GENERAL HEALTHCARE RESOURCES, INC.
The Professional Staffing Solution

OSHA IN-SERVICES REFERENCE MATERIAL

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GENERAL HEALTHCARE RESOURCES, INC.
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AGE SPECIFIC COMPETENCY and ELDER ABUSE

GOAL

This training program is designed to educate healthcare workers on the age specific basics and familiarize the healthcare worker to specific age identifiers and to define and assist in decreasing elder abuse.

OBJECTIVE

You will learn about specific general identifiers of the stages of human development indicating age demographics and information regarding elder abuse.

INTRODUCTION

Healthcare workers are responsible for their patients' safety. This would include treating the patients according to their own age level. Treating their patients within their age development will assist the healthcare worker to deliver proper care.

POINTS TO REMEMBER

Each person is moving through the life cycle at all times from birth to death.

The patient's life cycle stage can generally be identified by physical attributes, psychosocial tasks, common fears or stressors.

As healthcare workers, you can deliver appropriate care to each patient by identifying the life cycle the patient is currently in and modify the delivery of your treatment to be more effective and best treat the patient.

Abuse is any intentional or unintentional hurt of a person. Elder abuse is any intentional or unintentional hurt of a person who is approximately 60 years of age or older.

Abuse can be Domestic (in their home) or Institutional (in a facility).

Healthcare abusers can be doctors, nurses, hospitals, caregivers, unlicensed "professionals", and nonprofessional healthcare providers. Abusers may be family members, visitors or intruders.

Never assume why someone may abuse an elder.

Report all instances of abuse to your immediate on-site supervisor and your staffing specialist.

Be able to report specific information about the incident.

INFANCY
0 – 1 yrs old

Physical Attributes

Sits, crawls on belly & hands & knees, pulls up to stand momentarily & begins to walk. Responds to "no" & simple commands. Explores.

Psychosocial Tasks

Have caregiver assist, expect resistance, use sensimotor phase of learning. Gestures are imitated. *Model behavior you need them to do to ie open mouth. *Older infants remember past.

Trust vs. Mistrust

Learning to trust or mistrust depending on experiences. *Use sensimotor-learning phase with soft talk and skin stroking.

Major Fears/Stressors

Stranger Anxiety. Parental Attachment. Trust Issues.

TODDLER
1 – 2 yrs old

Physical Attributes

Walks, pulls, carries, tiptoes, scribbles, turn containers, hand dominance, recognizes people, single words, phrases, short sentences & repeating words.

Psychosocial Tasks

Egocentric-*describe procedure in terms/experiences they know. *Use firm direct approach with negative behavior. Limited time concept. *Prep child immediately prior to procedure.

Autonomy vs. Doubt

Parents/caregiver encourage child & reassure child when mistakes are made.

Major Fears/Stressors

Child to develop confidence lending to choice development, control & independence. *Give child choices when possible.

EARLY CHILDHOOD-PRESCHOOL
2 – 6 yrs old

Physical Attributes

Stands on 1 foot 10 sec or longer, swings, climbs, skips, & somersaults. Motor control gains.

Psychosocial Tasks

Preoperational Thought - *demonstrate equipment. Fears of bodily harm. *Draw pictures and show areas to treat. Increased language. *Get them to express themselves. Control fantasy vs. impulses. Struggling to balance adventure and more responsibility. Name objects & 4+ colors, some understanding of time. Wants to be like friends. Copies shape patterns, prints letters, dresses self & goes to bathroom.

Initiative vs. Guilt

Parents/caregiver consistent with discipline child learns behavior isn't allowed. No shame with make believe play.

Major Fears/Stressors

Guilt developed leads child to shy away from independence.

ELEMENTARY-MIDDLE SCHOOL
6 – 12 yrs old

Physical Attributes

Growth spurts, body change pre-puberty. Need 10 hrs sleep. Loose baby teeth. Eyes mature in size & function. Small muscles develop.

Psychosocial Tasks

School, using tools, & starting skills to be potential provider. Interest in learning. Explain procedure with correct medical terminology. Peers important. *Provide privacy from peers to preserve self-esteem.

Competency vs. Inferiority

Transitioning world of home to world of peers. Intellectual stimulation & productive pleasurable. Competence develops while seeking success. *Allow responsible activity-collecting own specimen.

Major Fears/Stressors

Unknown, failure, death, family & rejection.

ADOLESCENCE
12 – 18 yrs old

Physical Attributes

Rapid height & weight gain. Secondary sex characteristics, brain development, especially emotional neurons. 9.5 hrs sleep. Develop advanced reasoning, abstract thinking & meta-cognition.

Psychosocial Tasks

Changing attitude towards opposite sex. Establish identity, autonomy, intimacy, & comfort with sexuality & achievement. Body conscious *provide privacy.

Identity Vs. Role Confusion

Preparing to answer "Who Am I?" with prior stages of success, a plan for self & future developed. Present is more important than future *explain immediate effects/benefits of procedure.

Major Fears/Stressors

Confusion about life, self, sexual orientation, vocation, and personal fables – "it can't happen to me".

*** Indicates methods to help you treat the pediatric patient effectively.**

YOUNG ADULT 19 - 44 yrs old	MIDDLE ADULT/ADULT 45 – 65 yrs old	LATER ADULT 66+ yrs old
Physical Attributes None in this age group.	**Physical Attributes** Dry skin, reduced subcutaneous tissue with decreased skin turgor. Sleep apnea (found primarily in men and in postmenopausal women). Diminished bone density with decrease in stature. Need to reduce caloric intake to avoid weight gain.	**Physical Attributes** Skin fragile, dry & scaly. Decreased temperature regulation. Limited ability to compensate for increased heart rate, increased varicosity, reduced height & posture, reduced ease of ventilation & lung expansion, susceptible to falls, wider stance, less steady gait, muscle loss, incontinence, decreased senses, awake more often, constipation & chewing ability compromised.
Psychosocial Tasks Early-resolving issues from childhood Later-Adult roles developing at home, work and community. Forms lasting relationships with same & opposite sex.	**Psychosocial Tasks** The "sandwich generation" may have concurrent responsibilities for their children and aging parents (especially women) in mid-career, middle of generations, middle of life-span. Reactions to menopause may be depressing or liberating.	**Psychosocial Tasks** Coping with adjustments necessitated by illness, disability, etc. Need to confront own mortality, death of spouse or friends, etc. Performs cognitive tasks more slowly due to decreased senses.
Developmental Tasks Intimacy vs. Self-Isolation Reaching to others for relationships. Develop values, attitudes and interests related to roles. Life experiences assisting in gradual development of intellect. Form own opinion & make own decisions.	**Generativity Vs Self-absorption, Stagnation** Generativity-concern about providing for others equal to one's self; guiding next generation. Achieving financial & emotional security; maintain contact with children; letting go of parental authority; meeting needs of aging parents; prepare for retirement. *Significant persons: spouse, children, aging parents.	**Ego Integrity vs. Despair** Ego Integrity (accepts life and self as they are) vs. Despair. Moving towards acceptance of altered roles in society and family.
Major Fears/Stressors Separation of major relationships (social/work), finding career path, beginning a family & growing number of responsibilities. Child rearing is greatest burden now.	**Major Fears/Stressors** Major life decisions, financial burdens, disenchanted with work, life or self. Caregiver role to parent is stressful. Concerns of youth, appearance, sex appeal, dependency, etc. Time of maximum command of self & others & highest achievement in work accomplished.	**Major Fears/Stressors** Declining health, social isolation, loss of relevance, loss of independence or increased dependency on others. Vulnerability to injury due to slower decision-making and responses to stimuli, decreased visual and auditory acuity, reduced balance and equilibrium. Deaths of spouse and contemporaries, declining health.

ELDER ABUSE

Elder abuse is the intentional or unintentional hurt, (physical / emotional) of a person approximately sixty years of age or older.

CLASSIFICATION OF ABUSE – Domestic (in their home) or **Institutional** (in a nursing home, hospital or long term care facility).

A significant amount of abuse occurs in long-term care facilities, such as in nursing homes, out of sight of the general public. It can be physical abuse, emotional abuse, sexual abuse, neglect, financial exploitation, or healthcare abuse.

Healthcare abusers can be doctors, nurses, hospitals, caregivers, unlicensed "professionals," and nonprofessional healthcare providers.

DEFINITIONS

Physical: Any threat of or any physical force that results in injury, impairment or physical pain.

Emotional: Verbal or nonverbal act inflicting emotional pain or distress. (Verbal abuse, mental abuse, or psychological abuse). It is almost always accompanied by another form of abuse. Emotional abuse can range from a simple verbal insult to an extreme form of verbal punishment; examples: ignoring the elderly, isolating them from family & friends, scapegoating, harassment, name calling, humiliating, threatening to punish or deprive, treating them like infants, yelling or screaming.

Neglect: Physical or Emotional. Confinement, isolation, or withholding essential services. The caregiver may not provide for the necessities of life, such as food, water, shelter, clothing, healthcare, medicine, comfort, and safety. Abandonment, a type of neglect, is when the responsible caregiver deserts the vulnerable senior.

Self-Neglect: Elders can neglect themselves by not caring about their own health or safety. Elder self-neglect can lead to illness or injury. The seniors may deny themselves or ignore the need for: food, water, hygiene, proper clothing, medications or medical attention. Self-neglecting elders may have the following behavior: hoarding, leaving stove on or confusion.
Note: Some elders who are sound of mind may choose to deny themselves some health or safety benefits. This is not self-neglect, but rather personal choice; others must therefore be sensitive about intervention.

Sexual: Sexual contact with an elder without that person's consent. This includes coerced nudity, fondling, touching, kissing, and photographing in sexual positions, sexual assault of any type, showing them pornographic material, spying on them in the bathroom or bedroom or telling “dirty” stories.

Financial Exploitation: Someone illegally or improperly using an elder's assets, funds, or property.

Healthcare Fraud or Healthcare Abuse: Less visible than other forms; includes not providing healthcare but charging for it, overcharging, double billing, kick-backs for referrals or drugs, overmedicating or under-medicating, recommending fraudulent remedies for illnesses.

Medicaid Fraud: Any type of healthcare fraud or abuse but carried out in a Medicaid facility or funded by Medicaid.

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SIGNS & SYMPTOMS OF ELDER ABUSE

Warning Signs are frequent arguments between elder and caregiver or changes in personality or behavior of elder.

If you suspect elderly abuse, but aren't sure, look for clusters of the following physical and behavioral signs.

PHYSICAL ABUSE

- Unexplained bruises, pressure marks, black eyes, welts, lacerations, cuts, or burns
- Bone fractures or broken bones
- Sprains or dislocations
- Bite marks or restraint marks
- Broken glasses
- Underutilization of medication or overdose (via lab findings)
- Elder is not left alone with visitors
- Elder reports physical abuse

EMOTIONAL ABUSE

- Upset or agitated
- Withdrawn, depression or non-communication
- Sucking, biting or rocking (usually with dementia)
- Caregiver belittling or controlling elder
- Desertion at an institution (hospital, nursing home, etc or public locations)
- Physical or chemical restraints
- Elder reports emotional abuse

ELDER NEGLECT

- Dehydration, malnutrition, or hunger
- Physical weakness
- Hazardous or unsafe living conditions
- Unsanitary & unclean living
- Clothing unsuitable for weather
- Poor hygiene, foul body or household odor
- Lack of medical aids

SEXUAL ABUSE

- Bruises around breasts or genitals
- Unexplained VD or infections
- Unexplained vaginal or anal bleeding
- Torn, stained or bloody underclothing
- Elder reports sexual abuse

HEALTHCARE ABUSE

- Duplicate billings for services
- Pill counts are under or over the number the patient was prescribed
- Lack of inadequate medical care even though bills are paid

ABUSERS

Most abuse occurs in the home, and usually by a family member. Most commonly the perpetrators of elderly abuse are spouses or partners of elders. Next most frequent abusers are the adult children of elders.

Abusers can be men or women. Men ages thirty-six to fifty are the most common perpetrators.

In nursing homes & other long-term care facilities, abusers may be employees, visitors, or intruders.

Anyone associated with an elder may abuse them: friends, relatives, doctors, lawyers, bankers, accountants, clergy, caregivers, or strangers.

CAUSES OF ELDER ABUSE

Sometimes those who care for the elderly are not suited to the requirements of the job and they allow themselves to vent impatience, frustration, and anger on those whom they are supposed to be protecting. In nursing homes, in particular, staff may be prone to elder abuse because of **insufficient staffing, lack of training, stressful working conditions, and staff burnout.**

Sometimes neglect is not intentional; it may be the result of lack of adequate training on how to care for the elderly or because staff members cannot monitor needy elders in a timely manner.

Taking care of the elderly, whether at home or in an institution, can be very stressful. The incidence of depression is very high among caregivers. Caregivers habitually lack exercise and outdoor time, have inadequate nutrition, and need more sleep. Many people with dementia have trouble sleeping so caregivers are kept up caring for them. Caregivers have a high level of anxiety.

The amount of stress that the caregiver experiences depends upon: 1) the type of disease/dementia the patient has, 2) how caregiver perceives the responsibility, 3) the elder's thoughts of the caregiver, 4) if the caregiver finds the elder ungrateful, 5) the caregiver's ability to cope with stress, 6) if others help with care and 7) violence or aggression from the elder.

RESULTS OF ABUSE

Inability to Move	Incontinence	Longer Healing Times	Bed Sores
Depression	Loss of Dignity or Self Esteem	Worsening Medical Conditions	Death

SPEAKING WITH THE VICTIM OF ELDER ABUSE

RECOGNIZING ABUSE: AWARENESS & SENSITIVITY

- Focus on victim's safety AND avoid colliding with the abuser.
- Do not assume that stress, poor family communications, or poor care giving techniques are causing the problem.
- Keep in mind 75% of elder abusers are family members. Any family member may be a resource and/or perpetrator of abuse.
- No matter how surprising or unusual the accusation, or how confused a senior may appear, believe what is stated contains elements of truth. Try not to make assumptions.
- Sexual assault does happen to older and dependent adults, but is rarely revealed or addressed. Ask questions, such as "Are you touched in a way that makes you feel uncomfortable?".

PROVIDING SUPPORT AND EMPOWERMENT

- Validate the feelings of the elder who is reporting abuse.
- Provide assistance to the elder who is reporting the abuse, regardless of cognitive status, etc.

Victims of abuse are likely to be more open if speaking with someone they perceive as having shared values or life experiences. This may be someone of the same gender identity, race, age, language, sexual orientation, religion or class.

RESOURCES AND INFORMATION

- Advise the victim that there are resources for those abused and those who are abusing.

SAFETY CONSIDERATIONS

- **Use caution if discussing options with the victim. Do not irritate the situation. Advice must be realistic.**
- **Be sure the victim is speaking in a private place to ensure safety and confidentiality.**

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HOW TO REPORT ELDER ABUSE

If an elder is in danger: Notify your on-site supervisor and GHR staffing specialist.

If any incident occurs during shift, notify the on-site supervisor and GHR staffing specialist immediately.

Be prepared to provide the following:

- Who was abused?
- The location of the abuse (facility, floor, etc).
- The best approximate time of the incident and the date.
- All persons involved in the incident.
- Provide the most accurate & truthful description of the incident.

For more information contact the **National Domestic Violence Hotline: 1-800-799-7233** or email ndvh@ndvh.org. If you are deaf, call **1-800-787-3224 (TTY)** or email deafhelp@ndvh.org.

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BACK SAFETY

GOAL

This training program is designed to educate healthcare workers on prevention of back injuries. This program reviews: prevention, techniques, equipment and will educate the healthcare worker regarding personal factors which may contribute to back injuries.

OBJECTIVE

You will learn about proper techniques for safely moving patients and various items they may encounter on a daily basis.

INTRODUCTION

Back involvement is a large part of job performance for healthcare workers. They suffer one of the highest back injury rates in the country.
There are many influences that can impact back safety in the Healthcare Worker. There are 4 factors which contribute to back injuries or aggravating back injuries. They are: 1) Physical Demands of the work, 2) Equipment, 3) Work Practices and 4) Personal Factors.

Equipment / Devises for Healthcare Workers

The following equipment and devises are designed to reduce the stress of moving patients. The most common devices are listed below:

DRAW OR TRANSFER SHEETS: Heavy cotton bed linens placed under a patient; they are used to slide or reposition patients between horizontal surfaces. Slippery sheets or large plastic bags can be used in place of draw or transfer sheets.

SLIDE BOARDS: Thin plastic boards (bed length). The patient is slid/ rolled onto the board and it is pushed/pulled for the move.

GAIT BELTS: Canvas belts without handles, used to support patients being moved; they are fastened securely around the patient's waist and the worker grips the belt. TRANSFER BELTS are used like gait belts but are wider and have padded handles on each side; they allow for better control in case of a patient fall.

TRAPEZE BAR: Triangle-shaped device suspended above the bed. Patients are able to use them by assisting in positioning themselves in bed or assisting when they are transferred. The bars should be adjusted to the patient's elbows, so they are only slightly bent when grasping the bar.

TOTAL BODY LIFTS: Used to move patients who are fully dependent.

STAND-ASSIST LIFTS: Used to move patients from and to chairs, beds, showers, etc.

COMPACT LIFTS: Smaller versions of total body or stand-assist lifts.

AMBULATION LIFTS: Used to support patients during walking. Patients can push the lift as they walk. There is a strap across the patient's back to prevent them from falling backward.

TECHNIQUES FOR LIFTING & MOVING PATIENTS SAFELY

Many injuries can occur during the patient transfer. Always utilize the guides below and the following general rules, to avoid serious injury:

- Assess the situation & communicate the plan of action to the patient & other workers.
- Prior to move, remove any obstacles, correctly position equipment & lock all wheels in place.
- Maintain eye contact with patients & communicate the steps with them, to avoid resistance.
- Be alert for trouble & always ask for assistance.
- If you encounter a problem during the move, make notes, and alert your supervisor and staffing specialist immediately.

TURNING PATIETNS IN BED WITH OR WITHOUT A DRAW SHEET

- Position the bed at thigh level & lower the bed rail.
- Place your knee on the bed.
- Cross the patient's arms over his/her chest and cross his/her legs.
- Put one hand on the patient's shoulder, one hand on his/her hip & begin to roll the patient toward you.

REPOSITIONING PATIENTS IN BED WITH A DRAW SHEET—REQUIRES 2 WORKERS

- Position 1 worker on each side of the bed.
- Adjust the bed height to the waist of the smallest worker and lay the bed flat.
- Bend your knees. Point 1 foot in the direction of the move.
- Each worker grasps the draw sheet with both hands.
- Lift and move the patient in unison.

BED TO GURNEY TRANSFERS

- If possible, ask for assistance.
- Use a slide board or plastic bag under the draw sheet so you will slide the patient easily.
- Position the bed and gurney to the same height & place next to each other.
- Lock the wheels of each to ensure stability.
- Cross the patient's arms on his/her chest & legs.
- Stand on the far side of the gurney.
- Place your knee or get on the gurney kneeling.
- If you have assistance, slowly begin to slide/ pull the patient's body towards you, in unison.
- If you are alone, slide the patient, alternating between the legs and torso.

