Sunbridge
home health care

1313 13th Avenue Decatur, AL 35601
Office: 256-580-5800
Fax: 256-580-5801

Orientation Packet

Attached is the orientation packet. Please review all the documentation and make sure to sign the orientation form in the application packet. Below are the topics covered in orientation:

1. Timesheet and Errand form information
2. Reporting Instructions
3. Client's Rights and HIPAA
4. Job Descriptions (HM, PC, and Companion)
5. Effective Communication
6. Client Safety, Emergencies, and observing issues in the home
7. Elder Abuse and Neglect
8. Blood Borne Pathogens
9. TB Education

If you need more information on any topic or have questions, please contact your supervisor at 1-251-776-3725.

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Timesheet and Errand Form Explained

1. Timesheets:
    a. The purpose of the timesheet is to document what client's house you worked at, what you accomplished while there, and confirm the day and time your worked.
    b. The timesheet needs to be completed during each shift and signed by the client. You should not have the client sign in advance or for days you have yet to work.
    c. This is very important and prevents fraudulent activity by the worker and also works as a way to confirm the worker's time if the client says the worker was not there.
    d. Timesheets for the previous week should be sent to the SARPC work phone by 10 am each Monday. The phone number is 1-251-776-3725. Please just take a clear picture of the timesheet and text it to this phone.
    e. Timesheets are a requirement to be paid and need to be turned in on time.
    f. If you ever run out of time sheets, please let us know. Also, a copy of a time sheet was provided in your orientation packet, if you are able to make copies. Using notebook paper is fine until you have more timesheets. Not having a timesheet is not an excuse for not documenting your shift and having the client sign.
    g. Please notify your supervisor, if there are any questions regarding timesheets.

2. Errand Form:
    a. The errand form is very important. Whenever you take money from a client to go get their groceries, one of the errand forms needs to be completed.
    b. Make sure to complete the form accurately and have the client review and sign the form.
    c. The errand forms need to be submitted with your timesheets every Monday by 10am.
    d. These forms are used to help protect the worker from a client advising the worker stole money from them. So please make sure to utilize these forms. It will be the first thing your supervisor reviews if you are accused of not returning money to a client.
    e. These forms were included in your orientation packet, and can be emailed to you if you run out. If you are out of forms, please use notebook paper.

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WEEKLY SERVICE REPORT

Patient Name: | Date: | County:

Place a check in the box for each day a task is performed. Write an N in each box assigned but Not needed that day.

HOMEMAKER									COMPANION									
Days of the Week	S	M	T	W	T	F	S	Days of the Week	S	M	T	W	T	F	S	Days of the Week	S	M	T	W	T	F	S
Vacuum/Sweep/Mop								Make Bed								Assist/Supervise with							
Clean Oven/Stove								Tidy Living Area								Meal Plan/Prepare							
Defrost/Clean Refrig								Remove Trash								Laundry							
Change/Wash Linen								Purchase Groceries								Grocery Shopping							
Wash/Mend/Iron								Obtain Prescriptions								Essential HM Chores							
Wash Dishes								Remind to take Meds								Patient Bath							
Sanitize Bathroom								Write/Mail Letters								Grooming/Hygiene							
Assist Paying Bills								Assist with Phone								Remind to take Meds							
Plan/Fix/Serve Meal								Orient to Day Events								Go to Medical Visits							
Encourage Diet								See/Tell Condition															
Dust								**Total Service Time**								**Total Service Time**							

PERSONAL CARE									UNSKILLED RESPITE									
Bathe Client								Plan/Fix/Serve Meal								Personal Care	S	M	T	W	T	F	S
Skin/Hair/Oral Care								Essential HM Chores								Homemaker							
Dress Client								Bowel/Bladder								Supervise/Support							
Turn Client								Remind to take Meds															
In/Out of Bed								Monitor Condition															
Feed Client																							
Walk Client								**Total Service Time**								**Total Service Time**							

COMMENTS:

This is to certify that the information on this form is true, accurate and complete. I understand that I am certifying that I have received the services listed on the dates specified. (List services provided in services box below as: HM=homemaker, PC=personal care, CO=companion, UR=unskilled respite)

	DATE	TIME-IN a.m./p.m.	TIME-OUT a.m./p.m.	SERVICES	PATIENT SIGNATURE	WORKER SIGNATURE
S						
M						
T						
W						
T						
F						
S						

Reviewed by Supervisor & Date:

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MEDICAID WAIVER PROGRAM

Purchases for Client

Date: (CLIENT COPY)

I gave: $ cash check debit ebt

To purchase:

Client's Signature: Employee's Signature:

I RECEIVED THE CORRECT CHANGE AND/OR RECEIPT FOR THE PURCHASES MADE FOR ME BY THE HOMEMAKER.

Changed Received: $ Cards/Receipt Received:

Client's Signature: Employee's Signature:

MEDICAID WAIVER PROGRAM

Purchases for Client

Date: (OFFICE COPY)

I gave: $ cash check debit ebt

To purchase:

Client's Signature: Employee's Signature:

I RECEIVED THE CORRECT CHANGE AND/OR RECEIPT FOR THE PURCHASES MADE FOR ME BY THE HOMEMAKER.

Changed Received: $ Cards/Receipt Received:

Client's Signature: Employee's Signature:

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Reporting Instructions and Process

1. As our eyes and ears in the client's home, it is the responsibility and duty for you as Home Health Aides to report any signs of abuse, neglect, mistreatment, maltreatment and or anything that you feel is worth reporting.
2. As mandatory reporters, any thing reported to your supervisor will be reported to the appropriate parties.
3. The process for reporting any signs of abuse or neglect are as follows:
    a. Observe or witness the abuse/neglect
    b. Report the incident to your supervisor
    c. Depending on what you observed, you may be asked to complete and incident report.
    d. Depending on the report, either the case manager will be notified or DHR.
4. If you are not able to reach your supervisor to report an incident, you may always call our main line: 1-256-580-5800/1-251-776-3725
5. If you are not sure if something is abuse or neglect, it's never wrong to report it and allow the supervisor to look into it and determine if it should be passed along to the appropriate parties.

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3.11 CLIENT BILL OF RIGHTS

Client Rights and Responsibilities

Statement of Purpose:

It is anticipated that observance of these rights and responsibilities will contribute to more effective care and greater satisfaction for the client as well as the staff. The rights will be respected by all personnel and integrated into all Home Care programs. A copy of these rights will be given to clients and their families or designated representative. The client or his/her designated representative has the right to exercise these rights. In the case of a client adjudged incompetent, the rights of the client are exercised by the person appointed by law to act on the client's behalf. In the case of a client who has not been adjudged incompetent. Any legal representativa may exercise the client's rights to the extent permitted by law.

The Client has the right:

1. To be fully informed and knowledgeable of all rights and responsibilities before providing pre-planned care and to understand that these rights can be exercised at any time.
2. To choose a health care provider.
3. To request services from the Home Care Agency of their choice and to request full information from their agency before care is given concerning services provided, alternatives available, licensure requirements, organization ownership and control.
4. To be informed in advance about care to be furnished and of any changes in the care to be furnished before the change is made.
5. To be informed of the disciplines that will furnish care and the frequency of visits proposed to be furnished and to know that all staff is properly trained and competent to perform their duties.
6. To information necessary to give informed consent prior to the start of any procedure or treatment and any changes to be made.
7. To participate in the development and periodic revision of the plan of care.
8. Confidentiality and privacy of all information contained in the client record and of Protected Health Information.
9. To information necessary to refuse care within the confines of the law and to be informed of the consequences.
10. To treatment with utmost dignity and respect by all agency representatives, regardless of the client's chosen lifestyle, marital status, cultural mores, political, religious, ethical beliefs, whether or not an advance directive has been executed and source of payment without regard to race, creed, color, sex, age or handicap.
11. To have his/her property and person treated with respect, consideration and recognition of client dignity and individually.

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12. To receive and access services consistently and in a timely manner from the agency to his/her request for service.
13. To be admitted for service only if the agency has the ability to provide safe professional care at the level of intensity needed and to be informed of the agency's limitations.
14. To reasonable continuity of care.
15. To an individualized plan of care and teaching plan developed by the entire health team including the client and/or family.
16. To be informed of client rights under state law to formulate advanced care directives without fear of reprisal whether or not an advance directive is prepared and to know that the agency will follow the client's requests regarding the advance directive in providing care.
17. To be informed of anticipated outcomes of service/care and of any barriers in outcome achievement.
18. To be informed of client rights regarding the collection and reporting of information.
19. To expect confidentiality of services provided and of the access to medical records according to state statutes.
20. To be informed within a reasonable time of anticipated termination of service of plans for transfer to another health care facility/provider.
21. To be informed verbally and in writing and before care s initiated of the organization's billing policies and payment procedures and the extent to which:
    a. Payment may be expected from Medicaid, or any other federally funded program known to the organization.
    b. Charges that the individual may have to pay.
22. To be able to identify visiting staff members through proper identification.
23. To be informed orally and in writing of any changes in payment information as soon as possible, but no later than 30 days from the date that the organization becomes aware of the change.
24. To honest, accurate, forthright information, regarding the home care industry in general and his/her chosen agency in particular, including cost per visit, employee qualifications, names and titles of personnel, etc.
25. To access necessary services 24 hours a day, 7 days a week.
26. To be referred to another agency if he/she is dissatisfied with the agency or the agency cannot meet the client's needs.
27. To receive disclosure information regarding any beneficial relationship the organization has that may result in profit for the referring organization.
28. To education, instruction and a list of requirements for continuity of care when the services of the agency are terminated.
29. To be free of abuse, neglect and exploitation of any kind including agency employees, volunteers or contractors.
30. To privacy to maintain his/her personal dignity and respect.
31. To know that the agency has liability insurance sufficient for the needs of the agency.
32. To be advised that the agency complies with Subpart 1 of 42 CFR 489 and

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receive a copy of the organization's written policies and procedures regarding advance directives, including a description of an individual's right under applicable state law and to know that the agency will honor the client's advance directives in providing care.
33. To receive advance directives information prior to or at the time of the first home visit, as long as the information is furnished before care is provided.
34. To voice grievances regarding treatment or care that is (or fails to be) furnished, or regarding the lack of respect of property or recommend changes in policy, staff, or service/care without restraint, interference, coercion, discrimination, or reprisal and to know that grievances will be resolved and the client notified of the resolution within 30 days.
35. To be advised of the toll-free home health agency hot-line for the State of Alabama and the purpose of the hotline to receive complaints or questions about the organization. The State of Alabama Home Health Hotline Number is 1-800-356-9596. The number is operated 8AM to 5PM daily to receive complaints or questions about local Home Health Agencies. You may also register complaints in writing to:

Bureau of Home and Community Services
Alabama Department of Public Health
The RSA Tower
201 Monroe Street, Suite 1200
Montgomery, Alabama 36104

Phone: 1-800-225-9770

36. To not be denied equal opportunity because they or their family are from another country, because they have a name or accent associated with a national origin group because they participate in certain customs associated with a nation origin group or because they are married to or associate with people of a certain national group.
37. To be informed of the number to report child abuse is: 334-242-9500
38. To be informed of the hotline number to report Adult/Elder abuse, neglect, and exploitation at: 1-800-458-7214.
39. To be informed of the domestic violence hotline number at: 1-800-332-4443.

The Client has the responsibility:

1. To provide, to the best of his/her knowledge, accurate and complete information about:
    a. Past and present medical histories.
    b. Unexpected changes in his/her condition.
    c. Whether he/she understands a course of action selected.
2. To follow the treatment recommended by the particular handling of the case.
3. For his/her actions if he/she refused treatment or does not follow the physician's orders.

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4. For accruing that the financial obligations of his/her health care are fulfilled as promptly as possible.
5. To respect the rights of all staff providing service:
6. To notify the agency promptly in advance of an appointment or visit you must cancel.
7. To become independent in care to the extent possible, utilizing self, family and other sources.
8. To pay for care or services not covered by 3rd party payers.
9. For complying with the rules and regulations established by the agency and any changes subsequent to the rules.

Client's Signature

Date:

Admitting Person's Signature

Date:

Client Name (Last, First):

Medical Record Number:

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Health Insurance Portability and Accountability Act (HIPAA) Inservice Handout

1. What is HIPAA?

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

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

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

Further, HIPAA ensures immediate coverage without regard to pre-existing conditions for individuals who change jobs and insurance carriers. HIPAA also established a pilot program for medical savings accounts (MSAs) that allows individuals to create a "health insurance individual account" to purchase health services and retain unspent funds rather than paying monthly premiums. Further, to encourage the purchase of long-term care insurance, HIPAA allows employers to deduct premiums and most benefits are tax-free to the beneficiary. Additionally, to facilitate purchase of health insurance by self- employed persons, the law allows 80% of the annual premiums to be tax-deductible by 2006. While many health policy analysts agree that these provisions have little impact on reducing the number of uninsured, they do, however, think these efforts are worthwhile. At this time, however, attention to HIPAA is riveted on implementing and paying for the privacy, confidentiality, and security aspects of the legislation (DiBenedetto, 2003).

In 1996, HIPAA was viewed as a way to reduce administrative costs, provide better access to health information, reduce fraud, and guaranty privacy of health information. However, the American Hospital Association estimates that it may cost

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between $4 billion and $22 billion to implement the tenets of the law. A search of the literature failed to produce specifics regarding cost; however, according to Gue and Upham (2004), the majority of costs are associated with developing and implementing software that integrates providers, payers, and governmental agencies.

As part of the HIPAA rule promulgation, the Centers for Medicare and Medicaid Services CMS mandated standardization of transaction and code sets (TSC) to reduce duplication, confusion, and non-compliance. CMS standards rely on use of ICD-9 codes for discase classification, CPT codes for procedures, and national drug codes (NDC) for medications. CMS admits that problems with these coding sets exist; new ICD-10-CM and ICD-10-PCS are thought to reduce the ambiguity and facilitate full implementation of electronic processing. The industry is working toward integrating HIPAA fully, it is just taking longer than they hoped to get the electronic interfaces coordinated (Gue and Upham 2004).

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

1. establish routine use of EHRs in clinical practice,
2. connect health care workers in information exchange for clinical decision making,
3. enhance patients' ability to choose providers based on quality, and to integrate public health surveillance systems into an interoperable network to support new research and better care (Scott 2004, p. 34).

2. The Basics

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

A key factor for all health care providers and organizations to keep in mind is that, while HIPAA rules are strict, if state law covering the same topic is more stringent, the state law must be followed (Herrin, 2003). Health providers are well advised not to overlook state law as they accommodate HIPAA, Providers and organizations must remain up-to-date with both HIPAA and state law changes.

