



Student Orientation Packet

This orientation packet is designed to provide general orientation and basic safety information to those participating in educational opportunities at Broadlawns Medical Center (BMC).

Those of us at BMC are entrusted with the safety of our students, preceptors, and co-workers. Failure to follow safety policies, inadequate response to unsafe conditions, and lack of preparation for emergencies can put you and others at risk for injury or harm. As part of the BMC team, you have the responsibility for understanding and adhering to the general orientation and basic safety policies outlined on the following pages.

Please read and familiarize yourself with the information provided in this packet

This must be done one week prior to your first day at BMC. **No exceptions!**

Updated January 2016

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Statement of Mission, Vision and Values

Mission

“Working together to build a healthy community through the delivery of accessible cost effective and high quality patient care.”

Vision

- We will serve our diverse multi-cultural community through a continuum of quality, creative and cost-effective programs that promote wellness and treat illness.
- We will build on our reputation as a respected leader in training tomorrow’s health care professionals.
- We will be the employer of choice for individuals who are likewise committed to our mission, vision, and values.
- We will hold our employees to the highest standard of resource management through stewardship of services to our patients and community at-large.
- We will provide a team building work environment as well as competitive compensation and benefits, in-service training and skill development.
- We will optimize diagnostic and treatment services offered to keep pace with medical technology in the continuum of care.

Values

Acronym of EXCLL (pronounced “Excel”):

- **EX**cellence
- **C**ompassion
- **L**earning
- **L**eadership

Behaviors for Service Excellence

A commitment to our patients, employees and customers.

In order to achieve our mission and fulfill our vision, BMC needs people who share the values of Broadlawns Medical Center and model the *Standards of Excellence*. Values are demonstrated through behaviors and attitudes. These behaviors and attitudes establish a shared practice for excellence.

Standard: Empathy

Actions:

- I will communicate openly, accurately, and directly with everyone within the organization.
- I will treat individuals with respect and dignity.
- I will not shame or blame, but use the opportunity for development and self-growth.

Standard: Enthusiasm

Actions:

- I am committed to and am an advocate of Broadlawns Medical Center's mission, vision, and values and accountable to assure success of our Vital Signs scorecard objectives.
- I will promote a positive, productive teamwork environment.
- I will seek new learning and development opportunities.

Standard: Ownership

Actions:

- I will be action-oriented and commit to solving the problem.
- I will approach situations with an open mind in a non-judgmental, non-defensive manner.

Standard: Responsibility

Actions:

- I will follow through on my commitments.
- I will be responsible for keeping my job skills and knowledge current to enhance my productivity and effectiveness.
- I will respect and maintain each individual's right of privacy, confidentiality, safety and security.
- I am committed to assisting the patient or co-worker even if it is "not my job".

Standard: Adaptability

Actions:

- I will embrace diversity.
- I will demonstrate adaptability and flexibility in dealing with change.

Standard: Balance

Actions:

- I will work to satisfy the patient and customer while taking into account the resources and needs of the organization.
- I will be accountable for my actions.

Standard: Resilience

Actions:

- I will give each patient or employee a "healthy attitude free of conflict, bias and negativity."
- I will not participate in gossip or inappropriate criticism of others.

Student Guidelines

Work/Meal Breaks

Students may eat and/or take breaks in the Cafeteria and as arranged or agreed upon with your preceptor.

Parking

Students are permitted to park in Lot C “East FHC Lot” starting in the east row and moving west as needed.

Dress Code

Please dress in business casual/scrubs. Wear closed-toed shoes for clinical areas and all departments must wear socks or hose. You should consult with your instructor/preceptor for specific rules relating to dress code in the area or department in which you are working. You are to practice good personal hygiene.

Name Badges

All personnel, including students, are identified by an identification name badge to be worn at all times while working. As a student, you are required to wear a visitor badge. This visitor badge should be worn in a highly visible position (above waist with front of badge visible).

Reporting to Work

Students and their preceptor should have an agreed upon schedule. In the event that you are unable to report for your specified schedule or need to change your hours, please call your preceptor.

Duties

Any questions about your duties, hours or other issues should be directed to your preceptor or instructor.

Department Rules

Ask the preceptor in your assigned department to discuss the following rules that may be specific in that department:

- Food/drink allowed in department
- Break time
- Lunch time
- Correct way to answer the phone
- Whom/when to notify if unable to come to work
- Personal phone calls, use of cell phones

Equal Employment Opportunity

All health care facilities are equal opportunity employers that have established a policy that all employment decisions shall be based on qualifications, competence and job performance. Employment practices shall not be unlawfully influenced or affected by virtue of an applicant's or employee's race, color, religion, sex, sexual orientation, gender identity, national origin, age, mental or physical disability unrelated to ability to do a job or any other characteristic protected by law. This policy governs all aspects of employment promotion, assignment, discharge, and other terms and conditions of employment.

Health Insurance Portability and Accountability Act (HIPAA)

Background

HIPAA is a law that was passed and went into effect on April 14, 2003. While patient confidentiality has always been a part of healthcare, the original goal of HIPAA was to make it easier for people to move their medical records and get care more easily. One important part of HIPAA is that it focuses on keeping patient information confidential. It is illegal to release any type of health information inappropriately.

What types of information are considered to be confidential?

Patient identity or demographic information such as social security number, address, symptoms or reason the patient is being treated, medications, information regarding the patient's condition and any information regarding past treatments received.

General Rule

A Patient's Protected Health Information cannot be disclosed to another without the patient's consent.

- Protected Health Information is "any information, whether oral or recorded in any form or medium" that is created or received by a health care provider, health plan, public health authority, employer, life insurer, school or university, or health care clearinghouse"; and "relates to the past, present, or future physical or mental health or condition of an individual; the provision of health care to an individual; or the past, present, or future payment for the provision of health care to an individual," and that identifies the individual or for which there is a reasonable basis to believe can be used to identify the individual. Individually identifiable health information includes many common identifiers (e.g., name, address, birth date, Social Security Number).

How can I protect patient privacy?

- When performing your job, keep patient privacy in the forefront at all times. (Knock on a door before entering the room, sign off on your computer when not in use, keep the computer screen from being viewed by others, keep records or confidential papers secured and locked up)
- Know the BMC privacy policies
- Do not discuss patients in the hallway or lunch room
- Do not share patient information with others who do not have a need to know for their job
- Shred confidential information; make sure that contents of the shred bins cannot be removed

When can I release patient information?

