ALLCARE Nursing

Provider of Quality Healthcare Professionals

EMPLOYEE HANDBOOK

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Welcome!

Dear New Employees,

We would like to welcome you to Allcare Nursing Services Inc.

Each of us will play a role to ensure your successful integration into the company. You represent Allcare Nursing in the medical field and serve as the face of professionalism, integrity, and reliability. You prove that Allcare Nursing is a provider of reliable quality nurses.

We have put together this Employee Orientation and Annual Review Manual to provide information about our policies and standards. This manual should familiarize you with the outline of our company and our clients' expectations. Criteria in this manual are based upon the current recommendation and standards of the applicable voluntary and regulatory agencies.

Again, welcome to the team. We are excited that you have accepted our job offer and agreed upon your start date. I trust that this letter finds you mutually excited about your new employment with Allcare Nursing Services, Inc.

Sincerely,
Your Allcare Team

OUR COMMITMENT TO YOU

Allcare Nursing Services, Inc. provides top quality service, minimizing and/or eliminating hospital staff shortages. Our goal is to build a solid and continuous relationship based on reliability, performance, and trust.

Our office is located in Pasadena, CA and is open Monday through Friday 9:00am – 5:30pm. Our telephone number is 626-432-1999, which can also be contacted outside of normal business hours and in the event of an emergency. Allcare Nursing Services, Inc.'s on call staff will be available to assist you.

QUALITY ASSURANCE

Allcare Nursing Services recognizes that screening our nurses for certain clinical, academic and licensure requirements are necessary and part of the total qualification process of a "good nurse." Allcare Nursing Services, Inc. continually reviews and screens for other factors and requirements such as reliability, congeniality, responsiveness, acceptance of responsibilities and ability to perform with minimal supervision.

PERFORMANCE EVALUATION

To maintain consistency of high quality of nursing care and professionalism, we routinely conduct performance evaluation of our nurses working in our client facilities. This is also to acknowledge and address any areas of growth and improvement to prevent any occurrences.

ORIENTATION

Allcare Nursing Services conducts orientation of all our nurses to enable them to perform effectively. Specialized orientation programs can be arranged for specific hospitals, should the client require it, material for orientation can be developed by either the client or jointly with Allcare Nursing Services., Inc.

GENERAL INFORMATION

Allcare Nursing Services provides supplemental staffing to:

1. Acute Care Hospitals
   -We provide nursing and ancillary staff to various hospital departments
2. Permanent hospital staffing service
3. Long Term Acute Care
4. Skilled Nursing Facilities

OBTAINING A JOB ASSIGNMENT

1. Call our office to place yourself available for job assignments. Please let us know as early possible so we can find the right assignment for you.
2. Call to check in if you have not received a call from us by the day you are available to work, as we may have had trouble reaching you. When you accept a job assignment be sure you understand the time/shift and place you are to report.
3. We want to maintain contact with you, so if you move or become employed elsewhere or changed your telephone number, let us know.

REPORTING TO HOSPITAL

1. It is important that you report to the staffing/nursing office at the beginning of the shift. Be sure to arrive early enough to sign in at the Nursing/Staffing Office and still arrive on the assigned unit at the actual time the shift begins, especially if you may still have to change into hospital "scrub suits." In the event that you may be late reporting for work due to an emergency, notify Allcare Nursing Services stating the approximate time of your arrival so that we can notify the hospital, do not call the hospital yourself.
2. Sign out at the Staffing/Nursing office at the end of the shift.

RECORDING YOUR HOURS

1. Allcare Nursing Services sign-in sheets are provided for your use. These are kept in staffing office of each hospital where you may be assigned.
2. Time sheets must be correctly filled out at the time you report on and off duty. Incorrect time records may result in errors in your pay. Any overtime must be approved and initialed by the hospital supervisor. If you work overtime, call Allcare.

PAYROLL

1. You will be quoted your rate of pay according to your experience, specialty, and choice of
   Shift after your interview. Never discuss your rate of pay with clients or other Allcare Nursing Services employees.

2. Allcare Nursing Services is the actual employer of the nurses that are sent out to medical

facilities and clients that we contract with. Our payroll department deducts all taxes as required by law. We provide free of charge to nurses the following:

State Unemployment Insurance
Federal Unemployment Insurance
FICA Employer's Contribution
Workmen's Compensation Insurance
Liability Insurance and Malpractice Insurance

HOLIDAY PAY

Allcare Nursing Services recognizes and will pay the following holidays and shifts at time and one-half:

Christmas Day
Independence Day
Labor Day
Memorial Day
New Year's Day
Thanksgiving Day

For further information on holiday pay, consult with Allcare Nursing Services, Inc. payroll and management directly.

CANCELLATIONS/CHANGES IN SCHEDULES

1. At Allcare Nursing Services you have the right to accept or decline any assignment offered to you. When you accept an assignment, Allcare Nursing Services considers that a commitment on your part to arrive on time, appropriately dressed and prepared to work.
2. Please use good judgement when scheduling yourself to work. When circumstances do arise that require you to cancel out, Allcare Nursing Services is always willing to listen and evaluate the problem with you.
3. Allcare Nursing Services realizes that on rare occasion there may be circumstances which will cause an employee to cancel, if you must cancel:

   a. Notify Allcare Nursing Services immediately. We will notify the hospital after having arranged a replacement.
   b. Should you arrive for work and be cancelled, you will be compensated for four (4) hours pay. NOTE: You may be asked to remain on duty for the four hours, not necessarily on the unit that you have been originally assigned. Should you decline, it will be considered forfeiture of the compensation pay.
   c. If you are unable to complete an assignment because of illness or emergency, notify the Nursing Supervisor immediately as well as Allcare Nursing Services. Complete your time card and sign-in sheet accordingly.

d. Hospitals retain the right to cancel the nurse up to two hours prior to beginning of shift without penalty to them. If we have tried to reach you and you have been available and you report to work after the hospital cancelled you, you will be paid for your show-up time.

LUNCH BREAK POLICY

Employees who work excess of 10 hours are entitled to take two 30-minute meal periods. They are also entitled to waive one of those two meal periods as long as they sign a Meal Waiver. If an Employee misses their lunch period due to patient care and safety, Allcare Nursing Services, Inc.'s employee agrees to inform the charge nurse and have the supervisor sign off their approval on the sign-in sheet in the nursing office.

FLOATING POLICY

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

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

- The healthcare provider will immediately notify Allcare Nursing Services, Inc.,
- The Allcare Nursing Services, Inc. employee is obligated to inform the hospital of his/her professional limitations based upon the Nurse Practice Act standards and upon Allcare Nursing Services, Inc. client contract specifications as they relate to the assignment.
- The Clinical Liaison at Allcare Nursing Services, Inc. will work within the bounds of each discipline's Professional Association or State Governing Body and the client agreement to resolve the issue.
- Allcare Nursing Services, Inc. will pay healthcare professional for hours worked up until the end of his/her shift.
- Allcare Nursing Services, Inc. will pay nurse for hours worked up until the end of his/her shift.

UNUSUAL OCCURENCE

From time to time, interpersonal conflict may arise. It is important that you inform Allcare Nursing Services of such incidents as soon as possible.

Please follow these procedures in the events that a situation arises, which results in disagreement between Allcare Nursing Services employee and a representative of a client facility.

a. Avoid argument or confrontation. Maintain your professional demeanor, be calm and rational.
b. Call the Allcare Nursing Services office immediately. Speak with the Director of Nursing of designee. Describe the incident accurately.

c. As soon as your shift is complete, write and Unusual Occurrence Report describing the incident as accurate as possible. Note the date, time, place, and name of any witnesses present during the incident. Forward this report to the Allcare Nursing Services office within 24 hours of the incident.
d. Avoid any further comment of action after the above is completed. Continue with assigned task and complete work shift, if possible.
e. Allcare Nursing Services will not tolerate abuse of its personnel. We will explore every reasonable, fair, and peaceful method of alleviating conflicts and will be fully supportive of our own staff.
f. If you have any questions or concerns, please do not hesitate to call anyone of us.

PROCEDURES TO FOLLOW IN CASE OF INJURY ON THE JOB

Allcare Nursing Services, Inc. offers Workers Compensation insurance for its employees as mandated by the law. When an employee is injured at work, it is our duty to provide assistance, so the employee can return to work as soon as able.

When an injury occurs, the employee is to:

1. Report any incident promptly to the department supervisor and to Allcare Nursing Services.
2. In the case of an emergency situation, the employee is advised to go to the emergency department. Otherwise, Allcare Nursing Services, Inc. will advise the employee where to seek medical help.
3. A report of the injury must be made within 10 days in order for Workman's Compensation to cover expense.

STANDARDS OF CONDUCT

Standards of conduct are required for organization, mutual respect, and to promote efficiency, productivity and cooperation. Some types of conduct are impermissible and may lead to disciplinary action, possibly including immediate termination.

Although it is not possible to provide an exhaustive list of all types of impermissible conduct and performance, the following are some examples:

- Refusal to perform the duties of any job, within your classification assigned by a supervisor: deliberately delaying or restricting work or inciting others to delay or restrict work output.
- Any act which might endanger the life, safety or health of others.
- Threatening, intimidating, or coercing fellow employees.
- Sexual, verbal, physical, or visual forms of harassment directed at any person.
- Altering or falsifying entries on employee's time card, permitting another employee to make false entries on employee's time card, or approving incorrect entries.
- Willfully falsifying any Hospital record.
- Willfully destroying, damaging, defacing or stealing records, property, equipment, or the property of others on the Hospital premises.
- Disclosure of confidential information to unauthorized persons
- Bringing liquor, marijuana, narcotics, or other mind-altering drugs onto Hospital premises: consuming liquor or using marijuana, narcotics, or other mind-altering drugs on Hospital premises, or entering Hospital premises under the influence of liquor, marijuana, narcotics or other mind-altering drugs.
- Possessing or using explosives, firearms, knives or other dangerous weapons on Hospital premises, including the parking area.
- Failure to report to work for two consecutive scheduled working days, without proper notification and reasonable cause.
- Gross misconduct in the discharge of standards of work behavior or willful disregard of Hospital welfare, such as interference with Hospital operations or relationships with patients or employees.
- Insubordination: An unwillingness to submit to authority, a failure to acknowledge supervision, or a refusal to carry out a reasonable order. The following actions are considered insubordinate and will not be tolerated by any supervisor:
    - Physical or verbal abuse of a supervisor
    - Refusal to carry out a direct order
    - Failure to follow the Hospital's or the department rules and procedures.

Disciplinary Action

The following list includes examples of conduct which can result in **disciplinary action**. Disciplinary action generally reflects the degree of seriousness of the infraction, and one or more of the following actions may be taken: (1) verbal warning (2) written warning (3) suspension (4) termination.

- Excessive tardiness or absenteeism.
- Failure to observe department working hour schedules, shift start, shift end, rest and meal periods.
- Abuse of time during assigned working hours.
- Wasting time, intentional slowdown of productivity or intentional disruption of the work force.
- Failure to complete a time or record card as instructed.
- Repeated failure to wear employee identification badge while on duty.
- Failure to wear uniforms when required by policy.
- Failure to provide Agency with a current telephone number at which employee can be contacted.
- The use of foul or abusive language on Hospital grounds.
- Smoking within the confines of the Hospital building.
- Deliberate failure to observe safety rules and regulations.
- Distributing written or printed material of any description on Hospital premises during working hours in patient care areas.
- Posting of any materials by employees on Hospital property without authorization.
- Operation of gambling activities on Hospital grounds.
- Unsatisfactory work performance which includes: incompetence, inefficient or careless performance of duties, including failure to maintain reasonable standards of workmanship or productivity.

GENERAL STANDARDS

DRESS CODE GUIDELINES

To provide guidelines for professional appearance of the nursing staff of Allcare Nursing Services.

Nursing staff who fails to comply with dress code guidelines will be asked to return home without compensation until properly attired. Documentation of such an incident will be placed in employee's file.

1. General Considerations:
   - Clean, tidy appearance.
   - Clothing must be pressed and well-fitting.
   - Make-up should be natural and used in moderation.

2. Hair:
   - Hair shall be clean and groomed.
   - Shoulder length or longer hair shall be tied back.
   - Functional hair accessories only. Large bows, flowers, etc. are unacceptable.

3. Nails:
   - Nails should be clean and trimmed
   - Nail polish may be worn and must be free from peeling or chipping.
   - Nail polish is discouraged in the O.R.
   - Nails must be free from decorative objects (i.e, stones, initials, etc.).
   - Nail length shall not interfere with job performance responsibilities. If nail length becomes a problem with patient comfort or safety or with general employee responsibilities, the individual will be required to shorten his/her nails.

4. Jewelry:
   - Earrings - small styles including posts or hoops are acceptable.
   - Necklace - one small chain necklace with or without one small charm.
   - Rings - 1 ring per hand (wedding set is acceptable).
   - Watch - One professional looking watch.
   - One small gold or silver tone bracelet may be worn
   - In general, jewelry shall not be large or brightly colored. No nose jewelry will be allowed.

5. Identification Badge:
   - Name badge shall always be worn and be visible with picture showing.

6. Attire:
   Scrub or traditional uniforms may be worn within the guidelines listed below.
   a. Scrub Uniforms:
      - Scrub pieces, including cover-ups, must coordinate.
      - Coordinating turtlenecks may be worn under a scrub top.
      - Dresses may be white, solid color or pastel prints.
      - Lab-coat, jacket, or cover-up in uniform style may be white solid color/ pastel print.
      - No T-shirts, jeans, leggings, or sweatshirts will be allowed

SUBSTANCE ABUSE IN THE WORKPLACE

Employees who use or abuse drugs in the workplace cause costly problems for business and industry. In healthcare settings, habitual use of both legal and illegal drugs can not only cause problems for workers and their workplaces, but also for the patients who trust them with their care.

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

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

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

SEXUAL HARASSMENT AT WORK

It is the policy of Allcare Nursing Services to maintain a working environment free of sexual harassment and intimidation.

Federal and State laws provide that it is an unlawful practice for an employer to discriminate against any employee based on sex. Accordingly, sexual harassment of any employee violates such state and federal laws.

Sexual harassment includes, but is not limited to, unwelcome sexual advances, requests for sexual favors, and other verbal, visual or physical conduct of a sexual nature where:

a. Submission to such conduct is made an implied or explicit term or condition of employment.

b. Submission to or rejection of such conduct by an individual is used as the basis for employment decisions affecting such individual.

c. The conduct has the purpose or effect of substantially interfering with an individual's work performance or creating an intimidating, hostile or offensive working environment.

Allcare Nursing Services, Inc. maintains a strict policy which prohibits all forms of sexual harassment at the work place and covers all employees.

Anyone who feels they are being subjected to sexual harassment should promptly report the facts to the supervisor, or their designee.

The Employee Relations will promptly and confidentially investigate all such claims. The Employee Relations will recommend appropriate action to resolve the problem, which may include termination of any employee engaging in sexual harassment.

NONDISCRIMINATION POLICY

In accordance with Title VI of the Civil Rights Act of 1964 and its implementing regulation, Allcare Nursing Agency will, directly or through contractual or other arrangements, admit and treat all persons without regard to race, sex, color or national origin in its services and benefits, including assignments or transfers within the facility and referrals to or from the facility. Staff privileges are granted without regard to race, sex, color or national origin.

In accordance with Section 504 of the Rehabilitation Act of 1973 and its implementing regulation, Allcare Nursing Services will not, directly or through contractual or other arrangements, discriminate based on handicap in admissions, access, treatment or employment. The Director of Nursing has been designated as the coordinator for the implementation of this policy.

In accordance with the Age Discrimination Act of 1975 and its implementing regulation, Allcare Nursing Services will not, directly or through contractual or other arrangements, discriminate on the basis of age in the provision of services, unless age is a factor necessary to the normal operation or the achievement of any statutory objective.

WORKPLACE VIOLENCE

Healthcare providers routinely care for patients and visitors in a state of heightened emotional stress due to the illness/injury they or their loved one has suffered. When in this state, patients and visitors can become defensive, less tolerant and lose some process for rational thought. When confronted with long delays and often unsatisfactory solutions to their problem, they can act out.

A variety of forces can impact and trigger an incident of workplace violence or assault. Recognition of behavioral problems, prompt intervention, and strict enforcement of policies are the best solution to prevent these incidents.