The intent of HIPAA is to protect patients from unauthorized or inappropriate use and access to their health information. Further, the rules protect patients by giving them access to their health information so they know what has been documented about their health status. Proposed by- products of HIPAA are to improve quality of care,

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restore trust in the health care system, and improve the efficiency and effectiveness of information dissemination by building on existing legal frameworks. HIPAA also contains an administrative simplification section designed to improve the efficiency of health information coding to facilitate digital transfer of information between and among health care providers, payers, and health plans.

HIPAA creates safeguards so that only those people or entities having a real need to know health information will be able to access it (Calloway and Venegas 2002). The HIPAA rules complement other standards that protect patients' rights. Compliance with privacy rules promises to be a cornerstone of future JCAHO and Medicare/Medicaid surveys. Remember, compliance is mandatory, not voluntary.

3. Why is HIPAA Needed?

Health care professionals have long realized the need to protect patients from unauthorized use of their health information; at the same time, they want to have access to needed information when treating a patient. Widespread use of electronic data is facilitating the rapid transfer of information and the Institute of Medicine has urged the creation of standards so electronic records can be available (Follansbee, 2002).

Similarly, the public is greatly concerned about the privacy of their medical records. Prior to the electronic medical record, patient information was maintained in paper form and neatly locked away, accessible only to those who had authorized access. With computerized records information can be accessed, changed, distributed, and copied with far less regard for appropriate authorization (Follansbee, 2002).

Serious breaches of record confidentiality have occurred. An employee of the Hillsborough county health department was able to carry home a disk with the names of 4000 HIV positive patients. People have purchased used computers that contained prescription records of patients; Eli Lilly recently sent out an email with the names of patients taking Prozac; the University of Montana inadvertently placed the medical records of some 62 people on the internet. Consequently, patients, health care providers, and other health care entities are very concerned about confidentiality, restoring the public trust, and protecting themselves from lawsuits.

Yet, the ability of multiple providers to access a patient's record can significantly improve the overall quality of care. Think about the chronically ill individual who receives care from more than one or two specialist providers. If each provider has access to the most recent treatment plan, it stands to reason that care will be more coordinated, efficient, and effective.

4. Understanding HIPAA

HIPAA describes those affected by the law as "covered entities". Included under this

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umbrella are health care providers, health plans, health care clearinghouses, and business associates.

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

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

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

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

5. What Health Information is Protected

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

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

The law specifics that some information that is not individually identifiable can

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

All facilities must limit access to information only to those who have a need to know. A nurse who seeks information about a patient not under her care is violating the HIPAA rules. Similarly, health information can only be used for health purposes. Employers cannot use the information to screen candidates for hire or promotion. Financial institutions may not use it to determine lending practice. Only the patient can explicitly authorize employers, banks, and individuals to have access to his/her medical information.

HIPAA also established the "minimum necessary rule" which stipulates that only the minimum necessary information may be shared, even with the patient authorization. A classic example would involve treatment for a case of child or domestic abuse; the provider would, rather than providing an entire medical record, furnish the pertinent data furnished in the form of an abstract outlining the information that is necessary to provide treatment and protect the victim(s). The abstracted information could be provided to legal and law enforcement entities. Health providers involved in the treatment of patients are not subject to the minimum necessary rule and can have full access to all information that is needed to provide patient care. Health information that has implications for the public health and safety can be shared without consent. There are several situations where medical information can be shared: In Emergency 911 situations, when communicable diseases are involved, when law enforcement agencies participate, or if national defense or security is a factor.

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

1. cause of death even when the patient dies at home
2. reportable communicable diseases
3. child abuse
4. reporting an adverse drug reaction to the Federal Drug Administration
5. occurrence of cancer in a state with a cancer registry
6. meningitis, and
7. immunizations for children.

These examples are thought to be important to the health of the public (Campos-Outcalt 2004).

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6. Patient Consent and Authorization

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

Informed consent is signed at the first encounter the patient has with the provider/health care facility; the consent covers treatment, payment, and other health care information. The meaning and use of the patient's consent must be carefully explained to the patient. Facilities must explicate their disclosure process in a document called Information Practices. The American Hospital Association published a sample consent and explanation document that was 10 pages long. The document explains patient rights, as well as a description of how patient information is collected and used. Facilities must decide how and when the information concerning consent is presented to patients and how patients can use their right to revoke consent. Patients must also be advised about the agency's policy that covers conditions for admission that are related to consent.

Patients may also sign authorizations. These are required when information is used by the agency for purposes outside of treatment. Agencies must assess their policies and procedures to assure that they are always using an authorization when it is needed; some agencies may not realize that information sharing policies violate the patient's right to restrict release of data (Cichon, 2002). Patients must be fully informed about the way agencies use a signed authorization and are entitled to receive a free accounting every twelve months describing how their health information has been used.

HIPAA privacy regulations also mandate specific patient rights that include the following:

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

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

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

7. Practical Implication

Questions about the implications HIPAA rules have been numerous. Can an office or laboratory have a patient sign in sheet? Can you use a patient's name to call him into a treatment room? Can the patient's name be posted outside the hospital door? At this point, there is some agreement about some of these. As long as personal information regarding the patient's care or procedures to be done remain confidential, names can be outside hospital room doors, patients can be verbally called to treatment rooms, etc. New questions will undoubtedly arise in the future. Staying informed about the rules and regulations concerning HIPAA will be every health care worker's obligation.

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

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

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

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

Repositories that store human tissue and fluids for future scientific analysis, i.e., genotyping, cell lines, other biotechnologies, express concern that HIPAA will fundamentally change how those commercial repositories function. At question is whether property rights continue to apply to human tissue after removal from the body. Prior to HIPAA, the Supreme Court in California ruled on the side of future research and determined that property rights end when tissue is removed from the body (Allen 2004). However, depending on how HIPAA rules are interpreted, informed consent may be required in order for research to be conducted on removed tissue.

8. HIPAA and Research

Patients must sign an authorization to allow their information to be included in research projects. Information can only be disclosed in accordance with a research protocol approved by an institutional review board. All identifying individual information must be removed. One difficulty researchers may experience is the lack of specific guidance from HIPAA regarding construction of compliant, de-identified data sets, at this point researchers are developing strategies that they believe comply with the intent of privacy under HIPAA. Ongoing analysis of medical information is critical for developing strategies to improve patient outcomes and reduce medical errors (Clause, S.L.; Triller, D.M.; Bornhorst, C.P.; Hamilton, R.A.; Cosler, L.E. 2004). Information that can be used in compliance with HIPAA includes: gender, race, ethnicity marital status, dates of treatment if reported in years, age (for individuals older than 60, one must use 60+), and zip code if more than 20,000 reside in that zip code (Erlen, J.A. 2004).

9. Conclusion

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

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

Administrators are advised to be sure staff is well-trained and knowledgeable about the requirements of HIPAA. Similarly, they many want to scrutinize day-to-day practices to evaluate whether violations of patient rights are occurring.

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RECEIPT OF EMPLOYEE HANDBOOK

This is to acknowledge that I have received a copy of the Agency Employee Handbook and understand that it sets forth the terms and conditions of my employment as well as the duties, responsibilities, and obligations of employment with the company. I understand and agree that it is my responsibility to read the Employee Handbook and abide by the rules, policies, and standards set forth in the Employee Handbook.

I acknowledge that my employment with the Agency is not for a specified period of time and I can be terminated at any time for any reason, with or without cause or notice, by me or the company. I acknowledge that no oral or written statements or representations regarding my employment can alter the foregoing, I also acknowledge that no employee has the authority or enter into an employment agreement-express or Implied-providing for employment other than at-will.

I acknowledge that except for the policy of at-will employment, the company reserves the right to revise, delete, and add to the provisions of this Employment Handbook. All such revisions, deletions, or additions must be in writing and must be signed by the President of the company, No oral statements or representations can change the provisions of this Employee Handbook. I also acknowledge that, except for the policy of at-will employment, terms and conditions of employment with the company may be modified at the sole discretion of the company with or without cause or notice at any time. No implied contact concerning any employment-related decision, term of employment, or condition of employment can be established by any other.statement, conduct, policy, or practice.

I understand that the foregoing agreement concerning my at-will employment.status and the company's right to determine and modify the terms and conditions of employment is the sole and entire agreement between me and our Agency concerning the duration of my employment, the circumstances under which my employment may be terminated, and the circumstances under which the terms and conditions of my employment may change. I further understand that this agreement supersedes all prior agreements, understandings, and representations concerning my employment with the company.

If I have questions regarding the content or Interpretation of this handbook, I will bring them to the attention of my supervisor.

Name

Date:

Signature:

Sunbridge
home health care

Title of Position	Personal Care Worker (PCW)
Title of Immediate Supervisor:	Service Supervisor
Risk of Exposure to Bloodborne Pathogens:	HIGH

DUTIES OF POSITION

1. Provides personal care and related services in the home, under the direction, instruction end, supervision of the Service Supervisor.
2. Tasks to be performed by a PCW must be assigned by and performed under the supervision of a Service Supervisor who will be responsible for the client care/services provided by the PCW.
3. Under no circumstances may a PCW be assigned to receive or reduce any intravenous procedures, or any other sterile or invasive procedures, other than rectal temperatures of enemas.

POSITION RESPONSIBILITIES

1. Follows the plan of care to provide, safe, competent care/service to the client.
2. Helps the client to maintain good personal hygiene and assists in maintaining a healthful, safe environment.
3. Plans and prepares nutritious meals.
4. Assists the cllent with ambulation as approved,
5. Encourages the client to become as independent as possible according to the care plan.
6. Attempts to promote client's mental alertness through involvement in activities of interest.
7. Gives simple emotional and psychological support to the client and other members of the household and establishes a relationship with client and family which transmit trust and confidentiality.
8. Reports any change in the client's mental or physical condition or in the home situation to the supervisor.
9. Performs routine housekeeping tasks as related to a safe and comfortable environment for the client
10. Prepares a visit report promptly and incorporates same in the client record each visit.
11. Confirms on a weekly basis, the scheduling of visits so that other necessary visits by staff members can be coordinated.
12. Works with personnel of other community agencies involved in the client's care.

POSITION RESPONSIBILITIES

13. Attends in-service as required by regulation.
14. Confer with the Service Supervisor about client's status and care, participate in the planning of service.
15. Promptly report any change in client condition to the Service Supervisor.
16. Works within the PCW's scope of practice, as directed by a Service Supervisor and report in writing to the Service Supervisor.

JOB CONDITIONS

1. The ability to drive and the ability to access clients' homes which may not be routinely wheelchair accessible are required.
2. Hearing, eyesight and physical dexterity must be sufficient to perform a physical assessment of the client's condition and to perform client care.
3. On occasion, may be required to bend, stoop, reach and move client weight up to 250 pounds; lift and/or carry up to 30 pounds.
4. Must be able to communicate clearly, both verbally and in writing.

EQUIPMENT OPERATION

1. Use of BP cuff, thermometer and stethoscope, hand washing materials

COMPANY INFORMATION

1. Has access to all client service records which may be discussed with the supervisor.

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QUALIFICATIONS

1. Preferably a high school diploma or equivalent.
2. Must have completed a minimum of 75 hours of training which includes an introduction to personal care services.
3. Must be free from health problems that may be injurious to client, self and co-workers and must present appropriate evidence to substantiate this.
4. Must comprehend the basics of personal care, housekeeping and meal preparation.
5. Must understand and respect clients including ethics and confidentiality of care.

ACKNOWLEDGMENT:

Employee Signature: _____ Date: _____

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home health care

Title of Position	Companion/Homemaker
Title of Immediate Supervisor:	Service Supervisor
Risk of Exposure to Bloodborne Pathogens:	HIGH

POSITION RESPONSIBILITIES

1. Follows the plan of care to help the client to maintain good personal hygiene and maintain a healthful, safe environment, is to perform ONLY those functions specified for each individual client.
2. Receives written instructions from the supervisor.
3. Has knowledge of agency policies and procedures.
4. Is trained in first aid.
5. Is oriented and trained in all aspects of care to be provided to clients.
6. Is able to demonstrate competency in all areas of training for personal care.
7. Companion/Homemaker may assist clients with the following activities:
    a. Reminding the client to take medications and opening containers for the client;
    b. Housekeeping and laundry;
    c. Reminding client to bathe and take care of personal grooming and hygiene;
    d. Observation/supervision of snack, meal planning and preparation, and/or eating;
    e. Tolleting and toilet hygiene;
    f. Arranging for medical and dental care including transportation to and from the appointment;
    g. Grocery Shopping;
    h. Providing or arranging for social interaction;
    i. Providing transportation;
    j. Observing/reporting home safety;
    k. Administering emergency first aid;
    l. Assist with Communication.
8. Documents observations and services in the Individual client record.
9. Reports any change in the client's mental or physical condition or in the home situation to his/her immediate supervisor.

JOB CONDITIONS

1. The ability to drive and the ability to access clients' homes which may not be routinely wheelchair accessible are required.
2. Hearing, eyesight and physical dexterity must be sufficient to perform a physical assessment of the client's condition and to perform client care/services.

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home health care

JOB CONDITIONS

3. On occasion, may be required to bend, stoop, reach and move client weight up to 250 pounds; lift and/or carry up to 30 pounds.
4. Must be able to communicate clearly, both verbally and in writing.

EQUIPMENT OPERATION

1. Hand Washing materials.

COMPANY INFORMATION

1. Has access to all client medical records which may be discussed with the Service Supervisor.

QUALIFICATIONS

1. Completion of at least the ninth grade. Preferably a high school diploma or equivalent.
2. Must be free from health problems that may be injurious to client, self and co-workers and must present appropriate evidence to substantiate this.
3. Must comprehends the basics of housekeeping and meal preparation.
4. Must understand and respect clients including ethics and confidentiality of care.
5. Must be able to understand, read and write English.

ACKNOWLEDGMENT:

Employee Signature: Date:

TALKING WITH YOUR OLDER PATIENT

Tips for Improving Communication with Older Patients

Good communication is an important part of the healing process. Effective doctor-patient communication has research-proven benefits: Patients are more likely to adhere to treatment and have better outcomes, they express greater satisfaction with their treatment, and they are less likely to file malpractice suits.

Studies show that good communication is a teachable skill, Medical students who receive communication training improve dramatically in talking with, assessing, and building relationships with patients. Time management skills also improve. These studies suggest that the interview is integral to the process and outcomes of medical care.

Interpersonal communication skills are considered so important that they are a core competency Identified by the Accreditation Council on Graduate Medical Education and the American Board of Medical Specialties.

Learning — and using — effective communication techniques may help you build more satisfying relationships with older patients and become even more skilled at managing their care.

