Addressing Violence and Harassment in the Workplace

This course is part of a series of regulatory requirements for New Caregiver Orientation

- **Introduction**
- **Harassment and Other Inappropriate Behavior**
- **Workplace Violence**

Introduction

Welcome!

Upon completion of this course, learners will be able to:

- Recognize and appropriately respond to harassment
- Implement safety measures to reduce the risk of workplace violence

- Report workplace violence incidents via the appropriate method(s)
- Identify the early warning signs of violent behavior
- Anticipate how to respond in an active shooter situation

CONTINUE

Lesson 2 of 3

Harassment and Other Inappropriate Behavior

Our organizational values set our course. They provide a solid foundation to work from, and serve as our "north star" when we are looking for guidance on how to act.

PSJH Policy

As an expression of our value of Dignity, we respect the inherent worth of every person.

We demonstrate behaviors that create a supportive and inclusive work environment, and we share responsibility for maintaining a positive workplace.

We are committed to ensuring equal employment opportunities for all caregivers and prospective caregivers, consistent with our mission and core values.

As such, we will maintain a workplace free of discrimination and harassment based on race, color, gender, disability, genetic information, veteran status or military status, religion, age, creed, national origin,

gender identity or expression, sexual orientation, marital status, or registered domestic partner status or any other applicable legally protected status.

We also expect all caregivers, volunteers, vendors and affiliated individuals of our community will maintain a positive workplace free from any unacceptable conduct which creates an intimidating, hostile, or offensive work environment.

CONTINUE

Harassment Definition

- Unwelcome or unwanted conduct that denigrates (to deny the importance or validity of) or shows hostility or an aversion toward another person on the basis of any characteristic protected by law
- Can be verbal, physical, or sexual in nature

- Conduct is unwelcome if the caregiver did not solicit, instigate or provoke it, and the caregiver regarded the conduct as undesirable or offensive

It's important to remember that IMPACT DETERMINES HARASSMENT.

It doesn't matter whether you meant a particular joke or comment to be offensive; it's how that joke or comment was felt by the person who heard it.

Summary of Title VII – Definition of Sexual Harassment

Sexual Harassment actions

- Sexual advances
- Request for sexual favors
- Other sexual conduct (verbal, written or physical)

When these actions are unwelcome and:

- Affect job status
- Interfere with work performance
- Create a hostile work environment

CONTINUE

Caregiver Responsibility

Click the plus signs (+) below to learn more.

Report Harassment —

Harassment should be reported to your core leader or Human Resources. Reports may also be made to your core leader's manager or to the Integrity Hotline. Confidentiality will be maintained as much as possible consistent with legal obligations.

Immediately Investigated

All allegations of discrimination, harassment, or disruptive behavior will be immediately investigated.

Report Potential Harassment

All caregivers who suspect workplace harassment (to themselves or others) should report to your core leader or Human Resources.
Reports may also be made to your core leader's manager or to the Integrity Hotline.

No Retaliation for Cooperation

Retaliation for good faith reports of suspected workplace harassment is prohibited.

Complete the content above before moving on.

Impaired Professional Staff

It is everyone's responsibility to keep our patients and caregivers safe. If you suspect a coworker is impaired (for any reason), report immediately to the Nursing Supervisor, Clinic Manager, or house/administrative supervisor who will implement the appropriate response as identified in ministry policies.

Signs of Impairment:

- Slurred/incoherent speech
- Uncharacteristic moodiness
- Undue aggressiveness or disruptive conduct
- Lack of dexterity
- Dizziness
- Alcohol on breath

CONTINUE

Workplace Violence

What is Workplace Violence?

The Occupational Safety and Health Administration defines workplace violence as "any act or threat of physical violence, harassment, intimidation, or other threatening disruptive behavior that occurs at the worksite."

Four Types of Workplace Violence

	Type of Violence	Description	Example Scenarios
I	Criminal Intent	Perpetrator has no association with the workplace or caregivers.	A person with criminal intent commits armed robbery in a hospital parking garage.
II	Customer/Client	Perpetrator is a customer or patient of the workplace or caregivers.	• Intoxicated patient throws an object at phlebotomist • Patient's family member punches a nurse • Visitor verbally threatens front desk caregiver

	Type of Violence	Description	Example Scenarios
III	Worker-on-Worker	Perpetrator is a current or former caregiver of the workplace. Also commonly referred to as “lateral” or “horizontal violence.”	• One caregiver is bullying another caregiver at work • Recently fired caregiver assaults a former supervisor
IV	Personal Relationship	Perpetrator has a personal relationship with caregiver(s), none with the workplace.	Ex-husband assaults ex-wife at her place of work.

- Incidents of workplace violence have been on the rise over the years, yet they remain severely under-reported
- To encourage reporting, Providence St. Joseph Health maintains a firm policy against retaliation for reporting or cooperating in the investigation of a workplace violence incident
- Together, we can create and maintain a safe environment for our patients, our visitors, and our co-workers

The safety of caregivers, patients and all of those we serve is our first and foremost responsibility. Safety of everyone is very important.

Let's look at some key items to keep in mind.

- Take threats seriously and report them
- Be aware of your environment and any possible dangers
- Stay alert and observe what goes on around you and with your co-workers
- Report any concerns (even hunches or gut feelings) immediately
- Know the hospital codes and expectations surrounding each

Warning Signs of Violent Behavior – Early Signs

One (or more) of these signs doesn't necessarily mean that an individual will be violent, however, they should cause you to increase your attention to the situation. Being alert to these signs, and trying to understand why people may be behaving a certain way, helps us prevent a situation from escalating.

- Depression/Withdrawal
- Desperation/Hopelessness
- Paranoia
- Significant Decrease in Appearance/Hygiene
- Misuse of Alcohol/Drugs
- Harassing Behavior or Stalking
- Preoccupation With Weapons
- Frequent Use of Abusive Language
- Threatening Gestures
- History of Violent Behavior
- Agitated Behavior
- Irrational or Uncontrollable Anger, Rage
- Other Dramatic Behavior Changes

CONTINUE

Trauma & Workplace Violence

Have you ever wondered why a person is behaving a certain way?

A person's thoughts, emotions, and behaviors may be related to their experience with trauma.

Trauma refers to a "single event, multiple events, or a set of circumstances that is experienced by an individual as physically and emotionally harmful or threatening…"

CONTINUE

Trauma & Healthcare

What might activate a person's past history of trauma while accessing health care services?

- **Loss of Control.** For example, patients may not be able to control something simple such as when and what they eat.
- **Pain.** For example, the condition a patient has and/or the treatment they under go may cause them pain.
- **Uncertainty.** For example, patients may not know what their diagnosis is or whether they can afford their treatment.
- **Lack of sleep.** For example, due to the need for frequent monitoring a patient's sleep may need to be interrupted.
- **Lack of privacy.** For example, a patient may not be able to have a private room or may only be separated from others by a curtain while undergoing a procedure.
- **Changes in body image.** For example, a person may undergo an amputation or have scarring that alters the way their body looks.
- **Decreased mental clarity and flexibility.** For example, the medications a patient is taking may alter their cognitive status.

CONTINUE

How Can You Protect Yourself from Violence?

Click the plus signs (+) below to learn more about how to protect yourself from violence.

Plan —

Mentally prepare yourself for different types of situations. Having a plan of action in advance allows you to respond automatically and appropriately.

Identify

Recognize non-verbal signals of anxiety, aggression and imminent attack.

Act

Respond non-verbally, verbally or physically to people who are upset, verbally aggressive and/or physically assaultive.

Complete the content above before moving on.

We learned the importance of Plan, Identify, and Act. However there are more steps to keep in mind when dealing with upset, aggressive people.

1. Remain calm. Pause and breathe, speak softly, and don't argue.
2. Listen and validate the person's distress as a normal reaction to a stressful situation.
3. Focus on the person's need and not the behavior - comply with requests when possible and offer alternatives.

4. Show that you care. Give your full attention and reassure the person you are here to help.
5. Stay positive. "I want to help you" or "What can I do to help you feel more comfortable right now?"
6. Respect personal space.

Respect personal space, and stay outside of the 4-foot reactionary zone when someone is upset, agitated, or becoming aggressive

When efforts to diffuse a situation don't work:

- Get help from a colleague
- Call a Code Gray or the appropriate Plain Language code
- Keep an exit path open

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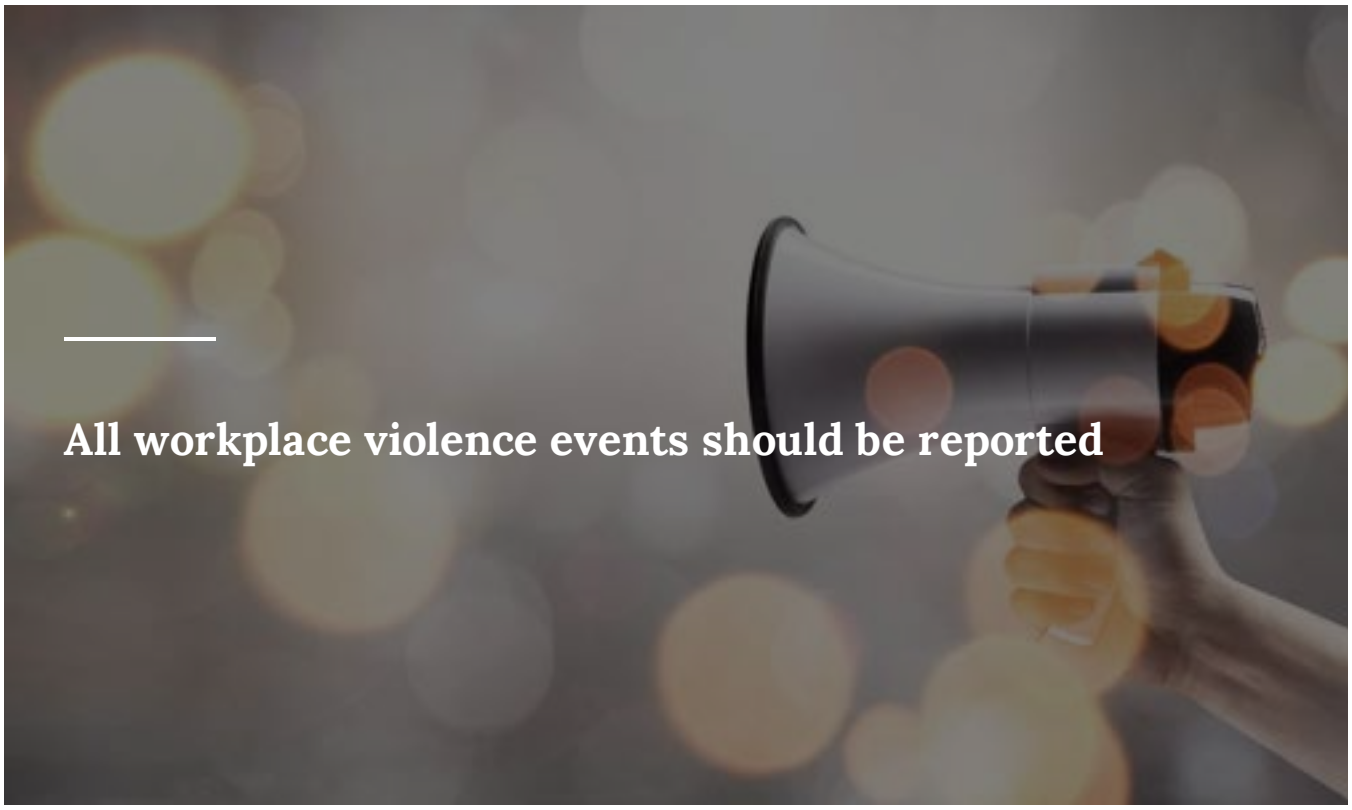


All workplace violence events should be reported

Report workplace violence events here:

- **HRP** for all workplace violence events
- **Corvel** for events that qualify as a Workers' Compensation claim (physical altercation or harm to Caregiver, stress or PTSD from an event, etc.)

To report a workplace violence event in HRP, utilize the **Speak Up for Safety Icon** on your workstation or within the **MyApps Portal**.

To report a Workers' Compensation claim to **Corvel**, please visit the **MyChoosewell** application that is available in the **MyApps Portal**. Select the **Leaves and Work-Related Incidents** icon to

report a work-related incident to Corvel.

To learn more about how your local ministry reports workplace violence, check with your Core Leader.

CONTINUE

Surviving an Active Shooter in a Healthcare Environment

Sometimes unexpected events happen, so it's even more important to be prepared and know what to do. What if there aren't any signs? Sadly shootings can happen any time, any place. That means we **ALL** have to be prepared.

Homeland Security has produced a video on how to be prepared and react to an active shooter situation: Surviving an Active Shooter in Healthcare Environment.

Pay close attention to Homeland Security's recommendation to: RUN...HIDE...FIGHT...

CONTINUE

Thank you for reviewing this information on how we can help avoid and respond to violent situations in the workplace. Together, we can create and maintain a compassionate, trauma-informed safe environment for our patients, our visitors, and our co-workers.

Local Resources

Click the button to the right to review local resources related to Workplace Violence.

RESOURCES

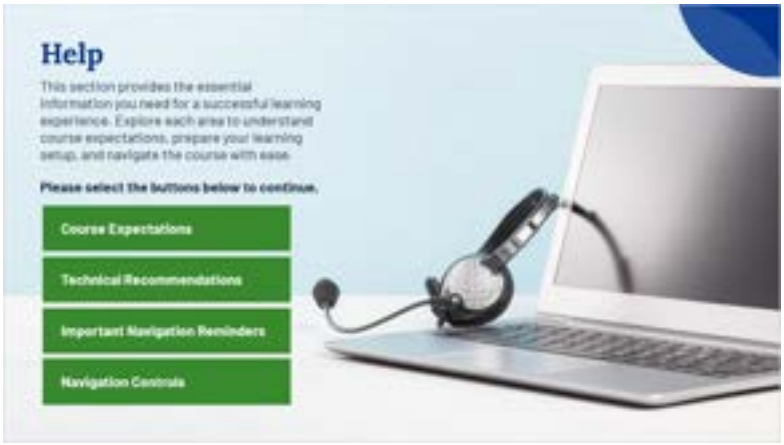
Congratulations! You have completed this eLearning module. Click the Exit Course link above to close this window.

Restraint and Seclusion Review Part 01

1. Basic Screens

1.1 Restraint and Seclusion Review Part 1

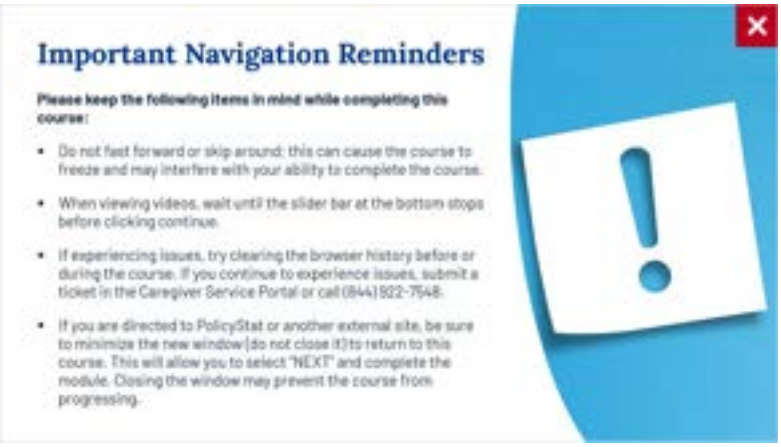
1.2 Help



Course Expectations (Slide Layer)

Technical Recommendations (Slide Layer)

Important Navigation Reminders (Slide Layer)



Navigation Controls (Slide Layer)

1.3 Untitled Slide

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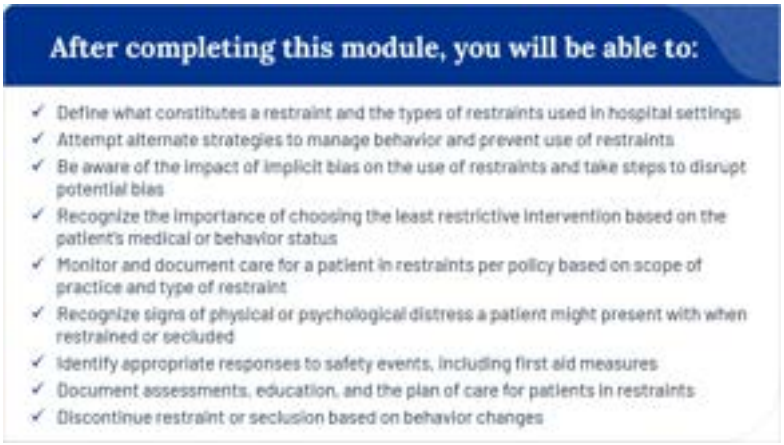


1.5 Text Scenario

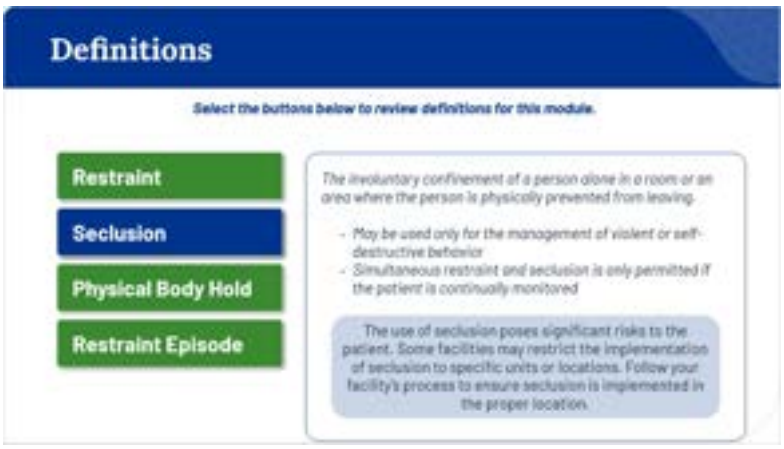
TJC (Slide Layer)

DNV (Slide Layer)

1.6 FAQ

Restraint (Slide Layer)

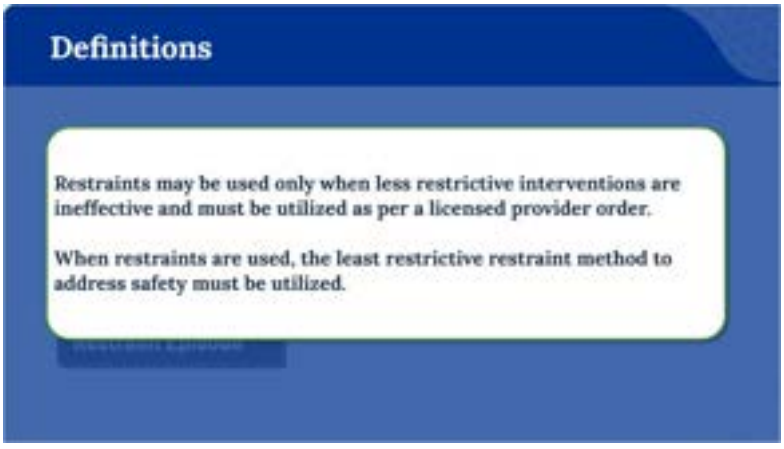
Seclusion (Slide Layer)



Physical Body Hold (Slide Layer)

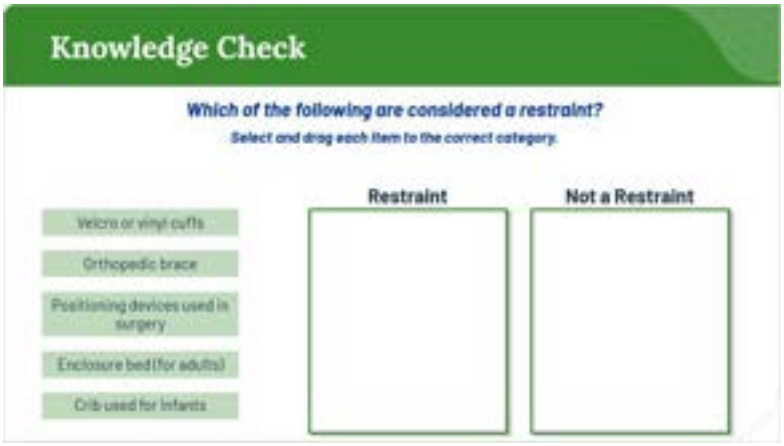
Restraint Episode (Slide Layer)

1.7 FAQ



1.8 Knowledge Check

(Drag and Drop, 10 points, 1 attempt permitted)



Drag Item	Drop Target
Velcro or vinyl cuffs	Restraint Landing
Enclosure bed (for adults)	Restraint Landing
Orthopedic brace	Not Landing
Crib used for infants	Not Landing
Positioning devices used in surgery	Not Landing

Drag and drop properties
Return item to start point if dropped outside any drop target
Snap dropped items to drop target (Tile)
Delay item drop states until interaction is submitted

Feedback when correct:

That's right! You selected the correct responses.

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Feedback when incorrect:

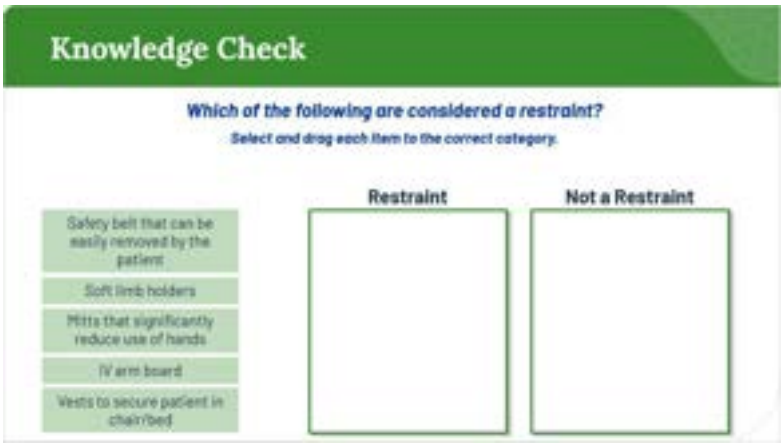
You did not select the correct response.

Correct (Slide Layer)

Incorrect (Slide Layer)

1.9 Knowledge Check

(Drag and Drop, 10 points, 1 attempt permitted)



Drag Item	Drop Target
Soft limb holders	Restraint Landing 1
Mitts that significantly reduce use of hands	Restraint Landing 1
Vests to secure patient in chair/bed	Restraint Landing 1
Safety belt that can be easily removed by the patient	Not Landing 1
IV arm board	Not Landing 1

Drag and drop properties
Return item to start point if dropped outside any drop target
Snap dropped items to drop target (Tile)
Delay item drop states until interaction is submitted

Feedback when correct:

That's right! You selected the correct responses.

Feedback when incorrect:

You did not select the correct response.

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Correct (Slide Layer)

Incorrect (Slide Layer)

1.10 Are Side Rails a Restraint?

1.11 T/F Knowledge Check

(Multiple Choice, 10 points, 1 attempt permitted)

Correct	Choice
X	Yes
	No

Feedback when correct:

The correct answer is yes. Holding a patient against their will due to violence (e.g., during administration of emergency medications or a takedown) is considered manual restraint. An order for violent restraints needs to be obtained and this would be documented under degree of restraint. Note: Therapeutic holding or comforting a child is not considered a restraint.

Feedback when incorrect:

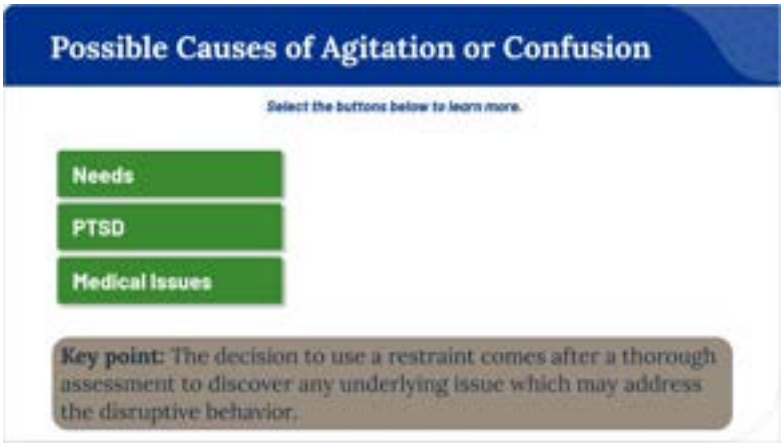
The correct answer is yes. Holding a patient against their will due to violence (e.g., during administration of emergency medications or a takedown) is considered manual restraint. An order for violent restraints needs to be obtained and this would be documented under degree of restraint. Note: Therapeutic holding or comforting a child is not considered a restraint.

Correct! (Slide Layer)

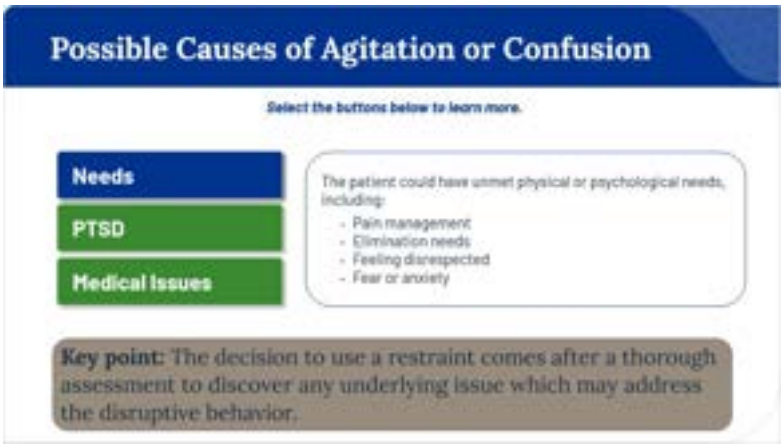
Incorrect (Slide Layer)

1.12 Causes for Restraint

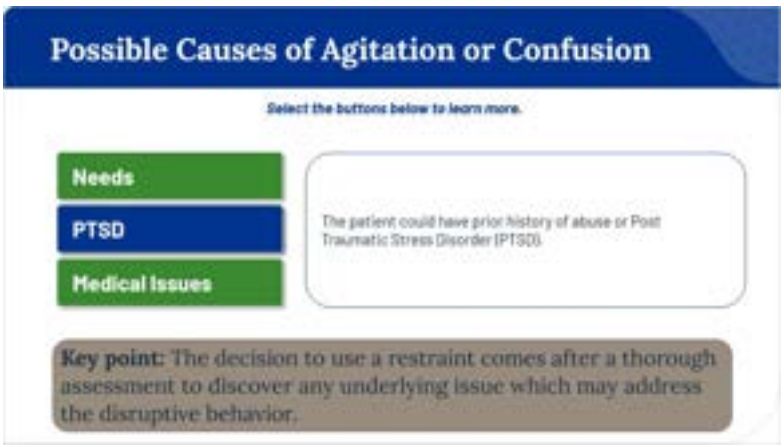
1.13 FAQ



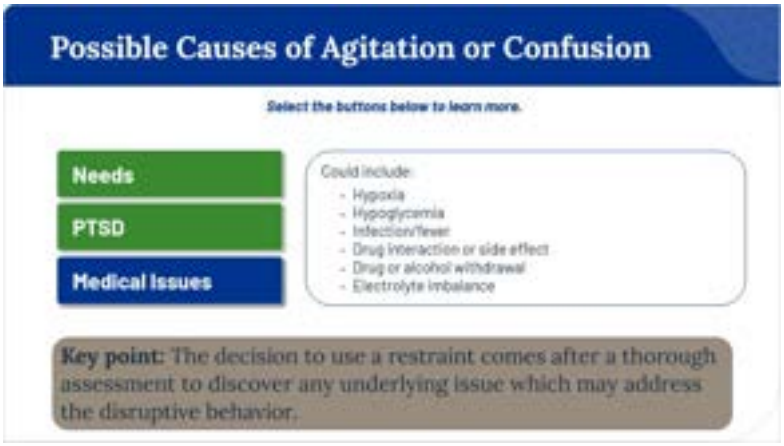
Needs (Slide Layer)



PTSD (Slide Layer)



Medical Issues (Slide Layer)



1.14 FAQ

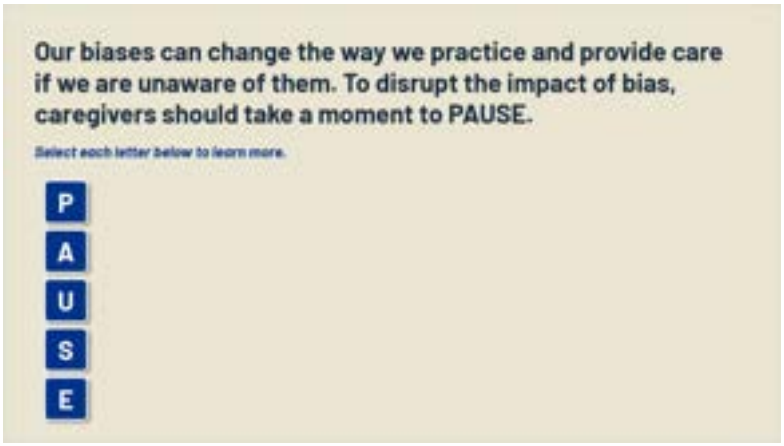
1.15 Our Goal Is Prevention of Restraint Use

1.16 FAQ

1.17 Title - Voiceover

Untitled Layer 1 (Slide Layer)

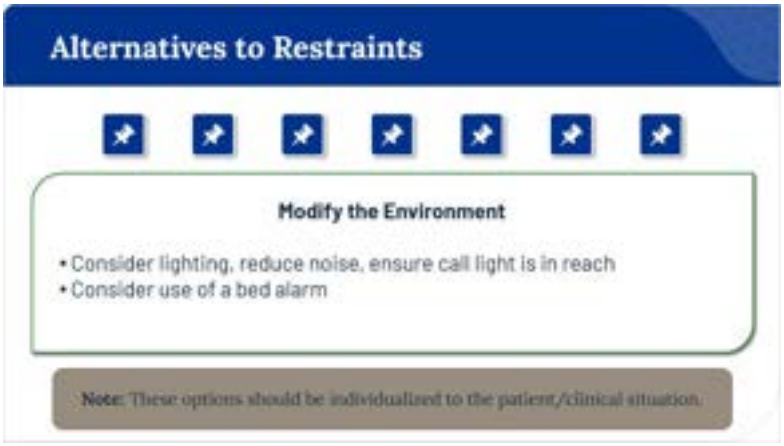
1.18 Title - Voiceover



1.19 FAQ

Companionship (Slide Layer)

Environment (Slide Layer)



Toileting (Slide Layer)

Pain meds (Slide Layer)

Design Creative Alternatives (Slide Layer)

Activities (Slide Layer)

Interventions (Slide Layer)

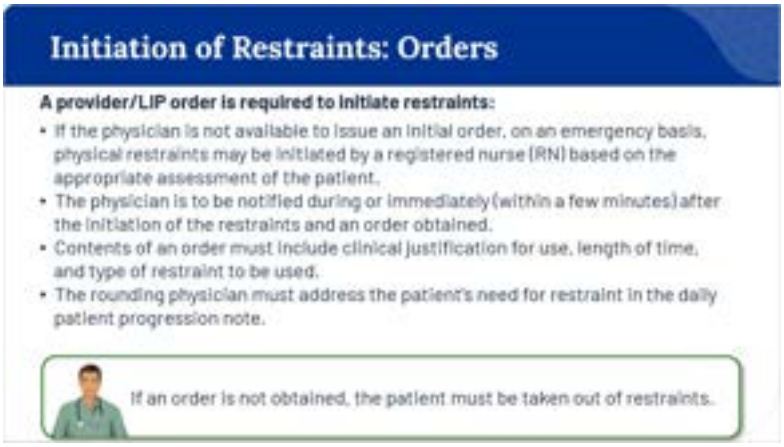
1.20 Orders

2. Orders RN

2.1 Indications for Restraint

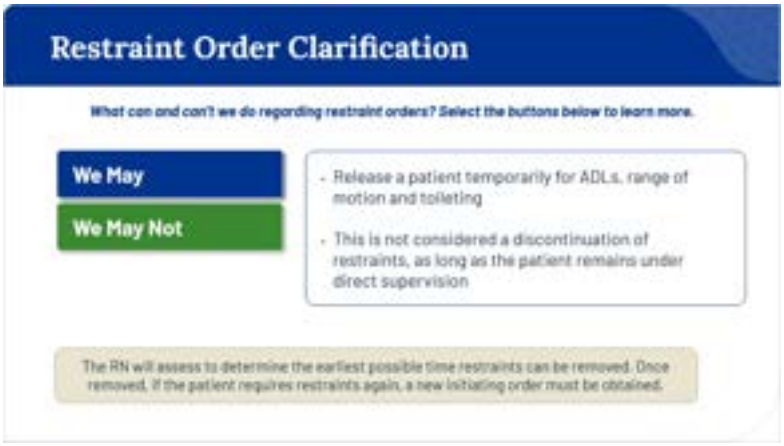
2.2 Indications for Restraint

2.3 FAQ



2.4 FAQ

We May (Slide Layer)



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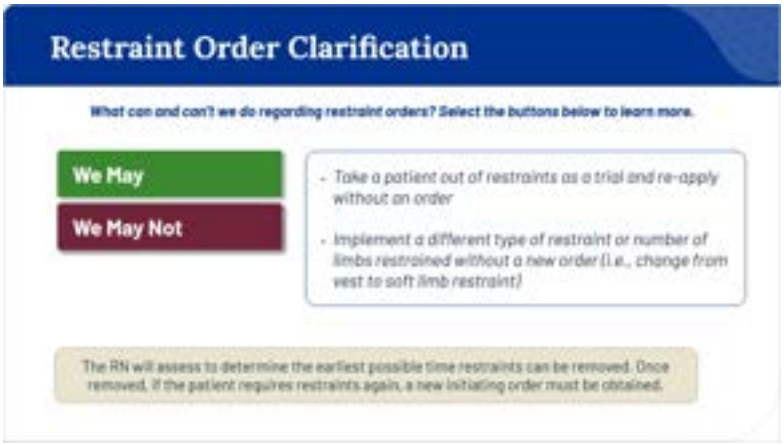
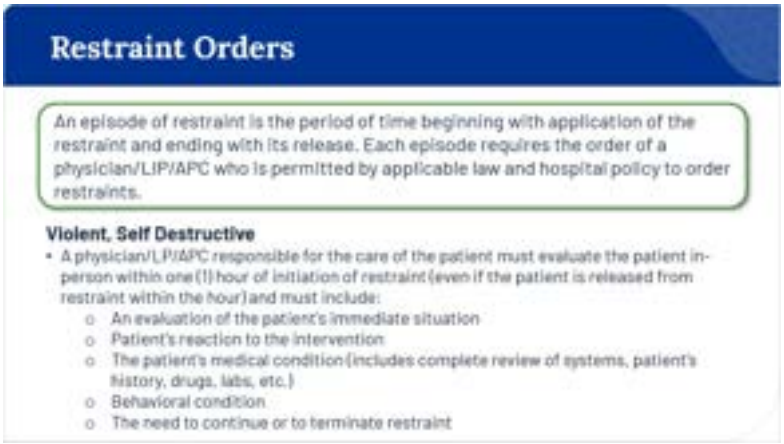
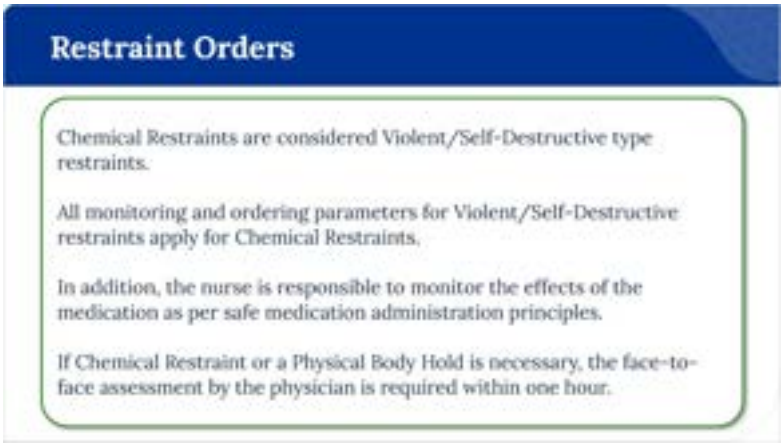


2.5 FAQ

2.6 FAQ



2.7 FAQ



2.8 T/F Knowledge Check

(Multiple Choice, 10 points, 1 attempt permitted)

Correct	Choice
	Yes
X	No

Feedback when correct:

The correct answer is no. Drugs or medications used as part of a patient's standard treatment are not considered a chemical restraint.

Feedback when incorrect:

The correct answer is no. Drugs or medications used as part of a patient's standard treatment are not considered a chemical restraint.

Correct! (Slide Layer)

Incorrect (Slide Layer)

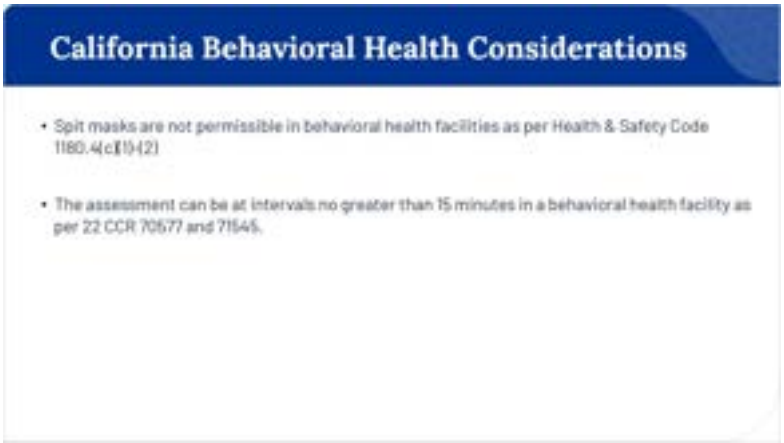
2.9 FAQ

2.10 FAQ

2.11 FAQ

Oregon (Slide Layer)

2.12 FAQ



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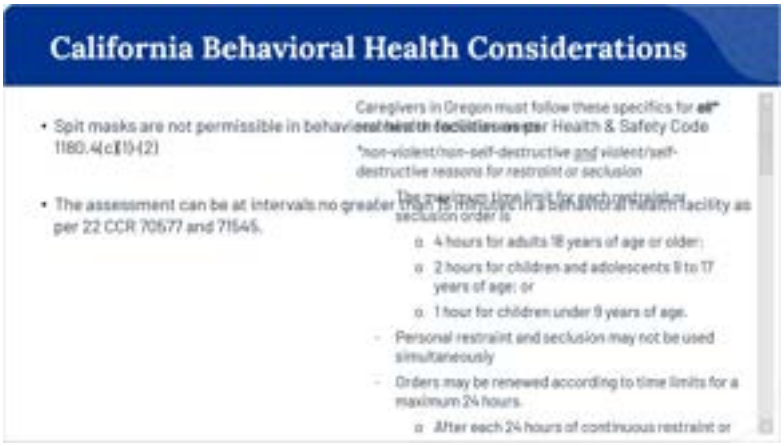
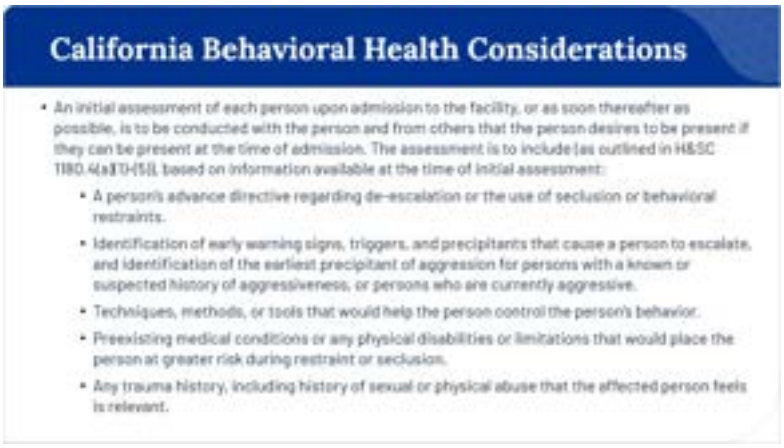


2.13 FAQ



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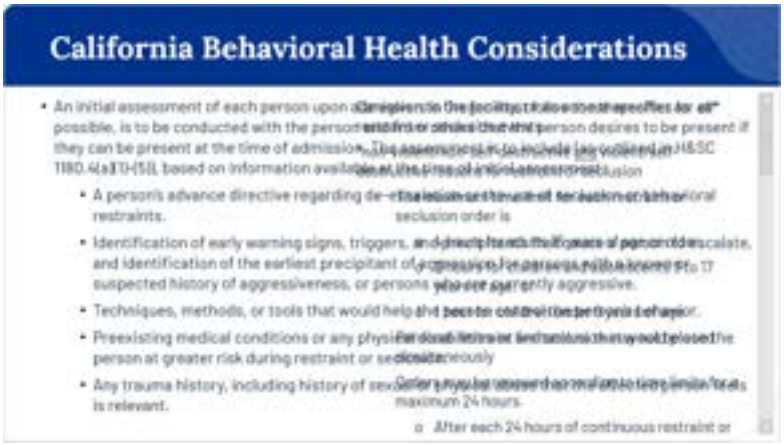

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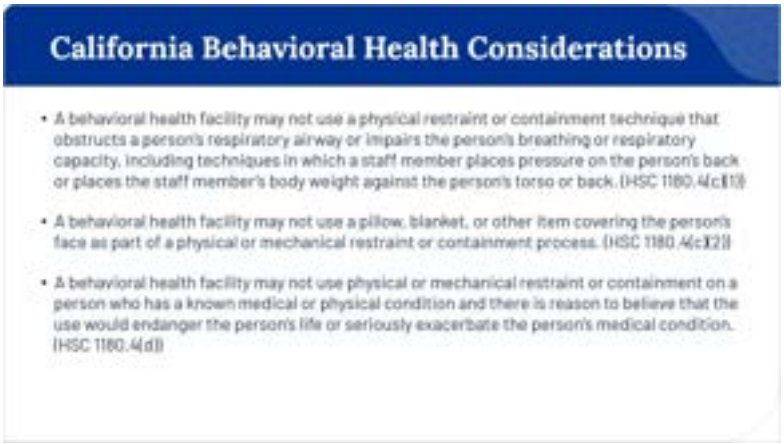

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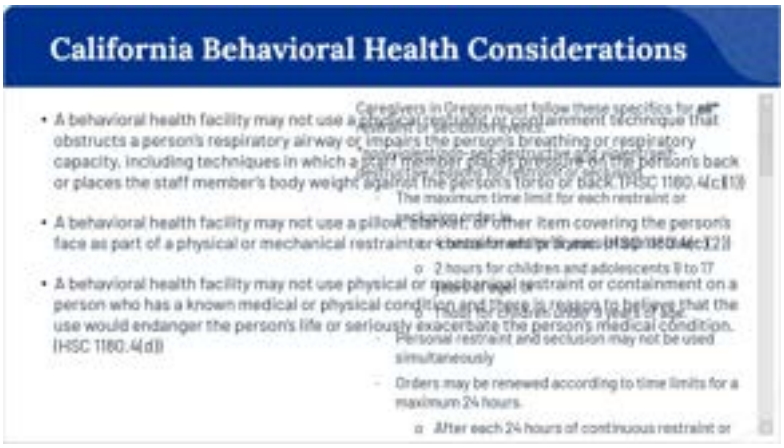

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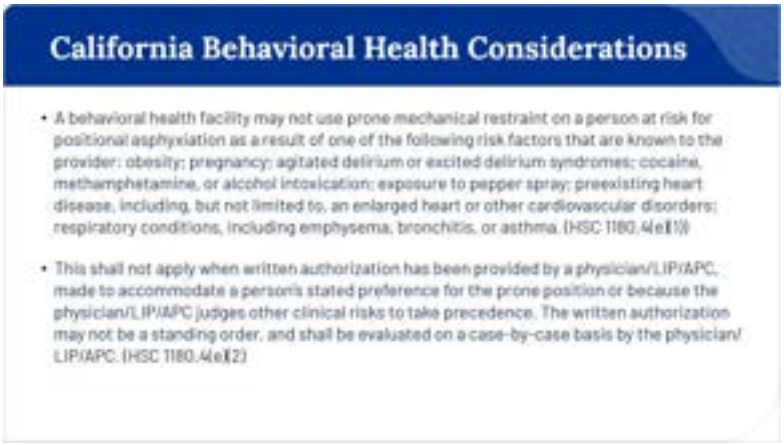

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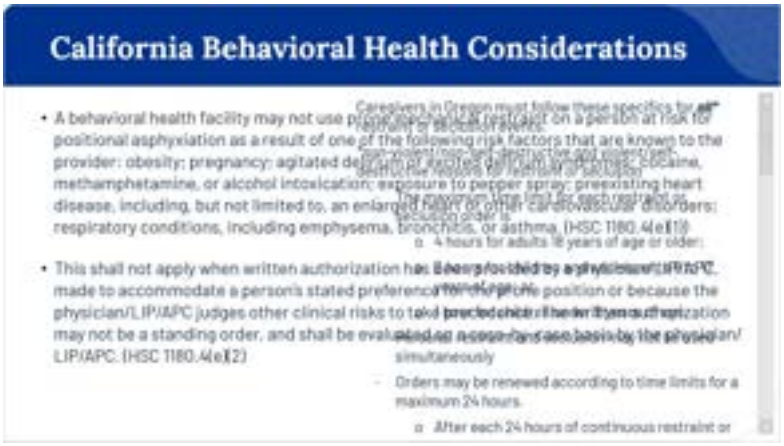

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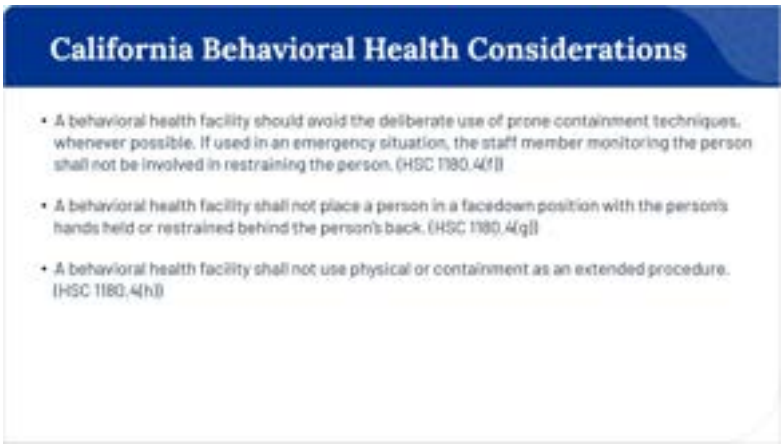

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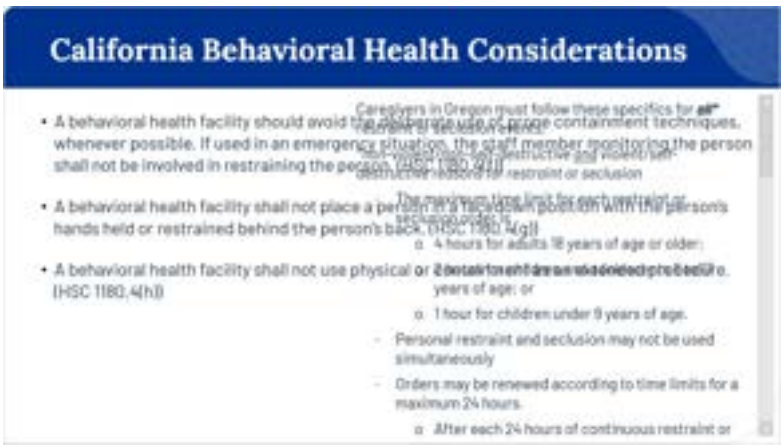
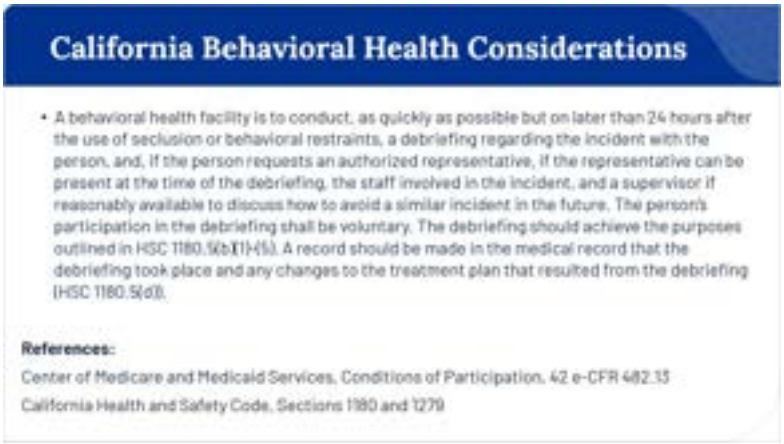
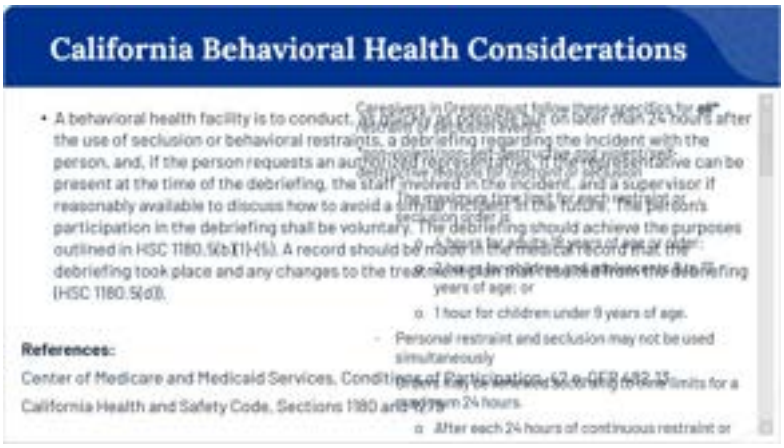


2.17 FAQ



Oregon (Slide Layer)



2.18 T/F Knowledge Check

(Multiple Choice, 10 points, 1 attempt permitted)

Correct	Choice
	Yes
X	No

Feedback when correct:

The correct answer is no. Law enforcement officers are to maintain custody and direct supervision of their prisoner. They are responsible for the use, application, and monitoring of these restrictive devices. Hospital staff are responsible for appropriate patient assessment and provision of safe, appropriate care.

Feedback when incorrect:

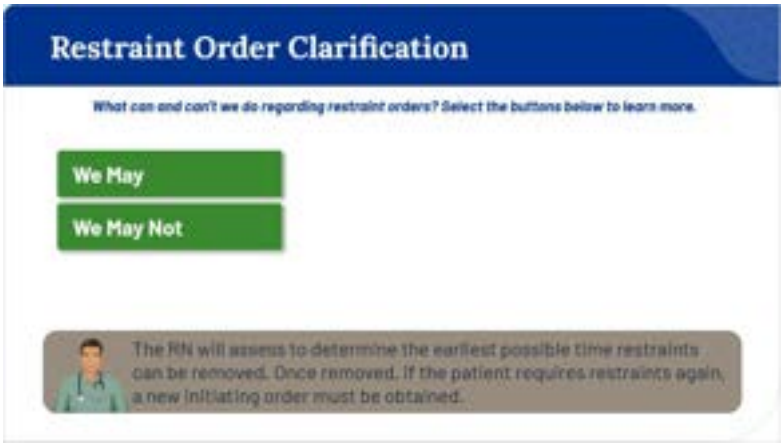
The correct answer is no. Law enforcement officers are to maintain custody and direct supervision of their prisoner. They are responsible for the use, application, and monitoring of these restrictive devices. Hospital staff are responsible for appropriate patient assessment and provision of safe, appropriate care.

Correct! (Slide Layer)

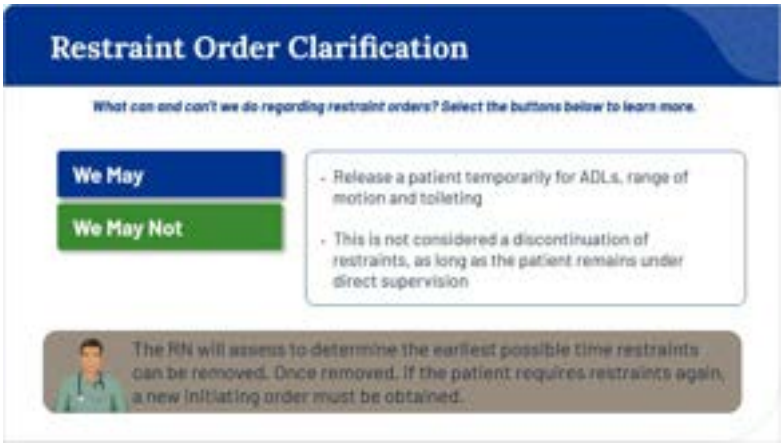
Incorrect (Slide Layer)

3. Orders NonRN

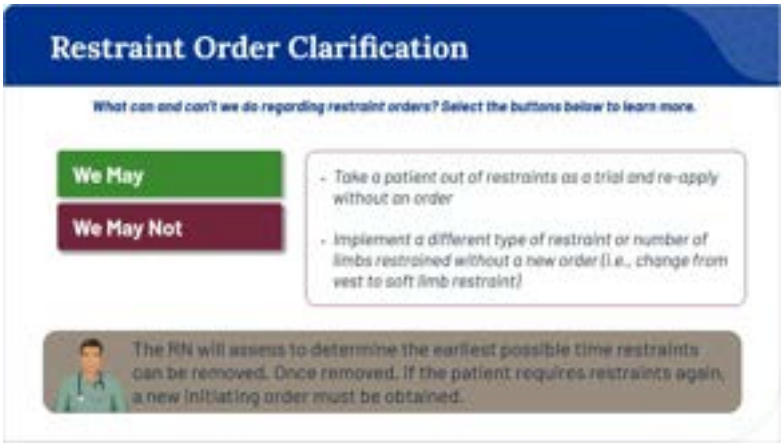
3.1 FAQ



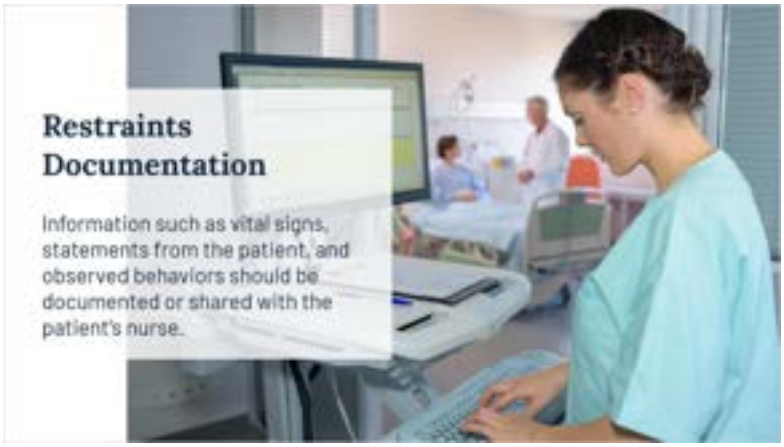
We May (Slide Layer)



We May Not (Slide Layer)



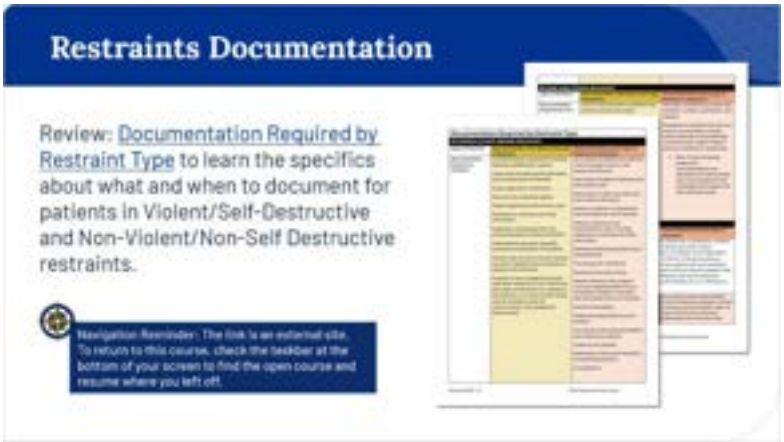
3.2 Untitled Slide



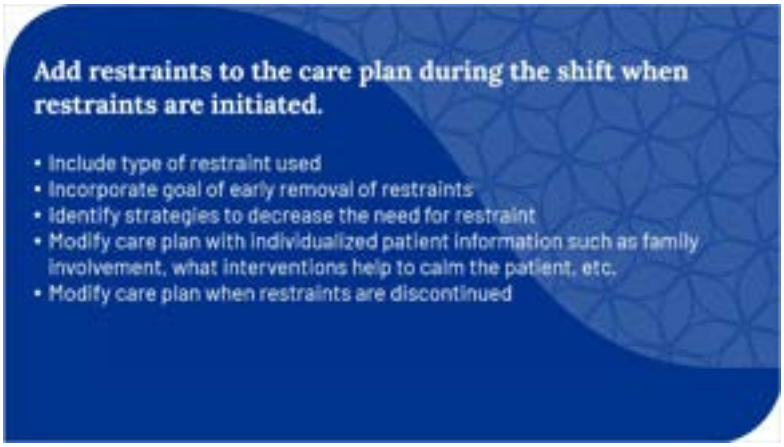
4. Documentation

4.1 Untitled Slide

4.2 FAQ



4.3 FAQ



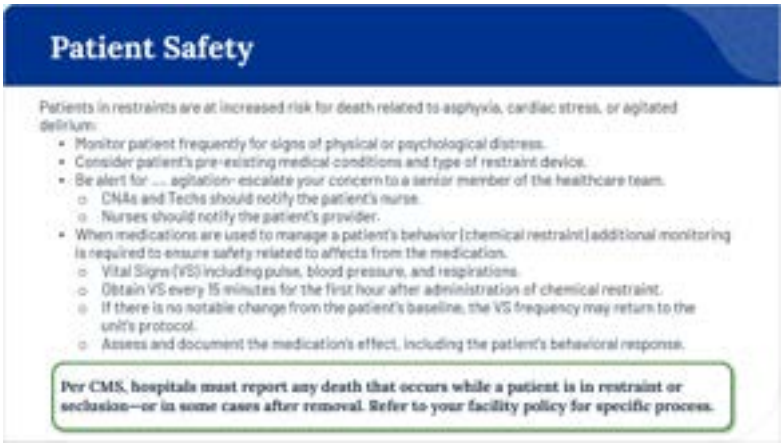
4.4 Patient Handoff

4.5 Restraint Documentation Resources

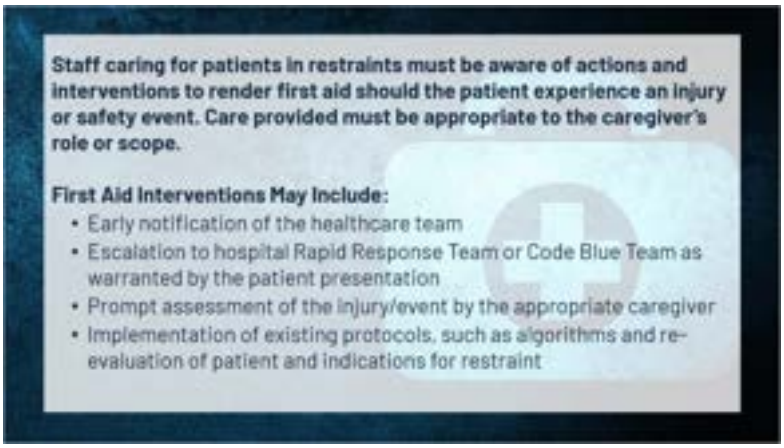
5. Application and Monitoring

5.1 Application of Restraints

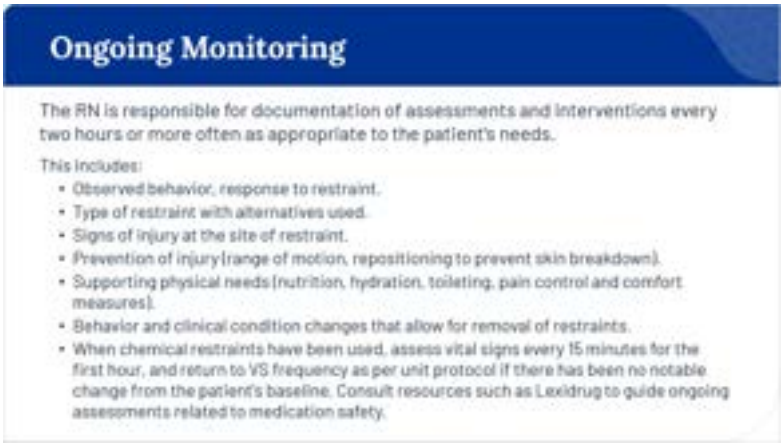
5.2 FAQ



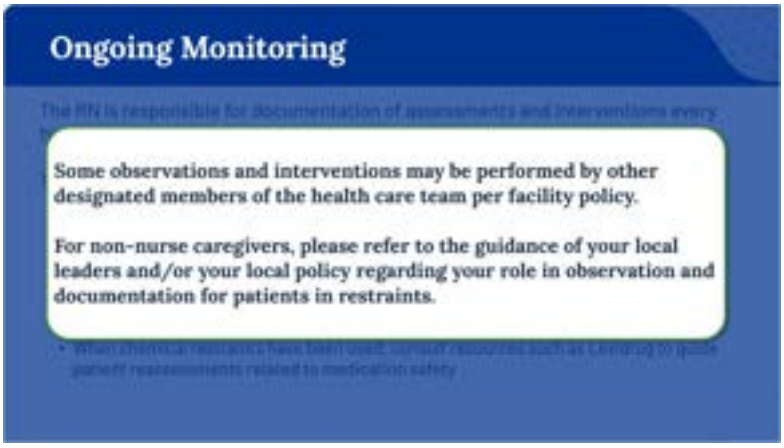
5.3 Untitled Slide



5.4 FAQ



5.5 FAQ



5.6 Untitled Slide

5.7 FAQ

NonViolent/NonSelf (Slide Layer)

Violent/Self (Slide Layer)

Seclusion (Slide Layer)

6. Conclusion

6.1 Thank you! You have completed the first half of the Restraint and Seclusion Review course.

Restraint and Seclusion Review Part 2

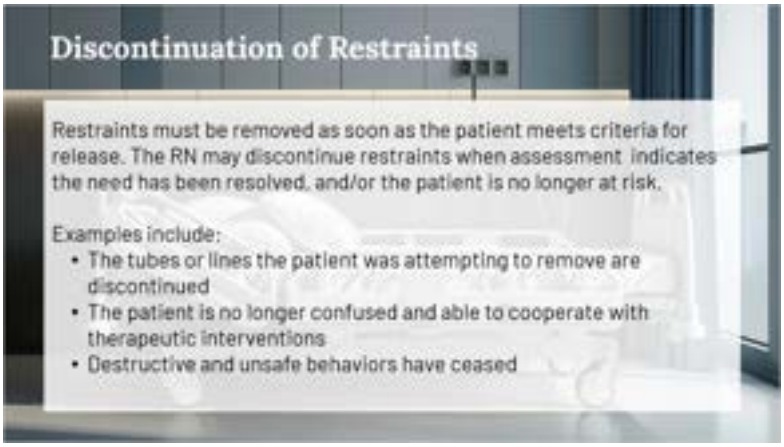
1. Untitled Scene

1.1 Restraint and Seclusion Review Part 2

1.2 Untitled Slide

2. DC of Restraints

2.1 Discontinuation of Restraints



2.2 Knowledge Check

3. RN Knowledge Check

3.1 Untitled Slide

3.2 Multiple Choice / Multiple Answer

(Multiple Response, 10 points, 1 attempt permitted)

Correct	Choice
X	Ask her if she is having pain at the IV site
	Apply hand mitts to prevent her from removing the dressing
X	Apply a protective sleeve or gauze to camouflage the IV site
	Apply a soft limb restraint to the hand opposite to the IV

Feedback when correct:

You chose the correct responses.

Feedback when incorrect:

The correct answers were to ask if she is having pain at the IV site and to apply a protective sleeve or gauze to camouflage the IV site.

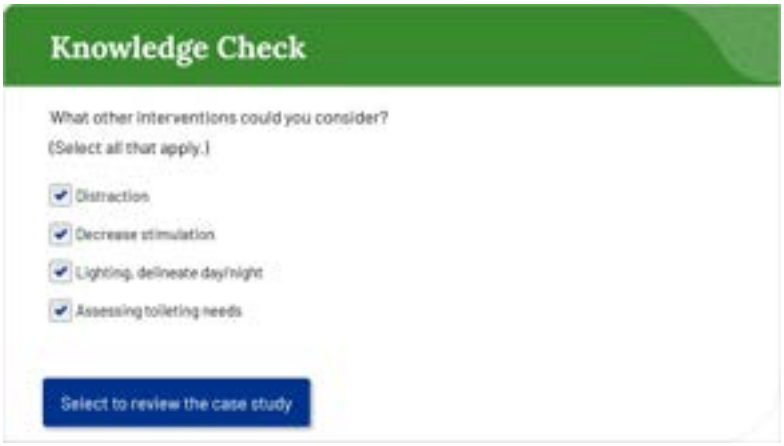
Incorrect (Slide Layer)

Correct (Slide Layer)

Untitled Layer 3 (Slide Layer)

3.3 Multiple Choice / Multiple Answer

(Multiple Response, 10 points, 1 attempt permitted)



Correct	Choice
X	Distraction
X	Decrease stimulation
X	Lighting, delineate day/night
X	Assessing toileting needs

Feedback when correct:

You chose the correct responses.

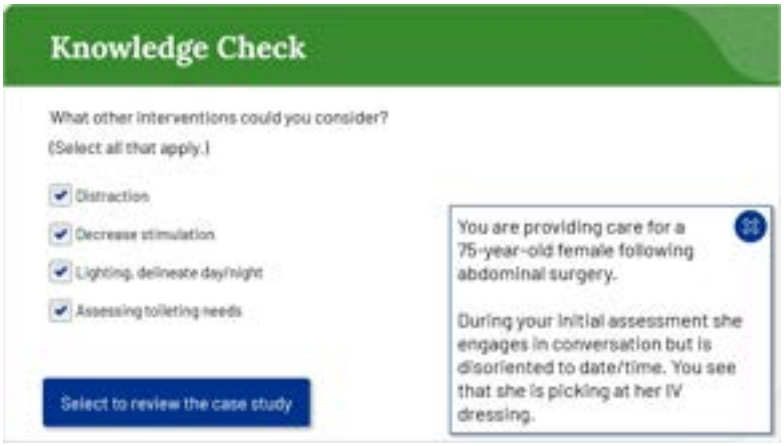
Feedback when incorrect:

All of these answers are correct.

Incorrect (Slide Layer)

Correct (Slide Layer)

Untitled Layer 3 (Slide Layer)



3.4 Untitled Slide

3.5 T/F Knowledge Check

(Multiple Choice, 10 points, 1 attempt permitted)

Correct	Choice
	Violent, self destructive
X	Non-violent, non-self destructive
	Chemical

Feedback when correct:

Non-Violent is the correct answer. The patient is demonstrating behavior that is interfering with treatment (pulling on lines, getting tangled in lines) and is non-responsive to redirection.

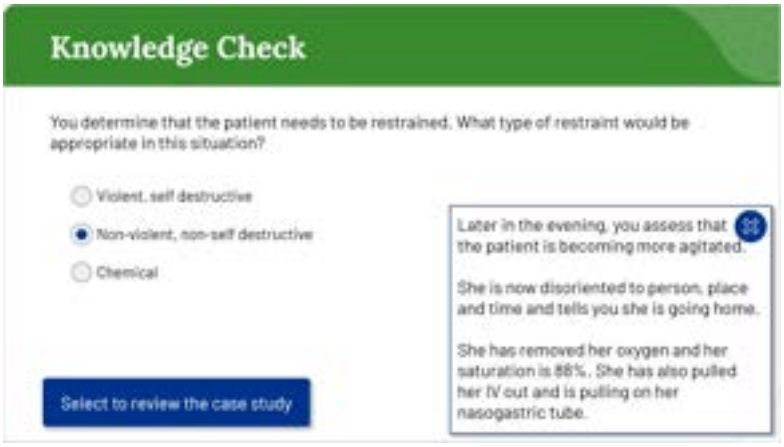
Feedback when incorrect:

Non-Violent is the correct answer. The patient is demonstrating behavior that is interfering with treatment (pulling on lines, getting tangled in lines) and is non-responsive to redirection.

Correct! (Slide Layer)

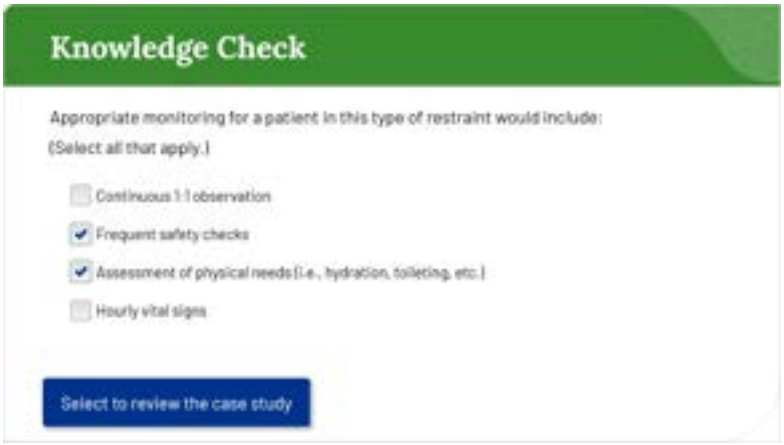
Incorrect (Slide Layer)

Untitled Layer 3 (Slide Layer)



3.6 Multiple Choice / Multiple Answer

(Multiple Response, 10 points, 1 attempt permitted)



Correct	Choice
	Continuous 1:1 observation
X	Frequent safety checks
X	Assessment of physical needs (i.e., hydration, toileting, etc.)
	Hourly vital signs

Feedback when correct:

You chose the correct responses.

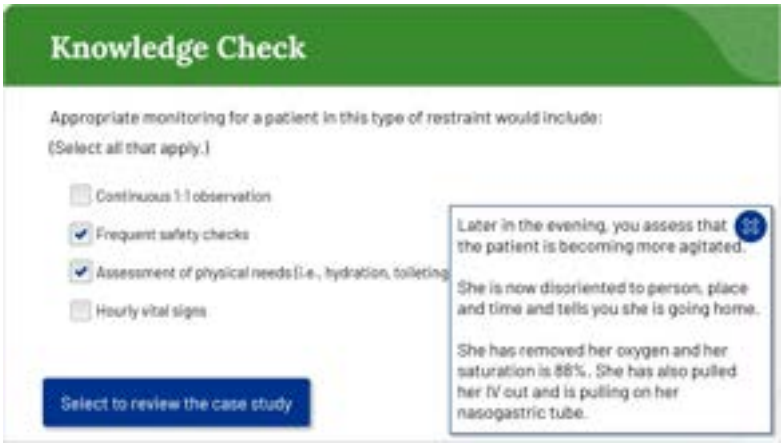
Feedback when incorrect:

The correct answers were frequent safety checks and assessment of physical needs (i.e., hydration, toileting, etc.).

Incorrect (Slide Layer)

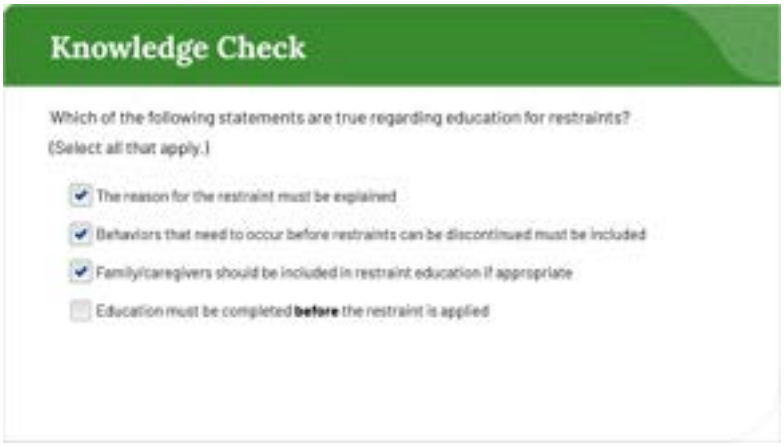
Correct (Slide Layer)

Untitled Layer 3 (Slide Layer)



3.7 Multiple Choice / Multiple Answer

(Multiple Response, 10 points, 1 attempt permitted)



Correct	Choice
X	The reason for the restraint must be explained
X	Behaviors that need to occur before restraints can be discontinued must be included
X	Family/caregivers should be included in restraint education if appropriate
	Education must be completed before the restraint is applied

Feedback when correct:

You chose the correct responses.

Feedback when incorrect:

The correct answers were the reason for the restraint must be explained, behaviors that need to occur before restraints can be discontinued must be included, and family/caregivers should be included in restraint education if appropriate.

Incorrect (Slide Layer)

Correct (Slide Layer)

3.8 Multiple Choice / Multiple Answer

(Multiple Response, 10 points, 1 attempt permitted)

Correct	Choice
X	The patient is able to safely manage themselves without the potential for serious risk to self or others
X	The patient is able to respond to direction and is not pulling at lines or tubing

Feedback when correct:

You chose the correct responses.

Feedback when incorrect:

Both answers are correct.

Incorrect (Slide Layer)

Correct (Slide Layer)

3.9 KC 1 of 12

(Multiple Response, 10 points, 1 attempt permitted)

Correct	Choice
X	Call for help to engage the care team
X	Elevate head of bed as an appropriate first aid measure
	Call Code Blue as an emergency response
	Administer oxygen as an appropriate first aid measure
X	Call Rapid Response

Correct (Slide Layer)

Incorrect (Slide Layer)

3.10 KC 2 of 12

(Multiple Response, 10 points, 1 attempt permitted)

Correct	Choice
X	Call for help to engage the care team
X	Untangle the patient’s wrists from the straps as an appropriate first aid measure
	Call Code Blue as an emergency response
	Administer oxygen as an appropriate first aid measure
X	Work with the care team to adjust the slack in the restraint straps to reduce risk of entrapment or strangulation

Correct (Slide Layer)

Incorrect (Slide Layer)

3.11 KC 4 of 12

(Multiple Response, 10 points, 1 attempt permitted)

Correct	Choice
X	Respond immediately to assess the patient and provide appropriate first aid measures such as cleansing and dressing their wounds
X	Document the presence of skin abrasions and patient response to interventions
	Release the restraints to prevent further skin damage
X	Consult WOCN if necessary to address the patient's wounds
X	Communicate with the patient's provider and request an updated restraint order as needed for use of the least restrictive means necessary to ensure patient safety
X	Complete incident report of this Medical Device Related Skin Injury

Correct (Slide Layer)

Incorrect (Slide Layer)

3.12 KC 8 of 12

(Multiple Choice, 10 points, 1 attempt permitted)

Correct	Choice
	Yes. We want to provide the least restrictive method necessary, and the nurse can decide based on the situation
X	No. Once fully released, a restraint may not be re-applied without a new order

Feedback when correct:

That's right! You selected the correct response.

Feedback when incorrect:

The correct answer is: No, a restraint cannot be released as a trial (and then reapplied if needed) to test whether the patient is ready to have them removed. Once fully released, a restraint may not be re-applied without a new order.

Correct (Slide Layer)

Incorrect (Slide Layer)

3.13 KC 9 of 12

(Multiple Choice, 10 points, 1 attempt permitted)

Correct	Choice
	Yes, always get a new order.
X	No. Bathroom privilege, Personal Hygiene, Range of Motion activity, and Nutrition/Hydration are all required at least every 2 hours as part of the restraint process. Restraints are not discontinued for these activities and re-application of the restraints do not require a new order.

Feedback when correct:

That's right! You selected the correct response.

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Feedback when incorrect:

The correct answer is: No. Bathroom privilege, Personal Hygiene, Range of Motion activity, and Nutrition/Hydration are all required at least every 2 hours as part of the restraint process. Restraints are not discontinued for these activities and re-application of the restraints do not require a new order.

Correct (Slide Layer)

Incorrect (Slide Layer)

3.14 KC 10 of 12

(Multiple Choice, 10 points, 1 attempt permitted)

Correct	Choice
	True
X	False

Feedback when correct:

They must all be removed unless you obtain a provider order changing the restraint type or points. You must follow the order as written.

Feedback when incorrect:

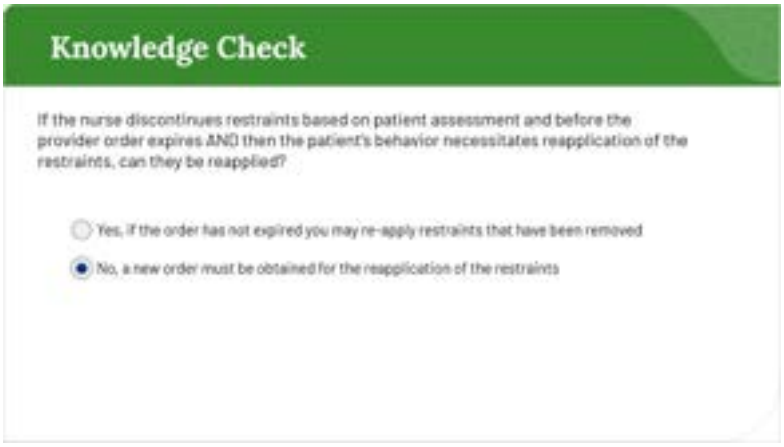
The correct answer is: False. They must all be removed unless you obtain a provider order changing the restraint type or points. You can choose to release part of the restraints ordered.

Incorrect (Slide Layer)

Correct (Slide Layer)

3.15 KC 11 of 12

(Multiple Choice, 10 points, 1 attempt permitted)



Correct	Choice
	Yes, if the order has not expired you may re-apply restraints that have been removed
X	No, a new order must be obtained for the reapplication of the restraints

Feedback when correct:

They must all be removed unless you obtain a provider order changing the restraint type or points.

Feedback when incorrect:

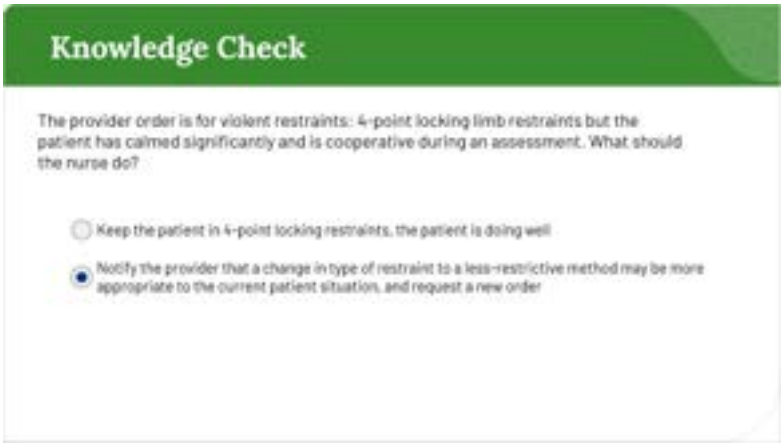
The correct answer is No. They must all be removed unless you obtain a provider order changing the restraint type or points.

Correct (Slide Layer)

Incorrect (Slide Layer)

3.16 KC 12 of 12

(Multiple Choice, 10 points, 1 attempt permitted)



Correct	Choice
	Keep the patient in 4-point locking restraints, the patient is doing well
X	Notify the provider that a change in type of restraint to a less-restrictive method may be more appropriate to the current patient situation, and request a new order

Feedback when correct:

The correct answer is to notify the provider that a change in type of restraint to a less-restrictive method may be more appropriate to the current patient situation, and request a new order.

Feedback when incorrect:

The correct answer is to notify the provider that a change in type of restraint to a less-restrictive method may be more appropriate to the current patient situation, and request a new order.

Correct (Slide Layer)

Incorrect (Slide Layer)

4. Non-RN Knowledge Check

4.1 Multiple Choice / Multiple Answer

(Multiple Response, 10 points, 1 attempt permitted)

Correct	Choice
X	Engaging the patient in conversation
X	Decreasing stimulation
	Setting strict limits
X	Increasing frequency of rounding

Feedback when correct:

You chose the correct responses.

Feedback when incorrect:

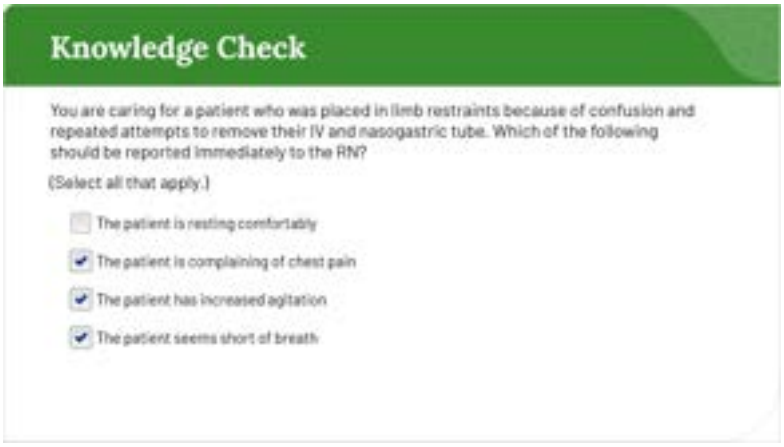
The correct answers are to engage the patient in conversation, decrease stimulation and increase the frequency of rounding.

Incorrect (Slide Layer)

Correct (Slide Layer)

4.2 Multiple Choice / Multiple Answer

(Multiple Response, 10 points, 1 attempt permitted)



Correct	Choice
	The patient is resting comfortably
X	The patient is complaining of chest pain
X	The patient has increased agitation
X	The patient seems short of breath

Feedback when correct:

You chose the correct responses.

Feedback when incorrect:

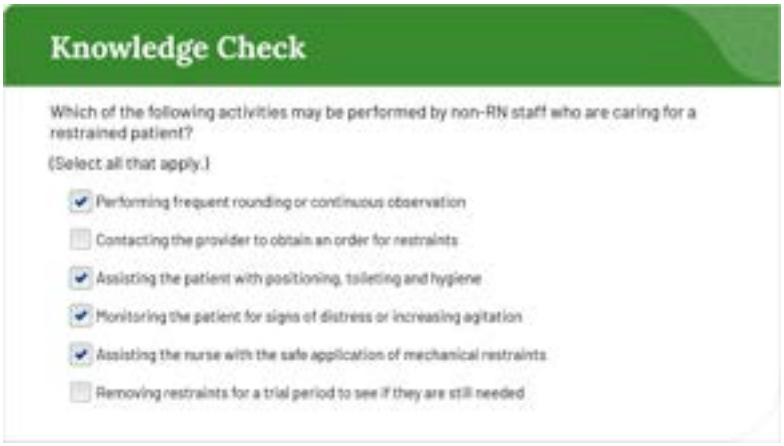
The correct answers are to report that the patient is complaining of chest pain, the patient has increased agitation and the patient seems short of breath.

Incorrect (Slide Layer)

Correct (Slide Layer)

4.3 Multiple Choice / Multiple Answer

(Multiple Response, 10 points, 1 attempt permitted)



Correct	Choice
X	Performing frequent rounding or continuous observation
	Contacting the provider to obtain an order for restraints
X	Assisting the patient with positioning, toileting and hygiene
X	Monitoring the patient for signs of distress or increasing agitation
X	Assisting the nurse with the safe application of mechanical restraints

Correct	Choice
	Removing restraints for a trial period to see if they are still needed

Feedback when correct:

You chose the correct responses.

Feedback when incorrect:

The correct answers are perform frequent rounding or continuous observation, assist the patient with positioning, toileting and hygiene, monitor the patient for signs of distress or increasing agitation and assist the nurse with safe application of mechanical restraints.

Incorrect (Slide Layer)

Correct (Slide Layer)

4.4 KC 1 of 12

(Multiple Response, 10 points, 1 attempt permitted)

Correct	Choice
X	Call for help to engage the care team
X	Elevate head of bed as an appropriate first aid measure
	Call Code Blue as an emergency response
	Administer oxygen as an appropriate first aid measure
X	Call Rapid Response

Correct (Slide Layer)

Incorrect (Slide Layer)

4.5 KC 2 of 12

(Multiple Response, 10 points, 1 attempt permitted)

Correct	Choice
X	Call for help to engage the care team
X	Untangle the patient’s wrists from the straps as an appropriate first aid measure
	Call Code Blue as an emergency response
	Administer oxygen as an appropriate first aid measure
X	Work with the care team to adjust the slack in the restraint straps to reduce risk of entrapment or strangulation

Correct (Slide Layer)

Incorrect (Slide Layer)

4.6 KC 3 of 12

(Multiple Response, 10 points, 1 attempt permitted)

Correct	Choice
X	Inform the patient's nurse that the patient needs appropriate first aid for the skin abrasions
X	Document the presence of skin abrasions and patient response to their restraints
	Call Code Blue as an emergency response
	Release the restraints to prevent further skin damage

Correct (Slide Layer)

Incorrect (Slide Layer)

4.7 KC 8 of 12

(Multiple Choice, 10 points, 1 attempt permitted)

Correct	Choice
	Yes. We want to provide the least restrictive method necessary, and the nurse can decide based on the situation.
X	No. Once fully released, a restraint may not be re-applied without a new order.

Feedback when correct:

That's right! You selected the correct response.

Feedback when incorrect:

The correct answer is: No, a restraint cannot be released as a trial (and then reapplied if needed) to test whether the patient is ready to have them removed. Once fully released, a restraint may not be re-applied without a new order.

Correct (Slide Layer)

Incorrect (Slide Layer)

4.8 KC 9 of 12

(Multiple Choice, 10 points, 1 attempt permitted)

Correct	Choice
	Yes, always get a new order.
X	No. Bathroom privilege, Personal Hygiene, Range of Motion activity, and Nutrition/Hydration are all required at least every 2 hours as part of the restraint process. Restraints are not discontinued for these activities and re-application of the restraints do not require a new order.

Feedback when correct:

That's right! You selected the correct response.

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Feedback when incorrect:

The correct answer is: No. Bathroom privilege, Personal Hygiene, Range of Motion activity, and Nutrition/Hydration are all required at least every 2 hours as part of the restraint process. Restraints are not discontinued for these activities and re-application of the restraints do not require a new order.

Correct (Slide Layer)

Incorrect (Slide Layer)

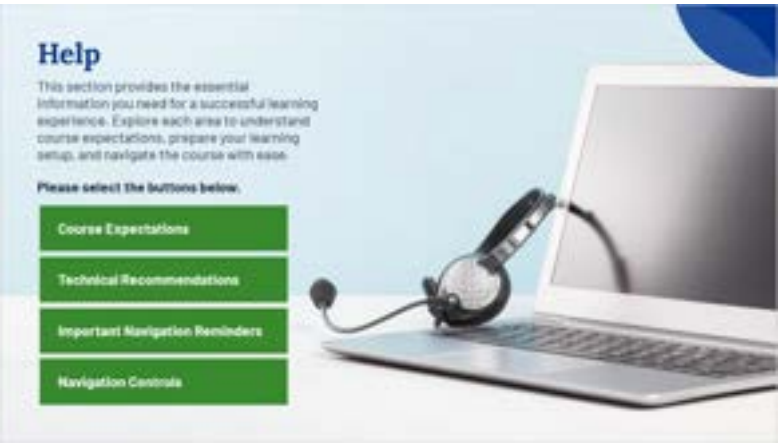
5. Conclusion

5.1 Untitled Slide

5.2 Thank you! You have completed Restraint and Seclusion Review.

6. Help

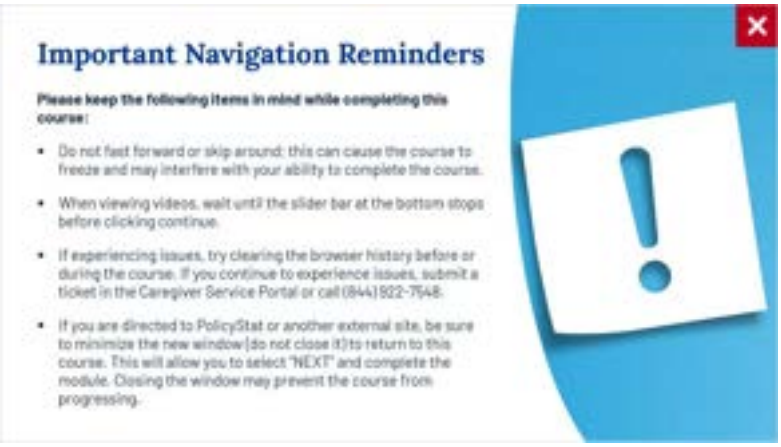
6.1 Help



Course Expectations (Slide Layer)

Technical Recommendations (Slide Layer)

Important Navigation Reminders (Slide Layer)



Navigation Controls (Slide Layer)

Stroke Awareness

1. PSJH_PPT_BEFAST

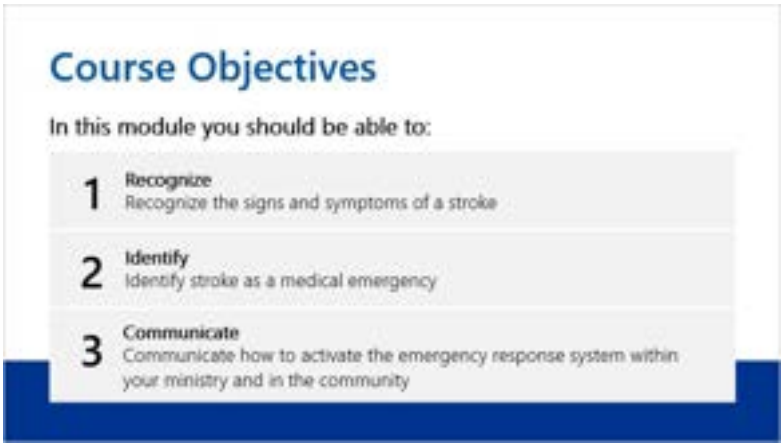
1.1 Stroke Awareness

Notes:

1.2 Welcome

Notes:

1.3 Objectives Layout



1.4 During a Stroke Every Minute Counts

Notes:

Clock ticking audio

1.5 A Stroke is a Medical

Notes:

1.6 A Stroke is a Medical Emergency

1.7 Time is Brain

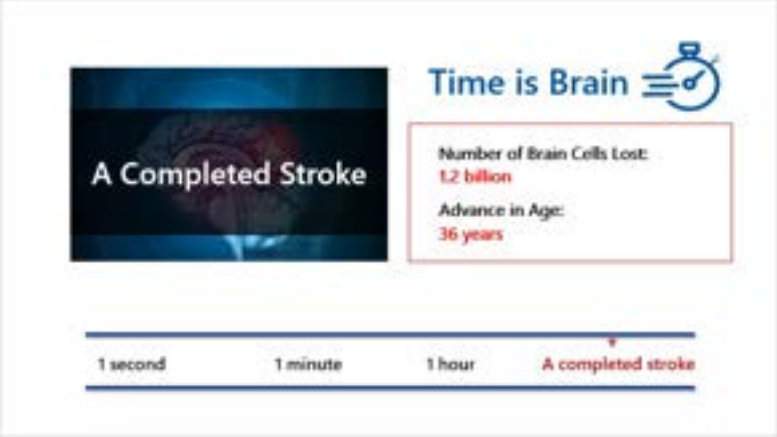
Notes:

1 second (Slide Layer)

1 minute (Slide Layer)

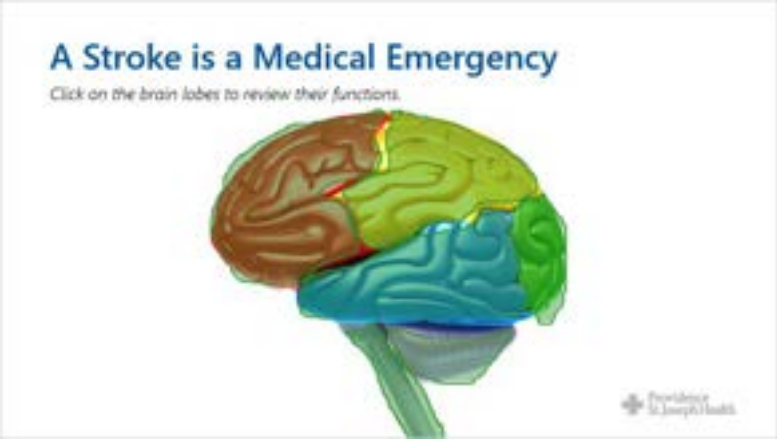
1 hour (Slide Layer)

A completed stroke (Slide Layer)



1.8 A Stroke is a Medical Emergency

1.9 A Stroke is a Medical Emergency



Frontal Lobe (Slide Layer)

Parietal Lobe (Slide Layer)

Occipital Lobe (Slide Layer)

Cerebellum (Slide Layer)

Brain Stem (Slide Layer)

Temporal Lobe (Slide Layer)

1.10 A Stroke is a Medical Emergency

1.11 A Stroke is a Medical Emergency

1.12 A Stroke is a Medical Emergency

1.13 Recognize

B Balance (Slide Layer)

E Eyes (Slide Layer)

F Face (Slide Layer)

A Arms (Slide Layer)

S Speech (Slide Layer)

T Time (Slide Layer)

1.14 Respond

1.15 Beyond BE FAST

Numbness (Slide Layer)

Confusion (Slide Layer)

Sight (Slide Layer)

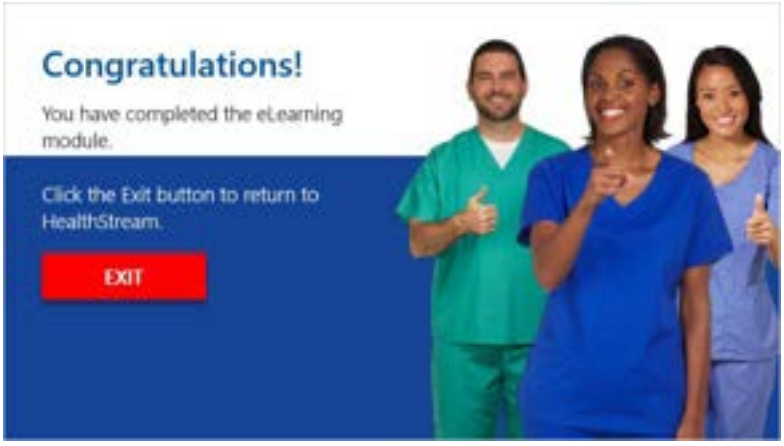
Mobility (Slide Layer)

Headache (Slide Layer)

1.16 When You Recognize a Stroke…

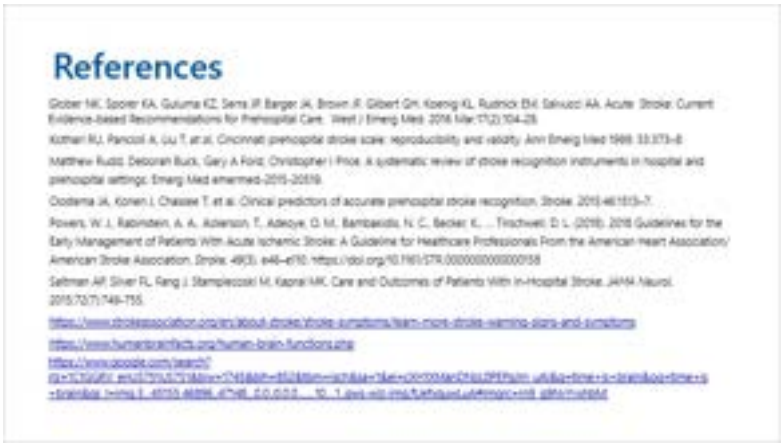
1.17 OK to overreact

1.18 You have completed the eLearning module. When you are ready to receive credit for the course, click on the "X" at the top right of the window.



2. PSJH_PPT_BEFAST

2.1 References



Fall Prevention and Management Part 1

1. Untitled Scene

1.1 Fall Prevention and Management

Notes:

1.2 Untitled Slide

Notes:

1.3 Untitled Slide

Notes:

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1.4 What is the Nurse's Role?

Notes:

Predictive Scheduler is an automated scheduling tool that uses a data-backed methodology to enable leaders to make evidence-informed staffing decisions, while allowing a new level of flexibility for our caregivers.

Managers can generate custom schedules, visualize forecasted volume predictions, compare schedule outputs, and gain insights through various scheduling stats. And it's all in one place!

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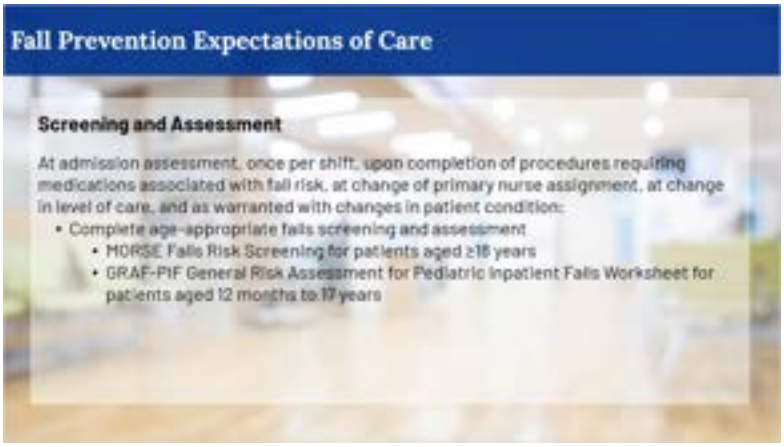
Click the Next button to view an introductory video about Predictive Scheduler.

Untitled Layer 1 (Slide Layer)

1.5 Untitled Slide



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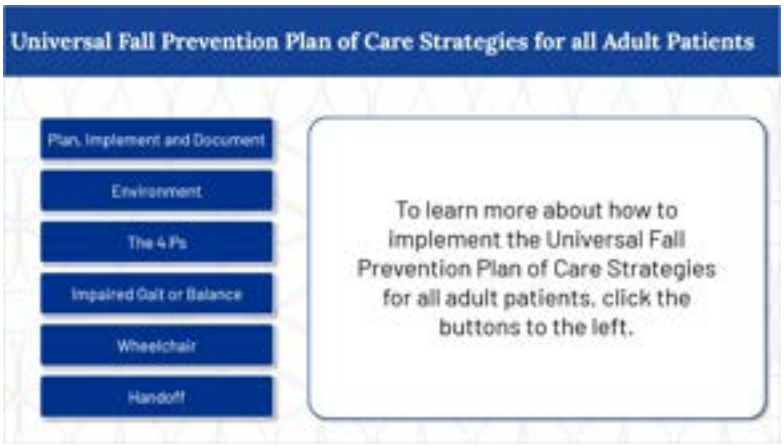
1.6 Untitled Slide

2. Adults only

2.1 Untitled Slide



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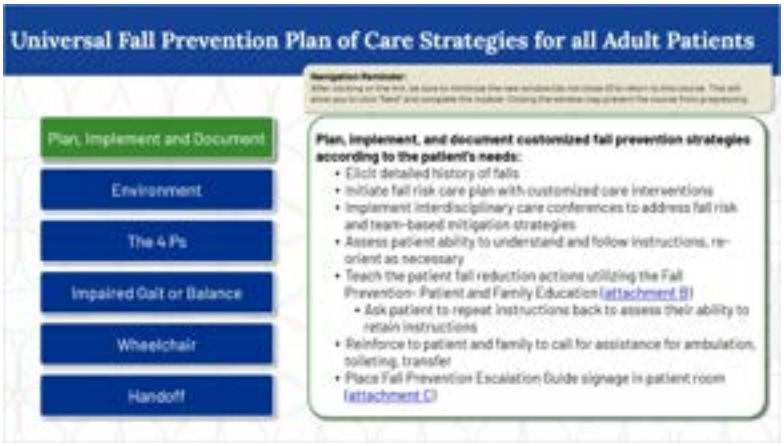
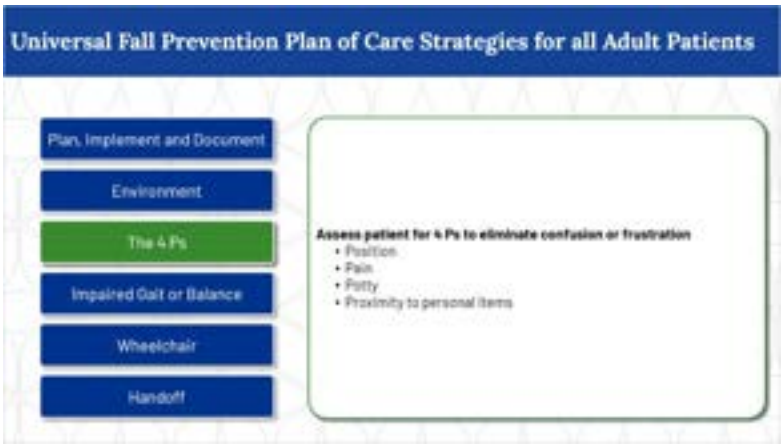
Plan (Slide Layer)

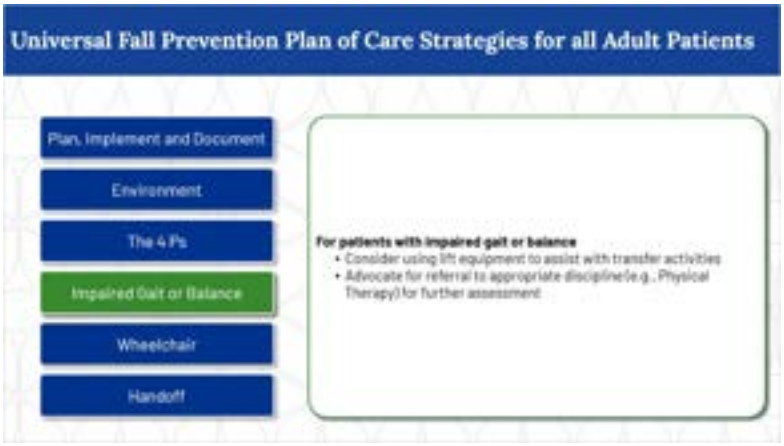


Environment (Slide Layer)

4 Ps (Slide Layer)



Impaired (Slide Layer)



Wheelchair (Slide Layer)

Handoff (Slide Layer)

2.2 Untitled Slide

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2.3 Untitled Slide

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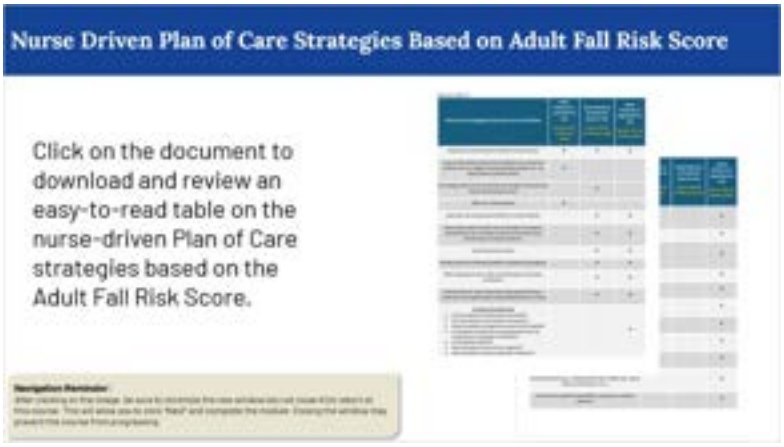
2.7 Untitled Slide



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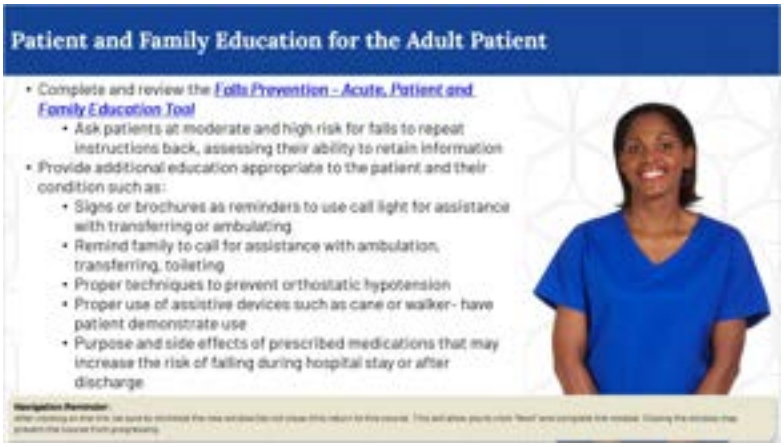
2.8 Untitled Slide



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Click the Next button to view an introductory video about Predictive Scheduler.

3. Untitled Scene

3.1 Thank you! You have completed the first half of the Fall Prevention and Management course.

Fall Prevention and Management Part 2

1. Untitled Scene

1.1 Fall Prevention and Management Part 2

1.2 Untitled Slide

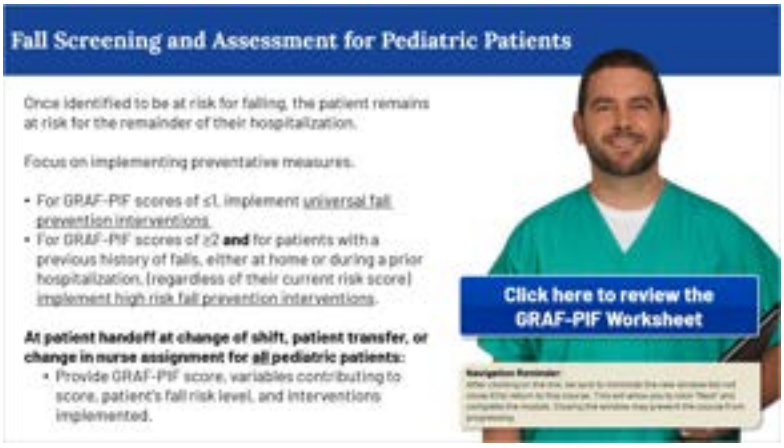
Notes:

2. Untitled Scene

2.1 Untitled Slide

3. Peds only

3.1 Untitled Slide



3.2 Untitled

L1 (Slide Layer)

L2 (Slide Layer)

L3 (Slide Layer)

L4 (Slide Layer)

L5 (Slide Layer)

L6 (Slide Layer)

L7 (Slide Layer)

L8 (Slide Layer)

R9 (Slide Layer)

R10 (Slide Layer)

R11 (Slide Layer)

R12 (Slide Layer)

R13 (Slide Layer)

R14 (Slide Layer)

R15 (Slide Layer)

3.3 Untitled

L1 (Slide Layer)

L2 (Slide Layer)

L3 (Slide Layer)

L4 (Slide Layer)

L5 (Slide Layer)

R1 (Slide Layer)

R2 (Slide Layer)

R3 (Slide Layer)

R4 (Slide Layer)

R5 (Slide Layer)

4. Untitled Scene

4.1 Untitled Slide

4.2 Untitled Slide

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4.3 Untitled Slide

Answer (Slide Layer)

4.4 Untitled Slide

4.5 Untitled Slide

4.6 Untitled Slide

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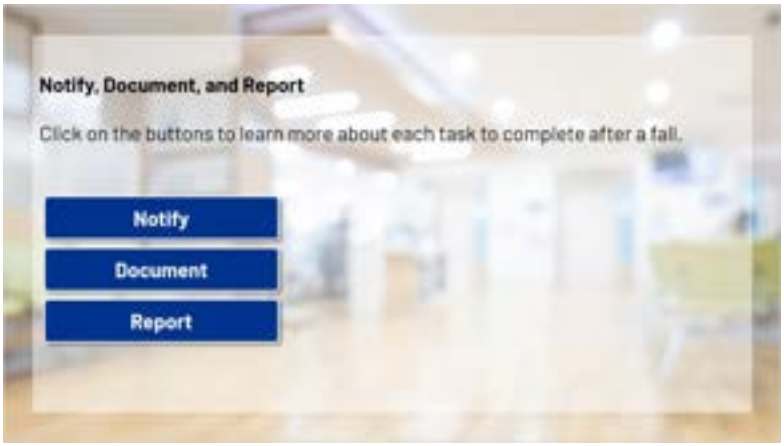
4.10 Untitled Slide

4.11 Untitled Slide



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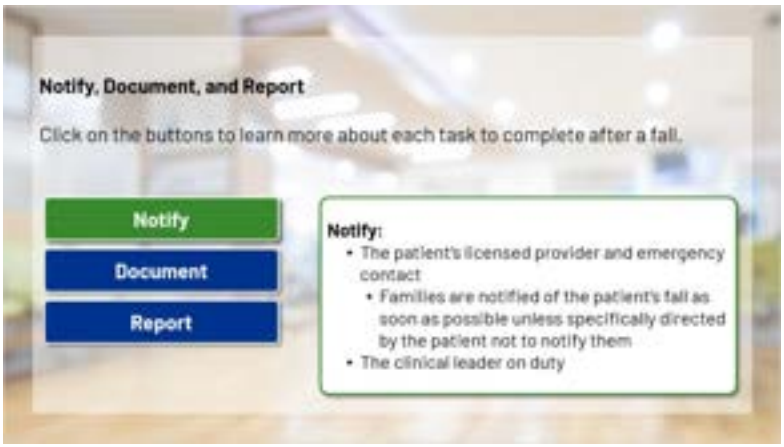
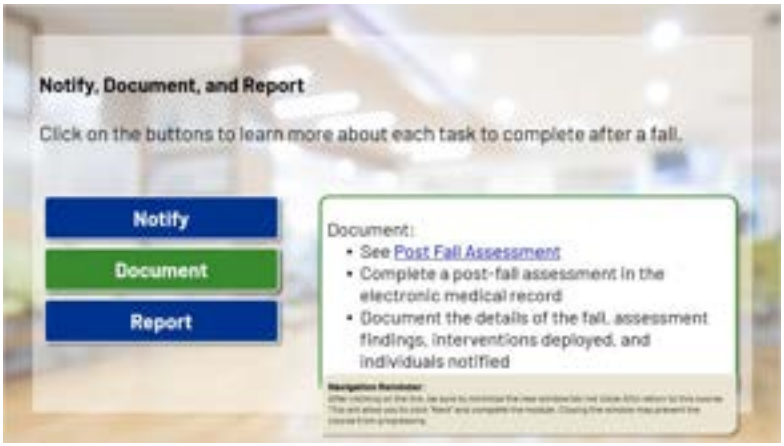
Notify (Slide Layer)



Document (Slide Layer)



Report (Slide Layer)

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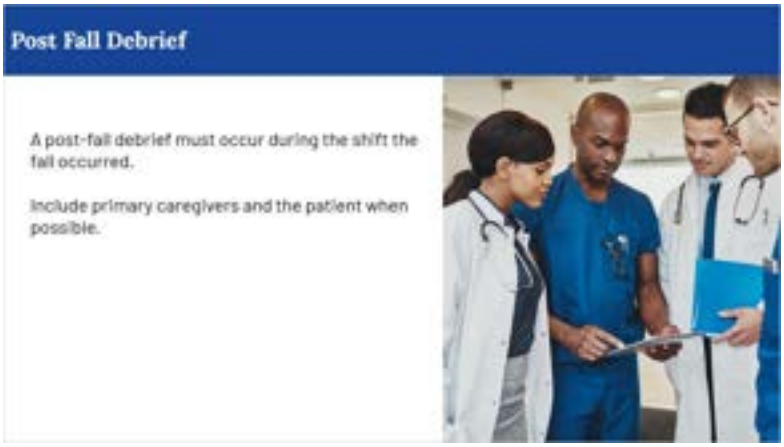

4.13 Untitled Slide

4.14 Untitled Slide

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4.15 Untitled Slide

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PROV: Antimicrobial Stewardship for Nursing

Click or tap the **Start Course** button to begin.

- Course Navigation
- Introduction
- Antimicrobial Stewardship
- The Nurse's Role in Antimicrobial Stewardship
- Knowledge Check
- References
- Conclusion

Course Navigation

Instructions

- You must move through this course in sequential order.
- Successful completion of this course requires viewing all content.
- You may exit the course and return to where you left off.

CONTINUE

Important Navigation Reminders

Please keep the following items in mind while completing this course:

1. Lessons load as you complete a section. If you do not see the continue or next lesson button, **scroll down** to load the lesson or locate the continue button.

2. Do not fast forward or skip around; this can cause the lesson/course to freeze and may interfere with your ability to complete the course.

3. If experiencing issues, try clearing the browser history before or during the course. If you continue to experience issues, submit a ticket in the Caregiver Service Portal or call (844) 922-7548.

4. When viewing videos, wait until the slider bar at the bottom stops before clicking continue.

5 Anytime you see an image, you can click to enlarge it.

6 If you are directed to PolicyStat or another external site, be sure to minimize the new window **(do not close it)** to return to this course. This will allow you to click "**Continue**" and complete the module. Closing the window may prevent the course from progressing.

CONTINUE

Introduction

Objectives

Upon completion of this module, the caregiver will be able to:

1. Understand the clinical importance of antimicrobial stewardship.
2. Understand the clinical importance of antimicrobial resistance.
3. Identify the ways nurses play a vital role and partner with the care team in antimicrobial stewardship activities.

CONTINUE

Antimicrobial Stewardship

What is Antimicrobial Stewardship (AMS)?

Antimicrobial stewardship is defined as a rational, systematic approach to the use of antimicrobial (antibiotic, antifungal and antiviral) agents in order to achieve optimal outcomes including cure, and reduction of toxicity, adverse effects, and resistance.

Why Does Antimicrobial Stewardship Matter?

1. To prevent **antimicrobial resistance**

2. To prevent the creation of Multidrug Resistant Organisms (**MDROs**)

ANTIMICROBIAL RESISTANCE | MULTIDRUG RESISTANT ORGANISMS (MDROS)

Antimicrobial Resistance *occurs when bacteria, viruses, fungi and parasites no longer respond to antimicrobial medicines. As a result of drug resistance, antibiotics and other antimicrobial medicines become ineffective and infections become difficult or impossible to treat, increasing the risk of disease spread, severe illness, disability and death.*

- Antimicrobial resistance is one of the top global public health and development threats, and was directly responsible for 1.27 million deaths in 2019
- The world faces an antibiotics pipeline and access crisis. There is an inadequate research and development pipeline in the face of rising levels of resistance

https://www.who.int/news-room/fact-sheets/detail/antimicrobial-resistance

ANTIMICROBIAL RESISTANCE | MULTIDRUG RESISTANT ORGANISMS (MDROS)

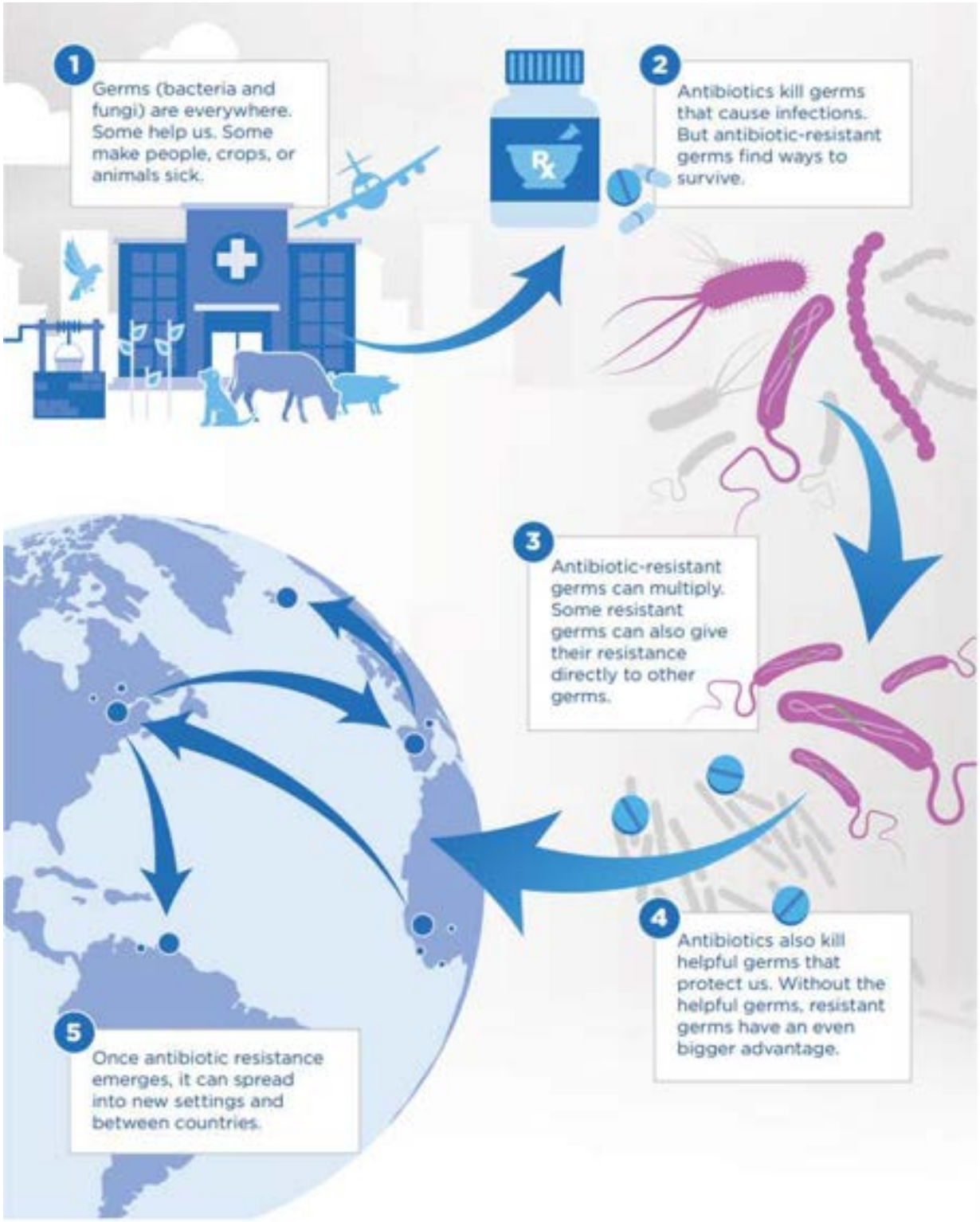
Multidrug Resistant Organisms (MDROs) *are defined as microorganisms, predominantly bacteria, that are resistant to one or more classes of antimicrobial agents.*

- These highly resistant organisms deserve special attention in healthcare facilities
- Prevention is important because options for treating patients with these infections are often extremely limited
- MDROs are associated with increased lengths of stay, increased healthcare costs, and patient mortality

https://www.cdc.gov/infection-control/hcp/mdro-management/background

Complete the content above before moving on.

How Antimicrobial Resistance Occurs



Discovery of new antibiotics has significantly slowed in the past decade so prudent use of current

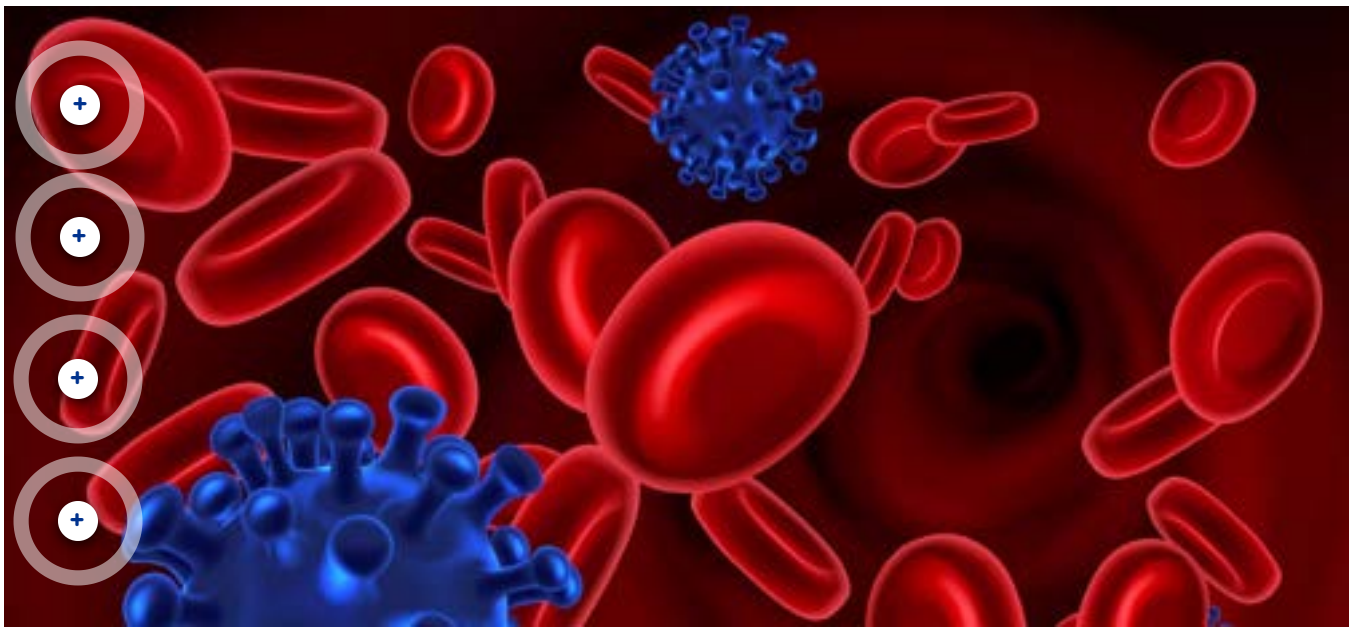
antibiotics is critical in ensuring their continued treatment efficacy.

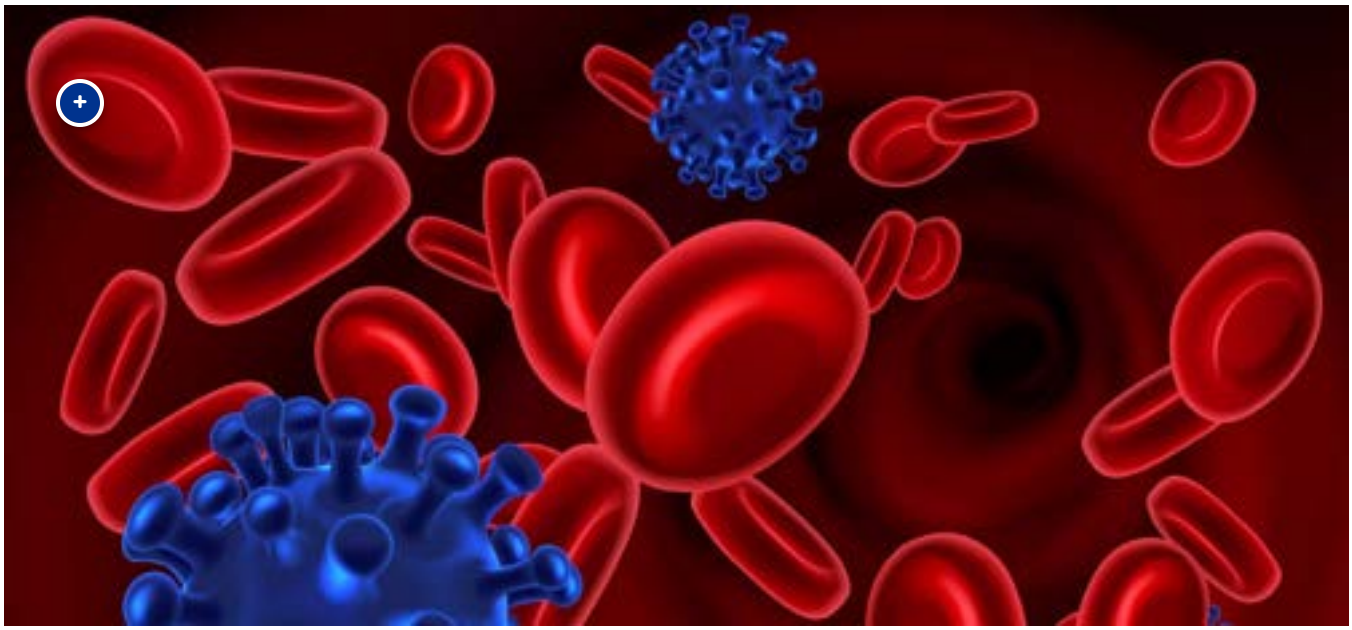
Antimicrobial Stewardship is a strategy we use to limit the development of antimicrobial resistance.

CONTINUE

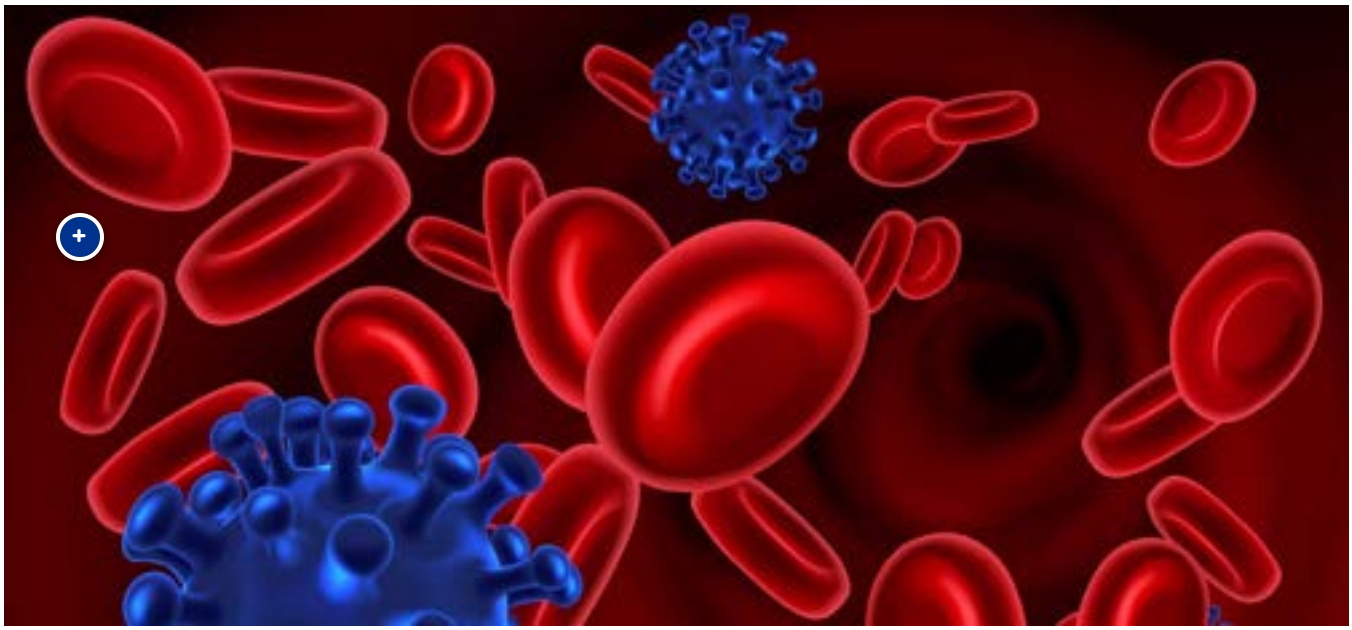
Importance of Antimicrobial Stewardship

Directions: Click or tap on each glowing circle to review more about the importance of Antimicrobial Stewardship. Review all to move on.





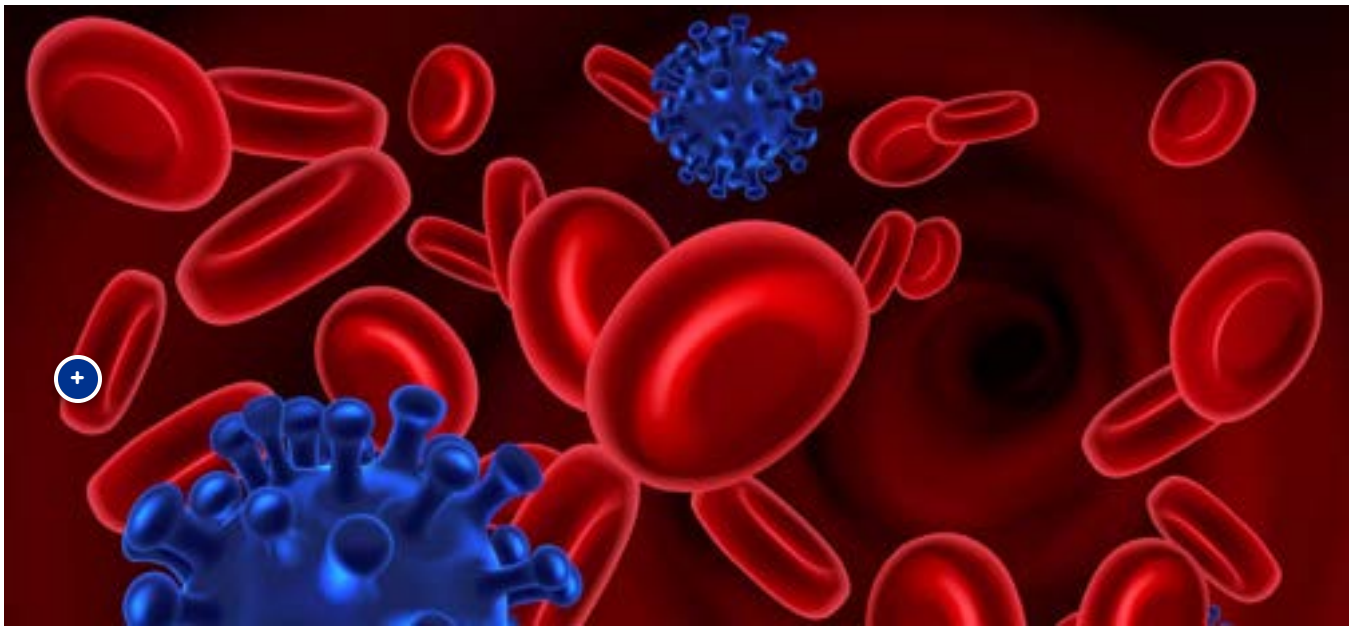
Antimicrobials are the only drug where use in one patient can impact the effectiveness in another



Multi-drug resistant organisms (MDROs) are a major public health concern

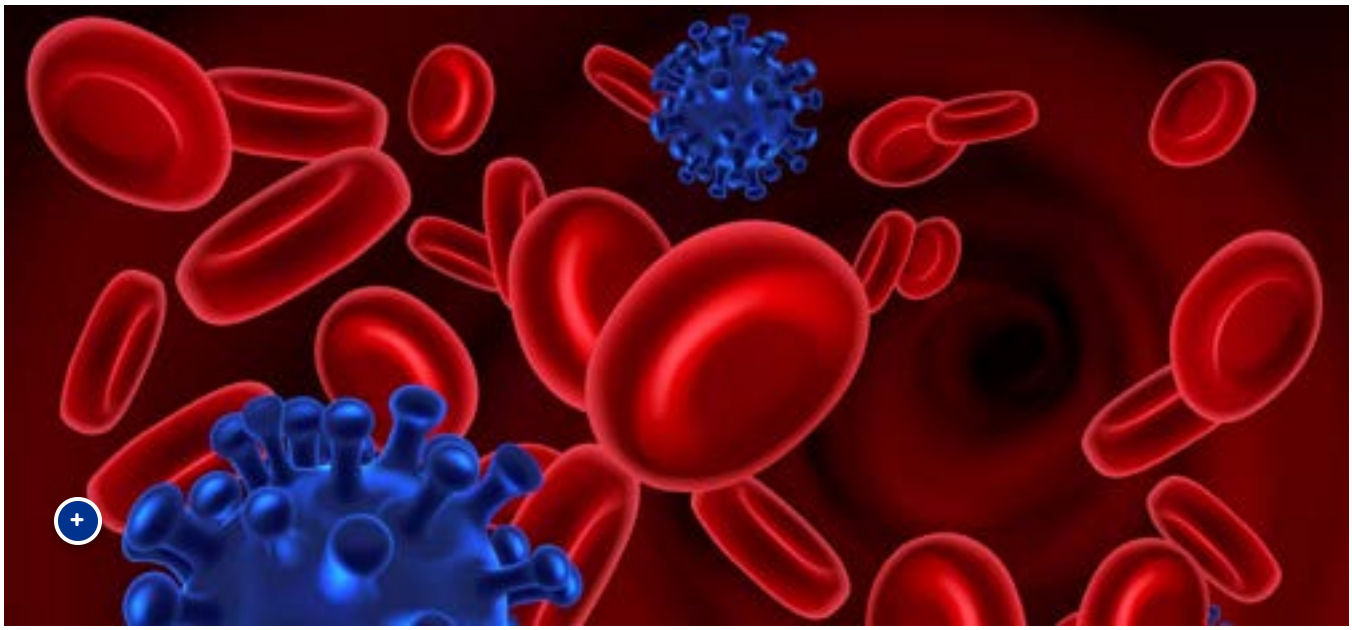
Some examples of MDROs you may be familiar with include:

- Carbapenem-resistant Acinetobacter
- Candida auris
- Clostridioides difficile
- Carbapenem-resistant Enterobacterales
- Drug-resistant Neisseria gonorrhoeae



Antimicrobials are not harmless, even one more day increases risk of adverse effects

- Adverse effects such as rash, dizziness, nausea, diarrhea, yeast infections, and *C difficile*
- Reactions from antibiotics cause 1 out of 5 medication-related visits to the emergency department
- In children, reactions from antibiotics are the most common cause of medication-related emergency department visits



Up to 50% of antimicrobial use in hospitals is unnecessary or inappropriate

Complete the content above before moving on.

The Nurse's Role in Antimicrobial Stewardship

Nurses are a key player in antimicrobial stewardship efforts!

Nurses can reduce the risk of antimicrobial resistance and the creation of additional MDROs by following and encouraging best practices around antimicrobial use:

Follow hand hygiene and other infection control measures to prevent spread of bacteria in the environment and between patients.

When using facility-approved environmental cleaning supplies (cloths, sprays, liquids) use them exactly as the manufacturer directs.

Observing the cleaning time (wet time) is important to fully destroy the bacteria on the surface.

- The surface must be repeatedly cleaned so that it remains wet for the entire length of time directed by the manufacturer.
- Read instructions on the container to verify cleaning time required by the manufacturer.

Follow best practices to prevent Hospital Acquired Infections such as CAUTI and CLABSI.

- Ensure daily patient bathing and other hygiene measures to reduce bacterial load in the patient's environment.
- Use aseptic technique for accessing CVLs.
- Use sterile technique when inserting IUC.
- CHG bathing for patients with CVL and per policy for vulnerable populations.
- Follow Nurse-Driven IUC Removal and Acute Urinary Retention protocols to reduce IUC use.
- Reduce use of intravascular lines by advocating for using oral route when the patient can take oral fluids and medications.

Document the patient's complete medication allergy history to support their provider's selection of the best antibiotic without unnecessarily eliminating options.

Thoughtful Culture Collection

- Whenever possible, ensure lab cultures are collected BEFORE antimicrobials are given (except if this would delay antimicrobial administration significantly).

- When cultures are drawn after antibiotics, the diagnostic sensitivity of the cultures is reduced, which can result in more difficult decisions about what organism to target with antibiotics.

Administer antibiotics as prescribed:

- On time
- Full prescribed dose

Educate patients/families about proper use of antibiotics:

- Antibiotics should not be prescribed for viruses- when you are sick you may not need an antibiotic.
- When prescribed an antibiotic, take the medication exactly as prescribed.
- Take exactly the amount prescribed at regular intervals as prescribed.
- Even if you begin to feel well before your medication regimen is complete, do not stop early. Take all of the prescribed medication.

PDF

Krames - When to Use Antibiotics.pdf
145.9 KB

CONTINUE

Antimicrobial Stewardship is a Team Effort

- The prescriber and pharmacist use antibiograms, a profile of antimicrobial susceptibility testing, to select the best empiric antimicrobial treatment while awaiting microbiology culture and susceptibility results.
- Infectious Disease Clinical Decision Team, and system and local antimicrobial stewardship teams:
    - Conduct antimicrobial utilization and resistance tracking and review
    - Develop and monitor adherence to dosing policies and treatment guidelines
    - Create/manage order sets

- Give provider-specific feedback and optimal prescribing information

Antimicrobial Stewardship Resources

- Your facility's Infection Preventionist and/or Pharmacy
- Your local facility's policy on PolicyStat

☐ By clicking the checkbox to the left I understand that my facility has an Antimicrobial Stewardship program and local resources available to me.

🔒 Complete the content above before moving on.

Knowledge Check

The following questions must be answered with 100% accuracy. You will have unlimited attempts to achieve the required score.

Question

01/04

Select All That Apply:

What are ways to reduce the development of antimicrobial resistance?

- [ ] Follow hand hygiene and other infection control measures with every patient
- [ ] Continue patient antibiotic therapy beyond the prescribed completion date to ensure the bacteria is eliminated
- [ ] Timely antimicrobial administration
- [ ] Collaborate with provider to reassess the antimicrobial administration route

Question

02/04

Complete documentation of allergy and reaction is important in determining antibiotic therapy.

- ○ True
- ○ False

Question

03/04

Select All That Apply:

How does the organization address antimicrobial resistance?

- [ ] The organization has established interdisciplinary antimicrobial stewardship committees to develop and review antimicrobial resistance prevention policies and procedures
- [ ] Nurses are a key player in antimicrobial stewardship efforts
- [ ] The AMS committees review provider prescribing practices for opportunities for improvement
- [ ] Nurses educate patients about appropriate antibiotic use

Question

04/04

Select All That Apply:

What resources do nurses have available to them if they have questions about the Antibiotic Stewardship Program?

- [ ] PolicyStat
- [ ] Infection Preventionist
- [ ] Google
- [ ] Pharmacy

References

Regulatory bodies recognize the urgent threat of antimicrobial resistance, and AMS is now of utmost priority. This module addresses The Joint Commission (TJC), Centers for Medicare & Medicaid Services (CMS), and Det Norske Veritas (DNV) requirements for annual Antimicrobial Stewardship education for all staff involved in antimicrobial ordering, dispensing, administration, and monitoring. The following resources were used in creating this module should you like to review:

- American Nurses Association, Centers for Disease Control and Prevention. Redefining the Antibiotic Stewardship Team: Centers for Disease Control and Prevention Recommendations from the American Nurses Association/Centers for Disease Control and Prevention Workgroup on the Role of Registered Nurses in Hospital Antibiotic Stewardship Practices. (Jul 26; White paper) Date: 2017.

- Avdic E, Cushinotto LA, Hughes AH, et al. Impact of an Antimicrobial Stewardship Intervention on Shortening the Duration of Therapy for Community-Acquired Pneumonia. Clin Infect Dis 2012;54(11):1581-7.
- Barlam TF, Cosgrove SE, Abbo LM, et al. Implementing an Antibiotic Stewardship Program: Guidelines by the Infectious Diseases Society of America and the Society for Healthcare Epidemiology of America. Clin Infect Dis. 2016;62(10):e51-e77.
- Center for Disease Control and Prevention. Antibiotic Resistance Threats in the United States, 2019. Atlanta, GA: U.S. Department of Health and Human Services, CDC; Updated Dec 2019, cited April 14, 2023. Available from: https://www.cdc.gov/drugresistance/pdf/threats-report/2019-ar-threats-report-508.pdf.
- Center for Disease Control and Prevention. Be Antibiotics Aware [Internet]. Atlanta, GA: U.S. Department of Health and Human Services, CDC; Updated October 7, 2021, cited April 14, 2023. Available from: https://www.cdc.gov/antibiotic-use/community/pdfs/aaw/au_arent_always_the_answer_fs_508.pdf
- Center for Disease Control and Prevention. Core Elements of Hospital Antibiotic Stewardship Programs. Atlanta, GA: US Department of Health and Human Services, CDC; 2019, cited April 14, 2023. Available at: https://www.cdc.gov/antibiotic-use/healthcare/pdfs/hospital-core-elements-H.pdf
- Center for Disease Control and Prevention. Publications with Antimicrobial Resistance Data [Internet]. Atlanta, GA: U.S. Department

of Health and Human Services, CDC; Updated February 15, 2023, cited April 14, 2023. Available from: https://www.cdc.gov/drugresistance/publications.html

- Fleming-Dutra EK, Mangione—Smith R, Hicks, LA. How to Prescribe Fewer Unnecessary Antibiotics: Talking Points That Work with Patients and Their Families. Am Fam Physician. 2016;94(3):200-202.
- Miller BJ, Carson KA, Keller S. Educating Patients on Unnecessary Antibiotics: Personalizing potential harm aids patient understanding. J Am Board Fam Med. 2020 Nov-Dec; 33(6): 969–977.
- Nicolle LE, Bradley S, Colgan R, et al. Infectious Diseases Society of America guidelines for the diagnosis and treatment of asymptomatic bacteriuria in adults. Clin Infect Dis 2005; 40:643.

CONTINUE

Conclusion

You have completed *Antimicrobial Stewardship for Nursing*.

Click 'Exit Course' above to close this window.

