
# Public Site - Annual Safety Training 2020 Volunteers & Volunteens

MONUMENT HEALTH

**Completion**
**At the end of each section there is a confirmation number listed. Please record that number for verification.**

**Please Note**
We are excited to officially transition to our new name and brand beginning January 17, 2020. As we are becoming Monument Health, you may see items (such as images, documents, policies, etc.) that say Regional Health within this training. All Regional Health branded items should be phased out by the end of the fiscal year (FY20).

- Fire and Electrical Safety
- Infection Control
- Patient and Resident Rights
- Restraints and Seclusions

- Nutrition and Hydration
- Caring for Patients With Unique Needs
- First Aid
- MRI Suitability for Employees and Guests

# Fire and Electrical Safety

## Fire Safety

Everyone has a role and responsibility in the event of a fire emergency, which may involve:

- relocating patients, residents, or visitors
- sounding the alarm
- calling the appropriate emergency response number

## RACE

*Click on the arrows next to the image below to view more information.*

Fire emergency response is summarized by the acronym **RACE**.

**R**

The R in RACE means rescue. Move everyone out of the area of the fire. Next move people in rooms on either side of the fire and rooms across the hall and rooms above and below the fire.


**A**

The A stands for alarm. Pull boxes/alarms are located throughout our healing environments at or near an exit. You should know where each pull box/alarm is located in your work area.

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**C**

The C stands for contain. The first step in defending against the threat of the fire and smoke is containment. Closing all doors can prevent smoke from spreading, cut off the flow of oxygen to a fire, and save lives.

**E**

E stands for extinguish. Handheld fire extinguishers are located throughout the healing environments. You should only attempt to extinguish small, contained fires, where your safety is assured. You should also have an escape route behind you and a staff member or other healthcare worker available to assist you.

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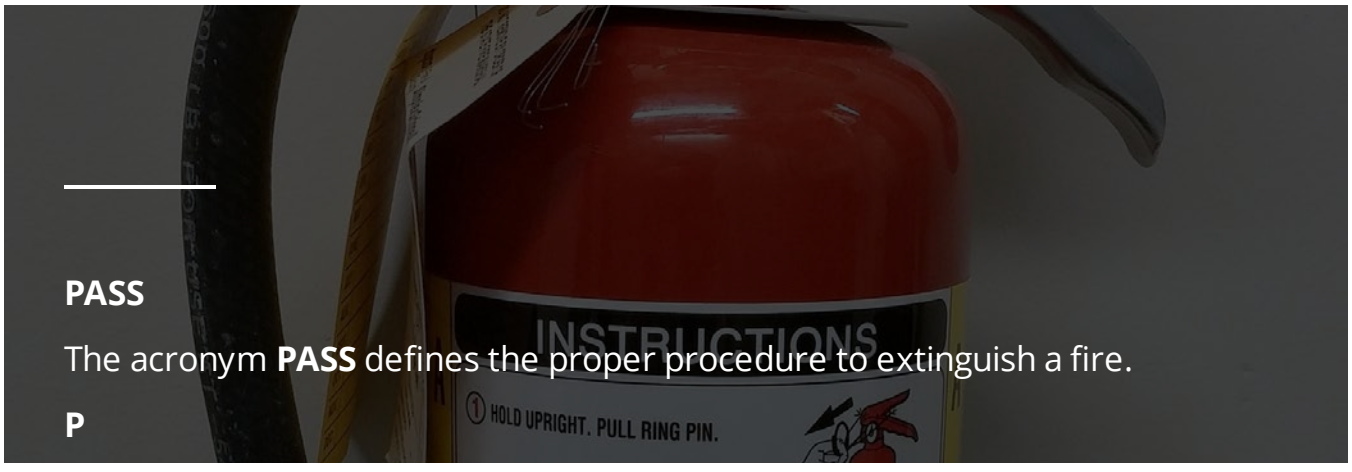
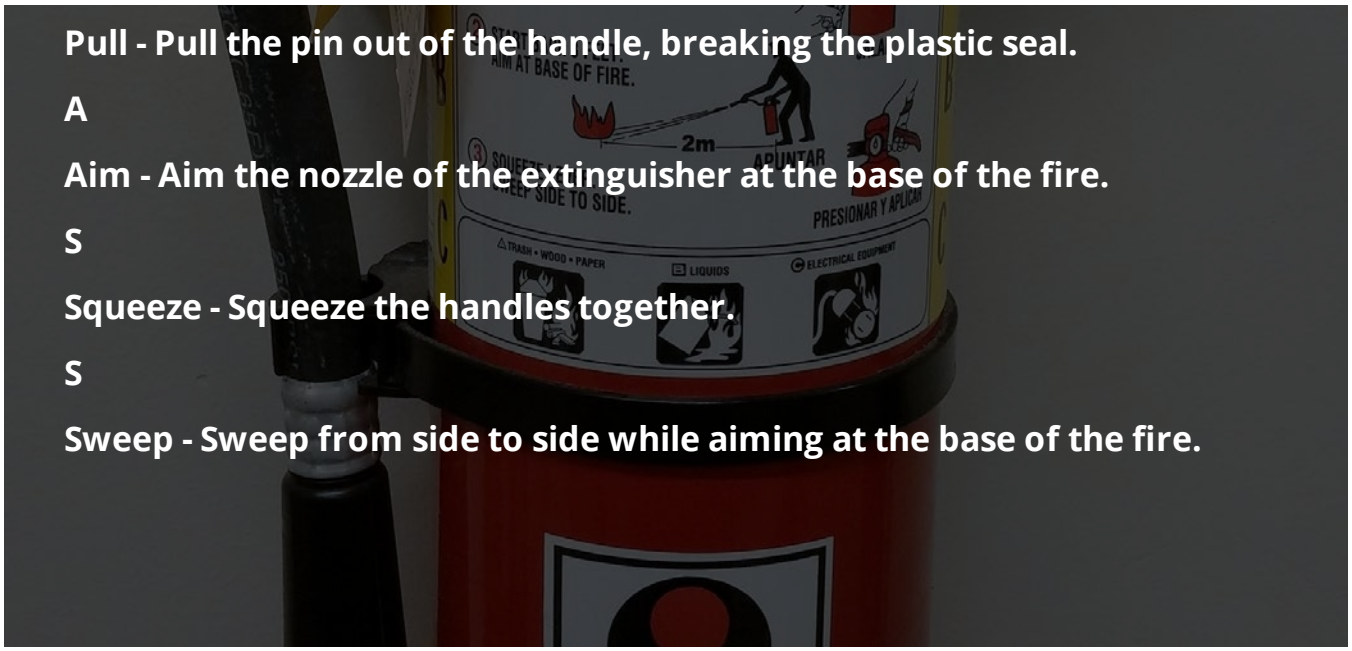



**PASS**

The acronym **PASS** defines the proper procedure to extinguish a fire.

