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LifeCare Hospital’s Mission, Beliefs, Core Clinical Standards, and Organizational Chart

**Environment of Care:** General Safety, Security, Hazardous Materials, Utilities, Clinical Equipment, Fire Safety and Prevention, Disaster Preparedness, Hospital Codes and Emergency Numbers

**Human Resources/Code of Conduct**
I.D. Badges, Time Clock/Payroll, Employee Rights, Benefits, Telephone Etiquette, Harassment, Cultural Competence, Dress Code, Smoking Policy, Call-off Policy, Impairment of Staff/Medical Staff, Open Door Policy, Workplace Violence, Cell Phone Usage, Customer Excellence Standards

**Infection Control/OSHA requirements:** Employee Health/Bloodborne Pathogens, Isolation Protocols, PPE, Standard Precautions, Hand Hygiene, TB, Hospital Acquired Infection Prevention, Workers Compensation

**Patient Rights/ Advanced Directives/Elder Abuse Identification and Reporting**

**Confidentiality/HIPAA, Corporate Compliance**

**Computer Applications:** Policies and Procedures, LMS Portal, LifeCare University, Computer Security

**Quality/Risk Management:** Incident Reporting, Patient Complaints/Grievances, Ethics, PI Teams, Patient Safety Plan/Anonymous Reporting, NPSG’s

**Body Mechanics/Ergonomics**

I HAVE BEEN INSTRUCTED ON THE ABOVE POLICIES, PROCEDURES AND PROTOCOLS. I HAVE BEEN GIVEN THE OPPORTUNITY TO ASK QUESTIONS AND HAVE HAD THOSE QUESTIONS ANSWERED TO MY SATISFACTION.

I HAVE BEEN ORIENTED TO THE LIFECare ICARE POLICIES & PROCEDURES INTRANET ACCESS PROCESS. I UNDERSTAND AND AGREE TO ABIDE BY THE RULES AND PROCEDURES SET FORTH BY LMS AND LIFECare HOSPITAL IN COMPLYING WITH ALL LIFECare POLICIES AND PROCEDURES AND REVISION PROCESS.

**Employee Name (PLEASE PRINT)______________________________**

**Employee Signature:** ________________________________

**Department:** ____________________________  **Date:** ________________
Historical eTime Attendance Record

**Directions:** Document the missed punch(es) below and submit to your department manager/supervisor as soon as possible.

*Date: __________

*Campus: ____________________  □ Not Applicable

*Employee PRINT Name: ____________________________

*Employee ID #: ______

(*Required Fields)

Missed Punches

<table>
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<th>In Punch</th>
<th>Out Punch</th>
<th>Transfer</th>
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This edit will process with the next pay period if turned in by 12:00 PM CST on the Friday before pay roll processing.

Employee Signature: _____________________________________________________________

Supervisor Signature: ____________________________________________________________
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# Program Evaluation: General Employee Orientation

**Date Attended:** ____________

<table>
<thead>
<tr>
<th>Topic</th>
<th>This program introduced new information or concepts?</th>
<th>The program was well organized?</th>
<th>The presenter seemed knowledgeable on the presented topic?</th>
<th>The presenter was clear and understandable?</th>
<th>The presenter engaged the audience in discussion?</th>
<th>What did you like best about this presentation?</th>
<th>What suggestions for improvement do you have for this presentation?</th>
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<td>Our Patients’ Right</td>
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What additional Comments would you like to provide?

______________________________________________________________________________________

Name (Optional) __________________________________________________________

**THANK YOU!**
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AFTER REVIEWING THE CONTENT IN THIS SECTION, YOU SHOULD:

- Know LifeCare’s mission, beliefs and core clinical standards
- Understand that disruptive behavior is not tolerated and know how to report it
- Embrace the company’s cultural diversity and “Rules of the Road”
- Embrace LifeCare’s standard for phenomenal customer service
- Understand and abide by LifeCare’s Code of Conduct
- Understand and abide by LifeCare’s HIPAA Privacy, Security and Confidentiality Statement

COMPANY OVERVIEW

- 26 hospitals in 9 states
- 18 freestanding locations; 8 hospital-in-hospital
- 1,332 licensed beds
- 4,400+ employees
- Support Center (Headquarters) in Plano, TX

CULTURE

Mission Statement: *We are building a company that cares for each patient’s body, mind and soul.*

BELIEFS

- **Integrity** – We value honest and ethical behavior
- **Compassion** – We value a caring and sensitive approach to care
- **Competence** – We value performance that meets the highest standards
- **Respect** – We value respect for each other, our patients and their families
- **Innovation** – We value a creative and innovative approach to problem solving
- **Passion** – We value employees whose passion for care and excellence drive superior outcomes

LifeCare Believes in Equal Opportunity

LifeCare is an equal opportunity employer. It is the policy of this company to prohibit discrimination of any type to employees and applicants, without regard to race, color, religion, sex (including sexual harassment), sexual orientation, national origin, age, disability, veteran status, or based on genetic information and/or genetic testing.
7 Core Clinical Standards

1. Active Physician Participation
Each LifeCare patient’s care is overseen by a highly skilled physician. The physician is an active participant in the treatment process and directs a team of caregivers, specialists, and therapists, ensuring that every decision supports the shared goal of maximizing a patient’s recovery potential.

2. Knowing Our Patients as People
We believe that the close relationships that develop between our caregivers and patients contribute to the healing process. Our staff members chose to work in a healthcare setting where a patient’s recovery takes time. This gives them an opportunity to develop personal relationships and celebrate incremental successes. These relationships are integral to the recovery process.

3. Complete Critical Care
LifeCare offers patients access to a high level of care which includes advanced technology and a specially trained team of expert caregivers. By bringing a full complement of critical care services to a patient, we can often avoid costly transfers that may result in complications or setbacks. And, by introducing aggressive therapies to even the most critically ill patients, we can prevent physical deterioration and begin the recovery process sooner.

4. Teamwork
We believe sharing expertise and information across medical disciplines is key to developing a treatment plan that fully addresses a patient’s recovery – not simply one aspect of it. Each treatment team includes experts in such areas as nursing, case management, pharmacy, nutritional services, physical therapy, occupational therapy, speech therapy, respiratory therapy, social services, and psychological services. This team works together to develop a personalized treatment plan that focuses on the well being of the entire person.

5. Dedicated Case Management
Each LifeCare treatment team includes a dedicated case manager. While patient’s medical team is supervised by a highly skilled physician, the case manager coordinates the written plan of care and works with the team to set goals and monitor the patient’s progress. This highly personalized approach has resulted in improved outcomes, shorter hospital stays and lower costs for numerous LifeCare patients.

6. Instilling Desire, Hope and Confidence
At LifeCare, we never forget that our patients are people. Just as we work to strengthen the body, we also work to nurture the mind and soul. We seek to instill desire, create hope and inspire confidence. Whether it is the simple act of dressing patients in their own clothes instead of a hospital gown or taking the time to get to know them – both now and as they were before illness or injury changed their lives – we give patients the tools they need to progress physically, mentally, and spiritually.

7. Patient and Family Involvement
The final – and most important – members of the treatment team are the patient and his/her loved ones. Because we believe knowledge is power, we give patients and families the information they need to be active participants in the recovery process – both in making decisions about the plan of care and in setting goals and working to meet them.
Disruptive Behavior
LifeCare strives to maintain a culture of safety through an established culture of acceptable behavior. Patient safety and clinical quality is paramount, and disruptive behavior by anyone - physicians, staff, visitors or vendors is not tolerated. If an employee sees disruptive behavior, he/she is expected to take action by reporting the incident to their supervisor and/or hospital Human Resources Representative.

Examples of disruptive behavior include (but are not limited to):

- Inappropriate anger or resentment: intimidating, abusive language, threats of violence
- Inappropriate words/actions: sexual comments/innuendos, ethnic slurs, no regard for personal dignity
- Inappropriate responses to patient or staff needs: late or unsuitable replies to pages or calls, rigid inflexible responses

Harassment and Discrimination
- LifeCare is dedicated to providing a safe and healthy work environment, free from harassment and discrimination
- LifeCare will not tolerate harassment or discrimination of any kind
- As a LifeCare team member, you are obligated to ensure that you do not harass or discriminate against others and report incidents of harassment or discrimination against others

Harassment means to worry or torment someone on a persistent basis
Discrimination occurs when a person, or group of people, are treated differently from another person or group of people
Discriminatory Harassment is defined as harassing and/or discriminating behavior that is severe or pervasive enough to create a hostile working environment and/or results in a tangible employment action

Types of Harassment
- Verbal—includes things such as making inappropriate sounds, what is said, written
- Physical—includes hitting, pushing, blocking someone’s way, inappropriate touching, leering, gestures
- Visual—includes calendars, pictures, any inappropriate object that can be clearly seen
- Harassment can also include requests for sexual favors, usually by a supervisor in return for something that benefits the employee
- Harassment can also be sexual or non-sexual conduct that creates a hostile, intimidating or offensive working environment that unreasonably interferes with an individual’s ability to perform the job

Both men and women can be victims OR harassers

What should you do if you are being harassed or know a co-worker is being harassed?
- Report it immediately to a supervisor and/or Human Resources
- In the event a supervisor is the harasser, report it to Human Resources
Cultural Competence

Our environment includes employees, patients and physicians from many different cultures and backgrounds.

- LifeCare is committed to integrity, ethical behavior and the highest moral conduct from its employees.
- We believe each employee and/or patient should be treated with dignity and respect at all times.
- We embrace each of our employees differences and promote a diverse workforce.
- We believe that diversity is defined as effectively using the talents of people of different backgrounds, experiences and perspective to provide exceptional patient care.

Sometimes, cultural and/or generational differences can create conflicts and misunderstandings among staff.

- Actions can be misinterpreted between people of different cultures.
- Employees can take advantage of the diversity in their workplace by respectfully asking each other about their culture’s beliefs and traditions.
- Conduct ourselves in a manner that encourages respectful interactions with others.
- Understand that respect for, and responsiveness to individual differences is critical to developing and maintaining effective relationships in our hospitals.

Characteristics of Generations

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<tr>
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</tr>
</thead>
<tbody>
<tr>
<td>Age Span</td>
<td>65 to 85 years old</td>
<td>46 to 64 years old</td>
<td>33 to 45 years old</td>
<td>15 to 32 years old</td>
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<tr>
<td>Population</td>
<td>75 million</td>
<td>78 million</td>
<td>45 million</td>
<td>80 million</td>
</tr>
<tr>
<td>Traits</td>
<td>•Conservative •Discipline •Respect for authority •Loyal •Patriotic</td>
<td>•Idealistic •Break the rules •Time stressed •Politically correct</td>
<td>•Pragmatic •Self-sufficient •Skeptical •Flexible •Media/Info/Tech savvy •Entrepreneurial</td>
<td>•Confident •Well-educated •Self-sufficient •Tolerant •Team builders •Socially/politically conscious</td>
</tr>
<tr>
<td>Defining Events</td>
<td>•Great Depression •World War II •Korean War</td>
<td>•Vietnam War •Woodstock •Watergate</td>
<td>•Collapse of communism •Missing children on milk cartons •Computers in school</td>
<td>•Clinton/Lewinsky •School shootings •Terrorism on U.S. soil •Corporate scandals</td>
</tr>
<tr>
<td>Work Is</td>
<td>Inevitable</td>
<td>Exciting adventure</td>
<td>Difficult challenge</td>
<td>To make a difference</td>
</tr>
<tr>
<td>Work Ethic</td>
<td>Loyal/dedicated</td>
<td>Driven</td>
<td>Balanced</td>
<td>Eager, but anxious</td>
</tr>
<tr>
<td>Employment Goals</td>
<td>Retirement for some</td>
<td>Second career</td>
<td>Work/life balance</td>
<td>Unrealistic</td>
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<tr>
<td>Education</td>
<td>A dream</td>
<td>Birthright</td>
<td>Way to get to an end</td>
<td>A given</td>
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<tr>
<td>Migration</td>
<td>AZ, FL, NC, NV</td>
<td>AZ, FL, GA, NV</td>
<td>AZ, CO, GA, TX</td>
<td>Mom and Dad</td>
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<tr>
<td>Technology</td>
<td>LP record</td>
<td>8-track</td>
<td>CD</td>
<td>iPod/MP3</td>
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<tr>
<td>Communication</td>
<td>Face to face</td>
<td>Telephone</td>
<td>Cellular phone</td>
<td>IM/Text messaging</td>
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<tr>
<td>TV</td>
<td>Peyton Place</td>
<td>Dallas</td>
<td>Melrose Place</td>
<td>The OC</td>
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<td>Sports</td>
<td>Joe DiMaggio</td>
<td>Joe Namath</td>
<td>Michael Jordan</td>
<td>Lebron James</td>
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<tr>
<td>Time at work is defined</td>
<td>Punch clock</td>
<td>Visibility</td>
<td>Why does it matter if I get it done?</td>
<td>Is it 5 PM? I have a life.</td>
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WHAT IS CULTURAL COMPETENCE?

Culture is often described as the combination of a body of knowledge, a body of belief and a body of behavior. It involves a number of elements, including personal identification, language, thoughts, communications, actions, customs, beliefs, values, and institutions that are often specific to ethnic, racial, religious, geographic, or social groups. For the provider of health information or health care, these elements influence beliefs and belief systems surrounding health, healing, wellness, illness, disease, and delivery of health services. The concept of cultural competency has a positive effect on patient care delivery by enabling providers to deliver services that are respectful of and responsive to the health beliefs, practices and cultural and linguistic needs of diverse patients. (Referenced from National Institute of Health, March 4, 2014. Retrieved from http://www.nih.gov/clearcommunication/culturalcompetency.htm)

Cultural Competence starts with Awareness!
- Grows with Knowledge
- Enhanced with Specific Skills
- Polished through Cross-Cultural Encounters

To Suspend Judgment One Must:
- Seek first to understand before being understood
- Observe and Actively listen without judging—remember listening does not equate to agreeing
- Be willing to allow people to feel what they feel
- Be willing to commit to future actions—way ahead

Culturally sensitive approach to asking inquiring about a health problem:
- What do you call your problem?
- What do you think caused your problem?
- Why do you think it started when it did?
- What does your sickness do to you? How does it work?
- How severe is it? How long do you think you will have it?
- What do you fear most about your illness?
- What are the chief problems your sickness has caused you?
- Anyone else with the same problem?
- What have you done so far to treat your illness: What treatments do you think you should receive? What important results do you hope to receive from the treatment?
- Who else can help you?

The LEARN Model (Berlin and Fowkes)
- Listen to the patient’s perception of the problem
- Explain your perception of the problem
- Acknowledge and discuss differences/similarities
- Recommend treatment
- Negotiate treatment
LIMITED ENGLISH PROFICIENCY—TRANSLATOR SERVICES

To ensure accurate and safe patient-staff communication occurs. Every attempt is made to secure qualified language translators to patients who have limited English proficiency (LEP). The Case Management/Social Services Department is responsible for maintaining a list of qualified language translators. All communication assistance will be provided free of charge to the patient.

Translators are made available by the following ways:

1. During the hiring process of any employee, languages spoken are identified and staff asked if they can assist in translation procedures.
2. Qualified employees from LifeCare, the host hospital, or vendor may be used for translators if agreeable with employee and patient. Untrained individuals should not be routinely utilized as interpreters during medical encounters.
3. If translators are not available by a or b above, the case manager/social worker contacts the contracted or available translator service. A fee for some translators may be required and will be paid by the facility.
4. With respect to patients, family members and friends of the patient are not to be used as interpreters, unless chosen by the patient

Working with an interpreter

- Acknowledge the interpreter as a communications professional.
- Briefly introduce yourself to the interpreter (name and nature of the call or visit), and describe the type of information you are planning to talk about with your patient.
- Give the interpreter the opportunity to introduce himself or herself to the patient.
- Recognize the interpreter is the medium, not the source, of the message and that he or she is not responsible for what the patient says or doesn’t say.

The interpreter session

- Allow enough time for the interpretation session.
- Speak in the first person directly to (or facing) your patient, instead of speaking to the interpreter.
- Speak clearly, at an even pace, and pause occasionally to ask the interpreter if he or she understands the Information you are providing and the questions you are asking.
- Remember, you do not need to speak especially slowly. This actually makes a competent interpreter’s job more difficult.
- Avoid interrupting during interpretation. In some languages, it may take longer to explain a word or a concept.
- Read body language in the cultural context. Watch the patient’s eyes, facial expressions, and body language. Look for signs of comprehension, confusion, agreement, or disagreement.
RULES OF THE ROAD

Professional Image
- Name badge must be visible at all times
- Wear clothes appropriate to your position; scrub colors (if applicable)
- Closed toe shoes with hosiery
- No artificial nails or perfume/cologne
- Remove piercings and cover tattoos

Smoking
- For the safety and health of all employees, patients, and visitors, smoking or the use of tobacco products, is prohibited within the hospital and its related structures
- Visitors are informed of the smoking/tobacco-free policy by posted signs, admitting personnel, and nursing personnel; "No Smoking" signs are displayed in the appropriate areas both inside and outside the hospital
- Smoking or use of tobacco products by visitors and employees may be permitted outside the facility in designated areas only; check with your local HR Representative

Drug-Free Workplace
- Random drug testing is conducted throughout the year and for any work-related injury

Solicitation/Distribution of Literature
- Solicitation of any type is not permitted in the hospital or on its premises at any time; this includes personal “for sale” postings, garage sales and side business ventures

Agency Badges
- You will use a badge to clock in and out before and after a shift and any meal periods (if applicable)
- At the beginning of each shift, obtain a badge (with applicable agency name and job title) from the designated person at the hospital—i.e., nursing supervisor, scheduler, receptionist
- Be sure to return the badge to the appropriate individual at the end of your shift
- Hours worked will be reviewed to ensure billed hours match corresponding badge swipes

What should you do if you forget to clock in at the beginning or end of a shift?
Notify a nurse supervisor and complete a “missed punch” form.