Compounding Medications_2024.11.05

1. Immediate Use Compounding (IUC)

1.1 Untitled Slide

Notes:

1.2 Untitled Slide

1.3 Untitled Slide

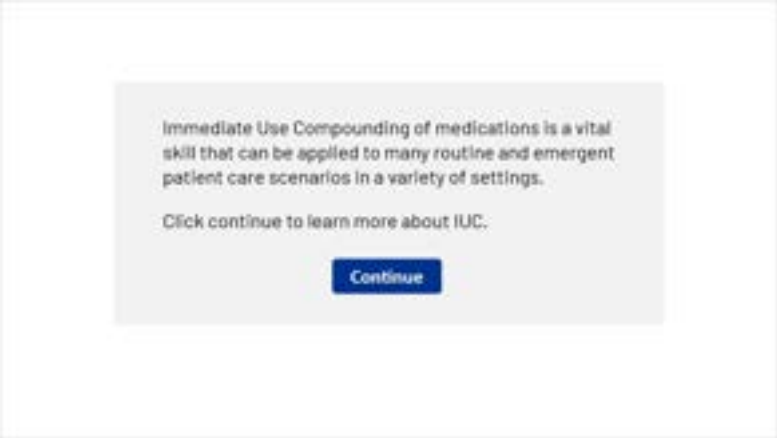
Notes:

As a caregiver in an acute care, ambulatory, clinic or home health setting, you're already familiar with mixing medications for your patients.

By following along with this presentation, you'll learn more about the process of immediate use compounding (IUC) and specific actions you can take when performing IUC to ensure patient safety and compliance with regulatory requirements.

1.4 Examples of Immediate Use Compounding (IUC)

Pop-up (Slide Layer)

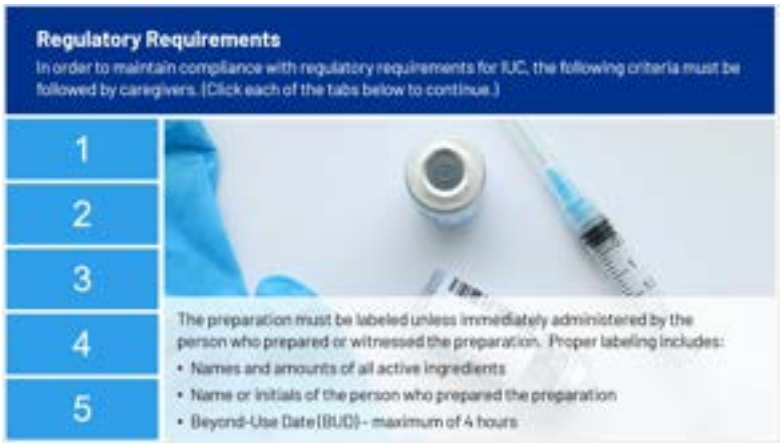


1.5 Untitled Slide

1.6 Untitled Slide

1.7 Regulatory Requirements

Tab E (Slide Layer)



Tab D (Slide Layer)

Tab C (Slide Layer)

Tab B (Slide Layer)

Tab A (Slide Layer)

1.8 Untitled Slide

1.9 Untitled Slide

Notes:

1.10 Click and Drag

(Drag and Drop, 10 points, 2 attempts permitted)

Drag Item	Drop Target
A reconstitution of Pantoprazole with 10mL NS for IV push administration.	Examples of Immediate Use Compounding (IUC)
Cefazolin 1 gram vial reconstituted with 2.5mL SWFI and further diluted into a 1-liter bag of normal saline for irrigation.	Examples of Immediate Use Compounding (IUC)
A preparation of a Norepinephrine drip during a code.	Examples of Immediate Use Compounding (IUC)
An injection of calcium gluconate from a vial into a 50mL or 100 mL NS bag for a patient in the ICU.	Examples of Immediate Use Compounding (IUC)
Withdrawing 40mg Lasix for IV administration through an IV port.	

Drag and drop properties
Return item to start point if dropped outside the correct drop target
Snap dropped items to drop target (Tile)
Delay item drop states until interaction is submitted

Feedback when correct:

Withdrawing Lasix for IV administration is not an example of IUC. All the other examples are correct.

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Feedback when incorrect:

Withdrawing Lasix for IV administration is not an example of IUC. All the other examples are correct.

Incorrect (Slide Layer)

Correct (Slide Layer)

1.11 Multiple Choice Question

(Multiple Choice, 10 points, 2 attempts permitted)

Correct	Choice
True	X
False	

Feedback when correct:

These are the correct steps to sterilize a surface.

Feedback when incorrect:

These are the correct steps to sterilize a surface.

Notes:

Incorrect (Slide Layer)

Correct (Slide Layer)

1.12 Multiple Choice Question

(Multiple Choice, 10 points, 2 attempts permitted)

Correct	Choice
True	X
False	

Feedback when correct:

Ampule necks, like the rubber septum on top of a vial, must be sterilized before use.

Feedback when incorrect:

Ampule necks, like the rubber septum on top of a vial, must be sterilized before use.

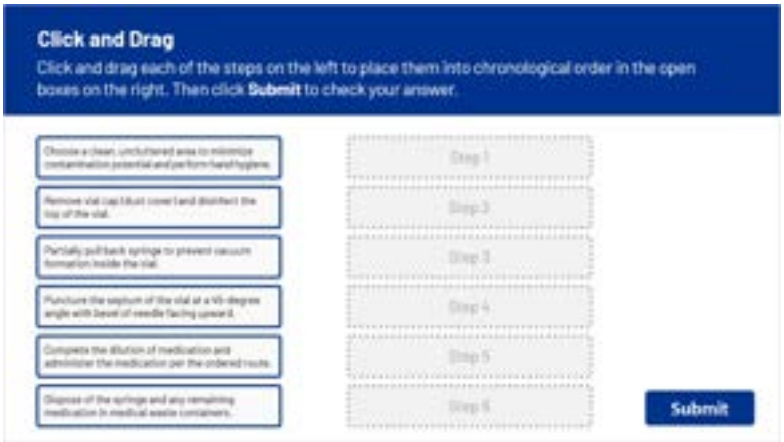
Notes:

Incorrect (Slide Layer)

Correct (Slide Layer)

1.13 DRAG-AND-DROP

(Drag and Drop, 20 points, 2 attempts permitted)



Drag Item	Drop Target
Choose a clean, uncluttered area to minimize contamination potential and perform hand hygiene.	Step 1
Remove vial cap (dust cover) and disinfect the top of the vial.	Step 2
Partially pull back syringe to prevent vacuum formation inside the vial.	Step 3
Puncture the septum of the vial at a 45-degree angle with bevel of needle facing upward.	Step 4

Drag Item	Drop Target
Complete the dilution of medication and administer the medication per the ordered route.	Step 5
Dispose of the syringe and any remaining medication in medical waste containers.	Step 6

Drag and drop properties
Snap dropped items to drop target (Snap to center)
Allow only one item in each drop target
Delay item drop states until interaction is submitted

Feedback when correct:

That's right! You placed the steps into the correct order.

Feedback when incorrect:

You did not place the steps into the correct order.

Incorrect (Slide Layer)

Correct (Slide Layer)

1.14 Multiple Choice Question

(Multiple Choice, 10 points, 2 attempts permitted)

Correct	Choice
True	
False	X

Feedback when correct:

Single dose containers used outside a pharmacy cleanroom environment cannot be used for more than one patient.

Feedback when incorrect:

Single dose containers used outside a pharmacy cleanroom environment cannot be used for more than one patient.

Notes:

Incorrect (Slide Layer)

Correct (Slide Layer)

1.15 Click and Drag

(Drag and Drop, 10 points, 2 attempts permitted)

Drag Item	Drop Target
Aseptic techniques, processes, and procedures are followed to minimize the potential for contamination.	Facts regarding Immediate Use Compounding (IUC)
Any unused starting component from a single-dose container must be discarded after the preparation is complete.	Facts regarding Immediate Use Compounding (IUC)
The preparation must be labeled unless it is immediately administered by person who prepared or witnessed preparation.	Facts regarding Immediate Use Compounding (IUC)
The mixture may contain more than 3 sterile products.	

Drag and drop properties
Return item to start point if dropped outside any drop target
Snap dropped items to drop target (Tile)
Delay item drop states until interaction is submitted

Incorrect (Slide Layer)

Correct (Slide Layer)

1.16 Quiz Results:

(Results Slide, 0 points, 1 attempt permitted)

Results for
1.10 Click and Drag
1.11 Multiple Choice Question
1.12 Multiple Choice Question
1.13 DRAG-AND-DROP
1.14 Multiple Choice Question
1.15 Click and Drag

Result slide properties	Passing Score
80%	

Notes:

Failure (Slide Layer)

Success (Slide Layer)

1.17 Untitled Slide

Notes:

PROV: Drug Diversion - Prevention and Detection

- Course Navigation
- Introduction
- How to Identify
- Risks
- Best Practices for Handling Controlled Substances
- Disposal of Controlled Substances
- State/Federal Regulations
- Prevention

Lesson 1 of 8

Course Navigation

- You must move through this course in sequential order.
- Successful completion of this course requires viewing all content.
- You may exit the course and return to where you left off.

Technical Recommendations

There are technical recommendations in order to access all components and ensure you have an optimal learning experience. Before you continue, please ensure your computer meets these minimum requirements:

Computer or Laptop	Web Browser	Operating System	Internet Connection	Other
Minimum screen size of 15" Audio capability	Latest version of **Microsoft Edge**	Windows 10 or higher Mac: Catalina OS	High speed internet (DSL/Cable) Reliable connection	Headphones, earbuds or speakers

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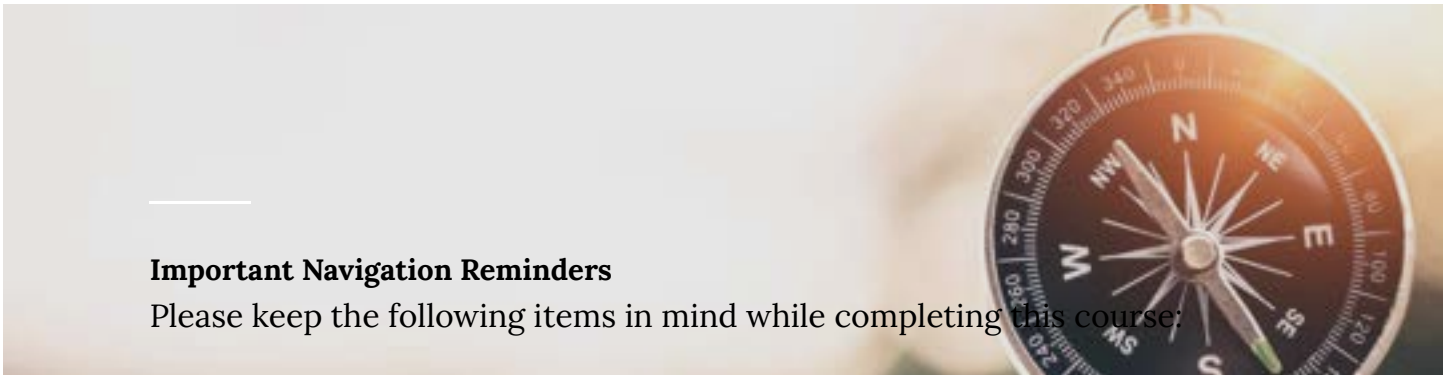

Important Navigation Reminders

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CONTINUE

Introduction

Learning Objectives

By the end of this course, learners should:

- Have reviewed an overview of Controlled Substances handling and diversion prevention
- Know how to identify potential risks
- Know how to dispose of Controlled Substances
- Understand state/federal regulations
- Prevent drug diversion
- Know how to report drug diversion or suspicion of drug diversion

CONTINUE

What is Drug Diversion?

Drug Diversion is the transfer or use of a prescription drug to anyone other than the intended recipient of the medication.

Misappropriation of medications in **any way** other than how they are intended for use or prescribed for use. Medications of any kind can be misappropriated or diverted. When medications are misappropriated by a workforce member it is considered theft.

Drug diversion is a crime that can have negative impacts on our patients, caregivers, and health system.

- **Patients:** Denial of pain relief, exposure to blood-borne pathogens, identity theft, fraud, and direct patient harm.
- **Caregivers:** Loss of license, career, and professional reputation

Approximately 10-15% of healthcare professionals will struggle with substance use disorders during their career, and many of these turn to drug diversion.

Where does Drug Diversion Occur?

- Acute Care (e.g. hospitals) - main focus of this presentation
- Retail Pharmacies
- Outpatient Infusion Centers
- Nursing Homes
- Hospice
- Home Infusion

CONTINUE

What are Controlled Substances?

A drug that is regulated by the Drug Enforcement Agency (DEA) because it may be abused or cause addiction.

Controlled Substance Schedules

Drugs and other substances that are considered Controlled Substances under the Controlled Substances Act (CSA) are divided into five schedules.

According to the US Bureau of Labor Statistics, drugs in the highest risk schedules (II, III, and IV) account for 94% of abused prescription drugs.

Select each section below to learn more about each schedule.

Schedule I

No currently accepted medical use in the United States, a lack of accepted safety for use under medical supervision, and a high potential for abuse.

- Examples include heroin, methamphetamine, MDMA (ecstasy).

Schedule II

A high potential for abuse which may lead to severe psychological or physical dependence.

- Examples include Oxycodone, Hydrocodone, Amphetamines (Adderall).

Schedule III

Potential for abuse is less than substances in Schedules I or II and abuse may lead to moderate or low physical dependence or high psychological dependence.

- Examples include buprenorphine, testosterone.

Schedule IV

Low potential for abuse relative to substances in Schedule III.

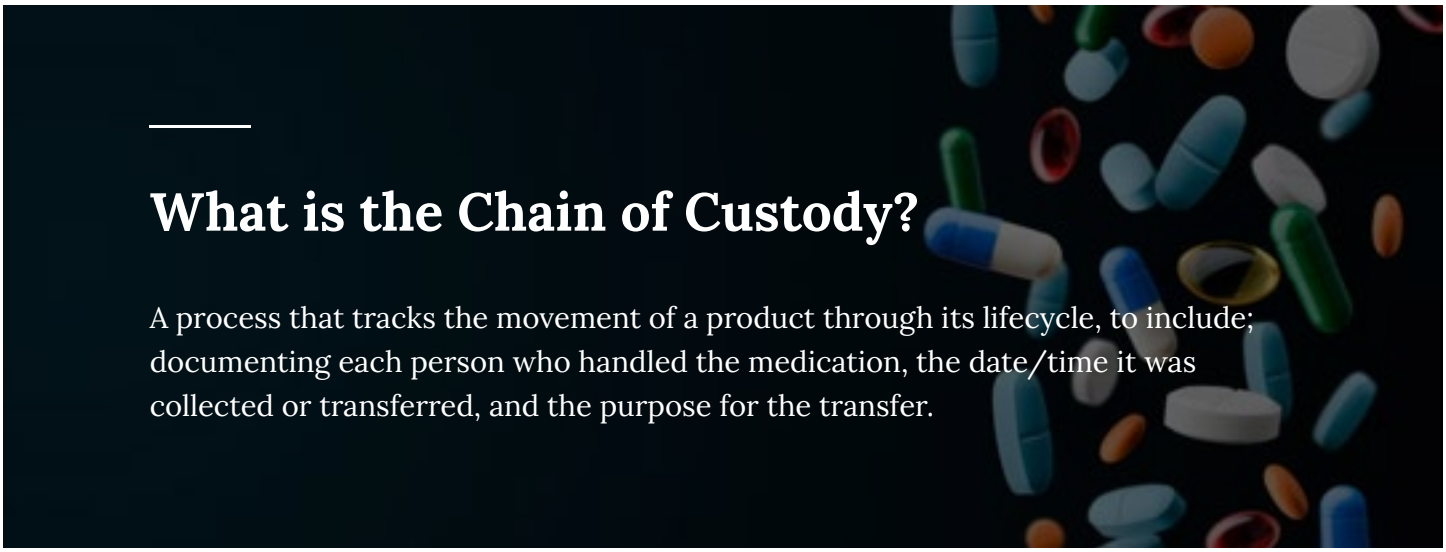
- Examples include alprazolam, carisoprodol.

Schedule V

Low potential for abuse relative to substances listed in Schedule IV and consist primarily of preparations containing limited quantities of certain narcotics.

- Examples include phenergan with codeine, pregabalin.

Expand and review the content above before moving on.



What is the Chain of Custody?

A process that tracks the movement of a product through its lifecycle, to include; documenting each person who handled the medication, the date/time it was collected or transferred, and the purpose for the transfer.

Drug diversion does not only affect Controlled Substances. Anytime a medication is removed, taken, given, or redirected to someone for whom it was not ordered or intended, this is drug diversion.

CONTINUE

How to Identify

Examples of Drug Diversion

- Personal use of hospital issued drugs on or off hospital property
- Redistribution of hospital issued drugs to unauthorized users (e.g. family members)
- Removal, misuse, stealing, and/or diverting non-controlled medication/drugs (and/or related supplies)
- Self-prescribing of Controlled Substances
- Removing Controlled Substances from a hospital location to be used on patients in another facility

The Facts:

Opioid addiction is a major driver of drug diversion.

More than 822,00 people have died since 2015 from a drug overdose. In 2024, 80,391 drug overdose deaths occurred in the United States.

- Among nurses, substance use disorders affect 500,000 individuals nationally.
- 87% of physicians have prescribed medications for themselves, and over 55% with painkiller prescriptions wrote them for themselves.
- There are an estimated 37,000 drug diverters each year.

Common Characteristics of a Diverter

Many diverters appear to be high-functioning professionals who are well-liked by their peers as the diverter may be willing to go "above and beyond" in their roles.

- Frequent volunteering for overtime or shift coverage
- Come early / stay late or insisting to cover nights/weekends/holidays
- Offering to administer medications for other nurses and handle waste for Controlled Substances

Contributing Factors for Abuse

Similar to healthcare fraud, drug diversion is typically driven by three factors:

- Pressure / Motivation to Divert
- Access / Opportunity
- Rationalization / Justification by the Diverter

Commonly Diverted Drugs

Click the cards below to reveal more information.

OPIOIDS

- HYDROmorphone
- Morphine
- FentaNYL (including patches)
- HYDROcodone
- OxyCODONE
- Methadone

STIMULANTS

- Dextroamphetamine
- Methylphenidate

DEPRESSANTS

- Benzodiazepines (e.g., ALPRAZolam, clonazePAM, lorazePAM)

OTHERS

- Propofol
- Trazodone
- Naloxone

Review the flashcards above before moving on.

What Classes of Prescription Drugs are Commonly Misused?

Click on the buttons below to learn more.

National Institute on Drug Abuse (NIDA)

NIDA

Institute for Safe Medication Practices

(2023, February 23). Drug diversion and COVID-19. ISMP Medication Safety Alert! Acute Care Edition, 28(4).

ISMP

Navigation Reminder: After clicking on the button, be sure to minimize the new window (do not close it) to return to this course. This will allow you to continue and complete the course. Closing the window may prevent the course from progressing.

Red Flags (Report Immediately)

- Broken / missing tamper seals
- Damaged / altered packaging
- Medication or associated supplies (e.g., syringes, needles) found in inappropriate locations or in personal belongings
- Suspected false documentation medical record or other chain of custody logs (Pyxis, paper, etc.)

Complete the content above before moving on.

Lesson 4 of 8

Risks

Click on each section below to review the risks associated with each topic.

Individual —

- Criminal offense
- Loss of career
- Health consequences
  - Overdose
  - Neglected health
  - Infection

Patients —

- Compromised safety (e.g., infectious disease exposure)
- Inaccurate documentation leading to poor record of care and potentially fraudulent billing
- Compromised treatment (e.g., inadequate pain relief or neglected care plan)
- Patient privacy (HIPAA violations by caregiver/diverter)

Hospital —

- Loss of reimbursement
- Repayment
- Loss of accreditation
- Drug diversion fines
- Reputational damage and decreased community confidence

Society —

Diversion and Opioid Use Disorder (OUD) is costly to society!

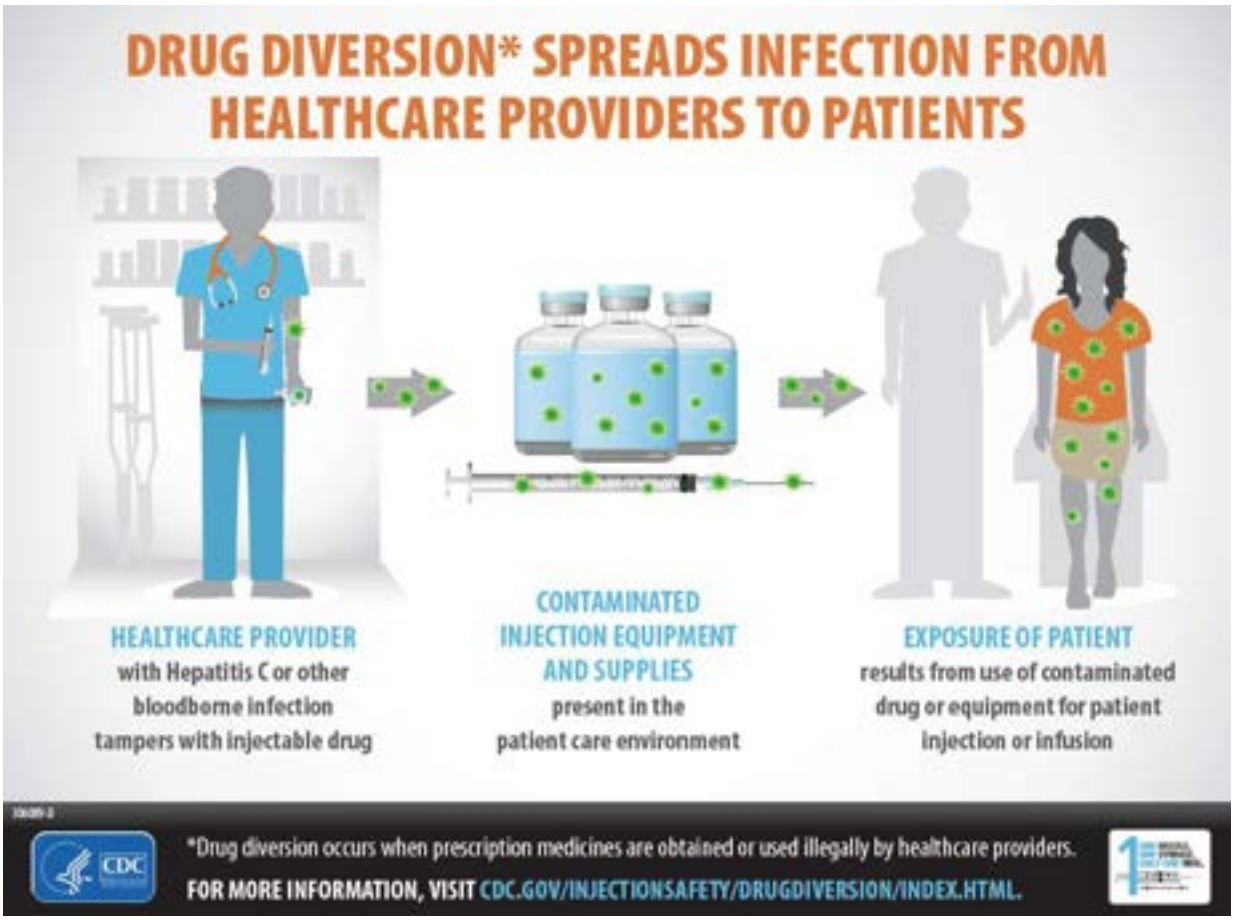
- Increased health expenditures (estimated over $70 billion per year)
- Loss of productivity (estimated over $120 billion per year)

Drug Enforcement Administration (DEA) fines due to drug diversion range from $1 million to $8 million.

CONTINUE

Drug Diversion is Dangerous

Diversion is also costly to the health of patients and healthcare providers.


DRUG DIVERSION* SPREADS INFECTION FROM HEALTHCARE PROVIDERS TO PATIENTS
HEALTHCARE PROVIDER
with Hepatitis C or other bloodborne infection tampers with injectable drug
CONTAMINATED INJECTION EQUIPMENT AND SUPPLIES
present in the patient care environment
EXPOSURE OF PATIENT
results from use of contaminated drug or equipment for patient injection or infusion
CDC
*Drug diversion occurs when prescription medicines are obtained or used illegally by healthcare providers.
FOR MORE INFORMATION, VISIT CDC.GOV/INJECTIONSAFETY/DRUGDIVERSION/INDEX.HTML.

CONTINUE

Best Practices for Handling Controlled Substances

Complete the content above before moving on.

Knowledge Check

Select all of the following that **are** best practices for handling Controlled Substances.

- [ ] Never witness in the ADM the wasting of a medication that you didn't actually see disposed

- [ ] Controlled Substances (CS) should only be removed from the Automated Dispensing Machine (ADM) (e.g., Pyxis) ***immediately*** prior to planned administration
- [ ] Controlled Substances will be wasted and discarded in an ***irretrievable*** manner
- [ ] Controlled Substances may ***be placed*** in the caregiver's pockets for safe keeping

SUBMIT

Answer the knowledge check above before moving on.

Disposal of Controlled Substances

Wrong Way to Dispose Controlled Substances

Drug diversion occurs when diverters reach in and take out partial vials of Controlled Substances! Some even drain liquid out of the bottom of sharps containers or trash bins knowing the risks!

Correct Way to Dispose Controlled Substances

Stericycle – CsRx Container

After witnessed waste, dispose as follows:

- Liquids & injectables: Draw up remaining controlled substance and inject contents into CsRx container (solution in container deactivates Controlled Substance)
- Tablets/capsules removed from packaging and dropped into containers
- Patches placed in container

Note: Make sure you visibly witness the wastage process.

Validate and verify!

Knowledge Check

Drug diversion occurs when diverter reaches in and takes partial vials of Controlled Substances from the waste bin.

- ◯ True
- ◯ False

SUBMIT

Answer the knowledge check above before moving on.

State/Federal Regulations

Legal/Regulatory Oversight

- *Drug Enforcement Administration (DEA)
- State and/or local law enforcement
- Board of Nursing
- Board of Pharmacy
- Medical Board
- The Joint Commission
- Centers for Medicare and Medicaid Services (CMS)
- Det Norske Veritas National Integrated Accreditation of Healthcare Organizations (DNV NIAHO)

Primary Regulator/Enforcement of the Controlled Substance Act

CONTINUE

Prevention

Systems of Prevention

Click the cards below to reveal more information.

Culture

The organization expects staff to report any suspected diversion or suspicious behavior.

Human Factor

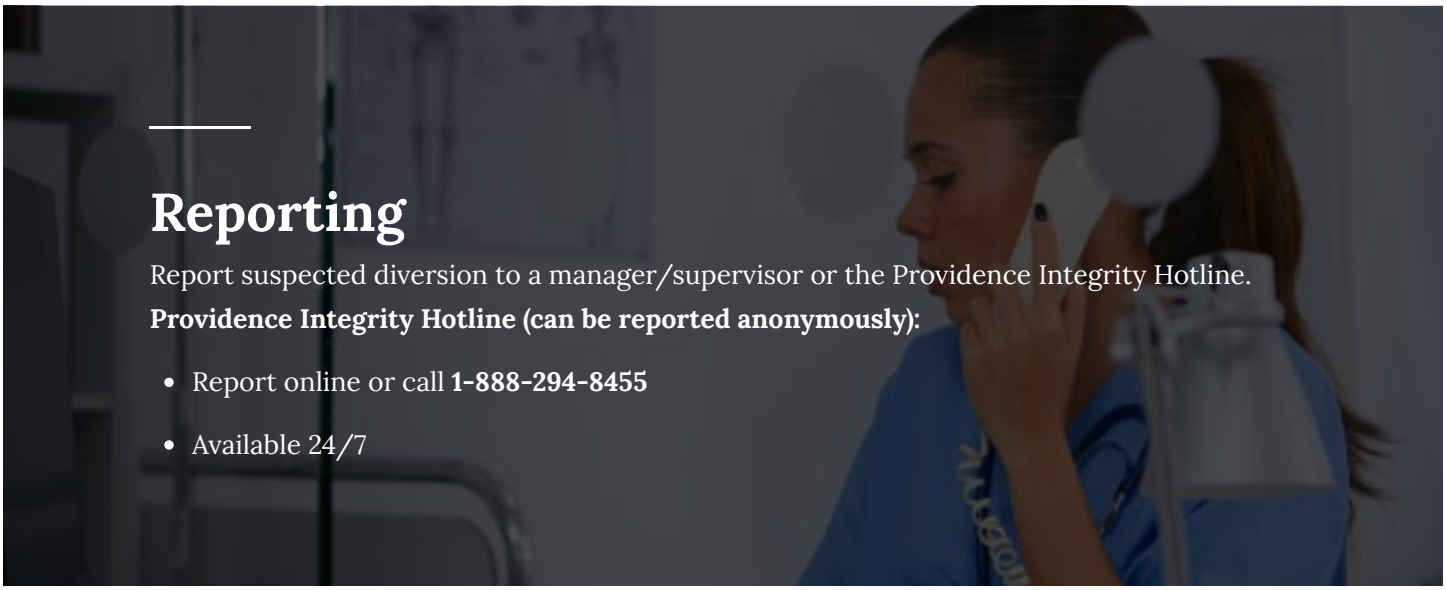
Vigilance cannot be understated! Every caregiver has a responsibility to safe- guard against drug diversion.

Proactive Diversion Monitoring

Providence utilizes next generation diversion monitoring software to provide enhanced transparency in Controlled Substance handling.

- Diversion prevention is a multidisciplinary effort. Core Leaders may be asked to review patterns or trends identified by this software.
- Please ensure you continue to practice safe Controlled Substance management and encourage best practices with your peers.
- If you become aware of a Controlled Substance discrepancy or missing Controlled Substance, please report your concerns immediately.

Complete the content above before moving on.



Reporting

Report suspected diversion to a manager/supervisor or the Providence Integrity Hotline.

Providence Integrity Hotline (can be reported anonymously):

- Report online or call **1-888-294-8455**
- Available 24/7

Do You Need Help?

These resources listed below can help to protect you and your license.

- **Substance Abuse and Mental Health Services Administration (SAMHSA) National Helpline: 1-800-662-HELP (4357)**
  - Free, confidential, 24/7 treatment referral and information service for individuals and families facing mental and/or substance use disorders.
- **National Drug Helpline: 1-844-289-0879**
  - Free, confidential, 24/7 information about substance use, treatment options, and support resources.

CONTINUE

Professional Recovery Programs by State

State	State Programs for Recovery
AK	https://www.fsphp.org/physician-health-committee-of-alaska

CA	The California diversion program for healthcare providers | Maximus https://www.pharmacy.ca.gov/licensees/personal/pharmacist_recovery.shtml
MT	https://www.montanarecoveryprogram.com/faqs https://www.rxmt.org/montana-board-of-pharmacy
NM	https://nmbon.sks.com/diversion-program-faqs.aspx https://nabp.pharmacy/bop_members/new-mexico/
OR	https://www.oregon.gov/oha/PH/DISEASESCONDITIONS/COMMUNICABLEDISEASE/HAI/PREVENTION/Documents/Lunch%20and%20Learn/Drug_diversion_part_1.pdf
TX	https://rnguardian.com/drug-diversion-and-your-rn-license-what-you-need-to-know-now/ https://www.pharmacy.texas.gov https://www.pharmacy.texas.gov/Newsletter/Help.asp
WA	https://doh.wa.gov/public-health-healthcare-providers/healthcare-professions-and-facilities/professional-resources/impaired-practitioner-programs https://www.wsparx.org/page/WRAPP?&hhsearchterms=%22recovery+and+assistance+and+program+and+pharmacy%22

Do You Think Someone Needs Help?

We have a duty to respond to diversion in a manner that promotes the safety of our patients and caregivers. Help is available!

- Reach out to any **Core Leader**
- Call **Human Resources**
- **Caregiver Assistance** is available 24/7: 844-875-5716
    - Confidential and free

Knowledge Check

Select all the ways that Providence supports a culture of safety and prevention of drug diversion.

- [ ] The organization expects staff to report any suspected diversion or suspicious behavior
- [ ] Every caregiver has a responsibility to safe- guard against drug diversion
- [ ] Core Leaders and pharmacy leaders have a responsibility to monitor against diversion

SUBMIT

Answer the knowledge check above before moving on.

Congratulations, you have completed the *Drug Diversion - Prevention and Detection* course. Click the *Exit Course* link above to close this window.

PROVSOUTH: Blood and Blood Products

The course provides an overview of steps to ensure safe non-emergent blood administration.

- **Course Navigation**
- **Objectives**
- **Non-emergent Blood Transfustions**
- **Before You Send for Pick Up of Your Blood Component**
- **Before You Send for Pick Up of Your Blood Component Assessment**
- **Blood Refusal**
- **Blood Component Transport**
- **Blood Component Transport Assessment**
- **At the Bedside**
- **At the Bedside Assessment**

- Nursing Considerations
- Nursing Considerations Assessment
- Documentation
- Healdsburg Hospital
- Petaluma Valley Hospital
- Queen of the Valley Medical Center
- St. Joseph Hospital Eureka and Redwood Memorial Hospital
- Santa Rosa Memorial Hospital
- Documentation Assessment
- Transfusion Reaction
- Transfusion Reaction Assessment
- Transfusion Related Acute Lung Injury (TRALI)
- Transfusion-Associated Circulatory Overload (TACO)
- Transfusion-Associated Circulatory Overload (TACO) Assessment
- Other Blood Transfusion Processes
- Other Blood Transfusion Processes Review

Knowledge Check

Summary

Course Navigation

- You must move through this course in sequential order.
- Successful completion of this course requires viewing the appropriate content and passing the assessment with a score of 100%.
- You may exit the course and return to where you left off.

Technical Recommendations

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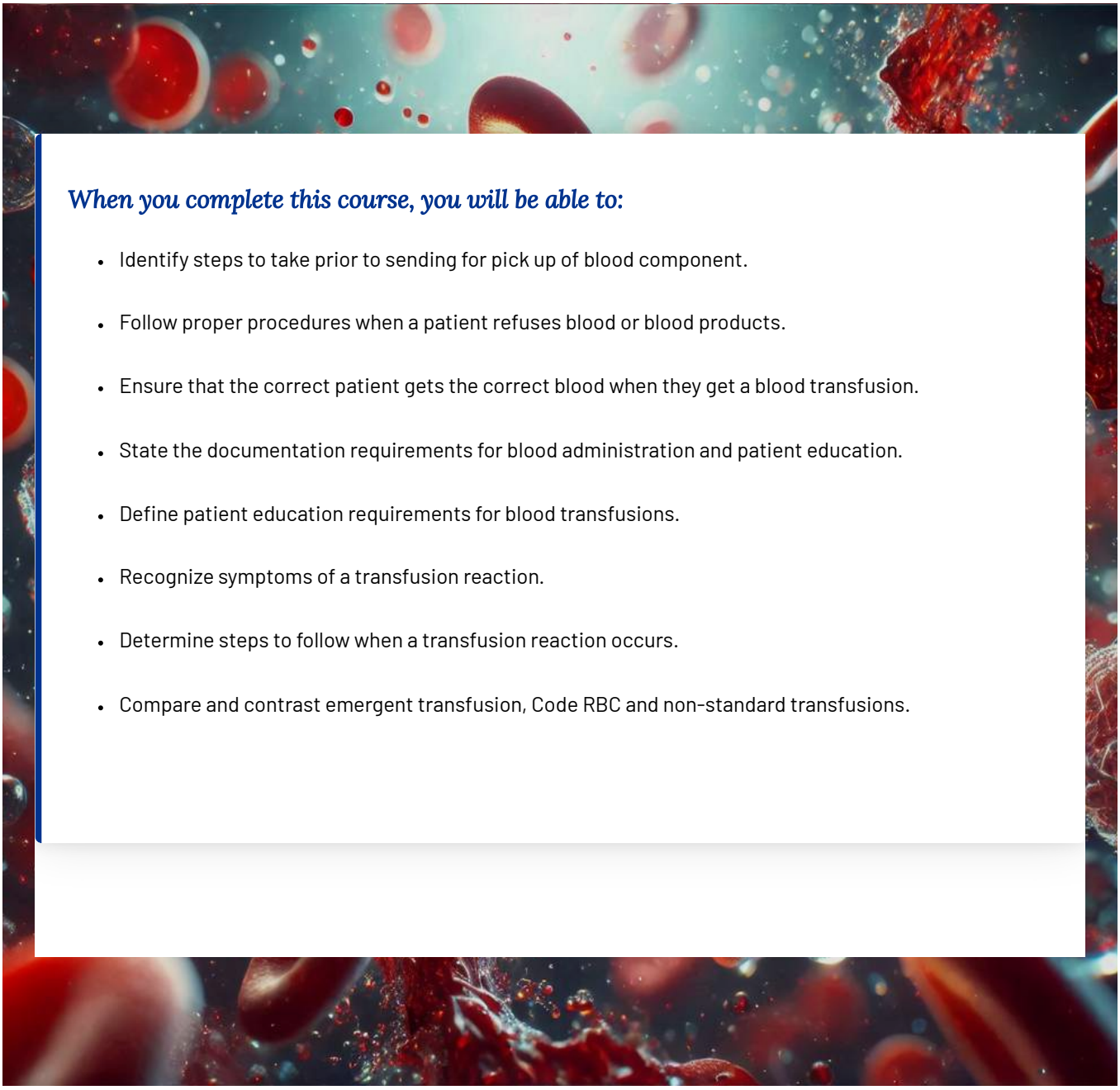
CONTINUE

Objectives



When you complete this course, you will be able to:

- Identify steps to take prior to sending for pick up of blood component.
- Follow proper procedures when a patient refuses blood or blood products.
- Ensure that the correct patient gets the correct blood when they get a blood transfusion.
- State the documentation requirements for blood administration and patient education.
- Define patient education requirements for blood transfusions.
- Recognize symptoms of a transfusion reaction.
- Determine steps to follow when a transfusion reaction occurs.
- Compare and contrast emergent transfusion, Code RBC and non-standard transfusions.

CONTINUE

Non-emergent Blood Transfustions

Key points regarding non-emergent blood transfusions:

- Must have written patient consent, including Provider giving informed consent.
- Patient must receive information on the right to refuse and education on blood transfusion.
- Blood must be cross-matched.
- Order entry must be completed in the EMR system.

CONTINUE

Before You Send for Pick Up of Your Blood Component

Before you send for pick up of your blood component you need:

- A physician order.
- A signed and witnessed consent.
- Paul Gann Act informational brochure provided to patient.
- A valid patient wristband.
    - ID band.
    - Red blood bank band from lab after they draw the blood (depending on your ministry).
- Patent IV access, 250 NS bag, and primed blood administration set.
- Equipment for obtaining vital signs. Be sure to advise provider of any fever prior to transfusion.
- Check for any pre-meds ordered, and any need for a blood warmer.

The Paul Gann Blood Safety Act mandates patients be informed of the risks and alternatives to blood transfusions. If you would like to review the brochure, "A Patient's Guide to Blood Transfusion," click the PDF link below.

Navigation Reminder: After clicking on the link, be sure to minimize the new window (do not close it) to return to this course. This will allow you to continue and complete the course. Closing the window may prevent the course from progressing.

PDF

blood_transfusion_english-print.pdf
483.6 KB

Tip: It is smart to call Blood Bank to validate unit is ready for pick up.

CONTINUE

Before You Send for Pick Up of Your Blood Component Assessment

Select all that apply. What items you need before you send for pick-up of your blood component?

- [ ] A physician order
- [ ] A signed and witnessed consent—Paul Gann Act copy
- [ ] A valid patient wristband
- [ ] Patent IV access, 250 NS bag, and primed blood administration set
- [ ] Equipment for obtaining vital signs
- [ ] Check for any pre-meds ordered, and any need for a blood warmer

SUBMIT

Complete the content above before moving on.

Blood Refusal

When a patient refuses blood or blood products, the patient must sign the appropriate form, e.g., a Refusal to Permit Blood Transfusion form.

Patients who state their intention to refuse blood or blood products must have appropriate alert attached to identification wristband.

CONTINUE

Blood Component Transport

Obtain the blood unit from the blood bank with the appropriate patient requisition and verify the following:

- Blood unit number
- Blood type (ABO/Rh) and Unit expiration date
- Patient's name
- Medical record number
- Blood Bank ID number

- Consent to Blood Transfusion
- Interpretation of crossmatch test, if performed
- Any additional ministry-specific verification requirements

If available, use barcode to verify the information.

Deliver the blood component (unit) to the intended area immediately; if blood is not going to be transfused, it must be returned to blood bank per ministry policy.

If a leak is identified in the component packaging, return the unit to the blood bank.

CONTINUE

Blood Component Transport Assessment

Select all that apply. Obtain the blood unit from the blood bank with the appropriate patient requisition and verify the following:

- [ ] Blood unit number
- [ ] Blood type (ABO/Rh) and Unit expiration date
- [ ] Patient's name
- [ ] Medical record number
- [ ] Blood Bank ID number
- [ ] Consent to Blood Transfusion
- [ ] Interpretation of crossmatch test, if performed

- [ ] Any additional ministry-specific requirements

SUBMIT

Complete the content above before moving on.

At the Bedside

If there are ANY questions regarding the unit of blood, paperwork or identity of the patient, return the unit to blood bank.

Validate the blood component by 2 licensed staff (e.g., RN, LVN, MD):

- Patient's full name, DOB, medical record number, and Blood Bank ID number

    - Use the patient wristband for ID
    - Always identify the patient with at least 2 unique identifiers
- Blood unit number
- Blood type (ABO/Rh) Unit & expiration date
- Interpretation of crossmatch tests, if performed

After the recipient is identified correctly, the blood component should be verified against the transfusion record (electronic or paper), consisting of:

- The donor unit identification number
- Component to transfuse
- ABORH of unit is compatible with ABORH of recipient
- Expiration date of unit

CONTINUE

At the Bedside Assessment

Validation of the blood component is done by 2 licensed staff (e.g., RN, LVN, MD), using at least 2 unique patient identifiers.

- ◯ True
- ◯ False

SUBMIT

Complete the content above before moving on.

Nursing Considerations

- Nurse to remain at bedside for the first 15 minutes of transfusion.
- One unit of blood may not hang longer than 4 hours.
- Two units may be administered with same tubing if not more than four hours have passed. Flush tubing between units.

- Use leukocyte removal filter for high-risk patients (per physician order).
- If you need to warm the unit, use an approved blood warmer.
- Never store blood components in an unmonitored refrigerator.
- Never piggyback or add medications to the blood bag or line—it could hemolyze or clot the blood.
- When priming a Y-site infusion set fill the chamber (by squeezing) with enough saline to cover the filter completely. This helps prevent lysis of the blood cell.

CONTINUE

Nursing Considerations Assessment

Can you piggyback or add medications to the blood bag or line?

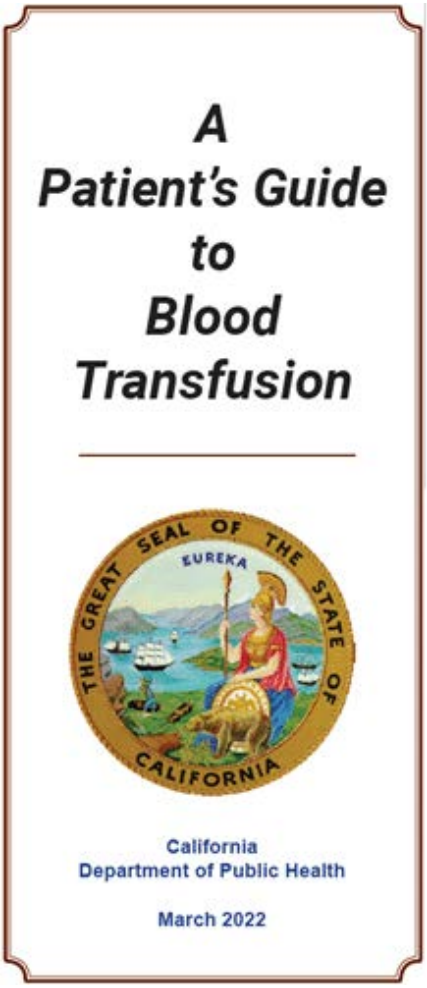
- ◯ Yes
- ◯ No

SUBMIT

Complete the content above before moving on.

Documentation

Patient Education



Document in the patient's medical record that you gave the pamphlet, "A Patient's Guide to Blood Transfusion" to the patient in compliance with the Paul Gann Blood Safety Act.

Northern California Ministry-Specific Policies

Directions: Click or tap the button that corresponds with your location to view ministry-specific information and your ministry's policy.

Healdsburg Hospital
Click or tap the button to the right for ministry-specific information.

CLICK OR TAP HERE

Petaluma Valley Hospital
Click or tap the button to the right for ministry-specific information.

CLICK OR TAP HERE

Queen of the Valley Medical Center
Click or tap the button to the right for ministry-specific information.

CLICK OR TAP HERE

St. Joseph Eureka and Redwood Memorial Hospital
Click or tap the button to the right for ministry-specific information.

CLICK OR TAP HERE

Santa Rosa Memorial Hospital
Click or tap the button to the right for ministry-specific information.

CLICK OR TAP HERE

Southern California Ministry-Specific Policies

Directions: Click or tap the button that corresponds with your location to view the ministry-specific policy. Once you have reviewed your policy, scroll to the bottom of the and click the **Continue** button to move on with the module.

Holy Cross Medical Center
Blood & Blood Products, Transfusion of (NICU) policy

CLICK OR TAP HERE

Holy Cross Medical Center
Blood Product Administration, Blood Product Refusal, and Transfusion Reaction Management policy

CLICK OR TAP HERE

Little Company of Mary Medical Center, San Pedro
Blood / Blood Product Administration and Transfusion policy

CLICK OR TAP HERE

Little Company of Mary Medical Center, Torrance
Blood / Blood Product Administration and Transfusion policy

CLICK OR TAP HERE

Mission Hospital, Laguna Beach and Mission Hospital, Mission Viejo
Blood Product Transfusion and Blood Warmer policy

CLICK OR TAP HERE

St. Joseph Hospital Orange
Blood and Blood Components, Administration of, LAB-701 policy

CLICK OR TAP HERE

St. John's Health Center
Blood Product Administration policy

CLICK OR TAP HERE

St. Joseph Medical Center, Burbank
Administration of Blood and Blood Products policy

CLICK OR TAP HERE

St. Jude Medical Center
Transfusion Therapy policy

CLICK OR TAP HERE

Tarzana Medical Center
Blood/Blood Components: Administration & Management policy

CLICK OR TAP HERE

Continue Module

Select the button to the right to navigate to the next lesson.

CONTINUE

Healdsburg Hospital

Always document in the patient's medical record the following with **EVERY** unit of blood:

1. Pre-transfusion Documentation

2. Previous Transfusion

3. Pre-transfusion Medication Given

4. Verification of Informed Consent

5. Whether There is a "Reaction" Noted (Answer *Yes* or *No*)

6. Vital Signs

Check vital signs:

- 30 minutes before transfusion
- 15 minutes after the transfusion is started
- Every hour during transfusion
- Upon completion of transfusion
- If administering blood products under pressure, vital signs must be taken every 15 minutes

7. Barcoding

- After two licensed nurses have checked the blood product, you will need to scan 4 different barcodes prior to initiating the transfusion
- Ensure you have completed all steps before proceeding

8. Start Rate

Starting rate is as follows for the following blood products unless otherwise ordered:

- **RBC:** 1-2 mL/minute
- **Plasma:** 2.5 mL/minute
- **Platelets:** 2-5 mL/minute
- **Cryoprecipitate:** As rapidly as tolerated
- **Granulocytes:** 1-2 mL/minute

9. Rate Change

- **RBC:** As rapidly as tolerated, 4mL/minute
- **Plasma:** As rapidly as tolerated, approximately 300 mL/hour
- **Platelets:** 300 mL/hour or as tolerated
- **Cryoprecipitate:** As rapidly as tolerated
- **Granulocytes:** 120-150 mL/hour or as tolerated

Review the table below for more information.

COMPONENTS	SUGGESTED INFUSION RATE (ADULT)		MAXIMUM INFUSION TIME & SPECIAL CONSIDERATIONS
	First 15 minutes	*After 15 Minutes*	
Whole Blood		Less than 4 hours	
Red Blood Cells, Leukocyte Reduced	1-2 mL/min (60-120 mL/hr)	As rapidly as tolerated; approximately 4 mL/min or 240 mL/hour	Less than 4 hours; For patients at risk of fluid overload, adjust flow rate to 1mL/kg/hr
Fresh Frozen Plasma	2-5mL/min (120-300mL/hr) during the 1st 5 minutes	As rapidly as tolerated (after the first 5 minutes); approximately 300 mL/hour	Less than 4 hours. Thaw time may be needed before issue For patients at risk of fluid overload, adjust flow rate to 1 mL/kg/hour
Platelets	2-5mL/min (120-300mL/hr) during the 1st 5 min	300 mL/hour or as tolerated (after the first 5 minutes)	Less than 4 hours Generally given over 1 hour. For patients at risk of fluid overload, adjust flow rate to 1 mL/kg/hour
Cryoprecipitate	As rapidly as tolerated	As rapidly as tolerated	Less than 4 hours. Infuse as soon as possible after thawing; pooling is preferred
Granulocytes	1-2mL/min (60-120 mL/hour)	120-150 mL/hour or as tolerated	One unit over ~2 hour period Closely observe for reactions

Click or tap the table above to zoom in.

---

10. Post-Transfusion Instructions

- The empty bag must be disposed of on the unit in a red bag (unless a transfusion reaction is suspected) and placed in a red biohazard container.
- Post-infusion testing should be performed as ordered.

- Vital signs should be checked at the completion of the transfusion.
- Resume previous IV infusion per MD order.
- Post transfusion patient education:
    - All patients who receive blood products must be educated regarding the possibility of transfusion reactions.
    - Review the post transfusion patient education with the patient/family.
    - Documentation of this is required in the medical record.

11. Post-Transfusion Documentation

- Complete the "Transfusion Record (TAR)" electronically or on paper (Appendix F) or Blood Bank Transfusion Form.
- Complete documentation in the patient health care record.

CONTINUE

Please click or tap the link below to review your ministry's policy:
Blood Product Transfusion: Donor or Autologous

Continue Module

Select the button to the right to continue to module.

CLICK OR TAP HERE

Petaluma Valley Hospital

Always document in the patient's medical record the following with **EVERY** unit of blood:

1. Pre-transfusion Documentation

2. Previous Transfusion

3. Pre-transfusion Medication Given

4. Verification of Informed Consent

5. Whether There is a "Reaction" Noted (Answer *Yes* or *No*)

6. Vital Signs

Check vital signs:

- Pre-transfusion
- 15 minutes after starting the transfusion
- Hourly during the transfusion
- Upon completion of the transfusion

7. Barcoding

- After two licensed nurses have checked the blood product, you will need to scan 4 different

barcodes prior to initiating the transfusion.

- Ensure you have completed all steps before proceeding.

8. Start Rate

- Starting rate for red blood cells (unless otherwise ordered) is 1-2 mL/minute.

9. Rate Change

- The flow of blood products during the first 50 mL should be regulated slowly. The rate of infusion may be increased if the patient's condition warrants.
- PRBCs: 2 hours per unit unless hemodynamically unstable.
- FFP: as indicated by patient's condition, usually ½ hour per unit.

- Platelets: as rapidly as patient tolerates; no longer than 2 hours.
- Cryoprecipitate: as rapidly as patient tolerates; no longer than 2 hours.
- Albumin: as indicated by patient condition and pharmacy or physician order recommendation.

10. Post-Transfusion Directions

- The empty bag must be disposed of on the unit in a red bag (unless a transfusion reaction is suspected) and placed in a red biohazard container.
- Post-infusion testing should be performed as ordered.
- Vital signs should be checked at the completion of the transfusion.
- Resume previous IV infusion per MD order.

- Post-infusion education: All patients who receive blood products must be educated of possible transfusion reactions:

    - Review the post transfusion patient education with the patient.
    - Documentation of this is required in the medical record (Attachment D, Post Patient Education Form).
    - Post education place one copy in the chart and give the original to the patient.

11. Post-Transfusion Documentation

- Complete the "Blood Product Administration BPA Record Form" (Attachment E, or document electronically).

- Complete documentation in the patient health record.

CONTINUE

Please click or tap the link below to review your ministry's policy:

Blood Transfusion Process

Continue Module

Select the button to the right to continue to module.

CONTINUE

Queen of the Valley Medical Center

Always document in the patient's medical record the following with **EVERY** unit of blood:

1. Pre-transfusion Documentation

2. Previous Transfusion

3. Pre-transfusion Medication Given

4. Verification of Informed Consent

5. Whether There is a "Reaction" Noted (Answer *Yes* or *No*)

6. Vital Signs

Check vital signs:

- Pre-transfusion
- 15 minutes after starting the transfusion
- Upon completion of the transfusion

7. Barcoding

- After two licensed nurses have checked the blood product, you will need to scan 4 different barcodes prior to initiating the transfusion.

- Ensure you have completed all steps before proceeding.

8. Start Rate

- Starting rate for RBC is 1-2 mL/minute (60-120/hour). Refer to policy for other blood products.

9. Rate Change

- As rapidly as tolerated.
- Infusion should not exceed 4 hours.
- For patients at risk of fluid overload, adjust flow rate to 1 mL/kg/hour.

10. Post-Transfusion Directions

- Change infusion rate change to "Zero" *at the end*.

- Complete that unit.
- Remove completed blood bag and blood tubing, and discard in RED disposal bag in infectious waste container.
- For non-emergent transfusions, complete documentation in the electronic medical record or on the BPA. Return the original BPA to Transfusion Service.
- Document total volume infused.
- Charge for blood.

CONTINUE

Please click or tap the link below to review your ministry's policy:
Blood Administration

Continue Module

Select the button to the right to continue to module.

CONTINUE

St. Joseph Hospital Eureka and Redwood Memorial Hospital

Always document in the patient's medical record the following with **EVERY** unit of blood:

1. Pre-transfusion Documentation

2. Previous Transfusion

3. Pre-transfusion Medication Given

4. Verification of Informed Consent

5. Whether There is a "Reaction" Noted (Answer *Yes* or *No*)

6. Vital Signs

- Obtain baseline vital signs immediately prior to initiating transfusion.
- Once the infusion is started, re-check vital signs at 15 minutes, and every hour thereafter, up to 4 hours, until transfusion is complete.
- On completion, take post transfusion vital signs.

7. Barcoding

- After two licensed nurses have checked the blood product, you will need to scan 4 different barcodes prior to initiating the transfusion.

- Ensure you have completed all steps before proceeding.

8. Start Rate

- Starting rate for blood products (unless otherwise ordered) is 1-2 mL/minute.

9. Rate Change

- If there are no signs of adverse reaction after “test dose” adjust flow to prescribed rate.
- Each unit should be given within 2-4 hours.
- Infusion rate is usually 150-300 mL/hour.

10. Post-Transfusion Disposal

- **Empty Bags:**

- Place tubing and empty blood bag in a plastic bag.
- Discard in the Hazardous Substance bin.

- **Partially Filled Bags (e.g., ran out of time to transfuse):**

  - Empty 1-2 containers of isolyzer in a red biohazard bag; place blood unit in bag.
  - Tie off bag and place in second red bag.
  - Place in Hazardous Substance bin

11. Post-Transfusion Documentation

- Record all vital signs on the electronic transfusion record (E-TAR), the paper TAR or Anesthesia record as applicable.

- Record time and date transfusion ended, post transfusion vital signs and/or any partial volumes transfused on the TAR. Record total volume transfused on the department-specific intake/output record.

- In surgery, where E-TAR is not used, it is important to document stop and start times on the Laboratory Transfusion Documentation form (yellow form) and return it to the Lab promptly.
- Place paper TAR in the Lab section of the patient chart. Send copy to lab.

CONTINUE

Please click or tap the link below to review your ministry's policy:

Blood and Blood Products

Continue Module

Select the button to the right to continue to module.

CONTINUE

Santa Rosa Memorial Hospital

Always document in the patient's medical record the following with **EVERY** unit of blood:

1. Pre-transfusion Documentation

2. Previous Transfusion

3. Pre-transfusion Medication Given

4. Verification of Informed Consent

5. Whether There is a "Reaction" Noted (Answer *Yes* or *No*)

6. Vital Signs

Check vital signs:

- 30 minutes before transfusion.
- 15 minutes after the transfusion is started.
- Every hour during transfusion.
- Upon completion of transfusion.
- If administering blood products under pressure, vital signs must be taken every 15 minutes.

7. Barcoding

- After two licensed nurses have checked the blood product, you will need to scan 4 different barcodes prior to initiating the transfusion.
- Ensure you have completed all steps before proceeding.

8. Start Rate

Starting rate is as follows for the following blood products unless otherwise ordered:

- **RBC:** 1-2 mL/minute
- **Plasma:** 2.5 mL/minute
- **Platelets:** 2-5 mL/minute
- **Cryoprecipitate:** As rapidly as tolerated
- **Granulocytes:** 1-2 mL/minute

9. Rate Change

- **RBC:** As rapidly as tolerated, 4mL/minute
- **Plasma:** As rapidly as tolerated, approximately 300 mL/hour
- **Platelets:** 300 mL/hour or as tolerated
- **Cryoprecipitate:** As rapidly as tolerated
- **Granulocytes:** 120-150 mL/hour or as tolerated

Review the table below for more information.

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Fresh Frozen Plasma	2-5mL/min (120-300mL/hr) during the 1st 5 minutes	As rapidly as tolerated (after the first 5 minutes); approximately 300 mL/hour	Less than 4 hours. Thaw time may be needed before issue For patients at risk of fluid overload, adjust flow rate to 1 mL/kg/hour
Platelets	2-5mL/min (120-300mL/hr) during the 1st 5 min	300 mL/hour or as tolerated (after the first 5 minutes)	Less than 4 hours Generally given over 1 hour. For patients at risk of fluid overload, adjust flow rate to 1 mL/kg/hour
Cryoprecipitate	As rapidly as tolerated	As rapidly as tolerated	Less than 4 hours. Infuse as soon as possible after thawing; pooling is preferred
Granulocytes	1-2mL/min (60-120 mL/hour)	120-150 mL/hour or as tolerated	One unit over ~2 hour period Closely observe for reactions

Click or tap the table above to zoom in.

---

10. Post-Transfusion Instructions

- The empty bag must be disposed of on the unit in a red bag (unless a transfusion reaction is suspected) and placed in a red biohazard container.
- Post-infusion testing should be performed as ordered.

- Vital signs should be checked at the completion of the transfusion.
- Resume previous IV infusion per MD order.
- Post transfusion patient education:
    - All patients who receive blood products must be educated regarding the possibility of transfusion reactions.
    - Review the post transfusion patient education with the patient/family.
    - Documentation of this is required in the medical record.

11. Post-Transfusion Documentation

- Complete the "Transfusion Record (TAR)" electronically or on paper (Appendix F) or Blood Bank Transfusion Form.
- Complete documentation in the patient health care record.

CONTINUE

Please click or tap the link below to review your ministry's policy:

Blood Products Transfusion, B13.1

Continue Module

Select the button to the right to continue to module.

CONTINUE

Documentation Assessment

What is the purpose of giving a patient a copy of the California Department of Health Services pamphlet to comply with the Paul Gann Blood Safety Act?

- ○ To provide information regarding the benefits, risks, and alternatives of the flu vaccine
- ○ To provide patients with information regarding measures to stop the spread of infections in healthcare settings
- ○ To provide information regarding the benefits, risks, and alternatives of transfusion of blood products collected from the patient or another person
- ○ To provide patients with information regarding principles of appropriate antibiotic use

SUBMIT

Complete the content above before moving on.

Transfusion Reaction

The most common signs and symptoms include fever, chills, urticaria, and itching. Some symptoms may resolve with little or no treatment. However, respiratory distress, high fever, hypotension, and hemoglobinuria may indicate a more serious reaction.

Signs and Symptoms of a Transfusion Reaction

If any of the below signs or symptoms are present, refer to your ministry's blood transfusion reaction policy, which includes notifying the physician, the blood bank and documenting appropriately in EMR.

- Fever (increase of 1 °C or 2 °F)
- Chills/Rigors
- Nausea/Vomiting
- Hypertension (rise in systolic BP > 30mmHg)
- Hypotension (fall in systolic BP > 30mmHg)
- Angioedema/Edema
- Cough
- Dyspnea/Shortness of breath
- Hypoxemia/ ↓ O2 Sat
- Wheezing/Stridor
- Bilateral Infiltrates/X-ray

- Tachycardia
- Bradycardia
- Shock
- Hemorrhage/Bleeding
- Urticaria/Hives
- Pruritus/itching
- Erythema/Flushing
- Lower back pain
- Chest pain
- Feeling of heat or a burning sensation along the vein
- Headache

Nursing Interventions

- **Stop the transfusion immediately!**
- Monitor the patient's vital signs.
- Change tubing, keep the IV open at a TKO rate with normal saline.
- Compare patient and blood unit identifiers.
- Notify the practitioner. (Note the time of call.) Notify the Blood Bank immediately.
- Return blood bag, tubing, and any solutions hung with the unit to Blood Bank.
- Complete a Suspected Blood Transfusion Reaction Report.
- Call the lab to draw a STAT post transfusion blood sample.
- If requested by blood bank or if bedside nursing observes hemogloburia—send the first voided urine after transfusion to the lab.
- Document transfusion reaction, patient response, and education provided.

CONTINUE

Transfusion Reaction Assessment

Select all that apply: Which of the following are symptoms of a Transfusion Reaction?

- [ ] Joint pain
- [ ] Chills and fever
- [ ] Feeling of heat or a burning sensation along the vein
- [ ] Blurred vision
- [ ] Lower back pain
- [ ] Chest pain
- [ ] Nausea and vomiting

- [ ] Headache
- [ ] Rash, urticaria
- [ ] Symptoms of shock
- [ ] Hypertension/Hypotension
- [ ] Respiratory changes such as coughing, wheezing, dyspnea/shortness of breath, hypoxemia

SUBMIT

Complete the content above before moving on.

Transfusion Related Acute Lung Injury (TRALI)

Transfusion Related Acute Lung Injury (TRALI) is an acute, often life-threatening reaction characterized by respiratory distress, hypo or hyper-tension and non-cardiogenic pulmonary edema. TRALI can occur from two to six hours post transfusion.

TRALI results from neutrophil-mediated damage to the pulmonary microvasculature. Due to diffuse alveolar capillary damage, there is a leakage of fluid into alveolar space.

- Hypoxia can occur within 2-6 hours of transfusion
- The mortality rate is 5-20%
    - TRALI is the leading cause of reported death from transfusions
- The incidence of TRALI is estimated to be 1:1000-1:5000

Directions: Select the plus sign (**+**) next to each statement to read more information. Review all to move on.

Clinical Signs —

Acute bilateral pulmonary edema, hemodynamic instability, fever, chills, dyspnea, cyanosis, shortness of breath, bilateral lung infiltrates.

Treatment

Respiratory and circulatory support (possible ventilator, vasopressors).

Prevention

There is no way to screen who might be at risk for TRALI. Ongoing assessment during and after transfusion ensures early intervention in the event of any transfusion reaction.

Complete the content above before moving on.

Transfusion-Associated Circulatory Overload (TACO)

The pathogenesis of TACO is thought to be similar to other causes of acute congestive heart failure: an increase in central venous pressure and pulmonary blood volume causes an increase in hydrostatic pressure leading to fluid extravasation into the alveolar space—pulmonary edema.

TACO is more common in patients with heart failure, kidney disease, extremes in age (elderly/pediatrics), and + fluid status.

TACO leads to significant increases in length of stay and mortality rates.

The incidence of TACO is estimated to be 1:10-100 transfusions.

Directions: Select the plus sign (**+**) next to each statement to read more information. Review both to move on.

Signs and Symptoms —

- Precordial pain
- Dyspnea
- Crackles

- Cyanosis
- Dry cough
- Jugular vein distention

Nursing Interventions

- Administer blood products slowly
- Use volume-reduced platelets to prevent fluid overload
- Administer the blood product using an electronic infusion device to maintain flow rate
- Position the patient in a semi-Fowler or upright position to increase venous resistance
- If the patient develops signs and symptoms of TACO, immediately stop the transfusion and notify the practitioner and transfusion services personnel

Complete the content above before moving on.

Transfusion-Associated Circulatory Overload (TACO) Assessment

The chest X-ray shows a complete "white out" of the lungs and TACO is confirmed.

Looking back to the original presentation of the patient – older age, history of myocardial infarction, congestive heart failure, and dialysis dependent – the team agrees that the patient was at a high risk for TACO.

Select all that apply: What are some steps that could have been taken prior to initiating transfusion to help mitigate the risk of TACO?

- [ ] Communicate to the clinician in charge that the patient's history is suspicious for risk of TACO.
- [ ] Don't transfuse the patient.
- [ ] Start with a slow transfusion rate.

- [ ] Transfuse 1 unit only, rather than the requested 2 units.
- [ ] Call the doctor who was in charge of the patient at the SNF facility who ordered the transfusion.

SUBMIT

Complete the content above before moving on.

Other Blood Transfusion Processes

Emergent Transfusion

The clinical situation is sufficiently urgent to require release of blood before completion of compatibility testing.

Code RBC/Code MTP

When a patient is hemorrhaging with massive blood loss and hemorrhage/hypovolemic shock, anticipation of the need for ongoing transfusion support as a result of intractablemechanical or coagulopathic bleeding, obsteric hemmorrhage with cumulative blood loss > 1500 mL, > 2 units of RBC transfused, vital signs unstable or suspicion of DIC a massive transfusion is called for, a physician order will be initiated to follow the massive transfusion protocol.

Non-Standard Transfusion

An aspect of transfusion or pre-transfusion compatibility testing for this patient is non-standard. Additional risks may be present that MD shall consider prior to transfusion.

If the patient has an antibody or other issue and the blood is not compatible with this patient's blood then a form must be signed by the provider for least incompatible blood "acknowledgement of non-standard transfusion" to be given.

CONTINUE

Other Blood Transfusion Processes Review

Please review these blood transfusion processes by selecting the cards below:

Emergent Transfusion

The clinical situation is sufficiently urgent to require release of blood before completion of compatibility testing.

Code MTP/Code RBC

When a patient is hemorrhaging with massive blood loss and hemorrhage/hypovolemic shock, anticipation of the need for ongoing transfusion support as a result of intractable mechanical or coagulopathic bleeding,

Non-standard Transfusion

An aspect of transfusion or pre-transfusion compatibility testing for this patient is non-standard. Additional risks may be present that MD shall consider prior to transfusion.

If the patient has an antibody

Complete the content above before moving on.

Knowledge Check

Answer the following questions with a score of 100% in order to complete this course. You will have unlimited attempts to achieve the required score.

Question

01/10

Select All That Apply:

Non-emergent blood administration must have patient consent and include:

- [ ] Provider giving informed consent
- [ ] Patient must receive information on the right to refuse and education on blood transfusion
- [ ] The blood must be cross-matched
- [ ] Order entry must be completed in the EMR system

Question

02/10

When a patient refuses blood or blood products, the patient must sign the appropriate form (e.g., a Refusal to Permit Blood Transfusion form), and must have appropriate alert attached to identification wristband.

- ◯ True
- ◯ False

Question

03/10

If the blood component (unit) is delivered to the intended area but not going to be transfused, you must:

- ◯ Dispose of the blood component
- ◯ Return the blood component to the Blood Bank immediately
- ◯ Keep it at the patient's bedside
- ◯ Refrigerate the blood component at the nurses station nearest the patient

Question

04/10

Select All That Apply:

Which of the following is true regarding validating the blood component?

- [ ] The blood component should be done by 1 licensed staff
- [ ] Identify the patient with one of the following, the patient's full name, DOB, or medical record number
- [ ] Verify the blood unit number
- [ ] Verify the blood type (ABO/Rh) unit and expiration date
- [ ] Verify the interpretation of crossmatch tests, if performed

Question

05/10

One unit of blood may not hang longer than:

- 1 hour
- 2 hours
- 4 hours
- 8 hours

Question

06/10

Select All That Apply:

For every unit of blood your patient has received you have documented medications given, verification of informed consent, vitals, no reaction indicated, start rate and rate change. What else do you need to document in the patient's EMR?

- [ ] Change infusion rate to "zero" at the end
- [ ] Complete the unit
- [ ] Total volume infusted
- [ ] Charge for the unit of blood (document units, not ***mls***)

Question

07/10

Select All That Apply:

What should you do if you suspect a blood transfusion reaction?

- [ ] Continue to monitor the patient's vital signs but wait until you see signs of shock to notify the practitioner and Blood Bank
- [ ] Dispose of the blood bag, tubing, and any solutions hung with the unit
- [ ] Immediately collect a post transfusion blood sample. This may be collected by the lab or the RN if lab is unavailable
- [ ] Do not change the tubing but keep the IV open at a TKO rate with normal saline
- [ ] Stop the transfusion immediately
- [ ] Notify the provider and Blood Bank immediately
- [ ] Document transfusion reaction, patient response, and education provided in the EMR

Question

08/10

Select All That Apply:

What are some of the clinical signs of Transfusion Related Acute Lung Injury (TRALI)?

- [ ] Hemodynamic instability
- [ ] Jugular vein distention
- [ ] Shortness of breath
- [ ] Bilateral lung infiltrates
- [ ] Fever, chills

Question

09/10

Transfusion is begun on the patient. The first unit of RBC was transfused without incident. Halfway through the second unit, you notice that the patient has developed isolated hives only, with no other symptoms.

What is the appropriate plan of action?

- ◯ Ignore the reaction because hives are unrelated to transfusions
- ◯ Ignore the reaction because the hives are isolated
- ◯ Decrease the rate of transfusion and see if the hives subside
- ◯ Stop the transfusion and call the attending physician and Blood Bank

Question

10/10

Select All That Apply:

What are the common signs and symptoms of a transfusion associated circulatory overload (TACO)?

- [ ] Dyspnea
- [ ] Hypoxia
- [ ] Systolic hypotension
- [ ] Jugular venous distension
- [ ] Pedal edema
- [ ] Fever

Summary

☐ By selecting the checkbox to the left, I attest that I have reviewed the appropriate policy and understood the content. If I have any questions about the policy or information contained therein, I will contact my supervisor.

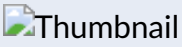
Complete the content above before moving on.

You should now be able to:

- Identify steps to take prior to sending for pick up of blood component.
- Follow proper procedures when a patient refuses blood or blood products.
- Ensure that the correct patient gets the correct blood when they get a blood transfusion.
- State the documentation requirements for blood administration and patient education.
- Define patient education requirements for blood transfusions.
- Recognize symptoms of a transfusion reaction.

- Determine steps to follow when a transfusion reaction occurs.
- Compare and contrast emergent transfusion, Code RBC and non-standard transfusions.

If you have any unit- or ministry-specific questions regarding blood and blood products or individual procedures within your ministry, please contact your nursing unit manager or preceptor.



Exit

Click to exit the course.

EXIT

[CCO] Homeless Discharge Requirements

Providence

This course will provide you with the background you need to apply the new protocol requirements under California Senate Bill 1152 when discharging a homeless patient.

- **Homeless Protocol Requirements**
- **Documentation**
- **Review**
- **Quiz**
- **What's Next**

Homeless Protocol Requirements

California Senate Bill 1152

California Senate Bill 1152 requires that:

- All patients must be assessed for homelessness

AND

- All of the elements of the Homeless Protocol must be documented in the EMR.

It ensures that all homeless patients have received a minimum level of assistance for their transition back into the community.

Elements of the Homeless Protocol

Click each image below to see an overview of the elements of the Homeless Protocol.

Homelessness is to be assessed:

a. Registration asks all patients for a physical home address.

b. If a P.O. Box is given, registration will attempt to identify if patient is homeless or not.

c. ED RNs, bedside RNs, and

A Discharge Plan for each homeless patient is required.

Discharge medications must be addressed.

a. Prescriptions and patient are referred to the closest open retail pharmacy or a minimal supply of medications may be dispensed (only if necessary).

Vaccinations appropriate to their presenting medical condition: a Licensed Independent Practitioner is to decide which vaccinations (if any) are appropriate. Patients may also be referred to a Federally Qualified Health Center, for example, a

Discharge food/meal offered. This can be a tray or boxed meal. The patient does not need to consume it prior to discharge

Patient clothing is assessed for seasonal appropriateness. Only dispense the needed clothing and not full sets of clothing unless indicated.

Transportation to discharge destination is addressed.
See below for more information.

Wristband is removed prior to discharge.

Behavioral, Medical, or affordable healthcare follow-up is addressed or documented as not needed. Patient will be screened for, and provided assistance to enroll in, any affordable health insurance coverage for which he or she is eligible.

Homeless destination is to be documented. If the destination is an accepting shelter, agency or provider AND patient agrees, document full name of person accepting patient or patient's refusal.
See below for more information.

Printed, written, or electronic information is sent to post-discharge servicing agencies regarding patient's medical or behavioral health care needs.

Click each tab below to see more information.

TRANSPORTATION TO DESTINATION | DOCUMENT DESTINATION | IN A DIFFERENT COUNTY

Within 30 miles or 30 minutes of the Ministry

The ministry must offer the homeless patient transportation to his/her post discharge destination if that destination is within 30 miles or 30 minutes of the ministry.

More than 30 miles or 30 minutes from the Ministry

If the patient requests to travel more than 30 miles from the ministry or more than 30 minutes from the ministry, then the care team should evaluate that request and consider sending unless sending out of county.

Supportive Services

The patient can go for supportive services from a social services agency, health care service provider, or nonprofit social services provider in another county, if the hospital has completed both of the following:

1. Given prior notification to the social services agency, health care service provider or nonprofit social services provider AND
2. obtained prior authorization from the social services agency, health care service provider or nonprofit social services agency to accept the specific patient.

Assist the Patient with finding an Appropriate Shelter

Every effort must be made to assist the patient with finding an appropriate shelter bed, based on availability, even if patient wants to go back to their tent.
If no shelter is accepting, discharge is not to be delayed.
The hospital should inform the patient of the shelter's future availability and work with the patient to identify a "residence" or "alternative destination" for the patient to go until the shelter is open.

What is a "Residence?"

"Residence" in this law means the location identified to the hospital by the homeless patient as his/her principal dwelling place. This could include a friend's home, a tent or park. Homeless patients have the legal right to go wherever they choose and hospitals are required to document any shelter offer and patient's refusal.

TRANSPORTATION TO DESTINATION | DOCUMENT DESTINATION | IN A DIFFERENT COUNTY

Residence in a Different County
If the shelter identified by the homeless patient as his/her "residence" is in a different county from the hospital, the patient **cannot** be sent there unless the shelter has accepted the patient in advance.

One reason the law was enacted was to prevent homeless patients from being dropped off at homeless shelters without warning and without available beds.

Alternative Destination
If there are no shelters that will accept a homeless patient, work with the patient to either Identify their "residence" and have the patient return there OR assist the patient in identifying an alternative destination and how they will get there.

Click all of the images and tabs above before moving on.

Documentation

Once a patient is identified as homeless, initiate the homeless protocol.

Documentation Requirements

All of the components of the law must be documented by the discharging caregivers.

Leadership has identified the ED or bedside RN as owning the final responsibility of ensuring that the homeless protocol has been completed and documented in collaboration with care management caregivers.

Click each topic below for more information.

Discharged at 2am?

Complete the homeless protocol even when the patient is discharged at 2am from the ED after a treat and release episode of care or if the patient went AMA from any hospital unit.

Homeless Discharge Checklist

The Homeless Discharge checklist must be completed prior to the discharge of all homeless patients.
See below for more instructions.

Failure to document

Failure to document that all appropriate steps have been taken can result in significant fines levied to the ministry; **Even for a single failure.**

Click each topic above before moving on.

Epic

Click the appropriate tab below for more information about how to document Homeless Protocols in Epic.

BEDSIDE NURSE	SURGICAL AND PROCEDURAL AREAS	CASE MANAGEMENT, SOCIAL WORK	ED NURSE

For more information about documenting Homeless Protocols in Epic for an Inpatient Nurse click here.

BEDSIDE NURSE	SURGICAL AND PROCEDURAL AREAS	CASE MANAGEMENT, SOCIAL WORK	ED NURSE

For more information about documenting Homeless Protocols in Epic for Surgical and Procedural areas click here.

BEDSIDE NURSE	SURGICAL AND PROCEDURAL AREAS	CASE MANAGEMENT, SOCIAL WORK	ED NURSE

For more information about documenting Homeless Protocols in Epic for Case Management/Social Work click here.

BEDSIDE NURSE	SURGICAL AND PROCEDURAL AREAS	CASE MANAGEMENT, SOCIAL WORK	ED NURSE

For more information about documenting Homeless Protocols in Epic for an ED Nurse click here.

Review

Homeless Protocol Elements

Review the homeless protocol elements and walk through the protocol with your preceptor before your new hire orientation ends.

Questions

For questions contact:

1. Your ministry Care Management department

OR

2. Your manager/supervisor/director

Quiz

You may encounter situations similar to the ones presented in this quiz, so please pay special attention to the questions and feedback you receive. They will help you to know how to handle encounters you have when discharging homeless patients.

Question

01/10

If a patient lives in a car parked at the same spot each night, is he/she homeless?

- ◯ Yes.
- ◯ No.

Question

02/10

If a patient lives in a recreational vehicle parked in different spots each night, is he/she homeless?

- ◯ Yes
- ◯ No

Question

03/10

What should you do when a patient who is homeless is brought in by the police?

Select the two correct answers.

- [ ] Refuse to release the patient to police custody.

- [ ] There is no need to follow the Homeless Protocols, because they are in police custody.

- [ ] Comply with the protocol to the extent you can do so without interfering with the police and their procedures.

- [ ] Document that you offered the required components of the protocol. If the police refuse to allow you to follow up with the protocol, document that fact.

Question

04/10

Does this law apply if the patient is a child whose parents are homeless?

- ◯ Yes
- ◯ No

Question

05/10

The patient is requesting a shelter. I contacted the local shelter, and they stated they won't have a bed for the patient until the next day. Are we required to keep the patient in the hospital until then?

- ◯ Yes
- ◯ No

Question

06/10

Compliance with the Homeless protocol must be documented in the electronic medical record in the Homeless Discharge section/checklist.

- ◯ Yes
- ◯ No

Question

07/10

Can a patient be discharged across county lines without prior consent, if the patient has identified a shelter in another county as their "residence"?

- ◯ Yes
- ◯ No

Question

08/10

If a homeless person comes to the hospital requesting a free meal or weather appropriate clothing, are we required to supply those when the patient does not present with a medical condition?

- ◯ Yes
- ◯ No

Question

09/10

Is it sufficient to refer a patient to a Federally Qualified Health Center, for example, a community clinic to receive screening for Infectious Diseases and/or vaccinations, such as the flu or hepatitis vaccines?

- ◯ Yes
- ◯ No

Question

10/10

What should you do if the patient leaves Against Medical Advice (AMA) before the discharge process is complete?

- Call the police.
- Notify security.
- Document clearly that the homeless patient left AMA prior to completing the discharge protocol.
- You don't need to complete the discharge protocol.

What's Next

You have now received credit for this course. You may retake the quiz to receive a higher score if you wish or you may exit the course.

Retake the Quiz

You may click the button to retake the quiz until you receive a higher score if you wish or you may exit the course.

RETAKE THE QUIZ

Exit the Course

If you are satisfied with your score you may click the button to exit the course.

EXIT THE COURSE

PROV: Constant Observation Part 1

Assignment for Nurses, CNAs, and Techs

- Course Objectives and Introduction
- Alternatives to Constant Observation
- Constant Observation
- Conclusion

Lesson 1 of 4

Course Objectives and Introduction

Navigation Tip: If you are directed to PolicyStat or another external site, be sure to minimize the new window (do not close it) to return to this course. This will allow you to continue and complete the module. Closing the window may prevent the course from progressing.

CONTINUE

After completing this course, you will:

- Understand the Constant Observer role
- Understand the RNs role in oversight of and assignment to the Constant Observer
- Be familiar with general principles that apply to patients requiring constant observation and areas of special consideration

- Be familiar with and practice effective communication including elements of therapeutic listening and communicating reportable observations to the RN
- Be familiar with the basics of situational awareness and how to maintain your safety and the safety of the patient

CONTINUE

Types of Observation Used in the Hospital

Click and review each card below for more information.

Close Observation

One Constant Observer to one or more patients in the same room or bay

Remote Visual Monitoring

Remote Visual Monitoring is provided by a caregiver that has received specialized training to perform visual monitoring via a camera

One-to-One Observation

One Constant Observer to one patient within line of sight, with no visual barriers in the same room or bay

- Observation type is chosen by the patient's care team based on the patient's current condition and needs
- As their condition and needs change, the type of observation provided may change

- Constant Observation is only used when alternatives have been attempted and found to be ineffective for the patient's plan of care

The RN's Role

The patient's RN will consider the cause of the patient's behavior. The RN's assessment drives interventions to address concerning patient behaviors. Alternative interventions to Constant Observation should be tried first.

If interventions are unsuccessful in reducing risk of patient harm, consider implementing constant observation.

Instructions: Select to expand each section below. You must select all sections to continue.

Implementing Constant Observation

- The patient's RN notifies the Charge Nurse of patient's need for continuous observation and follows campus-based plan for assigning a Constant Observer (CO)
- The RN reviews with CO the role and responsibilities of constant observer assignment utilizing the Constant Observer Guidelines and provides nursing bedside report as appropriate for specific patient(s) being assigned for continuous observation.

Note: *RN remains responsible for the nursing care of the patient throughout the shift, regardless of the presence of a Constant Observer*

Documentation

- The RN will frequently round on the patient in CO, assessing the patient's response, documenting the response in the shift summary, and adjusting the patient's care plan as needed
- When constant observation is discontinued, the RN documents rationale for the discontinuation

Discontinuing Constant Observation

- The RN will collaborate with the multi-disciplinary team to determine the appropriate time to discontinue constant observation (i.e., when patient deemed to no longer require this strategy to reduce potential for harm)

Note: *If physician initially ordered constant observation, physician order will be required to discontinue*

Complete the content above before moving on.

This training focuses on the role of the Constant Observer.

Challenges of Constant Observation

- The presence of a constant observer means the patient will have no privacy
- It interferes with the patient's socialization with friends and family
- **Constant observation is intrusive!**
    - The job is monotonous, and the observer can become distracted
    - It often stretches resources and creates staffing challenges in other areas of the hospital
    - It's costly to the organization

CONTINUE

Alternatives to Constant Observation

Alternative interventions should be tried before initiating Constant Observation.

For Patients with Altered Mental Status, (e.g., dementia, delirium, psychosis) Agitation, or Confusion

Alternatives to Try

- Decrease stimuli to decrease agitation
  - Lights, TV, environmental noise
- Address patient comfort
  - Toileting, pain, hunger

- Provide assistive devices as necessary
    - Hearing aids, dentures, turn on lights to enhance vision
- Make changes in the environment to make the space safer
    - Place call bells or other items within the patient's reach
    - Low bed and side rails as appropriate for safety
    - Reduce trip hazards (cords, lines, bedding)
- Offer distraction with other activities as appropriate
    - Reading material, visitors, activity boards/aprons
- Arrange for family to sit with patient if appropriate

Risk of Harm Associated with Altered Mental Status, Agitation, or Confusion

- Low: Consider Remote Visual Monitoring
- Moderate: Consider Constant Observation versus Remote Visual Monitoring
- High: Consider Remote Visual Monitoring or Constant Observation (may observe more than one patient)

Please review the alternatives to try above before moving on.

For Patients at Risk for Falls

Alternatives to Try

- Low bed

- Bed alarm
- Move closer to the RN station
- Increase frequency of rounding
- Offer distraction with other activities as appropriate
- Reading material, visitors, activity boards/aprons
- Arrange for family to sit with patient if appropriate

Risk of Harm from a Fall:

- Low: Consider Remote Visual Monitoring
- Moderate: Consider Remote Visual Monitoring
- High: Consider Remote Visual Monitoring or Constant Observation (may observe more than one patient)

Please review the alternatives to try above before moving on.

For Patients at Risk of Suicide/Self Harm

Alternatives to Try

- De-escalation techniques
- Trauma Informed Care techniques
- Decrease environmental stimuli
- Address patient comfort needs
- Address underlying causes of behavior

Risk of Harm from Patient Behavior:

- Low: Consider Remote Visual Monitoring
- Moderate: Consider Constant Observation versus Remote Visual Monitoring
- High: Constant Observation
    - The Constant Observer may not observe more than one patient if that patient is at high risk for suicide or other self-harm behavior

Please review the alternatives to try above before moving on.

For Patients at Risk for Elopement (leaving the building)

Alternatives to Try

Continue to review this lesson to learn more about alternatives including:

- De-escalation techniques
- Trauma Informed Care techniques

Risk of Harm from Elopement:

- Low: Remote Visual Monitoring
- Moderate: Consider Constant Observation versus Remote Visual Monitoring
- High: Constant Observation (may observe more than one patient)

Please review the alternatives to try above before moving on.

Specialty Population/Cognitive Deficits (e.g. Autism, Lesch-Nyhan, etc.)

Alternatives to Try —

Implement an individualized, holistic nursing plan of care.

- De-escalation techniques that work well for this patient
- Interventions that become ineffective
- Patient-specific comfort measures

Risk of Harm from Patient Behavior:

- Low: Consider Remote Visual Monitoring
- Moderate: Constant Observation (may observe more than one patient)
- High: Constant Observation (may observe more than one patient)

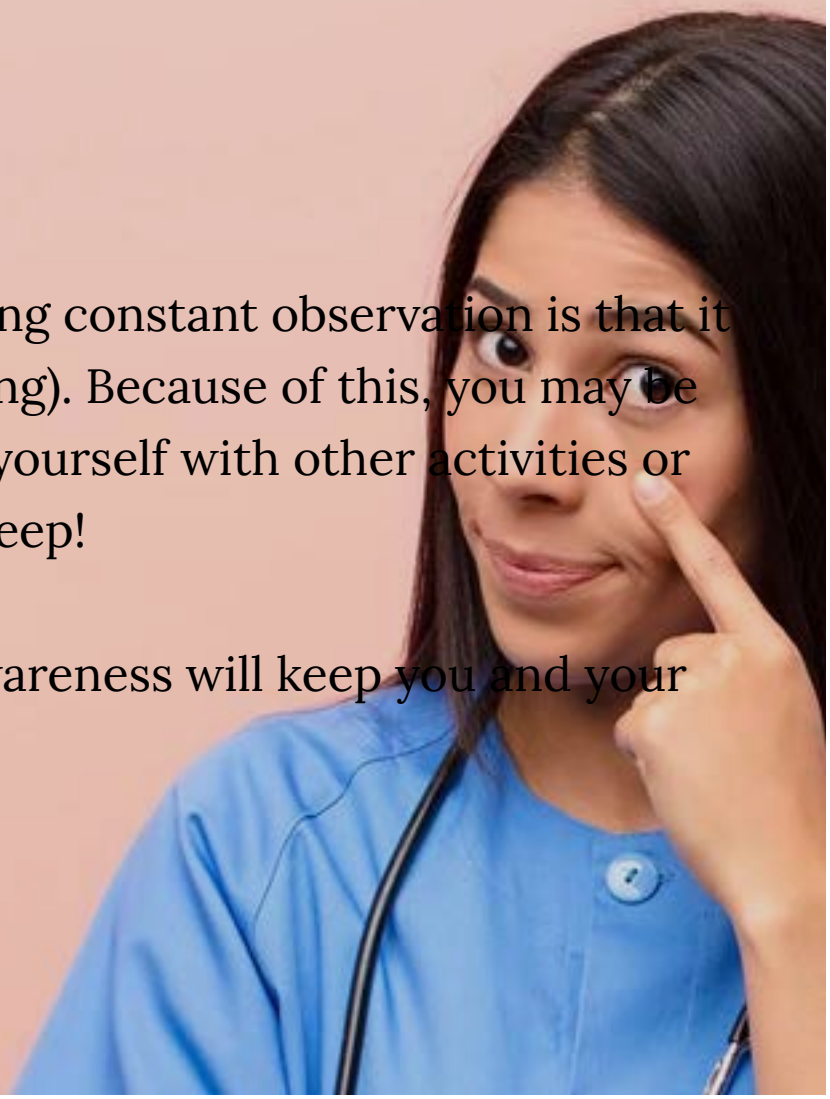
Please review the alternatives to try above before moving on.

Constant Observation

General Considerations

- A constant observer is one designated caregiver assigned to one patient to provide active, undivided attention, and direct visualization at all times
- Sometimes referred to as a sitter, a constant observer is much more than a "sitter." You are caring for a very **vulnerable person** who requires continuous monitoring.
- As a constant observer, your **only job** is to protect the patient by ***vigilantly*** observing for and reporting any safety concerns.

This means your eyes are on the patient at all times.



Stay Vigilant

One risk in performing constant observation is that it is monotonous (boring). Because of this, you may be tempted to distract yourself with other activities or possibly even fall asleep!

A relaxed state of awareness will keep you and your patient safe.

CONTINUE

Constant Observer - Frequently Asked Questions

See Constant Observer policy for requirements.

Expand and review each section below for more information.

When is Constant Observation used?

- When alternative interventions have been tried and have been insufficient to meet the patient's needs as a strategy to reduce patient harm from behavioral and non-behavioral risks

Patients may need Constant Observation when:

- Alternative interventions have been tried and have been insufficient to meet the patient's needs
- At risk from suicidal/harm ideation, self-harm behavior, poor impulse control, altered mental status, elopement, or falls

When you are assigned to be a Constant Observer, remember that alternative interventions have not been successful in keeping the patient safe. Your role as a Constant Observer is necessary and important!

- The patient's RN will collaborate with the care team to determine when to discontinue constant observation (i.e., when patient is deemed to no longer require this strategy to reduce potential for harm)
    - If the physician initially ordered constant observation, a physician order will be required to discontinue it

What are the responsibilities of the Constant Observer?

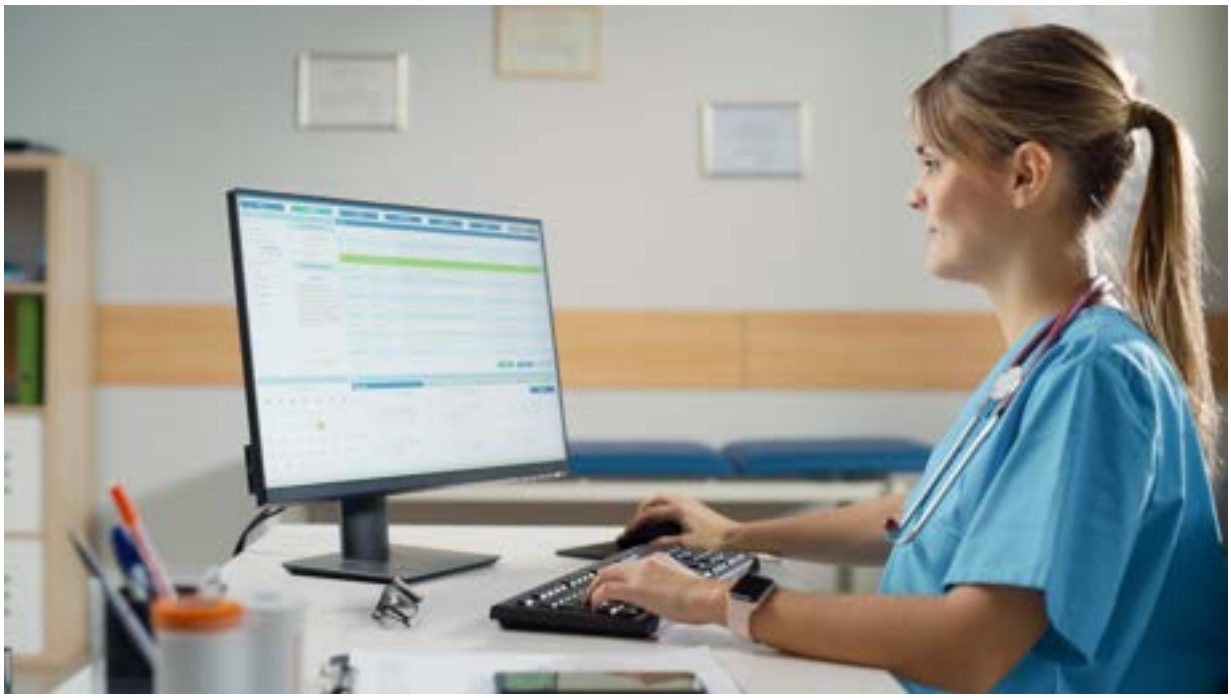
- Understand why the patient requires constant observation
    - If it is unclear to you, get more information from the patient's assigned nurse or Charge nurse
    - Find out what must be reported immediately to the nurse
- Introduce yourself to your patient
    - Tell them your name, your role, and how long you will be there
- Verify the identity of the patient
    - Ask them what name they prefer to go by
- Routinely observe the environment for potential risk factors impacting safety while also maintaining visual observation (eyes on) the patient at all times
- Notify the patient's nurse or charge nurse immediately of any changes in the patient's behavior, condition, or environment that could potentially decrease or increase the level of observation
- A Constant Observer may not observe more than one patient if that patient is at high risk or moderate risk for suicide or other self-harm behavior.
- The Constant Observer is to accompany the patient for any clinical tests or procedures off the unit, if determined by the patient's nurse to be the safest option for the patient
- Family members and visitors are not used as constant observers. Patient care and safety remains the responsibility of hospital caregivers.
- Do not leave patients alone in the bathroom or on toilet/commode. Remain close enough to intervene emergently, keep patient within your line of sight. Consider keeping door open while patient toilets, or slightly ajar to provide privacy while maintaining line of sight.

If a Constant Observer is assigned to monitor more than one patient, the Constant Observer must be positioned to maintain an unobstructed view of all assigned patients.
Additional caregivers must be used to ensure continuous observation if assisting with activity of one patient (e.g., toileting, ambulating in hall, or transporting) prevents the simultaneous, continuous observation of the other patients requiring constant observation.

Complete the content above before moving on.

Documentation

The Constant Observer needs to document in pertinent flowsheet in EMR every 2 hours, and at the end of their shift, and as indicated



A print copy of the Constant Observer Guidelines is provided below for reference purposes.

Navigation Reminder: After clicking on the link, be sure to minimize the new window (do not close it) to return to this course. This will allow you to continue and complete the course. Closing the window may prevent the course from progressing.

https://phs-phs.policystat.com/doc_attachment/view/63201772/

Expand and review each section above to continue.

Conclusion

Congratulations! You have successfully finished the initial eLearning segment of the *Constant Observation* module.

Please proceed to the second module to continue your learning journey.

Click 'Exit Course' above to close this window.

PROV: Constant Observation Part 2

Assignment for Nurses, CNAs, and Techs

- **Interacting With the Patient**
- **Keeping Yourself Safe**
- **Knowledge Checks**
- **Policy Review and Conclusion**

Interacting With the Patient

Navigation Tip: If you are directed to PolicyStat or another external site, be sure to minimize the new window (do not close it) to return to this course. This will allow you to continue and complete the module. Closing the window may prevent the course from progressing.

CONTINUE

CONTINUE

Interacting With the Patient

In the following slides, you'll learn about general expectations (*what are we asking of you?),* as well as therapeutic listening and trauma informed care.

Click START or the arrow button for more information.

1

What am I being asked to do?

Supporting a patient who requires this level of care for safety begins with building trust.

- Be friendly and courteous to your patient and their family
- Help to create a calm and organized environment
    - Too much light/not enough light, noise and activity levels, and an unfamiliar environment can increase confusion and disorganization
- Remind the patient of items in the room that will help to orient them
    - Items from home, orientation boards, clocks, calendars
- Provide care that ***is within your assigned duties and training, and to the degree that you are comfortable***
- Maintain direct line of sight observation of assigned patient(s) at all times (including during toileting)
    - Note: if the Constant Observer is assigned to multiple patients, an additional caregiver must be in place to observe the other patient(s) *before* the patient enters the bathroom.
- Refrain from activities that divert attention away from patient observation
- Redirect patient away from behavior that is unsafe

- Report your observations to the nurse ***early and often***

2

As a Constant Observer, what can I do?

1. Manage the stimulation in the room
    - Adjust lighting and volume to maintain a calm environment
2. Update the calendar and/or orientation board, keep the room organized
3. Keep familiar objects visible to the patient, reorient the patient to them if they get confused
4. Ensure patient wears the appropriate specialty items:
    - double-sided anti slip socks if at risk for falls
    - facility-designated security tag if at risk for elopement
    - facility-designated colored scrubs if at risk for falls
5. If you think you should inform the nurse, inform the nurse
6. **If you find yourself in a situation where you feel unsafe or if the patient is in imminent danger of harm, notify other caregivers by calling for help.**
    - **Don't take the time to use the call bell**

3

Therapeutic Communication

Be an active listener.

- Face the speaker and make eye contact
- Nod your head
- Keep your hands and feet still
- Focus on what is being said
- Don't interrupt
- Ignore distractions
- Ask open ended questions:
    - *"Tell me about your day."* instead of, *"How was your day?"*
- Use short sentences and repetition
- Help the patient by writing things down
- Speak slowly and clearly
    - Avoid elderspeak – e.g. overly endearing terms (*sweetie, honey*), using the collective "we" (*"And how are we today?"*), using child-like language (*"Do you need to use the potty?"*)
- Allow the patient time to think and answer

- Do not say, "*I understand how you feel*" instead say something like, *"It sounds like you have a lot hard stuff going on right now. I'm really glad that you are here."*

4

Thought Process Alteration

Commonly, patients who require constant observation are going to present with some sort of thought process alteration.

Common Causes	Signs and Symptoms
• Dementia • Delirium • Head injury • Medication overdose • Some psychiatric conditions • Withdrawal from alcohol and other substances	• Confusion and memory problems • Impulsivity • Disorganization • Moodiness • Aggressive or combative behavior • Hallucinations (talking to unseen others, seeing things that are not there) • Suspicion • Physical restlessness • Change in sleep pattern • Physical complaints

5

What might I say to a patient who is expressing discomfort or unease?

- *"You're in a safe place."*
- *"We are here to help you."*
- *"I can get someone to help you with that."*

Don't challenge perceptual disturbance. If someone is convinced that they are at home, there is no need argue with them.

6

Not sure what to say? Try using the 4 RE's.

1. **Re**assure: "I am here to help you"
2. **Re**orient: "You are in a safe place"
3. **Re**direct: "That is your IV, stop pulling at it"
4. **Re**peat: "You are safe"

Use of Trauma Informed Care

Trauma refers to *"a single event, multiple events or a set of circumstances that is experienced by an individual as* ***physically and emotionally harmful or threatening****..."*

Substance Abuse and Mental Health Services Administration, 2014

Trauma informed care seeks to realize the widespread impact of trauma and actively avoid re-traumatization.

Universal Practices for Trauma

- Introduce yourself by name, role, and length of relationship ("I will be here until 7:30pm")
- Always seek permission before physical touch
- Offer support at the first sign of distress
- Identify sources of distress exhibited through anxiety, agitation, hostility, and aggression
- Use de-escalation strategies and report observations to nurse early
- Offer choices – no power struggles, no arguing.
- Assist patients in communicating their needs most effectively by asking open ended questions
- Help patients identify and label what they might be thinking (e.g., *"many people are frustrated when..., overwhelmed by..., surprised when...")*

Do not ask, ***"what is wrong with the patient?"*** *Instead, ask* ***"what has happened to the patient?"***

9

Trauma may overwhelm a person's ability to cope.

Experiences that the patient has with you can **activate** sensation(s) or memories of trauma, leading to one or more of the following responses:

- Fight *(becoming angry)*
- Flight *(elopement, wandering)*
- Freeze *(not talking, closed body language, not able to act)*

10

Anger is one possible response, and is only the tip of the iceberg.

Click image to enlarge.

Key Point: Unmet emotional and physical needs are often at the root of the anger.

11

Reportable Observations: What are you looking for?

Changes in the patient's condition, mood, or activity level can be used as a signal to meet a need.

- Physical restlessness
- Change in vital signs
- Changes in how talkative or quiet someone becomes
- Comments regarding self-harm or suicide.
- Any self-harm or suicidal actions made by the patient
- Any other concerning observations you make regarding the patient or the care environment

Click through and review the slides above to continue.

Keeping Yourself Safe

Identifying When There is Increased Risk of Violence

We are committed to providing a safe and secure workplace.

At Providence we assess a patient's risk for violence so that we know how to better care for them while also keeping ourselves safe. We can do this best by knowing:

- Triggers for dangerous behavior
- Warning signs for dangerous behavior
- Tips and tricks for caring for the patient safely
- How to get help when you need it

Providence provides support and resources so you can feel confident and stay safe when caring for a patient who is at higher risk for violence.

Thumbnail

Complete the activity above to continue.

Communicating Concerns

Clinical Violence Alert and Epic Risk for Violence FYI Flag

Click image to enlarge.

Ensure you know and follow the communication methods in your facility that identify patients who pose a potential risk for violence. Connect with your core leader to determine your unit's visual cues

about patients' risk for violence.

Navigation Reminder: After clicking on the link, be sure to minimize the new window (do not close it) to return to this course. This will allow you to continue and complete the course. Closing the window may prevent the course from progressing.

For more information see Epic Learning - Risk for Violence

CONTINUE

Managing Elopement Risk

Report to the assigned nurse or charge nurse immediately if your patient is making statements about leaving the hospital.

- The care team will work to understand and address underlying causes of distress
- This is often a very dynamic experience
    - Expect that it will take some time and effort to help the patient feel comfortable about staying in the hospital

If the patient makes any movement to exit the room alert department staff by calling for help according to your facility's protocol.

You are not a human shield. If someone is insistent on leaving, do not block the doorway.

- Alert staff immediately and observe which direction the patient is heading
- Security will be called to help return the patient to the unit

Escalated Situations

Sometimes behavioral emergencies happen, when the patient poses an immediate danger to themself or others.

As the Constant Observer, when you observe an escalated situation, you need to call for help from a team that is trained to respond to behavioral emergencies.

Use your facility's process to call for help from the team trained to respond to behavioral emergencies.

- For example, some facilities call this a Code Gray, some facilities call this a Combative Person Code.

If the behavioral emergency response team has been called for your patient, and you have been trained as a team member, you may participate in the response. If you have not been trained to participate, stay available but out of the way.

CUS Conversation

How to make sure your concern is heard.

- Have you ever tried to have a conversation with one of your peers, colleagues, or leaders and not felt heard?
- High Reliability Organization (HRO) scripted CUS language ensures that our concern gets heard:
  - "I'm concerned..."
  - "I'm uncomfortable..."
  - "Stop. I don't think you are hearing me."

CONTINUE

Knowledge Checks

Test your knowledge of Constant Observation!

Answer each question below to continue to the course conclusion.

The role of the Constant Observer is *(select all that apply)*:

- [ ] Move between two rooms on a set schedule to provide observation at least every 15 minutes
- [ ] Always protect the patient by vigilant eyes-on observation
- [ ] Maintain unobstructed observation of patient while toileting
- [ ] Know what to watch for and what to report to the patient's nurse
- [ ] Report any concerns or odd behaviors to the patient's nurse

- [ ] If assigned to multiple patients, the Constant Observer may enter a room to assist one of the patients and leave the others unmonitored, as long as it is for a limited amount of time

SUBMIT

What is ***not*** appropriate for the Constant Observer to do *(select all that apply)?*

- [ ] Read a book to yourself
- [ ] Watch TV
- [ ] Sleep
- [ ] Use your personal phone
- [ ] Play cards with the patient, if helpful
- [ ] Read to the patient, if helpful

SUBMIT

When you are assigned to be a Constant Observer, you know that the patient *(select all that apply):*

- [ ] Is bored and needs entertainment
- [ ] Can't be placed in restraints
- [ ] Is unsafe being left alone
- [ ] Needs constant supervision because other interventions have not been successful to keep them safe

SUBMIT

Effective Communication with patients needing Constant Observation includes *(select all that apply):*

- [ ] Face the patient
- [ ] Nod your head when the patient is speaking
- [ ] Don't interrupt the patient
- [ ] Ask open-ended questions

SUBMIT

When working with patients who are disoriented, it is helpful to employ the 4 REs. Which of these are the 4 RE's? *(Select all that apply.)*

- [ ] Reassure

- [ ] Reorient
- [ ] Redirect
- [ ] Repeat
- [ ] Ramble about your favorite hobby
- [ ] Ridicule the patient's behavior
- [ ] Radiate a sense of calm

SUBMIT

What are elements of Trauma Informed Care? *(Select all that apply.)*

- [ ] Seek permission before physical touch

- [ ] Offer choices
- [ ] Observe and offer support at the first sign of distress
- [ ] Create strict rules
- [ ] Tell the patient they have problems

SUBMIT

What things should you as the Constant Observer report to the patient's nurse? *(Select all that apply.)*

- [ ] Specific behaviors the nurse tells you to report
- [ ] Increased respiratory (breathing) rate
- [ ] Change in affect (experience or display of emotions) For example, if the normally talkative patient becomes quiet or if the normally quiet patient

- [ ] becomes very talkative
- [ ] Restlessness
- [ ] Statements about self-harm or suicide
- [ ] Statements about plans to leave the hospital (for example, *"I've gotta get out of here"*)
- [ ] Behaviors that cause self-harm

SUBMIT

If you need ***immediate*** help (because you feel endangered, or the patient is unsafe) get help by:

- ○ Pushing the CODE button on the wall
- ○ Using Vocera, cell phone, or other device (as available in your facility) to call the patient's nurse

- ◯ Using the Nurse Call button to get help
- ◯ Alert peers by yelling for help loud enough for caregivers to hear in the hallway

SUBMIT

When you observe angry behavior by the patient *(select all that apply):*

- ☐ You should tell them to stop
- ☐ Alert peers by yelling for help loud enough for caregivers to hear in the hallway
- ☐ You should include this in your regular report to the nurse
- ☐ You can say to the patient *"I notice you are speaking loudly, are you frustrated?"*

- [ ] You can say to the patient *"How can I help?"*
- [ ] You should ensure you are physically safe

SUBMIT

Ways to ensure your physical safety when in a patient room include *(select all that apply):*

- [ ] Position yourself to maintain clear access to the exit/door
- [ ] Remove items that can be used for harm (for example: pens, scissors, cords, etc.)
- [ ] Offer to help the patient or get help to address their concerns
- [ ] Alert peers by yelling for help loud enough for caregivers to hear in the hallway

SUBMIT

Answer the knowledge check questions above to continue.

Policy Review and Conclusion

Review the PSJH-CLIN-1219 Constant Observer policy by clicking the link below.

Navigation Reminder: After clicking on the link, be sure to minimize the new window (do not close it) to return to this course. This will allow you to continue and complete the course. Closing the window may prevent the course from progressing.

https://phs-phs.policystat.com/policy/17897608/latest/

☐ By clicking the box to the left, I attest that I have reviewed the PSJH-CLIN-1219 Constant Observer policy linked above.

Complete the content above before moving on.

Congratulations! You have completed the *Constant Observation* module.

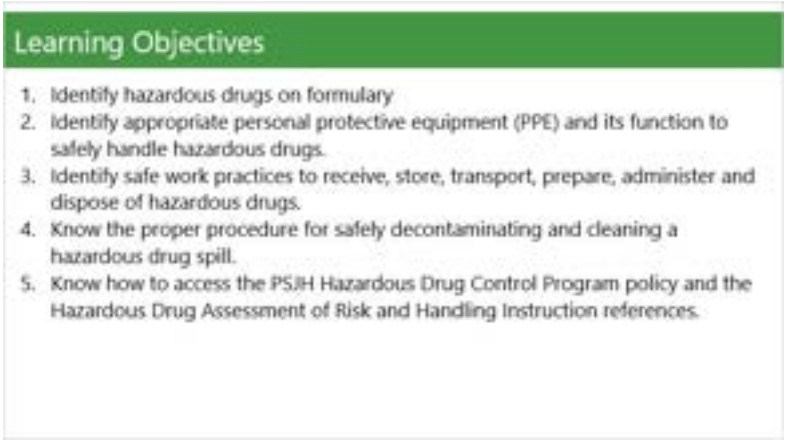
Click 'Exit Course' above to close this window.

Hazardous Drug Control Program - Nursing

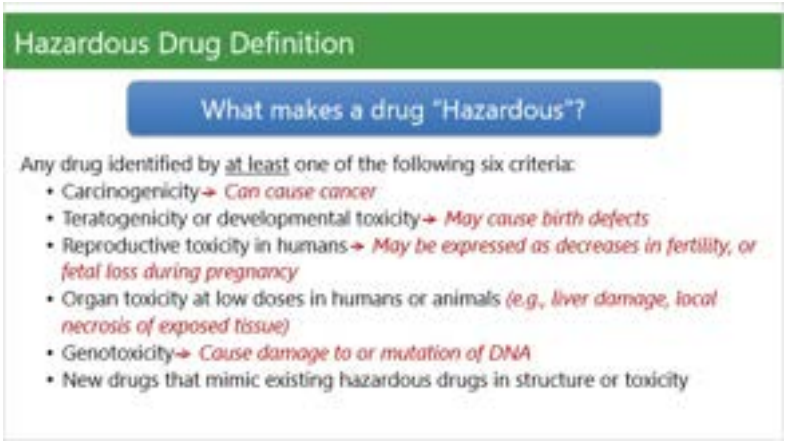
1. Untitled Scene

1.1 Untitled Slide

1.2 Untitled Slide

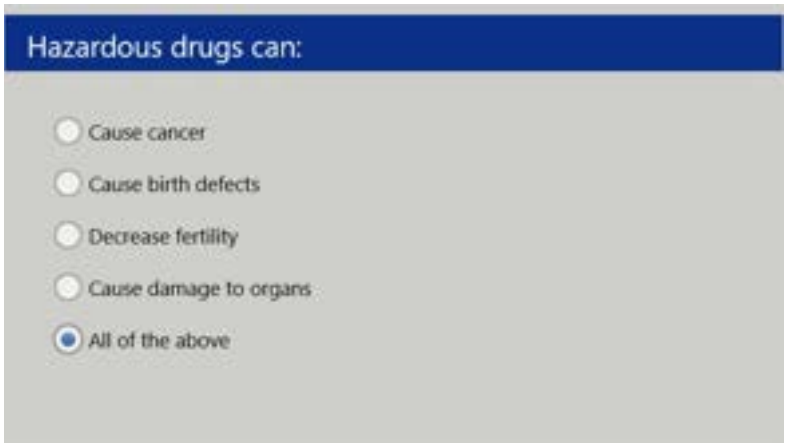


1.3 Untitled Slide



1.4 Hazardous drugs can:

(Multiple Choice, 10 points, 1 attempt permitted)



Correct	Choice
	Cause cancer
	Cause birth defects
	Decrease fertility
	Cause damage to organs
X	All of the above

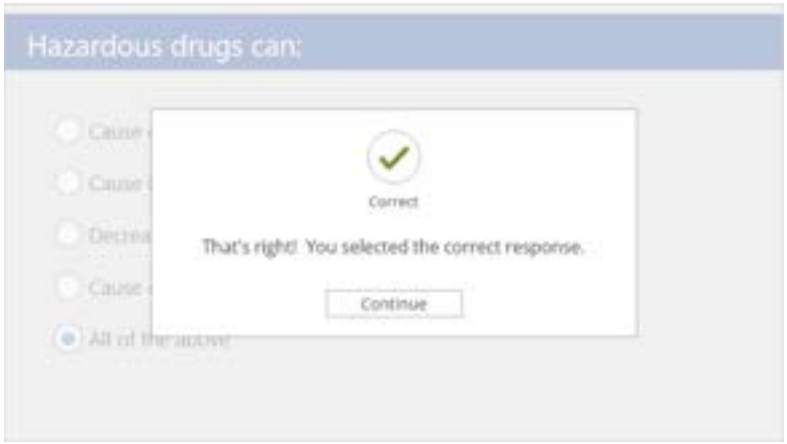
Feedback when correct:

That's right! You selected the correct response.

Feedback when incorrect:

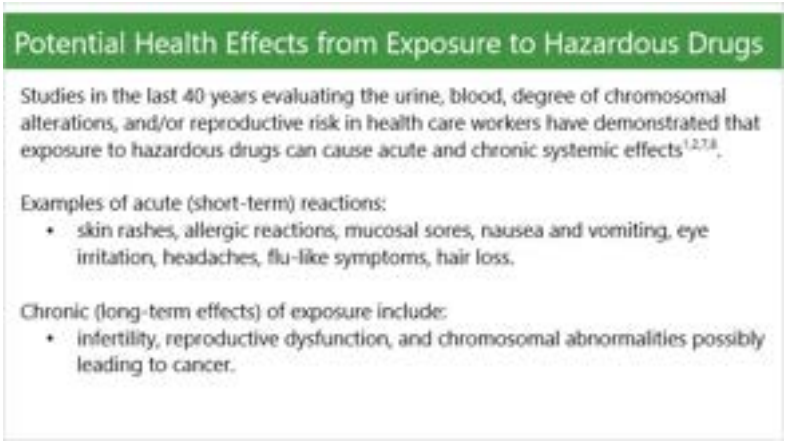
All of the answers are correct.

Correct (Slide Layer)

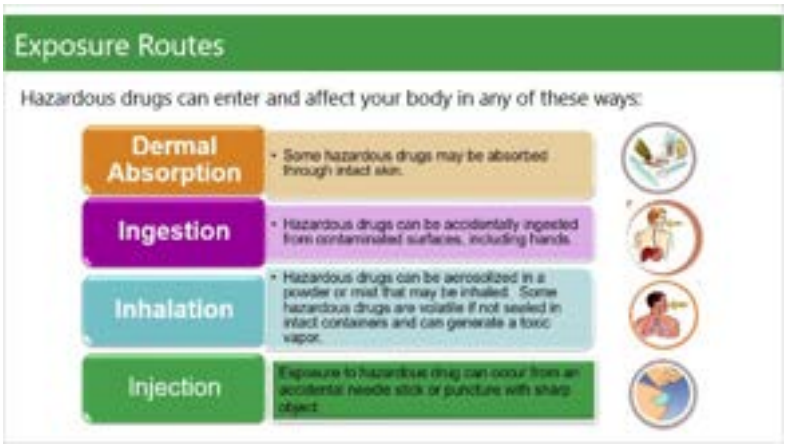


Incorrect (Slide Layer)

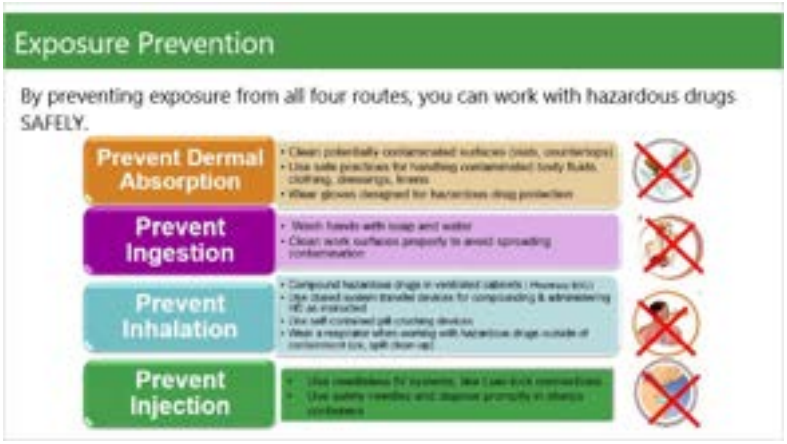
1.5 Untitled Slide



1.6 Untitled Slide

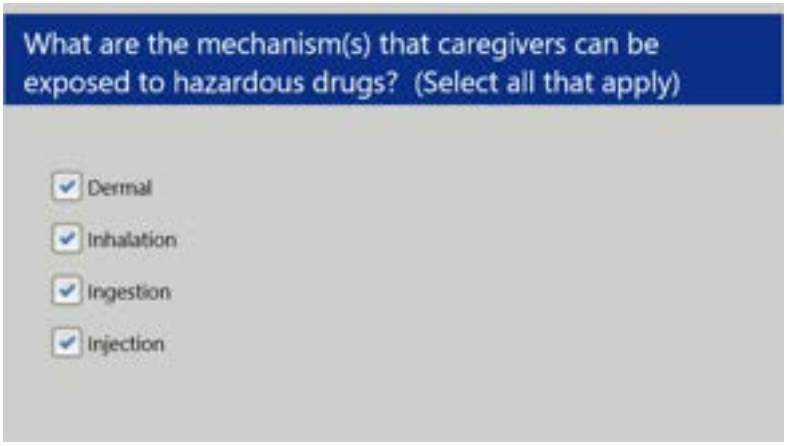


1.7 Untitled Slide



1.8 What are the mechanism(s) that caregivers can be exposed to hazardous drugs? (Select all that apply)

(Multiple Response, 10 points, 1 attempt permitted)



Correct	Choice
X	Dermal
X	Inhalation
X	Ingestion
X	Injection

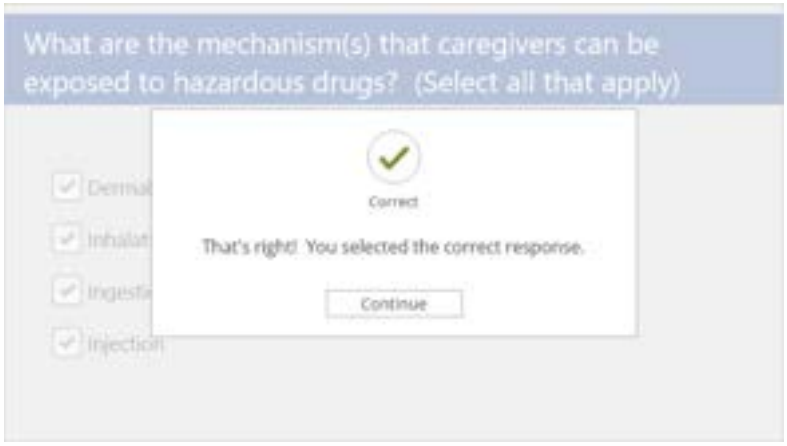
Feedback when correct:

That's right! You selected the correct response.

Feedback when incorrect:

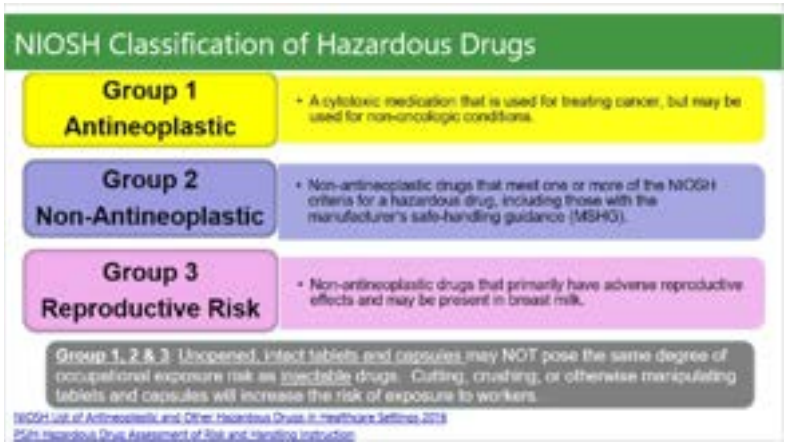
All of the answers are correct.

Correct (Slide Layer)



Incorrect (Slide Layer)

1.9 Untitled Slide



1.10 Untitled Slide

Group 1 (Slide Layer)

Group 2 (Slide Layer)

Group 3 (Slide Layer)

1.11 Which of the following are considered hazardous based on NIOSH criteria? (Select all that apply)

(Multiple Response, 10 points, 1 attempt permitted)

Correct	Choice
X	Azathioprine
X	Capecitabine
X	Oxytocin
X	Valganciclovir

X	Warfarin

Feedback when correct:

That's right! You selected the correct response.

Feedback when incorrect:

All of the answers are correct.

Correct (Slide Layer)

Incorrect (Slide Layer)

1.12 Untitled Slide

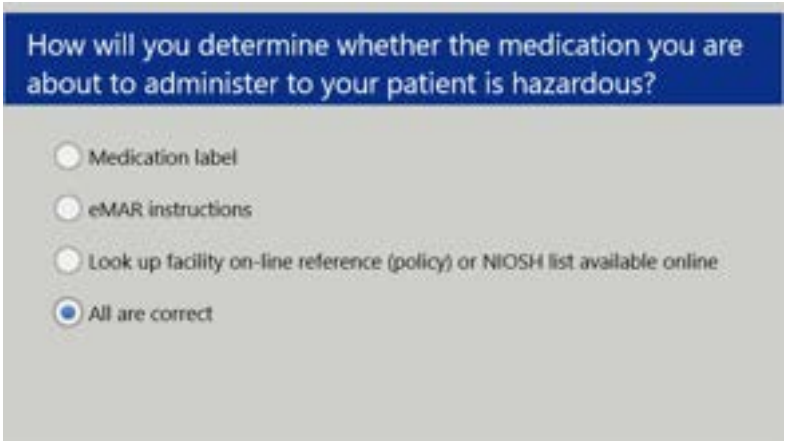
1.13 Untitled Slide

1.14 Untitled Slide

1.15 Untitled Slide

1.16 How will you determine whether the medication you are about to administer to your patient is hazardous?

(Multiple Choice, 10 points, 1 attempt permitted)



Correct	Choice
	Medication label
	eMAR instructions
	Look up facility on-line reference (policy) or NIOSH list available online
X	All are correct

Feedback when correct:

That's right! You selected the correct response.

Feedback when incorrect:

All of the responses are correct.

Correct (Slide Layer)

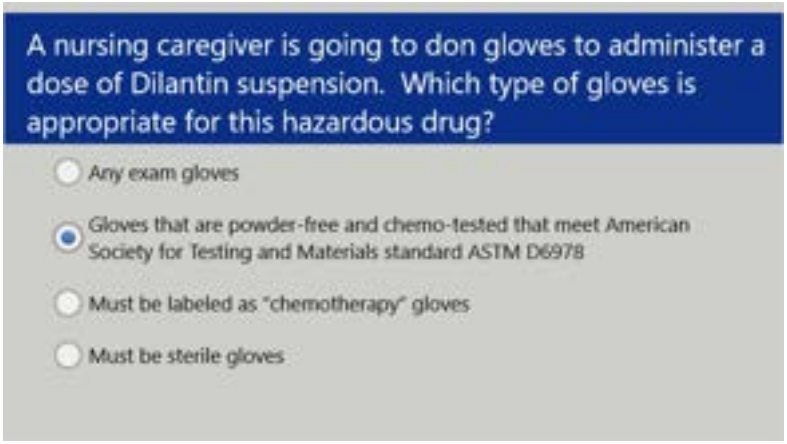
Incorrect (Slide Layer)

1.17 Untitled Slide

1.18 Untitled Slide

1.19 A nursing caregiver is going to don gloves to administer a dose of Dilantin suspension. Which type of gloves is appropriate for this hazardous drug?

(Multiple Choice, 10 points, 1 attempt permitted)



Correct	Choice
	Any exam gloves
X	Gloves that are powder-free and chemo-tested that meet American Society for Testing and Materials standard ASTM D6978
	Must be labeled as “chemotherapy” gloves
	Must be sterile gloves

Feedback when correct:

That's right! You selected the correct response.

Feedback when incorrect:

The correct response is Gloves that are powder-free and chemo-tested that meet American Society for Testing and Materials standard ASTM D6978.

Correct (Slide Layer)

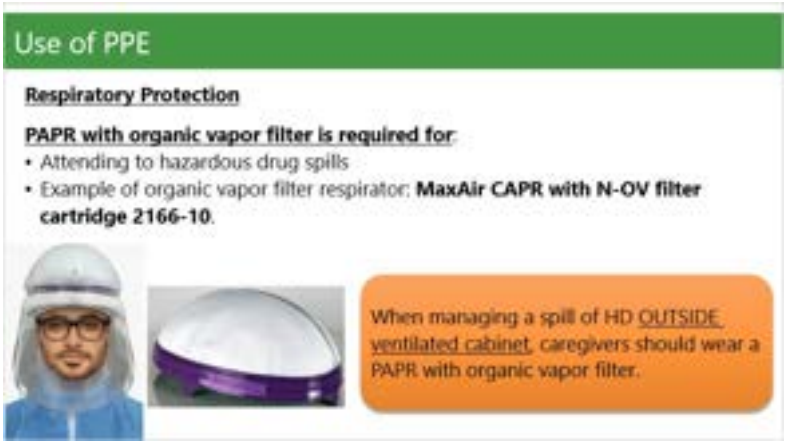
Incorrect (Slide Layer)

1.20 Untitled Slide

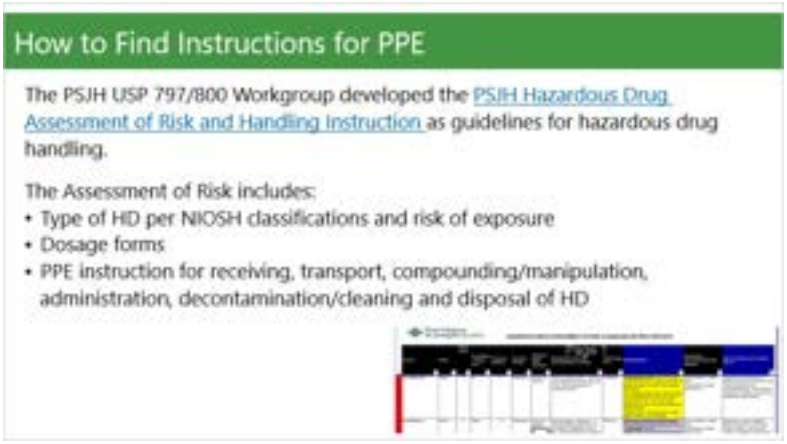
1.21 Untitled Slide

1.22 Untitled Slide

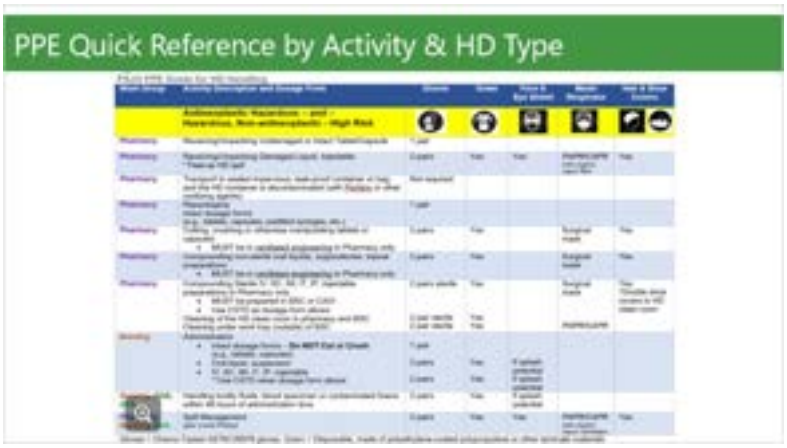
1.23 Untitled Slide



1.24 Untitled Slide

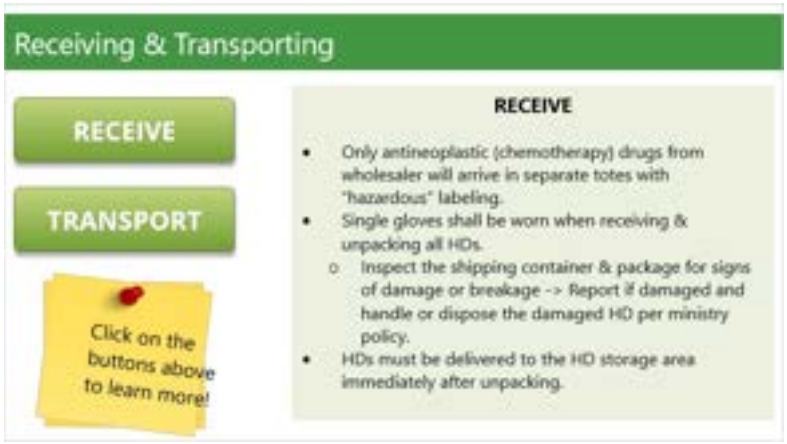


1.25 Untitled Slide



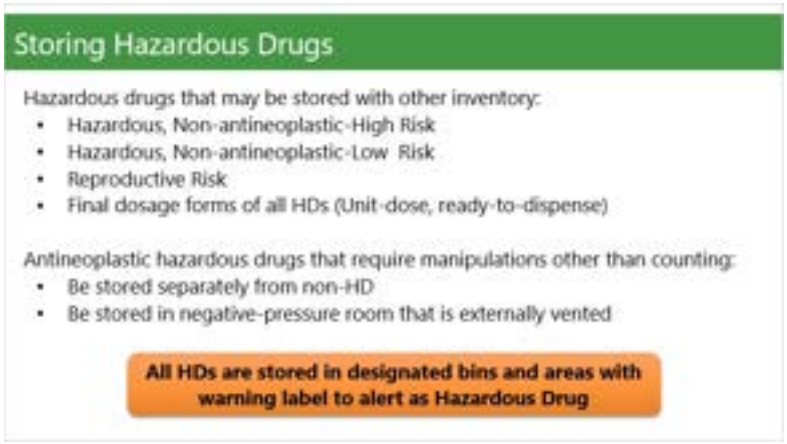
1.26 Untitled Slide

Receive (Slide Layer)

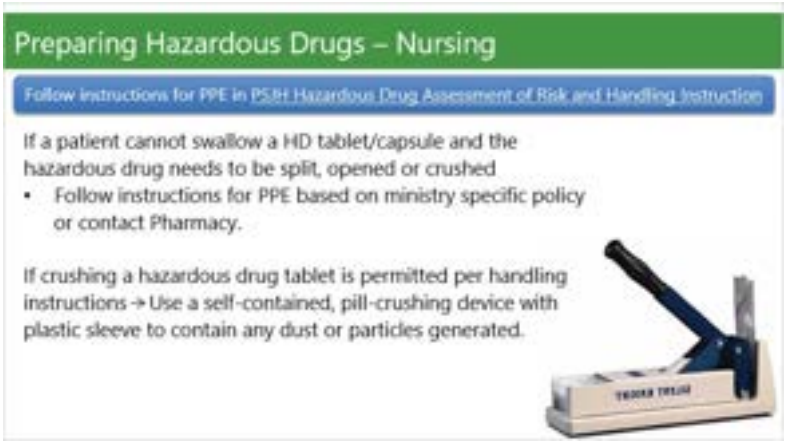


Transport (Slide Layer)

1.27 Untitled Slide

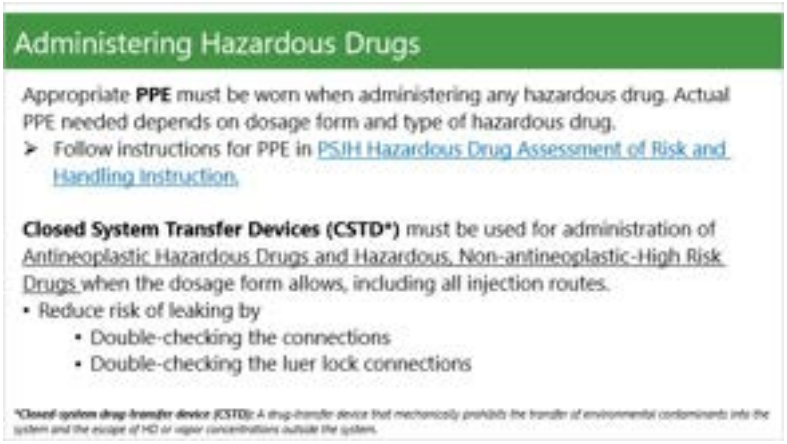


1.28 Untitled Slide



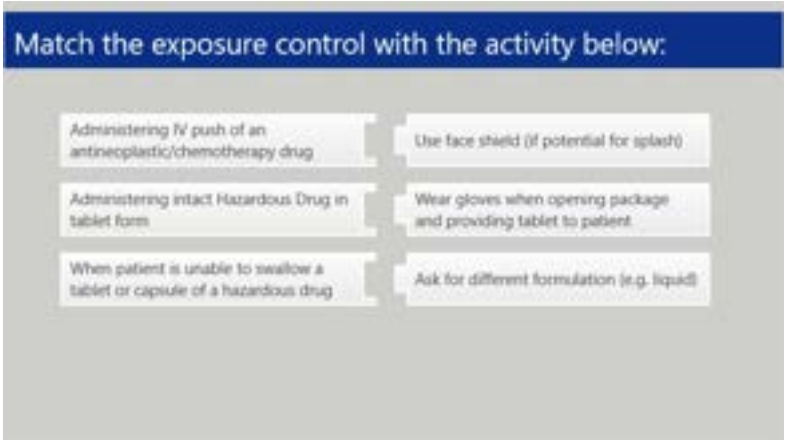
1.29 Untitled Slide

1.30 Untitled Slide



1.31 Match the exposure control with the activity below:

(Matching Drag-and-Drop, 10 points, 3 attempts permitted)



Correct	Choice
Administering IV push of an antineoplastic/chemotherapy drug	Use face shield (if potential for splash)
Administering intact Hazardous Drug in tablet form	Wear gloves when opening package and providing tablet to patient
When patient is unable to swallow a tablet or capsule of a hazardous drug	Ask for different formulation (e.g. liquid)

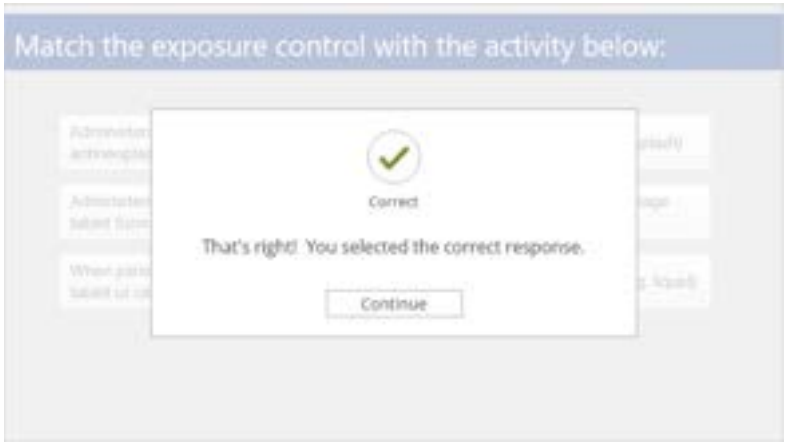
Feedback when correct:

That's right! You selected the correct response.

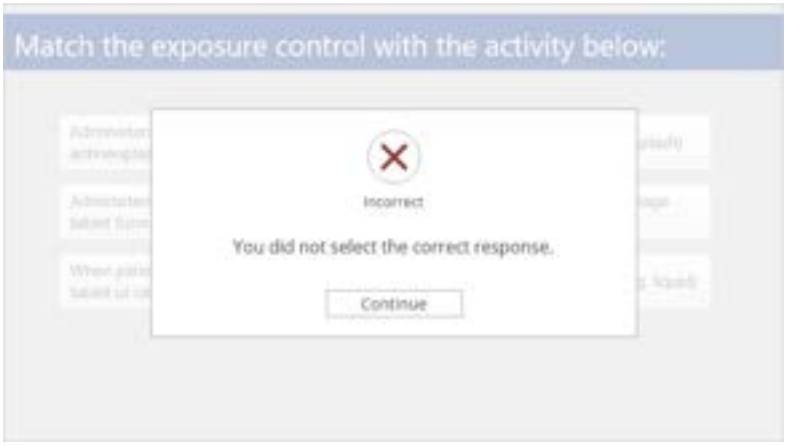
Feedback when incorrect:

You did not select the correct response.

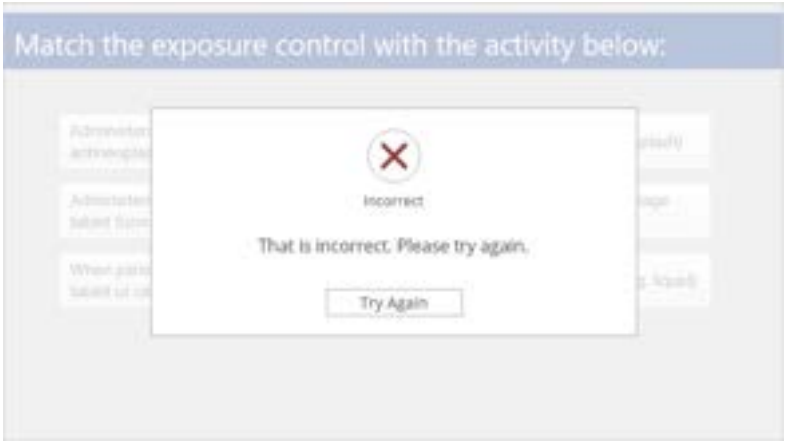
Correct (Slide Layer)



Incorrect (Slide Layer)



Try Again (Slide Layer)

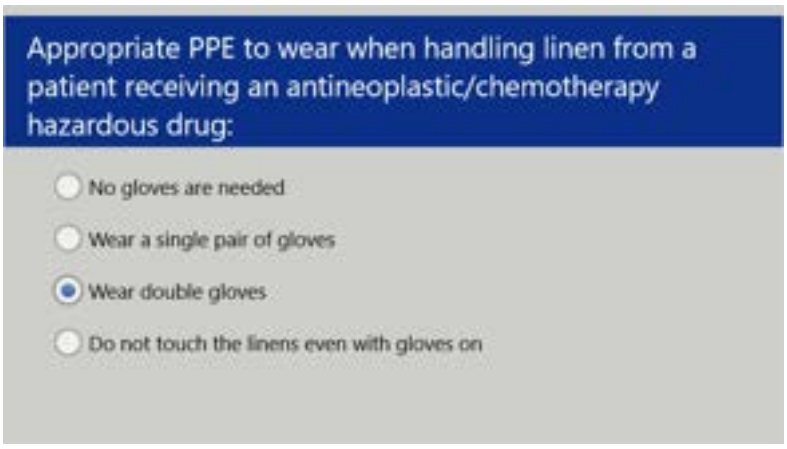


1.32 Untitled Slide

1.33 Untitled Slide

1.34 Appropriate PPE to wear when handling linen from a patient receiving an antineoplastic/chemotherapy hazardous drug:

(Multiple Choice, 10 points, 1 attempt permitted)



Correct	Choice
	No gloves are needed
	Wear a single pair of gloves
X	Wear double gloves
	Do not touch the linens even with gloves on

Feedback when correct:

That's right! You selected the correct response.

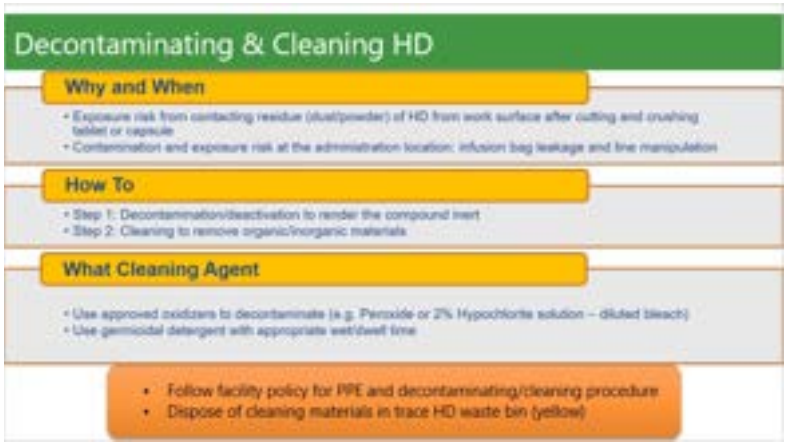
Feedback when incorrect:

The correct response is Wear double gloves.

Correct (Slide Layer)

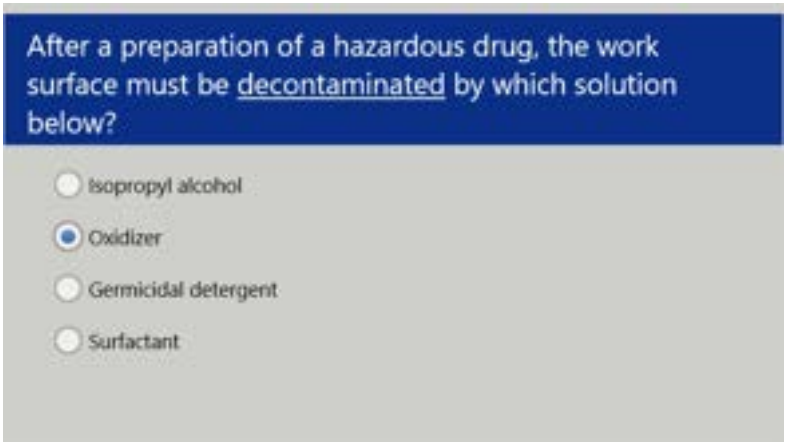
Incorrect (Slide Layer)

1.35 Untitled Slide



1.36 After a preparation of a hazardous drug, the work surface must be decontaminated by which solution below?

(Multiple Choice, 10 points, 1 attempt permitted)



Correct	Choice
	Isopropyl alcohol
X	Oxidizer
	Germicidal detergent
	Surfactant

Feedback when correct:

That's right! You selected the correct response.