There are four classifications of workplace assaults:

1. Customer-Client — These are simple, non-fatal assaults.
2. Criminal Intent — The assault is a result of an attempt to rob, steal or result of the commission of another crime. In this case, the assault is generally secondary to the intended crime.
3. Worker vs. Worker — These assaults can be extremely serious. Working in a stressful environment can create tension among employees.
4. Personal Relationships — These types of assaults are the result of personal relationships, otherwise known as domestic violence, which can interfere or jeopardize workplace safety.

The County of Los Angeles has a Zero Tolerance Policy for acts of workplace violence, including threats that do not rise to the level of physical violence. This policy requires mandatory reporting and discipline for any founded acts, regardless of criminal prosecution.

If one suspects an employee might commit an act of violence in the workplace, but no threats or assaults have been made, report the matter to one's supervisor immediately.

The key to prevention lies in intervention. If an employee is acting in an erratic manner or creating a hostile work environment, notify one's supervisor immediately.

Healthcare professionals are to be especially attentive to potentially violent situations and proper behavior to take if one should arise. It is of key importance to attend the facility's training sessions and to follow security protocols without exception. If an incident should occur, it is imperative to report it according to the facility's guidelines. Reporting incidents is an important tool in the prevention of future incidents. The actions of healthcare workers are critical in the prevention of workplace violence - recognizing a potential incident, dismissing a violent situation, and proper reporting after an incident has occurred.

Following Incidents

Following involvement in a violent incident, there are steps that healthcare workers should take. These steps may vary depending on the actual situation. Following are some general things of which healthcare workers should be aware:

- All incidents should be reported and logged immediately.
- They should receive prompt medical evaluation and treatment if necessary.
- Police should be notified.
- They should ask about their legal rights to prosecute the perpetrator

- To prevent similar incidents in the future, facility management may conduct debriefing meetings regarding the incident.
- It is recommended that they receive post-incident counseling and guidance.
- Offer input on any improvements that could be made.

Not all violent situations can be avoided or controlled. By staying calm and following basic guidelines, healthcare workers can help to prevent violent situations or bring a volatile situation under control. Workers are essential components for the maintenance of workplace safety and security.

BODY MECHANICS

GENERAL PRINCIPLES

- Keep the parts of the body as close to the vertical axis of the body as possible.
- Never remain in a bent position for long periods of time when the same results may be accomplished by an erect position.
- Keep a wide base of support by advancing one leg in front of the other. Use the largest, strongest, and greatest number of muscles when lifting. Utilize a mechanical advantage by bracing yourself.
- Make use of gravity and momentum whenever possible. Never lift a weight when you can slide it.
- Always assume a starting position that will allow unobstructed movement in range and direction.
- Whenever it is necessary to maintain a lower working position for a long period of time, kneel, do not bend.
- Always plan in advance with the patient and a helper, the exact method to be used in lifting or moving the patient.

LIFTING A WEIGHT

- Size up the object. Make sure it is not too heavy or bulky.
- Keep the parts of the body as close to the vertical axis as possible.
- Stand close to the weight you are going to lift.
- Keep a wide base of support by advancing one leg in front of the other.
- Keep your back straight and bend your hips and knees.
- Avoid quick and jerky movements.
- Lift upward by straightening your knees. Hold the weight as close to you as possible.
- Avoid twisting your body. Change direction by moving your feet.
- Get a good grip of the object.

TURNING A PATIENT IN BED

- Stand facing the patient with one leg advanced as close to the bed as possible.
- Shift your weight to the forward leg.
- Reach over the patient and take a firm hold of the patient's shoulder and hip that are the farthest away from you.
- Shift your weight from the forward leg to the backward leg as you straighten your elbows and roll the patient toward you.

MOVING THE SUPINE PATIENT TO THE NEAR SIDE OF THE BED

- The head and shoulders are moved first, then the hips and then the legs. Stand facing the patient with one leg in front of the other. The forward leg should be as close to the bed as possible.
- Shift your weight to the forward leg.

- Place your forward arm under the patient's upper trunk so that your hand controls the patient's opposite shoulder and supports the patient's neck. Extend your other arm under the patient's waist.
- Keep your back straight, flex both your hips and knees so that your shoulders are just above the level of the bed.
- "Rock" from your forward leg to your backward leg, thereby moving the patient to the side of the bed. The patient's body should ride on your forearms so that there is no rubbing of the skin. If the patient has decubitus, the patient should be lifted to the side of the bed to prevent further trauma. Move the patient's hips by placing your forward arm under the patient's waist and your other arm just below the patient's hips. Follow the above procedure.
- Move the patient's legs by placing the forward arm under the patient's thighs and your other arm under the patient's ankles. Follow the above procedure.

MOVING THE PATIENT UP IN BED

- Stand at the side of the bed, slightly facing the foot of the bed.
- Advance your leg which is farther from the side of the bed.
- Place one arm under the patient's shoulders, supporting the neck, and the other just below the patient's hips.
- If possible, the patient should assist in moving by flexing his knees and bracing his feet firmly on the bed.
- Shift your weight from your forward foot to your rear foot as the patient
- extends his knees and moves his body by synchronizing his movements with yours.
- If the patient is heavy and cannot assist, two people will be needed. The same procedure is followed with this addition: one person places his arms under the patient's shoulders and just
- above the patient's waist. The other person places one arm underneath the patient's waist and the other arm just below the patient's hips. Both persons move together.

MOVING THE PATIENT DOWN IN BED

- This procedure is the reverse of the above.
- If the patient can assist, he should be instructed to flex his knees and dig his heels into the bed as you shift your weight from the forward leg to the rear le

SAFETY MANAGEMENT

PATIENT SAFETY

Patient safety during hospitalization is a primary concern for each staff member. All nursing personnel are responsible for implementing safety measures. On admission and continuously thereafter, each nurse assesses his/her patient with regard to safety risks. The individualized plan of care will address safety needs and reflect ongoing assessment and interventions.

All patients admitted to the hospital are considered at risk for potential injury due to acuity of illness, medications and unfamiliar environment. Therefore, the patient will be assessed for safety risks on admission and throughout his stay, and the care plan will incorporate ongoing goals and interventions to provide an optimally safe environment for the patient.

The minimal standard of care shall include:

I. General Patient Safety on Nursing Units.

a. All patients will wear an identification band at all times. Nursing staff should verify correct spelling of patient's name, birth date, etc. Patients will be positively identified prior to administration of blood, medication, treatments, or examination by looking at the Identification Band and asking the patient his name.

b. All patients and their families will be oriented to their surroundings on the unit and in their rooms on admission and on transfer to another.

c. The call light will be within the patient's reach at all times. Nursing staff will instruct patient and family in its use.

d. Side rails will be available for both sides of the bed. The rails will be in a raised position whenever the nurse/physician determines that the patient is at risk for falls.

e. All patient-occupied beds are to be left in lowest position when nursing staff are not in attendance.

f. Wheels on bed, stretchers, wheelchairs, bedside commodes, and other rolling equipment should be locked when transferring a patient from one to the other.

g. Smoking is prohibited inside the hospital.

h. Postural Safety support! restraint may be used to prevent patients from falling or injuring themselves in accordance with the use of restraints policy of the hospital.

i. Patients with infectious diseases will be placed in isolation as appropriate.

j. Current American Heart Association Guidelines are followed for both ACLS and BCLS resuscitative measures.

k. Crash carts are checked each shift and readily available and restocked after each use.

FALL PREVENTION

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

A patient fall may also result in:

- Longer hospital stays
- Permanent injury
- Disability
- Death

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

- Orient patients to their surroundings.
- Show them how to use the call light and explain how and when to get assistance
- Ensure good lighting in rooms and bathrooms
- Keep beds at a low height
- Make sure path to bathroom is clear

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

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

<u>Infants and young children</u>

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

<u>Older adults</u>

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

<u>Sedated patients</u>

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

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

- The hospital environment
- Potential hazards
- Equipment being used.

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

Most injuries can be prevented!

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

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

Identify and correct safety hazards

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

FIRE SAFETY

Most hospitals fires are caused by people not things. Yet if you knew about it, you could prevent these accidents. About half of hospital fires are caused by careless smokers. Overused and undermaintained wiring and equipment are another source. More is at stake in a hospital fire than money or your job. Lives don't have a dollar value. Because evacuation is rarely practical in a hospital fire, sick and immobile patients need you to prevent fires and handle emergencies.

These accidents really happen:

- employee empties hot cigarettes into wastebasket, igniting the contents.
- outside workman drops a butt into a laundry chute which has been wedged open.
- overload outlet causes a cord to ignite.
- sparking toy ignites a bed in an oxygen tent.

Here are the worst hazards and what you can do about them:

Smoking:

- Warn transients like workman and visitors of special smoking dangers.
- Stop violators.
- Smoke in designated areas.
- Have large ashtrays in smoking areas.
- Collect cigarettes in butt containers.

Electrical:

- Check outlets, cords, and appliances for signs of wear and tears.
- Use extension cords approved by the building engineer. Don't overload outlets.

Your everyday cares:

- Take fire drills seriously. Repetition reinforces the correct response to a fire.
- Turn in the alarm at the first hint of smoke or fire--no guesswork.
- Learn fire alarm locations. Know how to find them in the dark.
- Learn to operate extinguishing equipment. Know how/when to help patients to safety.
- Know how to shut off electric power, oxygen, and gas supplies if you are asked.
- Know your assignment in a fire emergency.
- Observe and promote smoking rules.

- Challenge the presence of unauthorized persons in restricted areas.
- Look for and report electrical hazards or equipment that isn't working right.
- Keep your area clean and neat.

What to do in a fire:

- Rescue patients in immediate danger.
- Turn in alarm according to procedures.
- Close room doors and hall doors to stop air movement and smoke spread.
- Fight the fire with the right extinguisher or smother flames with blanket.
- Show calm. Tell patients that emergency plan is operating. Your self-assurance and good judgment prevent patient panic.

Check your work station for major sources of fire:

PATIENTS' ROOM, OFFICES, and PUBLIC AREAS

- No smoking near oxygen. Warn visitors.
- Devices which make heat (lamps, etc.) not near bedding and other things that burn.
- Electrical appliances and cords checked often and don't show wear and tear.
- No wires in doorways, windows, under rugs.
- Electrical outlets not overloaded.
- Appliances or toys brought in by patients or visitors checked for safety. No flammable or spark-producing toys allowed.

HALLS, DOORWAYS, STAIRS

- No smoking in these areas.
- All doors, stairs, corridors unobstructed.
- Exits marked with lighted exit signs.
- Emergency lighting works properly.
- Doors not held open with wedges.
- No cords through doorways, down stairs.

Follow these steps when using a fire extinguisher:

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

ELECTRICAL SAFETY

1. Before each use of any electrical device, inspect the power cord and plug for broken insulation, loose screws, or bent prongs. Special attention should be given to the point where the cord and plug join, as well as the location where the cord enters the device.
2. Water is a conductor of electricity. Do Not place liquids on top of electrical devices. Do Not set equipment on wet areas. Do Not use equipment on which liquids have been spilled. Do Not touch electrical equipment with wet hands.
3. No personally owned line powered electrical equipment should be brought into a hospital without first having the equipment checked by the electrical maintenance department.
4. No adapters or two (2) wire or two (2) pronged electrical devices should be brought into a hospital.
5. Electrical extension cords may be used only on a temporary basis and must be three (3) wire.
6. Any malfunctioning equipment should be immediately taken out of service and reported to the electrical maintenance department.
7. Electrical equipment use around the following types of patients electrically sensitive, requires special precautions. These patients have central pressure lines and external pacemakers.
    a. A small amount of electrical current (less than a normal person could feel) can travel through fluid filled catheters and external pacemaker wires to cause cardiac fibrillation.
    b. Do not use extension cords, unless approved for hospital use.
    c. Keep pacemaker wires and terminals insulated and dry. Use rubber gloves when manipulating pacemaker leads, connectors, and batteries.
8. The following precautions must be followed when using a defibrillator.
    a. The patient's chest must be dry. If the chest is damp, the discharge may pass over the body, not through it.
    b. For your safety, be sure the paddle handles are dry.
    c. Do not stand on anything wet.
    d. Do not touch the patient, or any conductor touching the patient.
    e. Be sure oxygen therapy is discontinued during defibrillation. Alcohol is a flammable liquid, be cautious when using it to clean paddles.

RADIATION SAFETY

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

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

ENVIRONMENTAL SAFETY

In every facility, it is important to follow security procedures. By taking simple security precautions, you can help to:

- Protect personal, patient, and institutional property
- Maintain a safe environment.

Personal Property

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

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

Patient Property

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

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

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

Institutional Property

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

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

"Security-sensitive" Areas

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

Security-sensitive areas may include the following:

- Pharmacy

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

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

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

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

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

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

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

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

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

CHEMICAL SAFETY

Allcare Nursing believes that every employee has the right to be informed about the different kinds of chemicals used in patient care and their surroundings. This could be as simple as cleaning agents or as complex as chemotherapy drugs.

UNDERSTANDING THE MATERIAL SAFETY DATA SHEET (MSDS)

An MSDS contains necessary safety information for proper management of hazardous materials. In addition to the MSDS, the manufacturer's product label is a fast and easy way to obtain information about how to work safely with a specific product.

Hazardous Substance Emergencies and Communication

Regardless of the type of work area, healthcare professionals could potentially face emergencies involving hazardous material, defined as material that is flammable, explosive, toxic, noxious, corrosive, biological, oxidizable, or radioactive. The source may be external - coming from a local chemical plant - or it may come from within the facility. The facility's emergency action plan should address these possibilities. Most healthcare facilities use and store some of the above-mentioned hazardous materials. They are therefore required by OSHA's Hazard Communication Standard (2 CFR 1910.1200) to inventory these materials, keep the manufacturer-supplied Safety Data Sheets (SDS) accessible to workers, label containers with the specific types of hazards that may be encountered, and train employees in ways to protect themselves against these hazards.

OSHA's Hazard Communication Standard (HCS) was revised in March 2012 in order to align with the United Nations' Globally Harmonized System of Classification and Labeling of Chemicals (GHS). New standardized label elements and Safety Data Sheets (SDS) requirements, two significant changes, were implemented on December 1, 2013, to improve worker understanding of hazardous chemicals found in the workplace.

Information on the label can be used to ensure proper storage of hazardous chemicals, as well as to help workers quickly locate first aid information when needed by employees or emergency personnel. The new labels and SDS will include the

- Product Identifier – Selected by the manufacturer, importer, or distributor, this identifier can be (but is not limited to) the chemical name, code number, or batch number.
- Signal Word – Used to indicate the relative level of severity, these words alert the worker to a potential hazard. There are only two signal words –"Danger" (for more severe hazards) and "Warning" (for less severe hazards). No matter how many hazards a chemical may have, there will be only one signal word per chemical – the one denoting the most severe of the potential hazards.
- Pictogram – Indicating the hazard category, at least one of the designated eight pictograms must be on each label. These pictograms are in the shape of a square set at a point, including a black hazard symbol on a white background with a red frame wide enough to be visible. Diagrams not fitting this description are

not permitted on the label. Multiple pictograms may appear on the label to depict the various hazards of an individual chemical.

- Hazard Statement – Describing the nature of the hazard of a chemical and the degree of hazard (where applicable), all applicable hazard statements, specific to the hazard classification category, must appear on the label. The same statement should always appear for the same hazard, without regard to chemical name or producer.
- Precautionary Statement(s) – Describing recommended measures taken to minimize or prevent adverse effects resulting from exposure to a hazardous chemical or improper storage or handling, these statements are required to appear on the label. When there are similar statements applicable to the chemical, the one that provides the most protective information will appear on the label.
- Name, address, and phone number of the manufacturer, distributor, or importer of the chemical.

Healthcare workers may need to use personal protective equipment (PPE) during an emergency. Facilities will supply the PPE and training about how and when to use it. PPE may include

- safety glasses, goggles, or face shields for eye protection;
- hard hats and safety shoes for head and foot protection;
- proper respirators;
- chemical suits, gloves, hoods, and boots for body protection from chemicals;
- special body protection for abnormal environmental conditions such as extreme temperatures;
- any other special equipment or warning devices necessary for hazards unique to the work site.

GENERAL EMERGENCY SPILLS AND EXPOSURES

A. Exposure
   1. Irrigate the contacted area with water.
   2. Immediately go to the Emergency Department and bring information about the spilled material (MSDS or container with label).

