# Core Concepts Competency Manual

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**College of Nursing**
**Core Concepts Competency Manual**
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## Purpose of the Core Concepts Competency Manual

To provide Lourdes nursing students and faculty with a quality and safety framework in the areas of: Infection Prevention & Control, Disaster Preparedness, Safety Awareness and Emergency Responses, Code Systems, Personal Conduct & Ethics, Customer Service, Diversity, Patient Privacy, Body Mechanics, and Prevention of Workplace Violence. Participating clinical agencies expect basic core competencies. The Self-Study Module format allows review of the information and complete a basic core competency evaluation. It provides a foundation for teaching and learning at the clinical site, and enables students to start safely as beginning professionals in the clinical rotation. It also allows hosting agencies to be confident that Lourdes students and faculty are able to understand general policies and procedures that are universal to healthcare today.

## Core Concepts Competency Student Learning Outcomes

The outcomes incorporate the Franciscan values found in the Lourdes Mission and Philosophy statements. They emphasize preparedness prior to entering into the clinical sites as is stated in the Philosophy of the Core Concepts Competency Curriculum. They are consistent with the Purpose of the Core Competencies—to enable students and faculty to have mastery of beginning competencies, and hosting agencies to have confidence in the safety and basic foundational understanding of Lourdes students entering clinical sites.

1. Incorporate knowledge from the Core Concepts Competency Manual as a prerequisite for safe and responsible actions in nursing clinical settings.
2. Collaborate with nursing faculty--clarifying clinical site-specific questions about application of content in the Core Concepts Competency manual prior to and during the clinical experience.
3. Integrate Franciscan, personal values and beliefs, and Core Concepts Competencies into a clinical nursing framework of quality and safety in customer care and satisfaction.
4. Engage in professional behaviors and collaboration with nursing faculty and other health care providers using the Core Concepts Competencies as a minimum standard of patient care and professional conduct.
5. Demonstrate an understanding and appreciation of human diversity in the provision of nursing care.
6. Explore patient safety, customer service, infection control, privacy, professional conduct, emergency preparedness, and violence prevention in the context of patient care.
7. Develop an understanding of current Core Concepts Competencies and the need for development and change in these competencies as best practices emerge and evolve.
8. Develop a commitment for continuous quality improvement and professional development that includes adaptation to different clinical sites.

## Core Concepts Competency Curriculum Objectives

After completion of the Core Concepts Competency Curriculum and obtaining a passing grade in the post-test, students will be able to:

1.  Develop an understanding of the Health Insurance Portability and Accountability Act and implications to patient care.  (SLO 1, 2, 3, 4, 6, 7, 8)
2.  Identify essential professional and ethical characteristics of nursing personnel.  (SLO 1, 2, 3, 4, 5, 6, 7, 8)
3.  Establish customer service guidelines within the healthcare setting. (SLO 1, 2, 3, 4, 5, 6, 7, 8)
4.  Examine key components to providing culturally competent care for all clients. (SLO 1, 2, 3, 4, 5, 7, 8)
5.  Understand the purpose of The Joint Commission National Patient Safety Goals. (SLO 1, 4, 6, 7, 8)
6.  Apply proper safe patient handling and best clinical practice in order to prevent healthcare workers risk for injury. (SLO 1, 2, 6, 7, 8)
7.  Understand and identify the importance and proper technique of hand hygiene and personal protective equipment (PPE). (SLO 1, 6, 8)
8.  Apply the knowledge and practice of transmission-based precautions in clinical situations involving blood borne pathogens and tuberculosis to ensure a safe work environment. (SLO 1, 2, 4, 6, 7, 8)
9.  Identify different Advanced Directives documents and components of the Ohio's Do-Not-Resuscitate Law. (SLO1, 2, 3, 5)
10. Identify the different types of disasters healthcare workers may be exposed to, the disaster code system and Ohio hospital/healthcare homeland security response guide, and the importance of vaccination against H1N1 flu virus, Ebola virus and Zika. (SLO 1, 2, 6, 8)
11. Identify fire, chemical and electrical safety guidelines. (SLO 1, 2, 6, 7)
12. Cite risk factors, prevention strategies, appropriate response behaviors that help to avoid or de-escalate workplace violence incidences. (SLO 1, 2, 3, 4, 5, 6, 8)

**Bachelor of Science in Nursing (BSN) Professionalism Position Statement:**

The Lourdes University College of Nursing (CON) along with the American Nursing Association (ANA) Code of Ethics believes that the profession of nursing is one that demands adherence to a set of ethical principles. These high ideals are necessary to ensure that quality and safe care is extended to patients. As a student of nursing, this does not start with graduation; rather, it begins with membership in a professional higher learning community such as the Lourdes University CON BSN program.

A professionalism competency standard will therefore be in place throughout the Lourdes University BSN nursing program. Successful adherence of the professional competency standards are required of every graduate of the Lourdes University BSN Nursing program. Professional competency standards will be represented in various areas within the nursing program including but not limited to classroom norms and clinical evaluations.

Lourdes University CON BSN Program Faculty and or staff will submit a written description for each record of exemplary adherence to and/or violation of the expected norms. Exemplary adherence to the professional standards would require an above and beyond demonstration of the professional behavior.  The student will also have a meeting with the respective person reporting the violation and have a written remediation plan to help develop the student's professional conduct.

If repeated behavior is seen without successful remediation the student may be dismissed from the nursing program.

**Supporting Policies and Regulations**:

Lourdes CON BSN program has a ***Clinical Student Conduct Policy while Providing Nursing Care*** that was developed utilizing the Ohio Board of Nursing standards for safe nursing care as it relates to student conduct  in accordance with chapter 4723-5-12 C of the Revised Code and the rules adopted under that chapter, Health Insurance Portability and Accountability Act of 1996 (HIPPA), and National Student Nursing Association's (NSNA) Code of Academic and Clinical Conduct as a guide for the professional competency standards.

The professional competency standard criteria will hold the student accountable to "actively promote the highest level of moral and ethical principles and accept responsibility for his or her actions" (NSNA Standard 6).

This will also allow the adherence to a Student's Pledge below to agree to Lourdes CON BSN Program student norms developed from the Lourdes University's academic pillars of community: reverence, service, and learning.

# Student Pledge and Acknowledgement of Receipt and having Read the Ohio Board of Nursing Ch. 4723-5-12 C

As a student of nursing, I believe there is a need to build and reinforce a professional identity founded on integrity, ethical behavior, and honor. This development, a vital process in my education, will help ensure that I am true to the professional relationship I establish between myself and society as I become a member of the nursing community. Integrity will be an essential part of my everyday life and I will pursue all academic and professional endeavors with honesty and commitment to service and in the best of my ability. *With this understanding, I agree to adhere to the Professional Competency Standards set by the Lourdes University CON BSN Program. I further acknowledge that I am in receipt of and have read a copy of the Ohio Board of Nursing's section 4723-5-12(C) of the revised code as set forth regarding student conduct and the standards for safe nursing care as set forth in the rules adopted under this chapter.*

*Adapted from the University Of Illinois College Of Pharmacy Pledge of Professionalism, 1193, the American Association of Colleges of Pharmacy Council, 1194, and the Ohio Board of Nursing retrieved from: http://codes.ohio.gov/oac/4723-5-12 Developed and adapted by the Lourdes College of Nursing 2016*

## To accomplish this goal of professional competence, as a student of nursing I will:

Maintain a Community of Reverence:
- Mutual respect for one another in all forms of communications.
- Demonstrate respect for a constructive learning environment.
- Assume goodwill when someone says or acts in undesirable way.
- Keep an open mind and promote a judgment free atmosphere.
- Be respectful of technology in the education setting.

Maintain a Community of Service:
- Develop collegial relationships with fellow students.
- Encourage one another with supportive statements and actions.
- Offer solutions to identified issues and or problems.

Maintain a Community of Learning:
- Proactive educational preparation is expected.
- Utilize and develop critical thinking skills for educational endeavors.
- Active engagement in educational activities.
- Utilize university resources and technology to enhance educational experience.

**\*The above list of professional competency standards does not represent an all-inclusive list of behaviors that could be addressed in each category.**

## I voluntarily make this Pledge of Professionalism and Receipt/Reading of OBN Standards 4723-5-12 C;

**Student Signature:** Click here to enter text.

**Lourdes University ID #:** Click here to number.          **Date:** Click here to enter a date.

**Rules Promulgated from the Law Regulating the Practice of Nursing 4723-5-12 (C), Ohio Board of Nursing Administrative Code: Student Conduct While Providing Nursing Care**

Retrieved from: *http://codes.ohio.gov/oac/4723-5-12*

(C) In addition to the policies required in paragraph (A) of this rule, the program administrator and faculty shall implement policies related to student conduct that incorporate the standards for safe nursing care set forth in Chapter 4723. of the Revised Code and the rules adopted under that chapter, including, but not limited to the following:

(1) A student shall, in a complete, accurate, and timely manner, report and document nursing assessments or observations, the care provided by the student for the patient, and the patient's response to that care.

