CORE IN-SERVICE & QUIZ TABLE OF CONTENTS

Bloodborne Pathogens & the Healthcare Worker

There is a national trend to increase protection to healthcare workers against bloodborne pathogens.

Many employees, such as direct healthcare workers, receive extensive training about preventing exposure to and the spread of bloodborne pathogens.

Training about bloodborne pathogens is important because of the potential exposure to contaminated surface areas in the patient homes, needles, vital signs monitoring equipment, patient wounds, body fluids drainage receptacles etc. through which bloodborne pathogens can spread.

Healthcare Workers Should Understand Basic Steps to:

Avoid becoming exposed to bloodborne pathogens at work.

Prevent exposing patients to bloodborne pathogens.

What are Bloodborne Pathogens?

Bloodborne pathogens are microorganisms carried by human blood and other body fluids that can cause disease in humans.

The most common bloodborne pathogen is Hepatitis B. Other pathogens we hear a lot about include HIV and Hepatitis C

spread through blood and contact with other body fluids.

How Are Bloodborne Pathogens Transmitted in the Workplace?

In the workplace, it is important to watch out for incidents where bloodborne pathogens can be transmitted.

Bloodborne pathogens can be transmitted through body fluids containing visible blood, body secretions or torn skin.

The Centers for Disease Control and OSHA state the safest measure is to always view blood and body fluids as if the contain bloodborne pathogens.

Be aware that pathogens in blood or body fluids may enter the body through: open cuts and nicks, skin abrasions, dermatitis acne, mucous membranes of the mouth, eyes or nose.

A person can become infected with bloodborne pathogens with contaminated objects like: sharp objects like needles, scissors, wound staples, contaminated surfaces (a major factor in the spread of the Hepatitis B Virus), body fluid collection receptacles like foley bags, wound vacuums, JP drains, chest tube drainage containers, soiled linen and wound dressings etc.

Common Bloodborne Pathogens

Hepatitis B

Hepatitis B Virus is the most common and contagious of the bloodborne pathogens.

It is the inflammation of the liver.

There is no cure for Hepatitis B but most will heal in approximately 6 months.

Hepatitis B infection can be life threatening and lead to cirrhosis and almost certain death if not healed. 30% of people with Hepatitis B show no signs or symptoms.

If symptoms show, the include fatigue, weight loss, fever, diarrhea, darkened urine and jaundice.

A blood test is necessary to diagnosis Hepatitis B. Blood, saliva and other body fluids may be infected. The Hepatitis B virus can live in dried blood for up to 7 days.

A series of 3 vaccinations can prevent Hepatitis B.

Hepatitis C

Hepatitis C is another virus that attacks the liver and causes inflammation.

Hepatitis C is 4 times more common than HIV.

It's transmission is 10 times lower than Hepatitis B.

Hepatitis C is not spread by kissing, hugging, sneezing, coughing, food or water, sharing eating utensils or drinking glasses or casual contact.

There is no vaccine for Hepatitis C.

HIV (Human Immunodeficiency Virus)

HIV is a highly-contagious and deadly blood borne pathogen.

HIV attacks the body's immune system.

It will not survive long outside the human body.

HIV is relatively difficult to transmit from an infected person to a worker as a result of an accidental exposure.

HIV can be spread by contact with blood and other body fluids, but it is transmitted mainly through sexual contact.

HIV is NOT transmitted by touching or working around people who carry the disease.

Many contagious people with the disease show no signs or symptoms of the disease for several years. Those infected with HIV will eventually develop AIDS. There is no cure for AIDS.

HIV, HBV and HCV are NOT transmitted by:

Touching an infected person.

Coughing and sneezing.

Using the same equipment, toilets or water fountains as an infected person (although toothbrushes, razors and other personal care articles, they should not be shared, as they might have blood on them.)

Cleaning up vomit, feces or urine.

The most common ways the viruses are transmitted are:

Sexual contact.

Shared drug needles.

Being stuck by an infected needle or other sharp instrument.

Direct contact between broken chaffed skin and infected blood or bodily fluids.

In addition, HBV can be transmitted through contacted with caked, dried blood or surfaces that have been contaminated.

How Can You Protect Yourself and Others From Infection?

1.Get Hepatitis B Vaccinations—Vaccinations for Hepatitis B involve a series of 3 shots which builds up the body's immunity to the Hepatitis B Virus.

2.Use Standard Precautions—Treat all blood and body fluids as if they are potentially infectious. Be aware that people who carry blood borne pathogens such as Hepatitis B and HIV come from all age groups, every socioeconomic class, every state, rural areas and inner cities.

3.Wash Your Hands—Hand washing is the universal and most important infection control practice.

4.Biohazard waste policy—Blood and other body fluids are considered regulated waste. Appropriate biohazard warning labels must be placed on regulated waste containers. Please respect the warnings on these labels.

Managing Bloodborne Pathogen Exposure

In the rare occurrence of a healthcare worker being exposed to blood or other potentially infectious material the following is the recommended procedure.

Flush the area with large quantities of soap and water for 3 to 5 minutes and render First Aid if needed.

Notify your supervisor.

Clean up the contaminated area using 1:10 solution of bleach or other approved cleaning material and the appropriate personal protective equipment as needed.

Contaminated equipment is to be placed in hazardous waste container.

Contaminated clothing is to be bagged.

ELDER ABUSE AND NEGLECT IN THE HOME SETTING

INTRODUCTION

Elder abuse is a crime that can occur in any setting by formal or informal caregivers. **Formal caregivers** are individuals who are volunteers or paid employees and are connected to the social service or health care systems. **Informal caregivers** are those persons who are family members or friends, and who account for 75% of majority of care provided to impaired elders living in the community. Statistics reveal that a high percentage of reported elder abuse cases are caused by informal caregivers. It is the unreported cases that there are no data reported, and is cause for concern. Formal caregivers need to be aware of the problem of elder abuse, share the knowledge with others, report issues or concerns, and be involved in prevention measures by making a commitment to reach out to those who are vulnerable.

DEFINITION OF ABUSE

Elder abuse is any intended, knowing, or careless act that causes potential or actual harm to an older person. The harm may be physical, mental, emotional, or financial. The abuse may include neglect and mistreatment, and misappropriation of the client's personal property.

TYPES OF ABUSE (National Center on Elder Abuse, 2006)

Physical abuse is the use of physical force that may result in bodily injury, physical pain or discomfort, or actual impairment. Examples of physical abuse may include, but are not limited to, striking (with or without an object), hitting, pushing, shoving, beating, shaking, slapping, kicking, pinching, and burning. Additional examples may include inappropriate use of drugs, use of physical restraints, force-feeding, and any other kind of physical punishment.

Emotional or psychological abuse is the causing of infliction of anguish, pain, or distress by performing verbal or nonverbal acts. Emotional or psychological abuse may include, but is not limited to, verbal assaults, threats, intimidation, insults, humiliation, and harassment. Additionally, treating an elder as an infant/child, isolating the client from others and activities, restricting communication, using the "silent treatment", and enforced social isolation are also examples of emotional and psychological abuse.

Sexual abuse is a non-consensual or unwanted sexual contact of any kind (forced, tricked, threatened or coerced) with an elderly person, whether or not the person is capable of giving consent or not. Examples of sexual abuse may include, but are not limited to unwanted touching, all forms of sexual assault and battery, such as coerced nudity, sodomy, rape, and sexually explicit photography.

Financial or Material Exploitation is the misappropriation of a client's personal property, and includes the illegal or improper use of an elder person's funds, property or assets. Examples of financial/material exploitation may include, but are not limited to, cashing a client's checks without permission, forging a client's signature, misusing or theft of a client's money or possessions, coercing or deceiving a client into signing any document, and the improper use of conservatorship, guardianship, or power of attorney.

Abandonment is the desertion of an elder by an individual with assumed responsibility for the care of that person, or by a person with physical custody of the elder. The individual may be a formal or informal caregiver for the elder person.

Self-neglect is a behavior of the client that threatens his/her own health or safety, and is evidenced by the client's refusal or failure to eat adequate food, drink enough fluids, wear adequate clothing, seek shelter, maintain

personal hygiene, take prescribed medication, and observe safety precautions. This behavior is not deemed to be self-neglect if the client is mentally competent, understands the consequences of his/her actions, and makes a voluntary decision to behave in ways that threaten his/her health or safety as a matter of personal choice. The actions and behaviors should be reported to the formal caregiver's supervisor and documented in the medical record.

RISK FACTORS

Elder abuse can occur in any client setting, therefore, all elder clients are at potential risk. The elder client is never to be considered responsible for any abuse inflicted upon them. The perpetrator is responsible. There are some factors that may contribute to clients being at a higher risk of abuse, such as persons who are:

- Socially isolated, lonely, or lack family or social support networks.
- Mentally compromised and therefore have increased dependence on the abuser.
- Vulnerable to problems of the abuser, such as the abuser being financially dependent on the victim, having a mental or emotional illness, alcohol or drug abuse problem, or being of an aggressive or hostile personality.
- Prone to self-neglect.

DEFINITION OF NEGLECT

Neglect, as differentiated from self-neglect, is the refusal or failure to provide necessary care, obligations or duties to the elder client. Neglect may include, but is not limited to, failure of the responsible person to pay for necessary services needed by the elderly client, failure to provide for basic life necessities such as food, water, clothing, personal hygiene, shelter, medicine, safety, comfort, and other essentials. Neglect may also include withholding meals or fluids, ordered treatments or hygiene; failure to assist with physical aids such as hearing aids, glasses, or dentures; and deliberate incorrect documentation of care rendered. Failure to provide social stimulation and ignoring the client are further examples of neglect.

IDENTIFICATION OF ABUSE AND ABUSERS

It is often difficult to identify elder abuse, or the perpetrator of the abuse. In many cases it is a family member who is involved, but not necessarily the informal caregiver. Stress and emotional instability of a family member may cause the unwanted behaviors. Adding to the problem is the fact that the elder client may not be physically or mentally capable of reporting the abuse because of being isolated, or too fearful or ashamed to tell anyone. The individual may be threatened or coerced into silence. As a formal caregiver, you should be aware of signs and symptoms of elder client abuse of all types, since a client may suffer from more than one type. Any and all cases of **suspected or actual** abuse should be reported immediately to the supervisor, and in turn to the state agency.

Possible Characteristics of Abusers

- Dependence on alcohol or drugs.
- History of abuse or domestic violence.
- Family dysfunction, dependency, or history of mental illness.
- Personal pressures such as economic stressors.
- History of long-term negative personality traits such as, hypercritical, bad temper, tendency to blame others for problems.
- Formal caregivers with criminal records (agency failed to do an employee background check).

- Employees who are overworked, have high turnover rates, and receive inadequate training for the caregiver position.
- Caregivers lack compassion, and empathy for the elderly and disabled.

Possible Signs of Elder Abuse

- Bruises, welts, pressure marks, burns, blisters, rope marks, slap marks, and explanations that do not "fit" with the explanation for the injury should arouse suspicion and should be reported to the supervisor.
- The client seems to withdraw from routine, normal activities, decreased alertness, sadness, unexplained fears, and unusual behaviors that may signal emotional abuse or neglect.
- Bruises or infected lesions around the breasts, genital area, unexplained venereal diseases, vaginal or anal bleeding, and the client report of being sexually assaulted or raped.
- Unexplained sudden changes in finances, altered wills, trusts, bank withdrawals, loss of property, and checks written as "gifts or loans" may be indicative of elder exploitation.
- Changes in personal effects such as need for medical or dental care, poor hygiene, overgrown hair and nails, untreated bedsores, and unusual weight loss are signs of neglect or mistreatment.

DOMESTIC VIOLENCE

Domestic violence is controlling behavior by one household member that is directed toward another member. Domestic violence includes any form of assault, battery, or criminal offence that causes bodily harm or death. Also included are such examples as name-calling or verbal abuse, isolation from family or friends, withholding funds, or threats of physical harm or sexual abuse. Individuals, who have been abused as children, many times become abusers themselves. Although no one knows exactly the number of elder abuse cases that exist, evidence reported by the National Center on Elder Abuse estimates that there are about 1-2 million elders who have been injured, exploited, or mistreated in the United States. Research figures suggest that only one in fourteen domestic elder abuse incidents is reported to authorities. As the population ages, the risks of elder abuse likewise increases. Suspected abuse must be reported, and caregivers have an obligation and responsibility to do so.

CAREGIVER ABUSE

Abuse of clients by formal caregivers can occur. Some examples of physical abuse by formal caregivers may include, but are not limited to hitting, rough handling, hurrying the client, threats, curses, actions or behaviors that cause client low self esteem, unwanted physical contact, gestures or remarks, misuse of a client's money or personal possessions, including eating a client's food, or stealing money or material objects. Trust your instincts. If you feel that something is wrong, it probably is. Notify your supervisor. One does not need to witness the abuse to report it. Suspected abuse should be reported. Let the authorities investigate and make the determination.

Caregivers who abuse clients are often individuals who are tired and overworked. They may have personal problems that interfere with their job performance; they easily lose patience and do not handle stress well. Some caregivers have been, or are, abused themselves, and resolve problems or issues by using abusive methods.

Prevention of abuse is the best alternative. As a caregiver, be aware of your feelings. Eat balanced meals and get enough rest before going to work. If a client is annoying, or unmanageable, withdraw from the situation. Make sure that the client is safe, and exit the room. Avoid confrontation. You may need to be reassigned from the case. There is **never an excuse for client elder abuse.**

Should elder abuse be suspected, be observant and report your suspicions. It is a legal and ethical responsibility. If you do not report abuse, you are as guilty as the perpetrator of the abuse, and can be held legally responsible.

REPORTING ABUSE/NEGLECT

It is extremely important to report all and any suspected or actual client abuse as soon as it is discovered. Notify the supervisor, and follow instructions. You do not need to prove abuse in order to report it. If the supervisor does not take action, the caregiver is obligated to do so. If the client suffers serious injury or harm, the police need to be notified. Adult Protective Services should also be called. Many states have toll-free numbers for reporting elder abuse. The National Center on Elder Abuse Web-site has every state's number for reporting elder abuse.

Report Elder Abuse/Neglect

Go to: www.elderabusecenter.org and click on to "Where to Report Abuse"
Or call: 1-800-243-4636
Or notify the local police department

CONCLUSION

Elder abuse and neglect in the home setting can be a reality, and one that the formal caregiver may suspect or encounter. It is important to know the different types of abuse and be able to identify signs of elder client abuse and neglect. Domestic violence is more common than even the number of reported cases. Be alert for possible signs, and know the agency's procedures for reporting abuse and neglect. It is every caregiver's legal responsibility to report suspected or actual abuse.

REFERENCES

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Emergency Preparedness Operations Details

Our Agency will completed Emergency Preparedness Planning, in compliance with State/Federal regulation and according to an All-Hazards Approach.

The Emergency Preparedness Plan will be activated by the agency Emergency Disaster Coordinator in collaboration in the event of a declared State of Emergency, severe inclement weather event, or other severe adverse condition.

1. DEFINITIONS

Emergency - An unexpected or sudden event that significantly disrupts the organization's ability to provide care or the "environment of care itself" or that results in the sudden, significantly changed or increase demand for the organizations services.

All Hazards Approach - an integrated approach to emergency preparedness planning that focuses on capacities and capabilities that are critical to preparedness for a full spectrum of emergencies or disasters, including internal emergencies and a man-made emergency (or both) or natural disaster. This approach is specific to the location of the provider or supplier and considers the particular type of hazards most likely to occur in their areas.

Disaster - The occurrence or imminent threat of widespread or severe damage, injury, or loss of life or property resulting from a natural or man-made cause, such as fire, flood, earthquake, wind, storm, wave action, oil spill or other water contamination, epidemic, air contamination, infestation, explosion, riot, hostile military or paramilitary action, or energy emergency.

Preparedness - Preparing for the potential of a disaster including, but not limited to: education and training, integration with community resources, developing response plans, organizing response and recovery activities, and conducting exercises are all preparedness efforts.

Mitigation - A process in which sustained actions are taken to reduce or eliminate long-term risk from natural and man-made hazards or disasters. Activities include, but are not limited to coordinating with state agencies, private sector agencies and organizations, and the public following disasters and emergencies.

Response - Actions taken immediately before an impending disaster or during and after a disaster to address the immediate and short-term effects of the disaster. These are the details of the plan given for others to follow in order for the Emergency Preparedness and Response plan to be successful.

Recovery - Activities implemented during and after a disaster designed to return an agency to its normal operations as quickly as possible.

2. COOPERATION/COLLABORATION WITH EMERGENCY OFFICIALS:

Our agency will be in contact with local/regional/state emergency preparedness officials during an emergency/disaster situation to collaborate efforts.

Our Agency will offer assistance during an emergency situation within the capabilities of our Agency.
All efforts will be documented on the EP Note & filed.

The Agency Emergency Coordinator will oversee communication with authorities having local jurisdiction during an emergency to provide information about the Agency's needs and ability to provide assistance.

3. PREPAREDNESS

a. ADMINISTRATIVE STAFF responsibilities:

Communication -

 Maintain a current staff roster and all applicable contact numbers (ie. home phone, cell phone, pager numbers, emergency numbers, special contact numbers of family/friends if employee is unreachable) for use as a communication tree.

 Set up and test, an emergency calling tree.

 Develop a backup communication plan for staff and patients, should the phone system not be working, ie. cell phones, walkie-talkies, e-mail-enabled wireless PDAs, meeting at a specific location, etc.

i. BACKUP COMMUNICATIONS PLAN: During an emergency event, should our Agency not be able to communication with staff or patients by normal channels (ie. phone system), we will establish communication with a designate local TV and radio station to facilitation communication.

See our Emergency Preparedness Plan for identification of back up communication channels.

 As applicable, meet & be in contact with local/state emergency planners to coordinate services, and advise of the Agency's needs and its ability to provide assistance to the local/regional authority having jurisdiction. This will be done by phone, email or in person meetings as appropriate.

 Disaster Coordinator will participate in community's disaster planning as appropriate.

 Ensure Agency Communication Logs are in place & current. (see LOGS). Logs include: patient, staff, physician, volunteer, emergency agencies, local emergency services.

ii. Patient Triage - The Clinical Manager will maintain a current patient roster, prioritized by care needs and based on specific services provided.

Criteria for prioritizing may include but are not limited to:

CLASS I - Life threatening (or potential) - requires ongoing medical treatment/care. Any equipment dependent upon electricity should be listed with the power company. Oxygen dependent patients should be supplied with a back-up tank from the supplier. Does not have a caregiver capable of providing care. Requires assistance with transportation to hospital or specialized shelter.

CLASS II - Not life threatening but patient might suffer severe adverse effects from interruption of services, ie. daily insulin, IV meds, sterile wound care with large amounts of drainage, symptoms controlled with difficulty, death appears imminent. Capable caregiver present. Will require transportation assistance to hospital or specialized shelter.