B. Spill
   a. If you know what you are dealing with, if the hazard is minimal and you are trained in clean-up, follow the prescribed procedure.
      Examples are:
      - A Pathology technician cleaning up an acid spill with acid absorbent
      - A nurse cleaning up a minor formalin spill with Formalex
      - A Mechanical employee cleaning up a minor diesel spill with vermiculite
      - A nurse cleaning up a manageable chemotherapy spill with a designated kit

   b. If the hazard is too great or if you are not trained or if you do not have any information about the chemical or are for any other reason unsure:
      - Alert other employees and the supervisor to the area of the hazard
      - Remove all persons from immediate danger and leave the area
      - Place a notice on the door to the room

REPORTING

A. Report a spill or incident to your supervisor. Report to your supervisor even if you've cleaned it up. It is important for follow-up and JCAHO reporting.
B. Report an industrial injury to your supervisor and to Employee Health
C. Report a threatened release or spill to your supervisor and the Safety Officer.

CHEMOTHERAPY/ANTINEOPLASTIC DRUG SAFETY

A. Introduction

I. Only registered nurses who have successfully completed a chemotherapy administration course are allowed to administer chemotherapy. However, it is important that all staff providing direct patient care be familiar with chemotherapy drug safety.

2. Exposure of healthcare personnel to these drugs as well as other substances in the healthcare setting has become of increasing concern in recent years. It is known that exposure to these drugs when administered for therapeutic reasons can have mutagenic (damage to chromosomes and cells), teratogenic (damage to the developing embryo or fetus) and/or carcinogenic (promote cancer development) effects.

Exposure to chemotherapy drugs can occur during:
a. Drug preparation
b. Drug transport
c. Drug administration and disposal
d. Direct contact with body fluids of patients receiving such drugs
e. IV spills from tube connections

B. Drug safety

1. Exposure during drug preparation can occur by absorption through the skin, inhalation of fumes, aerosols or powder or by ingestion of food or water if contaminated when located in the immediate area. Pharmacists and pharmacy technicians are at greatest risk of exposure due to the amount of their contact with chemotherapy. Preparation of chemotherapy drugs is therefore restricted to the pharmacy where special facilities and protocols can be implemented. Food and beverages are not allowed in the immediate area where chemotherapy drugs are prepared.

2. Once the chemotherapy is prepared for administration whether in the syringe or solution form, the preparations are placed in a clear plastic bag and then double-bagged in a yellow plastic bag labeled "Caution-Chemotherapy" before dispensing to the clinical area.

C. Handling of body fluids

1. Safety precautions must be considered when handling body fluids of patients who have received chemotherapy in the previous 7 days. Body fluids include blood, vomitus, urine or feces.

2. Universal or Standard Precautions include the use of chemotherapy gloves which are a direct barrier to skin exposure. Wearing a disposable long-sleeved and closed-front gown which is discarded after every use may be indicated in some situations where splatter or spray is possible.

D. Accidental exposure and spills

Accidental exposure requires immediate attention. When direct contact with chemotherapy occurs, remove contaminated gloves or gown and thoroughly cleanse the skin with soap and water. If eye exposure has occurred, a five-minute eyewash with water or an isotonic eyewash solution is recommended. Follow-up medical attention may be indicated.

EMERGENCY PREPAREDNESS

In addition to fire, there are other emergencies for which healthcare workers should be prepared in the workplace. Different hazards may be present in different units, and some hazards may be universal to all areas. It is the facility's responsibility to orient a worker to the various potential hazards in each work area and the worker's expected response. Workplace emergencies may be natural or man-made and may include:

- floods;
- hurricanes;
- earthquakes;
- tornadoes;
- toxic gas releases;
- chemical spills;
- radiological accidents;
- explosions;
- terrorist attacks;
- civil disturbances/ violence.

Emergency Action Plan

Similar to a fire safety plan, an emergency action plan will be in place. This plan will instruct all workers in

- the method for reporting emergencies;
- an evacuation policy and procedure;
- emergency escape procedures;
- names, titles, departments, and telephone numbers of individuals - both within and outside the facility - to contact for additional information or explanation of duties and responsibilities under the emergency plan;
- the procedure for employees who remain to perform shutdown of critical plant operation, operate fire extinguishers, or perform other essential services that cannot be stopped before evacuating;
- rescue and medical duties for workers designated to perform them;
- an assembly location and procedures to account for all those persons evacuated.

Emergency Alert System

Being prepared for an emergency includes recognizing the alert system in place in the workplace. The emergency alert system should

- be distinctive and be heard, seen, or otherwise perceived by all employees - including disabled workers - as the signal to either evacuate or perform specified actions;
- make available an emergency communications system, such as a public address system portable radio unit, to notify employees of the emergency and to contact first responders from law enforcement, emergency medical personnel, and the fire department.

Evacuation

In an emergency, healthcare workers may be required to evacuate the facility or remain to assist others. When an evacuation is required, all workers should be knowledgeable of the evacuation plan which should include:

- conditions under which an evacuation would be necessary;
- a clear chain of command;
- specific routes and exits;
- procedures for assisting others, including patients and disabled personnel;
- designation of the person responsible for shutting down vital operations and at what point that person should also evacuate;
- a system to account for patients and personnel following an evacuation.

Training

As part of orientation, healthcare workers will receive training about the various types of potential emergencies that may occur in their specific work areas and the proper course of action. Emergency preparedness training will include

- the worker's individual role and responsibilities;
- types of threats, hazards, and protective actions;
- notification, warning, and communications procedures;
- emergency response procedures;
- evacuation, shelter, and accountability procedures;
- location and use of common emergency equipment;
- emergency shutdown procedures;
- documentation in the facility's records that workers have completed training.

EARTHQUAKE/DISASTER PREPAREDNESS

1. Attempt to familiarize yourself with the facility/unit earthquake preparedness plan. You can reduce injuries to co- workers and patients and lessen the possibility of panic after the disaster has occurred by planning for all eventualities.
2. At least 2 persons in each unit or on each floor should assume leadership roles after the disaster has occurred it is the facility's responsibility to be sure they are properlytrained.
3. Understand how to protect yourself (and patients if possible) during an earthquake: Get under a desk or table or stand in a doorway away from the glass. Do not leave the building during thequake.
4. Attempt to locate and have available for immediate use, the telephone numbers and alternative means of communication with public safety agencies. When given the chance, participate in drills; take advantage of the opportunity to prepare for possible disasters.
5. In medication rooms, patient rooms, clean and dirty utility rooms be aware of high or top-heavy shelves, cabinets, machinery or any other equipment that could fall during a tremor. Heavy objects should not be on top shelves but stored in lower places.

6. Be aware of possible necessity to shut off lights, gas and water.
7. Attempt to locate several alternate routes of evacuation in the various parts of the unit and or facility, should you need to leave your work area because it is unsafe.
8. Consider the possibility that you may not be able to leave the premises and attempt to locate supplies on hand that may be needed.
9. Provide assistance for physically compromised patients and co-workers who are unable to leave the building without the aid of another person.
10. Attempt to locate areas of the facility that may be suitable as shelter areas should employees and patients be required to stay there after the disaster.
11. Attempt to locate contingency plans for continued operation of the hospital based on total and/or partial shut downs due to building/utility/communication/transportation failures. Try to identify key personnel, communication systems, utilities and other support needs for 24 hours, 72 hours, one week and one month, if available.
12. Organize Interdisciplinary Team and patients for whom they are responsible and determine what steps are to be taken in accordance with the hospital's earthquake plans.
13. Immediately check for injuries among fellow workers and render first aid as needed. Seriously injured persons should not be moved unless they are in danger of further injury. Be sure your entire area is checked for injured.
14. Check for fires and fire hazards, especially for gas leaks and damaged electrical wiring.
15. See that these are turned off at main vales and switches if required. Check for building damage and move patients to safe areas.
16. Do not use elevators or to run into the street.
17. Flashlights should be used if power is off, since sparks from a match or light switch could ignite leaking gas.
18. Immediately clean up dangerous materials that may have spilled.
19. After a major earthquake prepare for aftershocks which will be occurring and may cause more damage.

No one expects an emergency or disaster. However, it is a simple fact that emergencies do occur and can strike anyone, anywhere, at any time. Healthcare workers may be called to action when they least expect it. The best way to protect everyone in the work area is to be knowledgeable of the facility's emergency action plan and to expect the unexpected. With training and a full understanding of the emergency action plan, workers will be well-prepared to respond.

THE JOINT COMMISSION NATIONAL PATIENT SAFETY GOALS - HOSPITAL

The purpose of The Joint Commission's National Patient Safety Goals is to promote specific improvements in patient safety. The goals are provided in hospitals and describe evidence and expert-based consensus as solutions to these problems.

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

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

Use medicines safely
NPSG.03.04.01 Before a procedure, label medicines that are not labeled. For example, medicines in syringes, cups and basins. Do this in the area where medicines and supplies are set up.
NPSG.03.05.01 Take extra care with patients who take medicines to thin their blood.
NPSG.03.06.01 Record and pass along correct information about a patient's medicines. Find out what medicines the patient is taking. Compare those medicines to new medicines given to the patient. Give the patient written information about the medicines they need to take. Tell the patient it is important to bring their up-to-date list of medicines every time they visit a doctor.

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

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

Identify patient safety risks
NPSG.15.01.01 Reduce the risk for suicide.

Prevent mistakes in surgery
UP.01.01.01 Make sure that the correct surgery is done on the correct patient and at the correct place on the patient's body.
UP.01.02.01 Mark the correct place on the patient's body where the surgery is to be done.
UP.01.03.01 Pause before the surgery to make sure that a mistake is not being made.

Sources:

https://www.jointcommission.org/-/media/tjc/documents/standards/national-patient-safety-goals/2022/simple_2022-hap-npsg-goals-101921.pdf

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NURSING ESSENTIALS

UNIVERSAL PRECAUTION

The purpose of these precaution is to protect the caregiver from bloodborne pathogens and prevent the transmission of infectious agents between the caregiver and patients.

All health care providers will practice Universal Precautions at all times and in all settings. They shall use barrier devices provided for their safety when having direct contact with patients, their body fluids or articles soiled with their body fluids. (Federal Bloodborne Pathogen Rule Title 29 - 1910 amended).

1. Hands and other skin surfaces must be thoroughly washed with soap and water immediately following exposure to blood and other body fluids.

2. Gloves shall be worn when handling all blood and body fluids and while performing procedures where there is a potential for exposure such as a venipuncture and other vascular access procedures.

3. Gloves shall be removed, and hands washed following direct care with individual patients.

4. A barrier gown shall be worn to protect clothing whenever there is a likelihood of clothing becoming soiled with blood or body fluids.

5. Protective eye wear and surgical mask shall be worn whenever there is a likelihood of splashing blood or body fluids into the eyes or mouth.

6. Surgical entry into tissues, cavities or organs (invasive procedures), shall require the wearing of a barrier gown, gloves, surgical mask and protective eye wear or face shield.

7. Ambu bags, airways and other ventilation devices may be kept at the patient's bedside in case of impending resuscitation.

8. All specimens shall be enclosed in a plastic bag before being transported to the laboratory.

9. Extreme caution shall be taken to prevent percutaneous injuries from needles and other sharp instruments. All sharps and used needles must be discarded in the sharps disposal container. Do not recap or bend needles. Securely seal sharp containers when 2/3 full and place in an appropriate area for pick up.

10. All disposable items shall be discarded in the appropriate trash container.

11. All parenteral and mucous membrane exposure must be reported immediately to the Agency and the immediate supervisor of the facility.

ISOLATION POLICY

All health care providers who have contact with patients who are diagnosed with an infection or suspected of having a disease or infection which require institution of special precautions or isolation, shall comply with the specific isolation precautions in addition to Universal Precautions.

1. Place isolation sign in door or in highly visible location to all persons entering the room/unit.
2. Collect appropriate items/equipment that are needed for the specific isolation.
3. Place inside the room (as appropriate for type of isolation):
    a. Patient care equipment/supplies for immediate use.
    b. Gloves
    c. Sharps container
    d. Linen hamper with lid
4. Place on cart outside room (as appropriate for type of isolation):
    a. Isolation gowns (cuffed long sleeve)
    b. Masks
    c. Gloves

HAND HYGIENE

Hand hygiene is one of the best ways that healthcare professionals can reduce their risk of acquiring or transmitting infection on the job. They should always wash your hands with soap and water or decontaminate them with hand sanitizer between patients, upon completion of a task, with breakage of gloves, and after removing gloves. Hand hygiene does not eliminate the need for gloves when their use is appropriate; gloves will further reduce hand contamination. Conversely, the use of gloves does not negate the need for proper hand hygiene. Both hand hygiene and the use of gloves is necessary to enable healthcare professionals to offer the highest level of protection against infection to patients. Patients may be encouraged to participate in monitoring compliance with hand hygiene.

Each work area should be supplied with a convenient handwashing station or another means of hand decontamination (e.g. hand sanitizers) until handwashing facilities are available. When handwashing facilities are available, healthcare workers should wash their hands as soon as possible. If blood or potentially infectious material makes contact with their skin or mucous membranes, they should immediately wash the exposed area with soap and water or flush the mucous membranes with water.

There are two procedures described by the CDC for good hand hygiene: handwashing and hand decontamination. Good handwashing technique includes:

- using comfortably warm water and soap (either antibacterial or non-antibacterial);
- washing hands and wrists under running water for 30 seconds;
- washing under fingernails and rings;
- rinsing thoroughly and drying carefully with paper towels.
- turning the faucet off with a clean paper towel and discarding the used paper towels.

Healthcare workers should also keep their fingernails to less than ¼" long when caring for patients and avoid wearing artificial nails in the healthcare setting. Patients often have a weakened immune system, which puts them at high risk for infection. Long natural or artificial nails can transmit pathogens to patients despite the use of good handwashing technique and cause them to become even more ill than they originally were.

HAND DECONTAMINATION

Hand decontamination is appropriate only for those clinical situations in which the hands are not visibly soiled with potentially infectious material (e.g. blood, feces, or other body fluids). Hand decontamination can be done by using a preparation with a concentration of 60-95% ethyl alcohol or 0.1% benzalconium chloride, two types of full-spectrum sanitizers. Preparations containing triclosan kill bacteria, but not viruses.

In addition, consideration must be given to product characteristics that can affect acceptance, and therefore, usage of a hand sanitizer (e.g. smell, consistency, color, and the effect of dryness on hands). Hand sanitizers take very little time to use, save time for busy healthcare professionals, and work quickly to eliminate a wide variety of microbes. Contact dermatitis caused by the sanitizers is very uncommon.

To effectively use decontaminants, healthcare workers should vigorously rub the solution into their hands and continue to rub until their hands are completely dry. The use of hand sanitizers does not eliminate the need for washing with soap and water, but they do provide a convenient and safe way to eliminate the transfer of infectious materials from the hands. The guidelines for the use of hand rubs include the following:

- Ensure that the hands are not visibly soiled; if they are not, proceed with use of hand sanitizer.
- Apply the product to the palm of one hand in the portion recommended by the manufacturer.
- Rub the hands together until they dry, covering all surfaces of the hands and fingers.

Good hygiene practices include minimizing splashing, spraying, spattering, or generating droplets of any potentially infectious material. In addition, the following tips are important:

- Never eat, drink, smoke, apply cosmetics or lip balm, or handle contact lenses in work areas. Healthcare workers should ask their supervisors what areas have been set aside for these activities.
- Never mouth pipette/suction any blood or potentially infectious material.
- Never keep food or drink in refrigerators, freezers, shelves, cabinets, counters, or benchtops where blood or other potentially infectious materials are present.

