Required Orientation Clinical Topics for Clinical Staff

I acknowledge that I have received a copy of “Required Orientation Clinical Topics for Clinical Staff” including the following content areas:

- Needs of the Dying Patient
- Pain Management
- Abuse, Neglect and Exploitation
- Organ Donation
- Population Served
- Fall Reduction
- Restraints and Seclusion
- Reporting a Change in Patient Condition
- Infection Control

I agree that it is my responsibility to:

- Read this packet of information.
- Ask questions if I need additional information regarding any information covered in this packet.
- Abide by and observe any policies and procedures of The Johns Hopkins Hospital which are generally outlined in this packet.

Name (Please print)

__________________________
Signature

__________________________
Date

This packet includes basic information on many important topics relevant to working at The Johns Hopkins Hospital (JHH). Where possible, references are provided. It is not meant to be an all-inclusive study. Your department, office or unit may require more extensive education in any of the above areas. Please see your manager for more information.

2010 version
NEEDS OF THE DYING PATIENT
Overview

Most patients in the hospital die in the midst of an exacerbation of a chronic illness. Clinicians and families may not be prepared to address issues of dying because the patient came to the hospital for help to reverse the condition. Careful symptom management and attention to psychosocial and spiritual issues will help both the patient and the family who will live out their lives with these final memories of their loved one.
Goals May Change

A patient may be admitted with the goal of curing or reversing a condition. As the illness progresses, however, the goals may change. New goals may include rehabilitation, prolonging life so the person may see a grandchild marry or graduate, not prolonging dying or providing comfort in dying.

Once these new goals are established, the particular treatments to meet the goals are decided in discussions between the team and the patient and family. Goals for cure and for palliation (i.e., symptom management) can be simultaneous.
Resources for Establishing Goals

Sometimes there are conflicts among clinicians or with clinicians and families regarding the goals of care. There are JHH resources to help address such conflicts.

- Palliative care services are available in the pediatric (410-955-5503 or 410-955-6451) and adult medicine (410-614-5284) departments. These services are available to all staff.

- The JHH Ethics Service can be paged for assistance when conflicts arise. The Ethics Service pager is 3-6104.
Assisting Caregivers and Staff

JHH has developed the protocols below to assist caregivers and other staff. Type the web address into your browser if you are within the Hopkins network.

- **Establishing Goals of Care:**

- **Futile or Medically Ineffective Treatment:**
# About the Dying Process

The dying process can take days or even weeks. Some patients tend to linger in their dying while others have a sudden and swift decline. The uncertainty of a timeline can cause family distress. Educating the family about the normal dying process can help ease their distress.
### The Dying Process

#### Signs of Each Stage

| Signs of the Early Stage | • Bed bound  
|                          | • Loss of interest and ability in eating and drinking  
|                          | • Changes in cognition  
|                          | • Hypoactive delirium  
|                          | • Hyperactive delirium  
|                          | • Increasing sleepiness |

| Signs of the Mid Stage | • Mental status continues to decline  
|                       | • Upper airway secretions that patient is unable to clear ("death rattle")  
|                       | • Fever can be present with unidentifiable source |

| Signs of the Late Stage | • Comatose  
|                       | • Cool, mottled extremities from shunting blood to vital organs  
|                       | • Change in respiratory pattern: fast, slow or uneven breathing  
|                       | • Fever  
|                       | • Pain and other symptoms |
Comfort for Dying Patients

Many patients will have pain, shortness of breath, delirium and fatigue as they are dying. Patients may also experience emotional and spiritual distress. These symptoms can and should be managed to relieve distress at the end of life.

Collaboration with pastoral care, palliative care, social work and Child Life will help in addressing these symptoms. For the dying patient, interdisciplinary care from nursing, clergy, social work, medicine, nutrition, and other therapies is needed to meet the needs of both the patient and family.

For more information, contact the JHH palliative care services.
PAIN MANAGEMENT
Overview

Pain is defined as “an unpleasant sensory and emotional experience associated with actual or potential tissue damage or described in terms of such damage.”

Pain can be defined operationally as “what the patient says hurts” and it exists when the patient says it does. The “right” to be free of pain exists for all patients regardless of age or underlying disease process. Relief of pain and suffering is integral to the mission of JHH, and pain is considered the “5th vital sign.”
The physiology of pain is well established. Following an injury or disease, nerves transmit impulses to the brain which as they reach consciousness will be interpreted as pain.

However, pain is much more than that. It is impossible to assume how much pain a patient is experiencing. Many factors determine pain and how a patient will respond to it, such as:

- Age
- Culture
- Socio-economic factors
- Previous pain experience

- Fear and/or helplessness
- Sleep deprivation
- Time and place
- Anxiety
How You Can Help

Hospital staff can act as patient advocates. If any new pain or change in pain is noticed, or if it appears that interventions are not working, the nurse or doctor should be notified.

Non-nursing staff are often in a position to notice symptoms that are not seen by MDs or RNs.
ABC's of Pain Management

The following are the ABCs of pain management:

A  Assess pain at regular intervals using a self report measure if possible
B  Believe the patient
C  Choose the appropriate therapies
D  Deliver therapy in a logical, coordinated fashion
E  Empower and Education patients to control their pain
F  Follow-up

For more information, see the JHH Pain Protocol at:

(You must be within the Hopkins' intranet to access this document.)
Assess

Assess the pain at regular intervals.

At JHH, nurses and unlicensed assistive personnel (UAPs) screen every patient for pain on the following occasions:

- On admission
- At every outpatient encounter
- Before and after any surgical procedure

For non-nursing roles, your part in pain management would be to notify the RN if the patient reports any pain to you. You should also report if you observe obvious signs of pain when you are with the patient (for example, while doing a PT treatment or transporting a patient).
Believe

Believe the patient.

When assessing pain, use a patient reported measure when possible. There are various rating scales that may be used for screening based on the patient’s age and communication abilities. These scales can be found in the Pain Management protocol referenced in this lesson.
Choose

Choose the appropriate therapies.

Pain may be managed most effectively using a combination of medications and non-pharmacological approaches.

Pharmacological

There are a number of medications that are effective in managing a patient’s pain. Selecting the appropriate pharmacological intervention is a collaborative decision making process that involves authorized prescribers, pharmacists, and care givers along with the patient’s input.

Non-pharmacological

Non-pharmacological interventions should be considered based on patient preference and the degree of pain relief obtained. Options include heat or cold, massage and vibration, distraction (music, videos, games), relaxation techniques such as imagery, acupuncture, self-hypnosis, and transcutaneous electrical nerve stimulation (TENS).
Complications

• Pain management may be complex in some patient populations.
• Special attention should be paid to the following high risk patient groups:
  - Infants & children
  - Elderly
  - Women in labor
  - Non-English speaking patients or patients from other cultures
  - Patients with substance abuse background
  - Patients with communication difficulties
Deliver – Empower and Educate – Follow-up

**Deliver therapy in a logical, coordinated fashion.**

When pain occurs on a regular basis, medication should be given on an around-the-clock (ATC) schedule to ensure adequate pain relief.

**Empower and Educate patients to control their pain.**

Non-pharmacological interventions should be taught to the patient. Options include heat or cold, massage and vibration, distraction (music, videos, games), relaxation techniques (imagery), acupuncture, self-hypnosis, and transcutaneous electrical nerve stimulation (TENS).

