance and Clinical Services Department, along with your Supplemental Health Care Representative, will ensure the following:

- Health care professionals responsible for workers’ Hepatitis B vaccination and post-exposure evaluation and follow-up are given a copy of OSHA’s Bloodborne Pathogens Standard
- Health care professionals evaluating a worker after an exposure incident receives: a description of the health care professional’s job duties relevant to the exposure, routes of exposure, circumstances of exposure, results of source individual’s blood test (if possible) and relevant health care professional medical records, including vaccination status

Medical Records:
Medical records are maintained for each health care professional with occupational exposure by the Supplemental Health Care Quality Assurance and Clinical Services Department. These records are provided upon the request of the health care professional or to anyone having written consent of the health care professional within 15 working days of request. The medical record and exposure
records for each employee is preserved and maintained for at least the duration of employment, plus thirty (30) years. An OSHA 300 log documenting all health care professional exposures should also be maintained by the facility or site where the exposure occurred, a log of any exposures occurring at Supplemental Health Care would be maintained by Supplemental Health Care.

**Hepatitis B Vaccination Information:**
In order to ensure that our health care professionals are aware of the risks associated with Hepatitis B, we require that all health care professionals complete and sign a Hepatitis B Vaccination Form for our records. Below is a sample of the form you will be given to complete.

**Hepatitis B Vaccination Information – Sample Form**

![Hepatitis B Vaccination Information – Sample Form](image-url)
Hazard Communication Policy

Policy:
Health care professionals are our organization’s most important asset, and their safety and health is our greatest responsibility. It is the policy of this organization that every health care professional is entitled to work in a safe and healthful environment.

Health care professionals of Supplemental Health Care have a right to know the hazardous chemicals with which they work or to which they could be exposed, and the measures they can take to avoid injury or illness when working with these chemicals. We provide this general information and training in order to reduce the possibility of accidental exposure and to comply with the OSHA Hazard Communication Standard. As with any safety preparation, YOU MUST become familiar with the plan at the site where you are working. Contact the Quality Assurance and Clinical Services Department if you need further assistance or have questions that you need answered. 1.800.889.9169.

Purpose:
The Occupational Safety and Health Administration Hazard Communication Standard (29 CFR 1910.1200) requires that all employers develop and implement a "written hazard communication program". Our program, as put together in this document, is designed to implement the OSHA Hazard Communication Standard requirements in this organization.

OSHA's primary intent in issuing this standard is to ensure that health care professionals will receive as much information as needed concerning the hazards in their workplace. In our organizations, this information will be presented to our health care professionals prior to starting work, when changing jobs which change the hazardous substances to which they are exposed, or when new hazards are introduced into their work area.

The purpose of this program is to ensure that:
- All workers are aware of our Hazard Communication Compliance Plan and to ensure that it is available to all workers, their designated representatives, and OSHA
- All hazardous chemicals used in the workplace are labeled and that a list of chemicals is maintained
- Material Safety Data Sheets (MSDS) are available for all hazardous chemicals
- Health care professionals receive information and training so that they are informed of the requirements of the standard and trained about the hazards in their workplace
- All persons involved in non-routine work tasks are informed of hazards of such tasks
- Contractors and their workers are informed of hazards before performing work in our facility, that sub-contractors inform us of any hazardous materials brought into our facilities, and that we have procedures in place so that we can become aware of hazards we may encounter on the job site to which we may send health care professionals

Policies and procedures for non-routine tasks:
- On occasion, it is necessary for health care professionals to perform jobs which they do not perform on a routine basis and that may involve potential exposure to hazardous chemicals (e.g. carbon monoxide)
- Under such circumstances, it is the responsibility of the supervisor to determine the hazards which are present or may be created by the task. The supervisor is responsible for communicating this information to the health care professional. The supervisor will also make sure that any special equipment (e.g. portable ventilation system) and/or personal protective equipment is available and used to perform the work safely. This is especially important when
health care professionals enter confined space. OSHA standard 1910.146 details the requirements for entry into confined spaces.

- The supervisor should contact the Hazard Communication Coordinator at the facility for assistance if he/she has any difficulty with the items listed above.
- It is the health care professional’s responsibility to acquaint themselves with the adaptation of these hazards at the assigned facility and the measures the facility is taking to address the issues. Notify your Supplemental Health Care Representative with any concerns or questions.

**Material Safety Data Sheet (MSDS)**

Manufacturers and suppliers are required to provide MSDS's to their customers. OSHA requires that the contents of the MSDS be based on the results of specific testing procedures designed to determine the toxic and hazardous characteristics of each material.

The MSDS is used to get information about the properties of the chemicals you may work with and how these chemicals can be used safely.

Although the standard does not require a specific MSDS format, a commonly used one is that of OSHA Form 174. A MSDS is usually broken down into 8, 9, 10 or more sections. The number of sections in an MSDS has no effect on the quality of the data therein. Additionally, the different sections of an MSDS may be arranged in any sequence desired by the manufacturer.

In any case, the basic format that an MSDS will take is demonstrated by the model MSDS form used by OSHA:

- Section I identifies the material, giving its chemical and trade names. It also lists the name of the manufacturer as well as an emergency telephone number
- Section II lists all of the hazardous components of the material and their percent composition. It also gives the Permissible Exposure Limit (PEL) and/or Threshold Limit Values (TLV) for each component. The PEL is a value which indicates the maximum exposure a health care professional may have to the component. PEL’s are based on amounts intended to protect a working person from the harmful effects of chemical exposure over the course of a working lifetime

**Radiation Safety Review**

Every person is exposed to various types of radiation (ultraviolet, light, ionizing etc.) on a daily basis. As a health care professional you not only encounter naturally occurring background ionizing radiation, but also ionizing radiation such as x-rays, gamma rays, and other high-speed atomic particles in the course of carrying out your professional duties. Effects of excessive radiation include: genetic (mutations, chromosome anomalies etc.); somatic (cataracts, tumors, skin lesions etc.); adverse effects on growth of fetuses and young children; and premature aging or shortened life span.

The goal is to keep exposure **As Low as Reasonably Achievable (ALARA)** to prevent injury and any biologic effects of excessive radiation. The primary ways to limit exposure focus on the principles of time, distance and shielding:

- **Time** – Reduce the time you are exposed
- **Distance** – Maintain distance from radiation sources whenever possible
- **Shielding** – Wear protective shielding material when indicated

Other radiation safety practices include:

- Identify and observe radiation safety warning signs
• If indicated, wear film badge or other monitoring device
• Use disposable gloves and other personal protective equipment when handling or exposed to radioactive materials
• Observe and practice good hand washing techniques, including washing hands after working around/with radioactive material
• Dispose of any potentially contaminated materials in accordance with the facility’s policies and procedures
• Do not smoke, eat, drink or apply cosmetics in radioactive work areas (these practices increase the hazard of ingesting radioactive materials)
• If you become pregnant there may be additional risks to the fetus, therefore the facility may institute additional monitoring and evaluation of your duties. Follow the precautions specified by the department, facility or state guidelines.

It is your responsibility to familiarize yourself with the facility’s specific policies and procedures to maintain safety. Please consult your supervisor and/or the Radiation Safety Officer at the facility if you have questions or concerns. For additional information refer to www.osha.gov

Fire Safety and Prevention

Because a fire represents a serious threat to hospital workers, patients and facilities, fire safety is of paramount importance. All health care professionals are required to follow Supplemental Health Care's Fire Safety and Prevention Policy.

A general knowledge of fire and associated hazards is important in helping ensure that patients, workers and property are protected. There are four classes of fires:

• **Class "A"** fires are ordinary combustibles. Examples of class "A" fires are burning wood or paper

• **Class "B"** fires are burning flammable or combustible liquids. Burning gasoline or oil are examples of class "B" fires. Because the burning material is a liquid, these fires can spread easily, increasing the hazard. Water should not be used to extinguish class "B" fires, because the liquids will float on water, furthering the spread of the fire

• **Class "C"** fires are electrical fires. A fire in a computer, a copier, or an electrical panel box is an example of this class of fire. Conductive extinguishing media like water should not be used, because of the shock or electrocution hazard

• **Class "D"** fires are burning metal. Examples are burning metal chips in a machine shop or a structural fire on an aircraft. These fires burn at very high temperatures

For a fire to start, three elements must be present. These elements are fuel, oxygen, and a source of energy to cause the fuel to ignite. A very simple example is a lighted cigarette being thrown into a wastebasket. The fuel is the waste paper in the basket, oxygen is present in the air around us and the cigarette provides the ignition. To prevent fires, precautions must be taken to avoid conditions that bring together fuel and a source of ignition in the presence of oxygen.

Practically speaking, sources of ignition and fuel must be controlled. Good housekeeping and storage practices are used to control fuel sources. To control sources of ignition, "No Smoking" rules must be enforced. All personnel should be alert to other sources of ignition; for example, frayed or arcing wires,
or overheating equipment. Unauthorized appliances must not be brought into facilities. Hazards should be brought to the attention of a supervisor.

The hazards of fires are not limited to the heat of the fire. The smoke generated by a fire, or the panic that ensues causes many injuries and deaths. It is essential that you know your role and responsibilities in the event of a fire. The basic rule for Supplemental Health Care health care professionals is to evacuate if there is a fire. Do not attempt to fight the fire. However, you may have additional responsibilities, as a worker at the facility to which you are assigned. You will receive instruction in these responsibilities from your supervisor. Examples of these responsibilities include evacuating patients and shutting down equipment. In the event that you have no additional responsibilities, the following policy applies:

Before an Emergency:
- Familiarize yourself with the facility’s emergency plan
- Learn both your primary and secondary evacuation routes
- Become familiar with fire extinguisher location, types of extinguisher and use

Types of Fire Extinguishers:
(Extinguisher will be marked with corresponding letter “A – B – or – C”)
- Class A extinguishers – put out fires of ordinary combustibles
- Class B extinguishers – smother fires involving flammable liquids or gases
- Class C extinguishers – put out fires near or in electrical equipment
- A-B-C extinguisher – can be used to fight all three types of fires

To use an extinguisher remember the acronym P-A-S-S:
- Pull – pull the pin
- Aim – the nozzle at the base of the fire
- Squeeze – the handle
- Sweep – the extinguisher from side to side

Fires spread quickly. The first several minutes are critical in preventing the spread of the fire and for preventing injuries. Use the acronym R-A-C-E when you are presented with a fire emergency:
- Rescue – Rescue patients in immediate danger. Crawl low in the smoke to prevent inhalation and heat injuries
- Alarm – Do not hesitate to activate the alarm system and/or notify the hospital switchboard. Do not yell “fire” to prevent panic and alarm
- Confine – Confine the fire to the affected area by utilizing the hospital fire doors. Shut off oxygen if necessary
- Extinguish or Evacuate – If the fire is small you may be able to extinguish it. If you are unable to safely and quickly extinguish it, evacuation of patients may be necessary

If evacuation becomes necessary follow these simple rules:
- Remain calm, panic will only increase the danger
- Never use an elevator to evacuate
- Evacuate ambulatory patients quickly to decrease confusion and allow for easier access to non-ambulatory patients
- Evacuation should be done horizontally first – utilize the fire doors to keep patients in a safe area
- If evacuation needs to proceed vertically – work your way down to a lower level unless it is blocked by smoke or flames
Groups such as the young, elderly and psychiatric patients may require specialized assistance
Do not leave groups of patients unattended
Bring patient records with you if at all possible
When you are regrouped, account for all patients, visitors and personnel
Be prepared to assist firefighters with directions to involved area and any patients remaining in the unit

Electrical Safety Policy

In order to ensure the safety of Supplemental Health Care health care professionals, the following rules regarding electrical safety must be complied with at all times:

- Do not operate any equipment that is tagged as "Out of Service"
- Do not use any equipment that shows signs of damage. Inform the supervisor of damage to the equipment so that it may be taken out of service for inspection and repair

Examples include:
- Broken covers on light switches and electrical outlets
- Frayed or cut cords, or cords where the insulation has pulled away from the plug
- Equipment with cracked cases or housings
- Missing switches or blanks in panel boxes

Electrical Work Practices:
If you must work in proximity to equipment or circuits being serviced, maintenance personnel must provide the following safeguards, at a minimum:

- Safely de-energizing circuits or equipment. This includes stored energy capacitors and high capacitance elements
  - These procedures must make use of locks and tags, and shall not be dependent on push buttons, interlocks, selector switches, etc. as the sole source of protection
  - In the event that a lock cannot be used, a tag must provide equivalent safety
  - The de-energized condition must be verified. A qualified person will complete this by use of the operating controls and test equipment

- Details safely re-energizing circuits or equipment
  - A qualified person shall determine that it is safe to re-energize the circuit by test and visual inspections
  - Anyone affected by the re-energization shall be warned to stay clear of the circuits or equipment
  - Locks and tags shall be removed by the qualified person(s) who applied them. If the qualified person is absent, a qualified person may make the removal, but the qualified person who applied the lock(s)/tag(s) must not be available in the workplace, and that qualified person must be notified of the removal of lock(s)/tag(s) immediately upon their return
  - A visual determination must be made so that all persons are clear of circuits and equipment

Back Safety Policy / Body Mechanics

Lower back problems are the leading cause of injury and sick time in health professionals. The primary ergonomic risk you face as a health care professional is the lifting and transferring of patients. The use of good body mechanics, the special way of understanding and moving your body
to make the best use of strength and avoid fatigue, can help prevent back injury. More information can be obtained at www.osha.gov/SLTC/healthcarefacilities/training.