Effective communication has practical benefits. It can:

- Help prevent medical errors
- Lead to improved health outcomes
- Strengthen the patient-provider relationship
- Make the most of limited interaction time

Use proper form of address

Establish respect right away by using formal language. As one patient said, *"Don't call me Edna, and I won't call you Sonny."* Use Mr., Mrs., Ms., and so on. Or, you might ask your patient about preferred forms of address and how she or he would like to address you. Avoid using familiar terms, like "dear" and "hon," which tend to sound patronizing.

Be sure to talk to your staff about the importance of being respectful to all your patients, especially those who are older and might be used to more formal terms of address.

Make older patients comfortable

Ask staff to make sure patients have a comfortable seat in the waiting room and help with filling out forms if necessary. Be aware that older patients may need to be escorted to and from exam rooms, offices, restrooms, and the waiting area. Staff should check on them often if they have a long wait in the exam room.

Take a few moments to establish rapport

Introduce yourself clearly and do not speak too quickly. Show from the start that you accept the patient and want to hear his or her concerns. If you are in a hospital setting, remember to explain your role or refresh the patient's memory of it.

In the exam room, greet everyone and apologize for any delays. With new patients, try a few comments to promote rapport: *"Are you from this area?"* or *"Do you have family nearby?"* With returning patients, friendly questions about their families or activities can relieve stress.

Try not to rush

Older people may have trouble following rapid-fire questioning or torrents of information. By speaking more slowly, you will give them time to process what is being asked or said. If you tend to speak quickly, especially if your accent is different from what your patients are used to hearing, try to slow down. This gives them time to take in and better understand what you are saying.

Avold hurrying older patients. Time spent discussing concerns will allow you to gather important information and may lead to improved cooperation and treatment adherence.

Feeling rushed leads people to believe they are not being heard or understood. Be aware of the patient's own tendency to minimize complaints or to worry that he or she is taking too much of your time.

If time is an issue, you might suggest that your patients prepare a list of their health concerns in advance of their appointments. That way they are prepared and you have a sense of everything they'd like to cover during your time together. The National Institute on Aging has information on doctor-patient communication for older adults.

Avoid interrupting

One study found that doctors, on average, interrupt patients within the first 18 seconds of the initial interview. Once interrupted, a patient is less likely to reveal all of his or her concerns. This means finding out what you need to know may require another visit or some follow-up phone calls.

Use active listening skills

Face the patient, maintain eye contact, and when he or she is talking, use frequent, brief responses, such as *"okay," "I see,"* and *"uh-huh."* Active listening keeps the discussion focused and lets patients know you understand their concerns.

Demonstrate empathy

Watch for opportunities to respond to patients' emotions, using phrases such as *"That sounds difficult,"* or *"I'm sorry you're facing this problem; I think we can work on it together."* Studies show that clinical empathy can be learned and practiced and that it adds less than a minute to the patient interview. It also has rewards in terms of patient satisfaction, understanding, and adherence to treatment.

Avoid medical jargon

Try not to assume that patients know medical terminology or a lot about their disease. Introduce necessary information by first asking patients what they know about their condition and building on that. Although some terms seem commonplace—MRIs, CT scans, stress tests, and so on—some older patients may be unfamiliar with what each test really is. Check often to be sure that your patient understands what you are saying. You might ask the patient to repeat back the diagnosis or care plan in his or her own words—this can help with recall, as well. You may want to spell or write down diagnoses or important terms to remember.

"Tell me more about how you spend your days."

Although she complains of loneliness and long days in front of the television, Mrs. Lopez refuses to participate in activities at the community senior center. *"I don't want to hang around old people who have nothing better to do than compare health problems,"* she tells her doctor. *"Why not give it a try?"* her doctor asks. *"You might find members who share many of your same interests, including your love of gardening."* Six months later, when she sees the doctor again, Mrs. Lopez thanks her. She has joined the garden club and reports that the members all have green thumbs and are lively conversationalists. Better still, Mrs. Lopez's depressive symptoms seem improved.

Be careful about language

Some words may have different meanings to older patients than to you or your peers. Words may also have different connotations based on cultural or ethnic background. For example, the word "dementia" may connote insanity, and the word "cancer" may be considered a death sentence. Although you cannot anticipate every generational and cultural/ethnic difference in language use, being aware of the possibility may help you to communicate more clearly,

Use simple, common language, and ask if clarification is needed. Offer to repeat or reword the information: *"I know this is complex. I'll do my best to explain, but let me know if you have any questions or just want me to go over it again."*

Low literacy or inability to read also may be a problem. Reading materials written at an easy reading level can help.

Write down take-away points

It can often be difficult for patients to remember everything discussed during an appointment about their condition and care. Older adults can especially benefit from having written notes to refer back to that summarize major points from the visit. Try to make these notes simple and clear, avoiding ambiguous and complicated language. For example, you might write, *"Drink at least one 6-oz glass of water every two hours"* instead of *"Increase fluids."*

Ensure an understanding of the health information

Conclude the visit by making sure the patient understands:

- What is the main health issue
- What he or she needs to do
- Why it is important to act

One way to do this is the "teach-back method"—ask patients to say what they understand from the visit. Also, ask about any potential issues that might keep the patient from carrying out the treatment plan.

Compensating for hearing deficits

Age-related hearing loss is common. About one quarter of people between the ages of 65 and 75, and half of those over the age of 75 have disabling hearing loss. Here are a few tips to make it easier to communicate with a person who has lost some hearing:

- Make sure your patient can hear you, Ask if the patient has a working hearing aid. Look at the auditory canal for the presence of excess earwax.
- Talk slowly and clearly in a normal tone. Shouting or speaking in a raised voice actually distorts language sounds and can give the impression of anger.
- Avoid using a high-pitched voice; it is hard to hear.
- Face the person directly, at eye level, so that he or she can lip-read or pick up visual clues.
- Keep your hands away from your face while talking, as this can hinder lip-reading ability,
- Be aware that background noises, such as whirring computers and office equipment, can mask what is being said.
- If your patient has difficulty with letters and numbers, give a context for them. For instance, say, *"'m' as in Mary," "'two' as in twins,"* or *"'b' as in boy."* Say each number separately (for example, *"five, six"* instead of *"fifty-six"*). Be especially careful with letters that sound alike (for example, *m* and *n*, and *b, c, d, e, t,* and *v*).
- Keep a notepad handy so you can write what you are saying. Write out diagnoses and other important terms.
- Tell your patient when you are changing the subject. Give clues, such as pausing briefly, speaking a bit more loudly, gesturing toward what will be discussed, gently touching the patient, or asking a question.

Compensating for visual deficits

Visual disorders become more common as people age. Here are some things you can do to help manage the difficulties caused by visual deficits:

- Make sure there is adequate lighting, including sufficient light on your face. Try to minimize glare.
- Check that your patient has brought and is wearing eyeglasses, if needed.
- Make sure that handwritten instructions are clear.
- If your patient has trouble reading, consider alternatives such as recording instructions, providing large pictures or diagrams, or using aids such as specially configured pillboxes.
- When using printed materials, make sure the type is large enough and the typeface is easy to read. The following print size (14 pt) works well: "This size is readable,"

Discussing Covid-19

The risk for severe illness with COVID-19 increases with age, and older adults are at highest risk. Certain medical conditions can also increase risk for severe illness, Learn more about how to protect older adults and those with a higher risk from getting COVID-19.

For more information about effective communication

American Geriatrics Society
300-247-4779 (toll-free)
info.amger@americangeriatrics.org
www.americangeriatrics.org

American Society on Aging
800-537-9728
www.asaging.org
www. asaging.org/form/contact-us (email form)

Gerontological Society of America
202-842-1275
www.geron.org
Info@geron.org

This content is provided by the NIH National Institute on Aging (NIA). NIA scientists and other experts review this content to ensure it is accurate and up to date.

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COMMON MEDICAL EMERGENCIES

WHEN SECONDS COUNT....

1. Call 911 immediately. Send someone to make the call so you can stay with the person.
2. Do not move the person unless they are in immediate danger.
3. Do not give the person ANYTHING to eat or drink.
4. Teach your children how to use 911. They may have to make the call for you someday.

Convulsions/Seizures

Call 911 immediately
Maintain open airway
Turn person onto one side
DO NOT put ANYTHING into mouth
DO NOT restrain person

Burns

Remove the person from danger
Keep the person comfortable
Cool minor burned tissue
DO NOT over cool. Maintain body heat
DO NOT break blisters or remove burned skin or stuck clothing
DO NOT use butter or ointments

Eye Injuries

Flush objects with lots of water
For exposure to chemicals, gently flush eyes with clear water. Continue until help arrives. If the object does not easily wash out, call 911
DO NOT use drops or ointments
If either eye is injured, cover BOTH eyes

Neck or Back Injuries

Call 911 immediately
DO NOT move the person
DO NOT prop up the head
Thrust jaw forward to open airway

Bleeding

Stop the flow...
1. Direct pressure on the wound
2. Elevate wound higher than heart
3. Firm pressure on artery near site

If dressing becomes soaked, leave it on and place another one on top of it
DO NOT use tourniquets!

Broken Bones/Sprains/Strains

Keep the injured limb from moving
If a bone protrudes through the skin, cover it with a dry dressing, but DO NOT touch
Look for swelling, deformity and pain
Ice packs will minimize pain and swelling

Poisoning/Overdose

Call 911 immediately
Follow directions given by Poison Control
DO NOT induce vomiting unless instructed
Find the container(s) of what was taken

Bites or Stings

Insects
-Remove stinger if possible
-Apply cold compress
Snakes
-Keep the victim calm
-Call 911 immediately
-Avoid excessive movement
-Identify or describe the snake
-Keep the wound at or below heart level

Allergic Reaction

Remember people can have a serious reaction to a number of things...FOOD, MEDICINE, INSECTS... Look for rashes, hives, swelling of the face and neck, difficulty breathing, tightness in the neck and chest, CALL 911 NOW!

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FIRST AID GUIDE

BLEEDING

Before providing care, put on protective gloves or use a barrier between you and the victim, to reduce the chance of disease transmission while assisting the injured person. Cleanse your hands thoroughly with soap and water when finished.

Basic first aid treatment:

- CALL 911 for medical assistance.
- Keep the victim lying down.
- Apply direct pressure using a clean cloth or sterile dressing directly on the wound.
- DO NOT take out any object that is lodged in a wound; see a doctor for help in removal.
- If there are no signs of a fracture in the injured area, carefully elevate the wound above the victim's heart.
- Once bleeding is controlled, keep the victim warm by covering with a blanket, continuing to monitor for shock.

CLEANING & BANDAGING WOUNDS

- Wash your hands and cleanse the injured area with clean soap and water, then blot dry.
- Apply antibiotic ointment to minor wound and cover with a sterile gauze dressing or bandage that is slightly larger than the actual wound.

EYE INJURIES

- If an object is impaled in the eye, CALL 911 and DO NOT remove the object.
- Cover both eyes with sterile dressings or eye cups to immobilize.
- Covering both eyes will minimize the movement of the injured eye.
- DO NOT rub or apply pressure, ice, or raw meat to the injured eye.
- if the injury is a black eye, you may apply ice to cheek and area around eye, but not directly on the eyeball itself.

How to flush the eyes: If chemical is in only one eye, flush by positioning the victim's head with the contaminated eye down, to prevent flushing the chemical from one eye to another. Flush with cool or room temperature water for 15 minutes or more. Remove contact lenses after flushing.

BURNS

First Degree Burn: Skin will appear red and may be swollen or painful. Generally does not require medical attention.

Second Degree Burn: Skin will appear red, blistered and swollen. May require medical attention.

Third Degree Burn: Skin will be visibly charred and may be white. Usually very painful. REQUIRES MEDICAL ATTENTION.

Basic first aid treatment for 1st degree & some 2nd degree burns:

Submerge the burn area immediately in cool water until pain stops. If the affected area is large, cover with cool wet cloth. Do not break blisters if they are present. If pain persists but no medical assistance is needed, apply medicated first aid cream or gel and cover with sterile dressing. If medical attention is needed, do not apply any cream. Just cover with a dry, sterile dressing and seek medical help immediately. Basic first aid treatment for 3rd degree & some 2nd degree burns: CALL 911!! Third degree burns MUST RECEIVE MEDICAL ATTENTION IMMEDIATELY! DO NOT try to remove any clothing stuck to the burned area. Cover with sterile dressing or clean sheet. DO NOT apply any creams or gels.

CHEMICAL BURNS

- Flush the affected area with cool running water for at least 15 minutes.
- Remove all clothing and jewelry that has been contaminated.
- Monitor victim for shock and seek medical assistance.
- If chemical burn is in the eyes, flush continuously with water and seek medical attention

UNCONSCIOUSNESS

- Do not leave an unconscious victim alone except to call 911 for medical help.
- Assess the victim's state of awareness by asking if they are OK.
- Check the victim's Airway, Breathing, and Circulation (ABC's).
- If the victim’s ABC’s are not present, perform CPR, IMPORTANT: only a trained & qualified person should administer CPR.
- If ABC's are present and spinal injury is not suspected, place victim on their side with their chin toward the ground to allow for secretion drainage.
- Cover the victim with a blanket to keep warm and prevent shock. if victim communicates feeling warm, remove the blanket.

CHOKING

- Ask the victim, "Are you OK?"
- Do not interfere or give first aid if the victim can speak, breathe, or cough.
- If the victim cannot speak, breathe, or cough, ask for someone to call 911 and then perform the Heimlich maneuver (abdominal thrust),

How to perform the Heimlich maneuver: Position yourself behind the victim with your arms around the victim's stomach. Place the thumb-side of your fist above the victim’s navel and below the lower end of the breastbone. Take hold of your fist with your free hand and pull fist upward and in, quickly and firmly. Continue with thrusts until the object is dislodged or the airway is clear.

POISON

- Call your local Poison Control Center or 911 for immediate medical attention.
- Antidotes on labels may be wrong!! Do not follow them unless instructed by a physician.
- Never give anything by mouth (milk, water, Ipecac, etc.) until you have consulted with a medical professional.
- Keep a one ounce bottle of Ipecac on hand at all times in case of an emergency, and give only when instructed by a physician.
- If the poison is on the skin, flush skin with water for 15 minutes, then wash and rinse with soap and water.
- If poison is in the eye, flush with lukewarm water for 15 minutes. Adults can stand under the shower with eyes open. Always consult medical professionals after any eye injury has occurred.

ANIMAL BITES

- Control any bleeding by applying direct pressure or with elevation. To avoid risk of infection, do not close wound.
- Rinse the bite thoroughly, holding it under running water. Cleanse with soap and water and hold under water again for five minutes.
- Do not put ointments or medicines on wound. Cover with dry sterile bandage or gauze.
- Seek medical assistance immediately.
- Note: report animal and human bites to local police and/or health authorities.