(2) A student shall, in an accurate and timely manner, report to the appropriate practitioner errors in or deviations from the current valid order.

(3) A student shall not falsify any patient record or any other document prepared or utilized in the course of, or in conjunction with, nursing practice. This includes, but is not limited to, case management documents or reports, time records or reports, and other documents related to billing for nursing services.

(4) A student shall implement measures to promote a safe environment for each patient.

(5) A student shall delineate, establish, and maintain professional boundaries with each patient.

(6) At all times when a student is providing direct nursing care to a patient the student shall:

(a) Provide privacy during examination or treatment and in the care of personal or bodily needs; and

(b) Treat each patient with courtesy, respect, and with full recognition of dignity and individuality.

(7) A student shall practice within the appropriate scope of practice as set forth in division (B) of section 4723.01 and division (B)(20) of section 4723.28 of the Revised Code for a registered nurse, and division (F) of section 4723.01 and division (B)(21) of section 4723.28 of the Revised Code for a practical nurse;

(8) A student shall use universal and standard precautions established by Chapter 4723-20 of the Administrative Code;

(9) A student shall not:

(a) Engage in behavior that causes or may cause physical, verbal, mental, or emotional abuse to a patient;

(b) Engage in behavior toward a patient that may reasonably be interpreted as physical, verbal, mental, or emotional abuse.

(10) A student shall not misappropriate a patient's property or:

(a) Engage in behavior to seek or obtain personal gain at the patient's expense;

(b) Engage in behavior that may reasonably be interpreted as behavior to seek or obtain personal gain at the patient's expense;

(c) Engage in behavior that constitutes inappropriate involvement in the patient's personal relationships; or

(d) Engage in behavior that may reasonably be interpreted as inappropriate involvement in the patient's personal relationships.

For the purpose of this paragraph, the patient is always presumed incapable of giving free, full, or informed consent to the behaviors by the student set forth in this paragraph.

(11) A student shall not:

(a) Engage in sexual conduct with a patient;

(b) Engage in conduct in the course of practice that may reasonably be interpreted as sexual;

(c) Engage in any verbal behavior that is seductive or sexually demeaning to a patient;

(d) Engage in verbal behavior that may reasonably be interpreted as seductive, or sexually demeaning to a patient.

For the purpose of this paragraph, the patient is always presumed incapable of giving free, full, or informed consent to sexual activity with the student.

(12) A student shall not, regardless of whether the contact or verbal behavior is consensual, engage with a patient other than the spouse of the student in any of the following:

(a) Sexual contact, as defined in section 2907.01 of the Revised Code;

(b) Verbal behavior that is sexually demeaning to the patient or may be reasonably interpreted by the patient as sexually demeaning.

(13) A student shall not self-administer or otherwise take into the body any dangerous drug, as defined in section 4729.01 of the Revised Code, in any way not in accordance with a legal, valid prescription issued for the student, or self-administer or otherwise take into the body any drug that is a schedule I controlled substance.

(14) A student shall not habitually or excessively use controlled substances, other habit-forming drugs, or alcohol or other chemical substances to an extent that impairs ability to practice.

(15) A student shall not have impairment of the ability to practice according to acceptable and prevailing standards of safe nursing care because of the use of drugs, alcohol, or other chemical substances.

(16) A student shall not have impairment of the ability to practice according to acceptable and prevailing standards of safe nursing care because of a physical or mental disability.

(17) A student shall not assault or cause harm to a patient or deprive a patient of the means to summon assistance.

(18) A student shall not misappropriate or attempt to misappropriate money or anything of value by intentional misrepresentation or material deception in the course of practice.

(19) A student shall not have been adjudicated by a probate court of being mentally ill or mentally incompetent, unless restored to competency by the court.

(20) A student shall not aid and abet a person in that person's practice of nursing without a license, practice as a dialysis technician without a certificate issued by the board, or administration of medications as a medication aide without a certificate issued by the board.

(21) A student shall not prescribe any drug or device to perform or induce an abortion, or otherwise perform or induce an abortion.

(22) A student shall not assist suicide as defined in section 3795.01 of the Revised Code.

(23) A student shall not submit or cause to be submitted any false, misleading or deceptive statements, information, or document to the nursing program, its administrators, faculty, teaching assistants, preceptors, or to the board.

(24) A student shall maintain the confidentiality of patient information. The student shall communicate patient information with other members of the health care team for health care purposes only, shall access patient information only for purposes of patient care or for otherwise fulfilling the student's assigned clinical responsibilities, and shall not disseminate patient information for purposes other than patient care or for otherwise fulfilling the student's assigned clinical responsibilities through social media, texting, emailing or any other form of communication.

(25) To the maximum extent feasible, identifiable patient health care information shall not be disclosed by a student unless the patient has consented to the disclosure of identifiable patient health care information. A student shall report individually identifiable patient information without written consent in limited circumstances only and in accordance with an authorized law, rule, or other recognized legal authority.

(26) For purposes of paragraphs (C)(5), (C)(6), (C)(9), (C)(10), (C)(11) and (C)(12) of this rule, a student shall not use social media, texting, emailing, or other forms of communication with, or about a patient, for non-health care purposes or for purposes other than fulfilling the student's assigned clinical responsibilities.

## Professional Behavior/Standards

Nursing is a profession that has earned the public's trust. The importance of integrity, trustworthiness and honesty in students are very serious concerns due to the implications to patient safety. The American Nursing Association (ANA) Code of Ethics which guides the nursing profession to promote professional behavior is as follows:

## American Nurses Association Code of Ethics for Nurses

*Reprinted with permission from American Nurses Association, Code of Ethics for Nurses with Interpretive Statements, (c) 2001 Nursesbooks.org, Silver Spring, MD.*

The ANA House of Delegates approved these nine provisions of the new Code of Ethics for Nurses at its June 30, 2001 meeting in Washington, DC. In July 2001, the Congress of Nursing Practice and Economics voted to accept the new language of the interpretive statements resulting in a fully approved revised Code of Ethics for Nurses with Interpretive Statements.

- The nurse, in all professional relationships, practices with compassion and respect for the inherent dignity, worth and uniqueness of every individual, unrestricted by considerations of social or economic status, personal attributes, or the nature of health problems.
- The nurse's primary commitment is to the patient, whether an individual, family, group, or community.
- The nurse promotes, advocates for, and strives to protect the health, safety, and rights of the patient.
- The nurse is responsible and accountable for individual nursing practice and determines the appropriate delegation of tasks consistent with the nurse's obligation to provide optimum patient care.
- The nurse owes the same duties to self as to others, including the responsibility to preserve integrity and safety, to maintain competence, and to continue personal and professional growth.
- The nurse participates in establishing, maintaining, and improving healthcare environments and conditions of employment conducive to the provision of quality health care and consistent with the values of the profession through individual and collective action.
- The nurse participates in the advancement of the profession through contributions to practice, education, administration, and knowledge development.
- The nurse collaborates with other health professionals and the public in promoting community, national, and international efforts to meet health needs.
- The profession of nursing, as represented by associations and their members, is responsible for articulating nursing values, for maintaining the integrity of the profession and its practice, and for shaping social policy.

Students are held to the same standard of behavior as a practicing nurse. Failure to adhere to professional standards will often result in dismissal from a nursing program. Student conduct while providing nursing care includes, *but is not limited* to the following:

**National Student Nurses' Association, Inc. - Code of Academic and Clinical Conduct**

**Preamble**
Students of nursing have a responsibility to society in learning the academic theory and clinical skills needed to provide nursing care. The clinical setting presents unique challenges and responsibilities while caring for human beings in a variety of health care environments.
The Code of Academic and Clinical Conduct is based on an understanding that to practice nursing as a student is an agreement to uphold the trust with which society has placed in us. The statements of the Code provide guidance for the nursing student in the personal development of an ethical foundation and need not be limited strictly to the academic or clinical environment but can assist in the holistic development of the person.
**A Code for Nursing Students-As students are involved in the clinical and academic environments, we believe that ethical principles are a necessary guide to professional development. Therefore, within these environments we:**
1. Advocate for the rights of all clients.
2. Maintain client confidentiality.
3. Take appropriate action to ensure the safety of clients, self, and others.
4. Provide care for the client in a timely, compassionate and professional manner.
5. Communicate client care in a truthful, timely and accurate manner.
6. Actively promote the highest level of moral and ethical principles and accept responsibility for our actions.
7. Promote excellence in nursing by encouraging lifelong learning and professional development.
8. Treat others with respect and promote an environment that respects human rights, values and choice of cultural and spiritual beliefs.
9. Collaborate in every reasonable manner with the academic faculty and clinical staff to ensure the highest quality of client care.
10. Use every opportunity to improve faculty and clinical staff understanding of the learning needs of nursing students.
11. Encourage faculty, clinical staff, and peers to mentor nursing students.
12. Refrain from performing any technique or procedure for which the student has not been adequately trained.
13. Refrain from any deliberate action or omission of care in the academic or clinical setting that creates unnecessary risk of injury to the client, self, or others.
14. Assist the staff nurse or preceptor in ensuring that there is full disclosure and those proper authorizations are obtained from clients regarding any form of treatment or research.
15. Abstain from the use of alcoholic beverages or any substances in the academic and clinical setting that impair judgment.
16. Strive to achieve and maintain an optimal level of personal health.
17. Support access to treatment and rehabilitation for students who are experiencing impairments related to substance abuse and mental or physical health issues.
18. Uphold college policies and regulations related to academic and clinical performance, reserving the right to challenge and critique rules and regulations as per college grievance policy.