CLASS III - Visits could be postponed 24-48 hours without adverse effects, ie. sterile wound care with a minimal amount to no drainage, symptoms need intervention, but are fairly well controlled. Able to care for self or willing and able caregiver. Transportation available from family, friends, or others.

CLASS IV - Visits could be postponed 72-96 hours without adverse effects, ie. symptoms well-controlled. Able to care for self or willing and able caregiver. Transportation available from family, friends, or others.

 The Disaster Coordinator/Clinical Manager will maintain a current Physician log as part of our Communications plan.

iii. Secure Office Building

 Ensure fire extinguishers and smoke detectors are in appropriate places. Fire drills will be conducted at least annually. (documented by sign in sheet)

 All exits from the office are marked clearly for emergency routes. (EXIT)

 Post building layouts with identification of exits and fire extinguishers (evacuation map).

 Ensure entrances/exits are secure for staff working in agency.

 Mail safety - Make certain staff are able to identify suspect packages and letters, and steps to take such as: Don't open or smell; Isolate package or letter; Wash immediately with soap and remove contaminated clothing; Contact Administration and contact local law enforcement authorities.

 Identify equipment necessary for continued business operations. Develop a plan for how to replace or repair if damaged.

 Store extra supplies of items that may be needed during an emergency event.

 Know how to shut down heating/air condition system if necessary.

iv. Information Technology Systems - Ensure the following are in place:

 Anti-virus software, malware, and firewalls on all agency computers/laptops/tablets, etc.

 Ensure staff know not to open email from unknown sources with attachments.

 Use passwords and change on a frequent basis.

 Daily computer Back up (online, back-up disks, CDs, flash drive, etc), keeping one copy in a secure off-site location in case of an emergency event that limits access to the office location.

v. Emergency Financial Needs

 Meet with insurance carrier to review coverage for "acts of God" and/or other disasters. Review exclusions based on Disaster Declaration.

 Take inventory of Agency property, including photos.

 Make plan for paying creditors and meeting payroll.

 Make copies of financial/insurance records to be stored in safe off-site location (ie. bank vault/strong box - not another office or home) in case of disaster.

vi. Preparation for Utility Disruptions

 Plan ahead for potential disruptions in utilities, with possible extended disruptions. Speak with current service providers.

 Learn where turn-off valves are, and how/when to turn them off.

 Consider purchasing generators, if applicable to agency service plan/operations.

vii. Off-Site Location

 Make plans for an alternate location from which to operate if current office is not available, including communication systems, computer systems, and medical records, as applies.

viii. Media and Information Management

 In-service all staff for understanding that to ensure accuracy and continuity of information.

 Ensure all Agency specific information provided to a public source, be directed to the Administrator, or designated Emergency Team member.

b. CLINICAL STAFF responsibilities:

i. Communication

 Arrange for personal issues to be taken care of, ie. child care, groceries, medications.

 Keep vehicle full of fuel.

 Make sure Agency has an emergency phone list of names and numbers.

 Demonstrate education/understanding of agency's Emergency Preparedness Plan.

 Being an active participant at trainings, providing updated contact information for calling logs.

 Staff/volunteers/contractors will participate in emergency preparedness/response training annually.

 Staff will rotate on-call as appropriate and per job descriptions.

ii. Patient Triage

 Upon admission to our Agency and on an ongoing basis, the patient's condition and needs will be assessed for triage prioritization based on specific services provided.

 Upon admission to Agency and on an ongoing basis, the patient's location will be assessed for potential natural and/or man-made industrial disaster.

 Agency will provide patient/family with information on how to handle emergencies in the home related to a disaster. (Emergency Preparation Plan form) The Patient/family will also be educated on their responsibilities in the agency's emergency preparedness plan (SOC Documents). ie,. notify agency if relocate.

 The patient/family will be assisted with a patient-specific Emergency Preparation. The patient/family will be educated about this plan. The plan will be documented in the patient's medical record and communicated to Agency staff.

 Upon admission, patients will identify their 'evacuation relocation' plan which will be logged on the Patient Emergency Classification log. It will also be noted on the log, if the patient will require assist from local emergency management for evacuation from their residence, which staff will notify if emergency evacuation agencies of when needed.

 Upon admission, patients/family will be advised of the Agency plan if communications are severed during an emergency event (SOC Documents).

 Agency staff will advise local/state emergency officials of patients who require evacuation assistance during an emergency event.

4. MITIGATION

a. ADMINISTRATIVE STAFF responsibilities:

i. Communication

 The Administrator, or designee, will ensure that the office is adequately staffed.

 Emergency calling tree is utilized for contacting staff, volunteers and contracted staff. The calling tree is tested twice per year during drills & adjusted as changes occur.

 Training is provided for staff, volunteers and contracted staff for emergency preparedness planning at orientation and annually or as the plan changes.

ii. Patient Triage

 Administration will ensure adequate staffing is provided/back-up staffing plans in place.

 Contracts are reviewed for adequate supplies, equipment and medications during times of emergency.

 Emergency Disaster Coordinator/designee will be responsible for the monitoring of public information systems 24/7 for disaster related news and information, including after hours, weekends, and holidays. As needed, this information will be communicated to staff.

b. CLINICAL STAFF responsibilities:

i. Communication

 The staff members can communicate among themselves and the office via telephone, cell phones and pagers, walkie-talkies, e- mail-enabled PDAs, or other designated method that has been provided.

 Staff will educate patient/families on emergency planning, and will assist them with information to develop their own emergency plans.

 All patient/family education will be documented in the clinical record.

 Staff, volunteers, and contracted staff will attend emergency preparedness and response training at least annually or as the plan is revised.

ii. Patient Triage

 Coordination of patient care and communication regarding the patient's status will occur through verbal and written communication/case conferences which include all disciplines providing care. Coordination of patient care will include review and update of classification in the triage system when there are significant changes in the patient's condition and at least every 6o days.

 On-call books will be kept current with patient information.

 On-call reports will be given on all patients.

5. RESPONSE

The Administrator/designee will initiate and/or discontinue the activation of the Emergency Preparedness Plan.

a. ADMINISTRATIVE STAFF responsibilities:

i. Communication

If communication methods at our Agency site are disrupted, mobile communication systems, email-wireless PDA's, short-wave radios, and e-mail relays may be source utilized by the administrative staff.

 The emergency calling tree will be activated and patient triage begins.

 Back-up staff will be utilized as necessary to make patient contact.

 Volunteers may be used to support office needs, ie. copying, errands, filing, etc. as indicated.

 Disaster Coordinator/designee will be in contact with local emergency services and the Department to notify of disaster in progress as appropriate.

 Disaster Coordinator/designee will be responsible for oversight of documenting all aspects of the disaster, to include, names, decisions made, and times of actionable items.

ii. Patient Triage

 Clinical Manager will ensure that the patients are appropriately triaged.

 Our Agency will make appropriate referrals to assure continuity of care. This will include but not be limited to:

- Life-supporting equipment.
- Life-sustaining medication and/or nutrition.
- On-call/administrative staff will contact appropriate emergency community support systems, as appropriate to the patient.
- Local radio and/or television stations may be contacted by the Agency as a method of communicating with the patient population, if necessary.

 Agency staff will advise local emergency management officials/agencies of any patient who requires evacuation from their residence due to medical situation.

iii. Release of Patient Information During An Emergency/Disaster Event

 In the event of an emergency or disaster, protected health information (PHI) as defined by HIPAA may be shared with other healthcare providers without the patient's authorization. The clinical staff will advise the Clinical Manager of the need for sharing of patient info & will oversee the process.

 If a non-health care provider (ie. relative, neighbor, friend) requests PHI for a patient, the Agency must receive a HIPAA compliant authorization to release the PHI. This is unless the individual is the personal representative of the patient.

 The Agency may share patient information as necessary to identify, locate, and notify family members, guardians, or anyone else responsible for the patient's care of the patient's location, general condition, or death. In these cases, the Agency should get verbal permission from the patient when possible.

 Our Agency can also share patient information with anyone as necessary to prevent or lessen a serious and imminent threat to the health and safety of a person or the public, consistent with applicable law and standards of ethical conduct.

iv. Secure Office Building

 If an Agency is affected, administrator will determine if the removal of medical, personnel and financial records is necessary.

 Agency staff members will not jeopardize their safety to remove office contents (ie. medical records, personnel files) when a disaster has occurred at the Agency site.

b. CLINICAL STAFF responsibilities:

i. Communication

 If no method of communication is available, all staff who can safely travel, will report to the office location.

 Physicians & other medical professionals and appropriate disciplines involved in patient's care will be advised of patient/family status, as calls and visits are made.

 Patients may contact staff by calling the office number. If the office number is not operational, the call will be handled by the "on call" nurse or the backup communication method.

 If the answering service or the paging service is not operational, the agency will call forward to cellular "on call" phone (even if cell phone call won't go through, text messaging may still go through but, note that privacy isn't protected).

 Staff will maintain contact with the office for updates as possible.

 OFF DUTY STAFF & PATIENTS: The clinical manager/designee will follow up with any off duty staff & patients to determine services needed in the event that there is a disruption in service during or due to an emergency.
Our Agency will track & inform state and local officials of any off-duty staff or patients that we are unable to contact. All efforts will be documented.

ii. Patient Triage

Staff will contact patients according to patient triage prioritization.

 Staff will visit all patients as possible, based on time, disaster, and plan of care.

 Medications, supplies and equipment will be delivered as directed.

 Community emergency support services will be contacted and utilized as necessary, and as authorized by administration.

 Transportation for patients requiring evacuation will be coordinated from the office.

6. RECOVERY

The Administrator/designee will be responsible for oversight of the Recovery Phase of the Emergency Preparedness Plan.

a. ADMINISTRATIVE STAFF responsibilities:

i. Communication

• Administrator will receive full report on all disaster response activities, and Disaster Coordinator will develop a Continuity Recovery Plan:

- Response actions taken
- Necessary modifications to plans and procedures
- Training needs
- Recovery activities to date

• Any incidents that occurred will be documented, with action plans developed.

• Depending on disaster, various supports for staff may be offered, and staff encouraged to participate (ie. groups, counselors).
• Review Agency for ongoing care for patients and staff, preventative care, and professional counseling.
• Meet with local emergency response providers to review disaster response and formulate ongoing plans.

ii. Patient Triage

 Review Agency backup staffing plans for level of effectiveness.

 Ensure that patients that were moved, are placed back on schedule, and receiving care.

 Follow-up on any transfers or discharges of patients for continuity.

 Review on call logs.

iii. Secure Office Building

 Review & replenish office supplies and patient supplies.

 Review Agency contracts for effectiveness.

 If agency office is temporarily re-located during a disaster, agency will notify the Department per agency policy.

 If records are damaged during the disaster, the records must not be reproduced or recreated except from existing electronic records. Records reproduced from existing electronic records will contain:

- The date the record was reproduced.
- The agency staff member who reproduced the record.
- How the original record was damaged.

iv. Emergency Financial Needs

• Take inventory.
• Review costs expended/payers of patients.
• Contact insurance carrier.

b. CLINICAL STAFF responsibilities:

i. Communication

• Document any incidents that occurred during disaster.
• Meet with Administration to review activities of disaster response, and provide feedback for improvement.

ii. Patient Triage

•Contact all patients and notify their physician of patient status.
•Meet with all disciplines providing care to patients and re-classify patients for triage.
•Resume visit schedules.
•Assist patient/family with updating their emergency preparedness and response plan.

7. POST EVENT/DRILL ANALYSIS

Any time the Agency Emergency Preparedness Plan is activated for a real-world emergency or a drill, the Disaster Coordinator, along with the Emergency Team and other key staff as deemed appropriate, will meet to review the event/drill to determine if any aspects of the plan requires revision based upon the events.

The agency Emergency Preparedness Plan will be revised per the recommendations of the review team and approved by the Governing body.

All staff, volunteers and patients as appropriate, will be advised of any changes in the plan.

HIPAA

PURPOSE/GOALS

This in-service is designed to provide employees with an overview of the basic requirements of the Health Insurance Portability and Accountability Act (HIPAA). HIPAA also contains laws focused on reducing health care related costs, eliminating pre-existing clauses and waiting periods for individuals changing insurance plans, and increasing access to insurance for individuals. Strict guidelines for maintaining privacy, confidentiality, and security of health information are also part of HIPAA. But for home health, it is all about PRIVACY OF PATIENT INFORMATION.

GOALS FOR THE IN-SERVICE

Upon completion of this module, you will be able to:

1. Explain components of the HIPAA legislation.
2. Discuss how HIPAA expands availability of health care coverage.
3. Describe who is affected by the privacy and confidentiality pieces.
4. Explain protected health information (PHI) and individually identifiable health information (IIHI).
5. Describe processes utilized to assure patient information is confidential and secure.
6. Describe how HIPAA influences *informed consent* and the use of patient data for research.

INTRODUCTION

The Health Insurance Portability and Accountability Act of 1996 (HIPAA), also known as "Kennedy-Kassebaum" Act, passed congress in 1996. Many aspects of the legislation have been implemented in the ensuing years; the deadline for full implementation of the privacy and confidentiality requirements was April 14, 2003. Health care providers and organizations have strict guidelines that must be followed to remain within the law. While this module and most of our attention now is focused on the provisions of the legislation that deal with privacy, confidentiality, and security of patient records, HIPAA also contains other requirements that have an impact on employers, insurance companies, and purchasers of health insurance coverage.

HIPAA was designed to address public concerns about managed care, insurance availability, and insurance affordability. For example, HIPAA prohibits insurance companies from denying coverage because of:

1. preexisting conditions,
2. a family member's health status, or
3. whether or not an individual has been covered under a group policy and is seeking a personal health insurance policy.

Further, HIPAA ensures immediate coverage without regard to pre-existing conditions for individuals who change jobs and insurance carriers. Further, to encourage the purchase of long-term care insurance, HIPAA allows employers to deduct premiums and most benefits are tax-free to the beneficiary. Additionally, to facilitate purchase of health insurance by self- employed persons, the law allows 80% of the annual premiums to be tax- deductible by 2006. While many health policy analysts agree that these provisions have little impact on reducing the number of uninsured, they do, however, think these efforts are worthwhile. At this time, however, attention to HIPAA is riveted on implementing and paying for the privacy, confidentiality, and security aspects of the law.

In 1996, HIPAA was viewed as a way to reduce administrative costs, provide better access to health information, reduce fraud, and guaranty privacy of health information. However, the American Hospital Association estimates that it may cost between $4 billion and $22 billion to implement the tenets of the law. A search of the literature failed to produce specifics regarding cost; however, according to Gue and Upham (2004), the majority of costs are associated with developing and implementing software that integrates providers, payers, and governmental agencies.

As part of the HIPAA rule promulgation, the Centers for Medicare and Medicaid Services CMS mandated standardization of transaction and code sets (TSC) to reduce duplication, confusion, and non-compliance. CMS standards rely on use of ICD-9 codes for disease classification, CPT codes for procedures, and national drug codes (NDC) for medications. CMS admits that problems with these coding sets exist; new ICD-10-CM and ICD-10-PCS are thought to reduce the ambiguity and facilitate full implementation of electronic processing.

HIPAA is just the beginning of the ultimate conversion of healthcare information into an electronic health record (EHR). The Bush administration projects it will cost $100 million a year for 10 years primarily to fund demonstration projects and trial programs aimed at achieving four major goals:

1. establish routine use of EHRs in clinical practice,
2. connect health care workers in information exchange for clinical decision making,
3. enhance patients' ability to choose providers based on quality, and
4. integrate public health surveillance systems into an interoperable network to support new research and better care.

In 2013, HIPAA was modified, as described in the Federal Register/ Vol.78, No.17/ Friday, **January 25, 2013**/Rules and Regulations. The Department of Health and Human Services, Office for Civil Rights issued **its final rules to modify this HIPAA Privacy, Security, and Enforcement Rules** to implement statutory amendments under the Health Information Technology for Economic and Clinical Health Act (**HITECH)** to strengthen the privacy and security protection for individuals' health information.

The final rule is comprised of four final rules, which have been combined to reduce the impact and number of times certain compliance activities need to be undertaken by the regulated entities. According to the Federal Registry these rules are listed below.

Rule Number One:

- HIPAA emphasizes that covered entities should not use their business associates for Public Health Reporting. **Rule number one makes business associates directly liable for compliance with certain HIPAA Privacy and Security Rules' requirements.**
- It strengthens the limitations on the use and disclosure of protected health information (PHI) for marketing and fundraising, and prohibits the sales of PHI without the individual's written authorization.
- Expands the individual's rights to receive electronic copies of their health information and restricts disclosures to a health plan concerning treatment for which the individual has paid out of their pocket in full.
- This rule modifies the individual authorization and other requirements to facilitate research and disclosure of child immunization proof to schools, and to enable access to decedent information by family members or others.
- Requires modifications to, and redistributions of a covered entity's notice of privacy practices.
- The rule now adopts the **additional HITECH Act enhancements** to the Enforcement Rule not previously adopted in the October 30, 2009, interim final ruled and thus provisions addressing enforcement of noncompliance with the HIPAA rules due to willful neglect.

Rule Number Two:

- This rule adopts changes to the HIPAA Enforcement Rule to incorporate the increased and tiered civil money penalty structure provided by the HITECH Act, originally published as an interim final rule on October 30, 2009.

Rule Number Three:

- This final rule on Breach Notification for Unsecured Protected Health Information under the HITECH Act, which now replaces the breach notification rule's "harm" threshold with a more objective standard and supplants an interim final rule published in August 2009.

Rule Number Four:

- This is the final rule which modifies the HIPAA Privacy Rule as required by the Genetic Information Nondiscrimination Act (GINA) to prohibit most health plans from using or disclosing **genetic information** for underw4riting purposes, which was published as a proposed rule on October 7, 2009.

HIPAA BASICS

HIPAA contains provisions for **privacy** and **security**. Privacy rules have been promulgated and compliance was required by most health plans by April 14, 2003; plans with less than $5 million in annual receipts had until April 14, 2004 to fully comply. These rules have gone through several iterations, some as recently as March 2003 and refinements continue. Security rules that detail further requirements for the health care industry and patients were issued in October 2004.

A key factor for all health care providers to keep in mind is that, while HIPAA rules are **strict**, if state law covering the same topic is more stringent, the state law must be followed (Herrin, 2003). Providers and organizations must remain up-to-date with both HIPAA and state law changes.

The intent of HIPAA is to protect patients from unauthorized or inappropriate use and access to their health information. The rules protect patients by giving them access to their health information so they know what has been documented about their health status. Proposed outcomes of the HIPAA law are to improve quality of care, restore trust in the health care system, and improve the efficiency and effectiveness of information dissemination by building on existing legal frameworks.