**P**




## Fire Safety Recap

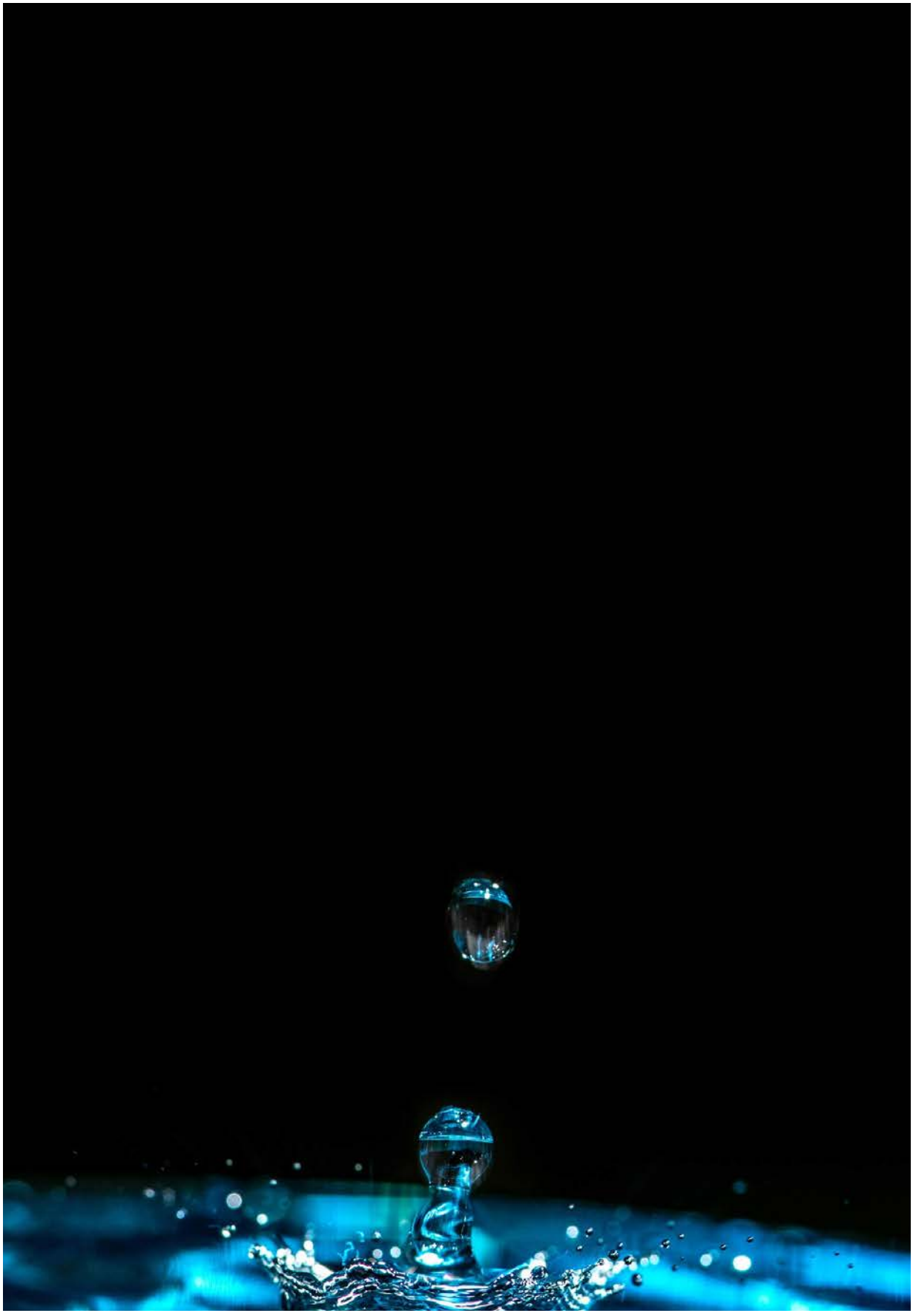
Each Monument Health healing environment has a fire plan and regular fire drills so that you know what to do in an emergency.

- Know the location of fire alarm pull-boxes in your work area.
- Know where fire extinguishers are located and how to use them.
- Know where the exits are.
- Take care to never block an exit.
- Know how to shut off oxygen in your facility.

## Electrical Safety

Electricity is the flow of electric power or energy. Electricity occurs in nature, such as lightning for example. Electricity can be made and sent over long distances and requires a conductor and a closed circuit.

## What Is a Conductor?



A material that can transmit electricity, and in which electric currents flow readily.

Examples of conductors include:

- ground/earth
- metals
- moist body tissue
- body fluids
- water

## What Is an Insulator?

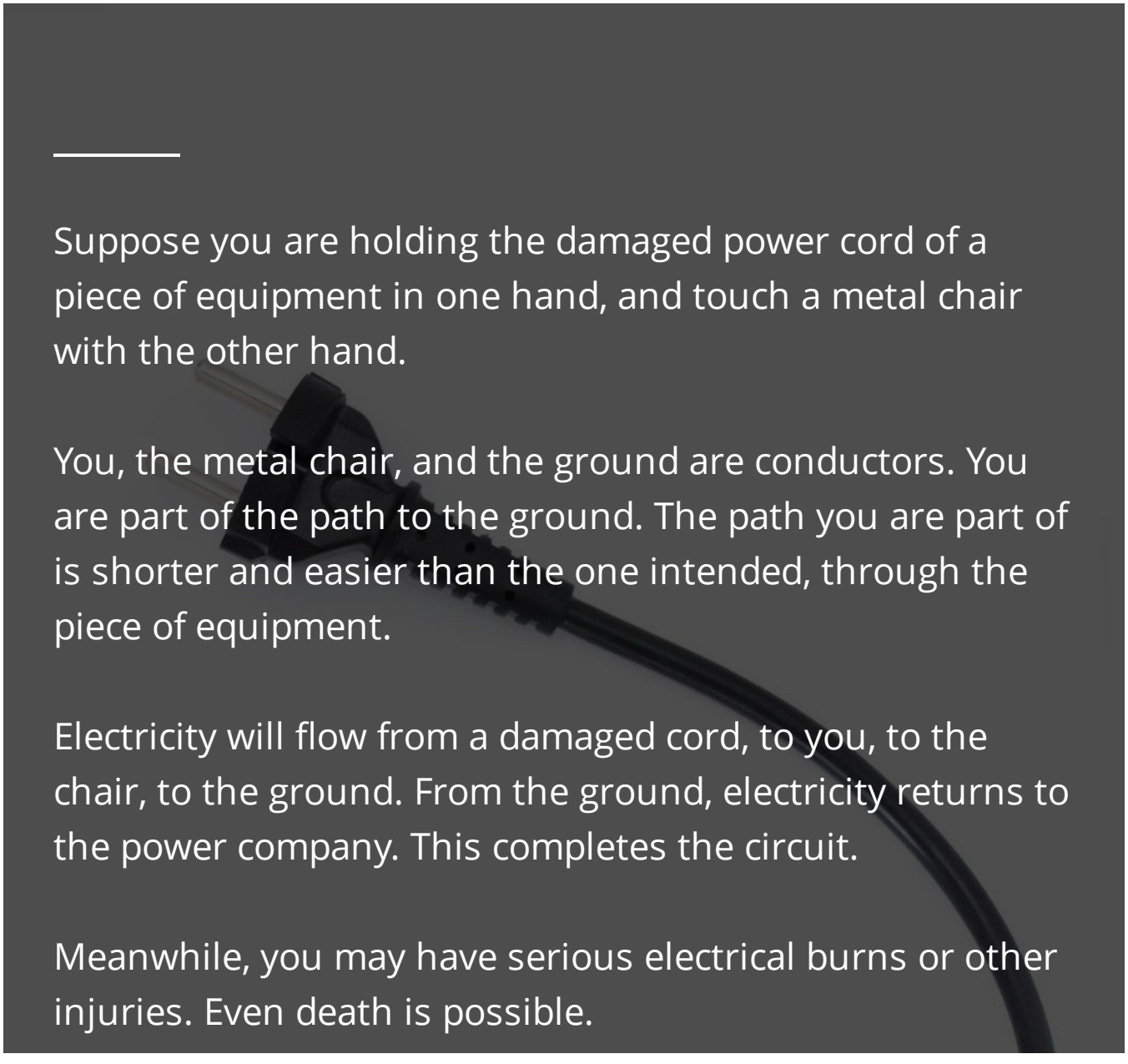
A material that can block the flow of electric current and force electricity to take a more difficult path.
Examples of insulators include:

- rubber
- plastic
- glass
- cloth
- wood

## Circuits

Electricity travels in a loop (circuit). When you plug in a piece of equipment, electricity flows from the outlet to the equipment and then back to the outlet. Anything that conducts electricity can become part of the circuit. Because bodies conduct electricity, you become part of a circuit.

## Circuits and You



Suppose you are holding the damaged power cord of a piece of equipment in one hand, and touch a metal chair with the other hand.

You, the metal chair, and the ground are conductors. You are part of the path to the ground. The path you are part of is shorter and easier than the one intended, through the piece of equipment.

Electricity will flow from a damaged cord, to you, to the chair, to the ground. From the ground, electricity returns to the power company. This completes the circuit.

Meanwhile, you may have serious electrical burns or other injuries. Even death is possible.

## Electrical Safety Recap

- Pay attention to warning signs.
- Electrical accidents often cause injuries, fires, and death.
- Electric shock happens when you become part of a circuit.
- Electric shock happens if a person touches a damaged device or an electrified object.

## Fire and Electrical Completion

Please record the following number for completion: 798412.

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# Infection Control

## Personal Protective Equipment (PPE)

PPE is specialized clothing or equipment worn by a caregiver for protection against a hazard. Remember that PPE is one of the methods to reduce exposure to infectious agents. PPE is the last line of defense in preventing your exposure to infectious agents.

Examples include, but not limited to:

- eye protection
- face masks or shields
- gowns/laboratory coats (fluid resistant)
- gloves
- ressuscitation and ventilation devices

## Gloves

You are required to wear gloves when:

- there may be contact with blood, body fluid, mucous membranes, and non-intact skin
- performing vascular access procedures (for example, drawing blood or inserting an IV)
- handling, touching, or cleaning contaminated items or surfaces

Replace contaminated, torn, or punctured gloves as soon as practical. If there is any doubt that a glove's ability to function as a barrier is compromised, the gloves should be replaced.