BED TO WHEELCHAIR TRANSFERS

- If possible, use a transfer belt.
- Adjust the bed to the lowest height.
- Put the wheelchair at the head of the bed and lock the wheelchair and bed in place.
- Assist the patient in sitting up on the edge of the bed by placing 1 of your hands under the shoulder blades and the other under the knees.
- Grasp the patient around the waist with both hands or grasp the transfer belt.
- Brace your knees against the patient's to lock them in place. This will help him/her stand.
- Rock the patient to a standing position. If the patient is able, he/she may assist by pushing up on the bed, as you rock forward.
- Bend your knees, move your feet to turn & lower the patient into the chair. (If possible, have patient reach for chair arms for extra support.)

WHEELCHAIR TO TABLE OR BED TRANSFERS

- Adjust the table or bed to the height of the patient's hip level.
- Position the wheelchair as close as possible to the table or bed. Lock both items in place.
- Bend your knees & wrap your arms around the patient's waist or grasp transfer belt with both hands.
- Lift the patient to a standing position. (If possible, he/she can assist by lifting off of the chair arms with his/her arms.)
- Sit the patient on the edge of the bed or table.
- Help the patient lay down.
- Utilize a draw sheet to reposition the patient.

FALLING PATIENTS

- DON'T TRY TO CATCH A FALLING PATIENT.
- You may try to slow their fall down by guiding him/her to the floor. Be sure to protect your back by keeping it straight. Don't bend.
- Try to protect the patient's head as much as you possibly can as you help him/her gently to the floor.
- DO NOT LIFT A PATIENT BY YOURSELF.
- CALL FOR HELP TO MOVE THE PATIENT FROM THE FLOOR.

PERSONAL FACTORS TO AVOID BACK INJURIES

There are many steps we can take to be sure our backs are in good working condition. These measures will help us avoid painful back injuries and prepare us for our everyday tasks.

- Good Posture—Ensure a proper "S" curve whether you are standing or sitting. Sleep on your side with your knees bent or on your back with your knees propped up slightly with pillows. This alleviates low back stress. Never sleep on your stomach with pillows under your head.
- Staying in Shape—Even a few extra pounds place unnecessary stress on our backs. Avoid food high in fat and sugars. When exercising, consult your physician before starting any exercise routine. If you are engaged in a physical activity and begin to notice some discomfort, stop the activity immediately.
- Use proper Body Mechanics and Movement Techniques– Never lift or move anything without using the general methods for moving or lifting.

TECHNIQUES FOR LIFTING & MOVING GENERAL ITEMS SAFELY

The following general techniques are to assist you in moving or lifting items safely.

1. **ASSESS THE SITUATION—ASK THE FOLLOWING QUESTIONS BEFORE MOVING**
   - How far do I have to carry or move the item?
   - Is the path clear for me to travel? (Check to see if anything will block your path. If so, move it safely aside. Prop doors open if necessary.)
   - Will I be able to see over the item I am moving or lifting?
   - Can you disassemble, carry and reassemble?
2. **SIZE UP THE ITEM**
   - Test a corner of the item. Can you safely lift by yourself? If not, seek assistance. Or, can you use a device to assist in the move?
   - If possible, use gloves to assist your grip on the item and to protect your hands from possible injuries.
3. **LIFTING THE ITEM**
   - Get as close as possible to the item. Your feet should be placed shoulder width apart.
   - Bend down at your knees to the item. ***DO NOT BEND YOUR BACK.***
   - Grasp the object firmly and keep the item close to you.
   - Slowly lift the item by straightening your legs. Be sure to keep your back straight and look straight ahead. Never look down.
   - If the item begins to fall, let it. ***DO NOT TRY TO CATCH A FALLING OBJECT.***
4. **CARRYING THE ITEM**
   - Keep your back straight and take your time. Keep the object close to you.
   - When turning, use your feet to make turns. Never turn at the waist. Turn your body all together.
   - Avoid lifting anything over your head.
   - If you become tired, take a break.
5. **SETTING THE ITEM DOWN**
   - Squat using your legs. Keep your back straight and the object close to you.
   - Focus straight ahead. Do not bend at the waist or look down.
   - Once the object is down, release the item. Do not drop the item into place. You may cause an injury releasing too quickly.

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BLOODBORNE PATHOGENS

GOAL

This training program is designed to assist healthcare workers in protecting themselves and their workplace from Bloodborne Pathogens. Healthcare workers that work with General Healthcare Resources, Inc. (GHR) will be required to complete the test annually to be kept aware of any changes that may take place throughout the year regarding safety measures. We also want to keep the issue fresh in your mind, so your safety is never compromised by unsafe practices.

OBJECTIVE

We are dedicated to protecting our healthcare professionals from bloodborne infections. From this booklet, we would like to arm our professionals with the knowledge and steps to eliminate and reduce the chances of contracting bloodborne infections by:

- Explaining the Epidemiology and Symptoms of Bloodborne Diseases, generally.
- Assessing the avenues of bloodborne pathogen transmission.
- Discussing Universal Precautions briefly and identify the appropriate methods for tasks that may involve exposure to blood or other potentially infectious material and understand the use and limitations of methods that will prevent or reduce exposure.
- Summarizing Personal Protective Equipment selection, use, handling and disposal.
- Reviewing the Hepatitis B vaccine.
- Distinguishing the identification of color-coding, labels or signs to assist in your work safety.
- Post Exposure Procedures and Follow-up.

INTRODUCTION

This annual review booklet of Bloodborne Pathogens is designed to educate and train you in safe practices regarding Bloodborne Pathogens. It will assist in protecting you against Bloodborne Pathogens. This booklet will cover many aspects of healthcare, whether you are directly involved with infected materials or if you are occasionally presented with bodily fluids or infected materials.

REFRENECES

Occupational Safety and Health Administration (OSHA 29 CFR 1910.1030) (2001)

Post-Exposure Plan – General Healthcare Resources 7-05

You may request the Occupational Safety & Health Administration 1910.1030 or the Post-Exposure Plan – 7-05 by General Healthcare Resources by putting your request in writing to:

Director of Human Resources, Inc.
General Healthcare Resources
2250 Hickory Road, Ste 220
Plymouth Meeting, PA 1962

BLOODBORNE PATHOGENS

Bloodborne pathogens are microorganisms that are present in blood and blood products, tissues and other potentially infectious materials (OPIM).

The risk level varies. However, all healthcare professionals are at risk due to the frequent exposure to the public and contaminated materials present.

The highest priority diseases are Hepatitis due to Hepatitis B Virus (HBV) or Hepatitis C Virus (HCV) and Acquired Immunodeficiency Syndrome (AIDS) from Human Immunodeficiency Virus (HIV).

BLOODBORNE HIGHEST PRIORITY DISEASES	OTHER POTENTIALLY INFECTIOUS MATERIALS (OPIM)	ALSO LISTED AS OTHER POTENTIALLY INFECTIOUS MATERIALS (OPIM)
▪ Hepatitis from Hepatitis B Virus (HBV) ▪ Hepatitis from Hepatitis C Virus (HCV) ▪ Acquired Immunodeficiency Syndrome (AIDS) from Human Immunodeficiency Virus (HIV) ▪ Viral Hemorrhagic Fevers (VHFs), which include: Ebola Hemorrhagic Fever, Lassa fever, Hantavirus Pulmonary Syndrome (HPS), and Hemorrhagic Fever with Renal Syndrome (HFRS).	▪ Semen ▪ Vaginal Secretions ▪ Cerebrospinal Fluid ▪ Pleural Fluid ▪ Peritoneal Fluid ▪ Pericardial Fluid ▪ Amniotic Fluid ▪ Synovial Fluid ▪ Breast Milk (possible) ▪ Saliva	▪ Unfixed tissues or organs. ▪ Cells, tissues, organ cultures containing HBV, HCV or HIV. ▪ Culture medium containing HBV, HCV or HIV. ▪ Blood or organs from animals with HBV, HCV, HIV or other Bloodborne Pathogens.

POST EXPOSURE FOLLOW-UP

If you believe you have been exposed, please notify your on-site supervisor immediately and advise your staffing manager as soon as possible. You should seek medical attention as soon as possible.
You must be able to provide the following regarding the exposure:

a) Source of Exposure
b) The circumstances surrounding the Exposure
c) Date and time of the Exposure
d) Who was involved in the Exposure

The necessary steps will be taken, as outlined in the General Healthcare Resources Exposure Plan. We will investigate and assist treating medical professionals in determining your risk. We will maintain the documents in accordance with 1910.1030(h)(1)(iv) and 29 CFR 1910.1020.

BLOODBORNE HIGHEST PRIORITY DISEASES

DISEASE	HEPATITIS B (HBV)	HEPATITIS C (HCV)	ACQUIRED IMMUNO-DEFICIENCY SYNDROME (AIDS)	VIRAL HEMORRHAGIC FEVOR (VHFs)
VACCINE	**YES-Lasts approx. 15 yrs* No Boosters***	**NO**	**NO**	**NO**
WHAT IS IT?	A virus that attacks the liver. Can cause lifelong infection, cirrhosis of the liver, liver cancer, liver failure & death.	Liver disease. Affects other parts when immune system fights self. (glomerulonephritis, essential mixed cryoglobulinemia, and porphyria cutanea tarda.)	HIV attacks T-4 lymphocytes; T-4 lymphocyte loss cripples immune system. Disease progression can lead to AIDS; incubation of approx. 5 years.	Illness groups caused by several virus families (Arenaviruses, filoviruses, bunyaviruses & flaviviruses). Vascular system damaged & body can't regulate itself.
SYMPTOMS	Present within 9-21 weeks post exposure. Jaundice, tiredness, loss of appetite, nausea, abdominal discomfort, dark urine, clay colored feces & joint pain. Adults show more symptoms than children.	Signs or symptoms of liver disease OR abnormal liver enzyme tests.	HIV may not be present. Can include: red, brown or purple blotches under skin, mouth, nose or eyelids. White spots on tongue, mouth or throat. Night sweats. Aids Related Complex (ARC) prior to AIDS: Swollen lymph nodes, Mycological oral infections, fatigue, and weight loss. AIDS: Immune system collapse, infection, malignant tumor & Neurological damage.	Vary: fever, fatigue, dizziness, muscle aches, strength loss, and exhaustion. Bleed under skin, internal organs, orifices (mouth, eyes, ears). Severe - shock, nervous system malfunction, coma, delirium, seizures & renal failure
VIRUS OUT-SIDE BODY SURVIVAL	**YES At least 7 days & capable of causing infection.**	**YES Survives on surfaces at room temperature for 16 hours to 4 days**	**YES Minute to hours. Depends on amt. of HIV in fluid & conditions. Host dependent.**	**UNKNOWN-aerosol possibility but viruses depends on host to continue.**
TRANS-MISSION	Contact with blood or body fluids of infected person. Can't be spread via causal contact. (ie. Hugging, food, water, coughing, sneezing or breast-feeding.)	Any activity involving direct contact with human blood including mother with HCV giving birth may transmit to child.	Activities when blood or OPIM containing HIV is transmitted into the body. (Precutaneous route, needle sticks, mucus membranes or open wounds). Cannot be spread via causal contact. (i.e. Hugging, food or water, coughing, sneezing or breast-feeding.)	Aerosol possible. Contact with urine, feces, saliva, and other excretions from infected rodents, mosquito or tick bites, or crushing tick. Secondary: fluid or objects holding fluid.
POST EXPOSURE TESTING & TREATMENT	Blood test. Detected 1-9 weeks post exposure. Treatment on vaccination usually anti-viral drugs for chronic infection. No treatment for recently acquired HBV. If known exposure: get treatment within 24 hrs -no later than 7 days.	Blood test or tests. Detection time 1-12 weeks. No treatment to prevent infection. Disease treatment pegylated interferon & ribavirin. Interferon monotherapy reserved for those in which ribavirinis contraindicated. Ribavirin, used alone, doesn't work.	Blood test-upon exposure 6, 12 & 24 weeks. To treat current infection, 4-week course of 3 antitrovial drugs to reduce transmission. For certain exposures, PEP (Post-exposure Prophylaxis) If known exposure: seek treatment immediately within hours of exposure.	Isolation-Blood tests. Supportive therapy & anti-viral drugs but no known cures or established treatment.

*Based on CDC's FAQs last reviewed on 6/1/05

REDUCE BLOODBORNE PATHOGEN EXPOSURE

Anyone coming into direct contact with blood or OPIMs is at risk! Therefore, there are many measures that can be taken to ensure that your workplace remains as safe as possible. These measures include:

PRACTICE WORKPLACE SAFETY WITH:

- Transmission Definitions and examples
- Universal Precautions and General Safety Guides
- Sharps & Needlesticks
- Engineering & Work Practice Controls
- Personal Protective Equipment (PPE)
- Housekeeping Procedures
- Regulated Medical Waste Disposal
- HBV Vaccination
- Post-Exposure Follow Up
- Hazard Communication
- Training

TRANSMISSION DEFINITIONS & EXAMPLES

Occupational exposure to various diseases occurs when blood or OPIM are transmitted into the body via:

- **Precutaneous Route:** Syringes or Needle Stick Injury. Scalpel incisions. Cuts with broken glass.
- **Open Sores or Wounds:** Chapped skin. Acne. Cold Sores. Cuts or burns.
- **Mucus Membrane Exposure** Surgery: Splash of blood on face & mouth. Centrifugation: Splash of HIV culture in eyes or mouth.
- **Needlesticks** Needle recapping. Autoinoculation. Improper sharps disposal.

UNIVERSAL PRECAUTIONS & GENERAL SAFETY GUIDES

ALL BLOOD OR OPIM IS CONSIDERED INFECTIOUS REGARDLESS OF THE PERCEIVED STATUS OF THE INIVDIUAL

- Wash hands & arms immediately after patient care with anitibacterial soap.
- Use the required personal protective equipment (PPE) when providing patient care.
- Treat all body fluids & soiled items as if they contain HIV, HCV, HBV or HFC.
- Put all personal property in designated areas. Don't smoke, eat, drink or store food in patient treatment areas.
- Maintain sanitary conditions in patient areas. Contaminated PPE must be disinfected before using again.
- Use gloves & eye protection when handling contaminated clothing. Presoak clothing with antibacterial solution before discarding or sending to laundry. Seek advice from the on-site supervisor for appropriate action.
- Fluid spills will be presoaked with antibacterial solution & let sit for 10 minutes. Wear gloves & eye protection. Warn others of the spill to avoid accidents. Seek advise from the on-site supervisor for appropriate action.
- Medical wastes are discarded properly every time.
- Any suspected exposure to HIV, HCV, or HBV must be reported to your supervisor immediately and to your staffing specialist as soon as possible.

SHARPS AND NEEDLESTICKS

PREVENT SHARP INJURIES:

Sharps are: syringes, scalpels, lancets, needles, disposable medical instruments, broken glass or similar item that can cut or puncture someone.

- All Sharps are disposed of in hard red plastic marked containers.
- Needles are not removed from syringes. **DO NOT CUT, BEND OR RECAP NEEDLES**.
- Never place any sharp into a regular trash.
- Do not exceed the manufacture's "fill line". Do not try to overfill containers.
- **SHARPS disposal applies to all sharps whether contaminated or not, used or unused, used separately or together of if they are used for any other purpose**.

PREVENT NEEDLESTICK INJURIES:

- Avoid using needles when safe alternatives are available.
- Use devices with safety features provided.
- **DO NOT RECAP NEEDLES.**
- Plan for safe handling & disposal of needles before use.
- Know how to use a needle prior to use. Ask the facility supervisor, if unsure.
- **Promptly use safety devise immediately after use & dispose of used needles in sharps disposal containers.**
- **Report all needlestick & sharps injuries immediately and seek immediate care.**
- Tell the facility about any needlestick hazards observed.
- Participate in infection prevention training.
- Get a hepatitis B vaccination.

ENGINEERING & WORK PRACTICE CONTROLS

In areas where blood or OPIM may be present you must be careful not to transmit Bloodborne pathogens. These controls will assist in minimizing exposure and isolating or removing hazards:

RESTRICTING ACTIONS

- No eating, drinking or smoking. No food or drink in refrigerators, etc where blood or OPIM may be present.
- Do not handle contact lenses, apply cosmetics or lip balm.
- Minimize splashing or spraying of generation droplets of blood or OPIM. (Centrifuges-use splash shield in front of tubes to remove caps.)
- Blood or OPIM are in containers preventing leaks during collection, handling, processing, storage, and transport of the specimens.
- Items that could puncture a primary container will be placed within a secondary puncture resistant container.
- If primary container becomes contaminated, the primary container shall be placed within a secondary container that prevents leakage during handling, processing, storage, transport, or shipping of the specimen.
- Use hard plastic containers designed for the sharps disposal with biohazard symbol. They are labeled with the universal biohazard symbol and are replaced frequently to avoid overfilling.
- Mechanical Pipettes: Use when handling blood or body fluids. MOUTH PIPETTING IS FORBIDDEN!
- Containment Devices: used for blood flow manipulation and for sterile cultures and pathogen work.
- Chemical and Mechanical Filters: vacuum lines to be protected with inline chemical and mechanical filters.

HANDLING CONTAINERS

Containers are not allowed to overfill. Advise your facility supervisor if a container is full. If you must move a container, you must:

- Close containers prior to move.
- Place in secondary container if spillage is possible.
- Secondary must be closable and constructed to hold the intended contents.
- Check to be sure containers are labeled & color-coded to reflect the contents.
- **DO NOT EMPTY, OPEN OR CLEAN REUSABLE CONTAINERS. THIS EXPOSES YOU TO GREAT INJURY.**

ADDITIONAL CONTROLS

1. Minimize aerosol generation when sonicating, grinding, slicing, centrifuging or performing other procedures that could cause splashing or create aerosol droplets.
2. Waste containers are leak proof, unbreakable, labeled with biohazard symbol & sealable or closeable.
3. Packaging or transporting specimens, processing or culturing must be performed in a biosafety cabinet or other containment system. If you are to perform some process, which can't be performed in a bio-safety cabinet, you must attempt to reduce aerosols.
4. Disinfection: Autoclaving (treats biohazard waste). Use clear or orange polyethylene plastic bags (strong and pliable and puncture resistant and recommended for autoclaving infectious materials.) Some chemicals will require disenfection – Chemical Disinfection due to volatile chemicals. The various types of disinfectants are listed below:

   - **Alcohols:** Ethyl or isopropyl alcohol at 70-80% concentration is a good general purpose disinfectant; not effective against bacterial spores.
   - **Phenols:** Effective against vegetative bacteria, fungi, & viruses containing lipids; unpleasant odor.
   - **Formaldehyde**: Concentration of 5-8% formalin is a good disinfectant against vegetative bacteria, spores, and viruses; known carcinogen; irritating odor.
   - **Quaternary Ammonium Compounds:** Cationic detergents are strongly surface active; extremely effective against lipoviruses; ineffective against bacterial spores; may be neutralized by anionic detergents (i.e. soaps).
   - **Chlorine:** Low concentrations (50-500 ppm) are active against vegetative bacteria and most viruses; higher concentrations (2,500 PPM) are required for bacterial spores; corrosive to metal surfaces; must be prepared fresh; laundry bleach (5.25% chlorine) may be diluted (one part bleach to 9 parts water) and used as a disinfectant.
   - **Iodine:** Recommended for general use; effective against vegetative bacteria and viruses; less effective against bacterial spores.
   - **Glutaraldehyde:** Very good disinfectant, but irritating.