SHARPS INJURIES

Sharps injuries are one of the most common occupational injuries that healthcare professionals experience. In 2010, it was reported that there were approximately 385,000 needlesticks and sharps-related injuries among hospital-based workers, not including similar injuries to healthcare professionals in nursing homes, clinics, emergency services, and homes. [8] "Sharps" are objects that can penetrate the skin or mucous membranes; they include needles, scalpels, broken glass, capillary tubes, and exposed ends of dental wire. Introduction of bloodborne pathogens through piercing of the skin or mucous membranes most commonly occurs when the healthcare professional is stuck by one of these sharp objects. In order to prevent sharps injuries on the job, workers should follow these guidelines:

- Never break, shear, bend, or recap needles. If recapping is required, use a one-handed method or mechanical device only.
- Promptly dispose of any used sharp in an appropriate container.
- Never reach into a sharps container for any reason. If it is full, the supervisor should be notified. Never try to squeeze "just one more" into the container.
- Never place a used sharp on the patient's bed, bedside tray, table, or any other surface where healthcare workers or anyone else may accidentally be injured.
- Never dispose of a used sharp in a trash can or any other receptacle other than the appropriately labeled, puncture-resistant, leak-proof, closeable container.
- Plan for the safe handling and disposal of sharps before using them.
- Never remove a used needle from a syringe by hand.
- Use needle-free systems, self-sheathing needles, or sharps with injury protection devices whenever possible. Suggest any of these devices to the supervisor when they are appropriate but not available.
- Report any sharps injury hazards in the workplace and offer helpful suggestions.
- Volunteer to help evaluate and select any devices that the facility may be considering to help reduce the risk of sharps injuries.
- If a sharps injury occurs on the skin, the area should be immediately washed with soap and water. If the injury occurs on a mucous membrane, flush it with clear water.
- Immediately report any sharps injury to the supervisor and fill out an incident report. Report the injury to the direct supervisor by the end of the shift. Completion of this form is necessary in some healthcare facilities for the receipt of Workers' Compensation benefits.
- Report any sharps injuries observed by healthcare workers.
- Carefully clean up any broken glass using a dustpan and brush, tongs, forceps, or another mechanical device. Never directly clean up the residue with bare hands. Wear eye protection during cleanup.
- Participate in training for the use of needlestick prevention devices. Healthcare workers should be sure they are comfortable with the use of the devices already in practice at their facilities.

The task of the housekeeping staff is to maintain a clean, safe, and sanitary environment. However, cleanliness and safety require a team effort, and therefore, it requires the participation of every healthcare worker. Here are ways

that healthcare workers can help:

- Clean any equipment and work surfaces with the designated disinfectant immediately following contact with blood or potentially infectious material.
- Place soiled laundry in color-coded, leak-proof containers without rinsing or sorting.
- Limit handling and agitation of laundry. Use gloves and other PPE if necessary.
- Carry filled laundry and trash bags away from the body.
- Never use the hands or feet to compact trash.
- Replace protective coverings on surfaces and equipment immediately following contamination or at the end of the shift.
- Recognize biohazard signs on bags or equipment as a warning of blood or potentially infectious material contamination.
- A fluorescent orange-red biohazard sign on a door indicates that handling of potentially infectious materials takes place inside. The special requirements on the sign should be reviewed before entering.

POST-EXPOSURE PLAN

If healthcare workers should experience an exposure to bloodborne pathogens, they should not panic. Instead, they should follow the steps listed below:

1. Wash the affected area with soap and water or flush affected mucous membranes with clear water.
2. Immediately report the exposure to facility management and seek emergency treatment from the facility-appointed licensed healthcare provider.
3. Begin treatment, if needed and chosen, within 1-2 hours of exposure, as written in the facility protocol.
4. Document the exposure for the facility and the company by completing an incident report.
5. Notify the direct supervisor as soon as possible so that a Workers' Compensation claim can be started.
6. Be sure to take advantage of all recommended follow-up care. Keep the direct supervisor updated on a frequent basis regarding follow-up care.

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MEDICATION ERROR PREVENTION

A medication error is a preventable event which causes incorrect medication administration and potential harm to the patient.

Medication errors contain multidisciplinary factors, which increases the possibility of an occurrence. Errors may involve the manufacturer, prescriber, dispenser (e.g. pharmacist. pharmacy technician), and/or administering individual (e.g. nurse, therapist). Places along the chain of drug delivery in which an error may occur include

- drug naming, labeling, packaging and distribution;
- prescription and communication of orders;
- compounding;
- dispensing;
- administration and usage;
- education;
- medication monitoring.

The purpose of drug therapy is to improve the quality of life for the patient. When a medication error occurs, this goal is often unrealized, and there may be many who suffer, including the patient, the patient's family members, and the healthcare professionals involved. When an error is reported or discovered, the facility's administration and any agencies to which the facility must report medication errors become involved. It is important to avoid making the discovery of a medication error a punitive event, but rather, it should be used as an opportunity to discover where the process of medication delivery can be improved.

TYPES OF MEDICATION ERRORS

Because of the many elements involved in the process of delivering medication to patients, there are many different errors that may occur. Some examples of errors include

- defects in manufacturing of a drug or drug delivery system (e.g. IV tubing, pump);
- ordered dosage of a medication that is either too weak, too strong, or that may react dangerously with another medication the patient is taking;
- order or administration of a drug to which the patient has an allergy;
- dispensing or administering the wrong medication, wrong medication strength, or wrong dosage;
- administration of medication by the wrong route, at the wrong time, or to the wrong patient.

Errors may also be caused by

- insufficient drug information (e.g. insufficient working knowledge/availability of information regarding the drug being administered);
- insufficient patient information (e.g. allergies, medical status, and any other medications being taken including herbs, vitamins, and other supplements);
- ineffective communication (e.g. failure to use common and well-known abbreviations, unclear handwriting, stray marks construed as decimal points, computer input errors, misunderstanding of phone orders, or improper communication of sound-alike drugs);
- deficiency of well-rested staff who are practicing in a focused atmosphere;
- improperly stored medications (e.g. look-alike/sound-alike drugs not stored in separate locations, dosages/medication strengths not clearly identified).

The effect of a medication error on a patient may range from little or no effect to devastating physiological and emotional repercussions and/or death. These effects may impact not only patients, but also their family members.

It is never easy to admit a mistake of any kind, but it is particularly difficult to report a mistake that may potentially

cause people's lives and livelihood to be at risk. This is often the reason medication errors go unreported. There is also a natural fear of blame and recrimination. No one likes the notoriety of having made a mistake. Having made medication errors may make it difficult to continue to work with other healthcare professionals who may question the ability of the worker to perform competently.

Many professionals fear losing their jobs, notations on their personnel files, and potential legal action. It often seems easier and safer not to report the incident. This unfortunate choice makes the process of eliminating medication errors even more difficult, because the error can neither be analyzed nor can systems be put in place to prevent similar errors from occurring in the future.

PREVENTING MEDICATION ERRORS

No single strategy is enough to prevent medication errors. Much like a safety net, many layers of preventive efforts will help to catch mistakes before they happen. You can help to prevent medication errors by understanding the system of root cause analysis: a step-by-step method to understand what went wrong, where improvements can be made, and how to monitor the changes made. A root cause analysis is *not* about placing blame, but a matter of making improvements. For medication errors, The Joint Commission (TJC) requires each root cause analysis to investigate patient identification procedures, staffing, and the staff orientation/training process.

In order to investigate staffing, it may be helpful to consider the following questions:

- Is there enough staff for patient census?
- Is overtime limited?
- Is the patient assignment and/or unit suitably matched to staff?
- Are supervisors available when needed?
- Are policies and protocols understood and monitored on a daily basis?

Orientation and training procedures may be evaluated by considering these questions:

- Is orientation/training ongoing and always available to staff regarding new medications and methods of administration?
- Are prescriptions written and dispensed by properly credentialed professionals?
- Is orientation of staff completed and documented?
- Is the actual assessment of staff medication administration included as part of an employee's review?
- Are written instructions unambiguous and exchanges between staff non-threatening?

In order for a root cause analysis to take place, the error must first be reported. Healthcare professionals must be familiar with the procedure for reporting errors at their facilities and report any error as soon as possible. Timely reporting will make it easier to reverse any negative effects and to determine what went wrong while the event is still fresh in the minds of everyone concerned. This will greatly increase the effectiveness of the root cause analysis. The error report should be kept confidential. If only appropriate staff members are made aware of the report, healthcare workers should be treated fairly and their assistance should be rewarded.

Utilizing the following strategies will also help to prevent errors:

- Use a system of checkpoints along the medication delivery route, such as in the following examples:
  - Nurses must verify correct medication and dosage three times before administration.
  - Nurses must double check the order that was transcribed by the unit secretary.
  - Pharmacists must double check the pharmacy technician's transcription and any medications dispensed.
  - Patients, as capable, may confirm their identities and the medications being received.
- Separate look-alike/sound-alike medications and store them in well-lighted, non-distracting areas away from toxic materials.

- Remove dangerous or high alert drugs from stock or label them distinctly.
- Use a system of double-checking certain high-alert drugs before administration, such as
  - neuromuscular blocking agents;
  - opioids;
  - concentrated potassium chloride;
  - magnesium;
  - chemotherapy drugs;
  - heparin;
  - insulin;
  - warfarin.
- Check medication expiration dates and discard expired drugs.
- Use unit dosing whenever possible.
- Avoid use of multiple-dose vials.
- Ensure that medication transcription and preparation areas are free from distraction.
- Take time to check and re-check the ordered medication, dosage, route, and time. Stay focused on the task at hand and don't rush!
- Know everything possible about the drugs to be administered, including information from seminars, journals, reference material, and package inserts.
- Use the 'read back' method when taking verbal orders - carefully read the order back to the prescriber to verify it has been written correctly.
- Have a colleague double-check dosage calculations.
- Use reference charts for infusion calculations or allow an infusion pump to do the calculation whenever possible.
- Set a standard routine when giving meds that includes checking the patient's identity and allergies.
- Review the patient's lab values and vital signs before medication administration.
- Utilize a set standard of abbreviations, excluding look-alikes such as od, qd, and qid. When in doubt, clarify!
- Type patient instructions whenever possible.
- Enlist the assistance of patients! Good patient teaching - especially drug name, dosage, and timing - will help patients to detect and help prevent errors and omissions. Teach patients to state their names and present their l.D. bands routinely before meds are given, and teach them to question the meds being given.

UNSAFE ABBREVIATIONS

Both TJC and the Institute for Safe Medication Practices (ISMP) recognize the fact that there are many common abbreviations related to medication administration that may be misunderstood when used in verbal, written, or computerized communication. In an attempt to prevent medication errors caused by unclear communication, TJC has published a list called the Official "Do Not Use" List [1], and the ISMP has published an expanded list of additional abbreviations called "ISMP's List of Error-Prone Abbreviations, Symbols, and Dose Designations" [2]. All of the listed abbreviations have been misinterpreted and involved in serious medication errors.

TJC's Official "Do Not Use" List appears in its entirety below. In facility efforts toward full compliance with the TJC

Health Care Staffing Services (HCSS) standards, it is every healthcare professional's responsibility to provide safety in all aspects of patient care, including charting. The abbreviations in the list below may *not* be used in charting; this requires 100% compliance in written and free-text computer entry of medication-related documentation and on pre-printed forms. As of mid-2012, TJC has not made this directive a requirement for pre-programmed health information technology systems (e.g. electronic medical records and CPOE systems), but it is a consideration for the future. [1]

OFFICIAL "Do Not Use" LIST

** 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.*

Do Not Use	Potential Problem	Use Instead
U (for Unit)	Mistaken for "0" (zero), the number "4" (four) or "cc"	Write "unit".
IU (International Unit)	Mistaken for IV (intravenous) or the number 10 (ten)	Write "International Unit".
Q.D., QD, q.d. qd (daily), Q.O.D., QOD, q.o.d., qod (every other day)	Mistaken for each other Period after the Q mistaken for "I" and the "O" mistaken for "I"	Write "daily". Write "every other day".
Trailing zero (X.0 mg) * Lack of leading zero (.X mg)	Decimal point is missed	Write X mg. Write 0.X mg.
MS, MSO4, MgSO4	Can mean morphine sulfate or magnesium sulfate Confused for one another	Write "morphine sulfate". Write "magnesium sulfate".

Being alert and aware of potential medication errors and their causes will help healthcare professionals avoid making an error themselves. By utilizing many strategies, working together with other healthcare professionals, and educating patients, they will be able to create the safety net that is so important in catching mistakes before medication errors happen.

References

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BLOOD GLUCOSE MONITORING

Blood glucose monitoring is done using a glucometer, a portable electronic device that measures the level of glucose in a drop of capillary blood that has been placed on a disposable test strip. The blood is usually retrieved from a finger, but it may also be drawn from the heel in babies or from the arms, thighs, or fleshy part of the hand of children and adults if the monitoring device allows this type of sampling.

Reasons for Testing

Blood glucose monitoring may be performed in order to screen the patient for either hypoglycemia or hyperglycemia. Although the testing rationale differs, the procedure is the same.

- Hypoglycemia – Hypoglycemia is defined as a serum glucose of < 50 mg/dL in men, < 45 mg/dL in women, or < 40 mg/dL in infants and children.
  - Acute – If the cause of hypoglycemia is something other than the use of oral hypoglycemic agents or insulin in a diabetic, additional lab testing may be necessary. Research has shown that the majority of adults coming to the emergency department with hypoglycemia had at least one laboratory abnormality (e.g. newly diagnosed or preexisting renal failure, hypokalemia, hyperkalemia, leukocytosis, and/or pyuria). Signs of an acute stroke, including hemiplegia, aphasia, and cortical blindness, have been reported with hypoglycemia. For the diabetic patient, potential causes of hypoglycemia include medication or dietary changes, new metabolic changes, recent illness, and occult infection. In each of these cases of hypoglycemia, it is important to correct and stabilize the blood glucose, determine the underlying cause, and treat the patient.
- Hyperglycemia – The level of blood glucose varies before and after meals and throughout the day; however, the normal range for most fasting adults is 80-120 mg/dL. A person who consistently has a blood glucose value higher than the normal range is considered hyperglycemic. The blood glucose level for a fasting adult should not exceed 126 mg/dL, because high levels of blood glucose damage blood vessels and the organs that receive blood supply from them.
  - Non-diabetic hyperglycemia – Not all hyperglycemia is related to diabetes mellitus.
    - Eating disorders – binge phase of bulimia nervosa, when the affected person eats an excessive amount of calories at once, usually foods that are high in simple and complex carbohydrates
    - Medications – beta blockers, thiazide diuretics, corticosteroids, niacin, pentamidine, protease inhibitors, L-asparaginase, and some antipsychotic agents
    - Physiologic stress – acute stressors (e.g. stroke or myocardial infarction)
  - Diabetic hyperglycemia – Chronic hyperglycemia, persisting even in fasting states, is the defining characteristic of diabetes mellitus. When a person experiences acute episodes of hyperglycemia without an obvious cause, the person may be either developing diabetes or showing a predisposition to the disease.

Monitoring Procedure

Perform blood glucose testing using the following steps:

- Have patients wash their hands using soap and water, then dry them thoroughly. If a patient is not ambulatory, the person performing the test may bring warm, wet washcloths to the bedside (one with soap on it), as well as a towel for drying the hands. There is controversy over whether the site may be cleansed with an alcohol prep pad without altering the blood glucose. If the alcohol prep pad is used, the alcohol should be allowed to dry completely before the skin is lanced. In the newborn, a warming device may be used on the heel in order to encourage capillary filling prior to cleansing the site and drawing the sample.
- Remove the test strip from the container and replace the cap to avoid damaging the remaining test strips.
- Insert the test strip into the meter.
- Prick the selected site with the lancet device. The side of the finger, instead of the tip, should be pricked, so that sore spots will not form on the part of the finger that is used the most. When sampling the heel of the newborn infant, the sides of the heel (on the bottom of the foot), rather than the back of the heel, should be used in order to avoid causing nerve damage to the foot.

- Squeeze or massage the site gently until a drop of blood forms.
- Touch the test strip to the blood, but not the skin at the site.
- Allow time for the glucometer to process the blood sample and display the blood glucose level on a screen. If the glucose level falls outside the prescribed range, the provider must be notified as soon as possible so that appropriate treatment may begin.

Preventing Transmission of Bloodborne Pathogens

Healthcare workers must observe the following guidelines while performing blood glucose monitoring in order to provide safe patient care and avoid transmitting bloodborne pathogens, such as hepatitis and HIV.

- Fingerstick Devices
  - The use of fingerstick devices should be restricted to use by a single individual. They should never be used for multiple persons. Sterile single-use lancets that permanently retract upon puncture add an extra layer of safety for both the patient and the healthcare worker.
  - Lancets must never be reused. They must be disposed of at the point of use in an approved sharps container.
- Blood Glucose Meters
  - If the blood glucose meter must be shared, it should be cleaned and disinfected after every use, as directed by the manufacturer, in order to prevent the transmission of blood and infectious agents. If the manufacturer does not specify how to clean and disinfect the unit, the meter should not be shared.
- General
  - Unused supplies should be maintained in clean areas separate from used supplies and equipment. Supplies must not be carried in the healthcare workers' pockets.
- Hand Hygiene – Handwashing with soap and water or the use of an alcohol-based hand rub
  - Wear gloves during blood glucose monitoring because this testing involves potential exposure to blood.
  - Change gloves between patient contacts. Change gloves that have touched potentially blood-contaminated objects or wounds made by lancet devices before touching clean surfaces. Discard used gloves in appropriate receptacles.
  - Perform hand hygiene immediately after removal of gloves and before touching other medical supplies.