HIPAA **creates safeguards** so that only those people or entities having a real 'need to know' health information will be able to access it. The HIPAA rules complement other standards that protect patients' rights, i.e., Community Health Accreditation Program (CHAP) and the Centers for Medicare and Medicaid Services (CMS). Compliance with privacy rules promises to be a cornerstone of future CHAP and Medicare/Medicaid surveys. Compliance is mandatory, not voluntary.

WHY HIPAA?

Health care professionals have long understood the need to protect patients from unauthorized use of their health information; at the same time, they want to have access to needed information when treating a patient. Widespread use of electronic data is facilitating the rapid transfer of information and the Institute of Medicine has urged the creation of standards so electronic records can be available.

Similarly, the public is greatly concerned about the privacy of their medical records. Prior to the electronic medical record, patient information was maintained in paper form and neatly locked away, accessible only to those who had authorized access. With computerized records information can be accessed, changed, distributed, and copied with far less regard for appropriate authorization.

Serious breaches of record confidentiality have occurred. An employee of the Hillsborough county health department was able to carry home a disk with the names of 4000 HIV positive patients. People have purchased used computers that contained prescription records of patients; Eli Lilly once sent out an email with the names of patients taking Prozac; the University of Montana inadvertently placed the medical records of some 62 people on the internet. Patients, health care providers, and other health care entities are very concerned about confidentiality, restoring the public trust, and protecting themselves from lawsuits.
Yet, the ability of multiple providers to access a patient's record can significantly improve the overall quality of care. Think about the chronically ill individual who receives care from more than one or two specialist

providers. If each provider has access to the most recent treatment plan, it stands to reason that care will be more coordinated, efficient, and effective

INCLUDED IN THE HIPAA LAW

HIPAA describes those affected by the law as "covered entities". Included under this umbrella are health care providers, health plans, health care clearinghouses, and business associates.

DEFINES Health care providers as: anyone who is paid for health care services or bills for services provided. The list is all inclusive: physicians, licensed health care providers, hospitals, outpatient physical therapists, social workers, certified nurse midwives, technicians administering X-rays done at home, home health agencies, pharmacists, providers of home dialysis supplies and equipment, nursing homes, nurses, and nurse administrators. This list means that any hospital or health facility worker who may see confidential patient information is included.

DEFINES A health plan as: any individual or group that pays for health care services. Included are health maintenance organizations (HMOs), insurance companies, Medicare/Medicaid, self-insured plans, employee group plans, federal plans such as CHAMPUS, military, veteran's administration, and Indian health services.

DEFINES Clearinghouses as: those entities that receive health information from providers and health plans. They typically are responsible for standardizing the information to improve claims processing. Included in this group are third-party administrators, billing services, and re-pricing agencies

DEFINES the business associates category as: covers a broad range of professionals and services. Included are attorneys, consultants, auditors, accountants, billing firms, data processing companies, and practice management firms. Nurses working as independent contractors, i.e., case managers, legal nurse consultants, and educators are included and subject to compliance with HIPAA law. A contract between the business associate and hiring agent must be in place before the associate can see any patient information.

WHAT HEALTH INFORMATION IS PROTECTED?

HIPAA created two new phrases to describe information protected by the legislation.
1) The medical record is now referred to as **protected health information (PHI).** This includes all information that is created by any covered entity. All forms of the information are part of protected health information, i.e., paper, electronic, video tapes, photos, audiotapes, and any information that has been duplicated, discussed, read from a computer screen, or shared over the internet.

2) The other new HIPAA phrase is **individually identifiable health information (IIHI).** Included in this category is any information that could reasonably be linked to a specific patient, such as a photo, name, address, date of birth, next of kin or responsible relative, medical record identifier, social security number, driver's license number, health beneficiary, account number, employer, finger, or voice prints.

The law specifies that some information that is not 'individually identifiable' can remain. Age that is reported as 60+ if the patient is older than 60, zip code if the patient lives within a zip code with greater than 20,000 people in it, race, gender, ethnicity, marital status, and the year only of the health care occurrence are not considered individually identifiable information and these data may be used in the aggregate.

All facilities must **limit access to information only to those who have a need to know**. For example:

- A staff member who seeks information about a patient not under their care is violating the HIPAA rules.
- Health information can only be used for health purposes.
- Employers cannot use the information to screen candidates for hire or promotion.
- Financial institutions may not use it to determine lending practice.
- Only the patient can explicitly authorize employers, banks, and individuals to have access to his/her medical information.

MINIMUM NECESSARY RULE is established: This rule stipulates that only the minimum necessary information may be shared, even with the patient authorization. For example in the treatment of a child or domestic abuse; the provider would, rather than providing an entire medical record, furnish the applicable information furnished in the form of an abstract outlining the information that is necessary to provide treatment and protect the victim(s). The abstracted information could be provided to legal and law enforcement entities. Health providers involved in the treatment of patients are not subject to the minimum necessary rule and can have full access to all information that is needed to provide patient care.

Health information that has implications for the public health and safety can be shared without consent. There are several situations where medical information can be shared:

- In Emergency 911 situations,
- When communicable diseases are involved,
- When law enforcement agencies participate, or
- If national defense or security is a factor.

The public health department is deemed a legitimate recipient of certain personal health information and providers must report some findings to the proper public health agency. Included are:

- Cause of death even when the patient dies at home
- Reportable communicable diseases
- Child abuse
- Reporting an adverse drug reaction to the FDA
- Occurrence of cancer in a state with a cancer registry
- Meningitis, and
- Immunizations for children.

These examples are thought to be important to the health of the public.

PATIENT CONSENT AND AUTHORIZATION

HIPAA makes a distinction between informed consent and patient authorization. Patients are entitled to know exactly how an entity plans to use the information.

INFORMED CONSENTS: are signed at the first Agency contact with the patient and covers treatment, payment, and other health care information.
The meaning and use of the patient's consent must be carefully explained to the patient. Facilities must explicate their disclosure process in a document called Information Practices. The American Hospital Association published a sample consent and explanation document that was 10 pages long. The document explains patient rights, as well as a description of how patient information is collected and used. Facilities must decide how and when the information concerning consent is presented to patients and how patients can

use their right to revoke consent. Patients must also be advised about the agency's policy that covers conditions for admission that are related to consent.

AUTHORIZATIONS: Patients may also sign authorizations required when information is used by the agency for purposes outside of care/treatment. Agencies must assess their policies and procedures to assure that they are always using an authorization when it is needed; some agencies may not realize that information sharing policies violate the patient's right to restrict release of data. Patients must be fully informed about the way agencies use a signed authorization and are entitled to receive a free accounting every twelve months describing how their health information has been used.
HIPAA privacy regulations also mandate specific **patient rights** that include the following:

1. Right to privacy notice requires disclosure and reasonable effort to assure that the patient understands the agency's policy concerning privacy of information.
2. Right to request restrictions means that patients may specify health information that cannot be released and/or, they may restrict to whom information can be released.
3. Right to access of PHI means that patients must be allowed to inspect and copy information contained in the agency's record.
4. Right to know what disclosures have been made means the agency must track all information released and be able to provide documentation to the patient.
5. Right to amend the PHI means that while patients may request amendments to the PHI and the agency must allow amendments, the agency may deny some requests.

All covered entities are required to comply with certain procedural rules. Most have had to develop new policies and procedures to address the many aspects covered under these rules. The following are some of the rules:

1. Agencies must appoint a **privacy officer** who will monitor and audit compliance.
2. Agencies must develop an **internal compliance process** that will assure no patient rights are violated, complaints are addressed and investigated, and that a process for remediation is in place.
3. **Training** must be provided to employees to assure that they are informed about patient rights and disclosure of information.
4. HIPAA requires that agencies **document any and all violations** and that sanctions parallel other disciplinary policies.
5. Agencies must have a **process for mitigating any harmful effect of disclosure**.
6. All **forms of communication** must be addressed in administrative safeguards.
7. Agencies must agree and have **policies that specify no retaliation for an employee or consumer who files a complaint.**

PRACTICAL IMPLICATIONS

Questions about the implications HIPAA rules have been numerous.

Can an office or laboratory have a patient sign in sheet?
Can you use a patient's name to call him into a treatment room?
Can the patient's name be posted outside the hospital door?

There is some agreement about some of these. As long as personal information regarding the patient's care or procedures to be done remain confidential, names can be outside hospital room doors, patients can be verbally called to treatment rooms, etc. New questions will undoubtedly arise in the future. Staying informed about the rules and regulations concerning HIPAA will be every health care worker's obligation.

Sign-in sheets, once disallowed, can now be used along with bedside charts as long as reasonable precautions are taken to safeguard patient information. Sign in sheets can only have the name and time; no information about the nature of the appointment can be included. The patient can give consent or may decline to have information given to family members; facility staff is not obligated to verify the identity of relatives.

HIPAA retains the rights of parents as the personal representative for minor children. There are exceptions, however. Parents may decide that the child and provider have a confidential relationship that excludes the parent from receiving information. A provider may choose to exclude the parent when abuse is suspected or when including the parent would endanger the child.

Patients have the right to restrict clergy visits and religious information. If the patient does want the clergy to visit, health care individuals should provide only the name and location of the patient. They should not provide any information about the patient's medical condition. Further, patients have the right to restrict informing callers or visitors that they are in the hospital. Most patients are asked on admission to the facility if they want such restrictions and, if they do, hospital workers may not acknowledge that a patient is in the hospital even including visitors, florists delivering flowers, etc.

Some information can be provided to law enforcement without patient consent. Emergency technicians can contact the police at a crime scene and convey nature and location of the crime. Information about a suspicious death may also be reported to the police. HIPAA has a one call rule that permits contacting an organ procurement agency following a death.

Repositories that store human tissue and fluids for future scientific analysis, i.e., genotyping, cell lines, other biotechnologies, express concern that HIPAA will fundamentally change how these commercial repositories function. At question is whether property rights continue to apply to human tissue after removal from the body. Prior to HIPAA, the Supreme Court in California ruled on the side of future research and determined that property rights end when tissue is removed from the body. However, depending on how HIPAA rules are interpreted, informed consent may be required in order for research to be conducted on removed tissue.

HIPAA AND RESEARCH

Patients must sign an authorization to allow their information to be included in research projects. Information can only be disclosed in accordance with a research protocol approved by an institutional review board. All identifying individual information must be removed. One difficulty researchers may experience is the lack of specific guidance from HIPAA regarding construction of compliant, de-identified data sets, at this point researchers are developing strategies that they believe comply with the intent of privacy under HIPAA. Ongoing analysis of medical information is critical for developing strategies to improve patient outcomes and reduce medical errors (Clause, S.L.; Triller, D.M.; Bornhorst, C.P.; Hamilton, R.A.; Cosler, L.E. 2004).

Information that can be used in compliance with HIPAA includes: gender, race, ethnicity marital status, dates of treatment if reported in years, age (for individuals older than 60, one must use 60+), and zip code if more than 20,000 reside in that zip code (Erlen, J.A. 2004)

CONCLUSION

HIPAA regulations require new behavior from health care professionals and health care agencies. Close coordination with other partners in health care delivery and reimbursement is mandatory to assure a continuous process of patient privacy.

Restrictions and the ability to amend IIHI give patients new control over their health information. Health care professionals may be challenged. Involving patients as active participants in their care will dispel and avoid potential problems.

MANAGING INFECTION CONTROL IN THE HOME SETTING

Germs, or **microbes,** are the culprits of infection**.** They are found on the skin, clothes, on objects, in food, air and water. They may cause disease by entering the body and changing cells. Some microorganisms are actually helpful, called **nonpathogens**, others are harmful and cause infection and are called **pathogens**. Some infections can be debilitating and some can even cause death. Preventing the spread of infection is everyone's responsibility. Infection control decreases risk of infection to clients, their families, friends, visitors, and health care workers. Each agency has policies and procedures for infection control. All employees are required to know them and to demonstrate competency in performing the procedures applicable to one's role.

DEFINITION OF AN INFECTION

An infection is the body's response to an invasion of germs called microorganisms or microbes. They are very small living things that cannot be seen without a microscope. Although some germs are helpful to humans, if they get in the wrong places on or in the body, they can cause infections. For example, if the normal flora, or nonpathogenic microbe, normally located in the bowel gets into the urinary tract, an infection may occur in the urinary tract. **Normal flora** are microbes that are necessary to maintain health, and are found in certain locations such as the skin, intestines, vagina, mouth and other areas. Normal flora act as a protection against pathogenic microbes, but may not always be successful.

Microbes live in humans, animals, plants, food, water and dirt. They require food, water and most need oxygen to survive. Germs survive best in a warm, moist and dark place where there is a food source. The human body has many such ideal places for the germs to grow.

INFECTION TRANSMISSION

Germs, or microbes, also called microorganisms, are of various types. They may be in the form of bacteria, viruses, parasites, yeasts or fungi. These organisms can be found in blood, body fluids and secretions such as saliva, sputum, nasal and vaginal discharge, and body excretions, such as feces. If these materials come in contact with another person, that person is at risk for developing an infection. Objects may also be contaminated with infectious organisms and pose risks to anyone who handles them. Examples of a possibly contaminated object might be floors, bathrooms, dirty laundry, bedpans, urinals, trashcans, sinks, invasive medical devices and utility rooms.

A **host** is the food source required for the germ to live and multiply such as a human. People, whose immune system is compromised due to illness or certain conditions, are very susceptible to infections.

Individuals Highly Susceptible to Infections

- Newborns
- Elderly
- Individuals with weakened or undeveloped immune systems
- Individuals with chronic disease
- Individuals with multiple health problems
- Clients with open areas, incisions, catheters, breathing tubes, intravenous, or other invasive devices

The most common means of spreading infection is the hands. There are five common ways to transmit infection from an infectious agent to a weakened or susceptible host. All that needs to happen is that a germ

contaminated source comes in contact with mucous membranes of the eyes, mouth, or nose, or any open cuts, abrasions, nicks, or any type of dermatitis or acne, and an infection may ensue. If the immune system, which is the body's mechanism for protecting itself against infection, is working, exposure to infection may prevent an infection from occurring. Lack of rest, stress, poor nutrition, chronic diseases or chemotherapy for cancer may weaken the body's immune system and cause the person to develop an infection.

Methods of Infection Transmission

- Direct Contact: This occurs when the germ is physically transferred directly from body surface to body surface. Examples include: touching, providing care as in rubbing, bathing, handling a clients bodily secretions (sputum) and excretions (urine, feces, vomit), or blood.
- Indirect Contact: This involves touching an object that is contaminated with germs. Examples include touching used dishes, bed linens, clothing, instruments or personal belongings.
- Droplet: This occurs when the germ is spread via droplets that are sent airborne from the infected person by talking, sneezing or coughing. The germs are spread for a distance of three feet. The droplets may land in a host's eyes, nose or mouth.
- Vehicle: This mode of transmission involves contaminated food, water, blood, medications or equipment as a vehicle. The vehicle may also be a vector such as a flea, mosquito, fly, rat or other vermin.
- Airborne: This method involves transmission over greater distances than droplet, and result in inhaling the pathogens that have been floating in the air, even for long periods of time. The microbes can be found on dust particles and moisture in the air.

SIGNS AND SYMPTOMS OF INFECTION

Infections are of two types and may co-exist in the body. A **localized** infection is generally located in one part of the body, although a person may have several localized infections, for example several mosquito bites may become infected. Signs and symptoms of a localized infection include:

- Redness, rashes, or skin changes
- Swelling or edema at the site
- Warmth at the site
- Drainage or visible pus under the skin or area involved
- Pain- describe and document

A **generalized** infection affects the entire body. An untreated localized infection may become generalized. Signs of a local infection may also exist with a generalized infection. Signs and symptoms of a generalized infection include:

- Fever, chills, sweating
- Fatigue
- Headache
- Increased pulse and respirations or changes in mental status
- Nausea
- Vomiting/diarrhea
- Sore throat/cough

A caregiver must observe for signs and symptoms of infection and report them immediately to his/her supervisor, and document what is observed. Any complaints that the client has should also be reported.

ENVIRONMENTAL SURVEILLANCE

Environmental surveillance is a responsibility of all caregivers. As the caregiver enters the home, both the client and the home environment must be assessed for actual or potential risks for infection. Assess for:

1. Persons especially at risk for infection
2. Lack of education regarding infections
3. Lack of running water, heat or electricity
4. Inability to flush toilets
5. Lack of proper waste disposal
6. Evidence of insects or rodents
7. Poor food handling or food storage
8. Inadequate or crowded sleeping or living conditions

All risks should be reported to the caregiver's supervisor. Follow the agencies policies and procedures for infection control and reporting. Some infections are required to be reported to State agencies, or the Centers for Disease Control and Prevention.

PREVENTION

Standard Precautions are those used for the care of ***all*** clients, whether or not they have an infectious disease. Standard precautions prevent unknown and known infectious diseases from spreading, since direct contact with blood, body fluids or body substances allow for disease transmission. Standard precautions include:

- Thorough washing of hands after accidental contact with blood and body fluids.
- Washing hands before and after applying gloves.
- Wearing gloves whenever there is any possibility of touching blood, body fluids, body secretions, excretions, nonintact skin, or mucous membranes. Sweat is not considered an excretion requiring gloves.
- Wearing a protective gown if clothing may come in contact with blood or body fluids.
- Wearing a mask or face shield, and protective eyewear if contact with droplets or splashes of blood or body fluids is a possibility.
- Handling soiled equipment and supplies properly to prevent contact transmission of microorganisms. Dispose of, clean and disinfect soiled equipment according to agency policies.
- Considering **all** soiled lined to be infectious.
- Disposing of sharp objects in the proper container.

Special or Transmission-based Precautions are used in addition to standard precautions with clients who have a diagnosed, or suspected, infectious disease that is easily spread from one person to another. There are three types of transmission-based precautions: Contact Precautions; Droplet Precautions, and Airborne Precautions. Transmission-based precautions require special protective wear. Consult the agency's Policy and Procedure Manual.

Handwashing, performed properly, is the one most important procedure for the prevention of disease transmission. It protects the client, the caregiver, families, and anyone who comes in contact with any of the above-mentioned individuals. The Centers for Disease Control and Prevention, (CDC), recommend washing the hands, vigorously, for 10-15 seconds. Follow agency policies for complete procedure. Avoid using bars of soap found in the home. Use soap provided by the agency to wash your hands. It is important to always wash hands:

- Prior to and after eating any food

- After using toilet facilities
- After grooming hair
- Prior to and after applying gloves, handling contact lenses, using any lip balm, or using cosmetics
- After coughing, sneezing or nose blowing
- After smoking
- Prior to and after providing client care
- After handling soiled linens or soiled items

Immunizations of clients and caregivers are a highly effective means of preventing infections. Caregivers should be immunized against hepatitis B, influenza, measles, mumps, rubella, and chicken pox.

