



Staff Relief Inc.

JCAHO MANDATORY ANNUAL INSERVICES

	MO____ ____	MO____ ____	MO____ ____	MO____ ____
1. Fire Safety in a Health Care Facility				
2. Electrical Safety in a Health Care Facility				
3. Patient Lifting, Moving, Restraints				
4. Universal Precautions				
5. Yearly National Safety Goals				
6. About Hazardous Materials				
7. Infection Control				
8. About Blood Borne Pathogens, Hepatitis, AIDS				
9. HIPPA				
10. Age Appropriate Care				
11. N95 Respirator Fitting and Training				
12. Cultural Diversity and Sensitivity				

Signature of Employee

Signature of Witness

Please print page 1 and return to Staff Relief Offices

Lifting and Moving Patients

1. Lifting and moving patients exposes your back to potential injury everyday
2. Your posture does play a role in hurting your back
3. Good body mechanics include bending your knees and moving your torso as one solid unit
4. Assistive devices in transferring patients include draw sheets, transfer belt and mechanical lifts
5. When a patient begins to fall, help them to the floor with as little impact as possible. Focus on protecting their head as you move down to the floor.
6. To reduce your risk of back pain, understand you back and follow through on the lifting techniques that you were taught in college or your higher learning facility
7. Remember assistive devices in transfers helps you **and** your patients

Restraints

- Alternative attempts should first be considered, there must be clinical justification for restraints.
- Consider least restrictive type of restraint plan.
- Staff must have knowledge of the cause for restraints and assessment verified.
- There must be adequate staff for monitoring and a physician must give the order.
- Always be familiar with the facilities policy.
- An RN should be present when restraints are applied and to evaluate that the application is on correctly.
- Make sure the patient's right, dignity and safety are maintained.

2009 National Patient Safety Goals Critical Access Hospital Program

National Patient Safety Goals

This chapter addresses the 2009 National Patient Safety Goals, requirements, and implementation expectations. This chapter has been reformatted to make it consistent with the structure of the standards in the manual. Implementation expectations have been added to each requirement and appear in the same format as elements of performance (EP's) in standards. In addition, rationales have been added to some of the requirements. Organizations providing care relevant to these goals are responsible for implementing the applicable requirements or effective alternatives. Compliance with these requirements is assessed throughout the accreditation cycle, through on-site surveys, and the Periodic Performance Review (PRP)¹. When an organization does not fully comply with a requirement, the organization will be assigned a requirement for improvement in the same way that noncompliance with an element of performance generates a requirement for improvement at a standard. All requirements for improvement must be addressed in an Evidence of Standards Compliance (ESC) Report. Failure to resolve a requirement for improvement affects an organization's accreditation decision, which could ultimately lead to a loss of accreditation.

The purpose of the Joint Commission's National Patient Safety Goals is to promote specific improvements in patient safety. The goals highlight problematic areas in health care and describe evidence and expert-based consensus to solutions to these problems. Recognizing that sound system design is intrinsic to the delivery of safe, high quality health care, the goals generally focus on system-wide solutions, wherever possible.

As with Joint Commission standards, accredited organizations are evaluated of continuous compliance with the specific requirements associated with the National Patient Safety Goals. If an organization thinks that an alternative approach meets the intent of the requirement and wishes to implement such an alternative, the organization must obtain Joint Commission approval.

The Joint Commission provides guidance on how to effectively comply with each goal's requirements. This guidance includes detailed answers to Frequently Asked Questions (FAQs), which are posted on the Joint Commission Website (<http://jcaho.org>).

A broadly representative Sentinel Event Advisory Group work with Joint Commission staff on a continuing basis to prioritize and develop goals, requirements, and implementation expectations. As a part of this development process, candidate goals, requirements, and implementation expectations are sent to the field for review and comment. The Advisory Group annually recommends selected existing and new goals, requirements, and implementation expectations to the Joint Commission's Board of Commissioners for review and approval. The Advisory Group also assists the Joint Commission in evaluating potential alternative to goal requirements that have been suggested by individual organizations.

¹ For those programs required to complete a PRP

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Goal 1

Improve the accuracy of patient identification

Requirement 1A

Use at least two patient identifiers when providing care, treatment or services.

Rationale for Requirement 1A

Wrong patient's errors occur in virtually all aspects of diagnosis and treatment. The intent of this goal is two-fold; first, to reliably identify the individual as the person for whom the service or treatment is intended; second to match the service or treatment to that individual.

Implementation Expectations for Requirement 1A

(M)C 1. Two patient identifiers are used when doing the following:

- Administering medications or blood products
- Collecting blood samples and other specimens for clinical testing
- Providing other treatments or procedures

(M)C 2. The patient's room number or physical location is not used as an identifier.

(M)C 3. Containers used for blood and other specimens are labeled in the presence of the patient.

Goal 2

Improve the effectiveness of communication among caregivers.

Requirement 2A

For verbal or telephone orders or for telephonic reporting of critical test results, verify the complete order or test result by having the person receiving the information record and "read-back" the complete order or test result.

Rationale for Requirement 2A

Ineffective communication is the most frequently cited category of root causes of sentinel events. Effective communication, which is timely, accurate, complete, unambiguous, and understood by the recipient, reduces error and results in improved patient safety.

