



**OSHA/JCAHO
HIPAA & ALZHEIMER'S**

Reading Materials

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Abuse: Child, Domestic, Elder, & Sexual

Child Abuse

Child abuse is defined as a non-accidental injury or pattern of injuries to a child. Child abuse is damage to a child for which there is no "reasonable" explanation. Child abuse includes non-accidental physical injury, neglect, sexual molestation, and emotional abuse.

Child abuse has become a national epidemic. More than one million children are confirmed each year as victims of child abuse and neglect by state departments of child protective services. And every day a minimum of three children die as a result. Violence in the home has been listed as a major factor contributing to the growth or reports of child abuse and neglect.

Domestic violence plays a significant part in child abuse.

Domestic violence often includes child abuse. Children may be victimized and threatened as a way of punishing and controlling the adult victim of domestic violence. Or they may be injured unintentionally when acts of violence occur in their presence. Often episodes of domestic violence expand to include attacks on children. However, even when children are not directly attacked, they can experience serious emotional damage as a result of living in a violent household. Children living in this environment come to believe that this behavior is acceptable.

Neither domestic violence nor child abuse is an isolated event. Both occur with some regularity, often increasing and becoming more serious. Adults who were abused as children have an increased risk of abusing their children; adults who grew up in a violent home are more likely to become perpetrators or victims of domestic violence. For a number of reasons including shame, secrecy, and isolation, both types of abuse are under-reported. Shrouding the violence in secrecy allows this behavior to continue. Educating the public about the extent of the problem establishes a foundation that permits victims to come forward.

Prevention efforts that reach patients before or soon after the birth of their baby, and provide intensive services on a moderately long-term basis can greatly reduce the incidence of child abuse as well as identify other problems such as domestic violence. Home visitors using a comprehensive approach can tailor their services to match a family's need. After establishing a trusting relationship with the family, the home visitor will be able to identify problems. While the home visitor may not be able to offer intervention services, he or she can provide resources and ensure the safety of the children.

Physical Abuse

Battering and beating, physically harming or injuring a child under the age of 18 by a person who is responsible for the child's welfare. Abuse is never a child's fault.

Indications of physical child abuse:

- Unexplained bruises and welts
- Unexplained burns
- Unexplained fractures
- Unexplained lacerations or abrasions
- Head injuries
- Human bite marks
- Frequent Injuries that are "accidental" or "unexplained"
- Wary of adult contacts
- Anger, aggression, hyperactivity (consistent)
- Apprehensive when other children cry
- Behavioral extremes
- Aggressiveness, withdrawal, introverted, extremely passive
- Frightened of parents or unnaturally dependent
- Frequently truant or late to school
- Afraid to go home

- Terrified to make a mess
- Reports injury by parents
- Young child who “takes care” of the parent
- Wears a long-sleeved or similar clothing to hide injuries
- Seeks affection from any adult with no discrimination
- Non-expression of his needs, non-communicative

Indications of physical child abuse:

Sometimes a parent’s demeanor or behavior can be an indicator that the child may be at risk or abuse or neglect:

- Seems unconcerned about child
- Seems anxious and overwhelmed by the child’s needs
- Takes an unusual amount of time to obtain medical care for the child
- Offers an inadequate or inappropriate explanation for the child’s injury
- Gives different explanations for the same injury
- Misuses alcohol or drugs
- Disciplines the child too harshly considering the child’s age or what he/she did wrong
- Sees the child as bad, evil, different, etc.
- Has a history of abuse as a child
- Attempts to conceal the child’s injury
- Takes the child to a different doctor or hospital for each injury
- Has poor impulse control

How to Report Child Abuse

Both the reporting party and the child who is allegedly being abused must reside in the same state for the following number to be valid. You may call Child Help/IOF Foresters National/Abuse Hotline **1-800-4-A-Child**.

Child Sexual Abuse

Child sexual abuse is forced, tricked or coerced sexual behavior between a young person and an older person. Sexual abuse may consist of any one of the following acts: nudity, disrobing, genital exposure, observation of the child, kissing, fondling, masturbation, oral-genital contact, child pornography, digital penetration, and vaginal or anal intercourse. There is no rule governing the age range between a victim and a perpetrator. However, when the perpetrator is under 18 years of age, often an age discrepancy of five years has been required to verify cases of sexual abuse where no force was involved.

While many estimates have been made that one in four girls and one in ten boys are abused prior to age 18, the national incidence rate of sexual abuse remains unknown. The estimate that one in four girls and one in ten boys are abused prior to age 18 became widely known simply from being repeated.

Sexual abuse occurs among all groups of the population. It happens to children in both rural and urban areas and in all socioeconomic and educational levels, and across all racial and cultural groups. Research has found that the absence of a parent from the home increases the child’s risk. In addition, interviews with perpetrators suggest that they look for vulnerable children. Such children are young and appear to be isolated, depressed, or lonely.

The degree of harm a child experiences as a result of sexual abuse depends upon the nature of the act, the age of the child, and the child’s general environment. Physical harm may include cuts, disfigurement, deformity, and pregnancy. Mental harm may consists of feelings of pain, panic, devastation, betrayal, shame, fear, guilt, and vulnerability that may persist throughout the victim’s life. While child sexual abuse may not always lead to permanent injury, one should assume that all sexual abuse experiences are potentially harmful. Also, it is important to reassure the child that he or she is not responsible for the assault.

Signs of Sexual Abuse

Symptoms of sexual abuse may include physical behavioral signs as well as indirect comments made by the child. There are several clues to look for when considering the possibility of child sexual abuse. A physical sign may be a discharge from the vaginal area or penis, irritation, pain, bleeding, injury to the genital or anal area, or discomfort in walking or sitting. A behavioral sign may be nervous, aggressive, hostile, or disruptive behavior towards adults, especially parents. But remember, one sign alone may not be a positive indication. If a number of signs are present, it is wiser to consider the possibility of sexual abuse.

Perpetrators of Sexual Abuse

Generally, children are sexual abused by adults who are related to them or known by them or their families. Acquaintance perpetrators are the most common abusers. Perpetrators of sexual abuse are not only adults. Many clinical settings currently are witnessing a dramatic increase in the number of adolescent offenders who have committed sexually aggressive acts against other children. The most vulnerable age for sexual abuse is between 7 and 13 years. Reported victims of sexual abuse are most often children of school age, although cases have been documented from infancy to adulthood.

You can get more information on sexual abuse or sexual abuse prevention programs from the American Association for Protecting Children, a division of the American Humane Association, at (800) 227-5242 or (303) 695-0811 or from Prevent Child Abuse America at (312) 663-3520.

DEFINING CHILD MALTREATMENT

There are four forms of child maltreatment: emotional abuse, neglect, physical abuse and sexual abuse.

Emotional Abuse: (also known as: verbal abuse, mental abuse, and psychological maltreatment) Includes acts or failures to act by parents or caretakers that have caused or could cause serious behavioral, cognitive, emotional, or mental disorders. This can include parents/caretakers using extreme and/or bizarre forms of punishment, such as confinement in a closet or dark room or being tied to a chair/or bed for long periods of time or threatening or terrorizing a child. Less severe acts, but no less damaging are belittling or rejecting treatment, using derogatory terms to describe the child, habitual scapegoat or blaming.

Neglect: The failure to provide for the child's basic needs. Neglect can be physical, educational, or emotional. **Physical neglect** can include **not** providing adequate food or clothing, appropriate medical care, supervision, or proper weather protection (heat or coats). It may include abandonment. **Educational neglect** includes failure to provide appropriate schooling or special educational needs, allowing excessive trancies. **Psychological neglect** includes the lack of emotional support and love, never attending to the child, spousal abuse, drug and alcohol abuse including allowing the child to participate in drug and alcohol use.

Physical Abuse: The inflicting of physical injury upon a child. This may include, burning, hitting punching, shaking, kicking, beating, or otherwise harming a child. The parent or caretaker may not have intended to hurt the child, the injury is not an accident. It may, however, been the result of over-discipline or physical punishment that is inappropriate to the child's age.

Sexual Abuse: The inappropriate sexual behavior with a child. It includes fondling a child's genitals; make the child fondle the adult's genitals, intercourse, incest, rape, sodomy, exhibitionism and sexual exploitation. To be considered child abuse these acts have to be committed by a person responsible for the care of a child (for example a baby sitter, a parent, or daycare provider) or related to the child.

If these acts were committed, it would be considered child assault and handled solely by the police and criminal courts. If you know or suspect any acts of the sort please report it to the authorities or you may call ChildHelp/IOF Foresters National/Abuse Hotline 1-800-4-A-Child.

Elder Abuse Awareness

What is elder abuse?

Elder abuse can take a number of forms and may be defined in various ways. It is most often defined as an action by a person in a position of trust, which causes harm to an elder. Harmful actions by strangers are usually not considered elder abuse.

The exact incidence of elder abuse is unknown. One estimate for the United States placed the number of seniors abused or mistreated at 1.5 million per year. The figure may be much higher since elder abuse is often not reported. In any event, with a rapidly growing elderly population, the numbers can be expected to rise.

Who are the victims of elder abuse?

Elder abuse can happen to anyone, although elders who have mental or physical disabilities are at the greatest risk. More women than men live to be elders, but both sexes are equally at risk for abuse. Their spouses, others by children, others by caregivers in institutions abuse some older people. As with other types of abuse, those who abuse elders usually keep the victim socially isolated.

What types of elder abuse occur?

There are many types of elder abuse:

Physical

- Hitting or pushing
- Sexual molestation
- Forced confinement in a room, bed or chair
- Non-prescribed restraints
- Overmedication

Emotional/Psychological

- Humiliating, insulting, name-calling or threatening
- Treating an elder like a child

Neglect

- Withholding food or medical attention
- Leaving a senior in an unsafe or isolated place

Financial

- Withholding money
- Forcing a senior to sell personal property
- Stealing an older person's money or possession
- Misusing Power of Attorney

Why does Elder Abuse Happen?

Researchers who have studied elder abuse across cultures identify several factors associated with elder abuse:

- The burden of responsibility on caregivers, which is growing heavier as older people live longer, can lead to elder abuse. This is especially true in cases where caregivers have to take care of physical needs, such as bathing and toileting.
- Economic problems, such as high unemployment, can increase the stress experienced by caregivers and also increase the potential for financial abuse. In addition, economic recession often meant that fewer resources are available to assist relatives in caring for the elderly.
- Cultural changes that lower the status of the elderly and lead to less respect from younger people can increase the likelihood of abuse.
- Personal problems on the part of relative or caregivers, such as substance abuse or mental or emotional impairments, can cause neglect of elders and sometimes abuse
- An increasing number of socially isolated elderly means that more older people are lonely and vulnerable to abuse.

- Elderly women are more likely to be abused, simply because they outnumber men. Women may also be more economically dependent on others.
- A lack of adequate housing can contribute to abuse; especially if family members feel forced to co-habit with elders.
- The extent to which a society tolerated aggression and crime is thought to be related to the incidence of elder abuse.
- Within families, a history of violence can mean that violence is used to respond to stress.
- Within institutions, elderly residents may be powerless and vulnerable, and staff may be underpaid, under qualified and overworked. These factors create a climate, which can contribute to elder abuse.

Unfortunately, victims of elder abuse are often reluctant to report offenders, and are not willing to pursue a criminal investigation. They may fear being abandoned by the abuser, or may have feelings of embarrassment and shame. It is important to be sensitive to feelings. Always respect the integrity of the victim. Warmth and empathy toward the victim can create an environment where he or she feels safe in discussing the abuse, and can begin to explore alternatives. Ultimately, elders are adults with the right to self-determination. If an elder is mentally competent, and chooses to remain in an abusive or neglectful environment, that decision must be respected. Follow-up through intermittent visits can reduce the risk of abuse; by making it clear to the abuser that the situation is being monitored.

What can be done about a suspected case of elder abuse?

Most elder abuse is against the law. If you are being abused or you know of someone who is, you can call the police. Social service agencies and health professionals can also provide advice or help. Public health department or community legal clinics are a good place to call.

You are required to report any elder abuse to your supervisor on staff immediately.

SEXUAL ABUSE

Health care professionals are prohibited from engaging in sexual abuse of any kind. The wide spectrum of behaviors encompassed by this regulation calls for a variety of sanctions. The most egregious behaviors encompassed by this regulation and cases of repeated violations, will incur the most serious sanctions that Arbor Medical Staffing can impose, up to and including separation.

Sexual abuse includes, but is not limited to:

- Conduct of a sexual nature which reasonably would be expected to have the effect of threatening or intimidating the person at whom such conduct is directed.
- Intentional physical contact with an intimate part of the body or another person without that person's consent.
- Sexual intercourse when such contact is achieved without consent; through physical force, coercion, or threat; or in situations in which the victim is unable to give consent because of physical or mental incapacitation by reason of drug or alcohol consumption, sleep, or unconsciousness.

Some examples of sexual abuse may be:

- Two health care professionals had been flirting with one another earlier in the evening. One of the health care professionals misinterprets responses from the other health care professional and forces sexual intimacy, ignoring requests that it stop.
- During the course of an evening, a couple is initially comfortable with sexual contact, but then one says the intimacy has gone too far and asks for it to stop, while the other continues the sexual contact despite those objections.
- A health care professional takes sexual advantage of another who is incapable, for one reason or another, of asserting unwillingness.
- A health care professional says "no" quietly or timidly, yet another health care professional continues to proceed with sexual advances.
- Any inappropriate or non-consensual contact such as pinching a person's buttocks.

Discussion of Consent. Intimate sexual activity requires consent. As stated in the policy above, an individual may be unable to give consent "because of physical or mental incapacitation by reason of drug or alcohol consumption, sleep, or unconsciousness". Consent to sexual activity may be communicated in a variety of ways, both verbal and non-verbal. One should presume there is no consent in

the absence of a clear, positive indication of consent. Verbal communication prior to engaging in sexual activity certainly can help to clarify for the individuals involved whether or not there is consent.

Likewise, non-consent or lack of consent may also be communicated in a variety of ways, both verbal and non-verbal. A verbal “no” (or its verbal or non-verbal equivalent) indicates unwillingness to participate in sexual activity. Even in the absence of a verbal “no”, physical resistance is not necessary to communicate a lack of consent, which can be communicated in a variety of other ways depending upon circumstances or context.

Frequently, an health care professional expresses confusion about the concept of consent, what it looks like and sounds like. There’s a great deal of misunderstanding and differently held beliefs about what is meant by a gesture, a word, a sigh – even between long-time friends or sexual partners. People who have been intimate in the past may mistakenly assume that the same forms of intimacy will always be welcome in the future. The use of alcohol or other drugs can cloud people’s understanding of whether consent has been given (or even sought). Consent and non-consent come in many forms, and it is important for all sexually active persons to seek clarity and mutuality with regard to the consensual nature of their sexual activity. It is also important to recognize that, however potentially awkward, talking about your own and your partner’s sexual desires, needs, and limitations is a basis for a positive relationship.

Advanced Directives

An Advanced Directive is a document stating your health care choices and naming someone to make the choices for you if you 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 decisions. These legal documents are called Advanced 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 a good idea to discuss decisions with family members. While it is not necessary to consult an attorney for your Advanced Directives to be a legally binding document, it is often helpful. If an Advanced Directive has not been executed and the patient is unable to make decisions, others will make healthcare decisions for that patient in consultation with 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 or relieve pain are not life sustaining procedures and would not be withheld under a Living Will.

A Durable Power of Attorney for Health Care is a document through which you name another person known as your "attorney-in-fact" or "agent" to make healthcare decisions for you if you are unable to make them. This agent is required to make decisions according to directions you may provide in the document or otherwise. If your wishes are not known, your agent shall make decisions in your best interest.

How does a Durable Power of Attorney for Health Care differ from a Living Will? Both documents apply only when you are unable to make healthcare decisions. A Living Will applies only if it is your intention to have life-sustaining procedures withheld or withdrawn and you are in a terminal condition. It is a directive to your physician.

A Durable Power of Attorney for Health Care lets you name an agent to make health care decisions in accordance with your wishes. If you wish, you may specify the health care you want or don't want. 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 you trust and who has consented to act as your agent. If your agent is unable or becomes unwilling to serve it is advisable to have named an alternate who can step in and act as your agent. Your agent can make any health care decisions regarding treatment of your physical or mental condition. In all cases, your agent must make decisions in accordance with your wishes. If you wish, you may limit the scope of your agent's authority.