Important body mechanics rules to follow:

- Use as many muscles or groups of muscles possible
- Maintain good posture - head erect, buttocks pulled in, stomach muscles tight, chest high, shoulders back
- Maintain the three natural curves in your back: the curve of your neck, middle back and lower back
- Have weight evenly balanced on both feet
- Broad based support, feet should be about 12 inches apart
- It is better to push, pull or roll than to carry something heavy
- Arm muscles support, leg muscles lift
- Size up the load. If load is too heavy or an awkward shape either get help or use a lifting device as per facility policy
- Make sure path is clear and free of obstacles and hazards
- Avoid wet and slippery areas – report hazardous conditions like loose carpets and wet flooring
- Don’t carry anything that blocks your vision

When you lift:

- Squat close to the load
- Center yourself over the load
- Keep your back straight
- Bend knees
- Grip firmly
- Lift by pushing up with your leg muscles
- Lift straight up, smoothly
- Hold load close to your body
- Pivot your feet, DO NOT TURN YOUR WAIST
- Turn with short steps – change directions slowly
- Count 1-2-3 when two or more people are lifting
- Establish count before you begin lifting
- Set object down properly - Let the legs do the work and bend knees, once load is secure on the floor, let go

Physical Restraint Devices / Fall Prevention

Fall Prevention:

- Fall prevention is an important aspect of care management. Recommendations for fall prevention are abundant and policies and procedures for preventing falls will vary between clients and facilities. Often a “Fall Assessment Tool” is used to determine the fall risk for each individual. Once the risk of a fall has been determined, appropriate measures can be taken to reduce the likelihood of a fall occurring.

Physical restraint devices:

Such as safety vest jackets, lap and wheelchair belts, and fabric body holders—may be beneficial to patients and their caregivers when used properly in settings ranging from nursing homes and hospitals to private homes. However, with increasing reports of injuries and deaths resulting from misuse of devices, the US Food and Drug Administration (FDA) is taking steps to ensure that health professionals and consumers have the information they need to use these devices safely.
Scope of the Problem:
- The FDA estimates that at least 100 deaths from improper use of restraints may occur annually. The FDA has received reports that many patients suffer burns, broken bones, and other injuries related to patient restraints. Many problems with restraint devices are never reported to the FDA. The agency has become aware of the magnitude of the problem from a variety of sources: the press, research in the field, and the FDA's Medical Device Reporting (MDR) System. Most reported deaths have occurred when patients tried to get out of the restraints for some reason, such as to go to the bathroom.
- Physical restraints are used with patients of all ages; however, most reported deaths and injuries have involved elderly patients living in nursing homes who were left unattended while restrained. At least one case is known of a child dying while being restrained.
- In the reported deaths, the cause was often asphyxiation due to strangulation. In many cases, the patient strangled after sliding down between a mattress and side rail while apparently trying to get out of bed. In a few cases, the patient slid forward while sitting in a wheelchair or geriatric chair and was strangled by the restraining device. From the reports the FDA has received, it appears that an increase awareness of the danger of misuse of patient restraints could prevent many deaths and injuries.

Uses for Restraints:
Used properly, restraints have many benefits for patients and caregivers in both institutions and homes. Restraints may help protect the elderly from falls which could result in injury or even death. If absolutely necessary, restraints also can help make medical treatment easier if a patient is temporarily uncooperative or highly agitated. If a patient is dangerous, restraints can protect other patients and workers from possible harm. Some patients feel safer and more secure, and need not to worry about falling if they use physical restraints. If certain medical procedures are being done at home or in an institution, such as changing an intravenous line or giving an injection, restraints can be useful to enable a patient to stay still.

Misuse of Restraints:
The misuse of physical restraints that can result in injury or death takes many forms:
- Inappropriate patient selection - Putting a restraint on certain patients may actually worsen their condition. For example, a chronically agitated patient may become more agitated with restraint
- Inappropriate use – Restraints should not be used unless necessary or when in the patient’s best interests
- Inadequate monitoring – Patients can be injured if they are not adequately monitored over long periods while they are restrained. In fact, if restraints are being used to avoid monitoring patients, then they are being misused. If a restraint is used for too long, and the patient is unable to move, various health problems may occur, including decubitus ulcers, nerve damage, and incontinence. Sensory deprivation from being restrained also may cause psychological problems. Mental and physical decline may also occur.

Patients in physical restraints need extra monitoring, not less

- Wrong type/incorrect application – Selecting the wrong type of restraint for a particular patient’s needs or putting a restraint on backwards or upside down, or using the wrong size, also increases the chance for injury or death

Recommendations:
Whether physical restraints are used in homes or institutions, the following general recommendations should be followed:

- Find alternatives to using restraints whenever possible
- Use with patient or family consent
- Discontinue use as soon as feasible
- Observe patient in restraints frequently
- Remove the restraints as often as possible to allow for normal body functioning and daily activities
- Apply and adjust the restraints so that it is comfortable for the patient

Follow the manufacturer’s direction to:

- Select the type of restraints recommended for the patient’s condition
- Use the correct size for the patient’s weight and height
- Note the front and back of the restraint and apply correctly
- Tie knots that can be released quickly
- Secure bed restraints to the bedsprings or frame, never to the mattress or bed rail. With an adjustable bed, secure the restraints to the parts of the bed that move with the patient.

Recommendations that particularly apply to institutions such as nursing homes include:

- Define a clear, written institutional policy on the use of restraint, and make it available to patients or residents and their families
- Display this policy and other instructions in a highly visible location, in foreign language as necessary.
- Provide regular health care professional and worker training – including demonstrations in proper use of restraints
- Obtain informed consent from patients or guardians before using restraints to prevent misunderstanding and to ensure cooperation
- Keep well documented patient records including, why, how, where, and for how long the restraint is used.
- Follow local and state laws regarding the use of these devices

Regulation of Physical Restraint Devices:
Even though there have been many reports of problems with various types of patient restraints, existing evidence does not indicate that these problems are a result of any particular restraint type, model or manufacturer. Rather, injuries and death appear to be due to problems that could be prevented with user education, training with device, and better product labeling. Therefore, the FDA has no plans to recall any of these devices from the market.

Since good labeling is critical to effective training in institutions and proper use of restraints at home, the FDA is working with the industry to improve the labeling on restraint devices. The goal is having clearer instructions, in warning labels will need to be affixed to the restraints devices where users can readily see them.

Reporting Problems:
Effective November 28, 1991, the safe Medical Devices Act of 1990 requires all hospitals, nursing homes, and acute-care facilities to report deaths related to the use of any medical device to the FDA and the manufacturer within 10 working days or to the FDA if the manufacturer is not known. Please report any misuse of patient restraints to your on duty supervisor immediately.
Medical Device Safety

Medical devices are those items that are used in the diagnosis, cure, mitigation, treatment or prevention of disease or condition. They affect structure and function in the body but are not metabolized or activated through a chemical reaction. Medical device use and safety is overseen by the US Food and Drug Administration.

Medical devices have the capability of causing injury and even death to the user or patient. Devices must be looked after and used properly.

- Medical devices differ greatly between facilities and settings, ensure that you are competent and have received training on the device
- Select the correct device and ensure that it is appropriate to the patient’s condition
- If you are not familiar or comfortable with the device being used, seek assistance and training
- Inspect all devices before using to ensure there are no signs of damage and that it is working properly:
  - Instructions, labeling, packaging
  - Defects
  - Software problems – Use errors
  - Failure to work as intended/malfunction
  - Interactions with other devices
  - Combinations of above
- Ensure that the device is setup safely
- Monitor the progress or function of the device and periodically assess the patient for response or issues
- Be familiar with response to issues or problems related to or with the device
- Report medical device problems when you think a device has or may have caused or contributed to death, serious injury, minor injury, “close call” or other potential for harm.
  - Report promptly to your supervisor and according to policy procedure at the facility you are working
  - Typically an incident report would also be completed
  - Remove and retain the device and any associated items – including packaging
- If no patient injury has occurred typically the device is removed from use, and reported to equipment management department at the facility. Make sure to completely fill out the appropriate form/report and make sure you include all possible details including equipment ID, manufacturer’s name, catalog number etc. and as much detail as possible about what is wrong with the device
- The importance of prompt and thorough reporting of medical device incidents impacts the public health and the good of patients and health care providers by:
  - Tracking issues and trends
  - Assisting Risk Management with claims and litigation
  - Providing information to manufacturers and the US FDA
  - Improving processes and outcomes

Sentinel Event

Adverse events are patient safety events that resulted in harm to a patient and should prompt notification of facility leaders, investigation and corrective actions. Patient safety events are events, incidents or conditions that could have resulted in, or did result in harm to a patient. Other patient safety events include no-harm events, close calls/near misses, and hazardous conditions.
A sentinel event is a subcategory of adverse events. A sentinel event is a patient safety event, not primarily related to the natural course of the patient’s illness or underlying condition, that affects a patient and results in death, permanent harm, temporary harm or intervention is required to sustain life. Sentinel events include but are not limited to:

- Patient suicide (in a facility where the patient receives around the clock care)
- Patient rape
- Administration of incompatible blood or blood products resulting in hemolytic transfusion reaction
- Surgery on the wrong patient or wrong body part
- Infant abduction or discharge to wrong family
- Unanticipated death of a full-term infant

Sentinel events must be reported in compliance with the institutions sentinel policy and immediately investigated. If you are involved in a sentinel event notify the appropriate personnel at the facility and, as soon as possible, notify your Supplemental Health Care Representative who will then communicate with the Vice President or Director of Quality Assurance and Clinical Services.

If you are involved in a sentinel event you will likely be part of the investigation of the event and comprehensive systematic analysis process (root cause analysis) coordinated by the facility. The comprehensive systematic analysis process focuses on processes and systems to identify strategies to reduce the risk of future similar incidents.

In the event you are involved in an issue that necessitates a Peer Review, it is the responsibility of the client or facility you are assigned to organize and run the formal Peer Review Process. However, Supplemental Health Care maintains a Peer Advisory Board that is available as a resource to the Vice President of Quality Assurance and Clinical Services who will support and assist you in the process.

**Process Improvement**

What is Process Improvement? *A phenomenon marked by gradual changes that lead towards a particular result.* Effective January 1, 2008 Supplemental Health Care adopted the set of three Stage II (standardized) performance measures established by The Joint Commission for Health Care Certification in order to meet the requirements for our certified offices. Supplemental Health Care is also involved in a variety of internal process improvement activities as well as activities related to our most valuable asset, our health care professionals. Goals of our process improvement activities include, but are not limited to:

- Improve consistency and establish operational excellence within the Supplemental Health Care organization
- Ongoing training and communication with Supplemental Health Care’s offices
- Feedback from clients reviewed and concerns or issues addressed
- Review and discuss survey findings with health care professionals

As part of your role with Supplemental Health Care we encourage you to become an active participant in our activities as well as the process with the client or facility where you are assigned.
Harassment Policy

Supplemental Health Care is proud of our tradition of a collegial work environment in which all individuals are treated with respect and dignity. Each individual has the right to work in a professional atmosphere, which promotes equal opportunities and prohibits discriminatory practices, including bullying and sexual harassment. Supplemental Health Care will not tolerate, condone or allow any form of harassment, whether engaged in by fellow health care professionals, supervisors, outside clients, or other non-employees who conduct business with this Company. Regardless of who the offender may be, or of the offender's relationship to the Company, the Company encourages reporting of all incidents of harassment, including harassment on the basis of: race, color, creed, religion, national origin, sexual orientation, age, gender, gender identity, genetics, citizenship, veteran status, disability, or any other characteristic protected by law or otherwise. Harassment is defined as unwelcome or unwanted behavior.