Adopted by the NSNA House of Delegates, Nashville, TN, on April 6, 2001.

The nursing profession demands that the individual be responsible, accountable, self-directed and professional in behavior. The process of becoming a professional person begins upon entering a professional education program.

*Students demonstrate professional behavior by:*
- *Actively engaging in classes and clinical experiences,*
- *Maintaining respectful behavior in all forms of communication with others (especially during difficult situations and including social media).*
- *Being on time and prepared for class/clinical, completing assignments on time*
- *Being punctual for all appointments.*

## Customer Service

Customer service or "bedside manner" is one of the most important functions of the health care industry. Surveys confirm that patients who receive good customer service report better health outcomes and higher levels of satisfaction with their overall healthcare. Every service provider of a healthcare facility should be trained in proper techniques and or principles for delivering superior customer service to patients.

### Compassion
Compassion is an important aspect of healthcare customer service. People in hospitals, clinics and doctor's offices are often sick, in pain and worried. Good customer service means understanding and empathizing with the patient in tough situations and changing your approach to fit the patient's needs. Without compassion, you run the risk of further upsetting a patient, which can have detrimental effects on overall health outcomes.

### Responsiveness
Good customer service in healthcare means providing an extra measure of responsiveness. Patients' needs should be met as soon as possible to avoid undue discomfort or worry. Oblige reasonable patient requests whenever possible, even if the request creates an inconvenience for you or other staff members. If you cannot provide what the patient needs, explain why and offer an alternative.

### Restraint
Healthcare customer service also involves displaying a high level of professional restraint in dealing with a diverse array of people and situations. A patient who is nervous, sick or in pain may become defiant and argumentative, and may lose his temper easily. Work to keep your responses to patients' requests cordial, empathetic and positive even if the patient is demanding or unruly.

### Attention
Paying attention to a patient's body language, tone of voice, and health conditions will help improve customer service in a healthcare setting. You must be able to tell when a patient is uncomfortable physically, mentally and emotionally in order to meet their needs. Missing important details can affect the outcome of care and is not good customer service.

**Customer Service Tips for Nurses:**
- Observe other more experienced nurses interacting with patients
- Communicate in simple terms/offer the patient to ask questions after explaining something.
- Give common courtesies – being polite, and asking about the patient's preferences or day.
- Maintain professional image
- Express interest and concern-remember to communicate respectfully and with empathy.


## <u>Providing Population Competent Care</u>

The steadily increasing diversity of the patient population and workforce in the United States has heightened awareness that all health care providers need to be more skilled in understanding and responding to differences. Race, age, gender, disability, religion, personality style, language, sexual orientation, and other cultural and socioeconomic factors influence health promotion and help- seeking behaviors.  Health care organizations are committed to creating an environment that is respectful of differences and consistently uses behaviors that communicate respect. All health care providers, including students, must learn to recognize, respect and work with patients across different developmental stages, from different cultures and with different values, beliefs, practices and rituals. This will eliminate barriers to the delivery of health care and generate improved, measurable outcomes.

**Barriers to Diversity:**
People who have negative attitudes towards other people's differences often engage in negative behaviors, including:
- **Prejudice**: a preconceived feeling or bias without getting to know a person.
- **Stereotyping**: applying a certain belief to all members of a particular group.
- **Discrimination**: treating people differently and unequally just because they are a member of a particular group. Discrimination can take many forms -- racism, sexism, ageism are all examples.

**Cultural Competence:**
Cultural competence supports the development of patient-centered care as well as family-centered care by providing individualized care that recognizes the patient's preferences; values and needs, and respects the patient or designee as a full partner in providing compassionate, coordinated, appropriate, safe and effective care. Cultural competence includes the knowledge, skills, and attitudes necessary for providing quality care to diverse populations and the commitment to minimize the negative behavior of healthcare providers to cultural differences. Providing culturally competent care includes:
- A willingness to learn about other cultures.
- Knowing and understanding cultural norms, attitudes, and beliefs and culturally influenced health behaviors.
- Listening to patients/residents carefully; asking questions sensitively.
- Valuing diversity.
- Recognizing personal biases, stereotypes, and prejudices. Eliminating stereotypes and generalizations. Avoiding words that suggest all or most members of a particular group are the same.

- Providing an interpreter so that the patient/resident can participate in decisions regarding care.
- Learning verbal and nonverbal cues of other cultures.
- Implementing nursing care to meet the needs of patients/residents based on cultural values and beliefs influencing health care and nursing practice.

**ACCESS Model: Delivering Transcultural Nursing Care**

The ACCESS Model (Narayanasamy, 2002) offers a framework to deliver transcultural nursing care. ACCESS stands for the components of the model: assessment, communication, cultural negotiation and compromise, establishing respect and rapport, sensitivity, and safety. The table below describes the components of the model.

| Components of the ACCESS Model | |
|---|---|
| **A** | **Assessment** <br> Focus on cultural aspects of clients' lifestyles, health beliefs, and health practices |
| **C** | **Communication** <br> Become aware of variations in verbal and nonverbal responses |
| **C** | **Cultural negotiation and compromise** <br> Become more aware of aspects of other people's cultures and of understanding clients' views and explaining their problems |
| **E** | **Establishing respect and rapport** <br> Portray genuine respect for clients' cultural beliefs and values |
| **S** | **Sensitivity** <br> Deliver diverse, culturally sensitive care to culturally diverse groups |
| **S** | **Safety** <br> Enable clients to derive a sense of cultural safety |

**Health Insurance Portability and Accountability (HIPAA)**


**What does HIPAA stand for?**
    **H**– Health
    **I** – Insurance
    **P**– Portability
    **A**– And Accountability
    **A**– Act

The federal Health Insurance Portability and Accountability Act (HIPAA) of 1996, along with state law, mandates the privacy and security of Protected Health Information (PHI), the portability of health insurance and simplification of electronic billing.

**Components of HIPAA**
1. Transactions (codes used in billing)
2. Privacy
3. Security

**What is the purpose of HIPAA?**
- Protects the privacy of an individual's health information.
- Ensures physical and technical security of an individual's health information.
- Governs the use and disclosure of an individual's health information for treatment, health care billing, research, marketing and other functions.

**The Privacy Rule**
The HIPAA Privacy Rule establishes minimum safeguards to protect confidentiality of an individual's health information. The HIPAA Privacy Rule protects:
- An individual's health information in all forms: electronic, paper, spoken and whether past, present or future.
- The rule protects individuals, living and dead, and or groups in both the public and private sector.

**What is Protected Health Information?**
Protected Health Information is commonly referred to as PHI. PHI is defined as facts about an individual's past, present or future physical or mental health condition.

**What information is included in PHI?**
Examples of PHI include:
- **Demographic Information:** Name, Address, Social Security Number, Date of Birth, Telephone Number, Email Address
- **Clinical Information:** Diagnoses, Test results, Procedures, Images or Photos, Past, Present, or Future Services
- **Billing Information:** Medical Record Number, Employer information, Charges, Collection Status

**Safeguarding Patient Information**

**Here are some ways that you can safeguard patient information.**

Be aware of how PHI can be seen or heard by others:
- Limit conversations to private areas, NEVER in elevators, hallways or other public places
- Close curtains and speak softly in semi-private rooms
- Do not leave records or documents unattended
- Never post PHI in view of the public
- Immediately retrieve documents from printers, faxes and copiers
- Use shredders or secured bins to discard PHI
- Protect printed/written PHI in ALL forms, i.e. name bands, prescription bottles, IV bags, etc.

Take special precautions with recorded and electronic information:
- Never leave health information on answering machines or voice mail
- Double check fax numbers, use a cover sheet
- Log off systems when done accessing patient information
- Turn monitors away from public view
- NEVER share your login information
- NEVER use someone else's login
- Choose a strong password- letters and numbers difficult for others to guess
- Protect disks, CD's, flash drives that contain PHI
- DO NOT open email attachments from unknown sources- could contain viruses
- Report suspicious emails

Additional guidelines:
- Know and follow facility policies
- Only access PHI needed to do your job
- Provide only the PHI others need to do their jobs
- Maintain professionalism and patient privacy at all times
- DO NOT contribute to gossip or spread of rumors

**The Joint Commission**

The Joint Commission (JC) seeks to continuously improve health care for the public, in collaboration with other stakeholders, by evaluating health care organizations and inspiring them to excel in providing safe and effective care of the highest quality and value. The Joint Commission evaluates and accredits more than 18,000 health care organizations and programs in the United States. To earn and maintain The Joint Commission's Gold Seal of Approval, an organization must undergo an on-site survey by a Joint Commission survey team at least every three years.