It is important to discuss your wishes with the person who will be your agent. You may also state your wishes on the Durable Power of Attorney for Health Care Form. If your agent doesn't know your wishes, he or she has a duty to act in your best interest considering your condition and prognosis. If you know you want life-sustaining procedures withheld or withdrawn when you are in a terminal condition, you may also want to sign a Living Will since it provides direction to your physician and you will not have to rely on an agent to communicate those wishes.

If you are uncertain about which documents are best for you, consult your physician or attorney for guidance. Put the original in a safe but accessible place. Provide copies to family members and, if a Durable Power of Attorney for Health Care has been executed, to the appointed agent and alternatives. Give a copy to your physician. You might wish to file a copy with your local hospital, if it accepts such forms.

Age Specific Criteria

INFANT: BIRTH TO ONE YEAR

Neonate: Birth to 1 month

Physical Development

Has Strong Reflexes:

- a. Automatic Grasp Reflex-Infant's fingers curve around finger placed in infant's palm
- b. Sucking Reflex-Neonate sucks on object placed in mouth
- c. Rooting Reflex-when cheek is brushed, neonate turns head toward stimulus and attempts to grasp with mouth
- d. Moro (Startle) Reflex-Generalized Activity in response to stimulation
- e. Babinski Reflex-when stroking outer sole of foot upward from heel to across ball of foot causes toes to hyperextend.

Normal Vital Signs: Pulse = 150 (+/-20), Respirations = 35 (+/-5)

Neonate has poor temperature regulation. Gains about 6 ounces per week. Grows approximately one inch during the first month. Fontanels are soft and flat. Umbilical cord should dry and fall off during the first or second week of life. Is unable to support the weight of his/her head.

PSYCHOSOCIAL DEVELOPMENT

Responds to environment through visual, auditory, tactile, and taste senses. Is totally dependent upon caregiver. Perceives self and parent as one. Responds to human voices and faces. Cries when uncomfortable, sleepy or hungry. Soft music and bright colored mobiles provide pleasant stimulation for neonate.

NURSING CONSIDERATIONS

Physical assessment should include temperature, pulse (counted for one full minute), respirations (also counted for one full minute), weight, head and chest circumference, length and assessment of fontanels. Perform the most uncomfortable or intrusive procedures last. First Hepatitis B Vaccination should be initiated by the age of two months.

Hold and cuddle during feeding. Maintain feeding schedule. Check for soiling of diapers. Always transfer neonate via crib, stretcher, or stroller. Keep warm. Place infant in supine position for sleeping ("Back to Sleep"). When keeping track of Intake and Output, weigh diapers for an accurate output. One cc of urine weighs about one gram.

TWO TO THREE MONTHS

Physical Development

Posterior fontanel closes around the second month. Head circumference increases by approximately 1.5 cm per month for the first six months. Startle, sucking and rooting reflexes begin at around three months. Normally, infant should gain about one ounce during the first six months of life.

Normal vital signs: Pulse = 130 (+/-20), Respirations = 35 (+/-10), Blood Pressure = 80/45(+/- 20/10)

Can strike at a toy but cannot grasp it. Able to hold head up when supported in the sitting position, but, it will bob forward. Rolls over. Around the third month, will purposefully put hand into mouth. Will make crawling movements when in prone position. Can push chest up with forearms. Will visually pursue sound by turning head.

Psychosocial Development

Laughs out loud, coos, blows bubbles and squeals. Crying becomes differentiated. Smiles at primary caregiver's face. Responds pleasurable to gentle touch and motion. Enjoys simple toys, such as a rattle, music box, or brightly colored mobile.

Nursing Consideration

Physical assessment should include vital signs, weights, head and chest circumference, length, assessment of fontanelles and reflexes and immunization status. DPT, Polio and HIB (H. Influenza type B) immunizations are initiated at 2 months. Second Hepatitis B vaccination should be administered one month after first dose was given, usually at two to three months of age. Perform most uncomfortable and intrusive procedures last.

Take precautions to prevent falls and rolling off surfaces. Keep side rails up on crib at all times. Transport using crib, stretcher, or stroller. Provide play stimulation. Hold and cuddle for feeding.

FOUR TO FIVE MONTHS

Physical Development

Holds head steady in a sitting position. Supports part of weight with legs when held in a standing position. Reaches out with hands. Brings hands together, plays with them, and puts them into mouth. Can grasp objects with both hands. Drooling begins at four months. At five months, birth weight should be doubled. Can transfer objects from one hand to the other. Rolls back to side. Can balance head well.

Normal vital signs: Pulse = 130 (+/-20), Respirations = 35 (+/-10) Blood pressure = 80/45(+/- 20/10)

Psychosocial Development

Begins to discriminate family members from strangers. Laughs out loud. Initiates social play. Sleeps longer periods at night. May have one or two naps during the day. At five months, will babble vowels such as "goo". Enjoys hearing self make vocal sounds and splashing in water. Imitates others. Searches for objects at point of disappearance.

Nursing Considerations

Physical assessments should include vital signs, weight, head and chest circumference, length, assessment of fontanelles, and immunization status. The second Polio, DPT and HIB are given at four months. Perform the most uncomfortable or intrusive procedures last.

Protect from fall injury. Assess environment for safety hazards. Provide variety of small, multi-textured and colored objects that can be held, BUT not swallowed. Use floating toys for the bath. Mobiles are entertainment for the crib. Talk, play, smile, and laugh with infant. Hold and cuddle. May introduce solid foods. Introduce one new food at a time, allowing a week before introducing the next new food to assess for food allergies. Introduce in this order: cereals, fruits, vegetables, then meats.

SIX TO EIGHT MONTHS

Physical Development

Brings objects to mouth at will. Bangs objects on table. Drops toy from hand to reach for another when it is offered. Lower incisors may begin to erupt. Upper central incisors may begin to erupt at around seven months. Drools constantly. Can sit alone. Begins to show food likes and dislikes. Can drink from a cup. Sucking and rooting reflexes disappear. At eight months, can eat finger foods, such as crackers, cookies and bread. Crawls forward and backward. Weight gain is approximately half an ounce daily from six to twelve months.

Normal Vital Signs: Pulse = 120(+/-20), Respirations = 30 (+/-10), Blood Pressure = 90/60 (+/-20/10)

Psychosocial Development

Begins to recognize the meaning of certain words and vocal tones. Begins to demonstrate fear of strangers. Enjoys looking at self in mirror. Imitates simple acts of others. Recognizes own name. Vocalizing "da", "ma", "ba". Holds arms out when wants to be picked up.

Nursing Considerations

Use drinking cup designed not to spill ("sippy cup") Provide sound making toys and larger toys with moving parts, such as set of measuring spoons, bowls and pots. Provide large, safe area for crawling, such as a playpen. Provide large, safe area for crawling, such as a playpen. Provide stimulation with simple games such as clapping hands, placing toy under blanket. Read, talk and sing to

infant while holding. Third DPT and HIB immunization is at six months. Third Hepatitis B vaccination is also given four months after first dose, usually in this time frame.

NINE TO TEN MONTHS

Physical Development

Hand and eye coordination perfected. Picks up small objects with pincer grasp. Pulls self to standing position. Able to step sideways while holding on to furniture.

Normal Vital Signs: Pulse = 120 (+/- 20), Respirations = 35 (+/- 10), Blood Pressure 90/60 (+/-20/10).

Psychosocial Development

Says first words, such as "dada" and "mama". Waves bye-bye. Enjoys playing games like "peek-a-boo and pat-a-cake". Cries when scolded. Repeats activities that attract attention.

Nursing Considerations

Remove all objects small enough to be swallowed or aspirated from play areas. Provide safe play area keeping objects above infant's reach. Provide walker for infant to push self around in. Expect some discomfort, drooling and low-grade fever with teething. Refrain from giving bedtime bottle that contains sugar-containing fluid. Counsel parent to minimize sweets in baby's diet and avoid adding salt.

ELEVEN TO TWELVE MONTHS

Physical Development

Holds cup alone. Scribble with crayon. Has tripled birth weight by twelfth month. Bowel movements are decreased to one or two per day. At eleven months may begin to stand alone for variable amount of time and begin to walk alone at twelve months. Cooperates with dressing. Takes toys out of box and puts them back into box. Grows about one half inch per month. Anterior fontanel closes between twelve and eighteen months. Babinski reflex disappears at twelfth month. Head and chest are equal in circumference.

Normal Vital Signs: Pulse = 120 (+/-20), Respirations = 25 (+/-5), Blood Pressure = 90/60 (+/- 20/20)

Psychosocial Development

Understands simple, short commands. Expresses frustration when restricted. Tantrums may begin. Enjoys simple games. Resists going to bed. Able to form two or three word sentences. Recognizes objects by name.

Nursing Considerations

Set limits. Maintain a regular bedtime schedule that parents have established at home. Provide toys which allow placing objects into a large container and taking them out again, such as large stacking blocks. Push and pull toys encourage walking. Play simple games such as rolling balls. Provide hazard-free play area. Begin weaning from bottle.

PEDIATRIC: ONE TO TWELVE YEARS

Toddler: one to Three Years Old

Physical Development

At one and a half years old, develops sphincter control. First upper and lower molars appear around fifteen months. At age two, the toddler has about sixteen teeth. Can crawl, run, jump, step backward and sideways. Can climb stairs alone. At two and a half years old, the child's weight is approximately four times birth weight. Height increases by about four to five inches per year. Learns to ride tricycle. Indicates when diaper needs to be changed. Attempts to spoon-feed self. By age three feeds self completely.

Normal Vital Signs: Pulse = 110 (+/- 20). Respirations = 25 (+/-m5), Blood Pressure = 99/60 (+/- 20/20).

Psychosocial Development

Less fearful of strangers. Hugs and kisses parents. Begins to imitate parents doing household chores. By age three, can use a noun, verb and object in a three word sentence. Has a vocabulary of over 300 words. Knows his/her own name. Shows pride in

independence. Uses "no" frequently. Temper tantrums are less by age three. Likes to do things without help. May begin to play with genitals as a process of self-exploration. At age two, treats other children as objects and cannot share possessions. By age three, is just beginning to understand taking turns and sharing. Begins learning simple rules.

Nursing Considerations

Provide toys like stuffed animals, dolls, musical toys, picture books, stacking blocks, balls, low slide, toy telephone, hammer and pegboard, pulling and pushing toys. Begin toilet training between eighteen and twenty-four months old. Teach how to brush teeth. Encourage parents to make first visit to the dentist. Use repetition to enhance memory and understanding. Don't expect child to understand sharing. Toddlers may be examined or have procedure done while sitting in parent's lap. Safety considerations include keeping crib rails up and use of canopy cribs. Immunizations during this time period include MMR (Measles, Mumps and Rubella) at fifteen months. The fourth and final Hib vaccine is given between twelve and fifteen months of age. A varicella immunization is also recommended at twelve to fifteen months of age.

PRESCHOOL: Three to Five Years Old

Physical Development

Birth length doubles by age four. Nighttime bowel and bladder control should be achieved by age three or four. Performs simple self-care skills independently. Moves with speed and agility. Can lace shoes and jump rope. By age five, can use pencil and scissors well.

Normal Vital Signs: Pulse = 92 (+/-5), Respirations = 25 (+/- 5), Blood Pressure =99/60 (+/-10/10)

Psychosocial Development

Can count to five. Knows primary colors. Understands concept of time in terms of morning, nights, later and so on. Believes that whatever moves is alive, such as car, hospital equipment. Thinking is concrete. Enjoys helping with simple chores around the house. Unable to comprehend the whole picture yet. Focuses on concrete details. Becomes concerned about even the smallest injury. Egocentric in thoughts and behavior. Engages in parallel play. Enjoys dolls, large puzzles, taking toys apart, finger paints, hand puppets, large crayons, play-dough, and moving toys, like pulling wagon.

Nursing Considerations

Limited ability to judge distances and own strength predisposes him/her to accidents. Preoperative teaching has little meaning, but post-operative re-teaching is meaningful and helpful. Band-Aid small scratches and injection sites. Intrusive procedures, such as throat swabs, rectal temperatures, blood drawing and IV starts are distressing and should be done in a treatment room.

Preschool children are more cooperative during physical examinations when they are allowed to actively participate, such as holding the equipment, examining you as you examine them. Provide simple explanations about the procedure.

Fifth DTP, fourth Polio and second MMR are given prior to entry into school.

MIDDLE CHILDHOOD: Six to Twelve Years

Physical Development

Greater muscle strength and coordination is gained. The child works and plays hard but tires easily. Able to complete more complex self-care skills. Starts to lose temporary teeth; acquires first permanent teeth between six and eight years of age. Growth spurt occurs between ten and eleven years with slow increase in heights and rapid increase in weight.

Normal Vital Signs: Pulse=80 (+/-20), Respirations=21(+/-5), Blood Pressure=103/60 (+/-20/20)

Psychosocial Development

Six to eight years of Age: Understands and uses classification systems. Enjoys collecting favorite things. Learns to get along with peers. Chooses best friends, usually of same sex. Will accept responsibility for routine household tasks with occasional reminders. Likes to participate in family decision-making. Likes rough and tumble play. Insists on being first in everything. Craves attention.

Eight to Ten Years of Age: Curious about everything. Becoming peer oriented. Begins hero worship. Ashamed of failures. Interested in schoolwork. Prefers companionship in play. May fight. Enjoys making things. Can consider alternative solutions to simple problems. Likes to belong to clubs. Fears the dark.

Ten to Eleven Years of age: May leave clothes where they fall. Prefers showers instead of baths. Needs constant reminder of personal hygiene. Preoccupied with right and wrong. Respects parents and their role. Has short outbursts of anger.

Nursing Considerations

Six to Ten Years Old: Enjoys table games, board games, jump rope, punching bags, roller skates, musical instruments, puppets, dolls, painting, coloring, magic tricks, dancing, puzzles, records, tapes, competition games, crafts, athletic sports, collecting things.

Ten to Eleven Years Old: Enjoys parties, talking on the phone, solitary play, reading mystery and love stories, going to the movies.

School-age children often enjoy actively participating in their examination and care. Allow them choices within acceptable limits. Provide simple explanations. Remember that they are modest and proud. Respect their modesty and keep them covered and screened when possible. Do not embarrass them-especially in front of other children.

School-aged children are well coordinated and more safety-conscious. Usually may ambulate freely. Keep bed in low position and side rails down during day unless otherwise ordered.

ADOLESCENCE: THIRTEEN TO SEVENTEEN YEARS

Physical Development

A growth spurt takes place between ten and sixteen years old. Girls retain more subcutaneous fat than boys do. Muscle development is greater in boys than in girls.

In females, breast development begins followed by the growth of pubic hair and axillary hair. The average onset of menarche is thirteen. Acne vulgaris may occur due to increased secretion of androgens.

In males, pubic hair growth occurs around age thirteen. The penis, scrotum, and testes become larger. The voice begins to deepen as the larynx and vocal cords increase in size and strength.

Normal Vital Signs: Pulse = 80 (+/-20), Respirations = 20(+/-4), Blood pressure = 120/78(+/-20/10)

Psychosocial Development

May have employment outside the home. Becomes independent and self-directed in schedules and homework. Begins to explore career options. Searches for new beliefs, resolves inconsistencies of old beliefs and begins to form a personal philosophy of life. Frequent mood swings. Sexual curiosity and fantasy are at a peak. Dating may be a major activity. May be sexually active. Engages in organized competitive sports. Uses slang within and outside peer group. Peer-oriented. Begins to sever ties with parents. Has fewer but closer friends. Enjoys shopping, driving cars, riding motorcycles, reading books, and magazines., "Hanging out" with peers. Meal skipping is common. Snacking becomes a part of eating pattern. Fast-food consumption is popular. May experiment with smoking, alcohol, and drugs

Nursing Considerations

Adolescents consider themselves adults. Physical Assessments are the same as for an adult. Adolescents may become extremely self-conscious and embarrassed. Provide privacy. Drape parts not being examined. Adolescents need adequate explanations. Allow involvement in decisions about care. Teach adolescent girls about self-breast examination.

ADULT: EIGHTEEN TO SIXTY-FOUR YEARS

Young Adulthood: 18 to 40 Years

Physical Development

Has achieved full physical maturity by age 20.

Psychosocial Development

Interests broaden into community and world affairs. Chooses, prepares for and practices a career. Becomes independent of parents. Adjusts to marriage or other intimate love relationship. Childbearing and child rearing are major concerns of those who have children.