Feedback when incorrect:

The correct response is Oxidizer.

Correct (Slide Layer)

Incorrect (Slide Layer)

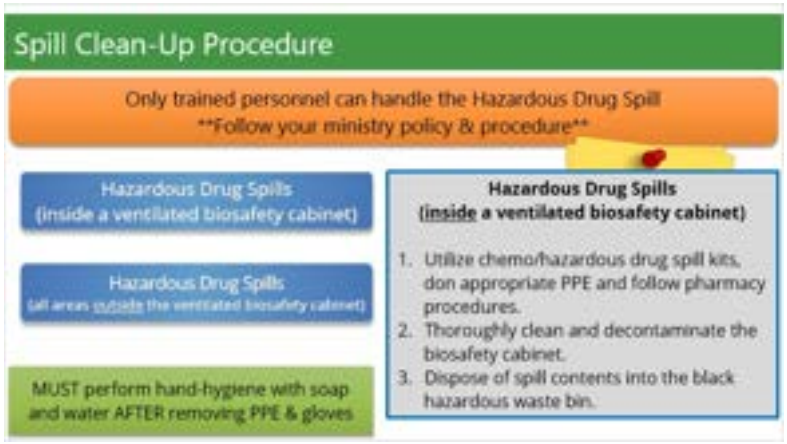
1.37 Untitled Slide

1.38 Untitled Slide

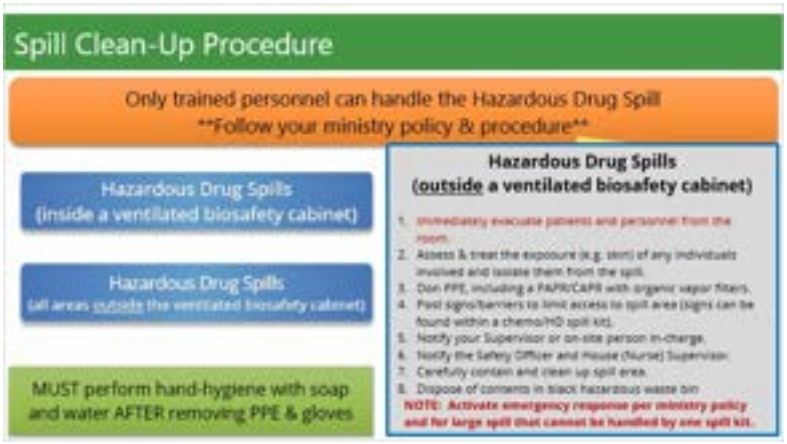
1.39 Untitled Slide

1.40 Untitled Slide

inside (Slide Layer)

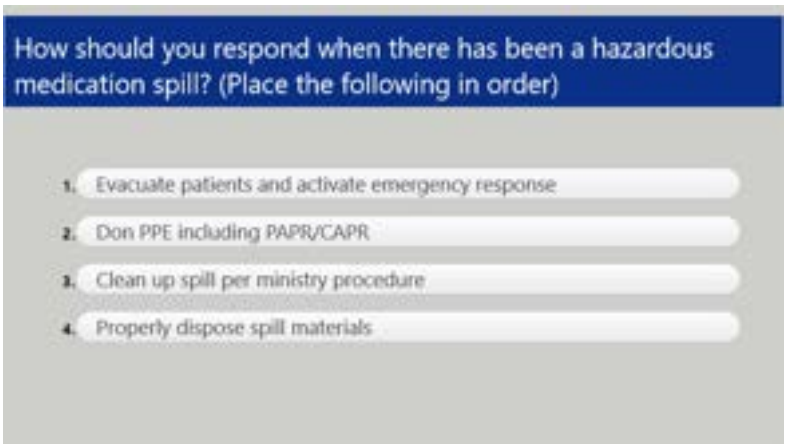


outside (Slide Layer)



1.41 How should you respond when there has been a hazardous medication spill? (Place the following in order)

(Sequence Drag-and-Drop, 10 points, 3 attempts permitted)



Correct Order
Evacuate patients and activate emergency response
Don PPE including PAPR/CAPR
Clean up spill per ministry procedure
Properly dispose spill materials

Feedback when correct:

That's right! You selected the correct response.

Feedback when incorrect:

You did not select the correct response.

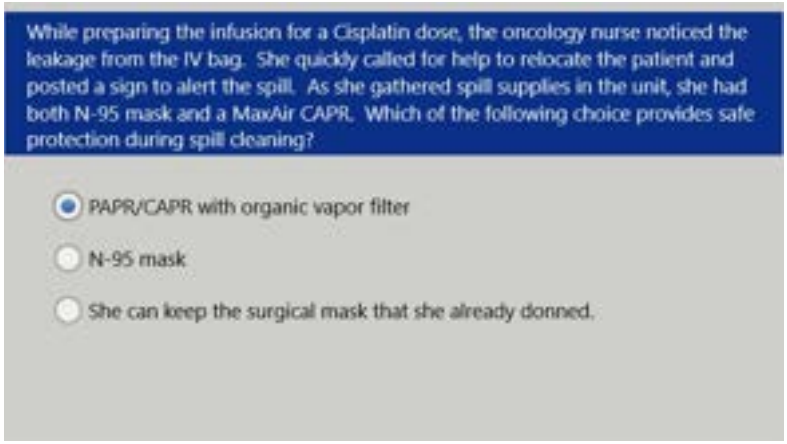
Correct (Slide Layer)

Incorrect (Slide Layer)

Try Again (Slide Layer)

1.42 While preparing the infusion for a Cisplatin dose, the oncology nurse noticed the leakage from the IV bag. She quickly called for help to relocate the patient and posted a sign to alert the spill. As she gathered spill supplies in the unit, she had both N-95 mask and a MaxAir CAPR. Which of the following choice provides safe protection during spill cleaning?

(Multiple Choice, 10 points, 1 attempt permitted)



Correct	Choice
X	PAPR/CAPR with organic vapor filter
	N-95 mask
	She can keep the surgical mask that she already donned.

Feedback when correct:

That's right! You selected the correct response.

Feedback when incorrect:

The correct response is PAPR/CAPR with organic vapor filter.

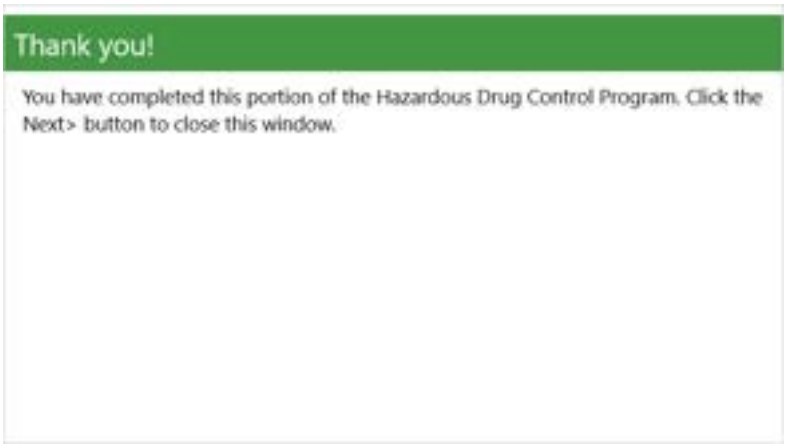
Correct (Slide Layer)

Incorrect (Slide Layer)

1.43 Untitled Slide

1.44 Untitled Slide

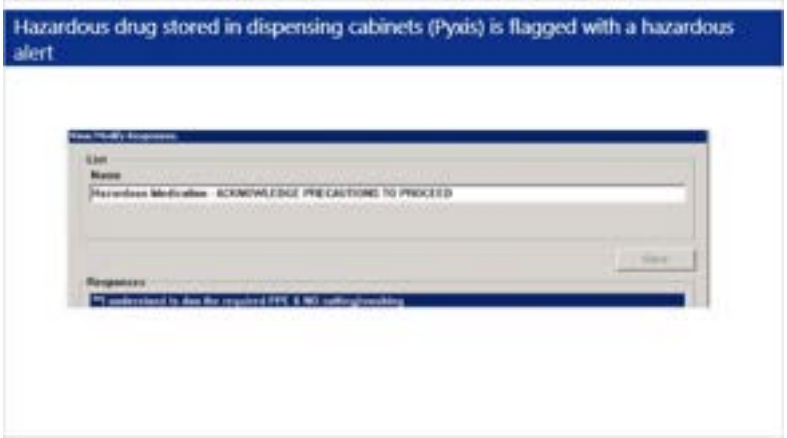
1.45 Untitled Slide



2. Lightboxes

2.1 Warning Label

2.2 Pyxis



3. Waste bins

3.1 Blue

3.2 Yellow

3.3 Black

4. Untitled Scene

4.1 Untitled Slide

High Consequence Infectious Diseases

Providence St. Joseph Health

This module is specific to Ebola Virus Disease. However, much of this information is pertinent for other High Consequence Highly Contagious Infectious Diseases.

- **Objectives**
- **Think Ebola: Early recognition is critical for infection control**
- **Background**
- **Identify**
- **Isolate**
- **Inform**
- **EVD Care Team Model**
- **Next Steps**

Objectives

This module is specific to Ebola Virus Disease. However, much of this information is pertinent for other High Consequence Highly Contagious Infectious Diseases.

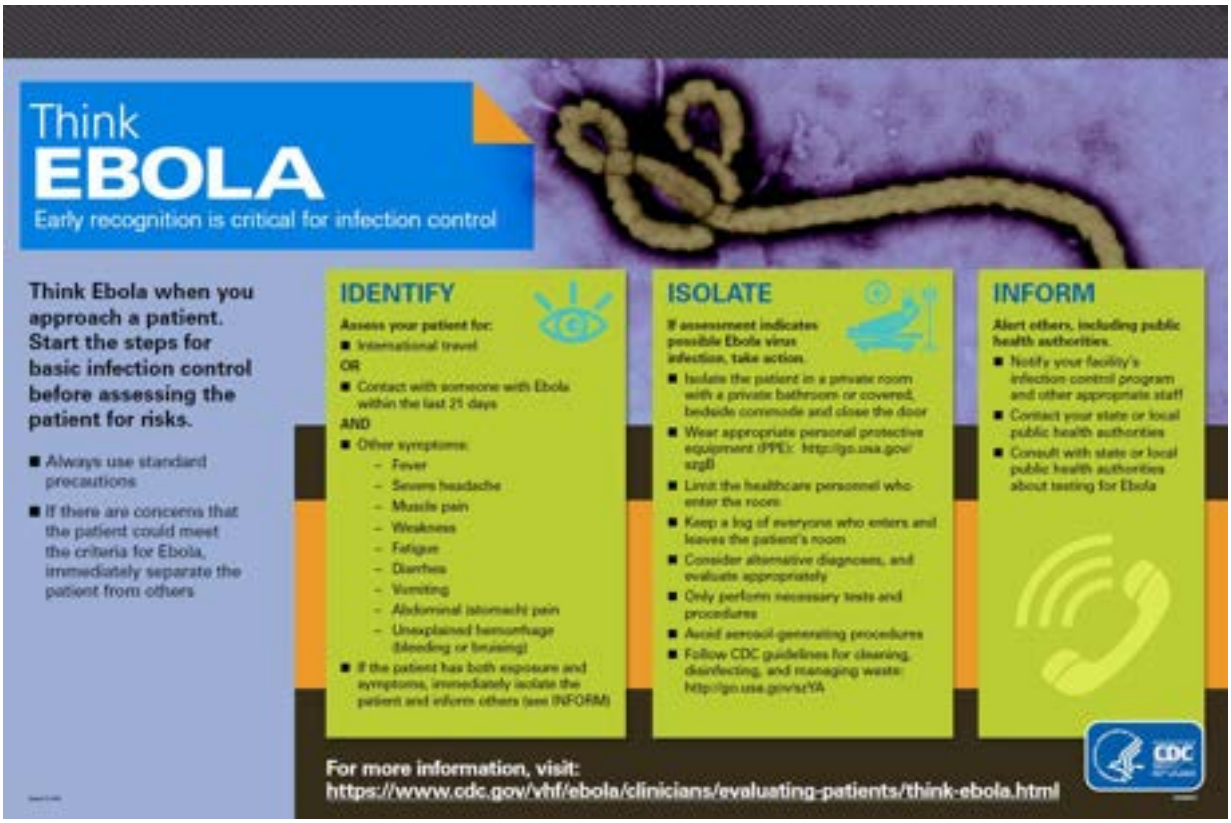
When you complete this course you will be able to:

1. Describe the main components of the Identify, Isolate, and Inform framework.
2. Define roles in safely caring for a patient with a highly infectious disease.
3. Describe processes in place to protect caregivers when caring for a patient with a highly infectious disease.

This course is intended to be a part of a comprehensive curriculum. It will be used in conjunction with a hands-on training, including ministry-specific information.

CONTINUE

Think Ebola: Early recognition is critical for infection control



For more information visit the CDC website.

CONTINUE

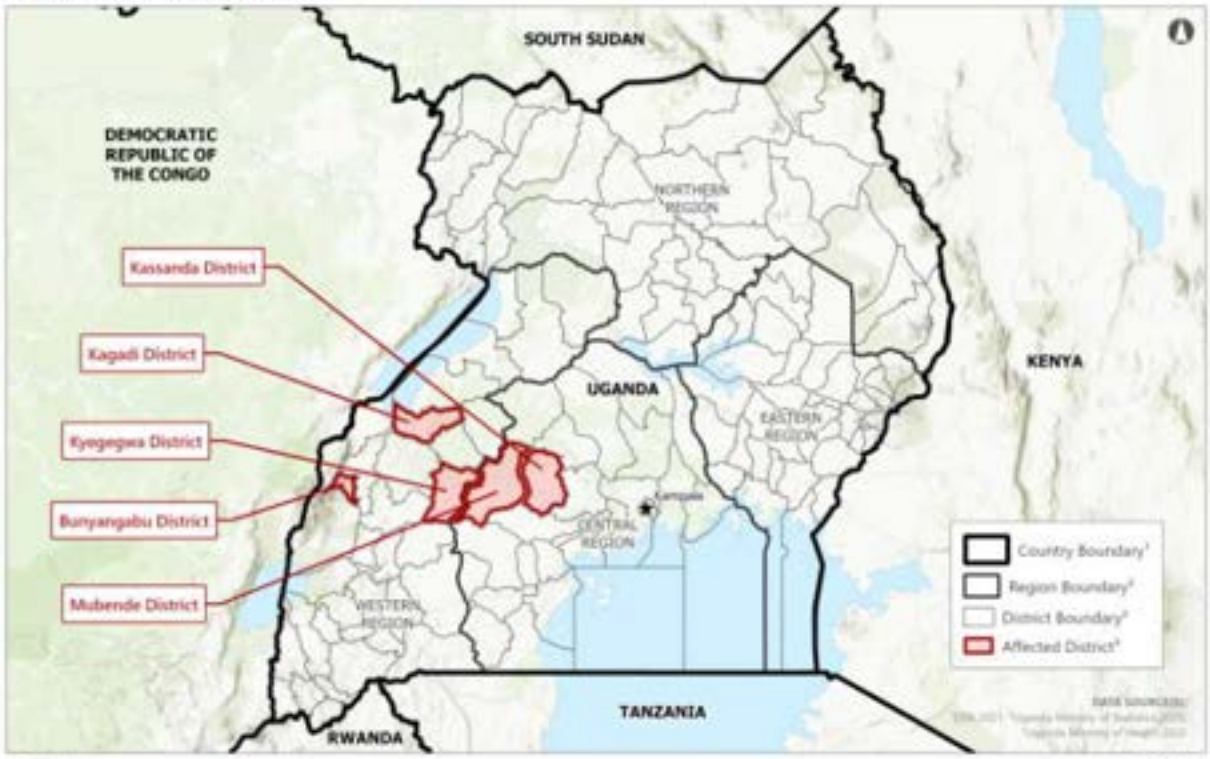
Background

Current Outbreak - Sudan ebolavirus

September 20, 2022, health authorities in Uganda declared an outbreak affecting the western and central region of Uganda caused by Sudan ebolavirus, a type of Ebolavirus.

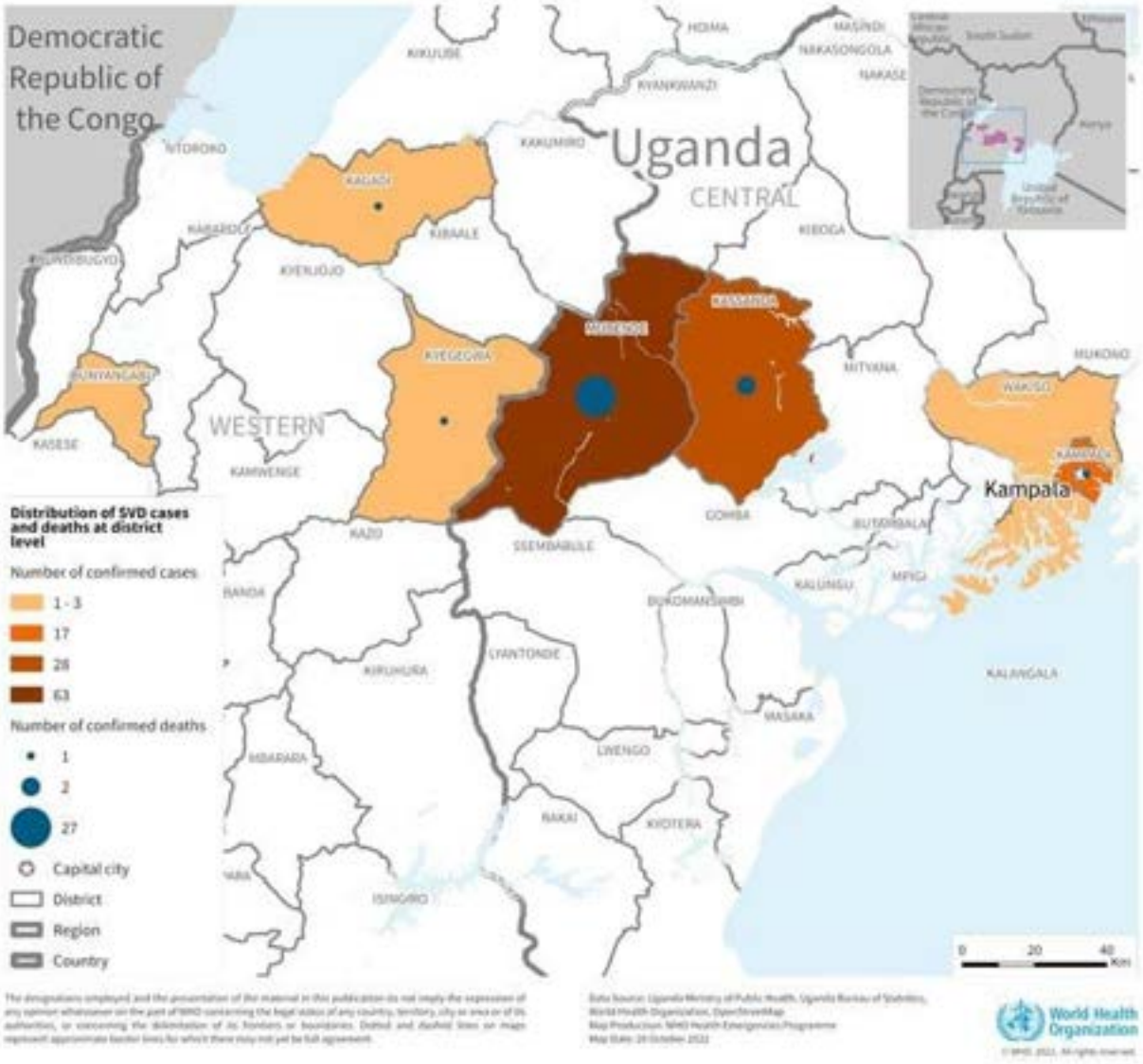
Uganda: Ebola Virus Disease Outbreak 2022

Districts Affected as of 4 Oct 2022



CDC ATSDR Centers for Disease Control and Prevention Agency for Toxic Substances and Disease Registry

Geospatial Research, Analysis, and Services Program



Ebola Virus Disease (EVD)

The incubation period is 2 to 21 days. A person infected with EVD cannot spread the disease until they develop symptoms.

Risk Factors

- Travel to an area of current active disease transmission in the past 3 weeks

- Contact with a person who has traveled to an area with active disease transmission in the past 3 weeks or recovered from active disease

Signs and Symptoms

- Severe headache
- Myalgia (muscle or body aches)
- Fever
- Weakness and fatigue
- GI symptoms
  - Nausea
  - Diarrhea
  - Abdominal pain
- Unexplained bleeding or bruising

Complete the content above before moving on.

Transmission

It takes a very small number of viral particles in contact with mucous membranes or non-intact skin for transmission to occur.

Ebolavirus can exist on surfaces for several hours or in body fluids for several days.

EVD is spread via:

- Direct contact with bodily fluids (stool, vomit, blood, urine, saliva, semen, breast milk) of a person diagnosed with EVD
- Direct contact with the deceased person's body or discharge (funeral or burial preparation or ceremonies)
- Contact with surfaces or equipment contaminated with bodily fluids of an infected person

Hospital Response: a Tiered Approach to Care

Frontline Hospitals —

- All Providence hospitals in California have been designated frontline hospitals
- Required to care for patient for up to 12-24 hours

Assessment Centers

- Required to care for patient until EVD confirmed or ruled out (up to 96 hours)

Treatment Centers

- Cedars Sinai Medical Center (California Treatment Center)
- Required to care for patient for the duration of illness

Complete the content above before moving on.

Notify Infection Prevention Department for assistance in coordinating local Public Health involvement in patient management.

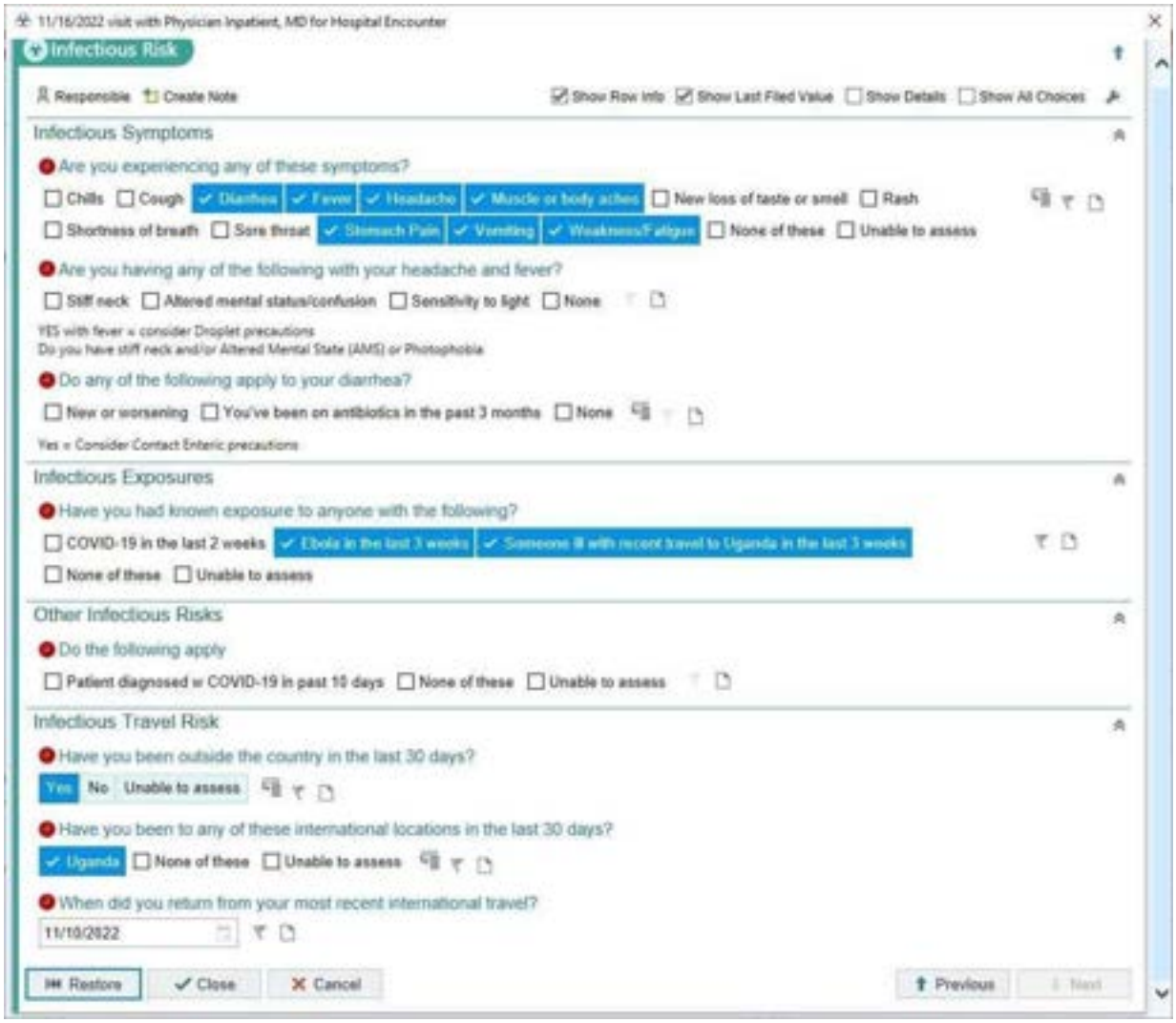
CONTINUE

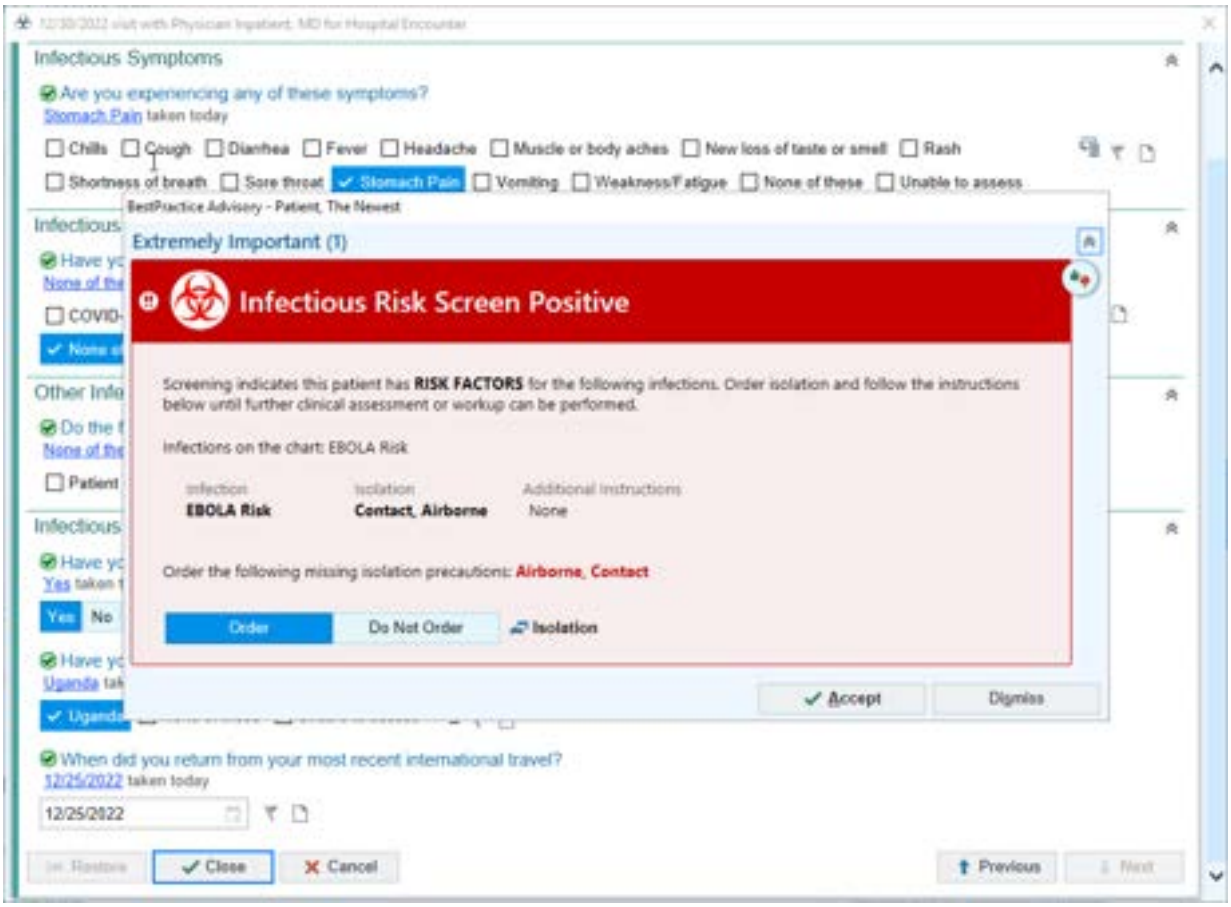
Identify

Patients are to be screened at all points of entry including:

1. Emergency Department
2. Urgent and Prompt Care
3. Labor & Delivery
4. Surgical Services
5. Other ambulatory services

EPIC Infectious Risk Screening


11/16/2022 visit with Physician Inpatient, MD for Hospital Encounter
Infectious Risk
Responsible
Create Note
Show Row Info
Show Last Filed Value
Show Details
Show All Choices
Infectious Symptoms
Are you experiencing any of these symptoms?
Chills
Cough
Diarrhea
Fever
Headache
Muscle or body aches
New loss of taste or smell
Rash
Shortness of breath
Sore throat
Stomach Pain
Vomiting
Weakness/Fatigue
None of these
Unable to assess
Are you having any of the following with your headache and fever?
Stiff neck
Altered mental status/confusion
Sensitivity to light
None
YES with fever = consider Droplet precautions
Do you have stiff neck and/or Altered Mental State (AMS) or Photophobia
Do any of the following apply to your diarrhea?
New or worsening
You've been on antibiotics in the past 3 months
None
Yes = Consider Contact Enteric precautions
Infectious Exposures
Have you had known exposure to anyone with the following?
COVID-19 in the last 2 weeks
Ebola in the last 3 weeks
Someone ill with recent travel to Uganda in the last 3 weeks
None of these
Unable to assess
Other Infectious Risks
Do the following apply
Patient diagnosed w COVID-19 in past 10 days
None of these
Unable to assess
Infectious Travel Risk
Have you been outside the country in the last 30 days?
Yes
No
Unable to assess
Have you been to any of these international locations in the last 30 days?
Uganda
None of these
Unable to assess
When did you return from your most recent international travel?
11/10/2022
Restore
Close
Cancel
Previous
Next



Epic Infectious Risk Screen Positive

CONTINUE

Isolate

Facts about Ebola
You can't get Ebola through air
You can't get Ebola through water
You can't get Ebola through food

Caregiver's greatest risk for contracting EVD is during doffing (removal) of PPE

Patient Placement

- Do not allow patients under investigation to wait in any public area.
- Place patient in Airborne Infection Isolation Room (negative pressure) or a private room with the door closed.
- Ensure patient has access to a private bathroom or bedside commode.
- Follow ministry guidelines for the best route to take to isolate the patient without exposing others.

Personal Protective Equipment

PPE that covers the clothing and skin and completely protects mucous membranes is required when caring for patients with EVD

- **Donning**
  - Must be completed in the proper order
  - PPE should NOT be modified while in the patient care area
- **During Patient Care**
  - PPE must remain in place and be worn correctly for the duration of work
  - In the event of a significant splash or breach, move to the doffing area to remove PPE as soon as it is safe to do so

- **Doffing**
    - Requires a structured procedure, a Trained Observer, a PPE Assistant, and a designated area for removal
    - Must be completed slowly and deliberately in the proper order to reduce the possibility of self-contamination

You will receive hands-on-training with your ministry-specific PPE

CONTINUE

Checklist

- A checklist for donning & doffing will be provided
- Checklist is single use

You will receive hands-on-training with the checklist

CONTINUE

Equipment & Supplies

- Verify adequate supplies & equipment are in room using the room readiness checklist
    - Do not overstock
- Use dedicated medical equipment
    - Preferably disposable
- Limit the use of unnecessary procedures involving sharps
- Avoid aerosol generating procedures, if possible, i.e., intubation

Supplies and equipment should not be moved outside of the room until cleared by Infection Prevention

CONTINUE

Visitors

- Do not allow visitor access to the patient
    - If necessary, limit the number to only those crucial for the patient's well-being and care, such as a child's parent. Consult with the local DPH for case-by-case exceptions.

- Visitors should not enter the isolation rooms/areas
- Screen visitors for signs and symptoms of EVD
    - Visitors that screen positive will become a Person Under Investigation (PUI)
    - Visitors that screen negative should be kept away from public areas as much as possible

CONTINUE

Environmental Hygiene

- Disinfecting Agent
    - EPA-registered Hospital approved disinfectant wipes on List L or List Q
    - **Bleach** is the preferred disinfectant
- Keep Environment Clean
    - Frequent cleaning and disinfection of donning & particularly doffing area
    - Cleanliness is the responsibility of the Direct CaregiverEVS will not enter the room

Cleanliness is the responsibility of the Direct Caregiver. EVS will not enter the room.

CONTINUE

Waste Management

- Only those trained to care for EVD patients may handle waste
- All waste generated from an EVD patient, **including linens**, will be classified as Category A Waste
- Category A Waste requires special handling
    - Must be triple packed
        - Primary leak-proof container (i.e., biohazard bag)
            - Wipe outside of bag with bleach
        - Secondary leak-proof container (i.e., biohazard bag)
            - Wipe outside of bag with bleach
        - Rigid leak-proof container (i.e., transport bin)
- Do not fill waste container more than half full
- Bags should be goose-neck tied
- **Do not compress waste bag to remove air!**

CONTINUE

Inform

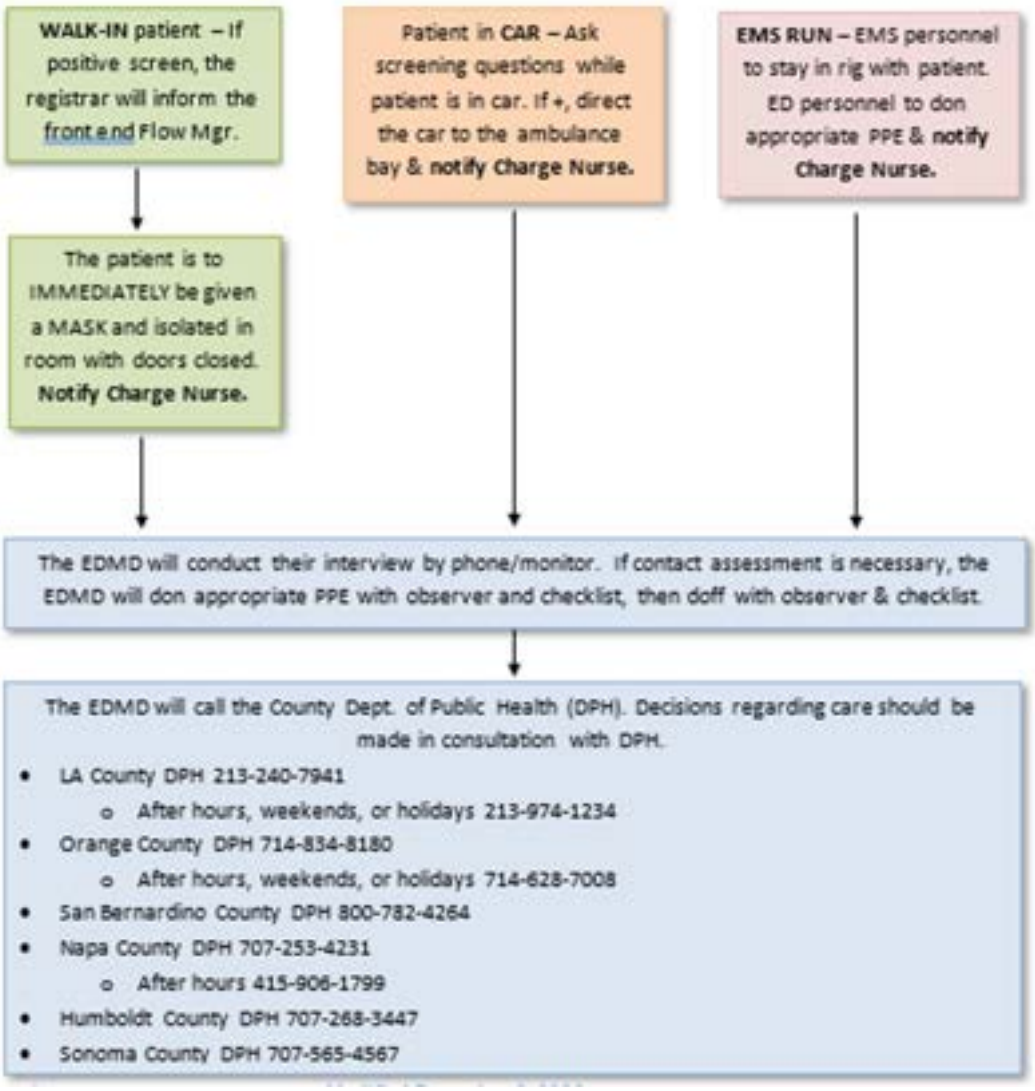
South Division Process Map for Frontline Hospitals:

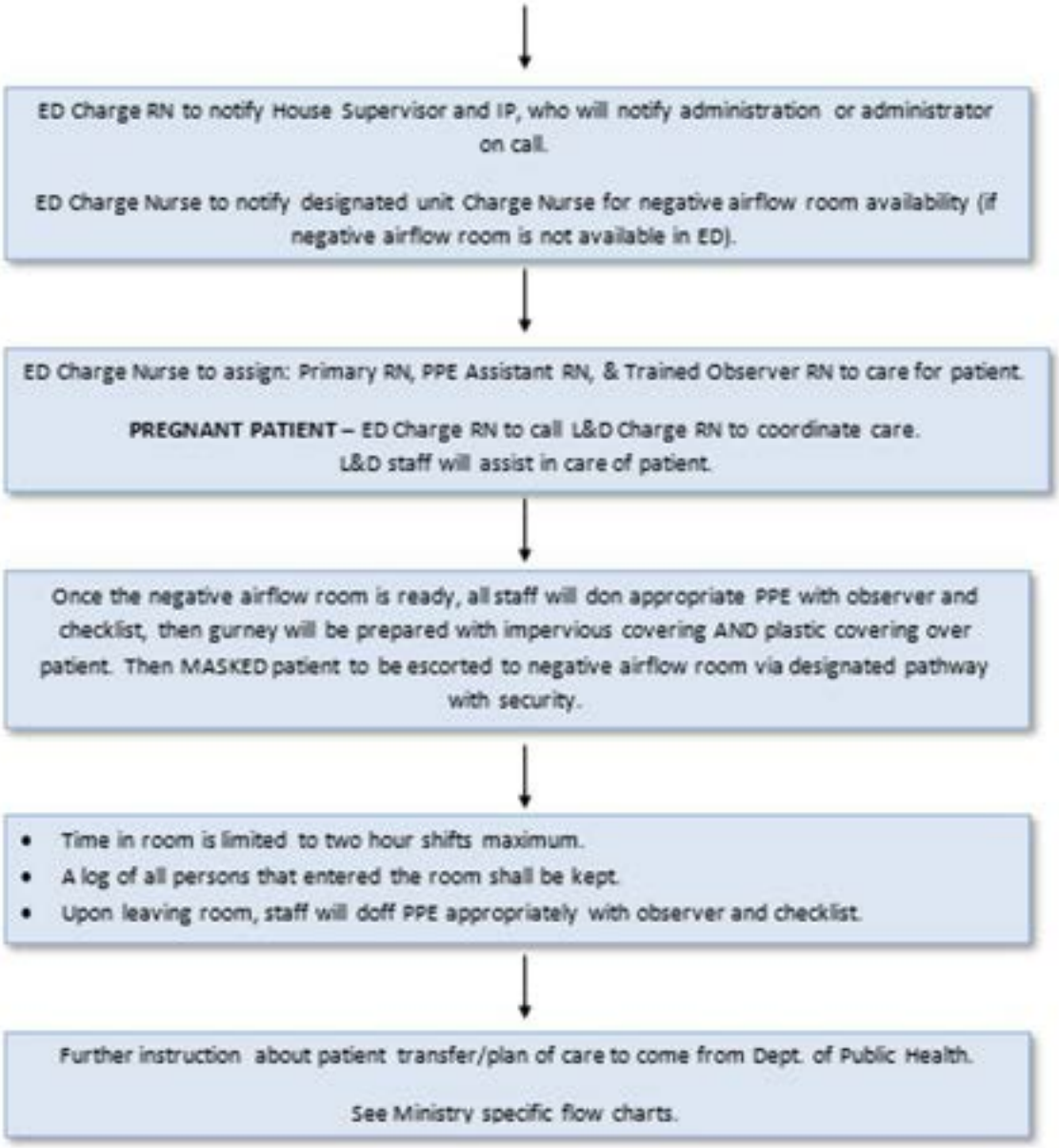
Suspect Ebola (Hemorrhagic Disease) Patients

All patients to be screened for travel to affected areas within the past 21 days or have had close contact with someone with confirmed Ebola*.

AND do they have any symptoms of Ebola including: Fever, headache, muscle or body aches, nausea, vomiting, diarrhea, unexpected bleeding or bruising?

*Ministry specific training will include communication directions.


WALK-IN patient – If positive screen, the registrar will inform the front end Flow Mgr.
Patient in **CAR** – Ask screening questions while patient is in car. If +, direct the car to the ambulance bay & **notify Charge Nurse.**
EMS RUN – EMS personnel to stay in rig with patient. ED personnel to don appropriate PPE & **notify Charge Nurse.**
The patient is to IMMEDIATELY be given a MASK and isolated in room with doors closed. **Notify Charge Nurse.**
The EDMD will conduct their interview by phone/monitor. If contact assessment is necessary, the EDMD will don appropriate PPE with observer and checklist, then doff with observer & checklist.
The EDMD will call the County Dept. of Public Health (DPH). Decisions regarding care should be made in consultation with DPH.
• LA County DPH 213-240-7941
o After hours, weekends, or holidays 213-974-1234
• Orange County DPH 714-834-8180
o After hours, weekends, or holidays 714-628-7008
• San Bernardino County DPH 800-782-4264
• Napa County DPH 707-253-4231
o After hours 415-906-1799
• Humboldt County DPH 707-268-3447
• Sonoma County DPH 707-565-4567



CONTINUE

Caregiver Safety Monitoring

- A written log will be kept at point of entry to patient room of all caregivers who have contact with the patient, room/equipment, or waste.
- Log will be sent periodically to Caregiver Health Services for monitoring of caregivers.
- Caregivers who have experienced a break in PPE or contact with body fluids from a suspected or confirmed EVD patient should report to Caregiver Health Services for follow-up and further instructions. Or use the language under the Care Team Model.

CONTINUE

EVD Care Team Model

Care Team Model

- Patients under investigation for suspected or confirmed high-risk contagious diseases (e.g., Ebola) require enhanced safety protocols.
- Once identified and isolated, these patients will require a three-person care team approach for safe donning & doffing of PPE.
- 3 Person Care Team Model
    - Direct Caregiver
    - PPE Assistant – "Buddy"
    - Trained Observer

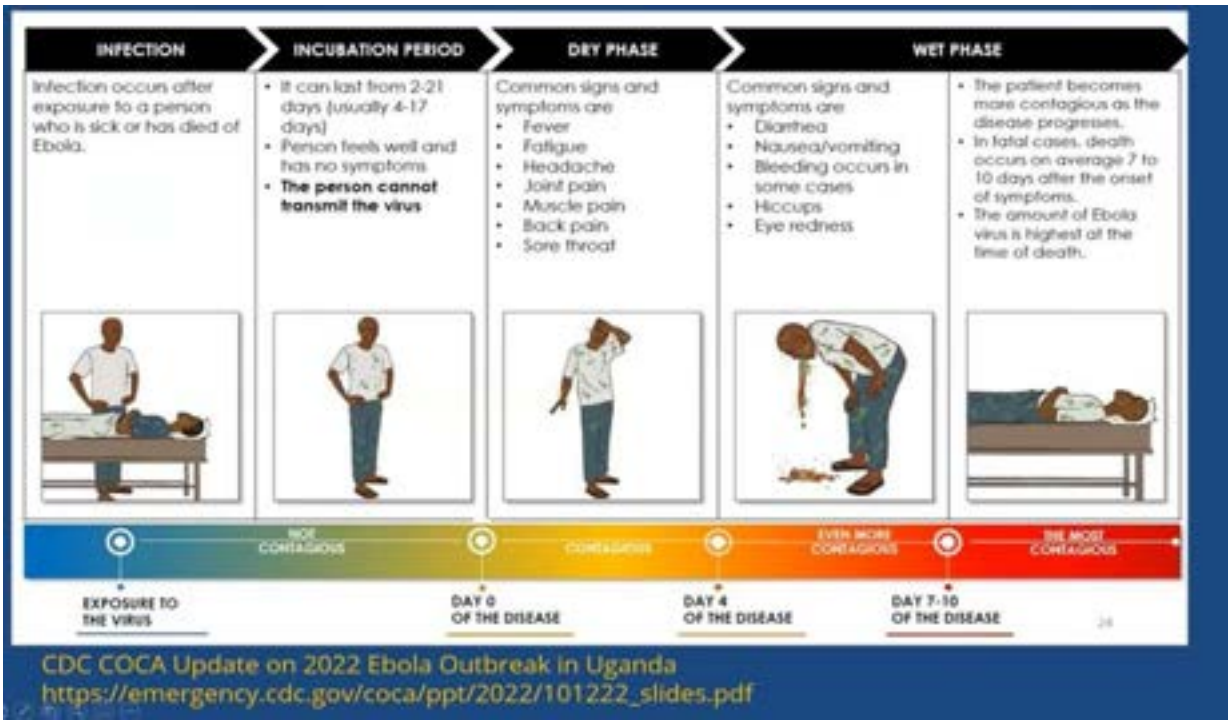
Any caregiver who experiences a break in PPE or comes into contact with a patient's body fluids will follow up with Caregiver Health Services.

CONTINUE

Roles & Responsibilities: Direct Caregiver

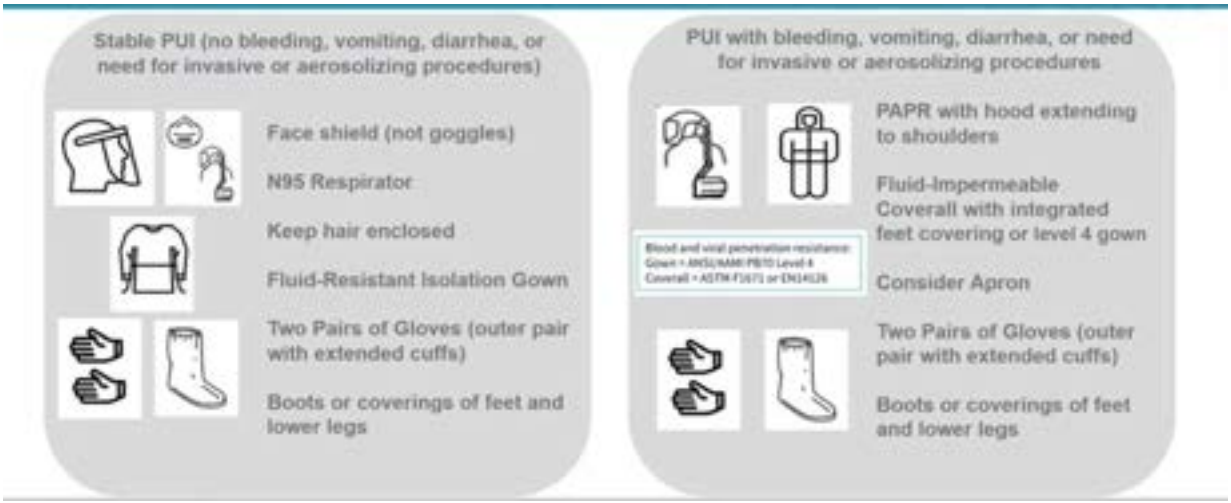
1. Wear recommended PPE
2. Provide patient care
3. Maintain cleanliness of environment including removal of specimens & biohazardous waste
4. Notify PPE Assistant and Trained Observer immediately if you need to exit the room
5. Listen to the PPE Assistant and Trained Observer for guidance
6. Keep hands away from face and limit surfaces touched
7. Maximum of 2 hours in room at a time
8. Take your time

CONTINUE



EVD Progression

CONTINUE



PUI = person under investigation, aka suspect case

PPE may be ministry-specific. Follow ministry-specific guidance.

CONTINUE

Roles & Responsibilities: PPE Assistant "Buddy"

1. Wear recommended PPE
2. Maintain visual contact of Direct Caregiver at all times during donning and doffing
3. Remain in the anteroom to assist Direct Caregiver and monitor safety
4. Assist and coach Direct Caregiver to safely don, doff, and dispose of PPE using the donning and doffing Checklists
5. Set up supplies and maintain cleanliness of anteroom
6. Report any breaches in safety

7 Be ready to enter room if emergency assistance is needed

8 Remain in the role for 2 hours

CONTINUE

Roles & Responsibilities: Trained Observer

1 No additional PPE required beyond universal masking

2 Remain outside the anteroom

3 Coordinate availability of resources (i.e., PPE, supplies, equipment)

4 Keep a written log of actions, including those entering & exiting room

5 Support the PPE Assistant in monitoring for safety

6 Duration of this role may be > 2 hours

CONTINUE

Next Steps

- You will receive in-person training at your Ministry, based on your role
- This training will include:
    - Ministry-Specific Process Maps/Flow Maps/Facility Maps
    - Ministry-Specific Communication
    - Contact list
- Return demonstration in each of the 3 roles
    - Direct Caregiver
    - PPE Assistant
    - Trained Observer

Congratulations!
You have completed this module.

You may now click on the "Exit Course" button.

South Division [CCO] POLST and Advance Directives

Providence

The course reviews key information related to advance directives and POLST which provide patients with the opportunity to document their healthcare requests in the event they cannot speak for themselves.

Objectives

Healthcare Directives & Caregiver Role

UNDERSTANDING ADVANCE DIRECTIVES & POLST

What is an Advance Directive? Who Benefits?

What is POLST? Who Benefits?

Northern California Caregivers: Documentation

POLST and Advance Directives Review

Summary

Objectives

Caregivers are able to:

1. Define the importance of advance directives and POLST for patients and our ministries.
2. Act as a resource and advocate to support the patient's right to be engaged and participate in their health decisions.

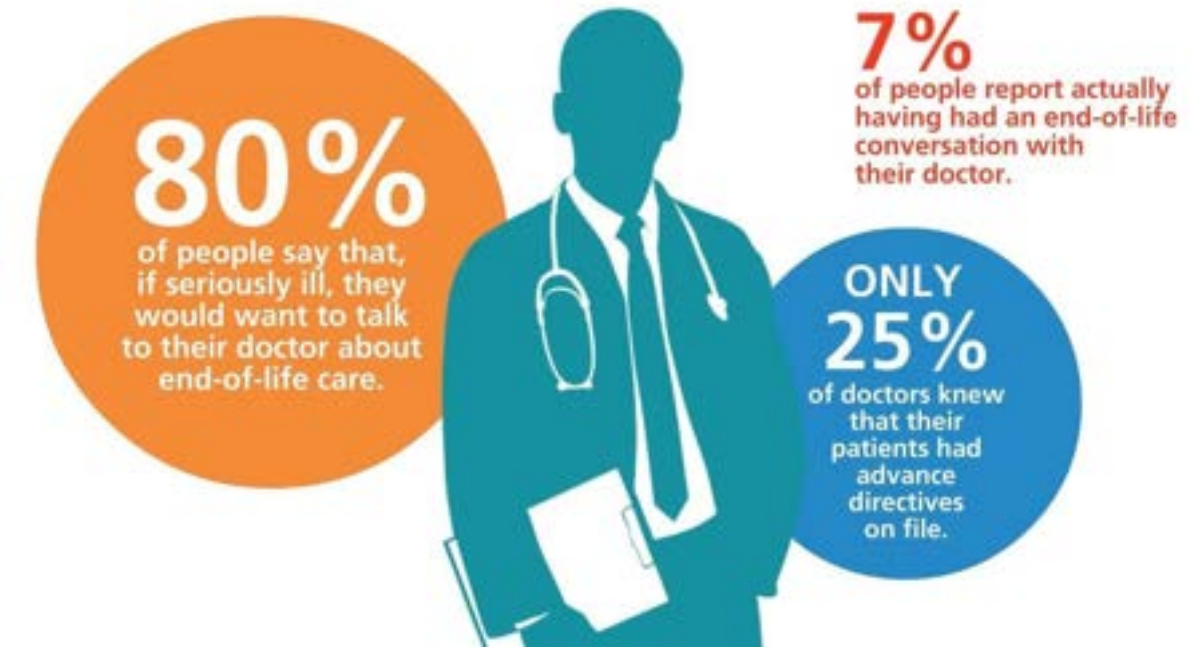
CONTINUE

Healthcare Directives & Caregiver Role

Why Healthcare Directives are Important

Healthcare directives (e.g., advance directives, POLST, Durable Power of Attorney for Healthcare, Living Will, code status) provide clear instructions for caregivers and doctors to follow to ensure patients' medical requests are fulfilled in the event they are incapacitated or unable to make choices on their own.

Caregiver Role



Click image to enlarge

The caregiver's role is to act as a resource and advocate for patients to understand their rights and options regarding healthcare directives.

Ask the patient if s/he has a healthcare directive. If not, support the patient in having an advance care planning conversation with his/her provider.

If a patient has already filed a Healthcare Directive, caregivers will find the directive noted in the EMR.

CONTINUE

What is an Advance Directive? Who Benefits?

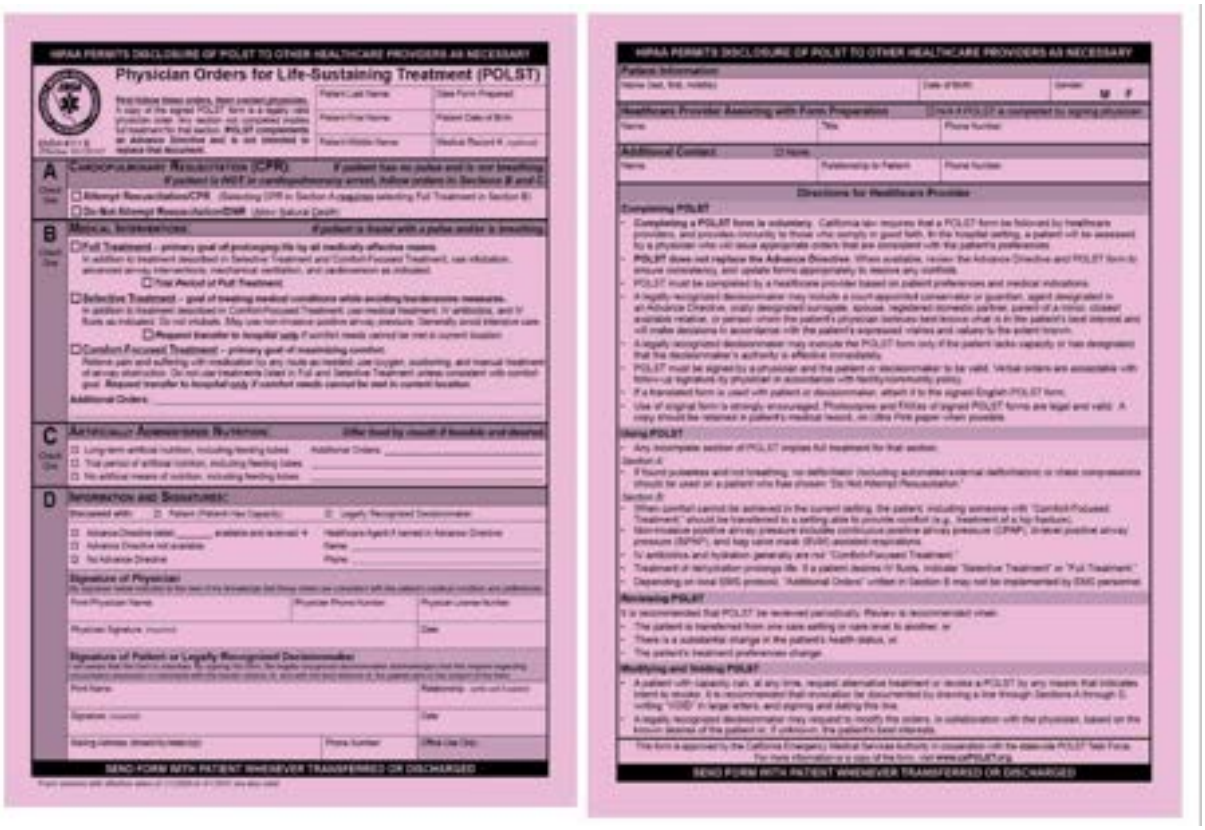
Federal and state law requires that patients are informed of their right to formulate Advance Healthcare Directives when admitted to the hospital.

What is an Advance Healthcare Directive?

An ***Advance Healthcare Directive*** provides patients with the ability to make their written medical request know in event that they become incapable to understand, propose or make decisions regarding treatment. Anyone over 18 years of age can request an advance directive to provide general instructions for treatment. The patient has the ability to appoint a decision maker.

CONTINUE

What is POLST? Who Benefits?



Click image to enlarge

What is POLST?

P**hysician **O**rders **for L**ife **S**ustaining **T**reatment **(POLST) is used when life-sustaining or life saving treatment should be rendered. A POLST form:

- Is a physician order recognized throughout the medical system.
- Is a portable document that transfers with the patient.

- Allows patients to choose or decline medical treatment in the event there is a medical emergency.
- Provides direction for healthcare providers when patients are faced with serious illnesses.
- Is a state standardized form (which also supports reporting).

Who benefits from having POLST?

Patients with the following conditions are recommended to have a POLST form:

1. Chronic, progressive illness.
2. Serious health complications.
3. Determined to be medically frail.

If the following statement is used to describe a patient's condition, this is an indication the patient may benefit from having a POLST form on file:

- *"It would not be a surprise if the patient passes away within a year."*

Northern California Caregivers
Review documentation requirements.

CLICK OR TAP

Southern California Caregivers
Continue to end of course.

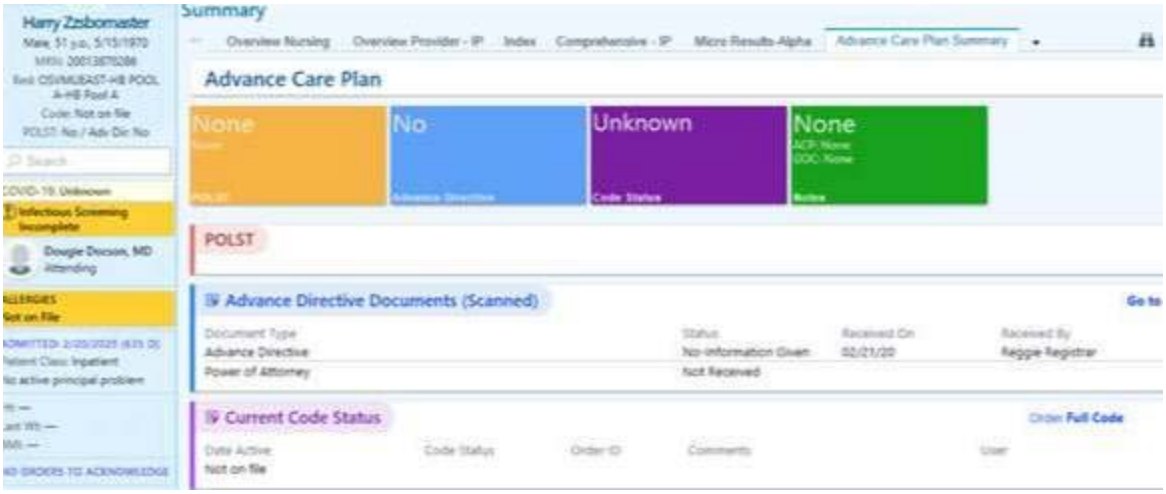
CLICK OR TAP

Northern California Caregivers: Documentation

When documenting in Epic, the POLST can be located in the Storyboard by using "hovering report has been added to the POLST/Advance Directive and Level of Care items to show an abbreviated version of the PSJH Advance Care Planning Summary report.

Clicking through the POLST/Advance Directive column will load the full version of the Advance Care Planning Summary report.

The goal is to maintain visibility of POLST forms and improve visibility of patients Advance Directive status.



CONTINUE

POLST and Advance Directives Review

Multiple choice:

_____ provide(s) clear instructions for caregivers and doctors to follow to ensure patients' medical requests are fulfilled in the event they are incapacitated or unable to make choices on their own.

- ◯ Advance directives
- ◯ POLST
- ◯ Living wills
- ◯ Durable power of attorney for healthcare
- ◯ Code status
- ◯ All of the above

SUBMIT

True or false:

If a patient has already filed a healthcare directive, caregivers will find the directive noted in the EMR.

- ◯ True
- ◯ False

SUBMIT

Fill in the blank:

Anyone over _____ years of age can request an advance directive to provide general instructions for treatment.

Type your answer here

SUBMIT

Multiple choice:

POLST is an abbreviation of which of the following?

- ○ Private orders for life saving treatment
- ○ Physical orientation towards life saving treatment
- ○ Potential orders for life sustaining treatment
- ○ Physician orders for life sustaining treatment

SUBMIT

Complete the content above before moving on.

Summary

Thank you for completing the POLST and Advance Directives course!

If you have any unit-specific questions, please contact your nursing unit manager or preceptor.

Exit

Click to exit the course.

EXIT

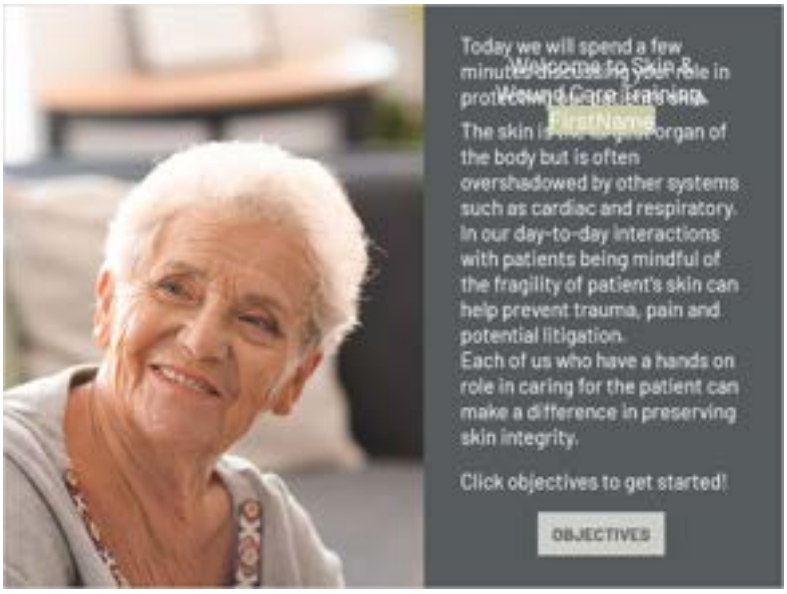
Skin and Wound Care

1. [CCO] Skin and Wound Care

1.1 Enter your name

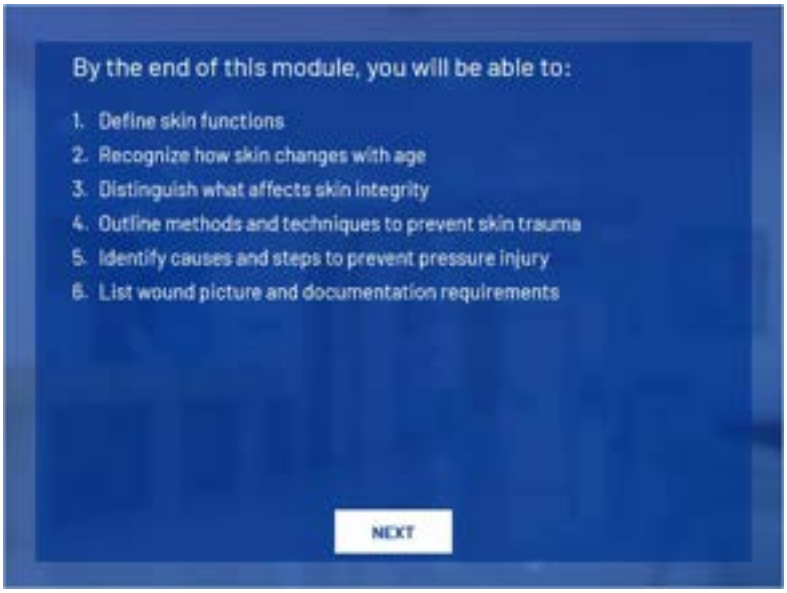
Notes:

1.2 Welcome

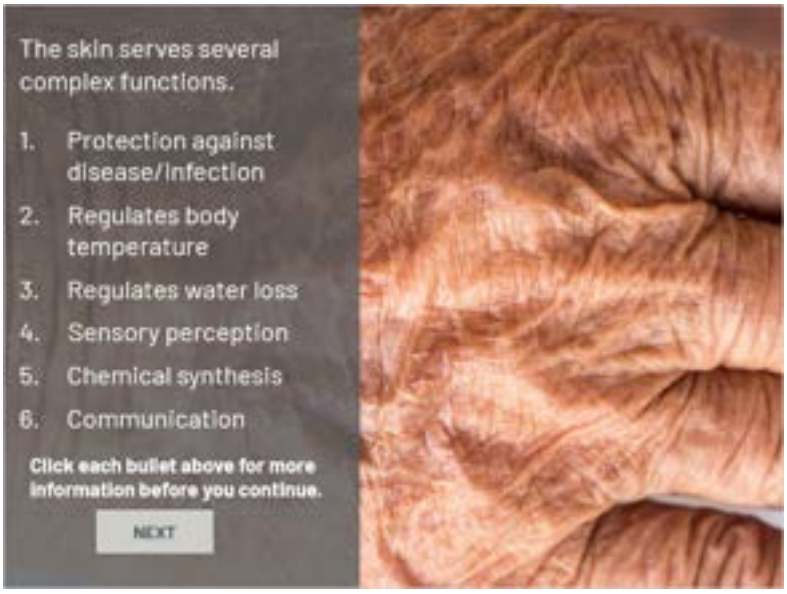


Notes:

OBJECTIVES (Slide Layer)



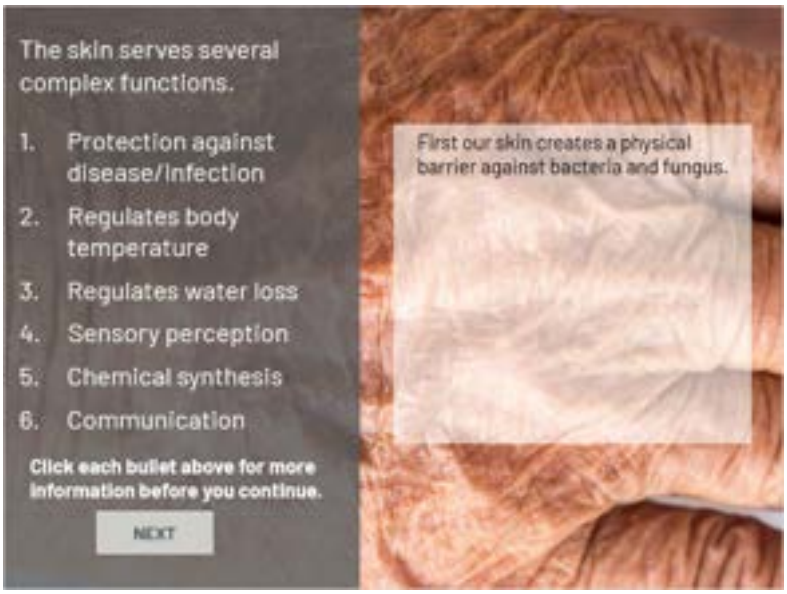
1.3 Skin Functions



Notes:

The skin serves several complex functions.
First our skin creates a physical barrier against bacteria and fungus.
The skin also regulates body temperature.
A person who has lost a significant portion of their skin such as a burn victim is not able to cool the body through perspiration and evaporation.
Third, the skin acts as a water resistent barrier so essential nutrients aren't washed out of the body.
Fourth, the skin is responsible for sensory perception.
Damaged skin can lose the ability to sense pressure, heat and touch.
Fifth, chemical synthesis of Vitamin D is an important skin function.
Lastly, damage to the facial skin can result in functional impairment such as inability to communicate joy or sadness through smiling or frowning.
Poor body image and self esteem can occur as a result of scars resulting from skin trauma.

1 (Slide Layer)



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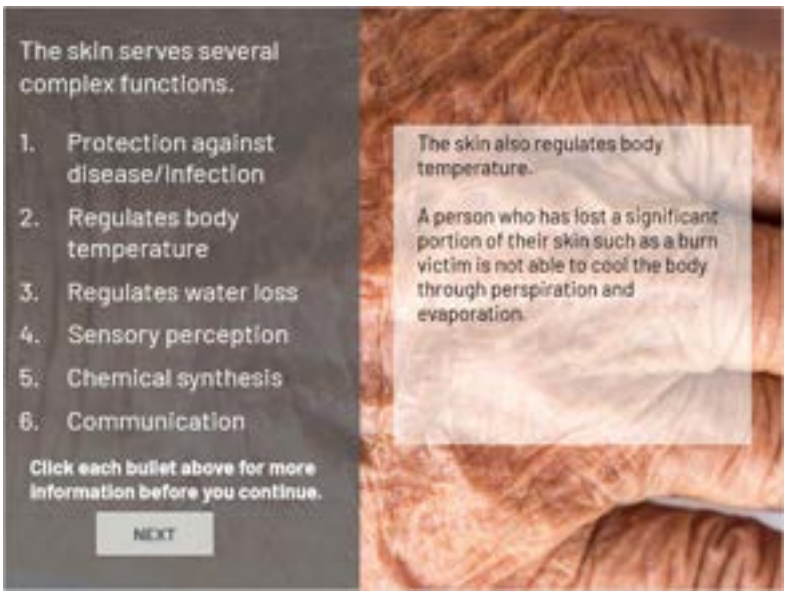
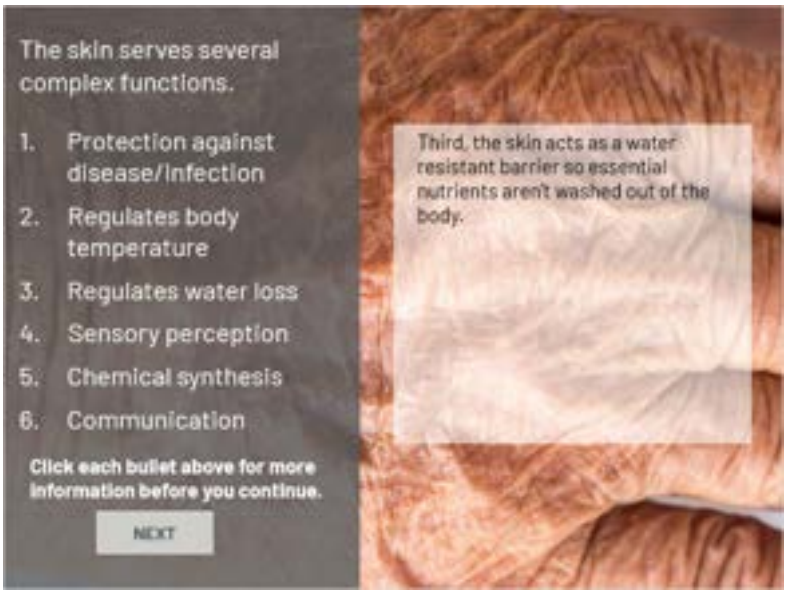


3 (Slide Layer)



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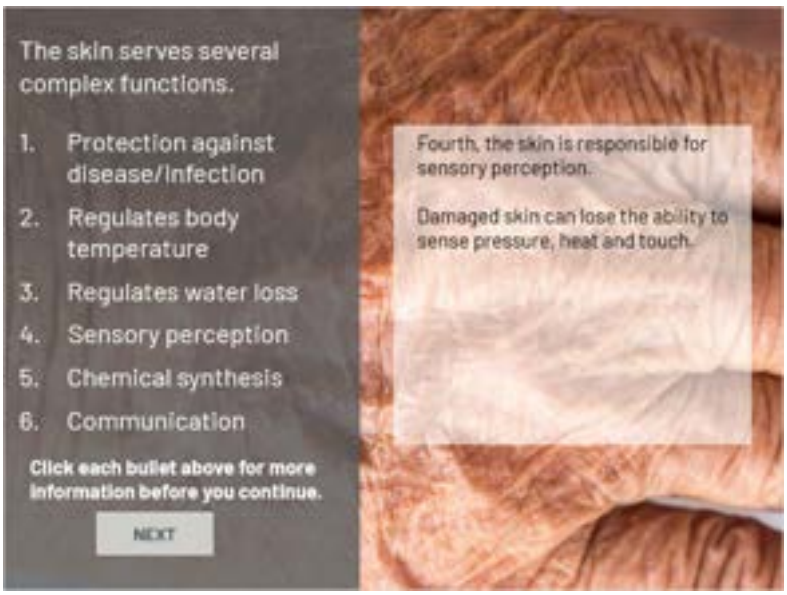

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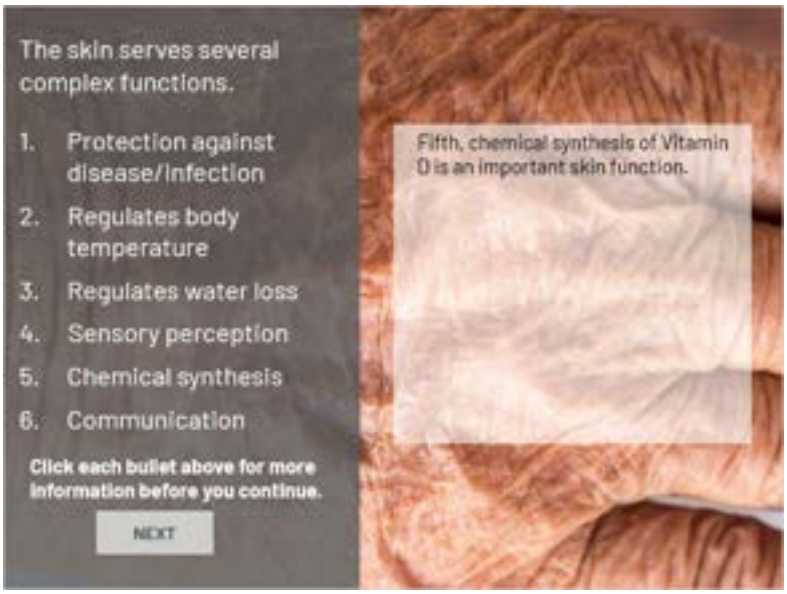

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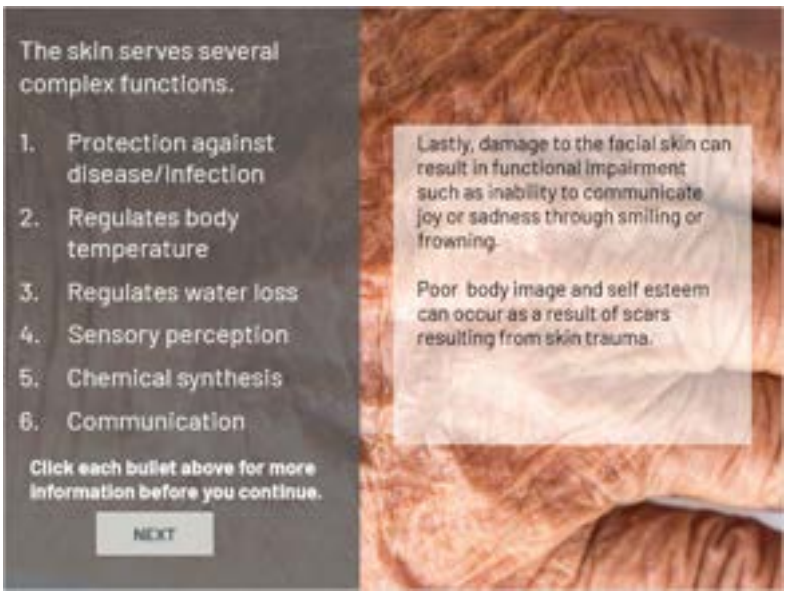
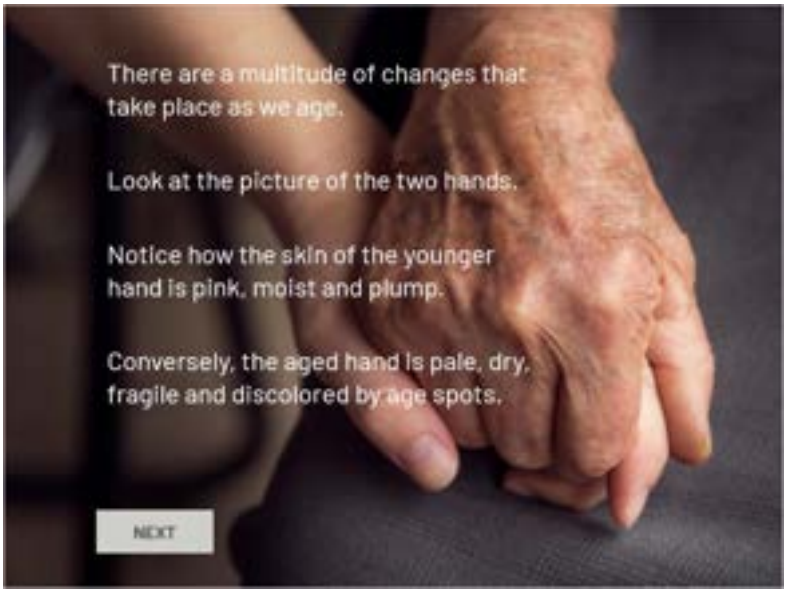
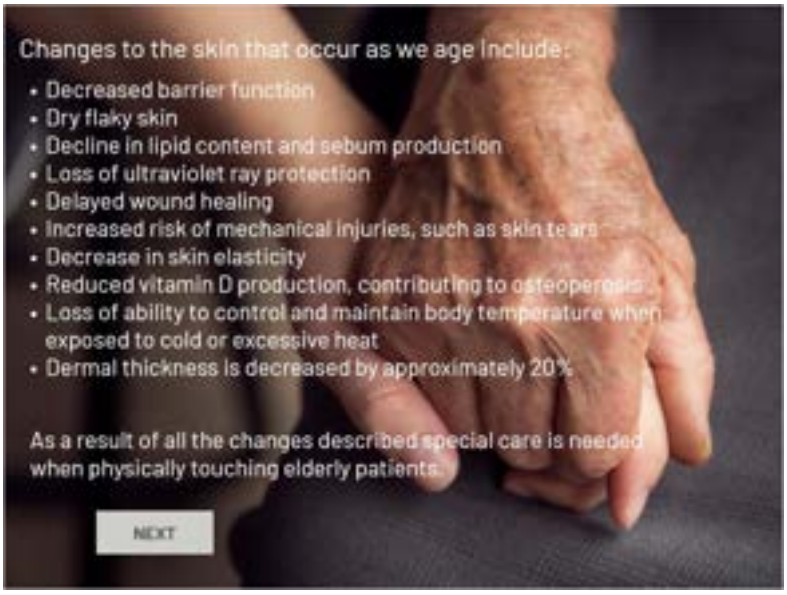


1.4 Skin Changes with Age



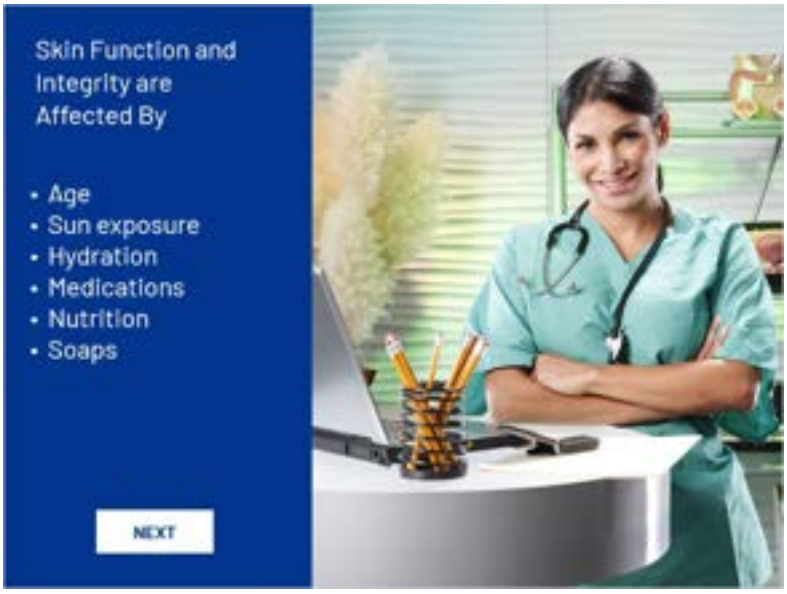
Notes:

1.5 Skin Changes with Age

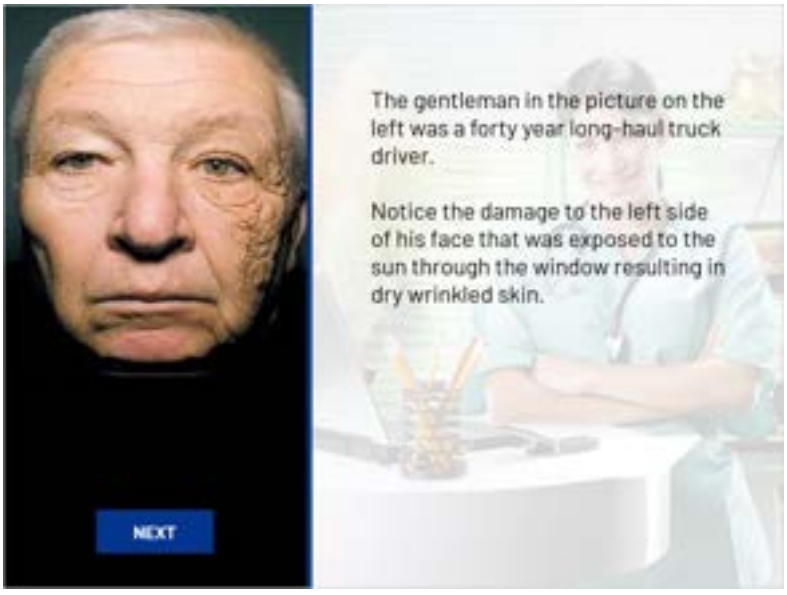


Notes:

1.6 Skin Function and Integrity



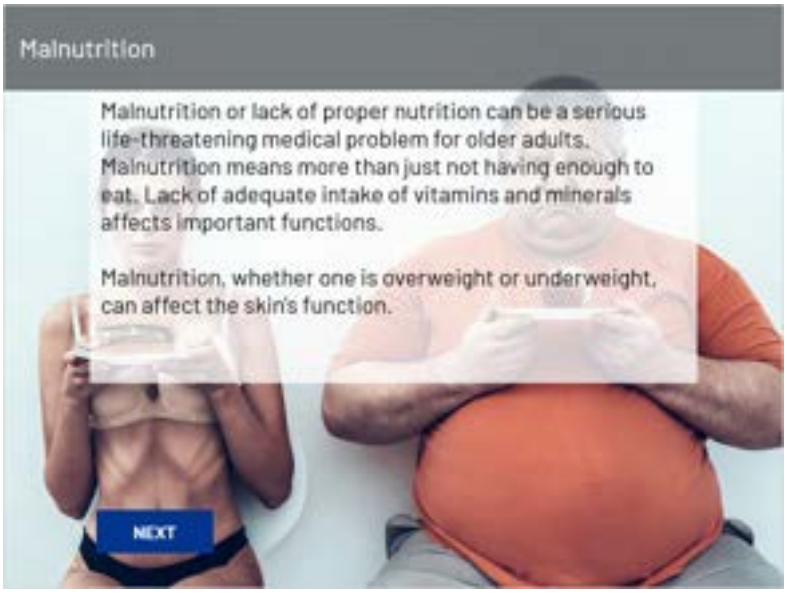
1.7 Skin Function and Integrity



1.8 Skin Function and Integrity

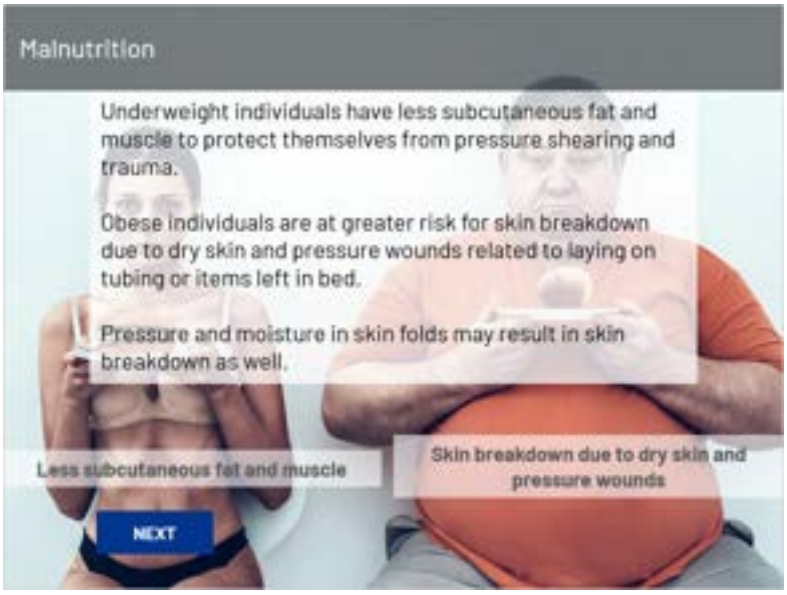
1.9 Skin Function and Integrity

1.10 Malnutrition



Notes:

1.11 Malnutrition



Notes:

1.12 Malnutrition

Notes:

1.13 The skin serves which of the following functions:

Select ALL that apply.

(Multiple Response, 10 points, 3 attempts permitted)

Correct	Choice
X	Protects against disease and infection.
X	Regulates body temperature.
	Regulates body weight.
X	Aids in Chemical synthesis.

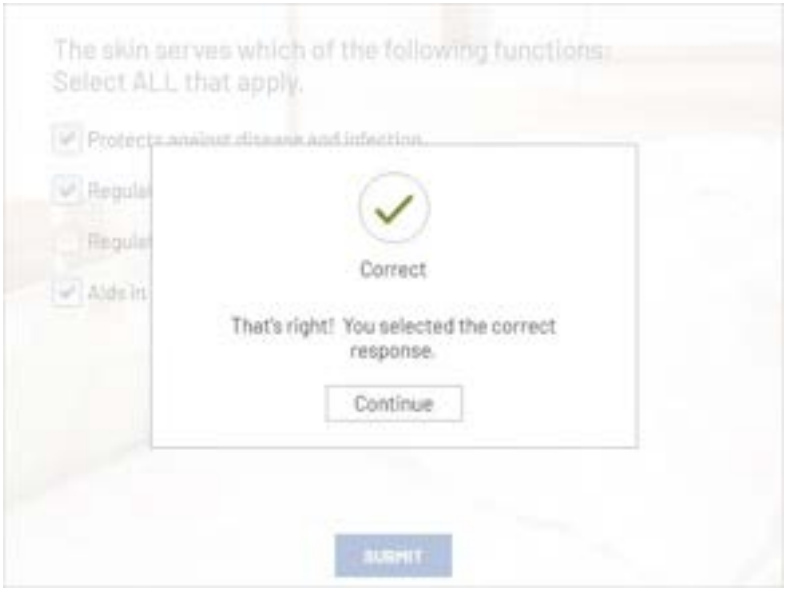
Feedback when correct:

That's right! You selected the correct response.

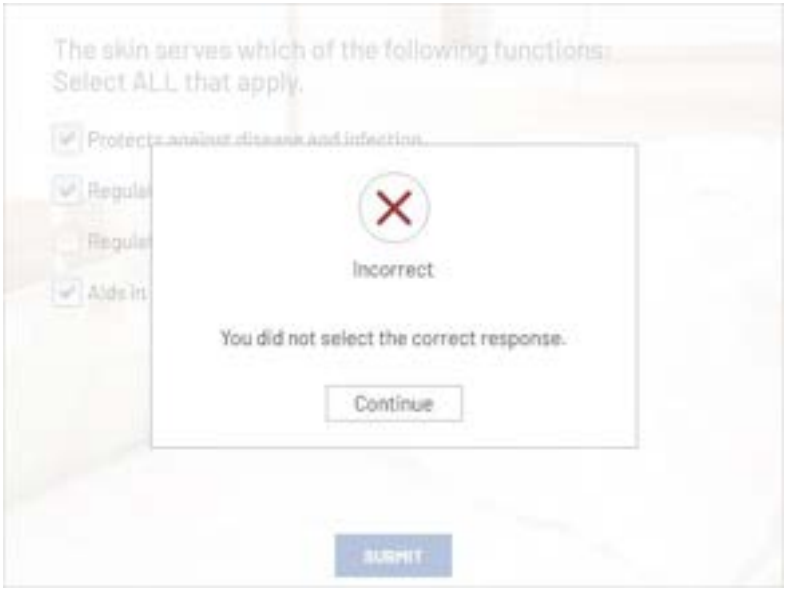
Feedback when incorrect:

You did not select the correct response.

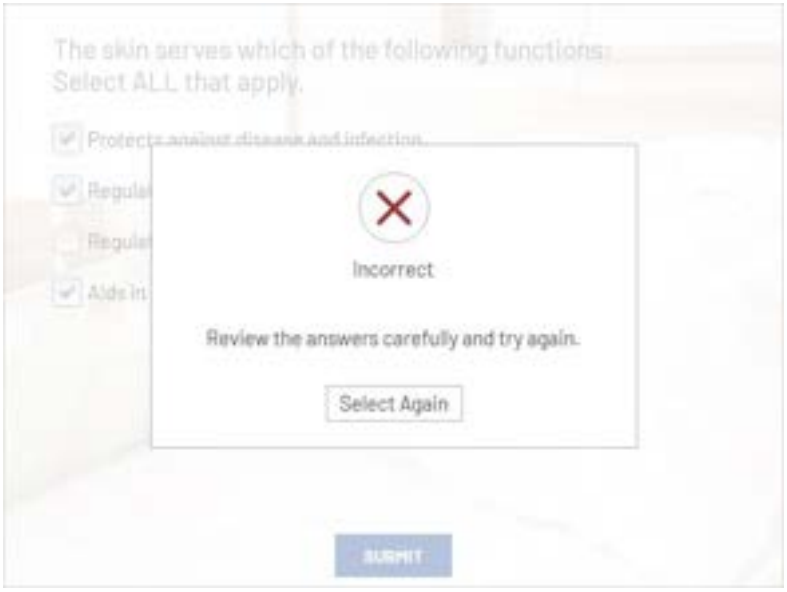
Correct (Slide Layer)



Incorrect (Slide Layer)



Try Again (Slide Layer)



1.14 Damaged skin can lose the ability to sense:

Select ALL that apply.

(Multiple Response, 10 points, 3 attempts permitted)

Correct	Choice
X	Pressure
X	Heat
X	Touch
	Light
	Sound

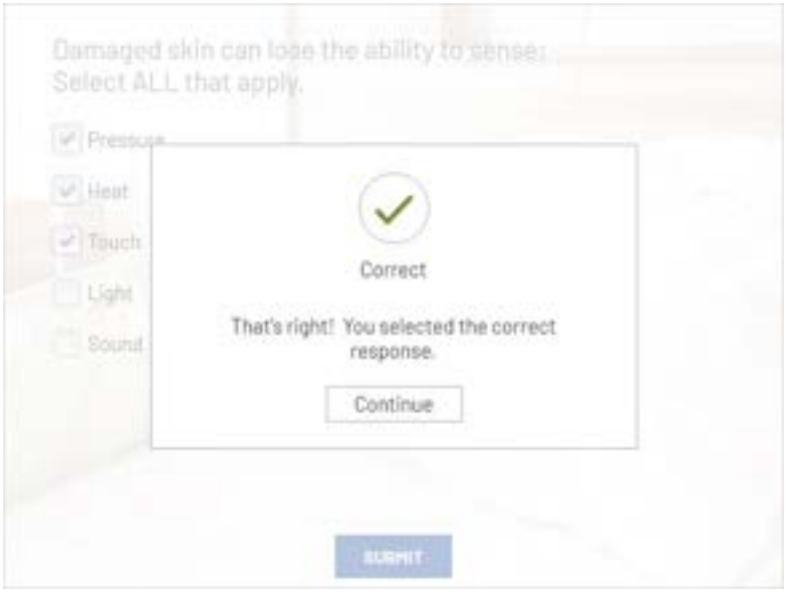
Feedback when correct:

That's right! You selected the correct response.

Feedback when incorrect:

You did not select the correct response.

Correct (Slide Layer)



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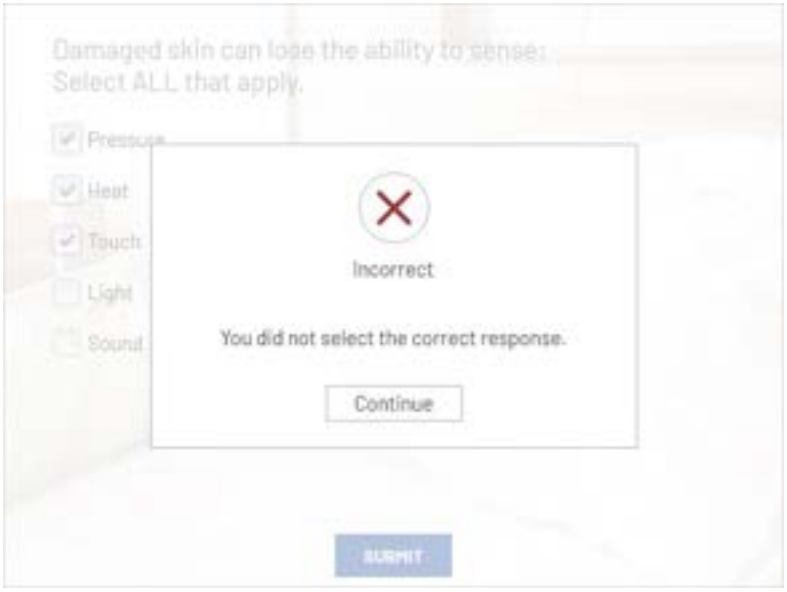

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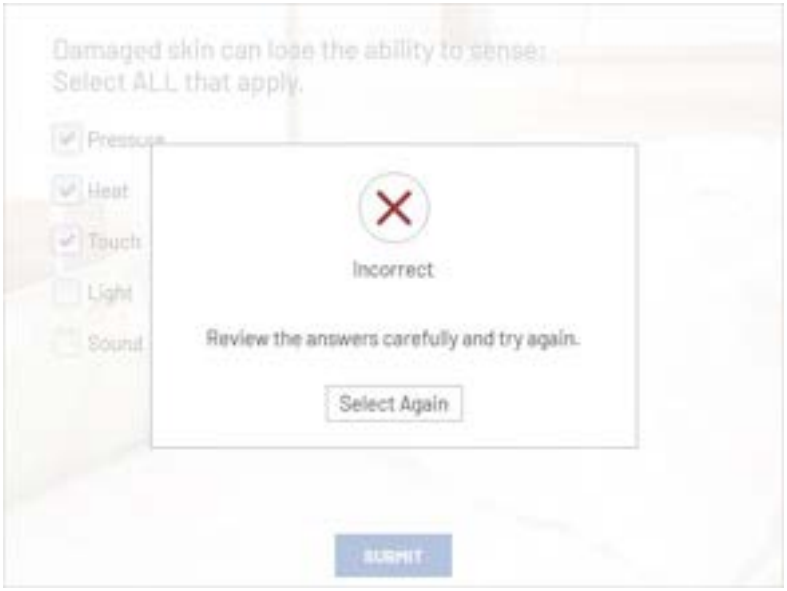


1.15 Which of the following changes to the skin occur as we age?

Select ALL that apply.

(Multiple Response, 10 points, 3 attempts permitted)

Correct	Choice
X	Loss of ultraviolet ray protection
X	Delayed wound healing
	Decreased risk of mechanical injuries
X	Loss of ability to control and maintain body temperature
X	Dermal thickness is decreased

Feedback when correct:

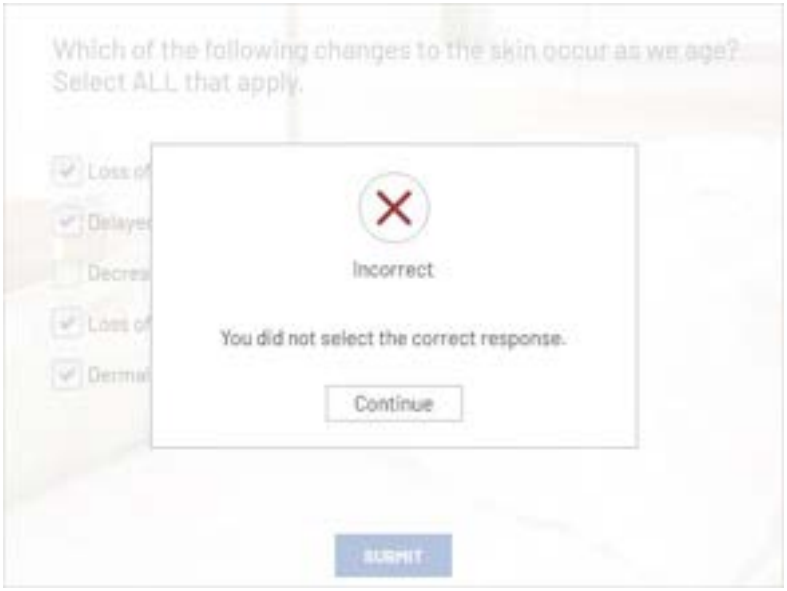
That's right! You selected the correct response.

Feedback when incorrect:

You did not select the correct response.

Correct (Slide Layer)

Incorrect (Slide Layer)



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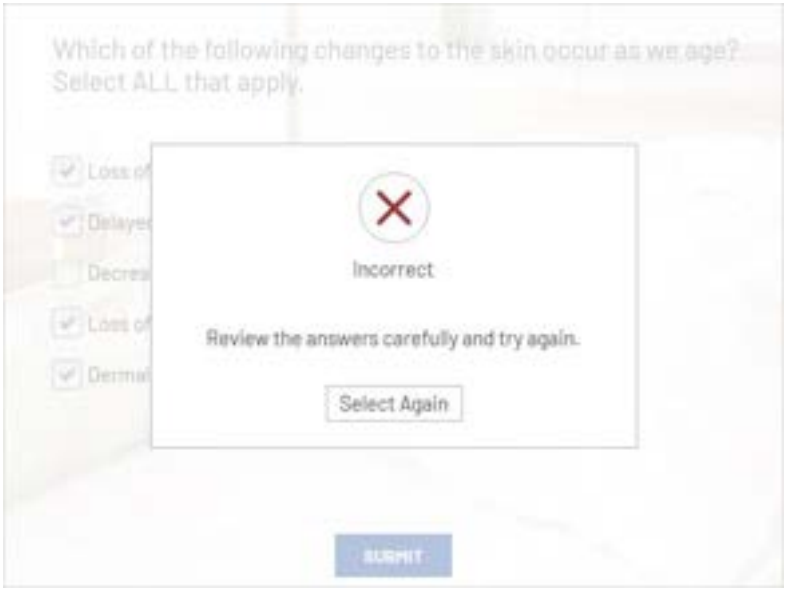


1.16 Skin function and integrity are affected by:

Select ALL that apply.

(Multiple Response, 10 points, 3 attempts permitted)

Correct	Choice
X	Age
X	Sun Exposure
X	Hydration
X	Medications
X	Nutrition

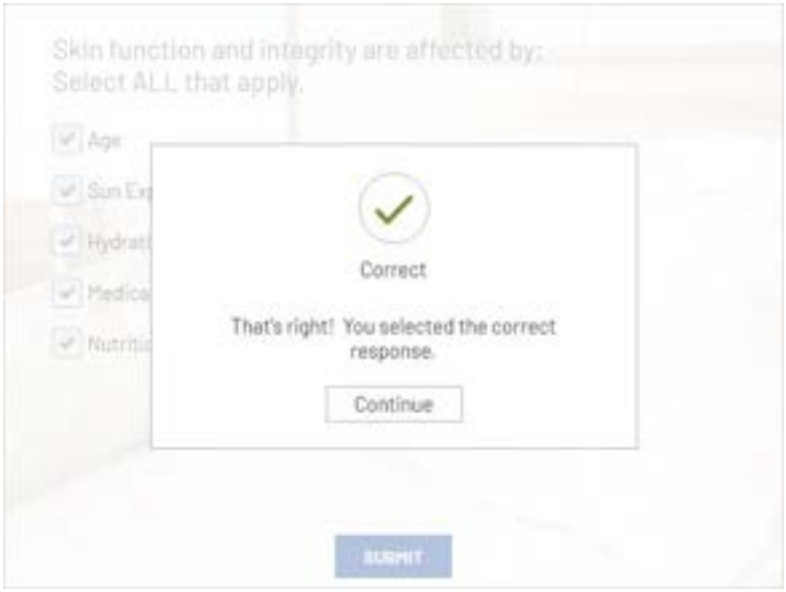
Feedback when correct:

That's right! You selected the correct response.

Feedback when incorrect:

You did not select the correct response.

Correct (Slide Layer)



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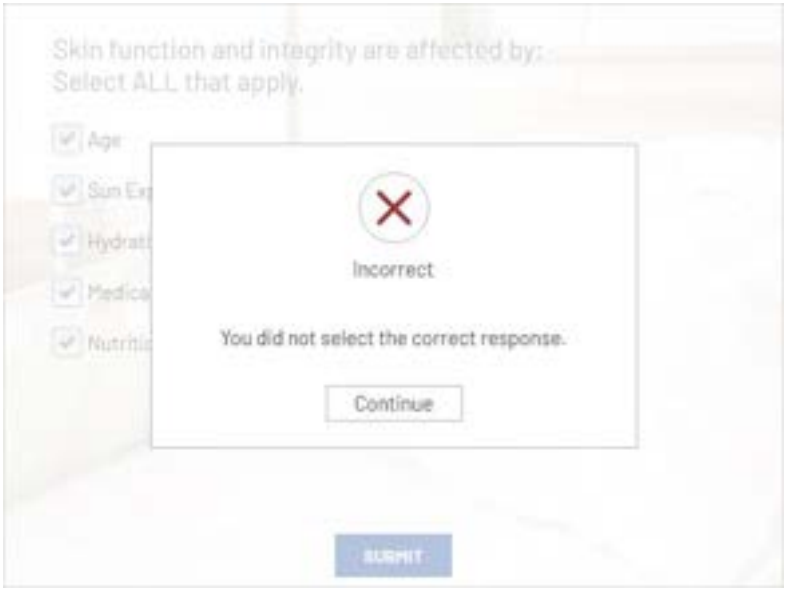

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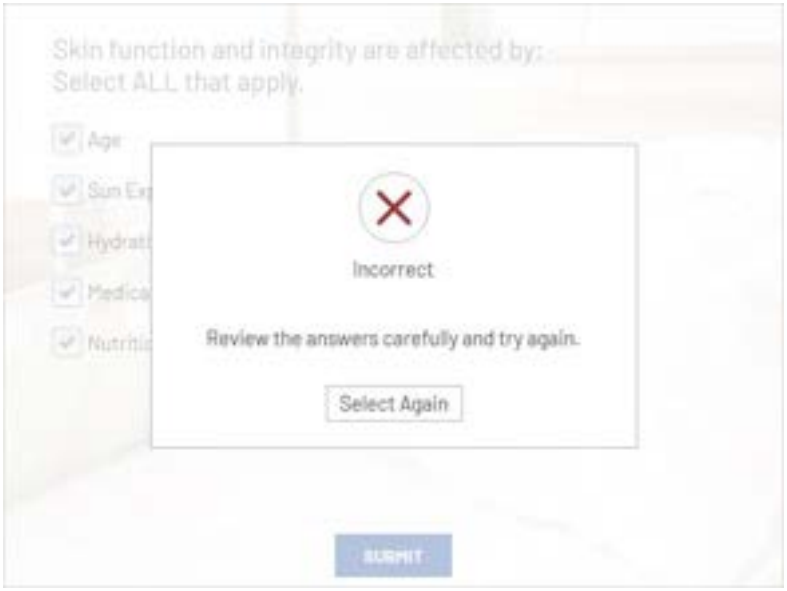
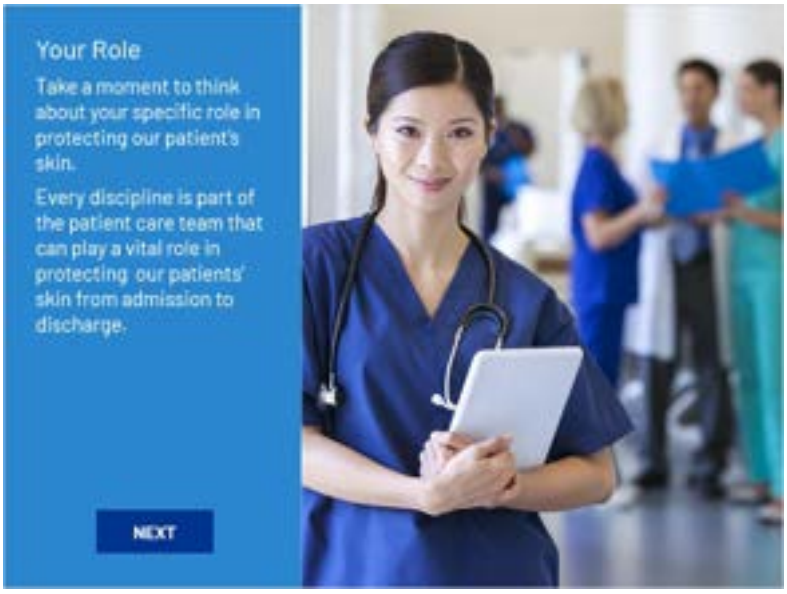


1.17 Your Role



Notes:

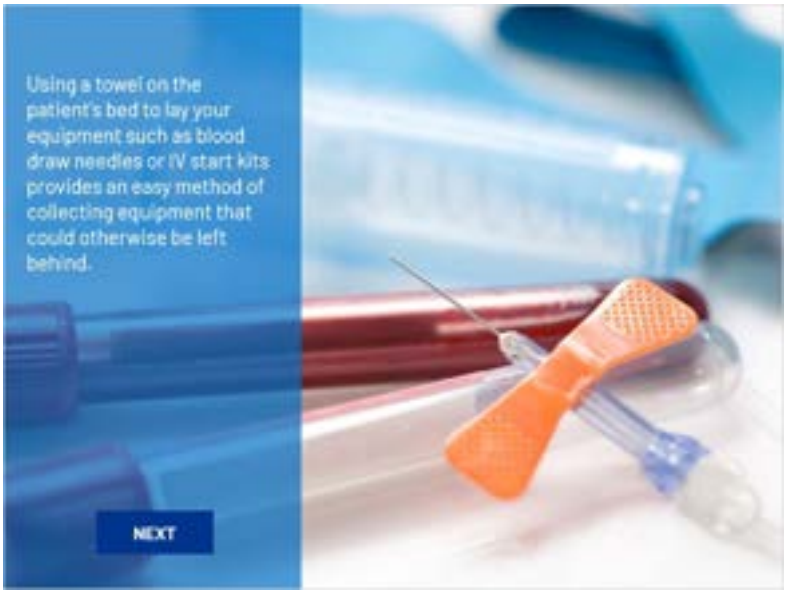
1.18 Two-nurse "4-eyes" skin check

1.19 A Wound Certified Registered Nurse

1.20 Everyone's Responsibility

1.21 Organize Your Supplies

1.22 Organize Your Supplies



1.23 Tape, Tourniquets, Hard Objects

1.24 Tape, Tourniquets, Hard Objects

1.25 Tape, Tourniquets, Hard Objects

1.26 Removing Tape

1.27 Push Pull Technique

1.28 Ask Patient if They Feel Discomfort

1.29 Securement Devices

1.30 BiPAPs

1.31 Movement Can Cause Skin Injury

1.32 Which of the following are ways you can minimize the potential of skin trauma?

Select ALL that apply.

(Multiple Response, 10 points, 3 attempts permitted)

Correct	Choice
X	Using gentle lifting techniques
X	Organize your supplies
X	Gather all equipment after procedures
X	Use a towel on the patient's bed to lay your equipment
	Use plastic tape
X	Promptly remove tourniquets

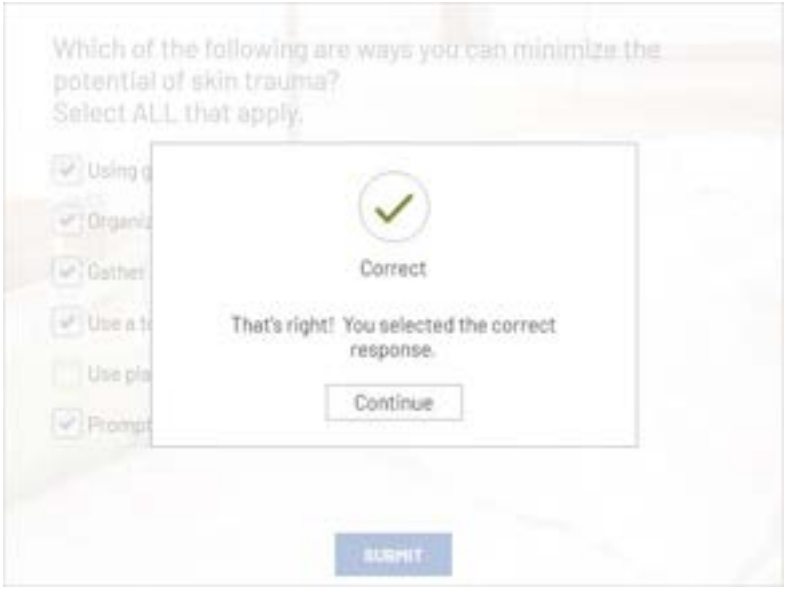
Feedback when correct:

That's right! You selected the correct response.

Feedback when incorrect:

You did not select the correct response.

Correct (Slide Layer)



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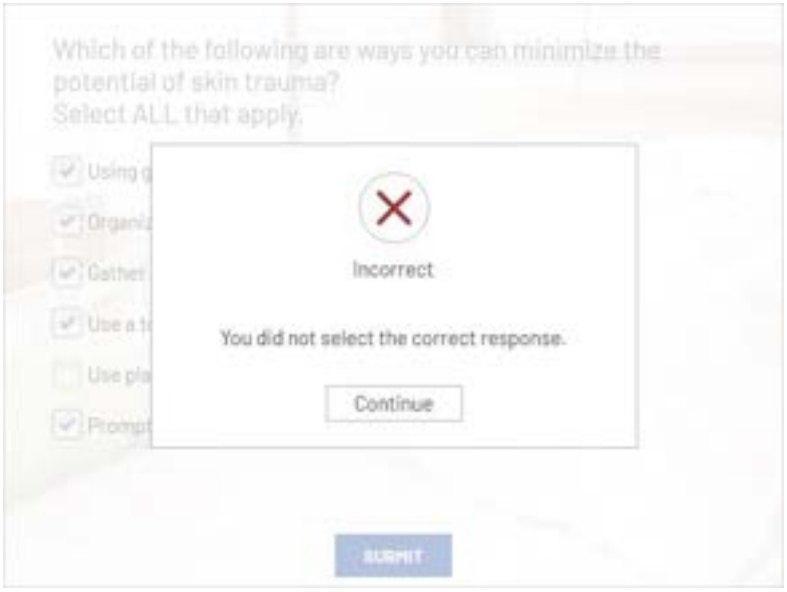

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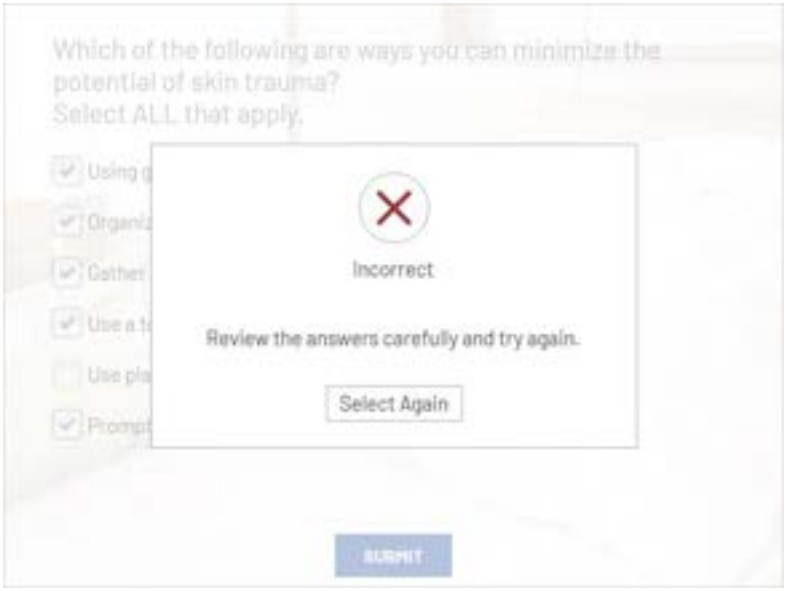


1.33 How should you remove tape from a patient's skin?

(Multiple Choice, 10 points, 3 attempts permitted)

Correct	Choice
	Hold down the skin with one hand and quickly pull back tape at a 90-degree angle.
X	Hold down the skin with one hand and gently pull back tape with your other hand.
	Soak the tape and skin in water until the tape is loosened from the skin.

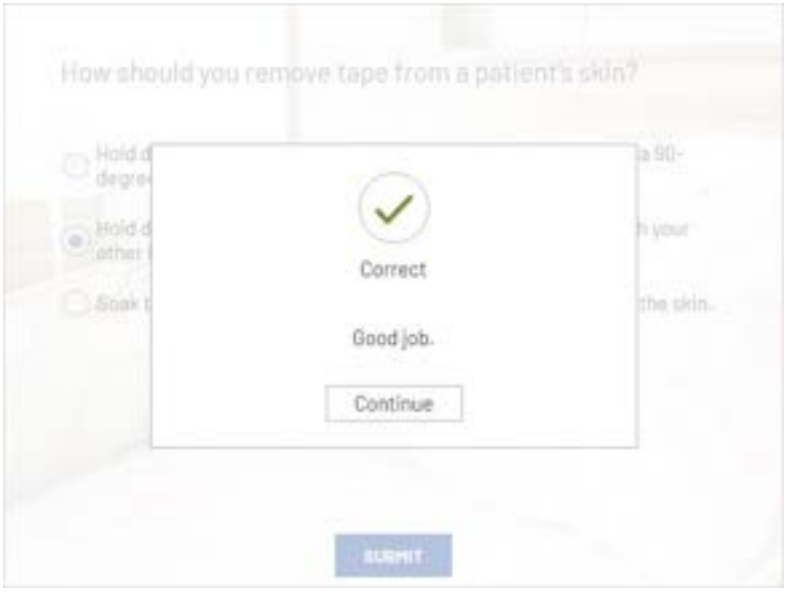
Feedback when correct:

Good job.

Feedback when incorrect:

You did not select the correct response.

Correct (Slide Layer)



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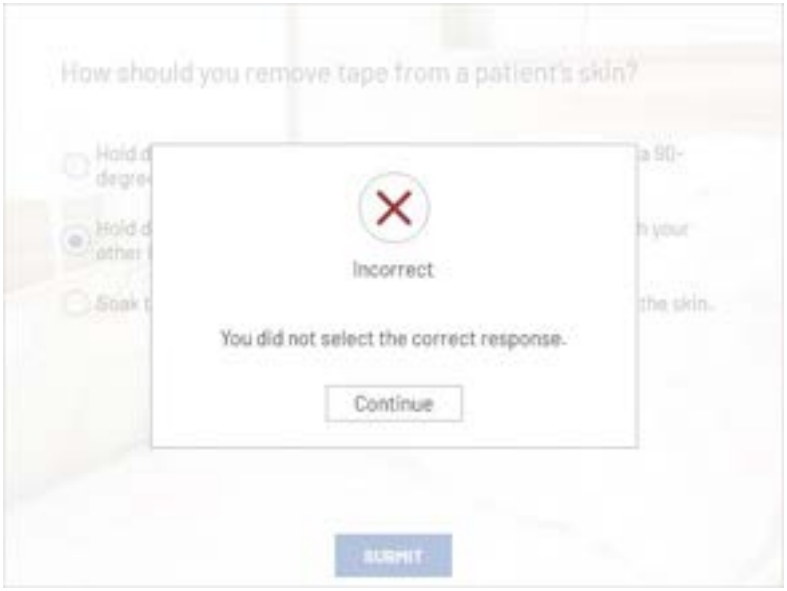

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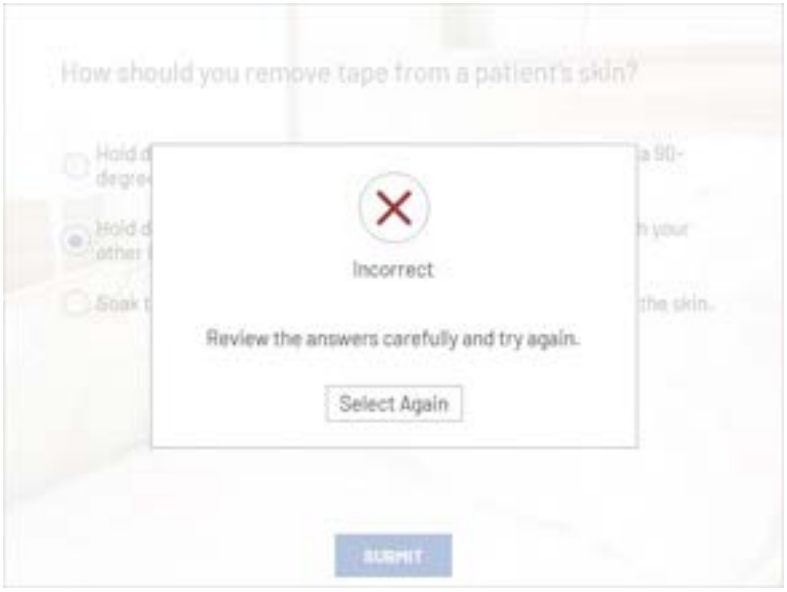
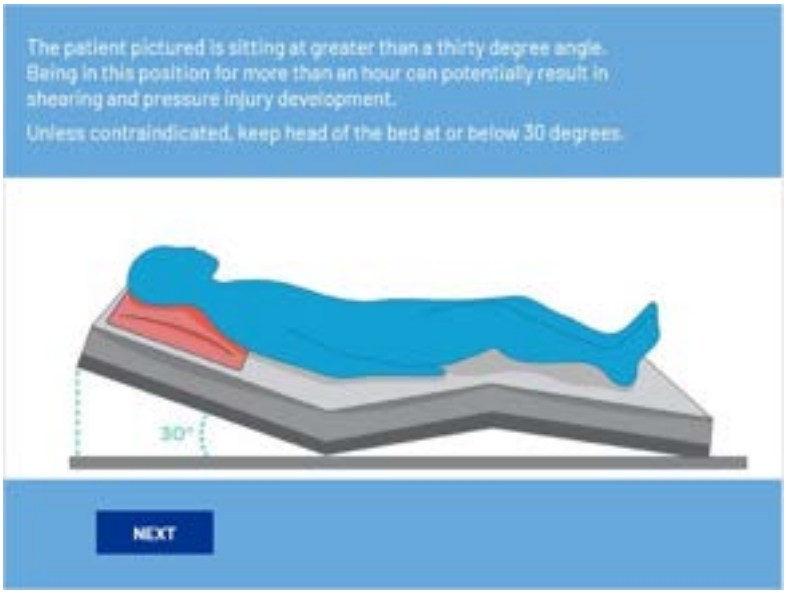


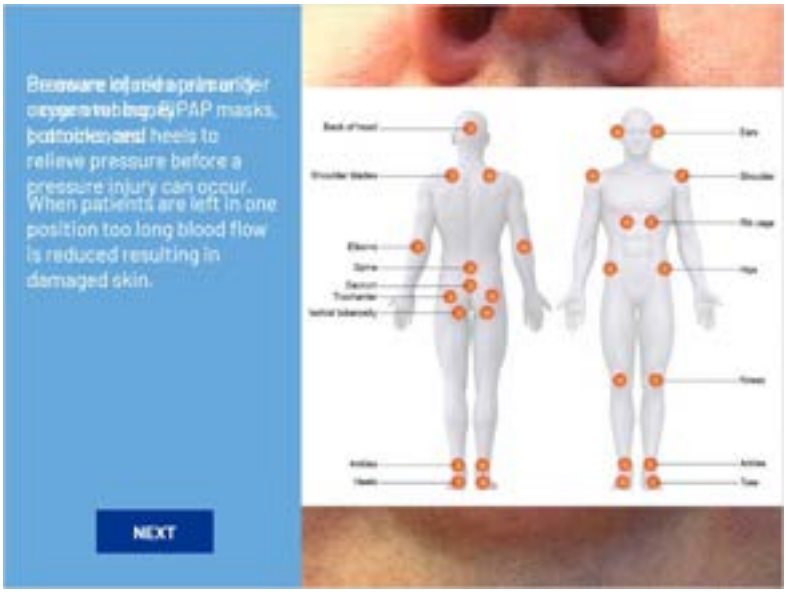
1.34 Bed Pans, Briefs, Pads

1.35 Bed Pans, Briefs, Pads

1.36 30 Degree Angle



1.37 Boney Prominences



1.38 Side Lying Position

1.39 Side Lying Position

1.40 To reduce the risk for developing pressure injuries you should:

(Multiple Choice, 10 points, 3 attempts permitted)

Correct	Choice
	Do not use any pads under the patient.

X	Only use one pad under a patient.
	Use multiple pads under the patient.

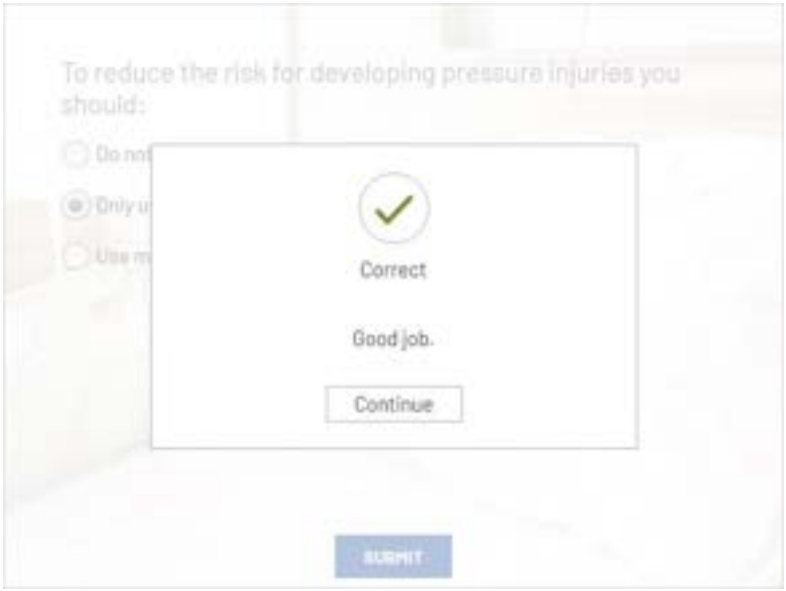
Feedback when correct:

Good job.

Feedback when incorrect:

You did not select the correct response.

Correct (Slide Layer)



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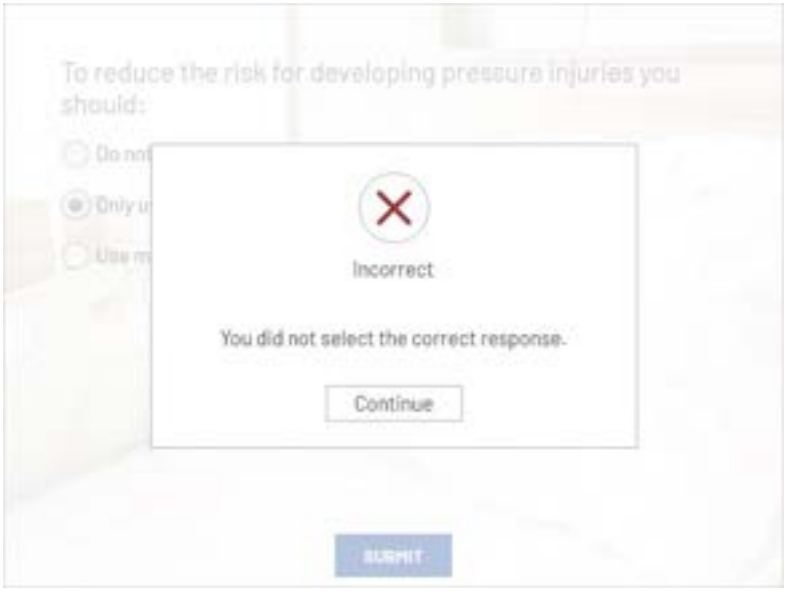
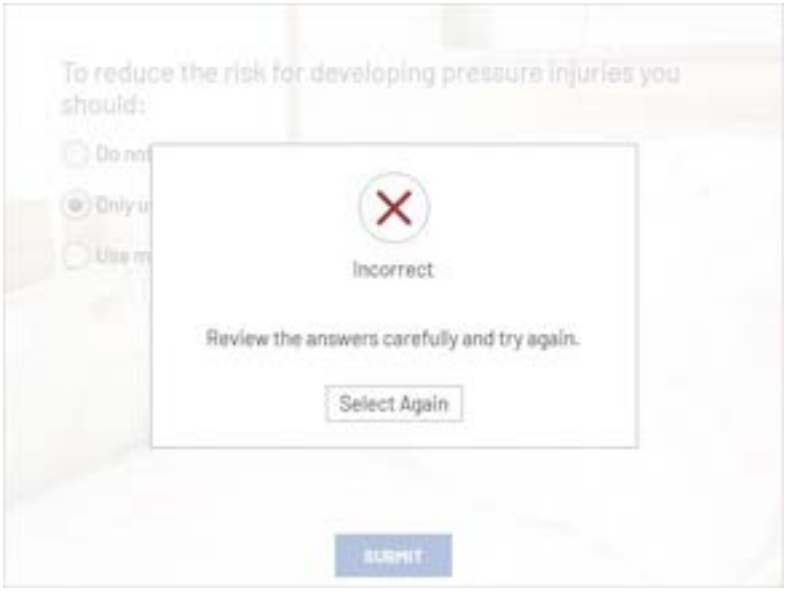
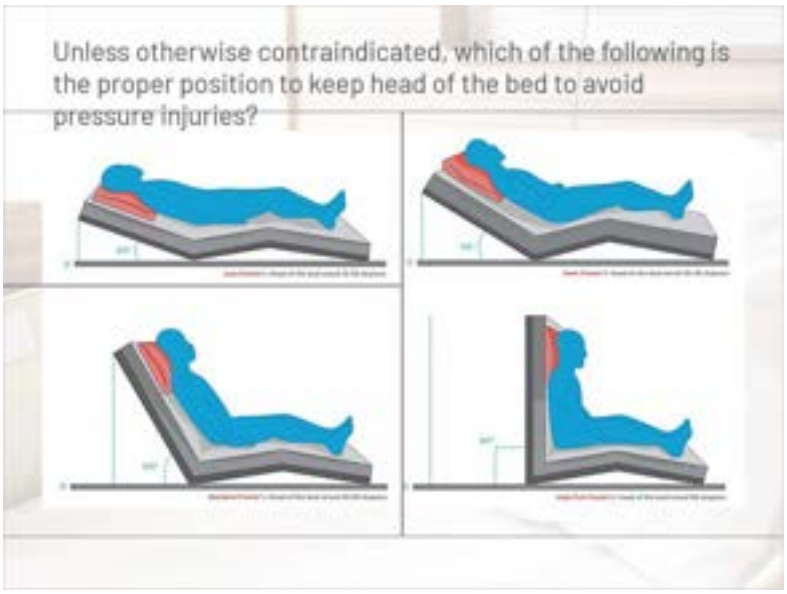


Try Again (Slide Layer)



1.41 Unless otherwise contraindicated, which of the following is the proper position to keep head of the bed to avoid pressure injuries?

(Hotspot, 10 points, 3 attempts permitted)



Feedback when correct:

Good job.

Feedback when incorrect:

You did not select the correct response.

Correct (Slide Layer)

Incorrect (Slide Layer)

Try Again (Slide Layer)

1.42 Which of the following areas should you consider when trying to minimize the potential of skin trauma from friction and/or pressure?

Select ALL that apply.

(Multiple Response, 10 points, 3 attempts permitted)

Correct	Choice
X	Under oxygen tubing
X	Under BiPAP masks
	Abdomen
X	Heels
	Fingers
X	Buttocks

Feedback when correct:

That's right! You selected the correct response.

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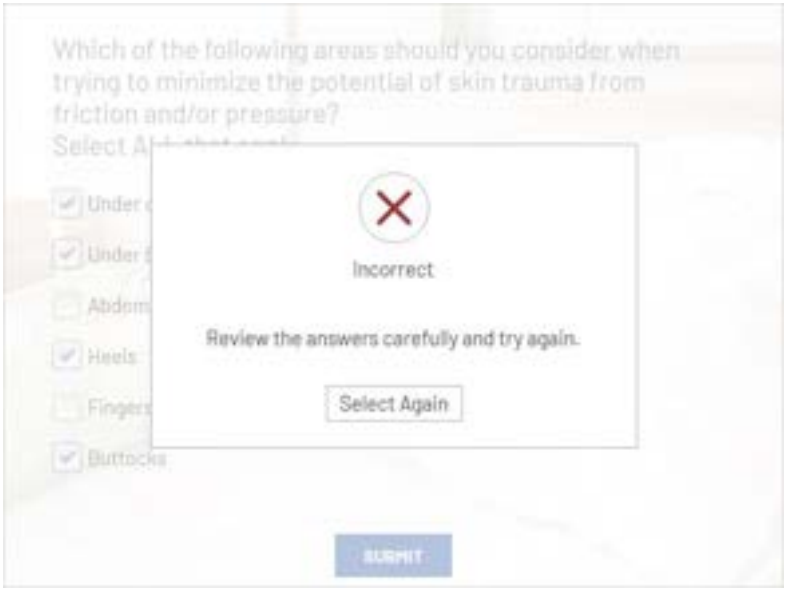
Feedback when incorrect:

You did not select the correct response.

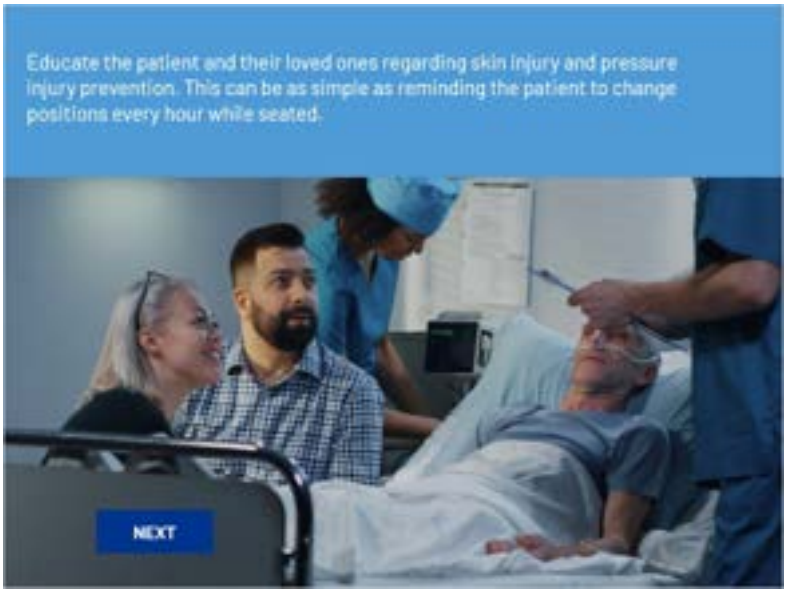
Correct (Slide Layer)

Incorrect (Slide Layer)

Try Again (Slide Layer)



1.43 Education



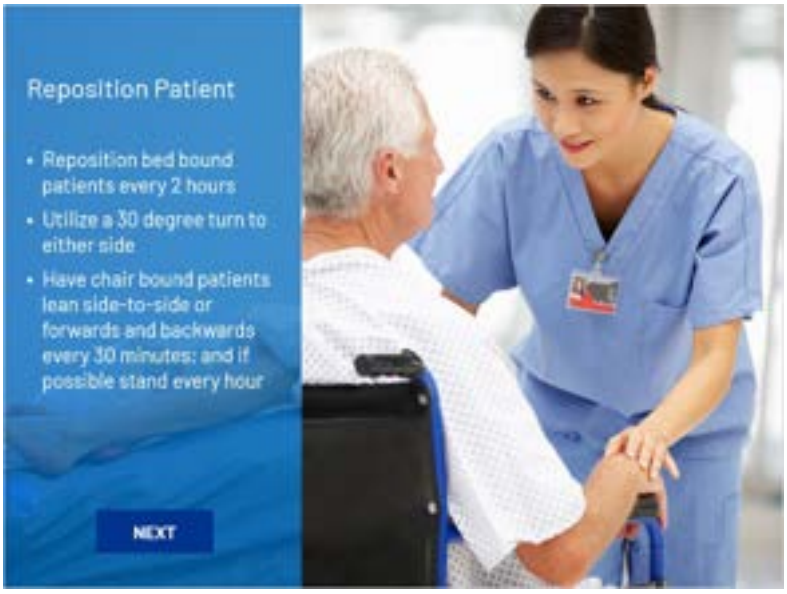
1.44 Braden Scale

Notes:

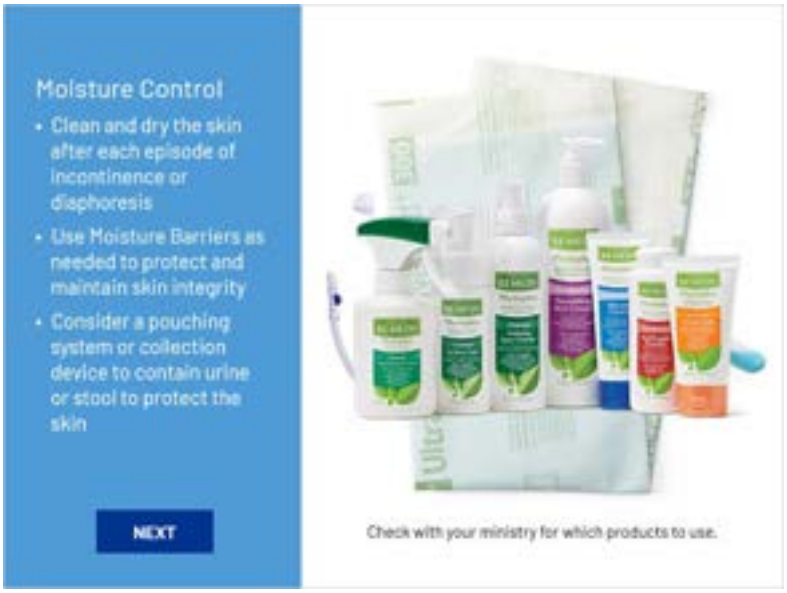
1.45 Heel Off Loading Boot

Notes:

1.46 Reposition Patient



1.47 Moisture Control



Notes:

1.48 Wound Pictures

1.49 Wound Pictures

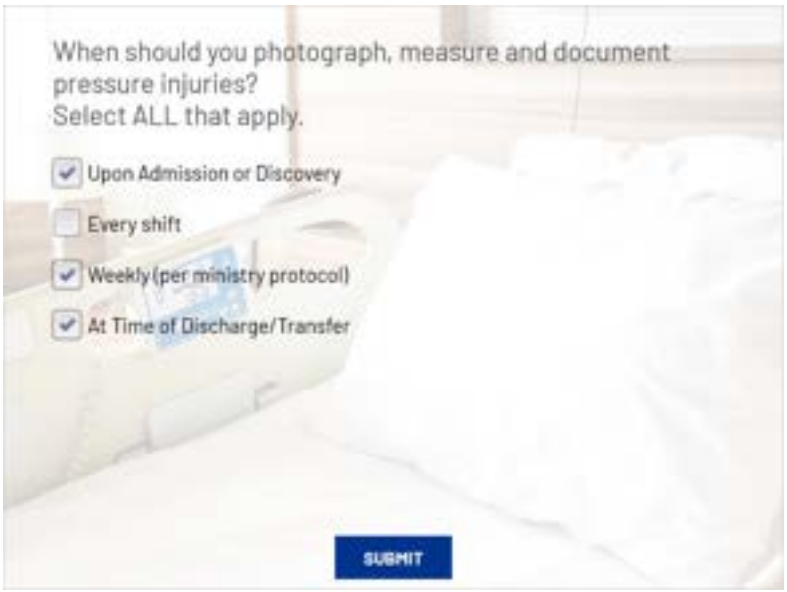
1.50 Wound Pictures

Notes:

1.51 When should you photograph, measure and document pressure injuries?

Select ALL that apply.

(Multiple Response, 10 points, 3 attempts permitted)



Correct	Choice
X	Upon Admission or Discovery
	Every shift
X	Weekly (per ministry protocol)
X	At Time of Discharge/Transfer

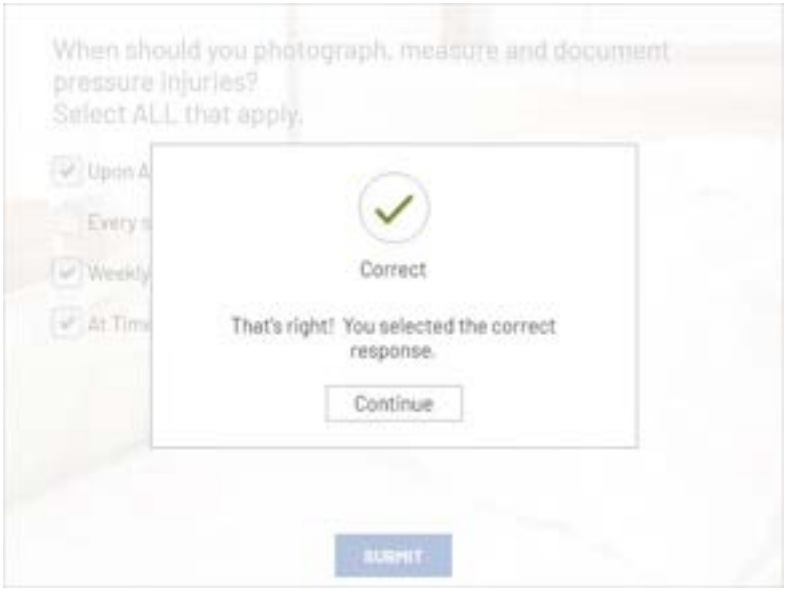
Feedback when correct:

That's right! You selected the correct response.

Feedback when incorrect:

You did not select the correct response.

