ANNUAL TRAINING & ORIENTATION MANUAL FOR HEALTHCARE PROFESSIONALS

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Annual Training and Orientation Manual for Healthcare Professionals

"The Company" ("The Company") assembled this training and orientation manual to provide its employees with an annual educational update and review of important policies and procedures related to working in healthcare facilities. This training opportunity is also intended to meet legislative and profession requirements promulgated by government agencies and accreditation organizations.

This self-study program is designed for use by all healthcare professionals employed by "The Company", regardless of job classification—although certain sections will not apply to every position.

Much of the manual is focused on safety-related topics since healthcare professionals are exposed to a unique variety of on-the-job hazards. Your understanding of this material is critical to ensure your own safety and that of your coworkers and the individuals under your care.

An annual review of this manual and successful completion of a post-test is a condition of on-going employment with "The Company". By reviewing the manual and taking the post-test you are attesting that you will follow the guidelines, policies, and any related regulations therein. The program may be completed electronically on the company website at www.yourcompany.com.

The contents of this manual provide a general, orientation on many topics. Many clients of "The Company" provide a separate orientation that you will be expected to complete as a condition of assignment at those facilities.

In addition, you must review "The Company's" "Benefits, Terms, and Conditions of Employment" which outlines specific policies required to be followed as a contingency of your employment with "The Company". The most current version is available on the "The Company" website (www.yourcompany.com) or from your local branch office.

As an employee of "The Company", you are required to abide by all "The Company" policies and procedures and those policies, procedures and guidelines of your assigned facilities/clients/institutions.

Hazardous Materials and SDS (also known as MSDS)

Chemicals pose a wide range of health hazards (such as irritation, sensitization, and carcinogenicity) and physical hazards (such as flammability, corrosion, and reactivity). Chemical manufacturers and importers are required to evaluate the hazards of the chemicals they produce or import, and to provide information about them through labels on shipped containers and more detailed information sheets called Safety Data Sheets or SDS (also named Material Safety Data Sheets or MSDS). The basic goal of hazard communication is to ensure that employers, facilities, employees and the public are provided with adequate, practical, reliable and comprehensible information on the hazards of chemicals, so that they can take effective preventive and protective measure for their health and safety.

All employers with hazardous chemicals in their workplaces must prepare and implement a written hazard communication program, and must ensure that all containers are labeled and employees are provided access to SDS/MSDS.

Starting in 2013 OSHA streamlined the hazardous chemical labels to standardize the labeling and pictograms to best illustrate what employees should do to avoid exposure and what to do in case of exposure to a hazardous chemical. This system is called GHS or Globally Harmonized System of Classification and Labeling of Chemicals.

OSHA has updated the requirements for labelling of hazardous chemicals under its Hazard Communication Standard (HCS). As of June 1, 2015, all labels will be required to have pictograms, a signal word, hazard and precautionary statements, the product identifier, and supplier identification.

Below are the common examples of the global labeling. The standardized label elements included in the GHS are:

- **Symbols (hazard pictograms)**: Convey health, physical and environmental hazard information, assigned to a GHS hazard class and category.
- **Signal Words:** "Danger" (more severe hazards) or "Warning" (less severe hazards) are used to emphasize hazards and indicate the relative level of severity of the hazard, assigned to a GHS hazard class and category.
- **Hazard Statements:** Standard phrases assigned to a hazard class and category that describe the nature of the hazard.

Hazard Communication Standard Pictograms and Hazards

Health Hazard	Flame	Exclamation Mark
		
▪ **Carcinogen** ▪ **Mutagenicity** ▪ **Reproductive Toxicity** ▪ **Respiratory Sensitizer** ▪ **Target Organ Toxicity** ▪ **Aspiration Toxicity**	▪ **Flammables** ▪ **Pyrophorics** ▪ **Self-Heating** ▪ **Emits Flammable Gas** ▪ **Self-Reactives**	▪ **Irritant (skin and eye)** ▪ **Skin Sensitizer** ▪ **Acute Toxicity** ▪ **Narcotic Effects** ▪ **Respiratory Tract Irritant**

	▪ **Organic Peroxides**	▪ **Hazardous to Ozone Layer (Non-Mandatory)**
Gas Cylinder  ▪ **Gases Under Pressure**	**Corrosion**  ▪ **Skin Corrosion/Burns** ▪ **Eye Damage** ▪ **Corrosive to Metals**	**Exploding Bomb**  ▪ **Explosives** ▪ **Self-Reactives** ▪ **Organic Peroxides**
Flame Over Circle  ▪ **Oxidizers**	**Environment (Non-Mandatory)**  ▪ **Aquatic Toxicity**	**Skull and Crossbones**  ▪ **Acute Toxicity (fatal or toxic)**

SDS/MSDS Sheets provide general information about the chemical agent including the following components:

1. Name of the substance, chemical, or agent and manufacturer
2. Ingredients and hazard section
3. Physical/chemical characteristics
4. Fire and explosion hazards
5. Health hazards
6. Reactivity section
7. Precautions for safe handling and use
8. Special precautions and protection information

When on assignment for "The Company" you should ask to review the Hazard Communication Program of the client/facility, if it is not made part of your orientation and you should follow any policies and procedures. You also have the right to view any SDS for chemicals you may be exposed to during the assignment and be trained on their proper use.

More information about the SDS can be found on the National Institute for Occupational Health and Safety (NIOSH) website: http://www.cdc.gov/niosh/topics/chemical-safety or at OSHA www.osha.gov.

Medical Waste

Medical Waste is generally defined as any solid waste that is generated in the diagnosis, treatment, or immunization of human beings or animals, in research pertaining thereto, or in the production or testing of biologicals, including but not limited to:

- Soiled or blood-soaked bandages
- Culture dishes and other glassware
- Discarded surgical gloves - after surgery or other procedures
- Discarded surgical instruments - scalpels
- Needles - used to give shots or draw blood
- Cultures, swabs used to inoculate cultures
- Removed body organs or tissue
- Lancets – used to draw blood

Several federal agencies regulate the disposal of medical waste. You should follow the policies and procedures at the facility you are working regarding the handling of these materials.

Source: U.S. Environmental Protection Agency

As an employee of "The Company", it is your responsibility to become familiar with and follow your assigned facilities corresponding policies and procedures.

Responding to Disasters

These guidelines for responding to natural and other emergencies are intended to provide general information on how to take action in such situations. When assigned to an institution or facility, it is your responsibility to become familiar with individual policies, procedures, and emergency plans as part of your orientation process and follow these policies, procedures, and plans in the cases of emergencies.

Some clients offer a formal orientation program that usually includes an explanation of the facility's emergency plans. If this information is not covered during an orientation, ask your supervisor to explain the appropriate policies and procedures when you arrive for your first shift. Key components to disaster plan generally include:

- A communication plan with call lists and other identified resources
- Direction of key personnel to specific areas or tasks
- Evacuation procedures
- Procedures for restricting access to the facility

In case of an emergency you will be expected to fully assist facility staff as they implement the necessary plans to respond to the emergent condition. This may include preparing for an influx of patients and/or the evacuation of existing patients.

"The Company's" National Response Capability

"The Company" is uniquely qualified to help our clients in the event of a major disaster and/or emergency through our 24/7 National Operations Center, network of local branch offices, and National Travel Services.

It is "The Company's" policy to assist federal and local emergency response organizations in the event of a large-scale disaster or emergency (weather-related, terrorist attack, industrial accident, etc.). "The Company" will implement the following procedures in response to a declared emergency, which necessitates the mobilization of medical personnel:

- "The Company" will place its local office(s) and/or National Operations Center on alert, informing them of the emergency. A member of senior management will be appointed to oversee the company's response. Additional staff will be called in, or reassigned, to the National Operations Center, depending on the scope of the event.

- The local office(s) and/or National Operations Center will contact hospitals and other medical institutions normally serviced by "The Company" to determine their immediate and special staffing needs.

- "The Company" will immediately notify its staff of healthcare professionals to determine the availability of resources. Personnel will be allocated to healthcare clients demonstrating the most urgent need. "The Company" will also use its extensive database of nursing professionals to contact individuals by e-mail even if they are not employed by the company.

- If necessary, "The Company" will alert all of its branch offices, with emphasis on those offices who employ healthcare professionals able to reach the event site by automobile. National Travel Services will contact and make arrangements for nurses able to travel from remote locations, if requested.

- The senior manager in charge of the event will notify the Federal Emergency Management Agency (FEMA) or the appropriate state office and/or agency of emergency management to offer the company's assistance.

- The company will continue to monitor and respond to the disaster and/or emergency through its 24/7 National Operations Center. The National Operations Center has back-up and recovery contingencies to ensure continuous operation.

There are many natural and man-made hazards that could lead to an emergency situation. Some of these include:

- Earthquakes
- Extreme Heat
- Fires
- Floods
- Hazardous Materials
- Hurricanes
- Nuclear Accidents or Attacks
- Terrorism (including bomb threats)
- Thunderstorms
- Tornadoes
- Winter Storms

The following information is a brief overview of some of these possible emergency events. More information about these and other hazards can be found on the FEMA website at www.fema.gov.

Weather Emergencies

Hurricane

A hurricane is a tropical storm with winds that have reached a constant speed of 74 miles per hour or more. Hurricane winds blow in a large spiral around a relative calm center known as the "eye." The "eye" is generally 20 to 30 miles wide, and the storm may extend outward 400 miles. As a hurricane approaches, the skies will begin to darken and winds will grow in strength. As a hurricane nears land, it can bring torrential rains, high winds, and storm surges. A single hurricane can last for more than 2 weeks over open waters and can run a path across the entire length of the eastern seaboard. August and September are peak months during the hurricane season that lasts from June 1 through November 30.

Lower floors of your institution may be subject to flash flooding and appropriate preventative actions will need to be taken. You should follow client instructions for ensuring patient safety and/or evacuation. If the eye of the storm passes over you, there will be a lull (lasting for a few minutes up to an hour). Stay in a safe place. Do not be lulled into getting hit by the other side of the storm while unprepared.

The National Weather Service will issue a hurricane and/or flash flood watches and warnings as necessary.

Tornado

A tornado is a violent windstorm characterized by a twisting, funnel-shaped cloud. It is spawned by a thunderstorm (or sometimes as a result of a hurricane) and produced when cool air overrides a layer of warm air, forcing the warm air to rise rapidly. The damage from a tornado is a result of the high wind velocity and wind-blown debris. Tornado season is generally March through August, although tornadoes can occur at any time of year. They tend to occur in the afternoons and evenings: over 80 percent of all tornadoes strike between noon and midnight.
Most tornadoes come from the southwest. This means that the extreme blast of wind will usually come from the same direction. Rooms on upper floors of buildings facing the approaching tornado will be the most dangerous

places because they will receive the maximum impact. Conversely, the safer places will be the lowest floor interior corridors.

Earthquake

An earthquake is a sudden, rapid shaking of the Earth caused by the breaking and shifting of rock beneath the Earth's surface. For hundreds of millions of years, the forces of plate tectonics have shaped the Earth as the huge plates that form the Earth's surface move slowly over, under, and past each other. Sometimes the movement is gradual. At other times, the plates are locked together, unable to release the accumulating energy. When the accumulated energy grows strong enough, the plates break free causing the ground to shake. Most earthquakes occur at the boundaries where the plates meet; however, some earthquakes occur in the middle of plates.

Ground shaking from earthquakes can collapse buildings and bridges; disrupt gas, electric, and phone service; and sometimes trigger landslides, avalanches, flash floods, fires, and huge, destructive ocean waves (tsunamis). Buildings with foundations resting on unconsolidated landfill and other unstable soil, and trailers and homes not tied to their foundations are at risk because they can be shaken off their mountings during an earthquake. When an earthquake occurs in a populated area, it may cause deaths and injuries and extensive property damage.

The best protection during an earthquake is to get under heavy furniture such as a desk, table, or bench.

Floods

Floods are the most common and widespread of all natural disasters--except fire. Most communities in the United States can experience some kind of flooding after spring rains, heavy thunderstorms, or winter snow thaws. Floods can be slow or fast rising but generally develop over a period of days.

Dam failures are potentially the worst flood events. A dam failure is usually the result of neglect, poor design, or structural damage caused by a major event such as an earthquake. When a dam fails, a gigantic quantity of water is suddenly let loose downstream, destroying anything in its path.

Man-Made Emergencies

Nuclear Attack or Accident

The main hazards of a nuclear attack and accident are blast, heat, fire, and fallout radiation. You may be able to protect yourself against blast and heat by getting inside the shelter area of the institution. You can protect yourself against fallout radiation by getting inside a fallout shelter (know where it is located at the institution) and stay there until you are told to come out by authorities that have the equipment to measure radiation levels.

It is most important that you follow the instructions of the fallout shelter leader or appropriate authorities. A person cannot “catch” radiation sickness from another person. Do not use food and water from normal sources until cleared by appropriate authorities.

Learn what the warning signals are to be used in your community, what they sound like, what they mean and what actions you should take when you hear them. If there should be a nuclear flash—especially if you feel the warmth from it—take cover instantly, and then move to a fallout shelter later.

Bomb Threat/Terrorism

If you receive a bomb threat by phone, try to get as much information as possible regarding the bomb threat and caller. When the caller hangs up, immediately notify Security, Engineering, and Administration, and wait for

further directions. If suspected explosive devices are found in your area, call Security and Engineering immediately.

For terrorist situations, contact authorities and stay in location or evacuate, however instructed.

For all emergencies, temporary healthcare professionals who are placed on assignment at client facilities should follow the emergency management plans specific to those institutions.

Fire Safety

According to the National Fire Protection Association, more than 8,000 hospital fires are reported each year. Hospitals are susceptible to fires because of the presence of flammable chemicals and materials, and large amounts of electrical and mechanical equipment.

As a nursing professional, you should never take fire alarms lightly. How you respond could save your life, and the lives of your patients.

The first few minutes of a fire are the most important. To respond appropriately the "RACE" formula tells you how to proceed and in what order.

R—Rescue patients who are in immediate danger.
A—Sound the fire alarm.
C—Confine the fire by closing doors and windows.
E—Extinguish the fire, if possible, or evacuate.

Of course, fire prevention is always preferable to fire response. You should always consider the following rules no matter what facility you are working in:

- Responsibility for fire prevention belongs to everyone.
- Watch for fire hazards and report them.
- Keep work areas clean and free of excess clutter.
- Store flammables in approved containers in isolated areas.
- Know the location of fire alarms and fire fighting equipment.
- Don't overload or misuse electrical equipment.
- Don't use unapproved extension cords.
- Don't store anything within 18 inches of ceiling sprinkler heads.

It is important that you become familiar with your surroundings during your orientation at a facility. You should ask to review a copy of the client's/facility's fire safety and response plan knowing the location of the closest fire extinguishers and fire exits. You should also learn which valves shut off oxygen and other gases in case of emergency.

For all emergencies, temporary healthcare professionals who are placed on assignment at client facilities should follow the emergency management plans specific to those institutions.

Electrical Safety

Electrical current has long been recognized as a serious workplace hazard. Practically all members of the workforce are exposed to electrical energy during the performance of their daily duties. This is especially true in medical settings due to the presence of large amounts of electrical equipment.

There are four main types of electrical injuries: electrocution (fatal), electric shock, burns, and falls caused as a result of contact with electrical energy. Additionally, electricity is also a leading cause of hospital fires.

Reducing and eliminating exposure to electrical hazards requires constant attention. You should become familiar with the equipment you use at each client facility, making special note of safety considerations. The following are general safety rules you should follow in all facilities:

- Always use equipment according to the manufacturer's specifications.
- Never bypass or disable equipment safety features.
- Report malfunction of equipment to the appropriate authority and take the equipment out of service.
- Always turn an appliance off before unplugging it.
- Do not use extension cords.
- Check for frayed or loose cords.
- When replacing lamps and bulbs, verify that the replacement matches fixture requirements.
- Determine the reason that a fuse operated or circuit breaker tripped before replacing or resetting.
- Know where your overcurrent devices are (i.e. circuit breakers and fuses) so they can be easily and quickly reached in case of emergency.

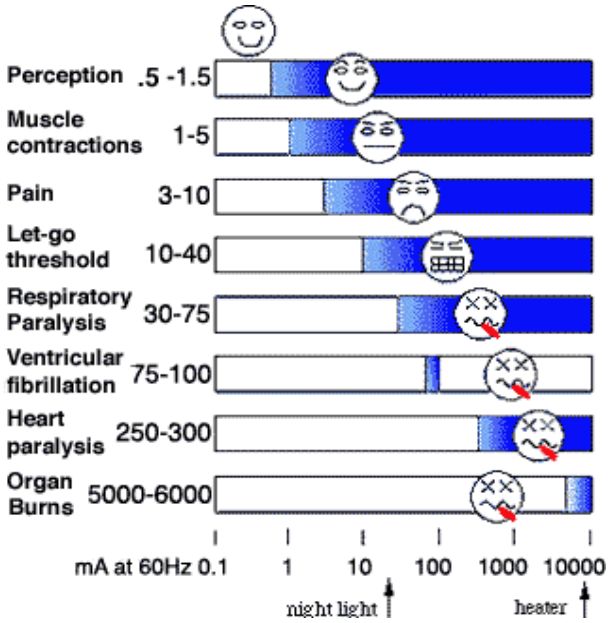


Chart Source: Hazards Control Safety Education and Training
http://www-training.llnl.gov/wbt/hc/Electrical/ES15.html

For all emergencies, temporary healthcare professionals who are placed on assignment at client facilities should follow the emergency management plans specific to those institutions.

Exposure Control Plan

Employees incur risk of infection and subsequent illness each time they are exposed to bloodborne pathogens or other potentially infectious materials (OPIM). This Exposure Control Plan was developed to reduce employee risk by minimizing or eliminating employee exposure incidents to such pathogens.

Employees of "The Company" generally work at facilities owned and controlled by client organizations. Therefore, this plan should be administered in conjunction with the exposure control plan, policies, and procedures maintained by the client organization.

Incorporated in this Exposure Control Plan are the following sections, which are part of this training manual. This information should be reviewed in conjunction with the policies and procedures contained herein:

- General Infection Control
- Bloodborne Pathogens, Universal Precautions, Standard Precautions
- Medical Waste Disposal
- Hand Hygiene
- Needle Stick Prevention
- Hepatitis B Vaccinations
- Tuberculosis
- SARS

Employees of "The Company" are directed to comply with universal and standard precautions, as directed by the client's policies and procedures. Employees must use appropriate protection and equipment during any procedure where occupational exposure is likely to occur. Occupational exposure refers to reasonable anticipated skin, eye, mucous membrane, or parenteral contact with blood or OPIM that may result from the performance of duties. The following is a partial list of where appropriate protection and equipment is required:

1. All contact with blood, and/or drainage from wounds and excretions.
2. All dressing changes, including skin tears.
3. Finger sticks.
4. All contact with respiratory secretions.
5. All used syringes and needles to be placed in a designated puncture resistant container.
6. Needles are not to be recapped.
7. All dental procedures, including oral care.

If exposure to blood or OPIM occurs, the following National Institute for Occupational Safety and Health (NIOSH) recommended steps should be followed:

- Wash needlesticks and cuts with soap and water.
- Flush splashes to the nose, mouth, or skin with water.
- Irrigate eyes with clean water, saline, or sterile irritants.
- Report the incident to your supervisor.
- Immediately seek medical treatment.
- If you have questions about appropriate medical treatment for occupational exposures to blood, 24-hour assistance is available from the Clinician's Post Exposure Prophylaxis Hotline (PEP line) at (1-888-448-4911). Generally post-exposure and follow-up includes:
    - A confidential medical exam.
    - Documentation of the route(s) of exposure and the circumstances under which the exposure incident occurred. Testing of the source individual's blood and making the results of the sources individual's testing, usually after consent, available to the exposed employee.
    - Administration of post-exposure prophylaxis, when medically indicated, as recommended by the

U.S. Public Health Service.

- If the employee refuses to submit to a medical exam and/or the administration of post-exposure prophylaxis, when it is indicated, no adverse action can be taken on that ground alone since the procedures are designated for the benefit of the exposed employee.

All exposures should be reported to "The Company" as soon as practical. "The Company" will notify its workers' compensation carrier as necessary.

"The Company" will track workers' compensation claims and other exposure incidents as required and applicable. It is the responsibility of the client to report occupational exposures that occur on their premises on their OSHA 300 Log. Each injury and illness should be recorded only once as per regulation.

As an employee of "The Company", it is your responsibility to become familiar with and follow your assigned facilities corresponding policies and procedures.

General Infection Control

Breaking the chain of infection is everyone's responsibility and is reliant of good work place controls and adhering to related policies and procedures. Included in this category are influenza outbreaks and pandemics.

PANDEMIC: A pandemic is an epidemic of infectious disease that is spreading through human populations across a large region; for instance a continent, or even worldwide. Throughout history there have been a number of pandemics, such as smallpox and tuberculosis. More recent pandemics include the HIV pandemic and the 2009 H1N1 flu pandemic. A pandemic flu spreads easily from person to person and can cause serious illness. Along with other infectious diseases, following basic infection control guidelines of "The Company" and your assigned facilities will help prevent the spread of infections.

