V.009

CLINICAL EMPLOYEE ORIENTATION & ANNUAL TRAINING

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SECTION I: INTELYCARE INTRODUCTION

Welcome

Welcome to IntelyCare! We're excited to have you on board and look forward to supporting your journey. This **Clinical Orientation and Annual Training Manual** is a centralized resource for understanding our standards, policies, and procedures—designed to help you succeed. As we grow, this document will evolve, and you'll review it annually to stay up to date.

Additionally, the **IntelyPro App provides free access** to education on specific topics, providing deeper insights into key areas of clinical practice. Be sure to utilize this valuable resource regularly!

Expectations

IntelyPro Expectations

As an IntelyPro, we have some important expectations to ensure a smooth and professional experience for everyone:

1. **Commitment:**
    a. Keep your commitments to shifts you have accepted, arrive on time, and accurately record your hours worked.
    b. Notify IntelyCare and the facility in advance if you need to be absent.
2. **Quality Care:**
    a. Provide high-quality care to all patients and residents.
    b. Follow IntelyCare's standards and the Clients' policies and procedures to ensure excellent patient/resident care.
3. **Respect and Professional Interaction:**
    a. Show respect for staff, patients, and residents.
    b. Maintain professional and courteous behavior at all times.
    c. Avoid inappropriate relationships with patients, residents, or their significant others.
4. **Responsibility**:
    a. Complete all assignments and document all your work.
    b. Contact IntelyCare if any issues arise during your shift.
    c. Maintain confidentiality of patient information in accordance with HIPAA and client policies.
5. **Policy Compliance:**
    a. Adhere to all IntelyCare policies, procedures, and standards of conduct.
    b. Participate in quality assurance, peer review, and risk management programs as required.
    c. IPs must also adhere to all policies and procedures of the facilities in which they work

IntelyCare Expectations

As an IntelyPro, you can expect the following from IntelyCare:

1. **Respectful Interaction:** We commit to treating you with respect and valuing your contributions to our team and our clients.
2. **Supportive Environment:**
    a. IntelyCare has dedicated Quality Nursing and Education Teams ready to support you. The IntelyCare office, located in Quincy, MA, is open Monday through Friday from 8:30 am to 5:00 pm EST. However, our Contact Center is available 24/7 for assistance
    b. **Phone: (617) 971-8344**
    c. **Email:** careteam@intelycare.com (non-urgent matters)
3. **Professional Development:**

   a. Access free courses and continuing education through the IntelyCare App.
   b. IntelyCare, Inc. is an accredited provider of nursing continuing professional development (NCPD) by the American Nurses Credentialing Center (ANCC) Commission on Accreditation.
4. **Clear Communication:** Transparent and timely communication regarding assignments, expectations, and any updates relevant to your role.
5. **Feedback and Recognition:** Constructive feedback on your performance and recognition for your hard work and dedication.

We are excited to have you onboard and look forward to working together!

SECTION II: THE JOINT COMMISSION, OSHA AND OTHER RULES & REGULATIONS

CLIENT POLICIES & PROCEDURES

In addition to following IntelyCare's policies, IntelyPros are responsible for finding, reviewing, and adhering to each specific facility's policies and procedures, as important differences may exist despite similarities across healthcare settings.

If there is a conflict between the Client's and IntelyCare's policies, defer to the facility's policies and procedures. If you have any concerns, immediately contact IntelyCare at:

IntelyCare Care Support Team
Available 24/7
Phone: 844-683-5922
Email CareTeam@intelycare.com

THE JOINT COMMISSION (TJC)

Cultural Diversity and Sensitivity

This section covers the multiple topics ranging from the importance of cultural diversity to best practices for delivering culturally sensitive care.

Importance of Cultural Diversity in Healthcare

1. **Enhanced Patient Outcomes**: Recognizing and respecting cultural differences can lead to better patient compliance, satisfaction, and overall health outcomes.
2. **Improved Communication:** Culturally competent care can enhance communication between healthcare workers and patients/residents, reducing misunderstandings and promoting better information exchange.
3. **Reduction of Health Disparities:** Healthcare disparities—differences in access, quality, and outcomes—stem from socio-economic, racial, ethnic, and geographical factors. These gaps lead to poorer health and higher disease rates. Understanding cultural influences on health is essential to promoting equitable care.
4. **Legal and Ethical Compliance:** Adhering to cultural diversity standards is not only a best practice but also a requirement by IntelyCare Policy, facility policy, and TJC.

Barriers to Cultural Sensitivity

Providing culturally sensitive care requires self-reflection on personal beliefs. The following barriers can lead to prejudice, discrimination, and racism, compromising patient care:

1. **Lack of Cultural Awareness** – Limited understanding of diverse cultures can create biases and misinterpretations.
2. **Stereotyping** – Assuming all members of a group share the same traits ignores individual differences.
3. **Cultural Judgment** – Evaluating other cultures by one's own standards can lead to unfair assessments.
4. **Negative Bias** – Holding negative assumptions about certain groups fosters discrimination.
5. **Ethnocentrism** – Viewing one's own culture as superior can result in exclusion and misunderstanding.

Recognizing and addressing these barriers helps ensure equitable and respectful care for all patients

Cross-Cultural Communication for Healthcare Workers

Effective communication is essential in healthcare, with 90% of activities relying on it. However, cultural differences can affect how messages are sent, received, and interpreted. **Cross-cultural communication** occurs when individuals from different cultural backgrounds exchange messages. The following strategies enhance clarity and understanding:

1. Verbal Communication
   a. Speak clearly and at a moderate pace.
   b. Repeat key points.
   c. Use simple, direct sentences.
   d. Prefer active verbs over complex phrasing.

2. Non-Verbal Communication
   a. Use visual aids like pictures and graphs.
   b. Incorporate facial expressions and gestures.
   c. Demonstrate key points when possible.
   d. Pause frequently to allow processing.

3. Interpretation & Perception
   a. **Silence:** Allow time for thought before responding.
   b. **Language Skills:** Do not mistake accents or grammar issues for a lack of intelligence.
   c. **Cultural Assumptions:** When unsure, assume differences rather than similarities.

4. Ensuring Understanding
   a. Never assume comprehension—confirm it.
   b. Ask individuals to repeat their understanding.
   c. Take frequent breaks, as second-language comprehension is mentally demanding.

5. Encouragement & Support
   a. Provide verbal and non-verbal encouragement.
   b. Reinforce without embarrassing the speaker.

By applying these strategies, healthcare workers can foster clearer, more effective cross-cultural communication, ensuring better patient interactions and care.

Cultural Considerations

1. **Time -** People of different cultural backgrounds may have different perceptions of time. Some people count time by a watch and see it as money saved, spent, or squandered. Others see time as a rhythm or cycle of growth.
   a. **Make allowances** for legitimate cultural differences about time. Do not jump to conclusions that others are irresponsible.
   b. **Negotiate** a time agreement that works for both parties.
   c. **Be patient** and persistent with others and yourself regarding time management.

2. **Space -** Cultural backgrounds influence perceptions of personal space. Getting too close may be seen as intrusive or aggressive, while staying too far may be perceived as cold or disinterested.
   a. Be flexible and aware that others may have different comfort levels regarding space.
   b. Adjust to where others feel comfortable with you.

3. **Touching -** Physical touch can have different meanings in different cultures, such as asserting power, greeting, wanting to be understood, showing affection, or congratulating.

4. **Communicate -** When communicating, be aware of:
   a. Tone of voice

b. Body posture
c. Breathing rate
d. Distance
e. Timing and pacing of speech patterns

Best Practices for Delivering Culturally Sensitive Care

1. **Respect and Empathy:** Always approach patients/residents and their families with respect and empathy, recognizing their cultural beliefs and practices.
2. **Active Listening**: Engage in active listening to understand the patient's perspective and healthcare needs fully.
3. **Patient and Resident Education**: Provide educational materials in the patient/resident's preferred language and ensure they understand their diagnosis and treatment options.
4. **Cultural Brokering**: Use cultural brokers or liaisons who can bridge the gap between healthcare workers and patients from diverse backgrounds.
5. **Non-Verbal Communication**: Be aware of non-verbal cues and body language that may differ across cultures.

Scenarios

Here are a few scenarios to help IPs apply cultural competence principles in practical settings.

1. **Language Barriers -** A patient with limited English proficiency requires an interpreter to understand their treatment plan. The IP arranges for a professional medical interpreter and uses visual aids to enhance communication.
2. **Religious Beliefs** - A residents' religious beliefs prohibit a medical procedure. The IP collaborates with the resident to find acceptable alternative without compromising the quality of care.
3. **Dietary Restrictions –** A resident has specific dietary restrictions based on cultural practices. The IP works with the dietary team to ensure the meals meet the resident's cultural needs.

Ethics of Care and Treatment

Ethical care is central to our patient-centered approach. This section defines ethical standards for IntelyPros, ensuring respectful, compassionate, and clinically effective care that upholds residents/patients' rights and dignity.

Ethical Principles

1. **Autonomy**
   a. **Key Concept(s):** Independence, self-direction, and freedom of choice.
   b. **Application**: Patient/residents have the right to choose their healthcare provider, healthcare facility, and make decisions about their treatment. Our role as healthcare professionals is to support this autonomy by providing comprehensive information and ensuring patients/residents understand their treatment options.
   c. **Example:** Facilitate informed decision-making by providing clear, accurate information and respecting patients and residents' choices.

2. **Beneficence**
   a. **Key Concept(s):** Acts of charity or kindness; treatment provided for the good of the patient/resident.
   b. **Application**: All care provided should prioritize the well-being and safety of the patient/resident Healthcare professionals must offer considerate and respectful care and address any concerns about the quality or value of care.
   c. **Example:** Ensure competent care, encourage patients/residents to voice concerns, and guide them through the complaint procedure when necessary.

3. **Confidentiality**
   a. **Key Concept(s):** Protection and secrecy of patient information.

b. **Application**: Information about patients/residents and their care must be kept confidential and shared only with those authorized or needing to know. Patients/residents have the right to understand how their information is used and who will receive it.
c. **Example:** Protect patient/resident information diligently and transparently communicate with patients about their information rights.

4. **Fidelity**
   a. **Key Concept(s):** Faithfulness to a pledge or duty.
   b. **Application**: Healthcare workers have a duty to advocate for patients/residents and protect their rights, demonstrating fidelity by upholding the Patients' Bill of Rights.
   c. **Example:** Act as patient/resident advocates and consistently support and uphold patient rights.

5. **Veracity**
   a. **Key Concept(s):** Truthfulness.
   b. **Application**: Ethical care requires supporting information disclosure and the right to make treatment decisions. Providing truthful information helps patients/residents make informed choices about their care.
   c. **Example:** Ensure all information shared with patients/residents is accurate and truthful to facilitate informed decision-making.

6. **Justice**
   a. **Key Concept(s):** Impartiality or fairness.
   b. **Application**: All patients/residents and their families must be treated fairly, without favoritism or discrimination based on personal traits such as race, color, gender, economic status, or social status.
   c. **Example:** Provide equal and unbiased treatment to all patients/residents, upholding their right to fair and just care.

Special Considerations – Informed Consent

Informed consent in healthcare is addressed often as it is a fundamental ethical and legal requirement that ensures patients/residents are fully aware of and understand the risks, benefits, and alternatives of a medical procedure, treatment, or intervention before agreeing to it. The concept is rooted in the ethical principle of **patient autonomy**.

The patient/resident must have the **mental capacity** to make the decisions to provide informed consent. If they do not, then a parent, guardian, healthcare surrogate, or durable power of attorney will need to provide consent on the patient/resident's behalf.

Important: If a patient/resident lacks the necessary information or capacity to provide informed consent and does not have a designated representative, they must inform the charge nurse, supervisor, or medical team ***immediately***.

Special Considerations – Advanced Directives

Advance directives are legal documents that enable individuals to make decisions about their future medical care in case they become unable to communicate due to illness or incapacity. These directives uphold the principle of patient/resident autonomy by ensuring that their preferences are respected when medical decisions need to be made.

Key Components of Advance Directives:

1. **Living Will** is a legal document that outlines a person's preferences for medical treatment if they become incapacitated and unable to communicate their wishes. It typically includes directives regarding life-sustaining interventions such as resuscitation, mechanical ventilation, tube feeding, and dialysis. This document ensures that the individual's choices regarding end-of-life care are honored.

2. **Durable Power of Attorney (POA) for Healthcare** designates a person (often called a healthcare agent, proxy, or surrogate) to make medical decisions on behalf of the individual if they are unable to do so. The appointed person should be someone the individual trusts to follow their wishes and act in their best interest. Unlike a living will, the durable POA for healthcare covers a broader range of decisions, not just those related to end-of-life care.
3. **Do Not Resuscitate (DNR) Order** is a specific type of advance directive that indicates a person's wish not to undergo cardiopulmonary resuscitation (CPR) if their heart stops or if they stop breathing. This order is typically placed in the patient's medical record and must be followed. It can be part of a broader advance directive or issued separately.
4. **Important:** Laws regarding Advanced Directives vary by each State.

Advanced Directive Guidelines

Written information regarding advance directives may be available to anyone and most often is administered through the admission, social work, pastoral care, and medical records departments. It is the responsibility of the registered nurse to ensure this documentation is available in the medical record.

1. Any competent patient/resident may sign a living will or durable power of attorney for healthcare.
2. Witnesses to a living will may not be:
   a. Related to the patient by blood or marriage.
   b. The patient's physician or employee of the physician.
   c. An employee of the Healthcare facility if the employee is providing direct care to the patient or is involved in the Healthcare facility's financial affairs.
   d. Be a patient of the Healthcare facility.
   e. Have a claim against the Healthcare facility.
3. Witnesses to a durable power of attorney for healthcare may not be:
   a. The person appointed as agent in the document.
   b. A provider of health or residential care.
   c. The operator of a community care facility.
   d. An employee or operator of a healthcare facility.

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

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

Process to Address Ethical Issues or Concerns

Contact IntelyCare for Any Ethical Questions, Issues, or Concerns.

IntelyCare Care Support Team
Available 24/7
Phone: 844-683-5922
Email CareTeam@intelycare.com

The Joint Commission Contact Information

Any individual or organization that has a concern about the quality and safety of patient care delivered by IntelyCare healthcare professionals, that has not been addressed by IntelyCare, is encouraged to contact The Joint Commission at complaint@jointcommission.org or by calling (800) 994-6610. IntelyCare demonstrates this

commitment by taking *no retaliatory or disciplinary action against* IPs when they report safety or quality of care concerns to TJC.

National Patient Safety Goals

Each year, The Joint Commission (TJC) gathers information about emerging patient and resident safety issues to develop their National Patient Safety Goals that they specialize by healthcare setting.

National Patient Safety Goals Summary

The following table summarizes this year's goals for Assisted Living Facilities (ALFs), Behavioral Health (BH), Hospitals, Office-Based Surgery, and Skilled Nursing Facilities (SNFs).

2025 National Patient Safety Goals		
Setting	**Description**	**Description**
ALL	Identify Patients and Residents 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.
Hospitals	Improve Staff Communication	NPSG.02.03.01 Get important test results to the right staff person on time
Ambulatory, Hospitals, and Office Based Surgeries (OBS)	Use Medications 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. Take extra care with patients who take medicines to thin their blood.
Ambulatory, Hospitals, SNFs	Use Medications Safely	NPSG.03.05.01 Take extra care with patients who take medicines to thin their blood
ALL	Use Medications Safely	NPSG.03.06.01 Record and pass along correct information about a patient's/resident's medicines. Find out what medicines the patient/resident is taking. Compare those medicines to new medicines given to the patient. Give the patient/resident written information about the medicines they need to take. Tell them it is important to bring an up-to-date list of medicines every time they visit a doctor.
Hospitals	Use Alarms Safely	NPSG.06.01.01 Make improvements to ensure that alarms on medical equipment are heard and responded to on time.
ALL	Prevent Infection	NPSG.07.01.01 Use the hand cleaning guidelines from the Centers for Disease Control and Prevention or the World Health Organization. **See OSHA - Infection Control**
ALFs and SNFs	Prevent Patients and Residents from Falling	NPSG.09.02.01 Find out which residents are most likely to fall. For example, is the resident taking any medicines that might make them weak, dizzy or sleepy? Take action to prevent falls for these residents.
SNF	Prevent Bed Sores	NPGS14.01.01Find out which patients and residents are most likely to have bed sores. Take action to prevent bed sores in these patients and residents. From time to time, re-check patients and residents for bed sores. **See Pressure Injuries (Bed Sore, Pressure Ulcers) Prevention section.**
Behavioral Health (BH) & Hospitals	Identify Patient Safety Risks	NPSG.15.01.01 Reduce the risk for suicide.
Ambulatory, BH, & Hospitals	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. Follow the hospital's written action plan and policy that describes how it will improve health care equity by addressing at least one of the health care disparities identified in its patient population.
Ambulatory, Hospitals, and OBS	Prevent Mistakes in Surgery	UP.01.01.01 Make sure that the correct surgery is done on the correct patient and at the correct place on the patient's body
		UP.01.02.01 Mark the correct place on the patient's body where the surgery is to be done.

2025 National Patient Safety Goals		
Setting	**Description**	**Description**
		UP.01.03.01 Pause before the surgery to make sure that a mistake is not being made.

For more detailed information on a specific goal in a particular setting, please refer to the relevant chapter in TJC guidelines: https://www.jointcommission.org/standards/national-patient-safety-goals/

Patient and Residents' Rights

Ensuring that all healthcare professionals are knowledgeable about patient and resident rights is crucial for delivering respectful and effective care. By understanding and upholding these rights, IntelyPros can foster a supportive and equitable healthcare environment for all patients and nursing home residents.

Patients' Bill of Rights

The Patients' Bill of Rights was created in 1997 by the U.S. Advisory Commission on Consumer Protection and Quality in the Healthcare Industry. These rights aim to ensure that patients receive high-quality care while maintaining their dignity, privacy, and autonomy.

1. **Information Disclosure**: Patients are entitled to accurate and understandable information about their health plans, professionals, and facilities to make informed decisions. This includes information about plan accreditation, compliance with licensing requirements, disenrollment rates, care management procedures, and details about networks and providers.
2. **Choice of Providers and Plans:** Patients have the right to select health care providers and plans that ensure access to high-quality care. This includes direct access to women's health services, specialists for complex conditions, and continuity of care during provider changes.
3. **Access to Emergency Services**: Patients can access emergency health care services whenever needed, based on a "prudent layperson" standard, without prior authorization if their life or health is at risk.
4. **Participation in Treatment Decisions:** Patients have the right to actively participate in decisions regarding their health care, with the ability to be represented by family members or guardians if they cannot make decisions themselves.
5. **Respect and Nondiscrimination:** Patients are entitled to respectful and considerate care, free from discrimination based on race, ethnicity, national origin, religion, sex, age, disability, sexual orientation, genetic information, or payment source.
6. **Confidentiality of Health Information:** Patients have the right to confidential communication with healthcare providers, and their health information must be protected. They also have the right to review, copy, and request amendments to their medical records.
7. **Complaints and Appeals:** Patients can access a fair and efficient process to resolve disputes with health plans, providers, and institutions, including internal reviews and independent external reviews.
8. **Consumer Responsibilities:** Patients are encouraged to assume reasonable responsibilities, such as maintaining healthy habits, participating in care decisions, respecting other patients and health workers, and becoming knowledgeable about their health coverage and options.

Residents' Bill of Rights

The Nursing Home Reform Act ensures that nursing home residents receive the care and services they need while maintaining their rights. These rights must be explained to residents in writing in a language they understand, both before and during their stay. Here are the key rights protected under Federal law:

1. **Be Treated with Respect:** Residents have the right to be treated with dignity, make their own schedules, and participate in activities of their choice, including decisions about their daily routines.
2. **Participate in Activities:** Residents can participate in an activities program designed to meet their needs and preferences.
3. **Be Free from Discrimination:** Nursing homes must comply with Civil Rights laws, ensuring no discrimination based on race, color, national origin, disability, age, or religion.
4. **Be Free from Abuse and Neglect:** Residents are protected from verbal, sexual, physical, and mental abuse. Nursing homes must report and investigate suspected abuse or neglect.
5. **Be Free from Restraints:** Physical and chemical restraints cannot be used for discipline or staff convenience.
6. **Make Complaints:** Residents have the right to voice complaints without fear of punishment, and nursing homes must address issues promptly.
7. **Get Proper Medical Care:** This includes being informed about health status, participating in care decisions, choosing doctors, and accessing medical records. Residents also have the right to create advance directives and refuse experimental treatment.
8. **Have Your Representative Notified:** The nursing home must inform residents' doctors and legal representatives of significant changes in their health or treatment plans.
9. **Get Information on Services and Fees:** Residents must be informed in writing about all services and fees, and how to apply for Medicare and Medicaid benefits.
10. **Self-Manage Their Money:** Residents can manage their own money or choose someone to do it for them. Nursing homes must have systems to protect residents' funds and provide full accounting.
11. **Get Proper Privacy, Property, and Living Arrangements:** Residents have the right to privacy in visits, phone calls, mail, and personal property. They must be notified of room or roommate changes.
12. **Spend Time with Visitors:** Residents can have private visits at any time, provided it doesn't interfere with the care of others. They can see anyone who provides health, social, legal, or other services.
13. **Get Social Services:** Necessary social services, including counseling, problem-solving, and discharge planning, must be provided.
14. **Leave the Nursing Home:** Residents can leave for visits or move out, provided they comply with the nursing home's policies. Health insurance coverage conditions may apply.
15. **Have Protection Against Unfair Transfer or Discharge:** Transfers or discharges are only allowed under specific conditions, such as health improvement or non-payment. Residents have the right to appeal and must receive a 30-day notice in non-emergency situations.
16. **Form or Participate in Resident Groups:** Residents can form or join groups to discuss nursing home policies and concerns, with the nursing home required to provide meeting space and act on grievances.
17. **Have Family and Friends Involved**: Family and friends can visit, participate in care planning with permission, and join family councils to ensure residents receive quality care.

Unexpected Patient Incidents

An **Unexpected Patient Incident** refers to an occurrence that was **not anticipated**, which **results in or has the potential to result in harm to a patient/resident.** This can encompass a wide range of events and complications during medical care.

Definitions

Unexpected Patient/Resident Incidents can fall into various categories, such as:

a. **Near Misses**: These are events that could have caused harm to a patient but did not, either by chance or through timely intervention.
b. **Errors:** An error is the failure of a planned action to be completed as intended or the use of a wrong plan to achieve an aim. These can include both **acts of commission** (doing something wrong) and **acts of omission** (failing to do something). Errors can include problems in practice (medication administration, providing care or treatments, etc.), products, procedures, and systems.
c. **Adverse Events**: These are injuries caused by medical management rather than the underlying condition of the patient/resident. For instance, an adverse drug reaction or surgical complications.

d. **Injuries:** This involves physical harm or damage to a patient resulting from the care provided or failure to provide necessary care. This includes any physical injury caused by medical treatment or procedures.
e. **Safety Hazards**: This refers to conditions in the healthcare setting that increase the likelihood of an adverse event, which can cause harm to patients, staff, or visitors. Safety hazards can arise from biological, chemical, enviro-mechanical or physical conditions or procedural failures.
f. **Sentinel Events**: These are unexpected occurrences involving death or serious physical or psychological injury, or the risk thereof. Sentinel Events can vary by healthcare setting.

Reporting Sentinel Events to TJC

Sentinel Events are the most serious type of unexpected patient incidents. TJC requires that these events be reported for further investigation to ensure patient and resident safety. Specific information for different healthcare settings can be found on TJC's website for **Sentinel Events**. Below is a list of the most common sentinel events:

1. **Death from Self-inflicted Injuries:**
   a. In a healthcare setting.
   b. Within 7 days of discharge from inpatient services or the ED.
   c. While receiving or within 7 days of discharge from behavioral health services (Day Treatment, PHP, IOP, Residential, Group Home, Transitional Supportive Living).
2. **Unanticipated Death of a Full-term Infant**
3. **Homicide:**
   a. Of any patient under care or supervision.
   b. Of a staff member, visitor, or vendor on site or providing care.
4. **Intrapartum Maternal Death**
5. **Severe Maternal Morbidity (permanent or severe harm)**
6. **Sexual Abuse/Assault:**
   a. Of any patient under care or supervision.
   b. Of a staff member, visitor, or vendor on site or providing care.
7. **Physical Assault (leading to Death, Permanent Harm, or Severe Harm):**
   a. Of any patient under care or supervision.
   b. Of a staff member, visitor, or vendor on site or providing care.
8. **Wrong-site, Wrong-patient, or Wrong Procedure Surgery**
9. **Discharge of an Infant to the Wrong Family**
10. **Abduction of Any Patient Under Care**
11. **Patient Elopement** from a 24-hour staffed care setting (including ED) leading to death, permanent harm, or severe harm.
12. **Blood or Blood Products Errors -** Unintended ABO and non-ABO incompatibilities, hemolytic transfusion reactions, or transfusions resulting in death, permanent harm, or severe harm.
13. **Retention of Foreign Object After Surgery or Invasive Procedure**
14. **Severe Neonatal Hyperbilirubinemia (bilirubin >30 mg/dL)**
15. **Fluoroscopy-related Permanent Tissue Injury:** When optimization was not implemented, or practice parameters not followed.
16. **Radiotherapy Errors**- Delivery to wrong patient, wrong body region, unintended procedure, or >25% above planned dose.
17. **Fire, flame, or unanticipated smoke, heat, or flashes** occurring during direct patient care caused by equipment operated and used by the organization.
18. **Patient Falls**:
    a. Resulting in any fracture.
    b. Requiring surgery, casting, or traction.
    c. Necessitating consult/management or comfort care for neurological or internal injury.
    d. Involving a patient with coagulopathy receiving blood products due to the fall.
    e. Leading to death or permanent harm from injuries sustained in the falls.

What to Do When an Unexpected Patient Incident Occurs?

In the event of an **unexpected patient/resident incident** related to the care, treatment, and services provided, the IntelyPro must perform **ALL** the following regardless of whether there was an adverse outcome:

1. **Stay with the patient/resident and ensure their safety.**
2. **Immediately alert** the charge nurse, supervisor etc. and the medical team.
3. **Follow the Client's policies and procedures** in addressing adverse events, near misses, errors, safety hazards, injuries, and sentinel events.
4. **Document the event.**

Each IntelyPro plays a vital role in ensuring a safe environment for patients, residents, visitors, and healthcare staff. They are encouraged to speak up about any concerns that may compromise safety or care quality.

Reporting Unexpected Patient Incidents

Healthcare facilities have protocols for promptly reporting and investigating these incidents, with a focus on identifying root causes and implementing corrective actions to prevent recurrence. Most Clients have a dedicated "**Patient Safety Reporting System**" or simply an "**Incident Reporting System.**" This system allows healthcare staff to report any incident that compromises patient/resident safety or quality of care.

If an IntelyPro witnesses or has an unexpected patient incident event, they must follow the Client's policies and procedures in documenting and reporting the event. In addition, the IntelyPro **must also** follow our internal policy to report the incident to IntelyCare by contacting:

IntelyCare Care Support Team
Available 24/7
Phone: 844-683-5922
Email: CareTeam@intelycare.com

Failure to adhere to the Client's or IntelyCare's policies and procedures for managing Unexpected Patient Incidents, including reporting, documenting, and cooperating in any related investigation, can result in termination.

OCCUPATIONAL SAFETY AND HEALTH ADMINISTRATION (OSHA)

Infection Control – Standard Precautions

Standard Precautions are used for ALL patient care. They involve practical measures and the use of personal protective equipment (PPE) to safeguard healthcare workers from infections and to minimize the transmission of infections between patients.

Hand Hygiene*

Hand Hygiene is a clinical safety matter. All healthcare workers, caregivers, or persons involved in direct or indirect patient/resident care should be able to perform hand hygiene correctly and at the right time. ***Hand hygiene is also a TJC requirement.**

Below are The Centers for Disease Control (CDC) Hand Hygiene Guidelines to keep healthcare workers, patients and residents, and the public safe. For more detailed information, please reference the following link: **Clinical Safety: Hand Hygiene for Healthcare Workers**.