Cleanup and proper waste disposal is necessary to assure that the client remains safe from transmission of infection, and that the environment and the caregiver are safe and protected as well. Reminders for cleanup and proper waste disposal include:

1. Properly dispose of any sharp objects.
2. Apply gloves before handling soiled items.
3. Clean bedpans and urinals with soap and water.
4. Used linens should never be shaken, held against one's self, put on the floor, or put with the family's laundry. Wash in hot water with detergent as soon as possible.
5. Contaminated walkers, canes or wheelchairs should be cleaned with a disinfectant solution.
6. Follow agency policies for cleaning equipment, such as stethoscopes, thermometers, scales, and other reusable items.
7. Most waste products can be put in the trash. Follow agency policy for the use of proper bagging and double bagging.
8. Flush blood, urine, feces, and other body substances in the toilet, not the sink. Review agency policies regarding proper cleanup of spills, and what materials must be disposed of in red biohazard bags.

Transport laboratory specimens in a leak-proof, puncture resistant container properly labeled. Always place your bag or supplies on a paper towel on a table or chair, keeping in your site at all times. Be aware of young curious children who may find your bag or supplies interesting playthings. Keep the bag clean at all times, and never return soiled equipment, such as a stethoscope, or supplies to the bag.

Teaching clients and families about infection control is every caregiver's responsibility. It is important that clients and families/visitors know how infections are transmitted, how to recognize the signs and symptoms of infection, how to prevent the spread of infections, and how to perform applicable procedures correctly in the client situation. Explain the importance of and encourage the client and family members regarding keeping updated on immunizations.

Reporting and documenting are critical in the infection control process. The CDC and agency policies dictate what diseases are reportable to State and Federal agencies. Infections must be monitored continuously, accurately documented and reported to the supervisor. Accidental exposures to actual or potential infectious materials must be reported to one's supervisor and agency policies followed. A medical evaluation and follow-up may be necessary.

CONCLUSION

Infection control is ongoing. It is a total commitment by all caregivers. Often one may not see the results of his/her practice of proper infection control policies and procedures. The self-assurance that one has done all that is expected for prevention and safety for the sake of the client, the environment and others who are in contact with the client, including every caregiver, is gratifying. There are numerous policies and procedures involved with infection control, and they need to be reviewed on a regular basis. Proper infection control practices, teaching, documenting and reporting are key to winning the war against infections.

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MEDICAL DEVICE REPORTING

INTRODUCTION

Due to increasing advances in technology, there lies concern as to whether there is safety in the use of these technological and biological endeavors. The manufacturer or the user may be at the root of the undesired effect. Since December 1984, the Federal Drug Administration (FDA), Medical Device Reporting (MDR) regulations have required companies that receive complaints of device malfunctions, serious injuries or death from medical devices to report them to the FDA. Evidence of under reporting existed. The Safe Medical Device Act (SMDA) of 1990 added two more activities: Post-market Surveillance for monitoring of products after being cleared to be marketed and sold and Device Tracking for the ability to trace certain devices at the user level. There was still much under reporting. The more serious the problem with the medical device, the less likely it was to be reported. A follow-up study in 1989 by the government's ener al Accounting Office (AO) indicated that serious under reporting still continued. More strict reporting rules were implemented in November 1991. The final medical device reporting rule was published December 11, 1995 and was implemented April 1996.

This program will bring the participant from the general functions of the FDA to the focus of this program which is the Medical Device Reporting requirements, the Act of 1995, the responsibilities of the manufacturer and the user. Resources that may be needed are identified, as well as where to obtain necessary information to maintain agency compliance. Professional staff must be aware of this act, and inform staff and clients about the need to report any malfunctions or adverse effects of any drug, medical device, radiological item or biological.

WHAT IS THE FDA?

The United States Food and Drug Administration (FDA) is an agency within the Department of Health and Human Services consisting of several centers and offices. It is responsible for protecting the public's safety, efficacy and security of human and veterinary drugs, biological products, medical devices, U.S. food supply, cosmetics, products that emit radiation and tobacco products. The FDA is also responsible for advancing public health by encouraging innovations that make medicines and foods more effective, safer and more affordable. The FDA is charged with helping the public receive accurate, timely science-based information to improve his/her health.

WHAT DOES THE FDA MONITOR?

The FDA monitors drugs, medical device reporting, biologics and radiological health. The FDA is also responsible for issuing safety alerts and notices regarding medical product recalls or problems. Each of these areas will be further explained.

Drugs. The FDA monitors the safety for using medications, medication errors, and prevention of untoward and adverse reactions to medications or drugs. For more information on this section, go to www.fda.gov and link onto the drug section.

Medical Device Reporting. The FDA monitors reports of adverse events and problems with medical devices. It also alerts health professionals and the public regarding the safe and proper use of devices and the health and safety of patients/clients. To report a mandatory medical device malfunction or ask questions about the MDR policy call: 301-796-6670, or 301-443-1240.

Biologics, Blood and Vaccines. Biologics include a wide range of products such as vaccines, blood and blood products, allergenics, somatic cells, gene therapy, tissues and recombinant therapeutic proteins. The FDA must be petitioned for authorization/approval to use investigational drugs or biological products. For additional information go to: www.fda.gov/BiologicsBloodVaccines/ResourcesforYou/...

Radiological Health. The FDA monitors information regarding medical imaging devices such as: X-rays and mammography; medical/surgical products such as surgical lasers and some consumer and business products such as cell phones or laser lights. Radiation safety, dose reduction, and emergency issues are a part of the monitoring process. Radiation-emitting products such as medical imaging, surgical and therapeutic products, home, business, and entertainment products and tanning products and equipment are included in this area of monitoring by the FDA. Additional information may be obtained by going to: www.fda.gov/ForHealthProfessionals/RadiologicalHealth/...

Alerts and Notices. Medical device problems may be the result of device malfunction. Problems may also be the cause of user error. The user, professional or general consumer, may not understand or follow the proper instructions for the device to function properly. The FDA issues alerts and warnings to explain why problems may occur, or to clarify correct procedures to follow to ensure safe and effective use of the device.

HISTORY OF THE MDR ACT

As mentioned earlier, the MDR Act of 1995 was the result of under reporting of medical device problems, a requirement since 1984. The legislation mandating facility reporting of medical device problem reporting was enacted by Congress to also provide more information to the FDA concerning medical device problems and malfunctioning issues. The Safe Medical Device Act of 1990 provided that device-related deaths must be reported to both the FDA and the manufacturer, and serious injuries must be reported to the manufacturer, or the FDA, if the manufacturer is unknown. This act also required that the user submit to the FDA a semi-annual report of all reports submitted during each period. These changes became effective November 28, 1991. These were then signed into law June 16, 1992 and included the reporting of adverse events as well. The important impacts of the 1992 Amendments on device users were to establish a single reporting standard for facility users, manufacturers, importers, and distributors and to clarify terms. The final rule was published on December, 11, 1995. It became effective July 31, 1996 for device users and manufacturers. This document provides the current provisions for medical device manufacturers. The goals of the regulation are to identify and monitor adverse events, and detect and correct problems in a timely manner. Both the user and the manufacturer/distributor, (including U.S. and imported devices) must report device related deaths, serious injuries and reportable malfunctions to the FDA. For additional information on medical device reporting requirements for manufacturers, domestic and foreign, go to www.fda.gov/MedicalDevices/DeviceRegulationanduidance...

UPDATE ON THE IMPACT OF THE FDAMA ACT OF NOVEMBER 27, 1997

Changes to the MDR Act became effective February 19, 1998 through the FDA Modernization Act (FDAMA) of 1997. On January 26, 2000, changes were published in the *Federal Register* regarding reporting requirements and became effective March 27, 2000. The reporting changes are:

- Medical device manufacturers, importers and distributors are no longer required to submit an annual certification statement;
- Domestic distributors are no longer required to submit MDR reports, but must continue to maintain records of adverse effects that are available to the FDA if requested;
- Importers must continue to follow the remaining requirements of the MDR regulations, 21 CFR 803, and
- Users must now submit annual reports instead of semi-annual reports to summarize their adverse event reports.

REPORTIN REQUIREMENTS

The FDA has mandated reporting requirements from both the problem device manufacturer and user. A summary of the reporting requirements for users is listed below.

What to Report	**Report Form # to Use**	**Report to**	**When**
Death	FDA Form 3500A	FDA & Manufacturer	Within 10 work days
Serious Injury	FDA Form 3500A	Manufacturer, FDA	Within 10 work days
		Only if manufacturer unknown	
Annual Report of	FDA Form 3419	FDA	Every January 1
Death & Serious Injury			

For additional MDR requirements and forms go to: http://www.fda.gov/downloads/Safety/MedWatch... FDA forms, instructions, and coding manuals can be obtained at: http://www.fda.gov. Reports should be submitted to:

Food & Drug Administration

Center for Devices and Radiological Health

Medical Device Reporting

PO Box 3002

Rockville, MD 20847-3002

If a user believes that a public health emergency exists, contact: FDA Emergency Operations Branch, Office of Regional Operations, HFC-162, Phone# 301-443-1240. The user must then follow-up with a FAXED report to: 240-276-3454.

WRITTEN REQUIREMENTS

User facilities must develop, implement and maintain written procedures for reporting adverse medical device events, such as deaths and serious injuries. Users must also establish and maintain MDR files. The FDA may disclose selective information from these reports to the public. The FDA will NOT disclose any specific information that would divulge trade secrets, personal patient information or user identification.

ENFORCEMENT

Enforcement of the MDR requirements has given the FDA the power to issue criminal and civil penalties to non-compliant users and manufacturers.

Criminal penalty authority*:* Non-compliance is prohibited under the Food, Drug and Cosmetic Act. Committing a prohibited act may cause the user to be subject to injunction proceedings and criminal penalties. Criminal penalties may be up to $1,000 fine and one year in prison for the first offense, if unintentional, and up to $10,000 and three years in prison for subsequent or intentional offenses.

Civil penalty authority: Civil penalties can be levied for non-compliance with the MDR requirements if the failure to comply was deliberate, or a risk to public health. A person who receives a civil penalty can request a hearing before an Administrative Law Judge, whose decision can be appealed to the Commissioner of the FDA. The Commissioner's decision can be appealed to the US Court of Appeals. Penalties may not be more than $15,000 per violation and not more than $1,000,000 for all violations contained in a single proceeding.

DEFINITIONS

The MDR has a listing of definitions of general terms used in the manual for "Medical Device Reporting for User Facilities" published in 1996. Definitions are also provided with the forms that are required to be submitted to the FDA for a malfunctioning device that has caused a death or serious injury. Some definitions are listed here, but are not all inclusive.

"Becomes Aware" A user becomes aware of a MDR reportable event when medical personnel employed by the facility have information that reasonably suggest that a reportable event has occurred.

"Caused or Contributed to" A device may cause or contribute to a patient's death or serious injury because of:

- Device Failure
- Malfunction
- Improper or Inadequate device design

- Improper Manufacture of the Item
- Incorrect Labeling
- User Error

Serious Injury: To be considered a serious injury, this type of injury or illness is one that:

- Is Life Threatening
- Results in Permanent Impairment of Body Function or Permanent Body Structure Damage
- Requires Medical or Surgical Intervention to Prevent Permanent Damage or Impairment

Malfunction: Failure of a device to meet performance expectations. Performance expectations include all claims indicated in the labeling for the device, its use and purpose for which the device is also marketed.

MedWatch: This is FDA's post-market surveillance program for reporting adverse events associated with all medical products regulated by the FDA, such as drugs, medical devices, biologics and special nutritional products.

MDR Reportable Event: A reportable event is one that the user becomes aware of information that reasonably suggests that a device has or may have been responsible for a death or serious injury.

Device User Facility: A hospital, ambulatory surgical facility, nursing home, outpatient diagnostic facility or outpatient treatment facility is considered device users.

Outpatient Treatment Facility: A distinct entity that operates for the purpose of providing nonsurgical therapeutic care such as medical, physical, occupational or **home healthcare** on an outpatient basis. Outpatient treatment facilities include ambulance companies, rescue services and **home healthcare groups**. An outpatient facility may be independently owned or part of another medical entity. An outpatient treatment facility is mandated to comply with the MDR regulations regardless of whether or not it is licensed by a Federal, State, municipal or local government, or whether or not it is recognized by an accredited organization. If an adverse event occurs, the outpatient facility must report the event regardless of the nature or location of the medical service provided by the outpatient treatment facility.

HOME USE DEVICES

A home use device is one that is intended for users in a non-clinical setting, is managed partly or totally by the user, requires adequate labeling for the user and may require training to use the device by a licensed medical provider to be used safely and effectively. Because changes in the healthcare environment have moved greatly from the clinical setting to the home environment, there are many more devices used in the home that at one time were strictly part of institutional care. This fact has implications for the need for safe and effective operation of these devices, especially for those with complex requirements for proper operation and maintenance. The FDA's Center for Devices and Radiological Health (CDRH) regulates medical devices, however, it is dependent on home care agencies to report medical device problems adversely affecting their clients.

PUBLIC HEALTH NOTIFICATIONS

The FDA's CDRH provides alerts and notices to the health care community regarding risks associated with the use of medical devices and recommendations on how to avoid the risks. Alerts are issued when the facts are not yet complete, but it is believed that the health care community should be aware of the potential dangers and risks associated with the medical device. This will allow the clinicians to make informed decisions regarding use of that particular device. This notification is called a **Preliminary Public Health Notification.** One can subscribe to FDA Public Health E-mail updates at: http://service.govdelivery.com/service/subscribe.html?code=USFDA_39.

CONCLUSION

The FDA, a government agency, has many functions and responsibilities. A major area that the FDA is involved with is Medical Device Reporting. There are many requirements of medical device manufacturers and device users that must be followed, or stiff penalties will result for non-compliance. Home healthcare is an area that the FDA seeks cooperation in identifying risks for adverse medical device events. Home Healthcare agencies are required to have policies and procedures in place. Requirements and the MDR Act can be found on the internet. There are many available resources on-line.

MEDICAL DEVICE REPORTING

REFERENCES

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3. http://www.fda.gov/BiologicsBloodVaccines/ResourcesforYou/... (5/17/10).
4. http://www.fda.gov/downloads/Safety/MedWatch... (5/13/10).
5. http://www.fda.gov/MedicalDevices/DeviceRegulationandGuida... (5/13/10)
6. http://www.fda.gov/MedicalDevices/Safety/ReportaProblem/uc (5/17/10).
7. http://www.fda.gov/MedicalDevices/ProductsandMedicalProced... (5/13/10).
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PROTECTION OF PATIENT RECORDS

Notice of Privacy Practices for PHI (Protected Health Information)

1. Ask the patient if they are okay with you to release information for treatment, payment, or operations of the Home Care Agency.

2. Ask if they have an individual medical power of attorney(representative) or have a legal guardian, that may exercise the individual's rights and make choices for them regarding their health information.

3. Obtain a list of those with whom you may share their information

4. Ask the patient if they have a specific way (i.e. home/work phone) or send mail to a specific address.

5. Let the patient know that they can receive an electronic or paper copy of their medical record and other health information the agency about them.

6. Let the patient know that the agency will correct any information the patient thinks is incorrect or incomplete.

7. Give the patient a copy of the privacy notice- paper or electronically

8. Ask the patient if they have a clear preference for how the agency can share their information in certain situations
    a. family, close friends, or other involved in their case
    b. information in a disaster relief situation
    c. information in a hospital directory

9. Patients need to be educated that if they are unable to tell the agency of their preference that the information may be shared if the agency believes it is in the best interest of the patient. The information may also be shared when needed to lessen a serious and imminent threat to health or safety.

Uses and Disclosures:

For Treatment: information may be used by doctors involved in the patient care and by nurses and health aides as well as by therapists, pharmacists, suppliers of medical equipment, or other persons involved in the patients care.

For Payment/Billing for Services: the agency may use the information for billing and payment purposes. The agency may disclose health information to the patient representative, or to another third- party payer. The agency may also contact the health plan to confirm coverage or to request prior approval for services that will be provided to them.

For Health Care Operations: The agency may disclose the patient health information as necessary for operating the agency, such as management, personnel evaluation, education and training, and to monitor the quality of care. The agency may disclose the patient health information to another entity with which the patient has or had a relationship with if that entity requests the patient information for certain of its health care operations or health care fraud and abuse detection or compliance activities.

To Do Research: The agency may use and disclose information of the patient for health research.

To Comply with the Law: The agency will share information about the patient if state or federal laws require it, including with the US Department of Health and Human Services if it wants to see that that the agency is complying with federal privacy law

To Respond to organ and tissue donation requests: The agency can share information about the patient with organ procurement organizations.

To work with a medical examiner or funeral director: The agency can share health information with a coroner, medical examiner, or funeral director when an individual die.

To Address workers' compensation, law enforcement, and over government requests:
The agency can share health information:
a. for workers' compensation claims
b. for law enforcement purposes or with a law enforcement official
c. with health oversight agencies for activities authorized by law
d. for special government functions such as military, national security, etc.

To Respond to lawsuits and legal actions: The agency can share information in response to a court or administrative order, or in a response to a subpoena. The agency will never share the patient information for the following purposes unless the patient gave written permission:
a. marketing purposes
b. sale of the information
c. most sharing of psychotherapy notes
d. the agency may contact the patient for fundraising efforts, but the patient can tell us not to again.

The agency may also share patient information in other ways that contribute to the public good, such as public health and research. The agency must meet conditions of the law before that information can be shared for these purposes.

How Can I protect Patient Health Information?

1. Know who the patient wants you to share the information with i.e. child, spouse, etc.

2. Know how the patient would like you to correspond with them

3. Do not take patient files out of the office area

4. Protect any records with patient information in your presence, in your car, etc.
   Ex: Do not leave open so the information can be read through a car window
   Be careful not to drop any information regarding patient in a parking lot
   Be careful to know let information fly way while in your possession

5. Place any records with patient information in a protective bag, nurse bag, etc. when caring out of office.

6. Do not take patient information home or leave open for other to read.

7. Be sure there is data encryption on your laptop, tablet, or smartphone.

8. Use secure e-mail that encrypted transmission.

9. Do not use personal cellphone to take patient pictures. Use a dedicated camera for use with office that can be directly downloaded to an encrypted office computer.

10. Don't accept patient information over the web or by unsecured e-mail.

11. Make sure **not to share sensitive information with others who shouldn't have access**, including co-workers or personal acquaintances.

12. Avoid accessing a patient's record unless needed for work or with written permission from the patient.

13. Minimize occurrences of others overhearing patient information. Do not use a patient's whole name within hearing distance of others.

14.Secure all paperwork containing Patient information by placing in a drawer or folder when not in use. Cover charts so patient names are not visible. Never leave records and other patient information unattended.

15. **Close computer programs containing patient information when not in use.**

16. Limit e-mail transmissions of Patient information to only those circumstances when the information cannot be sent another way.

17. Never share passwords between co-workers.

18. Always use a cover sheet when faxing patient information.

19. Properly dispose of patient information in a shredding bin.

20. Everyone should have a password to access patient information software.

21. It's also important to make sure any vendors or other businesses associated with the agency are properly following HIPAA standards as well.