Correct (Slide Layer)



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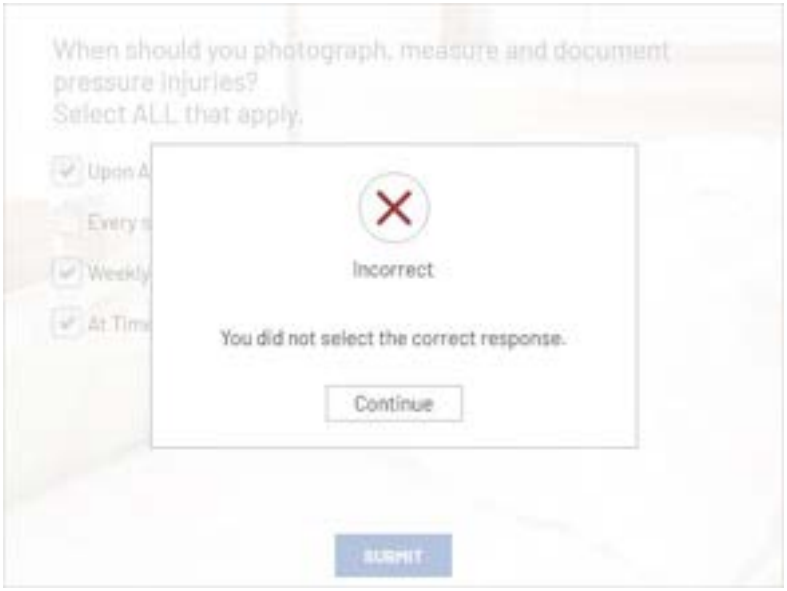
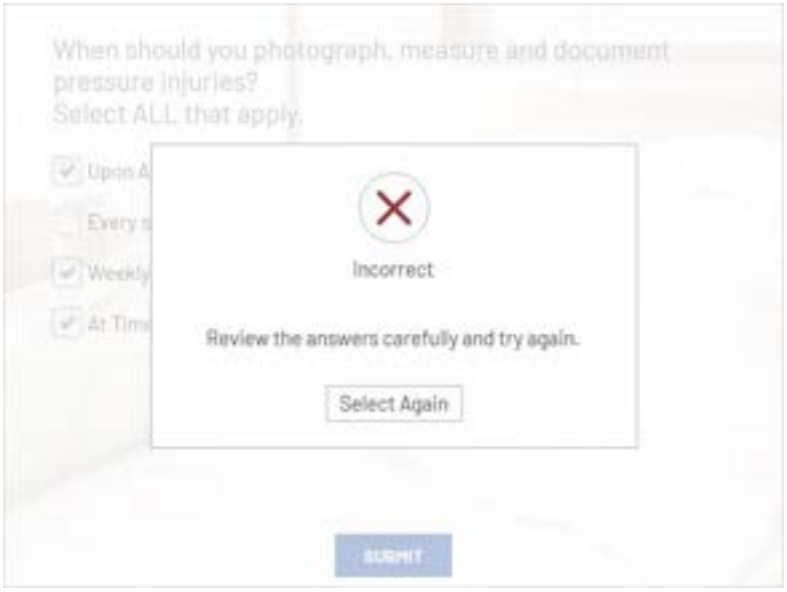
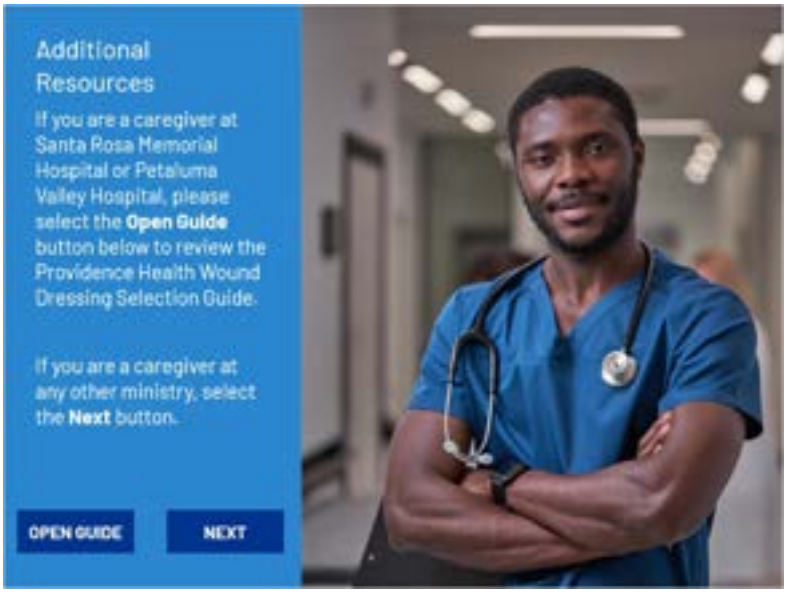


Try Again (Slide Layer)



1.52 Providence Health Wound Dressing Selection Guide

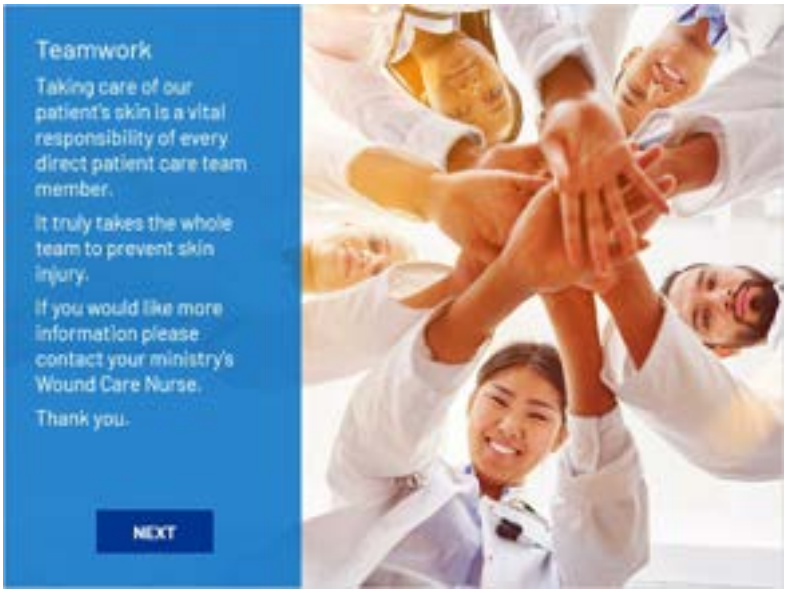


Notes:

Guide page 1 (Slide Layer)

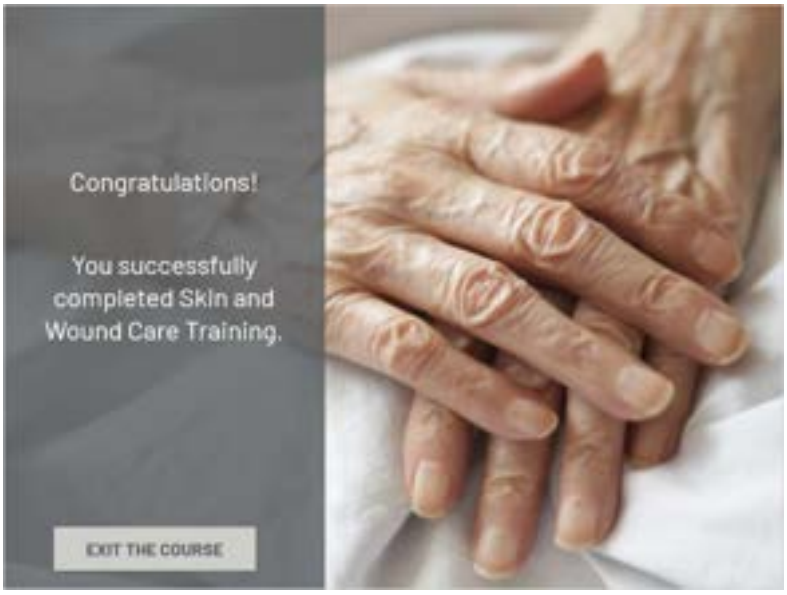
Guide page 2 (Slide Layer)

1.53 Congratulations!



Notes:

1.54 Success



Notes:

PROV: Care of Patients at Risk for Suicide - Direct Caregivers Part 1

This course provides an outline of the evidence-based processes and standards of care for caregivers to assess and then implement appropriate actions for patients who are at acute risk of self-harm or suicide.

- **Overview and Objectives**
- **Suicide Screening**
- **Suicide Risk Assessment**
- **Factors Impacting Risk**
- **Conclusion**

Overview and Objectives

Navigation Tip: If you are directed to PolicyStat or another external site, be sure to minimize the new window (do not close it) to return to this course. This will allow you to continue and complete the module. Closing the window may prevent the course from progressing.

CONTINUE

After completing this course you will be able to:

1. Define screening requirements to identify patients at risk for self-harm.
2. Use an evidence-based process to conduct a suicide risk assessment of individuals who screen positive for suicidal ideation.
3. Identify patient factors that may impact risk for or prevention of suicide.

4 Identify environmental safety risks and specific interventions used to mitigate those risks.

5 Understand when a Constant Observer should be initiated.

6 Define the purpose and requirements of a Safety Plan.

7 List documentation requirements for patients identified as at risk for suicide.

CONTINUE

Regulatory bodies require that hospitals have a process to reduce the risk of suicide and ensure patients receive care in a safe setting.

Expand and review both sections below for more information.

The Joint Commission National Patient Safety Goal (NPSG)

NPSG.15.01.01: Reduce the risk for suicide

- Elements include use of a validated screening tool, an evidence-based process to assess patients who screen positive for suicide risk,

implementing procedures to mitigate risk, documentation of the level of risk and mitigation plan, and procedures for follow-up care at discharge.

Centers for Medicare & Medicaid Services (CMS)

CMS Safe Care 482.13 (c)(2)

- Hospitals must provide the appropriate level of education and training to staff regarding the identification of patients at risk of harm to self or others, the identification of environmental patient safety risk factors and mitigation strategies.

This module provides a review of the suicide risk assessment and prevention processes used at Providence to keep our patients safe.

Complete the content above before moving on.

Suicide Screening

Who is at risk?

- Providence uses the Columbia Suicide Severity Rating Scale (C-SSRS) Screening Tool to help to identify patients with risk factors for suicide, so we can keep them safe while in our care.
- The C-SSRS Screening Tool is evidenced-based and consists of six questions which automatically calculate the level of risk for suicide. Staff may then base interventions on level of risk.

A print copy of the C-SSRS Screening Tool is provided below for reference purposes.

Navigation Reminder: After clicking on the link, be sure to minimize the new window (do not close it) to return to this course. This will allow you to click "Continue" and complete the module. Closing the window may prevent the course from progressing.

https://phs-phs.policystat.com/doc_attachment/view/63201365/

CONTINUE

Key Points for Screening

Click START or the arrow button and review the following slides.

1

Screening detects those patients that are at risk and identifies immediate safety needs.

2

For some patients, it is a relief to be asked directly and non-judgmentally about suicide.

3

Ask about suicide while getting information about psychiatric & substance abuse symptoms and history.

4

If you have difficulty asking these questions consider, “Some topics are hard to bring up, so we ask these questions of everyone.”

5

Ideally, screen during a time when the patient is alone and in a private area.

Asking someone if they are thinking about suicide does not give them the idea for suicide.

Click through and review each of the key points above to continue.

When do we screen?

All patients 12 years of age and older presenting to the emergency department or admitted as an inpatient will be screened for the risk of suicide utilizing the Columbia Suicide Severity Rating Scale (C-SSRS), regardless of their chief complaint or diagnosis.

Patients screened to be at risk for suicide will be assessed by a qualified clinician for their level of suicide risk. Minimally, the assessment will address ideation, plan, intent, suicidal or self-harm behaviors, risk factors and protective factors. The qualified clinician determines and documents the patient's overall risk.

Safety interventions will be implemented based on the patient's suicide risk level identified during screening and may be modified by the full risk assessment.

Remember: Patients being treated for a medical condition may have unknown behavioral health conditions, a change in prognosis, or psychosocial issues that may precipitate suicidal ideation and/or self-harm behaviors. This is why screening of everyone is so important.

Screening occurs in the ED and Inpatient areas.

Pediatric Patient Screening

All patients twelve years of age* and older presenting to the emergency department or admitted as an inpatient will be screened for the risk of suicide utilizing the Columbia Suicide Severity Rating Scale (C-SSRS), regardless of their chief complaint or diagnosis.

*If you work in a location where local requirements for screening include younger patients (e.g. patients 10 years of age) follow the requirements communicated by your local or facility policy

For pediatric patients aged 12 and above, the suicide risk assessment will also evaluate demonstrated and observed self-destructive behaviors, suicidal verbalizations, and/or history of suicide attempt or ideations.

Additionally, information from the parent, guardian or responsible adult accompanying the minor will be considered as a part of the assessment process.

The physician will be notified immediately, and the patient will be considered high-risk for suicide until otherwise determined by the physician.

For pediatric patients eleven (11) years or younger who are actively suicidal, notify the physician immediately and place with a constant observer.

CONTINUE

Screening Results - If the patient answers *"yes"* to any of the 6 questions of the C-SSRS Screening Tool, the screen is positive for

suicide risk and a comprehensive risk assessment should be completed by ministry designated personnel.

If your C-SSRS screening indicates high risk, take action to establish safety immediately, before moving ahead with the C-SSRS assessment.

- Notify the responsible physician, advanced practice clinician (APC) and/or designated behavioral health clinician of the outcome of the C-SSRS screen.
- Immediately establish continuous visual observation with a constant observer. The level of observation will be determined based on level of suicide risk. Do not leave patient unattended and always err on the side of caution.
- Implement the Constant Observer Risk Mitigation Checklist (Appendix C in policy). All objects that pose a risk for self-harm that can be removed without adversely affecting the ability to deliver medical care will be removed. Items required for direct patient care (e.g. oxygen and IV tubing, lightweight IV pole) do not need to be removed but will be closely monitored.
- Conduct a safety search including clothing worn by the patient. The search should be conducted in a culturally sensitive manner and with respect for the individual's dignity and privacy. Two (2) caregivers must be present, one (1) licensed caregiver of the same gender as the patient if possible. Belongings will be removed and placed in a secure area.

While awaiting further assessment, it is important to implement monitoring and interventions (per policy) to mitigate risk as warranted by the patient's level of risk.

For patients who demonstrate other concerning behavior, such as agitation, aggression, hostility, verbal threats, hallucinations, delusions, disorganized thinking and speech, bizarre or unusual behavior, consider establishing continuous visual observation with a constant observer.

CONTINUE

Suicide Risk Assessment

- If *C-SSRS* ***Screener*** suicide screen shows the patient is at ***any*** risk level (low, moderate or high), a full suicide risk assessment must be completed. The ministry-designated caregiver, physician, APC, behavioral health clinician or other qualified clinician will conduct the suicide risk assessment using the Columbia Suicide Severity Rating Scale (C-SSRS) Risk Assessment Tool.

- The comprehensive risk assessment includes asking about suicidal ideation, plan, intent, suicidal or self-harm behaviors, risk factors, and protective factors to determine and document the patient's overall risk.

A print copy of the C-SSRS Risk Assessment Tool is provided below for reference purposes.

Navigation Reminder: After clicking on the link, be sure to minimize the new window (do not close it) to return to this course. This will allow you to click "Continue" and complete the module. Closing the window may prevent the course from progressing.

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Identifying Suicidal Behavior

The tabs below show the different types of suicidal behavior. Consider this information when completing the C-SSRS Risk Assessment on your patients.

Click each tab to learn more.

ACTUAL ATTEMPT | INTERRUPTED ATTEMPT | ABORTED OR SELF-INTERRUPTED ATTEMPT | PREPARATORY ACTS OR BEHAVIOR

A potentially self-injurious act committed with at least some wish to die, as a result of act. Behavior was in part thought of as method to kill oneself.

- Intent does not have to be 100%.
- If there is any intent/desire to die associated with the act, then it can be considered an actual suicideattempt.
- There does not have to be any injury or harm, just the potential for injury or harm.

Inferring Intent: Even if an individual denies intent/wish to die, it may be inferred clinically from the behavior or circumstances. For example, a highly lethal act that is clearly not an accident so no other intent but suicide can be inferred (e.g., gunshot to head, jumping from window of a high floor/story).

ACTUAL ATTEMPT | INTERRUPTED ATTEMPT | ABORTED OR SELF-INTERRUPTED ATTEMPT | PREPARATORY ACTS OR BEHAVIOR

When the person is interrupted (by an outside circumstance) from starting the potentially self-injurious act (if not for that, actual attempt would have occurred).

- ***Overdose:*** Person has pills in hand but is stopped from ingesting. Once they ingest any pills, this becomes an attempt rather than an interrupted attempt.

- ***Shooting:*** Person has gun pointed toward self, gun is taken away by someone else, or is somehow prevented from pulling trigger. Once they pull the trigger, even if the gun fails to fire, it is an attempt.
- ***Jumping:*** Person is poised to jump, is grabbed and taken down from ledge.
- ***Hanging:*** Person has noose around neck but has not yet started to hang - is stopped from doing so.

ACTUAL ATTEMPT	INTERRUPTED ATTEMPT	ABORTED OR SELF-INTERRUPTED ATTEMPT	PREPARATORY ACTS OR BEHAVIOR

When person begins to take steps toward making a suicide attempt, but stops themselves before they actually have engaged in any self-destructive behavior.

- Examples are similar to interrupted attempts, except that the individual stops him/herself, instead of being stopped by something else.

ACTUAL ATTEMPT	INTERRUPTED ATTEMPT	ABORTED OR SELF-INTERRUPTED ATTEMPT	PREPARATORY ACTS OR BEHAVIOR

Acts or preparation towards imminently making a suicide attempt.

- This can include anything beyond a verbalization or thought, such as assembling a specific method (e.g., buying pills, purchasing a gun) or preparing for one's death by suicide (e.g., giving things away, writing a suicide note).

Source: National Suicide Prevention Lifeline's COLUMBIA-SUICIDE SEVERITYRATING SCALE (C-SSRS)Risk Assessment (Lifeline crisis center version)

Click and review each tab above to continue.

Difficulties in Assessing Risk

If a patient who presents for a non-behavioral problem is unwilling to participate in the screening process, observe patient for suicidal/self-harm behaviors and complete screening once patient is willing to participate.

If a patient who presents for a non-behavioral problem is unable to participate in the screening process, complete screening once patient is able, to participate.

For a patient who presents for a behavioral health problem is unable or unwilling to participate in the initial screening, or if it is suspected that the patient is withholding information during screening questions in answering the C-SSRS questions, assume the patient is at high risk for suicide until an assessment is completed by a physician, advanced practice clinician (APC) and/or designated behavioral health clinician.

For patients who demonstrate non-suicidal, maladaptive self-harm behaviors, immediately establish continuous visual observation with a constant observer and implement the interventions for a patient at high-risk for suicide.

For patients who demonstrate other concerning behavior, such as agitation, aggression, hostility, verbal threats, hallucinations, delusions, disorganized thinking and speech, bizarre or unusual behavior, consider establishing continuous visual observation with a constant observer.

Additional Steps to Take

Other things that may be included in the assessment and intervention for patients at risk for suicide:

- Encourage the patient to talk about their situation and express their feelings.
- Ask about their support system—do they have any family, friends, counselor, etc. who they can talk to?
- Ask about their coping strategies—is there anything they do now or have done in the past that has been helpful, i.e., talking to someone, going to counseling, praying, meditating, etc.
- Look for any strengths or "positives", i.e., times when they reached out for help, people or things that are important to them that they can still connect with.
- Elicit from the patient what they see as positives in their life at this time, what do they value, what is important to them.

Caution: Suicide contracts are not recommended, there is no evidence they decrease suicide risk, and they are not considered a legal document.

CONTINUE

Knowledge Check

Let's review the topics we just covered. Select the best response for each question.

If your patient screens negative (not at risk) with the C-SSRS screening tool, but you are suspicious, what should you do?

- ◯ Try to lighten the mood by making jokes.
- ◯ Try to talk them out of it by pointing out how selfish they are being.
- ◯ Immediately notify the police of what you have observed and/or heard from the patient.
- ◯ Assume the patient is at high risk for suicide until an assessment is completed by a qualified clinician.

SUBMIT

What additional step can you take during assessment and intervention for patients at risk of suicide?

- Encourage the patient NOT to talk about their situation.
- Don't ask about their family, friends, counselor, etc., because it may bring up negative feelings.
- Ask about their coping strategies—is there anything they do now or have done in the past that has been helpful.
- Remind them of times in the past when they reached out for help and were rejected.

SUBMIT

Answer the knowledge check questions above to continue.

Factors Impacting Risk

Factors that May Indicate a Higher Risk for Suicide Include:

- History of depression and/or anxiety.
- Other mental health issues (i.e. bipolar disorder, schizophrenia, major depression).
- Previous suicide attempt or attempts.
- Family history of suicide and/or mental health issues.
- Alcohol and/or other substance abuse.
- History of physical, sexual, and/or emotional abuse.
- Ongoing illness and/or physical pain.
- Co-morbid health problems, especially a newly diagnosed problem or worsening symptoms.
- Recent stressful event or events such as, loss of job or death of a loved one.
- Extreme difficulty coping—deep sadness, loss of interest, trouble sleeping and poor appetite.
- Impulsivity and poor self-control; engagement in reckless or high-risk behaviors.
- Access to guns, other weapons, medications, or other devices that can be used for self-harm.

Indicators of More Immediate Risk of Self-Harm

- Expressing or displaying feelings of hopelessness, unworthiness, lack of control over one's life, apathy about the future, self-reproach, distrust of others, fatalism and futility, obsession with death.
- Dramatic mood changes.
- Spoken or written threats of suicide.
- Making veiled or indirect statements about one's own death; feeling like there is no reason to live.
- Giving away personal possessions.
- Drafting a will or making funeral arrangements (this needs to be considered within the context of patient's situation and presence of other risk factors.)
- Procuring a weapon or lethal dose of drugs.
- Withdrawal from friends, family and coworkers.
- Withdrawal and loss of interest in activities that once brought pleasure.
- Exhibiting very depressed mood (sadness, melancholy, lack of interest in life).

- Extreme difficulty in coping.
- Demonstrating chronic or acute sleep disturbances.

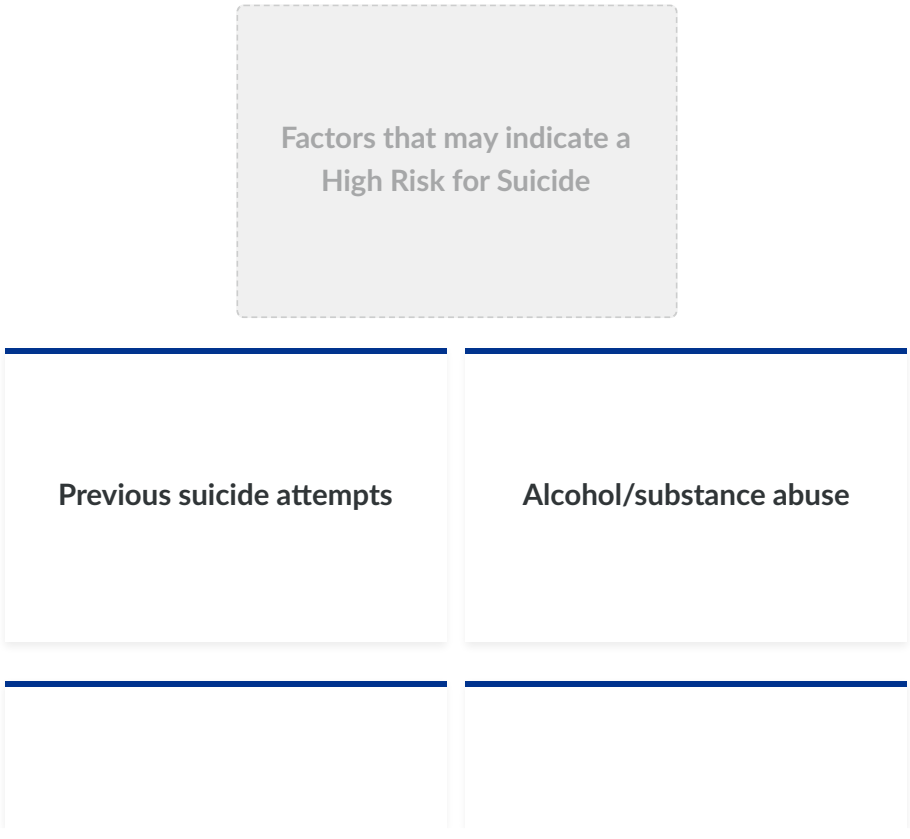
Protective Factors that May Decrease Risk

Protective factors are personal or environmental characteristics that help protect people from suicide.

Major protective factors for suicide include:

- Participation in effective behavioral health care; positive therapeutic relationships.
- Connectedness to individuals, family, community, and social institutions.
- Life skills, including problem-solving skills and coping skills, ability to adapt to change, reality-testing ability.
- Self-esteem and a sense of purpose or meaning in life.
- Cultural, religious, or personal beliefs that discourage suicide.
- Responsibility to children or beloved pets.

Drag each symptom below to the correct category on the left or right.



Other mental illness

History of depression and/or anxiety

Recent stressful event

Family history of suicide/mental illness

Access to weapons

History of abuse

Indicators of More Immediate Risk of Self-Harm

Dramatic mood changes

Giving away personal possessions

Buying a gun

Extreme difficulty coping

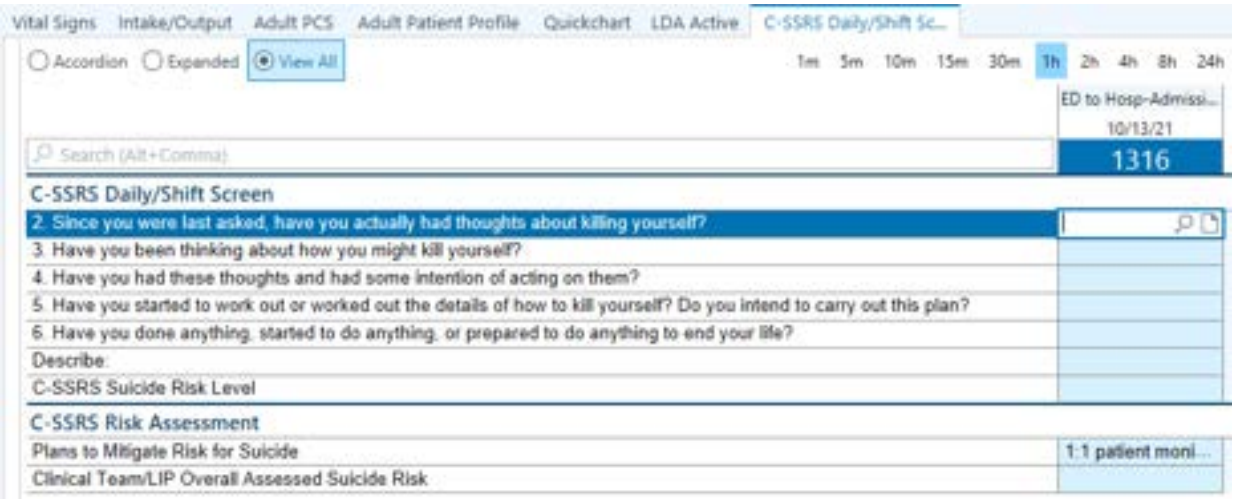
Chronic or acute sleep disturbances	Withdrawal from friends/family
Threats of suicide	Statements about one's own death

Complete the content above before moving on.

Ongoing Assessment of Suicide Risk

- The C-SSRS screener tool automatically calculates an initial suicide risk level based on patient responses
- The patient's overall risk for suicide is determined by the provider/clinical team, based on their full assessment of the patient

- For patients identified at risk, re-assessments are completed using the C-SSRS Daily Shift tool:
    - Per policy for patients in the ED
    - Each shift for inpatients
    - As needed based on patient condition



A print copy of the C-SSRS Daily Shift Tool is provided below for reference purposes.

Navigation Reminder: After clicking on the link, be sure to minimize the new window (do not close it) to return to this course. This will allow you to click "Continue" and complete the module. Closing the window may prevent the course from progressing.

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CONTINUE

Conclusion

You have successfully finished the initial eLearning segment of the *Care of Patients at Risk for Suicide – Direct Caregivers* module.

If you have any unit specific questions regarding suicide prevention or individual procedures within your ministry, please contact your nursing unit manager or preceptor.

Please proceed to the second module to continue your learning journey.

Click 'Exit Course' above to close this window.

PROV: Yale Swallow Protocol

Target Audience: All caregivers who need to assess the swallowing capabilities of their patient.

- Course Navigation
- Learning Objectives
- Introduction
- Yale Swallow Protocol
- Documenting in Epic
- Resources
- References
- Assessment
- Conclusion

Course Navigation

Technical Recommendations

There are technical recommendations in order to access all components and ensure you have an optimal learning experience. Before you continue, please ensure your computer meets these requirements:

Computer or Laptop	Web Browser	Operating System	Internet Connection	Other
Minimum screen size of 15" Audio capability	Latest version of **Microsoft Edge**	Windows 10 or higher Mac: Catalina OS	High speed internet (DSL/Cable) Reliable connection	Headphones, earbuds or speakers

A phone or tablet should not be used to complete this eLearning course.

Important Navigation Reminders

Please keep the following items in mind while completing this course:

- **View all content:** Successful completion of this course requires viewing all content and passing the assessment with a minimum score of 80%. You may exit the course and return to where you left off.
- **Progress saved:** You may exit the course and return to where you left off.
- **Scroll down to continue:** Lessons load as you complete a section. If you do not see the continue or next lesson button, scroll down to load the lesson or locate the continue button.
- **Links:** If you are directed to PolicyStat or another external site, be sure to check the **taskbar at the bottom** of your screen to find the open course and resume where you left off.
- **Images:** Select an image to view a larger version.

- **Technical Issues:** If experiencing issues, try clearing the browser history before or during the course. If you continue to experience issues, submit a ticket in the Caregiver Service Portal or call (844) 922-7548.

CONTINUE

Learning Objectives

Upon completion of this module, caregivers will be able to:

1. Understand the purpose of the swallow screening.
2. Understand what differentiates a swallow screening from a swallow evaluation, criteria and contraindications for performing each task, and what caregivers are allowed to perform each task.
3. Understand issues regarding what can and what cannot be accurately screened with relation to swallowing function.
4. Explain what the three-ounce water swallow test is and how it is administered.
5. Describe the three components of the Yale Swallow Protocol.
6. Review how to document the Nursing Bedside Swallow Screen in Epic.

CONTINUE

Introduction

This lesson reviews the importance of performing a bedside swallow screen using the Yale Swallow Protocol.

The Yale Swallow Protocol is a validated tool to identify risk for aspiration due to dysphagia in hospitalized patients.

- Nurses are responsible to screen patients at risk for aspiration.
- Speech-Language Pathologists (SLPs) are responsible for evaluating patients who have been screened as at risk for aspiration.
- Follow your local policy regarding inclusion/exclusion criteria.
- Find the Bedside Swallow Screen in Epic.

Early identification of aspiration risk improves patient outcomes.

CONTINUE

Nurses perform the Yale Swallow Screen and when necessary, engage Speech-Language Pathologists to perform a swallow evaluation.

Nursing Bedside Swallow Screen (Nursing BSS)	Speech-Language Pathologist (SLP) Swallow Evaluation

• Brief screen to rule out risk of aspiration
• Is **not** diagnostic
• Results in pass/fail
  ◦ Fail requires NPO orders and SLP swallow evaluation
  ◦ Should not be re-administered if the patient fails
  ◦ Screen may be repeated **IF** patient passes **THEN** there is a change in patient status with a new concern for aspiration risk **AND** the
	• In depth bedside and/or video-based evaluation of swallow function
	• Is diagnostic
	• Results in one or more of the following:
	  ◦ Dysphagia diagnosis
	  ◦ Diet recommendations
	  ◦ SLP treatment plan
	  ◦ Additional consultation or medical evaluation

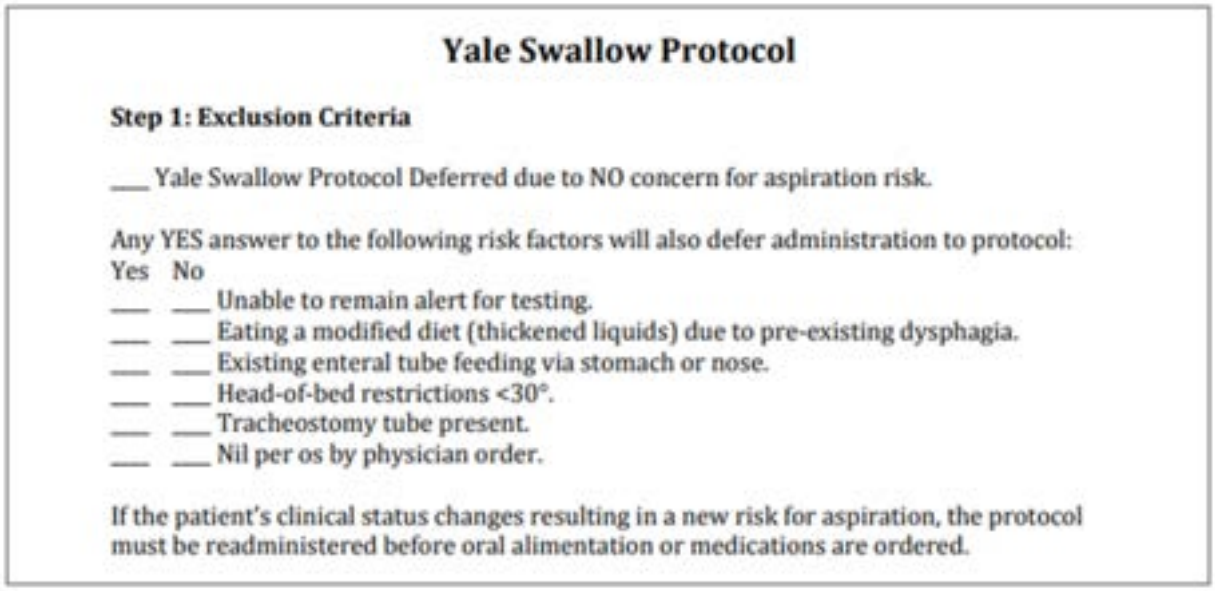
	patient is not being seen by SLP for swallowing therapy	

CONTINUE

Yale Swallow Protocol

Instructions: Select the directional arrows (<>) below to review the Yale Nursing Bedside Swallow Screen steps. Tip: Select images to view larger. All steps must be reviewed to continue.

Step 1



Yale Swallow Protocol

Step 1: Exclusion Criteria

___ Yale Swallow Protocol Deferred due to NO concern for aspiration risk.

Any YES answer to the following risk factors will also defer administration to protocol:

Yes	No	
___	___	Unable to remain alert for testing.
___	___	Eating a modified diet (thickened liquids) due to pre-existing dysphagia.
___	___	Existing enteral tube feeding via stomach or nose.
___	___	Head-of-bed restrictions <30°.
___	___	Tracheostomy tube present.
___	___	Nil per os by physician order.

If the patient's clinical status changes resulting in a new risk for aspiration, the protocol must be readministered before oral alimentation or medications are ordered.

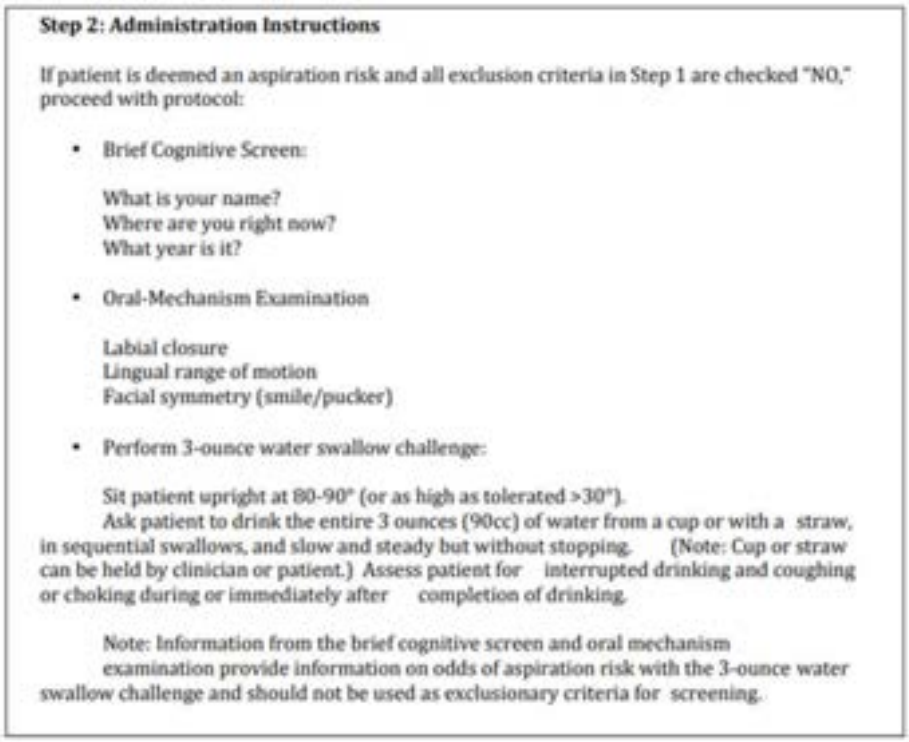
Determine if you can safely perform the bedside swallow screen using Yale Swallow Protocol. This step provides exclusion criteria.

Step 2

Before beginning the Yale Swallow Protocol, prepare by:

1. Gathering Supplies including —3 ounces (90ml) of cool or room temperature water — Oral hygiene supplies —Suction equipment.
2. Ensure head of bed is up as high as the patient will tolerate (>30 degrees).
3. Make sure the patient is wearing their dentures, eyeglasses, and/or hearing aids, as applicable.
4. Minimize distraction (turn off TV, ask visitors to step out, etc). 5. Perform oral care

Step 3



Step 2: Administration Instructions

If patient is deemed an aspiration risk and all exclusion criteria in Step 1 are checked "NO," proceed with protocol:

- Brief Cognitive Screen:

  What is your name?
  Where are you right now?
  What year is it?

- Oral-Mechanism Examination

  Labial closure
  Lingual range of motion
  Facial symmetry (smile/pucker)

- Perform 3-ounce water swallow challenge:

  Sit patient upright at 80-90° (or as high as tolerated >30°).
  Ask patient to drink the entire 3 ounces (90cc) of water from a cup or with a straw, in sequential swallows, and slow and steady but without stopping. (Note: Cup or straw can be held by clinician or patient.) Assess patient for interrupted drinking and coughing or choking during or immediately after completion of drinking.

  Note: Information from the brief cognitive screen and oral mechanism examination provide information on odds of aspiration risk with the 3-ounce water swallow challenge and should not be used as exclusionary criteria for screening.

If safe to do so, proceed with the screening. Follow the protocol.

Step 4

Step 3: Pass/Fail Criteria

Results and Recommendations

____ PASS: Complete and uninterrupted drinking of all 3 ounces of water without overt signs of aspiration, i.e., coughing or choking, either during or immediately after completion.

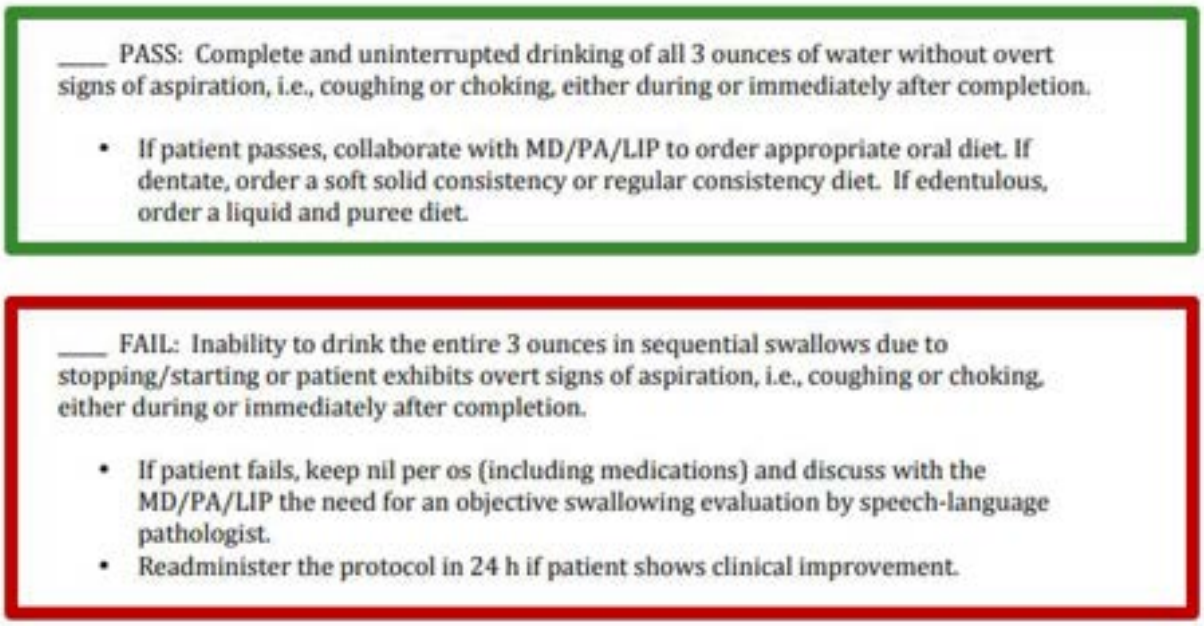
- If patient passes, collaborate with MD/PA/LIP to order appropriate oral diet. If dentate, order a soft solid consistency or regular consistency diet. If edentulous, order a liquid and puree diet.

____ FAIL: Inability to drink the entire 3 ounces in sequential swallows due to stopping/starting or patient exhibits overt signs of aspiration, i.e., coughing or choking, either during or immediately after completion.

- If patient fails, keep nil per os (including medications) and discuss with the MD/PA/LIP the need for an objective swallowing evaluation by speech-language pathologist.
- Readminister the protocol in 24 h if patient shows clinical improvement.

Follow the protocol to determine whether the patient has passed or failed the screening.

Follow the protocol for next steps based on whether the patient has passed or failed.



____ PASS: Complete and uninterrupted drinking of all 3 ounces of water without overt signs of aspiration, i.e., coughing or choking, either during or immediately after completion.

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- If patient fails, keep nil per os (including medications) and discuss with the MD/PA/LIP the need for an objective swallowing evaluation by speech-language pathologist.
- Readminister the protocol in 24 h if patient shows clinical improvement.

Complete the content above before moving on.

Knowledge Check

After determining it is safe to proceed with the Yale Swallow Protocol, how will you prepare the patient and environment? (Select **ALL** that apply)

- [ ] Gather Supplies: 3 ounces (90ml) of water
- [ ] Perform oral care
- [ ] Make sure the patient is wearing their dentures, eyeglasses, and/or hearing aids, if applicable
- [ ] Ensure head-of-bed is up as high as the patient will tolerate (greater than 30 degrees)
- [ ] Suction equipment available
- [ ] Minimize distraction (turn off TV, ask visitors to step-out, etc.)

SUBMIT

Complete the content above before moving on.

The patient is able to answer name and location but did not answer the year/date questions accurately. The patient follows directions and puckers and smiles. **Should you "Continue" or "Fail" the patient?**

- Continue
- Fail

SUBMIT

Complete the content above before moving on.

The patient has facial droop. They are sleepy and unable to follow directions. There is no respiratory or gurgling present. **Should you "Continue" or "Fail" the patient?**

- [ ] Continue
- [ ] Fail
- [ ] Defer the Yale Swallow Screening until the patient is alert

SUBMIT

Complete the content above before moving on.

True or False. You may proceed with a swallow screen if the patient is unable to have the head-of-the bed at 30 degrees or greater.

- [ ] True
- [ ] False

SUBMIT

Complete the content above before moving on.

True or False. If the patient has a feeding tube in place, a SLP must conduct an evaluation.

- True
- False

SUBMIT

Complete the content above before moving on.

Documenting in Epic

Find the Bedside Swallow Screen in Epic.

Nursing Bedside Swallow Screen (Emergency Department)

The screening tool is available in Stroke Narrator and ED Narrator.

Instructions: Scroll within the frame to review the PDF below. Select the "+" icon to zoom in.

Navigation Reminder: The links below are external sites. To return to this course, be sure to check the **taskbar at the bottom** of your screen to find the open course and resume where you left off.

Nursing Bedside Swallow Screen (Emergency Department) is also available as a PDF download as well as a link below.

PDF instructions: Select the file below to open and review its content.

PDF

nursing-bedside-swallow-screen-emergency-department.pdf
617 KB

Link available here: Nursing Bedside Swallow Screen (Emergency Department)

Nursing Bedside Swallow Screen (Inpatient)

The screening tool is available on the Stroke Care and the Adult PCS, Critical Care PCS, Pediatric PCS Body Care System flowsheets.

Instructions: Scroll within the frame to review the PDF below. Select the "+" icon to zoom in.

Navigation Reminder: The links below are external sites. To return to this course, be sure to check the **taskbar at the bottom** of your screen to find the open course and resume where you left off.

Nursing Bedside Swallow Screen (Inpatient) is also available as a PDF download as well as a link below.

PDF instructions: Select the file below to open and review its content.

PDF

nursing-bedside-swallow-screen-inpatient.pdf
913 KB

Link available here: Nursing Bedside Swallow Screen (Inpatient)

CONTINUE

Scenario

An 82-year-old patient is admitted to the hospital with slurred speech. He is intermittently alert and has difficulty following instructions. Medical history includes a feeding tube for enteral tube feeding.

Instructions: Proceed with documenting the Nursing Bedside Swallow Screen in the activity below. The activity must be completed to continue.

Complete the content above before moving on.

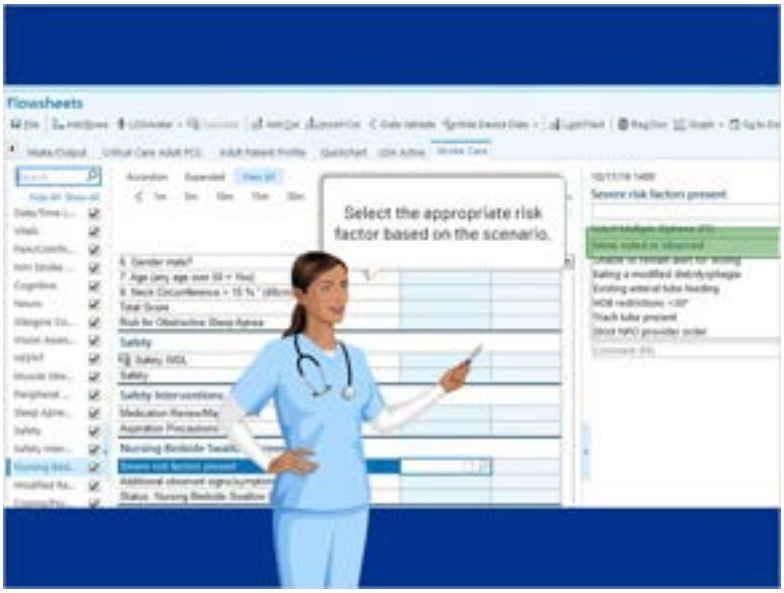
BPA Decision Support for Failed Screen

Nursing BSS Documentation Simulation

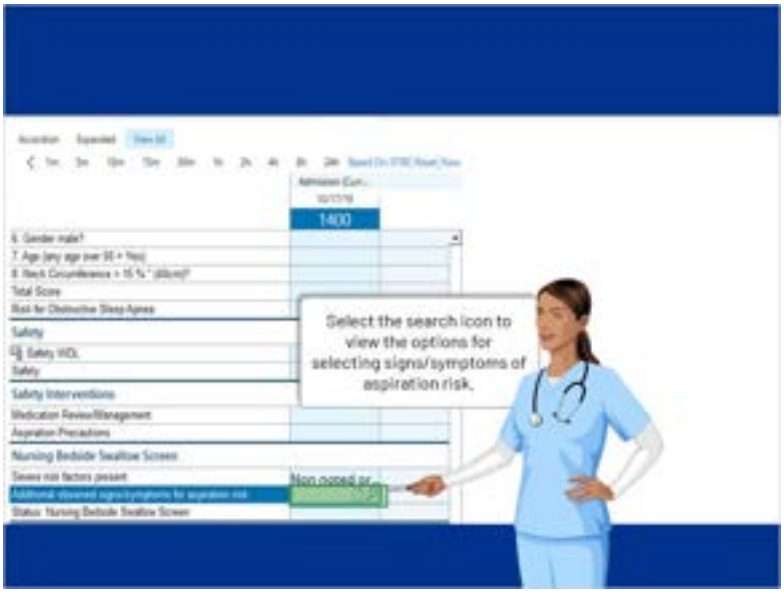
1. Nursing BSS Documentation

1.1 Untitled Slide

1.2 Untitled Slide

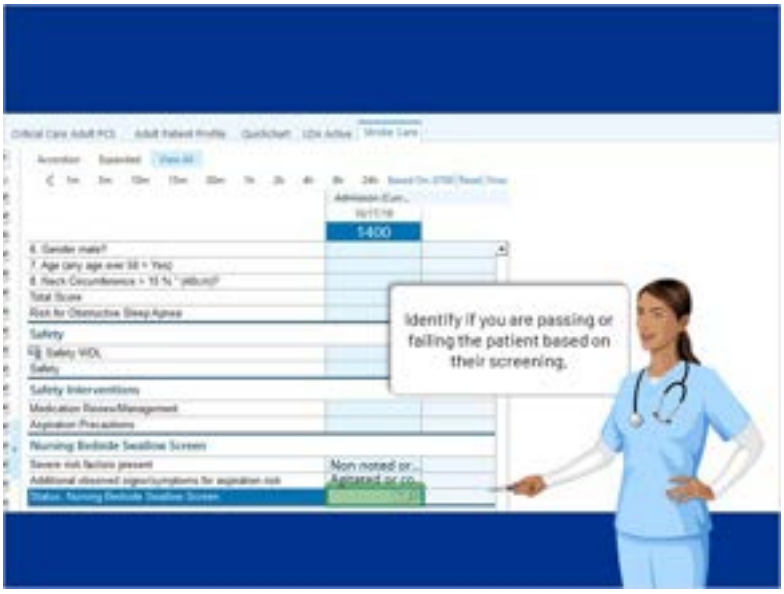


1.3 Untitled Slide



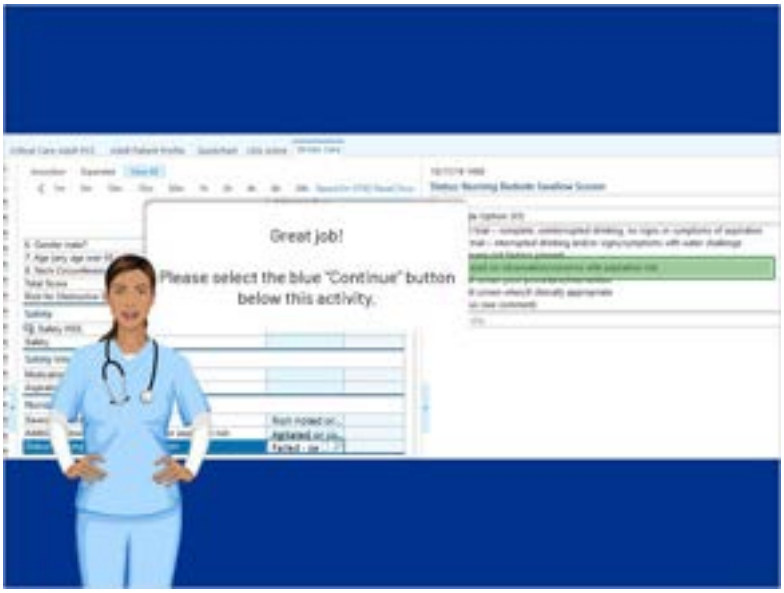
1.4 Untitled Slide

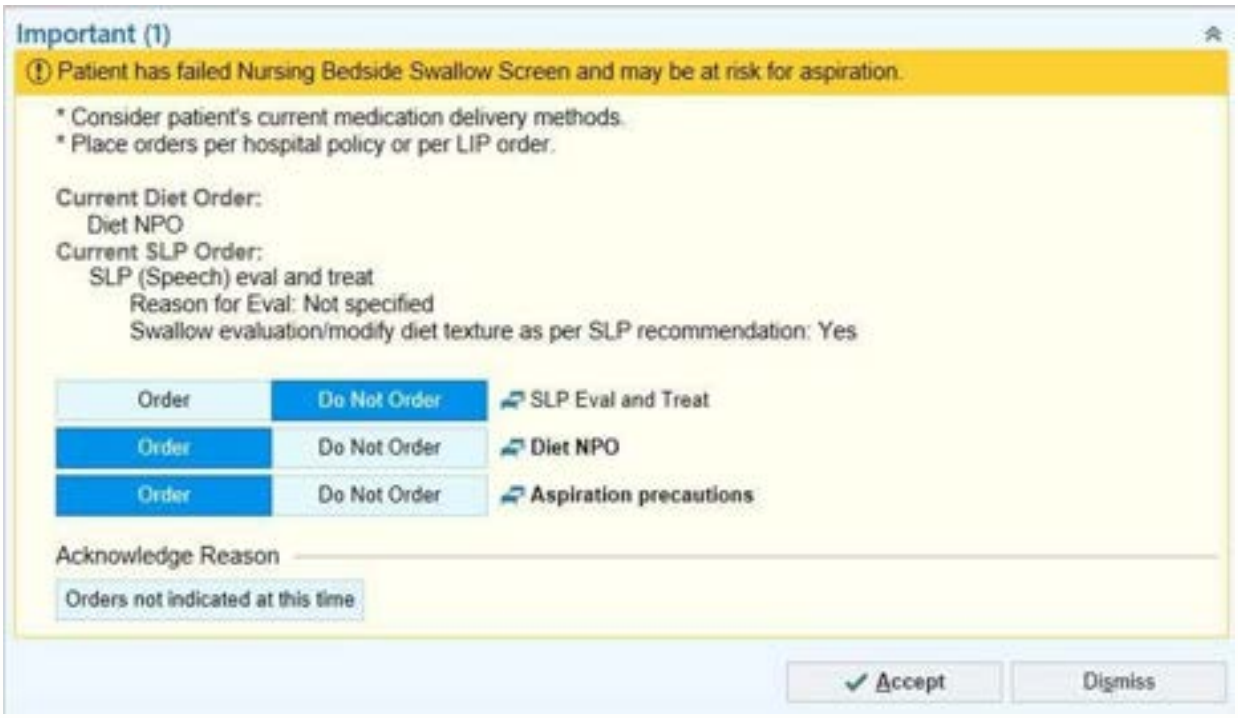
1.5 Untitled Slide



1.6 Untitled Slide

Correct (Slide Layer)

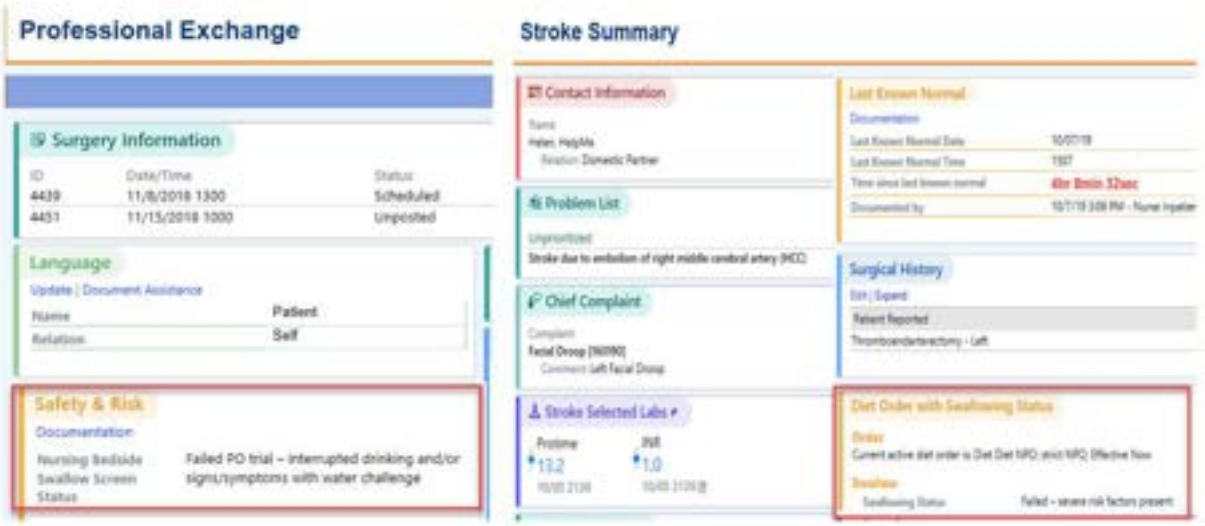




- BPA triggers upon filing failed status on nursing bedside swallow screening status flowsheet row
- Alerts the nurse that the patient is at risk for aspiration
- Reminder to consider medication delivery methods
- Prompts nurse to place orders for full speech evaluation, NPO order or aspiration Precaution order per hospital policy or LIP order
- It displays the current diet order and SLP (Speech) eval and treat order if either are present
- The BPA only fires to nursing

CONTINUE

Communicating Risk



Aspiration Risk is displayed in:

- The "Safety & Risk" section on Professional Exchange and Overview Reports
- The Stroke Summary Report

CONTINUE

Resources

The following colleagues are resources who can assist with your questions:

- Clinical Nurses Specialists
- Clinical Nurse Educators
- Speech-Language Pathologists

CONTINUE

References

1. Fedder, W. N. (2017). Review of evidenced-based nursing protocols for dysphagia assessment. Stroke, 48(4), e99-e101.

2. Leder, S. B., & Suiter, D. M. (2014). The Yale Swallow Protocol: An evidence-based approach to decision making. Springer.

3. Leder, S. B., Suiter, D. M., Warner, H. L., & Kaplan, L. J. (2011). Initiating safe oral feeding in critically ill intensive care and step-down unit patients based on passing a 3-ounce (90 milliliters) water swallow challenge. Journal of Trauma and Acute Care Surgery, 70(5), 1203-1207.

4. Leder, S. B., Suiter, D. M., Warner, H. L., Acton, L. M., & Siegel, M. D. (2011). Safe initiation of oral diets in hospitalized patients based on passing a 3-ounce (90 cc) water swallow challenge protocol. QJM: An International Journal of Medicine, 105(3), 257-263.

5. Suiter, D. M., Sloggy, J., & Leder, S. B. (2014). Validation of the Yale Swallow Protocol: a prospective double-blinded videofluoroscopic study. Dysphagia, 29(2), 199-203.

6. Warner, H. L., Suiter, D. M., Nystrom, K. V., Poskus, K., & Leder, S. B. (2014). Comparing accuracy of the Yale swallow protocol when administered by registered nurses and speech-language pathologists. Journal of clinical nursing, 23(13-14), 1908-1915.

CONTINUE

Assessment

Now it's time to check your knowledge! A minimum score of 80% is required to pass. You may retake this assessment as many times as needed.

Question

01/06

When is it appropriate to perform a Nursing BSS on a patient? Select all that apply.

- [ ] If the patient was unable to be screened because they were too sleepy, but now is more alert
- [ ] "Time limited head of bed restrictions" have been removed
- [ ] "NPO for tests or procedures," has been removed
- [ ] When a patient has previously passed but has had a decline in Medical or Neurological status

Question

02/06

Yes or No. If the patient has previously failed a Nursing BSS, can they be re-screened by the nurse?

- ◯ Yes
- ◯ No

Question

03/06

Yes or No. The RN may readminister the BSS in 24 hours if the patient shows clinical improvement.

- ◯ Yes
- ◯ No

Question

04/06

Play the video below. Did the patient pass or fail?

- ◯ Pass
- ◯ Fail

Question

05/06

Play the video below. Did the patient pass or fail?

- ◯ Pass
- ◯ Fail

Question

06/06

Play the video below. Did the patient pass or fail?

- ◯ Pass
- ◯ Fail

Conclusion

Congratulations, you have completed the *Yale Swallow Protocol* course.

Select 'EXIT COURSE' above to close this window.

Compliance

1. Intro

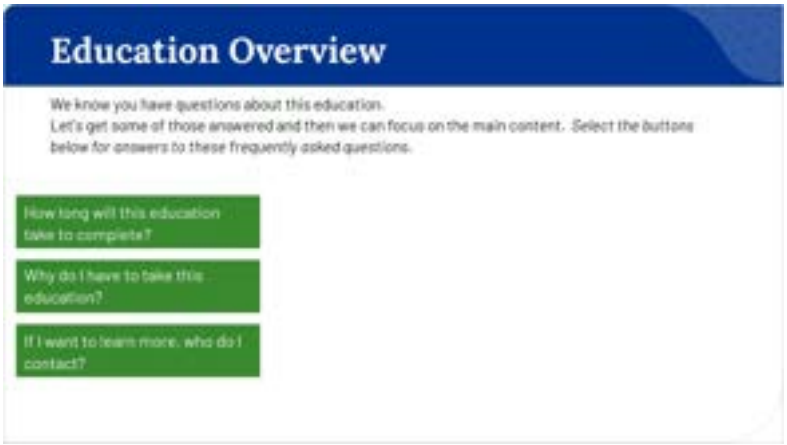
1.1 Title

Notes:

1.2 Welcome

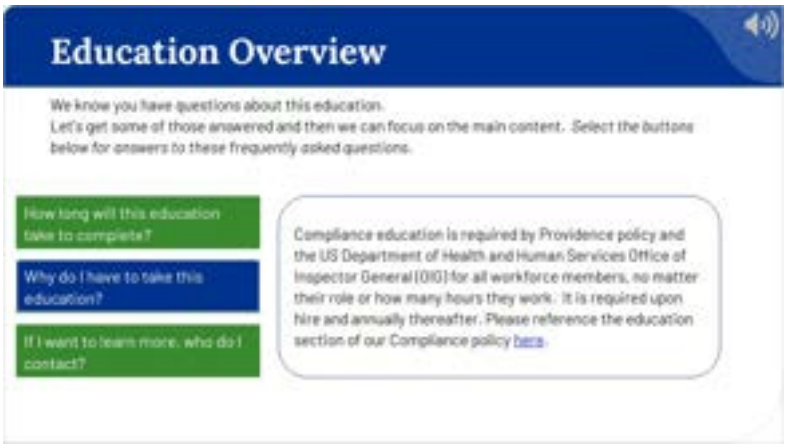
Audio (Slide Layer)

1.3 FAQ

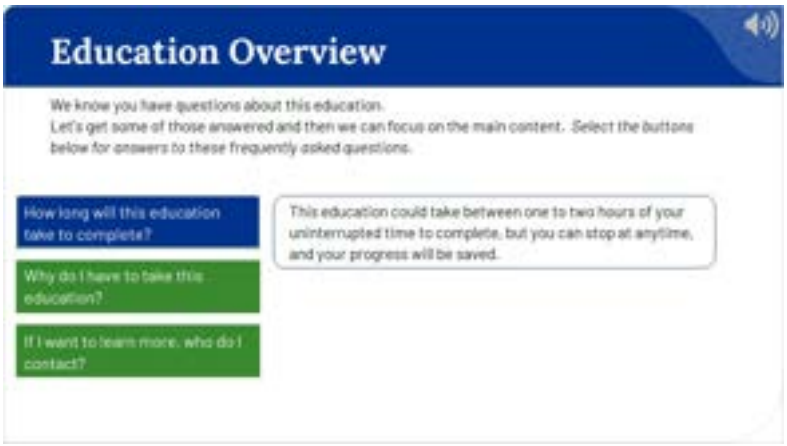


Notes:

Why (Slide Layer)



How long (Slide Layer)



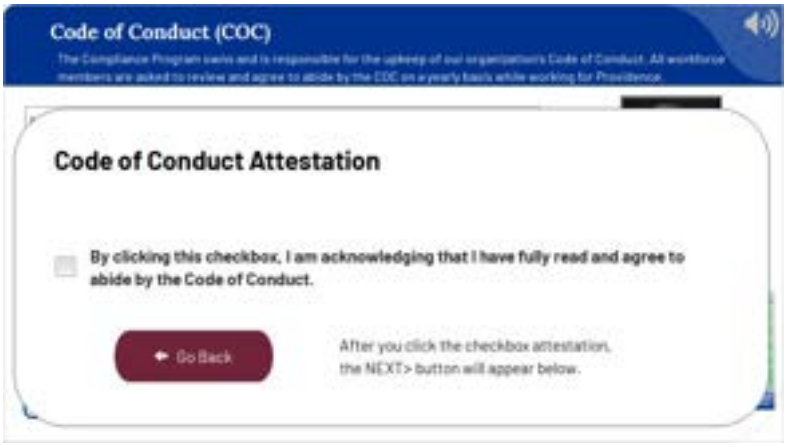
If I want (Slide Layer)

2. Compliance Program

2.1 Code of Conduct

Notes:

Attestation (Slide Layer)



2.2 Untitled Slide

2.3 Which document below explains the expectations Providence has of its employees and the critical importance of being honest and just in all our interactions with our patients, members, colleagues, payers and vendors. This document also details how to report a violation or concern about potential illegal or inappropriate actions.

(Multiple Choice, 10 points, 1 attempt permitted)

Correct	Choice
X	Code of Conduct

	Notice of Privacy Practices
	Compliance Program Overview
	The Elements of Compliance

Feedback when correct:

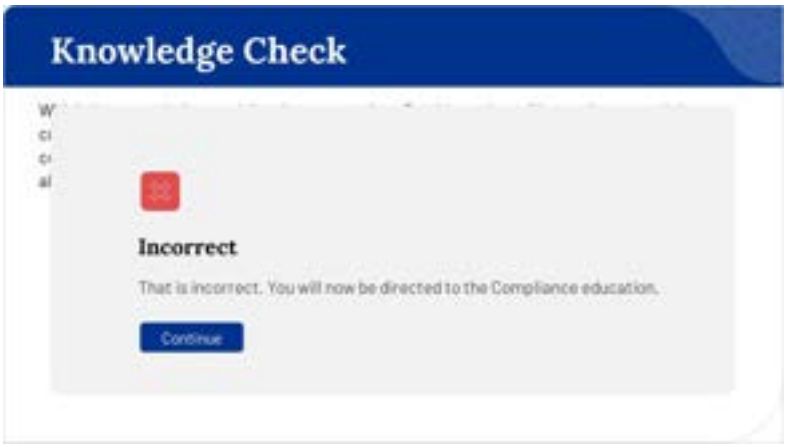
That is correct!

Feedback when incorrect:

That is incorrect. You will now be directed to the Compliance education.

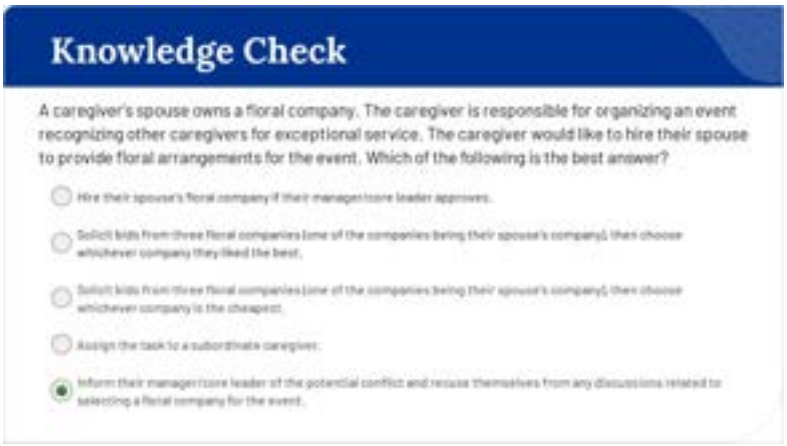
Correct (Slide Layer)

Incorrect (Slide Layer)



2.4 A caregiver's spouse owns a floral company. The caregiver is responsible for organizing an event recognizing other caregivers for exceptional service. The caregiver would like to hire their spouse to provide floral arrangements for the event. Which of the following is the best answer?

(Multiple Choice, 10 points, 1 attempt permitted)



Correct	Choice
	Hire their spouse's floral company if their manager/core leader approves.

	Solicit bids from three floral companies (one of the companies being their spouse's company), then choose whichever company they liked the best.
	Solicit bids from three floral companies (one of the companies being their spouse's company), then choose whichever company is the cheapest.
	Assign the task to a subordinate caregiver.
X	Inform their manager/core leader of the potential conflict and recuse themselves from any discussions related to selecting a floral company for the event.

Feedback when correct:

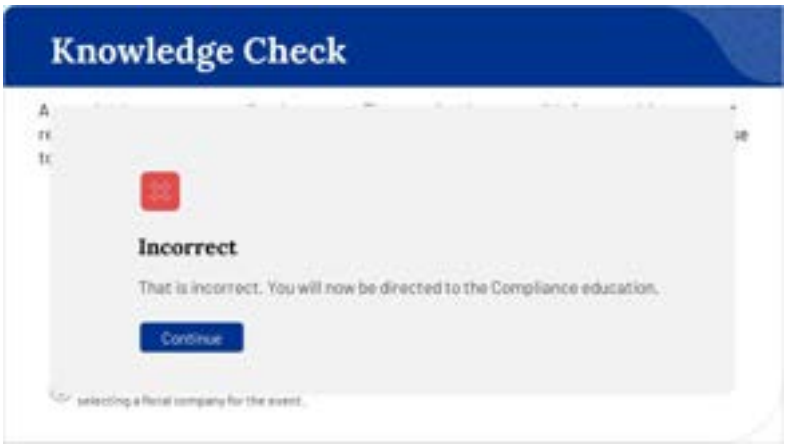
That is correct!

Feedback when incorrect:

That is incorrect. You will now be directed to the Compliance education.

Correct (Slide Layer)

Incorrect (Slide Layer)



2.5 The intentional deception or misrepresentation made by someone with knowledge that the deception will result in financial gain for the hospital/clinic or them personally is called --------.

(Multiple Choice, 10 points, 1 attempt permitted)

Correct	Choice
X	Fraud
	Waste
	Abuse

Feedback when correct:

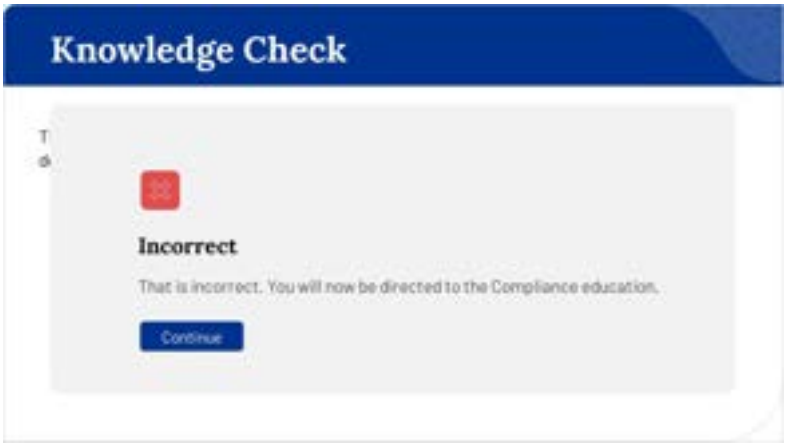
That is correct!

Feedback when incorrect:

That is incorrect. You will now be directed to the Compliance education.

Correct (Slide Layer)

Incorrect (Slide Layer)



2.6 A compliance department serves all of the following purposes except:

(Multiple Choice, 10 points, 1 attempt permitted)

Correct	Choice
X	Terminates non-compliant workforce members/enforce corrective actions.
	Supports initial and continuing compliance education and training.
	Works to ensure the organization adheres to regulations and laws.
	Maintains a mechanism (through the Integrity Hotline at 888-294-8455) for reporting integrity, compliance, privacy or legal concerns.

Feedback when correct:

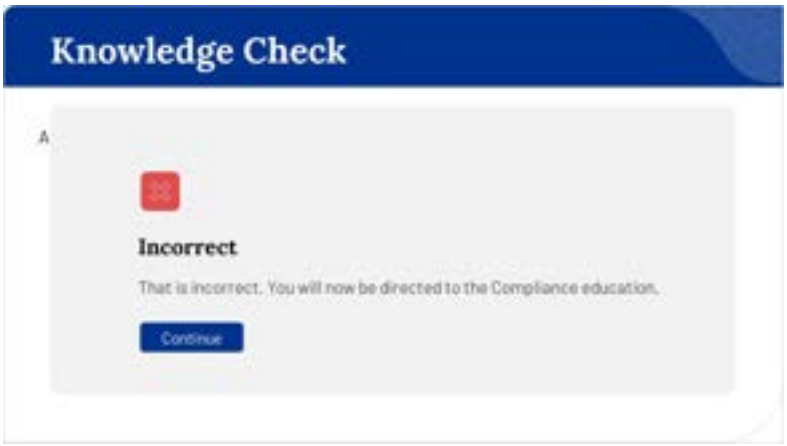
That is correct!

Feedback when incorrect:

That is incorrect. You will now be directed to the Compliance education.

Correct (Slide Layer)

Incorrect (Slide Layer)



2.7 We all see and hear a lot of information while performing our daily tasks. Which of the following situations should be reported to your supervisor, a compliance contact, or the Integrity Hotline?

(Multiple Choice, 10 points, 1 attempt permitted)

Correct	Choice
	A clinic or department routinely waiving costs and/or deductibles.
	A clinic or department charging excessively for services and/or supplies for medical care.
	A provider ordering specific tests on every patient regardless of their medical condition.
	A billing representative re-routing a payment refund to a private bank account.
X	All of the above

Feedback when correct:

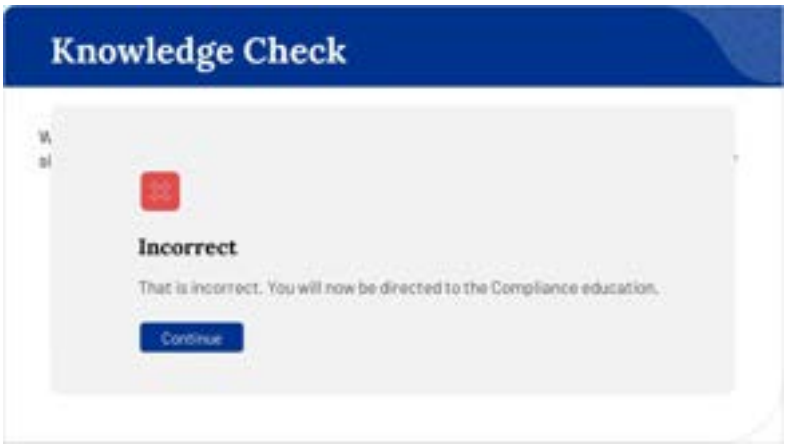
That is correct!

Feedback when incorrect:

That is incorrect. You will now be directed to the Compliance education.

Correct (Slide Layer)

Incorrect (Slide Layer)



2.8 It is important for all workforce members to contribute to drug diversion prevention, detection, and reporting for which of the following reasons?

(Multiple Choice, 10 points, 1 attempt permitted)

Correct	Choice
	Drug diversion puts patient and workforce member safety in jeopardy.
	Drug diversion can cause financial and reputational harm to the healthcare system.
	It is an expectation according to our system policies and Code of Conduct.
	Detecting diversion can help identify caregivers who need help with addiction.
X	All of the above

Feedback when correct:

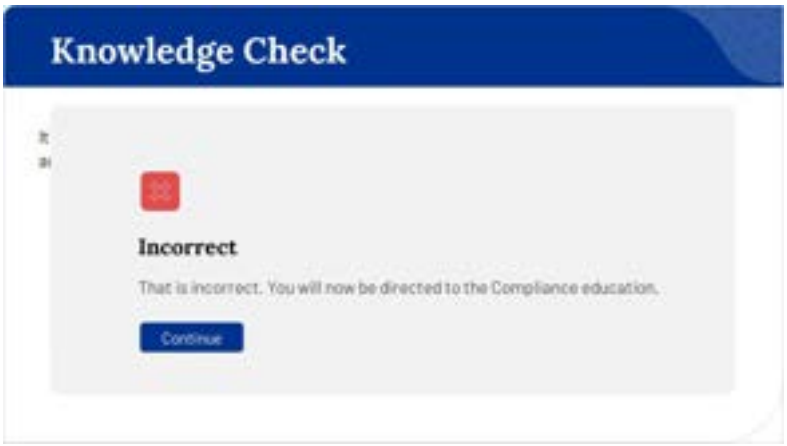
That is correct!

Feedback when incorrect:

That is incorrect. You will now be directed to the Compliance education.

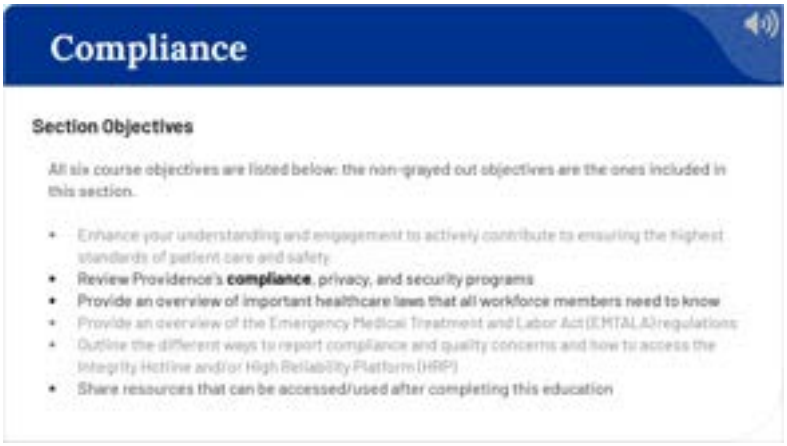
Correct (Slide Layer)

Incorrect (Slide Layer)



3. Untitled Scene

3.1 Information Security Overview



Notes:

All six course objectives are listed below; the non-grayed out objectives are the ones included in this section.

Enhance your understanding and engagement to actively contribute to ensuring the highest standards of patient care and safety.

Review Providence's compliance, privacy, and security programs.

Provide an overview of important healthcare laws that all workforce members need to know.

Provide an overview of the Emergency Medical Treatment and Labor Act (EMTALA) regulations.

Outline the different ways to report compliance and quality concerns and how to access the Integrity Hotline and/or High Reliability Platform (HRP).

Share resources that can be accessed/used after completing this education.

Audio (Slide Layer)

3.2 Compliance Program Overview

Notes:

Audio (Slide Layer)

3.3 Compliance Program Overview

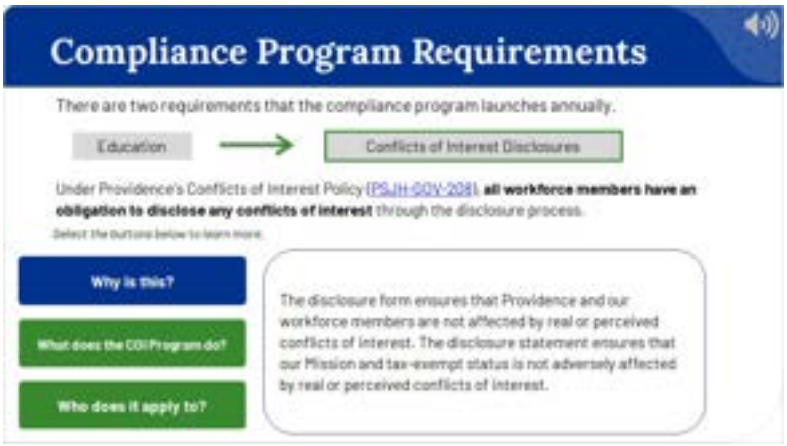
Notes:

Audio (Slide Layer)

3.4 Conflicts of Interest FAQ

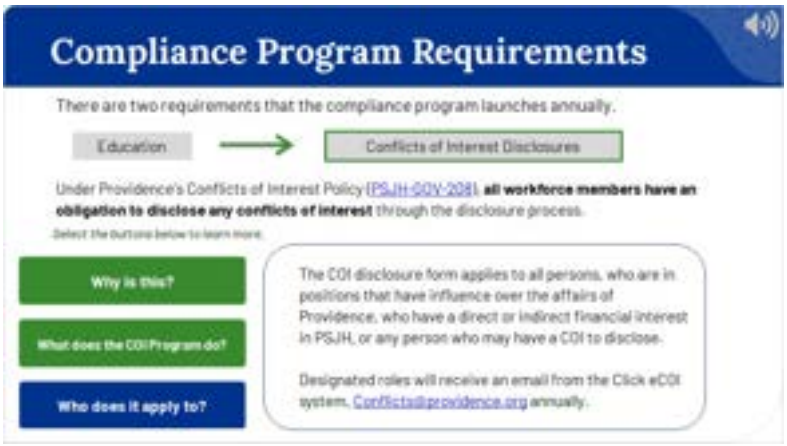
Notes:

1 (Slide Layer)



2 (Slide Layer)

3 (Slide Layer)



3.5 Conflicts of Interest FAQ

Notes:

Audio (Slide Layer)

3.6 Conflicts of Interest FAQ

Notes:

Audio (Slide Layer)

3.7 Conflicts of Interest FAQ

Notes:

Audio (Slide Layer)

3.8 Dr. Xander convinced the director of surgery to contract with Oxygen Masks Inc. It turns out that Dr. Xander's brother is the owner of Oxygen Masks Inc. Is this a potential conflict of interest?

(Multiple Choice, 10 points, unlimited attempts permitted)

Correct	Choice
X	Yes
	No

Feedback when correct:

That is correct!

This scenario does represent a potential Conflict of Interest (COI). A COI may occur when personal/outside interests or activities influence (or appear to influence) our actions and decisions regarding job-related duties, such as choosing an outside organization to give our business.

Conflicts of interest may arise from many sources including, but not limited to:

financial interests of yourself or a family member; service, employment or consulting arrangements with a competitor; the receipt of gifts from vendors or others with whom we do business; or use of resources to benefit an outside interest or your own personal interests.

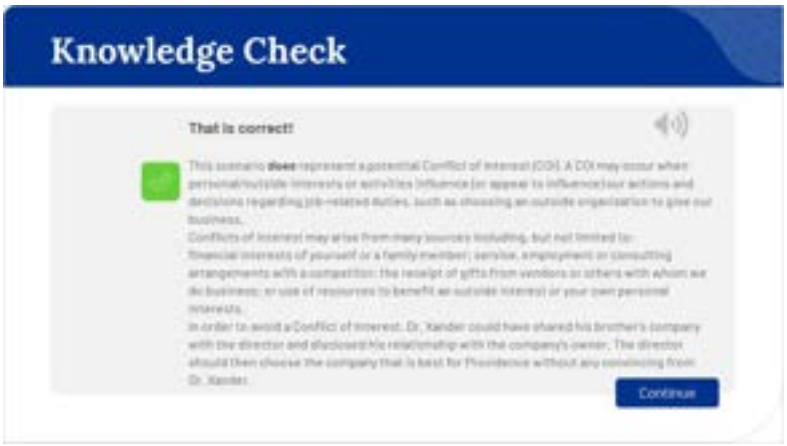
In order to avoid a Conflict of Interest, Dr. Xander could have shared his brother's company with the director and disclosed his relationship with the company's owner. The director should then choose the company that is best for Providence without any convincing from

Dr. Xander.

Feedback when incorrect:

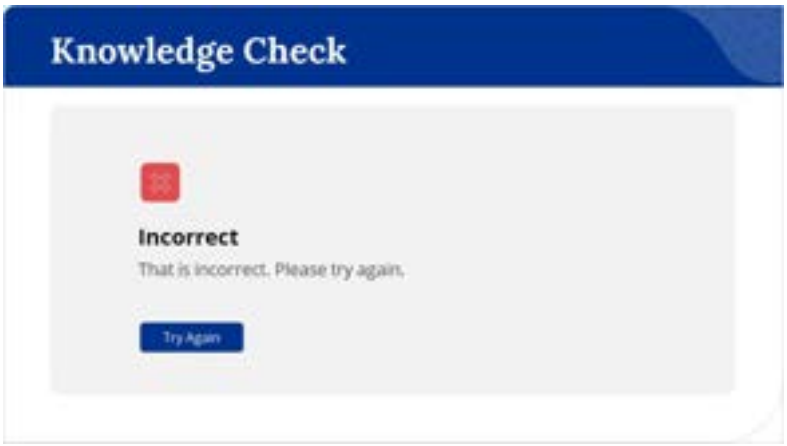
This is true.

Correct (Slide Layer)



Incorrect (Slide Layer)

Try Again (Slide Layer)



Audio (Slide Layer)

3.9 Conflicts of Interest FAQ

Notes:

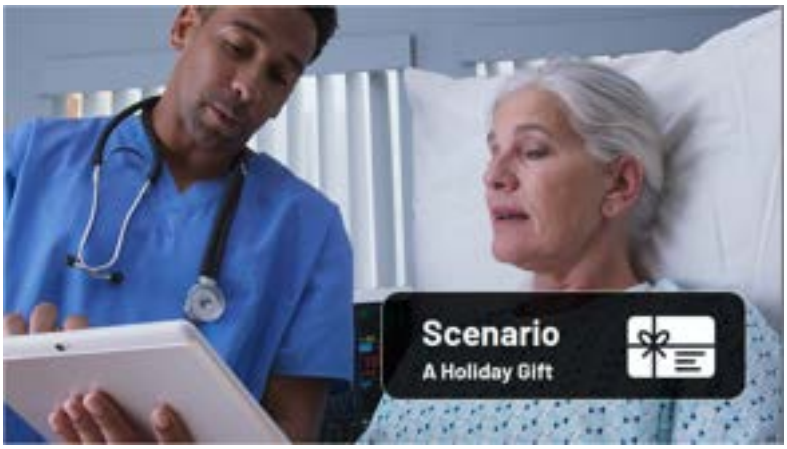
Audio (Slide Layer)

3.10 Conflicts of Interest FAQ

Notes:

Audio (Slide Layer)

3.11 Title

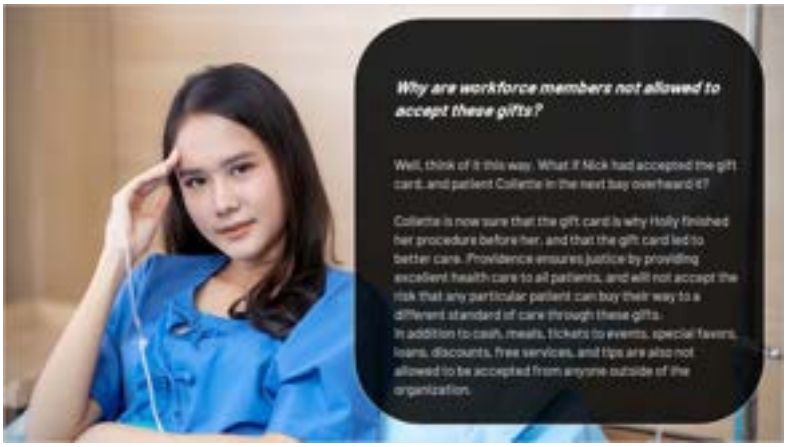


Notes:

3.12 Title

Notes:

3.13 Title



Notes:

3.14 Title

Notes:

3.15 Title

Notes:

3.16 Title

Notes:

3.17 Jason goes into the breakroom and sees a selection of donuts brought in by a software vendor. Is he allowed to accept a donut?

(Multiple Choice, 10 points, unlimited attempts permitted)

Correct	Choice
X	Yes

No

Feedback when correct:

Jason is allowed to accept a donut.

What you can accept from patients and their families, vendors, and Providers (who aren't directly employed by Providence):

Modest, perishable, and infrequent gifts such as flowers or food (box of chocolates, bagels, pizza, etc.) that can be shared among the department.

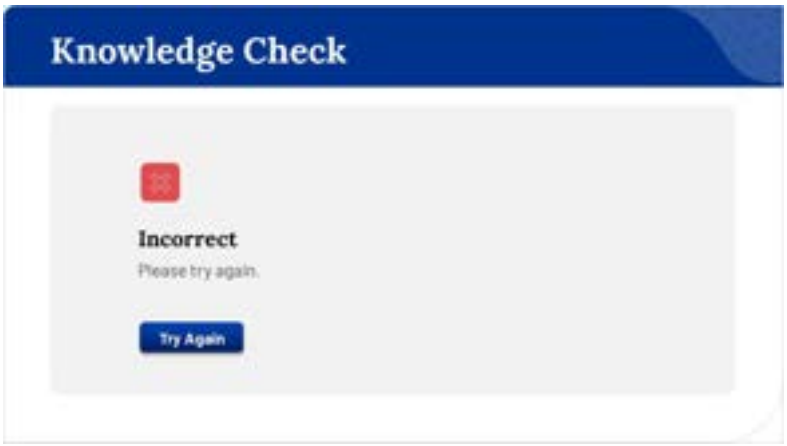
Please note that accepting frequent meals from patients and their families, vendors, or Providers (who aren't directly employed by Providence) is prohibited.

Holiday or Thank You card.

Please note gift cards or gift certificates of any value from outside of Providence are prohibited.

Correct! (Slide Layer)

Try Again (Slide Layer)



3.18 Knowledge Check

(Multiple Response, 10 points, unlimited attempts permitted)

Correct	Choice
X	A gift card given to me by my Core Leader
	A gift card from a vendor
X	A box of chocolates from a patient that can be shared with my department
	A gift card from a provider who is not employed by Providence

Feedback when correct:

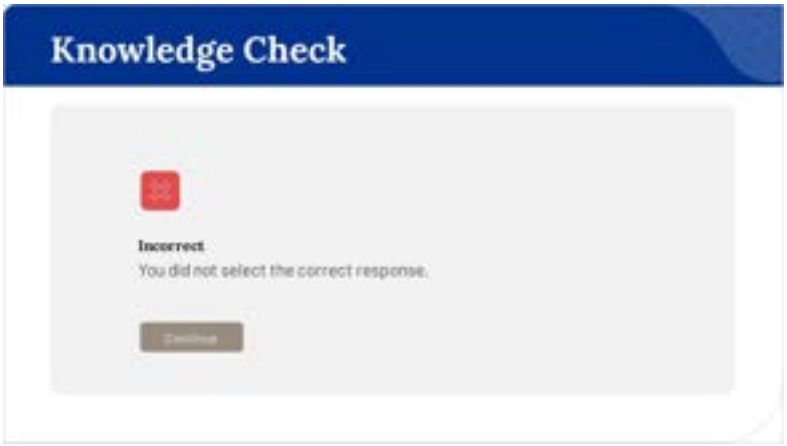
That's right!

Feedback when incorrect:

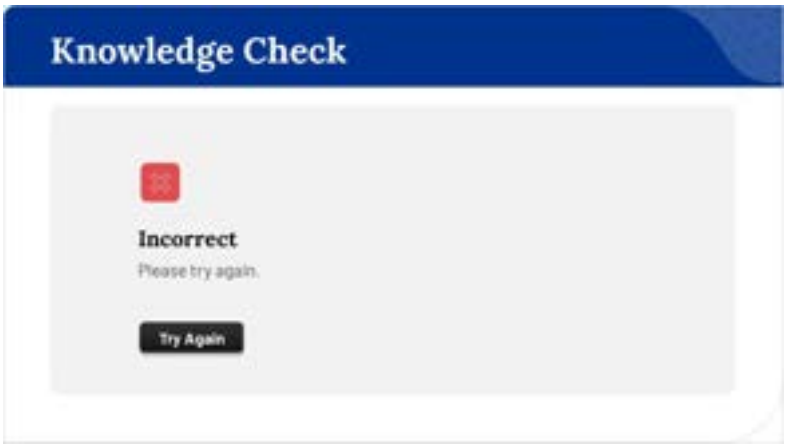
You did not select the correct response.

Correct (Slide Layer)

Incorrect (Slide Layer)



Try Again (Slide Layer)



3.19 Conflicts of Interest FAQ

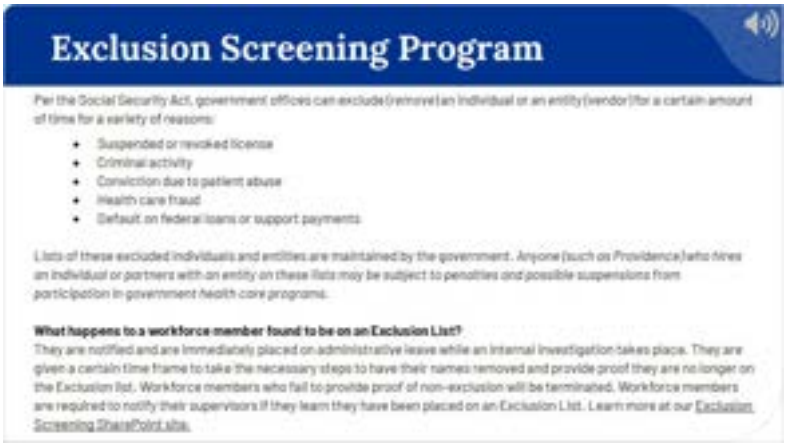
Notes:

1 (Slide Layer)

3 (Slide Layer)

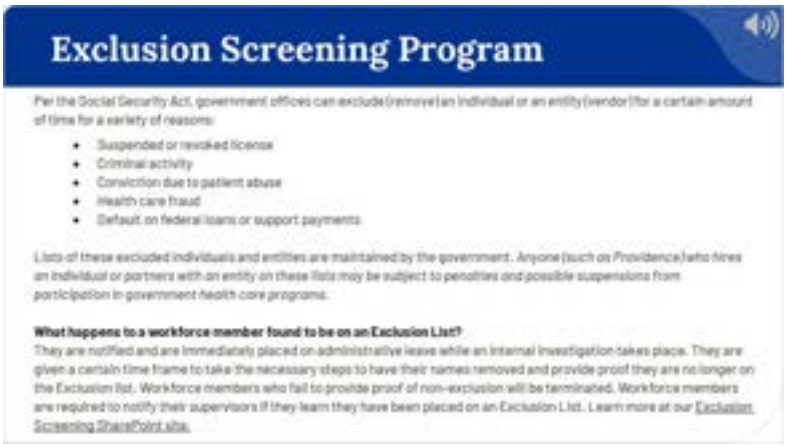
2 (Slide Layer)

3.20 Conflicts of Interest FAQ



Notes:

Audio (Slide Layer)



3.21 Compliance Related Healthcare Laws

Notes:

Audio (Slide Layer)

3.22 Physician Referrals (Stark Law): Physicians

Notes:

Audio (Slide Layer)

3.23 Which of the options below is NOT a requirement of appropriate medical documentation?

(Multiple Choice, 10 points, unlimited attempts permitted)

Correct	Choice
	Documentation must be clear and to the point.
	Documentation must identify who requested and provided the services preformed.
	Documentation must support all services billed, including laboratory tests, medications, and therapy sessions.
X	Documentation must include the patient's ability to pay for services.

Feedback when correct:

The patient's ability to pay is not part of appropriate medical documentation.

Documentation must:

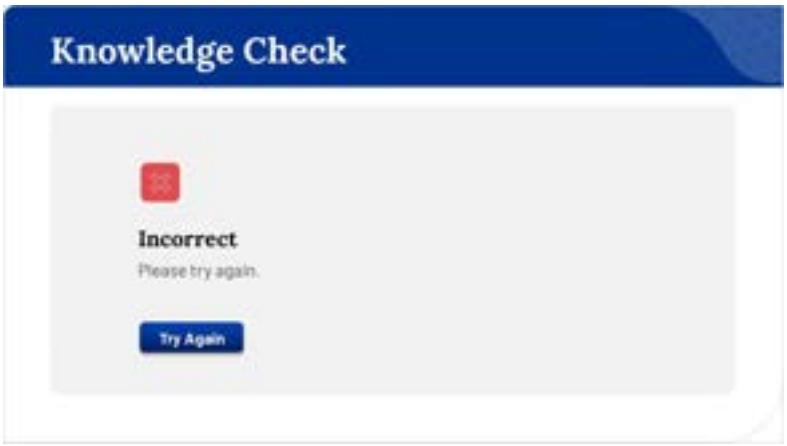
• Be clear and to the point.

• Identify who requested and provided the services performed

• Support all services billed, including laboratory tests, medications, and therapy sessions

Correct! (Slide Layer)

Try Again (Slide Layer)



3.24 Anti-Kickback Statute (AKS)

Notes:

Audio (Slide Layer)

Untitled Layer 5 (Slide Layer)

3.25 Fraud, Waste, and Abuse (FWA)

Notes:

Audio (Slide Layer)

Untitled Layer 5 (Slide Layer)

3.26 Washington State Law for Health Care Providers

Notes:

Audio (Slide Layer)

3.27 Reporting Compliance-Related Concerns

Notes:

Audio (Slide Layer)

3.28 Reporting Compliance-Related Concerns

Notes:

Audio (Slide Layer)

3.29 Compliance: How to Find Us

Notes:

Audio (Slide Layer)

Untitled Layer 5 (Slide Layer)

3.30 Compliance Program Overview

Notes:

Audio (Slide Layer)

3.31 Compliance Completion

Notes:

Audio (Slide Layer)

Cybersecurity

1. 3 Cybersecurity

1.1 Untitled Slide

1.2 The best ways to keep your online accounts secure include which of the following?

(Multiple Choice, 10 points, 1 attempt permitted)

Correct	Choice
	Using a phrase with at least 16 characters, including letters, number, and special characters.
	Changing your passphrase at least annually and not reusing them across accounts.
	Using multi-factor authentication (MFA).
	Keeping your software updated.
X	All of the above

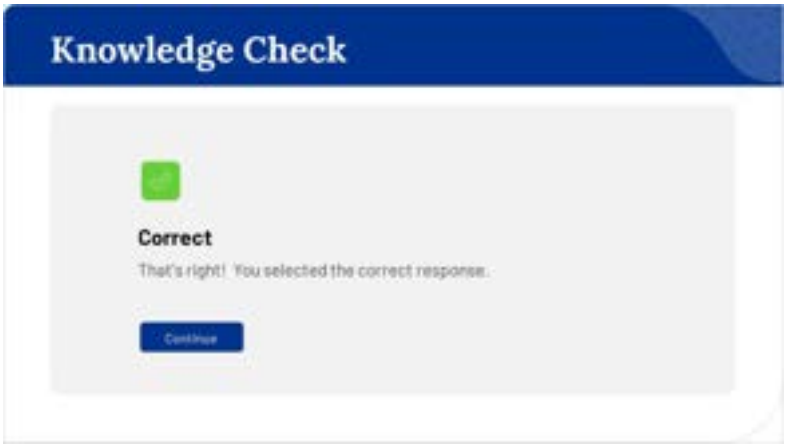
Feedback when correct:

That's right! You selected the correct response.

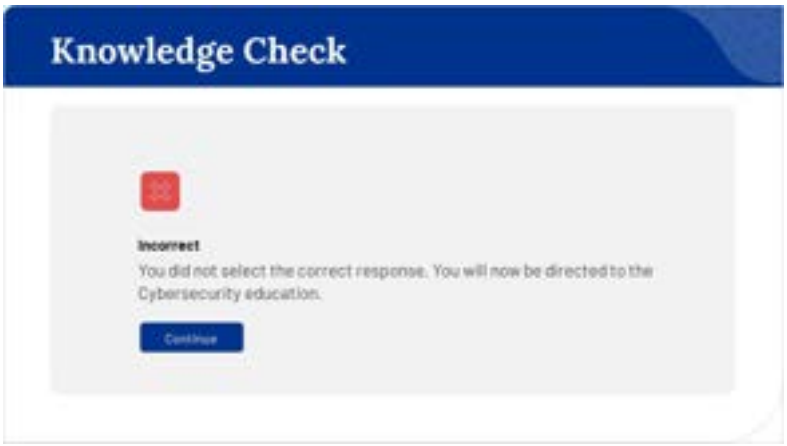
Feedback when incorrect:

You did not select the correct response. You will now be directed to the Cybersecurity education.

Correct (Slide Layer)



Incorrect (Slide Layer)



1.3 You receive an email that you think is suspicious. Which of the following actions is recommended to take?

(Multiple Choice, 10 points, 1 attempt permitted)

Correct	Choice
	Open the email and review the attachment.
X	Do not click links or attachments and report the suspicious email via the "Report A Phish!" button in Microsoft Outlook.
	Forward to a co-worker for their opinion.

	Open the attachment and delete the email from your mailbox.
	Save the attachment in your local files, disconnect from the network, and open the attachment.

Feedback when correct:

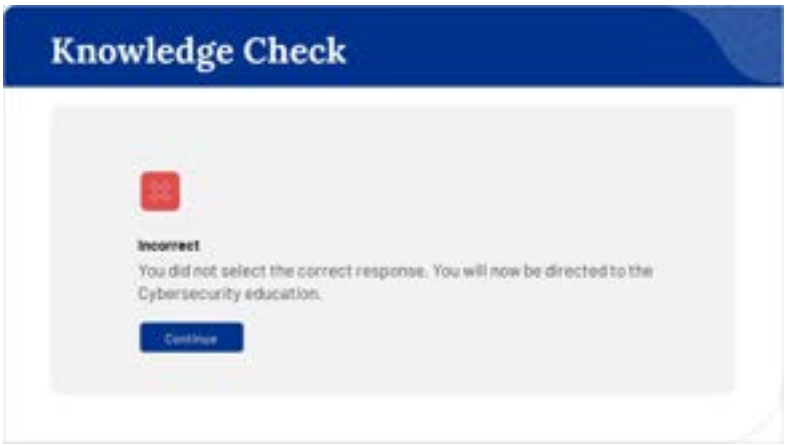
That's right! You selected the correct response.

Feedback when incorrect:

You did not select the correct response. You will now be directed to the Cybersecurity education.

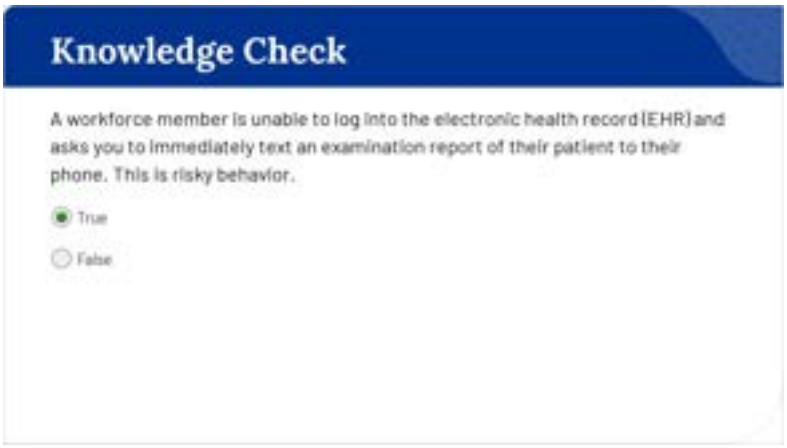
Correct (Slide Layer)

Incorrect (Slide Layer)



1.4 A workforce member is unable to log into the electronic health record (EHR) and asks you to immediately text an examination report of their patient to their phone. This is risky behavior.

(Multiple Choice, 10 points, 1 attempt permitted)



Correct	Choice
X	True
	False

Feedback when correct:

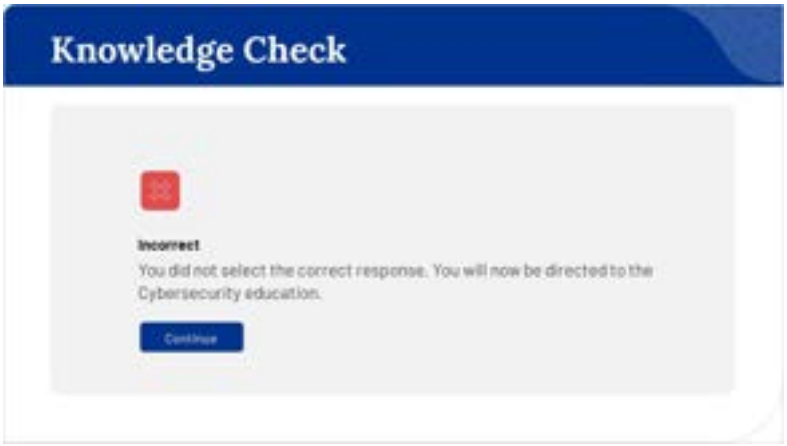
That's right! You selected the correct response.

Feedback when incorrect:

You did not select the correct response. You will now be directed to the Cybersecurity education.

Correct (Slide Layer)

Incorrect (Slide Layer)



1.5 Which of the following are NOT security incidents that should be reported to the Service Desk?

(Multiple Choice, 10 points, 1 attempt permitted)

Correct	Choice
	Your device has been lost or stolen.
	Your login credentials were provided to a third party, or you clicked on a malicious link.
	A credit card payment device has been tampered with.
X	Your machine has been turned off due to a power outage.
	You get a virus warning pop-up.

Feedback when correct:

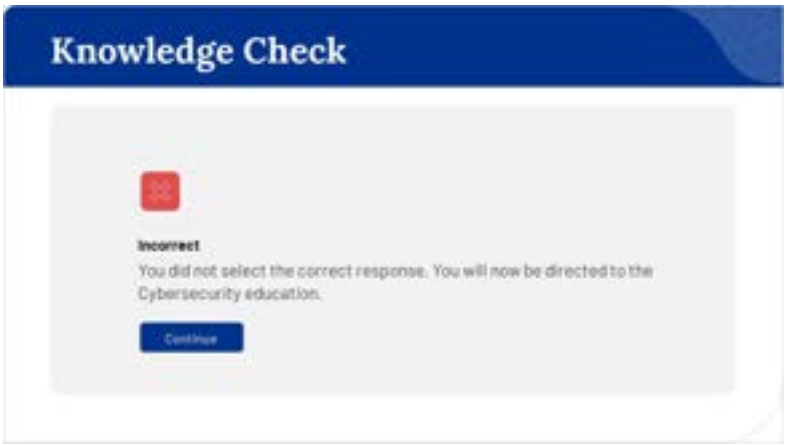
That's right! You selected the correct response.

Feedback when incorrect:

You did not select the correct response. You will now be directed to the Cybersecurity education.

Correct (Slide Layer)

Incorrect (Slide Layer)



1.6 You are unable to complete your work during your shift and decide to finish the remainder at home. You email the medical record numbers to your personal email account. This is an acceptable practice.

(Multiple Choice, 10 points, 1 attempt permitted)

Correct	Choice
	True
X	False

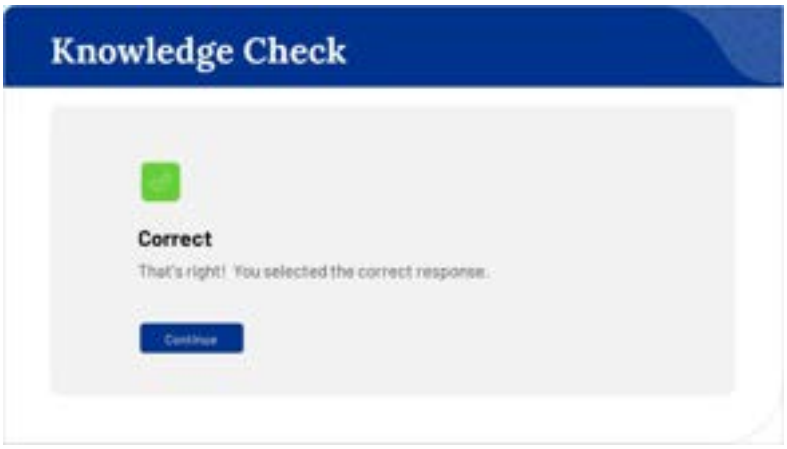
Feedback when correct:

That's right! You selected the correct response.

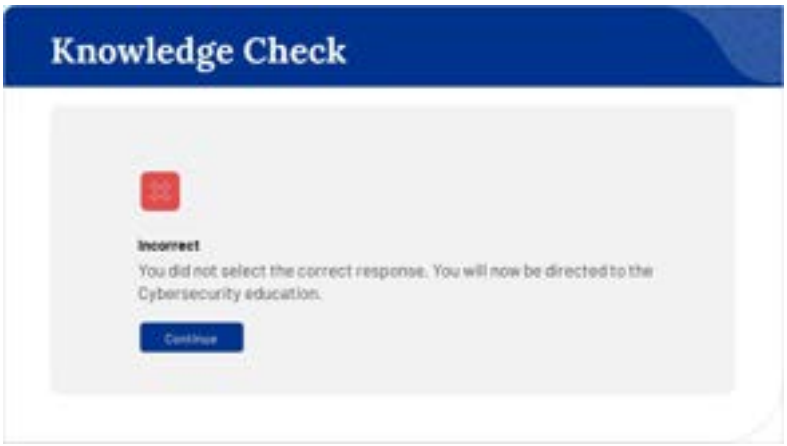
Feedback when incorrect:

You did not select the correct response. You will now be directed to the Cybersecurity education.

Correct (Slide Layer)



Incorrect (Slide Layer)



1.7 It is appropriate to use #secure# in the subject line to send encrypted PHI/Confidential data to which of the following?

(Multiple Choice, 10 points, 1 attempt permitted)

Correct	Choice
X	Authorized business partner at their company email.
	Personal email account of a workforce member.
	Your non-work email/personal email account once you have your manager's approval.

Physician’s home email account per their request.

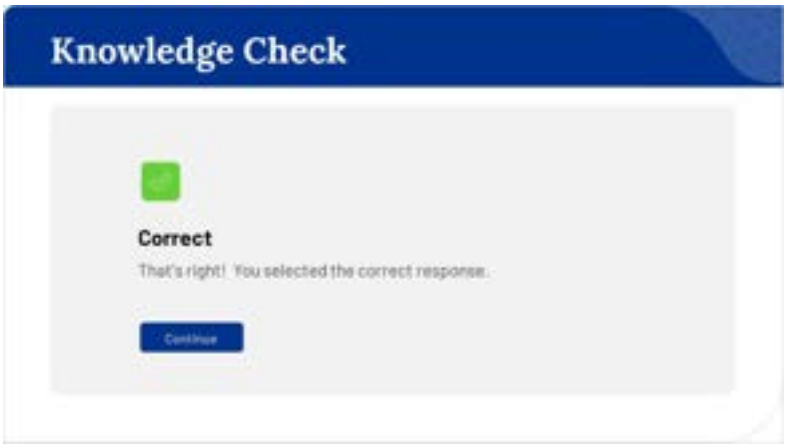
Feedback when correct:

That's right! You selected the correct response.

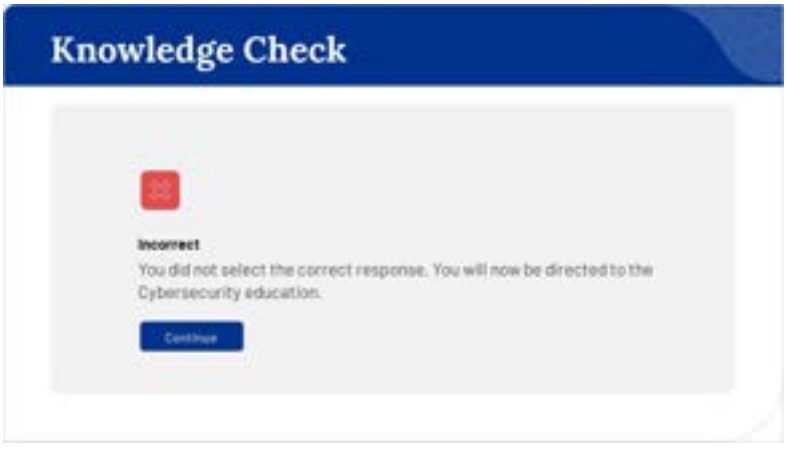
Feedback when incorrect:

You did not select the correct response. You will now be directed to the Cybersecurity education.

Correct (Slide Layer)



Incorrect (Slide Layer)



2. Untitled Scene

2.1 Information Security Overview

Notes:

All six course objectives are listed below; the non-grayed out objectives are the ones included in this section.

Understand your role and some key principles and tools to improve quality and safety.

Review Providence's compliance, privacy, and security programs.

Provide an overview of important healthcare laws that all workforce members need to know.

Outline the different ways to report compliance and quality concerns and how to access the Integrity Hotline and/or High Reliability Platform (abbreviated H.R.P).

Share resources that can be accessed/used after completing this education.

Audio (Slide Layer)

2.2 Information Security Overview

Notes:

Audio (Slide Layer)

2.3 Acceptable Use

Notes:

Audio (Slide Layer)

2.4 Personal Devices

Notes:

Audio (Slide Layer)

2.5 Video Examples

Video 1 (Slide Layer)

Video 2 (Slide Layer)

Video 3 (Slide Layer)

audio (Slide Layer)

2.6 Information Security Conclusion

Notes:

Audio (Slide Layer)

2.7 Physical Security

Notes:

Audio (Slide Layer)

2.8 Cybersecurity: How to Find Us

Notes:

Audio (Slide Layer)

2.9 Cybersecurity: Key Takeaways

Notes:

Audio (Slide Layer)

2.10 You receive an email with a link that says get a $10 Dave and Busters gift card when you register with us for your COVID-19 vaccine.

Is it safe to click?

(Multiple Choice, 10 points, unlimited attempts permitted)

Correct	Choice
	Yes
X	No

Feedback when correct:

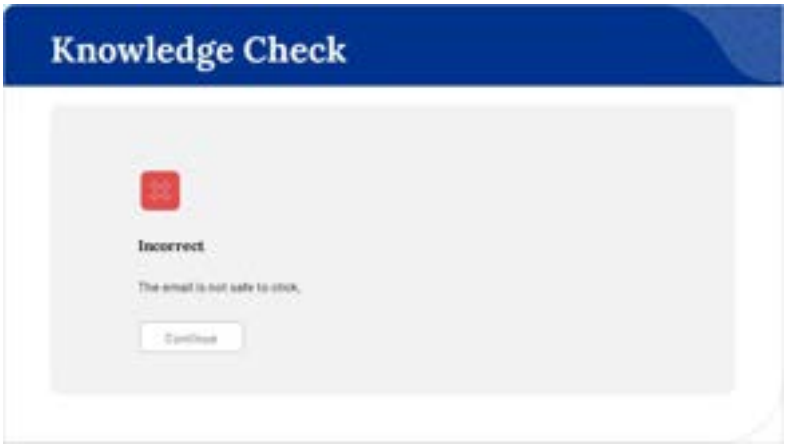
That’s right!

Feedback when incorrect:

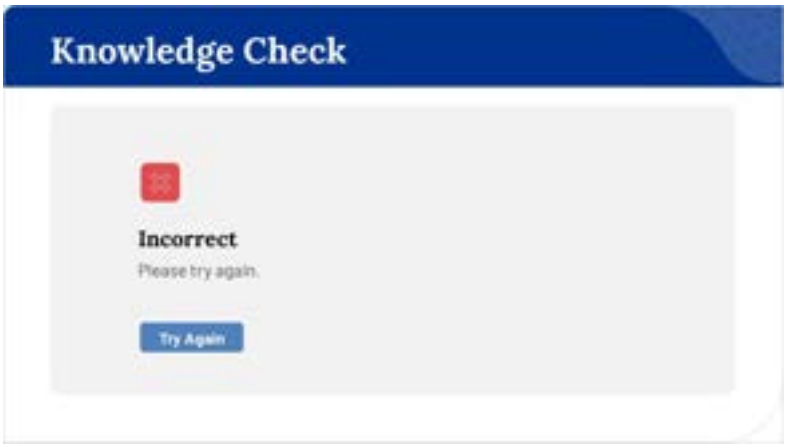
The email is not safe to click.

Correct! (Slide Layer)

Incorrect (Slide Layer)



Try Again (Slide Layer)



2.11 I can use my personal email address to send work-related emails from home, if necessary.

(Multiple Choice, 10 points, unlimited attempts permitted)

Correct	Choice
	True
X	False

Feedback when correct:

That’s right!

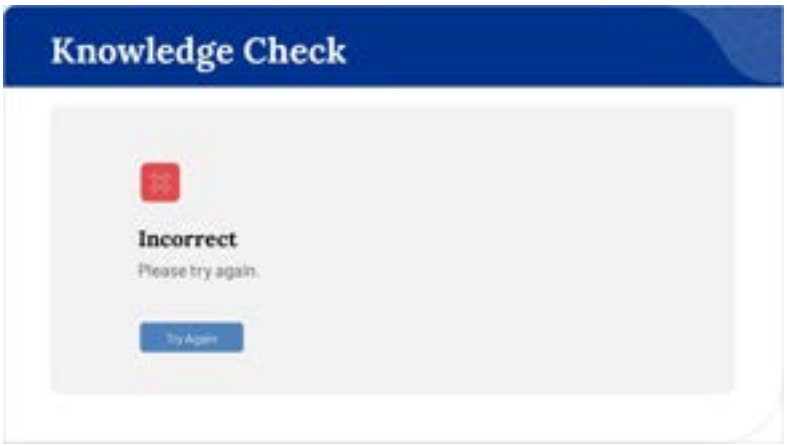
Feedback when incorrect:

You cannot use your personal email address to send work-related emails.

Correct! (Slide Layer)

Incorrect (Slide Layer)

Try Again (Slide Layer)



2.12 You receive a threatening email to your work email address stating unless you click this link to reset your account, your computer will be shut down and all your data will be lost. Is it safe to click?

(Multiple Choice, 10 points, unlimited attempts permitted)

Correct	Choice
	Yes
X	No

Feedback when correct:

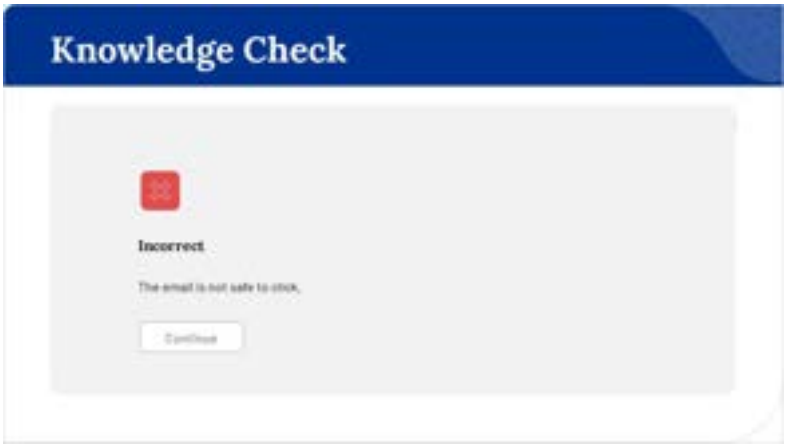
That’s right!

Feedback when incorrect:

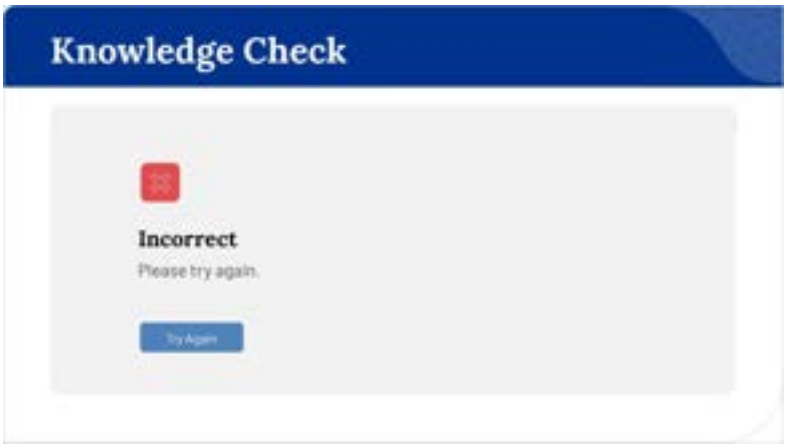
The email is not safe to click.

Correct! (Slide Layer)

Incorrect (Slide Layer)



Try Again (Slide Layer)



2.13 When sending confidential information to a business email address outside of Providence, put the following in the subject line:

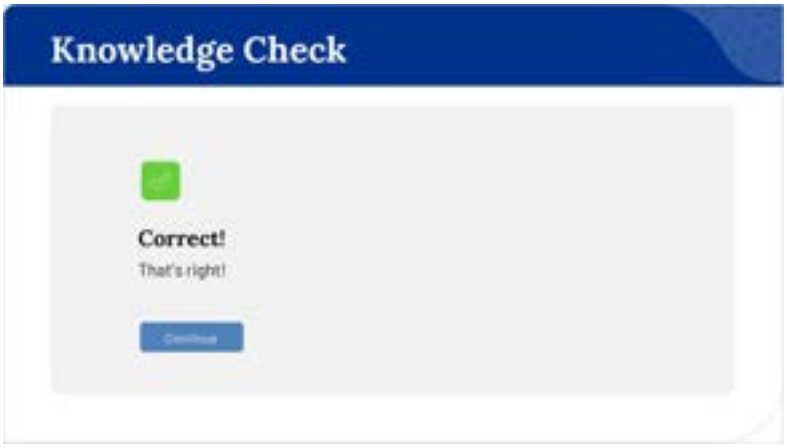
(Multiple Choice, 10 points, unlimited attempts permitted)

Correct	Choice
	#secret#
X	#secure#
	#confidential#

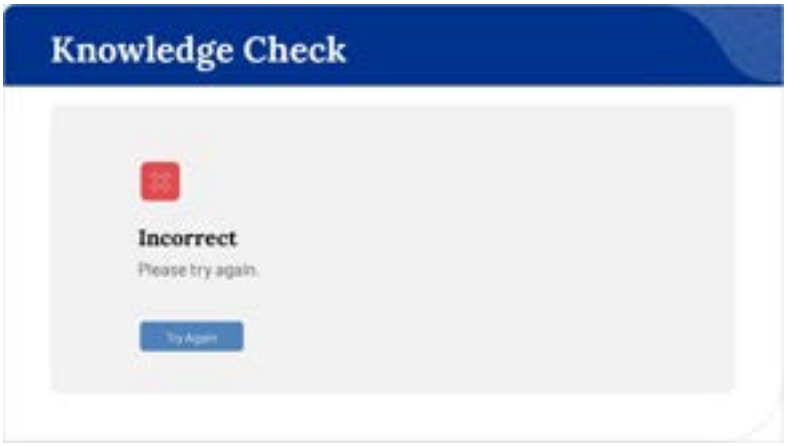
Feedback when correct:

That’s right!

Correct! (Slide Layer)



Try Again (Slide Layer)



2.14 Cybersecurity Completion

Notes:

Audio (Slide Layer)

Disclosure Program

1. Conclusion

1.1 Information Security Overview

Notes:

All six course objectives are listed below; the non-grayed out objectives are the ones included in this section.

Enhance your understanding and engagement to actively contribute to ensuring the highest standards of patient care and safety.

Review Providence's compliance, privacy, and security programs.

Provide an overview of important healthcare laws that all workforce members need to know.

Provide an overview of the Emergency Medical Treatment and Labor Act (EMTALA) regulations.

Outline the different ways to report compliance and quality concerns and how to access the Integrity Hotline and/or High Reliability Platform (HRP).

Share resources that can be accessed/used after completing this education.

Audio (Slide Layer)

1.2 Introduction

Notes:

Audio (Slide Layer)

1.3 Duty to Report

Notes:

Audio (Slide Layer)

1.4 Confidentiality and Non-Retaliation

Notes:

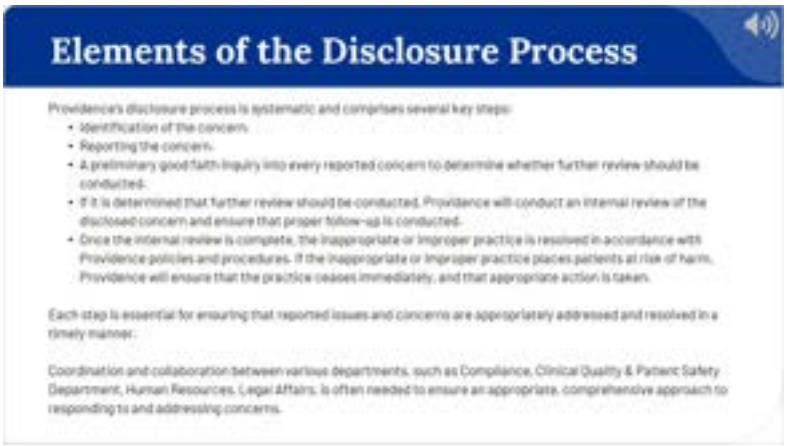
Audio (Slide Layer)

1.5 Providence's Non-Retaliation Policy

Notes:

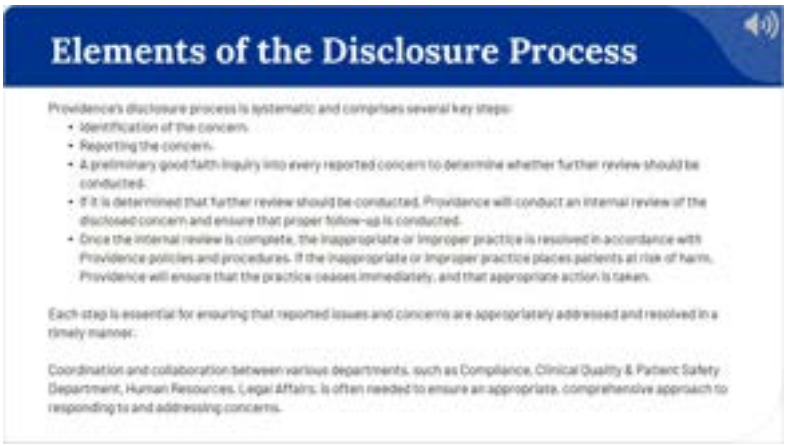
Audio (Slide Layer)

1.6 Elements of the Disclosure Process



Notes:

Audio (Slide Layer)



1.7 Providence prohibits retaliation for making a report in good-faith.

(Multiple Choice, 10 points, unlimited attempts permitted)

Correct	Choice
X	True
	False

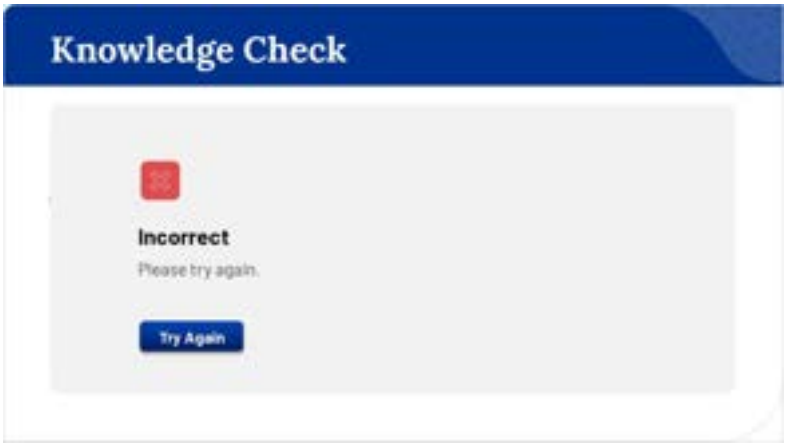
Feedback when correct:

That's right!

"Providence's Non-Retaliation policy, and to an extent, government law, protects workforce members from retaliation or harassment for having raised concerns about actual or potential wrongdoing or misconduct." - Code of Conduct

Correct (Slide Layer)

Try Again (Slide Layer)



1.8 Information Security Overview

Notes:

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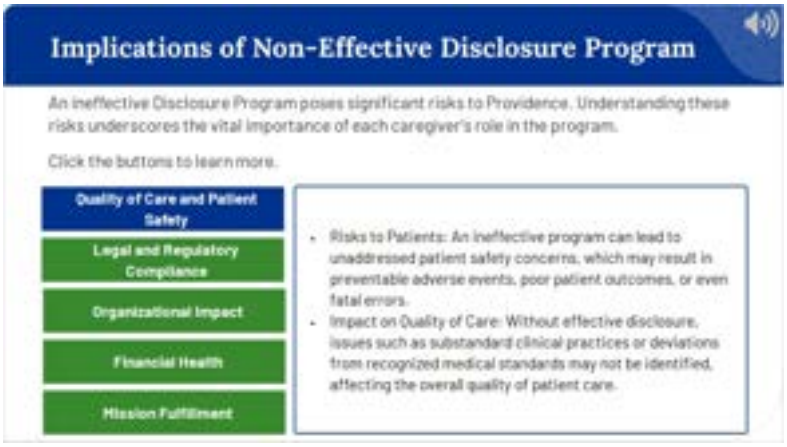
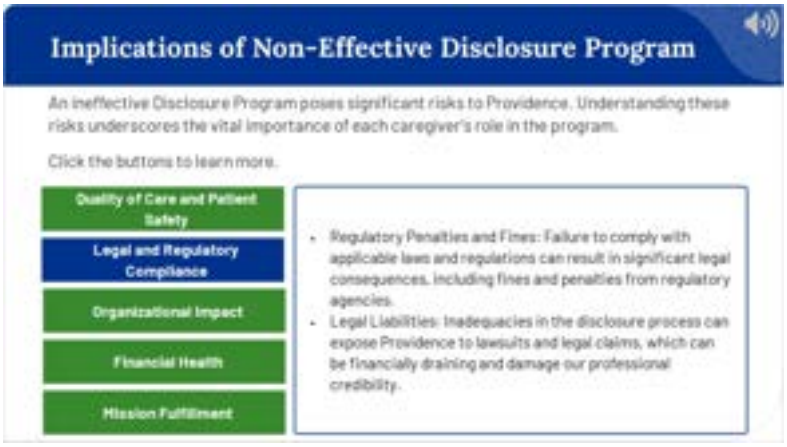
Audio (Slide Layer)

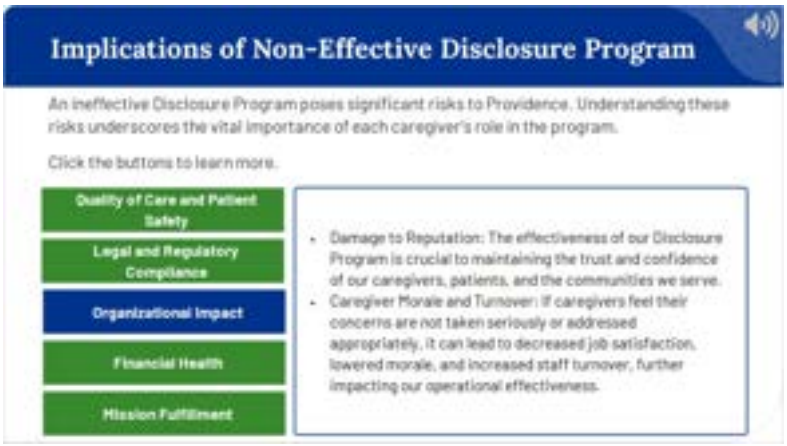
Quality (Slide Layer)



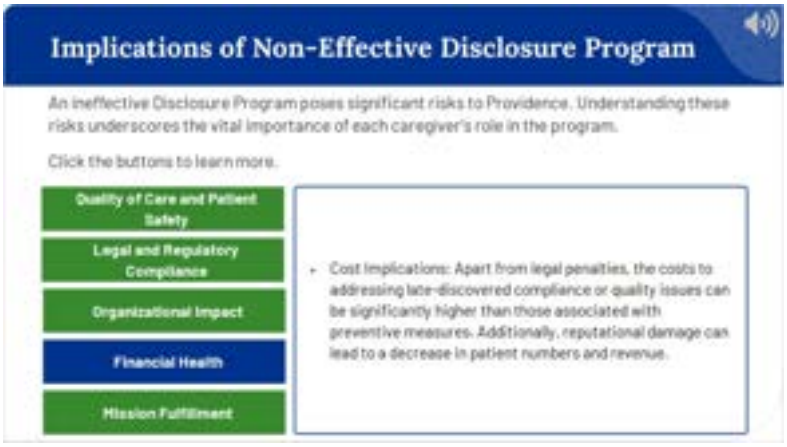
Legal (Slide Layer)



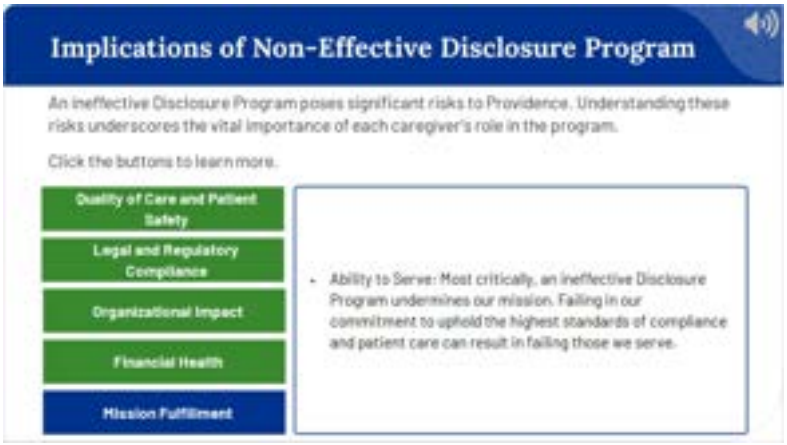
Organizational (Slide Layer)



Financial (Slide Layer)



Mission (Slide Layer)



1.9 Information Security Overview

Notes:

All six course objectives are listed below; the non-grayed out objectives are the ones included in this section.

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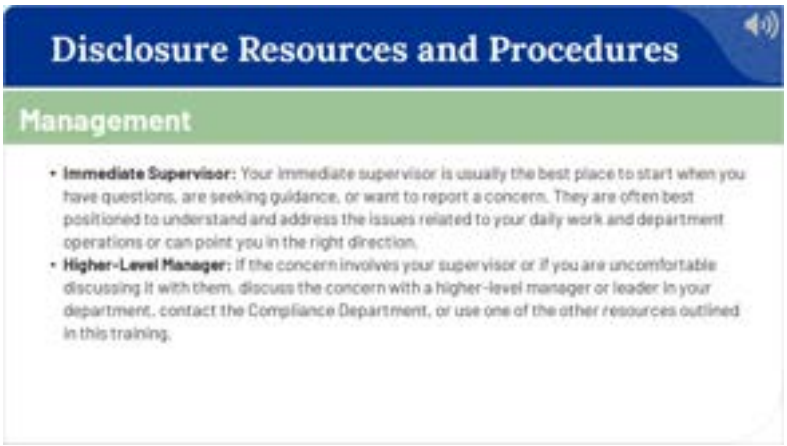
Audio (Slide Layer)

1.10 Information Security Overview



Notes:

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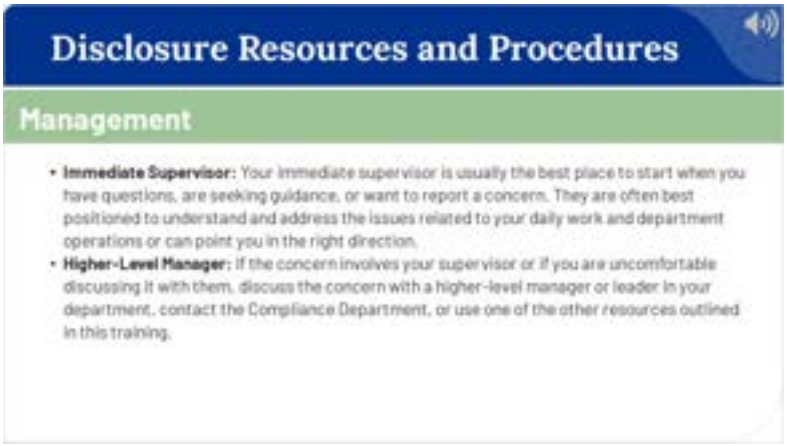
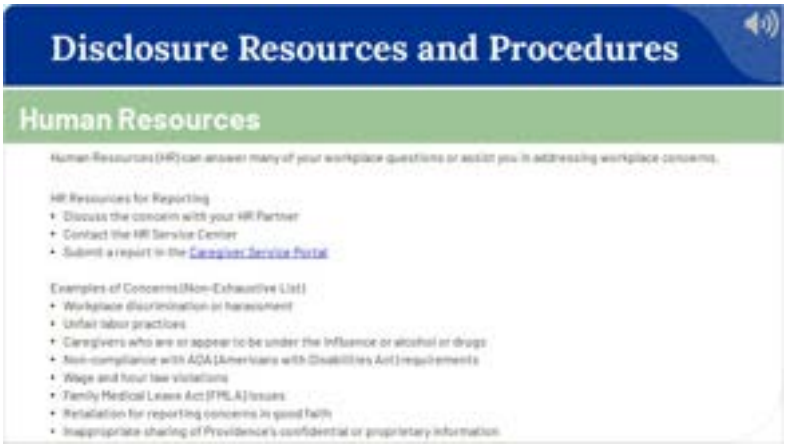
Audio (Slide Layer)



1.11 Information Security Overview



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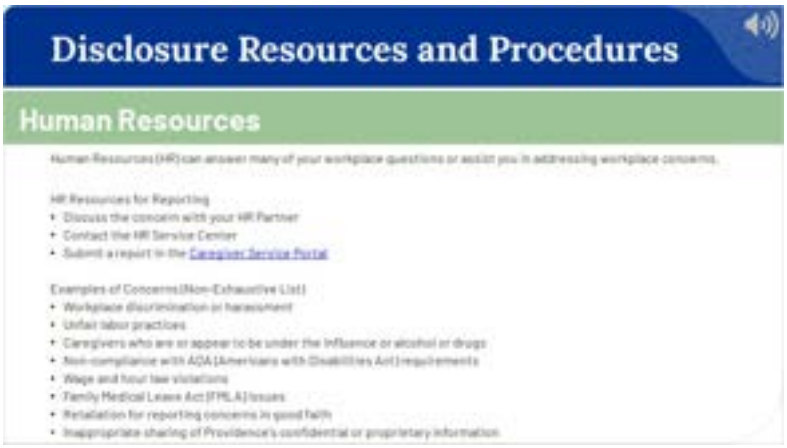

1.12 Information Security Overview

Notes:

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Outline the different ways to report compliance and quality concerns and how to access the Integrity Hotline and/or High Reliability Platform (HRP).

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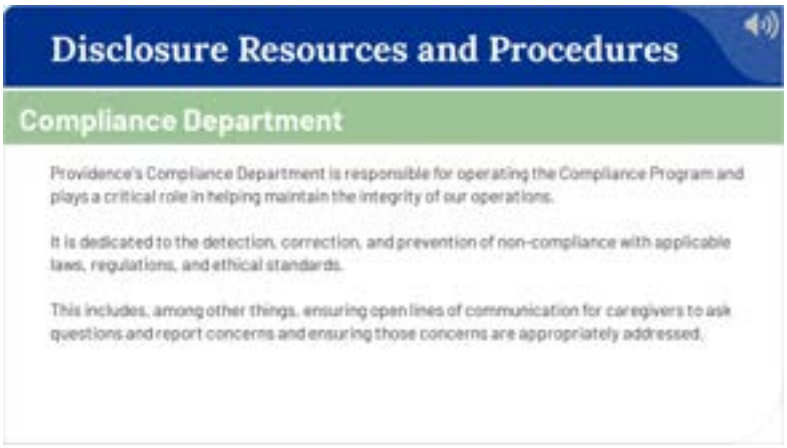

1.13 Information Security Overview

Notes:

All six course objectives are listed below; the non-grayed out objectives are the ones included in this section.

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Outline the different ways to report compliance and quality concerns and how to access the Integrity Hotline and/or High Reliability Platform (HRP).

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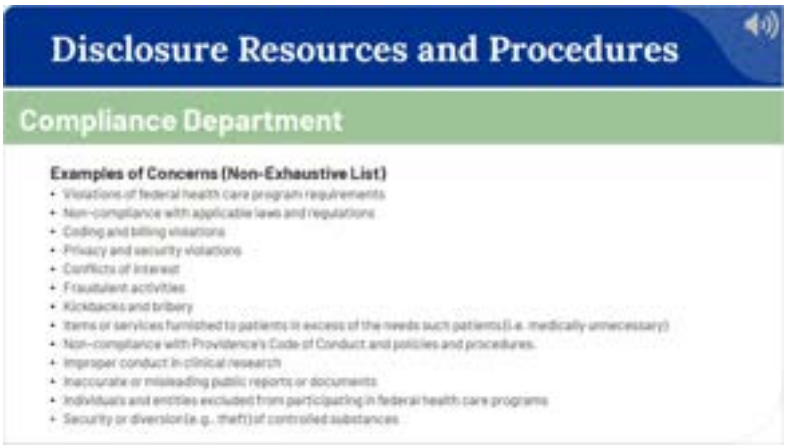
Audio (Slide Layer)

1.14 Information Security Overview



Notes:

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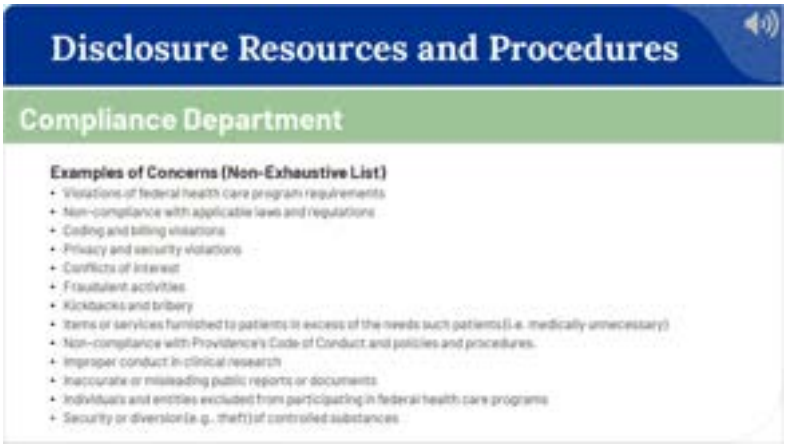
Audio (Slide Layer)



1.15 Information Security Overview

Notes:

All six course objectives are listed below; the non-grayed out objectives are the ones included in this section.

Enhance your understanding and engagement to actively contribute to ensuring the highest standards of patient care and safety.

Review Providence's compliance, privacy, and security programs.

Provide an overview of important healthcare laws that all workforce members need to know.

Provide an overview of the Emergency Medical Treatment and Labor Act (EMTALA) regulations.

Outline the different ways to report compliance and quality concerns and how to access the Integrity Hotline and/or High Reliability Platform (HRP).

Share resources that can be accessed/used after completing this education.

Audio (Slide Layer)

1.16 Information Security Overview

Notes:

All six course objectives are listed below; the non-grayed out objectives are the ones included in this section.

Enhance your understanding and engagement to actively contribute to ensuring the highest standards of patient care and safety.

Review Providence's compliance, privacy, and security programs.

Provide an overview of important healthcare laws that all workforce members need to know.

Provide an overview of the Emergency Medical Treatment and Labor Act (EMTALA) regulations.

Outline the different ways to report compliance and quality concerns and how to access the Integrity Hotline and/or High Reliability Platform (HRP).

Share resources that can be accessed/used after completing this education.