Meals and Breaks
- Depending on the length of your scheduled shift, you may be eligible to take a 30 minute unpaid meal period and/or 15 minute break periods
- Meal periods are normally unpaid; however, if you miss a meal period or are interrupted, you must cancel your meal deduction at the time clock
- Obtain permission and clock out before leaving the hospital on your meal period
Cell Phones & Electronic Devices
- Only used on breaks in non-patient areas
- Texting patient-related information is prohibited
- Cell phone photos are not permitted in any circumstance

Internet Usage
- Limit to business use only
- Avoid shopping and personal use

Social Networking/Media
Employees are prohibited from using social media to:
- Violate any patient’s right to privacy regarding their protected health information under HIPAA
- Defame, disparage, or harass LifeCare or its employees, patients, affiliates, vendors, referrals, physicians, business partners or any other stakeholders
- Circumvent policies prohibiting unlawful discrimination against current employees or applicants from employment
- Violate LifeCare’s privacy policies, other laws or ethical standards

PHENOMENAL CUSTOMER SERVICE
Every employee, and those working on our behalf, can transform the patient experience through:

- Phenomenal **Compassion**
- Phenomenal **Image**
- Phenomenal **Communication**
- Phenomenal **Service**
- Phenomenal **Accountability**

Expectation #1: Phenomenal Compassion
Staff should recognize patients as individuals (not just a diagnosis or illness) through compassion, one of LifeCare’s core beliefs.

Expectation #2: Phenomenal Image
You never get a second chance to make a first impression! To present a phenomenal image, you should:
- Wear clean/pressed, properly sized matching scrubs or business attire
- Wear name badge above the waist so it is clearly visible
- Cover visible tattoos and remove excessive jewelry/piercings
- Keep artificial nails at the salon if you are a patient care provider
- Speak English in patient care areas unless requested by a patient

Expectation #3: Phenomenal Communication
Once you say something, you can’t take it back! Phenomenal communication is imperative in building positive relationships with customers.
Phone Etiquette
- Answer phones in person by the second ring (voice mail system should pick up by the fourth ring)
- Use an appropriate greeting such as “LifeCare Hospitals of North Carolina, this is Nancy, how may I assist you?”; avoid answering with “hello,” or “unit only”
- Don’t assume you know who the caller is based on called ID
- Always ask permission to place a caller on hold; always thank them for holding
- Avoid “parking calls” or the eternal hold—studies show that most callers become annoyed and/or hang up after 17 seconds of being on hold
- Ensure calls are appropriately transferred by staying on the line and informing the received of who you are passing through
- End calls on a positive note and gently hang up receiver

Face to Face Communication
- Remember to introduce yourself
- Use patient care boards/white boards
- Talk “out loud” to communicate actions—i.e., “I’m pulling the curtain to give you more privacy”
- Provide education—use Lippincott online for patient handout materials
- Never miss an opportunity to make a lasting impression—i.e., “While I’m here, is there anything I can do to make your day phenomenal?”

Expectation #4: Phenomenal Service
Patients and family members enter our facility with a standard expectation of what good customer service looks like and how they should be treated. Our goal is to EXCEED customer expectations through phenomenal service. This means:
- You should feel empowered to save the day—address patient complaints and follow through to ensure expectations have been exceeded
- Get accustomed to “escorting” customers to where they need to be versus “pointing”

Expectation #5: Phenomenal Accountability
“It’s not my job” mentality is not acceptable—it takes a can-do attitude and a team approach to transform the patient experience. It’s not enough just to meet customer expectations. We must be phenomenal!

CODE OF CONDUCT
LifeCare is committed to integrity, ethical behavior, and the highest moral conduct from employees and others who act on our behalf. Each employee is expected to know, understand and abide by the guidelines outlined in the Code of Conduct. It serves to summarize the intent of the law, regulations, policies and procedures. Since the Code cannot address every issue, employees are expected to use good judgment to avoid improper or unlawful behavior.

Employees with questions about any part of the Code should seek advice from his/her supervisor, a member of the management staff, or the Compliance Officer.
Conducting Business
LifeCare's activities involve thousands of business transactions each day. We must have strict rules to guard against fraud or dishonesty and guidelines for addressing possible problems that may arise. LifeCare expects its employees to be compliant with:
- Medicare and Medicaid regulations
- Proper use of assets
- Trade Practices/Antitrust
- Compliance with Anti-Kickback Statute
- Gifts and entertainment restrictions
- Billing practices
- Employee relations, compliance with labor laws and background checks
- Health and safety; OSHA
- Appropriate use of pharmaceutical; prescription drugs

Government Investigations
Any information disclosed during a government investigation without authorization jeopardizes the rights of our patients and puts our organization at risk. Employees who are approached by an federal or state law enforcement agency or official seeking information about our organization or any of its patients, agents or employees should immediately contact the Compliance Officer before providing any information.

Quality of Care
LifeCare is committed to providing quality care to its patients. Our clinical providers are expected to:
- Assess the needs of patients under his/her care and deliver high-quality health services in a responsible, reliable and cost-effective manner, and
- Strive to uphold high standards of professional practice in our hospital facilities and programs

Employee Loyalty and Conflicts of Interest
Employees should avoid situations that may cause a conflict; if you consider outside ventures or positions that could conflict with LifeCare notify your supervisor immediately

Use of Information (HIPAA) - Safeguarding the Privacy of Our Patients
Our business requires us to gather a great deal of personal information about our patients. We are committed to protecting the privacy and security of the information created as a record of the care and services provided to our patients. LifeCare understands that while these records are required to provide patients with quality care, we have both an ethical and legal responsibility to protect our patients from the misuse of their information.

All patient related information, including billing, referral, medical records, and other individually identifiable information must be protected according to LifeCare policies, LifeCare Code of Conduct, and state and federal laws that include the HIPAA Privacy Rule, the HIPAA Security Rule, and the HITECH Act. Also, employee and company proprietary information is also considered confidential and is protected from improper use and disclosure. Access to, use of, and disclosure of patient, employee, and company information will only be executed in accordance with LifeCare policies, and state and federal laws and regulations.
Information Owned by Others
Other organizations and individuals have confidential information they strive to protect, but sometimes disclose for a particular business purpose. If you have access to another party's confidential information, you must prevent the misuse of their information. Never use, copy, or distribute their information, unless you are doing so in accordance with the terms of their agreement with our organization. This is especially true when acquiring software from others. Employees should never install personal copies of software from their home or personal computer for use on any computer equipment owned or operated by LifeCare.

Record Retention/Destruction
LifeCare is required by law to keep certain types of medical and business records for defined periods of time. LifeCare has a record retention and destruction policy that must be strictly followed. In addition, all records must be fully and accurately completed, and should never be falsified. Without accurate information, we can’t fulfill our obligations to our patients, co-workers and vendors. It is every employee’s responsibility to take great care in dealing with our records.

Commitment to Fairness
LifeCare recognizes that its greatest strength lies in the talents and abilities of its employees. Although the tasks of our employees are different, we have established guidelines to ensure that each employee is treated with fairness and equality. LifeCare provides equal opportunity for employment and advancement on the basis of ability and aptitude, without regard to race, color, creed, age, sex or sexual orientation, handicaps or national origin; and compensates employees according to their performance, and provides equitable benefits within the framework of prevailing practices.

LifeCare is committed to a work environment in which all individuals are treated with respect and dignity. Discrimination or harassment, of any kind, in or out of the workplace, is unacceptable and will not be tolerated. Disruptive behavior will also not be tolerated. Such conduct may be verbal or non-verbal and may involve the use of rude language, may be threatening, and may even involve physical contact. Additionally, behavior that interferes with the ability of others to effectively carry out their duties or that undermines a patient or their family member’s confidence in us shall also be considered disruptive.

Labor and Employee Relations Matters
LifeCare fully complies with all applicable wage and hour laws and other statutes regulating the employer-employee relationship and the workplace environment. If you have any questions about the laws governing labor and employee relations’ matters, please contact your Human Resources Department.

Employee Background Checks
LifeCare considers the care and safety of its patients to be of critical importance. In order to maintain the quality and safety of patient care, LifeCare conducts background checks, to include the HHS-OIG List of Excluded Individuals/Entities (LEIE), on applicants considered for employment, and reserves the right to recheck the background of current employees. In addition, all agency and temporary staff, together with physicians considered for staff privileges, will be checked against the LEIE and a background check will also be conducted by LifeCare and/or the employing entity.

Political Participation
Participation in the political process is one of every American citizen’s most basic rights. Federal laws, however, limit the nature and extent of political participation on the part of organizations. While LifeCare encourages its employees to participate in the political process, no LifeCare resources or facilities are to be utilized in support of any candidate or position. In addition, individuals who chose to run for political office are expected to do so on their personal time.

**Lobbying**
LifeCare will not contribute money, property or services to political parties or candidates, except through its affiliated company, LifeCare Management Services, L.L.C. However, employees, as individuals, may make political contributions at their own expense or participate in political campaigns on their own time. No employee may attempt to influence legislation on behalf of LifeCare without the prior approval of the Chief Compliance Officer.

**Questions Regarding the Code**
The Chief Compliance Officer is responsible for the implementation and ongoing operation of LifeCare’s Corporate Compliance Program, as well as making sure each employee abides by the Code of Conduct. Employees with questions about the Code should contact either their facility Compliance Officer or LifeCare’s Chief Compliance Officer.

**Reporting Violations**
LifeCare requires all employees to report suspect or questionable conduct (i.e., fraud, abuse, compliance concerns, violations of LifeCare’s Code of Conduct/policies/state or federal law) to their facility Compliance Officer, the Chief Compliance Officer, or anonymously by calling the Compliance Line at 800-472-6450. Failure to report known misconduct is a violation of company policy and this Code. Any manager or supervisor who receives a report of a potential Code violation must likewise immediately notify the Compliance Officer. There will be no retribution for those who report misconduct in good faith. HR related concerns (i.e., policy questions, questions about benefits, leaves of absence) can be answered through the facility HR Representative or by calling the HR Helpline at 866-707-7797.

**Investigation of Violations**
All reported violations of the Code of Conduct, hospital policies or applicable laws will be investigated in a timely manner. Employees are required to cooperate in the investigation of an alleged violation.

**Discipline for Violations**
Disciplinary actions may be taken for involvement in actions that violate the Code of Conduct, hospital policies, or prevailing laws; for failure to report any violation or to cooperate in an investigation; for failure to detect, or purposefully overlook violations of others; or for retaliation against anyone who reports possible or actual violations. Disciplinary action may include termination.

**Individual Judgment**
Employees are often faced with making critical decisions based on activities in the workplace. Remember to always use good judgment and common sense. If you believe anything within this Code of Conduct goes against your own good judgment, you are encouraged to discuss it with your supervisor or with the Compliance Officer.
HIPAA PRIVACY, SECURITY AND CONFIDENTIALITY STATEMENT

All patient related information, including billing, referral, medical records, and other individually identifiable information must be protected according to LifeCare policies, LifeCare Code of Conduct, and state and federal laws that include the HIPAA Privacy Rule, the HIPAA Security Rule, and the HITECH Act. Also, employee and company proprietary information is also considered confidential and is protected from improper use and disclosure. Access to, use of, and disclosure of patient, employee, and company information will only be executed in accordance with LifeCare policies, and state and federal laws and regulations.

- All requests for patient information, including copies of any part of the medical record, open or closed, MUST be referred to the Facility Privacy Officer/HIM Manager
- All complaints, concerns, and requests related to patient information, the medical record, and confidentiality must be immediately referred to the Facility Privacy Officer/HIM Manager
- All possible breaches or risks of such must be reported to the Facility Privacy Officer immediately
- All losses or thefts of electronic devices must be immediately reported to the HELP DESK

Violation of patient, employee, or company confidentiality, and any violation of LifeCare Privacy and Security policies, and/or any component of related state and federal laws may result in disciplinary action, up to termination of employment. Violations may also result in patient notification, and notification to state and federal agencies as required by law.

Examples of violations include, but are not limited to:
- Access of, use of, or disclosure of the medical record or any other PHI without proper authorization or valid job related reason
- Access of, use of, or disclosure peer review information without proper authorization
- Leaving a computer terminal unattended with protected health information (PHI) unsecured/failure to log out allowing improper access
- Writing or posting passwords, or security key codes, in an exposed location
- Sharing Passwords, using another person’s password to access any ePHI or IT system or program
- Failure to follow Privacy and Security policies
- Leaving PHI in a public area
- Discussing a patient in a public area, i.e. elevators, cafeteria, smoking areas, of any public arena
- Failure to properly secure electronic devices or paper information when transporting outside of the LifeCare facility
- Failure to immediately report the theft or loss of a portable electronic device, or paper based information, to the Privacy Officer and/or Security Officer.
- Intentionally introducing viruses into any LifeCare associated IT system
- Disabling IT implemented security measures of stationary or portable computers and other electronic devices

As an employee, or someone working on our behalf, you must understand and acknowledge that you are responsible for being compliant with all LifeCare Privacy, and Security Policies, and all state and federal laws.
AFTER REVIEWING THE CONTENT IN THIS SECTION, YOU SHOULD:

- Understand patient rights and responsibilities
- Understand the developmental and physiologic differences in adult populations
- Know what an Advance Directive is and when it’s used
- Be able to recognize signs of elder abuse and know what to do if you witness or receive allegations of ANY type of abuse

PATIENT RIGHTS

LifeCare respects the rights of every patient and provides each patient and staff member with information about rights and responsibilities related to their care, treatment or services.

- A hospital must inform each patient, or when appropriate, the patient’s representative (as allowed under state law), of the patient’s right, in advance of furnishing or discontinuing patient care whenever possible.

Patients have the right to:

- Treatment, care, and services within the hospital capability and mission and in compliance with law and regulation; patients and, when appropriate, their families are informed about the outcomes of care, treatment, and services.

- Participate in the development and implementation of their plan of care, including their discharge plan; the plan of care must meet both their medical and psychological needs.

- Have his or her cultural, psychosocial, spiritual, and personal values, beliefs, and preferences respected.

- Pastoral and other spiritual services.

- Formulate advance directives and to have hospital staff and practitioners who provide care in the hospital comply with these directives; in addition, patients have the right to review and revise advance directives and receive information on the extent to which the hospital is able, unable, or unwilling to honor advanced directives.

- Access, request amendment to, and receive an accounting of the disclosures regarding his or her own health information as permitted under applicable law and within timeframes outlined in applicable law.

- Make informed decisions regarding care and are involved in decisions and in resolving dilemmas about their care, treatment, and services; this right is not to be construed as a mechanism to demand the provision of treatment or services deemed medically unnecessary or inappropriate.

- Receive adequate information about the person(s) responsible for the delivery of their care, treatment, and services.

- Accept or refuse medical or surgical treatment, including forgoing or withdrawing life-sustaining treatment or withholding resuscitation services and services in accordance with law and regulation.

- Have a family member or representative of his or her choice and his or her own physician notified promptly of his or her admission to the hospital.
Patients have the right to:

- Effective communication which is appropriate to the age, understanding, & the language of the patient
- Freely voice complaints and recommended changes without being subject to coercion, discrimination, reprisal, or unreasonable interruption of care, treatment, and services; the hospital addresses the resolution of complaints from patients and their families
- Confidentiality, privacy, and security of their clinical record and protected health information; Consent is obtained for recording and filming made for purposes other than the identification, diagnosis, or treatment of the patients and the patient’s medical record, including all computerized medical information will be kept confidential
- Personal privacy and an environment that preserves dignity and contributes to a positive self image
- Be free from mental, physical, sexual, and verbal abuse, neglect and exploitation and access protective and advocacy services
- Receive care in a safe setting
- Participate in their pain management plan
- Receive adequate information to participate or refuse to participate in research, investigation and clinical trials (if applicable)
- Receive education and training specific to the patient’s needs and as appropriate to the care, treatment, and services provided
- Receive information in a timely manner of the need to plan for discharge or transfer; planning for discharge or transfer involves the patient and family members
- Reasonable access to care; individuals shall be accorded impartial access to treatment or accommodations that are available or medically indicated, regardless of race, creed, sex, national origin, religion, or source of payment for care
- Designate a decision-maker in the event that the patient is incapable of understanding a proposed treatment or procedure or is unable to communicate his or her wishes regarding care
- Be free from restraint of any form imposed as a means of coercion, discipline, convenience, or retaliation by staff; patients have the right to safe implementation of restraints by trained staff
- Receive visitors (subject to their consent) whom the patient designates, including but not limited to a spouse, a domestic partner, another family member, or a friend; patients may also designate or restrict visitors and have the right to withdraw or deny consent for visitation at any time

The hospital may not restrict, limit, or otherwise deny visitation privileges on the basis of race, ethnicity, culture, language, socioeconomic status, color, national origin, religion, sex, gender identity, sexual orientation, or disability.
TRANSITIONAL CARE RESIDENT RIGHTS (FOR PITTSBURGH TCC FACILITY)

Residents in the facility have the right to:

• Personal privacy and confidentiality of his/her personal and clinical records
• Refuse release of personal and clinical records except as provided by law
• Reside and receive services in the facility with reasonable accommodation of individual needs and preferences
• Exercise his/her rights as a resident of the facility and as a citizen or resident of the United States
• Upon written request, inspect and purchase photocopies of all records pertaining to the resident
• Be fully informed of his/her total health status, including but not limited to his/her medical condition
• Refuse treatment and refuse to participate in experimental research
• Choose a personal attending physician
• Be fully informed in advance about care and treatment and of any changes in that care or treatment that may affect the resident’s well being
• Participate in care planning and treatment or changes in care and treatment
• Be free of interference, coercion, discrimination, or reprisal from the facility in exercising his/her rights
• Be free from verbal, sexual, physical or mental abuse, corporal punishment, and involuntary seclusion
• Be free from any physical restraints imposed or psychoactive drug administered for the purposes of discipline or convenience and not required to treat the resident’s medical symptoms
• Examine the results of the most recent survey of the facility conducted by federal or state surveyors and any plan of correction in effect with respect to the facility
• Receive information from agencies acting as client advocates and be afforded the opportunity to contact these agencies
• Privacy in written communications, including the right to send and receive mail promptly that is unopened and to have access to stationary, postage, and writing implements at the resident’s own expense
• Receive visitors and have access to such visitors at any reasonable hour
• Have regular access to the private use of a telephone
• Share a room with his/her spouse when married residents live in the same facility and both spouses consent to the arrangement
• Participate in social, religious, and community activities that do not interfere with the rights of other residents in the facility
TRANSITIONAL CARE RESIDENT RIGHTS (FOR PITTSBURGH TCC FACILITY)

Residents in the facility have the right to:

- Immediate access by:
  - Any representative of the secretary of Health and Human Services
  - Any representative of the state
  - The resident’s individual physician
  - The state’s long-term care ombudsman
  - The agency responsible for the protection and advocacy system for developmentally disabled individuals
  - The agency responsible for the protection and advocacy system for mentally ill individuals
  - Immediate family or other relatives of the resident subject to the resident’s right to deny or withdraw consent at any time, or
  - Others who are visiting with the consent of the resident subject to reasonable restrictions and the resident’s right to deny or withdraw consent at any time

- Organize and participate in resident groups in the facility
- Choose activities, schedules, and health care consistent with his/her interests, assessments, and plans of care
- Interact with members of the community both inside and outside the facility
- Make choices about aspects of his/her life in the facility that are significant to the resident
- Refuse to perform services for the facility
- Perform services for the facility, if he/she chooses, with appropriate approvals and compensation as included in the resident’s plan of care
- Retain and use personal possessions, including some furnishings and appropriate clothing as space permits, unless to do so would infringe upon the rights or health and safety of other residents
- Voice grievances with respect to treatment or care that is, or fails to be, furnished without discrimination or reprisal for voicing the grievances
- Prompt efforts by the facility to resolve grievances the resident may have, including those with respect to behavior of other residents;
- Manage his/her financial affairs and the facility may not require residents to deposit their personal funds with the facility; and
- To self-administer drugs, unless this is determined to be an unsafe practice. Examine the results of the most recent survey of the facility conducted by federal or state surveyors and any plan of correction in effect with respect to the facility
PATIENT RESPONSIBILITIES

• A patient has the responsibility to provide, to the best of his/her knowledge, accurate and complete information about present complaints, past illnesses, hospitalizations, medications, and other matters relating to his/her health. He/she has the responsibility to report unexpected changes in his condition to the responsible practitioner. A patient is responsible for making it known whether he/she clearly comprehends a contemplated course of action and what is expected of him/her.