OSHA: "The Company" is in compliance with the OSHA Bloodborne Pathogen regulations (OSHA Standard #29 CFR 1910.1030). The training materials in this section ensure that "The Company" employees are aware of their rights and responsibilities. Furthermore, since employees of "The Company" work at facilities owned by client organizations, they may also receive site-specific training and/or orientation from the client, as necessary.

HEPATITIS B VACCINATION: "The Company" offers free access to the Hepatitis B Vaccination for all employees who are exposed to blood or other potentially infection materials (OPIM) as part of their job duties.

CONTROLLING THE SPREAD OF INFECTION: The most effective means of controlling the spread of infection is appropriate hand hygiene. Please read the separate section on this topic.

Health care professionals should also wear appropriate personal protective equipment (PPE) as required by Standard Precautions or by special Isolation precautions as posted for individual patients. PPE is provided by the client organization.

The use of good engineering controls will further assist in the prevention and elimination of infections. These controls, administered by client organizations, may include but are not limited to sharps handling devices, cleaning & disinfecting, biohazard disposal materials, PPE appropriate for the setting, and hand washing resources.

In addition, Health care professionals should:

- Avoid eating, drinking, smoking, applying cosmetics, and handling contact lenses if such activities would increase the likelihood of an exposure.
- Cough Etiquette: cover your nose and mouth when coughing or sneezing preferably by coughing or sneezing into the crook of your elbow can contain respiratory droplets and avoids infecting hands.

- ALWAYS practice hand hygiene (see related chapter).
- Avoid touching your eyes, nose, or mouth.
- Wear gloves when contacting biohazard materials and/or patients.
- Be educated and stay informed of current trends and outbreaks.
- Follow client guidelines, policies and procedure
- Get the appropriate vaccinations as recommended by your healthcare provider.
- Avoid working when sick. Call in to your local branch office if you have:
    - Conjunctivitis (eye infection)
    - Productive cough
    - Jaundice (yellow skin or eyes)
    - Nausea and vomiting
    - Sore throat
    - Open or draining sores
    - General rash
    - Diarrhea (not food related)
    - Fever

Hand Hygiene

Artificial Nails

Health care professionals should avoid wearing artificial nails and keep natural nails less than one quarter of an inch long if they care for patients at high risk of acquiring infections (e.g. patients in intensive care units or in transplant units). Some clients prohibit artificial nails or other personal expressions (tattoos, piercings) as part of their infection control policies. In such cases, "The Company" will enforce the more restrictive client policy.

Hand Washing

According to the Centers for Disease Control (CDC) appropriate hand washing results in a reduced incidence of both nosocomial and community infections. Guidelines from national and international infection prevention and control organizations have repeatedly acknowledged that hand washing is the single most important procedure for preventing infections.

Preferred methods of hand washing:

- Non-antimicrobial or antimicrobial soap and water are preferred.
- Alcohol hand rub or alternatively with antimicrobial soap and water
- Plain soap (detergents) is also somewhat effective in removing most transient microbial flora

The components of good hand washing include using an adequate amount of soap, rubbing the hands together to create some friction, and rinsing under running water. The mechanical action of washing and drying removes most of the transient bacteria present. Dry hands thoroughly after hand hygiene.

Washing hands as promptly and thoroughly as possible between patient contacts and after contact with blood, body fluids, secretions, mucous membranes, non-intact skin, wound dressings, excretions, and contaminated equipment or articles is an important component of infection control and isolation precautions. To help protect exposure to infectious materials you should wash your hands:

- Before and after a work shift.
- Before eating, drinking, or handling food or medications.
- After using the toilet; after hand contact with own mouth and nasal secretions (cough, sneezes, etc.).
- Before and after significant physical contact with any patient. More frequent hand washing is indicated between patients in high-risk areas (ICU, Nursery, Oncology) since these patients are more susceptible to infection.
- Before and after performing invasive procedures. Although gloves may be worn for certain procedures, hand washing before donning gloves and after removal is necessary because of the possibility of tears in the gloves.
- Between care activities on the same patient involving different body sites (i.e., care of Foley/IV/Wound/Trach).
- After contact with wounds or mucous membranes, or items such as dressings, bedpans, collecting devices, which may be contaminated with secretions, excretions, or blood.
- When there is a doubt about the possibility of hand contamination.

Procedures for Proper Hand Washing:

1. Remove hand jewelry as it may harbor pathogens.
2. Roll up sleeves.
3. Clean under fingernails (artificial fingernails should not be worn).
4. Wet hands and wrists before applying soap.
5. Lather well and apply friction to all surfaces of hands and wrists, between fingers and around nails.
6. Minimum scrubbing time is 10 seconds; if visible contamination, 15-30 seconds is advised.
7. Rinse well, holding hands downward.
8. Avoid touching sink and faucet.
9. Dry hands thoroughly with disposable paper towels prior to handling faucets.

10. Avoid using multi-use (cloth) hand towels.
11. Turn off manual faucets with paper towels to avoid recontamination of hands.

GO TO THE CDC WEB SITE FOR MORE INFORMATION. www.cdc.gov

BLOODBORNE PATHOGENS AND UNIVERSAL PRECAUTIONS

Bloodborne pathogens are pathogenic microorganisms that are present in human blood and can cause disease in humans. Some infections that can be transmitted through contact with blood and body fluids include:

- HIV, Hepatitis A, B, C, Staph and Strep infections, Gastroenteritis-salmonella, and shigella, Pneumonia, Syphilis, TB, Malaria, Measles, Chicken Pox, Herpes, Urinary tract infections, and Blood infections. The greatest risks are from HIV and Hepatitis B and C.

Universal Precautions is an approach to infection control to treat all human blood and certain human body fluids as if they were known to be infectious for HIV, HBV and other bloodborne pathogens. The OSHA Bloodborne Pathogen Standard requires:

- Employees to observe Universal Precautions to prevent contact with blood or other potentially infectious materials (OPIM).
- Under circumstances in which differentiation between body fluid types is difficult or impossible, all body fluids shall be considered potentially infectious materials.
- Treat all blood and other potentially infectious materials with appropriate precautions such as:
    - Use gloves, masks, and gowns if blood or OPIM exposure is anticipated.
    - Use engineering and work practice controls to limit exposure.

OPIM is defined as:

- The following human body fluids: semen, vaginal secretions, cerebrospinal fluid, synovial fluid, pleural fluid, pericardial fluid, peritoneal fluid, amniotic fluid, saliva in dental procedures, any body fluid that is visibly contaminated with blood, and all body fluids in situations where it is difficult or impossible to differentiate between body fluids;
- Any unfixed tissue or organ (other than intact skin) from a human (living or dead); and
- HIV-containing cell or tissue cultures, organ cultures, and HIV- or HBV-containing culture medium or other solutions; and blood, organs, or other tissues from experimental animals infected with HIV or HBV.

The Bloodborne Pathogens Standard (WAC 296-823) provides requirements to protect employees from exposure to blood or other potentially infectious materials (OPIM):

- Procedures in infection control are called Body Substance Isolation (BSI) and Standard Precautions. These standards define which body fluids and substances as infectious. Examples of personal protective equipment are gowns, gloves, shoe covers, masks, respirators, and safety glasses. With respirators, familiarize yourself with the make and model of respirator that is used at the client facility, assure you have undergone proper fit testing procedures and education.
- These standards incorporate not only the fluids and materials covered by the Bloodborne Pathogens Standard but expand coverage to include all body fluids and substances.

- For compliance with OSHA Standards, the use of either Universal Precautions or Standard Precautions is acceptable.

The CDC recommends Standard Precautions (combines major features of Universal Precautions and Body Substance Isolation) for the care of all patients, regardless of their diagnosis or presumed infection status.

- Standard Precautions apply to: 1) blood; 2) all body fluids, secretions, and excretions, *except sweat,* regardless of whether or not they contain visible blood; 3) non-intact skin; and 4) mucous membranes. Standard precautions are designed to reduce the risk of transmission of microorganisms from both recognized and unrecognized sources of infection in hospitals.

    - Standard precautions include the use of hand hygiene techniques, safe injection procedures, respiratory hygiene, cough etiquette, and appropriate personal protective equipment such as gloves, gowns, masks, and eyewear whenever touching or exposure to patients' body fluids is anticipated. (Client facilities will implement their environmental controls).

- Transmission-Based Precautions (i.e., Airborne Precautions, Droplet Precautions, and Contact Precautions) are recommended to provide additional precautions beyond Standard Precautions to interrupt transmission of pathogens in hospitals.

    - Transmission-based precautions can be used for patients with known or suspected to be infected or colonized with epidemiologically important pathogens that can be transmitted by airborne or droplet transmission or by contact with dry skin or contaminated surfaces. These precautions should be used in addition to standard precautions.

        - Airborne Precautions used for infections spread in small particles in the air such as chicken pox.
        - Droplet Precautions used for infections spread in large droplets by coughing, talking, or sneezing such as influenza.
        - Contact Precautions used for infections spread by skin-to-skin contact or contact with other surfaces such as herpes simplex virus.

    - Airborne precautions, droplet precautions, and contact precautions may be combined for diseases that have multiple routes of transmission. When used either singularly or in combination, they are to be used in addition to Standard Precautions.

What should you do if you are exposed to the blood of a patient/resident?

1. **Immediately following an exposure to blood**:
    - Wash needlesticks and cuts with soap and water
    - Flush splashes to the nose, mouth, or skin with water
    - Irrigate eyes with clean water, saline, or sterile irrigants

No scientific evidence shows that using antiseptics or squeezing the wound will reduce the risk of transmission of a bloodborne pathogen. Using a caustic agent such as bleach is not recommended.

2. **Report the exposure immediately** to the appropriate facility department and your direct charge person (e.g., occupational health, infection control) responsible for managing exposures. Then contact your branch office personnel. Prompt reporting is essential because, in some cases, post-exposure treatment may be recommended and it should be started as soon as possible. Discuss the possible risks of acquiring HBV, HCV, and HIV and the need for post-exposure treatment with the provider managing your exposure. You should have already received hepatitis B vaccine, which is extremely safe and effective in preventing HBV infection.

For other types of exposures, report to the appropriate facility department and your direct charge person responsible for managing exposures. Then contact your branch personnel.

Taken from the CDC website at www.cdc.gov

As an employee of "The Company", it is your responsibility to become familiar with and follow your assigned facilities corresponding policies and procedures.

Health Screening

Upon hire and as required by a client, "The Company" requires its healthcare professionals to present evidence of a recent health screening clearing an individual to work in a client setting. "The Company" only requires the results of health screening with the medical professional's name or signature and date of screening. It is recommended that specific system reviews and findings considered confidential not be shared with "The Company".

The purpose of the health screen is to ensure that employees are free from health conditions that would be of potential risk to patients, or which might interfere with the person's duties as a healthcare or allied worker.

Additionally, "The Company" requires information about the employee's most recent tuberculosis test to ensure compliance with "The Company's" Tuberculosis Prevention and Protection plan (annual). The employee may also need to provide evidence of vaccination against other diseases as required by law or specific clients.

The health screen can be completed using the "Physical Exam" form which is available on the company website or from your local branch office.

Health Screening Recommendations

- Update cervical cancer screening to starting at age 21 and occurring every 3-5 years for women aged 21-65 (previously pap smears started at age 18)
- Update colorectal cancer screening to starting at age 45 for average risk adults (previously age 50)
- Add lung cancer screening with annual low-dose CT for high-risk adults aged 50-80 who have a 20 pack-year smoking history
- Include prediabetes and diabetes screening for overweight or obese adults aged 35-70

Vaccine Recommendations Updates:

- Change shingles vaccination to 2 doses of Shingrix starting at age 50 versus just a single dose of Zostavax at age 60
- Update HPV vaccines to 2 doses for ages 15-26 (previously 3 doses up to age 26) and include ages 27-45 for shared decision making
- Add hepatitis B vaccination for adults with diabetes younger than 60 and other high-risk groups
- Include meningococcal B vaccine per individual clinical decision for ages 16-23

Hepatitis B Vaccine Program

POLICY:
It is the policy of "The Company" to offer employees in "at-risk" job classifications free immunizations against the Hepatitis B virus. Employees who wish to participate in this program should contact their local branch office for more information.

PURPOSE OF THE VACCINE PROGRAM:
The Hepatitis B vaccination program is intended to protect individuals who in the course of their work may be exposed to bloodborne pathogens from the Hepatitis B virus. Hepatitis B is a major infectious bloodborne occupational hazard to Health care professionals. In the United States, each year this virus causes over 2,000 cases of clinical acute hepatitis, over 400 hospitalizations, and approximately 200 deaths of Health care professionals. According to the vaccine manufacturer, Hepatitis B vaccination induces antibodies in over 90% of vaccinated patients. The vaccine is virtually 100% effective in preventing Hepatitis B in those who develop antibodies. It does not, however, protect against infection from other hepatitis viruses.

NATURE OF THE VACCINE:
Hepatitis B vaccine contains a deactivated form of Hepatitis B virus which induces the development of antibodies in most individuals three months of age and older. These antibodies immunize the individual from infection, which may otherwise result from exposure to carriers of the Hepatitis B virus. Hepatitis B vaccine is administered in three injections into the deltoid muscle of the upper arm over a period of six months.

RISKS:
Vaccination is a common procedure. The manufacturer of the vaccine claims that there are no known serious risks associated with the Hepatitis B vaccine, although unanticipated adverse reactions are possible. Hypersensitivity to any component of the vaccine is rare, but possible. This may necessitate the use of epinephrine in case of anaphylactoid reaction.

According to the manufacturer, minor temporary reactions are not uncommon, and you may experience soreness, swelling, warmth, or hardening at the site of the injection and/or a low-grade fever (less than 101 degrees F) during the first two days after the vaccination. High-grade fevers (over 102 degrees F) occur less frequently. It is also possible that you will experience minor systemic discomfort (such as malaise, fatigue, headache, nausea, muscle, and joint aches or rash) during the first few days following vaccination. If you experience other reactions, please contact your physician.

The Hepatitis B vaccine should be administered to you by a MD, RN, or LPN. Please consult with your provider about other possible risks from the vaccinations.

CAUTION:
If you are pregnant, think that you may be pregnant, or are lactating or breast-feeding, notify your physician immediately. Hepatitis B vaccine should not be taken under these circumstances without the express written order of your personal physician.

IF YOU ARE ALLERGIC TO YEAST YOU MUST NOT TAKE THE VACCINE.

Needlestick And Sharp Injury Prevention

Health care professionals handling sharp devices or equipment such as scalpels, sutures, hypodermic needles, blood collection devices, or phlebotomy devices are at risk for injury and exposure to bloodborne pathogens and other potentially infectious materials. Exposure most often occurs because of unsafe needle devices and the improper handling and disposal of needles or other sharps. Needlestick injuries can be substantially reduced by:

- Using safer needle devices and needleless devices. (Ask the client facility where you are working about the availability of these devices.)
- Proper handling and disposal of needles and other sharps.
- Do not bend, recap, or remove contaminated needles and other sharps unless such an act is required by a specific procedure or has no feasible alternative.
- Do not shear or break contaminated sharps.
- Have needle containers available near areas where needles may be found.
- Discard contaminated sharps immediately or as soon as feasible into appropriate containers.

Other contaminated sharps include scalpels, broken glass, broken capillary tubes, and razor blades. These sharps also represent a potential safety hazard. Sharp injuries can be prevented by:

- Wearing gloves when handling or touching contaminated items or surfaces.
- Disposing of regulated wastes properly.
- Not picking up broken glassware directly with the hands.
- Using capillary tubes that are not made of glass.
- Using needleless connector systems with I.V. setups when possible.
- Treating used disposable razors as contaminated waste.

What should you do if you are exposed to the blood of a patient/resident?

1. **Immediately following an exposure to blood**:
   - Wash needlesticks and cuts with soap and water
   - Flush splashes to the nose, mouth, or skin with water
   - Irrigate eyes with clean water, saline, or sterile irrigants

No scientific evidence shows that using antiseptics or squeezing the wound will reduce the risk of transmission of a bloodborne pathogen. Using a caustic agent such as bleach is not recommended.

2. **Report the exposure** to the appropriate facility department and your direct charge person (e.g., occupational health, infection control) responsible for managing exposures. Then contact your branch office personnel. Prompt reporting is essential because, in some cases, post-exposure treatment may be recommended and it should be started as soon as possible. Discuss the possible risks of acquiring HBV, HCV, and HIV and the need for post-exposure treatment with the provider managing your exposure. You should have already received hepatitis B vaccine, which is extremely safe and effective in preventing HBV infection.

For other types of exposures, report to the appropriate facility department and your direct charge person responsible for managing exposures. Then contract your branch personnel.

Taken from the CDC web site at www.cdc.gov.

As an employee of "The Company", it is your responsibility to become familiar with and follow your assigned facilities corresponding policies and procedures.

HIV and AIDS
Information for the Healthcare Provider
(Content attributed to the CDC-Center for Disease Control)

HIV is the **h**uman **i**mmunodeficiency **v**irus. It is the virus that can lead to acquired immune deficiency syndrome, or AIDS. CDC estimates that about 56,000 people in the United States contracted HIV in 2006. HIV damages a person's body by destroying specific blood cells, called CD4+ T cells, which are crucial to helping the body fight diseases.

AIDS stands for **A**cquired **I**mmuno**d**eficiency **S**yndrome.

Acquired – means that the disease is not hereditary but develops after birth from contact with a disease-causing agent (in this case, HIV).
Immunodeficiency – means that the disease is characterized by a weakening of the immune system.
Syndrome – refers to a group of symptoms that indicate or characterize a disease. In the case of AIDS, this can include the development of certain infections and/or cancers, as well as a decrease in the number of certain specific blood cells, called CD4+ T cells, which are crucial to helping the body fight disease.

Before the development of certain medications, people with HIV could progress to AIDS in just a few years. Currently, people can live much longer - even decades - with HIV before they develop AIDS. This is because of "highly active" combinations of medications that were introduced in the mid-1990s.

HIV and AIDS diagnoses: A diagnosis of AIDS is made by a physician using specific clinical or laboratory standards. AIDS is diagnosed when the immune system of a person infected with HIV becomes severely compromised (measured by CD4 cell count) and/or the person becomes ill with an opportunistic infection or illness. In the absence of treatment, AIDS usually develops 8 to 10 years after initial HIV infection; with early HIV diagnosis and treatment, this may be delayed by many years. With the release of the *Revised Surveillance Case Definitions for HIV Infection Among Adults, Adolescents, and Children Aged <18 Months and for HIV Infection and AIDS Among Children Aged 18 Months to <13 Years—United States, 2008*, CDC has moved to a staging system of HIV infection that includes AIDS (HIV infection, stage 3).

Occupational HIV Transmission and Prevention among Health Care Workers
Through December 2001, there were 57 documented cases of occupational HIV transmission to health care workers in the United States, and no confirmed cases have been reported since 1999. Occupational transmission of HIV is reported in the *Centers for Disease Control and Prevention (CDC) HIV Surveillance Report*[1] in the transmission category that includes hemophilia, blood transfusion, perinatal exposure, and risk factor not reported or not identified.
To prevent transmission of HIV to health care workers in the workplace, CDC offers the following recommendations.

Prevention Strategies
Health care workers should assume that the blood and other body fluids from all patients are potentially infectious. They should therefore follow infection control precautions at all times.
These precautions include

- routinely using barriers (such as gloves and/ or goggles) when anticipating contact with blood or body fluids,
- immediately washing hands and other skin surfaces after contact with blood or body fluids, and
- carefully handling and disposing of sharp instruments during and after use.

Safety devices have been developed to help prevent needle-stick injuries. If used properly, these types of devices may reduce the risk of exposure to HIV. Many percutaneous injuries, such as needle-sticks and cuts, are

related to sharps disposal. Strategies for safer disposal, including safer design of disposal containers and placement of containers, are being developed.

Although the most important strategy for reducing the risk of occupational HIV transmission is to prevent occupational exposures, plans for post-exposure management of health care personnel should be in place. CDC has issued guidelines for the management of health care worker exposures to HIV and recommendations for post-exposure prophylaxis (PEP): *Updated U.S. Public Health Service Guidelines for the Management of Occupational Exposures to HIV and Recommendations for Post-exposure Prophylaxis*[2] (September 30, 2005).

These guidelines outline a number of considerations in determining whether health care workers should receive PEP and in choosing the type of PEP regimen. For most HIV exposures that warrant PEP, a basic 4-week, two-drug (there are several options) regimen is recommended. For HIV exposures that pose an increased risk of transmission (based on the infection status of the source and the type of exposure), a three-drug regimen may be recommended. Special circumstances, such as a delayed exposure report, unknown source person, pregnancy in the exposed person, resistance of the source virus to antiviral agents, and toxicity of PEP regimens, are also discussed in the guidelines. Occupational exposures should be considered urgent medical concerns.