Supplemental Health Care encourages individuals who believe they are being harassed to firmly and promptly notify the offender that his or her behavior is unwelcome; the Company also recognizes that power and status disparities between an alleged harasser and a target may make such a confrontation impossible. In the event that such informal, direct communication between individuals is either ineffective or impossible, individuals should report the incident to their Supplemental Health Care Representative, the Human Resources Department or any member of the Senior Management Team of the Company.

Any allegation of harassment brought to the attention of the health care professional’s onsite supervisor, their Supplemental Health Care Representative, the Human Resources Department or any member of Senior Management Team of the Company will be promptly investigated. Confidentiality will be maintained throughout the investigatory process to the extent practical and appropriate under the circumstances.

Supplemental Health Care encourages a prompt reporting of complaints so that rapid response and appropriate action may be taken. This policy not only aids the complainant, but also helps to maintain an environment free from discrimination for all health care professionals. Health care professionals should also be aware of the time limits imposed by local, state and national governmental agencies for the filing of complaints of harassment or discrimination; those time limits are posted on the official notices, which are prominently displayed on office bulletin boards.

Supplemental Health Care will not in any way retaliate against an individual who makes a complaint of harassment or against any participant in the investigation, nor permit any health care professional to do so. Retaliation is a serious violation of this harassment policy and should be reported immediately. Any person found to have retaliated against another individual for reporting harassment will be subject to the same disciplinary action provided for harassment offenders.

Supplemental Health Care has developed this policy to ensure that all health care professionals can work in an environment free from harassment. The Company will make every effort to ensure that all health care professionals are familiar with the policy and know that any complaint received will be thoroughly investigated and appropriately resolved.

Workplace Violence

The workplace is considered any location, permanent or temporary, where a worker performs a work-related duty. Workplace violence prevention has become an important safety issue for all workers, particularly workers in health care facilities. In other workplaces, such as taxicabs or convenience
stores, violence most often relates to robbery. In contrast, violence in hospitals usually results from patients and their family members who feel frustrated, vulnerable, and out of control. Workplace violence includes: offensive or threatening language, and threatening or physical behavior leading to emotional or physical injury and/or death. Even though not every incident can be prevented, many instances of workplace violence can be prevented and/or the severity of injuries sustained by health care professionals reduced. Violence precautions indicate that violence should be expected but can be avoided or mitigated through preparation.

Factors that may place workers at risk for violence in the workplace (especially in health care facilities):
- Contact with the public
- Working with unstable or volatile persons in health care, social service or criminal justice settings

Poor environmental design:
- Poorly lit corridors, rooms, parking lots and other areas
- Unrestricted movement of the public
- Overcrowded, uncomfortable waiting rooms
- Long waits for service
- Working alone or in small numbers
- Working late at night or during early morning hours
- Working in high-crime areas
- Inadequate security
- Working in community-based settings
- Access to firearms
- Drug and alcohol abuse
- Availability/access to medications
- Lack of health care professional training and policies for preventing and managing crises with potentially volatile patients

Interventions by workers include, but are definitely not limited to:
- Self-awareness - fear, anger, communication skills, assertiveness
- Verbal De-escalation – decrease anger, de-escalate the emotions, express concern, non-confrontational tone, avoid arguing
- Physical Protection – don’t turn your back, make sure weapons out of reach, keep a safe distance, be aware of your surroundings, work in teams if possible
- Limit Setting – non-confrontationally establishing limits with the patient/family, zero tolerance for violence
- Environmental Designs (lighting, safe room for possibly violent patient, free from clutter that can be used as a weapon, furniture arranged to prevent entrapment of workers, emergency exits, waiting areas designed for delay in service)
- Install Security Devices (emergency signaling/alarms/monitoring, metal detectors, security cameras, lighting)
- Pharmacological Intervention (mental status exams, medications)
- Physical Containment (seclusion, restraints)
- Administrative Controls (staffing patterns to prevent personnel from working alone and minimize patient waiting time, restrict movement of public with card-controlled access, system for alerting security personnel)

All workers should be alert and cautious when interacting with patients and visitors. All health care professionals of Supplemental Health Care are expected to become familiar with the violence prevention policies and plans at the facility they are assigned. Health care professionals are encouraged to
promptly and accurately report workplace violence to their supervisor. By becoming aware of appropriate use and maintenance of protective equipment, adherence to administrative controls, and increased knowledge and awareness of the risk of workplace violence the worker may become safer and prevent/lessen injury to others.

**Domestic Violence**  
*Intimate Partner, Dependent Adult, Child and Elder Abuse*

The Welfare and Institutions Codes require any care custodial, health practitioner, or employee of a child/adult protective services agency, local law enforcement agency or health organization who has knowledge of, or observes a dependent child/adult in his or her professional capacity within the scope of his or her employment, who he or she knows has been the victim of physical abuse, or has injuries under circumstances, which are consistent with abuse where the dependent child/adult(s) statement indicate, or in case of a person with developmental disabilities, where his or her statement or other corroborating evidence indicate that abuse has occurred, to report the known or suspected instance of physical abuse to a child/adult protective services agency or a local law enforcement agency immediately, or as soon a practically possible, by telephone and to prepare and send a written report thereof within 36 hours of receiving the information concerning the incident.

In general there are four forms of abuse:

**Emotional Abuse:** Includes acts, or failures to act, that could cause serious behavioral, cognitive, emotional or mental disorders. Less severe but no less damaging acts include belittling or rejecting treatment, humiliation, insulting, name-calling or threatening

**Neglect:** Failure to provide for another’s basic needs; could be physical or emotional

**Physical Abuse:** The inflicting of physical injury and may include (but is not limited to) hitting, pushing, beating, burning, forced confinement, and non-prescribed restraints

**Sexual Abuse:** The inappropriate sexual behaviors with a child or non-consenting adult

These acts may include forced, tricked or coerced sexual behavior. There are usually three forms of abuse identified in the governing laws and welfare codes. Intimate partner violence, also known as domestic abuse, is abuse that occurs between adults. Child abuse is abuse or maltreatment occurring between an adult and a child. Elder abuse defined as an action by a person in a position of trust that causes harm to an elder. Harmful actions by strangers are usually not considered elder abuse.

The presentation of signs and symptoms may vary among the different groups; however identification, reporting and intervention are critical no matter what the age of the victim. Report any incidents of abuse to your on duty supervisor immediately.

**Elder Justice Act**

The Elder Justice Act, reporting reasonable suspicion of a crime in a long-term care facility, Section 1150 B of the Social Security Act, as established by section 6703(b) (3) of the Affordable Care Act, mandates specific individuals (including employees and contractors) of any long term care facility that receives more than $10,000 in Federal Funds are required to report to state agencies, and at least one local law enforcement agency, any reasonable suspicion of a crime against any resident or individual seeking care at the facility.
Individual workers are mandated to report, however the reporting requirement may be met through a joint or combined report with over individuals associated with the facility. Individuals reporting are not subject to any retaliation, harassment or discrimination since it is their legal right and obligation to report suspicion of a crime against a resident. The state agency and/or law enforcement agency may choose to combine the reports into a single investigation. Workers must become familiar with the policies and procedures at the facility to which they are assigned.

The Elder Justice Act reporting requirements include:

- If there is a serious bodily injury as the result of a crime of suspected crime against any resident the report must be made immediately, but no later than \textit{two (2) hours} after forming the suspicion. Otherwise, the report must be made not later than \textit{24 hours} after forming the suspicion.
- An individual report is made by contacting the local state agency or law enforcement agency.
- The LTC facility should have policies and procedures established to comply with this law.

\textbf{Medication Administration}

A Supplemental Health Care health care professional, typically a nurse, stating that he/she has obtained education and training in the health care field and is duly licensed and authorized to administer medications may be required to take a medication administration exam, and successfully pass with 80%

- All licensed health care professionals are required to follow the "Five Rights" to medication administration:
  - The Right Patient
  - The Right Medication
  - The Right Dose
  - The Right Time
  - The Right Route
- In addition to the “Five Rights” of medication administration some experts/facilities have added one or more “Rights”:
  - The Right Documentation
  - The Right Reason
  - The Right Assessment
  - The Right Response
  - The Right Client Education
  - The Right Equipment
  - The Right to Refuse
- Minimum of two \textit{patient identifiers} are to be used prior to administering medications. Typically this is the patient name and their unique patient/identification number. Most fundamental nursing courses describe the importance of verifying a patient's identity. This basic ritual and routine is integral to the medication administration process, treatments, and procedures. (see National Patient Safety Goal #1)
- Only approved abbreviations may be used
- The nursing process (or other appropriate professional guideline) guides decision-making regarding drug administration to ensure patient safety and meet medical and legal standards
- The (nursing) professional follows physician orders and is instructed to follow hospital guidelines and seek clarification when necessary
- The healthcare professional is encouraged to utilize medication references as needed and as is appropriate. Seek clarification from physicians, pharmacists and other appropriate healthcare professionals as needed.
• All health care professionals are to receive orientation prior to working independently on the unit and administering patient care
• National Patient Safety Goal #3 is to improve the safety of administering and using medications. The health care professional must familiarize themselves with the interventions implemented at their facility to address these safety measures including measures to address:
  - Sound-alike, look-alike drugs (“SALAD”) – such as separating these medications, altering lettering and packaging
  - High-risk/ High-alert medications: the acronym for these medications is “PINCH”:
    ▪ Potassium (and other electrolytes), PCA narcotics, Phenytoin (dilantin), Propofol (diprivan) and Promethazine (phenergen)
    ▪ IV Insulin, Intraspinal and Epidural medications
    ▪ Neonatal narcotics, Neuromuscular blockers and Nitroglycerin (IV)
    ▪ Chemotherapy (Cytotoxic meds), Critical Care medications (IV vasoactive and antiarrhythmic medications), Contrast media
    ▪ Heparin (other anticoagulants and antithrombolytics), Hypotonic/Hypertonic IV fluids
  - The Joint Commission recommends referencing The Institute for Safe Medication Practices (ISMP) List of Confused Drug Names to view the most current listing of look-alike/sound-alike medications

Corrective Action:
• In the event of a medication error, the Supplemental Health Care health care professional will report the error to their immediate supervisor and follow appropriate facility protocol
• Upon the hospital supervisor or nurse manager discretion and/or according to facility protocol, the facility supervisor will notify the local Supplemental Health Care Representative
• The Supplemental Health Care manager will notify the Quality Assurance and Clinical Services Department
• The Quality Assurance and Clinical Services Department will follow-up with the supervisor, facility and Supplemental Health Care health care professional with a plan of correction and appropriate action
• If the facility has any concerns about the Supplemental Health Care health care professionals they are encouraged to report to the Supplemental Health Care Representative/Manager
• The Manager will contact the Quality Assurance and Clinical Services Department for a plan of action/correction for the health care professional

**Pain Assessment and Management**

The International Association for the Study of Pain in 1979 defined pain as the “unpleasant sensory and emotional experience associated with actual or potential tissue damage, or described in terms of such damage.” (American Pain Society) Pain is a complex and subjective experience. The patient is the authority on their pain, not the health care provider. Pain is very common. Mismanaged or inadequately managed pain can be associated with many adverse physiological, psychological, financial and quality of life consequences. Barriers to appropriate assessment and management of pain include: health care system barriers; health care professional barriers; patient and family barriers; legal and societal barriers; tolerance, physical dependence and addiction barriers.

All patients are entitled to pain management. The health care professional is obligated to develop an organized approach to recognizing, treating and evaluating pain in their patient population:
• Identify the patient’s right to appropriate pain assessment and management
• Discuss with the patient their “pain-control goals”
• Assess and reassess the patient’s pain and document the results
• Utilize the pain assessment tools or pain scales used by the facility with the understanding that
  use of the appropriate scale is typically based on the patient’s age and cognitive status
• Educate the patient on their responsibility to inform the health care team about their pain so it
  may be promptly and adequately treated
• Collaborate with other health care professionals and other disciplines to treat and manage the
  patient’s pain
• Utilize patient-controlled analgesia and other pain management techniques appropriately
• Utilize non-pharmaceutical pain management measures such as distraction, music, massage and
  relaxation techniques in addition to medications
• Re-evaluation of pain after intervention is expected and must be documented
• Communicate with patients and families about the value of effective pain management on
  recovery and rehab
• Identify that pain is a personal experience and directly influenced by cultural, spiritual and ethnic
  beliefs and traditions
• Collect information to monitor the appropriateness and effectiveness of pain management
• Educate patients on the importance of proactive and adequate pain management and its effects
  on rehabilitation as well as alternative and complementary methods of pain relief
• Determine the competency of health care providers and educate them on pain assessment and
  management
• The health care professional must familiarize themselves with the pain policy and the standard
  of care at the facility they are assigned

**Skin Assessment**

Physical assessment of the skin begins with a general inspection followed by a detailed examination. Areas that are typically assessed include: color, temperature, turgor, moisture, odor, scars, masses, fingernails, toenails, capillary refill, lesions, birthmarks and moles. When preparing to assess the skin, wear gloves if the patient has any lesions, complains of itching skin, if the mucous membranes are to be examined or any exposure to body fluids is anticipated.