Hand Hygiene Reduces:

1. The potential spread of deadly germs to patients.
2. The spread of germs, including those resistant to antibiotics.
3. The risk of healthcare personnel colonization or infection caused by germs received from the patient.

When to When to Perform Hand Hygiene

1. Immediately before touching a patient.
2. Before performing an aseptic task such as placing an indwelling device or handling invasive medical devices.
3. Before moving from work on a soiled body site to a clean body site on the same patient.
4. After touching a patient or patient's surroundings.
5. After contact with blood, body fluids, or contaminated surfaces.
6. Immediately after glove removal.

Alcohol-Based Hand Sanitizer (ABHS)

When to Wash Hands with ABHS

Unless hands are visibly soiled, ABHS is preferred over soap and water in most clinical situations because it:

1. Is more effective at killing germs on hands than soap.
2. Is easier to use when providing care, especially when moving from soiled to clean activities on the same patient or when moving between care of patients in shared rooms.
3. Results in improved skin condition with less irritation and dryness than soap and water.
4. Improves hand hygiene adherence.

How to Wash Hands with ABHS

1. Put product on hands and rub hands together.
   a. The efficacy (effectiveness) of alcohol-based hand sanitizer depends on the volume applied to the hands. Use the right amount of alcohol-based hand sanitizer product to clean your hands.
2. Cover all surfaces and rub until hands feel dry (approximately 20 seconds).
3. Pay attention to the areas frequently missed – thumbs, fingertips and between fingers

Soap and Water

When to Wash Hands with Soap and Water

1. When hands are visibly soiled.
2. Before eating.
3. After using the restroom.
4. During the care of patients with suspected or confirmed infection during outbreaks of C. *difficile* and norovirus.

How to Wash Hands with Soap and Water

1. Wet hands with water.
2. Apply the manufacturer recommended amount of product to your hands.
3. Rub hands together vigorously for at least 15-20 seconds, covering all surfaces of the hands and fingers.
4. Rinse hands with water and use disposable towels to dry.
5. Use a towel to turn off the faucet.
6. Avoid using hot water to prevent drying of the skin.

Personal Protective Equipment (PPE)

IntelyPros should use Personal Protect Equipment (PPE) whenever there is a possible risk or expectation of exposure to an infectious material, including bloodborne pathogens. It is the last line of defense against a hazard.

PPE Selection

Choosing the correct PPE depends on the potential risk of exposure to a hazard:

PPE Examples	
Eyes	Safety Glasses, Goggles, Laser Protective Eyewear
Ears	Ear Plugs or Muffs
Face	Face Shield
Hands	Exam Gloves, Chemotherapy Gloves
Torso/Body	Fluid Resistant Gowns, Impervious Splash Suit, Laser Protective Clothing
Lungs	N95 Filtering Facepiece Respirator, Elastomeric Half-Mask Respirator, Powered Air-Purifying Respirator (PAPR), Surgical Mask, And Protective Shields and Barriers
Feet	Shoe Coverings

CDC Guidelines Summary for PPE

Gloves:

1. Wear gloves when there's a reasonable expectation of contact with blood, bodily fluids, mucous membranes, nonintact skin, or potentially contaminated intact skin (e.g., patients incontinent of stool or urine).
2. Choose gloves with appropriate fit and durability for the task:
   a. Use disposable medical gloves for direct patient care.
   b. Use disposable or reusable utility gloves for cleaning tasks.
3. Remove gloves after patient contact or environmental contact, ensuring proper technique to avoid hand contamination.
4. Use a new pair of gloves for each patient; never reuse gloves or wash them for reuse.
5. Change gloves during patient care when moving from contaminated to clean body sites.

Gowns

1. Wear a gown suited to the task to protect skin and prevent clothing contamination during procedures involving blood, body fluids, secretions, or excretions.
2. Wear a gown during direct patient contact if the patient has uncontained secretions or excretions.
3. Remove the gown and perform hand hygiene before leaving the patient's environment. Gowns should not be reused, even with the same patient.
4. Routine gown use upon entry to high-risk units (e.g., COVID, ICU, NICU) is **not** recommended.

Mouth, Nose, and Eye Protection:

1. Use PPE to protect the mucous membranes of the eyes, nose, and mouth during procedures likely to generate splashes or sprays of blood, body fluids, secretions, or excretions. Select masks, goggles, or face shields based on the anticipated exposure.
2. For aerosol-generating procedures (e.g., bronchoscopy, suctioning) in patients not suspected of having an infection requiring respiratory protection (e.g., tuberculosis, SARS), use one of the following: a full-face shield, a mask with an attached shield, or a combination of mask and goggles, in addition to gloves and a gown.

Correct Sequence for Putting on and Removing 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 CDC's recommended procedure for putting on and removing PPE should be tailored to the specific type of PPE. For more information on how to put on or the different ways to remove PPE, please refer to CDC's tip sheet on **PPE Sequence.**

Donning or Putting On PPE

1. **Gown**
   a. Fully cover torso from neck to knees, arms to end of wrists, and wrap around the back
   b. Fasten behind neck and waist
2. **Mask or Respirator**
   a. Secure ties or elastic bands at middle of head and neck
   b. Fit flexible band to nose bridge
   c. Fit snug to face and below chin
   d. Fit-check respirator
3. **Goggles or Face Shield**
   a. Place over face and eyes and adjust to fit
4. **Gloves**
   a. Extend to cover wrist of isolation gown
5. **Tips to Protect Yourself and Limit the Spread of Contamination**
   a. Keep hands away from face
   b. Limit surfaces touched
   c. Change gloves when torn or heavily contaminated
   d. Perform hand hygiene

Doffing or Removing PPE

There are **a variety** of ways to safely remove PPE without contaminating your clothing, skin, or mucous membranes with potentially infectious materials. **With all methods, be sure to 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**
   a. Outside of gloves are contaminated!
   b. If your hands get contaminated during glove removal, immediately wash your hands or use an alcohol-based hand sanitizer
   c. Using a gloved hand, grasp the palm area of the other gloved hand and peel off first glove
   d. Hold removed glove in gloved hand
   e. Slide fingers of ungloved hand under remaining glove at wrist and peel off second glove over first glove
   f. Discard gloves in a waste container
2. **Goggles or Face Shield**
   a. Outside of goggles or face shield are contaminated!
   b. If your hands get contaminated during goggle or face shield removal, immediately wash your hands or use an alcohol-based hand sanitizer
   c. Remove goggles or face shield from the back by lifting head band or earpieces
   d. If the item is reusable, place it in designated receptacle for reprocessing. Otherwise, discard in a waste container
3. **Gown**
   a. Gown front and sleeves are contaminated!
   b. If your hands get contaminated during gown removal, immediately wash your hands or use an alcohol-based hand sanitizer
   c. Unfasten gown ties, taking care that sleeves don't contact your body when reaching for ties
   d. Pull gown away from neck and shoulders, touching inside of gown only

e. Turn gown inside out
f. Fold or roll into a bundle and discard in a waste container

4. **Mask or Respirator**
   a. **The front of mask/respirator is contaminated — DO NOT TOUCH!**
   b. If your hands get contaminated during mask/respirator removal, immediately wash your hands or use an alcohol-based hand sanitizer
   c. Grasp bottom ties or elastics of the mask/respirator, then the ones at the top, and remove without touching the front
   d. Discard in a waste container
5. **Wash Hands or Use an Alcohol-Based Hand Sanitizer Immediately After Removing All PPE.**
6. Perform hand hygiene between steps if hands become contaminated and immediately after removing all PPE.

Respiratory Hygiene/Cough Etiquette

To prevent the spread of **ALL** respiratory infections, including influenza, healthcare settings should implement the following measures immediately upon first contact with potentially infected individuals:

Visual Alerts:

a. Display visual alerts in appropriate languages at entrances to outpatient facilities (e.g., emergency departments, clinics) instructing patients and their companions to report respiratory symptoms upon arrival and to follow Respiratory Hygiene/Cough Etiquette.
b. Include guidance on covering coughs and information about the proper use of personal protective equipment (PPE).

Respiratory Hygiene/Cough Etiquette:

c. Encourage individuals with respiratory symptoms to:
d. Cover their mouth and nose with a tissue when coughing or sneezing.
   i. Dispose of tissues in the nearest waste receptacle immediately after use.
   ii. Perform hand hygiene after contact with respiratory secretions or contaminated materials.
e. Ensure the availability of tissues, no-touch receptacles, and hand hygiene supplies in waiting areas.

Masking and Distancing:

f. During periods of increased respiratory infections in the community, offer masks (procedure or surgical) to coughing individuals.
g. Encourage them to sit at least three feet away from others in waiting areas when space allows. Some facilities may choose to implement this practice year-round.

Droplet Precautions:

h. Healthcare personnel should observe Droplet Precautions—wearing a surgical or procedure mask during close contact—alongside Standard Precautions when treating patients with respiratory symptoms, especially if fever is present. These precautions should remain in place until the infectious nature of the symptoms is ruled out.

Appropriate Patient Placement

Healthcare management and staff should factor in the potential for transmitting infectious agents when making patient-placement decisions. If a patient/resident poses a risk of spreading infections to others (such as through uncontained secretions, excretions, or wound drainage, or in the case of infants with suspected viral respiratory or gastrointestinal infections), they should be placed in a single-patient room if one is available.

Considerations for Patient Placement and Infection Control

a. Route(s) of transmission of the known or suspected infectious agent
b. Risk factors for transmission in the infected patient
c. Risk factors for adverse outcomes resulting from an HAI in other patients in the area or room being considered for patient-placement
d. Availability of single-patient rooms
e. Patient options for room-sharing (e.g., cohorting patients with the same infection)

Placement Based on Type of Transmission Precautions

For detailed guidance on proper patient or resident placement according to Contact, Airborne, or Droplet Precautions, please consult the CDC recommendations**: Transmission-Based Precautions V.B.2. Patient Placement**

Clean and Disinfect Patient/Resident Care Equipment

Properly handle, clean, and disinfect patient care equipment and instruments and devices. The area must also be cleaned and disinfected appropriately per CDC recommendations: **Transmission-Based Precautions IV.E. Patient-Care Equipment And Instruments/Devices**.

Textiles and Laundry

Handle the removal of used or contaminated textiles, fabrics, and/or clothing carefully and with minimal agitation to prevent contaminating the air, surfaces, and individuals. If laundry chutes are utilized, ensure they are properly designed, maintained, and operated to minimize the spread of aerosols from contaminated laundry. For more detailed information, consult the **Guidelines for Environmental Infection Control**.

Preventing Needle-Stick Injuries - Safe Practices

The following recommendations apply to the use of needles, cannulas that replace needles, and, where applicable, intravenous delivery systems

CDC Recommendations for Safe Injection Control

1. **Utilize aseptic technique** to prevent contamination of sterile injection equipment.
2. **Never administer medications from a syringe to multiple patients/residents,** even if the needle or cannula is changed.
3. **Treat needles, cannulas, and syringes as sterile, single-use items.** They should **not** be reused for another person or to access a medication or solution intended for subsequent use.
4. **Use fluid infusion and administration sets (e.g., IV bags, tubing, connectors) for a single patient only,** and dispose of them properly after use. Consider a syringe or needle/cannula contaminated once it has been used to enter or connect to a patient's IV infusion bag or administration set.
5. **Whenever possible, use single-dose vials for parenteral medications**.
6. **Do not administer medications from single-dose vials or ampules to multiple patients,** and do not combine leftover contents for future use.
7. **When using multidose vials, ensure both the needle/cannula and syringe are sterile** before accessing the vial.
8. **Store multidose vials outside the immediate treatment area** and follow the manufacturer's storage instructions. Discard the vial if sterility is compromised or questionable.
9. **Do not use bags or bottles of IV solution as a common source for multiple patients**.
10. **Wear a surgical mask when performing lumbar punctures**.

Additional CDC Safe Injection Resources

1. Sharps Safety for Healthcare Settings workbook.
2. Guidelines for infrastructure and routine practices in healthcare personnel.
3. Guidelines for epidemiology and control of selected infections transmitted among personnel and patients.
4. NIOSH healthcare worker information.
5. Occupationally Acquired Infections in Healthcare Settings.

Transmission-Based Precautions

Transmission-based precautions are infection control measures recommended by the CDC to prevent the spread of highly contagious or epidemiologically significant pathogens. These precautions are **used in addition to standard precautions** and are categorized into three types: Contact, Droplet, and Airborne. When standard precautions alone are insufficient to control the spread of an infection, these precautions provide an extra layer of protection.

Precaution Type	Purpose	Personal Protective Equipment (PPE)	Some Examples
Contact	Prevent the spread of infectious agents through direct or indirect contact with the patient/resident or their environment	Gown and gloves for all interactions with the patient/resident or their environment.	C. difficile, norovirus, VRE, other GI pathogens, RSV, most Staphylococcal (S. aureus) and MRSA wounds, etc.
Droplet	Prevent the transmission of pathogens spread through respiratory droplets that are expelled during coughing, sneezing, or talking.	Standard: Mask, eye protection (goggles), face shield. Aerosol-producing procedures: Fit-tested N95 or higher respirator, gloves, gown, face & eye protection	Respiratory viruses, B. pertussis, influenza, adenovirus, rhinovirus, N. meningitides, group A streptococcus (first 24 hours of antimicrobial therapy), etc.
Airborne	Prevent the spread of infections via tiny airborne particles that can remain suspended in the air and be inhaled	N95 or higher-level face mask, gloves, gown, eye protection. Airborne Infection Isolation Room (AIIR) often required.	Anthrax, tuberculosis, smallpox, measles, chickenpox, disseminated herpes zoster, etc.

CDC Resources:

For more detailed information on isolation precautions, please consult:

1. Transmission Based Precautions
2. Types and Duration of Precautions
3. Recommended Guidelines Isolation Precautions

Bloodborne Pathogens (BBPs)

Bloodborne Pathogens (BBP) are pathogenic microorganisms like hepatitis B virus (HBV), hepatitis C virus (HCV), and human immunodeficiency virus (HIV), etc. They are found in blood or other potentially infectious materials (OPIM) and can quickly spread disease. OPIM includes substances such:

1. Semen
2. Vaginal secretions
3. Body fluids (Cerebrospinal, Synovia, Pleural, Pericardial, Peritoneal, Amniotic fluid, Saliva, etc.)
4. Any body fluid visibly contaminated with blood.
5. Unfixed human tissues and cultures infected with HBV, HIV, etc.

Healthcare workers are at increased risk of BBP exposure due to their direct contact with blood. In this section we will explain the key components of **OSHA's Exposure to Bloodborne Pathogens Standard** 29 CFR 1910.1030. This manual covers the required training that must be completed upon hire and annually thereafter.

Exposure Control Plan (ECP)

IntelyCare advises each IntelyPro to find and familiarize themselves with each facility's Exposure Control Plan (ECP) to eliminate or minimize occupational exposure to bloodborne pathogens. All healthcare facilities are required to have an ECP in compliance with OSHA. This plan will include:

1. Assessment of Employee Exposure Risks
2. Implementation of Exposure Control Methods in Client Facilities
3. Universal Precautions
4. Engineering and Work Practice Controls
5. Personal Protective Equipment
6. Housekeeping
7. Hepatitis B Vaccination
8. Post-Exposure Evaluation and Follow-Up
9. Communication Of Hazards and Employee Training
10. Recordkeeping
11. Procedures For Evaluating Circumstances Surrounding Exposure Incidents

Engineering and Work Practice Controls

Refer to each facility's policy and procedures on engineering control and devices to isolate or remove potential hazards as what is offered can vary between different clients. To protect yourself adequately, be sure to:

1. Always use appropriate engineering controls, such as sharps disposal containers, safety-engineered devices (e.g., retractable needles) to reduce exposure risk.
2. Ensure proper disposal of sharps in puncture-resistant containers and promote safe handling practices.

Universal Precautions

OSHA standards mandate that healthcare workers to follow universal precautions to prevent contact with blood and OPIM. However, OSHA also allows the use of standard precautions as an alternative.

Standard precautions integrate the principles of universal precautions and body substance isolation, assuming all blood, body fluids (except sweat), non-intact skin, and mucous membranes may carry infectious agents, such as HIV, HBV, etc. They apply to all healthcare setting and are more comprehensive than universal precautions alone.

For more information on the CDC's Standard Precautions, refer to the *Infection Control – Standard Precautions* section of this manual.

Transmission of Bloodborne Pathogen Diseases

BBP can be transmitted through several different modes. The primary modes of transmission that are most common exposure risks to healthcare workers are noted with *:

Mode of BBP Transmission	Description
Percutaneous Exposure*	Injuries from contaminated needles or sharp objects (e.g., needlestick injuries, cuts from scalpels).
Mucous Membrane Exposure*	Contact with infected blood/ body fluids through the eyes, nose, or mouth (e.g., blood or OPIM splashing onto the body or clothing).
Non-Intact Skin Exposure*	BBPs enter broken/damaged skin, such as cuts, abrasions, or dermatitis
Human Bites	Transmission through bites that break the skin, exposing blood or saliva containing BBPs.
Sexual Transmission	Transmission via unprotected sexual contact with an infected person.

Mode of BBP Transmission	Description
Vertical Transmission (Mother to Child)	BBPs transmitted from mother to child during childbirth or breastfeeding.
Blood Transfusions and Organ Transplants	Transmission through receiving infected blood products or organs, although rare due to screening.
Shared Needles or Drug Equipment	BBPs transmitted through shared needles or drug paraphernalia contaminated with infected blood.

Bloodborne Pathogen Diseases: HBV, HBC, and HIV

Bloodborne pathogens (BBPs) are microorganisms present in human blood that can cause diseases in humans. The most common BBPs are hepatitis B virus (HBV), hepatitis C virus (HCV), and human immunodeficiency virus (HIV).

Disease	Description	Epidemiology	Acute Symptoms	Chronic Symptoms
Hepatitis B (HBV)	DNA virus that infects the liver. It spreads through contact with infected blood, semen, or other bodily fluids, commonly via unprotected sex, needle sharing, or from mother to child during birth.	Up to 2.4 million chronically infected in the U.S.; acute infection rates rising in opioid crisis states; thousands die annually. Vaccine is available.	Fever, fatigue, loss of appetite, nausea, vomiting, abdominal pain, dark urine, clay-colored stools, joint pain, jaundice; can be asymptomatic.	Often asymptomatic; can lead to cirrhosis, liver failure, or liver cancer over time.
Hepatitis C (HCV)	RNA virus that primarily affects the liver, often leading to chronic infection and long-term liver damage. Spreads through direct contact with infected blood, commonly via injection drug use, unsterilized medical equipment, or, rarely, from mother to child during birth.	2.4 to 4 million affected in the U.S. between 2017-2020; over half linked to injection drug use; no vaccine available	Typically, mild or asymptomatic; fatigue, fever, nausea, loss of appetite, abdominal pain, dark urine, and jaundice.	Often asymptomatic for decades; may lead to liver cirrhosis, liver failure, or liver cancer if untreated.
Human Immuno-deficiency Virus (HIV)	RNA virus targeting immune system cells, weakening the body's ability to fight infections; transmitted through specific bodily fluids, often via unprotected sex or shared needles.	Approx.1.2 million with HIV in the U.S. (2022) with 31,800 new infections reported: low occupational transmission risk but possible through needlesticks. No vaccine available.	Flu-like symptoms within 2-4 weeks: fever, sore throat, rash, swollen lymph nodes, muscle aches.	Often asymptomatic can progress to AIDS if untreated; Symptoms - rapid weight loss, recurring fever, extreme fatigue, prolonged lymph gland swelling, diarrhea, sores, neurological disorders.

Occupational Exposure:

Refers to the risk of encountering infectious materials, such as blood or body fluids, that may lead to the transmission of diseases like HBV. Healthcare workers are more likely to face this risk and are, therefore, required by OSHA to be offered the HBV vaccination.

Hepatitis B Vaccine:

Receiving the **HBV vaccine** is crucial for healthcare workers, as it provides protection against infection and helps prevent the spread of this potentially life-threatening virus. The HBV vaccine is a non-infectious, recombinant vaccine, meaning it is produced from yeast cultures rather than human blood or plasma:

1. **No Risk of Contamination:** The vaccine carries no risk of contamination from other bloodborne pathogens.
2. **No Chance of Developing HBV:** There is no possibility of contracting HBV from the vaccine itself.
3. Vaccine must be offered and provided free of charge to the worker within 10 days of the worker's first assignment to a job where occupational exposure may occur. **Exceptions:**
   a. If the worker has already received the HBV vaccine series.
   b. If antibody testing has shown that the worker is already immune.
   c. If the vaccine is contraindicated for medical reasons.
4. Employees have the right to decline the vaccine but must sign a declination form if they decide to do so.

HBV Vaccine Administration:

The administration of the HBV vaccine must follow the recommendations provided by the U.S. Public Health Service (USPHS) at the time of the vaccination. Key points include:

1. **Mode:** The HBV vaccine is administered as intermuscular (IM) injection, typically in the deltoid muscle.
2. **Complete the Series:** To ensure immunity, it is critical to complete the entire series of vaccinations as recommended. Note some brands have a 2-shot series and others have a 3-shot series.
3. **Effectiveness:** The majority of individuals who receive the **full course** of the HBV vaccine will develop immunity to the hepatitis B virus.
4. **Safety:** The vaccine is safe for everyone, including those who are already immune or those who are carriers of HBV.

Exposure Incidents & Follow-Up

An exposure incident is a specific eye, mouth, other mucous membrane, non-intact skin, or parenteral contact with blood or other potentially infectious materials (OPIM) while at work.

Recognizing Tasks and Activities with Exposure Risk

1. **Direct Contact with Blood or OPIM:**
   a. **Medical Procedures:** Any task that involves handling or manipulating blood, such as drawing blood, performing wound care, or handling blood samples in laboratories.
   b. **Cleaning and Disinfecting:** Cleaning up spills of blood or OPIM, or cleaning surfaces contaminated with these materials.
   c. **Handling Contaminated Items:** Handling items that may be contaminated with blood or OPIM, including linens, medical equipment, and instruments.
2. **Indirect Contact with Blood or OPIM:**
   a. **Waste Disposal:** Handling and disposing of waste that may contain blood or OPIM, such as used sharps or contaminated waste.
   b. **Contact with Contaminated Surfaces:** Touching surfaces or objects that have been in contact with blood or OPIM, including potentially contaminated floors, walls, or workstations.
3. **Tasks with Potential for Exposure:**
   a. **Emergency Situations:** Activities in emergency settings where blood or OPIM might be present, such as trauma care or resuscitation efforts.
   b. **Patient Care:** Any procedures involving bodily fluids or tissues, including those that may not visibly contain blood but could still be contaminated.

BBP & OPIM Post Exposure Follow-Up Plan & Reporting

All IntelyPros involved in direct patient care should be familiar with appropriate decontamination procedures and what actions to take in the event of a workplace exposure to BBP or OPIM.

If you experienced a needlestick injury or were exposed to the blood or other body fluid of a patient/resident, immediately follow these steps:

1. **Wash needlesticks and cuts with antiseptic soap and water for 15-20 minutes.**
2. **Flush splashes to the nose, mouth, or skin with water for 15 to 20 minutes.**
3. **Flush eyes with clean water, an eyewash, or sterile irrigants for 15-20 minutes.**
4. **Report the Incident:** Immediately report the exposure to their facility supervisor and IntelyCare. If possible, identify the source individual (patient/resident) involved in the exposure so the facility may obtain consent to test the source individual for bloodborne pathogens (HBV, HCV, HIV, etc.).
5. **Medical Evaluation:**
   a. A healthcare provider should conduct a post-exposure evaluation to assess the risk of infection and determine the need for post-exposure prophylaxis (PEP).
   b. The exposed IP should undergo confidential baseline blood testing as soon as possible after the exposure for HBV, HCV, and HIV status.
   c. Post-Exposure Prophylaxis (PEP):
      i. **HBV:** If the IP has not been vaccinated against HBV or did not develop immunity, they will be offered the HBV vaccine series. In some cases, HBIG (hepatitis B immune globulin) may be recommended.
      ii. **HCV:** There is no PEP for HCV; however, baseline and follow-up testing is crucial for early detection of infection.
      iii. **HIV:** If the exposure poses a significant risk of HIV transmission, the provider will initiate HIV PEP as soon as possible, ideally within hours of exposure. PEP should be continued for 4 weeks.
   d. Follow-Up Testing and Monitoring:
      i. **HIV Testing**: Follow-up HIV testing should be conducted at 6 weeks, 12 weeks, and 6 months post-exposure.
      ii. **HBV Testing:** Follow-up testing should be conducted according to the IP's vaccination and immune status.
      iii. **HCV Testing:** Follow-up testing should be conducted at 4-6 months post-exposure (anti-HCV and ALT levels). If early detection is desired, HCV RNA testing may be done at 4-6 weeks post-exposure.
6. **Counseling and Support:**
   a. The exposed IP will be provided with confidential counseling regarding the risks of transmission, the need for follow-up, and strategies to prevent secondary transmission.
   b. IntelyCare will offer psychological support or referral to mental health services if needed, especially in cases where the exposure is highly stressful.
7. **Documentation and Recordkeeping:**
   a. IntelyCare will maintain a confidential medical record for the exposed IP, including details of the exposure, the results of evaluations, and the outcomes of follow-up testing.
   b. IntelyCare will record all actions taken as part of the follow-up process, including any treatment provided and counseling sessions.
8. **Review and Prevention:**
   a. IntelyCare will review the circumstances surrounding the exposure with the Client to identify potential lapses in protocol or areas for improvement.
   b. IntelyCare and/or the Client will implement corrective actions to prevent similar exposures in the future, including additional training or changes in procedures.
9. **Compliance with OSHA Standards:** IntelyCare will ensure that all actions taken comply with OSHA's Bloodborne Pathogens Standard (29 CFR 1910.1030.

Biological Hazards

In addition to BBP and OPIM hazards, there are also other biological hazards that healthcare workers need to be vigilant about to protect themselves and patients/residents against transmission.

Tuberculosis

Tuberculosis (TB), caused by the bacterium *Mycobacterium tuberculosis*, spreads through airborne droplets when an infected person coughs, speaks, or sneezes. If inhaled, these droplets can lead to infection in the lungs or other parts of the body. TB poses a significant risk in healthcare settings, especially with multidrug-resistant (MDR) strains that resist standard treatments such as Isoniazid and Rifampin.

TB Symptoms

1. Persistent cough lasting 3 weeks or more
2. Unexplained weight loss
3. Night sweats
4. Fever and fatigue
5. Chest pain and difficulty breathing
6. Bloody sputum or coughing up blood (hemoptysis)
7. Loss of appetite
8. Hoarseness

Employee TB Screening

CDC recommends all U.S. health care personnel should be screened for TB upon hire.
All U.S. health care personnel should be screened for TB upon hire (i.e., preplacement).
TB screening includes:

1. A baseline individual TB risk assessment,
2. TB symptom evaluation
3. A TB test (e.g., TB blood test or a TB skin test), and
4. Additional evaluation for TB disease as needed.

Prevention and Control Measures

All healthcare settings are required to have a TB infection-control program to ensure effective management. This program focuses on the prompt detection of TB, the implementation of airborne precautions, the prevention of transmission, and the treatment of individuals with suspected or confirmed TB. In settings where TB patients are not expected, prompt referral to appropriate facilities is essential. The program should include the following:

1. **Administrative Controls:**
   a. Implement early patient screening to identify and isolate potentially infectious individuals.
   b. Remain alert for TB symptoms, especially in patients at higher risk.
2. **Environmental Controls:**
   a. Before transferring a patient suspected of having TB to an isolation room, ensure they wear surgical masks, minimize their presence in shared areas, and expedite their transfer to isolation.
   b. Utilize isolation rooms equipped with appropriate ventilation for patients diagnosed with TB.
   c. Post warning signs outside isolation rooms to prevent accidental entry.
   d. Use biological hazard warnings to identify areas or materials contaminated with TB.
3. **Respiratory Protection:**
   a. N95 respirators are the minimum required protection for healthcare workers in contact with patients with TB to prevent against TB.
   b. Healthcare facilities will provide workers fit testing and training for N95s prior patient contact/care.