• A patient is responsible for following the treatment plan recommended by the practitioner primarily for his/her care. This may include following the instructions of nurses and allied health personnel as they carry out the coordinated plan of care and implement the responsible practitioner’s orders, and as they enforce the applicable hospital rules and regulations. The patient and family are responsible for following the hospital rules and regulations concerning patient care and conduct. The patient is responsible for keeping appointments and, when he/she is unable to do so for any reason, for notifying the responsible practitioner. The patient is responsible for asking questions when they do not understand what they have been told about their care what they are expected to do. The patient is responsible for accepting the consequences of not following instructions. If the patient or family refuses treatment or fails to follow the practitioner’s instructions, they are responsible for the outcomes.

• The patient is responsible for being considerate of the rights of other patients and facility personnel and for assisting in the control of noise and the number of visitors. The patient is responsible for being respectful of the property of other persons and of the facility.

• All patients will be given accurate information regarding the facilities policy on collection methods on the patient’s portion of the bill after Insurance/Medicare payment has been made. Patients are always responsible for any co-insurance, deductibles, room rate difference and non-covered items.

POPULATION-SPECIFIC CARE
Understanding the developmental and physiologic differences in adult populations is key to providing population-specific care.

Traits of the Young Adult (Ages 20-45)

• Accepts self and stabilizes self-concept/body image
• Establishes independence from parent
• Assumes responsibilities and independent decision making
• Displays a basic need for closeness and personal commitment to another such as a spouse, parent and partner
• Establishes a vocation or profession that provides personal satisfaction, economic independence and a feeling of self-worth
Young Adult Considerations for Care

- Develop the plan of care to meet patient’s specific needs
- The majority of patient teaching for this age group is focused on health and safety education: the effects of drugs and drug abuse, alcohol, tobacco, sexual practices, healthy nutrition, weight control and exercise; young adults may be too embarrassed to ask for educational materials, so they should be provided appropriately without request
- Encourage independence in activities of daily living and participation in all aspects of the daily care
- Institute measures to preserve skin integrity
- Listen as patient meets his/her needs to talk to someone
- Assess pain and anticipate pain management needs
- Encourage patient to maintain independence as much as possible and especially in planning their health care

Traits of the Middle Adult (Ages 45-65)

- Discover and develop new interests and relationships
- Balance work and other roles
- Help growing/grown children
- Encounter role reversal with aging parents
- Achieve mature social and civic responsibilities
- Carry out life goals as well as formulating ideas and plans for the next generation
- Recognize that death is inevitable

Middle Adult Considerations for Care

- Develop the plan of care to meet patient’s specific needs
- Encourage participation in all aspects of the care continuum
- Include the patient’s significant other or other family members in teaching when appropriate
- Allow the adult to verbalize concerns and fears regarding illness or injury
- Listen as patient meets his/her needs to talk to someone; stress management techniques may help to deal with the stressful aspects of the patients care
- Assess the learning preference of the adult patients; some adults prefer written instructions and documentation; some prefer audiotapes or videotapes; some prefer a combination of learning methods
- Assess level of comfort; degenerative conditions and other physiologic changes may effect comfort and ability to sleep
- Encourage patient to maintain independence as much as possible and especially in planning their health care
- Provide assistive devices such as walkers, canes, wheelchairs, magnifying glasses, etc., as needed

Traits of the Older Adult (Ages 65+)

- Adjust to retirement, which may or may not be welcome
- Adjust to decreasing physical strength and health changes
- Learn to combine new dependency needs with the continuing need for independence
- Individual either emerges with a feeling of self-worth or experiences despair when he/she reviews life’s accomplishments
### Older Adult Considerations for Care

- Develop the plan of care to meet patient’s specific needs
- Institute measures to prevent physical injuries due to unfamiliar environment
- Encourage participation in care
- Institute measures to preserve skin integrity
- Listen as patient meets his/her needs to talk to someone
- Assess level of comfort; degenerative conditions and other physiologic changes may effect comfort and ability to sleep
- Encourage patient to maintain independence as much as possible and especially in planning their health care
- Provide assistive devices such as walkers, canes, wheelchairs, magnifying glasses, etc. as needed

### Physiology of Aging and Considerations for Care

<table>
<thead>
<tr>
<th>Body System</th>
<th>Physiological Changes</th>
<th>Effects</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cardiovascular</td>
<td>- Heart muscle decreased&lt;br&gt;- Force of contraction decreased&lt;br&gt;- Fat and collagen increased&lt;br&gt;- Vessel rigidity increased&lt;br&gt;- Vascular resistance increased</td>
<td>- Decreased cardiac output&lt;br&gt;- Activity intolerance (Space our activities)&lt;br&gt;- Fatigue</td>
</tr>
<tr>
<td>Respiratory</td>
<td>- Respiratory muscles weaken&lt;br&gt;- Increased thoracic wall rigidity&lt;br&gt;- Alveoli decreased&lt;br&gt;- Cilia action decreased&lt;br&gt;- Vascular changes in pulmonary capillary beds</td>
<td>- Impaired gas exchange&lt;br&gt;- Ineffective airway clearance&lt;br&gt;- Risk for infection&lt;br&gt;- Risk for aspiration</td>
</tr>
<tr>
<td>Nervous</td>
<td>- Conduction of nerve impulses slowed&lt;br&gt;- Loss of neurons in brain and spinal cord&lt;br&gt;- Major neurotransmitters decreased&lt;br&gt;- Peripheral nerve function lost&lt;br&gt;- Sensory input decreased</td>
<td>- Sensory perceptual deficit&lt;br&gt;- Sleep pattern disturbance&lt;br&gt;- Hypo or Hyperthermia&lt;br&gt;- Altered thought process</td>
</tr>
<tr>
<td>Integumentary</td>
<td>- Collagen decreased&lt;br&gt;- Skin tissue fluid decreased&lt;br&gt;- Capillary fragility increased&lt;br&gt;- Sensory receptors decreased&lt;br&gt;- SubQ fat may increase or decrease</td>
<td>- Skin less elastic&lt;br&gt;- Wrinkles and folds increased&lt;br&gt;- Skin bruises and tears easily&lt;br&gt;- Dry skin&lt;br&gt;- Skin heals slowly</td>
</tr>
<tr>
<td>Musculoskeletal</td>
<td>- Muscle fibers atrophy&lt;br&gt;- Ligament stiffening&lt;br&gt;- Cartilage erosion&lt;br&gt;- Calcium deposits increased&lt;br&gt;- Sclerosis of tendons</td>
<td>- Risk for falls&lt;br&gt;- Impaired physical mobility&lt;br&gt;- Self care deficit&lt;br&gt;- Pain</td>
</tr>
<tr>
<td>Gastrointestinal</td>
<td>- Salivary secretions decreased&lt;br&gt;- Gingival retraction&lt;br&gt;- Decreased GI mobility&lt;br&gt;- Intestinal villae decreased&lt;br&gt;- Decreased blood flow to bowel&lt;br&gt;- Pancreatic enzymes decreased</td>
<td>- Dry oral mucous membranes&lt;br&gt;- Taste changes&lt;br&gt;- Inadequate nutrition&lt;br&gt;- Constipation</td>
</tr>
</tbody>
</table>
Physiology of Aging and Considerations for Care (cont.)

<table>
<thead>
<tr>
<th>Body System</th>
<th>Physiological Changes</th>
<th>Effects</th>
</tr>
</thead>
<tbody>
<tr>
<td>Urinary</td>
<td>• Renal mass decreased</td>
<td>• Dehydration</td>
</tr>
<tr>
<td></td>
<td>• Glomerular filtration rate decreased</td>
<td>• Bladder capacity decreased</td>
</tr>
<tr>
<td></td>
<td>• Bladder smooth muscle and elastic tissue decreased</td>
<td>• Stress incontinence</td>
</tr>
<tr>
<td></td>
<td>• Sphincter control decreased</td>
<td>• Nocturia</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Excretion of toxins and drugs decreased</td>
</tr>
<tr>
<td></td>
<td>• Increased body fat</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Increased drug storage</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Decreased body water</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Decreased hepatic blood</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Decreased lean muscle mass</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Decreased renal function</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Decreased serum albumin</td>
<td></td>
</tr>
<tr>
<td>Visual Acuity</td>
<td>• Tear production decreased</td>
<td>• Eyes dry</td>
</tr>
<tr>
<td></td>
<td>• Corneal sensitivity decreased</td>
<td>• Visual acuity decreased</td>
</tr>
<tr>
<td></td>
<td>• Eye muscles atrophy</td>
<td>• Peripheral vision decreased</td>
</tr>
<tr>
<td></td>
<td>• Lens less elastic, more dense</td>
<td>• Night vision impaired</td>
</tr>
<tr>
<td>Auditory</td>
<td>• Ear drum thickens</td>
<td>• Conductive hearing loss</td>
</tr>
<tr>
<td></td>
<td>• Middle ear drum bone joints degenerated</td>
<td>• Sound conduction decreased</td>
</tr>
<tr>
<td></td>
<td>• Cochlea atrophies</td>
<td>• Balance deficits = Increased chance of falls</td>
</tr>
<tr>
<td></td>
<td>• Organ of Corti atrophies</td>
<td></td>
</tr>
<tr>
<td>Immune</td>
<td>• Decreased metabolic rate</td>
<td>• Weight gain</td>
</tr>
<tr>
<td></td>
<td>• Antibody production impaired</td>
<td>• Risk for infection</td>
</tr>
<tr>
<td></td>
<td>• Tlymphocytes decreased</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Auto-antibodies increased</td>
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</tbody>
</table>

Age-Related Changes and Risk of Adverse Drug Reactions

<table>
<thead>
<tr>
<th>Age-Related Change</th>
<th>Drug Effects</th>
<th>Adverse Drug Action Becomes More Common with Increased Age</th>
</tr>
</thead>
<tbody>
<tr>
<td>Increased Body Fat</td>
<td>Increased Drug Storage</td>
<td></td>
</tr>
<tr>
<td>Decreased Body Water</td>
<td>Increased Drug/Active Concentration</td>
<td></td>
</tr>
<tr>
<td>Decreased Hepatic Blood</td>
<td>Decreased Drug Clearance</td>
<td></td>
</tr>
<tr>
<td>Decreased Lean Muscle Mass</td>
<td>Increased Drug Tissue Concentration</td>
<td></td>
</tr>
<tr>
<td>Decreased Renal Function</td>
<td>Decreased Drug Elimination</td>
<td></td>
</tr>
<tr>
<td>Decreased Serum Albumin</td>
<td>Increased Free Drug Concentration</td>
<td></td>
</tr>
</tbody>
</table>

Example                  | Problem        |
--------------------------|----------------|
Aspirin                   | Bleeding       |
Antibiotics               | Nephrotoxicity |
Anticoagulants            | Bleeding/Hemorrhage |
Antidepressants           | Sedation       |
Antihypertensives         | Hypotension/Falls |
Antipsychotics            | Confusion       |
Diuretics                 | Hypokalemia    |
Sedatives/Hypnotics       | Drowsiness      |
ADVANCE DIRECTIVES

• An Advanced Directive (AD) is a formal document written in advance of an incapacitating illness or injury, in which people can provide for decision making about medical treatment should they become unable to make their own decision

• ADs include, but are not limited to, the following: Declaration (“Living Wills”), Durable Power of Attorney for Health Care, or regarding specific health care treatment or mental health declaration

• Federal and state laws require that patients over the age of 18 be advised of their rights to:
  – Make health care decisions
  – Formulate Advanced Health Care Directives
  – Accept or refuse medical or surgical treatment

• The patient can revoke, change or execute an AD at any time

• The facility will determine that each patient has executed wishes to provide, or wishes to change their ADs; if necessary, the facility will provide an opportunity to educate the patient and to allow the patient to develop ADs

• All ADs, either written or verbal, will be documented in the patient’s medical record; the patient is encouraged to provide a copy of the AD or to formulate a new one

• The patient's attending physicians will be notified of the presence of a patient's ADs (either verbal or written) or of any changes

• All employees or agents of the facility and its medical staff will honor the patient’s wishes regarding Ads; no patient will be discriminated against or receive conditional or compromised health care because of the presence or absence of any ADs

• ADs are only to be used in the event that the patient either lacks or loses the ability to make health care decisions

• The facility shall make a good faith effort to assist with the transfer of a patient’s care (facility, agent, employee, or physician) if, as a matter of conscience, that entity is unable to provide for the implementation of an AD

• The existence or lack of an AD does not determine an individual’s access to care, treatment and services; the facility will not discriminate against an individual based on whether he/she has executed an AD

• The facility will provide education to the staff regarding ADs
ELDER ABUSE RECOGNITION & REPORTING

- All employees or agents of the facility are required to report any suspected abuse or neglect of a patient to their supervisor or HR representative

What should you do if you witness or receive allegations of ANY type of abuse?

1. Immediately assure patient safety
   - If the alleged perpetrator is a visitor: ask them to leave the premises immediately; the visitor may be escorted by facility security or the local police department, if necessary
   - If the alleged perpetrator is a staff member: they will be removed from caring for the patient in question; upon discussion with the staff member’s supervisor and HR or Hospital Administrator, the staff member may be placed on paid administrative leave pending the outcome of the investigation
   - If the alleged perpetrator is a patient: he/she will be separated from other patients and closely monitored

2. Notify Department Manager or designee immediately

Recognizing Signs of Abuse

<table>
<thead>
<tr>
<th>DEFINITION</th>
<th>EXAMPLE</th>
<th>SYMPTOM</th>
</tr>
</thead>
<tbody>
<tr>
<td>Abandonment: The desertion of an</td>
<td>Leaving a patient alone for extended periods of time without adequate</td>
<td></td>
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<tr>
<td>older adult by a caregiver</td>
<td>supervision which endangers life</td>
<td></td>
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<tr>
<td>Verbal Abuse: The use of any oral,</td>
<td>Threats of harm, saying things to frighten the person, telling the person</td>
<td></td>
</tr>
<tr>
<td>written or gestured language that</td>
<td>he will never be able to see family again</td>
<td></td>
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<tr>
<td>includes disparaging and derogatory</td>
<td>Threatening to apply restraints if the person doesn’t stop “xx,”</td>
<td></td>
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<tr>
<td>terms to or within hearing distance</td>
<td></td>
<td></td>
</tr>
<tr>
<td>of the person, regardless of age,</td>
<td></td>
<td></td>
</tr>
<tr>
<td>ability to comprehend or disability</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Physical Abuse: The willful infliction of injury, unreasonable confinement, intimidation or punishment with resulting physical pain or mental anguish</td>
<td>Slapping, bruising, cutting, burning, physically restraining without justification</td>
<td>Physical Abuse: Unexplained bruises and welts, burns, fractures, lacerations or abrasions</td>
</tr>
<tr>
<td>Physical Neglect: Consistent hunger, poor hygiene, inappropriate dress, consistent lack of supervision, especially in dangerous activities or long periods, constant fatigue, unattended physical problems or medical needs, abandonment</td>
<td></td>
<td>Physical Neglect: Consistent hunger, poor hygiene, inappropriate dress, consistent lack of supervision, especially in dangerous activities or long periods, constant fatigue, unattended physical problems or medical needs, abandonment</td>
</tr>
<tr>
<td>Psychological Abuse: the threat of injury, unreasonable confinement and inability of the person to give consent</td>
<td>Threatening to physically harm the person every time he/she calls for assistance</td>
<td>Mental anguish, depression, unjustifiable anxiety, fear of caregiver</td>
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</table>
## Recognizing Signs of Abuse (cont.)