PERSONAL PROTECTIVE EQUIPMENT (PPE) & HOUSEKEEPING

GLOVES

Wear when you might have hand contact with blood or OPIM, non-intact skin & mucus membranes. Especially if you perform vascular access procedures and when handle or touch contaminated items or surfaces.

- **DISPOSABLE**: Do not wash or decontaminate for re-use. Replace as soon as they are contaminated, torn, punctured or when the barrier is compromised.
- **UTILITY**: Can decontaminate for re-use if glove isn't compromised. Discard if cracked, peeling, torn, punctured or show signs that barrier is compromised.

EYE AND FACE PROTECTION

Masks with eye protection devices (goggles or glasses with solid side shield or chin shields) are to be worn whenever splashes, spray, splatters or droplets of blood or OPIM may be generated and eye, nose, or mouth contamination can reasonably be anticipated.

ADDITIONAL PROTECTION

If you can anticipate gross contamination, wear the appropriate protective clothing. You can obtain additional protection with: lab coats, gowns, aprons, clinic jackets, caps, shoe covers, booties or similar outer garments.

If you cannot locate disposable PPE at the facility, please advise your immediate supervisor and follow up by advising your staffing specialist.

HOUSEKEEPING

All contaminated equipment or surfaces are cleaned after procedures and immediately after blood spills or OPIM. Use bleach solutions or EPA germicides. Medical or Infectious waste is always separated from other wastes. If you have any questions about a facility's procedures, speak with your immediate supervisor.

The facility might also utilize protective coverings such as plastic wrap or plastic coated counter top paper, which may be used to keep surfaces free of contamination:

CLEANING UP BLOOD SPILLS OR OPIM

- If there is any glass involved, remove it from the pool with a brush & dustpan, scoop, hemostat, forcepts, etc**.** **DO NOT USE HANDS!**
- Discard material into a puncture resistant container labeled biohazardous waste disposal.
- Use absorbents to soak up spill.
- Discard soaked towels and materials as designated by the facility. (If you are unsure, ask your facility supervisor)
- Wipe up all remaining spilled materials.
- When visually clean, use detergents or disinfectants to combat Bloodborne Pathogens.
- Apply another coat of detergent or disinfectant and allow it to set for 10 minutes or air dry.

MEDICAL WASTE DISPOSAL

- Medical or Infectious waste are separated into bags labeled "Infectious Waste-Biohazard". Place into leak proof bins marked "Infectious Waste-Biohazard"
- Infectious sharps are discarded into leak proof, puncture resistant containers.
- Clean spill immediately and disinfectant with chemical germicide must be used.
- After removing gloves or after contact with fluids, hands and other skin must be washed thoroughly and immediately with soap or other disinfectant in hot water.
- Steam sterilization (Autoclave) may be used on biological wastes that don't contain radioactive or hazardous materials. Dispose of in regular trash.
- Chemical decontamination may be used with liquid biohazard waste and disposed of in the sewage system.
- All reusable glasses must be decontaminated with a bleach solution (1:9) prior to wash and acid wash. Sterilize via autoclave.

HBV VACCINATION

The Hepatitis B vaccination is available, at no cost, to all GHR field employees who have occupational exposure, after receiving Bloodborne Pathogen training and within 10 working days of first shift.
GHR field employees may demonstrate proof of previous Hepatitis B vaccination series or antibody testing and has revealed that the employee is immune or the vaccine is not recommended due to a medical reasons or condition.
Any GHR field employee may decline the Hepatitis B vaccination, if they sign the Mandatory Declination and are aware that:

1) The employee may exercise their right to receive the vaccination series, free of charge, at any time after signing the declination, and
2) The employee understands the risks associated with exposure to the hepatitis virus until they receive the hepatitis B vaccination series.

HAZARD COMMUNICATION

The following is a universal symbol to indicate containers of regulated waste, refrigerators or freezers containing blood or other similar types of blood related containers. The containers with this symbol are used to store, transport or ship blood or OPIM. Blood released for transfusion purposes or other similar clinical use may not adhere to the labeling requirements.

BIOHAZARD

This label will be fluorescent orange or orange-red with lettering and symbols in a contrasting color. They will be posted at entrance of potential exposure, affixed to containers by string, wire, adhesive or other method that prevents loss or unintentional removal.

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It is provided at no cost to the employee. 1910.1030.g.2.i
Training provided prior to the initial assignment where the occupational exposure may exist and annually thereafter. 1910.1030.g.2.ii.
Annual training provided within 1 year of their previous training. 1910.1030.g.2.iii.
Training is carried out in accordance with OSHA standard for Occupational Exposure to Bloodborne Pathogens. (29 CFR 1910.1030.) 1910.1030.g.2.vi-viii.
Records are maintained for 3 years from the dates the training occurred. 1910.1030.h.2.i-ii
http://www.healthsafe.uab.edu/pages/biosafety/bbp/pages/page12.htm
http://www.healthsafe.uab.edu/pages/biosafety/bbp/pages/page15.htm
http://www.who.int/GlobalAtlas/PDFFactory/HIV/EFS_PDFs/EFS2004_US.pdf
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http://www2.fpm.wisc.edu/bbp/training/train.htm

GENERAL HEALTHCARE RESOURCES, INC.
The Professional Staffing Solution

CULTURAL DIVERSITY

GOAL

This training program is to decrease cultural misunderstandings that occur among healthcare workers, patients and co-workers. We want to increase knowledge and comfort level in the diverse working environments and ensure that each of you are able to provide appropriate care to a diverse patient population.

OBJECTIVE

You will be introduced to the diverse population that is present in the medical field, either as patients or co-workers. This topic will discuss basic ideas for healthcare workers to provide non-judgmental and appropriate medical care. This section will discuss:

- Some common cultural characteristics enabling the professional to have a better understanding of their patients and co-workers
- Some common susceptibilities among some ethnic and racial groups which will affect medical care
- Some techniques that can be utilized to provide the most appropriate care to their patients
- Factors that need to be considered in healthcare when dealing with a diverse population: some common health problems present with newly arrived immigrants and refugees and some "hot buttons" for all races, cultures and religions
- Work styles to better assist healthcare workers working in a diverse environment
- Strategies to build better working relationships

INTRODUCTION

Cultural competence requires acknowledging the Western culture and the social differences from the Non-Western cultures and how the different cultures respond to illness and treatment. To provide culturally competent care, we need to identify our own beliefs and social customs and realize that we are all colored by our own culture from birth and continue to evolve within that culture through socialization. We must recognize our own beliefs as one of many, not what is right or "normal".

You will review a summary of some cultural characteristics to help you understand other cultures generally. You will also review a brief summary of some racial and ethnic susceptibility to health problems. As medical providers, you must acknowledge the impact cultural norms have on people when they are faced with the added stress of illness or injury to them or a loved one. Therefore, you must treat each patient as an individual and address the individual needs of each patient.

You will also review a basic description of work styles among some culturally diverse societies and how the cultural norms may present themselves in the United States. There is also a section providing strategies for some common issues among healthcare workers. The culture differences described also apply to diverse work environments. In order to provide the best possible care, you must communicate and work well with your co-workers. It is important to remember that your co-workers come from varying cultures and you need to treat them individually with respect.

Equipment / Devises for Healthcare Workers

Included for your reference are basic summaries of some of the more common cultural characteristics, specific racial or ethnic medical susceptibilities, techniques to utilize with patients to provide appropriate medical care, a summary of culturally-based work styles and strategies to improve working relationships among a diverse group.

CULTURAL DIVERSITY – PATIENTS

MEDICAL INFORMATION AND TREATMENT:

- Must be considered in the context of the patient's cultural or religious beliefs
- Requires eliciting and integrating the patient's perspectives
- Must be available to all patients regardless of race or ethnicity

Use the **L.E.A.R.N. Model** to work with patients regarding their injury or illness:

- **Listen** with sympathy and understanding to the patient's perception of the illness or injury.
- **Explain** your perception of the problem.
- **Acknowledge** and discuss the differences and similarities.
- **Recommend** treatment.
- **Negotiate** agreement.

KEY POINTS TO REMEMBER

- Racial and ethnic minorities often receive lower quality of healthcare even when controlled for socioeconomic status or insurance coverage. This could be related to the lack of culturally diversity skills developed within the healthcare workers. **We must remember to treat the patient with the illness not the illness with the patient.**

- Higher cancer rates exist among all minority populations but differ with the type of cancer most prevalent in a group.

- There is evidence of varied reactions to standard treatments among different groups. **We must individualize treatment but keep in mind that different groups will sometimes metabolize drugs differently** (diabetes, depression & hypertension). Even with this information, we cannot generalize treatment. You must always treat the individual patient. Some examples include:
  - African-Americans, Asians, and Hispanic individuals metabolize some psychotropic drugs more slowly than the US population majority. Side effects can also vary.
  - Some Chinese eliminate the beta-blocker from their bodies at twice the rate of the population majority. This is important regarding beta-blockers used to treat hypertension, angina, heart attacks and migraine headaches. At the same time, however, some Chinese require only half the blood level of this medication as compared with the population majority to achieve the desired therapeutic effect.

The general guidance is to refrain from stereotyping by focusing on individualized treatment. For more information on reactions to standard treatments among different racial and ethnic groups, please visit http://www.patientcareonline.com and the May 15, 2000 issue of Patient Care, entitled "Caring for Diverse Populations."

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SAMPLE OF SOME CULTRUAL CHARACTERICS

AFRICAN AMERICANS

- Tradition of involving "whole village" or family in raising children.
- Major religions involve Christianity and Islam.
- Many households are headed by women.
- Sometimes discomfort and mistrust of the healthcare system; may be linked with a fear of being diagnosed with life-threatening disease or those diagnostic procedures are an invasion of privacy.
- Legacy of enslavement is that this group generally remains at lower economic level, receives less formal education and has worse health status indicators than any other ethnic group.

ASIANS

- Religions include Buddhism, Christianity, Hinduism, Islam, Sikh, Jain, Parsi and other traditional faiths.
- Highly esteemed cultural values: hard work, acceptance of life, respect for nature, self-control, respect for elders & family loyalty.
- Societies are patriarchal & children show respect to elders.
- Prefer practitioner of same sex and many expect that treatment will involve a shot or prescription.
- May not be polite to shake hands; a slight bow may be acceptable. May not be polite to hold eye contact with someone older or "superior". Smiling masks anger, frustration, and lack of knowledge or unhappiness too.
- Numbers are very important. Lucky numbers are 3 and 8. 3 in language sounds like the word "life". 8 sounds like the work for "prosperity". 4 is very UNLUCKY - it sounds like the word for "death".

EASTERN EUROPEANS

- Religions include Orthodox Christianity, Roman Catholicism, Islam & Judaism.
- Emotions expressed publicly. May not feel comfortable with personal questions. Note taking is suspicious.
- Relatives give moral and physical support.
- Smoking is common among men & awareness of 2nd hand smoke is low.
- Treatment not complete without a prescription.
- The sick are encouraged to communicate suffering with others.
- Food is appreciated. Good appetites are admired. Little awareness of the importance of exercise.
- Some adults use alcohol excessively.
- Many generations may live together.

HISPANICS / LATINOS

- Roman Catholicism is major religion and influences social life and traditions.
- Caribbean has many spiritual traditions, beliefs and practices of American and African cultures.
- Maintaining eye contact is valued.
- Friendly physical contact is common (touching of shoulder or upper arm).
- Friendliness and treating others with respect are highly valued.
- Education, degrees and titles are esteemed.
- Socializing and spending time with family and friends is a vital part of life.
- Cakes and sweets may be part of regular diet.
- Workers in US may send money back home to support family members.
- Children are highly valued and loved; parental discipline may be light when young.

NATIVE AMERICAN / AMERICAN INDIAN / ALASKA NATIVE

- Many variations among the groups.
- Family and tribal affiliations and obligations are important in daily life.
- Holistic perspective on life and health. Great care is taken to integrate physical, social, psychological and spiritual ways of healing.
- Many Native Americans living in reservations are living on allotted land that is remote and economically unproductive.
- Resident or reservation may suffer from poverty, poor nutrition, stress on family and inadequate access to healthcare. The healthcare systems must ration the care because they lack the funding to completely cover healthcare costs. This has a negative impact on the residents' health status.

SAMPLE OF SOME CULTRUAL CHARACTERICS (cont'd)

PACIFIC ISLANDERS

- Encompasses islands in Pacific Ocean.
- Holistic world view, emphasize interconnectedness of person, family, environment and spiritual world.
- Tight knit communities where family, community and church play prominent role.
- Ancestors and elders treated with deference. Interpersonal and social behavior based on mutual respect and sharing.
- Basic distrust of Western approaches to healthcare and treatment. Rarely respond positively to health education and treatment based on scare tactics to motivate behavior change.
- Low income and poverty are risk factors that contribute to health status.

SUB-SAHARAN AFRICANS

- Wide variety of religions and languages.
- Family includes people from village, friends, and distant blood relatives.
- Some religions/cultures practice polygamy.
- Close friend greeting: shake hands and ask about health of individual/family.
- Males and females are circumcised in most countries.
- Most African countries grow 1 root crop for starchy staple; prefer cooked vegetables to raw and common to season foods with hot peppers.

WESTERN ASIA / MIDDLE EAST

- Islam is the most common religion but other groups include Christians, Jews, Bahais, Druze, Parsis and Zoroastrians.
- Most people don't eat pork and do not like to be touched on the head.
- Prefer to be treated by same sex.
- Prefer treatment involving pills, injections or minor procedures.
- Most follow strict kosher diet and fasting with Muslims common during holy month with no food or drink between sunrise and sunset. The ill are exempt but fasting may extend to medications or injections during this holy period. For Muslims, no alcohol.
- Women may be secluded from men outside.

Management Sciences for Health: The Providers Guide To Quality Culture – Cultural Groups.
http://erc.msh.org/mainpage.cfm?file=5.1.0.htmodule=providerlanguage=English

SUSCEPTIBILITY TO HEALTH PROBLEMS AMONG SPECIFIC RACIAL, ETHNIC & CULTURAL GROUPS

AFRICAN AMERICANS

- Higher incidence of hypertensive, sickle cell anemia and diabetes.
- Obesity rates are high. Lactose Intolerant.
- Cardiovascular Disease (CVD) death rate exceeds rate for majority of population.
- Diabetes, complications including lower limb amputations and end stage renal disease is double than rate of majority of population.
- Women more likely than general population to be infected with HIV.
- 10% of males suffer mild form Glucose-6 phosphate dehydropinase (G-6PD) deficiency.
- Cancer death rate is approximately 35% higher than for the majority population.
- Certain diseases (prostate and breast cancer) may progress rapidly than in general population.

ASIANS

- Common cancer sites for women are lungs, breast, colon, stomach and pancreas. Invasive rates are higher among Southeast women in general versus US population.
- Cervical cancer incidence and mortality for Vietnamese exceed those of other minority or majority of population.
- Cancer among Chinese men: liver, colon, stomach and nasopharynx.
- Newcomers may have hepatitis, intestinal parasites, malaria and/or Hansen's disease.
- Common disease among Cambodians: TB, Hepatitis B and intestinal parasites (hookworm, giardia & strongyloides).
- Lactose intolerance is common.
- Some develop severe form of Glucose-6 phosphate dehydroginase (G-6PD) deficiency.

EASTERN EUROPEANS

- Diseases of digestive system in men are more common than in majority of population.
- Smoking and weight may be problems.
- Women have higher musculoskeletal complaints than majority of population.
- Tay-Sachs disease occurs in 1/3600 infants of Askhenazi Jewish heritage.

SUSCEPTIBILITY TO HEALTH PROBLEMS AMONG SPECIFIC RACIAL, ETHNIC & CULTURAL GROUPS (cont'd)

HISPANICS / LATINOS

- Diabetes is twice as prevalent than majority of population.
- Hypertension is common.
- Overweight and obesity are common in some.
- Cervical cancer is double of Non-Hispanics and European Americans.
- Lower incidence of breast, oral cavity, colorectal and urinary bladder cancer; their mortality from them is similar to the major population

NATIVE AMERICAN / AMERICAN INDIAN / ALASKA NATIVE

- Three times more likely to have diabetes than Non-Hispanic European Americans of similar age.
- Men and women suffer high rates of cancers (colon & rectum) vs. European Americans.
- 5-year survival rate for Native American women with cervical cancer is poorer than most ethnic groups.
- Lactose intolerance is common among Native Americans.

PACIFIC ISLANDERS

- Native Hawaiians have highest mortality rates of any US racial or ethnic group for cancers of breast, lung, ovary and stomach. Highest mortality rates for leukemia and non-Hodgkin's lymphoma.
- Mortality rates for heart disease, cancer and stroke are higher for Hawaiians than for total US population.
- Risk factors for heart disease, cancer and stroke are high among them and include hypertension, obesity, smoking, alcohol consumption and diabetes.

SUB-SAHARAN AFRICANS

- Higher incidence of Sickle Cell Anemia, but has been shown to provide some protection against malaria.
- Lactose intolerance is common.
- Frequent relapse of P. Vivax malaria common. Relapse of P. Ovale is less common but can occur several years after initial infection.
- Recent immigrants may suffer dental issues as a result of poor dental care of home county or increase of processed foods in US.
- Parasites (hookworm, schistosomiasis, strongyloides or giardia) may be present and affect overall health.
- Female Genital Mutilation regularly practiced. Estimates range 80% of women in Egypt, 5% Uganda and 98% in Djibouti and Somalia. There are severe health complications with this practice.
- Post-traumatic stress may be present.

WESTERN ASIA / MIDDLE EAST

- Many Egyptians suffer from parasitic disease; Schistosoma mansoni or Scistosomahaematobium. Female worm expels eggs-become lodged in liver and urinary tract. Problems resulting are cirrhosis, liver failure, portal hypertension, esophageal varice, bladder cancer and renal failure.
- Egyptians have highest rate of blindness.
- Typhoid and paratyphoid fevers, streptococcal disease, rheumatic fever and TB (check for BCG injection if positive TB test).
- Egyptian Americans prone to obesity, hypertension, lower back pain, cardiovascular diseases, lack of exercise and type II diabetes. Iranians protein/vitamin deficiency, hepatitis A & B, high rates of TB and syphilis.
- Genetic risks for b-thalassemia.
- Stomach intestinal problems (heartburn, constipation, hemorrhoids and impaction) - lack of roughage and fluids, rapid eating and straining.