Audio (Slide Layer)

1.17 Information Security Overview

Notes:

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Audio (Slide Layer)

1.18 Information Security Overview

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1.19 Information Security Overview

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Accountability (Slide Layer)

Awareness (Slide Layer)

Training (Slide Layer)

1.20 Information Security Overview

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Audio (Slide Layer)

1.21 What's next

Notes:

1.22 Which of the following situations could be reported to the High Reliability Platform?

(Multiple Choice, 10 points, unlimited attempts permitted)

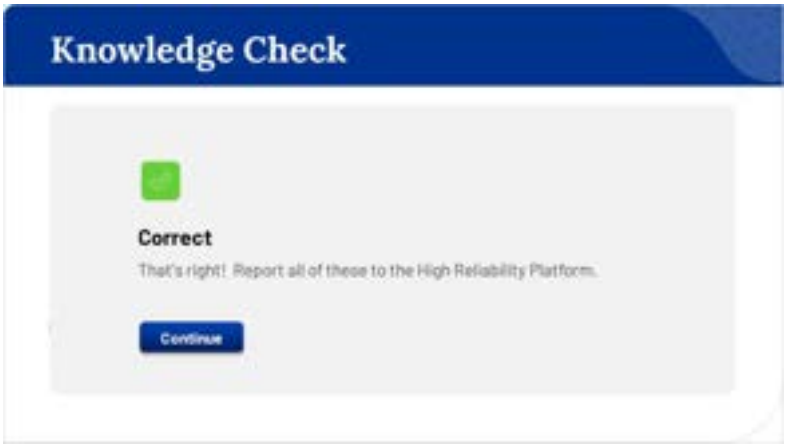
Correct	Choice
	A broken blood pressure monitor

	A workforce member who makes threats of harm to a coworker
	A wrong dose of medication given to a patient
X	All the above

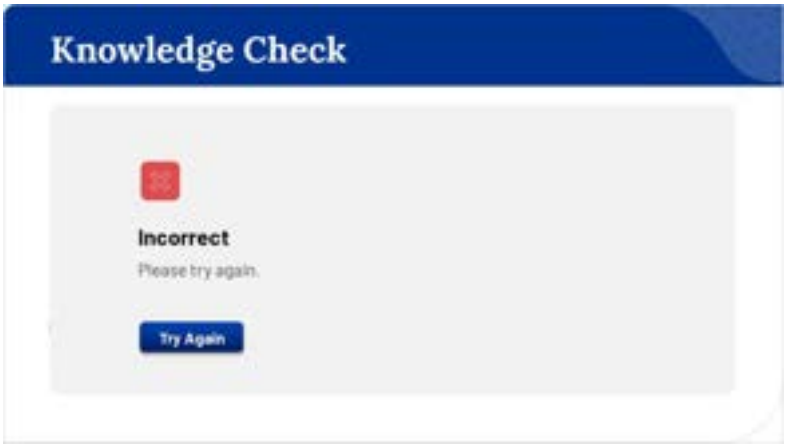
Feedback when correct:

That's right! Report all of these to the High Reliability Platform.

Correct (Slide Layer)



Try Again (Slide Layer)



1.23 Liam believes his coworker is retaliating against him because Liam brought forward a concern about his coworker's lack of medical documentation. Who could Liam report his concern to?

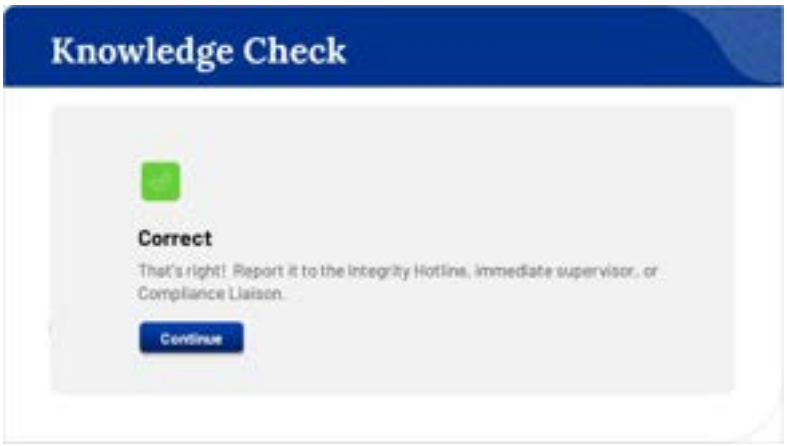
(Multiple Choice, 10 points, unlimited attempts permitted)

Correct	Choice
	The Integrity Hotline
	Liam's immediate supervisor
	Liam's Compliance Liason
X	Any of these

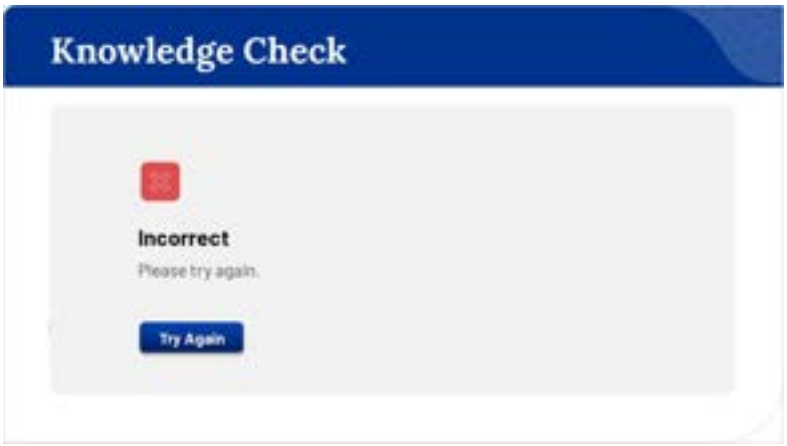
Feedback when correct:

That's right! Report it to the Integrity Hotline, immediate supervisor, or Compliance Liaison.

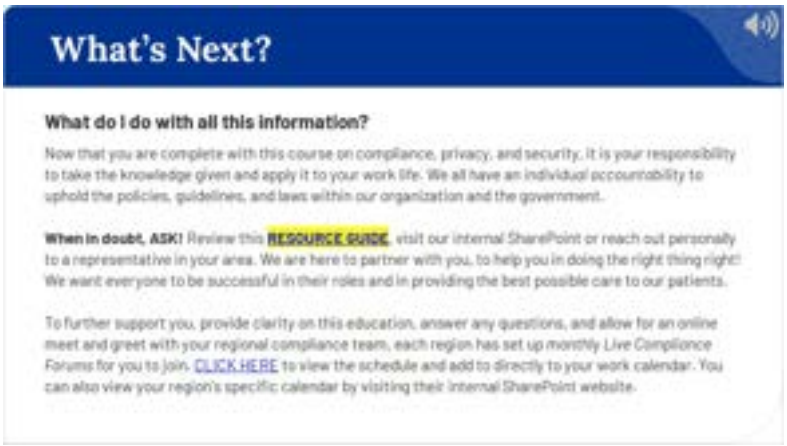
Correct (Slide Layer)



Try Again (Slide Layer)



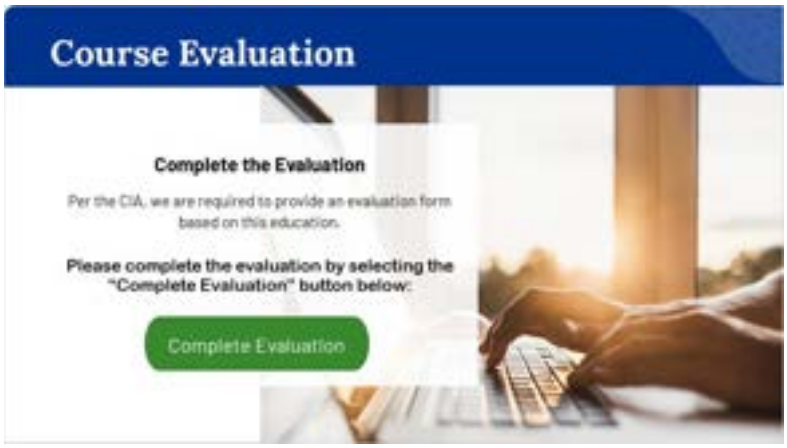
1.24 What's next



Notes:

Audio (Slide Layer)

1.25 Evaluation



Notes:

Untitled Layer 2 (Slide Layer)

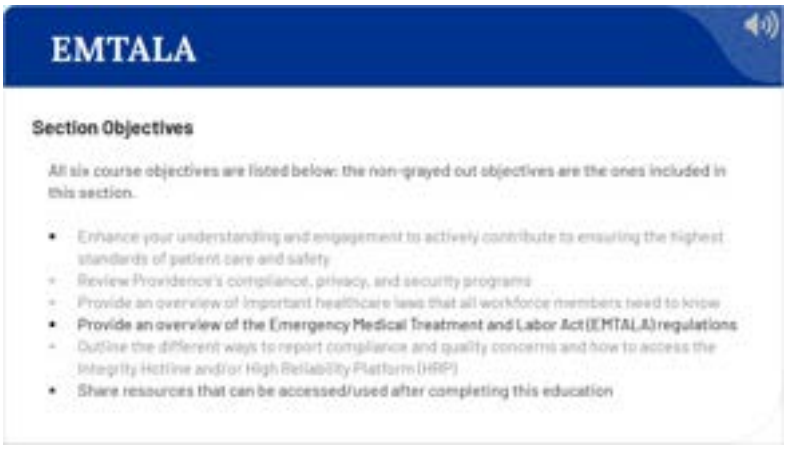
1.26 Conclusion

Notes:

EMTALA

1. EMTALA

1.1 Information Security Overview



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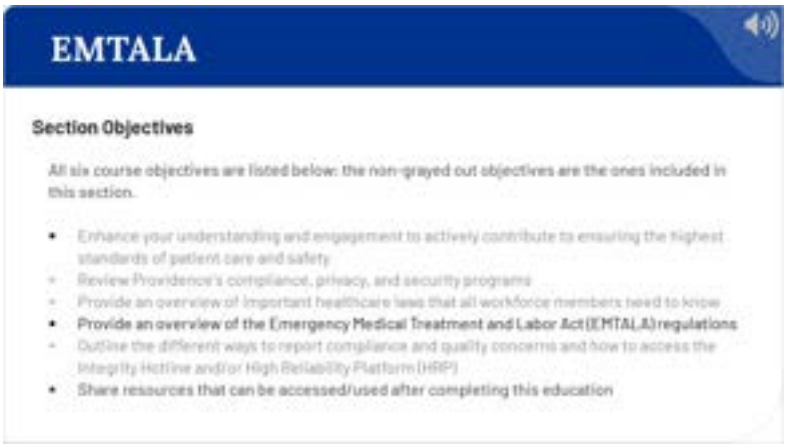
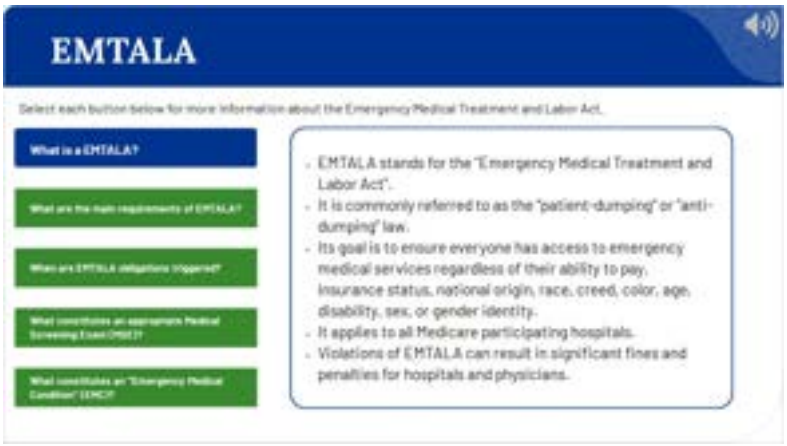
Audio (Slide Layer)



1.2 CIA FAQ

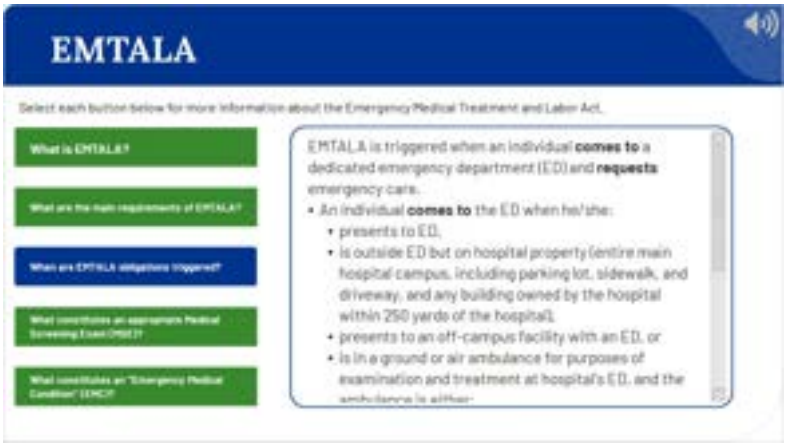
Notes:

What is (Slide Layer)

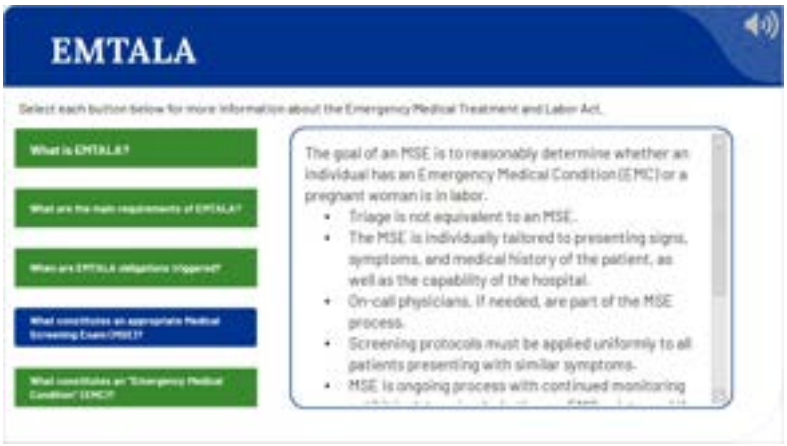


What are the main (Slide Layer)

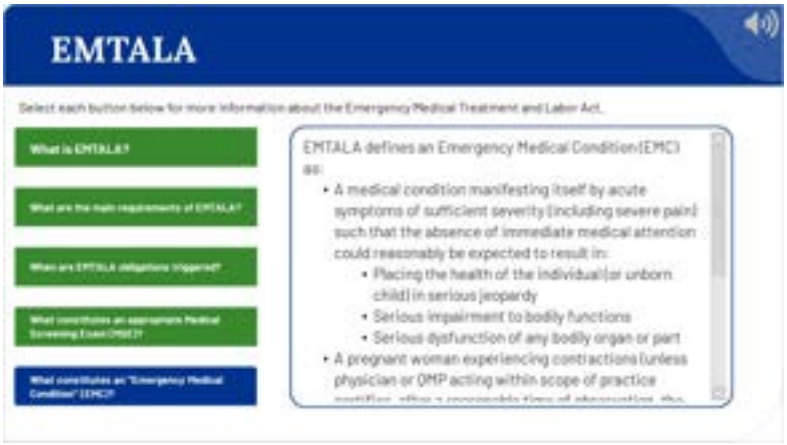
When are EMTALA (Slide Layer)



What constitutes MSE (Slide Layer)



What constitutes an EMC (Slide Layer)



1.3 Who does EMTALA apply to?

(Multiple Choice, 10 points, unlimited attempts permitted)

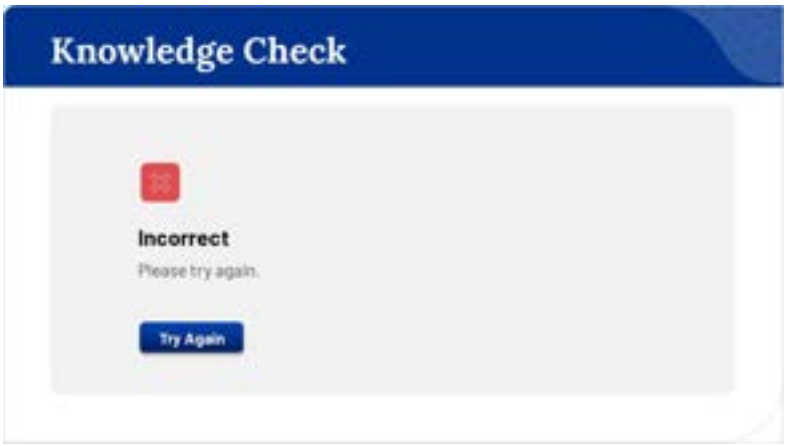
Correct	Choice
X	All patients regardless of race, ethnicity, financial ability to pay, disability
	In-patients of the hospital
	Patients undergoing scheduled out-patient care
	A laboratory not connected to any hospital

Feedback when correct:

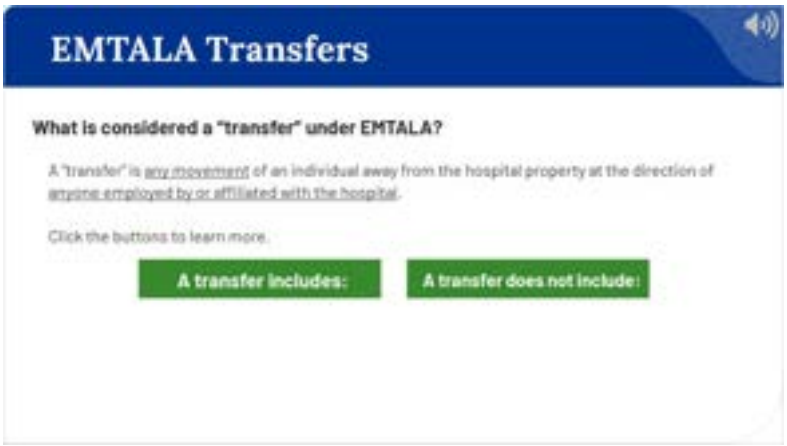
That's right. EMTALA applies to all patients regardless of race, ethnicity, financial ability to pay, disability.

Correct! (Slide Layer)

Try Again (Slide Layer)



1.4 Information Security Overview



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Audio (Slide Layer)

Include (Slide Layer)

Does not (Slide Layer)

1.5 Information Security Overview

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Audio (Slide Layer)

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Audio (Slide Layer)

1.7 Information Security Overview

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Audio (Slide Layer)

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Audio (Slide Layer)

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Audio (Slide Layer)

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Audio (Slide Layer)

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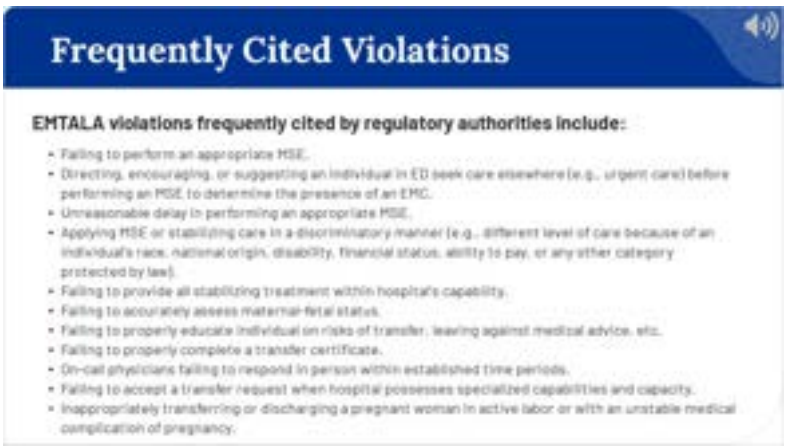
Audio (Slide Layer)

1.12 Information Security Overview



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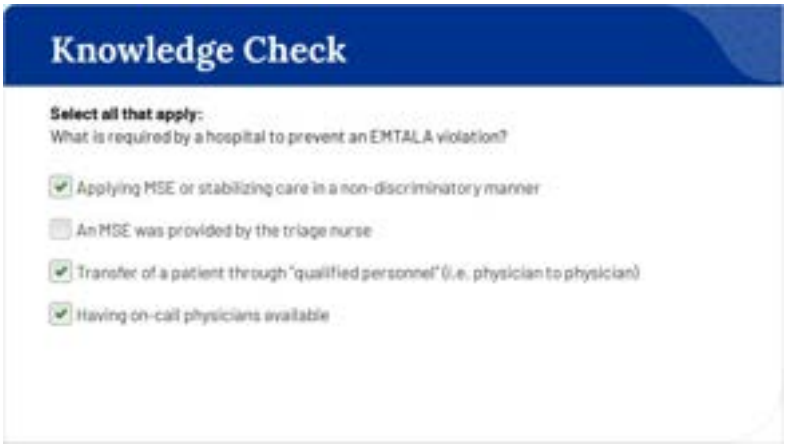
Audio (Slide Layer)

1.13 Select all that apply:

What is required by a hospital to prevent an EMTALA violation?

(Multiple Response, 10 points, unlimited attempts permitted)

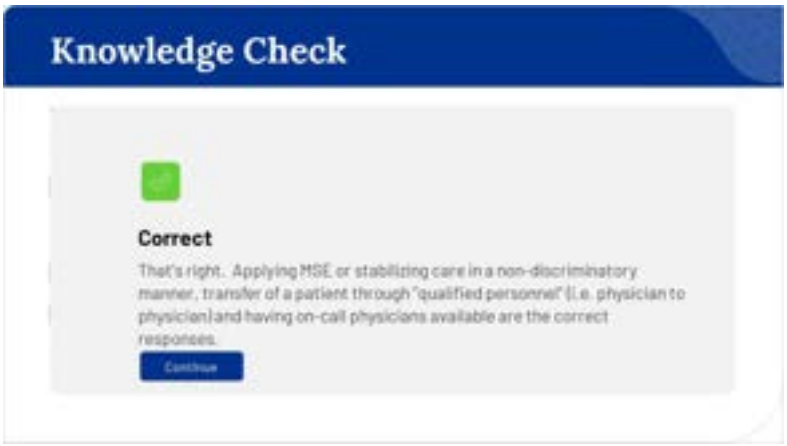


Correct	Choice
X	Applying MSE or stabilizing care in a non-discriminatory manner
	An MSE was provided by the triage nurse
X	Transfer of a patient through "qualified personnel" (i.e. physician to physician)
X	Having on-call physicians available

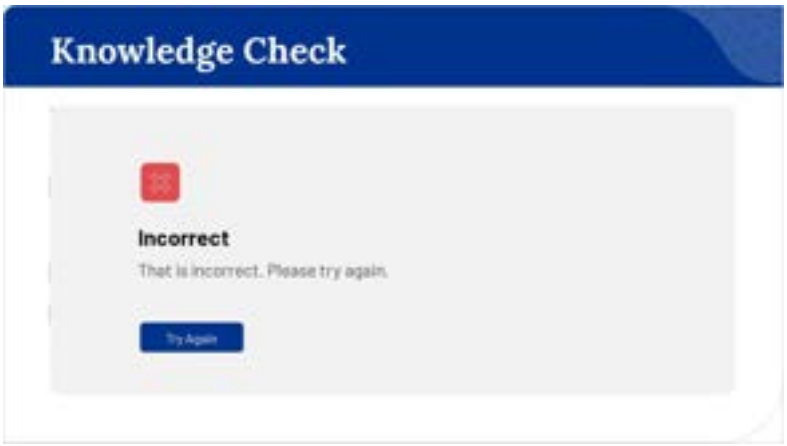
Feedback when correct:

That's right. Applying MSE or stabilizing care in a non-discriminatory manner, transfer of a patient through "qualified personnel" (i.e. physician to physician) and having on-call physicians available are the correct responses.

Correct (Slide Layer)



Try Again (Slide Layer)



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1.15 Information Security Overview

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Audio (Slide Layer)

1.16 Clutching her chest and struggling to breathe, Tina approaches the registration desk and asks the clerk if the hospital accepts her insurance. The clerk answers "no" but tells her that St. Shawn's hospital down the road does. Tina leaves the hospital.

What law does this scenario violate?

(Multiple Choice, 10 points, unlimited attempts permitted)

Correct	Choice
	Physician Referrals (Stark Law)

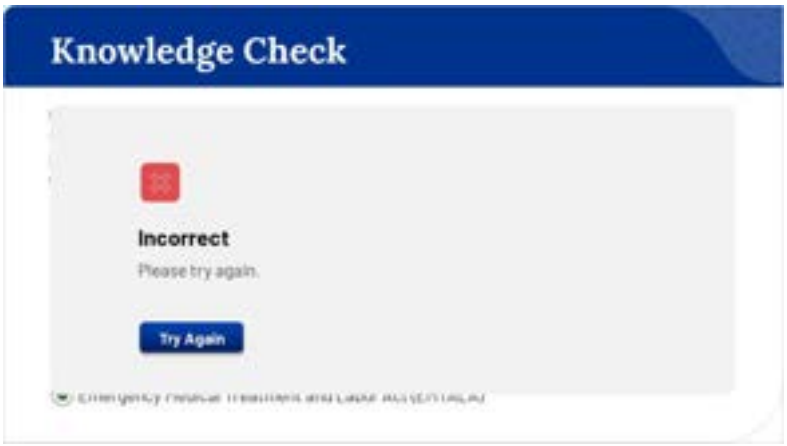
	False Claims Act (FCA)
	Anti-Kickback Statute (AKS)
	Fraud, Waste, and Abuse (FWA) Prevention
X	Emergency Medical Treatment and Labor Act (EMTALA)

Feedback when correct:

That’s right. EMTALA is violated in this scenario.

Correct! (Slide Layer)

Try Again (Slide Layer)



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1.18 EMTALA Completion

Notes:

PROV: HazCom - The Right to Understand

- Course Overview
- Safety Data Sheet
- HazCom Standard
- Label Elements
- Incora-HazCom
- Post Test
- Conclusion

Course Overview

Learning Objectives

- Learn the 5 elements under OSHA's new standard
- Learn the 2 signal words that indicate severity of the hazard
- Review the pictograms associated with chemical hazards
- Review the 16 sections on the new Safety Data Sheets (SDS)

Glossary

HazCom —

Hazard Communication Standard (HCS)

GHS —

Globally Harmonized System of Classification & Labeling of Chemicals

OSHA —

Occupational Safety & Health Administration

Pictogram —

A pictorial representation of the hazard

SDS —

Safety Data Sheets (formerly called MSDS)

Incora-HazCom —

Online chemical database which is accessible by ***all*** caregivers within the Providence system (including Covenant, Kadlec, etc.), and houses all Safety Data Sheets (SDS)

Expand and review the content above before moving on.

Note: the title of Hazard Communication is a bit misleading.

1. **The previous HazCom standard was last revised in 1994**
2. **In 2012, OSHA adopted new GHS-based HazCom regulations that standardized language and formatting on SDS**
3. **Therefore, this is current information and we follow OSHA's lead by calling this training Hazard Communication**

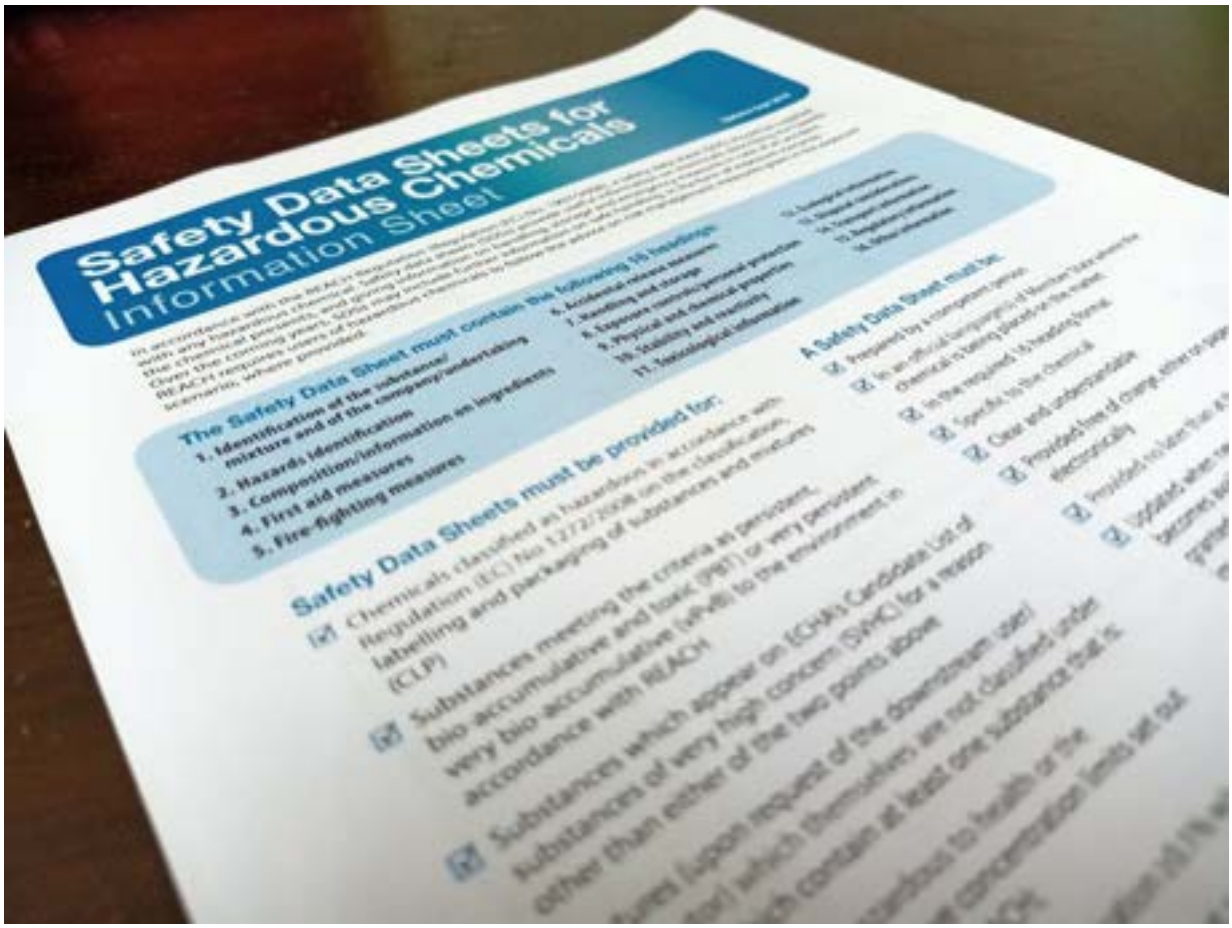
CONTINUE

Safety Data Sheet

The new Safety Data Sheets, formerly known as MSDS, have 16 standardized sections. Most SDS will be longer and more technical in nature due to the requirement for specific information in each section.

The Hazard Communication Standard (HCS) requires chemical manufacturers, distributors, or importers to provide Safety Data Sheets to communicate the hazards of hazardous chemical products.

As of June 2015, the HCS will require new SDS's to be in a uniform format, include the section numbers, headings, and associated information under the headings.



Section 1: Identification

Includes product identifier; manufacturer or distributor name, address, phone number; emergency phone number; recommended use; restrictions on use.

Section 2: Hazards Identification

Includes all hazards regarding the chemical; required label elements.

Section 3: Composition/Information on Ingredients

Includes information on chemical ingredients; trade secret claims.

Section 4: First Aid Measures

Includes important symptoms/effects, acute, delayed; required treatment.

Section 5: Fire Fighting Measures

Lists suitable extinguishing techniques, equipment; chemical hazards from fire.

Section 6: Accidental Release Measures

Lists emergency procedures; protective equipment; proper methods of containment and cleanup.

Section 7: Handling and Storage

Lists precautions for safe handling and storage, including incompatibilties.

Section 8: Exposure Controls/Personal Protection

Lists OSHA's Permissible Exposure Limits (PELs); Threshold Limit Values (TLVs); appropriate engineering controls; personal protective equipment (PPE).

Section 9: Physical and Chemical Properties

Lists the chemical characteristics.

Section 10: Stability and Reactivity

Lists chemical stability and possibility of hazardous reaction.

Section 11: Toxicological Information

Includes routes of exposure; related symptoms; acute and chronic effects; numerical measures of toxicity.

Section 12: Ecological Information

Lists environmental impact of chemicals.

Section 13: Disposal Considerations

Description of waste residues and information on safe disposal methods.

Section 14: Transport Information

Special precautions which a user needs to be aware of, or needs to comply with, in connection with transport or conveyance either within or outside their premises.

Section 15: Regulatory Information

Safety, health, and environmental regulations specific for the product in question.

Section 16: Other Information

Includes the date of preparation or last revision.

Expand and review the content above before moving on.

HazCom Standard

Globally Harmonized System (GHS) of Classification and Labeling of Chemicals

There are five new elements you need to understand within OSHA's new HazCom Standard.

Signal Words —

Danger = Highest Hazard Chemicals
Warning = Lower (Medium) Hazard Chemicals
No Signal Word = Low Hazard Chemicals

Pictograms —

A graphic (pictorial) representation of the hazard

Hazard Classification

Manufacturers are now required to "classify" their products according to the "intrinsic hazards of the ingredients that make up that product." Things like; flammable liquids, corrosive to metals, explosive, etc.

Hazard Statements

"Standardized," "assigned" phrases that describe the hazard. Things like; 'extremely flammable aerosol and vapor," or "toxic and corrosive liquids."

Precautionary Statements

Additional information that provides measures to be taken to minimize or prevent adverse effects of the hazard. There are four types of Precautionary Statements: Prevention, Storage, Disposal and Response to exposure or spillage of a Hazardous Material.

Expand and review the content above before moving on.

There are three GHS Hazard Classification elements.

HEALTH HAZARDS | PHYSICAL HAZARDS | ENVIRONMENTAL HAZARDS

- Acute Toxicity
- Carcinogenicity
- Skin Corrosion/Irritation
- Germ Cell Mutagenicity
- Aspiration Toxicity
- Reproductive Toxicity
- Serious Eye Damage/Eye Irritation
- Respiratory or Skin Sensitization
- Target Organ Systemic Toxicity - Single Exposure
- Target Organ Systemic Toxicity - Repeated Exposure

HEALTH HAZARDS | PHYSICAL HAZARDS | ENVIRONMENTAL HAZARDS

- Corrosive to Metals
- Explosives
- Flammable Gases
- Flammable Aerosols
- Oxidizing Gases
- Gases Under Pressure
- Flammable Liquids

- Flammable Solids
- Self-Reactive Substances
- Substances which, in contact with water, emit Flammable Gases
- Pyrophoric Liquids
- Pyrophoric Solids
- Self-Heating Substances
- Oxidizing Liquids
- Oxidizing Solids
- Organic Peroxides

HEALTH HAZARDS | PHYSICAL HAZARDS | ENVIRONMENTAL HAZARDS

- Acute Aquatic Toxicity
- Bioaccumulation Potential
- Chronic Aquatic Toxicity
- Hazardous to the Aquatic Environment
- Rapid Degradability

Select and review each tab above before moving on.

Label Elements

Classification is the starting point for the GHS. Once a chemical has been classified, the hazard(s) must be communicated to target audiences.

As in existing systems, labels and Safety Data Sheets (SDS) are the main tools for chemical hazard communication.

Let's review the required Label Elements (official OSHA definitions). As of June 1, 2015 all labels are required to have seven sections.

1. **Product Identifier (ingredient disclosure)**: name or number used for a hazardous product on a label or in the SDS.

2. **Supplier Identification**: the name, address and telephone number should be provided on the label.

3. **Precautionary Statements**: Precautionary information supplements the hazard information by briefly providing measures to be taken to minimize or prevent adverse effects from physical, health or environmental hazards. First aid is included in the precautionary information.

   There are four types of Precautionary Statements covering:

   - Prevention

- Response in cases of accidental spillage or exposure
- Storage
- Disposal

4

Hazard Pictograms: a composition that is intended to convey specific information about the hazards of a chemical. There are eight pictograms which are pictorial representations of the chemical hazards. Pictograms have a **RED** diamond on a **WHITE** background. At the center of the diamond is the pictorial representation of the hazard, such as flames for chemicals with Flammable hazards, exploding bombs for Explosive hazards, etc.

- Background Information
- Health Hazard
- Environment (non-mandatory)
- Exclamation Mark
- Exploding Bomb
- Skull and Crossbones
- Corrosion
- Flame
- Flame over Circle
- Gas Cylinder

5

Signal Words: the signal word indicates the relative degree of severity of a hazard. The signal words used in the GHS are:

- **Danger** for the more severe hazards

- **Warning** for the less severe hazards
- **No Signal Word =** low hazard chemicals

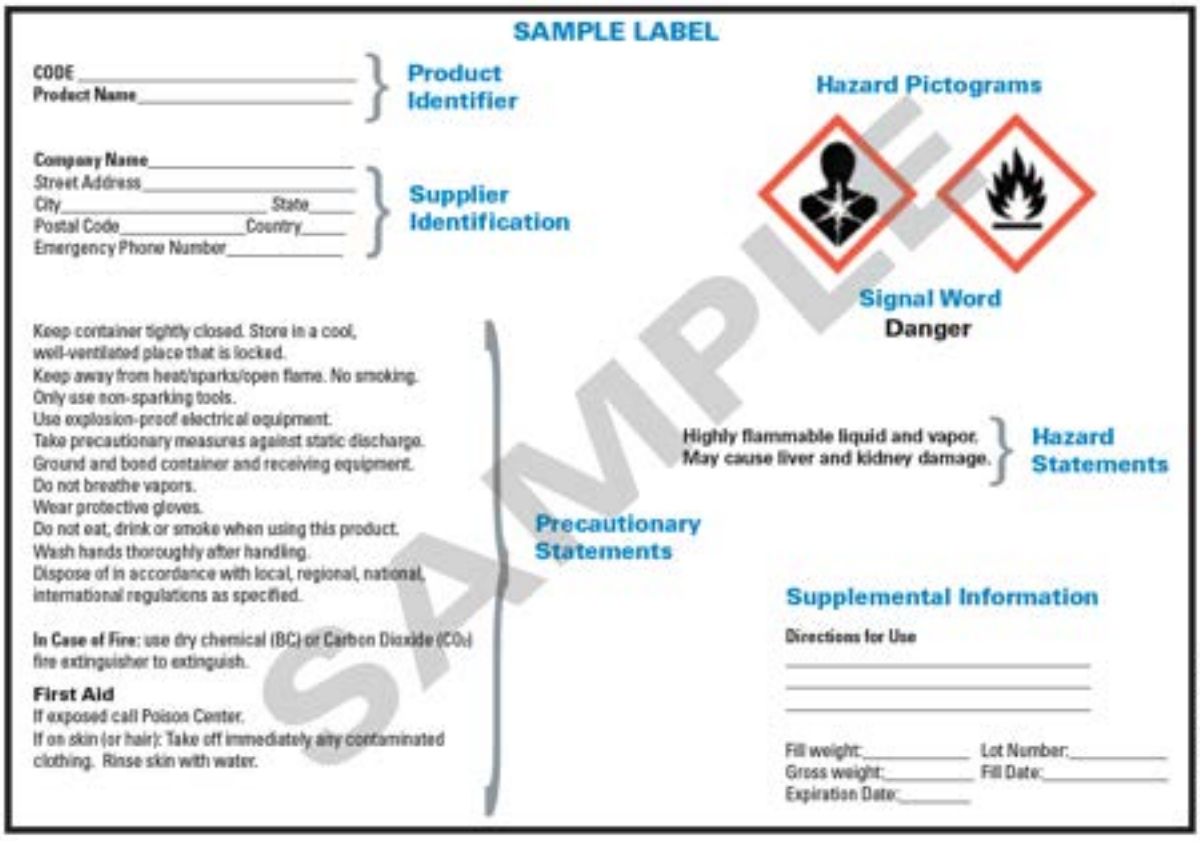
Signal words are standardized and assigned to the hazard categories within endpoints. Some lower level hazard categories do not use signal words. Only one signal word corresponding to the class of the most severe hazard should be used on a label.

6

Hazard Statements: are standard and assigned phrases that describe the hazard(s) as determined by hazard classification. An appropriate statement for each GHS hazard should be included on the label for products possessing more than one hazard.

7

Supplemental Information: information such as; directions for use, weight, fill date, and expiration date.



Workplace or Secondary Container Labels

OSHA allows Workplace or Secondary Container labels to be the same as the shipping label or they can contain only Product Identifier and "Words, pictures, symbols or combination thereof" that provides general information about the hazard(s) of the chemicals.

1910.1200(f)(6):Workplace labeling. Except as provided in paragraphs (f)(7) and (f)(8) of this section, the employer shall ensure that each container of hazardous chemicals in the workplace is labeled, tagged or marked with either.

1910.1200(f)(6)(i)The information specified under paragraphs (f)(1)(i) through (v) of this section for labels on shipped containers; or,

1910.1200(f)(6)(ii)Product identifier and words, pictures, symbols, or combination thereof, which provide at least general information regarding the hazards of the chemicals, and which, in conjunction with the other information immediately available to employees under the hazard communication program, will provide employees with the specific information regarding the physical and health hazards of the hazardous chemical.

CONTINUE

Incora-HazCom

Incora-HazCom *(previously called MaxCom)* is the online database that houses Safety Data Sheets (SDS).

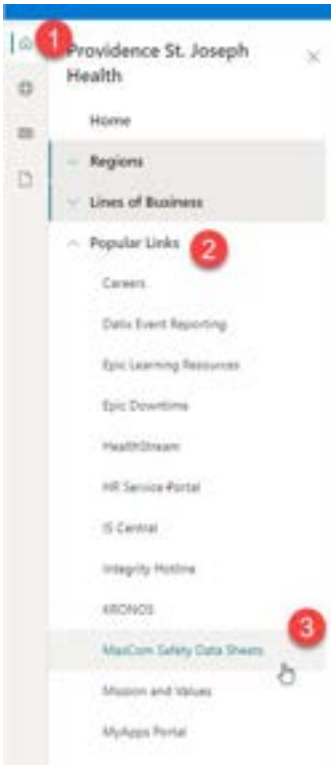
Click and review both sections below to learn more.

How do I find a chemical Safety Data Sheet (SDS)?

Incora-HazCom (formerly known as MaxCom) houses the OSHA-required Safety Data Sheets (SDS) for Providence and its affiliates.

1. OSHA requires companies to provide access to the Safety Data Sheets (SDS) for any hazardous chemical or pharmaceuticals in use with the work environment.
2. Every employee of Providence, St. Joseph, and affiliates have access to the Incora-HazCom online chemical database that is badged as MaxCom in SharePoint
    a. As such, any caregiver with a computer has access to SDS through SharePoint by clicking on the Azure|My Apps portal on their desktop, then choosing Apps, and then clicking on SharePoint
3. Once in SharePoint, click on the following:

Click image to enlarge.



Are there tutorials available on how to navigate and use Incora-HazCom?

Yes!

1. Incora-HazCom (MaxCom) is the system-level online database housing the OSHA-required Safety Data Sheets (SDS) that are accessible to all caregivers
2. There are quick and easy tutorials within Incora-HazCom that can be accessed 24/7 covering site use, navigation, and a variety of topics
    - To access the tutorials within the Incora-HazCom site, click on
        a. **Help** – on the left-hand side
        b. **General User Navigation** – to learn how to SEARCH for chemicals, select locations, select language, and other ways to navigate the Incora-HazCom site

    - Note: ***do not*** choose the “Training” button as that is misleading and directs people out of Incora-HazCom to a generic site with no training information

3. Monthly webinar trainings are hosted by Incora-HazCom, as well
    - Plus, there are multiple people throughout the hospitals who use and are familiar with the system and may be able to guide you in using Incora-HazCom
    - These individuals include Environmental Services Managers, Safety Officers, and your Core Leader

Expand and review both sections above to continue.

Post Test

Now it's time to show what you've learned after reviewing the content provided in this course. This brief post test only has four questions. You must answer each question correctly in order to successfully complete this course.

Question

01/06

Select the five new elements in the new standard.

- [ ] Signal Words
- [ ] Hazard Classifications
- [ ] Pictograms
- [ ] Hazard Statements
- [ ] Precautionary Statements
- [ ] Safety Data Sheets (SDS)

Question

02/06

Select the correct description for Danger & Warning (Signal Words).

- ◯ Highest chemical hazard and medium hazard chemicals
- ◯ Regular residential strength chemicals

Question

03/06

What is a Pictogram? *(Select all that apply)*

- [ ] A graphic representation of the chemical hazard
- [ ] A symbol on a white background framed within a red border
- [ ] There can be more than one pictogram associated with a chemical

Question

04/06

How many sections does the Safety Data Sheet (SDS) have?

- ◯ 6
- ◯ 12
- ◯ 16
- ◯ 20

Question

05/06

Who can access the OSHA-required Safety Data Sheets (SDS) in MaxCom/Incora-HazCom (*select all that apply*)?

- [ ] Managers
- [ ] Environmental Services
- [ ] Front-Line Patient Caregivers

Question

06/06

Identify the ways a caregiver can get help in using or navigating Incora-HazCom (MaxCom).

Select all that apply.

- [ ] Google
- [ ] Embedded tutorials in Incora-HazCom
- [ ] Use Safety Data Sheet Binder
- [ ] Ask Core Leader or Safety Officer

Conclusion

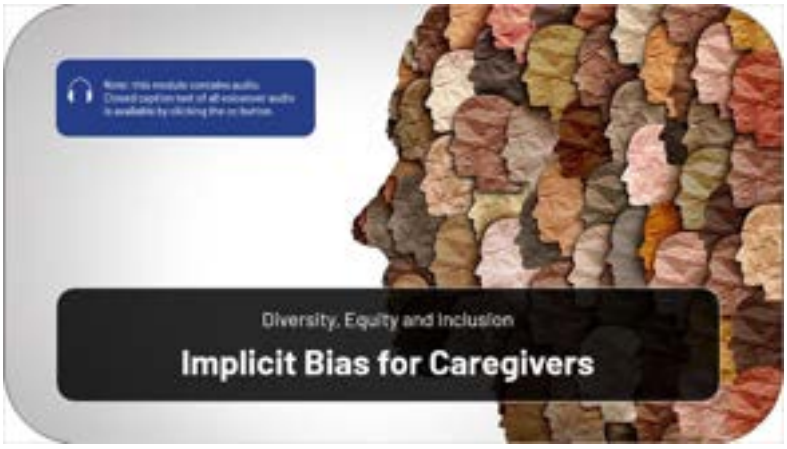
Congratulations, you have completed the HazCom - The Right to Understand course.

Select Exit Course above to return to HealthStream.

Implicit Bias Training for Caregivers

1. Untitled Scene

1.1 Title

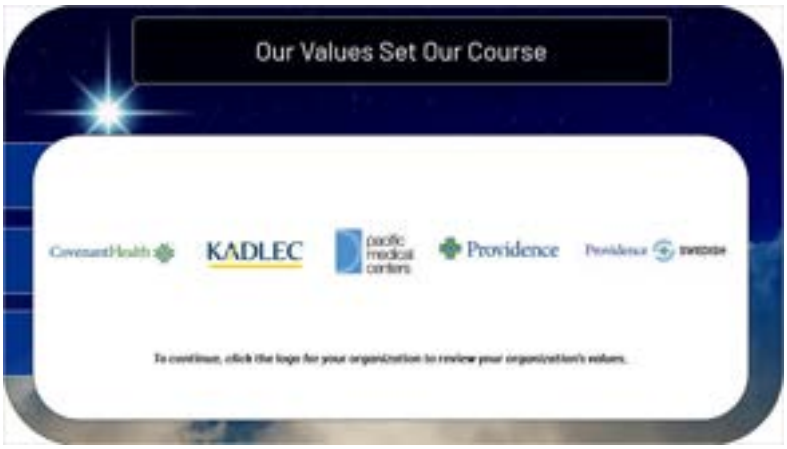


Notes:

1.2 Untitled Slide

Notes:

1.3 Untitled Slide



Notes:

Covenant (Slide Layer)

Kadlec (Slide Layer)

Pacific (Slide Layer)

Providence (Slide Layer)

ProvSwedish (Slide Layer)

1.4 Untitled Slide

Notes:

Values (Slide Layer)

1.5 Untitled Slide

Notes:

Diversity (Slide Layer)

Equity (Slide Layer)

Inclusion (Slide Layer)

1.6 Drag and drop each definition to match it to the correct term, then click "SUBMIT".

(Matching Drag-and-Drop, 10 points, 3 attempts permitted)

Correct	Choice
Diversity	Any dimension that can differentiate groups and people from one another.
Equity	Providing to people what they need to succeed based on their individual circumstances.
Inclusion	Engaging, involving, and valuing different ideas, backgrounds, and perspectives to form a positive organizational culture.

Feedback when correct:

That's right!

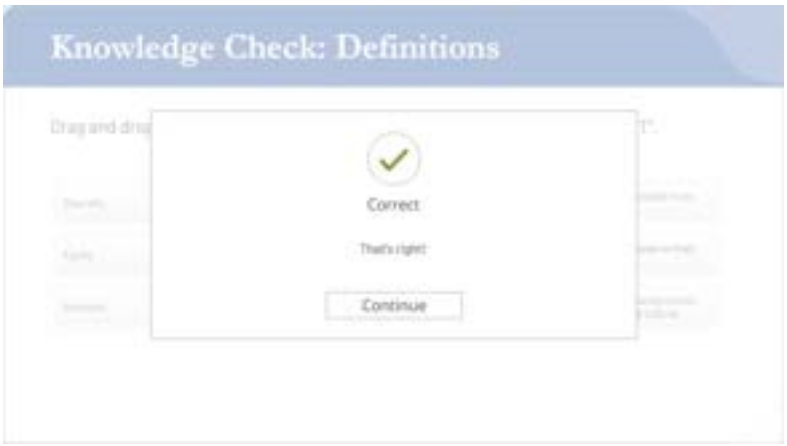
Feedback when incorrect:

Diversity = Any dimension that can differentiate groups and people from one another.

Equity = Providing to people what they need to succeed based on their individual circumstances.

Inclusion = Engaging, involving, and valuing different ideas, backgrounds, and perspectives to form a positive organizational culture.

Correct (Slide Layer)



Incorrect (Slide Layer)

Try Again (Slide Layer)

1.7 Untitled Slide

Notes:

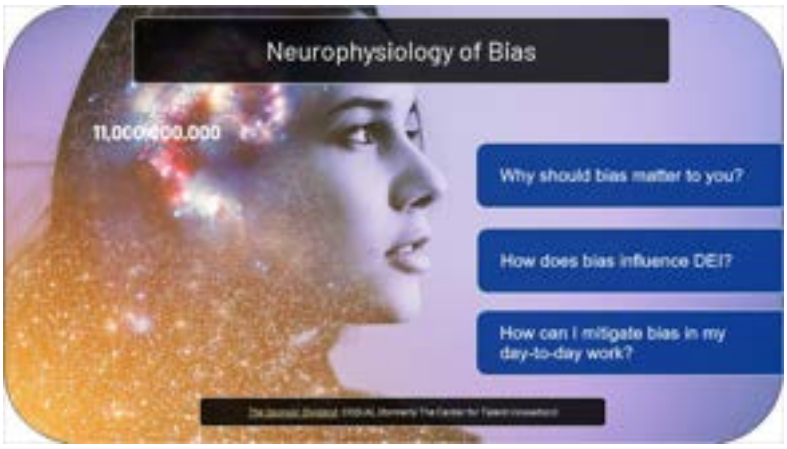
Values (Slide Layer)

Definitions (Slide Layer)

1.8 Untitled Slide

Notes:

1.9 Untitled Slide



Notes:

1.10 Untitled Slide

Notes:

1.11 Untitled Slide

Notes:

1.12 Untitled Slide

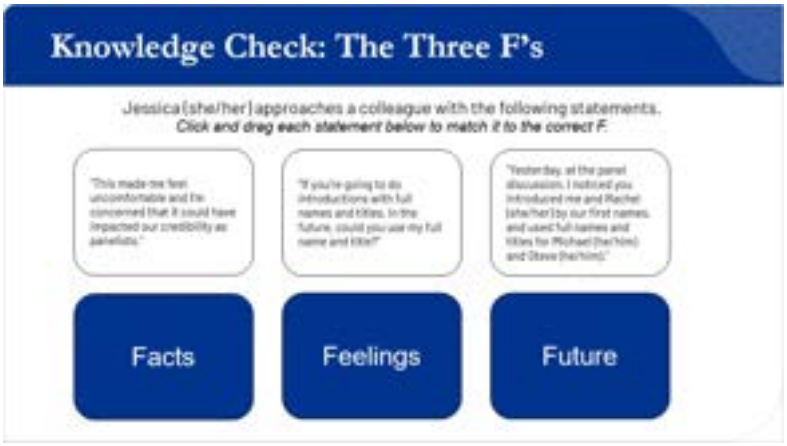
Notes:

1.13 Untitled Slide

Notes:

1.14 Knowledge Check: The Three F's

(Drag and Drop, 10 points, 3 attempts permitted)



Drag Item	Drop Target
"If you're going to do introductions with full names and titles, in the future, could you use my full name and title?"	Future

“This made me feel uncomfortable and I’m concerned that it could have impacted our credibility as panelists.“	Feelings
“Yesterday, at the panel discussion, I noticed you introduced me and Rachel (she/her) by our first names, and used full names and titles for Michael (he/him) and Steve (he/him).“	Facts

Drag and drop properties
Return item to start point if dropped outside any drop target
Snap dropped items to drop target (Stack random)
Allow only one item in each drop target

Feedback when correct:

That's right! You selected the correct response.

Feedback when incorrect:

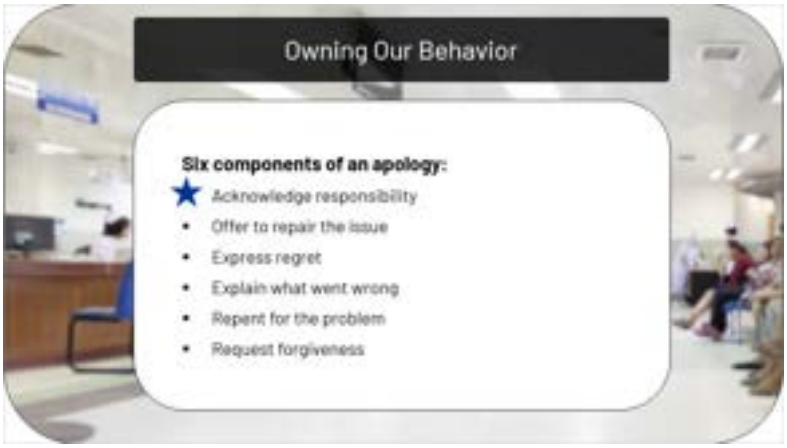
You did not select the correct response.

Correct (Slide Layer)

Incorrect (Slide Layer)

Try Again (Slide Layer)

1.15 Untitled Slide



Notes:

1.16 Untitled Slide

Notes:

Values (Slide Layer)

Definitions (Slide Layer)

Apology (Slide Layer)

1.17 Untitled Slide

Notes:

1.18 Untitled Slide

Notes:

1.19 Untitled Slide

Notes:

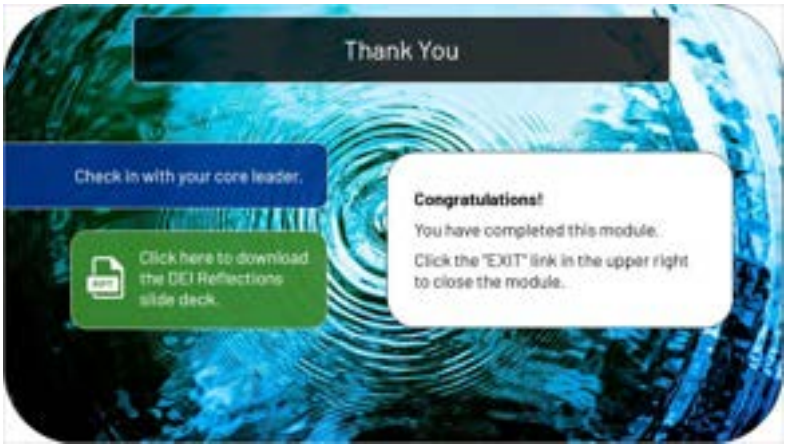
Values (Slide Layer)

Definitions (Slide Layer)

Apology (Slide Layer)

Action (Slide Layer)

1.20 Untitled Slide



Notes:

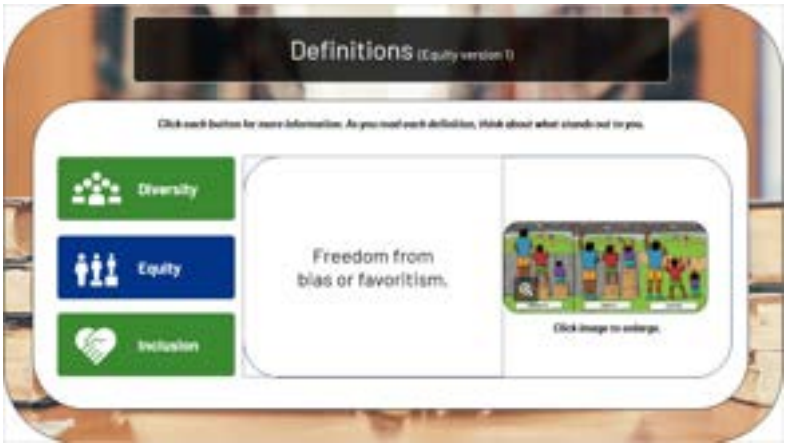
2. Untitled Scene

2.1 Untitled Slide

Notes:

Diversity (Slide Layer)

Equity (Slide Layer)



Inclusion (Slide Layer)

South Division [CCO] Infection Prevention: Special Topics

This course provides an overview of special topics in infection prevention including Hospital Onset Pneumonia, Clostridioides difficile (or C. difficile), Influenza and Aerosol Transmittable Disease (ATD).

Course Objectives

HOSPITAL ONSET PNEUMONIA

Hospital Onset Pneumonia Prevention

Hospital Onset Pneumonia Prevention Review

CLOSTRIDIOIDES DIFFICILE

What is Clostridioides difficile?

What is Clostridioides difficile? Review

How is Clostridioides difficile spread?

How is Clostridioides difficile Spread? Review

What are the Symptoms of Clostridioides difficile?

- What are the Symptoms of Clostridioides difficile? Review
- How to Identify Types of Stools?
- How to Identify Types of Stools? Review
- Who is at Risk for Contracting Clostridioides difficile?
- Who is at Risk for Contracting Clostridioides difficile? Review
- How to Treat Clostridioides difficile?
- How to Treat Clostridioides difficile? Review
- How to Prevent the Spread of Clostridioides difficile?
- How to Prevent the Spread of Clostridioides difficile? Review
- Isolation
- Isolation Review
- How to Ambulate a Clostridioides difficile Patient?
- How to Ambulate a Clostridioides difficile Patient? Review
- How to Transfer a Clostridioides difficile Patient?
- How to Transfer a Clostridioides difficile Patient? Review
- Patient and Family Education

- Patient and Family Education Review
- When a Clostridioides difficile Patient Goes Home
- When a Clostridioides difficile Patient Goes Home Review
- Resources

INFLUENZA

- What is Influenza (Flu)?
- What is Influenza (Flu)? Review
- Flu Symptoms
- Flu Symptoms Review
- How Flu Spreads
- How Flu Spreads Review
- Complications of Flu
- Complications of Flu Review
- Diagnosing Flu
- Diagnosing Flu Review
- Preventing Seasonal Flu

- Preventing Seasonal Flu Review
- CDC Vaccine Information Statement

AEROSOL TRANSMISSABLE DISEASE (ATD)

- Scope of ATD Standard
- Personal Protective Equipment (PPE)
- Occupational Exposure Risk
- Elements of the ATD Standard
- What is an Aerosol Transmissible Disease (ATD)?
- SARS - CoV-2 (COVID-19)
- Signs & Symptoms & Management of ATDs
- Wearing Respiratory Protection
- Other Ways to Reduce the Spread of ATDs
- Engineering Controls
- Physical Protection
- Vaccination Protection
- I Have Been Exposed, What Do I Do?

Why Annual Tuberculosis (TB) Screening?

ATD Resources

COURSE COMPLETED!

Conclusion

Course Objectives

HOSPITAL ONSET PNEUMONIA	CLOSTRIDIOIDES DIFFICILE (OR C. DIFFICILE)	INFLUENZA	AEROSOL TRANSMITTABLE DISEASE (ATD)

- List Pneumonia prevention considerations
- Identify interventions included in the ventilator bundle

HOSPITAL ONSET PNEUMONIA	CLOSTRIDIOIDES DIFFICILE (OR C. DIFFICILE)	INFLUENZA	AEROSOL TRANSMITTABLE DISEASE (ATD)

- Define what Clostridioides difficile is
- Recognize how Clostridioides difficile is spread
- Identify Clostridioides difficile symptoms
- Distinguish types of stools
- Assess who is at risk
- List treatment options
- Determine proper hand washing technique
- Identify Contact Enteric Precautions

- Distinguish proper environmental cleaning steps
- Recognize proper procedures to ambulate patient
- List family education requirements

HOSPITAL ONSET PNEUMONIA	CLOSTRIDIOIDES DIFFICILE (OR C. DIFFICILE)	INFLUENZA	AEROSOL TRANSMITTABLE DISEASE (ATD)

- Define what Influenza is
- Identify flu symptoms
- Recognize how flu is spread
- List complications of flu
- Determine how to diagnose flu
- State steps to prevent flu

HOSPITAL ONSET PNEUMONIA	CLOSTRIDIOIDES DIFFICILE (OR C. DIFFICILE)	INFLUENZA	AEROSOL TRANSMITTABLE DISEASE (ATD)

- Identify common Aerosol Transmissible Diseases (ATDs) as defined by CAL/OSHA
- Understand occupational exposure risks to ATDs
- Know how to identify and apply control measures to prevent the spread of ATDs
- Be aware of appropriate medical follow-up from ATD exposure incidents

Click to review the objectives for each topic in this course before moving on.

Hospital Onset Pneumonia Prevention

Pneumonia prevention considerations

Remember every patient is at risk

Elevate the head of bed.

- Provide good oral care EACH SHIFT.

- Provide extra oral care for patient with BiPap devices as secretions dry-out quickly.
- Oral care is provided for all intubated patients daily and per ministry specific policy and protocols.

Consider aspiration prevention.

Help us decrease re-admission rates!

Ventilator Associated Events

The ventilator bundle calls for a series of interventions including:

- Elevate head of the bed
- Daily “sedation vacation” and assessment of readiness to extubate
- Peptic ulcer disease prophylaxis
- Venous thrombo-embolism prophylaxis
- Oral care per ministry specific policy and protocol

Hospital Onset Pneumonia Prevention Review

Multiple Choice:

Which of the following is a pneumonia prevention consideration?

Select the BEST answer.

- ◯ Elevate the foot of bed.
- ◯ Consider aspiration prevention.
- ◯ Provide good oral care once a day.

SUBMIT

Multiple Choice:

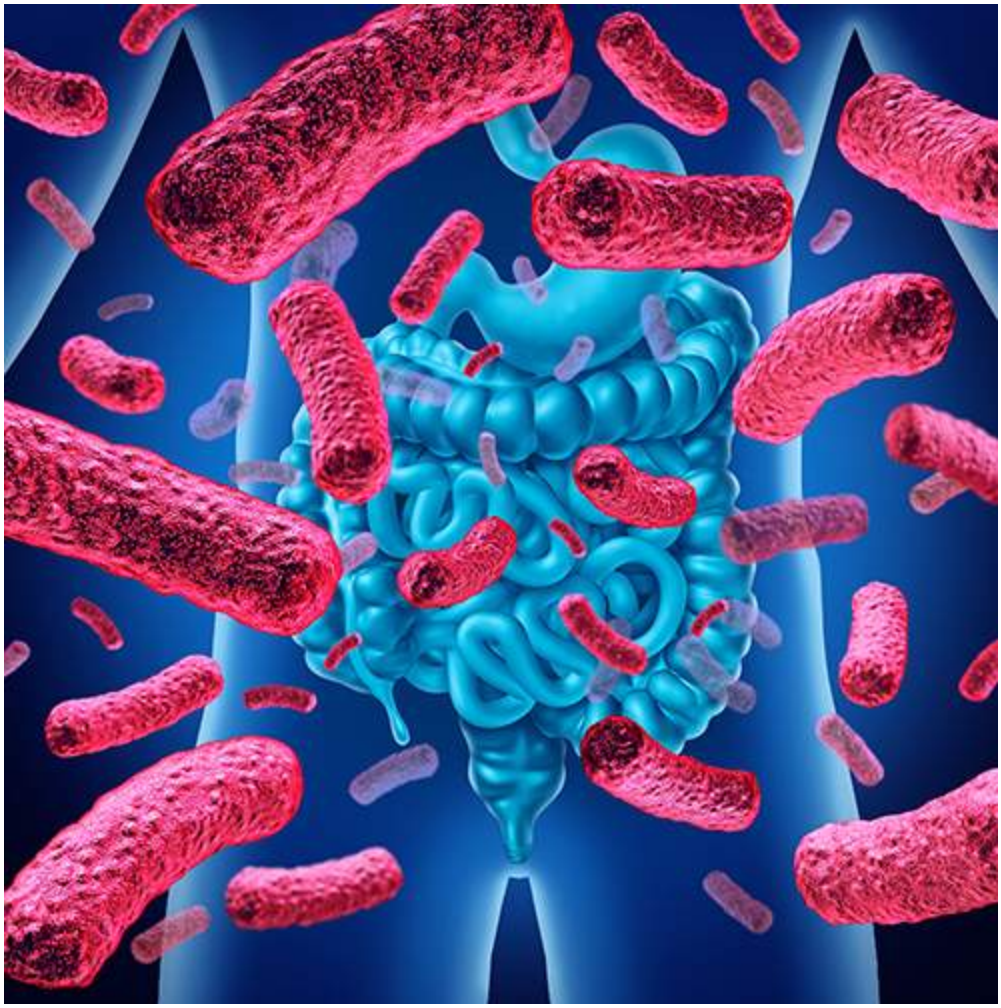
Which of the following is an intervention included in the ventilator bundle?

- ◯ Lyme disease prophylaxis.
- ◯ Sepsis prophylaxis.
- ◯ Elevate foot of the bed.
- ◯ Daily "sedation vacation" and assessment of readiness to extubate.

SUBMIT

Complete the knowledge checks above before moving on.

What is Clostridioides difficile?



Clostridioides difficile (pronounced klos-TRID-e-OY-dees dif-uh-SEEL), also known as "C. difficile" (See-difficile), is a bacteria that can normally live in the stomach and intestines.

Unlike most bacteria, Clostridioides difficile bacteria produce spores that can live on surfaces for months or even years. These spores are very difficult to kill, and have the potential to infect humans and cause a

variety of health problems.

CONTINUE

What is Clostridioides difficile? Review

Multiple Choice:

Select the BEST answer.

Clostridioides difficile:

- ( ) Is a bacteria that can only live outside the body.
- ( ) Produces spores that can live on surfaces for months or years.
- ( ) Spores are very easy to kill.
- ( ) Does NOT pose a significant health risk.

SUBMIT

Complete the knowledge check above before moving on.

How is Clostridioides difficile spread?

Clostridioides difficile is spread by spores found in stool. Also known as fecal-oral transmission.

Unclean hands or medical equipment contaminated with stool may spread the infection on things in the environment such as bed linens, bed rails, toilets, sinks, and personal belongings (e.g., cell phones, purses).

Transmission occurs when someone touches a contaminated surface and ingests the spores.

CONTINUE

How is Clostridioides difficile Spread? Review

Multiple Choice:

How can Clostridioides difficile be spread?

- ◯ Mainly by tiny droplets made when people cough, sneeze or talk.
- ◯ Bacteria or other germs that enter the patient's bloodstream.
- ◯ When someone touches a contaminated surface and ingests the Clostridioides difficile spores.
- ◯ Only through certain body fluids from a person who has Clostridioides difficile.

SUBMIT

Complete the knowledge check above before moving on.

What are the Symptoms of Clostridioides difficile?

The most common symptoms of Clostridioides difficile infection (CDI) include:

- Watery diarrhea
- Fever
- Loss of appetite
- Nausea
- Belly pain

- Tenderness

CDI may result in more serious conditions such as ileus, rectal prolapse, toxic megacolon, sepsis, and even death.

It is possible to be colonized with Clostridioides difficile and not experience any symptoms. These individuals may still shed Clostridioides difficile in stools for a prolonged period.

CONTINUE

What are the Symptoms of Clostridioides difficile? Review

Multiple Choice:

One of the most common symptoms of Clostridioides difficile infection (CDI) is:

- ○ Constipation
- ○ Low blood pressure
- ○ Increased appetite
- ○ Nausea

SUBMIT

Complete the knowledge check above before moving on.

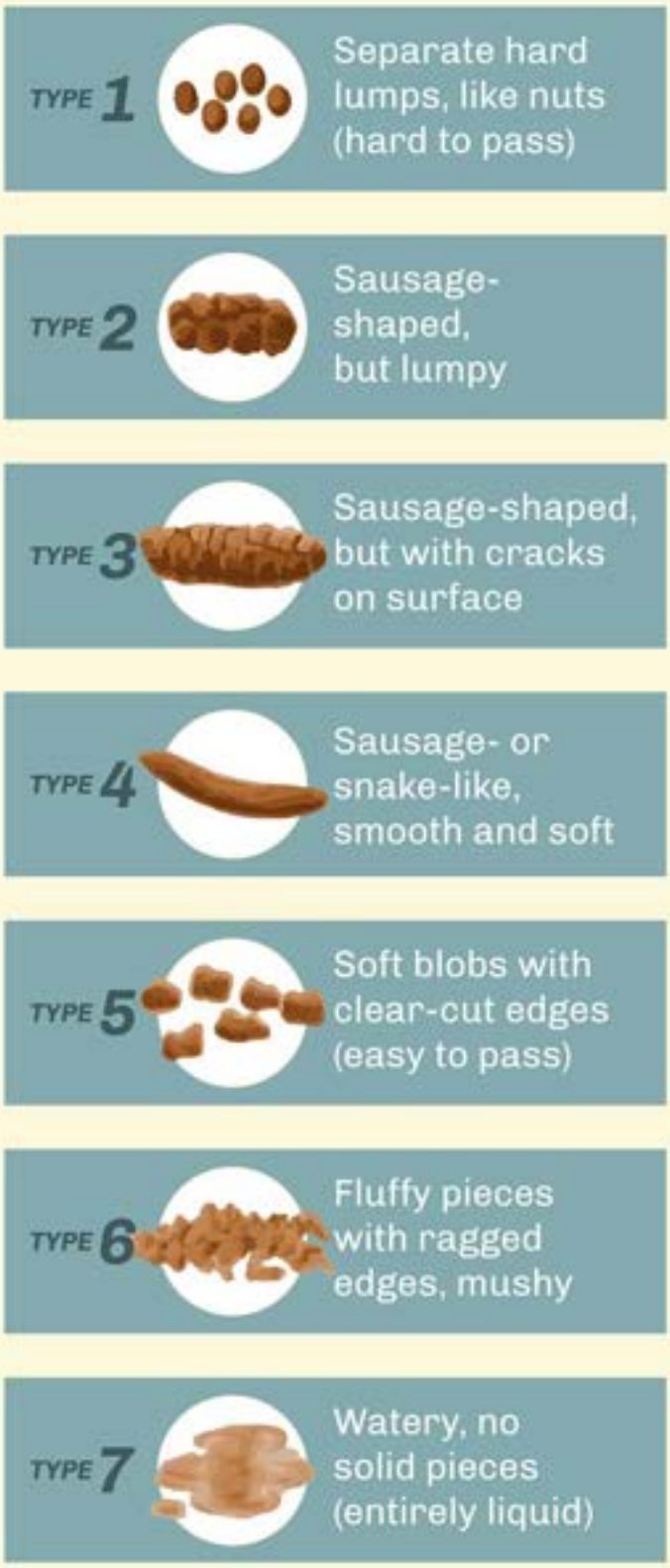
How to Identify Types of Stools?

The Bristol Stool Scale is a way to talk about shapes and types of stool. Document all stools with a Bristol score.

Note: Types 6 & 7 are considered loose/liquid stools suitable for Clostridioides difficile testing. Testing will ***not*** be performed on formed stools.

Bristol stool chart

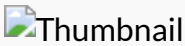
WebMD

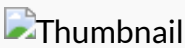


Click or tap to zoom in.

CONTINUE

How to Identify Types of Stools? Review





Remember: Types 6 & 7 are considered loose/liquid stools suitable for C. diff testing. Testing will not be performed on formed stools.

Complete the knowledge checks above before moving on.

Who is at Risk for Contracting Clostridioides difficile?

Typically, CDI occurs when the normal flora of the intestines is disrupted, usually as a result of antibiotics and/or proton pump inhibitors (PPI).

Other common risk factors include:

- Advanced age (> 65 years old)
- Underlying gastrointestinal issues or recent gastrointestinal surgery
- Tube feedings
- Nursing home residents
- Recurrent CDI episodes
- Immunosuppression
- Patients receiving chemotherapy
- Frequent hospitalizations

CONTINUE

Who is at Risk for Contracting Clostridioides difficile? Review

Multiple Choice:

Select the BEST answer.

Almost all patients who develop CDI:

- ◯ Are under 65 years old
- ◯ Have normal flora of the intestines
- ◯ Have never had CDI episodes before
- ◯ Are taking, or have recently been given, antibiotics and/or proton pump inhibitors

SUBMIT

Complete the knowledge check above before moving on.

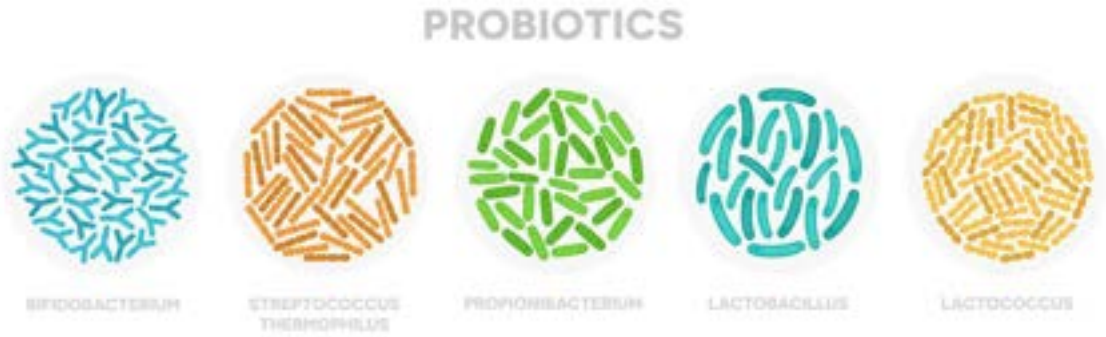
How to Treat Clostridioides difficile?

Treatment for CDI varies according to the severity of the illness. For some patients, stopping the inciting medication or changing antibiotics will help relieve symptoms.

Additional treatments may include:

More targeted antibiotics

Fluids to help guard against dehydration from diarrhea



Probiotics to replenish "good" bacteria in the intestines

GI surgery and fecal transplants for more severe cases

CONTINUE

How to Treat Clostridioides difficile? Review

Multiple Choice:

Treatment options for CDI include:

- ( ) Reduced fluid intake
- ( ) Less targeted antibiotics
- ( ) Stopping the inciting medication
- ( ) Reduced probiotic intake

SUBMIT

Complete the knowledge check above before moving on.

How to Prevent the Spread of Clostridioides difficile?

Environmental Cleaning

Use dedicated or disposable equipment when available.

Use a sporicidal to disinfect shared equipment (i.e., thermometers, IV poles, etc.) prior to removing from the patient's room. Bleach and Oxycide are the two most commonly utilized sporicidal agents effective against organisms such as Clostridioides difficile.

Patients to be placed in Contact Enteric precautions requiring cleaning with a sporicidal agent and washing of hands with soap and water when exiting the patient room.

Use per manufacturer's instructions.

- Wet time should be per these instructions
- If product dries before the full dwell time, reapply the product
- High-touch areas in the patient's room—such as bedrails, commodes, over-bed tables, nurse call lights, doorknobs, light switches, computer keyboards, and telephones—are cleaned daily with sporicidal agent (ex. bleach)

Once a patient is transferred to another unit or discharged, the room is terminally cleaned per protocol and disinfected with UV light (if available).

Hand Hygiene

Patients should be educated to wash their hands with SOAP AND WATER after using the restroom, after episodes of incontinence, and before eating, drinking and taking medications.

The best way to prevent the spread of C. diff is through proper hand washing with SOAP AND WATER. Rigorous rubbing and friction for at least 20 seconds will remove the C. diff spores from the hands.

Alcohol-based gel hand sanitizers
DO NOT kill C. diff spores.

CONTINUE

How to Prevent the Spread of Clostridioides difficile? Review

Select All That Apply:

Which of the following environmental cleaning steps should you take to prevent the spread of Clostridioides difficile ?

- [ ] Use a SPORICIDAL to disinfect shared equipment prior to removing from the patient's room.
- [ ] If product dries before the full dwell time, there is no need to reapply the product.
- [ ] High-touch areas in the patient's room should be cleaned every hour with SPORICIDAL.
- [ ] Once a patient is transferred to another unit or discharged, the room should be terminally cleaned per protocol and disinfected with UV light (if available).

SUBMIT

Complete the knowledge check above before moving on.

Isolation

Patients with either suspected or confirmed CDI must be isolated under CONTACT ENTERIC/ENTERIC CONTACT PRECAUTIONS.

How to identify a Clostridioides difficile room

Contact/Enteric Precautions sign should be easily visible outside of the patient's room.

While the format/color of the sign may vary, the order must be for contact enteric precautions.

Presumptively isolate— do not wait until test results to isolate. Initiate isolation at time of initial suspicion or order. Precautions are indicated for acute diarrhea.

Post and follow signs approved through ministry specific Infection Prevention Specialists for isolation precautions.

STOP

Enteric Precautions

(in addition to Standard Precautions)

Visitors please check with nurse before entering.
Visitantes por favor verifique con la enfermera antes de entrar.

EVERYONE MUST:

- Clean hands before putting on gown and gloves
- Wash hands with SOAP AND WATER when leaving room

ALL CAREGIVERS MUST:

- Clean and disinfect with sporicidal agent (i.e. bleach) as per hospital policy

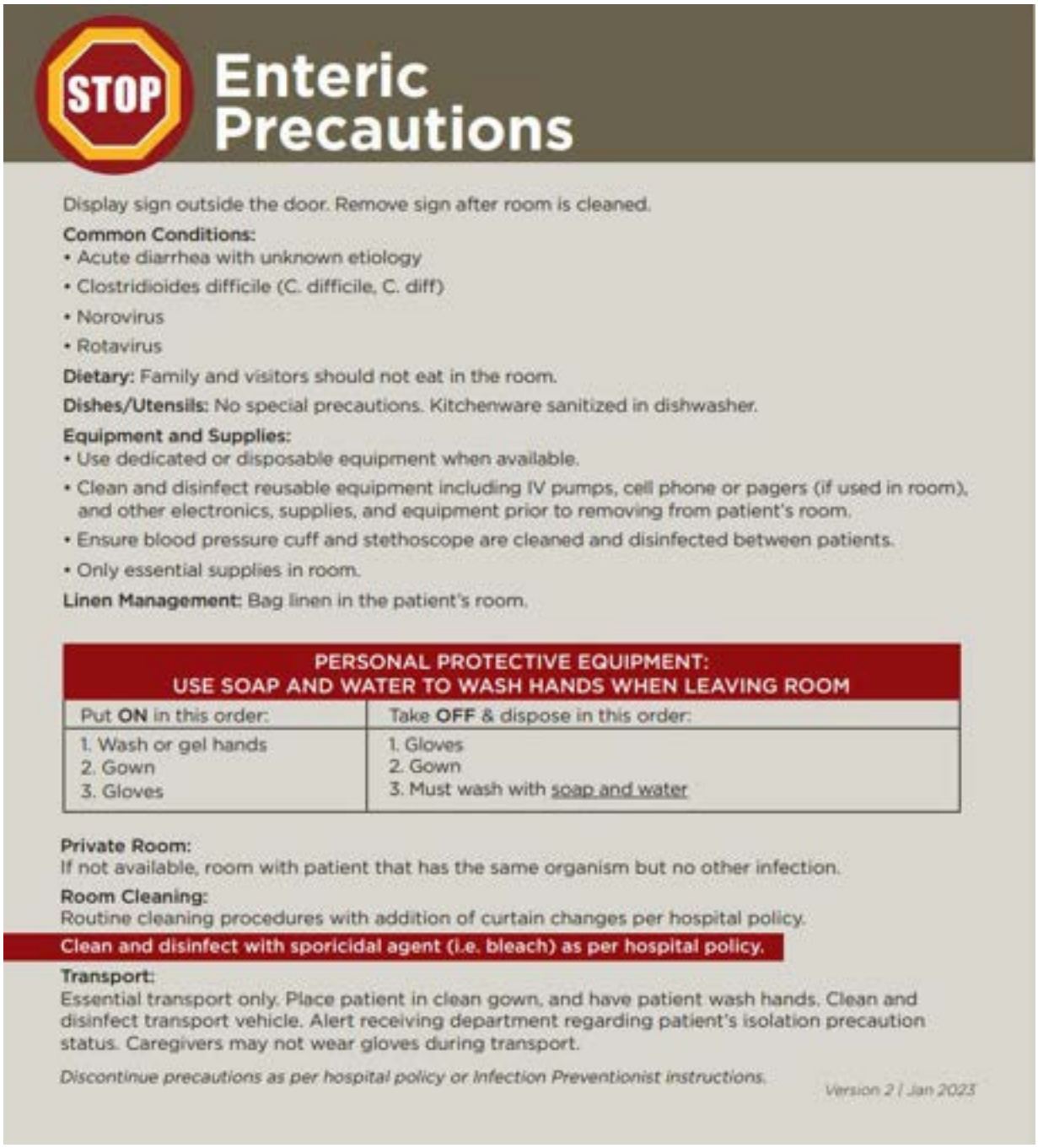
Gloves / *Guantes*

Gown / *Bata*

WIPE DOWN SIGN – DO NOT DISCARD!

Sign to be removed by Environmental Services after room cleaned

Thank You from Infection Prevention



Before entering a Clostridioides difficile room:

Thoroughly wash hands with soap and water, if visibly soiled, or gel in.

Don gown, then gloves.

Upon exiting the room:

Remove gloves, then gown.

Thoroughly wash hands again with soap and water.

CONTINUE

Isolation Review

Multiple Choice:

Which of the following is NOT something you need do prior to entering a patient's room with a Contact/Enteric Precautions sign?

- ◯ Don gown
- ◯ Don gloves
- ◯ Don a mask
- ◯ Thoroughly wash hands with soap and water

SUBMIT

Complete the knowledge check above before moving on.

How to Ambulate a Clostridioides difficile Patient?

If your ministry allows, patient under contact enteric precautions should only be ambulated outside their room accompanied by staff after assessment by Infection Prevention and if patient is continent/able to contain his/her bowels.

Ideally the patient is bathed before being put in a clean gown, practice may vary by ministry. The patient must wear a clean gown and thoroughly wash his or her hands with soap and water before leaving their room.

The patient should be advised not to touch any surrounding surfaces in the hospital or sit on furniture.

Assistive equipment (i.e., IV pole, wheelchair) should be wiped with a SPORICIDAL before leaving the patient's room.

Caregivers are not to wear PPE in the hallways.

CONTINUE

How to Ambulate a Clostridioides difficile Patient? Review

Select All That Apply:

Patients under contact enteric precaution should only be ambulated outside their room (if your ministry allows):

- [ ] When accompanied by staff after assessment by Infection Prevention
- [ ] If patient is continent/able to contain his/her bowels
- [ ] If patient wears a clean gown
- [ ] If patient thoroughly washes his or her hands with soap and water before leaving their room

SUBMIT

Complete the knowledge check above before moving on.

How to Transfer a Clostridioides difficile Patient?

Ensure the Isolation order is/has been entered into the patient's EMR.

Alert receiving department regarding patient's isolation precaution status.

Caregivers are not to wear PPE while transporting the patient.

Patient should have a clean gown and perform hand hygiene prior to transferring.

Your ministry may require you to drape a clean sheet over the gurney/patient. If so, the sheet should NOT come from inside the patient's room.

Only when necessary, should the patient be transferred in their own bed. Wipe down the head of the bed, foot of the bed, and the bed rails with a SPORICIDAL before transferring, as well as any accompanying patient equipment.

Always clean and disinfect the transport vehicle after use.

Wash hands with SOAP AND WATER.

CONTINUE

Transferring to Another Facility

Notify the receiving facility of the patient's diagnosis:

- Include date of specimen
- Current symptoms
- Treatment completion date (already completed or will finish on...)

Complete inter-facility transfer form specific to the ministry.

Document the name of the person notified, including the facility name.

CONTINUE

How to Transfer a Clostridioides difficile Patient? Review

Select All That Apply:

When transferring a patient with Clostridioides difficile you should:

- [ ] Ensure the Isolation order is/has been entered into the patient's EMR.
- [ ] Alert receiving department regarding patient's isolation precaution status.
- [ ] Ensure that the patient has a clean gown and performs hand hygiene prior to transferring.
- [ ] Always clean and disinfect the transport vehicle after use.
- [ ] Wash your hands after transfer.

SUBMIT

Select All That Apply:

When transferring a patient with Clostridioides difficile to another facility you should:

- [ ] Notify the receiving facility of the patient's diagnosis including the date of specimen, current symptoms, and treatment completion date.
- [ ] Complete inter-facility transfer form specific to the ministry.
- [ ] Document the name of the person notified, including the facility name.

SUBMIT

Complete the knowledge checks above before moving on.

Patient and Family Education

Patients and visitors should be educated on the necessity of applying Contact Enteric Precautions.

All family members should thoroughly wash hands with SOAP AND WATER, for at least 20 seconds, when entering and leaving the patient's room.

Visitors are not allowed to eat or drink inside the room and must abide by infection control policies. Refer to your ministry policy regarding visitation specifics.

CONTINUE

Patient and Family Education Review

Multiple Choice:

What should be communicated to family regarding Contact Enteric Precautions?

- ◯ Visitation by those 18 years old or younger should be encouraged.
- ◯ Visitors should be encouraged to eat or drink inside the room.
- ◯ All family members should thoroughly wash hands with soap and water, for at least 20 seconds, when entering and leaving the patient's room.
- ◯ There is no need for educating the family regarding Contact Enteric Precautions.

SUBMIT

Complete the knowledge check above before moving on.

When a Clostridioides difficile Patient Goes Home

- [ ] Wash your hands with soap and water every time you use the bathroom and always before you eat. Remind relatives and friends taking care of you to do the same.

- [ ] Try to use a separate bathroom if you have diarrhea. If you can't, be sure the bathroom is well cleaned before others use it.

- [ ] Take showers and wash with soap to remove any Clostridioides difficile germs you could be carrying on your body.

- [ ] A bleach disinfectant can be used at home to clean surfaces. Focus on regularly cleaning items that are touched by hand, such as doorknobs,

electronics, toilet flushers and toilet seats, etc.

- [ ] Laundry: If someone in your house has Clostridioides difficile, wash items they touch before others use them

Source: https://www.cdc.gov/c-diff/?CDC_AAref_Val=https://www.cdc.gov/cdiff/prevent.html#anchor_1540398538

BOTH the patient and their family should wash their hands often, with SOAP AND WATER, especially after going to the restroom and before preparing food.

CONTINUE

When a Clostridioides difficile Patient Goes Home Review

Multiple Choice:

What precautions should be taken to lower the patient's chances of spreading Clostridioides difficile after the patient has returned home?

- ○ The patient should take their medications exactly as prescribed.
- ○ Only the patient needs to wash their hands often, with soap and water, especially after going to the restroom and before preparing food.
- ○ No precautions need to be taken, since the patient can no longer spread Clostridioides difficile.

SUBMIT

Complete the knowledge check above before moving on.

Resources

Resources:

- Compendium Update: Strategies to Prevent Clostridium difficile Infections in Acute Care Hospitals: 2014 Update.
- Dubberke, E. R., Carling, P., Carrico, R., Donskey, C. J., Loo, V. G., McDonald, L. C.,...Gerding, D. N. (2014). Strategies to Prevent Clostridium diffcile Infections in Acute Care Hospitals: 2014 Update. Infection Control & Hospital Epidemiology, 35, S48-S65.
- HICPAC/CDC. (2007). Guidelines for Isolation Precautions: Preventing Transmission of Infectious Agents in Healthcare Settings [PDF file]: Retrieved from http://www.cdc.gov/hicpac/pdf/isolation/Isolation2007.pdf

Refer to related ministry policy or guideline for specific information. Your Infection Preventionist(s) can also assist.

- Isolation Precautions
- Hand Hygiene
- Cleaning of Movable Medical Equipment
- Clostridioides difficile Specimen Collection
- Clostridioides difficile Testing

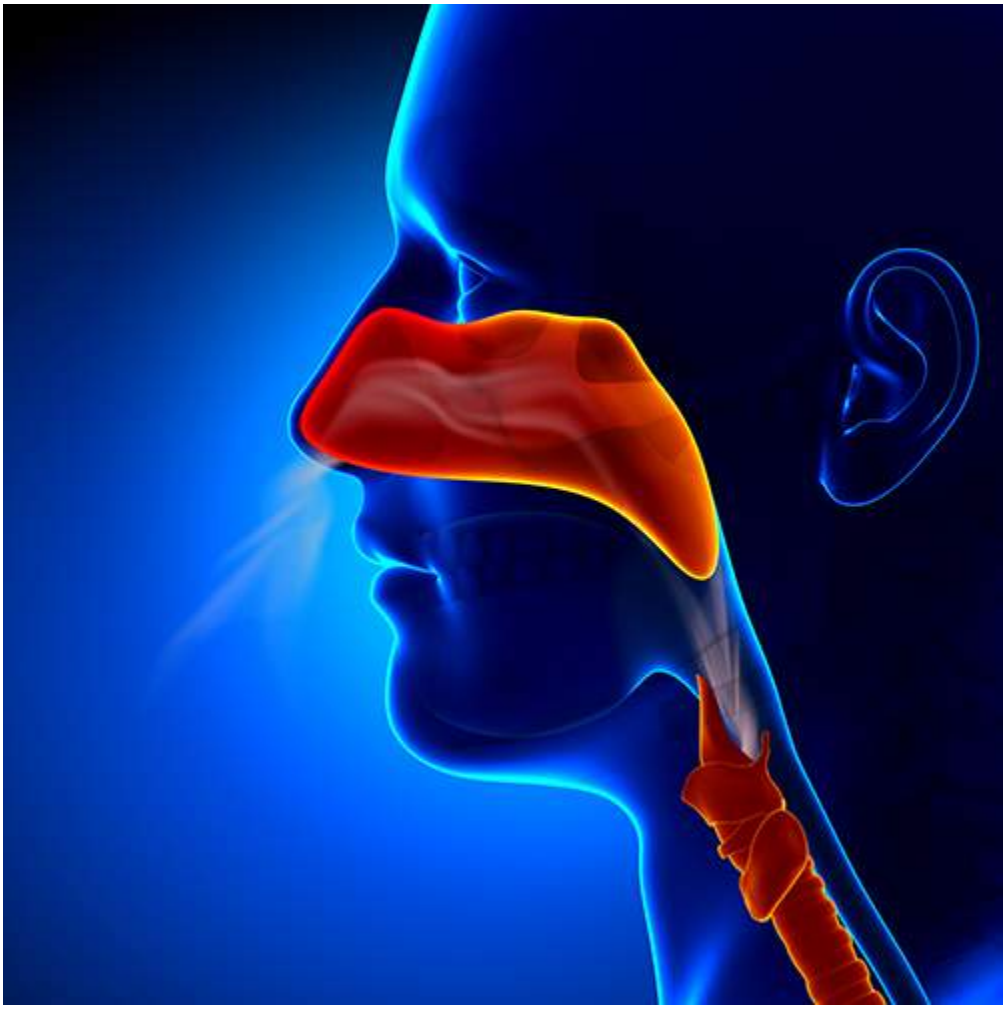
Guidelines developed in collaboration with the following department/services:

- Nursing
- Quality Improvement

- Environmental Services
- Clean Sweep Group Inc

CONTINUE

What is Influenza (Flu)?



Source: https://www.cdc.gov/flu/about/keyfacts.htm

Flu is a contagious respiratory illness caused by influenza viruses that infect the nose, throat, and sometimes the lungs. It can cause mild to severe illness, and at times can lead to death. The best way to prevent flu is by getting a flu vaccine each year.

CONTINUE

What is Influenza (Flu)? Review

Multiple Choice:

Influenza is:

- A contagious endocrine system illness caused by influenza viruses that infect the patient's glands.
- A contagious respiratory illness caused by influenza viruses that infect the nose, throat, and sometimes the lungs.
- A contagious circulatory system illness caused by influenza viruses that infect the bloodstream.
- A contagious nervous system illness caused by influenza viruses that infect the nerves and spinal cord.

SUBMIT

Complete the knowledge check above before moving on.

Flu Symptoms

Flu is different from a cold as it usually comes on suddenly. People who are sick with flu often feel some or all of these symptoms:

- Fever or feeling feverish/chills (Note: not everyone with flu will have a fever)
- Cough
- Sore throat

- Runny or stuffy nose
- Muscle or body aches
- Headaches
- Fatigue (tiredness)
- Some people may have vomiting and diarrhea, though this is more common in children than adults

Onset of Symptoms

The time from when a person is exposed and infected with flu to when symptoms begin is about 2 days, but can range from about 1 to 4 days.

Flu vs. COVID

Review the differences between flu and COVID as defined by the CDC by selecting the button to the right.

CLICK OR TAP

CONTINUE

Flu Symptoms Review

Multiple Choice:

Which one of the following is NOT a symptom of Influenza?

- ◯ Sore throat
- ◯ Muscle or body aches
- ◯ Confusion
- ◯ Headaches

SUBMIT

Complete the knowledge check above before moving on.

How Flu Spreads

Most experts believe that flu viruses spread mainly by tiny droplets made when people with flu cough, sneeze or talk. These droplets can land in the mouths or noses of people who are nearby. Less often, a person might get flu by touching a surface or object that has flu virus on it and then touching their own mouth, nose or possibly their eyes.

You may be able to spread flu to someone else even before symptoms appear.

Period of Contagiousness

Someone with the flu is contagious even before they know they are sick, as well as while they are sick.

People with flu are most contagious in the first 3-4 days after their illness begins.

Some otherwise healthy adults may be able to infect others beginning 1 day before symptoms develop and up to 5 to 7 days after becoming sick.

Place the patient in **Droplet Precautions** for 7 days after illness onset or until 24 hours after resolution of fever and respiratory symptoms, whichever is longer.

Some people, especially young children and people with weakened immune systems, might be able to infect others for an even longer time.

CONTINUE

How Flu Spreads Review

Multiple Choice:

How are flu viruses spread?

- ◯ Through bacteria or other germs that enter the patient's bloodstream.
- ◯ By contact with clothing or other personal items used by an infected person.
- ◯ Flu can only be passed through direct skin-to-skin contact.
- ◯ Mainly by tiny droplets made when people with flu cough, sneeze or talk.

SUBMIT

Complete the knowledge check above before moving on.

Complications of Flu

Complications of flu can include bacterial pneumonia, ear infections, sinus infections and worsening of chronic medical conditions, such as congestive heart failure, asthma, or diabetes.

People at High Risk from Flu

Anyone can get flu (even healthy people), and serious problems related to flu can happen at any age, but some people are at high risk of developing serious flu-related complications if they get

sick. This includes people 65 years and older, people of any age with certain chronic medical conditions (such as asthma, diabetes, or heart disease), pregnant women, and children younger than 5 years.

CONTINUE

Complications of Flu Review

Multiple Choice:

Which of the following is a common complication of influenza?

- ◯ Aneurysm
- ◯ Bacterial pneumonia
- ◯ Anemia
- ◯ Acute kidney failure

SUBMIT

Complete the knowledge check above before moving on.

Diagnosing Flu

It is very difficult to distinguish flu from other viral or bacterial respiratory illnesses based on symptoms alone. There are tests available to diagnose flu.

The most common are called "rapid influenza diagnostic tests (RIDTs)." RIDTs work by detecting the parts of the virus (antigens) that stimulate an immune response. These tests can provide results within approximately 10-15 minutes, but are not as accurate as other flu tests. Therefore, you could still have the flu, even though your rapid test result is negative.

Other flu tests are called “rapid molecular assays” that detect genetic material of the virus. Rapid molecular assays produce results in 15-20 minutes and are more accurate than RIDTs.

Many tests also include testing for COVID or other respiratory pathogens.

CONTINUE

Diagnosing Flu Review

Multiple Choice:

What is ***true*** about RIDTs?

- ( ) They detect genetic material of the virus.
- ( ) They can provide results within approximately 1-5 minutes.
- ( ) They are just as accurate as other flu tests.
- ( ) You could still have the flu, even though your rapid test result is negative.

SUBMIT

Complete the knowledge check above before moving on.

Preventing Seasonal Flu

The first and most important step in preventing flu is to get a flu vaccine each year. Flu vaccine has been shown to reduce flu related illnesses and the risk of serious flu complications that can result in hospitalization or even death. CDC also recommends everyday preventive actions (like staying away from people who are sick, covering coughs and sneezes and frequent handwashing) to help slow the spread of germs that cause respiratory (nose, throat, and lungs) illnesses, like flu.

How do flu vaccines work?

Flu vaccines cause antibodies to develop in the body about two weeks after vaccination. These antibodies provide protection against infection with the viruses that are in the vaccine. There are many vaccine options to choose from; but, according to the CDC, the most important thing is for all people 6 months and older to get a flu vaccine every year. If you have questions about which vaccine is best for you, talk to your doctor or other health care professional.

Benefits of flu vaccination

According to the CDC, there are many reasons to get a flu vaccine each year. Below is a summary of the benefits of flu vaccination.

- Flu vaccination can keep you from getting sick with flu.
- Flu vaccination can reduce the risk of flu-associated hospitalization for children, working age adults, and older adults.
- Flu vaccination helps prevent serious medical events associated with some chronic conditions.
- Vaccination helps protect women during and after pregnancy.
- Flu vaccine can be life-saving in children.
- Flu vaccination has been shown in several studies to reduce severity of illness in people who get vaccinated but still get sick.
- Getting vaccinated yourself may also protect people around you, including those who are more vulnerable to serious flu illness, like babies and young children, older people, and people with certain chronic health conditions.

CDC Flu Vaccination Studies

Click or tap the button to the right to review scientific studies that support the benefits of flu vaccination.

CLICK OR TAP

Getting Vaccinated

To protect the people we serve and each other, every caregiver is required to report receiving a vaccination, or to file a document declining the vaccination by a specified date for the upcoming flu season. This follows the recommended timeline from the CDC. Communication regarding timelines and vaccination events is shared by each ministry's Caregiver Health Services department or representative.

Local public health may also issue masking mandates and varies by county.

CONTINUE

Preventing Seasonal Flu Review

Select All That Apply:

What steps should you take to help prevent Flu?

- [ ] Get a flu vaccine each year.
- [ ] Stay away from people who are sick.
- [ ] Cover your mouth when coughing and sneezing.
- [ ] Wash your hands frequently.

SUBMIT

Complete the knowledge check above before moving on.

CDC Vaccine Information Statement

Click or tap the link below to view the CDC Vaccine Information Statement.

PDF

Influenza (Flu) Vaccine - What you need to know.pdf
130.5 KB

CONTINUE

Scope of ATD Standard

- [ ] Respiratory protection for airborne & droplet disease transmission
- [ ] Training and record keeping
- [ ] Engineering controls & work practice controls
- [ ] Vaccinations
- [ ] Annual Tuberculosis (TB) evaluation
- [ ] Exposure incident review

CONTINUE

Personal Protective Equipment (PPE)

N95 Respirators

Powered Air Purifying Respirators (PAPR)

CONTINUE

Occupational Exposure Risk

Category 1 - Caregivers who have the MOST risk of occupational exposure

- Nursing (Inpatient/Outpatient)
- Patient Care Technicians
- Licensed Independent Practitioners:
    - Hospital based Physicians
    - Nurse Practitioners
    - Physician Assistants
    - Perfusionists
- Laboratory
- Respiratory Care
- Environmental Services
- Radiology/Nuclear Med

- Electrodiagnostic Testing
- Rehab Therapy
- Clinical Registry
- Transport
- Departments performing AGPs

Category 2 - Caregivers who have SOME risk of occupational exposure

- Facilities
    - Maintenance
    - Biomedical
- Emergency Department:
    - Secretaries
    - Clerks
    - Admitting
- Infection Prevention
- Dieticians
- Chaplains

- Social Workers
- Case Management
- Security
- Volunteers
- Contractors & Vendors

CONTINUE

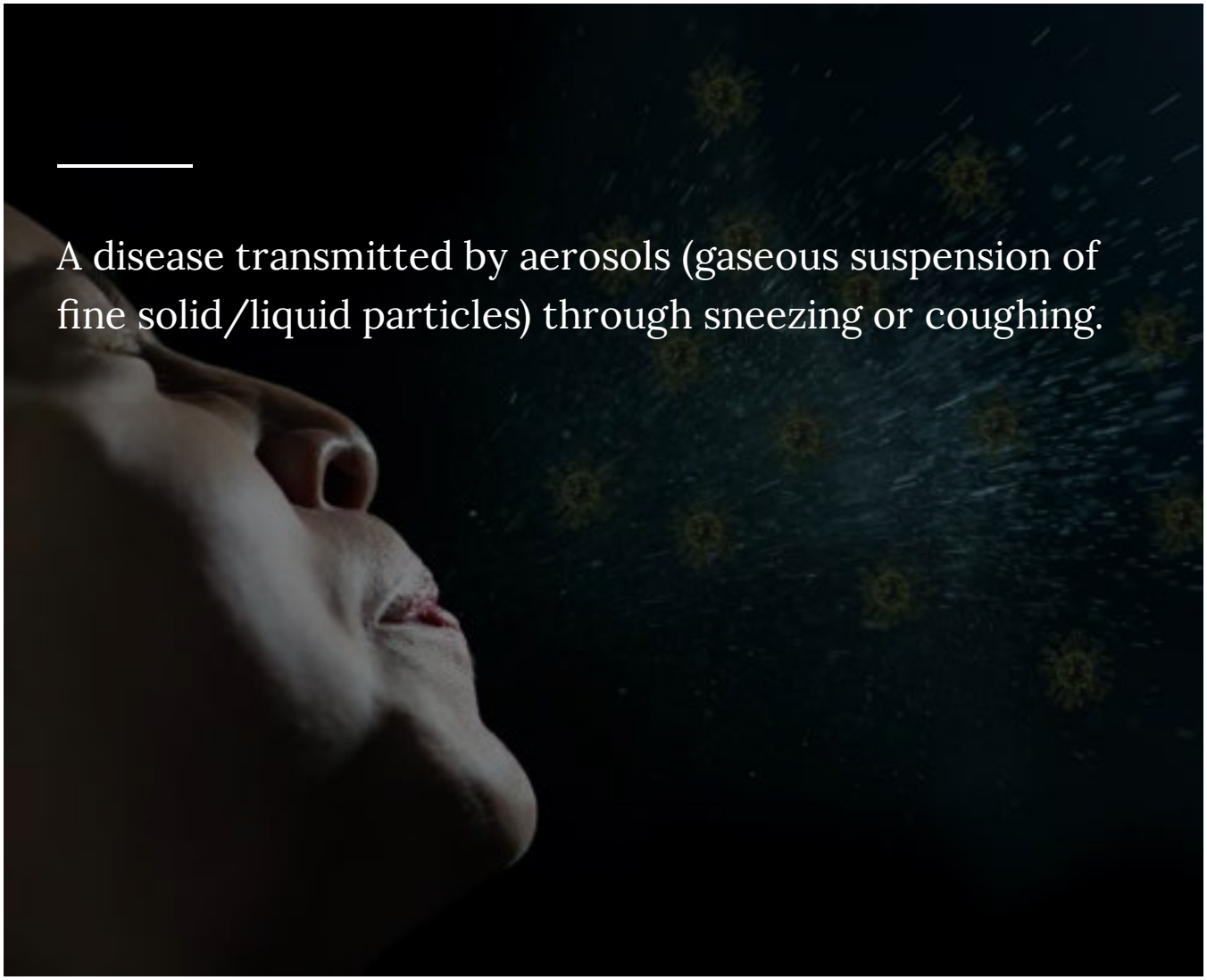
Elements of the ATD Standard

- [ ] Written procedures/plans
- [ ] Source control
- [ ] Engineering, work practice & administrative controls
- [ ] Respirators
- [ ] Communication
- [ ] Training
- [ ] Recordkeeping
- [ ] Routine medical services

  - Vaccinations (flu for everyone, other vaccines for susceptible heathcare workers)
  - Annual TB Plan evaluation
  - Annual risk assessment
  - Post exposure follow up
  - Removal from work when necessary
  - Respirator medical evaluations

CONTINUE

What is an Aerosol Transmissible Disease (ATD)?



Diseases Spread Via the Air (Airborne Infectious

Diseases)

1. Airborne spore release (anthrax)
2. Avian influenza
3. Varicella disease
    - Chicken pox (Varicella)
    - Shingles (Zoster)
4. MPox
5. Severe Acute Respiratory Syndrome (SARS)
6. Smallpox
7. Tuberculosis (Suspect/Confirmed)
8. Measles (Rubeola)
9. Novel or unknown pathogen
10. Any other disease or pathogen for which the State or local Health Department recommends Airborne Infection Isolation (AII)

Diseases Spread by Droplet Contact

1. Diphtheria
2. Influenza (seasonal)
3. Meningococcal disease
4. Mumps
5. *Mycoplasma pneumonia*
6. Pertussis
7. Plague (pneumonic)
8. Rubella
9. Viral hemorrhagic fevers (e.g., Ebola Virus)
10. Any other disease or pathogen for which the State or local Health Department recommends Droplet Precautions

CONTINUE

SARS - CoV-2 (COVID-19)

Transmission-based precautions must be followed with suspected or confirmed COVID-19. N95 respirator, eye protection, gown, and gloves shall be worn. Per CalOSHA, if an AGP (Aerosol Generating Procedure) is being performed, don a PAPR.

Patient may be contagious when asymptomatic. Utilize appropriate PPE, including eye protection for any close, personal contact with any suspected or confirmed COVID-19 patients.

Symptoms may include fever, cough, shortness of breath. Onset can vary between 2-14 days post exposure.

Identify known COVID-19 exposure history or vaccination status.

Administrative Controls:

- Exclude caregivers and other personnel not directly involved in patient care
- Cohorting patients
- Just in time fit testing if appropriate

CONTINUE

Signs & Symptoms & Management of ATDs

Signs & Symptoms

Symptoms will depend on the infectious disease present.

- Sneezing
- Sore throat
- Chills, fever
- Cough
- Shortness of breath
- Muscle aches
- Diarrhea
- Anorexia
- Night sweats
- Bloody sputum
- Vomiting

Remember to wear the medical face mask, or respirator as appropriate, within 6 feet of any patient with an "undiagnosed" respiratory illness.

Management of ATDs

Respiratory hygiene & cough etiquette

Patient must be placed in an Airborne Infection Isolation Room (AIIR) or transferred to another facility that has one **within 5 hours** IF:

- There are no AIIR's available in the hospital
- Reasonable search to find an AIIR outside the area has occurred and none are available
- All appropriate precautions have been implemented
- The local health department has been contacted
- Situation must be reassessed every 24 hours by a medical provider

CONTINUE

Wearing Respiratory Protection

When Do You Need to Wear Special Respiratory Protection?

Click on each image below to learn when to wear that item.

When entering an Airborne Infection Isolation Room (patient is on Airborne Precautions) wear a fit-tested N95 respirator or PAPR.

When entering a Droplet Precaution room wear a medical face mask that provides the best fit (e.g., Procedure, Surgical Mask or respirator).

When assisting with High Hazard Procedures on patients on Airborne Precautions a PAPR is required.

Complete the content above before moving on.

What is Required for Effective Use of Respirators?

Click on each image below to find out.

N95 Respirators require:

- Medical evaluation and initial fit testing
- Annual fit testing
- Removal of facial hair

Powered Air Purifying Respirator (PAPR) requires:

- Medical evaluation
- Instructional training

Complete the content above before moving on.

When Do You Need to Wear a PAPR?

As of September 1, 2010, it is a requirement that healthcare workers wear a PAPR during the performance of "High Hazard Procedures" on ***suspect*** **or confirmed patients** on Airborne Precautions, UNLESS it is felt it would interfere with successful performance of the task.

Wear a PAPR for the following High Hazard Procedures:

- Any clinical, surgical & lab procedure that may aerosolize pathogens
- Sputum induction
- Intubation & bronchoscopy
- Open circuit suctioning
- Aerosolized administration of meds
- Pulmonary function testing

Remember to wear the PAPR for 1 hour after the patient leaves the room.

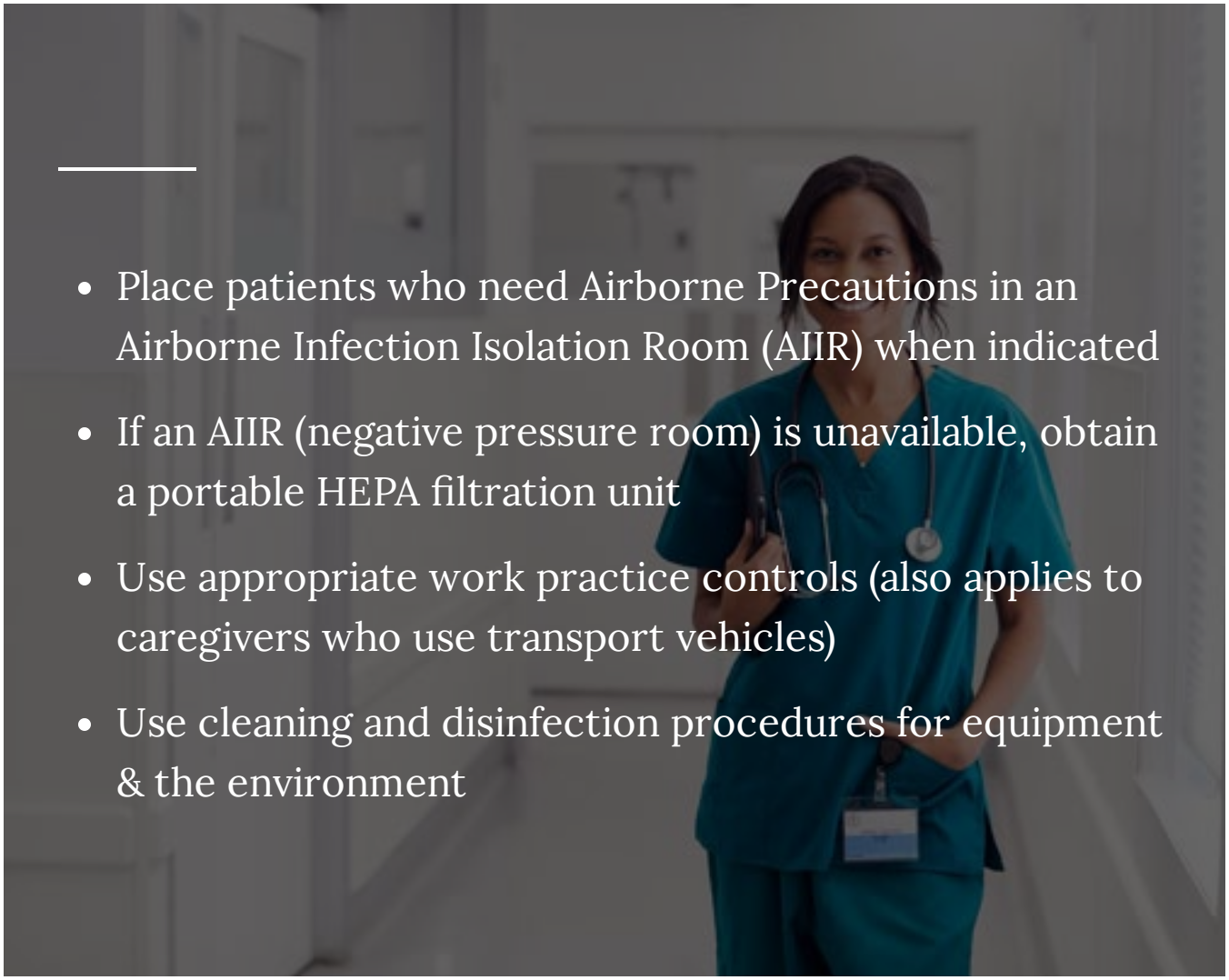
CONTINUE

Other Ways to Reduce the Spread of ATDs

- [ ] Limit caregivers to only those necessary for care of the patient
- [ ] Instruct patient to cover mouth and nose when coughing or sneezing; give tissue when needed
- [ ] Apply procedure mask to the **patient** during transport out of room for tests
- [ ] Hand hygiene
- [ ] Offer vaccinations for vaccine preventable diseases, provide TB screening; provide post exposure follow-up

CONTINUE

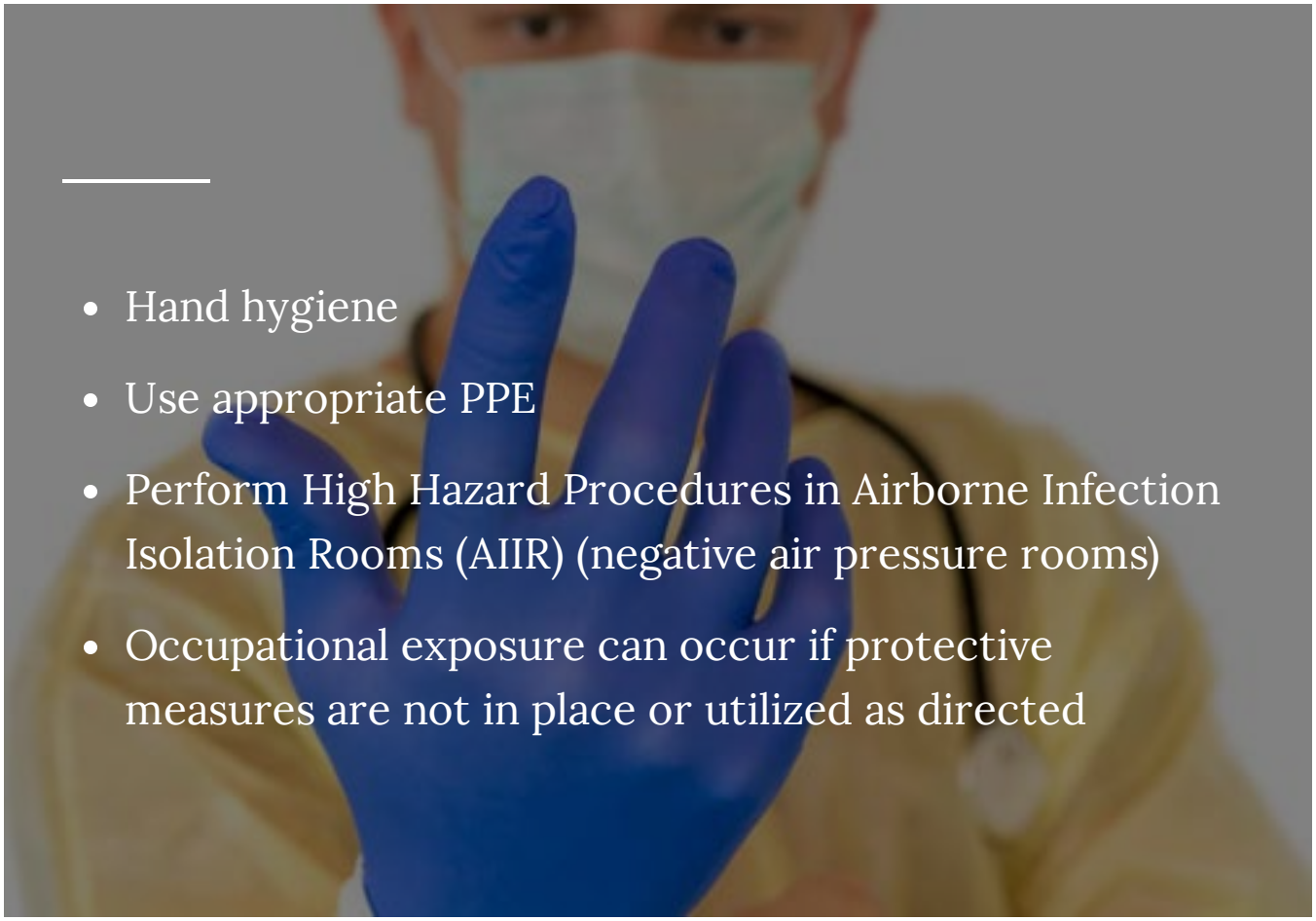
Engineering Controls



- Place patients who need Airborne Precautions in an Airborne Infection Isolation Room (AIIR) when indicated
- If an AIIR (negative pressure room) is unavailable, obtain a portable HEPA filtration unit
- Use appropriate work practice controls (also applies to caregivers who use transport vehicles)
- Use cleaning and disinfection procedures for equipment & the environment

CONTINUE

Physical Protection



- Hand hygiene
- Use appropriate PPE
- Perform High Hazard Procedures in Airborne Infection Isolation Rooms (AIIR) (negative air pressure rooms)
- Occupational exposure can occur if protective measures are not in place or utilized as directed

CONTINUE

Vaccination Protection

Effective Sept. 1, 2010, employers must offer the following vaccines for susceptible health care workers:

- Mumps, measles, rubella (MMR)
- Varicella (chickenpox) vaccine
- Tetanus, diphtheria, acellular pertussis (Tdap)
- Influenza

All vaccines listed above are currently offered at your local Caregiver Health Services free of charge to all caregivers.

If you choose to decline a vaccination you must sign a declination form for each vaccine refused. If you change your mind, you must make an appointment with your local Caregiver Health Services.

CONTINUE

I Have Been Exposed, What Do I Do?

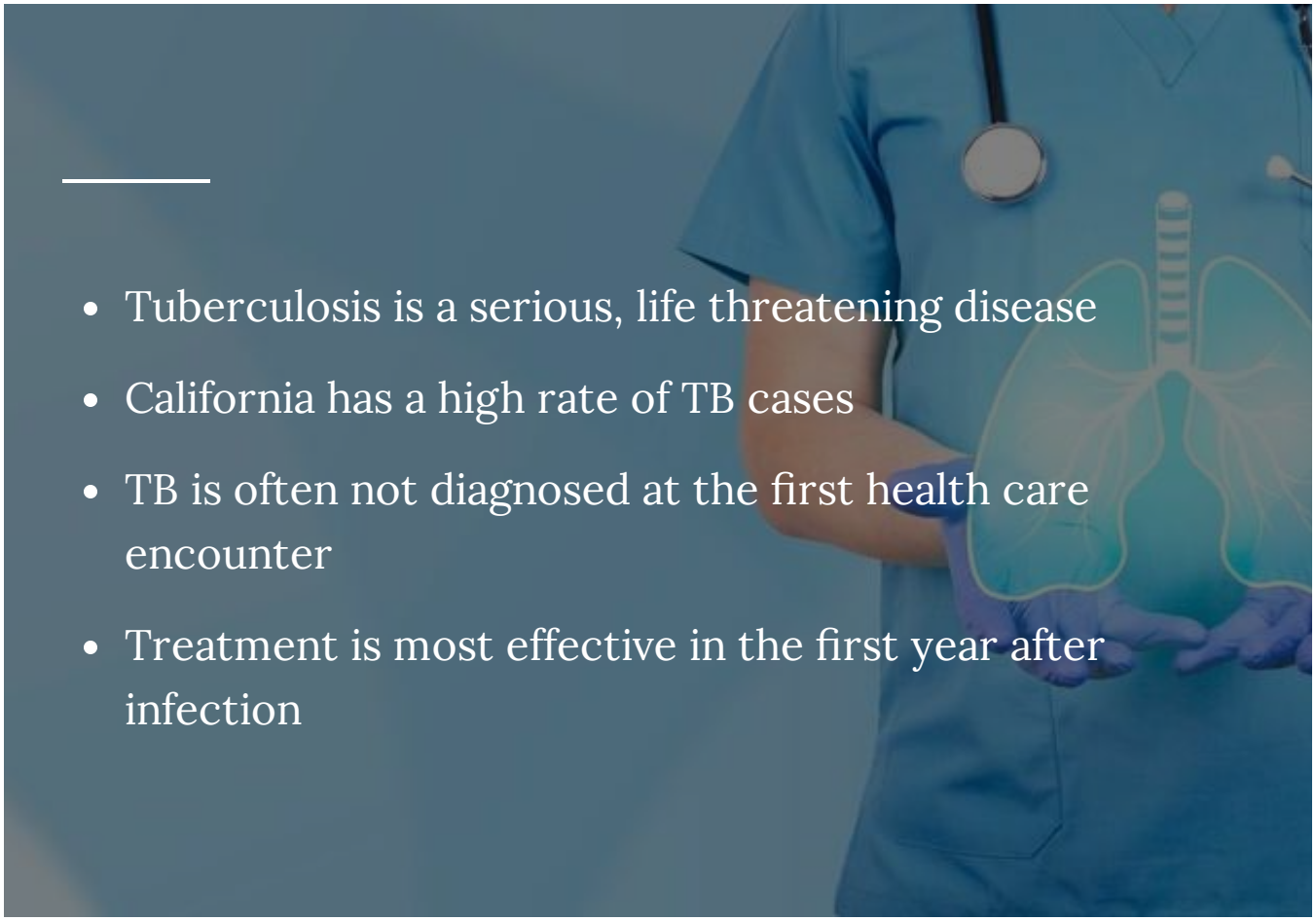
Exposure can occur from a patient with a suspected or confirmed ATD when engineering/work practice controls were not in place or followed. When circumstances indicate that transmission of an ATD could have occurred, post exposure follow-up will be provided by your local Caregiver Health Services.

- [ ] Notify your Core Leader, then enter a Workers Compensation claim via the HR Portal.

Exposure follow-up will include notification of caregivers of employers other than Providence ministries (i.e., Emergency Medical Services First Responders).

CONTINUE

Why Annual Tuberculosis (TB) Screening?



- Tuberculosis is a serious, life threatening disease
- California has a high rate of TB cases
- TB is often not diagnosed at the first health care encounter
- Treatment is most effective in the first year after infection

CONTINUE

ATD Resources

Please refer to your local ministry:

- Policy and Procedures manual
- Environment of Care Team
- Infection Prevention Department
- Caregiver Health Services Department

CAL/OSHA reference: http://www.dir.ca.gov/Title8/5199.html

CONTINUE

Conclusion

Congratulations, you have completed the *Infection Prevention: Special Topics* course!

If you have any unit-specific questions, please contact your supervisor. Click the Exit Course link in the upper right to close this window.

Privacy

1. Untitled Scene

1.1 PHI Attestation

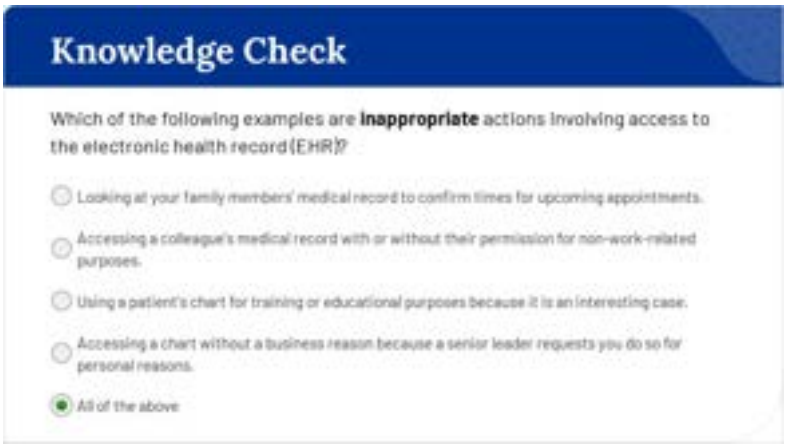
Notes:

Audio (Slide Layer)

1.2 Untitled Slide

1.3 Which of the following examples are inappropriate actions involving access to the electronic health record (EHR)?

(Multiple Choice, 10 points, 1 attempt permitted)



Correct	Choice
	Looking at your family members' medical record to confirm times for upcoming appointments.
	Accessing a colleague's medical record with or without their permission for non-work-related purposes.

	Using a patient's chart for training or educational purposes because it is an interesting case.
	Accessing a chart without a business reason because a senior leader requests you do so for personal reasons.
X	All of the above

Feedback when correct:

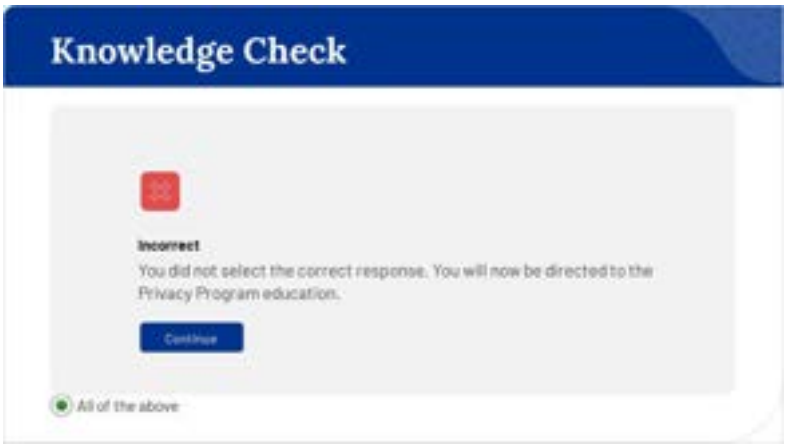
That's right! You selected the correct response.

Feedback when incorrect:

You did not select the correct response. You will now be directed to the Privacy Program education.

Correct (Slide Layer)

Incorrect (Slide Layer)



1.4 Providence policy allows workforce members with access to the electronic health record (EHR) to view their own medical records.

(Multiple Choice, 10 points, 1 attempt permitted)

Correct	Choice
	True
X	False

Feedback when correct:

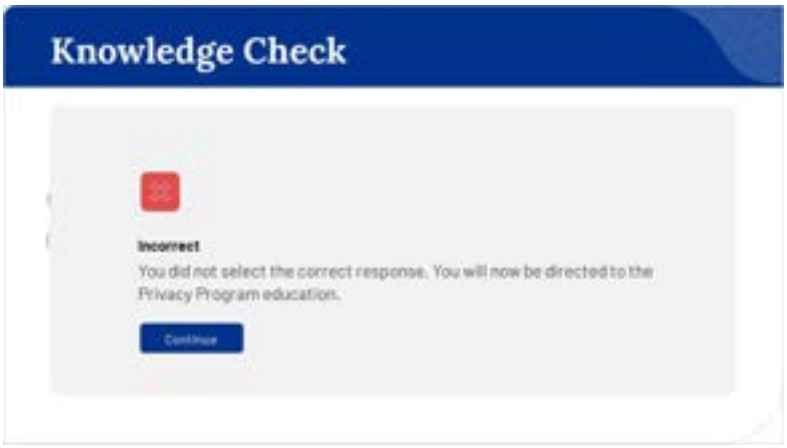
That's right! You selected the correct response.

Feedback when incorrect:

You did not select the correct response. You will now be directed to the Privacy Program education.

Correct (Slide Layer)

Incorrect (Slide Layer)



1.5 Which of the following are violations of Providence policies?

(Multiple Choice, 10 points, 1 attempt permitted)

Correct	Choice
	Viewing any part of the medical record without a work-related reason including patient name and address only.
	Posting patient information/PHI/pictures, even if seemingly de-identified, to social networking sites or blogs.
	Discussing PHI with colleagues who are not directly involved in the patient's care.
	Leaving PHI in unsecured areas, including regular trash cans, where anyone can view the information.
X	All of the above

Feedback when correct:

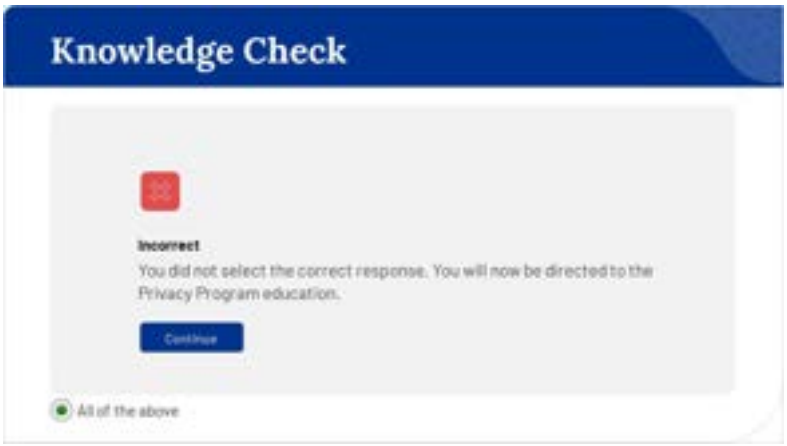
That's right! You selected the correct response.

Feedback when incorrect:

You did not select the correct response. You will now be directed to the Privacy Program education.

Correct (Slide Layer)

Incorrect (Slide Layer)



1.6 Your access to the Providence electronic health record (EHR) systems is monitored 24/7 to ensure that access follows Providence policies governing use of the Providence EHR.

(Multiple Choice, 10 points, 1 attempt permitted)

Correct	Choice
X	True
	False

Feedback when correct:

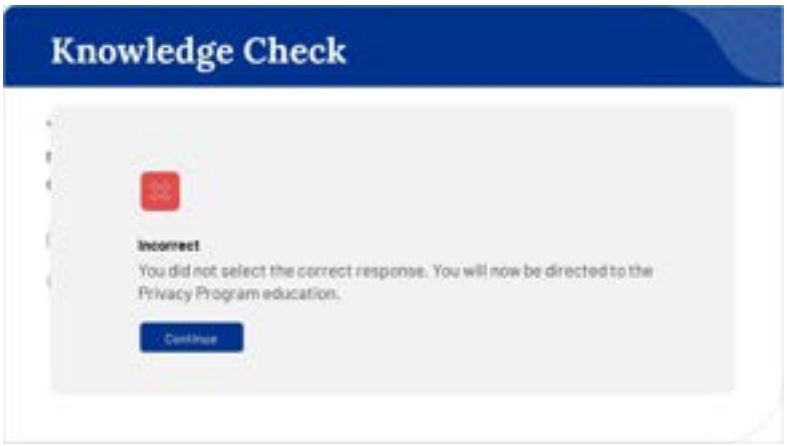
That's right! You selected the correct response.

Feedback when incorrect:

You did not select the correct response. You will now be directed to the Privacy Program education.

Correct (Slide Layer)

Incorrect (Slide Layer)



1.7 In which of the following situations is it appropriate for a workforce member of Providence to post Personal Health Information (PHI) of a patient on a social media platform?

(Multiple Choice, 10 points, 1 attempt permitted)

Correct	Choice
	Verbal consent has been received from the patient to post on your social platform.
	The PHI has been de-identified.
X	It is never appropriate to post patient's PHI on a social media platform.
	The PHI is posted in good faith for the community's awareness and safety.

Feedback when correct:

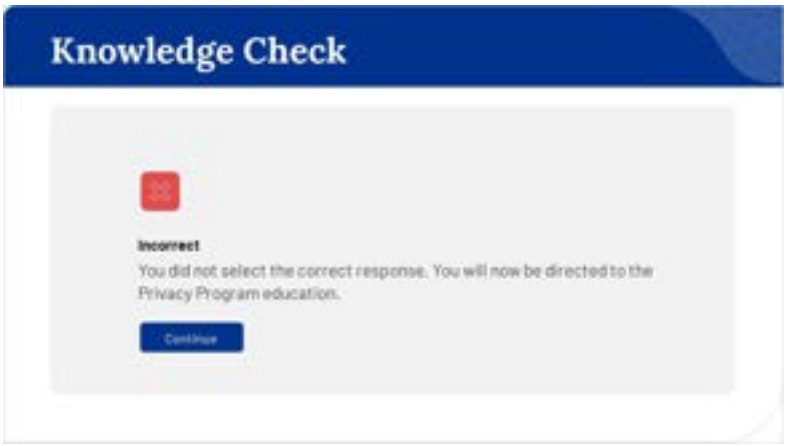
That's right! You selected the correct response.

Feedback when incorrect:

You did not select the correct response. You will now be directed to the Privacy Program education.

Correct (Slide Layer)

Incorrect (Slide Layer)



1.8 Which statements below best describes compliance with the "minimum necessary" standard in reference to protected health information?

(Multiple Choice, 10 points, 1 attempt permitted)

Correct	Choice
	Requesting the ages rather than the dates of birth for patients in relation to a quality related project where patient age is permitted to be used.
	Leaving a message on a patient's voicemail simply indicating that the patient should contact Providence at their earliest convenience.
	Reviewing only specific modules in multiple patient records that were involved in a registration error to ensure the correction and accuracy of the records.
	Using only the appropriate training modules in Epic to train a new Workforce Member.
X	All of the above

Feedback when correct:

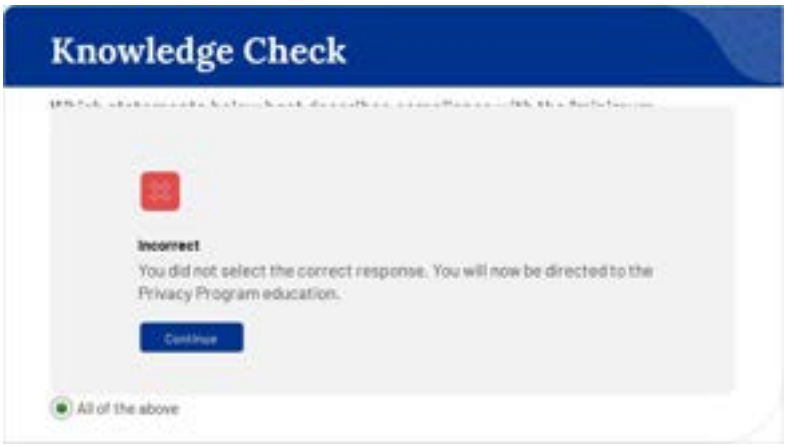
That's right! You selected the correct response.

Feedback when incorrect:

You did not select the correct response. You will now be directed to the Privacy Program education.

Correct (Slide Layer)

Incorrect (Slide Layer)



1.9 It is generally acceptable for a workforce member to use their personal device to take a picture or video of an interesting procedure or of an item or object that is removed from a patient during surgery (i.e.; tumor or growth) for the purpose of educating other workforce Members.

(Multiple Choice, 10 points, 1 attempt permitted)

Correct	Choice
	True
X	False

Feedback when correct:

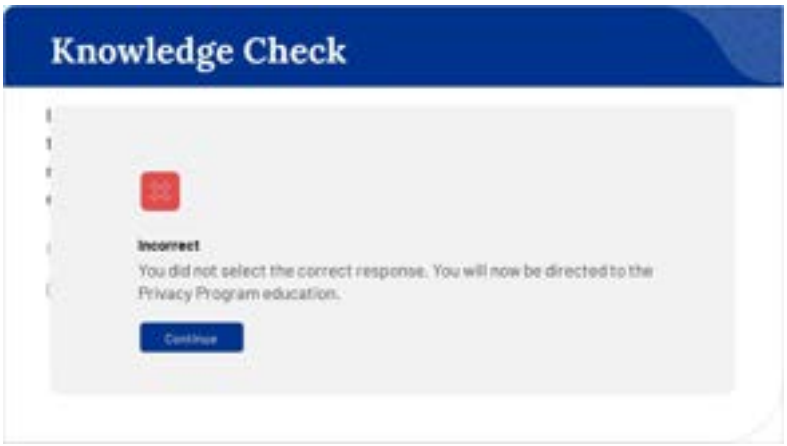
That's right! You selected the correct response.

Feedback when incorrect:

You did not select the correct response. You will now be directed to the Privacy Program education.

Correct (Slide Layer)

Incorrect (Slide Layer)



2. Untitled Scene

2.1 Information Security Overview

Notes:

All six course objectives are listed below; the non-grayed out objectives are the ones included in this section.

Enhance your understanding and engagement to actively contribute to ensuring the highest standards of patient care and safety.

Review Providence's compliance, privacy, and security programs.

Provide an overview of important healthcare laws that all workforce members need to know.

Provide an overview of the Emergency Medical Treatment and Labor Act (EMTALA) regulations.

Outline the different ways to report compliance and quality concerns and how to access the Integrity Hotline and/or High Reliability Platform (HRP).

Share resources that can be accessed/used after completing this education.