National Patient Safety Goal #14 addresses the prevention of health care associated pressure ulcers. Pressure ulcer risk assessment should be completed on admission of patients and at least once daily. Patients should be assessed for the presence of pressure ulcers and the risk for developing pressure ulcers using a scale such as the Braden Scale for Predicting Pressure Sore Risk. The Braden Scale components include: Sensory Perception, Moisture, Activity, Mobility, Nutrition, Friction and Shear.

Pressure Ulcers should be staged using a wound resource or scale: Deep Tissue Injury, Stage 1 (non-blanchable redness), Stage II (partial thickness loss of dermis), Stage III (full thickness tissue loss), Stage IV (full thickness tissue loss with exposed bone, tendon or muscle), Unstageable (full thickness tissue loss).

The health care professional must familiarize themselves with the skin assessment and risk assessment policy and standards of care at the facility they are assigned. Interventions and treatments may vary greatly depending on the setting and by facility.
Assessment and Planning

The cyclical and ongoing process of assessment, diagnosis, planning, implementation and evaluation is typically known as the nursing process. The nursing process is not something unusually complex; on the contrary, it is simply a systematic process of decision making. Regardless of the reason for the encounter, the routine assessment of the patient’s needs promotes systematic evaluation and discovery of the patient’s problems. As each of the problems is identified, a measurable goal is established. After goals are established and the plan implemented ongoing evaluation and reassessment is necessary.

Supervision/Leadership and Delegation

As a representative of Supplemental Health Care the health care professional is expected to promote a positive work environment through personal example and teamwork. While carrying out your duties with Supplemental Health Care you will not be asked to perform in a manner other than that which is reasonable and customary within your profession. Health Care professionals shall not be called upon to perform services outside the general job description provided by the facility. If at any time you are not comfortable or qualified with a reassignment of duties, including being asked to perform in a leadership role, please notify your supervisor and notify your Supplemental Health Care Representative.

The delegation process should be consistent with the systematic process of decision making and must include an assessment of the patient, circumstances/setting, ascertaining the competence of the individual receiving the delegated task (delegatee) as well as confirming there are adequate resources including supervision. Certain components of the process, such as assessment, evaluation and professional judgment must not be delegated. Supervision, monitoring and evaluation / follow-up are crucial components of delegation. The delegatee is accountable for the acceptance of the delegation as well as his/her actions while carrying out the task.

Permission to delegate according to state practice acts and the skills of the delegatee related to state guidelines and practice acts must also be part of the decision making prior to the delegation of a task. The delegation decision-making process is continuous.

The Five Rights of Delegation provide a guideline to facilitate decisions about delegation:

- **Right Task**
  - Appropriate to be delegated for a specific patient

- **Right Circumstance**
  - Available resources, appropriate patient setting and other factors considered

- **Right Person**
  - Right person is delegating the right task to the right person to be performed on the right person

- **Right Direction/Communications**
  - Clear and concise description of the task including conveying the objective of the task and the limits and expectations
  - Both/all parties involved accept accountability for their roles in performance of the task

- **Right Supervision**
  - Appropriate intervention, monitoring, evaluation and feedback
  - Evaluate the patient and the performance of the task
Documentation

“If it wasn’t charted it wasn’t done”! It has been said that the best protection from liability is good patient care, however good documentation is the best protection from malpractice. Not only must written communication survive the scrutiny of multiple regulatory and accrediting agencies, it must do so without contributing to excessive labor costs. Documentation, whether written or electronic, has a number of basic do’s and don’ts rules to follow:

Do:

- Familiarize yourself and seek out training on the computerized system of documentation at the facility you are assigned to
- Print or write clearly / legibly
- Use waterproof, ball-point black ink
- Confirm you are charting on the correct chart or computer screen
- Chart precautions or preventive measures such as bed rails and call lights
- Chart patient care at the time you provide it
- Chart medications and treatments, as well as the patient’s response to them
- If you must chart information at a later time, indicate “late entry” and include the date and time of the late entry
- Documentation should reflect the nursing or decision making process and reflect your professional skill set
- Record phone calls to interdisciplinary team members, including physicians, and include the exact time, message, intervention or response
- Only use acceptable abbreviations
- When charting what someone else said, heard, felt etc. use quotations and indicate the person who is being quoted
- Chart objective descriptions and quantities as much as possible

Don’t:

- Don’t alter a patient record – this may be a criminal offense
- Don’t chart care ahead of time – if something unexpected occurs you may not be able to carry out the care that you have charted - this would be considered fraud
- Don’t use abbreviations that are not accepted, including The Joint Commission “Do Not Use” listing of abbreviations
- Don’t chart a patient symptom or complaint without charting your intervention or response

There are many styles and formats for charting. It is the duty of the health care professional to become familiar with the style and form of charting used at the facility assigned. One common charting format is SOAP.

- S = Subjective (Observations, Information, Patient or other’s descriptions or story)
- O = Objective (Observations from assessment or exam)
- A = Assessment (Diagnosis)
- P = Plan (Plan, treatment, interventions)

Continuity of Care

Improving continuity of care requires efforts by the health care system, by the people receiving care, and by their family members. Interdisciplinary care is coordinated care provided by multiple types of practitioners, including doctors, nurses, physical therapists, occupational therapists, social workers and pharmacists. These practitioners make an organized, conscious effort to communicate, cooperate, and
concur with each other about a person’s care. The goal of interdisciplinary care is to ensure that people and patients move safely and easily from one place of care to another and from one health care practitioner to another. Coordinated interdisciplinary care is essential for frail patients, those with multi-system disorders, those who need to see several different types of health care practitioners, those on multiple medications or therapies, when treatment is complicated or when it involves transition from one place of care to another.

Patients can help participate in their health care by keeping a current copy of their medical record. Keeping a copy of the medical record is useful as a reference for information about disorders, medications being taken, treatments and tests done, and even payments made. This information can be extremely helpful for people to explain a problem or issue to a new or existing health care practitioner.

**Point of Care Testing**

Point of care testing is diagnostic testing that is conducted at or near the patient’s location and enables decisions to be made faster than those where lab tests must be evaluated by a standard lab. Annual review of point of care testing (POCT) is required by Joint Commission and Clinical Laboratory Improvement Amendments (CLIA) to verify that testing procedures and quality control measures are followed to ensure optimal patient care.

Point of Care Testing is performed when it has been ordered by the patient’s health care provider and must be performed by qualified health care professionals who have completed training and competency assessment at the facility. Typically POCT is performed by MDs, RNs, LPN/LVNs, and trained MAs. The health care professional must familiarize themselves with the policies and the standard of care at the facility they are assigned.

Typical Point of Care Testing procedures include:

- Accu-Check or other blood glucose screening or monitoring system for quantitative determination of glucose in whole blood
- Urine Dipstick reagent strips designed to screen for a variety of substances contained in the urine that may indicate health or disease (i.e.) glucose, bilirubin, ketones, blood, pH, protein, leukocytes, urobilinogen, nitrites, and specific gravity
- Colo-Screen guaiac test for detection of fecal occult blood
- Gastroccult screening for detecting the presence of occult blood and pH of gastric aspirate or vomitus
- HemoCue B-Hemoglobin system for quantitative determination of hemoglobin in capillary, venous and arterial whole blood
- Urine hCG for qualitative detection of human chorionic gonadotropin (hCG) in urine to aid in the early detection pregnancy.

**Informed Consent**

Informed consent is a legal condition where the person has agreed to a procedure or treatment after having an appreciation and understanding of the facts and implications of the action or inaction. Many times informed consent may be implied, however the degree to which consent is implied or inferred may make it legally difficult to determine and may be legally invalid. In the medical community explicit agreement by means of signature is typically the norm. Certain conditions must exist or be absent to make obtaining an informed consent possible:
• The individual needs to be in possession of relevant facts, including risks and benefits of the procedure or treatment
• The individual needs to be mentally competent without impairment of judgment or mental illness at the time of consenting (including drugs, alcohol intoxication, insufficient sleep etc.)
• The person must be generally authorized to give consent (i.e. not a minor or mentally ill)
• The person must not possess fear of social, psychological or physical retaliation or pressure (no coercion)
• Informed consent must not be implied or assumed, it should be stated explicitly

This section is only a brief overview. It is the health care professional’s duty to familiarize themselves with the facility and state specific issues related to the complicated legal issues surrounding informed consent and the appropriate methods of documentation.

**Nutrition**

Nutrition plays a major role in both health promotion and disease prevention, in addition to being a therapeutic tool in the treatment of medical, surgical and emotional illness. Health care professionals should develop the basic skills necessary to assess nutritional status and provide nutrition support. A healthful diet can help rebuild the body's cells and energy level. Patients admitted to the hospital are screened for nutritional risk as part of the initial assessment. Once an at risk patient is identified, the dietitian assesses the patient and determines the level of risk and complexity including: age; diagnosis/procedure or treatment; NPO/enteral status; metabolic/mechanical problems; height/weight changes; and laboratory values. A formal physician referral is typically not required for nutrition assessment. Nutrition consultants should be utilized when appropriate to help provide counseling for at-risk patients. Nutritionists, registered dieticians and licensed dieticians have specialized training in public health nutrition, wellness and disease prevention, medical nutrition therapy, and nutrition education and counseling for patients and the general public.

Assessment of nutrition status is vitally important in long-term care settings for both optimal patient care and to meet regulatory standards. Careful nutrition assessment leads to development of an individual plan of care to optimize nutrition status. Dietary intake can be influenced by a multitude of patient factors, including but not limited to:

- Nutritional knowledge
- General health status (diseases, habits, family history)
- General lifestyle (habits, hobbies, environment)
- Socioeconomic state (ability to purchase and prepare food)
- Psychosocial and mental health issues (depression, dementia, eating disorders)
- Culture (family, community, religion, ethnic background)

**Sedation**

Conscious sedation is the use of medications to minimally depress the level of consciousness in a patient; the patient should maintain ability to continually and independently maintain a patent airway and respond appropriately to verbal commands and stimulation. Conscious sedation is achieved by administering the same medications and delivery methods used for deep sedation and anesthesia and therefore require specialized knowledge and training. Health care providers that administer, monitor, and recover patients from conscious sedation must possess and demonstrate knowledge regarding anatomy, physiology, dysrhythmias and other conscious sedation related complications. They must also have knowledge and training on the pharmacological sedation agents and the reversal agents. Additionally, they must have the skills and access to equipment allowing for assessing, diagnosing and
treating any complications that may occur before, during and after conscious sedation administration. The availability of a code team or resuscitation team is considered an additional resource. The Joint Commission standards reiterate the standard that the person administering the medication must be qualified to manage the patient at whatever level of sedation or anesthesia is achieved, either intentionally or unintentionally and must by competent to perform the emergencies that occur from conscious sedation.

Prior to sedating the patient the following must be available during sedation administration and recovery:

- Documented history and physical on the chart prior to receiving conscious sedation
- Assess and verify patient’s NPO status
- Trained health care professionals able to observe and monitor the patient uninterrupted from time of sedation until discharge
- Ability to perform continuous appropriate documentation
- Oxygen and airway management equipment – present and functioning
- Suction – present and functioning
- Patent IV and IV fluids
- Cardiac monitoring equipment – present and functioning
- Continuous vital sign monitoring equipment
- Pulse Oximetry
- Resuscitative equipment and medications (including reversal agents) readily available

The sedation agents used depend on the type, duration and severity of the procedure being done. Differences in the patient’s health status and ability to metabolize medications must be also considered during the selection and administration of the medications. Conscious sedation is frequently used for the pediatric patient. Pediatric patients must also be evaluated for past medical history, ability to cooperate and communicate as well as the potential for untoward reactions to the medications. Informed Consent must be obtained from the parent or guardian and education/follow-up must include both the child and the adults accompanying the child.