Building Better Prevention Programs for Health Care Workers
Continued diligence in the following areas is needed to help reduce the risk of occupational HIV transmission to health care workers.

Administrative efforts. All health care organizations should train health care workers in infection control procedures and on the importance of reporting occupational exposures. They should develop a system to monitor reporting and management of occupational exposures.

Development and promotion of safety devices. Effective and competitively priced devices engineered to prevent sharps injuries should continue to be developed for health care workers who frequently come into contact with potentially HIV-infected blood and other body fluids. Proper and consistent use of such safety devices should be continuously evaluated.

Monitoring the effects of PEP. Data on the safety and acceptability of different regimens of PEP, particularly those regimens that include new antiretroviral agents, should be continuously monitored and evaluated. Furthermore, improved communication about possible side effects before starting treatment and close follow-up of health care workers receiving treatment are needed to increase compliance with the PEP.

As an employee of "The Company", it is your responsibility to become familiar with and follow your assigned facilities corresponding policies and procedures.

Tuberculosis Facts and Information

The transmission of tuberculosis (TB) is a recognized hazard among Health care professionals. Consider the following:

- Eight million new tuberculosis (TB) cases occur each year in the world and 3 million people die of the disease.
- In the United States, after several decades of decline, TB cases increased 20 percent between 1985 and 1992. Reasons for the increase included:
    - The HIV epidemic.
    - Immigration of persons from areas with a high prevalence of TB.
    - Transmission of TB in high-risk environments, such as correctional facilities, homeless shelters, hospitals, and nursing homes.
    - Deterioration of the TB public health care infrastructure.
- During the resurgence of TB, outbreaks of multidrug-resistant TB occurred in hospitals and prisons, resulting in high death rates and transmission to Health care professionals.
- The 21,337 TB cases reported in 1996 represent the fourth consecutive year of decline, suggesting the successful use of new resources in different areas of the U.S. to better detect and treat persons with active TB and latent infection.
- While the decrease in TB cases is encouraging, there are several areas of concern which will require expanded efforts:
    - TB cases continue to increase in many areas.
    - Outbreaks of drug-resistant TB continue in many areas.
    - An estimated 10 to 15 million persons in the U.S. are infected with *Mycobacterium tuberculosis*. Without intervention, about 10 percent of these persons will develop TB disease at some point in life.

- Directly observed therapy is not available for many persons with active TB who have difficulty completing a full course of TB treatment.

- An increasing proportion of TB cases in the U.S. are among individuals born in areas with a high prevalence of TB, and international collaboration needs to be strengthened to prevent and control TB in these persons.

Mycobacterium tuberculosis is spread by airborne particles, known as droplet nuclei that can be generated when persons with pulmonary or laryngeal TB sneeze, cough, speak, or sing. Persons who share the same airspace with persons with infectious TB disease are at greatest risk for infection. Infection occurs when a susceptible person inhales droplet nuclei containing tubercle bacilli and these bacilli become established in the alveoli of the lungs and spread throughout the body.

Identifying TB Infection

A person exposed to an individual with infectious TB or who has other risk factors for TB as noted above should be given a tuberculin skin test.

The Mantoux tuberculin skin test is the preferred method of skin testing. The Mantoux tuberculin skin test is the intradermal injection of purified protein derivative (PPD) of killed tubercle bacilli, usually on the inner forearm. The site is examined by a trained health care worker 48 to 72 hours after injection for induration (palpable swelling). The diameter of induration is measured and recorded; erythema or bruising is disregarded.

Identifying TB Disease

If the skin test result is positive or if symptoms suggestive of TB are present (e.g., productive and prolonged cough, fever, chills, loss of appetite, weight loss, fatigue, or night sweats), a chest radiograph should be obtained to help rule out active pulmonary TB. The chest radiograph may also be used to detect the presence of fibrotic lesions suggestive of old, healed TB or silicosis.

Acid-fast bacilli (AFB) smears and cultures should be performed on sputum specimens of all persons who have symptoms of TB or whose chest radiograph suggests TB. A positive AFB smear is an indication for beginning treatment for TB. However, a positive AFB smear may also indicate the presence of nontuberculous mycobacteria. A positive culture for *Mycobacterium tuberculosis* is the only definitive proof of TB disease.

Health care providers of HIV-infected persons should be aware of atypical patterns of TB disease in these persons. Extrapulmonary TB is more common. Also, pulmonary TB may present in an unusual manner (e.g., in the lymph nodes or in the lower part of the lungs).

All persons with TB infection or TB disease should be offered counseling and HIV-antibody testing, because medical management may be altered in the presence of HIV infection.

Prevention of Tuberculosis

The main purpose of preventive therapy is to prevent latent infection from progressing to clinically active TB disease. Therefore, persons with positive tuberculin skin test results who do not have clinically active disease should be evaluated for preventive therapy. TB is usually curable if effective treatment is instituted without delay.

Reporting

TB reporting is required by law in every state. All new TB cases and suspect cases should be reported promptly to the health department by the clinician. Cases may also be reported by infection control nurses or by pharmacies when TB drugs are dispensed. In addition, all positive TB smears and cultures should be reported promptly by laboratories. Early reporting is important for the control of TB and it gives clinicians access to the resources of the health department for assistance in case management and contact investigation.

Infection Control Measures

The spread of TB in health care settings can be minimized by implementing CDC recommendations for preventing TB transmission in these settings. The early detection, isolation, and treatment of disease in persons with infectious TB are essential to controlling transmission. TB should be suspected in all persons with symptoms consistent with TB (for example, cough, fever, night sweats, chills, fatigue, weight loss or loss of appetite), especially those with confirmed or suspected HIV infection and undiagnosed pulmonary disease. Precautions should be taken to prevent airborne transmission of infection until TB is diagnosed and treated or ruled out.

Effective AFB isolation should be initiated for persons with confirmed or suspected TB to reduce the risk that they will expose others. Precautions should be taken during and immediately after procedures that may induce coughing, such as bronchoscopy, sputum collection, the aerosol induction of sputum, and the administration of aerosolized medication, such as pentamidine.

Anti-tuberculosis drug treatment should be promptly initiated for persons with active disease to render them noninfectious. Persons at high risk for TB infection should be screened and, if infected, evaluated for preventive therapy. Ongoing TB screening should be provided to Health care professionals who have regular contact with persons with TB or HIV infection.

Respiratory Protection

Wearing a respirator reduces your chances of becoming infected with TB. The client's infection control committee determines under what circumstances respirators must be worn and which employees are required to wear them. In addition, the Occupational Safety and Health Administration (OSHA) currently requires the use of respirators and is enforcing their use under the general duty clause while developing specific standards for preventing TB in Health care professionals.

Wearing surgical masks is not sufficient. Recent research has shown that many surgical masks do not do a good job of removing all TB bacteria. Some surgical masks fit so poorly that they provide very little protection from any airborne hazard.

Adapted from information from the CDC and NIOSH websites.

As an employee of "The Company", it is your responsibility to become familiar with and follow your assigned facilities corresponding policies and procedures.

TUBERCULOSIS: PREVENTION & PROTECTION PLAN

"The Company's" plan for Tuberculosis Infection Control is based on current Centers for Disease Control and Prevention (CDC) Guidelines for Preventing the Transmission of Mycobacterium Tuberculosis in Healthcare Facilities.

"The Company" Risk Assessment Team:

The following individuals are responsible for evaluating risk factors for "The Company". The Risk Assessment Team has the authority to implement and enforce the TB Infection control policies of this organization and meet only as needed for identified issues.

- Insert Name
- Insert Name

"The Company" is not a patient care facility and has minimal risk exposure to TB. However, "The Company" field employees' work in client facilities that may range from minimal to high risk for TB exposure.

These guidelines are intended to provide general information as required by OSHA. These guidelines should be applied in any setting where patient care is provided. When assigned to an institution or facility, it is your responsibility to become familiar with their policies and procedures as part of your orientation process.

At Risk Job Classifications:

Please see the separate section on jobs at risk to TB and other bloodborne pathogens or OPIM.

Health Screenings

"The Company" requires pre-employment PPD or chest x-ray to provide evidence of negative TB test, and at least annually thereafter.

TB Testing

- You should receive the Mantoux skin test or PPD, at the time of hire. This will serve as a baseline for later comparison. In some situations, clients, may require QuantiFERON.
- If you have previously tested positive, have had adequate treatment for the disease, or have previously recovered from TB, you are exempt from a skin test. You should have a chest radiograph or sputum smear if symptoms develop. You should also complete "The Company's" TB evaluation form annually.
- As long as you are PPD-negative, you should be tested annually. If you are exposed frequently to active TB patients or perform high-hazard procedures, you should be tested more frequently. Refer to your facility's guidelines to determine appropriate testing intervals for your position.
- If you have an unprotected exposure, you should have a skin test done immediately.
- If you experience any symptoms of active TB, you should immediately report your symptoms and promptly be tested for active TB. You should monitor your own health as carefully as you monitor your patients.

Education

"The Company" will educate and train employees about TB epidemiology, symptoms, risks of infection and effective measures to prevent transmission through this Manual. The training will include the benefits of a TB

screening program. Training will be appropriate to their risk category and will be performed prior to assignment to any duties that could result in exposure. Training will be conducted at least annually thereafter.

"The Company" requires our employees to review the incorporated section called Tuberculosis Facts and Information and to complete a written examination both pre-employment and annually thereafter.

Exposure Control Plan

All "The Company" employees should review and be familiar with "The Company" exposure control plan. Please carefully review the appropriate section of this manual.

As an employee of "The Company", it is your responsibility to become familiar with and follow your assigned facilities corresponding policies and procedures.

Severe Acute Respiratory Syndrome (SARS)

SARS is a severe viral illness that was first reported in Asia in February 2003. The illness is characterized by a variety of symptoms including fever, cough, and shortness of breath. In a minority of patients (6-9%), SARS may even progress to death. SARS has been reported in North America among persons returning from travel to Asia, among Health care professionals, and among others in contact with individuals with SARS. Because new outbreaks may occur, workers should be aware of the recommended measures to prevent occupational SARS infection.

Transmission
SARS is spread primarily by close contact with a SARS patient or contact with respiratory secretions/body fluids from a SARS patient. Transmission from contaminated objects has been reported. The incubation period is typically between two and seven days.

Signs and Symptoms
SARS presentation is typical of a respiratory viral illness. Patients usually present with a high fever (> 100.4 F), cough, chills, and headache. Most will progress to develop pneumonia and some will even require mechanical ventilation.

Diagnosis and Treatment
In the United States, the Centers for Disease Control and Prevention (CDC) classifies patients as either suspect or probable cases, depending on symptoms, history of exposure or other evidence of disease. A number of serological and other testing methods are being developed, including those to detect evidence of a newly identified SARS-associated coronavirus (SARS-CoV). Antiviral agents, steroids and other treatment options have been used to treat SARS patients with varying success; some SARS patients have required ventilator support.

Workplace Policies and Procedures
OSHA and the CDC have published SARS-related guidance for several occupational settings. Both agencies emphasize the need to prevent occupational transmission of SARS through early recognition, work procedures, and engineering controls.

Early Recognition involves knowing the signs and symptoms of SARS and appropriately isolating affected individuals. Symptomatic workers should seek medical attention immediately and receive medical clearance prior to returning to the worksite. When seeking healthcare for a possible diagnosis of SARS, symptomatic individuals should alert the healthcare facility so that proper precautions can be taken. Patients suspected of SARS infection should wear a surgical mask and have appropriate isolation to prevent the spread of infection. Health care professionals with an unprotected high-risk exposure to SARS should be excluded from duty for 10 days after exposure.

Work Procedures to prevent the spread of disease include frequent hand cleansing and avoiding direct contact with body fluids of SARS patients. Personal protective equipment (PPE) is appropriate in healthcare facilities and certain occupational settings, such as airline clean up, when SARS infection is a known risk. Staff should not sort soiled linens suspected of SARS contamination at the point of use. Laundering soiled linens in warm water and detergent has been advised. Compressed air should not be used for cleaning areas where SARS patients or their body fluids were present.

Engineering Controls include use of airborne isolation rooms or negative air pressure environments for aerosol generating procedures (e.g. sputum induction in SARS patients) and handling laboratory specimens in biological safety cabinets.

Protective Equipment for Healthcare Facilities
Health care professionals face a real risk of acquiring SARS through their jobs and the precautions recommended

for them are stringent. To prevent transmission of SARS in healthcare settings, PPE appropriate for standard, contact, and airborne precautions, in addition to eye protection, is recommended for all contact with SARS infected patients. Standard precautions include hand washing. Contact precautions include the use of gown and gloves for contact with the patient or the patient's environment. Airborne precautions include the use of a respirator approved by the National Institute for Occupational Safety and Health (NIOSH) (see below).

PPE is only effective if used correctly. SARS infection in Health care professionals has been reported in locations where infection control precautions were not followed and PPE was not appropriately used. Special attention should be given to the use of disposable PPE (or proper disinfection of re-usable PPE) and proper donning and doffing procedures to prevent the spread of infectious particles through PPE use.

Respirator Considerations for Healthcare Facilities

Respirators should be used in the context of a complete respiratory protection program in accordance with OSHA regulations and client policies. Some "The Company" client facilities require Fit Testing. Appropriate respirators are NIOSH approved and are at least as effective as N-95. Hood or helmet powered air-purifying respirators (PAPRs) provide protection for workers who have fit limitations (e.g. facial hair). PAPRs and higher levels of respirator protection (e.g. full-face piece) have been used during certain aerosol-generating procedures. Although surgical masks provide protection for large droplets, they are not adequate protection against airborne or aerosol particles.

Due to documented transmission through contaminated objects, disposable respirators and other PPE should be discarded after use. Reusable respirators should be decontaminated after each use according to manufacturer recommendations. Removal of PPE should minimize the potential for self-contamination and workers should be educated on standard procedures. Hand cleansing is necessary following the removal of PPE.

Taken from the OSHA website.

AT RISK JOB CLASSIFICATIONS

Employees in the following job classifications may have contact with blood, or other potentially infectious materials, as part of their job duties. This list is comprehensive though not all inclusive.

- Registered Healthcare Professionals
- Licensed Practical Healthcare Professionals
- Registered Nurse
- Licensed Practical/Vocational Nurse
- Nurse Aide
- Registered Nurse Practitioner
- Nurse Anesthetist
- Physician Assistant
- Radiology Tech
- X-Ray Tech
- Home Health Aide
- Psych/Behavioral Health Tech
- Unit Clerk or Unit Assistant
- Critical Care Registered Nurse
- Registered Respiratory Therapist
- Qualified Medicine Aide
- Mental Health Worker
- Companion/Sitter
- Ultrasound Technician
- Medical Assistant
- Physical Therapist
- Speech Therapist
- Occupational Therapist
- Physical Therapy Assistant
- Occupational Therapy Assistant
- Speech Therapy Assistant
- Scrub Tech/Operating Tech
- Pharmacist
- Phlebotomist
- Medical Lab Technician
- Medical Technologist
- Monitor Technician
- MRI Technician
- Orthopedic Technician
- Mammographer
- Environmental Services
- Emergency Medical Technician
- Paramedic
- Dietician
- Dental Assistant
- Dental Hygienist

WORKERS' COMPENSATION AND RETURN TO WORK PROGRAM

"The Company" provides employees with a comprehensive Worker's Compensation insurance program. Coverage is subject to applicable State requirements. Workers Compensation provides benefits after a specified waiting period. "The Company" will provide worker's compensation insurance to its staff or temporary healthcare professionals and administrative employees in accordance with respective state laws and regulations. "The Company" will report job-related injures and illnesses to its insurance companies in a timely manner.

"The Company" will assist employees returning to work from a work-related injury or illness by offering assignments that comply with the employees work restrictions, when possible.

Work-related Injury or Illness Procedures

The employee or temporary healthcare employee shall contact "The Company" as soon as feasible after suffering a job-related accident or illness. "The Company" shall direct the employee to appropriate medical care as indicated.

"The Company" shall direct the employee to complete a drug test. It is the policy of "The Company" to test all employees regardless of fault, if they experience an on the job injury requiring treatment from a medical professional.

The drug test will be performed within the first 24 hours of the occurrence and failure to submit a drug test within 24 hours will be deemed a refusal. The branch will facilitate the drug test request by making arrangements for the employee to be driven to the testing site if necessary.

For information regarding positive drug test results, refer to the Drug Testing Policy for "The Company"

The branch office or national operations center shall gather the necessary information and will make a first report of injury with the insurance carrier.

"The Company" reserves the rights to interpret, change, suspend, cancel, or dispute, with or without notice, all or any part of this Policy and Procedures or provisions discussed herein.

Employees have the right to refuse to undergo drug and/or alcohol testing. Refusal to submit to a post-accident/injury test may affect the employee's ability to receive workers' compensation benefits.

In the event the provision of this Policy contravene the requirements of applicable state or local law, this Policy will be deemed to be modified to comply with state or local law. To the extent that applicable state or local law permits adherence to standards or provision other than those set forth in this Policy, this Policy is deemed supplemented so as to permit the Company to utilize those other standards or provisions.

Substance Abuse/Drug Testing

SUBSTANCE ABUSE POLICY

By accepting these Benefits, Terms & Conditions of Employment you are giving consent for "The Company" to conduct drug screens.

Substance abuse in our society poses a threat of danger to us all. "The Company" accepts its responsibility to all of its employees to provide a safe work environment. "The Company" also recognizes its responsibility to its clients and to the general public to ensure that their safety and trust in our organization is protected. In accordance with this, and in compliance with the federal Drug Free Work Place Act of 1988, "The Company" is committed to maintaining a Drug Free Work Place.

To ensure that the company meets its legal and ethical requirements, the following Substance Abuse policy has been implemented. Employees should read the contents of this policy carefully as they will be held responsible for understanding and complying with it. This policy explains your rights and responsibilities as they relate to "The Company"' Drug Free Workplace and Drug and Alcohol Testing programs. Compliance with this policy is required as a condition of employment.

1.0 Covered Employees

This policy applies to employees and prospective employees of "The Company" who provide or will provide temporary services to the organization's clientele. These employees include, but are not limited to Registered Nurses, Licensed Practical, or Vocational Nurses, Certified Nurse's Assistants, Home Health Aides, as well as ancillary/allied service personnel.

2.0 Policy

2.1 "The Company" prohibits the use, possession, transfer, diversion, or sale of alcohol and/or illegal drugs or prescription drugs obtained illegally while working, or on any premises owned or operated by the company and its clients. It also prohibits reporting for work on behalf of "The Company" under the influence of alcohol and/or illegal drugs and reporting for work on behalf of "The Company" under the influence of prescription drugs that adversely affect work performance or impairs the employee's ability to complete work assignments.

2.2 Violation of this policy may result in disciplinary action, up to and including termination. "Illegal Drugs" means illicit drugs and controlled substances, and includes prescription medications, which contain a controlled substance and are used for a purpose for which they were not prescribed or intended.

3.0 Consequences of Non-Compliance

Employees who are found to be in violation of this policy will be subject to disciplinary actions including possible termination. Disciplinary actions may also include, but will not be limited to formal reprimand, suspension without pay, or other actions as required by state and local regulatory authorities.

4.0 Drug/Alcohol Testing

4.1 Pre-Employment Drug Testing

"The Company" requires successful pre-employment drug testing as a condition of employment for all temporary employees. Once directed by branch office personnel, the new employee has to report for testing at the pre-arranged time and the approved site. Employees not meeting this requirement may be disqualified from employment for the interim and can reapply after six (6) months. Furthermore, many of our clients require pre-employment drug testing of all temporary employees placed on assignment at their facilities. Therefore, when stipulated by service contract or agreement, and/or in accordance with state law, "The Company" will require its employees to comply with the client's policies and procedures in order to be eligible for work assignments with that particular client.

4.2 Reasonable Suspicion And Post Accident/Injury/Additional Testing

An employee will be requested or required to undergo a drug and/or alcohol test if there is a reasonable suspicion that the employee: (1) is under the influence of alcohol and/or illegal drugs; (2) has violated the policy statement above, or "The Company" Drug-Free Work Place policy; (3) has caused himself/herself or another person to sustain a personal injury, (4) has caused a work-related accident, or (5) upon client request/expectation/requirement.

If impairment is alleged and when notified appropriately and timely "The Company" will take reasonable precautions to protect the safety of the employee involved, whenever possible.

4.3 Right to Refuse to Undergo Drug and Alcohol Testing and the Effect Thereof

Any employee has the right to refuse to undergo drug and/or alcohol testing. An employee who refuses to be tested or whose behavior prevents meaningful completion of drug and/or alcohol testing will be subject to termination or other disciplinary action in conformity with company policy. Refusal to submit to a post-accident/injury test may also affect the employee's ability to receive workers' compensation benefits.

4.4 Rights in Case of a Negative Dilute

If a test result comes back as a negative dilute, the applicant or employee will be required to undergo an additional drug screen within 24 business hours. If the second drug screen comes back as a negative or negative dilute then the drug screen is considered negative.

