V.008

CLINICAL EMPLOYEE ORIENTATION & ANNUAL TRAINING

INITIAL AND ANNUAL TRAINING

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WELCOME

Welcome to the IntelyCare, Inc. Team! We are looking forward to an exciting and rewarding career opportunity in working with you. This clinical employee training will serve as your point of reference for standards, policies, and procedures that IntelyCare, Inc. employees are expected to follow.

WHAT IS INTELYCARE?

IntelyCare is a nursing agency that allows providers to have the flexibility and earn higher wages by picking up on-demand assignments from skilled nursing facilities. Our Clinical Staff members are known as “IntelyPros”.

WHY YOU WILL LOVE IntelyCare, Inc.

We will always provide the personalized service you expect from a small, boutique firm. When you call IntelyCare, Inc., you'll speak to a person. When you send us a message, we'll contact you promptly. We are committed to open and timely communication with every one of our clients and employees.

WHAT IS EXPECTED OF ME WHILE WORKING FOR INTELYCARE?

- Don’t ‘Call Out’ of your shifts unless absolutely necessary.
- Arrive at shifts on time
- Show respect for staff and residents
- Complete Assignments
- Follow all IntelyCare policies

ADMINISTRATIVE BASICS

Availability of IntelyCare, Inc. Office Staff

The IntelyCare, Inc. office, located in Quincy, MA is open Monday through Friday from the hours of 8:30 am – 5:30 pm. Our local telephone number is (617) 971-8344. Outside of normal business hours and in the event of an emergency, please contact us at the same number listed above. IntelyCare, Inc.'s on-call staff will be available to assist you.

In the event of an emergency, natural disaster, or another uncontrollable event, IntelyCare, Inc. will continue to provide service to you through our network from a location where phones and computers are functional. IntelyCare, Inc. will do everything possible to support you in meeting your needs during a crisis situation(s). A copy of our Emergency Management Plan is available upon request.

Work-Related Injuries and/or Exposures

IntelyCare, Inc. provides Workers Compensation insurance for its employees as required by law. It is our philosophy that if an employee is injured while at work, we intend to assist that employee to return to work as soon as possible. The employee is obligated to report a work-related injury to IntelyCare, Inc. as soon as possible. An Injury Report Form needs to be completed at the facility, by the employee as soon as possible after the injury.

Depending on the severity of the injury and when the injury is reported will determine where a physician will see the employee.

- In the case of an emergency situation, the employee is advised to go to the emergency department. If it is not an emergency situation, IntelyCare, Inc. will advise the employee to follow up with their primary health care provider. The injury will be reported to the worker's compensation insurance provider who will manage the employees' return to work.

Holiday Pay

Holiday pay varies for each client facility. For further information on holiday pay, consult with IntelyCare, Inc. payroll and management directly.

Lunch Break Policy

IntelyCare, Inc. employees agree to take thirty (30) minutes and up to a maximum of one (1) hour for meal periods (dep, unless otherwise specified by facility policy. If the facility requests IntelyCare, Inc. employees to work their lunch period due to patient care and safety, IntelyCare, Inc. employees agree to obtain a supervisor signature from a Client Manager/charge nurse for each The Vice President of Clinical Operations applicable shift.

Orientation

Healthcare facility orientation information or requirements will be provided to IntelyCare, Inc. employees prior to the assignment start by a representative of the client facility.

Clinical Supervision

The Vice President of Clinical Operations provides clinical staff supervision for IntelyCare, Inc.'s healthcare professionals. She has an understanding of the scope of services provided by the disciplines supervised. The Vice President of Clinical Operations utilizes the appropriate practice acts, the professional licensing and certification boards, and professional associations as clinical resources, as needed. It is the Vice President of Clinical Operations responsibility to identify and report aberrant or illegal behavior to professional boards and law enforcement agencies.

Floating Policy

IntelyCare, Inc. employees may only be placed in assignments that match the job description for which IntelyCare, Inc. assigns them. If an employee is asked to float to another department with the customer, the department must be a similar department or unit, and the float employee must have demonstrated previous competency and have the appropriate certifications, credentials for that department/unit. Employees should only be floated to areas of comparable clinical diagnoses and acuities.

The following procedures should be followed for healthcare professionals and nurses in particular who are assigned to an area in which they do not feel competent:

- The healthcare provider will immediately notify IntelyCare, Inc.,
- The IntelyCare, Inc. employee is obligated to inform the Healthcare facility of his/her professional limitations based upon the Nurse Practice Act standards and upon IntelyCare, Inc. client contract specifications as they relate to the assignment.

- The Vice President of Clinical Operations at IntelyCare, Inc. will work within the bounds of each discipline's Professional Association or State Governing Body and the client agreement to resolve the issue.
- IntelyCare, Inc. will pay healthcare professionals for hours worked up until the end of his/her shift.
- IntelyCare, Inc. will pay nurses for hours worked up until the end of his/her shift.

CODE OF BUSINESS ETHICS

The first element of the Code of Business Ethics is putting the interests of the client facilities and ultimately the patient above our personal and individual interests. It is in the best interest of IntelyCare, Inc. to avoid conflicts of interest between the client Healthcare facility, employees, and staff.

IntelyCare, Inc. has developed corporate compliance guidelines to supplement and reinforce our client facilities' existing policies and procedures. It is also meant to assist IntelyCare, Inc. to comply with all applicable laws, rules, and regulations.

- All employees are responsible for conducting their jobs in a manner reflecting standards of ethics that are consistent with accepted criteria for personal integrity
- Preserving IntelyCare, Inc. reputation for integrity and professionalism is an important objective. The manner in which employees carry out their responsibilities is as important as the results they achieve.
- All activities are to be conducted in compliance with both the letter of the law and spirit of the law, regulations and judicial decrees.
- No employee should, at any time take any action on behalf of IntelyCare, Inc., which is known or should be known to violate any law or regulation.
- Information about the healthcare provider's medical condition and history is required during the hiring process. IntelyCare, Inc. recognizes this health information and electronic information must be held securely and in confidence. It is the policy of IntelyCare, Inc. that clinical staff specific information is not to be released to anyone outside of IntelyCare, Inc. without a court order, subpoena of the applicable statute.
- Marketing materials, regardless of medium, shall accurately describe the services, facilities, and resources of IntelyCare, Inc.
- To maintain high standards of performance, IntelyCare, Inc. employs only those individuals it believes are most qualified without regard to race, color, religion, sex, age, national origin, handicap or disability in compliance with all federal and state laws regarding discrimination.
- IntelyCare, Inc. is committed to maintaining a workplace environment in which employees are free from sexual harassment.
- IntelyCare, Inc. will not tolerate violence or threats of violence in the workplace, including but not limited to abusive language, threats, intimidation, inappropriate gestures, and/or physical fighting by any employee. These actions are strictly prohibited and may lead to severe disciplinary action up to and including termination.
- IntelyCare, Inc. recognizes that its employees and clinical staff are its most valuable assets and is committed to protecting their safety and welfare. Employees are required to report accidents and unsafe practices or conditions to their supervisors or other management staff. Timely action will be taken to correct unsafe conditions.
- Employees that are licensed or certified in any profession shall follow all applicable rules and professional codes of conduct pertaining to that profession, in addition to the rules stated herein.
- IntelyCare, Inc. prohibits the use or possession of illegal drugs and alcohol abuse on IntelyCare, Inc. property or while engaged in company activity.
- IntelyCare, Inc. is committed to providing initial and ongoing education for all employees regarding their responsibilities to uphold the code of business ethics and this set of IntelyCare, Inc.'s Corporate Compliance guidelines.
- IntelyCare, Inc. prohibits field staff to discuss bill rates of Health Care facilities or special rates of IntelyCare, Inc. with other healthcare providers.
- IntelyCare, Inc. prohibits field staff to discuss personal or business affairs of any employee (field or office staff) with any individual not directly involved with the said personal or business affair.
- IntelyCare, Inc. is committed to protecting the privacy, confidentiality, and security of personal (education, employment and health) information of its employees. This policy is designed to assure compliance with applicable state and federal laws and regulations.
- IntelyCare, Inc. is committed to protecting its own and its client's trade secrets, proprietary information and other internal information.
- It is the desire of IntelyCare, Inc. to provide authorized third parties with information whenever requested while committing to our responsibility to control the release of information to protect the privacy and confidentiality of the employee and/or corporate information.

- Employees are not authorized to issue any statement, written or oral, to any news media representative or grant any public interview pertaining to the company's operations or financial matters.

Any employee that becomes aware of any ethical issues or unethical practices must immediately report it to their supervisor. If the supervisor is unavailable or you believe it would be inappropriate to contact that person, because of their involvement in the situation, you should immediately contact the IntelyCare, Inc. Corporate Office or any other member of management. Any employee can raise concerns and make reports without fear of reprisal or retaliation.

All reports and inquiries are handled confidentially to the greatest extent possible under the circumstances. You may choose to remain anonymous, though in some cases that can make it more difficult to follow up and ensure resolution to the situation.

IntelyCare, Inc. wants every employee to report violations of our ethical or other principles whenever you see them or learn about them. In fact, it is a requirement of your employment. If you do not know whether something is a problem, please ask a member of management.

STANDARDS OF CONDUCT

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

EMPLOYEE RESPONSIBILITIES

IntelyCare, Inc. Employee is and shall be duly licensed to practice his/her profession in any State where IntelyCare, Inc. Field Employee is assigned and shall maintain current professional standing at all times. Evidence of such licensing shall be submitted to IntelyCare, Inc. prior to commencing the Assignment. IntelyCare, Inc. Field Employee agrees to give immediate notice to IntelyCare, Inc. in the case of suspension or revocation of his/her license, initiation of any proceeding that could result in suspension or revocation of such licensing, or upon the receipt of any notice or any other matter which may challenge or threaten such licensing.

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

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

IntelyCare, Inc. Field Employee agrees to work all scheduled shifts as directed by Client (including weekends and holidays).

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

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

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

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

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

Employee agrees not to disclose any IntelyCare, Inc. trade secrets or any confidential or proprietary information of IntelyCare, Inc., IntelyCare, Inc. employees, Clients, or patients of Clients. IntelyCare, Inc. Field Employee further agrees not to compete either as a direct competitor or with a competing company at the Client assignment where IntelyCare, Inc. Field Employee has been placed by IntelyCare, Inc.

GENERAL STANDARDS

The following set of standards are to inform and guide all staff assigned to work in Healthcare facility units. The guidelines below include but are not limited to the following:

- Patient care providers are to render care in a manner that enhances the personal dignity and rights of each patient. Any form of patient abuse and/or neglect will not be tolerated, and patient care providers are to support IntelyCare, Inc.'s policies and procedures in this regard.
- Interactions with all Healthcare facility patients, visitors, employees, physicians, vendors, etc., must be conducted in a courteous and professional manner at all times ensuring that IntelyCare, Inc. is always presented in the most favorable light.
- The practice of counseling of the patient regarding personal problems and / or participation of the IntelyCare, Inc. patient care provider in conversations with patients about topics not relevant to the plan of care--is discouraged and unacceptable.
- Patients are to be dealt with equally and fairly and the selection of "favorites" is not acceptable
- Appropriate language is to be used at all times when an IntelyCare, Inc. patient care staff member is at an IntelyCare, Inc. client facility, and in any patient care area private and / or public. Abusive, profane, threatening, demeaning, language resulting in violation of HIPAA regulations or compromising patient confidentiality can result in immediate termination
- Touching patients, except in the direct delivery of care or by a greeting, is prohibited
- Socializing with patients and/or patient's significant others outside of the facility is unacceptable
- Socializing with patients and/or patients' significant others after discharge from the Healthcare facility is prohibited. Staff are not to call, date, nor develop personal or social relationships with patients, former patients, or family/significant others of patients, including giving personal information or residential phone numbers. Staff should discuss with their manager, any matter of concern regarding their contacts with current or former patient/family members of a patient's significant others.
- All staff will uphold all rules and regulations related to patient confidentiality in all areas including patient care, public, and non-patient care areas. These rules and regulations include but are not limited to the following:
    - Patient care providers are not to divulge to anyone any information or records concerning any patient without proper authorization. Unauthorized release of confidential information may constitute a ground for termination and/or civil action.
    - Conversations regarding patients are not to be held in the presence of other patients or any other person not privileged to this communication.
    - Problems of a patient are not to be discussed with another patient.
    - Patients are not to be named or discussed with anyone in or outside of the facility who does not have the legal right to receive information about the patient.
- Personal problems, concerns or personal life information of patient care providers are not to be discussed with any patient, patient group or family/significant others.
- Staff is not to discuss disagreements or criticize other patient care providers or physicians within the earshot of patients/families/significant others. A professional difference of opinion must be discussed in an appropriate private space.
- Behavior in patient areas and at the nurses' station shall be oriented toward patient care. Personal reading and conversations, including personal phone calls, are not to be conducted in these areas.
- Employees must avoid any situation, which involves a possible conflict between their personal interests and those of IntelyCare, Inc. Staff shall not solicit and are encouraged not to accept gifts or compensation of any kind from any individual or IntelyCare, Inc. outside of IntelyCare, Inc. as a consequence of their position at IntelyCare, Inc.
- Any inappropriate interactions between patients and staff, staff and staff, or staff and others within the Healthcare facility will be met with the investigation and quick response within the framework of IntelyCare, Inc. policy and procedure.
- Employees who are licensed or certified in any profession shall follow all applicable rules or professional codes of conduct pertaining to that profession, in addition to the rules stated herein.
- All IntelyCare, Inc. patient care staff will be expected to maintain English proficiency standards and use English exclusively during all paid working hours.
- The client's name badge must be worn at all times while on assignment, above the waist with name and title fully visible.

- While at the Healthcare facility, all employees must follow these basic rules:
    - Eating and drinking are only permitted in the cafeteria, designated employee lounges, unit conference rooms and in private offices, when not in use for patient care.
    - Sleeping is not permitted during paid working hours.
    - Personal phone calls on the unit during work time are prohibited, except in emergency situations
    - Assigned duties must be carried out in a timely, efficient manner as directed or delegated.
    - When entering a patient room and/or when greeting a patient, practice the following.
        - Knock before entering
        - Greet the patient by name
        - If it is the first contact of the day, introduce yourself by name and title
        - Tell the patient why you are in the room.
    - When exiting a pt room IntelyCare, Inc. patient care staff is expected to:
        - Inform the Patient / Family that you are leaving
        - State time you expect return
        - Ask if there is anything the pt. / family needs before you leave

DRESS CODE/FINGERNAIL POLICY

Dress code policy must be followed at all times while on the Healthcare facility premises. The IntelyCare, Inc. dress code includes but is not limited to the following:

- Clothing must be clean, neat, and allow for quick, efficient movement as necessary in the performance of job duties, including emergencies. Professional healthcare attire is mandatory.
- Unacceptable attire includes but is not limited to:
    - Bare midriffs
    - Low cut, tank, tube or sleeveless tops
    - Transparent, provocative, excessively form-fitting or revealing clothing
    - Mini skirts
    - Sweat (warm-up) shirts or pants
    - Clothing with printed messages, caricatures or pictorial representations (e.g., university logos, beverage cans, and cartoon characters) applications that have the potential of falling off (e.g. sequins, glitter) shorts. Note: Exception business attire that is identified by a small logo (e.g. Polo insignia).
    - Denim jeans (any color).
    - Spandex tights or leggings.
    - Fishnet stockings.
    - Hats (other than nursing caps).

Note: Exceptions to these rules may be made with the written approval of the manager when the job expectations demand different attire.

- Jewelry is to be kept at a minimum and be in keeping with the general safety and infection control practices for the employee and the patient. Long dangling earrings, large or excessive necklaces and/or bracelets, and sharp rings are not acceptable.
- Fingernails must be kept short, clean, and natural; no artificial applications are to be worn.
- Hair must be neat and well-groomed.
- Shoes must be clean, in good repair, provide good support and protection and allow for quick and efficient movement as necessary in the performance of job duties, including emergencies. Open-toed shoes are not permitted. Socks or stockings must be worn at all times.
- If going between two different facilities (example: working a shift after your other staff job) your required to change into a clean uniform to prevent transmission of potential infection.

CELL PHONE USAGE POLICY

Cell phones/ smartphones are an essential component to being an IntelyCare provider. The use of these devices shall be limited to the ‘start’ of the shift to ‘Check In’ and at the end of the shift to ‘Check Out’. Important: as per the policy of any healthcare facility, mobile devices are not allowed to be utilized while on the unit and can be assumed as violating the HIPAA protected rights of patients.

CUSTOMER SERVICE/ COMMUNICATION GUIDE

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

Behaviors of Exceptional Customer Service

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

Standards of Service Excellence

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

TELEPHONE COURTESY

Telephone courtesy guidelines include but are not limited to:

- Answering the phone, preferably by the third ring
- Identify yourself by giving your department and name.
- Identify the caller and what they are requesting
- When leaving the line, before placing the caller on hold, ask the caller if he/she can hold the line and wait for the caller's response
- When returning to the line, thank the caller for waiting
- When you give the call to another person, inform them both that they have a call and who the caller is.
- Try not to leave the caller holding for more than thirty (30) seconds. If you have to handle several calls at the same time or are unable to find the requested information or person quickly, ask if the caller would prefer to wait or to be called back.
- If the person receiving the call is not available, advise the caller of this and offer the options of speaking with someone else or leaving a message
- After taking a message, repeat the message to the caller to confirm that you have taken it down correctly and thank the caller.
- When transferring a call, let the caller know that you are transferring the call and why. Also, identify the extension to which you are transferring in case the caller is inadvertently disconnected.
- Allow your voice to reflect courtesy and a smile. What and how you say what you say makes a difference.
- Employees are to seek guidance from their manager when there are questions, concerns or problems with these rules or any other part of their employment.

Any violations of the Code of Conduct will be investigated and may result in disciplinary action up to and including termination, per IntelyCare, Inc. Policy and Procedures.

SUBSTANCE ABUSE: DRUGS IN THE WORKPLACE

IntelyCare, Inc. believes that maintaining a workplace that is free from the effects of drug and alcohol abuse is the responsibility of all persons involved in our business, including IntelyCare, Inc. employees and clients.

The use, possession, sale or transfer of illegal drugs or alcohol on company property, in company vehicles, or while engaged in company activity is strictly forbidden. Also, being under the influence of drugs or alcohol, while on company property, in company vehicles, or while engaged in company activities is strictly forbidden. A violation of this policy will result in disciplinary action up to and including termination. Depending upon the circumstances, other action, including notification of appropriate law enforcement agencies, may be taken against any violator of this policy. In accordance with the Drug-Free Work-Place Act of 1989, as a condition of employment, patient care providers must comply with this policy and notify management within five (5) days of conviction for any use of, or distribution of a controlled substance. Failure to do so will result in immediate termination of employment pending the outcome of any legal investigation and conviction.

For the protection of our employees, the public and to ensure an environment as free from the influence of illegal drugs as is reasonably and practically possible, the company reserves the option to conduct a "for cause" drug screen for the presence of illegal drugs under certain conditions. Consent to the testing program will be a condition of further employment of each and every employee. If any director, manager, supervisor or other company officer or client representative has any suspicion that an employee under his or her supervision may be affected by or under the influence of illegal drugs, the employee under suspicion will be asked to undergo a laboratory test to determine the presence of illegal drugs. Refusal to take the test will subject the employee to immediate termination. Additionally, consistent with the law, drug and alcohol screening tests will be given after accidents or near misses, or upon reasonable suspicion of alcohol or drug use, when a client requires pre-assignment testing, or upon any other circumstances which warrant a test.

SEXUAL AND OTHER UNLAWFUL HARASSMENT

IntelyCare, Inc. is committed to providing a work environment that is free from all forms of discrimination and conduct that can be considered harassing, coercive, or disruptive, including sexual 'harassment. Actions, words, jokes, or comments based on an individual's sex, race, color, national origin, age, religion, disability, sexual orientation, or any other legally protected characteristic will not be tolerated.

Sexual Harassment is defined as unwanted sexual advances, or visual, verbal, or physical conduct of a sexual nature. This definition includes many forms of offensive behavior and includes gender-based harassment of a person of the same sex as the harasser. The following is a partial list of sexual harassment examples.

- Unwanted sexual advances—verbal and/or non-verbal.
- Offering employment benefits in exchange for sexual favors
- Making or threatening reprisals after a negative response to sexual advances.
- Visual conduct that includes leering, making sexual gestures, or displaying of sexually suggestive objects or pictures, cartoons or posters.
- Verbal conduct that includes making or using derogatory comments, epithets, slurs, or jokes.
- Verbal sexual advances or propositions.
- Verbal abuse of a sexual nature, graphic verbal commentaries about an individual's body, sexually degrading words used to describe an individual, or suggestive or obscene letters, notes, e-mails or invitations.
- Physical conduct that includes touching, assaulting or impeding or blocking movements.

Unwelcome sexual advances (either verbal or physical), requests for sexual favors, and other verbal or physical conduct of a sexual nature constitute sexual harassment when:

- Submission to such conduct is made either explicitly or implicitly as term or condition of employment;
- Submission or rejection of the conduct is used as a basis for making employment decisions, or
- The conduct has the purpose or effect of interfering with work performance or creating an intimidating, hostile, or offensive work environment.

Upon experiencing or witnessing sexual or other unlawful harassment in the workplace, report it immediately to your supervisor. If the supervisor is unavailable or you believe it would be inappropriate to contact that person, you should immediately contact

the IntelyCare, Inc. Corporate Office or any other member of management. You can raise concerns and make reports without fear of reprisal or retaliation.
All allegations of sexual harassment will be quickly and discreetly investigated. To the greatest extent possible, the alleged victim's confidentiality, that of any witnesses, and the alleged harasser will be protected against unnecessary disclosure. When the investigation is completed, the alleged victim will be informed of the outcome of the investigation.

Any supervisor or manager who becomes aware of possible sexual or other unlawful harassment must immediately advise the Director of Human Resources or any member of management so the allegation can be investigated in a timely and confidential manner. Anyone engaging in sexual or other unlawful harassment will be subject to disciplinary action, up to and including termination of employment.

PHYSICAL ASSAULT/WORKPLACE VIOLENCE

IntelyCare, Inc. is committed to providing a safe and secure workplace and an environment free from physical violence, threats and intimidation. Employees are expected to report to work to perform their jobs in a nonviolent manner. Conduct and behaviors of physical violence, threats or intimidation by an employee may result in disciplinary action up to and including discharge and/or other appropriate action.

IntelyCare, Inc. will not permit employment-based retaliation against anyone who, in good faith, brings a complaint of workplace violence or who speaks as a witness in the investigation of a complaint of workplace violence.

Definitions
Workplace violence is any physical assault, threatening behavior or verbally abusive remark that is made in the workplace and/or effect the workplace behavior of an employee, which includes but is not limited to:

1. Verbal Abuse: Any verbal expression issued with the intent of creating fear or intimidation in another individual, or group of individuals, or verbal remarks or comments expressed in a loud, harsh or threatening tone of voice or in a joking manner within the workplace.
2. Physical Abuse: Any intentional movement of the body, which may include touching, gestures, pushing, striking, stalking or any unwanted intrusion of "reasonable space" of an employee. Any intentional use of any object toward an individual.
3. Creating a Hostile Work Environment: Any intentional nonphysical action that can be considered intimidating, or harassing with the intent of creating an environment that has the purpose or effect of unreasonably interfering with an individual's performance of where behaviors create Healthcare facility or threatening environment.

Responsibilities

1. Management: Management will foster an environment that is safe and free from workplace violence and will take action immediately to reduce the effects of workplace violence and/or verbal or physical abuse.
2. Employee: Employees will conduct themselves in such a way to reduce the possibility of any conflicts or acts that would create a violent, abusive or unsafe workplace environment for themselves or others. Employees will notify management of workplace violence incidents, which have occurred on or off-site that has the potential of impacting the work environment. Employees will remove him/herself from any situation that may result in workplace violence. This means that if confronted with a potential situation involving workplace violence, an employee must make a serious attempt to retreat from the situation and report to management

SAFETY MANAGEMENT

LIFE SAFETY (FIRE) MANAGEMENT

General Rules

When fire strikes, the actions taken during the first few minutes make the difference between containment and catastrophe. It is with the training of personnel that proper action can be taken during these very important first few minutes and disaster averted.

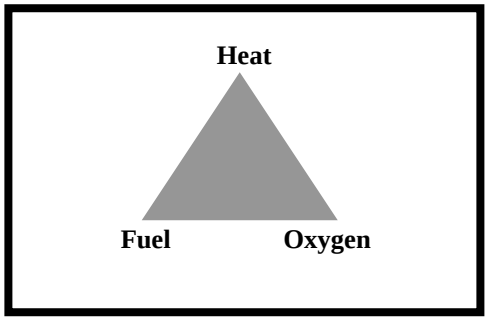
Important locations you need to know:

- Fire extinguisher in your department
- Closest fire-alarm pull
- Evacuation route
- Fire doors and walls
- Next safe fire zone (smoke compartments)

Important facility conditions to maintain:
- Keep emergency exits, firefighting equipment and fire-alarm pull stations clear at all times
- Never put door wedges under doors that prevent doors from closing.
- Keep doors closed unless they are controlled by an electromagnetic system.
- Keep all corridors and exits clear of all unnecessary traffic and/or obstruction.
- Keep telephone lines clear for fire control.

Creation of fire

A fire requires that the following three elements (known as the fire triangle) are present at the same time to burn:



If the sides of the triangle are not allowed to meet – if the triangle does not form, there will be no fire.

In the event of a fire, follow the below action plan:

R Rescue- remove everyone in immediate danger from the fire area.
A Alarm- Pull the nearest FIRE ALARM box and alert PBX to announce a Code Red
C Contain- Close the door and isolate the fire
E Extinguish/evacuate- With proper extinguisher, fight fire without endangering yourself

When using a fire extinguisher, follow the below action plan:

P Pull- Pull out the safety pin
A Aim- Aim the nozzle at the base of the fire, standing about 10 feet away from the fire.
S Squeeze- Squeeze the handle
S Sweep- Sweep the nozzle from side to side

ENVIRONMENTAL SAFETY

In every facility, it is important to follow security procedures. By taking simple security precautions, you can help to:
- Protect personal, patient, and institutional property

- Maintain a safe environment.

Personal Property

There are a number of security precautions that you can take at your facility to help protect your own personal property:

1. Lock car doors.
2. Secure all valuables.
3. Keep purses and wallets in a locked area or locker.

Patient Property

Patients should be encouraged to leave their valuables at home. If patients choose to bring their valuables into the facility with them, you can help to keep them safe by:

1. Securing patient valuables
2. Educating patients about security.

Follow your facility policy for securing patient valuables. For example, valuables may be placed in the facility safe according to policy. You can educate patients by explaining the visitor policy, including who can visit, visiting hours, and any restrictions. You should also explain how patients can identify staff.

Institutional Property

There are also things you can do to protect institutional property:

1. Keep restricted areas locked
2. Report missing or damaged equipment.

"Security-sensitive" Areas

Some areas in your facility may be restricted or "security-sensitive." This means that only people who need to be in these areas should be there.

Security-sensitive areas may include the following:

- Pharmacy
- Operating rooms
- Obstetrics (especially the Nursery)
- Pediatrics
- Medical Information Systems
- Medical Records
- Billing.

If you work in a security-sensitive area, follow facility policies and procedures to keep them secure. Procedures that should be followed all the time, especially in security-sensitive areas may include:

1. Wearing your ID badge
2. Keeping doors locked
3. Reporting missing or damaged equipment.

You should wear your ID badge according to facility policy. If you lose your badge, you should report it and have it replaced immediately. It is important for you to be properly identified. It is also important to insure no-one else uses your badge.

In addition to wearing your own ID badge, you should be suspicious of people who are not wearing proper identification. Remember, wearing a lab coat or scrubs does not mean someone is an employee.

You should also be sure to keep doors to security-sensitive areas locked. Do not prop doors open that are supposed to be secure. If you do see someone acting suspiciously, report it to your security personnel.

There are good reasons that some areas need to be secure. For example, the pharmacy must restrict access to drugs. In Obstetrics (particularly the Nursery), it is important to guard against infant abduction. Medical Records contain sensitive personal information. By following procedures, you can help keep these areas secure.

In addition to protecting personal, patient, and institutional property, it is important to ensure your personal safety. Take the following simple precautions:

1. Do not walk alone to your car at night.
2. Park in well-lit areas.
3. Do not keep valuables in your car.
4. Report any potential security hazards.
5. For your own safety, do not walk alone to your car at night or any time you feel uncomfortable. Follow your facility procedure to get an escort. Park in well-lit areas and do not keep valuables in your car, especially in plain sight. If you do have valuables in your car, lock them in the trunk.
6. Report anything that you feel might be a security hazard. This includes such things as burned out lights in a stairwell or garage. If you feel someone is acting suspiciously, notify security personnel immediately.

Some areas in your facility are "security-sensitive areas." These are areas with limited or restricted access. Security-sensitive areas may include the following:

- Pediatrics and Obstetrics (especially the Nursery), because of the risk of infant or child abduction
- Pharmacy, because of access to drugs
- Medical Information Systems and Medical Records, because of access to confidential information.
- Billing
- Your facility may have policies restricting access to these areas. There may also be security devices, such as alarms and video cameras. Restricted access to security areas applies to everyone, even staff. Only people who need to be in a restricted area should be there.

EMERGENCY PREPAREDNESS/DISASTER SAFETY

Emergencies or disasters can be classified as either "internal" or "external."