**Follow-up**

Follow-up with the patient to determine if his or her level of pain relief is adequate, after therapies are initiated.
ABUSE, NEGLECT AND EXPLOITATION
Healthcare practitioners are in a unique position to provide early detection and intervention of abuse and neglect. They tend to be the first or only professionals to whom victims of abuse or neglect may turn. It is important for healthcare workers to be aware of the signs of abuse and neglect and to know what to do if issues of abuse or neglect are suspected. Assessment of abuse and neglect should be a routine part of all care.
Use FASAP

If you suspect that a co-worker is a victim of abuse please speak with the individual and encourage him or her to seek assistance from the Faculty and Staff Assistance Program (FASAP). Contact your supervisor or FASAP for assistance. For more information about FASAP, go to www.fasap.org or call 5-1220 or 443-997-3800.
Part 1: Intimate Partner Abuse and Domestic Violence

Background

Domestic abuse or violence is a pattern of coercive behavior characterized by the control of one person over another, usually by an intimate partner. This may occur through physical, sexual, emotional, verbal or economic abuse. It occurs in all levels of society and all communities. Abuse or violence occurs in all racial, ethnic and socioeconomic backgrounds.
Prevalence Rates

Women are most likely to be abused, with a prevalence rate of 85-95%. One out of every three American women will report being a victim of domestic abuse or violence at some point in her life.

Child abuse is reported to occur in 45-50% of families where domestic violence occurs.
A repeating cycle of violence is common and consists of these three phases:

1. **TENSION BUILDING PHASE**
2. **ACUTE BATTERING PHASE**
3. **LOVING CONTRITION OR “HONEYMOON PHASE”**

The most dangerous period in an abusive or violent relationship is when an individual decides to leave.
## Definitions and Indicators of Partner Abuse

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<thead>
<tr>
<th>TERM</th>
<th>DEFINITION</th>
<th>INDICATORS</th>
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<tbody>
<tr>
<td><strong>Physical Assault and Battery</strong></td>
<td>An act that causes serious bodily harm. Un-permitted touching or the threat of harm with the ability to carry it out.</td>
<td>Bruising; fractures; lacerations; reports of pushing, punching, slapping, choking, kicking; reports of using weapons or hurting children</td>
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<tr>
<td><strong>Sexual Assault/Rape</strong></td>
<td>Non-consensual sexual contact of any kind. Forcing sexual acts against someone’s will or attacking sexual parts of the body.</td>
<td>Bruises around breasts, genital area or thighs; unexplained venereal diseases or infection; unexplained vaginal or anal bleeding</td>
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<tr>
<td><strong>Psychological/Verbal Abuse</strong></td>
<td>Fear induced by intimidating looks, actions, gestures, loud voices, or threats. Unkind or harsh statements affecting ones self-esteem.</td>
<td>Isolation, stalking, criticism, humiliation, threats or other intimidation, harassment, lying, jealousy, possessiveness, manipulation, controlling of activities, monitoring calls or visitors, abusing pets/property</td>
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</table>
What You Should Know About Partner Abuse

Employees who have contact with patients should be aware of the legal aspects of partner abuse and how to respond to individuals who may be victims.

Legal Requirements:

Maryland has no law mandating the reporting of domestic violence. Disclosures of intimate partner abuse or domestic violence are confidential unless a child or a "vulnerable adult" is in suspected danger or a victim of abuse (see definition in next topic).

Should an individual choose to do so, a formal report of events can be made to local law enforcement. Victims also have the right to file for an Ex Parte order (a civil court order which directs the abuser to refrain from further abuse and refrain from further contact with the victim).

What You Can Do:

Making Referrals

The most important thing you can do is to refer all reports of domestic violence to the hospital social worker or physician. The social worker is responsible for creating a detailed assessment, counseling support, planning for the victim’s safety, and referring the victim to appropriate community resources.

Providing Reassurance

It is important to reassure victims. Tell individuals that you believe them and that they are not alone. Tell them that they do not deserve abuse or mistreatment and that the violence is not their fault. Tell them that domestic violence is a crime and that there is help in the community.
What You Should Know About Partner Abuse (Continued)

Helpful Tips:

RADAR
RADAR is a helpful domestic violence intervention:
R = Routinely Screen Female Patients
A = Ask Direct Questions
D = Document Your Findings
A = Assess Patient Safety
R = Review Options & Referrals

Asking Questions
Incorporate routine questions related to domestic violence into daily practice. Say something like “Because violence is so common in many women’s lives, I’ve begun to ask about it routinely.” Then follow these guidelines:

• Interview patients alone (without significant other or children present)
• Sit eye-to-eye with a patient; provide positive eye contact
• Ask direct questions such as:
  - “Are you in a relationship where you have been physically hurt or threatened?”
  - “Have you ever been hit, punched or slapped by your partner?”
  - “Are you afraid of anyone at home?”
  - “Do you feel safe at home?”
Part 2: Elder/Vulnerable Adult Maltreatment and Exploitation

Background

Neglect is the most common form of maltreatment reported in the elderly and vulnerable population. Statistics show that adult children are the most frequent abusers of the elderly followed by other family members and spouses.

Many victims of abuse are embarrassed or ashamed. They may be frightened of retaliation or feel guilty for being dependent, imagining they are “causing” the abuse to occur. Victims may be afraid the abuser will be prosecuted. As a result of these feelings, adult maltreatment tends to be greatly underreported. It may be hidden as a "family secret".
Who Are Vulnerable Adults?

A “vulnerable adult” is described as an adult over the age of 18 who lacks the physical or mental capacity to provide for his or her daily needs. Abuse or maltreatment of elderly or vulnerable adults happens to almost 2 million adults (per year-question asked JHMI) from all racial, ethnic and socioeconomic backgrounds. It is most prevalent toward women. Incidents may occur in patient homes or in institutions.
Risk Factors for Vulnerable Abuse

Risk factors for elder/vulnerable abuse include:

- A family history involving abusive relationships
- Mental illness or alcohol/drug dependence in patient or caregiver
- Extreme caregiver stress
- Social isolation of patient
- Declining physical or mental capacity of the patient accompanied by increasing care needs
- Economic pressures
## Definitions and Indicators of Elder/Vulnerable Abuse

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<td>Physical Abuse</td>
<td>The use of physical force that may result in bodily injury, physical pain, or impairment.</td>
<td>• Bruises, welts, lacerations, black eyes</td>
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<td>• Broken bones, joint dislocations</td>
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<td>• Untreated injuries in various stages of healing</td>
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<td>Sexual Assault</td>
<td>Non-consensual sexual contact of any kind, including sexual contact with individuals incapable of giving consent.</td>
<td>• Bruises around breasts, genital area or thighs</td>
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<td>• Unexplained venereal diseases or infections</td>
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<td>• Unexplained vaginal or anal bleeding</td>
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<td>Neglect</td>
<td>The refusal or failure to provide life necessities such as food, water, clothing, shelter, personal hygiene, medication, comfort/pain management and personal safety or supervision. Neglect can be intentional or unintentional.</td>
<td>• Dehydration</td>
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<td>• Malnutrition</td>
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<td>• Untreated wound</td>
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<td>• Poor personal hygiene</td>
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<td>• Untreated health problems</td>
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<td>• Hazardous or unsanitary living environments</td>
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| Self Neglect | Behaviors of an elderly person that threatens his or her own health or safety. These behaviors generally involving life necessities such as food, water, living environment, personal hygiene, and required medications. Self-neglect does not include older adults who are mentally competent and can fully understand the consequences of his or her actions.                                                                                     | • Dehydration  
• Malnutrition  
• Untreated medical conditions  
• Hazardous or unsanitary living environments |
| Financial Exploitation | Illegal or improper use of an elder or vulnerable adult’s funds, property, or assets. This may include such actions as cashing checks without permission; forging signatures; stealing money or possessions; and coercing or deceiving an individual into signing documents.                                                                                                           | • Sudden bank account changes  
• Abrupt changes in a will  
• Unexplained disappearance of funds or possessions  
• Sudden appearance of uninvolved family claiming their right to funds or possessions |
What You Should Know About Elder/Vulnerable Abuse

Employees who have contact with patients should be aware of the legal aspects of elder and vulnerable adult abuse and how to respond to individuals who may be victims.