BEE STING

- If possible, remove stinger by scraping it off with a blunt edge (e.g. credit card)
- Clean the wound and apply cold compress to reduce swelling.
- Remove tight clothing and jewelry from areas near the bite in case swelling occurs.
- Watch for signs of shock or allergic reaction. Signs include swelling or itching at the wound site, dizziness, nausea or difficulty breathing. Seek medical attention immediately if any of these signs occur.
- Continue monitoring the victim for shock until medical help arrives.
- Check victim's Airway, Breathing, and Circulation (ABC's). If ABC's are impaired then call 911 and begin CPR. IMPORTANT: only a trained & qualified person should administer CPR.

Cooking Safety

Cooking brings family and friends together, provides an outlet for creativity and can be relaxing. But did you know that cooking fires are the number one cause of home fires and home injuries? By following a few safety tips you can prevent these fires.

"COOK WITH CAUTION"

- Be on alert! If you are sleepy or have consumed alcohol don't use the stove or stovetop.
- Stay in the kitchen while you are frying, boiling, grilling, or broiling food. If you leave the kitchen for even a short period of time, turn off the stove.
- If you are simmering, baking, or roasting food, check it regularly, remain in the home while food is cooking, and use a timer to remind you that you are cooking.
- Keep anything that can catch fire — oven mitts, wooden utensils, food packaging, towels or curtains — away from your stovetop.

If you have a small (grease) cooking fire and decide to fight the fire...

- On the stovetop, smother the flames by sliding a lid over the pan and turning off the burner. Leave the pan covered until it is completely cooled.
- For an oven fire, turn off the heat and keep the door closed.

If you have any doubt about fighting a small fire...

- Just get out! When you leave, close the door behind you to help contain the fire.
- Call 9-1-1 or the local emergency number from outside the home.

Cooking and Kids

Have a "kid-free zone" of at least 3 feet (1 metre) around the stove and areas where hot food or drink is prepared or carried.

FACTS

- The leading cause of fires in the kitchen is unattended cooking.
- Most cooking fires in the home involve the kitchen stove.

NATIONAL FIRE PROTECTION ASSOCIATION
The leading information and knowledge resource on fire, electrical and related hazards

Your Logo

nfpa.org/education

Candle Safety

Candles may be pretty to look at but they are a cause of home fires — and home fire deaths. Remember, a candle is an open flame, which means that it can easily ignite anything that can burn.

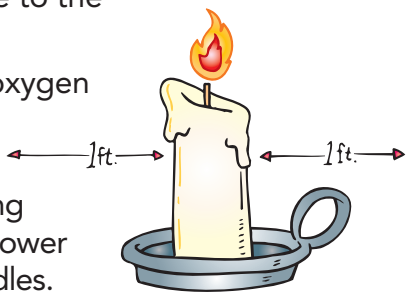
"CANDLE WITH CARE"

- Blow out all candles when you leave the room or go to bed. Avoid the use of candles in the bedroom and other areas where people may fall asleep.
- Keep candles at least 1 foot (30 centimetres) away from anything that can burn.

Think about using flameless candles in your home. They look and smell like real candles.

IF YOU DO BURN CANDLES, make sure that you...

- Use candle holders that are sturdy, and won't tip over easily.
- Put candle holders on a sturdy, uncluttered surface.
- Light candles carefully. Keep your hair and any loose clothing away from the flame.
- Don't burn a candle all the way down — put it out before it gets too close to the holder or container.
- Never use a candle if oxygen is used in the home.
- Have flashlights and battery-powered lighting ready to use during a power outage. Never use candles.



Candles and Kids

Never leave a child alone in a room with a burning candle. Keep matches and lighters up high and out of children's reach, in a locked cabinet.

FACTS

- **December** is the peak month for home candle fires.
- More than **one-third** of home candle fires started in the bedroom.
- **Three of every five** candle fires start when things that can burn are too close to the candle.

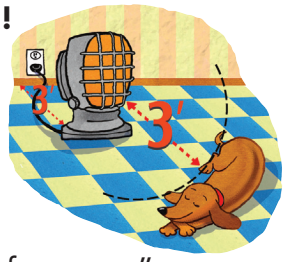
NATIONAL FIRE PROTECTION ASSOCIATION
The leading information and knowledge resource on fire, electrical and related hazards

Your Logo

Heating Safety

There is something about the winter months and curling up with a good book by the fireplace. But did you know that heating equipment is one of the leading causes of home fire deaths? With a few simple safety tips and precautions you can prevent most heating fires from happening.

BE WARM AND SAFE THIS WINTER!



- Keep anything that can burn at least three-feet (one metre) away from heating equipment, like the furnace, fireplace, wood stove, or portable space heater.
- Have a three-foot (one metre) "kid-free zone" around open fires and space heaters.
- Never use your oven to heat your home.
- Have a qualified professional install stationary space heating equipment, water heaters or central heating equipment according to the local codes and manufacturer's instructions.
- Have heating equipment and chimneys cleaned and inspected every year by a qualified professional.
- Remember to turn portable heaters off when leaving the room or going to bed.
- Always use the right kind of fuel, specified by the manufacturer, for fuel burning space heaters.
- Make sure the fireplace has a sturdy screen to stop sparks from flying into the room. Ashes should be cool before putting them in a metal container. Keep the container a safe distance away from your home.
- Test smoke alarms at least once a month.

Heating Equipment Smarts

Install wood burning stoves following manufacturer's instructions or have a professional do the installation. All fuel-burning equipment should be vented to the outside to avoid carbon monoxide (CO) poisoning.

Install and maintain CO alarms to avoid the risk of CO poisoning. If you **smell** gas in your gas heater, do not light the appliance. Leave the home immediately and call your local fire department or gas company.

FACT

Half of home heating fires are reported during the months of **December**, **January**, and **February**.

NATIONAL FIRE PROTECTION ASSOCIATION
The leading information and knowledge resource on fire, electrical and related hazards

Smoking
& Home Fire Safety

The place where we feel safest — at home — is where most smoking-materials structure fires, deaths, and injuries occur. Smoking materials are the leading cause of fire deaths. Smoking material fires are preventable.

Smoking Safety

- If you smoke, use only fire-safe cigarettes.
- If you smoke, smoke outside. Most deaths result from fires that started in living rooms, family rooms and dens or in bedrooms.
- Keep cigarettes, lighters, matches, and other smoking materials up high out of the reach of children, in a locked cabinet.

Put It Out

- Use a deep, sturdy ashtray. Place it away from anything that can burn.
- Do not discard cigarettes in vegetation such as mulch, potted plants or landscaping, peat moss, dried grasses, leaves or other things that could ignite easily.
- Before you throw away butts and ashes, make sure they are out, and dousing in water or sand is the best way to do that.

Smoking and Medical Oxygen

Never smoke and never allow anyone to smoke where medical oxygen is used. Medical oxygen can cause materials to ignite more easily and make fires burn at a faster rate than normal. It can make an existing fire burn faster and hotter.

ELECTRONIC CIGARETTES

Fires have occurred while e-cigarettes were being used, the battery was being charged, or the device was being transported. Battery failures have led to small explosions. Never leave charging e-cigarettes unattended. E-cigarettes should be used with caution.

FACTS

- The risk of dying in a home structure fire caused by smoking materials rises with age.
- One out of four fatal victims of smoking-material fires is not the smoker whose cigarette started the fire.

Name of Organization Goes Here

Contact Information Goes Here

NFPA

Your Source for SAFETY Information

NFPA Public Education Division • 1 Batterymarch Park, Quincy, MA 02169

Electrical Safety

Flipping a light switch. Plugging in a coffeemaker. Charging a laptop computer. These are second nature for most of us. Electricity makes our lives easier. However, we need to be cautious and keep safety in mind.

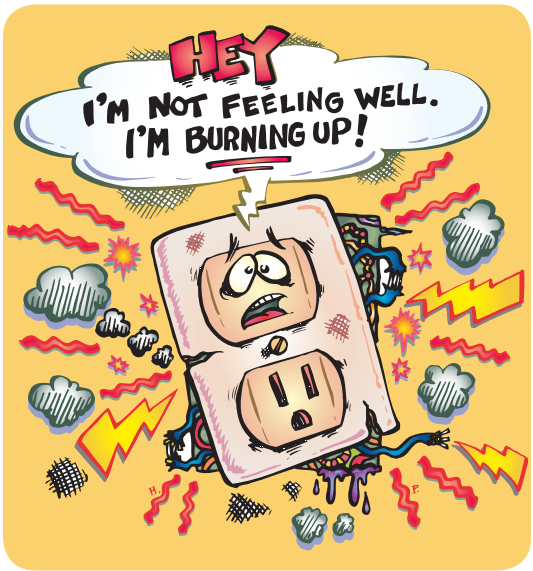
SAFETY TIPS

- Have all electrical work done by a qualified electrician.
- When you are buying or remodeling a home, have it inspected by a qualified private inspector or in accordance with local requirements.
- Only use one heat-producing appliance (such as a coffee maker, toaster, space heater, etc.) plugged into a receptacle outlet at a time.
- Major appliances (refrigerators, dryers, washers, stoves, air conditioners, microwave ovens, etc.) should be plugged directly into a wall receptacle outlet. Extension cords and plug strips should not be used.
- Arc-fault circuit interrupters (AFCIs) shut off electricity when a dangerous condition occurs. Consider having them installed in your home.
- Use ground-fault circuit interrupters (GFCIs) to reduce the risk of shock. GFCIs shut off an electrical circuit when it becomes a shock hazard. They should be installed inside the home in bathrooms, kitchens, garages and basements. All outdoor receptacles should be GFCI protected.
- Test AFCIs and GFCIs once a month according to the manufacturer's recommendations. You do not need a flame to start a fire. Fires can start when heat builds up near things that burn. This can happen when a hot light bulb is near things that burn, such as cloth or paper, or a cord has been placed under a carpet.
- Check electrical cords to make sure they are not running across doorways or under carpets. Extension cords are intended for temporary use. Have a qualified electrician add more receptacle outlets so you don't have to use extension cords.
- Use a light bulb with the right number of watts. There should be a sticker that indicates the right number of watts.

IMPORTANT REMINDER

Call a qualified electrician or your landlord if you have:

- Frequent problems with blowing fuses or tripping circuit breakers
- A tingling feeling when you touch an electrical appliance
- Discolored or warm wall outlets
- A burning or rubbery smell coming from an appliance
- Flickering or dimming lights
- Sparks from an outlet



NATIONAL FIRE PROTECTION ASSOCIATION
The leading information and knowledge resource on fire, electrical and related hazards

Your Logo

ELDER ABUSE AND NEGLECT: PREVENTING, RECOGNIZING, AND REPORTING INSERVICE HANDOUT

1. Ways Elders are Abused

- Stealing or mismanaging the money, property, or belongings of an older person. Also called exploitation.
- Using physical force to cause physical pain or injury.
- Failing to provide something necessary for health and safety, such as personal care, food, shelter, or medicine.
- Causing emotional or psychological pain. Includes isolation, verbal abuse, threats, and humiliation.
- Confining someone against his will, or strictly controlling the elder's behavior. Includes improper use of restraints and medications to control difficult behaviors.
- Forcing sexual contact without the elder person's consent, including touching or sexual talk.

Other Ways Elders Are Abused:

- Over-medicating
- Denying aids such as walkers, eyeglasses, or dentures
- Dirty living conditions
- Inadequate heating and air conditioning

2. How to recognize caregiver stress

Are you an overly stressed caregiver? Answer Yes or No.

1. I am frequently unable to sleep because I have so much on my mind.
2. Most of the time I don't feel very good.
3. I have difficulty concentrating, and often forget to do routine tasks.
4. I feel depressed or sad much of the time.
5. I feel worried and anxious almost all the time.
6. I lose my temper easily and become angry at other people.
7. I don't think there's anything wrong with me; I just wish everyone else would stop doing things that upset me.
8. Most days I feel irritable and moody, often snapping at others.
9. I feel tired almost all the time, and just drag myself through my days.
10. I'm too busy to do anything fun or to go out with my friends.

Any "yes" answers could be a sign of excessive stress. More than three "yes" answers should prompt you to talk to your supervisor or physician about the way you are feeling.

Caregivers who are feeling too much stress are more likely to be abusive or neglectful of the people in their care. To be a good caregiver, you must care for yourself as well as others.

3. Signs of Elder Abuse and Neglect

Be concerned if you see an elderly person showing these new behaviors or signs:

Personality and behavior changes:

1. Becoming withdrawn, unusually quiet, depressed, or shy.
2. Becoming anxious, worried, easily upset.
3. Refusing care from caregivers.
4. Not wanting to be around people, not wanting to see visitors.

Physical signs:

1. Bruises or burns.
2. In a woman, vaginal bleeding or bruising of the genitals or thighs.
3. Fractures
4. Unreasonable or inconsistent explanations for injuries
5. Frequent emergency room visits

Signs of possible neglect:

1. Weight loss, malnutrition, or dehydration.
2. Insufficient clothing, shoes, or basic hygiene items.
3. Medications not filled or taken.
4. Doctor visits not scheduled or kept.
5. Unclean appearance or smell.
6. Skin ulcers or sores.
7. Declining health.

While most of these things are controlled in an institution, it is possible for any of them to occur anywhere. Abusive or neglectful caregivers can be professionals as well as family members. It is important for everyone to be alert to the signs.

4. Report Abuse or Neglect

Anyone who knows of an elderly person being abused or neglected is obligated to notify the proper authorities. Reporting procedures vary by state. Any aide who suspects abuse of a resident by either a family member or another professional caregiver should first report it to his or her supervisor. You should become familiar with any statements of rights that your state has issued to protect the elderly and residents of care facilities—ask your supervisor for a copy.

Every state has an office or department that deals with abuse and neglect of the elderly. There are different names for these offices: Human Services, Adult Protective Services, Health and Welfare, Department of Aging, etc.

5. Child Abuse Inservice

Purpose

The purpose of this course is to assist healthcare professionals in identifying and responding to child abuse.

Objectives

After completing this course, the learner will be able to meet the following five objectives:

1. define child abuse,
2. identify the signs and symptoms of the different forms of child abuse,
3. identify the impact of abuse on children,
4. identify resources for reporting child abuse, and
5. identify the healthcare professional's role in identification and prevention of child abuse.

What is Physical Abuse?

Physical abuse is the use of physical force that may result in bodily injury, physical pain, or impairment. Physical abuse may include acts of violence like striking, hitting, beating, pushing, shoving, shaking, slapping, kicking, pinching, and burning. This abuse may not have been intended to hurt the child; but an injury may have resulted from over- discipline or physical punishment.