Is continually adjusting to stress and satisfaction of work, spouse, parents, and children. Establishes a personal set of values and formulates a meaningful philosophy of life. Need for ability to cope with change. Period of reaching psychosocial maturity. Understanding level of maturity will enhance appropriate plan of care. Consider the following criteria:

1. Determination of independence
2. Ability to apply knowledge and experience
3. Ability to communicate experiences to others.
4. Sensitivity to others.
5. Ability to deal constructively with frustration.
6. Ability to maintain self-control.
7. Willingness to assume responsibility.

Nursing Considerations

Hospitalization may pose a serious stress on the family, especially if the ill person provides the major source of income for the family. Illness of a family member necessitates role changes at home, which may also be an additional stressor. Involve in planning own care. Keep informed of treatment plan along with reason for interventions.

Middle Adulthood: 41-64 years

Physical Development

A decrease in bone density and mass causes a decrease in height as the individual gets older. Muscle tone decreases, causing the person to appear "flabbier". Visual acuity often diminishes, necessitating eyeglasses. Adjustment to menopause.

Psychosocial Development

Learns and adjusts to role as grandparents. Maintains contact with extended family. Reaches and maintains a satisfactory performance in career. Develops adult leisure time activities. Readies self both financially and psychologically for retirement. First awareness that one is becoming "old".

Nursing Considerations

Same as for Young Adulthood

GERIATRIC: 65 YEARS AND UP

Physical Development

Vulnerability to disease increases due to general diminution of function. Ability to maintain homeostasis decreases. The rate of cellular reproduction declines.

Integument changes include wrinkling, sagging, growths, and discolorations, loss of hair for men and growth of hair on women's faces, drying and thinning of hair. Musculoskeletal changes include decrease in bone mass, loss of elasticity in joints, degeneration of cartilage and connective tissue and gradual decrease in muscle mass. Pulmonary alterations include decreases in breathing capacity, residual lung volume, and total lung capacity. Metabolic rate declines. Changes in digestive system include slowed peristalsis, periodontal disease (which is preventable!) and decrease in secretion of digestive juices. Cardiovascular changes include narrowing or loss of elasticity of blood vessels. Renal atrophy predisposes to urinary tract infection and diminished renal function. There is decreased hormone secretion. Sexual function declines due to tissue changes that reduce the flexibility of the vagina and firmness of the penis.

There is LITTLE change in IQ. Skills and abilities tend to become obsolete from disuse rather than from deterioration of mental capacity. Memory losses affect more recent events, whereas events of long ago are remembered.

Psychosocial Development

Retirement introduces many changes in schedule, reduced income, and leisure time activities. There may be a change in living facilities, such as moving from a home to a congregate living facility. A warmer climate is often sought. Individual has often experienced the death of close family members or friends and may reflect on his/her own death. Often has developed close religious ties.

Nursing Considerations

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Feelings of worth, pride, and usefulness need to be maintained. Suggest volunteer work to meet these goals. Suggest natural seasoning for foods such as lemon or onion as sense of taste and smell decline. Encourage intake of high fiber diet and at least two to three liters of fluid to prevent constipation. Acidic fluids will help maintain acid urine, thus reducing the risk of urinary tract infection. Yearly dental check-up should be recommended. A regular exercise program is useful, such as walking or bicycling. Protect from hazards as agility and balance decline with aging. Medications often require smaller doses due to degenerative changes in body functions.

Prepared by the Florida Health Care Association with the assistance of the Alzheimer Resource Center of Tallahassee, Florida to meet the statutory requirement of 400.4785(1) (a) F.S.

ALZHEIMER'S DISEASE (AD) AND RELATED DEMENTIAS

History

Alzheimer's disease (AD) was first discovered in 1906 by a German doctor named Alois Alzheimer. It is a disorder of the brain, causing damage to brain tissue over a period of time. The disease can linger from 2 to 25 years before death results. AD is a progressive, debilitating and eventually fatal neurological illness affecting an estimated 4-5 million Americans. It is the most common form of dementing illness.

Alzheimer's disease is characterized clinically by early memory impairment followed by language and perceptual problems. This disease can affect anyone - it has no economic, social, racial or national barriers.

Causes

There is no one cause for Alzheimer's disease. AD may be sporadic or passed through the genetic make-up. The disease causes gradual death of brain tissue due to biochemical problems inside individual brain cells. The symptoms are progressive, but there is great variation in the rate of change from one person to another. Although in the early stages of Alzheimer's the victim may appear completely healthy, the damage is slowly destroying the brain cells. The hidden process damages the brain in several ways:

- Patches of brain cells degenerate (neuritic plaques)
- Nerve endings that transmit messages become tangled (neurofibrillary tangles)
- There is a reduction in acetylcholine, an important brain chemical (neurotransmitter)
- Spaces in the brain (ventricles become larger and filled with granular fluid)
- The size and shape of the brain alters - the cortex appears to shrink and decay

Understandably, as the brain continues to degenerate, there is a comparable loss in mental functioning. Since the brain controls all of our bodily functions, an Alzheimer victim in the later stages will have difficulty walking, talking, swallowing and controlling bladder and bowel functions. They become quite frail and prone to infections such as pneumonia.

Dementia vs. Normal Aging

As a person grows older, he/she worries that forgetting the phone number of a best friend must mean he/she is becoming demented or getting Alzheimer's disease. Forgetfulness due to aging or increased stress is *not* normal aging and is *not* dementia.

"Dementia" is an encompassing term for numerous forms of memory loss. There are many types of dementia such as Alzheimer's disease, Multi-Infarct dementia or Parkinson's disease. When a person has dementia, he/she will lose the ability to think, reason and remember and will inevitably need assistance with everyday activities such as dressing and bathing. Changes in personality, mood are also symptoms of dementia. Many dementias are treatable and reversible. Alzheimer's disease is the most common form of untreatable, irreversible dementia.

Alzheimer's Disease - Stages of Progression

Alzheimer's Disease can be characterized as having early, middle, and late stages through which the patient gradually progresses, but not at a predictable rate. The range of the course of the disease is 2-25 years. NOTE: Stages very often overlap. Everyone progresses through these stages differently.

First Stage: This is a very subtle stage usually not identified by either the impaired person or the family as the beginning signs of the disease. Subtle changes in memory and language along with some confusion occur at this time. The family usually denies or excuses the performance deficiencies at this stage.

- Forgetfulness/memory loss
- Impaired judgment

- Trouble with routines
- Lessening of initiative
- Disorientation of time and places
- Depression
- Fearfulness
- Personality change
- Apraxia (forgetting how to use tools and equipment)
- Anomia (forgetting the right word or name of a person)

Second Stage: As Stage 1 moves onto Stage 2, there is usually a particular significant event which forces the family (and impaired person) to consider that something is really wrong. At this time, they usually go to a doctor to diagnose the problem.

- Poor short-term memory
- Wandering (searching for home)
- Language difficulties
- Increased disorientation
- Social withdrawal
- More spontaneity, fewer inhibitions
- Agitation and restlessness, fidgeting, pacing
- Developing inability to attach meaning to sensory perceptions: (taste, touch, smell, sight, hearing)
- Inability to think abstractly
- Severe sleep disturbances and/or sleepiness
- Convulsive seizures may develop
- Repetitive actions and speech
- Hallucinations
- Delusions

Third (Final Stage): This stage is the terminal stage and may last for months or years. The individual will eventually need total personal care. They may no longer be able to speak or recognize their closest relatives.

- Little or no memory
- Inability to recognize themselves in a mirror
- No recognition of family or friends
- Great difficulty communicating
- Difficulty with coordinated movements
- Becoming emaciated in spite of adequate diet
- Complete loss of control of all body functions
- Increased frailty
- Complete dependence

COMMON PROBLEMS WITH DEMENTIA

Delusions

Suspiciousness: accusing others of stealing their belongings
 People are "out to get them"
 Fear that caregiver is going to abandon (results in AD person never leaving caregiver's side)
 Current living space is not "home"

Hallucinations

Seeing or hearing people who are not present

Repetitive actions or questions

They forget they asked the question
 Repetitive action such as wringing a towel

Wandering

Pacing

Sundowning: trying to get "home"

Generally feeling uncomfortable or restless

Increased agitation at night

Losing things / Hiding things

Simply do not remember where items are

Might hide things so that people don't "steal" them

Inappropriate sexual behavior

Person with AD loses social graces and is only doing what feels good

Agnosia: inability to recognize common people or objects

A wife of forty years will become a stranger to the person with AD, he might even think she is the hired help

Might not recognize a spatula or the purpose of the spatula and/or cannot verbalize the name or purpose of the object

Apraxia: loss of ability to perform purposeful motor movements

Cannot tie a shoe or manipulate buttons on a shirt

Catastrophic reactions

(Causes) AD person often becomes excessively upset and can experience rapidly changing moods. The person becomes overwhelmed due to factors such as too much noise, too many people around, unfamiliar environment, routine change, being asked too many questions, being approached from behind.

(Reactions) AD person may become angry, agitated, weepy, stubborn or physically violent. It is best to attempt to avoid catastrophic reactions rather than dwell on how to handle them.

HANDLING DISTURBING BEHAVIORS

One of the most difficult challenges for caregivers is how to handle some of the disturbing behaviors that Alzheimer's can cause. Symptoms such as delusion, hallucinations, angry outbursts, suspiciousness, failure to recognize familiar people and places are often the most upsetting behaviors for families. The following points may help in responding to disturbing symptoms.

First, try to understand if there is a precipitating factor causing the behavior. Were there household changes, too much noise or activity, was the daily routine upset? Time of day can also affect behavior (Sundowning). Being aware of these factors can help to better plan activities or anticipate problems.

1. Keep tasks, directions and routine simple without being condescending
2. Always give the person plenty of time to respond
3. Attempt to remain calm and remind yourself that the behavior is due to the disease
4. Avoid arguing
5. Write down the answers to frequently asked questions, then remind them to look at the message
6. Reduce environmental noise: television, radio, too many people talking
7. Use distraction when unacceptable behavior starts: bring them into a different room, start talking about childhood or another favorite topic, show them magazines, ask them to help you do something like dusting or sweeping
8. Do not overreact or scold for problem behavior: redirect or distract instead
9. Be reassuring with touch, eye contact and tone of voice
10. Find the familiar: old pipe, favorite chair, family pictures
11. Avoid denying hallucinations: try non-committal comments like, "You spoke with your mother, I miss my mother too"
12. Be sure to inform physician of hallucinations, no matter how tame
13. Restless behavior or pacing is usually unavoidable, however you can make the environment safe by installing locks that are above reach, remove unnecessary obstacles, make sure the person is wearing some kind of identification

Alzheimer Resource Center of Tallahassee: (850) 561-6869 Website: www.arc-tallahassee.org

Alzheimer's Foundation of America Website: <http://www.alzfdn.org>

BLOOD BORNE PATHOGENS AND NEEDLESTICK PREVENTION

Reading material for Blood borne Pathogens and Needlestick Prevention can be found at the website for OSHA at

<http://www.osha.gov/CLTC/bloodbornepathogens>

BODY MECHANICS / ERGONOMIC PROTOCOLS

An analysis of any patient lifting and repositioning task involves an assessment of the needs and abilities of the patient involved. This assessment allows staff members to account for patient characteristics while determining the safest methods for performing the task, within the context of a care plan that provides for appropriate care and services for the patient. Such assessments typically consider the patient's safety, dignity and other rights, as well as the need to maintain or restore a patient's functional abilities.

The patient assessment should include examination of factors such as:

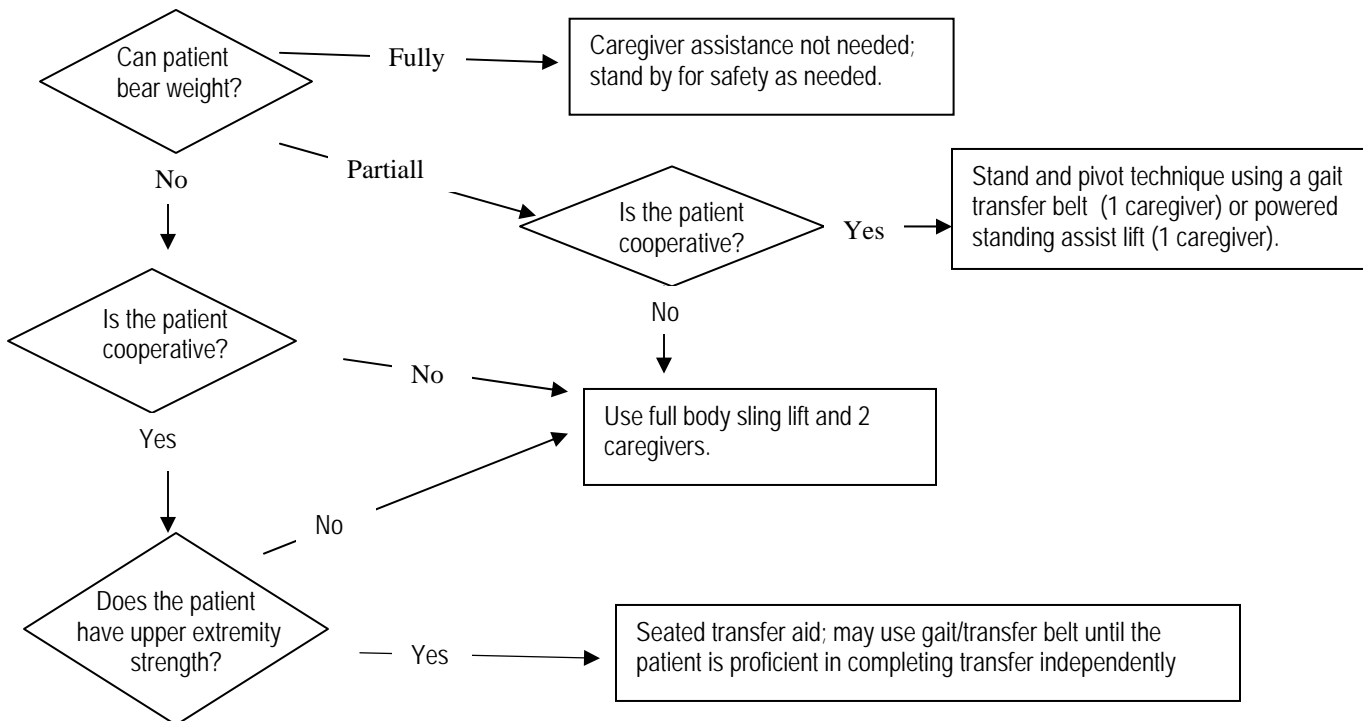
- The level of assistance the patient requires
- The size and weight of the patient
- The ability and willingness of the patient to understand and cooperate and
- Any medical conditions that may influence the choice of methods for lifting or repositioning.

These factors are critically important in determining appropriate methods for lifting and repositioning a patient. The size and weight of the resident will, in some situations, determine which equipment is needed and how many caregivers are required to provide assistance. The physical and mental abilities of the resident also play an important role in selecting appropriate solutions.

The recommended solutions presented in the following pages are not intended to be an exhaustive list, nor does OSHA expect that all of them will be used in any given facility. The information represents a range of available options that a facility can consider using.