For more information, please visit www.jointcommission.org

**Safety**

# 2016 Hospital National Patient Safety Goals

The Joint Commission
Accreditation
*Hospital*

**The purpose of the National Patient Safety Goals is to improve patient safety. The goals focus on problems in health care safety and how to solve them.**

**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. |
| NPSG.01.03.01 | Make sure that the correct patient gets the correct blood when they get a blood transfusion. |

**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. Make sure the patient knows which medicines to take when they are at home. 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. |
| NPSG.07.03.01 | Use proven guidelines to prevent infections that are difficult to treat. |
| NPSG.07.04.01 | Use proven guidelines to prevent infection of the blood from central lines. |
| NPSG.07.05.01 | Use proven guidelines to prevent infection after surgery. |
| NPSG.07.06.01 | Use proven guidelines to prevent infections of the urinary tract that are caused by catheters. |

**Identify patient safety risks**

| | |
|---|---|
| NPSG.15.01.01 | Find out which patients are most likely to try to commit 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. |

### Speak Up

The "Speak Up" program is sponsored by The Joint Commission and other safety-focused organizations and urges patients to get involved in their care.

- **S**peak up – patients have the right to ask questions if they do not understand or have concerns.
- **P**ay attention to the care they receive – Make sure they are getting the right treatments and/or medications.
- **E**ducate themselves about their diagnosis, medical tests they are going to undergo and the treatment plan.
- **A**sk a trusted family member or friend to be their advocate.
- **K**now what medications they are taking and why they take them.

- **U**se a hospital they trust.
- **P**articipate in all decisions about their treatment.


### Disaster Management/Emergency Preparedness

**Disaster** = A situation that occurs when a disruption to a facility or community, due to a natural or man-made hazard, results in many injuries, the loss of lives, or the destruction of a large amount of property.

**Emergency** = A situation resulting from a man-made or natural hazard, requiring a rapid response to minimize damage.

According to the Occupational Health & Safety Administration, some examples of disasters or emergencies that health care workers may come into contact with include but are not limited to:
- Lifting and moving patients,
- Needle sticks,
- Slips, trips, and falls, and the potential for agitated or combative patients or visitors.
- Chemical- biological
- Terrorism- bioterrorism
- Radiation- nuclear
- Natural or weather related events

All facilities must have a disaster management plan and as a student assigned to that facility it is your responsibility to become familiar with that plan in the unlikely event that it must be activated while you are on the premises.

Each clinical site will have a system for activating emergency response teams. These teams are thoroughly trained for potential emergencies. Each facility must have a plan of action that includes inflow of mass casualties, use of various fire extinguishers, shutdown procedures, evacuation procedures and activation of alarms and disaster codes.

Below you will find **the Ohio Emergency Code System**. These are universal throughout Ohio.

| CODE NAME | EVENT |
|---|---|
| Code Red | Fire |
| Code Adam | Infant/Child Abduction |
| Code Black | Bomb/Bomb Threat |
| Code Gray | Severe Weather |
| Code Orange | Hazardous Material Spill/Release |
| Code Blue | Medical Emergency - Adult |
| Code Pink | Medical Emergency - Pediatric |
| Code Yellow | Disaster |
| Code Violet | Violent Patient/Combative |
| Code Silver | Person with Weapon/Hostage Situation |
| Code Brown | Missing Adult Patient |

In the event of an emergency, quickly follow the instructions of your instructor, preceptor or unit supervisor. Every facility must have emergency evacuation routing maps displayed to help you plan your route of escape and patient evacuation. Familiarize yourself with these escape routes; you are responsible for knowing the unit and facility safety and disaster plan.

**Below is a copy of the Ohio Hospital/Healthcare Homeland Security Response Guide:**

| LEVEL | RECOMMENDED EMERGENCY ACTION STEPS |
|---|---|
| **SEVERE (RED)** A WMD terrorist incident has occurred which requires an immediate process to identify, acquire, and plan the use of federal resources to augment state and local authorities in response to limited or major consequences of a terrorist use or employment of WMD. | • Consider activating the command center and initiating disaster preparedness plan.<br>• Notify all department heads via call tree.<br>• Consider lock down and control access procedures and implement positive identification of all persons, no exceptions<br>• Implement parking restrictions and park vehicles away from facility.<br>• Place traffic and pedestrian barriers in place as needed<br>• Scrutinize all deliveries.<br>• Put up signage indicating patient treatment areas, information area, family area, etc. as needed.<br>• Check all suitcases, briefcases, packages, etc. brought into the facility.<br>• Secure all doors. Maintain a security presence at a single point of access to each building.<br>• Check identification of all visitors. Visiting hours may be altered.<br>• Make frequent checks of perimeter and critical facilities.<br>• Consider providing family care facilities for staff responding to Red Alert.<br>• Arrange for food service to provide meals to staff.<br>• Alert CFO to begin collecting expense data (personnel, equipment, supplies, etc.)<br>• Ensure supply inventories for 3-5 day supply<br>• Consider initiating process for early patient discharge or transfers |
| **HIGH (ORANGE)** A threat assessment indicates that the potential threat is credible, and confirms the involvement of WMD in the developing terrorist incident. | • Normal daily operations are unaffected.<br>• Review security operations for changes as needed.<br>• Advise administration of threat level<br>• Administration to determine response based on local activities.<br>• Check supply inventories for 3-5 day supply.<br>• Test all telecommunication equipment for operational readiness.<br>• Consider limiting access points to hospital and enforce entry control procedures.<br>• Review media protocol |
| **ELEVATED (YELLOW)** Intelligence or an articulated threat indicates a potential for a terrorist incident, however, this threat has not yet been assessed as credible. | • Normal daily operations are unaffected.<br>• Review security operations for changes as needed.<br>• Review incident command structure and command center operations.<br>• Review media protocols.<br>• Ensure communications equipment is operational and available. |
| **GUARDED (BLUE)** Received threats that do not warrant actions beyond normal liaison notifications or placing assets or resources on a heightened alert (operating under normal day-to-day conditions). | • Normal daily operations are unaffected.<br>• Review security operations for changes as needed. |
| **LOW (GREEN)** Normal operating conditions | • Normal daily operations are unaffected. |

## Fire Safety

Fire safety becomes everyone's job at a worksite. Employers should train workers about fire hazards in the workplace and about what to do in a fire emergency. This plan should outline the assignments of key personnel in the event of a fire and provide an evacuation plan for workers on the site.

> **R.A.C.E.**
> **Rescue** the patient or any person from immediate danger.
> **Alarm**. Pull an alarm or notify another person to pull an alarm.
> **Contain** the fire and smoke by closing doors and windows.
> **Extinguish** the fire if it does not put you in danger. Extinguish with an appropriate fire
>     extinguisher. If you cannot safely extinguish the fire, leave the area.
>
> **P.A.S.S.**
> **Pull** the pin.
> **Aim** at the base of the fire.
> **Squeeze** the handle.
> **Sweep** back and forth.

Most facilities have class A, B, C fire extinguishers that can be used on three different kinds of fires: Class A (ordinary combustibles such as wood or paper), Class B (flammable liquid fires such as grease or gasoline) or Class C (electrical fires). However, it is your responsibility to recognize which fire extinguisher is available in your clinical area, its appropriate use, and the location of fire extinguishers and fire alarm pull boxes.

**\*In case of a fire, do not use elevators**

## Electrical Safety

Electrical equipment failure is the second leading cause of fires in health care facilities. Because electrical equipment is used throughout client and support areas of health care facilities, all employees should know how to use electrical equipment safely and the steps to take in case of an electrical hazard.

Health care facilities must have plans for meeting their emergency power needs during a power outage. When the emergency power system is in use, only the RED wall outlets are functional. Only critical electrical equipment should be utilized during a power failure.

Health care workers must often operate electrical equipment. When you are called upon to do so, follow these safety guidelines:
- Use only electrical equipment that you have been trained to use.
- Keep electrical cords or connections away from water or other liquids.
- Do not operate electrical appliances inside an oxygen canopy.
- Plug only one piece of medical electronic equipment into each outlet
- Do not use extension cords not approved by the health care facility. (A multiple outlet strip can be used to support office computers, however.)
- Do not use adapters that convert three prongs to two prongs in health care facilities.

- Do not use personal appliances in health care facilities.
- Instruct clients on the facility's policy regarding use of personal equipment from home.
- Do not attempt to fix outlet connections by bending prongs on the plug.

**\* If a piece of equipment fails, immediately disconnect it from its power source and notify your instructor.**

## Chemical Safety

**The Hazard Communication standard (HCS)** has been revised to align with the United Nations Globally Harmonized System of Classification and Labelling of Chemicals (GHS Revision, 2009).Chemicals pose a wide range of health hazards (such as irritation, sensitization, and carcinogenicity) and physical hazards (such as flammability, corrosion, and reactivity). OSHA's Hazard Communication Standard (HCS) is designed to ensure that information about these hazards and associated protective measures is disseminated. This is accomplished by requiring chemical manufacturers and importers to evaluate the hazards of the chemicals they produce or import, and to provide information about them through labels on shipped containers and more detailed information sheets called **safety data sheets (SDSs)**. Chemical manufacturers and importers are required to evaluate the hazards of the chemicals they produce or import, and prepare labels and safety data sheets (SDSs) to convey the hazard information to their downstream customers. All employers with hazardous chemicals in their workplaces must have labels and SDSs for their exposed workers, and train them to handle the chemicals appropriately.