An internal emergency is one that directly involves the facility and is a threat to the staff and patients, such as an in-house fire, a toxic chemical spill, or a natural disaster such as a tornado, earthquake, or hurricane that causes damage to the facility.

An external emergency is one that occurs outside of the facility and does not directly threaten the staff, patients and others inside the building(s). The indirect effect on the facility is the possibility of large numbers of casualties arriving for treatment. External disasters include such things as:

- Accidents involving buses, trains, airplanes or multiple vehicles
- Explosions
- Chemical spills
- Large fires
- Violent incidents involving a large group of people
- Natural disasters occurring outside the facility such as tornadoes or floods.

All organizations must have an emergency management plan or disaster plan so that patient care can continue if a disaster occurs. Healthcare facility disaster/emergency management plans must:

- Address both external and internal disasters
- Include general activities that will occur no matter what the emergency situation
- Allow specific responses to the types of disasters the facility might face
- Include a plan for evacuation of the Healthcare facility if all or part of the facility is damaged or non-functional.

When there is an emergency situation that could affect many workers, a Healthcare facility's Healthcare facility wide-notification system will be activated to let you know what is going on and the location. The notification will direct you to take action according to the type of emergency.

Evacuation

Healthcare facility evacuation is an entirely different process than is recommended for schools and factories. Leaving the Healthcare facility is the very last resort, while in other establishments the objective is to clear the building as quickly as possible.

Familiarity with several types of evacuation is a necessity in any Healthcare facility. There are four types of evacuation. Each may be a separate and complete operation, or all four may have to be used in successive stages if circumstances so require.

1. Partial Evacuation: This is removing one or more patients from a dangerous room or ward. When the patients are removed, an attempt must be made to subdue the fire with the extinguisher and hose line. If this is impossible the door must be closed and the threshold sealed with a wet towel or blanket. If the fire continues to grow, then the next step is to proceed with the horizontal or vertical evacuation.

2. Horizontal Evacuation: This type of evacuation takes place when fire or heavy smoke from a single room or ward threatens to spread to the adjoining area. All patients should be moved laterally by bed, cart, wheelchair, gurney, blanket or other conveyance to the nearest and safest protected area. Patients in immediate danger should be moved first, including those who might be separated from safety if the fire enters the corridor. Next to move (and contrary to some opinion) should be the ambulatory patient. Panic is never caused by helpless people. Those who are ambulatory should be pre-instructed to line up outside their rooms, form a chain by holding hands and follow a lead person into the safe area. The rooms should be checked for stragglers and all windows and doors closed. When horizontal evacuation is ordered, the personnel in the receiving area should assist in the removal of the patients if needed.

3. Vertical Evacuation: This is the downward movement of patients to a safe area. This may be one or two floors below, or it may be down and out of the building. If the movement is out of the building, it should be an area far enough from the building to be safe and also to be out of the way of the fire department. In most cases, this movement will be preceded by a horizontal movement to a safe stairwell. The priority for movement is the same for a horizontal movement.

4. Total Evacuation: This means vacating all floors to a place of safety. The cause would be possible conflagration or an enemy air attack warning, or dense smoke and fumes. A place of safety might mean the basement, or even leaving the building, or even leaving the city. It would be necessary to use all stairways and safe elevators. It would require the help of everyone available. This action must be undertaken floor by floor with enough trained help above and below to keep traffic moving quickly and properly by stairs and elevator.

Untrained or unassigned personnel would report to the manpower pool under the direction of personnel. Remember this, more good work could be accomplished and less panic created by the work of two dozen competent people than by 300 anxious but untrained volunteers.

There should be carrying teams to get the patients downstairs and fire escapes. These practically trained people should be called loaders, movers and carriers. It would certainly be a much more orderly arrangement than for a single team to tackle all three phases.

<u>Emergency Removal</u>

In a Healthcare facility fire, the first duty of the personnel is to remove the patient(s) who are in immediate danger. This may require moving one person or many. If eight out of twenty-five are helpless as acknowledged, then it seems sensible to assume that the proper time to learn removal techniques would be before rather than during the fire.

Three considerations may be dominant factors in emergency patient handling:
1. The nature of the emergency
2. The weight and condition of the patient
3. The strength and adaptability of the rescuer

Of all the possible equipment for evacuation, the BLANKET is more important than any other. It can be used to smother fire, drag a patient from the room, made into a stretcher with or without poles, used for carrying in halls, on stairs, or fire escapes. Eight or ten infants can be carried easily and safely in a blanket.

There should be no uncertainty in bed fires. The rule is to get the patient on the floor. In oxygen tank fire: FIRST SHUT OFF THE OXYGEN, THEN GET THE PATIENT ON THE FLOOR. In both situations, if you throw a blanket on the floor, you can use it to smother fire or as a drag. The fear of handling people who are on fire is undeserved. Bodies do not burn, they cook. So really all you have to contend with is the night clothing and the hair, once you free the patient from the bed.

In case of fire, do not be surprised to find the patient on the floor. He/she will get out of the bed if he/she can. If the patient is supposed to be in the room and you cannot see or feel him, look under the bed, or in the closets or elsewhere.

Earthquake/Disaster Preparedness

1. Attempt to familiarize yourself with the facility/unit earthquake preparedness plan. You can reduce injuries to co- workers and patients and lessen the possibility of panic after the disaster has occurred by planning for all eventualities.

2. At least 2 persons in each unit or on each floor should assume leadership roles after the disaster has occurred. It is the facility's responsibility to be sure they are properly trained.

3. Understand how to protect yourself (and patients if possible) during an earthquake: Get under a desk or table or stand in a doorway away from the glass. Do not leave the building during the quake.

4. Attempt to locate and have available for immediate use, the telephone numbers and alternative means of communication with public safety agencies. When given the chance, participate in drills; take advantage of the opportunity to prepare for possible disasters.

5. In medication rooms, patient rooms, clean and dirty utility rooms be aware of high or top-heavy shelves, cabinets, machinery or any other equipment that could fall during a tremor. Heavy objects should not be on top shelves, but stored in lower places.

6. Be aware of possible necessity to shut off lights, gas and water.

7. Attempt to locate several alternate routes of evacuation in the various parts of the unit and or facility, should you need to leave your work area because it is unsafe.

8. Consider the possibility that you may not be able to leave the premises and attempt to locate supplies on hand that may be needed.

9. Provide assistance for physically compromised patients and co-workers who are unable to leave the building without the aid of another person.

10. Attempt to locate areas of the facility that may be suitable as shelter areas should employees and patients be required to stay there after the disaster.

11. Be sure the fire extinguishers are kept in good working order and that you know how to use them.

12. If your building is windowless, consider alternative means of ventilation and lighting if the power is off.

13. Attempt to locate contingency plans for continued operation of the Health Care facility based on total and/or partial shutdowns due to building/utility/communication/transportation failures. Try to identify key personnel, communication systems, utilities and other support needs for 24 hours, 72 hours, one week and one month, if available.

14. Organize the Interdisciplinary Team and patients for whom they are responsible and determine what steps are to be taken in accordance with the Health Care facility's earthquake plans.

15. Immediately check for injuries among fellow workers and render first aid as needed. Seriously injured persons should not be moved unless they are in danger of further injury. Be sure your entire area is checked for the injured.

16. In the event of fatalities, cover bodies and notify the coroner. They should not be moved.

17. Check for fires and fire hazards, especially for gas leaks and damaged electrical wiring.

18. See that these are turned off at main values and switches if required. Check for building damage and move patients to safe areas.

19. Do not use elevators or run into the street.

20. Flashlights should be used if power is off, since sparks from a match or light switch could ignite leaking gas.

21. Immediately clean up dangerous materials that may have spilled.

22. Limit use of "land-line" and mobile telephones for outside calls except in genuine emergencies. Use battery-powered radios for damage reports and information from public safety agencies.
23. Check closets and storage areas very carefully, watching for falling objects.

24. After a major earthquake prepare for aftershocks which will be occurring and may cause more damage.

25. Check that all telephones are correctly "on hook" so the system does not indicate "busy" to incoming or internal calls.

ELECTRICAL SAFETY

Much of the work to support patient care depends on electrical devices. A few basic reminders will help you to maintain a safe workplace.

- All outlets are "grounded" outlets, accepting three-prong plugs. Never try to introduce another kind of plug into the outlets.
- Water and electricity is a bad mix. Never try to plug something in, or run an appliance, if water is in the area. Clean up the water first. Electricity passes easily through water and can cause serious harm to you and others around you.
- If you notice an electrical hazard, contact your supervisor immediately.

CHEMICAL SAFETY/HAZARDOUS COMMUNICATIONS

A variety of chemicals are used to support patient care, including things as simple as cleaning agents or complicated medications such as chemotherapy drugs. It is your legally protected right to know about these chemicals.

Understanding the Material Safety Data Sheet (MSDS)

The Hazard Communication Standard is also known as the Workers' Right-to-Know standard. You have the right to know about the chemical hazards in your workplace. The MSDS and manufacturer's product label(s) are a fast and easy way to obtain information about how to work safely with a specific product.

A hazardous substance is one, which causes physical or related health hazards, may be found on Lists issued by the State of California such as: "List of Regulated Substances," "Pesticide 200 Ingredients" and/or "The Safe Drinking Water and Toxic Enforcement Act of 1986" also popularly known as "Proposition 65."

Information within the MSDS

1. Identification of product: You will find the product name, manufacturer's name, address, telephone and emergency number.
2. Hazardous ingredients: Lists of all the ingredients in the product.
3. Physical data: Provides information on how to work with the chemical and describes the physical characteristics.
4. Fire and Explosion Hazard data: Specifies if the material may present a fire or explosive hazard and under what conditions the hazard exists.
5. Health hazard data: Identifies the symptoms related to overexposure (nausea, vomiting, and dizziness).
6. Reactivity Data: Describes what materials will react with the chemical you're using.
7. Spill/leak procedures: Addresses how to respond to an accident spill or leak.

8. Control measures and special precautions: Specifies the type of PPE that you should wear when handling the product.
9. Handling and storage precautions: Describes how to safely store and handle materials.

The following are examples of some important information one may find on an MSDS.

Physical Hazards

The coverage of physical properties associated with the specific material may include the following information:

1. Compressed gas: such as high-pressure oxygen and nitrous oxide cylinders.
2. Explosive: substance that can explode under certain conditions of release.
3. Flammable or combustible: substance that burns easily such as alcohol.
4. Organic peroxide: derivative of hydrogen peroxide.
5. Pyrophoric: ignites spontaneously in air under certain conditions.
6. Unstable: reactive substance.
7. Water reactive: such as strong acids and bases when mixed with water.

Health Hazards

Disseminated as hazardous to your health are chemical substances. Both liquids and solids may be identified on a MSDS and are indicated as:

1. Carcinogens: these cause cancer, reproductive toxicity in males or females, reproductive toxins can result in fetus damage.
2. Toxic: a substance that acts as a poison.
3. Irritants: these may cause irritation to any body part.
4. Corrosives: these can cause damage to body tissue.
5. Sensitive: these can cause allergic reactions.
6. Hepatotoxin: this is a liver poison.
7. Nephrotoxin: this is a kidney poison.
8. Neurotoxin: this is a nerve poison.
9. Hematopoietic System: Act on the system resulting in blood poisoning.
10. Substance compounds: damaging to lungs, skin, eyes or mucous membranes upon contact.

Acute and Chronic Exposure

An acute exposure is a short-term exposure to a substance and can cause dermatitis, headaches, or rashes.
A chronic exposure is a long-term exposure and can cause cancer or permanently damage a biological system.

Routes of Entry

1. Through inhalation (painting, stripping floors, anesthesia gas waste).
2. Through absorption (handling formaldehyde and glutaraldehyde).
3. Through ingestion (this can occur if you handle poisonous chemicals and do not wash your hands before eating, smoking or applying cosmetics. This can also occur if containers are not properly handled, labeled, sealed).
4. Injection (accidental needle sticks).

Your responsibilities when handling hazardous materials

1. Read the label and MSDS of new chemicals you are working with.
2. Follow warnings and precautions
3. Use appropriate PPE
4. Learn emergency procedures for the chemicals with which you work.
5. Act in a sensible manner, be a safe and responsible worker.
6. Never use hazardous material substances you're not trained to use
7. Never place a chemical substance into an unlabeled container.
8. Never mix substances without asking your supervisor first.
9. Always ask your supervisor if you have a question about any substance.

Handling Hazardous Materials

Infectious waste: Separate infectious waste from other waste as soon as the material becomes a waste

Blood or body fluids: Minimize your risk by containing, removing, and disinfecting all blood or body fluid spills as quickly and effectively as possible.

Wear PPE: PPE stands for "Personal Protective Equipment." A PPE is an item you use for safety when working with chemicals. Some examples of PPE are Utility gloves, Safety glasses, Goggles, Gowns, Ventilators and Masks PPE is listed on the MSDS (Material Safety Data Sheet) for all the chemicals you work with. The PPE necessary for each substance are determined by the ways the substance can harm you.

There are three ways that a chemical substance may harm you:

- Breathing the chemical
- Having physical contact with the chemical
- Swallowing the chemical

Breathing the chemical
The chemical may have toxic fumes that can injure your lungs if you breathe them. For example, cleaning materials, especially bleach, are toxic when inhaled.
Appropriate PPE for toxic fumes may include:

- Special mask
- Ventilator

In addition, always use these products in a well-ventilated area. If you begin to feel dizzy or weak or have difficulty breathing when using a product, you need to leave the area immediately.

Having physical contact with the chemical
The chemical may injure any part of the body that comes in contact with it. Your eyes are in danger from liquid splashing into them. Any exposed skin is also at risk.

Appropriate PPE to prevent physical contact may include:

- Goggles, safety glasses, or other eye protection
- Gown
- Gloves
- Mask

In addition, flushing with water is usually the most immediate treatment for any accidental splashing of solutions in your eyes or on your skin.

Swallowing the chemical
Some chemicals are dangerous if swallowed. To prevent swallowing a solution that may have splashed on your fingers, always wash your hands thoroughly after coming in contact with anything that should not be swallowed.
Appropriate PPE to prevent swallowing may include:

- Mask (that covers your nose and mouth to prevent the solution from being splashed onto your lips)
- Gloves (to protect against hand to mouth transfer).

In addition, if you should accidentally swallow a harmful chemical, tell your supervisor immediately. You will probably be sent to the Employee Health Nurse or to your Emergency Department.

THE JOINT COMMISSION EDUCATION

The Joint Commission emphasizes prevention - identifying problems and correcting them before anything happens. The organization has definitions that you need to know for the following terms:

- Error

- Sentinel Event
- Near Miss
- Hazardous Condition

Error

An Error is an unintended act of either omission or commission, or an act that does not achieve its intended outcome. In other words, an Error is:

- Something was done by accident
- Something that should have been done but was not
- Something that was done that did not have the expected result.

An example of an Error is a patient's blood pressure not being measured when it should have been.

Sentinel Event

A Sentinel Event is an unexpected occurrence **that actually happened** and which either resulted in death or serious physical or psychological injury or carried a significant risk thereof. Serious injury specifically includes loss of limb or function.

An example of a Sentinel Event is the wrong dose of medication being given to an infant, causing death.

Certain types of events are reported to The Joint Commission under their Sentinel Event policy, whether they actually or potentially resulted in death or serious injury. These events are:

- Rape
- Patient suicide
- Infant abduction or discharge to the wrong family
- Hemolytic transfusion reaction involving the administration of blood or blood products
- Surgery on the wrong patient or wrong body part.

Near Miss

This term is used to describe any process variation which could have led to a Sentinel Event, but the Sentinel Event did not actually happen because of some kind of intervention. A recurrence of the process variation carries a significant chance of a serious adverse outcome.

Here is an example of a Near Miss. By mistake, a patient is handed a medication to which she is allergic, and which could lead to death or serious illness. Fortunately, she recognizes the medication is different from what she is usually given, questions staff about it, and ultimately receives the correct medication, instead. In this case, the process variation is that the patient is not wearing a wrist band listing her allergies, and that the information about her allergies is not available to staff anywhere else.

Hazardous Condition

This refers to any set of circumstances (other than the disease or condition for which the patient is being treated) which significantly increases the likelihood of a serious adverse outcome.

In other words, a Hazardous Condition is:

- Something that could cause the patient harm.
- Something other than the patient's disease or condition.

An example of a Hazardous Condition is a power outage and simultaneous failure of the back-up generator that shuts down life-support systems for some patients, meaning staff must manually ventilate affected patients until power is restored.

All Healthcare facilities must have a plan to identify risks to patient safety. They must also have policies for reporting and investigating sentinel events, near misses, and hazardous conditions.

ANNUAL NATIONAL PATIENT SAFETY GOALS

The National Patient Safety Goals are derived primarily from informal recommendations made in The Joint Commission's safety newsletter, Sentinel Event Alert. The Sentinel Event database, which contains de-identified aggregate information on sentinel events reported to The Joint Commission, is the primary, but not the sole, source of information from which the Alerts, as well as the National Patient Safety Goals, are derived. The following National Safety Goals are for Assisted Living Facilities (ALFs), Skilled Nursing Facilities (SNFs), and Hospitals.

1. Identify Patients and Residents Correctly (ALL)
    - Use at least two patient identifiers whenever administering medications or blood products; taking blood samples and other specimens for clinical testing or providing any other treatments or procedures. This is to ensure the correct resident or patient is receiving the correct medication, treatment, specimen collection, etc. For example, use the patient's name **and** date of birth.
    - **Do Not Use** the patients or resident's room number or physical location identifier.
    - Label containers used for blood and other specimens **in the presence** of the resident.
    - Use distinct methods of identification for newborn patients (Hospitals Only)
        - Examples of methods to prevent misidentification may include the following:
            - Distinct naming systems could include using the mother's first and last names and the newborn's gender (for example, "Smith, Judy Girl" or "Smith, Judy Girl A" and "Smith, Judy Girl B" for multiples).
            - Standardized practices for identification banding (for example, using two body sites and/or bar coding for identification).
            - Establish communication tools among staff (for example, visually alerting staff with signage noting newborns with similar names).

2. Improve staff communication (Hospitals).
    - Get important test results to the right staff person on time.
    - Critical results of tests and diagnostic procedures fall significantly outside the normal range and may indicate a life-threatening situation. The objective is to provide the responsible licensed caregiver these results within an established time frame so that the patient can be promptly treated.
    - Learn and follow the facility's protocols for critical results of tests and diagnostic procedures, including:
        - The definition of critical results of tests and diagnostic procedures
        - By whom and to whom critical results of tests and diagnostic procedures are reported
        - The acceptable length of time between the availability and reporting of critical results of tests and diagnostic procedures.

3. Use medications safely (ALFs and SNFs)
    - Take extra care with patients or residents who take anticoagulants, medicines to thin their blood. (SNF)
        - Follow your facility's protocols and evidence-based practice guidelines for reversal of anticoagulation and management of bleeding events related to each anticoagulant medication.
        - Provide education from the facility to your patients, residents, and families specific to the anticoagulant medication prescribed, including the following:
            - Adherence to medication dose and schedule
            - Importance of follow-up appointments and laboratory testing (if applicable)
            - Potential drug–drug and drug–food interactions
            - The potential for adverse drug reactions.
        - When your facility has them available, only use oral unit-dose products, prefilled syringes, or premixed infusions.
        - Note: For pediatric patients and residents, prefilled syringe products should be used only if specifically designed for children.

- When heparin is administered intravenously and continuously, use the facility's programmable pumps in order to provide consistent and accurate dosing.

- Record and pass along correct information about a patient's or resident's medicines. Find out what medicines they are taking.
  - Obtain information (for example, name, dose, route, frequency, duration, purpose) on the medications the resident is currently taking when they move into, admitted, or is accepted into the facility. This information is documented in a list or other format designated by your facility that is useful to those who manage medications.
  - This information is updated whenever the resident's medications change, for example, after treatment in another setting, such as a hospital or physician's office.

- Compare those medicines to new medicines given to the patient or resident. Give them written information about the medicines they need to take. Tell the patient or resident it is important to bring their up-to-date list of medicines every time they visit a healthcare provider.
  - Current medications include those taken at scheduled times and on an as-needed basis. Contact the prescriber with any concerns about specific medications.
  - Provide a good faith effort to obtain complete information on current medications from a patient, resident, and/or other sources.
  - Compare the medication information the resident brought to the facility with the medications ordered for the resident by the physician or other licensed practitioner to identify and resolve discrepancies.
  - Discrepancies include omissions, duplications, contraindications, unclear information, and changes. A qualified individual, identified by the facility, does the comparison.
  - Provide the patient or resident (or family as needed) with written information on the medications the patient or resident should be taking when they leave the organization's care (for example, name, dose, route, frequency, duration, purpose), **(SNF only).**
  - Explain the importance of managing medication information to the patient or resident when they leave the organization's care.
    - Examples include instructing the patient or resident to give a list to their primary care provider; to update the information when medications are discontinued, doses are changed, or new medications (including over-the-counter products) are added; and to always carry medication information in the event of emergency situations, **(SNF only)**

4. Use medications safely (Hospitals)
   - **Before a surgery or procedure**, label all medications, medication containers, and other solutions on and off the sterile field in perioperative and other procedural settings for safe medication management. Medication containers include syringes, medicine cups, and basins.
     - In perioperative and other procedural settings **both on and off the sterile field**:
       - Label medications and solutions that are not immediately administered. This applies even if there is only one medication being used.
         - Note: An immediately administered medication is one that an authorized staff member prepares or obtains, takes directly to a patient, and administers to that patient without any break in the process.
       - Labeling occurs when any medication or solution is transferred from the original packaging to another container.
       - Medication or solution labels include the following:
         - Medication or solution name
         - Strength
         - Amount of medication or solution containing medication (if not apparent from the container)
         - Diluent name and volume (if not apparent from the container)
         - Expiration date and time
           - The date and time are not necessary for short procedures, as defined by the hospital.
       - All medications and solutions and their labels are reviewed by entering and exiting staff responsible for the management of medications.
     - Verify all medication or solution labels both verbally and visually. Verification is done by two individuals qualified to participate in the procedure whenever the person preparing the medication or solution **is not** the person who will be administering it.
     - Label each medication or solution as soon as it is prepared unless it is immediately administered.
     - Immediately discard any medication or solution found unlabeled.

- Remove all labeled containers on the sterile field and discard their contents at the conclusion of the procedure. This does not apply to multiuse vials that are handled according to infection control practices.

- **Take extra care with patients who take anticoagulants**. Follow the hospital's approved protocols & procedures, and evidence-based practice guidelines for:
  - The initiation and maintenance of anticoagulant therapy that address medication selection; dosing, including adjustments for age and renal or liver function; drug–drug and drug–food interactions; and other risk factors as applicable.
  - The reversal of anticoagulation and management of bleeding events related to each anticoagulant medication.
  - The perioperative management of all patients on oral anticoagulants.
    - Note: Perioperative management may address the use of bridging medications, timing for stopping an anticoagulant, and timing and dosing for restarting an anticoagulant.
  - Addressing the need for baseline and ongoing laboratory tests to monitor and adjust anticoagulant therapy.
    - Note: For all patients receiving warfarin therapy, use a current international normalized ratio (INR) to monitor and adjust dosage. For patients on a direct oral anticoagulant (DOAC), follow evidence-based practice guidelines regarding the need for laboratory testing.
  - Identifying, responding to, and reporting adverse drug events, including adverse drug event outcomes
  - Evaluating anticoagulation safety practices, taking actions to improve safety practices, and measuring the effectiveness of those actions in a time frame determined by the hospital.
  - Providing education to patients and families specific to the anticoagulant medication prescribed, including the following:
    - Adherence to medication dose and schedule
    - Importance of follow-up appointments and laboratory testing (if applicable)
    - Potential drug–drug and drug–food interactions
    - The potential for adverse drug reactions.
  - When the has them available, only use oral unit-dose products, prefilled syringes, or premixed infusions.
    - Note: For pediatric patients and residents, prefilled syringe products should be used only if specifically designed for children.
  - When heparin is administered intravenously and continuously, use the facility's programmable pumps in order to provide consistent and accurate dosing.

- **Maintain and communicate accurate patient medication information**:
  - Obtain information on the medications the patient is currently taking when they are 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.
  - Define the types of medication information (for example, name, dose, route, frequency, purpose) to be collected in non-24-hour settings.
    - Note: Examples of non-24-hour settings include the emergency department, primary care, outpatient radiology, ambulatory surgery, and diagnostic settings.
  - 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.
  - Provide the patient (or family, caregiver, or support person as needed) with written information on the medications the patient should be taking when they are discharged from the hospital or at the end of an outpatient encounter (for example, name, dose, route, frequency, purpose).
  - Explain the importance of managing medication information to the patient when they are discharged from the hospital or at the end of an outpatient encounter.
    - Note: Examples include instructing the patient to give a list to their 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.

5. Use Alarms Safely (Hospitals)
   - Clinical alarm systems are intended to alert caregivers of potential patient problems, but if they are not properly managed, they can compromise patient safety.
     - Recognize that alarm system safety is a hospital and patient safety priority.
     - Provide input as appropriate on the most important alarm signals based on the risk to patients :
       - if the alarm signal is not attended to or if it malfunctions,
       - if specific alarm signals are needed or unnecessarily contribute to alarm noise and alarm fatigue
   - Follow the hospital's policies and procedures for managing the alarms including:
     - Clinically appropriate settings for alarm signals
     - When alarm signals can be disabled
     - When alarm parameters can be changed
     - Who in the organization has the authority to set alarm parameters, change them, or set them to "off".
     - Monitoring and responding to alarm signals
     - Checking individual alarm signals for accurate settings, proper operation, and detectability
   - Complete any hospital education as requested on purpose and proper operation of alarm systems for which you are responsible.

6. Prevent infection (ALL).
   - Comply with current hand cleaning guidelines from the Centers for Disease Control and Prevention (CDC) or the World Health Organization (WHO).
   - Set and use goals for improving hand cleaning.

7. Prevent patients and residents from falling (ALFs and SNFs)
   - Find out which patients and residents are most likely to fall. For example, is the patient or resident taking any medicines that might make them weak, dizzy or sleepy? Take action to prevent falls for these patients and residents. See Fall Prevention section.

8. Prevent bed sores (SNF)
   - Find out which patients and residents are most likely to have bed sores. Take action to prevent bed sores in these patients and residents. From time to time, re-check patients and residents for bed sores. See Pressure Injuries (Bed Sore, Pressure Ulcers) Prevention section.

9. Identify patient safety risks (Hospitals)
   - **Reduce the risk of suicide.** Suicide of a patient while in a staffed, round-the-clock care setting is a frequently reported type of sentinel event. Identification of individuals at risk for suicide while under the care of or following discharge from a health care organization is an important step in protecting these at-risk individuals.
     - For psychiatric hospitals and psychiatric units in general hospitals:
       - The hospital conducts an environmental risk assessment that identifies features in the physical environment that could be used to attempt suicide; the hospital takes necessary action to minimize the risk(s) (for example, removal of anchor points, door hinges, and hooks that can be used for hanging).
     - For nonpsychiatric units in general hospitals:
       - Follow the hospital's procedures to decrease the risk of suicide for patients at high risk for suicide, such as one-to-one monitoring, removing objects that pose a risk for self-harm if they can be removed without adversely affecting the patient's medical care, assessing objects brought into a room by visitors, and using safe transportation procedures when moving patients to other parts of the hospital.
       - Follow hospital policies on routinely assessing clinical areas to identify objects that could be used for self-harm and remove those objects, when possible, from the area around a patient who has been identified as high risk for suicide.
       - Complete any requested hospital training or checklists to identify equipment that should be removed if monitoring a high-risk patient.
     - Follow hospital policies and procedures, screen all patients for suicidal ideation who are being evaluated or treated for behavioral health conditions as their primary reason for care using a validated screening tool

- Follow the hospital's evidence-based process to conduct a suicide assessment of patients who have screened positive for suicidal ideation. The assessment directly asks about suicidal ideation, plan, intent, suicidal or self-harm behaviors, risk factors, and protective factors.
- Document patients' overall level of risk for suicide and the plan to mitigate the risk for suicide.
- Follow written policies and procedures addressing the care of patients identified as at risk for suicide.
    - At a minimum, these should include the following:
        - Training and competence assessment of staff who care for patients at risk for suicide.
        - Guidelines for reassessment
        - Monitoring patients who are at high risk for suicide
- Follow hospital written policies and procedures for counseling and follow-up care at discharge for patients identified as at risk for suicide.
- Comply with hospital policies and procedures for screening, assessment, and management of patients at risk for suicide.

10. Improve Health Equity (Hospitals)

- Improving health care equity for the hospital's patients is a quality and safety priority.
- The hospital designates an individual(s) to lead activities to improve health care equity for the hospital's patients.
- The hospital assesses the patient's health-related social needs (HRSNs) and provides information about community resources and support services.
    - Note 1: Hospitals determine which HRSNs to include in the patient assessment. Examples of a patient's HRSNs may include the following:
        - Access to transportation
        - Difficulty paying for prescriptions or medical bills
        - Education and literacy
        - Food insecurity
        - Housing insecurity
- The hospital identifies health care disparities in its patient population by stratifying quality and safety data using the sociodemographic characteristics of the hospital's patients.
- Follow the hospital's written action plan and policy that describes how it will improve health care equity by addressing at least one of the health care disparities identified in its patient population.