Signs and symptoms of physical abuse may be:

- Bruises, black eyes, welts, lacerations or rope marks
- Bone fractures, broken bones or skull fractures
- Open wounds, cuts, punctures or untreated injuries in various stages of healing
- Sprains, dislocations or internal injuries/bleeding
- Physical signs of being subjected to punishment or signs of being restrained
- A sudden change in behavior
- A child's report of physical abuse

What is Neglect?

Neglect is the failure to provide for the child's basic needs. 43% of identified neglect cases were physical neglect, which includes unsafe housing, not being fed nutritionally adequate meals, inadequate clothing, and grossly inadequate hygiene. 37% of identified neglect cases were inadequate supervision of children and 21% were failure or delay in providing health care. Assessing child neglect requires consideration of cultural values and standards of care and recognition that poverty may contribute to the failure to provide the necessities of life.

The Study of National Incidence and Prevalence of Child Abuse use the following standardized categories and definitions of child neglect:

- Refusal of Health Care
- Delay in Health Care
- Abandonment

- Expulsion
- Other Custody Issues Other
- Physical Neglect Inadequate
- Supervision Inadequate
- Nurturance/Affection
- Chronic/Extreme Abuse or Domestic Violence
- Permitted Drug/Alcohol Abuse
- Permitted Other Maladaptive Behavior
- Refusal of Psychological Care
- Delay in Psychological Care
- Other Emotional Neglect
- Permitted Chronic Truancy
- Failure to Enroll/Other Truancy
- Inattention to Special Education Need

What is Sexual Abuse?

Sexual abuse is the employment, use, persuasion, inducement, enticement, or coercion of any child to engage in, or assist any other person to engage in, any sexually explicit conduct or simulation of such conduct for the purpose of producing a visual depiction of such conduct.

This may include fondling a child's genitals, intercourse, incest, rape, sodomy, exhibitionism, voyeurism, exposure to pomography, or commercial exploitation through prostitution or pornographic material. Consensual sexual contact with a child is statutory rape. The age of consent for sexual contact is defined by each state.

Signs and symptoms of sexual abuse include:

- Bruises around the breasts or genital area
- Unexplained venereal disease or genital infections
- Unexplained vaginal or anal bleeding
- Torn, stained, or bloody underclothing
- A torn or scarred hymen
- Frequent urinary tract infections
- Sexual acting out,
- A child's report of sexually assault or rape
- Bruising or petechiae of the hard and soft palate or lacerations of the frenulum that can result from forced oral penetration

What is Psychological Abuse?

Psychological/emotional abuse includes acts or omissions by the parents or caregivers. This can cause serious behavioral, cognitive, emotional, or mental disorders. Psychological abuse is almost always present when other forms of abuse are identified. This can include constant verbal abuse, harassment, belittling, humiliation, isolation from friends and family and intimidation. Signs and symptoms of psychological abuse include:

- Being emotionally upset or agitated
- Being extremely withdrawn and non-communicative or non-responsive
- Unusual behavior, like sucking, biting, or rocking Aggression, depression, eating disturbances and regression
- A child's report of being verbally or emotionally mistreated

Withholding Medical Treatment

Withholding of medically indicated treatment is the failure to respond to the infant's life-threatening conditions by providing treatment (including appropriate nutrition, hydration, and medication) that in the treating physician's or physicians' reasonable medical judgment, will be most likely to be effective in ameliorating or correcting all such conditions. But the term does not include the failure to provide treatment (other than appropriate nutrition, hydration, and medication) to an infant when, in the treating physician's or physicians' reasonable medical judgment:

- The infant is chronically and irreversibly comatose
- The provision of such treatment would merely prolong dying; not be effective in ameliorating or correcting all of the infant's life-threatening conditions; or otherwise, be futile in terms of the survival of the infant
- The provision of such treatment would be virtually futile in terms of the survival of the infant and the treatment itself under such circumstances would be inhumane.
- This is a major concern with severely disabled newborns. Food and water must always be provided regardless of the extent of disabilities, and quality of life cannot be a criterion for deciding appropriate medical treatment,
- Federal regulations require Child Protective Services programs to actively investigate reported cases of withholding of medical treatment. Hospitals are required to observe the provisions of the law and to post notices of the law in newborn nurseries.

Prenatal Exposure to Drugs

Pregnant women who abuse alcohol have exposed their fetuses to the serious mental and physical disabilities known as fetal alcohol syndrome. An estimated 73% of pregnant women have used alcohol sometime during their pregnancy. The incidence of fetal alcohol syndrome is 1.9 births per 1,000. Prenatal exposure to cocaine and other drugs also results in negative developmental disorders.

Shaken Baby Syndrome

When a baby is vigorously shaken, the head moves back and forth. A baby's head and neck are susceptible to head trauma because the muscles are not fully developed, and the brain tissue is exceptionally fragile. Shaken Baby Syndrome occurs most frequently in infants younger than six months old, but it can occur up to age three The sudden whiplash motion causes the injury to the baby. That motion can cause bleeding inside the head and increased pressure on the brain, causing the brain to pull apart. Often, there are no obvious outward signs. Shaken Baby Syndrome is one of the leading forms of fatal child abuse. Head trauma is the leading cause of disability due to abuse of infants. Shaken baby syndrome is often misdiagnosed and under diagnosed.

Munchausen's Syndrome by Proxy

Munchausen's syndrome by proxy (MSBP) is when a parent commits physical abuse while trying to intentionally fabricate illnesses in their children. The existing research is based on a small number of cases and needs to be expanded. However, the research suggests that victims of MSBP experience significant psychological and psychiatric symptomatology in both childhood and adulthood. Most cases of MSBP are believed to go undetected, so the actual incidence of this

type of abuse is unknown. Because of the sometimes-extreme abuse inflicted by parents with MSBP (e.g., broken bones, poisoning), their children are at great risk for serious physical and psychiatric morbidity.

Factors Influencing Child Abuse

The incidence of child maltreatment varies as a function of family income, family structure, family size, and the metropolitan status of the county. As circumstances deteriorate, maltreatment becomes more prevalent and more severe.

Child characteristics:

- The highest victimization rates were for the 0-3 age group, 13.9 per 1,000
- Victimization rates by race/ethnicity ranged from 4.4 per 1,000 for Asian/Pacific Islander to 25.2 per 1,000 for African American victims
- 43% of the fatalities were younger than 1 year of age, and 86% were younger than 6 years of age
- 38% of the fatalities were associated with neglect
- Girls were sexually abused more often than boys
- Boys had a greater risk of serious injury and emotional neglect than girls
- Children are vulnerable to sexual abuse from age three on
- Older children have greater opportunities for escape, and are more able to defend themselves and/or retaliate
- Pre-maturity, difficult temperament and mentally handicapped children have been associated with parents that are less responsive and less attentive to their needs
- Physical abuse peaks in the 4-8 year old age range. Psychological abuse peaks in the 6-8 year old range and remains at a similar level through adolescence

Research indicates that young children, ages 3 and younger, are the most frequent victims of child fatalities. NCANDS data for 2006 demonstrated that children younger than 1 year accounted for 44.2% of fatalities, while children younger than 4 years accounted for more than three-quarters (78.0%) of fatalities. These children are the most vulnerable for many reasons, including their small size, dependency, and inability to defend themselves. Fatal child abuse may be due to acute or chronic abuse. Repeated abuse over a period of time (e.g., battered child syndrome) is a chronic situation and an acute abuse may involve a single, impulsive incident (e.g., drowning, suffocating, or shaking a baby). In cases of fatal neglect, the child's death results from a caregiver's failure to act. The neglect may be chronic (e.g., extended malnourishment) or acute (e.g., an infant or child who drowns after being left unsupervised in the bathtub).

In 2006, 41.1% of child maltreatment fatalities were associated with neglect alone. Physical abuse alone was cited in almost one-quarter (22.4%) of reported fatalities. Another 31.4% of fatalities were the result of multiple maltreatment types. In 2006, one or both parents were responsible for 75.9% of child abuse or neglect fatalities.

14.7% of fatalities were the result of maltreatment by non-parent caretakers, and the remaining 9.5% represents unknown or missing information.

Family characteristics

- Children of single parents have a 77% greater risk of being harmed by physical abuse; an 87% greater risk of being harmed by physical neglect; and an 80% greater risk of suffering serious injury or harm from abuse or neglect.

- Children in the largest families were physically neglected at nearly three times the rate of those who came from single-child families.
- Children from families with annual incomes below $15,000 as compared to children from families with annual incomes above $30,000 per year were over 22 times more likely to experience some form of maltreatment.
- Children from the lowest income families were 18 times more likely to be sexually abused, almost 56 times more likely to be educationally neglected, and over 22 times more likely to be seriously injured from maltreatment.
- The estimated rate of neglect among families with four or more children was almost double the rate among families with three or fewer children.

Abuser Characteristics

The ability to provide adequate care for a child depends partly on the parent's emotional maturity, coping skills, knowledge about children, mental capacity, and parenting skills. Alcohol or drug abuse is often present in cases of child neglect.

- 62% of perpetrators were female.
- 87% of all victims were maltreated by at least one parent.
- The most common pattern was a child victimized by a female parent acting alone.
- Neglect and physical abuse were more frequently perpetrated by a female parent.
- Sexual abuse was more frequently perpetrated by a male parent.
- The following are five characteristics of neglectful mothers
  - Impulse-ridden
  - Apathetic
  - Suffering from reactive depression
  - Mentally retarded
  - Psychotic
- High-risk parents may be identified using the following indicators
  - Poverty
  - Mental retardation
  - Drug abuse
  - Lack of social support
  - History of being maltreated
  - Methods of Assessing for potential abuse
  - Observing parent and infant interactions for indicators of poor bonding
  - Standard risk assessment instruments.

Impact of Abuse on Children

Physical abuse or neglect is associated with a large number of interpersonal, cognitive, emotional, behavioral, and substance abuse problems. There is also an associated increase in psychiatric disorders and increased mental health services utilization. There is an association between physical abuse and the risk for suicidal behavior, particularly in adolescents. Aggressive and delinquent behaviors are frequently correlated with physical abuse.

Psychological maltreatment may have a stronger relationship to long-term psychological functioning than other forms of maltreatment. Psychological abuse is a stronger predictor than physical maltreatment of a wide array of problems, including internalizing and externalizing behaviors, social impairment, low self-esteem, suicidal behavior, as well as current and previous psychiatric diagnoses and hospitalizations.

A history of physical abuse increased a subject's odds of attempting suicide by almost 5 times, while a history of psychological abuse increased the odds of a suicide attempt by more than 12 times. Perceived emotional rejection by parents has been associated with poor adolescent and young adult outcomes in substance abuse and delinquency.

Abused children may have impaired cognitive abilities, poor academic achievement and deficits in both receptive and expressive language. Abused adolescents report deficits in social functioning, like impaired styles of interpersonal attachment, engaging in more aggression in their peer relationships, and exhibiting more abusive or coercive behaviors in dating relationships. Abuse victims are at increased risk for a variety of child and adolescent psychiatric diagnoses, including depressive disorders, anxiety disorders, conduct disorder, oppositional defiant disorder, attention-deficit/hyperactivity disorder and substance abuse.

Reporting Child Abuse

Each State has specific agencies to receive and investigate reports of suspected child abuse and neglect. Usually, this is done by child protective services (CPS), within a Department of Social Services, Department of Human Resources, or Division of Family and Children Services. A list of that contact information is at the end of this course.

In some States, police departments also may receive reports of child abuse or neglect. If you don't know whom to call, you can call Childhelp USA, National Child Abuse Hotline at 1-800- 4-A-CHILD (1-800-422-4453; TDD 1-800-2-A-CHILD). This Hotline is available 24 hours, 7 days a week. They can tell you where to file your report and can help you make the report. State Toll-Free Child Abuse

Child abuse victims come into frequent contact with health professionals, but physicians often only treat their injuries. Because there is a lack of training on what to look for and how to ask about abuse, health professionals often fail to identify victims. Opportunities for intervention are missed and victims continue to suffer the adverse health consequences of physical and emotional abuse.

Early intervention with parents identified as high risk for neglect, using home health visitation, has proven to be an effective prevention strategy. Home visitors can initiate contact with the mothers during their pregnancy or at the time of their delivery in the hospital, and should provide follow-up in-home visits for up to 2 years.

Healthcare professionals are often the first to observe abuse and neglect, and their observations are often crucial in substantiating that abuse has occurred. They can help by:

- Reporting suspected cases of child abuse to Children's Protective Service
- Documenting abuse in the medical record
- Safeguarding evidence
- Providing medical advice, referrals, and safety planning
- Showing empathy and compassion
- Identifying the somatic signs and symptoms of abuse
- Evaluating the plausibility of explanations given for common injuries and conditions
- Providing expert testimony

- Assessing cognitive status and health factors that affect it
- Treating injuries or health problems that result from abuse
- Performing abuse screenings
- Encouraging clinics, hospitals, health maintenance organizations, or other medical providers to develop or adopt protocols for screening and responding to abuse Provide referrals to legal and social services
- Learning more about child abuse

Screening questions should always be asked in a private room, away from the batterer and preceded by assurances of strict confidentiality. Health care providers should also be trained to find ways to separate the patient from their parent if the latter demands to accompany the patient into the examining room.

Summary

Child fatalities due to abuse and neglect are a serious problem in the United States. Fatalities disproportionately affect young children and most often are caused by one or both of the child's parents.

Child fatality review teams have been created to accurately count, respond to, and prevent child abuse and neglect fatalities, as well as other preventable deaths.

Prevention is one way of helping to prevent abuse, neglect and untimely deaths from occurring. The child fatality review process helps identify risk factors that may assist prevention professionals. These prevention teams are demonstrating effectiveness in translating review findings into action by partnering with child welfare and other child health and safety groups. In some States, review team annual reports have led to State legislation, policy changes, or prevention programs.

In 2003, the Office on Child Abuse and Neglect, within the Children's Bureau, Administration for Children and Families, U.S. Department of Health and Human Services, launched a Child Abuse Prevention Initiative to raise awareness of the issue in a much more visible and comprehensive way than ever before.

Today, "The Prevention Initiative" is an opportunity to work together in communities across the country to support parents and promote safe children and healthy families. Increasingly, this effort focuses on promoting protective factors that enhance the capacity of parents, caregivers, and communities to protect, nurture, and promote the healthy development of children. Healthcare professionals working in emergency rooms and clinics need to take the initiative to report child abuse findings to the proper authorities in a timely manner before deaths occur to our nation's innocents.

BLOODBORNE PATHOGENS
INSERVICE HANDOUT

1. WHY IS IT IMPORTANT TO PROTECT YOURSELF FROM CONTACT WITH BLOOD AND BODY FLUIDS?

Although they can't be seen, there are hundreds of tiny organisms living in blood and other body fluids that can cause disease in humans. They are called "bloodborne pathogens."