<table>
<thead>
<tr>
<th>DEFINITION</th>
<th>EXAMPLE</th>
<th>SYMPTOM</th>
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</thead>
<tbody>
<tr>
<td><strong>Sexual Abuse</strong>: sexual abuse that results from threats, force or the inability of the person to give consent</td>
<td>Harassment (improper language, jokes) fondling, inappropriate touching or exposure</td>
<td>Difficulty in walking or sitting; torn, stained or bloody underclothing, pain or itching in genital area; bruises or bleeding in external genitals; vaginal or anal areas; diagnosis of sexually transmitted disease</td>
</tr>
<tr>
<td><strong>Financial Exploitation</strong>: an improper course of conduct with or without informal consent of the older adult that results in monetary, personal or other benefit, gain or profit for the perpetrator or caregiver</td>
<td>Hoarding or squandering money, disparity between income and lifestyle, unauthorized or unexplained bank withdrawals, fear or anxiety when discussing finances</td>
<td></td>
</tr>
<tr>
<td><strong>Active Neglect</strong>: the willful deprivation by a caregiver of goods or services essential to avoid a clear and serious threat to physical or mental health</td>
<td>Active Neglect: Deliberate abandonment or deliberate denial of food or health related services/poor hygiene/unattended physical/medical needs; withholding of medicine, food, clothing, heat, housing, assistance with ADLs</td>
<td>Emotional Maltreatment: Habit disorder (sucking, biting, rocking); conduct disorders (antisocial, destructive); withdrawal, agitation, low self-esteem, neurotic traits (sleep disorders, speech disorders, psycho-neurotic reaction (hysteria, obsession, compulsion, phobias, hypochondrias)</td>
</tr>
<tr>
<td><strong>Passive Neglect</strong>: the deprivation by a caregiver of goods or services, which are necessary to maintain physical or mental health, without a conscious attempt to inflict physical or emotional distress</td>
<td>Passive Neglect: Denial or service because of inadequate knowledge, infirmity, or disputing the value of prescribed services/ unintentionally ignored or left alone.</td>
<td></td>
</tr>
<tr>
<td><strong>Self Neglect</strong>: a person, often living alone, who plays a role in his/her deterioration because of mental or physical impairment, mismanagement of medication, substance dependency or willful denial of intervention</td>
<td>Self Neglect: Consider hunger, poor hygiene, Inappropriate dress, constant fatigue or listlessness, unattended physical/medical needs</td>
<td></td>
</tr>
</tbody>
</table>

## Recognizing Suspicious Behaviors

- Patient or significant other makes verbal outcry or otherwise communicates that assault, abuse or neglect has occurred
- Patient or significant other describes an accident that does not fit the injuries; story seems unlikely or improbable
- Care givers have different versions of the accident or there is discrepancy in history of injury/physical harm; the explanation varies
- Patient and/or caregivers are vague about the details of the accident or injury
- There is a claim that the injuries were self inflicted which the patient is clearly unable to have inflicted them
- Accident/injury is blamed on other relatives, care givers, etc.
- Care giver has waited a significant period of time before reporting incident
- There is a history of frequent injury, hospital ER visits, or physician’s visits
- Patient displays lack of reaction to obviously painful injury, or is overly submissive to treatment
- Patient fearful of being alone with caretaker
- There has been a delay in seeking medical treatment
- Consent for diagnostic procedures is refused
- Caregiver displays lack of concern and interest in the patient’s condition and prognosis
- History taking questions are responded to with resistance, irritation, or hostility
- Patient and/or caregiver avoid eye contact; appear nervous, preoccupied when asked questions
- Patient does not appear to expect comfort from the caregiver/significant other injuries found on physical exam and x-ray not reported by caregiver/significant other
AFTER REVIEWING THE CONTENT IN THIS SECTION, YOU SHOULD:

- Understand the purpose of the Joint Commission’s National Patient Safety Goals and identify those applicable for hospitals
- Apply best practices and methods for implementation of the National Patient Safety Goals
- Understand the facts about Incident Reporting
- Understand the difference between a complaint and grievance and the process for reporting
- Understand the importance of infection prevention and how this applies to quality care

QUALITY AND RISK MANAGEMENT

The Quality Management department of LifeCare Hospitals operates on the basis of efficiency, appropriateness, availability, timeliness, effectiveness, continuity, safety, respect and caring. Our staff members share a commitment to deliver high quality, compassionate care. Areas that may fall under the QM umbrella include: Risk Management, Infection Control, Employee Health, Environmental Safety, Workers’ Comp, HIPAA, Patient Safety, Ethics, TJC, and much, much more. The Quality Management (QM) department is in place to help achieve our goal of high quality care. Please report any quality issues to the QM Department.

Risk Management is designed to prevent and/or reduce fortuitous loss to the hospital. It also: identifies and prevents future problems and minimizes the impact of problems. A good Risk Management Program provides a safe hospital environment and contributes to the quality of patient care. The goal of the program is to ensure that once a situation has occurred, there is prompt reporting and investigation. The sooner the healthcare team and administration can respond the better chance the facility has to avoid litigation and minimize potential damages.

Patients tend to sue when they...

- Are dissatisfied with the quality or cost of care
- Feel they have somehow been wronged
- Have sustained an injury
- Feel they have received a less than perfect result
- Perceive nurses, doctors, and hospital healthcare team members as rude, callous and unsympathetic

Why Communication is Key

- Patients use the lawsuit as a way to resolve disputes because they are most often not given any other alternative to resolve their problems
- This is often because no one communicated with the patient and/or family following a disagreement about hospital care

FACT!

- Statistics show that patients are less likely to sue if employees take the time to establish a positive relationship.
- The type of patient most likely to file a claim is a patient who perceives that the healthcare professional DID NOT CARE ABOUT HIM OR HER during that admission or treatment. It usually has little to do with the patient’s occurrence.
Good Communication is the key to defusing a potentially bad situation.

In addition to medical problems a patient may have personal problems. The patient may be stressed and perceive a problem where there is none.

Communication

- One kind of communication that affects patient perception is interaction between the healthcare professionals.

- When communicating with your peers:
  - Respect their opinion
  - Do not use the medical record as a battleground
  - Do not contradict or criticize treatment by a peer in the presence of a patient or family
  - Do not blame a member of the healthcare team for an occurrence
  - Do not discuss your opinion of the treatment with the patient
  - If you have concerns about staffing, discuss with your supervisor in a private setting

- Everyone should use easy to understand language with patients

- Patients need to maintain control and retain a sense of dignity while in the hospital

- Remember that it takes a lot less time to explain a procedure to a patient and/or family member than it takes to defend a lawsuit

Steps to Minimize Risk

- Follow LMS established policies and procedures
- Document clearly and completely
- Use your chain of command
- Communicate in a caring manner to patients
- Work together as a team

Ethics

The Ethics Committee is a trans-disciplinary committee of the Medical Staff which supports the delivery of ethical patient care at the facility.

Making decisions about care sometimes presents questions, conflicts or other dilemmas for the hospital and the patients, family, or other decision-makers. Issues may include admission, treatment or discharge and may be especially difficult when issues involve care at the end of life. Various mechanisms are available to assist with resolution. Individuals who need to be involved are identified and included in the resolution process. If you have an ethical dilemma notify your supervisor or the patient’s case manager to consult the ethics committee.
INCIDENT REPORTING

**Why do we complete an Incident Report?**
The incident report is a record of an occurrence or event that is **NOT routine** in the care of a patient or the operation of the hospital. It is a record of the facts that are an essential component of the follow up and resolution of the event. The Incident Report can:

- Help track trend and correct problems
- Provide a means to investigate further
- Help to protect the patients, visitors, staff members
- May be discoverable
- Document the facts as you know them

**Who completes the Incident Report?**
The incident report should be completed by the person who has the **best knowledge** of the incident.

**When is the Incident Report completed?**
Complete the incident report ASAP after the event is discovered.

**Who do I tell that an Incident Report was completed?**
Report the incident to your Supervisor ASAP.

**What events prompt an Incident Report?**
- **ANY** occurrence or near miss involving a patient, visitor, physician, staff member, agency personnel, or volunteer
- **ALL** events or occurrences that are **NOT routine** in the operation of the hospital

---

### Slips/Trips/Falls
- Patient/Visitor/any person falls
- Patient/visitor/any person injuries

### Procedure Events
- Procedural errors
- IV line issues
- Transfusion issues
- Transfusion reactions
- Wrong or missed treatments
- Patient misidentification
- Incomplete records
- Consent issues

### Safety and Security
- Safety issues
- Security issues
- Leaving against medical advice (AMA)
- Abusive behavior
- Hazardous material spills
- Possession of contraband
- Equipment tampering
- Equipment malfunctions
- Visitor issues
- Confidentiality issues
- Restraint issues
- Any real or potential quality issues
What events prompt an Incident Report? (continued)

Medication Errors/Events:
- Wrong patient
- Wrong drug
- Wrong dose
- Wrong time
- Wrong rate
- Wrong diluents
- Wrong protocol
- Wrong label
- Omitted dose
- Given without an order
- Given with documented allergy
- Patient took own meds
- Adverse drug reaction
- Narcotic discrepancies

Wound/Skin Related Events:
- Wrong care/treatment performed
- Care/Treatment omitted
- Consents not signed prior to sharps debridement
- Documentation omitted of sharps debridement
- Nosocomial/Hospital Acquired pressure ulcers

Report anything that you believe/feel:
- May be incomplete, omitted or an error
- May be a “near miss”
- May need further investigation or possible correction
- Is just not “right”

How to complete the Incident Report
- Briefly describe the incident or event
- Be objective and describe the facts as you know them

Things to document...
- How, where & when the event/person was found
- The patient/person’s explanation of the event
- Use the patient/person’s own words if possible
- The family’s response to the event
- Corrective action taken to prevent a reoccurrence of the incident

Document the facts of the occurrence in the medical record
- Patient assessment
- Physician notification and orders
- Results of physician orders
- Family notification
- Outcome of the incident

Do not document in the medical record that an Incident Report was completed
### Additional NEED to KNOW Incidents:

<table>
<thead>
<tr>
<th>Incident</th>
<th>Definition</th>
<th>Example</th>
</tr>
</thead>
</table>
| Near Miss                     | - Any process variation which *did not reach the patient* or did not affect the outcome  
                             | - Reoccurrence carries a significant chance of a serious adverse outcome | Catching a medication error right before administration                  |
| Health Care Error/Incident    | - Unintended act, of omission or commission, that did not achieve its intended outcome | An order for a blood test was not transcribed into the laboratory ordering system, therefore the test was not obtained |
| Adverse Event                 | - Untoward, undesirable, & usually *unanticipated event* such as death or serious injury of a patient | A death resulting from a blood transfusion reaction                     |
| Sentinel/Serious Event        | - An unexpected occurrence involving death or serious physical or psychological injury, or the risk thereof  
                             | - Serious injuries specifically include a loss of limb or function       | Patient has a stroke as a result of a medication error                   |
| Disclosure                    | - Information provided to the patient and/or family members regarding an unanticipated outcome | Letter to the a daughter stating that her mother experienced a fall resulting in a laceration that required sutures |
| Infrastructure Failure        | - A significant disruption of service that compromises patient safety     | - A Patient elopement  
                             | - Utility Failure  
                             | - Routine generator test that results in the failure of critical equipment |
| Reasonable Suspicion of a crime | All employees are required by the Patient Protection and Affordable Care Act and the Elder Justice Act of 2009 to report the reasonable suspicion of a crime against a resident in a nursing home to his/her charge nurse, supervisor, director, or administrator.  
                             | Crime – is an act that is forbidden by a public law  
                             | Crime Against a Resident – is defined as the actions of an individual which results in the injury or exploitation of a resident. Crimes include physical, sexual and mental abuse and the misappropriation of resident property. |

- Contact your Quality/Risk Manager with any questions or problems concerning the Incident Report
- Notify the Quality/Risk Manager immediately for serious incidents
PATIENT/FAMILY COMPLAINTS AND FORMAL PATIENT GRIEVANCES

Complaint Policy
The patient/family complaint process is a mechanism that allows patients/families to make complaints regarding patient treatment and care and by which prompt resolution of problems can be accomplished.

Formal Grievance Policy
The grievance process is a formal mechanism for patients and their families to make grievances regarding patient treatment and care. Patients or family members may file a formal grievance by addressing their concerns verbally or in writing. The grievance process is required by CMS.

Why have a Complaint and Grievance Process?
- Identifying and correcting complaints and/or grievances early and in a timely manner, improves patient safety, prevents or decreases the likelihood of liability and improves patient/family satisfaction.
- It also provides a means to track and record potential issues that may or will be questioned in the future.
- Patient complaints and grievances are important to the patient; make them important to you.

Examples of a Complaint include (but are not limited to): “Room is too hot, food is cold, too noisy, etc.”

Situations Considered a Grievance
If a patient care complaint cannot be resolved at the time of the complaint by the staff present, is postponed for later resolution, is referred to other staff for later resolution, requires investigation, and/or requires further actions for resolution, then the complaint is considered a grievance.

- A Medicare Beneficiary billing complaint related to rights and limitations provided by 42 CFR § 489
- A complaint regarding disagreement with coverage decisions or premature discharge
- A written complaint is always considered a grievance, whether from an inpatient, outpatient, released/discharged patient or their representative regarding the patient care provided, abuse or neglect, or the hospital’s compliance with Conditions of Participation. This includes an e-mail or fax complaint.
- All verbal or written complaints regarding abuse, neglect, patient harm or hospital compliance with CMS requirements
- If a patient or a patient’s representative telephones the hospital with a complaint regarding their patient care, or with an allegation of abuse or neglect, or failure of the hospital to comply with one or more of the Conditions of Participation, or other CMS requirements
- Whenever the patient or the patient’s representative request their complaint be handled as a formal complaint or grievance or when the patient requests a response from the hospital
- Patient or family report theft or loss of property
- Breech of confidentiality
- All financial disputes
<table>
<thead>
<tr>
<th>Complaint</th>
<th>Grievance</th>
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</thead>
<tbody>
<tr>
<td><strong>Definition</strong></td>
<td>An <em>expression of dissatisfaction</em> or concern that can be resolved by the staff present <em>at that time</em>. For example: Cold food, room too hot, Call light not answered fast enough</td>
</tr>
<tr>
<td><strong>Efforts towards resolution are immediately provided</strong></td>
<td>Yes</td>
</tr>
<tr>
<td><strong>Resolution is immediate</strong></td>
<td>Yes</td>
</tr>
<tr>
<td><strong>Patient and Families are Informed</strong></td>
<td>Information regarding the Complaint and Grievance process is included in the admission packet, education material, and is explained to the patient, family members or representatives at the time of admission by the assigned Business Office Representative and or the Admitting Nurse, Case Manager and/or Social Worker.</td>
</tr>
<tr>
<td><strong>Documentation</strong></td>
<td>Complaint Form</td>
</tr>
<tr>
<td>After Completing the appropriate form, to whom is it submitted/reported to?</td>
<td>Department Supervisor - will verify that complaint is resolved</td>
</tr>
<tr>
<td><strong>To whom does the Supervisor submit/report the form to?</strong></td>
<td>Quality Manager <em>within 72 hours</em></td>
</tr>
<tr>
<td><strong>Patient/family are kept informed of all efforts made to resolve their grievance</strong></td>
<td>Yes</td>
</tr>
<tr>
<td><strong>Evaluated and Reported</strong></td>
<td>Monthly for trends and part of the Quality Improvement Efforts</td>
</tr>
<tr>
<td><strong>Other Notes</strong></td>
<td>If resolution was not achieved through the actions of the staff or Department Supervisor, the issue becomes a grievance</td>
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Anonymous Reporting and Duty to Report (for Pennsylvania facilities)
If you are a healthcare worker and feel a patient in your facility suffered an unanticipated injury involving clinical care, your first obligation is to report this internally via your organization’s patient safety plan (notify the patient safety officer).

If you are not satisfied with the manner in which the report was handled by the organization, then you may consider submitting an Anonymous Report with the Pennsylvania Patient Safety Authority.

Anonymous Report to PSA
- All information is confidential
- You will not be subject to any retaliatory action for reporting an event that has caused harm to a patient
- You will be protected by the strongest Whistleblower Law in Pennsylvania

In order to file an anonymous report...
- You must be a healthcare worker in the facility where the event occurred.
- Patient must have suffered harm or death resulting from clinical care given in your facility.
- Before submitting, you must make sure you or someone else has filed a report within your facility according to your healthcare facility’s Patient Safety Plan.

Failure to Report/Notify
If a medical facility discovers that a licensee providing health care services in the medical facility during a serious event failed to report the event, the medical facility shall notify the licensee’s licensing board of the failure to report.
- Applies to any requirement of Act 13
  - Disclosure to patient/family
  - Report to patient safety officer by healthcare worker
  - Report of patient safety officer to PSA
  - Report by facility to licensing boards
- Considered a violation of the Health Care Facilities Act (state hospital regulations)
- Subject to administrative penalty of $1000 per day

HOW DOES PATIENT SAFETY RELATE TO MY JOB? When witnessing an incident...
1. Restore and maintain patient safety
2. Preserve information/resources/evidence
3. Report incident to your supervisor/risk manager
4. Any incident/near miss, infrastructure failure or serious/sentinel event shall be reported immediately or as soon thereafter as reasonably practicable, but in no event later than 24 hours after the occurrence or discovery.
NATIONAL PATIENT SAFETY GOALS

What are the National Patient Safety Goals?
- In 2002, The Joint Commission established its National Patient Safety Goals (NPSGs) program; the first set of NPSGs was effective January 1, 2003. The NPSGs were established to help accredited organizations address specific areas of concern in regards to patient safety.
- Understanding the Language
  - The Joint Commission numbers their standards and the National Patient Safety Goals; example: NPSG 1 is known as 01.01.01
  - Although there are many goals, only some are applicable for Hospitals; we will review each goal that is for hospitals

NPSG: 01.01.01 - Use at Least Two Patient Identifiers When Providing Care, Treatment & Services

Why do we have to use two identifiers?
- To reliably identify the individual as the person for whom the service or treatment is intended
- To match the service or treatment to that individual

Therefore, the two patient/client/resident-specific identifiers must be directly associated with the individual and the same two identifiers must be directly associated with the medications, blood products, specimen containers (such as on an attached label), other treatments or procedures.

How do we complete the identification with the two identifiers?
- The staff actively involves the patient, in the identification and matching process
- Using the patient’s armbands, compare the patient name and ID number to the order/MAR would be the two identifiers
- Use person-specific information as the “identifier,” not the room number

When do we complete the identification with the two identifiers?
Prior to providing treatment, care or services such as:
- Medications administration (Nursing and Respiratory Meds)
- Administration of Blood Products [01.03.01 Identifiers need to be “qualified transfusionists” (Registered Nurse)]
- Obtaining laboratory samples (this includes blood, stool, urine, sputum, wounds, etc.)
- Radiological tests or procedures

You must label the sample in the presence of the patient!
Does it apply to reporting critical test results?
Yes! This are important safety-related aspects of patient care, which for purposes of this requirement, fall under the EP for the use of two identifiers for “other treatments or procedures.”

We are a behavioral health care facility. The individuals in our care do not always wear wristbands. What other methods are acceptable for the “two identifiers”?
A common approach in these situations is to include the individual’s photograph in the clinical record for purposes of visual identification by staff.