11. Prevent errors in surgery (Hospitals)

- **Conduct a pre-procedure verification process**. Hospitals should always make sure that any procedure is what the patient needs and is performed on the right person. The frequency and scope of the verification process will depend on the type and complexity of the procedure.
    - Follow the hospital's preprocedural process to verify the correct procedure, for the correct patient, at the correct site. Involve the patient in verification process when possible.
    - Identify the items that must be available for the procedure and use a standardized list to verify their availability. At a minimum, these items include the following:
        - Relevant documentation (for example, history and physical, signed procedure consent form, nursing assessment, and pre-anesthesia assessment)
        - Labeled diagnostic and radiology test results (for example, radiology images and scans, or pathology
        - and biopsy reports) that are properly displayed.
        - Any required blood products, implants, devices, and/or special equipment for the procedure
            - Note: The expectation of this element of performance is that the standardized list is available and is used consistently during the preprocedural verification. It is not necessary to document that the standardized list was used for each patient.
    - Match the items that are to be available in the procedure area to the patient.

- **Mark the procedure site**
    - Identify those procedures that require marking of the incision or insertion site. At a minimum, sites are marked when there is more than one possible location for the procedure and when performing the procedure in a different location would negatively affect quality or safety.
        - Note: For spinal procedures, in addition to preoperative skin marking of the general spinal region, special intraoperative imaging techniques may be used for locating and marking the exact vertebral level.

- Mark the procedure site before the procedure is performed and, if possible, with the patient involved by a licensed independent practitioner who is ultimately accountable for the procedure and will be present when the procedure is performed. In limited circumstances, the licensed independent practitioner may delegate site marking to an individual who is permitted by the hospital to participate in the procedure and has the following qualifications:
    - An individual in a medical postgraduate education program who is being supervised by the licensed independent practitioner performing the procedure; who is familiar with the patient; and who will be present when the procedure is performed.
    - A licensed individual who performs duties requiring a collaborative agreement or supervisory agreement with the licensed independent practitioner performing the procedure (that is, an advanced practice registered nurse [APRN] or physician assistant [PA]); who is familiar with the patient; and who will be present when the procedure is performed.
        - Note: The hospital's leaders define the limited circumstances (if any) in which site marking may be delegated to an individual meeting these qualifications.
    - The method of marking the site and the type of mark is unambiguous and is used consistently throughout the hospital. Note: The mark is made at or near the procedure site and is sufficiently permanent to be visible after skin preparation and draping. Adhesive markers are not the sole means of marking the site.
    - A written, alternative process is in place for patients who refuse site marking or when it is technically or anatomically impossible or impractical to mark the site (for example, mucosal surfaces or perineum).
        - Note: Examples of other situations that involve alternative processes include: - Minimal access procedures treating a lateralized internal organ, whether percutaneous or through a natural orifice - Teeth - Premature infants, for whom the mark may cause a permanent tattoo.

- **A time-out is performed before the procedure** as a final assessment that the correct patient, site, and procedure are identified.
    - Follow hospital procedures on conducting or participating in a time-out immediately before starting the invasive procedure or surgical incision.
    - The time-out has the following characteristics:
        - It is standardized, as defined by the hospital.
        - It is initiated by a designated member of the team.
        - It involves the immediate members of the procedure team, including the individual performing the procedure, the anesthesia providers, the circulating nurse, the operating room technician, and other active participants who will be participating in the procedure from the beginning.
    - When two or more procedures are being performed on the same patient, and the person performing the procedure changes, perform a time-out before each procedure is initiated.
    - During the time-out, the team members agree, at a minimum, on the following:
        - Correct patient identity
        - The correct site
        - The procedure to be done
    - Document the completion of the time-out.
        - Note: The hospital determines the amount and type of documentation.

DO-NOT-USE LIST

The Joint Commission has created a list of abbreviations, acronyms, symbols, and dose designations that are not to be used throughout the organization. The Do-Not-Use list applies to all orders and medication-related documentation and information that is handwritten or computer entered as free text

Do Not Use	Why	Use Instead
U (unit)	Mistaken for “0” (zero), the number “4” (four) or “cc”	Write “unit”

IU (International Unit)	Mistaken for IV (intravenous) or the number 10 (ten)	Write "International Unit"
Q.D., QD, q.d., qd (daily) D.O.D., QOD, q.o.d., qod (every other day)	Mistaken for each other. Period after the Q mistaken for "I" and the "O" mistaken for "I"	Write "daily" Write "every other day"
Trailing zero (X.0 mg)* Lack of leading zero (.X mg)	Decimal point is missed	Write X mg Write 0.X mg
MS MSO_4 and $MgSO_4$	Can mean morphine sulfate or magnesium sulfate. Confused for one another.	Write "morphine sulfate" Write "magnesium sulfate"

INFECTION CONTROL: UNIVERSAL PRECAUTIONS AND BLOODBORNE PATHOGENS

IntelyCare, Inc. strives to educate employees on nosocomial infections and their method of transmission and to provide education on work practices; engineering control and personal protective equipment prevent the spread of nosocomial infections.

Nosocomial Infections

Nosocomial infections are infections which are a result of treatment in a Healthcare facility or a healthcare service unit, but secondary to the patient's original condition. Infections are considered nosocomial if they first appear 48 hours or more after Health Care facility admission or within 30 days after discharge. This type of infection is also known as a Healthcare facility-acquired infection.

Nosocomial infections are even more alarming in the 21st century as antibiotic resistance spreads. Reasons why nosocomial infections are so common include:

- Health Care facilities house large numbers of people who are sick and whose immune systems are often in a weakened state.
- Increased use of outpatient treatment means that people who are in the Healthcare facility are sicker on average;
- Medical staff move from patient to patient, providing a way for pathogens to spread;
- Many medical procedures bypass the body's natural protective barriers;
- Routine use of anti-microbial agents in Health Care facilities creates selection pressure for the emergence of resistant strains

The Spread of Germs

Germs can be spread through 4 different modes of transmission

1. Airborne transmission: Occurs by dissemination of either airborne droplet nuclei (small-particle residue of evaporated droplets containing microorganisms that remain suspended in the air for long periods of time) or dust particles containing the infectious agent. Microorganisms transmitted by airborne transmission include *Mycobacterium tuberculosis* and the rubeola and varicella viruses.
2. Droplet transmission: Contact of the mucous membrane of the nose, mouth or eye with infectious articles can be produced by coughing, sneezing, talking or procedures such as bronchoscopy or suctioning. Droplet transmission requires close contact between the source and the susceptible person because particles remain airborne briefly and can travel. Microorganisms transmitted by droplet transmission include the common cold and flu.

3. Blood borne transmission: Germs can live in the bloodstream and in other body fluids that contain blood components. A person's skin prevents germs from entering into the body, but if the skin is broken because of a cut, it is possible for infected blood of another individual to enter. Mucous membranes, found in the mouth, vagina, or rectum may also allow germs to

spread through contact with blood and/or secretions containing blood. Unprotected sexual contact can lead to this method of transmission.

4. Direct Contact Method: Infectious agents can spread directly or indirectly from one infected person to another, often on contaminated hands. The best protection is proper hand washing (Please see Centers for Disease Control and Prevention Hand Hygiene Guideline for more information on proper hand washing).

General Prevention

General steps to follow to prevent the spread of germs are:

- Following the Infection Control policies of your facility
- Identifying the people, patients, and staff, who are most at risk
- Washing your hands
- Staying healthy by getting plenty of rest, eating properly, and exercising
- Getting vaccinated against flu and hepatitis B
- Washing your hands
- Following the standard recommended precautions with everyone
- NOT coming to work if you are sick.

CDC HAND HYGIENE GUIDELINES

Improved adherence to proper hand hygiene has been shown to terminate outbreaks in health care facilities, to reduce transmission of antimicrobial resistant organisms and reduce overall infection rates.

The Centers for Disease Control (CDC) has released the following guidelines to improve adherence to hand hygiene in health care settings.

The six steps in routine hand washing are:

1. Wet hands thoroughly under running water. Warm or hot water is best.
2. Lather with soap from a dispenser
3. Wash hands thoroughly, for 20 seconds, using friction. Be sure to include the backs, palms, wrists, between fingers, and under fingernails.
4. Rinse hands thoroughly under running water.
5. Leave the water running and use a paper towel or an air dryer to dry hands thoroughly.

The four steps to round alcohol hand rubs are:

1. Pour the alcohol hand rub in the palm of one hand
2. Rub both hands together
3. Rub all parts of the wrist, hand, and fingers
4. Rub until completely dry

STANDARD PRECAUTIONS

Standard Precautions combine the major elements of Universal Precautions and Body Substance Isolation. Standard Precautions call for the use of gloves and other personal protective equipment to guard against anticipated or accidental contact with any body fluid, secretion, or excretion.

Personal Protective equipment is to be utilized when there is a break in the skin or when working around mucus membranes. All employees shall follow Standard Precautions in order to minimize and/or eliminate exposure to blood-borne pathogens and communicable diseases. All body substances shall be treated as a potential source of infection and all facilities shall provide an adequate supply of Personal Protective Equipment in appropriate sizes to ensure all personnel have access when required.

At a minimum, all employees should follow these basic practices:

1. Hand protection

Protect your hands by wearing latex/hypoallergenic gloves (the correct size) when:

- Emptying a Foley catheter
- Emptying a bedpan
- Starting an IV
- Dealing with trauma in the emergency room
- Pricking the finger for blood glucose
- Handling blood specimens
- Drawing arterial or venous blood
- Cleaning biomedical equipment.

2. Body protection

Wear gown, mask, and goggles to cover any part of your body that could be splashed or sprayed (or otherwise come in contact with) the blood and/or body fluids of another person (for example, when caring for a trauma patient in the Emergency Department or when assisting in a procedure where exposure is possible).

3. General protection

- Dispose of all materials containing blood in the proper waste containers.
- Use a barrier device instead of performing direct mouth-to-mouth ventilations during CPR.
- Avoid contact with blood from needles by using safety devices provided by your facility.
- Never recap a needle (if you miss, you could jab your finger).
- Dispose of all sharps (needles, blades, IV catheters) in the proper disposal box.
- Wash your hands after removing gloves.
- Do not eat, drink, and apply make-up or contact lenses in areas where exposure to body fluids is possible.

OCCUPATIONAL SAFETY AND HEALTH ADMINISTRATION (OSHA) GUIDELINES

BLOODBORNE PATHOGENS

The Occupational Safety and Health Administration (OSHA) has a Standard which was developed to protect the healthcare worker. The Bloodborne Pathogen Standard addresses the potential exposure of healthcare workers to blood and body fluids in the work environment. Bloodborne pathogens are Hepatitis B, C and Human Immunodeficiency Virus (HIV).

Hepatitis

Hepatitis is a serious disease of the liver, an organ necessary for life. Hepatitis B and C, the two most serious kinds of hepatitis, are similar kinds of liver infection that are caused by different viruses. Methods of blood-borne transmission of both Hepatitis B and C include:

- Blood splashes from minor cuts and nosebleeds
- Procedures that involve blood (especially in health care)
- Hemodialysis (using kidney machines)
- Sharing personal items like nail clippers, razors, and toothbrushes
- Sharing needles for intravenous drug use

In order to prevent the spread of Hepatitis:

- Follow Standard Precautions.
- Receive the Hepatitis B vaccine at no cost, if you are not already immune to the virus.
- Maintain good personal hygiene habits.

Human Immunodeficiency Virus (HIV)

HIV is the virus that causes AIDS. A condition in which the immune system begins to fail, leading to life-threatening opportunistic infections. Once this virus enters and infects the body, the person is said to be "HIV Positive." However, the person may be infected with the virus for up to 10 years or more before developing AIDS. The routes of transmission for HIV are:

- Sexual route: Acquired through unprotected sexual relations, wherein infected sexual secretions of one partner come into contact with the genital, oral or rectal mucous membranes of another
- Blood/blood product route: Accounts for infections in intravenous drug users, hemophiliacs and recipients of blood transfusions and other blood products.
- Mother-to-child: Occurs in utero during pregnancy and intrapartum at childbirth.

In order to prevent the spread of HIV:

- Follow Standard Precautions
- Wear protective equipment
- Abstain from sex or sex-related activities when the HIV status of your partner is doubtful or not known.
- If you are HIV infected and pregnant, take appropriate medication to reduce the chances of passing the virus to your unborn child.
- If you are HIV infected, DO NOT breastfeed.
- NEVER share needles, including needles used for tattoos, body piercing, or injecting steroids.

Tuberculosis

Tuberculosis is a common and deadly infectious disease caused mainly BY *Mycobacterium tuberculosis*. Tuberculosis most commonly attacks the lungs (but can also affect the central nervous system, the lymphatic system, the circulatory system, the genitourinary system, bones, joints and even the skin. Tuberculosis is curable, but it involves taking medication for a very long time. TB is caused by airborne bacteria and spreads through coughing, sneezing, talking, laughing, and breathing.
Healthcare professionals and persons exposed to TB need to have a Purified Protein Derivative (PPD) skin test or a chest X-ray. Positive test results indicate the person is infected with TB but may not have TB disease. He or she may be given preventive therapy to kill germs that are not doing any damage now but, could break out later.

To protect yourself and others from contracting tuberculosis, follow your facility's recommended Special Precautions in addition to Standard Precautions.
Special Precautions for the treatment of TB patients:
- Place TB patients in private rooms.
- Ventilate rooms directly to the outside if possible, to prevent the circulation of TB germs to other areas of the facility.
- Wear a special "fit-tested" mask (and receive training in how to wear it correctly) when entering the room and while in the room.
- Explain to patients and visitors how to use special masks.
- Keep patients in their rooms as much as possible.
- Encourage patients to cough or sneeze directly into tissues and to dispose of them.
- Have patients wear masks when being transported to other areas of the Healthcare facility

Post Exposure and Follow up Plan

An exposure incident to blood borne pathogens involves specific eye, mouth, mucous membrane, or parenteral contact with blood or other potentially infectious materials that result from the performance of an employee's duties. All employees involved in direct patient care should be familiar with appropriate decontamination procedures, IntelyCare, Inc. shall make immediately available a confidential medical evaluation and follow-up the exposed individual. Post-exposure follow-up shall be:

- Made available at no cost to the employee
- Performed by or under the supervision of a licensed healthcare professional who has a copy of all relevant information related to the incident.
- Made available at a reasonable time and place.

IntelyCare, Inc.'s post-exposure and follow-up, shall include the following:

- Documentation of the route(s) of exposure, and the circumstances under which an exposure incident occurred.
- Identification and documentation of the source individual
- Collection and testing of blood for HIV and HBV serological status
- Post-exposure prophylaxis, as recommended by the U.S. Public Health Service
- Counseling

- Evaluation of reported illness

The company maintains confidential medical records for each employee with occupational exposure. Records are kept for the duration of employment plus thirty (30) years. Each record shall contain the employee's name, social security number, hepatitis B vaccine history, and a record of all post-exposure follow-up.

MEDICATION SAFETY AND DOCUMENTATION

What are medication errors?

Medication errors are errors involving drugs that cause, or could cause, harm to a patient. They may be errors in prescribing, dispensing or administering, and they include both errors that reach the patient as well as those errors that do not reach the patient. They can occur in any patient care area or in the pharmacy.

What are common sources of medication errors?

- Lack of knowledge about drugs: with so many new drugs being developed each year, it's never been more important to understand what each drug can do and how to use it properly.
- Lack of patient information: Ensuring medication safety means it's important to know key information about each patient, including his/her age, weight, clinical status, known drug allergies and use of other medications (herbs, supplement, vitamins, other holistic remedies) and the potential for interactions.
- Poor communication: Problems can result from things such as:
    - Not using standardized abbreviations
    - Handwriting that's hard to read
    - Verbal miscues (for example, mispronouncing a drug's name)
    - Unclear decimal points
- Storage and stocking of drugs: For example, the risk of someone picking up the wrong drug is higher when the two drugs are similarly packaged (but are very different).
- Equipment used to administer drugs: Variations in the design of IVs and infusion pumps can cause confusion. Poor maintenance and not understanding how to program automated equipment also increases the risk of medication errors.
- Patient identifications: A good system to identify patients, such as armbands, may be in place. However, the system must be utilized (i.e. the armbands must be checked) in order for it to work
- Distractions: Ringing telephones, too much conversation, and interruptions can cause even the most careful healthcare worker to lose concentration.

How can medication errors be prevented?

Contrary to popular belief, most medication errors are not due to a careless individual act but are related more directly to some type of system failure or inefficiency. Medication errors can be prevented if everyone in the organization:

- Works together across departments, including physicians, pharmacists, nurses, support staff and administrators
- Focuses on systems, which means improving procedures to help prevent mistakes.
- Takes blame away from employees and looks at the process(es) that led to the error
- Helps patients understand their medications, follow their treatment plans, and take an active role in their care at every step along the way.
- Uses benchmarks to compare challenges and successes of other health care organizations with their own.
- Reports errors voluntarily so that a root cause analysis can be done. A root cause analysis is a step-by-step method to understand what went wrong and why. It allows us to make improvements in a system and monitor changes to see how well they are working.

Medication Administration and safety

- Administered by a licensed nurse upon a written order by a staff physician
- Pour medications immediately before administration. No pre-pouring!

- Always check the patient ID band and Medication Sheet. Two forms of identification must be used.
- Patients must take all medications in the presence of the administering nurse.
- Medications can be given 1 hour before or 1 hour after the scheduled time.
- Double check all insulin, chemotherapy agents, anticoagulants and PCA narcotics with another licensed nurse.
- Practice the Seven Rights of Medication Administration
    1. The Right Patent
    2. The Right Medication
    3. The Right Dose
    4. The Right Time
    5. The Right Route
    6. The Right Reason
    7. The Right Documentation

Medication Documentation

- Document the time the medication was given on the Medication Administration Record (MAR)
- Include injection site for all injections
- Chart on the Nurses' Notes and MAR all PRN medications and the results
- When the patient is discharged, place all unused medications in a labeled bag and return to the pharmacy
- Document the medication at the time it is administered- No pre-charting!

Narcotics

- Two nurses must witness and sign any narcotic wasted.
- Every narcotic must be signed for on the narcotic sheet
- The narcotic count must be correct before you leave at the end of the shift. Discrepancies must be brought to the immediate attention of the unit manager/supervisor.

Intravenous - IV

- Nurse may monitor or discontinue IV therapy
- IV certified LVNs may start and superimpose IV fluids through a peripheral line
- Only an RN can add or regulate IV medications
- IV tubing is to be labeled at the time of initial use with the date, time and expiration date
- All IV tubing is to be changed every 72 hours, except TPN tubing, which is changed every 24 hours
- IV sites must be assessed every 2 hours

Why is clinical documentation so important?

- Communication
- Quality of care issues
- Compliance: reimbursement verification
- Fulfills federal, state, regulatory and accreditation requirements
- Supports if Standard of Care was met
- Memories fade, aids in defense in lawsuits when present
- May be used as teaching tools

Basic charting tips

- Use a pen, black ink is preferred
- Print legibly
- Date, time and sign all entries
- Don't use white out or obliterate entries
- Use approved abbreviations
- Record objective information- be clear and concise

Good Documentation Habits

- Use language that patient understands for discharge instructions and patient education material
- Documentation of actions, conversations with the patient, family members, physicians
- Documentation of safety precautions reviewed with the patient and/or family
- Description of unusual incidents
- Documentation of contacts with the provider

- Contemporaneous, chronological
- Do not editorialize, criticize, add 'hearsay'
- Avoid blaming another person or department
- Complete all boxes / forms accurately
- Do not leave open lines on records between documentation entries
- Verification informed consent was obtained
- Instructions given to patient/verbalization of understanding
- Do not alter entries

Alteration of Records

- Medical records should never be 'edited' after the fact
- Never document in anticipation of an event
- Never chart for someone else
  - Exceptions
    * Code situations
    * Supervisor starting an IV per your request
- You may be personally assessed for penalties related to falsification of documentation
- Alterations in a record can make the case indefensible

Late Entries

- Late entries are placing additional information in the medical record when pertinent information was missed or not written in a timely manner.
- A general guideline when late entries can be added is within 7 days. Consult your Supervisor or Risk Manager for guidance if necessary.
- Should not be used if there has been adverse outcome to patient or there is known litigation
- Must have a 'home' – notation should specify the date and time. See below.
  Example:
  4/20/07 1600: Late Entry for 4/19/07 at 0800:
  Patient also complained of pain at the base of the neck and bleeding from the nose. Dr. Jones notified. CT of head ordered along with CBC & diff, INR.

Corrections

Draw a single line through entry, initial; write the correct information. Review your Healthcare facility's policy for corrections. Sign and date the entry.

Example:
4/19/07 0800: Pt found on floor in ~~room~~ LN hallway; BP:165/66
VS: 36.8-136-20
Dr. Jones notified. Orders for MRI obtained

SUSPECTED ABUSE: IDENTIFICATION, TREATMENT AND REPORTING

Elder/Adult Abuse

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

Signs and Symptoms of Elder/Adult Abuse

- Patient or family member states that abuse is happening in the home
- Explanation for injuries is inconsistent with the injury
- Family or caregiver attempts to conceal injury
- Indications that someone is exploiting patient's finances or property
- Delay in seeking treatment
- Multiple bruises or injuries in various stages of healing

- Human bite marks
- Burns especially on back or buttocks
- Bruises in the shape of a hand or fingers
- Patient's behavior changes in the presence of the family or caregiver

Child Abuse

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

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

Signs and Symptoms of Child Abuse

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

NEGLECT

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

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

Signs and Symptoms of Elder/Adult Neglect, Including Self-Neglect

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

Signs and Symptoms of Child Neglect

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

Spousal/Partner Violence

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

Signs and Symptoms of Spousal/Partner Violence

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

Exploitation

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

- The treatment team may identify possible history of abuse, neglect, or exploitation

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

Abuse Reporting

It is the policy of all IntelyCare staff (both clinical and non-clinical) to report all instances of suspected abuse, neglect, or exploitation to the appropriate authorities. Any nurse, CNA, or employee having reasonable cause to believe that an individual (including elder adult) is being abused, neglected, or exploited, or is a condition which is the result of abuse, neglect, or exploitation will immediately report this belief to the appropriate State Authority, such as the Department of Public Health, in accordance to such authorities published guidelines.

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

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

NURSING ESSENTIALS

RESTRAINTS

It is the policy of IntelyCare, Inc. that the patient has the right to be free from any physical or chemical restraints unless it is necessary for the patient's safety or the safety of others. Restrictive devices/restraints will be applied when the safety of the patient and/or others are in jeopardy when less restrictive measures have proved inadequate. Restraints shall not be used in a manner that causes injuries. Employees must provide safely for patients and employees and prevent injuries.

IntelyCare does NOT consider this portion of this manual / orientation to be a sign off or competency on using restraints, however, this is an informational module on general best practices. You will be required to complete in-person training and understand each Licensed Healthcare Facilities internal policies and procedures prior to utilizing any restraints ordered by a Physician.

BEHAVIOR MODIFICATION RESTRAINT: "Behavior modification restraint means the use of a physical or mechanical device to involuntarily restrain the movement of the whole or a portion of a patient's body for the reason of controlling his/her physical activities in order to protect him/her or others from injury (such as the use of 5-point restraints to keep a patient from injury or soft ties to keep a confused patient from self-injury). The following are not behavior modification restraint:

1) Safety Restraint;
2) The use of side rails or, in the case of infants, the use of a safety net to keep patients from falling out of bed;
3) handcuffs applied by peace officers;
4) isolation for control of communicable disease.

Behavior modification restraints shall only be used when alternative methods are not sufficient to protect the patient or prevent injury.

There are two types of behavior modification restraint: psychiatric behavior modification restraint ("psychiatric restraint" used hereunder). A psychiatric restraint is used for patient with signs of acute mental illness who appear to be a danger to themselves or others. A medical restraint is used for patients whose primary diagnosis is medical and for whom psychiatric Healthcare facility ization is not indicated.

Of limbs, attention should be given to the patient's needs including hydration, elimination and nutrition. A report of the clinical assessment shall be recorded in the medical record. All restraints shall be released at least every two hours.

Medical Restraint with Permission of Patient/Family

When other forms of medical restraint are to be imposed (for example, to restraint a confused patient from pulling at naso-gastric tube or intravenous line), a separate consent should be obtained when possible. In the case of a minor, consent should be obtained from the parents or guardian. In the case of a confused or comatose adult, consent may be obtained from the immediate family or conservator.

Steps to follow:
1. A physician's order is required.
2. In addition to usual nursing evaluation and care, the patient's needs, including hygiene, elimination and nutrition, shall be assessed at least every two hours.
3. Supports shall be released at least every two hours.

Medical Restraint without Permission

It is not always possible to get the consent of the patient, family or conservator for the imposition of medical restraint. In such cases, the following procedures should be used:

Steps to follow:
1. An assessment of the patient, either by physician or a registered nurse, is required prior to instituting medical restraint. The assessment shall consider the use of less restrictive means to protect the patient and shall be documented in the medical record.
2. Medical restraint shall be imposed upon the order of a licensed independent practitioner. In an emergency, a registered nurse may initiate the use of a medical restraint (without consent). The emergency implementation shall continue beyond one hour only with a physician's order. Verbal orders may be accepted.
3. All physician orders for medical restraint shall be time limited. PRN orders shall not be given or accepted. Upon expiration of the time-limited order, a physician must review and renew the order.
4. Devised to be used may include soft ties, Posey vests, mittens, etc. Hard leather restraints shall not be used for medical restraint.
5. Any patient in medical restraint (without consent) shall be observed at intervals not greater than fifteen minutes. The exact time interval of observation may be more frequent and shall be determined by the clinical condition of the patient. Staff shall document these observations in the medical record at the end of each shift more frequently as the condition of the patient or findings of the observation dictate.
6. Each patient in restraint shall be assessed by an appropriate clinical staff member at least every two hours. At the time of the patient assessment the clinical staff member shall comment on the patient's clinical condition, circulation, condition of limbs and attention should be given to the patient's needs including hydration, elimination and nutrition. A report of the clinical assessment shall be recorded in the medical record.

Safety Restraint

There are two types of safety restraint: adaptive support and patient protection.

1. Adaptive Support: Adaptive support is the use of mechanisms or devices intended to permit a patient to achieve maximum normative bodily functioning (such as the use of orthopedic appliances, braces, splints to prevent contracture or devices intended to give postural support.
2. Patient Protection: In the context of the policy, "patient protection" means the use of mechanisms intended to compensate for a specific physical deficit or prevent safety incidents not related to cognitive dysfunction (such as the use of a bed rail with safety net to keep the patient from falling out of bed during sleep.). [NOTE: The use of side rails alone is not considered restraint. This is a protective measure taken to keep all Healthcare facility patients from falling out of bed].

Steps to follow:

1. A physician's order is required. PRN orders may be used.
2. In addition to usual nursing evaluation and care, the patient's needs, including hygiene, elimination and nutrition, shall be assessed at least two hours.
3. Supports shall be released at least every two hours.

Routine Treatment Immobilization

Routine treatment immobilization means the use of mechanisms employed during medical, diagnostic or surgical procedures that are considered a regular part of such procedures (such as body restraint during general anesthesia, board immobilization of the site of intravenous therapy, immobilization during magnetic resonance imaging, etc). The patient's consent for the procedure includes or implements consent for necessary positioning and support. No separate order is required for such immobilization. Documentation of the immobilization is part of the documentation of the procedure itself.

General Restraint Guidelines

1. Restraints shall not be ordered on a PRN basis.

Restraints shall be only employed on the written order of a physician after personal evaluation of the patient's physical and mental status. When the physician is not immediately available to assist the patient and make a determination regarding his/her need to be restrained can be made by a registered nurse (RN), after careful assessment of the patient. All registered nurses shall be authorized to initiate or terminate the use of restraints as permitted by individual facility policy.

2. Evaluation of Patient

All patients using restraints shall be evaluated for ongoing need of restraints and continued use shall be closely monitored, with the maximum time between observations being two hours.

3. Responsibilities of the Physician

The physician shall assess the patient to ascertain the restraint is justified. After consideration of the alternatives to restraint, an order for restraints must be written on the order sheet and should include:
a) type of restraint; b) the starting and ending times; c) indications for use; and d) level/frequency of evaluation. Verbal orders must be signed within 24 hours of implication.

4. Responsibilities of Nursing

Documentation in the medical record shall include:

1. Time and type of restraint applied, noting skin condition and color
2. Reason for application of restraints
3. Time restraint are released/removed
4. Needs of the patient are addressed: ADLs hygiene, fluids, and elimination
5. Prior alternatives considered and lack of effectiveness

6. Functional assessment

5. Monitoring of Patients in Restraints

All patients in restraints of any kind shall be closely monitored, with the maximum time between observations being two hours. Monitoring shall include condition of skin, observations that support adequate circulation, and observation for bruises, abrasions, and lacerations.

6. Application of Restraints

Restraints must be carefully selected to be of appropriate size for the patient. Restraints are to be secured to the bed frame, if the patient is in bed; never to the side rails. Use of restraints will be discontinued as soon as feasible.

When using wrist and ankle restraints, a finger's width of space must be maintained between the skin of the wrist/ankle and the restraining device.

Vest Restraints are to be applied with the crossing ties in the back, as per manufacturer's directions. The patient must be able to maximally expand their chest wall without hindrance.

Soft leather restraints shall be used only for severely combative individuals.

Mittens are placed on the hand with the palm on the smooth side of the mitt. Mittens shall be removed every two hours to prevent contracture and the circulation assessed.