Conclusion

By educating staff and patients on protection of patient health information by the agency, the agency and patients can become more sensitive and help fight identity and medical fraud.

The Resurgence of Tuberculosis

INTRODUCTION

During the past two decades, both institutional and non-institutional health care environments have experienced increases in the numbers of individuals requiring care, and the trend is expected to continue for the next 50 years at least. [CDC, Emerging...2001] The result is a spectrum of health care delivery that is greater than ever before. The individuals requiring care in the various health care settings are also more acutely ill and often immunocompromised, causing them to be more susceptible to infections and other adverse events. Therefore, infection control processes are of paramount importance in all health care settings today.

Tuberculosis, (TB), or *Mycobacterium tuberculosis*, (MTB), or *M. tuberculosis,* also referred to as MTB, was chosen as the topic for this program because TB is considered a global infectious disease threat, and the subject was of interest to many nurses who wanted updated information. The highest incidence of TB is occurring in Southeast Asia, Africa, and Eastern Europe. Cases of TB in the United States was on a decline until the late 1980's, but due to the AIDS epidemic, lack of knowledge and poor diagnosis by health care providers, a decline in funding for TB control, and increased immigration of persons from countries with high incidences of TB, rates for TB began to rise. Since 2000, cases of TB have fallen to 5.8 per 100,000 persons in the United States, but clinicians must continue to keep TB in mind as they assess and diagnose individuals. [Trezza, 2001] Increases in TB cases have also been attributed to substance abuse, homelessness, poverty, and a decline in the public health infrastructure. [CDC, Tuberculosis control...1993] HIV infection is considered as the most critical factor in the resurgence of TB, and the greatest risk factor for developing the active form of the disease. [Scharer, 1995] During the 1990's one of the areas of outbreak was in long term care settings. [Scott, 2001] Because of the increased frailty of these residents, they were easily susceptible to contracting TB from health care staff or others, or developing latent TB infection. Most long term care facilities now skin test all residents on admission and all staff on hire to establish a baseline and to prevent outbreaks as much as possible.

Clinicians must continue to assess for TB symptomotology. There continue to be at least 18,000 newly diagnosed cases of TB in the United States annually, about 15 million cases of latent TB, and the multidrug-resistant form of the disease continues to spread. [CDC, Tuberculosis elimination...1999] The disease mainly affects the lungs, but a third of the patients also have involvement of other organs such as the meninges, bone, joints, genitourinary tract, and abdomen. [Zaidi & Conner, 2001] There are also atypical presentations that will be mentioned later, that could possibly blur the diagnostic picture. Having a plethora of knowledge and resources regarding TB will assist the health care practitioner in proper care and treatment of the disease and its prevention.

This program will focus on updated TB information, and not stress that which has been known for years, unless considered relevant to the discussion. The definition of TB, its transmission, types, such as active pulmonary TB, multi-drug-resistant, and latent TB infection will be presented. The pathophysiology, signs, symptoms, and diagnostics, along with preventive measures, infection control processes, and reporting requirements will also be included. Clinical management, interventions, and a special emphasis on TB in the elderly, will provide the final areas that will conclude this program. It is suggested that if additional information is desired, the reader seek out the resources mentioned in the text, and listed at the end of the program.

DEFINITION/TRANSMISSION

Tuberculosis is a disease caused by *Mycobacterium tuberculosis*, which is bacteria that can affect any part of the body, but the most common place is the lungs.

The transmission of TB is primarily through the air by droplet infection from one person to the other when a person with the disease of the lungs or throat coughs, sneezes, laughs, or even talks in the presence of others. Unusual modes of transmission include wounds, if they are irrigated using a high pressured system, respiratory treatments, bronchoscopic procedures, autopsies, and direct inoculation either in the laboratory, or inadequately sterilized fiberoptic bronchoscopic equipment. The probability of contracting the disease increases with the intimacy and duration of contact with the infected person, as well as the degree of infectiousness. The bacteria then settle in the lungs of the newly infected person and begin to multiply. From there, the bacteria may migrate to other parts of the body such as the kidneys, spine or brain. TB in the lungs is contagious, but not if it is only in the kidney, spine or brain.

Active Pulmonary TB

TB bacteria become active when the immune system can't prevent them from multiplying. The person is in an active disease process. Pulmonary TB is the most contagious form of the disease. Health care workers are at a higher risk for contracting TB due to their increased exposure rate. In some cases the immune system can keep the disease under control for a while, but it may develop into an active case at a later time when one's immune system is compromised.

Individuals Prone To Compromised Immune Systems [CDC, Frequently...2002]

- Babies, young children, elderly
- Those infected with HIV/AIDS
- Substance abusers
- Diabetics, particularly if uncontrolled
- Those with silicosis
- Those with cancer of the head and neck
- Those with leukemia or Hodgkin's disease
- Those with severe kidney disease
- Those with low body weight
- Those receiving certain medical treatments, such as steroids, organ transplants

Multidrug-Resistant TB

Multidrug-resistant TB, or MDR TB, is the development of TB caused by the M. tuberculosis bacteria becoming resistant to more than one of the drugs used to treat the disease. This can happen if the TB patient does not follow the prescribed treatment plan. Drug resistance may be more common in people [CDC, Frequently...2002] who:

- May have spent time with a person who has drug-resistant TB disease
- Do not take their medication regularly
- Do not take all of their prescribed medications
- Develop the disease again, after having taken the TB medication in the past
- Reside in areas where drug-resistant TB is common

Patients with MDR TB have a serious condition and can be a great danger to high-risk individuals such as children and HIV-infected persons. The drugs prescribed to treat MDR TB are less effective than the usual medications prescribed for TB, and they have more side effects. The course of treatment is lengthened from 6 months, to 18-24 months, thereby increasing the cost of treatment. The cure rate is decreased from 100% to 60%. Outbreaks of MDR TB have

occurred in Florida, New York City, in hospitals, and in correctional institutions. Many of the infected persons also had HIV infection. A National Action Plan was implemented in 1992 by the Center for Disease Control (CDC). The plan assisted states to revise their TB-control laws and regulations, and encouraged the treatment and prevention of MDR TB. [CDC, Tuberculosis control...1993]

Many books have been written about TB; at least 220 were listed on Amazon in January 2002. The issue of MDR TB has been raised, but should the global epidemic erupt, will the world leaders be surprised at the resurgence? Will those in leadership positions be committed to addressing what is sure to become a serious worldwide problem? Let us hope that scientific, pharmaceutical, and political considerations regarding compliance, new treatment modalities, and any illusions/realities involving a TB vaccine are mutually discussed. [Reichman & Tanne, 2002]

DEFINITION/TRANSMISSION (Cont.)

Latent TB Infection

Latent TB infection refers to the condition when the TB bacteria are alive, but inactive in the body. This occurs when the person is exposed to the TB bacillus, but is able to fight the bacteria and render them inactive. The bacteria may remain inactive for the person's lifetime, or they may become active, especially if the immune system becomes weakened. Individuals with latent TB infection:

- Have no symptoms, do not feel sick
- Cannot spread the TB infection to others
- Usually have a positive reading when tested for TB
- Have a normal chest x-ray and sputum test
- May develop the disease in later life if not treated for latent TB infection

The decision of whether or not to treat a person with latent TB infection is determined by the size of the tuberculin skin test reaction, the person's age and the individual's risk factors of becoming an active case for TB. Included in this group are patients who: [Pope, 2002]

- Are HIV infected, especially if exposed to persons with active disease
- Are children less than five years old
- Have identified social risk factors, such as substance abuse, barriers to completing treatment plans, mental health problems, or homelessness

It is important to note that in a study of five US states, there were less than a third of all contacts with infectious TB cases with newly detected latent TB infection cases, that were documented to have completed treatment. [Reichler, 2002] It is critical to achieve high rates of completion of treatment plans in order to maximize public health efforts to eliminate TB in this country, and hopefully in the world as well.

PATHOPHYSIOLOGY

The M. tuberculosis bacillus is rod-shaped and an aerobe, distinctive for its small size (1-4 microns long, 0.3-0.6 microns in diameter), its slow rate of culture replication (~ than 24 hours), and the high lipid content of its cell wall.

The high lipid content makes it hydrophobic, thus contributing to the organism being acid-fast. The wax-like coating is believed to protect it from drying, and allows it to remain viable in the air for hours. Approximately 90% of people with TB infection will contain the infection, never know that they were infected, and never become symptomatic. Of the 10% who were not able to contain the infection, half will develop the disease in two years, and half will develop it during their lifetime. [Pope, 2002]

Initially the TB bacillus enters the body by way of the respiratory tract, but it can establish itself almost anywhere in the body. The bacilli first lodge in the lung alveoli and multiply in the warm, moist climate of the lungs. They are then engulfed and digested by the body's protective macrophages. However, these bacilli are capable of dividing inside the macrophages. From the lungs the macrophages carry the bacilli to the lymph nodes, and from there they may travel throughout the body. The initial infection usually goes undetected, and is termed latent TB infection. The person is not contagious unless an active pulmonary disease with symptoms develops. Approximately 5-15 % of latent cases become active within two years of becoming infected. People who are HIV positive, or are immunocompromised in any way, are most likely to develop an active case of TB. The most common sites for the TB infection are the lungs and larynx because of the high oxygen content which aerobes prefer. Other sites can include the liver, kidneys, lymph nodes, any soft tissue organ, and the central nervous system, involving the spine and brain. Tuberculosis meningitis often occurs in young children less than four years old, although it can be found in adults diagnosed with AIDS. [Trezza, 2001]

The CDC along with several physician groups advise preventive treatment for high risk individuals known to be newly infected, or having a high probability of having been infected with the TB bacillus. [CDC, Management...2002]

SIGNS/SYMPTOMS AND DIAGNOSTIC PROCEDURES

Signs and symptoms of active TB depend on where in the body the bacteria have invaded. Most commonly the TB bacteria affect the lungs. Signs and symptoms of pulmonary TB include:

- A bad cough, lasting longer than 2 weeks
- Coughing up blood or sputum from deep inside the lungs
- Chest pain
-

Other TB disease symptoms include:

- Weakness or fatigue
- Weight loss
- Anorexia
- Chills/fever
- Night sweats

The person with active TB disease may spread TB to others. Usually the individual has a positive skin test reaction, and may have an abnormal chest x-ray and/or a positive sputum smear or culture.

Although not particularly common, peritoneal TB may be misdiagnosed as peritoneal carcinoma, and should be considered in the differential diagnosis in patients with abdominal pain, fever and weight loss. Appropriate tests should be performed. The disease is rapidly fatal unless it is detected and treated, at which time it can become curable. [Zaidi, & Connor, 2002]

Diagnosis

The primary diagnostic evaluation for TB is the Mantoux tuberculin skin test. A positive reaction to the skin test can detect infection from the TB bacillus from 2-10 weeks after exposure. However, the test determines whether infection has occurred, but does not indicate whether the infection is currently active. The test is read 48-72 hours after injection of the TB serum just under the skin, not drawing any blood. The serum is a purified protein derivative (PPD) antigen.

Steven Avalos-Bock, 2001, explains and illustrates the correct procedure for administering the PPD skin test. When reading the results, Avalos-Bock maintains that one should:

- Measure the **induration**, or the area of hardened tissue, only, and record the measurement in millimeters. Avoid including areas of erythema or ulceration in the measurement.
- Describe the injected area in 48-72 hours and avoid using the terms as simply positive or negative results.
- In some patients with TB, or are elderly, or may be immunocompromised, the induration may be questionable, requiring the person to undergo other diagnostic testing.
- The induration only means that the patient has been exposed to TB bacteria, and is exhibiting an immune response to the PPD skin test. It cannot determine whether the person has latent or active TB infection.
- A newly identified induration is cause for further patient diagnostic work-up, such as a chest x-ray, sputum culture/sensitivity, and evaluation for TB symptoms, mentioned earlier.

The first method for diagnosis for TB is the PPD skin test. Other diagnostic tests that are performed to confirm pulmonary TB are chest x-rays and sputum evaluations for mycobacterial organisms. These specimens can be readily smeared, stained, and screened for the presence of the TB acid-fast bacillus, which is characteristic of this disease. Three acid-fast smears result in a presumptive diagnosis of TB and the need for treatment. Confirmation of the diagnosis of TB is made in 6-8 weeks after the culture proves the growth of the TB bacillus. [Christensen & Kockrow, 1995, p. 902-3]

PREVENTION

Prevention is the key to controlling or even eradicating TB. There is a common comorbidity between individuals with HIV and TB. The CDC recommends that that all patients with TB should be HIV tested, and those persons diagnosed with HIV should be TB tested as well. Despite the CDC recommendations, clinicians are only selectively testing TB patients for HIV based on their own perceptions of patient risk. This can cause a missed diagnosis of TB or HIV. [Stout, et al, 2002]

Prevention for Patients and Staff

Preventing exposure to TB is the goal for patients and staff. Working in a health care setting increase one's exposure to infectious diseases, TB being among them. Once a person becomes symptomatic, diagnosis, care and treatment must begin immediately.

The PPD skin test is the only way to determine if a person has latent TB. Individuals should be tested if they:

- Have been with a person with or suspected TB. A second test may be necessary depending upon the time of exposure and the test. A 10-12 week interval may be recommended.

- Have HIV infection or any other condition that increases one's risk for TB
- Think that they might have TB
- Are from a high risk country (Latin America, Caribbean, Africa, Asia, Eastern Europe, and Russia)
- Reside in the US in high risk environments, such as, homeless shelters, migrant farm camps, prisons, jails, and possibly nursing homes.

Some people may have been vaccinated with BCG vaccine, which is not widely used in the US, but is administered many times to infants and small children in high risk countries. The BCG vaccine may cause a positive reaction to the PPD skin test. Further assessment and evaluation is necessary to determine the cause of the reaction. The vaccine, BCG, was named after two French scientists, Calmette and Guerin.

It is important to remember that TB is an airborne pathogen, and cannot be spread through handshakes, sitting on toilet seats, or dishes and utensils. Once a person has been on TB medication for 2-3 weeks, he/she may no longer be infectious. It is critical that the patient take the medication exactly as prescribed to allow healing and prevent further infection. It is also important for the patient to keep all scheduled medical appointments. Once diagnosed, the individual should reveal the names of contacts, who may have been exposed to him/her, so that further evaluations may be made as to the likelihood that that person could develop active TB. [CDC, Management…2002]

Many anti-tuberculosis drugs are becoming ineffective due to the resistance of the TB bacillus to these medications. It would be of tremendous benefit if a vaccine were developed against TB. One of the leading causes of death, globally, remains that of TB. The BCG vaccine is administered in many countries, other than in the US. It is effective in preventing miliary TB (TB that has spread to the entire body via the bloodstream) and TB meningitis, but not pulmonary TB, which is the most contagious type of the disease. The BCG vaccine is given to infants and children in the US if they cannot be separated from a contagious adult, and are unable to take long-term prophylactic medications. The CDC advises that young children, who are contacts to infectious TB patients, be treated with latent TB medication until or unless they are excluded from being infectious. [Watson, 2001]

In cases where a person's immune system is compromised, their bodies are unable to react to the PPD skin test, and a false negative reading may result. If this is suspected, it may be necessary to perform anergy skin testing. Anergy skin testing is a means of obtaining information regarding cellular immune system competence, but there are problems associated with its reliability. The result is that the clinician is unable to base treatment decisions on the test results. The procedure involves administering skin tests for mumps and Candida, used together, with cut-off diameters of 5 mm of induration. This testing should only be used as part of a multifaceted patient assessment. It is not recommended in the US for HIV infected persons because of its lack of usefulness in the HIV infected population. [CDC, Anergy …1997]

Infection Control Processes

There are specific infection control measures that must be observed when an individual is diagnosed as having active TB. These measures should be instituted as soon as possible. The TB organisms are spread by coughing, sneezing, laughing, or talking into the air, and can remain suspended in the air, or land on dust particles, or remain as evaporated droplets for long periods of time. If the patient is institutionalized, certain airborne precautions must be observed. [Borton, 2001, Trezza, 2001]

Airborne Precautions:

- The patient's room should have negative air pressure.
- There should be at least 6-12 air exchanges per hour.

- There should be adequate room ventilation (air vents) to the outside.
- If the patient **must** leave the room, s/he must wear a surgical mask.
- Anyone not immune, or immunocompromised, should not enter the room.
- If someone who is susceptible to TB, or if susceptibility is unknown, s/he should wear respiratory protection.
- Staff should wear an individually fitted N-95 particulate respirator mask.
- The institution's infection control or epidemiology department should be promptly notified, as well as other health care entities.

If the patient is at home, and infectious, s/he must be aware of precautions to observe in order to protect him/herself and others by: [CDC, Frequently...2002]

- Following the medication treatment plan exactly as prescribed.
- Keeping the mouth covered whenever coughing, sneezing, or laughing.
- Using disposable tissues to cover the mouth, putting them in a closed paper sack, and throwing them away.
- Avoiding close personal contact with others; no school, work, and sleep alone, away from others.
- Closing the bedroom door and opening the window to air out the room several times a day if possible. Using an exhaust fan to blow out room air is helpful. TB bacteria spread in small closed spaces. Changing room air will decrease chances of others who enter the room from becoming infected.

Reporting Requirements

The communicable nature of TB has resulted in much attention by the CDC, state and local health agencies to develop laws specific to prevention and control of this disease. A committee was organized by the CDC to develop current, revised laws and recommendations that would be consistent in all states, and that would permit a rapid review and amendment of policies and practices as new information became available.

The goals of any state TB program should be to prevent, control, and to hopefully eliminate TB. One way toward this end is to protect the public by assuring that persons with TB receive appropriate care and treatment. An effective state TB control program should have systems that: [CDC, Tuberculosis control...1993]

- Include the development and implementation of comprehensive programs that address the needs of persons with TB, including proper treatment, and follow-up.
- Integrate TB services with drug and alcohol treatment programs.
- Expand public education about TB, especially for high-risk areas and groups.
- Require the application of recommended infection control measures in health care facilities and congregate living environments.
- Ensure mandatory reporting of confirmed and suspected cases of TB.
- Safeguard the confidentiality and civil liberties of persons diagnosed with TB.
- Protect individuals with TB from unlawful discrimination.
- Finance the treatment of indigent persons.

There are many reporting requirements when a person is diagnosed with TB. Each state has designated health care professionals that are responsible to report cases of TB to local and state health departments. All states must then report all cases to the CDC. States vary in their reporting systems, so it is advised that the clinician review the rules and regulations for his/her respective state where s/he is practicing. Reporting requirements and CDC recommendations are designed to achieve the Strategic Plan's mission of eliminating TB in the United States by the year 2010.