NPSG: 02.03.01 - Improve the Effectiveness of Communication Among Caregivers
- The appropriate procedure for Verbal Orders:
  1. Write down the verbal order given on the Physician Order sheet
  2. “Read back” exactly what you wrote down
  3. Confirm the information with the physician

- Do not use list of abbreviations
  - See hospital policy on ICARE for accepted abbreviations
  - TJC has official list of abbreviations that are not permitted for use ANYWHERE on the Medical Record

<table>
<thead>
<tr>
<th>Abbreviation not to be used</th>
<th>Potential Problem</th>
<th>Preferred Term</th>
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</thead>
<tbody>
<tr>
<td>U (for unit)</td>
<td>Mistaken as zero, four or cc.</td>
<td>Write “unit”</td>
</tr>
<tr>
<td>IU (for international unit)</td>
<td>Mistaken as IV (intravenous) or 10 (ten).</td>
<td>Write “international unit”</td>
</tr>
<tr>
<td>Q.D., Q.O.D. (Latin abbreviation for once daily and every other day)</td>
<td>Mistaken for each other. The period after the Q can be mistaken for an &quot;l&quot; and the “O” can be mistaken for &quot;l&quot;.</td>
<td>Write “daily” and “every other day”</td>
</tr>
<tr>
<td>Trailing zero (X.0 mg), Lack of leading zero (.X mg)</td>
<td>Decimal point is missed.</td>
<td>Never write a zero by itself after a decimal point (X mg), and always use a zero before a decimal point (0.X mg)</td>
</tr>
<tr>
<td>MS, MSO₄, MgSO₄</td>
<td>Confused for one another. Can mean morphine sulfate or magnesium sulfate.</td>
<td>Write “morphine sulfate” or “magnesium sulfate”</td>
</tr>
</tbody>
</table>

Critical Tests and Results
- Each hospital and laboratory has a defined Critical Tests and Results list/policy
  - By whom and to whom critical results of tests and results are reported
- For example: Radiology Technologist reports Critical results to the patient’s assigned Nurse
  - Define acceptable length of time between availability of results and reporting
Hand-off Communication

- Use a standardized approach to hand-off communication between caregivers
  - That includes an opportunity for each caregiver to ask and respond to questions about the patient’s status
- This requires interactive communication
- Interruptions during hand-offs are limited to minimize the possibility that information fails to be conveyed

The SBAR (Situation-Background-Assessment-Recommendation) technique provides a framework for communication.

- Opportunities for hand-off communication include but are not limited to:
  - Nursing shift change
  - Temporary assumption of patient care responsibility
  - Transfer between nursing units
  - Reporting of critical test results
  - Transferring of patient duties between clinical professionals

Mrs. Smith is having increasing dyspnea and is complaining of chest pain.

The supporting background information is that she had a total knee replacement two days ago. About two hours ago she began complaining of chest pain. Her pulse is 120 and her blood pressure is 128/54. She is restless and short of breath.

My assessment of the situation is that she may be having a cardiac event or a pulmonary embolism.

I recommend that you see her immediately and that we start her on 02 stat. Do you agree?

NPSG: 03.04.01 - Improve the Safety of Using Medications

- Before a procedure, label medicines that are not labeled. For example, medicines in syringes, cups and basins. Do this in the area where medicines and supplies are set up
- Standardize and limit the number of drug concentrations
- Identify look alike/sound alike drugs
  - Review the list annually (July 08)
  - TaLLmaN LettERiNg
  - Prevent errors
  - Many medications look alike. Be careful to use the medication ordered. Use the “five rights” for medication administration to prevent errors

Look-alike medications

- Aminophylline
- Normal Saline
- Dobutamine
- 1% Lidocaine
- Dopamine
- Magnesium
Multi-Use Vials - A multi-dose vial is a bottle of liquid medication (injectable) that contains more than one dose of medication and is approved by the FDA for use on multiple persons. A new, sterile needle and syringe should always be used to access the medication in a multi-dose vial.

When do multi-dose vials that have been punctured or opened need to be discarded?
Multi-dose vials are to be discarded 28 days after first use unless the manufacturer specifies otherwise (shorter or longer). [Nurse opening the vial is responsible to write the expiration date on the vial as month/day/year]

Does the multi-dose vial need to be labeled with a new expiration date once it is opened or punctured?
Yes. Standard MM.03.01.01, EP 7 requires all stored medications are labeled with expiration date

- Labeling occurs when any medication or solution is transferred from the original package to another container
  - Label ALL medications, containers or other solutions on or off a sterile field
  - For example: medications prepared for a procedure need to be labeled
- Immediately discard any medication or solution found unlabeled

Reduce the likelihood of patient harm associated with the use of anticoagulant therapy
- Anticoagulation is a high risk treatment
- Implementation of a defined anticoagulation management program (2009)

Maintain and communicate accurate patient medication information
- Obtain information on the medications the patient is currently taking when he or she is admitted to the hospital (i.e. Medication Reconciliation)
  - Compare the medication information the patient brought to the hospital with the medications ordered for the patient by the hospital in order to identify and resolve discrepancies
  - Note: Discrepancies include omissions, duplications, contraindications, unclear information, and changes
- A qualified individual, identified by the hospital, does the comparison

Provide the patient (or family as needed) with written information on the medications the patient should be taking when he or she is discharged from the hospital or end of outpatient encounter
- Education should include: Name of medication, Dose, Route, Frequency, Purpose
- Explain the importance of managing medication information to the patient when he or she is discharged from the hospital or at the end of an outpatient encounter.
NPSG: 07.01.01 – Reduce the risk of Health Care-Associated Infections

- Comply with CDC hand hygiene guidelines
- One of the most important ways to address healthcare associated infections is by improving the hand hygiene of health care staff

Access these “Best Practices” for Hand Hygiene in the Policies on ICARE

Implement evidence-based practices to prevent health care associated infections due to multiple drug-resistant organisms (MDROs). Access these “Best Practices” for MDROs in the

Recommendations

• Encourage the use of meticulous Hand Hygiene practices
• Training provided in general orientation to all employees including technique, process, products
• Detailed training provided in clinical orientation including the prevalence of “bugs” and their life span on fomites, what products to use when (soap, foam, gel).
• Speak-up material placed in admission packets for all patients, Speak-up posters placed for staff and patient
• Training of visitors regarding hand hygiene and isolation
• Compliance with CDC recommendations and Lifecare policy regarding Hand Hygiene

Policies on ICARE

• Constant, meticulous Hand Hygiene practices
• Patient assessment: Assess for symptoms of infection daily, Assess for risk of MDRO infection, Perform active surveillance testing at time of admission
• Implement Contact Precautions for all colonized or infected patients.
• Place patients in private rooms if available.
• Maintain adequate supplies for hand hygiene and PPE readily available for use
• Daily ‘Semi-terminal’ cleaning of the patient room by Housekeeping and respective disciplines using appropriate cleaning agents
• Terminal clean of the room post discharge of any patients with an MDRO including cleaning of the privacy curtains
• Avoid the use of multi-patient electronic thermometers as the handles of these devices may become contaminated
• Use patient dedicated care items and equipment
• Implement a lab based alert system to notify clinicians of new diagnosis of an MDRO
• Implement a system that identifies readmitted or transferred patients who are colonized or infected with an MDRO
• Provide information regarding MDRO to patients and family
• Evaluate the performance of interim and terminal cleaning of the patient room by environmental staff
Implement best practices for preventing surgical site infections
Access these “Best Practices” for SSIs in the Policies on ICARE

- Constant, meticulous Hand Hygiene practices
- Patient assessment
  - Assess for symptoms of infection daily
  - Assess for the presence of SSI risk factors
  - Assess impact of co-morbidities on wound healing
- Provide intravenous antimicrobial prophylaxis within 1 hour before incision
- Discontinue prophylactic antimicrobials within 24 hours after surgery
- Surgical site preparation: Do not remove hair at the operative site unless the hair will interfere with procedure. Remove hair by use of clippers or depilatory method; do not use razors to remove hair.
- Conduct post-operative SSI surveillance for at least 30 days for procedures identified by MEC as high risk for infection. If SSI identified, notify the hospital where the original procedure was performed
- Provide information regarding SSI to patients and family

Implement best practices for preventing infections of the urinary tract that are caused by catheters
Access these “Best Practices” for CAUTI Prevention in the Policies on ICARE

- Perform hand hygiene immediately before and after insertion or any manipulation of the catheter device or site.
- Patient assessment for: symptoms of infection daily, foley catheter need daily and discontinue foley usage as soon as possible, Evaluate alternative methods (ie., condom catheters), Indications for the use of indwelling urinary catheters are:
  - Output monitoring in critically ill patients
  - Management of urinary retention or urinary obstruction
  - Assistance in pressure ulcer healing
  - To improve comfort for care at the end of life, if needed (CDC).
- Ensure good daily Peri-care
- Anchor the Foley catheter safely to prevent movement and urethral traction (Velcro leg strip, clip, etc.)
- Maintain appropriate catheter level placement. Do not permit urine in the drainage bag to travel up the drainage tubing. Keep the drainage bag below the level of the bladder at all times.
- Maintain a sterile, continuous closed drainage system. Replace system if a break in asepsis occurs.
- Ensure competent staff insert the urinary catheter using aseptic technique and sterile equipment.
- Maintain unobstructed urine flow; empty the drainage bag regularly and avoid allowing the drainage spigot to touch the collecting container.
- Obtain urine sample from the sampling port with a sterile needle and syringe after cleaning the port with a disinfectant.
- Do not change the catheter routinely upon admission
- Document initial placement date and time of Foley catheter, indications for catheter, who inserted the catheter, and the date and time of removal. Also mark bag with date of insertion/placement
- Use standard precautions including the use of gloves and gowns as appropriate during any manipulation of the catheter or collecting system.
- If obstruction occurs and it is likely that the catheter material is contributing to obstruction, change the catheter
- Track Foley Days and identify hospital CAUTI rates
- May change foley catheter if infection has been confirmed and antibiotics have been administered for 48 hours.
NPSG: 15.01.01 Identification of Patients at Risk for Suicide

- This applies to patients who are in psychiatric hospitals or patients being treated in general hospitals for emotional or behavioral disorders
  - Identify specific patient characteristics and environmental features that may increase or decrease the risk for suicide
  - Address the patient’s immediate safety needs and most appropriate setting for treatment
- When an at risk patient leaves the care of the hospital, provide suicide prevention information (such as a crisis hotline) to the patient and his or her family

NPSG: 16.01.01 Improve the recognition and response to changes in a patient’s condition

- Health care staff are able to directly request additional assistance from a specially trained individual(s) when the patient’s condition appears to be worsening
  - Activate your Rapid Response Team
- Critical events, such as cardiopulmonary and/or respiratory arrest, are often preceded by warning signs for six to eight hours on average before the event!

If you suspect a change in your patient’s condition, even the smallest change, activate your Rapid Response Team to initiate treatment - NEVER WAIT! These symptoms may include (but are not limited to):

- RESPIRATORY rate <8 or >36
- New onset pulse oximeter reading less than 85% for more than 5 min (unless patient is known to have chronic hypoxemia).
- HEART RATE: <40 OR >140 with new symptoms (chest pain, shortness of breath, dizziness); or any rate greater than 160
- BLOOD PRESSURE: <80 OR >200 systolic or 110 diastolic with symptoms (neurologic change, chest pain, difficulty breathing)
- ACUTE NEUROLOGIC CHANGE: (i.e. acute loss of consciousness, sudden collapse, seizure, sudden loss of movement (or weakness) of face, arm or leg
- Bleeding into airway or uncontrolled bleeding
- Unexplained agitation more than 10 min.
- Color change of patient or extremity, ex. pale, dusky, gray or blue
- In-house trauma or suicide attempt
- More than one stat page required to assemble a team needed to manage a crisis
(UP.01.01.01; UP.01.02.01; UP.01.03.01) - Universal Protocol (Pre-procedure verification, Marking the operative site, Time Out Procedures)

Wrong site, wrong procedure, wrong person surgery can and must be prevented!

NPSG.06.01.01 Use Alarms Safely
Make improvements to ensure that alarms on medical equipment are heard and responded to on time.

- Evaluate whether the alarms are sufficiently audible with respect to distance and competing noises
- Evaluate whether alarms are visual
- Decrease false-positive alarms
- Do not overuse physiologic monitoring
- Never turn off the alarms

For More Information
The National Patient Safety Goals for each program and more information are available on The Joint Commission website at www.jointcommission.org.
INFECTION PREVENTION PROGRAM

Key Concepts:
- Apply Infection Prevention Concepts to prevent Healthcare Associated Infections (HAI’s)
- Identify how to prevent the spread of Multi-Drug Resistant Organisms (MDRO’s)
- Demonstrate excellent Hand Hygiene (HH)
- Understand when to use Personal Protective Equipment (PPE) appropriately
- Provide a clean environment
- Educate ourselves, our patients, our families on Infection Prevention Practices

Hand Hygiene
- Clean hands are the single most important factor in preventing the spread of dangerous germs, healthcare-associated infections and antibiotic resistance in healthcare settings
- Improving hand hygiene will help prevent the spread of germs from one patient to another
- Wash for 15-30 seconds (Sing Happy Birthday)
- Reach all surfaces, including wrists, and under nails

“5 Moments for Hand Hygiene”
- Before contact with the patient and/or their environment
- When performing an aseptic task
- When moving from a contaminated body part to a clean body part during patient care
- Before and after glove usage
- After contact with the patient and/or their environment

When should you wash your hands with soap and water?
- When hands are visibly dirty or contaminated
- When moving from a contaminated-body site to a clean body site during patient care
- Before eating
- After
  - Utilizing the restroom
  - Contact with body fluids or excretions, mucous membranes, non-intact skin, and wound dressings
  - All contact with the patient and/or their environment when in isolation for C-diff

When can you use either soap and water or alcohol hand rub?
- If hands are not visibly soiled
  - Before:
    - Direct patient contact/environment
    - Donning sterile/non-sterile gloves
  - After Contact with:
    - The patient
    - Inanimate objects (including medical equipment) in the immediate vicinity of the patient.
- After removing gloves
Fingernails and Artificial Nails
- Chipped nail polish promotes organism growth, even after careful hand washing.
- Artificial nails are more likely to harbor gram negative pathogens and yeast on their fingertips than natural nails, both before and after hand washing.
- Optimal nail length should not exceed ¼ inch.
- Expectation at work: LifeCare clinicians should have unchipped, natural nails that are short in length.

Jewelry
- Expectation at work: LifeCare clinicians should remove excessive jewelry and piercings.

PPE: Personal Protective Equipment

Gloves
- When touching blood, body fluids, secretions, excretions, and contaminated item.

Gown
- To protect skin and prevent soiling of clothing during procedures and patient care activities that are likely to generate splashes or sprays of blood and body fluids.

Mask/Goggles
- To protect mucous membranes of the eyes, nose and mouth during procedures & patient care activities that are likely to generate splashes or sprays of blood and body fluids.

Footwear
- When in a sterile environment such as an OR Special Procedures area.

Did You Know...

- Data show that health care personnel may be more inclined to use alcohol-based hand rubs because they are more convenient to use.
- Recent studies show that these hand rubs actually reduce the number of bacteria on the hands more effectively than washing hands with soap and water.
- When decontaminating hands with an alcohol-based hand rub, apply product to palm of one hand and rub hands together, covering all surfaces of hands and fingers, until hands are dry.
- It is neither necessary nor recommended to routinely wash hands after each application of the alcohol-based hand rub.
What is an MDRO?
- Bacteria and other microorganisms that have developed resistance to antimicrobial drugs
  - Infections vary depending on the organism
- Possible sites may include skin infections, UTIs, blood stream infections, pneumonia, wound and surgical site infections

What is MRSA?
- Staph aureus is a bacteria that normally lives on our skin and in our nasal passages
- Methicillin-resistant Staphylococcus aureus (MRSA) is a type of bacteria that has become resistant to common antibiotics that were once used to treat it
- Vancomycin is the antibiotic of choice for MRSA

Community Acquired MRSA
- Easier to treat
- Less resistant
- When a patient is admitted with Community Acquired MRSA it is easier to discontinue Isolation Precautions

Hospital Acquired MRSA
- Harder to treat
- More resistant
- More difficult to discontinue Isolation Precautions

What is VRE?
- Vancomycin Resistant Enterococci
- Enterococci are bacteria that are normally present in the GI Tract
- These bacteria can sometimes cause infections.
  - Vancomycin is an antibiotic that is often used to treat infections caused by enterococci.
  - Some enterococci have become resistant to vancomycin and are called vancomycin-resistant enterococci (VRE).
  - Most VRE infections occur in hospitals.

Did You Know...
MRSA can survive in the environment up to 9 WEEKS!

What is C. difficile?
- Produces two exotoxins (these toxins make the patient ill)
  - Toxin A
  - Toxin B
- Commonly associated with antibiotic-associated diarrhea (AAD)
C. difficile (continued)

- Clinical symptoms include
  - watery diarrhea
  - fever
  - loss of appetite
  - nausea
  - abdominal pain and/or tenderness

How is C. difficile transmitted?

- C. difficile is shed in feces
  - Any surface, device, or material (e.g., commodes, bathing tubs, and electronic rectal thermometers) that becomes contaminated with feces may serve as a reservoir for the C. difficile spores
- C. difficile spores are transferred to patients mainly via the hands of healthcare personnel who have touched a contaminated surface or item

What is Acinetobacter?

- A group of bacteria commonly found in soil & water and on the skin
  - Acinetobacter baumannii accounts for about 80% of reported infections
  - Not all Acinetobacter is Multi-Drug Resistant, however most cases seen in the hospital setting are

Transmission Based Precautions

- Also known as “Isolation Precautions”
- The type of isolation precautions depends upon the organism involved and location of the infection

Standard Precautions

- Assume all patients have everything!!
- Formally known as “Universal Precautions”
- Standard Precautions includes:
  - Hand Hygiene

Did-You-Know...

C. difficile can survive in the environment up to 5 MONTHS!

Did-You-Know...

C. difficile can survive in the environment up to 1 MONTH with diligent environmental cleaning practices!

Remember...