Implementation Expectation for Requirement 2A

(M)C 1. The receiver of the information writes down the complete order or test result or enters it into a computer

(M)C 2. The receiver of the information reads back the order or test result.

(MC) 3. The receiver of the information receives confirmation from the individual who gave the order or test result.

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Requirement 2B

Standardize a list of abbreviations, acronyms, symbols, and dose designations that are not to be used throughout the organization.

Implementation Expectations for Requirement 2B

A1. The organization develops a standardized list of abbreviations, acronyms, symbols and dose designations that are not to be used throughout the organization.

A2. The list of abbreviations not to be used includes the following:

- Uu
- IU
- Q.D., QD, q.d., qd
- Q.O.D., QOD, q.o.d., qod
- Trailing zero (X.0 mg)²
- Lack of leading zero (.X mg)
- MS
- MSO₄
- MgSO₄

(M)C 3. The organization implements the “do not use” list and applies this list to all orders and all medication-related documentation when handwritten or entered as free text into a computer.

A4. Preprinted forms do not include any abbreviations identified as not to be used.

Requirement 2C

Measure, assess, and if appropriate, take action to improve the timeliness or reporting, and the timeliness of receipt by the responsible licensed caregiver, of critical test results and values.

Implementation Expectations for Requirement 2C

A1. The organization defines critical tests and critical results/values.

A2. The organization defines the acceptable length of time between the ordering of critical tests and reporting the test results and values.

A3. The organization defines the acceptable length of time between the availability of critical results/values and receipt by the responsible licensed care giver.

² Exception: A “trailing zero” may be used only where required to demonstrate the level of precision of the value being reported such as for laboratory results, imaging studies that report size of lesions, or catheter tube sizes. It may not be used in medication orders or other medication-related documentation.

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A4. The organization collects data on the timeliness of reporting critical test results/values

A5. The organization assesses the data and determines whether there is a need for improvement.

A6. The organization takes appropriate action to improve and measure the effectiveness of those actions.

Requirement 2D

Not applicable

Requirement 2E

Implement a standardized approach to “hand-off” communications, including an opportunity to ask and respond to questions.

Rationale for Requirement 2E

The primary objective of a “hand-off” is to provide accurate information about a patient’s care, treatment, and services, current condition, and any recent or anticipated changes. The information communicated during a hand off must be accurate in order to meet patient safety goals.

In health care there are numerous types of patient hand offs, including but not limited to nursing shift changes, physicians transferring complete responsibility for a patient, physicians transferring on-call responsibility, temporary responsibility for staff leaving the unit for a short time, anesthesiologist report to post-anesthesia recovery room nurse, nursing and physician hand off from the emergency department to inpatient units, different hospitals, nursing homes and home health care, critical laboratory and radiology results sent to physician offices.

Implementation Expectations for Requirement 2E

(M)C 1. The organization process for effective “hand off” communication includes: Interactive communication allowing for the opportunity for questioning between the giver and the receiver of patient information.

(M)C 2. The organization’s process for effective “hand off” communication includes: Up-to-date information regarding the patient’s care, treatment and services, condition and any recent or anticipated changes.

(M)C 3. The organization’s process for effective “hand off” communication includes: A process for verification of the received information including repeat-back to read-back, as appropriate.

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A 4. The organization's process for effective "hand off" communication includes: An opportunity for the receiver of the hand off information to review relevant patient historical data, which may include previous care, treatment and services.

(M)C 5. Interruptions during hand offs are limited to minimize the possibility that information would fail to be conveyed or would be forgotten.

Goal 3

Improve the safety of using medications

Requirement 3B

Standardize and limit the number of drug concentrations used by the organization.

Rational for Requirement 3B

When medications are part of the patient treatment plan, appropriate management is critical to ensuring patient safety. The development of standardized and redundant systems has been shown to decrease errors and improve outcomes.

Implementation Expectation for Requirement 3B

A 1. Standardize the drug concentrations used by the organization.

A 2. When more than one concentration of drug is necessary, the number of concentrations are limited to the minimum require to meet patient care needs.

Requirement 3C

Identify and, at a minimum, annually review a list of look-alike/sound-alike drugs used by the organization, and take action to prevent errors involving the interchange of the drugs.

Implementation Expectations for Requirement 3C

A 1. Identify a list of look-alike/sound-alike (LASA) drugs used by the organization (the list must include a minimum of 10 look-alike/sound-alike drug combinations selected from the tables of LASA drugs posted on the Joint Commission website).

A 2. Review the list of look-alike/sound-alike drugs used by the organization at least annually.

A 3. The organization takes action to prevent errors involving the interchange of the drugs.

Requirement 3D

Label all medications, medication containers (for example, syringes, medicine cups, basins) or other solutions on and off the sterile field.

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Rationale for Requirement 3D

This risk reduction activity is consistent with safe medication practices and addresses a recognized risk point in the safe administration of medications in perioperative and other procedural settings.

Errors, sometimes tragic, have resulted from medications and other solutions removed from their original containers and placed into unlabeled containers. Medications or other solutions in unlabeled containers are unidentifiable. This unsafe practice neglects basic principle of medication management safety yet has been routine in many organizations with respect to medication transferred to the sterile field.