Legal Requirements:
Under Maryland law health practitioners, police officers and human service workers are required to report suspected elder/vulnerable adult abuse and neglect. It is the responsibility of city, county and state agencies to investigate reports of suspected abuse or neglect.

The investigating agencies include:

- Department of Social Services, Adult Protective Services: investigates alleged elder/vulnerable adult maltreatment in domestic or community based settings.
- Department of Aging, Long Term Care Ombudsman Program: investigates alleged elder/vulnerable adult maltreatment in nursing home and long-term care facilities.
- Department of Health and Mental Hygiene, Office of Health Care Quality: investigates alleged elder/vulnerable adult maltreatment in all licensed and federally certified facilities such as nursing homes and hospitals.
- Local law enforcement: investigates alleged elder/vulnerable adult maltreatment in all settings, including community and institutional.
- Office of the Attorney General, Medicaid Fraud Control Unit: investigates and prosecutes incidents of abuse and neglect of elder/vulnerable adults residing in facilities that receive Medicaid funds.
What You Should Know (Continued)

What you can do:
The most important thing you can do is to report any suspected maltreatment or indicators of maltreatment to the hospital social worker or patient’s physician. The hospital social worker is responsible for completing a detailed assessment and reporting any suspected maltreatment to the appropriate community investigating agency. If you feel a patient has been abandoned at the hospital this should also be reported to social work for early intervention.

The following are some helpful tips:
Incorporate routine questions related to elder/vulnerable adult maltreatment into daily practice. Interview patients and caregiver separately.

Ask direct questions such as:
• “Has anyone at home ever hurt you?”
• “Are you afraid of anyone at home?”
• “Has anyone ever touched you without your consent?”
• “Has anyone ever failed to assist you when you needed help?”
• “Are you alone a lot?”
• “Have you ever signed any documents that you didn’t understand?”
Part 3: Child Abuse and Neglect

Background

Child physical abuse, sexual abuse, and neglect constitute an alarming medical and social problem in the United States. Statistics show that the numbers continue to rise from 1996-2003.

The majority of cases in Maryland involve neglect with as many as 14,411 cases investigated in 2003. There were 12,063 cases of physical abuse investigated and 4,074 cases of sexual abuse investigated in that same year.
## Definitions and Indicators of Child Abuse and Neglect

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<td>Physical Abuse</td>
<td>Any injury to a child in which a child’s health or welfare is at harm or at-risk of harm, caused by a parent, household or family member, or one who has responsibility for supervision of the child.</td>
<td>There are many indicators of child physical abuse, sexual abuse, and neglect. Signs and symptoms can range from an injury that may or may not be visible to only behavioral indicators. You may see bruising, broken bones, or failure to gain weight. Some studies show that there are medical findings in only 4% of sexual abuse cases. There are usually multiple factors present that would lead someone to suspect abuse. Medical professionals will look at all of the injuries and behaviors and determine if they are consistent with the story the family or caretaker provides. Ultimately, if there is an injury or behavior that causes suspicion one should take it seriously. You should report the injury or behavior and leave it to the professionals to determine if the child has suffered abuse or neglect. Always give the benefit of the doubt to the child.</td>
</tr>
<tr>
<td>Sexual Abuse</td>
<td>Any act that involves sexual molestation or exploitation of a child, whether injuries are sustained or not, by a parent or other person who is responsible for the supervision of a child.</td>
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<tr>
<td>Neglect</td>
<td>A minor child who is suffering, or at risk of suffering, physical or mental harm or injury from being left unattended or from a failure to give proper care and attention to a child.</td>
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</table>
What You Should Know About Child Abuse and Neglect

Employees who have contact with patients should be aware of the legal aspects of child abuse and neglect, and how to respond to individuals who may be victims.

Legal Requirements:

Any person who has reason to believe that a child has been subjected to abuse or neglect shall contact the local Department of Social Services (DSS) or local law enforcement agency. The number for Baltimore City DSS is 410-361-2235.

Reporting only requires suspicion of abuse or neglect. Reporting to DSS can be done anonymously. If done in good faith there is no liability for making such a report.

What You can Do:

If you suspect child abuse or neglect and are unsure of how to proceed, or need further guidance, you can contact the Johns Hopkins Hospital Child Protection Team. The clinical coordinator can be contacted at 410-614-6164 or one can contact the hospital operator to speak to the medical professional on call. The team is available 24 hours a day 7 days a week.

What can you do to help an adult who seems frustrated with a child? It can be uncomfortable to watch a child being mistreated by an adult in a public place. There are some things you can do to help out! Here are a few ideas:

- Avoid negative remarks. This can increase the adult’s frustration and make things worse.
- Start a conversation with the adult to direct attention away from the child. Try something like “She seems to be trying your patience. Is there anything I can do?” or “My child has gotten upset like that too.”
- If the child is misbehaving, divert the child’s attention by talking to the child.
- Praise the child and parent at the first opportunity.
Key Points

• Routinely assess patients for abuse and neglect.

• Contact your supervisor or FASAP if you believe a co-worker is a victim of abuse or encourage the co-worker to contact FASAP
  – FASAP Contact Info: www.fasap.org or 410-955-1220 or 443-997-3800

• **Domestic Violence**: refer all reports of domestic violence to the hospital social worker or physician

• **Elder/Vulnerable Adult Abuse**: under Maryland law health practitioners are required to report **suspected** elder/vulnerable adult abuse and neglect. Contact the patient’s social worker or physician.

• **Child Abuse**: Any person who has reason to believe that a child has been subjected to abuse or neglect must contact the local Department of Social Services (DSS) or local law enforcement agency.
  – Contact Info: Baltimore City DSS is 410-361-2235. Reporting to DSS can be done anonymously.
ORGAN DONATION
In Maryland, there are currently over 2400 people waiting for organ transplants. The majority are waiting for kidneys, livers, and lungs.

As a Level 1 Trauma Center, JHH is often in the position to identify and refer potential organ and tissue donors to the Maryland Donor Referral Line. The Maryland Donor Referral Line (410-242-1773) is a 24 hours referral center that activates the local Organ Procurement Organization, the Living Legacy Foundation.

Staff should be prepared to answer questions or refer family members to experts.
Types of Donors: Following Brain Death

Organ donors are classified into three types: Organ donation following brain death, organ donation following cardiac death, and tissue donation.

**Organ donation following brain death:**

- Patients must have severe cerebral impairment that meets the criteria for a Glasgow Coma Scale 3.

- Patients are on artificial life support (ex: mechanical ventilation) and end organ perfusion continues despite neurological death (patient still has organized cardiac activity).

- Organs and tissues can be recovered.