- Providers have the right to report a communicable disease to state health agencies.
- Police have the right to certain information about patients if they are a suspect in a criminal investigation.
- The court has the right to order a facility to release information.
- Hospital staff may call funeral directors or coroners when a patient dies.
- Hospital staff must report crime victims, suspicious deaths and gunshot wounds.

How do I report a violation?

- Report violations or suspected violations to the hospitals privacy officer. The violation may be reported anonymously.
- Broadlawns' Privacy & Security Officer – Neil Hansen – 282-2305
- Corporate Compliance & HIPAA Confidential phone line – 282-5647

Confidentiality

What you see here, what you hear here, you leave here.

No matter where you are working in the health organization, you may hear or see intimate and private information about patients. This information is confidential and must **never** be disclosed to others except as it is required in caring for the patient.

Use discretion when discussing patient information with other members of the health care team who have a need to know. Do not use the hallways, cafeteria, elevators, or other open areas as a meeting place to discuss patient information, as there is no guarantee that information will not be overheard by other employees, patients or visitors.

Patients have the right to expect that all communications and records pertaining to their care will be treated as confidential. The patient's right to confidentiality is protected by both federal and state courts. Unauthorized release of this information may subject the institution, providers and staff to civil and criminal liability or professional disciplinary actions.

A breach of confidential information pertaining to a patient's medical, mental, personal, or financial conditions are considered an "intolerable offense" and will be considered adequate justification for discharge or dismissal.

The confidentiality policy of the medical center is located in the Broadlawns Medical Center's Administrative Policy, C-0504 (Confidentiality Policy).

Students are also referred to policies A-0825 (Release of Information), A-0107 (Release of Patient Information to the Media) and A-0202 (Orders of the Court).

<p style="text-align: center;">The Joint Commission (TJC) 2016 Hospital National Patient Safety Goals (NPSG)</p>

The purpose of the National Patient Safety Goals is to improve patient safety. The goals focus on problems in health care safety and how to solve them.

Identify Patients Correctly

- Use at least two ways to identify patients. For example, use the patient's name *and* date of birth. This is done to make sure that each patient gets the correct medicine and treatment.
- Make sure that the correct patient gets the correct blood when they get a blood transfusion.

Improve Staff Communication

- Get important test results to the right staff person on time.

Use Medicines Safely

- Before a procedure, label all medicines that are not labeled. For example, medicines in syringes, cups and basins. Do this in the area where medicines and supplies are set up.
- Take extra care with patients who take medicines to thin their blood.
- Record and pass along correct information about a patient's medicines. Find out what medicines the patient is taking. Compare those medicines to new medicines given to the patient. Make sure the patient knows which medicines to take when they are at home. Tell the patient it is important to bring their up-to-date list of medicines every time they visit a doctor.

Use Alarms Safely

- Make improvements to ensure that alarms on medical equipment are heard and responded to on time.

Prevent Infection

- Use the hand cleaning guidelines from the Centers for Disease Control and Prevention or the World Health Organization. Set goals for improving hand cleaning. Use the goals to improve hand cleaning.
- Use proven guidelines to prevent infections that are difficult to treat.
- Use proven guidelines to prevent infection of the blood from central lines.
- Use proven guidelines to prevent infection after surgery.
- Use proven guidelines to prevent infections of the urinary tract that are caused by catheters.

Identify Patient Safety Risks

- Find out which patients are most likely to try to commit suicide.

Prevent Mistakes in Surgery

- Make sure that the correct surgery is done on the correct patient and at the correct place on the patient's body.
- Mark the correct place on the patient's body where the surgery is to be done.
- Pause before the surgery to make sure that a mistake is not being made.

The purpose of the National Patient Safety Goals is to improve patient safety. The goals focus on problems in health care safety and how to solve them.

Tobacco-Free Environment

As a healthcare organization, staff is responsible not only for the treatment of disease but for taking steps to promote the prevention of illnesses and injuries. It is the mission of all staff to set the standard for and demonstrate healthy lifestyles for the communities in which we serve. Tobacco use is widely recognized as a major preventable cause of many diseases in smokers and non-smokers alike. For these reasons, all health care organizations have been designated as tobacco-free institutions.

- Smoking or otherwise using tobacco products (including cigarettes, cigars, chewing tobacco, snuff, pipes, etc.) on property is prohibited.
- Tobacco use in any vehicle when on property is prohibited. Tobacco use in vehicles by visitors is discouraged.
- The distribution or sale of all tobacco products is prohibited.
- All employees, physicians, students, visitors, patients, vendors, contract workers, and volunteers must comply with this policy.

As a student, you are expected to set the example for patients and visitors by adhering to a tobacco-free environment policy. Violation of this policy will result in disciplinary action.

Drug-Free Workplace

Position Statement

The use or possession of illegal drugs as well as the abuse of alcohol and other intoxicants creates a serious threat to the health and well-being of the user and in some instances to fellow employees, students, and private citizens. Students have a responsibility to provide a work/learning environment free of drugs and alcohol.

In compliance with the Drug Free Workplace Act of 1988, all students are herein notified that the unlawful manufacture, distribution, dispensation, possession or use of a controlled substance is prohibited on the health care organization's premises, in the workplace, or in such places and at such times that the above activities have or could have an adverse effect on work performance or behavior or interferes with the rights and privileges of co-workers or the public.

Sanctions

Anyone who violates the Drug-Free Workplace Act of 1988 will be subject to disciplinary action. Following an appropriate investigation and subject to the procedures which are part of the policies governing the medical center, the student can be subject to disciplinary actions and/or educational sanctions including reprimand, suspension or termination.

Criminal Conviction

Any student who receives a criminal drug statute conviction for a violation occurring in the workplace must notify their preceptor and the BMC Student Education contacts within five (5) days of conviction.

Refer to Administrative Policy H-0110 (Substance Abuse).

Drug Addiction in Health Care Professionals

The abuse of prescription drugs—especially controlled substances—is a serious social and health problem in the United States today. People addicted to prescription medication come from all walks of life. However, the last people we would suspect of drug addiction are health care professionals—those people trusted with our well-being. Yet health care workers are as likely as anyone else to abuse drugs.

Even though the vast majority of DEA registered practitioners comply with the controlled substances law and regulations in a responsible and law-abiding manner, you should be cognizant of the fact that drug-impaired health professionals are one source of controlled substance diversion. Many have easy access to controlled substance medications; and some will divert and abuse these drugs for reasons such as relief from stress, self-medication or to improve work performance and alertness.

This guide will help you recognize the signs that may indicate that a colleague or c-worker is diverting controlled substances to support a substance abuse problem.

What are my responsibilities?