Implantation Expectations for Requirement 3D

A 1. Medications and solutions both on and off the sterile field are labeled even if there is only one medication being used.

A 2. Labeling occurs when any medication or solution is transferred from the original packaging to another container.

A 3. Labels include the drug name, strength, amount (if not apparent from the container), expiration date when not used within 24 hours, and expiration time when expiration occurs in less than 24 hours.

(M) C4. All labels are verified both verbally and visually by two qualified individuals when the person preparing the medication is not the person administering the medication.

A 5. No more than one medication or solution is labeled at one time.

A 6. Any medications or solutions found unlabeled are immediately discarded.

(M) C7. All original containers from medications or solutions remain available for reference in the perioperative/procedural area until the conclusion of the procedure.

A 8. All labeled containers on the sterile field are discarded at the conclusion of the procedure.

(M) C9. At shift change or break relief, all medications and solutions both on and off the sterile field and their labels are reviewed by entering and exiting and personnel.

Goal 4

Not applicable

Goal 5

Not applicable

Goal 6

Not applicable

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Goal 7

Reduce the risk of health care-associated infections.

Requirement 7A

Comply with current Centers for Disease Control and Prevention (CDC) hand hygiene guidelines.

Rationale for Requirement 7A

Compliance with the CDC hand hygiene guidelines will reduce the transmission of infections agents by staff to patients, thereby decreasing the incidence of healthcare associated infections.

Implementation Expectation for Requirement 7A

(M) C1. Comply with current Centers for Disease Control and Prevention (CDC) hand hygiene guidelines³

Requirement 7B

Manage as sentinel events all identified cases of unanticipated death or major permanent loss of function associated with a health care-associated infection.

Rationale for Requirement 7B

A significant percentage of patients who unexpectedly die or suffer major permanent loss of function have healthcare associated infections. These unanticipated deaths and injuries meet the definition of a sentinel event and, therefore, are required to undergo a root cause analysis. The root cause analysis should attempt to answer the questions (1) why did the patient acquire an infection and, (2) given the fact of the infection, why did the patient die or suffer permanent loss of function?

Implementation Expectations for Requirement 7B

(M) C 1. The organization manages all identified cases of unanticipated death or major permanent loss of function associated with a health care-associated infection as sentinel events (that is, conducts a root cause analysis).

A 2. The root cause analysis addresses the management of the patient before and after the identification if infection.

Goal 8

Accurately and completely reconcile medications across the continuum of care.

³ Organizations are required to comply with all 1A, 1B, !C CDC recommendations.

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Requirement 8A

There is a process for comparing the patient's current medications with those ordered for the patient while under the care of the organization.

Rationale for Requirement 8A

Patients are most at risk during transitions in care (hand-offs) across settings, services, providers, or levels of care. The development, reconciliation and communication of an accurate medication list throughout the continuum of care is essential in the reduction of transition-related adverse drug events.

Implementation Expectations for Requirement 8A

(M) C1. The organization, with the patient's involvement, creates a complete list of the patient's current medications at admission/entry.

(M) C2. The medications ordered for, administered to, or dispensed to the patient while under the care of the organization are compared to those on the list and any discrepancies (e.g., omissions, duplications, potential interactions) are resolved.

Requirement 8B

A complete list of the patient's medications is communicated to the next provider of service when a patient is referred or transferred to another setting, service, or practitioner or level of care within or outside the organization.

Implementation Expectations for Requirement 8B

(M) C1. The patient's accurate medication reconciliation list (complete with medications prescribed by the first provide of services) is communicated to the next provider of service, whether it be within or outside the organization.

(M) C2. The next provider of service checks the medication reconciliation list again to make sure it is accurate and in concert with any new medications to be ordered/prescribed.

(M)C 3. The complete list of medications is also provided to the patient on discharge for the organization.

Goal 9

Reduce the risk of patient harm resulting from falls.

Requirement 9B

Implement a fall reduction program including an evaluation of the effectiveness of the program.

Rational for Requirement 9B

Fall account for a significant portion of injuries in hospitalized patients, long term care residents, and home care recipients. In the context of the population if serves, the

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services it provides, and its environment of care, the organization should evaluate its patients' risk for falls and take action to reduce the risk of falling and to reduce the risk of injury, should a fall occur. The evaluation could include fall history, medications and alcohol consumption review, gait and balance screening, walking aids, assistive technologies and protective devices assessment and environmental assessments.

Implementation Expectations for Requirement 9B

A 1. The organization establishes a fall reduction program.

(M)C 2. The fall reduction program includes an evaluation as appropriate to the patient population, settings and services provided.

A 3. The fall reduction program includes interventions to reduce the patient's fall risk factors

(M)C 4. Staff receive education and training for the fall reduction program

(M)C 5. The patient and patient's family is educated on the fall reduction program and any individualized fall reduction strategies.

A 6. The fall reduction program is evaluated to determine the effectiveness of the program. (Outcome indicators such as decreased number of falls and decreased number and severity of fall-related injuries could be used.)