- It is important that staff do not discuss donation options with families until a consult with the Living Legacy Foundation has been made. The Living Legacy Foundation determines donation suitability.
Types of Donors: Following Cardiac Death

- Patients with severe acute irreversible central nervous system injury who do not meet the criteria for brain death and for whom the family or surrogates have decided to withdraw life-support.
- The degree of neurological injury should in all cases necessitate the need for mechanical ventilation.
- The liver, pancreas, and kidneys may be recovered.
- It is important that staff do not discuss donation options with families until a consult with the Living Legacy Foundation has been made. The Living Legacy Foundation determines donation suitability.
Types of Donors: Tissue Donation

• Tissue donation can occur when either brain death or cardiopulmonary death has been declared.
• Each potential tissue donor is evaluated on an individual basis.
• One tissue donor can enhance the lives of over 100 recipients.
• It is important that staff do not discuss donation options with families until a consult with the Living Legacy Foundation has been made. The Living Legacy Foundation determines donation suitability.
JHH has several resources to help assist families and caregivers with this process.

To support ethical organ and tissue donation and to meet the spiritual and emotional needs of families, JHH has three interdisciplinary protocols. You can view these if you are within the Hopkins’ network.

• **Organ Donation following Brain Death:**

• **Organ Donation following Cardiac Death:**

• **Death, Care After:**
Resources

Maryland Donor Referral Line, the Living Legacy Foundation

Web site: www.theLLF.org; Phone: 410-242-1173

Family Advocate

The Family Advocate is a JHH chaplain who has received special training for this role. The Family Advocate serves as a 24 hour dedicated resource for providing impartial emotional, spiritual and crisis intervention support to the family of any patient with severe neurological injury. This support is available irrespective of the likelihood of subsequent organ donation. He or she is available by paging 410-283-6000.

Transplant Coordinator

The JHH Donation Program Coordinator is responsible for supporting the donation process, education of hospital staff, data collection and monitoring of family and staff satisfaction with the organ donation process. This person may also serve as a family advocate and may be reached on beeper 410-283-6667.
POPULATION SERVED
DIFFERENCES THROUGH THE AGES

JOHNS HOPKINS
MEDICINE
INTERACTIVE
Welcome

At Johns Hopkins, our highest priority is the care we provide to patients. This care should be individualized to meet the needs of each person. One aspect of meeting a patient’s needs is to understand the unique characteristics of their age group including:

- Developmental highlights
- Safety considerations
- Service considerations
- Additional tips

In this course, you will learn about the differences and similarities of all age groups beginning with birth and ending with late adulthood. Knowing this information will help you adjust your behavior and communication to meet the unique needs of the age group with whom you are interacting.
Birth to 4 Weeks

Developmental Highlights
• Smiles randomly
• Enjoys being held, cuddled, touched, talked to and smiled at
• Cry is strong when hungry or uncomfortable

Safety Considerations
• Car seat required

Service Considerations
• Do not approach newborn directly or too quickly
• Approach primary caretaker(s) with a smile and make an appropriate comment about the newborn if the situation arises
4 to 8 Weeks

Developmental Highlights
- Makes noises with throat
- Moves eyes
- Begins to smile in response to stimulation
- Begins to follow objects with eyes
- Responds to and enjoys:
  - Mobiles
  - Human faces
  - Being held, rocked, and cuddled

Safety Considerations
- Car seat required

Service Considerations
- Do not approach newborn directly or too quickly
- Approach primary caretaker(s) with a smile and make an appropriate comment about the newborn if the situation arises
Developmental Highlights

- Smiles in response to another’s smile
- Looks around in search of speaker
- Responds differently to familiar vs. unfamiliar
- Responds to and enjoys:
  - Increased contact with family members
  - Rattles
  - Easily grasped objects
  - Free-play with hands

Safety Considerations

- Car seat required
- Do not leave baby unattended on the floor or any other surface
- Remove all objects that could be eaten if the baby is on the floor
- Remove all cords and other objects that the baby could use to strangle him or herself

Service Considerations

- Smile and talk to infant
- Do not approach newborn directly or too quickly
- Approach primary caretaker(s) with a smile and make an appropriate comment about the newborn if the situation arises
**Developmental Highlights**

- Recognizes familiar objects
- Laughs aloud
- Babbles, coos, and gurgles when talked to
- Enjoys having other people around and being talked to
- Responds and enjoys increased contact with family, physical movement, copying others, soft toys, large toys, plastic rings, *banging* toys, and block toys

**Safety Considerations**

- Car seat required
- *Baby-proof* the environment
- Remove all objects that could be harmful to the baby (e.g. cords, ropes, objects small enough to be eaten, chemicals)

**Service Considerations**

- Smile and talk to infant
- Do not approach newborn directly or too quickly
- Approach primary caretaker(s) with a smile and make an appropriate comment about the newborn if the situation arises.
Developmental Highlights

- Lets you know his/her feelings through sounds, crying, cooing
- Babbles
- Demonstrates excitement
- Vocalizes syllable sounds like *Ma, Da*, etc.
- Imitates adult sounds
- Responds to own name by vocalizing or stopping activity
- Turns head to side on hearing sounds
- Shows fears and is afraid of being separated from caretaker(s)
- Shows signs of frustration

Safety Considerations

- Car seat required
- *Baby-proof* the environment
- Make sure objects that could be swallowed are moved
- Make sure that all objects (physical, chemical, electrical, etc.) are removed

Service Considerations

- Call infant by name if known
- Make sure that the infant always has an eye on the primary caretaker(s) to avoid a strong cry (separation anxiety)

Age-Specific Care

- Involve child and caretaker(s) in the child’s care during feeding, diapering, and bathing
- Encourage child to communicate; smile
- Speak softly
- Help educate the caretaker(s)
9 to 12 Months

Developmental Highlights
• Copies sounds; says Ma-Ma and Da-da
• Responds to own name
• Imitates gestures and facial expressions
• Plays peek-a-boo
• Shakes head for No
• Responds when asked to do something simple
• Stops activity in response to No!
• Shows fear of strange voices
• Shows emotions such as anger, joy, affection, jealousy

Safety Considerations
• Car seat required
• Put small or sharp objects out of reach
• Make sure the environment is crawl- and walk-proof
• If baby is in danger, say No or No-No firmly

Service Considerations
• Play peek-a-boo with hands
• Ensure infant always has an eye on the primary caretaker(s) to avoid a strong cry (separation anxiety)
• Do not get upset if baby cries when you show up or when you talk to the infant (may show fear of strangers)

Caretaker Tips
Caretaker may experience a degree of stress while child is ill. Signs of this type of stress:
• Anger or hostility toward the staff
• Rude, uncooperative, and/or demanding behavior
• Suspicious behavior as though staff is hiding something from them
12 to 15 Months

Developmental Highlights
• Knows 2-3 words
• Jabbers expressively
• Recognizes the meaning of No, No-No
• Shows emotion, e.g. joy, anger, frustration
• May indicate when diaper is wet
• Imitates simple acts
• Understands names of people

Safety Considerations
• Car seat required
• Baby-proof the environment
• Make sure baby changing areas are clean and functional
• Make sure baby does not run out into the street, parking lot, on escalators, or on elevators

Service Considerations
• Smile and talk to baby
• Use a strong No! if the child is in danger; is likely to respond

Caretaker Tips
• Stay calm when caretakers express anger, hostility, or indifference
• Show flexibility by making changes or modifying care to help ease the pressure of the caretakers
• Say, “I realize this must be upsetting for you.” Show your understanding
• Honor the caretaker as a partner in the child’s treatment
15 to 18 Months

Developmental Highlights
• Knows 2-3 words
• Uses jargon
• Shakes or nods head to Yes and No questions
• Comprehends up to 50 words

Developmental Highlights (continued)
• Responds to and enjoys:
  - Solitary play and watching others play
  - Running
  - Water play
  - Riding toys
  - Outdoor activities
  - Throwing
  - Scribbling
  - Looking at books
  - Repetitive songs and toys
  - Push-and-pull toys