Culture Sensitive Healthcare-Middle Eastern American Patients: www.diversityresources.com/rc_sample/me.html

PATIENT ASSISTANCE

Healthcare workers can assist the patients by:

- Showing respect for their past and their particular cultural, religious, and other practices.
- Taking time to listen, to elicit each patient's view of her/his illness and the type of treatment he/she expects, and to empathize.
- Encouraging the patient to seek community and other resources that may help him/her adapt to the new environment.

Healthcare workers use many Techniques to elicit all necessary medical information to build a framework for culturally competent medical treatments.

Listen to the Patient about the injury/ illness:

- What are the patient's own descriptive terms used to describe the illness/injury?
- What does the patient think caused the problem?
- What makes it better or worse?

Look for clues about the Patient:

- Is the patient wearing or displaying religious objects?
- Does the patient make or avoid eye contact?
- Does the patient keep a certain distance or try to be close?
- Does the speaker look away from listener? Looking too intensely in some cultures is aggressive. Some cultures respond to the speaker when listening to let the speaker know they understand. In other cultures they may be silent and look away while the speaker is talking which is not meant to be a lack of interest or understanding.

Observe Gestures and Language:

- Some gestures in one culture can mean something entirely in another. The "OK" (making a circle with your thumb & forefinger) is considered rude to some Asian individuals.

Verbal Communication:

- Some words in one language may have offensive meanings in another.
- Don't assume that someone with an accent doesn't understand your language.
- Talking louder to compensate is irritating, patronizing and offensive.
- Speak slowly if someone does not comprehend what you are saying.

Learn about individual and cultural health views:

- What are you doing to care for your illness?
- Has it worked?
- Is anyone else treating your illness?
- How would you describe the other treatment?

Their treatments may be strange to you. Accept their practices when possible. Discuss risks of the remedies interactions with treatment team before rejecting the patient's remedies.

Understand the Relationships:

- Ask about the patient's family.
- If a spouse/family member is involved in care, ask for his or her views on the treatment and response.
- Allow extended family to visit during death if these are expected practices.

Evaluate Time Relationship:

- Some cultures think of time as a general part of a day. They might view a 2:15pm appointment as sometime in mid-afternoon.

Expressing Opinions and Pain:

- People in some cultures believe it is rude to complain, disagree or say no. These individuals will signal pain in other subtle ways.
- Some cultures encourage individuals to share pain. Be sure to listen to the patient complaining or disagreeing to get to the root of the problem. Do not assume that the person is just "difficult".

FACTORS TO CONSIDER

Healthcare workers should take the following factors into consideration when caring for a patient:

- **Country of origin**: How long the patient has lived here will affect his/her view towards health.
- **Preferred language**: If given the advantage to talk or read about care in his/her own language, the patient will feel less anxious and understand the care better.
- **Views about health**: Some patients and family will see the illness as a supernatural cause and punishment for sins or they might see a need for traditional cures (herbal remedy or specific diet).
- **Relationships**: The patient may expect certain individuals to be involved in care, allowed to visit or not allowed to visit.
- **Religion**: This will affect the patient's consent to treatment, schedule of care, room arrangement, birth and death practices, dietary considerations and family involvement.
- **Age**: The patient may view illness as a normal process of aging. An adolescent might be sensitive about privacy and how treatment will affect their appearance. A middle-aged person might worry about financial issues while hospitalized.
- **Gender**: A patient may prefer to receive care from a same sex provider. Some cultural values prohibit touching between members of the opposite sex, including spouses during childbirth.
- **Socio-economic status**: Financial problems may keep a patient from seeking or following treatment.
- **Physical or mental disability**: Patients will have diverse views about how disabling a certain condition is, how to explain mental illness (some may believe it to be supernatural), expression of pain, and treatment acceptance or rejection.

Hot Buttons for all races, cultures and religions are:

- Superstitions and Customs
- Death and Dying
- Religious Beliefs
- Family Roles
- Patient Autonomy
- Dietary Practices
- Physical Space and Body Language

Some Common Health Problems in Newly Arrived Immigrants and Refugees include:

- **AIDS/HIV and Tuberculosis (TB)**: All refugees and immigrants applying for permanent visas to the US are required to be screened for TB and HIV. If positive, they are held until treatment is complete or they are no longer contagious. Temporary Visas are not required to be screened.
- **Hepatitis B**: Commonly found in parts of the developing world, Amazon, Southern Eastern and Central Europe, Middle East and Indian sub-continent.
- **Parasites**: Intestinal and Hematological are common throughout developing world.
- **Incomplete Immunization**: Rubella, measles, Hepatitis B and diphtheria.
- **Post Traumatic Stress Disorders**: Result of intensive civil strife and armed conflict in their country.
- **Malaria**: Relapses seen in people traveling or living in sub-Saharan Africa, Asia and Latin America.
- **Lead Poisoning**: Common in children from high pollution areas using diesel and leaded fuel.

- **Female Genital Mutilation (FGM):** 28 African countries, 5 countries on Arabian Peninsula, Indonesia and Malaysia. Approach this subject in a sensitive and responsive manor. Some women are deeply upset about having undergone the procedure and others believe it is a normal part of life. There are many complications related to this procedure.

CULTURAL DIVERSITY – WORKFORCE

Just as healthcare workers are dealing with a very diverse patient population, they are also facing a very diverse healthcare workforce population. Differences among staff can create communication problems and lead to unnecessary conflict. Your co-workers, just like you patients, are shaped based on cultural values, beliefs and behaviors. These factors will influence you and your co-workers communication, decision-making and clinical practice.

WORK STYLES

Egalitarian Society:

- American Culture – Everyone is to be equal.
- More comfortable questioning authority because they feel they are equal to others.
- Informal Culture. Our speech and our professional's dress are informal and in our culture is a demonstration of openness, friendship, acceptance, and accessibility.
- Task accomplishment is important.
- Direct Communication – Low Context Culture
- Communication is clear and direct. Meaning is transferred with explicit verbal communication not from the context of the situation. Direct eye contact is important and getting directly to the business at hand. (i.e. I worked last holiday and I think it is unfair that I have to work the next holiday. Can you change my schedule?)
- Time is direct and language uses linear markers. A 9:15am meeting means the meeting starts at 9:15am and you are to be present at that time. Language is also linked. A boss giving instructions might say, "First, you do this. Second, you do this
- English-Area Specific Idioms and Use shorter sentences. Refrain using idioms that don't translate well because they are culturally based. (i.e. let sleeping dogs lie). Keep sentences short and simplify the language.

Hierarchic Society:

- Great respect given based on: age, sex, occupation & wealth. Problems arise if women are supervising men from male-dominated societies - men are "superior" to women.
- Difficulty questioning authority & don't usually take initiative to perform work on their own. Physicians from this culture might find questioning staff offensive & object.
- Formal Culture. Informality is seen as presumptuous & rude. Casual appearance conveys a lack of respect & professionalism. Therefore, patients will lack confidence and trust. Personalism - highly valued trait where one shakes hands, addresses formally & asks about family well being before discussing issues.
- Tasks achieved within a context where rapport & relationships are emphasized.
- Indirect Communication – High Context Culture
- Non-verbal gestures, voice tone, nature of relationship are just as or more important than the content of the message. The situation to which something is said carries great meaning. Eye contact is disrespectful. (i.e. A nurse is more likely to talk about the unfair scheduling with co-workers or a charge nurse, whom is seen as having "informal" leadership power, rather than to a direct supervisor.) The nurse will encourage the charge nurse to act, after pointing out the need for a better holiday scheduling system.)
- Time is fluid and approximate. Not exact. A 9:15am meeting means you should arrive around that time. This is culturally based and does not denote laziness or irresponsibility. They are just not used to running their lives according to the clock. They must adjust that cultural influence working in the US. So, they may need a private explanation of punctuality and why it is important to be on time, especially in a healthcare setting.
- Speaking with others in a common native tongue in a foreign county helps the person stay connected to language & culture.

STRATEGIES FOR BETTER WORKING RELATIONSHIPS

These strategies will ease any tensions arising in a culturally diverse workplace. You may use either method based on your role in the facility. These are just a few things you can do to ensure correct clinical skills and productivity.

Person-Centered Strategies

- Understand the difference in role relations. Acknowledge the cultural differences that will affect your co-workers. Find out how individuals prefer to be addressed. Observe staff members to determine the dominant norms.
- Being aware of people's perception of what it takes to be a "good employee". An Egalitarian society worker will challenge authority and work more independently. Someone from a Hierarchic society may not seem to take initiative on the job but they are demonstrating respect. You want to observe the norms of the facility and emulate them to meet the expectations.
- Be aware of personal space and touching. It is important to talk about these differences. In some cultures very close talking and personal space is much smaller and may be seen as threatening or aggressive to those who have larger personal space.
- Understand that communication styles differ in their level of formality. In some cultures, informal communication is seen as rude and in others formal communication is seen as snobbish. It is best to be formal until an understanding or trust is established.
- Don't be hurt if foreign staff members speak another language in front of you. Remember, they are staying connected with their heritage. If you are speaking the foreign language, explain what you are talking about to colleagues who speak only English. If you don't speak the language being spoken in front of you, you might say, "You seem to be having a good conversation. Can you share it with me?"
- Speaking clearly and facing co-workers who have difficulty comprehending directions in English. Get them to describe what you have told them to check their understanding. Language skills are built overtime slowly. Your patience will help them improve their English speaking abilities.

Organization-Centered Strategies

- Closely define job duties and expectations. If you are supervising, recognize that some cultures will take the position description literally while others may only use as a guide. Be clear with your directions.
- Facilitate open communication. Watch for signs of misunderstandings and conflicts. Help clarify meanings without taking sides. If more than 2 members of a team are involved in a dispute, advise your immediate supervisor.
- Helping culturally diverse co-workers/staff learn appropriate ways to behave and interact in the mainstream culture. Explain accepted ways to address co-workers and patients. Help orient them to the mainstream work styles, communication, formality or informality, time orientation and the location where they will work.
- If you notice that a co-worker or someone you are supervising is having difficulty with the mainstream norms, refer them to your supervisor. Your supervisor will have the resources to direct the individual, so they are more comfortable with the mainstream norms.

GENERAL HEALTHCARE RESOURCES, INC.
The Professional Staffing Solution

FIRE SAFETY

GOAL

This training program is designed to educate healthcare workers on fire safety. This program reviews: prevention, techniques, equipment and will educate the healthcare workers regarding potential hazards and emergency situations.

OBJECTIVE

You will learn about, proper fire safety techniques for safely dealing with emergency fire situations, and moving patients. They will learn about fire identification and the equipment used to extinguish the fires.

INTRODUCTION

Healthcare workers are responsible for their own and their patients' safety, while under their care. There are many influences that can impact fire safety for the healthcare worker. The healthcare workers must assist in identifying potential fire hazards, extinguishing fires when safe, and evacuation of their patients when necessary.

POINTS TO REMEMBER FOR FIRE SAFETY

Smoke detectors, extinguishers and other fire alert systems should work properly. Any unusual activity must be reported to your immediate supervisor.

Familiarize yourself with your facility's fire escapes, evacuation plans and extinguishers.

Never use an elevator. Always use the stairs. Be cautious of closed doors.

Check doors with the back of your hand. It is more sensitive to heat then the palms.

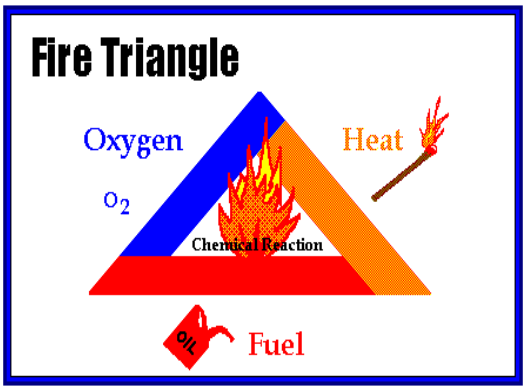
After going through doors, shut them. If you can, shut windows to help contain the fire.

Smoke rises. Go to floor and use wet cloth if possible and take small short breaths. Get to fresh air quickly and seek medical attention.

Don't run around if clothes catch fire. STOP, DROP, ROLL. Cover face with hands. Keep legs and arms close to the body. Continue to roll until flames are smothered.

Use caution with flammable or combustible materials.

Always remain calm.



THESE ITEMS ARE PRESENT TO PRODUCE FIRES:

- **OXYGEN:** Enough to sustain combustion
- **HEAT:** Preparing the material to the ignition temperature
- **FUEL:** Any flammable or combustible material
- **CHEMICAL, EXOTHERMIC REACTIONS:** Chemicals combined to produce reactions

Prevent fires - keep the fuel & ignition sources separate!

CLASS A FIRES:

Wood, paper, cloth, plastics & rubber.

PREVENTION:

- Keep combustible material away from heat.
- Practice good housekeeping.
- Don't let piles of paper, etc. build up.
- Dispose of cigarettes properly.
- Keep matches & lighters away from children.

EXTINGUISHER:
Water Type / Air Pressurized Water

- Removes heat.
- Large silver containers and large squirt guns.
- Gauge located on handle.
- DO NOT USE THIS EXTINGUISHER ON FLAMMABLE LIQUID. (It can cause it to spread.)
- DO NOT USE ON ELECTRICAL FIRES. (Increases the risk of electrocution. If you have to, use on unplugged or de-engergized equipment.)

SYMBOL

CLASS B FIRES:

Flammable liquid or gasses, gasoline, oil, propane or paint thinner, etc.

PREVENTION:

- Be careful with flammable or combustible liquids. Some have fumes that are heavier than the air. They can travel long distances and are ignited by ignition sources such as sparks, static discharges or pilot lights.
- Store gasoline in approved containers.
- Wait until gasoline equipment has cooled before refueling.

EXTINGUISHER:
CO2 – Carbon Dioxide

- Removes oxygen. Cools the fuel.
- Red containers.
- No Gauge.
- Due to pressure, dry ice might shoot out of horn. Could also use dry chemicals, or foam.

SYMBOL

CLASS C FIRES:

Electrical Fires.
Any energized electrical equipment in class A or B fires.

PREVENTION:

- Don't overload wall outlets.
- Ensure that cords and wires are in good working condition. Replace the items if they become frayed or damaged.
- Don't run cords under carpets through doors or windows.

EXTINGUISHER:
DRY CHEMICAL or CO2

- Fires in this class pose a shock hazard, so extinguishers for this class do not conduct electricity back to you.
- Shoots a thin layer of dust to separate the fuel from the oxygen.
- Pressurized with Nitrogen.

SYMBOL

USE A FIRE EXTINGUISHER WITH P.A.S.S.

If it is safe, the alarm is active, the fire is contained and you are knowledgeable, use a fire extinguisher with P.A.S.S.

PULL: Twist the pin as you pull to help break the seal.

AIM: Aim the extinguisher's hose or nozzle at the bottom of the fire. Pressure of the extinguisher contents can cause a flare up of the fire. Aiming at the front of the base of the fire pushes the fire away from you.

SQUEEZE: Squeeze the handle hard and all the way down or the valve might not completely open.

SWEEP: Use a sweeping motion **with the hose back and forth across the fire, pushing it away from you until it goes out.**

Extinguishers empty in 15 seconds. If fire not out, put it on its side safely out of the way and LEAVE IMMEDIATELY.

R.A.C.E. - 4 MAJOR STEPS IN FIRE SAFETY

RESCUE / REMOVE: Everyone from the area. If a fire occurs in a patient room, the staff should immediately remove the patient from the area. The patient should be taken to an area away from the fire.

ALARM: Relay the information to others about the fire danger and sound the alarms.

CONTAIN: Close all openings, such as, doors, windows, etc. This will shut off the Oxygen supply. All doors should be shut and locked, if possible.

EVACUATE / EXTINGUISH: Extinguish with the proper extinguisher ONLY if you have time and are assured safe evacuation. If you are unsure on how to use a fire extinguisher, evacuate the area.

HOSPITAL EVACUATIONS

HORIZONTAL: Move the patients to a safe point/unit on the same floor.

VERTICAL: Move the patients to a lower floor towards safety.

OUT OF BUILDING: Remove the patients from the facility.

All other locations may require you to evacuate differently depending upon facility structure, etc. Be sure to familiarize yourself with the emergency route and extinguishers at the various locations.

GENERAL HEALTHCARE RESOURCES, INC.
The Professional Staffing Solution

PATIENT BILL OF RIGHTS AND RESPONSIBILITIES

GOAL

This training program is designed to educated healthcare workers on the Patient Bill of Rights and Responsibilities, so they are aware of the rights and responsibilities that are given to every patient. Healthcare workers should be able to advise patients of their rights and responsibilities thereby creating a comfortable and knowledgeable relationship with their patients. The advantage of this relationship is a better healthcare team made up of a qualified team and an educated and empowered patient.

OBJECTIVE

As healthcare workers, you have chosen a profession in which you care for patients selflessly. This Bill of Rights introduces the government regulations that safeguard and empower patients to assess and assist in their own healthcare plans with the healthcare team. You will be able to identify:

- The rights given to patients.
- The patient's responsibilities that accompany those rights
- Ways in which the patient's rights are supported
- Generally, how you can support the patient's rights everyday regardless of the setting

INTRODUCTION

The Patient Bill of Rights and Responsibilities have many goals, including: strengthening patient confidence in the healthcare system, reinforcing strong relationships with patients and their healthcare team and assigning responsibility to the patient to safeguard their own health.

While there are many rights and responsibilities listed within the Bill of Rights, we will review the basic forms of these rights that you, as a healthcare worker, will be required to uphold.

REFRENECES

Your Medicare Rights and Protections (2003) http://www.medicare.gov/Publications/Pubs/pdf/10112.pdf Retrieved 7/25/05

Florida Patent Bill of Rights, Florida Patient's Bill of Rights and Responsibilities s381.026 (1) – (6) www.doh.state.fl.us/mga/Profiling/billofrights.htm Retrieved 7/25/05

How to Choose a Home Care Provider. National Association of Home Care http://www.nahc.org/Consumer/wamraap.html Retrieved 7/27/05

Patient Bill of Right. New Jersey Division of Consumer Affairs based on P.L. 1989, c.170 and P.L.1971, c.136 (C.26:2H-1 et seq.) www.state.nj.us/lps/ca/bme/strateg/patientrights.htm Retrieved 7/25/05

Hospital Patient Rights New Jersey Dept of Health & Human Services, www.web.doh.state.nj.us/hpr/patientrights.shtml. Retrieved 7/25/05

PATIENT BILL OF RIGHTS

Patients can feel powerless when they are being treated for an illness or receiving long term care at a facility. Healthcare professionals can assist their patients to regain a sense of power over health situations by conveying and adhering to the Patient Bill of Rights.