**Goal 10
Not applicable**

**Goal 11
Not applicable**

**Goal 12
Not applicable**

**Goal 13
Encourage patients' active involvement in their own care as a patient safety strategy.**

Requirement 13A
Define and communicate the means for patients and their families to report concerns about safety and encourage them to do so.

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Rationale for Requirement 13A

Communication with patients and families about all aspects of their care, treatment or services is an important characteristic of a culture of safety. When patients know what to expect, they are more aware of possible errors and choices. Patients care is an important source of information about potential adverse events and hazardous conditions.

Goal 14

Not applicable

Goal 15

Not applicable

Universal Protocol

Wrong site, wrong procedure, wrong person surgery can be prevented. This universal protocol is intended to achieve that goal. It is based on the consensus of experts from the relevant clinical specialties and professional disciplines and is endorsed by more than 40 professional medical associations and organizations.

In developing this protocol, consensus was reached on the following principles:

- Wrong site, wrong procedure, wrong person surgery can and must be prevented.
- A robust approach – using multiple, complementary strategies – is necessary to achieve the goal of eliminating wrong site, wrong procedure, wrong person surgery.
 - Active involvement and effective communication among all members of the surgical team is important for success.
 - To the extent possible, the patient (or legally designated representative) should be involved in the process.
 - Consistent implementation of a standardized approach using a universal consensus-based protocol will be most effective.
 - The protocol should be flexible enough to allow for implementation with appropriate adaptation when required to meet specific patient needs.
 - A requirement for site marking should focus on cases involving right/left distinction, multiple structures (fingers, toes), or levels (spine).
 - The universal protocol should be applicable or adaptable to all operative and other invasive procedures that expose patients to harm, including procedures done in settings other than the operating room.

In concert with these principles, the following steps, taken together, comprise the Universal Protocol for eliminating wrong site, wrong procedure, and wrong person surgery.

- Pre-operative verification process
 - Purpose: To ensure that all of the relevant documents and studies are available prior to the start of the procedure and that they have been review and are consistent with each other and with the patient's expectations and with team's understanding of the intended patient, procedure, site and, as

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- applicable, any implant. Missing information or discrepancies must be addressed before starting the procedure.
- Process: An ongoing process of information gathering and verification beginning with the determination to do the procedure, continuing through all settings and interventions involved in the preoperative preparation of the patient, up to and including the “time out” just before the start of the procedure.
 - Marking the operative site
 - Purpose: To identify unambiguously the intended site of incision or insertion.
 - Process: For procedures involving right/left distinction, multiple structures (such as fingers and toes), or multiple levels (as in spinal procedures), the intended site must be marked such that the mark will be visible after the patient has been prepped and draped.
 - “Time out” immediately before starting the procedure
 - Purpose: To conduct a final verification of the correct patient, procedure, site and, as applicable, implants.
 - Process: Active communication among all members of the surgical/procedure team, consistently initiated by a designated member of the team, conducted in a “fail-safe” mode, i.e., the procedure is not started until any questions or concerns are resolved.

Universal Protocol

The organization fulfills the expectation set forth in the Universal Protocol

Requirement 1A

Conduct a pre-operative verification process as described in the Universal Protocol

Implementation Expectations

(M)C 1. Verification of the correct person, procedure and site should occur during the following (as applicable):

- At the time of surgery/procedure is scheduled
- At the time of admission or entry into the facility
- Anytime the responsibility for care of the patient is transferred to another caregiver.
- With the patient involved, awake and aware, if possible.
- Before the patient leaves the preoperative area or enters the procedure/surgical room

(M)C 2. The following is reviewed prior to the start of the procedure

- Relevant documentation (e.g. H&P consent)
- Relevant images, properly labeled and displayed
- Any required implants and special equipment

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Requirement 1B

Mark the operative site as described in the Universal Protocol

Implementation Expectations

(M)C 1. Make the mark at or near the incision site; do not mark any non-operative site(s) unless necessary for some other aspect of care.

A2. The mark must be unambiguous (Note: for example, use initials or “YES” or a line representing the proposed incision; consider that “X” may be ambiguous.)

(M)C 3. The mark must be positioned to be visible after the patient is prepped and draped.

A 4. The method of marking and type of mark should be consistent throughout the organization.

(M)C 5. At a minimum, mark all cases involving laterality, multiple structures (fingers, toes, lesions), or multiple levels (spine). (Note: In addition to pre-operative skin marking of the general spinal region, special intraoperative radiographic techniques are used for marking the exact vertebral level).

(M)C 6. The person performing the procedure should do the site marking.

(M)C 7. Marking must take place with the patient involved, awake and aware, if possible.

Requirement 1C

Conduct a “time out” immediately before starting the procedures as described in the Universal Protocol

Implementation Expectations

(M)C 1. The final verification process must be conducted in the location where the procedure will be done, just before starting the procedure.

(M)C 2. The process must involve the entire operative team, use active communication, and must, at least, include:

- Correct patient identity
- Correct side and site
- Agreement on the procedure to be done
- Correct patient position
- Availability of correct implants and any special equipment or special requirements.

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(M)C 3. The process is briefly documented, such as in a checklist (Note: the organization should determine the type and amount of documentation.)

A4. The organization should have processes and systems in place for reconciling differences in staff responses during the final verification process.