TB Post Exposure Follow-Up Plan & Reporting

Immediate Actions Following Exposure:

1. The exposed IP must immediately report the exposure to their facility supervisor and IntelyCare.
2. Follow the facility's post-exposure protocols, which may include TB testing, medical evaluation, and monitoring.
3. Exposed IPs may require a TB skin test (TST) or Interferon-Gamma Release Assay (IGRA) to detect infection.
4. Additional testing and monitoring will be required if the initial test is positive.

TB Treatment

1. Healthcare workers with Latent TB Infection (LTBI) are infected with *Mycobacterium tuberculosis* but do not have active TB disease. They are asymptomatic and are not contagious. Treatment is recommended to prevent the progression to active TB disease.
2. If active TB is diagnosed, immediate treatment is necessary to prevent further spread.
3. There are several treatment regimens recommended in the United States for TB disease.
   a. Treatment can take 4, 6, or 9 months depending on the regimen recommended based on if the TB is latent or active, drug-resistant, and if there are any co-morbidities or risk factors.
   b. Treatments typically include a combination drug regimen of Rifapentine-Moxifloxacin or Rifampin-Isoniazid-Pyrazinamide-Ethambutol (RIPE).

Return to Work:

Employees with TB disease should be allowed to return to work when they:

1. Have had three negative AFB sputum smear results (109–112) collected 8–24 hours apart, with at least one being an early morning specimen because respiratory secretions pool overnight; and
2. Have responded to antituberculosis treatment that will probably be effective based on susceptibility results.
3. In addition, healthcare workers with TB disease should be allowed to return to work when a healthcare practitioner knowledgeable and experienced in managing TB disease determines that employees are noninfectious. Consideration should also be given to the type of setting and the potential risk to patients/residents.

Documentation and Recordkeeping:

1. IntelyCare will maintain a confidential medical record for the exposed IP, including details of the exposure, the results of evaluations, and the outcomes of follow-up testing.
2. IntelyCare will record all actions taken as part of the follow-up process, including any treatment provided and counseling sessions.
3. Review and Prevention:
   a. IntelyCare will review the circumstances surrounding the exposure with the Client to identify potential lapses in protocol or areas for improvement.
   b. IntelyCare and/or the Client will implement corrective actions to prevent similar exposures in the future, including additional training or changes in procedures.
4. **Compliance with OSHA Standards:** IntelyCare will ensure that all actions taken comply with **OSHA's Bloodborne Pathogens Standard (29 CFR 1910.1030)**, including maintaining accurate records and ensuring timely follow-up.

Influenza

Influenza Types

1. **Seasonal:** An acute respiratory infection caused by influenza viruses that circulate annually during fall and winter.
2. **Pandemic:** Occurs when a new influenza A virus strain emerges and spreads globally.
3. **Avian:** Infection caused by avian influenza A viruses, primarily affecting birds but occasionally humans.
4. **Swine**: A respiratory disease in pigs caused by influenza A viruses that can also infect humans.

Influenza Populations Most at Risk

Type of Influenza	Populations Most at Risk
Seasonal	Children under 5 (especially under 2); Adults 65+; pregnant women; Individuals with chronic conditions; **healthcare workers;** LTC residents
Pandemic	**All populations** (due to lack of immunity); young children, elderly, pregnant women, individuals with underlying health conditions
Avian	Poultry workers; individuals near live animal markets; **healthcare workers handling infected patients**
Swine	Individuals in contact with pigs; **healthcare workers**; children, elderly, those with chronic conditions

Influenza Symptoms

Flu Type	Symptoms
Seasonal	Fever/chills; cough; sore throat; runny/stuffy nose; muscle/body aches; headaches; fatigue; vomiting/diarrhea (children)
Pandemic	Similar to seasonal flu; can include severe respiratory symptoms leading to pneumonia
Avian	High fever; cough; sore throat; muscle aches; shortness of breath Severe cases: Pneumonia, ARDS, multi-organ failure
Swine	Similar to seasonal flu Some cases: Severe respiratory illness, pneumonia

Influenza Prevention

Prevention strategies for all influenza types include vaccination (where applicable), isolation precautions, and PPE usage as a part of strict infection control practices.

Influenza Type	Vaccine	Precautions	PPE
Seasonal	Annual Flu vaccine	Droplet precautions	Surgical masks, gloves, gowns
Pandemic	Pandemic-specific vaccine when available	Droplet precautions, airborne precautions for aerosol-generating procedures	N95 respirators, face shields, gloves, full-body-gowns
Avian	No widely available vaccine	Airborne, droplet, and contact precautions:	N95 respirators, gloves, gowns, eye protection
Swine	Annual flu vaccine (includes H1N1 strain)	Droplet precautions, Cont precautions if high environmental contaminati risk	Masks, gloves, gowns

Influenza Treatment

1. Antiviral drugs like oseltamivir (Tamiflu), zanamivir (Relenza), and baloxavir (Xofluza) can be used to treat influenza. However, their effectiveness can vary depending on the specific type and strain of the virus.
2. Early antiviral treatment, usually within 48 hours of symptom onset, is key to maximizing the benefits by reducing the severity and duration of symptoms.
3. In severe cases, especially with avian or pandemic influenza, supportive care in a hospital setting may be necessary in addition to antiviral treatment.
4. Antiviral treatment should always be guided by clinical judgment and local health authority recommendations.

Chemical Hazards & Communication

Physical Hazards in Chemical Safety

Healthcare workers encounter various chemicals that pose significant physical hazards. Understanding and adhering to OSHA regulations is essential for ensuring a safe working environment. This chart outlines basic, but key physical hazards related to chemical safety.

Physical Hazard	Hazards	Basic Safety Measures
Compressed Gas	High pressure; explosion risk if mishandled. Example oxygen, nitrous oxide, etc.	- Secure cylinders to prevent falling - Use appropriate regulators - Store in ventilated areas - Label clearly with contents and hazards
Explosives	Explosion risk under heat, shock, or pressure	- Store in approved, secure facilities - Handle carefully to avoid impact - Keep away from incompatible substances - Implement inventory controls
Flammable or Combustible	Easy ignition; fire and explosion risks. Example, alcohol, etc.	- Store in approved containers - Use in ventilated areas - Keep away from ignition sources - Label containers with hazard warnings
Organic Peroxide	Highly reactive; fire and explosion risks. Example - Chemicals derived from hydrogen peroxide.	- Store in cool, dry, ventilated areas - Avoid contamination - Handle carefully to prevent shock - Use appropriate PPE
Pyrophoric	Ignites spontaneously on air contact	- Store under inert atmospheres - Handle with care to avoid air exposure - Use correct fire extinguishing agents - Train employees thoroughly
Unstable Chemicals	May decompose or react violently	- Identify conditions causing instability - Store in controlled environments - Use stabilizers if needed - Train on hazards and emergency procedures
Water Reactive	Violent reaction with water; heat or toxic gas release. Example – strong acids or bases.	- Store away from moisture in airtight containers - Avoid water-based fire extinguishers - Clearly label and isolate - Train on handling and emergency response

Chemical Hazards

A wide range of chemicals is used in patient and resident care, from everyday cleaning agents to complex medications like chemotherapy drugs. OSHA regulations provide healthcare workers the legal right to be informed about these chemicals and their potential hazards.

Routes of Entry

Understanding how hazardous substances can enter the body is critical for preventing exposure: Always use the recommended PPE to minimize your risk of harmful exposure.

1. **Inhalation:** Breathing in hazardous substances, such as during painting, stripping floors, or exposure to anesthesia gas waste can injure lungs. Always use chemicals in well-ventilated areas. If you feel dizzy, weak, or have difficulty breathing, leave the area immediately
1. **Absorption:** Chemicals entering the body through skin contact, as with formaldehyde and glutaraldehyde.

2. **Ingestion:** Swallowing chemicals, often due to poor hygiene practices like eating, smoking, or applying cosmetics without washing hands after handling toxic substances.
3. **Injection:** Accidental introduction of chemicals into the body via needle sticks or other punctures.

Types of Chemical Exposure

1. **Acute Exposure:** Short-term exposure that may result in immediate effects like dermatitis, headaches, or rashes.
2. **Chronic Exposure:** Long-term exposure that can lead to severe health issues, including cancer or irreversible damage to body systems.

Effects of Chemical Hazards

Health hazards indicate the potential harmful effects of chemicals on human health, categorized as follows:

1. **Carcinogens:** Substances known to cause cancer or reproductive harm.
2. **Toxins:** Chemicals that can poison the body, affecting various organs and systems.
3. **Irritants:** Substances causing irritation to skin, eyes, or respiratory system.
4. **Corrosives:** Materials that can cause severe damage to body tissues upon contact.
5. **Sensitizers:** Chemicals that can trigger allergic reactions after repeated exposure.
6. **Hepatotoxins:** Substances that can damage the liver.
7. **Nephrotoxins:** Chemicals that may harm the kidneys.
8. **Neurotoxins:** Substances that can cause damage to the nervous system.
9. **Hematopoietic Toxins:** Chemicals that affect the blood, potentially leading to conditions like anemia or other blood disorders.
10. **Organ-Specific Toxins:** Substances damaging specific organs, such as the lungs, skin, eyes, or mucous membranes.

Safety Data Sheet (SDS)

SDSs are standardized documents providing detailed information about chemicals, including hazards, safe handling practices, and emergency measures to protect both staff and residents/patients.

SDS Sections

You will find the following information on each SDS.

SDS Section	Content Description	Application
1. Identification	Identifies the chemical, recommended uses, and supplier information.	Ensure proper identification and use of chemicals.
2. Hazard(s) Identification	Details the chemical's potential hazards, with warning labels.	Understand and communicate hazards to prevent exposure and injuries.
3.Composition/ Information on Ingredients	Lists chemical ingredients, including impurities and stabilizing additives.	Know the components for Body, especially in case of allergic reactions or sensitivities.
4. First Aid	Provides immediate care instructions in case of exposure.	Follow these instructions during emergencies to minimize harm.
5. Firefighting	Offers guidance on extinguishing fires involving the chemical.	Use the recommended extinguishing media to safely control fires.

SDS Section	Content Description	Application
6. Accidental Release	Describes procedures for handling spills or releases safely.	Implement these measures promptly to prevent chemical exposure and contamination.
7. Handling and Storage	Outlines safe handling and storage precautions, including incompatibilities.	Store and handle chemicals properly to avoid dangerous reactions and ensure safety.
8. Exposure Controls/Personal Protection	Recommends exposure limits, engineering controls, and PPE.	Use appropriate PPE and controls to minimize exposure risks in the workplace.
9. Physical and Chemical Properties	Lists characteristics like appearance, odor, boiling point, etc.	Identify chemicals correctly and understand their behavior under different conditions.
10. Stability and Reactivity	Describes stability and potential hazardous reactions.	Be aware of conditions that could cause dangerous reactions and plan accordingly.
11. Toxicological Information	Provides data on health effects and symptoms of exposure.	Recognize symptoms of exposure and take preventive or corrective actions.
12-15. Environmental, Regulatory, and Transport Information	Covers ecological impact, disposal, transport regulations, and other regulatory details.	Follow proper disposal methods, comply with transport regulations, and consider environmental impacts.
16. Other Information	Includes additional information like preparation or revision dates.	Keep updated on the latest information and changes to SDSs for ongoing safety.

Proper Labeling and Identification

1. All containers of hazardous chemicals must be properly labeled with the chemical name, hazard warnings, and the manufacturer's details.
2. Secondary containers (e.g., smaller bottles used on-site) must also be labeled appropriately.

Handling Hazardous Materials

Proper handling of hazardous materials is essential to ensure safety:

1. **Infectious Waste:** Separate infectious waste from other waste immediately when it becomes waste to prevent contamination.
2. **Blood or Body Fluids:** Contain, remove, and disinfect blood or body fluid spills promptly to minimize risk.
3. **Chemical Hazards:** Review labels and SDS sheets before use, ensuring to take the recommended precautions along with the correct PPE.

Personal Protective Equipment (PPE)

PPE is crucial for safety when working with chemicals. The SDS specifies necessary PPE based on the substance's potential hazards. Common types of PPE include:

1. **Utility Gloves:** Protect hands from contact with hazardous materials.
2. **Safety Glasses/Goggles:** Protect eyes from splashes or vapors.
3. **Gowns:** Protect skin and clothing from spills.

4. **Ventilators/Masks:** Protect lungs from inhaling toxic fumes.

Responsibilities When Handling Hazardous Materials

1. Healthcare facilities are required to inform staff how to locate their SDSs. **Ask** if the location isn't provided.
2. **Review** the relevant SDS before using any chemical.
3. **Follow** warnings and precautions.
4. **Use** the recommended PPE.
5. **Learn** emergency procedures for the chemicals with which you work.
6. **Never** use hazardous material substances you're not trained to use
7. **Never** place a chemical substance into an unlabeled container.
8. **Never** mix substances without asking your supervisor first.
9. **Always** ask your supervisor if you have a question about any substance.
10. **Consult** the SDS immediately in case of a chemical spill or exposure and follow their exposure instructions, including seeking medical attention. **Notify** your immediate facility supervisor and IntelyCare.

Latex Allergy

Latex allergy, particularly due to natural rubber latex (NRL), is a significant concern in healthcare environments. This section provides an overview of the types of allergic reactions, and strategies to minimize exposure in compliance with OSHA standards.

Types of Reactions

1. **Irritant Contact Dermatitis:**
   a. The most common reaction associated with glove use.
   b. Presents as dried, cracked, and split skin.
   c Not an allergic reaction but can lead to sensitization by breaking the skin barrier.
2. **Type IV Delayed Hypersensitivity (Allergic Contact Dermatitis):**
   a. Typically caused by chemicals used in the processing of NRL.
   b. Symptoms appear 24-72 hours after exposure, resembling poison ivy reactions (blistering, itching, crusting).
3. **Type I Immediate Hypersensitivity:**
   a. The most serious reaction, also known as IgE/histamine-mediated allergy.
   b. Can cause localized reactions (e.g., hives) or systemic symptoms (e.g., asthma, anaphylaxis).
   c. Symptoms can develop within minutes of exposure and may be life-threatening.

Recommended Risk Reduction Strategies

To minimize the risk of latex allergies, it is crucial to adhere to the following guidelines:

1. **Primary Prevention:**
   a. Reduce exposure to allergenic NRL proteins by providing suitable non-latex alternatives.
   b. Use low-allergen, powder-free NRL gloves if latex gloves are necessary.
   c. Ensure proper hand hygiene and thorough cleaning of residual powder from the workplace.
   d. Employers must provide alternatives (e.g., glove liners) for employees allergic to the standard gloves provided.

IntelyPros with a Latex Allergy

Any IntelyPro requiring an accommodation for a latex allergy, please contact Care Support by calling **844-683-5922** or emailing **CareTeam@intelycare.com**

Oxygen Safety

Oxygen is a vital medication used to support patient/resident respiratory needs across various healthcare settings. However, improper handling and use can lead to significant safety risks, such as fire hazards and equipment malfunctions. This section serves as a refresher on the safe management of oxygen.

Guideline	Additional Information
Oxygen is a medication.	Oxygen should not be adjusted without a medical order or a facility policy (depending on state regulations).
Store oxygen cylinders correctly.	When using oxygen cylinders, store them upright, chained, or in appropriate holders so that they will not fall. Full oxygen tanks should be stored separately from partially full or empty oxygen tanks.
Use tank holders appropriately.	When transporting a patient, proper tank holders must be used per regulations. Tanks should never be placed on the bed.
Do not allow smoking near the oxygen devices.	Oxygen supports combustion. No smoking is permitted around any oxygen devices.
Keep oxygen cylinders away from heat sources.	Keep oxygen delivery systems at least 5 feet from any heat source.
Check for electrical hazards in the home or hospital prior to use.	Determine that electrical equipment in the room or home is in safe working condition. A small electrical spark in the presence of oxygen will result in a serious fire. The use of a gas stove, kerosene space heater, or smoker is unsafe in the presence of oxygen. Avoid items that may create a spark (e.g., electrical razor, hair dryer, synthetic fabrics that cause static electricity, or mechanical toys) with nasal cannula in use. Petroleum-based lubricants should not be used on the lips or around the nasal cannula.
Check levels of oxygen in portable tanks.	Check oxygen levels of portable tanks before transporting a patient to ensure that there is enough oxygen in the tank.

Radiation Safety

Radiation safety is a critical component of occupational health in healthcare settings where workers may be exposed to ionizing radiation. Be sure to review and follow your facility's specific policies and procedures regarding radiation safety.

Overview of Radiation Hazards

a. **Ionizing Radiation**: Radiation that carries enough energy to detach electrons from atoms, potentially causing cellular damage. Common sources in healthcare include X-rays, CT scans, and radioactive materials used in treatment.
b. **Non-Ionizing Radiation**: Lower energy radiation, such as UV rays and MRI scanners, which do not typically cause ionization but may still pose health risks.

c. **Permissible Exposure Limits (PEL)**: OSHA has set exposure limits for ionizing radiation. Facilities must ensure that workers do not exceed these limits during their work activities.
d. **Monitoring and Dosimetry**: Facilities must provide personal dosimeters to workers who are likely to receive more than 10% of the annual dose limit. Dosimetry records must be maintained for each worker.
e. **Pregnant Workers** should consult with their supervisor or safety officer to discuss exposure limitations, as the developing fetus is at increased risk

Basic Principles to Mitigating Radiation Exposure

a. **Shielding**: Personal protective equipment (PPE) such as lead aprons, gloves, and thyroid shields must be worn when working in areas with potential radiation exposure.
b. **Time**: Reduce the time spent near radiation sources to minimize exposure.
c. **Distance**: Increase the distance between the worker and the radiation source whenever possible.

Radiopharmaceutical Therapy and Brachytherapy

Here are some basic guidelines in maintaining safety while caring for patients undergoing radiation treatments.

Radiopharmaceutical Therapy

1. **Form:** Radioactive drugs that are usually administered systemically.
2. **Therapy:** Used for both diagnostic and therapeutic purposes. For example, they can be used in imaging (like PET scans) or for treating specific types of cancer (e.g., radioactive iodine for thyroid cancer).
3. **Minimize Exposure:** Limit time in the patient's room; follow specific "stay times" on the patient's door.
4. **Protective Gear:**
   a. Wear gloves when handling items; dispose of them before exiting.
   b. Use gowns if prolonged exposure or close contact is necessary.
   c. Shoe covers are required; remove them upon leaving to prevent contamination spread.
5. **Disposable Items:** Prefer disposable plates and utensils; dispose of them in the designated waste container.
6. **Linen and Waste Management:**
   a. Place bedclothes, towels, and linen in the provided laundry bag for monitoring.
   b. Check all room items for contamination before removal.
   c. Excess food/drinks: Flush down the toilet.
   d. Urine and stool: Encourage patient self-management; dispose of via the sanitary sewer.
7. **Patient Hygiene:** Avoid assisting with bathing during the first 48 hours unless approved; encourage daily bathing.
8. **Medical Equipment:** Use disposable bedpans/urinals if possible; otherwise, clean thoroughly. Monitor equipment before reuse.
9. **Bodily Fluids:** Collect vomitus or gastric contents for disposal by the hazardous waste technician if not flushable.
10. **Room Reassignment:** Survey for contamination and decontaminate as needed before releasing the room to housekeeping.

Brachytherapy (Sealed Radioactive Source Implants)

1. **Form**: Involves placing a sealed radioactive source directly inside or next to the treatment area.
2. **Application:** Primarily used for localized cancer treatment, such as prostate, cervical, or breast cancer.
3. **Limit Time in Room:** Minimize time at the patient's bedside; follow "stay times" on the door.
4. **Linen Disposal:** Place laundry in a linen bag or radioactive waste box until cleared by Radiation Oncology.
5. **Restricted Access:**
   a. Housekeeping only enters escorted and should perform essential cleaning only.
   b. Visitors: Must be 18+ years old, non-pregnant, and remain 6 feet away; limit visits to 1-2 hours/day.
   c. Pre-Discharge Survey: Conduct a radiation survey before patient discharge; remove caution signs before releasing the room.

Reporting and Responding to Radiation Incidents

1. **Incident Reporting**: Any incident involving unexpected radiation exposure must be reported immediately to the facility and IntelyCare. This includes equipment malfunctions or accidental exposure.
2. **Medical Evaluation**: Workers exposed to radiation beyond permissible levels must undergo a medical evaluation to assess potential health impacts.

Slips, Trips, and Falls

Slips, trips, and falls are common causes of healthcare workplace injuries. It is essential to implement proactive measures to prevent these incidents and ensure a safe working environment.

Identifying and Mitigating Hazards

1. **Slips:**
   a. Slips can occur when walking surfaces are wet, oily, or otherwise contaminated.
   b. Mitigation: Ensure that any spills, such as water, oils, or other liquids, are cleaned up immediately. Use wet floor signs to alert others of potential hazards until the area is dry and safe.
2. **Trips:**
   a. Trips can result from obstacles in walkways, such as cables, clutter, or uneven surfaces.
   b. Mitigation: Remove obstacles from walkways, secure loose carpets or rugs, and ensure that cords and cables are properly organized and out of the way.
3. **Falls:**
   a. Falls often occur due to unsafe ladder usage, unstable walking surfaces, or poor lighting.
   b. Mitigation: Use ladders safely by ensuring they are stable and placed on even surfaces. Regularly inspect and repair uneven flooring and ensure adequate lighting in all areas to improve visibility.

Safe Work Practices

1. Always wear appropriate footwear that provides adequate traction and is suitable for the work environment.
2. Maintain clean and organized workspaces to reduce the risk of trips.
3. Be vigilant when moving through areas that may present slip or trip hazards, such as wet floors or cluttered hallways.
4. Use caution when working elevated surfaces, ensuring that all equipment is in good condition and properly secured.

Reporting and Responding to Incidents

1. Employees must report all incidents of slips, trips, or falls to their facility supervisor and IntelyCare immediately, regardless of whether an injury occurred.
2. Supervisors should investigate all reported incidents to determine the cause and take corrective action to prevent future occurrences. This may include reviewing work practices, enhancing training, or improving workplace conditions.

Staff Ergonomics and Injury Prevention

OSHA emphasizes proper body mechanics are vital for protecting the health and safety of healthcare workers. By following evidence-based practices for lifting, sitting, standing, and back care, healthcare professionals can prevent or reduce the risk of musculoskeletal disorders (MSDs) and maintain a safer work environment.

Lifting

1. **Assess the Situation:** Before lifting, evaluate the task to identify potential hazards and determine the safest approach.

2. **Engage Strong Muscle Groups:** Utilize the muscles of the legs, hips, and arms, which are the body's strongest, to reduce back strain.
3. **Maintain Neutral Spine Alignment:** Keep the spine's natural curves aligned to minimize injury risk.
4. **Bend at Knees and Hips:** Avoid bending at the waist; instead, bend your knees and hips, lifting with your legs to protect your back.
5. **Establish a Stable Base:** Position your feet shoulder-width apart to provide a broad base of support.
6. **Keep Objects Close:** Hold the load close to your body to reduce leverage forces on the spine.
7. **Avoid Lifting Above Waist Level:** Lifting objects higher than your waist increases the risk of back strain.
8. **Push Rather Than Pull:** Pushing allows for better use of body weight and reduces strain compared to pulling.
9. **Seek Assistance When Needed:** Collaborative lifting can prevent overexertion injuries.

Sitting

1. **Use Supportive Seating:** Choose chairs that provide adequate support to the back, particularly the lower back, to maintain proper posture.
2. **Ensure Feet Rest Flat:** Both feet should rest flat on the floor to promote proper posture and reduce leg strain.
3. **Avoid Slouching:** Maintain an upright posture and change positions frequently to prevent muscle stiffness.
4. **Prevent Twisting and Overreaching:** Position yourself directly in front of your work to minimize strain.
5. **Align Work at Eye Level:** Keeping your work at eye level reduces neck strain.

Standing

1. **Maintain Proper Posture:** Stand close to your work area with an erect back, chin in, pelvis tucked under, and knees slightly flexed to maintain spinal alignment.
2. **Ensure Even Weight Distribution:** Keep a broad base with your feet and distribute weight evenly to enhance balance.
3. **Avoid Prolonged Static Positions:** Regularly stretch and change positions to prevent muscle fatigue.

Back Care and Injury Prevention

1. **Practice Good Posture Consistently:** Maintaining proper body mechanics at all times reduces the risk of musculoskeletal injuries.
2. **Change Positions Frequently:** Regular movement prevents stiffness and maintains flexibility.
3. **Engage in Regular Exercise:** Regular physical activity enhances musculoskeletal health.
4. **Ensure Adequate Rest:** Proper sleep is essential for muscle recovery and overall health.
5. **Manage Stress Effectively:** Stress management can alleviate muscle tension and prevent injury.
6. **Seek Assistance for Heavy Lifting:** Teamwork reduces individual strain and injury risk.
7. **Maintain a Safe Work Environment:** Keeping the work area free of hazards prevents accidents.
8. **Wear Appropriate Footwear:** Shoes with non-skid soles reduce the risk of slips and falls.
9. **Report Accidents Promptly:** Immediate reporting ensures timely intervention and prevention of future incidents.
10. **Monitor Patient Safety Closely:** Vigilance prevents accidents and ensures a safe environment.
11. **Secure Equipment During Transfers:** Ensuring brakes are applied to wheelchairs or beds prevents unintended movement during patient handling.
12. **Adjust Equipment Height Appropriately:** Proper height reduces strain during patient handling.
13. **Adhere to Ergonomic Principles:** Consistent ergonomic practices prevent cumulative trauma disorders.

Workplace Safety Standards

Emergency Action Plan (EAP)

An emergency action plan (EAP) is a document required by OSHA standard 29 CFR 1910.38(a). The purpose of an EAP is to facilitate and organize facility and staff actions during emergencies. Well-developed emergency plans ensure that everyone understands their roles and responsibilities, which will result in fewer and less severe injuries and less structural damage to the facility during emergencies.

Each facility is required to have an EAP: 29 CFR 1910.38(c). For your safety and those of your patents/residents and coworkers, familiarize yourself with each facility's EAP. Each plan must include but is not limited to:

1. Means of reporting fires and other emergencies
2. Evacuation procedures and emergency escape route assignments
3. Procedures for employees who remain to operate critical plant operations before they evacuate
4. Accounting for all employees after an emergency evacuation has been completed
5. Rescue and medical duties for employees performing them
6. Names or job titles of persons who can be contacted

Electrical Safety

Much of the work to support resident and patient care depends on electrical devices. OSHA Standard 29 CFR 1910 Subpart S requires that healthcare facilities have and electric safety protocol to prevent electrical injuries. This includes understanding the proper use of electrical equipment, recognizing hazards, and following safety protocols.

A few basic reminders will help you to maintain a safe workplace:

1. Request training on any equipment that you are unfamiliar with prior to use.
2. All outlets are "grounded" outlets, accepting three-prong plugs. Never try to introduce another kind of plug into the outlets.
3. Never try to plug something in, or run an appliance, if water is in the area. Clean up the water first. Electricity passes easily through water and can cause serious harm to you and others around you.
4. If you notice an electrical hazard, contact your supervisor immediately.

Exit Routes

Most facilities have floor diagram maps with arrows that designate the exit route assignments. These maps should include locations of exits, assembly points, and equipment (such as fire extinguishers, first aid kits, spill kits) that may be needed in an emergency.

Fire Safety

Fire Safety Standards [29 CFR 1910 Subpart E] ensures that healthcare facilities have effective fire prevention measures, emergency response plans, and protective equipment in place. These standards are designed to minimize the risk of fire, ensure the safe evacuation of occupants, and protect the lives of everyone within the facility. Refer to your facility's policies and procedures for Fire Safety.