END OF LIFE CARE

As with all patient care, end of life care must emphasize comfort, relief of pain and distress, with provision of physical and emotional support. The patient and family as desired must be included in making decisions based on their personal beliefs and values. Many people do not consider their personal definitions regarding the meaning and purpose of life until crisis, illness, and/or suffering force the awareness of life as a finite experience. Staff will act with awareness of the psychological and spiritual aspects of support and care, participating in an interdisciplinary team that "affirms life and regards dying as a normal process," allowing the patient to die with dignity, while supporting the family during the final illness and their bereavement.

EMERGENCY CODES

In all cases, you should know what your department-specific responsibilities are. Each Healthcare facility has a disaster plan designed to direct how to carry out patient care during an internal and external disaster. Always be prepared to respond to the following situations: Actual colors associated with specific emergency situations may vary from one facility to another. Please identify the "codes" associated with each facility upon arrival.

- Code Red: Fire
- Code Blue: Life Threatening situation

What is my role in a disaster?

If you are on duty when a disaster strikes, you have certain duties to perform:

- Contact your Supervisor to find out where to report, or if you should continue your work assignment. Use pay phones if personal calls are necessary.
- Wear your photo identification badge at all times. Your photo ID will get you through Police roadblocks

Communication

The backup communication system includes: use of pay phones, use of FAX machines, the distribution of 2-way radios to all patient care areas; and the use of runners in a disaster.

Supplies and Equipment

Backup supplies and equipment are available for disasters.

AGE SPECIFIC EDUCATION

As healthcare workers, it's crucial to recognize that individuals undergo significant physical, psychosocial, and emotional changes during their development and as they age. These changes stem from a combination of genetic factors and lifestyle choices. This

review outlines changes associated with ages across the lifespan. It will provide some tips for helping you to remain sensitive and responsive to the evolving needs of their patients or residents.

Newborns (0 – 1 month)

- Newborns exhibit reflex movements and respond to stimulation, such as grasping a finger when it touches their palm.
- Psychosocially, newborns aim to develop trust rather than mistrust in their environment.
- Care for newborns involves promoting bonding between parents and the baby, encouraging physical contact, and involving parents in healthcare decisions. It's crucial to emphasize hygiene practices and educate caregivers on proper handling and feeding techniques.
- Communication with newborns occurs primarily through the parent or caregiver. Caregivers should feel comfortable asking questions and receiving understandable answers. Demonstrating procedures and speaking to the baby, even though they don't yet speak, is important for their development. Crying is their primary form of communication, indicating discomfort or needs, and should never be ignored.

Infants (1 – 12 months)

- During this period, infants undergo rapid physical development, tripling their birth weight and acquiring gross motor skills like walking with assistance. They also begin to refine fine motor skills such as the pincer grasp.
- Cognitive development includes progressing from tracking objects with their eyes to actively searching for them. By 12 months, many infants utter their first understandable words.
- The psychosocial goal of the newborn is to also to attain trust as opposed to mistrust.
- Care strategies involve encouraging physical contact, involving parents in healthcare decisions, promptly meeting infant needs to foster trust, emphasizing hygiene practices, and educating parents about immunization records. Providing stimulating toys and games supports development, with infants enjoying bright colors, musical toys, and exploration tools.
- Communication methods remain consistent with those used with newborns.

Toddlers (1-3 years)

- Gross motor skills progress rapidly during the toddler years (1-3 years), enabling children to walk, jump, catch, and roll a ball. Fine motor skills also advance as they attempt to balance blocks and draw circles.
- Toddlers demonstrate emerging cognitive abilities, including planning actions before execution and imitating models. Language development expands with increased vocabulary, improved articulation, sentence structure, and listening skills.
- Psychosocially, the goal is for toddlers to achieve autonomy and independence, contrasting with feelings of doubt or shame.
- Patient care considerations involve maintaining consistency in caregiving staff, approaching toddlers calmly, allowing parental presence to alleviate separation anxiety, and using the toddler's own words to describe pain or illness. Offering choices, honesty, and simple explanations before procedures are essential. Providing stimulating toys and games tailored to their age supports development.
- Communication with toddlers should involve simple language, avoidance of baby talk, and reinforcement of positive behavior by parents and caregivers.

Preschool (3-6 years)

- Children at this age are actively developing skills, utilizing language effectively, and gaining increased control over their actions. They can articulate their needs more clearly due to their growing command of language.
- Psychosocially, the goal for preschoolers is to develop initiative rather than guilt, encouraging them to explore and take on new challenges.
- Patient care considerations for preschoolers involve ensuring consistency in caregiving staff, encouraging parental involvement, and maintaining up-to-date immunizations. Pretend play and the use of real equipment can help alleviate fears, while offering choices and setting limits empowers preschoolers.
- Communication should be honest, avoiding medical jargon and using familiar terms. Providing simple explanations and reassurance is essential, along with encouraging participation and addressing any questions they may have.

School-age (6-12 years)

- Children in this age group develop athletic abilities and strong eye-hand coordination, often enjoying participation in team sports and organized activities.
- They demonstrate improved memory and attention span, engaging in games with rules and hobbies like collecting items of interest.

- The psychosocial goal for this age is to attain competence as opposed to inferiority, encouraging them to tackle challenges and develop skills confidently.
- Patient care considerations involve acknowledging and addressing schoolchildren's fears and pain, providing clear explanations of procedures, and reassuring them that illness is not their fault. Involving them in decision-making and offering choices empowers them, while maintaining privacy and addressing concerns about school and friendships is important. Providing stimulating activities and allowing visits from friends or classmates supports their emotional well-being.
- Communication techniques should involve including schoolchildren in conversations and instructions, preparing them for procedures, using age-appropriate language, and encouraging them to express fears and anxieties. Avoiding shaming language and providing reassurance are crucial for fostering a supportive environment.

Adolescents (12-20 years)

- This age group undergoes significant physical growth, experiencing muscle development and hormonal changes associated with puberty.
- Adolescents transition from concrete to abstract thinking, gaining increasing independence and autonomy.
- Psychosocially, the goal is for adolescents to establish their role identity versus role confusion, seeking clarity and direction in their social and personal lives.
- Patient care considerations include respecting their need for privacy and independence, involving them in healthcare decisions, and addressing their fears and concerns honestly. Recognizing and supporting their coping mechanisms, maintaining open communication, and providing opportunities for self-care, such as breast and testicular self-examinations, are essential.
- Communication should involve both adolescents and parents, addressing advanced concepts, and fostering a respectful, non-judgmental atmosphere. Offering access to a phone for social contact is also important for their well-being.

Young adults (20-45 years)

- This age group typically enjoys peak physical fitness and health.
- They possess strong cognitive abilities, drawing on their experiences and knowledge to navigate life, solve problems, and engage in creative thinking, which contributes to their sense of identity and purpose.
- The psychosocial goal for this age is to attain intimacy versus isolation.
- Care considerations for all adults involve sensitivity to the impact of hospitalization on their work and family life, allowing them to express concerns, addressing emerging health issues like vision or hearing deficits, and involving them in decision-making. Providing choices, respecting their autonomy, and including family members in care discussions are essential.
- When communicating with adults, ensure clarity by explaining procedures and providing clear instructions. Define medical terms for better understanding and maintain honesty and transparency while maintaining respect. Encourage them to express fears and preferences while respecting their choice of address.

Middle adulthood (45-60 years)

- During middle adulthood, many individuals become increasingly cognizant of the gradual physical changes associated with aging.
- Psychosocially, the goal for middle adults is to achieve generativity, emphasizing productivity and contribution to society rather than feelings of stagnation.
- Patient care concerns and communication techniques for middle adults remain consistent with those used for young adults.

Early Older Adulthood (60-75 years)

- Most individuals reach early older adulthood, typically characterized by the onset of chronic diseases such as high blood pressure, arthritis, heart disease, and cancer.
- For this age and older, the psychosocial aim is to achieve integrity, finding a sense of fulfillment and wisdom rather than succumbing to feelings of despair.
- Vision and hearing decline, with the majority needing glasses for reading and experiencing hearing loss. Many rely on daily medications.
- Patients in this stage may confront mortality as they lose friends and loved ones, especially during healthcare admissions. Concerns about limited income and fear of permanent disability are common, alongside arthritis and chronic pain issues.
- Providing an age-friendly environment with adjusted lighting, extra learning time, and accessible communication methods supports their well-being.
- Fear of permanent disability may be a worry for healthcare facility patients in early older adulthood.

Middle Older Adulthood (75-85 years)

- By age 75, individuals typically manage three chronic conditions and rely on multiple medications daily, experiencing declines in vision and hearing.
- Many in this stage fear loss of independence and resist nursing home placement, potentially affecting their health decisions. Vulnerability to depression requires careful assessment, while spiritual and social services offer crucial support.
- Arthritis pain may be prevalent but underreported, impacting physical activity. Proper pain management and tailored care environments are essential to their well-being.

Late Older Adulthood (85+ years)

- Beyond 85 years, disabilities and chronic illnesses worsen, increasing dependency on others for daily tasks.
- Healthcare facility stays can be stressful due to routine disruptions. Care should prioritize function maintenance and individualized environments to promote independence.
- Older adults may not report pain due to fear or habituation, necessitating observation of nonverbal cues. Aspiration precautions, skin care, and delirium monitoring are vital. Reminders and life review can provide comfort during this final journey.

EMERGENCY TREATMENT OF PATIENTS (EMTALA)

Federal law requires that a facility take care of any patients who need emergency care, regardless of their ability to pay for care. Unless the patient is pregnant and in labor, a facility can transfer the patient to a more appropriate Healthcare facility once the patient has been stabilized and once the facility has verified that that the next facility has room.
IntelyCare, Inc. provides special education with regards to this legislation. You should be aware that if someone asks you about getting emergency treatment for any condition, you should refer that person to the Emergency Department or call the House Supervisor. It is against the law to send a patient away who seeks treatment for an emergency condition.
If you will be working in ER, please make sure you receive and complete IntelyCare, Inc.'s education module on EMTALA.

THE HIPAA PRIVACY RULE

A patient's right of privacy and confidentiality is protected by law. No one, including spouses, friends, or attorneys, is permitted to review the patient's medical record without prior written authorization, except as required by law (court order or subpoena) or other regulation.

- Only information that is pertinent to a patient's treatment may be disclosed to other practitioners. Only authorized Healthcare facility personnel have access to medical records. All requests for medical information must be referred to the Health Information Management department.
- All employees are required to sign a confidentiality statement upon employment.

To decrease the risk of uninvolved persons over hearing or seeing confidential patient information:

- Confine discussion of patient care information to the patient care areas
- Keep computer ID/passwords confidential. Unauthorized use of ID/passwords may be subject to disciplinary action.
- Exit computer programs and log off before leaving the work station.

What is HIPAA?

The HIPAA Privacy Rule is a Federal Law that went into effect on April 14, 2003. The law protects the confidentiality of our patients' protected health information, or PHI. Protection of patient privacy and confidentiality is also required by the Center for Medicaid Services (IntelyCare, Inc.) and the Joint Commission.
Healthcare has a tradition of privacy. People have kept patient information private as far back as the fourth century BC with the Hippocratic Oath. However, with the advanced communications technologies in use today, safeguarding the privacy of patient information is more of a challenge. The HIPAA Privacy Rule reflects these new concerns.
The HIPAA law is complex. Protecting patients' healthcare information involves two considerations: Privacy and Security. There are differences between the two that you should know.
"Privacy" is concerned with the disclosure of information about a patient to the patient directly, or to those to whom we reasonably believe the information can be disclosed if it is consistent with good health care professional practices. (See HIPAA Privacy.)
"Security" is concerned with the processes, procedures, and technologies that we use to make sure that the people viewing or changing the information are really the ones who are authorized to do so. (See HIPAA Security.)

What information is protected?
All patients (including celebrities and our own employees) have the right to privacy, and this extends to their personal health information, referred to in the HIPAA Privacy Rule as "Protected Health Information," or PHI.

What types of information is protected?
- Paper records
- Computerized information
- Oral communication

What are examples of PHI?
- Face sheets
- Results of exam/evaluation
- Test results
- Treatment and appointment information
- Patient bills
- Photographs
- Paper records
- Computerized patient records and information

Releasing Patient Health Information (PHI)
What information can be released only with the Patient's approval?
As a general rule, Medical Records can only be released to outside parties with the patient's approval, or if there is a law requiring release. (See following section, below.) Again, as a general rule, this information can be released to outside parties only by the Health Information Management Department (Medical Records), or in some cases, the Records Custodian of each department.

Who are the Records Custodians?
Each department or unit that maintains PHI has a "records custodian" to approve access to PHI, for purposes other than routine treatment, payment or operations purposes. Records Custodians may include department leaders and supervisors, unit secretaries, or other persons designated by department leaders

What are the Authorization Requirements?
A written authorization, signed by the patient or legal representative, must be obtained for any release of information except when the release is required by law, or when the information is used for the routine purpose of treatment, payment, or operations. For example, we are permitted to share our patients' PHI with other providers such as physicians to treat the patient, or we may submit PHI to insurance companies to obtain payment, all without patient authorization.

What about releasing Patient's Protected Health Information (PHI) verbally in discussions with friends and family?
When the patient is present and has the capacity to make his or her decisions, we may disclose PHI to friends and families, if one of the following conditions is met:
- We obtain the oral agreement of the patient or legal representative;
- We provide the patient with an opportunity to object to the disclosure, and the patient does not object;
- We infer from the circumstances that the patient does not object to the disclosure. For example, when a friend has brought the patient to the emergency room for treatment.

When the patient is not present, or when the patient is incapacitated due to an emergency, it's okay to make the disclosure if our decision is consistent with good health care professional practices. For example, when a patient is brought to the emergency room, we may inform relatives and others involved in the patient's care that the patient has suffered a heart attack and we may provide updates on the patient's progress and prognosis when the patient is unable to make decisions about such disclosures.
Whatever information we disclose to the patient's friends or families should be directly relevant to that person's involvement. For example, a neighbor picking up a patient can be told that the patient is unsteady on his feet; however, the neighbor should not be told that a tumor was removed.

How is Protected Health Information handled for Minors?
If a patient is a minor (under 18 years of age), the patient's parents or guardian may receive or direct the use and disclosure of PHI on behalf of the patient, except for "Emancipated Minors."

Emancipated Minors are children who have been released from the control of parents or guardians, and may control their own PHI, in the same manner as an adult:

- Anyone who is not yet 18 years old but is legally married or who is a parent.
- Anyone who is not yet 18 years old, but has been legally married and is now divorced, or a widow or widower.
- Anyone who is not yet 18 years old but is maintaining his or her own residence and is self-supporting. A reasonable effort to contact parents must be made.
- Anyone who is not yet 18 years old, and is pregnant.

Minors Who Are Not Emancipated: Any minor (under 18 years of age) may without parents' consent, approval, or notification have the right, in the same manner as an adult, to protect their health information for the voluntary treatment of:

- Alcohol or drug abuse
- Testing and treatment for sexually transmitted disease

BODY MECHANICS & SAFE PATIENT HANDLING

Ensuring the safety of both healthcare workers, patients, and residents is paramount in any healthcare setting. Incorporating correct body mechanics, ergonomic (designing the job to fit the worker) principles, and patient transfers prevents staff injuries and patient harm. The following prevention points, when adhered to, will promote safety.

Lifting

- Assess the situation and plan how to accomplish it before beginning.
- Use the muscles of the legs, hips and arms – the strongest in the body. Keep a neutral spine.
- Bend knees and hips avoid bending at the waist, and lift with your legs, not your back
- Keep feet at shoulder width to provide a broad base of support.
- Make sure the object is close to you, do not-overreach, and carry the load close to you.
- Avoid lifting higher than your waist.
- Push and don't pull.
- Ask for help.

Sitting

- Use chairs that provide support to the back, particularly the lower back.
- Both feet should be able to rest flat on the floor.
- Avoid slouching, walk around and stretch occasionally, or change position often to avoid strain.
- Avoid twisting and overreaching
- Position yourself directly in front of your work and make sure your work is at eye-level to avoid neck strain.

Standing

- Stand close to your work area with your back erect, chin in, pelvis tucked under and knees slightly flexed.
- Maintain a broad base with your feet and ensure even weight bearing.
- Avoid prolonged positions and slouching – stretch occasionally.

Back Care and Points for Prevention

- Use good posture at all times and proper body mechanics.
- Change position frequently.
- Exercise regularly and eat a well-balanced diet to control your weight.
- Ensure enough rest at night.
- Practice stress reduction techniques, such as yoga and relaxation.
- Ask for help in lifting or moving heavy objects.
- Keep the work area safe – clean up spills, wet floor signs; ensure no loose equipment, boxes on flooring, no loose power cables, close drawers. Notify appropriate personnel immediately, such as maintenance.
- Wear shoes with non-skid soles.

- Walk and don’t run.
- Report any accidents of patients or visitors to the staff supervisor immediately.
- Monitor safety of patients closely.
- Ensure brakes are applied to the wheelchair or bed when moving patients.
- Adjust height of bed or table to waist / mid-to-upper thigh level when moving patients.
- Maintain ergonomics at all times.

Safe Patient Handling Principles:

1. Check the patient's care plan for any physical limitations or injuries. Ensure it includes specific needs and assistance levels. Patients with sudden changes or multiple conditions may require special attention. Verify if they can assist and assess their cooperation. Avoid using a lift if the patient is agitated or combative. Check the patient's weight and physical condition to match with lift guidelines. Ensure equipment is in good condition and enough staff is available.
2. Use the appropriate assistive device and seek guidance if unsure. Always have two caregivers present for lifts and transfers.
3. Discuss the activity plan with other staff before handling the patient.
4. Lock the wheels when transferring from a wheelchair, bed, or stretcher to promote independence.
5. Seek assistance if unable to safely move the patient alone, especially after a fall.
6. Avoid moving patients while off balance.
7. Keep the patient close and maintain a straight back when lifting to engage leg and torso muscles, reducing strain on the back.
8. Avoid lifting patients with extended arms, excessive reaching, or fixed postures for extended periods. Follow recommended guidelines for safe lifting.
9. Respect residents' right to refuse care and prioritize their comfort during transfers. Address any discomfort promptly and ensure their safety by involving additional caregivers if necessary. Pay attention to resident preferences to ensure comfort and safety.

Proper transfer of patients is critical to maintaining the safety of patients. There are various types of assistive devices used when it comes to transferring residents. The types of assistive devices include walkers, canes, and mechanical lifts.

- **Walkers:** A rolling walker or 4-legged walker allows an individual to use their arms to bear their body weight and provide assistance with the affected leg. It is important to remind patients to stand up straight and keep the walker on ground level within one step of the patient's body at most. Instruct the individual to move the walker on step forward, hold the walker for support, and press through the handrails as needed for support. The individual should step forward with affected leg into the middle of the walker and step unaffected leg forward to land next to the affected leg. This process is then repeated.

- **Canes:** Canes are intended for minor balance or stability problems. The top of the cane should reach the cease in the wrist and hold the cane opposite the side of the affected leg. If being used for balance, hold in the non-dominant hand. To climb stairs, the cane first should go up the step, then “up with the good leg, down with the bad leg”.

- **Total Mechanical Lift**
  - Total Mechanical Lift provides a safe transfer for patients/residents from a supine to seated position or seated to seated transfer. A Total Mechanical Lift will be used by those patients/residents who have no weight bearing abilities or who have been assessed to need a Total Mechanical Lift for transfer.
  - <u>Equipment/Personnel</u>
    - Total mechanical Lift
    - Two (2) or more caregivers
  - <u>Procedure</u>
    1. There must be two caregivers present with their hands on the Total Mechanical Lift.
    2. Adjust bed to a height that promotes good body mechanics.
    3. Visually inspect sling for signs of wear and tear. Do not use any sling that is visibly damaged.
    4. Position patient/resident on the appropriate sling.

5. Position lift with the base open so that the spreader bar is perpendicular to the patient's/resident's shoulders and hovering above the chest.
6. Attach the sling straps without pulling or tugging, to the desired setting.
7. Verbally prepare patient/resident for transfer.
8. Gently raise the patient/resident minimally from the surface.
9. Turn the patient's/resident's legs towards the perpendicular support bar of the lift during the move.
10. Gently lower the patient/resident into a chair.
11. Remove sling from under the patient.
12. Before a resident/patient that is on the floor is moved, touched or mechanically lifted, a licensed professional must assess the resident/patient. In order to promote safe resident/patient handling, use a full mechanical lift when getting a resident/patient off the floor.

- Key points:
  - The two methods for the hammock sling applications are:
    - The cross through method and the cradle method.
    - The cross through method is the safer method that anchors the patient/resident.
    - The cradle method is used on a patient/resident with an amputee of their lower extremity(ies), and for a patient/resident who experiences discomfort in the cross through method (i.e., patient/resident with increased girth at their thigh).

- **Sit/Stand Mechanical Lift**
  - A Sit/ Stand Mechanical Lift provides a safe seat-to-seat transfer for the patient/ resident who has partial weight bearing capabilities in one or both legs and has good cognition. The patient/resident must be able to move from a supine position to sitting position and balance in a sitting position on the edge of the bed.
  - Equipment/Personnel
    - Sit/Stand mechanical Lift
    - Two (2) or more caregivers
  - Procedure
    1. Apply a proper harness so that the bulk of the harness rests in the patient's/ resident's lower back region. Tighten the inner belts so that they fit snug to the patient. Apply leg straps if applicable.
    2. Position the Sit/Stand Mechanical Lift with the base of the lift open and lift is facing patient/resident.
    3. Instruct/assist the patient to place feet in the foot-plate of the lift.
    4. Attach the strap of the harness to the lift without pulling or tugging.
    5. Instruct/assist patient/resident to grasp handles on lift with arms on the outside of the harness.
    6. Close the legs on the lift during movement of the lift with the patient in it. Do not move the lift with the legs open.
    7. Verbally prepare patient/resident for transfer.
    8. Instruct/ assist patient/resident to lean back into the harness as they are gently lifted minimally from the surface.
    9. Transfer patient/resident to new surface.
    10. There must be two caregivers present with their hands on the Total Mechanical Lift.

UNDERSTANDING CULTURAL DIVERSITY

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

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

Ethnocentrism

Ethnocentrism is the act of judging another culture based on preconceptions that are found in the values and standards of one's own culture – especially regarding language, behavior, customs, and religion. These aspects or categories are distinctions that define each ethnicity's unique cultural identity.

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

Approaches to Minimize Conflict in a Cultural Setting

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

Cross Cultural Communications for Healthcare Workers

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

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

Verbal Behavior

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

Non-Verbal Behavior

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

Attribution

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

Comprehension

- UNDERSTANDING: Do not assume that they understand. Assume that they do not

- CHECK: Have the people repeat their understanding
- BREAKS: Take more breaks, second language comprehension is exhausting.

Motivation

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

Strategies to Communicate Effectively

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

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

Time

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

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

Space

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

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

Touching

When people touch physically it means different things.

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

Communicate

When you communicate, be aware of:

- Tone of voice

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

DISCHARGE PLANNING

This Fact Sheet discusses a Healthcare facility's responsibilities to assist with nursing home placement and right to challenge Healthcare facility discharge decisions. All of the information applies only to persons on Medicare, although there are similar rights under other health insurance programs.

WHAT IS Healthcare facility DISCHARGE PLANNING?

Healthcare facility discharge planning is a service to assist patients in arranging the care needed following a Healthcare facility stay. Discharge planners help arrange services including home care, nursing home care, rehabilitative care, out-patient medical treatment and other help. Healthcare facility discharge planning is usually handled by the Healthcare facility's Social Services Department.

If a patient needs help arranging nursing home care, ask the doctor to contact the Social Work Department. If a Healthcare facility discharge planner does not contact the patient within a short time, contact the Social Work Department directly for assistance. Discharge planning services in Medicare certified Healthcare facilities must meet the following standards:

- Healthcare facilities must identify and evaluate persons who may need discharge planning assistance.
- The evaluation must be done on a timely basis and must determine the need for services after the Healthcare facility stay and the availability of these services.
- The results of the evaluation must be discussed with the patient or patient's representative.
- If requested by the patient's physician, the Healthcare facility must help develop and implement a discharge plan for the patient.
- Discharge planning must be provided or supervised by a social worker, registered nurse or other appropriately qualified person.

If a patient needs nursing home care, the Healthcare facility's discharge planner should provide information about local nursing homes, and should help identify homes that have vacancies.

The Healthcare facility cannot force a patient to go to any particular nursing home or discharge a patient to a nursing home without the patient's legal representative's consent. If the Healthcare facility believes that a patient no longer needs Healthcare facility care and is refusing appropriate discharge, it must issue notice to the patient of its determination. This notice can cause the patient to become responsible for payment of continuing Healthcare facilitization, subject to the patient's right to appeal. The notice and appeals rights are discussed below.

PATIENT RIGHTS AND RESPONSIBILITIES

IntelyCare, Inc. employees must uphold their role as advocates and recognize the consumer/patients' right to dignity, individual value systems, access to medical care and confidentiality. In being that advocate, nurses should be able to speak up to protect the health and safety of patients in their care without fear of retaliation.

The Patient's Bill of Rights

The Patients' Bill of Rights was conceived in 1998 by the U.S. Advisory Commission on Consumer Protection and Quality in the Healthcare Industry. Its purpose is to promote healthcare quality and support the public as they navigate through the healthcare system. The seven areas of rights and responsibilities are:

1. Information Disclosure: Patients have the right to accurate and easily-understood information about their health plan, health care professionals, and health care facilities. If a patient speaks another language, has a physical or mental disability, or just doesn't understand something, assistance must be provided so that the patient can make informed health care decisions.
2. Choice of Providers and Plans: Patients have the right to a choice of health care providers who can provide high-quality health care when needed.

3. Access to Emergency Services: Patients who have severe pain, injury, or sudden illness that convinces them they are in serious danger, have the right to be screened and stabilized using emergency services. These services should be provided whenever and wherever needed, without the need to wait for authorization and without any financial penalty.
4. Participation in Treatment Decisions: Patients have the right to know their treatment options and to take part in decisions about their care. Parents, guardians, family members, or others that a patient selects can represent them if they cannot make their own decisions.
5. Respect and Non-discrimination: Patients have a right to a considerate, respectful care from doctors, health plan representatives, and other health care providers without discrimination.
6. Confidentiality of Health Information: Patients have the right to talk privately with health care providers and to have their health care information protected. Patients also have the right to read and copy their own medical record. Patients have the right to ask that a doctor change their record if it is not accurate, relevant, or complete.
7. Complaints and Appeals: Patients have the right to a fair, fast, and objective review of any complaint they have against their health plan, doctors, Healthcare facilities or other health care personnel. This includes complaints about waiting times, operating hours, the actions of health care personnel, and the adequacy of health care facilities.

The Six Ethical Principles of the Patient's Bill of Rights

The Patients' Bill of Rights supports six basic principles of ethics:

1. Autonomy: Independence, self-direction, and freedom of choice. When patients choose a healthcare provider, a healthcare facility, or make decisions about treatment, they are exercising autonomy. The Patients' Bill of Rights supports autonomy by supporting the patients' right to the choice of plan and healthcare providers that ensures access to appropriate health care. The healthcare professional's duty is to support patients' autonomy by ensuring that patients understand their treatment options.
2. Beneficence: Acts of charity or kindness. As a principle of ethical care it means that treatment provided is for the good of the patient. The principle of beneficence means that patients should receive considerate and respectful care and have the opportunity to let healthcare workers know when they are not receiving the quality or value of care necessary. Healthcare professionals should assist patients to voice their concerns through a complaint procedure. The principle of beneficence indicates that healthcare providers must provide competent care so the patient is safe and is treated with respect.
3. Confidentiality: Private or secret. As a principle of ethical care it means that information about patients and their care is protected and shared only with those who have the right or the need to know. The patient also has a right to know how information about him will be used by others, and who will receive that information. The principle respects that patients have the right to know about their treatment and to review their own records.
4. Fidelity: Faithfulness, as in a pledge or duty. As a principle of ethics it means healthcare workers have a duty to be patients' advocates and to protect patients' rights. Fidelity is demonstrated by upholding the Patients' Bill of rights.
5. Veracity: Truthfulness. As a principle of ethics it means supporting both information disclosure and the right to make treatment decisions as described in the Patients' Bill of Rights. Correct and truthful information helps patients to make informed choices.
6. Justice: Impartiality or fairness. As a principle of ethics it means that all patients and their families are treated the same, without favoritism or discrimination based on race, color, gender, economic status, social status, or any other personal trait. All people have the right to fair and unbiased treatment.

Informed Consent

Informed consent is a process in which consent is obtained for a treatment or healthcare service when the patient knows about and understands the treatment, including its implications, benefits and risks, and the alternatives. The patient must know they have the right to accept or refuse the treatment or service.

Before undergoing treatment, patients must give consent. Some patients may not be capable of giving consent because of age, mental competence, or other possible factors. As such, a designated guardian (such as parent, relative, friend or caregiver) represents that patient. Healthcare workers must ensure that the consent is "informed" and signed by either the patient or the guardian.

Advance Directives

Advance Directives: Documents written in advance of serious illness or injury which state choices for medical treatment or names someone to make treatment decisions on behalf of that individual should he/she become unable to make or communicate such decisions. Advance directives promote an individual's control over his/her own healthcare decisions. All patients entering the healthcare system must be given the opportunity to complete an advance directive document which will define the patients' preferences in end-of-life decisions or at any time that they are unable to convey their own wishes regarding healthcare. Advance directives are voluntary and are supported by the Patient's Bill of Rights dependent upon state law, there may be two or more types of advance directives: the living will and the durable state of attorney/health care surrogate, as examples.