Some of these organisms are harmless and can be handled easily by the body's immune system, but others can cause severe illness, such as hepatitis or AIDS.

Bloodborne diseases: HIV, Hepatitis B, Hepatitis C

Bloodborne pathogens include the hepatitis B virus (HBV), the hepatitis C virus, the human immunodeficiency virus (HIV) that causes autoimmune deficiency syndrome (AIDS), and others.

These pathogens are transmitted through contact with infected body fluids such as blood, semen, and vaginal secretions. Exposures occur (a) if the skin is punctured by a contaminated needle, razor, or other sharp item or (b) when broken skin or mucous membranes are splashed with blood or body fluid. Fortunately, most exposures do not result in infections.

Standard Precautions are designed to prevent transmission of HIV, HBV, and HCV. Standard Precautions must be observed in all situations where there is potential for contact with blood or other potentially infectious body fluids.

Standard Precautions apply to:

- Blood
- Semen
- Vaginal secretions
- Saliva
- Cerebrospinal fluid
- Synovial fluid
- Pleural fluid
- Peritoneal fluid
- Pericardial fluid
- Amniotic fluid
- Feces
- Nasal secretions
- Sputum
- Sweat
- Tears
- Urine
- Vomitus

Treat all human blood and body fluids as if they are infectious. Remember who you are protecting—**YOURSELF!**

2. HANDWASHING

Handwashing is the single most important thing you can do to prevent the spread of infection. Thorough handwashing removes pathogens from the skin.

Wash hands before and after all client or body fluid contact. Immediately wash hands and other skin surfaces that are contaminated with blood or body fluids. When wearing gloves, wash hands as soon as the gloves are removed.

Germicidal hand rubs are recommended **only** when you can't wash.

3. PROPER HANDWASHING PROCEDURE

1. Remove watch or push it up your arm. You should not wear rings or bracelets at work.
2. Do not touch the sink with your hands while you are washing, and stand back from the sink to keep it from touching your clothes.
3. Use warm water. Hot water may dry skin.
4. Either bar soap or liquid soap is okay. If using a bar, rinse it first and hold it the whole time you are lathering. Soap does not have to be an antiseptic type, unless you are doing an invasive procedure such as catheterization.
5. Wet your wrists and hands.
6. Apply plenty of soap. Work up a thick lather all over your hands and wrists, between your fingers and thumbs, and on the back of your hands and wrists.
7. Vigorously rub all areas of your hands, fingers, and wrists for **a minimum of 10-15 seconds**. Sixty seconds is better.
8. Clean under your nails by using the nails on your other hand, or rub your nails into the palm of your other hand. Clean around the top of your nails.
9. Rinse with warm water, letting water run down from wrists to fingertips and into the sink.
10. Dry with a clean paper towel and throw it away.
11. Turn off the faucet with a clean, dry paper towel and throw the towel away.
12. Use lotion on your hands to prevent irritation and chapping, which makes skin more prone to infection.

4. GLOVES

- Use gloves in all situations where you may come in contact with blood or body fluids.
- Use gloves for client care involving contact with mucous membranes, such as brushing teeth.
- Change gloves and wash hands between client contacts.
- Use gloves when you have scrapes, scratches, or chapped skin.
- Do not wash or disinfect disposable gloves for reuse.

5. PROTECTIVE BARRIERS

Protective barriers, including gloves, reduce the risk of your skin or mucous membranes being exposed to potentially infective blood and body fluids. You should wear the appropriate barriers for the work you are doing.

Employers must provide suitable personal protective equipment (PPE) in the right sizes. Protective equipment includes gloves, gowns, masks, eye protection, face shields, mouthpieces, resuscitation devices, etc. Hypoallergenic gloves, glove liners, powderless gloves, or other alternatives must be available for those who are allergic to latex gloves.

The equipment you need depends on your work. When splashing of blood or body fluids is likely, wear the following PPE in addition to gloves:

- Mask if your face could be splashed with blood or body fluids.
- Eye protection if your eyes could be splashed with blood or body fluids.
- Gown if your clothing or skin could be splashed.

6. PROPER DISPOSAL OF SHARP ITEMS

A "sharp" is any object that can penetrate the skin, such as needles, scalpels, broken glass, broken capillary tubes, and exposed ends of wires. A sharp is contaminated if it has been in contact with blood, body fluids, or body tissues.

Contaminated sharps must be disposed of properly. Follow your organization's policies. A puncture-proof biohazardous container must be used in care facilities. Biohazardous waste from facilities (not from client's homes) must be disposed of by specially licensed companies.

- Be careful to prevent injuries from needlesticks and other sharp instruments after procedures, when cleaning used instruments, and when disposing of used needles. Do not recap or manipulate needles.
- Nursing and personal care facilities should be using, or planning to use, needleless injection systems or needles with injury protection. If you must use a regular needle, remember:
  - Do not recap needles. If it is absolutely necessary to recap a needle, use one hand to slide the needle into a cap lying on a flat surface. Do not hold the cap in your other hand while recapping.

Tips:

- Use thick rubber household gloves to protect your hands during housekeeping chores or instrument cleaning involving potential blood contact.
- Treat all linen soiled with blood or body secretions as potentially infectious.
- Surfaces that have been contaminated with blood or body fluids should be cleaned with a disinfectant according to your organization's policies.

7. TIER SYSTEMS

TIER 1: Standard Precautions

Basic precautions to be used at all times, with all clients, to prevent transmission of bloodborne diseases:

1. Frequent, thorough handwashing.
2. Wear gloves when you might touch blood or body fluids.
3. When splashing of blood or body fluids is likely, wear the following, depending on the situation:
    a. Masks
    b. Eye protection
    c. Gowns
4. Safe use and disposal of sharp items.

TIER 2: Additional Precautions

Based on Type of Disease and How It Is Transmitted:

1. Airborne
2. Contact
3. Droplet

8. IF AN EXPOSURE OCCURS

Immediately following an exposure to blood or body fluids:

- Wash needlesticks and cuts with soap and water.
- Flush splashes to the nose, mouth, or skin with water.
- Irrigate eyes with clean water, saline, or sterile irritants.

Next,

- Report the exposure at once. Treatment may be recommended, and it should be started as soon as possible. See a medical professional.
- Discuss the possible risks and the need for treatment with the person managing your exposure.
- Remember that mandatory testing of a client is not legal. Clients who might be the source of an infection must give consent to be tested.

Worker's Rights

The Occupational Safety and Health Administration (OSHA) is a federal agency that guarantees rights to a safe workplace. Under OSHA's rules, workers who might be exposed to contaminated blood or body fluids have specific rights.

Employers must train workers who might be exposed to blood or body fluids about the hazards and how to protect themselves. This training must occur during working hours at orientation at no cost to the employee, and annually thereafter.

Standard precautions must be practiced at all times. Puncture-proof and leak-proof containers must be provided for disposal of sharp items. There must be a system for reporting exposures to blood or body fluids,

Employers must provide free hepatitis B vaccine, free protective equipment and free immediate medical evaluation and follow-up for anyone exposed to blood or body fluids. Employees must receive confidential treatment, and their medical records must be protected.

Workers' responsibilities

Always use standard precautions.

- Actively participate in evaluating safer equipment and encouraging your organization to purchase safer equipment. Be open to new products or practices that could prevent exposure and protect workers and clients.
- Be immunized against hepatitis B, getting the series of three injections.
- Report all exposures immediately after cleaning and disinfecting the exposed skin or mucus membranes.
- Comply with post-exposure recommendations of your organization.
- Support other workers who have been exposed. HIV-infected workers who continue working deserve support and confidentiality.
- Know your own HIV/HBV/HCV status. If you are positive for any of these viruses, you do not pose a risk for clients if you don't do invasive procedures.

9. HUMAN IMMUNODEFICIENCY VIRUS (HIV) IS THE VIRUS THAT CAUSES AIDS

Risk of infection after exposure

- Needlestick is the most common cause of work-related infection.
- Risk factors include the amount of blood or fluid, the puncture depth, and the disease stage of the infected person.
- The average risk of HIV infection after a needlestick or cut exposure is 1 in 300. The risk after exposure of the eye, nose, skin, or mouth to positive blood is less than 1 in 1000. If the skin is damaged, the risk may be higher.

Treatment after exposure

- There is no vaccine against HIV.
- Post-exposure treatment is not always recommended. A physician or exposure expert should advise you.
- Drugs used to prevent infection may have serious side effects.
- Perform HIV-antibody testing for at least 6 months after exposure.

99.7% of needlestick/cut exposures do not result in HIV infection.

Hepatitis B Virus (HBV)

Risk of infection after exposure

- Hepatitis B vaccine prevents this disease. Persons who have received the

vaccine and developed immunity are at virtually no risk for infection. A series of three (3) injections are required, given initially, then 1-2 months later, then 4-6 months after the first injection.
- Workers should be tested 1-2 months after the vaccination series to make sure the vaccination has provided immunity.
- For the unvaccinated person the risk from a single needlestick or cut exposure ranges from 6%-30%, depending on the level of virus in the infected person's blood. A higher concentration of virus makes it more likely that someone exposed to that blood will become infected.

Treatment after exposure

- Everyone with a chance of exposure to blood or body fluids should receive hepatitis B vaccine, preferably during training, *unless it is contraindicated because of allergies, pregnancy, or potential pregnancy*.
- Hepatitis B immune globulin (HBIG) effectively prevents HBV infection after exposure. Recommendations for post-exposure management of HBV may include HBIG and/or hepatitis B vaccine. The decision to begin treatment is based on several factors, such as:
  - Whether the source person is positive for hepatitis B.
  - Whether the worker has been vaccinated.
  - Whether the vaccine provided immunity.

Hepatitis C Virus (HCV)

Infection with HCV carries a great potential for chronic liver disease and can lead to liver failure, liver transplants, and liver cancer.

Risk of infection after exposure

- Hepatitis C Virus (HCV) is a growing problem.
- The risk for infection after a needlestick or cut exposure to HCV-infected blood is 1.8%.
- The risk after a blood splash is unknown but is believed to be very small; however, HCV infection from such an exposure has been reported.

Treatment after exposure

- There is no vaccine against hepatitis C and no treatment after an exposure that will prevent infection.
- Immune globulin (HBIG) is not recommended.
- Following recommended infection control practices is vital.
- There are several tests that should be performed in the weeks after an exposure and for 4-6 months afterward. Confer with a physician or an exposure specialist.

Additional Precautions for infection control

If you know or suspect that a client has a disease that is spread in one of the following ways, use these extra precautions, **in addition to Standard Precautions:**

Airborne germs can travel long distances through the air and are breathed in by people. Examples of diseases caused by airborne germs: TB, chickenpox, shingles.

- Wear a mask. If the client has, or might have, tuberculosis, wear a special respiratory mask (ask your supervisor). A regular mask will not protect you.
- Remind the client to cover nose and mouth when coughing or sneezing.
- Treat the client's used tissues or handkerchiefs as infected material.

Contact germs can cause the spread of disease by touch. Examples of diseases caused by contact germs: pink-eye, scabies, wound infections, MRSA.

- Wear gloves.
- Treat bed linens, clothes, and wound dressings as infected material.
- Wear a gown if the client has drainage, has diarrhea, or is incontinent.
- Use a disinfectant to clean stethoscopes, blood pressure cuffs, or other equipment.

Droplet germs can travel short distances through the air, usually not more than three feet. Sneezing, coughing, and talking can spread these germs. Examples of diseases caused by droplet germs: flu, pneumonia.

- Wear a mask when working close to the client (within three feet).

Tuberculosis (TB) Facts

TB Can Be Treated

What is TB?

"TB" is short for a disease called tuberculosis. TB is spread through the air from one person to another. TB germs are passed through the air when someone who is sick with **TB disease** of the lungs or throat coughs, speaks, laughs, sings, or sneezes. Anyone near the sick person with **TB disease** can breathe TB germs into their lungs.

TB germs can live in your body without making you sick. This is called **latent TB infection**. This means you have only inactive (sleeping) TB germs in your body. The inactive germs cannot be passed on to anyone else. However, if these germs wake up or become active in your body and multiply, you will get sick with **TB disease**.

When TB germs are active (multiplying in your body), this is called **TB disease**. These germs usually attack the lungs. They can also attack other parts of the body, such as, the kidneys, brain, or spine. **TB disease** will make you sick. People with **TB disease** may spread the germs to people they spend time with every day.

If the **TB disease** is in your lungs, you may:

- cough a lot,
- cough up mucus or phlegm ("flem"),
- cough up blood, or
- have chest pain when you cough.

You should ALWAYS COVER YOUR MOUTH when you cough!

If you have **TB disease**, you may also:

- feel weak,
- lose your appetite,
- lose weight,
- have a fever, or
- sweat a lot at night.

These are symptoms of **TB disease**. These symptoms may last for several weeks. Without treatment, they usually get worse.

If you get **TB disease** in another part of the body, the symptoms will be different. Only a doctor can tell you if you have **TB disease**.

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Division of Tuberculosis Elimination

CDC

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Signature: _____ Date: _____

TB Facts: *You Can Prevent TB*

What should I do if I have TB?

If you have latent **TB infection**, you may need medicine to prevent getting **TB disease** later. One or more drugs are used to treat latent **TB infection**. It is important that you take your medicine exactly as your doctor or health care worker tells you.

TB disease can also be treated by taking medicine. If you have **TB disease**, it is very important that you finish the medicine, and take the drugs exactly as you are told. If you stop taking the drugs too soon, you can become sick again. If you do not take the drugs correctly, the germs that are still alive may become difficult to treat with those drugs. If you have **TB disease**, it takes six months and possibly as long as one year to kill all the TB germs.

Remember, you will always have TB germs in your body unless you kill them with the right medicine.

People who are more likely to get sick from **TB disease** include:

- those with HIV infection (the virus that causes AIDS);
- those who have been recently infected with TB (in the last two years);
- those who inject illegal drugs;
- babies and young children;
- elderly people;
- those who were not treated correctly for TB in the past; and
- those with certain medical conditions such as diabetes, certain types of cancer, and being underweight.

These people have conditions that make the body weaker, so it is difficult for them to fight TB germs.

Protect your family and friends from TB — take ALL your TB drugs!

TB Elimination
Tuberculosis: General Information

What is TB?

Tuberculosis (TB) is a disease caused by germs that are spread from person to person through the air. TB usually affects the lungs, but it can also affect other parts of the body, such as the brain, the kidneys, or the spine. A person with TB can die if they do not get treatment.

What are the Symptoms of TB?