A number of protocols have been developed for systematically examining patient needs and abilities and/or for recommending procedures and equipment to be used for performing lifting and repositioning tasks. The following are some examples:

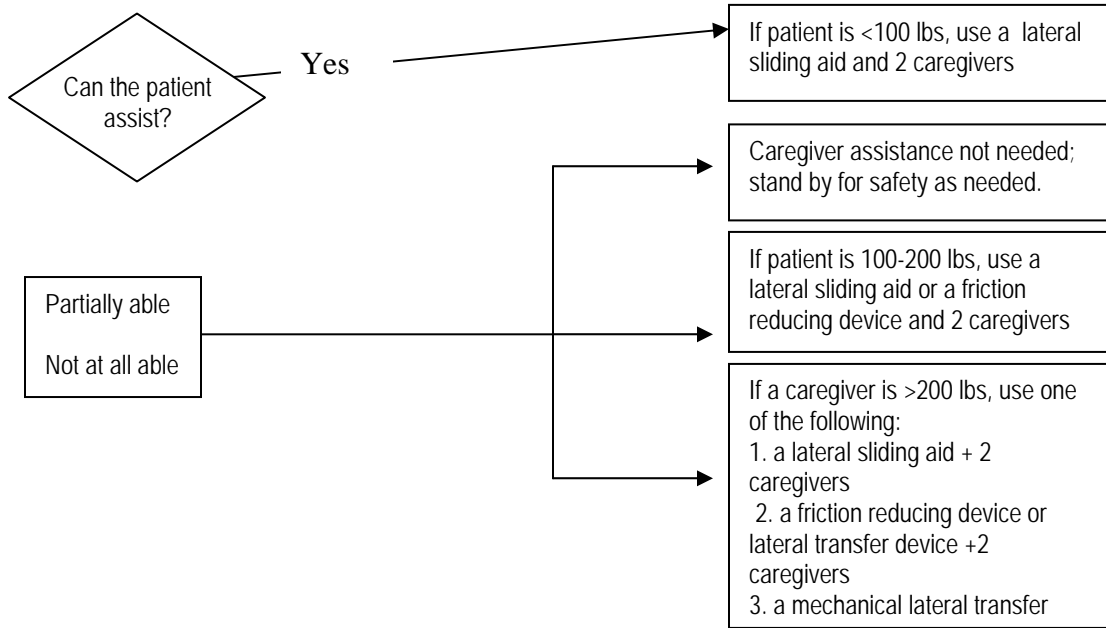
1. Transfer to and from : Bed to chair, chair to toilet, chair to chair , or car to chair



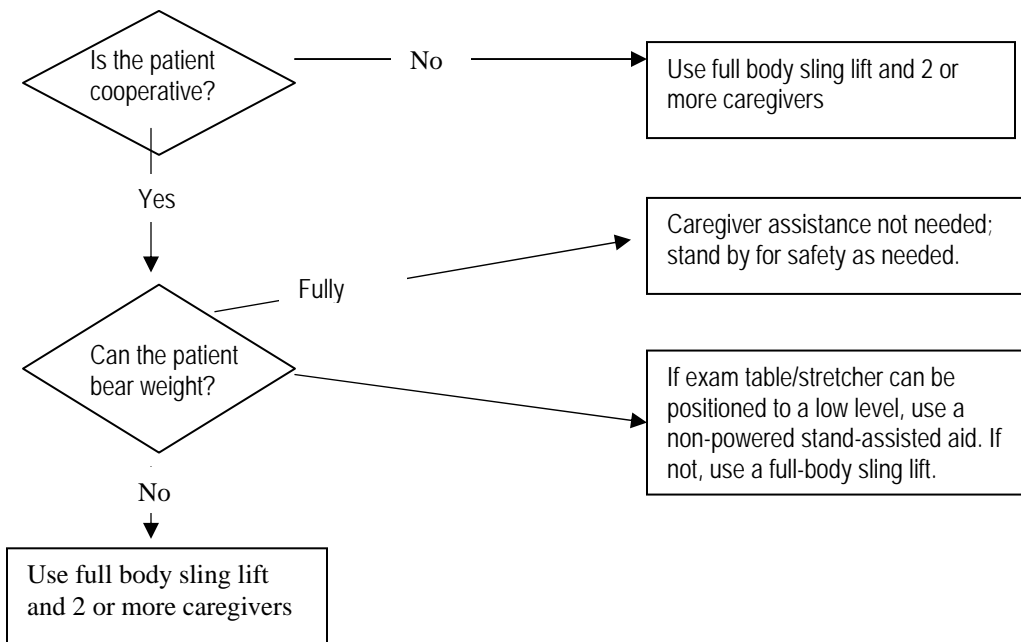
Source: The Patient Safety Center of Inquiry, Tampa, Florida, Veteran's Health Administration and Department of Defense. 10/2001

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2. Lateral Transfer to and from: Bed to Stretcher, Trolley



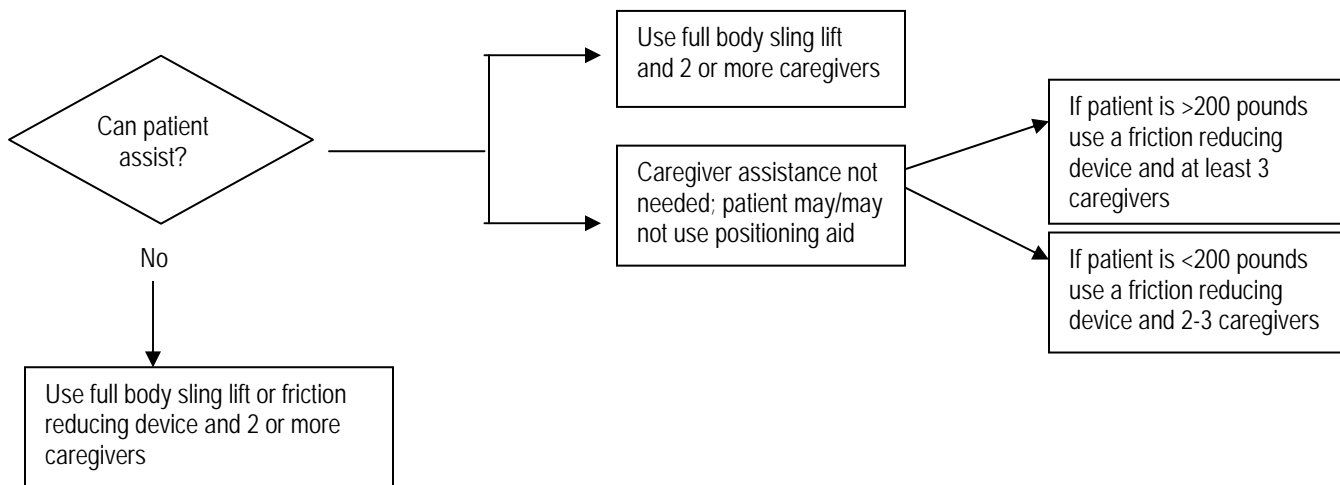
3. Transfer to and from: Chair to Stretcher



High-Low exam tables and stretchers would be ideal.

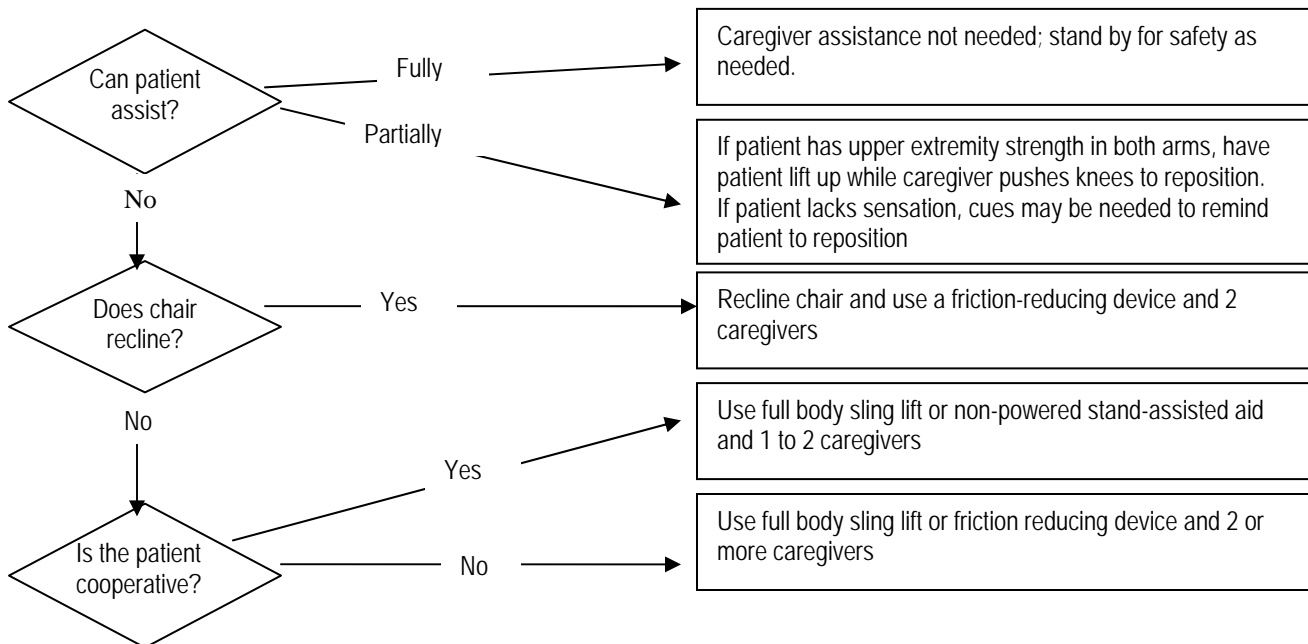
Source: The Patient Safety Center of Inquiry, Tampa, Florida, Veteran's Health Administration and Department of Defense. October 2001

4. Reposition in Bed: Side to Side, Up in Bed



- This is not a one-person task-DO NOT PULL FROM HEAD OF BED.
- When pulling a patient up in bed, the bed should be flat or in Trendelenburg position to aid in gravity, with the side rail down.
- For patient with stage 3 or 4 pressure ulcers, care should be taken to avoid shearing force.
- The height of the bed should be appropriate for staff safety (at the elbows).
- If the patient can assist when repositioning "up in bed", ask the patient to flex the knees and push on the count of three.

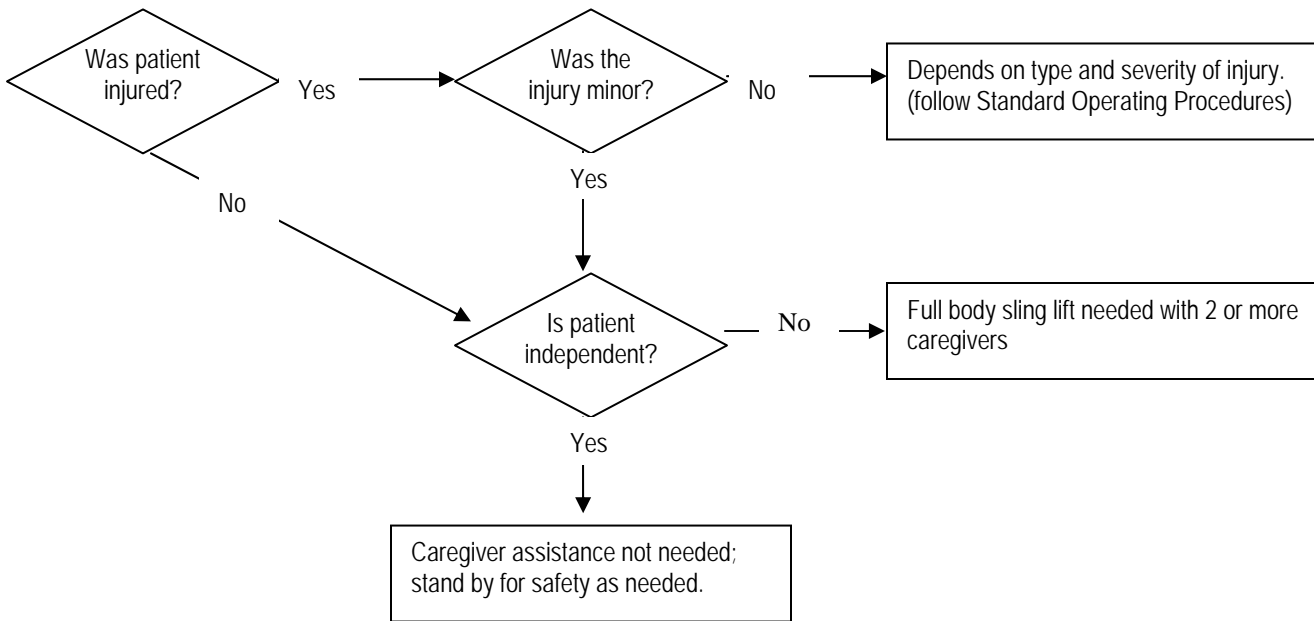
5. Reposition in Chair: Wheelchair and Dependency Chair



- This is not a one-person task. DO NOT PULL FROM BEHIND CHAIR
- Take full advantage of chair functions, eg, chairs that recline or use of armrest to reposition
- Make sure the chair wheels are locked

Source: The Patient Safety Center of Inquiry, Tampa, Florida, Veteran's Health Administration and Department of Defense. 10/2001

6. Transfer a Patient Up From the Floor



Use full body sling that goes all the way down to the floor (most of the newer models are capable of this)

Source: The Patient Safety Center of Inquiry (Tampa, FL), Veterans Health Administration & Department of Defense, October 2001

More information on ergonomics and other safety and health issues is available on OSHA's website at www.osha.gov. See the index at the top of the home page.

CULTURAL DIVERSITY SKILLS IN HEALTH CARE SETTINGS

Healthcare workers need clinical skills to address the vast diversity in social, cultural and linguistic experiences of patients. The quality of the interactions between the caregiver and the patient are affected by the cultural diversity that exists. This diversity can affect the patient's ability to discuss symptoms, stick to treatment plans or his beliefs regarding the respect he receives from caregivers and the healthcare system, according to the U.S. Agency for International Development.

Types of Cultural Diversity

Cultural diversity extends beyond some of the overt differences such as race, physical appearance, sexual orientation, national origin (or languages spoken), gender or religion. Included are less obvious differences such as age, education, economic status, vision, hearing or mobility impairment, and mental health challenges. Other factors are health-related beliefs and values, disease prevalence and the efficiency of treatment (outcome). Training must address methods to communicate in all of these possible scenarios.

Competency

Cultural competence starts with the desire not to allow prejudices to keep us from treating every individual with respect. Evaluating our own level of cultural competency has to be part of our ongoing effort in providing the best healthcare to our patients.

We should study our own cultural checklists and become aware of personal attitudes, beliefs, biases, and behaviors that may influence our care of patients as well as our working relationships with fellow professionals from various racial, ethnic and social backgrounds. All clinical encounters are multi-cultural. Developing a relationship with our patients as in a partnership can help maintain our humility in this process so we can better understand all of the factors which make up the environment in which they live.

There is no way to paint broad strokes to represent any particular group of people. Even within ethnic and cultural classifications, treatment must be made on a person by person basis. Clinical and preventive care needs to be evidence-based, flexible, authentic, and ethical. Care must be tailor-made for each and every patient.

Understanding patient and community barriers to care are just the beginning. As a profession, we need to confront racism, sexism, classism, and other forms of prejudice and discrimination that occur in clinical encounters.

Patient Adherence to Treatment and Medicine

The challenge to treatment for any patient, regardless of culture, is adherence to treatment. Effective communication between the caregiver and patient who come from diverse cultures can cause problems in the efficiency of the treatment since adherence to instructions for medication, etc, is the key.

Adherence to treatment is a complex issue. Food and diet are closely related to culture. A plan of care often includes a change in diet. Some cultures even have strict beliefs about the kinds of food a woman can eat during pregnancy or has recently given birth. Others follow food guidelines based on religious beliefs. By showing respect and understanding, you will be able to elicit pertinent information about beliefs and traditions that may pose a challenge to adherence.

Finding ways to make the dietary changes that are necessary can be challenging. For example if your patient needs to reduce salt and their culture enjoys soy sauce with every meal, it may be a difficult change. Maybe to suggest a salt reduced soy sauce would be beneficial to the patient and those he/she eats with. There are other dietary issues, of course, but a gradual approach can be a successful one. Suggesting dessert with one or two meals a week instead of every meal might be a way to lower sugar ingestion. Setting smaller goals can lead the way to healthier eating and success of treatment.

Non-Judgmental Approach

Put yourself in your patient's shoes by imagining their viewpoint, values and day to day routines and problems. Encourage honesty and openness with you about their beliefs and concerns. Take the time needed to ask questions and really listen to their responses. By giving the respect needed to gain their trust, you will demonstrate your willingness to learn about them and their illness. This will elicit a more honest and complete response.

For example ask questions like:

- What is your opinion on the cause of your illness?
- How has it impacted your life?

- Have you tried any remedies?
- Do you have friends or relatives who can help with your treatment, or watch your children while you go to follow up appointments?
- Can you read the directions on the medicine? If not is there some one who can help with that.

Listen to the patient carefully, giving your full attention. Rephrase their comments and repeat to them so that they understand you have heard them correctly or can correct you if you did not. Miscommunication can be increased if the caregiver and patient are from different cultures.

Working With an Interpreter

Professional interpreters are trained to convey messages without the distortion that can result from expressing their own opinions and are proficient in two languages, that of the provider and the patient. Family members and friends may modify what the patient has actually said. Title VI of the civil Rights Act of 1964 guarantees individuals with limited English proficiency any language assistance they need to guarantee "meaningful access" to health and social services that receive any form of federal funding.

Being bilingual in English and another language does not qualify an individual as an interpreter. A professional interpreter has the skills needed to understand what both people want to say and make their messages clear in two languages. The term "interpret" refers to spoken language and to "translate" refers to the written word. Most professional interpreters are able to do both well. Medical interpreters have additional skills that enable them to work in the health care setting.