General Rules

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

1. **Important Locations You Need to Know:**
   a. Fire extinguisher in your department
   b. Closest fire-alarm pull
   c. Evacuation route
   d. Fire doors and walls
   e. Next safe fire zone (smoke compartments)

2. **Important Facility Conditions to Maintain:**
   a. Keep emergency exits, firefighting equipment and fire-alarm pull stations clear at all times.
   b. Never put door wedges under doors that prevent doors from closing.
   c. Keep doors closed unless they are controlled by an electromagnetic system.
   d. Keep all corridors and exits clear of all unnecessary traffic and/or obstruction.
   e. Keep telephone lines clear for fire control.

Responding to Fires (RACE)

The **RACE** protocol provides a structured approach for responding to fire emergencies, helping to reduce risks to both people and property. This acronym serves as a guide for healthcare workers and other employees to follow when a fire occurs.

1. **R** - **Rescue**: Rescue anyone in immediate danger from the fire, if it is safe to do so.
2. **A** - **Alarm**: Activate the fire alarm to alert others to the fire and call for emergency assistance.
3. **C** - **Contain**: Close doors and windows to contain the fire and prevent it from spreading.
4. **E** - **Extinguish or Evacuate**: Extinguish the fire if it is small. If the fire is too large or spreading rapidly, assist in evacuating residents/patients the area immediately per facility emergency procedures.

Extinguishing Fires

- **Types Of Fire Extinguishers**

If a fire is small enough to extinguish, use the correct fire extinguisher. Determine the type of fire and use the extinguisher rated for that specific class of fire. In many facilities, multi-class extinguishers (e.g., ABC) are available to cover a range of fire hazards.

In healthcare facilities, the most common types of fire extinguishers are selected based on the specific fire risks present in these environments. Given the presence of various materials and equipment, healthcare facilities typically have a combination of fire extinguishers to address different types of fires. Here are the most common types:

Fire Extinguisher	Use For Fires Involving	Symbol
Class A	Combustibles (wood, paper, cloth, rubber, some plastics)	Green triangle with an "A"
Class B	Flammable liquids (gasoline, oil, grease, paint)	Red square with a "B"
Class C	Electrical equipment (appliances, wiring, circuit breakers)	Blue circle with a "C"
Class D	Combustible metals (magnesium, titanium, potassium, sodium)	Yellow star with a "D"
Class K	Cooking oils and fats (in commercial kitchens)	Black hexagon with a "K"
Class ABC	Class A, B, and C fires	Contains individual symbols for A, B, and C
Class BC	Class B and C fires	Contains individual symbols for B and C

- **PASS**

The **PASS** technique is a universal method for operating all portable fire extinguishers. If the fire is small and manageable, trained staff should use PASS to quickly and effectively extinguish it. This approach ensures that anyone can confidently handle an extinguisher in an emergency

1. **P - Pull** the pin on the fire extinguisher.

2. **A** - **Aim** the nozzle or hose at the base of the fire.
3. **S** - **Squeeze** the handle to release the extinguishing agent.
4. **S** - **Sweep** the nozzle from side to side at the base of the fire until it is extinguished.

Important: Only attempt to extinguish a fire if it is safe to do so and you have a clear evacuation route. If the fire is too large or spreading rapidly, focus on evacuating patients and staff immediately.

Emergency Response Hazards Plan

OSHA and federal regulations require healthcare facilities, to have comprehensive policies, procedures, or plans in place to address emergency response hazards. These hazards include:

1. **Chemical Spills or Releases:** Exposure to hazardous chemicals, toxic substances, or gases during industrial accidents or transportation incidents.
2. **Biological Hazards**: Situations involving exposure to infectious agents or biological toxins, which can occur in pandemics or bioterrorism events.
3. **Radiological Hazards**: Exposure to radioactive materials, which can happen in the event of a nuclear power plant accident, radiological dispersal device (dirty bomb), or transportation incident involving radioactive materials.
4. **Physical Hazards**: Risks associated with physical injuries during emergencies, such as those from explosions, structural collapses, or fires.
5. **Natural Disasters**: Events like earthquakes, floods, or hurricanes that can create hazardous conditions for workers responding to the emergency.

Roles and Responsibilities of Clinical Staff

Clinical staff are required to respond to emergencies according to the facility's emergency preparedness plan.
1. **Know how to access** the facility's emergency preparedness plan and emergency contact list.
2. **Verify and follow** your facility supervisor's directive on your role and responsibilities during the emergency.
3. **Maintain clear communication** among staff, patients/residents, and emergency responders.

Patient/ Resident Safety During Emergencies

Patient/resident safety is the top priority during an emergency. Several key concerns must be addressed, including:

Concern	Considerations
Mobility	Assess patients' mobility, determine how many can ambulate independently, and plan for the assistance required during an emergency.
Medical Needs	Ensure continuity of care, including portable oxygen, medical equipment, and medication administration during and after evacuation or relocation.
Food, Water, and Shelter	Prepare for scenarios where the facility might be isolated, ensuring adequate food, water, power, and temperature control.

Evacuation and Shelter-in-Place Considerations:

Evacuating patients from emergencies (including fires) in a healthcare facility is a critical and complex process that requires careful planning, coordination, and execution. The process typically follows these key steps:

Evacuations may be partial, complete, horizontal, or vertical, depending on the type and extent of the emergency, including fires.

1. **Types:**
   a. **Immediate Danger Zone:** Evacuate patients/residents who are in the immediate vicinity of the emergency hazard first, especially those who are immobile, in critical condition, or on life support.
   b. **Partial**: Move some patients, possibly based on medical conditions or specific areas of the facility.
   c. **Complete**: Evacuate all patients, staff, and visitors from the facility or area.
   d. **Horizontal Evacuation:** Move patients laterally on the **same floor** to a safe area away from the fire. This is often the preferred method to avoid stairways or elevators.
   e. **Vertical Evacuation:** If the fire threatens the entire floor or building, evacuate patients/residents to a lower floor or outside the building. Use stairways, not elevators, for vertical evacuation.
2. **Important Considerations:**
   a. **Utilize equipment**, such as evacuation chairs, stretchers, and sleds, especially for those who are immobile or require assistance.
   b. **Triage:** Prioritize the evacuation based on the severity of the patients/residents' conditions and their mobility. Those who can walk should be directed to evacuate with minimal assistance, while staff assist those who are bedridden or incapacitated.
3. **Post-Evacuation Actions**
   a. **Accounting for Patients/Residents:** Once evacuated, account for all patients/residents, staff, and visitors to ensure no one is left behind.
   b. **Patient/Resident Care:** Provide necessary care and comfort to those evacuated, especially those who may be in shock or distress.
   c. **Coordination with Emergency Services:** Coordinate with local fire departments and emergency medical services for further assistance, patient/resident transport, and re-entry plans.

Shelter in Place: Preferred action when patients can safely remain in their current location.

Decision-Making: **The decision to evacuate or shelter in place will be made by the person in charge, and staff should not begin evacuation procedures until instructed.**

Medical and First Aid Standards

This section is intended as a refresher on essential first-aid practices. Depending on your healthcare setting, access to first-aid supplies and emergency personnel may vary. Use what is available to you and follow your facility guidelines along with your CPR and First Aid training.

Get Medical Attention for All Injuries

Seek Immediate Care: Every injury, no matter how small, requires prompt medical attention. Minor injuries, such as splinters or small cuts, can lead to serious infections if left untreated. Always seek examination and treatment to prevent complications.

Important: If this is a medical emergency and you are waiting for emergency assistance, DO NOT MOVE the victim unless there is safety risk (i.e., fire).

Bloodborne Pathogen and OPIM Exposure

Refer to the BBP & OPIM Post Exposure Follow-Up Plan & Reporting section of this manual.

Bleeding

Bleeding is the most visible result of an injury. Each of us has between five and six quarts of blood in our body. Most people can lose a small amount of blood with no problem, but if a quart or more is quickly lost, it could lead to shock and/or death.

1. **Apply Direct Pressure:** Use a clean cloth and apply direct, firm pressure with the palm of your hand on the wound until the bleeding stops. Direct pressure is better than a pressure points or a tourniquet for controlled bleeding because it stops blood circulation only at the wound
2. **Elevate the wound** above the heart to slow the bleeding.
3. **Do Not Remove the Cloth:** Once bleeding stops, do not remove the cloth as it may disturb clotting.
4. **Use Pressure Points if Necessary:** For severe bleeding, apply pressure to the major pressure points located either on the inside of the upper arm between the shoulder and elbow, or in the groin area where the leg joins the body.
5. **Avoid Tourniquets:** Only use a tourniquet in extreme emergencies, such as a severed limb, as they can cause severe damage to nerves and blood vessels, possibility resulting in loss of limb.

Burns

There are a many different types of burns. Each of the burns can occur in a different way, but treatment for them is very similar.

1. **Types of Burns:** Burns can be thermal, chemical, electrical, or contact burns.
2. **General (Non-Electrical) Burn Treatment:**
    a. **Flush with Water.** Immediately flush the burn with cold water for at least 30 minutes. If the burn is small enough, keep it covered under water. Flushing takes priority —Flush the burn FIRST, even before calling for help.
    b. **Do Not Remove Stuck Clothing.** Remove only clothing not adhered to the burn by cutting or tearing it.
    c. **Avoid Scrubbing or Applying Substances.** Do not scrub the burnt skin or apply ointments, soap, or home remedies to it.
    d. **Cover the burn with a clean, cotton material**. If you do not have clean, cotton material, do not cover the burn with anything.
    e. **Keep the person warm:** You can also cover them with a blanket to maintain normal body temperature until help arrives.
    f. **Avoid Scrubbing or Applying Substances.** Do not scrub the burns or apply ointments, soap, or home remedies to it.
3. **For Electrical Burn Treatment:**
    a. **Don't touch** someone who has been in contact with electricity unless you are clear of the power source.
    b. Once the person is clear of the power source, your priority is to **check for any airway obstruction, and to check breathing and circulation**.
    c. **Administer** CPR if necessary.
    d. Once the person is stable, you can then follow general burn treatment from above:
        i. **Flush the Burn with Water.**
        ii. **Do Not Remove Stuck Clothing**
        iii. **Avoid Scrubbing or Applying Substances to the burn.**
        iv. **Cover the burn with a clean, cotton material**.
        v. **Keep the person warm.**

Cardiac or Respiratory Arrest

Follow your CPR training for any patient or resident in cardiac or respiratory distress or arrest. Be sure to verify their code status to ensure the patient or resident does not have a DNR directive prior to initiating CPR.

Choking

If you suspect a person of choking, ask them to cough, speak, or breathe. ***If they can do none of these things perform the following first aid steps for choking:***

a. Stand behind the person and locate the bottom rib with your hand.
b. Move your hand across the abdomen to the area above the navel then make a fist and place your thumb side on the stomach.
c. Place your other hand over your fist and press into the person's stomach with a quick upward thrust until the food is dislodged.

Heat Exhaustion & Heat Stroke

Heat exhaustion and heat stroke are two different things, although they are commonly confused as the same condition.

Aspect	Heat Exhaustion	Heat Stroke
Cause	Prolonged exposure to high temperatures, often with dehydration.	Failure of the temperature regulation system, leading to dangerously high body temperature.
Environments	Poor air circulation, around open furnaces, heavy machinery, or outdoor settings.	Extremely hot and humid environments, often with prolonged exposure to heat.
Symptoms	- Excessive fatigue - Dizziness and disorientation - Normal skin temperature, but damp and clammy skin	- Mental confusion or delirium - Collapse or unconsciousness - High fever with dry, hot skin - Rapid pulse and breathing - Nausea or vomiting
Skin	Normal temperature but damp and clammy	High fever with dry, hot, and often mottled skin **(unable to produce sweat).**
Treatment	1. Immediately move to a cool, shaded area. 2. Hydrate with cool water. 3. Rest: Rest and recover in a cool environment.	1. Immediately move to a cool, shaded area. 2. Pour cool water over the body or use wet cloths. 3. Monitor Vital Signs: Be prepared for CPR. 4. Seek Immediate Medical Help and Call Emergency Services. 5. Do Not Give Fluids: Avoid giving anything to drink.
Urgency	Moderate—requires prompt attention to prevent escalation to heat stroke.	Critical—requires immediate medical attention to prevent death or permanent damage.

Poisoning

1. **Remove the Poison:**
   a. Solid poisons: Remove from mouth. However, don't attempt this with infants because it could force the poison further down their throat.
   b. Gas poisons: Ensure your safety and use the correct PPE (i.e. correct respirator) before removing the victim to fresh air.
   c. Corrosive substances: Flush affected skin with water for 30 minutes.
2. **Seek Medical Help:** Take the poison container or label with you when seeking help.
3. **Eye Contact:** Flush the eyes with clean water for at least 15 minutes.

Shock

Shock can be life-threating if it is not treated quickly. Shock occurs when the body's important functions are threatened by not getting enough blood or when the major organs and tissues don't receive enough oxygen. Even if the injury doesn't directly cause death, the victim can go into shock and die.

1. **Symptoms:** Pale or bluish skin – cold to the touch, vomiting, dull and sunken eyes, unusual thirst.
2. **First Aid for Shock:**
   a. Maintain an open airway.
   b. Control any visible bleeding.
   c. Keep the person on their back with legs elevated (about 12 inches) unless contraindicated.
   d. Cover with blankets to maintain body heat.
   e. Do not give food or drink.
   f. **If unconscious or bleeding from the mouth**, lay the person on their side.
   g. Stay with the person until (more) medical help arrives.

Report All Injuries

As with getting medical attention for all injuries, it is equally important that you report all injuries to your immediate facility supervisor and IntelyCare.

OTHER REGULATIONS

Emergency Codes

Emergency codes are standardized alerts, often represented by colors or phrases (i.e. Code Blue), used in healthcare settings to communicate specific emergency situations quickly and efficiently without causing panic.

All IntelyPros should become familiar with the emergency codes at their facility. Below is a review of the most common codes, but as a reminder, code colors and phrases can differ by facility.

Emergency Code Types	Description	Required Staff Action
Medical Emergency/Cardiac Arrest	Indicates a life-threatening medical situation requiring immediate resuscitation.	Staff should initiate CPR and activate the emergency response team.
Fire	Alerts staff to a fire in the building, requiring evacuation or fire control measures.	Staff must activate fire alarms and follow fire safety protocols.
Bomb Threat	Denotes a bomb threat or suspicious package.	Staff should initiate evacuation and notify security and law enforcement.
Infant or Child Abduction	Alerts staff to the abduction of a child or infant within the hospital.	Staff must secure exits and report any suspicious activities.
Hazardous Material Spill	Indicates a chemical or biological hazard.	Staff must isolate the area, don personal protective equipment (PPE), and notify specialized teams.
Mass Casualty Incident	Signals an influx of patients due to a major disaster or accident.	Staff prepare for triage and manage resources effectively.
Active Shooter	Informs staff of an active shooter or armed individual.	Staff must implement lockdowns, evacuate if safe, and follow law enforcement guidance.
Evacuation	Calls for a partial or full evacuation due to an unsafe environment.	Staff assist patients and visitors to designated safe areas.
Violent Person	Alerts staff to a person exhibiting violent or aggressive behavior.	De-escalation teams and security are mobilized.

Emergency Treatment of Patients (EMTALA)

The Emergency Medical Treatment and Labor Act (EMTALA) is a federal law that ensures anyone seeking care in a hospital emergency department is provided with a medical screening and stabilizing treatment, regardless of their ability to pay or insurance status. Its significance lies in promoting equitable access to emergency care, preventing patient "dumping" based on financial considerations, and safeguarding patient safety and legal compliance for healthcare facilities.

HIPAA, PHI, and Confidentiality Guidelines

Protecting patient and resident information is a cornerstone of ethical and legal healthcare practice. This section provides IntelyPros with a comprehensive understanding of the regulations, policies, and best practices surrounding the handling of Protected Health Information (PHI). The Health Insurance Portability and Accountability Act (HIPAA), along with related laws such as the HITECH Act and 42 CFR Part 2, establishes the framework for ensuring the confidentiality, integrity, and availability of patient data.

By adhering to these guidelines, healthcare professionals safeguard patient trust, uphold organizational compliance, and prevent legal or financial penalties. This section highlights the key concepts, from patient rights and data security to breach management and cultural competence, equipping staff with the knowledge needed to handle PHI responsibly in various scenarios.

Regulation Overview

Regulation	Key Features	Application
HIPAA (1996)	**Privacy Rule**: Regulates the use and disclosure of Protected Health Information (PHI).	Applies to all PHI formats (paper, electronic, verbal) related to patient health, treatments, and payments.
	Security Rule: Requires administrative, physical, and technical safeguards for ePHI.	Ensures secure handling of electronic health systems to prevent unauthorized access or breaches.
	Breach Notification Rule: Mandates organizations to notify affected individuals, the Department of Health and Human Services (HHS), and, when applicable, the media of breaches.	Provides transparency and allows patients to take protective action when breaches occur.
HITECH Act (2009)	Increases penalties for HIPAA violations, with fines up to $1.5 million for repeated breaches.	Enforces stricter compliance for organizations and business associates handling ePHI.
	Expands HIPAA's scope to include business associates like vendors and contractors.	Ensures extended accountability throughout the healthcare ecosystem.
	Promotes the adoption of Electronic Health Records (EHRs) and enhances their security.	Encourages technological advancement while safeguarding patient data.
42 CFR Part 2	Provides strict confidentiality protections for mental health and substance use disorder records.	Requires explicit patient consent for sharing, even for treatment purposes, with heightened penalties for non-compliance.
State-Specific Laws	Many states impose stricter data protection requirements beyond HIPAA. Examples include:	
	Expedited Breach Notifications: Shorter reporting timelines for notifying patients of data breaches.	Ensures patients are informed quickly so they can take steps to protect their information.
	Sensitive Data Protections: Stricter rules for sharing PHI related to HIV/AIDS, reproductive health, mental health, or genetic data.	Adds additional safeguards for specific conditions or populations, depending on the state.
	Additional Consent Requirements: Some states mandate more explicit patient consent for sharing/accessing PHI.	Staff must verify and document consent according to state law to ensure compliance.

Understanding Protected Health Information (PHI)

1. **PHI encompasses any information that can identify a resident/patient and relates to their:**
    a. Past, present, or future physical or mental health condition.
    b. Healthcare services received.
    c. Payment details for healthcare services.
2. **PHI exists in various forms:**
    a. Paper Records: Charts, forms, and printed reports.
    b. Electronic PHI (ePHI): Digital records stored in EHRs, emails, or mobile devices.
    c. Verbal Communication: Conversations between healthcare providers about patient care.
3. **ePHI Security** - Given the increasing reliance on electronic systems, securing ePHI is critical. Key considerations include:
    a. Encryption: Protecting data during storage and transmission.
    b. Mobile Device Usage: Prohibiting the storage of PHI on personal devices unless explicitly authorized and secured.
    c. Cloud Storage: Ensuring cloud-based systems comply with HIPAA security standards.
4. **Minimum Necessary Rule** - Under HIPAA, healthcare staff must access, use, or disclose only the minimum amount of PHI necessary to perform their job responsibilities. For example, a billing clerk only needs access to financial information, not clinical notes.

Patient/Resident Rights and Confidentiality

a. **HIPAA Rights** – Patients/Residents are entitled to specific rights under HIPAA, including:
    a. **Access to Records**: Patients/Residents can review and obtain a copy of their health records.
    b. **Request for Amendments**: Patients/Residents can request corrections to incorrect or incomplete information.
    c. **Restriction Requests**: Patients/Residents can limit who can access their PHI or how it is shared.

b. **Informed Consent** - Staff must obtain documented patient consent before disclosing PHI for non-treatment purposes (e.g., marketing or research). Informed consent ensures that patients/residents are aware of how their information will be used and their rights regarding its disclosure.

c. **Cultural Sensitivity** – Patients/Residents from diverse cultural backgrounds may have specific preferences regarding how their PHI is handled. For example, certain cultures may prioritize confidentiality within family structures. Healthcare staff must respect these differences to foster trust and compliance.

d. **Social Media Policies** -Posting patient-related content or photos on social media is strictly prohibited, even if identifiers are removed. Even seemingly harmless posts (e.g., workplace anecdotes) can unintentionally lead to a HIPAA violation.

Workplace Communication and PHI

1. **Secure Verbal Communication**
    a. Avoid discussing patient information in public or unsecured areas such as elevators, cafeterias, or hallways.
    b. Use private spaces, such as conference rooms or nurse stations, for sensitive discussions.
2. **Written Communication**
    a. Securely store patient records in locked cabinets or secure electronic systems when not in use.
    b. Dispose of unneeded documents containing PHI by shredding or using secure disposal bins.

3. **Electronic Communication**

Type of Communication	Best Practice
Email	Encrypt messages containing PHI and send only to authorized recipients.

Mobile Devices	Use organization-approved devices with password protection and multi-factor authentication (MFA).
EHR Systems	Log out immediately after use to prevent unauthorized access.

4. **Devices:** All patient and resident documentation **must ONLY be documented within the facility UNLESS** the facility has provided a facility laptop or other device for this purpose.

Cybersecurity Awareness

1. **Recognizing Threats -** Healthcare environments are frequently targeted by cybercriminals. Common threats include:
   a. **Phishing**: Fraudulent emails designed to steal login credentials or deploy malware.
   b. **Ransomware**: Malicious software that locks systems until a ransom is paid.
2. **Password Management -** Create strong passwords with a mix of uppercase letters, lowercase letters, numbers, and symbols.
   a. Avoid sharing passwords or writing them down in unsecured locations.
   b. Change passwords regularly and immediately after a suspected breach.
3. **Reporting Suspicious Activity** - If you notice suspicious emails, system malfunctions, or unauthorized access, immediately report the incident to your facility supervisor or IT department.

Mental Health and Substance Use Records

Mental health and substance use records are subject to **42 CFR Part 2**, which mandates stricter controls for disclosure. **Consent must be explicit and renewed for each instance of disclosure**, even if sharing with other healthcare providers.

Reporting and Managing Breaches

Defining a Breach - A breach is an unauthorized access, use, or disclosure of PHI that compromises its security or privacy.
If a breach does occur:
1. **Contain**: Prevent further unauthorized access by isolating the affected systems or data.
2. **Report**: **Immediately** notify your supervisor, the compliance team, and follow facility protocol.
3. **Document**: Record details of the incident, including the cause, scope, and actions taken.

Avoiding Common Privacy Violations

Here are the most common violations and practical strategies to prevent them. Remember to always follow IntelyCare and facility policies on privacy and confidentiality in addition to established laws and regulations.

1. **Discussing patient cases on social media:** Sharing any details related to patient care, even without identifiers, on social media platforms, potentially exposing PHI.
   a. Avoid discussing or sharing patient/resident-related information on any social media platform.
   b. Keep work-related matters private and respect facility confidentiality guidelines.

2. **Unauthorized sharing of PHI:** Disclosing PHI to individuals or entities not authorized to access it or without proper patient consent.
   a. Confirm that individuals requesting PHI are authorized to receive it.
   b. Always verify patient consent before sharing information, especially for non-treatment purposes.

3. **Using unsecured devices or networks:** Accessing or storing PHI on personal devices or using unsecured public networks, risking data breaches.
   a. Only use organization-approved devices when accessing PHI. **ALL charting and documentation must be done at the facility.** The only exception is if facility has provided you with a tablet or computer for documentation.

4. **Failure to recognize phishing attempts:** Falling victim to fraudulent emails or messages designed to steal credentials or deploy malicious software.
   a. Be cautious of emails asking for sensitive information or containing unfamiliar links
   b. Report suspicious emails or messages to the facility IT department immediately.

5. **Accessing PHI without authorization:** Viewing or "snooping" into patient/resident records without a valid, work-related purpose.
   a. Access patient records only when directly involved in their care or other authorized duties.

6. **Storing PHI in unsecured locations:** Leaving paper or electronic records in open or accessible areas where unauthorized individuals could view them.
   a. Store physical records in locked drawers or cabinets when not in use.
   b. Log out of workstations and secure electronic devices when stepping away.

7. **Failure to report breaches promptly:** Delaying or failing to notify appropriate parties after discovering a breach, violating the HIPAA Breach Notification Rule.
   a. Immediately report any suspected or confirmed breaches to your facility supervisor or compliance officer.
   b. Do not attempt to resolve breaches on your own; follow reporting protocols.

8. **Improper handling of facility devices:** Losing or misplacing devices containing PHI or failing to secure them with encryption or passwords.
   a. Keep facility mobile devices containing PHI in secure locations when not in use.
   b. Never store PHI on personal devices.

9. **Improper use of personal devices:** Using personal smartphones, tablets, or computers to access or store PHI without authorization or encryption.
   a. Never access or store PHI on personal devices.

10. **Overheard verbal communications:** Discussing patient information where unauthorized individuals might overhear, such as elevators, hallways, or cafeterias.
    a. Speak quietly and use non-identifiable terms when discussing patient information in shared spaces.
    b. Move conversations to private areas whenever possible.

11. **Failure to use the Minimum Necessary Rule:** Accessing or disclosing more PHI than required for a specific task, violating HIPAA's standard of limiting unnecessary exposure.
    a. Limit the information you access or share to what is necessary for completing your task.
    b. Be aware of and follow role-specific access guidelines.

12. **Unsecured email communication:** Sending PHI through unencrypted emails, exposing sensitive information during transmission.
    a. Avoid sending PHI via personal or unencrypted email accounts.
    b. Use organization-provided secure email systems or approved communication tools for sending sensitive information.

Understanding the Consequences of Privacy Violations

Privacy violations can have serious consequences for healthcare professionals and organizations, including fines, corrective actions, employment termination, criminal charges, and even loss of professional licenses. Adhering to

HIPAA, state laws, and organizational policies is critical to protecting patient trust and maintaining professional integrity.

Penalties for HIPAA and PHI violations depend on the severity of the negligence. Fines range from $100 to $50,000 per violation, with annual caps of $1.5 million. More severe offenses, like willful neglect or intentional misuse of PHI can lead to criminal charges, fines up to $250,000, and up to 10 years in prison.

Medical Equipment Management

Effective medical equipment management ensures patient/resident safety, regulatory compliance, and operational reliability. This section covers key procedures for SMDA compliance, equipment inspection, and safe usage practices.

Safe Medical Devices Act (SMDA) Compliance

1. Remove malfunctioning equipment from service immediately and generate a facility repair order.
2. For serious injury or illness incidents:
    a. Isolate equipment for Risk Management review.
    b. Submit an incident report and notify your facility supervisor for FDA and manufacturer reporting.

Safe Equipment Use

1. Operate and maintain equipment only if trained.
2. All equipment must be inspected by Facilities Management before use.
3. Ensure equipment has passed safety tests and displays current inspection stickers before use.
4. Educate patients and families on equipment operation and safety precaution as appropriate.
5. Remove, label, and process malfunctioning or damaged equipment immediately.
6. Keep battery-powered equipment charged when not in use.
7. Remove equipment from rooms when unused and prepare it for reuse per facility policies.
8. Follow IntelyCare and facility cell phone policies to prevent interference with equipment

Utility Management

All facilities have Utility Failure Plans that identify what action you need to take in the event of one of more utility failures. Ensure you know the location of the Utility Failure Plan and contact your facility supervisor, Safety Management, Department Manager or Safety Coordinator if you have any questions.