MDROs are most commonly spread via horizontal transmission
- Caregiver-to-patient
- Environment-to-patient

Standard Precautions must be used in the care of all patients, regardless of their diagnosis when handling or there is a potential to come in contact with:

- Blood
- Body fluids
- Secretions and excretions (except sweat)
- Non-intact skin
- Mucous membranes
<table>
<thead>
<tr>
<th>Precaution</th>
<th>Gloves</th>
<th>Gown</th>
<th>Mask</th>
<th>Other</th>
</tr>
</thead>
<tbody>
<tr>
<td>Contact</td>
<td>✓</td>
<td>✓</td>
<td>if splashing is possible</td>
<td>wash hands with soap &amp; water (NO waterless hand sanitizer). Use BLEACH for cleaning surfaces, daily, and terminal cleaning</td>
</tr>
<tr>
<td>Contact Enhanced</td>
<td>✓</td>
<td>✓</td>
<td>if splashing is possible</td>
<td></td>
</tr>
<tr>
<td>Droplet</td>
<td></td>
<td>✓</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Airborne</td>
<td></td>
<td></td>
<td>N95 Mask</td>
<td>Negative Pressure Room Required</td>
</tr>
<tr>
<td>Protective/Neutropenic</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>special dietary restrictions, no fresh plants or fruit permitted</td>
</tr>
</tbody>
</table>

**Blood Borne Pathogens**

- **Blood**
  - Human blood, human blood components, and products made from human blood

- **Bloodborne Pathogens**
  - Pathogenic microorganisms that are present in human blood and can cause disease in humans. These include but are not limited to: Hepatitis B & C, HIV, and Syphilis

- **Contaminated**
  - Presence or the reasonably anticipated presence of blood or other potentially infectious materials on an item or surface

- **Contaminated Laundry**
  - Laundry which has been soiled with blood or other potentially infectious materials or may contain sharps.

- **Exposure Incident**
  - A specific eye, mouth, other mucous membrane, non-intact skin, or parenteral contact with blood or other potentially infectious materials that results from the performance of an employee's duties.

- **Other Potentially Infectious Materials**
  - (1) The following human body fluids: semen, vaginal secretions, cerebrospinal fluid, synovial fluid, pleural fluid, pericardial fluid, peritoneal fluid, amniotic fluid, any body fluid that is visibly contaminated with blood, and all body fluids in situations where it is difficult or impossible to differentiate between body fluids;
  - (2) Any unfixed tissue or organ (other than intact skin) from a human (living or dead); and
Engineered Sharps Injury Protection Device
- Element or mechanism built into a needle device or other type of sharp that effectively reduces the risk of an exposure incident

Sharps Safety
- Use Biohazard puncture resistant containers for sharps disposal
  - Remove container when it is **3/4 FULL**
- **DO NOT BEND, BREAK OR RECAP NEEDLES**
  - Always engage the needle’s engineered safety device
  - Remove all sharps from disposable and reusable trays before further processing or disposal
  - Use extreme caution when handling linen or trash bags as they may inadvertently contain sharps
    - Hold bag away from your body when transporting
  - Get help with agitated patients when sharps are to be used
  - Do not place garbage in the sharps container
    - This includes: syringe wrappers and pill packets
    - This creates unnecessary bulk in the container and may lead to a needle-stick
    - Only needles, syringes and medication vials should be placed in the sharps container

Red Biohazard Bags

<table>
<thead>
<tr>
<th>CAN go in RED Bag</th>
<th>CANNOT go in RED Bag</th>
</tr>
</thead>
<tbody>
<tr>
<td>Items with Blood on them</td>
<td>Garbage</td>
</tr>
<tr>
<td>Blood Transfusion products and tubing</td>
<td>Perineal garbage (feces &amp; urine)</td>
</tr>
<tr>
<td>Suction Canisters</td>
<td>Medications</td>
</tr>
<tr>
<td>Wound Drainage (including wound VAC canisters)</td>
<td>Chest tube canisters</td>
</tr>
<tr>
<td>Hemodialysis Products</td>
<td>Hemodialysis Products</td>
</tr>
</tbody>
</table>
A Clean Environment - Can help prevent HAIs

**Disinfectant Wipe**
- For general environmental cleaning

**Bleach Wipe**
- For daily and terminal cleaning of ALL Isolation Rooms

**Remember: One Cloth = One Wipe!**

**Equipment and Linens**
- Equipment and linens soiled with bodily fluids should be handled in a way that avoids cross-contamination
- Clean and reprocess reusable equipment appropriately *before use* on another patient
- Discard single-use items appropriately

**BBP Employee Exposure**
- If skin or mucous membranes come into direct contact with blood or body fluids, wash or flush with large amounts of water as soon as possible
- **Notify your supervisor as soon as possible**
- Complete the Employee Injury Report.
  - Ensure all fields on the Employee Injury Report is completed
  - This required by OSHA and LifeCare Policy
  - Assists us to analyze risks associated with products
- Report the incident to Employee Health
- Refusal of Medical Care
  - If an injured employee refuses medical care, the supervisor should ensure the refusal is documented on the Employee Injury Exposure Report
  - The employee must immediately submit to a drug screen even if refusing treatment

**Hepatitis B Vaccine**
- Recombinant (man-made from yeast)
- Non-infectious
- All Employees are eligible to receive the Hepatitis B Series
  - Most people develop immunity after all 3 injections are completed
  - If you do not develop an antibody response, you can receive the series of three injections again, if you do not have an antibody response again, then you have not developed antibodies to Hep B. (roughly 5% of people do not develop antibodies)

**Annual TST Screen** (TST – Tuberculin Skin Test)
- Negative TST - skin test required
- Positive TST - TB questionnaire
  - A chest X-ray would be required only if you develops signs or symptoms of TB
  - As long as you continue to have a negative TST, you will be required to have a skin test annually

**Tuberculosis Questionnaire**

*Do you have:*
- Positive TST - Was it indurated?
- Weakness
- Productive Cough/Coughing up Blood
- Persistent Weight Loss (unplanned & not dieting)
- Night Sweats
- Shortness of Breath
- Chest Pain with Cough
- Swollen Neck Glands
Flu Vaccine

- Available for ALL employees, physicians, and volunteers free of charge
- The CDC recognizes the flu season be from **October 1st thru March 31st**

There are some states where Flu Vaccines are mandatory

- Our policy states that if you are working in the following patient care areas:
  - Radiology
  - Special Procedures
  - Dialysis
  - Any patient care area

**You will be required to wear a surgical mask if you decline the flu vaccine, regardless of the reason for declaration. You can continue to wear the same mask until it becomes damp or wet.**

- Failure to comply with wearing the mask will result in the progressive disciplinary process
- If you receive the flu vaccination elsewhere, documentation is required that you received the vaccination
- A sticker for your name badge will be provided after receiving the flu vaccine

**Infection Prevention - Your Responsibility**

- As a healthcare worker, you have personal responsibility for infection control in your facility
- Maintain immunity to vaccine-preventable diseases such as:
  - Hepatitis B
  - Measles
  - Varicella (chickenpox)
  - Rubella
  - Mumps
- Report all unprotected exposures, such as accidental needlesticks
- Stay home from work when you are sick

**Patient and Family Education**

- Teach patient and family members **WHY** good hand hygiene is important, show them **HOW** to wash their hands, tell them **WHEN** they should wash their hands and show them **WHERE** the alcohol-based hand rubs are and **WHAT** it is used for.
- Patient education sheets – you may print from Lippincott Advisor
- Call Infection Control for questions or problems
- Infection Control Practitioner assesses and disseminates the current information
AFTER REVIEWING THE CONTENT IN THIS SECTION, YOU SHOULD:

- Be able to define healthcare ergonomics
- Recognize high-risk patient care activities
- Identify risks in patient care environments
- Know why mechanical aids are needed when moving and handling patients
- Use algorithms to identify safe patient handling and movement strategies
- Understand the importance of assessing patients to select the right combination of equipment and personnel needed to handle or move them safely
- Apply positioning and mobility techniques that are safe for patient and caregiver
- Understand how to properly use equipment (training to be done within each facility)

BODY MECHANICS AND SAFE PATIENT HANDLING

Many work related activities require you to push, pull, lift, and carry. By using proper body mechanics, you are avoid musculoskeletal injury and fatigue and reduce the risk of patients and others.

The Different between Body Mechanics and Ergonomics

**Biomechanics**
- Study of the mechanics of muscular activity and how muscular activity leads to internal loading of body tissues such as ligaments, joints and other soft tissues
- Useful in determining whether the manual patient handling task creates unacceptably high forces within the body and whether or not a manual lift is “safe” or not

**Body Mechanics**
- A belief that reliance on “correct” body positions or “body movements” will somehow provide protection from the force associated with lifting and moving patients
- Does not incorporate safe manual handling techniques in combination with equipment and technology

Who is at risk?
- Healthcare workers are at especially high risk for back injuries when compared to the average American worker.
- Back injuries are the most common job-related health problem among healthcare workers.
- Healthcare workers whose job requires them to lift and/or move patients are at highest risk.

Risk Factor for Injury:
- Primary risk factors:
  - Force (Lifting heavy masses or weights)
  - Repetition (Frequency of Lift)
  - Awkward postures: Reaching, Twisting, Bending (lifting and lowering)
- Secondary risk factors:
  - Fatigue
  - Not asking for help
  - Long shifts
Risk Factors in the Work Environment

- Slippery or wet surfaces
- Physical obstructions (cabinets, toilets)
- Obstructions on floor surfaces/uneven floor surfaces
- Uneven work surfaces (different heights between caregivers’ arms and bed, different heights between wheelchair and toilets)
- Too small or too difficult-to-access spaces
- Too small a width to the entrance way
- Poor arrangement of furnishings
- Poor bathing area design
- Poor design of chairs

Risk Factors in the Job Task

- Reaching and lifting loads far from the body
- Lifting heavy loads (greater than 35 pounds under ideal conditions)
- Twisting while lifting
- Reaching low or high to begin a lift
- Moving a load a great distance
- Frequent lifting (more than 12 lifts a shift)
- Unassisted lifting
- Awkward posture of caregiver

Risk Factors related to Musculoskeletal disorders

- Unexpected changes during the lift (combative or falling patient)
- Excessive pushing or pulling forces required to accomplish task
- Lack of ability to grasp the patient securely (no handles)
- Totally dependent, unpredictable or combative patient
- Patient’s inability to understand
- Patient’s special medical conditions such as burns or strokes

HIGH Risk Activities if completed without assistance

- Transferring patient from bathtub to wheelchair, wheelchair to shower/commode chair, wheelchair to bed, bed to stretcher, and vice versa
- Lifting a patient from the floor
- Weighing a patient
- Bathing a patient in bed, in a shower chair, or on a shower trolley or stretcher
- Undressing/dressing a patient, including applying antiembolism stockings
- Repositioning patient in bed from side to side or to the head of the bed
- Repositioning patient in geriatric chair or wheelchair
- Making an occupied bed
- Feeding a bed-ridden patient
- Changing absorbent pad when bed is occupied
The Spine

- The purpose of the following information is to help minimize injury to your spine
- You can be proactive by learning some basic 'preventive' body activities
- The four curves of the spine
  - Cervical lordosis, Thoracic kyphosis, Lumbar lordosis, Sacral kyphosis

Visualize Proper Posture

- Visualize a plumb line hanging from each ear lobe. In good posture the plumb line will drop straight down from the ear lobe through the shoulder area, down the middle of the arm through the anklebone. Your chin should be slightly tucked, shoulders slightly back and level with the pelvis shifted forward allowing the hips to align with the ankles.
- Be aware of your posture during daily activities. When experiencing back or neck pain, check your posture. Correcting your posture may help.
- Good posture should be a part of all activities to minimize harmful stress to the spine.

Pushing and pulling correctly

- Stand close to the object, and place one foot slightly ahead of the other, as in a walking position. Tighten your leg muscles and set your pelvis by simultaneously contracting the abdominal and gluteal muscles.
- To push, place your hands on a stable part of the object and flex your elbows. Lean into the object by shifting weight from your back leg to your front leg, and apply smooth, continuous pressure.
- To pull, grasp the object and flex your elbows. Lean away from the object by shifting weight from your front leg to your back leg. Pull smoothly, avoiding sudden, jerky movements.
- After you’ve started to move the object, keep it in motion; stopping and starting uses more energy.

Minimize Bending and Twisting

- One movement that tends to aggravate back pain, more than others, is bending and twisting simultaneously!
- Combined, these movements place force on the facet joints and the discs. Some people often bend and twist to pick an object off the floor, reach for the milk in the refrigerator, pull a file out of the cabinet, and so on.
- Stand with your feet 10” to 12” (25.5 to 30.5 cm) apart and one foot slightly ahead of the other to widen the base of support.
- Lower yourself by flexing your knees, and place more weight on your front foot than on your back foot. Keep your upper body straight by not bending at the waist.
- To stand up again, straighten your knees and keep your back straight.
Plan for Lifting and Carrying

- Test the weight of the object to be lifted. An easy way to determine if you can lift it without assistance is to try pushing the object with your foot.
  - However, even lightweight objects that are large in size, or cumbersome, may best be handled with assistance.
- Plan where you are going. If moving the object to another location, clear obstacles out of the way. Plan the best way to hold or grip the object to keep it close to your body before lifting.

Lifting and Carrying Correctly

- Assume the stooping position directly in front of the object to minimize back flexion and avoid spinal rotation when lifting.
- Grasp the object, and tighten your abdominal muscles.
- Stand up by straightening your knees, using your leg and hip muscles. Always keep your back straight to maintain a fixed center of gravity. Keep the weight of the object as close to your body as possible.
- Carry the object close to your body at waist height—near the body's center of gravity—to avoid straining your back muscles, as shown in the illustration below.
- To turn directions use your feet to pivot. Do not twist!

Should I push or Pull?

- Pushing is the correct answer. When you push an object you use the muscles in your legs and back.
- When pulling some people have the tendency to use their back muscles to yank and pull.
- It is easier to keep your back straight while pushing.
- Lean into the object using your body weight to help push the object.

Mimic the Golfers Pick-up Trick

- Have you ever watched a golfer pick up a ball or place their tee? The body mechanics they have been taught to use can benefit non-golfers too. This method makes it safer to pick a lightweight object off the floor and come back to a standing position without using the muscles in the low back.

**Follow these easy steps**

- Face the object
- Place all your body weight on one leg
- Using the hand on the un-weighted side, lean on stable object (such as a desk)
- Slightly bend the weighted knee
- Bend straight over from the hip keeping the back straight
- As you bend let the un-weighted leg come off the floor in line with the upper body
- Reverse the steps to come to a standing position
Reaching Up, Down or All Around

- Many of the same principles of good body mechanics in lifting apply to reaching.
  - Determine the object’s weight, size, location and planned destination. Don’t hesitate to ask for assistance!
- Remember the basics:
  1. clear obstacles out of the way
  2. get close to the object
  3. face the object
  4. use your legs and feet for proper stable positioning
  5. determine the best way to hold the object
  6. maintain good posture
  7. do not bend and twist simultaneously
- If a ladder or stepstool is required to access the object make sure it is stable and adequate to position your body close to the object.
- Standing on tiptoes places your body in a precarious position!
- Avoid body positions that hyperextend the neck such as looking overhead especially for prolonged periods of time. This can cause stress to the spine resulting in pain!

Smart Storage

- Plan how you will store things to make them easy to get to and remove
  - The heaviest and most frequently used items should be stored at waist height. This can help make it easier to face the object, get close, and pull it toward your body, while maintaining good posture.
  - Lighter and less frequently used items can be stored on higher, or lower, shelves.

Telephone Tip

- If you spend a great deal of time talking on the phone, try using a headset. This will help you avoid cradling the phone between your ear and shoulder. Headsets also allow both hands to be free.

Chairs and Sitting

- Whether you are working at a desk or watching television the right chair is helpful for good posture, body mechanics and comfort.
- The way you sit is as important as what you sit on! Position your buttocks at the rear of the seat. If you are short you may need a cushion to fill the gap between your buttocks and the back of the chair seat. When properly seated there should be some space between the back of the knees and the chair seat. Lean your spine against the back of the chair to relax muscles in the spine.
- If your chair is equipped with a lumbar support adjust it to fit the curve in your low back. A towel rolled up can be used as a lumbar support.
- Make sure the armrests are positioned to support the weight of your arms. This allows the neck and shoulders to relax.
- A footrest can help you maintain good posture. Position the footrest so the knees are level with the hip joint.
- Avoid sitting for prolonged periods of time. Get up, walk and stretch!
Working at a Desk or Computer Workstation

- With the right chair and a few accessories you can make working at a desk ergonomically correct. Work directly facing the desk or computer. The monitor should be at eye level and visible without turning the head or body. An articulating arm can be used to house the keyboard at the correct height for working and can be easily pushed to the side when not needed.

Computer Monitor Tips

- The screen should be at a comfortable horizontal distance for viewing. If you can’t position this at a comfortable viewing distance, it is better for the eyes to have the screen too far away and zoom into the content rather than sit too close to the screen. The most comfortable viewing distance is usually at least an arm’s length away from your body.
- Neck pain can be caused by working in a twisted posture. To eliminate neck twisting, place the computer monitor directly in front and facing you; not at an angle to left or right side. Your eyes should be in line with an imaginary point on the screen - about 2” below the top of the visible screen image when you are seated comfortably.
  – A screen that is too high or low can also cause neck and shoulder strain. You will tilt your head backwards to look up if the screen is too high and crane your neck forwards if too low.

Working with Documents

- If you work with documents, consider a document holder that positions the paper so it can be comfortably seen
- There are different types of document holders. Some are attached to the computer screen. Others are freestanding. Look for the one that is right for you.

Other Considerations

- Wear shoes with low heels, flexible nonslip soles, and closed backs to promote correct body alignment, facilitate proper body mechanics, and prevent accidents
- When doing heavy lifting or moving, remember to use assistive or mechanical devices, if available, or obtain assistance from coworkers; know your limitations and use sound judgment
- Mechanical and other assistive devices have been shown to significantly decrease incidences of low back injury in nursing personnel

Rules to Remember

- If you can’t push it with your foot, get help
- If is weighs more than 40 lbs ..Get help
- If in doubt... Get help
- Strong back and abdominal muscles can help decrease the risk of injury
- Stay fit!! Extra weight increases the stress on the back, as well as the joints in your hips & knees
- Never reach out with a load. Keep the loads close to the body
- Never twist. Move your feet
- Never lift over shoulder height
Equipment and Movement Aids - These aids work by bearing most of the load, reducing the load by lowering the friction between skin against cloth.
- Powered, mechanical full-body lifts (either mobile or ceiling mounted)
- Powered, mobile sit-to-stand lifts
- Friction-reducing devices
- Transfer belts

Environmental Assists
- A clutter-free bedside environment to allow for free movement of equipment and personnel
- Coworker attitudes supportive of ergonomic interventions
- Adequate supply of modern safe patient handling equipment conveniently located and in good working order
- Safe patient handling equipment that does not markedly slow the care process.