- You have a legal and ethical responsibility to uphold the law and to help protect society from drug abuse.
- You have a personal responsibility to protect your practice from becoming an easy target for drug diversion. You must become aware of the potential situations where drug diversion can occur and safeguards that can be enacted to prevent this diversion.

Sexual and Other Forms of Harassment

We are committed to providing a work environment that is free of unlawful harassment, actions, words, jokes, or comments based on an individual's sex, sexual orientation, race, ethnicity, age, religion, or any other legally protected characteristic.

Sexual misconduct, both over and subtle, can create an offensive work environment and is thus prohibited. Specifically, the following conduct is illegal, as defined in the Equal Employment Opportunity Commission's Sexual Discrimination Guidelines:

- Unwelcome sexual advances, requests or physical conduct of a sexual nature when:
 - submission to such conduct is made either explicitly or implicitly a term or condition of an individual's employment;
 - submission to or rejection of such conduct by an individual is used as the basis for employment decisions affecting such individual, or such conduct has the purpose or effect of substantially interfering with an individual's work performance or creating an intimidating, hostile or offensive work environment.

If you have a reason to believe that you have been the victim of any type of unlawful harassment, you should immediately report the facts of the incident to your supervisor/preceptor or the BMC Human Resources Director.

Any employee, student or volunteer, engaging in any improper harassment, will be subject to disciplinary action, up to and including discharge.



Multiculturalism in Healthcare

By Howard Ross

Areas all over the United States are becoming much more racially, ethnically, culturally and linguistically diverse. Previous record inflows of immigrants at the turn of the 20th century have been surpassed; the foreign-born now number more than 33 million. One in nine Americans is an immigrant. Nearly one-fifth of U.S. residents speak a language other than English at home.

Our nation's increasing diversity has made providing care to diverse populations a challenge for many health care organizations. With the increasing diversity, there is a concomitant need to understand cross-cultural differences. This ethical imperative is particularly critical, given the numerous reports that document significant health disparities.

The Mosaic

Not only are the demographics changing in unprecedented ways, but so too are the notions of assimilation and the idea of the "melting pot." Even the national motto *E Pluribus Unum* (from many, one) is under scrutiny.

There appears to be more of a sense that--especially as immigrant populations reach a critical mass in many communities--individual immigrants follow different paths to incorporation in American society. These range from the classic ideal of blending into the middle class, to a downward assimilation into an underclass, and to integration into immigrant communities.

With today's emphasis on diversity and ethnicity, it has become easier than ever for immigrants to avoid the melting pot. In fact, even the metaphor is changing; many now prefer such terms as the "salad bowl" and the "mosaic."

Multiculturalism

Different cultural views on health care can be at odds with the perspective of U.S. providers. These include variations in patient recognition of symptoms, patterns of seeking care, ability to communicate

symptoms to a provider who understands their meaning, ability to understand the prescribed management strategy, expectations of care, and adherence to preventive measures and medications. The following are three examples:

1. A Japanese man has a ruptured appendix and needs immediate surgery. Although he was not very anxious about the surgery initially, he started refusing to have the surgery after being taken to his room.

Cultural explanation: Being aware of some Japanese beliefs about death may help health care providers understand the cause of his anxiety. In Japanese, "four" is pronounced in the same way as the word that means "death." This makes many Japanese patients uncomfortable in a hospital room with a number four.

2. Following surgery, Mr. Ramirez is reluctant to participate in self-care or to ambulate. His family has complained to the hospital administration that the nurses are not doing their job assisting Mr. Ramirez with activities of daily living.

Cultural explanation: The American health care system's emphasis on patient self-care to hasten recovery may directly conflict with a Latino belief that a patient should be assisted in daily tasks for the duration of the illness because the patient needs to conserve energy in order to recover. Knowing this, the hospital staff could explain that it is necessary for Mr. Ramirez to get out of bed in order to prevent post-operative complications.

3. A Vietnamese mother was observed by hospital staff to be neglecting her newborn baby. After repeated attempts by hospital staff to engage the mother in conversation by praising the baby, the mother became quite agitated.

Cultural explanation: Some traditional Vietnamese believe that potentially evil

spirits are attracted to infants. In an effort to protect their babies, parents try not to attract attention to them.

As can be seen from these examples, when sociocultural differences between patient and provider aren't appreciated, explored or communicated, the provider risks patient dissatisfaction, poor adherence to treatment protocols and poorer health outcomes. Confusion and conflict often can be averted when there is an understanding of cultural differences.

Culturally Competent Health Care

In order to effectively provide services to people outside the dominant culture, the health care provider must learn how people view their world. "Cultural competence" is a concept that has received widespread attention as a way of providing health services for communities with diverse cultural backgrounds, migration experiences, socioeconomic circumstances and languages. Although many precise definitions abound, "cultural competence" is generally communicated as a set of behaviors, attitudes and policies among health systems and professionals to enable them to provide cross-cultural health care.

Health care institutions can prepare and deliver culturally competent health services to diverse cultural groups through three main conceptual approaches that focus on awareness, knowledge and skills:

Awareness regarding all the influences impacting patients. Such awareness is the benchmark for cross-cultural care. Typically, this is accomplished when health care organizations implement staff training programs that provide opportunities for self-reflection, which necessarily includes identifying

one's own culture, biases and reactions to diverse health values.

Knowledge about the attitudes, values, beliefs and behaviors of ethno-cultural groups. With the huge array of cultural, ethnic, national and religious groups in the United States along with the multiple influences, such as acculturation, socioeconomic status and intragroup variation, it is difficult to learn a set of unifying facts or cultural norms. Cultural information is extremely useful in directing the health care provider to ask pertinent questions within each individual's cultural context.

Skills development that melds knowledge about the cultures with appropriate health services approaches. Such approaches must provide methods for eliciting patients' understanding of their illness or conditions and allow providers to adjust their practice style to meet patients' specific and varying needs.

Each health care organization can use these approaches to create a community of learning that embraces the unique qualities and experiences of a diverse patient population. Failure to take sociocultural factors into account may unintentionally lead to stereotyping, and in worse cases, poor outcomes because of miscommunication or misunderstanding.

Howard Ross is president and founder of Cook Ross Inc., a diversity training and change management firm specializing in health care. He is based in Silver Spring, Md.

This article 1st appeared on 2006-10-31 in HHN Magazine online site.

Safety Procedures

Fire Safety

Your preceptor/supervisor will go over the fire evacuation route with you and help you locate the fire alarm pull stations and fire extinguishers in your area.