Guidelines for the Universal Protocol for Preventing Wrong Site, Wrong Procedure and Wrong Person Surgery™

These guidelines provide detailed implementation requirements, exemptions and adaptations for special situation.

Pre-operative verification process

1. Verification of the correct person, procedure, and site should occur (as applicable)
 - At the time the surgery/procedure is schedule.
 - At the time of admission or entry into the facility
 - Anytime the responsibility for care of the patient is transferred to another caregiver.
 - With the patient involved, awake and aware, if possible

2. A preoperative verification checklist may be helpful to ensure availability and review of the following, prior to start of the procedure:
 - Relevant documentation (e.g. H&P consent)
 - Relevant images, properly labeled and displayed
 - Any required implants and special equipment

3. Marking the operative site
 - Make the mark at or near the incision site. Do NOT mark any non-operative site(s) unless necessary for some other aspect of care.
 - The mark must be unambiguous (e.g., use initial or “YES” or a line representing the proposed incision, consider that “X” may be ambiguous).
 - The mark must be made using a marker that is sufficiently permanent to remain visible after completion of the skin prep. Adhesive site markers should not be used as the sole means of marking the site.
 - The method of marking and type of mark should be consistent throughout the organization.
 - At a minimum, mark all cases involving laterality, multiple structures (fingers, toes, or lesions), or multiple levels (spine). Note: In addition to pre-operative skin markings of the general spinal region, special intraoperative radiographic techniques are used for marking the exact vertebral level).
 - The person performing the procedure should do the site marking.
 - Marking must take place with the patient involved, awake and aware, if possible.
 - Final verification of the site mark must take place during the “time out”
 - A defined procedure must be in place for patients who refuse site marking.
 - Exemptions

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- i. Single organ cases (e.g., Cesarean section, cardiac surgery).
- ii. Interventional cases for which the catheter/instrument insertion site is not predetermined (e.g., cardiac catheterization).
- iii. Teeth --- BUT, indicate operative tooth name(s) on documentation OR mark the operative tooth (teeth) on the dental radiographs or dental diagram.
- iv. Premature infants, for whom the mark may cause a permanent tattoo.

4. “Time out” immediately before starting the procedure

Must be conducted in the location where the procedure will be done, just before starting the procedure. It must involve the entire operative team, use active communication, and be briefly documented, such as in a checklist (the organization should determine the type and amount of documentation) and must, at the least, include:

- Correct patient identity
- Correct side and site
- Agreement on the procedure to be done
- Correct patient position
- Availability of correct implants and any special equipment or special requirements.

The organization should have processes and systems in place for reconciling differences in staff responses during the “time out”.

5. Procedures for non-OR settings including beside procedures.

- Site marking must be done for any procedure that involves laterality, multiple structures or levels (even if the procedure takes place outside of an OR).
- Verification, site marking, and “time out” procedures should be as consistent as possible throughout the organization, including the OR and other locations where invasive procedures are done.
- Exception: Cases in which the individual doing the procedure is in continuous attendance with the patient from the time of decision to do the procedure and consent from the patient through to the conduct of the procedure may be exempted from the site marking requirement. The requirement for a “time out” final verification still applies.

HIPAA Privacy Keys to Success

Education for Nursing Staff & Therapists

HIPAA and Its Purpose

What is HIPAA?

- Health Insurance Portability and Accountability Act of 1996
- It's a federal law
- HIPAA is mandatory, penalties for failure to comply

Purpose:

- Protect health insurance coverage and improve access to healthcare
- Reduce fraud and abuse
- Improve quality of healthcare in general
- Reduce healthcare administrative costs (electronic transactions)

Facility Privacy Official

- Each Facility has an FPO
- Responsible for:
 - Privacy Program
 - Patient Complaints
 - Privacy Rights of Patients
 - Requests for Privacy Restrictions
 - Facilitating the Training and Education of Staff

HIPAA Terminology

- **HIPAA:** Health Insurance Portability Accountability Act
- **PHI:** Protected Health Information
- **CE:** Covered Entity (Hospital)
- **OHCA:** Organized Health Care Arrangement (The hospital and medical staff will be considered an Organized Health Care Arrangement)
- **DRS:** Designated Record Set (the medical record and billing record)
- **AOD:** Accounting of Disclosure – Patients right to AOD
- **Directory:** Hospital census list used by volunteers and operators with patient name and room number
- **TPO:** treatment, payment, healthcare operations

How will HIPAA affect you?

- Coversheets with confidential statement needs to be used on all external faxes.
 - Screens will need to be placed out of public view when possible
 - Patient charts will need to be placed in secure area
 - PHI will need to be placed in Shred-It containers not trash
 - Patient family members will give a pass code for other than directory releases
 - Patient information should only be accessed if there is a need to know
 - Not discussing PHI in public places. Nursing stations and joint treatment areas like OR, ER double occupancy rooms or OK.
-
- Registration will be giving out a Notice of Privacy Practices brochure to every patient concerning our patient privacy protection policy.
 - Patients will be given the option to “opt-out” of our directory
 - Authorizations need to be obtained from patient to release information for reasons other than for treatment, payment or healthcare operations (TPO)

What is Protected by HIPAA (PHI)?