Safety Considerations
• Car seat required
• Baby-proof the environment

Service Considerations
• Smile and talk to baby
18 to 24 Months

Developmental Highlights
- Talks in two-word combinations
- Vocabulary of about 300 words
- Imitates speech
- Points correctly to body parts
- Verbalizes needs
- Obeys simple commands
- Fears parents leaving
- Has a strong sense of Mine!
- May become less willing to do what you ask
- May throw temper tantrums
- Does not readily ask for help

Safety Considerations
- Car seat required; baby-proof the environment
- Make sure that the baby does not take any object that is harmful
- Repeat command if baby refuses to obey
- Provide help if you notice that a safety issue is at hand
- Tell baby to behave safely (e.g. crossing the street)
- Protect from harm if a tantrum is thrown
- Be aware that you could get bitten, scratched, or kicked during a tantrum
- Protect property if a tantrum is thrown

Service Considerations
- Smile and talk to baby
- Make sure that baby is reassured that primary caretaker(s) will return if separated

Caretaker Tip
- Use words that caretakers will understand. Explain medical terms.
2 to 4 Years

Developmental Highlights
- Speech is 50-75% intelligible
- Talks in 3-4 to 4-6 word combinations
- Knows first and last name
- Understands long and complex sentences
- Knows physical needs
- Uses play to learn, express self, and work out fears
- Temper tantrums and negative behavior may continue

Safety Considerations
- Car seat required (until weight reaches 40 pounds)
- Explain in simple terms why certain behaviors or objects are dangerous and harmful (while removing objects from child)

Service Considerations
- Ask child if he or she wants certain foods and drinks
- Lean down and forward when interacting with child
- Honor requests to place foods in certain places, e.g. nothing touching on the plate

Caretaker Tip
Caretakers want to know what their alternatives are. They can be good partners in care if they know their choices and the consequences of each. It will help them make the best decisions for the patient.
5 Years

Developmental Highlights
• Vocabulary of 1500-2100 words
• Speech is 90-100% intelligible
• Can count to 5 -10
• Comprehends cold, tired, etc.
• Uses play to learn, express self, and work out fears; pretends
• Plays with peers; marches and swings
• Enjoys rhymes and riddles

Safety Considerations (continued)
• Explain simply to child the differences between safe and unsafe behaviors and the consequences of dangerous behavior
• Help caretaker(s) teach child safety rules

Service Considerations
• Lean forward and interact with child
• Recognize peers of child as important
• Call child by first name, by last name if appropriate, or both
• Let child make food choices
• Use toys and games to teach child and to reduce fears
• Encourage child to ask questions, play with others, talk about feelings

Caretaker Tip
Take advantage of possible teaching opportunities. Promote safety and healthy habits with 5-year-olds, such as good nutrition, personal hygiene, bike helmets, and safety belts.
6 to 8 Years

Developmental Highlights

• Uses language correctly
• Begins reading, writing, adding, and subtracting
• Attention span lengthening
• Tells time by hour
• Gives address
• Cooperative family member
• Has a concept of death

Developmental Highlights (continued)

• Enjoys:
  - Same-sex peers
  - Outdoors; competitive games
  - Board games
  - Songs; riddles and rhymes
  - Imitative play
  - Arts and crafts
  - Books and stories

Safety Considerations

• Seat belt required
• Alert child to stay focused when doing any activity, particularly outdoor activities
• Protect children who are naturally drawn to dangerous situations

Service Considerations

• Call child by name
• Interact with child and peers if it seems appropriate

Young Children
8 to 10 Years

Developmental Highlights
- Can name from memory and describe differences between objects
- Participates fully in conversation with adults
- Begins separation from family
- Learns by doing
- Understands past, present, and future
- Understands death as permanent, biological, and universal
- Becomes extremely critical of parents
- May be independent, disobedient, defiant; rejects discipline
- May glorify another family
- Tries to be more grown up

Safety Considerations
- Seat belt required
- Repeat directions firmly to protect child
- Needs to be reminded of dangerous situations
- Explain the consequences of dangerous behaviors, even those resulting in actual physical death

Service Considerations
- Interact with child as you would with an adult
- Honor their striving for independence

Caretaker Tips
- Points to remember:
  - Don’t ignore the patient while talking to the caregiver(s)
  - Don’t give painful or complicated information hurriedly or abruptly over the phone
  - Don’t use inappropriate humor or words aimed at the patient or caregiver(s)
  - Don’t give false hope
**Developmental Highlights**

- Very verbal
- Can verbalize feelings, but privately
- Understands humor
- Enjoys interacting with peers of both sexes
- Appearance becomes important
- Copies teenage dress and slang
- Continues to be self-conscious
- May worry and exhibit nervous behavior
- Awakening interest in world beyond home and community
- Can be assisted to make logical decisions

**Safety Considerations**

- Seat belt required
- No smoking under age 18
- No drinking under age 21
- Explain safe behavior using logical explanations and reasoning
- Be cautious of risky behavior when in a crowd because of peer pressure
- Model appropriate male/female relationships

**Service Considerations**

- Interact with honesty and respect
- Honor the fact that appearance and self-consciousness are important to child
- Provide comfort and assurance if you notice worry or nervous behavior
- Humor can go a long way to developing a relationship
12 to 15 Years

Developmental Highlights
• Able to interpret social classes and emotional state of others
• Able to gain and maintain attention in socially acceptable ways
• Beginning interest in dating
• Increasing concern of physical appearance
• Need for privacy continues
• Extremely idealistic
• Able to consider potential alternatives to situations not yet experienced
• Interested in making independent decisions
• Reasons through trial and error
• Has difficulty understanding consequences of their own behavior

Safety Considerations
• Seat belt required
• No smoking under age 18
• No drinking under age 21
• Explain safe behavior using logical explanations and reasoning
• Be cautious of the increasing impact of peer pressure
• Clearly communicate the immediate consequences of engaging in unsafe behavior

Service Considerations
• Interact with respect
• Pay attention to the increasing emphasis on physical appearance
• Respect the need for privacy
15 to 18 Years

Developmental Highlights

- Decisions continue to be influenced by peers and significant adults though becoming increasingly independent
- May question authority figures and seek out ways to change a situation which seems unfair
- Need for privacy continues
- Formulates sex role identity
- Experiences mood changes and unpredictable reactions; being unable to make decisions is common
- Experiments with adult behavior

Safety Considerations

- Seat belt required
- No smoking under age 18
- No drinking under age 21
- Model appropriate male/female relationships
- Enforce limits using strategies other than parental power; instead use reasoning, explanation, and self protection

Service Considerations

- Interact with respect and dignity
- Make certain not to refer to person as child, boy, girl, etc.
- Respect need for privacy
- Pay attention to increasing emphasis on physical appearance
Early Adulthood (18 to 29 Years Old)

**Developmental Highlights**

- Establishes personal identity and a residence
- Develops intimate relationships outside the family
- Establishes a personal set of values and a career that provides satisfaction, security, and a feeling of contribution

**Safety Considerations**

- Seat belt required
- No drinking under age 21
- Emphasize the consequences of being an adult from a legal perspective
- Focus on the fact that pre-teens (10-12 years) model their behavior based upon what Early Adults do

**Service Considerations**

- Interact in a way that respects the other
- Anticipate a need and meet the need
- Listen to concerns and respond
Young Adulthood (30 to 44 Years Old)

Developmental Highlights
- Continues work on the developmental tasks of early adulthood
- Manages a household, possibly some children, and a career
- Maintains friendships