Patients also have responsibilities to go along with the rights. Proper treatment is a team approach among the patients, direct care workers and others as needed to deliver the most medically sound and appropriate treatment.

THREE GOALS FOR THE PATIENT BILL OF RIGHTS

1. Treating patients as individuals by all healthcare workers and insurance companies.
2. Encouraging a strong relationship between patients and their healthcare team.
3. Educating patients that they must play a significant role in their treatment. The education begins with the explanation of their responsibilities along with their rights.

RIGHTS INCLUDED IN THE BILL OF RIGHTS

- The Right to Information
- The Right to Respect
- The Right to Participate
- The Right to Privacy
- The Right to Quality Care
- The Right to Accurate Financial Information
- The Right to Make a Complaint
- The Right of Residents
- The Right of Home Care Clients

THE RIGHT TO INFORMATION

DESCRIPTION OF RIGHTS:

The right to be informed of:

- Diagnosis, treatments and prognosis, risks involved in treatment and possible alternatives (if available), time frames of the treatment and if the treatment is experimental. Information must be in layman's terms, so patient can make an informed decision and supply an informed consent prior to any procedure (except in emergency situations)
- Any side-effects that may or may not occur as a result of a patient refusing treatment; to cease activities that may contribute to their condition.
- Healthcare workers' identity with location and contact information. The identities must also be clear. As a healthcare worker, you must wear a nametag, which indicates your name, professional license/job title.
- Appropriate patient and visitor conduct is expected at the facility.
- If the facility accepts the Medicare assignment rate, when the patient requests to know that information.
- Facility's life saving policies, methods & use of life support.
- Facility's patient support services.

PATIENT RESPONSIBILITY:

- Inform the healthcare professionals of medical history, illnesses, hospitalizations and medications.
- They are to tell someone when they experience new health problems or when symptoms re-occur.
- Be honest with healthcare team when asked to report any activities that may interfere with treatment, etc.
- If they are unsure or confused about their healthcare rights, they must ask.
- Knowing the patient and visitor conduct policies at the facility and to follow the rules.
- Advise the facility of any advance directives (Power of Attorney, Living Will and Do Not Resuscitate Order -DNR) and supply copies if necessary.
- Assume that medical information is shared amongst the team so appropriate care is provided.

SUPPORT RIGHTS BY:

- Using layman's terms to describe all aspects of diagnosis, treatments, prognosis, risks, if procedures are experimental and alternatives available. Advise your facility supervisor if an interpreter is needed.
- Be sure that patients understand their healthcare rights.
- Wear your nametag everyday and identify yourself to your patients upon entering their room.
- If patients are asking questions about their healthcare, advise your facility supervisor. Answer what you can and let the supervisor know if a doctor or other professional is needed.
- Remind patients of facility rules. Assist if they have any questions.

THE RIGHT TO RESPECT

DESCRIPTION OF RIGHTS:
- Healthcare professionals must act in an appropriate manner. (Ethical, honest, respectful and considerate)
- Receive appropriate care regardless of race, culture, religion, age, gender or physical disability.
- No abuse of any kind or neglect.
- Entitled to a high quality of life and free from unnecessary physical or chemical restraints.
- Personal belongings are kept and are treated with care and respect.

PATIENT RESPONSIBILITY:
- Patients must show respect for all members of their healthcare team regardless of race, color, age, sex or religion.
- Be considerate of other patients close to them.

SUPPORT RIGHTS BY:
- Be sensitive to the patients & respect their decisions.
- Don't offend patients, i.e. "honey", etc. Use the titles (Mr., Ms, Mrs.) or first names based on their preference.
- Their personal preferences are to be honored everyday. (I.e. Options re: food or dress)
- Don't touch personal items, unless necessary. If so, be careful & put them back.

THE RIGHT TO PARTICIPATE

DESCRIPTION OF RIGHTS:
- Making decisions about own care, change mind about care and refuse treatment.
- Entitled to advance directive if they want one. It also extends to living wills or other advance directives.
- Patient can decline treatment, as long as they are aware of the risks involved without the treatment, etc.
- Patient has access to emergency services, if when and where the need arises.
- Have an interpreter provided if necessary.

PATIENT RESPONSIBILITY:
- If they are unsure of something, they must ask for clarification.
- They must follow their treatment schedule, including appointments.
- They must submit copies of any advance directives, living wills, etc., so there is not confusion regarding the patient's care.

SUPPORT RIGHTS BY:
- Show respect advance directives.
- If DNR "Do Not Resuscitate" Order is in place, know what to do if the patient stops breathing.
- Encourage patients to adhere to their treatment schedules.
- Allow patients to refuse care, but be sure to document the refusal and advise facility supervisor.
- Encourage patients to help themselves. Even if tasks are small this will help them maintain some independence.

THE RIGHT TO PRIVACY

DESCRIPTION OF RIGHTS:
- Confidentiality and privacy from all who are providing care, during exams or routine care.
- Able to privately visit, telephone or receive and write mail with friends and family members.

PATIENT RESPONSIBILITY:
- Patients must share personal information that has some degree of effect on their health or their care.
- Respect the privacy of their healthcare professionals.
- Safeguard their personal belongings.

SUPPORT RIGHTS BY:
- Knock before entering a room.
- Don't share confidential information in public areas or with family or friends or co-workers.
- Written information is to be kept confidential.
- Allow privacy with visitors or when on the telephone.

THE RIGHT TO QUALITY CARE

DESCRIPTION OF RIGHTS:
- Expect the main team of professionals will be consistent, as much as possible.
- Treat patient as individual.
- Expect that their healthcare professionals will keep the patient safe from harm.
- Patient will receive proper and consistent care, including exercise, as tolerated, regardless of ability to pay.
- Entitled to emergency services for a condition that will decline without treatment.
- To be advised of any changes in treatment plan prior to the changes.
- To transfer to another facility or to seek additional treatment, as seen as viable and reasonable by the healthcare team.
- To have advanced directives honored.
- Advised of follow-up care after discharge.
- Allowed appropriate time frame to set up follow up care after discharge.

PATIENT RESPONSIBILITY:
- Reflect and change their lifestyle choices if it is negatively affecting their health.
- Acknowledge all patients have a right to quality care and that what they request may not be conducive to other patient's needs.
- Follow the rules of the facility.

SUPPORT RIGHTS BY:
- Help the patients avoid injury.
- Keep your promises to your patients and try to maintain a routine schedule as much as possible.
- Maintain your clinical skills and knowledge. Be sure to keep up to date on the most current information you can use on the job.
- Help the patients perform exercises.

THE RIGHT TO ACCURATE FINANCIAL INFORMATION

DESCRIPTION OF RIGHTS:
- Information is to be provided about costs of treatments or services and what the out of pocket contribution will be. If actual amount is not available, prior to the treatments, a fair and reasonable estimate will be provided to the patient upon request.
- Patients may request an itemized bill and have expenses explained, upon request.
- To receive financial counseling at the facility regarding their healthcare costs and to have resources explained to them.

PATIENT RESPONSIBILITY:
- Patient must supply the correct information for billing purposes. This includes insurance carrier information.
- Patient must assume responsibility for those charges not covered or considered "out of pocket" expenses.

SUPPORT RIGHTS BY:
- Assisting the patient as much as possible with questions about billing contacts in the facility.
- Advise the supervisor if the patient is requesting itemized billing or an explanation of billing.

THE RIGHT TO COMPLAIN OR FILE A COMPLAINT

DESCRIPTION OF RIGHTS:

- Patients have the right to complain without enduring consequences from their healthcare professionals.
- They may switch to another facility or treating team if switch is desired.
- Patients may be informed and have the facility's grievance procedures explained. The patient is entitled to a prompt and fair response to the grievance submitted.
- The patients have the option of taking the complaint to the state if they are not satisfied with how the organization handles the complaint. Or, patient can go directly to the state.
- Sufficient time to file a wrongful discharge or to engage in the discharge appeal process.

PATIENT RESPONSIBILITY:

- The patient should assume that you are cooperating with the rules of General Healthcare Resources, various governmental agencies and the facilities in which you are placed.

SUPPORT RIGHTS BY:

- Advise facility supervisor if a patient wants to file complaints. Review procedure & explain to patient. Advise GHR - ASAP.
- Build trust. Let the patient tell you about their concerns.
- Stay calm if the facility supervisor advises that a complaint has been filed against you. Let the supervisor hear all facts. Advise GHR -ASAP.
- Avoid complaints by: helping every patient not just "one of yours". This is illegal, violates their rights and can be abuse & neglect. Also, review care plan to provide proper care.

THE RIGHT OF RESIDENTS

DESCRIPTION OF RIGHTS:

- Residents of Nursing Homes and Assisted Living Facilities have the same rights as if they were living in their own homes.
- Examples of those rights: 24/7 family visits with privacy, refusal to see some visitors, financial control, own furniture and clothes, participate or decline to participate in activities, leaving facility to go shopping with family or friends and to move freely about without restraints provided they are kept safe and free of harm to themselves or others.

PATIENT RESPONSIBILITY:

- Patients need to adhere to the rules of the facility. (i.e. if there are designated areas for activities, that is where the activity should be performed.)
- Patients, while entitled to the rights of their own home, cannot infringe on the rights of others at the facility.

SUPPORT RIGHTS BY:

- Provide a comfortable non-threatening environment so the patients are free to make choices and voice their opinion.
- Support resident's decisions regarding activities.
- If patient is engaging in activities that interfere with another patient's rights, calmly go over the facility rules with the patient, if they are broken, or speak to your supervisor about negotiating between the two patients.

THE RIGHT OF HOME CARE CLIENTS

DESCRIPTION OF RIGHTS:

- Have the right to receive proper medical care at home, as long as the home does not contain any safety problems.
- Free to make own decisions, as long as patient is deemed competent to make his/her own decisions.
- Can decide and select which caregivers come to their home.
- Home patients have the right to know what to do in an emergency. They should be told specifically, who to call in an emergency of any kind.
- Home patients have the right to be told about the state home health hotline and telephone number they can call with any questions or complaints about their care or home health agencies.

PATIENT RESPONSIBILITY:

- Patients have to be aware of items that prevent safety problems in their home. (i.e. No electricity available when medications need refrigeration)
- Patients must be sure that the home is safe for the healthcare team. (If you are physically threatened, leave the home immediately and contact your GHR Staffing Specialist.)
- Patients must keep all appointments and be home for scheduled visits. If they are not home, they should notify GHR as soon as possible.

SUPPORT RIGHTS BY:

- Advise patients of any safety hazards they should look out for to provide proper care, in your absence. Explain the dangers of those safety issues. (i.e. electricity, refrigeration, etc.)
- Advise client's guardian if safety hazards exist. If no guardian, advise your GHR Staffing Specialist.
- Give patient phone number to contact GHR, in case the patient will not be home during the scheduled home care visits.

WHAT YOU CAN DO TO SUPPORT PATIENT RIGHTS

- **TREAT THE PATIENT AS AN INDIVIDUAL**: Listen to your patients. Each is an individual and different from your other patients.
- **PATIENT PRIVACY**: The patient has a right to privacy.
  - Family members frequently want to be involved in their loved one's healthcare decisions. This is acceptable if the patient wants his family's assistance.
  - Do not use the patient's last name if speaking on the telephone to another entitled party regarding treatment.
  - Keep your patient documentation private. When you go from one room to the next, be sure not to let the next patient see your prior patient's notes, etc.
  - Don't gossip about the patients, even to other members of the healthcare team, unless it will impact the patient's healthcare or treatment.
- **EXPLAIN ALL PROCEDURES**: Be sure to explain the procedures to your patients before you perform them. Your patients will feel more comfortable and will more likely cooperate with you.
- **BE HONEST**: Answer all patient questions honestly. If you don't know an answer or are unsure of the answer, always tell them that you are not sure and you would have to check.
- **FOLLOW UP**: If you promise a patient a certain action to be performed or are checking on information for them, be sure to limit any delay as much as possible.
- **PUT THE NEEDS OF THE PATIENT FIRST**: Your job is to put your patient's needs first. This shows that you are truly concerned about them and you will avoid violating the patient's healthcare rights.
- **OPEN COMMUNICATION**: Be sure that your patient knows and feels comfortable with coming to you or your GHR staffing supervisor first, should they have a complaint. All patients have the right to complain to the state if they are unhappy with treatment, but if the patients are comfortable, we might be able to remedy a situation before it goes to the state level.
- **KNOW YOUR AUDIENCE**: Be sure to speak to your patients in words they will understand. Don't use slang they are not familiar with or use medical terms they may not know.
- **PICTURES WORTH A 1000 WORDS**: If you are treating a patient who does not speak English or does not speak fluently, use pictures of items to communicate. (i.e. hygiene-use pictures of toothbrushes or hairbrushes and clothes to indicate the activities you will assist with next or have them indicate to you what they want)

WHAT YOU CAN DO TO SUPPORT PATIENT RIGHTS (cont'd)

- **INDEPENDENCE**: Be sure to encourage independence. Let the patient make the choices regarding their care. (i.e. if they are loosing weight and don't want to eat, don't pressure them, just be sure to document it)
  - Don't threaten your patient's to cooperate in any way. You may not enforce desired behavior by withholding other activities. (i.e. you can't say if you don't eat, bathe or take medications, you will not be allowed to go out later).
- **KEEP YOUR PATIENTS SAFE**: Always make sure to keep your patients safe from potential dangers. This includes reporting any violations of a patient's rights by a co-worker or superior. Always speak up for the patients who can't or won't speak for themselves. You must pay attention to your patients and ensure that their needs are being met. In most cases, you are the patient's first line of defense against abuse, neglect or other violations of the patient's rights from family members, friends or your coworkers.

GENERAL HEALTHCARE RESOURCES, INC.
The Professional Staffing Solution

SEXUAL HARASSMENT

GOAL

This training program will arm healthcare workers with the knowledge and responsibility to create an inclusive and respectful environment for all. They will also become aware of their rights and contacts should an incident arise during the course of their time working with General Healthcare Resources, Inc. They will also be equipped to assist a patient, at a facility, if the patient reports an incident that may qualify as sexual harassment.

OBJECTIVE

To ensure a respectful working environment for you and all people you encounter. We have outlined sexual harassment to inform you of the topic and what to do if you believe you are a victim of sexual harassment.

This training outlines the basics of Sexual Harassment and includes:

- Types of harassment and the behaviors associated with harassment
- Specific examples of harassment
- Guides to assist an you in knowing if your own behavior is sexual or unwanted
- What to do if the you believe you are a victim of sexual harassment

INTRODUCTION

Healthcare workers working with General Healthcare Rsources are required to review this training, as they are representatives of General Healthcare Resources. This means they share the responsibility to create a respectful environment for all, and they are entitled to a respectful environment.

Healthcare workers will be provided with basic information about this topic including: Basics, Types of Harassment, Behavior Associated with Harassment, Examples of Harassment and what is the Course of Action to take if they believe they have been a victim of sexual harassment.

SEXUAL HARASSMENT BASICS

- It's a form of sex discrimination.
- Anyone can be a victim of sexual harassment, and anybody can be a perpetrator. Sexual harassment victims can be male or female, and so can their harassers.
- A man can sexually harass another man, and a woman can sexually harass another woman.
- In the workplace, conduct would be considered sexual harassment if it's unwelcome, based on a person's sex, and interferes with that person's ability to do his or her job.
- The Equal Employment Opportunity (EEOC) Commission defines sexual harassment and accepts complaints of sexual harassment.

THE SEXUAL HARASSMENT BASICS

The Equal Employment Opportunity Commission's definition of sexual harassment includes unwelcome sexual advances, requests for sexual favors and other physical or verbal conduct of a sexual nature when it meets any of the following:

- Submission to such conduct is made either explicitly or implicitly a term or condition of an individual's employment status.
- Submission to, or rejection of, conduct is used as the basis for employment decisions affecting that individual.
- The conduct has the purpose or effect of unreasonably interfering with an individual's work or creates an intimidating, hostile or offensive environment for working, learning or living.

TWO BASIC TYPES OF UNLAWFUL SEXUAL HARASSMENT
Quid Pro Quo and Hostile Environment.
Both involve unwelcomed conduct of a sexual or gender related nature.

Quid Pro Quo
"Something for Something"

In work, it means asking for sexual favors of some kind in exchange for special treatment, or the threat of ill treatment if the victim will not consent to sexual favors.

- "Sexual conduct" may be verbal or physical, and the "asking" may be done either openly or implied but must be unwelcome.
- In either case, the harassment is unlawful whether or not the victim objects and then harmed in some way, or gives in so as to avoid the harm.
- Examples: A supervisor lets a subordinate know that he/she will be laid off or won't get a promotion unless he/she gives in to the supervisor's sexual advances.

Hostile Environment

In work, it takes place when speech or conduct of a sexual nature is so severe, persistent or pervasive that it interferes with the victim's performance, or creates an intimidating, hostile or offensive working environment. This includes intimidating or harassing conduct of a non-sexual nature that is directed at an individual (or group) because of his/her/their gender.

Examples:
- Talking about sex
- Using crude/offensive language
- Telling dirty jokes
- Unnecessary or inappropriate touching
- Showing sexual graphic pictures or materials
- Sexually suggestive gestures
- Giving or promising favorable treatment to those who consent to sexually related activities
- Sabotaging someone's work because of the person's gender
- Physically intimidating, like blocking someone's path

The conduct need not be sexual in nature. Sexual harassment means objectionable conduct directed at another person because of his or her gender (male or female). So conduct that isn't even sexual in nature may be considered sexual harassment if it's directed at a woman *because* she's a woman, or at a man *because* he's a man.

Examples:
- Several female employees sabotage a male co-worker's work because he is a man. Even though the behavior is not sexual, their acts constitute sexual harassment because their behavior is motivated by the victim's gender.
- A male employee constantly stares at a female employee for long periods while she is working. She tells him to stop, but he keeps staring. Even though the act of looking at someone is not sexual, unwelcome staring can be perceived as inappropriate if motivated by the victim's gender.

TYPES OF BEHAVIOR SURROUNDING HARASSMENT

Both involve unwelcomed conduct of a sexual or gender related nature.

What is UNWELCOMED BEHAVIOR?	Is the harasser's INTENT relevant?	CONSENSUAL RELATIONSHIPS
▪ The recipient did not ask for it, consent to it, or initiate it, particularly if he/she has indicated that the conduct is not wanted or that he/she finds it offensive. ▪ The fact that the victim has not complained does <u>not</u> necessarily mean the conduct is welcome. ▪ On the other hand, if the individual actively participates in sexual banter without giving any indication he/she finds it offensive, it will probably be considered welcome. But even where this may be happening keep in mind that some people may feel they have to "go along to get along" and, whether they say so or not, find it objectionable. ▪ Some sexual comments/advances are so blatant and crude as to be inherently offensive. These will almost always be deemed unwelcome.	▪ It doesn't matter whether the alleged harasser intended to harass the victim. The conduct is evaluated from the victim's perspective. Many offenders may be completely unaware of how their actions are being perceived. ▪ Example: Where the victim is female, courts apply a "reasonable woman standard", asking whether a reasonable woman would have found the conduct in question so severe and pervasive that it created a hostile environment.	▪ Consensual sexual relationships between co-workers often sour to the point where conduct once considered welcome becomes unwelcome. Both parties in a romantic relationship have the right to end it at any time, and to do so without fear of retaliation on the job. ▪ The second problem is that if those involved in a romantic relationship engage in behaviors in the workplace that create a hostile work environment for other third party employees. ▪ Romantic relationships raise concerns about favoritism and may be distracting to other employees, which may impact others in a negative way.