Audio (Slide Layer)

2.2 Privacy Program Overview

Notes:

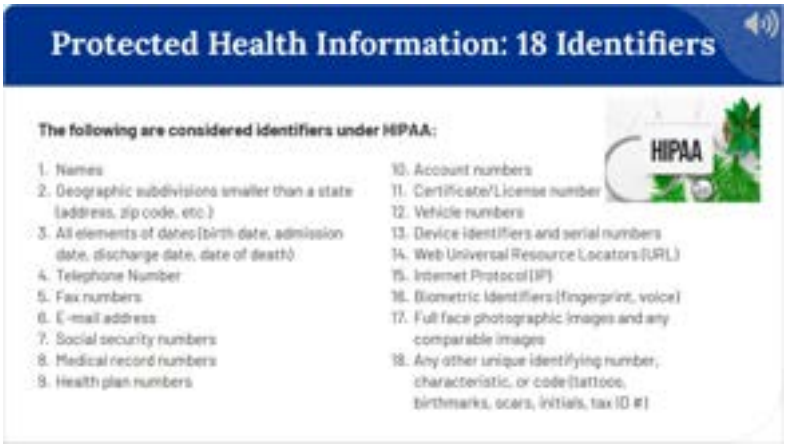
Audio (Slide Layer)

2.3 Privacy Program Overview

Notes:

Audio (Slide Layer)

2.4 Compliance Program Overview



Notes:

2.5 Privacy Program Overview

Notes:

Audio (Slide Layer)

Appropriate (Slide Layer)

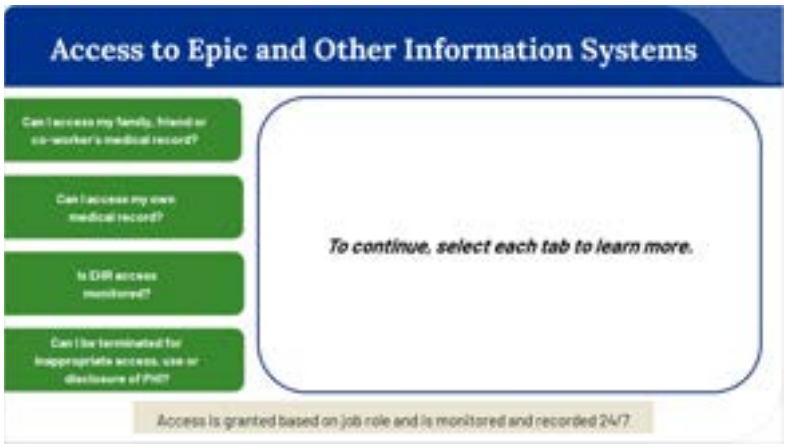
Not appropriate (Slide Layer)

2.6 Privacy Program Overview

Notes:

Audio (Slide Layer)

2.7 PHI and Medical Record Access



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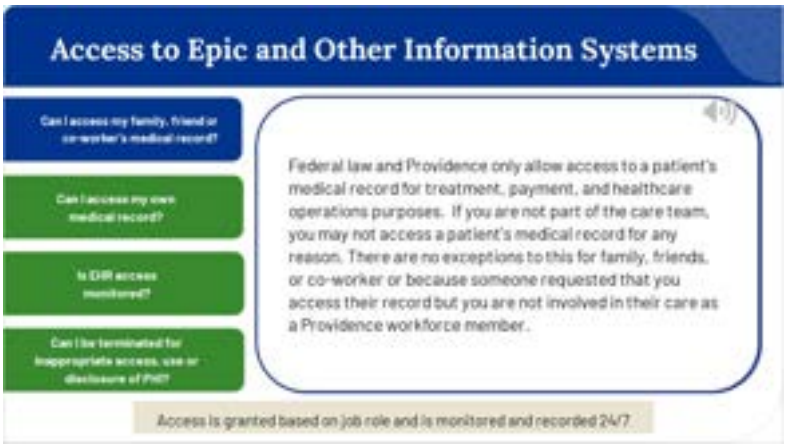
1 (Slide Layer)



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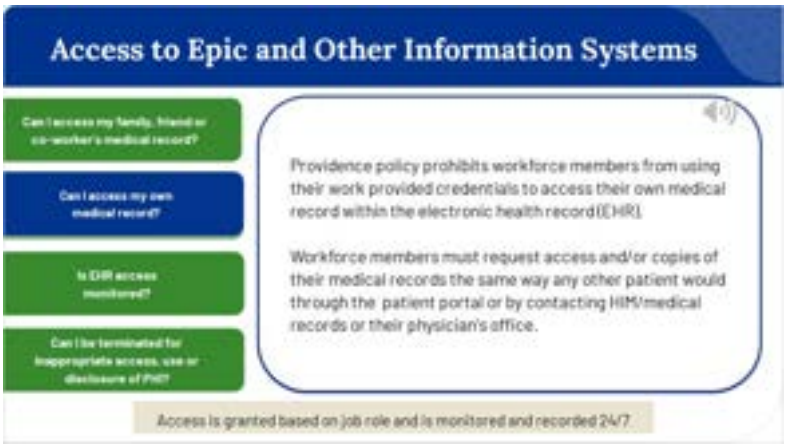

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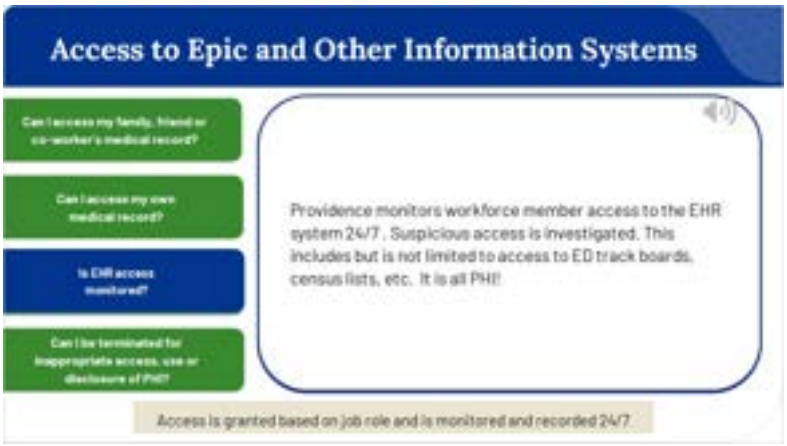

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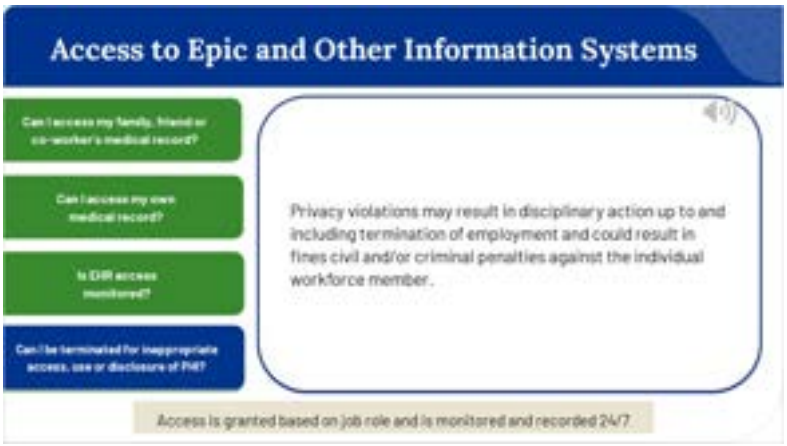
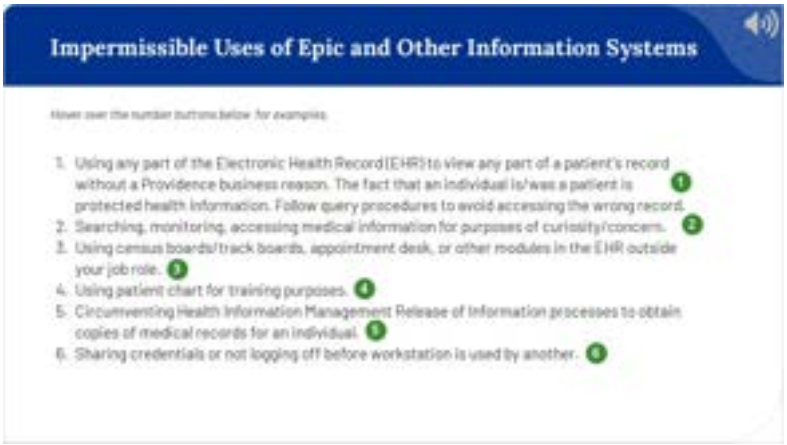


2.8 Privacy Program Overview



Notes:

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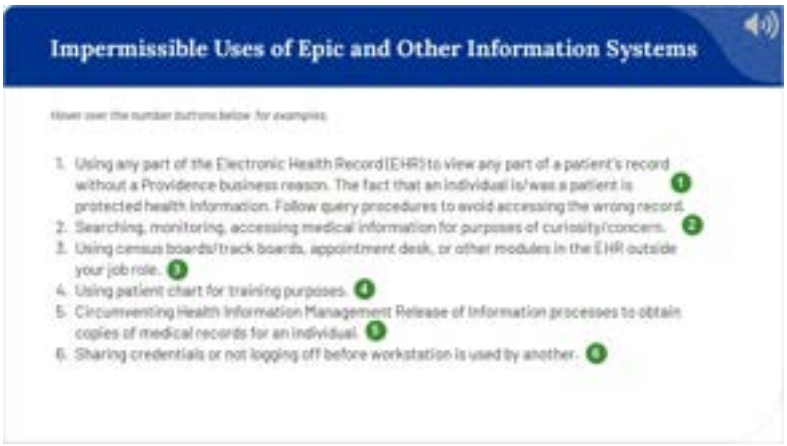
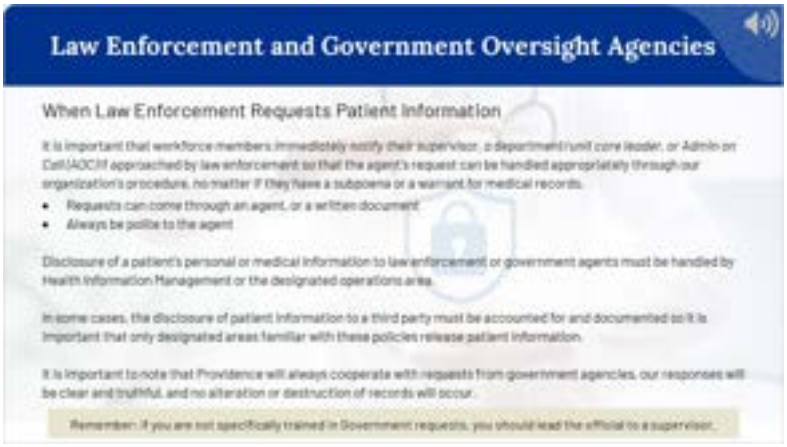


2.9 Compliance Program Overview



Notes:

2.10 Title

Notes:

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2.11 Title

Notes:

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2.12 Privacy Program Overview

Notes:

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2.13 Privacy Program Overview

Notes:

Audio (Slide Layer)

2.14 Social Media

Notes:

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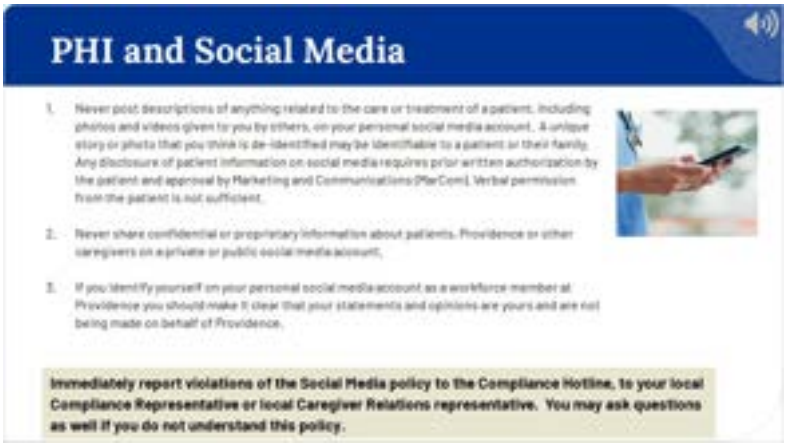
2.15 Privacy Program Overview



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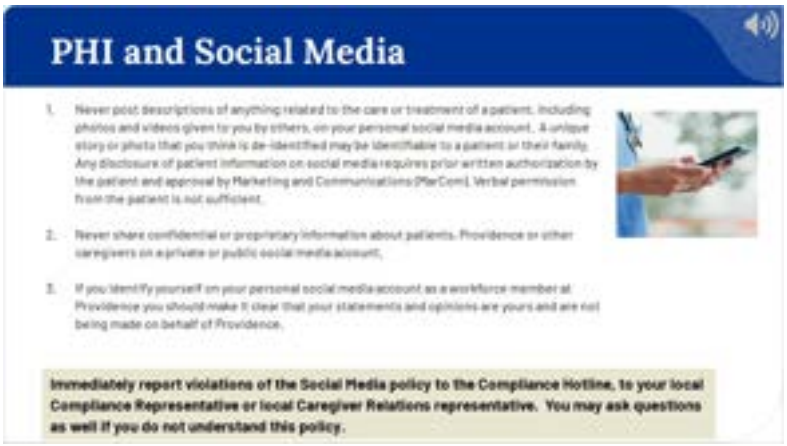

2.16 Title

Notes:

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2.17 Privacy Program Overview

Notes:

Audio (Slide Layer)

2.18 Privacy Program Overview

Notes:

Audio (Slide Layer)

2.19 Privacy: Key Takeaways

Notes:

Audio (Slide Layer)

2.20 Knowledge Check

(Multiple Response, 10 points, unlimited attempts permitted)

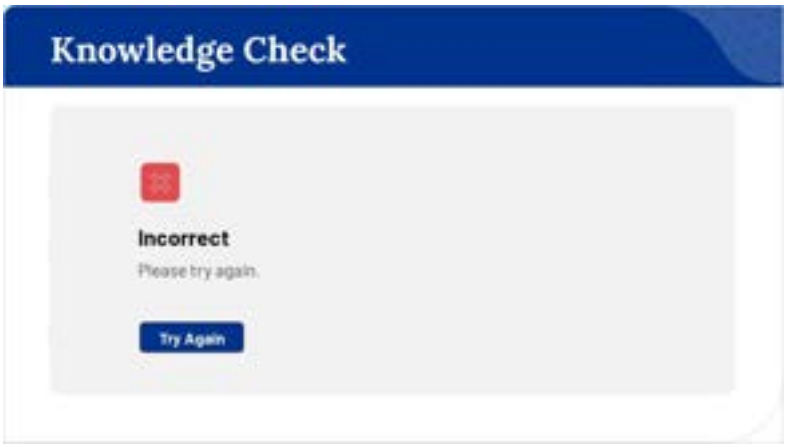
Correct	Choice
X	If a coworker asks you to look up their medication dosage, you are not permitted to access this record, unless it is your job to do so.
X	If your friend asks you to look up and share their child's immunization record so they can register them in school, you are not permitted to do so unless it is your job.
X	If you see on the news that a celebrity was recently in a car accident, do not access any part of the record unless they come to your location, and you are actively working on the account or are part of the patient's care team.

Feedback when correct:

That's right! All three statements are true.

Correct (Slide Layer)

Try Again (Slide Layer)



2.21 Patty Patient posts a positive review after receiving services at a Providence urgent care clinic and the clinic manager posts a response to the patient:

"Hi Patty Patient. I am so glad you came in yesterday and that it was a great experience for you. Whenever you are in town, we are here for you!"

Does the clinic manager's post violate the Providence social media policy?

(Multiple Choice, 10 points, unlimited attempts permitted)

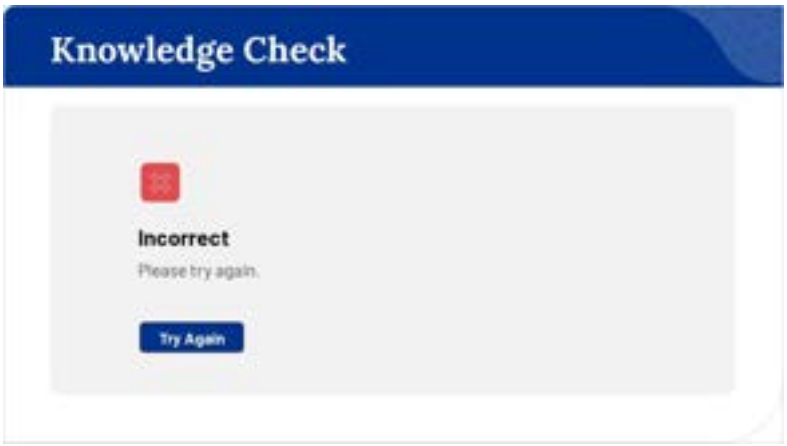
Correct	Choice
X	Yes
	No

Feedback when correct:

That's right!

Correct! (Slide Layer)

Try Again (Slide Layer)



2.22 Privacy Completion

Notes:

Audio (Slide Layer)

Quality

1. 3 Quality

1.1 Information Security Overview

Notes:

All six course objectives are listed below; the non-grayed out objectives are the ones included in this section.

Enhance your understanding and engagement to actively contribute to ensuring the highest standards of patient care and safety.

Review Providence's compliance, privacy, and security programs.

Provide an overview of important healthcare laws that all workforce members need to know.

Provide an overview of the Emergency Medical Treatment and Labor Act (EMTALA) regulations.

Outline the different ways to report compliance and quality concerns and how to access the Integrity Hotline and/or High Reliability Platform (HRP).

Share resources that can be accessed/used after completing this education.

Audio (Slide Layer)

1.2 Quality and Patient Safety

Audio (Slide Layer)

1.3 Our Quality & Patient Safety Program

Notes:

Audio (Slide Layer)

1.4 The Quality Assurance and Performance Improvement (QAPI) Program

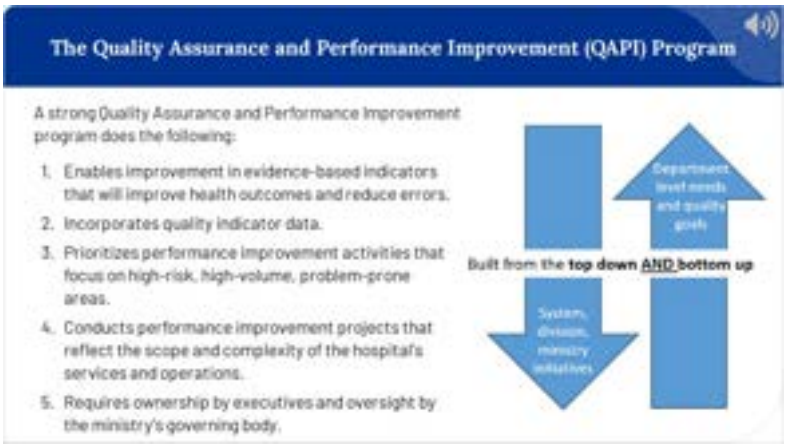
Notes:

Audio (Slide Layer)

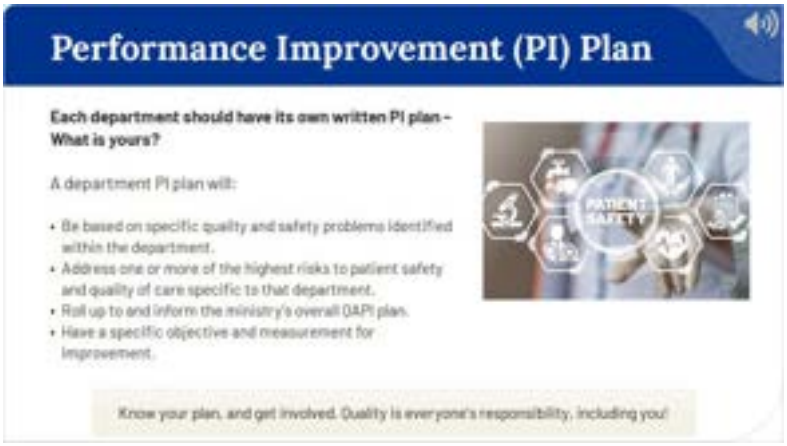
1.5 The Quality Assurance and Performance Improvement (QAPI) Program

Notes:

Audio (Slide Layer)



1.6 Performance Improvement (PI) Plan



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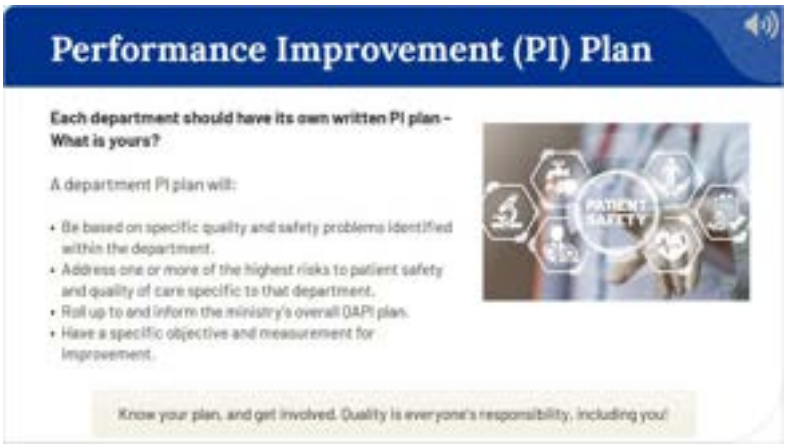


1.7 Knowledge Check

(Multiple Response, 10 points, unlimited attempts permitted)

Correct	Choice
X	Outlines executive sponsorship and governing board oversight
X	Data-driven
X	Includes high-risk, problem-prone areas

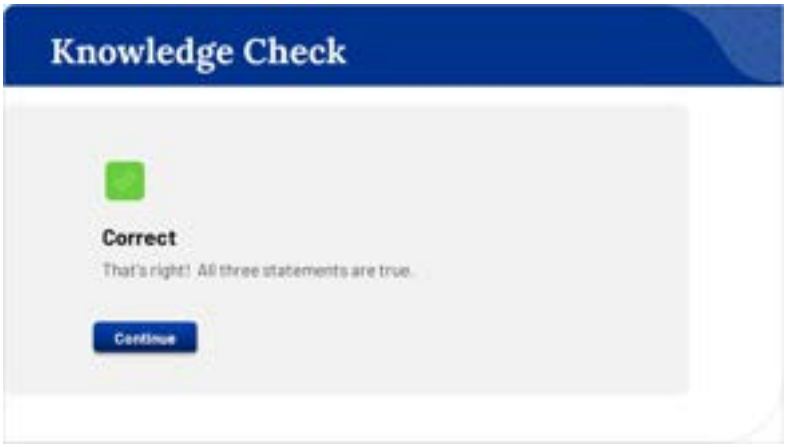
Feedback when correct:

That's right! All three statements are true.

Feedback when incorrect:

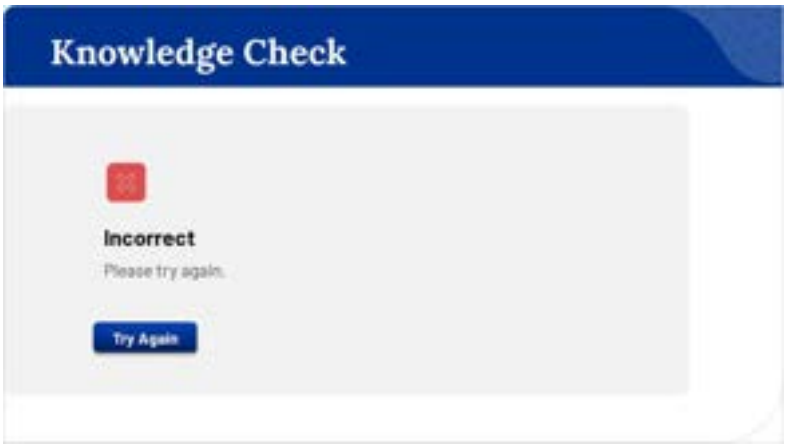
You did not select the correct response.

Correct (Slide Layer)



Incorrect (Slide Layer)

Try Again (Slide Layer)



1.8 Two Important Methods for Improving Quality & Patient Safety

Notes:

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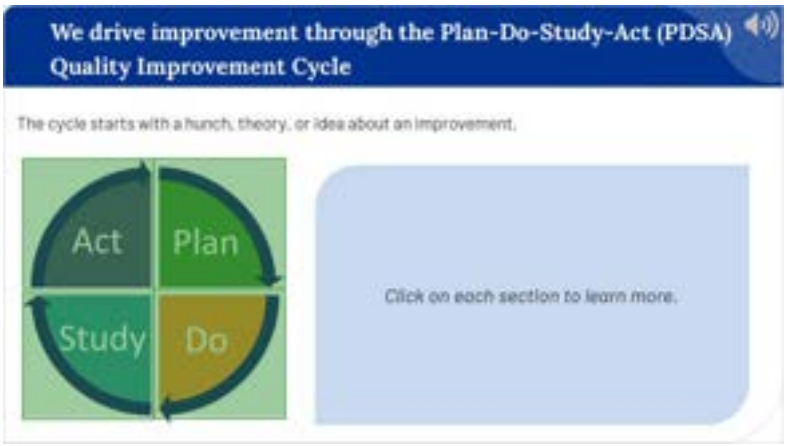
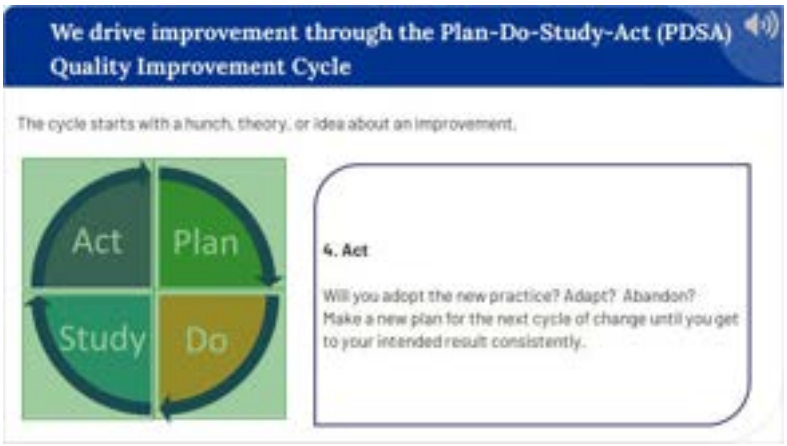
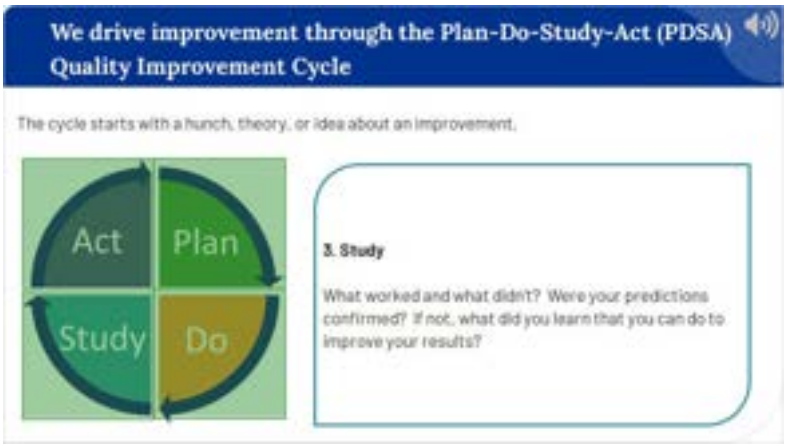
1.9 We drive improvement through the Plan-Do-Study-Act (PDSA) Quality Improvement Cycle



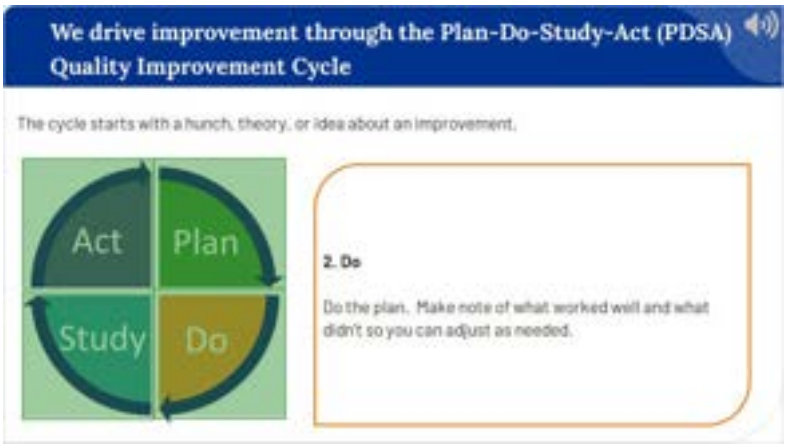
Act (Slide Layer)



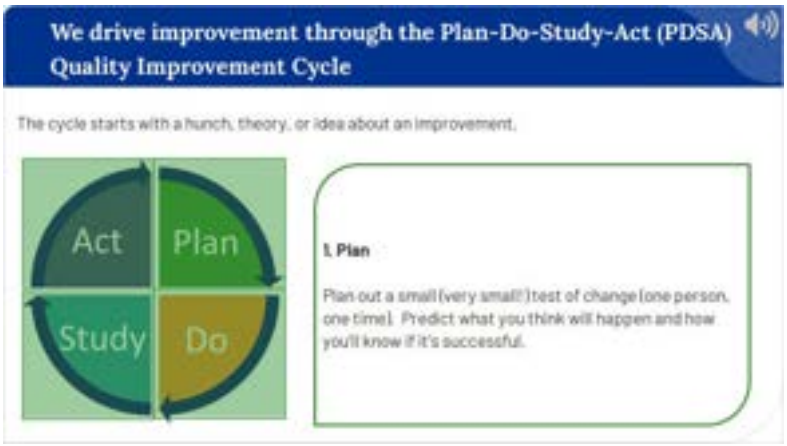
Study (Slide Layer)



Do (Slide Layer)



Plan (Slide Layer)



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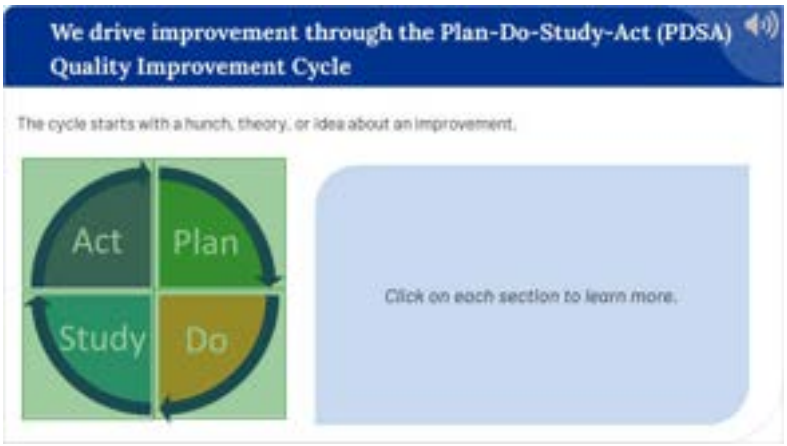


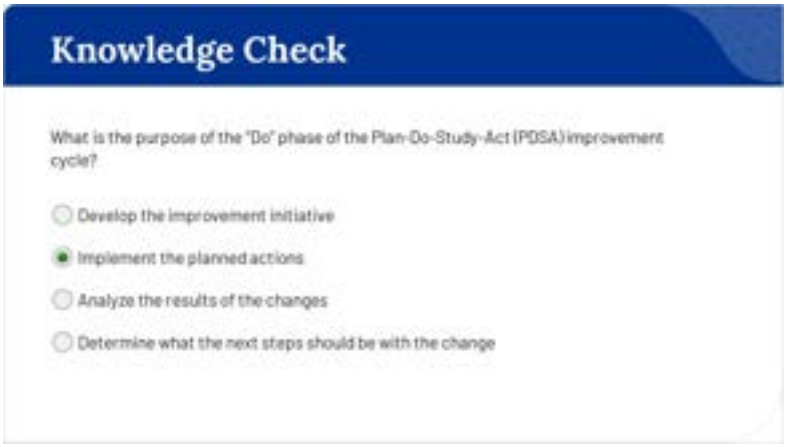
2. Safety

2.1 Providence Safety Improvement Cycle

Audio (Slide Layer)

2.2 What is the purpose of the "Do" phase of the Plan-Do-Study-Act (PDSA) improvement cycle?

(Multiple Choice, 10 points, unlimited attempts permitted)



Correct	Choice
	Develop the improvement initiative
X	Implement the planned actions
	Analyze the results of the changes
	Determine what the next steps should be with the change

Feedback when correct:

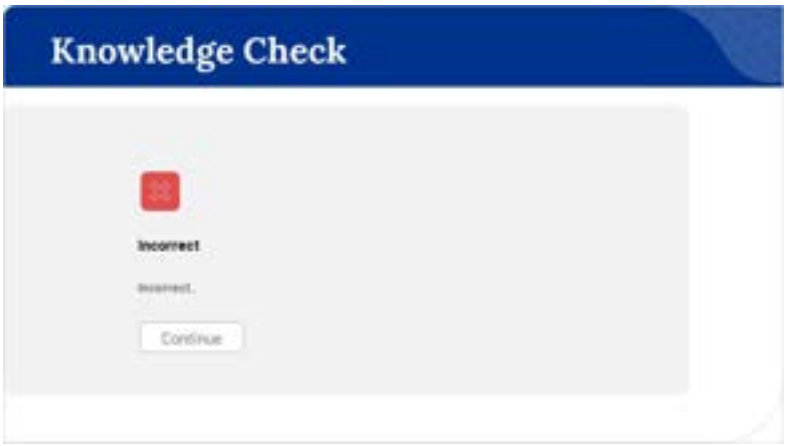
Yes! “Implement the planned actions” is the purpose of the “Do” phase of the Plan-Do-Study-Act (PDSA) improvement cycle.

Feedback when incorrect:

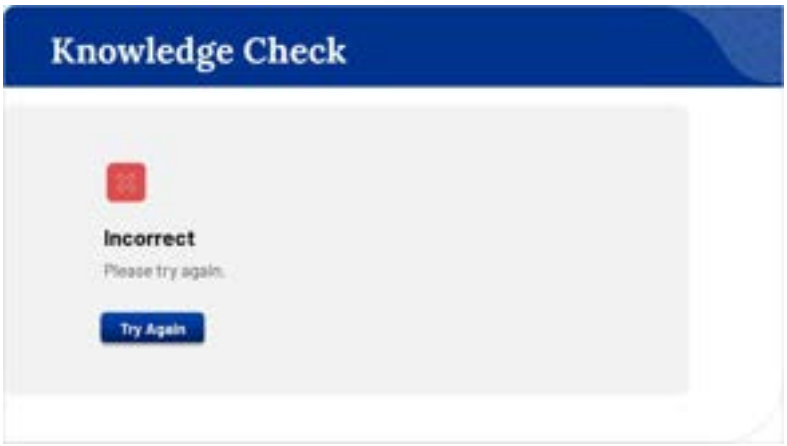
Incorrect.

Correct! (Slide Layer)

Incorrect (Slide Layer)



Try Again (Slide Layer)



2.3 Practice our Caring Reliably Error Prevention Tools and Tones to Connect for High Reliability

Audio (Slide Layer)

2.4 Scenario: It is a sweltering hot July day and your building's air conditioning system is down. You observe one of your coworkers propping open the entrance to your office suite to improve air flow.

Knowing that doors should not be propped because of fire safety, which tool should you use to express your safety concern with your coworker?

(Multiple Choice, 10 points, unlimited attempts permitted)

Correct	Choice
X	Escalate using Concern, Uncomfortable, Stop (CUS)
	Ask Clarifying Questions
	Know Why and Comply

Feedback when correct:

Well done!

Feedback when incorrect:

You did not select the correct response.

Correct! (Slide Layer)

Incorrect (Slide Layer)

Try Again (Slide Layer)

2.5 Scenario: An RN is receiving a new patient onto his unit from another unit. During the handoff he receives instructions for a complex dressing change. He is not sure that he fully understands the instructions and does not want to make assumptions.

Which tool should he use to avoid guessing and to make sure he clearly understands how to do the dressing change?

(Multiple Choice, 10 points, unlimited attempts permitted)

Correct	Choice
	Escalate using Concern, Uncomfortable, Stop (CUS)
X	Ask Clarifying Questions
	Know Why and Comply

Feedback when correct:

Well done!

Feedback when incorrect:

You did not select the correct response.

Providence's CIA ends in March 2027.

Correct! (Slide Layer)

Incorrect (Slide Layer)

Try Again (Slide Layer)

2.6 Scenario: Patient Registrar was checking in a well-known patient for their clinic visit with their doctor. When the patient approached the greet desk the Registrar welcomed them by name, and after checking them in, had them take a seat in the lobby. The Registrar did not ask the patient to verify their name and date of birth which is the standard practice.

What tool should the Registrar have used to prevent the possibility of a patient ID error?

(Multiple Choice, 10 points, unlimited attempts permitted)

Correct	Choice
	Escalate using Concern, Uncomfortable, Stop (CUS)
	Ask Clarifying Questions
X	Know Why and Comply

Feedback when correct:

Well done!

Feedback when incorrect:

You did not select the correct response.

Providence's CIA ends in March 2027.

Correct! (Slide Layer)

Incorrect (Slide Layer)

Try Again (Slide Layer)

2.7 Scenario: Auditor Dan reviewed a prior authorization for patient Ilhan's upcoming knee surgery and noticed that the diagnosis code did not match the scheduled operation. Dan called the treating physician's office to confirm the diagnosis code so that the medical necessity could be verified.

Select All that Apply: What Caring Reliably behavior(s) did he use?

(Multiple Response, 10 points, unlimited attempts permitted)

Correct	Choice
X	Have a Questioning Attitude
X	Pay Attention to Detail
X	Communicate Clearly
X	Speak Up for Safety

Feedback when correct:

Well done!

Feedback when incorrect:

A corporate integrity agreement (CIA) outlines requirements that an organization (like Providence) agrees to as part of a civil settlement. As part of that agreement, the organization agrees to the CIA obligations in exchange for the Office of Inspector General's (OIG) agreement that it will not prevent an organization from participating in, or billing, Medicare, Medicaid, or other Federal health care programs. Per the Corporate Integrity Agreement (CIA), Providence is required to add Quality and CIA content to the Annual Compliance, Privacy, and Security Education.

Correct (Slide Layer)

Incorrect (Slide Layer)

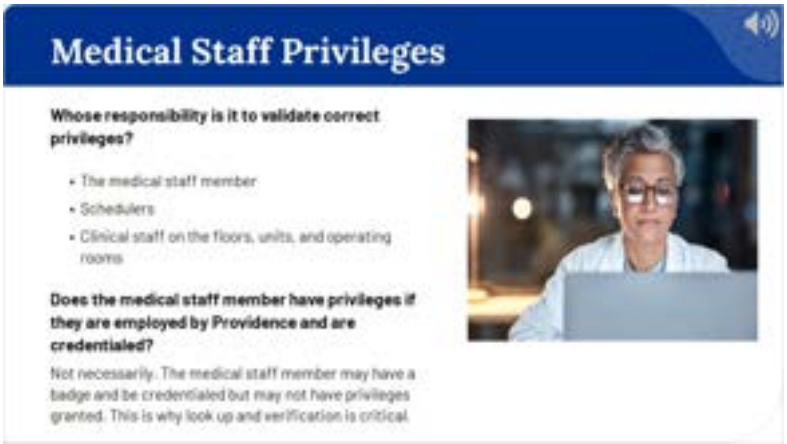
Try Again (Slide Layer)

Audio (Slide Layer)

2.8 Credentialing and Privileging

Audio (Slide Layer)

2.9 Medical Staff Privileges



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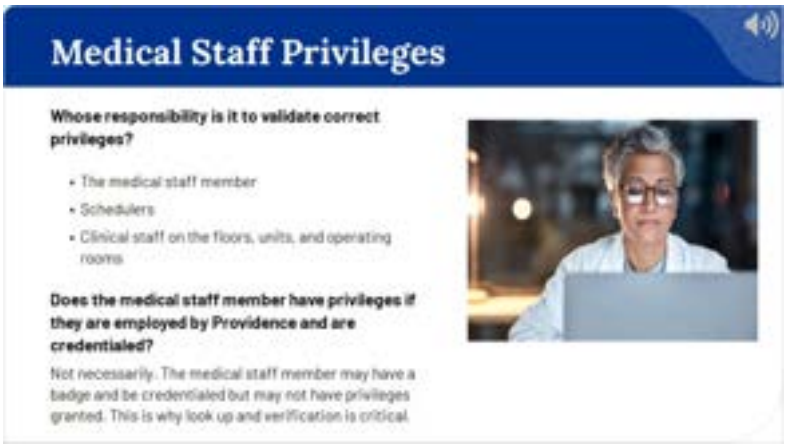
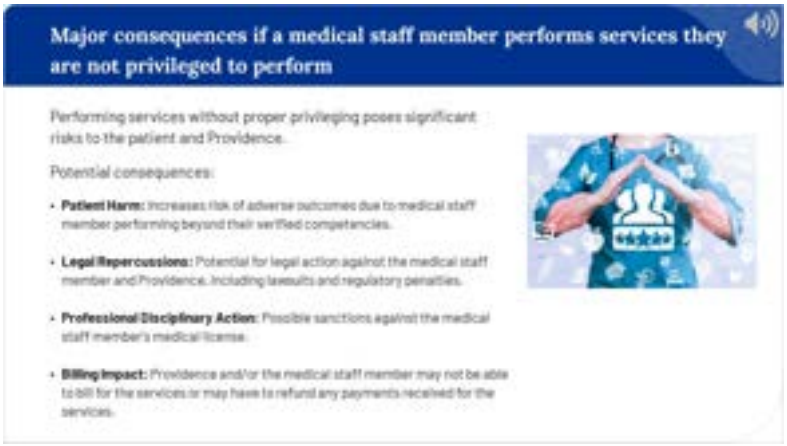


2.10 Major consequences if a medical staff member performs services they are not privileged to perform



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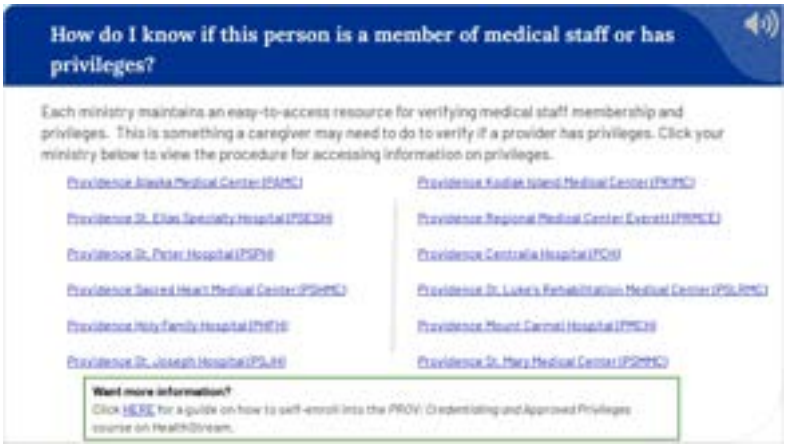
2.11 How do I know if this person is a member of medical staff or has privileges?



Notes:

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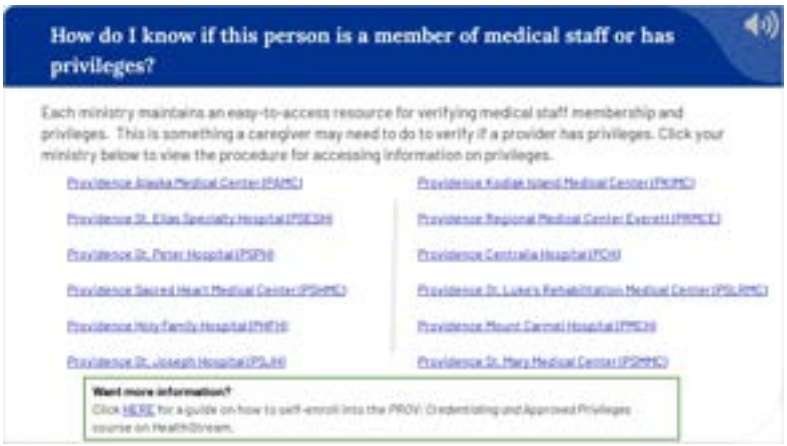


2.12 If a physician has a badge at my ministry, I should expect they are able to provide whatever patient care they deem necessary.

(Multiple Choice, 10 points, unlimited attempts permitted)

Correct	Choice
	True
X	False

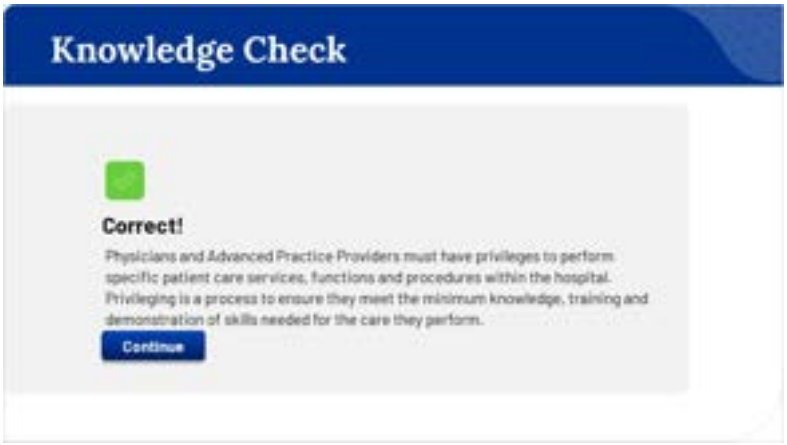
Feedback when correct:

Physicians and Advanced Practice Providers must have privileges to perform specific patient care services, functions and procedures within the hospital. Privileging is a process to ensure they meet the minimum knowledge, training and demonstration of skills needed for the care they perform.

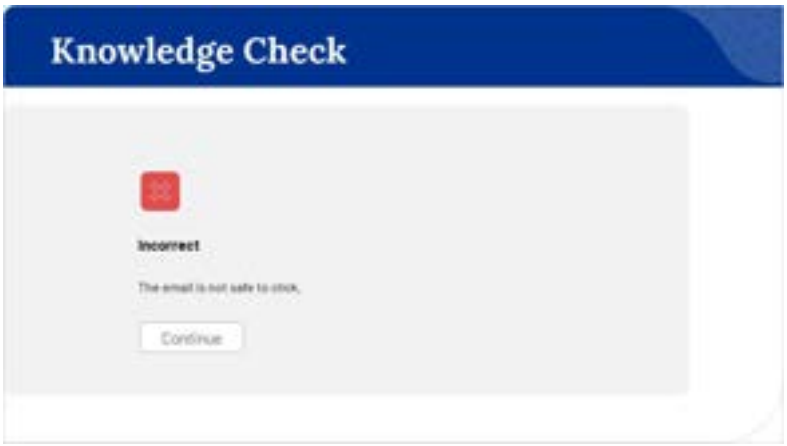
Feedback when incorrect:

The email is not safe to click.

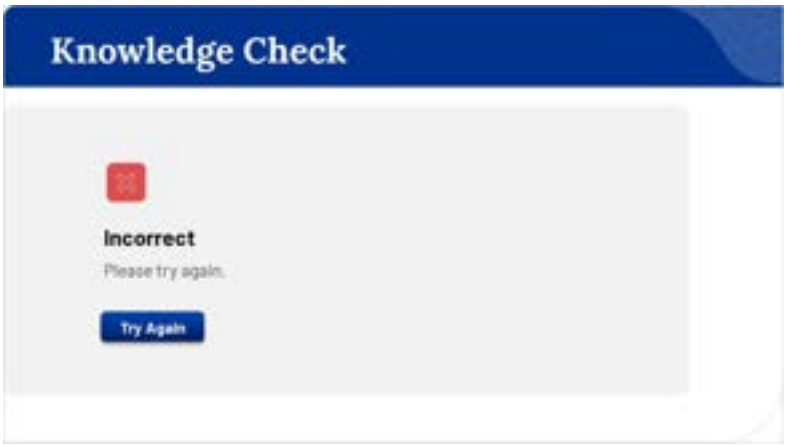
Correct! (Slide Layer)



Incorrect (Slide Layer)



Try Again (Slide Layer)



2.13 Speak up for Safety: Quality & Safety Event Reporting

Audio (Slide Layer)

2.14 Speak up for Safety: Quality & Safety Event Reporting

Audio (Slide Layer)

2.15 Speak up for Safety: Quality & Safety Event Reporting

Audio (Slide Layer)

2.16 Event Reporting Made Easy

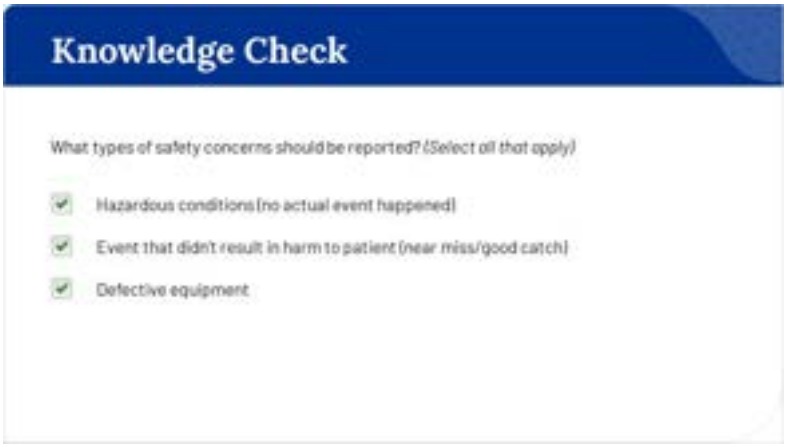
Audio (Slide Layer)

2.17 Other Ways to Share Quality & Safety Concerns

Audio (Slide Layer)

2.18 Knowledge Check

(Multiple Response, 10 points, unlimited attempts permitted)



Correct	Choice
X	Hazardous conditions (no actual event happened)
X	Event that didn't result in harm to patient (near miss/good catch)
X	Defective equipment

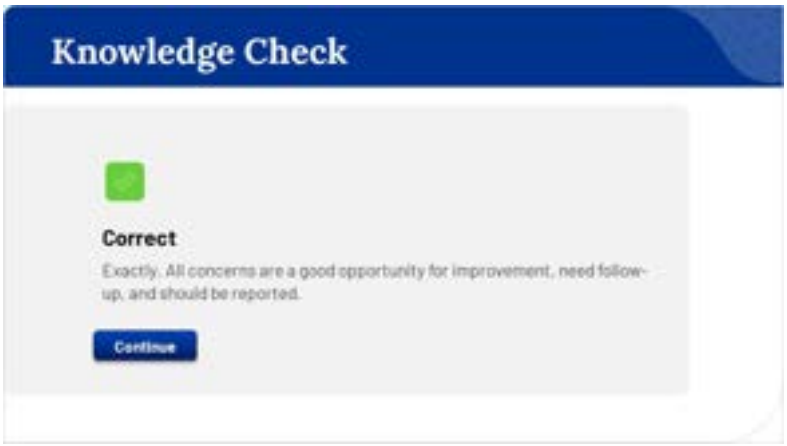
Feedback when correct:

Exactly. All concerns are a good opportunity for improvement, need follow-up, and should be reported.

Feedback when incorrect:

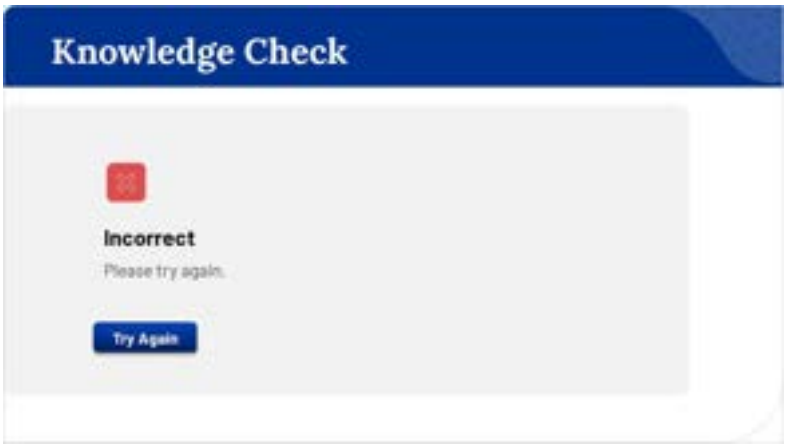
You did not select the correct response.

Correct (Slide Layer)



Incorrect (Slide Layer)

Try Again (Slide Layer)



2.19 Quality Completion

Notes:

Audio (Slide Layer)

PROV: Care of Patients at Risk for Suicide - Direct Caregivers Part 1

This course provides an outline of the evidence-based processes and standards of care for caregivers to assess and then implement appropriate actions for patients who are at acute risk of self-harm or suicide.

- **Overview and Objectives**
- **Suicide Screening**
- **Suicide Risk Assessment**
- **Factors Impacting Risk**
- **Conclusion**

Overview and Objectives

Navigation Tip: If you are directed to PolicyStat or another external site, be sure to minimize the new window (do not close it) to return to this course. This will allow you to continue and complete the module. Closing the window may prevent the course from progressing.

CONTINUE

After completing this course you will be able to:

1. Define screening requirements to identify patients at risk for self-harm.
2. Use an evidence-based process to conduct a suicide risk assessment of individuals who screen positive for suicidal ideation.
3. Identify patient factors that may impact risk for or prevention of suicide.

4 Identify environmental safety risks and specific interventions used to mitigate those risks.

5 Understand when a Constant Observer should be initiated.

6 Define the purpose and requirements of a Safety Plan.

7 List documentation requirements for patients identified as at risk for suicide.

CONTINUE

Regulatory bodies require that hospitals have a process to reduce the risk of suicide and ensure patients receive care in a safe setting.

Expand and review both sections below for more information.

The Joint Commission National Patient Safety Goal (NPSG)

NPSG.15.01.01: Reduce the risk for suicide

- Elements include use of a validated screening tool, an evidence-based process to assess patients who screen positive for suicide risk,

implementing procedures to mitigate risk, documentation of the level of risk and mitigation plan, and procedures for follow-up care at discharge.

Centers for Medicare & Medicaid Services (CMS)

CMS Safe Care 482.13 (c)(2)

- Hospitals must provide the appropriate level of education and training to staff regarding the identification of patients at risk of harm to self or others, the identification of environmental patient safety risk factors and mitigation strategies.

This module provides a review of the suicide risk assessment and prevention processes used at Providence to keep our patients safe.

Complete the content above before moving on.

Suicide Screening

Who is at risk?

- Providence uses the Columbia Suicide Severity Rating Scale (C-SSRS) Screening Tool to help to identify patients with risk factors for suicide, so we can keep them safe while in our care.
- The C-SSRS Screening Tool is evidenced-based and consists of six questions which automatically calculate the level of risk for suicide. Staff may then base interventions on level of risk.

A print copy of the C-SSRS Screening Tool is provided below for reference purposes.

Navigation Reminder: After clicking on the link, be sure to minimize the new window (do not close it) to return to this course. This will allow you to click "Continue" and complete the module. Closing the window may prevent the course from progressing.

https://phs-phs.policystat.com/doc_attachment/view/63201365/

CONTINUE

Key Points for Screening

Click START or the arrow button and review the following slides.

1

Screening detects those patients that are at risk and identifies immediate safety needs.

2

For some patients, it is a relief to be asked directly and non-judgmentally about suicide.

3

Ask about suicide while getting information about psychiatric & substance abuse symptoms and history.

4

If you have difficulty asking these questions consider, “Some topics are hard to bring up, so we ask these questions of everyone.”

5

Ideally, screen during a time when the patient is alone and in a private area.

Asking someone if they are thinking about suicide does not give them the idea for suicide.

Click through and review each of the key points above to continue.

When do we screen?

All patients 12 years of age and older presenting to the emergency department or admitted as an inpatient will be screened for the risk of suicide utilizing the Columbia Suicide Severity Rating Scale (C-SSRS), regardless of their chief complaint or diagnosis.

Patients screened to be at risk for suicide will be assessed by a qualified clinician for their level of suicide risk. Minimally, the assessment will address ideation, plan, intent, suicidal or self-harm behaviors, risk factors and protective factors. The qualified clinician determines and documents the patient's overall risk.

Safety interventions will be implemented based on the patient's suicide risk level identified during screening and may be modified by the full risk assessment.

Remember: Patients being treated for a medical condition may have unknown behavioral health conditions, a change in prognosis, or psychosocial issues that may precipitate suicidal ideation and/or self-harm behaviors. This is why screening of everyone is so important.

Screening occurs in the ED and Inpatient areas.

Pediatric Patient Screening

All patients twelve years of age* and older presenting to the emergency department or admitted as an inpatient will be screened for the risk of suicide utilizing the Columbia Suicide Severity Rating Scale (C-SSRS), regardless of their chief complaint or diagnosis.

*If you work in a location where local requirements for screening include younger patients (e.g. patients 10 years of age) follow the requirements communicated by your local or facility policy

For pediatric patients aged 12 and above, the suicide risk assessment will also evaluate demonstrated and observed self-destructive behaviors, suicidal verbalizations, and/or history of suicide attempt or ideations.

Additionally, information from the parent, guardian or responsible adult accompanying the minor will be considered as a part of the assessment process.

The physician will be notified immediately, and the patient will be considered high-risk for suicide until otherwise determined by the physician.

For pediatric patients eleven (11) years or younger who are actively suicidal, notify the physician immediately and place with a constant observer.

CONTINUE

Screening Results - If the patient answers *"yes"* to any of the 6 questions of the C-SSRS Screening Tool, the screen is positive for

suicide risk and a comprehensive risk assessment should be completed by ministry designated personnel.

If your C-SSRS screening indicates high risk, take action to establish safety immediately, before moving ahead with the C-SSRS assessment.

- Notify the responsible physician, advanced practice clinician (APC) and/or designated behavioral health clinician of the outcome of the C-SSRS screen.
- Immediately establish continuous visual observation with a constant observer. The level of observation will be determined based on level of suicide risk. Do not leave patient unattended and always err on the side of caution.
- Implement the Constant Observer Risk Mitigation Checklist (Appendix C in policy). All objects that pose a risk for self-harm that can be removed without adversely affecting the ability to deliver medical care will be removed. Items required for direct patient care (e.g. oxygen and IV tubing, lightweight IV pole) do not need to be removed but will be closely monitored.
- Conduct a safety search including clothing worn by the patient. The search should be conducted in a culturally sensitive manner and with respect for the individual's dignity and privacy. Two (2) caregivers must be present, one (1) licensed caregiver of the same gender as the patient if possible. Belongings will be removed and placed in a secure area.

While awaiting further assessment, it is important to implement monitoring and interventions (per policy) to mitigate risk as warranted by the patient's level of risk.

For patients who demonstrate other concerning behavior, such as agitation, aggression, hostility, verbal threats, hallucinations, delusions, disorganized thinking and speech, bizarre or unusual behavior, consider establishing continuous visual observation with a constant observer.

CONTINUE

Suicide Risk Assessment

- If *C-SSRS* ***Screener*** suicide screen shows the patient is at ***any*** risk level (low, moderate or high), a full suicide risk assessment must be completed. The ministry-designated caregiver, physician, APC, behavioral health clinician or other qualified clinician will conduct the suicide risk assessment using the Columbia Suicide Severity Rating Scale (C-SSRS) Risk Assessment Tool.

- The comprehensive risk assessment includes asking about suicidal ideation, plan, intent, suicidal or self-harm behaviors, risk factors, and protective factors to determine and document the patient's overall risk.

A print copy of the C-SSRS Risk Assessment Tool is provided below for reference purposes.

Navigation Reminder: After clicking on the link, be sure to minimize the new window (do not close it) to return to this course. This will allow you to click "Continue" and complete the module. Closing the window may prevent the course from progressing.

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Identifying Suicidal Behavior

The tabs below show the different types of suicidal behavior. Consider this information when completing the C-SSRS Risk Assessment on your patients.

Click each tab to learn more.

ACTUAL ATTEMPT | INTERRUPTED ATTEMPT | ABORTED OR SELF-INTERRUPTED ATTEMPT | PREPARATORY ACTS OR BEHAVIOR

A potentially self-injurious act committed with at least some wish to die, as a result of act. Behavior was in part thought of as method to kill oneself.

- Intent does not have to be 100%.
- If there is any intent/desire to die associated with the act, then it can be considered an actual suicideattempt.
- There does not have to be any injury or harm, just the potential for injury or harm.

Inferring Intent: Even if an individual denies intent/wish to die, it may be inferred clinically from the behavior or circumstances. For example, a highly lethal act that is clearly not an accident so no other intent but suicide can be inferred (e.g., gunshot to head, jumping from window of a high floor/story).

ACTUAL ATTEMPT | INTERRUPTED ATTEMPT | ABORTED OR SELF-INTERRUPTED ATTEMPT | PREPARATORY ACTS OR BEHAVIOR

When the person is interrupted (by an outside circumstance) from starting the potentially self-injurious act (if not for that, actual attempt would have occurred).

- ***Overdose:*** Person has pills in hand but is stopped from ingesting. Once they ingest any pills, this becomes an attempt rather than an interrupted attempt.

- ***Shooting:*** Person has gun pointed toward self, gun is taken away by someone else, or is somehow prevented from pulling trigger. Once they pull the trigger, even if the gun fails to fire, it is an attempt.
- ***Jumping:*** Person is poised to jump, is grabbed and taken down from ledge.
- ***Hanging:*** Person has noose around neck but has not yet started to hang - is stopped from doing so.

ACTUAL ATTEMPT	INTERRUPTED ATTEMPT	ABORTED OR SELF-INTERRUPTED ATTEMPT	PREPARATORY ACTS OR BEHAVIOR

When person begins to take steps toward making a suicide attempt, but stops themselves before they actually have engaged in any self-destructive behavior.

- Examples are similar to interrupted attempts, except that the individual stops him/herself, instead of being stopped by something else.

ACTUAL ATTEMPT	INTERRUPTED ATTEMPT	ABORTED OR SELF-INTERRUPTED ATTEMPT	PREPARATORY ACTS OR BEHAVIOR

Acts or preparation towards imminently making a suicide attempt.

- This can include anything beyond a verbalization or thought, such as assembling a specific method (e.g., buying pills, purchasing a gun) or preparing for one's death by suicide (e.g., giving things away, writing a suicide note).

Source: National Suicide Prevention Lifeline's COLUMBIA-SUICIDE SEVERITYRATING SCALE (C-SSRS)Risk Assessment (Lifeline crisis center version)

Click and review each tab above to continue.

Difficulties in Assessing Risk

If a patient who presents for a non-behavioral problem is unwilling to participate in the screening process, observe patient for suicidal/self-harm behaviors and complete screening once patient is willing to participate.

If a patient who presents for a non-behavioral problem is unable to participate in the screening process, complete screening once patient is able, to participate.

For a patient who presents for a behavioral health problem is unable or unwilling to participate in the initial screening, or if it is suspected that the patient is withholding information during screening questions in answering the C-SSRS questions, assume the patient is at high risk for suicide until an assessment is completed by a physician, advanced practice clinician (APC) and/or designated behavioral health clinician.

For patients who demonstrate non-suicidal, maladaptive self-harm behaviors, immediately establish continuous visual observation with a constant observer and implement the interventions for a patient at high-risk for suicide.

For patients who demonstrate other concerning behavior, such as agitation, aggression, hostility, verbal threats, hallucinations, delusions, disorganized thinking and speech, bizarre or unusual behavior, consider establishing continuous visual observation with a constant observer.

Additional Steps to Take

Other things that may be included in the assessment and intervention for patients at risk for suicide:

- Encourage the patient to talk about their situation and express their feelings.
- Ask about their support system—do they have any family, friends, counselor, etc. who they can talk to?
- Ask about their coping strategies—is there anything they do now or have done in the past that has been helpful, i.e., talking to someone, going to counseling, praying, meditating, etc.
- Look for any strengths or "positives", i.e., times when they reached out for help, people or things that are important to them that they can still connect with.
- Elicit from the patient what they see as positives in their life at this time, what do they value, what is important to them.

Caution: Suicide contracts are not recommended, there is no evidence they decrease suicide risk, and they are not considered a legal document.

CONTINUE

Knowledge Check

Let's review the topics we just covered. Select the best response for each question.

If your patient screens negative (not at risk) with the C-SSRS screening tool, but you are suspicious, what should you do?

- ◯ Try to lighten the mood by making jokes.
- ◯ Try to talk them out of it by pointing out how selfish they are being.
- ◯ Immediately notify the police of what you have observed and/or heard from the patient.
- ◯ Assume the patient is at high risk for suicide until an assessment is completed by a qualified clinician.

SUBMIT

What additional step can you take during assessment and intervention for patients at risk of suicide?

- Encourage the patient NOT to talk about their situation.
- Don't ask about their family, friends, counselor, etc., because it may bring up negative feelings.
- Ask about their coping strategies—is there anything they do now or have done in the past that has been helpful.
- Remind them of times in the past when they reached out for help and were rejected.

SUBMIT

Answer the knowledge check questions above to continue.

Factors Impacting Risk

Factors that May Indicate a Higher Risk for Suicide Include:

- History of depression and/or anxiety.
- Other mental health issues (i.e. bipolar disorder, schizophrenia, major depression).
- Previous suicide attempt or attempts.
- Family history of suicide and/or mental health issues.
- Alcohol and/or other substance abuse.
- History of physical, sexual, and/or emotional abuse.
- Ongoing illness and/or physical pain.
- Co-morbid health problems, especially a newly diagnosed problem or worsening symptoms.
- Recent stressful event or events such as, loss of job or death of a loved one.
- Extreme difficulty coping—deep sadness, loss of interest, trouble sleeping and poor appetite.
- Impulsivity and poor self-control; engagement in reckless or high-risk behaviors.
- Access to guns, other weapons, medications, or other devices that can be used for self-harm.

Indicators of More Immediate Risk of Self-Harm

- Expressing or displaying feelings of hopelessness, unworthiness, lack of control over one's life, apathy about the future, self-reproach, distrust of others, fatalism and futility, obsession with death.
- Dramatic mood changes.
- Spoken or written threats of suicide.
- Making veiled or indirect statements about one's own death; feeling like there is no reason to live.
- Giving away personal possessions.
- Drafting a will or making funeral arrangements (this needs to be considered within the context of patient's situation and presence of other risk factors.)
- Procuring a weapon or lethal dose of drugs.
- Withdrawal from friends, family and coworkers.
- Withdrawal and loss of interest in activities that once brought pleasure.
- Exhibiting very depressed mood (sadness, melancholy, lack of interest in life).

- Extreme difficulty in coping.
- Demonstrating chronic or acute sleep disturbances.

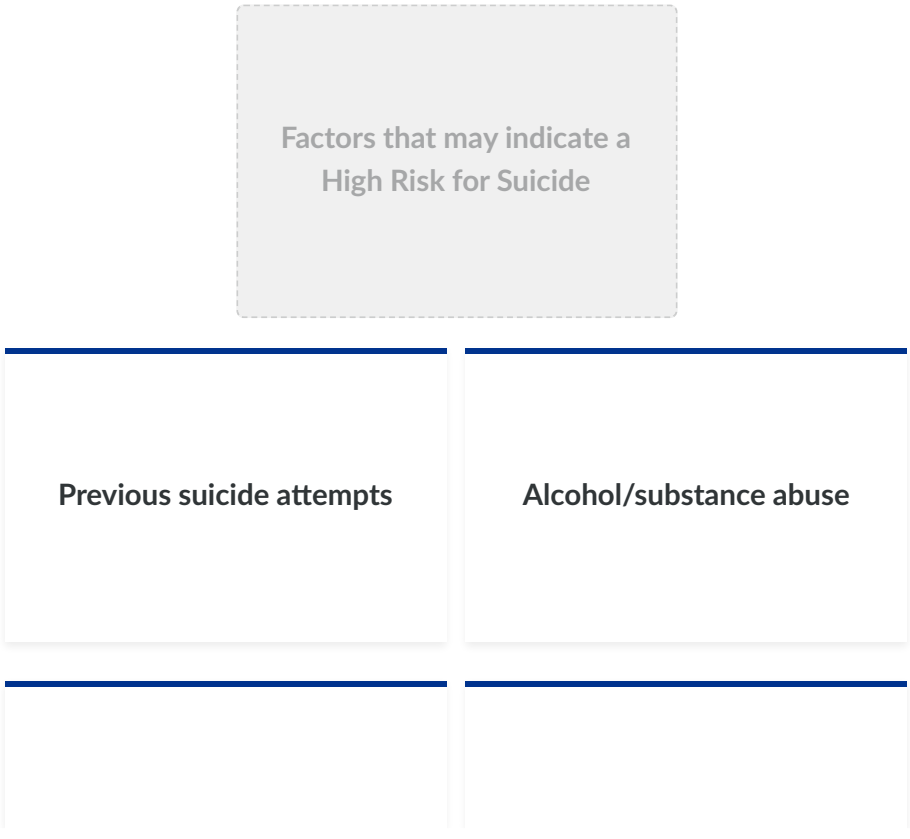
Protective Factors that May Decrease Risk

Protective factors are personal or environmental characteristics that help protect people from suicide.

Major protective factors for suicide include:

- Participation in effective behavioral health care; positive therapeutic relationships.
- Connectedness to individuals, family, community, and social institutions.
- Life skills, including problem-solving skills and coping skills, ability to adapt to change, reality-testing ability.
- Self-esteem and a sense of purpose or meaning in life.
- Cultural, religious, or personal beliefs that discourage suicide.
- Responsibility to children or beloved pets.

Drag each symptom below to the correct category on the left or right.



Other mental illness

History of depression and/or anxiety

Recent stressful event

Family history of suicide/mental illness

Access to weapons

History of abuse

Indicators of More Immediate Risk of Self-Harm

Dramatic mood changes

Giving away personal possessions

Buying a gun

Extreme difficulty coping

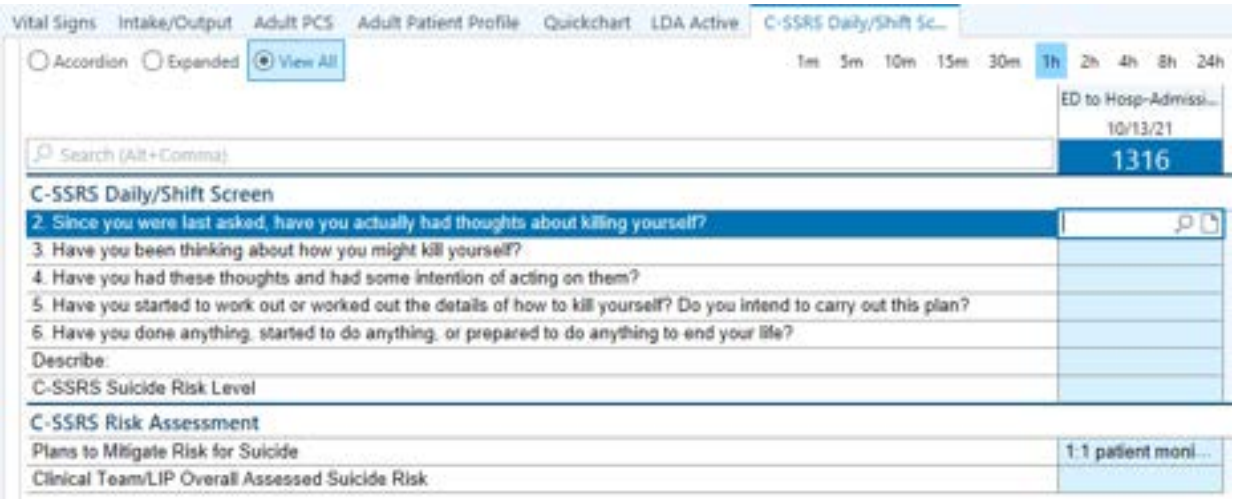
Chronic or acute sleep disturbances	Withdrawal from friends/family
Threats of suicide	Statements about one's own death

Complete the content above before moving on.

Ongoing Assessment of Suicide Risk

- The C-SSRS screener tool automatically calculates an initial suicide risk level based on patient responses
- The patient's overall risk for suicide is determined by the provider/clinical team, based on their full assessment of the patient

- For patients identified at risk, re-assessments are completed using the C-SSRS Daily Shift tool:
    - Per policy for patients in the ED
    - Each shift for inpatients
    - As needed based on patient condition



A print copy of the C-SSRS Daily Shift Tool is provided below for reference purposes.

Navigation Reminder: After clicking on the link, be sure to minimize the new window (do not close it) to return to this course. This will allow you to click "Continue" and complete the module. Closing the window may prevent the course from progressing.

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CONTINUE

Conclusion

You have successfully finished the initial eLearning segment of the *Care of Patients at Risk for Suicide – Direct Caregivers* module.

If you have any unit specific questions regarding suicide prevention or individual procedures within your ministry, please contact your nursing unit manager or preceptor.

Please proceed to the second module to continue your learning journey.

Click 'Exit Course' above to close this window.

PROV: Drug Diversion - Prevention and Detection

- Course Navigation
- Introduction
- How to Identify
- Risks
- Best Practices for Handling Controlled Substances
- Disposal of Controlled Substances
- State/Federal Regulations
- Prevention

Lesson 1 of 8

Course Navigation

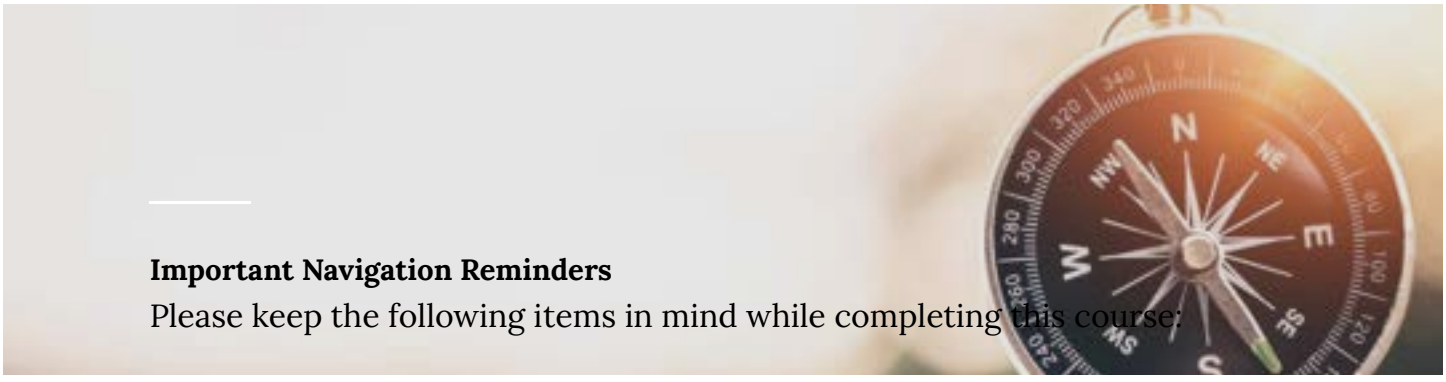
- You must move through this course in sequential order.
- Successful completion of this course requires viewing all content.
- You may exit the course and return to where you left off.

Technical Recommendations

There are technical recommendations in order to access all components and ensure you have an optimal learning experience. Before you continue, please ensure your computer meets these minimum requirements:

Computer or Laptop	Web Browser	Operating System	Internet Connection	Other
Minimum screen size of 15" Audio capability	Latest version of **Microsoft Edge**	Windows 10 or higher Mac: Catalina OS	High speed internet (DSL/Cable) Reliable connection	Headphones, earbuds or speakers

A phone or tablet should not be used to complete this eLearning course.



Important Navigation Reminders

Please keep the following items in mind while completing this course:

1. Lessons load as you complete a section. If you do not see the continue or next lesson button, **scroll down** to load the lesson or locate the continue button.

2. Do not fast forward or skip around; this can cause the lesson/course to freeze and may interfere with your ability to complete the course.

3. If experiencing technical issues, try clearing the browser history before or during the course. If you continue to experience issues, submit a ticket in the Caregiver Service Portal or call (844) 922-7548.

4. When viewing videos, wait until the slider bar at the bottom stops before selecting continue.

5. Anytime you see an image, you can select it to enlarge.

6. If you are directed to PolicyStat or another external site, be sure to minimize the new window (do not close it) to return to this course. This will allow you to continue and complete the module. Closing the window may prevent the course from progressing.

CONTINUE

Introduction

Learning Objectives

By the end of this course, learners should:

- Have reviewed an overview of Controlled Substances handling and diversion prevention
- Know how to identify potential risks
- Know how to dispose of Controlled Substances
- Understand state/federal regulations
- Prevent drug diversion
- Know how to report drug diversion or suspicion of drug diversion

CONTINUE

What is Drug Diversion?

Drug Diversion is the transfer or use of a prescription drug to anyone other than the intended recipient of the medication.

Misappropriation of medications in **any way** other than how they are intended for use or prescribed for use. Medications of any kind can be misappropriated or diverted. When medications are misappropriated by a workforce member it is considered theft.

Drug diversion is a crime that can have negative impacts on our patients, caregivers, and health system.

- **Patients:** Denial of pain relief, exposure to blood-borne pathogens, identity theft, fraud, and direct patient harm.
- **Caregivers:** Loss of license, career, and professional reputation

Approximately 10-15% of healthcare professionals will struggle with substance use disorders during their career, and many of these turn to drug diversion.

Where does Drug Diversion Occur?

- Acute Care (e.g. hospitals) - main focus of this presentation
- Retail Pharmacies
- Outpatient Infusion Centers
- Nursing Homes
- Hospice
- Home Infusion

CONTINUE

What are Controlled Substances?

A drug that is regulated by the Drug Enforcement Agency (DEA) because it may be abused or cause addiction.

Controlled Substance Schedules

Drugs and other substances that are considered Controlled Substances under the Controlled Substances Act (CSA) are divided into five schedules.

According to the US Bureau of Labor Statistics, drugs in the highest risk schedules (II, III, and IV) account for 94% of abused prescription drugs.

Select each section below to learn more about each schedule.

Schedule I

No currently accepted medical use in the United States, a lack of accepted safety for use under medical supervision, and a high potential for abuse.

- Examples include heroin, methamphetamine, MDMA (ecstasy).

Schedule II

A high potential for abuse which may lead to severe psychological or physical dependence.

- Examples include Oxycodone, Hydrocodone, Amphetamines (Adderall).

Schedule III

Potential for abuse is less than substances in Schedules I or II and abuse may lead to moderate or low physical dependence or high psychological dependence.

- Examples include buprenorphine, testosterone.

Schedule IV

Low potential for abuse relative to substances in Schedule III.

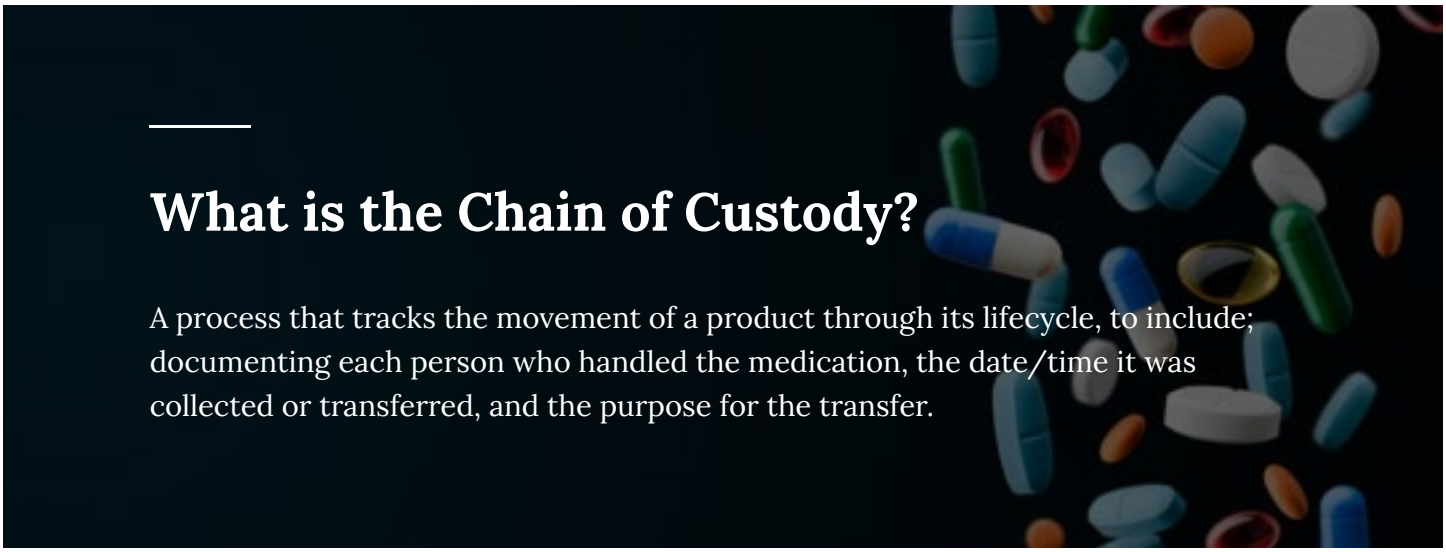
- Examples include alprazolam, carisoprodol.

Schedule V

Low potential for abuse relative to substances listed in Schedule IV and consist primarily of preparations containing limited quantities of certain narcotics.

- Examples include phenergan with codeine, pregabalin.

Expand and review the content above before moving on.



What is the Chain of Custody?

A process that tracks the movement of a product through its lifecycle, to include; documenting each person who handled the medication, the date/time it was collected or transferred, and the purpose for the transfer.

Drug diversion does not only affect Controlled Substances. Anytime a medication is removed, taken, given, or redirected to someone for whom it was not ordered or intended, this is drug diversion.

CONTINUE

How to Identify

Examples of Drug Diversion

- Personal use of hospital issued drugs on or off hospital property
- Redistribution of hospital issued drugs to unauthorized users (e.g. family members)
- Removal, misuse, stealing, and/or diverting non-controlled medication/drugs (and/or related supplies)
- Self-prescribing of Controlled Substances
- Removing Controlled Substances from a hospital location to be used on patients in another facility

The Facts:

Opioid addiction is a major driver of drug diversion.

More than 822,00 people have died since 2015 from a drug overdose. In 2024, 80,391 drug overdose deaths occurred in the United States.

- Among nurses, substance use disorders affect 500,000 individuals nationally.
- 87% of physicians have prescribed medications for themselves, and over 55% with painkiller prescriptions wrote them for themselves.
- There are an estimated 37,000 drug diverters each year.

Common Characteristics of a Diverter

Many diverters appear to be high-functioning professionals who are well-liked by their peers as the diverter may be willing to go "above and beyond" in their roles.

- Frequent volunteering for overtime or shift coverage
- Come early / stay late or insisting to cover nights/weekends/holidays
- Offering to administer medications for other nurses and handle waste for Controlled Substances

Contributing Factors for Abuse

Similar to healthcare fraud, drug diversion is typically driven by three factors:

- Pressure / Motivation to Divert
- Access / Opportunity
- Rationalization / Justification by the Diverter

Commonly Diverted Drugs

Click the cards below to reveal more information.

OPIOIDS

- HYDROmorphone
- Morphine
- FentaNYL (including patches)
- HYDROcodone
- OxyCODONE
- Methadone

STIMULANTS

- Dextroamphetamine
- Methylphenidate

DEPRESSANTS

- Benzodiazepines (e.g., ALPRAZolam, clonazePAM, lorazePAM)

OTHERS

- Propofol
- Trazodone
- Naloxone

Review the flashcards above before moving on.

What Classes of Prescription Drugs are Commonly Misused?

Click on the buttons below to learn more.

National Institute on Drug Abuse (NIDA)

NIDA

Institute for Safe Medication Practices

(2023, February 23). Drug diversion and COVID-19. ISMP Medication Safety Alert! Acute Care Edition, 28(4).

ISMP

Navigation Reminder: After clicking on the button, be sure to minimize the new window (do not close it) to return to this course. This will allow you to continue and complete the course. Closing the window may prevent the course from progressing.

Red Flags (Report Immediately)

- Broken / missing tamper seals
- Damaged / altered packaging
- Medication or associated supplies (e.g., syringes, needles) found in inappropriate locations or in personal belongings
- Suspected false documentation medical record or other chain of custody logs (Pyxis, paper, etc.)

Complete the content above before moving on.

Lesson 4 of 8

Risks

Click on each section below to review the risks associated with each topic.

Individual —

- Criminal offense
- Loss of career
- Health consequences
  - Overdose
  - Neglected health
  - Infection

Patients —

- Compromised safety (e.g., infectious disease exposure)
- Inaccurate documentation leading to poor record of care and potentially fraudulent billing
- Compromised treatment (e.g., inadequate pain relief or neglected care plan)
- Patient privacy (HIPAA violations by caregiver/diverter)

Hospital —

- Loss of reimbursement
- Repayment
- Loss of accreditation
- Drug diversion fines
- Reputational damage and decreased community confidence

Society —

Diversion and Opioid Use Disorder (OUD) is costly to society!

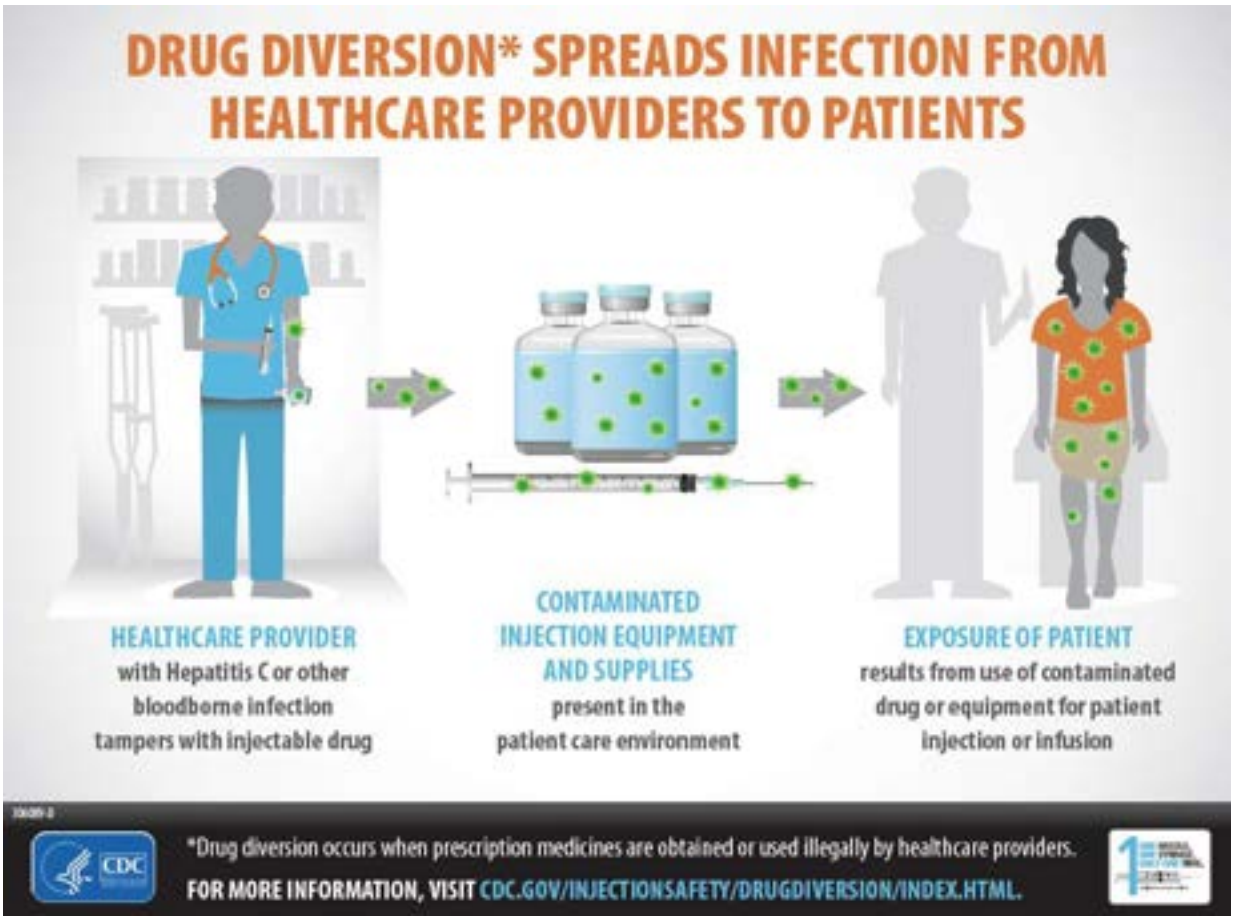
- Increased health expenditures (estimated over $70 billion per year)
- Loss of productivity (estimated over $120 billion per year)

Drug Enforcement Administration (DEA) fines due to drug diversion range from $1 million to $8 million.

CONTINUE

Drug Diversion is Dangerous

Diversion is also costly to the health of patients and healthcare providers.


DRUG DIVERSION* SPREADS INFECTION FROM HEALTHCARE PROVIDERS TO PATIENTS
HEALTHCARE PROVIDER
with Hepatitis C or other bloodborne infection tampers with injectable drug
CONTAMINATED INJECTION EQUIPMENT AND SUPPLIES
present in the patient care environment
EXPOSURE OF PATIENT
results from use of contaminated drug or equipment for patient injection or infusion
CDC
*Drug diversion occurs when prescription medicines are obtained or used illegally by healthcare providers.
FOR MORE INFORMATION, VISIT CDC.GOV/INJECTIONSAFETY/DRUGDIVERSION/INDEX.HTML.

CONTINUE

Best Practices for Handling Controlled Substances

Complete the content above before moving on.

Knowledge Check

Select all of the following that **are** best practices for handling Controlled Substances.

- [ ] Never witness in the ADM the wasting of a medication that you didn't actually see disposed

- [ ] Controlled Substances (CS) should only be removed from the Automated Dispensing Machine (ADM) (e.g., Pyxis) ***immediately*** prior to planned administration
- [ ] Controlled Substances will be wasted and discarded in an ***irretrievable*** manner
- [ ] Controlled Substances may ***be placed*** in the caregiver's pockets for safe keeping

SUBMIT

Answer the knowledge check above before moving on.

Disposal of Controlled Substances

Wrong Way to Dispose Controlled Substances

Drug diversion occurs when diverters reach in and take out partial vials of Controlled Substances! Some even drain liquid out of the bottom of sharps containers or trash bins knowing the risks!

Correct Way to Dispose Controlled Substances

Stericycle – CsRx Container

After witnessed waste, dispose as follows:

- Liquids & injectables: Draw up remaining controlled substance and inject contents into CsRx container (solution in container deactivates Controlled Substance)
- Tablets/capsules removed from packaging and dropped into containers
- Patches placed in container

Note: Make sure you visibly witness the wastage process.

Validate and verify!

Knowledge Check

Drug diversion occurs when diverter reaches in and takes partial vials of Controlled Substances from the waste bin.

- ◯ True
- ◯ False

SUBMIT

Answer the knowledge check above before moving on.

State/Federal Regulations

Legal/Regulatory Oversight

- *Drug Enforcement Administration (DEA)
- State and/or local law enforcement
- Board of Nursing
- Board of Pharmacy
- Medical Board
- The Joint Commission
- Centers for Medicare and Medicaid Services (CMS)
- Det Norske Veritas National Integrated Accreditation of Healthcare Organizations (DNV NIAHO)

Primary Regulator/Enforcement of the Controlled Substance Act

CONTINUE

Prevention

Systems of Prevention

Click the cards below to reveal more information.

Culture

The organization expects staff to report any suspected diversion or suspicious behavior.

Human Factor

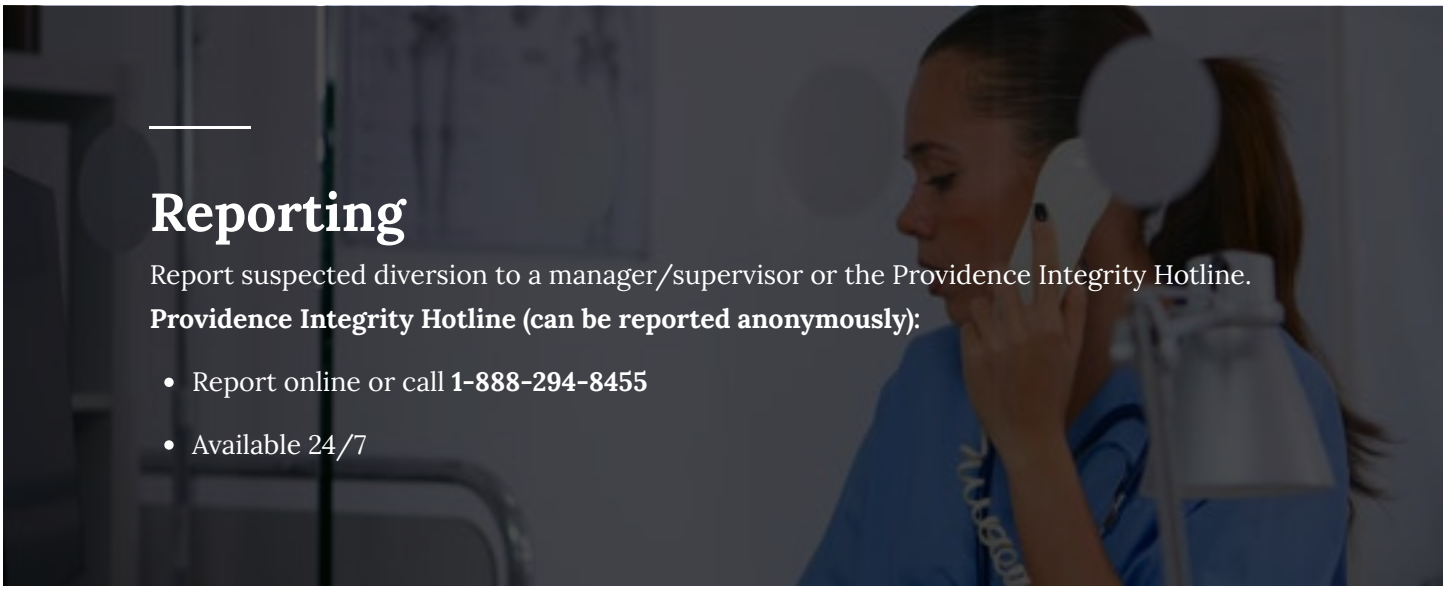
Vigilance cannot be understated! Every caregiver has a responsibility to safe- guard against drug diversion.

Proactive Diversion Monitoring

Providence utilizes next generation diversion monitoring software to provide enhanced transparency in Controlled Substance handling.

- Diversion prevention is a multidisciplinary effort. Core Leaders may be asked to review patterns or trends identified by this software.
- Please ensure you continue to practice safe Controlled Substance management and encourage best practices with your peers.
- If you become aware of a Controlled Substance discrepancy or missing Controlled Substance, please report your concerns immediately.

Complete the content above before moving on.



Reporting

Report suspected diversion to a manager/supervisor or the Providence Integrity Hotline.

Providence Integrity Hotline (can be reported anonymously):

- Report online or call **1-888-294-8455**
- Available 24/7

Do You Need Help?

These resources listed below can help to protect you and your license.

- **Substance Abuse and Mental Health Services Administration (SAMHSA) National Helpline: 1-800-662-HELP (4357)**
  - Free, confidential, 24/7 treatment referral and information service for individuals and families facing mental and/or substance use disorders.
- **National Drug Helpline: 1-844-289-0879**
  - Free, confidential, 24/7 information about substance use, treatment options, and support resources.

CONTINUE

Professional Recovery Programs by State

State	State Programs for Recovery
AK	https://www.fsphp.org/physician-health-committee-of-alaska

CA	The California diversion program for healthcare providers | Maximus https://www.pharmacy.ca.gov/licensees/personal/pharmacist_recovery.shtml
MT	https://www.montanarecoveryprogram.com/faqs https://www.rxmt.org/montana-board-of-pharmacy
NM	https://nmbon.sks.com/diversion-program-faqs.aspx https://nabp.pharmacy/bop_members/new-mexico/
OR	https://www.oregon.gov/oha/PH/DISEASESCONDITIONS/COMMUNICABLEDISEASE/HAI/PREVENTION/Documents/Lunch%20and%20Learn/Drug_diversion_part_1.pdf
TX	https://rnguardian.com/drug-diversion-and-your-rn-license-what-you-need-to-know-now/ https://www.pharmacy.texas.gov https://www.pharmacy.texas.gov/Newsletter/Help.asp
WA	https://doh.wa.gov/public-health-healthcare-providers/healthcare-professions-and-facilities/professional-resources/impaired-practitioner-programs https://www.wsparx.org/page/WRAPP?&hhsearchterms=%22recovery+and+assistance+and+program+and+pharmacy%22

Do You Think Someone Needs Help?

We have a duty to respond to diversion in a manner that promotes the safety of our patients and caregivers. Help is available!

- Reach out to any **Core Leader**
- Call **Human Resources**
- **Caregiver Assistance** is available 24/7: 844-875-5716
    - Confidential and free

Knowledge Check

Select all the ways that Providence supports a culture of safety and prevention of drug diversion.

- [ ] The organization expects staff to report any suspected diversion or suspicious behavior
- [ ] Every caregiver has a responsibility to safe- guard against drug diversion
- [ ] Core Leaders and pharmacy leaders have a responsibility to monitor against diversion

SUBMIT

Answer the knowledge check above before moving on.

Congratulations, you have completed the *Drug Diversion - Prevention and Detection* course. Click the *Exit Course* link above to close this window.

Emergency Preparedness

This course is part of a series of regulatory requirements for New Caregiver Orientation

- **Introduction**
- **What is a Disaster?**
- **Emergency Operations Plan**
- **Roles and Responsibilities**
- **Emergency Response**
- **Evacuation**
- **Conclusion**

Introduction

Welcome!

Upon completion of this course, learners will be able to:

- Identify the parts of an Emergency Operations Plan (EOP)
- Know when we would activate the EOP

- Know your role and responsibility before, during and after an emergent event
- List types of possible disaster events in your region, and how to respond
- Understand how your hospital as a whole responds to incidents

In any emergency, muscle memory takes over and we respond the way we've trained. Practice safety procedures frequently.

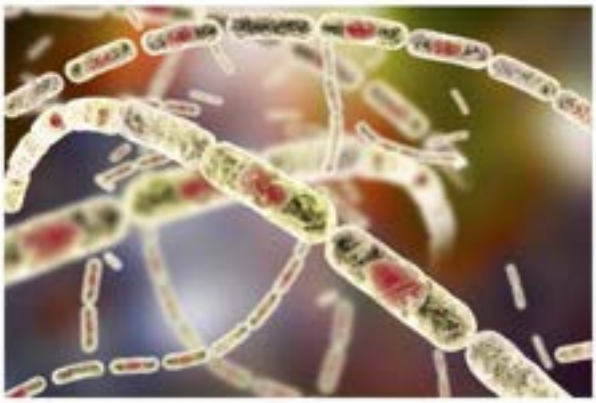
CONTINUE

What is a Disaster?

A disaster is a non-routine event that has the ability to threaten or overwhelm any hospital resources.

Problems or events - either planned or unplanned, external or internal, that cannot be resolved using day-to-day processes within expected time frames.

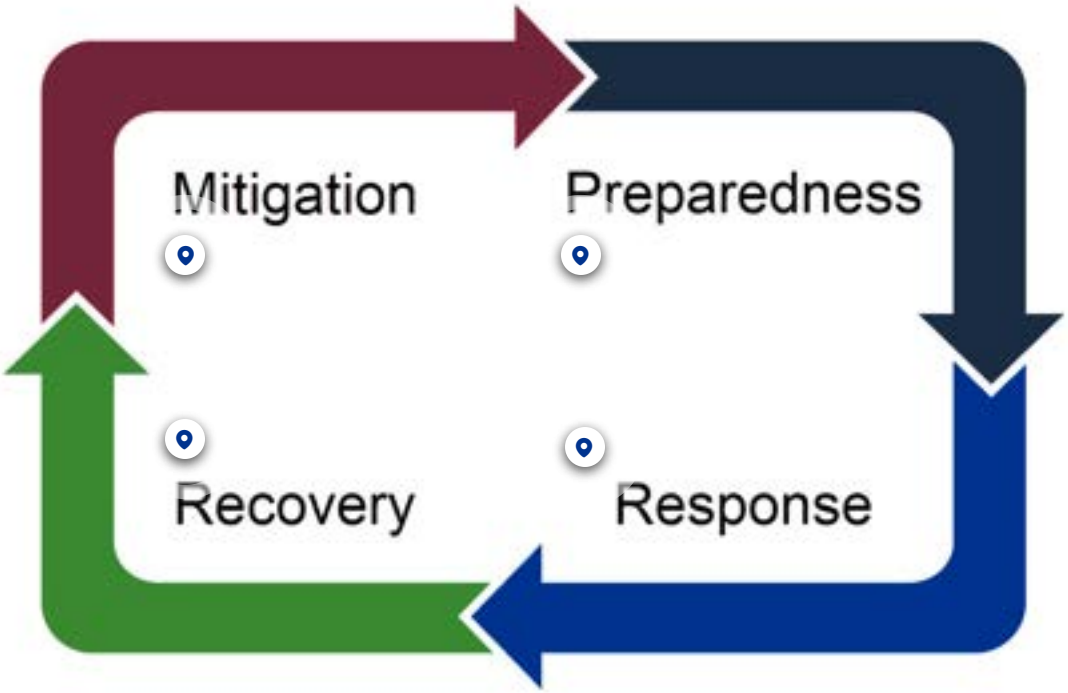
The Hazard Vulnerability Analysis (HVA) is the cornerstone to any hospital emergency management program.
This document analyzes potential hazards in our area and determines the top hazards that could affect your facility.

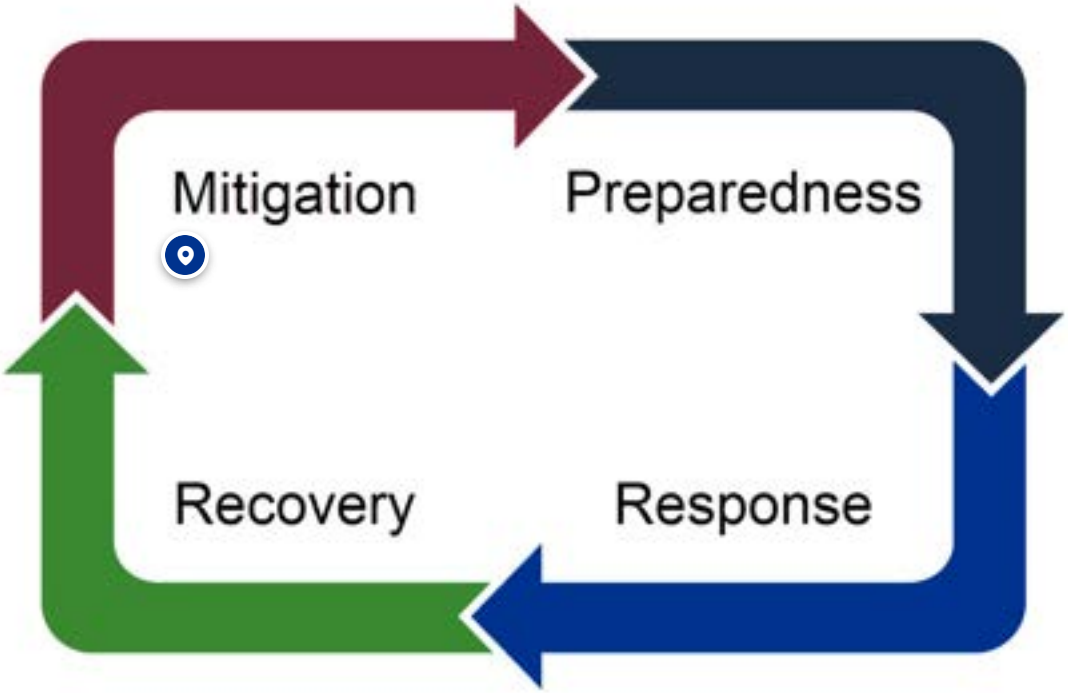


Complete the content above before moving on.

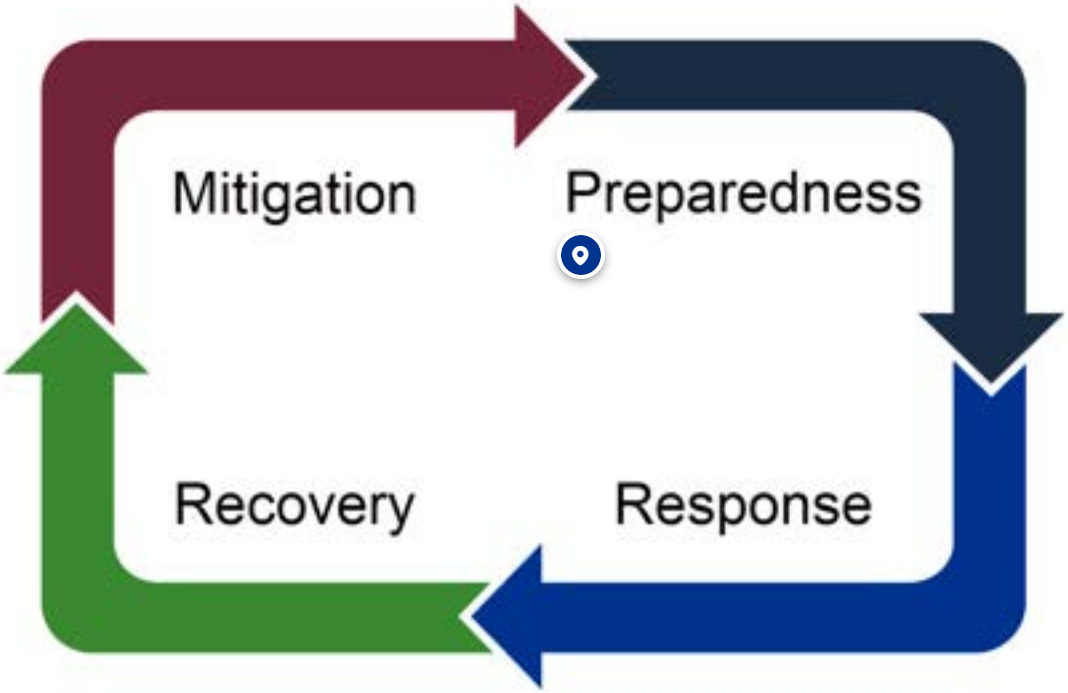
Emergency Management Cycle

There are four phases of the Emergency Management Cycle. Click on the icons below to learn more.

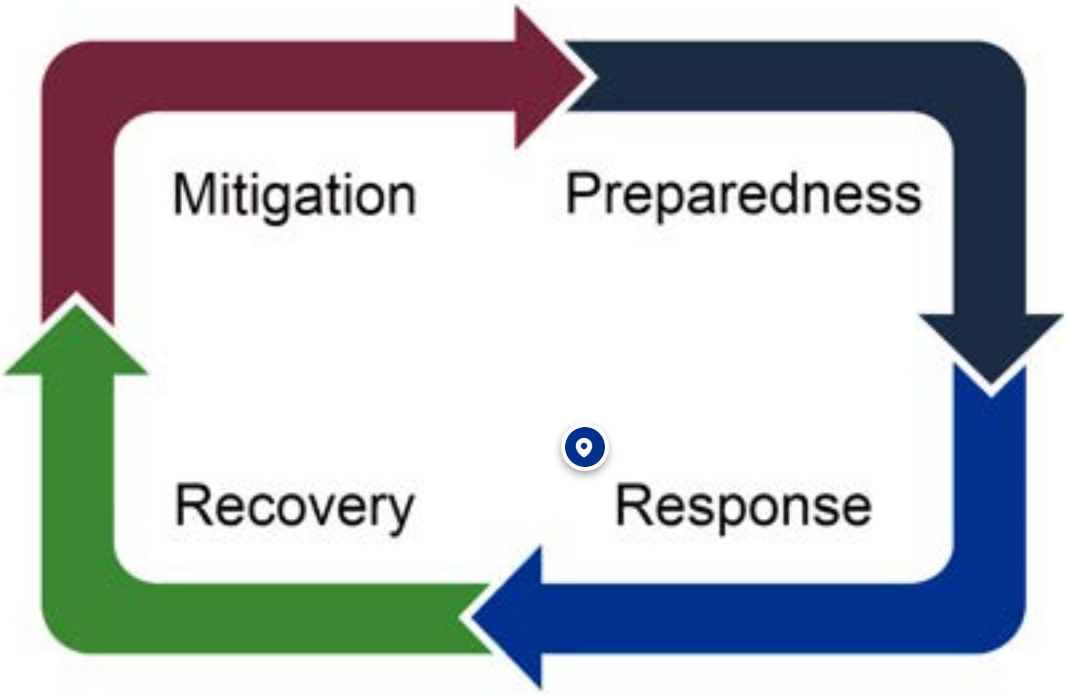

Mitigation
Preparedness
Recovery
Response



The **Mitigation** Phase occurs before an incident, with a goal of lessening the impact of a disaster.

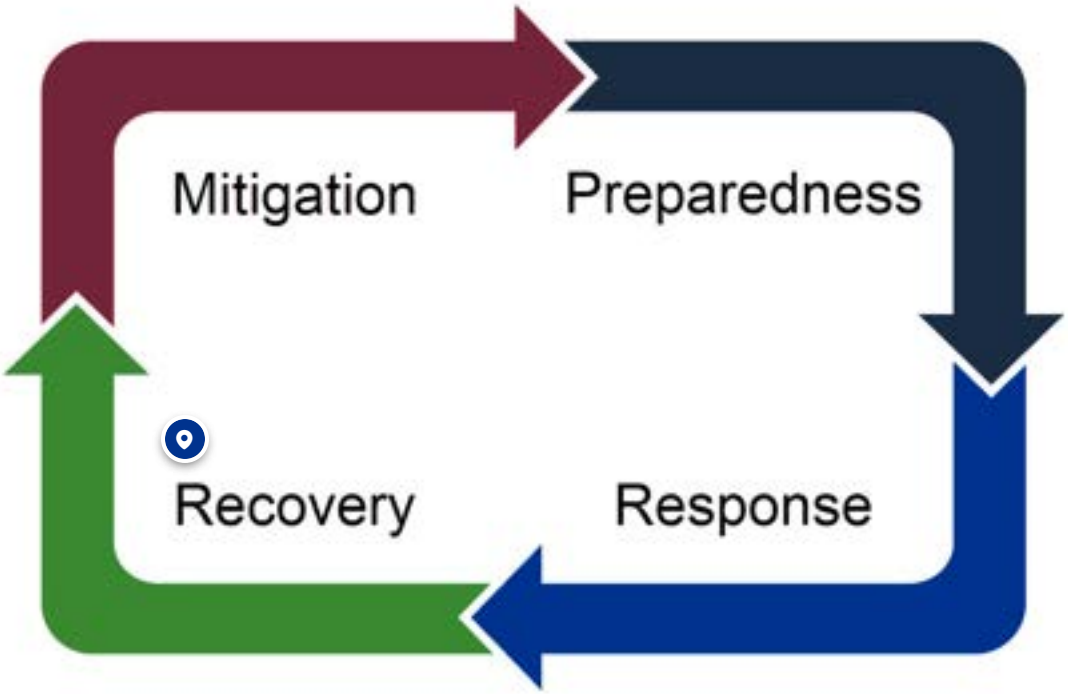


The **Preparedness** Phase occurs before an incident, and prepares hospital caregivers to respond to an event.



When a disaster strikes, the hospital will enter the **Response** Phase.

This phase is focused on life safety and bringing the hospital back to normal operations.



Recovery attempts to restore the hospital back to normal operations.

This process can take a long time – potentially years.

Complete the content above before moving on.

Emergency Operations Plan

Every hospital is required to have an Emergency Operations Plan (EOP). This plan outlines the hospital's strategy to prepare for, respond to, and recover from any incident.

We know that different disasters often have similar impacts. Our EOP is designed to support response to those impacts. This is called the "all hazards" approach.

EOPs are reviewed and refined each year to reflect lessons learned from each activation whether that's an exercise or live event.

Each year, Emergency Management provides training events/exercises to practice hospital response to these top hazards and works closely with community partners.
Depending on your role, these events may involve evacuation drills, patient surge exercises and other activities.
These exercises are evaluated to find room for improvement with the hospital's response to the exercise.

Check with your Emergency Manager for more information about your EOP.

The EOP is a living document designed to inform and adapt our approach to different aspects of preparedness and response.

Click the plus signs (+) below to review some examples of what is covered in an EOP.

Communications —

Communications includes internal communications within Providence, external communications with the community and governing bodies, and communication with patients and families.

Communication methods may include overhead page, Everbridge, radio, press releases, etc.

Continuity of Operations

The methods for returning to normal business operations when facilities or services are severely impacted.
Continuity of operations plans identify essential services and how the facility will maintain or restore operations during and after a disaster.

Medical Surge

A patient surge is an influx of patients that contributes to a broad strain on hospital resources.
Examples of incidents that could trigger a patient surge include influenza epidemic, mass casualty incidents within the community, and receiving patients from other evacuating hospitals.
Triage and patient tracking are essential to surge planning.

Staff and Family Support

Staff and family support includes strategies for supporting the physical, mental, and spiritual needs of staff, patients, and families during and after a crisis.
The Behavioral Health Concierge resource is an example of staff and family support.

Volunteers in Emergencies

During an emergency, each department will determine if they have available caregivers who could be redistributed through the Labor Pool.
This would always be done with the oversight of a Command Center.

The EOP provides tools for the approval and deployment of medical professionals with expired or out-of-state licenses in the event of extreme need.

Complete the content above before moving on.

Roles and Responsibilities

Hospital Incident Command System (HICS)

Providence uses the Hospital Incident Command System (HICS) during a disaster.
There are many advantages for using HICS, they include:

- Pathways and tools for communicating with local authorities and government agencies
- Common terminology and plain language, i.e., no lingo
- Manageable span of control
- Modular organization – can be scaled to include only the positions needed for incident
- Predictable lines of authority, with clear chains of command

When a disaster happens, the designated incident commander will report to the command center. They will then determine whether other leaders are needed to manage the incident.

The Incident Command Team can include representatives from:

- Emergency Department
- Administration
- Nursing
- Security
- Public relations
- Spiritual care
- Ancillary services
- Environmental services

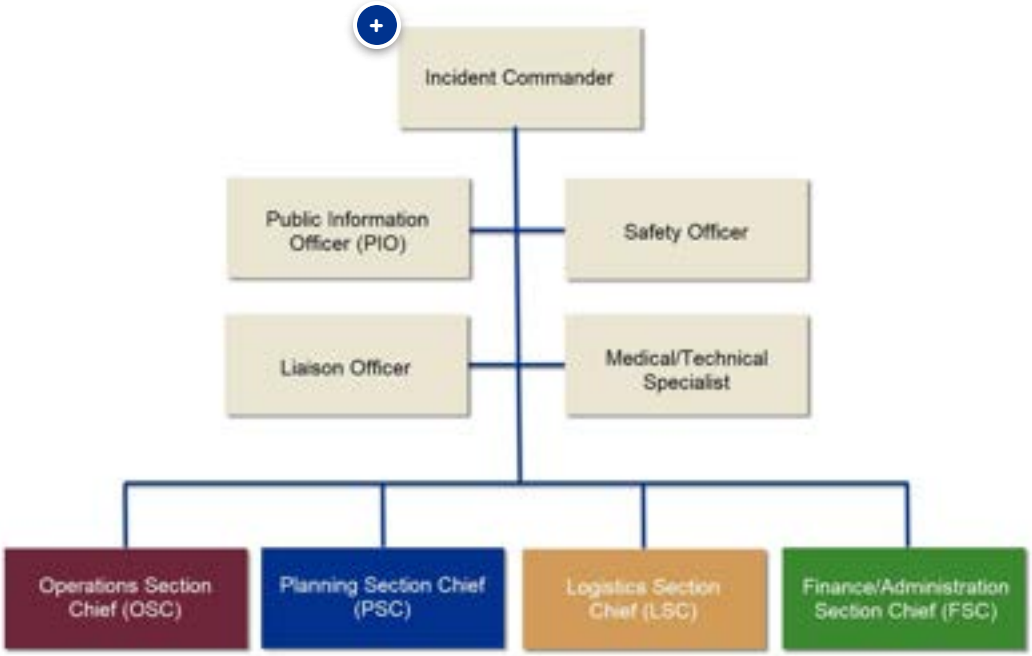
- Facilities/Engineering
- Environmental safety

Positions of HICS

Command staff includes the Incident Commander, the Public Information Officer, the Safety Officer, The Liaison Officer, and the Medical or Technical Specialist.

Click the plus signs (+) below to learn more about the roles.

Incident Commander
Public Information Officer (PIO)
Safety Officer
Liaison Officer
Medical/Technical Specialist
Operations Section Chief (OSC)
Planning Section Chief (PSC)
Logistics Section Chief (LSC)
Finance/Administration Section Chief (FSC)



Incident Commander

The overall authority for the direction and scale of the response. Typically, this person would be a hospital supervisor or administrator.

Public Information Officer

Works with Incident Commander to coordinate messaging to staff, patients, and family and the community at large.

Safety Officer

Singularly focused on responder (caregiver) safety. They are the only person other than the Incident Commander who can stop response operations if safety is a concern.

Liason Officer

Works with any outside responding agencies (eg county government, law enforcement, etc) as a representative of the hospital.

Medical/Technical Specialist

Subject matter expert (SME) selected based on the nature of the incident.
Examples:

- A flooding ceiling SME would be an engineer
- A pandemic SME would be an infectious disease specialist

Operations Section Chief

Is responsible for the tactical operations (mass casualty incident or MCI, HazMat, electrical outage, etc.) during an event such as patient care and security

Planning Section Chief

Collects and evaluates information, monitors resources, and maintains documentation for the incident

Logistics Section Chief

Provides support for the incident to include supplies, equipment, and staff

Finance/Administration Section Chief

Manages all accounting, funding, time keeping, and costs during an incident

Complete the content above before moving on.

Emergency Preparedness is Everyone's Responsibility

A successful response to an emergency depends on caregivers understanding what to do for each overhead page. Caregivers should follow normal chain of command, unless directed otherwise, and be adaptable to changing situations.

Caregiver and patient safety are our first priority and understanding your role in an emergency is critical to achieving that goal.

Many lives may depend on a quick response. One way we ensure this is building skills with training and exercises. Disaster training helps ensure that caregivers will be ready to provide a quick and effective response.

There are people at your ministry who specialize in preparing you and your colleagues for emergencies.

Check with your supervisor to better understand your role and your departments role during disaster response.

CONTINUE

Emergency Response

During an Emergency

- Protect yourself, triage self and area, report problems, provide assistance
- Be aware of your surroundings and ready for further directions from the overhead paging system
- Be aware that during emergencies, your ministry is functioning under its Emergency Operations Plan
- Follow your normal chain of command and operational procedures unless instructed otherwise, and await direction and additional information as it is available
- Always communicate clearly with plain language

CONTINUE

Evacuation

While some incidents may require moving from one part of the hospital to another, a full hospital evacuation is an extremely rare and serious event.

Evacuation Types

Click the tabs below to learn more about evacuation.

HOSPITAL BUILDING | CLINICS/ MEDICAL OFFICE BUILDINGS

Evacuation will not occur unless you have been directed to do so by an Administrator, Public Safety (i.e., police, fire), a Nursing Supervisor, or designated Incident Commander.

Types of evacuation in an acute care setting include **horizontal** and **vertical** evacuation.

- **Horizontal evacuation** means to move from one smoke compartment to another. For instance, an active fire on one side of a unit would force staff to move themselves and patients to the other side of a fire door.
- **Vertical evacuation** means to move to a different floor or empty the entire building of people. For instance, if a hospital were to fall in a designated evacuation zone for an approaching wildfire, a vertical evacuation would likely be necessary.

HOSPITAL BUILDING

CLINICS/ MEDICAL OFFICE BUILDINGS

During a fire or other emergencies, caregivers, patients, and guests will immediately evacuate to outside of the building to your assembly area to await further instruction.

If you do not have pre-determined areas, check with your manager for more specific information.

A third option would be to Defend in Place.

Defend in Place means you should be listening for directions and have a heightened awareness while continuing your normal work.

One example of a defend in place scenario is a brief power outage.

Complete the content above before moving on.

Bonus Tips for Personal Preparedness

- Be prepared! Have emergency kits at home, work, and in your car.
- Make a plan for those you love including children, the elderly, and your pets
- Get first aid/safety training (refer to your previous safety training for the specifics)
- Have a week's worth of medications ready for you and your family
- Aim to have a 3-day food and water supply
- Ensure a fire extinguisher is in your home

CONTINUE

Conclusion

- Know your unit's specific disaster plan and standard operating procedures
- Know your department's escape routes, gathering place and evacuation priorities
- Know the location of your department's disaster equipment and supplies
- Understand that critical information will be cascaded through your core leader from the command center during an emergency
- Be aware that your ministry has an Emergency Operations Plan and leadership on site who have been trained in incident management skills

Congratulations! You have completed this eLearning module. Click the Exit Course link above to return to close this window.

If you want to learn more about emergency management, there are free courses you can take through the Federal Emergency Management Agency (FEMA).

We suggest beginning with the introductory courses of IS-100, IS-200, and IS-700. These courses can be taken by clicking here. FEMA IS-800, ICS-300 and ICS-400 are the next steps in building a more robust foundation in ICS proficiency.

The IS-800 course and exam can be taken online here. ICS-300 and ICS-400 are multi-day in-person courses focused on a large-scale expanding incidents.

Infection Prevention

This course is part of a series of regulatory requirements for New Caregiver Orientation

- **Introduction**
- **Standard Precautions**
- **Hand Hygiene**
- **Personal Protective Equipment (PPE)**
- **Transmission-Based Precautions (Isolation)**
- **Multi-Drug Resistant Organisms**
- **Tuberculosis (TB)**
- **Respiratory Hygiene/Cough Etiquette for Patients and Caregivers**
- **Cleaning and Disinfection**
- **Bloodborne Pathogens**

- Sharps Safety
- Injection Safety
- Biohazardous Waste and Spills
- High-Consequence Infectious Diseases/Special Pathogens
- Important Caregiver Health Considerations

Introduction

Welcome!

Infection Prevention is critical for the safety of both our patients and caregivers. This module will provide you with the information you need to prevent the spread of infection.

Upon completion of this course, learners will be able to:

- Know when to use hand hygiene
- Don and doff Personal Protective Equipment (PPE) correctly
- Incorporate Infection Prevention practices to reduce the spread of infection
- Know how to look for the different isolation precautions
- Know when to use Standard Precautions
- Perform respiratory hygiene/cough etiquette
- Understand how to prevent bloodborne pathogen exposure
- Recognize how to appropriately handle, clean, and disinfect medical equipment, instruments, and devices
- Prevent and control the spread of Multi-Drug Resistant Organisms (MDROs)
- Handle sharps safely
- Know the steps to take to properly dispose of biohazardous waste

CONTINUE

Infections can spread easily in healthcare facilities. Hospital-acquired infections are common and can be deadly. Infection Prevention practices are an important way to break the chain of infection and prevent hospital-acquired infections.

Break the Chain of Infection

There are many different germs and infections inside and outside of the healthcare setting. Despite the variety of viruses and bacteria, germs spread from person to person through a common series of events. **Therefore, to prevent germs from infecting more people, we must break the chain of infection.**

Complete the content above before moving on.

Providence has Infection Preventionists for many locations! Be sure to ask your supervisor how to contact the Infection Preventionist assigned to your location.

An Infection Preventionist is responsible for preventing and controlling the spread of infections.

Keeping our patients and caregivers safe is their number one priority.

If you have questions or would like to offer feedback about your local Infection Prevention Program procedure or policies, please refer to your local Infection Preventionist or NCO virtual buddy.

Infection Prevention and You

Who are infection preventionists?

Infection preventionists use their detective skills to find the bad germs and make sure everyone is doing the right things to keep you safe.

Catheters or other devices will be placed in your body after your skin receives proper cleaning.

Your healthcare workers will wear gloves, gowns, and masks at the right times.

If you are in isolation, you and your visitors may need to do this too.

Healthcare workers will clean their hands before and after they care for you.

Your room and any equipment that is used on you will be clean.

APIC Association for Professionals in Infection Control and Epidemiology

www.apic.org/InfectionPreventionandYou

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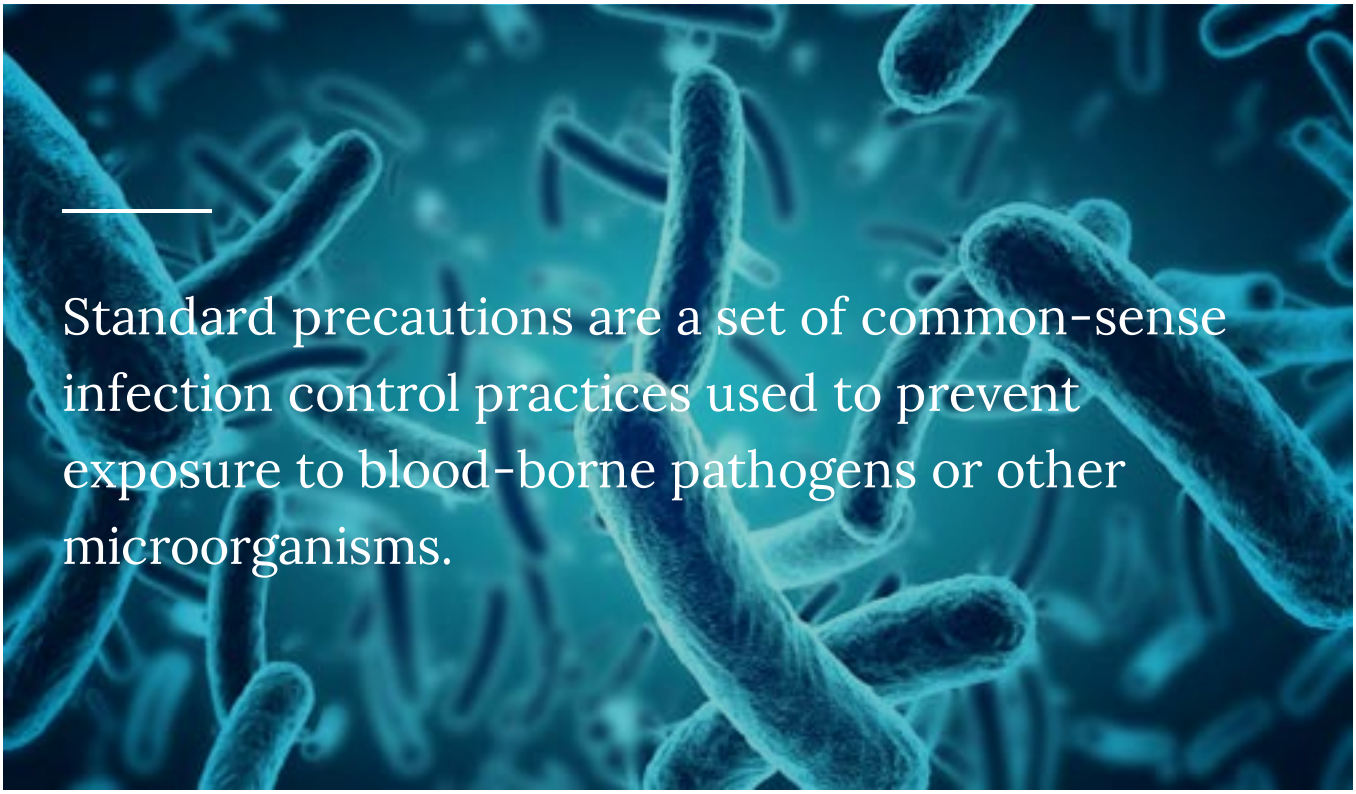
CONTINUE

Standard Precautions



Standard precautions should be used by all caregivers at all times.

This applies to both clinical and non-clinical caregivers and every patient (regardless of diagnosis) as well as any supplies, equipment, or materials that might have blood or other potentially

infectious materials.

Even patients who look and feel healthy can carry germs in their blood or body fluids that can transmit illness to another person without the use of Standard Precautions.

Standard Precautions Include:

- [ ] Hand hygiene
- [ ] Personal protective equipment (PPE)
- [ ] Appropriate patient placement (Isolation precautions)
- [ ] Respiratory hygiene / cough etiquette
- [ ] Appropriate handling, cleaning, and disinfection of medical equipment, instruments and devices
- [ ] Appropriate handling of linens
- [ ] Sharps safety and safe injection practices (Clinical Caregivers Only – will be shared during clinical orientation)
- [ ] Proper disposal of biohazardous waste

CONTINUE

Hand Hygiene

Hand hygiene is the number one way to prevent the spread of infection!

Compliance with the proper hand hygiene is an expectation of all caregivers.

Access to hand hygiene products is provided in all work locations.

Hand hygiene will be performed before or after the following activities:

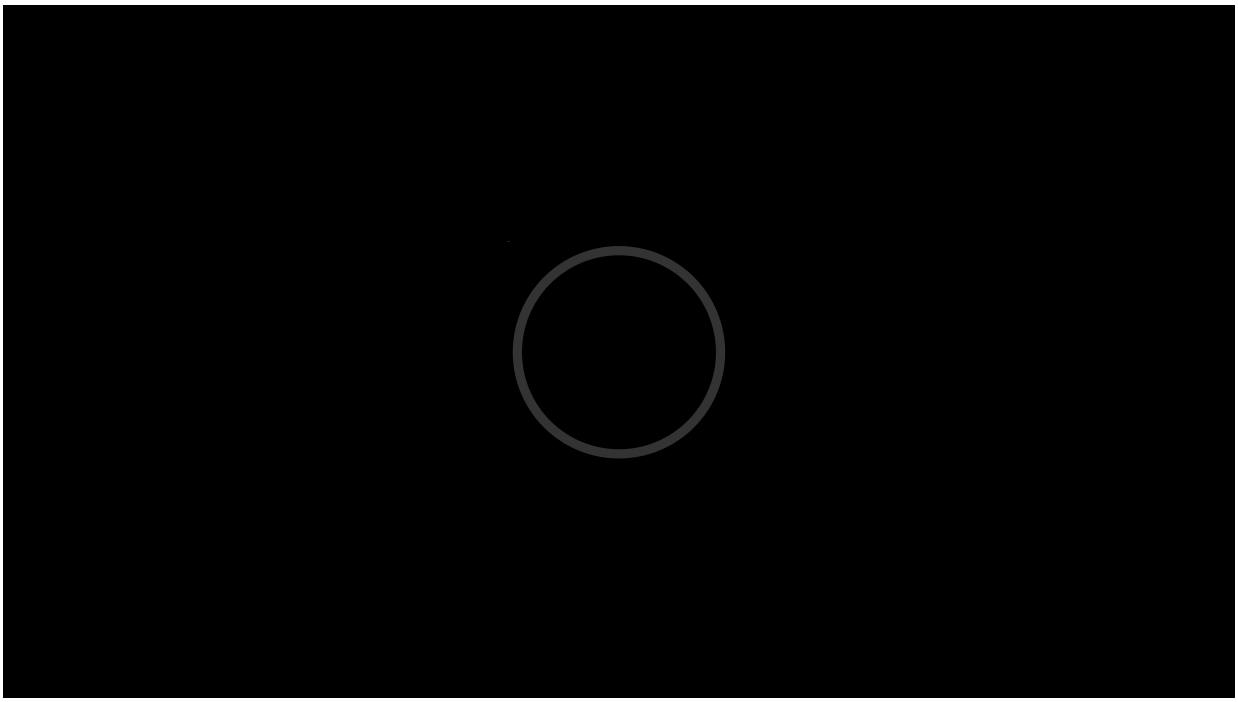
Indication	Product Selection
• After personal restroom use • Before preparing food or eating • After direct contact with blood or body fluids (without gloves)	Soap and water

• When leaving the room of a patient in Special Contact/Contact Enteric precautions, regardless of glove use or contact with the patient or the environment	
• Before putting on gloves or other PPE (e g., gown or mask) • Upon entering patient room, before touching the patient • Before a clean/aseptic task like handling an invasive device for patient care (e g, indwelling urinary catheters, central lines, drains, etc.) regardless of glove use • During care of the same patient, when moving between a contaminated body site to another clean body site (e g., pericare to central line dressing change) • After contact with patient surroundings (e g., IV pumps, suction containers) • Upon exiting patient room or after touching the patient • After removing gloves or other PPE (e g., gown or mask)	Alcohol Based Hand Sanitizer (ABHS) or soap and water

CONTINUE

Watch the video below to learn how to clean your hands.

VIMEO



Infection Prevention - Hand Washing

This video outlines the proper methods of hand washing and hand sanitizing.

VIEW ON VIMEO >

Handwashing Steps

1 First, wet hands with water

2. Apply soap to hands. Spread soap over entire area of hands, wrists, under nails, thumb and between fingers

3. Rub hands together vigorously for at least 15 seconds

4. Rinse hands with water and dry thoroughly with a disposable towel

5. Use towel to turn off faucet. If possible, use the same towel to open the door

If possible, use the same towel to open the door if needed.

To download a copy of the How to Handwash poster created by WHO, please click the link below.

PDF **how-to-handwash-poster.pdf**
457.3 KB

Alcohol Based Hand Rubs

1. When decontaminating hands with an alcohol-based hand rub, apply product to palm of one hand and rub hands together, covering all

surfaces of hands and wrists including the fingers, thumb, and nails until hands are dry

2 It should take 20 seconds for hands to dry, if an adequate volume of alcohol-based hand rub is used

3 Adhere to the manufacturer's instructions for use

Alcohol needs contact time and air drying to be effective to kill germs.

Never towel dry.

To download a copy of the How to Handrub poster created by WHO, please click the link below.

PDF **how-to-handrub-poster.pdf**
426.2 KB

CONTINUE

Fingernails

Nail grooming is essential for good hand hygiene. Fingernails should not extend beyond the fingertips. Chipped nail polish promotes the growth of micro-organisms on fingers; therefore, **nail polish should be in good condition with no chipping.**

Artificial nails are substances or devices applied or added to the natural nails to extend or augment (e.g., sculpt or shape) the wearer's own nails. These include bonding, extensions or tips, acrylic overlays, resin wraps, or acrylic fingernails. They have been proven to harbor micro-organisms and cannot be worn by caregivers who have direct contact with patients and supplies that touch the patient or the patient environment.

This includes and is not limited to:

1. Entering the patient's room
2. Exams, procedures, treatments, nursing care, or surgery
3. Preparing or dispensing medication or blood products for patient use (e.g., Nursing, Pharmacy, Lab)
4. Preparing equipment or supplies for patient use (e.g., Materials Management)
5. Preparing food, beverages, and/or serving food
6. Working in the Operating Room (OR) and Sterile Processing Department (SPD)

The use of gloves does not affect the restriction on long or artificial nails.

CONTINUE

Hand Sanitizing Products and Hand Lotions

Only institutionally provided and approved hand sanitizers, hand lotions and creams are used by caregivers in the clinical setting.

Approved hand sanitizers, hand lotions and creams have been evaluated for interactions with hand care products and gloves.

Healthcare workers with hand/skin irritation should discuss their concerns with their supervisor and Caregiver Health Services to develop a plan for resolving the irritation.

CONTINUE

Compliance

Compliance with hand hygiene is monitored routinely in all patient care areas by one of the following methods: independent direct observations, self-direct observations, peer and / or patient observation.

Barriers to performing job duties which require hand hygiene will be evaluated on a case by case basis in conjunction with local infection prevention, Caregiver Health and HR.

Any caregiver who wears a brace, cast, splint, or other device which covers part or all of the hand or wrist should be evaluated to determine if alternative options are available.

Any breaks in skin integrity (cuts and abrasions) on the hands and wrist should be covered with a clean water-resistant bandage and the bandage should remain clean, dry, and intact.

For more information about our Hand Hygiene policy, refer to PolicyStat here.

CONTINUE

Personal Protective Equipment (PPE)

Use whatever PPE is necessary to prevent contact with patients' blood, body fluids, mucous membranes, secretions, excretions and non-intact skin. Non-intact skin includes rashes, skin sores and open wounds even if no drainage is present. Your employer is responsible for providing and training on how to use PPE, and you are responsible for wearing it correctly.

There are various types of PPE and many factors influencing PPE selection.

Click on the plus signs (+) below to learn more about each type of PPE and when to use.

Gloves

Gloves are a protective barrier for hands.
Use when touching blood, body fluids, secretions, excretions, contaminated items; for touching mucus membranes and nonintact skin.
Change gloves:

- During use if torn and when heavily soiled (even during use on the same patient)

- After use on each patient (never use the same gloves for more than one patient)

Exam and surgical gloves are never reused or washed.
Gloves are removed when the need for protection no longer exists and hand hygiene should be practiced immediately after removal of gloves.
If worn with a gown, the gloves should extend over the cuff of the gown to make sure no skin is left uncovered.
Limit opportunities for "touch contamination" - protect yourself, others, and the environment:

- Don't touch your face or adjust PPE with contaminated gloves
- Don't touch environmental surfaces except as necessary during patient care
- Do not wear gloves when walking in hallways or outside of patient care areas

Gowns/Aprons

Gowns and/or aprons are a protective barrier for skin and clothing.

- Always use for patient in Contact precautions
- Use whenever there is the possibility that your clothing or skin might come in contact with patients' blood or body fluids or non-intact skin
- Fluid resistance matters – choose the right gown for the task
- Gowns should never be reused and should be discarded at point of use (non-disposable gowns should be placed in a soiled linen hamper for laundering)

Face Protection

Choose the right type based on anticipated exposure.
Use during patient care activities likely to generate splashes or sprays of blood, body fluids, secretions, or excretions.

Masks – protect nose and mouth from splash and inhalation of droplets

- Should fully cover nose and mouth

- Always use for patients in Droplet Precautions or with any patient who is coughing or sneezing.
- Under most situations, masks are only used once and discarded. Talk to your supervisor about what situations might cause extended use or re-use.

Goggles – protect eyes

- Should fit snugly over and around eyes
- Personal glasses are not a substitute for eye protection
- Antifog feature improves clarity

Face shields- protect face, nose, mouth, and eyes

- Should cover the front and sides of the face

If face protection is reusable, disinfect after use and/or if contaminated. For extended use and reuse, refer to your local training/policies.

Respirators

The purpose of respiratory protection is to protect from inhalation of infectious aerosols (e.g., Mycobacterium tuberculosis).
PPE types for respiratory protection:

- Particulate respirators (N95)
- Half- or full-face elastomeric respirators
- Powered air purifying respirators (PAPRs/ CAPRs)

All respirators require medical clearance and training and some require fit-testing before use. Do not use a respirator unless you have been trained on that specific respirator type by designated staff within PSJH.

Respirators should be donned and removed outside of the patient room.

Respirators are required for high hazard procedures and must always be used for the following:

1. Patients on Airborne precautions
2. If the patient is receiving an aerosol generating procedure (AGP) like open suctioning of airways, sputum induction or bronchoscopy and there is concern that the patient has a respiratory virus like COVID or influenza
3. During LEEP procedures

Examples of AGP procedures from CDC:

- Open suctioning of airways
- Intubation/extubation
- Bronchoscopy
- CPR
- Sputum induction
- Non-invasive ventilation (e.g., BIPAP, CPAP)
- Manual ventilation

Complete the content above before moving on.

Key Points to Remember:

- [ ] Perform hand hygiene immediately before donning
- [ ] Don before contact with the patient, generally before entering the room
- [ ] Remove and discard carefully either at the doorway or immediately outside patient room

- [ ] Perform hand hygiene immediately after removal

- [ ] Only staff who have been medically screened and trained/fit tested may put on a respirator. This is for your own safety to assure it is providing effective protection for you.

Click on the arrows below (<>) to review a few examples on how to safely don and doff your PPE.

SEQUENCE FOR PUTTING ON PERSONAL PROTECTIVE EQUIPMENT (PPE)

The type of PPE used will vary based on the level of precautions required, such as standard and contact, droplet or airborne infection isolation precautions. The procedure for putting on and removing PPE should be tailored to the specific type of PPE.

1. GOWN

- Fully cover torso from neck to knees, arms to end of wrists, and wrap around the back
- Fasten in back of neck and waist

2. MASK OR RESPIRATOR

- Secure ties or elastic bands at middle of head and neck
- Fit flexible band to nose bridge
- Fit snug to face and below chin
- Fit-check respirator

3. GOGGLES OR FACE SHIELD

- Place over face and eyes and adjust to fit

4. GLOVES

- Extend to cover wrist of isolation gown

USE SAFE WORK PRACTICES TO PROTECT YOURSELF AND LIMIT THE SPREAD OF CONTAMINATION

- Keep hands away from face
- Limit surfaces touched
- Change gloves when torn or heavily contaminated
- Perform hand hygiene

CDC

HOW TO SAFELY REMOVE PERSONAL PROTECTIVE EQUIPMENT (PPE) EXAMPLE 1

There are a variety of ways to safely remove PPE without contaminating your clothing, skin, or mucous membranes with potentially infectious materials. Here is one example. **Remove all PPE before exiting the patient room** except a respirator, if worn. Remove the respirator **after** leaving the patient room and closing the door. Remove PPE in the following sequence:

1. GLOVES

- Outside of gloves are contaminated!
- If your hands get contaminated during glove removal, immediately wash your hands or use an alcohol-based hand sanitizer
- Using a gloved hand, grasp the palm area of the other gloved hand and peel off first glove
- Hold removed glove in gloved hand
- Slide fingers of ungloved hand under remaining glove at wrist and peel off second glove over first glove
- Discard gloves in a waste container

2. GOGGLES OR FACE SHIELD

- Outside of goggles or face shield are contaminated!
- If your hands get contaminated during goggle or face shield removal, immediately wash your hands or use an alcohol-based hand sanitizer
- Remove goggles or face shield from the back by lifting head band or ear pieces
- If the item is reusable, place in designated receptacle for reprocessing. Otherwise, discard in a waste container

3. GOWN

- Gown front and sleeves are contaminated!
- If your hands get contaminated during gown removal, immediately wash your hands or use an alcohol-based hand sanitizer
- Unfasten gown ties, taking care that sleeves don't contact your body when reaching for ties
- Pull gown away from neck and shoulders, touching inside of gown only
- Turn gown inside out
- Fold or roll into a bundle and discard in a waste container

4. MASK OR RESPIRATOR

- Front of mask/respirator is contaminated — DO NOT TOUCH!
- If your hands get contaminated during mask/respirator removal, immediately wash your hands or use an alcohol-based hand sanitizer
- Grasp bottom ties or elastics of the mask/respirator, then the ones at the top, and remove without touching the front
- Discard in a waste container

5. WASH HANDS OR USE AN ALCOHOL-BASED HAND SANITIZER IMMEDIATELY AFTER REMOVING ALL PPE

PERFORM HAND HYGIENE BETWEEN STEPS IF HANDS BECOME CONTAMINATED AND IMMEDIATELY AFTER REMOVING ALL PPE

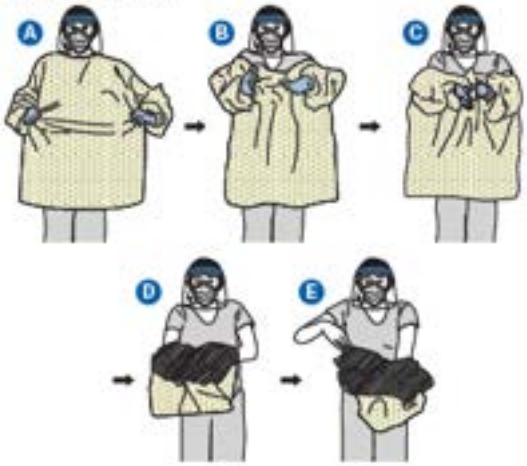
CDC

HOW TO SAFELY REMOVE PERSONAL PROTECTIVE EQUIPMENT (PPE) EXAMPLE 2

Here is another way to safely remove PPE without contaminating your clothing, skin, or mucous membranes with potentially infectious materials. **Remove all PPE before exiting the patient room** except a respirator, if worn. Remove the respirator after leaving the patient room and closing the door. Remove PPE in the following sequence:

1. GOWN AND GLOVES

- Gown front and sleeves and the outside of gloves are contaminated!
- If your hands get contaminated during gown or glove removal, immediately wash your hands or use an alcohol-based hand sanitizer
- Grasp the gown in the front and pull away from your body so that the ties break, touching outside of gown only with gloved hands
- While removing the gown, fold or roll the gown inside-out into a bundle
- As you are removing the gown, peel off your gloves at the same time, only touching the inside of the gloves and gown with your bare hands. Place the gown and gloves into a waste container



2. GOGGLES OR FACE SHIELD

- Outside of goggles or face shield are contaminated!
- If your hands get contaminated during goggle or face shield removal, immediately wash your hands or use an alcohol-based hand sanitizer
- Remove goggles or face shield from the back by lifting head band and without touching the front of the goggles or face shield
- If the item is reusable, place in designated receptacle for reprocessing. Otherwise, discard in a waste container

3. MASK OR RESPIRATOR

- Front of mask/respirator is contaminated — DO NOT TOUCH!
- If your hands get contaminated during mask/respirator removal, immediately wash your hands or use an alcohol-based hand sanitizer
- Grasp bottom ties or elastics of the mask/respirator, then the ones at the top, and remove without touching the front
- Discard in a waste container

4. WASH HANDS OR USE AN ALCOHOL-BASED HAND SANITIZER IMMEDIATELY AFTER REMOVING ALL PPE

PERFORM HAND HYGIENE BETWEEN STEPS IF HANDS BECOME CONTAMINATED AND IMMEDIATELY AFTER REMOVING ALL PPE

CDC

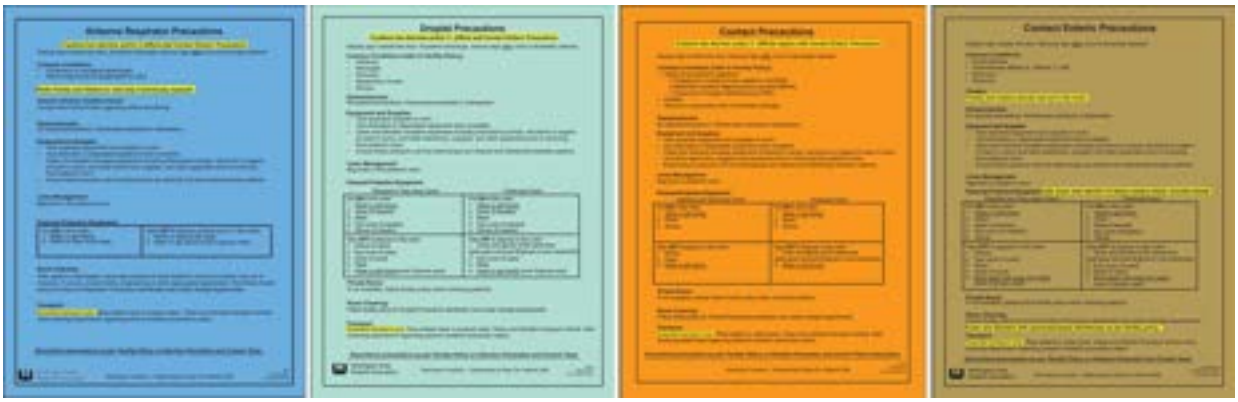
Complete the content above before moving on.