## Glove Removal

*Please watch the video by clicking here. Note: This video does **not** contain audio.*

## Masks, Eye Protection, Face Shields

*Please watch the video by clicking here. Note: This video **does** contain audio.*

# Personal Protective Equipment

**Donning Personal Protective Equipment**

The type of PPE used will vary based on the level of precautions required, such as standard and contact, droplet, or airborne infection isolation precautions. The procedure for putting on and removing PPE should be tailored to the specific type of PPE.

*Please watch the Donning video by clicking here. Note: This video **does** contain audio.*

# Personal Protective Equipment Work Practices

1. Remove any garment penetrated by blood or body fluid as soon as possible.
2. Remove all PPE prior to leaving your work area or point of use.
3. Place removed PPE in a designated area or container for washing, decontamination, or disposal.
4. Wash hands with soap and water or hand antiseptic as soon as possible after removing gloves or other protective clothing, or after direct contact with blood or body fluid.
5. Keep hands away from face.
6. Change gloves when torn or heavily contaminated.
7. Perform hand hygiene.

# Doffing Personal Protective Equipment

Remove all PPE before exiting the patient room except a respirator, if worn. Remove the respirator after leaving the patient room and closing the door.

Perform hand hygiene between steps if hands become contaminated and immediately after removing all PPE.

*Please watch the doffing video by clicking here. Note: This video **does** contain audio.*

## Hand Hygiene

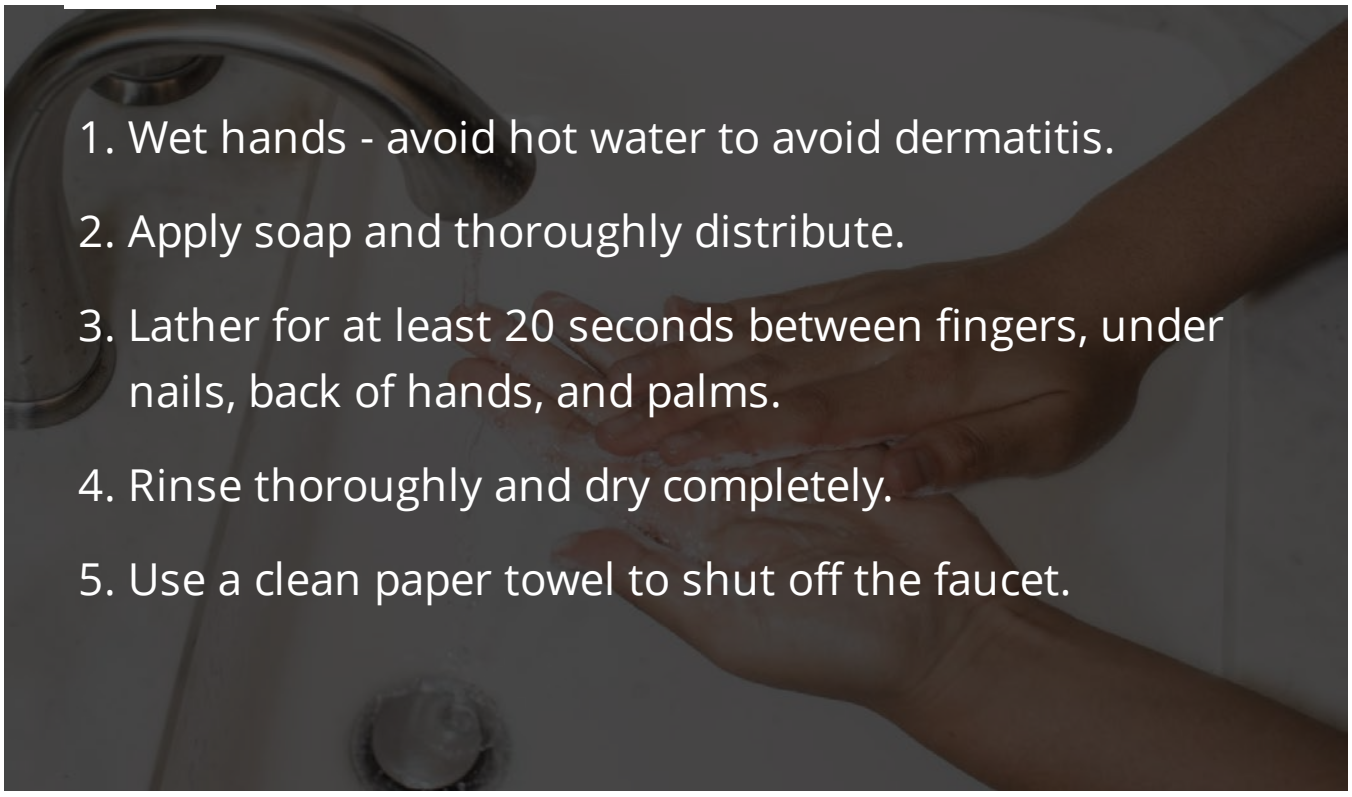
Hand hygiene is a general term that applies to either handwashing, antiseptic hand wash, antiseptic hand rub, or surgical hand antisepsis.

Cleaning your hands before and after patient/resident contact is one of the most important measures for preventing the spread of infections.



## Handwashing Steps

Use soap and water when hands are visibly soiled.




**Note:** Certain situations call for hand hygiene with soap and water, such as after caring for a patient suspected of or diagnosed with Clostridium difficile (C. diff), Norovirus, or Enterovirus D-68.

## Steps to Using Alcohol-Based Hand Rubs (Foam, Gel, etc.)


ALCARE PLUS®
Antiseptic Handrub
with Emollients
Place fingers under
spout & pull forward
STERIS

- Apply product to palm of hand.
- Rub hands together covering all surfaces of hands and fingers.
- Rub until dry. **DO NOT** dry your hands with a towel.
- Be sure to use the volume of product recommended by manufacturer.
- Non-surgical applications:
- Steris - Allcare Plus (purple label): **Golf ball-sized**.
- Do wash your hands with soap and water after using foam 5-10 times. The emollients in the foam will build up and need to be rinsed off.

# Which is better, hand washing or alcohol-based hand products?

**Belief**

Alcohol-based hand rub/rinses/gels dry hands out more than soap and water.

**Reality**

Alcohol-based rinses or gels containing emollients caused substantially less skin irritation and dryness than the soaps or antimicrobial detergents tested.

Source: CDC MMWR, Guideline for Hand Hygiene in Health-Care Settings, October 25, 2002. Vol. 51, No. RR-16. (p. 13)

# How to Handrub?

## RUB HANDS FOR HAND HYGIENE! WASH HANDS WHEN VISIBLY SOILED

**Duration of the entire procedure:** 20-30 seconds

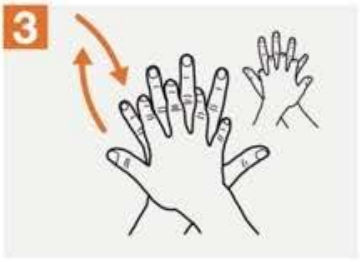
1a 1b

Apply a palmful of the product in a cupped hand, covering all surfaces;

2

Rub hands palm to palm;

3



Right palm over left dorsum with interlaced fingers and vice versa;

4

Palm to palm with fingers interlaced;

5

Backs of fingers to opposing palms with fingers interlocked;

6

Rotational rubbing of left thumb clasped in right palm and vice versa;

7

Rotational rubbing, backwards and forwards with clasped fingers of right hand in left palm and vice versa;

8

Once dry, your hands are safe.

World Health Organization | Patient Safety — A World Alliance for Safer Health Care | **SAVE LIVES** Clean **Your** Hands



WHO acknowledges the Hôpitaux Universitaires de Genève (HUG), in particular the members of the Infection Control Programme, for their active participation in developing this material.