- Name
- Address, including street, city, county, zip code and equivalent geocodes
- Names of relatives
- Name of employers
- Birth date
- Telephone numbers
- Fax Numbers
- Electronic e-mail addresses
- Social Security Number
- Medical Record Number
- Health Plan Beneficiary Number
- Account Number
- Certificate/License Number
- Any Vehicle or Other Device Serial Number
- Web Universal Resource Locator (URL)
- Internet Protocol (IP) Address Number
- Finger or Voice Prints
- Photographic Images
- Any other unique identifying number, characteristic or code.

What is a Covered Entity (CE)?

Health plans, Health care clearinghouses, and Health care providers that transmit electronically for billing

- Examples
 - Hospitals
 - Physician Practices
 - Insurance Companies
 - Ambulance Transportation Services
 - Hospice
 - Home Health

What does that mean to me?

- You can share information without patient authorization as it related to TPO
- Other covered entities will request only minimum necessary to perform their job
- You may request the minimal information necessary from them for reason of TOP without patient authorization
- May need to verify the requestor according to policy

Disclosing PHI to Family Members and Friends who call the unit

- Patient will be assigned a four-digit pass code that information
- Distribution of pass code will be needed to get non-directory will be responsibility of patient
- May be changed during treatment
 - Revocation and password change form must be routed to FPO
- Pass code will be last 4-digits of patient account number

Verification of Requestors

- Requestors via phone will need:
 - Patient SS#, DOB and one of the following:
 - Account number, street address, MR#, birth certificate, insurance card or policy number
 - Scenarios
 - Unknown physician calling from cell phone
 - Family member or friend calling without pass code

External Faxing Guidelines

- Limit when possible
- Verify fax number
- Utilize present numbers when applicable
- Locate fax machine is secure location
- ALWAYS use cover sheet with confidentiality statement for transmittals
- Highly sensitive information should NEVER be faxed (HIV status, abuse records, etc.)

Patient's Right to Access

- Forward to HIM for processing
- Must be able to provide access and/or hard copy of record
- If patient is in-house, HIM will manage access process

Patent's Right to Amend

- Forward request to HIM for processing
- Right of patient to provide amendment (append) to records
- Cannot change or omit documentation already in the medical record
- If patient is in-house HIM will manage amendment process

Patients' Right to Opt-Out of Directory

- Patient can opt-out of directory at anytime but it will mostly likely occur during the admission process
- You may not acknowledge the patients is in the facility or give information about the patient to friends, family, or other who may inquire
- Can still release information to family and friends with 4-digit pass code as defined in the Use and Disclosure of PHI to Family Members and Friends policy.
- Forward any request for opt-out to Registration for processing

Right to Privacy Restrictions

- Patients have the right to request a privacy restriction of their PHI
- **NEVER** agree to a restriction that a patient may request
- All requests must be made in writing and given to the FPO to make a decision on
- NO request is so small that it should not be routed to the FPO

Patient Privacy Complaints

- FPO must maintain complaint log in accordance with the complain process
- **ALL** privacy complaints must be routed to the FPO
- Responses cannot be accompanied by retaliatory actions by the hospital
- Disposition of complain must be consistent with the facility's Sanctions for Privacy Violations
- Risk Management module of Meditech may be used for complaint tracking

Accounting of Disclosures (AOD)

- Right to an accounting of disclosures of protected health information
- An individual has a right to receive an accounting of disclosures of protected health information made by a covered entity in the six years prior to the date on which the accounting is requested, except for disclosures:
 - For TPO
 - To the patient
 - For directory purposes
 - To law enforcement or correctional institutions
 - For national security

How will Accounting of Disclosures (AOD) affect me?

- **You must enter information into the AOD for:**
 - State mandated reporting
 - Suspected Abuse Victims
 - Certain Disease reporting such as STD's
 - Brain Injury
 - Law Enforcement, Judicial & Administrative proceedings
 - Organ and Tissue Donations
 - Health Oversight Activities (JCAHO)

Notice of Privacy Practices

- Patient will receive Notice upon each registration
- Outlines patient rights
 - Right to access
 - Right to amend
 - Right to Confidential Communication
 - Right to Privacy Restriction
 - Right to Opt out of Directory
- Please read Notice of Privacy Handout

Sanctions

- 3 levels of violations that require disciplinary action
 - Accidental and/or due to lack of proper education
 - Purposeful violation of privacy policy or an unacceptable number of previous violations
 - Purposeful violation of privacy policy with associated potential for patient harm

Sharing information with other treatment providers

- We can share information with physicians and office staff, hospitals, or other treatment facilities just as we do today
- Need to verify the requestor according to the policy
- Patient information (PHI) can be released for reasons of treatment, payment or healthcare operations (TPO)

Confidential Communications

- Request for use of alternate address or phone number for future contact
- Route any request for Confidential Communications to Admissions
- Should communicate only with alternate address given

Common Exposures on Nursing Units

- Discussions of patient information in public places such as elevators, hallways, and cafeterias
- Printed or electronic information left in public view
- Printed charts left on counters
- PHI in regular trash
- Records that are accessed without need to know in order to perform job duties
- Unauthorized individuals hearing patient sensitive information such as diagnosis treatment