Discharge criteria may vary from facility to facility, however typical discharge scales include the following guidelines:

- Stable respiratory status
- Stable circulatory status
- Stable level of consciousness/able to follow commands
- Able to retain oral fluids
- Able to void
- Stable out of bed for 30 minutes prior to discharge
- Discharged with a written order and follow-up instructions
- Under observation of a responsible person with appropriate transportation

**Resuscitation**

Cardiopulmonary resuscitation (CPR) is an emergency medical procedure for persons/patients experiencing respiratory arrest and/or cardiac arrest. It is a combination of rescue breathing and chest compressions delivered to persons/patients thought to be in cardiac arrest. CPR in the community and by trained health care professionals both focus on chest compressions and ventilation techniques, however the health care professional has additional equipment and advanced procedures at their disposal. CPR is an effort to deliver a small amount of blood flow to the brain and heart until normal heart function is restored.
Cardiac arrest in adults is most often caused by the abnormal heart rhythm called ventricular fibrillation (VF). During ventricular fibrillation the heart quivers and does not have an organized pumping mechanism. Defibrillation is the administration of an electrical shock to the chest, and in addition to CPR, and is the preferred method to treat ventricular fibrillation. Defibrillation is an attempt to eliminate the ineffective fibrillation heart rhythm and allow the normal or organized rhythm to resume. Defibrillation may not be effective for all forms of cardiac arrest but may be effective in treating the most common cause of sudden cardiac arrest, ventricular fibrillation.

All health care professionals during their CPR training and practice should be trained on the Automatic External Defibrillator (AED). This portable, easy to use device allows the health care professional, as well as the lay person, the ability to accurately interpret cardiac rhythms requiring electrical shock and the automated delivery of that shock in an attempt to reverse ventricular fibrillation.

The health care professional’s role during resuscitation will vary greatly from setting to setting. They may simply be the initial person to discover the arrest, begin CPR and call for assistance (9-1-1 if outside a hospital) or they may be an active member of the Cardiac Arrest/Resuscitation team. It is the duty of all trained health care providers to become familiar with the cardiac arrest procedures at the facility assigned and their assigned role. Ultimately all trained health care providers must maintain current CPR (Basic Life Support) for Health Care Providers certification while associated with Supplemental Health Care.

Cultural Competence Overview

The term cultural competence by health care professionals has a range of interpretation throughout the health care system. Generally cultural competency encompasses the concepts of cultural diversity, cultural sensitivity and cultural awareness. This information is simply an overview of some of the concepts the health care professional must consider as they inevitably come into contact with a multitude of cultures as they perform their daily duties.

When considering cultural awareness and cultural sensitivity health care professionals generally begin with generalizations or stereotypes about the culture of the individual they are caring for. There is a great difference between these two concepts. A stereotype is generally considered an assumption, a conclusion, about a culture. Whereas generalizations are considered a starting point, they indicate trends. Generalizations may or may not be accurate about a particular patient but they supply the health care professional with a starting point as they care for the individual.

One reason for many of the conflicts and misunderstandings throughout the health care system come from the conflict between the values of the health care system and that of the individual patient. The following is a partial listing of concepts that need to be taken into consideration when caring for an individual patient.

The affect the patient’s culture will have on the patient’s acceptance and adherence to the treatment plan should also be considered:

- Values – things they hold important and therefore affect their behavior
- Religion and their theory about reality
- The individual vs. the family
- Independence vs. dependence
- Privacy vs. Openness
- Health/Fitness – what is their definition of healthy
- Physical appearance – what is their definition of beauty
- Modesty
- Self-control vs. expressiveness
- Present vs. Past vs. Future time orientation
- Social structure – democratic vs. hierarchical
- Gender roles – men, women, children
- Gender and taboos
- Food
- Alternative medicine and health care providers

The challenges of caring for patients of multiple cultures can often be overcome simply through effective communication. The appropriate use of professional interpreters cannot be overemphasized. Family members, friends and "informal" interpreters are more likely to modify what the patient has actually stated, whereas professional interpreters are trained to convey messages without interjecting their own opinions, beliefs or prejudices. Laws and regulations guarantee non-English speaking patients “meaningful access” to health and social services that receive any form of federal funding. As a Supplemental Health Care health care professional you must become acquainted with the policies, procedures and resources at the facility you are assigned when it comes to accessing services of a professional interpreter.

When the health care professional is able to converse with the patient from another culture the primary way to convey empathy, interest and concern is through effective communication. Activities that can contribute to effective communication include:
- Asking non-judgmental questions to help understand the patient’s perspective
- Attentive listening – listening for clues on the patient’s comprehension of the situation and course of treatment
- Working with the patient (and family - when appropriate and desired by the patient) to set goals and to understand their ability to adhere to the recommended treatment plan
- Involve the patient and family (when appropriate/desired) in the decision making and treatment planning process
- Observation and appreciation for nonverbal communication by the patient as well as the health care professional’s own nonverbal communication:
  - Facial expressions
  - Hand and arm gestures
  - Head movements
  - Physical space
  - Touching
  - Eye contact
  - Posture

In conclusion, cultural competence by the health care professional is an ongoing process. Cultural sensitivity, cultural diversity and cultural awareness are an inevitable part of the health care profession. This is simply an overview of some of the concepts the health care professional must consider. All health care professionals must continue their cultural awareness training on a daily basis as they communicate and interact with their patients.

**Spirituality**

Spirituality is another factor that plays an important part in health and health care interactions and decisions. Spirituality is differentiated from religion; it is identified as a more personal search for and an understanding of “something bigger than oneself”. For many patients life-threatening illnesses may spark questions regarding the purpose and meaning of life. Spirituality becomes an integral part of
patient care and the healing process and their understanding of their illness. Spiritual care impacts the patient, family and ultimately may affect the patient’s will to live.

Basic assessment of the patient’s spiritual and emotional needs may occur during the initial assessment or during a more appropriate point in the patient interaction. Questions that should be addressed during the spiritual assessment or history include:

- Is the patient part of a religious community or spiritual community
- Does spirituality or religion assist the patient to cope during times of stress or does it cause stress
- Is the patient having any spiritual questions or concerns
- Are there spiritual or religious beliefs which may affect the patient’s medical care
- Are there any spiritual or religious beliefs, ceremonies, traditions which could be allowed and integrated into the medical treatment plan

Spiritual care is interdisciplinary, however typically is a collaborative effort coordinated by the chaplains and pastoral care counselors. It is the health care professional’s duty to continue their spirituality awareness training and explore the options and resources available at the facility you are assigned.

### Dementia and Alzheimer’s Awareness

Dementia is not a single specific disease rather it is a group of symptoms that are caused by various diseases or conditions. The deterioration is more than might be expected from normal aging and is due to damage or disease. Dementia is associated with behavioral changes and loss of cognitive functioning to such an extent that it interferes with a person’s daily life and activities. Forgetfulness is usually the first symptom exhibited, it ranges in severity from the mildest stage, when it is just beginning to affect a person’s functioning, to the most severe stage, when the person must depend completely on others for basic activities of daily living. There are two types of dementia. Reversible dementia which improves with treatment and may be caused by drugs, depression, infection, brain tumors, head injury. Irreversible dementia progressively becomes worse and cannot be cured.

The most common form of irreversible dementia is Alzheimer’s disease. More than half of all dementia cases, as many as 70 percent, are related to Alzheimer’s. The chemistry and structure of the brain changes causing the brain cells to die prematurely. The second most common type of dementia is caused by issues with blood vessels (veins and arteries) and is labeled Vascular Dementia. Mixed Dementia is when Alzheimer’s disease and vascular dementia occur at the same time. Some scientists theorize that mixed dementia occurs more frequently than previously believed, and it may become even more common as people age.

Common signs of Dementia and Alzheimer’s disease include:

- Memory Loss
- Disorientation
- Language difficulties
- Personality changes
- Agitation and mood swings
- Poor hygiene
- Odd behavior
- Confusion
- Decreased or poor judgment
- Challenges in planning or solving problems
- Difficulty completing familiar tasks
- Difficulty with words in speaking or writing
- Misplacing Objects and decrease ability to retrace steps
- Withdrawal from usual social or work activities
- Difficulty understanding visual images and spatial
- Repetitive language and behavior

### Stages of Alzheimer’s:

Alzheimer’s is a progressive decline in cognitive function and generally occurs in stages as it progresses:
- Stage I – Absence of Impairment – Normal adult functioning
- Stage II – Minimal Impairment – Minimal lapses in memory or cognitive problems
- Stage III – Noticeable Cognitive Decline – Others notice changes in memory or behaviors
- Stage IV – Early-stage/Mild Alzheimer’s – Cognitive decline is apparent
- Stage V – Middle-Stage / Moderate Alzheimer’s – Assistance with daily tasks is required
- Stage VI – Moderate to Late-Stage / Severe Alzheimer’s – Personality and behavior changes
- Stage VII – Late-Stage/Severe Alzheimer’s – Communication very limited, total care required

Communication strategies and skills when caring for a person with dementia:
- Create a positive tone for communication:
  - Attitude and body language can be interpreted stronger than using words
  - Speak in a pleasing and respectful manner
  - Do not try to restrain the person during a period of agitation
- Speak slowly, distinctly and in a reassuring tone:
  - Use facial expressions to help communicate your message
  - Limit distractions and noise
  - Use nonverbal cues and touch to assist the person to focus
  - State the message clearly
  - Use simple words and sentences
  - Sit or stand face-to-face when talking
  - Address person by name
  - Use a rather low voice and speak slowly
- Ask simple, answerable questions:
  - Ask one question at a time
  - Ask questions that may be answered “yes” or “no”
  - Be patient when waiting for the reply
  - When the person is struggling for an answer, suggest words
  - Strive to listen for the meaning and underlying feelings

Strategies for activities of daily living when caring for a person with dementia:
- Make tasks manageable
- Break down activities into a series of steps
- Use visual clues
- Maintain structure by following the same routine and keeping objects and furniture in the same place
- Support and encourage the person to do as much for himself/herself as possible
- Monitor personal comfort

Strategies for dealing with agitation and challenging behaviors will include:
- Create a calm environment; reduce noise and clutter in the room
- Maintain a comfortable room temperature
- Monitor and reduce the number of persons in the room and frequency of interruptions
- Maintain structure by keeping objects and furniture in the same place
- Maintain a consistent routine
- Try gentle touch, soothing music, reading or walks to quell agitation
- Acknowledge the person’s anger over the loss of control in their life; reassure them you understand their frustration
- Distract the person with a snack or an activity
- Minimize sugar, junk food and caffeine intake
- Assess discomfort/pain, hunger, thirst, constipation, full bladder, fatigue, infections and skin irritation
- Do not confront or argue about facts that you know are incorrect
- Let the person express their wish and don’t point out their mistake

Injury prevention includes:
- Assess the level of cognitive disorders such as change to orientation to people, places and times, range, attention, thinking skills
- Assess the level of impaired ability of competence, impulsive behavior and a decrease in visual perception
- Assist family and caregivers to identify the risk of hazards that may arise
- Provide privacy and security, minimize sources of hazards in the environment
- Use safety locks on doors and gates
- Keep dangerous objects out of reach, ensure there are no guns in the house
- Divert attention when person is agitated or exhibiting dangerous behaviors such as attempting to get out of bed or climbing over the bars of the bed

**Advance Directives and End of Life**

An **Advance Directive** is a document stating health care choices and names someone to make choices for the patient if they become unable to do so.

Competent adults have the right to refuse or accept medical treatment after being informed of the procedures and risks. However, there is growing concern over how medical care decisions will be made when people are unable to make decisions for themselves. Today, medical technology presents us with a number of treatments that prolong life. Some people do not want such treatment; others wish to take advantage of every procedure available. Often, decisions must be made when the patient is no longer able to state preferences.

A growing number of people are stating their health care choices in writing while they are still able to make these decisions. These legal documents are called Advance Directives, more commonly known as a Living Will and Durable Power of Attorney for Health Care.

It is advised to speak to a physician about the effect of withholding or withdrawing different treatments. It is also a good idea to discuss decisions with family members. While it is not necessary to consult an attorney for Advance Directives to be a legally binding document, it is often helpful.

If an Advance Directive has not been executed and the patient is unable to make decisions, others will make health care decisions for that patient in consultation of a physician. These decision-makers should be guided by the patient’s intentions. However, with a Living Will or Durable Power of Attorney for Health Care, the patient will have a greater assurance that their wishes will be carried out.
A **Living Will** is a document directing the patient’s physician that certain life-sustaining procedures should be withheld or withdrawn if the patient is in a terminal condition and unable to decide for themselves.

A **life-sustaining procedure** is any mechanical or artificial means which, sustains, restores or supplants a vital body function and which would only prolong the dying process for a terminal patient. A mechanical respirator is an example. In addition, medication or medical procedures necessary to provide comfort for pain are not life sustaining procedures and would not be withheld under a Living Will.

A **terminal condition** is an irreversible condition that, without life-sustaining procedures, will result in death in a relatively short time or a state of permanent unconsciousness from which there is no likely recovery. The attending physician, following consultation with another physician, must make the determination of terminal condition. A Living Will takes effect only when there is a terminal condition and the patient is unable to make decisions.