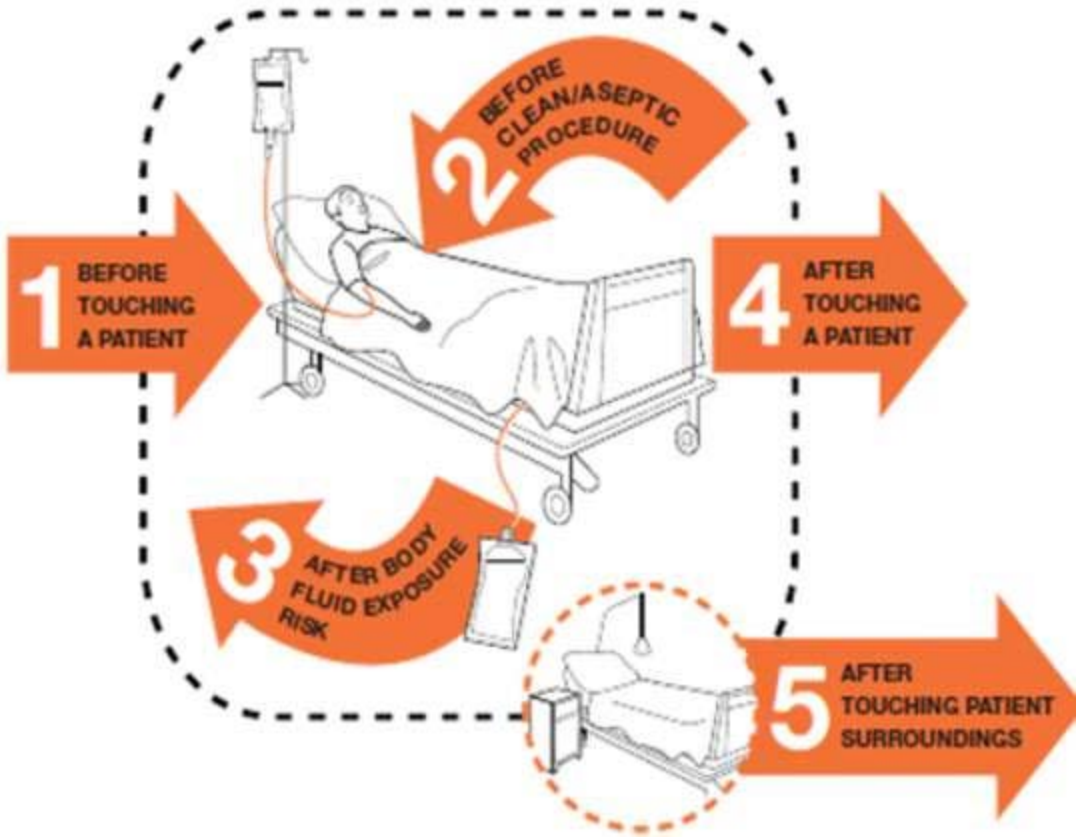
May 2009

# Foam In/Foam Out

Monument Health has a catch phrase to remind everyone to "foam in" when going into a patient's/resident's room or patient area and to "foam out" upon leaving the patient/resident room or patient/resident area.

Alcohol-based hand rubs are very efficient cleansers when there is no visible contamination. Alcohol-based foam or gel has been placed outside almost every patient room and in many areas throughout the healing environment.

*Please watch the video by clicking here. Note: This video **does** contain audio.*




# Airborne Infections and Communicable Diseases

**Tuberculosis (TB)**

If you see the signs and symptoms of TB (fever, night sweats, persistent cough, weight loss, loss of appetite, or coughing blood) you need to initiate airborne isolation and discuss TB concerns with the provider.

# Isolation Precautions

Monument Health provides facilities and services for isolation procedures necessary to help prevent transmission of infections and communicable diseases among patients, residents, caregivers, and visitors.

Remember that Standard Precautions will be used with all patients at all times. Patients will be placed in appropriate precautions for known or suspected infectious diseases.

Below is a list of precautions that could be used at Monument Health. The colored square corresponds to the colored sign used for each precaution.


# Isolation Precautions

*Click on the arrows next to the image below to view more information.*


**Droplet Precautions**

- Mumps
- Whooping Cough
- Influenza


**Airborne Precautions**

• Chickenpox & Measles

• Suspected or confirmed cases of Laryngeal or Pulmonary Tuberculosis


**Bleach Contact Precautions**

• C. difficle

• Norovirus

Wash Hands with soap and water


**Contact Precautions**

- Multi-Drug Resistant Organisms
- MRSA, VRE, ESBL, CRE, KPC
- Rotavirus


**Special Pathogen Precautions**

- SARS
- Smallpox
- Ebola
- MERS

**Call Infection Control Immediately**

## PPE for Isolation Situations


PPE must be d**ON**ned AFTER performing hand hygiene outside of an isolation room.
PPE must be d**OFF**ed at the room threshold and disposed of in the isolation room.
Hand hygiene should be performed outside of an isolation room, after removing PPE.

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## Infection Control Completion

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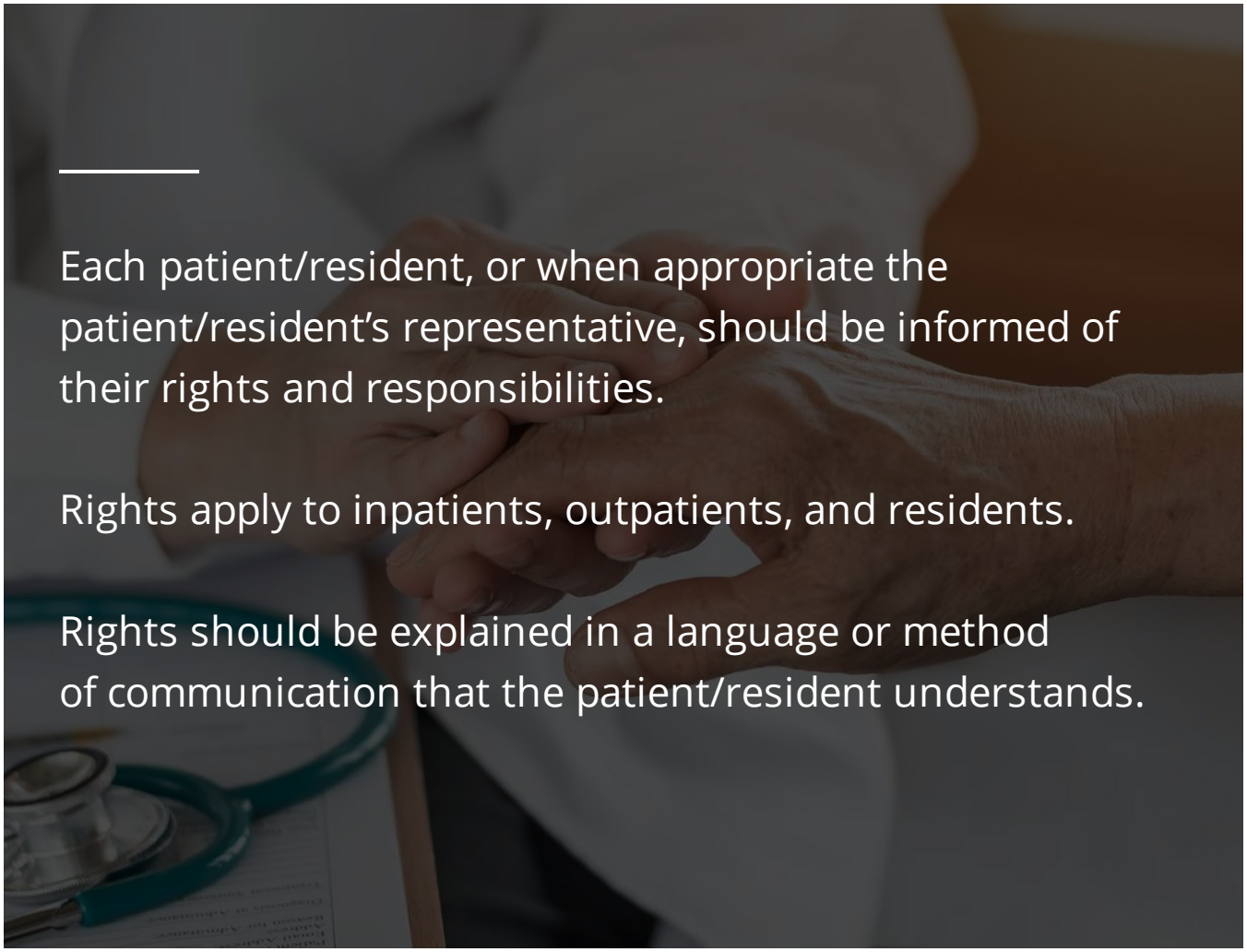
# Patient and Resident Rights




## Patient/resident rights include, but are not limited to:

- notification of rights
- participation in care decisions

- access to appropriate care without discrimination
- refusal of care
- access to appropriate services without discrimination
- freedom from unnecessary restraints
- safe, considerate, and respectful care
- end of life care
- interpretive services
- notice of unanticipated care

## Grievances

Monument Health hospitals and senior care healing environments have established a process for prompt resolution of grievances (Policy GB-8311-03).