**The SDSs should include:**
- **Identification-**label, recommended use and restrictions of use, contact info for the responsible party, emergency number
- **Hazardous Identification-** classification (class and category), signal word(s), hazard statement, pictogram symbol or a description of the symbol, unknown acute toxicity percentage if the ingredient with unknown acute toxicity is present at a concentration > or equal to 1%
- **Composition-** chemical name, common name and synonyms, chemical abstract service registry number and unique identifiers. If chemical is a mixture exact % or concentration ranges of all ingredients must be classified above and below the health risk limits.
- **First-aid measures-** necessary first aid measures by route of exposure, most important symptoms and when they occur, whether medical attention is needed immediately
- **Fire-fighting measures-** extinguishing media to use, required PPE
- **Accidental release measures-**precautions, PPE, spill cleanup, methods, materials for containment
- **Handling and storage**-precautions for safe handling, storage conditions
- **Exposure and controls/personal protection**- permissible exposure limit, American of Governmental Industrial hygienists threshold limit value and others controls
- **Physical and chemical properties**-appearance, odor, melting point, pH, etc...
- **Stability and Reactivity**-chemical stability, possible hazardous reactions, etc..
- **Toxicological information**-routes of exposure, symptoms related to characteristics

**HCS Pictograms and Hazards:**

| Health | Flame | Exclamation Mark | Gas Cylinder | Fatal |
|---|---|---|---|---|

| Corrosion | Explosives | Oxidizers | Aquatic Toxicity |
|---|---|---|---|

## Abuse and Neglect

Abuse and Neglect are serious problems that heath care workers could encounter in the clinical setting.  If you suspect a problem related to abuse and/or neglect, notify your clinical instructor and/or primary nurse immediately.  If you still feel concerned that the problem is not being taken seriously, notify the charge nurse of the unit.  Health care workers are obligated to report abuse/neglect to the Department of Human Services for follow-up.  This can be done in writing or orally by phone.

## Abuse/Neglect in Children

According to the most recent report of data from the National Child Abuse and Neglect Data System (NCANDS), in 2012, there were approximately 679,000 instances of confirmed child maltreatment. The overall national child victim rate was 9.2 child victims per 1,000 children in the population. State child victim rates varied dramatically, ranging from 1.2 child victims per 1,000 children to 19.6 child victims per 1,000 children.

- ▪ Maltreatment can take many forms, and some children can suffer from more than one type. Since 1999, the majority of children confirmed to be victims of child maltreatment experienced neglect. The following are the percentages of children who experienced maltreatment in 2005 (USDHHS, 2007):

| | | | |
|---|---|---|---|
| Neglect | 62.8% | Emotional/psychological abuse | 7.1% |
| Physical abuse | 16.6% | Medical neglect | 2.0% |
| Sexual abuse | 9.3% | Other | 14.3% |

Consider the possibility of **physical abuse** when the child:
- Has unexplained burns, bites, bruises, broken bones, or black eyes
- Has fading bruises or other marks noticeable after an absence from school
- Seems frightened of the parents and protests or cries when it is time to go home
- Shrinks at the approach of adults
- Reports injury by a parent or another adult caregiver

Consider the possibility of **neglect** when the child:
- Is frequently absent from school
- Begs or steals food or money
- Lacks needed medical or dental care, immunizations, or glasses
- Is consistently dirty and has severe body odor
- Lacks sufficient clothing for the weather
- Abuses alcohol or other drugs
- States that there is no one at home to provide care

Consider the possibility of **emotional maltreatment** when the child:
- Shows extremes in behavior, such as overly compliant or demanding behavior, extreme passivity, or aggression
- Is either inappropriately adult (parenting other children, for example) or inappropriately infantile (frequently rocking or head-banging, for example)
- Is delayed in physical or emotional development
- Has attempted suicide
- Reports a lack of attachment to the parent

Consider the possibility of **sexual abuse** when the **child**:
- Has difficulty walking or sitting
- Suddenly refuses to change for gym or to participate in physical activities
- Reports nightmares or bedwetting
- Experiences a sudden change in appetite
- Demonstrates bizarre, sophisticated, or unusual sexual knowledge or behavior
- Becomes pregnant or contracts a venereal disease, particularly if under age 14
- Runs away
- Reports sexual abuse by a parent or another adult caregiver

**Types of Elder Abuse**

**Passive and Active Neglect**: With passive and active neglect the caregiver fails to meet the physical, social, and/or emotional needs of the older person. The difference between active and passive neglect lies in the intent of the caregiver. With active neglect, the caregiver intentionally fails to meet his/her obligations towards the older person. With passive neglect, the failure is unintentional; often the result of caregiver overload or lack of information concerning appropriate caregiving strategies.

**Physical Abuse**: Physical abuse consists of an intentional infliction of physical harm of an older person. The abuse can range from slapping an older adult to beatings to excessive forms of physical restraint (e.g. chaining).

**Material/Financial Abuse**: Material and financial abuse consists of the misuse, misappropriation, and/or exploitation of an older adult's material (e.g. possessions, property) and/or monetary assets.

**Psychological Abuse**: Psychological or emotional abuse consists of the intentional infliction of mental harm and/or psychological distress upon the older adult. The abuse can range from insults and verbal assaults to threats of physical harm or isolation.

**Sexual Abuse**: Sexual abuse consists of any sexual activity for which the older person does not consent or is incapable of giving consent. The sexual activity can range from exhibitionism to fondling to oral, anal, or vaginal intercourse.

**Violations of Basic Rights**: Violations of basic rights is often concomitant with psychological abuse and consists of depriving the older person of the basic rights that are protected under state and federal law ranging from the right of privacy to freedom of religion.

**Self-Neglect**: The older person fails to meet their own physical, psychological, and/or social needs.

**Domestic Violence/Partner Abuse**

**What is domestic violence?**
Domestic violence, also called Battery, Partner Abuse, and Spousal Abuse is a type of abuse. It involves injuring someone, usually a spouse or partner, but it can also be a parent, child or other family member. Some types of abuse include the following:

- Physical abuse is the use of physical force to inflict harm, such as hitting, kicking/biting.
- Sexual abuse means any forced sexual activity.
- Emotional abuse includes threats, constant criticism and put-downs.
- Controlling access to money and controlling activities are other abusive behaviors.

Domestic violence is a serious problem. It is a common cause of injury. Victims may suffer physical injuries such as bruises or broken bones. They may suffer emotionally from depression, anxiety or social isolation.

**What should I know about domestic violence?**
Violence against a partner or a child is a crime in all states. According to the Centers for Disease Control and Prevention, one out of every four women and one out of every nine men in the United States are victims of domestic violence at some point in their lives. Abuse happens to people of all races, ages, incomes and religions. It is hard to know exactly how common domestic violence is, because people often do not report it. There is no typical victim. It happens among people of all ages. It affects those of all levels of income and education. People who are hurt by their partners, parents or guardians do not cause the abuse. Alcohol and drugs do not cause abuse, although they can make the violence worse. Abuse can begin, continue, and even increase during pregnancy.

## Preventing Workplace Violence

Workplace violence, recognized as a specific category of violent crime, calls for distinct responses from healthcare workers, employers, law enforcement, and the community. Preventing workplace violence in healthcare is especially important. According to the Bureau of Labor Statistics, Occupational Injuries and Illnesses (SOII) reported an estimated 154,460 nonfatal occupational injuries and illnesses involving days away from work during the 2003 to 2012 time period. The Healthcare and Social Assistance Industry accounted for over two-thirds of these injuries and illnesses each year.

Prevention strategies include but are not limited to: zero tolerance; panic buttons/alarms; cameras/lighting/security patrols; education to recognize the early signs of violent behavior; and learning of proper intervention techniques to de-escalate situations.