Unspoken Communication

- The "OK" sign in Japan is the symbol for money, in other countries it is the symbol for "nothing" or zero. In some eastern European countries and others throughout the world, the gesture represents a bodily orifice and is very offensive
- To cross your fingers in the US is to hope for "good luck", but to hold them behind your back means you are being less than truthful. In Russia this is a rude gesture of rejection.
- In Iran, you would be considered extremely vulgar if you gave the "thumbs up" sign.
- Using your forefinger to point in many cultures is very rude. Use your entire hand instead.
- Winking can be a romantic invitation in Latin America and in China it is considered very rude
- Filipinos will point to an object by shifting their eyes toward it or pointing with their lips, rather than using their hands (as in Venezuela).
- The symbol for "yes" in some cultures may be a nod and in some cultures to say "yes" one would swivel the head from side to side. To indicate "no" Saudis tip their heads back and click their tongues while Lebanese point their heads upward and raise the eyebrows.
- In the Middle East and Asia touching another person's head is considered offensive. It is very inappropriate to pat a child on the head.
- Throughout the Middle East and in some African cultures, the left hand is reserved for bodily hygiene. Therefore, one should never offer the left hand for shaking or to receive anything.
- In India, it is considered rather offensive to step on someone's foot. Apologies must be made immediately.

This is of course not intended to be an exhaustive list of all the "unspoken" communication rules. This is a small representation and should make the caregiver aware that there are many ways to offend and therefore sabotage your efforts to communicate on a respectful level. It will affect your ability to treat your patient fully and gain the desired results.

Even your posture can speak for you when you do not realize it!

Gender Related Rules

Some cultures are very strict about what can be discussed openly with men and women. Crossing the gender line can be very taboo. For example, a man should never be interpreting for a woman with her obstetrician as well as in the case of a woman interpreting for a man with his urologist or any other specialist. Great care should be taken.

Alternative Medicine and Dietary Factors

The diet of any given culture is as diverse as our languages. Family members can be an enormous aid in designing an appropriate diet for the patient. Involving family will help to insure that the diet is adhered to after the patient is released from the hospital and as they continue their daily life at home with a diet that is beneficial and not harmful.

A patient's family can also be a valuable source of information concerning other medications prescribed by others and also alternative medicines the patient may be taking. You may be unfamiliar with these medications so keeping open communication with the family will be extremely helpful.

In summarizing, cultural awareness and competency could result in removing barriers to

- Avoiding drug complications
- Successful patient education
- A patient seeking health care due to trust
- Correct diagnoses due to medical history
- Better screening and testing due to more knowledge of various cultural factors
- Adherence to medical treatment and advice because the patient better understands

Other information on this subject can be found at www.culturaldiversity.org.

EMERGENCY PREPAREDNESS

There are 4 types of emergencies that can strike at any time. They usually strike without warning and can be devastating. They can occur within or outside of a medical facility. Without planning and organizing for such events, emergency resources and services cannot be deployed.

The plan that is developed around the day to day routine of the healthcare staff is the most effective and successful plan to use. An external emergency or disaster is one that has an impact on a facility that requires services outside the available resources. An internal disaster happens within the facility and threatens to disrupt the overall care of patients and the safety and health of the staff as well.

The facility plan of action should already be in place and as a health care provider, you will be advised of the proper protocol during orientation. According to the Joint Commission Standards, an effective emergency plan includes 4 key elements:

- Mitigation- plan ahead to lessen the severity and impact of an emergency
- Preparation- build needed resources such as supplies/equipment, training and orientation for staff, outside service agreements to assist, and periodic drills
- Response-define prearranged locations to report to and other organizational steps staff can take to lessen confusion and ensure a more orderly response
- Recovery- restoring and resuming services and normal operations will take community response and staff coordination and support

All of the following must be part of the protocol of the facility where you are assigned. Your orientation in this facility should include the plan for emergencies and disasters. For the health care provider the following steps should be taken or followed according to the plan the facility already has in place:

1. **EVACUATION** - patients should be evacuated to a secure place. Staff and patients should remain there until given the "all clear". Charts should be removed by the designated staff member and taken to the prearranged area.
2. **EQUIPMENT AVAILABILITY** - You should know where the following items are located so that the least amount of time will be used to collect them.
 - Keys-housekeeping staff will be aware of the location of all the keys
 - Blankets- additional blankets may be needed and gotten from housekeeping staff
 - Oxygen Tanks (portable)- the ED, Stress Room or Respiratory Therapy areas of the facility
 - Carts- the ER, Ambulatory Care Unit, Surgery, Radiology, Ultrasound, EKG / Stress Room
 - Other- bandages, sutures, sterile scrub brushes, saline, skin cleanser, waterless hand cleaner, gloves, fracture immobilization, splinting and casting material, backboard, and support equipment (chest tube, airway, suture trays, etc.)
3. **PATIENT IDENTIFICATION** - One person should be assigned to be responsible for patient id practices. They will keep a list of patients, their location within the facility and condition.
4. **RECORDS** - In order to preserve patient records and move the records and equipment necessary for their care to another facility, a person will need to be assigned this task.
5. **SECURITY and PUBLIC INFORMATION** – The medical facility should have security in place to guard against unauthorized entry following a disaster. In addition, phone staff should be advised not to give out any information concerning a disaster to any caller.
6. **RECOVERY** – The facility, as part of their emergency plan, will have pre-disaster photos of equipment and buildings already in place. Similarly, after the disaster, photos can be taken by facility designees to document the effects and damage caused by the disaster. This does not come under the scope of health care provider.

All medical facilities should conduct drills and training for emergencies. This way any potential problem can be revealed and corrected before they are actually tested. Joint Commission mandates hospitals to hold at least 2 disaster drills per year to include treatment and transportation exercises. The Joint Commission evaluates the staff and the plan once a year.

GENERAL SAFETY PROCEDURES

Here are some general guidelines for all health care providers to follow which will be universal. They address the most common disasters. You **MUST** review your facility's own plan for emergencies.

Fires

Having an accepted plan for fire emergency and hazards in the workplace is of the utmost importance. There are many fire hazards in the healthcare environment that can harm patients and staff if you do not have a plan. Many healthcare facilities use the "R.A.C.E." system when a fire breaks out. Using the word RACE is a convenient way to remember what to do.

R= Rescue (or remove) patients and staff in immediate danger

A=Alarm (or activate the alarm)

C=Contain the fire

E=Extinguish the fire

EARTHQUAKES

Almost no place on earth is free from earthquakes. They are not infrequent and can occur up to several million each year across the globe. Some are extremely devastating and others are barely noticed. The main concern for medical institutions is the loss of power. Use the following as general guidelines and always be up to date on the individual policies of the facility where you work.

During the Quake

1. Don't panic. If you are inside, stay inside. The greatest danger is from falling debris just outside the building and near the outside walls. Instruct all people inside to move into the hallways. If there is no time, have all take cover under beds or tables. Stay away from windows and glass.
2. Never use an open flame device. No candles, no matches. Put out any cigarettes and fires. If you are outside, move away from the building and utility wires. Once outside, stay there until all shaking stops.

After the Quake

Here are steps to take after the shaking stops:

1. Check for injuries. Follow treatment procedures as instructed
2. Do not use open flame devices until the building has been inspected and declared safe
3. Once building has been declared safe, check the utilities. If you smell gas, open windows and shut off the main gas valve.
4. Do not use telephones, unless you absolutely have to.
5. If the building is damaged, do not allow anyone to enter until "All Clear".

Fires can be caused by earthquakes. They can be even more devastating than the earthquake because they damage equipment, utilities and water sources. Be especially alert for fires, leaking gas and other dangerous effects of the quake. If there is a fire, you MUST follow the procedures set forth for fires unless told otherwise.

BOMB THREATS

Steps to follow during a bomb threat received by phone should include the following:

1. Don't panic
2. Keep the caller on the line as long as possible
3. Record every word spoken by the caller as best you can.
4. Listen for any strange or unusual background noises which might be helpful in providing clues to law enforcement.
5. Listen for accents, gender, speech impairments, nervousness, and whether the voice is familiar or unfamiliar.
6. Record everything you can. You may not be able to recall as well as you think you can when the moment has passed.

After the caller hangs up, IMMEDIATELY contact the switchboard and give as much information as possible. This person should contact the Police Department and then make this announcement over the intercom:

"ATTENTION PLEASE. CODE 50 IS NOW IN EFFECT"

The switchboard operator will use whatever code is appropriate for your facility. All staff should be familiar with the code system in the facility. They will differ. For example one facility may use color, another number and still others use letters or any combination of these. It is up to you and the emergency preparedness team to ensure all staff know the codes.

The following services and community responders will need to be contacted:

Fire Department

Hospital Administrator

All Nursing Administrators/Managers

Safety Management Director

Environmental Services Director

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Maintenance

Once a search has begun, only authorized law enforcement will remain in the building. The removal of any suspicious or dangerous item (s) will be conducted by the appropriate authorities as quickly as possible. Once the building has been secured and determined safe, the "All Clear" should be announced.

RIOTS

Riots or civil disturbances **MUST** be part of your emergency preparedness plan. In this case, you should notify your supervisor who will in turn notify the appropriate people in authority. It is important that the hospital entrance nearest the location of the occurrence is secured. Always remember to remain calm. Those in charge will take steps to handle every situation. Your job is to ensure the safety and comfort of your patients and to report any incident to the proper authorities. Make no attempt to negotiate, make promises or concessions with any one involved in the disturbance.

A facility's Emergency Preparedness Plan is only useful if it is practiced and updated regularly. It is also only effective if the staff of health care providers is made aware of this plan and is regularly given orientation and practice implementing the steps to be taken. The safety of the patient is the responsibility of the health care provider. The Emergency Preparedness Plan will enable you to fulfill that promise to your patient in most emergent situations.

ENVIRONMENTAL AND FIRE SAFETY

Introduction

No matter where you work in the healthcare field, you come across unique and possibly fatal hazards everyday. This handbook will show you how to protect yourself from some of the most common hazards.

Slips, Trips & Falls

You can reduce your risk of injury from slips, trips and falls if you are aware of your surroundings. Sources of slip, trip and fall hazards include:

- Wet floors
- Un-tacked carpets
- Cords
- Poor lighting or too much lighting

If you observe a hazard, correct it or report it to your supervisor. In addition:

- Don't rush down corridors. Take shorter, slower steps. Maintain your center of balance under you.
- Wear sensible shoes with good traction and support.

Back Safety

Some healthcare workers have as much strain on their backs as construction workers. To avoid back injury, stay physically fit and maintain good posture.

When lifting patient or heavy items:

- Bend your hips and knees – not your waist
- Lift with your leg muscles – not your back or arm muscles
- Avoid twisting
- Never lift a load higher than your waist
- Keep the load close to your body
- If you need help lifting or moving a load, ask for it.

Electrical Safety

To manage electricity safely:

- Report all shocks immediately – even tingles
- Never work around electricity when you or your surroundings are wet. Remove metal jewelry, watches and belt buckles.
- Don't use so-called "octopus" adapters. Plugging too many cords into one outlet can overload the circuit.
- Check GFCI outlets regularly. Push the test button. The reset button should pop out. Press the reset button to reactivate.
- Examine all cords and plugs routinely. Replace any that are damaged or that heat up when used.
- Keep cords away from heat and water. Don't run cords under rugs or through doorways.
- Never attach cords to the floor, wall or other objects with tacks or pins.
- Use grounded, three-hole outlets or adapt ungrounded outlets with a standard plug adapter. Never break off or bend the third prong on a grounded plug.
- Don't use damaged outlets or adapters that let you plug extra cords into an outlet.
- Don't use any electrical device that blows a fuse, trips a circuit breaker, shocks or appears damaged.
- Follow safety instructions when using electrical equipment.

Fire Safety

Prepare yourself before fire strikes in your workplace:

- Memorize all exit and emergency routes.
- Identify all fire alarms.
- Learn how to operate fire extinguishers.
- The first 2-3 minutes are most critical. It is a RACE for safety.

Remember, smoke and heat are just as deadly as flames:

- Don't touch or open any door without first testing the amount of heat radiating from it.
- Stay low to the floor to avoid inhaling too much smoke.

Disinfections and Sterilization

Develop a mental eye for spotting potential hazards that cannot be seen, heard, felt or smelled:

- Recognize what needs to be disinfected and sterilized and learn appropriate methods for each.
- Generally, semi-critical equipment can be disinfected. Critical equipment requires the more effective sterilization.

Handling Medical Waste

Blood and other body fluids can carry the human immunodeficiency virus (HIV), the hepatitis B virus (HBV), drug-resistant organisms (DRO's) and radioactive waste. Therefore, it is important that all medical waste related to patient care be treated as potentially hazardous.

Examples of medical waste include:

- Sharps
- Blood
- Body Fluids
- Specimens
- Soiled laundry
- Dirty dressings

Blood Borne Pathogens

Your employer has developed an Exposure Control Plan to help implement the requirements of OSHA's Blood Borne Pathogens Standard. Make sure you are familiar with both documents. Treat all medical waste and blood as contaminated and act accordingly.

- Needle sticks are one of the most common ways diseases are transmitted on the job. Do not bend, recap, shear, or break used needles and other sharps.
- Immediately after using sharps, place in an appropriate, puncture-resistant, leak proof, color-coded container
- Minimize splashing, spraying, and spattering when performing procedures involving blood or other potentially infectious materials.
- Separate and label all medical waste at the source. Use separate containers for each type of waste.
- Red or red-orange labels, bags or containers with the biohazard symbol warn you that contents are biohazardous materials.
- Don't eat, drink, smoke, apply cosmetics or handle contact lenses where there is a reasonable likelihood of occupational exposure.
- Don't keep food or drink in refrigerator, freezer, cabinets or on shelves, countertops or benches where blood or other potentially infectious materials are present.

Good Housekeeping

Your facility's Exposure Control Plan lists specific methods and schedules for cleaning surfaces that may be contaminated. Some general rules:

- Protective coverings on equipment and surfaces must be replaced if contaminated or at the end of the work shift.
- Use a broom and dustpan or tongs to pick up broken glass – not your hands.
- Handle contaminated laundry as little as possible and with minimal agitation.
- Use leak proof bags to transfer contaminated laundry.

Personal Protective Equipment

Personal protective equipment (PPE) is a vital barrier between your body and danger. PPE may include:

- Gloves
- Gown
- Apron
- Goggles
- Face Shield
- Mouthpiece
- Resuscitation bags or other ventilation devices

Disposable single-use gloves are the most common type of PPE. Heavy-duty utility gloves are used for housekeeping duties and direct contact with medical waste.

- Cover cuts and abrasions with bandages before being gloved.
- Replace PPE as soon as practical if contaminated or immediately if torn or punctured and no longer offering barrier protection.

Hazard Communication

In addition to medical waste, there are other hazardous substances on the job such as cleaning solvents, anesthetics and radioactive materials.

Your written HazCom Program provides a range of information and training. Become familiar with it and know where it is located. In particular, it will tell you:

- Which hazards are in your work area
- How to identify and read Material Safety Data Sheets (MSDSs)
- What you should do if a label is missing or torn
- What happens when substances are mixed
- How to dispose of hazardous substances
- What first aid to give in an emergency

Radiation Safety

There are two primary ways you can encounter radiation in a healthcare environment:

- External beam sources, like x-rays or gamma rays.
- Radioactive sources used internally for patient diagnosis or treatment.

Follow these guidelines to avoid harmful effects of exposure:

- Minimize your time exposed to radiation source.
- Maximize distance between yourself and radiation source.
- Use shielding and protective clothing when appropriate.
- Never touch anything with a radioactive warning label unless you are trained and authorized to do so.
- When caring for patients being treated with radioactive materials, dispose of syringes, radioactive liquid and other waste properly.
- You may enter the room of a patient being treated with radiation to perform normal duties, but you should limit the time spent in the room.

Hand washing & Glove Removal

Hand washing keeps you from transferring hazardous materials from your hands to other areas of your body, patients, or the environment.