4.5 Rights in Case of a Positive Test

4.5.1 Confirmatory Test – if the initial results on a drug test are positive, the sample tested will be subject to a second, confirmatory test. No employee will be terminated, discipline, discriminated against solely on the basis of an initial positive results.

4.5.2 Medical Review Officer (MRO) - If the confirmatory test is positive, the applicant or employee will be notified of the test results by a MRO of the screening vendor and will be allowed to submit information, directly to the MRO, to explain the positive test result. The MRO will either confirm the positive result or determine that the test result is negative. The applicant or employee must communicate *directly* with the MRO within in the defined time period as set by the MRO. Non-communication may result in upholding the positive result.

4.5.3 Second Confirmatory Test - If the employee is not satisfied with the positive test result he or she may, at his or her own expense, request a second confirmatory retest of the original sample, conducted either by the original testing laboratory or by another licensed laboratory.

4.6 Additional Rights of Applicants & Employees

An applicant or employee who undergoes drug testing, upon their request, may be verbally provided with the results. The drug screen test results are the property of "The Company" and cannot be copied and given to the employee unless required by law.

4.7 Consequences of A Positive Test Result

4.7.1 If an applicant has a positive confirmatory test on a pre-employment test, any conditional job offer will be withdrawn immediately and the applicant will be ineligible for employment with "The Company" until they satisfy a two-year waiting period.

4.7.2 If an employee has a positive confirmatory test on any drug screen, that employee will be terminated.

4.7.3 A positive confirmatory post-accident/injury test may affect the employee's eligibility to receive workers' compensation benefits (*see also Worker's Compensation section*).

4.8 Confidentiality

The fact that an employee has been requested to or required to take a drug and/or alcohol test, the results of the test, and information acquired in the alcohol and/or illegal drug testing process shall be treated in a manner consistent with the company's treatment of other private and confidential information concerning employees (see Employment Relationship section). Voluntary disclosure by an employee of the excessive use of alcohol and/or illegal drugs before being confronted, tested, or otherwise involved in drug and/or alcohol-related discipline or proceedings will also be treated in a manner consistent with the company's treatment of other private and confidential information concerning employees.

Protecting Your Back

Back problems are the leading cause of work-related injuries for Health care professionals. Fortunately, practicing good posture, proper lifting mechanics, and the use of mechanical equipment can greatly reduce or eliminate most of these injuries.

Practice Good Posture

- Never bend from the waist only, bend the hips and knees.
- Change from one task to another before fatigue sets in.
- Check body position frequently, drawing in the abdomen, flattening the back, and bending the knees slightly.
- Maintain correct posture. In correct, fully erect posture, a line dropped from the ear will go through the tip of the shoulder, middle of hip, back of kneecap and front of anklebone.
- When sitting, relieve strain by sitting well forward and straighten back by tightening abdominal muscles.
- Use a footrest to relieve swayback in both sitting and standing positions.
- Never lift a heavy object higher than the waist.
- Always turn and face the object you wish to lift.
- Never carry anything heavier than you can manage with ease.

Lifting Tips

- Tuck your pelvis…by tightening your stomach muscles to keep your back aligned. Keep your feet shoulder width apart.
- Bend your knees…to let your legs do the lifting. Be sure to maintain the natural curve of your back.
- Hug the load…to keep under it as much as possible. Be sure to grasp the load at opposite corners.

- Avoid twisting…by pointing your feet, knees, and chest in the same direction. Lift the object then turn your body as a whole.

Use of Mechanical Devices

Patient transfers are a routine and necessary part of the nursing profession. They are also a major cause of acute and repetitive back injuries. Whenever possible, employees should use mechanical lifting equipment and patient transfer systems. These devices include:

- Sling-type lifts
- Lean-stand assist lifts
- Wheel chairs
- Repositioning devices
- Pivot discs
- Gait belts

You should become familiar with the equipment available at each client facility as part of your orientation. It is your responsibility to make sure that the equipment is used as needed, used properly, and used only for its intended purpose.

As an employee of "The Company", it is your responsibility to become familiar with and follow your assigned facilities corresponding policies and procedures.

Violence in the Workplace

Today more than 5 million U.S. hospital workers from many occupations perform a wide variety of duties. They are exposed to many safety and health hazards, including violence. Recent data indicate that hospital workers are at high risk for experiencing violence in the workplace. According to estimates of the Bureau of Labor Statistics (BLS), 2,637 nonfatal assaults on hospital workers occurred in 1999-a rate of 8.3 assaults per 10,000 workers. This rate is much higher than the rate of nonfatal assaults for all private-sector industries, which is 2 per 10,000 workers.

Several studies indicate that violence often takes place during times of high activity and interaction with patients, such as at meal times and during visiting hours and patient transportation. Assaults may occur when service is denied, when a patient is involuntarily admitted, or when a health care worker attempts to set limits on eating, drinking, or tobacco or alcohol use.

What is workplace violence?

Workplace violence ranges from offensive or threatening language to homicide. The National Institute for Occupational Safety and Health (NIOSH) defines workplace violence as violent acts (including physical assaults and threats of assaults) directed toward persons at work or on duty.

Examples of violence include the following:

- Threats: Expressions of intent to cause harm, including verbal threats, threatening body language, and written threats.
- Physical assaults: Attacks ranging from slapping and beating to rape, homicide, and the use of weapons such as firearms, bombs, or knives.
- Muggings: Aggravated assaults, usually conducted by surprise and with intent to rob.

Where may violence occur?

Violence may occur anywhere in the hospital, but it is most frequent in the following areas:

- Psychiatric wards
- Emergency rooms
- Waiting rooms
- Geriatric units

What are the risk factors for violence?

The risk factors for violence vary from hospital to hospital depending on location, size, and type of care. Common risk factors for hospital violence include the following:

- Working directly with volatile people, especially, if they are under the influence of drugs or alcohol or have a history of violence or certain psychotic diagnoses.
- Working when understaffed-especially during meal times and visiting hours.
- Transporting patients.
- Long waits for service.
- Overcrowded, uncomfortable waiting rooms
- Working alone.
- Poor environmental design.
- Inadequate security.
- Lack of staff training and policies for preventing and managing crises with potentially volatile patients.
- Drug and alcohol abuse.

- Access to firearms.
- Unrestricted movement of the public.
- Poorly lit corridors, rooms, parking lots, and other areas.

Safety Tips for Healthcare Workers

- Watch for signals that may be associated with impending violence:
  - Verbally expressed anger and frustration.
  - Body language such as threatening gestures.
  - Signs of drug or alcohol use.
  - Presence of a weapon.

- Maintain behavior that helps diffuse anger:
  - Present a calm, caring attitude.
  - Don't match the threats.
  - Don't give orders.
  - Acknowledge the person's feelings (for example, "I know you are frustrated").
  - Avoid any behavior that may be interpreted as aggressive (for example, moving rapidly, getting too close, touching, or speaking loudly).

- Be alert:
  - Evaluate each situation for potential violence when you enter a room or begin to relate to a patient or visitor.
  - Be vigilant throughout the encounter.
  - Don't isolate yourself with a potentially violent person.
  - Always keep an open path for exiting-don't let the potentially violent person stand between you and the door.

- Take these steps if you can't defuse the situation quickly:
  - Remove yourself from the situation.
  - Call security for help.
  - Report any violent incidents to management at the facility and “The Company”.

Adapted from the National Institute for Occupational Safety and Health (NIOSH) website. DHHS (NIOSH) Publication No. 2002-101.

Report any workplace violence issues with your facility charge person and your branch office personnel.

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 etc. 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, room traffic, bright lighting).
- Unskilled Caregiving (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 an alternative

De-escalation techniques:

- Note when a situation first escalates as demonstrated by louder voice, fidgeting, verbal sounds and 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 (e.g. 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 the 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

As an employee of "The Company", it is your responsibility to become familiar with and follow your assigned facilities corresponding policies and procedures.

Sentinel Events

Healthcare professionals carry a burden of great responsibility for the well-being and safety of the patients and residents they serve. Occasionally, there are unexpected events that lead to negative patient and/or organizational outcomes. You should be aware of these situations so you can react appropriately.

Sentinel events are defined by the Joint Commission (Joint Commission) as:

- 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 change of a serious adverse outcome.

Sentinel events are subject for review by Joint Commission when any of the following criteria are met:

- The event has resulted in an unanticipated death or major permanent loss of function, not related to the naturally course of the patient's illness or underlying condition, or
- The event is one of the following (even if the outcome was not death or major permanent loss of function unrelated to the natural course of the patient's illness or underlying condition):
- Suicide of a patient in a setting where the patient receives around-the-clock care (e.g., hospital, residential treatment center, crisis stabilization center)
- Unanticipated death of a full-term infant
- Infant abduction or discharge to the wrong family
- Rape
- Hemolytic transfusion reaction involving administration of blood products having major blood group incompatibilities
- Surgery on the wrong patient or wrong body part

Events that meet any of these criteria should be reported in compliance with that institution's sentinel event policy. Furthermore, the employee should contact "The Company" if he or she was involved in providing care to the patient or resident for which the sentinel event occurred.

WORK SCHEDULE EFFECTS

Work Schedule Effects
Extended or unusual work shifts may be more stressful physically, mentally and emotionally. Non-traditional shifts and extended work hours may be disruptive to the body's regular schedule, leading to increased fatigue, stress, and lack of concentration. Fatigue is the inability to continue effective performance of a mental or physical task. The symptoms of fatigue, both mental and physical, vary and depend on the person and his or her degree of overexertion. Some examples include:

- Weariness
- Sleepiness
- Irritability
- Reduced alertness, lack of concentration and memory
- Lack of motivation
- Increased susceptibility to illness
- Depression
- Headache
- Giddiness
- Loss of appetite and digestive problems

These effects may lead to an increased risk of errors, injuries, and/or accidents. **Therefore, "The Company" suggests that employees work no more than 16 hours a day or 60 hours a week when applicable to the job assignment.**

"Work Schedule Effects" information taken from: U.S. Department of Labor Occupational Safety & Health Administration web site and the AANA-American Association of Nurse Anesthetist's web site.

HIPAA PRIVACY RULE

The Health Insurance Portability and Accountability Act (HIPAA) of 1996 was designed to streamline all areas of the healthcare industry and to provide additional rights and protections to participants in health plans.

The law contains five Titles that incorporate a variety of provisions from creditable coverage and tax-related issues to healthcare fraud and privacy. HIPAA Title II contains the HIPAA Privacy Rule that ensures that personal medical information shared with doctors, hospitals, and others who provide and pay for healthcare is protected.

Covered Entities

HIPAA affects a wide range of healthcare organizations, referred to as "covered entities" under the law. These include:

- Health plans
- Healthcare clearinghouses
- Healthcare providers who transmit certain health information in electronic form (includes most hospitals and other clients of "The Company")

Protected Health Information (PHI)

When a patient gives personal health information to a covered entity, that information becomes PHI. PHI includes any health information in oral, recorded, printed, or other medium that relates to:

- an individual's past, present, or future physical or mental health or condition;
- the provision of healthcare to an individual; or
- the past, present, or future payment for the provision of healthcare to an individual.

PHI includes physician notes, names and addresses, social security numbers, and billing information.

Business Associates

A covered entity may disclose protected health information to a business associate if the covered entity obtains satisfactory assurance that the business associate will appropriately safeguard the information.
Covered entities must have a Business Associate Contract (BAC) with their business associates that binds the business associate, among other things, to comply with the covered entities' privacy practices and to provide protections for any PHI that it receives from the covered entity. "The Company" has BACs with many of its clients and is therefore obligated to safeguard PHI.

Rules for the Use of PHI

The Privacy Rule protects the use and disclosure of PHI. With few exceptions, PHI can't be used or disclosed by anyone unless it is permitted or required by the Privacy Rule.

When using or disclosing PHI a covered entity must make reasonable efforts to limit protected health information to the minimum necessary to accomplish the intended purpose of the use, disclosure, or request. Employees with

a legitimate need to access PHI should be given permission subject to the limitation of accessing only that information needed to perform their job.

Generally, PHI disclosure is permitted:

- For treatment, payment, and healthcare operations
- With authorization or agreement from the individual patient
- For disclosure to the individual patient
- For incidental uses, such as nurses talking to patients in a semi-private room

A covered entity is responsible for protecting its patient's individually identifiable health information. Any document containing PHI must be securely stored or disposed of in appropriate receptacles.

Privacy Notice and Patient Privacy Rights

- Patients have the right to adequate notice regarding the use and disclosure of their PHI.
- Patients my also obtain copies of their PHI and, with some exceptions, can correct or amend the information.
- Patients can also request a history of non-routine disclosures for six years prior to the request.

Penalties for Noncompliance

If you violate the Privacy Rule, HIPAA imposes civil penalties and also allows criminal penalties for knowingly disclosing PHI.

Violating the Privacy Rule is also a violation of "The Company's" policy and may subject you to disciplinary action, including termination.

ARRA (American Recovery and Reinvestment Act

The American Recovery and Reinvestment Act of 2009, abbreviated ARRA (Pub.L. 111-5), is an economic stimulus package enacted by the 111th United States Congress in February 2009. This Act added a number of guidelines for HIPAA which include the HITECH (Health Information Technology for Economic and Clinical Health Act) provisions. Some guidelines have been implemented and others will be converted into regulations. Below are the key highlights of the Act as it relates to HIPAA.

Key Highlights of ARRA Related to Healthcare Privacy

- The ARRA law was developed over several months by Congress and signed by the President on February 17, 2009 – the effective date.
- The Office of the National Coordinator for Health Information Technology (ONC) is codified and advisory committees for policy and standards established. The Coordinator, along with the two committees, a to-be-named chief privacy officer, and existing HIPAA related agencies will be addressing both the changes required by ARRA as well as other confidentiality, privacy, and security issues and standards identified as part of their process in the future.
- ARRA has several provisions that extend HIPAA privacy, security, and administrative requirements to business associates (BAs). In addition, there are new provisions for HIPAA-covered entities and BAs, as well as provisions for those not considered HIPAA-covered.
- Breach requirements (identification and notification) are established both for HIPAA-covered entities and non-HIPAA-covered entities, essentially any organization holding personal health information.
- The Act calls for HHS regional office privacy advisors and an education initiative on the uses of health information.

- Restrictions are further established on the sales of health information.
- Accounting requirement is established for disclosure related to treatment, payment, and operations.
- Access requirements are established for individuals related to healthcare information in electronic format.
- Conditions are instituted for marketing and fundraising functions.
- Personal health record information with non-HIPAA entities is now protected.
- Use of de-identified data and —minimum necessary‖ data will be addressed.
- Enforcement is improved and penalties are increased.
- The HHS Secretary and the Federal Trade Commission are required to provide a number of reports to Congress and guidance to the entities who are involved with healthcare data.

You are required to follow all HIPAA/ARRA/HITECH Privacy and Security regulations and those policies as outlined by your assigned facilities.

HIPAA SECURITY RULE

The Security Rule provides covered entities with the provisions for safeguarding electronic protected health information. All covered entities must be in compliance with the Security Rule no later than April 20, 2005. The Security Rule is divided into three components, Administrative Safeguards, Physical Safeguards, and Technical Safeguards.

Administrative Safeguards = The administrative functions that should be implemented to meet the security standards. These include assignment or delegation of security responsibility to an individual and security training requirements.

Physical Safeguards = The mechanisms required to protect electronic systems, equipment and the data they hold, from threats, environmental hazards and unauthorized intrusions. They include restricting access to electronic protected health information and retaining off-site computer backups.

Technical Safeguards = The automated process used to protect data and control access to data. They include using authentication controls to verify that the person signing onto a computer is authorized to access that electronic protected health information, or encrypting and decrypting data as it is being stored and/or transmitted.

Since significant amounts of health information are stored electronically on computers it is essential that healthcare providers protect that information with good computer security practices.

The facilities where you are assigned should have specific policies addressing the various components of the Security Rule. Please become familiar with these policies if you use their computer systems on your assignment.

General Safeguards include:

- ✓ Protect your computer passwords at all times.
- ✓ E-mails containing protected health information (PHI) should be treated with great caution.
- ✓ Do not leave computers unattended while signed on to a system.
- ✓ If you must leave the computer for a short period of time, lock the computer (control, alt, delete).
- ✓ Make sure monitors cannot be viewed by others allowing for unauthorized access to PHI.
- ✓ Remember that the “minimum necessary rule” applies to computer information as well as hard copy information. That is only access the information you need to do your job.

You are required to follow all HIPAA/ARRA/HITECH Privacy and Security regulations and those policies as outlined by your assigned facilities.

HEALTHCARE TECHNOLOGY

Technology is transforming how healthcare is delivered and managed. This section will provide an overview of key technologies like EHRs, telehealth, mHealth apps, data analytics and artificial intelligence.

Electronic Health Records (EHRs)

EHRs are digital documentation systems that:

- Record patient health information and history
- Streamline workflow and communication
- Reduce errors through decision support tools
- Enable data sharing between providers

It is important to accurately and thoroughly document care in the EHR per facility guidelines.

Telehealth

Telehealth refers to remote clinical services like:

- Video visits to assess and diagnose patients
- Remote patient monitoring with wearable devices
- Text-based care and coaching

Telehealth expands access to care while reducing costs. Proper use of platforms and safeguarding of information is essential.

mHealth Apps

Mobile health apps allow patients to:

- Access health records
- Manage medications
- Track symptoms and biometrics
- Obtain patient education

Recommending credible apps as appropriate aids ongoing self-management.

Healthcare Data Analytics

Data analytics applies artificial intelligence to:

- Predict risks like hospital readmissions
- Identify high-cost patients for intervention
- Develop customized treatment plans
- Automate diagnostic and operational workflows

While improving efficiency, ethical use of data that protects privacy is vital.

Artificial Intelligence (AI)

AI is transforming healthcare through tools like:

- Clinical decision support systems
- Automated medical coding
- Virtual health assistants
- Precision medicine platforms

AI holds great promise but also potential risks if not properly validated. An ethics-first approach is critical as applications evolve.

Leveraging technology effectively while minimizing risks will enable improved access, efficiency, quality and safety in healthcare.

PATIENT'S RIGHTS

In 1973 the American Hospital Association developed the Patient's Bill of Rights (see below) to give guidance that would support the delivery of effective patient care. The Association replaced the Patient's Bill of Rights with the Patient Care Partnership. (This revision can be found on the AHA's web site in brochure form at www.aha.org). The Patient Care Partnership informs patients about what they should expect during their hospital stay with regard to their rights and responsibilities.

The Patient Care Partnership: Patient Expectations

- High quality care
- Clean and safe environment
- Involvement in their care
- Protection of their privacy
- Help when leaving the hospital
- Help with their billing claims

Facilities will have their own Patient Rights statement and policies and patients will be provided a copy of their Patient Rights.

"The Company" expects its employees to be aware of these rights and abide by these rights within the scope of their practice.

In addition to abiding by assigned facilities Patient Rights policies, "The Company" employees should also follow these basic principles which focus on the rights and expectations presented in the Patient Care Partnership.

- Treat patients with courtesy and respect, preserving their dignity, rights and involvement in their own care
- Introduce and identify yourself to your patients
- Carefully listen to your patients
- Be attentive to their needs and concerns
- Be clear in your explanations
- Be respectful of patient's privacy rights and abide by all policies

American Hospital Association's Patient's Bill of Rights:
The Patient's Bill of Rights was developed by the American Hospital Association to give guidance that would support the delivery of effective patient care. "The Company" encourages its employees to respect these rights within the scope of their practice.

1. The patient has the right to considerate and respectful care.
2. The patient has the right and is encouraged to obtain from physicians and other direct caregivers relevant, current, and understandable information about his or her diagnosis, treatment, and prognosis.
3. Except in emergencies when the patient lacks the ability to make decisions and the need for treatment is urgent, the patient is entitled to a chance to discuss and request information related to the specific procedures and/or treatments available, the risks involved, the possible length of recovery, and the medically reasonable alternatives to existing treatments along with their accompanying risks and benefits.
4. The patient has the right to know the identity of physicians, nurses, and others involved in his or her care, as well as when those involved are students, residents, or other trainees. The patient also has the right to know the immediate and long-term financial significance of treatment choices insofar as they are known.
5. The patient has the right to make decisions about the plan of care before and during the course of treatment and to refuse a recommended treatment or plan of care if it is permitted by law and hospital policy. The patient also has the right to be informed of the medical consequences of this action. In case of such refusal, the patient is still entitled to appropriate care and services that the hospital provides or to be

transferred to another hospital. The hospital should notify patients of any policy at the other hospital that might affect patient choice.