DOCUMENTATION

Why is clinical documentation so important?

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

Good Documentation Habits

- Use language patient understands for discharge instructions and patient education material
- Documentation of actions, conversations with the patient, family members, physicians
- Documentation of safety precautions reviewed with the patient and/or family
- Description of unusual incidents
- Documentation of contacts with the provider
- Contemporaneous, chronological
- Do not editorialize, criticize, add 'hearsay'
- Avoid blaming another person or department
- Complete all boxes / forms accurately
- Do not leave open lines on records between documentation entries
- Verification informed consent was obtained
- Instructions given to patient/verbalization of understanding
- Do not alter entries

Alteration of Records

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

Late Entries

- Late entries are placing additional information in the medical record when pertinent information was missed or not written in a timely manner.
- A general guideline of when late entries can be added is within 7 days. Consult your Supervisor or Risk Manager for guidance if necessary.

- Should not be used if there has been adverse outcome to patient or there is known litigation

- Must have a 'home' – notation should specify the date and time. See below.

  Example:

  4/20/17 1600: Late Entry for 4/19/17 at 0800:
  Patient also complained of pain at base of neck and bleeding from nose. Dr. Jones notified, CT of head ordered along with CBC & diff, INR.

CORRECTIONS

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

Example:

4/19/17 0800: Pt found on floor in ~~room~~ LN hallway; BP:165/66 VS:
36.8-136-20
Dr. Jones notified. Orders for MRI obtained

PATIENT EDUCATION

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

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

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

How is Patient/Family Education Implemented?

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

The Nurse Role in Patient Education

- Asses/re-assess patient including cultural and religious beliefs
- Identifies learning barriers
- Identifies learning need
- Provides in room orientation
- Plans for patient teaching in collaboration with patient/family and involves interdisciplinary team
- Demonstrates use of equipment, rehabilitative techniques, assistive devices
- Explains treatment plan, verifies patient's knowledge about procedures
- Explains medication in collaboration with clinical pharmacist
- Teaches/demonstrates self-care, personal hygiene

- Provides discharge instructions such as:
    - Follow up appointment with physician
    - Danger signals and symptoms to report
    - Medications, food-drug interactions
    - Provides patient with education materials
    - Self-care
    - Activity, assistive devices
    - Access to resources
    - Pain Management
    - Return to work and driving

AGE SPECIFIC EDUCATION

As people age, they continue to experience physical and emotional changes. These changes are the result of the many experiences and influences, including the genes we inherit and the lifestyles we choose. This review will outline the common changes that occur with age. It will provide some tips for helping you to remain sensitive to our patients.

Early Older Adulthood (60-75 years)

The average American lives to be 77.2 years old. Most adults will live well into early older adulthood. People in early older adulthood usually have at least one chronic disease. High blood pressure, arthritis, heart disease and cancer are the most common. Most people in this age group will need eyeglasses to read. Many will suffer from the loss of hearing associated with old age. Most women have gone through menopause. Many in this group require daily mediations.

People in this age group are beginning to lose friends and loved ones to the inevitable process of death and dying. Hospitalization may cause fear as patients confront their mortality. Other concerns relate to limited income, since many have retired. Fear of permanent disability may be a worry for hospitalized patients in early older adulthood. Arthritis is common in this age group. Older adults often experience both chronic and acute pain. Consistent use of the pain scale will help older adults evaluate their pain.

You can help to create an environment that is friendly to aging patients. Adjust lighting to help patients better navigate the hospital environment. Provide extra time for learning to help older adults retain the information presented. Use verbal as well as written instruction to help them learn. Make sure the telephone is within reach, the call light is close by and that the room is clutter-free to promote safety and independence.

Middle Older Adulthood (75-85 years)

The average 75year old has three chronic conditions and takes about 5 medications a day. Many in this group feel their body is “wearing out.” Almost all need glasses to see. Most have reduced hearing.

Hospitalization can be frightening in particular ways for this group. Many have been struggling to live independently and most do not want to be placed in a nursing home. As a result of these fears, patients may

make health decisions that are not in their best interest, like ignoring signs of disease, because they are afraid of the consequences.

People in this group are vulnerable to depression which may not be obvious to you. Assessment should include an evaluation of coping skills. Providing spiritual and social services can be especially helpful for this age group, since it can take time to get someone to open up about these issues.

Many patients in this group, like those in the previous group, live with arthritis pain. They may not talk about this pain unless you specifically ask about joint or muscle aches. Good pain management will help them participate in physical activities like walking and physical therapy.

Late Older Adulthood (85 plus years)

With age the number and severity of disabilities increases. Chronic diseases progressively get more severe and many patients are diagnosed with new illnesses. Most in this group are frail and increasingly dependent on other people to assist them with their daily tasks. Older adults fear changes to their routine, so a hospitalization can be particularly stressful.

Care for adults at this stage in life should focus on improving or maintaining function. Allow the patient to express needs and then tailor the care environment to meet those needs. Maintaining a user-friendly environment will promote independence.

Some older adults may not report pain due to fear of losing independence. Others have been living with arthritis and other pain so long that they no longer express their discomfort verbally. Look for nonverbal signs of pain including confusion, inability to ambulate, grimacing, and decreased range of motion. Adults in this age group have decreased cough ability and decreased swallowing skills. Aspiration precautions should be used with all frail older adults. In this age group, skin becomes thin. Patients become at risk for skin tears and pressure ulcers. People of any age can become confused while hospitalized, but the likelihood is greater for older patients. Memory loss is not necessarily a part of the aging process. So if you speak with someone who seems to be losing memory, that patient should probably be evaluated for underlying illness. In many cases, we can find a cause and a solution. Confusion that is normal at admission may develop into delirium. This condition may indicate an underlying illness, such as infection, that needs to be treated. Frequent reminders about time, date, season and weather may help older adults regain a sense of security and confidence.

Patients who have lived this long have experienced many losses. Life review is common in this group. Many will enjoy telling you about “how it used to be.” Reviewing the past can help people achieve closure. Pastoral care and social work can provide assistance to patients beginning this profound and affecting final journey

CULTURAL COMPETENCY

Cultural competency is achieved when the healthcare professional employs certain attitudes, behaviors, and skills in order to provide healthcare in a cross-cultural environment. It reflects the caregiver's ability to acquire and effectively use knowledge of a patient's preferred communication method, healthcare beliefs and practices, and cultural attitudes and values.

It is imperative to become conscious of one's own cultural attitudes in order to begin to learn and understand those of another culture. It is not easy to face the possibility that personal negative stereotypes and prejudices are present which would keep healthcare professionals from treating all individuals with the respect they deserve. However, it is necessary for healthcare professionals to be completely honest in order to understand the possible biases they may be harboring, whether intentional or not. By facing both the positive and negative assumptions they may have made about those who are culturally different from them, they are then free to move forward to learn about and care for their patients with respect and understanding.

While it is important to recognize some of the cultural beliefs and practices of the population that healthcare professionals regularly serve, it is impossible to know everything about every culture with which they may come in contact. With today's mobile society, there is a real possibility of encountering persons from anywhere in the world. One must also bear in mind that each patient comes from a unique background with an individual history, belief system, health status, and communication style, regardless of any similarities to a cultural group.

Healthcare professionals must take cues from their patients and be in tune with their body language and personal space. They should be attentive to touching and greetings - some cultures may bow instead of shaking hands. Healthcare workers may find that while some patients are comforted by a caring touch, others find it uncomfortable or disrespectful. Many people from the Middle East and Western Asia believe that the crown of the head is the place where the soul resides; therefore, they do not like to be touched on the head, because they fear that the soul will be offended or scared away - a life-threatening situation. Remember, cultural differences are not only found within populations from other countries; they also exist within religious, sexual, and economic communities within the US.

Considerations for Provision of Culturally Competent Care

1. Language and communication
2. Level of education
3. Understanding the causes of illness
4. Treatments, cures, and cultural remedies for illnesses and injuries
5. The role of family, friends, and community
6. The role of a "healer" or spiritual entity
7. Beliefs in death and dying

Application of Cultural Knowledge to Practice

Once the personal cultural belief system of the healthcare professional is identified and understood, it becomes easier to move toward recognizing, accepting, and incorporating beliefs and practices of another culture into the healthcare provided to patients. The following is a useful tool that may help healthcare professionals to gain appropriate knowledge and effectively assess and treat a patient who is a member of another culture.

A FRAMEWORK FOR CULTURALLY COMPETENT CLINICAL PRACTICE

- **Explanation:** What do you think may be the reason you have this problem? What do friends, family, and others say about your symptoms? Do you know anyone else who has had or who now has this kind of problem? Have you heard about/read about/seen this problem on TV/radio/newspaper/internet? (If patients cannot offer an explanation, ask what most concerns them about their problems.)
- **Treatments:** What kinds of medicines, home remedies, or other treatments have you tried? Is there anything you eat, drink, do, or avoid on a regular basis to stay healthy? Tell me about it. What kind of treatment are you seeking from me?
- **Healers:** Have you sought any advice from alternative or folk healers, friends, or other people who are not doctors for help with your problems? Tell me about it.
- **Negotiate:** Try to find options that will be mutually acceptable to you and your patient and that incorporate the patient's beliefs, rather than contradict them.
- **Intervention:** Determine an intervention with your patient that may incorporate alternative treatments, spirituality, and healers as well as other cultural practices (e.g. foods eaten or avoided in general and/or when sick).
- **Collaboration:** Collaborate with the patient, family members, other healthcare team members, healers, and community resources.

SUSPECTED ABUSE:

IDENTIFICATION, TREATMENT AND REPORTING

ELDER/ADULT ABUSE

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

SIGNS AND SYMPTOMS OF ELDER/ADULT ABUSE

- Patient or family member states that abuse is happening in the home
- Explanation for injuries is inconsistent with the injury
- Family or caregiver attempts to conceal injury
- Indications that someone is exploiting patient's finances or property
- Delay in seeking treatment
- Multiple bruises or injuries in various stages of healing
- Human bite marks
- Burns especially on back or buttocks
- Bruises in the shape of a hand or fingers
- Patient's behavior changes in the presence of the family or caregiver

CHILD ABUSE

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

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

SIGNS AND SYMPTOMS OF CHILD ABUSE

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

NEGLECT

With an adult, neglect means failure to provide…the goods or services, which are necessary to avoid physical harm, mental anguish, or mental illness. With a child, neglect includes leaving the child in a situation where the child would be exposed to a substantial risk of harm, i.e., and failure to seek or follow through with medical care, failure to provide food, clothing, or shelter.

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

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

SIGNS AND SYMPTOMS OF CHILD NEGLECT

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

SPOUSAL PARTNER/VIOLENCE

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

SIGNS AND SYMPTOMS OF SPOUSAL PARTNER/VIOLENCE

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

EXPLOITATION

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

- The treatment team may identify possible history of abuse, neglect, or exploitation
- Any staff member suspecting child and or adult abuse and/or neglect is required to report suspicions according to local law and the rules and regulations of the state's Department of Human Services (DHS) or appropriate agency. If clarification is necessary concerning the criteria for reporting in Adult Protective Supervisor will occur without disclosing the identity of the patient and/or family.
- The report to DHS may be made orally or in writing. It shall include:
    a) The name, age, and address of the person

b) The name address of the person responsible for care
c) The nature and extent of the person's condition
d) The basis of the reporter's knowledge
e) Any other relevant information
f) Documentation shall occur in the appropriate section of the patient record.

- If circumstances allow, the reporting procedure will be discussed with the patient and/or family involved, prior to the report being made. Consent will be obtained if deemed appropriately by the treatment team.
- Outside agency personnel requesting information about the family should be referred to the patient's physician or other appropriate staff.
- Any act of omission is reportable. A reportable suspicion includes a child victims or abuse shall be documented in the appropriate section of the medical record.
- Symptoms resulting from abuse will be addressed by the patient's treatment team.
- Documentation of physical marking should include photographic documentation (with appropriate patient identification) and included in the appropriate portion of the patient's medical record.
- Any other evidentiary material of abuse released by the patient will be included in the appropriate portion of the patient's medical record.
- Adult patients shall be given information regarding legal counsel
- Physical injuries requiring medical attention will be treated as deemed necessary by the patient's physician.

ABUSE REPORTING

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

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

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

RESTRAINTS AND SECLUSIONS

The use of restraints and seclusion can both help and harm a patient. Patients must be protected from the use of seclusion or restraint as a means of coercion, discipline, convenience, or retaliation by staff. Standards guiding the use of restraints and seclusion have been set forth by both the Centers for Medicare & Medicaid Services (CMS) and The Joint Commission (TJC). These standards include policy and protocol to be mandated by both the individual facility and the state. It is important for healthcare professionals to be aware of these standards as well as the individual policies of both the facility and state in which they are working.

Restraints: Any method of physically restricting freedom of movement, physical activity, or normal access to a person's body. Physical restraints are devices, materials, or equipment attached or adjacent to patients' bodies, which they cannot easily remove. Restraints may include medication used to control behavior or restrict freedom of movement that is not a standard treatment for patients' medical or psychiatric conditions.

Seclusion: Solitary confinement of a person in a room or an area from which the person cannot voluntarily leave.

Before restraints or seclusion may be initiated, careful assessment of the patient must be made in order to determine their clinical appropriateness. All efforts to use other preventive strategies or alternatives must be made first. The use of restraints and seclusion can potentially cause physical and psychological harm, loss of dignity, violation of individual rights, and even death. Appropriate use can prevent patients from harming themselves and others. They may be justifiably employed as part of the planned care of patients.

Restraints and/or seclusion may be used

- to improve a patient’s well-being;
- when less restrictive interventions are determined to be ineffective;
- to protect the patient from harm;
- to protect others from harm;
- in response to emergent and/or dangerous behavior;
- for patients with addictive disorders;
- as a part of planned care;
- as standard practice (e.g. preventing a postoperative patient from removing an endotracheal tube, IV, or other medically necessary device).

Restraints and/or seclusion should not be used as a means of

- coercion;
- staff convenience;
- retaliation;
- discipline or punishment.

Patient Care and the Use of Restraints

All patients should expect to receive respectful care that maintains their dignity. Restraints and seclusion can potentially have serious adverse effects on patients. Each time that use of restraints and seclusion seems necessary, staff members must ensure that the

- patient is respected as an individual;
- environment is safe and clean;
- patient is able to participate in his or her own care;
- patient's modesty, visibility, and comfortable body temperature are maintained;
- patient's needs are met, including adequate exercise, nourishment and personal care.

Standards for the use of restraints and seclusion vary based on the patients' needs. Two defined areas of healthcare may require the use of restraints and seclusion: behavioral health and acute medical-surgical care. Many of the rules are the same, but some rules either do not apply to certain situations or are specific to a unique situation. It is important to know how the rules pertain to the needs of specific patients.

An example of appropriate restraint usage in acute medical-surgical care is the patient undergoing a medical or surgical procedure who may require restraint to prevent harm. When patient behaviors become unexpectedly aggressive or destructive, restraints or seclusion may be necessary as an emergency measure to protect the patient or others. This emergency use would be considered a behavioral use of restraint or seclusion.

Notice that the terminology refers to restraints and seclusion for behavioral patients and restraints for acute medical-surgical patients. This is because seclusion would not be an effective intervention for acute medical-surgical patients.

The following standards apply to the use of restraints for acute medical-surgical patients and to both restraints and seclusion for behavioral health patients:

1. Choose restraints and/or seclusion when other less restrictive measures have been found ineffective in protecting the patient or others from harm.
2. Use restraints and/or seclusion in accordance with the order of a physician or licensed independent practitioner (LIP) that has been permitted by the facility and/or state to order them.
3. Write orders for restraints and/or seclusion specific to the situation at hand - never as a standing order or on an as needed basis (PRN).
4. Consult the patient's treating provider as soon as possible if restraints and/or seclusion are ordered by a non-treating provider.
5. Use restraints and/or seclusion in accordance with a written modification of the patient's care plan.
6. Implement restraints and/or seclusion in the least restrictive manner possible.
7. Use restraints and/or seclusion in accordance with safe and appropriate restraining techniques.
8. End restraints and/or seclusion at the earliest possible time.
9. Continually assess, monitor, and reevaluate the patient.
10. Train staff with direct patient contact in proper and safe use of restraints and/or seclusion on an ongoing basis.
11. Document use of restraints and/or seclusion in the patient's medical record, reflecting facility policy.