CLINICAL MANAGEMENT/INTERVENTIONS

Clinical management of TB is primarily that of drug therapy, and the focus is elimination of the organism from the host. The infectiousness of the disease declines once drug therapy is begun, even before the sputum tests negative. As symptoms decrease, especially the cough, the person may be taken off isolation. This can occur two weeks after treatment has begun. Treatment for TB is long, typically 6-9 months, but may be longer for cases other than pulmonary TB. It is very important that the drug therapy plan be followed as prescribed to avoid the risk of relapse.

Drug therapy involves the prescription of more than one drug in case the TB organism becomes resistant to one of the drugs. Two or more drugs will prevent the drug resistant factor from developing. Drugs to treat TB are classified into two categories; first and second line drugs. [Christensen & Kockrow, 1995]

First-line TB Drugs

Drug:	**Side Effects:**	**Interventions**
Isoniazid	Peripheral neuropathy, liver toxicity, increased blood sugar, bone marrow suppression	Monitor liver function, emphasizing long term (LT) therapy required, tell pt. to report numbness and tingling of extremities
Rifampin (rifampicin)	Flu-like symptoms, hematopoietic reactions, liver toxicity, rash, body fluids red-orange colored, SOB, heartburn, mouth/tongue soreness, increased sun sensitivity, dizziness, confusion	Give on empty stomach, emphasize LT therapy, may increase metabolism of other drugs, may stain soft contact lenses, avoid sun exposure, check liver function
Rifampin and INH (in a fixed combination)		
Pyrazinamide (PZA)	Hyperuricemia, exacerbates gout, liver toxicity	Monitor liver function and serum uric acid, advise no alcohol intake, LT therapy required
Ethambutol	Optic neuritis, blurred vision/decreased visual acuity, hyperuricemia, exacerbates gout, drowsiness, confusion, GI effects, liver toxicity, thrombocytopenia	Do baseline visual exam at start of therapy, LT therapy required, check liver function
Streptomycin1	Broad spectrum antibiotic may cause renal dysfunction or failure, ototoxicity	Monitor BUN and serum creatinine, keep pt. well hydrated, adjust doses based on serum levels

Second-line TB Drugs

Drug:	Side Effects:	Interventions
Ethionamide	Dermatitis, alopecia, low blood pressure, drowsiness, convulsions, GI symptoms, hepatitis, visual problems, thrombocytopenia	Monitor liver/blood studies, assess mental status, give with meals, LT therapy, no alcohol
Para-aminosalicylate Sodium (PAS)	N/V, diarrhea, abd. pain, hypersensitivity reactions, livers toxicity, leukopenia, thrombocytopenia	Monitor blood/liver studies, take with food, discard if discolored, use with caution in peptic ulcer disease or CHF, LT therapy required
Cycloserine, Capreomycin, Kanamycin, Amikacin	These are antibiotics. See Streptomycin above for side effects and interventions, or check a drug reference book.	

Interventions are focused on preventing complications and transmission of the TB disease. Patient teaching is of utmost importance, especially regarding transmission and compliance with the prescribed medication regime. By strictly adhering to the prescribed medication plan, the patient can almost always be cured. The drug most prescribed for the treatment of TB is INH. It is taken for 6-9 months, or even longer in some cases. It is often prescribed in combination with other drugs. Individuals who have latent TB, and are not treated, should be familiar with the symptoms of the disease.

There have been fatal and severe liver injuries associated with the use of Rifampin and Pyrazinamide used to treat latent TB infection. This has resulted in revisions in the American Thoracic Society/CDC treatment recommendations in the US. These recommendations, as well as determining who should be tested and treated for latent TB, can be found in the CDC update reference. [CDC, Update...2001]

TUBERCULOSIS IN THE ELDERLY POPULATION

The increasing numbers of people age 65 and older are a population at risk for TB. This age group is more vulnerable because of their decreased cell-mediated immunity, possible increased travel, close community living arrangements, and institutionalization, particularly in nursing homes. The elderly also have higher frequencies of latent TB infection due to prior exposures during a time when TB was more prevalent and treatment not as effective. In 1995, 23% of the reported cases of TB in the US occurred in this age group, and persons living in long term care facilities had four times the increased rate of active TB. Due to these reasons, TB will continue to emerge in the geriatric population. [Strausbaugh, 2001]

CONCLUSION

The incidence of TB is rising in the developed world. There are three distinctions in categorizing TB. They are active, most commonly the pulmonary type, the multidrug-resistant type, which has posed treatment challenges, and latent TB infection. The primary diagnostic tool for TB is the Mantoux, or PPD, skin test. A positive reaction indicates a need for further diagnostics. Prevention of TB is the key to control and eradication of the disease. There are specific infection control measures that must be observed when a person is diagnosed with TB. There are also many reporting requirements for health care professionals when an individual has been confirmed as having TB. Clinical management is focused on drug therapy and patient teaching, particularly regarding strict adherence to the prescribed medication regime and the prevention of disease transmission. The elderly are at risk for TB. Based on prior exposure and latent TB infection, the disease will continue to be a problem source in the geriatric population.

In the United States there are many different laws and regulations for the control of TB. The CDC has developed recommendations to encourage consistency among the states for TB control programs. The goals of each TB control program are to prevent, control, and appropriately treat individuals who are infected with TB, while at the same time protecting them from unlawful discrimination because of their diagnosis, and assuring confidentiality and civil liberties.

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SAFETY CONSIDERATIONS FOR THE HEALTHCARE WORKER

INTRODUCTION

Caregivers, upon entering a home, may encounter many actual or potential safety risks. The government agency that is concerned with the health and safety of workers, called the Occupational Safety and Health Administration (OSHA), reports that the healthcare industry has more job-related injuries and illnesses than most other hazardous industries. This module is designed to address those safety considerations a home health aide may encounter on the job, and provide awareness to prevention of accidents. The safety of both the client and the caregiver are included in this program. For specific policies and procedures developed by the agency on these topics, the home health aide is encouraged to review the agency manual. Illness prevention and transmission are addressed in the infection control module.

Children and the elderly have more accidents than other age groups. Children often lack the concept of safety, while older adults are subject to physical changes of aging, disease processes, mental impairments, life changes and losses, and effects of medications, all of which contribute to their increased susceptibility to accidents and injuries.

SAFETY CONCERNS IN THE HOME

Safety concerns in the home should always be a forerunner in the caregiver's mind. Every home is a different environment, has unpredictable safety hazards, and can be a prime target for accidents to occur.

Accidents

Accidents or injuries may be the result of carelessness or negligence such as:

- Moving or lifting incorrectly
- Failure to use equipment correctly, such as locking wheelchair brakes
- Lack of knowledge by either the client or caregiver regarding equipment use
- Failure to clean spills, wet floors
- Not removing loose carpets or rugs
- Clutter and debris in walkways
- Electrical cords in walkways
- Allowing glare; or poor lighting
- Wearing improper footwear
- Rushing, or not watching where one is going
- Not checking the temperature of hot liquids, resulting in burns
- Careless smoking, or improper disposal of smoking materials
- Drinking or eating poisonous substances due to poor vision or carelessness
- Respiratory failure due to choking, drowning, smoke inhalation or electrical shock
- Not correcting situations that are potentials for accidents to happen

Hazards

Hazards in the environment must be corrected immediately, or at least minimized until an appropriate person is able to remove or reduce the hazard. Every attempt must be made to make the environment safe for the client, caregiver or anyone entering the home. Listed are examples of home hazards that may exist, but they are not all inclusive:

- Limited supplies and equipment resulting in improper or inadequate performance of necessary care
- Inability to perform care adequately due to small space and rooms crammed with furniture
- Clients living in poor conditions: sagging beds; worn, broken down furniture; unclean, unkempt surroundings; bathrooms that are too small, and narrow stairways
- Clients living in dangerous neighborhoods which could lead to a home invasion
- Severe weather conditions that could lead to difficulties for caregivers to enter the home, or cause a potential for harm to the client

ACCIDENT PREVENTION

Common sense is often the single, most important factor for accident prevention. If the caregiver is aware of a potential accident source, that source must be dealt with immediately. Listed are some accident preventive measures:

- Always correctly identify the client before entering the home
- Clean spills immediately
- Use all equipment as directed by agency policy/procedure, or manufacturer's directions
- Use safety equipment as per agency policy
- Make the client's environment as safe as possible. Encourage use of safety bars, rails, shower chairs, bath mats, and the like
- Check client's footwear for proper fit, traction, support, need for repair.
- No walking in stocking feet or unsupportive slippers
- Lock wheels on equipment
- Encourage adequate lighting
- Report faulty operation of equipment or other safety hazards
- Use proper body mechanics
- Always follow agency policies and procedures
- Keep walkways free from clutter

GENERAL PRINCIPLES OF BODY MECHANICS

Body mechanics is a term used to refer to the body being utilized to produce motion. When performed correctly, the action performed will be done in a safe, efficient manner. Proper body mechanics should be observed at all times, not just in the workplace. Proper body mechanics should be maintained while walking, sitting, standing, working, lifting or moving objects. Change positions frequently, stretch and relax. Change the position of the client frequently if s/he is unable to do so. This prevents fatigue and back strain. Follow Agency policies and procedures for specifics on proper body mechanics. Reasons for following the principles of correct body mechanics are:

1. Protection of the client from injury
2. Protection of the caregiver from injury
3. Conservation of the body's energy and fatigue prevention

General Principles of Proper Body Mechanics

- Maintain balance by standing with feet 8-12 inches apart.
- Bend at the knees, not at the waist.
- Keep the back straight, especially when lifting.

- Use large muscles when lifting, such as those in the arms and legs. Thigh muscles are the strongest; back muscles are the weakest.
- When lifting, stand close to and hold the person or object as close to the body as possible.
- If turning with a heavy object or person is necessary, do so with your entire body. Never twist when turning.
- Perform coordinated, smooth body movements.
- If possible, push preferably, or pull an object, rather than lifting it.
- Always use correct posture. Avoid stress and strain on the body.
- When possible, work at a proper, comfortable height to avoid strain on back muscles.
- Plan ahead to avoid risks of body injuries to the client or self.
- Avoid lifting heavy objects higher than the waist.
- Maintain physical fitness.
- Seek assistance if the client or task is unsafe to move or handle. Notify the supervisor if the situation is determined unsafe.

GENERAL PRINCIPLES OF FIRE SAFETY

Fire safety is everyone's responsibility. Fire prevention is the key. There are certain elements that are required for a fire to start, **fuel, oxygen and a spark**. Since oxygen is in the air, and fuel is anything that will burn, it is the spark that is needed to complete the cycle.

Fires are often caused by careless disposal of smoking materials. Other causes include defective electrical equipment, overloaded circuits, ungrounded plugs, improper use of appliances, improper disposal of trash, cooking materials, flammable liquids, and oxygen equipment. If the client needs more oxygen than is present in normal air, an oxygen tank or concentrator may be necessary. Special procedures must be followed. Check with agency policies and procedures regarding oxygen safety and management.

Once the caregiver enters the client's home, s/he should become oriented to the following emergency factors:

- Be aware of the location of all exits
- Plan, with the client if possible, routes for quick emergency exits
- Know the location of telephones and smoke detectors in the home
- Know the client's telephone number
- Ask if the client has any fire extinguishers, where located, and learn how to operate them

Should a fire occur while you are in a client's home, it is extremely important not to panic, scream, or run. Remain calm, and follow the universal RACE system.

RACE SYSTEM

R -----**Remove or rescue** persons in immediate danger.
A -----**Activate** the Alarm by calling 911.
C -----**Contain or Confine** the fire and smoke by closing doors, windows.
E -----**Extinguish** the fire if very small, or **Evacuate** the building.

It is important to know that a smoldering fire is very dangerous, and can erupt into an uncontrollable blaze. Smoke can be a killer. More people die of smoke inhalation than from fire itself. Observe the agency's procedures on the operation of fire extinguishers. Review the type that the client may have in the home. Always remember to point the fire extinguisher nozzle toward the base of the fire. If trapped in a room that may have a fire beyond it, refrain

from opening doors, unless you check with the back of the hand for heat radiating from them. Remain close to the floor to avoid inhaling excessive smoke. Covering the mouth and nose with a damp cloth may also filter out smoke. Actions during the first few minutes are key to safety and survival.

GENERAL PRINCIPLES OF ELECTRICAL SAFETY

Pain and injuries, even death, may occur to clients and caregivers from electrical shocks. The following principles are not all inclusive, but they identify precautions for managing electrical safety.

- Assess electrical outlets for safety before using home medical equipment.
- Assure that the medical equipment is from a JCAHO certified Durable Medical Equipment Company. Check with the supervisor before using it.
- Examine cords and plugs prior to use for safety. Report to the supervisor any unsafe equipment, such as damaged plugs or those that heat up when used. Do not use any defective equipment.
- Avoid putting electrical cords near water or heat sources.
- Never run cords in walkways, under rugs, or put tacks, pins or nails through cords or wires.
- Use three-holed grounded electrical outlets if possible, and never break off a third prong on a grounded plug.
- Avoid using electrical adapters that allow one to use additional plugs in a single outlet. The extra demand for electricity may cause a "short" or overload the outlet.
- Always disconnect the power source before cleaning any electrical equipment.
- Be aware of where the circuit breaker is in the home in case it becomes necessary to turn off the power to the home, or to a section of the home.
- In case of a power outage at the client's home:
    - Know if the client has well or city water. If it is well water, no water can be used in the home or the well will go dry.
    - Notify the local power company if the client is on any life support equipment on admission. The company will put the home on a "Priority One" list for power restoration.
    - Inform the power company if the client has an emergency generator, and how long it will last.

PERSONAL SAFETY CONSIDERATIONS

This section will address personal safety considerations not involved with infection transmission, such as the proper handling of medical waste, handwashing, or proper use of personal protective equipment. Although these topics are included as personal safety considerations, the caregiver should resort to the agency policy and procedure manual for proper performance of these skills.

Personal safety of the caregiver is becoming more important as our society increases in violence, mental illness, and abuse of alcohol and drugs. The caregiver must be aware of the environment as s/he travels to and from client homes. Be cautious, be careful, and be alert. Review the client's record for potential problems prior to the visit. Always know where the client lives, keep a map handy, have change available for making phone calls, avoid carrying a purse, and have a cell phone to use in an emergency. Knock on the client's door and identify yourself before entering. Never attempt to break up domestic arguments. Should a situation be assessed as unsafe for any reason, exit the area, and notify the supervisor and the police if necessary.

Should personal defense become necessary, hand-held alarms, noise devices, screaming, "Fire!" or "No!" kicking, acting insane, using approved chemical/pepper sprays are ways to ward off aggressive or assaultive individuals.

CONCLUSION

Caregivers are exposed to many safety threats and hazards. Knowing how to prevent accidents and injuries to oneself and the client will maintain a safe environment in which to work. Following the general principles of body mechanics, fire and electrical safety, as well as personal safety will enable the caregiver to confidently manage in a complex client/work relationship. Be aware, keep healthy, and follow the rules of safety.

SAFETY CONSIDERATIONS FOR THE HEALTHCARE WORKER

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GRIEVANCES/COMPLAINT PROCEDURE: INTERNAL AND EXTERNAL POLICY

POLICY:
It is the policy of this Agency to provide a formal process for a customer (internal & external) to follow in reporting a complaint/grievance and an established method of processing the complaint/ grievance.

PROCEDURE:

1. Signal Health Group Inc. will investigate all complaints/grievances presented. Timeframes for investigation includes after agency hours.
2. All patients upon admission to Signal Health Group Inc. & staff upon hire/orientation will be provided written and verbal information regarding Signal Health Group Inc.'s complaint/grievance process.
3. Upon receiving a patient/family complaint/grievance, written or verbal, the receiving person shall:
   a. Forward the complaint to the Administrator/Director of Professional Services for processing.
   b. Complete a Complaint Report documenting:
      i. Date and time of complaint
      ii. Date and time of alleged occurrence
      iii. Name and address of person reporting complaint
      iv. Name of staff receiving complaint
      v. Description of alleged incident
      vi. Name and discipline of staff allegedly involved in the incident and
      vii. Inform complainant that investigation shall ensue.
   c. Obtain written statement from all persons allegedly involved in incident
   d. Investigate the incident as fully as possible
   e. Reach a finding with appropriate response
   f. Implement discipline and/or corrective action (if warranted)
   g. Inform Administrator of complaint, investigation and finding
   h. Respond to complainant in writing as to the resolution and (if any) remedy proposed within 10 days.
   i. Establish in writing a 30 day period to affect the resolution/remedy
   j. Assure that complaint and all associated documentation is filed
   k. Forward summary of the complaint to Customer Feedback Committee.
   l. If Signal Health Group Inc. receives an appeal to the decision, the Administrator will review and forward to the Governing Body immediately for review.
   m. Complaints will be retained for a period of three (3) years.

CORPORATE COMPLIANCE PROGRAM

COMMITTEE SPECIFICS:

a. The Corporate Compliance Committee will meet once per year.

b. The GB will designate a Corporate Compliance Committee which will be composed of:

i. A member of the Governing Body
ii. Administrator
iii. Chief Financial Officer (if in place)
iv. HR Director (if in place)
v. Ad Hoc members

MEETING TOPICS:

At the meeting, The Corporate Compliance Committee will review:

a. The report of the Corporate Compliance Officer (CCO).
b. Any fraud alerts issued by the Officer of the Inspector General (OIG).
c. Topical issues with respect to corporate compliance in the general health care industry and in the Home Health Care industry in particular.
d. "Hot-line referrals" made to the CCO.
e. It will make recommendations with respect to the improvement of compliance efforts, which will be subject to final approval by the GB.
f. It will review the effectiveness of recommendations that were implemented as the result of previous committee meetings.

The CCO shall annually review all reported violations or incidents of misconduct/compliance and business ethics policies, and report such to the GB.

COMMUNICATION

Communication means exchanging information with others. We exchange information about feelings, opinions, or facts. People let others know how they feel or what they want all day an even during the night. You can tell if your friend, supervisor, or client is happy, in pain, sad or bored. They can tell the same about you!
You can tell if a sleeping client is in pain or resting comfortably. Communication takes place in several ways: through verbal exchange, written words, and through body language or nonverbal methods. Communication is necessary so that people function together – in other words, so they can "get along". Developing the ability to get along with people, clients, visitors and fellow workers **IS A VERY IMPORTANT PART OF YOUR JOB**. *Being a good communicator is essential.*

Verbal Communication – exchange of ideas or information through spoken works. The tone of your voice, the speed at which you speak, your inflection, and your actual choice of words are all part.
Written Communication – anytime your write or draw, you are communicating. The neatness, legibility, the choice of works and how you give the written work to the reader sets the scene for how it is received. When documenting the care or tasks completed, employees must always remember to sign their name and title.
Nonverbal Communication – your body language. As much as 90% of communication can be through our nonverbal cues. No words can be spoken but a clear message is given and received by others.
Body language includes:

-The way we do or do not look at people
-The way we stand, with our hands in pockets, on hips or at our sides
-Where we stand, close to the person or far away
-What else we may be doing at the time, on our phones, reading, folding laundry

Basic Rules for Communication –
Be a nonjudgmental observer and listener. It is important to learn to receive information in a nonjudgmental way; that is in an accepting manner without expressing your opinions. When you work in a client's home, they often ask your opinion. If you are not sure or you think your opinion will be upsetting or cause friction, you might say, "This is your house and here it is more important how you feel about this situation than how I feel."