6. The patient has the right to have an advance directive (such as a living will, health care proxy, or durable power of attorney for health care) concerning treatment or designating a surrogate decision-maker and to expect that the hospital will honor that directive as permitted by law and hospital policy.
7. Health care institutions must advise the patient of his or her rights under state law and hospital policy to make informed medical choices, must ask if the patient has an advance directive, and must include that information in patient records. The patient has the right to know about any hospital policy that may keep it from carrying out a legally valid advance directive.
8. The patient has the right to privacy. Case discussion, consultation, examination, and treatment should be conducted in a manner that will protect each patient's privacy.
9. The patient has the right to expect that all communications and records pertaining to his/her care will be treated confidentially by the hospital, except in cases such as suspected abuse and public health hazards when reporting is permitted or required by law. The patient has the right to expect that the hospital will emphasize confidentiality of this information when it releases it to any other parties entitled to review information in these records.
10. The patient has the right to review his or her medical records and to have the information explained or interpreted as necessary, except when restricted by law.
11. The patient has the right to expect that, within its capacity and policies, a hospital will make reasonable response to the request of a patient for appropriate and medically indicated care and services. The hospital must provide evaluation, service, and/or referral as indicated by the urgency of the case. When medically appropriate and legally permissible, or when a patient has so requested, a patient may be transferred to another facility. The institution to which the patient is to be transferred must first have accepted the patient for transfer. The patient also must have the benefit of complete information and explanation concerning the need for, risks, benefits, and alternatives to such a transfer.
12. The patient has the right to ask and be told of the existence of any business relationship among the hospital, educational institutions, other health care providers, and/or payers that may influence the patient's treatment and care.
13. The patient has the right to consent to or decline to participate in proposed research studies or human experimentation or to have those studies fully explained before they consent. A patient who declines to participate in research or experimentation is still entitled to the most effective care that the hospital can otherwise provide.
14. The patient has the right to expect reasonable continuity of care and to be informed by physicians and other caregivers of available and realistic patient care options when hospital care is no longer appropriate.
15. The patient has the right to be informed of hospital policies and practices that relate to patient care treatment, and responsibilities. The patient has the right to be informed of available resources for resolving disputes, grievances, and conflicts, such as ethics committees, patient representatives, or other mechanisms available in the institution. The patient has the right to be informed of the hospital's charges for services and available payment methods.

Patient-Centered Care and Communication

Providing care that is compassionate, empowering and tailored to patients' needs and preferences is essential. This section will cover techniques like shared decision making, motivational interviewing and teach back.

Shared Decision Making

Shared decision making involves clinicians and patients jointly:

- Discussing treatment options
- Sharing benefit/risk information
- Considering patient values, preferences and circumstances
- Coming to mutual decisions regarding care plans

This collaborative approach results in improved patient satisfaction, adherence and outcomes.

Motivational Interviewing

Motivational interviewing is a conversational technique that involves:

- Establishing rapport and a judgement-free zone
- Asking open-ended questions to explore readiness for change
- Affirming patient self-efficacy and autonomy
- Guiding the patient towards commitment to change

This method helps patients overcome ambivalence and enhance motivation.

Teach Back

The teach back technique requires patients to re-explain medical information and instructions to confirm comprehension. It involves:

- Using plain language without medical jargon
- Limiting content and checking understanding
- Having the patient explain back in their own words
- Clarifying any inconsistencies

Teach back improves retention, adherence and outcomes.

Patient-centered communication fosters relationships based on trust, empathy and mutual decision making. Applying techniques like shared decision making, motivational interviewing and teach back person-centered care.

Advance Directive (Living Will)

An Advance Directive is a legally binding written document that expresses the patient's wishes for end of life care if they are no longer able to participate in the decision-making process.

As a nurse (or other healthcare professional) you should be aware of the existence of an Advance Directive for the patients or residents under your care. Patients should be asked about the existence of an Advance Directive upon admission to the facility. Advance Directives should be noted in the medical record and saved according to the policies and procedures of each client facility.

Educating patients and residents about Advance Directives will vary according to the practices of the client. You should become familiar with these policies during your orientation. You may be asked to help explain the purpose and benefits of an Advance Directive. When necessary you should encourage the patient to discuss treatment options with their physician.

If a patient has an Advance Directive, but did not bring it to the facility upon admission, you should remind the family to bring it or offer to have a patient advocate assistance in developing a new one if appropriate to your assignment.

Patient Assessment and Care

The patient assessment is the gathering of information about a patient's physiological, psychological, sociological, and spiritual status. The purpose of the patient assessment is to collect data of patient's health status, to identify deviations from normal, to discover the patient's strengths and coping resources, to point actual problems, and factors that place the patient at risk for health problems.

It is the process of collecting, validating, and organizing data. It is the first and most important step in the nursing process. Nursing Assessment identifies the patient's strengths and limitations and is performed not just once, but continuously throughout the nursing process. After performing the initial assessment, you establish your baseline, identify nursing diagnoses, and develop a plan. Then, as you implement your plan, you also assess your patient's response. Finally, you assess the effectiveness of your plan of care for your patient.

Assessments can be comprehensive or focused.

Comprehensive assessment examines the patient's overall health status. A comprehensive assessment is usually the initial assessment.

Focused assessment is problem oriented and may be the initial assessment or an ongoing assessment. Focused assessment is frequently performed on an ongoing basis to monitor and evaluate the patient's progress, interventions, and response to treatments. Even when a focused assessment is performed, it is important to look at the entire picture. A problem in one system will affect or be affected by every other system so scan your patient from head to toe and note any changes in other systems. Look for clues or pertinent data that will help you formulate your diagnosis.

Methods of Collecting Data

- Interviews
- Observation
- Physical Assessment

The nursing assessment is an important part of the multidisciplinary assessment as the patient assessment is not unique to nursing. It is also an integral part of medical practice. The goal of medical practice is to diagnose and treat disease and the goal of nursing process is to diagnose and treat human responses to actual or potential health problems. Nursing assessment focuses on physiological and psychological responses and the psychosocial, cultural, developmental, and spiritual dimensions. It identifies patients' responses to health problems as well as their strengths. Optimal level of wellness is the Nursing's aim.

Medical and nursing assessments should not contradict each other in promoting the patient's health and wellness. Often, data obtained through the nursing assessment contribute to the identification of medical problems.

Other departments conduct assessments as well. By working together in a collaborative relationship, nursing, medicine and ancillary departments ensure the best possible care for patients.

Patient Assessment is an ongoing process. Every patient encounter provides you with an opportunity for assessment no matter what your role is in the patient's care.

Documentation

The assessment is documented in the patient's medical or nursing records, which may be on paper or as part of the electronic medical record which can be accessed by all members of the healthcare team.

Patient Plan of Care

Care planning is an essential part of healthcare, but is often misunderstood. Without a specific document delineating the plan of care, important issues are likely to be neglected. Care planning provides a "road map" of sorts, to guide all who are involved with a patient/resident's care. The care plan has long been associated with nursing, and many people believe that is the sole domain of nurses. This view is damaging to all members of the interdisciplinary team, as it shortchanges the non-nursing contributors while overloading the nursing staff. To be effective and comprehensive, the care planning process must involve all disciplines that are involved in the care of a patient/resident.

The first step in care planning is accurate and comprehensive assessment. In the acute care setting, a thorough admission nursing assessment should be followed by regular reassessments as often as the patient's status demands. In the long- term care setting, the MDS (Minimum Data Set) is the starting point for assessment. Home health utilizes the OASIS assessment. Other settings will have established protocols for initial assessments and ongoing reevaluation.

As an employee of "The Company", it is your responsibility to become familiar with and follow your assigned facilities corresponding policies and procedures.

Use of Restraints

Restraints are any physical, mechanical, or pharmacological means used to restrict a patient's freedom of movement, activity, or access to their own body. The use of restraints is closely monitored by medical staff and can be used only when proper orders are attained and all state and facility policies are followed.

The use of restraints is often controversial and raises serious concerns about patient rights and the potential for physical or psychological harm. Over the last few years there has been a movement away from the use of restraints. However, there are a number of scenarios where the use of restraints is clinically prudent and recommended. Examples of these situations occur when you need to:

- Protect patients from harming themselves, staff, or family members.
- Assess disoriented or uncooperative patients.
- Initiate medically necessary procedures in uncooperative patients.
- Prevent elopement while patients are evaluated for suicidal or homicidal behavior.
- Protect disorientated patients from falls.

Restraints must never be used as a means of coercion, discipline, convenience, or retaliation by staff!

There are several types of restraints including:

1. Physical Restraints – devices that restrict physical movement or bodily access.
   - Vest
   - Soft wrist or ankle wrap
   - Roll belt
   - Leather strap
   - Handcuffs (applied by law enforcement officials)

2. Chemical Restraints - drugs that control mood
   - Sedatives
   - Tranquilizers

3. Seclusion – involuntary confinement is a room or secluded area.

Restraints should be employed as a last resort and their use must be consistent with federal and state laws, hospital licensing and accreditation requirements and the facilities own policies and procedures. When using restraints, the least restrictive method should be used and then, only under the order of a medical doctor or other licensed professional with the authority to authorize restraints.

Once in use, restraints should be monitored frequently. The need for using restraints should also be reassessed continuously. Restraints can lead to patient injuries, even death, if not closely watched.

Healthcare professionals should also use caution whenever caring for patients in restraints as injuries can occur from violent behavior.

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Preventing Patient Falls

Fall prevention is an important aspect of care management. Falls are dangerous for elderly people, and even if serious injury is avoided they can cause anxiety and reduce social and physical activity.

Falls rarely "just happen". They are due to a number of factors that create a climate in which a fall is likely to occur. Risk factors may be physical, functional, cognitive, or psychological and can occur either alone or in conjunction with each other. These risk factors have been shown to increase exponentially with a person's age and their degree of illness or disability.

Physical factors associated with falls include slowed reaction time, gait changes, hearing loss, declining balance, and decreased sensory perception associated with normal aging; decreasing mobility and functional ability; degenerative disease such as osteoporosis; use of ambulation aids; and the use of medications such as diuretics, hypotensives, and hypnotics. Cognitive factors include balance deficits and impaired perception of the ability to do things that depend on correct ability assessment. The psychological factors associated with falls are fear of losing independence, fear of repeated falling and depression.

Recommendations for fall prevention are abundant and policies and procedures for preventing falls will vary between clients and facilities. Usually, these procedures advocate the use of a Fall Assessment Tool to determine the fall risk for each patient or resident. Once the risk is known, appropriate measures can be taken to reduce the likelihood of a fall for that individual. You should be aware of the dangers of patient falls and takes steps to ensure that patients and residents under your care are managed in a safe manner.

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Abuse and Neglect

Elder and Child abuse and neglect are a growing problem that occurs all too common in our society. Abuse is a problem that affects everyone—individuals from all racial, ethnic, and socioeconomic groups. Abuse can occur with seniors who are full of life and independent as well as those who or physically or mentally frail. Abuse can be caused by family members, caregivers, and even strangers. Family members are the most common abusers when the victim lives outside of a healthcare facility. Abuse and neglect often arise from misunderstanding or ignorance.

Domestic violence, also known as domestic abuse, spousal abuse, child abuse or intimate partner violence (IPV), can be broadly defined as a pattern of abusive behaviors by one or both partners in an intimate relationship such as marriage, dating, family, friends or cohabitation. Domestic violence has many forms including physical aggression (hitting, kicking, biting, shoving, restraining, slapping, throwing objects), or threats thereof; sexual abuse; emotional abuse; controlling or domineering; intimidation; stalking; passive/covert abuse (e.g., neglect); and economic deprivation. Domestic violence may or may not constitute a crime, depending on local statutes, severity, and duration of specific acts, and other variables. Alcohol consumption and mental illness can be co-morbid with abuse, and present additional challenges when present alongside patterns of abuse.

The American Medical Association defines elder abuse or neglect as "an act or omission, which results in harm or threatened harm to the health or welfare of an elderly person." Elder abuse is associated with a higher mortality and increased health care costs due to a higher frequency of office and hospital visits.

Child abuse and neglect are defined by Federal and State laws. The Child Abuse Prevention and Treatment Act (CAPTA) is the Federal legislation that provides the following definition of child abuse and neglect; “Any recent act or failure to act on the part of a parent or caretaker, which results in death, serious physical or emotional harm, sexual abuse, or exploitation, or an act or failure to act which presents an imminent risk of serious harm"[1]

Basic Definitions

- Physical Abuse (non-accidental injury)
  - Slapping, hitting, bruising, beating or any other intentional act that causes someone physical pain, injury or suffering.
  - Also includes excessive forms of restraint used to confine someone against their will (i.e., tying, chaining, or locking someone in a room).

- Emotional Abuse
  - Threatening, intimidating or humiliating an individual and causing them emotional pain, distress or anguish.
  - Emotional abuse can be verbal or non-verbal; it includes insults, yelling and threats of harm or isolation.

- Sexual Abuse/Exploitation
  - Any sexual activity to which the older or dependent adult does not consent or is incapable of consenting. Non-consensual sexual activity includes everything from exhibitionism to sexual intercourse.
  - The employment, use, persuasion, inducement, enticement, or coercion of any child to engage in, or assist any other person to engage in, any sexually explicit conduct or simulation of such conduct for the purpose of producing a visual depiction of such conduct; or
  - The rape, and in cases of caretaker or interfamilial relationships, statutory rape, molestation, prostitution, or other form of sexual exploitation of children, or incest with children"[2]

- Financial or Material Exploitation
  - Misuse, mishandling, or exploitation of the individual's property, possessions, or financial assets.

- Neglect
  - Intentional or unintentional failure of a caregiver to support the physical, emotional, and social needs.
  - Neglect can include denying food, shelter, clothing, medication, health services, or contact with friends and family. Neglect is the most common form of elderly mistreatment in domestic settings. Failure to educate is also considered a definition of neglect with children.

- Isolation
  - Acts intentionally committed for the purpose of preventing, and that do serve to prevent, an individual from receiving his or her mail or telephone calls.
  - Elderly: Telling a caller or prospective visitor that an elder or dependent adult is not present, or does not wish to talk with the caller, or does not wish to meet with the visitor where the statement is false, is contrary to the express wishes of the elder or the dependent adult, whether he or she is competent or not, and is made for the purpose of preventing the elder or dependent adult from having contact with family, friends, or concerned persons.
  - Physical restraint of an individual for the purpose of preventing the individual from meeting with visitors or responsible parties.

- Abandonment
  - A caregiver deserts the elderly or dependent person
  - A parent or caregiver deserts the child.

- Self-Neglect (elderly)
  - An elderly or dependent adult fail to meet their own physical, psychological, or social needs or they threaten their own health or safety in any way.

Abuse Warning Signs
As a healthcare professional, it is important that you become aware of the warning signs of abuse and neglect. ***You should report suspected abuse to the designated person at the facility where you are working and/or to the appropriate government agency. In many states, you are required by law to report observed or suspected elder and child abuse. PLEASE BE FAMILIAR WITH AND FOLLOW YOUR STATE REQUIREMENTS FOR REPORTING.***
The following indicators by themselves do not necessarily signify abuse or neglect. The may be helpful clues however, in the assessment of abuse.

Possible Indicators of Physical Abuse
- Cuts, lacerations, puncture wounds
- Bruises, welts, discoloration of the skin
- Any injury incompatible with the individual's history
- Any injury which has not been properly cared for
- Poor skin condition or poor skin hygiene
- Dehydration and/or malnourishment
- Loss of weight
- Burns
- Soiled clothing or bedding
- Withdrawal of the individual from social situations

Possible Indicators of Financial Abuse

- Unusual or inappropriate activity in bank accounts
- Recent changes to will when the person is incapable of making such decision
- Unusual concern by caregiver or family member that an excessive amount of money is being expended on the care of the individual
- Numerous unpaid bills and/or forged checks
- Placement in a residential care facility which is not commensurate with the size of the older person's estate
- Lack of amenities, such as TV, clothing, grooming items, etc. that the estate can afford
- Missing belongings
- Caregivers or relatives who are dependent on the individual for money or housing

PAIN MANAGEMENT

Pain Management is the field of medicine concerned with the diagnosis and treatment of pain. Pain is generally divided into two main types: acute and chronic. **Acute** pain is the result of tissue damage, is generally temporary and has an identifiable cause, such as trauma. Due to the short-term nature of acute pain, persistent psychological reactions rarely result. **Chronic** pain by definition is pain that persists for six months or more and may take a long time to reverse. Chronic pain may be the result of a specific injury (such as an injury to back or knee) or an ongoing chronic medical problem (like neuropathy, arthritis, cancer, or referred pain). Chronic pain may also result from conditions difficult to diagnose or occur for no apparent cause. Chronic pain often limits everyday functioning and may lead to additional stressors such as sleep problems, medication side effects, and reduction in the capacity for performing work, financial hardship, and strain on significant relationships.

Pain Management
Pain management generally benefits from a multidisciplinary approach that includes pharmacologic measures (analgesics such as narcotics or NSAIDs and pain modifiers such as tricyclic antidepressants or anticonvulsants), non-pharmacologic measures (such as interventional procedures, physical therapy and physical exercise, application of ice and/or heat), and psychological measures (such as biofeedback and cognitive therapy).

The treatments for chronic pain are as diverse as the causes. From over-the-counter and prescription drugs to mind/body techniques to acupuncture. Relief may be found by using a combination of treatment options. Often, pain pathways are set up that continue to transmit the sensation of pain even though the underlying condition or injury that originally caused pain has been healed. In such situations, the pain itself is frequently managed separately from the underlying condition of which it is a symptom, or the goal of treatment is to manage the pain with no treatment of any underlying condition (e.g. if the underlying condition has resolved or if no identifiable source of the pain can be found).

Pain Management - Opioid Stewardship:

When managing pain, clinicians must balance pain relief with the serious risks associated with opioid misuse, addiction and overdose. This section covers responsible opioid prescribing and stewardship.

Opioid Stewardship

When prescribing opioids, following CDC guidelines on proper patient selection, dosing, duration, monitoring and discontinuation can enhance safety.

- Screen for past or current substance abuse before initiating opioids
- Start at the lowest effective dose and monitor for side effects
- Only provide the quantity needed based on the expected duration of pain
- Avoid opioids and offer non-opioid alternatives whenever possible
- Check state prescription drug monitoring program databases

- Assess risk factors for opioid-related harms like respiratory depression
- Develop individualized pain treatment plans with defined goals
- Monitor pain levels and functional status regularly
- Create a tapering schedule for discontinuation

Through careful patient selection, prescribing practices, and monitoring, clinicians can effectively manage pain while reducing opioid misuse and overdose.

Pain Assessment/Reassessment
A pain assessment should include a detailed history, physical examination, psychological assessment, and diagnostic evaluation. Patient's pain should be assessed in the following areas; the patient's self-report, pain intensity (using a rating scale such as Numeric Pain Intensity Scale, Simple Descriptive Pain Intensity Scale, Visual Analog Scale-VAS or Wong-Baker Faces Pain Intensity Scale), location, quality and patterns of radiation, onset duration and variation of patterns, alleviating and aggravating factors, current pain management regimen and effectiveness, and effects of pain on daily functions.

Also there are challenges to assessing pain for different populations such as various age groups (elderly, infants, and children), burn survivors, cancer and AIDS patients, patients at the end of life and patients who have difficulty communicating. With certain populations, the patient may have cognitive or sensory impairments for communicating pain. Or with AIDS and cancer, pain may be related to either the disease process or the treatment, so proper assessment is critical.
Pain should be reassessed at regular intervals to ensure the patient's pain is being relieved. Reassessment of pain should include evaluating the effectiveness of the treatment and assessing any new pain to determine if it is related to the progression of the condition, to a new cause or if it is related to the treatment. The assessment intervals are based on the type of pain, such as acute (trauma, surgery) or chronic (burns, cancer, arthritis).

Pain Treatment
Drug Therapy: Nonprescription and Prescription
Milder forms of pain may be relieved by over-the-counter medications such as Tylenol (acetaminophen) or nonsteroidal anti-inflammatory drugs (NSAIDs) such as aspirin and Aleve. Both acetaminophen and NSAIDs relieve pain caused by muscle aches and stiffness, but only NSAIDs can also reduce inflammation (swelling and irritation). Topical pain relievers are also available, such as creams, lotions, or sprays that are applied to the skin in order to relieve pain from sore muscles and arthritis.

If over-the-counter drugs do not provide relief, stronger medications, such as muscle relaxants, anti-anxiety drugs (such as Valium), antidepressants, prescription NSAIDs such as Celebrex, or a short course of stronger painkillers (such as Codeine, Fentanyl, Percocet, or Vicodin) may be prescribed. Also, a limited number of steroid injections at the site of a joint problem can reduce swelling and inflammation therefore decreasing pain symptoms.

(In April 2005, the FDA asked that Celebrex carry new warnings about the potential risk of heart attacks and strokes as well as potential stomach ulcer bleeding risks. At the same time the FDA asked that over-the-counter anti-inflammatory drugs -- except for aspirin – revise their labels to include information about potential heart and stomach ulcer bleeding risks).

Patient-controlled analgesia (PCA) is another method of pain control. The patient is able to self-administer a premeasured dose of pain medicine by activating a computerized pump. The pump is connected to a small tube that allows medicine to be injected intravenously, subcutaneously, or into the spinal area.
Another form of pain treatment is the nerve block. In a nerve block, is a local medication used to block the group of nerves that causes pain to a specific organ or body region.