A **Durable Power of Attorney for Health Care** is a document that names another person as “attorney-in-fact” or “agent” to make health care decisions for the patient, if they are unable to make them. This agent is required to make decisions according to directions provided in the document or otherwise. If the wishes are not known, the agent shall make decisions in the best interest of the patient.

**How does a Durable Power of Attorney for Health Care differ from a Living Will?** Both documents apply only when the patient is unable to make health care decisions. A Living Will applies only if the intention is to have life-sustaining procedures withheld or withdrawn and the patient is in a terminal condition. It is a directive to the physician. A Durable Power of Attorney for Health Care names an agent to make health care decisions in accordance to the wishes of the patient. The health care wanted or not wanted may be specified. Its application is not restricted to patients with a terminal condition or to decisions about life-sustaining procedures.

The person named in a Durable Power of Attorney for Health Care should be someone that is trusted and who has consented to act as an agent. It is advisable to name an alternate agent in case the agent appointed becomes unable or unwilling to act on the behalf of the patient. The agent can make any health care decision the patient can make regarding treatment of physical or mental condition. In all cases, the agent must make decisions in accordance with the wishes of the patient. If desired the scope of the agent’s authority may be limited.

It is important that the wishes are discussed with the person who will be the agent. Wishes may also be stated on the Durable Power of Attorney for Health Care form. If the agent does not have knowledge of the desires or wishes, he or she has a duty to act in the best interest considering the condition and prognosis of the patient. If it is known that life-sustaining procedures want to be withheld or withdrawn in the event of a terminal condition, a Living Will should be signed since it provides direction to your physician and they will not have to rely on an agent to communicate those wishes.

If a patient is uncertain about which documents are best, they should consult their physician or attorney for guidance. The original should be put in a safe but accessible place. Copies should be provided to family members and, if a Durable Power of Attorney for Health Care has been executed, to the appointed agent and alternates. A copy should be given to the physician. A copy should be filed with the hospital, if it accepts such forms.
Advance Directives executed by previously competent adult patients will be honored and will guide treatment decisions to the extent provided in the document. Adult patients retain the right to make the decision to accept or reject offered treatment so long as they are able to do so, whether or not they have executed and Advance Directive.

Despite the numerous documents that may be in place health care professionals who treat patients approaching the end of life face ethical, moral and legal issues. These issues involve quality of life, the right to refuse medical treatment, futility of treatment, euthanasia, and even physician assisted suicide. With the advances of medical treatment there is a tremendous burden of balancing quality of life and the financial and emotional burden imposed on the patient, family and even society.

**Palliative care** is medical care or treatment that concentrates on reducing the severity of the symptoms or disease, thereby preventing or relieving suffering and improving the quality of life for patients with serious or terminal illness; whereas **curative care** is directed at halting or delaying progression of the disease itself or providing a cure. Health care professionals must collaborate with the patient and interdisciplinary team and support efforts to comply with the agreed upon plan of care. Health care professionals must ensure respectful, responsive care of the dying patient with particular attention to patient comfort and pain management.

**Anatomical Gift Act**

The Uniform Anatomical Gift Act of 2006 is the basis for organ donation throughout the United States and reflects revisions of the earlier 1968 and 1987 Uniform Acts. These acts have been adopted in every state, although there are some minor variations among the states' laws. Basically, the laws maintain that competent adults may make gifts of an organ or organs in the event of their deaths. Most frequently adults make their wishes known through reporting to the Department of Motor Vehicles in their state, the information is then maintained in a registry. Advance Directives, such as a living will or durable power of attorney for medical care, can instruct the person's agent to donate the person's organs or tissues upon the person's death. As with living wills, the durable power of attorney for medical care is only effective if, in addition to the agent, the family and the person's physician know of its existence.

A law enforcement officer, firefighter, paramedic or other emergency rescuer is required to make a reasonable search of an individual who the person reasonably believes is dead or near death for a document of gift or other information identifying the individual as a donor or as an individual who made a refusal. If a document of gift or a refusal is located during the search, the person responsible for conducting the search should send the document of gift or refusal to the hospital with the individual. If no source of the donor information is immediately available, a hospital, as soon as practical after the individual’s arrival at the hospital, should also make a reasonable search.

To assist in the evaluation of potential donors, federal law requires hospitals receiving Medicare and Medicaid funding to refer all deaths or near deaths to organ procurement organizations or a designated third party for possible eye, organ, and/or tissue donation. Because organ donation is voluntary, routine inquiry laws were initially enacted in by several states. The laws, with the aim to increase the potential donor pool, require hospital personnel to request consent of potential candidates or their families, for donation, or at least inform them of the option.

This section is only a brief overview. The Uniform Anatomical Gift Act is very detailed, as are the many federal and state statutes which also closely regulate organ donation and procurement. The health
The health care professional must familiarize themselves on the facility and state specific issues related to the complicated moral, medical, and legal issues surrounding organ donation and transplantation.

**Emergency Medical Treatment and Active Labor Act (EMTALA)**

The Emergency Medical Treatment and Active Labor Act (EMTALA) is a law designed to govern when and how a patient may be refused treatment or transferred from one hospital to another when they are in an unstable medical condition. EMTALA was passed as part of the Consolidated Omnibus Budget Reconciliation Act of 1986 (COBRA) to ensure public access to emergency services regardless of an individual’s ability to pay. EMTALA applies to “participating hospitals”; facilities which accept payment from Medicare and Medicaid. EMTALA essentially applies to most hospitals within the US, except Military and Shriner’s. EMTALA is primarily a non-discrimination statute enacted to prevent patients that are unable to pay from being treated differently, or unfairly, compared to patients who are covered by health insurance. Its purpose is to prevent hospitals from refusing to treat patients or transferring them to “charity hospitals” or “county hospitals” because they are unable to pay or are covered under Medicare or Medicaid. The purpose of the statute is to prevent the practice of “patient dumping.”

A patient that presents to the emergency department requesting examination or treatment for a medical condition must be provided with an appropriate medical screening by a qualified medical person to determine if he/she is experiencing an “emergency medical condition.” If the person is experiencing an emergency medical condition the hospital is then obligated to either provide them with treatment until they are stable or to transfer them to another hospital while conforming with the statues guidelines for transfers.

It is imperative that any individual working in contact with Emergency Services at a hospital become acquainted with the provisions in EMTALA. The guidelines in EMTALA include, but are not limited to:

- Definition of an “emergency medical condition”
- Provisions for pregnant women in active labor
- When a patient can be transferred to another facility
- What is meant by “stabilized”
- What constitutes an appropriate transfer
- What to do if the patient refuses examination and/or treatment
- What to do if the patient requests transfer
- What if an emergency medical condition is not properly diagnosed at the transferring hospital
- If the hospital can inquire about the patient’s ability to pay
- What obligations are imposed on receiving hospitals
- Obligations on ambulance services
- Monetary, civil and malpractice penalties incurred for violations
- And many, many more issues

The health care professional must familiarize themselves on the facility and state specific issues related to the complicated moral, medical, and legal issues surrounding patient transfers.
Health Insurance Portability and Accountability Act (HIPAA)
Health Information Technology for Economic and Clinical Health Act (HITECH Act)

http://www.hhs.gov/ocr/privacy/hipaa/understanding/index.html
https://www.healthit.gov/policy-researchers-implementers/health-it-legislation-and-regulations

This section serves as a review of important Health Insurance Portability and Accountability Act of 1996 (HIPAA) and Health Information Technology for Economic and Clinical Health Act (HITECH Act) requirements. The objective of the review is as follows:

- To heighten your awareness of and commitment to HIPAA and HITECH regulations
- To renew your working understanding of HIPAA and HITECH requirements
- To reinforce the role you play in creating and maintaining organizational integrity, ethics, compliance and the protection of the privacy of health information

**Reporting Concerns:**
There will be no retribution for asking questions, raising concerns about the Code of Conduct or for reporting possible improper conduct that is done in good faith. Any colleague who deliberately makes a false accusation with the purpose of harming or retaliating against another colleague may be subject to disciplinary action, up to and including termination.

We encourage the resolution of issues at the local level whenever possible. To obtain guidance on an ethics or compliance issue or to report a potential violation, you may choose from several options:

- Consult your Supervisor
- Consult your Supplemental Health Care Representative
- Consult Supplemental Health Care’s Facility Privacy Official (FPO), Vice President of Quality Assurance and Clinical Services, 1.800.889.9169

Any one of these options is an easy and anonymous way to report possible violations or obtain guidance on an ethics or compliance issue. You are encouraged to use these options anytime. In order to properly investigate reports, it is important to provide enough information about your concern.

**Information Security:**
It is the health care provider’s obligation to learn and practice the measures to protect the confidentiality, integrity, and availability of written and electronic patient information. Patient Financial Information, Clinical Information, and User Passwords are all examples of confidential information. A User ID without a password is not confidential and is frequently included in directories and other tools widely available. The person granting access to a system or application typically assigns a User ID to the end user, and the User ID is sometimes used for identification, tracking and other maintenance procedures.

If you have access to information systems, please keep in mind that your password acts as an individual key to the facilities network, critical patient care and business applications, and it must be kept confidential.

**Confidential Information:**
A patient’s diagnosis, the facility’s marketing strategy and computer network configurations are all considered confidential information. Individuals with access to confidential information shall not disclose or discuss any confidential information even after an assignment, shift or contract is completed and/or the health care professional is terminated. Furthermore, confidential information shall not be removed from the Client’s secure location and/or facility premises; violation of this policy may result in
disciplinary action up to and including termination. This policy remains in force after voluntary or involuntary separation from SHC.

No Supplemental Health Care colleague or health care partner has a right to any patient information other than that necessary to perform his or her job. Although you may use confidential information to perform your function, it must not be shared with others unless the individuals have the need to know this information and have agreed to maintain the confidentiality of the information.

Patient or Confidential information should never be sent via email. If it is necessary to send Patient information to a business associate outside of assigned facility, arrangements other than email must be made, and the Client’s Facility Privacy Official (FPO) written permission must be obtained prior to sending.

Privacy:
HIPAA and its implementing regulations set forth a number of requirements regarding ensuring the privacy of protected health information (PHI). The HITECH Act encourages the use of technology with health information and records. In addition, The HITECH Act widens the scope of privacy and security protections available under HIPAA, increases the potential legal liability for non-compliance, as well as provides for increased enforcement.

- HIPAA requires health care entities to appoint a facility privacy official (FPO). The FPO in a facility oversees and implements the Privacy Program and works to ensure the facility’s compliance with the requirements of the HIPAA Standards for Privacy of Individually Identifiable Health Information. The FPO is also responsible for receiving complaints about matters of patient privacy. Supplemental Health Care recommends each health care professional assigned to any/all Client facilities find out who is the facility’s designated FPO.

- HIPAA regulations contain a number of restrictions on the transmission of PHI; however, they do not prevent faxing or mailing health information as long as certain precautions are taken. The regulations mandate that health information not be sold.

- A Notice of Privacy Practices must be made available to all patients, posted on the facility’s Internet site (unless the facility does not have a site) and the consent form language must refer to the notice. Patients do need to sign an acknowledgement form confirming receipt of the notice.

- Patients have the right to access any health information that has been used to make decisions about their health care at any facility. They can also access billing information. They may review the paper chart (supervised) or be provided a hard copy.

- A patient may have access to all the records in the designated record set. This record set includes any information that is maintained, collected, used or disseminated by a facility to make decisions about individuals. The paper record is the legal medical record and a copy should be provided upon request (electronic access is not appropriate). A patient may be denied access under certain circumstances (e.g., when a person may cause harm to him or herself or others, or when protected by peer review). The designated facility FPO has more information on the right to access.

- A patient may add an amendment to any accessible record for as long as the record is maintained by a facility. The request for amendment should be made in writing to the facility.
The designated facility FPO should have any/all necessary information regarding the right to amend.

- While patients have a right to amend their record that does not mean that health information can be deleted from the record. The patient may submit an addendum correcting or offering commentary on the record, but no information may be deleted from the record.

- Everyone is responsible for protecting patients’ individually identifiable health information. Any piece of paper that has individually identifiable health information must be disposed of in appropriate receptacles. The paper must be handled and destroyed securely. The elements that make information individually identifiable include: name, zip or other geographic codes, birth date, admission date, discharge date, date of death, email address, social security number, medical record/account number, health plan ID, license number, vehicle identification number and any other unique number or image.

- HIPAA privacy regulations do not prevent facilities from storing the medical record at the patient’s bedside. However, the facilities must implement reasonable safeguards to protect an individual’s privacy. For example, possible safeguards may include limiting access to the area by non-employees or placing patient charts in holders with the identifying information facing the wall.