Be a Careful Listener. Always listen when someone speaks to you. Listen to what the person says. Listen to what information is left out of the conversation. Listen for the speaker's tone of voice and his breathing patterns. Is it fast? Is it slow and slurred? Does it make sense? Is it appropriate to ask

questions? Listen to what the speaker says, not what you think he says. Pay special attention when a client gives a complaint or brings up a problem. Sometimes it is helpful to write down important information as you hear it. Do not always trust your memory.

Be Sensitive. Sometimes the client does not want to talk, respect their moods. Saying nothing may have more meaning then any words or facial expressions on your part. Sometimes a pat on the shoulder or hand means more to a client then anything you can say.

Be Courteous and Tactful. Courtesy means being polite, Tact means being considerate of others/ doing and saying the right thing at the right time. Never be critical or impolite. If you are not clear as to what you have heard, you can summarize what you "think" you heard and ask the speaker if that is correct.

Emotional Control. Sometimes a client or a visitor can upset you. You feel like making a rude or nasty remark…DON'T DO IT! Remember, that the client is worried about themselves, their illness, or their family. Client or family stress levels may affect their ability to communicate and listen. Be sensitive to this. Speak in simple terms. Do not be upset if you must repeat yourself several times. Be understanding if they repeat themselves too. Lean to be patient and accept constructive criticism and suggestions from your patient, supervisor and coworkers. Remember, the end goal is only to provide the best possible care for the patients.

Using the Telephone. If you wear or carry a cell phone, put it on silent mode while you care for the client. If you receive a personal call, you can answer it after you leave the house. NEVER speak on your phone pertaining to personal issues while you are caring for a client. NEVER take a client's picture. NEVER discuss one client while at another's home. This is an unacceptable invasion of privacy and is a violation of HIPAA and could subject you to disciplinary action as well as criminal/ civil charges.

Relationships with clients. You may spend more time with the client than anyone. Often you are the only person a client will see all day. As a result, it is easy to see how some clients will develop a very strong attachment to you. This may make you feel good. However, keep in mind that ultimately you may be harming your clients progress towards independence. Therefor it is important you maintain professional boundaries with all clients and families. This means that while you provide care in a friendly manner, it is important to not become too emotionally involved. Indications that your too involved; spending extra time off the clock with your clients, thinking you are the only person that can provide care to your client, or developing feelings of friendship. *Family and Visitors*. Staff are to **NEVER** have visitors while at patient's house, however, the patients themselves may have visitors.
Tips for dealing with patient visitors.

-Listen to visitors. Whether it is a suggestion, a complaint, or "passing the time of day," listen. Some suggestions by visitors can be very helpful in providing care.
-Do not get involved in family affairs. Never take sides in family quarrel.
-If a visitor asks you a question about your client, politely say that you "do not feel comfortable answering on behalf of the client and that they may want to ask the client for this information". If not careful, this could become a HIPAA violation.
-Visitors may arrive at the house and give you orders: "While I'm here to watch Mama, you clean the bathroom." Be open about your responsibilities. Explain that your supervisor sets up the service plan and that you will need to discuss all changes with them.

PATIENT RIGHTS & RESPONSIBILITIES POLICY

These Rights and Responsibilities will be followed by all employees of Signal Health Group Inc. that provided care/services to you in your residence. Our Agency protects and promotes the exercise of rights at any time. You have the right to exercise these rights at any time without fear of reprisal or discrimination in care/services.

As a patient of our Agency, you have the right to:

1. Be informed of your Patient Rights.
2. Exercise these rights at any time.
3. Have your property and person treated with respect.
4. Be free from neglect, or verbal, mental, sexual, and physical abuse, including injuries of unknown source, and/or misappropriation of patient property by anyone furnishing services on behalf of our Agency.
5. Voice and report grievances or complaints regarding treatment or care that are (or fail to be) delivered, the lack of respect for property and/or person, or the violation of any rights to the Agency, accrediting body, and state or local agencies.
6. Participate in, be informed about, and consent or refuse care in advance of and during treatment, where appropriate, with respect to:
    a. Completion of all assessments;
    b. The care to be furnished, based on the comprehensive assessment;
    c. Establishing and revising the plan of care;
    d. The disciplines that will furnish the care;
    e. The frequency of visits;
    f. Expected outcomes of care, including patient-identified goals, and anticipated risks/benefits;
    g. Any factors that could impact treatment effectiveness;
    h. Any changes in the care to be furnished.
7. Receive all services outlined in the plan of care.
8. Have a confidential clinical record. Access to or release of patient information and clinical records is available with a written request of the agency.
9. Be advised of:
    a. The extent to which payment for Agency services may be expected from Medicare, Medicaid, or any other federally-funded or federal aid program known to the Agency,
    b. The charges for services that may not be covered by Medicare, Medicaid, or any other federally-funded or federal aid program known to the Agency,
    c. The charges the individual may have to pay before care is initiated; and
    d. Any changes in the information provided when they occur. The Agency must advise the patient and representative (if any), of these changes as soon as possible, in advance of the next home health visit in accordance with CMS notice requirements.
    e. The Agency must comply with the covered/non-covered patient services notification requirements.
10. Have a confidential patient record and access to or release of patient information and records in accordance with Health Insurance Portability and Accountability Act (HIPAA) law and regulation (45 CFR parts 160 and 164).

11. Receive proper written notice, in advance of a specific service being furnished, if the Agency believes that the service may be non-covered care; or in advance of the Agency reducing or terminating on-going care. The Agency must also comply with the requirements of notifying patients regarding termination of services.
12. Be advised of the names, addresses, and telephone numbers of the following Federally-funded and state-funded entities that serve the area where the patient resides (as listed in your SOC document STATE RESOURCES):
    a. Area Agency on Aging (AAA)
    b. Center for Independent Living (CIL)
    c. Protection and Advocacy Agency
    d. Aging and Disability Resource Center (ADRC)
    e. Quality Improvement Organization (QIO)
13. Be free from any discrimination or reprisal for exercising your rights or for voicing grievances to the Agency or an outside entity.
14. Be informed of the right to access auxiliary aids and language services, and how to access these services.
15. Be advised of our Agency's transfer & discharge policies.
16. Be informed how to contact (contact information & hours of operation) of the state toll free hotline, and if the agency is accredited, the accreditation body hotline, and that its purpose is to voice grievances or receive complaints/questions about local Agencies and to receive complaints concerning the implementation of Advance Directive requirements.
17. Our agency will honor any court decisions concerning competency and the role of the appointed representative.
18. To be informed in writing of policies and procedures for implementing advance directives and have health care providers comply with advance directives in accordance with state laws.

ETHICAL STANDARDS/CODE POLICY

POLICY:

Signal Health Group Inc. and its employees will adhere to a code of ethics in the delivery of agency care/services.
Ethical issues arising in the care of patients in the home setting will be addressed and resolved in a timely manner.

PROCEDURE:

1. Orientation of all direct employees and contracted employees will include information on Signal Health Group Inc.'s code of ethics.
2. Employees who face ethical issues when providing care are advised to immediately contact their supervisor. Such issues may surround religious or cultural beliefs.
Ethical issues may include but not be limited to the following situations:

a. Patients who refuse treatment or care decisions regarding the withholding or withdrawal of treatment.
b. Patients who do not comply with the physician's plan of treatment or do not fulfill their responsibilities regarding the care or service they receive.
c. Lack of consideration or respect for patients' rights, confidentiality of records or release of financial information.
d. Patients who may be victims of child or elder abuse or who can no longer take care of or provide for themselves.
e. Patients who live in an environment that poses a threat or risk to themselves or to our Agency staff.

3. Signal Health Group Inc.'s Ethics Committee (QA Program) will be advised of the conflict. The following individuals will, when practical, participate in discussions and the decision making process involving patient care issues as part of an Ethics Committee and formulate a written plan for resolution. (See Corporate Policy: Committees/Ethics)

a. Patient and/or caregiver
b. Primary Care Physician
c. Primary Care Nurse
d. Administrator
e. Clinical Supervisor
f. Legal Counsel
g. Board Member and/or Professional Advisory Committee Member

The written plan will identify expected behaviors and/or actions to be taken, specific dates for follow-up, and delineate consequences to actions if plan is not followed as discussed and were given to the patient/caregiver and primary care physician.

CODE OF ETHICS

Our Agency was founded to deliver high quality, reliable home care services that improve the human condition for recipients and their families in the process of providing this care.

Our Agency seeks to establish and retain the highest possible level of public confidence.

This Code of Ethics, adopted by the Governing Body of our Agency, serves as a statement to inform the general public and staff that our Agency stands for integrity and ethical standards, has established acceptable guidelines for ethical conduct, and advances notice to government officials, payer, and referral sources that our Agency is committed to abide by all applicable laws and regulations.

Rights and Responsibilities

It is inherent in the declaration of this Code of Ethics that our Agency pledges to protect and preserve the rights of patients and staff, to deal with them in an honest and ethical manner, and maintain confidentiality.

It is anticipated that observance of the rights and responsibilities will contribute to more effective care and greater satisfaction for the recipient as well as our Agency. The rights will be respected by all agency personnel and integrated into all programs. A copy of these rights and responsibilities will be given to each patient upon admission and to the staff upon hire.

Relations with Outside Organizations

Our Agency shall honestly and conscientiously cooperate in providing information about referrals and shall work together with other organizations to assure comprehensive services to recipients and their families.

Our Agency shall participate in public dialogue and advocate solutions with other organizations that will improve the health status of the community and promote quality care.

Our Agency will cooperate with all reasonable and lawful demands made by governmental investigations or law enforcement agents.

Our Agency shall prevent written, copied or electronic documentation from being altered or destroyed in anticipation of a request or as a result of a request for those documents by any authorized, lawful investigation.

Fiscal Responsibilities
Our Agency will ensure that:

- All billed services are consistent with the amount and types of care provided and are compliant with program regulations and guidelines.

- The cost per hour, visit or day includes only legitimate expenses and reasonable earnings.
- No kickbacks or payoffs are received or paid. (no solicitation or remuneration for patient referrals)
- All accounts receivable are handled according to agency policy.
- Pay scales are consistent with the area and discipline and compensation include only those travel and business expenses that are within a reasonable norm.

Our Agency shall maintain accounting records according to acceptable accounting principles and practices and have our Agency financial records audited annually by an independent CPA firm.

Relations with the Public
Our Agency will be truthful in all forms of professional and agency communication, and avoid disseminating information that is false, misleading, or deceptive.

Our Agency shall ensure that all oral and written statements will fairly represent service, benefits, cost, and agency capabilities. This shall include information descriptive of home care in general, as well as agency specific information.

Our Agency shall work to ensure that all people have reasonable access to care.

Personnel
Our Agency will be an equal opportunity employer and comply with all applicable laws, rules, and regulations. This means that our Agency shall hire qualified employees and utilize them at the level of their competency. Our Agency shall hire adequate staff to meet the needs of the recipient of care. All staff is oriented to our Agency Code of Ethics.

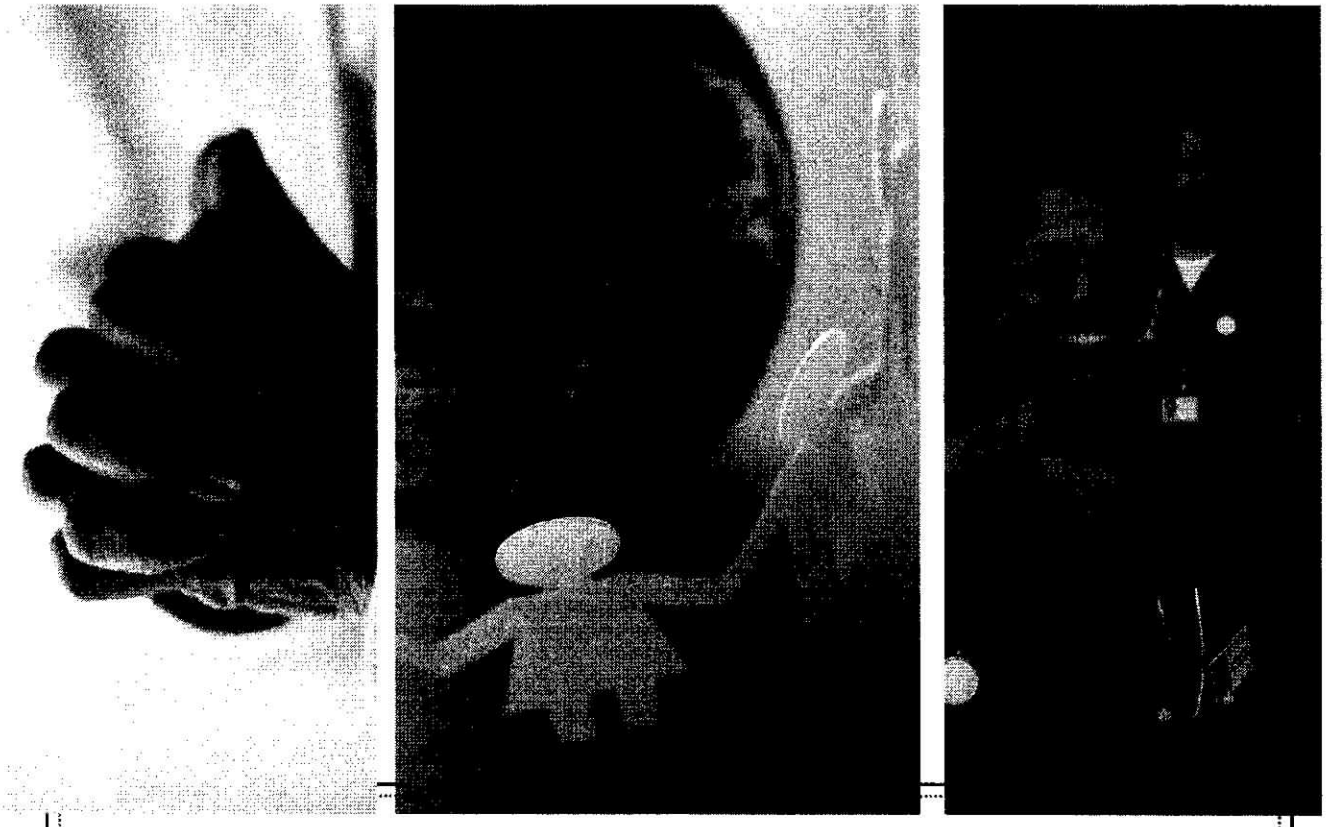
Our Agency shall have written personnel policies and make them available to all employees that shall include an ongoing evaluation process, supervision, continuing education, and other conditions of employment.

Our Agency management shall lead the organization in the use and improvement of standards of management and sound business practices. This means it must uphold the values, ethics, and mission of our Agency and conduct itself professionally with honesty, integrity, respect, fairness, and good faith in a manner that will reflect upon our Agency consistent with this Code of Ethics.

IN THE KNOW

...developing **top-notch** CNAs, one inservice at a time

877.809.5515
www.knowingmore.com
info@knowingmore.com



A Professional Growth Module:

UNDERSTANDING CULTURAL DIVERSITY

IN THE KNOW

Developing Top-Notch CNA's, One Inservice at a Time

There are more than 100 ethnic groups and more than 200 Native American groups living in the United States today.

What Is Cultural Diversity?

There's a lot of talk about cultural diversity these days. But what does cultural diversity really mean?

"Culture" is a name for all the beliefs and behaviors shared by a particular group of people. "Diversity" is another word for variety.

So, "cultural diversity" means that a variety of groups with different beliefs and behaviors live together in the same place. There have always been many diverse cultures living together within the United States. But, cities and towns across America are becoming more diverse every year!

Your job brings you in touch with many people every day. Chances are, your coworkers and clients are a culturally diverse group. For example, you may work with people who grew up speaking Spanish...or who believe that sickness robs a person's soul...or who wear a special necklace to guard against the Evil Eye.

Some of these cultural differences may seem strange, funny or even stupid. However...your beliefs may seem just as strange to other people.

To get along in a culturally diverse environment, it's important to:

- Learn all you can about the differences between people.
- Try to accept other people's habits and beliefs—even if you don't agree with them.
- Look at each day as an opportunity to learn something new about another culture.

Keep reading to learn more about the exciting and challenging issue of cultural diversity!

Your Sense of Culture Comes From...

- Where you live.
- How often you move to a new place.
- Your race.
- The language(s) you speak.
- Your religious beliefs.
- The size of your family.
- Your values.
- The foods you prefer.
- The work that you do.
- Whether you are male or female.
- Your political beliefs.
- Your family traditions.

Every person has the right to receive courtesy and respect from others.

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IMPORTANT!

Throughout this inservice, you'll read a lot of generalizations about people—since we are discussing the *general* traits of different cultures. It's important to learn about these common cultural traits and beliefs...without making any judgments. Please keep in mind that regardless of their racial, ethnic or religious background, your clients and coworkers are <u>individuals</u>...and may not behave like other members of their culture.

Describe Yourself...

Please think of one or two sentences that best describe who you are. You can use this space to write down your thoughts.

I am: _____

_____

_____

When describing yourself, don't think about it too long. Just jot down the first things you would want someone to know about you.

What Did You Come Up With?

"America is a beautiful mosaic. Different people, different beliefs, different yearnings, different hopes, different dreams."
Jimmy Carter

What words did you use <u>first</u> in your description? You may have written about yourself in terms of:

- Sex. ("I am a woman...")
- Nationality. ("I am Irish...")
- Age. (I am thirty-six...")
- Race. ("I am an Asian American...")
- Job. ("I am a nursing assistant...")
- Personality. ("I am a kind person...")
- Location. ("I am a New Yorker...")
- Physical Traits. ("I am strong...")

NOTE: Obviously, there is no right or wrong way to describe yourself. But, this exercise may show what you value most about yourself—and your culture.

A Few Words on Culture...

In any discussion on cultural diversity, it's important to review the definitions for a few important terms. They include:

- **Culture** is a name for all the beliefs and behaviors shared by a particular group of people.
- **Behaviors** are the ways people act based on the beliefs and values they have learned.
- **Beliefs** are "truths" that most people living in a particular culture agree on...and live their lives by.
- When beliefs are grouped together, they form **values**—a *code of ethics* that tell members of a culture what is right and what is wrong.

▼

"Preservation of one's own culture does not require contempt or disrespect for other cultures."