SECTION III: CLINICAL TOPICS

Age Specific Education

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

Development Across the Lifespan

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

Stage of Development	Key Characteristics	Care Strategies	Communication Techniques
Prenatal Development	Conception occurs, all major body structures form. Maternal health, nutrition, teratogens, and labor are primary concerns.	Educate on proper nutrition, teratogens, and labor processes.	N/A
Newborns (Birth – 1 month)	Rapid physical adjustments to life outside the womb; reflexes (e.g., rooting, sucking) are prominent. Sleep and feeding dominate their routines.	Encourage skin-to-skin contact, establish feeding routines (breastfeeding/ formula), educate parents on newborn care (e.g., safe sleep, cord care), and promptly meet basic needs.	Use soothing tones, provide consistent physical comfort, and respond promptly to crying.
Infancy (1 – 12 months)	Rapid physical growth; tripling of birth weight. Development of gross motor skills (e.g., rolling, sitting) and fine motor skills (e.g., pincer grasp). Cognitive abilities progress from tracking objects to recognizing and searching for them.	Foster trust by meeting needs promptly; encourage physical contact; involve parents in care; provide stimulating toys and games.	Use soothing tones, maintain physical presence, and respond to cries consistently.
Toddlerhood (1 – 3 years)	Development of gross motor skills (e.g., walking, jumping) and fine motor skills (e.g., stacking blocks, drawing). Language skills expand with growing vocabulary and sentence structure. Increased independence and exploration.	Maintain consistency in caregiving; approach calmly; allow parental presence to ease anxiety; provide choices and honest, simple explanations.	Use simple, clear language; avoid baby talk; reinforce positive behaviors.
Early Childhood (3 – 5 years)	Develops language, independence, and understanding of the world; imaginative perceptions.	Encourage exploration, pretend play; involve parents and maintain immunizations.	Use age-appropriate terms; address fears and questions simply.
Middle Childhood (6 – 11 years)	Refines motor skills, engages in academic and social activities, and builds cognitive abilities.	Support structured activities, offer privacy, and address school/friendship concerns.	Involve children in conversations; use clear, straightforward language.
Adolescence (12 – 19 years)	Physical growth, puberty, abstract thinking, and increasing independence.	Respect privacy and independence; promote coping mechanisms and self-care.	Foster open communication; involve both adolescents and parents.

Stage of Development	Key Characteristics	Care Strategies	Communication Techniques
Early Adulthood (20 – 39 years)	Physical and cognitive peak; focus on career, love, and identity.	Respect autonomy; involve in healthcare decisions; address work/family concerns.	Provide clear, transparent instructions; encourage expression of fears and preferences.
Middle Adulthood (40 – 64 years)	Noticeable aging; peak productivity in personal and professional life.	Address physical and emotional changes; respect autonomy in care decisions.	Maintain clarity and respect in communication.
Late Adulthood (65+ years)	Varies by health and activity level: **Young-old** (65 – 79 years) maintain productivity; **Old-old** (80+ years) face chronic illness and dependency.	Provide age-friendly environments; support independence and address fears about disability.	Observe non-verbal cues for pain; ensure comfort with tailored interventions.
Death and Dying	Final stage of life; focuses on dignity and personal choices.	Advocate for respectful care honoring patient wishes; provide emotional support to families.	Address needs with compassion and clarity.

Best Practices for Clinical Documentation

Accurate and timely documentation is critical for ensuring safe patient/resident care. Documentation is a legal record reflecting the care provided, a communication tool for healthcare team members, and a foundation for care decisions.

Proper documentation demonstrates professionalism, supports compliance with legal and regulatory standards, and contributes to quality improvement and research. The following guidelines and best practices should be followed when documenting patient or resident care.

Documentation Principles

The American Nurses Association (ANA) outlines six core principles for high-quality documentation:

1. **Accessible and Accurate:** Ensure documentation is clear, concise, accurate, and relevant to patient care.
2. **Comprehensive:** Include all aspects of the nursing process and patient interactions.
3. **Timely**: Record information promptly and in sequence.
4. **Confidential:** Protect patient information in compliance with legal and institutional policies.
5. **Auditable**: Maintain legibility and standardized terminology for quality reviews.
6. **Aligned with Standards:** Adhere to the facility's policies and applicable legal guidelines.

Items to Include in Documentation/Charting

1. Patient/resident health status and drug information
2. Nursing/Nursing Assistant actions/interventions.
3. Changes in the patient or residents' condition including assessment findings, communications, interventions and response.
4. All preventative measures taken, such as fall precautions or isolation protocols.
5. Medication Administration (see Specific Document Guidelines section)
6. Conversations with the patient/resident, family members, and/or the healthcare team.
7. Patient/Resident education provided and their response.

General Documentation Practices

1. **Chart in the Correct Record:** Verify the patient's name, date of birth, and medical record number.
2. **Be Prompt**: Document as soon as possible after providing care or making observations to ensure accuracy.
3. Use a professional tone and avoid opinionated language or assumptions.
4. **Be Accurate and Objective:** Record facts, observations, and actions taken avoiding subjective or opinionated language. Be precise and avoid vague terms.
5. **Include Relevant Details:** Document all nursing assessments, resident patient complaints, changes in condition, interventions, and responses.
6. **Follow the Nursing Process** (for nurses): Ensure documentation reflects assessment, planning, implementation, and evaluation.
7. Use the resident/patient's own words in quotations when reporting subjective data.
8. Follow facility guidelines for documentation, including using only facility-approved abbreviations.
9. In cases of paper charting:
    a. Ensure legibility in handwritten notes.
    b. Use blue or black ink.
    c. Date, time and sign all entries.
    d. Do not leave open lines on records between documentation entries.

Specific Documentation Guidelines

1. **Medication Administration in the Medication Administration Record (MAR):**
    a. Patient/resident name, date of birth, and medical record number (if not already included).
    b. Medication name, dosage, route, injection/IV site (if SQ, IM, or IV) and time of administration.
    c. Patient/resident response to the medication and any adverse reactions observed.
    d. Do **NOT** pre-chart any medication administration.
2. **Patient Education:** Document educational sessions, materials provided, and the patient's understanding (e.g., using teach-back methods). Use language that patient/resident understands for discharge instructions and patient education material.
3. **Non-Adherence:** Note instances of missed appointments, refusal of care, or treatment rejection.
4. **Delegated Tasks:** Include verification of task completion by those under your supervision.
5. **Communication with Providers:** Record all phone calls, including the time, message, and response.
6. **Test Results:** Track and document abnormal diagnostic results and follow-up actions.

Correcting Clinical Records and Documentation Errors

Use your facility's approved procedures to correct documentation errors. Clearly identify all corrections as late entries or amendments, including the date and time of the update. Incomplete or incorrect documentation may require you to return to the facility to make the necessary corrections.

1. **A Late Entry** - is used to document information that was **omitted** from the original charting at the time care was provided. It is typically entered shortly after the initial documentation.
    a. Clearly label the entry as a "Late Entry."
    b. Include the current date and time of the late entry, along with the date and time the care or observation occurred.
    c. Write the additional details factually and accurately.
    d. **Example:** *"Late Entry: 11/20/2024, 10:00 AM – Patient's blood pressure at 8:00 AM was 140/90. Medication administered as ordered, patient tolerated well."*
2. **An Amendment** - is used to correct or clarify an error or inaccuracy in the original documentation. It does not add omitted information but rather modifies or updates the existing record to ensure accuracy.
    a. Clearly label the entry being amended (e.g., reference the original date and time of the record).
    b. Use the current date and time for the amendment.

c. Explain the correction or clarification while maintaining the integrity of the original entry (do not delete the original).
d. **Example**:
"Amendment: 11/20/2024, 11:30 AM – The medication documented on 11/19/2024 at 2:00 PM was incorrectly recorded as 5 mg. Correct dose administered was 2.5 mg."

3. **Strikethrough Correction (Paper Charts only)** - allows for a correction to be made while preserving the original entry for transparency and legal compliance.
   a. Draw a single, straight line through the incorrect entry. The original text must remain legible. Avoid scribbling out the mistake.
   b. Clearly write the corrected text next to or above the original error.
   c. Use the same line or the next available space.
   d. Add your initials, professional title, and the current date next to the correction.
   e. Do not use correction fluid, tape, or erasers to remove the error, as this can appear as falsification.

Risk Management, Legal, and Ethical Compliance

1. Ensure all entries are signed, dated, and timed accurately.
2. Do not alter or delete/destroy documentation entries. If correction is needed, add an amendment.
3. Do not falsify documentation. **Note, the following can fall under falsifying documentation**:
   a. Creation of new records when records are requested
   b. Pre-dating or post-dating entries.
   c. Adding to existing documentation (except as described in late entries, amendments, and corrections)
   d. Pre-Charting: Documentation of care before it has been provided.
4. Do not chart for others: Document only what you directly observed or performed.
5. Adhere to ALL state and federal regulations in documentation.
6. Maintain security and HIPAA confidentiality of all patient/resident -related documentation.
7. **Avoid Copy-Pasting:** Prevent errors by avoiding repetitive copying, especially for high-risk entries like medication dosages or lab results.
8. **Special Considerations:**
   a. **Patient/Resident Incidents**: Document accidents, injuries, and related actions taken. Follow IntelyCare's and the facility's policies on incident reporting.
   b. **Interpreters**: Record the use of interpreters, including their contact information and the patient's consent to their use.
   c. **Discharge and Transfers:** Assess and document the patient's condition before discharge or transfer, including any instructions provided.

Dementia Training

Cognitive Assessment

Cognitive assessments are critical for identifying mental status changes. While formal cognitive testing is typically performed by licensed professionals, nursing assistants and other direct caregivers can informally assess cognitive function during routine care or casual conversations.

Informal Cognitive Assessment Includes:

- **Short-Term Memory**: Can the resident recall a simple instruction after five minutes?
- **Long-Term Memory**: Can the resident remember past significant events or people?
- **Orientation to Time, Place, and Person**: Ask about the day, location, and the identity of familiar individuals.
- **Decision-Making Skills**: Evaluate the resident's ability to make independent decisions (e.g., choosing meals or clothing).

- **Hallucinations and Delusions**: Identify perceptions or beliefs that are not based on reality (e.g., seeing things that are not present).
- **Disorganized Thinking**: Note any incoherence or inappropriate responses in conversation.

Alzheimer's Disease and Other Related Dementias

Dementia is a progressive condition that damages neurons and brain tissue, leading to cognitive and functional decline. Understanding how Alzheimer's Disease and Related Dementias (ADRD) affect brain function enables better support for individuals living with these conditions, fostering more empathetic care and effective strategies that preserve dignity and quality of life.

1. Alzheimer's Disease

Alzheimer's Disease (AD) is the most common form of dementia, affecting over six million Americans, primarily those aged 65 and older. It is the seventh leading cause of death in the U.S. and is characterized by progressive cognitive decline.

Pathophysiology

- **Key Features:** Amyloid plaques (protein clumps), neurofibrillary tangles (twisted tau fibers), loss of neural connections, and acetylcholine deficiency.
- **Affected Brain Areas:** Begins in the **entorhinal cortex and hippocampus** (memory) before spreading to the **cerebral cortex** (language, reasoning, and social behavior).

Progression and Symptoms

- **Early Stage (Mild)**
  - **Cognitive Impact:** Forgetting recent events/names, difficulty planning, misplacing items.
  - **Functionality:** Can perform daily activities but struggle with complex tasks (e.g., finances).
- **Moderate Stage**
  - **Cognitive Impact:** Increased confusion, language difficulties, frustration, behavioral changes.
  - **Functionality:** Struggles with personal care and executive functions (e.g., decision-making, safety awareness).
- **Late Stage (Severe)**
  - **Cognitive Impact:** Loss of communication skills, memory loss, sleep disturbances.
  - **Functionality:** Full dependence on caregivers for all daily activities.

Life Expectancy

- **Average:** 8–10 years after diagnosis.
- **Varies:** Can range from 15–20 years, but shorter if diagnosed in late 80s or 90s.

2. Vascular Dementia

Vascular Dementia (VD) is the second most common dementia type (15–20% of cases). It results from reduced blood flow due to strokes or vascular conditions.

Pathophysiology

- **Causes:** Hypertension, diabetes, hyperlipidemia, smoking, obesity.
- **Brain Damage:** Multiple minor strokes or small vessel disease lead to neuron death.
- **Imaging Findings:** MRI shows strokes, white matter changes, and vascular abnormalities.

Progression and Symptoms

- **Early Stage (Mild)**

- **Cognitive Impact:** Difficulty planning, organizing, and solving problems.
- **Functionality:** Challenges in following step-based tasks (e.g., making coffee).

- **Moderate Stage**
  - **Cognitive Impact:** Increased confusion, reduced ability to perform daily tasks.
  - **Functionality:** Resembles Alzheimer's but with a stepwise decline.
- **Severe Stage**
  - **Cognitive Impact:** Severe confusion, hallucinations, mood swings.
  - **Functionality:** Complete dependence on caregivers, higher stroke/heart attack risk.

Life Expectancy

- **Average:** ~5 years (lower than Alzheimer's due to increased stroke risk).

3. Lewy Body Dementia

Lewy Body Dementia (LBD) accounts for 10–15% of dementia cases and results from **alpha-synuclein protein deposits** (Lewy bodies) in the brain.

Key Symptoms

- **Cognitive:** Fluctuating confusion, memory loss, impaired judgment.
- **Motor:** Parkinsonism (tremors, stiffness, slow movement).
- **Behavioral:** Hallucinations, aggression, REM sleep disorder.

Progression and Symptoms

- **Early Stage**
  - **Mild:** Stiffness, movement difficulties, occasional cognitive lapses.
  - **Unpredictable Decline:** Symptoms can worsen rapidly, even within a day.
- **Moderate Stage**
  - **Cognitive Impact:** Increased memory issues, speech difficulties, hallucinations.
  - **Functionality:** Requires help with routine tasks.
- **Severe Stage**
  - **Cognitive Impact:** Profound confusion, loss of speech, paranoia.
  - **Functionality:** 24-hour care required for all daily needs.

Life Expectancy

- **Average:** ~6 years (higher fall/infection risk).

4. Frontotemporal Dementia (FTD)

FTD is a rare dementia that primarily affects **younger adults (ages 45–64)** and involves the **degeneration of the frontal and temporal lobes**.

Pathophysiology

- **Caused by:** Tau and TDP43 protein accumulation.
- **Primary Effects:** Behavioral changes, personality shifts, language difficulties.

Subtypes

1. **Behavioral Variant:** Affects **frontal lobes**, leading to personality and social behavior changes.
2. **Primary Progressive Aphasia:** Affects **temporal lobes**, causing language impairment.

Progression and Symptoms

- **Mild (Early Stage)**
  - **Symptoms:** Subtle personality shifts, mild speech/language difficulties.
  - **Functionality:** Independent but noticeable behavioral changes.
- **Moderate (Mid-Stage)**
  - **Symptoms:** Difficulty with speech, relationships, and daily tasks.

- **Functionality:** Increased forgetfulness, disorientation, and mobility issues.
- **Severe (Late Stage)**
  - **Symptoms:** Memory loss, significant motor impairments, full dependency.
  - **Functionality:** Requires 24/7 care, high fall risk.

Life Expectancy

- **Average:** 6–8 years.
- **With ALS or Motor Neuron Disease:** 2–3 years.

Person-Centered Approaches to Care

Person-centered care focuses on treating individuals with **Alzheimer's Disease and Related Dementias (ADRD)** with dignity, respect, and empathy. This approach prioritizes their unique **needs, preferences, and abilities,** fostering **autonomy, safety, and meaningful engagement.**

Core Principles

1. **Individualized Care** – Tailor routines to the person's abilities and preferences.
2. **Effective Communication** – Use clear, reassuring language and nonverbal cues.
3. **Behavioral Sensitivity** – Address changes in mood and cognition with empathy.
4. **Safety & Risk Management** – Ensure a secure environment while maintaining dignity.
5. **Family & Care Team Collaboration** – Involve family members in care planning for a holistic approach.

Supporting Activities of Daily Living (ADLs)

As ADRD progresses, individuals may struggle with **bathing, dressing, grooming, and hygiene.** Caregivers play a vital role in maintaining **comfort, independence, and self-esteem**

Bathing Assistance

- **Never leave the person alone** in the bathroom.
- Use **shower chairs** and ensure **optimal water temperature.**
- Engage in **casual conversation** to reduce stress.
- Seek **professional assistance** if bathing becomes unsafe.

Dressing Assistance

- Provide **comfortable clothing** and arrange items in **sequential order.**
- Offer **limited choices** to simplify decisions.
- Encourage **independent dressing** while assisting as needed.

Grooming & Hygiene

- Maintain **oral health** with appropriate toothbrushes and regular dental visits.
- Keep **nails and hair clean,** scheduling salon/barber visits as needed.
- Support personal grooming (e.g., **makeup, shaving**) to boost self-esteem.

Managing Behavioral & Psychological Challenges

Individuals with ADRD may experience **agitation, anxiety, apathy, depression, and stress.** Understanding triggers and using **compassionate strategies** can improve well-being.

Agitation & Aggression

- Identify **triggers** (e.g., **pain, frustration, confusion**).
- Avoid confrontation; instead, **redirect attention** to calming activities.

- Provide **reassurance and a safe space** for emotional expression.

Anxiety & Depression

- Recognize signs: **restlessness, withdrawal, sleep changes**.
- Maintain a **calm environment** and avoid overwhelming stimuli.
- Encourage **social engagement, physical activity, and routine structure**.
- Seek professional support if symptoms persist.

Apathy & Motivation Challenges

- Break tasks into **simple, manageable steps**.
- Encourage participation **without pressure**—focus on **process over results**.
- Foster a **positive, supportive atmosphere**.

Stress Management

- Build **trust and emotional connection**.
- Use **music, storytelling, or familiar objects** for comfort.
- Encourage **relaxation activities** like gentle walks or deep breathing.

Addressing Sleep Disruptions & Sundowning

Individuals with ADRD may experience **confusion, agitation, and disorientation** in the evening (sundowning).

Preventing Sundowning

- Establish a **consistent sleep routine**.
- Create a **calm, well-lit evening environment**.
- Encourage **daytime activity** to promote nighttime rest.
- Limit **caffeine and other stimulants** before bedtime.

Interventions

- **Light therapy** to regulate sleep cycles.
- **Melatonin supplements** (if recommended by a provider).

Intimacy & Sexuality in ADRD

Dementia affects **intimacy, relationships, and sexual behavior**. Some individuals may experience **reduced, heightened, or inappropriate expressions of sexual desire**. Caregivers must navigate these challenges with **empathy, respect, and ethical considerations**.

Care Considerations

- **Acknowledge Emotional & Physical Needs** – Recognize that individuals with dementia still require **affection, companionship, and emotional connection**.
- **Ensure Safety & Boundaries** – Balance **autonomy with appropriate redirection** while ensuring dignity.
- **Support Effective Communication** – Educate caregivers on how to **approach sensitive topics** with patients and families.

Caregiver Responsibilities

1. **Supporting Emotional & Sexual Needs**
   - Respect patients' ongoing need for **companionship and affection**.
   - Offer **nonjudgmental support** to maintain dignity.

2. **Consent & New Relationships**
   - Assess whether both parties **consent** to a new relationship.
   - Communicate with families **sensitively** while ensuring patient rights.
3. **Protecting Vulnerable Individuals**
   - Be **vigilant** against potential sexual abuse.
   - Report **concerns or incidents** to appropriate authorities.
4. **Maintaining Confidentiality & Respect**
   - Handle **sensitive situations with discretion**.
   - Support families with **clear, empathetic communication**.

Navigating Challenges in Long-Term Care

In long-term care settings, caregivers must balance **autonomy, privacy, and ethical caregiving**. Factors such as **loneliness, social isolation, and financial stress** can influence intimacy concerns. Open conversations between **families, healthcare teams, and caregivers** ensure patient well-being while upholding ethical care standards.

Promoting Respect & Dignity

Intimacy is an integral part of **human identity**. Caregivers should:

- **Encourage open communication** with patients and families.
- **Provide emotional support** in a compassionate manner.
- **Foster a safe, respectful environment** for meaningful connections.

By adopting a **holistic approach**, caregivers can enhance the **emotional well-being and dignity** of patients and residents.

Hallucinations

Individuals with impaired senses and memory lapses, commonly associated with Alzheimer's Disease and Related Dementias (ADRD), may experience hallucinations or develop suspicions about people or situations around them. Hallucinations vary widely among individuals in terms of content, complexity, duration, and intensity. These experiences can lead to feelings of mistrust, fear, or paranoia, often causing distress for both the patient and the caregiver.

Strategies for Managing Hallucinations

1. **Maintain a Calm Environment:** Create a comforting and reassuring environment to reduce triggers that may contribute to hallucinations. Ensure adequate lighting, minimize noise, and remove objects that could be misinterpreted.
2. **Avoid Confrontation:** Refrain from arguing or directly challenging the patient's perceptions. Instead, respond with simple, empathetic answers that do not escalate their fears or distress.
3. **Replace "Missing" Items:** If a patient frequently believes an object is missing, consider replacing it with a duplicate to alleviate their concerns.
4. **Use Distraction Techniques:** Redirect the patient's attention to a new activity, such as going for a walk, engaging in music therapy, or helping with simple tasks. Distraction can often reduce the intensity of hallucinations and help the individual refocus.
5. **Clarify Reality Gently:** When appropriate, assist the patient in distinguishing between illusions and reality without invalidating their feelings. Use simple language and a reassuring tone to provide clarity.

Providing Emotional Support

Caregivers should approach patients experiencing hallucinations with patience, understanding, and empathy.

Building trust is essential to managing these episodes effectively while preserving the patient's dignity and emotional well-being.
By combining environmental adjustments, gentle communication, and engaging activities, caregivers can mitigate the effects of hallucinations and enhance the quality of life for individuals living with ADRD.

Wandering

Wandering is a common behavior in individuals with ADRD, often triggered by disorientation and restlessness. It poses significant safety concerns and requires proactive management by caregivers.

- **Preventive Measures:**
  - Secure the Environment: Safeguard doors and windows to prevent wandering.
  - Use visual cues or barriers to discourage exit attempts.
- **Monitor Behavior:**
  - Keep track of the individual's daily routines and identify potential triggers for **wandering, such as restlessness or confusion.**
- **Responding to Wandering:**
  - **Immediately notify** your supervisor that the resident is missing and follow the facility protocol.
  - Search Nearby Areas: If a person wanders off, begin the search in hazardous spots, adjacent areas, or locations they are fond of visiting.
  - Leverage Technology: Utilize GPS tracking devices to monitor their movements and simplify the search and retrieval process.

By staying vigilant and implementing preventive strategies, caregivers can reduce the risks associated with wandering while ensuring the safety and well-being of individuals living with ADRD.

End Of Life Care

End-of-life care focuses on ensuring comfort, dignity, and quality of life for patients/residents nearing death, while providing practical support to their loved ones. This care addresses physical, emotional, and spiritual needs, respecting individual values and preferences. For healthcare staff, delivering effective end-of-life care is essential to easing the transition for both the patient/resident and their family, fostering peace and closure during this critical stage.

Physical Comfort Measures

a. **Pain Management**: Regular assessment of pain is critical. Use validated pain scales to evaluate severity and adjust treatment accordingly. Administer prescribed medications such as opioids or adjuvants on a schedule that prevents breakthrough pain. Consider non-pharmacological options like heat therapy or relaxation techniques.
b. **Symptom Control:** Address common end-of-life symptoms proactively. For example:
   a. Dyspnea: Administer oxygen or bronchodilators as prescribed and employ positioning to ease breathing.
   b. Nausea: Provide antiemetics and small, bland meals if oral intake is still possible.
   c. Agitation: Ensure the environment is calm and reduce sensory overload. Use sedatives when indicated.
c. **Skin Integrity:** Perform routine skin checks, use pressure-relieving devices, and apply barrier creams to prevent breakdown.

Communication with Patients/Residents and Families

1. **Providing Honest Information:** Maintain transparency about the patient's/resident's condition while delivering information in a compassionate manner. Use layman's terms to ensure understanding.
2. **Active Listening:** Acknowledge the patient's/resident's and family's emotions and provide validation without judgment.
3. **Encouraging Participation:** Empower families to be involved in caregiving tasks they are comfortable with, such as assisting with feeding or providing companionship.

Emotional and Spiritual Support

a. **Support Emotional Needs:** Being present is one of the most effective ways to support a patient/resident or family emotionally. Offer comforting words and reassurance to help reduce feelings of isolation.
b. **Address Spiritual Concerns:** Ask patients/residents or families about their spiritual needs. Offer access to clergy or spiritual advisors and respect rituals or practices they wish to perform.
c. **Coping Strategies**: Provide families with information about support groups or grief counseling services. Explain the grieving process to normalize their emotions.

Ethical and Legal Considerations

1. **Advance Directives**: Ensure the care plan aligns with the patient's/resident's documented wishes. Collaborate with the interdisciplinary team if conflicts arise.
2. **Confidentiality:** Maintain privacy by discussing sensitive issues in private spaces and sharing information only with authorized parties.
3. **Ethical Decision-Making:** Use the principles of beneficence, non-maleficence, autonomy, and justice to navigate complex situations.

After Death Care

a. **Post-Mortem Care**: Position the body respectfully, ensuring the eyes and mouth are closed, and follow institutional protocols regarding hygiene and shroud preparation.
b. **Family Support:** Offer family members the opportunity to spend time with the deceased. Provide information about immediate next steps, such as contacting the mortuary or obtaining death certificates.
c. **Self-Care for Staff:** Acknowledge that providing end-of-life care can be emotionally taxing. Participate in peer debriefing or counseling sessions to process experiences.

Fall Prevention

Falls among patients and residents in healthcare facilities remain a significant concern. These events often lead to extended hospital stays, permanent injuries, disabilities, or fatalities. To address this, many facilities have implemented comprehensive Fall Prevention Programs aimed at identifying and mitigating fall risks among high-risk patients.

The Prevalence of Falls

Falls are particularly common among older adults, posing a significant public health challenge. Each year, millions of individuals aged 65 and older experience a fall. Alarmingly, more than one out of four older adults fall annually, yet less than half report these incidents to healthcare providers. Additionally, falling once significantly increases the likelihood of future falls, highlighting the importance of proactive prevention strategies.

The Impact and Costs of Falls

Falls result in substantial injuries and place a strain on healthcare systems. Key statistics include:

1. **Injuries**: One in 10 falls leads to injuries severe enough for older adults to limit their activities or seek medical care.
2. **Emergency Department Visits**: Each year, approximately 3 million older adults visit emergency departments due to fall-related incidents.
3. **Hospitalizations**: Around 1 million fall-related hospitalizations occur annually among older adults.
4. **Hip Fractures**: Falls are the leading cause of hip fractures, accounting for 88% of hip fracture-related emergency visits and hospitalizations. In 2019, 83% of hip fracture deaths were attributed to falls.

Patients at Risk for Falls

Certain patient and resident populations are at a higher risk of falling, including:

1. **Infants and Young Children**: Developing motor skills and curiosity make this group prone to falls.
2. **Older Adults**: Individuals over 65, particularly those aged 80 and older, are more likely to fall due to factors such as reduced mobility, visual and auditory impairments, and chronic conditions.
3. **Sedated Patients**: Sedation increases the risk of disorientation and impaired hazard recognition.

Strategies to Prevent Patient Falls

Fall prevention is a critical aspect of patient safety in healthcare facilities. Evidence-based strategies include:

1. **Assess Risk and Implement Interventions**: Conduct comprehensive assessments to identify fall risk factors (e.g., age, medications, physical limitations) and implement individualized interventions.
2. **Orientation to the Environment**: Familiarize patients with their surroundings, including call light usage, to re
3. duce disorientation.
4. **Maintain Proper Lighting**: Ensure adequate lighting in all areas, particularly at night, to minimize tripping hazards.
5. **Bed Positioning**: Keep beds at their lowest height when not providing care to reduce the impact of potential falls.
6. **Clear Pathways**: Remove clutter, cords, and other obstacles from walkways, especially those leading to the bathroom.
7. **Patient and Family Education**: Educate patients and their families on safe mobility, recognizing hazards, and implementing prevention techniques.
8. **Evaluate Effectiveness**: Regularly assess fall prevention strategies to ensure their effectiveness and adapt as necessary.
9. **Identify and Correct Safety Hazards**: Proactively address hazards such as spills, loose rugs, and improper disposal of equipment.
10. **Adhere to Standards of Care**: Follow established safety protocols during all procedures and treatments to ensure consistency and reduce risks.

By integrating these strategies into daily practice, healthcare teams can create safer environments and significantly reduce the incidence of falls and related injuries.

Malnutrition And Dehydration

Malnutrition and dehydration are significant concerns in healthcare, especially among elderly residents and patients, many living in long-term care facilities. These conditions can severely impact physical and cognitive health, increase susceptibility to illnesses, and elevate the risk of morbidity and mortality. This section aims to provide practical guidance for identifying, preventing, and managing malnutrition and dehydration.