1. The right to be informed of the process for resolution of grievances.
2. Prompt resolution with clear definition of time frames for response.
3. Written notification of resolution.

## Restraints

Each patient or resident has the right to receive care in a safe setting.

The initiation or discontinuing the use of restraints is based off of the safety of the patient, resident, caregiver, provider, or others.

Restraints may only be used to ensure the immediate physical safety of the patient, resident, caregiver, physician, or others and must be discontinued at the earliest possible time.

*A restraint is any device or manual method that immobilizes or reduces the ability of a patient or resident to move his or her arms, legs, or head freely.*

A restraint can be something as simple as brakes on wheelchairs, rails on bed, or more obvious such as wrist restraints.

If you encounter a safety concern with the use of restraints, ensure the safety of the patient or resident first, then contact the nursing caregiver in charge.

Please remember that something as simple as setting the brakes on a patient's wheelchair can be considered a restraint if the patient or resident is unable to remove them themselves.

## Support Person

Each patient or resident has the right to identify a support person.

The support person may not necessarily be the same person who helps make medical decisions.

The patient shall have access to the support person at all times.

The name of the designated support person will be documented in the medical record upon admission.

## Summary

In an effort to provide comprehensive, quality health care, each patient/resident should be informed of their rights before receiving or discontinuing care.

## Patient and Resident Rights

Please record the following number for completion: 498342.

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# Restraints and Seclusions

## Color-Coded Patient Wrist Bands

The color-coded alert system is meant to designate certain medical conditions consistently throughout Monument Health facilities, thereby communicating patient/resident safety risks to all caregivers and providers.

Please review the chart below to familiarize yourself with the wrist band colors and what they mean.

| | |
|---|---|
| County Mental Hold | Green |
| Fall Risk | Yellow |
| Restricted Extremity | Pink |

## Patient and Resident Rights

Each patient or resident has the right to receive care in a safe setting. The safety of the patient, resident, caregiver, or others is the basis for initiating and discontinuing the use of restraints or seclusion.

All patients and residents have the right to be free from restraints or seclusion, of any form, imposed as a means of coercion, discipline, convenience, or retaliation by caregivers.

Restraints or seclusion may only be imposed to ensure the immediate physical safety of the patient/resident, a caregiver, or others and must be discontinued at the earliest possible time.

These rights apply to all patients or residents, regardless of age, in all hospitals and long-term care facilities.

## Decision to Use Restraints or Seclusion

The decision to use restraints or seclusion is not driven by diagnosis, but by comprehensive individualized patient or resident assessment.

This assessment is used to determine the least restrictive measures to maintain patient/resident safety.

This assessment also determines if the use of less restrictive measures poses a greater risk than the use of restraints.

The assessment also includes a physical assessment to identify any underlying medical problems that may be causing the behavior changes in the patient/resident.

- Temperature elevations
- Hypoxia
- Hypoglycemia
- Drug interactions or drug side effects

For residents of long-term care healing environments, the assessment must consider attaining or maintaining the resident's highest practical level of physical and psychosocial well-being.

## Discontinue the Use of Restraints or Seclusion

Caregivers must assess and monitor a patient's or resident's condition on an ongoing basis to ensure that the patient is released from restraint or seclusion at the earliest possible time.

Restraint or seclusion may only be used while an unsafe situation continues.

Once an unsafe situation ends, the use of restraint or seclusion should be discontinued.

The decision to discontinue the restraint or seclusion should be based on whether the need for restraint or seclusion is no longer present.

Additionally, can the patient's/resident's needs be addressed using a less restrictive method, such as modifying the environment or care routine?

**What Is a Physical Restraint?**

Any manual method, physical or mechanical device, material or equipment, attached or adjacent to the body, that immobilizes or reduces the ability of a patient or resident to move his or her arms, legs, or head freely.

If the individual cannot remove the device easily and it restricts freedom of movement or normal access to one's body, it is a restraint.

**Example of a Physical Restraint**

**What Is a Chemical Restraint?**

A drug or medication when it is used as a restriction to manage the patient's behavior or restrict the patient's/resident's freedom of movement and is not a standard treatment or dosage for the patient's/resident's medical condition.

This definition is not intended to interfere with the appropriate use of medications to treat serious mental illness or medical conditions such as insomnia or anxiety.

A patient with wrist restraints that are attached to their bed is an obvious example of a restraint.

Bed side-rails can also be a restraint if they are used to prevent the patient from voluntarily getting out of bed.

In long-term care, bed side-rails are prohibited unless they are necessary to treat a resident's medical symptoms.

**Example of a Chemical Restraint**

A patient is suffering from alcohol withdrawal and becomes violent and aggressive.

Caregivers use a medication ordered by a physician to treat symptoms of alcohol (ETOH) withdrawal.

This is **NOT** a chemical restraint but a standard treatment for alcohol withdrawal.

## What Is a Medical Protective Device?

Devices that immobilize but are usual, customary, and necessary for a procedure or treatment are **NOT** considered restraints. Examples include:

1. IV arm board to stabilize an IV, unless it is tied down or attached to a bed.
2. Mechanical support to achieve proper body position, balance, or alignment such as leg braces, head, or neck braces.

3. Positioning or securing devices such as those used to maintain position during MRI, CT scan, or surgery.

4. Recovery from anesthesia is considered part of the surgical procedure; therefore, medically necessary restraints and do not require monitoring.

5. Enclosed framed wheeled walkers with or without a posterior seat are not restraints unless the patient/resident cannot easily open the gate and exit the device.

## Examples Of Medical Protective Devices

1. Age or developmentally appropriate safety interventions

2. Bedside rails used to keep the patient/resident from voluntarily getting out of bed are considered restraints

Remember that regular use of restraints is not part of a falls prevention program.

## What Is Intent to Use?

If the device or drug is used to restrict the freedom of movement of a patient/resident, it may be a restraint. This is true if:

- patient/resident cannot easily remove the device
- the drug used is not a standard treatment or dose

## What Are Law Enforcement Restraints?

> The use of these devices are not considered safe, appropriate health care restraint interventions for use by caregivers. Law enforcement officers are responsible for the use of these restraints.

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The use of handcuffs, manacles, shackles, or other chain-type devices applied by non-facility employed or contracted law enforcement officials for custody, detention, and public safety reasons are **NOT** restraints governed by Centers for Medicare/Medicaid Services rules.

Caregivers are still responsible for appropriate assessment and care of the prisoner.

## What Is Seclusion?

The involuntary confinement of a patient/resident alone in a room or area from which the person is physically prevented from leaving.

Seclusion may only be used for the management of violent or self-destructive behavior.

## What Is Not Seclusion?

A physically restrained patient/resident alone in an unlocked room does not constitute seclusion.

Confinement on a locked unit or ward where the patient/resident is with others does not constitute seclusion.

## How and Why to Use Restraints

Restraints may only be used when less restrictive interventions have been determined to be ineffective to protect the patient, resident, caregivers, or others from harm.

**For Long-Term Care Residents**

- Restraints may be used to permit medical treatment to proceed unless the resident has previously made a valid refusal of the treatment.
- If unanticipated violent behavior places him/her in danger, they do not have the right to refuse the use of restraints.
- The use of restraints must be a part of the care planning discussed with the resident or their legal representative.

## Orders for Restraints

**Orders for restraints may never be written as pro re nata (PRN) orders or standing orders!**

**For Long-Term Care:**

A physician's order must be present reflecting the medical condition requiring restraints.

The Centers for Medicare/Medicaid Services (CMS) will hold the healing environment ultimately responsible for the appropriate use of restraints.

## Use of Restraints for Violent or Self-Destructive Behavior

Document the use of restraints for violent or self-destructive behavior in Acute Care.

When a restraint or seclusion is used for the management of violent or self-destructive behavior jeopardizing the immediate physical safety of the patient, caregivers, or others, the patient must be seen face-to-face within one hour of the intervention by a physician, PA, or RN with training in restraint use.

Caregiver must evaluate the following items during their assessment:

1. The patient's immediate situation
2. The patient's reaction to the intervention
3. The patient's medical and behavioral condition
4. The need to continue the restraint

While the patient is restrained, the assessment must include behavior, fluids, toileting, circulation, and range of motion (ROM) to extremity and to determine if the restraints can be removed.

## Documenting Use of Restraints for Violent or Self-Destructive Behavior

In Acute Care, documentation must include:

- one hour evaluation
- description of behavior and intervention used
- alternatives or less restrictive interventions attempted
- patient's condition or symptom
- patient's response to interventions used/rationale for intervention

## Use of Restraints for Unanticipated Violent or Aggressive Behavior

Restraints may be used, as a measure of last resort, if the behavior places the resident or others in imminent danger.