Fitting Instructions (Must be followed each time respirator is worn)

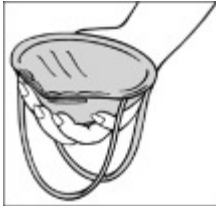


Fig. 1



Fig. 2



Fig. 3



Fig. 4

1. Cup the respirator in your hand, with the nosepiece at your fingertips, allowing the headbands to hang freely below your hand.
 2. Position the respirator under your chin with the nosepiece up. Pull the top strap over your head resting it high at the top back of your head. Pull the bottom strap over your head and position it around the neck below the ears.
 3. Place your fingertips from both hands at the top of the metal nosepiece. Using two hands mold the nose area to the shape of your nose by pushing inward while moving your fingertips down both sides of the nosepiece.
- ! Pinching the nosepiece using one hand may result in improper fit and less effective respirator performance. Use two hands.
4. Perform a User Seal Check prior to each wearing. To check the respirator-to-face seal, place both hands completely over the respirator and exhale. Be careful not to disturb the position of the respirator. If air leaks around nose, readjust the nosepiece as described in step 3. If air leaks at the respirator edges, work the straps back along the sides of your head.

**If you CANNOT achieve proper seal, DO NOT enter the isolation or treatment area.
See your supervisor.**

Removal Instructions

See step 2 of *Fitting Instructions* and cup respirator in hand to maintain position on face. Pull bottom strap over head. Still holding respirator in position, pull top strap over head and remove respirator.

Electrical Safety

Objectives:

- Identify basic rules of electrical safety
- Identify unsafe conditions related to electrical safety
- Emergency response for electrical shock victim
- Identify difference between normal and emergency receptacles in the hospital
- Identify factors which affect the severity electrical shock

It is hard to imagine life without electricity. As wonderful as this utility is, it can be very dangerous...Life Threatening

To protect yourself, your co-workers, and your patients, we need you to practice and strictly follow electrical safety procedures.

Electrical facts:

- Electricity always tries to reach the ground. It travels over conductors: anything that allows electricity to flow. People, water, damp ground, metal and even trees are excellent conductors.
- An “insulator” is the opposite of a conductor – Electricity cannot flow easily through insulators like plastic, rubber, dry wood or glass.
- The electrical grounding provided by the ground wire and third prong on the plug carries hazardous leakage current away before it can cause a shock. Never remove a ground prong from a power cord.
- A special receptacle outlet called a Ground Fault Circuit interrupter should be installed in areas where water and electrical equipment or service can come into contact. These special receptacles have a built in circuit breaker designed to shut off electric power within as little as 1/40 of a second.

Effects of electric current in the human body:

- The severity of the shock received when a person become a part of an electric circuit is effected by three primary factors: 1. the amount of current flowing through the body (measures in amperes), 2. the path of the current through the body, and 3. the length of time the body is in the circuit.
- As the table illustrates, a difference of less than 100 milliamperes exists between a current that is barely perceptible and one that can kill. Muscular contraction caused by stimulation may not allow the victim to free themselves from the circuit and the increased duration of exposure increases the dangers of the shock victim. For example, a current of 100 mill amperes for 3 seconds is equivalent to a current of 900 mill amperes applied for .03 seconds in causing fibrillation. The so-called low voltages can be extremely dangerous because all other factors being equal, the degree of injury is proportional to the length of time the body is in the circuit. Low voltage does not imply low hazard

Current	Reaction
1 Milliampere	Perception level. Just a faint tingle.
5 Milliampere	Slight shock felt; not painful but disturbing. Average individual can let go, however, strong involuntary reactions to shocks in this range can lead to injuries
6-25 Milliamperes (women) 9-30 Milliamperes (men)	Painful shock, muscular control is lost. This is called the freezing current or “let-go” range.
50-150 Milliamperes	Extreme pain, respiratory arrest, severe muscular contractions* Individual cannot let go. Death is most likely
10,000 Milliamperes	Cardiac arrest, severe burns and probable death

* If the extensor muscles are excited by the shock, the person may be thrown away from the circuit

Practicing electrical safety at work and home:

- Use only (UL) listed equipment, including appliances
- Keep electrical equipment , machinery and work areas clean, dry and free of debris
- Keep access to electrical panels and or power source connection clear
- Make sure all electrical equipment is ground properly
- Secure power cords to the back of desks or workstations to keep off the floor and reduce hazards.
- Avoid use of extension cords. Ask for sufficient outlets to be installed
- Make sure hands are dry before handling electrical devices
- Unless you are authorized, stay away from area containing major electrical service or equipment
- Do not use any electrical device, machinery, equipment, etc. while you are touching metal or anything wet.
- Do not over-ride or short-cut safety devices designed into electrical (or mechanical) equipment.
- Accidental or unexpected starting of electrical equipment can cause severe injury or death. Before any inspections or repairs are made, the electrical current should be turned off. The switch or controls should be locked out of service and tagged to show that services is being performed and should not be turned on. This process is called LOCK OUT-TAG OUT. It protects worker by keeping equipment de-energized and preventing shock or injury.