Living Will: A "Living Will" is a document that gives direction about the medical care, and limitations of medical care, desired by the patient when he or she is either in a permanent vegetative state with no hope of recovery or has an imminently terminal condition and is unable to make his or her needs known.

Healthcare Surrogates/Durable State of Attorney: A document which names someone to make medical care dictions for another, should that person become unable to make them for themselves. This document may include instructions about treatments and individuals that he/she may or may not want, should he/she become seriously ill or injured.

Guidelines

Written information regarding advance directives may be available to anyone and most often is administered through the admission department, Social Work department, Pastoral Care department, Medical Records department. It is the responsibility of the registered nurse to assure this documentation is available in the medical record.

Any competent patient may sign a living will or durable power of attorney for healthcare. Witnesses to a living will may not be:

- Related to the patient by blood or marriage
- The patient's physician or employee of the physician
- An employee of the Healthcare facility if the employee is providing direct care to the patient or is involved in the Healthcare facility's financial affairs
- Be a patient of the Healthcare facility
- Have a claim against the Healthcare facility

Witnesses to a durable power of attorney for healthcare may not be:

- The person appointed as agent in the document
- A provider of health or residential care
- The operator of a community care facility
- An employee or operator of a healthcare facility

Each adult (or their representative), who registers as an inpatient, should be asked if they have living will and/or durable power of attorney for healthcare. If the patient has a living will and/or durable power of attorney for healthcare, it shall be noted on the appropriate form and be made part of the medical record.

If a patient decides to revoke a written advance directive, the appropriate department should be notified by the patient's physician or staff nurse. Said department shall explicitly mark the advance directive as being revoked and should clearly document the date of the revocation. A patient may revoke an advance directive at any time, regardless of the patient's mental state of competency.

UTILITY MANAGEMENT

Utilities are basic building services. They include:

- Electricity: Emergency Electrical Service is supplied from a Healthcare facility's emergency powerhouse generators. When normal service fails, the generators support essential building systems, fire safety systems and pre-designated medical equipment. Most Healthcare facilities have an Uninterruptible Power Supply (UPS) System. It permits power sensitive equipment to function normally during transitions in power supply.
- Water: Water is needed for drinking, cooking, bathing, cleaning, flushing the toilet, steam production, heating and cooling systems and cooling some clinical equipment.
- Sewer: The Sewer Service allows for waste disposal from the facility.
- Natural gas: Healthcare facilities use natural gas as the primary fuel for the boilers to make steam and hot water. Natural gas also supports food service and lab processes. The Healthcare facility may have a backup diesel fuel supply to fire the boilers if the natural gas supply fails.

- Piped Medical gases: Medical gases include oxygen, nitrogen, nitrous oxide and carbon dioxide. They are supplied from the Healthcare facility medical gas storage systems. Medical Gases are distributed to specific outlets throughout the Healthcare facility. Medical Air is also distributed via special outlets throughout the Healthcare facility.
- Heating, Ventilation and Air Conditioning Systems (HVAC): The functions of HVAC include heating to support room comfort, ventilation to support air quality and infection control and cooling to support human comfort and in some locations, equipment function.
- Fire Protection System: Fire protection systems are operated and maintained by the Healthcare facility's Physical Plant and Maintenance Departments. Smoke detection systems are designated to operate at all times. Fire sprinklers turn on when a defined temperature is reached. Fire alarms are triggered by either the smoke detection of fire sprinkler systems. They produce audible alarms and visual strobe signals.
- Pneumatic tube systems
- Telephones
- Computers

Code White: Utility Failure

The purpose of a Code White is to alert employees to a Healthcare facility-wide failure of one or more of the above utility systems. All departments and units have Utility Failure Plans that identify what action you need to take in the event of one of more utility failures. Make sure you know the location of the Utility Failure Plan and contact the Healthcare facility Safety Management, Department Manager or Safety Coordinator if you have any questions.

PATIENT EDUCATION

Patient/family teaching has been recognized as an essential activity fundamental to every nursing, medical and allied specialty. The growing awareness that individuals can be more responsible and participate in their own health is prompting the providers, policy makers, regulatory agencies and payers to strengthen patient and family education in every phase of patient care.

Patient and family education is interactive and appropriate to the patient's age and length of stay. It includes, but is not limited to:

- Helping the patient adopt or function more independently
- Information about access to additional resources
- When and how to obtain further treatment
- Safe and effective use of medication and medical equipment
- Potential drug – food interaction
- Nutrition information/counseling on modified diets as appropriate
- Rehabilitative techniques, including activity and assistive devices
- Maintenance of good standards for personal hygiene and grooming, including brushing teeth, bathing, caring for hair and nails, and using the toilet
- Information on patient/family responsibilities for the patient's health care needs (e.g. self-care, signs and symptoms to report, etc.) including the knowledge and skills to carry out these responsibilities.

How is Patient/Family Education Implemented?

- Patient teaching is based on assessed learning need
- Assessment includes consideration of cultural and religious practices
- Barriers to learning are identified
- Age-appropriate teaching is matched with developmental stage
- Education is provided by the appropriate health care professionals (Pharm D, MD, RN, LCSW, RD, RCP, RT, OT, SLP and other disciplines involved with the patient's care)
- Educational materials (video and print) utilized are medically current, instructionally correct, cost effective and developmentally coordinated through the Patient Education Committee.

The Nurse Role in Patient Education

- Asses/reassess patient including cultural and religious beliefs
- Identifies learning barriers

- Identifies learning need
- Provides in room orientation
- Plans for patient teaching in collaboration with patient/family and involves interdisciplinary team
- Demonstrates use of equipment, rehabilitative techniques, assistive devices
- Explains treatment plan, verifies patient's knowledge about procedures
- Explains medication in collaboration with clinical pharmacist
- Teaches/demonstrates self-care, personal hygiene
- Provides discharge instructions such as:
- Follow up appointment with physician
- Danger signals and symptoms to report
- Medications, food-drug interactions
- Provides patient with education materials
- Self-care
- Activity, assistive devices
- Access to resources
- Pain Management
- Return to work and driving

MEDICAL EQUIPMENT MANAGEMENT

The Safe Medical Devices Act, in an effort to monitor incidents involving equipment, requires all healthcare personnel to follow up on problems or incidents involving equipment promptly. If a piece of equipment does not function properly:

- Take it out of service and generate a work order generated for its repair.
- If the item has been involved in an incident causing serious illness or injury to anyone in our facility, the equipment should be isolated and saved for Risk Management to examine.
- Fill out an incident report.
- Report the incident immediately to Risk Management. Risk Management staff will evaluate the incident for reporting to the FDA and manufacturer.

In order to provide quality patient care with the least amount of risk possible, all Facilities have developed an Equipment Management Program. All equipment (clinical or non-clinical) must be inspected by the Facilities Management Department prior to its initial use. "Equipment" is defined as all equipment, fixed or portable, that is used for the diagnosis, treatment, monitoring or care of patients, which could pose a physical and/or clinical risk to a patient and/or operator during use.

- All employees who operate, monitor or maintain clinical equipment must be trained to do so safely.
- Employees are required to be familiar with the clinical equipment inspection stickers affixed to each piece of equipment.
- All equipment should have the facility's inspection sticker on it that indicates the equipment was inspected; the equipment passed the electrical safety test and how frequently the equipment is tested.

Clinical Equipment

In order to provide quality patient care with the least amount of risk possible, the Facilities Management Department has developed a Clinical Equipment Management Program.

Clinical equipment is defined as all equipment, fixed or portable, that is used for the diagnosis, treatment, monitoring or care of patients, and which could pose a physical and/or clinical risk to a patient and/or operator during use.

All equipment (clinical or non-clinical) must be inspected by the Facilities Management Department prior to its initial use.

Many different types of clinical equipment are used to help treat patients in your facility. Some of these are:
- Ventilators
- IV (Intravenous) pumps
- Glucose-testing monitors
- Cardiac monitors

- Enteral pumps
- Radiant warmers
- Hypothermia blankets
- EKG (Electrocardiograph) machines
- Electric beds

Clinical equipment can be an important part of a patient's treatment, but there are things that can go wrong. There are three types of risk factors, or potential problems, that can arise in the use of clinical equipment:

1. Malfunction
2. Improper use
3. Damage to equipment

It is important that you do not use any equipment that you have not been trained to use. You need to know the following information about any equipment you use:

1. How to operate it
2. The purpose of the equipment and the intended results
3. Monitoring and observation activities - what to observe, frequency precautions, and adverse reactions
4. Contraindications - warning signs
5. Troubleshooting - including how to respond to alarms
6. Care and maintenance
7. Backup procedures and equipment

In addition to proper training, there are other things you can do to help ensure that equipment functions properly and safely:

1. Teach patients and their families about any equipment, including how it works, its purpose, safety precautions, signs of problems, what to do if problems arise, and when to notify staff.
2. At the first sign of a malfunction, take equipment out of use. Label it so that others do not use it, and follow the policy of your facility for repair.
3. If equipment has a battery backup, keep it plugged in whenever possible so that it stays fully charged.
4. Remove equipment from rooms when it is no longer needed to prevent it from being damaged and to make it available for others to use. Follow the policy of your facility to prepare the equipment for use with another patient, including disinfecting, cleaning, re-inspecting, and recalibrating where required.
5. If any equipment is dropped, take it out of service immediately. Even though it may seem intact, there might have been damage to some components that could pose a safety hazard.
6. Cellular phones have been found to interfere with some electrical equipment. Your facility may have a policy that bans cell phones in the facility or within certain areas.

PAIN MANAGEMENT

Pain management is a complex, subjective and highly unpleasant sensory or emotional experience caused by a physical, neurological or emotional response to noxious stimuli. Pain can be acute or chronic in nature. No two people experience or express their pain alike. The most reliable indication of the existence and intensity of pain is the patient's testimony, and its measurement is considered the 5th vital sign. Many factors can influence the severity of pain, including the personal meaning of pain, additional anxiety, tension, depression, fatigue, and sleeplessness. Chronic pain is the most frequent cause of reduced quality of life. Untreated acute pain in Healthcare facilities patients can cause longer Healthcare facility stays, delayed healing and fear and anxiety.

When you are providing care, moving, lifting a patient or performing procedures, ask the patient if they are having pain. Do not assume a patient is not in pain just because he or she doesn't speak up. Often, careful moving or re-positioning may help.

Patient pain level will be assessed using ETRMC's Universal Pain Assessment 10-point scale. Pain management includes main assessment, planning, intervention, reassessment of patient responses to pain management measures, and education of patients and family regarding pain management. Patient assessment, reassessment and education must be documented on the medical record.

Pain control measures fall into two categories:

1. Pharmacological interventions
2. Non-pharmacological interventions

Pharmacological interventions are pain control methods that use medications. These include:

1. Opiates, such as morphine and codeine
2. Non-opiates, such as acetaminophen
3. Adjuvants, a variety of drug types that are usually used to supplement opiates or non-opiates.

Non-pharmacological interventions are alternative measures that do not use drugs. The methods that are selected will depend on the needs of the patient. Non-pharmacological pain management methods include:

1. Relaxation and distraction techniques
2. Physical interventions.

<u>Relaxation and distraction techniques</u>

These techniques work best if they are practiced before they are needed for pain relief. They include:

- Deep breathing (with focus on breathing techniques)
- Listening to music
- Guided imagery
- Biofeedback
- Hypnosis.

<u>Physical Interventions</u>

Physical interventions that can help in the treatment of pain include:

- Massage
- Exercise (especially for chronic pain)
- Application of heat or cold (not longer than 20 minutes; be careful of extremes of heat or cold that could damage tissue)
- Acupuncture
- Position change
- TENS unit (trans-electrical nerve stimulation therapy).

A TENS unit controls pain by stimulating the nerves at the pain location and helping to block pain signals.

When using drugs to control pain, the best strategy is to use the **least strong** drug which still gives adequate pain relief. If the intervention does not relieve the pain, it may require:

- An increase in dosage
- An increase in frequency
- An increase to the next level of drug.

Usually, pain control measures begin with non-opiates (non-narcotic) drugs. Non-opiates, such as acetaminophen (Tylenol) are generally available in both over-the-counter and prescription strengths. Non-opioids are usually taken orally or by suppository. The most common side effect of acetaminophen is hepatotoxicity (liver involvement). This is most common with an overdose.

Non-opiates also include NSAIDS (non-steroidal anti-inflammatories), such as Advil and Motrin. These may also be used in combination with opiates. The most common side effects of NSAIDS are:

- Gastric irritation
- Prolonged bleeding time.

The name, **opiates**, refers to drugs that are based on opium. They can be either natural or synthetic. Opiates are used for moderate to severe pain.

Pure Agonists

One class of opiates, known as "pure agonists", which refers to their specific mechanism for pain relief, includes:

- Morphine
- Hydromorphone (Dilaudid)
- Fentanyl
- Codeine.

Increased dosage of pure agonists provides increased analgesia (pain relief) and side effects. Side effects include:

- Euphoria
- Sedation
- Constipation
- Nausea
- Vomiting
- Itching
- Urinary retention
- Hypotension
- Respiratory distress.

Over time, patients may develop a tolerance for opiates, meaning they require higher dosages to achieve the same pain relief. However, the usual reason for increasing dose is because of disease progression. Patients who have received opiates for a long period of time may experience withdrawal when the drug is stopped. This means that patients should not be taken off the drug suddenly but should gradually decrease the drug level over several days.

There are two important things to remember about opiates and other pain drugs:

1. Drug-seeking behavior is NOT a sign of addiction.
2. Drug-seeking behavior IS a sign of inadequate pain relief.

Other opiates

Other types of opiates, nalbuphine (Nubain) and butorphanol (Stadol), provide less analgesia, but also fewer side effects. There is also a limit to their effectiveness. After a point, higher doses do not increase analgesia. These drugs are sometimes used to reverse analgesia and side-effects caused by pure agonists.

Administration of opiates

Opiates can be given orally. As pain level increase, they are administered in other ways which deliver a higher level of pain relief:

- Sublingually (under the tongue)
- Buccally (placed in the cheek area if patient unable to swallow)
- Dermal patch (for continuous release)
- Intravenous (IV) by continuous infusion or intermittent dosage
- Patient-controlled analgesia (PCA) using intravenous delivery
- Intramuscular or subcutaneous injection
- Suppository.

Adjuvants

Other drugs that may help in pain control are called adjuvants. These include:

- Corticosteroids
- Antidepressants
- Local anesthetics
- Anticonvulsants.

These drugs are used to:

1. Enhance the effectiveness of a primary analgesic
2. Limit the side effects of a primary analgesic (usually an opiate)

3. Treat concurrent symptoms that increase pain
4. Provide analgesia for certain types of pain that are not relieved by opiates.

RADIATION SAFETY

Time, Distance and Shielding prevent unnecessary exposure to radiation. Spend only the needed time in the radiation area, keep your distance from the source of radiation and use proper shielding when radiation equipment is being used. To do this, routine testing and evaluation of equipment, procedures, personnel monitoring and continuing education are critical. Those involved with Radiation need to attend an annual refresher course on Radiation Safety. The classes are listed in the Memorial Academy catalog.

- Always observe radiation warning signs
- Enter areas employing radioactive sources only for authorized and necessary purposes.
- Do not attempt to clean up spills on floors and countertops labeled "Caution: Radioactive Materials." These may be radioactive and require special clean-up procedures.

FALL PREVENTION

Most facilities have developed a Fall Prevention Program to identify those patients who are at highest risk to fall, with the intent of reducing injuries.

A patient fall may also result in:

- Longer Healthcare facility stays
- Permanent injury
- Disability
- Death

There are things you can do to help prevent patient falls:

- Assess the patient or resident's risk for falls and implement intervention to reduce or eliminate those risks.
- Orient them to their surroundings.
- Show them how to use the call light and explain how and when to get assistance.
- Ensure good lighting in rooms and bathrooms.
- Keep beds at a low height.
- Make sure path to bathroom is clear.
- Educate the patient and resident and their families as needed on any individualized fall reduction strategies
- Evaluate the effectiveness of all fall reduction activities, including assessment, interventions, and education.

You can also learn to recognize patients who are at risk for falls. These include:

- Infants and young children
- Older adults
- Sedated patients.

Infants and young children

These patients are immature, and they often do not understand what they should or should not do. Their motor skills are still developing, so they can fall easily. They are also full of curiosity.

Older adults

The majority of falls occur in patients over 65 with the highest number in the 80-89 age group. These patients may be unsteady on their feet. They may also have problems with hearing and eyesight.

Sedated patients

Patients who are sedated may not be able to understand instructions. They often cannot recognize dangers and may become confused.

Patient education can also help prevent falls. Teach patients and their families about:

- The Healthcare facility environment
- Potential hazards
- Equipment being used.

In addition to patient falls, there are other types of injuries. These include injuries from misuse of equipment and burns from hot liquids. These injuries are less frequent than falls, but all have one thing in common:

Most injuries can be prevented!

There are several things you can do to help prevent injuries:

1. Identify and correct safety hazards.
2. Take care in using equipment.
3. Follow the standard of care when doing procedures and treatments.

Identify and correct safety hazards

- **Slips**, such as water on the floor, should be cleaned up.
- **Trips**, or obstacles, should be removed.
- **Sharps**, such as needles or glassware, should be properly disposed of.

PRESSURE INJURIES (BED SORES, PRESSURE ULCERS) PREVENTION

1. Follow the hospital or facility policy for risk identification, prevention, and treatment of pressure injuries.
2. Perform an initial systematic assessment at admission to identify patients and residents at risk for pressure injuries. Risk assessment tools such as the Braden Scale or the Norton Scale should be used in conjunction with a clinical assessment.
3. Periodically reassess each patient's and resident's risk for either developing a pressure injury or worsening of their existing pressure injury. Take action to address any identified risks. Follow the facility's protocols.
4. When a pressure injury is diagnosed, treatment to stop the progression of the wound should be immediate and align with best practices and facility protocols.
5. Documentation must include prevention methods, treatment plans, wound measurements, description of any exudate, wound stage, and photographic imaging when available.
6. Reassess pressure injury risk or wound condition at intervals defined by the facility or as ordered by a physician or other licensed practitioner.
7. Take action to address any identified risks to the patient or resident for pressure injuries, including the following:
    - Prevent injury to patients and residents by maintaining and improving tissue tolerance.
    - Keep skin clean and dry.
    - Prevent friction and shear.
    - Protect against the adverse effects of external mechanical forces.

8. Provide education from the facility to patients, residents, and families receive education on pressure injury prevention.

CLIENT ELOPEMENT

Prevention is the key: Clients at risk for elopement should be monitored regularly. Typically, these clients will have a monitored device such as a 'wander guard' wrist or ankle bracelet applied.

- Don't give out code alarms
- Assess for 'wander guard' band placement regularly
- Don't prop doors open and keep alarms to doors set
- Respond to all alarms immediately

- Stay calm and keep family calm
- Notify Security/Supervisor
- Call internal code or 911
- Know your facility exits, checks all exits, and assign a watch person at all exits
- Be prepared to participate in a unit/facility search
- If client cannot be found in the facility or on the grounds, notify police (911) immediately

DE-ESCALATION TECHNIQUES

Healthcare professionals periodically are exposed to agitated and sometimes combative behavior. Some types of agitated/combative behavior found in healthcare settings include resisting care, verbal and physical aggression, and sudden negative mood changes when a patient/ resident is unable to control feelings. De-escalation is a technique used during a potential crisis situation in an attempt to prevent a person from causing harm to you, themselves, or others.

Agitated/ combative behavior may be caused by a number of health conditions or psychosocial and environment factors, such as :

- Dementia (including Alzheimer's and other organic brain diseases).
- Serious health conditions (head trauma, terminal illness, severe pain, loss of hearing or sight, etc)
- Psychosocial causes (life changes, perceived loss of control, displaced anger, fear, substance abuse, past history)
- Environment (noise, roon traffic, bright light)
- Unskilled Caregiver (overly authoritarian caregiver, rough or hurried handling).

Basic Communication and Listening Techniques

- Identify yourself and your role
- Anticipate their questions
- Explain processes and procedures in plain terms
- Speak calmly and at an average volume; speak deliberately and respectfully (do not challenge the individual or shame/ disrespect the individual
- Be conversational, not authoritarian; do not argue or contradict
- Acknowledge their emotional pain, feelings of helplessness and fears
- Listen to the person's frustration and empathize with their feelings (but not the behavior)
- Understand how they perceive the situation, try to understand the cause of their reaction
- What do they want that they are not getting?
- Address their concerns and restate them to clarify
- Offer a solution or alternative

DE-ESCALATION TECHNIQUES

- Note when a situation first escalates as demonstrated by a louder voice, fidgeting, verbal sounds, and a build-up of energy
- Demonstrate qualities that will put the person at ease (calming, understanding voice)
- Be proactive, not reactive
- Reassure them of your desire to help
- Avoid arguing or defending previous actions
- Avoid threatening body language (arms crossed) or verbalizations
- Calmly/ respectfully, but decisively, outline limits of the situation
- Safety is always first and foremost; be aware of available back-up resources

  If the situation continues to escalate you will typically observe more physical cues (louder or shutting down, more agitated actions or statements). Also as emotions increase, auditory processing abilities decrease. Staff needs to intervene to defuse the situation by:

- Communicate information in simple terms and give some choices if possible to help empower the person
- Stay at eye level, but do not maintain constant eye contact as this may be misunderstood as a challenge
- Position yourself between the person and the exit; do not turn your back; allow extra physical space between you and individual and do not stand fully in front of the individual
- Don't refer to rules and policies, instead focus on safety and healthcare reasons for any directions given to the person
- Respond selectively such as answer informational questions no matter how rudely asked; but do not answer abusive/ insulting questions
- Limit stimulation and traffic in the immediate area
- Be aware of potential hazards in the area (stethoscope, treatment tools, walkers, canes, etc.)
- Call for assistance as needed.

CODE STATUS, RESUSCITATION, DNR..WHAT DOES IT ALL MEAN?

"Code Status' essentially means the type of emergent treatment a person would or would not receive if their heart or breathing were to stop. The topic of code status can be confusing to many. Too often, code status is not discussed fully until there is a crisis with one's health status. At the time, the information can seem even more confusing or a person may not be able to fully communicate their personal wishes related to treatment options. We have provided content below to help you get started with understanding code status.

What is a Healthcare facility Code Status?
All patients who are admitted to a Healthcare facility or skilled nursing facility are assigned a code status. As stated above, 'Code Status' essentially means the type of treatment a person would or would not receive if their heart or breathing were to stop.

This treatment can be summarized as four categories (commonly referred to as resuscitative efforts), which include:

- Cardiopulmonary Resuscitation (CPR)- includes providing breaths and chest compressions. Simplified, this is an attempt to 'physically jump start the heart.'
- Defibrillation- provides an electrical shock via pads or paddles. Simplified, this is an attempt to 'electronically jumpstart the heart'.
- Specific Cardiac Arrest Medications- Medications indicated for an event when a person's heart has stopped beating to sustain life. Simplified, this is an attempt to 'chemically jumpstart the heart.'
- Intubation and Mechanical Ventilation- involves placing a breathing tube that can be connected to a ventilator (breathing machine), if a person cannot breathe on their own.

LEVEL OF CODE STATUS

While resuscitative efforts are standardized from the American Heart Association, the terms used to define code status vary from institution to institution. The following levels are usually (but not an all- inclusive list):

- **Full Resuscitation**- all resuscitative and aggressive curative treatment are provided.

- **Do Not Attempt Resuscitation (DNAR) or Do Not Resuscitate (DNR)-**order designating that in the event of a cardiac or respiratory ARREST, resuscitation will not be attempted. All other aggressive treatment desired will be provided as appropriate.

- **Comfort Measures Only**- in the event of a cardiac or respiratory ARREST, ALLOW NATURAL DEATH. Do NOT attempt resuscitation (CPR, Cardiac Arrest Medications, Defibrillation, Intubation). AGGRESSIVE TREATMENT WILL BE DISCONTINUED OR NOT BE PROVIDED and only treatment to promote comfort will be provided.

Resuscitative efforts are most successful when all components can be offered together. Although it is commonly not recommended, some institutions may allow a patient to have only certain resuscitation efforts in the event of a medical emergency (e.g. no defibrillation, but allow intubation). This consideration should be well discussed and only offered if

possible benefits outweigh the risks. Please note: Medications cannot circulate in the body without a heartbeat. Therefore, the option to have Cardiac Arrest Medications without CPR would not be beneficial.

Common Misconceptions: DNAR does not imply that the healthcare team will do nothing in the event of a patient change in status or that the patient will receive substandard care. Alternatively, full code does not imply that the medical team will continue interventions on a patient that they deem are of no benefit.

*****Please check your individual facilities (and States) specific policies in regards to Code Status as this resource is only an initial resource on general guidelines, but not a source that prevails your facility or State guidelines on 'Code Status'.*****

Dementia Training

Foundations of Dementia and Dementia Care

A person with dementia may start to behave differently as their condition progresses. They may develop behaviors that are challenging and distressing for caregivers, themselves and others around them. This fact sheet outlines some behaviors that a person with dementia might develop, and explains some of the common causes for these. It also looks at how caregivers can support a person with dementia and deal with situations caused by these behaviors.

These out-of-character behaviors can be difficult to understand, are often caused by confusion and distress, and may indicate underlying needs. Looking at the causes of the behavior and identifying the needs of the person can help to reduce these behaviors, or make them easier to cope with.

Changes in behavior

Causes of changes in behavior in people with dementia

When a person with dementia behaves differently, this is often mistakenly seen as a direct result of the dementia or simply as another symptom of the condition. However, this is often not the case. The behavior may have many causes, including difficulties relating to dementia (such as memory loss, language or orientation problems), but also mental and physical health, habits, personality, interactions with others and the environment. Dementia can make the world a confusing and frightening place as the person struggles to understand what is going on around them. Though it may confuse the caregiver, the behavior will have meaning to
the person with dementia.

The possible causes of someone behaving out of character may be divided into biological (ex. being in pain), psychological (ex. perceiving a threat) or social (ex. being bored).

The person with dementia may be influenced by an environment that is unable to support or meet their needs. Disorientation is a common feature of dementia, so an environment that is difficult to navigate and confusing can increase distress.

When supporting a person with dementia who is behaving out of character, it's important to see beyond the behavior itself and think about what may be causing it. Sometimes behavior can be a result of frustration in the way others around the person are behaving, a sense of being out of control, or a feeling of not being listened to or understood.

People with dementia have the same basic needs as everyone else. However, they may be less able to recognize their needs, know how to meet them, or communicate them. Behavior may be an attempt to meet a need (ex. removing clothing because they are too hot or walking around because they are bored or feel they need to be somewhere), or to communicate a need (ex. shouting out because they need the toilet). Dementia can make the world a confusing and frightening place as the person struggles to understand what is going on around them. Though it may confuse the caregiver, the behavior will have meaning to

the person with dementia. It is likely to be an attempt to enhance and maintain a sense of wellbeing and ease distress. Any response should involve trying to see things from the person's perspective

Types of behavior

The following section discusses some of the most common forms of behavior that a person with dementia may develop, and gives some suggestions to help support the person. Everyone experiences dementia in their own way, and caregivers will need to find out what works best for the person.

Restlessness

People with dementia may develop various restless behaviors such as fidgeting, pacing and agitation. Causes of restlessness in people with dementia can include:

- pain or discomfort, ex. arthritic or dental pain
- a medical reason, ex. depression or the side effects of medication
- a basic need, ex. hunger, thirst or needing the toilet
- a feeling, ex. anxiety or boredom
- communication problems

the environment – it may be too hot or too cold, over-stimulating or under-stimulating.
Restless behavior can be difficult for caregivers because it can take many forms and can be very tiring. However, there are some things that may help.

Repetitive behavior

People with dementia often carry out the same activity, make the same gesture, say the same thing or ask the same question repeatedly. This may be because they feel anxious and frightened, and want comfort, security and reassurance. The person's natural interaction with their surroundings may have been disrupted by memory problems, confusion, disorientation or boredom, so they may be trying to make sense of their situation by asking about and exploring it. Repetition may also be a

result of memory loss, and the person not being able to remember what they have done or said, or the answer they received to a question.

Repetition can be exhausting for caregivers, who may become irritated and frustrated that they can't have a break. Caregivers may think that the person is being deliberately difficult. It can also be frustrating for people with dementia, especially if their questions are unanswered and they are left feeling anxious and insecure.

Shouting and screaming

The person may scream, shout or moan or use abusive language, occasionally or repeatedly. This can be very distressing for caregivers and the person with dementia, and can cause emotional strain between them.

There are many possible reasons for why a person shouts, including:

- pain or discomfort
- attempting to communicate a need, ex. hunger or thirst
- a feeling, ex. anxiety, loneliness or boredom
- under-stimulation or over-stimulation
- a response to a hallucination or misperception
- communication problems

an unsupportive environment – ex. it may be too hot, too cold or too dark. If the person is shouting and screaming it may be aggressive.

Walking

Some people with dementia start to walk about more. This may not be a problem for the person with dementia. However, it can be very stressful for caregivers, especially if the person stays out for long periods of time or leaves the home unexpectedly or during the night. Caregivers may feel that the person is walking aimlessly (sometimes referred to as 'wandering'), but there will often be a purpose to the walking. If caregivers can work out why the person is walking, it will help them put strategies in place.