Safety Considerations
- Seat belt required
- No drinking and driving
- Clearly communicate the rules and the consequences of violation the rules

Service Considerations
- Interact in a way that respects the other
- Anticipate the need and meet the need
- Listen to concerns and respond
- Be patient due to the multiple demands and priorities of managing a household, a career, friends, and maybe children
Middle Adulthood (45 to 65 Years Old)

Developmental Highlights

• Discovering and developing new satisfaction
• Helping growing and grown children
• Creating a pleasant, friendly, and comfortable home
• Balancing work with other roles
• Accepting that they are now having to take care of their aging parents
• Achieving social and civic responsibility
• Accepting and adjusting to physical changes of middle adulthood

Safety Considerations

• Seat belt required
• No drinking and driving
• Watch out for role overload and doing too much with too few resources

Service Considerations

• Interact in a respectful manner
• Be patient with the pressures of managing multiple priorities and perhaps caring for kids and aging parents (Sandwich Generation)
Late Adulthood (65+ Years Old)

Developmental Highlights

• Adapting to physical changes that accompany aging
• Redirection of energy and talents to new roles and activities
• Development of a personal view of death

Safety Considerations

• Seat belt required
• No drinking and driving
• Be alert for disorientation due to early signs of confusion and forgetfulness (dementia) or the mixing of prescribed medications
• Be alert to preventing falls and slips that might result in breaks and cuts

Service Considerations

• Interact in a way that shows respect for person, age and wisdom
• Speak in a normal volume unless you know the patient has a hearing impairment
• Walk at a normal rate unless you know that an ambulatory problem exists
• Make sure printed materials are in large print
FALL REDUCTION
Fall Risk Categories and Interventions

Introduction

Patients may be at risk of falling due to their physiological or mental status or because of treatment protocol or regimens. All inpatients are assessed for fall risk based on completion of the JHH Fall Risk Assessment tool.

High Fall Risk (Red Flag)

Criteria:

• Risk assessment tool score of >13
• Automatic high risk per fall history (during this hospitalization or 1 or more falls within the past 6 months)
• Per patient care protocol (e.g. seizure precaution protocol)

Interventions:

• Initiate basic and advanced safety interventions such as gait transfer belts, “low” beds, enclosed beds, fall alarms, etc.
Moderate Fall Risk (Yellow Flag)

Criteria:

- Risk assessment tool score of 6 to 13

Interventions:

- Initiate basic and additional fall safety interventions

Low Fall Risk

Criteria

- Risk assessment tool score of 0 to 5

Interventions:

- Initiate basic fall safety interventions
Basic Fall Risk Interventions

Basic fall safety interventions to be initiated with all patients:

**SPILLS**
- Clean spills immediately and place “Danger - Wet Floor” signs promptly
- Use properly fitted, nonskid footwear

**THE HOSPITAL BED**
- Keep bed in lowest position during use unless impractical
- Keep bed side rails up
- Secure locks on beds, stretchers and wheelchairs

**ASSISTING THE PATIENT**
- Orient patient to surroundings
- Place call light and frequently needed objects within patient reach
- Encourage patients and their families to call for assistance when needed
- Display special instructions for vision and hearing
- Assure adequate lighting

**CLUTTER**
- Remove excess equipment, supplies and furniture from rooms and hallways
- Keep floor clutter-free
- Secure excess electrical and telephone wires
Johns Hopkins provides several important resources regarding fall risk that you can download.

- **Fall Risk Assessment: Prevention and Management:**
  

- **Appendix A: Assessment Tool:**
  
Johns Hopkins provides several important resources regarding fall risk that you can download:

**Appendix B: Intervention by Risk Category:**

**Appendix C: Patient Education on Preventing Falls in Hospital:**

**Appendix D: Patient Education on Preventing Falls at Home:**
RESTRAINTS AND SECLUSION
Introduction

This is a brief overview to restraints and seclusion, a critical topic for some practitioners.

We urge you to get more in-depth information from your department if restraints and seclusions are used in your clinical practice.

Important definitions are shown below.

**Restraint** is any manual method, physical or mechanical device, material or equipment that immobilizes or reduces the ability of the patient to move his/her arms, legs, head or body freely. A restraint is designed so that it cannot be easily removed by the patient.

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

• The decision to use restraints is a difficult one, involving complex issues that pose significant risks to patients and to the hospital. When using restraints or seclusion, the practitioner must strike a balance between patient safety and the patient’s dignity and well-being.

• Failure to correctly use restraints and monitor patients who are in restraints can lead to serious injury or even death.

• A hospital may be sued for negligence if adequate precautions are not taken to protect those at risk of harming themselves or others. Hospitals are responsible for protecting impaired, elderly, incapacitated or unstable patients.

• On the other hand, hospitals have also been sued for false imprisonment when patients were restrained against their wishes.
The risk of injury from restraints is significant even when they are used and applied properly. Thus, the Joint Commission has implemented strict standards:

- The standards emphasize using alternatives to restraints when ever possible. When restraints are needed, the least restrictive type of restraint is used that is appropriate for the patient’s condition.

- The standards include detailed information about the frequency of patient assessment and documentation.

- The standards depend on the type of restraint or the use of seclusion.

- A physician’s order is required for restraints or seclusion. Complete documentation is required for all assessments.
Medicare and Medicaid

As a hospital that participates in the Medicaid and Medicare programs, JHH is also subject to the program rules which emphasize:

- The patient’s right to be free from use of seclusion or restraint of any form, as a means of coercion, convenience, or retaliation.

- Preventive strategies and alternatives to restraint and seclusion should be attempted before instituting restraint or seclusion. Refer to the JHH Restraint Policies for alternatives and least restrictive restraints.

- Use of *least restrictive* measures when restraint or seclusion is clinically justified and alternatives are ineffective. Refer to the JHH Restraint Policies for alternatives and least restrictive restraints.

- Frequent patient assessment and discontinuation of restraint or seclusion as soon as possible.

- Staff must use techniques to identify the behaviors, events and environmental factors that may trigger circumstances leading to restraints and seclusion.

- Staff must also accurately identify specific behavioral changes indicating the restraint and seclusion should be discontinued.
Restraint Protocols

To protect patients and comply with regulatory agencies, JHH has two restraint protocols and an appendix you can download:

- **Non-Violent Patient:**
  

- **Violent or Self-Destructive:**
  

- **Appendix: Types of Physical Restraint by Level of Restriction:**
  
  http://www.insidehopkinsmedicine.org/hpo/index.cfm?
Key Points

• Staff caring for patients in restraints must receive special training.

• If you have not received special training on restraints (required yearly), you should never attempt to tie or untie a patient’s restraints without asking the RN for assistance.

• Four raised side rails is now considered a restraint in some circumstances. Always check with the patient’s nurse prior to making any change to side rails.

• Always notify the patient’s nurse if you have any concerns about a patient in restraints.

• Drugs used to treat agitation and anxiety should be used for that purpose alone. These drugs cannot be used off-label.
REPORTING A CHANGE IN PATIENT CONDITION
Rationale

Did you know that a significant number of critical inpatient events are preceded by warning signs? According to the Joint Commission, an early response to changes in a patient’s condition by specially trained individual(s) may reduce cardiopulmonary arrests and mortality.
The Johns Hopkins Hospital maintains several different teams that respond to medical emergencies. For example, there are:

- Adult Code Teams
- Adult Rapid Response Team or RRT (used in inpatient areas only)
- Pediatric Rapid Response Team (also responds to codes)
- Difficult Airway Response Team (DART)
- Intubation/Anesthesia Only Team (for Adult ICUs/ED only)
- Neonatal Resuscitation Team

All teams are contacted by calling 410-955-4444 (on campus: 5-4444)
Emergency Medical Response

- Each team consists of individuals with specific training to deal with different kinds of medical emergencies.