- When dealing with any potentially hazardous material, always thoroughly wash your hands before and after handling it.
- No barrier is 100 percent effective. After each activity, remove gloves and wash hands before putting on a new pair.
- When removing gloves, pull one glove off from the outside top and hold in gloved hand. With exposed hand, peel second glove down from top tucking first glove inside second. Don't touch outside of glove. Dispose of entire bundle promptly in the proper waste receptacle.
- Wash all surfaces of the hands with soap, friction and running water for a minimum of 15 seconds.
- If infectious material gets on your hands, the sooner you wash it off, the less your chance of becoming infected.
- If hands or any areas come in contact with blood or other potentially infectious material, wash with non-abrasive soap and running water immediately.
- If mucous membranes are exposed to contamination, flush with water for about 15 minutes, then seek medical attention.
- If there is no sink in your work area, appropriate antiseptic hand cleanser or novelettes will be provided. But you must still wash with soap and running water as soon as possible.
- Wash hands between patients so as not to transfer contaminants.

ETHICS IN HEALTHCARE

There are 2 major ethical dilemmas facing the health care professional today:

1. Have I correctly and truthfully documented the care I provided to the patient? For example, was proper care given to the patient, did I actually administer the medication, did I follow the proper treatment plan and protocol, was any medication error reported even if there was no adverse effect, etc.
2. Did I receive any financial remuneration from the patient or client? For example did I receive a small thank you in the way of a \$5 tip or in the case of a physician, did I receive a trip to the islands by the pharmaceutical company for prescribing their medications?

There are many ways these 2 methods of behaving unethically could affect you. You could be viewed in a professional light that is less positive by your peers, patients or clients. You could also be in violation of your company's policies on such things and be terminated.

Your role as a health care professional places you in an elect group of those who are trusted with the health and health care decisions of others. You are an advocate for your patient and are bound by laws and ethics and your won moral beliefs as well. Ethics in the field of nursing or healthcare is something that needs to be taught to students so that they can carry it with throughout their careers.

The invisible line between right and wrong can be easily crossed. Training in ethics for healthcare providers is important at the very beginning of the education program. If it is taught early on and continued throughout the training and education, then it has a better chance of becoming part of the thinking and decision making process of a nursing student or working professional.

HEALTH CARE PROFESSIONAL HARASSMENT POLICY

Definition

Health Care Professional Harassment exists when workplace conduct denigrates or shows hostility or aversion toward an individual because of his/her race, color, religion, gender, national origin, age, disability or sexual orientation.

Specifically, this refers to conduct which:

- Has the purpose or affect of creating an intimidating, hostile or offensive work environment; or
- Unreasonably interferes with a person's work performance; or
- Adversely affects a person's employment opportunity.

Examples include, but are not limited to, offensive stories or jokes, slurs, obscenities. Assault, unwanted touching, displays or derogatory posters, cartoons, drawings, computer images and treating persons of particular race, sex, etc. in a harsh abusive or derogatory manner.

Reporting Procedure

- Any Health Care Professional who experiences any form of sexual harassment should let the harasser know that his/her behavior, comments or gestures are unwelcome and offensive. In other words, tell the person to stop.
- If you prefer not to confront the offending party, or if you confront them and your attempts fail, you should report the complaint to a manager or shift supervisor.
- Management will conduct a thorough investigation of every complaint in as confidential a manner as possible.
- After the investigation, if the determination is made that unacceptable conduct has occurred, Arbor Medical Staffing will take corrective action up to, and including, termination of the harasser; steps will be taken to prevent further harassment and appropriate action will be taken to remedy the victim's loss, if any.

Protection against Retaliation

Arbor Medical Staffing prohibits retaliation against any Health Care Professional who reports harassment, files a complaint, testifies, assists or participates in any manner in an investigation.

Additional Information on Harassment

The Florida Commission on Human Relations (FCHR) is the state agency that resolves complaints of unlawful discrimination, including sexual harassment. More information can be found at their website: <http://fchr.state.fl.us/>

The Equal Employment Opportunity Commission (EEOC) is the federal fair employment agency that resolves sexual harassment claims. To contact the commission, consult directory assistance for Washington, D.C.

HAZARDOUS COMMUNICATIONS AND CHEMICALS

What You Don't Know

As a healthcare worker, you know the power of chemicals. They make your job easier, more effective – and they help save lives.

Yet it takes just a moment of carelessness, ignorance or poor judgment to turn one of these powerful tools into a destructive weapon.

Because when it comes to chemicals, what you don't know can hurt you – and fast.

That's why the Hazard Communication Standard developed by the Occupational Safety and Health Administration (OSHA) is so important. It guarantees your "Right-to-Know" about potential chemical hazards in your workplace.

Your employer has developed a Hazard Communication Program based on OSHA's Hazard Communication Standard. It will help you learn about the hazardous chemicals you may be exposed to on the job and steps you and your employer can take for your safety and protection.

Knowing the Risks

A chemical can be a physical hazard, a health hazard or both.

- A physical hazard can cause a dangerous situation like a fire or an explosion.
- A health hazard can damage your health when a chemical is inhaled, eaten, or splashed on your skin or in your eyes.
- Acute health hazards hurt you rapidly, after short-term exposure. Examples: poisoning and chemical burns.
- Chronic health hazards harm you more slowly, after long-term exposure. Examples: cancer and heart damage.

No One is Immune

You probably know that chemicals are used somewhere in your facility, such as the laboratory. But here are some facts you may not know:

- Hazardous chemicals are used throughout healthcare facilities, even in nursing units. For example, powerful anti-cancer drugs can actually cause cancer and other serious health problems in nurses and pharmacists who mix them and in housekeeping staff that clean up spills and remove waste.
- Chemicals aren't just liquids in containers. Your Hazard Communication Program covers chemicals in all forms – solids, liquids, gases, vapors, fumes and mists. If it is a hazard and you can be exposed to it, it will be covered in the Hazard Communication Program. Here are some examples:
 - Anesthetic gases can cause headaches, nausea, decreased mental alertness, impaired motor coordination, birth defects, miscarriages and cancer.
 - Ethylene oxide, a gas used to sterilize hospital equipment, can damage skin, respiratory and nervous systems, and cause sterility, birth defects and cancer.
 - Oxygen, used in operating and recovery rooms, may be piped throughout some hospitals, making other materials highly flammable.

Products like disinfectants and grease cutters seem harmless, but they're solvents that can damage skin and eyes.

- Some chemicals used in healthcare facilities can cause reproductive damage, including birth defects, infertility, impotence and miscarriage.
 - Reproductive hazards can affect both men and women.
 - Reproductive hazards may possibly be caused by ethylene oxide, fluorinated hydrocarbons, anti-cancer drugs, mercury, nitrous oxide, formaldehyde and various ingredients in cleaning solutions.
 - If you are pregnant or plan to be, understand that your unborn baby may be particularly vulnerable.

Your HAZCOM Program

You can find out how to work safely with the hazardous chemicals in your workplace by reading your employer's written Hazard Communication Program. It includes:

- A list of all hazardous chemicals present in your facility, including those in unlabeled pipes

- Information about how your employer will provide warning labels, Material Safety Data Sheets (MSDS) and information and training for employees who work with hazardous chemicals on a routine or non-routine basis.
- The names and numbers of those who are responsible for seeing that the program is carried out in your facility.

Labels Protect You

A warning label is designed to alert you that a chemical is dangerous. It will show:

- The product's chemical name
- Any hazardous ingredients
- Hazard warnings
- The chemical manufacturer's name and address

By law, every chemical shipped into your facility must have a warning label attached to it by its producer. After that, your employer is responsible for seeing that containers stay labeled. This includes:

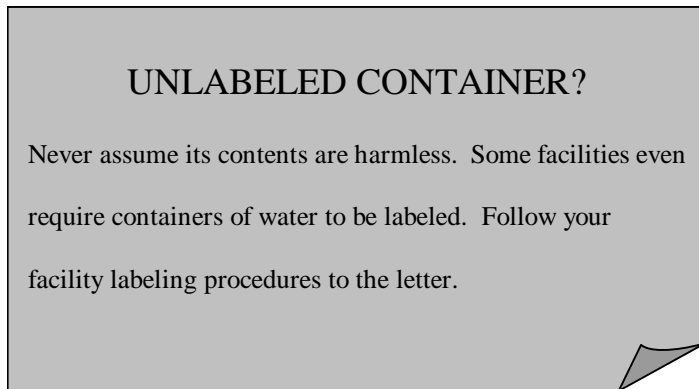
- Replacing any damaged, incomplete or missing labels
- Seeing that the new container is labeled when a chemical is transferred to another container.

Label Requirements

Labels are not required:

- If a number of stationary containers in an area hold chemicals with similar hazards. Your employer can post warning signs instead of labeling each container.
- On pipes that contain chemicals – even if they contain hazardous chemicals or gases
- When you transfer a chemical from a labeled container to a portable one. The portable container does not have to be labeled if you plan to use that chemical immediately yourself.

Never leave an unmarked container of a hazardous chemical unattended.



MSDS: Your Next Step

For detailed information about the hazards of a chemical and how to control them, check out the chemical's Material Safety Data Sheet (MSDS). Even though a chemical's identity can be withheld if it is a trade secret, the manufacturer must provide full information on the chemical's hazards and how to control them.

- Chemical suppliers must provide an MSDS on every hazardous chemical they ship into your workplace.
- Your employer ensures that the MSDS for every chemical you work with is available to you in your work area during working hours.
- To see the MSDS for a chemical you work with, just ask your supervisor.

MSDS all contain similar vital information on a number of key points, including:

- The name of the chemical on the product container, its chemical name and any common names, such as "formalin" for formaldehyde

- The manufacturer name, address, phone number, plus an emergency phone number you can use to get immediate information on specific chemical hazards
- Any hazardous ingredients of a chemical
- Safe exposure limits, such as Permissible Exposure Limits (PEL) and Threshold Limit Values (TLV)
- Physical information to help you identify the chemical and its characteristics, such as appearance, odor, boiling point, vapor pressure, vapor density, solubility in water, melting point and evaporation rate.
- Fire and explosion information:
 - The chemical flash point, or temperature at which it ignites
 - What to put on the fire to extinguish it safely
 - Special firefighting techniques and equipment
 - Any unusual fire or explosion hazards
- Health hazards caused by the chemical itself
- Symptoms of overexposure, both acute and chronic
- Medical conditions that may be aggravated by exposure
- How the chemical can cause cancer
- First-aid emergency procedures—sometimes listed separately at the beginning of the form for quick reference
- Dangers from chemical reactions with the material:
 - Conditions or other materials that can cause reactions with chemicals you are using
 - Any dangerous substances that can be produced in reaction with other chemicals or in atmospheric change

How to deal with spills and leaks:

- Clean up techniques
- Personal protective equipment to be used during clean up
- How to dispose of waste material properly

Always notify your supervisor of a chemical spill immediately. And make sure you are trained and wearing appropriate protective gear before you attempt clean up.

- Special protection information on the MSDS includes any personal protective equipment you'll need to work safely with the chemical.
- Additional special precautions to follow when handling the chemical may include:
 - What you need to clean up a spill or extinguish a fire
 - Other health and safety information
- Get to know the MSDS for the chemicals you work with now—before the problem occurs
- Two MSDS for the same chemical? Use the MSDS with the most complete information
- Check the date of the last revision to find out how correct the MSDS information is.

Training: Off To A Safe Start

Another important source of information on hazardous chemicals is your employer's training program. You will be trained before working with chemicals and whenever the hazards change. You will learn:

- How to understand your facility's written Hazard Communication Program
- How to read and use warning labels and MSDS

It will also cover:

- How to detect the release of hazardous chemicals
- The specific hazards you face from chemicals you may be exposed to on the job
- How to protect yourself on the job through the use of personal protective equipment and safe work practices

It's Up To You

Your "Right-to-Know" does no good unless you exercise it. Be sure to read all warning labels and check out the MSDS for the chemicals you work with. Then put that knowledge to work for you on the job by wearing appropriate personal protective equipment and following safety procedures carefully.

HIPAA PARTICIPANT TRAINING GUIDE

On completion of the HIPAA Training Guide, you will:

- Have knowledge of the origins and intent of HIPAA
- Have understanding of the Security Rule and the Privacy Rule
- Have knowledge of the definitions and regulations pertaining to Protected Health Information (PHI)
- Have knowledge of enforcement and criminal penalties associated with HIPAA

What is HIPAA?

Congress passed a law, the Health Insurance Portability and Accountability Act of 1996 (HIPAA) to improve efficiency and effectiveness of the health care system. The law included:

- A series of “administrative simplification” provisions that required the Department of Health and Human Services (HHS) to adopt national standards for electronic health care transactions; and
- The adoption of security and privacy standards in order to secure protected health information (PHI).

Origins and Intent of HIPAA

The intent of HIPAA is to reduce administrative costs of providing health care, to make it easier to transmit and use medical information and to create national standards. A result of this plan ensures privacy and security of personal health information.

The act is comprised of two major legislative actions:

1. Health insurance reform that included a wide array of provisions designed to make health insurance more affordable and accessible.
2. Administrative simplification of creation, retention, and transmission of electronic health information.

Who is covered by HIPAA?

1. *Organizations*: Those that provide or pay for health services, or exchange health care data of any kind are subject to HIPAA. All health care providers (physicians, nurses, etc); all health plans (HMOs, insurers); and all health information clearing houses are “covered entities”.

2. *Patients*: HIPAA extends protection to every patient whose information is collected, used or disclosed by such covered entities. It imposes responsibilities on the entire workforce of a covered entity to secure those rights. A covered entity's work force includes all employees, volunteers and business associates. Arbor Medical Staffing, as a provider of health care staffing, is a business associate of “covered entities” (hospitals, clinics, doctor offices, etc)

What is HIPAA about?

- Protection of health information (security)
- Proper use of health information (privacy)
- Promotion of electronic data interchange

Security Standards

Security Standards are defined as controls to protect confidential information from unauthorized access, modification or destruction. The goals of these standards are to ensure confidentiality, integrity and availability. These goals are based on good business practices. These standards include the.

Privacy Rule.

The effective date of this rule is April 14, 2003.

The Privacy Rule covers the following Protected Health Information (PHI):

- which can be transmitted or maintained in any form or medium
- which can be created or received by a covered entity
- created or received by a covered entity
- related to a past, present, or future physical or mental condition
- related to the provision of health care
- related to the past, present, or future payment for the provision of health care

HIPAA affects information, not just electronic records. It protects individually identifiable information and all medical records in ANY form, electronic, paper or verbal whether or not it has ever been transmitted or maintained electronically.

What is not covered?

Only adequately anonymous (unidentifiable) information is not covered by HIPAA. This is information that would be impossible to identify the person to whom the data refers.

Provisions of the Privacy Rule

- Privacy Notice: A notice of privacy practices must be made available to all patients.
- Patients have new privacy rights: Including requesting restrictions on how an organization can use their information and requesting that changes or corrections be made to their PHI.
- Authorizations: The use and disclosures of PHI is generally allowed without the patient's authorization when it is for the purpose of treatment, payment for health services or health care operations purposes.
- Minimum necessary information: Covered entities must limit their use and disclosure of PHI to the "minimum necessary" to accomplish the intended purpose.
- Business Associates: Covered entities must have contracts with business associates that protect PHI.

What does HIPAA mean to me?

- You must protect PHI in all forms (oral, written, faxed or electronic) in which you work.
- You must be familiar with and comply with all privacy policies and procedures where you work
- You can be subject to civil and criminal penalties for violating HIPAA privacy violations.

Enforcement & Criminal Penalties

There are significant penalties for violating the privacy regulations of HIPAA. Both organizations and individuals, who commit violations, may be subject to fines.

- Civil penalties are \$100/incident, capped at \$25,000 for each calendar year, per person, per standard for each requirement or prohibition that is violated. Enforcement is by the HHS/Office of Civil Rights.
- Criminal penalties for the knowing violation of the Rule can be up to \$250,000 and 10 years in prison. The criminal penalties are enforced by the Department of Justice.

After reading, complete the HIPAA certificate and fax it back to your local Arbor Office

INFECTION CONTROL AND BLOOD BORNE PATHOGENS

Everyone who works in healthcare needs to be concerned about infection control-whether you have direct contact with patients and their body fluids and specimens, or brief, casual contact with patients and the things they use. Every day, you and your patients can be exposed to infectious materials. The goal is to follow precautions and develop work habits that protect both patients and healthcare workers from infection.

This information will explain:

- How infections are spread
- Standard Precautions
- Transmission – Base Precautions
- Immunizations, placement evaluations, and work restrictions
- What to do if you are exposed
- The most common mistakes made by healthcare workers and how you can avoid them.

How Infections are Spread

All infections occur when an infection agent is transmitted to a susceptible person, called a host.