Operator will announce: “Fire alarm. (Location). Hospital staff activate fire response procedures

Remember RACE

- R**escue persons in immediate danger.
- A**larm pull fire alarm; dial 350, (911 if off-site) giving location of fire (dept./building/floor) – even during a drill.
- C**ontain fire by closing doors where fire is located.
- E**xtinguish the fire. Do only if properly training and equipped.

Tornado Safety

Operator will announce three times:

“Weather alert. (Descriptor). Take immediate precautions.”

Your preceptor/supervisor will go over the tornado escape route for your area.

Patient Care Areas: Move patients (who can’t be moved to the basement) into an interior corridor; close patient room doors; assure adequate staff is available to care for these patients and those who are directed to the basement

In patient care areas, move patients who can’t be moved to the basement) into an interior corridor; close patient room doors; assure adequate staff is available to care for these patients and those who are directed to the basement.

Electrical Safety

If equipment has been dropped or damaged, do not operate it as a shock hazard may exist. Have it checked by Plant Operations.

Report to your preceptor/supervisor immediately, any of the following:

- Frayed, worn, burned wire
- Broken, bent loose plugs
- Loose cable connectors
- Loose switches, control knobs
- Overheated equipment
- Equipment that has produced a shock

Emergency Codes

Emergency	Announcement	Example
Major disaster in city. Refer to Disaster Plan. Decontamination Event. Refer to Bio-Terrorism Tab.	Internal OR External Emergency + City Alert OR Decontamination Event + Activate Incident Command	<i>Internal Emergency, Decontamination Event, Activate Incident Command</i>
Abduction or elopement of missing child or adult.	Missing Adult OR Missing Child + Description + Hospital staff survey your work areas	<i>Missing Child, approximately 8 years old with red shirt and blue jeans, hospital staff survey your work areas.</i>
Any medical emergency including cardiac arrest – adult.	Medical Emergency + Code Blue + Location	<i>Medical Emergency, Code Blue, Med/Surg</i>
Any medical emergency including cardiac arrest – child.	Medical Emergency + Code Pink + Location	<i>Medical Emergency, Code Pink, Pediatric Clinic</i>

Out of control individual (patient / visitor / staff)	Security Assistance + Code Green + Location	<i>Security Assistance, Code Green, Inpatient Behavioral Health</i>
Fire: actual or drill.	Fire Alarm + Location + Hospital staff activate fire response procedures	<i>Fire Alarm, Sands Main Entrance, Hospital staff activate fire response procedures</i>
Evacuate: specified area or entire facility.	Evacuation + Location + Staff follow evacuation procedures	<i>Evacuation, Intensive Care Unit, Staff follow evacuation procedures</i>
An active shooter within the facility. Will announce action required (clear all hallways). Will not announce location.	Attention, Attention + Hostile Threat + Patients, Visitors and Staff Immediately Clear All Hallways	<i>Attention, Attention, Hostile Threat, Patients Visitors and Staff immediately clear all hallways.</i>
Tornado or Severe Weather Warning – take immediate precautions.	Weather Alert + Descriptor + Take immediate precautions	<i>Weather Alert, Tornado Warning, Take immediate precautions</i>

Right-to-Know Law

The Hazardous Communication Standard is a Federal Occupational Safety and Health Administration (OSHA) law adopted by the State of Iowa. Iowa OSHA calls it the Right-to-Know Law.

As students, you have a right to know what chemicals you use on the job, and hazards associated with the use of those chemicals. You also have a right to know how to protect yourself against these hazards.

There are three major parts of the Right-To-Know Law.

1. Chemical Inventory List

A list of all the chemicals used routinely in a given department. Some departments may not have any chemicals that are regulated by OSHA, and will have no chemical inventory list.

The inventory lists the product name, company name, chemical classification, and the health, flammability, and reactivity ratings.

2. Material Safety Data Sheets (MSDSs)

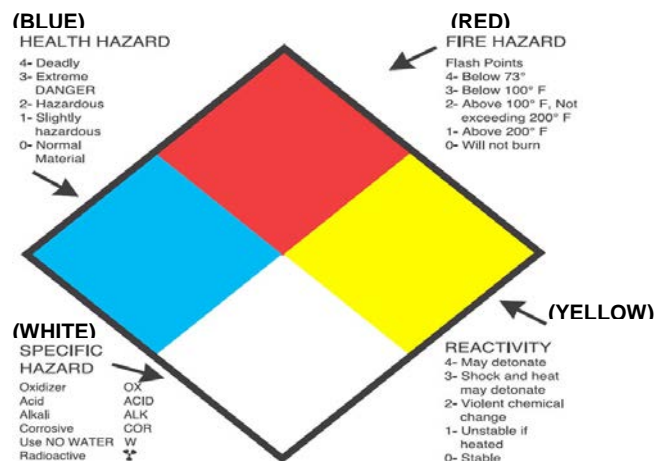
For every chemical on the chemical inventory list, there is a corresponding MSDS. The emergency department has a copy of every MSDS in the entire hospital.

Every MSDS contains the following information:

- General Information: chemical name, manufacturer, etc.
- Hazardous Ingredients
- Physical Data: boiling point, melting point, appearance, color, etc.
- Fire and Explosive Data: flash point, special fire fighting information, other hazards associated with a fire or explosion of the chemical
- Threshold Limit Value (TLV): the average 8 hour occupational exposure limit
- Reactivity Data: chemical stability, incompatibility with other chemicals
- Spillage and Leakage Procedure: includes steps to prevent injury, special waste disposal methods
- Protection Information: use of respiratory protection, special ventilation, use of protective clothing
- Special Precautions: needed for handling, transporting, using the product

3. Warning Labels

Every chemical and every container, regardless of size or purpose is labeled as follows:



- Health Hazard Rating (H): risk to health, or severity of injury likely to occur from exposure.
- Flammability Hazard Rating (F): degree of flammability or the amount of heat needed before ignition (based on the flash point).
- Reactivity Hazard Rating (R): degree to which the chemical reacts with other substances (how stable the chemical is – the more stable, the less reactive).
- Specific Hazard (S): the chemical requires special precautions (special PPEs, radioactive, etc.).

Ratings:

- 0 – (H) minimal hazard; (F) non-flammable; (R) normally stable
- 1 – (H) slight hazard; (F) ignites when heated; (R) unstable at high temperatures
- 2 – (H) moderate hazard; ignites with moderate heat; (R) unstable but does not detonate
- 3 – (H) serious hazard; (F) ignites under normal temperatures; (R) detonates with an initiation source.
- 4 – (H) severe hazard; (F) very flammable; (R) detonates at normal temperatures.