Trigger Point Injections

Trigger point injection is a procedure used to treat painful areas of muscle that contain trigger points, or knots of muscle that form when muscles do not relax. Using a small needle, a local anesthetic (which sometimes includes a steroid) is injected into a trigger point. With the injection, the trigger point is made inactive and the pain is alleviated. Usually, a brief course of treatment will result in sustained relief.

Trigger point injection is used to treat muscle pain in the arms, legs, lower back, and neck. In addition, this approach has been used to treat fibromyalgia, tension headaches, and myofascial pain syndrome (chronic pain involving tissue that surrounds muscle) that does not respond to other treatment.

Physical Therapy
Physical therapy helps to relieve pain by using special techniques that improve movement and function impaired by an injury or disability. Along with employing stretching and pain-relieving techniques, a physical therapist may use, among other things, TENS to aid treatment.

TENS
Transcutaneous electrical nerve stimulation therapy, more commonly referred to as TENS, uses electrical stimulation to diminish pain. During the procedure, low-voltage electrical current is delivered through electrodes that are placed on the skin near the source of pain. The electricity from the electrodes stimulates the nerves in an affected area and sends signals to the brain that "scramble" normal pain signals, offering short-term pain relief. While effective in the short-term, long-term effectiveness of TENS remains questionable.

Bioelectric Therapy
Bioelectric therapy relieves pain by blocking pain messages to the brain. Bioelectric therapy also prompts the body to produce endorphins, chemicals that decrease or eliminate painful sensations by blocking the message of pain from being delivered to the brain.

Bioelectric therapy can be used to treat many chronic and acute conditions causing pain, such as back pain, muscle pain, headaches and migraines, arthritis, TMJ disorder, diabetic neuropathy, and scleroderma.

Bioelectric therapy is effective in providing temporary pain control and can be used as part of a total pain management program. When used along with conventional pain-relieving medications, bioelectric treatment may allow pain sufferers to reduce their dose of some pain relievers by up to 50%.

Surgical Implants
When standard medicines and physical therapy fail to offer adequate pain relief, a patient may be a candidate for a surgical implant to help control pain. There are two main types of implants to control pain._

Intrathecal Drug Delivery: Also, called infusion pain pumps or spinal drug delivery systems. The surgeon makes a pocket under the skin that's large enough to hold a medicine pump. The pump is usually about one inch thick and three inches wide. The surgeon also inserts a catheter, which carries pain medicine from the pump to the intrathecal space around the spinal cord. The implants deliver medicines directly to the spinal cord, where pain signals travel. For this reason, intrathecal drug delivery can provide significant pain control with a fraction of the dose that would be required with pills. In addition, the system can cause fewer side effects than oral medications because less medicine is required to control pain.

Spinal Cord Stimulation Implants: In spinal cord stimulation, low-level electrical signals are transmitted to the spinal cord or to specific nerves to block pain signals from reaching the brain. In this procedure, a device that delivers the electrical signals is surgically implanted in the body. A remote control is used by the patient to turn the current off and on or to adjust the intensity of the signals. Most people describe the feelings from the simulator as being pleasant and tingling. Two kinds of spinal cord stimulation systems are available. The unit that is more commonly used is fully implanted and has a pulse generator and a non-rechargeable battery. The other

system includes an antenna, transmitter, and a receiver that relies upon radio frequency. The latter system's antenna and transmitter are carried outside the body, while the receiver is implanted inside the body.

Exercise
Although resting for short periods can alleviate pain, too much rest may actually increase pain and put the patient at greater risk of injury when they again attempt movement. Research has shown that regular exercise can diminish pain in the long term by improving muscle tone, strength, and flexibility. Exercise may also cause a release of endorphins, the body's natural painkillers. Some exercises are easier for certain chronic pain sufferers to perform than others; such as swimming, biking, walking, rowing, and yoga.

Psychological Treatment
Pain can alter a patient's personality, disrupt sleep, and interfere with work and relationships. In turn, depression and anxiety, lack of sleep, and feelings of stress can all make pain worse. Psychological treatment provides safe, non-drug methods that can treat pain directly by reducing high levels of physiological stress that often aggravates pain. Psychological treatment also helps improve the indirect consequences of pain by helping patients learn how to cope with the many problems associated with pain. A large part of psychological treatment for pain is education, helping patients acquire skills to manage their pain.

Alternative Therapies
In the past decade, strong evidence has accumulated regarding the benefits of mind-body therapies, acupuncture, and some nutritional supplements for treating pain. Other alternative therapies such as massage, chiropractic therapies, therapeutic touch, certain herbal therapies, and dietary approaches have the potential to alleviate pain in some people. However, the evidence supporting these therapies is less concrete.

Mind-Body Therapies
Mind-body therapies are treatments that are meant to help the mind's ability to affect the functions and symptoms of the body and can help alleviate discomfort related to chronic pain. Mind-body therapies use various approaches including:

- Relaxation Techniques (Yoga used as a relaxation technique is particularly good for strengthening muscles without putting additional strain on the body).
- Meditation (Meditation has been shown to reduce stress-related pain when it is practiced regularly).
- Feedback (Electromyographic [EMG] biofeedback alerts a patient to the ways in which muscle tension is contributing to pain and then methods to control the pain can be taught).
- Guided Imagery/Visualization (Pain controlling technique in which the patient visualizes the pain as an image with shape, color, size and motion and the patient then alters the image with a smaller, more pleasant image).
- Pain Journaling (Recording in a journal, pain episodes and the causative and corrective factors surrounding them. Reviewing the journal regularly can result in areas of change that can impact the handling of pain, viewing it as a part of a patient's life-not all of their life).
- Hypnosis (Hypnotherapy and self-hypnosis may help patients block or transform pain through refocusing techniques).

Acupuncture
Acupuncture is thought to decrease pain by increasing the release of endorphins, chemicals that block pain. Many acu-points are near nerves. When stimulated, these nerves cause a dull ache or feeling of fullness in the muscle. The stimulated muscle sends a message to the central nervous system (the brain and spinal cord), causing the release of endorphins that block the message of pain from being delivered to the brain.

Acupuncture may be useful as an accompanying treatment for many pain-related conditions, including headache, low back pain, menstrual cramps, carpal tunnel syndrome, tennis elbow, fibromyalgia, osteoarthritis (especially of the knee), and myofascial pain. Acupuncture also may be an acceptable alternative to or may be included as part of a comprehensive pain management program.

Chiropractic Treatment and Massage
Chiropractic treatment is the most common nonsurgical treatment for back pain. Improvements of people undergoing chiropractic manipulations were noted in some trials. However, the treatment's effectiveness in treating chronic back and neck pain has not been supported by compelling evidence from the majority of clinical trials. Further studies are currently assessing the effectiveness of chiropractic care for pain management.

Massage is being increasingly used by people suffering from pain, mostly to manage chronic back and neck problems. Massage can reduce stress and relieve tension by enhancing blood flow. This treatment also can reduce the presence of substances that may generate and sustain pain. Available data suggest that massage therapy, like chiropractic manipulations, holds considerable promise for managing back pain. However, it is not possible to draw final conclusions regarding the effectiveness of massage to treat pain due to the limitations of available studies.

Therapeutic Touch and Reiki Healing
Therapeutic touch and Reiki healing are thought to help activate the self-healing processes of an individual and therefore reduce pain. Although these techniques, referred to as “energy-based”, do not require actual physical contact, they do involve close physical proximity between practitioner and patient.
In the past few years, several reviews evaluated published studies on the efficacy of these healing approaches to ease pain and anxiety and improve health. Although beneficial effects with no significant adverse side effects were reported in several studies, the limitations of some of these studies make it difficult to draw definitive conclusions. Further studies are needed before the evidence-based recommendation for using these approaches for pain treatment can be made.

Nutritional Supplements
There is solid evidence indicating that glucosamine sulfate and chondroitin sulfate relieve pain due to knee osteoarthritis. These natural compounds were found to decrease pain and increase mobility of the knee and were well tolerated and safe.
Other dietary supplements, such as fish oils, also show some evidence of benefit, although more research is needed.

Herbal Remedies
It has been difficult to draw conclusions about the effectiveness of herbs. If herbal preparations are used to better manage pain, it is of critical importance that the patient shares this information with their doctor. Some herbs may interact with drugs the patient is receiving for pain or other conditions.

Dietary Approaches to Treating Pain
Some people believe that changing dietary fat intake and/or eating plant foods that contain anti-inflammatory agents can help ease pain by limiting inflammation.
A mostly raw vegetarian diet was found helpful for some people with fibromyalgia, but this study was not methodologically strong. Weight loss achieved by a combination of dietary changes and increased physical activity has been shown to be helpful for people suffering from osteoarthritis. Still, further research is needed to determine the effectiveness of dietary modifications as a pain treatment.

Things to Consider
Alternative therapies are not always benign. As mentioned, some herbal therapies can negatively interact with other medications.

Other Options: Pain Clinics
Some patients, no matter what treatment approach they try, still suffer from debilitating pain. For them, pain clinics (special care centers devoted exclusively to dealing with intractable pain) may be the best course of

treatment. Some pain clinics are associated with hospitals and others are private; in either case, both inpatient and outpatient treatment are usually available.

Pain clinics generally employ a multidisciplinary approach, involving physicians, psychologists, and physical therapists. The patient as well should take an active role in his or her own treatment. The aim in many cases is not only to alleviate pain but also to teach the chronic sufferer how to come to terms with pain and function in spite of it.

Various studies have shown as much as 50% improvement in pain reduction for chronic pain sufferers after visiting a pain clinic, and most people learn to cope better and can resume normal activities.

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Wound Care

A wound is a break in the epidermis (outer layer of the skin). Different kinds of wounds may be treated differently from one another, depending upon how they occurred and their severity.

There are basically 4 phases to the wound care healing process: inflammatory (clot formation and specialized cell development), proliferative (new cell and blood vessel development, remodeling (tissue strengthening) and epithelialization (laying down new skin/epithelial cells).

Some of the most common wounds treated include:

- **Decubitus ulcers (pressure ulcers)**
  A pressure ulcer is an area of unrelieved pressure over a defined area, usually a bony prominence, resulting in ischemia, cell death, and tissue necrosis. Pressure ulcers particularly affect persons with impaired sensation, prolonged immobility, or advanced age.
- **Diabetic Foot Ulcers**
  These sores often occur on the feet of people with Type 1 and Type 2 diabetes. Up to 25% of people with diabetes develop foot problems. Diabetic foot ulcers usually occur on the bottom of the foot. If undetected, the sore may become larger and infected. This may lead to an amputation of a toe, a foot, or even a leg.
- **Lower Leg Ulcer**
  Lower leg ulcers are non-healing skin wounds on the lower leg, foot, or toes. Causes of leg ulcers include trauma to the skin, poor circulation, smoking, diabetes, high blood pressure, high cholesterol, and atherosclerosis (a narrowing of a vessel).
- **Venous Stasis Ulcers**
  Venous ulcers are located below the knee and are primarily found on the inner part of the leg, just above the ankle. These ulcers are common in patients who have a history of leg swelling, varicose veins, or a history of blood clots in either the superficial or the deep veins of the legs.
- **Arterial (Ischemic) Ulcers**
  Arterial ulcers are usually located on the feet and often occur on the heels, tips of toes, between the toes where the toes rub against one another or anywhere the bones may protrude and rub against bed sheets, socks, or shoes. Arterial ulcers also occur commonly in the nail bed if the toenail cuts into the skin or if the patient has had recent aggressive toe nail trimming or an ingrown toenail removed.
- **Bone Infection**
  Bone infections are almost always caused by bacteria. Over time, the result can be destruction of the bone itself. Bone infections may occur at any age. Certain conditions increase the risk of developing such an infection, including sickle cell anemia, injury, the presence of a foreign body (such as a bullet or a screw placed to hold together a broken bone), intravenous drug use (such as heroin), diabetes, kidney dialysis, surgical procedures to bony areas, and untreated infections of tissue near a bone.
- **Gangrene**
  Gangrene is a complication of cell death (or necrosis) characterized by the decay of body tissues, which become black and smell bad. It is caused by infection, usually the result of insufficient blood supply, and is often associated with diabetes and long-term smoking. This condition is most common in the lower extremities.
- **Skin Tears and Lacerations**
  A skin tear is a traumatic wound which separate the first several layers of skin from one another. **Radiation**

Burns
Radiation burns occur from exposure to radiation and can be as mild as sunburn to burns caused by radiation used in the treatment of cancer.

- **Postoperative Infection**
  Postoperative infections are caused by bacteria entering the surgical incision area. Postoperative wound infections can delay recovery and increase the length of a hospital stay. Multiple risk factors can contribute to an increase in postoperative wound infection, including age, concurrent diseases (such as diabetes), malnutrition, and other skin infections.

Various Wound Treatments:

- **Specialty Wound Dressings**
  Medicines and dressings can sometimes encourage wounds to close and heal. Transparent adhesive dressings are semi-permeable and occlusive. They reduce the risk of healthy skin degeneration and secondary infections.
- **Debridement**
  The removal of dead tissue around the wound, or debridement, is often needed to clean the wound and promote healing. Three of the debridement procedures commonly used is enzymatic debridement, mechanical nonselective debridement, and sharp debridement.
- **Specialized Equipment**
  Specialized equipment may be used in the treatment of some wounds. This equipment may include ultrasound and ultraviolet heat lamps.
- **Antibiotics**
  Antibiotics are often used, even if an infection is not clearly present. This is done to prevent an infection. Usually antibiotics are administered for 4-6 weeks.
- **Alleviation of Weight-bearing Wounds**
  Keeping pressure off of foot ulcers promotes healing. Sometimes special mattresses, cushions, special casts, or boots are used to "off-load" pressure from the ulcer.
- **Blood Sugar Control**
  Infected ulcers are likely to cause high blood sugar levels. High blood sugar levels lower immune response and prevent wound healing. Adjustments in diet or medications can aid in fighting infections and healing wounds. Sometimes insulin shots are needed in the short term to achieve optimal blood sugar control.
- **Skin Grafts**
  A bio-engineered skin graft or human skin graft can be used to treat diabetic foot ulcers which fail to heal with conventional treatments. Skin grafts have been shown to speed up the healing process.
- **Surgery**
  Bypass surgery to improve blood flow within the arteries of the legs may help with wound healing and spare amputations. As a last resort, amputation surgery may be needed to stop the spread of infection to the rest of the body
- **Hyperbaric**
  Hyperbaric oxygen therapy helps heal wounds. Over the course of several treatments, many patients achieve wound healing that is not otherwise possible using other methods.

As an employee of "The Company", it is your responsibility to become familiar with and follow your assigned facilities corresponding policies and procedures.

Federal Survey Tag F309 for Skilled Nursing Facilities

Under the Omnibus Budget Reconciliation Act of 1987 (OBRA '87) the federal government added requirements for skilled nursing facilities that received reimbursement from Medicare and Medicaid. With the passage of OBRA, skilled nursing facilities were required to provide services to help each resident achieve and maintain the highest practicable level of physical, mental, and psychosocial well-being in accordance with the comprehensive assessment and plan of care.

The Federal Survey Tag F309 states, "To provide to each resident all the necessary care and services such that the resident can attain or maintain the highest practicable physical, mental, and psychosocial well-being". The regulations state, "the facility must ensure that the resident obtains optimal improvement and/or does not deteriorate within the limits of a resident's right to refuse treatment and within the limits of recognized pathology and the normal aging process". Note: These are the minimum federal guidelines that a health care provider is required to follow. The Act emphasizes using a person's strengths and capabilities to help them function as independently as possible; giving them choice in determining their care and activities, and allowing them to continue their normal daily routine, habits, and interests.

How does OBRA impact long-term care facilities/providers?

- The facility must provide or obtain rehabilitative services such as physical therapy, occupational therapy, and speech-language pathology.
- The regulation states that the facility must provide a systematic assessment and monitoring process for identifying residents who require skilled therapy intervention and refer those residents needing services to rehabilitation.
- Residents must be assessed by use of the Minimum Data Set (MDS) upon admission to the facility, quarterly, annually, and promptly after a significant change (improvement or decline) in a resident's physical or mental condition.
- Residents demonstration a significant change in condition must be referred to appropriate services such as PT, OT, ST, dietary, nursing, social services for intervention.
- A Care Plan must be developed for each resident and must reflect a true interdisciplinary team approach towards planning the care for the resident.

- Once a problem has been identified, the facility is required to provide an intervention. If the facility does not identify a problem and a clear intervention is not on the care plan, the facility can face disciplinary action during the state survey process.

The following areas of function are to be assessed:

- Cognition and Dementia
- Activities of Daily Living (ADLs)-potential and functional
- Communication
- Urinary incontinence & indwelling catheter usage
- Falls
- Nutrition status
- Feeding tubes
- Dehydration and fluid intake/maintenance
- Vision abilities
- Rehab potential
- Activities
- Pressure ulcers-risk and status
- Dental care
- Restraints-physical and chemical
- Psychosocial well-being
- Psychotropic drug usage

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Value-Based Care and Quality Improvement

The healthcare industry is transitioning from volume-based to value-based care that focuses on improving quality and outcomes. This section will discuss key concepts like value-based care models, quality improvement processes, and health care performance metrics.

Value-Based Care

Value-based care links payments to improved health outcomes. Popular models include:

- Accountable Care Organizations (ACOs) - Provider groups coordinated to optimize care efficiency
- Patient-Centered Medical Homes - Primary care-led team care with coordinated services
- Bundled Payments - Single payment for all care related to a treatment or condition
- Pay-for-Performance - Bonuses tied to achieving health outcome targets

The goal is high-value, high-quality and cost-effective care.

Quality Improvement Processes

Quality improvement (QI) involves systemic and continuous actions to improve efficiency, outcomes, and patient satisfaction. QI projects utilize techniques like:

- Root cause analysis to identify performance issues
- Lean and Six Sigma to reduce errors and waste
- Plan-Do-Study-Act cycles to test and implement changes
- Technology like dashboards to monitor progress

Having a mindset of constant improvement is key.

Key Performance Metrics

Key performance indicators (KPIs) track care quality and health outcomes. Common metrics include:

- Readmission rates
- Mortality rates
- Infection rates
- Patient satisfaction scores
- Preventive care service percentage
- Cost per patient cohort

Monitoring metrics identifies areas needing improvement.

Driving value through better outcomes, processes, and costs should be central to every clinician's mindset and role.

Medication Safety

Following appropriate medication administration practices is a vital part of an overall patient safety program. Specific policies and procedures will vary between clients. It is vital that you become familiar with and understand the medication practices at the facilities you are assigned.

Rights of Medication Administration
Although procedures and equipment will vary between clients, safe medication practice can be summarized by the Seven Rights:

1. Right Patient
    - Confirm correct patient by armband check and verbal review.
    - Observe patient taking medications.

2. Right Medication
    - Verify written and verbal orders and medication label.
    - Verify patient allergies.
    - Verify compatibility when mixing drugs.

3. Right Dosage and Time
    - Check the order; obtain correct unit dose medication.
    - Review knowledge of medication (side effects, precautions) and any pertinent lab values related to the medication.
    - Verify when medication should be given

4. Right Route
    - Check the order and appropriateness of the route ordered.
    - Confirm that the patient can take or receive the medication by the ordered route.

5. Right Method
    - Wash hands prior to administration.
    - Position patient to enable safe medication administration.
    - Administer medication through appropriate route.
    - Prepare injectables with aseptic technique.
    - Never leave medications unattended.

6. Right Time
    - Verify written and verbal orders.
    - Review patient chart.

7. Right Education
    - Provide patient education regarding medications.
    - Refer to pharmacy or physician when indicated.

8. Right Assessment, Evaluation and Documentation
    - Assess, evaluate and document vital signs if indicated.
    - Waste, and document, all unused portions of vials, unless labeled multi-dose.
    - Document all medications and patient responses in medication administration system and patient chart.

As an employee of "The Company", it is your responsibility to become familiar with and follow your assigned facilities corresponding policies and procedures.

Joint Commission: "Do Not Use" Abbreviation List

The Joint Commission's "Do Not Use" List does not apply to preprogrammed health information technology systems.

Abbreviation	Potential Problem	Intended Meaning	Correct Documentation
U or u	Mistaken as "0" (zero), the number "4" (four) or "cc"	Units	Write "unit"
IU	Mistaken as IV (intravenous) or the number 10 (ten)	International unit	Write "International unit"
Q.D., QD, q.d., qd	Latin abbreviations that are mistaken for each other	Once daily, every day	Write "daily"
Q.O.D., QOD, q.o.d., qod	The periods are mistaken for something else	Every other day	Write "every other day"
Use of a zero *after* a decimal point (X.0 mg)* [Trailing Zero]	Decimal point is missed		Do not use trailing zeros. Write X mg
Lack of leading zero *before* a decimal point (.X mg)	Decimal point is missed		Use a zero before a decimal point (write 0.X mg)
MS	Mistaken for one another. Can mean morphine sulfate or magnesium sulfate	Morphine sulfate	Write "morphine sulfate"
MSO_4		Morphine sulfate	Write "morphine sulfate"
$MgSO_4$		Magnesium sulfate	Write "magnesium sulfate"

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

***Exception:** A "trailing zero" may be used only where required to demonstrate the level of precision of the value being reported, such as for laboratory results, imaging studies that report size of lesions, or catheter/tube sizes. It may not be used in medication orders or other medication-related documentation.