- Staff must be aware of the existence of these different teams, their geographical boundaries and types of emergencies for which each team responds.

- For more information about responding to a medical emergency and to see a list of available teams, please copy this url for the "Cardiopulmonary Resuscitation and Rapid Response Teams" policy and enter it into your browser.
  https://hpo.johnshopkins.edu/hopkins/policies/39/48/policy_48.pdf?_=0.230549563627
How do I get the right team?

Call the Hospital’s emergency number: **5-4444**. Let the dispatcher know the 4W’s:

1. **What kind of emergency?**
   Medical, fire, or security?

2. **Who needs help?**
   Adult, child, neonate? Inpatient?

3. **Where is help needed?**
   Building, floor, room number, name, phone number.

4. **Which emergency team is needed?**
   Medical emergency (Code team), urgency (RRT), Difficult Airway Response Team (DART), pediatric patients (Pediatric RRT—same team responds to code calls and RRT calls).

If there is ever doubt about which team to call, call the adult arrest team for an adult patient and the pediatric rapid response team for a child.
The following pages have important answers to questions about the JHH Rapid Response Teams:

**What are the suggested criteria for activating Adult RRT calls?**

- General concern (from patient, family or staff) that the individual- “just doesn’t look or feel right”
- Change in mental status and/or level of consciousness.
- HR <45 or >130
- RR <8 or >30
- O2 saturation <90% despite 60% O2
- New seizure or prolonged seizure
- In Neuroscience population, Na+ <130 or >155
Activating Adult Rapid Response Team

Who should activate the Adult Rapid Response Team?

- Any staff member can activate the adult RRT.
- Patients and families should be encouraged and educated to seek assistance if the patient’s condition changes or worsens.
- In Adult units, the RN can assist the patient and family with the notification of the appropriate RRT team.
Activating Pediatric RRT Calls

What are the suggested criteria for activating Pediatric RRT calls?

- General concern (from patient, family or staff) that the individual- “just doesn’t look or feel right”
- Change in mental status and/or level of consciousness
- Worsening respiratory status (e.g., significant change in respiratory pattern and rate, increased oxygen requirements, decreased saturations)
- O2 saturation <90% despite 60% O2
- Seizure with apnea
- Circulatory compromise (e.g., hypotension, poor perfusion, decrease urine output)
- Cardiac or respiratory arrest
- SVT (pulse > 220)
- Sudden onset of confusion, numbness and weakness, vision loss, severe headache, dizziness or imbalance (stroke symptoms)
Who should activate the Pediatric Rapid Response Team?

- Pediatric RRT responds to both urgent (RRT) and emergent (code) situations
- Any staff or family member can activate the pediatric RRT
- Families should be encouraged and educated to seek assistance if their child’s condition worsens
- Families can directly activate the Pediatric RRT Team
- Directions for activating the team are posted in all pediatric patient rooms or they can ask their RN for assistance

REMEMBER: Pediatric RRT responds to both urgent (RRT) and emergent (code) situations.
When and how should the Neonatal Rapid Response Team be called?

• This team would get called anytime a baby is being born outside of the delivery room.
• The Neonatal RRT responds to both urgent (RRT) and emergent (code) situations in newly born infants.
• This team is not for other infants or children who are covered by the Pediatric RRT.
• Activate the Neonatal RRT by calling 5-4444 (or 410-955-4444) and letting the dispatcher know that you have a newborn infant that requires the Neonatal RRT.
# Key Points Summarized

<table>
<thead>
<tr>
<th>Situation</th>
<th>Appropriate Team</th>
<th>Important Note</th>
</tr>
</thead>
<tbody>
<tr>
<td>Change in <strong>Adult Patients</strong> from outpatient, testing, and procedure areas</td>
<td>CODE TEAM</td>
<td>The Adult Rapid Response Team (RRT) does not cover outpatient, testing and procedure areas</td>
</tr>
<tr>
<td><strong>Pediatric Patients</strong></td>
<td>PEDIATRIC RRT for both rapid response and codes</td>
<td>Make sure to specify that you have a pediatric emergency and request the Pediatric RRT</td>
</tr>
<tr>
<td><strong>Neonatal Patients</strong> (any delivery outside of the delivery room)</td>
<td>NEONATAL RRT</td>
<td></td>
</tr>
<tr>
<td><strong>Adult Visitors, Parents, or Staff</strong> who need emergent help (even in the Children’s Center)</td>
<td>ADULT CODE TEAM</td>
<td></td>
</tr>
</tbody>
</table>
Topics in this module:
• Hand Hygiene
• Standard Precautions
• Transmission-based Viruses
• Respiratory Viruses
• Prevention of Central Line-associated Blood Stream Infection (CLABSI)
• Prevention of Surgical Site Infection (SSI)
• Prevention of Ventilator-Associated Pneumonia (VAP)
• Catheter-Associated Urinary Tract Infections (CAUTI)
# Tuberculosis

## The Basics

**At-risk Populations:** people who are HIV positive, homeless, incarcerated, immunocompromised or from countries with a high-incidence of tuberculosis

**Signs and Symptoms:** Cough, new infiltrate, fever, night sweats, weight loss, hemoptysis, and/or fatigue.

## Policies

- Annual TB Testing is required for all Hopkins’ employees engaged in patient care or who enter patient care areas. **TB Hospital Policy**
- Only HEIC can remove a patient from airborne precautions, call: 5-8384 pager: 410-283-3855

## Infection Control Strategy:

Place the patient on airborne precautions upon admission

- Negative pressure room, PAPRs or Fit-tested N95 respirator
- Provide surgical mask (not PAPR) to the patient if out of his/her room
About Flu and Respiratory Viruses

Epidemics of influenza and RSV occur each winter. Influenza alone causes ~36,000 deaths and >200,000 hospitalizations annually.

Timing is variable so surveillance is conducted to determine when to institute prevention and control measures.

The Respiratory Virus Policy (IFC022) provides guidance on prevention and control measures.

Additional information relevant to the specific season is posted on the HEIC website.
To keep yourself healthy and to prevent the spread of respiratory viruses to and between your patients, follow this prescription.

1. Receive influenza vaccine each year. It is available free of charge from Occupational Health. Influenza vaccination is mandatory for all staff.

2. Stay home if you have a fever and respiratory symptoms. You must be cleared by Occupational Health before returning to work.

3. Cough or sneeze into your sleeve.

4. Wear a mask for patient care if you have respiratory symptoms but no fever.

5. Always practice good hand hygiene.
The Path For Patient Care

Patients suspected of having a respiratory virus must be placed on droplet precautions and tested.

All patients who test positive for Influenza, RSV, Adenovirus, Parainfluenza, rhinovirus or Human Metapneumovirus must remain on droplet precautions until asymptomatic. Some patients also require a negative test.

Call HEIC (5-8384) to remove patients from droplet precautions.

You must assess all inpatients and ED patients for respiratory viruses. Respiratory testing varies for immunocompromised and immunocompetent patients.
Prevention of Central Line-Associated Blood Stream Infection

CLABSIs are associated with **POOR OUTCOMES**

- 500 to 4,000 U.S. patients die annually due to CLABSIs
- Average increased length of stay is 7 days
- Estimated cost per CLABSI is $3,700-29,000

Central lines are used on 48% of ICU patients.