Malnutrition

Malnutrition refers to an imbalance between nutrient intake and the body's requirements, leading to undernutrition or overnutrition. In elderly patients, malnutrition often manifests as unintended weight loss, reduced muscle mass, and decreased physical and cognitive function.

Risk Factors:

1. Cognitive decline, such as dementia or Alzheimer's disease
2. Feeding challenges (e.g., difficulty using utensils or self-feeding)
3. Oral health issues, including poor dentition or ill-fitting dentures
4. Dysphagia (difficulty swallowing)
5. Chronic conditions such as diabetes, renal disease, and gastrointestinal disorders
6. Rapid weight loss or changes in diagnostic markers (e.g., low serum albumin)

Warning Signs:

1. Decreased appetite or food intake
2. Weight loss of more than 5% over a month
3. Fatigue, weakness, or loss of energy
4. Dry skin, brittle hair, or slow wound healing

Dehydration

Dehydration occurs when the body loses more fluids than it takes in, leading to an imbalance that disrupts normal physiological functions. This can affect blood circulation, temperature regulation, and waste elimination. Dehydration may result from inadequate fluid intake, excessive fluid loss (e.g., sweating, diarrhea, or vomiting), or a combination of both. In older adults, dehydration is particularly concerning due to a reduced sense of thirst and physiological changes associated with aging.

Risk Factors:

1. Reduced sense of thirst due to aging
2. Medications with diuretic effects (e.g., diuretics, antihistamines)
3. Difficulty accessing fluids due to physical limitations
4. Cognitive impairments, such as forgetfulness

Warning Signs:

1. Dry mucous membranes (mouth, tongue)
2. Decreased urine output or dark-colored urine
3. Confusion or dizziness
4. Rapid heart rate and low blood pressure

Supporting Nutrition and Hydration

To effectively address malnutrition and dehydration in vulnerable populations, healthcare staff must work collaboratively and fulfill specific roles tailored to their scope of practice. This section outlines the key responsibilities of nursing assistants and nurses, emphasizing their critical contributions to monitoring to monitoring,

prevention, and management. By fostering teamwork and maintaining clear communication, healthcare teams can ensure residents and patients receive the highest quality care.

Nursing Assistants	
Category	**Responsibilities**
Create a Pleasant Dining Environment	• Encourage residents to participate in mealtimes. • Minimize disruptions and ensure a calm atmosphere.
Maintain Hygiene and Safety	• Wash hands thoroughly before assisting each resident. • Ensure residents are seated comfortably and safely.
Assist with Meals	• Verify the resident's dietary plan, including texture modifications and preferences. • Offer appropriate utensils or assistive devices (e.g., non-slip plates). • Provide support while allowing residents to eat at their own pace.
Monitor and Report	• Document food and fluid intake as directed. • Observe for swallowing difficulties or changes in dietary tolerance. • Report decreased food/fluid or concerns of aspiration to the nurse.

Nurses	
Category	**Responsibilities**
Collaborate	• Participate in initial and routine nutritional assessments with interdisciplinary teams • Ensure dietary plans are comprehensive and individualized.
Supervise Dining Activities	• Monitor adherence to proper feeding techniques and policies. • Provide feedback and guidance to frontline staff.
Assess and Document	• Use validated tools like the Malnutrition Universal Screening Tool (MUST) or Mini Nutritional Assessment (MNA). • Record dietary intake, skin integrity concerns, and hydration status.
Promote Hydration	• Encourage fluids during medication administration and throughout the day. • Adjust care plans based on hydration needs and risk factors.

Medication Administration Safety

Who Is Authorized to Administer Medications?

Medication administration must be performed by a licensed nurse (RN or LPN/LVN) based on a valid written order from a licensed provider with prescriptive authority, such as a physician, nurse practitioner, or physician assistant. This ensures that medications are prescribed and administered accurately, following clinical judgment and evidence-based practices to promote patient safety.

Exception: Certified Medication Aides (CMTs)

In certain states, Certified Medication Aides (CMTs) are permitted to administer specific medications under RN or clinician supervision. CMTs are typically Certified Nursing Assistants (CNAs) who have completed additional training and certification in medication administration. The scope of practice for CMTs varies by state and facility regulations. If you are a CMT or supervising a CMT, always refer to state-specific laws and facility policies to ensure compliance with medication administration guidelines.

Preparation

Medications should be prepared immediately before administration. **Do not pre-pour medications**. Preparing medications immediately reduces the risk of errors due to environmental contamination, misidentification, or unintended alterations in dosage.

Important Note: Some facilities require dual nurse verification — **two nurses** to sign off on the preparation and/or the administration of insulin, narcotics, and other high-risk medications. Be sure to follow state regulations and facility-specific policies when preparing and administering medications.

Patient Identification

Always verify the patient's identity by checking at least two identifiers, such as the patient ID band and a verbal confirmation of their name and date of birth. This is critical to prevent wrong-patient errors, as mandated by The Joint Commission's National Patient Safety Goals.

Supervised Administration

Patients must take all medications in the presence of the administering nurse (or CMTs) to ensure they consume the correct dose and to observe for any immediate reactions.

Important Note: Some facilities mandate two nurses to sign off on all **insulin, narcotic, and other high risk preparation** administration and **lab specimens. Ensure to follow facility policy on medication policies.**

Timing

Medications can be given within a "medication window" of one hour before or one hour after the scheduled time, unless otherwise indicated for time-critical medications. This flexibility allows for safer administration while maintaining therapeutic drug levels.

Narcotic Count Verification

A full narcotic count must be conducted and verified at the end of each shift. Any discrepancies must be reported immediately to the supervisor for investigation, which maintains accountability and prevents diversion.

The Seven Rights of Medication Administration

1. **Right Patient**: Confirm patient identity using two identifiers to avoid wrong-patient errors.
2. **Right Medication**: Confirm the medication name on the prescription matches the medication in hand and is appropriate for the patient/resident and their condition.

3. **Right Dose**: Administer the correct dose as prescribed, considering the patient's age, weight, and condition
4. **Right Time**: Administer medication at the appropriate time or within an acceptable timeframe.
5. **Right Route**: Administer via the intended route (e.g., oral, IV).
6. **Right Reason**: Confirm that the medication is indicated for the patient's specific condition.
7. **Right Documentation**: Accurately record all details of medication administration immediately in the patient's chart.

LPN/LVN Scope of Practice for Intravenous (IV) Medications

The scope of practice for LPNs/LVNs in IV therapy varies by state. Generally, they are allowed to start peripheral upon IV certification, with limitations on certain medications and routes, such as IV push, or high-risk drugs.

Some states permit certified LPNs/LVNs to administer IV medications under RN or physician supervision, while others restrict this practice entirely. RNs typically have full authorization to administer IV therapy, including IV push medications, as part of their broader scope of practice except for chemotherapy.

Nurses should always consult their state's Board of Nursing guidelines and scope of practice as well as follow facility policies and procedures related to the administration IV medication.

Understanding Medication Errors

The National Coordinating Council for Medication Error Reporting and Prevention (NCC MERP, 2021), defines **medication errors** as:

"Any preventable event that may cause or lead to inappropriate medication use or patient harm while the medication is in the control of the healthcare professional, patient, or consumer."

These errors can occur at any point in the medication process, from prescribing and dispensing to administering and monitoring. Recognizing and preventing medication errors is critical to ensuring patient safety. Even minor mistakes can result in serious harm or adverse outcomes, making it essential for healthcare professionals to follow strict protocols and maintain vigilance to safeguard patient well-being.

Preventing Medical Errors

This section outlines key practices and guidelines that nurses should follow to minimize the risk of medication errors.

Type of Med Error	Description	Prevention Strategies
Prescription Errors	Occurs when the wrong drug, dosage, or route is prescribed, or patient's allergies or conditions are not considered.	- Review prescriptions for completeness and accuracy before administering. - Confirm unclear prescriptions with the prescribing provider. - Check patient allergy and medical history.
Omission Errors	Happens when a prescribed dose is not administered as scheduled.	- Create/follow a checklist to track scheduled medications. - Set reminders or alarms for time-sensitive medications. - Conduct end-of-shift double-checks for missed doses.
Wrong Dose Errors	Occurs when a patient receives more or less than the prescribed dosage.	- Always verify the dosage calculation with another nurse. - Check the medication label and order carefully before administration.

Type of Med Error	Description	Prevention Strategies
Wrong Time Errors	Happens when medications are given outside the prescribed time frame.	- Adhere to the facility's medication policy. - Prioritize medications based on urgency and schedule. - Communicate with team members about timing adjustments.
Unauthorized Drug Errors	Occurs when a patient is given a medication that wasn't prescribed for them.	- Verify the medication against the patient's MAR (Medication Administration Record) before administering. - Use two patient identifiers every time. - Utilize bar-code scanning systems.
Administration Errors	Occurs when medications are given via the wrong route (e.g., oral medication given intravenously).	- Confirm the route of administration in the medication order. - Clearly label medications during preparation. - Seek clarification if the prescribed route seems unclear or unusual.
Dispensing Errors	Pharmacy-related errors during preparation or labeling of medication.	- Double-check medication labels and packaging before administration. - Alert the pharmacy immediately if you suspect an error. - Use bar-code scanning systems to confirm medications.
Monitoring Errors	Failure to observe and recognize the patient's response to a medication, especially for drugs that require monitoring.	- Monitor the patient's response after administering medications (e.g., vital signs, labs). - Document observations promptly and accurately. - Report adverse effects immediately.

Mental and Behavioral Health Basics

Understanding mental and behavioral health is critical for healthcare workers in long-term care, residential facilities, and acute care settings. Residents and patients often face complex emotional, psychological, and behavioral challenges that significantly impact their overall health and quality of life. By recognizing the interconnected nature of mental and behavioral health, healthcare providers can deliver more effective, compassionate, and individualized care.

Mental Health refers to the emotional, psychological, and social well-being of an individual. It focuses on how people think, feel, and behave and includes conditions like depression, anxiety, and schizophrenia. Mental health disorders often have biological, genetic, or neurological roots and may require psychotherapy, medication, or other therapeutic approaches.

Behavioral Health is a broader term that encompasses mental health but focuses specifically on how behaviors impact an individual's well-being. It includes habits like eating, drinking, and exercising and conditions related to substance abuse or behavioral patterns. Behavioral health often addresses how unhealthy behaviors contribute to mental or physical health challenges.

Common Mental and Behavioral Health Conditions

Anxiety

Anxiety Disorders are a group of mental health conditions marked by excessive fear, worry, or nervousness that interfere with daily activities, often accompanied by physical symptoms.

Common Types:

- **Generalized Anxiety Disorder (GAD):** Persistent and excessive worry about various aspects of life.
- **Panic Disorder:** Sudden episodes of intense fear or discomfort, often accompanied by physical symptoms.
- **Social Anxiety Disorder**: Fear of social situations due to fear of judgment or embarrassment.

Signs and Symptoms:

- Excessive worry or fear that is difficult to control.
- Restlessness, fatigue, or difficulty concentrating.
- Irritability and muscle tension.
- Sleep disturbances, including insomnia.
- Physical symptoms such as sweating, trembling, rapid heart rate, or shortness of breath.

Depression

Depression falls under a series mood disorders characterized by persistent feelings of sadness, hopelessness, or loss of interest in daily activities, often accompanied by physical symptoms.

Common Types:

- **Major Depressive Disorder (MDD):** Severe episodes of depression lasting at least two weeks.
- **Persistent Depressive Disorder (Dysthymia):** Chronic depression lasting two years or more.
- **Seasonal Affective Disorder (SAD):** Depression occurring in a seasonal pattern, often during winter months. including major depressive disorder (MDD), persistent depressive disorder (dysthymia), and seasonal affective disorder (SAD).

Signs and Symptoms:

- Loss of interest or pleasure in activities once enjoyed.
- Changes in appetite or weight (increase or decrease).
- Difficulty sleeping (insomnia) or sleeping too much (hypersomnia).
- Fatigue or decreased energy.
- Feelings of worthlessness or excessive guilt.
- Difficulty concentrating or making decisions.
- Recurrent thoughts of death or suicide.

Addressing Safety: Suicidal Ideation

- Suicidal ideation refers to thoughts or preoccupations about ending one's life. It can be categorized into **passive** and **active** suicidal ideation, both of which require serious attention and appropriate intervention.
    - **Passive Suicidal Ideation:** The individual has thoughts of death or dying but does not have a specific plan or intent to act. Example: "I wish I could go to sleep and never wake up."
    - **Active Suicidal Ideation:** The individual has thoughts of ending their life, often with a specific plan or intent to carry it out. Example: "I am planning to harm myself by [specific method]."

What to Do if a Resident or Patient Expresses Suicidal Ideation:

- **Stay Calm and Supportive:** Remain nonjudgmental and compassionate. Listen actively and validate their feelings. Avoid dismissing or minimizing their thoughts.
- **Assess the Risk:** Determine the severity of the ideation by asking directly: "Are you thinking about hurting yourself or ending your life?", "Do you have a plan for how you would do this?"
  - High-risk factors include active ideation, a specific plan, access to means, and a history of previous attempts.
- **Ensure Immediate Safety: Do not leave the individual alone if they are at imminent risk. Remove access to potential means of self-harm, such as sharp objects, medications, or weapons.**
- **Notify Appropriate Personnel:** Inform the healthcare team, including supervisors, mental health professionals, or crisis teams. Follow facility policies and procedures for reporting and managing suicidal ideation.
- **Provide Resources:** Offer contact information for crisis hotlines, such as the National Suicide Prevention Lifeline at **988**. Encourage professional mental health support through therapists, counselors, or psychiatric services.
- **Document and Follow Up:** Document the situation thoroughly, including the patient's statements, actions taken, and individuals notified. Participate in follow-up care to ensure ongoing support and monitoring.

Bipolar Disorder

Bipolar Disorder is characterized by mood swings that include emotional highs (mania or hypomania) and lows (depression). Key symptoms include:

Common Types:

- **Bipolar I Disorder:** At least one manic episode, often followed or preceded by depressive episodes.
- **Bipolar II Disorder:** Episodes of hypomania (less severe than mania) and major depressive episodes.
- **Cyclothymic Disorder:** Chronic fluctuating moods with less severe highs and lows over at least two years.

Signs and Symptoms:

- **Mania or Hypomania:** Increased energy, activity, or restlessness. Euphoria, irritability, or an exaggerated sense of self-confidence. Decreased need for sleep. Racing thoughts or rapid speech. Impulsivity or engaging in risky behaviors.
- **Depression:** Symptoms like major depressive disorder, including feelings of sadness and loss of energy.

Post-Traumatic Stress

Post-Traumatic Stress Disorder (PTSD) is a mental health condition triggered by experiencing or witnessing a traumatic event, leading to prolonged psychological distress.

Common Types:

- **Acute Stress Disorder:** Symptoms occur within the first month after trauma but may develop into PTSD.
- **Complex PTSD:** Results from prolonged or repeated trauma, often involving relational or interpersonal difficulties.
- **Intrusion:** Recurrent, involuntary, and distressing memories or dreams of the event. Flashbacks or reliving the trauma as if it were happening again.
- **Avoidance:** Avoiding places, people, or activities that remind the individual of the trauma.
- **Negative Changes in Mood and Cognition:** Persistent negative emotions (e.g., fear, anger, guilt, or shame). Difficulty remembering key aspects of the traumatic event. Feelings of detachment or estrangement from others.
- **Arousal and Reactivity:** Hypervigilance, exaggerated startle response, or irritability. Difficulty sleeping or concentrating.

Schizophrenia

Schizophrenia is a chronic and severe mental health disorder that affects how a person thinks, feels, and behaves, often causing a disconnect from reality (psychosis), impairing daily functioning, and leading to significant challenges in relationships, work, and self-care.

Common Types:

- **Paranoid Schizophrenia:** Characterized by delusions or auditory hallucinations, often involving persecution or grandiosity, with relatively intact cognitive and emotional functioning.
- **Disorganized Schizophrenia (Hebephrenic):** Defined by disorganized speech, erratic behavior, and inappropriate or flat emotions, often disrupting daily routines.
- **Catatonic Schizophrenia:** Marked by abnormal motor behavior, including immobility, purposeless movement, or resistance, often with echolalia or echopraxia.
- **Undifferentiated Schizophrenia:** A mix of hallucinations, delusions, and disorganized thinking that does not fit specific subtypes.
- **Residual Schizophrenia:** A state where prominent symptoms have lessened, but social withdrawal, emotional flatness, or odd beliefs persist.

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Signs and Symptoms:

- **Positive Symptoms:** Hallucinations (hearing, seeing, or feeling things that are not there). Delusions (false beliefs that are not based in reality). Disorganized thinking and speech.
- **Negative Symptoms:** Reduced emotional expression or flat affect. Social withdrawal and lack of interest in daily activities. Difficulty initiating and sustaining tasks.
- **Cognitive Symptoms:** Impaired memory or attention. Difficulty with decision-making or understanding information.

Attention Deficit Disorder

Attention Deficit Disorder with Hyperactivity (ADHD) is a neurodevelopmental disorder characterized by pervasive patterns of inattention, hyperactivity, and impulsivity that interfere with daily functioning or development, often appearing before age 12.

Common Types:

- **Predominantly Inattentive Presentation:** Characterized by difficulty sustaining attention, following instructions, and organizing tasks, without significant hyperactivity or impulsivity. Formerly referred to as attention deficit disorder (ADD).
- **Predominantly Hyperactive-Impulsive Presentation:** Marked by excessive energy, fidgeting, impulsive actions, and difficulty remaining still or quiet.
- **Combined Presentation:** Involves significant symptoms of both inattention and hyperactivity-impulsivity, affecting multiple areas of life.

Signs and Symptoms:

Signs and symptoms vary in severity and impact daily life, often requiring individualized treatment plans combining behavioral strategies, therapy, and/or medication.

- **Inattention:** Difficulty concentrating, organizing, or completing tasks. Frequent daydreaming and making careless mistakes.
- **Hyperactivity:** Inability to sit still, excessive talking, or constant movement. Difficulty engaging in quiet activities.
- **Impulsivity:** Interrupting conversations, difficulty waiting turns, or making hasty decisions. Acting without regard for consequences.

Eating Disorders

Eating Disorders are complex mental health conditions characterized by persistent disturbances in eating behaviors, thoughts, and emotions related to food, body weight, and shape. They can result in severe physical, psychological, and social impairments, often requiring comprehensive, multidisciplinary treatment to address their multifactorial causes and potentially life-threatening complications.

Common Types with Signs and Symptoms:

- **Anorexia Nervosa:** Characterized by an intense fear of gaining weight, persistent restriction of food intake, and a distorted body image leading to dangerously low body weight. Key Behaviors: Severe calorie restriction, excessive exercise, and denial of the seriousness of low body weight.
- **Bulimia Nervosa:** Marked by recurrent episodes of binge eating followed by compensatory behaviors like self-induced vomiting, laxative abuse, fasting, or excessive exercise to prevent weight gain. Key Behaviors: Eating large quantities of food in a short time, feelings of shame or guilt, and purging behaviors.
- **Binge-Eating Disorder:** Defined by recurrent episodes of eating unusually large quantities of food in a discrete period, accompanied by feelings of loss of control and distress, without compensatory behaviors. Key Behaviors: Eating when not physically hungry, eating alone due to embarrassment, and feeling disgusted or guilty afterward.
- **Avoidant/Restrictive Food Intake Disorder (ARFID):** Involves limited food intake due to a lack of interest in eating, sensory sensitivities, or fear of adverse consequences (e.g., choking), leading to nutritional deficiencies or failure to meet energy needs. Key Behaviors: Avoidance of specific food groups, significant weight loss, and reliance on nutritional supplements or tube feeding.

Substance Use Disorders

Substance Use Disorders (SUD) are chronic conditions that involve the compulsive use of substances despite harmful consequences. They are characterized by **impaired control, cravings, tolerance, and withdrawal**. These disorders affect the brain's **reward and motivation systems** and often require **comprehensive, multidisciplinary treatment.**

Common Types:

- **Alcohol Use Disorder (AUD):** Chronic misuse of alcohol characterized by cravings, loss of control over drinking, tolerance, and withdrawal symptoms.
- **Opioid Use Disorder:** Dependence on prescription painkillers or illicit opioids like heroin, leading to physical and psychological harm.
- **Stimulant Use Disorder:** Misuse of drugs like cocaine, methamphetamine, or prescription stimulants, resulting in addiction and increased energy or focus.
- **Cannabis Use Disorder:** Persistent and problematic use of marijuana that interferes with daily functioning and causes withdrawal when stopped.
- **Sedative, Hypnotic, or Anxiolytic Use Disorder:** Misuse of medications like benzodiazepines or sleep aids, leading to dependence and withdrawal symptoms.
- **Tobacco Use Disorder:** Dependence on nicotine through cigarettes, vaping, or other products, causing withdrawal symptoms and significant health risks.

General Signs and Symptoms:

- **Behavioral Changes:** Neglecting responsibilities at work, school, or home. Loss of interest in previously enjoyed activities. Engaging in risky or illegal activities to obtain substances. Social withdrawal or associating with a new group involved in substance use.
- **Physical Symptoms:** Changes in appetite or sleep patterns (e.g., insomnia or hypersomnia). Weight loss or gain. Poor hygiene or grooming habits. Unexplained injuries or frequent illnesses.
- **Psychological Symptoms:** Mood swings, irritability, or aggressive behavior. Anxiety, paranoia, or depression. Memory issues or confusion. Lack of motivation or focus.

- **Cravings and Loss of Control:** Intense urges to use substances despite negative consequences. Inability to stop or reduce use even after multiple attempts.

Withdrawal Symptoms (Vary by Substance)

- **Alcohol**
  - Tremors, sweating, anxiety, nausea, and vomiting.
  - Severe withdrawal (delirium tremens): Confusion, hallucinations, and seizures.
- **Opioids**
  - Muscle aches, sweating, diarrhea, vomiting, runny nose, and yawning.
  - Severe anxiety, agitation, and insomnia.
- **Stimulants (e.g., cocaine, methamphetamine)**
  - Fatigue, intense depression, increased appetite, and sleep disturbances.
  - Irritability and paranoia.
- **Cannabis**
  - Irritability, insomnia, decreased appetite, and restlessness.
  - Flu-like symptoms in some cases.
- **Sedatives or Benzodiazepines**
  - Anxiety, tremors, sweating, seizures, and insomnia.
  - Rebound symptoms (e.g., intensified anxiety or agitation).
- **Tobacco/Nicotine** - Irritability, intense cravings, difficulty concentrating, increased appetite, and sleep disturbances.
- **Inhalants**
  - Nausea, tremors, headaches, and irritability.
  - In severe cases: confusion or psychosis.
- **Hallucinogens** - Rare withdrawal, but long-term use may cause flashbacks or persistent psychosis.

Dual Diagnosis

Dual Diagnosis, also known as co-occurring disorders, refers to the presence of both a mental health disorder and a substance use disorder in the same individual. These conditions interact in complex ways, often exacerbating one another, and require integrated treatment approaches that address both issues simultaneously.

Special Note

Mental and behavioral health interventions share common approaches, including therapy, medication management, and crisis intervention. While **mental health** focuses on emotional and psychological conditions like depression and anxiety, **behavioral health** addresses how habits and actions—such as substance use or disordered eating—impact overall well-being. Despite these distinctions, both fields are deeply connected, and effective care requires a **holistic approach**. Behavioral health interventions, which focus on modifying harmful behaviors and promoting healthier coping strategies, will be explored in the next section.

Interventions for Behavioral Health Problems

Managing behavioral health issues requires a proactive, holistic approach that goes beyond immediate crisis responses. Interventions focus on addressing the root causes of behavioral challenges, creating supportive environments, and using tailored strategies to improve emotional and mental well-being. These approaches aim to enhance the quality of care while reducing the likelihood of future behavioral episodes.

Therapeutic Approaches for Emotional and Cognitive Challenges

1. **Look for Causes**: Identify and address potential triggers such as pain, hunger, or emotional distress.
2. **Reorientation and Validation** - For confused individuals, gently reorient them to the present or validate their feelings if reorientation increases distress.
3. **Therapeutic Communication**
   - Use open-ended questions to explore feelings and concerns.

- Avoid arguing or correcting delusional beliefs. Instead, acknowledge feelings and offer reassurance.
- Ask Questions: Allow residents to express why they are upset.
- Avoid Threats or Arguments: These can escalate tensions and worsen the situation.
- Speak Calmly and Slowly: A gentle tone can help prevent escalation of behavior.

Environmental Adjustments

1. **Create a Calm Space** - Reduce noise, dim lights, and remove unnecessary stimuli.
2. **Establish Routine** - Consistency in daily activities can reduce anxiety and agitation.

Medication Management

1. Administer PRN medications for agitation as prescribed and document effectiveness.
2. Work with the interdisciplinary team to review medications contributing to behavioral changes.

Non-pharmacological Approaches

1. **Sensory Interventions**: Weighted blankets, aromatherapy, or soothing music.
2. **Activities**: Provide simple, engaging activities to redirect focus, such as coloring, puzzles, or gardening.
3. **Physical Exercise**: Encourage light physical activity to release tension.

Know the Crisis Intervention Plan for Severe Behavioral Episodes

1. **Team Response**
   - Learn the designated behavioral emergency code
   - Understand your role on the de-escalation team.
2. **Physical Interventions** - Use restraints only as a last resort and in compliance with legal and facility guidelines.
3. **Post-Crisis Review** - Conduct a debriefing to evaluate the incident, identify triggers, and adjust care plans.

Documentation and Reporting

Thorough documentation and reporting are essential for ensuring continuity of care, evaluating the effectiveness of interventions, and maintaining a safe environment. Accurate records help identify patterns, refine care plans, and support communication among team members, ultimately improving outcomes for residents and staff.

Document the Following:

- Precipitating factors and observed triggers.
- Verbal and non-verbal cues exhibited by the individual.
- De-escalation strategies employed and their effectiveness.
- Medications administered (if any) and their observed effect.
- Outcome of the intervention and any injuries (staff or patient).

Report the Following:

- Significant incidents, such as those involving physical intervention or harm, to supervisors and the interdisciplinary team immediately.
- Any trends or repeated behaviors that may require adjustments to the care plan.
- Compliance with regulatory and facility-specific protocols for incident reporting, including completing required forms or logs.

By combining accurate documentation with timely reporting, healthcare teams can improve communication, ensure accountability, and enhance the quality of care provided.

Key Considerations

Addressing behavioral challenges effectively requires adapting strategies to the specific needs of long-term care and acute care settings. Individualized care plans, cultural sensitivity, and adherence to legal and ethical standards ensure that interventions are both person-centered and compliant with regulations, fostering safety and respect across diverse care environments.

- **Cultural Sensitivity**: Respect cultural norms and communication styles that may influence behavior. Disruptive behaviors may be influenced by cultural or personal factors, such as unfamiliar environments or language barriers. Staff should take time to understand the resident's cultural context and explore solutions that are respectful of these differences
- **Individualized Care Plans**: Collaborate with families to understand triggers, preferences, and effective calming techniques
- **Legal and Ethical Standards:** Adhere to state and federal guidelines on the use of restraints and patient rights.

De-Escalation of Aggressive and Violent Behavior

The safety of residents, visitors, and healthcare staff is paramount in all care settings. Aggressive and violent behavior as well as behavioral health challenges can pose risks to all involved. This section outlines practical strategies to de-escalate aggression, address behavioral health concerns, and maintain a safe, respectful, and therapeutic environment for everyone.

Understanding the Cause

Aggressive or violent behavior can stem from multiple factors, including:

- **Medical conditions**: Delirium, infections, neurological disorders (e.g., dementia, Parkinson's).
- **Psychiatric conditions**: Anxiety, depression, bipolar disorder, schizophrenia, PTSD.
- **Environmental triggers**: Overstimulation, change in routine, unmet needs.
- **Medications or substance use**: Side effects or withdrawal symptoms.

Signs of Escalation

- Increased pacing or restlessness.
- Verbal threats, shouting, or inappropriate language.
- Clenched fists, physical tension, or raised voice.
- Agitation or refusal to follow requests.