- Any member of the workforce with a legitimate need to know to perform their job responsibilities may access a patient’s health information. However, the amount of information accessed should be limited to the minimum amount necessary to perform their job responsibilities.

- The hospital directory or listing of patients, information desk or volunteers should contain only patient name, room/location and condition in general terms. Patient diagnosis or procedures should not be released. Also, this information may not be released about confidential patients or patients who ask not to be listed in the directory nor have their whereabouts known.

- List of patients may be provided to clergy. The lists should consist of the patient name, room/location, and may include the condition in general terms. The list should be restricted by religion, and not include confidential patients; confidential information such as social security numbers should not be included. If any questions or concerns regarding release of list to clergy, please seek out facility FPO.

- Under the revised HIPAA and HITECH Acts, as a health care provider you are required to immediately report any use or disclosure of any personal health information (PHI) that is not authorized by the Client’s FPO. This requirement includes any actual or perceived breaches of unsecured PHI (i.e. laptop stolen, social media posting etc.). Such reports must be made as soon as possible and within three (3) calendar days of your becoming aware of such improper use or disclosure or actual or perceived breach of unsecured PHI; notify your immediate supervisor and Supplemental Health Care Representative.

- Under no circumstances shall you be deemed in any respect to be the owner of any PHI received by you from a Client’s facility, or created by you on behalf of the Client’s facility. All PHI created or received by you while on assignment at a Client facility will remain the sole property of that Client.
Family Educational Rights and Privacy Act (FERPA)  

The Family Educational Rights and Privacy Act (FERPA) is a Federal law that protects the privacy of student education records. The law applies to all schools that receive funds from programs of the U.S. Department of Education; however, FERPA generally does not apply to most private elementary schools and secondary schools, as they do not receive U.S. Department of Education funding.

FERPA gives parents certain rights with respect to their children's education records, however the rights transfer to the student when he or she reaches the age of 18, or attends a postsecondary school at any age. Students to whom the rights have transferred are "eligible students." Typically, schools must have parent or eligible student written permission in order to release any information from a student's education record. FERPA allows schools to disclose records, without consent, under certain circumstances including but not limited to:

- School officials with legitimate educational interest
- Specified officials for audit or evaluation purposes
- Organizations conducting certain studies for, or on behalf of, the school
- To comply with a judicial order or lawfully issued subpoena
- Appropriate officials in cases of health and safety emergencies

Refer to http://www2.ed.gov/policy/gen/guid/fpco/ferpa/index.html or Supplemental Health Care’s School Staffing Guidelines for additional information related to working in schools.

Business Courtesies (i.e. Gifts and Entertainment) and Conflict of Interest

Supplemental Health Care expects all health care professionals to avoid engaging in any activity or practice, which is an actual or potential conflict of interest with Supplemental Health Care or our clients. A conflict of interest occurs when there exists direct or indirect personal gain that potentially could influence your judgment or actions. All possible conflicts of interest must be disclosed. These conflicts include the acceptance of gifts and entertainment of any value. It is important to avoid the appearance of impropriety when giving gifts to clients or receiving gifts, meals or entertainment from individuals that are seeking to do business with Supplemental Health Care. Disclosure is the key. Health care professionals should not accept gifts, payments, fees, services or discounts where these would or might improperly influence performances of services. At least annually, please review potential conflicts of interest and disclose them if you have not already done so. Once disclosed or identified, conflicts of interest will be reviewed by the Senior Management Team and appropriate internal action and disclosure to the client, as necessary, will occur.

Population Specific Guidelines for Health Care Providers

Every health care provider, no matter what their specialty, must have a basic understanding of age-specific stages of development and milestones. The normal physiological and psychosocial responses change with age. It is essential that the health care provider develop an awareness of the expected responses across the lifespan in order to provide appropriate care and intervention. This module will provide a basic review and competency assessment of human growth and development across the lifespan. Remember this is only a guide; assessment and interventions must be adapted to the individual.

Assessment of growth and development focuses on three major areas: physical, cognitive/perceptual, and psychosocial. Physical capabilities include gross and fine motor skills as well as strength, energy/fatigue, stamina and pain. Cognitive/perceptual capabilities include thought, perception,
understanding and reasoning. Psychosocial capabilities are reflected by relationships established with family, friends, and others.

Objectives: At the completion of this module the learner will be able to:
1. Identify major growth and developmental milestones for each age group discussed
2. Identify cognitive/perceptual changes that occur for each age group discussed
3. Identify psychosocial changes associated with each age group
4. Recognize how health care providers take age-specific milestones into consideration when interacting and caring for patients/clients
5. Identify safety issues and possible interventions for each age group
## Population Specific Guidelines
### (Neonatal Population)

**AGES:** Birth to 28 Days  
**ERIKSON’S DEVELOPMENTAL TASK:** Trust vs. Mistrust

<table>
<thead>
<tr>
<th>GROWTH AND DEVELOPMENT (Physical)</th>
<th>COGNITIVE AND PERCEPTUAL</th>
<th>PSYCHOSOCIAL</th>
<th>APPLICATION TO PATIENT CARE</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Reflexive physical functioning</td>
<td>Sensorimotor stage:</td>
<td>• Totally dependent on others for all physiological and emotional needs</td>
<td></td>
</tr>
<tr>
<td>• All organs maturing and stabilizing</td>
<td>• Responds to sensory stimuli</td>
<td>• Interactions with parent/caregiver during routine care can enhance or detract from attachment process</td>
<td></td>
</tr>
<tr>
<td>• Able to lift head briefly</td>
<td>• Interacts with environment in a reflexive or accidental manner</td>
<td>• Sensitive parent/caregiver learns to “read” infant’s cues and provides for infant’s needs.</td>
<td></td>
</tr>
<tr>
<td>• Sporadic movement of extremities</td>
<td>• Language skills not developed</td>
<td>• Infant responds by ceasing to cry, smiling, or sleeping.</td>
<td></td>
</tr>
<tr>
<td>• Stares at objects</td>
<td>• Inarticulate crying and non-verbal cues indicate needs</td>
<td>• Attachment may be altered if either parent or infant experience health problems during the birth</td>
<td></td>
</tr>
<tr>
<td>• Immature temperature regulation</td>
<td></td>
<td></td>
<td>• Infants have lower immunity response to infection</td>
</tr>
<tr>
<td>• Frequent feedings, usually every 3 to 4 hours of breast milk or formula from bottle</td>
<td></td>
<td></td>
<td>• Hand washing is essential</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>• Observe for nonverbal cues: crying, facial expression, body position, movement of extremities</td>
</tr>
</tbody>
</table>

### Safety:
- Keep neonate warm/regulate temperature
- Prevention of falls
- Maintain skin integrity/diapers
- Correct use of car seat
- Prevention of airway obstruction/obligate nose breathers
- Avoid sprays in same room/respiratory irritation
Population Specific Guidelines  
(Infant Population)

**AGES:** 29 Days to 12 Months  
**ERIKSON’S DEVELOPMENTAL TASK:** Trust vs. Mistrust

<table>
<thead>
<tr>
<th>GROWTH AND DEVELOPMENT (Physical)</th>
<th>COGNITIVE AND PERCEPTUAL</th>
<th>PSYCHOSOCIAL</th>
<th>APPLICATION TO PATIENT CARE</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Voluntary motor skills replace reflexive behavior</td>
<td>• Engages in systematic imitative behavior</td>
<td>• Primary gratification is in sucking and having needs met</td>
<td>• Infants have lower immunity response to infection, hand washing is essential</td>
</tr>
<tr>
<td>• Hand and eye coordination development</td>
<td>• Babbles sounds and utters few words</td>
<td>• Smiles to familiar face</td>
<td>• Use familiar items or objects (stuffed toys) to assist in procedures</td>
</tr>
<tr>
<td>• Begin supported sitting and advance to independent sitting, creeping, standing, and walking with support</td>
<td>• Attaches meaning to words</td>
<td>• Imitates simple acts of others</td>
<td>• Use soothing measures during procedure (stroking skin, talking softly, pacifier)</td>
</tr>
<tr>
<td>• Develops pincer grasp</td>
<td>• Differentiates self and environment</td>
<td>• Fear of stranger and separation anxiety</td>
<td>• Assess for and manage pain; use oral route if possible</td>
</tr>
<tr>
<td>• Tooth eruption, expect some discomfort, drooling and low-grade fever with teething.</td>
<td>• Play remains an important component in self-concept development</td>
<td>• Makes simple needs known by gestures</td>
<td>• Cuddle and hug child after procedures</td>
</tr>
<tr>
<td>• Poor temperature regulation</td>
<td>• Begins to understand a cause-effect relationship</td>
<td>• Infants have lower immunity response to infection, hand washing is essential</td>
<td>• Must keep infant warm but don't overheat</td>
</tr>
<tr>
<td>• Advancing diet from bottles of breast milk or formula to drinks from “sippy cup” to solids</td>
<td>• Concept of abject permanence develops</td>
<td>• Use familiar items or objects (stuffed toys) to assist in procedures</td>
<td>• Avoid sprays in same room, resp. irritation</td>
</tr>
<tr>
<td>• Minimize sweets in baby’s diet &amp; avoid adding salt</td>
<td>• Primary gratification is in sucking and having needs met</td>
<td>• Prevention of falls/rails up</td>
<td>• Place child “Back to Sleep”</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Smiles to familiar face</td>
<td>• Maintain skin integrity</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Imitates simple acts of others</td>
<td>• Correct use of car seat</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Fear of stranger and separation anxiety</td>
<td>• Keep hazardous equipment/objects out of reach &amp; where could be pulled down</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Makes simple needs known by gestures</td>
<td>• Prevention of airway obstruction</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>• Infant will wave arms &amp; grab for items, keep small objects out of infant’s grasp, everything will go in the infant’s mouth</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>• Safety:</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>• Must keep infant warm but don't overheat</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>• Avoid sprays in same room, resp. irritation</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>• Prevention of falls/rails up</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>• Place child “Back to Sleep”</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>• Maintain skin integrity</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>• Correct use of car seat</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>• Keep hazardous equipment/objects out of reach &amp; where could be pulled down</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>• Prevention of airway obstruction</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>• Infant will wave arms &amp; grab for items, keep small objects out of infant’s grasp, everything will go in the infant’s mouth</td>
</tr>
</tbody>
</table>
## Population Specific Guidelines  
### (Toddler Population)

**AGES:** 13 Months to 3 Years  
**ERIKSON’S DEVELOPMENTAL TASK:** Autonomy vs. Shame and Doubt

<table>
<thead>
<tr>
<th><strong>GROWTH AND DEVELOPMENT (Physical)</strong></th>
<th><strong>COGNITIVE AND PERCEPTUAL</strong></th>
<th><strong>PSYCHOSOCIAL</strong></th>
<th><strong>APPLICATION TO PATIENT CARE</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>Motor skills rapidly develop:</td>
<td>Starts expressing individual preferences</td>
<td>Less fearful of strangers</td>
<td>Safety – This stage is all about safety</td>
</tr>
<tr>
<td>Crawl, run, jump, step backward, sideways and climb stairs.</td>
<td>“No” is a favorite reply</td>
<td>Begins to imitate parents doing household chores</td>
<td>Toddlers must be watched every moment</td>
</tr>
<tr>
<td>Heart size increases</td>
<td>Egocentricity characteristic. Contributes to sense of self and is reflected in phrases such as “mine” and “I do it”</td>
<td>Fear is expressed</td>
<td>“Into everything” – close supervision</td>
</tr>
<tr>
<td>Diaphragmatic breathing</td>
<td>Fear is expressed</td>
<td>Energetic, impulsive and demanding</td>
<td>Drowning prevention, remove buckets &amp; keep bathroom doors closed</td>
</tr>
<tr>
<td>Developing sphincter control</td>
<td>Energetic, impulsive and demanding</td>
<td>Follows simple commands</td>
<td>Correct use of car seat</td>
</tr>
<tr>
<td>Attempts to feed self, by age 3 feeds self completely</td>
<td>They are mobile and very curious</td>
<td>They are mobile and very curious</td>
<td>Remove poisons, clutter, prevention of falls</td>
</tr>
<tr>
<td>Increasing teeth, 16 teeth by age 2</td>
<td></td>
<td></td>
<td>Protect from electrical outlets / equipment</td>
</tr>
<tr>
<td>Vulnerable to fluid deficits, 60% of total body weight is fluid</td>
<td></td>
<td></td>
<td>Keep hazardous equipment/objects out of reach &amp; where could be pulled down</td>
</tr>
</tbody>
</table>