Environmental Assists
- Take responsibility for knowing how equipment works and whether it is available.
- Assess the client and the environment using the Assessment Criteria and Care Plan for SPH Movement.
- Select the appropriate algorithm.
- Gather the appropriate equipment and other staff members, if needed.
- Organize the physical environment and the equipment to ensure safe completion of the task. This includes locking wheels of the bed or chair, putting the bed/stretcher at the correct height, removing clutter, and making sure any mobile equipment is charged/ready to use.
- Make sure other team members, if any, know their roles; rehearse if necessary.
- Position yourself using the principles of body mechanics (listed above).
- Coach the patient. Tell patients what actions you plan and what you expect from them. Show them what to do, and then help them move through the activity.
Transferring with a Hydraulic Lift

Using a hydraulic lift to raise the immobile patient from the supine to the sitting position allows safe, comfortable transfer between bed and chair. It’s indicated for the obese or immobile patient for whom manual transfer poses the potential for nurse or patient injury. Although most hydraulic lift models can be operated by one person, it’s better to have two staff members present during transfer to stabilize and support the patient.

1. Gather and prepare the appropriate equipment.
2. Perform hand hygiene.
3. Put on gloves if necessary.
4. Confirm the patient’s identity.
5. Explain the procedure to the patient. Move IV lines or drainage bags.
6. Raise the opposing side rail.
7. Roll the patient onto his side toward you, and raise the side rail.
8. Go to the opposite side of the bed, lower the side rail, and place the sling under the patient’s buttocks.
9. Fanfold the far side of the sling against the patient’s back and buttocks.
10. Roll the patient toward you onto the sling and raise the side rail.
11. Go to the opposite side of the bed, lower the side rail, reach under the patient, and gently pull the sling flat under the patient.
12. Roll the patient onto his back and center him on the sling.
13. Place the chair next to the head of the bed.
14. Raise the bed until the base of the lift can fit under the bed and set the adjustable base to its widest width.
15. Move the lift so that the lift arm is perpendicular to the bed and directly over the patient.
16. Connect the ends of the chains to the side arms of the lift and the end to the sling.
17. Face the hooks away from the patient.
18. Tighten the turnscrew on the lift and then pump the handle or turn it clockwise until the patient has assumed a sitting position.
19. Move the patient steadily until he’s positioned above the wheelchair.
20. Release the turnscrew and turn the lift handle counterclockwise to lower the patient onto the seat.
21. Fasten the seat belt.
22. Unhook the sling from the lift, and leave the sling in place.
23. Remove and discard your gloves, if worn, and perform hand hygiene.
Four-Person Lift Sheet Transfer
Transfer from bed to stretcher, one of the most common transfers, may require the help of one or more coworkers, depending on the patient’s size and condition and the primary nurse’s physical abilities. In the lift sheet transfer, workers place a sheet under the patient and lift or slide him onto the stretcher. Depending on the patient’s size and condition, a lift sheet transfer can require two to seven people.

You should always remember to maintain good body mechanics—a wide base of support and bent knees—when transferring a patient to reduce the risk for injury to the patient and yourself. To reduce the risk for injury to the patient during transfer, make sure that the patient maintains proper body alignment—back straight, head in neutral position, and extremities in a functional position.

1. Gather coworkers and equipment to assist with the lift.
2. Perform hand hygiene. Put on gloves, if necessary.
3. Confirm the patient’s identity.
4. Explain the procedure to the patient.
5. Ask team members to remove watches and rings.
6. Place the stretcher parallel to the bed; lock the wheels of both.
7. Adjust the bed to the same height as the stretcher.
8. Position the patient.
9. Position yourself at the center of the stretcher; have one team member stand at the patient’s head and the other two stand on the other side next to the bed.
10. The team leader instructs the team to hold the edges of the sheet under the patient and grasp them close to the patient.
11. The team leader tells the team members when to lift or slide the patient onto the stretcher.
12. Position the patient on the stretcher, apply the safety straps, and raise and secure the side rails.
13. Remove and discard your gloves, if applicable, and perform hand hygiene.

Special Considerations
- Use of assistive devices is strongly recommended. A hydraulic lift is a mechanical means for a one-person-dependent transfer, with moveable and lockable wheels for positioning and moving, a base that can be widened to fit around chairs or toilets, and a hydraulic release valve that is tightened to close and lift and loosened to open and lower. Most are made up of a single seat sling made of canvas and nylon netting, chains, and hooks connected to a spreader bar.
- When transferring an immobile or markedly obese patient from bed to stretcher, first lift and move him in increments to the edge of the bed. Then rest for a few seconds, repositioning the patient if necessary, and lift him onto the stretcher.
- If a team member isn’t available to guide equipment, move IV lines and other tubing first to make sure it’s out of the way and not in danger of pulling loose (disconnect tubes if possible).
- Whenever possible, use a friction-reducing device during the transfer to help improve patient safety and decrease the risk for back injury.

Sliding Board Transfer
Transfer from bed to stretcher, one of the most common transfers, can require the help of one or more coworkers, depending on the patient's size and condition and the primary nurse's physical abilities. You should always remember to maintain good body mechanics—a wide base of support and bent knees—when transferring a patient to reduce the risk of injury to the patient and yourself. To reduce the risk of injury to the patient during transfer, make sure that the patient maintains proper body alignment—back straight, head in neutral position, and extremities in a functional position.

1. Gather coworkers and the appropriate equipment.
2. Ask team members to remove watches and rings.
3. Perform hand hygiene and put on clean gloves, if necessary.
4. Confirm the patient's identity.
5. Explain the procedure to the patient.
6. Place the stretcher parallel to the bed; lock the wheels of both.
7. Adjust the bed to the same height as the stretcher.
8. Move any lines or tubes attached to the patient.
9. Stand next to the bed and instruct a coworker to stand next to the stretcher.
11. Turn the patient slightly on his side by pulling the bed sheet toward you; have a coworker place the sliding board beneath the patient.
12. Ease the patient onto the sliding board and release the sheet.
13. Instruct a coworker to grasp the near side of the sheet and gently lift the patient onto the stretcher.
14. Instruct the coworker to reach over the patient, grasp the far side of the sheet, and logroll the patient toward her.
15. Remove the sliding board as your coworker returns the patient to the supine position.
16. Position the patient on the stretcher, apply safety straps, and raise and secure the side rails.
17. Clean and disinfect the sliding board.
18. Perform hand hygiene.

Special Considerations
When transferring an immobile or markedly obese patient from bed to stretcher, first lift and move him, in increments, to the edge of the bed. Then rest for a few seconds, repositioning the patient if necessary, and lift him onto the stretcher. If a team member isn't available to guide equipment, move IV lines and other tubing first to make sure it's out of the way and not in danger of pulling loose (disconnect tubes if possible).

Whenever possible, use a friction-reducing device to increase patient safety and decrease the risk of back injuries.

Transfer from bed to wheelchair
For the patient with diminished or absent lower-body sensation or one-sided weakness, immobility, or injury, transfer from bed to wheelchair may require partial support to full assistance—initially by at least two persons. Subsequent transfer of the patient with generalized weakness may be performed by one nurse. After transfer, proper positioning helps prevent excessive pressure on bony prominences, which predisposes the patient to skin breakdown.

1. Gather the appropriate equipment.
2. Perform hand hygiene.
3. Confirm the patient’s identity.
4. Explain the procedure to the patient.
5. Position the wheelchair and lock its wheels.
6. Lock the bed wheels and raise the footrests on the wheelchair.
7. Check the pulse rate and blood pressure with the patient supine.
8. Help the patient put on pajama bottoms and slippers or shoes.
9. Raise the head of the bed.
10. Allow the patient to rest briefly and bring him to the dangling position.
11. Tell the patient to move to the edge of the bed and place his feet flat on the floor.
12. Stand in front of the patient and block his toes with your feet and his knees with your knees.
13. Place the gait belt on the patient.
14. Flex your knees and place your arms around the patient’s back.
15. Tell the patient to place his hands on the edge of the bed.
16. Ask the patient to push himself off the bed.
17. Supporting the patient as needed, pivot toward the wheelchair, keeping your knees next to his.
18. Tell the patient to grasp the farthest armrest of the wheelchair with his closest hand.
19. Help the patient lower himself into the wheelchair.
20. Instruct the patient to reach back and grasp the other wheelchair armrest as he sits.
21. Help the patient move his buttocks against the back of the chair.
22. Fasten the seat belt and check his pulse and blood pressure.
23. Place the patient’s feet on the footrests pointed straight ahead.
24. Position the patient’s knees and hips with the correct amount of flexion and in appropriate alignment.
25. Position the patient’s arms on the wheelchair armrests.
26. Remove the gait belt, if necessary.
27. Perform hand hygiene.

Special Considerations
- If the patient starts to fall during transfer, ease him to the closest surface—bed, floor, or chair. Never stretch to finish the transfer. Doing so can cause loss of balance, falls, muscle strain, and other injuries to you and to the patient.
- If the patient has one-sided weakness, follow the preceding steps, but place the wheelchair on the patient’s unaffected side. Instruct the patient to pivot and bear as much weight as possible on the unaffected side. Support the affected side because the patient will tend to lean to this side. Use pillows to support the hemiplegic patient’s affected side to prevent slumping in the wheelchair.
- The use of a gait belt is contraindicated if the patient has had recent thoracic or abdominal surgery. To transfer this patient without a gait belt, place your arms around the patient’s back above the waist but below the axilla and tell the patient to put his hands on the edge of the bed. Then proceed with the steps of a transfer.

Referenced from: Lippincott Procedures Transfer from bed to wheelchair  http://procedures.lww.com/lnp/view.do?pid=1160761&s=p
SAFE ENVIRONMENT OF CARE

The goals and objectives of the Safety Program are:
1. Reduce and control environmental risks and hazards
2. Prevent accidents and injuries
3. Maintain safe conditions for patients, visitors and staff

- The Safety Program is developed, controlled and monitored by the Safety Committee.
- LifeCare Hospitals of Safety Officer is:
  - Is appointed by the CEO/Hospital Administrator
  - Duties include the day-to-day oversight of the Safety Management Program

Your responsibilities related to Safety
- We are ALL safety monitors.
- Any employee that witnesses a potential safety problem should report it to their Supervisor or to the Safety Officer immediately.
- If an safety incident occurs, complete an Incident Report as soon as possible.

1. General Safety – Please adhere to all the safety guidelines outlined in LifeCare’s Safety Management Program found on ICARE.
  - WALK - Don’t run thru the halls
  - Do not stand on chairs
  - SPILLS – if you spill something or find a spill please clean it up immediately.
  - REPORT - Unsafe conditions or needed repairs
  - Be Cautious of Wet Floor Signs
  - Open Doors Slowly and DO NOT prop open doors

2. Security - Please adhere to all the safety guidelines outlined in LifeCare’s Security Management Program found on ICARE.
  - Key control is a must; report lost keys immediately
  - All must wear identification
    - Employees (and others working on our behalf)=Badges
    - Patients=Armbands
  - No weapons or contraband allowed on the property. (Including: drugs, drug paraphernalia, alcohol, etc.
  - Keep emergency traffic lanes clear and park in designated spaces

Use of Communication & Electronic Device Policy
- Our hospitals prohibit the use of personal communication & electronic devices when
- Use of such devices undermines the integrity of an individual(s) right to privacy
- Affects the quality of patient care
- Interferes with the efficient operation of the hospital
- At no time may an employee take or receive personal or business-related phone calls in patient care/visitor areas
Media
• NO ONE is allowed to release any information to the media except the CEO or his representative
• There will be no unauthorized photography of patients
• Patient identification must remain confidential

Valuables
• The Nurse or PCT is responsible for taking an inventory of patient valuable and belongings upon admission and anytime new belongings are brought into the hospital. This must be documented on the “Patient Belongings form.”
• KEEP your valuables secured!!

Sensitive Security Areas:
Certain areas or departments within the hospital have limited access to protect the safety of our patients and employees. Only personnel working in these areas may have access. These areas include:
• Pharmacy/Medication Rooms & Carts
• All mechanical/electrical spaces
• Health Information Management
• Business Office
• Human Resources

YOUR ROLES/RESPONSIBILITIES related to Security:
• You are the eyes & ears of security, do not go where you feel unsafe, and report suspicious activity or unlocked areas

3. Hazardous Materials Please adhere to all the safety guidelines outlined in LifeCare’s Hazardous Materials Management Program found on ICARE.

OSHA’s “Right to Know Law”
• Protection under OSHA's Hazard Communication Standard (HCS)
• All employees have both a need and a right to know the hazards and the identities of the chemicals they are exposed to when working.
• They also need to know what protective measures are available to prevent adverse effects from occurring.

The Safety Data Sheets (SDS)
• Formally known as “MSDS”
• SDS are located Online: LifeCare Standard Links —> “MSDS Online”
• Provide detailed information in a document prepared by the manufacturer or importer of a chemical that describes the:
  – Section 1. Identification
  – Section 2. Hazard(s) identification
  – Section 3. Composition/information on ingredients
  – Section 4. First-Aid measures
  – Section 5. Fire-fighting measures
  – Section 6. Accidental release measures
  – Section 7. Handling and storage
  – Section 8. Exposure controls/personal protection
  – Section 9. Physical and chemical properties
  – Section 10. Stability and reactivity
  – Section 11. Toxicological information
  – Section 12. Ecological information
  – Section 13. Disposal considerations
  – Section 14. Transport information
  – Section 15. Regulatory information
  – Section 16. Other information, including date of preparation or last revision
### Product Label

**Precautionary statement(s):** means a phrase that describes recommended measures that should be taken to minimize or prevent adverse effects resulting from exposure to a hazardous chemical or improper storage or handling.

Reference the label to ensure proper storage of hazardous chemicals.

The label may be used to quickly locate information on first aid when needed.

Chemicals have multiple hazards, different pictograms are used to identify the various hazards.

The precautionary statements will be the same on the label and on the SDS.
What do I do if there is a hazardous materials spill??

Secure the spill – block off the area
Protect people from the spill
Inform other, dial your emergency Number
Leave clean-up up to the response team - get the SDS

4. Medical Equipment Please adhere to all the safety guidelines outlined in LifeCare’s Medical Equipment Management Program found on ICARE.

Medical Equipment is defined as ALL equipment whether purchased, leased, rented, on loan, or owned by the hospital that comes into contact with a patient

- Examples of medical equipment include (but are not limited to): IV pumps, Enteral feeding pumps, ventilators, wound VACs, specialty beds, etc.

Bio-Medical Department Inspects and tests medical equipment for electrical safety and proper functioning before it is allowed to go into service. This includes medical equipment the patient may brings in from home

Using Medical Equipment... Be Safe!

- Each employee receives instruction on the proper and safe operation of any equipment they will need to operate
- It is YOUR responsibility to operate that piece of equipment as instructed
- Do not use equipment if you have not been instructed on its safe use and operation

If equipment malfunctions:

- 1st - STOP USING IT!
- 2nd - Remove it from the patient’s room
- 3rd - Complete “Defective Equipment form” and attach to device
- 4th - Notify the Bio-Medical Technician
- Note: In the event of an incident involving clinical equipment and a patient: the Risk/Quality Manager and Nurse in Charge must be notified immediately and an Incident Report must be completed

Safe Medical Devices Act

The Safe Medical Devices Act is a regulation administered by the FDA, that requires device user facilities and distributors to submit reports of deaths related to medical devices to the FDA and to manufacturers. Serious injuries and illnesses related to medical devices must be reported to manufacturers.
Medical Alarms
- All clinical equipment alarms must be activated with appropriate settings and are sufficiently audible with respect to distances and competing noises in the facility
- Verify the settings of the alarms daily
- If you use it, you’re responsible for ensuring the alarm is audible
- **ALL STAFF MUST** respond to all clinical alarms, including but not limited to: ventilator alarms, infusion pump alarms, gas pressure alarms, and other medical equipment alarms

5. Utility Equipment
Please adhere to all the safety guidelines outlined in LifeCare’s Utility Management Program found on ICARE.

Facility Services should be contacted for the following equipment problems:
- **Electricity** Emergency power kicks in within 10 seconds via **red outlets**
- Strongly *discourage* patients to bring personal appliances to the hospital. If they insist contact Facility Services and they will check the appliance for safety before it is in use.
- **Extension Cords:** May not be used on a permanent basis. Temporary use only when provided by Facility Services

6. Fire Safety
Please adhere to all the safety guidelines outlined in LifeCare’s Life Safety- Fire Management Program found on ICARE.

Fire Safety Prevention:
- Keep passageways clear, items on one side of the hall
- **DO NOT BLOCK DOORWAYS, STAIRWAYS and HALLS**
- **NEVER WEDGE OR PROP OPEN FIRE DOORS**
- NEVER MICROWAVE CLOTH OR METAL OBJECTS; microwaves are to be used only for the re-heating of food
- Electrical equipment can be a fire hazard if in bad condition or if used improperly
- Use only grounded plugs & outlets
- Check AND REPORT wires that are cracked, brittle, or frayed
- Don’t overload outlets
- You should know the location of the nearest fire extinguishers and alarms in your environment
Storage Areas

- No items to be stored within **18 inches** from the bottom of any sprinkler head
- The lowest shelves on a storage area has to be sealed
- Nothing can be stored on the floor
- There has be a clean and clear aisle from the rear of the storage area to the exit
- Do NOT store items so that they block a fire extinguisher, pull station, oxygen shut-off valve, light switch or mechanical equipment. For example: Do not park the linen cart under a pull station

Oxygen Safety

- Store oxygen cylinders in designated storage areas
- Life Safety code **prohibits Oxygen Storage with any equipment that is plugged in for charging** i.e. IV Pumps, scales, etc.
- Oxygen tanks may **not be stored on patient equipment**, example: wheelchairs and stretchers
- **Oxygen must be in a secure device at all times**
- Never smoke around oxygen
- **Shut OFF Main Oxygen Supply Valves** and **Medical Gas when instructed to do so**

Actual Fire or Fire Alarm Response

Upon Discovery of Smoke or Fire:

**R** - Remove Persons in Immediate Danger
**A** - Activate the Fire Alarm System Using the Nearest Pull Station
**C** - Contain Smoke and Fire by Closing Doors (DO NOT TURN OFF LIGHTS)
**E** - Extinguish the fire if it is safe to or Evacuate the Fire Zone Using the Nearest Exit

- If smoke is seen coming from under a closed door remember to feel the door for heat with the back of your hand before opening it, if it is hot, **DO NOT OPEN IT** – if you do the new supply of air will feed the fire and you may be injured
- If you must enter a room where there is smoke, keep low to the floor both on the way in and when leaving with a victim
- Remain Calm
- Terminate all non essential phone calls and procedures

**Code RED = FIRE**
7. Emergency Management Plan - Please adhere to all the safety guidelines outlined in LifeCare’s Emergency Management Program found on ICARE.