Some reasons why people may walk include relieving boredom or anxiety, revisiting a past habit (ex. collecting the children from school or taking the dog for a walk) or confusion. The person may also feel that they have somewhere to be. Walking may offer the person a chance to be independent, give them something to do and opportunities for exercise. Sleep disturbance and night-time waking

Sleep disturbances are common for people with dementia, and often lead to caregivers also experiencing problems with their sleep.

A person with dementia may get up repeatedly during the night and may become disoriented when they wake. They may get dressed or try to leave the house. This may make the person tired during the day and they may sleep for long periods. All of this can be very stressful for caregivers. People with dementia may not be aware that they experience any problems during the night.

Dementia can affect people's sleep patterns. This is separate and different from normal age-related sleep difficulties. It can cause problems with the sleep-wake cycle and also interfere with the person's 'body clock'. Disturbed sleep can have a

negative impact on a person's wellbeing (as well as that of their sleeping partner), so strategies to improve sleep will be beneficial.

Sundowning

Sometimes a person with dementia will exhibit an increase in certain behaviors in the late afternoon or early evening. For example, becoming more agitated, aggressive or confused. This is often referred to as 'sundowning'. This pattern may continue for several months and often occurs in those in the moderate to severe stages of dementia. It can be particularly distressing for caregivers if they are trying to relax or have some quiet time.

Hiding, hoarding and losing things

A person with dementia may hide, hoard or lose items. This can be very frustrating for caregivers who may have to spend time finding the items
or trying to find out from the person where the objects are. Hiding and
hoarding may be an attempt by the person to remain in control of their situation. The person may also be experiencing paranoia or delusions and believe their items will get stolen, meaning they may try to hide or protect them. Losing things may be the result of the person forgetting where they have put them, especially if they have already put them in an unusual place.

Accusing

A person with dementia may make accusations against people around them, including family, friends and caregivers. The most common accusations are that others are trying to steal from them or harm them. They may also accuse their partner of being

unfaithful, or of being an impostor. These false accusations can be distressing for someone caring for a person with dementia. Often the accusations are based on a hallucination or delusion on the part of the person with dementia.

Trailing and checking

A person with dementia may follow their caregiver around, check that they are nearby, repeatedly call out or ask for people, or ask to go home when they are already there. This can be frustrating and tiring for caregivers. It can also be upsetting for the person with dementia.

Living with dementia can make people feel insecure and anxious. They may feel a constant need to be reassured, because the world around them no longer makes sense. This is why they may shadow caregivers and constantly seek reassurance that they are not alone. They may also have forgotten where the caregiver is and follow them as a means of checking they are still there.

Trailing and checking may also indicate another underlying need. For example, if a person with dementia is asking for parents who have died,or asking to go home when they are actually in their home, it may reflect a need to feel secure and safe.

It is important to address the underlying emotion and need behind what the person is asking for. Confronting them with the truth might not help, and may make the person feel more upset and distressed.

Losing inhibitions

Sometimes a person with dementia can lose their inhibitions and may behave in ways that others find embarrassing. This can include being rude, saying things that are socially inappropriate (ex. commenting that someone is overweight), talking to strangers, undressing in public, and apparent sexual disinhibition (ex. touching themselves inappropriately in public).

It is unlikely that the person is being inappropriate on purpose. When addressing the situation, it is important to uphold their dignity and prevent unnecessary distress.

This can be embarrassing and distressing for both the person with dementia and those around them. They may not understand that what they are doing is inappropriate. It is unlikely that they are being inappropriate on purpose. When addressing the situation, it is important to uphold the person's dignity and prevent unnecessary distress.

A person with dementia may have trouble finding the right word, they may repeat words and phrases, or may become 'stuck' on certain sounds. In addition, people with dementia are likely to have other sensory impairments (such as sight or hearing problems) which can also make it harder to communicate. If someone is not able to express themselves properly, they can lose confidence, or feel anxious, depressed or withdrawn. They may also behave in ways others find odd, because they are trying to communicate what they can no longer say with words.

Dementia and language

Problems with language can occur in all forms of dementia. This is because the diseases that cause dementia can affect the parts of the brain that control language. How and when language problems develop will depend on the individual, as well as the type of dementia and the stage it is at. These problems will also vary day to day. In some forms of dementia – such as frontotemporal dementia – it is very likely to be one of the first symptoms that is noticed.

One sign that a person's language is being affected by dementia is that they can't find the right words. They may use a related word (ex. 'book' for 'newspaper'), use substitutes for words ex.g 'thing to sit on' instead of chair) or may not find any word at all. Another sign is that they may continue to have fluent speech, but without any meaning – for example, they may use

jumbled up words and grammar. Dementia can also affect the person's ability to make an appropriate response, either because they may not understand what you have said or meant.

There may eventually come a time when the person can hardly communicate at all using language. This can be distressing for them and those supporting them, but there are ways to maintain communication and support the person to express themselves.

Dementia can also affect a person's cognitive abilities. A person with dementia may have slower speed of thought, or not be able to understand complex ideas. This can also affect their ability to communicate. For example, they may take longer to process thoughts and work out how to respond to what is being said.

Other factors can affect a person with dementia's communication, including pain, discomfort, illness or the side-effects of medication.

Tips: communicating with someone with dementia

Before you speak

Make sure you're in a good place to talk – quiet, with good lighting and without too many distractions (ex. no radio or TV on in the background).

Get the person's full attention before you start.

Position yourself where the person can see you as clearly as possible (ex.
with your face well-lit) and try to be on the same level as the person, rather than standing over them.

Sit close to the person (although not so close you are in their personal space) and make eye contact.

Make sure your body language is open and relaxed.

Have enough time to spend with the person. If you feel rushed or stressed, take some time to calm down.

Think about what you are going to talk about. It may be useful to have an idea for a particular topic ready. You can also use the person's environment to stimulate topics.

If the person is finding it hard to understand, consider breaking down what you're saying into smaller chunks so that it is more manageable.

Ask questions one at a time, and phrase them in a way that allows for a
'yes' or 'no' answer (ex rather than asking someone what they would like to do, ask if they would like to go for a walk) or in a way that gives the person a choice (ex 'would you like tea or coffee?').

Rephrase rather than repeat, if the person doesn't understand what you're saying. Use non-verbal communication to help (ex.pointing at a picture of someone you are talking about).

If the person becomes tired easily, it may be better to opt for short, regular conversations.

As dementia progresses, the person may become confused about what is true and not true. If the person says something you know is not true, try to find ways of steering the conversation around the subject and look for the meaning behind what they

are saying, rather than contradicting them directly. For example, if they are saying they need to go to work is it because they want to feel useful, or find a way of being involved and contributing? Could it be that they are not stimulated enough?

Listening

Listen carefully to what the person is saying,and offer encouragement.
If you haven't understood fully, rephrase what you have understood and check to see if you are right. The person's reaction and body language can be a good indicator of what they've understood and how they feel.

If the person with dementia has difficulty finding the right word or finishing a sentence, ask them to explain it in a different way. Listen out for clues. Also pay attention to their body language. The expression on their face and the way they hold themselves can give you clear signals about how they are feeling.

Allow the person plenty of time to respond – it may take them longer to process the information and work out their response. Don't interrupt the person as it can break the pattern of communication.

If a person is feeling sad, let them express their feelings. Do not dismiss a person's worries – sometimes the best thing to do is just listen, and show that you are there.

Body language and physical contact

Non-verbal communication is very important for people with dementia, and as their condition progresses it will become one of the main ways the person communicates. You should learn to recognize what a person is communicating through their body language and support them to remain engaged and contribute to their quality of life.

A person with dementia will be able to read your body language. Sudden movements or a tense facial expression may cause upset or distress, and can make communication more difficult.

Make sure that your body language and facial expression match what you are saying.

Never stand too close to someone or stand over them to communicate – it can feel intimidating. Instead, respect the person's personal space and drop to or below their eye level. This will help the person to feel more in control of the situation.
Use physical contact to communicate your interest and to provide reassurance – don't underestimate the reassurance you can give by holding the person's hand or putting your arm around them, if it feels appropriate.

Sensory impairment

A number of people with dementia will have some form of sensory impairment (such as sight loss, hearing loss or both). People with both sensory impairments and dementia are likely to have additional difficulties with their communication. However, there is still a lot you can do to help them communicate effectively.

All of the tips and suggestions in this factsheet may be useful for people with dementia who have difficulties communicating. A number of additional suggestions for people with sensory impairments are outlined below.

Hearing loss

Most people over 70 will have some degree of hearing loss. They may consider themselves as deaf, 'hard of hearing' or having 'acquired hearing loss'. This may be due to age-related damage or other causes (such as noise damage, infection, diseases or injury).

In comparison, people who are born deaf or become deaf at a young age are considered to have 'profound deafness'. They may consider themselves as Deaf (often referred to as Deaf with a capital D), use British Sign Language (BSL) as their first language and identify with the Deaf community.

How a person with hearing loss communicates will depend on a range of factors including:

- the type of hearing loss they have

- whether they use a hearing aid, BSL, lip-reading or a combination of all
- of them
- personal preference and life history.

There are strong links between dementia and hearing loss that suggest hearing loss can make developing dementia more likely. People with hearing loss are likely to experience more difficulties as a result of their dementia. They may already find it harder to communicate, and not being able to hear what is going on around them or hear other people speak can add to their confusion. Both dementia and hearing loss can also make people feel socially isolated, so having both conditions at once can be very difficult for someone. This makes good communication extremely important.

Tips: Communicating with someone with hearing loss

If the person uses a hearing aid, check that it is fitted and working properly. If you think the hearing aid isn't working or if you need help checking it, speak to your GP or make an appointment with the audiology department at your local Healthcare facility.

- Ask the person if they would like to lip-read.

- Turn your face towards the person and ensure your face is well-lit so your lip movements can be easily seen.

- Don't shout or over-exaggerate words or lip movements (this can actually make it harder for the person to understand you).

- Speak clearly and slightly slower, but keep the natural rhythms of your speech.

- Don't cover your mouth.

- Consider using visual clues such as objects or pictures to help.

- It may be helpful to check if the person has too much ear wax, as this may make any hearing loss and communication difficulties worse.

- Sight loss

Many people experience some degree of sight loss as they get older. This may be age-related, or due to a condition such as cataracts or age-related macular degeneration. Many people with sight loss will need glasses to help them see.

People with sight loss are likely to experience more difficulties as a result of their dementia. Not being able to see what is around them can lead to a greater sense of disorientation and distress, as well as decreased mobility and a risk of falls. Having both dementia and sight loss can also make people feel isolated from those around them. This makes good communication extremely important.

Communicating with a person with dementia and sight loss may be difficult as the person may not be able to pick up on non-verbal cues or follow a conversation as easily. There is a lot you can do to help them.

Tips: Communicating with someone with sight loss

- Check the person is wearing their glasses, if needed, and that these are clean and that the prescription is up-to-date.

- If someone has more than one pair of glasses, ensure they are labelled or marked for the activity they have to be used for – for example, reading glasses.

- Introduce yourself or try to gain the person's attention before starting or ending a conversation. If you don't, they may become confused about who is talking, be unsure if they are being spoken to, and may not know if people enter or leave the room.

- If you are helping the person with a task, let them know what you are going to do before and during it.

- Use references when describing where something is – for example, your water is on the table on your right. It may be helpful to use imaginary hands on a clock face to describe where something is, especially for people who have lived with sight loss for many years (ex. the cup is in front of you at 12 o'clock position).

- Make the most of the physical environment – for example, make sure there is good lighting, which is consistent, even and can be adjusted.

- Try to reduce shadows as the person may mistake them for obstacles.

- The person may not be able to pick up on non-verbal communication, such as body language. Bear this in mind when talking to them.

- If you are communicating with someone in writing, such as sending them a letter, think about the color of paper and font size (for example, black text on white or yellow paper often makes text easier to read, as does text).

People with learning disabilities are 10 times more likely to have serious sight problems than other people. They are also at greater risk of developing dementia at a younger age, particularly people with Down's syndrome. You should make sure a person with learning disabilities and dementia has a communication passport – a practical tool that gives information about a person's complex communication difficulties, including the best ways to communicate with them.

Person-centered care

What is person-centered care?

Person-centered care involves tailoring a person's care to their interests, abilities, history and personality. This helps them to take part in the things they enjoy and can be an effective way of preventing and managing behavioral and psychological symptoms of dementia.
The key points of person-centered care are:
- treating the person with dignity and respect
- understanding their history, lifestyle, culture and preferences, including their likes, dislikes, hobbies and interests
- looking at situations from the point of view of the person with dementia
- providing opportunities for the person to have conversations and relationships with other people
- ensuring the person has the chance to try new things or take part in activities they enjoy.

Family, caregivers and the person with dementia (where possible) should always be involved in developing a care plan based on person-centered care. Their knowledge and understanding of the person is extremely valuable to make sure the care plan is right for them.

Providing adequate fluids and nutrition

In the early stages of Alzheimer's, people are usually able to manage their diets and meal preparation. They may forget to buy bread or leave the salt out of a recipe, but they generally eat and drink adequately — or at least as well as they did before the onset of dementia.

As dementia progresses, a number of changes may occur that affect diet, not necessarily in order:

- People may forget about eating and begin skipping meals and fluids. The first sign may be an unexplained loss of weight. People may develop urinary infections and constipation because of dehydration.

- People may forget they have eaten and eat repeatedly or drink large amounts of fluids, sometimes resulting in urinary incontinence. They may begin gaining weight, sometimes rapidly.

- People may eat only a few different items rather than a well

-balanced diet. Many people begin eating primarily sweets and other junk foods, such as potato chips, partially because they like the foods but also because these foods are easy to access and don't require cooking.

- People may not chew food adequately or may eat very rapidly, increasing the risk of choking.

- People may experience dysphagia, with recurrent episodes of choking and aspiration. This usually becomes more pronounced in later stages of Alzheimer's.

- People may forget to do mouth care, resulting in caries, or may forget to wear—or refuse to wear—dentures, making chewing solid foods problematical.

In a licensed facility, observation includes staying with people while they eat—rather than just putting a tray of food in front of them—and watching how they handle the food. This is especially important when people are first admitted. Observation also includes noting carefully how much people eat or drink during the meal. If half of the food is left on a plate, then the task is to figure out why. It may be because of personal food preferences or it may be that the person is unable to cut food into bite-sized pieces or may be unable to chew certain foods.

Additionally, people should be carefully observed as they eat and drink:

- Do they cut food, such as meat, into bite-size pieces or put large pieces into their mouths

- Do they avoid eating certain foods? Which food? Why?

- Do they handle utensils correctly?

    - Can they cut meat or other foods with a knife?

•Do they gulp food and liquids or chew and swallow adequately?

•Do they tend to choke on foods or liquids

•Do they spill fluids or drop food? If so, why? Do they have tremors or are they inattentive?

Stimulating Activities

Family and friends

Often friends and relatives enjoy these types of reminiscence activities and are willing to bring photos and objects with them. This is a great way of involving visitors in stimulating activities.
Sometimes it can be a bit stressful for visitors if they are unsure of how they should act or what they can do with the person with dementia. You can help by preparing them in advance, especially with tips on communication. Social contact is very important and you should encourage as many visitors as possible, as long as the person with dementia enjoys them.

One caregiver got friends and relatives to tape anecdotes onto a cassette for the person with dementia to listen to. The tapes can be enjoyed together, as a chance to reminisce, or the person can listen alone. You may find that the person enjoys visits from grandchildren or friends' children. Children are usually very happy to communicate in any way they can with people. They may enjoy playing games the person with dementia remembers from his or her childhood.

Memory boxes

Putting together a memory box is a good way of stimulating and drawing out memories. Put favorite objects, old photos, and items from the person's work in the box to be examined. If the person is agitated, looking at the objects may calm him or her down. During quiet moments, when the person is tired or you don't want to go out somewhere, looking at the photos and objects can be a very relaxing way of being together.

Life story book

In the same way as the memory box you can also put together a life story book. You could combine photos with notes about his or her:

- mother and father, sisters and brothers
- children
- work
- places he or she has visited or lived in
- favorite holidays
- friends
- hobbies
- favorite foods, least favorite foods
- colors
- favorite films, music
- likes and dislikes
- politics.

Photos, postcards, scraps of material from old clothes or bed covers and other memorabilia can be added to the story book. This can be a very enjoyable activity for both of you. As the person's illness progresses it will become more important that the memories are all written down and recorded so that others can help the person recall those important times.

If the person does have to go into a care home this book can be taken and shown to the staff. It will provide them with a very valuable history and background of the person's life, which will help them to get to know him or her.

Creative activities

Writing

You may find that the person you care for enjoys writing if he or she has mild dementia. Perhaps you could suggest he or she writes about school days, past holidays and family meetings, so that grandchildren will be able to read about his or her past. These stories could be made into a book with photos and old postcards. Even later on, writing postcards and birthday cards can be a way for the person to keep in touch with friends and family.

Art

Producing artwork is often exciting and interesting. Even if the person has not painted a picture since his or her school days, being creative with paints and other craft materials can be very enjoyable and satisfying. Remember that the end results do not have to look like
'works of art'.

Depending on the person's interests and what he or she enjoys doing there are many different types of projects you could enjoy together. Painting on plant pots or wooden photo frames, or even small pieces of furniture like wooden stools can be very satisfying and produce some great results. Look around art shops for ideas. There are kits available for sand art, painting by numbers and collage kits. Art galleries and exhibitions are also likely to be a source of interest and a subject for discussion. For most people it's best to use adult materials because items obviously meant for children can offend.

Knitting, sewing and embroidery

If the person you care for has always knitted or done embroidery or tapestry you may find he or she retains these skills for a long time. You might have to encourage him or her to start and be prepared to help with each stage, but it is worth persevering. The end result can give a wonderful sense of satisfaction.

Gardening

Gardening is another favorite activity enjoyed by many people. Gardening provides a change of scene and will also ensure you both get some fresh air and exercise. It may be a good idea for the person to have his or her own patch of garden to dig and plant in. Weeding, trimming lawn edges, sweeping paths and general tidying in the garden can all be tasks many people with dementia can cope with. However, make sure he or she doesn't use electrical equipment or potentially dangerous tools.

Try to plan the garden so that there are lots of different varieties of plants, with bright colors and interesting scents - for example, lavender and rosemary. These can be stimulating and enjoyable for people with dementia even late on in the illness.

If you do not have access to a garden, indoor gardening, such as planting bulbs and herbs in pots can be an enjoyable activity too.

BASICS OF BEHAVIORAL HEALTH CARE

One of the primary responsibilities of the clinical staff in a long-term care facility is to care for the behavioral health needs of the residents. There are five things you need to know to meet that responsibility.

1) Know what behavioral health problems a resident has.
2) Do a basic assessment of a resident's level of cognitive ability.
3) Identify harmful and potentially harmful behaviors.
4) Identify the signs and symptoms of a distressed mood.

#1 Knowledge of Behavioral Health Problems

The clinical staff should have basic knowledge about specific behavioral health problems like anxiety, bipolar disorder, post-traumatic stress disorder, and schizophrenia. But your primary responsibility is to know that a resident *has* a behavioral health problem, understand how these problems manifest and know how to care for a resident who has a behavioral health disorder. Example: Does he/she have anxiety or dementia? Has the resident been depressed, agitated, physically violent, or has she/he been wandering?

#2 Cognitive Assessment

A cognitive assessment is a way of determining a resident's mental abilities and function.

The formal cognitive assessment process of a resident's mental health is outlined below. The clinical staff typically do not perform this assessment. However, you do have a responsibility for recognizing abnormal changes in a resident's cognitive ability, a basic cognitive assessment can be done quickly and easily, and it does not need to be a structured process: You can do an informal cognitive assessment of a resident during routine care and during a casual conversation. Examples of how this can be done are outlined below.

1) Short-term memory: Can the resident remember something important that you said five minutes ago? Testing someone's short-term memory is often done by telling someone a list of five short, simple words; wait five minutes and ask her/him to repeat the words back to you.

2) Long-term memory: Can the resident remember something important that she/he was told yesterday or a week ago?

3) Time, place, and person: Asking someone about time, place, and person is one of the most common ways of evaluating someone's mental ability.

- Time: What day is today? What year is it?
- Place: Where are you? What is this place? How long have you been here?
- Person: What is your name? What is my name, and who am I? People will usually remember their names, so asking a resident to identify someone else is a better way of determining if the resident can correctly recognize other people.

4) Decision-making skills: Assessing someone's decision-making skills is more complicated, but it is not difficult. What you want to know is if the resident can make the decisions that he/she needs to so that she/can function independently.

5) Hallucinations and delusions: Does the resident have any hallucinations or delusions? A hallucination is a visual or auditory perception of something that does not exist, i.e., the resident is "seeing things" or "hearing things." A delusion is an irrational idea or a belief that has no basis in reality. Example: The resident thinks that she/he is being poisoned and that her thoughts are being controlled by radio waves.

6) Disorganized thinking: If the resident cannot focus on one thing, if the resident's conversation is not appropriate to the situation, or if his/her thoughts and conversation do not make sense, this is disorganized thinking.

#3 Identifying Harmful and Potentially Harmful Behaviors

Mental and psychosocial disorders, dementia, and other behavioral health problems often cause disruptive, harmful, and potentially harmful behaviors.[3-5] Harmful and disruptive behaviors can be 1) Physical, like hitting, kicking, or scratching, or wandering or, 2) Verbal, like cursing, screaming, or inappropriate conversation.

Harmful and disruptive behavior that directly affects a resident also includes interference with care and rejection of care. Interference with care is defined as any behavior that disrupts the routines or processes by which care is given.[2] Rejection of care is defined as any behavior, physical or verbal, that prevents care from being accepted or delivered.[2]

Harmful or potentially harmful behaviors and disruptive behaviors are easy to identify. The clinical staff should identify harmful and disruptive behaviors when they occur. It is also important to document the frequency of these behaviors, the circumstances during which they occur, why they are occurring, and the impact of these behaviors.

- Frequency: How often do harmful/disruptive behaviors occur? Are they occurring more often?
- Circumstances: When does the harmful/disruptive behavior occur? Does it occur at a specific time of the day or during a specific activity? Examples:
  1) For residents who have dementia, a change of routine can be upsetting, and they may respond to the stress by being physically or verbally aggressive.[4]
  2) People who have dementia can become confused during the later part of the day, and this phenomenon is called sundowning.[4] Sundowning has been reported to happen to up to 14% of nursing home residents.[4]
  3) Does the harmful/disruptive behavior occur when certain people are close by or are providing care? Does it occur during bathing, ambulating, or a medical procedure?
- Why: The why of harmful/disruptive behaviors occur was partly discussed in the previous section on circumstances. However, it is important to remember that behavioral problems can be caused by physical, emotional, and psychological circumstances.
  1) Physical: Being sick is stressful for anyone, and a resident's behavioral problems may be happening because she/he is ill and/or simply not feeling well. This situation is made worse if the resident cannot, for whatever reason, let you know that they are in physical distress.[6] And for patients who have communication problems, they may just be uncomfortable, hungry, or thirsty, or need to use the toilet, but they cannot tell you what they want.
  Being overmedicated or undermedicated can cause behavioral health problems, as can an adverse effect to a medication. Pain can also cause harmful/disruptive behavior.
  2) Emotional stress that may not upset someone else can cause harmful/disruptive behavior in residents who have a cognitive disorder, a communication disorder, or a serious psychological condition.
  3) Psychological stress that may not upset someone else can cause harmful/disruptive behavior in residents who have a cognitive disorder, a communication disorder, or a serious psychological condition.
- Impact: What is the impact of harmful/disruptive behavior? Does it cause physical harm to a resident or someone else? Does it interfere with the daily routine of the facility?

#4 Identifying Signs and Symptoms of a Distressed Mood

Mood distress is a serious condition that is associated with adverse physical and psychological effects and poor outcomes.[2] The CMS recommends that every long-term care facility resident be assessed for mood distress,[2] and that the assessment should include the nine questions listed below.[2] These questions are commonly used to determine if someone is depressed, and depression is a common type of mood distress.

In the past two weeks have you been bothered by:
1) Little or no pleasure in doing things.
2) Feeling down, depressed, or hopeless.
3) Trouble falling, staying asleep, or sleeping too much.
4) Feeling tired or having little energy.
5) Poor appetite or overeating
6) Feeling bad about yourself. Feeling that you are a failure or that you have let yourself or your family down.
7) Trouble concentrating on things, such as reading the newspaper or watching television
8) Moving or speaking so slowly that other people could have noticed? Or the opposite — being so fidgety or restless that you have been moving around a lot more than usual.
9) Thoughts that you would be better off dead or thoughts of hurting yourself in some way

Doing the mood assessment is <u>not</u> the responsibility of the clinical staff, but the clinical staff should know these signs and symptoms of mood distress.

INTERVENTIONS FOR BEHAVIORAL HEALTH PROBLEMS

The clinical staff is responsible for keeping residents healthy and safe and for a resident who has behavioral health problems, you must know how to intervene if the resident's behavior is disruptive and/or dangerous.

Harmful or Disruptive Physical and Verbal Behavior

If there is harmful, disruptive, or potentially harmful physical or verbal behavior, the first step is to decide if this behavior is an immediate and serious risk to anyone's health and safety.[7]

If the answer is yes, maintain a safe distance from the resident,[8] have the other residents (If any are nearby) leave the area and call for help. Long-term care facilities should have a protocol that outlines what to do if a resident's behavior is causing or may cause a health and safety risk. In a situation like this, you may be asked to help physically restrain a resident.

There are techniques that can be used to help control and stop harmful or disruptive physical and verbal behavior. Examples are provided below.

1) Look for a cause: A resident who is acting out physically or verbally, or both is upset or feels threatened.[6] There may be an easily identifiable cause (Pain, an emotionally upsetting situation) or not, and the resident may (Or may not) be able to tell you why she/he is being physically and verbally aggressive. And even if you know what the problem is there may not be a quick fix. But there is always a reason for this type of behavior, and you should try and identify it.[12]

2) Feelings, not facts: Someone whose behavior is harmful or disruptive is upset, and his/her feelings are the most important thing to that person. Telling someone that their behavior is dangerous, disruptive, or inappropriate — "talking sense to them" — is unlikely to be helpful. If it is safe to do, let the resident talk about her/his feelings.[8] Remember, even though it may not be obvious or logical to you or other staff members, the resident has a reason for his/her behavior, and letting them talk about it can be helpful.

3) Ask questions: This is related to feelings, not facts. Ask the resident why he/she is upset.[7] This allows the resident to explain the behavior.

4) Do not argue and do not make threats: This is also related to feelings, not facts. Don't argue with someone whose behavior is harmful or disruptive and don't make threats.[7] The resident is unlikely to respond to a "logical" argument about why the behavior is wrong and/or why the behavior should be stopped, and a threat is likely to make the situation worse.

5) Speak slowly, calmly, and use your normal tone of voice.[7]

6. Distraction: A resident who is upset may respond to distraction.[7] Distraction is simply a way of getting a person to focus on something other than the cause of harmful/distracting behavior.

Wandering

Wandering is a common behavior in people who have dementia.[13-15] Wandering is usually thought of as someone who leaves home or leaves a facility and becomes lost.

This type of behavior does happen, and it is a serious consequence of wandering, but it is not the only aspect of this behavior. It is more accurate to describe wandering as a combination of restlessness, disorientation, and physical activity like pacing and repetitive physical acts.[13,15] Signs of wandering or that the resident is likely to wander include:

- Difficulty locating areas of the residence, e.g., bathroom or bedroom
- Disorientation
- Getting lost even in familiar places
- Leaving the residence
- Pacing
- Repetitive physical activity
- Restlessness
- Talking about going home
- Talking about the need to go to work.

Wandering can be prevented with physical changes in the environment like door locks, cameras, and GPS tracking devices. For direct caregivers, wandering can be prevented, or at least the consequences of wandering can be prevented by 1) Identifying residents who are at risk for wandering, 2) Reorient the resident to the surroundings, e.g., "You are at home and you are in your room." 3) If possible, organize daily activities into a predictable routine.[15]

Cognitive Problems

Cognitive problems can have a serious adverse effect on a resident's health and safety. Direct caregivers do not have to do a structured assessment of a resident's cognitive abilities. As was mentioned before, you can do an informal cognitive assessment of a resident during routine care or during a casual conversation.

Recognizing abnormal changes in a resident's cognitive abilities is one of your responsibilities. You should notify the resident's nurse if the resident has an abnormal change in any of the following cognitive areas.

1) Short-term memory: Example – You told the resident that you will be back in five minutes to help her out of bed. When you return, she asks you what the next activity will be.
2) Long-term memory: Example – The resident cannot remember that his birthday was last week and that his family had visited him.
3) Time, place, and person: The resident cannot correctly identify a) The day of the week or the year, b) Her/his location, or c) People that he/she has known for a long time.
4) Decision-making skills: Example – The resident had been able to independently
5) Hallucinations and delusions: Example - The resident said that someone is standing in his room; no one is there. He also says that for the past year the pharmacy has been putting poison in his medications.
6) Disorganized thinking: Example – When the resident is asked how she is feeling, she begins to talk about a meal she had last night.

Mood Distress

The physical signs of mood distress are obvious, but they are not specific to mood distress. For example, someone who has mood distress may have a poor appetite, trouble concentrating, or be fidgety and restless. These are signs of mood distress, but they could also be caused by a physical illness, and mood distress can only be diagnosed after an examination by a mental health professional. Also, some aspects of mood distress are personal feelings — the resident feels like a failure or feels that she/he would be better off dead — and these feelings are not easily shared.