If you come across an unlabeled container, treat it as if it were hazardous until it is known to be otherwise. Your preceptor will review with you: the Chemical Inventory List; proper chemical handling, storage, and usage procedures; and location and use of personal protective equipment.

Infection Control

Standard Precautions and Isolation Guidelines

General Information

Standard Precautions, maintains that all body substances (oral and body secretions, blood, feces, urine, droplet or airborne spray from a cough, tissues, vomitus, wound and other drainage) are potentially infectious.

Transmission Based Precautions are for patients documented or suspected to be infected with highly transmissible pathogens for which “additional precautions” are needed to prevent nosocomial transmission. The “additional precautions” may be combined together for patients who have multiple infections and transmission routes.

Standard Precautions

A. Soap & Water vs. Gel

Hand hygiene is the single most important method of infection prevention. Hand washing is indicated whenever the hands are soiled; after removing gloves; and before and after each new patient contact. If hands have gross contamination like blood, stool, etc, you have to use soap and water for 15 seconds. If hands are clean you can use the alcohol foams which kill 99.9% of pathogens.

B. Gloves

Gloves are put on just before contact with oral and body secretions, blood, feces, urine, tissues, vomit, wound, non-intact skin, and contaminated items. Hands must be washed immediately after taking off the gloves and prior to leaving the patient care area. New gloves should be used when going from one “event” to another with the same or different patient. Gloves should be replaced during treatment if the efficacy of the glove has been compromised (i.e. torn or damaged).

C. Gowns

Gowns must be used when it is likely that the employee’s clothing could become soiled. Gowns must be removed and placed in a red bio-hazardous bag prior to leaving the patient care site. Gowns should be replaced during treatment if the efficacy of the gown has been compromised (i.e. torn or damaged).

D. Masks

Masks must be used if the suspicion of or confirmation of a respiratory communicable (i.e. RSV, meningococcal meningitis, tuberculosis) disease is present. Masks are also indicated if significant exposure to droplet or airborne spray from a cough is likely or if splattering of body fluids may occur. Masks should be replaced during treatment if they become soiled with moist body fluids. Surgical masks may be used for suspected or confirmed respiratory communicable disease except tuberculosis. NIOSH approved filters must be used for tuberculosis control. See Administrative Policy I-0211 (TB Control Plan) for more specific information in regard to Mycobacterium Tuberculosis management.

E. Other Protection Devices

Goggles, hair covers, and shoe covers are indicated when splattering of body fluids may occur.

F. Private Rooms

Private rooms are needed for patients with suspected or confirmed communicable diseases transmitted via the air (i.e., RSV, meningococcal meningitis and tuberculosis). A red sign reading “STOP”, “check with the nurse before entering” is placed on the door. This is to warn persons entering the room that precautions are necessary prior to entering. Private rooms are also used for patients who soil the room with body substances in a manner that may inadvertently infect the roommate. Exception: Patients with the same disease may room together if there is no other room available.

G. Non-immune Exceptions

Susceptible personnel are not permitted to care for patients’ with Varicella. Roommates immune to the patient’s disease or who are currently infected with the same disease may share rooms if there is no other room available.

H. Patient Care Equipment

Handle used patient-care equipment soiled with blood, body fluids, secretions, and excretions with gloves. Avoid contamination of clothing, and transfer of microorganisms to other patients and environments. Ensure that reusable equipment is not used for the care of another patient until it has been appropriately cleaned and reprocessed and single use items are properly discarded.

I. Linen

Handle, transport and process linen visibly soiled with blood, body fluids, secretions and excretions with gloves. Prevent contamination of clothing by holding the bag away from you or wearing a gown while transporting. Wash your hands after removing gloves or touching soiled linens.

Infection Control—Continued

J. Occupational Exposure to Bloodborne Pathogens

Prevent sharps injuries by utilizing the safety devices available to you. Never recap needles. Dispose of sharps in puncture resistant container, immediately after use. Report exposures to your immediate supervisor as soon as possible after they occur. Medications can be given that may prevent transmission of bloodborne disease.

Transmission Precautions

A. Airborne Precautions

In addition to Standard Precautions, use airborne precautions for patients known or suspected to be infected with microorganisms transmitted by airborne droplet nuclei. These microorganisms may remain suspended in the air and can be widely dispersed by air currents within the room or over a long distance.

Examples: Mycobacterium Tuberculosis, Varicella Pneumonia, Measles.

1. Requirements: Private room with negative air flow at 6 air exchanges per hour, respiratory protection using a dust mist filter for all except tuberculosis (See TB Control Plan for guidelines for the prevention of the transmission of TB).
2. Personnel who are susceptible to measles and varicella are not permitted to care for the patient with these diseases.
3. Surgical mask for the patient for transport only when medically necessary.

B. Droplet Precautions

In addition to Standard Precautions, use Droplet Precautions for a patient known or suspected to be infected with microorganisms transmitted by droplets that can be generated by the patient during coughing, sneezing, talking or during procedures.

Examples: Invasive Haemophilus influenza type b disease, Neisseria meningitidis disease, multidrug-resistant Streptococcus pneumoniae disease, Diphtheria, Mycoplasma pneumonia, Pertussis, Pneumonic plague, Streptococcal pharyngitis, pneumonia, influenza, mumps, Parvovirus B19, RSV, Rubella

1. Requirements: Private room, Respiratory Protection using a dust mist filter for all contact within three feet of the patient.
2. Surgical mask for the patient for transport, only when medically necessary.

C. Contact Precautions

In addition to Standard Precautions, use Contact Precautions for a patient known or suspected to have infection with microorganisms that can be transmitted by direct contact.

Examples: RSV, Hepatitis A herpes simplex, Impetigo, Scabies, Staphylococcal skin infections, Lice/pediculosis, respiratory infections in children, draining abscesses/wounds.

1. Requirements: Private room, gown and gloves when in contact with the microorganism and strict hand washing. Remove gown and gloves on leaving patient room and dispose in trash bag.
2. Transport patient only when medically necessary. Ensure that all staff/departments are aware of the isolation precautions.
3. When possible keep non-critical, reusable patient care equipment, (e.g. BP cuff, thermometer, commode), at the patient's bedside to avoid sharing between patients. If unavoidable, thoroughly clean the device before using it for another patient.

Infection Control—Continued

D. Enhanced Precautions

In addition to standard precautions, use enhanced precautions for patients known or suspected to have clostridium difficile diarrhea.