**What contributes to potential for violence in health care?**
- Highly specialized interventions that can be confusing for patients and families
- Significant delays as sickest patients are attended to first
- Uncertain and highly significant outcomes
- Patients/families/visitors under the influence of alcohol and/or drugs
- High stress, unexpected emergency situations within families
- History of violence in response to stress
- Medical diagnosis that may be complicated by poor coping mechanisms
- Cultural issues and lack of staff sensitivity
- Attitudes of healthcare workers toward patients
- Lack of preparedness in healthcare workers to recognize signs of escalation
- Under-reporting and lack of management support

**What are some appropriate responses that student nurses can/should take?**
- Awareness—note person's verbal anger, body language, patterns of behavior
- Assessment of contributing factors that could be leading up to violence escalation
- Be calm and caring—acknowledge feelings
- Respect personal space and promote personal dignity
- Be aware of surroundings and a safe exit routes from the situation
- Set clear and simple limits but give the individual choices.
- Avoid being argumentative, bossy, condescending, or giving orders
- Get help early…enlist assistance from instructor, primary nurse, charge nurse, or security.
- Report any incident immediately to one of the above.
- Seek medical treatment if necessary. Debrief with instructor 1:1 or in student debriefing session
- Avoid sensationalizing the situation with others…respect patient's privacy

## Safe Patient Handling and Mobility

In order to establish a safe environment for nurses and patients, ANA supports actions and policies that result **in the elimination of manual patient handling**.

| Myth | Reality |
|---|---|
| Proper body mechanics including use of gait belts prevent patient handling injuries | Decades of research shows that "proper" body mechanics are not an effective way to reduce injuries. |
| Safe Patient Handling and Mobility ( SPHM) technology is not affordable | The benefits of SPHM include a rapid return on investment, savings associated with reduced healthcare worker and patient injuries |
| Smaller, lighter patients do not warrant use of SPHM technology | ANA recommends elimination of all manual lifting. National Institute of Occupational Safety and Health recommends no more than 35 pounds, under the best ergonomic conditions. |
| Healthcare workers who are physically fit are less likely to be injured | Research does not support this. These healthcare workers are sought after to help with manual lifting. |
| It is much faster to manual lift than to take time to get SPHM technology | SPHM should be conveniently located, it is often more time to gather a team of healthcare workers to lift manually |
| The majority of the time, manually lifting or transferring, healthcare workers do not obtain injury | Manual lifting results in micro injuries to the spine and can accumulate into a debilitating injury. |
| Using SPHM technology is impersonal | Safety and quality of care are the goals. Healthcare workers can effectively use SPHM technology while incorporating professional, and caring behavior |

The American Nursing Association (ANA) in collaboration with a national working group and other professional organizations, has released "*Safe Patient Handling and Mobility: Interprofessional National Standards*," a 40-page outline of eight evidence-based standards to prevent injury.

Daley (2013 as cited in nurse zone) reported that nurses lift the equivalent of about 1.8 tons in an eight-hour shift. Most injuries are a result of cumulative effects. Registered nurses suffered 12,000 musculoskeletal injuries resulting in missed workdays in 2011, and nursing assistants experienced the highest rate of such injuries at 25,000--more than any other occupation.

### *Safe Patient Handling and Mobility (SPHM) Interprofessional National Standards*
- **Culture of Safety**- ensuring safe levels of staffing, creating a non-punitive environment, and developing a system for communication and collaboration.
- **Sustainable SPHM programing** a safe patient handling and mobility program
- **Ergonomic design principles** to provide a safe environment of care
- Selecting, installing and maintaining safe patient handling **technology**
- Establishing a system for **education,** training and maintaining competence
- Integrating **patient-centered assessment**, care planning and technology; including safe patient handling

- **Reasonable accommodations and post-injury return to work policies;**
- Comprehensive **evaluation system**.
- The book also includes a glossary and appendices with tools and resources.

**Some Safe Patient Equipment used in the Toledo area**:
- The Sarasteady (patient stander)
- Hovermat (lateral transfer mattress)
- Maxi-Move (Total patient lift)
- Maxi-slides Sara Plus and Sara 3000 (Sit to stand lift) * see picture below

*



**Remember to**:
1. Take responsibility for knowing how equipment works and its availability
2. Assess the client and the environment, using the Assessment Criteria and Care Plan.
3. Gather the appropriate equipment and other staff members needed.
4. Organize the physical environment and the equipment to ensure safe completion of the task.
5. Procedures with two or more caregivers require communication and coordination. Make sure your team members know their role. Rehearse if necessary.
6. Coach the patient. Tell the patient what action you plan and expect from them.

**The Value of SPHM**
- Improved quality of care
- Improved healthcare recipient mobility
- Decrease in healthcare recipient falls and pressure ulcers
- Increase in healthcare recipient satisfaction
- Increase in healthcare worker satisfaction
- Savings due to reduction in worker's compensation, patient falls and pressure ulcers, and employee turnover

## Fall Prevention

Falls are the result of patient-related factors (confusion, etc.), co-morbidities (hypotension, UTI, etc.), and the environment (wet floors, slippers, etc.)
- Patients must be assessed for fall risk upon admission to the hospital and are re-assessed at least every 24 hours
- Fall prevention strategies are based upon individual patient need
- All patients regardless of fall risk should be oriented to the room environment, lights, call system, side rails, and level of assistance needed

Routine safety interventions:
- Hourly patient rounding
- Call light in reach – "Call Don't Fall"
- Bed wheels locked
- Top rails are up except in case of chest tube
- Ensure the environment is free of hazards for falls
- Bed in lowest position
- Furniture neatly arranged
- Rest periods for tired patients
- Answer calls in timely manner

Additional Fall Risk interventions include:
- Patient and/or Family education about fall prevention
- Frequent patient observation
- Use non-skid footwear
- Fall Risk prevention in Plan of Care
- Provide diversion activity
- Assist/supervise patient when transferring, walking, or toileting
- Fall Risk Identification per Hospital Policy – such as yellow arm band or red slippers and door/chart stickers and flags.
- Bed alarms

## Core Measures
Core measures use evidence-based medicine to perform patient care that has been proven to result in better outcomes for patients.
- There are certain qualifications that must be met in the national clinical focus areas to ensure higher payment from Medicare and other payers
- The National Clinical Focus Areas are:
  - Heart Failure (HF)
  - Acute Myocardial Infarction (AMI)
  - Pneumonia (PN)
  - Surgical Care Improvement Project (SCIP)
  - Stroke (STK)

**Heart Failure Core Measures**

To meet the standard of practice the patient must:
- Have complete discharge instructions
- Have a left ventricular function assessment
- Have an ACE inhibitor or an ARB prescribed at discharge

**Acute MI Core Measures**
- Aspirin given at arrival and prescribed at discharge
- Beta blocker given at arrival and prescribed at discharge
- ACE Inhibitor/ARB prescribed at discharge
- Thrombolysis within 30 minutes
- Percutaneous coronary intervention within 90 minutes
- Adult smoking cessation counseling

**Pneumonia Core Measures**
- Oxygenation assessment
- Blood cultures performed before 1st antibiotic given at the hospital, and within 24 hours of hospital arrival
- Adult smoking cessation counseling
- Antibiotic given within 6 hours of hospital arrival
- Initial antibiotic selection for community required pneumonia in immunocompetent patients
- Influenza and pneumococcal vaccinations upon discharge

**Surgical Care Improvement Project Core Measures (SCIP)**

Infection Prevention:
- Recommended antibiotic given within one hour prior to surgery
- Antibiotic discontinued within 24 hours after surgery
- Appropriate hair removal
- Normothermia (colon patients)
- Glucose control (cardiac patients)

Venous thromboembolism prophylaxis:
- Ordered by the physician
- Received by the patient

Cardiovascular:
- Patients on beta blockers prior to admission receive them within the hospital

**Stroke Core Measures**
- Venous thromboembolism prophylaxis
- Anti-thrombotic medication prescribed upon discharge
- Anticoagulation therapy for atrial fibrillation/flutter
- Thrombolytic therapy
- Anti-thrombotic therapy by end of hospital day 2
- Statin medication prescribed on discharge
- Stroke education performed within the hospital
- Patient assessed for rehabilitation

## Infection Control

Infection control addresses factors related to the spread of infections within the health-care setting. Infection control is the discipline concerned with preventing nosocomial or healthcare-associated infections. It is an essential part of health care practice. The Federal Occupational Health and Safety Administration (OSHA) set regulations that instruct health care workers on important guidelines to create a safe work environment. The following information regarding infection control is generic information. Each clinical facility has its own specific policies and procedures, which follow an OSHA Exposure Control Plan. It will be the responsibility of your instructor/supervisor to orient you to the location of the Hospital Infection Control Policies and Exposure Control Plan.

## Standard Precautions

Standard precautions are a set of infection control practices used to prevent transmission of diseases that can be acquired by contact with blood, body fluids, non-intact skin (including rashes), and mucous membranes. Body fluids that can transmit infection include; blood, semen, vaginal secretions, cerebrospinal fluid, synovial fluid, pleural fluid, pericardial fluid and amniotic fluid. Standard precaution measures are to be used when providing care to all individuals, whether or not they appear infectious or symptomatic.