When does an ENVIRONMENT become HOSTILE?	Factors Relevant if Environment is Considered Hostile.
Conduct must be unwelcome and it must meet the following 2 requirements: ▪ Victim must have been personally offended by the conduct. ▪ Conduct must be so severe that any reasonable person would have found it offensive.	▪ Unwelcomed conduct - Frequency & Severity ▪ Was conduct physically threatening or humiliating or simply an offensive word? ▪ Did conduct unreasonably interfere with work? ▪ Was there an effect on the victim's physiological well-being?

SOME TYPES HARASSMENT

Sexual Harassment occurs in a variety of circumstances, not just male boss/female employee.

TO YOU – PERSONALLY

- You have experienced unwelcomed behavior. They can affect employment decisions or you might have disruptions in work because of it or a hostile environment.
- Example: Co-worker, supervisor or subordinate repeatedly asks for dates after you telling them no.

PEER TO PEER

- Sexual harassment between peers; usually involves people from unequal authority.
- It is normally easier to stop. Ask the person directly and clearly to stop the behavior. If it continues, you should report it to a supervisor so they may intervene.
- Example: A co-worker may make sexual jokes that make the other co-worker uncomfortable.

SUBORDINATE HARASSMENT OF A SUPERVISOR

- Not very common but just as serious.
- Harasser may be intimidating or victim is not able to exert his/her authority.
- If asked to stop and the behavior continues, seek supervisor assistance to intervene.
- Example: Subordinate makes Supervisor uncomfortable with explicit language.

SAME SEX HARASSMENT

- It does not have to be a member of the opposite sex to be harassment. Same sex harassment is illegal.
- Ask the harasser to stop the behavior. If it continues seek assistance through your supervisor to intervene.
- Example: One manager tells sexual jokes to another manager. After being asked to stop the joke telling, manager teases the target.

THIRD PARTY HARASSMENT

- Persons offended by a hostile work environment & aren't a direct participant or target.
- Critical factor of sexual harassment is whether it is unwelcome. The workplace isn't always a voluntary environment. Usually we work in close proximity to each other. If people are practicing uncomfortable behavior, a third person may be unable to avoid observing it.
- If you are in a 3rd Party Harassment situation, you should tell the individuals that you are not comfortable with their behavior. If the behavior continues, you should discuss this with your manager, so they may intervene.
- Example: Hearing telephone conversations about sex, etc.

MEN ARE HARASSED

- Men may play a subordinate role and become the target of harassment by a female or male superior.
- EEOC reported that in 2003 men reported approximately 14% of the harassment cases.

IS YOUR BEHAVIOR SEXUAL OR UNWANTED?

It is extremely important for you to be aware of your behavior and the possible impacts. Some individuals will let you know if they find your behavior offensive and would like it to stop. However, there are reasons why many individuals will not tell you that your behavior is sexual or unwanted.

Below are a few questions to ask yourself about your own behavior to determine if your conduct is sexual or unwanted. This will help you to ensure that you are not sending the wrong messages.

1. Regarding behavior: Is there a unbalanced level of initiation? If yes, your behavior may be unwelcome.
   Example: Do I put my arm around others or touch them in other ways but they don't do the same to me? Have I asked this person out many times but the person always declines and doesn't ask me out in return?
2. Would I do this to a person who is the gender opposite of those I am sexually attracted to? If no, this may very likely be sexual.
   Example: As a male sales associate, I massage my female co-worker's shoulders. Would I do it if my co-worker were male?
3. If this behavior were public, would I continue? If no, your behavior is very likely inappropriate.
   Example: If I was videotaped and it aired to the public, would I be embarrassed or uncomfortable?
4. When there is a difference in power, harassment is always possible. When I perform this behavior, am I engaged in an equal power relationship? If no, your behavior is very likely sexual.
   Example: Supervisor-employee, gender balance, seniority, etc.
5. When you perform this behavior, would you be comfortable continuing if your spouse or significant other were standing next to you? If no, your behavior is very likely inappropriate.
6. Would you want your child, sister, significant other, spouse, mother, father, grandmother, etc. to endure the behavior from someone? If no, your behavior is very likely to be inappropriate.

WHAT TO DO IF YOU ARE HARASSED?

- Don't take it. Tell someone.
- Speak with your Staffing Supervisor or Department Manager. If you are not comfortable doing so, please advise the Director of Human Resources.
- General Healthcare will investigate your complaint and take effective action to remedy the situation. The only individuals who will know about the situation are those who "need to know" to complete the investigation.
- You may also file a complaint with the U.S. Equal Employment Opportunity Commission (EEOC).
- General Healthcare Resources will not retaliate against you for filing a complaint. Action will be taken against anyone who does retaliate against you for filing a complaint.

THE REASONABLE PERSON STANDARD

- Used to determine if an unwelcome behavior of a sexual nature causes someone to take offense. It has risen out of attempts to interpret what behaviors should be considered sexual harassment. Many people perceive behaviors in different ways. The courts have stated that to be illegal the acts or behaviors must be severely or pervasively offensive to a reasonable person in similar circumstances.
- A one time unwelcome behavior will seldom qualify as sexual harassment unless it is sufficiently severe according to the reasonable person standard.

GENERAL HEALTHCARE RESOURCES, INC.
The Professional Staffing Solution

TUBERCULOSIS

GOAL

This training program is designed to educate healthcare workers on the healthcare issue of Tuberculosis (TB). This program reviews: The history, classifications, high risk contracts, symptoms, diagnosis, transmissions, treatments, transmission preventions, infectiousness, contact investigations and confidentiality.

OBJECTIVE

By working through this manual, you will be able to recognize the risks involved with Tuberculosis and how they can better protect themselves and assist in controlling the disease.

INTRODUCTION

Healthcare workers are working in "high risk" settings everyday, in which the Tuberculosis threat is great. Healthcare worker need to be educated to be able to properly protect themselves and others from the disease. In addition, healthcare workers need to assist in the containments of the disease in order to decrease the number of cases in the U.S.

Personal Protection Equipment & Systems to prevent TB Transmission

The following equipment and devises are designed to reduce your exposure to possible TB disease or infection. They will also assist in containing the spread of TB.

Personal Masks and Personal Respirators: **NIOSH-certified N95 HEPA respirators** are recommended. They should be worn when dealing with diseased patients to prevent infection. Surgical masks are INEFFECTIVE; they can only be used on the patient when a worker is transporting a patient out of an Isolation Room.

Isolation Rooms: **Patient Isolation, Respiratory Isolation or AFB** (Acid Fast Bacilli) **Isolation** are specific areas used when a patient is suspected as possibly carrying active TB and pose a threat to others around them.

Effective Ventilation: Exhaust fans in an institution where a worker may be exposed. Hospitals maintain negative pressure in Isolation Rooms to minimize the risk to other rooms. Clean air is drawn in from the outside while a window or door is opening. No air escapes. The fans move all airborne particles after the patient leaves the booth and before another person goes into the booth. HEPA filters are used to trap 99.97% of the particles that are larger than .3 micron.

VOCABULARY

Acid-fast bacilli (AFB) - mycobacteria stained after washed in an acid solution; may be detected under a microscope in stained smear
Active case finding – identifying unreported TB cases through lab & pharmacy audits, etc.
Adherence agreement – written understanding between healthcare worker and patient; indicates activities they both agree to carry out; for some, this written commitment increases the adherence
Adherence plan – plan based on patient's understanding & acceptance of TB diagnosis; addresses adherence barriers, details delivery method and treatment, and monitors adherence of patient
Adherence to treatment - following recommended treatment and taking all medications in entirety
Adverse reaction - negative side effects resulting from a drug (i.e. hepatitis, nausea, and headache)
AFB logbook – logbook kept in the mycobacteriology lab containing results of acid-fast bacilli (AFB) smear examinations; it may be called a smear mycobacteriology log
AIDS – acquired immunodeficiency syndrome; immune system is weak and less able to fight some infections and diseases; caused by infection with the human immunodeficiency virus (HIV)
Alveoli – air sacs of lungs at the end of airway; TB infection begins with a droplet nuclei reaching sacs
Anergy - inability to react to a skin test because of a weakened immune system, often caused by HIV infection or severe illness
Anergy testing - skin tests; use 2 substances (not tuberculin); people with no reaction to substances, including tuberculin, after 48 to 72 hrs (less than 3 millimeters of induration)
Bacteriologic examination - tests done in a mycobacteriology laboratory to diagnose TB disease; includes exam of a specimen under a microscope, culturing and doing drug susceptibility testing
Baseline skin test - tuberculin skin test given to employees or residents in certain facilities when they start their job or enter the facility (see **TB screening program** and **two-step testing**)
BCG - Bacille Calmette-Guérin, a vaccine for TB disease that is used in many countries but rarely used in the United States; may cause a false-positive reaction to the tuberculin skin test
Boosted reaction - positive reaction to TB skin test, due to boosted immune response from skin test given up to 1 yr earlier; occurs in those who were infected a long time ago & ability to react to tuberculin lessened; two-step used to tell between boosted reactions and recent infection reactions.
Booster phenomenon – skin tested years after infected with *M. tuberculosis* may have negative reaction to initial skin test, then a positive reaction to skin tests given up to one year later; the first test boosts immune response; two-step testing differentiates between boosted & recent infection reactions
Bronchoscopy - procedure to obtain pulmonary secretions or lung tissue with a bronchoscope; it is used when patients can't cough up sputum on their own and an induced specimen can't be obtained
Clinic-based DOT – directly observed therapy delivered in a TB clinic or comparable facility
Close contact –anyone with prolonged, frequent, or intense contact with an infectious TB person; close contacts are more likely to become infected with *M. tuberculosis* than others not close
Combined pill – fixed-dose combination capsule or tablet; may enhance adherence; in the US, FDA licensed isoniazid and rifampin (Rifamate) and of isoniazid, rifampin, and pyrazinamide (Rifater)
Concentric circle approach – contacts tested in order of exposure time and risk; close contacts and high-risk people tested first; includes contacts from contact environment (household or residential, etc)
Contact investigation – procedure to identify those exposed to someone with infectious TB, evaluating for latent TB infection (LTBI) TB disease, and providing treatment for LTBI or TB disease
Continuation phase - period after 1st 8 weeks of treatment, when tubercle bacilli remaining after the initial phase are killed
Cough-inducing procedures - procedures to make a patient cough, such as sputum induction, bronchoscopy, and the administration of aerosolized pentamidine
Court-ordered DOT – Directly Observed Therapy administered by order of a public health official or court with authority; used when patients are nonadherent despite best efforts of TB program staff
Diabetes mellitus – disease where body's sugar usage ability is weakened
Diagnostic evaluation - used to diagnose TB disease; includes medical history, chest x-ray, collection of specimens for bacteriologic exam, and possibly a tuberculin skin test
Directly observed therapy (DOT) - strategy devised to help patients adhere to treatment; a healthcare worker or another person watches the TB patient swallow each dose of the prescribed drugs
Directly observed therapy for latent TB infection (LTBI) – strategy which helps patients at high risk of developing TB disease stick to treatment for LTBI; person watched swallowing each dose
Droplet nuclei – small droplets (1 to 5 microns in diameter) expelled when a person who has infectious TB coughs or sneezes; can remain suspended in air for hours depending on environment
Drug susceptibility pattern - drugs to which tubercle bacilli is susceptible & it is resistant
Engineering controls - systems to prevent transmission of TB in healthcare facilities, includes ventilation, high-efficiency particulate air (HEPA) filtration, and ultraviolet germicidal irradiation
Erythema - redness around the injection site when a Mantoux skin test is done; erythema is not considered when the reaction size is measured because redness doesn't indicate a TB infection
Ethambutol - drug used to treat TB disease; may cause vision problems; shouldn't be given to children who are too young to be monitored for vision changes
Exposure to TB – time spent with or near someone with infectious TB disease
Extrapulmonary TB – TB disease that occurs in places other than the lungs, such as the lymph nodes, pleura, brain, kidneys, or bones; most types of extrapulmonary TB are not infectious
False-negative reaction - negative reaction to tuberculin skin test in a person who has TB infection; anergy, recent infection (within the past 10 weeks), or young age (younger than 6 months old)
False-positive reaction - positive reaction to TB skin test in a person who does not have TB infection; may be caused by infection with nontuberculous mycobacteria or a vaccination with BCG
Field-based DOT – DOT delivered in a setting outside the TB clinic or facility; possible sites for field DOT include a doctor's office, patient's home, workplace, school, public park, or restaurant
Field investigation –visiting home, shelter, workplace, etc where patient said he/she spent time while infectious; identify contacts and evaluate environmental characteristics in which exposure occurred
First-line TB drugs – initial drugs used for treating TB disease; include isoniazid (INH), rifampin (RIF), pyrazinamide (PZA), and either ethambutol (EMB) or streptomycin (SM)
Gastric washing - procedure done by inserting a tube through the nose and passing into the stomach; may be useful for obtaining sputum from children who produce little or no sputum with cough
Healthcare worker – any health professional who cares for and manages a TB patient, including physicians, nurses, outreach workers, hospital discharge planners, pharmacists, and social workers

VOCABULARY - continued

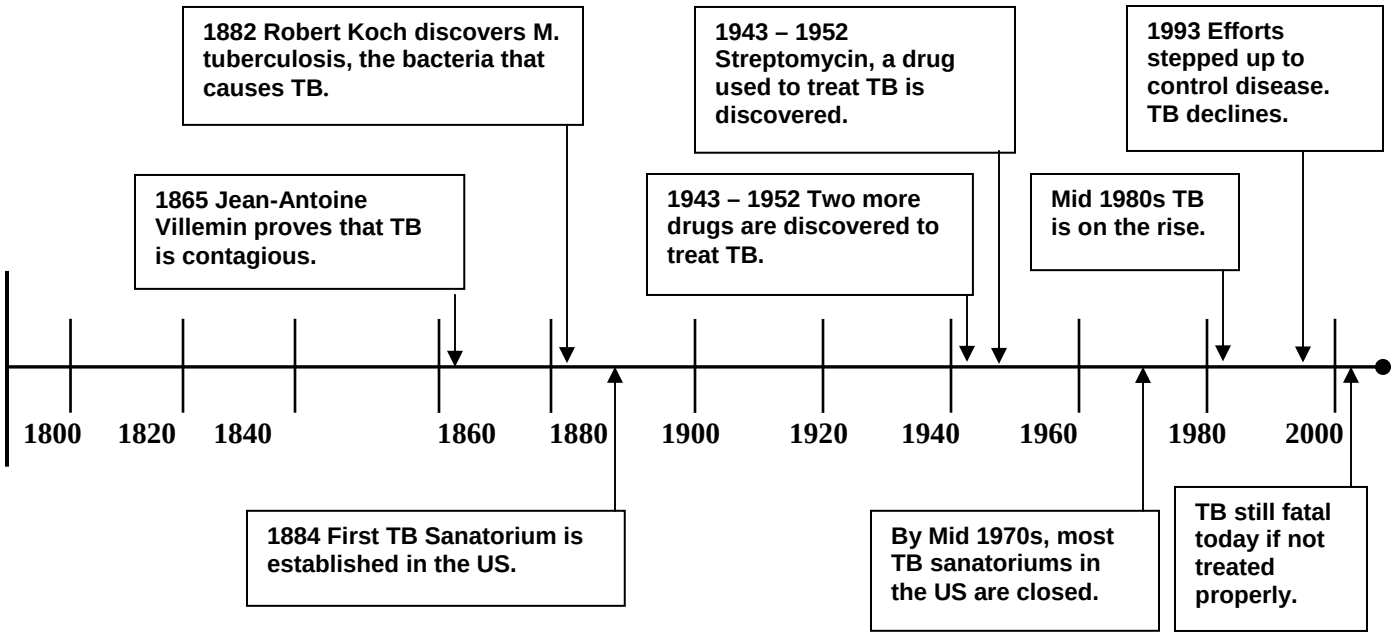
HEPA filters - special filter used in ventilation systems to help remove droplet nuclei from the air
Hepatitis - damage to the liver, causing nausea, vomiting, abdominal pain, fatigue, & dark urine; several drugs used to treat TB infection or disease can cause hepatitis
High-priority contacts – contacts at most risk for TB infection or disease; contacts most likely to be infected and high-risk contacts
High-risk contacts – Contacts at high risk of developing TB if they become infected with *M. tuberculosis* (children 0-4 yrs, HIV & other immunosuppressed persons, and some medical conditions)
HIV – human immunodeficiency virus, the virus that causes AIDS
Index patient – person with suspected or confirmed TB disease who is the initial case reported to the health department; the index case may or may not be the source case (see source patient)
Induced sputum - sputum obtained by having patients inhale a saline (salt water) mist, causing a deep cough; the procedure is used to help patients cough up sputum if they can't on their own
Induration - swelling that can be felt around the site of injection after a Mantoux skin test is done; reaction size is the diameter of the swollen area (excluding redness) measured across the forearm
Infection control practitioner – trained healthcare professional responsible for controlling and preventing the spread of infectious diseases in a hospital or other healthcare setting
Infection rate – percentage of contacts with similar exposure (e.g., close, other-than-close) that have a newly identified positive skin test reaction (5 or more millimeters of induration)
Infectious – capable of spreading infection; a person who has infectious TB disease expels droplets containing *M. tuberculosis* into the air when he or she coughs or sneezes
Infiltrate - collection of fluid and cells in lung tissues; visible on chest x-ray of pulmonary TB disease
Initial phase - the first 8 weeks of treatment, during which most of the tubercle bacilli are killed
Intermittent regimen - treatment schedule; patient takes prescribed medication 2 or 3 times weekly at the appropriate dosage
Isolate - a group of organisms separated, from a specimen; in a *M. tuberculosis* isolate, the organisms have been identified as *M. tuberculosis* (a positive culture for *M. tuberculosis*)
Isolation room - room with characteristics to prevent the spread of droplet nuclei by a TB patient
Isoniazid - drug most often used for preventive therapy and also used to treat TB disease; although relatively safe, it may cause hepatitis and other adverse reactions in some patients
Latent TB infection (LTBI) – TB infection; those with latent TB infection carry organism causing TB but don't have disease, are asymptomatic, noninfectious & usually positively react to skin test
Liver function tests - tests done to detect damage to the liver
Military TB – TB disease occurring when tubercle bacilli enter blood and go to body parts; it grows & causes disease in multiple sites; chest x-ray looks like millet seeds scattered throughout lung
Multidrug-resistant TB (MDR TB) - TB resistant to isoniazid and rifampin; more difficult to treat than drug-susceptible TB
Multiple-puncture test - TB test; punctures forearm skin with short prongs or tines to inject tuberculin (tine test); easy and convenient but aren't accurate and shouldn't determine TB infection
Mycobacteria – a kind of bacteria; mycobacteria can cause a variety of diseases
Mycobacteriology laboratory - lab dealing specifically with *M. tuberculosis* & other mycobacteria
Mycobacterium africanum – a type of tuberculous mycobacteria, closely related to *M. tuberculosis*, that can cause a disease similar to TB in humans; it is very rare in the US
***Mycobacterium avium* complex** – type of nontuberculous mycobacteria; can cause disease in humans
Mycobacterium bovis – type tuberculous mycobacteria causing similar TB in cows; before milk pasteurization, mycobacteria spread through milk; in US now, *M bovis* rarely affects humans
Mycobacterium tuberculosis – organism causing TB (humans); AKA tubercle bacillus; belongs to Mycobacteria, a bacteria group
Negative pressure - ventilation system designed so air flows from the corridors into an isolation room, ensuring contaminated air cannot escape from the isolation room to other parts of the facility
Nonadherence – inability or refusal to take TB drugs as prescribed
Nontuberculous mycobacterium – doesn't cause TB disease and not usually spread from one to another; example is *M. avium* complex
Other-than-close contacts – contacts with less intense and frequent, or shorter durations of contact to the TB patient than close contacts
Period of infectiousness – time during which a person with TB disease is capable of transmitting *M. tuberculosis*; usually estimated by determining the date of symptom onset, especially coughing
Peripheral neuropathy - damage to sensory nerves of hands and feet, causes tingling or a weakened sense of touch in hands and feet
Personal respirators - masks designed to filter droplet nuclei; used everywhere TB may be spread
PPD skin test - a tuberculin skin test
Preventive therapy - medication given to those with TB infection to prevent developing TB disease
Purified protein derivative (PPD) - the type of tuberculin used in the Mantoux skin test
Pulmonary TB – TB disease occurring in the lungs (about 85% of all US cases), typically causing a cough and an abnormal chest x-ray; pulmonary TB is usually infectious if untreated
pyrazinamide - drug to treat TB disease, usually initial treatment phase; shouldn't be given to pregnant women
Resistant - able to grow in the presence of a particular drug
Rifampin - drug to treat TB; preventive therapy with positive skin test reaction of those who have been exposed to isoniazid-resistant TB; side effects: hepatitis, body fluids orange, and drug interactions
Secondary case – contact who developed TB disease as a result of transmission from index patient
Second-line TB drugs – drugs used to treat TB that is resistant to first-line TB drugs (for example, capreomycin, kanamycin, ethionamide, cycloserine, ciprofloxacin, amikacin)
Silicosis – lung disease caused by inhaling silica dust; used in glass and ceramics; occurs often in mining and foundry workers
Skin test conversion - a change in a skin test reaction from negative to positive between screening intervals
Skin test conversion for contacts –different from standard skin test; change from less than 5 mm on 1st skin test to a reaction of greater than or equal to 5 mm on the 2nd, 10-12 weeks post exposure
Source case investigation – find source when recent transmission likely; determine: who transmitted to index patient, child or person in cluster of skin test conversions, is person infectious, was case reported to health department, and were others infected