1. Clostridium difficile, diarrhea caused by enteric pathogen spores.
2. Requirements: Private room, gown and gloves when in contact with the patient or patient's environment. Hand hygiene should be soap and water only. Do not use alcohol foams! Remove gown and gloves when leaving patient room and dispose in trash bag.
3. Transport patient only when medically necessary.
4. Dedicate patient equipment for duration of hospitalization if possible. If unavoidable, thoroughly clean the device with a 1:10 bleach product prior to re-use.
5. Housekeeping will clean patient's rooms with a 1:10 dilution of a bleach product to kill the spores.

E. Bloodborne Exposures

If you are exposed to blood or body fluids, report this immediately to your preceptor. Do not let the known source of exposure leave until the blood samples have been obtained. Your preceptor will help you get to Employee Health, get exposure source tested, get baseline testing for yourself and start HIV prophylaxis if necessary. If incident occurs after routine office hours you will present to the Emergency Department for the same care.

If you have question, contact your preceptor.

Mandatory Reporting Guide Child and Dependant Adult Abuse

Physical Abuse

Consists of anything one person does to another that causes physical pain.

Signs and Symptoms may include

- Physical injuries
- Unexplained injuries
- Inconsistent or unlikely explanations of injuries
- Contradictory explanations of injuries given by the patient and the caregiver
- Lab findings indication medication overdoes or under-medication

Physical Neglect

The Department of Health and Human Services' *Third National Incidence Study of Child Abuse and Neglect (NIS-3)* defines physical neglect as any of the following:

- Refusal of health care—failure to provide or allow needed care in accordance with recommendations of a competent health-care professional for a physical injury, illness, medical condition, or impairment.
- Delay in health care—failure to seek timely and appropriate medical care for a serious health problem that any reasonable layperson would have recognized as needing professional medical attention.
- Abandonment—desertion of a child without arranging for reasonable care and supervision.
- Expulsion—other blatant refusals of custody, such as permanent or indefinite expulsion of a child from the home without adequate arrangement for care by others or refusal to accept custody of a returned runaway.

- Inadequate supervision—leaving a child unsupervised or inadequately supervised for extended periods of time, or allowing the child to remain away from home overnight without knowing or attempting to determine the child's whereabouts.
- Other physical neglect—may include inadequate nutrition, clothing or hygiene; conspicuous inattention to avoidable hazards in the home; and other forms of reckless disregard for the child's safety and welfare (e.g., driving with the child while intoxicated, leaving a young child unattended in a car).

Sexual Abuse

According to Iowa law, sexual abuse is defined as a sex act committed by one person by force on another person, or against that other person's will.

Signs and symptoms may include:

- Injury to the genital area
- Unexplained STIs or genital infections

Behavioral Abuse and Neglect

Signs and symptoms may include:

- Extreme withdrawal
- Depression or agitation
- Childish behavior
- Mixed feelings toward caregivers or family members
- Confused or disoriented
- Shows fear out of normal context
- Tells unbelievable stories
- Cautions about talking openly
- Makes statements that are contradictory or ambivalent

Financial Abuse and Neglect

The misuse of a person's funds and assets; obtaining property and funds without his/her knowledge and full consent, or in the case of an elderly person who is not competent, not in his/her best interests.

Signs and symptoms may include:

- Substandard care despite adequate resources
- Confusion or lack of awareness with regard to finances
- Sudden transfer of assets to a family member or other caregiver
- Signatures on checks or financial documents are forged
- Numerous unpaid bills
- Valuable items, such as art or jewelry are missing

If you notice any of these signs or symptoms, notify your preceptor immediately.

Identifying Victims of Abuse and Neglect

The Joint Commission includes a standard for victims of abuse. An important element of this standard is being able to recognize the criteria for victims of:

- physical assault,
- rape,
- sexual molestation,
- domestic abuse,
- adult neglect or abuse,
- child neglect or abuse.

Child Abuse

- Physical: abuse of a child includes any injury inflicted by a parent, guardian, or other caretaker.
- Emotional: Emotional abuse of a child occurs when a child is repeatedly shamed, humiliated, terrorized, or rejected.
- Sexual: Sexual abuse is the involvement of a child in any sexual activity for which he or she is not developmentally ready.

Physical findings most commonly associated with child abuse include

- Injuries on multiple body sites
- Injuries in different stages of healing
- Injuries inadequately explained by the history provided

Specific types of injuries that may be a sign of physical abuse:

- Bruises and welts if they form irregular patterns and resemble the shape of articles used to inflict injury: hand, teeth, belt buckle, and electrical cord.
- Burns that may indicate abuse include:
 - cigar burns, especially on the soles of the feet, palms of the hands, back or buttocks
 - immersion burns, which appear stocking-like on the feet/legs, glove-like on the hands/arms, and donut shaped on the buttocks or genitals
 - patterned burns resembling an electrical appliance, such as an iron, burner, or grill
- Cuts and abrasions often indicate abuse and include:
 - robe burns, especially on the wrists, ankles, neck, or torso
 - cuts/abrasions on the palate, mouth, gum, lips, eyes, or ears
 - cuts/abrasions on the external genitalia
- Fractures to the skull, ribs, long bones.
- Abdominal injuries may include bruises on abdominal wall and small intestine, liver rupture and injury to the kidneys.
- Central nervous system injuries including subdural hematoma (due to violent shaking or blunt trauma).

Child Neglect

Child neglect occurs when a parent, guardian, or caretaker fails to meet any of the basic needs of a child. These needs may be physical, development, or psychological.

Historical findings that may indicate neglect are

- lack of well-child care for chronic illnesses
- lack of necessary health aids

Identifying Victims of Abuse and Neglect—Continued

Behavioral findings that may indicate neglect are

- depression
- anxiety
- bedwetting
- sleep disturbances
- excessive masturbation
- poor interpersonal skills (lack of cuddliness, avoiding eye contact, preferring inanimate objects to people)
- discipline problems
- aggressive behavior
- role reversal, in which the child assumes the role of the parent/caretaker
- excessive responsibilities at home, including childcare responsibilities

If you suspect child abuse has occurred, you should notify your preceptor immediately!

Children most often do not disclose abuse or neglect. Therefore, to identify victims, healthcare staff must remain alert to the possibility of abuse, with the awareness of:

- Risk factors for child abuse
- Indicators of child physical abuse, sexual abuse, and neglect

Recommendations

- Identify the child who may have been abused and/or neglected.
- Take emergency measures needed to prevent further injury.
- Provide medical evaluation and treatment of injuries or conditions resulting from abuse and/or neglect.
- Provide accurate and complete medical evaluation consistent with the diagnosis of child abuse and/or neglect.
- Remain objective and nonjudgmental towards parent and child.
- Attempt to establish or maintain a therapeutic alliance with the family.
- Attempt to secure medical evaluation of other children present at the household.
- Social work can help facilitate a report to the appropriate authorities.