PUBLIC INFORMATION

CLABSI rates in Maryland ICUs are being reported to the state and are available to the public.
# CLABSI Prevention Techniques

<table>
<thead>
<tr>
<th>Line Insertion</th>
<th>Line Maintenance</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Perform hand hygiene before and after catheter insertions or manipulation</td>
<td>1. Perform hand hygiene before and after catheter insertions or manipulation</td>
</tr>
<tr>
<td>2. Use chlorhexidine for skin preparation</td>
<td>2. Hub care</td>
</tr>
<tr>
<td>3. Use full barrier precautions during insertion</td>
<td>3. Site care</td>
</tr>
<tr>
<td>4. Avoid using the femoral site in adult patients</td>
<td>4. Tubing care</td>
</tr>
<tr>
<td>5. Assess the need for the catheter each day and remove ASAP</td>
<td>5. Assess the need for the catheter each day and remove ASAP</td>
</tr>
</tbody>
</table>
CLABSI Prevention: Insertion

*Tabs - 5 Tabs (Including Introduction)*

Last Modified: Mar 04, 2014 at 08:27 PM

**PROPERTIES**

Show interaction in menu as: **Single item**

Allow user to leave interaction: **After viewing all the steps**
CLABSI Prevention: Maintenance

Process - 4 Steps (Including Introduction)

Last Modified: Mar 04, 2014 at 08:28 PM

**PROPERTIES**

Show interaction in menu as: Single item

Allow user to leave interaction: After viewing all the steps
PRE-OPERATIVE INTERVENTIONS

• Identify and treat remote infections
• Postpone elective procedures until remote infection resolves
• Control glucose (HA1c to <7%)
• Encourage cessation of pre-operative smoking (>30 days prior)
• Chlorhexidine bathing the night before and day of surgery
For the Patient
• If hair removal is necessary, use clippers, not razors
• Allow skin antiseptic to dry
• Maintain normothermia (>36.0°C)
• Control serum glucose (<200)
• Deliver antimicrobial prophylaxis
  – Use the right agent, right dose, right timing (within 1 hour before incision)
  – Re-dose every 3-4 hours, for > 1500cc blood loss
  – Ensure proper dose for obese patients

For Invasive Procedure/OR Personnel
• Proper attire with masks tied (completely covering nose and mouth)
• Hair covered
• No jewelry
• Proper surgical scrub of hands and nails
• Proper aseptic and sterile technique
• No artificial nails
• Control OR traffic
POST-OPERATIVE INTERVENTIONS

- Cover incision with a sterile dressing
- Perform hand hygiene and use sterile technique for dressing changes
- Control blood glucose (<200)
- Maintain normothermia
- Discontinue prophylactic antibiotics (unless indicated)
Ventilator Associated Pneumonia Prevention

86% of healthcare-associated pneumonias are associated with mechanical ventilation: more than 250,000 cases/year occur in the U. S.

- Maintain the head of bed between 30-45 degrees
- Chlorhexidine oral care for all adult intubated patients
- Subglottic ETT tubes for patients expected to be intubated for greater than 72 hours
- Daily sedation vacation
- Daily assessment of readiness to extubate
Impact of Catheter Associated Urinary Tract Infections

- 12-25% of all hospitalized patients have a urinary catheter inserted
- Risk of CAUTI increases by 3-7% each day that a urinary catheter is in place
- 80% of healthcare associated UTIs are catheter related
- Morbidity and cost per case are low but potential for sepsis and death exist
- Cumulative burden of CAUTI is substantial
CAUTI Prevention Strategies

Avoid indwelling catheters and minimize duration of placement
  • Evaluate the need for catheter daily

Consider alternative methods of catheterization
  • Diaper
  • Condom catheter
  • Suprapubic catheter
Foley Insertion and Maintenance Care

• Practice hand hygiene
• Place with aseptic technique
• Secure catheter after insertion to prevent movement or urethral traction
• Unless obstruction is anticipated (e.g., bleeding after prostatic or bladder surgery) bladder irrigation is not recommended
  – If obstruction is anticipated, closed continuous irrigation suggested to prevent obstruction
• Maintain a closed drainage system
  – Risk of developing CAUTI doubles in the 24 hours after disconnection of the catheter from collecting tube
• Maintain unobstructed urine flow (no kinking of bag or catheter)
  – Never allow bag to sit on the floor
  – Don’t lift the drainage bag above the bladder level (pertains to mobile patients too. Educate patient on proper ways to secure foley when mobile)
• Routine perineal and foley care during daily bathing/showering is recommended.
  – Comfort Bath products (including Chlorohexidine cloths) can be used for routine cleansing. Always use a separate cloth for the perineum.
### Infection Prevention and Control Resources

- **HEIC Contact Information:** Office 410-955-8384; Emergency Pager 410-283-3855
- **HEIC Intranet Website:** [http://intranet.insidehopkinsmedicine.org/heic](http://intranet.insidehopkinsmedicine.org/heic)
- **HEIC Internet Website:** [http://www.hopkinsmedicine.org/heic/index.html](http://www.hopkinsmedicine.org/heic/index.html)
- **Hospital Policies Online for all HEIC policies and Patient Education tools:** [https://hpo.johnshopkins.edu/hopkins/?event=manual&manualid=39](https://hpo.johnshopkins.edu/hopkins/?event=manual&manualid=39)
- **CDC’s HAI Website:** [http://www.cdc.gov/hai/](http://www.cdc.gov/hai/)
- **Association for Professionals in Infection Control (APIC):** [http://www.apic.org](http://www.apic.org)
- **Society for Hospital Epidemiology of America (SHEA):** [http://www.shea-online.org/](http://www.shea-online.org/)
- **Maryland Healthcare Commission (Hospital compare):** [http://mhcc.maryland.gov/consumerinfo/hospitalguide/index.htm](http://mhcc.maryland.gov/consumerinfo/hospitalguide/index.htm)
- **Maryland Hospital Association Website:** [http://www.mhaonline.org/](http://www.mhaonline.org/)
The Johns Hopkins Hospital Stroke Center

- Stroke is the nation's fourth leading cause of death.
- Currently the Johns Hopkins Hospital (JHH) is designated as a Joint Commission and Maryland Institute for Emergency Medical Services Systems (MIEMSS) Comprehensive Stroke Center.
- Stroke education is an important mission of the center. Early recognition of stroke symptoms is imperative so the patient is treated promptly.
- Brain Attack Teams have been established to emergently treat patients with stroke.
Signs and Symptoms of Stroke

It is important to recognize these sudden changes which may indicate stroke:

• Numbness or weakness of face, arm or leg
• Confusion, trouble speaking or understanding
• Trouble seeing in one or both eyes
• Trouble walking, dizziness, loss of balance or coordination
• Severe headache with no known cause
Stroke

• If signs and symptoms of stroke are present outside of the hospital, call 911 immediately.
Brain Attack Team

• In the event the patient has signs and symptoms of stroke within a JHH non-clinical area (e.g., hospital lobby, cafeteria, or Outpatient Center), call x5-4444.
Brain Attack Team

• In the event the patient has signs and symptoms of stroke within a JHH clinical area, contact the BAT and Primary Team immediately.

• TO NOTIFY THE BRAIN ATTACK TEAM (BAT), call HAL (Hopkins Access Line) at x5-9444.
  – If the BAT Team is delayed in responding (longer than 6 minutes), please call the HAL Line again at x5-9444, and ask to speak with the Stroke Attending on call.
Summary

- TIME IS BRAIN SO KNOW THE SIGNS AND ACT IN TIME.