VOCABULARY - continued

Source patient – person with infectious TB disease transmitting *M. tuberculosis* to others; identified through a contact or source case investigation and may or may not be the index patient
Sputum - phlegm from deep in the lungs, collected in a sterile container for processing and exam
Streptomycin - drug to treat TB; may cause hearing problems; shouldn't be given to pregnant women.
Susceptible - able to be killed by a particular drug
Symptoms of TB disease – generally weight loss, fatigue, malaise, fever and night sweats. pulmonary: coughing, chest pain breathing or coughing & coughing sputum or blood; extrapulmonary: depends on body part affected
TB screening program - employees and residents of a facility periodically given skin tests; identifies people who have TB infection, disease and determines whether TB is being transmitted in the facility
Transmission – the spread of an organism, such as *M. tuberculosis*, from one to another; depends on the contagiousness of the patient, type of environment, and length of exposure
Treatment for LTBI – medication given to prevent latent TB infection developing into TB disease
Tubercle bacilli – another name for *Mycobacterium tuberculosis* organisms that cause TB disease
Tuberculin - protein from tubercle bacilli that has been killed by heating; used to see if person has TB infection; not a vaccine
Tuberculin skin test – test to detect TB infection
Tuberculin unit - standard strength of tuberculin used in the US and Canada; strength - 5 tuberculin units used for Mantoux TB skin test

Tuberculosis mycobacteria –can cause TB disease or other diseases very similar to TB; the tuberculous mycobacteria are *M. tuberculosis*, *M. bovis*, and *M. africanum*
Two-step testing - strategy in TB screening to distinguish boosted reactions (caused by TB infection many years before) from recent infection reaction; if a negative reaction to an initial skin test, a second test is given 1-3 weeks later; a positive reaction to 2nd test probably represents a boosted reaction, not recent infection; two-steps are used in many TB screening programs when beginning a job
Ultraviolet germicidal irradiation - lamps that give off ultraviolet light, killing tubercle bacilli contained in droplet nuclei
Ventilation systems - air systems designed to maintain negative pressure and exhaust air properly; designed to minimize the spread of TB in a health care facility
Window period – time span between date of initial TB skin test with negative reaction and date of follow-up tuberculin skin test that should take place 10 to 12 weeks after exposure; after window ends, a repeat skin test should be administered to each contact that had an initial negative reaction
Window period prophylaxis – practice of providing treatment for latent TB infection to high-risk contacts with initial negative skin test reaction less than 10-12 weeks after exposure; if contact has a negative skin test after window period, treatment for latent TB infection is usually stopped

TUBERCULOSIS MAJOR EVENT HISTORY



TUBERCULOSIS SUMMARY

Tuberculosis is a disease caused by bacteria known as ***Mycobacterium tuberculosis***. (***M.tuberculosis*** is sometimes called tubercle bacilli). It is spread through the air from person to person. Tuberculosis used to be the leading cause of death in the US. The types of tuberculosis are based on the location of the tuberculosis. The types of TB are:

- ***Pulmonary TB*** – TB affecting the lungs
- ***Extrapulmonary TB*** – TB affecting any body part
- ***Military TB*** – enters the blood and travels to all parts, grows and causes disease at multiple sites
- ***Drug Resistant TB*** – strain of TB that is resistant to the usual drugs to treat TB

Those ***infected*** with TB don't feel sick; they have symptoms and can't spread TB but they may develop the disease in the future. If infected they can be treated and cured. Also, they can take medication, so they never develop the disease.

TUBERCULOSIS INFECTION

People who are exposed to TB and breathe in the bacteria become infected, but the body is able to fight the bacteria and stop it from growing. Infection begins when the tubercle bacilli multiply in the ***alveoli***, small air sacs of the lungs. A small number enter the blood and spread but the body's immune system usually keeps the bacilli under control. The bacteria are inactive but remain alive and can become active.

- They don't have symptoms or feel sick
- They can't spread it
- Skin test is POSITIVE
- Can develop TB disease if no ***preventative therapy*** received

Most people with the infection stage never develop the disease. However, in those with weak immune systems, the bacteria can become active and cause the disease.

TUBERCULOSIS DISEASE

The TB bacteria are active if the immune system can't stop it. It multiplies. Some develop the disease soon after infection, before the immune system can fight it. Others develop it later, when the immune system weakens. Those with weak immune systems include:

- Babies and young children
- HIV positive individuals
- Substance abusers

Those with certain conditions have weak immune systems:

- Diabetes Mellitus
- Silicosis
- Cancer of the head or neck
- Leukemia or Hodgkin's disease
- Sever kidney disease
- Low body weight
- Certain medical treatments. (Corticosteriod or organ transplants.)

MULTI-DRUG RESISTANT TUBERCULOSIS

This strain of TB developed over the years that have become resistant to many drugs used to treat TB. They are hazardous because there is a delay in recognizing that patients have it and they can remain infectious, until diagnosed.

The ***Multi-Drug Resistant TB*** can develop if:

1. Medications are taken erratically and patients aren't following the prescribed regimen because:
   - They may start to feel better long before treatment is done. The length of drug treatment is 6-9 months and can be as long as 2 years in drug resistant cases.
   - Side effects are too much.
   - The cost of the healthcare.
   - Some are transient.
2. Drugs or dosages are not appropriate.
3. TB infection came from someone with Multi-Drug Resistant TB.

Stopping Multi-Drug Resistant Tuberculosis:

- Patients participate in preventing general transmission of TB so Multi-Drug Resistant TB can't be passed to others.
- Gene research has identified a gene linked to Isoniazid resistance. (Isoniazid and ***Rifampin*** are 2 of the most effective drugs used to treat TB.)
- It is very important for the patients to be educated. They must understand and must follow the directions for drug treatment fully.
- Observed Therapy – Patients are observed taking the medication, as prescribed, to ensure compliance.

WHO ARE "HIGH RISK" CONTACTS

TB EXPOSURE OR INFECTION – HIGHER RISK CONTACTS

- ***Close contacts:*** Anyone who spent time with someone with infectious TB disease. They are at high risk of being infected with M. tuberculosis.
- ***Racial and Ethnic Minorities:*** In 1997, more than 75% of the TB cases reported in the US were in racial and ethnic minorities. In 1997, 33.3% were made upon Non-Hispanic blacks, 24.5 % white, Non-Hispanic, 21.3% Hispanic, 19.3% Asian or Pacific Islander, 1.3% American Indian, Alaskan Native, .2% Unknown. A major reason for these rates may be a greater proportion of people in the groups have other risk factors for TB. They include birth in a country where TB is common, HIV infection, low socioeconomic status. (i.e. low level of employment or income) and exposure to TB in a high-risk setting.
- ***Foreign-Born Persons:*** Of all TB cases reported to CDC in 1997, 39% were in foreign-born persons. Many entering the US aren't screened for the disease: students, tourists and undocumented illegal aliens. Others are screened upon applying for immigration or refugee status. Those tested, if positive are required to receive treatment before entering. However, some have the disease but aren't infectious at the time and don't have the disease but can become infectious for months or years after entering.
- ***Elderly:*** Many were exposed to and infected with M. tuberculosis at a young age (TB was common). With cases reported in 1997, 24% were 65 years of age or older. Those in nursing homes are at a higher risk due to special settings.
- ***Low Income:*** From 1985 – 1992, the average rate of TB cases was almost 8 times higher in areas with the lowest household income than areas with the highest. The reasons for this aren't entirely clear, but some possible ones are crowding, inadequate living conditions, malnutrition and poor access to healthcare.
- ***Homeless People:*** In 1997, about 7% of TB patients were homeless. Some reasons of disease after infection include: malnutrition and poor access to healthcare. Some areas might be more likely to be infected with HIV.
- ***Those Injecting Illicit Drugs:*** They are more likely to be exposed or infected with M. tuberculosis. A large portion have risk factors for exposure (lower-income and poor access to healthcare). They are also at a high risk of developing TB disease once infected because they are more likely to be HIV infected and have weakened immune systems.
- ***Special Settings:*** In certain settings the risk of being exposed to TB is higher than in others. Many people in these facilities are at risk for TB. The risk of exposure is higher if the facility is crowded. Such settings include: Healthcare facilities, Nursing Homes, Correctional Facilities, Homeless Shelters and Drug Treatment Facilities.

TB DISEASE DEVELOPMENT - HIGHER RISK CONTACTS

- Those with AIDS.
- Those with HIV infections.
- People with medical conditions appearing to increase the risk; diabetes mellitus, silicosis, prolonged therapy corticosteroids, immunosuppressive therapy, certain cancers, kidney disease, certain intestinal conditions and low body weight (10% below ideal weight).
- Those recently infected with M. tuberculosis (within 2 years) are the highest at risk to develop the disease. After the 2 years the chances drop but are still present.
- Chest x-rays with findings suggesting previous TB.
- Those who inject illicit drugs.

TB TRANSMISSION, SYMPTOMS, INFECTION, DISEASE DIAGNOSIS

TRANSMISSION

- TB is spread through the air from one person to another via droplet nuclei.
- It is expelled into the air when a person with the disease of the lungs coughs or sneezes.
- Droplets are projected into the air and are suspended.
- People in the area may breathe in the infected air.
- TB occurring in other parts of the body, (i.e. spine, kidneys are usually not infectious).
- **Commonly, TB is transmitted when healthcare workers and patient come in contact with those who have unsuspected TB disease and aren't receiving adequate treatment and have not been isolated**.

DISEASE SYMPTOMS

Can depend on the body part where the TB bacteria is growing. It usually grows in the lungs. If so, the symptoms include:

- A persistent cough that lasts longer than 2 weeks
- Coughing up blood or ***sputum*** (phlegm from deep in the lungs)
- Pain in the chest
- Weakness or fatigue
- Weight loss
- No appetite
- Chills
- Fever
- Night sweats

TB INFECTION DIAGNOSIS

A *TB skin test* used to determine if a person has TB infection. *Mantoux tuberculin skin test* is the preferred method because it is the most accurate. A needle and syringe are used to inject *tuberculin* between the layers of skin of the forearm (usually). The site is evaluated after 48-72 hours for a reaction. The *induration* (swelling) is measured on a scale, not the redness. ***Two-Step Testing*** **is preferred for healthcare employees when they start a job because it can tell the difference between *boosted reactions* and those caused by recent infection reaction. They are then screened yearly thereafter.**

TB DISEASE DIAGNOSIS

These are the **four steps in diagnosing TB Disease**:

1. **MEDICAL HISTORY**: Asking patient about possible exposure and infections, assessing risk factors, watching for symptoms of the disease.
2. **TUBERCULIN SKIN TEST**: They should continue to be evaluated for the disease during skin waiting period or regardless of test reading.
3. **CHEST X-RAY**: Assists in ruling out Pulmonary TB Disease. They can also check lung abnormalities for those who have the symptoms of the disease. However, X-RAYS CANNOT CONFIRM THAT A PERSON HAS TB DISEASE.
4. **BACTERIOLOGIC EXAMINATION**: A specimen is obtained from the patient if they are suspected to have Pulmonary Disease. The specimen is cultured or grown to determine if it contains M. tuberculosis. A POSITIVE CULTURE CONFIRMS TB DISEASE DIAGNOSIS. After the specimen has been cultured it is tested for drug susceptibility. This aids in determining which drugs will work best for the patient.

What are False-Negative Reactions?

Some people may not react to the two-step testing even though they are infected with *M. tuberculosis*. The causes of these false-negative reactions may include, but are not limited to, the following:

- Cutaneous anergy
- Recent TB infection (within 10-12 weeks of exposure)
- Very old TB infection (many years)
- Very young (less than 6 months old)
- Recent live-virus vaccination (e.g. measles and smallpox)
- Overwhelming TB disease
- Some viral illnesses (e.g. measles and chicken pox)
- Incorrect method of two-step administration
- Incorrect interpretation of reaction

What are False-Positive Reactions?

Some people may react to the two-step testing even though they are not infected with *M. tuberculosis*. The causes of these false-positive reactions may include, but are not limited to, the following:

- Infection with nontuberculosis mycobacteria
- Previous BCG vaccination
- Incorrect method of two-step administration
- Incorrect interpretation of reaction
- Incorrect bottle of antigen used

TB TREATMENT, TREATMENT RESPONSE & CONFIDENTIALITY

TREATMENT

Preventative Therapy (PT) medication is given to those who have the infection to prevent the disease from developing.

PT is given to high risk people and others with positive skin test reactions, younger than 35 and those who have negative skin test reactions who have been exposed. People suspected of having the disease or who have been adequately treated for TB infection or disease should not get preventative therapy.

Patients are evaluated monthly for adverse reactions are before starting treatments. (Obtaining baseline to detect any abnormalities that may interfere with treatment.)

Patients receiving treatment are evaluated every month for signs of hepatitis and other reactions to the ***isoniazid***. Those with great risk for hepatitis should have ***liver function tests*** before starting the isoniazid preventative therapy.

Using only drug treatments of TB disease or patient non-adherence can create drug resistance.

Daily and intermittent regimens are reserved for children with certain types of Extrapulmonary TB, pregnant women and people with drug resistant TB. The treatment may last longer or involve different schedules.

Direct Observed Therapy (DOT) – Someone designated to observe patients taking every medication to ensure absolute adherence.

TREATMENT RESPONSE

To find out if the patients are responding, bacteriologic evaluation should be completed during the treatment. Patients who show the following should be reevaluated carefully:

- Symptoms don't improve during the 1st 2 months of treatment.
- Symptoms become worse after an initial improvement period.
- Cultures are still positive after 2 months of treatment.
- Culture results become positive after they were negative, during treatment period.

In some cases, X-rays can be used to monitor the patients' response to the current treatment.

CONFIDENTIALITY

A patient can ignore a doctor's advice or refuse treatment. However, a patient with infectious TB may lose that right if officials believe there is a risk of infecting others. If the patient continues to disregard medical advice or is unable to adhere to treatment, he/she may be required by law to do so. If the patient doesn't adhere to DOT voluntarily, he/she may be ordered to do so, by a health official or a court (***Court-ordered DOT***).

Healthcare workers have a responsibility to protect patients' confidentiality. However, healthcare workers may have to override these rights in some cases, ONLY IN THE INTEREST OF PROTECTING THE PUBLIC'S HEATLH. Some patients with TB disease have their rights limited, until they are no longer infectious. No one else may be physically harmed by the patients' actions or decisions.

TB is considered a significant threat to the public's health. The disclosure of patient information to applicable individuals is allowed for the purpose of TB control.

If a patient travels or moves, the health department of the home jurisdiction should notify the receiving health department. As much information as possible is relayed between the jurisdictions, within limits of current laws and regulations regarding confidentiality of the patient.

PREVENTING TB TRANSMISSION

Goals of TB Prevention & Control Programs

- Identify and treat persons with active TB disease.
- Identify and evaluate exposed contacts and offer appropriate treatment.
- Test high risk individuals for infection and disease.
- Provide treatment for Latent TB Infection (LTBI) to prevent active TB.

Every healthcare facility must have an action plan suited to the environment to maximize the safety of their staff and patients. The CDC recommends the following actions to protect individuals:

High Risk Patient Screening

- You must assess if the person qualifies for this category for exposure, infection and/or TB disease. The Mantoux skin test is the most common with suspected infection.

Appropriate Therapy

- It is most important to implement the accurate anti-TB therapy to cure the disease. This will reduce the cough and therefore the projected droplets nuclei.