The general symptoms of TB disease include feelings of sickness or weakness, weight loss, fever, and night sweats. The symptoms of TB disease of the lungs also include coughing, chest pain, and the coughing up of blood. Symptoms of TB disease in other parts of the body depend on the area affected.

How is TB Spread?

TB germs are put into the air when a person with TB disease of the lungs or throat coughs, sneezes, speaks, or sings. These germs can stay in the air for several hours, depending on the environment. Persons who breathe in the air containing these TB germs can become infected; this is called latent TB infection.

What is the Difference Between Latent TB Infection and TB Disease?

People with latent TB infection have TB germs in their bodies, but they are not sick because the germs are not active. These people do not have symptoms of TB disease, and they cannot spread the germs to others. However, they may develop TB disease in the future. They are often prescribed treatment to prevent them from developing TB disease.

People with TB disease are sick from TB germs that are active, meaning that they are multiplying and destroying tissue in their body. They usually have symptoms of TB disease. People with TB disease of the lungs or throat are capable of spreading germs to others. They are prescribed drugs that can treat TB disease.

What Should I Do If I Have Spent Time with Someone with Latent TB Infection?

A person with latent TB infection cannot spread germs to other people. You do not need to be tested if you have spent time with someone with latent TB infection. However, if you have spent time with someone with TB disease or someone with symptoms of TB, you should be tested.

What Should I Do if I Have Been Exposed to Someone with TB Disease?

People with TB disease are most likely to spread the germs to people they spend time with every day, such as family members or coworkers. If you have been around someone who has TB disease, you should go to your doctor or your local health department for tests.

How Do You Get Tested for TB?

There are tests that can be used to help detect TB infection: a skin test or TB blood tests. The Mantoux tuberculin skin test is performed by injecting a small amount of fluid (called tuberculin) into the skin in the lower part of the arm. A person given the tuberculin skin test must return within 48 to 72 hours to have a trained health care worker look for a reaction on the arm. The TB blood tests measures how the patient's immune system reacts to the germs that cause TB.

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What Does a Positive Test for TB Infection Mean?

A positive test for TB infection only tells that a person has been infected with TB germs. It does not tell whether or not the person has progressed to TB disease. Other tests, such as a chest x-ray and a sample of sputum, are needed to see whether the person has TB disease.

What is Bacille Calmette–Guèrin (BCG)?

BCG is a vaccine for TB disease. BCG is used in many countries, but it is not generally recommended in the United States. BCG vaccination does not completely prevent people from getting TB. It may also cause a false positive tuberculin skin test. However, persons who have been vaccinated with BCG can be given a tuberculin skin test or TB blood test.

Why is Latent TB Infection Treated?

If you have latent TB infection but not TB disease, your doctor may want you to take a drug to kill the TB germs and prevent you from developing TB disease. The decision about taking treatment for latent infection will be based on your chances of developing TB disease. Some people are more likely than others to develop TB disease once they have TB infection. This includes people with HIV infection, people who were recently exposed to someone with TB disease, and people with certain medical conditions.

How is TB Disease Treated?

TB disease can be treated by taking several drugs for 6 to 12 months. It is very important that people who have TB disease finish the medicine, and take the drugs exactly as prescribed. If they stop taking the drugs too soon, they can become sick again; if they do not take the drugs correctly, the germs that are still alive may become resistant to those drugs. TB that is resistant to drugs is harder and more expensive to treat. In some situations, staff of the local health department meet regularly with patients who have TB to watch them take their medications. This is called directly observed therapy (DOT). DOT helps the patient complete treatment in the least amount of time.

Additional Information

CDC. Questions and Answers About TB
http://www.cdc.gov/tb/publications/faqs/default.htm

http://www.cdc.gov/tb

TB Elimination

The Difference Between Latent TB Infection and TB Disease

What is TB?

Tuberculosis (TB) is a disease caused by a germ called *Mycobacterium tuberculosis* that is spread from person to person through the air. TB usually affects the lungs, but it can also affect other parts of the body, such as the brain, the kidneys, or the spine. When a person with infectious TB coughs or sneezes, droplet nuclei containing *M. tuberculosis* are expelled into the air. If another person inhales air containing these droplet nuclei, he or she may become infected. However, not everyone infected with TB bacteria becomes sick. As a result, two TB-related conditions exist: latent TB infection and TB disease.

What is Latent TB Infection?

Persons with latent TB infection do not feel sick and do not have any symptoms. They are infected with *M. tuberculosis*, but do not have TB disease. The only sign of TB infection is a positive reaction to the tuberculin skin test or TB blood test. **Persons with latent TB infection are not infectious and cannot spread TB infection to others**.

Overall, without treatment, about 5 to 10% of infected persons will develop TB disease at some time in their lives. About half of those people who develop TB disease will do so within the first two years of infection. For persons whose immune systems are weak, especially those with HIV infection, the risk of developing TB disease is considerably higher than for persons with normal immune systems.

Of special concern are persons infected by someone with extensively drug-resistant TB (XDR TB) who later develop TB disease; these persons will have XDR TB, not regular TB disease.

A person with latent TB infection

- Usually has a skin test or blood test result indicating TB infection
- Has a normal chest x-ray and a negative sputum test
- Has TB bacteria in his/her body that are alive, but inactive
- Does not feel sick
- Cannot spread TB bacteria to others
- Needs treatment for latent TB infection to prevent TB disease; however, if exposed and infected by a person with multidrug-resistant TB (MDR TB) or extensively drug-resistant TB (XDR TB), preventive treatment may not be an option

What is TB Disease?

In some people, TB bacteria overcome the defenses of the immune system and begin to multiply, resulting in the progression from latent TB infection to TB disease. Some people develop TB disease soon after infection, while others develop TB disease later when their immune system becomes weak.

The general symptoms of TB disease include

- Unexplained weight loss
- Loss of appetite
- Night sweats
- Fever
- Fatigue
- Chills

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The symptoms of TB of the lungs include

- Coughing for 3 weeks or longer
- Hemoptysis (coughing up blood)
- Chest pain

Other symptoms depend on the part of the body that is affected.

Persons with TB disease are considered infectious and may spread TB bacteria to others. If TB disease is suspected, persons should be referred for a complete medical evaluation. If it is determined that a person has TB disease, therapy is given to treat it. TB disease is a serious condition and can lead to death if not treated.

A person with TB disease

- Usually has a skin test or blood test result indicating TB infection
- May have an abnormal chest x-ray, or positive sputum smear or culture
- Has active TB bacteria in his/her body
- Usually feels sick and may have symptoms such as coughing, fever, and weight loss
- May spread TB bacteria to others
- Needs treatment to treat TB disease

Additional Information

1. American Thoracic Society (ATS) and CDC. Diagnostic standards and classification of tuberculosis in adults and children. (PDF) *Am J Respir Crit Care Med 2000*; 161. http://ajrccm.atsjournals.org/cgi/content/full/161/4/1376
2. CDC. Questions and Answers About TB. http://www.cdc.gov/tb/publications/faqs/default.htm
3. CDC. Multidrug-Resistant Tuberculosis (MDR TB). http://www.cdc.gov/tb/publications/factsheets/drtb/mdrtb.htm
4. CDC. Extensively Drug-Resistant Tuberculosis (XDR TB). http://www.cdc.gov/tb/publications/factsheets/drtb/xdrtb.htm

http://www.cdc.gov/tb

November 2011

TB Elimination
Diagnosis of Tuberculosis Disease

When Should You Suspect Tuberculosis (TB)?

TB is a disease caused by *Mycobacterium tuberculosis*. TB disease should be suspected in persons who have the following symptoms:

- Unexplained weight loss
- Loss of appetite
- Night sweats
- Fever
- Fatigue

If TB disease is in the lungs (pulmonary), symptoms may include:

- Coughing for ≥3 weeks
- Hemoptysis (coughing up blood)
- Chest pain

If TB disease is in other parts of the body (extrapulmonary), symptoms will depend on the area affected.

How Do You Evaluate Persons Suspected of Having TB Disease?

A complete medical evaluation for TB includes the following:

1. Medical History

Clinicians should ask about the patient's history of TB exposure, infection, or disease. It is also important to consider demographic factors (e.g., country of origin, age, ethnic or racial group, occupation) that may increase the patient's risk for exposure to TB or to drug-resistant TB. Also, clinicians should determine whether the patient has medical conditions, especially HIV infection, that increase the risk of latent TB infection progressing to TB disease.

2. Physical Examination

A physical exam can provide valuable information about the patient's overall condition and other factors that may affect how TB is treated, such as HIV infection or other illnesses.

3. Test for TB Infection

The Mantoux tuberculin skin test (TST) or the TB blood test can be used to test for *M. tuberculosis* infection. Additional tests are required to confirm TB disease. The Mantoux tuberculin skin test is performed by injecting a small amount of fluid called tuberculin into the skin in the lower part of the arm. The test is read within 48 to 72 hours by a trained health care worker, who looks for a reaction (induration) on the arm.

The TB blood test measures the patient's immune system reaction to *M. tuberculosis*.

4. Chest Radiograph

A posterior-anterior chest radiograph is used to detect chest abnormalities. Lesions may appear anywhere in the lungs and may differ in size, shape, density, and cavitation. These abnormalities may suggest TB, but cannot be used to definitively diagnose TB. However, a chest radiograph may be used to rule out the possibility of pulmonary TB in a person who has had a positive reaction to a TST or TB blood test and no symptoms of disease.

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5. Diagnostic Microbiology

The presence of acid-fast-bacilli (AFB) on a **sputum smear** or other specimen often indicates TB disease. Acid-fast microscopy is easy and quick, but it does not confirm a diagnosis of TB because some acid-fast-bacilli are not *M. tuberculosis*. Therefore, a **culture** is done on all initial samples to confirm the diagnosis. (However, a positive culture is not always necessary to begin or continue treatment for TB.) A positive culture for *M. tuberculosis* confirms the diagnosis of TB disease. Culture examinations should be completed on all specimens, regardless of AFB smear results. Laboratories should report positive results on smears and cultures within 24 hours by telephone or fax to the primary health care provider and to the state or local TB control program, as required by law.

6. Drug Resistance

For all patients, the initial *M. tuberculosis* isolate should be tested for drug resistance. It is crucial to identify drug resistance as early as possible to ensure effective treatment. Drug susceptibility patterns should be repeated for patients who do not respond adequately to treatment or who have positive culture results despite 3 months of therapy. Susceptibility results from laboratories should be promptly reported to the primary health care provider and the state or local TB control program.

Additional Information

1. American Thoracic Society (ATS) and CDC. Diagnostic standards and classification of tuberculosis in adults and children. (PDF) *Am J Respir Crit Care Med 2000*; 161. http://ajrccm.atsjournals.org/cgi/content/full/161/4/1376

2. ATS, CDC, and Infectious Diseases Society of America. Treatment of tuberculosis. *MMWR* 2003; 52 (No. RR-11). http://www.cdc.gov/mmwr/PDF/rr/rr5211.pdf

3. Centers for Disease Control and Prevention. Guidelines for the investigation of contacts of persons with infectious tuberculosis and Guidelines for using the QuantiFERON®-TB Gold test for detecting Mycobacterium tuberculosis infection, United States. *MMWR* 2005; 54 (No. RR-15). http://www.cdc.gov/mmwr/pdf/rr/rr5415.pdf

4. Updated Guidelines for the Use of Nucleic Acid Amplification Tests in the Diagnosis of Tuberculosis. *MMWR* 2009;58(1). http://www.cdc.gov/mmwr/preview/mmwrhtml/mm5801a3.htm?scid=mm5801a3_e

http://www.cdc.gov/tb

Testing for Tuberculosis (TB)

Tuberculosis (TB) is a disease that is spread through the air from one person to another. When someone who is sick with TB coughs, speaks, laughs, sings, or sneezes, people nearby may breathe TB bacteria into their lungs. TB usually attacks the lungs, but can also attack other parts of the body, such as the brain, spine, or kidneys.

There are two types of TB:
1. **Latent TB infection**
2. **TB disease**

TB bacteria can live in the body without making a person sick. This is called **latent TB infection.** People with latent TB infection do not feel sick, do not have TB symptoms, and cannot spread TB bacteria to others. Some people with latent TB infection go on to develop **TB disease**. People with TB disease can spread the bacteria to others, feel sick, and can have symptoms including fever, night sweats, cough, and weight loss.

There are two kinds of tests that are used to determine if a person has been infected with TB bacteria: the tuberculin skin test and TB blood tests.

Tuberculin Skin Test (TST)

What is a TST?

The Mantoux tuberculin skin test is a test to check if a person has been infected with TB bacteria.

How does the TST work?

Using a small needle, a health care provider injects a liquid (called tuberculin) into the skin of the lower part of the arm. When injected, a small, pale bump will appear. This is different from a Bacille Calmette-Guerin (BCG) shot (a TB vaccine that many people living outside of the United States receive).

The person given the TST must return within 2 or 3 days to have a trained health care worker look for a reaction on the arm where the liquid was injected. The health care worker will look for a raised, hard area or swelling, and if present, measure its size using a ruler. Redness by itself is not considered part of the reaction.

What does a positive TST result mean?

The TST result depends on the size of the raised, hard area or swelling. It also depends on the person's risk of being infected with TB bacteria and the progression to TB disease if infected.

- Positive TST: This means the person's body was infected with TB bacteria. Additional tests are needed to determine if the person has latent TB infection or TB disease. A health care worker will then provide treatment as needed.
- Negative TST: This means the person's body did not react to the test, and that latent TB infection or TB disease is not likely.

Who can receive a TST?

Almost everyone can receive a TST, including infants, children, pregnant women, people living with HIV, and people who have had a BCG shot. People who had a severe reaction to a previous TST should not receive another TST.

How often can a TST be given?

Usually, there is no problem with repeated TSTs unless a person has had a severe reaction to a previous TST.

Testing for TB in People with a BCG

People who have had a previous BCG shot may receive a TST. In some people, the BCG shot may cause a positive TST when they are not infected with TB bacteria. If a TST is positive, additional tests are needed.

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TB Blood Tests

What is an Interferon Gamma Release Assay (IGRA)?

An IGRA is a blood test that can determine if a person has been infected with TB bacteria. An IGRA measures how strong a person's immune system reacts to TB bacteria by testing the person's blood in a laboratory.

Two IGRAs are approved by the U.S. Food and Drug Administration (FDA) and are available in the United States:

1) QuantiFERON®-TB Gold In-Tube test (QFT-GIT)
2) T-SPOT®.TB test (T-Spot)

How does the IGRA work?

Blood is collected into special tubes using a needle. The blood is delivered to a laboratory as directed by the IGRA test instructions. The laboratory runs the test and reports the results to the health care provider.

What does a positive IGRA result mean?