The following additional standards apply to restraints and seclusion for patients receiving behavioral healthcare:

1. Within 1 hour of initiation, a physician or other LIP must see the patient in person and evaluate the need for restraints or seclusion.
2. Continuation of orders may be renewed for the same time periods as above. A face-to-face reassessment by a physician or other LIP is necessary every 8 hours for adults (or every 4 hours for children and youth) until they are released from restraints and/or seclusion. The order and/or facility policy will determine the person who is qualified to reassess the patient (e.g. an RN) and make a decision to continue restraints or seclusion.
3. Monitoring of the patient for the following is to be continuous or no less often than every 15 minutes (as appropriate):
   - Signs of injury associated with the application of restraint or seclusion;
   - Nutrition/hydration;
   - Circulation and range of motion in the extremities;
   - Vital signs;
   - Hygiene and elimination;
   - Physical and psychological status and comfort;
   - Readiness for discontinuation of restraint or seclusion.
4. Reassessment related to monitoring will determine the patient's well-being.
5. Reassessment related to time-limited orders will determine the need for continued use.
6. If staff has used appropriate criteria to terminate restraints or seclusion early, and the same behavior is evident, the original order may be reapplied.
7. Restraints and seclusion may be used simultaneously only if the patient is continuously monitored by a staff member either face-to-face or by video and audio equipment that is close to the patient.

The following standards apply to the use of restraints for patients receiving acute medical surgical care:

1. An RN may initiate justifiable use of restraint but immediately notify the physician or other LIP of this change in the patient's condition.
2. An order for this non-behavioral restraint must be obtained from a physician or other LIP within 12 hours.
3. A physician or other LIP must conduct an in-person assessment of the patient within 24 hours and document an order at that time.
4. A physician or other LIP must reassess the patient and authorize continued restraint usage every 24 hours.
5. Monitoring occurs at a minimum of every 2 hours and is accomplished by observation, interaction, or direct examination of the patient. Monitoring will determine the following:
   - The patient's physical and emotional well-being;
   - Maintenance of the patient's rights, dignity, and safety;
   - Possible effective use of less restrictive methods;
   - A change in behavior or clinical condition that may indicate readiness for removal of restraints;
   - If restraints have been properly applied, removed, or reapplied.
6. Each facility may establish its own protocols for certain specific conditions (e.g. intubation or post-traumatic brain injury) in which restraint may be necessary to prevent patients from harming themselves or interfering with lifesaving medical intervention. Such protocols will authorize a certain staff member to initiate, maintain, and terminate restraint without an order, but only when the guidelines for clinical justification have been met. The protocol will also provide guidance with regards to assessment of the patient, criteria for restraint application, criteria for monitoring and reassessing the patient, and termination of the restraint. Initiating restraint without such a protocol requires an order from a physician or other LIP.

DOCUMENTATION

Documentation of the use of restraints and seclusion must be made in the patient's medical record and must be consistent with the facility's policies. Typically, documentation will include the following:

- Documentation of each use;
- Clinical justification for use;
- Results of patient monitoring and reassessment;
- Significant changes in patient condition;
- Adherence to facility policy and procedure;
- Reference to the specific protocol when restraint is used as part of a protocol;
- Measures taken to protect the rights of the patient.

Healthcare professionals will find that many of the rules regulating restraints and seclusion will be specific to the facilities in which they are working and will affect their responsibilities in their specific healthcare capacities. For example, facilities will have policies that have been constructed in conjunction with state laws to determine who is authorized to give, receive, and record verbal orders. Therefore, healthcare professionals (e.g. RNs, LPNs, and behavioral health technicians) must determine whether they are allowed to accept verbal orders for restraints and seclusion and from whom - the treating physician, an LIP, or a resident. Facility policy will also define protocols that contain restraint and other relevant policies. It is each healthcare professional's responsibility to know these protocols as they pertain to his or her own job duties. In addition, these protocols must be specifically referenced when documented in the patient's medical record.

Each facility will also have preferences in the types of restraints used, and it will require training in order to become familiar with specific types of restraints and how to use them appropriately. It is imperative for all healthcare professionals to obtain restraint training on a regular basis and to be competent in the correct application method of the restraints they are using. TJC stipulates that facilities provide staff orientation, which not only provides ongoing education in prevention and appropriate use, but also encourages the use of alternatives to restraints and seclusion. Healthcare workers may be able to avoid the use of restraints and seclusion by using other interventions. As previously stated, alternative methods should be exhausted before restraints and seclusion are utilized.

END OF LIFE CARE

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

ORGAN AND TISSUE DONATION

One person can save or improve the lives of as many as fifty people by donating vital organs and tissues such as the heart, liver, kidneys, lungs, cornea, skin, and bones. [1][5] Organs and tissues may be used for transplantation in order to save a life or for medical research to help prevent or cure disease. Patients may have already made the decision to become organ donors. In some instances, it is the healthcare professional who shares in the responsibility of identifying patients who are potential organ donors and notifying their providers. Healthcare professionals may also encounter questions about organ donation; the following information should help healthcare workers discuss this topic with their patients with both knowledge and compassion.

Organ Donation Facts

- Over 122,000 U.S. patients are currently waiting for an organ transplant; another new patient is added to the national organ transplant waiting list every 10 minutes. [2]
- Every day, an average of 22 people die while waiting for a transplant of a vital organ or other tissue, such as a heart, liver, kidney, pancreas, lung, or bone marrow. [2]
- In 2014, more than 8,500 deceased donors made possible approximately 24,000 organ transplants. In addition, there were nearly 6,000 transplants from living donors. [3]
- More than 1 million tissue transplants are done each year and the surgical need for tissue has been steadily rising. Tissues that can be donated after death include corneas, skin, veins, heart valves, tendons, ligaments and bones. [3][5]
- Anyone can be an organ donor, despite the person's age, race, or medical history. [6]

The healthcare professional should document all discussions about organ and tissue donation in the patient's medical record. Charting should include:

- communication with family and/or provider regarding possible organ or tissue donation;
- identification of the patient as a potential donor according to facility's criteria for donation;
- documentation of brain death and the time the patient is pronounced dead by the provider;
- documentation of patient transfer to the surgical suite; write 'Transferred to OR' and sign the chart.

If the patient would like further information, the following sources can be recommended:

- personal healthcare provider;
- clergy member;
- state or local medical association;
- local kidney, heart, lung, or liver foundation;

- a regional transplant group/hospital, organ procurement organization, or tissue bank.

Healthcare professionals should check their facility policy and procedure manuals to find out their specific responsibilities during the process of organ and tissue donation. They should also consider becoming organ donors themselves, because this action could save many lives.

References:
[1] Mayo Clinic Staff. (2013). Organ donation: Don't let these myths confuse you. Retrieved from http://www.mayoclinic.com/health/organ-donation/FL00077

[2] U.S. Department of Health and Human Services | Health Resources and Services Administration. (2015). Organ Procurement and Transplantation Network (OPTN). Retrieved from http://optn.transplant.hrsa.gov

[3] Donate Life America. (2015). Statistics. Retrieved from http://donatelife.net/statistics/

[4] United Network for Organ Sharing (UNOS). (2015). Retrieved from https://www.unos.org/

[5] American Transplant Foundation. (2015). Facts and myths. Retrieved from http://www.americantransplantfoundation.org/about-transplant/facts-and-myths/

[6] Donate Life America. (2015). Learn the facts. Retrieved from http://donatelife.net/understanding-donation/learn-the-facts/

EMERGENCY CODES

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

- Code Red: Fire
- Code Blue: Life Threatening situation
- Code White: Life threatening situation for pediatrics
- Code Pink: Infant abduction
- Code Purple: Child Abduction
- Code Orange: Hazardous Materials Spill
- Code Gray: Potential or real violence occurring in the facility
- Code Yellow: Bomb threat
- Code Silver: Person with weapon or hostage situation

What is my role in a disaster?

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

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

Communication

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

PATIENT RIGHTS AND RESPONSIBILITIES

Allcare Nursing Services, Inc. employees must respect the rights of the patient and recognize that each patient is an individual with unique health care needs, and because of the importance of respecting each patient's personal dignity, provides considerate, respectful patient focused care. These rights and responsibilities are outlined in both State and Federal regulations (CMS), as well as hospital accreditation standards (Joint Commission).

Patients and family members receive a copy of these rights and responsibilities upon admission. In addition, they are posted throughout our client hospitals.

THE PATIENTS' BILL OF RIGHTS

As recorded on the Official California Code of Regulations, the Patients' Rights in a General Acute Care hospital include, but are not limited to:

(1) Exercise these rights without regard to sex, economic status, educational background, race, color, religion, ancestry, national origin, sexual orientation, disability, medical condition, marital status, registered domestic partner status, or the source of payment for care.

(2) Considerate and respectful care.

(3) Knowledge of the name of the licensed healthcare practitioner acting within the scope of his or her professional licensure who has primary responsibility for coordinating the care, and the names and professional relationships of physicians and nonphysicians who will see the patient.

(4) Receive information about the illness, the course of treatment and prospects for recovery in terms that the patient can understand.

(5) Receive as much information about any proposed treatment or procedure as the patient may need in order to give informed consent or to refuse this course of treatment. Except in emergencies, this information shall include a description of the procedure or treatment, the medically significant risks involved in this treatment, alternate courses of treatment or nontreatment and the risks involved in each and to know the name of the person who will carry out the procedure or treatment.

(6) Participate actively in decisions regarding medical care. To the extent permitted by law, this includes the right to refuse treatment.

(7) Full consideration of privacy concerning the medical care program. Case discussion, consultation, examination and treatment are confidential and should be conducted discreetly. The patient has the right to be advised as to the reason for the presence of any individual.

(8) Confidential treatment of all communications and records pertaining to the care and the stay in the hospital. Written permission shall be obtained before the medical records can be made available to anyone not directly concerned with the care.

(9) Reasonable responses to any reasonable requests made for service.

(10) Leave the hospital even against the advice of members of the medical staff.

(11) Reasonable continuity of care and to know in advance the time and location of appointments as well as the identity of persons providing the care.

(12) Be advised if the hospital/licensed healthcare practitioner acting within the scope of his or her professional licensure proposes to engage in or perform human experimentation affecting care or treatment. The patient has the right to refuse to participate in such research projects.

(13) Be informed of continuing health care requirements following discharge from the hospital.

(14) Examine and receive an explanation of the bill regardless of source of payment.

(15) Know which hospital rules and policies apply to the patient's conduct while a patient.

(16) Have all patients' rights apply to the person who may have legal responsibility to make decisions regarding medical care on behalf of the patient.

(17) Designate visitors of his/her choosing, if the patient has decision-making capacity, whether or not the visitor is related by blood, marriage, or registered domestic partner status, unless:

(A) No visitors are allowed.

(B) The facility reasonably determines that the presence of a particular visitor would endanger the health or safety of a patient, a member of the health facility staff, or other visitor to the health facility, or would significantly disrupt the operations of the facility.

(C) The patient has indicated to the health facility staff that the patient no longer wants this person to visit.

(18) Have the patient's wishes considered for purposes of determining who may visit if the patient lacks decision-making capacity and to have the method of that consideration disclosed in the hospital policy on visitation. At a minimum, the hospital shall include any person living in the household.

(19) This section may not be construed to prohibit a health facility from otherwise establishing reasonable restrictions upon visitation, including restrictions upon the hours of visitation and number of visitors.

regarding medical care on behalf of the patient.

-Section 70707, Title 22 California Administrative Code

Patient Self Determination Act of 1990 - Amends titles XVIII (Medicare) and XIX (Medicaid) of the Social Security Act to require hospitals, skilled nursing facilities, home health agencies, hospice programs, and health maintenance organizations to: (1) inform patients of their rights under State law to make decisions concerning their medical care; (2) periodically inquire as to whether a patient executed an advanced directive and document the patient's wishes regarding their medical care; (3) not discriminate against persons who have executed an advance directive; (4) ensure that legally valid advance directives and documented medical care wishes are implemented to the extent permitted by State law; and (5) provide educational programs for staff, patients, and the community on ethical issues concerning patient self-determination and advance directives.

-H.R.4449 : Patient Self Determination Act of 1990

INFORMED CONSENT

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

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

ADVANCE DIRECTIVES

Advance directives are written documents that express patients' wishes regarding medical care decisions when patients are unable to speak for themselves. These situations may arise when patients become physically or mentally incapable of making decisions and/or communicating personal wishes. For example, patients may be suffering with

- sustained brain damage that is irreversible;
- a coma that is expected to be permanent;
- a terminal illness that is expected to cause death within a short period of time.

There are two types of advance directives. Patients may have one or both; in some cases, both types may be contained in the same document.

1. **Living Will:** This will is termed 'living' because it is in effect while the patient is alive. This document specifies the medical care either wanted or not wanted if debilitation or terminal illness occurs, resulting in the inability to communicate personal wishes. Before the living will can guide decision-making, two physicians must certify that the patient is unable to make medical decisions and that the patient is in the medical condition specified in the state's living will law (e.g. "terminal illness" or "permanent unconsciousness").
2. **Durable Power of Attorney for Health Care:** This document is also known as a Medical Power of Attorney. This written document names a specific person (called a healthcare proxy or an agent) to make medical care decisions if the patient becomes unable to do so. Before this goes into effect, the patient's physician must determine that the patient is unable to make personal medical decisions. Once the patient's healthcare proxy is actively making medical decisions, if the patient regains the ability to make personal medical decisions, the proxy cannot continue to act on the patient's behalf. Additionally, before the healthcare proxy can decline life-sustaining treatment for the patient, a second physician may be asked to confirm the personal physician's assessment that the patient is unable to make personal medical decisions.

EMERGENCY TREATMENT OF PATIENTS (EMTALA)

The Emergency Medical Treatment and Active Labor Act (EMTALA) is a statute under the larger umbrella of the Consolidated Omnibus Budget Reconciliation Act (COBRA). EMTALA is designed to enhance access by all persons to emergency services and prohibit discrimination in the provision of emergency services to persons presenting with similar types of conditions regardless of financial or insurance status.

Although there are many components of the EMTALA law, some basic requirements include: providing a medical screening examination to all patients seeking examination or treatment for a medical condition, providing stabilizing treatment to those patients with emergency medical conditions and maintaining logs of all patients that present for care and transfers in and out of the facility.

Allcare Nursing Services, Inc. provides special education with regards to this legislation. You should be aware that if someone asks you about getting emergency treatment for any condition, you should refer that person to the Emergency Department or call the House Supervisor. It is against the law to send a patient away who seeks treatment for an emergency condition.

THE HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT (HIPAA)

HIPAA is a comprehensive piece of legislation that protects an individual's health information and give the patient certain rights. The security regulation requires organizations to protect individually identifiable electronic health information. These rules help to protect patients' privacy and confidentiality by careful management of their protected health information (PHI). Healthcare professionals must be aware of, and comply with, the HIPAA standards regulating the use and release of an individual's PHI. Violations of these standards are classified as felonies. They must also be aware that since these regulations are now federal law, there are both civil and criminal sanctions associated with their violation, which can carry penalties of prison time and fines, with amount of the fine dependent upon category.

Examples of HIPAA violations are as follows.

- Inadvertent violation - If healthcare workers access the medical records of a co-worker to determine a birth date or look up a neighbor's records out of curiosity, they have committed inadvertent violations of HIPAA standards.
- Intended violation - If healthcare workers sell patient information for personal or financial gain, this is considered an intended or willful violation of HIPAA standards. This is more serious than inadvertent or accidental release of information. Selling a celebrity's medical record to a tabloid newspaper or selling health information to a marketing or pharmaceutical company for personal profit is considered an intended or willful violation.

HIPAA calls upon all covered entities to learn the rules of privacy and confidentiality and to conscientiously practice them. A covered entity is an organization that may come into contact with PHI, including hospitals, nursing homes, provider practices, laboratories, pharmacies, insurance companies, payers, or other healthcare services. Healthcare professionals working for one of these covered entities are the backbone of the facility's strength in protecting patients' privacy and the confidentiality of their PHI.

Patient Privacy and Confidentiality Privacy and confidentiality are integral parts of the patients' total satisfaction and dignity that will be experienced while they are receiving care.