Direct caregivers should be able to recognize the signs and symptoms of mood distress, and you should notify the resident's nurse if any of the following are present.

1) Little or no pleasure in doing things.
2) The resident seems to be or says that she/he feels down, depressed, or hopeless.
3) Trouble falling, staying asleep, or sleeping too much.
4) Feeling tired or having little energy.
5) Poor appetite or overeating
6) Difficulty concentrating.
7) Moving or speaking abnormally slowly or being very fidgety or restless. that you have been moving around a lot more than usual.
8) The resident says that he/she feels hopeless, talks about self-harm, mentions feelings of failure.

TRAUMA-INFORMED CARE

The Centers for Medicare & Medicaid (CMS) requires long-term care facilities that participate in their programs to provide trauma-informed care.[1,16]

"*Trauma-informed care.* The facility must ensure that residents who are trauma survivors receive culturally-competent, trauma-informed care in accordance with professional standards of practice and accounting for residents' experiences and preferences in order to eliminate or mitigate triggers that may cause re-traumatization of the resident.."[16]

"The facility must have sufficient staff who provide direct services to residents with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with §483.70(e).

These competencies and skills sets include, but are not limited to, knowledge of and appropriate training and supervision for:
(1) Caring for residents with mental and psychosocial disorders, as well as residents with a history of trauma and/or post-traumatic stress disorder, that have been identified in the facility assessment conducted pursuant to §483.70(e)."[1]

Post-traumatic stress disorder (PTSD) and trauma are common experiences, and they can be debilitating and incapacitating.[17-20.] Trauma and PTSD can be caused by being the victim of or witnessing traumatic mental and emotional experiences, physical violence, sexual violence, or a serious injury,[20] and trauma, and PTSD often cause intense and recurring emotional, physical, and psychological signs and symptoms.[18-20]
The Substance Abuse and Mental Health Services Administration (SAMHSA) definition of trauma underline and support many of the points.

"Individual trauma results from an event, series of events, or set of circumstances that is experienced by an individual as physically or emotionally harmful or life-threatening and that has lasting adverse effects on the individual's functioning and mental, physical, social, emotional, or spiritual well-being."[17]

Trauma-informed care is a well-established approach for working with people who have a history of trauma or PTSD. The four basic principles of the trauma-informed approach:[17]

1) Realization: Healthcare providers must be aware that trauma and PTSD are common conditions.
The staff should avoid and prevent behaviors and experiences that can re-traumatize a resident.
2) Recognition: Healthcare facilities, including long-term care facilities, must assess residents for the presence of these disorders, and the staff must be able to recognize someone who has been affected by trauma or has PTSD.
3) Respond: Long-term care facilities should develop a plan of care for residents who have been affected by trauma or who have PTSD, and the staff should be educated and trained on how to use this plan of care.
4) Re-traumatization:
The trauma-informed approach to care emphasizes safety, resident input, and consideration of personal, cultural, and gender issues that may play a part in someone's experience of re-traumatizing events.[17] In simple terms, nursing professionals who are working in a long-term care facility and who are caring for someone with a history of trauma or PTSD are responsible for
1) Knowing that someone has a history of trauma or PTSD.
2) Knowing the triggers can cause re-traumatization. For example, someone who suffered physical violence may be re-traumatized if he/she becomes physically violent and needs to be restrained. Or someone who was the victim of mob violence may be triggered by crowds. The trauma/PTSD assessment should identify someone's re-traumatization triggers, but nursing professionals can also, if they have a trusting relationship with the resident, ask her/him what behaviors and situations re-traumatize them.
3. Knowing the plan of care.

MALNUTRITION AND DEHYDRATION

Malnutrition
Malnutrition is complex and may be difficult to diagnose in elderly people. The following risk factors may lead to the condition: decreased cognition, difficulty feeding oneself, dentition issues, dysphagia issues, decreased physical ability/weakness, skin breakdown, constipation, and medical conditions which may contribute such as diabetes, renal disease, abnormal diagnostic results, and rapid weight loss.

Dehydration
Dehydration is the loss of water and salts essential for normal body function and is caused by not drinking or taking in enough fluids. Risk factors are similar to malnutrition and can impact on physical and cognitive well- being.

Nursing Assistant in Dining Room Support

- Resident's participation and enjoyment in the meal service
- Promote an engaging, pleasant atmosphere and reduce disruptive situations
- Complete hand washing/hygiene on entering the dining area and frequently throughout the meal service. Wash hands between service to each resident
- Position the resident comfortably and safely for eating and drinking
- Check that the resident's dentures are in place, if worn
- Check that the resident is comfortable, e.g. toileted prior to going to the dining room
- Follow the routine schedule, policies and procedures and arrive on time to help in the dining room
- Maintain awareness of the resident's nutritional and hydration needs and have access to the dietary plan of care.
- Offer the resident a choice of menus, including beverages
- Give correct meal to the resident, e.g. staff plating the meal checks the resident's diet and preferences and staff delivering the plate checks that the correct plate is delivered to the correct resident
- Allow the resident to eat and drink at his/her own pace
- Do not serve the meal to a resident until a caregiver is ready to assist the resident where assistance is needed

- Sit and maintain eye contact with the resident/s when feeding and feed with a teaspoon
- Encourage the resident to participate at his/her level of ability and desire
- Ensure that any necessary assistive devices are available for the resident use
- Refrain from personal conversations or use of personal phones or text messaging while in a resident's area
- Check that the resident's face and hands and wheelchair as appropriate are clean before the resident leaves the dining area
- Record or report the resident's diet and fluid intake as directed
- Report any swallowing, behavioral or changes in diet or fluid intake
- Monitor for tolerance to current diet texture and fluid consistency, reporting any concerns and making adjustments for safe food and fluid intake
- Provide mouth care following a meal
- Staff assisting in Snack Service support resident's participation and enjoyment in the snack service
- Serve the snack and beverages at the assigned time
- Offer the snack in an engaging manner
- Check that the resident is comfortable and positioned in a safe manner
- Maintain awareness of the resident's nutritional plan of care and offer the resident choice
- Allow the resident to enjoy the beverage/ snack at his/her own pace
- Offer appropriate assistance and encouragement as needed
- Record and or report the resident's intake as directed

Registered Nurses and Licensed Practical Nurses

- Work collaboratively within the nutrition and hydration programs to identify and mitigate nutrition, dietary service and hydration risks
- Ensure that medication provision, treatments and diagnostic services are not completed during mealtimes
- Direct the frontline staff emphasizing the need to follow policies and procedures so that resident dietary needs are offered in a safe manner
- Monitor dining room and snack activities ensuring proper feeding techniques are being used
- Collaborate with the interdisciplinary team in the assessment process on admission, every 6 months, and if the resident's plan of care becomes ineffective
- Use a collaborative approach to developing and implementing the plan of care including giving clear directions for direct care staff
- Complete documentation in health records, the plan of care, progress and reassessment
- Follow up on identified risks and situations and evaluate the outcome
- Report a resident's skin integrity issues to the dietitian and interdisciplinary care team members
- Encourage fluids when medication is being administered and at other times during the day
- Encourage the resident to share customary routines and preferences with the interdisciplinary team
- Complete and submit dietitian referral request as required

HIV Training for Nursing Professionals

THE EPIDEMIOLOGY OF HIV/AIDS

- **THE U. S.**

According to the available data, in 2017, 38,739 people were newly diagnosed with HIV in the US and dependent areas. The two thirds of them (66%) were men having sex with men (MSM) and bisexual men and one quarter (24%) heterosexuals. The rest of newly diagnosed were categorized as people who inject drugs (6%) and gay and bisexual men who inject drugs (3%), respectively.

Regarding the age of newly diagnosed individuals, one third (34.7%) were aged between 25-34 years, and 21% between 13-24 years. Other age groups tend to be less represented among people who discovered their HIV status.

At the end of 2015, an estimated 1,122,900 adolescents 13 years and older and adults were living with HIV in the US, while 6 out of 7 people knew they were living with HIV.

In 2016, 15,807 deaths occurred among people living with HIV in the US. Even though HIV infection has been reported in all US states, the District of Columbia and US dependencies, almost half of the deaths among HIV infected persons occurred in the South, almost one quarter in the Northeast, 1/6 in the West, 1/9 in the Midwest and 2% in the dependent areas (CDC, 2019a).

ETIOLOGY OF HIV INFECTION

Human Immunodeficiency Virus (HIV) is a retrovirus that affects the immune system and leads to various pathological conditions called acquired immunodeficiency syndrome (AIDS). HIV virus primarily attacks the cells of the immune system, so the disease manifests in the reduced ability of the body to deal with both infectious diseases caused by other viruses, bacteria, fungi and protozoa as well as with the development of malignant tumors. The primary target of HIV viruses are CD4+ T lymphocytes and their reduction consequently leads to death in HIV-infected individuals.

Stages of HIV infection

1. Acute HIV infection starts immediately after the virus enters the body. The virus attacks and destroys CD4 lymphocytes and multiplies rapidly. Flu-like symptoms such as fever, headache, throat pain, swelling of the lymph nodes may occur 2-4 weeks after infection with HIV. During the acute stage, the level of HIV in the blood is very high, which greatly increases the risk of HIV transmission.

2. Clinical latency stage or "asymptomatic stage" or "chronic HIV infection" infected persons have no symptoms, but the virus continues to multiply and thus can be transmitted.

3. **Acquired Immunodeficiency Syndrome (AIDS)** is the final stage of HIV infection, when the immune system is severely damaged and immunosuppression leads to opportunistic infections. AIDS is diagnosed if CD4 count is less than 200 cells/mm^3 or in the presence of opportunistic infections (AIDSinfo, 2019a).

MODES OF TRANSMISSION FOR HIV

Even though HIV infection has been one of the greatest public health interests for over three decades, this condition is still accompanied with a number of misconceptions, especially regarding transmission. The lack of knowledge about HIV/AIDS generates stigma, which proves to be one of the major obstacles for utilizing preventive, treatment and care services (Majahaj et al, 2008).

HIV virus in infected individuals can be detected in the majority of blood fluids. However, only some of them contain sufficient concentration of the virus for transmission: blood, semen, breast milk and vaginal and cervical secretions.

Tears, sweat, urine, feces or saliva do not contain enough virus to be infective. Therefore, hugging, shaking hands, closed-mouth kissing, sharing toilets or dishes - any casual social contact with an infected person is not harmful. Mosquitoes and any other insects or pets cannot transmit HIV virus; it also cannot be spread through the air (through coughing, sneezing or spitting) (HIV.gov, 2019).

Sexual transmission

Sexual contact with an HIV infected individual, without using a condom is the most common way of transmission. Anal sex has the highest transmission risk, especially receptive anal sex, even though insertive is also risky. A less risky way of becoming infected with HIV is through vaginal sex. Receptive partners are generally at increased risk then insertive ones. Oral sexual contact has the lowest risk for HIV transmission (HIV.gov, 2019).

Injection drug use

HIV virus can be directly injected in the bloodstream of a person who shares needles or syringes, rinse water, cotton or other equipment (called *works*) with an infected individual during shared drug preparation or use. By this way, some other bloodborne diseases could also be transmitted, including Hepatitis B or C (HIVcare.org, 2019).

Transfusion

First cases of HIV transmission through transfusion of contaminated blood was reported in the USA in 1982. Since then, great efforts have been made to minimize the risk of HIV infection by using highly sensitive laboratory tests to detect the virus and by using questionnaires for potential blood donors to exclude those at risk of being infected. The estimated risk of acquiring HIV

infection through transfusion is one in 1.5 million. The latest case of such virus transmission was reported in 2008 in Missouri (MMWR, 2010).

Perinatal

HIV virus can be transmitted from mother to a fetus during pregnancy, birth or breastfeeding. The risk of transmission is significantly higher if a mother living with HIV does not take medicine or is not aware of her HIV status (HIV.gov, 2019).

Occupational exposure

The risk of occupational transmission of HIV virus to health care workers is considered to be extremely low. Between the first reported case in 1999, up to the end of 2013, 58 cases of health care workers who acquired HIV infection at work have been reported in the US, though this figure might be higher, because such reporting is voluntary.

Estimated risk for healthcare workers exposed to needlesticks containing HIV infected blood is 0.23% or 2.3 in 1,000 in which such injury may result in HIV transmission. In case of splashing of body fluids of an infected patient to intact skin or mucous membranes of a health care worker, the risk is near zero (CDC, 2019b).

HIV TESTING

HIV testing is an important strategy in reducing infection dissemination. If a person knows their HIV status, it is possible to reduce morbidity and mortality and to improve quality of life by immediately referring to medical services. Besides that, behavior modification might also prevent further spread of the virus (KFF, 2019).

Who should be tested?

According to the CDC recommendations, routine HIV screening in health care settings should be performed in all persons aged 13-64. For those at higher risk, tests should be repeated annually. Higher risk include having unprotected sex (anal, vaginal or oral), having unprotected sex with partners infected with HIV, sharing needles or other equipment for drug use, being a sex worker, being occupationally exposed or having sex witha partner who has any of previously mentioned risk factors (CDC, 2019c).

Types of HIV tests

Three main types of HIV tests include:

a) Antibody tests

The most widely used HIV tests are antibody tests or immunoassay. They are designed to detect antibodies that are produced by the host against the virus. Those tests are usually positive 3 to 12 weeks after the infection.

Rapid HIV tests are designed to produce results in less than 30 minutes. They can be performed with either finger-stick sample of blood, plasma or oral fluid sample.

Urine HIV tests use urine samples to detect antibodies against the HIV virus.

a) Nucleic Acid Test (NATS)

Nucleic Acid tests detect antigen (HIV) before the host produces antibodies against it. Those tests are highly sensitive and specific to RNA and DNA viral nucleic acids and can be valid 7-28 days after the infection occurs.

b) Combination tests

Nowadays, the fourth generation of tests are used to diagnose HIV infection that, besides IgM and IgG antibodies, also enables the simultaneous detection of the presence of the p24 antigen. By applying such tests, the presence of an infection can be determined after two weeks.

Confirmation testing

If the initial test in the laboratory is positive, the follow-up test on the same blood specimen as the initial test is performed. If a rapid test is positive, a person will be directed for follow-up testing to confirm the diagnosis (CDC, 2019d).

OCCUPATIONAL INFECTION CONTROL

The most effective strategy for the prevention of occupationally acquired HIV virus is preventing exposure to blood and body fluids. This includes routine use of barriers (gloves and/or goggles). Hand and other skin surface washing is another cost-effective strategy, along with careful handling and disposing of sharp instruments after use.

The Occupational Safety and Health Administration (OSHA) released Occupational Exposure to Bloodborne Pathogens Standard which prescribes measures to protect health care workers against the health risks of exposure to bloodborne pathogens. If a health care worker receives a needlestick or other substantial exposure to HIV, herpes simplex virus or hepatitis B virus, the employer's protocol based on guidelines issued by the U. S. Public Health Service (USPHS) should be followed.

Post-exposure prophylaxis should start as soon as possible. In case of occupational exposure to HIV virus, the USPHS **post-exposure prophylaxis (PEP)** guideline recommends:

- To determine the HIV status of exposure source patient (if possible) to explore the need for HIV PEP
- To start PEP medication regimen (combination of three or more antiretroviral drugs) within 72 hours after exposure and continue during the following four weeks
- Expert consultation
- Close follow-up, including counseling, base and follow up HIV testing and monitoring of drug toxicity. If a fourth-generation of test is available, follow-up testing can end four months after exposure; if not, testing should be ended six months after exposure (Kuhar et al, 2018).

CLINICAL MANAGEMENT

- **Antiretroviral therapy (ART)**

Nowadays, ART has converted the HIV infection from a deadly disease to a chronic condition. It is recommended to start with ART as soon as the diagnosis is revealed. Regular treatment will minimize virus activity (reduce viral load), thus prevent its transmission, and decrease morbidity and mortality. The patient is prescribed a combination of HIV drugs (HIV regimen). Some side effects are possible, but the benefits of HIV medicines far outweigh the risk of side effects.

- **Prevention and treatment of opportunistic infections**

Opportunistic infections (OIs) occur in people whose immunity is weakened by the HIV virus. Most common OIs are candidiasis, pneumonia, tuberculosis, salmonella infection and the herpes simplex 1 virus infection. The treatment of these conditions include antibiotics, antiviral or antifungal drugs. The most effective prevention of OIs is regularly taking ART.

- **Pre-exposure prophylaxis for prevention of HIV infection**

Truvada is a pre-exposure prophylaxis (PrEP), which is aimed for non-infected persons who might be at risk of acquiring HIV infection (continuous sexual intercourse with an HIV infected partner, gay or bisexual men who are not in a monogamous relationship and don't use condoms for anal sex or have another STD and for heterosexuals who practice unprotected sex outside monogamous relationships with partners at risk) (AIDSinfo, 2019b)

Since the beginning of the AIDS epidemic 1981, more than 36 million people have died of this condition. In the last 38 years, many efforts have been made in terms of prevention and treatment. ART transformed HIV infection from a deadly disease to a chronic condition. However, there is still a significant number of newly diagnosed each year. Prevention is still the key strategy in HIV prevention, and healthcare professionals have a crucial role. To stop the epidemic, it is necessary to increase coverage with testing, availability and patients' adherence to treatment.

- **State of Florida Specific Information:**

In 2017, 4,949 new cases of HIV infection were reported in Florida, while 2,044 persons were diagnosed with AIDS. The highest number of newly diagnosed with HIV were aged between 20-29 years. During the same year, an estimated 116,944 persons were living with HIV in Florida. The counties with the highest prevalence of HIV were Miami-Dade, Broward, Palm Beach, Hillsborough and Orange (FL DOH, 2019a).

The most common way of HIV transmission in Florida was among MSM (61%), female heterosexual contact (19%), male heterosexual contact (13%) and intravenous drug users (4%). Men were four times more likely to be diagnosed with HIV (78%) compared to women (22%) (FLO DOH, 2019b).

African/American representatives were most frequently diagnosed with HIV in 2017 (42%); 31% of newly diagnosed were Hispanics, one quarter were Caucasians, while the rest (2%) were in the category of "others" (Asian/Pacific Islanders, American Indians and mixed races) (FLO DOH, 2019c).

Almost one quarter (23%) of people who received HIV diagnosis in 2017 in Florida were aged 50 years or more, while 33% of newly diagnosed with AIDS were older adults. During the same year, approximately half of people living with HIV in Florida (52%) were in that age group (FLO DOH, 2019d).

Who should be tested?

According to the CDC recommendations, routine HIV screening in health care settings should be performed in all persons aged 13-64. Florida is leading in the number of HIV tests (over 360,000 in 2016) performed at over 1,400 sites, including health care facilities, no-profit organizations, mobile testing units, jails, outreach events and other community places (FLO DOH, 2019e). In Florida, 4,949 people were diagnosed with HIV in 2017, while during the same year, 116,944 people were living with HIV and an additional 2,044 with AIDS.

Testing and Informed Consent in Florida

Back in 1988, The Omnibus AIDS Act was amended in Florida. This act directly addresses doctors, nurses and other health care professionals, pointing out that the most effective way to stop this epidemic is to educate the public about HIV transmission, risks of being infected and the benefit of voluntary treatment.

The Omnibus AIDS Act includes following premises:

- **Obtaining consent**

In Florida, before HIV testing, each person must be informed about the test and give their consent to be tested. The consent given upon explanation must be included in the patient's medical record. Testing cannot be conducted without informed consent or on the blood specimen with unspecified tests, even though the patient's general consent had been given. The HIV test has to be explained to the patient in a clear and understandable way.

In the case of **minors**, parental permission is not required for children whom health care professionals judge to be mature enough to consent or refuse HIV testing. However, for infants and young children, informed consent of a parent or legal guardian is obligatory.

Pregnant women are advised to conduct testing for HIV (opt-out testing) and other STDs, between 28 and 32 gestational weeks. If they refuse HIV testing, the written refusal must be submitted and included in the medical record.

- **Testing without informed consent**

There are situations when HIV testing without informed consent can be conducted:

  - Emergencies – when treatment is indicated by HIV status

- Therapeutic privilege – in case of acute illness when the test result is necessary for diagnosis and management planning
- Sexually transmissible diseases – for convicted sex workers, inmates prior to release or court-ordered autopsies
- Criminal acts – court ordered by a victim for defendant in case of transmission of body fluids during criminal offense
- Organ or tissue donations – blood donations, sperm donation, corneal removals, eye enucleations, other tissues
- Research – for epidemiological studies that ensure test subject anonymity

- **Confidentiality**

Anonymous HIV tests in Florida are available at county health departments and registered testing sites, as well as in private sector doctors' offices and hospitals, which must provide pre- and post-test counseling for all clients.

The Florida Omnibus AIDS Act declared information about HIV testing as **super confidential** and test results are specifically protected. There are four special handling requirements unique to HIV test results: 1) providers may disclose test results if a patient authorizes the release to the third party in a written form, 2) realizing of test results upon court-ordered subpoena, 3) disclosure of test results must be accompanied by the warning statement, which indicates that state law prohibits further disclosure of the information without patients written consent and 4) "need to know" limit access to HIV test results to patient care providers, administrative workers or those who handle body fluids or tissues.

Permitted disclosure is possible in the limited number of cases (the test subject or his/her representative; a newborn medical record (mother's HIV status); The Department of Health; a patient's sex or needle-sharing partner¸ authorized medical and epidemiologic researchers; Hospital staff, administrators, and healthcare workers who provide aid and care to the subject, **on a need-to-know** basis, especally in case of significant exposure to body fluids; to appropriate authorities in the course of reporting child sexual abuse or neglect; adults responsible for a child who is placed in foster care or for adoption; an exposed healthcare worker who exercises the right to subpoena the medical records of the patient and demand that HIV status be determined; healthcare facilities and providers involved with the transfer of human body parts and tissues; peer review and health program monitoring; within correctional facilities; healthcare professionals reporting to public health authorities; medical examiners. **Breaches of confidentiality** implies violations of Florida Omnibus AIDS Act confidentiality requirements. It is a first-degree misdemeanor (subject to up to one year of imprisonment) and subject to disciplinary action by the licencing body, for health care professionals for anyone who unintentionally reveals an individual's HIV status. A 1998 amendment makes it a third degree felony (with up to five years of imprisonment) for any person who maliciously or for monetary gain disclose an individual's diagnosis of a sexually transmissible disease, including HIV. The Florida Supreme Court held that anyone could be sued for negligence and other causes based on violation of Act's duty of confidentiality.

- **Notification of test results**

Tested individuals must be notified of the results accordingly with Act's confidentiality requirements.

- **Post-test counseling**

The Florida Department of Health has developed "Model Protocols on Counseling and Testing". A post-test counseling for a person who was diagnosed with HIV infection must receive information about: a) medical and support services, b) importance of notifying partners who may have been exposed and c) prevention of further HIV transmission (Hartog, 2013).

OCCUPATIONAL INFECTION CONTROL

In Florida, it is required for health care workers who are occupationally exposed to blood or other potentially infectious material (OPIM) to be trained for: a) careful handling and disposal of sharp instruments during and after use; b) recommendation for housekeeping and waste disposal; c) handling contaminated laundry and d) handling of regulated waste.

- **Texas Specific Information:**

What you should know about HIV, AIDS and the workplace:

• HIV is the virus that causes AIDS, a disease that destroys a person's immune system.

• There are only a few ways that a person can be exposed to HIV - most of which don't involve work related situations.

• It is easy to protect yourself from being exposed to HIV, both in your personal life and in workplace settings.

General information:

Acquired Immune Deficiency Syndrome (AIDS) is the final stage of an infection caused by the Human Immunodeficiency Virus (HIV) and is also known as Stage 3 HIV. HIV attacks the body's immune system, hurting the body's ability to fight off diseases and other infections. There is no cure for HIV or AIDS. There are also no clear symptoms of HIV infection, although some people may have flu-like symptoms for a few days after they are infected with HIV. But, even if an infected person has no symptoms, feels, and looks healthy, he or she can still pass the virus to others. HIV medication, when taken as prescribed to a person living with HIV, helps the person stay virally suppressed which makes transmitting HIV to a person who does not have HIV rare. This is sometimes called Treatment as Prevention (TasP). HIV is spread from person to person in the following body fluids:

• blood

• vaginal secretions

• semen

• breast milk

People living with HIV do not pose a threat to co-workers or clients during casual, day-to-day activities and contacts.

You CANNOT become HIV positive through:

• handshakes
• dishes, utensils, or food
• hugs or casual touching
• sneezing or coughing
• close working conditions
• air
• telephones, office equipment, or furniture
• water
• sinks, toilets, or showers
• insect

There are only a few ways for a person to come in contact with HIV:

• by having sex, either anal, oral, or vaginal, without the use of a condom;

• by sharing needles, syringes, and other instruments that break the skin, such as tattoo and/or ear/ body piercing needles;

• from an HIV positive mother to her baby during pregnancy, birth, or breastfeeding; and

• by encountering HIV positive blood either through an open wound or through a blood transfusion. Risks from transfusions, however, are now very low because of blood-screening, which started in 1985.

How HIV/AIDS affects you in your workplace:

As you can see from the information on the last page, most of the behaviors that pass HIV from one person to another do not occur in the workplace. The only way that most people in the average workplace could be exposed to HIV would be if they had an open wound and someone else's infected blood entered their body through that broken skin.

How to avoid HIV exposure in the workplace:

It is easy to avoid being exposed to HIV and other blood-borne diseases by using good personal hygiene and common sense at all times:

• keep broken skin covered with a clean, dry bandage;

• avoid direct contact with blood spills;

• wear gloves to clean spills that contain visible blood; and

• clean blood spills with an appropriate disinfectant or 1:10 solution of freshly mixed household bleach and water. After cleanup, wash hands thoroughly with soap and running water.

Ways to reduce your risk for HIV exposure in your personal life:

• Do not have sex (abstain)

• Delay having sex until you are in a faithful relationship with one person who you know is not living with HIV.

• If you choose not to abstain from sex or to limit sex to one faithful, partner not living with HIV, then always use a latex condom every time you have sex (oral, anal, or vaginal). If used correctly and every time you have sex, latex condoms can provide protection against HIV and other sexually transmitted diseases (STDs).

• If you think you may be in situations where you may come in contact with HIV, ask your provider about pre-exposure prophylaxis (PrEP). PreP are drugs given to people who are not living with HIV to help them lower their changes of contracting HIV if exposed.

• If you have a drug habit, do not share needles or syringes. If you can't stop sharing needles/syringes, clean them with bleach and then rinse them with water between every use. Also, do not share any other type of needles, such as tattoo and ear/body piercing needles.

• The best thing for your health is to stop using drugs. If you need help to stop using, call the National Drug Abuse Hotline at 1-800-662-4357.

If you work with someone who is living with HIV and/or AIDS:

If you have a cold, flu or other virus, remember that people living with HIV do not have a healthy immune system. They are more likely to become ill from a virus that a healthy person's body could easily fight. Remember, too, that PLWH are just like anyone else living with an ailment: they need caring, support, and understanding. DSHS HIV/STD Program | (737) 255-4300 | dshs.texas.gov

Reference :Texas Department of State Health Services/DSHS HIV/STD Program

COMPLAINT RESOLUTION (STAFF AND CUSTOMER)

A Customer Service Complaint is any complaint and/or concern from one of our valued customers regarding a situation or incident that results in dissatisfaction of that customer. The purpose of our complaint policy is to:

- To have a positive impact in improving customer service and satisfaction.
- To understand the causes that underlie a complaint and to focus on making changes to systems and processes to reduce the probability of a similar complaint in the future.
- To prevent potentially compensable events and to protect corporate financial resources potentially jeopardized by customer dissatisfaction.
- To analyze and trend data to identify opportunities for organizational performance improvement.

All IntelyCare, Inc. patient care providers and internal office staff are entitled to full and equal accommodations, advantages, facilities, privileges and services provided by the company.

IntelyCare, Inc. accepts complaints from persons who believe that they have experienced a violation of their rights. The following guidelines shall be followed in resolving complaints.

- Complaints must be filed within 30 days of the alleged act.
- The complaint is the written document that describes the occurrence and why the person filing the complaint believes the action or incident was in violation of his/her rights.
- An individual seeking to file a complaint needs to contact IntelyCare, Inc. management. An intake interview or phone interview will be conducted with the complaining party.
- After a careful screening process, the complaint is investigated to determine if there is sufficient evidence to support the allegation. The complaint documentation must contain a claim which constitutes a violation of the complaining person's rights.
- A complaint may be settled at any time after it is filed. Opportunities will be given to all parties involved to ask questions, provide information, and suggest witnesses in order to resolve the complaint.
- As the investigation proceeds, individuals will be interviewed and pertinent records and documents will be reviewed.
- The person filing the complaint must cooperate fully by providing accurate information and by supplying documents to support the allegations.
- All information gathered in the course of an investigation is subject to disclosure unless otherwise protected by the individual's right to privacy (e.g. medical records).
    - Restoration of previously denied rights.
    - Correction of other harm(s) resulting from the violation(s).
    - Modification of practices that adversely affect persons protected under law
    - Other actions to eliminate the effects of violation of rights.