Bloodborne Pathogens & Universal Precautions

Objectives

- Explain the meaning of Bloodborne Pathogens
- Identify measures of protection against bloodborne pathogens

What are Bloodborne Pathogens?

Bloodborne Pathogens are micro-organisms (germs) that are present in blood and certain body fluids of an infected person. They may be transmitted from one person to another and cause disease.

These include Hepatitis B Virus (HBV) and Human Immunodeficiency Virus (HIV) as well as other pathogens.

Exposure to a bloodborne pathogen is a risk for employees of healthcare facilities.

How can you become infected?

- Contact with blood and certain body fluids through these mechanisms:
 - Needle sticks on punctures with other sharps
 - Exposure to mucous membranes (eyes, nose, mouth) by blood or body fluid splash, spray or droplet).
 - Contact with non-intact skin
 - Skin contact
 - Mother to Child

How can you decrease your risk of acquiring HBV or HIV on the job?

- Follow Universal Precautions (follow guidelines below 1 thru 13). Universal Precautions means that blood and body fluid from all patients must be handled as if they were infected with a bloodborn pathogen.

1. Hand washing

- Between patient contacts
- After removing personal protective attire (especially gloves).
- Before leaving the restroom
- After contact with blood/body fluids or after handling contaminated items
- Before eating

Note: Proper techniques for hand washing:

- Use an approved soap.
- Running water
- Minimum 10-15 seconds of active washing
- Dry hands with a paper towel
- Turn of faucet with a paper towel
- Discard paper towel in water can.

2. Wear gloves when expecting to:

- Touch items of surfaces contaminated with blood/body fluids.
- Handle blood/body fluid specimens
- Come into contact with patient's open skin, lesions, and membranes
- Perform vascular access procedures (obtaining a blood sample, IV insertion, etc.)
- Remember to always wash hands after removing gloves.

3. Wear face shield or combination mask and eyewear when at risk of splashing, spray, or droplet exposure, etc.

4. Wear approved protective clothing: apron, lab coat, barrier gown, etc.

5. If protective clothing is penetrated by blood/body fluids, remove immediately.

6. Remove and dispose of protective attire immediately in a designated container.

7. Handle sharps in a safe manner and dispose of immediately in a designated container.

8. Wash hands and other skin or mucous membranes immediately if there is contact with blood/body fluids

9. Keep you workspace safe by promptly cleaning blood/body fluid with approved disinfectant. Absorb gross amounts first and discard in bio-hazard bag. Then apply the disinfectant.

10. Perform all task involving blood/body fluids in a manner that will minimize splashing, spatters, spray, etc.

11. Clean up broken glassware with devices, not your hands

12. Do not eat, drink, apply cosmetics or lip balm or handle contact lenses in a work area where risk for exposure exists.

13. Do no bend, break, or recap contaminated needles. Take used sharps directly to the disposal container. Do not lay down, it may be forgotten.

Respiratory Protection for Reduction of Tuberculosis Transmission

Objectives

- Identify type of respiratory protection used for TB
- List the requirements of a respiratory protection program
- Identify examples of when a respirator is required
- Understand why respirator testing is necessary

Respirator Selection

The OSHA standards for respiratory protection requires the use of a National institute of Occupational Safety and Health (NIOSH) approved respirator for protection against workplace exposure to TB

Respiratory Protection Program Requirements

OSHA also requires a respiratory protection program be developed and implemented when such respirators or utilized.

- Written Program – written procedures governing the selection and use of respirators must be established.
- Respiration Selection – Respirators shall be selected on the bases of hazards to which personnel are exposed
- Training – Individual Respirator users must be instructed and trained in the proper use of respirator s and their limitations
- Fit Testing – Individual Fit Testing must be performed to ensure a face-piece to face seal
- Approved Respirators – Only NIOSH approved respirators can be utilized
- Donning Respirators – Individual respirator wearers should conduct a “face seal check” prior to entering a patient room. Do not use with beards or other facial characteristics which interferes with correct seal fit.
- Storage – Respirators must be stored in a convenient, clean and sanitary location.

What is the purpose of the PPD skin test?

The PPD skin test will determine if a person has been infected with the tubercle bacillus. The test must be read by a trained individual within 48-72 hours.

How often do you need to receive a PPD skin test?

- All personnel will receive a PPD skin test at the time of employment unless their status is already known
- PPD skin tests are required once a year unless you are working in a high risk area
- High risk areas require their employees to be tested once every 3 months.
- High risk area or procedures include
 - Frequent exposure to persons with TB
 - Aerosol Treatments
 - Bronchoscopy
 - Spulum induction
 - Suctioning
 - Endorrecheal incubation
 - Autopsy

What do you do if you are exposed to TB?

- Contact the Employee Health Department. Complete an Employee Occurrence Report
- Participate in evaluation, treatment, and follow-up as directed by Employee Health
- If PPD test is positive (generally indicates you have been infected), you will be evaluated and placed on preventive therapy, if necessary.
- Work restriction to prevent transmission to others will be at the direction of Employee Health.
- Inspection – Respirators used routinely must be inspected according to procedures. Worn, deteriorated or soiled respirators must be replaced. Work Place Surveillance – Appropriate surveillance of work area conditions and degree of employee exposures or stress must be maintained