Infection agents can be:

- Viruses
- Bacteria
- Fungi

They can be found in or on the following:

- Blood
- Body Fluids
- Feces
- Body Surfaces
- Contaminated Items
- Contaminated surfaces

Some important point about spreading infection

- You do not have to look sick to spread an infection
- You may be exposed without becoming a host if you are immune or able to resist infection
- You become sick only when a large enough dose enters your body and overcomes its defense system.

The Chain of Transmissions

The method by which infection moves is called the route of transmission. If you prevent an infectious agent from reaching a susceptible host, you break the chain of transmission and prevent the infection from spreading.

In healthcare settings, infections usually spread by droplet, airborne or contact transmission. Those most susceptible are:

- Elderly
- Newborns
- The chronically ill
- Those with compromised immune systems
- People with surgical incisions, catheters and other pathways that allow easy entry into the body.

Healthcare personnel can prevent transmissions by following Standard Precautions with all patients regardless of their specific diagnosis or infection status.

Standard Precautions:

- Apply to blood, all bodily fluids, excretions and secretions except sweat, plus non-intact skin and mucous membranes.
- Protect against blood borne pathogens such as HIV, Hepatitis B,C
- Protect against pathogens from moist body substances

Healthcare workers must follow Standard Precautions with all patients and in all healthcare settings. Standard Precautions require that you:

- Wear gloves when touching blood, body fluids, secretions, excretions and contaminated surfaces
- Wash your hands after contact with body substances even if you wear gloves
- Wash your hands and change gloves between patients and between touching clean and dirty sites on the same patient.
- Wear a mask, eye protection and a gown if splashes or spatters are possible
- Know where to find respiratory – assistive devices such as ventilators
- Be sure reusable equipment is cleaned and disinfected before your use it on another patient
- Handle all patient care equipment to prevent exposure to other patients, visitors and healthcare workers.
- Keep used patient care equipment – including soiled linens – away from your skin, mucous membranes and clothing
- Don't let used equipment or linens contaminate surfaces or clean items
- Never bend, recap or break used needles unless the procedure requires it
- Place used sharps in a designated disposal container immediately after use
 - Note: Eighty percent of exposures are related to sharps. Handle sharps with care. Use needles safety devices whenever appropriate.

Transmission-Based Precautions

When a patient has an infection that spreads very easily, you must add a second level of infection control, called Transmissions-Based Precautions. Transmission-Based Precautions are based on how the infection is spread and are followed along with Standard Precautions.

Transmission-Based Precautions used in healthcare include:

- Droplet Precautions
- Airborne Precautions
- Contact Precautions

Droplet Precautions

Used with patients whose illnesses are transmitted when large droplets are propelled a short distance through sneezing, coughing or suctioning and land in another person's eyes, nose or mouth. Examples are mumps, rubella, and some strep infections. You must:

- Isolate or separate the patient from others by at least three feet; or segregate with patients who have the same infection
- Wear a mask when working within three feet of the patient
- Limit the patient's movement
- Mask the patient during transport

Airborne Precautions

Used with patients with tuberculosis, measles, chickenpox, zoster, and other infections that are transmitted by airborne droplet nuclei which travel and stay in the air for long periods of time. You must:

- Isolate the patient in a closed room with negative air pressure; the room must be either private or shared by patients who have the same infection
- Wear a special respirator while in the room
- Limit movement of the patient
- Mask the patient during transport

Contact Precautions

Used with infections that are easily transmitted by direct patient contact or by contact with a contaminated object or surface. Examples include two highly infectious drug-resistant organisms, MRSA (methicillin-resistant staphylococcus aureus) and VRE (vancomycin-resistant enterococcus), and infections such as zoster, scabies, and impetigo. You Must:

- Put on gloves before entering a room
- Wash your hands with a special antimicrobial cleaner before leaving the room
- Wear a gown in some patient-care situations
- Avoid unprotected contact with items touched by or used on the patient
- Dedicate equipment to that patient whenever possible

Other Actions You Can Take

- Get Immunized against infections
- Complete Health Inventory Forms
- Follow Work Restrictions
- Beware of Latex Sensitivity

If you are EXPOSED

If you contact infectious materials such as body substances or contaminated items:

- Don't panic
- Wash the affected area immediately
- Flush with large amounts of running water
- Do not use Bleach or abrasive soaps
- REPORT THE EXPOSURE to your supervisor and to Arbor Medical Staffing immediately
- ACT immediately

Hand washing

Washing your hands frequently and properly is the single most important action you can take to prevent the spread of infection. According to APIC, healthcare workers wash their hands only half as often as they should.

Summary

You can break the chain of infection transmission and protect your patients, your co-workers, and yourself by following the above simple rules.

Reading material for Infection Control Guidelines from the department of Health and Human Services can be found on the Centers for Disease Control and Prevention @: <http://www.cdc.gov/ncidod/dhqp/guidelines.html>

Reading material for Bloodborne Pathogens and Needlestick Prevention are listed on the OSHA guidelines: <http://www.osha.gov/SLTC/bloodbornepathogens> - 1910.1030

NATIONAL PATIENT SAFETY GOALS FOR HOSPITALS 2011

National Patient Safety Goals for Hospitals is meant to inform healthcare providers how to reliably identify patients for whom services and treatments are intended. Patients can be identified in several ways, for example, patient name, telephone number or assigned identification number.

TWO PATIENT IDENTIFIERS

Care givers must use at least 2 patient identifiers for the following:

- Administering medications
- Administering blood or blood components
- Collecting blood samples and other specimens
- Providing treatments or procedures
- Label specimen containers in the presence of the patient

The patient's room number is NEVER used as a patient identifier.

For blood or blood component transfusion always use the 2-person verification process. When using the 2-person method, one is the qualified transfusionist and the other is there as designated by the facility to confirm the patient ID.

When working in a facility, you must be aware of the facility's written procedures to address the following:

- What is the definition of critical results of tests and diagnostic procedures
- Who conducts and who reports the critical results of tests and diagnostic procedures
- Who will implement the procedures for managing critical results of tests and diagnostics
- Who will schedule the efficient reporting of critical results of tests and diagnostics

LABEL ALL MEDICATIONS AND CONTAINERS

When solutions or medications are removed from their original containers and put into unlabeled ones, medications and other substances can become lethal. In order to prevent medication errors follow these guidelines:

- Label medications and solutions that are not immediately administered.
- Label any medication or solutions that is transferred from the original package and put into another
- Labels should include name of the medication, strength and quantity to be taken, dilutant and volume, date of preparation and the expiration date or time of day

Labels must be verified verbally and visually. The 2 person verification process is used here also.

ANTI-COAGULATION THERAPY

Anti-coagulation Therapy has its own set of rules and procedures to ensure the safety of the patient. It requires education of the patient as well as the family of the patient. Cooperation is also required of the patient because these medications must be monitored regularly and in a timely manner. Your patient must understand the risks involved with these types of medications. These education points are very important when working with anti-coagulants:

- Follow up monitoring
- Patient / Family compliance
- Potential for reactions and interactions of other drugs and possibly, food.

HAND HYGIENE

Hand hygiene is key to the safety and wellness of patients in your care. The Centers for Disease Control & Prevention (DCD) and the World Health organization (WHO) have discovered that simply washing your hands will greatly reduce the contraction of infection caused by health care givers.

Hand hygiene policies should be in place in your facility and this policy should be encouraged and stressed. Revisiting the subject frequently will help to foster the practices of hand washing and hygiene to prevent the transfer of disease and bacteria from one patient

to another. This applies to but is not limited to methicillin-resistant staphylococcus aureus (MRSA), Clostridium difficile (DCI), vancomycin-resistant enterococci (VRE) and other multidrug-resistant organisms (MRDOs)

Hospitals have different risks and different kinds of patient populations. Because of this, the prevention and control of contact infection from health care giver and patient or patient to patient infection must be specific to the facility.

In order to prevent and control the risk of infection in the patient population, the facility should:

- Perform risk assessments regularly for multi-drug resistant organism (acquiring and transmitting)
- Once the assessment for risk is complete, the staff must be educated concerning the infections relating to health care, MRDOs, and policies for initial orientation of the staff.
- Patients and families (if necessary) who are infected must be educated about the health care-associated policies on infection.
- The facility must monitor and measure the outcomes and processes of the prevention of the MRDOs to include the following:
 - MRDO infection rates
 - compliance with guidelines/procedures
 - evaluation of the education process provided to staff and health care providers
- Implement an alert system that identifies new patients with MRDOs. It is up to the facility to determine the various means of alert.

CENTRAL LINE CATHETERS

Central Line (CVC and PICC) Catheters can be a source of bloodstream infection. Once again education is key in managing central lines and bloodstream infections.

- Educate patients and their families before inserting the catheter concerning bloodstream associated infections
- Observe all policies and procedures concerning the reduction of central line-associated infections
- Perform regular risk assessments for central line infection, monitor the compliance and then evaluate the effectiveness of prevention methods.
- Use a checklist for the catheter insertion that is standardized for all health care providers to include hand hygiene protocols.
- Use a supply cart that carries all necessary components for the insertion of central venous catheters
- Use the standardized protocol for sterile barrier precautions
- Use an antiseptic for skin preparation during the insertion that is endorsed by professional organizations
- Use a standardized method to disinfect catheter hubs and ports before accessing.
- Evaluate all catheters on a regular basis and remove any that are nonessential.

SURGICAL SITE INFECTION

Surgical Site Infection prevention requires education and procedures as seen above. Health care providers, patients and their families need to be aware of the risks and ways to prevent infection at the surgical site. Part of the effort to reduce infection in these cases is the following:

- Regularly perform risk assessment on surgical site infections
- Use a standard protocol which uses the best methods of practice
- Monitor the compliance with the protocol used
- Evaluate the effectiveness of the prevention efforts
- Administer antimicrobial agents for prophylaxis for specific diseases or procedures according to scientific findings or endorsements

ADVERSE DRUG REACTIONS

VI. Adverse drug reactions can occur when communication about medications is not clear. When a patient's care is changed, the number of errors can increase. Making sure the medication list is accurate and fixing any discrepancies can significantly reduce the risk of adverse reactions.

- Upon admission, a complete list of the current medications and dosages taken at home plus any known allergies should accompany the patient.
- The medications ordered for the patient while in the hospital must be compared to those on the list from home. Any differences must be reconciled and documented while the patient is in the hospital (the changes must accompany the

patient through any transfers within the facility) or rehab facility if applicable. If the patient continues any of the newly prescribed medications, they will be added to the list and sent home when the patient is discharged.

The next care provider or facility must have the accurate list of reconciled medications (and allergies) in order to prevent the adverse drug reaction event. The communication of this list allows the next health care provider to safely prescribe new medications that may be needed and to also safely follow already prescribed protocols for the patient.

Upon discharge, the hospital or facility must provide a complete and reconciled list of the patient's medications to the patient, and the patient's family if necessary. This transfer of information will reduce the transition-related adverse drug events.

In settings such as the emergency room, urgent care clinic, outpatient radiology, ambulatory care and behavioral health care, where medications are not usually used (or used minimally), the list of medications is still important. It is not however necessary to provide the dose, frequency, etc.

PATIENTS AT RISK FOR SUICIDE

Identifying patients who are high risk for suicide is the first step in protecting them following their discharge. Assessment should be made which would identify special patient characteristics and physical surroundings which may increase or decrease the risk for suicide. Information should be provided to the family or caregivers concerning suicide prevention and crisis hotlines.

SITE MARKING

Universal Protocols for Preventing WRONG SITE, WRONG PROCEDURE, WRONG PERSON surgeries apply to all invasive procedures. Deep sedation or general anesthesia place the patient at most risk although there are other factors.

A pre-procedure process should be implemented to verify the RIGHT SITE, RIGHT PROCEDURE, RIGHT PERSON. Items for the procedure must be identified, available and matched to the correct patient for the procedure.

Site marking is done to prevent errors when there is more than one possible location for a surgery or procedure such as fingers, toes, limbs and organs. In the case of tonsils, hysterectomy, etc, site marking is not necessary.

The person who marks the site for surgery is possibly the surgeon or one performing the procedure or another individual who is designated by the team. Depending on the flow and efficiency of the operation this is a matter for the team to decide. According to the Joint Commission, the "site mark is a communication tool about the patient for members of the team. Therefore the individual who knows the most about the patient should mark the site." Most frequently that will be the person performing the procedure. Even when the marking of the site is delegated, the licensed independent practitioner is fully accountable for all aspects of the procedure.

Procedures to follow should include the following:

- List the procedures that require marking of the site for incision/insertion (in cases where there are more than one possible site)
- Involve the patient in the marking of the site if possible, before the procedure is performed.
- The licensed independent practitioner (and who is ultimately accountable) should mark the site or another may be delegated who has the proper credentialing.
- The method of marking must be able to be read/interpreted without question and is a mark used throughout the facility. It must be visible after skin is prepared and draped.
- If a patient refuses site marking or it is impossible to mark the site, a written alternative process must be in place.

TIME OUT

A time out should be performed before the anesthesia in order to include the patient in the assessment before surgery. All activities should be suspended so that team members can be active in the confirmation process. When all questions and concerns are resolved, then the procedure can commence.

If more than one procedure is being performed on the same patient, a time out for each procedure should be the rule.

Team members need to agree on the following during the time out:

- Patient identity
- Site for the procedure
- Surgery/procedure to be performed.

2011 Revised National Patient Safety Goals

Medication Reconciliation Effective 7/1/11

The 2011 Core Mandatory II (Nursing & Allied) and 2011 NPSG(Nursing & Allied) Modules will be updated effective June 1, 2011 to reflect this new revision.

NPSG.03.06.01

Maintain and communicate accurate patient medication information.

Elements of Performance for NPSG.03.06.01

1.) Obtain information on the medications the patient is currently taking when he or she is admitted to the hospital or is seen in an outpatient setting. This information is documented in a list or other format that is useful to those who manage medications.

Note 1: Current medications include those taken at scheduled times and those taken on an as-needed basis.

Note 2: It is often difficult to obtain complete information on current medications from a patient. A good faith effort to obtain this information from the patient and/or other sources will be considered as meeting the intent of the EP.

2.) Define the types of medication information to be collected in non–24-hour settings and different patient circumstances.

Note 1: Examples of non–24-hour settings include the emergency department, primary care, outpatient radiology, ambulatory surgery, and diagnostic settings.

Note 2: Examples of medication information that may be collected include name, dose, route, frequency, and purpose.

3.) Compare the medication information the patient brought to the hospital with the medications ordered for the patient by the hospital in order to identify and resolve discrepancies.

Note: Discrepancies include omissions, duplications, contraindications, unclear information, and changes. A qualified individual, identified by the hospital, does the comparison.

4.) Provide the patient (or family as needed) with written information on the medications the patient should be taking when he or she is discharged from the hospital or at the end of an outpatient encounter (for example, name, dose, route, frequency, purpose).

Note: When the only additional medications prescribed are for a short duration, the medication information the hospital provides may include only those medications.

5.) Explain the importance of managing medication information to the patient when he or she is discharged from the hospital or at the end of an outpatient encounter.

Note: Examples include instructing the patient to give a list to his or her primary care physician; to update the information when medications are discontinued, doses are changed, or new medications (including over-the-counter products) are added; and to carry medication information at all times in the event of emergency situations.

Reference: National Patient Safety Goal on Medication Reconciliation. (2011). Retrieved from http://www.jointcommission.org/npsg_reconciling_medication/

PATIENT BILL OF RIGHTS AND RESPONSIBILITIES

The Patient's Bill of Rights was adopted in 1973 by the American Hospital Association and is monitored by the Joint commission on Accreditation of Healthcare Organizations (JCAHO) to ensure the patient's right to receive healthcare is honored by healthcare facilities and healthcare workers. All patients have the right to healthcare that protects their dignity, psychosocial, spiritual and cultural beliefs.

The Patient's Bill of Rights for each and every patient:

1. The Right to Respectful Treatment that maintains a patient's dignity.
2. The Right to Privacy and Confidentiality
3. The Right to be in Communication with persons outside any facility in which they are seeking healthcare.
4. The Right to Make Informed Decisions
5. The Right to Participate in All Aspects of Healthcare
6. The Right to Advance Directive
7. The Right to Impartial Access to Care
8. Knowledge of Rights and Responsibilities in Receiving Care

PATIENTS RESPONSIBILITIES

Just as patients have rights while in the hospital, they also have responsibilities to ensure that the proper care can be provided. The following are the Patient's responsibilities:

1. The responsibilities to provide accurate information about their present illness and past medical history
2. Seeking clarification when necessary to fully understand their health problems and the proposed plan of action
3. Following through on the agreed plan of care
4. Following the rules and regulations of the healthcare facility and considering the rights of others.
5. Providing information for insurance claims and working with the healthcare facility to make proper arrangements when necessary.