Our goal is to always provide you with a consistent level of service. If for any reason you are dissatisfied with our service or the service, we encourage you to contact the IntelyCare, Inc. Management to discuss the issue. IntelyCare, Inc. has processes in place to resolve complaints in an effective and efficient manner. If the resolution does not meet your expectation, we encourage you to call the IntelyCare, Inc. corporate office at (617) 971-8344. A corporate representative will work with you to resolve your concern. Any individual that has a concern about the quality and safety of patient care delivered by IntelyCare, Inc. health care professionals, which has not been addressed by IntelyCare, Inc. management, is encouraged to contact the Joint Commission at www.jointcommission.org or by calling the Office of Quality Monitoring at 630.792.5636. IntelyCare, Inc. demonstrates this commitment by taking no retaliatory or disciplinary action against employees when they do report safety or quality of care concerns to The Joint Commission.

HUMAN RESOURCES: EMPLOYMENT APPLICATION PROCESS

In keeping with our standard of excellence, IntelyCare, Inc.'s initial application process and ongoing quality assurance initiatives are designed with the primary goal to provide the highest quality of nursing professionals possible. Our objectives include:

- To recruit and employ those professionals who are dedicated to quality care with proven skill histories.
- To provide a thorough orientation for each nurse so that he/she may perform his/her work in a safe and effective manner.
- To provide consistent opportunities for staff education via our in-service training and staff development program.
- To monitor the quality of nursing performance through regular on-site evaluations
- To work closely with clients while modifying our service concepts to meet their needs.

Each applicant undergoes a stringent screening process to verify skills and commitment to nursing excellence.

Proof of Citizenship or Ability to Work as Required by Law

IntelyCare, Inc. verifies eligibility to work in the United States. The U.S. Immigration and Naturalization Service requires that employees show proof of citizenship/eligibility to work by completing an Employment Eligibility Verification Form (I-9). Failure to produce the necessary proof according to the applicable laws will result in the postponement of employment.

Background Checks

IntelyCare, Inc. may perform criminal background checks on applicants, which may include a felony and misdemeanor search in the state the applicant resides and may also include states and counties of residence/employment for the previous 7 years when specified in the written agreement between IntelyCare, Inc. and its clients. Criminal background checks can also be conducted post-employment based upon a reasonable suspicion of criminal activity.

In addition, IntelyCare, Inc. verifies that applicants are not included in the Office of Inspector General's (OIG) or the Excluded Parties List System (EPLS) databases of excluded providers.

License/Certification/Education Verification

Applicants may be required to provide valid, original professional licenses to practice their profession in the state of the assignment, Basic Cardiac Life Support (BCLS) certification and any other professional certifications required for the practice of their specialty when specified in the written agreement between IntelyCare, Inc. and its clients. IntelyCare, Inc. conducts primary source verification of professional licenses in all states where IntelyCare, Inc. Inc. is employing the provider or offering placement for the provider, with the appropriate licensing bodies to verify issue date, expiration date, active status of license and to determine if a license has ever been suspended, revoked, restricted, reprimanded, sanctioned or disciplined. Any disciplinary action on a professional license can be terms for non-employment with IntelyCare, Inc. and falsification of any documentation will render the applicant completely ineligible for employment with IntelyCare, Inc.

Positions that require a specific educational requirement and/or certification must have verification of such. Where education and licensure are required, but the license may not be obtained without meeting the education requirements, it is not necessary to confirm education, but only to verify the license (Specific example would be an RN where state licensure is required and completion of an approved nursing program or completion of a certain number of continuing education units. In this case, the individual may not obtain state licensure or renewal without completion of an approved program or continuing education units, therefore only license verification would be required. If the position requires state licensure as an RN and a Master's degree, then both the licensure and the education would need to be verified).

It is the employee's responsibility to maintain a current valid license. Failure to do so will result from removal from duties and progressive discipline. Employees are required to immediately notify IntelyCare, Inc. if a license/certification is suspended or revoked prior to education.

Reference Checking

IntelyCare, Inc. verifies at least one reference from previous employers or from clinical peers that may provide information related to the applicant's knowledge and applied job skill proficiency or confirm dates of employment.

Pre-Employment Skills and Competency Assessment

To ensure that work is performed safely and efficiently in the Healthcare facility setting, all applicants are required to complete a competency self-assessment for every unit and specialty to which they will be assigned. All current competency assessment tools are maintained in their personnel file.

Applicants must also complete a competency examination for every specialty to which they would like to be assigned and receive a passing score of at least 70%. Any applicant not receiving a passing score on their first time will be given one additional opportunity to re-take the competency exam and pass. Failure to achieve a passing score of at least 70% within the first two attempts is automatically ineligible for employment with IntelyCare, Inc. in addition, all staff must complete a Pharmacology examination and receive a passing score of at least 70%. Any applicant not receiving a passing score on their first time will be

given one additional opportunity to retake the Pharmacology exam and pass. Failure to achieve a passing score of at least 70% within the first two attempts is automatically ineligible for employment with IntelyCare, Inc.

Health Screening

Applicants may need to go through a screening process when specified in the written agreement between IntelyCare, Inc. and its clients, to demonstrate that they are free from communicable disease and are free from any health impairment that is of potential risk to the patient, caregiver, other employees, or that may interfere with the performance of duties. All applicants may need to provide:

- Clearance for Work: are only required when specified in the written agreement between IntelyCare, Inc. and its clients. If required, the applicant will submit a written clearance for work conducted within the last twelve months prior to hire date. The Clearance for Work shall include whatever specifications are in the written agreement between IntelyCare, Inc. and its clients, which may or may not include a medical history, physical examination, laboratory work as indicated, and a written report to indicate that the employee is physically and medically qualified to perform the duties to be assigned. In addition, annual physicals are required thereafter
- Tuberculosis Test: are only required when specified in the written agreement between IntelyCare, Inc. and its clients. TB tests if required may need to be conducted within the last twelve months prior to hire date. The TB test may show a negative result. Applicants who test positive as a tuberculin reactor are required to submit documentation of a negative chest x-ray showing no abnormalities and/or provide proof of prophylactic antibiotic therapy. One clear chest x-ray is required for individuals following a positive skin test or documented history of positive skin test, repeat chest X rays thereafter are not required for those who present positive skin results, repeat chest x rays are only required when specified in the written agreement between IntelyCare, Inc. and its clients. Applicants with positive TB results must also complete a TB questionnaire upon hire and annually thereafter when specified in the written agreement between IntelyCare, Inc. and its clients.
- Vaccinations: are only required when specified in the written agreement between IntelyCare, Inc. and its clients. If required the applicant will Submit proof of exposure to or immunization to Rubella, Rubeola, mumps, and Varicella zoster.
- Drug Test: are only required when specified in the written agreement between IntelyCare, Inc. and its clients. If required the applicant will submit a drug screen that may screen any or all of the following: amphetamines, barbiturates, benzodiazepines, cannabinoids, cocaine, meperidine, Methadone, Opiates, Phencyclidine, Propoxyphene
- Hepatitis B: are only required when specified in the written agreement between IntelyCare, Inc. and its clients. Must provide proof of vaccination to Hepatitis B or sign waiver/declination. The Hepatitis B vaccine and vaccination series shall be made available at no cost to all employees. Employees shall not receive the vaccination if they have previously received the Hepatitis B vaccination series or have antibody resting which reveals the employee is immune or for whom the vaccine is contraindicated for medical reasons.

*** *Please note that random drug screening and drug screening for cause may occur at any time.*

Interview and Education

Applicants whose qualifications are in question are interviewed by the Vice President of Clinical Operations . Interviews are designed to determine applicant's knowledge, competence and skills in specified areas of expertise. Interviews are based on actual events and circumstances that applicants are likely to encounter in the work environment.

Applicants are also oriented to IntelyCare, Inc.'s general policies and procedures, as well as specific administrative policies on overtime and scheduling. Orientation for select Healthcare facilities is also provided, as specified by select client Healthcare facilities.

Applicants are also oriented and asked to acknowledge their comprehension of a variety of topics, including, but not limited to:

- Medication: administration, safety and prevention of errors
- Abuse: Child, elder and reporting, SCAN
- Sexual and domestic violence, assault, rape

- Drugs in the workplace, workplace violence
- Safety: electrical, fire, environmental, safety signals
- Hazardous materials
- Infection control and CDC Hand Guidelines
- OSHA and bloodborne pathogens
- Dress code and fingernail policy
- JCAHO education, National Patient Safety Goals, List of Abbreviations/Do-not-use
- Patient rights/advance directives
- Emergency preparedness
- End-of-life care
- Code situation policies
- Sentinel event policies and procedures
- Restraints
- Age-specific education
- HIPAA
- Pain Management
- Body Mechanics
- Documentation: of patient care, transcribing of physician orders
- Conscious Sedation
- Patient safety and education
- Fall prevention

The completion of orientation shall be documented and signed by the applicant. And the form will be retained in the employee's personnel record.

Maintaining Nursing Personnel Files

All personnel files are maintained by HR, HR monitors relevant requirements and expirations of any requirements. Requirements are kept current through daily alerts of soon-to-expire or expired requirements.

Orientation
IntelyCare, Inc. will provide all new employees with an orientation to the company's policies and procedures. Each employee will receive an Employee Handbook.

Some facilities require some form of orientation. The amount of time required by each facility varies. Some facilities require computer training classes and orientation prior to the first shift. The IntelyCare Mobile APP will explain required orientation to all employees prior to scheduling the first shift with a facility. Orientation time worked at the facility is paid at the orientation rate. (Usually less than regular pay rate)

Some facilities require that their specific pre-employment orientation "packets" be completed by the prospective caregiver at IntelyCare, Inc. before the first shift is worked, and there is no pay for this required activity.

<u>The first time you visit a facility the following guidelines should be followed:</u>
- Report approximately 15 minutes early for orientation (it may vary for each facility).
- Carry photo ID for evidence of identity when reporting for assignment
- Have your IntelyCare ID Badge with you
- Report to the appropriate supervisor
- It is expected that the healthcare practitioner locates and comply with the facility policy and procedures manual, locate fire pulls, crash cart, med. room, linen cart, and appropriate exits before your shift starts.
- Always dress in proper attire when working at the facility. Orientation is only paid when the time has been properly verified by facility staff.

Occasionally, an IntelyCare, Inc. employee may show up early as directed for orientation shift and no one is available for orientation. Please take it upon yourself to utilize this time to become familiar with the floor layout and the location of vital items you may need in order to function effectively on your shift. It will be to your advantage to have knowledge of the location of the policy and procedures manual, fire pulls, crash cart, med. room, linen cart, and appropriate exits prior to the onset of your shift.

IntelyCare, Inc. attempts to provide a comprehensive and thorough pre-employment orientation and in- service training that reflects current compliance and promotes safe healthcare delivery. The program includes, but is not limited to the following:

- Age Specific
- Disaster Preparedness
- Cultural Diversity
- Environmental Safety
- Hazardous Chemicals
- HIPAA
- Infection Control/Blood borne Pathogens
- Abuse
- Domestic Violence
- Ethics for Healthcare
- Annual National Patient Safety Goals
- Pain Awareness
- Patient Restraints
- Patient Rights
- Workplace Violence

PERFORMANCE IMPROVEMENT AND EDUCATION PROGRAM

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

Initial Assessment

Upon hire, one of IntelyCare, Inc.'s Recruiters must inform new hires of all the competencies that must be met. For the initial assessment, the competency self-assessments will serve as the baseline assessment. Review and education for errors on any competency exams, pharmacology exams and additional examinations will also serve as areas of improvement.

Ongoing - Quarterly Assessments

IntelyCare, Inc. has attempted to implement a continuous, systematic and coordinated approach to measure and assess Healthcare facility's feedback on all agency personnel being utilized. The following assessments are utilized to ensure employee performance and customer satisfaction:

- Caregivers are assessed by the charge nurse, nurse manager or client designee once during their assignment or at least quarterly. Assessment focuses on professionalism, safety, patient care, compliance, assessment, planning and documentation.

Any unsatisfactory scores will be reviewed and discussed with each nurse and methods for improvement recommended by IntelyCare, Inc.'s Vice President of Clinical Operations . For more information on IntelyCare, Inc.'s Progressive Discipline Program, please see Progressive Discipline Program.

Periodic Assessments

IntelyCare, Inc.'s Vice President of Clinical Operations conducts annual assessments of all staff. Quarterly performance evaluations are solicited via the healthcare facilities feedback web platform. The Vice President of Clinical Operations and clients evaluate employee job performance based on the functions and standards as outlined in the job descriptions. The Vice President of Clinical Operations and employee will identify strengths, accomplishments and areas for improvement and

development. All Healthcare facility reviews, including initial and random assessments are also incorporated into the ninety-day and annual performance review. Employees will also update their competency self-assessments at this time.

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

Employee Performance Review

- Every healthcare professional employed by IntelyCare, Inc., who is currently working and has worked in the last year, will have an annual performance evaluation carried out by the IntelyCare, Inc., during the month of May or at the anniversary of their date of hire.
- Per Diem providers are eligible for annual evaluations if the provider has worked a minimum of 8 hours during the preceding year and are active during the current year at the anniversary of the date of hire.
- IntelyCare, Inc. will attempt to obtain feedback from client representatives regarding clinical staff competence and ongoing performance of professional employees. Unfortunately, some clients will not cooperate with IntelyCare, Inc. in this regard, so IntelyCare, Inc. conducts phone solicitation of feedback from its clients.
- Feedback from our clients regarding clinical and/or professional performance is addressed with our employees immediately. Follow-up with our clients is completed within an appropriate time frame.
- Annual skills checklists which apply to specialty areas of work will be completed by every health professional employed by IntelyCare, Inc.
- When training needs are identified, an opportunity to complete the training will be provided at the earliest possible occasion.
- The company assesses aspects of employee's competence at hire, at performance evaluation and as needed or required by state licensing agencies, to ensure that employees have the skills or can develop the skills to perform and continue to perform their duties.
- Vice President of Clinical Operations is responsible to ensure that any areas of development that are identified are addressed.

Education

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

Disciplinary Action

IntelyCare, Inc. has established workplace standards of performance and conduct as a means of maintaining a productive and cohesive working environment. A positive, progressive approach is taken to solve discipline problems, which appeals to an employee's self-respect, rather than create the fear of losing a job. Our system emphasizes correction of offensive behavior. If correction of the problem and sustained improvement does not occur, termination may result.

The following may be grounds for disciplinary action, up to and including termination:

- Accepting an assignment and not reporting to work or not notifying us.
- Unauthorized possession, use, or removal of property belonging to IntelyCare, Inc. or any client of IntelyCare, Inc.
- Failure to comply with all safety rules and regulations, including the failure to wear safety equipment when instructed.
- Reporting to work under the influence of alcohol, illegal drugs, or in possession of either item on company premises or work sites of client companies.
- Lewd, unacceptable behavior, possession of weapons or explosives and provoking, instigating or participating in a fight is prohibited at IntelyCare, Inc. and/or at its client Healthcare facilities.
- Violation of the harassment policy.
- Insubordination of any kind is grounds for immediate termination. (For example, refusal to carry out your supervisor's

reasonable works request).

- Leaving an assignment without notice i.e. patient or assignment abandonment.
- Falsifying records, including but not limited to time records or claims pertaining to injuries occurring on company premises or work sites of client companies or personnel records.
- Disclosing confidential information without authorization.
- Disregard for established policies and procedures.
- Excessive cancellations or tardiness.
- Discourtesy to clients or fellow employees.

Do Not Send Policy and Process

IntelyCare, Inc. is committed to providing a higher standard of service to our clients and to the delivery of safe, quality patient care. As an IntelyCare, Inc. employee, you play a very valuable role in our success in delivering excellent customer service and in our ability to achieve Joint Commission Certification. We are implementing a "Do Not Send" **Prevention** Program.

- Below is the DNR Termination Policy.
- Following the Termination Policy are the Do Not Send Prevention Curriculum and the Do Not Send Prevention Quiz
- **You will be held responsible for the information in the curriculum** and quiz in both your clinical and professional / behavioral performances **every time you work for IntelyCare, Inc.**
- ***When a performance issue arises, IntelyCare, Inc. will use the point system outlined below. As you can see, significant performance issues or ongoing performance issues could result in termination. By implementing this program, it is our goal to reduce the number of performance issues and/or Do Not Sends.***

Termination Policy

The following point system is used to determine termination as a result of Do Not Sends.

1 Point — Attitude / lack of professionalism / customer service

2 Points

- Clinical incompetence – poor clinical performance
- No call No show.
- Poor time management
- Medication Error
- Documentation Deficiencies Lack of Compassion

3 Points

- Danger to patients.
- Departing facility before end of shift secondary to dissatisfaction with assignment.
- Do Not Send from any healthcare facility

5 Points

- Illegal Behavior (Includes false identity; falsified documentation, use of or distribution of controlled substances etc.)
- Pt. abandonment. When a nurse is under investigation for above behavior they will be considered terminated until exonerated from all accusations.
- Error resulting in Pt. Death or Permanent physical or mental damage
- Self-terminating block booking assignment without proper notice to facility or Staffing Agency.

A nurse who receives 5 points will be Reviewed by a quality team for termination.
Any nurse involved in illegal activity will be terminated immediately

Please feel free to contact the IntelyCare, Inc. office, if you have any questions

Do Not Send Prevention: Curriculum

Do Not Sends are usually subjective in nature. However, there are things we as Agency nurses can do to avoid Do Not Sends.

1. Be on time to all shifts.
Be 15 minutes early, arriving on the floor, when working at a Healthcare facility for the first time.

To ensure being on time, preparation begins the night before, or day of your night shift.

Have clothes, nursing tools, lunch etc. prepared before sleeping.

Get to bed early to ensure 8 hrs of sleep.

Awake early enough to eat before you leave for shift.

Make sure you have accurate directions and facility phone number before you begin driving to the shift.

Do not sign in and out at the same time.

Rationale: Arriving early allows the Agency nurse to familiarize themselves with the unit, get organized, meet the Charge Nurse and make a positive first impression. Signing in and out at the same time is fraud.

2. Take a detailed report.
Head to toe, system by system, Neuro to Skin.

Review your patient's charts, (ten to twenty minutes per chart) after report, and before lunch.

Rationale: This is of paramount importance! Sets the tone for the start of the shift, provides the foundation for the plan of care, focus of initial assessments and interventions.
Taking a detailed report and reviewing the pt's chart during the first half of your shift also prepares the Agency nurse to give a knowledgeable, relevant report.

3. Show Initiative.
Find the Charge nurse, introduce yourself, ask to be shown around, and inquire who your resource person may be for the shift (if initial shift @ facility), if not the Charge nurse.

Communicate early and often any relevant information to the Charge nurse such as: changes in patient condition, difficulty with or questions about; assignment, staff, equipment or documentation tools.

Rationale: Allows Charge nurses to make adjustments or provide assistance in a timely manner, in order to provide the safest patient care and prevent a delay in patient treatment.

4. Avoid handling personal business during shift.
Talking on mobile phones or using facility information systems for personal use (other than in an emergency or away from patient care area during breaks) is a sure way to make an impression that will reflect poorly on the Agency nurse.

Rationale: This behavior often leads directly to a Do Not Send.

***5. When in Rome*… Make every attempt to do things, the way the Facility you are working in, does things.**
Some Facilities want two nurses to sign off on all **insulin** administration, **narcotic** administration and **lab specimens**.

Please respect all of our facilities policies and procedures, without complaint or argument.

However, if you have been asked to perform a task or procedure you feel will place a patient in danger or you feel unqualified to perform, contact your immediate supervisor and/or go up the chain of command until you feel you have been able to express your concern professionally and respectfully.

If one of us as agency nurses encounters a situation in which you feel obligated to challenge a request, in order to maintain the safest patient care environment. It is of vital importance that you:

1. Communicate with IntelyCare, Inc.
2. Document the incident in your own words before leaving the facility.
3. Furnish signed and dated copies of your documentation of the incident to IntelyCare, Inc., the Nursing Supervisor of the facility in which you were working and retain a copy for yourself.

Rationale: Knowledge of, and compliance with each facility's policies and procedures are fundamental elements of professionalism, providing safe patient care and creating an impression that makes a facility ask for an Agency nurse by name.

6. Practice the 7 rights of medication administration.

1. Right Patient
2. Right Medication
3. Right Dose
4. Right Time
5. Right Route
6. Right Reason
7. Right Documentation

If an agency nurse is confused regarding any aspect of the medication administration process, clarification with the physician becomes an immediate priority, to ensure safe medication administration.

Rationale: Medication errors are serious, and can lead to negative patient outcomes, extended Healthcare facilitization, severe injury and death. Most importantly for a careful, knowledgeable and conscientious Agency nurse, medication errors are almost always preventable.

7. Be conscious of Joint Commission National Patient Safety Goals in your practice.

In addition to this manual, a complete and current set of National Patient Safety Goals should be posted or easily accessible on any unit in any Acute Care Facility.

Rationale: "The mission of The Joint Commission is to continuously improve the safety and quality of care provided to the public" through the "support of performance improvement in healthcare organizations."

8. Ask the Charge nurse to Audit your Charting a few hours before the end of shift.

Having the charge nurse review our documentation, within a couple of hours of the end of your shift, displays exceptional accountability, reduces the healthcare provider and facility's exposure to liability. Thorough documentation also helps convey important information to the following shift and ensures the necessary facts will be available when and if the chart is reviewed in the future.

Rationale: Complete documentation, is an essential component of effective, efficient nursing. Since many Agency nurses work in multiple facilities in a short period of time, it is not an easy task to dot every "i" and cross every "t", without help from a knowledgeable source.

9. Practice excellent customer service.

Customer service extends further than our patients and their families; it includes every person we come into contact with while we are working. Our customers are every nurse, pharmacist, physician, respiratory care practitioner, etc. Every time we interact with another human being at work it is imperative that we greet that person with a friendly and helpful attitude.

Rationale: Treating our patients, their families, our colleagues and interdisciplinary team members with friendliness, respect and kindness creates an environment where being helpful and taking the extra step to solve someone's problem is not the exception but the "norm".

10. Take excellent care of your patient(s).

The reason Healthcare facilities exist is because people who are ill, injured or have had major surgery require 24-hour care. The necessity of 24-hour care is the reason why tens of thousands of Healthcare facilities across the US continue to operate, often at a loss.

Keep the person you are taking care of clean. Be gentle. Communicate kindly and effectively. Listen carefully. Show respect, for your patient's privacy, age, culture, family and human existence. Spend time teaching them, explaining what is happening at any given moment. Explain what you are doing or giving your patients and why.

Rationale: As direct patient care providers taking good care of our patients what we should expect of ourselves, it is what we are expected to do. It is our ethical obligation. It is our job.

11. Remember This! … When we are working for a TEMPORARY Staffing Firm "We are PERMANENTLY on PROBATION"

There are common reasons many of us work for Staffing Firms. We enjoy the flexibility, often making our own schedules, increased pay, getting paid sooner, working in new environments and meeting new people. We also need to be aware that there are trade-offs or things we give away for those benefits.

We are not employees of the facilities in which we are working. We are not "on staff". We are not members of the union. We cannot expect to receive fair treatment. We will almost never get the best assignment. We might be "ganged up" on. We might not get help as soon as we ask for it. If we complain we can expect to be asked not to return. We have to out-perform our colleagues "on staff" every shift. We can never get comfortable.

Rationale: The key to being "successful" and enjoying our careers as providers who work for temporary staffing forms… is having as many places to work as possible. Having a wide range of choices will allow us to minimize interruptions to income when our favorite places do not need us. The sooner we let go of our expectations of being treated as if we were employees of the facilities we work in, on a TEMPORARY basis the greater chances we have of being successful.

REPORTING ANY ISSUES

Assignment Issues

Issues may arise while an employee is on assignment for IntelyCare, Inc. As a representative of IntelyCare, Inc. and as a responsible and mature nursing professional, it is important that professionalism and integrity are maintained throughout the conflict resolution process and that above all, patient safety is the priority.

Common issues that may arise are:

- Conflict with Healthcare facility staff
- Conflict with patient and/or patient family members
- Unfair patient assignments, or "dumping"
- Assignment to a unit for which you are incapable of safely performing your duties

In the event of any of the above events:

1. Contact the nursing supervisor for assistance
2. If escalation is required, contact IntelyCare, Inc. for mediation
3. Complete an incident report at the facility (if required)
4. Complete an incident report at IntelyCare, Inc. (if required)

Blood Borne Exposure

An exposure incident to blood borne pathogens involves specific eye, mouth, mucous membrane, or parenteral contact with blood or other potentially infectious materials that result from the performance of an employee's duties. All employees involved in direct patient care should be familiar with appropriate decontamination procedures.

In the event of exposure to any blood borne pathogens:

1. Immediately and thoroughly was the contaminated area or flush mucous membranes with water.
2. Notify your on-site supervisor at your current Healthcare facility and give report and/ or narcotic count to the supervisor and/or nurse that will be relieving you.
3. Fill out an Employee Incident Report at the healthcare facility you are staffing.
4. Contact IntelyCare to notify us of the incident and that you have notified the supervisor of said incident and are leaving to seek medical attention.
5. Go to the nearest Healthcare facility/ urgent care facility.

IntelyCare, Inc. shall make immediately available a confidential medical evaluation and follow-up the exposed individual. Post-exposure follow-up shall be:

- Made available at no cost to the employee
- Performed by or under the supervision of a licensed healthcare professional who has a copy of all relevant information related to the incident.
- Made available at a reasonable time and place.

IntelyCare, Inc.'s post-exposure and follow-up, shall include the following:

- Documentation of the route(s) of exposure, and the circumstances under which an exposure incident occurred.
- Identification and documentation of the source individual
- Collection and testing of blood for HIV and HBV serological status
- Post-exposure prophylaxis, as recommended by the U.S. Public Health Service
- Counseling
- Evaluation of reported illness

The company maintains confidential medical records for each employee with occupational exposure. Records are kept for the duration of employment plus thirty (30) years. Each record shall contain the employee's name, social security number, hepatitis B vaccine history, and a record of all post-exposure follow-up.

CLINICAL INCIDENTS AND SENTINEL EVENTS

As a healthcare provider, it is your duty and responsibility to promptly report any unsafe condition, sentinel event or unusual event that can result in a sentinel event. Everyone is expected to participate in maintaining a safe environment for patients, visitors, physicians and their coworkers. This means taking an active role in reporting any and all unsafe conditions, unusual or sentinel events. All such events should always be reported immediately to your charge nurse, nursing supervisor and IntelyCare, Inc.'s Vice President of Clinical Operations .

Clinical staff must recognize the importance of following effective procedures and are encouraged to speak up if something has compromised or might compromise patient safety and quality.

A Clinical Incident is any event or series of events that resulted in or had the potential to result in an adverse patient outcome. Clinical staff should notify IntelyCare, Inc. of any clinical incidents that occur while on assignment, regardless of an adverse outcome.

A sentinel event is an unexpected occurrence involving death or serious physical or psychological injury, or the risk thereof. Serious injury specifically includes loss of limb or function. The phrase "or the risk thereof" includes any process variation for which a recurrence would carry a significant chance of a serious adverse outcome.

Such events are called "sentinel" because they signal the need for immediate investigation and response.

Examples of Clinical Events

- Omission of treatment
- Deviation from policy
- Medication errors
- Improper equipment usage
- IV or Blood complications
- Patient fall
- Inaccurate clinical assessment
- Patient or physician complaint

Examples of Sentinel Events

- Any patient death, paralysis, coma or other major permanent loss of function associated with a medication error
- A patient commits suicide within 72 hours of being discharged from a Healthcare facility setting that provides staffed around-the-clock care.
- Any elopement, that is an unauthorized departure, of a patient from an around-the-clock care related setting resulting in death (suicide, accidental death, or homicide) or in a temporary or major loss of function.
- A Healthcare facility operates on the wrong side of the patient's body.
- Any intrapartum (related to the birth process) maternal death.
- Any perinatal death related to a congenital condition in an infant having a birth weight greater than 2500 grams.
- A patient is abducted from the Healthcare facility where he or she receives care, treatment or services.
- Assault, homicide, or other crime resulting in patient death or major permanent loss of function.
- A patient fall that results in death or major permanent loss of function as a direct result of the injuries sustained in the fall
- Hemolytic transfusion reaction involving major blood group incompatibilities
- A foreign body, such as some sponge or forceps that was left in a patient after surgery

Joint Commission's Sentinel Event Policy

The Joint Commission has defined a sentinel event policy that you should be aware of. This policy has four goals:

1. To have a positive impact in improving patient care, treatment and services and preventing sentinel events
2. To focus the attention of an organization that has experienced a sentinel event on understanding the root causes that underlie the event, and on changing the organization's systems and processes to reduce the probability of such an event in the future.
3. To increase the general knowledge about sentinel events, their causes, and strategies for prevention.
4. To maintain the confidence of the public and accredited organizations in the accreditation process

In the event of deviation of practice according to the professional practice act, fraudulent behaviors, narcotic abuse or deviation and/or other aberrant or illegal behavior, each event is documented, and a report is made, which includes information from the customer. The Vice President of Clinical Operations reports each situation according to the guidelines of the appropriate professional association.

Healthcare facilities have protocols for promptly reporting and investigating these incidents, with a focus on identifying root causes and implementing corrective actions to prevent recurrence. Additionally, organizations are required to develop processes for sharing lessons learned and best practices internally to foster a culture of continuous improvement. By complying with these requirements, healthcare institutions strive to enhance patient safety, mitigate risks, and uphold the highest standards of care delivery.

If you witness or have a clinical incident or sentinel event, follow the hospital’s and IntelyCare’s policy to report it. Most hospital have a "Patient Safety Reporting System" or simply an "Incident Reporting System." This system allows healthcare staff to report any adverse events, near misses, or incidents that compromise patient safety or quality of care.