### Safety
- Toddlers must be watched every moment  
- “Into everything” – close supervision  
- Drowning prevention, remove buckets & keep bathroom doors closed  
- Correct use of car seat  
- Remove poisons, clutter, prevention of falls  
- Protect from electrical outlets / equipment  
- Keep hazardous equipment/objects out of reach & where could be pulled down  
- Explain procedure in relation to what child will, see, hear, taste, smell and feel  
- Emphasize cooperation  
- Tell child it's okay to cry  
- Expect resistance  
- Use firm, direct approach  
- Ignore temper tantrums  
- Use distraction techniques (singing, music, stories)  
- Give one direction at a time  
- Use play to demonstrate procedure  
- Allow choices whenever possible  
- Allow child to participate and help
**Population Specific Guidelines**  
*(Pre-school Population)*

**AGES:** 3 Years to 5 Years  
**ERIKSON’S DEVELOPMENTAL TASK:** Initiative vs. Guilt

<table>
<thead>
<tr>
<th>GROWTH AND DEVELOPMENT (Physical)</th>
<th>COGNITIVE AND PERCEPTUAL</th>
<th>PSYCHOSOCIAL</th>
<th>APPLICATION TO PATIENT CARE</th>
</tr>
</thead>
</table>
| • Physical changes occur at a slow even and continuous pace  
• Neuromuscular skills refine  
• Dresses self, washes face and hands, brushes teeth and takes care of own toilet needs | • Concrete thinking  
• Continued egocentric  
• Uses mental symbols  
• Thinking can include past or future events  
• Questions progress from “why” to “where” and “how”  
• Asks meaning of words, talks constantly, counts, identifies coins, knows the days of the week, follows three-step directions in order and memorizes his address | • Play is critical for early development  
• Engages in parallel play  
• Plays together and demonstrates preferences for friends  
• Can tolerate limited separation from parents  
• Strives for individuality and questions/explores own abilities  
• Increasing language, motor and cognitive skills  
• Learning to express emotions and develop a conscience for moral development and control of actions | Safety – This stage is all about safety  
Accidents – are the leading cause of death  
• Drowning prevention, remove buckets & keep bathroom doors closed  
• Correct use of car seat  
• Remove poisons, clutter,  
• Protect from electrical outlets / equipment  
• Limited ability to judge distance & strength predisposes them to accidents  
• Prevention of falls  
• Keep hazardous equipment/objects out of reach & where could be pulled down  
• Explain procedure in simple terms, use dolls or other toys to assist  
• Encourage child to “play out” procedure  
• Use Band-Aids when possible  
• Encourage parents to participate  
• Involve child in care and praise for helping and cooperating  
• Use non-intrusive procedures whenever possible (tympanic or axillary temp, oral meds) |
Population Specific Guidelines  
(School Age Population)

AGES: 6 Years to 11 Years  
ERIKSON’S DEVELOPMENTAL TASK: Industry vs. Inferiority

<table>
<thead>
<tr>
<th>GROWTH AND DEVELOPMENT (Physical)</th>
<th>COGNITIVE AND PERCEPTUAL</th>
<th>PSYCHOSOCIAL</th>
<th>APPLICATION TO PATIENT CARE</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Steady growth occurs</td>
<td>• Vocabulary increases</td>
<td>• Family and school are major factors affecting the child’s developing personality and self-image</td>
<td>• Respect their modesty, keep them covered and screened when possible</td>
</tr>
<tr>
<td>• Child is taller and thinner than preschooler</td>
<td>and uses rules of grammar and syntax</td>
<td>• Enjoy brief separation from family</td>
<td>• Do not embarrass them</td>
</tr>
<tr>
<td>• Body fat decreases and muscle mass increases</td>
<td>• Cognitive operation of concrete thinking is mastered</td>
<td>• Play is cooperative</td>
<td>• Allow child to manipulate equipment as appropriate</td>
</tr>
<tr>
<td>• Child works and plays hard but tires easily</td>
<td>• Use more logic in their thinking, but limited to here and now</td>
<td>• Friends are important part of social contacts, usually with children of same sex</td>
<td>• Encourage active participation (removing dressings, opening packages)</td>
</tr>
<tr>
<td>• Proportions continue to be more adult-like</td>
<td>• Comprehension of cause-effect relationship increases &amp; concept of time is better understood</td>
<td>• Observes and imitates the attitudes, values and behaviors of those significant people in his environment</td>
<td>• Allow responsibility for simple tasks and include child in decision making</td>
</tr>
<tr>
<td>• Starts to lose temporary teeth</td>
<td>• Begins to appreciate another’s perspective</td>
<td>• In this age of industry, the child is determined to master tasks</td>
<td>• Gain child’s cooperation while explaining what is expected</td>
</tr>
<tr>
<td></td>
<td>• Demonstrates a public and private self</td>
<td>• Child may do daring things to get friend’s approval</td>
<td>• Suggest ways of maintaining control (deep breathing, relaxation)</td>
</tr>
</tbody>
</table>

Safety

- Accidents are the leading cause of death
- Report any statement related to suicide or self-harm
- Child may be very physical and active in sports, emphasize safety
- Child may not know their limits
- May have communicable disease, be sure to use good hand washing
- Be aware of and report substance, physical &/or sexual abuse

- Respect their modesty, keep them covered and screened when possible
- Do not embarrass them
- Allow child to manipulate equipment as appropriate
- Encourage active participation (removing dressings, opening packages)
- Allow responsibility for simple tasks and include child in decision making
- Gain child’s cooperation while explaining what is expected
- Suggest ways of maintaining control (deep breathing, relaxation)
Population Specific Guidelines  
(Adolescence Population)

AGES: 12 Years to 18 Years  
ERIKSON’S DEVELOPMENTAL TASK: Identity vs. Role Confusion

<table>
<thead>
<tr>
<th>GROWTH AND DEVELOPMENT (Physical)</th>
<th>COGNITIVE AND PERCEPTUAL</th>
<th>PSYCHOSOCIAL</th>
<th>APPLICATION TO PATIENT CARE</th>
</tr>
</thead>
</table>
| • Dramatic growth of skeleton, muscle and viscera  
  • Reproductive system maturation  
  • Average age of menarche is 13  
  • Acne vulgaris may occur due to increased secretion of androgens | • Frequent mood swings  
  • Develops abstract thought, conceptual and logical thinking  
  • Engages in introspection, self-examination and personal critique  
  • Begins to establish personal identity  
  • Do not often look ahead to the consequences of their behavior | • Close peer relationships with experimentation, impulsiveness and sense of invulnerability  
  • Heightened sexuality, concern with body image  
  • Begins to establish independence and sever ties with parents  
  • Develops moral standards  
  • Begins to explore career options  
  • May have employment outside the home  
  • May engage in organized, competitive sports  
  • Males often feel they must prove their courage, they often do not know their limits  
  • Searches for new beliefs, resolves inconsistencies of old beliefs and begins to form a personal philosophy of life | • Explain activities, routines and procedures in logical and thorough manner even if complex  
  • Provide choices and control whenever possible  
  • Talk to patient as an adult, avoid authoritative or childish approach  
  • Encourage peer visitation  
  • Pay particular attention to privacy - very fearful of embarrassment  
  • Assess and meet menarche needs in females (onset begins 11-13 yrs.)  
  • Matter-of-fact approach to overt sexual behavior  
  • Educate on nutrition – meal skipping, eating disorders, consumption of fast food |

Safety

- Accidents are the leading cause of death  
- Educate on safety related to motor vehicles, sports and other risky activities  
- Assess for illicit substance abuse when parents or peer not present  
- Assess whether sexually active (safe sex, contraceptives, pregnancy)

**Safety**

- Accidents are the leading cause of death  
- Educate on safety related to motor vehicles, sports and other risky activities  
- Assess for illicit substance abuse when parents or peer not present  
- Assess whether sexually active (safe sex, contraceptives, pregnancy)
# Population Specific Guidelines (Adult Population)

**AGES:** 18 Years to 64 Years  
**ERIKSON’S DEVELOPMENTAL TASK:**  Intimacy vs. Isolation (18 - 40 Years)  
**Generativity vs. Stagnation (40 – 64 Years)**

<table>
<thead>
<tr>
<th>GROWTH AND DEVELOPMENT (Physical)</th>
<th>COGNITIVE AND PERCEPTUAL</th>
<th>PSYCHOSOCIAL</th>
<th>APPLICATION TO PATIENT CARE</th>
</tr>
</thead>
</table>
| • Growth stabilizes, full physical maturity by age 20  
• Adults 40 – 65 may begin to have diminished hearing and visual acuity  
• Adults 40 – 65 may begin to have decrease in bone density and mass and muscle tone may begin to decrease  
• Adjustment to menopause and decreasing hormones  
• Possible appearance of receding hairline in men, increase in facial and body hair in men and women | • Mental performance stabilizes and gradually declines (decreased short-term memory, recall and synthesis of new information)  
• Tends to ignore physical symptoms when ill  
• Examines life goals, relationships and parenthood  
• Recognizes limitations (physical, psychological, emotional) | • Lifestyle centers around work, family, and community  
• Emotional health related to resolution of family and job stresses (parenting, empty nest syndrome, finances, career issues, retirement)  
• Life-style modifications (health, sexuality, midlife crisis, relationships) | • Address patient in manner preferred  
• Encourage proper nutrition & exercise to maintain musculoskeletal strength & normal weight  
• Emphasize importance of preventative health care (self-exams, screenings etc.)  
• Provide options for communication with family and work when appropriate  
• Assess impact of hospitalization/illness (family, work, body image)  
• Maintain adult privileges: decision making responsibility and personal preferences  
• May be intolerant to heat/cold  
• Encourage self-care as appropriate |

**Safety**

- Emphasize normal safety precautions  
- Screen for substance abuse, stress and mental health issues/depression  
- Use maximum lighting when possible during patient contact
Population Specific Guidelines  
(Elder Population)

**AGES:**  > 65 Years  
**ERIKSON’S DEVELOPMENTAL TASK:** Ego Integrity vs. Despair

<table>
<thead>
<tr>
<th>GROWTH AND DEVELOPMENT (Physical)</th>
<th>COGNITIVE AND PERCEPTUAL</th>
<th>PSYCHOSOCIAL</th>
<th>APPLICATION TO PATIENT CARE</th>
</tr>
</thead>
</table>
| • Decreased bodily functions: cortical atrophy; cardiac output; arteriosclerosis; vital capacity; cough strength; liver and renal metabolism; GI motility; muscle strength, mass, balance, coordination and mobility; skin elasticity and moisture; peripheral circulation; response to sensory stimuli; reproductive organs; immune system response | • Decline in mental functions (processing of information requires more time)  
• Shares wisdom, repository of knowledge and experiences  
• Sleep disturbances | • Adjusts to losses (work, relationships, bodily functions)  
• Develops support systems, pursues recreational interests  
• Adjusts to change in social role (grand-parenting, increasing dependence)  
• Concerns regarding health  
• Reviews life accomplishments, acceptance of death  
• Decreased trust of outside world | • Explain activities, routines, procedures slowly, use low tones when speaking  
• Face patient when speaking, don’t shout  
• Address patient in manner preferred, avoid using ”honey”, ”sweetie”, ”dear”  
• Use visual and hearing aids as needed  
• Give important information in writing  
• Maintain skin integrity: moisturize dry skin, cleanse skin when soiled, use soap sparingly, use creams without alcohol, use tape sparingly, turn/reposition frequently |

- Safety
  - Vulnerability to disease & injury as bodily functions decrease
  - Institute fall prevention
  - Maintain body temp.
  - Assess for substance and elder abuse
  - Presence of confusion and decreased mental capacity = increased risk of injury
  - Burn prevention related to decreased sensation: do not use hot water bottles or heating pads, avoid smoking, cooking etc.
  - Assess for medication interactions: poly-pharmacy, food-drug interactions, appropriate dose and frequency

---

**Additional Information:**
- **Physical Development:** Decreased bodily functions include cortical atrophy, decreased cardiac output, arteriosclerosis, decreased vital capacity, decreased cough strength, decreased liver and renal metabolism, decreased GI motility, decreased muscle strength, mass, balance, coordination and mobility, decreased skin elasticity and moisture, decreased peripheral circulation, decreased response to sensory stimuli, decreased reproductive organs, and decreased immune system response.
- **Cognitive and Perceptual Development:** Decreased mental functions require more time to process information, and decreased sensory impairments include decreased vision, hearing, taste, touch and smell.
- **Psychosocial Development:** Adjustments to losses include work, relationships, and bodily functions, and decreased trust of outside world.
- **Application to Patient Care:** Strategies include explaining activities, routines, and procedures slowly, using low tones when speaking, facing the patient when speaking, addressing the patient in a manner they prefer, avoiding terms of endearment, using visual and hearing aids as needed, maintaining skin integrity, and assessing and managing nutritional needs, including swallowing difficulties.