Adult Abuse

Adult abuse/neglect is any form of mistreatment that results in harm to an older person. Adults are anyone 18 years of age or older, and dependent adults are those unable to protect their own interests, according to chapter 235B.2 (4) of the Code of Iowa.

- Physical Abuse
 - Acts of violence that may result in pain, injury, impairment or disease; to include:
 - pushing, striking, slapping, or pinching;
 - force-feeding;
 - incorrect positioning;
 - inappropriate use of physical restraints; and/or
 - inappropriate use of medications.

Identifying Victims of Abuse and Neglect—Continued

- **Physical Neglect**
Failure to provide items or services necessary for optimal health and functioning; to include:
 - withholding meals, fluids, physical therapy, or hygiene; and/or
 - failure to provide physical aid such as eyeglasses or hearing aids.

- **Sexual Abuse**
Nonconsensual sexual contact of any kind.

- **Psychological Abuse**
Conduct that causes mental or emotional distress; to include:
 - verbally berating, harassing, or intimidating an older person;
 - threatening an older person with punishment or deprivation;
 - humiliating an older person; and/or
 - intentionally isolating an older person from family, friends or activities.

- **Psychological Neglect**
Failure to provide adequate social stimulation

- **Financial Abuse**
Misuse of income or resources; to include:
 - stealing money or possessions;
 - forcing an older person to sign contracts, assign durable power of attorney, purchase goods or make changes to a will.

- **Financial Neglect**
Failure to use available funds or resources to maintain the health and well being of an older person

Recommendations

- Find out about reporting guidelines.
- Learn about services available to victims and their families.
- Be aware of the people around you so you can pick out the signs of abuse.
- Participate and be involved in community-based programs.
- Be an advocate for the protection of vulnerable adults.

If you suspect a case of adult abuse, you should notify your preceptor immediately!

Identifying Victims of Abuse and Neglect—Continued

Domestic Abuse

In domestic abuse, the victim is an adult or adolescent (in 85% of cases, a woman). The abuser is a person (most often a man) who is, was, or wishes to be in an intimate or dating relationship with the victim.

The dynamics of the abuse are quite specific: the abuser engages in a pattern of violent and/or threatening behaviors, with the goal of establishing control over the victim. The abusive behaviors may include:

- inflicting physical injury;
- psychological abuse;
- sexual assault, including rape;
- isolating the victim from family, friends, and other sources of social support;
- depriving the victim of clothing, food, necessary medication or other essential items; and/or
- intimidating or threatening the victim.

Indicators of domestic abuse can include patterns such as

- failure to keep medical appointments or comply with medical advice (abusers often restrict access of victims to medical help, medication, etc);
- secrecy or obvious discomfort when questioned about intimate relationships and the possibility of abuse;
- presence of a partner who:
 - controls or dominates your interview with the patient,
 - appears unreasonably anxious or concerned,
 - will not leave the patient alone with you;
- unusually high number of healthcare visits;
- repeated return visits with vague complaints;
- inconsistent or unlikely explanations for injuries;
- health problems often associated with abuse (for example, chronic pain without apparent cause, insomnia, substance abuse, mental health problems);
- high number of sexually transmitted diseases, pregnancies, miscarriages and/or abortions;
- physical injury during pregnancy, especially on the breasts or abdomen; and/or
- repeated vaginal or urinary tract infections.

As part of a standard health history, patients should be asked direct questions regarding physical, emotional, and sexual abuse by past or current intimate partners, whether or not there are obvious indicators of abuse. Direct, routine inquiry into domestic abuse helps communicate support to victims and validate domestic abuse as a legitimate healthcare issue. This increases the likelihood that victims will disclose and discuss abuse. Many victims, however, will not share information, due to embarrassment, shame, or fear of the abuser.

If the patient discloses abuse, contact your preceptor immediately!

If the patient denies abuse:

- Respect his or her right not to disclose.
- Inform the patient of your ongoing support and availability.
- Offer the patient information on domestic violence resources available in the community.

Identifying Victims of Abuse and Neglect—Continued

Abuse Response/Reporting

Broadlawns hospital-wide policy P-0200, Child Abuse, Newborn Safe Haven, Dependent Adult Abuse, Domestic Violence and Sexual Assault, has been modified to include the following specific action steps to be taken in the event an allegation of abuse in the medical center by a staff member or provider is reported:

1. In the event witnessed or suspected abuse has occurred at the Medical Center by a staff member or provider, the following actions will be taken:
 - a. Immediately separate the staff member/provider from the patient.
 - b. Immediately report the incident to supervisory personnel.
 - c. Complete an incident report
2. Supervisory personnel will notify Risk Management personnel/Administration, who will then evaluate the situation and comply with all legally required reporting requirements, such as DHS/DIA, licensing boards, and law enforcement as applicable. This evaluation will include witness interviews, and review of video recordings if available, and will be completed within 3 business days following the reported allegation.
3. The staff member/provider will be placed on administrative leave away from the medical center with no patient contact during the investigatory process.
4. In instances involving a provider and patient, the patient shall be reassigned to another provider and the prior provider shall discontinue all involvement in the patient's care, including performing assessments or writing orders, etc.

Badging Requirements During Fluoroscopy

The Iowa Department of Public Health requires that all students in healthcare training schools and all facilities where fluoroscopic procedure are performed wear individual monitoring devices (film badges). If badges are not provided by the school for the students, the facility is responsible to provide the film badges.

Students in these training programs are considered occupational workers during the clinical component of their training when they must remain in the room/operator during fluoroscopy procedures.

Broadlawns Medical Center staff is responsible for monitoring students to ensure that the film badges are worn during fluoroscopic procedures where the student is present. Staff will control the occupational dose to individual adults and monitor exposures from sources of radiation at levels sufficient to demonstrate compliance with occupational dose limits.

No students will be allowed in radiology procedures without a radiation exposure badge. No exceptions!

Falls

To meet the safety needs of the inpatient. All inpatients will be assessed for their individual risk of falling, utilizing fall assessment. Patients identified as having a risk for falling will have appropriate interventions initiated, for the expressed purpose of fall prevention and the promotion of patient safety.

All patients are assessed for the risk of falling. If it is determined they are at risk, interventions will be used to reduce those risks and maintain a safe environment. A fall risk assessment scale is presented under the fall assessment intervention in Meditech.