- Positive IGRA: This means that the person has been infected with TB bacteria. Additional tests are needed to determine if the person has latent TB infection or TB disease. A health care worker will then provide treatment as needed.
- Negative IGRA: This means that the person's blood did not react to the test and that latent TB infection or TB disease is not likely.

Who can receive an IGRA?

Anyone can have an IGRA in place of a TST. This can be for any situation where a TST is recommended. In general, a person should have either a TST or an IGRA, but not both. There are rare exceptions when results from both tests may be useful in deciding whether a person has been infected with TB.

IGRAs are the preferred method of TB infection testing for the following:

- People who have received the BCG shot
- People who have a difficult time returning for a second appointment to look at the TST after the test was given

How often can an IGRA be given?

There is no problem with repeated IGRAs.

Who Should Get Tested for TB?

TB tests are generally not needed for people with a low risk of infection with TB bacteria.

Certain people should be tested for TB bacteria because they are more likely to get TB disease, including:

- People who have spent time with someone who has TB disease
- People with HIV infection or another medical problem that weakens the immune system
- People who have symptoms of TB disease (fever, night sweats, cough, and weight loss)
- People from a country where TB disease is common (most countries in Latin America, the Caribbean, Africa, Asia, Eastern Europe, and Russia)
- People who live or work somewhere in the United States where TB disease is more common (homeless shelters, prison or jails, or some nursing homes)
- People who use illegal drugs

Choosing a TB Test

Choosing which TB test to use should be done by the person's health care provider. Factors in selecting which test to use include the reason for testing, test availability, and cost. Generally, it is not recommended to test a person with both a TST and an IGRA.

Diagnosis of Latent TB Infection or TB Disease

If a person is found to be infected with TB bacteria, other tests are needed to see if the person has TB disease.

TB disease can be diagnosed by medical history, physical examination, chest x-ray, and other laboratory tests. TB disease is treated by taking several drugs as recommended by a health care provider.

If a person does not have TB disease, but has TB bacteria in the body, then latent TB infection is diagnosed. The decision about taking treatment for latent TB infection will be based on a person's chances of developing TB disease.

Related Links

CDC. Tuberculosis (TB): http://www.cdc.gov/tb

Basic TB Information: http://www.cdc.gov/tb/publications/factsheets/general/tb.htm

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TB Elimination

Interferon-Gamma Release Assays (IGRAs) – Blood Tests for TB Infection

What are they?

Interferon-Gamma Release Assays (IGRAs) are whole-blood tests that can aid in diagnosing *Mycobacterium tuberculosis* infection. They do not help differentiate latent tuberculosis infection (LT BI) from tuberculosis disease. Two IGRAs that have been approved by the U.S. Food and Drug Administration (FDA) are commercially available in the U.S. They are:

- QuantiFERON® – TB Gold In-Tube test (QFT–GIT);
- SPOT® *TB* test (T–Spot)

How do they work?

IGRAs measure a person's immune reactivity to *M. tuberculosis*. White blood cells from most persons that have been infected with *M. tuberculosis* will release interferon-gamma (IFN-g) when mixed with antigens (substances that can produce an immune response) derived from *M. tuberculosis*.

To conduct the tests, fresh blood samples are mixed with antigens and controls. The antigens, testing methods, and interpretation criteria for IGRAs differ (see Table 1).

What are the advantages of IGRAs?

- Requires a single patient visit to conduct the test.
- Results can be available within 24 hours.
- Does not boost responses measured by subsequent tests.
- Prior BCG (bacille Calmette-Guérin) vaccination does not cause a false-positive IGRA test result.

What are the disadvantages and limitations of IGRAs?

- Blood samples must be processed within 8-30 hours after collection while white blood cells are still viable.
- Errors in collecting or transporting blood specimens or in running and interpreting the assay can decrease the accuracy of IGRAs.
- Limited data on the use of IGRAs to predict who will progress to TB disease in the future.

Table1: **Differences in Currently Available IGRAs**

	QFT–GIT	T–Spot
Initial Process	Process whole blood within 16 hours	Process peripheral blood mononuclear cells (PBMCs) within 8 hours, or if T-Cell Xtend® is used, within 30 hours.
M. tuberculosis Antigen	Single mixture of synthetic peptides representing ESAT-6, CFP-10 and TB7.7	Separate mixtures of synthetic peptides representing ESAT–6 and CFP-10
Measurement	IFN-g concentration	Number of IFN-g producing cells (spots)
Possible Results	Positive, negative, indeterminate	Positive, negative, indeterminate, borderline

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Limited data on the use of IGRAs for:

  - » Children younger than 5 years of age;
  - » Persons recently exposed to *M. tuberculosis*;
  - » Immunocompromised persons; and
  - » Serial testing.
- Tests may be expensive.

What are the steps in administering an IGRA test?

Confirm arrangements for testing in a qualified laboratory, and arrange for delivery of the blood sample to the laboratory in the time the laboratory specifies to ensure testing of samples with viable blood cells.

- Draw a blood sample from the patient according to the test manufacturer's instructions.
- Schedule a follow-up appointment for the patient to receive test results.
- Based on test results, provide follow-up evaluation and treatment as needed.

How do you interpret IGRA test results?

IGRA interpretations are based on the amount of IFN-g that is released or on the number of cells that release IFN-g. Both the standard qualitative test interpretation (positive, negative, or indeterminate) and the quantitative assay measurements (Nil, TB, and Mitogen concentrations or spot counts) should be reported.

As with the tuberculin skin tests (TSTs), IGRAs should be used as an aid in diagnosing infection with *M. tuberculosis*. A positive test result suggests that *M. tuberculosis* infection is likely; a negative result suggests that infection is unlikely. An indeterminate result indicates an uncertain likelihood of *M. tuberculosis* infection. A borderline test result (T-Spot only) also indicates an uncertain likelihood of *M. tuberculosis* infection.

A diagnosis of LTBI requires that TB disease be excluded by medical evaluation. This should include checking for signs and symptoms suggestive of TB disease, a chest radiograph, and, when indicated, examination of sputum or other clinical samples for the presence of *M. tuberculosis*. Decisions about a diagnosis of *M. tuberculosis* infection should also include epidemiological and historical information.

Recommendations on when to use IGRA tests

- IGRAs can be used in place of (but not in addition to) TST in all situations in which CDC recommends TST as an aid in diagnosing *M. tuberculosis* infection, with preferences and special considerations noted below. This includes contact investigations, testing during pregnancy, and screening of health care workers and others undergoing serial evaluation for *M. tuberculosis* infection. Despite the indication of a preference, use of the alternative test (FDA-approved IGRA or TST) is acceptable medical and public health practice. Caution in interpretation should be used when testing certain populations because of limited data on the use of IGRAs (see Updated Guidelines for Using Interferon Gamma Release Assays to Detect *Mycobacterium tuberculosis* Infection, United States).
- Populations in which IGRAs are preferred for testing:
  - » Persons who have received BCG (either as a vaccine or for cancer therapy); and
  - » Persons from groups that historically have poor rates of return for TST reading.
- TST is preferred over IGRAs for testing children less than 5 years of age.
- As with TST, IGRAs generally should not be used for testing persons who have a low risk of infection and a low risk of disease due to *M. tuberculosis*.
- Each institution and TB control program should evaluate the availability and benefits of IGRAs in prioritizing their use.

- Routine testing with both TST and IGRA is not recommended. However, results from both tests might be useful in the following situations:
  - » When the initial test is **negative** and:
    - – The risk for infection, the risk for progression to disease, and the risk for a poor outcome are high (e.g., HIV infected persons or children under 5 years of age who are exposed to a person with infectious TB).
    - – There is clinical suspicion for TB disease (e.g., signs, symptoms, and/or radiographic evidence suggestive of TB disease) and confirmation of *M. tuberculosis* infection is desired.
    - – Taking a positive result from a second test as evidence of infection increases detection sensitivity.
  - » When the initial test is **positive** and:
    - – Additional evidence of infection is required to encourage acceptance and adherence (e.g., foreign-born healthcare workers who believe their positive TST is due to BCG). A positive IGRA might prompt greater acceptance of treatment for LTBI as compared with a positive TST alone.
    - – The person has a low risk of both infection and progression from infection to TB disease. Requiring a positive result from the second test as evidence of infection increases the likelihood that the test reflects infection. An alternative is to assume, without additional testing, that the initial result is a false positive or that the risk for disease does not warrant additional evaluation or treatment, regardless of test results.
  - » In addition, repeating an IGRA or performing a TST might be useful when the initial IGRA result is indeterminate, borderline, or invalid and a reason for testing persists.

Multiple negative results from any combination of these tests cannot exclude *M. tuberculosis* infection. Steps should be taken to minimize unnecessary and misleading testing of persons at low risk.

Selection of the most suitable test or combination of tests for detection of *M. tuberculosis* infection should be based on the reasons and the context for testing, test availability, and overall cost of testing.

Can IGRAs Be Given To Persons Receiving Vaccinations?

As with TST, live virus vaccines might affect IGRA test results. However, the effect of live virus vaccination on IGRAs has not been studied. Until additional information is available, IGRA testing in the context of live virus vaccine administration should be done as follows:

- Either on the same day as vaccination with live-virus vaccine or 4-6 weeks after the administration of the live-virus vaccine
- At least one month after smallpox vaccination

Additional Information

Centers for Disease Control and Prevention. Updated Guidelines for Using Interferon Gamma Release Assays to Detect *Mycobacterium tuberculosis* Infection, United States. (PDF) *MMWR* 2010; 59 (No.RR-5). http://www.cdc.gov/mmwr/preview/mmwrhtml/rr5905a1.htm?s_cid=rr5905a1_e

http://www.cdc.gov/tb

TB Elimination
Tuberculin Skin Testing

What is it?

The **Mantoux tuberculin skin test** (TST) is the standard method of determining whether a person is infected with *Mycobacterium tuberculosis*. Reliable administration and reading of the TST requires standardization of procedures, training, supervision, and practice.

How is the TST Administered?

The TST is performed by injecting 0.1 ml of tuberculin purified protein derivative (PPD) into the inner surface of the forearm. The injection should be made with a tuberculin syringe, with the needle bevel facing upward. The TST is an intradermal injection. When placed correctly, the injection should produce a pale elevation of the skin (a wheal) 6 to 10 mm in diameter.

How is the TST Read?

The skin test reaction should be read between 48 and 72 hours after administration. A patient who does not return within 72 hours will need to be rescheduled for another skin test.

The reaction should be measured in millimeters of the induration (palpable, raised, hardened area or swelling). The reader should not measure erythema (redness). The diameter of the indurated area should be measured across the forearm (perpendicular to the long axis).

How Are TST Reactions Interpreted?

Skin test interpretation depends on two factors:

- Measurement in millimeters of the induration
- Person's risk of being infected with TB and of progression to disease if infected

Classification of the Tuberculin Skin Test Reaction

An **induration of 5 or more millimeters** is considered positive in

- » HIV-infected persons
- » A recent contact of a person with TB disease
- » Persons with fibrotic changes on chest radiograph consistent with prior TB
- » Patients with organ transplants
- » Persons who are immunosuppressed for other reasons (e.g., taking the equivalent of >15 mg/day of prednisone for 1 month or longer, taking TNF-α antagonists)

An **induration of 10 or more millimeters** is considered positive in

- » Recent immigrants (< 5 years) from high-prevalence countries
- » Injection drug users
- » Residents and employees of high-risk congregate settings
- » Mycobacteriology laboratory personnel
- » Persons with clinical conditions that place them at high risk
- » Children < 4 years of age
- » Infants, children, and adolescents exposed to adults in high-risk categories

An **induration of 15 or more millimeters** is considered positive in any person, including persons with no known risk factors for TB. However, targeted skin testing programs should only be conducted among high-risk groups.

What Are False-Positive Reactions?

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

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

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What Are False-Negative Reactions?

Some persons may not react to the TST even though they are infected with *M. tuberculosis*. The reasons for these false-negative reactions may include, but are not limited to, the following:

- Cutaneous anergy (anergy is the inability to react to skin tests because of a weakened immune system)
- Recent TB infection (within 8-10 weeks of exposure)
- Very old TB infection (many years)
- Very young age (less than 6 months old)
- Recent live-virus vaccination (e.g., measles and smallpox)
- Overwhelming TB disease
- Some viral illnesses (e.g., measles and chicken pox)
- Incorrect method of TST administration
- Incorrect interpretation of reaction

Who Can Receive a TST?

Most persons can receive a TST. TST is contraindicated only for persons who have had a severe reaction (e.g., necrosis, blistering, anaphylactic shock, or ulcerations) to a previous TST. It is not contraindicated for any other persons, including infants, children, pregnant women, persons who are HIV-infected, or persons who have been vaccinated with BCG.

How Often Can TSTs Be Repeated?

In general, there is no risk associated with repeated tuberculin skin test placements. If a person does not return within 48-72 hours for a tuberculin skin test reading, a second test can be placed as soon as possible. There is no contraindication to repeating the TST, unless a previous TST was associated with a severe reaction.

What is a Boosted Reaction?

In some persons who are infected with *M. tuberculosis*, the ability to react to tuberculin may wane over time. When given a TST years after infection, these persons may have a false-negative reaction. However, the TST may stimulate the immune system, causing a positive, or boosted reaction to subsequent tests. Giving a second TST after an initial negative TST reaction is called two-step testing.

Why is Two-Step Testing Conducted?

Two-step testing is useful for the initial skin testing of adults who are going to be retested periodically, such as health care workers or nursing home residents. This two-step approach can reduce the likelihood that a boosted reaction to a subsequent TST will be misinterpreted as a recent infection.

Can TSTs Be Given To Persons Receiving Vaccinations?

Vaccination with live viruses may interfere with TST reactions. For persons scheduled to receive a TST, testing should be done as follows:

- Either on the same day as vaccination with live-virus vaccine or 4-6 weeks after the administration of the live-virus vaccine
- At least one month after smallpox vaccination

Additional Information

1. American Thoracic Society and CDC. Diagnotic standards and classification of tuberculosis in adults and children. (PDF) A*m J Respir Crit Care Med 2000*; 161. http://ajrccm.atsjournals.org/cgi/content/ful/161/4/1376
2. CDC. Guidelines for preventing the transmission of Mycobacterium tuberculosis in health-care settings, 2005. *MMWR* 2005; 54 (No. RR-17). www.cdc.gov/tb/publications/guidelines/infectioncontrol.htm
3. CDC. Mantoux Tuberculin Skin Test: Training Materials Kit (2003).
4. CDC. Targeted tuberculin testing and treatment of latent tuberculosis infection. *MMWR* 2000; 49 (No. RR-6). www.cdc.gov/MMWR/PDF/rr/rr4906.pdf

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October 2011