Privacy

- refers to a patient's right to decide what personal health information may be shared with others;
- allows the patient to decide how any information is shared and with whom it may be shared;
- protects the patient from having personal and medical information discussed where it can be overheard (e.g. elevators, hallways, waiting areas).
- includes the protection of the patient's physical privacy during examinations and treatments.

Confidentiality limits access to a patient's personal and medical information to

- those who have a need to know, including the patient;

- those who provide care to the patient.

It is important for patients to be assured that their medical information will remain confidential. If patients feel that confidentiality may be breached in any way, they may withhold vital information that could compromise their care. Helping patients understand their rights and the facility's policies regarding privacy and confidentiality will not only give patients the security they need but will also ensure compliance with the HIPAA standards.

Protected Health Information (PHI)

Unless healthcare professionals are new to healthcare, the issues of privacy and confidentiality are not new to them. The world is constantly changing; modes of communication and access to information are simultaneously easier and more complex. For these reasons, HIPAA standards were created for the protection of individuals, because it is both legally and ethically correct to do so. HIPAA has determined what must be protected and has named these specific types of information protected health information (PHI). PHI is defined as any information that can be used to identify an individual - including demographic information.

PHI meets the following criteria:

- It is created or received by a healthcare provider, health plan, employer, or healthcare clearinghouse.
- It relates to the past, present, future physical/mental health, or condition of an individual.
- It describes the past, present, or future payment for the provision of health care to an individual.

Releasing any PHI, other than for reasons that are permissible is a direct violation of HIPAA privacy regulations. Some elements that make a patient's information individually identifiable are

- name;
- identifying characteristics (e.g. occupation);
- address;
- employer;
- relatives' names;
- birthdate;
- telephone and fax numbers;
- email addresses;
- social security number;
- medical record number;
- member or account number;
- certificate number;
- voiceprint;
- fingerprints;
- genetic information;
- photographs;
- codes.

RISK MANAGEMENT AND INCIDENT REPORTS

Risk Management:

Clinical risk management concerns itself with the process of improving the safety and quality of healthcare services by identifying events or incidents that put patients, their families and visitors, and employees at risk of harm, and then acting to prevent or control these risks. Comprehensive risk management protects the facility and its employees from losses sustained in lawsuits and provides safe, satisfying, and cost-effective healthcare to patients. Healthcare workers are more likely to become involved in litigation because they provide hands-on care. This leaves them open for liability because of their involvement in incidents such as

- assessment that may be incorrect, incomplete, or inappropriate;
- treatment that may be incorrect, incomplete, or inappropriate;
- errors in medication administration;
- adverse reactions to procedures or medications;
- slip and fall incidents;
- failure to provide safe and appropriate care;
- inadequate documentation;
- failure to report a change in patient status;
- the use of faulty equipment.

Additional factors that may contribute to patient dissatisfaction are poor communication, unrealistic expectations of healthcare providers and treatment outcomes, and depersonalized service. Shorter hospital stays and increased outpatient procedures bring about increased family responsibilities which must be addressed. This makes it imperative for healthcare workers to communicate well and meet the specialized educational needs of patients and their families.

Incident Report:

Should any incident occur which could affect the quality of care or patient safety, an incident report must be filed. The facility will supply guidelines for completing an incident report, including information about the department or person to whom the incident should be reported. Incident reports are part of the legal component of problem identification, and therefore, they can help to prevent similar incidents in the future. These reports are reviewed and examined in order to devise corrective actions. Incident reports also help to identify trends that may be affecting patient/employee care and safety.

In addition to filing incident reports, members of the healthcare team can practice other risk-reducing activities. Proper communication between healthcare workers and patients and their family members is essential in establishing confidence and personalized service. Being a good listener, providing compassionate understanding, and presenting a pleasant bedside manner will add to a patient's overall satisfaction. All of these activities will help to reduce the likelihood of a lawsuit.

Healthcare workers are an essential part of risk management. They should be sure that they report any potential problems that they may encounter and follow facility procedures if they are involved in an incident.

DISCHARGE PLANNING

Over the course of a patient's healthcare experience, treatment will likely involve being relocated from one healthcare setting to another. A patient's transfer could be as simple as sending a healthy newborn home with its parents or as complex as sending a patient requiring mechanical ventilation from the hospital to a rehabilitation facility with the eventual goal of returning home. Regardless of the level of complexity, it is best to begin planning for a patient's discharge as early in the hospital stay as possible. Discharge planning is a multidisciplinary effort involving many different professionals working as a team to gain the best possible outcome for the patient.

Discharge planning should include

- patient evaluation judging the appropriateness of discharge;
- determination of the discharge destination that will provide the best quality care and resources;
- financial resources available to the patient;
- the goals of care from the perspectives of the patient, the family, and the healthcare professionals who have been and will be involved in the patient's care.

When preparing and implementing a written discharge plan, healthcare workers should clearly define the

- necessary educational materials, training aids, and assessment tools;
- anticipated amount of time to complete the process and discharge the patient;
- team member access to patient and family for information gathering and training;
- source(s) and limits of funds to implement the plan;
- adequacy of physical and financial support to implement the discharge plan;
- necessary personnel for a successful discharge plan outcome.

Discharge planning begins as soon as the patient has entered care. The more teaching and confidence that is incorporated into the patient's care by healthcare workers, the easier the transition will be for the patient upon transfer to a new care setting. Discharge teaching should begin as much in advance of the actual discharge date as possible. Family members that will be responsible for the patient's care should be involved and encouraged to ask questions and express any concerns or anxieties before the patient is discharged.

Patients and their families may have difficulty understanding and remembering the details of the plan of care they are to carry out once they are transferred from the facility. Patients should be given a written plan and be subsequently contacted by healthcare professionals to determine whether or not they are following the recommended plan in the new care setting.

PAIN MANAGEMENT

Pain is a subjective experience that indicates either actual or potential tissue damage. Pain has both sensory and emotional components: it creates a sensation in one or more parts of the body, but because the sensation is always unpleasant, it is also considered to be an emotional experience. Caregiver expertise is required to adequately assess, treat, and teach the patient in pain based on the individual patient's circumstances.

Pain is generally viewed as being either acute or chronic. Acute pain usually has a sudden onset and sharp quality and is often a warning of disease or threat to the body. This type of pain, variable in intensity, usually lasts no longer than 6 months; it ends when the cause of pain has been treated or healed. Acute pain that is unrelieved can lead to chronic pain, a type of pain that continues even though the injury or disease has been healed. The pain signals associated with chronic pain may have originated with an initial injury or infection, but they can remain active in the central nervous system for months or years. Treatment is more complex for chronic pain than for acute pain because of the necessity of using a multidisciplinary treatment approach and the length of time treatment may continue.

Pain Management Standards and Patient Rights

In 2001, standards were set in place for the management of pain in all facilities accredited by The Joint Commission (TJC). These organizations have since been required to

- recognize the right of patients to appropriate assessment and management of pain;
- screen patients for pain during their initial assessment and, when clinically required, during ongoing, periodic reassessments;
- educate patients suffering from pain and their families about pain management.

Pain Management Goals

Each person experiences pain differently. Two people with the same injury or disease process may describe their experience of pain in very different ways. Therefore, the goals of pain management must consider the individual patient's circumstances. The goals of pain management will also be different depending on the type of pain the patient is experiencing. General goals for a pain management program include:

- reduction of the incidence and severity of pain;
- enhancement of the patient's comfort and satisfaction;
- effective pain relief leading to fewer post-operative complications and shorter stays.

Pain Assessment

The American Pain Society (APS) observed in 1995 that a primary step toward effective treatment of pain would be to improve the assessment and recording of patient reports of pain. In late 1998, the Veterans Health Administration (VHA) announced a national campaign called "Pain As the 5th Vital Sign". Initiated throughout the VHA system in 1999, it required the use of a numeric scale during every patient encounter to help the patient self-report pain on a scale of 0-10. Any rating above 4 was to activate a prompt comprehensive pain assessment and intervention to relieve the patient's pain. Since the implementation of this initiative in the VHA system, it has become common practice nationally to assess pain using some form of a numeric rating scale during each patient encounter, as well as before and after administration of analgesics.

All patients have the right to the assessment and treatment of pain. Pain is a personal experience and cannot be measured in the same way as other medical problems with a blood test or an x-ray. Self-reporting is the single most reliable method of assessing pain. An integral part of self-reporting depends on the positive and trusting relationship

between the patient, family members (as appropriate), and the healthcare professional making the pain assessment. Patient teaching is also vitally important. Each organization is required to have its own policy and procedure for pain assessment in place. It is imperative for Allcare Nursing Services, Inc. clinicians to become familiar with and follow their organizations' protocol for pain assessment including the

- initial assessment;
- frequency of assessment;
- recording of assessment and findings;
- implemented pain management techniques;
- effectiveness of the implemented pain management techniques;
- specifics of the pain including
  - location;
  - quality;
  - onset;
  - frequency;
  - intensity;
  - what intensifies it;
  - what makes it better;

The pain assessment tool is generally a scale with either numerical values or facial expressions, which can help patients to rank their pain. These tools are helpful for all patients regardless of age, sex, language spoken, and cultural background. Some tools are designed for specific populations; for example, the Wong-Baker FACES® Pain Rating Scale is particularly useful with children. The use of a pain rating scale can be helpful in assessing a patient's pain. With a preoperative patient, it is helpful to review this tool with the patient before the patient experiences pain. Pain rating tools help the professional assess the intensity of pain, but other characteristics, such as location and character of the pain, must also be assessed.

Although these tools can be effective in making an accurate assessment of the intensity of pain that will assist in providing the information needed to manage a patient's pain, a review of professional literature since 2006 has unfortunately revealed that screening for pain has not met the overall goal of improving the quality of pain management for patients. It is thought that greater efforts toward implementing pain management measures based on the patient's self-report is necessary; it is not sufficient to gather the data unless follow-through on the patient's report is implemented effectively.

Pain Relief Strategy

Pain relief needs vary based on many factors: the origin of the pain, the patient's medical condition, the specific procedure being performed, pain tolerance, types of available interventions, personal preferences, cultural beliefs, age, and gender. Successful pain management focuses on controlling any factors that initiate or exacerbate pain, including physiologic, psychologic, pathologic, emotional, cognitive, environmental, and social factors.

The best strategy for successful pain relief is a flexible approach that includes

- a multidisciplinary approach, including all members of the healthcare team, the patient, and family members (when appropriate);
- proactive pain control that encompasses pain prevention methods;
- initial assessment and frequent reassessment;
- use of pharmacologic and non-pharmacologic therapies.

CONSCIOUS SEDATION

Conscious Sedation or Moderate Sedation/Analgesia (MSA) describes the result of the use of medications to minimally depress the level of consciousness yet allow the patient to independently maintain an open airway. The patient's protective reflexes and ability to respond purposefully to verbal commands and/or tactile stimulation are also maintained.

MSA is commonly used for a variety of surgical and diagnostic procedures, including closed reductions of fractures, endoscopic procedures, and radiological procedures. The primary distinguishing feature of MSA is the ability of the patient to independently maintain a patent airway. MSA is achieved when the patient experiences the onset of slurred speech yet remains able to respond appropriately to simple commands.

The administration of medications that cause MSA requires constant monitoring of the patient. Safe and effective management of these medications requires their administrator to be able to recognize and respond immediately to any adverse reaction or procedural complication. Providers and nurses who administer medications causing MSA must have the ability to focus solely on the task at hand, to recognize the presence of complications, and to intervene effectively if complications occur.

The patient's provider is responsible for obtaining informed consent prior to the procedure. Responsibilities of the nurse include patient assessment, medication administration, and uninterrupted monitoring before, during, and after sedation. Additional responsibilities include the ability to

- apply knowledge of anatomy, physiology, and pharmacology to potential complications of medications causing MSA;
- assess care requirements of the patient before, during, and after the administration of medications causing MSA;
- assess, diagnose, and intervene competently in accordance with institutional protocols if procedural complications occur;
- present current evidence of training in age-appropriate airway management and life support competency (BLS, ACLS, PALS, NRP) as required by professional organizations and institutional policies;
- recognize cardiac dysrhythmias and intervene emergently and effectively if they occur;
- recognize potential adverse reactions of each type of medication being administered for MSA;
- recognize whether equipment necessary for patient monitoring during MSA is available and functioning properly;
- understand the use of oxygen delivery devices.

If an outpatient procedure is to be performed, discharge and follow-up instructions should be given to the patient and/or the person responsible for the patient's care before the patient is sedated.

Patient Assessment

Prior to receiving medications causing MSA, patients must have current documentation of a medical history and physical assessment in their medical records. This assessment, though variable by institution, should also include the individual's

- age;
- airway status;
- allergies;
- anesthetic history;
- current medications;
- fasting (NPO) status;
- laboratory studies;
- mental status;
- vital signs;
- weight.

Some patients may not be candidates for MSA. The American Society of Anesthesiology (ASA) recommends that the use of MSA be restricted to those patients who are classified as ASA I (without systemic disease) or ASA II (with mild or well-controlled systemic disease). Patients who are evaluated as ASA III (with multiple or moderate controlled systemic diseases) may require additional consultation with the healthcare team in order to determine whether or not they may have MSA. Patients who are classified as ASA IV (with poorly controlled systemic disease) or ASA V (moribund) are not candidates for MSA; rather, they may require other forms of sedation or possibly anesthesia.

Further, a patient's fasting (NPO) status must be clearly assessed before receiving medications causing MSA. The patient who will receive these medications should not consume solid food or full liquids 6-8 hours prior to sedation and should not consume clear liquids 3-4 hours prior to sedation. When MSA could be utilized for an emergency procedure, careful consideration must be given to the risk of potential regurgitation or aspiration. It may be safer to delay the procedure (and sedation), as long as the delay would not increase the patient's risk for a poor outcome. Each facility should have a protocol for aspiration prevention for circumstances such as these.

Management and Monitoring

Healthcare professionals need to follow the specific institutional policies for the management and monitoring of patients receiving medications causing MSA. These policies may include

- reading, understanding, and following institutional guidelines for patient monitoring, drug administration, and protocols for management of procedural complications or emergencies;
- assurance that selection and ordering of agents being used to achieve MSA are done by a qualified anesthesia provider or attending provider;
- assurance that registered nurses who are not qualified anesthesia providers do not administer agents classified as anesthetics, including, but not limited to, ketamine (Ketalar®), propofol (Diprivan®), etomidate (Amidate®), thiopental (Pentothal®), methohexital (Brevital®), and nitrous oxide;
- administration of medications according to institutional policy, including validation of the provider's order, obtaining medications, and following these rights of medication administration:
  1. right patient;
  2. right medication;
  3. right dose;
  4. right route;
  5. right time.
- adherence to all national and state guidelines when administering any intravenous medication;
- resolution of any discrepancy between the guidelines and the provider's order before MSA begins;
- documentation of all medications on the patient's medical record.
- requirement that the healthcare professional monitoring the patient receiving medications causing MSA have no other responsibilities during the procedure;
- requirement that another healthcare professional be called in to assist the provider if assistance with the procedure is necessary;
- requirement that patients receiving MSA have
  1. vascular access maintained throughout the procedure;
  2. supplemental oxygen available during and after MSA;
  3. monitoring and documentation of physiologic measurements before, during, and after the procedure;
- adherence to the following standards of monitoring:
  1. assessment and recording of baseline blood pressure, cardiac rate and rhythm, respiratory rate, oxygen saturation, and level of consciousness;
  2. assessment and recording of the above parameters at least every 5 minutes during the procedure, every 5-15 minutes during recovery, and every 15 minutes once
     - at least 30 minutes have passed since administration of the last sedating medication;
     - the patient's vital signs are at baseline levels;
     - the patient returns to the pre-sedation level of consciousness and stability
- expectation that any unexpected response by the patient, such as dyspnea, cardiac dysrhythmias, diaphoresis, or an inability to arouse the patient will be immediately reported to the provider;.
- experiencing good pain control;
- experiencing no dizziness or syncope while out of bed;
- able to void;
- able to retain oral fluids without nausea or vomiting;
- given a written order for discharge and instructions for follow-up with the provider;
- leaving the facility under the care of a responsible person who is providing transportation from the hospital, if being discharged home.

EMPLOYMENT APPLICATION PROCESS

Allcare Nursing Services, Inc. recognizes that screening our nurses for certain clinical, academic and licensure requirements are necessary and part of the total qualification process of a "good nurse." Allcare Nursing Services, Inc. conducts a thorough initial application process and screening to be continuously aligned with this belief. Each applicant undergoes a rigorous screening process to verify skills and competence of our nurses. We also continually review and screen for other factors and requirements such as reliability, congeniality, responsiveness, acceptance of responsibilities and ability to perform with minimal supervision.