Reducing the Possible Air Contamination

- Patients must cover their mouths with tissues when coughing or sneezing.
- **Isolation Rooms:** "Patient Isolation", "Respiratory Isolation", or AFB Isolation (Acid Fast Bacilli).
- **Effective Ventilation**: Exhaust fans in any institution where a worker may come into contact with the airborne TB bacteria. Hospitals maintain negative pressure in isolation rooms to minimize risk in other rooms. Clean air is drawn into the rooms from outside when a door or window is opening. No air escapes. They use powerful exhausts in booths designed for cough producing procedure (administer aerosolized medications and sputum induction). The fans can move all airborne particles after the patient leaves the booth and before the next one goes into it. The air cannot go outside. HEPA filters are used to trap 99.97% of particles > .3micron. (supplemental)
- **Masks and Personal Respirators**: NIOSH-certified N95 HEPA respirators are recommended. (NIOSH-cert N95). N=Not resistant to oil. 95% = efficiency. They should be worn when dealing with diseased patients to prevent infection. **Surgical masks are ineffective** because they don't form an adequate seal around the face and can't filter droplet nuclei. They can be used on the patients when a worker is transporting a TB patient out of the isolation room.

Screen Healthcare Personnel Regularly

- Personnel are tested every year in any environment where TB might be seen or treated.
- Tested every 6 months in high-risk settings when higher numbers of positive skin tests or skin test conversions are present among the staff.

Patient Education and Communication

- Communication is essential for patients and the workers who care for them.
- The patients are more likely to adhere to the treatment plan if they understand their illness, what to expect and believe in the benefits of treatment. It is the responsibility of both the patient AND healthcare worker for adherence. Patients' decisions are often reflective on how much help they get from healthcare workers.
- Avoids others exposed to TB.
- Serious complications can re-hospitalize patients. They may develop multi-drug resistant TB.

Investigate - Control Outbreaks

- Consult a physician experienced with TB. You will receive a skin test. (You will need a 2nd test 10 weeks post infection, since the immune system can take several weeks to react after infection). If positive, will test further with chest x-ray and phlegm tests for the lungs and blood or urine for other tests, since the infection can be anywhere in the body.
- Receive and adhere to the appropriate preventative therapy.
- Actively prevent possible TB transmissions.

Rapid diagnosis of Active TB Disease

- Absolutely necessary. Infection can spread the disease during the time it takes to diagnosis it.

Special Consideration: Children

- The transmission was relatively recent.
- Person transmitting could still be infectious.
- Other adults and children in household and community have been exposed and if they are infected, they may develop disease in the future.

INFECTIOUSNESS

The infectiousness level of a TB patient will vary. The levels are related to the number of tubercle bacilli and what the patient expels into the air. Patients expelling more tubercle bacilli are more infectious. Those expelling less are less infectious.

Patients are more likely to be infectious when:

- They have TB of the lungs or larynx.
- They have a cavity in the lung.
- They are coughing or receiving ***cough-inducing procedures***.
- They do not cover their mouth when coughing.
- They have acid-fast bacilli on their sputum smear.
- They are not receiving adequate treatment.

Decreasing Infectiousness

Infectiousness appears to decline quickly after treatment begins but this can vary from patient to patient. These are some signs of decreasing infectiousness:

- Receiving treatment for 2-3 weeks.
- Symptoms have improved. (Coughing less or fever is reducing).
- 3 Consecutive negative sputum smears from collections on different days.

When showing signs of TB Disease:

- The patient should be isolated immediately away from others. (In hospitals, use isolation rooms).
- The patient should get a diagnostic evaluation immediately.

Infection control programs are used to detect TB disease early, isolate, and quickly treat those with the disease. The control programs are made up of 3 controls: Administrative, Personal Respiratory Protection and Education and TB screening.

Engineering controls consist of the following in healthcare facilities:

- Ventilation systems.
- HEPA filtration and UVGI (ultraviolet germicidal irradiation). These 2 are used in conjunction with other measures and are never used alone.

When administrative and engineering controls are not fully protecting the worker from infectious droplet nuclei, the worker should use personal respirators to filter out droplet nuclei.

CONTACT INVESTIGATION

When ARE Investigations Performed

- High clinical suspicion of TB
- AFB sputum negative smear appears (to ensure low risk of transmission)
- A young child has TB (find source)
- A severely immunosuppressed person doesn't have a known history of TB infection but has the disease (find source)
- Clusters of TB skin test conversions are found at high risk facilities

When AREN'T Investigations Performed

- Extrapulmonary TB; it doesn't carry transmission risks
- Those with diseases caused by NON-tuberculosis mycobacteria only (i.e. Mavium complex)
- Young children; they are rarely infectious.

Investigation Procedure

- Identifies people exposed to someone with infectious TB
- Evaluates people for Latent TB infection (LTBI) and TB disease
- Provides appropriate treatment for those with LTBI and TB disease

Investigations Involve

- Medial record review
- Patient interview
- Field investigation
- Risk assessment for TB transmission
- Decision about priority of contacts
- Evaluation of contacts
- Treatment and follow-up for contacts
- Decision about whether to expand the testing series
- Evaluation of contact investigation activities

It is important to find the contacts with TB disease or LTBI so they can be given treatment. It is also important to find those at a high risk of developing the TB disease and may need treatment for LTBI until it is clear whether they have TB infection.

GENERAL HEALTHCARE RESOURCES, INC.
The Professional Staffing Solution

WORKPLACE VIOLENCE

GOAL

This training program is to increase the healthcare worker's awareness of the risk factors for violence in healthcare settings and to provide strategies for reducing exposure to these factors and to limit the amount of violent incidents present among healthcare workers.

OBJECTIVE

You will learn to define the factors contributing to workplace violence, where the violence occurs, effects of violence, how to best handle stressful situations and the profiles of perpetrators and victims.

INTRODUCTION

According to the Department of Justice, the workplace is the most dangerous place to be in America. The CDC (Center for Disease Control) has classified workplace violence as a National Epidemic. Healthcare workers are becoming the targets of workplace violence. Healthcare workers must become aware of their environments and the people around them so they may properly ensure their safety.

Workplace homicide is the fastest growing category of murder in the US and is now the leading job-related death for women and the 2nd leading cause for men. The real danger is the amount of physical and verbal violence that occurs. Only .1% of the average 1 million reported incidents per year resulted in murder. Verbal violence continues to outnumber physical incidents, but it is important to remember that 1 in 4 workers are attacked, threatened, or harassed each year.

Potential aggressors can be identified. 85% of previous workplace violence perpetrators could have been identified as "loose cannons".

POINTS TO REMEMBER

Workplace violence ranges from verbal violence to bodily injury. It is defined as violent acts directed towards persons who are at work or on duty.

Healthcare violence differs from usual workplace violent acts. It involves patients, their family or friends. Their violence stems from feelings of frustration, vulnerability and lack of control over health situations or emergencies.

Anyone in a healthcare setting may be exposed to acts of violence. Violence may occur anywhere; there are many factors that contribute to workplace violence and no one person is immune.

The effects of violence can range greatly depending on the situation and location of the act.

Practical safety tips will assist workers in ensuring the safety of themselves, their patients and their co-workers.

You must report all types of violence or potentially violent situations or persons to your immediate on-site supervisor and to your staffing specialist.

Be able to report specific information about the incident and those involved.

REFERENCES: Information contained within the booklet comes from Larry J. Chavez, B.A., M.P.A. of Critical Incident Associates and the GHR Training Solutions Company (not affiliated with General Healthcare Resources "GHR").

INTRODUCTION

Healthcare workers are exposed to many safety and health hazards, including violence. They are at a higher risk than other occupations to be exposed to workplace violence.

Several studies indicate that violence often takes place during times of high activity and interaction with patients. These high activity times and interactions are meal times, during visiting hours and during patient transportation.

Assaults may occur when a service is denied, when a patient is involuntarily admitted, or when a healthcare worker attempts to set limits on eating, drinking, or tobacco or alcohol use.

WHAT IS WORKPLACE VIOLENCE?

Workplace violence ranges from verbal violence (offensive or threatening language) to bodily injury (up to and including homicide). Workplace violence is defined as violent acts directed towards persons who are at work or on duty.

Some examples of workplace violence are:

- **THREATS**: Expressions of a person's intent to cause an individual harm. They can include verbal threats, threatening body language and written threats.
- **PHYSICAL ASSAULTS**: Unwanted actions or touching of another. These can include: slapping, beating, rape, homicide and the use of any other "weapons", such as guns, knives, bats and other equipment used to cause bodily harm.
- **MUGGINGS**: These are aggravated assaults with the intent to rob the victim. They are usually a surprise to the victim and take place when the victim's guard is down.

Healthcare violence differs from other workplace violent acts. Other workplace violent acts usually revolve around robbery. These would occur in convenience stores, taxis, etc.

The usual aggressors in healthcare violence are:

- Patients
- Patients' family members
- Patients' friends

The acts of violence usually originate from the aggressors feeling:

- Frustrated
- Vulnerable
- Out of control

EXAMPLES OF WORKPLACE VIOLENCE

Some cases in which violence has been reported in healthcare settings include:

An elderly patient verbally abused a nurse and pulled her hair when she prevented him from leaving the hospital to go home in the middle of the night.

An agitated psychotic patient attacked a nurse, broke her arm, and scratched and bruised her.

A disturbed family member whose father had died in surgery at the community hospital walked into the emergency department and fired a small-caliber handgun, killing a nurse and an emergency medical technician and wounding the emergency physician.

WHO IS AT RISK?

Anyone working in a healthcare setting may be exposed to acts of violence. Nurses and aides have the most direct contact with patients and therefore, a greater risk of being exposed to violence. However, all healthcare workers and providers should be aware of the risks, as they themselves, could be exposed to acts of violence.

WHERE MAY VIOLENCE OCCUR?

Violence may occur anywhere. For healthcare personnel, the location of violence can be in the following areas:

- Psychiatric wards
- Emergency rooms
- Waiting rooms
- Geriatric units
- Garage parking / Outdoor parking (late at night or early mornings)
- Public transportation stations (unguarded—late at night or early mornings)
- Unused stairwells or corridors

EFFECTS OF VIOLENCE

The effects of violence can range greatly depending on the situation and location of the act. They may include the following:

- Minor physical injuries
- Serious physical injuries
- Temporary and permanent physical disability
- Psychological trauma
- Death

Violence may also have negative organizational outcomes, such as low worker morale, increased job stress, increased worker turnover, reduced trust of management and coworkers, and a hostile working environment.

RISK FACTORS FOR VIOLENCE

The risk factors for healthcare workers are varied; they will vary in size and vary with the type of care provided. The most common risk factors are listed below:

- Working directly with volatile people, especially if they are under the influence of drugs or alcohol or have a history of violence or certain psychotic diagnoses
- Working when understaffed, especially during meal times and visiting hours
- Transporting patients
- Long waits for service
- Overcrowded, uncomfortable waiting rooms
- Working alone
- Poor environmental design
- Inadequate security
- Lack of staff training and policies for preventing and managing crises with potentially volatile patients
- Drug and alcohol abuse
- Access to firearms
- Unrestricted movement of the public

- Poorly lit corridors, rooms, parking lots, and other areas

SAFETY TIPS FOR HEALTHCARE WORKERS

Healthcare workers should always be alert for potential violence in and around the workplace. The following are guides to assist you in keeping alert and aware of your environment and those around you.

Watch for signals that may be associated with impending violence:
- Verbally expressed anger and frustration
- Body language such as threatening gestures
- Signs of drug or alcohol use
- Presence of a weapon

Maintain behavior that helps diffuse anger:
- **PRESENT A CALM, CARING ATTITUDE.** The person has a compelling need to communicate his grievance to someone now! Even if he is wrong, the individual is acting on perceptions that are real to him. In the overwhelming number of cases, the person just wants fairness.
- **DON'T MATCH THE THREATS.**
- **DON'T GIVE ORDERS.** Be calm, courteous, respectful, open and honest with the patient. Never belittle, embarrass or verbally attack a hostile person.
- **PRACTICE ACTIVE LISTENING.** Stop what you are doing and give the person your full attention. Listen to what is really being said. Use silence and paraphrasing. Ask clarifying, open-ended questions.
- **ACKNOWLEDGE THE PERSON'S FEELINGS.** For example, "I know you are frustrated".
- **WHAT IS THE RESOLUTION?** A person will more readily agree to a resolution that he helped formulate. And, it might surprise you that the person's suggestion may be very reasonable.
- **AVOID ANY BEHAVIOR THAT MAY BE INTERPRETED AS AGGRESSIVE.** For example, moving rapidly, getting too close, touching, or speaking loudly. Make eye contact (but don't stare). Allow verbal venting of emotion. Let the person have his say (not necessarily his way). Ignore challenges and insults — don't take it personally; redirect attention to the real issue.
- **PRESERVE THE INDIVIDUAL'S DIGNITY.** Switch the focus from what you can't do toward what you can. With the person's permission, call in additional resources — e.g., supervisor, manager, patient advocate, security, or police.
- **DON'T ISOLATE YOURSELF WITH A POTENTIALLY VIOLENT PERSON.**
- **ALWAYS KEEP AN OPEN PATH FOR EXITING.** Don't let the potentially violent person stand between you and the door.

Be alert:
- Evaluate each situation for potential violence when you enter a room or begin to relate to a patient or visitor.
- Be vigilant throughout the encounter.

Take these steps if you can't defuse the situation quickly:
- Remove yourself from the situation.
- Call security for help.
- Report any violent incidents to your on-site direct supervisor and inform your staffing specialist.

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PERPETRATORS & VICTIMS GENERAL PROFILES

PERPETRATORS OF WORKPLACE VIOLENCE	VICTIMS
▪ 80% are male ▪ Usually white ▪ Usually over 30 ▪ 3% are former employees ▪ 20% are current employees ▪ 66% are strangers ▪ Males are usually attacked by strangers ▪ Women are usually attacked by someone they know ▪ Domestic violence is the fastest growing category of workplace violence	▪ Anyone with extensive contact with the public, especially if limited attention can be or is paid to customer satisfaction (i.e. airline rage, etc) ▪ Anyone working in bureaucratic organizations where limited attention is paid to employee satisfaction ▪ Supervisors and managers are high risk (employee boss murders have doubled during the past 10 years)

HOW TO PREDICT POTENTIAL WORKPLACE VIOLENCE

P.O.S.T.A.L:

Profile + **O**bservable Warning Signs + **S**hotgun + **T**riggering Event = **A**lways **L**ethal

Profile of Potentially Violent Persons:

- Previous history of violence
- Significant tenure or migratory job history
- Emotional problems
- Loner, withdrawn, fears change, feels no one listens to him/her
- Antagonistic relationship with others
- Some type of obsession (i.e. weapons, violent acts, romantic/sexual, zealot (political, religious, racial), the job, neatness & order))

Observable Warning Signs:

- Strange behavior (i.e. deteriorating appearance or hygiene, becoming reclusive, erratic behavior)
- Emotional problems (i.e. drug/alcohol abuse, under unusual stress, depression, inappropriate emotional display)
- Performance problems (i.e. attendance, etc.)
- Interpersonal problems (i.e. conflicts, hyper-sensitivity, resentment)
- Violent and threatening behavior, hostility, approval of the use of violence
- "End of the Rope", indicators of impending suicide, has a plan to "solve" problems

Shotgun:

(Not required to non-lethal violence)

- Access to and familiarity with weapons.

Triggering Events:

- Being fired, laid off, suspended or passed over for a promotion
- Disciplinary action, poor performance, criticism from boss or co-worker
- Bank/court action (i.e. foreclosure, restraining order or custody hearings)
- Benchmark date (i.e. company anniversary, chronological age, famous birthdays, etc)
- Failed or spurned romance, personal crisis

PROTECT YOURSELF AGAINST WORKPLACE VIOLENCE

Use D.O.G.G.S. to protect your self:

If needed, you can defuse a violent person by remembering that he or she is a big balloon that is going to burst. You must gradually deflate, not puncture, it. You can do this by confirming a person's perspective without agreeing with it.

D.O.G.G.S.: **D**efusing **O**f **G**rievance **G**rants **S**afety

To use the D.O.G.G.S method, you must:

1. Understand the mindset of the potentially violent person.
The person has a need to communicate the grievance to someone now. Even if he/she is wrong, the individual is acting on perceptions that are real to him/her. Most often, the person just wants fairness.

2. Practice "Active Listening".
Stop what you are doing and give the person your full attention. Listen to what is really being said. Use silence and paraphrasing. Ask clarifying, open-ended questions.

3. Build trust and provide help. Avoid confrontation.
Be calm, courteous, respectful, patient, open and honest. Never belittle, embarrass, or verbally attack a hostile person.

4. Allow a total airing of the grievance without comment or judgment.
Make eye contact but don't stare. Allow verbal venting of emotion. Let the person have his/her say (not necessarily his/her way). Ignore challenges and insults — don't take it personally; redirect attention to the real issue.

5. Allow the aggrieved party to suggest a solution.
A person will more readily agree to a resolution that he/she helped formulate. And it might surprise you that the person's suggestion may be very reasonable.

6. Move toward a win-win resolution.
Preserve the individual's dignity. Switch the focus from what you can't do toward what you can. With the person's permission, call additional resources (i.e. supervisor, Human Resources, Employee Assistance Program, security, or police).

Eliminating violence in the workplace should be a top priority for everyone.

GENERAL HEALTHCARE RESOURCES, INC.
The Professional Staffing Solution

NO WEAPONS POLICY

General Healthcare Resources (GHR) supports an environment that is safe and free of violence for all clients, employees, independent contractors and patients. To achieve this goal, GHR prohibits the wearing, transporting, storage, presence or use of dangerous weapons into any GHR office or client facility, in which you have been assigned, regardless of whether or not you are licensed to carry the weapon. This policy does not apply to law enforcement personnel or security personnel engaging in official duties during that time.

1. Prohibited weapons include any form of weapon or explosive restricted under local, state or federal regulation, including all firearms, illegal knives or other weapons covered by the law. Legal chemical dispensing devices such as pepper sprays that are sold commercially for personal protection are not covered by this policy. If you have a question about whether an item is covered by this policy, please contact the Director of Human Resource. You will be held responsible for making sure that any potentially covered item you possess is not prohibited by this policy.

2. This policy applies to all contract and temporary employees, including independent contractors performing services as assigned by GHR, whether or not they are licensed to carry a concealed handgun.

3. GHR property and GHR client facilities covered by this policy include, without limitation, all GHR offices or any client location to which an employee or independent contractor has been assigned to render services on behalf of GHR.

4. Failure to abide by all terms and conditions of the policy may result in discipline for employees up to and including termination.

5. THIS POLICY SHALL NOT BE CONSTRUED TO CREATE ANY DUTY OR OBLIGATION ON THE PART OF GHR TO TAKE ANY ACTIONS BEYOND THOSE REQUIRED OF AN EMPLOYER BY EXISTING LAW.

6. If you become aware of someone violating this policy, either at an assigned GHR client facility or GHR office location, please contact the Director of Human Resources as soon as possible. DO NOT attempt to remove the weapon from the individual or to discuss the matter with the individual.

Director of Human Resources:
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