Harmful or Disruptive Behaviors

If not addressed early or appropriately behaviors can escalate to:

- **Physical**: Hitting, kicking, scratching, or wandering.
- **Verbal**: Screaming, cursing, or inappropriate speech.
- **Interference with Care**: Refusing or disrupting care.

De-Escalation Strategies

De-escalation is a critical skill for managing acute aggressive or violent behavior while minimizing harm in the moment. It involves using calm, structured, and compassionate approaches to reduce tension and prevent escalation. By focusing on communication, safety, and empathy, healthcare staff can effectively diffuse challenging situations and create a safer environment for all.

Key Strategies

- **Stay Calm and Maintain a Neutral Tone** - Speak slowly and clearly using a calm, reassuring voice. Avoid raising your voice or showing frustration.
- **Establish a Safe Environment** - Maintain a safe distance and ensure there's a clear exit route for yourself. Remove potentially harmful objects from the area.
- **Listen Actively and Empathize** - Allow the individual to express their feelings without interruption. Reflect their emotions to demonstrate understanding (e.g., "I can see that you're upset about…").

- **Set Boundaries and Limits** - Politely but firmly outline acceptable behavior: "I want to help you, but I need you to lower your voice first."
- **Use Non-threatening Body Language** - Avoid crossing arms, making direct eye contact, or sudden movements. Maintain open and relaxed postures.
- **Distract and Redirect** - Shift focus to neutral or calming topics (e.g., "Can we talk about your favorite activity?"). Offer a walk or a snack.
- **Involve the Individual in Problem-Solving** - Ask how you can help or offer choices: "Would you prefer to sit in the lounge or the garden?"
- **Know When to Exit or Call for Help** - If the situation escalates beyond your control, immediately call for additional assistance or follow the facility's crisis protocol.

Culturally Appropriate Behavioral Health Management

Cultural beliefs, practices, and stigmas significantly influence how residents express symptoms, interpret care, and respond to interventions. Providing culturally sensitive care is essential for fostering trust, ensuring effective communication, and improving outcomes. Clinical staff should approach residents, patients, and their families with respect and cultural humility, adapting care to honor their unique perspectives and needs.

Behavioral health management must be flexible and adaptable to diverse populations and care settings. Respect, cultural sensitivity, and trauma-informed practices are foundational to addressing disruptive behaviors in a manner that promotes dignity and trust. Tailoring interventions to cultural contexts helps mitigate misunderstandings and fosters a more inclusive and therapeutic environment

Key Strategies for Culturally Sensitive Care

1. **Cultural Awareness**
   a. Recognize that perceptions of behavioral health vary widely across cultural groups.
   b. **Example**: In some cultures, emotional distress such as sadness or anxiety may manifest as physical symptoms, like headaches, fatigue, or stomach pain.
   c. Be mindful of cultural stigma that may impact willingness to discuss or seek care for mental health concerns.

2. **Addressing Language Barriers**
   a. Always use trained medical interpreters when language differences exist to ensure accurate, clear, and respectful communication.
   b. Avoid relying on family members as interpreters, as this can compromise confidentiality and lead to misunderstandings.

3. **Incorporating Spiritual and Community Resources**
   a. Collaborate with cultural or spiritual leaders when appropriate to address behavioral health concerns within the resident's cultural framework.
   b. Respect religious practices, traditions, and dietary preferences, which may influence care decisions or behavioral responses.
4. **Respect for Cultural Norms and Communication Styles**
   a. Understand that behaviors or expressions of distress may be shaped by cultural or personal factors, such as unfamiliar environments, language challenges, or non-verbal communication norms.
   b. Take time to explore the resident's cultural context, showing empathy and openness to identify solutions that align with their beliefs and values.

Patient & Resident Restraints

It is the policy of IntelyCare, Inc. that the patient has the right to be free from any physical or chemical restraints unless it is necessary for the patient's safety or the safety of others. Restrictive devices/restraints will be applied

when the safety of the patient and/or others are in jeopardy when less restrictive measures have proved inadequate. Restraints shall not be used in a manner that causes injuries.

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

Purpose and Indication of Restraints

Restraints are interventions or devices used to limit a patient's movement to ensure safety and prevent harm. The type or technique of restraint or seclusion used must be the least restrictive intervention that will be effective to protect the patient/resident, staff member(s), or others from harm. They can be physical, chemical, or environmental.

Indications for Restraint Use:

1. To prevent self-harm or harm to others.
2. To prevent interference with medical treatments or devices.
3. To manage severe behavioral disturbances when less restrictive interventions are ineffective.

Goals of Restraint Use:

1. Ensure patient, resident, and staff safety.
2. Maintain the therapeutic environment.
3. Preserve the dignity and rights of the patient.

Legal and Ethical Considerations

1. **Rights and Dignity**: Residents and patients have the right to be free from unnecessary restraints and to receive care that respects their dignity and autonomy.
2. **Informed Consent Requirements**: Obtain informed consent from the patient or their legal representative before applying restraints, except in emergencies where immediate action is necessary.
3. **Legal Implications of Misuse**: Improper use of restraints can lead to legal consequences, including allegations of abuse or negligence.
4. **Federal and State Regulations**: Adhere to regulations set by authorities such as the Centers for Medicare & Medicaid Services (CMS) and state laws governing restraint use, including:
    a. **Physician or Licensed Practitioner Order -** Restraint or seclusion must be ordered by an authorized physician or licensed practitioner responsible for patient care.
    b. **No Standing or PRN Orders -** Restraint or seclusion orders must never be written as standing orders or PRN (as needed).
    c. **Consultation with Attending Physician -** If the attending physician did not order the restraint or seclusion, they must be consulted as soon as possible.
    d. **Time Limits for Violent/Self-Destructive Behavior -** Orders may be renewed up to **24 hours** with the following time limits:
        - **Adults (18+ years):** 4 hours
        - **Children (9-17 years):** 2 hours
        - **Children (<9 years):** 1 hour
        - After 24 hours, a physician or licensed practitioner must **see and assess** the patient before writing a new order.
    e. **Time Limits for Non-Violent/Non-Self-Destructive Behavior -** Orders may be renewed as per facility/hospital policy.
    f. Each order for restraint used to ensure the physical safety of the non-violent or non-self-destructive patient may be renewed as authorized by hospital policy.

Restraint Types and Application

Physical Restraints

1. **Physical Restraints**: Devices or methods that restrict movement, for safety purposes. Examples include:
   a. **Soft Restraints**: Fabric or padded restraints (e.g., wrist, ankle, or hand mitts) designed to prevent injury without causing discomfort.
   b. **Leather Restraints**: Durable restraints often used for patients who exhibit extreme aggression or require stronger control.
   c. **Posey/Vest Restraints**: A vest worn by the patient and secured to a bed or chair to prevent falls or self-injury.
   d. **Four-Point Restraints**: Wrist and ankle restraints used simultaneously to restrict all limb movement.
   e. **Bed Rails**: Raised side rails on a bed to prevent patients from falling or leaving the bed unsafely.
2. **Proper Application Techniques:**
   a. Select the most appropriate restraint type for the patient's needs.
   b. Follow facility protocols and manufacturer's instructions for proper application.
   c. Ensure the restraint is secure but not too tight to avoid restricting circulation or causing injury.
   d. Allow for normal range of motion whenever possible.
3. **Monitoring and Documentation Requirements:**
   a. Assess the patient every 15 minutes for Violent/Self-Destructive and at least every 1 hour for Non-Violent/Non-Self-Destructive restraints or more frequently based on facility protocol.
   b. The nurse should assess:
      - Vital sign monitoring
      - Circulation, range of motion, and skin Integrity check
      - Intake and output
      - Hygiene/elimination
      - Physical comfort and psychological status
      - Readiness for release of restraint.
   c. Proper documentation of each assessment includes:
      - Type of restraint used.
      - Rationale for application.
      - Duration of use.
      - The above assessment

Chemical Restraints

1. **Chemical restraints** involve the use of medications to manage a patient's behavior or limit mobility when other measures fail. Examples include:
   a. Sedatives: Medications like lorazepam (Ativan) or midazolam (Versed) to calm agitation.
   b. Antipsychotics: Medications such as haloperidol (Haldol) or olanzapine (Zyprexa) to address aggression or severe agitation.
   c. Benzodiazepines: Drugs like diazepam (Valium) to manage anxiety or agitation.
2. **Administration Guidelines:**
   a. Medications should only be used after other interventions have proven ineffective.
   b. A provider's order is required before administration, except in emergency situations.
   c. Use the lowest effective dose for the shortest duration necessary to manage the behavior.
3. **Monitoring and Documentation of Side Effects and Adverse Reactions:**
   a. Observe for common side effects like drowsiness, confusion, or over-sedation.
   b. Monitor closely for serious adverse effects, such as respiratory depression, hypotension, or allergic reactions.
   c. Adjust or discontinue the medication as needed based on patient response and condition.
   d. Document any side effects and adverse reactions, who was notified, interventions, and re-assessments.

Environmental Restraints

1. **Environmental restraints** involve controlling a patient's mobility or access to certain areas by modifying their surroundings. Examples include:
   a. Seclusion Rooms: A specially designed room where a patient can be isolated for safety reasons.
   b. Locked Units: Secure areas in a facility where patient movement is restricted to specific zones.
   c. Lap Belts or Wheelchair Belts: Restraints used to prevent falls or unsafe transfers.
2. **Usage Guidelines and Limitations:**
   a. Use only as a last resort after all other interventions have failed.
   b. Ensure the environment is free from hazards and meets the patient's basic needs, including access to food, water, and hygiene.
   c. Frequently reassess the necessity of the environmental restraint, aiming for the shortest possible duration based on facility protocol.
3. **Monitoring, Reassessment, and Documentation:**
   a. Conduct regular checks to ensure patient safety and emotional well-being.
   b. Document the rationale for the use, duration, and observations of the patient's condition.
   c. Engage in ongoing evaluations to determine if the restraint can be removed or replaced with less restrictive measures.

Releasing Restraints and Post-Restraint Care

Criteria for Removal:

1. Restraints should be removed as soon as the patient demonstrates improved behavior and no longer poses a risk to themselves or others.
2. Evaluate the patient's condition for medical or behavioral stabilization.

Safe Removal Process:

1. Gradually release restraints, monitoring the patient's response throughout.
2. Provide positive reinforcement to encourage self-control and cooperation.
3. Conduct a physical assessment to check for injuries, skin breakdown, or other complications.
4. Offer emotional support to address potential psychological trauma related to restraint use.
5. Hold a debriefing session with the patient, family, and care team to discuss the restraint episode, identify triggers, and develop a plan to avoid future restraint use.

Communication and Patient-Centered Care During Restraint Use

1. **Maintaining Patient Dignity:**
   a. Ensure that restraints are applied and monitored with the patient's dignity in mind.
   b. Minimize discomfort by regularly repositioning the patient and providing comfort measures, such as padding or blankets.
   c. Respect cultural and personal preferences to the greatest extent possible.
2. **Communication with Patients and Families:**
   a. Transparent Dialogue: Explain the reasons for restraint use, expected duration, and steps being taken to ensure safety and comfort.
   b. Emotional Support: Provide reassurance and compassion to reduce the patient's and family's anxiety or distress.

Trauma Informed Care (TIC)

Healthcare professionals, including nurses, nursing assistants, and other staff, are mandated by the Centers for Medicare & Medicaid Services (CMS) to deliver trauma-informed care (TIC) in long-term care facilities. This requirement ensures that residents who are trauma survivors receive culturally competent, trauma-sensitive care that adheres to professional standards of practice. Facilities must consider residents' unique experiences, preferences, and histories to identify and address potential triggers, ultimately aiming to prevent re-traumatization and promote healing.

Trauma-Informed Care Emphasizes:

1. **Realization**: Recognize that trauma and PTSD are common conditions.
2. **Recognition**: Identify residents who have experienced trauma.
3. **Response**: Develop individualized care plans to address triggers and avoid re-traumatization.
4. **Re-traumatization Prevention**: Avoid practices or behaviors that might trigger past trauma, such as physical restraint or loud environments.

While not mandatory in all environments, TIC is recognized as a best practice that helps healthcare teams understand and respond to the effects of trauma. It improves patient outcomes, prevents re-traumatization, and fosters a supportive atmosphere. Adopting TIC also benefits staff by building a culture of empathy, trust, and resilience, making it valuable in any healthcare setting.

What is Trauma?

Trauma is any experience that causes intense psychological or physical stress, often disrupting an individual's sense of safety, control, and well-being. Common examples include abuse, neglect, violence, loss, and medical trauma. Responses to trauma are individual and situational, necessitating a universal application of trauma-informed principles in care delivery.

Adverse Childhood Experiences (ACEs) are defined as potentially traumatic events that occur before the age of 18. These experiences can have lasting negative effects on health, emotional well-being, and social outcomes throughout a person's life. ACEs can disrupt a child's healthy brain development, influence stress response systems, and significantly elevate the risk for chronic conditions, mental health challenges, and social difficulties

Key categories of ACEs include:

1. **Abuse**:
   a. Physical: Infliction of physical harm.
   b. Emotional: Persistent verbal assaults, humiliation, or rejection.
   c. Sexual: Involvement in sexual activities without consent or age-appropriate understanding.
2. **Neglect**:
   a. Physical Neglect: Failure to provide basic needs such as food, shelter, or medical care.
   b. Emotional Neglect: Lack of affection, support, or emotional security.
3. **Household Challenges**:
   a. Parental separation or divorce.
   b. Witnessing domestic violence.
   c. Living with a family member who has mental illness or substance abuse issues.
   d. Having a parent or family member incarcerated.

Medical Trauma is the psychological and emotional distress that arises from medical events, illnesses, or treatments. This type of trauma can occur in various contexts and is influenced by an individual's perception of the event. Individuals experiencing medical trauma may develop anxiety, fear of healthcare environments, or even avoidance behaviors. Recognizing and addressing this trauma is critical to providing empathetic, trauma-informed care.

Common sources of medical trauma include:

1. **Acute Illness or Injury**: Sudden life-threatening events such as strokes, heart attacks, or accidents.
2. **Chronic Illness or Long-Term Treatment**: Ongoing medical management for conditions like cancer, diabetes, or autoimmune diseases.
3. **Invasive Procedures**: Surgery, frequent hospitalizations, or experiences in intensive care units.
4. **Pandemic-Related Experiences**: COVID-19-related trauma, including isolation, grief, and severe illness.

Community Violence refers to exposure to acts of interpersonal violence committed in public areas, often outside the home. This includes witnessing or being a victim of physical assaults, gang activity, shootings, or other unsafe situations within a community. Community violence disrupts a person's sense of safety and security and may result in post-traumatic stress symptoms, hypervigilance, or difficulty trusting others.

Bullying involves repeated, intentional acts of harm or harassment toward an individual, often within a school, workplace, or social setting. This can take the form of verbal, physical, or cyberbullying. Victims of bullying may experience low self-esteem, anxiety, depression, or social withdrawal. When experienced during formative years, both community violence and bullying can disrupt emotional development and increase the risk for mental health disorders.

Older Adults with Neglect or Serious Mental Illness (SMI)

Both neglect and SMI in older adults necessitate trauma-informed, multidisciplinary care to ensure their safety, dignity, and well-being.

1. **Neglect in older adults** refers to the failure of caregivers or family members to meet the basic needs of elderly individuals, such as providing adequate food, medical care, or social interaction. Self-neglect can also occur when an older adult is unable to care for themselves due to physical or mental health challenges. Neglect often results in physical deterioration, social isolation, and feelings of abandonment.
2. **Serious mental illness (SMI)** in older adults encompasses chronic mental health conditions such as schizophrenia, bipolar disorder, or severe depression that significantly impair daily functioning. Older adults with SMI may face compounded challenges due to age-related physical health decline, lack of supportive networks, or stigma surrounding mental illness. Without proper care, this population is at heightened risk for poor health outcomes, homelessness, or abuse.

Important Note: Full disclosure of trauma history may not always be available. Therefore, staff should universally adopt trauma-informed practices to avoid re-traumatization.

Approaches to Patient and Resident Care

Trauma-informed care (TIC) improves patient engagement, health outcomes, and adherence to treatment. It emphasizes building trust, promoting resilience, and ensuring safety and respect. It is a fundamental component of compassionate, high-quality care.

Substance Abuse and Mental Health Services Administration (SAMHSA) Key Principles of Trauma-Informed Care

1. **Safety:** Create physical and emotional safety in interactions and care settings.
2. **Trustworthiness and Transparency:** Build trust through open communication and transparent decision-making.
3. **Peer Support:** Recognize and respect lived experiences of patients and caregivers.
4. **Collaboration and Mutuality:** Level power dynamics and engage patients as active participants in their care.
5. **Empowerment, Voice, and Choice:** Support self-advocacy, shared decision-making, and patient choice.
6. **Cultural, Historical, and Gender Sensitivity:** Avoid stereotypes and address cultural, gender, and historical contexts in care.

Implementation Strategies for Trauma-Informed Care

By integrating trauma-informed principles into daily practice, healthcare staff can ensure care delivery is compassionate, competent, and culturally sensitive.

1. **Resident Assessment**
   a. Use validated screening tools (e.g., Trauma Screening Questionnaire [TSQ]) during admission to identify trauma histories and related needs.
   b. Ensure assessments are conducted in a culturally sensitive manner, respecting individual differences.
   c. Maintain privacy during assessments to foster trust and encourage honest disclosure.

2. **Care Planning**
    a. Develop individualized care plans that incorporate the resident's trauma history, preferences, and potential triggers.
    b. Engage residents in goal-setting and shared decision-making to promote a sense of empowerment and control over their care.
    c. Provide clear and consistent information about care plans, procedures, and expectations.

3. **Environment and Interactions**
    a. **Create a Safe and Respectful Environment:** Maintain physical and emotional safety by ensuring privacy, reducing environmental stressors, and promoting comfort.
    b. **Introduce Yourself and Your Role:** Clearly introduce yourself and your role during every interaction to build trust.
    c. **Communicate Effectively:** Use plain, respectful language, provide anticipatory guidance, and confirm understanding through teach-back methods.
    d. **Adopt a Non-Threatening Approach:** Maintain open, non-threatening body language and avoid using triggering language or behaviors.
    e. **Ask for Consent:** Always ask for permission before initiating physical contact, and ensure residents feel in control of their personal space.
    f. **Anticipate Patient Needs:** Be proactive in addressing potential concerns or anxieties by explaining procedures clearly and addressing questions promptly.

4. **Documentation and Communication**
    a. Document trauma history, triggers, and coping strategies in the care plan to ensure continuity and consistency across the care team.
    b. Use clear, accurate, and person-centered language in all documentation to reinforce transparency and trust.

5. **Interdisciplinary Collaboration**
    a. Collaborate with mental health professionals, social workers, and family members (with resident consent) to provide comprehensive support.
    b. Address cultural, spiritual, and gender-related needs by working with an interdisciplinary team that respects and accommodates the resident's unique experiences and preferences.

6. **Foster Empowerment and Resilience**
    a. Support residents in advocating for themselves and having a voice in their care decisions.
    b. Encourage shared decision-making to help residents regain a sense of control and rebuild resilience.
    c. Remain calm under stress and provide reassurance during challenging situations to create a sense of stability and trust.

Pain Management

Pain is a multifaceted and subjective experience that significantly affects patients' quality of life and recovery processes. Effective pain management is a cornerstone of nursing care, aiming to alleviate suffering and enhance functional outcomes. Pain is generally classified into three categories:

1. **Acute Pain**: Short-term pain that typically follows injury or surgery and resolves as healing occurs.
2. **Chronic Pain**: Persistent pain lasting beyond the usual course of acute illness or injury, often exceeding three to six months.
3. **Procedural Pain**: Pain associated with medical procedures or interventions.

Pain Assessment

Accurate pain assessment is crucial for developing effective pain management strategies. Nurses play a pivotal role in evaluating pain using standardized tools to ensure precise measurement and monitor treatment outcomes.

Common Pain Assessment Tools:

1. **Numeric Rating Scale (NRS)**: Patients rate their pain on a scale from 0 (no pain) to 10 (worst imaginable pain).
2. **Visual Analog Scale (VAS)**: A 10 cm line where patients mark a point representing their pain intensity.
3. **Facial Expressions:**
    a. **The Wong-Baker Scale** assesses pain in individuals aged **3 years and older** using facial expressions and verbal descriptors, including smiling faces.
    b. **The FPS-R** is used to assess pain intensity in individuals aged **4 years and older**, focusing solely on facial expressions without smiling faces.
4. **FLACC Scale (Face, Legs, Activity, Cry, Consolability):** Based on observable behaviors such as facial grimacing, restlessness, and crying in babies and young children.
5. **Modified FLACC Scale:** Adapted to better assess pain in individuals with **cognitive or developmental disabilities**, who may exhibit atypical pain behaviors.

Frequency of Pain Assessment

Regular pain assessments are essential to monitor changes and evaluate the effectiveness of interventions. The frequency of assessments should be individualized based on patient/resident needs and clinical settings.

Generally, pain should be assessed:

1. **At regular intervals** as specified by clinical guidelines or medical orders (e.g., every 4 to 8 hours).
2. **Before and after administering pain-relief interventions** to evaluate effectiveness.
3. Whenever there is a **change in the patient's condition** or reports of new pain.
4. Reassessment after pain interventions should occur at intervals appropriate to the intervention's onset of action:
    a. **Oral medications**: Reassess approximately 45 to 60 minutes post-administration.
    b. **Intramuscular injections**: Reassess about 30 minutes after administration.
    c. **Intravenous medications**: Reassess within 15 minutes post-administration.

Pain Management Interventions

A multimodal approach, combining pharmacological and non-pharmacological interventions, is often the most effective in managing pain.

Non-Pharmacological Interventions

1. **Physical Methods**: Application of heat or cold packs, massage therapy, and transcutaneous electrical nerve stimulation (TENS) can alleviate musculoskeletal pain.
2. **Cognitive-Behavioral Techniques**: Relaxation exercises, guided imagery, and distraction techniques help patients manage pain perception.
3. **Interventional Procedures:** Techniques such as nerve blocks and epidural injections may be considered for certain pain conditions that are complex or severe, often in collaboration with specialized pain management teams.

Pharmacological Interventions

Medication Category	Use	Common Side Effects	Serious Side Effects
Non-Opioid Analgesics			
Acetaminophen (Tylenol)	Mild to moderate pain	Generally well-tolerated; occasional nausea	Hepatotoxicity (risk increases with >4,000 mg/day)
Ibuprofen, Naproxen	Pain with inflammation	Gastrointestinal upset (nausea, dyspepsia)	Gastrointestinal bleeding, cardiovascular events, renal impairment
Opioid Analgesics			
Morphine, Oxycodone	Moderate to severe pain	Drowsiness, nausea, constipation, dizziness	Respiratory depression, dependence, potential for misuse. (Note can be short or long-acting formulations
Adjuvant Medications			
Antidepressants Amitriptyline, Duloxetine	Neuropathic pain	Dry mouth, drowsiness, weight gain, sexual dysfunction	Increased risk of suicidal thoughts in young adults, serotonin syndrome (rare but serious)
Anticonvulsants Gabapentin, Pregabalin	Neuropathic pain	Dizziness, fatigue, peripheral edema, weight gain	Severe hypersensitivity reactions, misuse potential, respiratory depression (when combined with opioids)
Topical Agents Lidocaine, Capsaicin	Localized neuropathic or musculoskeletal pain	Mild skin irritation, redness	Allergic reactions, systemic toxicity (rare, with overuse of lidocaine patches)

Tolerance, Dependence, Addiction, and Withdrawal

Effective pain management in patients with substance use disorders (SUDs) requires understanding the distinctions between tolerance, physical dependence, addiction, and withdrawal.

1. **Tolerance** refers to a physiological state where repeated use of a drug leads to reduced effectiveness, necessitating higher doses to achieve the same effect. This is a normal adaptation and does not, by itself, indicate addiction.
2. **Physical Dependence** is characterized by the body's adaptation to a drug, leading to withdrawal symptoms if the drug is abruptly discontinued. Like tolerance, physical dependence is a physiological response and is not synonymous with addiction.
3. **Addiction or Substance Use Disorder** is a complex condition marked by compulsive drug seeking and use despite harmful consequences. It involves psychological and behavioral components, including impaired control over drug use, craving, and continued use despite negative outcomes.
4. **Withdrawal** encompasses the symptoms that occur when a dependent individual reduces or stops drug use. Symptoms can range from mild (e.g., anxiety, sweating) to severe (e.g., seizures), depending on the substance and level of dependence.

Special Considerations

Managing pain in patients with substance use disorders necessitates a balanced approach to provide relief while minimizing the risk of misuse. Cultural beliefs and individual differences significantly influence pain perception and expression; thus, culturally sensitive care is essential. Ethical considerations include respecting patient autonomy and ensuring equitable access to pain management resources.

Documentation and Communication

Thorough documentation of pain assessments, interventions, and patient responses is vital for continuity of care. Clear communication among healthcare providers, patients, and families ensures that pain management plans are understood and effectively implemented.

Pressure Injury Prevention and Management

Risk Identification and Assessment

1. **Policy Adherence**: All staff must strictly adhere to the hospital or facility's policies and protocols for identifying, preventing, and managing pressure injuries.
2. **Initial Assessment**: Nurses should perform a systematic risk assessment upon admission to identify patients or residents at risk of developing pressure injuries. This assessment should incorporate validated risk assessment tools, such as:
    - Braden Scale for Predicting Pressure Sore Risk
    - Norton Scale

3. **Ongoing Assessment**: Nursing should conduct skin, pressure injury, and wound assessments at regular intervals as specified by facility policy or whenever a patient's condition changes.
    - Conduct scheduled skin assessments weekly, following facility guidelines.
    - Evaluate high-risk areas or established pressure injuries or wounds daily, unless directed otherwise by the wound specialist or healthcare provider.

4. **Pressure Injury and Wound Assessments**: All assessments should align with facility protocols and include:
    - Measuring wound size and depth (admission, weekly, new wound/injury, or worsening changes).
    - Evaluating exudate, wound edges, and surrounding skin (daily).
    - Checking for signs of infection or healing progress (daily).

5. **Documentation and Intervention**: Document all findings promptly and implement appropriate preventive measures if risks are identified. To ensure timely and effective management.

Preventive Strategies

1. **Skin and Tissue Management**
    - Inspect skin daily, focusing on bony prominences and areas of increased pressure.
    - Keep skin clean, dry, and moisturized to maintain integrity.
    - Use pH-balanced cleansers and avoid harsh soaps.
2. **Minimize Mechanical Forces**
    - Reduce friction and shear by proper handling techniques (e.g., using lift devices instead of dragging).
    - Avoid tight or poorly fitting clothing; inspect for buttons, zippers, and seams that may cause localized pressure.
3. **Repositioning and Offloading**
    - Reposition patients every 1–2 hours for bedbound individuals.
    - For those in chairs or wheelchairs, shift weight every 15 minutes if feasible.
    - Avoid raising the head of the bed above 30 degrees to reduce sliding and shear forces.
    - Use pillows or wedges to support body alignment and prevent direct pressure on bony areas.
4. **Support Surfaces**
    - Utilize specialized mattresses or overlays (e.g., foam, air, or gel) for at-risk patients.
    - Confirm proper function and maintenance of support surfaces regularly.

- If a resident or patient requires specialized equipment to prevent or facilitate the healing of pressure injuries, promptly consult the nurse or medical team to obtain the proper evaluation and treatment orders.

Stages of Pressure Injuries

Pressure injuries are classified into stages based on their severity, depth, and tissue involvement.