Verification of Identity and Work Eligibility

Allcare Nursing Services, Inc. verifies each applicant's eligibility to work in the United States. As required by the U.S. Immigration and Naturalization Service, we assure that our applicants show proof of citizenship/eligibility to work by completing an Employment Eligibility Verification Form (I-9) and by providing documents listed on the I-9 form as proof of identity and employment authorization. Failure to do so will result in unacceptance of employment.

License/Certification Verification

All positions requiring licenses and certifications require verification during the preemployment interview process. Employees who are licensed or certified must present proof at the time of pre-employment interview and, if hired, bi-annually or as required thereafter. This is to provide appropriate guidelines regarding the verification of each employee's licenses and certifications that are required to perform patient care duties.

It is the responsibility of the employee to ensure his/her license/certification is current and that all requirements for licensure are fulfilled and documented. If an employee does not possess evidence of license renewal and the existing license has expired, the Staffing Coordinator or Compliance Manager will verify license online on the respective regulatory board's website. An employee without current licensure/certification will not be permitted to work.

Reference Checks

Allcare Nursing Services, Inc. verifies applicant's employment history and job performance using at least two professional references from previous or current employers. Applicants are to get at least a satisfactory evaluation to continue with application process. We evaluate their clinical and professional performance to verify if applicant is a good fit to the company.

Background Checks

Allcare Nursing Services, Inc. performs criminal background checks on applicants, which includes at a minimum a felony and misdemeanor search in the state of California and may also include states and counties of residence/employment for the previous 7 years. Criminal background checks can also be conducted while employed based upon a reasonable suspicion of criminal activity.

Pre-Employment Skills Assessment/Competency Examinations

All applicants are required to complete a pre-employment skills assessment and a competency exam pertaining to their specialty to accurately assess their capability in performing safe and efficient patient care. Applicants must receive a passing score of 80% for their competency exam. If the applicant is unable to pass the first time, they will be given one additional attempt to take the exam. If the applicant is unable to pass the competency exam after two attempts, he or she won't be eligible for employment with Allcare Nursing Services, Inc. In addition, RNs and LVNs must complete a Pharmacology exam with a passing score of 80%. Applicants are given 2 attempts to pass the exam. If unable to do so, the applicant won't be eligible to work with Allcare Nursing Services, Inc.

During the application process, our Director of Nursing evaluates applicant competency through review of all competency self-assessments, competency examination, references and in-person or telephone interview. A position description that specifies job duties, expectations, qualifications and special requirements commensurate with the position are reviewed with each applicant as well.

Health Screening

Employees must substantiate their ability to safely perform the essential functions of their job by successfully completing a physical evaluation. Job offers will be contingent upon satisfactory completion of the health screening process. This evaluation will include the following:

- Physical examination- conducted within three months prior to hire date and annually thereafter.
- PPD skin test or QuantiFERON and/or chest x-ray (if positive)- If applicant tested negative, annual PPD skin test is required. If applicant tested positive, a chest x-ray is a must and is valid for 4 years.
- Proof of vaccinations of or immunization (titers) to MMR, varicella, and Hepatitis B. (Declination to Hep B vaccine is acceptable)
- 10-panel drug screen (*Please note that random drug screening may occur at any time.)*

During the initial interview by the Staffing coordinator or Director of Nursing, applicants will be advised of the necessity for a pre-employment physical evaluation. Prior to receiving a final commitment of employment and commencing work, each prospective employee must complete a pre-employment physical evaluation. The extent of the evaluation will reflect the requirements of the position applied for, as set forth in the job description and performance standards.

All physical evaluation information will be placed in the individual employee's health record. Access to this information will only be by written authorization from the employee due to its confidential nature, except in a medical emergency requiring immediate access to the employee's medical history or as otherwise permitted by law.

MAINTAINING NURSING PERSONNEL FILES

It is the policy of Allcare Nursing Services, Inc. that personnel records on all personnel will be maintained in compliance with the policy. This is to ensure confidentiality and conform to legal requirements regarding personnel records. Credentials are kept current through daily alerts of soon-to-expire or expired documents.

Hardcopies of personnel files are kept in a locked and secured file cabinet and digital copies are stored in a secured cloud storage application. Files can only be accessed by the Staffing/Compliance Coordinator, Recruiter, Director of Nursing, and Administrator.

ORIENTATION

It is the policy of Allcare Nursing Services, Inc. to provide a general orientation program for all new employees on their first day of employment. This is to assure accuracy in the completion of all State and Federal mandated new hire documents, as well as to orient new employees in Allcare Nursing Services policies and procedures. Each employee will receive an Employee Handbook.

Some facilities require some form of orientation. The amount of time required by each facility varies. Some facilities require computer training classes and orientation prior to the first shift worked. The staffing coordinator will explain required orientation to all employees prior to scheduling first shift with a facility. Some facilities offer paid orientation, however, some don’t. Please contact the staffing coordinator for details.

EDUCATION

Compliance with continuing education is the responsibility of Allcare Nursing Services, Inc. to ensure that all clinicians are current and up-to-date with evidence-based practices. Allcare Nursing Services, Inc. keeps record of available resources for continuing educations, certifications like BLS, ACLS, MAB, etc, and specialty certifications. Our clinicians are requested to send copies of any mandated certificates and/or continuing education certificates obtained to be added on their file. Failure to keep any of the mandated items current may result in suspension from assignment until said item/s is/are updated.

Allcare Nursing Services, Inc. encourages all staff to further their skills and knowledge as nursing professionals. Allcare Nursing Services, Inc. facilitates ongoing education of staff through:

- Annual in-services on:
  - Age Related Nursing Care Issued
  - Blood Glucose Monitoring
  - Body Mechanics
  - Code of Conduct
  - Confidentiality
  - Conscious Sedation
  - Cultural Diversity
  - Domestic Violence
  - Do-not-Send Prevention
  - "Do Not Use List" abbreviations
  - Dress Code/Nail Policy
  - Drug Free Workplace
  - Emergency Preparedness
  - End of Life Care
  - Fire and Electrical Safety
  - General Safety / Security
  - Hazardous Materials Communications
  - HIPAA
  - Infection Control / Bloodborne Pathogens
  - Job Description
  - Joint Commission Patient Safety Goals
  - Medication Error Prevention
  - National Patient Safety Goals
  - Organ and Tissue Donation
  - Pain Management Survey
  - Patient Education
  - Patient Fall Prevention
  - Patient Rights and Advance
  - Physical Assault – Work Place Violence
  - Radiation Safety
  - Restraint Devices
  - Risk Management/ Incident Report
  - Sexual Assault
  - Suicidality and Suicidal Assessment
  - Suspected Abuse and Neglect (child/adult/elderly)
- Education Reimbursement (if applicable)

PERFORMANCE EVALUATIONS

It is the policy of Allcare Nursing Services that employees are to be given regular performance evaluations. Performance evaluations provide the vehicle for the agency and the employee to discuss the employee's work performance, including, but not limited to the employee's initiative, work ethic, attitude, working relationships with others, job knowledge and other job-related factors, and to set goals and objectives to improve performance.

The purpose of performance evaluations is to standardize the performance evaluation procedure and to enhance the communication between Allcare Nursing and employee, about management's expectations and the employee's performance. Evaluations should be as objective and constructive as possible; and should communicate both positives and negatives, where appropriate.

Performance Evaluations are a tool to be used in the effort to add value to the employee and the agency. An employee should receive performance evaluations on the occasions listed below:

1. Probationary (3 months)
2. Annually

- Allcare Nursing Services, Inc. will attempt to request feedbacks from client representatives regarding clinical staff performance and competence. Unfortunately, some clients will not respond to Allcare Nursing's inquiry, so we follow a "competence by exception" philosophy. If we don't get any feedbacks from our clients, unless there is a written evidence of performance concerns, we will assume that our clinicians are meeting performance expectations.
- Once we receive feedbacks from our clients regarding poor clinical and/or professional performance, counseling is immediately provided to prevent further occurrences from happening and also to see if we can have our client reevaluate clinician's performance after counseling.
- The company assesses aspects of employee's competence at hire, at performance evaluation and as needed or required by state licensing agencies, to ensure that employees have the skills or can develop the skills to perform and continue to perform their duties.
- Any unsatisfactory scores will be reviewed and discussed with each nurse and methods for improvement recommended by Allcare Nursing Services, Inc.'s Director of Nursing. Performance Evaluations are a tool to be used in the effort to add value to the employee and the agency.

CLINICAL INCIDENTS AND SENTINEL EVENTS

As a healthcare provider, it is your duty and responsibility to promptly report any unsafe condition, sentinel event or unusual event that can result in a sentinel event. Everyone is expected to participate in maintaining a safe environment for patients, visitors, physicians and their coworkers. This means taking an active role in reporting any and all unsafe conditions, unusual or sentinel events. All such events should always be reported immediately to your charge nurse, nursing supervisor and Allcare Nursing Services, Inc.'s Clinical Liaison.

Clinical staff must recognize the importance of following effective procedures and are encouraged to speak up if something has compromised or might compromise patient safety and quality.

A Clinical Incident is any event or series of events that resulted in or had the potential to result in an adverse patient outcome. Clinical staff should notify Allcare Nursing Services, Inc. of any clinical incidents that occur while on assignment, regardless of an adverse outcome.

A sentinel event is an unexpected occurrence involving death or serious physical or psychological injury, or the risk thereof. Serious injury specifically includes loss of limb or function. The phrase "or the risk thereof" includes any process variation for which a recurrence would carry a significant chance of a serious adverse outcome.

Such events are called "sentinel" because they signal the need for immediate investigation and response.

EXAMPLES OF CLINICAL EVENTS

- Omission of treatment
- Deviation from policy
- Medication errors
- Improper equipment usage
- IV or Blood complications
- Patient fall
- Inaccurate clinical assessment
- Patient or physician complaint

EXAMPLES OF SENTINEL EVENTS

- Any patient death, paralysis, coma or other major permanent loss of function associated with a medication error
- A patient commits suicide within 72 hours of being discharged from a hospital setting that provides staffed around-the-clock care.

- Any elopement, that in unauthorized departure, of a patient from an around-the-clock care setting resulting in a temporally related death (suicide, accidental death, or homicide) or major loss of function.
- A hospital operates on the wrong side of the patient's body.
- Any intrapartum (related to the birth process) maternal death.
- Any perinatal death related to a congenital condition in an infant having a birth weight greater than 2500 grams.
- A patient is abducted from the hospital where he or she receives care, treatment or services.
- Assault, homicide, or other crime resulting in patient death or major permanent loss of function.
- A patient fall that results in death or major permanent loss of function as a direct result of the injuries sustained in the fall
- Hemolytic transfusion reaction involving major blood group incompatibilities
- A foreign body, such as a sponge or forceps that was left in a patient after surgery

JOINT COMMISSION'S SENTINEL EVENT POLICY

The Joint Commission has defined a sentinel event policy that you should be aware of. This policy has four goals:

1. To have a positive impact in improving patient care, treatment and services and preventing sentinel events
2. To focus the attention of an organization that has experienced a sentinel event on understanding the root causes that underlie the event, and on changing the organization's systems and processes to reduce the probability of such an event in the future.
3. To increase the general knowledge about sentinel events, their causes, and strategies for prevention.
4. To maintain the confidence of the public and accredited organizations in the accreditation process

In the event of deviation of practice according to the professional practice act, fraudulent behaviors, narcotic abuse or deviation and/or other aberrant or illegal behavior, each event is documented and a report is made, which includes information from the customer. The Clinical Liaison reports each situation according to the guidelines of the appropriate professional association.

COMPLAINT RESOLUTION (STAFF AND CUSTOMER)

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

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

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

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

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

- Other actions to eliminate the effects of violation of rights.

Our goal is to always provide you with a consistent level of service. If for any reason you are dissatisfied with our service or the service, we encourage you to contact the Allcare Nursing Services, Inc. Management to discuss the issue. Allcare Nursing Services, Inc. has processes in place to resolve complaints in an effective and efficient manner. If the resolution does not meet your expectation, we encourage you to call the Allcare Nursing Services, Inc. corporate office at 626-432-1999. A corporate representative will work with you to resolve your concern. Any individual that has a concern about the quality and safety of patient care delivered by Allcare Nursing Services, Inc. healthcare professionals, which has not been addressed by Allcare Nursing Services, Inc. management, is encouraged to contact the Joint Commission at www.jointcommission.org or by calling the Office of Quality Monitoring at 630.792.5636. Allcare Nursing Services, Inc. Staffing. demonstrates this commitment by taking no retaliatory or disciplinary action against employees when they do report safety or quality of care concerns to the Joint Commission.

DO-NOT-SEND PROCESS AND EMPLOYMENT TERMINATION POLICY

Allcare Nursing Services, Inc. is dedicated to ensuring that our team consists of exceptionally skilled and capable clinicians, proficient in delivering safe and quality patient care. As an employee of Allcare Nursing Services, Inc., your integral contribution significantly impacts our success in providing outstanding customer service and attaining Joint Commission certification.

As an integral component of our ongoing Quality Improvement Process, we consistently assess the performance of our clinicians to identify opportunities for growth and improvement. We actively seek feedback from our clients, who may submit incident reports or complaints concerning clinician performance in specific situations. In response, we conduct thorough investigations, considering perspectives from all parties involved, and provide necessary counseling as warranted. We also advocate for continuing education materials to support ongoing improvement, aiming to enhance performance and mitigate future occurrences.

In the event of a performance concern, we will apply the point system detailed below. Notably, substantial or persistent performance issues may lead to termination. The implementation of this program aligns with our objective to minimize the occurrence of performance issues and/or Do-Not- Sends. A healthcare professional accruing 5 points becomes eligible for termination.

1 point - Professional misconduct; poor customer service

3 points - Insufficient clinical proficiency, including, but not limited to, poor clinical performance, medication errors, complaints for incomplete documentation per specific unit policy, etc.

5 points - Patient endangerment

Association with illegal activities, including, but not limited to, falsifying medical records (personal and/or patient care), fraud, illicit drug and controlled substance use, etc.

SICK LEAVE AND PAID TIME OFF POLICY

1. Sick Leave Policy:

a. Accrual:
- Sick leave accrues at a rate of one hour for every 30 hours worked, starting from the first day of employment.

b. Usage:
- Sick leave can be utilized for personal illness, medical appointments, or caring for a sick family member.
- Employees must promptly inform their supervisor about illness and provide an estimated duration.

c. Payment:
- Sick leave is either fully paid or partially paid, with the rate of pay during sick leave being the regular hourly rate.

d. Carryover and Payout:
- Unused sick leave doesn't carry over and expires at the end of the year. Also, there is no payout of unused sick leave upon termination.

e. Notification:
- Employees are required to notify their supervisor of the need for sick leave within a specified timeframe.

f. Intermittent Leave:
- Intermittent sick leave may be granted with supervisor’s approval.

2. Paid Time Off (PTO) Policy:

a. Accrual:
- PTO accrues at a specified rate, beginning on the first day of employment. (PTO benefits are available to eligible employees) (All regular full-time employees are eligible to PTO hours.)

b. Usage:
- PTO may be used for vacation, personal time, or family events.
- Requests for PTO must be submitted in advance within a specified timeframe.

c. Payment:
- PTO is either fully paid or partially paid, with the rate of pay during PTO being the regular hourly rate.

d. Carryover and Payout:

- Unused PTO carries over annually, and the company may choose to provide a payout of unused PTO upon termination.

e. Holiday Policy:
- Company holidays are separate from PTO and are detailed in the company holiday schedule.

f. Scheduling:
- Certain blackout dates may apply during designated periods, such as busy seasons.

g. Notification:
- Employees must submit PTO requests through the designated system or process.

3. General Provisions:

a. Employee Eligibility:
- Sick leave and PTO benefits are available to eligible employees, as defined by specific criteria.

b. Review and Update:
- The policy will be reviewed annually and updated as necessary.

c. Compliance:
- All employees are expected to adhere to local labor laws and regulations governing sick leave and PTO.

d. Confidentiality:
- Medical information related to sick leave will be treated confidentially.

4. Employee Responsibilities:

a. Reporting Procedures:
- Employees must follow specified reporting procedures when requesting sick leave or PTO.

b. Advance Notice:
- Advance notice is required for PTO requests, with the specific timeframe outlined.

c. Documentation:
- Documentation may be required for extended periods of sick leave.