## Hand Hygiene

Washing your hands is the single most important way to prevent the spread of infection

**When to use soap and water**
- When hands look dirty or have blood, body fluids, or other substances on them
- Before eating
- After using the restroom
- After exposure to any spores (ex. C. Difficile or Anthrax)

**When to use alcohol-based hand rub (or soap and water)**
- Routine cleaning of hands if not visibly soiled
- Before and after direct contact with patients
- Before inserting indwelling urinary catheters, intravenous catheters, or other invasive devices that do not require a surgical procedure
- After contact with a patient's intact skin (ex. when taking a pulse or blood pressure and lifting a patient)
- If moving from a contaminated body site to a clean body site during patient care
- After removing gloves or other personal protective equipment
- Before preparing/administering medications
- Before preparing or serving food
- After coughing, sneezing, or blowing and wiping the nose
- After contact with inanimate objects (including medical equipment) in the patient's room
- Upon leaving an isolation room
- Anytime hands may be contaminated

**Hand hygiene techniques**

**Alcohol hand rub**
- Ensure hands are not visibly soiled
- Apply a palm full of alcohol-based hand rub and cover all surfaces of hands
- Rub hands until thoroughly dry

**Soap and Water**
- Wet hands with warm (not hot) water and apply the amount of soap necessary to cover all surfaces
- Vigorously rub hands together for **15** seconds paying close attention to fingertips, nail beds, and between the fingers
- Rinse hands thoroughly under running water
- Dry hands with a paper towel
- Turn faucet off with a paper towel
- Apply hand lotion as needed

**"My five moments for hand hygiene"**
1. Before touching a patient
2. Before clean/aseptic technique
3. After body fluid exposure risk
4. After touching a patient
5. After touching patient surroundings

**Other aspects of hand hygiene**
- Do not wear artificial OR gel nails or extenders when having direct contact with patients
- Keep natural nails short (no longer than ¼ inch beyond fingertip)
- Nail polish may be worn, but must not be chipped or broken and must be well maintained
- Jewelry should be kept to a minimum
- Wear gloves when contact with blood or other potentially infectious materials, mucous membranes, and non-intact skin could occur

**Personal Protective Equipment (PPE)**

Personal protective equipment (PPE) includes protective equipment for the eyes, face, hands, extremities, protective clothing, respiratory devices, and protective shields and barriers.

**Types of PPE**

**Face Masks, Goggles and Eye Shields**
- Use when there is a possibility of exposure to the eyes from blood or body fluids
- Masks should cover the nose and mouth, be thrown away after each use or replaced if they become moist

**Protective Gowns**
- Gowns are worn to protect clothes when splashes and spills or possible

**Gloves**
- Use gloves when contact with blood or other potentially infectious materials, body, fluids, mucous membranes, and non-intact skin, or soiled equipment or surfaces could occur
- Use for all cleaning and disinfecting
- Must be changed between patient contacts
- Use hand hygiene after removing gloves
- Take gloves off as soon as possible if torn or soiled

**Respiratory devices**
- Approved respirators are to be used if caring for patients with suspected or confirmed TB
  For more information, please visit www.osha.gov

**Safe Injection Practice**

Nursing staff are the most frequently injured employees from needle sticks according to the Exposure Prevention Information Network (EPINET). **Data shows needle stick injuries occur most frequently in patient rooms most likely due to unsafe needle devices, or improper handling and disposal of needles**

**To prevent needle sticks**:
- Always engage safety device when available immediately after use
- Place contaminated sharps in a labeled, puncture resistant container immediately
- Do not recap, bend, break, or hand-manipulate used needles
- Do NOT place needles in trash or linen
- Do NOT leave needles in bed or on bedside tables.
- Do NOT overfill sharps container
- Utilize ALL needleless components when available

**If you are exposed to blood or body fluids via**:
- a needle stick injury
- splash to mouth, nose or eyes
- a sharps injury
- non-intact skin

**Immediately follow these steps:**
- ✓ Wash needle sticks and cuts with soap and water
- ✓ Flush splashes to the nose, mouth, or skin with water
- ✓ Irrigate eyes with clean water, saline, or sterile irritants
- ✓ Report the incident to your supervisor/instructor immediately
- ✓ Complete the required incident reporting as instructed
- ✓ Always follow instructions for post-injury surveillance.
- ✓ All information is confidential and you will receive appropriate instructions and counseling.

### Infectious Waste

- Biohazard signs are to be placed on any item containing body fluids.
- All lab specimens must be transported according to facility policy.
- Handle laundry in a manner that prevents transfer of microorganisms to others and to the environment.
- Soiled patient care equipment should be handled in a manner that prevents transfer of microorganisms to others and to the environment; wear gloves if visibly contaminated and perform hand hygiene.
- Blood and other potentially infectious body substances in amounts sufficient that could cause infection should be discarded into red bags or containers labeled "Infectious Waste" or "Bio hazardous Waste".

### Blood borne pathogens

Blood borne pathogens are viruses, bacteria, and other microorganisms that are carried in a person's blood and/or body fluids.  These pathogens cause diseases such as HIV and Hepatitis B and C. Exposure to blood borne pathogens by contact with blood or body fluids is an inherent risk with direct patient care. Keeping that exposure to an absolute minimum is important to your safety and wellbeing.

**The OSHA standards for reducing risks of blood borne pathogens include**:
- Disposal of used or contaminated sharps in sharp containers
- Use of standard precautions for all patients and all tasks that involve a reasonable likelihood for exposure to blood or body fluids
- Use of personal protective equipment
- Hand washing must be done after the removal of PPE, following contact with blood or other potentially infectious material, and/or prior to or following patient care.
- Containers used for transfer or disposal of anything contaminated with blood or infectious materials should display the biohazard label and be closable and leak proof.
- Avoid splashing, spraying, spattering, or creating droplets of blood or other fluids.
- Do not bend, recap, or break needles or sharps.
- Mouth pipetting or suctioning of body fluids is prohibited
- Change sharps containers when contents reach fill line.
- Blood and other potentially infectious body waste that drip or flake when compressed is discarded in red bags or containers marked with the biohazard label.
- Spills of blood or body substances must be contained and cleaned up immediately using PPE and a hospital approved disinfectant
- Do not eat or drink or apply makeup or lip balm in patient care areas

For additional information, go to OSHA hospital blood borne pathogens website
http://www.osha.gov/SLTC/etools/hospital/hazards/bbp/bbp.html#Osharps

**Transmission Based Precaution**

Infectious organisms can be readily transmitted from one person to another. Transmission-based precaution categories have been recommended by the Centers for Disease Control to prevent transmission of infections in hospitals. Transmission- Based Precautions are used when the routes of transmission are not completely interrupted using Standard Precautions alone. **Transmission based isolation precautions are used in conjunction with Standard precautions.** Students are responsible for understanding each category and following isolation procedures as appropriate.

| Category | Description | PPE | Comments | Example of Diseases |
|---|---|---|---|---|
| Contact | Transmitted by direct or indirect contact with contaminated items | Gloves Gown | Generally in private rooms | MRSA, EBSL, VRE, and Lice |
| Contact-Enteric | Transmitted by direct or indirect contact with contaminated items | Gloves Gown | Use Bleach disinfecting products for cleaning | for unexplained diarrhea or confirmed C.Diff |
| Droplet | Transmitted by large particle droplets generated by aerosolization (coughing, talking, etc.) | Mask | Special ventilation not required. Transmittable distance = 3 ft. | Pertussis, and Bacterial Meningitis |
| Droplet-Plus | Transmitted by large particle droplets generated by aerosolization (coughing, talking, etc.) | Mask PAPR or N95 for procedure | Procedures: bronchoscopy, suctioning, intubation, or extubation | For suspected or confirmed Influenza |
| Airborne or AFB (Acid Fast Bacilli) | Can be suspended in air for long periods, dispersed air currents | N95 PAPR | Negative pressure room required, door kept closed at all times | Tuberculosis (TB), chicken pox and measles |

Please see the CDC website for further information.

**Tuberculosis (TB)**
TB is a communicable disease caused by a bacterium called Mycobacterium Tuberculosis. These microorganisms are spread through airborne transmission. TB precautions are used for patients with known or suspected pulmonary tuberculosis. The name for these precautions may vary from one facility to another. Regardless, airborne precautions always require a fit-tested N95 respirator mask.

There are three stages of TB infections.
1. Exposure
2. Latent non-infection- in this stage a person will have a positive PPD skin test, but will not be contagious or display symptoms
3. Active TB disease- symptoms which may include a bad cough that lasts 3 weeks or longer, bloody sputum, weakness or fatigue, weight loss, fever, chills, and night sweats. TB is contagious.

**Clostridium difficile**  *(C-Difficile)*

Clostridium difficile, also known as C. diff, is a germ that can cause diarrhea. Most cases of C. diff infection occur in patients taking antibiotics.  The most common symptoms of a C. diff infection include:

-Watery diarrhea          -Loss of appetite

-Fever & Nausea          -Belly pain and tenderness

C. difficile is generally treated for 10 days with antibiotics.  People in good health usually do not get C. diff.  People who have other illnesses or conditions requiring prolonged use of antibiotics and the elderly are at greater risk of acquiring this disease.

The bacteria are found in feces.  People can become infected if they touch items or surfaces that are contaminated with feces, and then touch their mouth or mucous membranes.  Healthcare workers can spread the bacteria to other patients or contaminate surfaces through hand contact.  Do not use an alcohol based hand sanitizer for a patient with C.diff.  It is recommended to use soap and water to remove the C.diff spores.

Another example of a possible emergency that a healthcare worker may face includes a **flu, H1N1 pandemic, Ebola virus, or spread of the Zika Virus.**

The Center for Disease Control or CDC states the monovalent **H1N1** vaccine is safe, effective, and the best way to be protected from H1N1 influenza. *Nurses should be vaccinated to protect themselves, their families, their patients, and their communities.