Pressure Injury Stage or Type	Description
Stage 1: Non-Blanchable Erythema of Intact Skin	Skin appears red or discolored and does not blanch when pressure is applied. The affected area may feel warm, firm, or painful.
Stage 2: Partial-Thickness Skin Loss with Exposed Dermis	Presents as an open wound or blister with partial-thickness loss of skin. The wound bed is pink or red and moist, with no visible slough or eschar.
Stage 3: Full-Thickness Skin Loss	Full-thickness loss of skin with visible subcutaneous tissue. May include slough, eschar, or tunneling. Bone, tendon, or muscle are not exposed
Stage 4: Full-Thickness Skin and Tissue Loss	Full-thickness loss with exposed muscle, tendon, or bone. Often includes slough, eschar, and tunneling. Risk of osteomyelitis is high.
Unstageable: Obscured Full-Thickness Skin and Tissue Loss	Wound is covered by slough or eschar, obscuring the wound bed and depth. Cannot be staged until the wound bed is visible.
Deep Tissue Injury: Persistent Non-Blanchable Deep Red, Maroon, or Purple Discoloration	Results from intense or prolonged pressure and shear. May present as intact or non-intact skin with underlying soft tissue damage.

Pressure Injury Management

1. **Immediate Treatment**: Nursing should notify the medical team to obtain treatment orders as soon as a pressure injury is identified, adhering to evidence-based practices and facility protocols. If nursing assistants or healthcare staff notice signs of a wound or pressure injury during their care of a resident or patient, they should also notify the nurse immediately.
2. **Comprehensive Documentation**: Ensure to record the following details in the nursing assessment:
    d. Prevention strategies implemented
    e. Wound characteristics - e.g., size, depth, exudate, and stage
    f. Photographs - strictly following facility policy, if allowed (and never on the IP's personal device).
    g. Ongoing treatment plan
3. **Collaborative Care** Involve multidisciplinary teams, including wound care specialists, dietitians, and physical therapists, to address all contributing factors.
4. **Nutritional Support**
    a. Adequate Nutrition and Hydration: Encourage a diet rich in protein, vitamins (e.g., Vitamin C), and minerals (e.g., zinc) to support tissue repair and maintenance per medical orders.
    b. Hydration: Maintain adequate fluid intake to promote skin elasticity and overall health.
5. **Patient and Family Education** - Clinicians should educate patients and caregivers about the importance of repositioning, skin care, and nutritional support.

Reporting Suspected Abuse & Neglect

Mandated Reporting

Mandatory reporting laws require healthcare workers to report suspected or confirmed abuse or neglect of vulnerable populations to state or local authorities. These laws typically apply to children, individuals with

disabilities, and the elderly. Some states also extend mandatory reporting to include intimate partner violence (IPV) or abuse. These laws cover various forms of mistreatment, such as physical, sexual, emotional, financial abuse, and neglect.

IntelyPros must be familiar with the abuse and mandatory reporting laws of the states they work in. Each state has its own policy and law governing the definitions of what is reportable and the reporting requirements.

IntelyCare's Policy on Suspected Abuse, Neglect or Exploitation.

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

Suspected abuse, neglect and/or exploitation should also be reported directly to the Nurse Manager/Nurse Director/Charge Nurse and should follow state and facility reporting procedures.

To effectively identify and report abuse, it is essential for healthcare professionals to understand the unique signs and characteristics associated with different vulnerable populations. The following sections will provide a high-level overview the different types of abuse and warning signs for children, intimate partners, and the elderly.

Children

Abuse and neglect in children ages 18 years and under is a critical public health issue. It is estimated that one in eight children will experience some form of mistreatment before reaching adulthood. Homicide remains among the top five causes of death across all pediatric age groups. The impact of childhood abuse can extend into adulthood with long-term physical and psychological conditions.

Type of Abuse and Definition	Child Abuse Symptoms/Warning Signs
Physical Abuse Intentional use of physical force that can result in physical injury. Examples include hitting, kicking, shaking, or other shows of force against a child.	- Unexplained injuries such as bruises, broken bones, or burns - Injuries that don't match the explanation - Injuries incompatible with the child's developmental ability
Emotional Abuse involves harming a child's self-worth or mental health. This includes verbal or emotional attacks, such as persistent criticism or ridicule, as well as behaviors like isolating, neglecting, or rejecting the child.	- Delayed or inappropriate emotional development - Loss of self-confidence or self-esteem - Social withdrawal or loss of interest - Depression or anxiety - Avoidance of certain situations (e.g., refusing to go to school) - Desperately seeking affection - Decrease in school performance - Regression of developmental skills
Sexual Abuse is any sexual activity involving a child. This may involve physical contact, such as sexual touching, oral-genital contact, or intercourse. It can also include non-contact abuse, such as exposing a child to sexual acts or pornography, filming or observing a child in a sexual context, sexual harassment, or exploiting a child through prostitution or sex trafficking	- Sexual behavior or knowledge inappropriate for the child's age - Pregnancy or sexually transmitted infections - Genital or anal pain, bleeding, or injury - Child reports sexual abuse - Inappropriate sexual behavior with other children
Neglect Failure to meet a child's basic physical and emotional needs, including housing, food, clothing,	- Poor growth or excessive weight with unaddressed medical issues - Poor personal hygiene - Lack of clothing or supplies to meet physical needs - Hoarding or stealing food

Type of Abuse and Definition	Child Abuse Symptoms/Warning Signs
education, access to medical care, and emotional support.	- Poor school attendance - Lack of appropriate medical, dental, or psychological care - Lack of necessary follow-up care
General Symptoms of Abuse - An abused child may feel guilt, shame, or confusion and may hesitate to disclose the abuse, particularly if the abuser is a trusted individual. These are general signs that **may** indicate abuse.	- Withdrawal from friends or activities - Changes in behavior (aggression, anger, hostility, hyperactivity) - Depression, anxiety, or unusual fears - Sleep problems or nightmares - Rebellious or defiant behavior - Self-harm or suicide attempts

Intimate Partner

Intimate partner violence (IPV) is a pervasive yet sometimes overlooked form of abuse. Nearly one in three women will experience IPV at some point in their lives. Although women are the primary victims, IPV also affects men, with approximately 17% of IPV victims are male. Healthcare professionals play a vital role in identifying and addressing this form of abuse to prevent further harm.

Definition	IPV Warning Signs
Physical Violence- Intentional use of physical force to cause harm or injury.	Unexplained injuries, frequent visits to healthcare facilities, inconsistent explanations of injuries, and partner's overly controlling behavior during medical visits.
Emotional Abuse - Behaviors that undermine self-worth, such as insults, humiliation, or intimidation.	Patient appears anxious, fearful, or withdrawn; difficulty making decisions independently; and reports of feeling "worthless" or "stupid."
Sexual Violence -Forcing a partner to engage in sexual acts without consent.	Unexplained genital or rectal injuries, sexually transmitted infections, reports of being pressured or coerced into sex, and hesitation to discuss sexual history.
Economic Abuse Controlling a partner's financial resources or access to economic independence.	Patient may lack access to money, has no control over personal finances, mentions inability to buy necessities, or describes their partner as overly controlling about finances.
Economic Abuse - Causing emotional distress through threats, manipulation, or isolation.	Patient displays excessive fear of displeasing their partner, describes isolation from friends or family, and reports threats or manipulation.
Digital Abuse - Using technology to stalk, harass, or control a partner.	Patient mentions their partner constantly monitors phone or social media, receives excessive texts or calls, or feels unable to use technology freely.
Stalking -Repeated, unwanted attention or harassment causing fear or emotional distress.	Patient reports feeling followed, watched, or harassed; describes unwanted gifts or messages; and exhibits fearfulness when discussing their partner or ex-partner.

Elderly

Abuse and neglect among the elderly is a significant issue, affecting an estimated 10% of individuals aged 60 and older. Factors such as poor physical health, functional limitations, and living in institutional settings, including nursing homes, increase the likelihood of elder abuse. Elder abuse often goes unreported, making it one of the most under-recognized forms of mistreatment.

Type of Abuse	Elder Abuse Symptoms/Warning Signs
Physical Abuse - Inflicting bodily harm through actions such as hitting, pushing, slapping, or restraining an elder against their will.	- Bruises, welts, black eyes, or lacerations - Bone fractures or untreated injuries - Rope marks, signs of restraint - Behavioral changes - Medication overdose or underuse - Caregiver refusal to allow visitors alone -Elder reports verbal mistreatment
Emotional/ Psychological Abuse - Using verbal threats, yelling, humiliation, or isolation to harm an elder's emotional well-being	- Agitation, depression, or withdrawal - Personality changes (e.g., excessive apologizing) - Unusual behaviors (e.g., rocking, biting) - Controlling caregiver behavior - Caregiver prevents contact between elder and loved ones - Elder reports verbal mistreatment
Sexual Abuse - Forcing an elder to participate in or watch sexual acts against their will.	- Bruises near genital areas - Unexplained STIs or infections - Vaginal or anal bleeding - Bloodstains on sheets - Fearfulness around specific individuals - Elder reports sexual assault
Financial Exploitation - Misusing an elder's money, assets, or property, often through theft, fraud, or manipulation.	- Sudden bank account changes - Unexplained asset transfers - Forged signatures - Missing valuables - Unpaid bills despite adequate resources - Elder reports financial abuse
Neglect* **-** Failing to meet an elder's basic needs, including food, shelter, healthcare, and hygiene. **Abandonment*** **-** Deserting an elder who needs care, often without making arrangements for their well-being	- Malnutrition, dehydration, or untreated sores - Poor personal hygiene - Unsafe or unsanitary living conditions - Unattended medical needs - Elder left in a public place (e.g., hospital, store) - Lack of food or basic necessities - Unsafe environment (e.g., no heat or water) - Elder reports neglect or abandonment - * Signs for neglect or abandonment can overlap

Safe Patient/Resident Handling Guidelines

Ensuring safe patient/resident handling is crucial to minimize injury risks for both patients/residents and healthcare workers. Adhering to established guidelines and utilizing appropriate assistive devices enhances safety, comfort, and dignity during transfers.

General Safe Handling Guidelines

1. **Assess the Patient/Resident:**
   a. Review the care plan for any physical limitations, injuries, or specific assistance needs.
   b. Determine the patient's/resident's ability to assist and their level of cooperation.
   c. Avoid using a lift if the patient/resident is agitated or combative; consult the medical team for alternatives.
2. **Prepare the Environment:**
   a. Ensure all equipment is in good working condition.
   b. Confirm that sufficient staff is available for the transfer.
   c. Lock wheels on wheelchairs, beds, or stretchers during transfers to prevent movement.
3. **Use Appropriate Assistive Devices:**

a. Select devices based on the patient's/resident's weight-bearing ability and cognitive function.
b. Seek guidance if unsure about the appropriate device.
c. Always have at least two caregivers present for lifts and transfers.

4. **Communicate Effectively**:
   a. Discuss the transfer plan with all involved staff before handling the patient/resident.
   b. Clearly explain the procedure to the patient/resident to ensure understanding and cooperation.
5. **Maintain Proper Body Mechanics**:
   a. Keep the patient/resident close to your body during transfers.
   b. Maintain a straight back and lift using your legs to reduce strain.
   c. Avoid lifting with extended arms or excessive reaching.
6. **Seek Assistance When Necessary**:
   a. If unable to safely move the patient/resident, request additional help.
   b. After a fall, ensure a licensed professional assesses the patient/resident before moving them.
7. **Respect Patient/Resident Autonomy**:
   a. Honor the patient's/resident's right to refuse care.
   b. Address any discomfort promptly and involve additional caregivers if necessary to ensure safety.

Assistive Devices for Transfers

Selecting the appropriate assistive device is essential for safe and efficient patient/resident transfers. The choice depends on the patient's/resident's physical and cognitive abilities.

Device Type	Details	Best For
Total Mechanical Lift	- Provides full support for non-weight-bearing patients/residents. - Used for supine-to-seated or seated-to-seated transfers.	- Patients/residents with no weight-bearing ability or those requiring full assistance for transfers.
Sit/Stand Mechanical Lift	- Facilitates seat-to-seat transfers for patients/residents with partial weight-bearing capability. - Requires good cognitive function and ability to sit and balance at the edge of the bed.	- Patients/residents with partial weight-bearing ability and sufficient cognitive function.
Hammock Slings	Special Slings that can be used with lifts: - **Cross-Through Method**: Anchors the patient/resident securely. - **Cradle Method**: Suitable for patients/residents with lower extremity amputations or discomfort with the cross-through method.	- Cross-Through: Most patients/residents. - Cradle: Patients/residents with amputations or specific comfort needs.

Procedures for Using Assistive Devices

IMPORTANT

ALL Mechanical Lifts Require a MINIMUM of 2 (two) Healthcare Workers to Operate.

IntelyPros are strictly prohibited from using manual lift alone due to the serious risk of harm or injury, including death, to the patient/resident.

Total Mechanical Lift

Category	Steps
Preparation	1. **Ensure two caregivers are present, each with hands on the lift.** 2. Adjust the bed height to promote proper body mechanics. 3. Inspect the sling for wear or damage; do not use if damaged.
Positioning	1. Place the patient/resident on the appropriate sling. 2. Position the lift with its base open, aligning the spreader bar perpendicular to the patient's/resident's shoulders and hovering above the chest.
Transfer	1. Attach the sling straps securely without pulling or tugging. 2. Verbally prepare the patient/resident for the transfer. 3. Gently raise the patient/resident slightly off the surface. 4. Turn their legs toward the perpendicular support bar during the move. 5. Gently lower the patient/resident into the chair. 6. Remove the sling once the patient/resident is securely seated.
IMPORTANT	1. **A minimum of two (2) caregivers must be present to operate the lift.** 2. A licensed professional must assess any patient/resident who is on the ground before moving them. 3. Use a full mechanical lift for patients/residents being moved off the ground.

Sit/Stand Mechanical Lift

Category	Steps
Preparation	1. **A minimum of 2 (two) caregivers must be present to operate the lift.** 2. Apply the harness snugly around the patient's/resident's lower back, securing inner belts. 3. Use leg straps if applicable.
Positioning	1. Position the lift with the base open and facing the patient/resident. 2. Instruct/assist the patient/resident to place their feet on the lift's footplate. 3. Attach the harness straps to the lift without pulling or tugging. 4. Instruct/assist the patient/resident to grasp the handles on the lift with their arms outside the harness.
Transfer	1. Close the lift's base legs before moving the patient/resident; do not move the lift with the legs open. 2. Verbally prepare the patient/resident for the transfer. 3. Assist the patient/resident to lean back into the harness while gently lifting them slightly off the surface. 4. Transfer the patient/resident to the new surface.
IMPORTANT	**A minimum of 2 (two) caregivers must be present to operate the lift.**

Walking Aids

Walking aids, when used correctly, play a vital role in enhancing the mobility and overall well-being of patients/residents. *These devices improve stability, facilitate smoother walking, and promote greater independence*, enabling individuals to perform daily activities with increased confidence and ease. Proper usage empowers patients/residents to regain control of their movement and maintain their quality of life.

IMPORTANT: Patients/residents with abnormal gait or ill-fitting walking aids are at high fall risk. ***Consult the medical team for a physical therapy (PT) evaluation to assess and recommend the best device IF a walking aid has not been already prescribed.***

Canes

Canes are essential mobility aids designed to enhance stability, balance, and independence for patients/residents. This section outlines the types of canes, proper fit, safety basics, and instructions for walking, navigating steps, and using stairs safely.

Type	Details	Best For
Single-Point Canes	- Used for early balance problems. - Minor assistance or minimal unweighting of the opposite leg.	Patients with mild balance or weight-bearing issues.
Four-Point Canes	- Rectangular base with four supports. - Provides more stability than single-point canes.	- Hemiplegia. - Paresis of an arm, leg, or both. - Greater stability needs.

Task	Steps
Proper Fit for Canes	1. Patient/resident wears normal shoes. 2. Arm hangs loosely at the side. 3. Measure the distance from the wrist to the floor (should equal the distance from the hip socket to the floor). 4. Adjust the cane height so its top matches the measured distance. 5. Ensure a 20 to 30-degree elbow bend when holding the cane.
Cane Safety Basics	1. Wear nonskid shoes or slippers. 2. Hold the cane opposite the injury, pain, or weakness (unless otherwise instructed). 3. Ensure the cane tip or prongs are firmly on the ground before applying weight. 4. Avoid placing the cane too far ahead to prevent slipping. 5. Use a chair with armrests when sitting or standing.
Walking with a Cane	1. Stand firmly with a grip on the cane. 2. Move the cane and weaker leg forward together. 3. Place weight on the cane to reduce pressure on the weaker leg. 4. Step past the cane with the strong leg. 5. Repeat until the destination is reached.
Navigating Steps/Curbs (Going Up)	1. Step up with the strong leg. 2. Bring the cane and weaker leg to meet the strong leg. 3. Use the cane for balance.
Navigating Steps/Curbs (Going Down)	1. Place the cane on the lower step. 2. Step down with the weaker leg first, using the cane for support. 3. Bring the stronger leg to meet the weaker leg.
Using a Cane on Stairs (Going Up)	1. Hold the handrail and use the cane in the opposite hand. 2. Step up with the strong leg. 3. Bring the weaker leg and cane to the same step. 4. Pause for balance if needed.
Using a Cane on Stairs (Going Down)	1. Hold the handrail and use the cane in the opposite hand. 2. Place the cane on the lower step. 3. Step down with the weaker leg. 4. Bring the stronger leg to the same step. 5. Pause for balance if needed.

Crutches

Crutches are essential mobility aids designed to provide support and stability for patients/residents with temporary or long-term mobility challenges. This section outlines the different types of crutches, their best uses, and instructions for use.

IMPORTANT: Age may contraindicate crutch use due to coordination or strength limitations. ***Consult the medical team with any concerns about crutch safety***

Crutch Type	Description

– Best for temporary mobility support and with good arm strength.	- Common and best for short-term use. - Transfers most body weight to arms and torso. - Not ideal for those with wrist issues, weak upper body, or poor coordination. - Crutches should be 1–2 inches below the armpits, with handgrips aligned at the hip line, creating a slight elbow bend. - Weight rests on hands, not underarms, to avoid nerve damage.
Forearm (Lofstrand) – Best for long-term mobility needs and sufficient upper body strength.	- Better for long-term use. - Transfers weight to upper arms. - Requires good upper body strength. - Cuff height should be 3 fingers below the elbow.
Platform – Best for severe neurological disabilities or minimal arm stability.	- Designed for patients/residents needing weight transfer to arms. - More stable but less maneuverable than other crutches. - Suitable for severe neurological disabilities with decreased stability.

Using Crutches	Steps
Walking with Crutches	1. Move both crutches forward about 18 inches. 2. Swing forward, keeping weight off the injured leg. 3. Absorb weight on crutch handles, not underarm supports. 4. Take short steps and rest as needed.
Navigating Stairs with Crutches (Going Upstairs)	1. Place crutches on ground level. 2. Step up with the uninjured leg. 3. Bring crutches to the next step.
Navigating Stairs with Crutches (Going Downstairs, Weight Bearing)	1. Place crutches on the next lower step. 2. Step down with the weaker leg. 3. Quickly bring down the uninjured leg.
Navigating Stairs with Crutches (Going Downstairs, Non-Weight Bearing)	1. Hold crutches on the next lower step. 2. Keep injured leg forward. 3. Hop down with the uninjured leg.
Standing Up with Crutches	1. Hold both crutches in the hand on the injured side. 2. Use the other hand to push off the chair.
Sitting Down with Crutches	1. Lower into the chair slowly, holding crutches on the injured side. 2. Keep crutches within reach.

Walkers

Walkers are widely used mobility aids that provide stability and support for patients/residents with balance or strength impairments. This section outlines the various types of walkers and provides instructions for their safe use to promote independence and reduce fall risks.

Type of Walker	Description
Standard Walker - Best for significant balance issues and sufficient upper body strength.	- Most stable type of walker. - Four legs with nonskid rubber tips to prevent slipping. - Requires lifting to move forward.
Two-Wheel Walker - Best for with poor upper body strength who need moderate stability.	- Two wheels on the front legs, nonskid tips on the back legs. - Does not require lifting to move forward, reducing energy use.
Four-Wheel Walker (Rollator) - Best for high-functioning persons needing light support and rest breaks due to poor endurance.	- Four wheels for smooth movement. - May include brakes, a seat, and a basket. - Least stable of all walkers; can slide if brakes are not set.

Using a Walker	Steps
Walker Basics	1. Wear nonskid shoes or slippers. 2. Ensure rubber grips are secure on the walker to prevent slipping. 3. Front-wheeled walkers must have nonskid tips on the back legs. 4. Do not use walkers on stairs (contraindicated). 5. Look forward while walking, not at the feet.

	6. Take your time; it may take time to get used to the walker.
Walking with a Walker	1. Stand with toes halfway between the front and back legs of the walker. 2. Roll or lift the walker a step's length ahead. 3. Place the walker firmly on the ground. 4. Lean slightly forward and hold the walker for support. 5. Step forward with one leg, then the other leg to meet it. 6. Repeat the cycle.
Standing Up with a Walker	1. Position the walker in front of the chair. 2. Push off the chair using the armrests (not the walker handles). 3. Grasp the walker handles once standing and steady yourself before walking.
Sitting Down with a Walker	1. Position the walker directly in front of the chair. 2. Back up to the chair until the backs of the legs touch it. 3. Reach for the armrests and lower yourself slowly into the chair, keeping the walker in front for stability.

Additional Transfer and Repositioning Devices

Lateral Transfers			
Device	**Purpose**	**When to Use**	**Points to Remember**
Draw Sheets, Transfer Cots, Slippery Sheets, Boards/Mats with Vinyl Coverings and Rollers, Air-Assist Lateral Sliding Aid, Slide Boards, etc.	To reduce friction force when transferring a resident.	Transferring a partial- or non-weight bearing resident between 2 horizontal surfaces such as bed to stretcher or gurney while lying on their back.	**More than one caregiver needed;** not suitable for bariatric residents; use devices with handles; ensure surfaces are at the same level; synchronize the transfer motion between caregivers.
Convertible wheelchair, Geri or cardiac chair to bed; beds that convert to chairs	To perform lateral transfer without lifting the resident in and out of wheelchairs.	For residents who are partial- or non-weight bearing; aids in repositioning totally dependent or very heavy residents.	**More than one caregiver needed**; motorized height adjustment preferred; ensure device is in good working order; lock wheels; adjust device to waist height to avoid back strain.
Transfer boards – wood or plastic (some with movable seat	To transfer residents with good sitting balance from one surface to another.	For transferring residents from bed to wheelchair, wheelchair to car seat or toilet, and for residents needing additional safety support.	**More than one caregiver needed;** use a cushion/towel for comfort; Ensure clothing is present between the resident's skin and device. Combine with gait belts if needed; ensure wheels are locked and transfer surfaces are at the same level.

Scale Transfers			
Device	**Purpose**	**When to Use**	**Points to Remember**
Scales with Ramp, Built-in Bed Scales	To reduce the need for additional transfer of residents to weighing device.	For partial- or non-weight bearing, or totally dependent residents.	Some wheelchair scales can accommodate larger wheelchairs; built-in bed scales may increase the weight of the bed and prevent it from lowering to appropriate work heights.

Transfer from Sitting to Standing Position			
Device	**Purpose**	**When to Use**	**Points to Remember**
Lift Cushions and Lift Chairs	To assist residents who need help standing and ambulating.	For weight-bearing, cooperative residents that have the physical and cognitive capacity to operate lever or controls	Always ensure device is in good working order before use and is rated for the resident weight to be lifted. Lift cushions may not be suitable for heavier residents;
Stand-assist devices (fixed to bed or chair or be free-standing)	To help residents pull themselves up from sitting to standing position.	For residents who are weight-bearing, cooperative, and can pull themselves up. Independent residents who need an extra boost to stand	Ensure the device is stable and rated for the resident's weight; check attachment stability; can aid resident independence.

Repositioning			
Device	**Purpose**	**When to Use**	**Points to Remember**
Electric Powered Height Adjustable Bed	To reduce caregiver bending during resident care, transfer, and repositioning activities.	For all activities involving resident care, transfer, repositioning in bed, etc.	Device should have easy-to-use controls within reach; ensure the bed is adjustable within 20 seconds; beds that lower closer to the floor may be needed for fall-prone residents; beds raised and lowered by an electric motor are preferred over crank-adjust beds.
Trapeze Bar, Hand Blocks, Push-Up Bars	To help residents with upper body strength reposition themselves.	For residents with upper body strength who can assist in repositioning themselves in bed.	Ensure bed wheels are locked, bedrails are lowered, and bed is adjusted to caregiver's waist height; heavy-duty trapeze frames are available for bariatric residents; can aid resident independence.
Pelvic Lift Devices (Hip Lifters)	To assist residents in toileting with minimal lifting.	To assist cooperative residents who can sit up to a position on a special bedpan.	Use correct body mechanics, lower bedrails, and adjust the bed to caregiver's waist height to reduce bending.

Bathing, Showering, and Toileting			
Device	**Purpose**	**When to Use**	**Points to Remember**
Height Adjustable Bathtub	To assist residents in bathing and to reduce awkward postures for caregivers.	For bathing residents who sit directly in the bathtub or need help climbing into a low or easy-access tub.	Adjust the tub to the caregiver's waist height; reduces caregiver bending and reaching; increases resident safety and comfort.

Bathing, Showering, and Toileting			
Device	**Purpose**	**When to Use**	**Points to Remember**
Shower and Toileting Chairs	To assist partially dependent residents with bathing and toileting.	For showering and toileting residents who have some weight-bearing capacity, can sit up unaided, and are able to bend hips, knees, and ankles.	Ensure chair moves smoothly; chair is high enough to fit over the toilet; has removable arms, adjustable footrests, safety belts; ensure brakes lock effectively and weight capacity is sufficient.
Toilet Seat Risers	To assist residents with toileting by reducing the effort required to lower/raise themselves.	For partially weight-bearing residents who can sit up unaided and have upper body strength.	Ensure the riser is stable and can accommodate the resident's weight and size; grab bars and height-adjustable legs add safety and versatility.
Bath Boards and Transfer Benches	To assist residents in bathing by providing support during transfers.	For bathing residents who are partially weight-bearing, have good sitting balance, can use upper extremities, are cooperative, and can follow instructions.	Ensure the board has height adjustable legs; may not be suitable for heavy residents; can be used with gait or transfer belts and/or grab bars.
Grab Bars and Stand Assists	To provide additional support and security during bathing, showering, and toileting.	For residents who are partially weight-bearing, can use upper extremities, and are cooperative.	Ensure bars are securely fastened to walls before use; long-handled devices reduce bending, reaching, and twisting required by the caregiver.
Height Adjustable Shower Gurney or Lift Bath Cart	To assist non-weight bearing residents with bathing.	For bathing non-weight bearing residents who are unable to sit up.	Transfer resident to the cart using lift or lateral transfer devices; ensure the cart is power-driven to reduce force required to move and position it; may not be suitable for bariatric residents.
Built-in or Fixed Bath Lifts	To assist partially weight-bearing residents with bathing where space is limited.	For bathing residents who have good sitting balance, can use upper extremities, are cooperative, and can follow instructions.	Ensure the lifting device is in good working order and rated for the resident's weight; seat should easily rotate and lower the resident into the water.

Gait Belts/Transfer Belts

Gait belts/transfer belts with handles assist healthcare workers with resident/patient transfer such as bed-chair, chair-chair, or chair-car; repositioning in chairs; ambulation support; and in some cases, guiding/controlling falls or assisting **a resident after a fall.**

1. The patient/resident must be partially dependent, have some weight-bearing capacity, and are cooperative.
2. **More than one caregiver may be needed**.
3. Belts with padded handles are easier to grip and increase security and control.
4. Always transfer to resident's strongest side.
5. Use good body mechanics and a rocking and pulling motion rather than lifting when using a belt.

6. Belts may not be suitable for ambulation of heavy residents or residents with recent abdominal or back surgery, abdominal aneurysm, etc.
7. Should not be used for lifting residents.
8. Ensure belt is securely fastened and cannot be easily undone by the resident during transfer and a layer of clothing is between residents' skin and the belt (to avoid abrasion).
9. Lower bedrails, remove arms and footrests from chairs, and other items that may obstruct the transfer.
10. Keep back straight, bend legs, and stay as close to resident/patient as possible.
11. For use after a fall, always assess the patient/resident for injury prior to movement. If resident can regain standing position with minimal assistance, use gait or transfer belts with handles to assist them.

REFERENCES

Available Upon Request