All healthcare professionals are to adhere to the Joint Commission Do Not Use List and to any facility-specific Abbreviation List policies and procedures.

Development of the "Do Not Use" List

In 2001, The Joint Commission issued a *Sentinel Event Alert* on the subject of medical abbreviations. A year later, its Board of Commissioners approved a National Patient Safety Goal requiring accredited organizations to develop and implement a list of abbreviations not to use. In 2004, The Joint Commission created its "Do Not Use" List to meet that goal. In 2010, NPSG.02.02.01 was integrated into the Information Management standards as elements of performance 2 and 3 under IM.02.02.01. For more information: Contact the Standards Interpretation Group at 630-792-5900 at The Joint Commission.

2023 Joint Commission National Patient Safety Goals

The purpose of the National Patient Safety Goals is to improve patient safety. The goals focus on problems in health care safety and how to solve them. The information below is taken from The Joint Commission website. Please refer to their website (https://www.jointcommission.org/-/media/tjc/documents/standards/national-patient-safety-goals/2023/2023-hap-npsg-goals-102122_simple.pdf) ***and*** your assigned facilities for any additional instructions or resources pertaining to the National Patient Safety Goals.

As an employee of "The Company", it is your responsibility to become familiar with and follow these safety goals, and to become familiar with and follow your assigned facilities corresponding policies and procedures. It is your duty as a healthcare provider to help promote patient safety.

Goal 1: Identify Patients Correctly ***Improve the accuracy of patient identification.***	
NPSG.01.01.01 **(Ambulatory, Behavioral Health, Critical Access Hospital, Home Care, Hospital, Laboratory, Nursing Care Center, Office-Based Surgery)**	**Use at least two patient identifiers when providing care, treatment or services.** • Use at least two patient identifiers when administering medications, blood, or blood components; when collecting blood samples and other specimens for clinical testing; and when providing treatments or procedures. The room number or physical location is not used as an identifier. (See also MM.05.01.09, EPs 7 and 10; NPSG.01.03.01, EP 1) • Label containers used for blood and other specimens in the presence of the patient/individual served. (See also NPSG.01.03.01, EP 1). • Use distinct methods of identification for newborn patients. Note: 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).
NPSG.01.03.01 **(Ambulatory, Critical Access Hospital, Hospital, Office-Based Surgery)**	**Eliminate transfusion errors related to patient misidentification.** • Before initiating a blood or blood component transfusion: - Match the blood or blood component to the order. - Match the patient to the blood or blood component. - Use a two-person verification process or a one-person verification process accompanied by automated identification technology, such as bar coding. (See also NPSG.01.01.01, EPs 1 and 2) • When using a two-person verification process, one individual conducting the identification verification is the qualified transfusionist who will administer the blood or blood component to the patient. • When using a two-person verification process, the second individual conducting the identification verification is qualified to participate in the process, as determined by the organization.
Goal 2: Improve Communication ***Improve the effectiveness of communication among caregivers.***	
NPSG.02.03.01 **(Critical Access Hospital, Hospital, Laboratory)**	**Report critical results of tests and diagnostic procedures on a timely basis.** • Develop written procedures for managing the critical results of tests and diagnostic procedures that address the following (Laboratory-collaborate with organization leaders): - 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.

	• Implement the procedures for managing the critical results of tests and diagnostic procedures. • Evaluate the timeliness of reporting the critical results of tests and diagnostic procedures.
Goal 3: Use Medicines Safely ***Improve the safety of using medications.***	
NPSG.03.04.01 **(Ambulatory, Critical Access Hospital, Hospital, Office-Based Surgery)**	**Label all medications, medication containers, and other solutions on and off the sterile field in perioperative and other procedural settings**. Note: Medication containers include syringes, medicine cups, and basins. • 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. Refer to NPSG.03.04.01, EP 5, for information on timing of labeling. • In perioperative and other procedural settings, both on and off the sterile field, labeling occurs when any medication or solution is transferred from the original packaging to another container. • In perioperative and other procedural settings both on and off the sterile field, 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 when not used within 24 hours - Expiration time when expiration occurs in less than 24 hours Note: The date and time are not necessary for short procedures, as defined by the organization. • 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. 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. • 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. Note: This does not apply to multiuse vials that are handled according to infection control practices. • All medications and solutions both on and off the sterile field and their labels are reviewed by entering and exiting staff responsible for the management of medications.
NPSG.03.05.01 **(Ambulatory, Critical Access Hospital, Hospital, Nursing Care Center)**	**Reduce the likelihood of patient harm associated with the use of anticoagulant therapy.** • Critical Access Hospitals/Hospitals/Nursing Care Centers: Use only oral unit-dose products, prefilled syringes, or premixed infusion bags when these types of products are available. Note: For pediatric patients and residents, prefilled syringe products should be used only if specifically designed for children. • Use approved protocols for the initiation and maintenance of anticoagulant therapy. • Before starting a patient or resident on warfarin, assess the patient's or resident's baseline coagulation status; for all patients receiving warfarin therapy, use a current International Normalized Ratio (INR) to adjust this therapy. The baseline status and current INR are documented in the clinical record. Note: The patient's or resident's baseline coagulation status can be assessed in a number of ways, including through a laboratory test or by identifying risk factors such as age, weight, bleeding tendency, and genetic factors. • Use authoritative resources to manage potential food and drug interactions for patients receiving warfarin. • When heparin is administered intravenously and continuously, use programmable pumps in order to provide consistent and accurate dosing. • A written policy addresses baseline and ongoing laboratory tests that are required for

	anticoagulants. • Provide education regarding anticoagulant therapy to prescribers, staff, patients, residents, and families. Patient/resident/family education includes the following: - The importance of follow-up monitoring - Compliance - Drug-food interactions - The potential for adverse drug reactions and interactions • Evaluate anticoagulation safety practices, take action to improve practices, and measure the effectiveness of those actions in a time frame determined by the organization.
NPSG.03.06.01 **(Ambulatory, Behavioral Health, Critical Access Hospital, Home Care, Hospital, Nursing Care Center, Office-Based Surgery)**	**Maintain and communicate accurate patient medication information.** • Obtain and/or update information on the medications the patient/resident/individual served is currently taking, no matter what the setting. This information is documented in a list or other format that is useful to those who manage medications. Note 1: The organization obtains the patient's/resident's/individual's medication information at the beginning of an episode of care. The information is updated when the patient's/resident's/individuals' medications change (for example for Nursing Care Centers, after treatment in another setting, such as a hospital or physician's office). Note 2: Current medications include those taken at scheduled times and those taken on an as-needed basis. See the Glossary for a definition of medications. (Nursing Care Centers-contact the prescriber with any concerns about specific medications). Note 3: It is often difficult to obtain complete information on current medications from the patient/resident/individual. A good faith effort to obtain this information from the patient/resident/individual and/or other sources will be considered as meeting the intent of the EP. • Define the types of medication information to be collected in different settings and patient/resident/individual circumstances. Note 1: Examples of such settings include primary care, urgent and emergent care, ambulatory surgery, convenient care, outpatient radiology, and diagnostic settings. Examples of non-24-hour settings include the emergency department, primary care, outpatient radiology, ambulatory surgery, and diagnostic settings. Note 2: Examples of medication information that may be collected include name, dose, route, frequency, and purpose. • For organizations that prescribe medications: Compare the medication information the patient/resident brought to the organization with the medications ordered for the patient/resident by the organization in order to identify and resolve discrepancies. Note: Discrepancies include omissions, duplications, contraindications, unclear information, and changes. A qualified individual, identified by the organization, does the comparison. (See also HR.01.06.01, EP 1) • For organizations that prescribe medications: Provide the patient/resident (or family as needed) with written information on the medications the patient/resident should be taking at the end of the episode of care or when he/she leaves the organization's care or outpatient encounter (for example, name, dose, route, frequency, purpose). Note: When the only additional medications prescribed are for a short duration, the medication information the organization provides may include only those medications. For more information about communications to other providers of care at the end of an episode of care, or when the patient/individual is discharged or transferred, refer to Standard PC.04.02.01. • For organizations that prescribe medications: Explain the importance of managing medication information to the patient/resident at the end of the episode of care/hospitalization/outpatient encounter. Note: Examples include instructing the patient/resident to give a list to his or her primary care physician; to update the information when medications are discontinued, doses are changed, or new medications (including over-the-counter products) are added; and to carry medication information at all times in the event of emergency situations. (For information on patient/resident education on medications, refer to Standards PC.02.03.01 and PC.04.01.05.). For Home care: • Compare the medication information the patient is currently taking with the medications ordered for the patient in order to identify and resolve discrepancies. Note: Discrepancies include omissions, duplications, contraindications, unclear

	information, and changes. A qualified individual, identified by the organization, does the comparison. (See also HR.01.06.01, EP 1). Provide the patient (or family as needed) with written information on the medications the patient should be taking when he or she leaves the organization's care (for example, name, dose, route, frequency, purpose). Note: When the only additional medications prescribed are for a short duration, the medication information the organization provides may include only those medications. For more information about communications to other providers of care when the patient is discharged or transferred, refer to Standard PC.04.02.01. Explain the importance of managing medication information to the patient. Note: Examples include instructing the patient to give a list to his or her primary care physician; to update the information when medications are discontinued, doses are changed, or new medications (including over-the-counter products) are added; and to carry medication information at all times in the event of emergency situations. (For information, on patient education on medications, refer to Standards MM.06.01.03, PC.02.03.01, and PC.04.01.05.)
Goal 6: Clinical Alarm Safety ***Reduce the harm associated with clinical alarm systems.***	
NPSG.06.01.01 **(Critical Access Hospital, Hospital)**	**Improve the safety of clinical alarm systems.** • Leaders establish alarm system safety as a critical access hospital priority. • Identify the most important alarm signals to manage based on the following: - Input from the medical staff and clinical departments - Risk to patients if the alarm signal is not attended to or if it malfunctions - Whether specific alarm signals are needed or unnecessarily contribute to alarm noise and alarm fatigue - Potential for patient harm based on internal incident history - Published best practices and guidelines (For more information on managing medical equipment risks, refer to Standard EC.02.04.01.). • Establish policies and procedures for managing the alarms identified in EP 2 above that, at a minimum, address the following: - 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 - Who in the organization has the authority to change alarm parameters - Who in the organization has the authority to set alarm parameters to "off" - Monitoring and responding to alarm signals - Checking individual alarm signals for accurate settings, proper operation, and detectability (For more information, refer to Standard EC.02.04.03). • Educate staff and licensed independent practitioners about the purpose and proper operation of alarm systems for which they are responsible.
Goal 7: Prevent Infections ***Reduce the risk of health care-associated infections.***	
NPSG.07.01.01 **(Ambulatory, Behavioral Health Care, Critical Access Hospital, Home Care, Hospital, Laboratory, Nursing Care Center, Office-Based Surgery)**	**Comply with either the current Centers for Disease Control and Prevention (CDC) hand hygiene guidelines or the current World Health Organization hand hygiene guidelines.** • Implement a program that follows categories IA, IB, and IC of either the current Centers for Disease Control and Prevention (CDC) or the current World Health Organization (WHO) hand hygiene guidelines. (See also IC.01.04.01, EP 1). Note: This element of performance applies only to organizations that provide physical care. • Set goals for improving compliance with hand hygiene guidelines. (See also IC.03.01.01, EP 1). Note: This element of performance applies only to organizations that provide physical care. • Improve compliance with hand hygiene guidelines based on established goals. Note: This element of performance applies only to organizations that provide physical care.
NPSG.07.03.01 **(Critical Access Hospital, Hospital, Nursing Care Center)**	**Implement evidence-based practices to prevent health care-associated infections due to multidrug-resistant organisms in acute care hospitals.** • Conduct periodic risk assessments (in time frames defined by the organization/critical access hospital/hospital) for multidrug-resistant organism acquisition and transmission. (See also IC.01.03.01, EPs 1–3). • Educate staff and licensed independent practitioners about multidrug-resistant organisms and prevention strategies. Education occurs upon hire or granting of initial

	privileges and periodically thereafter as determined by the organization. Note: The education provided recognizes the diverse roles of staff and licensed independent practitioners and is consistent with their roles within the organization. • Educate patients/residents, and their families as needed, who are infected or colonized with a multidrug-resistant organism about health care–associated infection prevention strategies. • Implement a surveillance program for multidrug-resistant organisms based on the risk assessment. Note: Surveillance may be targeted rather than organization/hospital-wide. • Measure and monitor multidrug-resistant organism prevention processes and outcomes, including the following: - Multidrug-resistant organism infection rates using evidence-based metrics - Compliance with evidence-based guidelines or best practices - Evaluation of the education program provided to staff and licensed independent practitioners (See also MM.09.01.01, EP 5) Note: Surveillance may be targeted rather than organization/hospital-wide. • Provide multidrug-resistant organism process and outcome data to key stakeholders, including leaders, licensed independent practitioners, nursing staff, and other clinicians. • Implement policies and practices aimed at reducing the risk of transmitting multi-drug resistant organisms. These policies and practices meet regulatory requirements and are aligned with evidence-based standards (for example, the Centers for Disease Control and Prevention (CDC) and/or professional organization guidelines). • When indicated by the risk assessment, implement a laboratory-based alert system that identifies new patients/residents with multidrug-resistant organisms. Note: The alert system may use telephones, faxes, pagers, automated and secure electronic alerts, or a combination of these methods. • When indicated by the risk assessment, implement an alert system that identifies readmitted or transferred patients and residents who are known to be positive for multidrug-resistant organisms. Note 1: The alert system information may exist in a separate electronic database or may be integrated into the admission system. The alert system may be either manual or electronic or a combination of both. Note 2: Each organization/hospital may define its own parameters in terms of time and clinical manifestation to determine which readmitted patients and residents require isolation.
NPSG.07.04.01 **(Critical Access Hospital, Hospital, Nursing Care Center)**	**Implement evidence-based practices to prevent central line-associated bloodstream infections.** • Educate staff and licensed independent practitioners who are involved in managing central lines about central line–associated bloodstream infections and the importance of prevention. Education occurs upon hire or granting of initial privileges and periodically thereafter as determined by the organization. • Prior to insertion of a central venous catheter, educate patients and, as needed, their families about central line–associated bloodstream infection prevention. • Implement policies and practices aimed at reducing the risk of central line–associated bloodstream infections. These policies and practices meet regulatory requirements and are aligned with evidence-based standards (for example, the Centers for Disease Control and Prevention (CDC) and/or professional organization guidelines). • Conduct periodic risk assessments for central line–associated bloodstream infections, monitor compliance with evidence-based practices, and evaluate the effectiveness of prevention efforts. The risk assessments are conducted in time frames defined by the critical access hospital/hospital, and this infection surveillance activity is organization/hospital-wide, not targeted. • Provide central line–associated bloodstream infection rate data and prevention outcome measures to key stakeholders, including leaders, licensed independent practitioners, nursing staff, and other clinicians. • Use a catheter checklist and a standardized protocol for central venous catheter insertion. • Use a standardized supply cart or kit that contains all necessary components for the insertion of central venous catheters. • Perform hand hygiene prior to catheter insertion or manipulation.

	• Use maximum sterile barrier precautions during central venous catheter insertion. • For adult patients, do not insert catheters into the femoral vein unless other sites are unavailable. • Use an alcoholic chlorhexidine antiseptic for skin preparation during central venous catheter insertion unless contraindicated. • Use a standardized protocol to disinfect catheter hubs and injection ports before accessing the ports. • Evaluate all central venous catheters routinely and remove nonessential catheters. *Nursing Care Centers:* • Educate staff and licensed independent practitioners who are involved in managing central lines about central line–associated bloodstream infections and the importance of prevention. Education occurs upon hire or granting of initial privileges and periodically thereafter as determined by the organization. • Prior to insertion of a central venous catheter, educate patients and residents and, as needed, their families about central line–associated bloodstream infection prevention. • Use a standardized protocol to disinfect catheter hubs and injection ports before accessing the ports. • Evaluate all central venous catheters routinely and remove nonessential catheters
NPSG.07.05.01 **(Ambulatory, Critical Access Hospital, Hospital, Office-Based Surgery)**	**Implement evidence-based practices for preventing surgical site infections.** • Educate staff and licensed independent practitioners involved in surgical procedures about surgical site infections and the importance of prevention. Education occurs upon hire, annually thereafter, and when involvement in surgical procedures is added to an individual's job responsibilities. • Educate patients, and their families as needed, who are undergoing a surgical procedure about surgical site infection prevention. • Implement policies and practices aimed at reducing the risk of surgical site infections. These policies and practices meet regulatory requirements and are aligned with evidence-based guidelines (for example, the Centers for Disease Control and Prevention (CDC) and/or professional organization guidelines). • As part of the effort to reduce surgical site infections: - Conduct periodic risk assessments for surgical site infections in a time frame determined by the organization. - Select surgical site infection measures using best practices or evidence-based guidelines. - Monitor compliance with best practices or evidence-based guidelines. - Evaluate the effectiveness of prevention efforts. Note: Surveillance may be targeted to certain procedures based on the organization's/practice's risk assessment. • Measure surgical site infection rates for the first 30 or 90 days following surgical procedures based on National Healthcare Safety Network (NHSN) procedural codes. The organization's measurement strategies follow evidence-based guidelines. Note 1: Surveillance may be targeted to certain procedures based on the organization's risk assessment. Note 2: The NHSN is the Centers for Disease Control and Prevention's health care–associated infection tracking system. NHSN provides facilities, states, regions, and the nation with data needed to identify problem areas, measure progress of prevention efforts, and ultimately eliminate health care–associated infections. For more information on NHSN procedural codes, see http://www.cdc.gov/nhsn/CPTcodes/ssi-cpt.html. 5. • Provide process and outcome (for example, surgical site infection rate) measure results to key stakeholders. • Administer antimicrobial agents for prophylaxis for a particular procedure or disease according to methods cited in scientific literature or endorsed by professional organizations. * Footnote *: A limited number of National Patient Safety Goals contain requirements for practices that reflect current science and medical knowledge. In these cases, the element of performance refers to a practice that is cited in scientific literature or endorsed by professional organizations. This means that the practice used by the organization must be validated by an authoritative source. The authoritative source may be a study published in a peer-reviewed journal that clearly demonstrates the efficacy of that practice or endorsement of the practice by a professional organization(s) and/or a government agency(ies). It is not acceptable to

	follow a practice that is not supported by evidence or widespread consensus. During the on-site survey, surveyors will explore the source of the practices the organization follows. • When hair removal is necessary, use a method that is cited in scientific literature or endorsed by professional organizations. * Footnote *: A limited number of National Patient Safety Goals contain requirements for practices that reflect current science and medical knowledge. In these cases, the element of performance refers to a practice that is cited in scientific literature or endorsed by professional organizations. This means that the practice used by the organization must be validated by an authoritative source. The authoritative source may be a study published in a peer-reviewed journal that clearly demonstrates the efficacy of that practice or endorsement of the practice by a professional organization(s) and/or a government agency(ies). It is not acceptable to follow a practice that is not supported by evidence or widespread consensus. During the on-site survey, surveyors will explore the source of the practices the organization follows.
NPSG.07.06.01 **(Critical Access Hospital, Hospital, Nursing Care Center)**	**Implement evidence-based practices to prevent indwelling catheter-associated urinary tract infections (CAUTI).** • Educate staff and licensed independent practitioners involved in the use of indwelling urinary catheters about CAUTI and the importance of infection prevention. Education occurs upon hire or granting of initial privileges and when involvement in indwelling catheter care is added to an individual's job responsibilities. Ongoing education and competence assessment occur at intervals established by the organization. • Educate patients and residents who will have an indwelling catheter, and their families as needed, on CAUTI prevention and the symptoms of a urinary tract infection. Note: See FAQs about "Catheter-associated Urinary Tract Infection" at http://www.sheaonline.org/images/patients/NNL_CA-UTI.pdf. • Develop written criteria, using established evidence-based guidelines, for placement of an indwelling urinary catheter. Written criteria are revised as scientific evidence changes. Note: Examples of criteria for placement of an indwelling urinary catheter include the following: - Critically ill patients who need accurate urinary output measurements – Patients/residents with acute urinary retention or bladder outlet obstruction – Patients/residents who require prolonged immobilization (for example, a potentially unstable thoracic or lumbar spine or multiple traumatic injuries such as pelvic fractures) - Incontinent patients and residents with an open sacral wound or perineal wounds - Perioperative use for selected surgical procedures, such as patients undergoing urologic surgery or other surgery on contiguous structures of the genitourinary tract; patients who will have a prolonged duration of surgery (catheters inserted for this reason should be removed in a post-anesthesia care unit); patients anticipated to receive large-volume infusions or diuretics during surgery; patients needing intraoperative monitoring of urinary output - End-of-life care - Neurogenic bladder. • Follow written procedures based on established evidence-based guidelines for inserting and maintaining an indwelling urinary catheter. The procedures address the following: - Limiting use and duration - Performing hand hygiene prior to catheter insertion or maintenance care - Using aseptic techniques for site preparation, equipment, and supplies - Securing catheters for unobstructed urine flow and drainage - Maintaining the sterility of the urine collection system - Replacing the urine collection system when required - Collecting urine samples Note: There are medical conditions that require a prolonged use of an indwelling urinary catheter in order to avoid adverse events and promote patient safety. Examples can include, but are not limited to, patients with a spinal cord injury, multiple sclerosis, Parkinson's disease, and spina bifida. • Measure and monitor catheter-associated urinary tract infection prevention processes and outcomes in high-volume areas by doing the following: - Selecting measures using evidence-based guidelines or best practices - Having a consistent method for medical record documentation of indwelling urinary catheter use, insertion, and maintenance - Monitoring compliance with evidence-based guidelines or best practices - Evaluating the effectiveness of prevention efforts Note:

	Surveillance may be targeted to areas with a high volume of patients using in-dwelling catheters. High-volume areas are identified through the hospital's risk assessment as required in IC.01.03.01, EP 2.
Goal 9: Reduce Falls ***Reduce the risk of patient harm resulting from falls.***	
NPSG.09.02.01 **(Home Care, Nursing Care Center)**	**Reduce the risk of falls.** • Assess the patient's or resident's risk for falls. • Implement interventions to reduce falls based on the patient's or resident's assessed risk. • Educate staff on the fall reduction program in time frames determined by the organization. • Educate the patient/resident and, as needed, the family on any individualized fall reduction strategies. • Evaluate the effectiveness of all fall reduction activities including assessment, interventions and education. Note: Examples of outcome indicators to use in the evaluation include decreased number of falls and decreased number and severity of fall-related injuries.
Goal 14: Pressure Ulcers ***Prevent health care-associated pressure ulcers (decubitus ulcers)***	
NPSG.14.01.01 **(Nursing Care Center)**	**Assess and periodically reassess each resident's risk for developing a pressure ulcer and take action to address any identified risks.** • Create a written plan for the identification of risk for and prevention of pressure ulcers. • Perform an initial assessment at admission to identify patients and residents at risk for pressure ulcers. • Conduct a systematic risk assessment for pressure ulcers using a validated risk assessment tool such as the Braden Scale or Norton Scale. • Reassess pressure ulcer risk at intervals defined by the organization. • Take action to address any identified risks to the patient or resident for pressure ulcers, including the following: - Preventing injury to patients and residents by maintaining and improving tissue tolerance to pressure in order to prevent injury - Protecting against the adverse effects of external mechanical forces. • Educate staff on how to identify risk for and prevent pressure ulcers.
Goal 15: Risk Assessment ***The organization/hospital identifies safety risks inherent in its patient population.***	
NPSG.15.01.01 **(Behavioral Health, Hospital)**	**Identify patients at risk for suicide.** Note: This requirement applies only to psychiatric hospitals and patients being treated for emotional or behavioral disorders in general hospitals. • Conduct a risk assessment that identifies specific characteristics of the patient/individual served and environmental features that may increase or decrease the risk for suicide. • Address the immediate safety needs and most appropriate setting for treatment of the patient/individual served. • When a patient/individual at risk for suicide leaves the care of the organization/hospital, provide suicide prevention information (such as a crisis hotline) to the patient/individual and his or her family.
NPSG.15.02.01 **(Home Care)**	**Identify risks associated with home oxygen therapy, such as home fires.** • Conduct a home oxygen safety risk assessment before starting oxygen therapy in the home and when home care services are initiated that addresses at least the following: - Whether there are smoking materials in the home - Whether or not the home has functioning smoke detectors Note: Home care staff may ask the patient and family whether smoke detectors are functioning or may test the smoke detectors if they are accessible. However, testing smoke detectors is not required. - Whether there are other fire safety risks in the home, such as the potential for open flames Document the performance of the risk assessment. (For more information on coordination among different providers of care, refer to PC.02.02.01, EPs 1 and 10, and PC.02.03.01, EP 5.)

	• Reevaluate potential fire risks at intervals established by the organization. Evidence of unsafe practices leading to potential risk is used to establish these intervals. Document the reevaluation of potential fire risks. • Inform and educate the patient, family, and/or caregiver about the following: - The findings of the safety risk assessment - The causes of fire - Fire risks for neighboring residences and buildings - Precautions that can prevent fire-related injuries - Recommendations to address the specific identified risk(s) Document the provision of information and education. (For more information on coordination among different providers of care, refer to PC.02.02.01, EPs 1 and 10, and PC.02.03.01, EP 5.). • Assess the patient's, family's, and/or caregiver's level of comprehension of identified risks and compliance with suggested interventions during home visits. Document this assessment. • Implement strategies to improve patient and/or family compliance with oxygen safety precautions when unsafe practices are observed in the home. This includes notifying the licensed independent practitioner ordering the oxygen. Document the implementation of strategies to address compliance. Note: Other strategies to be considered include additional education, placing written reminders in specific locations, and exploring alternative living arrangements with the patient and family.
Universal Protocol for Preventing Wrong Site, Wrong Procedure, Wrong Person Surgery	
UP.01.01.01 **(Ambulatory, Critical Access Hospital, Hospital, Office-Based Surgery)**	**Conduct a pre-procedure verification process to verify patient and surgical site.** • Implement a pre-procedure process to verify the correct procedure, for the correct patient, at the correct site. Note: The patient is involved in the 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 pre-procedure 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.
UP.01.02.01 **(Ambulatory, Critical Access Hospital, Hospital, Office-Based Surgery)**	**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. • The procedure site is marked 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 organization 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 organization's/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 organization. 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
UP.01.03.01 **(Ambulatory, Critical Access Hospital, Hospital, Office-Based Surgery)**	**A time-out is performed before the procedure.** • Conduct a time-out immediately before starting the invasive procedure or making the incision. • The time-out has the following characteristics: - It is standardized, as defined by the organization/practice. - 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. Note: For organizations providing telehealth surgical services: Based on current UP requirements, telehealth staff who are physically present in the operating room and participating in a surgical procedure are actively involved in the timeout. • 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 Note: For organizations providing telehealth surgical services: Based on current UP requirements, telehealth staff who are physically present in the operating room and participating in a surgical procedure are actively involved in the timeout. • Document the completion of the time-out. Note: The organization/practice determines the amount and type of documentation.

Floating Between Units

Healthcare professionals are being asked to float between hospital units more often because of the continuing shortage in many areas. Employees of “The Company” are often uniquely prepared for this challenge and opportunity because they work at various facilities on different units regularly. This presents a value to our clients and the patients under your care. It also benefits you because the more flexible you are, the more assignments you can receive.

To help make floating between units a safe and positive experience, please review the following reminders:

- Before you begin your assignment or shift, find out which units you may be asked to float to and whether or not there is a specific rotation for floating nurses.
- Floating should be limited to areas or units that match your skills and experience. Inform the client of areas/specialties which you are qualified (by “The Company” standard’s) to work.
- Know who your resource person is on the unit you are assigned. Introduce yourself and ask questions, if necessary.
- Be helpful to nurses who float to your unit.

- Give the best care you can and treat patients and families, as you would like to be treated.
- Remember, patient care and safety always comes first.

"The Company" wants you to be a valuable resource to our clients and their patients. However, if you feel you are being treated unfairly, or put in an unsafe situation or one outside the scope of your qualifications, please contact your local office immediately. We are available 24 hours a day, seven days a week.

Skills Checklist and Age Specific Self-Assessment

Healthcare professionals employed by “The Company” are required to provide an annual update on the nursing/professional skills learned, improved, or mastered during the previous year as well as a self-assessment regarding their understanding of age specific concept.

The most effective way of completing these requirements is by signing into your personal profile on the “The Company” website (www.yourcompany.com), which was created at the time of application. After signing in, you can update your file with new credentials and skills.

If you are unable to complete the checklists and self-assessment on-line, contact your branch office. You may complete the process via phone with your local branch office representative.

Ethical Code of Conduct

Healthcare Ethics

Ethical issues arise frequently in healthcare environments. As a healthcare professional, it is imperative to have a strong ethical foundation to guide your practice. This section will cover key healthcare ethics topics including patient autonomy, end-of-life care and social determinants of health.

Patient Autonomy

Patient autonomy refers to the right of patients to make their own health decisions, including refusing treatment if desired. As providers, we must respect patients' autonomy by:

- Giving full informed consent about treatments
- Ensuring capacity to make healthcare choices
- Not coercing or imposing personal views
- Respecting advance directives like living wills
- Involving family if requested by the patient
- Protecting privacy and confidentiality
- End-of-Life Care

Ethical dilemmas frequently arise in end-of-life care around issues like:

- Withholding or withdrawing life support
- Pain management vs over sedation
- Artificial hydration and feeding
- Palliative and hospice care options
- Right to die and assisted death in some jurisdictions

It is important to honor patient or surrogate wishes, provide symptom relief, and avoid prolonging suffering when decline is irreversible.

Social Determinants of Health

Social determinants like income, education, environment, and social supports can greatly impact health outcomes. Healthcare providers should advocate to:

- Screen patients for social needs like food and housing insecurity
- Connect patients with community resources and services

- Address health literacy and support navigation of the health system
- Consider socioeconomic factors in treatment plans

Making ethical choices in healthcare often requires balancing competing values, duties, and outcomes. Maintaining compassion, patient-centeredness and integrity underlie sound ethical practice.

While at Work

Employees of "The Company" are expected to perform their work duties is a competent, courteous, efficient, and honest manner. Employees are responsible for adhering to all policies, rules, directives, and procedures promulgated by "The Company" and the clients where that employee is assigned.

A fundamental principle that underlies all healthcare practice is respect for the dignity and human rights of every individual. The need for healthcare is universal surpassing all individual differences whether or not the healthcare professional agrees with the individual served and irrespective of the nature of the health problems. Healthcare professionals respect those served as individuals and promote the welfare of the individuals served. When acting within one's role as a healthcare professional, the professional recognizes and respects the boundaries that establish limits to relationships and reports any ethical concerns to the appropriate authority within "The Company".

"The Company" requires its employees to be free of conflicting interests and activities that may prevent them from acting in the best interest of the company, its clients, and their patients or residents. It is incumbent on all employees to conduct their business and personal activities in a manner that does not adversely reflect upon the reputability of "The Company" or their ability to perform as a healthcare professional.

Employees may not from solicit accept gratuities, gifts, or other consideration from clients, patients, residents, or vendors that would create appear to create an appearance of impropriety or favoritism. Small non-monetary gifts (less than $5.00 in value) may be accepted at the discretion of the employee. Employees must decline all other offers of gifts or contact "The Company" management for guidance.

"The Company" engages in rigorous, but fair and ethical competition with its competitors. Employees should not disparage or make false statements about competing staffing firms or their employees. Likewise, employees should not make derogatory statements about "The Company" or its personnel. Instead, problems or complaints should be brought to the attention of company management.

Off Duty

Regarding off-duty conduct, "The Company" generally regards off-duty activities of employees to be personal and no concern to the company. However, certain types of off-duty activities by employees represent the potential of a material or ethical business concern to "The Company". For that reason, the following is established to indicate potential conditions of concern and guide employees.
Employees who engage in, or are associated with illegal conduct, the nature of which adversely affects "The Company", or their own ability or credibility to carry out their employment responsibilities, may be subject to disciplinary action, including termination.

Employees may engage in off-duty employment, provided that:

1. The employment does not conflict with the employee's work schedules, duties, and responsibilities.
2. The employment does not create a conflict of interest or incompatibility with "The Company's" employment.

3. The employment does not create a detrimental effect upon the employee's work performance or attendance with "The Company".
4. The employment does not create a detrimental effect upon the reputation of "The Company".

Diversity

"The Company" is dedicated to helping its clients and the patients they serve get the best temporary healthcare services possible. Creating an atmosphere that fully utilizes the talents and capabilities of a diverse workforce is a critical element of meeting this objective.

This commitment to diversity extends beyond simply reducing or preventing discrimination. Diversity refers to valuing and including employees who have different backgrounds, viewpoints, communication styles and approaches to problem solving.

A diverse workforce includes employees of varying ethnicity, race, color, language, ancestry, national origin, gender, religion, socioeconomic status, veteran status, and disability status, as well as other unique factors.

Through a diverse workforce, we are better able to meet the needs of healthcare recipients. "The Company" is committed to a policy that integrates diversity into its recruitment, hiring, and promotion practices. All "The Company" employees have the responsibility to behave in a way that creates a cultural environment where diversity accepted, even celebrated.

Anti-Discrimination Policy

It is the policy of "The Company" to create a work environment free of discrimination in which applicants and employees can enjoy equal opportunity in all aspects of their employment. "The Company" does not discriminate against an employee or applicant for employment on the basis of race, color, national origin, sex, pregnancy status, sexual orientation, age, religious affiliation, marital status, disability status, or any other classification protected by applicable discrimination laws.

"The Company" policy provides that:

1. In establishing qualifications for employment, no provision, requirement, or test will be adopted that would be discriminatory on the basis of any classification listed above, except where a bona fide occupational qualification exists.
2. No questions in any examination, application for, or other personnel proceeding will be worded to elicit information concerning protected characteristics from an applicant, eligible candidate, or employee.
3. No appointment to or removal from a position will be effected in any manner by the person's protected characteristics.
4. "The Company" recognizes the value of and accepts responsibility for providing reasonable accommodations to qualified individuals with disabilities.
5. No retaliation will be directed towards any individual who files a complaint of discrimination in accordance with company policy or applicable law.

The Human Resources Director of "The Company" has been designated Equal Employment Opportunity Officer of the company. The Human Resources Department is responsible for monitoring the company's equal employment opportunity and affirmative action programs and providing equal employment opportunity training. Individual managers and branch directors are responsible for ensuring that their employment practices comply with company policy and applicable state and federal law.

Complaints of discrimination of any type should be immediately reported to the Human Resources Director at "The Company's" corporate office or a senior manager (Vice President/Regional Manager).

Diversity, Equity, and Inclusion

Providing culturally sensitive, equitable care is an important competency for healthcare professionals. This section will cover concepts like implicit bias, cultural competence, health disparities and culturally sensitive care.

Implicit Bias

Implicit biases are automatic associations our brains make that can influence our actions and behaviors towards others. Common examples include biases based on race, ethnicity, gender, age, disability, sexual orientation and more. It is important to be aware of our own implicit biases so that we can mitigate them and provide non-judgmental care. Strategies to reduce implicit bias include:

- Taking validated implicit association tests to uncover subtle biases
- Identifying situations where biases tend to emerge at work
- Seeking out counter-stereotypical information
- Slowing down decision making processes to make less instinctual determinations
- Countering biased thoughts through mindfulness and perspective taking
- Cultural Competence

Cultural competence refers to the ability to understand, appreciate and interact with people from cultures or belief systems different from one's own. It encompasses:

- Awareness of one's own cultural lens and assumptions
- Attitudes of respect, openness and curiosity
- Knowledge of diverse cultural practices and worldviews
- Skills like communication techniques and conflict resolution

Culturally competent care benefits patients through improved:

- Access to care
- Utilization of services
- Patient understanding and adherence
- Cross-cultural communication

Health Disparities

Health disparities refer to the differences in health outcomes among segments of the population. Disparities are often related to social determinants of health like income, education, geography, access to care. Addressing health disparities requires multi-level strategies like:

- Collecting patient demographic data

- Tailoring treatment approaches to cultural norms
- Leveraging community health workers
- Improving health literacy
- Removing barriers to care
- Culturally Sensitive Care

Providing culturally sensitive care involves being respectful of diverse cultural backgrounds and beliefs. Strategies include:

- Inquiring about the patient's values, beliefs and traditions
- Using qualified interpreters for limited English patients
- Translating materials into languages spoken by common patient groups
- Ensuring physical accessibility for patients with disabilities
- Displaying images and materials reflecting patient diversity

Fostering diversity, equity and inclusion at every point of care is key to reducing disparities and providing optimal treatment tailored to the patient's needs and preferences.

Harassment, Including Sexual Harassment

Harassment, including sexual harassment, is strictly prohibited by "The Company". Any employee who engages in any of the acts or behavior defined below violates company policy, and such misconduct will subject an employee to corrective action up to and including immediate termination.

Employees who feel they have been discriminated against on the basis of sex, or sexually, or in any other manner harassed, should immediately report such incidents, following the procedure described below, without fear of reprisal. Confidentiality will be maintained to the extent permitted by the circumstances.

HARASSMENT is verbal or physical conduct designed to threaten, intimidate, or coerce and it includes verbal taunting (including racial and ethnic slurs) and other hostile acts.

SEXUAL HARASSMENT includes unwelcome sexual advances, requests for sexual favors, and other verbal or physical conduct of a sexual nature, when such conduct:

- Is made explicitly or implicitly a term or condition of employment, or
- Is used as a basis for an employment decision, or
- Unreasonably interferes with an employee's work performance or creates an intimidating, hostile, or otherwise offensive environment.

Sexual harassment does not refer to behavior or occasional compliments of a socially acceptable nature. It refers to behavior that is unwelcome, that is offensive, that lowers morale and therefore interferes with work effectiveness.

Sexual or other forms of harassment of an employee by any company employee, supervisor, or manager will not be tolerated. Sexual harassment by a non-employee, for example, a customer, vendor, or supplier, is also prohibited.

Complaints of harassment of any type should be immediately reported to the Human Resources Director at "The Company's" corporate office or a senior manager.

Deficit Reduction Act/False Claims Act

Effective January 1, 2007 was Section 6032 of the Deficit Reduction Act of 2005. With this Section, certain health care organizations were required to develop policies and inform employees about certain fraud, waste, and abuse laws; False Claims Act and related laws; and the whistleblower provisions to those laws.

The Deficit Reduction Act (DRA) requires health care organizations to provide certain information regarding the Federal and State false claims acts, administrative remedies for false claims and statements, whistleblower protections and health care organizations processes for detecting fraud, waste, and abuse.

The False Claims Act (FCA) prohibits the knowing submission of false or fraudulent claims or the making of a false record or statement in order to secure reimbursement from a government-sponsored program such as Medicare or Medicaid.

A Whistleblower is an individual with knowledge of potential violations who has filed a civil suit for him or herself and for the Government.

Compliance Training

In addition to training on the False Claims Act and fraud, waste and abuse policies, healthcare professionals should receive education on other key healthcare compliance laws.

Stark Law

The Stark Law prohibits physicians from making referrals to entities for certain designated health services if the physician (or close family member) has a financial relationship with that entity.

Anti-Kickback Statute

The Anti-Kickback Statute prohibits knowingly providing compensation in exchange for patient referrals or recommendation of a healthcare product or service that is reimbursable by a Federal health program.

To adhere to these laws:

- Do not accept gifts, trips, or compensation for referrals
- Avoid relationships causing overutilization
- Document legitimate compensation arrangements
- Consult compliance officer about any concerns

Violations can result in significant penalties. Being aware of applicable laws governs choices.

"The Company's" temporary healthcare professional employees are required to abide by their assigned facilities' policies and procedures (including Code of Conduct, Corporate Compliance, and Standards of Conduct policies) as they relate to the Deficit Reduction Act and the False Claims Act.

"The Company's" temporary healthcare professional employees are also required to participate in any related training held by their assigned facilities regarding the Deficit Reduction Act, the False Claims Act and related policies and procedures.

As an employee of "The Company", it is your responsibility to become familiar with and follow your assigned facilities corresponding policies and procedures.

Clinician Wellbeing and Burnout Prevention

Managing stress and promoting personal wellness are essential to avoid burnout as a healthcare professional. This section provides tips to foster clinician well-being.

Recognizing Burnout

Burnout is characterized by emotional exhaustion, depersonalization, and feelings of ineffectiveness. Warning signs include:

- Chronic fatigue despite adequate sleep
- Lacking enthusiasm for work
- Mental distancing from patients
- Irritability or sadness
- Lack of productivity and focus
- Physical ailments from stress

Practicing Self-Care

Effective self-care strategies involve:

- Setting boundaries and taking breaks
- Maintaining work-life balance through proper scheduling
- Engaging in relaxation techniques like meditation, yoga, or mindfulness
- Fostering supportive personal relationships
- Pursuing outside interests and hobbies
- Eating a healthy diet and exercising regularly
- Getting adequate sleep
- Practicing effective time management

Seeking Support

If feeling overwhelmed reach out to:

- A mental health professional for counseling
- Colleagues for advice on coping
- Your manager for modified work arrangements

- Employee assistance programs offered by the employer

Promoting clinician wellness helps avoid fatigue, disengagement, and despair. Make self-care a priority.