Transmission-Based Precautions (Isolation)

Transmission-based precautions (also known as isolation) are used for patients with specific infectious diseases. You must follow the instructions on the sign before entering the room.

Although the signs may look different in each region, the content will be very similar.

Transmission-based precautions **DO NOT** replace standard precautions, they are always used in addition to standard precautions.



The isolation sign will tell you what PPE **MUST** be worn to enter the room, regardless of what activity you plan to perform or amount of patient contact you intend to have.

When an isolation sign includes the word "respirator" you may only enter if you have been trained, fit tested, and may only wear the specific type of respirator on which you have been trained.

Please note that your state or local area may have additional guidance (ex: Cal/OSHA for California).

CONTINUE

Multi-Drug Resistant Organisms

Some examples include:

- MRSA (Methicillin Resistant Staphylococcus aureus)
- VRE (Vancomycin Resistant Enterococci)
- CRE (Carbapenem Resistant Enterobacteriaceae)
- ESBL (Extended Spectrum Beta Lactimase)

- C. auris

The prevention and control of MDROs is a national priority, and includes the following strategies:

- Hand hygiene
- Isolation precautions (in some cases)
- MDRO monitoring and alerting
- Bundle strategies to prevent device-associated and surgical site infections
- Appropriate cleaning and disinfection
- Patient and family education
- Appropriate use of antimicrobials

Antimicrobial Stewardship

Upwards of 50% of antibiotic use in hospitals are unnecessary or inappropriate. Antibiotic overuse contributes to antibiotic resistance, C. diff infection, increased cost, and worse patient outcomes.

Antimicrobial stewardship is the practice of optimizing antibiotic therapy including drug selection, dosing, and duration of therapy.

- Primary strategies: Prospective audit and feedback (ie. review of antibiotics with the intent of providing feedback to prescriber) and preauthorizing (i.e., requiring preapproval of certain antibiotics before prescribing)
- Secondary strategies: Education, local guidelines, clinical pathways / order sets

CONTINUE

Tuberculosis (TB)

What is an Aerosol Transmissible Disease (ATD)?

An ATD is a disease transmitted by aerosols (gaseous suspension of fine solid/liquid particles) through sneezing or coughing.

Click or tap each icon below to review possible signs and symptoms of ATDs.

TB

- Prolonged cough >3 weeks
- Night sweats
- Bloody sputum

Measles or Chickenpox

- Rash all over the body

> **Note: the symptoms will depend on the infectious disease present.**

What are some examples of ATDs?

Aerosol Transmissible Diseases include Chickenpox, Measles, Disseminated Herpes Zoster (Shingles), Severe Acute Respiratory Syndrome (SARS), Tuberculosis, and Middle East Respiratory Syndrome (MERS).

Complete the content above before moving on.

What is Tuberculosis?

Tuberculosis (TB) is caused by a bacterium called *Mycobacterium tuberculosis*. The bacteria usually attack the lungs, but TB bacteria can attack any part of the body such as the kidney, spine, and brain. Not everyone infected with TB bacteria becomes sick. As a result, two TB-related conditions exist:

- Latent TB infection (non-infectious)
- Active TB disease (infectious)

If not treated properly, TB disease can be fatal.

How is tuberculosis transmitted?

TB bacteria are spread through the air from one person to another. The TB bacteria are put into the air when a person with active TB disease of the lungs or throat coughs, speaks, or sings. People nearby may breathe in these bacteria and become infected.

Symptoms of TB disease depend on where in the body the TB bacteria are growing. TB bacteria usually grow in the lungs (pulmonary TB).

Click the cards below to learn what symptoms you might see in someone with TB.

Symptoms of TB

- A bad cough that lasts 3 weeks or longer
- Pain in the chest
- Coughing up blood or sputum (phlegm from deep inside the lungs)

Additional **Symptoms of TB**

- Weakness or fatigue
- Weight loss
- No appetite
- Chills
- Fever
- Sweating at night

Complete the content above before moving on.

Symptoms of TB disease in other parts of the body depend on the area affected.

Precautions

If a patient is exhibiting signs/symptoms suspicious for TB, the following measures should be taken:

- **Ensure appropriate patient placement in an airborne infection isolation room (AIIR), i.e., negative pressure room**. In settings where Airborne Precautions cannot be implemented due to limited engineering resources, masking the patient and placing the patient in a private room with the

door closed will reduce the likelihood of airborne transmission until the patient is either transferred to a facility with an AIIR or returned home.

- **Use personal protective equipment (PPE) appropriately,** including a fit-tested NIOSH-approved N95 or higher level respirator for healthcare personnel.
- **Limit transport and movement of patients** outside of the room to medically-necessary purposes. If transport or movement outside an AIIR is necessary, instruct patients to wear a surgical mask, if possible, and observe Respiratory Hygiene/Cough Etiquette.

Risk factors for getting TB

Health care personnel should be considered to be at increased risk for TB if they answer "yes" to any of the following statements.

1. Temporary or permanent residence (for ≥1 month) in a country with a high TB rate (i.e., any country other than Australia, Canada, New Zealand, the United States, and those in western or northern Europe) **OR**
2. Current or planned immunosuppression, including human immunodeficiency virus infection, receipt of an organ transplant, treatment with a TNF-alpha antagonist (e.g., infliximab, etanercept, or other), chronic steroids (the equivalent of prednisone ≥15 mg/day for ≥1 month), or other immunosuppressive medication **OR**
3. Close contact with someone who has had infectious TB disease since their last TB test

Reducing the risk of TB transmission in our clinical settings:

Administrative Controls **Engineering Controls**

- Written exposure control plan
- Training
- Early isolation and identification
- Annual risk assessment
- Follow local public health guidance for discharge or transfer of TB patients
- Properly functioning negative pressure isolation rooms

Respiratory protection (PPE)

Caregivers working in airborne isolation rooms or near patients with known or suspected TB.

- Powered air purifying respirators (PAPRs)
- N95 respirators after proper training, testing, and certification for use

PAPR/CAPR and N95 respirators need proper training. N95 respirators require fit testing prior to use and fit checking for proper seal before each use. Work with your local supervisor to learn more about fit testing.

CONTINUE

If you experience an exposure to Tuberculosis any other ATDs in the workplace, report this to Caregiver Health Services immediately.

TB Testing

Click the plus signs (+) below to learn more about TB testing in the workplace.

New Hire Baseline Process —

Upon hire, all health care personnel are screened for TB upon hire. The PSJH TB screening includes:

- A baseline individual TB risk assessment
- TB symptom evaluation,
- A TB test, most often a blood test (e.g., TB blood test or a TB skin test), and

- Additional evaluation for TB disease as needed, such as a chest x-ray

Information from the screening tools above is used to interpret the results. Health care personnel with a positive TB test will receive a chest x-ray to rule out TB disease. Additional evaluation may be needed based on those results.

Health care personnel with a documented history of a prior positive TB test receive a baseline individual TB risk assessment and TB symptom screen upon hire.

Annual Testing

Annual TB testing is performed where there is evidence of ongoing transmission or a regulatory requirement to do so. Compliance with annual testing is required.

Post - Exposure

Post-exposure testing is performed to help determine if an infection has occurred. A baseline test is performed and testing repeats at 8-10 weeks post last exposure unless directed otherwise by the local health department. Complying with post-exposure testing is required.

What happens if a caregiver has a positive TB test?
A caregiver with a positive TB test will require further evaluation. This may mean a repeat test, chest x-ray, and likely evaluation by a physician. The TB history, symptom, and risk assessment are all taken into consideration in determining what action is necessary.

Complete the content above before moving on.

What is the difference between TB and latent TB infection (LTBI)?

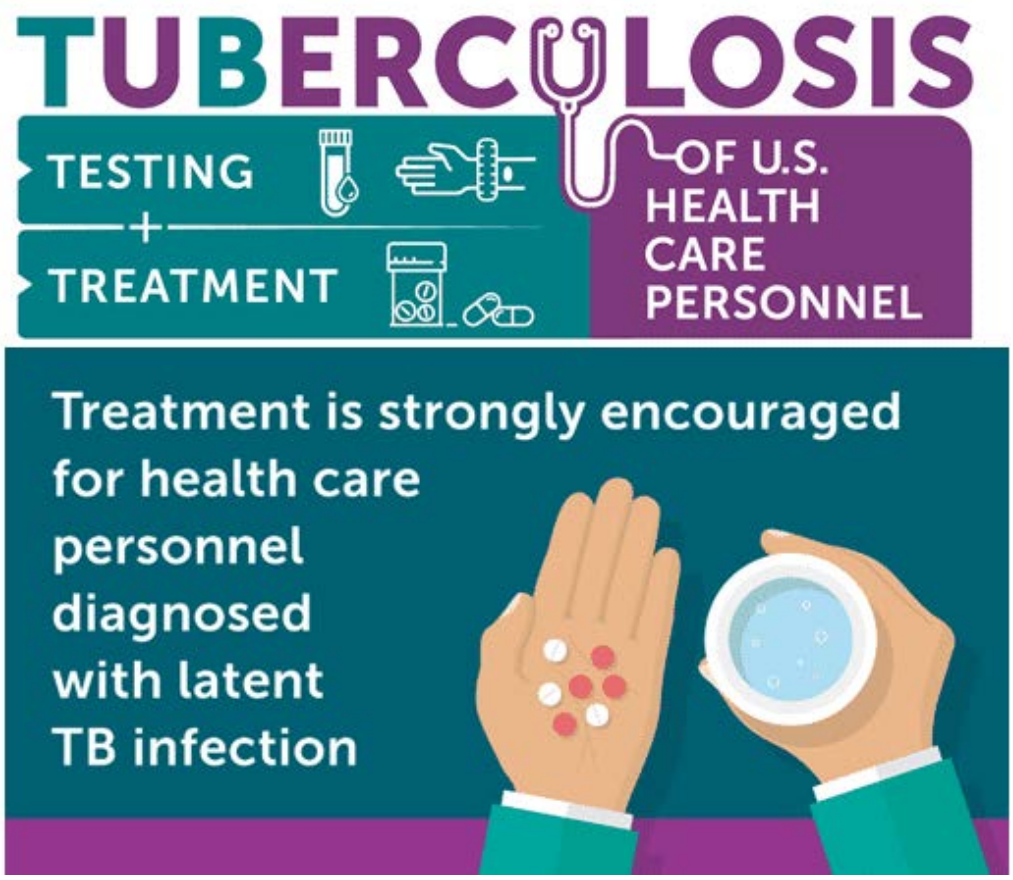
A Person with Latent TB Infection	A Person with TB Disease
Has no symptoms	**Has symptoms that may include:** • a bad cough that lasts 3 weeks or longer • pain in the chest • coughing up blood or sputum • weakness or fatigue • weight loss • no appetite • chills • fever • sweating at night
Does not feel sick	Usually feels sick
Cannot spread TB bacteria to others	May spread TB bacteria to others
Usually has a skin test or blood test result indicating TB infection	Usually has a skin test or blood test result indicating TB infection
Has a normal chest x-ray and a negative sputum smear	May have an abnormal chest x-ray, or positive sputum smear or culture
Needs treatment for latent TB infection to prevent TB disease	Needs treatment to treat TB disease

CONTINUE

Newest CDC guidelines

The Centers for Disease Control and Prevention (CDC) revised its guidelines for TB prevention in healthcare settings in 2019. Some of the primary changes are:

- A thorough TB testing and risk factor assessment for all healthcare personnel upon hire
- Annual surveillance only in areas with ongoing transmission
- Annual education for all healthcare personnel
- Identification and treatment for healthcare personnel with LTBI


TUBERCULOSIS
TESTING
+
TREATMENT
OF U.S. HEALTH CARE PERSONNEL
Treatment is strongly encouraged for health care personnel diagnosed with latent TB infection

CONTINUE

Respiratory Hygiene/Cough Etiquette for Patients and Caregivers

The following measures to contain respiratory secretions are recommended for all individuals with signs and symptoms of a respiratory infection:

- Cover your mouth and nose with a tissue when coughing or sneezing
- If tissue is not available, cough or sneeze into your elbow or sleeve
- Use the nearest waste receptacle to dispose of the tissue after use
- Perform hand hygiene after having contact with respiratory secretions and contaminated objects/materials

Healthcare facilities should ensure the availability of materials for adhering to Respiratory Hygiene/Cough Etiquette in waiting areas for patients and visitors.

- [ ] Provide tissues and no-touch receptacles for used tissue disposal
- [ ] Provide masks and separate persons with respiratory symptoms
- [ ] Provide conveniently located dispensers of alcohol-based hand rub. Where sinks are available, ensure that supplies for hand washing (i.e.,

soap, disposable towels) are consistently available.

CONTINUE

Cleaning and Disinfection

All patient supplies, linen, medical equipment, devices, and instruments must be cleaned and disinfected or sterilized according to the manufacturer's instructions for use before being used on a patient.

Linen is single patient use only and should be placed in a soiled linen bag immediately after use. Do not hold linen against your body or clothing, and avoid activities that agitate soiled linen. Wear a gown if contact between soiled linen and your clothing cannot be prevented.

Patient supplies are either single use or reusable.

- A vitals machine is an example of a reusable supply. Reusable items must be cleaned and disinfected between patient use.
- Examples of a single use patient supplies are gauze, tubing, and/or syringes. Patient single use supplies should be discarded immediately after use.

Patient equipment, devices, and instruments may be single use (use in a single procedure), single-patient use (use by a single patient), or reusable depending on the manufacturer's instructions for use. Any item that is reused must be either disinfected or sterilized according to the manufacturer's recommendations. You will be trained on the appropriate disinfection or sterilization practices for the items that you will use during the course of your work. If you are not trained or unsure about how to disinfect or sterilize a product, ask your supervisor.

Environmental surfaces are an important vehicle for the transmission of infection. Common high touch surfaces like bed rails, door handles, light switches, and keyboards require frequent disinfection .

In order for disinfectant to work, the surface being disinfected must remain wet for the amount of time indicated on the label. This is sometimes referred to as contact time, wet time or dwell time.

CONTINUE

Bloodborne Pathogens

According to OSHA, Bloodborne pathogens (BBP) are microorganisms that can be present in human blood and body fluids. People can have these pathogens in their blood and look and feel perfectly healthy, but can still infect and cause disease to others if they are exposed.

BBP can be transmitted through contact with contaminated blood and other potentially infectious material (such as body fluids) via direct contact with broken skin, mucous membranes or needle/instrument puncture. BBP exposures can also occur from splash or splatter to mucus membranes (i.e. eyes, mouth, etc.).

BBP are transmitted by sharing needles/syringes, unprotected sexual contact, mother-to-baby, or through sharps injuries/needle sticks.

Common BBP Facts

HIV	Hepatitis B	Hepatitis C
Most fragile of three viruses	Most easily transmitted of the three	Most common reason for liver transplant
Attacks immune system	May cause liver cancer	Most common chronic bloodborne infection in the US

HIV	Hepatitis B	Hepatitis C
Symptoms may start in 1-6 weeks: swollen glands, fever, fatigue, rash	Symptoms: jaundice, fatigue, abdominal or joint pain, nausea/vomiting	Symptoms: jaundice, fatigue, abdominal or joint pain, nausea/vomiting
Treatment can delay onset; no cure, no vaccine	Safe and effective vaccine available	No vaccine available; treatment now available

CONTINUE

To protect you, OSHA requires your facility to have a Bloodborne Pathogens Exposure Control plan. Your leader or designee can show you where this is located and can review this with you in a language that makes it easy to understand.

OSHA also requires your employer to offer Hepatitis B vaccination free of charge. This vaccine is 95% protective after the 3 dose series. Ask your supervisor or Caregiver Health Services how to receive the vaccine.

If you are exposed to blood or body fluid, perform first aid immediately and then report the exposure to your supervisor. Do not wait until the end of your shift. Follow the exposure process according to your specific facility, your supervisor can explain this to you if you are unsure. Medical follow-up and treatment will be provided if it is needed.

First aid for exposures:

- Gently wash wounds and skin with soap and water
- Flush splashes to the nose, mouth, or skin with water
- Irrigate eyes with clean water, saline, or sterile irrigant

CONTINUE

Sharps Safety

Sharps Containers are to be used for the disposal of:

- All used needles and syringes
- Syringes removed from their sterile packaging, even if not used

No item classified as a sharp, including syringes with needles, should ever be placed in a recycling container.

Check your local policy regarding sharps disposal.

When Handling Sharps, Remember:

- Be aware of your surroundings
- Stop if you feel rushed or distracted and focus on the task
- Avoid passing sharps and use verbal alerts when moving sharps
- Watch for sharps in linen, beds, on the floor and waste containers
- Hold bags with linen or medical waste away from your body when lifting or carrying
- Never reach into a sharps container to retrieve a sharp
- Be responsible for the device you are using
- Always activate sharps safety features
- Dispose of sharps in sharps containers only
- Keep fingers back from container opening when disposing of sharps
- Never recap needles
- Don't allow sharps containers to become overfull. Change before the fill line is reached or when ¾ full.

CONTINUE

Injection Safety

Injection Safety Guidelines

- [ ] Follow proper infection control practices and maintain aseptic technique during the preparation and administration of injected medications (e.g., disinfect skin, perform hand hygiene)
- [ ] Never administer medication from the same syringe to more than one patient, even if the needle is changed
- [ ] Never enter a vial with a used syringe or needle
- [ ] Do not use medications packaged as single-dose or single-use for more than one patient
- [ ] Do not use bags of intravenous solution as a common source of supply for more than one patient
- [ ] Limit the use of multi-dose vials and dedicate them to a single patient whenever possible. Label the syringe and date multi-use vials according to your ministry policies.
- [ ] Always use face masks when injecting material or inserting a catheter into an epidural or subdural space

Watch the video below to learn more about how to make injections safe.

YOUTUBE

Check Your Steps! Make Every Injection Safe

The One & Only Campaign urges healthcare providers to recognize the differences between single-dose vials and multi-dose vials, and to understand appropriate uses of each container type. This information can save lives. Created by the Safe Injection Practices Coalition, this short video details critical information to ensure every injection is a safe one.

VIEW ON YOUTUBE >

Click here for more information.

CONTINUE

Biohazardous Waste and Spills

Effective segregation and disposal of biohazardous waste are essential for preventing the spread of infections within the hospital. This helps maintain a sterile environment and reduces the risk of hospital-acquired infections (HAIs).

What do we consider biohazardous waste?

- [ ] Items with large amounts of blood; liquid or dried
- [ ] Human tissue
- [ ] Used instruments such as dirty scopes
- [ ] Leftover food from patient meals

SUBMIT

If blood is released when an item is compressed, it is considered biohazardous.

Complete the content above before moving on.

Handling Biohazardous Waste

- **Wear appropriate PPE**
- **Use a biohazard sticker on a closed container(i.e. transporting a dirty instrument in a closed container)**
  - Ensure that the biohazard stickers are visible on the lockable lid and sides of a rigid, leak-proof container
- **Use a biohazard bag if transporting heavily blood or body fluid soaked material (like wound dressing)**
  - Ensure that the bag is sealed prior to transporting
  - Discard biohazard waste in labeled biohazard bins

CONTINUE

In the event of a spill of biohazardous materials:

Click on the pulsing icons (+) below to learn how to handle biohazardous material spills.

Keep others away from spill

If spill is small, don appropriate PPE before cleaning

Pick up broken glass or sharps with a dust pan and a scraper or forceps (not hands) and place in a sharps container

Wipe up spill with a paper towel (not linen) or an absorbent pad.

Clean area with approved disinfectant

Repeat with a second application of disinfectant and allow to dry

Dispose of all items saturated with blood or other potentially infectious material in a red bag/ biohazardous waste container

Perform hand hygiene after removing PPE

For large spills, refer to your local policies.

CONTINUE

High-Consequence Infectious Diseases/Special Pathogens

Review the scenario below, then answer the questions that follow.

Mr. James Smith, a 45-year-old businessman, arrives at an urban emergency department (ED) complaining of fever, cough and shortness of breath. He appears visibly unwell and is sweating profusely. Upon initial questioning, he reveals that he recently returned from a business trip in the Arabian Peninsula, an area currently experiencing an outbreak of Middle East Respiratory Syndrome (MERS).

CONTINUE

Suspect patients with a high consequence infectious disease / special pathogen are more likely to be seen in emergency departments or urgent cares. To reduce the risk of exposure to others, protocols should focus on the following process:

- ○ Identify patients at high risk as soon as possible
- ○ Place the patient in appropriate isolation precautions
- ○ Inform your supervisor and other key stakeholders
- ○ All of the above

SUBMIT

It is important to identify patients with high consequence infectious diseases / special pathogens as soon as possible when entering the facility. What steps can be taken to reduce

risk of exposure to others?

- Provide masks at entrance
- Post signage with pictures to help self-identify need to put on a mask
- Ask what symptoms they have (e.g., respiratory, fever, rash)
- Ask about recent travel history
- All of the above

SUBMIT

Complete the content above before moving on.

Important Caregiver Health Considerations

Vaccinations are a key component in preventing disease transmission and most are available to you at no cost through Caregiver Health Services or through local pharmacies.

- Providence St. Joseph Health strongly supports caregiver vaccination and encourages you to be vaccinated for communicable diseases
- Your local regulatory agency or state law may mandate the use of masks in healthcare facilities if you do not receive the influenza and/or COVID-19 vaccine
- Caregiver Health can facilitate Hepatitis B immune globulin (HBIG) for employees who have had exposure without the vaccine. This is followed by the vaccination series.
- Your local regulatory or state law may mandate caregivers who are non-immune to a vaccine-preventable disease be furloughed from work after an exposure to a communicable disease. It is extremely important to know your immunity status and keep vaccinations up to date, to prevent communicable disease transmissions for yourself, family, co-workers, patients, and the community at large.

If you would like more information about the vaccines that are provided at no cost, please reach out to your local Caregiver Health team.

CONTINUE

DO NOT COME TO WORK SICK

Caregivers with the following symptoms should notify their core leader and Caregiver Health Services and not come to work:

- A fever of 100.0F or higher, by itself or with any of the following symptoms: shortness of breath, acute muscle pain, acute fatigue, loss of taste or smell cough, runny nose, or sneezing, sore throat, swollen glands in the neck or an undiagnosed rash
- Any draining skin lesions which cannot be contained by an occlusive dressing
- Redness and/or discharge from either eye
- Acute vomiting and/or diarrhea (3 or more loose stools in 24 hr.) such as gastroenteritis lasting longer than 24 hours, or which is accompanied by other symptoms (e.g. fever, abdominal cramps). This must be evaluated by their healthcare provider before returning to work.
- New, undiagnosed rash (+/-fever) must be evaluated by their primary care provider and cleared through Caregiver Health Services before returning to work

CONTINUE

Let's do a quick knowledge check comparing Employer and Employee responsibilities.

Drag each responsibility into the correct category.

EMPLOYER

Provide a safe environment, promote safe work habits

Ensure appropriate types and sizes of PPE are available

Provide training/education regarding BBP, including a BBP Exposure Control Plan

Document occupational injuries/exposures, retain records employment + 30 years

EMPLOYEE

Follow policies/procedures including all elements of BBP Exposure Control Plan

Use appropriate PPE as directed, report non functional or damaged PPE

Promptly report all worksite injuries and exposures

Receive training as required

Complete the content above before moving on.

Congratulations! You have completed this eLearning module. Click the Exit Course link above to close this window.

EMTALA Trends, Documentation, and Ethical Challenges for Obstetrical Care

1. EMTALA Trends, Documentation, and Ethical Challenges for Obstetrical Care

1.1 Intro

Notes:

1.2 Key Objectives

Notes:

1.3 EMTALA

Notes:

Developer
10-16 are linked
11-12 linked
13-15 linked

1.4 What is EMTALA?

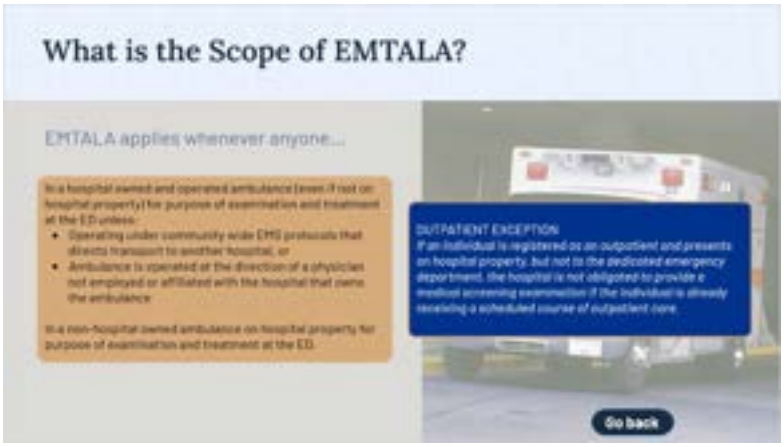
Notes:

1.5 Scope

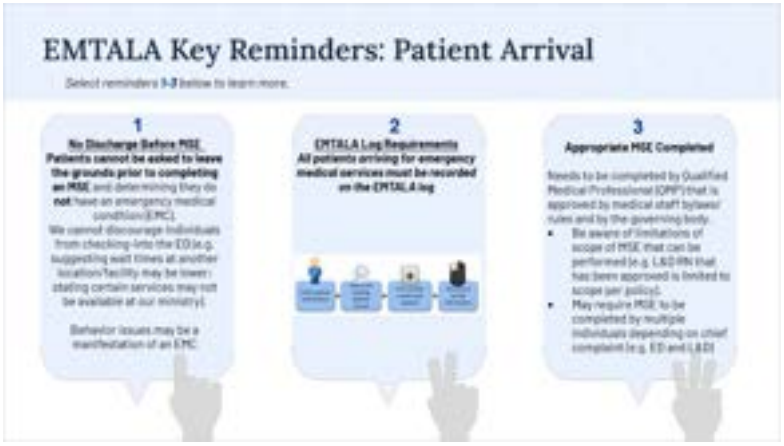
Notes:

Outside property (Slide Layer)

Ambulance (Slide Layer)



1.6 Key Reminders



Notes:

Developer 3 through 9 all go together
4 and 5 are linked
6-9 are linked

1.7 MSE & EMC

Notes:

Developer 3 through 10 all go together
4 and 5 are linked
6-10 are linked
10 should be last

1.8 Medical condition

Notes:

Developer 3 through 9 all go together
4 and 5 are linked
6-9 are linked

1.9 Emergency med cond

Notes:

Developer 3 through 9 all go together
4 and 5 are linked
6-9 are linked

ethical_religious directives (Slide Layer)

psych example (Slide Layer)

1.10 Transfer of Unstabilized Patient with EMC

Instance 1 (Slide Layer)

Instance 2 (Slide Layer)

Patient transfer (Slide Layer)

Documentation (Slide Layer)

1.11 ERDs

Notes:

Developer
10-16 are linked
11-12 linked
13-15 linked

1.12 Untitled Slide

Notes:

1.13 Untitled Slide

Notes:

Developer
10-16 are linked
11-12 linked
13-15 linked

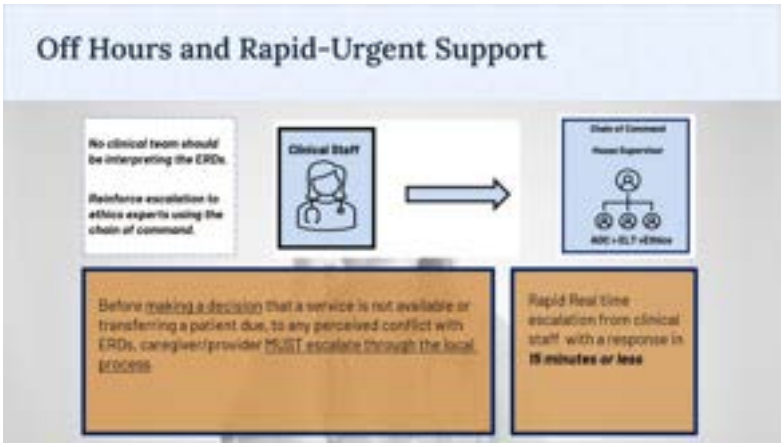
1.14 Untitled Slide

Notes:

Developer – can you make the two blue boxes buttons? See how below
Business Hours – Call local office number or operator between 8:00 and 16:00 M-F
Off Hours – see slide 15

Developer
10-16 are linked
11-12 linked
13-15 linked

1.15 Untitled Slide



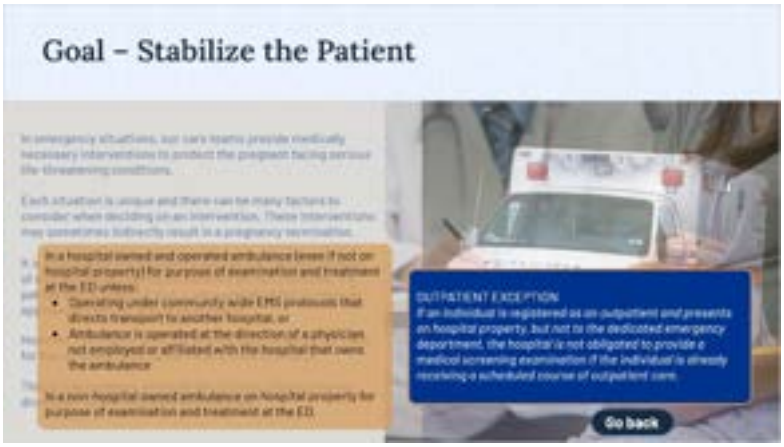
Notes:

1.16 Goals

Notes:

Outside property (Slide Layer)

Ambulance (Slide Layer)



1.17 Wrap-up

Notes:

Developer
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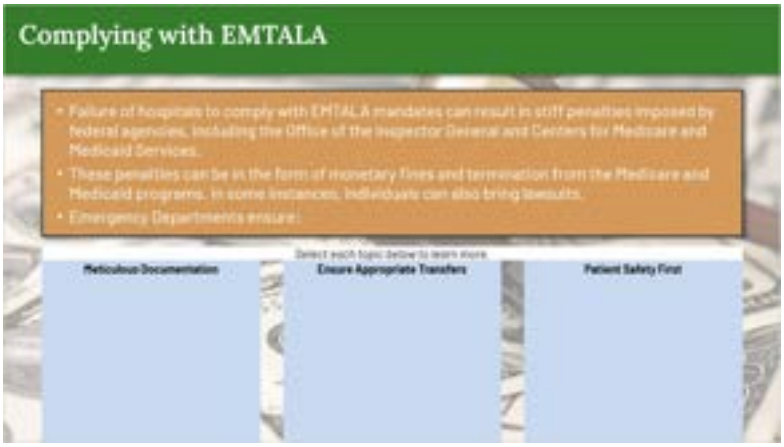
11-12 linked
13-15 linked

1.18 Complying with EMTALA



Notes:

Developer 16 and 17 Linked

1.19 Conclusion

Notes:

Patient Advocacy

This course is part of a series of regulatory requirements for New Caregiver Orientation

- **Introduction**
- **Patient Rights**
- **Patient Considerations and Sensitivity**
- **Serving the Patient in Their Time of Need**
- **Responding to Victims**
- **Safe Surrender/Safe Place Program**
- **Directives, Acts, and Preferred Language**

Introduction

Welcome!

Upon completion of this course, learners will be able to:

- Identify and report suspicion of abuse, neglect or exploitation
- Understand patient treatment and visitation rights

- Understand when Advance Healthcare Directives need to be implemented
- Know resources for interpretation services
- Know how to address a Safe Surrender/Safe Place Program situation
- Communicate with your patients according to Age Appropriate Care Guidelines
- Incorporate cultural awareness and sensitivity into daily practices

CONTINUE

Patient Rights

Patient Rights

- [ ] Patients or their surrogate decision maker have the right to refuse treatment
- [ ] Even if a patient has signed a consent for treatment, they may revoke that consent at any time

- [ ] If the patient or their surrogate decision maker refuses treatment, document it in their medical record

Patient Visitation Rights

- [ ] Visitor policy specifies that every patient has the right to determine who may and may not visit them
- [ ] Children may be allowed with adult supervision
- [ ] The patient has the right to select a support person
- [ ] We will not restrict or deny visitation privileges on the basis of race, color, national origin, culture, language, physical or mental disability, religion, sex, sexual orientation, gender identity, or on any other criteria disallowed under the law

Click on the heart-shaped icons below to review some important points about Patient Rights.

Full and equal visitation shall be offered to people who are designated by a patient as a support person, consistent with the patient's references or wishes. These visitors may include but are not limited to spouse, domestic partner, family member, or friend.

The hospital may restrict visitor access based on the clinical needs of the patient, communicable disease of the patient or visitor, failure of the visitor to adhere to laws and regulations and inappropriate behavior while on site.

Visiting restrictions will be explained to patients upon request.

Patients also have a right to request their visitors, including family members, be restricted.

Complete the content above before moving on.

Patient Considerations and Sensitivity

"Our job is to respect each difference while providing competent care. Our patients deserve to be in an environment that is free of prejudice regarding their beliefs."

- Avani

"Our caregivers and patients have a multitude of different cultures, beliefs, rituals, and languages. Supporting patients in their spiritual and cultural beliefs is good for their health and healing."

- Anthony

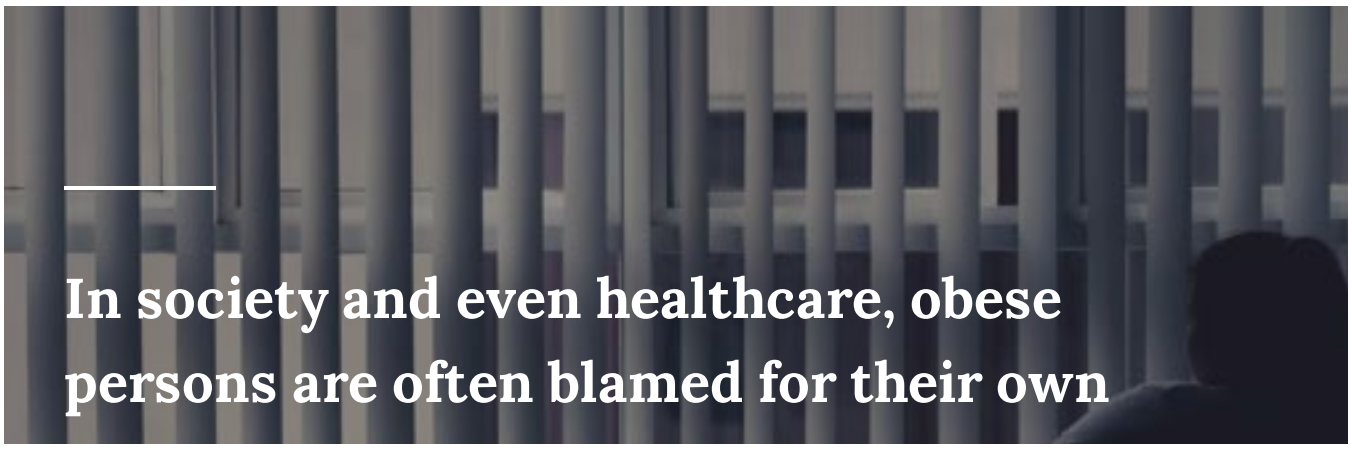
CONTINUE

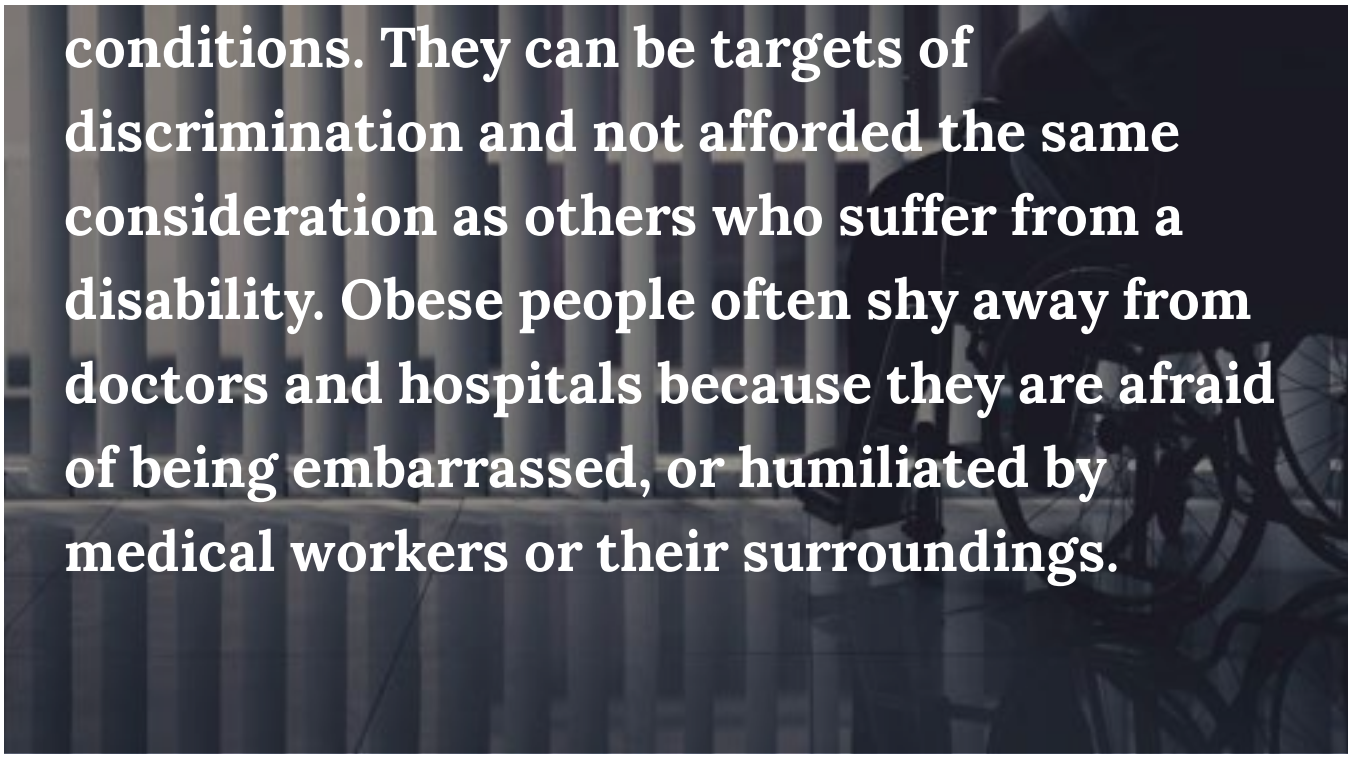
How can we increase our cultural awareness and sensitivity in the busy healthcare environment in which we practice every day? We can do this by developing general skill sets based on knowledge and respect.

What do awareness and sensitivity look like in action?

- [ ] Facilitating language - appropriate use of interpreters, providing clear information so the patient can understand their care plan
- [ ] Negotiating the family environment
- [ ] Understanding patient beliefs and experiences
- [ ] Compassionately respecting patient and human rights

CONTINUE





Understanding the challenges of a bariatric patient is the key to providing safe and effective care. The goal is to make the patient less stressed and anxious.

Be mindful of your communication and body language. Avoid labels that identify patients as obese.

Plan ahead. A bariatric patient may need specialized equipment. Know the availability of such equipment in your unit/facility.

CONTINUE

Providence caregivers need to provide an affirmative, inclusive, and respectful environment for all patients.

Creating a safe and inclusive space for LGBTQIA+ patients and their loved ones can lead to a more trusting relationship with health care providers, and improved communication about their unique needs for care.

Providence St. Joseph Health is working to improve patient satisfaction, engagement, and health outcomes for sexual and gender minorities, especially transgender patients. Caregiver tools have been developed to collect this information and to help clinicians make accurate decisions when there is incongruence between legal sex, sex assigned at birth, and gender identity.

CONTINUE

People grow and develop in stages that are related to their age and share certain qualities at each stage. Every patient population has

unique needs and requires specific treatments.

Meet Unique Needs of Age Group

In order to assure that each patient's care meets their unique needs, caregivers who interact with patients as part of their job must develop skills and competencies for delivering age-appropriate communication, care, and treatments.

By adhering to the guidelines for each specific age group, caregivers can bond and build trust with patients and meet their psychological needs as well.

Age Specific Care Guidelines

Click the plus signs (+) below to learn more about each patient age group.

Infants and Toddlers (Approximate ages 0-3 years)

Healthy Growth and Development:

- Physical - rapid growth rate, especially the brain
- Mental - senses, explores, plays, communicates by crying, facial expressions, babbling, then baby talk and simple sentences
- Social/emotional - is trusting, dependent, beginning to develop a sense of self

Communication: Parents/legal guardians provide security and physical closeness, parent/child bonding; love and security are vital needs.
Safety: Needs a safe environment for exploring, playing, and sleeping.
Health: Immunizations, proper nutrition, sleep, skin care, oral health, routine screenings.
Examples of age-specific care for infants and toddlers:

- Involve child and parent/legal guardian in care
- Cuddle and hug the child
- Provide safe toys and the opportunity to play
- Encourage the child to communicate - smile, talk softly, laugh
- Help parents/legal guardians learn about proper care

Young Children (Approximate ages 4-6 years)

Healthy Growth and Development:

- Physical - grows at a slower rate, motor skills improve, dresses self, is toilet trained
- Mental - symbols become important, memory improves, and imagination is active
- Social/emotional - identifies with parents/legal guardian, is more independent, sensitive to others' feelings; note: safeguard against drowning associated with becoming independent at this age; exhibits fears; likes stories; may be aloof with strangers

Communication: Parents/legal guardians and staff working with young children should offer praise and give rewards, state rules as necessary, encourage play as young children love to learn through games. In the hospital setting, staff may give a toy stethoscope, and reassure the child that procedures are not punishment.
Safety: Teach safety habits (bike/skate helmets, seat belts, swimming pools, and team sports)
Health: Continue immunizations, checkups, teach healthy nutritional habits, and good personal hygiene, including the importance of handwashing.
Illnesses: At this age, the child's immune system is still immature. Subject to the onset of juvenile diabetes, colds, earaches, head lice, mumps, and ringworm
Examples of age-specific care for young children:

- Involve parents/legal guardians and child in care - let the child make some choices, like food or juice choices; let the child feel they are helping
- Use play techniques - toys, games, fun, etc., to teach children and to reduce fear
- Encourage the child to ask questions, play with others if appropriate in the setting, and talk about feelings
- Help parents/legal guardians teach child safety rules

Older Children (Approximate ages 7-12 years)

Healthy Growth and Development:

- Physical - grows slowly until that spurt at puberty
- Mental - active, eager learner, understands cause and effect, can read, write and do math
- Social/emotional - focuses on school activities and "fitting in," while also developing a greater sense of self, negotiates for greater independence; needs to learn to cope with peer pressure

Communication: Encourage them, and give them the opportunity to feel competent and useful; build their self-esteem - ask them to help and praise them for helping; give them tasks they can do successfully (if

they can't mow the whole yard, give them half the yard to mow for now); they need a measure of privacy
Safety: Continue to promote safety habits (school safety, etc.): encourage them to resolve conflicts peacefully instead of hitting; etc.
Health: Continue to keep up immunizations and checkups; continue to teach healthy nutritional habits, and good personal hygiene, including the importance of handwashing; provide information on smoking, drugs, alcohol, and sexuality.
Illnesses: Mumps and measles are common for this age group. If they're not vaccinated, they can still get these diseases; also sore throats, head lice, ringworm, etc.
Examples of age-specific care for older children:

- Allow the child to make some care decisions ("In which arm do you want the vaccination?)
- Help build self-esteem - ask the child to help you do a task, and recognize his/her achievements
- Guide the child in making healthy, safe lifestyle choices (choosing apple juice over a carbonated beverage)
- If appropriate to the situation, help parents talk with the child about peer pressure, sexuality, alcohol, tobacco, other drugs (make appropriate referrals to social workers in the case of management department)

Adolescents (Approximate ages 13-20 years)

Healthy Growth and Development:

- Physical - grows in spurts; matures physically; is able to reproduce
- Mental - can think abstractly; goes beyond simple solutions, considers many options; able to make independent decisions; can consider consequences; chooses own values; is idealistic; thinks about the future
- Social/emotional - develops own identity; builds close relationships; tries to balance the desire to be part of a peer group with family interests; is concerned about appearances; challenges authority. At this age, may also set career goals and choose lifestyle; likes to feel in control of self. In a hospital setting will want to know what test they're going to do next, and what is involved.

Communication: Key concepts are their need for privacy, respect, and acceptance, and the need to learn teamwork
Safety: Discourage risk-taking; promote safety habits (safe driving, violence prevention, the hazards of gangs, etc.)
Health: Continue regular checkups and update immunizations; promote sexual responsibility; advise against substance abuse
Illnesses: Viruses (sties in their eyes, etc.), acne, athlete's foot, mononucleosis, hepatitis

Examples of age-specific care for adolescents:

- Treat more as adult than child; respect their opinions; avoid authoritarian approaches (don't order them around; they will probably rebel)
- Show respect and patience - be considerate of how being in the hospital, or the procedures, etc., are affecting them (may be affecting their appearance); their friendships and their friends' opinions are very important to them
- Provide guidance in making positive healthy choices in the hospital setting (set example for when they go home); correct misinformation
- Encourage communication between doctor & adolescent, and if appropriate, between parent/legal guardian & adolescent
- Encourage them to ask a question regarding any fears they may have
- Involve them in decision-making (even letting them choose their nurse - they'll cooperate better with someone they "click" with)

Young Adults (Approximate ages 21-39 years)

Healthy Growth and Development:

- Physical - reaches physical and sexual maturity; nutritional needs are for maintenance, not growth
- Mental - acquires new skills and information, uses these to solve problems
- Social/emotional - seeks closeness with others; sets career goals and chooses lifestyle (if it hasn't already done so by now); chooses community and starts own family; this can be a stressful age: is the person meeting their goals? illness adds to stress - staff in a hospital setting should be aware of this

Communication: Needs support and honesty, needs respect for personal values; they need telephones and activity; they need respect for their choices.
Safety: Provide information for hazards at home and work; information regarding back safety (avoiding injuries); hurricane/disaster preparedness
Health: Encourage regular checkups, update immunizations (tetanus, hepatitis, flu, pneumonia); promote a healthy lifestyle (proper nutrition, exercise, weight, etc.); inform about health risks (heart disease, diabetes, cancer, etc.)
Illnesses: Heart disease, lung disease, diabetes, cancer, thyroid disease, gastrointestinal disease, increases blood pressure, signs of stress (diarrhea, ulcers), backaches, prostatitis for males, etc.
Examples of age-specific care for young adults:

- Support in making health care decisions
- Encourage healthy and safe habits at home and at work
- Encourage choices for stress reduction
- Acknowledge/respect commitments to family, career, community
- Acknowledge/address worries about the future

Middle Adults (Approximate ages 40-64)

Healthy Growth and Development:

- Physical - begins to age; may develop/manifest chronic health problems (heart disease, lung disease, etc.); hormonal changes (menopause for women)
- Mental - remains mentally active, builds on what he/she already knows; uses life experience to continue to learn to create, solve problems
- Social/emotional - hopes to contribute to future generations; stays productive; balances dreams with reality; plans for retirements; may care for children and parents (sandwich generation); needs to feel life is meaningful (does not like to feel "stuck")

Communication: Keeps a hopeful attitude; concentrates on strengths, not limitations
Safety: Address age-related changes (e.g., change in senses, slowing reflexes); increase following time in traffic to allow for a slower reflex response; abuse and neglect to show up
Health: Encourage regular checkups and immunizations; encourage preventive care; address age-related changes (taste buds change, vision changes); address risk factors for heart disease, etc; continue to emphasize the need for exercise, good nutritional habits; diet and exercise to control adult-onset diabetes; stress-related lifestyle can impact health in major ways (divorce, loss of a job, etc.)
Illnesses: Signs are more evident - heart disease, gastrointestinal disease, cancer (skin cancer, etc.), arthritis
Examples of age-specific care for middle adults:

- If appropriate and with respect for privacy, may encourage talking about concerns, plans, finances
- Acknowledge physical, mental, social abilities and plans
- Guide in planning for healthy, active retirement

Older Adults (Approximate ages 65-79 years)

Healthy Growth and Development:

- Physical - continues to age gradually (aging is more noticeable); natural decline in some senses and physical abilities (but older adults do not always decline in all physical and mental abilities)
- Mental - continues to be an active learner and thinker; memory skills may start to decline
- Social/emotional - takes on new roles (may volunteer); balances independence with the need to be dependent in some ways; life review (friends begin to die, make new friends and many other life issues)

Communication: Respect; avoid isolation; encourage acceptance of aging and limitations; driving equals independence; address the sense of loss after retirement
Safety: Promote home safety (especially to avoid falls)
Health: Monitor health more closely; promote physical, mental, social activity; guard against depression, apathy (suicide rate rises in this age group; sometimes suicide pacts among married couples); update immunizations (flu, pneumonia)
Illnesses and Ailments: Joints get stiffer; skin changes and gets thinner; they bleed more easily and heal more slowly; Alzheimer's disease shows up more frequently; osteoporosis, arthritis; for men BPH (benign prostatic hypertrophy) - a lot of hospital admissions may start around this age
Examples of age-specific care for older adults:

- If appropriate and with respect for privacy, encourage talking about feelings, fears, loss, grief, life
- Inform about home safety (ramps, bathtub grips), and medication safety
- Provide support for any impairments - refer to social workers
- Encourage socialization - with peers as a volunteer, etc.
- Support end-of-life decisions, provide information
- Provide nutritional support, information, and counseling
- Encourage as much independence as possible, provide opportunities for physical, mental, social activities
- Assist in self-care

Elderly and Older Frail Adults (Approximately 80 years or older)

Healthy Growth and Development:

- Physical - physical abilities decline; increased risk for chronic illness; major health problems; skin may become very fragile and subject to breakdown (handle with care, using palms of hands rather than fingertips); body's ability to regulate heat decreases
- Mental - continues to learn; memory skills and/or speed of learning may decline; confusion often signals illness or a problem with medications; confusion is not necessarily a sign of permanent loss of mental abilities
- Social/emotional - lives as independently as possible; accepts end of life (and related issues) and personal losses

Communications: Encourage expression of thoughts and feelings; avoid despair; use humor and stay positive
Safety: Ensure safe living environment; eliminate hazards; prevent falls and injuries
Health: promote self-care and independence; monitor health more closely; emphasize proper diet, activities and rest; decrease stress update immunizations
Illnesses and Ailments: More illnesses and ailments, and more pronounced existing illnesses and ailments; increased or decreased blood pressure; circulation problems, feeling cold
Examples of age-specific care for elderly and older frail adults:

- Encourage talking about feelings, fears, loss, grief, life review, end-of-life decision, provide resources
- Help to stay positive, avoid despair
- Continue to encourage appropriate independence - physical, mental, social activities (classes and programs for older adults to keep the brain stimulated)
- Promote safety in the home (safety grips, ramps, etc.); medication safety (remembering to take medications and watching for adverse reactions)
- Help take steps to reduce stress
- Physical care - change position slowly, frequently, to avoid skin breakdown
- Ensure warmth
- Ensure safety in the hospital setting to avoid falls and injuries

CONTINUE

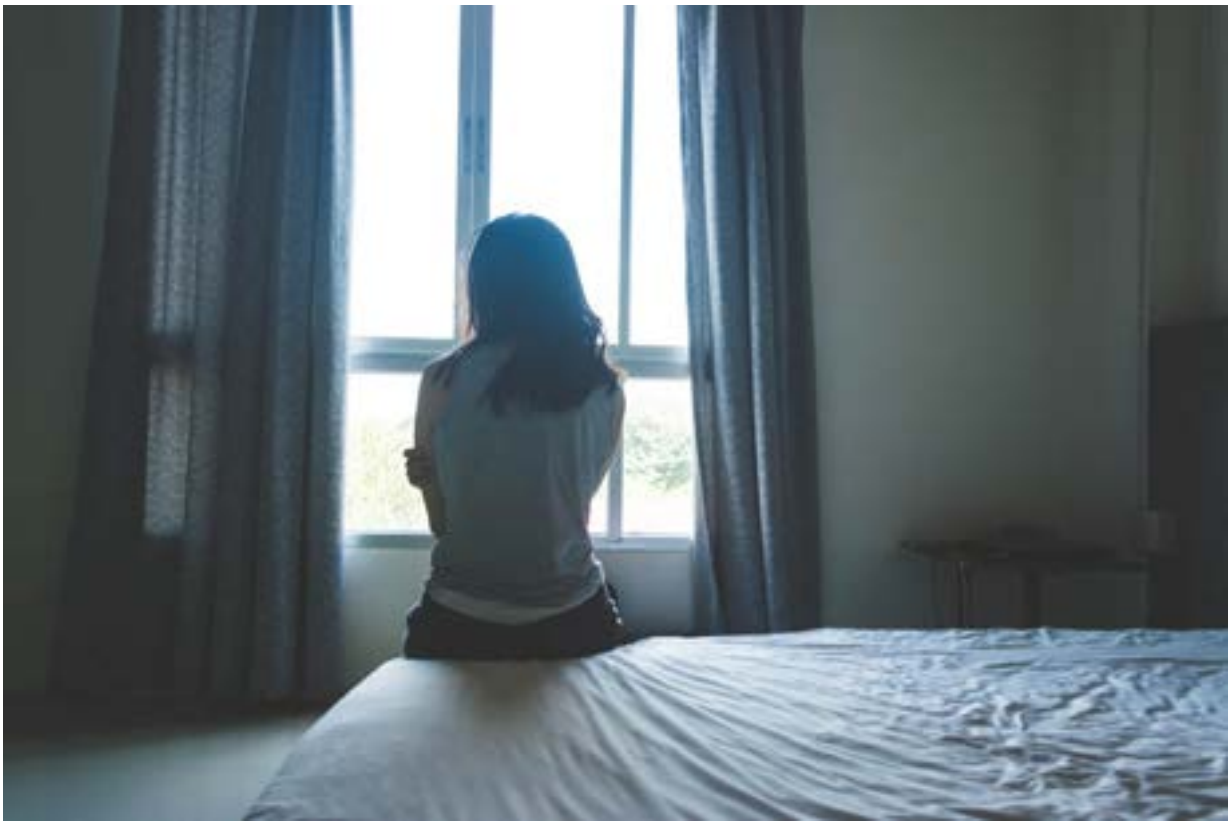
Serving the Patient in Their Time of Need

Freedom from Abuse

All healthcare staff must be able to identify abuse or neglect as well as the extent and circumstances of abuse in order to give the appropriate care.

It is our policy to:

- Identify victims of abuse
- Report known or suspected abuse to the proper authorities, per legal mandate
- Care for and refer for protective services
- Prevent abuse whenever possible



CONTINUE

What Does Abuse Look Like?

Patients may be experiencing one of a number of forms of abuse; physical, emotional, financial, neglect, domestic violence, human trafficking, or other violence, and identifying those being abused can sometimes be tough.

Click the plus signs (+) below to learn more about types of abuse.

Physical

Physical abuse is any intentional act causing injury or trauma to another person by way of bodily contact.

Examples include:

- Bruises or abrasions
- Broken or fractured bones
- Burns or scalds
- Bite marks
- Sexual abuse

Neglect

Failure of a caretaker to provide the goods and services or care necessary to maintain the health or safety of a vulnerable child or adult.

Examples include:

- Abandonment
- Imprisonment in the home
- Failure to feed a dependent person
- Conduct that endangers the person's physical or psychological well-being
- Leaving a person sitting or lying in urine or stool

Psychological/Emotional

Verbal harassment, threats, criticism, and isolating behaviors are types of psychological abuse.

Examples include:

- Verbal abuse
- Threats of physical harm
- Cultural shaming
- Racial slurs
- Threats of abandonment
- Social isolation

Financial/Economic

Improper, unauthorized removal of a person's money, property, or possessions.

Examples include:

- Cleaning out bank accounts
- Selling off possessions
- Improper use of Power of Attorney or guardianship
- Forcing a vulnerable adult to work against his/her wishes

Domestic Violence

A pattern of assaultive and coercive behaviors, including physical, sexual and psychological attacks. Economic coercion that adults or adolescents use against their intimate partners is another example.

Indicators include:

- Overly attentive partner
- Delay in seeking medical care
- Multiple cuts, scrapes and/or bruises in various stages of healing

- Inconsistent description of how injuries occurred
- Emergent presentation for medically insignificant trauma

Human Trafficking

Human trafficking is the recruitment, transportation, transfer, harboring or receipt of persons for the purpose of exploitation.

Examples include:

- Prostitution
- Sexual exploitation
- Forced labor
- Slavery

Complete the content above before moving on.

All caregivers are required to report cases of known or suspected abuse of vulnerable adults and children. In addition to the mandatory requirement to report to the appropriate protective agency, the caregiver will report to their supervisor or to a nurse supervisor.

Prior to reporting to a protective agency, it may be necessary to collaborate with other members of the healthcare team to determine if suspicion of abuse exists.

Reporting Protocol:

1. Notify person in charge
2. Call clinical social worker. If a social worker is unavailable, work with your Core Leader, Charge Nurse, and Provider to follow the next steps
3. Complete report for Adult Protective Services or Child Protective Services

CONTINUE

Responding to Victims

Treating a Victim

When treating a victim of abuse or suspected abuse, including human trafficking, it is important to create an environment where they can feel safe. Have visitors wait in waiting areas, use a calm voice, ask questions without placing blame or judgment, and reassure them that help is available. Obtain appropriate consultation from members of the healthcare team.

CONTINUE

Domestic Violence/Partner Abuse

If you believe the patient is a vulnerable adult, please contact a social service clinician, charge nurse or house supervisor to discuss the reporting process. In the Ambulatory environment, please contact the patient's care provider and clinic manager.

- Interview in private

- Express concern for safety and well being
- Report as appropriate for vulnerable patients (those who do not have decision making capacity and patients under the age of 18 years)
- If a report of harm is made due to the patient's vulnerability, please discuss with social work/house supervisor and ensure a discussion is had with the patient about the report
- Address patient safety in the discharge plan. This may include letting them know about appropriate community resources from which they could benefit.
- Refer to your local policy for your specific reporting requirements

CONTINUE

- [ ] Be aware of the warning signs of abuse

- [ ] Report suspected abuse immediately
- [ ] Manage your own stress properly so that you do not risk taking anger and frustration out on patients or each other

CONTINUE

Safe Surrender/Safe Place Program

This program allows a parent or legal guardian to confidentially surrender an infant, three days old or younger, to any hospital emergency room, enforcement officer, firefighter, or medical person without legal consequences of abandonment.

Any caregiver or medical staff member on duty at the hospital must accept an infant up to 72 hours old that is surrendered by a person having lawful custody. If it turns out the infant is more than 72 hours old, the state protective agency can help with placement.

What to do if you are approached:

If you are approached by someone who wants to surrender their newborn, ask them to walk with you to the Emergency Department.

The Emergency Department caregiver is trained for these situations and has all the paperwork that needs to be completed by the person surrendering an infant.

If the person surrendering an infant refuses to go to the ED with you but still wants to leave the baby, you can take the baby to the emergency room.

- If you are unsure and need help, you can contact the Emergency Department, a clinical social worker, or the house supervisor for assistance
- If possible ask about newborn's family medical history
- The person surrendering newborn is not required to stay and cannot be held for questioning

- Do offer to provide support through the hospital chaplain or clinical social worker

CONTINUE

Directives, Acts, and Preferred Language

Advance Healthcare Directives

Federal and state law requires that patients be informed about their right to complete advance healthcare directives upon being admitted to the hospital.

Ideally, individuals are having conversations about their end-of life wishes with their primary care physicians, families, financial planners, and other trusted professionals before an emergency health situation occurs.

Healthcare directives (e.g., advance directives, POLST, Durable Power of Attorney for Healthcare, Living Will, code status) provide clear instructions for caregivers and doctors to follow to ensure patients' medical requests are fulfilled in the event they are incapacitated or unable to make choices on their own.

It is important for the healthcare provider to review the advance directive with the patient when the patient has decision-making capacity (or surrogate if not) to be sure the document reflects the patient's current wishes.

Advance directive forms are available on our website or in a patient's medical record.

CONTINUE

Preferred Language of Communication

Individuals With Limited English Proficiency

The heart of all human interactions is the ability to communicate effectively. To ensure safe, high-quality care, we provide interpreter services at no charge to all patients and their companions who have Limited English Proficiency, or who request the use of an interpreter.

All patients have the right to a free qualified medical interpreter for accuracy in their communication on sensitive topics and during such times as:

- End-of-life decisions or terminal illness
- Significant exchange of information for diagnosis
- Explanation of medical conditions, treatment options, tests, medications, surgery and/or other

- Obtaining informed consent for treatment
- Discharge, after-care, and other follow-up instructions
- Providing mental health services, including group or individual counseling for patients and family
- During childbirth
- Anytime requested by the patient or their company

CONTINUE

Translating Vital Documents

To meet the needs of people with limited English proficiency, written materials may be translated from English into other languages, following your local policy/procedure. **Translating vital documents into patient's preferred languages is a requirement.**

The type of auxiliary aid or service necessary to ensure effective communication will vary in accordance with:

- The method of communication used by the individual
- The nature, length, and complexity of the communication involved

- The context in which the communication is taking place

Services may include, but are not limited to:

- In-person interpreters
- Telephonic/over the phone interpreters (OPI)
- Video remote interpreters (VRI)

CONTINUE

Individuals With Disabilities

Caregivers should consult with individuals with disabilities whenever possible to determine the type of auxiliary aid needed to ensure effective communication. However, the ultimate decision as to what measures to take rests with the facility, provided that the method chosen results in effective communication.

To be effective, auxiliary aids and services must be provided in accessible formats, in a timely manner, and in such a way as to protect the privacy and independence of the individual with a disability.

ASSESSMENT | DOCUMENTATION | WALK-IN REQUESTS

Each patient must be assessed for their communication needs at each appointment or medical encounter; document updated information.

Patients with sensory loss (hearing, speech and/or vision loss) have "Primary Consideration" meaning that we must consult with the person with a communication disability to discuss what aid or service is appropriate, to ensure that they receive effective communication.

To learn more about Primary Consideration, go to ADA.gov.

ASSESSMENT | DOCUMENTATION | WALK-IN REQUESTS

Document the patient's assistive device needed or preference in their medical record.

You may not arbitrarily reschedule an appointment if an interpreter is not available; consult with the patient to determine the best manner to communicate and only reschedule if they request this.

ASSESSMENT	DOCUMENTATION	WALK-IN REQUESTS

Covered entities may require reasonable advance notice from people requesting aids or services, based on the length of time needed to acquire the aid or service, but may not impose excessive advance notice requirements.

"Walk-in" requests for aids and services must also be honored to the extent possible. Interpretation must be made available regardless of the interaction and time of day (e.g. if the patient is present or on the phone).

ADA Requirements: Effective Communication

ADA.ORG

Law, Regulations & Standards

ADA.ORG

Complete the content above before moving on.

Who Can Serve As Interpreter?

Interpretation must be performed by a qualified medical interpreter. We may not require an individual with a disability to bring another individual to interpret for him or her.

In addition, we may not rely on an adult accompanying an individual with a disability to interpret or facilitate communication, *except in the following circumstances*:

- In an emergency involving an imminent threat to the safety or welfare of an individual or the public where there is no interpreter available
- Where the individual with a disability specifically requests that the accompanying adult interpret or facilitate communication, the accompanying adult agrees to provide such assistance, and reliance on that adult for such assistance is appropriate under the circumstances
    - **We should document that they offered an interpreter, and the patient declined**
    - **We should still have a qualified interpreter listen to ensure proper translation**

We may not rely on a minor child to interpret or facilitate communication, except in an emergency involving an imminent threat to the safety or welfare of an individual or the public where there is no interpreter available.

Click on the plus-shaped (+) icons below to learn more about interpretation.

Provided in the requestor's preferred method if available and reasonable

For deaf patients, an in-person interpreter should be scheduled and caregivers should use the VRI until in-person interpreter arrives. For deaf-blind patients, an in-person interpreter is always required.

Check your local hospital/regional policies and resources for regionally approved in-person, phone, and /or Video Remote Interpreter (VRI) services.

For Caregivers

Documentation is required in the Epic Language/Communication flowsheet for each interpretive service used during the encounter.
Bilingual caregivers may or may not provide interpretive services in accordance with your region's policy.

Complete the content above before moving on.

Congratulations! You have completed this eLearning module. Click the Exit Course link above to close this window.

PROV: Medication Administration Safety, Part 1

The safe administration of medication is a complex process relying on many caregivers and processes. The purpose of this review is to highlight the tools available to help ensure safety for our patients and caregivers to decrease preventable errors, identify errors, and mitigate harm.

Please note this course is composed of two parts. You must complete Part 1 and Part 2 to receive credit for the course.

- Course Navigation
- Course Objectives
- Medication Administration Process
- Process Step: Order
- Process Step: Dispense
- Process Step: Administer
- Process Step: Monitoring
- Key Points in Safe Medication Administration Best Practices

Process Step: Controlled Substance Diversion Monitoring

Part 1 Completion

Course Navigation

- You must move through this course in sequential order.
- Successful completion of this course requires viewing all content.
- You may exit the course and return to where you left off.

Technical Recommendations

There are technical recommendations in order to access all components and ensure you have an optimal learning experience. Before you continue, please ensure your computer meets these minimum requirements:

Computer or Laptop	Web Browser	Operating System	Internet Connection	Other
Minimum screen size of 15" Audio capability	Latest version of **Microsoft Edge**	Windows 10 or higher Mac: Catalina OS	High speed internet (DSL/Cable) Reliable connection	Headphones, earbuds or speakers

A phone or tablet should not be used to complete this eLearning course.

Important Navigation Reminders

Please keep the following items in mind while completing this course:

1. Lessons load as you complete a section. If you do not see the continue or next lesson button, **scroll down** to load the lesson or locate the continue button.

2. Do not fast forward or skip around; this can cause the lesson/course to freeze and may interfere with your ability to complete the course.

3. If experiencing technical issues, try clearing the browser history before or during the course. If you continue to experience issues, submit a ticket in the Caregiver Service Portal or call (844) 922-7548.

4. When viewing videos, wait until the slider bar at the bottom stops before selecting continue.

5. Anytime you see an image, you can select it to enlarge.

6. If you are directed to PolicyStat or another external site, be sure to minimize the new window (do not close it) to return to this course. This will allow you to continue and complete the module. Closing the window may prevent the course from progressing.

CONTINUE

Course Objectives

Upon completion of this course, the caregiver will be able to:

1. Identify tools and resources available to support safe medication administration.
2. Review the nurse's role in safe medication administration.

CONTINUE

Lesson 3 of 10

Medication Administration Process

To err is human.

Act well your part, there all the honor lies.

Alexander Pope

Errors occur with the interaction of humans and the systems we build.

Healthcare is a human-based system. As such, a system without errors is not possible. However, we can work to create systems that are ultra-safe and reduce the risk of errors reaching our patients.

Facilities within the Providence family of organizations are charged with being High Reliability Organizations (HROs), that consistently prevent major accidents or failures, despite inherit risks.

This lesson focuses on the nurse's role in reducing error during the medication administration process.

In a study that observed medication administration at 36 hospitals, nearly 20% of all medication administrations contained an error.

CONTINUE

Medication Administration is a common, but complex process.

- Despite new technologies, error rates during administration remain high.
    - 25% are preventable (Makary & Daniel, 2016).
- More than half of all medication errors occur in the administration phase (Azar et al, 2023).
- Nearly 5% of hospitalized patients experience an adverse drug event (ADE).
- Nurses play an essential role in protecting patients from harm and reporting ADEs. They are often the last line of defense.

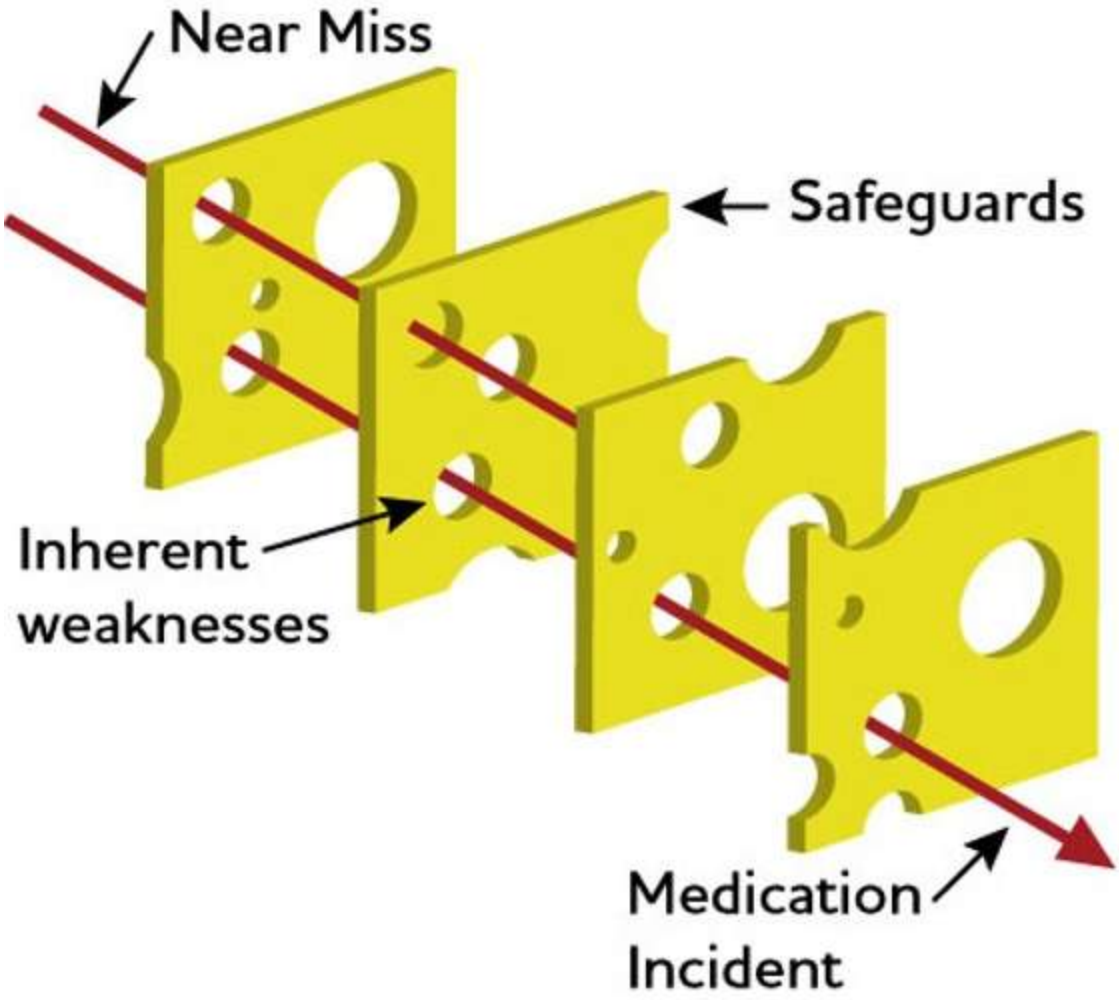
CONTINUE

The Swiss Cheese Model

Safeguards against patient harm are represented as slices of Swiss cheese.

The holes in each slice represent weaknesses, risk for error, or flaws in the system of safeguards. When the holes in different safeguards (slices) align, a hazard can pass through.

The Swiss cheese model shows the importance of understanding the weaknesses and the need for multiple layers of defense to prevent failure.



Adapted from James Reason. *Managing the Risks of Organizational Accidents*, 1997.

Instructions: Select each card below to learn more. You must review all to continue.

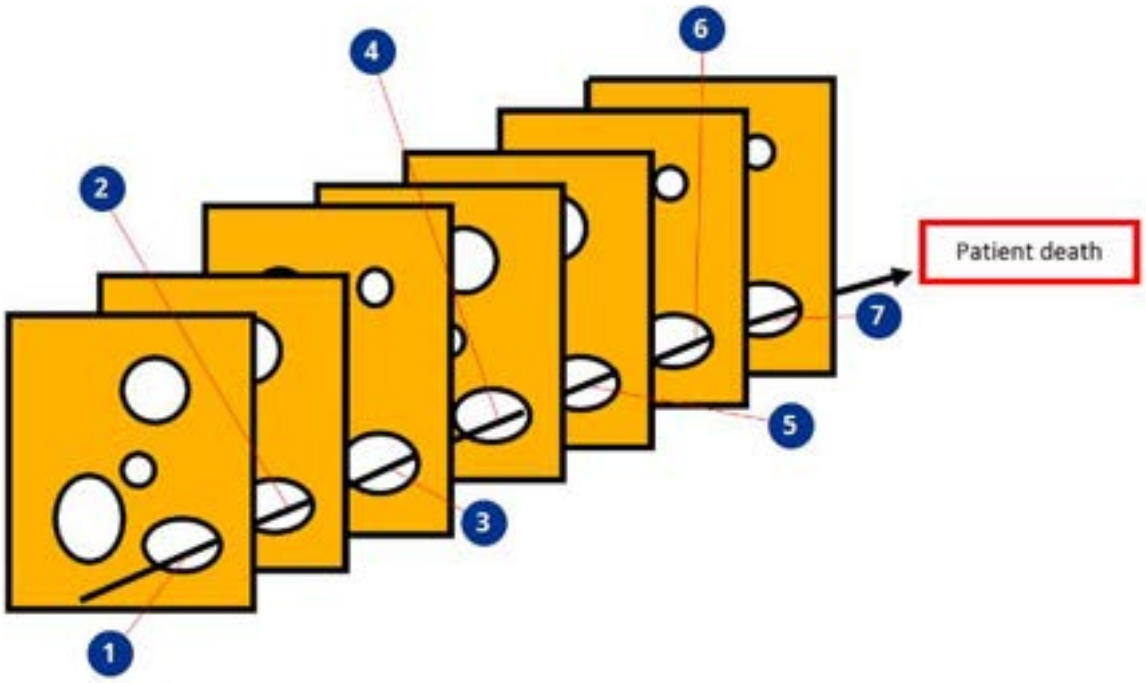
- Barcode medication administration
- Using Alaris Drug Library
- Using Alaris Interoperability
- Verifying two patient identifiers before a

- Manual programming of the Alaris pump
- Failure to independently verify information during a dual sign off
- Skipping the two-patient identifier step because you know the patient

Complete the content above before moving on.

Medication Administration Error Case Study

Instructions: Review the error below that received wide-spread media coverage. Select each icon to read each step in the case study. You must select all icons to continue.



Complete the content above before moving on.

Nurses are involved in four of the six steps of medication administration:

- Order
- Dispense
- Administer
- Monitor

Instructions: Review the medication administration process below. The green steps indicate the most error prone steps in the process. Select each icon to learn more. You must select all icons to continue.

Each step presents an opportunity for error *and* an opportunity for intention, attention, and care to reduce the risk of error.

Review our High Reliability Behaviors and Tools by clicking here.

TOOLBOX FOR EVERYONE
(High Reliability Behaviors and Tools)

CARING RELIABLY
Be Compassionate. Be Safe. Be Reliable.

Tones to Connect

Smile and greet others	Introduce and explain roles	Listen with empathy and intent to understand	Communicate positive intent	Provide an opportunity for others to ask questions

PAY ATTENTION TO DETAIL
- Self Check using STAR
- Peer Check

COMMUNICATE CLEARLY
- SBAR
- 3 Way Repeat Back/Read back
- Phonetic & Numeric Clarification
- Ask Clarifying Questions

HAVE A QUESTIONING ATTITUDE
- Validate & Verify
- Know Why & Comply

OPERATE AS A TEAM
- Brief, Execute, Debrief (BED)

SPEAK UP FOR SAFETY
- Escalate using CUS (Concern, Uncomfortable, Stop)
- Event Reporting

Providence

Complete the content above before moving on.

Team Effort

As part of the commitment to fostering a Culture of Safety, Providence has implemented the following processes and tools to enhance medication safety:

Complete the content above before moving on.

Despite the safeguards to prevent error, more than half of all medication errors occur in the administration phase, and 25% of these errors could be prevented.

(Makary & Daniel, 2016)(Azar et al, 2023)

CONTINUE

Process Step: Order

Safety Tool: Computerized Provider Order Entry (CPOE)

CPOE increases medication safety by:

- Minimizing the use of verbal or telephone orders.
- Eliminating illegible writing or use of inappropriate abbreviations.
- Guiding prescribers to address all components of an appropriate medication order.

Ensure you have a complete and correct order.

- A complete order ***will*** contain:
    - the date and time of the order.
    - the medication name.
    - the dose of the medication.
    - the route of the medication.
    - the frequency of the medication.
    - if a fluid medication, the rate (ml/hr).
    - if a PRN medication, the **indication and intervals** must be included.
    - prescriber authentication (signature on written order or verified by Epic login).

- An appropriate order ***will not*** contain:
    - Ranges for frequencies (e.g., Morphine 0.5mg every 3-4 hours prn severe pain).
    - Unapproved abbreviations.

- Additional considerations:
    - Verify that correct patient information is recorded in the EMR to ensure appropriate medication and dosage is prescribed:
        - Allergies (including type of reaction).
        - Weight (must be in kg).

Remember to operate as a team:

Contact the provider or pharmacist if you have questions or concerns regarding a medication order.

Implementing Orders

Although CPOE is an important safety tool, nursing critical thinking is required for safe medication administration. In reviewing the order, nurses consider:

1. Does the order make sense for the patient?
2. Do I know why I am giving the med to this patient?
3. Does the current patient condition contraindicate the medication?
4. When it is appropriate to hold a medication, document the reason.

- Review Document a Medication as Not Given from the MAR in Epic Learning Resources.

Navigation Reminder: After clicking on the link, be sure to minimize the new window (do not close it) to return to this course. This will allow you to continue and complete the course. Closing the window may prevent the course from progressing.

CONTINUE

Process Step: Dispense

Safety Tool: Pyxis

The automated dispensing cabinet (Pyxis) provides multiple features to support safe medication administration. These features include:

Access Control

- Provides safe storage of medications.
- Restricts access to medications through appropriate access configuration (e.g., using profiles or override functions), reducing the potential for inadvertently selecting the wrong medication.

Medication Stocking and Dispensing

- Allows for separation of high-alert meds, reversal agents, look alike/sound alike names & packaging, agents prone to diversion.
- CDCs and Dispense Notes are medication warnings and safety reminders that display on the screen.

A Platform for Documentation of Medication Wasting

EMERGENCY Access - Override Function

In emergent situations only, when a stored medication is needed, but there is no active order on the patient profile, nurses may use the override function.

- Pyxis requires a minimum number of characters when searching for medications on override to reduce the risk of selecting the wrong medication.
- Policies are used to guide the use of this functionality to support safety.
- When possible, the override function should be limited to emergent situations and rescue medications as this function reduces other safety features of Pyxis.
- Note: Not all medications will be available on override. Each facility sets the list of medications available in a particular unit. This is also a safety measure to reduce the risk of removing the wrong medication.

CONTINUE

Process Step: Administer

Electronic Medical Record: Epic

The electronic medical record (EMR) provides a number of tools to support safe medication administration. Some specific features of Epic including:

Medication Administration Record (MAR) highlights key information:

- New medication orders.
- Medications with incomplete first dose education.
- Missed or overdue medications.

- Provides an option to message pharmacy with questions re: medication dosing, administration times, etc.
- High-risk or controlled medications require dual verfication.
- Alerts.
    - Allergies.
    - Incorrect administration times.
    - Overdue medications.

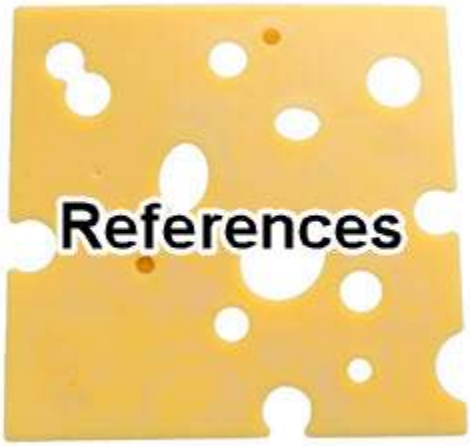
Barcode medication administration (BCMA) provides:

- Medication rights validation for ordered medications.
    - Right patient, right medication, right time, right dose, right route.
- Pop-up notifications:
    - Patient is not scanned (patient identity has not been validated and verified).
    - Medications scanned do not match orders on patient chart (incorrect medication).
    - A medication is too soon or late (not the right time).

- Administration of same medication by a different route.

Smart Pumps and Pump Interoperability provide:

- Smart pumps utilize guardrails and the drug library to reduce manual infusion programming errors.
- Pump Interoperability (where available) ensures accurate data capture (i.e., pump information is integrated into the medical record).



Information and/or links to reference resources within the workflow:

- Drug Reference access: links to Lexidrug available in the MAR.
- Information about hazardous medications is accessible via the MAR.
    - Icons provide visual cues to the caution and handling instructions.
    - Caregivers can "hover to discover" on the icon or label to review the PPE, handling and disposal information.

Medication reconciliation at admission and discharge:

- Documentation of prior to admission medications to support decision making and medication safety during admission and appropriate planning for medications after discharge.

Pharmacy verification:

- Pharmacists review ordered medications for allergies, contraindications and accuracy.

Team communication:

- Send pharmacy questions about medication dosing, side effects, etc.

When in doubt, start a dialog with Pharmacy prior to medication administration

Instructions: Select each icon to review the safety tools available in the medication order in Epic.

You must select all icons to continue.

Complete the content above before moving on.

Hover to Discover

"Hover to discover," or moving the cursor over text in the EMR, is a tool to provide additional information to support safety. An example of this safety tool found in the MAR is identification of medication hazards and appropriate PPE.

Instructions: Select each icon to learn more. You must select all icons to continue.

Complete the content above before moving on.

High Alert Medications/ High Risk Medications

Instructions: Select each tab to learn more about tools and strategies for high alert/high risk medication administration safety. You must select all tabs to continue.

Depending on your facility and practice environment, certain medications require dual sign-off/dual verification prior to administration. These may include:

INSULIN | CONTROLLED SUBSTANCES | SEDATIVES | ANTICOAGULANTS

- Dose check system.
- Correct infusion pump rate (smart pumps).
- Appropriate weight (stated, actual, ideal, etc.).

INSULIN | CONTROLLED SUBSTANCES | SEDATIVES | ANTICOAGULANTS

- Pyxis storage.
- PCA set up double-check, use appropriate tubing.
- Co-signing for rate or dose changes.
- Lock box (Plexi-glass).
- Protocols for pain management (order sets, multi-modal).
- Understand long vs. short acting (online drug reference in Epic).

INSULIN	CONTROLLED SUBSTANCES	SEDATIVES	ANTICOAGULANTS

- Use caution when administering sedatives with controlled substances.
- Being prepared to reverse (nurse ensures reversal agent order and available PRN).
- Respiratory depression monitoring (sedation scales in Epic).

INSULIN	CONTROLLED SUBSTANCES	SEDATIVES	ANTICOAGULANTS

- Patient education regarding:
  - Compliance.
  - Drug-food interactions.
  - Possible reactions.
  - Monitoring.

The most common type of harm includes **hypotension**, **bleeding**,

hypoglycemia, **delirium**, **lethargy**, **bradycardia**, and **opioid-induced respiratory depression**.

Complete the content above before moving on.

Dual Sign-Off (Dose check system)

- An **independent double check** of a high-alert medication is a procedure in which two clinicians *separately* check a medication before it is administered to a patient.

- DO check independently. Each caregiver must consider the rights of medication administration and then compare for accuracy.

- Do NOT perform the check together so as to avoid being influenced by the expected results. If you have a set expectation, it is less likely you will detect a mistake.

Tall Man Lettering

We follow FDA recommendations to use tall man lettering as an additional safety feature for look-alike and sound-alike medications. For example:

- hydrALAZINE vs. hydrOXYzine
- CARBOplatin vs. CISplatin

CONTINUE

Barcode Medication Administration (BCMA)

Barcode technology provides an additional check to ensure several rights of medication administration. This system is designed to prevent medication errors and generate accurate documentation of medication administration.

BCMA validates:

- Patient to receive medication is correctly identified *(right patient)*.
- Specific drug scanned matches the medication, dose, and route indicated in the order on the scanned patient's chart *(right medication, right dose, right route)*.

- The administration time *(right time)*.

When there is a mismatch between the scanned patient wrist band and/or medication, pop-up warnings are provided for the nurse to consider to help prevent medication errors. It is important for each of these messages to be reviewed prior to administering the medication.

> **"It is never the tool that decides.**
>
> **It's the hands -and the heart- of the one who wields it."**
>
> — Kevin Sands

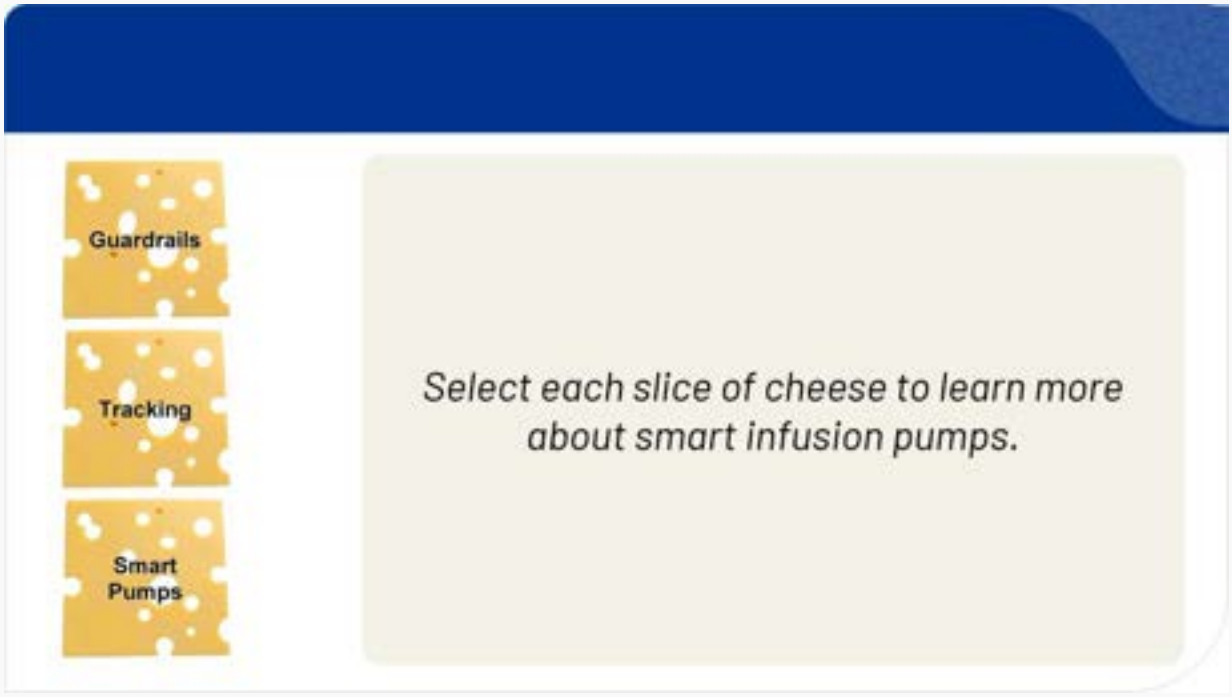
A tool is only as good as its user! You have to use BCMA correctly to benefit from the safety features it offers.

Complete the content above before moving on.

Smart Infusion Pumps

"The use of infusion pumps with Dose Error Reduction Software (DERS) can decrease medication errors."

- 2022-2023 ISMP Targeted Medication Safety Best Practices for Hospitals



Complete the content above before moving on.

Medication Preparation

Vials

Always utilize an alcohol pad to swab the rubber stopper on a vial BEFORE accessing the vial. This includes the first access after the protective cap (dust cover) is removed from the top of the rubber stopper.

Single-Dose Vials

Single-dose vials are still just for single use. Waste any remaining medication in the vial and get a new one for the next dose.

Multi-Dose Vials

- When you open a multi-dose vial, document a beyond use date on the vials. The beyond use date is 28 days ***after*** the vial is open, unless the manufacturer's expiration date occurs first.
- Never use a multi-dose vial unless the beyond use date is written on the vial itself and has not passed.
- Do not use multi-dose vials for multiple patients in clinical areas.
- Dedicate and label each multi-dose vial for single patient use only.

Glass Ampules

Improper opening of glass ampules can cause injury.

Proper Opening and Preparation of Medications from Glass Ampules

- Tap the top of the ampule with your finger.
    - Sends medication into the body of the ampule.

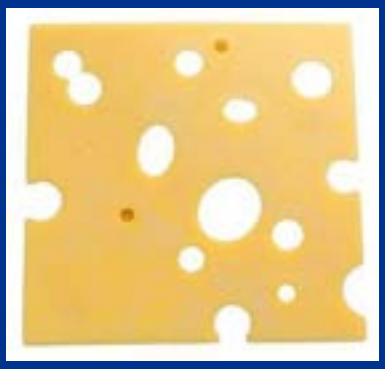
- Use a sterile gauze pad or an alcohol wipe between your thumb and index finger and the ampule neck. Snap open away from your body (away from face and eyes).
- Use a filter straw or filter needle to draw up the medication.
    - Ensures no shards of glass will be drawn up into the syringe.

- Discard the filter straw or needle into a sharps container.

- Prepare the syringe as you would normally for an IV or IM injection.

CONTINUE

Process Step: Monitoring



Monitoring for Effects and Side Effects

Safety Tool: Drug Reference

- The nurse is accountable for understanding the anticipated response to the medication (i.e., reason the patient is receiving the medication) as well as potential side effects. Refer to a valid resource, such as Lexidrug or Micromedex, with any questions.

- Some medications specify parameters for titration or indications to hold a medication. Be sure to document your assessment of the parameters and

the reason if a medication is withheld.

- Notify the provider of adverse drug reactions.

CONTINUE

Monitoring for Over-Sedation

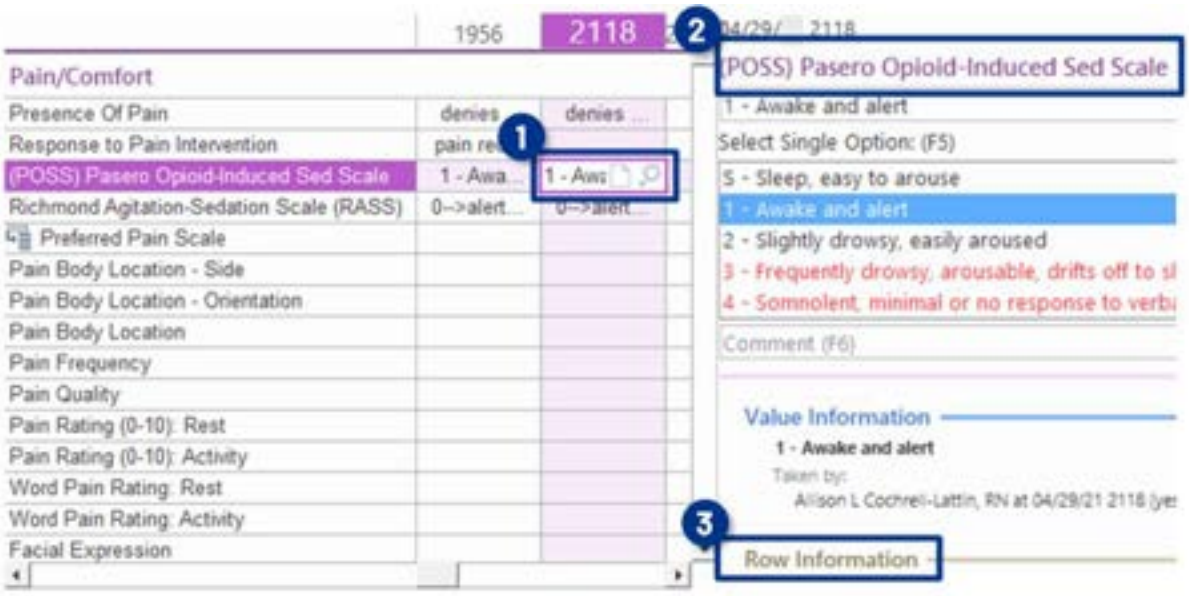
Safety Tool: EHR - Integrated Scales

Oversedation and Pasero Opioid-Induced Sedation Scale (POSS). Sedation is an indicator of evolving respiratory depression, a life- threatening adverse effect of opioids.

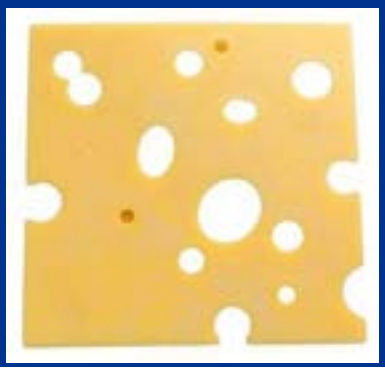
Providence has integrated scales that monitor the level of sedation into the EHR (Epic).

POSS is used to assess level of sedation and identify potential interventions based on sedation level.

Instructions: Select each icon to learn more. You must select all icons to continue.



Complete the content above before moving on.



Reversal Agents

Test Yourself

Instructions: Before you select the arrow icon at the bottom right of the cards below to reveal the corresponding reversal agent, test yourself to see if you can recall what they are. Select all to move on.

Opioids	**Reverse with nalaxone (Narcan)** ***Respiratory depression:*** Titrate agent using 1-10 micrograms/kg every 1-2 minutes as necessary until effective respiratory effort

Benzodiazepines

Reverse with flumazenil (Romazicon)

- Dose = 0.2 mg
- May repeat, as needed

Barbiturates

NO specific reversal agent

- Treat symptoms and provide supportive therapy

Remember:
Not every medication has a reversal agent!

Refer to Epic for specific administration instructions.

Complete the content above before moving on.

HRP at Providence is Making a

Difference!

Both products to the left are from the same manufacturer.

Pyxis stocking only requires one barcode from one package of a batch to be scanned when loading. If another medication becomes mixed in the batch being loaded, it could be mistakenly placed in the wrong bin.

You can see the potential for product mix up when stocking in Pyxis in the image to the left. These two products were found in the same bin in the main pharmacy. The near miss was reported through HRP.

The local medication safety officer shared the event with the system Medication Safety Committee members, reported it to the manufacturer, and reported it to the Institute for Safe Medication Practices (ISMP).

This resulted in a national publication in their Acute Care Medication Alert newsletter and a change in packaging by the manufacturer.

Reporting of both safety events and near misses results in changes within Providence and even across the nation to prevent the potential for future errors.

CONTINUE

Key Points in Safe Medication Administration Best Practices

Complete the content above before moving on.

Process Step: Controlled Substance Diversion Monitoring

Regulations require a clear chain of custody for controlled substances—from purchase to administration or disposal—to prevent theft or diversion.

CONTINUE

Best Practices for Handling Controlled Substances

Instructions: Select each tab to learn more. You must select all tabs to continue.

SOFTWARE MONITORING | CAREGIVER ROLE

- Controlled substances obtained from Pyxis are fully accounted for by what is recorded on the MAR and validated via waste.
- Controlled substances pulled from Pyxis via override are linked to an order.
- Patterns of administration that could indicate possible drug diversion are identified.

SOFTWARE MONITORING | CAREGIVER ROLE

The caregiver's role in managing controlled substances includes:

- Always ensure the security of a controlled substance.
- Report any concerns, discrepancies, or missing controlled substances as soon as possible.

Complete the content above before moving on.

Wasting and Disposing of Controlled Substances (per Policy)

Complete the content above before moving on.

To prevent diversion, controlled substances are wasted and discarded in a way that ensures they can't be retrieved. In the presence of the witness, the medication is disposed of in a designated controlled substance container designed to safely and compliantly prevent diversion.

Never cosign wasting of a medication if you didn't actually observe disposal of that medication.

Disposal of Controlled Substances

Instructions: Select to expand each section below. You must select all sections to continue.

Liquids and Injectables —

Liquids and injectables are drawn up and injected into the container, which contains a solution to deactivate the controlled substance.

Tablets and capsules —

Tablets and capsules are removed from packaging and dropped into the container.

Patches —

Patches are placed in the container.

Complete the content above before moving on.

Part 1 Completion

Congratulations!

You have successfully completed Part 1 of the PROV: Medication Administration Safety course.

Please select the exit button below to close this window.

Exit Module

Select the button to the right to exit the course.

Please note you must complete Part 1 and Part 2 to receive credit for the course.

EXIT

PROV: Medication Administration Safety, Part 2

The safe administration of medication is a complex process relying on many caregivers and processes. The purpose of this review is to highlight the tools available to help ensure safety for our patients and caregivers to decrease preventable errors, identify errors, and mitigate harm.

Please note this course is composed of two parts. You must complete Part 1 and Part 2 to receive credit for the course.

PART 2

- Course Objectives
- Knowledge Check
- Quiz
- Part 2 Completion

Course Objectives

Welcome to Part 2! Here, we will verify your knowledge of the content provided in Part 1.

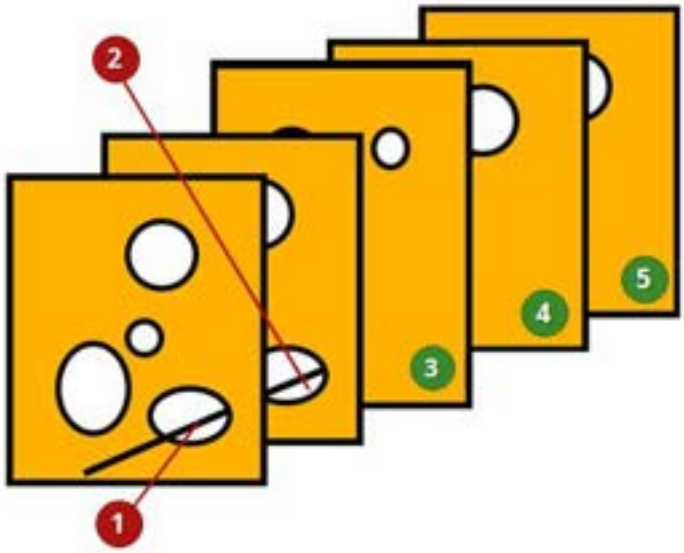
As a reminder the course objectives are as follows:

1. Identify tools and resources available to support safe medication administration.
2. Review the nurse's role in safe medication administration.

CONTINUE

Knowledge Check

Instructions: Select each icon to learn more about a near miss that involved labeling IV lines. You must select all icons to continue.



For this example, what are the steps that the nurse could have taken to avoid the incorrect medication being administered to the patient?

Select all that apply.

- [ ] Labeling lines

- [ ] Validating with second nurse that the lines are labeled correctly
- [ ] Validating with second nurse that the rates are correct
- [ ] Trace the line from pump to patient

SUBMIT

Ensure each line is labeled, traced between source and patient, and running at the prescribed rate.

Complete the content above before moving on.

Quiz

Complete this quiz with a score of 100% to continue.

Question

01/09

Your patient, Mr. Rivera, is due for his scheduled metoprolol. Mr. Rivera's provider submitted the order for metoprolol as indicated below.

What are your next steps?

Step 1	Read admin instructions
Step 4	Assess current BP and HR against parameters in order
Step 2	Administer if SBP is >100 and HR is greater than 50
Step 3	Document in the MAR if medication needs to be held

Question

02/09

A verbal order for Humalog insulin sliding scale was given with no order placed in Epic. The nurse attempted to remove Humalog via override from Pyxis, but the only insulin available on override was regular insulin. The nurse saw insulin on the medication label and mistook it for the correct type. Regular insulin removal was overridden and administered.

What medication administration safety issues do you notice? Select all that apply.

- [ ] Provider order not in Epic using CPOE
- [ ] Nurse selected incorrect medication
- [ ] The nurse inappropriately used the override function in a non-emergent situation
- [ ] The nurse failed to Pay Attention to Detail and STAR (Stop, Think, Act, Review) because there was no written order against which to compare the medication label

Question

03/09

A four-month-old child was in the ED with fever. His weight upon arrival was 16.8 lb. The child's weight was entered into Epic as 16.8 kg.

An order for acetaminophen 15 mg/kg was entered in Epic. Pharmacist questioned documented weight and left order in verification queue awaiting clarification of weight. In the meantime, the acetaminophen was removed on override and given at an incorrect dosage.

This medication error represents a Swiss cheese event.

Which of the following were errors (holes in the slices of cheese)? Select all that apply.

- [ ] The incorrect medication dose was removed on override and administered
- [ ] The incorrect unit was used to enter patient weight
- [ ] The nurse didn't verify the patient weight and question if the dose and documented weight made sense for the patient

Question

04/09

Patient had an order for hydrochlorothiazide 12.5mg, but a 25mg tablet was dispensed with the intention of having the tablet split prior to administration. Medication was not scanned prior to administration, so patient received the full 25mg tablet. Scanning tablet prior to administration would have presented nurse with "partial package" warning in Epic.

What BCMA errors do you notice? Select all that apply.

- [ ] Do not circumvent safety tools
- [ ] We must use safety tools to benefit from them
- [ ] Pay attention to safety pop-ups
- [ ] Report any problems with safety tools

Question

05/09

It is time to administer your patient's pain medication. You assess the patient using POSS and the level of sedation score is 3.

What do you do?

Pasero Opioid-induced Sedation Scale (POSS)

Level of Sedation	Appropriate Action
S = Sleep, easy to arouse	• Acceptable • No action necessary • May increase opioid dose if needed
1 = Awake and alert	• Acceptable • No action necessary • May increase opioid dose if needed
2 = Slightly drowsy, easily aroused	• Acceptable • No action necessary • May increase opioid dose if needed
3 = Frequently drowsy, arousable, drifts off to sleep during conversation	• Unacceptable • Monitor respiratory status and sedation level closely until sedation level is stable at less than 3 and respiratory status is satisfactory • Decrease opioid dose by 25% to 50% (if permitted by order or protocol), or notify the practitioner or anesthesiologist for orders • Consider administering a non-sedating, opioid-sparing non-opioid, such as acetaminophen or a non-steroidal anti-inflammatory drug, if not contraindicated.
4 = Somnolent, minimal or no response to verbal and physical stimulation	• Unacceptable • Stop opioid use • Consider administering naloxone (if permitted by order or protocol) • Notify the practitioner • Monitor respiratory status and sedation level closely until sedation level is stable at less than 3 and respiratory status is satisfactory

The *Pasero opioid-induced sedation scale* is a valid and reliable sedation scale used to assess sedation during opioid use for pain management. The scale provides nursing interventions for various levels of sedation that may include increasing the opioid dose in a patient who's easily aroused but reports unacceptable pain relief, or decreasing or holding a dose in a patient who's overly sedated. The practitioner's opioid order or facility protocol should permit you to decrease the dose if the patient is overly sedated. When performing an assessment, keep in mind that even a sedated patient may arouse when approached or touched. To properly assess sedation, observe how quickly the patient arouses and answers a simple question. The patient who arouses easily should be able to answer the question completely without falling back to sleep.

Lippincott Procedures. Pain Management. Pasero Opioid-induced sedation scale. December 14, 2018

- Administer the pain medication
- Administer a partial dose of the pain mediation using your professional judgement
- Do not administer the pain medication
- Report the score to the patient's prescribing provider and administer the pain

medication

Question

06/09

A hypotensive patient has an order for norepinephrine. Their nurse removed the medication via override before pharmacy had verified the order.

A second nurse manually programming the pump asked for the norepinephrine concentration. First nurse reported "16 mcg" (meaning 16 mcg/mL or 4 mg/250 mL), but the second nurse misunderstood this to be "16 mg" (16 mg/ 250 mL). The pump was programmed for the incorrect concentration. The error was caught during the infusion verify process later in the shift and corrected.

Note: Pump interoperability can only be used for orders verified by pharmacy.

Which safety tools would support preventing this error? Select all that apply.

- [ ] Independent double check against the MAR in Epic without influence from the other nurse
- [ ] Validate and verify after the independent double check
- [ ] Use of Alaris Pump Guardrails or Pump Interoperability (if available)
- [ ] Do not use override except in emergent situations

Question

07/09

RN called Pharmacy and said the patient's TPN was not scanning. The nurse stated that two RNs had confirmed that the product was correct, and the electrolytes on the label appear to match the formula ordered in Epic. RN said she would start the bag while Pharmacy was looking into it, although Pharmacy advised her not to do so until they could confirm the bag is correct.

While Pharmacy investigated the issue, the RN noticed that the bag was ordered for a different rate. She inspected the label further and noticed that the name on the label was for a different patient.

Meanwhile, the pharmacist had reviewed the electrolytes between the two TPN orders and had identified that the electrolytes on each order were different as well.

The TPN had already been connected to the patient's IV line, so that bag had to be wasted and a new bag had to be compounded.

Which safety tools would support preventing this error? Select all that apply.

- [ ] Have a Questioning Attitude
- [ ] Validate and Verify before proceeding
- [ ] Pay Attention to Detail and STAR when you see a BCMA pop-up
- [ ] Remember that if the process isn't working correctly, check it out

Question

08/09

Ceftriaxone 2g was retrieved from the patient bin in the medication room. The medication was administered while RN was waiting for the bedside computer to load, as the RN planned to scan the medication barcode after administration.

The RN realized afterwards that the medication was administered to the wrong patient. Fortunately, the patient was not allergic, so no adverse effects occurred.

Which of the following steps would have helped prevent this error? Select all that apply.

- [ ] Scanning the patient's wrist band and the medication barcode prior to administration

- [ ] Stopping the administration process when prompted by the error message that would have resulted from the barcode scanning process

Question

09/09

While on new-hire orientation, an RN entered the room with acetaminophen oral solution for the pediatric patient. The patient's parents said the patient had been receiving acetaminophen through their IV.

RN placed oral solution in a syringe and attempted to administer via syringe pump. The syringe pump could not push medication through the small-bore tubing and began alarming.

The orientee asked their preceptor to look at pump. The preceptor disconnected syringe and educated the patient's parents that the IV acetaminophen had been changed to oral solution.

Which of the following steps would have helped prevent this error? Select all that apply.

- [ ] Know Why and Comply – Use Enfit connectors to prevent inadvertent connection and administration of oral medications through and IV line

- [ ] Know Why and Comply – Use barcode medication administration process to verify the correct patient, medication, dose, and route

- [ ] Have a Questioning Attitude – When something doesn't seem right, take a minute to investigate

Part 2 Completion

Congratulations!

You have successfully completed Part 2 of the PROV: Medication Administration Safety course. Please select the exit button below to close this window.

Exit Module

Select the button to the right to exit the module.

Please note you must complete Part 1 and Part 2 to receive credit for the course.

EXIT

PROV: Pain Management

This course provides education to Providence caregivers about best practices for pain management, including Multimodal Pain Management.

- **Course Expectations**
- **Course Objectives**
- **Pain Assessment**
- **Pain Management**
- **Multimodal Pain Management**
- **Scheduled vs. Non-Scheduled MMPM**
- **Analgesic Range Orders**
- **MMPM Best Practices**
- **Safe Use of Opioids**
- **Services Available to Support Patients with Complex Pain Needs**

- **Summary of Key Points**
- **Knowledge Check**
- **Conclusion**

Course Expectations

Technical Recommendations

There are technical recommendations in order to access all components and ensure you have an optimal learning experience. Before you continue, please ensure your computer meets these requirements:

Computer or Laptop	Web Browser	Operating System	Internet Connection
Minimum screen size of 15" Audio capability	Latest version of **Microsoft Edge**	Windows 10 or higher Mac: Catalina OS	High speed internet (DSL/Cable) Reliable connection

A phone or tablet should not be used to complete this eLearning course.

CONTINUE

Important Navigation Reminders

Please keep the following items in mind while completing this course:

1. Lessons load as you complete a section. If you do not see the continue or next lesson button, **scroll down** to load the lesson or locate the continue button.

2. Do not fast forward or skip around; this can cause the lesson/course to freeze and may interfere with your ability to complete the course.

3. If experiencing issues, try clearing the browser history before or during the course. If you continue to experience issues, submit a ticket in the Caregiver Service Portal or call (844) 922-7548.

4. Anytime you see an image, you can click to enlarge it.

5. If you are directed to PolicyStat or another external site, be sure to minimize the new window **(do not close it)** to return to this course. This will allow you to select "**CONTINUE**" and complete the module. Closing the window may prevent the course from progressing.

CONTINUE

Instructions

- You must move through this course in sequential order.
- Successful completion of this course requires viewing all content and passing the assessment with a score of 100%.
- You may exit the course and return to where you left off.

CONTINUE

Course Objectives

Upon completion of this course, the caregiver will be able to:

1. Understand the nurse's role in pain assessment
2. Recall best practices for Multimodal Pain Management (MMPM)
3. Administer appropriate analgesic interventions based on patient's assessed pain level and order of use guidelines
4. Recall best practices for safe use of opioids
5. Access available resources to support patients with complex pain management needs

CONTINUE

Pain Assessment

Individualized Pain Assessment

Patients should have an individualized pain assessment that considers the following three factors:

Instructions: Select to expand each section below. You must select all sections to continue.

Patient's description

The patient's description of the pain:

- Where is the pain located?
- How do you describe the pain?
- What brings the pain on?
- What makes the pain worse?
- What makes the pain better?
- What problems does the pain cause?
- Are you able to participate in activities of daily living?

- Are you able to focus on a task?

Nurse's observations

The nurse's observations of the patient's behavior and physical responses commonly associated with pain include:

- Altered body position
- Moaning, sighing, grimacing, crying, restlessness, immobility
- Elevated blood pressure, tachycardia, dyspnea, pallor, diaphoresis

Cultural influences

Consider the patient's cultural influences related to pain. Some patients may have a stoic response to pain while others may display a more emotive response. It is important for caregivers to examine the reasons behind a patient's non-verbal behaviors.

For example:

- A patient may not ask for pain medication because they feel it is disrespectful to ask or that their request will not be honored.
- A patient who grimaces or groans to express their pain may not believe they must also verbalize it.

Complete the content above before moving on.

Using Standardized Pain Rating Scales

Use an age and developmentally appropriate standardized pain rating scale. If the patient has cognitive impairment or limited language skills, use the pain scale that works best for the patient. Use the same scale for subsequent assessments for consistency and reliability.

Instructions: Select each tab to learn more. You must select all tabs to continue.

FACES PAIN SCALE - REVISED	WONG BAKER FACES	MEASURING YOUR PAIN	REVISED FLACC

Faces Pain Scale - Revised (FPS-R)

Instruction for Faces Pain Scale-Revised "These faces show how much something can hurt. This face [point to left-most face] shows no pain. The faces show more and more pain [point to each from left to right] up to this one [point to right-most face] – it shows very much pain. Point to the face that shows how much you hurt [right now]."

Score the chosen face 0, 2, 4, 6, 8, or 10, counting left to right, so '0' = 'no pain' and '10' = 'very much pain.' Do not use words like 'happy' and 'sad'. This scale is intended to measure how children feel inside, not how their face looks. (Once again, say "hurt" or "pain," whichever seems right for a particular child.)

FACES PAIN SCALE - REVISED | WONG BAKER FACES | MEASURING YOUR PAIN | REVISED FLACC

Wong-Baker FACES Scale

From Wong D.L., Hockenberry-Eaton M., Wilson D., Winkelstein M.L., Schwartz P., Wong's Essentials of Pediatric Nursing, ed. 6, St. Louis, 2001, p. 1301. Copyrighted by Mosby, Inc. Reprinted by permission.

Measuring Your Pain

In the scale, 0 means no pain, and 10 is the worst pain possible.

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FACES PAIN SCALE - REVISED	WONG BAKER FACES	MEASURING YOUR PAIN	REVISED FLACC

rFLACC

Categories	Scoring		
	0	1	2
F **Face**	No particular expression or smile	Occasional grimace or frown, withdrawn, disinterested ***appears sad or worried***	Frequent to constant frown, clenched jaw, quivering chin ***distress-looking face: expression of fright or panic***
L **Legs**	Normal position or relaxed	Uneasy, restless, tense ***occasional tremors***	Kicking, or legs drawn up ***marked increase in spasticity, constant tremors or jerking***
A **Activity**	Lying quietly, normal position, moves easily	Squirming, shifting back and forth, tense ***mildly agitated (e.g., head back and forth, aggression); shallow, splinting respirations intermittent sighs***	Arched, rigid, or jerking ***severe agitation, head banging, shivering (not rigors); breath-holding, gasping or sharp intake of breath; severe splinting***
C **Cry**	No cry (awake or asleep)	Moans or whimpers, occasional complaint ***occasional verbal outburst or grunt***	Crying steadily, screams or sobs, frequent complaints ***repeated outbursts, constant grunting; silent cry in ventilated patients can be used in assessing this category***
C **Consolability**	Content, relaxed	Reassured by occasional touching, hugging, or being talked to, distractible	Difficult to console or comfort ***pushing away caregiver, resisting care or comfort measures***

© 2002, The Regents of the University of Michigan. Used with permission.

- The rFLACC can be used for: 1. Children, 2. Children with cognitive impairment through age 18 years, 3. Nonverbal patients in the ICU setting – children and adults
- Each of the 5 categories (F) Face; (L) Legs; (A) Activity; (C) Cry; (C) Consolability is scored from 0 – 2, which results in a total score between zero and ten.
- **Patients who are awake**: Observe for at least 1 – 2 minutes. Observe legs and body uncovered. Reposition patient or observe activity, assess body for tenseness and tone. Initiate consoling interventions if needed.
- **Patients who are asleep**: Observe for at least 2 minutes or longer. Observe body and legs uncovered. If possible, reposition the patient. Touch the body and assess for tenseness and tone.
- The revised FLACC (rFLACC) can be used for children with cognitive disability. The additional descriptors (in bold) are included with the original FLACC. The nurse can review with parents the descriptors within each category. Ask them if there are additional behaviors that are better indicators of pain in their child. Add these behaviors to the tool in the appropriate category.

Complete the content above before moving on.

Pain Management

Pain Management Includes Non-Pharmacological Interventions

When a patient is in pain, the nurse is responsible for providing pain management. Pain management should include non-pharmacological interventions.

Instructions: Select to expand each section below to learn about various ways you can include non-pharmacological interventions in pain management. You must select all sections to continue.

Offering emotional support by... —

- showing your concern by **slowing down and spending time talking** with the patient
- assessing the patient's **spiritual and cultural needs**

Assisting the patient with... —

- **repositioning** to reduce tension, muscle spasms, and relieve pressure on bony prominences
- applying **cold or warm compresses** if appropriate
- performing passive **range of motion exercises and/or massage** to reduce muscle tension and prevent stiffness
- creating a **soothing environment** by modifying the lights, sounds, and other stimuli as appropriate

Providing the patient with... —

- **distraction**, guided imagery, music therapy
- a soothing **head-to-toe bath** with packaged bath wipes to reduce perception of pain
- **cleansing face and hands** to reduce the perception of pain
- **oral care** to reduce mouth dryness and reduce oral bioburden

Encouraging the patient to... —

- **splint or support incisions** as appropriate, when coughing or changing position
- use **deep breathing exercises** to reduce tension and anxiety

Complete the content above before moving on.

Involve Your Team

A team approach to helping manage a patient's pain can be especially helpful. Consider engaging your Nursing Assistant, Spiritual Care, Social Work, Music Thanatology, and Volunteer colleagues as appropriate.

Pharmacologic interventions for pain management are determined in collaboration with the patient's licensed provider. Multimodal Pain Management can be particularly helpful.

CONTINUE

Multimodal Pain Management

What is Multimodal Pain Management?

Multimodal pain management (MMPM) is the use of a combination of opioid and non-opioid medications to act on different pain pathways, including:

Acetaminophen and Non-Steroidal Anti-Inflammatory Drugs (NSAIDs):

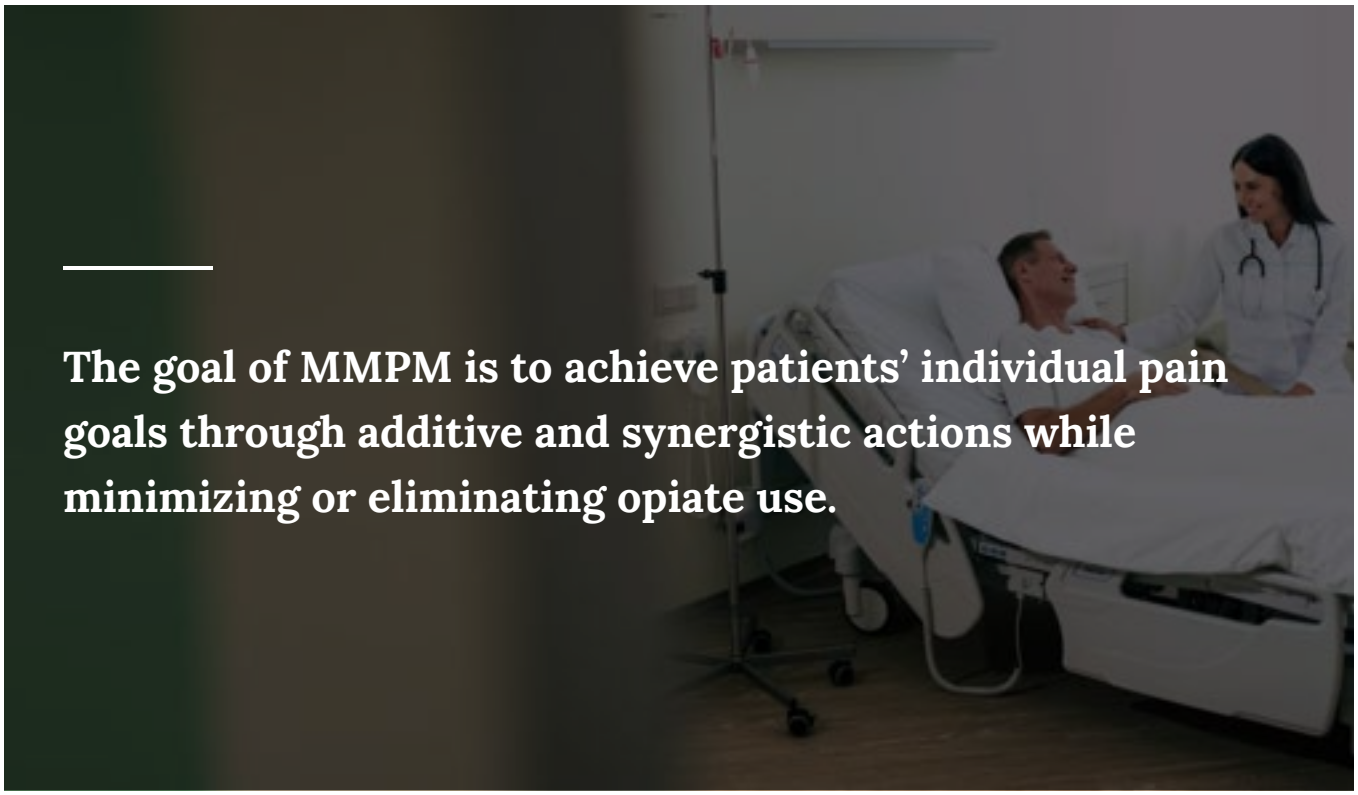
- Ibuprofen
- Ketorolac
- Naproxen

Opioids:

- Morphine
- Oxycodone
- Hydromorphone

Gabapentinoids:

- Gabapentin
- Pregabalin



MMPM is not just medication.
Incorporate nonpharmacological interventions along with prescribed medication to help the patient achieve their desired pain goal.

CONTINUE

Specific Components of MMPM Orders Help Guide Safe Medication Administration

Instructions: Select each icon to learn more about the components of MMPM orders. The icons will turn gray when selected. You must select all icons to continue.

Complete the content above before moving on.

Assessment of Pain

MMPM orders guide nurses to select their non-opioid or opioid intervention based on:

- The patient's reported pain intensity
- Pain assessment
- Respiratory and sedation level
- Pain goal

Analgesic Class	Administration Instructions	Pain Scale*
Acetaminophen	**Mild pain:** Give as first line medication. If ineffective, give with NSAID as ordered. **Moderate pain:** Give with NSAID as ordered. If ineffective, give with opioid as ordered. **Severe pain:** Give acetaminophen with NSAID and opioid as ordered.	**Mild Pain** – NRS: 1-3
NSAIDs	**Mild pain:** Give if pain is not controlled with acetaminophen or if acetaminophen not ordered. **Moderate pain:** Give with acetaminophen as ordered. If ineffective, give with opioid as ordered. **Severe pain:** Give NSAID with acetaminophen and opioid as ordered.	**Moderate Pain** – NRS: 4-7
Opioids	**Moderate pain:** Give if pain is not controlled with acetaminophen and NSAID or if other pain medications are not ordered. **Severe pain:** Give opioid with acetaminophen and NSAID as ordered.	**Severe Pain** – NRS: 8-10

*Nominal Rating Scale (NRS): 0-10 scoring.

Select the table above to zoom in.

CONTINUE

Scheduled vs. Non-Scheduled MMPM

There are two types of MMPM order sets that a provider can choose from:

1. Scheduled MMPM order set
2. Non-Scheduled MMPM order set

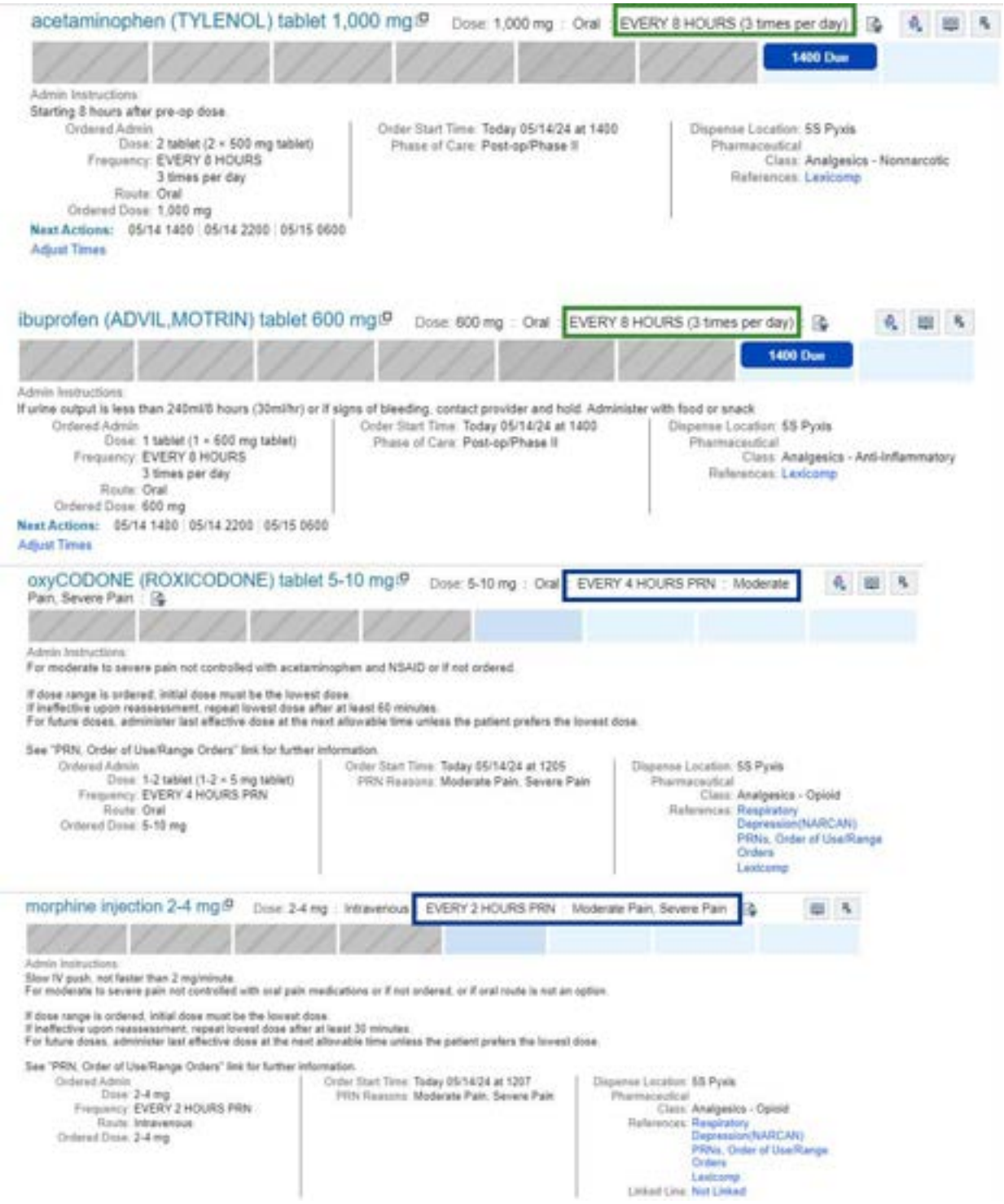
What are the Differences Between Scheduled and Non-Scheduled MMPM Order Sets?

Scheduled MMPM Order Set

Post-op MMPM orders include:

- Scheduled acetaminophen and NSAIDs
- PRN opioids

The intent of the Scheduled MMPM Order Set is to add the PRN opioid if the pain is not controlled with the scheduled acetaminophen and NSAIDs.



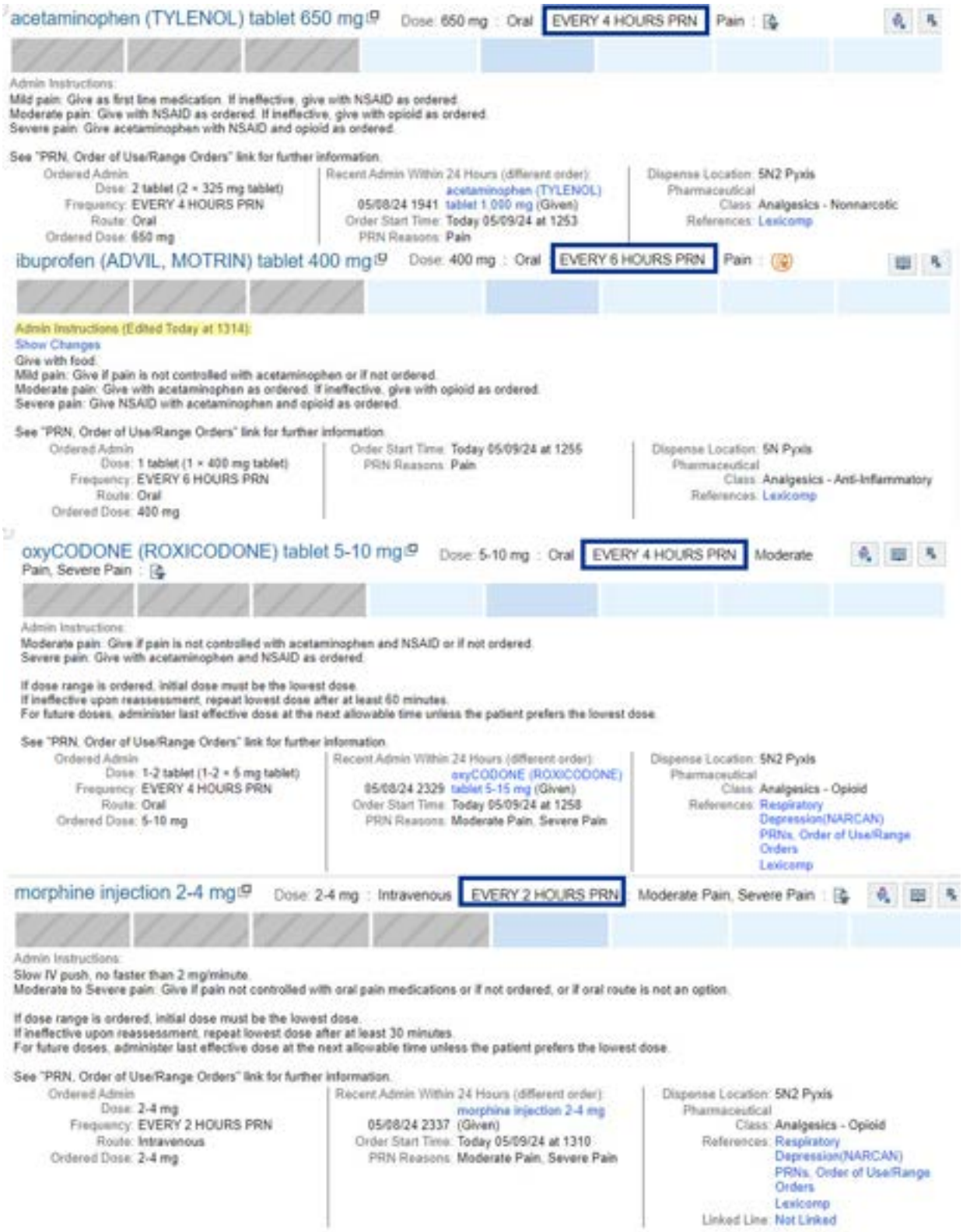
Select the image above to zoom in.

Non-Scheduled MMPM Order Set

Non-Scheduled MMPM Order Sets include:

- PRN acetaminophen and NSAIDs
- PRN opioids

Note: All medications in a Non-Scheduled MMPM Order Set are PRN as opposed to scheduled.



Select the image above to zoom in.

If an opioid is required to achieve adequate pain control, the RN will **continue to give the acetaminophen and NSAID as scheduled.**

CONTINUE

Analgesic Range Orders

Range Dose Initiation

MMPM orders may include a variation of analgesic medications that are prescribed with a dose range.

Examples:

- Oxycodone **5-10** mg every 4 hours prn moderate to severe pain
- Morphine **2-4** mg IV every 4 hours prn moderate to severe pain

Range doses do not exceed 2 times the lowest dose of the medication.

If a dose range is ordered, the *initial dose must be the lowest dose*.

- Inpatient units **CAN NOT** continue with a higher dose from the ED, procedural areas, or PACU as larger loading doses are often given in these areas and may lead to oversedation if continued.

- If admission/boarder/Phase 2 orders are initiated in the ED, procedural areas, or PACU starting with the lowest dose, these orders **CAN** be continued in the inpatient setting.

CONTINUE

Range Dose Assessment and Adjustments

When administering any pain medication, the RN should reassess the patient's pain level ***after the medication has reached peak effect***.

Instructions: Select each card to review when each medication delivery method reaches peak effect. You must review all to continue.

IV	30 minutes
Oral	60 minutes

Intramuscular (IM)/ Subcutaneous (SQ)/ Rectal	60 minutes

Complete the content above before moving on.

Upon reassessment, if the patient's pain level has not reached their pain goal with the initial, lowest dose of PRN range order medication, the RN may administer the next dose within the interval as long as the **total dose does not exceed the maximum of the prescribed dose range**.

Note: If the order for an opioid has a frequency that is less than the peak effect of the drug (e.g., several order sets have IV opioids ordered as q10 minutes PRN), the RN must perform a pain reassessment prior to giving the next dose.

CONTINUE

Guideline: PRN Analgesics – Order of Use and Opioid Range Orders

This document provides guidance if the prescriber's pain medication orders do not include specific instructions for the "order of use" of multiple prn pain medications or implementation of range orders.

Guideline: PRN Analgesics – Order of Use and Opioid Range Orders

This document provides guidance if the prescriber's pain medication orders do not include specific instructions for the "order of use" of multiple prn pain medications or implementation of range orders.

Always refer to local policy for additional information.

A. **Route of administration order of use:** 1 = Oral (if tolerating PO intake); 2 = IV; 3 = Rectal; 4 = IM/Subcutaneous (if not IV access)

B. **Multimodal pain management (MMPM)** uses a combination of analgesic medications that act on different pathways, and non-drug therapies, to meet patients' pain goals while minimizing opioid requirements.

C. **Assessment of pain:** Use pain screening tools appropriate to the patient (e.g., Nominal Rating Scale (NRS) using 0-10 scoring, Critical Care Pain Observation Tool (CPOT) using 0-8 scoring). Administer analgesic based on pain intensity and assessment of the individual patient.

Analgesic Class	Administration Instructions	Pain Scale*
Acetaminophen	**Mild pain:** Give as first line medication. If ineffective, give with NSAID as ordered. **Moderate pain:** Give with NSAID as ordered. If ineffective, give with opioid as ordered. **Severe pain:** Give acetaminophen with NSAID and opioid as ordered.	**Mild Pain** – NRS: 1-3
NSAIDs	**Mild pain:** Give if pain is not controlled with acetaminophen or if acetaminophen not ordered. **Moderate pain:** Give with acetaminophen as ordered. If ineffective, give with opioid as ordered. **Severe pain:** Give NSAID with acetaminophen and opioid as ordered.	**Moderate Pain** – NRS: 4-7
Opioids	**Moderate pain:** Give if pain is not controlled with acetaminophen and NSAID or if other pain medications are not ordered. **Severe pain:** Give opioid with acetaminophen and NSAID as ordered.	**Severe Pain** – NRS: 8-10

*Nominal Rating Scale (NRS): 0-10 scoring.

D. **Range Dose Initiation, Assessment, and Adjustments**

- If a dose range is ordered, the initial dose must be the lowest dose.
  - Inpatient units may not continue with a higher dose from the ED, procedural areas, or PACU as larger loading doses are often given in these areas and may lead to oversedation if continued.
  - If admission/boarder/Phase 2 orders are initiated in the ED, procedural areas, or PACU starting with the lowest dose, these orders can be continued in the inpatient setting.
- Assess symptom relief and adverse effects (e.g., sedation level, respiratory rate) after the medication reaches its peak effect:
  - Approximate opioid peak effect: IV 30 min, ORAL 60 min, IM/Subcutaneous/Rectal 60 min

Example: oxyCODONE 5-10 mg PO every 4 hours prn moderate or severe pain [4-hour dosing interval]
If dose range is ordered, initial dose must be the lowest dose. If ineffective upon reassessment, repeat lowest dose. For future doses, administer last effective dose at the next allowable time unless the patient prefers the lowest dose.
- Initial dose: Give lowest dose = 5 mg PO oxyCODONE given at 0900
- Reassess after peak effect (PO opioid peak effect after approximately 60 minutes) for pain relief and adverse effects.
  - At 1000: If inadequate pain relief and no intolerable adverse effects may give an additional 5 mg (repeat lowest dose) – Additional 5 mg PO oxyCODONE given at 1000. Total dose 10 mg PO oxyCODONE.
  - At 1100: Patient comfortable, no adverse effects.
  - At 1400 (4 hours from last dose): Reassess patient. If patient continues to report moderate or severe pain, and no adverse effects, the patient may receive 10 mg oxyCODONE (total given in previous dosing interval). Continue to assess pain and adverse effects (e.g., sedation level, respiratory rate).

  - Give subsequent doses based on the documented effectiveness of previous dose as well as the patient's level of sedation and respiratory status. Total dose within the dosing interval may not exceed the maximum of the prescribed dose range (e.g., no more than 10 mg oxyCODONE may be given within the 4-hour dosing interval).
  - Patient may be given a lower dose or lesser potent agent upon request, only if part of the prescriber's existing range and pain orders.
  - Contact the prescriber for inadequate pain relief within the ordered frequency interval or if intolerable adverse effects.

E. **Assessment of sedation level:** Use Pasero Opioid-Induced Sedation Scale (POSS) or Richmond Agitation-Sedation Scale (RASS) as appropriate to the patient.

[Approved by MSC (June 2024); Nursing CDT (April 2024)]

guideline-multiple-prn-pain-meds-and-range-orders-2024 (1).pdf
241.7 KB

CONTINUE

Range Dose Expectations

The patient may be given a lower dose or less potent agent upon request *if the lower dose or less potent agent are a part of the prescriber's existing range and pain orders*.

Example:

The example below uses this MMPM order set.

A patient is given another 5 mg of oxycodone 60 minutes after being given the first dose of 5 mg oxycodone for moderate/severe pain that is greater than the patient's reported pain goal.

4 hours from the second 5mg dose of oxycodone, the RN reassesses the patient's pain.

The patient reports moderate to severe pain but does not like how 10 mg of oxycodone makes them feel and would prefer to attempt to control their pain with only 5 mg of oxycodone, acetaminophen, and ibuprofen.

Since oxycodone 5mg is a part of the range order, and acetaminophen and ibuprofen are ordered as part of the MMPM order set, the RN may medicate the patient with the lesser dose/agent.

RN will document a complete pain assessment and select the option for "Patient preferred less potent medication" in the Pain Managment Intervention field.

CONTINUE

Administering a Lower Dose or Less Potent Agent

IMPORTANT: If the patient is given a lower dose or less potent agent per the patient request, this *must be documented* as part of the pain assessment that the lower dose/less potent agent administered is per the patient's preference.

MMPM orders include language that allows for this option without contacting the provider.

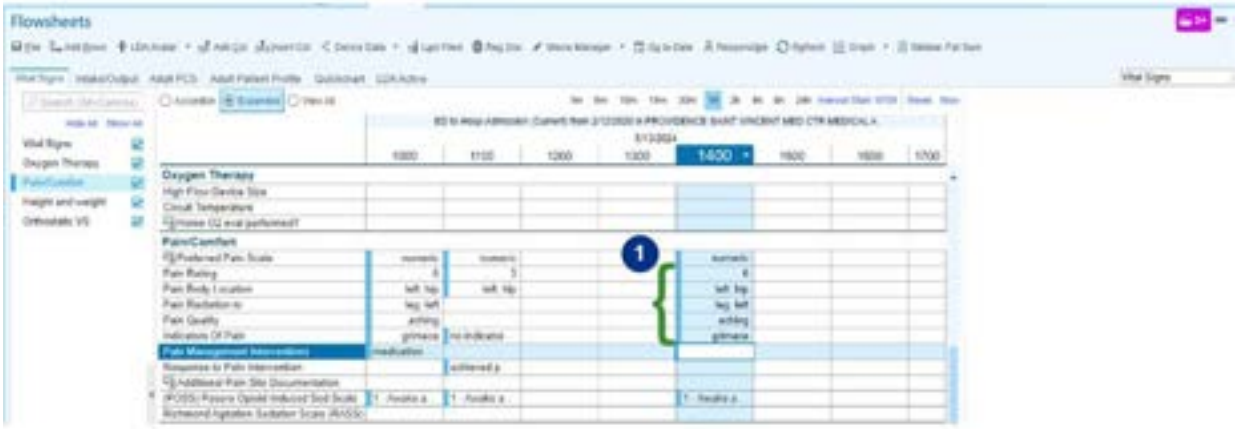
Instructions: Review the MMPM order below. Select the part of the order that indicates the language that allows you to provide a lower dose per the patient's preference.

Complete the content above before moving on.

Documenting Lower Dose or Less Potent Agent

Remember, documenting patient preferences for pain management, including a preference for a less potent dose, is done on the Vital Signs flow sheet with pain assessment documentation. Review the process below by selecting the icons and following the prompts to complete the interaction below.

Instructions: Review the process for documenting patient preference in Epic. Select the icons and follow the prompts to complete the interaction below.



Complete the content above before moving on.

Multimodal is Key!

IMPORTANT: Remember that the premise of MMPM is to use a *combination* of analgesic pain

medications to minimize the use of opioids.

The RN should still administer the non-opioids in an effort to minimize opiate use if:

- The patient's pain assessment requires administration of an opioid (i.e., the patient's initial pain assessment is severe pain),

or

- The patient requires escalation to an opioid for pain not relieved by a non-opioid,

or

- The patient has post-op order set that includes scheduled non-opioids.