## Use of Restraints for Non-Violent or Non-Self Destructive Behavior

To use restraints in the Acute Care setting, the following must be in place:

- A physician's order, unless applied in an emergency situation. An order must then be obtained immediately after placing the restraints. The time limits for the renewal of orders are dependent on healing environment policy.
- Assessment for behavior, toileting, fluids, circulation, and ROM of the extremity, as well as a determination if the restraint can be removed, must take place. Assessment frequency is dependent on patient status and healing environment policy.
- Documentation must include a description of the patient's behavior, the intervention used, alternatives or less restrictive interventions attempted, the condition that warranted the use of restraints, and the patient's response to the interventions used including the rationale for the use of the intervention.

In Long-Term Care the use of restraints is identified on each resident's care plan and must include:

- medical symptoms that warrant a need for restraint
- type of restraint to be used
- reason for the use of the restraint
- when the restraint is to be used

Residents who are restrained will be given position changes and motion no less than every two hours.

Careful observation of any resident in a restraint is required of all direct caregivers!

Continued use of a resident's restraints will be evaluated quarterly and as needed by the interdisciplinary teams utilizing a physical restraint. A Reduction/Elimination Assessment will be placed in the resident's medical record.

## Use of Restraints Examples

*John Doe, age 24, with a history of drug abuse presents to the Emergency Department after a motor vehicle accident. He is yelling obscenities and threatening violence. After the physician assesses him for injuries, he tries to strike the physician. Attempts are made to calm him with de-escalation techniques and security is called, but he is still violent.*

- Restraints are appropriate in this situation only when other less restrictive attempts to keep the patient and caregivers safe have failed. The physician must perform a face-to-face evaluation of the patient within one hour of placing restraints on this patient and the order must be renewed every four hours for no more than 24 hours total.
- Assessment must be based on patient status and healing environment policy but must include continuous monitoring of the patient's status and include behavior, circulation, respirations, skin integrity, or other parameters. Documentation must include behavior that required restraints, type of restraint used, alternatives attempted, and the patient's response to the restraints.
- Once the unsafe situation ceases the restraints must be removed.

*Bob, age 22, is a resident of a long-term care healing environment. Bob is wheelchair-bound but can feed himself. When he is taken to the dining room for meals, he is accompanied by caregivers and placed at his table in his wheelchair. The wheelchair is pushed up to the table and the wheels are locked.*

- The wheelchair placed up to the table with the wheels locked is considered a restraint unless Bob can unlock the wheels or move the chair himself. A resident is never to be left unattended in this situation and the wheels are never locked in this situation.
- Bob should be monitored closely while in this situation as he may require rescue if the situation becomes unsafe (i.e. he slips down in the chair and his breathing becomes restricted.)
- Any restriction of the freedom of movement which a resident cannot easily remove without assistance is a restraint.

## Use of Restraints

Patients and residents of any age have the right to be free from restraints in all settings.

If restraints are used to manage violent or self-destructive behavior, there must be careful management of the patient/resident, including ongoing monitoring and assessment.

If restraints are used to manage non-violent or non-self destructive behavior, ongoing monitoring and assessment are still necessary.

The use of restraints or seclusion is appropriate to provide a safe care environment, but only while an unsafe situation exists.

They should be discontinued as soon as the unsafe situation or medical symptom ends.

## Restraints and Seclusions Completion

Please record the following number for completion: 974621.

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# Nutrition and Hydration

## Nutrition, Hydration, and Dietary Assistance

The facility must ensure that each patient/resident:

- maintains acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless their clinical condition demonstrates that this is not possible;
- is offered sufficient fluid intake to maintain proper hydration and health; and
- is offered a therapeutic diet when there is a nutritional problem and the healthcare provider orders the therapeutic diet.

## Objectives

Upon completion the participant will be able to:

- identify signs of nutritional and hydration problems
- identify signs/symptoms of malnutrition and dehydration
- describe factors that may result in unintended weight loss
- recognize and report changes
- recognize steps that caregivers can take to help improve nutrition and hydration

## Clinical Problems Linked to Nutrition

Nutrition is an important focus to provide quality care in acute, rehabilitation, and long-term care settings.

Optimal health and/or healing for patients/residents relies on good nutrition and adequate hydration.

Clinical problems could include:

- obesity
- diabetes
- cardiovascular disease
- cancers
- gout
- respiratory ailments
- inflammatory bowel disease
- drug–nutrient interactions
- mechanical swallowing difficulties requiring diet modification
- food intolerance/allergy immunogobulin adverse reactions to food

## Identifying Nutritional Problems

1. Aging increases the risk of malnutrition
2. Body functions slow as part of the aging process
3. Loss of vision

4. Weakened sense of smell and taste
5. Decreased saliva production
6. Dentures, tooth loss, or poor dental health
7. Slower digestion
8. Loss of independence/Physical limitations
9. Chronic disease processes
10. Unexplained weight loss

## Malnutrition

Definition: Any disease-promoting condition due to either an inadequate or an excessive exposure to nutrients.

**Common causes include:**

- inadequate calorie consumption
- inadequate intake of essential vitamins/minerals
- improper absorption/distribution of foods
- overeating
- intoxication/drug abuse

**Malnutrition signs include:**

- poor appetite
- brittle nails
- depression

- dry hair or skin
- increased irritability
- lack of energy
- poor concentration
- sores around the mouth

**Malnutrition possible outcomes include:**

- confusion and memory loss
- weakness and increased risk for falls
- inability to fight off or recover from illness
- loss of muscle mass
- skin issues
- impairment of organ function
- anemia and other abnormal lab values
- death

## Hydration

Hydration is the process by which the correct water ratio is maintained within the body.

# Dehydration

Definition: The clinical consequences of negative fluid balance.

Dehydration is caused by low fluid intake, high fluid loss, or a combination of both.

**Dehydration is classified as:**

- Hypotonic – salt-loss
- Hypertonic – water-loss
- Isotonic – salt-water loss is equal

**Dehydration signs and symptoms include:**

- rapid weight loss
- weak/rapid pulse
- dry mucous membranes
- dry tongue
- reduced axillary sweat
- reduced skin turgor
- sow capillary refill
- sunken eyes
- upper-body muscle weakness
- confusion
- speech difficulty
- reduced urine output
- increased urine concentration

**Possible dehydration outcomes include:**

- confusion and disorientation
- abnormal vital signs
- urinary tract infections
- skin pressure injuries
- pneumonia
- death

## Unintended Weight Loss

- Serious problem for the elderly.
- Can be an indication of a serious medical condition.
- Can lead to increased weakness and frequent falls.
- Can lead to skin breakdown.
- Residents with certain diseases are at higher risk.
- Accurate weights are essential and must be done weekly or as specified in Physician orders.

## Improving Nutrition and Hydration

- Be aware and report change
    - report difficulty swallowing
- Recognize and follow special diets
    - National Dysphagia Diets
    - thickened liquids (nectar, honey, pudding thick)

    - carb counting, cardiac diets, etc.

- Proper positioning
    - get the patient/resident out of bed for meals preferably
    - sit the patient up at 90 degrees

- Encourage adequate fluid intake
    - offer fluids frequently with cares and activities

- Assist patients/residents requiring help
    - ensure adequate food and fluid consumption
    - cut foods and pour liquids as needed

- Allow time to complete the meal
    - do not rush the meal – allow the patient/resident to chew and swallow each bite

- Honor food likes and dislikes
    - find alternatives if the patient/resident requests different foods

- Food preparation
    - season food as desired by the patient/resident
    - ensure proper food temperature without touching food

- Use assistive devices
    - consult Occupational and Speech Therapy when needed

- Make eating a sociable event
    - encourage conversation

- Keep noise and distractions to a minimum
- Encourage independence
    - allow patients to feed themselves where able, if needing assistance

- if unable to feed self, allow the patient to choose what food to eat/drink

## Reference

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## Nutrition and Hydration Completion

Please record the following number for completion: 732158.

CONTINUE

# Caring for Patients With Unique Needs

## Patient-Centered

For people using healthcare services, it is important to remember that being treated as an individual is an essential component of their whole experience and in retaining their dignity during what may be a stressful situation.