- Our Emergency Management Plan provides us framework for decision making during unusual incidents that disrupt the normal hospital operations
- It is imperative that YOU know your part in this Plan and to appropriately respond when such plans are put into effect

What do I do when the Emergency Management Plan is in effect?
- All personnel should immediately report to their designated department assignment area (if safe to do so)
- Staffing: All departments should complete a list of available personnel and forward it to the Command Center

What is the Command Center?
- Area of communication within the hospital during a disaster and with external emergency services and systems, such as police, EMS, or fire
- Serve as an information gathering point for available beds, available physicians and other staff, etc.
- It is Equipped with the Emergency Supply Cart, emergency power, computers, phones, etc.

Who’s in charge??
- An Incident Commander will be established; this will be the most senior leader within the building (i.e. CEO, Safety Officer, Nursing supervisor)

What does the Incident Commander do??
- Initial briefing of all staff at the start of the Emergency/Incident, and to maintain communications with the staff and outside authorities throughout the incident
- Makes ultimate decisions about management of the incident.
- Assesses the need for evacuation.

Do we have additional resources available for us?
- There is an Emergency resource Kit located Command Center that includes:

When would we use this plan?
- Internal Emergency/Incidents include those situations that occur within the hospital
  - Examples: Flood, Loss of Electricity, Phone system down, call bell system down, chemical spill, hostage situation, missing patient
- External Emergency/Incidents include those situations that occur outside the hospital
  - Examples: Train derailment, tornado warning, mass shooting, disaster in another hospital, Bioterrorist attack
**Bioterrorism** - Biological agents pose very serious threats given their fairly accessible nature and the potential for their rapid spread.

These agents are circulated in the following ways:
- The use of aerosols (spray devices)
- Oral (contaminating food/water)
- Dermal exposure (direct skin contact)
- Injection

Bioterrorism agents identified by the Center for Disease Control (CDC) include:
- Anthrax
- Botulism
- Plague
- Smallpox
- Tularemia
- Brucellosis
- Q fever
- Viral hemorrhagic fevers
- Viral encephalitis disease associated with staphylococcal enterotoxin B.

If you suspect that a package or piece of mail may be contaminated,

**Do not handle the package/piece of mail**
**Activate the emergency response team.**
**Immediately secure the area where package/mail is located**

*Any person that came into contact or potentially came into contact with the agent is considered contaminated until designated otherwise.*
**Bomb Threat**

Should you ever receive a warning call:

- REMAIN CALM
- Follow the Bomb Threat Checklist (located next to each phone)
- Prolong the conversation if possible
- Write down everything you remember
- Notice background noises and distinguishing voice characteristics
- Ask where and when the bomb will explode
- Note if the caller appears very familiar with the hospital’s environment
- Notify the: Hospital Security/CEO/Safety Officer and Clinical Managers/Director/Person in Charge

**What will happen when a bomb threat is received?**

- All entrances will be secured and limited to necessary employees or persons
- Police will be notified
- Emergency Management Plan is referenced

**Hostage Situation**

If you witness a hostage situation occurring **Activate Emergency Response**:

- Advise: location of situation and as much detail as you can.
- You will then report back to your department.
- Local Authorities will be notified
- Building will potentially be in lockdown based on local authority recommendation

**Patient/Child Missing/Elopement**

**Immediate Response:**

- If a staff member suspects a patient is missing from the unit, they will immediately notify the Unit Manager or Nurse in Charge.
- A thorough search of the unit will be conducted and if the patient is not located:

**If unable to locate the patient:**

- Initiate emergency response
- Provide the following information to the search team:
  - Patient’s name, age, sex
  - Description (clothes, hair & eye color, height, weight, any other distinguishing characteristics)
  - Home unit

**Potential/Actual Acts of Violence**

**Immediate Response if in direct location of acts of violence:**

- Call for help
- Implement Crisis Prevention and Intervention techniques to defuse/deescalate the situation.

**Response Team:**

- One person from every department should report to the code area and will be directed by the team leader.
- Behavioral/Crisis management techniques will be used to defuse the situation.
Warning Signs of Potentially Violent Individuals
There is not an exact method to predict when a person will become violent. One or more of these warning signs may be displayed before a person becomes violent but does not necessarily indicate that an individual will become violent. A display of these signs should trigger concern as they are usually exhibited by people experiencing problems.

- Irrational beliefs and ideas
- Verbal, nonverbal or written threats or intimidation
- Fascination with weaponry and/or acts of violence
- Expressions of a plan to hurt him/herself or others
- Externalization of blame
- Unreciprocated romantic obsession
- Taking up much of supervisor’s time with behavior or performance problems
- Producing a fear reaction among coworkers and/or client(s)
- A drastic change in belief system(s)
- Displays of unwarranted anger
- New or increased source of stress at home or work
- Inability to take criticism
- Feelings of being victimized
- Intoxication from alcohol and/or other substance(s)
- Expressions of hopelessness or heightened anxiety
- Productivity and/or attendance problems
- Violence towards inanimate objects
- Steals or sabotages projects or equipment
- Lack of concern for the safety of others

Approaches to Diffuse or De-escalate Conflict

Undivided Attention
When people are paid attention to they feel validated; they feel important. The converse is also true: people feel less important and sometimes feel they need to up the ante if they feel like they need attention. Paying attention doesn't just mean saying, "I'm listening." It means looking at the person, making eye contact if it's culturally appropriate, and virtually listening with the entire body. By really listening, and conveying that through body language as well as words, an staff member can take away the person's reason for escalating the situation.

Be Nonjudgmental
If someone says, "The sewers are talking to me," an staff member’s immediate reaction might be to think that the person is crazy. That reaction, especially if verbalized, will probably upset the individual even more. Even if not said aloud, that attitude may be conveyed through the staff member’s body language. If someone is psychotic, he/she may tune into the nonverbal communication much more than words. So besides paying attention to what is said, ensure that body language and tone are nonjudgmental as well. This will go a lot further in calming the individual.

Focus on Feelings
Going back to the previous example, if an individual says, "The sewers are talking to me," a feeling response might be, "That must be pretty scary," or even, "Tell me what that feels like." Most likely it will elicit a response that is positive, since the individual will know that the staff member understands what's happening.
Approaches to Diffuse or De-escalate Conflict

Allow Silence
If the individual doesn't immediately answer a question, it doesn't mean he/she didn't hear you. It may mean he/she are thinking about an answer, or even that he wants to make sure they are saying the right thing. Allow a moment of silence. If the person's face registers confusion, then repeat the question and let the silence happen again.

Clarify Messages
When a person makes a statement, the staff member may think he knows what the person means. The only way to be sure is to ask. Sometimes a question may be perceived as challenging and can make the subject defensive. So restatement is used instead. For example, a family member might say, "I don't want my mother to be here anymore." The nurse might think she knows what the person is saying, but instead of just making an assumption the nurse could restate, "Oh, you're ready to take your mother home?" The family member could say, "Yes." Or perhaps, "No, I don't want my mother to face this prolonged battle with cancer". It is important to fully understand what is being communicated.

Develop a Plan
Devise a plan before one is needed. Decisions made before a crisis occurs are more likely to be more rational than those made when on the receiving end of emotional outbursts. Think about those things that are upsetting and practice dealing with those issues ahead of time. This is called strategic visualization and is effective in helping people get through some stressful and even dangerous moments.

Use a Team Approach
It is easier to maintain professionalism when assistance is nearby. Support and back up are both crucial pieces to a planned approach to conflict.

Recognize Personal Limits
One of the most important actions in any crisis is for the individual to remain in control of himself/herself. Know what your limits are. Know that sometimes it's not easy to leave problems alone. Sometimes the most professional decision is to let someone else take over, if that's an option.

Debrief
Be sure to debrief with coworkers, team members, or a supervisor after a major incident. Talking about it can relieve some of the stress and is also a good time to start planning for next time: what was done correctly, what could have been handled better, how could the response be improved the next time a similar situation occurs. This serves to assist in being able to rationally detach in the future.

No matter what the situation, keeping the lines of communication open can help to de-escalate a potentially dangerous crisis.

-Source: Law and Order Magazine, August 2003
Person with a Weapon/Active Shooter

Key Term: Active Shooter
- An individual actively engaged in killing or attempting to kill people in the hospital or on the hospital campus
  - Active Shooters generally begin shooting at numbers of people without warning
  - Active shooter situations are unpredictable and evolve quickly

Recognizing Potential Workplace Violence
- An active shooter in your workplace may be a current or former employee, or an acquaintance of a current or former employee.
  - Intuitive managers and coworkers may notice characteristics of potentially violent behavior in an employee.
  - Alert the Human Resources Department and/or Department Supervisor if you believe an employee or coworker exhibits potentially violent behavior.

The first employee to identify an active shooter situation:
1. Should call the hospital emergency number and announce a Code Silver. Include the location of the incident and a description of the person(s) with the weapon, and type of weapon if known.
2. Evacuate patients, visitors and staff if safely able to do so.

The Receptionist/Unit Secretary upon notification will:
1. Overhead page “Code Silver” and the location three times.
2. Give all available information to the Safety Officer or the Nurse in Charge.
3. Notify hospital Administration

The first Administrative staff or Safety Officer to arrive on the scene will:
- Assess the situation
- Secure the area if not already completed
- Report the following information to relay to the local Police Department at 911.
- Number of shooters, Number of victims, Exact location of the shooter, Type and number of weapons possibly in the possession of the shooter

In our unique environmental, considerations for Healthcare include:
- Diverse population – can’t turn anyone away
- Patient, family, friends, staff, vendors moving about the hospital at any time of the day
- Open access to the public 24/7 with multiple access points
- Duty to provide care and protect the vulnerable
- Heighten anxiety and frustration levels and the last place people want to be
## General Orientation Program

### COPING WITH AN ACTIVE SHOOTER SITUATION

- Be aware of your environment and any possible dangers
- Take note of the two nearest exits in any facility you visit
- If you are in an office, stay there and secure the door
- Attempt to take the active shooter down as a last resort

Contact your building management or human resources department for more information and training on active shooter response in your workplace.

### PROFILE OF AN ACTIVE SHOOTER

An active shooter is an individual actively engaged in killing or attempting to kill people in a confined and populated area, typically through the use of firearms.

### CHARACTERISTICS OF AN ACTIVE SHOOTER SITUATION

- Victims are selected at random
- The event is unpredictable and evolves quickly
- Law enforcement is usually required to end an active shooter situation

### CALL 911 WHEN IT IS SAFE TO DO SO

### HOW TO RESPOND WHEN AN ACTIVE SHOOTER IS IN YOUR VICINITY

1. **Evacuate**
   - Have an escape route and plan in mind
   - Leave your belongings behind
   - Keep your hands visible

2. **Hide Out**
   - Hide in an area out of the shooter’s view
   - Block entry to your hiding place and lock the doors
   - Silence your cell phone and/or pager

3. **Take Action**
   - As a last resort and only when your life is in imminent danger
   - Attempt to incapacitate the shooter
   - Act with physical aggression and throw items at the active shooter

### HOW TO RESPOND WHEN LAW ENFORCEMENT ARRIVES

- Remain calm and follow instructions
- Put down any items in your hands (i.e., bags, jackets)
- Raise hands and spread fingers
- Keep hands visible at all times
- Avoid quick movements toward officers such as holding on to them for safety
- Avoid pointing, screaming or yelling
- Do not stop to ask officers for help or direction when evacuating

### INFORMATION

**YOU SHOULD PROVIDE TO LAW ENFORCEMENT OR 911 OPERATOR**

- Location of the active shooter
- Number of shooters
- Physical description of shooters
- Number and type of weapons held by shooters
- Number of potential victims at the location
**Inclement Weather** - The Emergency preparedness plan code should be activated for weather related disasters:

- Hurricane
- Tornado
- Earthquake
- Flash Flood

**Cardiac Arrest**

- Activate Emergency Response
- Begin Basic Life Support interventions
- Follow American Heart Association guidelines for Advanced Life Support Resuscitation

**Rapid Response Team**

- For acute change in a patient’s medical condition
- Activate Emergency Response
- Follow Rapid Response Team Guidelines

**Emergency Evacuation**

Evacuation refers to the movement of patients and personnel from the hospital or any of its components in as rapid and safe a manner as possible under the existing situation.

**4 levels of Evacuations:**

- **Immediate** - from the area of immediate danger
- **Horizontal** Evacuation is the evacuation of immediate danger, beyond corridor fire doors and/or smoke zones into an adjacent secure area on the same floor.
- **Vertical Evacuation** is the evacuation from one floor(s) to the floor(s) above or below.
- **Out of Building Evacuation**
  - Abandon the building
  - Only the Incident Commander, hospital administrator, or Chief of the local fire department can make the decision to evacuate the building
**Radiation Safety**

*Radiation Facts:*
- Radiation exists EVERYWHERE.
- 82% of our total exposure comes from NATURAL sources*
- 18% of our total exposure comes from MAN-MADE sources*

(*NCRP report No.93)

**LifeCare Hospital’s Radiation Safety Officer:**
- Maintains proper functioning and maintenance of radiology equipment
- Monitors employee radiation exposure (Radiology and Speech Staff)
- Annual evaluations of all radiation producing equipment in conjunction with a Physicist
- Reports to Environmental Health and Safety Committee

**Natural Sources**
- Radon gas
  - Found in nearly all rock/soil
  - Accounts for 55% of our total exposure*
- Cosmic sources
  - Sun and other space objects
  - Account for 8% of our total exposure*
- Terrestrial sources
  - Items (other than radon gas) naturally occurring in the surrounding rock/soil
  - Account for 8% of our total exposure*
- Internal
  - Found inside the body (Carbon-14 and radioactive Potassium)
  - Accounts for 11% of our total exposure*

**Man-Made Sources**
- Medical X-ray
  - Accounts for 11% of our total exposure*
  - Includes: CT, Fluoroscopy (UGI, etc.), Interventional Radiology/Cardiac Cath Lab
- Nuclear Medicine
  - Accounts for 4% of our total exposure*
  - Radioisotopes are injected/ingested
- Consumer products
  - Accounts for 3 % of our total exposure*
  - Includes: Domestic water supply, Mining products, Smoke detectors, TV sets

**Goal:** *ALARA* - To keep radiation exposure As Low As Reasonably Achievable with Radiation Safety Protocols
- Maintain good Radiation Hygiene
- Monitor exposure of Radiation workers
- Clear unnecessary personnel from area
- Shield those who must stay in the exam room
How to protect yourself:

- **Time** - Less time spent in Radiation, the lower the exposure
- **Distance** - The greater the distance from the exposure source, the lower the exposure
- **Shielding** - The more barriers between you and the source, the lower the exposure

Why is X-ray dangerous?

- X-ray is an ionizing radiation. This means that the radiation interacts with the cells of the body and creates ions. Too much of this can cause cellular damage, such as skin burns or damage to cells.
- While safety limits for exposure have been set, there is no minimum threshold at which it can be said that there is absolutely no risk of damage.

Why you should care?

- The majority of the exams done at LifeCare are done with a mobile x-ray machine
- You might be asked to assist the technologist with a difficult patient
- You might need to see the same patient that the technologist is currently examining
- You have the responsibility to be aware of your surroundings in order to help keep yourself safe
  - If you don’t have to be there while an x-ray is being taken, LEAVE the room
  - If you can’t get out of the room, WEAR a lead apron or use another barrier
  - If you are pregnant or think you could be, LEAVE the room

Reminder: CAUTION

- Most lead aprons do NOT cover your back.; be aware of where the x-ray tube/beam is
- NEVER fold a lead apron, this can cause cracks in the lead and decrease the shielding ability of the apron
AFTER REVIEWING THE CONTENT IN THIS SECTION, YOU SHOULD:

- Know how to access “LifeCare Standard Links” for frequently accessed websites
- Know how to access ICARE, the company’s intranet
- Know how to search for company policies
- Know how to access and navigate the portal for department specific information
- Know how to access “LifeCare University,” the online learning management system
- Know how to access Lippincott online for procedures and skills, patient handouts, and more!

LOGGING IN TO YOUR COMPUTER

Your HR representative or supervisor should provide an initial User Name and Password for computer access. You will be prompted to change your initial password to something unique—do not write down or share computer passwords. Once you are logged in to the network, you should have several network locations that are now accessible to you.

USING “LIFECARE STANDARD LINKS”

- Open Internet Explorer
- Click on “Favorites” from the toolbar
- Click on “LifeCare Standard Links” for online quick links to sites such as:
  - ICARE, the company Intranet
  - Concur, expense reporting system
  - HealthStream, a.k.a., “LifeCare University,” online learning management system
  - ADP iPAY statements, electronic paycheck information

ACCESSING ICARE

- Access ICARE through “LifeCare Standard Links”
- Important phone numbers such as the HR Helpline, I.S. Service Desk and Compliance Line are on the home page
- LifeCare policies and procedures can be accessed under the “General” section
  - You can search for policies by department using the “Browse by Department” dropdown
  - You can also search by Keyword
Viewing policies on ICARE

- To view and/or print a policy, click on the applicable link
- The policy will open as a .pdf

ACCESSING THE PORTAL (FOR DEPARTMENT SPECIFIC INFORMATION)

- The portal can be accessed from the “General” section
- Click on the “LifeCare Intranet Portal” link to navigate directly to the portal home page
- Department specific sites can be located using the “Department” dropdown; access depends on your role/job function
- The HR portal contains instant access to the employee handbook and important benefits information
Additional helpful links can be found on the right side of the portal home page under “Links”

ACCESSING HEALTHSTREAM/LIFECARE UNIVERSITY
- LifeCare University (via HealthStream’s Learning Center platform) is used for annual online training
- Access the home page through “LifeCare Standard Links” > HealthStream
- Employees log in using their employee ID and password located on the log in home page
- All employees are required to complete several courses within 30 days from date of hire. Login to not be delinquent.

LIPINCOTT ONLINE RESOURCES
- Lippincott Procedures and Skills includes step by step, highly detailed instructions for thousands of procedures
- Lippincott Advisor includes information on National Guidelines, drug information, patient education handouts and more!
- Both can be accessed from ICARE under “Clinical Services”