In the event that a patient is unable to speak for him / herself, then a designated person such as a power of attorney, immediate family member etc., will be responsible for furnishing the information needed for the healthcare team to care for the patient.

PHYSICAL RESTRAINTS ACKNOWLEDGEMENT

Physical Restraint devices – such as safety vests and 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. But with increasing reports of injuries and deaths resulting from misuse of the devices, the FDA is taking steps to ensure 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, and 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, 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 increased awareness of the danger of misuse of patient restraints could prevent many death and injuries.

Uses for Restraints

Used properly, restraints have many benefits for patients and care givers in both institution 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 staff from possible harm. Some patients feel safer and more secure, and need not 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 a 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 can occur, including decubitus ulcers, nerve damage, and incontinence. Sensory deprivation can cause psychological problems. Over time, mental and physical decline can 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 chances 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 patients 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 restraint's recommended for the patient's condition
- Use the correct size for the patient's weight and height
- Not 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 home include:

- Define a clear, written institutional policy on the use of restraints and make it Available to patients or residents and their families
- Display this policy and other instructions in a highly visible location and in foreign language(s) as necessary
- Provide regular staff 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 was used. Also document every two hours in the nursing progress note that the restraints were loosened and the area restrained was inspected, skin care performed and patient position changed.
- 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 deaths appear to be due to problems that could be prevented with user education, training with the 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 staff training in institutions and proper use of restraints at home, the FDA is working with the industry to improve the labeling on restraint devices. New labeling will be required later this year. The goal is having clearer instructions, in different languages, with helpful graphics and other visual aids. Moreover, visible warning labels will need to be affixed to the restraint devices where users can readily see them.

Reporting Problems

Effective November 28, 1991, the Safe Medical Devices Act of 1990 requires all hospital, nursing homes, and acute-care facilities to report deaths related to the use of any medical device to the FDA and the manufacturer within ten (10) working days. They must also report serious injuries or illnesses to the manufacturer within ten (10) working days or the FDA if the manufacturer is not known.

Please report any misuse of patient restraints to your supervisor on staff immediately.

TUBERCULOSIS

WHAT IS TB?

Tuberculosis (often called TB) is an infectious disease that usually attacks the lungs, but can attack almost any part of the body. Tuberculosis is spread from person to person through the air.

When people with TB in their lungs or throat cough, laugh, sneeze, sing, or even talk, the germs that cause TB may be spread into the air. If another person breathes in these germs there is a chance that they will become infected with tuberculosis. Repeated contact is usually required for infection.

It is important to understand that there is a difference between being infected with TB and having TB disease. Someone who is infected with TB has the TB germs, or bacteria, in their body. The body's defenses are protecting them from the germs and they are not sick. This is referred to as latent TBI.

Someone with TB disease is sick and can spread the disease to other people. A person with TB disease needs to see a doctor as soon as possible. This is referred to as active TBII.

It is not easy to become infected with tuberculosis. Usually a person has to be close to someone with TB disease for a long period of time. TB is usually spread between family members, close friends, and people who work or live together. TB is spread most easily in closed spaces over a long period of time. However, transmission in an airplane, although rare, has been documented.

Even if someone becomes infected with tuberculosis, that does not mean they will get TB disease. Most people who become infected do not develop TB disease because their body's defenses protect them. Most active cases of TB disease result from activating old infection in people with impaired immune systems.

Experts believe that about 10 million Americans are infected with TB germs. Only about 10 percent of these people will develop TB disease in their lifetime. The other 90 percent will never get sick from the TB germs or be able to spread them to other people.¹

TB is an increasing and major world wide problem, especially in Africa where the spread has been facilitated by AIDS. It is estimated that nearly 1 billion people will become newly infected, over 150 million will become sick, and 36 million will die worldwide between now and 2020 -- if control is not further strengthened. Each year there are more than 9 million cases and close to 2 million deaths attributed to TB; 100,000 of those 2 million deaths occur among children.²

WHO GETS IT?

Anyone can get TB. However, some groups are at higher risk to get active TB disease. The groups that are at high risk include:

- People with HIV infection (the AIDS virus)
- People in close contact with those known to be infectious with TB
- People with medical conditions that make the body less able to protect itself from disease (for example: diabetes, the dust disease silicosis, or people undergoing treatment with drugs that can suppress the immune system, such as long-term use of corticosteroids)
- Foreign-born people from countries with high TB rates
- Some racial or ethnic minorities
- People who work in or are residents of long-term care facilities (nursing homes, prisons, some hospitals)
- Health care workers and others such as prison guards
- People who are malnourished
- Alcoholics, IV drug users and people who are homeless

WHAT ARE THE SYMPTOMS OF TB?

A person with TB infection will have no symptoms. A person with TB disease may have any, all or none of the following symptoms:

A cough that will not go away
Feeling tired all the time

Weight loss
Loss of appetite
Fever
Coughing up blood
Night sweats

These symptoms can also occur with other diseases so it is important to see a doctor and to let the doctor determine if you have TB.

It is also important to remember that a person with TB disease may feel perfectly healthy or may only have a cough from time to time. If you think you have been exposed to TB, get a [TB skin test](#).

HOW DOES TB DISEASE DEVELOP?

There are two possible ways a person can become sick with TB disease:

The first applies to a person who may have been infected with TB for years and has been perfectly healthy. The time may come when this person suffers a change in health. The cause of this change in health may be another disease like AIDS or diabetes. Or it may be drug or alcohol abuse or a lack of health care because of homelessness.

Whatever the cause, when the body's ability to protect itself is compromised, TB infection can become active TB disease. In this way, a person may become sick with TB disease months or even years after they first breathed in the TB germs.

The other way TB disease develops happens much more quickly. Sometimes when a person first breathes in the TB germs the body is unable to protect itself against the disease. The germs then develop into active TB disease within weeks.

WHAT IS THE TB SKIN TEST?

The TB skin test is a way to find out if a person has TB infection. Although there is more than one TB skin test, the preferred method of testing is to use the Mantoux test.³

For this test, a small amount of testing material is placed just below the top layers of skin, usually on the arm. Two to three days later a health care worker checks the arm to see if a bump has developed and measures the size of the bump. The significance of the size of the bump is determined in conjunction with risk factors for TB.

Once the doctor knows that a person has TB infection he or she will want to determine if the person has TB disease. This is done by using several other tests including a chest X-ray and a test of a person's mucus (the material that is sometimes coughed up from the lungs).

Q: Should you get a skin test each year to check on TB?

A: Only if you are at high risk for getting or transmitting TB or your jobs request it.

The advice for most people is to get a tuberculin test if you have symptoms or if you are living in close contact or have otherwise been in close contact with someone who recently came down with active TB disease. (Some people get skin tests because of their jobs, in a school or hospital, for example, to make sure they have not contracted TB and will not infect others if they have TB).

If you fall into one or more of the high-risk categories for TB noted earlier, for example, if you are HIV-positive, never had a skin test before, or there is no record of the last result, you should be tested.

If you're not sure, ask your doctor. TB can be prevented, even if you are at risk.

WHAT IS THE TREATMENT FOR TB? Treatment for TB depends on whether a person has active TB disease or only TB infection. A person who has become infected with TB, but does not have active TB disease, may be given preventive therapy. Preventive therapy aims to kill germs that are not doing any damage right now, but could so do.

If a doctor decides a person should receive preventive therapy, the usual prescription is a daily dose of isoniazid (also called "INH"); an inexpensive TB medicine. The person takes INH for nine months (up to a year for some patients), with periodic checkups to make sure the medicine is being taken as prescribed.

What if the person has active TB disease? Then treatment is needed.

Years ago a patient with TB disease was placed in a special hospital for months, maybe even years, and would often have surgery. Today, TB can be treated with very effective drugs.

Often the patient will only have to stay a short time in the hospital and can then continue taking medication at home. Sometimes the patient will not have to stay in the hospital at all. After a few weeks a person can probably even return to normal activities and not have to worry about infecting others.

The patient usually gets a combination of several drugs (most frequently INH plus two to three others including rifampin, pyrazinamide and ethambutol). The patient will probably begin to feel better only a few weeks after starting to take the drugs.

It is very important, however, that the patient continue to take the medicine correctly for the full length of treatment. If the medicine is taken incorrectly or stopped the patient may become sick again and will be able to infect others with TB. As a result, public health authorities recommend Directly Observed Therapy (DOT), in which a health care worker insures that the patient takes his/her medicine.

If the medicine is taken incorrectly and the patient becomes sick with TB a second time, the TB may be harder to treat because it has become drug resistant. This means that the TB germs in the body are unaffected by some drugs used to treat TB.

Multi-drug resistant TB is very dangerous, so patients should be sure that they take all of their medicine correctly.

Regular checkups are needed to see how treatment is progressing. Sometimes the drugs used to treat TB can cause side effects. It is important both for people undergoing preventive therapy and people being treated for TB disease to immediately let a doctor know if they begin having any unusual symptoms.

WHAT IS MULTI-DRUG RESISTANT TB? Multi-drug resistant tuberculosis (called MDR-TB for short) is a very dangerous form of tuberculosis. Some TB germs become resistant to the effects of some TB drugs. This happens when TB disease is not properly treated.

These resistant germs can then cause TB disease. The TB disease they cause is much harder to treat because the drugs do not kill the germs. MDR-TB can be spread to others, just like regular TB.

It is important that patients with TB disease follow their doctor's instructions for taking their TB medicine so that they will not develop MDR-TB.

CAN A TB PATIENT INFECT OTHERS? Yes, if they have TB disease and it is not being treated. Once treatment begins, a patient ordinarily quickly becomes noninfectious; that is, they cannot spread the disease to others.

There is little danger from the TB patient who is being treated, is taking his or her medication continuously, and is responding well. The drugs usually make the patient noninfectious within weeks.

TB is spread by germs in the air, germs put there by coughing or sneezing. Handling a patient's bed sheets, books, furniture, or eating utensils does not spread infection.

Brief exposure to a source of TB rarely infects a person. It's day-after-day close contact that usually does it.

TB: WHAT YOU SHOULD DO

Find out if you're infected.

Certain people such as those infected with HIV or health care workers should be tested regularly. You should be tested if there's any chance you have been infected, recently or many years ago.

If the test is negative:

A negative reaction usually means that you are not infected and no treatment is needed. However, if you have TB symptoms your doctor must continue to look for the cause. Sometimes, when a person has only recently been infected, or when his or her immune system isn't working properly, the test may be falsely negative.

If the test is positive:

A significant reaction usually means that you have been infected with the TB germ. It does not necessarily mean that you have TB disease. Cooperate with the doctor when he or she recommends a chest X ray and possibly other tests.

If the doctor recommends treatment to prevent sickness, follow the recommendations. If medicine is prescribed, be sure to take it as directed.

If you don't need treatment, do what the doctor tells you to do about follow-up. The doctor may simply say to return for another checkup if you get into a special risk situation for TB sickness or develop symptoms.

If you are sick with TB disease, follow the doctor's recommendations for treatment.

If you're a health worker:

Your local American Lung Association can provide you with more comprehensive information developed for health professionals on the diagnosis, treatment and control of TB.

Footnote:

- I. Definition of latent disease: Inactive disease. Person does not have symptoms.
- II. Definition of active disease: Bacteria is active. Person has symptoms of TB and is infectious.

Sources

1. Centers for Disease Control and Prevention. Status of the Tuberculosis Epidemic in the U.S. July 1999.
2. World Health Organization. Global TB Control Report, 2003.
3. American Thoracic Society and Centers for Disease Control and Prevention. Targeted Tuberculin Testing and Treatment of Latent Tuberculosis Infection. American Journal of Respiratory and Critical Care Medicine. Vol. 161(4), April 2000.
4. American Thoracic Society, Centers for Disease Control and Prevention and Infectious Disease Society of America. Treatment of Tuberculosis. Morbidity and Mortality Weekly Report Vol. 52 (RR-11), 2003.

Research supported by the American Lung Association has contributed significantly to scientific progress in understanding and treating respiratory disorders



**Certificate
Of
Alzheimer's Disease & Related Dementias**

Participant Name

Position

Arbor Medical Staffing
Agency

Arbor Medical Staffing Representative

Date



Certificate
of
HIPAA Compliance Participant Training

Participant Signature

Printed Name

Position

Arbor Medical Staffing Representative

Date



OSHA/JCAHO Signature Form

Abuse: Domestic, Elder, Child and Sexual

I have read and understand the signs and symptoms of Domestic Violence/Abuse, Elder Abuse, Child Abuse and Sexual Abuse as well as the protocol to follow if suspected, including utilizing the child abuse hotline, 1-800-4-A-CHILD.

Advanced Directives

Advance directives are the legal documents, such as the living will, durable power of attorney and health care proxy, which allow people to convey their decisions about end-of-life care ahead of time. I understand that every patient must be informed of all advanced directives and will make known any advanced directives that the patient does have.

Age Specific Statement

I comply with the age-specific job requirements mandated by the Joint Commission on the Accreditation of Healthcare Organizations (JCAHO) compliance standards for the following age groups:

- | | | |
|-----------------------------------|--------------------------------------|--|
| <input type="checkbox"/> Neonates | <input type="checkbox"/> Preschool | <input type="checkbox"/> Young Adults |
| <input type="checkbox"/> Infants | <input type="checkbox"/> School Age | <input type="checkbox"/> Middle Adults |
| <input type="checkbox"/> Toddlers | <input type="checkbox"/> Adolescents | <input type="checkbox"/> Geriatrics |

Alzheimer's Disease (AD) and Related Dementias

I have read and understand the symptoms, stages and common problems associated with and caring for Alzheimer Patients and those with Related Dementias.

Bloodborne Pathogens and Needlestick Prevention

I have read and understand the OSHA guidelines for Bloodborne Pathogens and needlestick Prevention listed at <http://www.osha.gov/SLTC/bloodbornepathogens>

Body Mechanics/Ergonomics Acknowledgement

I have read and understand the current protocols and regulations regarding proper Body Mechanics and Ergonomics

Cultural Diversity

I have read and understand the concepts and case studies for Cultural Diversity.

Emergency Management Preparedness

I have read and understand the OSHA guidelines for Emergency Preparedness and Response. <http://www.osha.gov/SLTC/emergencypreparedness>

Environmental and Fire Safety

I have read and understand the protocols to follow to prevent hazards regarding, Fire, Electrical and Environmental surrounding and maintaining a safe work place.

Ethics for Healthcare

I have read and understand the Healthcare Compliance Associations Code of Ethics for HCW's @ <http://www.hccainfo.org/Content/NavigationMenu/AboutHCCA/ProfessionalEthics/codeofethicsFINAL11-14-03.pdf>

Harassment Policies

I have read and understand the *Arbor Medical Staffing* Harassment Policy and know the reporting procedure to take if I feel harassment exists in the work place.

Hazardous Communications and Chemicals

I have read and understand the protocols to follow for hazardous materials according to the Occupational Safety and Health Administration (OSHA) and the Material Safety Data Sheet (MSDS) for chemicals.

HIPAA

I have read and understand the "Health Insurance Portability and Accountability Act" and understand the compliance protocol. **After reading, complete the HIPAA certificate and scan or fax it back to your Arbor office.**

Infectious Disease Control and Bloodborne Pathogens

I have read and understand the Infection Control Guidelines from the Department of Health and Human Services as listed on the Centers for Disease Control and Prevention @ <http://www.cdc.gov/ncidod/dhgp/guidelines.html>.

2011 National Patient Safety Goals

I have read and understand The Joint Commission Standards for National Patient Safety Goals listed @ http://www.jointcommission.org/standards_information/npsgs.aspx.

Patient Rights and Responsibilities

I have read and understand the Patient's Bill of Rights that was adopted in 1973 by the American Hospital Association and is monitored by the Joint commission on Accreditation of Healthcare Organizations (JCAHO) to ensure the patient's right to receive healthcare is honored by healthcare facilities and healthcare workers.

Physical Restraints Acknowledgement

I have read and understand the current protocols and regulations regarding physical restraints, their use and misuse.

Tuberculosis

I have read the education material on Tuberculosis and understand the definition, symptoms, various tests and requirements concerning Health Care Providers and this disease

Arbor Medical Staffing has provided me with training, manuals, advice, instructions or documentation of all of the above OSHA and JCAHO material. All reading materials are to be viewed on the web site at www.Arborstaff.com and click on "Resources".

Signature

Date

Print Name