## There Are Many Factors That Make Each Patient Unique

1. Medical diagnosis (chronic or acute)
2. Age
3. Gender
4. Religion
5. Race
6. Physical or learning disabilities – ability to make their own healthcare decisions
7. Communication concerns – hearing/vision deficits, ability to speak or understand English
8. Individual health beliefs


## Getting to Know Your Patient

- All caregivers should introduce themselves when addressing the patient. This includes students who may be observing the caregiver.
- Listen to and address any health beliefs, concerns, and preferences that the patient has. Be aware that these affect how and whether they engage with treatment.
- Avoid making assumptions about the patient based on their appearance or other personal characteristics.
- Treat patients with respect, kindness, dignity, compassion, understanding, courtesy, and honesty.

- Respect the patient's right to confidentiality - clarify who they feel should have access to their healthcare information.

- Do not discuss the patient in their presence without involving them in the discussion.
- Listen to and discuss any fears or concerns the patient has in a non-judgmental and sensitive manner.
- Accept and support that the patient may have different views from healthcare professionals about the balance of risks, benefits, and consequences of treatments. This includes the right to refuse treatments, even if you don't agree.
- Different cultures and religions have specific practices they may follow related to the provision of healthcare. Acquaint yourself with these practices, getting information from reputable sources of information.

## Communication

Communication is probably the biggest tool when providing patient care.

- Ensure that the environment is conducive to discussion and that the patient's privacy is respected, particularly when discussing sensitive, personal issues.
- Maximize patient participation in communication, for example:
    - maintaining eye contact with the patient (if culturally appropriate)
    - positioning yourself at the same level as the patient
    - ensuring that the patient is appropriately covered (if applicable)
- Ask the patient how they wish to be addressed and ensure that their choice is respected and used.
- Establish the most effective way of communicating with each patient and explore ways to improve communication. Examples include using pictures, symbols, large print, Braille, different languages, sign language or communications aids, or involving an interpreter, a patient advocate, or family members.
- Avoid using jargon. Use words the patient will understand, define unfamiliar words, and confirm understanding by asking questions.
- Use open-ended questions to encourage discussion.

## Take Your Time!

Finding out what your patient's needs and beliefs are can make caring for them less stressful for all parties involved. Take time to identify the factors that could affect the patient's ability to make informed healthcare decisions. Understanding and accepting their views and beliefs will assist in providing better quality of care while preserving the rights of the patient.

## Caring for Patients with Unique Needs Completion

Please record the following number for completion: 243654.

CONTINUE

# First Aid

## Positional Asphyxia

This may occur when a patient's position prevents them from breathing adequately while in restraints. The patient will be positioned in such a way to provide adequate respiratory function.

**Action** if respiratory status is compromised.

1. Stay calm and call for help.
2. Initiate Rapid Response Team (RRT) or Code Blue.
3. Reposition the patient if you are able.
4. If the patient is in restraints, remove the restraint if safe to do so or wait for help.

- To prevent complications include proper positioning.
- Consider medical conditions such as obesity, chronic respiratory conditions, cardiac conditions, trauma, etc.

## Attempted Hanging

**Action** if hanging is attempted:

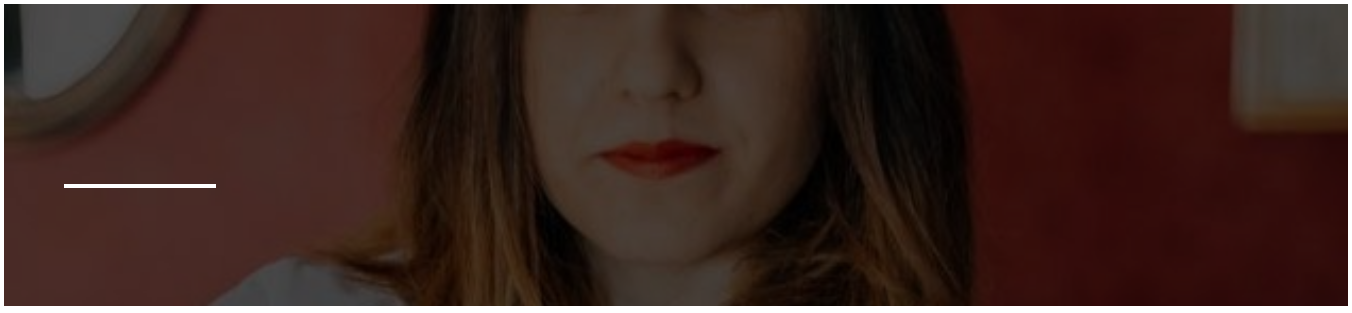
1. Stay calm and call for help; utilize the call button if available.
2. Initiate Rapid Response Team (RRT) or Code Blue if the patient is unresponsive.
3. Attempt to remove the patient from the hanging position. You may need to wait for help from additional assistance.
4. Attempt to remove noose from neck. Use scissors if necessary and available.

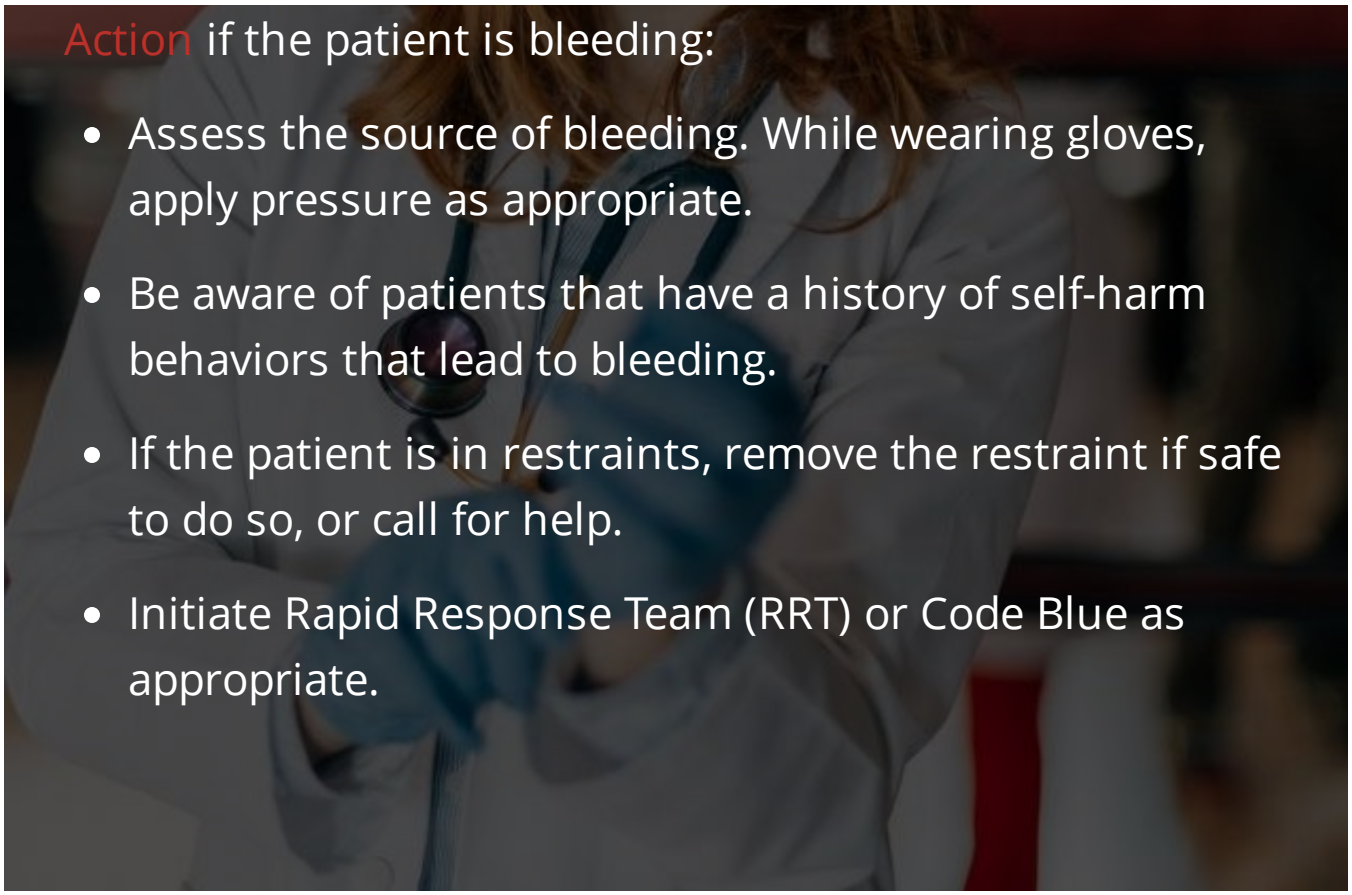
## Choking

**Action** if the patient is choking:

1. If in restraints, remove the restraints if safe to do so or wait for help.
2. Assess airway; initiate appropriate intervention such as abdominal thrust.
3. Initiate Rapid Response Team (RRT) or Code Blue as appropriate.