Procedure

Inpatients are to be assessed for the risk of a fall upon admission, transfer from one unit to another, transfer from one room/environment to another, following a change in condition or level of care, any fall while hospitalized, post procedure of any procedure involving sedation, and on Wednesdays during the day shift. Due to the rapidly changing condition of OB patients, they are to be assessed on admission and after delivery. The patient score of 0 – 35 is considered to be Low Risk for falls, the score of 36 – 70 is considered to be at Moderate Risk for falls, and the score of greater than 70 is considered to be at High Risk for falling. Document interventions daily on the 7-3 shift. Even though documentation is only required every 24 hours, it should be understood that interventions are to be maintained/carried out continuously.

Definition of a Fall

A sudden unexpected decent from standing, sitting or horizontal position. This includes witnessed and un-witnessed events. Falls will include incidents in which the person is found lying on the floor and/or on some object. The following incidents, while reportable, are not considered falls:

1. Incidents in which someone is eased to the floor by another who had been assisting the patient
2. As a consequence of sustaining a violent blow
3. A loss of consciousness
4. A sudden onset of paralysis such as with a stroke or seizure

Post-Fall Occurrence

Steps to follow once a fall has occurred:

1. Conduct a physical assessment and provide emergency care as needed.
2. Notify the physician and report any signs of injury.
3. Conduct a post fall huddle to identify factors that contributed to the event.
4. Complete the variance report in the QM section of Meditech and forward to Director and Risk Management.
5. Reassess patient for risk of falling, initiate or review fall interventions and develop an individualized care plan goal relating to risk of fall or general safety goal.
6. Communicate to the patient that they are a fall risk and the importance of calling for assistance before getting out of bed.
7. If family is available, notify them of the fall and develop a plan for safety.

Fall Risk and Injury Risk Stratification

Fall Risk

1. Patient is at Low Risk for Falls if score is 0-35. Implement:
 - a. Low bed
 - b. Non-slip foot wear
 - c. Lock moveable transfer equipment prior to transfer
 - d. Individualize equipment to patient needs
 - e. Medication review
 - f. Keep room free of obstacles
 - g. Place patient items and call light within patient's reach

- h. Communicate the risk of falling in report and when transporting to other areas.
- i. Assess for visual and hearing impairments.
- 2. Patient is at Moderate Risk for Falls if score is 36-70. Implement above interventions plus the following:
 - a. Place a star on the doorframe that signifies patient is a fall risk
 - b. Place yellow arm band on patient
 - c. Provide patient with yellow non-skid socks
 - d. Observe patient every one (1) hour at a minimum
 - e. Toilet patient every two (2) hours while awake and at HS
 - f. Use wheelchair, commode, walker, cane as appropriate
 - g. Activate bed alarm, if available
 - h. PT/OT screen if patient has new mobility issues
 - i. When possible, place patient in room that has high visibility
 - j. Remind patients and families that patient is at risk for falls and to ask for assistance
 - k. Provide re-orientation as appropriate
- 3. Patient is at High Risk for Falls if score of 70 or higher. Implement above interventions plus the following:
 - a. Provide patient with non-skid slippers
 - b. Ask family members to stay with patient or consider the use of a sitter
 - c. Assess patient need for specialized equipment (perimeter mattress, etc.)

Injury Risk

- 1. Patient is considered Low Risk for Falls and High Risk for Injury if
 - a. Patient fall risk assessment score is Low Risk, but patient has one of the following conditions:
 - i. age equal to or greater than 50,
 - ii. underlying bone pathology (fracture, bone mets, osteoporosis),
 - iii. Hx of coagulation impairment (on Coumadin, heparin or decreased platelets),
 - iv. detox patient or
 - v. narcotic naïve.
- 2. Patient is considered Low Risk for Falls and Low Risk for Injury if
 - a. fall risk assessment is low and does not have any of the ***above listed*** conditions.
- 3. Patient is considered High Risk for Falls and High Risk for Injury if
 - a. fall risk assessment is greater than 36,
 - b. age equal to or greater than 50,
 - c. underlying bone pathology (fracture, bone mets, osteoporosis),
 - d. Hx of coagulation impairment (on Coumadin, heparin or decreased platelets),
 - e. detox patient or
 - f. narcotic naïve.
- 4. Patient is considered High Risk for Falls and Low Risk for Injury if
 - a. fall risk assessment is 70 or higher and does not have any of the ***above listed*** conditions.
- 5. Any patient identified as Low risk for falling and high risk for injury if they did fall will also have a yellow band and yellow slippers for identification of their risk.

Restraints and Seclusion

Definitions

Physical restraint— any manual method, physical or mechanical device, material or equipment that immobilizes or reduces the ability of a patient to move arms, legs, body or head freely.



- Medical restraint—(non-violent, non self-harm) utilized to support medical healing when patient behavior threatens to interrupt or undermine active and necessary medical treatment.
- Behavioral restraint—(violent and self-harm) utilized to protect the individual against serious injury to self or others because of an emergency or crisis situation where patient behavior becomes more aggressive or violent.

Seclusion—the involuntary confinement of a patient alone in a room or area from which the patient is physically prevented from leaving.

Is it seclusion if you are preventing someone from leaving an area but they perceive you as preventing them from leaving?

DHS or police are on their way to talk to you...you can't leave yet.



What does this mean to me?

As a student you have a responsibility to ensure a safe and respectful environment. That means if you see a patient restrained or secluded that is in a non-safe environment or non-respectful environment tell the nurse IMMEDIATELY!

What does SAFE and RESPECTFUL look like?

- Patient is covered and on the bed.
- Patient can breathe easy and can speak.
- Neck is free of obstruction
- Head can move freely.
- Extremities and head are pink.
- Patient is not trying to get self undone or have a free extremity.

Preserve Patient Dignity

- Announce yourself before entering the patient's room.
- Report if the patient is found exposed.
- Give the patient as much privacy as possible (pull the curtain, shut the door).
- Don't treat the patient differently just because they are restrained.

As a student you are NOT to apply, manage or remove restraints without your preceptor there to supervise.

If caring for a patient that has restraints in use, please review the hospital policy (P-0119) with your preceptor and discuss what your specific role is for that patient.

Handcuffs

- Broadlawns Medical Center staff NEVER use handcuffs with patients. Only Peace Officers use handcuffs with patients.
- Patients in handcuffs must be attended by a Peace Officer at all times.
- Once the handcuffs are applied, the Peace Officer is responsible for the individual.
- Broadlawns Security/Public Safety staff are NOT Peace Officers/Police.