**Ebola protocol for healthcare workers**:

CDC encourages all U.S. healthcare providers to assess patients for
- Elevated body temperature or subjective fever; or
- Severe headache, fatigue, muscle pain, vomiting, diarrhea, abdominal (stomach) pain, or unexplained hemorrhage (bleeding or bruising Ask patients with Ebola-like symptoms about their travel histories to determine if they have lived in or traveled from West Africa, or had contact with an individual with confirmed Ebola, within the previous 21 days.

 **Know what to do if they have a patient with Ebola symptoms:**
- First, properly isolate the patient.
- Then, follow infection control precautions to prevent the spread of Ebola. Avoid contact with blood and body fluids of infected people. U.S. healthcare workers should follow CDC's "Guidance on Personal Protective Equipment To Be Used by Healthcare Workers During Management of Patients with Ebola Virus".

**Zika Virus:**
- As of June 22, 2016, active Zika virus transmission is occurring in 39 countries and territories in the Americas, 8 countries and territories in Oceania/Pacific Islands, and 1 country in Africa (http://www.cdc.gov/zika/geo/active-countries.html).
    - Among cases identified in 2015-16, Zika virus transmission has occurred primarily through the bite of infected *Aedes* species mosquitoes.
    - Zika virus can also be transmitted from mother to fetus during pregnancy and through sexual transmission from infected males to their sexual partners.

- As of June 22, 2016, over 819 confirmed cases of Zika virus infection have been identified in the continental United States.
  - All cases were in persons with either a recent travel history to areas with ongoing transmission or an epidemiologic link with an individual with such travel history (i.e., through maternal-fetal or sexual transmission).
  - Public health officials have determined that Zika virus poses a potential public health emergency.

**What are the symptoms of Zika virus infection:**
- Many people with Zika virus infection are asymptomatic.
- Symptomatic patients typically experience a mild illness characterized by fever, rash, joint pain, or conjunctivitis. Clinical illness is usually self-limited and lasts a week or less. Clinical illness recognition can be complicated in that not all symptomatic patients report all of these symptoms, and Zika manifestations overlap significantly with those seen in other viral infections. Although the exact incubation period is yet to be determined, it is considered to be about 3 days to 2 weeks.
- Based on a review of available evidence, CDC has concluded that Zika virus infection in pregnancy is a cause of microcephaly (a birth defect characterized by small head size and impaired cranial and neural development in fetuses and infants) and other serious abnormalities of the brain.
- In addition, it has been linked to central nervous system injury, placental insufficiency, fetal growth restriction, and fetal loss, eye abnormalities, and hearing impairment.
- Limited information is available currently about the spectrum of defects caused by prenatal Zika virus infection, the relative and absolute risks of adverse outcomes among fetuses whose mothers were infected at different times during pregnancy, and factors that might affect a woman's risk of adverse pregnancy or birth outcomes.
- It is also important to note that Zika virus infection is not the sole suspected cause of microcephaly in fetuses and infants.

## Multidrug-Resistant Organisms  (MDRO)



Multi-drug resistant organisms (MDRO) are common bacteria that have developed resistance to multiple types of antibiotics.  These bacteria are present on the body of many people, including on the skin, in the nose or other moist areas of the body and in secretions.  Antibiotic resistance often occurs following frequent antibiotic use or frequent exposure to a healthcare setting.  For most healthy people these bacteria do not cause a problem.  The most common MDROs are MRSA and VRE.

## Methicillin-resistant Staphylococcus Aureus (MRSA)

MRSA is a type of staph bacteria that is resistant to certain antibiotics called beta-lactams.  These antibiotics include methicillin and other more common antibiotics such as oxacillin, penicillin, and amoxicillin.  In the community, most MRSA infections are skin infections.
More severe or potentially life-threatening MRSA infections occur most frequently among patients in healthcare settings.  The CDC reports that approximately 18,650 persons died in 2005 during a hospital stay related to these serious MRSA infections.
MRSA is mainly spread to other patients through people's hands, especially the hands of healthcare

personnel. Hands may become contaminated with MRSA bacteria following contact with MRSA- infected (or colonized) patients.  If appropriate hand hygiene such as washing with soap and water or using an alcohol-based hand rub is not performed, the bacteria can be spread when the healthcare provider touches other patients.

**Vancomycin-Resistant Enterococci (VRE)**
Enterococci are bacteria that are normally present in the human intestines and in the female genital tract and are often found in the environment.  These bacteria can sometimes cause infections. Vancomycin is an antibiotic that is often used to treat infections caused by enterococci.  In some instances, enterococci have become resistant to vancomycin and thus are called vancomycin- resistant enterococci (VRE).  Most VRE infections occur in hospitals.
VRE is spread from person to person.  VRE can get onto a caregiver's hands after they have contact with other people with VRE or after contact with contaminated surfaces.  VRE can also be spread directly to people after they touch surfaces that are contaminated with VRE.

## Patient Rights

**Choices**
- The patients have a right to make choices regarding care that affects him/her.
- Protect your patient's right to choose by offering choices as you care for them.

**Privacy**
- This is an important right! The patient has a right to privacy behind a closed door/curtain.
- Respect their privacy by always knocking /checking before entering and wait for a response.
- If you accidentally interrupt the patient, quickly excuse yourself and leave the room. Make sure privacy is provided during care, by drawing the curtains around the bed or shutting the patient's door.
- Keep the patient's body as covered as possible while providing care.

**End-of-life Care**
- Patients have the right to receive treatments to manage symptoms and keep them comfortable at the end of life. These types of treatments are known as palliative care.
- Palliative care can also help people manage symptoms of non-life-limiting conditions, such as rheumatoid arthritis.
- The goal of palliative care is to help people maintain comfort and quality of life, regardless of whether their disease is curable. Based on patient preferences, palliative care may be combined with other treatments to prolong your life or to cure your condition.

## Advanced Directives

## Living Will

A Living Will is a written, legal document that describes instructions on the kind of medical treatments or life-sustaining treatments an individual wants taken in the event they are no longer able to make decisions due to illness or incapacity.

A Living Will becomes effective when an individual becomes terminally ill and unable to express their wishes regarding healthcare or when the individual becomes permanently unconscious. Ohio Law requires that a Living Will created after December 15, 2004 must include a person's preferences about Anatomical gifts (organ and tissue donation).

**Healthcare Power of Attorney**

A healthcare power of attorney is a document which states who has been appointed to make healthcare decisions on behalf of another person when they are incapacitated. This becomes effective even if the person is only temporarily unconscious and medical decisions need to be made.

**Do-Not-Resuscitate (DNR)**

*The following information is taken from "Choices: Living Well at the End of Life" the Ohio advanced directives packet (Fifth ed.)*

Ohio's Do-Not-Resuscitate (DNR) Law gives individuals the opportunity to exercise their right to limit care received in emergency situations in special circumstances.  The law authorizes a physician to write an order letting health care personnel know that a patient does not wish to be resuscitated in the event of a cardiac arrest (no palpable pulse) or respiratory arrest (no spontaneous respirations or the presence of labored breathing).

The DNR Comfort Care Program allows this specific DNR Comfort Care Order to be used in multiple settings and practice areas including but not limited to nursing facilities, residential care facilities, hospitals, outpatient areas, home, and public places.  For a DNR Comfort Care Order to be useful in multiple settings it must be recognizable by health care workers. The Ohio Department of Health has developed a standard order form that is generally recognized.

Unlike a Living Will and Health Care Power of Attorney, a DNR Order must be written and signed by a physician or an advanced-practice nurse after consultation with the patient.

DNR Comfort Care is a legally-sanctioned program that is implemented according to a standardized protocol.  The DNRCC Order is implemented at different points, depending upon the patient's wishes and must be consistent with reasonable medical standards.

The two options within the DNR Comfort Care Protocol are the DNR Comfort Care (DNRCC) Order and the DNR Comfort Care-Arrest (DNRCC-Arrest) Order.  With a DNRCC Order, a person receives any care that eases pain and suffering, but no resuscitative measures to save or sustain life. With a DNRCC-Arrest Order, a person receives standard medical care until the time he or she experiences a cardiac or respiratory arrest.

After the State of Ohio DNR Protocol has been activated for a specific DNR Comfort Care patient, the Protocol specifies that emergency medical services and other health care workers are to do the following:

| WILL: | WILL NOT: |
| --- | --- |
| Suction the airway | Administer chest compressions |
| Administer oxygen | Insert artificial air way |
| Position for comfort | Administer resuscitative drugs |
| Splint or immobilize | Defibrillate or cardiovert |
| Control bleeding | Provide respiratory assistance (other than that listed in WILL column) |
| Provide pain medication | Initiate resuscitative IV |
| Provide emotional support | Initiate cardiac monitoring |
| Contact other appropriate health care providers such as hospice, home health, attending physician/CNS/CNP | |

If you have responded to an emergency situation by initiating any of the **WILL NOT** actions prior to confirming that the DNR Comfort Care Protocol should be activated, discontinue them when you activate the Protocol. You may continue respiratory assistance, IV medications, etc., that have been part of the patient's ongoing course of treatment for an underlying disease.

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