## Bleeding






## Seizures

**Action** if the patient is having a seizure:

1. Stay calm and call for help.
2. To prevent injury, clear the area around the patient of anything hard or sharp.
3. Stay with the patient. Ensure the patient is in a safe position so they are not hitting their head.
4. Ease the patient to the floor if possible or wait for help.

## First Aid Reminders

If there is not an RN present when the medical emergency occurs, please notify the RN immediately.

In any situation, if a patient becomes unresponsive, initiate CPR and the Rapid Response Team (RRT) or Code Blue process.

Obtaining a set of vital signs in any medical situation is recommended.

## First Aid Completion

Please record the following number for completion: 487954.

CONTINUE

# MRI Suitability for Employees and Guests

## Objectives

By the end of this lesson, learners will be able to recognize the importance of MRI safety. During the lesson learners will:

- identify what an MRI scanner is
- identify what the missile affect in MRI is
- identify ways to prevent the missile effect
- recognize MRI safety zones
- recognize employee MRI screening

## What Is MRI?

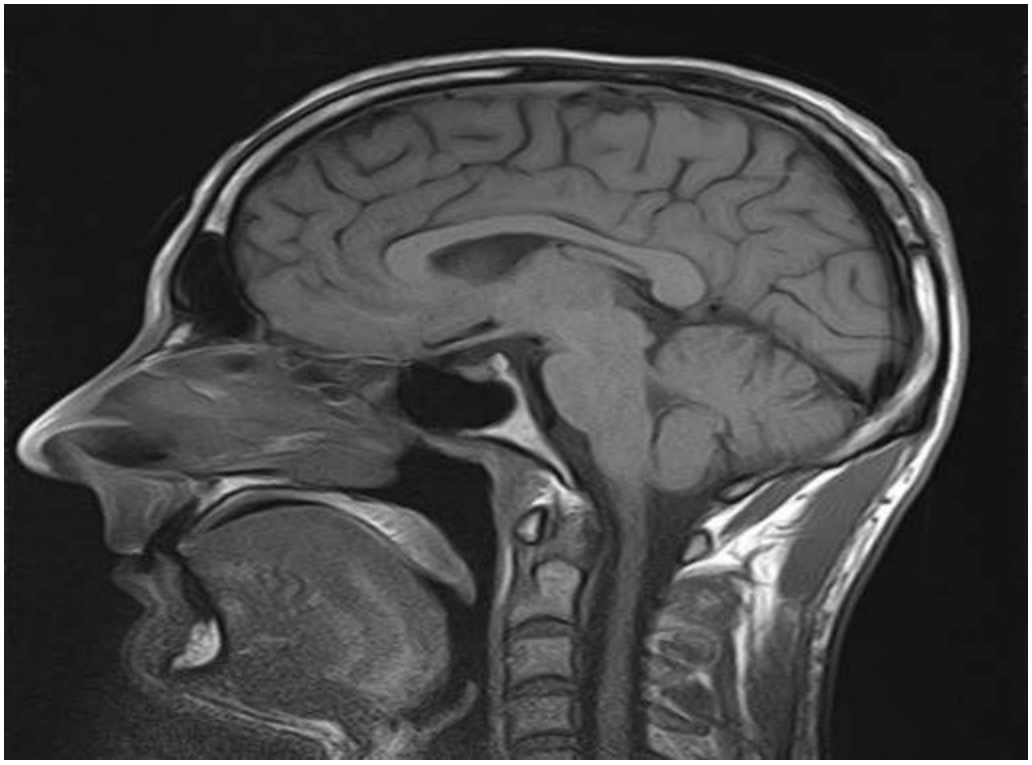


Image of an MRI

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**MRI** stands for **Magnetic Resonance Imaging**.

MRI machine

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An MRI machine takes images of the body using a powerful magnet and radiofrequency.

# Hidden Danger

**What are the hazards in the MRI?**

The powerful MRI magnet is **always** on!

*Click on each of the + markers in the image below to learn more.*

**Danger**

**Any** metallic object, including medical devices, present a danger!

**Danger**

Dangers arise when a metallic item is brought into the MRI scanner. The item becomes a projectile that flies to the center of the MRI scanner with deadly force!

## Why Is the MRI so Dangerous?

The MRI scanners at Rapid City Hospital are 1.5 tesla in strength.

A 1.0 tesla strength crane is strong enough to pick up junk cars.

Left Image - MRI scanner; Right Image - Crane lifting car

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The MRI scanner magnet is stronger than a crane.

## The Magnet Is Always On

Accidents happen when people assume the magnet is off and bring a metal item into the room, or when they are unaware of metal being brought into the room, such as metal items in someone's pockets.

The magnet in MRI scanners is **ALWAYS ON**; whether it be day, night, weekend, holiday etc.


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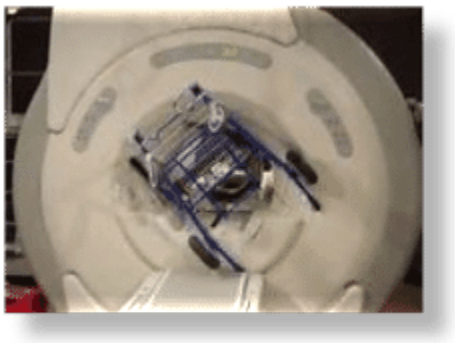
## The Missile Effect



Metal object in MRI scanner

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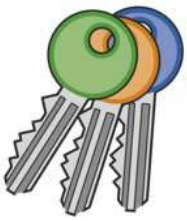
The closer a metal object comes to the magnet, the more powerful the force is.

The metal object becomes a projectile that may fly through the air at 45 MPH with deadly force, harming anyone in its path.

A few examples of items that may become deadly projectiles in the MRI scanner are shown below.



Cell phone, keys, wheelchair, oxygen tank, stethoscope, scissors, IV pole


Patient bed stuck in MRI scanner

## Don’t let this happen to you!

# Steps You Can Take to Prevent the Harmful Missile Effect

- Increase your awareness of the dangers in MRI.
- Control access to the MRI area.
- Follow clearance before entrance procedures.

- Screen for metallic implants, metallic foreign body, pregnancy, pacemaker, ICD, and electronically magnetically activated devices.
- Remove all personal metal items such as pagers, cell phones, jewelry, credit cards, keys, etc.

## Identifying MRI Safe Items

Items that are safe to go into MRI scanner are items that are nonferrous and not attracted to the powerful magnet used in MRI.  The definition of nonferrous is a metal other than iron and alloys that do not contain appreciable amount of iron.

MRI compatible wheelchairs, monitors, and patient gurneys are safe to enter the MRI room.

MRI Safe items are marked with a green **MRI SAFE** label.


Clearly labeled MRI SAFE items

## Screening Process

To keep our patients and employees safe, MRI staff will screen everyone by asking questions about metal items. Click the link below to view, print and complete the employee screening form.

http://regionalhealth/rh/university/Resources/Clinical%20Development/MRI%20Suitability%20for%20Employee%20or%20Guest%20004147-20160120.pdf

The form will ask about these items which are not safe in MRI area.

- Pacemaker/pacing wires
- Cardiac defibrillator
- Aneurysm clip
- Middle ear implants
- Resolution clip or swallowed GI pillcam
- Magnetic dental work
- History of metal in your eyes
- Currently pregnant

# Turn in all completed forms to MRI Supervisor!

## MRI Zones

Our accrediting agencies recommend progressive signage and clearance standards.

**Zone 1** – Where general public is

**Zone 2** – Where screening process occurs

**Zone 3** – MRI Control area where you must have clearance from MRI staff to enter this area

**Zone 4** – Where the MRI Scanner is

## MRI Access

If you need access to zones 2, 3, or 4, contact the MRI Supervisor. The MRI Supervisor will verify that you have completed the quiz at the end of this training and you will be given the door code which provides access to the MRI.

## Summary

- Remember the MRI Scanner is **ALWAYS ON**!
- Increase your awareness of the dangers, such as the missile effect.
- Control access to the MRI area.
- Follow clearance before entrance procedures.
- Screen for metallic implants, metallic foreign body, pregnancy, pacemaker, ICD, and electronically magnetically activated devices.
- Remove all personal metal items such as pagers, cell phones, jewelry, credit cards, etc.

## MRI Suitability for Employees and Guests Completion

Please record the following number for completion: 897624.

CONTINUE