CONTINUE

MMPM Best Practices

- For all patient's tolerating oral intake, the goal is to provide adequate pain relief with an oral non-opioid or a combination of an oral non-opioid and oral opioid per the patient's pain assessment.

Best practice is to transition the patient to oral medications when possible.

- IV opioids may be included in an MMPM order set for pain not controlled with the oral opioid options or if the patient is unable to tolerate oral medications.
- The RN must contact the prescriber for inadequate pain relief with oral analgesics within the ordered frequency interval or if the patient experiences intolerable adverse effects.

IV medications ordered as part of an MMPM order set are not intended to pre-medicate for anticipatory pain (e.g., dressing changes or physical therapy). IV analgesics for the purpose of pre-medication or anticipatory pain require a separate order with administration instructions that address their use in those types of situations.

CONTINUE

Safe Use of Opioids

Safe Use of Opioids

When administering opioid medications, follow best practices for safe medication administration, and monitor the patient for adverse outcomes related to opioid treatment. Monitor the patient's respiratory rate, oxygen saturation (pulse oximetry), end-tidal carbon dioxide level (capnography) if available, and sedation level using a standardized sedation scale.

Pasero Opioid-induced Sedation Scale (POSS)

Level of Sedation	Appropriate Action
S = Sleep, easy to arouse	• Acceptable • No action necessary • May increase opioid dose if needed
1 = Awake and alert	• Acceptable • No action necessary

	• May increase opioid dose if needed
2 = Slightly drowsy, easily aroused	• Acceptable • No action necessary • May increase opioid dose if needed
3 = Frequently drowsy, arousable, drifts off to sleep during conversation	• Unacceptable • Monitor respiratory status and sedation level closely until sedation level is stable at less than 3 and respiratory status is satisfactory • Decrease opioid dose by 25% to 50% (if permitted by order or protocol), or notify the practitioner or anesthesiologist for orders • Consider administering a non-sedating, opioid-sparing non-opioid, such as acetaminophen or a non-steroidal anti-inflammatory drug, if not contraindicated
4 = Somnolent, minimal or no response to verbal and physical stimulation	• Unacceptable • Stop opioid use • Consider administering naloxone (if permitted by order or protocol) • Notify the practitioner

	• Monitor respiratory status and sedation level closely until sedation level is stable at less than 3 and respiratory status is satisfactory

The *Pasero opioid-induced sedation scale* is a valid and reliable sedation scale used to assess sedation during opioid use for pain management. The scale provides nursing interventions for various levels of sedation that may include increasing the opioid dose in a patient who's easily aroused but reports unacceptable pain relief, or decreasing or holding a dose in a patient who's overly sedated. The practitioner's opioid order or facility protocol should permit you to decrease the dose if the patient is overly sedated. When performing an assessment, keep in mind that even a sedated patient may arouse when approached or touched. To properly assess sedation, observe how quickly the patient arouses and answers a simple question. The patient who arouses easily should be able to answer the question completely without falling back to sleep.

Lippincott Procedures. Pain Management. Pasero Opiod-induced sedation scale. December 14, 2018

References

Copyright 1994, Chris Pasero. Used with permission. -Established validity and reliability (0.903 by Cronbach's alpha) Nisbet A, Mooney-Cotter M. (2009). Selected sedation scales for reporting opioid-induced sedation assessments: Validity, reliability, ease of use, clinical decision making, and nursing confidence Pain Management Nursing 10 (3) 154-164. Research currently underway by these researchers on the use of the POSS in pediatric patients. -Established validity and reliability (0.909 by Cronbach's alpha) by Dempsey SJ, Davidson J, Cahill D, Agan D. (2008). Selection of a Sedation Assessment Scale for Clinical Practice: Inter-rater Reliability, Ease of Use and Applicability Testing of the Richmond-Agitation-Sedation and Pasero Opioid-Induced Sedation Scales. Poster presentation, NAON Congress, Tampa, FL May, 2009.

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Adverse Effects of Opioids

- Respiratory depression
- Drowsiness or sedation
- Constipation
- Nausea
- Vomiting
- Dependence

CONTINUE

Services Available to Support Patients with Complex Pain Needs

What To Do When Your Patient Has Complex Pain Needs

Patients whose pain is not managed successfully with the prescribed treatments should have their pain taken seriously. Unresolved pain can indicate another problem or serious issue. This must be addressed with the patient's care team.

Complex Regional Pain Syndrome (CRPS) is long-lasting pain and inflammation that can occur after an injury or event such as surgery, trauma, stroke, or cardiac arrest. The syndrome is sometimes associated with nerve damage but can occur without damage to a nerve. CRPS can occur in children and adults.

People living with CRPS experience pain that is more acute than typical pain and can be present despite the absence of visible injury.

It is important to take the patient's report of pain seriously. Collaborate with the care team in advocacy for patients who need specialized pain management services.

Available options vary by location, but complex pain management services provided by Providence include:

- Interventional Pain Management
- Pain Medicine
- Palliative Care
- Physical Therapy
- Rehabilitation

CONTINUE

Summary of Key Points

MMPM Key Points

Instructions: Select to expand each section below. You must select all sections to continue.

Key Point #1

Use nonpharmacological **and** pharmacological interventions to treat your patient's pain.

Key Point #2

Utilize the administration guidelines/order of use instructions within the MAR to select the appropriate analgesic option based on the patient's assessed pain level.

Key Point #3

When indicated per the administration guidelines, combine multiple analgesic medications to control the patient's pain while minimizing the use of opioids.

- Follow each medication's dose range and interval when administering each medication.
    - This may mean that medications are staggered at different times.
- When an opioid is required for severe pain or inadequate pain control with a non-opioid (i.e., acetaminophen and ibuprofen), the RN should administer the non-opioid analgesics ***in addition to*** the opioid for their synergistic properties and potential to minimize opioid use.

DO NOT stop administering the non-opioid analgesics just because the opioid is required!

Key Point #4

Closely monitor the patient's response to opioid medications to avoid oversedation.

- Use the ***Pasero Opioid Induced Sedation Scale***.

Key Point #5

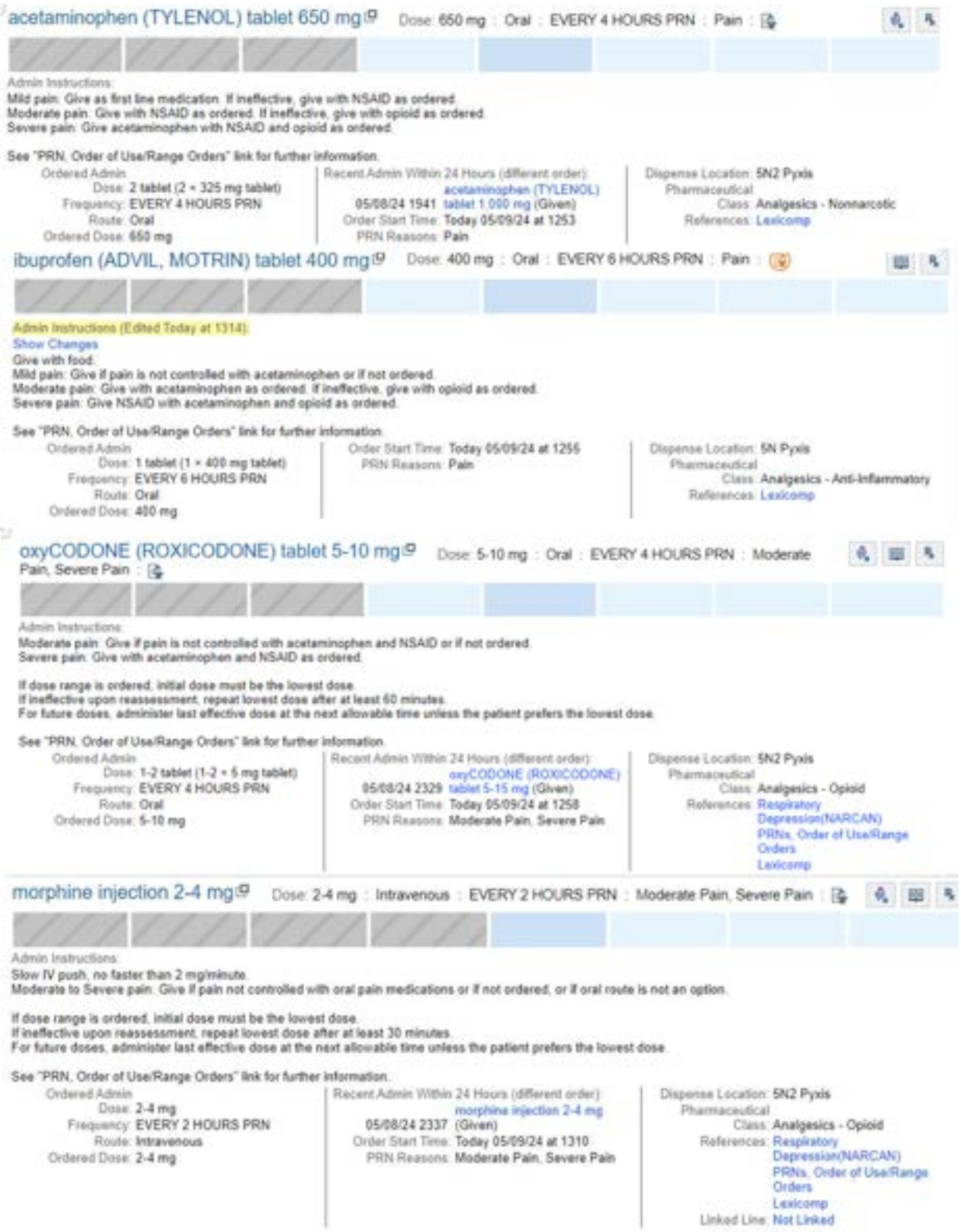
Notify the provider if the analgesics ordered do not adequately control the patient's pain.

- Remember: The goal for patients tolerating oral intake is pain control with PO analgesics. You must notify the provider and anticipate a new order for an

alternative opioid analgesic(s) when: IV analgesics are consistently required in addition to oral opioids for adequate pain control or the IV analgesics are not effective.

Complete the content above before moving on.

Knowledge Check



Instructions: Using the MMPM order block above, select your response to the questions below then select the **Submit** button.

Question #1: Based upon the MMPM order block above and the information in the Assessment and Intervention Summary shown here, what intervention(s) should you provide to the patient at 0900?

Assessment and Intervention Summary		
Time	Patient Assessment	Intervention(s)
0900	Newly admitted patient reports pain of 3/10	?

- [ ] Acetaminophen 650 mg
- [ ] Ibuprofen 400 mg
- [ ] Oxycodone 5 mg
- [ ] Morphine 2 mg IV
- [ ] Call the provider

Complete the content above before moving on.

Question #7

The nursing pain assessment should: (select all that apply)

- [ ] Employ standardized pain assessment scales appropriate to the patient's age and cognitive ability
- [ ] Include thoughtful inquiry taking into account any possible cultural

- [ ] influence on the patient's expression of pain
- [ ] Be performed 30 minutes after IV medication administration
- [ ] Be performed 60 minutes after PO medication administration
- [ ] Include an assessment of sedation level when opioids are administered

SUBMIT

Complete the content above before moving on.

Question #8

True or False: To administer an opioid for pain management when a range dose order is present, the nurse can select the initial dose based on the patient's size and pain level.

- ○ True
- ○ False

SUBMIT

Complete the content above before moving on.

Question #9

If a patient has complex pain needs, the nurse should: (select the best option)

- Advocate for multiple prescriptions for pain medication at discharge
- Administer as much pain medication as possible during their shift so the patient can sleep more
- Advocate for a consult with the local complex pain management specialist

SUBMIT

Complete the content above before moving on.

Question #10

Your patient Sam Arthur has oxycodone 5-10mg PO ordered every 4 hours for moderate pain. Mr. Arther complains of moderate pain at 1300, so you administer 5mg of oxycodone at that time. At your 1400 reassessment, Mr. Arthur reports his pain is well controlled. At 1530 Mr. Arthur complains of increasing pain and requests another dose. You administer another 5mg of oxycodone at 1530. At your 1630 reassessment, Mr. Arther states his pain is not controlled. **What should you do?** (select the best option)

- ◯ Administer 5mg of oxycodone at 1630.
- ◯ Try another intervention or call the provider. Mr. Arthur can have another 5mg of oxycodone at 1700, four hours after the initial 5mg dose was administered.
- ◯ Try another intervention or call the provider. Mr. Arthur can have another 5mg of oxycodone at 1930, four hours after the maximum dose was administered.

SUBMIT

Complete the content above before moving on.

Conclusion

You have completed the PROV: *Pain Management* module.

Select 'EXIT COURSE' above to close this window.

[CCO] Glycemic Management

Providence

The glycemic management course describes various types of diabetes, identifies resources related to patient diabetes education and care, insulin administration, hyperglycemia, and hypoglycemia management.

Objectives

DIABETES

What is Diabetes?

Glycemic Management

Hyperglycemia vs. Hypoglycemia

GLYCEMIC & DIABETIC INTERVENTIONS

Inpatient Carbohydrate Consistent Diet

INSULIN USE

Insulin Therapy

DIABETES RESOURCES

Patient Education

Diabetes Resources

CONCLUSION

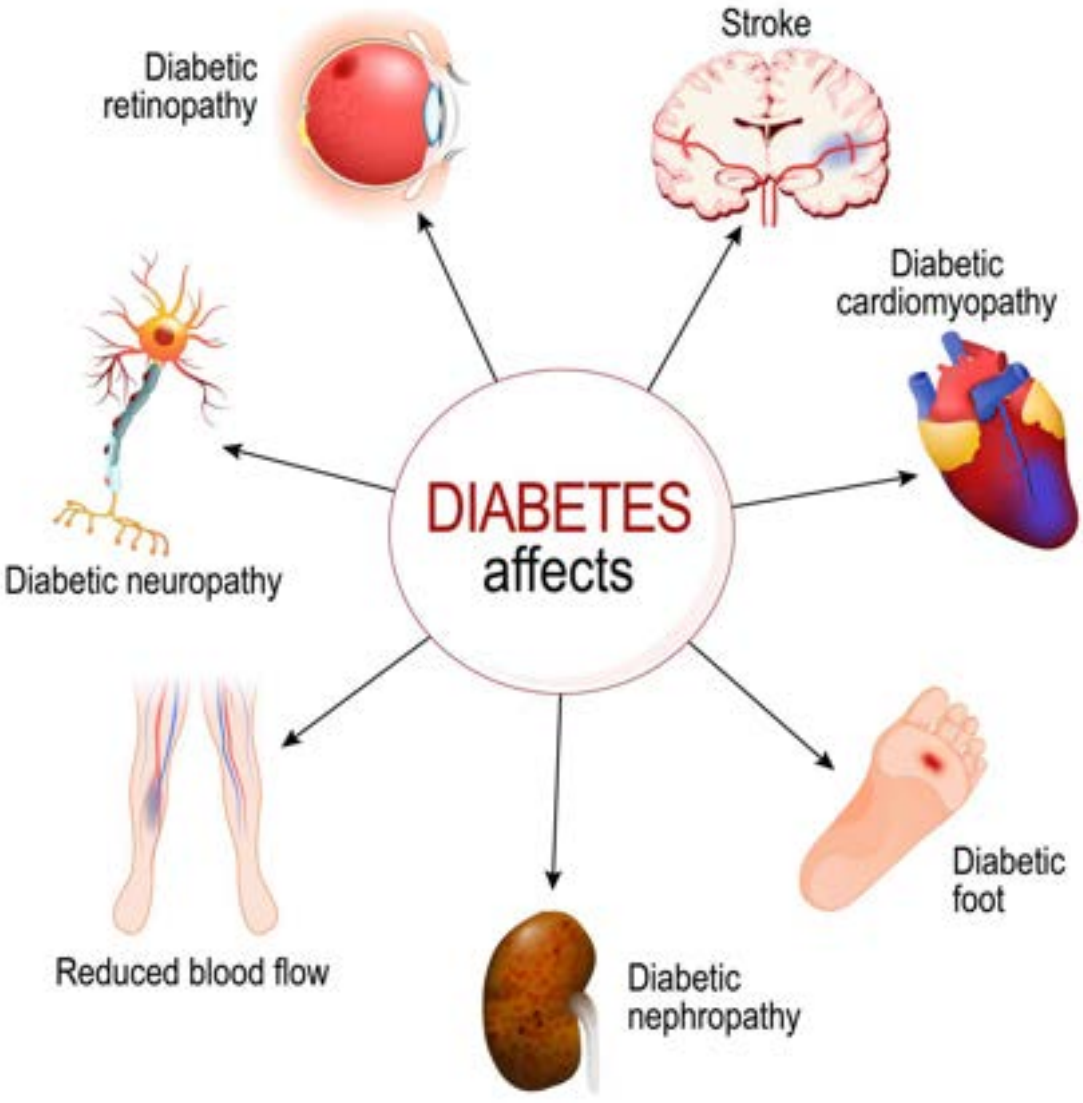
Summary

Objectives

Upon completion of the course, you will be able to:

1. Describe diabetes and identify the types.
2. Understand goals of glycemic management for hospitalized patient.
3. Distinguish between hypoglycemia and hyperglycemia.
4. Understand hypoglycemia management and prevention.
5. Estimate and document patient's meal intake.
6. Identify insulin type/action and appropriate administration.
7. Identify process for in-patient insulin pump use.
8. Prepare patients for transitional care from hospital to home by providing basic diabetes education and care.

What is Diabetes?



Potential Impacts from Diabetes

- Diabetes is a group of diseases characterized by hyperglycemia that result from defects in the body's ability to produce or use insulin.
- Insulin is needed to transport glucose from the bloodstream into the body's cells. The cells need glucose for energy production. When glucose cannot move into the cells, too much glucose remains in the bloodstream causing hyperglycemia.
- Hyperglycemia can cause damage to the blood vessels, nervous system and internal organs (American Diabetes Association, 2019).

Types of Diabetes & Causes

The following table summarizes types of diabetes and causes (American Diabetes Association, 2023):

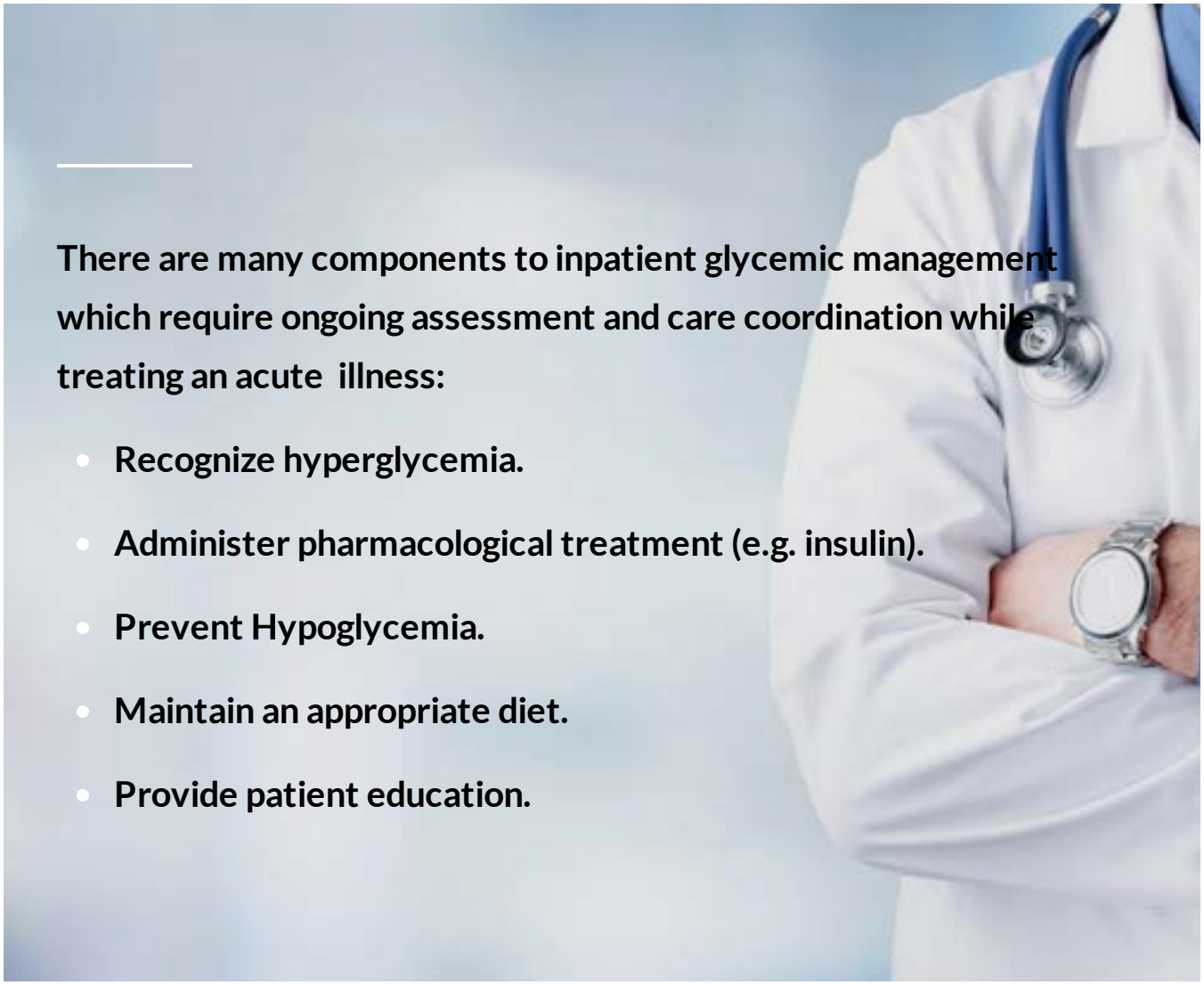
Types of Diabetes	Causes & Impact
Type 1 Diabetes	• Causes autoimmune β-cell destruction, usually leading to insulin deficiency • Can occur at any age, including latent autoimmune diabetes of adulthood

	• The body does not make insulin • The treatment is required insulin replacement therapy (insulin injections) • Usually leading to absolute insulin deficiency
Type 2 Diabetes	• Is the most common type of diabetes • Can occur at any age • Runs in families (hereditary) • This form involves non-autoimmune progressive loss of adequate β-cell insulin secretion frequently on the background of insulin resistance and metabolic syndrome • Treatment may include any or all of the following: lifestyle modifications, oral diabetes medications and/or insulin replacement therapy
Gestational Diabetes Mellitus (GDM)	• Diagnosed in the second or third trimester of pregnancy • Caused by insulin resistance due to placental hormones • Can be resolved after pregnancy if there are no underlying diabetes or prediabetes before pregnancy • Maternal risk to develop type 2 diabetes after deliver

	• Individuals diagnosed with GDM should receive lifelong screening for prediabetes to allow interventions to reduce diabetes risk and for type 2 diabetes to allow treatment at the earliest possible time
Other Types of Diabetes & Causes	• Monogenic diabetes syndromes (such as neonatal diabetes and maturity-onset diabetes of the young) • Diseases of the exocrine pancreas (such as cystic fibrosis, pancreatitis or pancreatectomy) • Drug- or chemical-induced diabetes (such as with glucocorticoid use, chemotherapy, in the treatment of HIV/AIDS, or after organ transplantation)

Lesson 3 of 9

Glycemic Management



Inpatient Glycemic Management

Glycemic management policies are intended to ensure the safety and proper care of people with diabetes during hospitalization. Please review ministry-specific guidelines/policies with your preceptor or charge nurse:

1. Care of the patient with diabetes or dysglycemia (glucose abnormalities)
2. Hypoglycemia management
3. Continuous external insulin pump therapy
4. Adult IV insulin infusion (columnar)

Please review guidelines below related to admission assessments and anticipated orders:

Admission Assessment

- Past medical history (type 1, type 2 or GDM)
- Document patient home medications including last time taken
- Assess patient nutritional status & start a diabetes care plan

- Assess patient understanding of diabetes (blood glucose monitoring, medications, sign and symptoms hyperglycemia/hypoglycemia, nutrition and sick-day management)

Anticipated Orders on Admission

- A1c *(recommended for patients with diabetes or hyperglycemia if not performed in the past 3 months)*
- Point of care testing (POCT) glucose
- Insulin (diabetes oral medications are discouraged while patient is in the hospital)
- Carbohydrate consistent diet
- Hypoglycemia management orders

Inpatient Glucose Targets

Blood glucose goals should be individualized with consideration of the patient's age, length of time since diagnosis, frequency of hyper/hypoglycemic events, and patient's comorbidities.

The following are inpatient glucose targets. Please note: *critical value test results are individualized by ministry.*

Adult patient (non-pregnant) and Pediatric

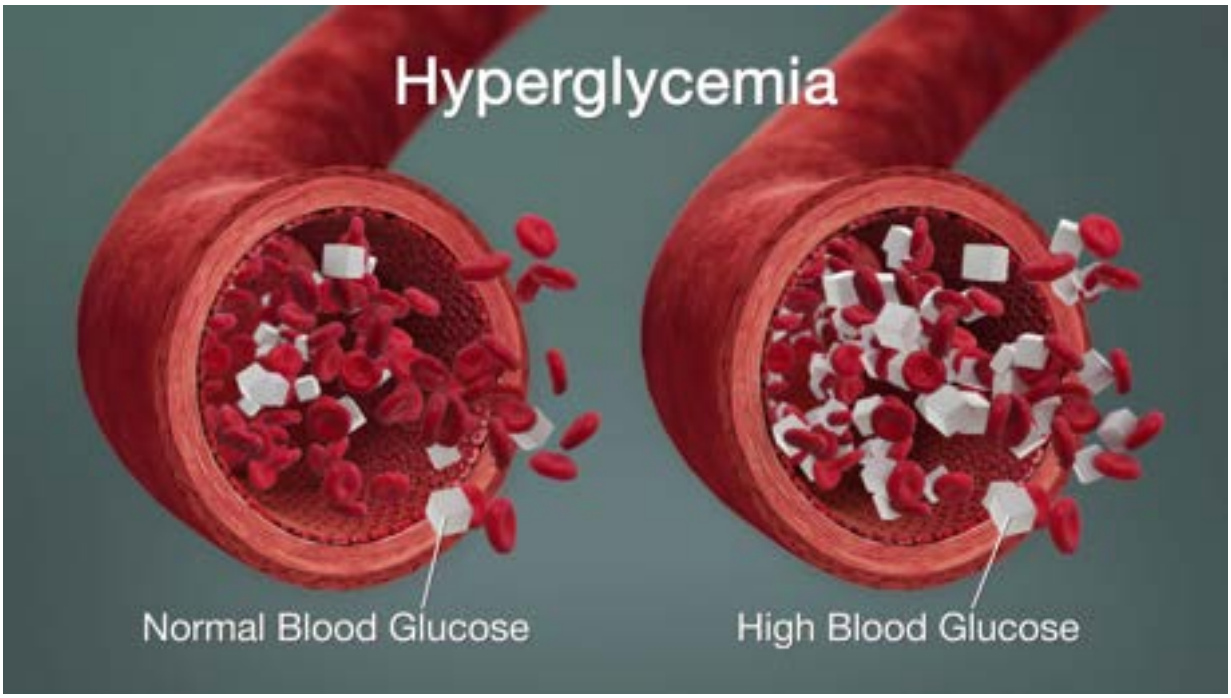
- [ ] Blood Glucose goal: 140–180 mg/dL
- [ ] Hyperglycemia BG >180 mg/dL
- [ ] Hypoglycemia BG <70 mg/dL

For Pregnant Patients:

- [ ] Blood Glucose goals: Fasting <95 mg/dL and 1 hour post prandial <140 mg/dL or 2 hour post prandial blood glucose < 120 mg/dL
- [ ] Hypoglycemia BG <70 mg/dL

Please contact your unit manager or preceptor for blood glucose variations. Source: ADA glucose target guidelines.

Hyperglycemia vs. Hypoglycemia



Hyperglycemia Review

HYPERGLYCEMIA
SYMPTOMS

Hyperglycemia for hospitalized patients is defined as blood glucose levels above 180 mg/dL.

Common causes of hyperglycemia for hospitalized patients include:

- Insulin deficiency.
- Insulin resistance.
- Inadequate or missed doses of medication.
- Mismatch between insulin and intake.
- Use of corticosteroids or vasopressors.
- Stress, illness, infection, wound, and surgery.
- Lack of physical activity.

Hyperglycemia Intervention Considerations

Please review the following considerations:

- All patients with diabetes or hyperglycemia should have their A1C done on admission or during hospitalization.
- All patients with diabetes or hyperglycemia should have their point of care glucose monitoring on admission and during

hospitalization.

  - The frequency depends on the patient's nutritional status and provider order (i.e. AC/HS, Q4 hr. or Q6 hr.).
  - For pregnant patients, blood glucose monitoring is recommended before meals and 1—hour postprandial (this check is for assessment only).

- Let provider know if Blood Glucose (BG) >180 on two occasions within 24 hours.
- Refer to your ministry's specific guidelines for critically high blood glucose (i.e., BG >400 mg/dL).
- Administer insulin per order parameters.
- Provide carbohydrate consistent diet.
- Night snacks are discouraged unless patient is not eating dinner.

Hypoglycemia Review

HYPOGLYCEMIA
SYMPTOMS

SWEATING

PALLOR

IRRITABILITY

HUNGER

LACK OF COORDINATION

SLEEPINESS

Hypoglycemia is defined as a blood glucose level less than 70 mg/dL.

Common Causes of Hypoglycemia for Hospitalized Patients:

1. Critical illness (hepatic, renal or cardiac failure, sepsis).
2. Insulinoma.
3. Recent surgery.
4. Advanced age (frailty).
5. History of alcohol abuse or withdrawal.
6. Too much medication (oral diabetes pills or insulin).
7. Continuation of oral diabetes medications with or without insulin.
8. Mismatch between insulin and food intake (e.g. fast acting insulin given to a patient with decreased intake, missed meal or vomiting).
9. NPO; Interruption of TF/ TPN.
10. Hyperkalemia treatment with insulin.
11. Steroids titration.

12 Transport off unit after insulin given.

Hypoglycemia Intervention Considerations

1. Hypoglycemia can be life-threatening. After identifying hypoglycemia, treatment should begin immediately.

2. As a reminder, the “Rule of 15” is the first step of treatment for all patients: 15 grams of carbohydrates and re-check in 15 minutes. If patient remains hypoglycemic, repeat treatment, recheck blood glucose in 15 minutes, and notify a the provider.

3. Inform the provider when the patient's BG less than 70mg/dL x 2 or less than 50mg/dL x 1.

4. After any episode of hypoglycemia, the treatment regimen should be reviewed/changed with provider as necessary to prevent further hypoglycemia.

5. Always follow the insulin administration parameters for patients with poor appetite or who are not eating.

6. Give insulin when tray is in front of the patient.

7. Clarify with prescribing provider if oral diabetes medications are ordered.

8. Hyperkalemia treatment with insulin: perform POCT glucose and give D50 5 minutes before insulin followed by blood glucose checks.

9. Notify physician for adjustment of insulin orders when there is a change in steroid dose.

10 If corticosteroids dose changes (ex: Solumedrol, Prednisone) notify provider (patient may need adjustment of insulin orders).

11 During the transition of care (ED to floor, floor to floor, floor to procedure area) hand-off communication should include last blood glucose check result, last dose of insulin, last meal taken and/or parenteral nutrition (tube feeding and/or continues bolus).

Hypoglycemia Event Documentation

- Assessment - Hypoglycemia signs and symptoms patient reported and/or nurse observed.
- Interventions - Hypoglycemia treatment (glucose gel, juice or D50).
    - ANY oral treatments such as juice or milk must be documented in Epic I/O Flow Sheet at the time it was given
    - Recovery snack/meal intake (given after patient no longer hypoglycemic).
    - Provider notification.
- Outcome - Patient response to the treatment.

Inpatient Carbohydrate Consistent Diet

A *Carbohydrate Consistent Diet* is a standard hospital meal plan that provides a consistent amount of carbohydrate at each meal.

The following summarizes a standard hospital diet for patients with diabetes. Please click on the ***plus (+) sign*** for more information:

Carbohydrate Consistent Diet Serving Sizes

- 45 grams (3 servings)
- 60 grams (4 servings)
- 75 grams (5 servings)

Clear Liquids

- Carbohydrates are in the form of juices and jello.
- Sugar is the only source of energy on this diet.

Full Liquids

- Carbohydrates are in the form of dairy and juices.

Tube Feeding

- Disease specific formulas.

TPN

- Carbohydrates in the form of dextrose.

Meal Intake Documentation

1. When the meal is complete, visually evaluate the patient's tray.
2. Estimate the percent of food eaten based on the amount of food remaining.
3. Document patient meal intake using increments of 0-25-50-75-100%.
4. If the patient's insulin dose is based on carbohydrates, please document carbohydrate intake.

The following are examples of estimates of meal intakes.
Please click each flash card for more information:

0% - Patient refused meal OR
ate one or two bites of any item.

25% - Patient ate at least 1/2 of one item of protein or starches.

50% - Patient ate at least 1/2 of every item on the tray (1/2 starches, protein, and desert), and only a few items are left such as vegetables or soup.

75% - Patient ate most of the food (starches, protein, and desert), and only a few items are left such as vegetables or soup.

100% - Entire meal is consumed except for minimal amount of food left (i.e., 1/2 vegetables or a few spoons of soup is left).

Insulin Therapy

In the hospital setting, insulin is a preferred treatment to manage hyperglycemia

1. Basal Insulin.
2. Bolus or Nutritional Insulin.

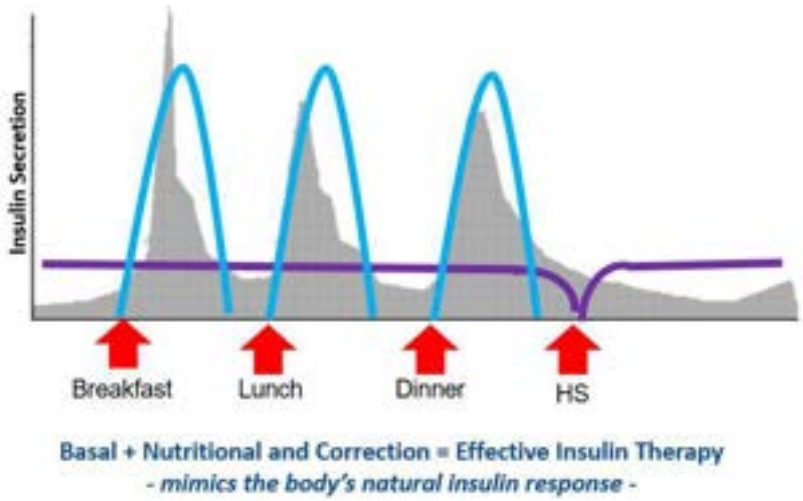
Basal Insulin or Long Acting Insulin

- The amount of insulin necessary to regulate blood glucose levels overnight and between meals
- If FBG below 140 mg/dL or trending down, consider contacting the provider as the next dose may need to be lowered
- Usually administered once or twice a day
- Onset 2 hours and duration up to 24 hours

Bolus Insulin

- It is a rapid acting type of insulin onset 15-30 minutes, peaks in 1-2 hours and continue to work 4-5 hours
- Nutritional Insulin' usually given as a bolus dose to regulate blood glucose levels following a meal
- Correction Scale' is additional bolus dose and given to correct elevated blood glucose levels (administered per parameters AC/HS or q 6 hrs)

Basal and bolus (nutritional plus correction) insulin regimens are the preferred treatments for hospitalized patients. See chart below for comparison of the physiological insulin release vs. basal and bolus insulin treatment.



Insulin Pump Care

Patients can receive insulin through an insulin pump while in the hospital.

The following procedure should be considered:

1. Physician order.
2. Patient signs an agreement.
3. Hospital meter must be used for blood glucose monitoring.
4. Patient uses own supplies (hospital will provide fast acting insulin that is on formulary).

5. Nurse does not manage insulin pump but must assess site and ensure patient's ability to use the pump.
6. Nursing documentation: MAR and flow sheet.
7. If pump is discontinue or removed, alternative insulin treatment must be ordered.
8. Must be disconnected for MRI, X-Ray, or CT scan.
9. Must be removed if patient is suicidal.

Patient Education

Teachable Moments

Take advantage of the following opportunities or *teachable moments* during the patient's hospital stay to provide

diabetic education and address patient questions/concerns:

- **During medications administration:**
  - Review instructions on dosage and side effects.
  - Teach patient to self-administer insulin.
- **When checking patient blood glucose level:**
  - Demonstrate and discuss monitoring technique & target levels.
- **During meal time:**
  - Discuss meal plan, portion size and how food affects blood glucose.
  - For more comprehensive diet education obtain RD consult.
- **Listen to the patient and ask questions:**
  - Involve patient in self-care.

Preparing a Patient for Discharge

Assess the level of understanding of and preparedness for diabetes self-management including:

- Home blood glucose monitoring regimen and goals
  - Is patient clear about the diabetes care plan?
  - Does patient have a glucose monitor for home use? If a glucometer is needed, please ask the provider for a prescription.
- When and how to take medications

    - Does patient know how to inject insulin and how to prevent and to treat hypoglycemia?
- Recognition of signs and symptoms of hyperglycemia and hypoglycemia
- Nutritional habits
- Sick-day management
- Appropriate home sharp disposal.

Consider whether the patient would benefit from outpatient diabetes education and collaborate with providers, case managers, social workers, registered dietitian, your diabetes educator (if applicable), or community care coordinator to help arrange for patient discharge and follow-up care.

When preparing patients for self-care, please consider discussing the following topics.

Click on each flashcard below.

- Help patients understand the importance of routine glucose monitoring.
- Discuss what blood glucose values mean, how to look for trends, and interpret the numbers.
- Remind patient that

Explain patient medication instructions before discharged.

A key part of managing diabetes is eating healthy food everyday. The patient may benefit from an RD consultation related to diet education.

- Explain that regular exercise can improve BG levels, health, and quality of life.
- Recommended time is 30 minutes of physical activity a day (some patients may need medical clearance).

- Encourage patients to check their feet daily for cuts, bruising, or swelling.
- Remind patient to never walk barefoot and wear comfortable shoes that fit well.

To reduce stress levels, suggest patient exercise regularly, eat healthy, well balanced meals, sleep 7 to 8 hours, and practice relaxation techniques such as yoga.

Diabetes Resources

The following resources are available related to patient education (find what resources are available within your ministry from your preceptor or charge nurse):

1. Diabetes patient education T.V. channel *(ministry specific)*.
2. Diabetes ministry specific intranet site.
3. Krames on Demand which include handouts or videos.
4. Diabetes education department or your diabetes resource team.

Summary

Thank you for completing the Glycemic Management course! We hope you will be able to apply the following key points you learned from the course to care for your patients within your unit:

1. Describe diabetes and identify the types.
2. Understand goals of glycemic management for hospitalized patient.
3. Distinguish between hypoglycemia and hyperglycemia.
4. Understand hypoglycemia management and prevention.
5. Estimate and document patient's meal intake.
6. Identify insulin type/action and appropriate administration.
7. Identify process for in-patient insulin pump use.
8. Prepare patients for transitional care from hospital to home by providing basic diabetes education and care.

For unit specific questions related to Glycemic Management, please contact your unit manager or preceptor.

Safety in the Workplace

This course is part of a series of regulatory requirements for New Caregiver Orientation

- **Introduction**
- **Emergency Codes/Plain Language Critical Event Notification**
- **Fire Protection and Response**
- **Hazardous Materials**
- **Electrical Safety**
- **Magnetic Resonance Imaging (MRI)**
- **Radiation Safety**
- **Medical Gas Safety**

Introduction

Welcome!

Upon completion of this course, learners will be able to:

- Recall the meaning of various emergency codes
- Clean up an incidental spill

- Locate resources for handling hazardous materials
- Use chemicals safely
- Use cords and outlets properly
- Understand the four levels of MRI Safety Zones
- Define ALARA
- Know how to store medical gas cylinders
- Describe RACE or PASS for fire response

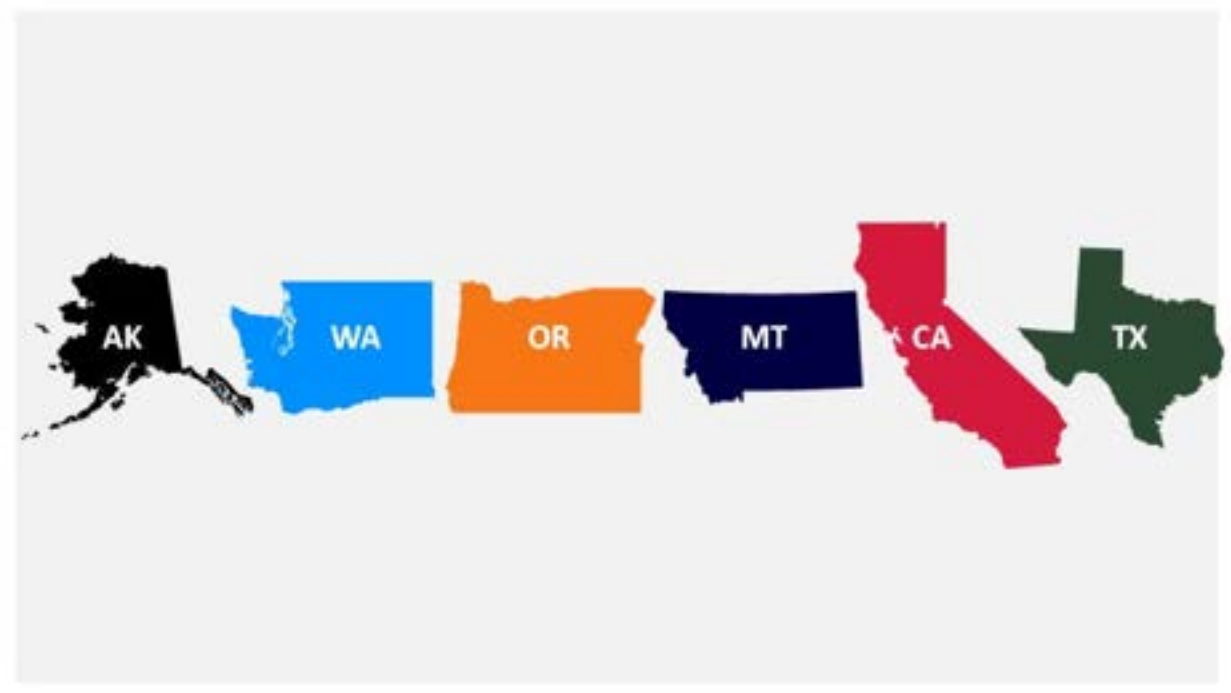
CONTINUE

Emergency Codes/Plain Language Critical Event Notification

Emergency Codes, Plain Language Critical Event Notification, and responses vary by region. All caregivers must be familiar with their specific guidelines.

Where can you find your codes and/or plain language critical event information? It may be on the back of the card with your ID badge. Depending on facility, it may be found on the Emergency Codes Poster.

Click on your state below to review more information about Emergency Codes/Plain Language Critical Event Notification.



Complete the content above before moving on.

Fire Protection and Response

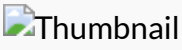
How Can You Help?

- [ ] Adhere to the PSJH Smoking Policy, which states, "The use of tobacco, in any form, is prohibited in or on any property owned or leased by Providence"
- [ ] Remove damaged or faulty equipment from service
- [ ] Tag and submit malfunctioning equipment for repair (including description of problem)
- [ ] Do not use any piece of equipment that you have not been trained to use
- [ ] Keep hallways clear at all times
- [ ] Keep items stored on shelves further than 18 inches from sprinkler heads

CONTINUE

In Case of Fire

Click on the icons below to learn more about what to do in case you encounter a fire.



Complete the content above before moving on.

Knowledge Check

You're doing great! Let's review the material we just covered.

What is the correct four word sequence for proper fire extinguisher use?

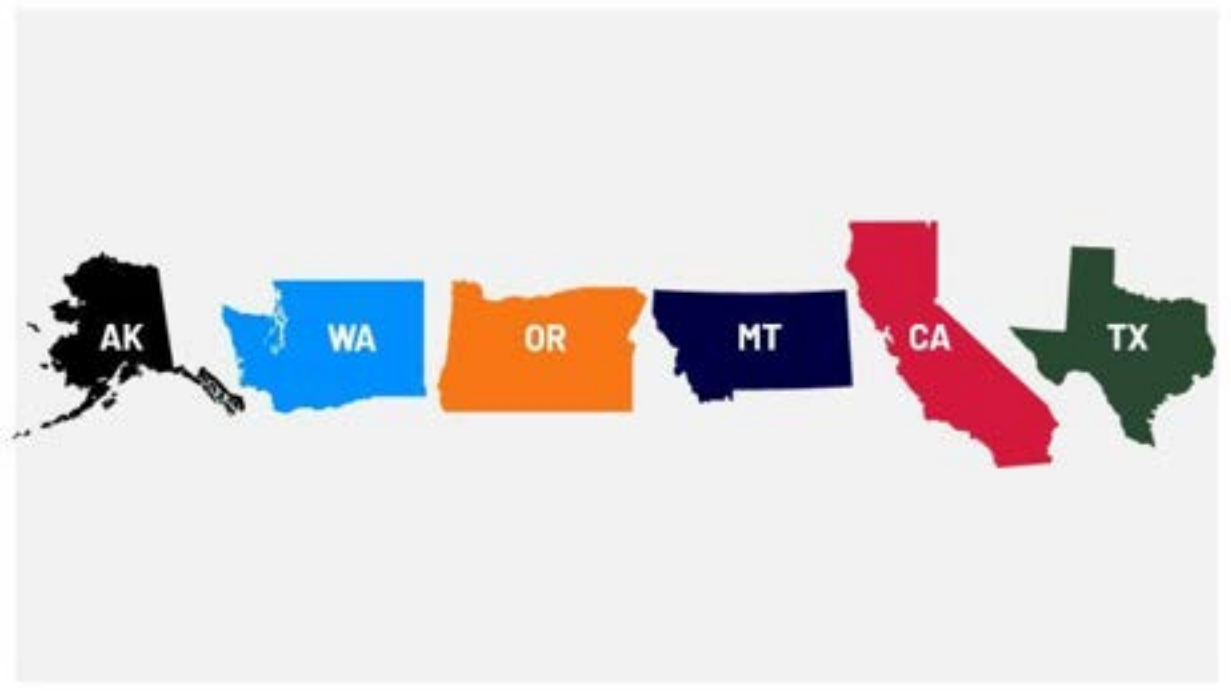
- Pull, Aim, Squeeze, Spray
- Pull, Aim, Squeeze, Sweep
- Pull, Aim, Sweep, Squeeze
- Pull, Aim, Sneeze, Sweep

SUBMIT

Complete the content above before moving on.

During a Fire Alarm

Click your region to reveal how to respond to a fire alarm.



Each department is to develop a specific response to support these plans. Respond in accordance with these procedures and those developed by your department. A large-scale incident may develop into a CODE TRIAGE.

Complete the content above before moving on.

During an Emergency

- Protect yourself, triage self and area, report problems, provide assistance
- Follow your department's specific Fire Response Plan, Standard Operating Procedure (SOP), and the facility's overall Disaster Plan
- Be aware of your surroundings and ready for further directions from the overhead paging system
- Follow the Hospital Incident Command System (HICS)
- Follow your chain of command
- Always communicate clearly with plain language

CONTINUE

Hazardous Materials

A hazardous material (HazMat) is any item or agent (biological, chemical, radiological, and/or physical), which has the potential to cause harm to humans, animals, or the environment, either by itself or through interaction with other factors.

HazMat safety is the type of thing most of us don't think about until something happens. And when it does, the first few seconds are critical.

It's important that we are all familiar with hazardous materials we may encounter each day:

- How to use them safely
- What to do if something goes wrong
- What protective gear you need

Being prepared means knowing how to prevent and how to respond to emergencies.

CONTINUE

Usage and Protection

Use chemicals safely by following a few simple guidelines:

1. When chemicals are stored, be sure hazardous materials are properly segregated and in the proper cabinet. Please note that not all chemicals require storage in a cabinet. Refer to the product label and/or chemical's Safety Data Sheet (SDS) for more information.
2. Don't mix chemicals unless specified by the manufacturer.
3. Always wear appropriate Personal Protective Equipment issued by your department.

Secondary containers may be used but must be labeled with:

- Name of the hazardous chemical
- Appropriate health and/or physical hazard warnings

These can be handwritten but must be:

- Legible
- Written in English
- Prominently displayed on the container

Chemical Emergency Response

All our preparation can reduce but not eliminate emergencies.

An incidental spill is a release of a hazardous substance that does not pose a significant safety or health hazard to caregivers in the immediate vicinity, nor does it have the potential to become an emergency.

Response to a Chemical Emergency varies by region/facility. Each caregiver should be able to clean up their own incidental spill if they are trained to do so; otherwise call for hazardous spill.

CONTINUE

Electrical Safety

A hot outlet can be an indication of unsafe wiring:

- Unplug cords from the outlet
- Report the hazard

Do not use outlets or cords with exposed wiring. Report damaged outlets or cords. All outside electrical devices (i.e. corded devices brought in from home) need to be approved by Facilities and/or Biomedical Engineering.

It is very common to have fires and equipment failures due to bad wiring and wrong amperage used by household and/or homemade power cords brought into the facility.

CONTINUE

Use cords and outlets properly

All multi-plugs must be approved by Medical Engineering or Facilities Department depending on your facility policy.

- Do not bend, stretch, or kink power cords excessively
- Do not jerk cords from outlets; pull on the plug
- Do not rest equipment on power cords
- Do not use tape on power cords or plug outlets
- Use only power cords with three-prong plugs, never use:
  - Adapters two-prong plugs
  - Broken three-prong plugs

CONTINUE

When to use Power Strips:

Line-operated medical equipment is used in a patient care room/area, inside the patient care vicinity:	Line-operated medical equipment is used in a patient care room/area, outside the patient care vicinity:	Line-operated medical equipment is not used in a patient care room/area, inside and outside the patient care vicinity:
Strips have to be permanent component of a rack-, table-, pedestal-, or cart-mounted and tested medical equipment assembly	UL strips could be used for medical and non-medical equipment	UL strips could be used with precautions
Strips providing power to medical equipment in a patient care room/area must be **UL 1363A** or **UL 60601-1**	Strips providing power to medical equipment in a patient care room/area must be **UL 1363A** or **UL 60601-1**	
Power strips cannot be used for non-medical equipment	Strips providing power to non-medical equipment in a patient care room/area must be **UL 1363**	

CONTINUE

Magnetic Resonance Imaging (MRI)

There are many caregivers who may be in an MRI area. These may include someone transporting a patient, Environmental Services staff, or staff monitoring the patient. All caregivers need to be aware of important safety issues when working in or near an MRI treatment area.

Safety is critical and mandatory.

The Static Magnetic Field is up to 60,000 times stronger than that of the earth. The pull of the magnet gets stronger the closer the metal object gets to the scanner. The Static Magnetic Field is always on.

Click the cards below to learn about real examples of ignored safety compliance.

Tearing of brain tissue from movement of an aneurysm clip.

Injury to patient when scissors were pulled out of a nurse's hand and struck a patient.

Patient death when metal oxygen tank accelerated toward the magnet and fractured a patient's skull.

Complete the content above before moving on.

RF fields produce heat and interferes with electronic equipment.

Hazards:

- Radio Frequency (RF) fields can induce electrical currents in metal implants or cables, which produce heat, resulting in severe burns (i.e. heat from ECG cables, pulse oximeters, etc.)
- Electronic device failure or malfunction due to electromagnetic interference (i.e. pacemaker, deep brain stimulator, Internal Cardiac Defibrillator).

Only Use Approved Fire Extinguishers

The MR-Safe, UL/ULC approved fire extinguisher has a completely non-magnetic stainless-steel shell and non-magnetic valve, hose, and nozzle.

The unit was tested by Magnetic Resonance Safety Testing Services and shown to be non-magnetic to 3.0 Tesla. The extinguisher can safely be mounted within the MRI room.

CONTINUE

Controlling access to the MRI area supports safety.

Four levels of MRI Safety Zones exist

Zone I	All areas freely accessible to the general public without supervision. Magnetic fringe fields in this area are less than 5 Gauss (0.5 mT).
Zone II	Still a public area, but the interface between unregulated Zone I and the strictly controlled Zones III and IV. MR

	safety screening typically occurs here under technologist supervision.
Zone III	RESTRICTED ACCESS: An area near the magnet room where the fringe, gradient, or RF magnetic fields are sufficiently strong to present a physical hazard to unscreened patients and personnel.
Zone IV	RESTRICTED ACCESS: Zone IV is synonymous with the MRI magnet room itself. This zone has the highest field (and greatest risk) and from which all ferromagnetic objects must be excluded.

If in doubt, leave it out.

CONTINUE

Access Control

You must have permission to enter **EACH TIME** you go in the scan room.

Access is limited to trained MRI staff.

Patients/visitors/ caregivers are screened and then accompanied by trained caregiver.

Removal of ALL Metallic Objects

Thoroughly screen patients **prior** to entering MRI Scan Room:

- Name Badges
- Watches
- Keys
- Cell Phones/Pagers
- Scissors
- Stethoscope
- Hearing Aids
- Jewelry
- Coins
- Hair Accessories
- Any Other Metallic Objects

Inspection is REQUIRED for objects such as:

- Oxygen Cylinders

- Stretchers
- Monitoring Equipment
- Any Other Similar Devices

CONTINUE

MRI Safety Summary

Drag the statements to the correct answer to check your knowledge.

True

The MRI magnet is always on.

All objects are considered unsafe in the MRI environment until approved.

MRI staff will always follow pre-screening protocols for anyone entering.

Injuries/Deaths have occurred as a result of not following safety precautions.

False

Anyone can go into the MRI scan room at any time.

REMEMBER: **If you are ever unsure about MRI safety measures, please reach out to the MRI Tech for help.**

Complete the content above before moving on.

Radiation Safety

- [ ] Minimize the time you spend near radiation
- [ ] Maximize your distance from the source
- [ ] Use lead shielding such as aprons or walls
- [ ] Wear a dosimeter badge if required when working around radiation

Radiation Policy

It is the policy of Providence Health & Services to maintain occupational radiation exposure levels

As Low As Reasonably Achievable (ALARA)

Do Not Enter any area with these signs posted, unless authorized by the Department or Area Manager. These signs and labels warn of potential radiation exposure in the area.

- [ ] Don't fold or crumple lead aprons (causing cracks)
- [ ] Check lead apron each time prior to donning for any cracks or holes
- [ ] Alert others to radiation exposure
- [ ] Shield
- [ ] Use appropriate signage

CONTINUE

Medical Gas Safety

Restrain all Cylinders

All cylinders must be restrained to prevent them from tipping over.

A wheeled cart, wall bracket or similar restraint is acceptable.

02 cylinders CANNOT be left in the wheeled cart for storage.

They may not be left lying on beds or standing unsupported! These 02 tanks can become ***missiles*** if they fall or are hit just right, causing major damage or harm.

CONTINUE

Keep EMPTY cylinders separate while in storage

Medical gas cylinder storage areas will be designated as either, "FULL", "PARTIAL" or "EMPTY".

FULL cylinders are defined as those which have never been opened. Make sure there are no more than 12 FULL cylinders stored in any smoke compartment.

Once the regulator valve has been opened , the cylinder is considered PARTIAL and it may no longer be stored in the FULL storage area.

Users will **reference the built-in pressure gauge** to ensure there is enough medical gas to meet the patient's need in the PARTIAL storage area.

CONTINUE

Some locations will use an Empty rack and Full/Partial rack system.

The same rules apply: **Empties must be separated**.

Label Storage Areas

Signs must be used to designate storage locations. Cylinders must be separated in different storage racks.

Some departments do not have room for three storage areas and may choose to have two storage areas:

- FULL/PARTIAL
- EMPTY

Separate empty cylinders

Those cylinders defined as empty shall be segregated from all other cylinders that are intended for patient care use.

Your facility will determine and document what level is "empty".

Only cylinders in storage need to be separated and labeled

Single E cylinders on 2-wheeled carts; cylinders which are attached to a piece of medical equipment, a bed, stretcher or wheelchair; or cylinders available to a patient for use in their room are considered to be "in-use" even if the valve is not connected and gas is not actively being used at the moment.

"In-use" cylinders, like this E-cylinder on a 2-wheeled cart does not need to be labeled nor does it count toward your total amount of cylinders in a suite.

Hazards associated with compressed gases include oxygen displacement, fires, explosions, and toxic gas exposures, as well as the physical hazards associated with high pressure systems. Special storage, use, and handling precautions are necessary in order to control these hazards. Learn more by clicking here.

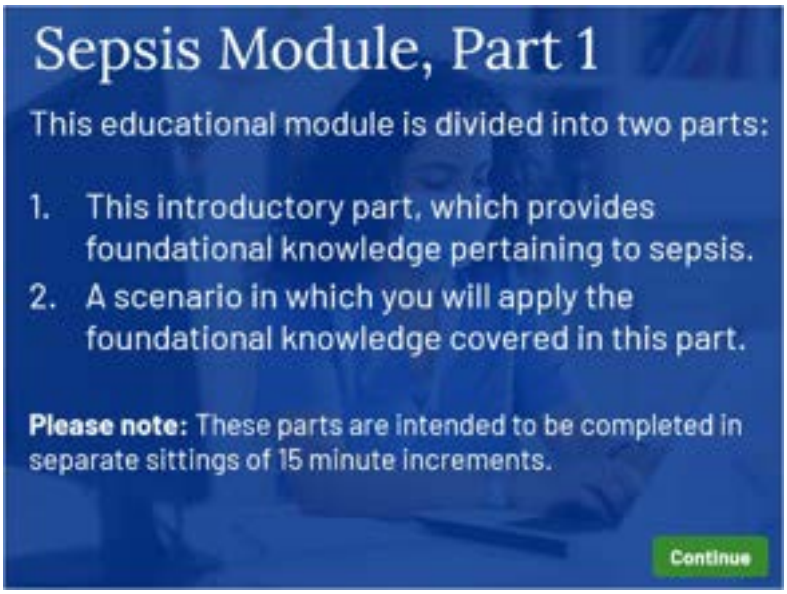
CONTINUE

Congratulations! You have completed this eLearning module. Click the Exit Course link above to close this window.

Sepsis Module Part 1 v3

1. Intro

1.1 Intro and directions



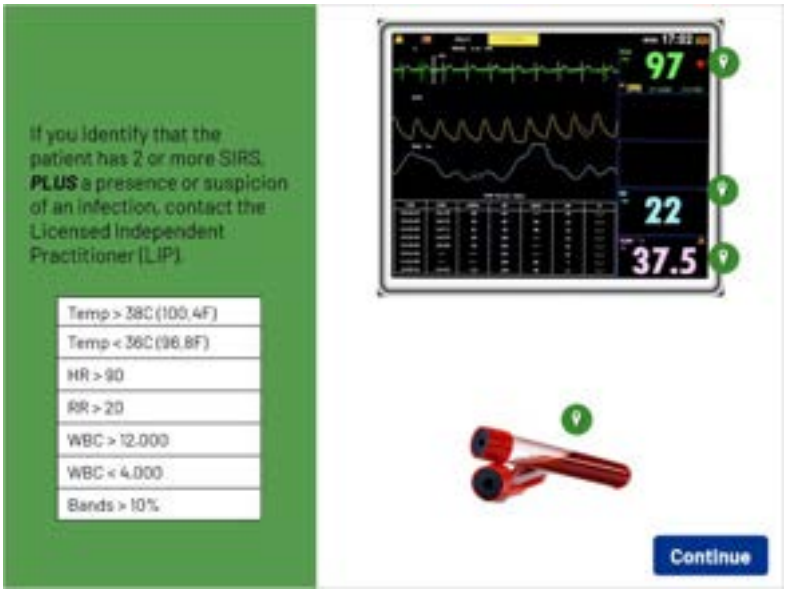
1.2 Sepsis definition

1.3 Sepsis importance

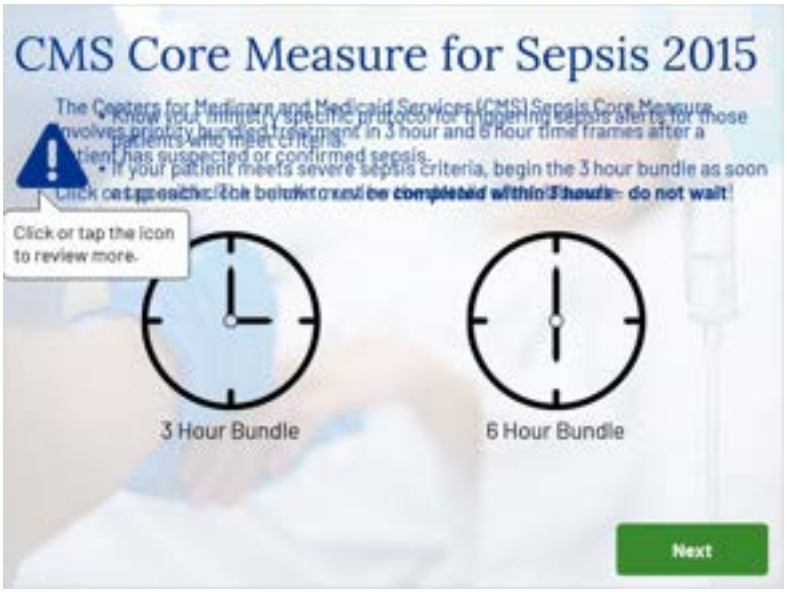
Clock (Slide Layer)

1.4 SIRS

is infection present (Slide Layer)

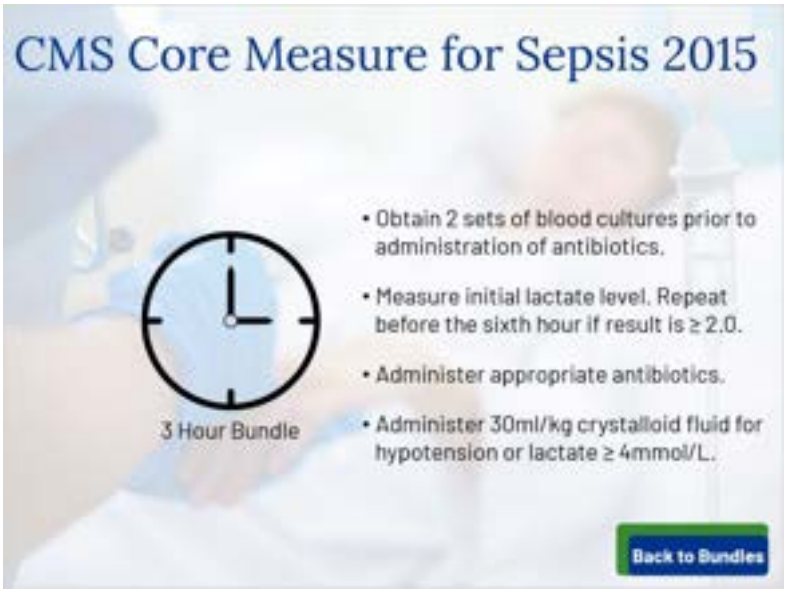


1.5 CMS Bundles

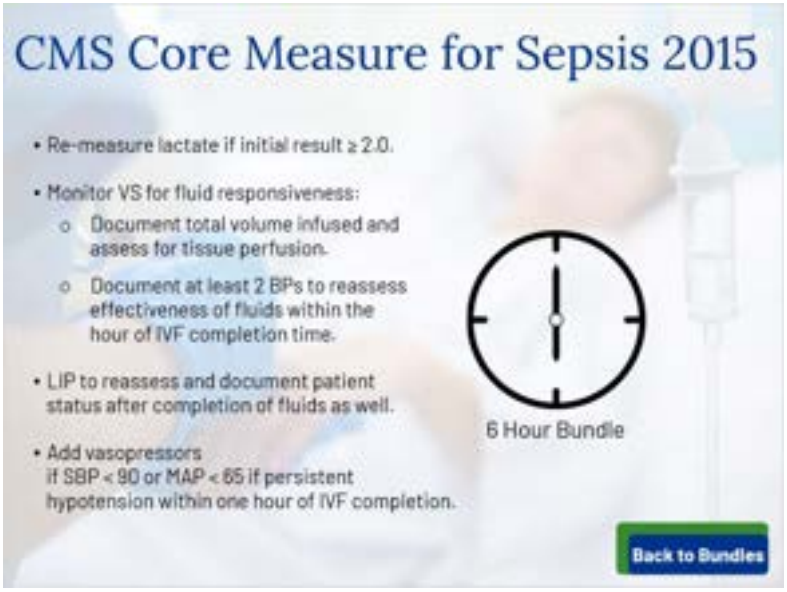


Notes:

3 hr bundle (Slide Layer)



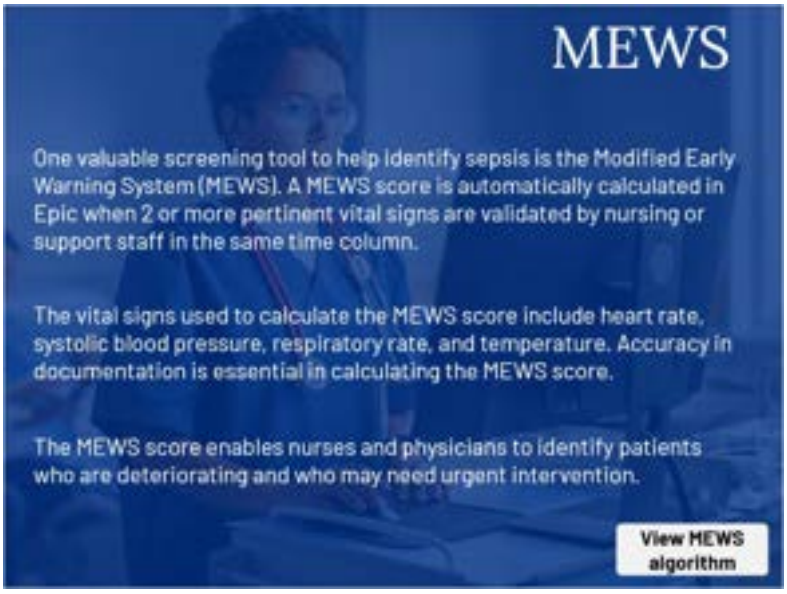
6 hr bundle (Slide Layer)



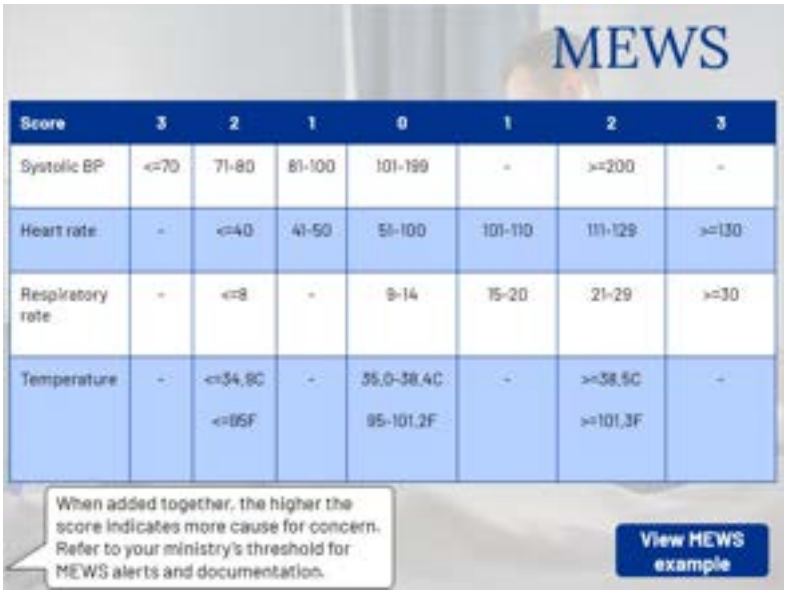
1.6 To Be Continued

Notes:

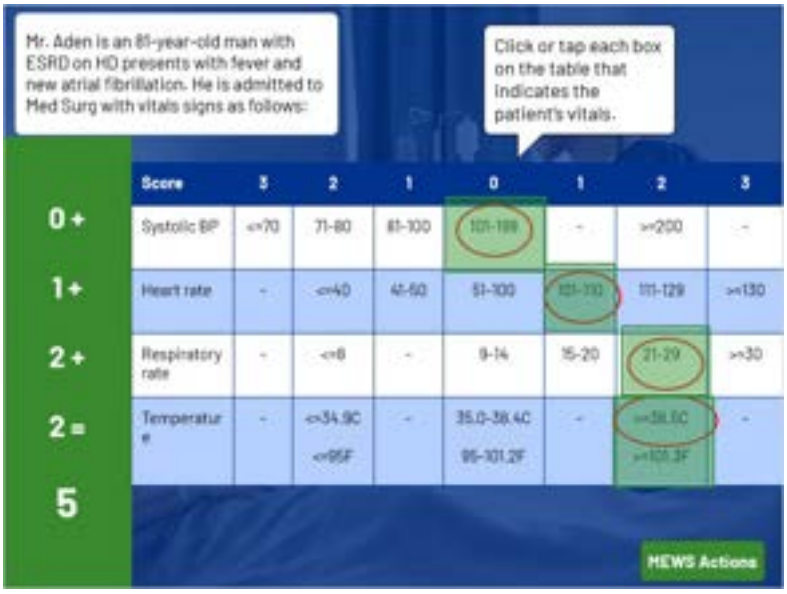
1.7 MEWS definition



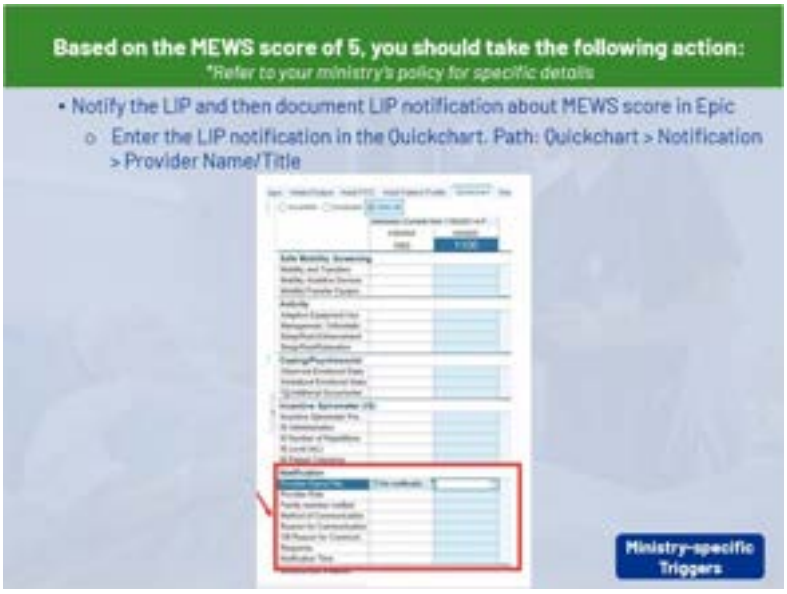
1.8 MEWS algorithm



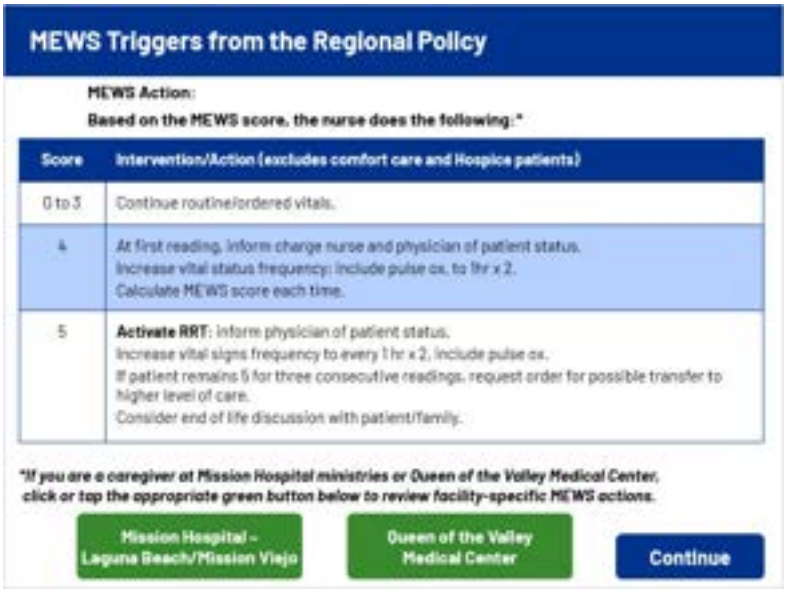
1.9 MEWS example



Epic actions (Slide Layer)

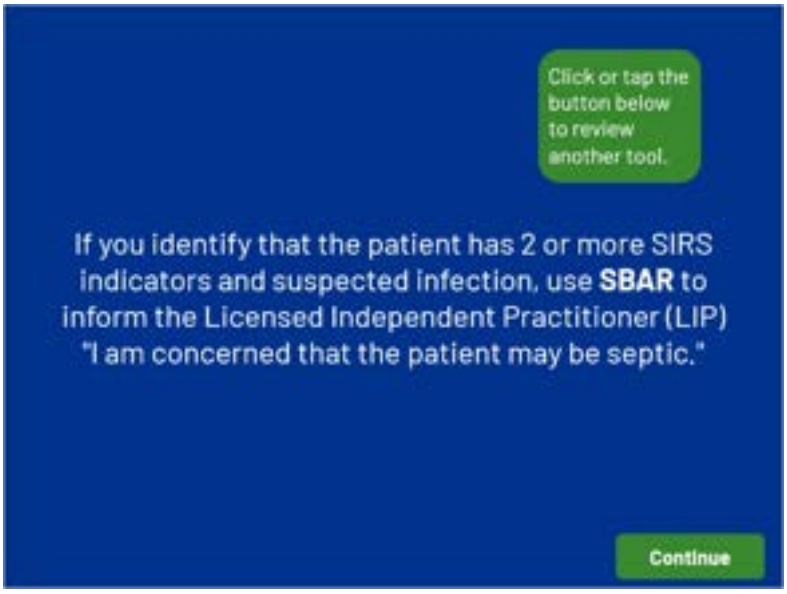


1.10 Ministry-specific

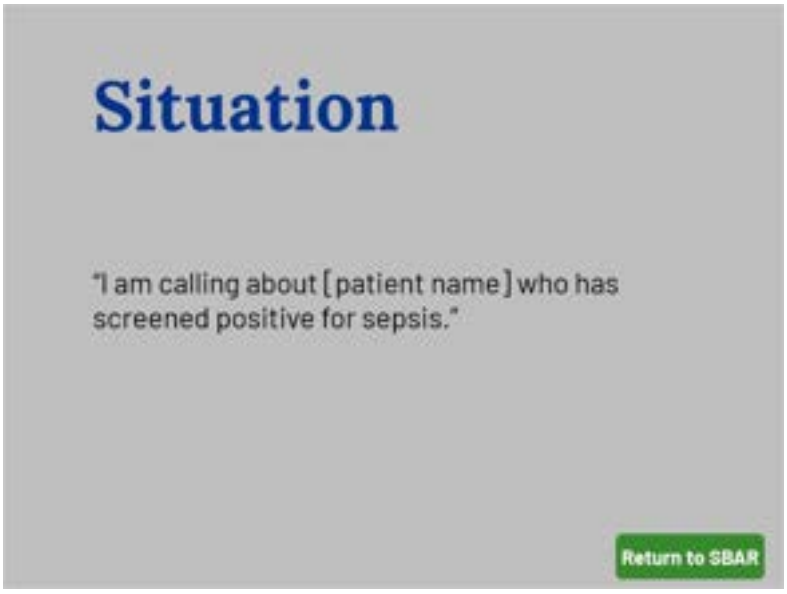


MH Laguna Beach (Slide Layer)

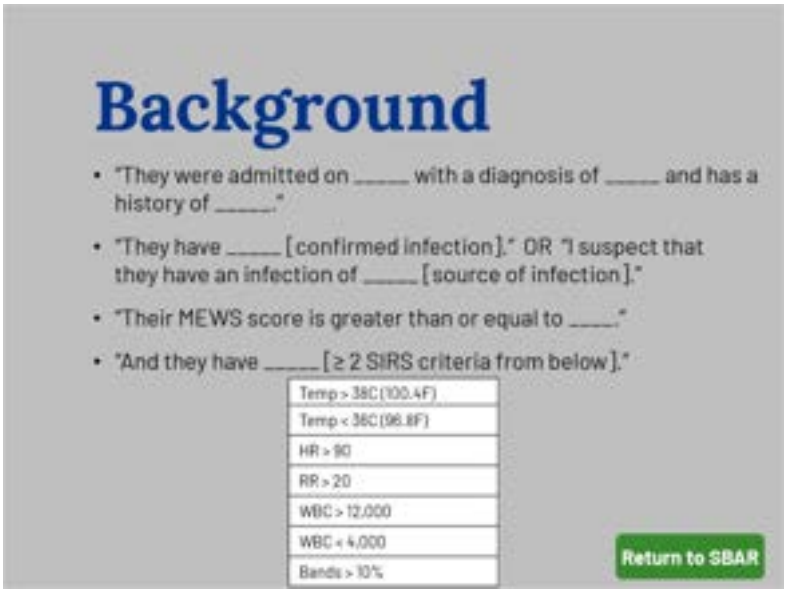
1.11 SBAR



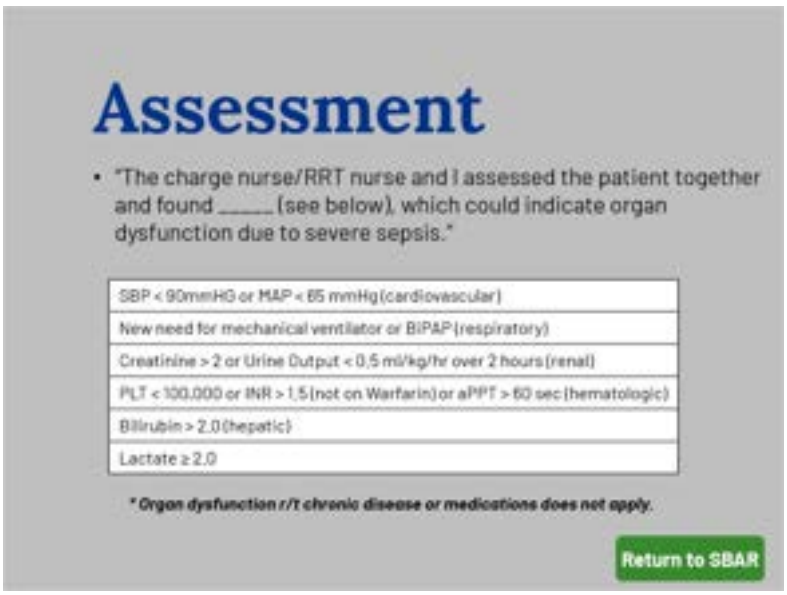
Situation (Slide Layer)



Background (Slide Layer)



Assessment (Slide Layer)

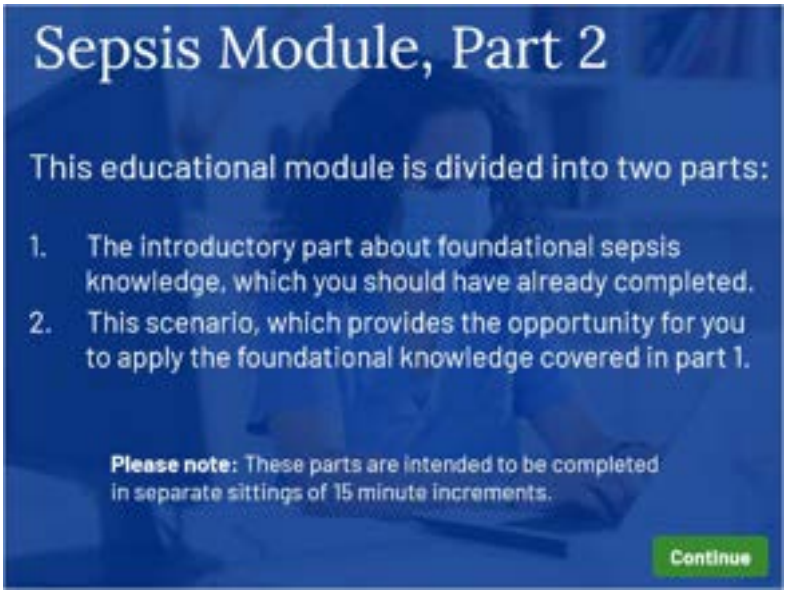


Recommendaton (Slide Layer)

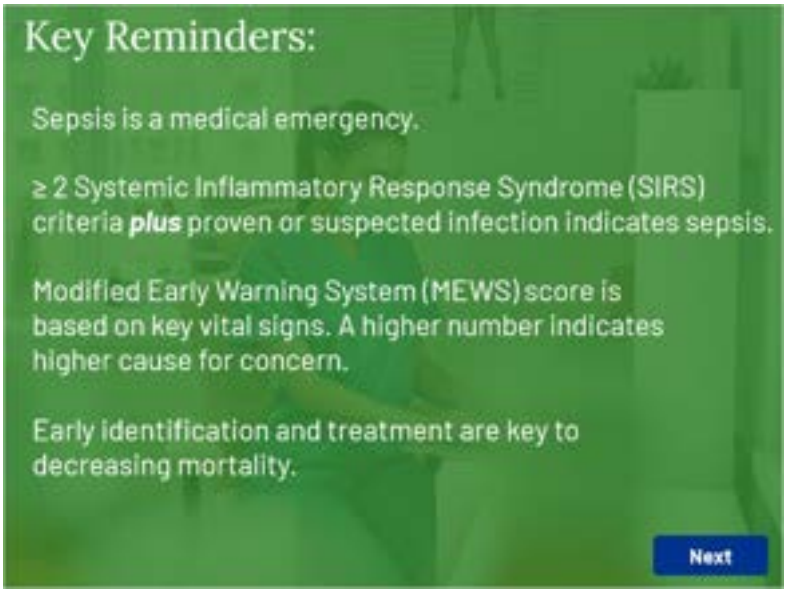
Sepsis Module Part 2

1. Scenario

1.1 Directions



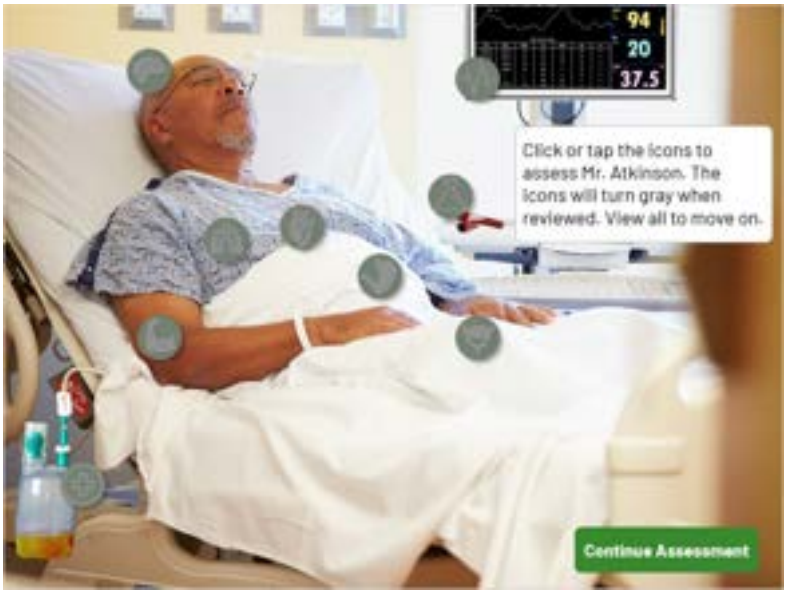
1.2 Key Reminders



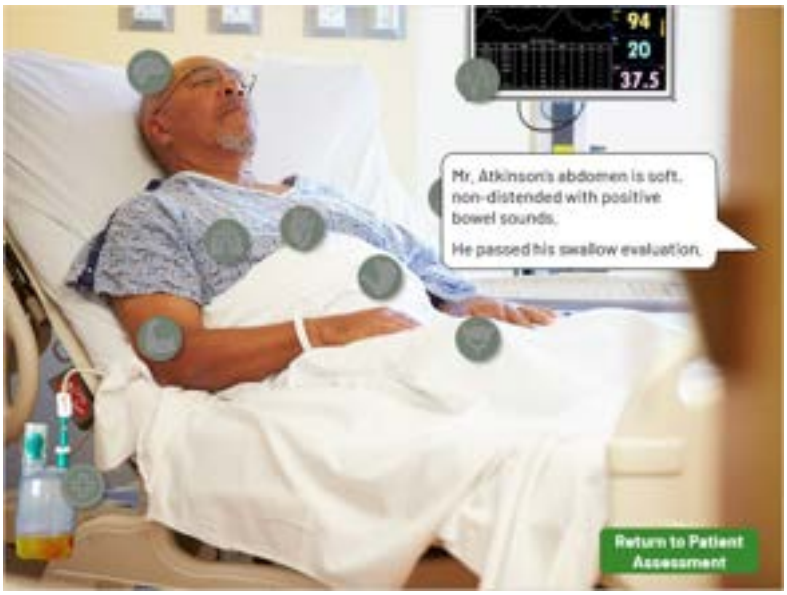
1.3 Transition

1.4 Intro

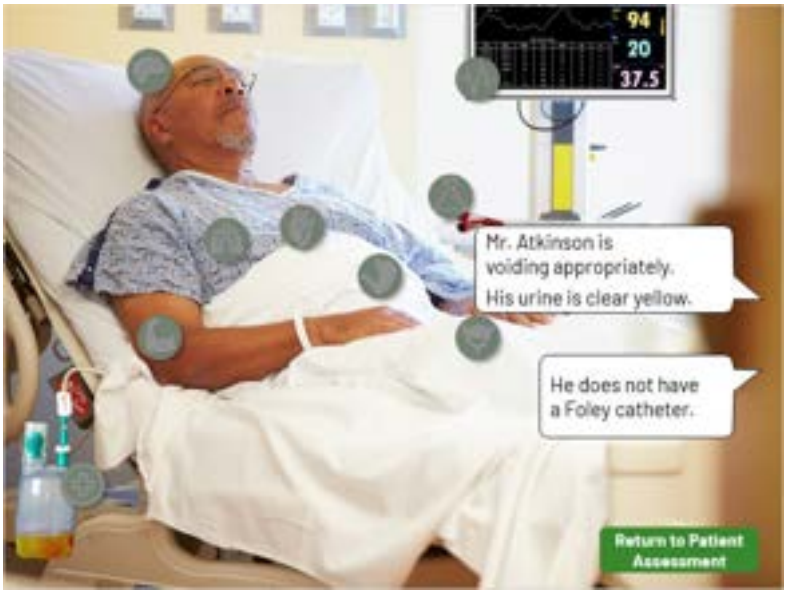
1.5 Physical patient evaluation



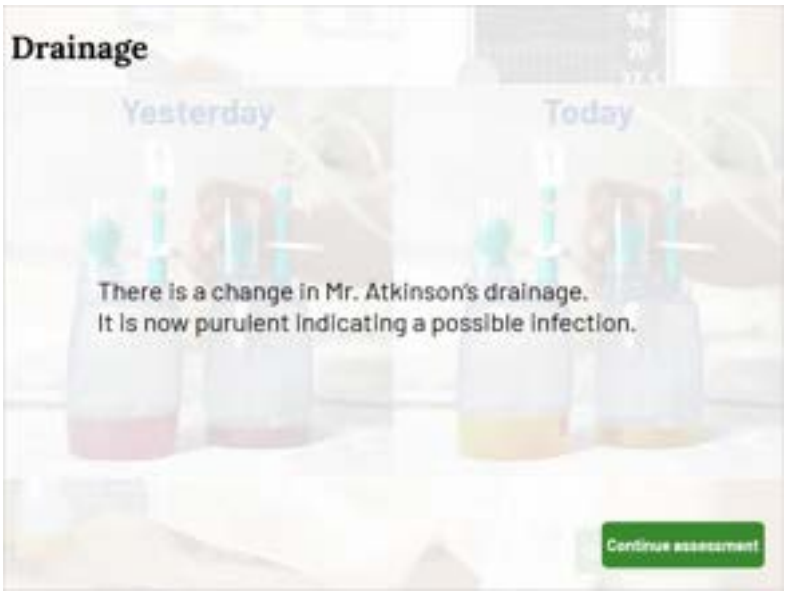
Stomach (Slide Layer)



Voiding (Slide Layer)

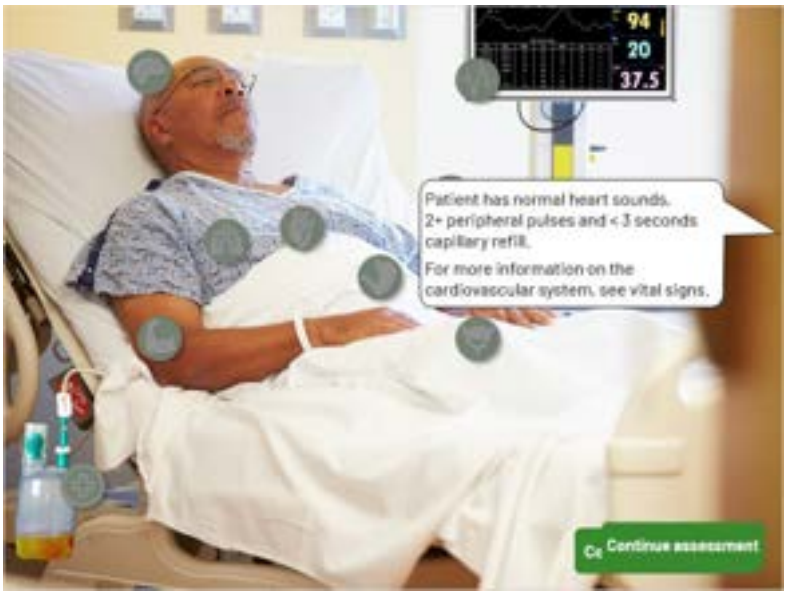


Drainage (Slide Layer)

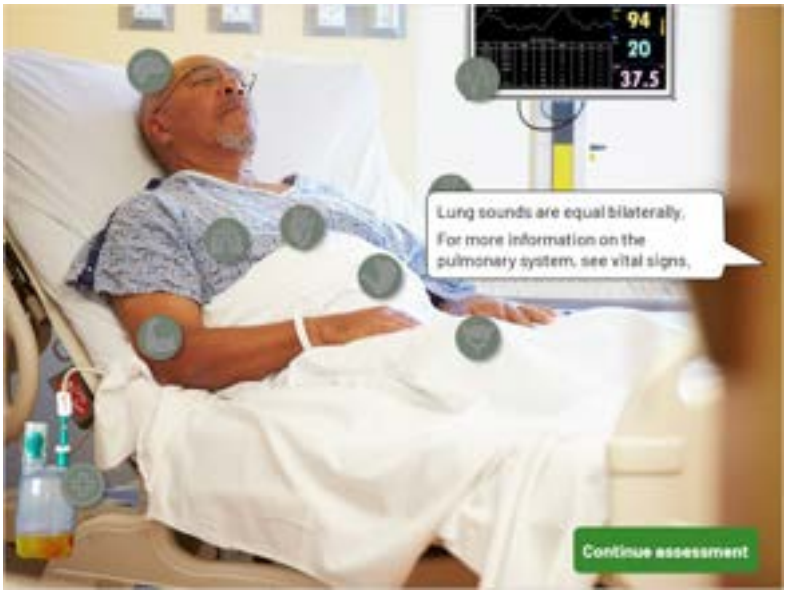


Labs (Slide Layer)

Cardio (Slide Layer)



Respiratory Rate (Slide Layer)

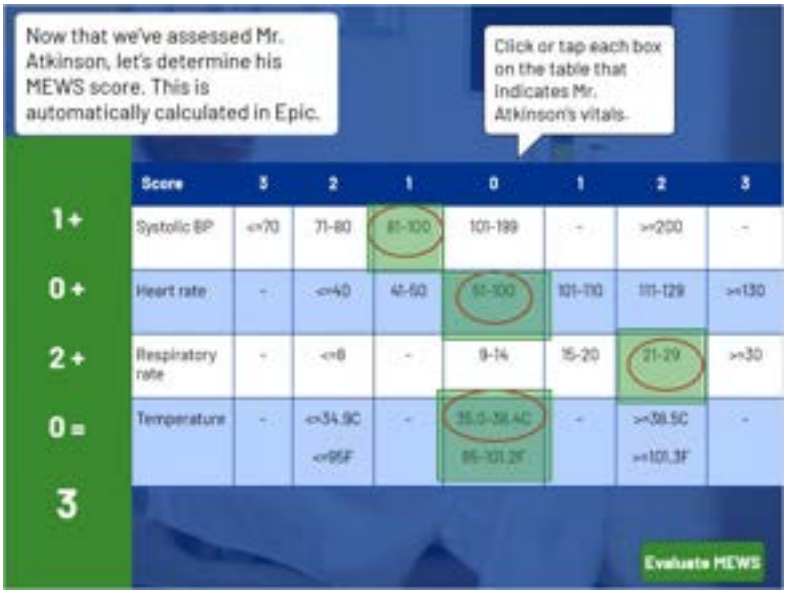


ALC (Slide Layer)

Vitals (Slide Layer)

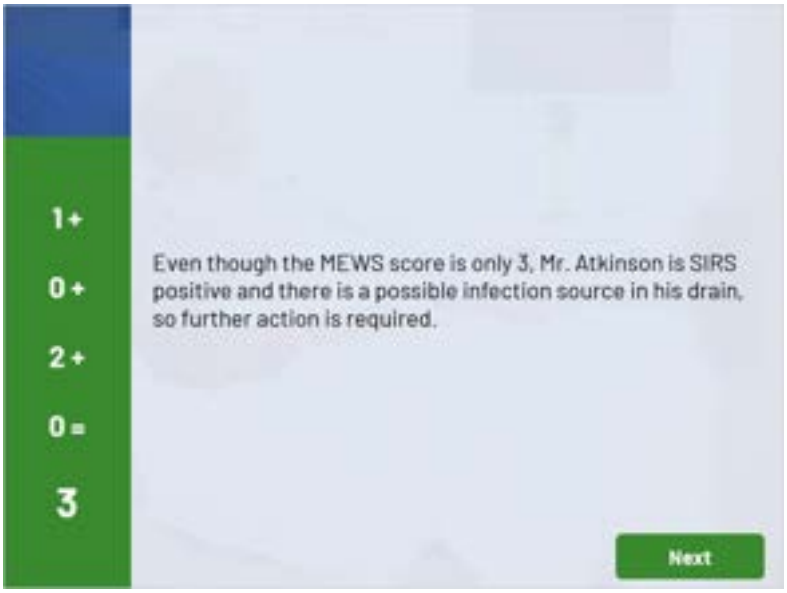
Musculoskeletal (Slide Layer)

1.6 Assess for MEWS



Notes:

MEWS interventions (Slide Layer)



1.7 Pick Many

(Pick Many, 10 points, unlimited attempts permitted)

Correct	Choice
X	Mr. Atkinson has an elevated heart rate and is hypotensive and tachypneic (2 SIRS).
X	Mr. Atkinson's WBC are higher this morning.
X	Mr. Atkinson has purulent drainage in their drain.
X	I'm concerned Mr. Atkinson may be septic.

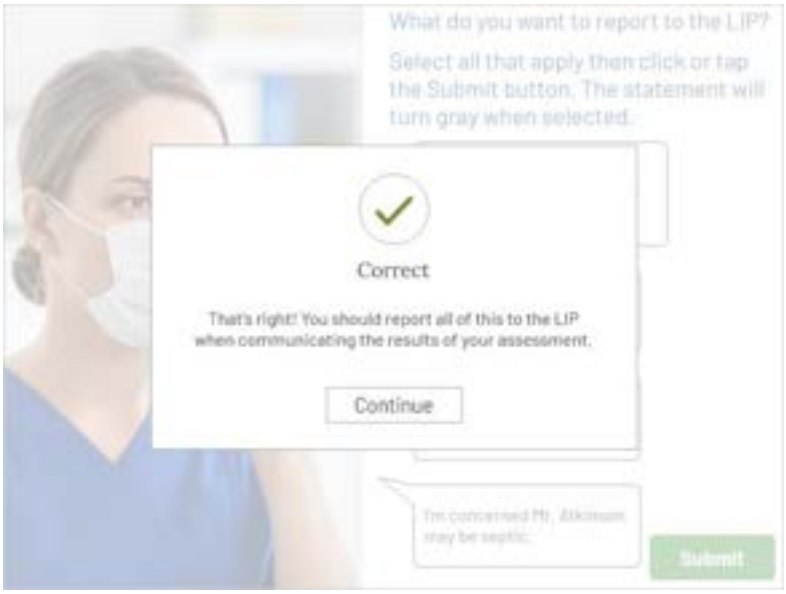
Feedback when correct:

That's right! You should report all of this to the LIP when communicating the results of your assessment.

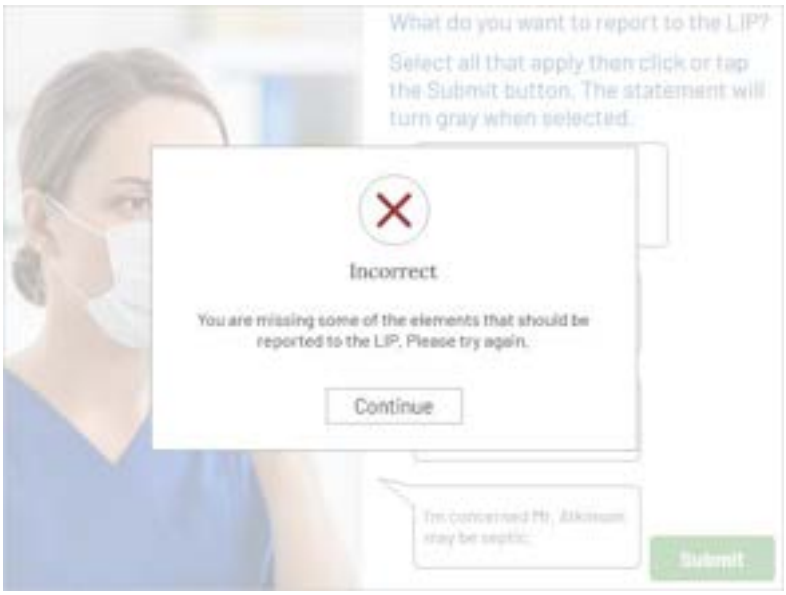
Feedback when incorrect:

You are missing some of the elements that should be reported to the LIP. Please try again.

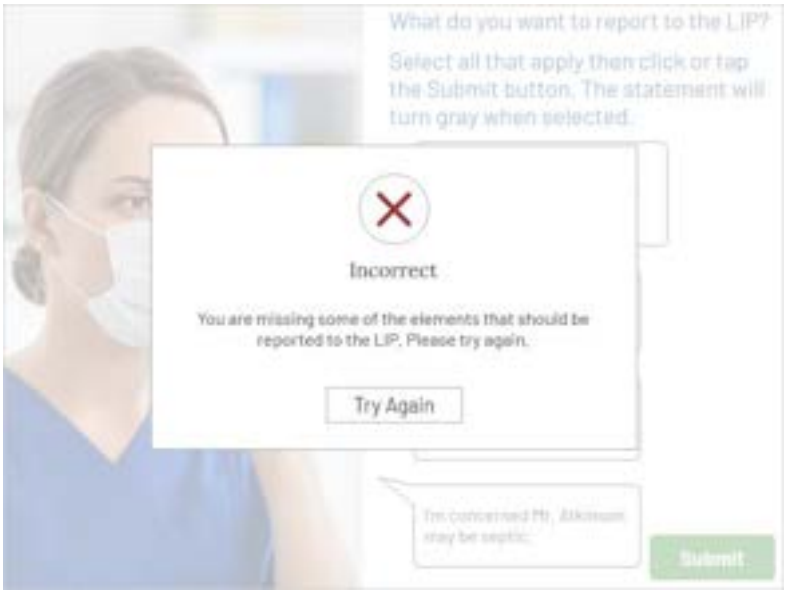
Correct (Slide Layer)



Incorrect (Slide Layer)



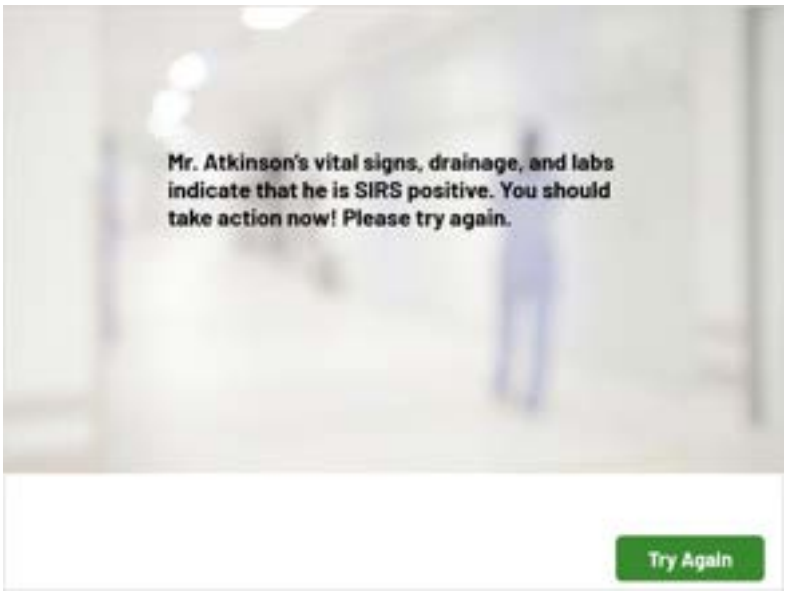
Try Again (Slide Layer)



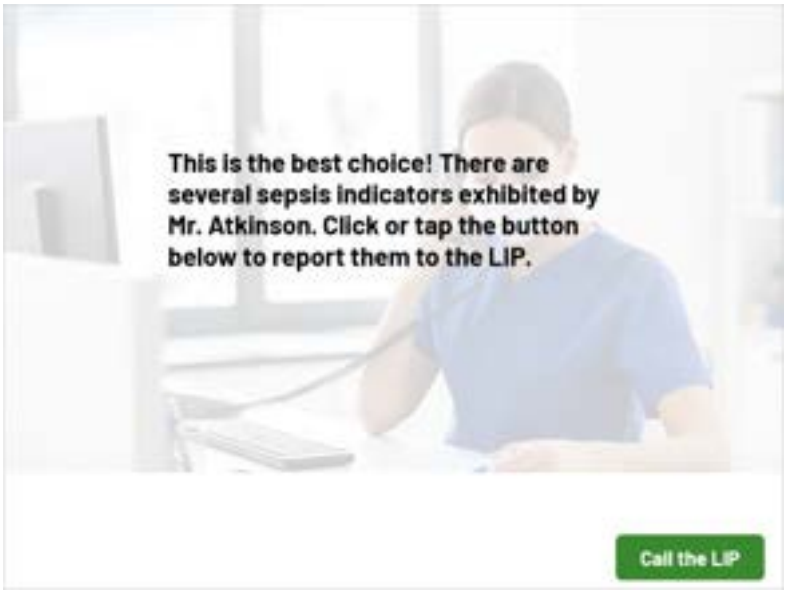
1.8 After Assessment

Supervisor (Slide Layer)

Watchpatient (Slide Layer)



LIP (Slide Layer)



1.9 Do you know the best way to communicate SBAR to the LIP? Drag and drop the appropriate phrase from the right column to the SBAR word it matches.

Click or tab the button to submit your response.

(Matching Drag-and-Drop, 10 points, unlimited attempts permitted)

Correct	Choice
Situation	“I am calling about [patient name/room number] who has screened positive for sepsis.”
Background	“I suspect that he/she has an infection of _____ [source of infection]."
Assessment	“The charge nurse/RRT nurse and I assessed the patient together and found _____, which could indicate organ dysfunction due to severe sepsis.”
Recommendation	“Would you like to order blood cultures and a serum lactate? Would you like to order an antibiotic?"

Feedback when correct:

That's right! Select the Continue button to move on to the Sepsis Management Order Set.

Feedback when incorrect:

You did not select the correct response.

Correct (Slide Layer)

Incorrect (Slide Layer)

Try Again (Slide Layer)

1.10 Order set received

Begin tasks (Slide Layer)

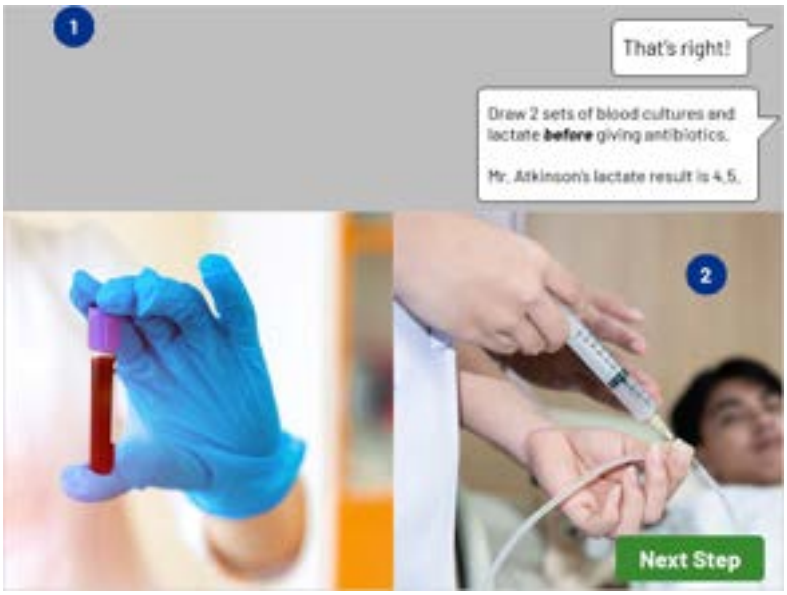
Call Sepsis Nurse (Slide Layer)

Try again (Slide Layer)

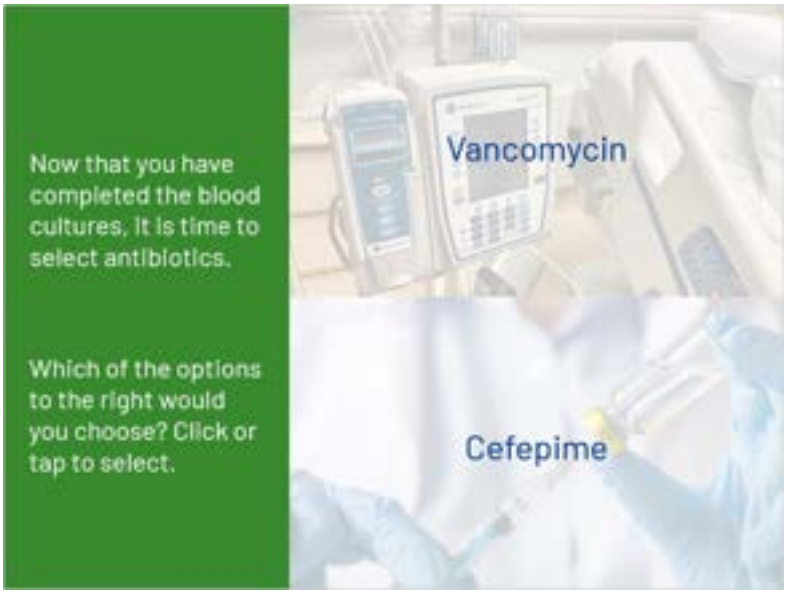
1.11 Labs or antibiotics

Antibiotics (Slide Layer)

Labs (Slide Layer)

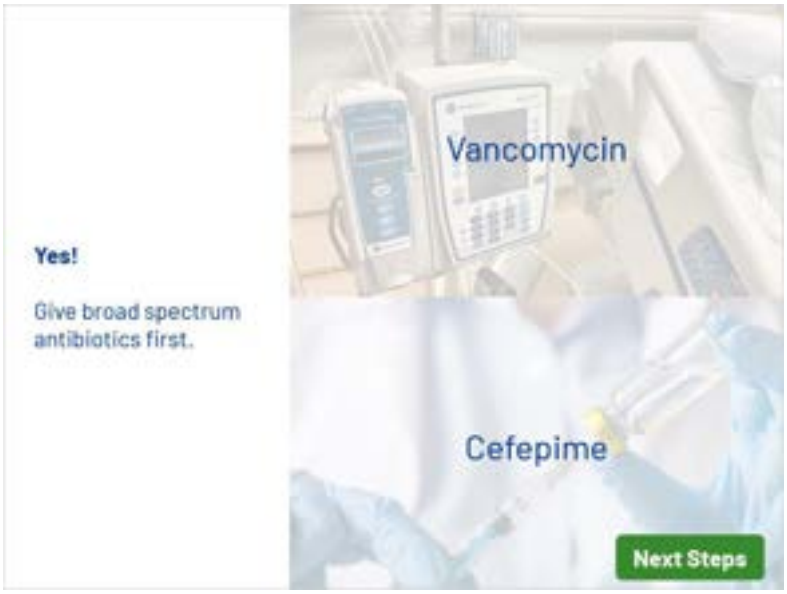


1.12 Narrow or broad antibiotics



Vanco narrow spectrum (Slide Layer)

Cefepime broad spectrum (Slide Layer)

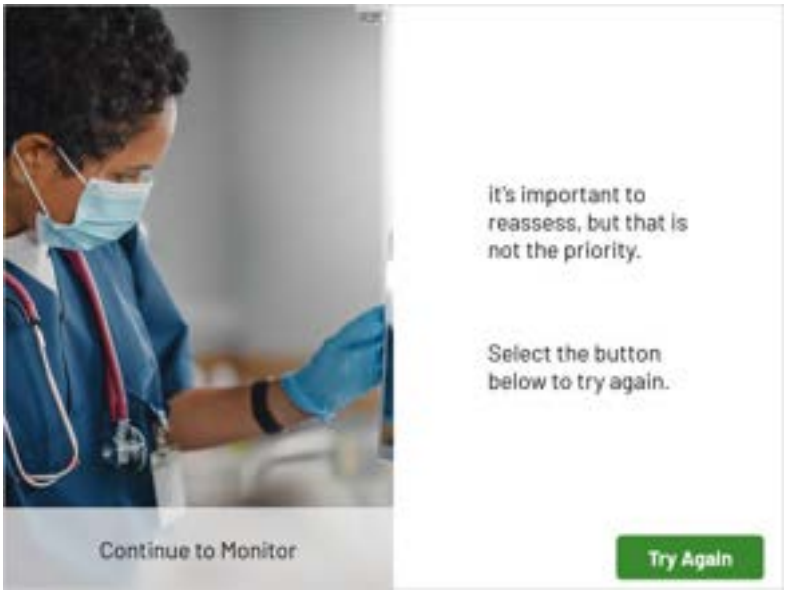


1.13 Fluids done

1.14 Reassess vitals

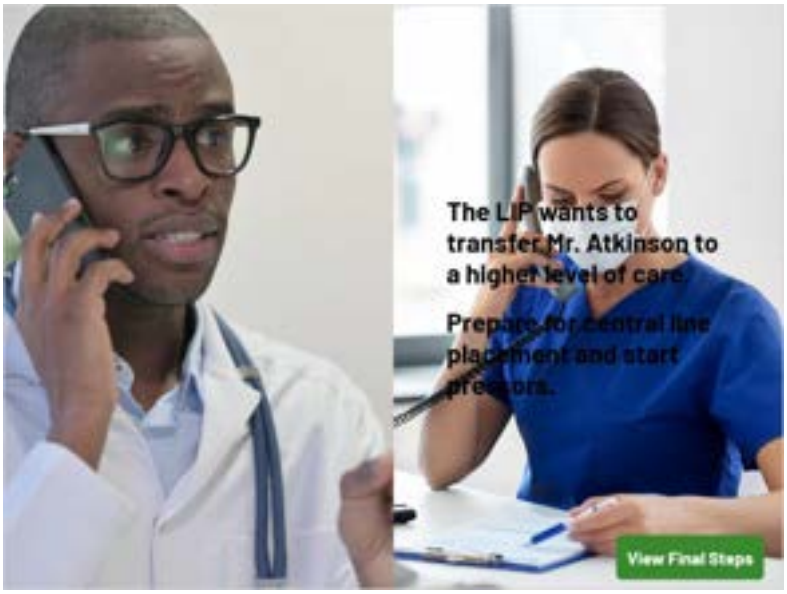
1.15 Chart or LIP

Monitor (Slide Layer)

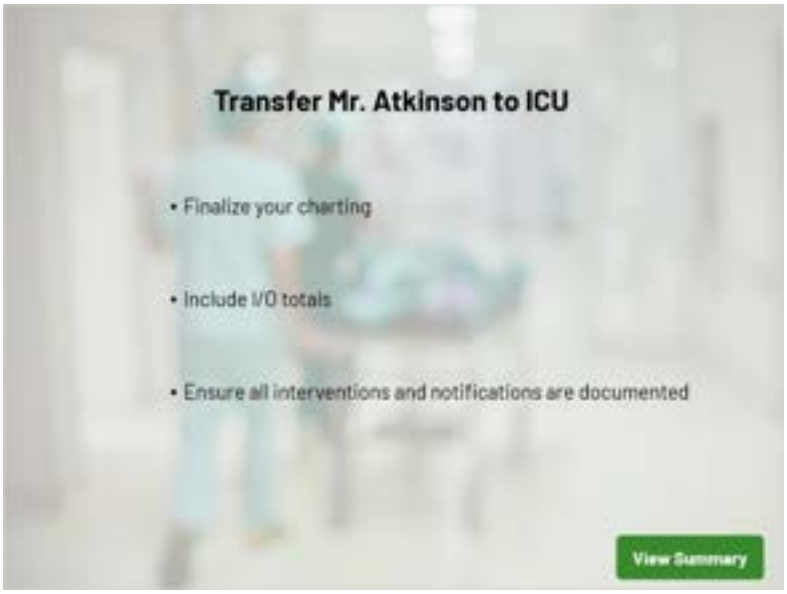


LIP (Slide Layer)

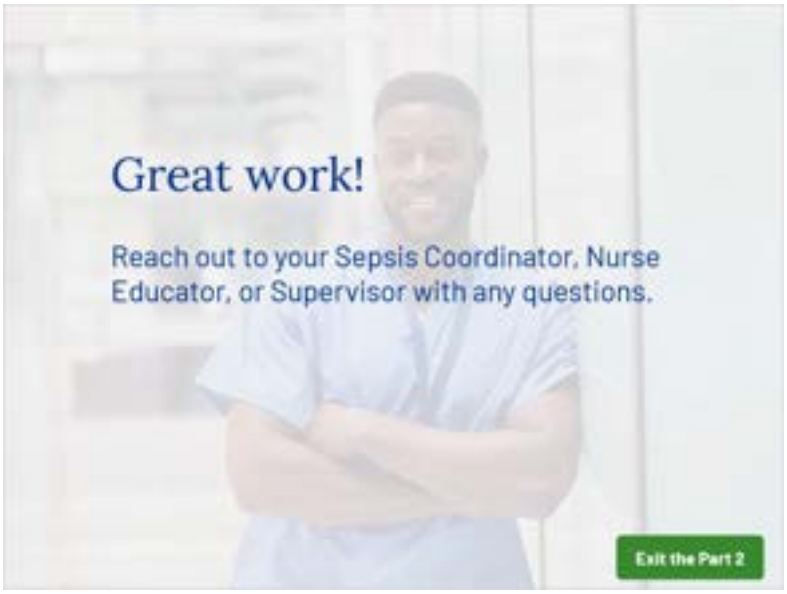
1.16 LIP Orders



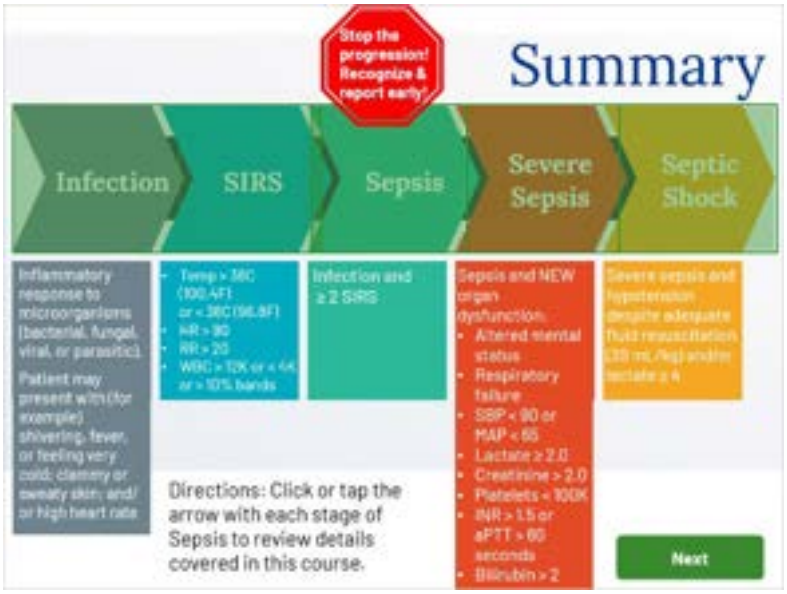
1.17 Last Steps



1.18 Exit



1.19 Summary



1.20 Resources

1.21 References

1.22 Sepsis importance

SOUTH DIVISION ORIENTATION GUIDE 2026

Introduction to Providence Ministries: Mission, Vision, Values

At Providence, we use our voice to advocate for vulnerable populations and needed reforms in health care. We are also pursuing innovative ways to transform health care by keeping people healthy, and making our services more convenient, accessible, and affordable for all.

- **Mission:** As expressions of God's healing love, witnessed through the ministry of Jesus, we are steadfast in serving all, especially those who are poor and vulnerable.
- **Vision**: Health for a Better World.
- **Promise:** "Know me, care for me, and ease my way"
- **Values**
    - **Compassion**: We reach out to those in need and offer comfort as Jesus did. We nurture the spiritual, emotional, and physical well-being of one another and those we serve. Through our healing presence, we accompany those who suffer.
    - **Dignity**: We value, encourage, and celebrate the gifts in one another. We respect the inherent dignity and worth of every individual. We recognize each interaction as a sacred encounter.
    - **Justice:** We foster a culture that promotes unity and reconciliation. We strive to care wisely for our people, our resources, and our earth. We stand in solidarity with the most vulnerable, working to remove the causes of oppression and promoting justice for all.
    - **Excellence:** We set the highest standards for ourselves and our ministries. Through transformation and innovation, we strive to improve the health and quality of life in our communities. We commit to compassionate, safe, and reliable practices for the care of all.
    - **Integrity**: We hold ourselves accountable to do the right things for the right reasons. We speak the truth with courage and respect. We pursue authenticity with humility and simplicity.

Epic Training

- Epic training is completed within orientation as assigned by Clinical Informatics according to your role.

Cultural Diversity

What you Need to Know About Other Cultures	American hospitals are increasingly serving an ethnically diverse patient population. In order to provide optimal care, it is essential to understand that not all cultures share the same beliefs regarding health and illness, nor do they agree on what is appropriate treatment for disease, or what is proper behavior when ill.

Actions Speak Louder Than Words	Different cultures have different non-verbal communication and "personal space" – the amount of space we need between us and another individual to feel comfortable. It is important to consider this and take cues from the patient.
Attitude	Understanding that different people's ways of doing things may be different, but equally valid is essential. It is important to realize that cultural beliefs and traditions are adaptations to different environmental circumstances and evolved because they lead to the survival of its members. The healthcare practitioner who tries to understand the beliefs and values of his or her patients will be much more effective than one who merely sees them as strange.
Knowledge	Knowing something about different cultures' beliefs, values, and traditions is important. While no one can be expected to know everything about every culture, we can learn something about the most common patterns of the populations we commonly serve, while keeping in mind the fact that there is tremendous variation both within each group, and among individuals

- **Interpreter Services**
  - Interpreter services must be used for any non-English speaking patients.
  - Only qualified healthcare interpreters should be used to interpret.
  - Only qualified healthcare interpreters may sign on the consent form as a witness.
  - Bilingual family members should not be used to interpret.
  - Caregivers must contact the interpreter services as needed for patient care and/or education.
- **Spiritual Resources**
  - The Providence approach to healthcare is holistic, addressing the mind, body, and spirit of those in our care. Chaplains and spiritual care volunteers readily visit all inpatients providing spiritual resources and support that is patient centered.

Chain of Command

Follow the chain of command process for concerns that may arise.

Report immediate concerns to your supervisor/manager

Follow up with the manager if concerns continue and escalate according to policy.

Patient Rights and Responsibility

Providence ensures both patients and employees have a clear understanding of patient rights and responsibilities.

Patients have the right to access care, to respect and dignity, to privacy and confidentiality, to informed consent, to refuse care, to continuity of care, to adequate pain control, to communicate about your care, to a safe environment, to request and receive accurate information about their bill, to be free of restraints, to have their wishes honored, to their medical records, and to information on hospital policies.

Patients have the Responsibility:

- To be as accurate and complete as possible when providing medical history and treatment information.
- To report unexpected changes in your condition to your doctor and take part in decisions about your care. Ask your nurse or doctor questions if you have concerns about your care.
- To consider your physicians advice and follow the treatment plan recommended. This includes notifying your physician if you are unable to keep an appointment. If treatment is refused or not followed, you are responsible for your actions.
- To examine your bill and assure that financial obligations are fulfilled as promptly as possible. Please provide correct information for insurance claims and make payment arrangements if needed.
- To consider the rights of others. Please be considerate of other patients and hospital personnel.
- To abide by Providence hospital and clinical policies.
- To provide us with a copy of your medical advance directives or living will if you have one.
- To work with caregiver to complete a care checklist if requested.

Patient Privacy (HIPAA)

HIPAA is the acronym for the federal law known as the **Health Insurance Portability and Accountability Act** of 1996. Under HIPAA, "covered entities" must comply with the regulations that are enforced by the Office of Civil Rights and the Department of Health and Human Services (DHHS).

- Violations of patient privacy will result in termination, may result in civil or criminal prosecution, and will be reported to the California Board of Nursing.
- HIPAA regulations require that individuals' medical information be kept secure and private. As healthcare workers, we are in constant contact with confidential patient information. Therefore, it is our responsibility to meet this requirement of HIPAA.
- It is easy to forget how important patient privacy is unless you are a patient. Privacy is a basic patient right.
- Safeguarding that right is an ethical obligation of our profession. Whether working in the hospital, ambulatory care clinic, long-term care facility, home health agency, or rehabilitation center, everyone is responsible for patient confidentiality. This includes everyone who encounters the patients such as nurses, doctors, students, volunteers, patient billing, and housekeeping caregivers alike.
- Providing processes and guidelines that ensure administrative, physical, and technical security for patients' identity, physical or psychological condition, emotional status, or financial situation is vitally important. Follow these guidelines:
    - Patient information is shared with other healthcare workers on a "need to know" basis.

- Never share any patient information, patient photos on any social media format or site.
- Never discuss your experience with patients or family members outside of the clinical setting including casual conversations and social media.
- Information is never released without written consent from the minor's parent or guardian.
- Confidential information is never discussed in areas where others can overhear you (hallways, elevators, informal social settings, etc.).
- Breeches of confidentiality are reported to the department director/manager.
- Computerized records are kept confidential, just like any other medical record and are accessed on a "need to know" basis as it directly relates to patient care delivery.
- Keep computer screens and open charts from view of public traffic.
- Log off when leaving the computer.
- Avoid sharing your password with anyone.
- Avoid using someone else's user ID and password to access secured sites.

Information Technology

- Information Technology (IT) is intended to improve access to patient information, enhance efficiency, and facilitate communication amongst the healthcare team. All usage is to be professional, ethical, and lawful, and consistent with policies.
- Caregivers are not to access the Internet and are not to download or install software of any kind. Users are responsible for safeguarding the user ID and password.
- Access should not be shared with anyone at any time.
- Please follow ministry policy and procedure to ensure documentation is appropriately signed before your departure from the clinical area.

Cell Phone Use

- Cell phones may not be used in patient care areas except for patient care needs.

Abuse and Neglect: Adult and Child

- It is the policy of Providence to identify victims of abuse, to report known or suspected abuse to the proper authorities per legal mandate, to care for and refer for protective services, and to prevent abuse whenever possible. All patients are assessed for possible abuse.
- Caregivers need to be able to identify abuse or neglect as well as the extent and circumstances of the abuse or neglect to give the patient appropriate care.
- Included in the patient assessment are screening triggers for abuse/neglect/exploitation.
- For abuse reporting, contact the Clinical Social Work department or the Nursing Supervisor.

Workplace Violence Prevention (Harassment)

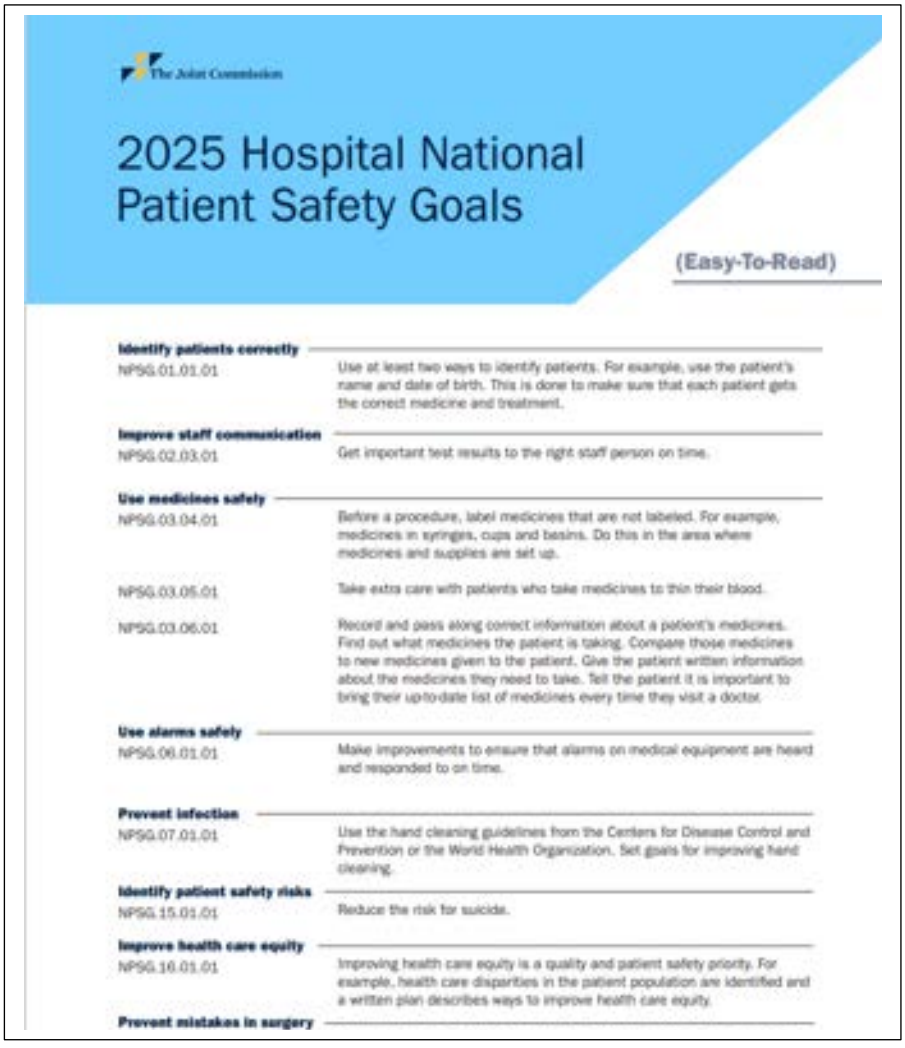
- **See something? Say something!**
  - Providence is committed to providing a safe, secure environment. We will not tolerate any act of violence toward patients, guests, or caregivers.

- **Please Report!**
  - To effectively prevent and respond to workplace violence, we rely on caregivers to report any incident or condition that creates an unsafe, hostile, or uncomfortable work environment f you're the victim of workplace violence, including bullying, you need to report it.
  - We have resources to help you cope with and resolve the situation. Don't be afraid to report it. We will not tolerate any form of reprisal against you if you report an incident.
- **Providence takes every report seriously.**
  - Contact your local security department for immediate assistance.

Suicide Prevention

- The detection and treatment of suicide ideation in all types of healthcare treatment settings is crucial.
- If a patient indicates to any caregiver that he/she feels hopeless about life, stay with the patient and do not leave the patient alone under any circumstance until you are able to notify a supervisor or manager and additional support is present.
- In non-behavioral healthcare units that are not designated specifically for the treatment of psychiatric patients, ligature and other self-harm risks must be identified.
- Ligature Risks is defined as anything which could be used to attach a cord, rope, or other material for the purpose of hanging or strangulation.
- All objects that pose a risk for self-harm that can be removed without adversely affecting the ability to deliver medical care should be removed.

National Patient Safety Goals (NPSG)



The Joint Commission

2025 Hospital National Patient Safety Goals

(Easy-To-Read)

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.

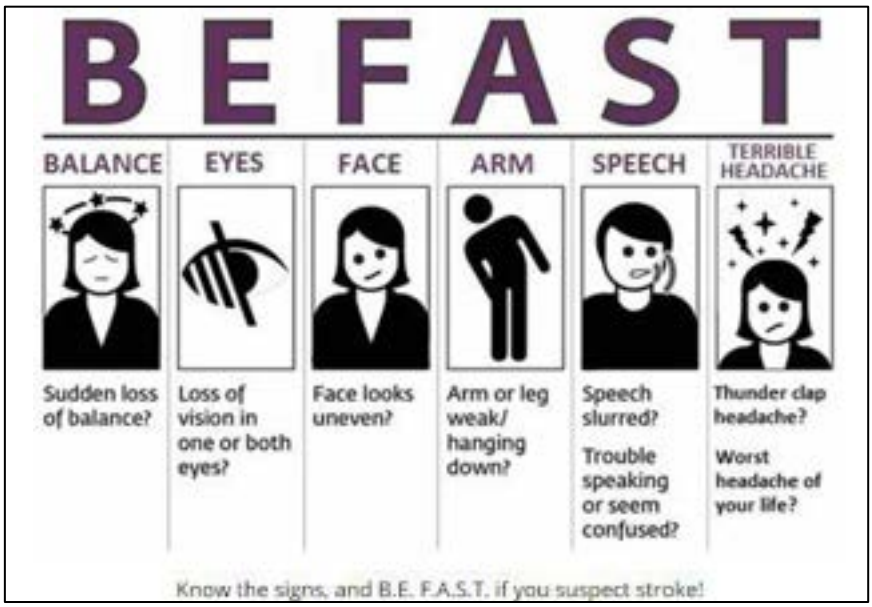
Prevent infection
NPSG.07.01.01 — Use the hand cleaning guidelines from the Centers for Disease Control and Prevention or the World Health Organization. Set goals for improving hand cleaning.

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

Improve health care equity
NPSG.16.01.01 — Improving health care equity is a quality and patient safety priority. For example, health care disparities in the patient population are identified and a written plan describes ways to improve health care equity.

Prevent mistakes in surgery

Learn the signs and symptoms of stroke.



Infection Prevention

Hand Hygiene

- Proper handwashing and drying are the most effective means of infection control. Wash your hands when they are dirty, before eating, before entering a room; when you leave a room, and when donning and doffing PPE.
- Change gloves between patients and wash your hands! Waterless, alcohol-based sanitizer is also available in designated locations on patient care areas.

Blood borne pathogen exposure occurs (needle stick, etc.)

- If you have a needle stick, sharps accident or unprotected exposure to blood or body fluids, notify your supervisor or manager immediately!
- Utilize sharps container for disposal of bio-hazardous waste sharp objects, needles, syringes, blades, and broken glass.

Isolation Practices

Standard Precautions require healthcare workers (and others) whose activities involve contact with patients or with blood and body substances to:

• Observe a single level of precautions for all patients regardless of their known disease status.
• Routinely use appropriate protective barriers and procedural precautions to prevent needle sticks, mucous membrane, and non-intact skin exposure to blood and body substances.
• Wear gloves when touching blood, body substances, mucous membranes, or non-intact skin of patients, and when handling items soiled with blood or body substances.
• Wear face protection (masks and protective eyewear) and fluid-resistant gowns during procedures that are likely to generate droplets or splashes of blood or body substances.
• Use extreme care when handling needles, scalpels, and other sharp instruments. Do NOT recap needles. Sharp-engineered devices are required of all caregivers when available. Dispose of

sharps (needles and disposable instruments) into puncture-resistant containers at point-of-use. Failure to properly dispose of contaminated needles and sharps is a serious breach of infection control policies and can lead to discipline and/or termination.

• Perform hand hygiene between patient contact, after removing gloves, or when soiled with blood or body substances.

• Use resuscitation barrier devices for mouth-to-mouth breathing.

Contact Precautions

- Wear gown and gloves
- Used for multidrug resistant organisms (i.e., MRSA & VRE)

Contact Precautions: Clostridium difficile (C. diff)

- Characteristics:
  - Diarrhea & abdominal pain
  - Forms spores; prolonged environmental survival
  - These rooms MUST be cleaned with bleach.
  - Wash **hands with soap and water ONLY**

Droplet Precautions

- Droplet precautions are used for infectious agents transmitted by large particle droplets, infectious air is usually within 3 feet of the patient (I.e., bacterial meningitis, influenza, adenovirus, mumps, parvovirus b19, Pertussis, Meningococcal pneumonia/meningitis, and Rubella)

Airborne Precautions

- Measles (Rubeola)
- Varicella (Chickenpox)
- Tuberculosis, pulmonary

Isolation Rooms

- **Patient placement -** Patients who are suspected of or have been identified of having a communicable disease or Multidrug Resistant Organism (MDRO) should be placed in a single-patient room (when available) or a comparable environment based per hospital policy and protocol to prevent transmission. Please confirm the specific practice in each clinical area.
- Negative Air Pressure Rooms must be used for Airborne Precautions.

COVID-19 Guidelines and PPE

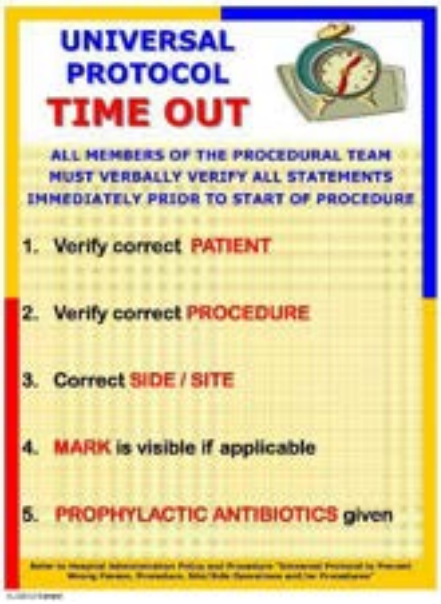
- Caregivers are required to wear Providence ministry-provided PPE.
- Please see images of CDC guidelines related to donning and doffing of PPE.

Preventing Surgical Site Infections

- Use the following guidelines to prevent surgical site infections:
- Ensure patient uses CHG wipes/or CHG bath; CHG bathing is replacing routine bathing during the entire hospital stay, for all inpatients. Do not use this product above the jawline. Allow to air dry. Do not wipe off. Dispose of cloths in trash
- Perform hand hygiene prior to patient contact.

Universal Protocol

- The purpose of Universal Protocol aka "Time Out" is to promote correct patient, correct procedure, and correct surgical and invasive procedures through a three-component process.
- The process involves pre-operative/invasive procedural verification, surgical site marking when required and a formal "Time Out" process prior to the initiation of any surgical or invasive procedure.



Restraints

- Restraints are utilized as a therapeutic or safety measure to prevent harm to the patient or others.
- Please see policy regarding initiation, application. and removal of restraints.

Fall Prevention

- To promote safety, all patients are assessed for their fall risk upon presentation for care, admission, every shift throughout their stay, and if necessary, immediately post-fall.
- Preventing falls is a three-step process:
    1. Identifying risk factors related to patient and environment.
    2. Developing a tailored or personalized plan to decrease risk.
    3. Consistently carrying out the plan.

Medication Safety

Follow the Six Rights of Medication Administration

1. Right patient 2. Right medication 3. Right use	4. Right time 5. Right dose 6. Right route

Safe Pt. Handling

- It is every caregiver's responsibility to become familiar with and use the entire safe patient handling system available to promote a safe environment for our patients and co-workers.
- All patient lifts & transfers are performed in ways minimizing strain.
- Mechanical assist devices are readily available and used when appropriate.
- This system centers on the use of lifting devices, transfer aides and in some locations, a Patient Lift Team. Please ask for unit specific information.

Basic Body Mechanics and Back Safety

Remember these simple rules to help you avoid injury:

- Lift with your legs not your back. Your leg muscles are the most powerful muscles in your body. Keep your back straight. Bend your knees and lower your center of gravity for stability.
- Use of broad base of support. Stand with feet apart at least the width of your hips for side-to-side stability. Stand with one foot slightly forward of the other for forward- backward stability.
- Move as close to the object/person you will be lifting as possible. The weight of the object increases greatly by the distance it is held away from the body.
- Always lift straight up, balance the load, and then pivot with your feet toward the direction you wish to move. Lifting and twisting (no pivot) is the cause of 80% of all back injuries, so move those feet.
- Use a footstool, ladder, etc., to raise your hips (center of gravity) as near the object to be lifted from overhead. Never try and lift blindly without testing the load. You should be able to see over the top of the object begin lifted or as near as possible.
- If you have sized up the situation and determined it is too much for one person, get help, do not attempt to do this task alone; get assistance when lifting large objects.

Ergonomics

When working at computer stations, follow these simple rules:

- Documents should always be directly in front of you; NEVER twist your neck to read.
- Position screens at an appropriate distance, adjusting the screen face to avoid reflection. Display terminals should be about 20 degrees below the line of sight.
- Keep thighs parallel to floor as well, with feet ON the floor or at a footrest. Wrists should be flat and straight with NO tension in the shoulders. Your back should be straight but slightly reclined, with firm lumbar support.
- The home row should be fingertip height on your keyboard.
- Get up and move around! Mix up daily tasks so that you don't sit for long periods of time.

Fire Safety (Response)

To call a Code Red: (WHEN YOU SEE SMOKE OR FLAME)

- Dial site emergency number, tell the operator "Code Red – and your location.
- Pull the nearest fire alarm pull box.

Code Red Procedure

- Close all doors (to contain smoke).
- Visitors are to remain on the nursing unit.
- No one is to use the elevators.
- Wait in your assigned area for further instruction.

Electrical Safety

Five steps to avoid electrical accidents:

1. The third prong on the power plug is one of the most important safety features on some devices. **Do not plug** in hospital equipment without a third prong!
2. **Do not use** extension cords except in an approved emergency.
3. **Do not unplug** devices by pulling on the power cord.
4. **Do not use** obviously defective equipment.
5. **Never use** a device that is or has been wet or gives off small shocks.
6. Notify the supervisor or manager of any malfunctioning equipment.

MRI Safety

- **Safety Zones**
  - **Zone 1:** All non-MRI areas in which there are no MRI hazards.
  - **Zone 2:** Area outside all MRI-related hazards for MRI patient/visitor receiving, waiting, and screening.
  - **Zone 3:** Restricted to only persons successfully screened, for any areas with magnetic field hazards or direct access to magnet room (Zone 4)
  - **Zone 4:** Magnet room

- **MRI Safety Precautions:**
  - The MRI magnet is on 24/7 - 365 days/year and all safety precautions must be followed to prevent accidents
  - MRI Magnet is extremely powerful bringing all magnetic metal toward it, sometimes at high speed. Leave any metal objects outside of the MRI suite
  - ***DO NOT*** go in Magnet room alone, check with Manager if the room needs to be entered at night or off duty times
  - Patients with pacemakers, neuro-stimulators, and brain aneurysm clips need further evaluation by the MRMD, MRSO or the MRI technologist.
  - Remember this mnemonic MRI=Metal Results (in) Injury

Radiation Safety

- Three primary ways to protect yourself from exposure:
  - **Time -** When dealing with patients who have been treated with a therapeutic dose, limit the time you spend with patient.
  - **Shielding -** Use appropriate lead aprons, gloves and glasses when working around x-ray equipment which is in use
  - **Distance -** Generally, if you are at least 6 feet away from the source, you receive less than 3% exposure

Hazardous Chemicals

You are the most knowledgeable on the hazards of materials in your possession.

- Know properties of biological materials/chemicals you use before you handle them.
- Know what appropriate work practices are & use them, wear appropriate PPE.
- Know what appropriate clean-up procedures are for the materials you use.

Safety Data Sheets (SDS) lists:

- Chemical Identity – Name of chemical, manufacturer, how to contact.
- Hazardous Ingredients – list of ingredients that can be dangerous.
- Physical/Chemical Characteristics – what it looks and smell like
- Fire and Explosion Data – when will it burn, when will it explode.
- Reactivity - adverse reaction with other substances
- Health Hazard Data – how it may harm you, routes of entry.
- Precautions and Safe Handling - spill measures, disposal, etc.
- Control Measures – PPE (Personal Protective Equipment)

LINK: https://app.maxcomsc.com/maxcomsc/index.jsp?ju=SJO&jp=sds