Cesar Chavez

- An **homogenous society** is one in which most of the people share the same beliefs and values.
- The United States is a **heterogeneous society**, meaning that its members come from a number of different cultural groups.
- **Ethnicity** is a *group identity* based on culture, language and/or religion.
- People are considered **ethnocentric** if they believe that their own cultural values and traditions are superior to others.
- **Race** is a *biological* term for classifying people who have the same physical characteristics.
- **Racism** is the belief that some human population groups are naturally superior or inferior to others simply because of their genetic characteristics.
- When people from one culture are thrust into another culture, they may feel **culture shock**—a form of anxiety that comes from not being able to predict how others will behave.
- **Cultural blindness** comes from the assumption that people are all basically alike. People who are culturally "blind" believe that whatever works with members of one culture should work within *all* other cultures.
- The term **cultural competence** was first used in relation to health care services—but has now spread to schools and other industries across America. For health care workers to be culturally competent means that they must provide services that are respectful of and responsive to the cultural and language needs of *each* client.

"When you learn something from people, or from a culture, you accept it as a gift, and it is your lifelong commitment to preserve it and build on it."

Cellist Yo-Yo Ma

More Good Words to Know!

Generalization. When we *generalize* about people, we assume that everyone in a certain group or culture behaves the same way. But, at the same time, we know that everyone is an individual, and we accept it when people are different.

- Example: *Sally is a CNA at a nursing home where many of the residents are Jewish and follow a Kosher diet. When a new resident, Mr. Goldberg, moves in, Sally doesn't offer him milk when his meal includes meat. (She generalizes that because he is Jewish, he must eat Kosher foods.) But, when Mr. Goldberg asks her for milk, Sally learns that he does not follow a Kosher diet. Now, she remembers to offer him milk at every meal.*

▼

It is human nature to fear the unknown. Unfortunately, fear is the basis of many stereotypes and prejudices.

Stereotype. When we *stereotype* others, we make up our minds about people based on a certain idea we have of them...without ever taking the time to find out about them as individuals.

- Example: *John is a nursing assistant in a hospital. In the past, he has cared for patients from the Middle East who were very vocal about every pain or discomfort they felt. So, when his new patient, a man from the Middle East, begins to moan and groan constantly about his pain, John doesn't report it. (In his mind, he stereotypes his patient as a noisy, grumbling Middle Easterner.) But, John is making a big mistake by not paying attention to his patient as an individual!*

Prejudice. When we have a *prejudice* about people, we judge them before the facts are known. (Sometimes, even when we know the truth, we still hang onto our false beliefs.)

- Example: *Jim is a home health supervisor. He grew up believing that fat people are lazy. Currently, Jim's best employee is overweight—and not the least bit lazy. Yet, Jim still doesn't like to hire people who are heavy. He is prejudiced against heavy people.*

Values. When people see a particular behavior or tradition as important, they are said to *value* it. Each culture has its own set of values.

- Example: *Most white Americans value privacy, especially when they are sick. Often, they will pay more for a private room in a hospital and probably want to have a lot of private time. However, people from other cultures—such as Asians and Hispanics—tend to stick closely to sick family members. They put more value on the strength of the family than they do on privacy.*

Be careful not to stereotype people based on their appearance or clothing.

Health Beliefs From Around the World

When you were growing up, what did you learn about:

- How to stay healthy?
- How to know when you were sick?
- How to behave when you were ill?
- What to do to get healthy again?

The answers to these questions are some of your beliefs about health and disease. People from other cultures have health beliefs about a variety of topics, including:

The Cause of Disease

- Most Americans believe that germs cause disease—because this is what scientists say is true. But not all cultures share this belief.
- Other cultures feel that people get sick if their bodies are not in balance...or their souls are lost, weak or stolen...or because they deserve a disease for something they've done wrong.

Blood Transfusions & Blood Tests

- Some religious groups, including Jehovah's Witnesses, believe that blood transfusions are forbidden by God—even if the procedure would save someone's life.
- In some cultures, people refuse to have their blood drawn. They're afraid of becoming weak or of losing their souls if even a small amount of blood is taken from their bodies.

Prayer

- In some cultures, people believe that God will heal them if they pray hard enough—and if they *deserve* to get better.
- Keep in mind that some people are in the habit of praying at certain times each day. And, they may want to get into a special position at prayer time.

Sacred Symbols

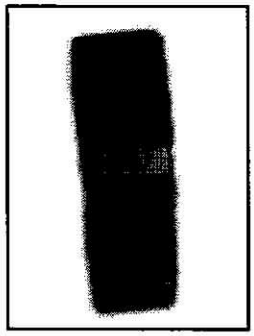
- Many cultures encourage the use of objects to protect people from illness. These sacred objects include charms, necklaces, rosaries, bracelets, pieces of clothing, special candles and papers with bible verses written on them.

Evil Eye

- Belief in the "evil eye" is common in many cultures across South America, the Middle East, Africa and parts of Asia.
- People who believe in the evil eye are afraid that they can become sick if someone looks at them the wrong way. (However, most cultures have ways of protecting themselves from the power of the evil eye.)

Lucky & Unlucky Numbers

- In the Chinese and Japanese language, the word for the number 4 is pronounced the same as the word for "death". So, for example, a Chinese man may feel unlucky if he's admitted to the hospital in Room 404.
- Other cultures, such as the Navaho, believe that the number 4 is lucky. For example, a Navaho woman may believe that a medicine will do more good if taken four times a day rather than three.



In China, the numbers 8 and 9 are considered lucky. The number 8 means "wealth" and the number 9 means "long life".

More Cultural Health Beliefs

Hair

- Some cultures, such as the Sikh religion, forbid people to cut or shave any of their body hair.
- There are Native American cultures that believe it's a sign of good health for a child to have long, thick hair. If a child's hair is cut or shaved, they believe the child may weaken or die.

Bathing

- People from some cultures believe that a layer of dirt helps protect them from illness. Bathing too frequently is seen as unhealthy.
- In other cultures, bathing is a kind of ritual that must be done at certain times of the day, week or month.

Dietary Practices

- During the Muslim religious festival, Ramadan, followers are forbidden to eat from sunrise to sunset.
- Orthodox Jews will not eat pork or shellfish, nor will they mix meat and dairy products in the same meal.
- In some countries, such as Pakistan, people classify foods as *hot* or *cold* depending on how each food affects the body. For example, Pakistanis believe that beef and potatoes make their bodies hot inside, so they only eat them in winter. In summer, they eat "cooling" foods, such as chicken and fruit.
- People who practice the Hindu religion are forbidden to eat beef.
- People from different cultures grow up with their own food likes and dislikes. For example, Asian people usually enjoy having rice every day. And, people who live near water tend to eat a lot of seafood.

Modesty

- Many cultures value modesty, and some have strict rules about it. For example, in some Asian cultures, doctors only touch female patients when taking their pulse.
- For Southeast Asians, the area between the waist and knees is especially private and must be covered at all times.
- Hispanic women also tend to be very modest about any kind of bodily function.

Folk Medicine

- Every culture has its own beliefs about how to treat disease. Many of these "folk" treatments have been used for centuries (and probably with some success).
- Many Asians believe that rubbing the body with a coin until red marks appear will cure a person's disease.
- "Cupping" is another kind of folk medicine that is practiced in Asia, Latin America and parts of Europe. It involves heating a glass and placing it on the body. This creates a "vacuum" under the glass which pulls the disease out of the body (and creates a red mark on the skin).
- American doctors treat a high fever by trying to cool the person down. But, in the Japanese and Hispanic cultures, most people believe that a fever should be treated by piling blankets on the person until a sweat breaks out.

People in many cultures rely on faith healers rather than physicians to cure their illnesses.

Let's Look At Dementia...

Every culture has different beliefs about health and disease. To illustrate this point, let's take a look at how a few cultures within the United States *tend* to view a particular health condition: dementia.

Dementia is a very common diagnosis, but the way people approach this condition depends partly on their individual cultural beliefs.

Our focus will be on *four* different cultural groups:

- African Americans
- Hispanic Americans
- Japanese Americans
- Chinese Americans

However, please remember that we are discussing this issue in general terms. Not everyone in the above four cultural groups has the same beliefs.

This information on cultural beliefs and dementia has been gathered from a variety of research studies and surveys. It is adapted here from information found on the Ethnic Elders Care Network.

Dementia affects people of all races and cultures. Worldwide, there is a new case of dementia every seven seconds!

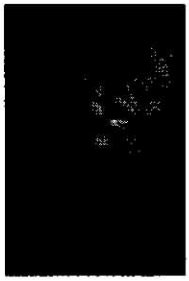
What Do African Americans Believe About Dementia?

Instead of using a medical diagnosis of dementia to describe someone's condition, some African Americans prefer to use terms like "his mind is slipping" or "she's out of her head today" or "he's just not with it".

- Unfortunately, dementia, such as Alzheimer's disease, is up to four times more common among African Americans than among Caucasians. Yet, many African Americans believe that dementia is a normal part of aging rather than an illness.
- They tend to blame the dementia on:
  - Stress.
  - Excess anxiety.
  - Smoking.
  - Alcohol abuse.
  - God's will.
- African Americans also tend to blame heredity, believing that dementia runs in families, especially among people who worry a lot or who have "spells".
- Because many African American families value their elders, they are more likely to care for relatives with dementia at *home*—rather than putting them in a health care facility.
- African American friends, neighbors and church members tend to come together as a community to help a family deal with dementia.

African Americans tend not to be concerned about dementia until the symptoms are advanced.

How Do Hispanic Americans View Dementia?



Many Hispanic Americans believe that stress plays a factor in the development of dementia.

- Many Hispanic Americans view dementia as a mental illness—something that can bring shame, embarrassment and stigma to the entire family.
- Because of shameful feelings, some Hispanic people may try to hide or deny the memory and behavior issues that come with dementia.
- In Hispanic American families, it is most often the female members who care for a person with dementia. If there is no female relative available, then a male relative will be called on to help.
- Even when dealing with dementia, Hispanic Americans tend to avoid seeking help from people outside the family. They believe that to do so would be sharing a shameful family secret—and would put their responsibilities and burdens on the shoulders of others.

What About Japanese Americans?

- Many Japanese American families believe that dementia is *unavoidable* and is simply a normal part of getting older.
- Others see the symptoms of dementia (such as paranoia and delusions) as a form of mental illness. In fact, the word for dementia in Japanese is **kichigai** which means *crazy* or *insane*.
- Japanese people with dementia tend to be cared for by their families.

Japanese Americans tend to keep quiet about a family member with dementia. To discuss it might cause them to "lose face" in the community.

Dementia Beliefs Among Chinese Americans

Traditionally, Chinese people with dementia are cared for by the oldest son and his wife.

- Some Chinese families do not feel that the symptoms of dementia require medical attention.
- Like the Japanese, some Chinese Americans believe that dementia is a shameful mental illness, similar to schizophrenia. They may hide their sick relative from the community and avoid sharing their "family secret" with others.
- Many Chinese Americans believe that people develop dementia because it is their fate to do so. They feel that the condition may be "payback" for the sins of the family.
- Some Chinese Americans feel that dementia comes from an imbalance between the body's two energies—the "yin" and the "yang".

Other Cultural Differences

Language

- Obviously, people from different cultures may not speak English, or they may have learned English as a second language.
- English, like every language, has its own expressions that may not be understood by people from other cultures—even if they have studied English. For example, if you tell people from another culture that your client is "getting cold feet" about having surgery, they'll probably tell you to put socks on your client's feet!
- Slang words can also be difficult to understand, even by people who speak the same language. For example, if you told a British woman that the nurse is going to give her a shot in the fanny, she would be shocked. *(In England, South Africa and Australia, "fanny" is slang for the genitals.)*
- Any language can be confusing when the same word has two different meanings. For example, in Mexico, the word "horita" means "right now". In Puerto Rico, the same word means "in an hour or so".
- Many Asian languages do not use pronouns (like "he" and "she"). So, a Japanese coworker might refer to every client as "he". This can be confusing!
- In some cultures, silence is an important part of communicating. For example, Navaho people use periods of silence as time to think about what they want to say. So, if they are asked a question, they might be silent until they've thought about their answer.
- In some cultures, such as in the Middle East, men are seen as dominant over women. They are used to giving orders to women and having them obey right away. This may cause communication problems between a male Middle Eastern client and a female American nurse aide.

Time Orientation

- Keep in mind that people from different cultures may view time differently. For example, some cultures are *past-oriented,* meaning that they tend to focus on the "good old days". Traditions and history are valued the most. People who are past-oriented may feel that health problems are better solved with old home remedies rather than new medications.
- Other cultures tend to focus on the *future.* This means that people think in terms of what's ahead of them. They tend to value *new* drugs, *new* surgeries, and the *prevention* of future health problems. People who are future-oriented like to follow schedules and are often very prompt. For example, if they make an appointment for 3:15, they'll be there on time (or even early).
- Some cultures tend to focus more on the *present.* For them, concentrating on the here-and-now is most important. They may not see the value of planning ahead and they don't live their lives watching the clock. Sometimes, present-oriented people may be tardy or may fail to meet a time deadline. This doesn't mean they are being thoughtless or lazy. It's just part of their culture. They were raised to live fully in the present and usually don't consider being late a problem .

People from every country in the world have moved to the United States.

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Other Cultural Differences, continued

Eye Contact

- In the American culture, looking someone in the eye is considered polite. But, in other cultures, direct eye contact is disrespectful.
- People in some cultures believe that you can harm someone—or steal his spirit—by looking him right in the eye.
- Eye contact between members of the opposite sex may be seen as a sexual invitation.

Gestures

- The way people move their hands, arms and bodies can mean different things to different people. For example, think about the hand gesture that means "OK" to Americans. In Japan, this gesture means "money". To a French person, it means "zero". To people from Mexico and Brazil, it is an obscene gesture.
- If you motion with your first finger for someone to "come here", your gesture might be misunderstood. For example, in the Philippines, this gesture is only used to call animals, not people.
- A simple "thumbs up" gesture is a good thing to most Americans. But, to people from Iran, it's the same thing as giving someone "the finger".

Personal Space

- People from different cultures have their own attitudes and behaviors about personal space. For example, most white Americans are "territorial" about the space right around their bodies. They feel uncomfortable if strangers stand closer than two or three feet to them.
- Some cultures put more value on the personal space around them, and for others, it's not an important issue. For example, Hispanics tend to be comfortable with people standing within 18 inches of them, while Japanese people prefer a distance of 3 to 6 feet.
- When people are sick, they tend to allow strangers to come closer than normal.

Touching

- In general, Asians are taught that touching in public—even a handshake—is disrespectful. They prefer to greet each other with a nod or a bow.
- Hispanic people tend to enjoy greeting each other with a casual hug.
- Orthodox Jews and Muslims may have rules against being touched by people of the opposite sex.

America is changing. The white majority is getting smaller...and older in age. The African-American, Hispanic, Asian and Native American populations are young and growing. Cultural diversity is a normal part of life in our country!

How do you feel when people "invade" your personal space?

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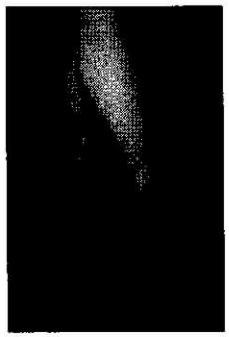
Working with People From Other Cultures

- In order to work with people from different cultures, you need to understand your own values and beliefs. What do you consider "normal"? How accepting are you of people with different beliefs?
- It also helps to be honest with yourself about any prejudices you may have developed over the years. Keep in mind that most prejudices are based on fear...fear of the unknown. The more we learn about different cultures, the more we'll be able to understand others.
- Be sure to ask how your clients want to be addressed. Sometimes, first and last names may be in a different order than you're used to. For example, if your client is an Egyptian man named Aziz Mohamad, you should call him Mr. Aziz...not Mr. Mohamad.
- Be honest if you're not sure how to pronounce someone's name. Your effort to get it right will be appreciated! (And, if clients mispronounce *your* name, let them know.)
- Try not to "guess" where your clients are from. If you're wrong, you might offend them. For example, if you ask a Korean woman if she's from China, she'll probably be insulted.
- If your clients are wearing anything unusual, keep in mind that they may be doing so for religious or cultural reasons. You may see a thread woven into their hair, a medicine bundle on a string around their neck or a ribbon wrapped around their wrist. Don't remove any item from your client without their permission!
- Give your clients private time as needed so that they may pray. Supporting their spiritual needs will go a long way toward helping them get well.
- Before you report that your client has no appetite, make sure he or she is able to eat the foods being offered. (Remember that in some cultures people are forbidden to eat certain foods.) Do your best to support the dietary needs and preferences of all your clients.
- Be patient with family members. Depending on their culture, it may be very important for them to take part in their loved one's care. Allow them to help as much as possible—while still getting your job done.
- Sometimes, it may seem that family members become more demanding than your clients! But, keep in mind that many people become demanding when they feel scared, helpless or out of control. Try giving the family small, helpful tasks they can do such as rubbing lotion on the client's hands and feet.



It's part of human nature to develop some prejudices. It's how you *deal* with them that's important.

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More Practical Tips For You...

- Keep in mind that people from different cultures have different attitudes about toileting. For example, in some Asian countries, toilets are level with the ground. To have a bowel movement, people squat over the hole. So, people from Asia may not be comfortable using a bedpan in bed. Don't be surprised if you find them squatting over the bedpan on the floor. Remember...to them, this is normal behavior.

- Remember that clients who are present-oriented aren't very good at planning ahead. They may need extra reminders about taking their medications on time.

- Don't take it personally if a client asks for a different caregiver. For example, a Muslim man will probably feel more comfortable with a male caregiver, and an Orthodox Jewish woman will prefer a woman's help with her personal care.

- In some cultures, saying "please" and "thank you" are not necessary at the workplace. You may think that people are being rude, but to them it's just normal. Don't take it personally.

- Your workplace probably has a policy against taking gifts from clients or their family members. But, clients from other cultures may want to give gifts to the people who care for them. It may be insulting to them if you refuse their gift. If so, be sure you tell your supervisor about the gift. The best solution may be to share it with your coworkers.

- If you feel uncertain about how to behave around people from other cultures, wait and see what they do. Then, do the same!

- Americans tend to speak loudly and to look people in the eye when we talk to them. People from other cultures may find our manner disrespectful. You might consider lowering your voice and giving them plenty of time to speak.

- Keep in mind that some of your clients and coworkers have been discriminated against at some point. They may be very sensitive and defensive due to these painful experiences in their past. Be patient and understanding.

- It's impossible to remember all the specific differences for every culture. Just keep an open mind and treat each person at work as an individual.

We hope this inservice has increased your awareness of your own cultural beliefs and values. All people must practice in order to achieve "cultural competence"—and the first step is understanding our own feelings about different cultures.

Encouraging cultural diversity is not new. Back in the 1890's, a nurse named Florence Nightingale taught British health care workers about the health beliefs of their Indian patients.

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